



THE ECC EPIDEMIC

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ARE YOU MISSING THE DIAGNOSIS OF THE MOST COMMON CHRONIC DISEASE OF CHILDHOOD?

Several years ago, I had one of those pediatric wake-up calls that scared me. I was attending to the care of a 2 1/2-year-old child with Beckwith-Wiedemann syndrome. He lived in a low-income family, and temporarily had fallen through the health insurance safety net. For some reason, his Medicaid insurance had lapsed, and here he was in my office appearing very ill with a temperature of 40° C (104° F). His left maxillary area was quite swollen and dusky red. I looked in his mouth, and not surprisingly, found an infected first left upper molar surrounded by a very erythematous gingiva. His teeth were riddled with cavities.

Fortunately, I was able to urgently admit him to the county hospital through a colleague in the emergency room. He did well with IV antibiotics, and was discharged four days later on oral clindamycin, and referred for outpatient extraction of the tooth by the oral surgery department through the county health department. This case, including EMS transport, hospital services, and outpatient dental surgical intervention, resulted in an \$8,000 cost to the health care system. The parents had to absorb some of this cost, and are still making monthly payments to the hospital.

After this experience, I began to look at the teeth of young children a little more carefully. It soon became apparent to me that *more than half* of my patients had

dental caries! During this time, I supervised a teaching clinic and had medical students rotating through daily. As a teacher and clinician, I knew that I needed to improve my knowledge on the diagnosis and management of dental disease in children, to better inform and educate my students, and my patients' parents.

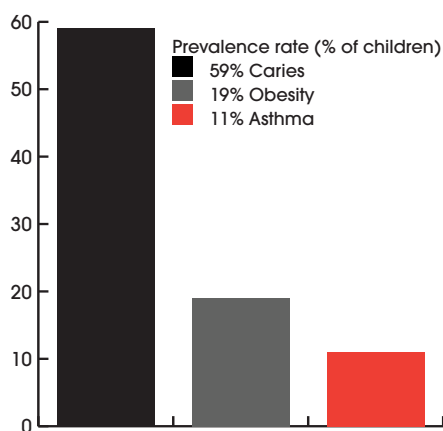
This personal wake-up call has become a call to action in my professional life. It is my goal to convince you, the reader, to take ownership and assume some responsibility for the prevention and early diagnosis of this chronic disease affecting millions of our children.

At the top of its class

The American Academy of Pediatric Dentistry's (AAPD) most recent definition of early childhood caries (ECC) is paraphrased as follows: ECC is the presence of one or more decayed (noncavitated or cavitated), missing (due to decay), or filled tooth surface in any primary tooth in a child younger than six years (71 months or younger).¹ More serious cases are classified as severe early childhood caries, or S-ECC, previously known as "bottle rot" or "nursing caries." Characteristics of S-ECC include any sign of smooth-surface caries in children younger than 3; or, in the 3- to 5-year-old age group, any cavitated, missing, or filled smooth surfaces in the primary maxillary anterior teeth. Additionally, S-

Figure 1

Chronic disease prevalence rates in school age children



ECC may be defined as an overall decayed, missing, or filled (DMF) score as follows: age 3 with DMF ≥ 4 , age 4 ≥ 5 , or age 5 ≥ 6 .¹

In terms of incidence, the numbers are staggering. ECC is the most common chronic disease among American children, affecting *more than half* of all 7-year-olds. It is three times more prevalent than obesity, and five times more prevalent than asthma (Figure 1).²

Children in poverty are particularly at risk, with dental caries rates as high as 80%. Yet less than a third of these children receive any dental care.³ ECC/S-ECC not only have the potential to affect a child's nutritional intake, but also their ability to pay attention in school, and to sleep at night.⁴ Most importantly, the decay on a child's primary teeth can spread to their permanent teeth, inevitably setting up the child for persistent and progressive tooth decay during their lifetime. Burt Edel-

stein, DDS, of the Children's Dental Health Project (www.CDHP.org) believes that ECC may have broader implications for health, describing caries as, "often the first significant acquired pathology in children...and a sentinel for other health-behavior related risks for disease" later in life.⁵

