PEDIATRIC DENTISTRY MINI CLINICS

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OUR DENTAL
TOOLBOX

PEDIATRIC MINI CLINIC TOPICS:

PREVENTION: 1ST DENTAL VISIT

1ST VISIT BY 1ST BIRTHDAY

- The American Academy of Pediatric Dentistry recommends the 1st dental visit by 1st birthday
  - Primary teeth begin to erupt around 4-6 months of age

- A child's risk of developing dental caries can start with the eruption of teeth and introduction of pathogenic bacteria into the mouth:
  - Sharing utensils
  - Blowing on food to cool it
  - Kissing baby on the mouth

- The 1st Visit is important for prevention, education, and creation of a dental home
  - Children seen by a dentist around age 1 are more likely to see the dentist on an ongoing basis, and less likely to require restorative or emergency visits.

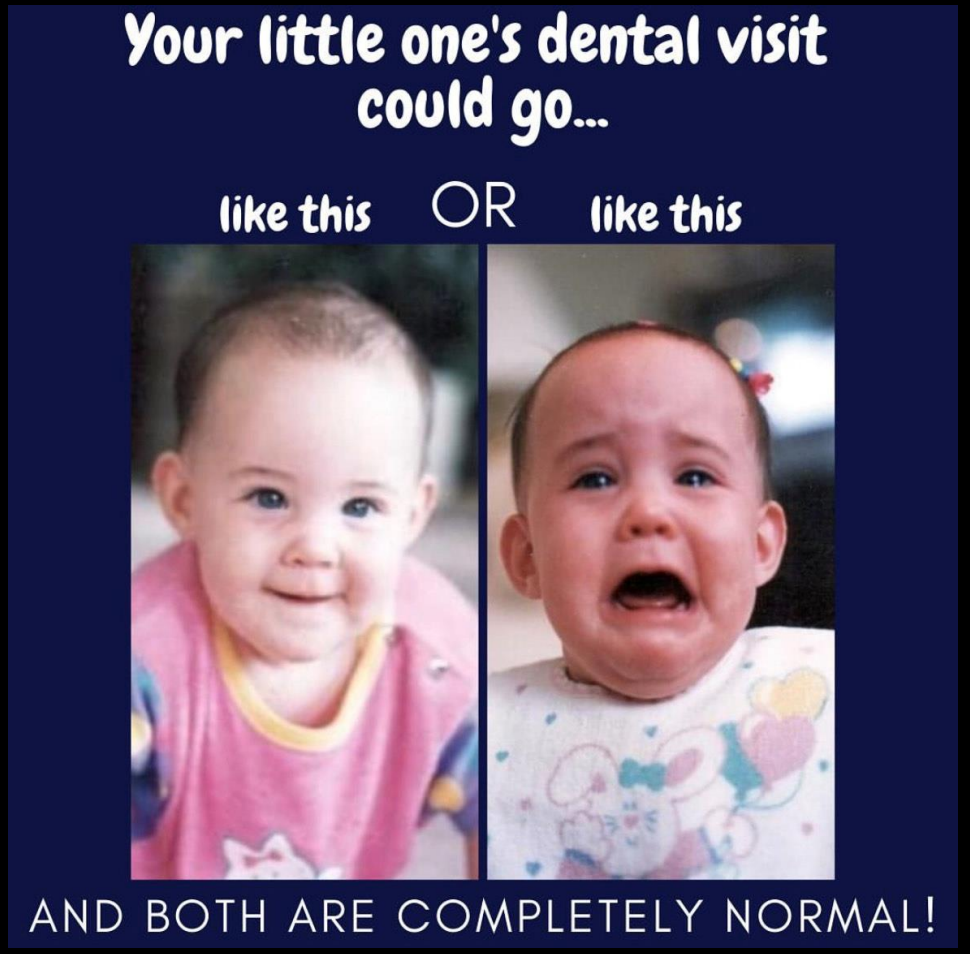
Smith Patterson. (2020, March 6). *A child's first dental visit*. Decisions in Dentistry. https://decisionsindentistry.com/article/a-childs-first-dental-visit/

PREPPING PARENTS AND CAREGIVERS FOR 1ST VISIT

- Children who come for their first dental visit under the age of 4 are considered pre-cooperative

- Setting expectations is important:
  - Child may cry / scream (singing!)
  - Child may be very active
  - Child may be totally fine

- This is all very normal, age appropriate behavior!

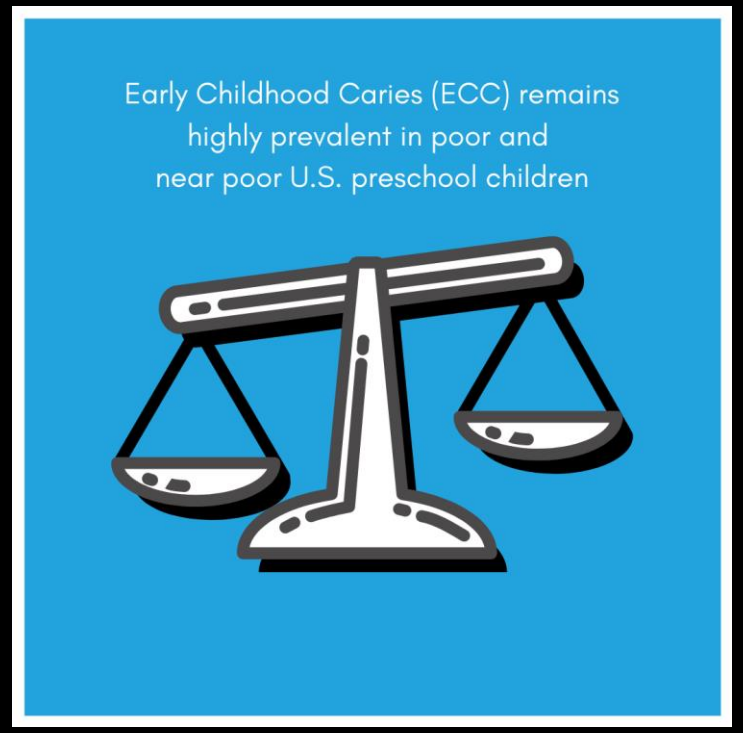


ORAL EXAMINATION

- Examining children can be tough!

- Knee to Knee Position for Exams helps providers and caregivers see:
  - Child is held facing caregiver with child's legs wrapped around caregiver's waist
  - Child leans back onto a pillow in the examiner's lap
  - Caregiver holds child's hands for comfort and safety
  - Dentist does exam and cleaning while caregiver helps stabilize the arms and legs

EARLY, ROUTINE DENTAL VISITS ARE IMPORTANT:



American Academy of Pediatric Dentistry. (2021). Chairside Guide: Silver Diamine Fluoride in the Management of Dental Caries Lesions. *THE REFERENCE MANUAL OF PEDIATRIC DENTISTRY*, 578–579. https://www.aapd.org/media/Policies_Guidelines/R_ChairsideGuide.pdf

CARIES RISK ASSESSMENT

- Assessing a patient's unique individual caries risk is critical for tailoring dental education and prevention

- Topics to Discuss with Parents:
  - Parent/Caregiver dental history
  - Diet including foods and beverages
  - Bottle feeding
  - Homecare
  - Fluoride Exposure
  - Plaque Score
  - Any obvious dental caries or incipient lesions

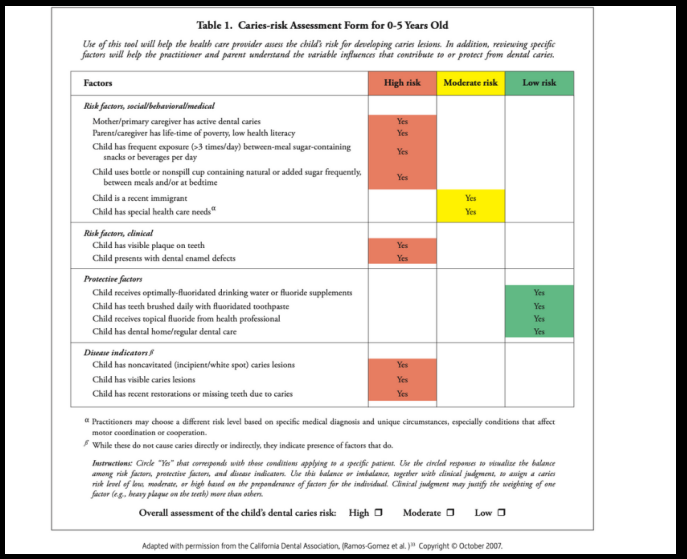


Table 1. Caries-risk Assessment Form for 0-5 Years Old

Use of this tool will help the health care provider assess the child's risk for developing caries lesions. In addition, reviewing specific factors will help the practitioner and parent understand the variable influences that contribute to or protect from dental caries.

