Infant dental care — persistence and finesse

James Baker isn't the only one conducting quiet diplomacy. Our own Academy leadership has been working behind the scenes to lobby for a variety of pediatric dental health issues with the American Academy of Pediatrics and other groups concerned about the health of children. One of the most notable issues is infant dental care. A few years ago, this was a dead issue. The first dental visit was, plain and simple, at three years of age — case closed, no discussion. Despite resistance from the medical community and passivity by our own dental colleagues, the Academy advocated a first visit between six and 12 months of age. A few pediatric dentists took on the establishment and publicly advocated this change on behalf of the dental health of children. Many more quietly went about the business of developing the concept of early intervention into a way of practice.

On a national level, our dental diplomats began planting the seeds of interest in the minds of those concerned with improving health for all children. We were able to catch the attention of such groups as Women, Infants and Children, and Healthy Mothers, Healthy Babies National Coalition, largely because of the continuing problem of nursing caries. Preventive dental care is being spoken about in the same breath as prenatal counselling and family planning. In at least one of the proposed national health bills, dental prevention is cited as a priority. Recently, our leadership has turned again to the American Academy of Pediatrics to address this issue. The outlook for a change looks brighter, but it hasn't happened yet.

The pursuit of a change in the accepted age of the first dental visit looked at first like a dog chasing its tail. We would argue that early intervention would stop nursing caries, increase fluoride adequacy in more children, identify some dental problems early, and head off others in some of the more difficult-to-treat patients, such as the handicapped. The pat response from opponents was that no data existed to show a cost-benefit from early intervention. The impasse was broken by those child health advocates who recognized that growing segments of the population — the poor and the underserved — still had problems with dental caries and traditional strategies were not working. The problem of nursing caries in these populations stands out like a sore thumb. Many of these advocates are veterans of the Head Start experience and know the dental needs of young children and the benefits of intervention.

When opponents of infant dental intervention begin to talk about the issue logically, they realize that no data support the age of three years! As well as anyone can recall, age three seemed as good a time as any, since all the primary teeth were present. It may well be that, at the time, finding a dentist to see a child younger than three was nearly impossible! The time has come for us to be as critical of an arbitrary choice of three years of age as we are concerned about justifying earlier intervention.

The work of our leadership in this arena of advocacy should create optimism for a change in the recommended age for the first dental visit. Some medical and general dental colleagues already have "jumped ship" and have advocated earlier intervention. Excerpts from the professional literature range from a hint that early dental intervention may help to frank advocacy of the practice.

Other reasons for optimism that early intervention may become the standard of care are all around us. The new possibilities for predicting caries experience using *Streptococcus mutans* testing, advances in adhesive composite technology that will allow placement of sealants on moist tooth surfaces, the persistence of nursing caries despite efforts at education (and the condition's staggering cost), and the declining willingness of practitioners to use sedation all speak to a need to address dental health at an earlier age. The lagging response of the poor and minority populations to traditional preventive approaches which reduced caries for others eventually must lead to clinical studies with infant dental intervention on a grand scale.

It is not unreasonable to predict, as well, that demand will create the standard for us. For most parents, the cost of an initial visit is well worth the benefit of disease prevention. As the debate on the relative infection risks of different "exposure-prone" procedures continues, the potential "insurance" against future exposure afforded by early prevention sounds better and better to more and more of the American public. Public health officials concerned with populations prone to nursing bottle caries would be foolish to ignore the benefits of this practice. Don't be surprised to see a selective application of the practice to some groups without clinical studies.

We have the efforts of our own colleagues to thank for the current momentum. The untiring diligence of members of the Dental Care Committee, our liaison representatives with the American Academy of Pediatrics, and our officers – often working with American Society of Dentistry for Children counterparts — has meant the difference. What was once considered overtreatment is now gaining recognition as a beneficial and important aspect of infant health. The greatest diplomatic test may lie ahead. As one pediatrician colleague told me recently, "I agree with early dental intervention... as long as I can provide it!" The diplomacy will lie in negotiating the roles of dental and medical providers, but more so in helping our medical colleagues recognize their own limitations in this area because of the lack of education in medical schools and residencies.

The role of individual members is clear. The medical community at the state and local level needs education and greater awareness of the benefits of the practice of early intervention. Have lunch with a medical colleague — pediatrician or family practitioner — and talk about some of the children with nursing caries you've shared as patients. Tell that colleague what you're doing for infants and talk about what he or she can do as well. A grassroots movement coupled with the efforts at the top may be all it takes to make infant dental intervention a reality for all children.

Pediatric Dentistry, The Journal of the American Academy of Pediatric Dentistry promotes the practice, education and research specifically related to the specialty of pediatric dentistry.

Pediatric Dentistry is the official publication of the American Academy of Pediatric Dentistry, the American Board of Pediatric Dentistry, and the College of Diplomates of the American Board of Pediatric Dentistry. The Academy invites submission of reports of original research, case history reports, scientific review articles, editorials, statements of opinions pertinent to pediatric dentistry and papers of scientific, clinical, and professional interest which are presented at the annual sessions of the Academy. Contributions do not necessarily represent the views of the Academy, nor can the Academy guarantee the authenticity of any research reported herein.

Pediatric Dentistry (ISSN 0164-1263) is published bimonthly in February, April, June, August, October, and December. Second class postage paid at Chicago, Illinois and additional mailing offices. *Publications Department:* American Academy of Pediatric Dentistry, 211 E. Chicago Ave., Suite 1036, Chicago, IL 60611-2616. Return postage guaranteed.

Subscription Information: Contact American Academy of Pediatric Dentistry, Publications Dept., 211 E. Chicago Ave., Suite 1036, Chicago, IL 60611-2616. Subscription rates: NONMEMBERS — individual subscription - $65; institutional - $80 (add $35 per volume for delivery outside USA); single copies - $17 (add $6 per issue for delivery outside USA). MEMBERS receive *Pediatric Dentistry* as a benefit of membership and can order back issues at $45 per volume and $14 per single issue. Checks and money orders in US dollars payable to American Academy of Pediatric Dentistry. Cancellations are not accepted.

Change of Address: POSTMASTER: send address changes to *Pediatric Dentistry,* American Academy of Pediatric Dentistry, 211 E. Chicago Ave., Suite 1036, Chicago, IL 60611-2616. Six weeks' advance notice required. Claims for nondelivery must be made to this address within 30 days (US) or 60 days (foreign) of issue date.

Advertising: All inquiries and insertion orders for retail and classified advertising should be sent to Advertising Manager, American Academy of Pediatric Dentistry, 211 E. Chicago Ave., Suite 1036, Chicago, IL 60611-2616. Telephone inquiries can be made at 312-337-2169.

Pediatric Dentistry reserves the right to accept or reject all advertising submitted as well as the right to withdraw any ad. Placement of an advertisement in *Pediatric Dentistry* should not be construed as an endorsement by the Publications Dept. or the American Academy of Pediatric Dentistry.