Recently, the Centers for Disease Control and Prevention reported that the prevalence rate of tooth decay is actually rising among 2- to 5-year olds, from 24% in a 1990-1994 survey, to 28% in the most recent 2000-2004 NHANES III survey.⁶ This 15% increase represents 600,000 additional preschoolers with the disease as compared to caries levels in the 1990s. This recent and rapid rise in ECC incidence is the basis for the claim that we are now facing an early childhood caries disease epidemic. This is despite steady expansion of the use of fluoridated waters and dentifrices over the past 30 years, the increased use of dental sealants in primary teeth, as well as many other dental public health initiatives. Given the significance of this epidemic, all medical and dental organizations now recommend that children have their first dental visit by age 1. However, financial and health care workforce constraints continue to make this an unrealized goal.

The roots of ECC/S-ECC

ECC is a multifactorial infectious disease that starts as soon as the baby teeth begin to emerge. Additionally, mothers often pass the cariogenic bacteria, including *S mutans*, to their infants in the first year of life (more on this later). The ecology of these bacteria depends upon the presence of hard tooth enamel surfaces, upon which plaque-forming bacterial biofilms can grow. Fueling the plaque biofilm are fermentable carbohydrates, which are found in fruit juices (fructose), milk (lactose), and foods (sucrose, simple starches). The bacterial fermentation of these carbohydrates provides energy for bacterial growth as well as the

production and excretion of sticky polysaccharides, which promote adherence of the plaque biofilms to the teeth.

The cariogenic species are acidophilic, thriving in acidic environments. They all produce organic acids (lactic and pyruvic acid) as waste products. When a child with caries infection ingests a sugary beverage or food, their mouth pH will quickly drop from the neutral range to a pH of 3.0 to 4.0. It then takes about 20 minutes for saliva to buffer and neutralize the acid attack.

In the meantime, significant demineralization can occur. These acid attacks eventually produce chalky white erosions (“white spots”) on the enamel, usually near the gum lines of the maxillary primary incisors where plaque is most difficult to remove, because of the overriding upper lip and low salivary flow. This zone of demineralization further facilitates increased plaque adherence and progression of the dental biofilm. Brownish discoloration of the demineralized enamel signals a more advanced process (Figures 2, 3A, and 3B).

Unless the plaque in and around these white spots is actively removed by brushing, allowing for salivary calcium and phosphorus to diffuse back into the damaged tissue, the erosions will often progress to cavities that may need restorative treatment by the dentist. It is crucial that providers (and parents) understand that white-spot lesions represent early and potentially reversible areas of dental decay, and that missing or downplaying the existence of these spots can prove to be costly—both medically and financially.

The costs of doing nothing

ECC can turn into S-ECC in a matter of months, and has the potential to progress to severe local or systemic infection, or in some cases, life-threatening illness. Recently, national media outlets reported the heartbreaking story of a 12-year-old boy from Maryland,



Figure 2

Lifting the lip to reveal a healthy set of teeth and gums.



Figure 3A

White spot and early brown spot demineralizations.



Figure 3B

White spots typically appear first on the upper front incisors where salivary flow is minimal; the dental caries disease process can potentially be arrested or even reversed at this stage.



Figure 4

This child with S-ECC will require dental surgery (pulpotomies and placement of crowns) to restore function and maintain space for the eruption of the permanent teeth.



Figure 5

Advanced S-ECC; "These are flesh-eating bacteria," notes Joel Berg, DDS.

Deamonte Driver, who died from complications of an untreated dental abscess that resulted in a disseminated brain infection.⁷

The emotional aspects of dental caries can also be traumatic for a young child and their parents. Many children with extensive decay or abscess, for example, will have space loss or shiny steel caps inserted as part of an orthodontic treatment plan (Figures 4, 5). This, in turn, may cause the child to feel self-conscious or embarrassed about their appearance in the company

of their peers, with school attendance being adversely affected.