Factors	High risk	Moderate risk	Low risk
Risk factors, social/behavioral/medical			
Mother/primary caregiver has active dental caries	Yes		
Parent/caregiver has life-time of poverty, low health literacy	Yes		
Child has frequent exposure (>3 times/day) between-meal sugar-containing snacks or beverages per day	Yes		
Child uses bottle or nonspill cup containing natural or added sugar frequently, between meals and/or at bedtime	Yes		
Child is a recent immigrant		Yes	
Child has special health care needs[α]		Yes	
Risk factors, clinical			
Child has visible plaque on teeth	Yes		
Child presents with dental enamel defects	Yes		
Protective factors			
Child receives optimally-fluoridated drinking water or fluoride supplements			Yes
Child has teeth brushed daily with fluoridated toothpaste			Yes
Child receives topical fluoride from health professional			Yes
Child has dental home/regular dental care			Yes
Disease indicators[β]			
Child has noncavitated (incipient/white spot) caries lesions	Yes		
Child has visible caries lesions	Yes		
Child has recent restorations or missing teeth due to caries	Yes		

[α] Practitioners may choose a different risk level based on specific medical diagnosis and unique circumstances, especially conditions that affect motor coordination or cooperation.

[β] While these do not cause caries directly or indirectly, they indicate presence of factors that do.

Instructions: Circle "Yes" that corresponds with those conditions applying to a specific patient. Use the circled responses to visualize the balance among risk factors, protective factors, and disease indicators. Use this balance or imbalance, together with clinical judgment, to assign a caries risk level of low, moderate, or high based on the preponderance of factors for the individual. Clinical judgment may justify the weighting of one factor (e.g., heavy plaque on the teeth) more than others.

Overall assessment of the child's dental caries risk: High ❒ Moderate ❒ Low ❒

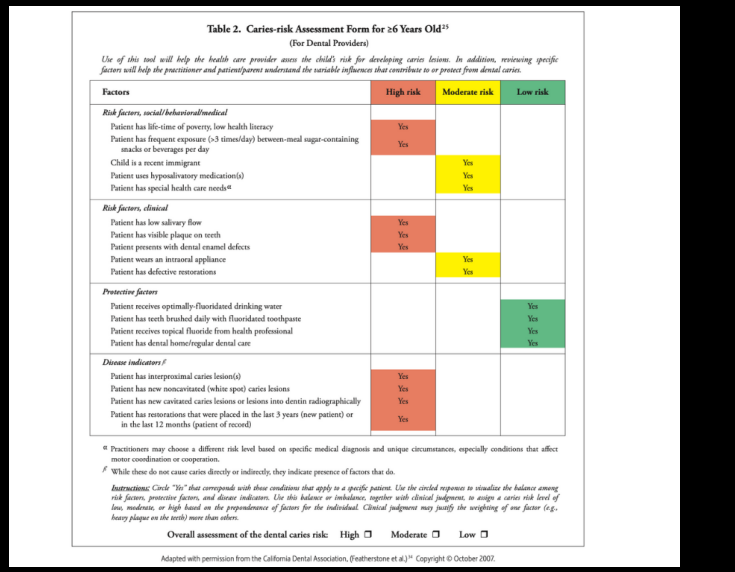


Table 2. Caries-risk Assessment Form for ≥6 Years Old[25]
(For Dental Providers)

Use of this tool will help the health care provider assess the child's risk for developing caries lesions. In addition, reviewing specific factors will help the practitioner and patient/parent understand the variable influences that contribute to or protect from dental caries.

Factors	High risk	Moderate risk	Low risk
Risk factors, social/behavioral/medical			
Patient has life-time of poverty, low health literacy	Yes		
Patient has frequent exposure (>3 times/day) between-meal sugar-containing snacks or beverages per day	Yes		
Child is a recent immigrant		Yes	
Patient uses hyposalivatory medication(s)		Yes	
Patient has special health care needs[α]		Yes	
Risk factors, clinical			
Patient has low salivary flow	Yes		
Patient has visible plaque on teeth	Yes		
Patient presents with dental enamel defects	Yes		
Patient wears an intraoral appliance		Yes	
Patient has defective restorations		Yes	
Protective factors			
Patient receives optimally-fluoridated drinking water			Yes
Patient has teeth brushed daily with fluoridated toothpaste			Yes
Patient receives topical fluoride from health professional			Yes
Patient has dental home/regular dental care			Yes
Disease indicators[β]			
Patient has interproximal caries lesion(s)	Yes		
Patient has new noncavitated (white spot) caries lesions	Yes		
Patient has new cavitated caries lesions or lesions into dentin radiographically	Yes		
Patient has restorations that were placed in the last 3 years (new patient) or in the last 12 months (patient of record)	Yes		

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Overall assessment of the dental caries risk: High ❒ Moderate ❒ Low ❒

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CARIES RISK ASSESSMENT

- Caries risk assessment is part of a comprehensive approach based on age of the child
- Caries risk assessment is the determination of the likelihood of increased incidence of caries (new cavitated or incipient lesions) during a certain time
- Can also include the likelihood that a present lesions will change in size or activity

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CARIES RISK ASSESSMENT

- Limitations of risk factors include:
- Past caries experience is not necessarily useful in young children – activity may be more important
- Low salivary flow is very difficult to measure
- Frequent sugar consumption is hard to quantify
- SES factors are a proxy for various exposures or behaviors which can affect caries risk

Table 2. Caries-risk Assessment Form for ≥6 Years Old[25]

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Overall assessment of the dental caries risk: High ❒ Moderate ❒ Low ❒

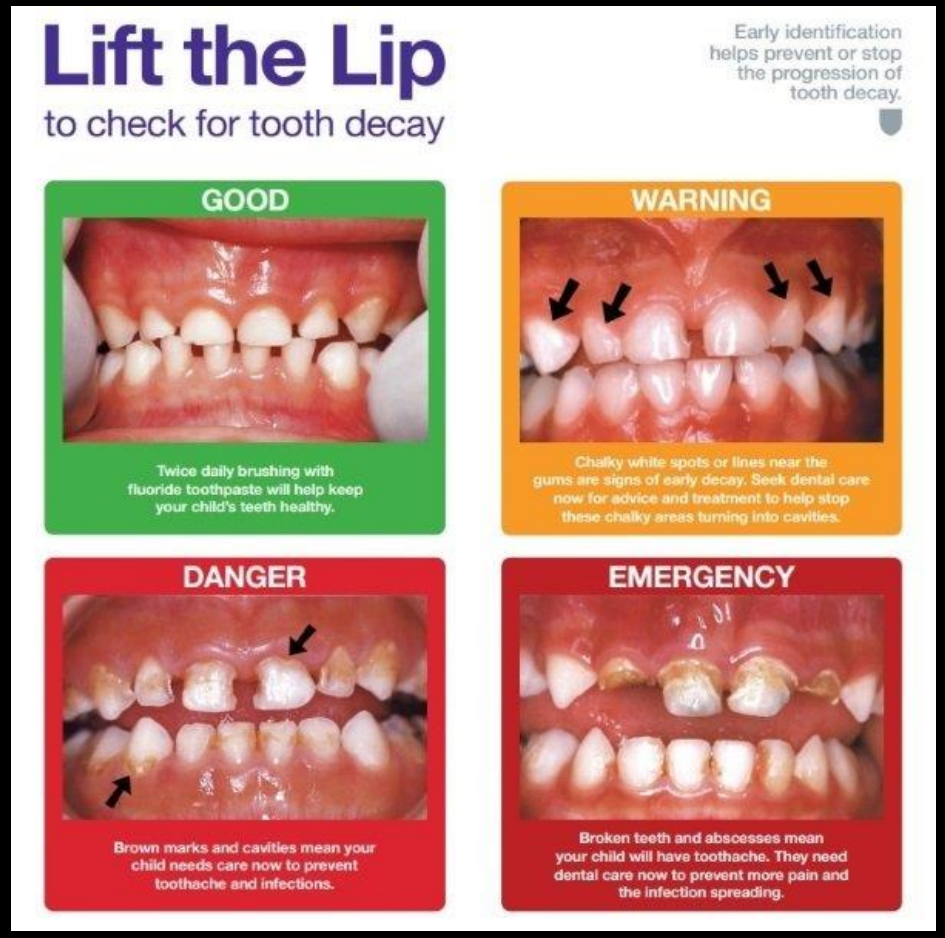
Adapted with permission from the California Dental Association, (Featherstone et al.)[34] Copyright © October 2007.

