Dietary Counseling - Time for a Nutritionist in the Office?

Among the benefits of early dental visits for children is the opportunity to provide anticipatory guidance to caregivers on a variety of topics. Not least among these is dietary and nutritional counseling. Nainar and Mohummed provide a concise review of this topic in their article, "Diet Counseling During the Infant Oral Health Visit," which appears in this issue. At these initial visits, we can assist parents in getting off on the right foot when it comes to dietary control of dental caries. We should also use this opportunity to help them avoid potentially more serious diet-related conditions resulting from childhood obesity.

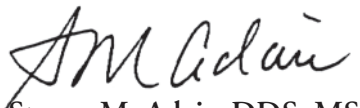
A year ago, this journal's previous editor, Dr. Milton I. Houpt, brought to our attention the looming crisis of obesity among the nation's children and adolescents. He referenced a policy statement by the American Academy of Pediatrics[1] that prompted a good deal of media attention on the issue of childhood obesity. In fact, an earlier online article in *Pediatrics*[2] presented the recommendations of an expert committee to guide physicians, nurse practitioners, and nutritionists in the evaluation and treatment of overweight children and adolescents. This problem has been with us for some time now. The 1971–1974 National Health and Nutrition Examination Survey I (NHANES I) found that 4% of children ages 6 to 11 and 6% of adolescents ages 12 to 19 were overweight. Data from NHANES 1999–2000 indicated that those percentages had increased to 13% and 14%, respectively. The cost (in 2001 dollars) of health care for obesity-related conditions in 6- to 17-year-olds increased from $35 million in 1979 to $127 million in 2000.

Many of the risks associated with obesity in adults are well known—type 2 diabetes, heart disease, stroke, and hypertension, to name a few. It is alarming that these same risks are also increasing among obese children. Other weight-related issues in children include fatty liver disease, obstructive sleep apnea, and orthopedic problems. A survey published in the *Journal of the American Medical Association*[3] revealed that the self-reported quality of life among obese children was similar to that reported by children with cancer. The study concluded that the effects of obesity on social well-being lead to depression, even in the absence of physical difficulties.

Why is this happening? Today, children watch an average of 4 hours of television per day, plus additional time watching videos and playing computer games. The American Academy of Pediatrics recommends that TV and video viewing be limited to 1 to 2 hours per day. Physical activity is on the decline, both during and outside of school. The percentage of children participating in physical education programs dropped to 21% in 1999, down from 42% in 1991. Fewer than 25% of children engage in even 20 minutes of daily vigorous activity. I find it interesting that the creators of computer games are developing products that actually get kids up and moving in such activities as dancing.

The other half of the obesity equation is, of course, diet. In our faced-paced, busy lives, we have become more reliant on highly processed "convenience" foods. These foods often contain sucrose and refined carbohydrates with high glycemic indices, not to mention high levels of fat and calories. While these foods can stave off hunger for short periods, they create spikes in insulin levels that lead to hypoglycemic states and increased hunger. Children have increasingly become accustomed to "portable" foods, from the all-day sippy cup to snacks in the car. Many caregivers are unaware of the impact that these dietary demands have on their child's overall health. Meanwhile, pediatric dental offices are engaged in diet counseling every day. Our focus, of course, is the prevention of dental caries. But we, more than many other health care providers, have an opportunity to provide dietary information on a periodic, ongoing basis. Why not use those opportunities to convey to caregivers information on more global dietary issues, such as the effects of simple sugars on insulin levels, and the health risks of a high-fat, high-calorie diet? Our recommendations for healthy eating should concern the whole patient, and not just the patient's teeth.

The vision of the American Academy of Pediatric Dentistry is "optimal health and care for infants, children, adolescents, and persons with special health care needs." We have a wonderful opportunity to make an impact on our patients' health through comprehensive nutritional and dietary counseling that goes beyond the prevention of dental disease alone. Perhaps some offices may find it beneficial to use the services of a nutritionist, in-office or by referral, who is well-versed in the impact of diet on the dentition, yet who can also educate caregivers about their child's overall nutritional needs. Let's graduate patients from our practices who not only have good oral health, but whose general health reflects our vision for their well-being.



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2. Barlow SE, Dietz WH. Obesity evaluation and treatment: Expert Committee recommendations. *Pediatrics*. 1998;102:e29.
3. Schwimmer JB, Barwinkle, TM, Varni JW. Health-related quality of life of severely obese children and adolescents. *JAMA*. 2003; 289:1813-1819.