The chronic pain that can be associated with S-ECC can be equally traumatic. I will never forget the new family I saw in my general pediatric clinic one day. Mom, Dad, and all three brothers were together in an exam room waiting for me to do routine physicals on the boys. When I walked into the room, I noticed two things right away. First, both parents and the two older boys were heavysset, while the youngest child, age 5, was thin. Then the youngest child smiled, and I immediately noticed that he had nubs for front teeth. Further exam of his mouth revealed that almost all his teeth were decayed. He was skinny because it hurt too much to eat!

Sadly, many children often present to dental clinics or their primary care providers for the first time with what we now consider to be late-stage disease. Contributing factors to this phenomenon include parents' lack of understanding of the disease process, physicians and nurse practitioners failing to diagnose and refer children with early and reversible signs of ECC to dental services, and, in some cases, general dentists being uncomfortable seeing preschool-age children.

Other factors include parents' concerns with the need for child restraints in order to perform dental procedures on non-cooperative children, and the circumstance that these procedures must often be performed with the parent outside of the dental operator. Of course, many parents and providers are rightly concerned over the potential risks of sedation or general anesthesia, which is often required to treat and restore the decayed teeth.

Finally, we encounter the problem of payment for services. Many dental plans do not cover routine dental prophylaxis under age 3, and have monetary caps on coverage for the extensive restorative treatments needed for S-ECC. A child with advanced S-ECC needing

Table 1**Screening tool for assessing dental caries risk in infancy**

- Caregivers or siblings who have caries
- Visible plaque or white spots on the teeth
- Suboptimal exposure to fluoridated water
- Lower socioeconomic groups
- Drinking juice from bottles, and nighttime milk bottles
- Frequent intake of sugar or cooked starch (eg, sport drinks, juice, crackers, cereals) between meals
- Special-needs patients (preemies, developmentally delayed, immunosuppressed)

If high-risk (multiple risk factors or suspected enamel lesions), then early dental referral is strongly advised before age 1; otherwise, the goal is a routine dental home for all children at age 1.

multiple fillings, crowns, pulpotomies, and/or extractions with placement of spacers can easily expend thousands of dollars in services.

Fortunately, the current ECC disease model now recognizes that early caries disease can and should be managed medically,⁸ providing a window for early intervention. How then, should providers and parents proceed?

Diagnosis, treatment, and prevention

All parents and medical providers must learn to closely inspect the child's teeth. The caries disease almost invariably starts on the upper incisors, where protective salivary flow is minimal. Persistent, heavy dental plaque, which is easy to see with close visual inspection,

**Figure 6**

A 2 1/2-yr-old child with S-ECC that was put to bed with a sippy cup containing apple juice.

tion, is the first warning sign. As previously mentioned, clinical findings of a few white-spot lesions are the hallmark of early (medical) disease, which is often reversible. In most cases, these lesions can be identified by lifting the baby's upper lip, and carefully looking for chalky white spots on the upper tooth enamel surfaces adjacent to the gum line (Figure 3A). These lesions are areas of demineralization, and can progress into deep, often painful, brown cavitations (Figure 6). Children with brown cavitations require urgent referral to a pediatric dentist.

In addition to visual inspections, medical providers should conduct a risk assessment for early dental caries. In 2003, the American Academy of Pediatrics (AAP) mandated that the cornerstone of ECC prevention efforts must be the routine application of a caries risk assessment evaluation by the primary care clinician for all young children, optimally at the six month well-child visit, and the establishment of a dental home by age one or earlier if oral pathology is identified (see "A call for collaboration").⁹ This recommendation is based upon the published oral health guidelines of both the AAP and the AAPD.

Working together, these two organizations have recently updated a consensus guideline for promoting oral health in all children and adolescents, which has

been published in the third edition of *Bright Futures*.¹⁰ A detailed Caries-Risk Assessment Tool (CAT) is included, but a rapid caries-risk screening tool is also described in **Table 1**, for busy practices.

