Editorial

Publicity for Children's Oral Health: A Perfect Storm

"Does the flap of a butterfly's wings in Brazil set off a tornado in Texas?
– Edward Lorenz, meteorologist

The perfect storm of publicity for children's oral health began earlier this spring with the reports of a 12-year-old boy in Maryland who died from brain complications arising from a decayed tooth.[1] This unfortunate event sparked interest in the media. Winds began to blow.

Then on April 30, the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics released data showing that the dental caries prevalence among preschool children has increased in recent years. To most practicing pediatric dentists and generalists who treat young children, this came as no surprise. The data were based on a comparison of oral health information from the 1988-94 and 1999-2004 National Health and Nutrition Examination Surveys (NHANES). The prevalence of dental caries among children ages 2-5 years was 24% in the earlier study, and rose to 28% in the 1999-2004 survey, an increase of 17%. Given that caries rates have generally declined over the past 40 years, this increase came as a surprise to some folks, but probably not to readers of these pages. You would also not be surprised to learn that caries prevalence increases were the greatest among children who live at or below 200% of the federal poverty line (FPL). This includes poor children ages 6-11, whose caries prevalence also increased. Children that age from families with incomes below the FPL had 3 times the prevalence of untreated tooth decay compared to those living above the FPL. Racial and ethnic disparities persist as well. Mexican American schoolage children were 1.6 times as likely to have decay in their permanent teeth. Readers interested in obtaining a copy of the report and press release can do so through the American Academy of Pediatric Dentistry (AAPD) website.[2]

The publicity winds quickened and the waves of exposure began to grow. Propelled by the developing storm, the CDC release generated further national interest in children's oral health. News outlets all over the country reported the story, and several turned to the AAPD for follow-up (see the press release online[2]). The importance of the age 1 visit was emphasized by medical reporters and guest experts, including ADA president Kathy Roth, on local and national television.

The final elements of the storm grew from the Domestic Policy Subcommittee of the House Oversight and Government Reform Committee, which held a public hearing on May 2 to investigate pediatric dental Medicaid issues. The Centers for Medicare and Medicaid Services (CMS) came under specific scrutiny regarding implementation (or lack thereof) of its Guide to Children' s Dental Care in Medicaid, which was rewritten by AAPD under contract to CMS in 2004. An indictment of the Medicaid dental program in Maryland was delivered by AAPD member Norman Tinanoff, chair of pediatric dentistry at the University of Maryland. Among the major problems identified in the hearing was–gasp!–that low Medicaid reimbursement rates for dental services adversely impact access to care for that portion of the population who needs it the most. Those interested in viewing a video of the subcommittee hearing can find it online.[3]

Prior to the development of the storm, the Children's Dental Health Improvement Act of 2007 began wending its way through Congress. To date Senator Jeff Bingaman's bill S739 has garnered 10 Senate co-sponsors, and Congressman John Dingell's bill HR 1781 has attracted 56 House cosponsors, some of whom might have felt the coming storm. If passed, this bill will authorize $40 million to allow health departments and community health centers to hire additional dental providers to serve the underserved children of this country. It would also provide grants and other incentives to states to improve Medicaid reimbursement rates for dental care. In addition, S 1224, introduced on April 25 by Senators Rockfeller, Snowe, and Kennedy would reauthorize the State Children's Health Insurance Program (SCHIP), including a specific guarantee of SCHIP dental coverage.

At the eye of the storm sits your Academy, patiently and persistently advocating for improved children's oral health and supporting legislation to that end. Perhaps this perfect storm of publicity will help propel these bills into law. What a beautiful rainbow that would make.

References

1. The Washington Post. Boy's death fuels drives to fund dental aid to the poor. Available at: "http://www.washingtonpost.com/wp-dyn/content/article/2007/03/02/AR2007030200827.html". Accessed May 16, 2007.
2. American Academy of Pediatric Dentistry. CDC Report Shows Increase in Children's Tooth Decay. Available at: "http://www.aapd.org/hottopics/news.asp?NEWS_ID=674". Accessed May 16, 2007.
3. Committee on Oversight and Government Reform. Oversight Adequacy of the Pediatric Dental Program for Medicaid Eligible Children. Available at: "http://oversight.house.gov/story.asp?ID=1292". Accessed May 16, 2007.

Editor-in-Chief

Letters to the Editor

Enough With "Evidence Based" Titled Articles.

Andrew L. Sonis, DMD.

In the past 12 months there have been well over 1000 articles published in the medical and dental literature with "evidence-based" in the title. However, those students of Dr. David Sackett, credited with creating the evidence-based medical model, appreciate that all articles in our journals represent some level of evidence-based medicine or dentistry.

The hierarchy of evidence as presented by Sackett ranges from personal opinion to meta-analyses of randomized clinical trials, so to include "evidence-based" in a manuscript title is meaningless. A more appropriate approach would be to identify the article by the type and level of evidence it presents, i.e., case report, cohort study, randomized clinical trial, etc.

Things That Make You Go Hmm

Irwin M. Seidman, DDS

"I am floundering in a fluoride fog, fostered by frequent fears and fed by fragmented factual and fictitious factoids" was one of the lead statements made by Dr. Casamassimo in his recent guest editorial. He goes on to explain his frustration with the American Dental Association and its recent recommendation regarding the use of fluoridated water in reconstituting infant formulas. I, for one, applaud their action and say Bravo! Yes, I am a practicing pediatric dentist. No, I am not one of those ultras who believe that any chemical either naturally occurring or man made is the curse of the devil and will cause unmentionable harm if either applied topically or ingested. Yes, I practice using the fluoride supplementation guidelines set up in 1994 that recommend that children between the ages of 6 months and 3 years should be ingesting 0.25mg of fluoride per day. The "nursery or infant waters" in question all contain fluoride in the amount of 1mg/l. If infants, who are on formula, are taking four 8 ounce bottles a day reconstituted with optimally fluoridated water they are receiving four times more supplement than the suggested daily dose. I understand that 32 ounces is only 996 mL, but close enough. In its announcement the ADA stated that "Infants less than one year old may be getting more than the optimal amount of fluoride if their primary source of nutrition is powdered or liquid concentrate infant formula mixed with water containing fluoride." Their suggestion is that when using a product that needs to be reconstituted, parents and caregivers should consider using water that has no or low levels of fluoride. What is the ADA asking us to do? Calculate dosages! Gee, we do it all the time; why not now?

Dr. Casamassimo says that we (pediatric dentists) are "also more realistic when it comes to compliance and the difficulty of adding still another parental decision to the complexities of preventing both early childhood caries and dental fluorosis." OK, Mom, make one of your child's bottles with nursery water and the other three without. Now the parent has to remember which bottle was which and did they give it that day or not. Why not recommend fluoride drops, two drops daily? The AAPD had a relationship with the Coca Cola Corporation. Coca Cola has the license to bottle Dannon Water which includes their nursery water. Why not help develop a product containing a lower level of fluoride that will be easier to use for younger children? No one is telling us not to recommend fluoride they are just asking us to consider how much we are using.

Fragmented factual and factitious factoids.....not in our journal....things that make you go hmm!