American Academy of Pediatric Dentistry. Caries-risk assessment and management for infants, children, and adolescents. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2023:301-7.

EARLY CHILDHOOD CARIES

- The disease of early childhood caries (ECC) is the presence of 1 or more decayed (noncavitated or cavitated lesions), missing (due to caries), or filled tooth surfaces in any primary tooth in a child 6 or younger.

- In children younger than 3 years of age, any sign of smooth-surface caries is indicative of severe early childhood caries (**S-ECC**)



American Academy of Pediatric Dentistry. Policy on early childhood caries (ECC): Classifications, consequences, and preventive strategies. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2020:79-81.

ANTICIPATORY GUIDANCE

Brushing Small children

- Smear size amount of toothpaste for children under 3
- Pea size amount for children over the age of 3
- Parents and caregivers should be main brushers
- Begin flossing once the teeth touch together

Tooth Eruption

- Primary teeth typically start to erupt between 4-6 months of age
- Normal Signs of Teething: Drooling, Irritability, Face Rubbing, Low Grade Fever
- Parents and caregivers should never use amber teething necklaces (choking hazard) or topical anesthetics to treat

Nonnutritive habits

- Pacifier use beyond 18 months can influence the developing occlusion
- Prolonged thumb and pacifier use can lead to anterior/posterior crossbite, increased overjet, and decreased overbite
- The AAPD recommends to have habits stop by age 3

Fluoride Exposure

- Drinking water, toothpaste, Halo Effect
- Fluoride supplements can be considered for children with high caries risk with drinking water less than 0.6 ppm F
- Before prescribing determine potential sources of dietary fluoride (infant formula, water at school/daycare, prepared food, juice, etc)

ANTICIPATORY GUIDANCE

Trauma Prevention

- As children begin walking and playing accidents and dental trauma can occur
- Safety – Outlets/Electrical Chargers and Not putting play objects in their mouth
- Potential for dental trauma to occur as children learn to walk, use the stairs, and run
- For older children: dental safety when playing sports

Tongue/Lip Tie

- Tongue Tie – shallow latch on breast, slow/poor weight gain, prolonged feeding times, irritability from swallowing excessive air
- Maxillary Lip Frenum - treatment considered if attachment has traumatic force on gingiva and papilla blanches when pulled, diastema wider than 2 mm
- Work with an SLP for school age children
- Multi-disciplinary team – IBILC, SLP, Myofunctional therapist, Dentistry

Dietary Counselling

- Baby bottle dental decay occurs from nighttime or prolonged feeding throughout the day
- Increased risk for cavities if a bottle, transportable cup or juice boxes are given throughout the day
- Frequent consumption of sugary or starchy foods throughout the day plays a role in caries formation
- Water is the preferred beverage for children from 1-5 years of age

MINIMALLY INVASIVE DENTISTRY

FLUORIDE VARNISH

- The American Academy of Pediatric Dentistry recommends that children at risk of cavities receive fluoride at least every 6 months
- Fluoride varnish contains 5% sodium fluoride or 22,600 parts per million fluoride
- Children who are at high caries risk can benefit from more frequent visits along with the application of fluoride varnish

FLUORIDE VARNISH

- Benefits of Fluoride Varnish application:
  - Quick and easy to apply
  - Strengthens enamel
  - Can help stop early tooth decay and decalcifications
  - More frequent fluoride application visits also give dentists an opportunity to review homecare, diet, and other caries risk factors

- Fluoride varnish application has been shown to have a 37% decrease in the incidence of decayed/missing/filled surfaces in primary teeth

Marinho VCC, Worthington HV, Walsh T, Clarkson JE. Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews 2013, Issue 7. Art. No.: CD002279. DOI: 10.1002/14651858.CD002279.pub2. Accessed 10 November 2024.

SILVER DIAMINE FLUORIDE (SDF)

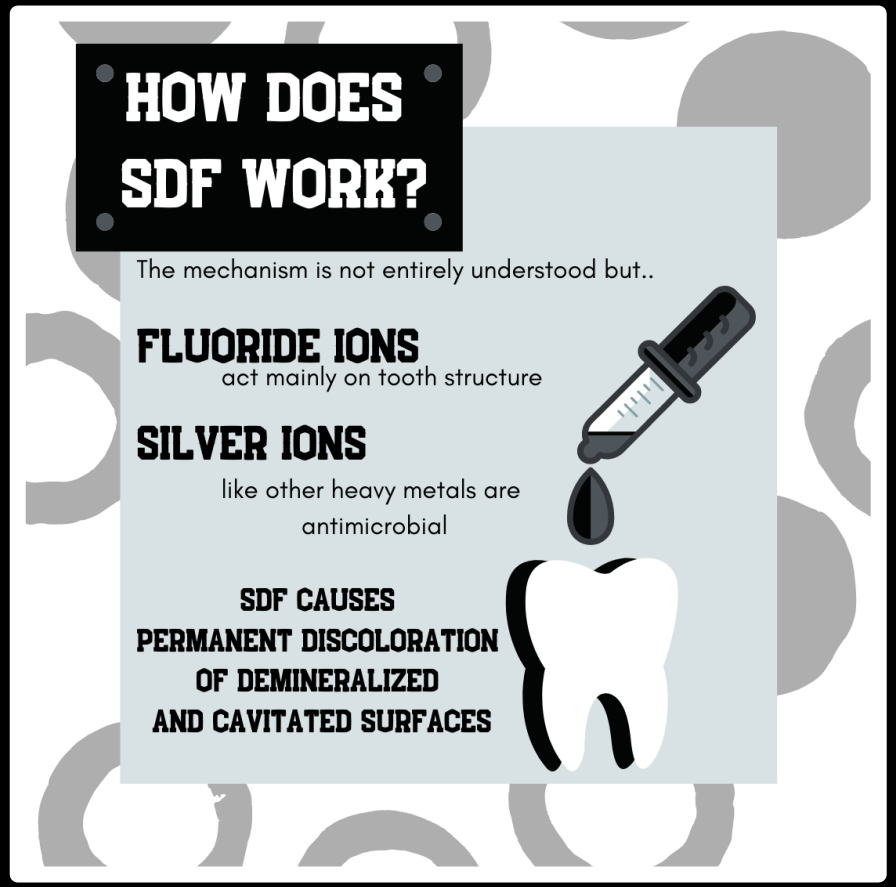
- Silver Diamine Fluoride is a liquid solution containing silver and fluoride
- 38% SDF is used in the United States
  - Contains 44,800 ppm fluoride compared to:
    - OTC Toothpastes: 1000-1500 ppm fluoride
    - Prevident: 5000 ppm fluoride
    - 5% Sodium Fluoride Varnish: 22,600 ppm fluoride
- SDF and other silver containing products have been used outside the United States for many years

Zheng, F. M., Yan, I. G., Duangthip, D., Gao, S. S., Lo, E. C. M., & Chu, C. H. (2022). Silver diamine fluoride therapy for dental care. *The Japanese dental science review*, *58*, 249–257. https://doi.org/10.1016/j.jdsr.2022.08.001

MECHANISM OF ACTION

Potential SDF Mechanisms of Action:

- Inhibits Demineralization and Promotes Remineralization
  - Reacts with tooth hydroxyapatite to form calcium fluoride and silver phosphate
  - The calcium fluoride ultimately leads to the production of fluorapatite
  - Fluorapatite is less soluble than hydroxyapatite (especially in an acidic environment)
- Inhibits Biofilm Formation and Anti-microbial:
  - Silver ions like other heavy metals are anti-microbial
  - Fluoride at high concentrations is also anti-microbial
- Stains carious and demineralized tooth structure black