One of the most important and least appreciated risk factors associated with dental caries is the presence of active tooth decay in the mother. Transmission of the *S mutans* bacteria from mother to baby has been shown to occur as early as 2 months of age when DNA-identical bacteria may be detected in mothers, and in tongue scrapings from their infants.¹¹ Thus good maternal oral hygiene, and daily use of caries-inhibitive xylitol chewing gums beginning shortly after birth, has become an important disease prevention tool.

Xylitol is a naturally occurring 5-carbon sugar alcohol that is found in most plant materials, as well as normal human metabolism, involving the pentose-phosphate shunt pathways. Due to xylitol's pentose sugar structure, it tends to interfere with the normal bacterial fermentation of hexose sugars such as glucose, which the cariogenic bacteria are dependant upon for their growth and proliferation. The recommended dose is two grams of xylitol, or two pieces of gum chewed regularly by a new mother three times per day for six months.¹² In a similar gum-chewing regimen, regular use of xylitol chewing gum was also shown to decrease caries rates in school-age children.¹³

A call for collaboration

There is no debate that early referral by the primary care provider to a dental disease specialist (aka the pediatric dentist) routinely at age one, and earlier if there are signs of pathology, remains the foundation of successful long-term caries disease management. Dr. Joel Berg, Professor and Chairman of Pediatric Dentistry at the University of Washington recently stated unequivocally that the concept of the universal Age One Dental Home is the most important development to occur within the field of pediatric dentistry in the past decade.¹⁴

The fact that most American children with early childhood caries present for their first dental visit well after age 1, and often with late-stage disease, suggests that there is an inadequate community standard of care for ECC in most parts of our country. **In other words, children's primary health care**

providers are failing to recognize caries disease in its earliest stages, during which time urgent dental intervention can effectively prevent disease progression, and in some cases even reverse the disease process.

The epidemic of early childhood caries in our country and around the world requires a new paradigm for prevention and care. There are approximately 6,000 practicing pediatric dentists in America, and obviously they are not able to see all of our nation's pre-school aged children. Fortunately, unlike in years past, many general dentists are now willing to see younger children for their initial dental evaluations. The bottom line is that the dental community desperately needs our teamwork and support. By focusing more attention on high-caries-risk populations, limited dental services can be more efficiently utilized.

Nutritional counseling should include not only a discussion of patterns of bottle and sippy cup use, but also recognition of the hidden sugars in “cooked starch,” such as breads, French fries, snack crackers, cereals, and chips. Cooked starches can get trapped between teeth, and promote tooth decay as readily as pure sugar. Limiting sugar-containing cough and cold syrups and medications that can cause dry mouth, such as antihistamines, is another important strategy that is often overlooked.

Additionally, nighttime bottles and delayed bottle weaning, nighttime breastfeeding beyond age 1, and the use of juice sippy cups (Figure 6) all contribute to early and persistent over growth of the enamel surfaces by cariogenic plaque. Further exacerbating the problem is inadequate infant oral hygiene practices by the child’s caregiver. Therefore, a daily routine of wiping the baby’s gums should be established in the first few months of life, and daily brushing should begin as soon as the first teeth appear.

Unfortunately, many infants and toddlers are averse to brushing, and if parents give in too easily, the poor oral hygiene behavior becomes habitual. A potential solution to this challenge is the use of xylitol-saturated disposable tooth wipes. Recently introduced into the consumer market, these wipes were shown not only to be effective for plaque removal from the front teeth, but also more readily acceptable as an oral hygiene regimen by maternal-infant pairs.¹⁵

But perhaps the most important preventive measures against this epidemic are the serial application of topical fluorides by a health care provider, and/or daily use of rice grain-sized smears of anti-cariogenic toothpastes containing fluoride. These measures should be initiated either prophylactically at age 1 if risk factors are present, or at the first sign of a white spot.

While the use of fluoride varnishes in young children are still considered “off-label” by the FDA, this is not a major concern for practicing pediatricians who



Figure 7

The “knee-to-knee” technique for examining and brushing the baby teeth.

are simply following the lead of the pediatric dental profession. A recent report by pediatric dentists of a fluoride varnish trial in infants aged 6 to 18 months demonstrated significant clinical benefit, and no harm.¹⁶ Many children’s medical providers are now learning to apply fluoride varnishes in their offices to augment the preventive efforts of children’s dentists,¹⁷ and to provide more aggressive medical therapeutics at the time of early caries diagnosis, pending urgent evaluation by the dentist.

