Oral Health Care for the Internationally Adopted Child: A Case Report

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ABSTRACT

While the health considerations of the internationally adopted child have been widely discussed in the medical scientific literature, there has not been substantial discourse on the oral health needs of international adoptees. The purpose of this case report is to review some of the medical implications associated with international adoption and, more importantly, highlight some of the potential oral health complications present in this at-risk group of children. (*J Dent Child*. 2004;71:190-192)

KEYWORDS: INTERNATIONAL ADOPTION, ORAL HEALTH CARE

In 2002, 20,099 children were adopted internationally by families in the United States. Although they were from more than 20 countries, the majority of these children came from China, Russia, Guatemala, South Korea, and the Ukraine (Table 1).[1] As the numbers of internationally adopted children continue to increase, the contemporary health care team must be prepared to address some of the unique challenges associated with these children and their families. The total health of the adopted child must be assessed, including the child's oral health condition. The purpose of this case report was to review some of the medical implications involved in international adoption and highlight the special oral health care needs and concerns of the internationally adopted child.

GENERAL HEALTH ISSUES

The health status and management of internationally adopted children have been previously discussed in the scientific literature.[2-7] In poor-resource countries, the prevalence of infectious diseases such as tuberculosis and intestinal parasites is high, and prenatal screening for infectious diseases such as syphilis, hepatitis B, and HIV infections is uncommon.[2] Post-adoption screenings for international adoptees are important for the health of the child and his or her family and community.

Current recommendations for laboratory examination may include:

1. hepatitis B surface antigen, surface antibody, and core antibody;
2. HIV testing;
3. Mantoux test;
4. stool examination for ova and parasites;
5. rapid plasma regain for syphilis;
6. complete blood count with erythrocyte indices;
7. Hepatitis C virus testing.

An assessment of the child's immunization status, as recommended by the American Academy of Pediatrics' Committee on Infectious Diseases in the *Red Book*, should be a priority.[3] Most experts also recommend pretravel counseling and vaccination updates for parents traveling to bring home their adopted children.[4]

The psychological implications for the adopted child are of great importance as well. International adoption raises unique issues and challenges for the child and adoptive parents. The child's emotional vulnerability, including fears of rejection, loss, grief, identity, and feelings of shame and/or guilt, must be addressed by qualified health care practitioners.[5] Pediatric health care professionals should work to foster positive parent-child relationships. This relationship has been shown as a strong resource for parents during challenging times of behavioral and emotional growth and discovery.[6] Parents and health care professionals should make every attempt to enhance the children's self-esteem and decrease their emotional vulnerability.[7]

ORAL HEALTH ISSUES

Little attention in the scientific literature has been given to the oral health care of internationally adopted children. It has been shown that the dental health of immigrant children is significantly poorer than that of nonimmigrant children.[8] Furthermore, research has suggested that immigrant children have more unsatisfactory dietary habits and a higher frequency of carious and filled teeth.[9] According to the American Academy of Pediatrics' Policy Statement on Oral Health Risk Assessment, the prevention of caries in children is dependent upon identifying

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Table 1. Countries of Origin (Top 5)	
Birth country	No. of adopted children
China	5,053
Russia	4,939
Guatemala	2,219
South Korea	1,779
Ukraine	1,106

high-risk individuals at an early age.[10] Unfortunately, the availability of dental services is often nonexistent prior to the internationally adopted child coming to the United States. Since dental caries in children is 5 times more common than asthma and 7 times more common than hay fever,[11] care must be taken to screen the internationally adopted child for oral health problems and disparities.

Every internationally adopted child should begin to receive oral health risk assessments soon after his/her homecoming. The Caries Risk Assessment Tool provided by the American Academy of Pediatric Dentistry[12] may be used to determine the relative risk of caries of the patient. While information regarding foster/institutional care related to international adoption may be incomplete, questions directed at newly espoused dietary practices, behavior reward systems (ie, candy or sugary snacks given as rewards for appropriate behavior), fluoride exposure, and oral hygiene should be an integral component of the initial health assessment performed by the pediatric health care professional. International adoptees with special health care needs, from low socioeconomic backgrounds, with demonstrable caries, plaque, demineralization, and/or staining, and/or having a history of bedtime bottle/sippy cup use should be immediately referred to a dentist for the establishment of a dental home.[13]

Internationally adopted children suspected of having untreated dental and/or oral health care needs often require comprehensive oral examinations, dental radiographs, and oral physiotherapy instructions focused on improving oral hygiene. In cases of severe caries experience and/or cooperation problems, children may require in-depth care, which may include procedures performed under oral sedation or general anesthesia. The number of internationally adopted children seen in the Pediatric Dental Clinic at the University of Kentucky is following national trends and continues to rise. The following brief case report provides an example of some of the internationally adopted child's special oral health care needs.

DESCRIPTION OF CASE

A five-year-old girl was presented to the Pediatric Dental Clinic at the University of Kentucky in September 2003. She was seen in the pediatric dentistry clinic 1 week after arriving in the U.S. In the interim, she visited her pediatrician for an initial evaluation and assessment. Her pediatrician performed an oral screening examination and immediately referred her to the University of Kentucky Pediatric Dental Service. Her dentition was mutilated by caries, and comprehensive dental therapy was required.