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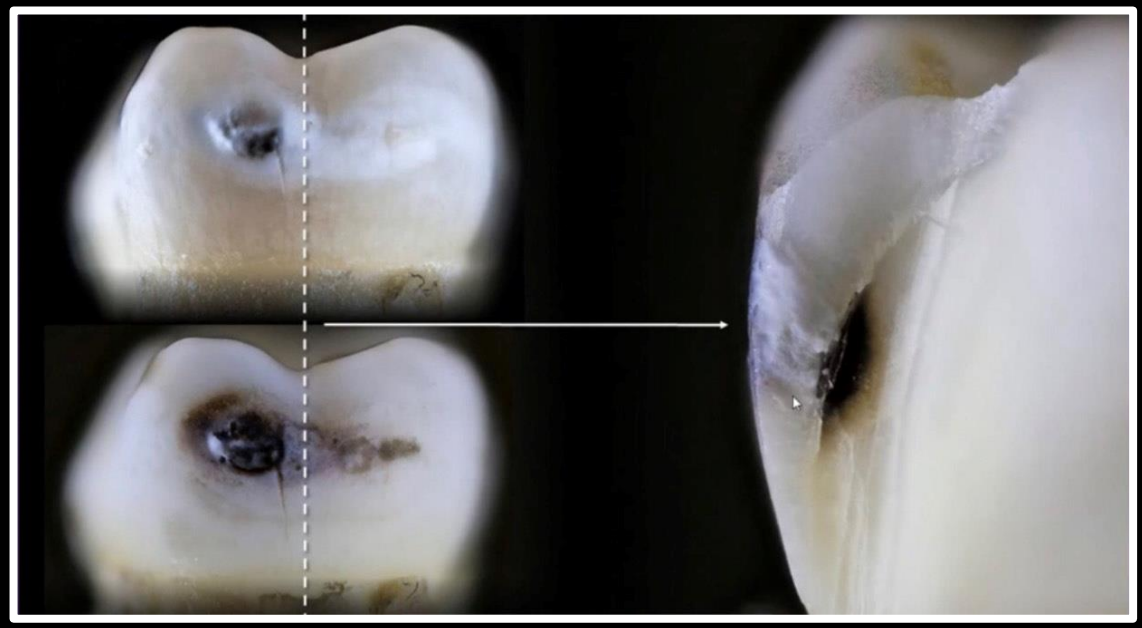
SDF ARMAMENTARIUM

- Advantage Arrest 38% SDF
- Vaseline
- Superfloss
- Dry Angle
- Microbrush
- Dappen Dish

ARRESTS DECAY

- Demineralized enamel and dentin surfaces are stained black
- Increased microhardness of carious lesions after SDF placement
  - The fluoride component of SDF contributes to remineralization and fluorapatite formation
  - Creates hard, more caries resistant tooth structure
- Demineralized teeth treated with SDF have less mineral loss than teeth without SDF treatment
  - Less soluble silver phosphate and silver chloride create a protective layer decreasing calcium and phosphorous loss



Oliveira, B. H., Rajendra, A., Veitz-Keenan, A., & Niederman, R. (2019). The Effect of Silver Diamine Fluoride in Preventing Caries in the Primary Dentition: A Systematic Review and Meta-Analysis. *Caries research*, *53*(1), 24–32. https://doi.org/10.1159/000488686

CASE SELECTION

- Patients with:
  - High caries risk who have active or cavitated caries lesions in anterior or posterior teeth
  - Behavioral /medical challenges and cavitated caries lesions
  - Multiple cavitated caries lesions that may not all be treated in 1 visit
  - Dental caries lesions that are difficult to treat
  - Patients without access to dental care or difficulty accessing dental care

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SDF APPLICATION

CASE 1: W.R. – 1YR/7MOS

- Neuroblastoma Diagnosis at 9 months old
  - Chemotherapy
  - Tumor resection
  - Bone marrow transplant
  - Radiation
  - Immunotherapy
- First dental visit at 1year 7 months old
  - Silver Diamine Fluoride applied
- Remission at 24 months

Special thanks to Dr. Ed Ginsberg for the case

CASE 1: W.R. – 24 MONTHS

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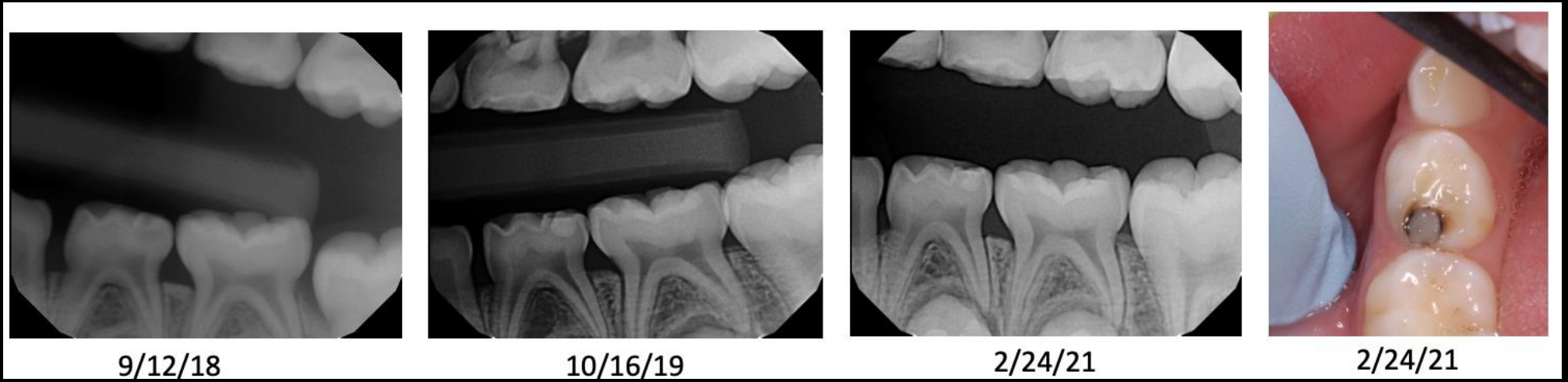
CASE 2: SMART TECHNIQUE



Special thanks to Dr. Ed Ginsberg for the case

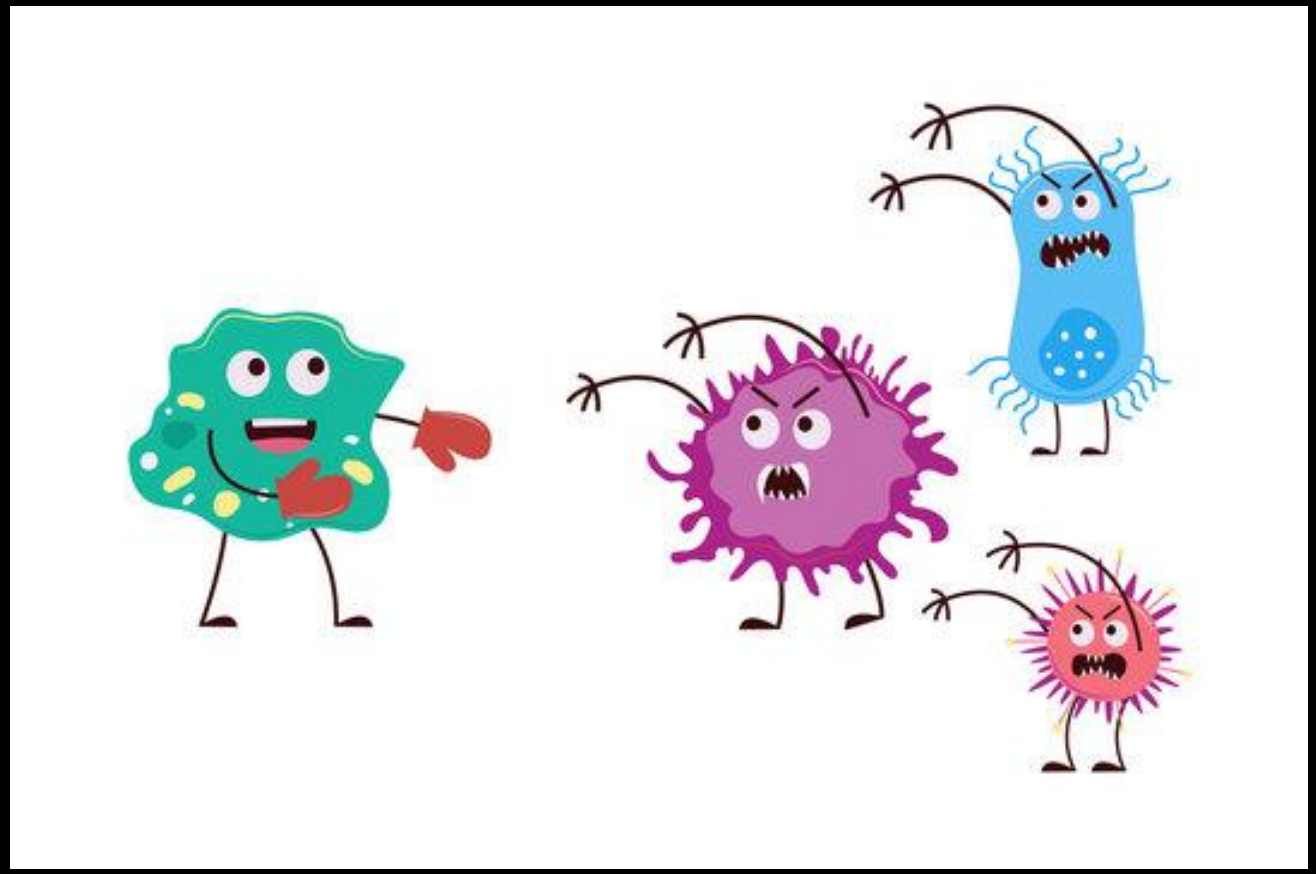
What minimally invasive options do we have if the cavitated lesion site is larger or multi-surface?

