THSteps Dental Guidelines

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Appendix N

N.1 American Academy of Pediatric Dentistry Periodicity Guidelines

Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children

Originating Committee
Clinical Affairs Committee

Review Council
Council on Clinical Affairs

Adopted
1991

Revised

Purpose
The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners make clinical decisions concerning preventive oral health care for infants, children, and adolescents. Because each child is unique, these recommendations are designed for the care of children who have no contributory medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from the normal.

Methods
This guideline is a compilation of pediatric oral health literature and national reports and recommendations, in addition to related policies and guidelines published in the AAPD Reference Manual.1-24 The related policies and guidelines provide references for individual recommendations. Some recommendations are evidence-based, while others represent best clinical practice and expert opinion.

Background
The AAPD emphasizes the importance of professional oral health intervention very early in childhood. Caries-risk assessment15 is an essential element of contemporary clinical care for infants, children, and adolescents. Continuity of care is based on the assessed needs of the individual patient. Although evidence-based research supporting the benefits of an infant dental intervention is limited, there is sufficient evidence that certain groups of children are at greater risk for development of early childhood caries (ECC) and would benefit from infant oral health care. ECC can be a costly, devastating disease with a lasting detrimental impact on the dentition and systemic health issues.7 The characteristics of ECC and the availability of preventive methods support anticipatory guidance as an important strategy in addressing this significant pediatric health problem. Major benefits of early intervention, in addition to assessment of risk status, include analysis of fluoride exposure and feeding practices, as well as oral hygiene counseling. The early dental visit should be seen as the foundation upon which a lifetime of preventive education and oral health care can be built. Clinicians must consider each infant’s, child’s, and adolescent’s individual needs and risk indicators to determine the appropriate interval and frequency of dental visits.

Recommendations

Birth to 12 months

1. Complete the clinical oral examination with appropriate diagnostic tests to assess oral growth and development, pathology, and/or injuries; provide diagnosis.
2. Provide oral hygiene counseling for parents, guardians, and caregivers, including the implications of the oral health of the caregiver.
3. Remove supragingival and subgingival stains or deposits as indicated.
4. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe systemic fluoride supplements, if indicated, following assessment of total fluoride intake from drinking water, diet, and oral hygiene products.
5. Assess appropriateness of feeding practices, including bottle and breast-feeding, and provide counseling as indicated.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for nonnutritive oral habits (eg, digit, pacifiers).
9. Provide required treatment and/or appropriate referral for any oral diseases or injuries.
11. Consult with the child’s physician as needed.
12. Based on evaluation and history, assess the patient’s risk for oral disease.
13. Determine the interval for periodic re-evaluation.
12 to 24 months
1. Repeat birth to 12-month procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease.
2. Assess appropriateness of feeding practices, including bottle, breast-feeding, and no-spill training cups, and provide counseling as indicated.
3. Review patient’s fluoride status—including any childcare arrangements, which may impact systemic fluoride intake—and provide parental counseling.
4. Provide topical fluoride treatments every 6 months or as indicated by the individual patient’s needs.

2 to 6 years
1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Complete a radiographic assessment of pathology and/or abnormal growth and development, as indicated by individual patient’s needs.
3. Scale and clean the teeth every 6 months or as indicated by individual patient’s needs.
4. Provide pit and fissure sealants for primary and permanent teeth as indicated by individual patient’s needs.
5. Provide counseling and services (athletic mouthguards) as needed for orofacial trauma prevention.
6. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient’s needs.
7. Provide required treatment and/or appropriate referral for any oral diseases, habits, or injuries as indicated.
8. Assess speech and language development and provide appropriate referral as indicated.

6 to 12 years
1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease.
2. Provide substance abuse counseling (eg, smoking, smokeless tobacco).
3. Provide counseling on intraoral and perioral piercing.

12 years and older
1. Repeat 6- to 12-year procedures every 6 months or as indicated by individual patient’s risk status/susceptibility to disease.
2. At an age determined by patient, parent/guardian, and pediatric dentist, refer the patient to a general dentist for continuing oral care.

