9. Casamassimo PS. Children with special health care needs: Patient, professional, and systems issues. In: *Proceedings of the Interfaces Project, 2002.* Washington DC: Children's Dental Health Project; 2002.
10. Beck JD, Offenbacher S. Oral health and systemic disease: Periodontitis and cardiovascular disease. J Dent Educ 1998;62:859-70.
11. Meyer DH, Fives-Taylor PM. Oral pathogens: From dental plaque to cardiac disease. Curr Opin Microbiol 1998;1:88-95.
12. US Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, Md: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health; 2000.
13. Langmore SE, Terpenning MS, Schork A, et al. Predictors of aspiration pneumonia: How important is dysphagia? Dysphagia 1998;13:69-81.
14. Meraw SJ, Reeve CM. Dental considerations and treatment of the oncology patient receiving radiation therapy. J Am Dent Assoc 1998;129:201-5.
15. Glassman P, Wong C, Gish R. A review of liver transplantation for the dentist and guidelines for dental management. Spec Care Dentist 1993;13:74-80.
16. Gomez-Moreno G, Cutando-Soriano A, Arana C, Scully C. Hereditary blood coagulation disorders: Management and dental treatment. J Dent Res 2005;84:978-85.
17. National Institutes of Health. Consensus development conference statement. Oral complications of cancer therapies: Diagnosis, prevention, and treatment. J Am Dent Assoc 1989;119:179-83.
18. American Academy of Pediatric Dentistry. Guideline on dental management of pediatric patients receiving chemotherapy, hematopoietic cell transplantation, and radiation. Reference Manual. Pediatr Dent 2006-2007; 28(suppl):185-90.
19. National Association of Children's Hospitals and Related Institutions. Available at: "www.childrenhospital.net". Accessed June 3, 2008.
20. Edelstein BL. Conceptual frameworks for understanding system capacity in the care of people with special health care needs. Pediatr Dent 2007;29:108-16.
21. Stiefel D. Adults with disabilities. In: Bonito AJ, Cooper Ly, eds. *Dental Care Considerations of Disadvantaged and Special Care Populations: Proceedings of the Conference, April 18-19, 2001, Baltimore, Md.* Washington, DC: US Government Printing Office; 2001:1-26.
22. The Advisory Board Company: *Operations of Children's Dental Centers.* Washington DC: The Advisory Board Company; 2005.
23. Nowak AJ, Casamassimo PS. The dental home: A primary care oral health concept. J Am Dent Assoc 2002; 133:93-8.
24. Field M. Dental *Education at the Crossroads: Challenges and Change.* Washington, DC: National Academy Press; 1995.
25. Mouradian WE, Corbin SB. Addressing health disparities through dental-medical collaborations, part II: Cross-cutting themes in the care of special populations. J Dent Educ 2003;67:1320-6.

Abstract of the Scientific Literature

Randomized controlled trial of the effect of anticipatory guidance on management of teething symptoms

*This paper reported the effect of anticipatory guidance provided in the form of printed information on maternal management of teething symptoms in their infants. Participants were enrolled into a larger parent randomized controlled trial (**RCT**) to prevent early childhood caries (**ECC**). Those mothers recruited in the intervention arm of the main study received oral health promotional materials during pregnancy and when their infant was 6 and 12-months-of-age. Specific literature related to teething was mailed to mothers at the 6 month milestone. This material included information on teething, its management, eruption times of primary teeth, common signs and symptoms of teething, along with tips on how to ease teething pain and discomfort. Data were available for 232 mothers and infants in the test group and 209 maternal-infant dyads in the control group. There was no apparent difference in maternal reporting of teething symptoms between the groups. Drooling, biting, and irritability were the most noted symptoms reported by mothers. Those mothers who received oral health materials as part of the RCT did manage their infant's symptoms differently than those serving as controls. They were significantly less likely to give their child teething medication (P<.03) and more likely to massage their infant's gums (P<.005) than those mothers who did not receive any oral health literature. This study concluded that providing information on teething can lead to more conservative and non medicinal management of teething discomfort.*

***Comment:** Clear signs and symptoms of childhood teeth are difficult for both parent and health professionals to observe. Despite the fact that teething discomfort is common there is great variability among providers regarding tips they provide parents to manage their child's teeth pain. This study provided mothers with information on teething coinciding with the eruption of a child's first tooth; at a time when it is most useful and needed. Equipping mothers with information on recognizing and managing teething pain appears to potentially reduce the reliance on infant teething medications. This may help in reducing the risk of potentially overmedicating a child.* **RJS**

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Plutzer K, Spencer AJ, Keirse MJ. How first-time mothers perceive and deal with teething symptoms: a randomized controlled trial. Child Care Health Dev 2011; Mar 6. doi: 10.1111/j.1365-2214.2011.01215.x. [Epub ahead of print]