HALL TECHNIQUE

- Placement of a stainless steel crown over a carious lesion in a primary molar without:
  - Local anesthesia
  - Caries excavation
  - Tooth preparation
- Aimed to increase a child's compliance and operator comfort as local anesthetic is eliminated.

WHY DOES THIS WORK?

The cariogenic biofilm is removed from the oral environment by the placement of the SSC.



INDICATIONS

- Fearful or anxious children where behavior guidance is unsuccessful
- Primary teeth with deep or multi surface caries **without pulpal involvement**
  - Radiographs are very important!!
- Treatment where equipment for conventional procedures are not available

CONTRAINDICATIONS

- Teeth that show signs or symptoms of pulpal involvement
- Teeth considered non-restorable
- Patients with a significant medical history i.e. cancer, endocarditis
- Morphology which would make crown placement difficult
- The crown can’t be placed without compromising the patient’s airway

VIDEO-HALL CROWN TECHNIQUE

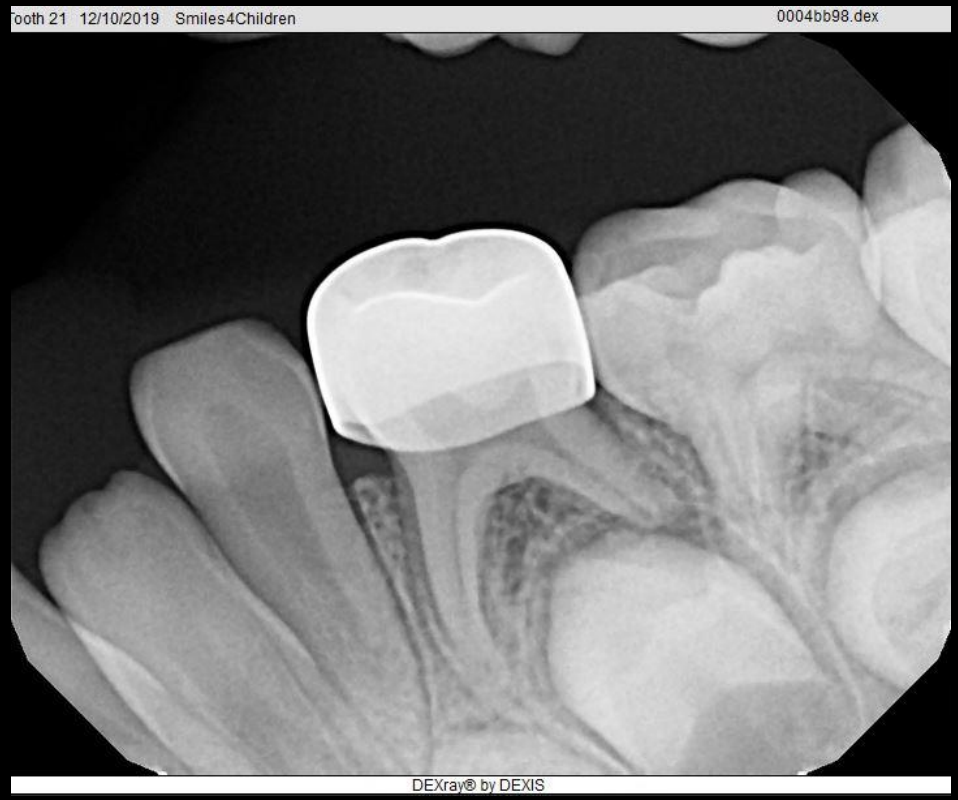
HALL CROWN CASE

- Patient diagnosed with Autism, initially seen for treatment at 6 years 3 months old due to cavities on bitewing on 5/28/2019
- Due to behavior and sensory concerns treatment was originally planned as a sedative to be placed without local or nitrous. An ortho separator was placed to open the contact for access
- Discussed with mom, may consider a hall crown depending on behavior

Special thanks to Dr.Rachael Simon for the case

HALL CROWN CASE

- Treatment Visit 6/11/19:
  - Patient arrived for initial treatment plan of sedative restoration on #L
  - Caries excavation was attempted with slow speed however patient became agitated and upset
  - Updated the treatment plan to Hall Crown placement due to behavior and ability for patient to tolerate treatment
  - Placed Size 6 Ion SSC and cemented with Fuji I Cement
  - Post Op PA taken 12/2019



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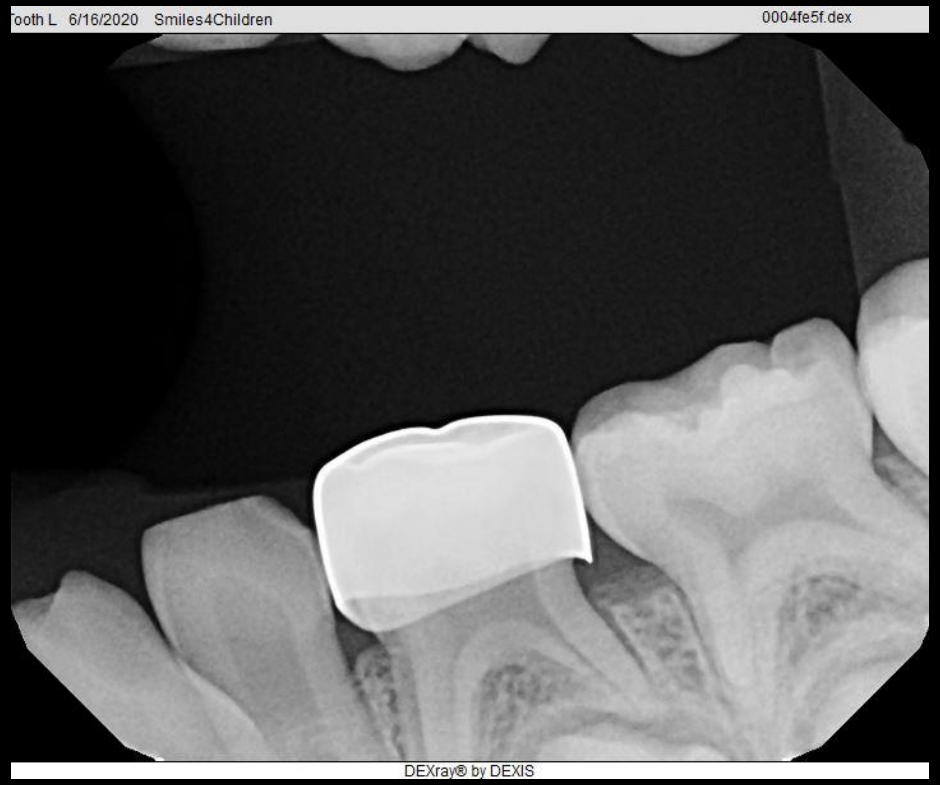
HALL CROWN FOLLOW UP

