Guest Editorial

Celebrate but rededicate AAPD infant oral health care guideline—are we ready to celebrate?

After 25 years are we ready to celebrate and claim success with the 1986 AAPD Infant Oral Health Care guideline? It states that an oral health risk assessment should be conducted by the child's primary health care provider by 6 months of age, followed by an oral examination and assessment at 12 months of age by a dentist, establishing a dental home and developing an appropriate interval for periodic reevaluation based upon the individual risks of the infant? (http://www.aapd.org/media/Policies_Guidelines/G_InfantOralHealthCare.pdf)

Before we celebrate, I'd like to offer my perspective of some of the events that took place in the 1980's, the decade when the AAPD guideline was developed and announced.

- In 1989, a NIH publication reported on the 1986-87 survey of school children's oral health and stated that 50% of school children never had a cavity. About the same time, a report in the Journal of the American Dental Association (1988) as well as in the New York Times, reported the downward trend in cavities in children and the NY Times even labeled cavities "The Endangered Species". NIDR officials also stated that "dental caries had been conquered"!
- In 1988, the Council on Dental Education and Licensure (**ADA**) initially refused to re-recognize pediatric dentistry as a specialty during a review of all the dental specialties as mandated by the House of Delegates. One ADA leader expressed his belief that there wouldn't be any need for the specialty in the near future!
- The American Academy of Pediatrics (**AAP**), Recommendations for Preventive Health Care of Children and Youth in the '70s and '80s stated that the first dental visit be around 36 months. At an AAP Committee on Practice and Ambulatory Medicine meeting, the committee charged with developing periodicity schedules, AAPD representatives requested they change the first recommendation to 1 year and were accused of requesting the change primarily for financial gain!
- In a 1988 report, the author stated that the prevalence of Baby Bottle Tooth Decay (BBTD) in USA was no higher than 5%, yet by 1993, reports of BBTD were around 25% in Head Start populations and up to 85% in Native American infants and toddlers!

So, why would AAPD develop a guideline for the first visit at a time when NIH was reporting as many as 50% of school aged children never had dental decay, the ADA leadership was questioning the need to re-recognize the specialty of pediatric dentistry and our colleagues, the pediatricians , were recommending the first visit at 36 months?

First, the NIH survey did not report or consider primary teeth. When the data were analyzed it was noted that around 50% of primary teeth had decay before the child entered first grade.

Secondly, pediatric dentists were treating the infants and toddlers with BBTD, not the ADA leadership or AAP leadership. Finally, it was beginning to be recognized that this common infectious disease process needed to be identified early in infant and toddlers, prior to the development of cavities for preventing the destruction of primary teeth and the eventual progression to the developing permanent dentition. There was also growing literature that supported the fact that once established, Early Childhood Caries (ECC) was difficult to stop with restorations or preventive recommendations.

Drury et al in 1999 stated, "Early identification of dental caries, especially in infants and toddlers, is a prerequisite for the secondary prevention of dental caries and for preventing the destruction of primary teeth". But much earlier, Jordon (1927), University of Iowa Extension Bulletin (1929), Hogeboom (1933), McBride (1937), Black (1937), Cheney (1947), Fass

(1962), McDonald (1963), Doykos (1967) to name a few authors, all had discussed the importance of early care, primary prevention!

I was one of the early proponents (along with Anderson, Sanger, Schneider, Moss and many others) for the change to one year for the first visit, having experienced patient after patient with rampant decay and what was commonly called Baby Bottle Tooth Decay in my private practice during the late '60s and '70s. There had to be a better way than waiting for the disease to destroy the teeth and invade the pulps. Our kids were visiting their pediatrician on a routine basis from birth on to prevent disease and for periodic immunizations. So what were we waiting for? Why didn't we see infants as soon as their teeth erupted? Better yet, how about even earlier? How about starting as early as with mom during her pregnancy?

In 1968 I introduced an oral health component in our local hospital's prenatal classes and suggested the parents make an appointment for themselves and for their infant as soon after the first tooth erupts. We published the paper, "Prevention of dental disease from nine months in-utero to eruption of the first tooth" (1976). There was no fluoride in the drinking water in our community, so that became the focus for our immediate attention. We asked questions about the family and siblings, brushing habits and daily lifestyles. At the time, I didn't realize it, but I was performing what would eventually be called a risk assessment. After a few years of experience, I went on the speaking circuit and shared my experiences with other dental professionals, became involved in the American Society of Dentistry for Children and co-authored the report, "Adapting a Simple Preventive Dental Program for Children in your Office" (1972).

Eventually, I became active with AAPD committees and the AAPD Board of Trustees and in 1984, I recommended the first visit guideline. It was tabled, 'for insufficient evidence'! But in 1986, through the efforts of the AAPD Clinical Affairs Committee, the guideline was accepted by the AAPD membership.

In 1986 there were around 1927 AAPD active and life members and 158 residents completing training. Today there are around 5300 active and life AAPD members and around 380 residents completing training each year. Almost all communities with a water system are adding fluoride to the drinking water. Almost all toothpastes contain fluoride. There are hundreds of designs and styles of manual and motorized tooth brushes for toddlers and children. AAP now recommends the first visit at 1 year, as does the ADA and other health organizations. The specialty has been American Dental Association/ Council on Dental Education and Licensure re-recognized twice since the 1980's and is now leading the dental profession in advocacy and prevention. We have introduced the concepts of anticipatory guidance and the dental home. We are recognized as the experts in oral health care for the children with special health care needs.

Is it time to celebrate? Even though I retired from the clinical practice of pediatric dentistry a few years ago, today is the greatest time in my career. Yes we should celebrate but rededicate our efforts! Why? Too many of my colleagues are not practicing the full scope of care that they were trained in. Fluoride in water is under threat, the mid-level provider is being pushed with a poor track record in early childhood caries management of young children, the ability of pediatric dentists to do sedation is under assault and the Medicaid system in many states is under attack. So celebrate but with restraint! Get back in the trenches with a smile, because we have moved the front lines to age one through doubt, derision and debate. We are winning the war on ECC in spite of the battles yet ahead! "Get it Done in Year One" for a lifetime of healthy smiles!

References available on request.

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