Wizards of O–S

I can explain that raspy sound heard the day the American Dental Association announced its March 2006 conference on oral-systemic (O-S) relationships. It was the collective sound of several thousand pediatric dentists scratching their heads in wonderment.

The collective thought was similar. "This is news?"

The O-S relationship is so much a part of pediatric dental practice that few of us think twice about the little girl with Down syndrome or the young adult with cerebral palsy smiling in his wheelchair in our waiting room. On average, almost 1 of every 6 children has a disability by federal definition, and as most pediatric dentists know, we are seeing most of these children and the special needs adults they become.

I was told that the reason the American Academy of Pediatric Dentistry (AAPD) did not have more of a role in the conference was that we didn't have enough quality evidence-based literature. The star of the show, so to speak, was the periodontal-prematurity association that NIDCR has pumped millions of dollars into recently. No question that this is an important association --- the cost of caring for one very-low-birth-weight child can run into the millions of dollars. The fact that little is ever said about who takes care of the oral health of these tens of thousands of permanently disabled premature infants (and that would be us) with their many medical, oral, and behavioral needs speaks volumes to how little dentistry's leadership knows about the real extent of the O-S relationship and the involvement of the specialty of pediatric dentistry in the care of children and adults with special needs.

The lack of evidence on how systemic conditions affect oral health, and as important, the converse, is not difficult to explain. With fewer than 4,000 pediatric dentists and maybe just a tenth of that number in hospitals and dental schools, there is little time to spend cataloging and publishing. It is unlikely that the social, psychological, and physiological relationships we see every day will ever be detailed. The numbers of children with any one condition are often too small to study and of little interest to all but the most focused of journals.

Pediatric dentists for decades have been the first to see special needs children and cope with their needs and those of their families. Beginning with the child with cleft palate or the premature child (now getting so much attention), we address the concerns of families and play a role in helping these children thrive. We routinely deal with parental guilt, their anger at the health care system (including dental) that is often at best uncaring and at worst incompetent to deal with their child's special needs. We are the front line of dentistry dealing with the effects of medical pain on behavior of children in the health care setting. We have by necessity become experts in drug interactions and the effects of disease on the oral cavity and vice versa. We are the ones our medical colleagues query about oral lesions, inability to eat, the effects of special diets, and getting children ready for complex surgeries that may be threatened by dental infection. We are the ones who, after surgery or because of a craniofacial abnormality affecting the mouth, create a smile.

It is a sad commentary on American dentistry, and a fitting capstone statement to this editorial, that we pediatric dentists are now forced to be skilled in geriatrics because so few of our colleagues are willing to accept our aging special needs patients with their accumulating medical issues and polypharmacy!

In November 2006 in Chicago, the AAPD will host a conference on oral health in special needs patients. The conference will bring together families, the medical community, patients, advocates, and pediatric dentists to develop an action plan for education, advocacy, and dental practice. And yes, we plan to invite the leaders of dentistry. A part of the conference will address evidence to support policies related to special needs care, but a far more valuable and meaningful outcome will be the consensus statements of needed action built upon the individual experiences, pain, suffering and achievements of many "n's of one" who have navigated the oral health care system as both pilot and passenger.

Unlike the fictional Wizard of Oz, we wizards of O-S needn't tell poor Dorothy how to find her way home. If she has found her way to a pediatric dentist, she is home.

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