- This patient returned for subsequent recall visits



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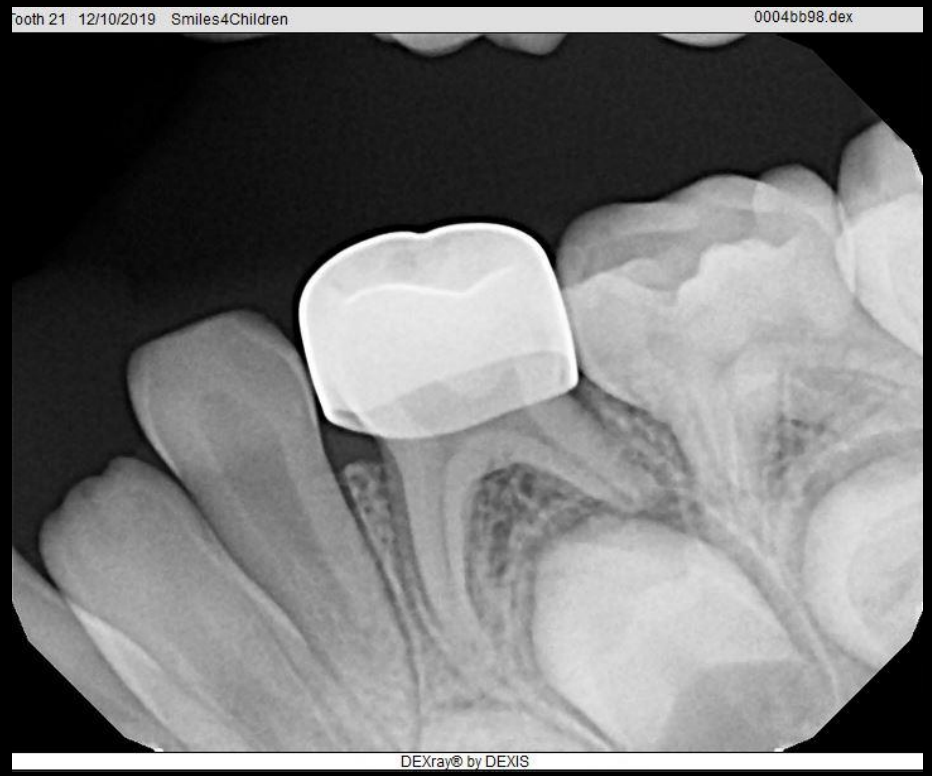
HALL CROWN SUCCESS

- In a study comparing Hall Crowns vs Traditional SSC Crowns researchers found:
  - There was no statistically significant difference (P-value > 0.05) between the conventional SSC restoration and the Hall technique for both primary and secondary outcomes
    - Primary outcomes/major failures: irreversible pulpitis, dental abscess, peri-radicular radiolucency, and crown loss with tooth unrestorable
    - Secondary outcomes/minor failures: crown loss and tooth restorable, crown perforation, secondary/marginal caries, and reversible pulpitis



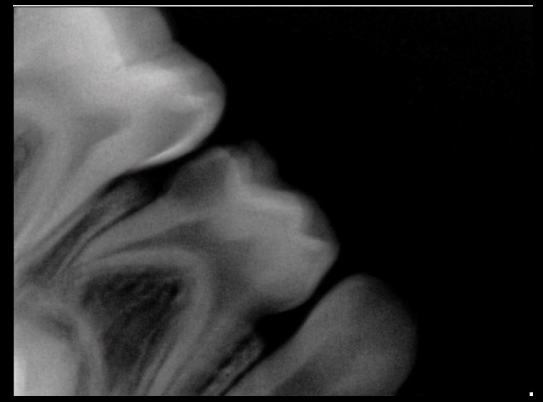
Ayedun OS, Oredugba FA, Sote EO. Comparison of the treatment outcomes of the conventional stainless steel crown restorations and the hall technique in the treatment of carious primary molars. Niger J Clin Pract. 2021 Apr;24(4):584-594. doi: 10.4103/njcp.njcp_460_20. PMID: 33851682.

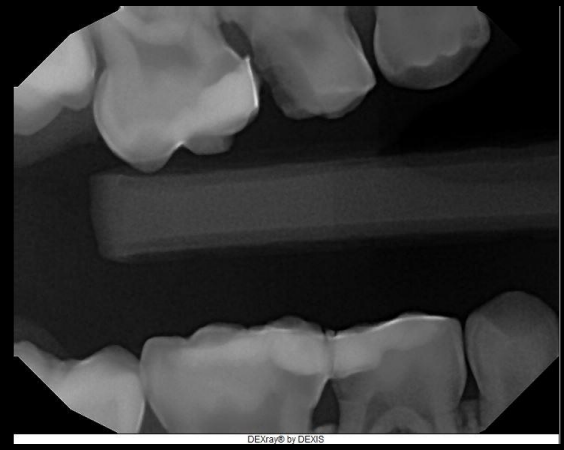
RESTORATIVE DENTISTRY

RESTORATION CHOICES

- Each material for restorative treatment in primary teeth has pros and cons:
  - Composite
  - Resin Modified Glass Ionomer
  - Stainless Steel Crown
  - Sealants

- Restorative choices are based on:
  - Caries risk assessment
  - Dental age vs Chronological age
  - Behavior





FACTORS TO CONSIDER WHEN CHOOSING RESTORATIVE MATERIALS

- Ease of handling
- Longevity of restorations
- Anti-caries effect
- Cost Effectiveness
- Esthetics

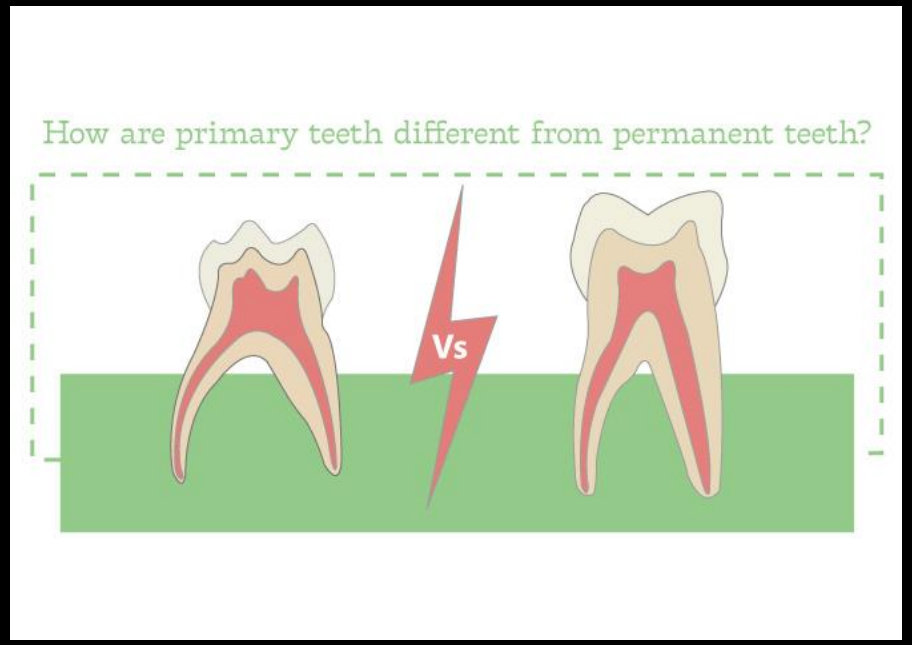
Finucane, D. (2019, May 30). *Restorative treatment of primary teeth: An evidence-based ...* Wiley Online library. https://onlinelibrary.wiley.com/doi/10.1111/adj.12682

CHRONOLOGIC VS DENTAL AGE

- Chronologic age is a child's age in years and months
- Can be helpful to document age in years and months to have an idea about behavior and cooperation level
- Panoramic radiographs can help to establish dental age compared to chronologic age
- The dental age is the child's age according to how they present from a dental development standpoint:
  - Children's dental age can match what we would expect for their chronological age
  - Children can be dentally delayed
  - Children can be dentally advanced
- Consider a child's dental age when considering restorative options

PRIMARY VS PERMANENT TEETH

- Primary tooth pulps are larger in relation to the crown
  - Pulp involvement can happen more quickly
- Pulp horns are closer to the dentin enamel junction
  - Especially toward the mesiofacial
- Greater constriction of the cementoenamel junction
  - More prominent cervical constriction
  - Excessive gingival extension of preps can lead to loss of the gingival floor
- Broader, flatter contacts
- Enamel and dentin are lighter in color



COMPOSITE

- Recommended for:
  - Class 1 and Class 2 restorations in primary and permanent teeth
  - Enamel defects or malformations
  - Restorations of traumatic fractures
  - Good evidence for use in moderate to low caries risk patients where isolation can be achieved
- Survival Rates:
  - Class 1 primary/permanent teeth: 90% at 10 years
  - Class 2 primary molars: >90% at 3 years post placement
  - Strip Crowns on primary anterior teeth: 80% at 36 months post placement
- Main reason for restoration failure is recurrent caries

American Academy of Pediatric Dentistry. Pediatric restorative dentistry. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2022:401-14.