References
**Recommendations for Pediatric Oral Health Care**

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

<table>
<thead>
<tr>
<th>Age</th>
<th>6–12 months</th>
<th>12–24 months</th>
<th>2–6 years</th>
<th>6–12 years</th>
<th>12 years and older</th>
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<tbody>
<tr>
<td>Clinical oral examination</td>
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<tr>
<td>Assess oral growth and development</td>
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<tr>
<td>Caries-risk assessment</td>
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<tr>
<td>Prophylaxis and topical fluoride treatment</td>
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<tr>
<td>Fluoride supplementation</td>
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<tr>
<td>Oral hygiene counseling</td>
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<tr>
<td>Dietary counseling</td>
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<tr>
<td>Injury prevention counseling</td>
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<tr>
<td>Counseling for nonnutritive habits</td>
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<tr>
<td>Substance abuse counseling</td>
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<tr>
<td>Counseling for intraoral/ perioral piercing</td>
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<tr>
<td>Radiographic assessment</td>
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<td>Treatment of dental disease/injury</td>
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<tr>
<td>Assessment and treatment of developing malocclusion</td>
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<tr>
<td>Pit and fissure sealants</td>
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<tr>
<td>Assessment and/or removal of third molars</td>
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<tr>
<td>Referral for regular and periodic dental care</td>
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</tbody>
</table>

1. First examination at the eruption of the first tooth and no later than 12 months.
2. By clinical examination.
3. As per AAPD “Policy on the use of a caries-risk assessment tool (CAT) for infants, children, and adolescents.”
4. Especially for children at high risk for caries and periodontal disease.
5. As per American Academy of Pediatrics/American Dental Association guidelines and the water source.
6. Up to at least 16 years.
7. Appropriate discussion and counseling should be an integral part of each visit for care.
8. Initially, responsibility of parent; as child develops, jointly with parents; then, when indicated, only child.
9. At every appointment discuss the role of refined carbohydrates, frequency of snacking.
10. Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing.
11. At first discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
12. As per AAPD “Clinical guideline on prescribing dental radiographs.”
13. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and/or fissures; placed as soon as possible after eruption.
G U I D E L I N E S  F O R  P R E S C R I B I N G  D E N T A L  R A D I O G R A P H S

The recommendations in this chart are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient’s health history and completing a clinical examination. Because every precaution should be taken to minimize radiation exposure, protective thyroid collars and aprons should be used whenever possible. This practice is strongly recommended for children, women of childbearing age and pregnant women.

<table>
<thead>
<tr>
<th>TYPE OF ENCOUNTER</th>
<th>PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient* being evaluated for dental diseases and dental development</td>
<td>Child with Primary Dentition (prior to eruption of first permanent tooth)</td>
</tr>
<tr>
<td></td>
<td>Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.</td>
</tr>
<tr>
<td>Recall patient* with clinical caries or at increased risk for caries**</td>
<td>Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe</td>
</tr>
<tr>
<td>Recall patient* with no clinical caries and not at increased risk for caries**</td>
<td>Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe</td>
</tr>
</tbody>
</table>
## GUIDELINES FOR PRESCRIBING DENTAL RADIOGRAPHS, cont’d.

<table>
<thead>
<tr>
<th>TYPE OF ENCOUNTER</th>
<th>PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Child with Primary Dentition (prior to eruption of first permanent tooth)</td>
</tr>
<tr>
<td>Recall patient* with periodontal disease</td>
<td>Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.</td>
</tr>
<tr>
<td>Patient for monitoring of growth and development</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development</td>
</tr>
<tr>
<td>Patient with other circumstances including, but not limited to, proposed or existing implants, pathology, restorative/endodontic needs, treated periodontal disease and caries remineralization</td>
<td>Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.</td>
</tr>
</tbody>
</table>

*Clinical situations for which radiographs may be indicated include but are not limited to:

### A. Positive Historical Findings
- Previous periodontal or endodontic treatment
- History of pain or trauma
- Familial history of dental anomalies
- Postoperative evaluation of healing

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5. Remineralization monitoring
6. Presence of implants or evaluation for implant placement

B. Positive Clinical Signs/Symptoms
1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract (“fistula”)
9. Clinically suspected sinus pathology
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical erosion

**Factors increasing risk for caries may include but are not limited to:**
1. High level of caries experience or demineralization
2. History of recurrent caries
3. High titers of cariogenic bacteria
4. Existing restoration(s) of poor quality
5. Poor oral hygiene
6. Inadequate fluoride exposure
7. Prolonged nursing (bottle or breast)
8. Frequent high sucrose content in diet
9. Poor family dental health
10. Developmental or acquired enamel defects
11. Developmental or acquired disability
12. Xerostomia
13. Genetic abnormality of teeth
14. Many multisurface restorations
15. Chemo/radiation therapy
16. Eating disorders
17. Drug/alcohol abuse
18. Irregular dental care