28 references

7. Roberts JF. Treatment of vital and nonvital primary molar teeth by 1-stage formocresol pulpotomy: Clinical success and effect upon age at exfoliation. Int J Paediatr Dent 1996;6:111-5.
8. Thompson KS, Seale NS, Nunn ME, Huff G. Alternative method of hemorrhage control in full-strength formocresol pulpotomy. Pediatr Dent 2001;23:217-22.
9. Pruhs RJ, Olen GA, Sharma PS. Relationship between formocresol pulpotomies on primary teeth and enamel defects on their permanent successors. J Am Dent Assoc 1977;94:698-700.
10. Rølling I, Poulsen S. Formocresol pulpotomy of primary teeth and occurrence of enamel defects on the permanent successors. Acta Odontol Scand1978;36:243-7.
11. Messer LB, Cline JT, Korf NW. Long-term effects of primary molar pulpotomies on succedaneous bicuspids. J Dent Res 1980;59:116-23.
12. Mulder GR, van Amerongen WE, Vingerling PA. Consequences of endodontic treatment in primary teeth. Part 2: A clinical investigation into the influence of formocresol pulpotomy on the permanent successor. J Dent Child 1987;54:35-9.
13. Landis JR, Koch GG. The measurement of observer agreement for categorical data. Biometrics 1977;33: 159-74.
14. Vargas K, Packham B. Radiographic success of ferric sulfate and formocresol pulpotomies in relation to early exfoliation. Pediatr Dent 2005;27:233-7.
15. Hicks MJ, Barr ES, Flaitz C. Formocresol pulpotomies in primary molars: A radiographic study in a pediatric dentistry practice. J Pedod 1986;10:331-6.
16. Lunt RC, Law DB. A review of the chronology of eruption of deciduous teeth. J Am Dent Assoc 1974;89:872-9.
17. Coll JA, Sadrian R. Predicting pulpectomy success and its relationship to exfoliation and succedaneous dentition. Pediatr Dent 1996;18:57-63.
18. Venham LL. Pulpotomy Technique: A Histological Study [master's thesis]. Columbus, Ohio: The Ohio State University; 1967.
19. García-Godoy F. Penetration and pulpal response by two concentrations of formocresol using two methods of application. J Pedod 1981;5:102-35.
20. Rølling I, Hasselgren G, Tronstad, L. Morphologic and enzyme histochemical observation on the pulp of human primary molars 3 to 5 years after formocresol treatment. Oral Surg Oral Med Oral Pathol 1976;42:518-28.
21. Rølling I, Lambjerg-Hansen H. Pulp condition of successfully formocresol-treated primary molars. Scand J Dent Res 1978;86:267-72.
22. Kahl J, Easton J, Johnson G, Zuk J, Wilson S, Galinkin J. Formocresol blood levels in children receiving dental treatment under general anesthesia. Pediatr Dent 2008; 30:393-9.
23. Kurji ZA, Sigal MJ, Andrews P, Titley K. A retrospective study of a modified 1-minute formocresol pulpotomy technique Part 1: Clinical and Radiographic Findings. Pediatr Dent 2011;33(2):131-8.

Abstract of the Scientific Literature

Birth timing: An influence on the prevalence of cerebral palsy

*The goal of this study was to evaluate the influence of gestational age on the birth of infants at risk for cerebral palsy (**CP**). Gestational age was determined by the last menstrual period (LMP) and ultrasound in 1998 and beyond. The study used data from the national health and insurance registries in Norway, where each citizen has a specifically unique identification number and all births are recorded in the Medical Birth Registry of Norway. The Norwegian Data Inspectorate, the Norwegian Directorate of Health, the Office of the National Registrar, and the Norwegian Labor and Welfare Organization approved the study. All births with a gestational age of no less than 16 weeks have been recorded in the registry since 1967. In this study data from all the live single births having a gestational age of 37- 44 weeks from 1967-2001 were evaluated. For this time period of 35 years a total of 2,024,215 live births were recorded. Excluded from the study were infant cases which had missing data, preterm births, gestational age >44 weeks, birth weights not comparable with gestational age, multiple births, infants with malformations, and children dying prior to age 4 years. This left a total of 1,682,441 births with a gestational age of 37- 44 weeks as the cohort for analysis. For statistical analysis each week of gestation from week 37- week 44 was evaluated. Relative risks (RR) was estimated by the ratio of prevalence using 40 weeks as the reference and log-binomial regression was used with adjustments for birth year, sex, mother's age, single mother status, mother and father's educational levels and immigrant status of mother and father. Statistical analysis was performed by SPSS version 17.0. The lowest birth risk for CP was found at 40 weeks of delivery with the highest risk at 37 and 42 weeks. Several factors are indicated as associated with the cause for cerebral palsy, but it has not been determined if congenital problems with the fetus are more of a cause than problems with the delivery process itself. The timing of delivery as too early or too late appears to increase the risk of cerebral palsy.*

Comment:** Patients with a diagnosis of cerebral palsy are routinely treated by pediatric dentists. For CP and all special needs patients, included in the medical history should be a review of the pregnancy and birth histories. This information is important in aiding confirmation of dental anomalies resulting from developmental insults during gestation. **JGJ

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Moster D, Wilcox AJ, Vollset SE, Markestad T, Lie RT. Cerebral palsy among term and postterm births. JAMA 2010;304:976-82.

39 references