RESIN MODIFIED GLASS IONOMER

- Resin Modified Glass Ionomers release fluoride ions
  - They can also absorb ions at their surface
  - The exchange of ions such as fluoride helps prevent adjacent tooth demineralization and enhance remineralization

- Indications for use:
  - Long term temporization of a tooth for caries control or deferred definitive treatment
  - Replacement of primary tooth structure where:
    - Restoration will not receive excessive force
    - Isolation is adequate but not ideal
    - Patients where caries risk factors are not controlled
    - Patients where behavior requires quick delivery of treatment

Velan, Elizabeth, et al. “Restorative Dentistry and Dental Materials .” *The Handbook of Pediatric Dentistry*, edited by Arthur J Nowak and Paul S Casamassimo, 5th Edition ed., American Academy of Pediatric Dentistry, Chicago, Illinois, 2018, pp. 158–176.

STAINLESS STEEL CROWNS

- Recommended for:
  - Extensive Caries where other restorative options are likely to fail
  - Circumferential cervical decalcification
  - Developmental defects on primary and permanent teeth
    - Hypoplasia
  - Teeth treated with pulpotomy or pulpectomy
  - Strong consideration for patients with high caries risk

- SSC Benefits:
  - Full coverage
  - Combat recurrent decay
  - Provide strength and long-term durability

- Survival Rate:
  - Traditional SSC on primary teeth: 95%
  - Hall Crown: 95%

Velan, Elizabeth, et al. “Restorative Dentistry and Dental Materials .” *The Handbook of Pediatric Dentistry*, edited by Arthur J Nowak and Paul S Casamassimo, 5th Edition ed., American Academy of Pediatric Dentistry, Chicago, Illinois, 2018, pp. 158–176.

SEALANTS

- 80-90% of caries in permanent teeth are in pits/fissures

- Consider Placement:
  - High caries risk patients
  - Posterior teeth with deep pits and fissures
  - Non-cavitated small caries on occlusal surface
  - Sealing over completed restorations

- "Seal is the Deal"
  - Bonded and sealed composite restorations placed over frank cavitated lesions arrested the progress of these lesions over a period of 10 years

Mertz-Fairhurst, E. J., Curtis, J. W., Jr, Ergle, J. W., Rueggeberg, F. A., & Adair, S. M. (1998). Ultraconservative and cariostatic sealed restorations: results at year 10. *Journal of the American Dental Association (1939)*, *129*(1), 55–66. https://doi.org/10.14219/jada.archive.1998.0022

PEDIATRIC RESTORATIVE CHOICES

Composite

- Pros:
  - Esthetic
  - Micromechanical seal between tooth and restoration
  - Better wear resistance than RMGI
- Cons:
  - Technique sensitive
  - Increased chair time
  - Recurrent caries

Resin Modified Glass Ionomer

- Pros:
  - Releases fluoride
  - More moisture tolerant than composite
  - Ease of placement
- Cons:
  - Surface finish not as smooth as resin
  - Surface wear is greater than resin
  - Longevity concerns over time

Stainless Steel Crown

- Pros:
  - Full coverage to restore form and function
  - Protects remaining tooth structure from caries formation
- Cons:
  - Not esthetic
  - Can increase localized gingivitis but this can improve with good oral hygiene

Sealant

- Pros:
  - Protects susceptible grooves and fissures in molars and premolars
- Cons:
  - Technique and Isolation sensitive

BEHAVIOR MANAGEMENT

Evaluating Behavior

- Frankl Scale
  - F1 – Definitely Negative
  - F2 – Negative
  - F3 – Positive
  - F4- Definitely Positive
- Keep behavior visit notes at each appointment
  - Gives you an idea of what to expect

Non-Pharmacologic Vs Pharmacologic

- Non-Pharmacologic
  - Tell Show Do, Distraction, Etc
  - Nitrous Oxide
- Pharmacologic
  - Oral Sedation
  - Dental rehabilitation in the hospital setting

BEHAVIOR NOTES

ACCOMPANIED BY: Mom/Back
AGE OF PATIENT (yrs/months): 7/3
WEIGHT (lbs): 84
BEHAVIOR: Coop, tight lips, high hands at times, touchy

ACCOMPANIED BY: Mom (Rm)
AGE OF PATIENT (yrs/months): 4/1
WEIGHT (lbs): 40
HEIGHT (in): --
BEHAVIOR: Coop, sunglasses, chair half reclined

ACCOMPANIED BY: Mom-Back
AGE OF PATIENT (yrs/months): 3/4
WEIGHT (lbs): 30.8
BEHAVIOR: chair laid half back, sunglasses, TSD

ACCOMPANIED BY: Mom/Back
AGE OF PATIENT (yrs/months):5/5
WEIGHT (lbs):43
HEIGHT (in): NA
BEHAVIOR:coop
PERSONAL REMARKS: Loves sparkles, starting kindergarten in the fall!!

ACCOMPANIED BY: Dad (back)
AGE OF PATIENT (yrs/months): 7/1
WEIGHT (lbs): 61
HEIGHT (in):
BEHAVIOR: Mostly coop, chair slightly reclined, dad sat next to him on bench, sits up occasionally fussing, "Ahhhh", dad very encouraging, counting helps

.....v coop and nervous initially. Very helpful to TSD as appropriate (rubber dam, high speed sound, low speed etc), patient loves Virignia Tech and Ravens - did well with distraction and sedation.
.....Father Back
.....Assistant: ED/SI Doctor: JV
N/V: TX Complete and RC Visit

ACCOMPANIED BY: mom-back
AGE OF PATIENT (yrs/months): 18/11
WEIGHT (lbs): UTO
BEHAVIOR :Comes back with walker, in chair layed 1/3rd back, blisonic, 2 assistants- one to hand/suction and one to chart, music helps, coarse prophy paste, likes to rock to music on short breaks, strong tight lips, slight head jerks at times- used blisonic, green/yellow scaler, green scaler.
PERSONAL REMARKS: Loves music!!

NON-PHARMACOLOGIC BEHAVIOR MANAGEMENT

Tell Show Do

- Verbally explain the procedure in age appropriate language
- Demonstrate the visual, auditory, tactile aspects of the procedure
- Without deviating complete the procedure

Distraction

- Diverting patient's attention from what may be perceived as an unpleasant procedure
- Can use imagination, audio, or visual distraction techniques

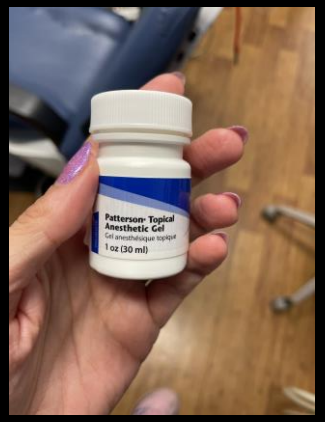
Descriptive Praise

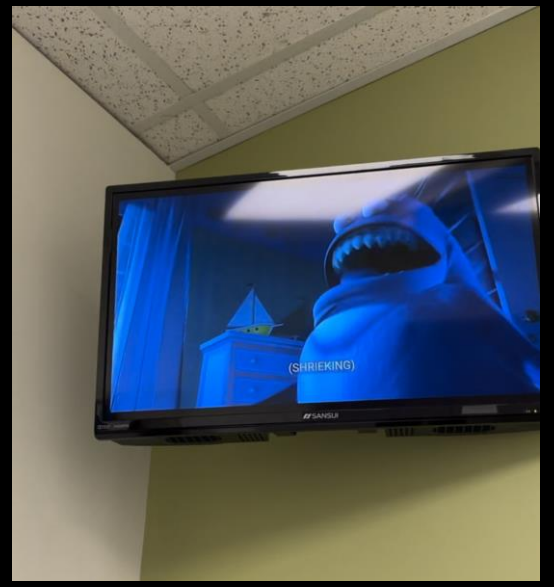
- Emphasizes specific cooperative behaviors (ie. Great job keeping your hands still) rather than general praise (you're doing great)