The application of fluoride varnish is most easily accomplished with two adults sitting knee-to-knee, child supine in their laps, with one controlling the arms and legs and the other responsible for brushing (Figure 7). Single adults can also accomplish this task with practice. This technique can and should be shared with parents, along with proper brushing techniques (see Parent Guides in English and Spanish on pages xx).

Dental screening: Done in 60 seconds

Surely, we can teach ourselves to routinely query the parent about caries risk factors, and look at the child’s teeth on a regular basis. The whole process takes less than a minute, and can be done at the time of the throat exam during a well-visit:

“Mom, do you or your other kids have cavities?”

“Are you brushing your baby’s teeth every day?”

“Look how pretty these front baby teeth are...but we have to clean that plaque off a little better.”

“I know a dentist that will see your child at age 1; please give them a call, or I will refer you if you like.”
Or, in one out of four children, “I see a white spot. This needs immediate attention.”

In fact, parents are uniformly pleased and impressed when I exam the baby teeth with my otoscope light prior to examining the throat. And the nutritional counseling that I do for caries prevention dovetails perfectly (almost word for word) with the obesity prevention counseling that I am already doing anyway. More caries prevention talking points are presented in **Table 2**.

If I suspect ECC or identify significant ECC risk factors, I include this in my patient encounter note as part of the clinical assessment ([ICDM] code for dental caries: 521.00) and make sure that the patient problem

list is updated to include ECC (or risk of ECC). I then document a patient care plan, which includes oral hygiene and nutritional counseling, a recommendation to begin early brushing of the baby teeth with a pea-sized smear of standard over-the-counter 1,000 ppm fluoride toothpaste (which normally is recommended to be initiated at age 2 in low-risk patients), or an application of fluoride varnish to the teeth. Finally, I document in my chart a referral to a pediatric dentist for definitive care and management. The referral is classified as urgent if I suspect ECC, in which case my staff facilitates a referral process similar to any other formal medical referral that I make (cardiology, gastroenterology, ear-nose-throat, etc).

After seeing the patient, the pediatric dentist will usually send me a consult note that documents the

Table 2

Caries prevention timeline for infancy

Pregnant and new moms should practice especially good oral hygiene. After the baby is born, moms should chew gums with xylitol (should be the first or second ingredient) three times a day for six months

Breastfeeding should be encouraged to enhance the child’s immune defenses, including oral immune defenses

Beginning at 2 to 4 months of age, start cleaning the mouth with a clean wet towel, gauze, or toothwipes

Use fluoridated water (or “nursery water”) for infant formula preparation and cooking after 6 months of age

Start brushing the baby teeth with water at least once a day (bedtime) between 6 and 9 months (nighttime feeders must be brushed in the morning too)

Fruit juices should only be given twice a day from a standard cup, and always with food

Avoid snack foods with high refined sugar or starch content

Once they learn to hold their own bottle, bottle-fed babies should only be given water in their bottle between meals or at night

See a dentist as soon as possible on or after the first birthday; take advantage of fluoride varnishes or treatments if recommended

Cleaning teeth every day is the most important message.

presence and severity of caries disease, treatment plan, and timing of follow-up, which is then filed in the medical chart. This helps me in two ways: 1) I receive feedback on the accuracy of my diagnosis—ie, maybe what I thought were brown-spot caries lesions were actually enamel stains not requiring treatment—and 2) by filing the note in the chart I have a reference for determining the timing of future dental follow-up, which helps me in my “gatekeeper” role as the patient’s primary care provider.¹⁸

Dr. Wagner would like to thank Dr. Oskouian for providing a careful review and editing of the technical aspects of this article, the photos of children with ECC from her dental practice, and advice on the need for collaboration between the fields of children’s medicine and dentistry.

