Needs

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Many children lack a centre point from where coordinated, comprehensive and ongoing oral health care is provided. Often adolescents with SHCN can “fall through the net” when their care is transferred from the paediatric dentist or clinic to that of the general dentist.

Oral health status

Although the overall oral health of the general population is improving, disparities still exist in oral health needs among certain special needs groups. Individuals with mental retardation (MR), for example, have worse oral health and oral hygiene compared with the general population.1-3 Dental problems are among the top ten limiting secondary conditions, according to estimates by MR. Traci et al.4 found the estimated prevalence rate of oral hygiene problems was 451 per 1,000 individuals with MR compared with 1.2 percent in the general population.5

More than 80 craniofacial syndromes have been reported that can affect oral development with 25 percent associated with mental impairment.6 Muscle dysfunction contributes to malocclusion, particularly in people with cerebral palsy.7 Teeth that are crowded or out of alignment are more difficult to keep clean, contributing to periodontal disease and decay.8

Tooth anomalies are variations in the number, size and shape of teeth. Morphological patterns in SHCN children also can be disturbed. For example, children receiving chemotherapy for childhood cancer can result in a higher prevalence of various malformations in teeth.9

Children treated in the early years of their lives displayed the most severe dental defects, suggesting that immature teeth are at a greater risk of developmental disturbances than fully developed teeth.10 People with Down syndrome, oral clefts, ectodermal dysplasia or other conditions may experience congenitally missing, extra or malformed teeth.

Risk factors

Oral hygiene A number of factors may predispose an individual with SHCN to oral pathologies. The oral hygiene among individuals with MR has been shown to be considerably poor compared with individuals in the general population.11 Those with MR often have impaired physical coordination and cognitive sequenc- ing skills that limit independence in task completion.12

Medication Other factors include a lack of saliva as a side effect to multiple medication use13 or the high sugar content of some medicines.

Systemic factors The very nature of the child’s disability may also predispose to oral health problems, such as individuals with Down syndrome who may be more susceptible to gingivitis and other periodontal diseases because they are thought to have underlying abnormal immuno-logic responses.14

Oral development

Tooth eruption may be delayed, accelerated or inconsistent in children with growth disturbances. The gingivae may appear red or bluish-purple before erupting teeth break through into the mouth. Eruption depends on genetics, the development of the jaw, muscular action and other factors. Children with Down syndrome may show delays of up to two years.15

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Oral trauma Trauma to the face and mouth occur more frequently in people who have mental retardation, seizures, abnormal protective reflexes or muscle incoordination. Self-mutilation in children with MR may involve the oral and orofacial tissues where the lips or tongue may be chewed.

Strategies for oral health care

A number of strategies that can be employed by the general dentist and his team have been recently suggested by the National Maternal and Child Oral Health Resource Centre.16 These include:

• Work with parents and care givers to promote self care, healthy diet and access to regular dental care.

• Educate the whole dental team in assessment, prevention and early intervention methods such as oral hygiene advice, dietary advice, regular screenings and topical application of fluoride varnish or calcium enriched gel where needed.

• Be willing to coordinate care with specialists or other health care professionals.

• Offer practical help and recommendations to aid in oral hygiene maintenance such as the use of power toothbrushes and other appropriate oral hygiene aids, mouthwashases and toothpastes.

Providing oral care to patients with developmental disabilities, however, may simply require adaptation of the skills we use every day. In fact, most people with mild or moderate developmental disabilities can be treated successfully in the general practice setting. Keeping our knowledge base up to date will enable us to provide appropriate care for the special health care needs child.

A complete list of references is available from the publisher.