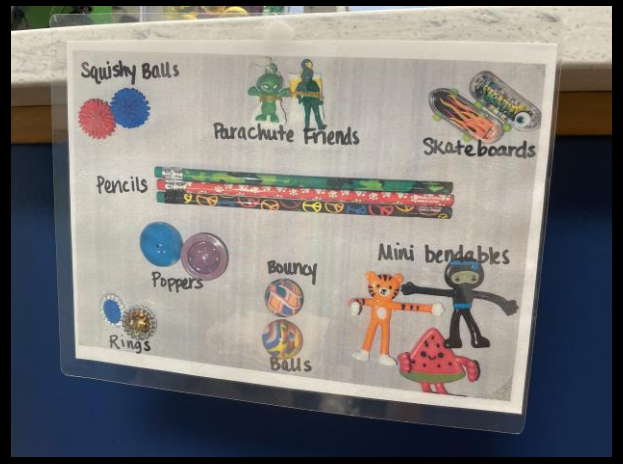
Desensitization

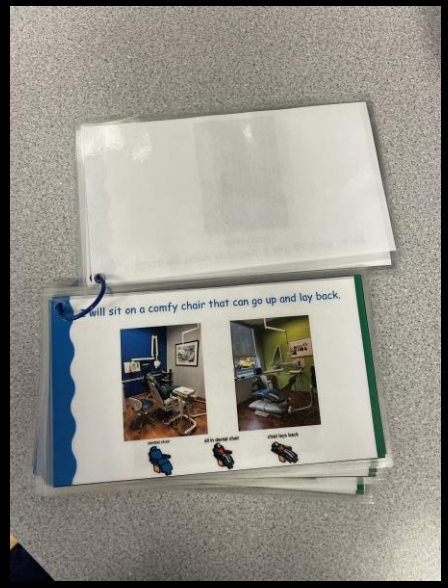
- Diminishes emotional responsiveness to a negative stimulus after progressive exposure to it

PEDIATRIC DENTAL DISTRACTIONS









NITROUS OXIDE OR "HAPPY AIR"

Objectives

- Reduce anxiety
- Reduce untoward movement and reaction to dental treatment
- Increase tolerance for longer appointments
- Reduce gagging

Indications

- Fearful, anxious patient
- Patients whose gag reflex interferes with dental care
- A cooperative child undergoing a lengthy dental procedure

Contraindications

- Some chronic obstructive pulmonary disease
- Current upper respiratory tract infection
- Recent middle ear disturbance/surgery
- 1st trimester of pregnancy
- Treatment with bleomycin sulfate
- MTHFR and cobalamin deficiency

CHILD FRIENDLY LANGUAGE

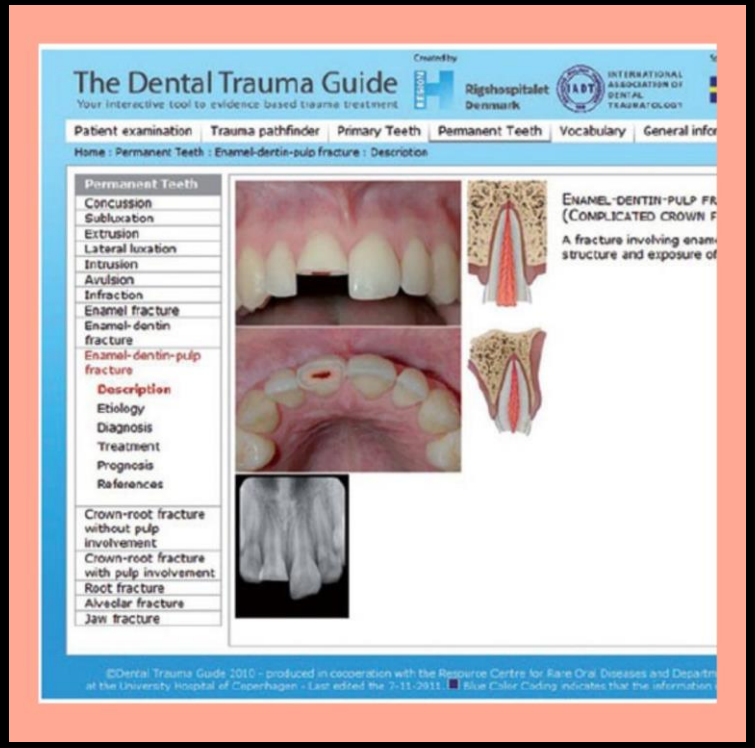
WHEN TO REFER

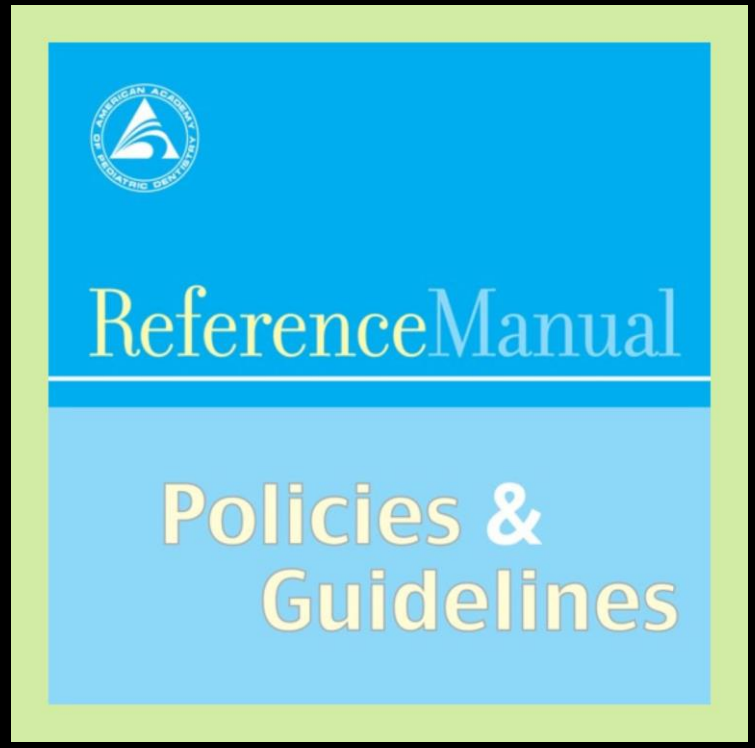
- Uncooperative or pre-cooperative child
- Patients with extensive dental needs needing multiple visits
  - Over time behavior can worsen with each subsequent visit
- Patients who may benefit from nitrous oxide, oral sedation or being a GA Case
- Patients with special health care needs or complex medical history that may need treatment in the hospital setting

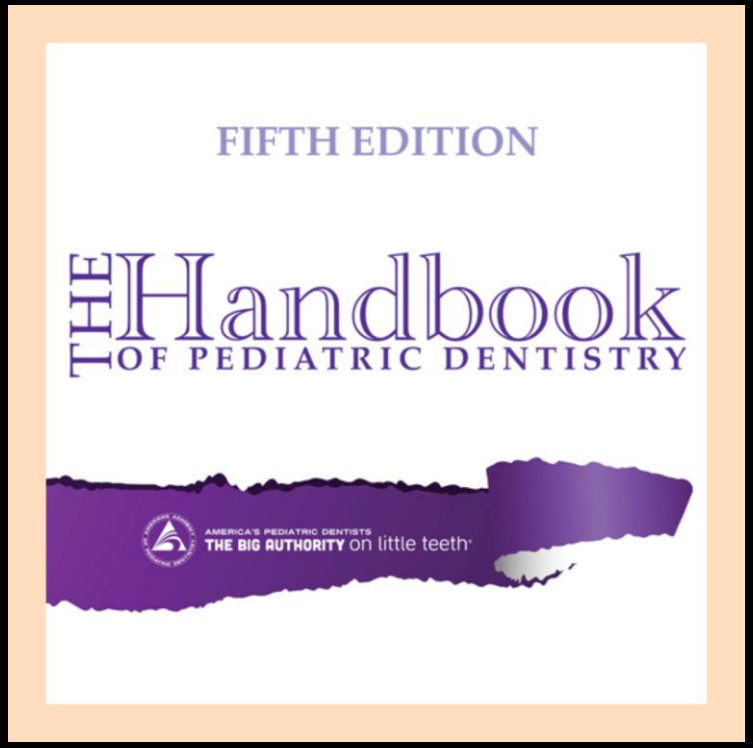
FINAL THOUGHTS

- Early prevention and early initial visit are key to the creation of a dental home
- Always consider chronologic age vs dental age and caries risk when treatment planning
- Every child is different and each approach to care is unique!

PEDIATRIC DENTAL RESOURCES







“YOU TREAT A DISEASE, YOU WIN, YOU LOSE. YOU TREAT A PERSON, I GUARANTEE YOU, YOU’LL WIN, NO MATTER WHAT THE OUTCOME.” – PATCH ADAMS

Thank you! What else would you like to know?

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