Looking for pediatric dental services?

Clinic services

Many of today’s pediatric dental residency programs operate in conjunction with a satellite clinic where children can receive dental services.

A valuable resource to keep in mind.

Local dentists

A list of local pediatric dentists is available through the AAPD’s “Find a pediatric dentist” tab on their home page (www.aapd.org).

This database of providers is updated weekly.

It’s time to assume more responsibility

We know the feeling of satisfaction we experience when we give good medical advice, and make an early and accurate diagnosis on behalf of our patient. In particular, most pediatricians take personal pride in their ability to diagnose and manage the numerous infectious diseases of childhood. See how good you will feel when you make this important diagnosis, and begin to provide an effective caries prevention or treatment plan for your patients.

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CONTEMPORARY pediatrics **GUIDE for PARENTS**

Right from the start: A maternal and infant health oral program*

Early childhood tooth decay

Did you know that tooth decay is the most common childhood disease? Forty percent of American children have cavities by age 6. Worst of all, if children get cavities in their baby teeth, the infection almost always passes to their permanent teeth. You can help prevent this disease.

Mom, your oral health matters

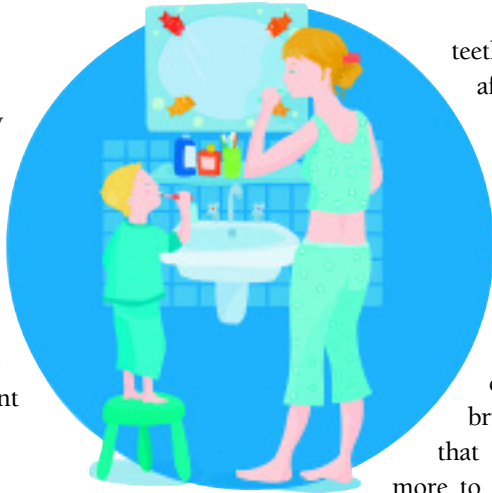
One of the biggest risks for your baby to get early tooth decay is the presence of dental cavities in your mouth. That's because tooth decay is a bacterial infection that can be transmitted from you to your baby. Everyone in the family should keep their teeth clean (brush and floss) to reduce the bacteria levels.

Sugar feeds tooth decay

The tooth decay bacteria use sugar for energy, and they produce an acid that dissolves calcium, which causes a hole in the tooth. Any food or drink with sugar is potentially a problem; this includes juices, sodas, sports drinks, infant formula, and sweetened milk. Remember, after age 1 cups are always better than bottles. Another common form of sugar that is often overlooked is cooked starch—the white flour that's in crackers, cereal, chips, and junk foods in general. Give your child whatever you feel is right and healthful, but be sure to clean their gums and teeth afterward.

Clean your baby's gums and teeth early (4 months)

The decay process can start as soon as the child's first tooth pokes out from the gum, typically at 5 to 9 months. To stop the attack from happening, it's important to begin cleaning baby's mouth very early, starting at 4 months. Simply wipe baby's gums and



teeth several times a day, especially after feedings.

The tooth-brushing habit (6 to 9 months)

Your child should be encouraged to brush their teeth themselves, as soon as they can hold a toothbrush, but parents should be there to supervise and complete the brushing. The night brushing is critical, as the bacteria that cause cavities have 12 hours or more to grow as your child sleeps. Make sure this brushing is done as effectively as possible to stop those cavity-causing bacteria from moving into your child's mouth as a permanent resident. A good rule of thumb is for parents to help with brushing until their child can write their name in cursive letters, which typically occurs at age 6 or 7.

Look closely and often at your baby's teeth (9 to 12 months)

The first sign of a cavity is a white spot. These spots often start on the upper front teeth at the gum line. To look for these spots, lay your baby in your lap and lift their upper lip using your fingers. If you don't take care of your baby's first teeth, your child may wind up with a lifelong struggle with tooth decay.

