

## The practice of pediatric dentistry isn't what it used to be

The pediatric dentist encounters many problems today: high office overhead costs, reduced dental needs of the young child (except in certain areas of the country), ever-increasing paperwork related to insurance programs and employee benefits. But would we want to return to what some often refer to as the "Golden Days of Dentistry" from several decades ago?

There are a few members of our Academy who began practicing or teaching soon after World War II. In those days no one talked of the busyness problem. More child and adult patients were seeking dental care than could be accommodated. What else can these Academy members recall? There are many not so pleasant memories.

Almost every preschool child who came to the dental office in the 1940s and 1950s had rampant caries. Parents did not usually bring the child to the dental office until just before first grade. By then there was often irreparable damage to the teeth and developing dentition. Preventive measures included teaching improved oral hygiene, restricting refined carbohydrates, and taking the *Lactobacillus acidophilus* count to check on the child's compliance with the dentist's recommendation on refined sugar restriction. Topical fluorides were not introduced until the early 1950s and most large communities were without water fluoridation adjusted to 1 ppm.

Black copper cement and Fleck's red copper cement were used extensively to restore posterior primary teeth. These materials were used because it was theorized that their germicidal properties would prevent the progression of any remaining caries. Base plate gutta percha also was used as a temporary restoration for primary teeth. Many general practitioners felt that the pulp of the primary tooth was too large to allow a conventional silver amalgam cavity preparation and restoration. Silicate cement, the only tooth-color material, was used to restore proximal lesions in anterior teeth, and there were many of them. It was common practice for the dentist to disk the proximal surfaces of the carious anterior primary teeth and apply Howe's Ammoniacal silver nitrate and

reduce it with oil of cloves or eugenol. As a result of this treatment, many children hesitated to smile because they would show tapered, blackened teeth.

Restoring a fractured anterior tooth was a real challenge because the acid etch resin technique had yet to be introduced. The only restoration that could be placed successfully on a fractured anterior tooth was a modified three-quarter cast gold crown with the incisal area filled with silicate cement. At best this was an esthetically poor restoration.

Arsenic materials often were used to devitalize the remaining pulp in primary teeth that had carious pulp exposures. Local anesthetic solutions were not nearly as effective as those of today, and "pressure anesthesia" was often utilized to anesthetize inflamed pulp tissue in primary and permanent teeth. A pellet of cocaine was placed over the pulp exposure site and covered with a moistened pledget of cotton; pressure then was applied to the cotton to force the solution into the pulpal tissue.

Ethyl chloride was often used as an analgesic inhalant, and steel burs in conventional belt driven handpieces at speeds of 7000-8000 RPM were used to laboriously prepare cavities in permanent teeth.

Dental auxiliaries were not utilized routinely in the dental office. Dental hygienists were in short supply, since only a few dental schools offered dental hygiene training programs. Not until the early 1960s were dental assisting training programs developed to provide the dentist with auxiliaries trained in 4-handed dentistry.

Advances in preventive dentistry, dental materials, and dental equipment have changed the practice of dentistry for children almost beyond the dreams of those who founded our Academy in 1947. They would agree that dentistry for children, now referred to as the practice of pediatric dentistry, isn't what it used to be—*Thank Goodness*.