Due to the patient's severe dental disease, acute situational anxiety, and inability to cooperate in the normal dental setting, it was determined that her needs could best be fulfilled in the operating room under general anesthesia. During her surgery, it was discovered that her needs were greater than originally thought (Figure 1). She required multiple full coverage metal crowns, silver (amalgam) fillings, and resin restorations. She also needed pulp therapy for her lower left

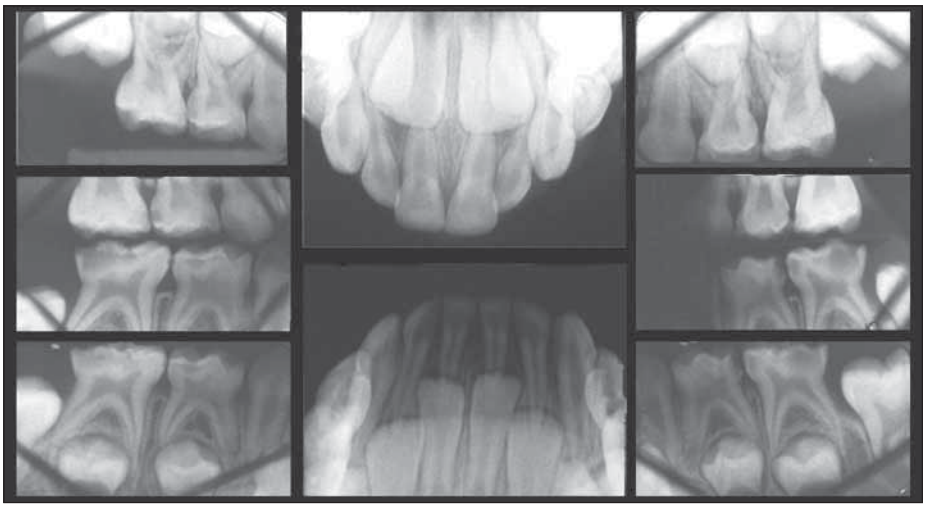

Figure 1. Intraoperative pretreatment radiographs.

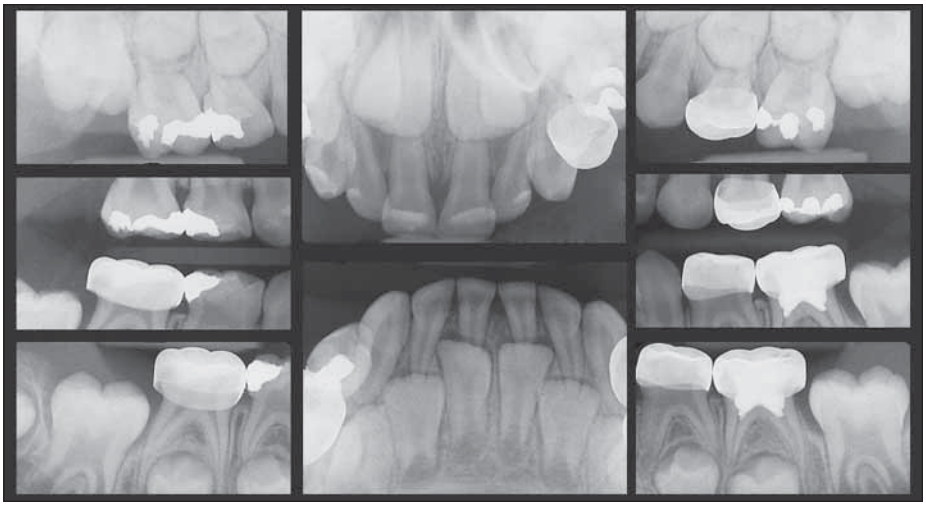

Figure 2. Intraoperative post-treatment radiographs.

second primary molar. The entire surgical experience, from induction to extubation, was $3^1/_2$ hours in duration. Recovery was as anticipated, with no adverse or unwanted occurrences. At the 1-week follow-up appointment, her mother reported that the child was no longer complaining or crying because of mouth pain and that her nutritional intake had increased significantly.

DISCUSSION

Fortunately for this child, her physician was rather observant and knowledgeable and recognized the need for specialty oral health care. All too often, however, the adopted child needlessly suffers from dental disease because of a lack of appreciation by the parent or health care professional. Anticipatory guidance should include oral hygiene instructions, diet and nutrition counseling, and fluoride supplementation (if warranted). While routine examination of the internationally adopted child focuses on the individual's physical and emotional well-being, the pediatric health care practitioner must learn to recognize the need for oral health assessment and appropriate referral to and treatment by a dentist. Future research and advocacy is needed to help eliminate oral health disparities prevalent among internationally adopted children. A heightened sense of knowledge and increased awareness is warranted by all pediatric health care providers. Recommendations for oral health care professionals may be found in Table 2.

By providing comprehensive and appropriate care, which includes an emphasis on total-body wellness, the team of health care professionals (including the pediatric dentist, pediatrician, etc,) may contribute to the entire family's health and happiness.

Table 2. Guide for the Oral Health Care Professional

Concern	Recommendation
Immunization status	Confirm with physician/health care provider
Psychological and emotional needs/insecurities	Listen to and counsel patients and caregivers
Night-time bottle use; sippy cup use; elevated carbohydrate/sugar intake	Provide age-appropriate nutrition and dietary counseling for patients and caregivers
Demonstrable plaque	Provide age-appropriate oral hygiene instructions for patients and caregivers
Demonstrable caries and demineralization	Perform caries risk assessment tool (available at www.aapd.org)
High caries rate	Fluoride supplementation (only after thorough assessment of fluoride status)
Uncooperative behavior	Provide alternative behavior management approaches for in-depth care (ie, oral sedation, general anesthesia)

CONCLUSIONS

A comprehensive dental examination should be an integral component to any health evaluation for internationally adopted children. A policy statement supported and endorsed by the American Academy of Pediatric Dentistry and the American Academy of Pediatrics may provide the impetus and leadership needed to promote oral health care for this at-risk group of children.

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