See the dentist at age 1

Starting at birth, every baby needs a "medical home" for regular doctor visits to ensure they stay healthy and get their vaccinations on time. Many parents don't realize that babies need a "dental home" after their baby's first birthday, or even sooner if there's a problem. The dentist can help you make sure your baby doesn't get early childhood tooth decay. It's a whole lot easier to prevent tooth decay than it is to treat it.

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IMAGE: GETTY

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Desde el principio: Un programa materno-infantil de salud oral*

Caries durante la niñez temprana

¿Sabía usted, que la enfermedad más común de la niñez, son las caries? El 40% de los niños americanos desarrollan caries antes de los 6 años de edad. Lo peor de todo es que, si los niños desarrollan caries en sus dientes “de leche” (los que se caen), la infección casi siempre se pasa a los dientes permanentes. Usted puede ayudar a la prevención de este padecimiento.

Mamá, la salud oral de usted es importante

Una de las causas más importantes para obtener caries durante la edad temprana, es la presencia de cavidades dentales en la boca de usted. Eso ocurre porque las caries, son infecciones bacterianas que pueden ser transmitidas de usted a su bebé. Todos en la familia deben mantener sus dientes limpios (cepillo y uso de hilo dental), para reducir así, el nivel de bacterias en la boca.

El azúcar favorece la caries dental

Las bacterias de las caries dentales, utilizan azúcar para obtener energía y al mismo tiempo producen un ácido que erosiona el calcio del diente, produciéndose una cavidad. Cualquier bebida o alimento con azúcar es un problema potencial; mencionaremos los jugos, los refrescos gaseosos, las bebidas “deportivas”, las leches infantiles y las leches azucaradas. Recuerde que después del año de edad, es preferible el uso de vaso, al uso de botella. Otra fuente de azúcar que a veces se pasa por alto, son los almidones cocidos—la harina blanca que contienen ciertas galletas, los cereales, las papas fritas (chips), y en general, la comida “chatarra”. Déle a su niño lo que crea conveniente y saludable, pero al final, asegúrese de limpiar sus encías y dientes.

Limpie las encías y los dientes de su bebé a temprana edad (4 meses)

El proceso de caries puede comenzar tan pronto como el primer diente brota de la encía, cosa que ocurre generalmente entre los 5 y los 9 meses. Para evitar que esto suceda, es importante empezar a limpiar la boca del bebé, desde los 4 meses de edad. Simplemente limpie las encías y los dientes varias veces al día, especialmente después de las comidas.

El hábito de cepillarse los dientes (6 a 9 meses)

Su hijo debe ser motivado a cepillarse los dientes el sólo, tan pronto como pueda sostener un cepillo dental, pero los padres deben estar presentes para supervisar el cepillado. El lavado de dientes “de la noche” es de suma importancia, pues las bacterias que producen las cavidades, tienen 12 horas o más para desarrollarse mientras su hijo duerme. Asegúrese que el cepillado sea hecho con la mayor efectividad posible, con el fin de impedir que la bacteria productora de cavidades se introduzca como residente permanente en la boca de su hijo. Una buena regla empírica consiste, en que los padres ayuden con el cepillado hasta que el niño sepa escribir su nombre en letra cursiva, lo que generalmente ocurre entre los 6 y 7 años de edad.



Examine detenida y repetidamente los dientes de su hijo (8 a 12 meses)

La primera señal de una cavidad es una mancha blanca. Estas manchas generalmente comienzan en los dientes frontales superiores, al margen de la encía. Para buscar estas manchas, recueste al bebé en su regazo y con los dedos, levante el labio superior. Si usted no cuida los primeros dientes del bebé, éste puede terminar en una lucha de por vida contra las cavidades dentales.

Vea al dentista al año de edad

Desde su nacimiento, todo bebé necesita de “un hogar médico” para visitas de rutina, que promueven su salud y la obtención de vacunas a tiempo. Muchos padres no saben que sus hijos necesitan también de “un hogar dental” a partir del primer cumpleaños, o antes, si existe algún problema. El dentista puede ayudar a asegurar que el bebé no adquiera caries durante la niñez temprana. Es mucho más fácil prevenir las caries que tratarlas.

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