United States is poor and caries figures are at an all-time high. What are the reasons for this? Fernandez: Actually, the oral health of children in the U.S. has improved significantly over the past few decades when you look at a national sample across all age groups. Today, most American children have excellent oral health, but a significant subset suffers from a high level of oral disease.

The most advanced disease is found primarily amongst children living in poverty, some racial/ethnic minority populations, children with special health-care needs, children with HIV/AIDS infection. You might be referring to the National Health and Nutrition Examination Survey (NHANES) that demonstrated an increase in dental caries from 24 percent to 28 percent in the 2- to 5-year-old group.

The reasons for this are presently unclear, but this increase has reignited efforts in the U.S. to improve access to care for this age group and to begin to address the issue of ECC.

Fernandez: Early childhood caries [ECC] has increased not only in the U.S., but also worldwide. Should this area be considered a new priority in pediatric dentistry?

Fernandez: Early childhood caries, and efforts in the intervention and treatment of early dental decay, has always been a priority.

In order to combat the current national epidemic of ECC in young children effectively, a more comprehensive, collaborative approach to the education of parents by all newborn and pediatric health-care providers, such as nurses, pediatricians, and general dentists, is essential. The American Academy of Pediatricians [AAP] began a collaborative effort with pediatric dentists to address the issue of ECC. The AAP has made strides in developing educational programs for pediatricians and family physicians to identify at-risk children and refer them for dental treatment.

However, for many children, access to dental care remains a problem and the number with dental caries seems to be growing. Many children do not have dental insurance; thus, they postpone dental treatments until the problem is so advanced that it can no longer be treated.

It is unfortunate that even parents who have third-party coverage for dental care [Medicaid, Child Health Plus] and are from lower socioeconomic backgrounds often fail to seek dental care as part of general health-care services. As a result, pre-school children with Medicaid may still have untreated decayed teeth.

Frequent bottle feeding at night has been identified as a driving factor for ECC. Other studies have found a microbiological connection between mother and child, labeling ECC a transmissible disease. What is your opinion on this latest research and will it affect the way children should be treated?

Dr. Neal Herman: The nursing bottle is part of many children’s lives. The AAP recommends a gradual wean from the bottle at age 1 year of age, as the milk is not necessary in a child’s diet after that age.

ECC is a bacterial disease that requires more than one mode of treatment to be successful. The most effective approach to ECC — the “drill and fill” solution of the past — is the “drill and decay” solution of today.

The surgical approach to ECC — the “drill and fill” solution of the past — is the “drill and decay” solution of today. The goal of treatment is to preserve the hard structures of the teeth as much as possible. Therapeutic interventions, particularly utilizing fluoride varnish, have shown promise in preventing and reversing carious lesions.

Much more work must be done to document its success, but at least this “medical model” has begun to address the fact that ECC is a bacterial disease that requires more than just filling the holes that are merely its symptoms.

Root-canal treatments in primary teeth are also becoming more common. Does the treatment differ in any way from that of permanent teeth?

Dr. Lily Lim: We’re not sure that pulp therapy is on the increase but if it is, it’s probably because more parents and dentists realize it’s best to try to preserve a primary tooth rather than extract it whenever possible.

The goals of treatment for primary teeth are not much different than for permanent teeth. In both cases, diseased portions of the dental pulp are removed in an effort to preserve the hard structure of the tooth for functional or cosmetic purposes. Anatomical and physiological differences between primary and permanent teeth make a difference to the principle of root-canal treatment.

A permanent tooth requires an inert, solid, nonresorbable material that can last a lifetime, and gutta-percha fits that bill.

Fluoride varnish has proven to be a godsend, although most of the evidence to date is empirical and anecdotal. Good long-term longitudinal studies are needed to prove conclusively what we already know as clinicians — an intensive regimen of fluoride varnish, along with advice on proper oral-care practices, can control and often reverse dental decay, as well as prevent it.

Lim: Starting in infancy, children at risk for dental decay should be receiving twice yearly applications of fluoride varnish, whether by a dentist or dental professional, or as part of the overall care at their pediatricians. More than 40 states in the U.S. have implemented such programs, and the outcomes are impressive — as much as 40 percent fewer children with early signs of ECC.

Fernandez: Collaboration between other health providers and the dental professions is key to combating the incidence of ECC.

Fernandez: Collaboration between other health providers and the dental professions is key to combating the incidence of ECC.

You will be presenting at this year’s PDAA Congress in Pasay City. What will the participant be able to take home from your presentation?

Lim: At New York University [NYU] through education, outreach, training and collaboration with other health professionals, we have developed a multi-faceted approach to the many aspects of oral-health problems. Our presentation will describe the coordination of the strategies and programs that NYU employs, particularly in combating ECC.

Herman: Our presentation will examine and offer solutions to the management of ECC. We will offer a clinical therapeutic protocol that effectively stabilizes and/or arrests active caries, and that suggests a disease-intervention model of care that replaces restoration of teeth as the primary approach to the treatment of ECC in infants, toddlers and pre-school children.

Fernandez: Participants will learn about setting up an infant oral-health program in their offices using an auxiliary. The auxiliary should be able to conduct a risk assessment, provide anticipatory guidance and prescribe an individualized preventive program. Our presentation will outline the steps in establishing an infant oral-health program in the dental office.