

Clinical Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children

Originating Committee
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1991

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1992, 1996, 2000, 2003

Purpose

The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners make clinical decisions concerning preventive oral health care for infants, children, and adolescents. Because each child is unique, these recommendations are designed for the care of children who have no contributory medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from the normal.

Methods

These guidelines are a compilation of pediatric oral health literature and national reports and recommendations, in addition to related policies and guidelines published in the AAPD Reference Manual.¹⁻²⁴ The related policies and guidelines provide references for individual recommendations. Some recommendations are evidence-based, while others represent best clinical practice and expert opinion.

Background

The AAPD emphasizes the importance of professional oral health intervention very early in childhood. Caries-risk assessment¹¹ is an essential element of contemporary clinical care for infants, children, and adolescents. Continuity of care is based on the assessed needs of the individual patient. Although evidenced-based research supporting the benefits of an infant dental intervention is limited, there is sufficient evidence that certain groups of children are at greater risk for development of early childhood caries (ECC) and would benefit from infant oral health care. ECC can be a costly, devastating disease with a lasting detrimental impact on the dentition and systemic health issues.⁷ The characteristics of ECC and the availability of preventive methods support anticipatory guidance as an important strategy in addressing this significant pediatric health problem. Major benefits of early intervention, in addition to assessment of risk status, include analysis of fluoride exposure and feeding practices as well as oral hygiene counseling. The early dental visit should be seen as the foundation upon which a

lifetime of preventive education and oral health care can be built. Clinicians must consider each infant's, child's, and adolescent's individual needs and risk indicators to determine the appropriate interval and frequency of dental visits.

Recommendations

Birth to 12 months

1. Complete the clinical oral examination with appropriate diagnostic tests to assess oral growth and development, pathology, and/or injuries; provide diagnosis.
2. Provide oral hygiene counseling for parents, guardians, and caregivers, including the implications of the oral health of the caregiver.
3. Remove supragingival and subgingival stains or deposits as indicated.
4. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe systemic fluoride supplements, if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.
5. Assess appropriateness of feeding practices, including bottle and breast-feeding, and provide counseling as indicated.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for nonnutritive oral habits (eg, digit, pacifiers).
9. Provide required treatment and/or appropriate referral for any oral diseases or injuries.
10. Provide anticipatory guidance for parent/guardian/caregiver.
11. Consult with the child's physician as needed.
12. Based on evaluation and history, assess the patient's risk for oral disease.
13. Determine the interval for periodic re-evaluation.

12 to 24 months

1. Repeat birth to 12-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. Assess appropriateness of feeding practices, including bottle, breast-feeding, and no-spill training cups, and provide counseling as indicated.
3. Review patient's fluoride status—including any childcare arrangements, which may impact systemic fluoride intake—and provide parental counseling.
4. Provide topical fluoride treatments every 6 months or as indicated by the individual patient's needs.

2 to 6 years

1. Repeat 12- to 24-month procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Complete a radiographic assessment of pathology and/or abnormal growth and development, as indicated by individual patient's needs.
3. Scale and clean the teeth every 6 months or as indicated by individual patient's needs.
4. Provide pit and fissure sealants for primary and permanent teeth as indicated by individual patient's needs.
5. Provide counseling and services (athletic mouthguards) as needed for orofacial trauma prevention.
6. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs.
7. Provide required treatment and/or appropriate referral for any oral diseases, habits, or injuries as indicated.
8. Assess speech and language development and provide appropriate referral as indicated.

6 to 12 years

1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. Provide substance abuse counseling (eg, smoking, smokeless tobacco).
3. Provide counseling on intraoral and perioral piercing.

12 years and older

1. Repeat 6- to 12-year procedures every 6 months or as indicated by individual patient's risk status/susceptibility to disease.
2. At an age determined by patient, parent/guardian, and pediatric dentist, refer the patient to a general dentist for continuing oral care.

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Recommendations for Pediatric Oral Health Care

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal.

The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of *very* early professional intervention and the continuity of care based on the individualized needs of the child.

Age	6–12 months	12–24 months	2–6 years	6–12 years	12 years and older
Clinical oral examination ¹	•	•	•	•	•
Assess oral growth and development ²	•	•	•	•	•
Caries-risk assessment ³	•	•	•	•	•
Prophylaxis and topical fluoride treatment ⁴		•	•	•	•
Fluoride supplementation ^{5,6}	•	•	•	•	•
Anticipatory guidance ⁷	•	•	•	•	•
Oral hygiene counseling ⁸	Parents/guardians/ caregivers	Parents/guardians/ caregivers	Patient/parents/ guardians/caregivers	Patient/parents/ guardians/caregivers	Patient
Dietary counseling ⁹	•	•	•	•	•
Injury prevention counseling ¹⁰	•	•	•	•	•
Counseling for nonnutritive habits ¹¹	•	•	•	•	•
Substance abuse counseling				•	•
Counseling for intraoral/ perioral piercing				•	•
Radiographic assessment ¹²			•	•	•
Treatment of dental disease/injury	•	•	•	•	•
Assessment and treatment of developing malocclusion			•	•	•
Pit and fissure sealants ¹³			•	•	•
Assessment and/or removal of third molars					•
Referral for regular and periodic dental care					•

1. First examination at the eruption of the first tooth and no later than 12 months.
2. By clinical examination.
3. As per AAPD "Policy on the use of a caries-risk assessment tool (CAT) for infants, children, and adolescents."
4. Especially for children at high risk for caries and periodontal disease.
5. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.
6. Up to at least 16 years.
7. Appropriate discussion and counseling should be an integral part of each visit for care.
8. Initially, responsibility of parent; as child develops, jointly with parents; then, when indicated, only child.

9. At every appointment discuss the role of refined carbohydrates, frequency of snacking.
10. Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing.
11. At first discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
12. As per AAPD "Clinical guideline on prescribing dental radiographs."
13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and/or fissures; placed as soon as possible after eruption.

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