Introduction

For practitioners who wish to offer the infant oral health visit in their practice, some new knowledge and skills may be needed, and it is hoped that the following advice and systematic approach will facilitate both practitioner and family. The visit should include a formal caries risk assessment, which is generally best achieved with the aid of a tool such as the Caries Risk Assessment Checklist (CRAC), which is suitable for all children, or a specific tool aimed at the 0-3 age group, such as the American Academy of Pediatric Dentistry’s (AAPD) Caries-risk Assessment Tool (CAT).2

The dental team should be adequately prepared and the practice suitably set up to receive young children and their accompanying siblings, buggies and other needs. Some simple toys in the waiting room, and some well-timed distraction, can go a long way to making the visit pleasant for all (Figure 1). If there is paperwork to be completed, it may be preferable to send this by post or email prior to the visit. A simple written explanation of the aims and objectives of the visit and a description of the techniques for examination and preventive care may be useful so that parents know what to expect.

A systematic approach to the infant oral health visit

With the right approach, the infant oral health visit can be a positive experience for dentist, parent and baby.

Figure 1: Some simple toys in the waiting room, and some well-timed distraction, can go a long way to making the visit pleasant for all.

Figure 2: The risk assessment and educational components of the visit should be carried out early in the session.

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Minimising stress

It is recommended by the authors that the risk assessment and educational components of the visit are carried out early in the session, and that the clinical examination is left as close as possible to the end (Figure 2). This way, if baby and parent are relaxed, transfer of information between the parent and the dental team is easier. Examination in the knee-to-knee position is advised for efficient examination of the oral cavity, and for the parent’s and baby’s comfort and stress reduction. A dental chair is not needed, but an adequate light source is required. Some babies get upset at the time of examination: this is entirely normal and developmentally appropriate.

Practical advice

Demonstration of the appropriate method of tooth brushing is valuable, and although routine use of 1,450ppm fluoride toothpaste is not suggested for most children in Ireland until age two, showing the correct amount of paste on the brush can be helpful, particularly if there are older siblings in the family. It should be emphasised that there is greater benefit from fluoride toothpaste if it is not rinsed off after brushing. Fluoride varnish application should follow the clinical examination. Only a very small amount is needed, allaying concerns around toxicity. Discussion of dietary practices should be in line with other healthcare professionals’ current advice, particularly around breastfeeding and weaning to solid food in this age group. Current advice is widely available via the HSE’s baby and child health website – www.hse.ie/health/child/.

History

The medical, dental and social history for an infant should include the following:

- the child’s perinatal and ongoing medical history;
- caries risk assessment (CRAC or AAPD);
- trauma;
- systemic and topical fluoride status (water, formula and toothpaste);
- feeding practices (use of bottles while asleep, snacks between meals); and,
- non-nutritive sucking habits (thumb/soother).

Examination

Examination is best carried out in the knee-to-knee position, and should include the following key features:

- examination for caries, trauma, and dental, soft tissue and anatomical disturbances (Figures 3a-d);
- “lift the lip” demonstration (Figure 4); and,
- tooth brushing demonstration (Figure 5a-c).

FIGURE 5a-c: A tooth brushing demonstration should form part of the examination.
Preventive care

Basic preventive care is best carried out in the knee-to-knee position at the time of examination, provided the parent is prepared and consent is achieved before beginning:
- remove any soft and hard deposits; and,
- apply 5% NaF fluoride varnish to erupted teeth, by drying first with some gauze and applying the varnish with a gloved finger (Figure 6).

Treatment of severe early childhood caries (SECC)

If any evidence of smooth surface caries is encountered in a child under three years of age, by definition, this is severe early childhood caries. Preventive interventions in the first year of life are critical. The following treatments are suggested according to the level of caries seen:

**White spot lesions**

Apply fluoride varnish, and educate about oral health and diet. Advise home use of a smear of 1,450ppm toothpaste twice daily, without rinsing after brushing.

**Cavitated lesions in upper incisors**

Manage as above, and consider interim therapeutic restoration (ITR) with glass ionomer as a preventive and therapeutic approach.

**Large cavitated lesions in incisors**

Manage as above, and consider use of full coverage restorations (e.g., stainless steel crowns +/- white facing), particularly if compliance for prevention is an issue.

**Extensive disease with/without pulpal involvement**

Manage as above, and consider referral to a specialist provider for definitive care.

Establishing the dental home and periodicity of review

The dental home is an ongoing relationship between the dental team and the patient and family. The infant oral health visit allows early establishment of a dental home and results in an increased awareness of all issues that will have an impact on the child’s oral health (Figure 7). Once the first visit is accomplished, the relationship begins, and this is continued as follows:
- determine the interval for periodic review (three, six or 12 months) based on risk; and,
- if needed, refer to a specialist provider, with arrangements for follow-up at the dental home.

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The infant oral health visit can help to build a family-friendly practice, and could be included as part of a visit for another family member, or can be offered and billed as a stand-alone visit. Education and preventive advice is best offered in a non-judgemental way, with an understanding of the values and motivating factors held by the family. A communication style known as motivational interviewing is particularly useful in this setting. Advice and preventive interventions go hand in hand, and the application of fluoride varnish is an evidence-based, operator-applied caries-preventive intervention that results in a 37% reduction in dmft in children under five. Parents who value this effect will usually be happy to return periodically for fluoride varnish application and clinical review.

With adequate planning, a team approach, some enthusiasm and a little practice, the infant oral health visit can be a very rewarding experience for all.

References
