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Editorial

Do we ever learn?

'Little can be accomplished for the grown-up people: the intelligent man begins with the child.'

– J. W. Goethe (1749–1832)

Dentistry is a fascinating branch of medicine. The development of methods, technologies and materials to rehabilitate diseased dentitions and improve aesthetics has exploded. In dental journals and textbooks, we are swamped with glossy possibilities and high-tech restorative solutions which benefit patients, but also challenge and stimulate dentists. In fact, most dental resources are used to repair and re-repair the dentition of the adult population. Of course, it is only a good thing if treatment needs can be solved in ways which guarantee function, aesthetics, durability and the patients' full satisfaction.

Most dental restorative treatment from childhood to old age has a clear relationship to caries in younger people, the treatment of primary carious lesions, and later in life, recurrent caries, failed restorations (e.g. root fillings and bridge works) and other complications. In a broad sense, you can say that most restorative treatment is a result of failed prevention, or measures which came too late, combined with low dental awareness and lack of knowledge.

From the patients' point of view, surely, the ideal situation would be to have healthy teeth without restorations. We know that caries starts early in life, and there is also a clear positive relationship between early caries and caries later in life. We also know that that the multi-factorial caries disease has to be looked upon as a result of attitudes, knowledge, dental awareness and social factors (e.g. factors which are closely related to the patient/family itself). Theoretically, the earlier that caries disease control is achieved, the better oral health will be from a lifelong perspective.

In this issue of the journal, a paper describes the detrimental effect of high caries prevalence on the general health and well-being of pre-school children. The quality of life of these individuals improved dramatically after comprehensive dental treatment under general anaesthetic. Another paper in this issue describes high caries prevalence in young African children, and how it can be related to social and behavioural factors. Therefore, even if caries has decreased in children in the western world during the past few decades, there is strong evidence today that the dental profession has great difficulties in controlling caries in the population of young children. Recently, however, there have been several encouraging attempts in children's dentistry to intervene in the caries process early in the child's life. The introduction of the interceptive caries treatment philosophy, fissure sealing programmes and minimal invasive dentistry will, if used continuously, result in a dramatic improvement in oral health over time.

In most societies, it will be difficult for dental teams to reach very young children and their families so as to inform and instruct them about caries control measures, and importantly, base this on behavioural science. A possible way to intervene successfully in the behaviour of the youngest children is to integrate oral health messages and measures in the general health information that is given

to most children during the first 1–2 years of life by child health personnel. At the age of 2–3 years, at the latest, children should be under the control of the dental team.

Increasing dental awareness and introducing caries control measures early in a child's life should be priorities for all dentists given the responsibility and privilege of working with children. It is the only way to secure good oral health for life: Do we ever learn?

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