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Editorial

The expanding role of the pediatric dentist — dental care for the adolescent

A short time ago I was attracted by a headline in a midwestern newspaper, *The Newest Specialty — Doctors Who Serve Teens.* The article focused on a group practice of physicians who limit their patients to adolescents — the only MDs in the state whose training and practice are geared exclusively to persons 10-21 years old. As a subspecialty, adolescent medicine is relatively new, created in 1952 by a Boston internist who developed the nation's first clinic for adolescent health care. In 1977 the American Medical Association, responding to a variety of cultural, psychological and biological trends, formally recognized the area as a unique branch of medicine similar to geriatrics and neonatology.

Our Academy members have been reminded by Machen (1987) that adolescents currently comprise 20% of the nation's population and that this percentage will remain the same or decrease slightly in the year 2000. He also noted that historically the adolescent has been perceived as a dental patient with an increase in dental caries due to a larger intake of refined carbohydrates, superimposed on careless oral hygiene habits.

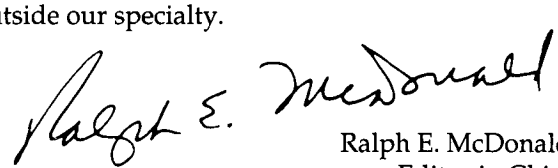
As a result of the unique nature of adolescent dental problems, the American Academy of Pediatric Dentistry has taken the position that the long-term health of the permanent dentition is more likely to be assured if the dental needs of the adolescent are under the care of a pediatric dentist.

While it is true that the dental caries rate is declining, the problem remains a serious one in the adolescent patient. In addition, there are particular psychological and social problems that the pediatric dentist may encounter during treatment of these patients. During adolescence many teens, especially girls, who have been somewhat chubby throughout childhood become very conscious of their appearance and begin to restrict their food intake. When this reduced appetite is carried to the extreme, anorexia nervosa results. This condition can be life threatening and is currently the most prevalent eating disorder in U.S. adolescent girls.

A failure to gain weight during the active preadolescent growth phase or the sudden loss of weight in adolescence should alert the pediatric dentist to the possibility of a developing anorexic state. The condition may be associated with various personality changes, such as irritability, increased compulsiveness, striving for perfection, physical overactivity, and withdrawal from social interest, all of which may well signal the onset of anorexia nervosa. The dietary deficiencies associated with this condition may also contribute to a decrease in the amount and pH of saliva and an increase in dental caries susceptibility. Gingivitis also may be noted when anorexia nervosa (self-induced starvation) and bulimia (a cycle of food binges followed by self-induced vomiting or laxative/diuretic abuse) occur. Also, there may be damage to the dentition; a type of tooth destruction (erosion) that is more severe on the lingual surface of the teeth.

The pediatric dentist is aware that in the teenage patient he/she should look for evidence of juvenile periodontitis, an aggressive form of the disease that affects the first permanent molars and often the incisors. Effective treatment modalities of juvenile periodontitis of both the generalized and localized types include surgery and the use of tetracyclines. Early treatment of this disease can prevent a devastating loss of permanent teeth in the late adolescent and early adult years.

As noted by Baer (1987), the adolescent age group can be a difficult age group for the health professional to work with and the success rate initially may be low. However, as health professionals, and particularly as pediatric dentists, we must strive to communicate with adolescents. Also, if we detect problems beyond our scope, we should have a referral system to send these patients to competent health professionals outside our specialty.



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