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. Dental problems are among the top 10 limiting secondary conditions, and inadequate oral hygiene among individuals with MR. Traci et al. found the estimated prevalence rate of oral hygiene problems was 451 per 1,000 individuals. Dental caries is one of these. The prevalence of gingivitis is 2.8 percent of women and found 5.3 percent of men and adolescents with MR compared with the general population.3,4 Dental problems are reported with respect to gingivitis, periodontal disease, bruxism and a lack of masticatory ability. Periodontal disease can occur in children with atypical development. More than 80 craniofacial syndromes have been reported that can affect oral development with 25 percent associated with mental impairment.11 Muscle dysfunction contributes to malocclusion, particularly in people with cerebral palsy. Teeth that are crowded or out of alignment are more difficult to keep clean, contributing to periodontal disease and dental decay.

**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 commonly poor compared with individuals in the general population. Those with MR often have impaired physical coordination and cognitive sequencing skills that limit independence in task completion.2 Medication Other factors include a lack of saliva as a side effect to multiple medication use 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 immunologic responses.

**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, growth of the jaw, muscular action and other factors. Children with Down syndrome may show delays of up to two years.12 Malocclusion and crowding of the teeth occur frequently in children with atypical development. More than 80 craniofacial syndromes have been reported that can affect oral development with 25 percent associated with mental impairment. Muscle dysfunction contributes to malocclusion, particularly in people with cerebral palsy. Teeth that are crowded or out of alignment are more difficult to keep clean, contributing to periodontal disease and dental decay.

**Periodontal health**

Similar findings also have been reported with respect to gingivitis, periodontal disease, bruxism and lack of masticatory ability. Periodontal disease can occur in children with impaired immune systems or connective tissue disorders and inadequate oral hygiene. The prevalence of gingivitis is estimated to be 1.2 to 1.9 times the prevalence of the general population. Periodontal disease also has been shown to be more prevalent among individuals with MR compared with the general population. Sturme and Hinds4 found 53 percent of those examined with MR had malnutrition and 29 percent had lack of systemic care. In addition, Oilo et al. examined the wear of teeth among individuals with MR and found 5.3 percent of men and 2.8 percent of women had unacceptable tooth wear that required treatment compared with 1.2 percent in the general population.

**Needs**

From Page 1

**Interaction**

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