Examination of Paediatric Patients

They aren’t little adult teeth

Consent

- Do not perform any examination on a patient under 18 without prior consent from a appropriate care giver

Seeing Paediatric Patients Alone

- DON’T
- If nitrous oxide or other sedation modality is being used REALY DON’T
- Patients have been abused by dentists. Do not put yourself in a position were allegations can be made against you and you have no witnesses.

How is a Paediatric Exam Different than an Adult

- Physical, psychological and emotional differences
- Behavioural assessment
- Preventive focus as opposed to rehabilitative
- Assessment of growth and development
- Third person in the relationship. Caregiver.

Medical History

- Like with adults you will have a medical history on the child.
  - For the most part children are much healthier than adults
  - Common to mention heart murmurs. The majority are benign.
    - If the child has “Grown out of it” or is not followed by Cardiology you are usually good but you can send a request for more information to their physician.

Medical History

- List of Medications
- Allergies
- Immunizations

AAPD Recommendations

- The American Academy of Pediatric Dentistry Recommends the first visit no later than one year of age or eruption of first tooth whichever comes first.
- They talk of the child having a “Dental Home”
- Canadian Academy endorses this position
- While an intra oral examination should be part of this visit its primary role is risk assessment and parental education
    - This can start during the pregnancy. Clear evidence that maternal oral health can affect the child.

In General What Does An Exam Include

- Assessment of:
  - General health/growth
  - Pain/Chief Concern
  - Extraoral soft tissues
  - Temporomandibular joints
  - Intraoral soft tissues
  - Oral hygiene and periodontal health
  - Intraoral soft tissues
  - Developing occlusion
  - Caries Risk
  - Behavior of the child

How to Examine Very Young Children

- From McDonald and Avery: Dentistry for the Child and Adolescent Patient, 9th edition

6 to 12 Months/First Visit

- Complete clinical exam with adjunctive diagnostic tools as needed
    - Radiographs as determined by child's history, clinical findings and susceptibility to oral disease also to assess oral growth and development, pathology and injuries.
- Complete caries risk assessment
- Oral hygiene counselling for care giver including care givers oral hygiene
- Clean teeth and remove stains and deposits as needed.

AAPD Guidelines

6 to 12 Months/First Visit

- Assess fluoride exposure both topical and systemic.
  - Don’t assume they are drinking tap water.
- Feeding practices including bottle and breast.
- Age appropriate injury counselling.
- Nonnutritive oral habits
- Anticipatory guidance
- Overall growth and development
- Physician consult as needed
- Determine interval for recall

12 to 24 Months

- Repeat procedures from 6 to 12 month
- Return to feeding practices
    - Should be stopping bottle use

2 to 6 Years

- Repeat 12 to 24 month procedures with age appropriate hygiene instructions
- Scale and clean as needed
- Pit an fissure sealants for caries susceptible anterior and posterior teeth
- Oral trauma counselling including mouth guards where appropriate
- Assessment and referral if needed for malocclusion
- Assessment and treatment for any oral diseases, habits and injuries
- Assess speech and language

6 to 12 Years

- Repeat procedures for 2 to 6 year olds
- Substance abuse counselling (smoking and chewing tobacco)
- Counseling intraoral/perioral piercings

12 Years and Older

- Repeat 6 to 12 year procedures
- Assess third molars in late adolescence

Caries Risk Assessments

- Oral Hygiene
- Diet (Snacking, bottle feeding, intake of fermentable carbohydrates)
- Fluoride status
- Previous caries
- Special needs
- Appliance wear

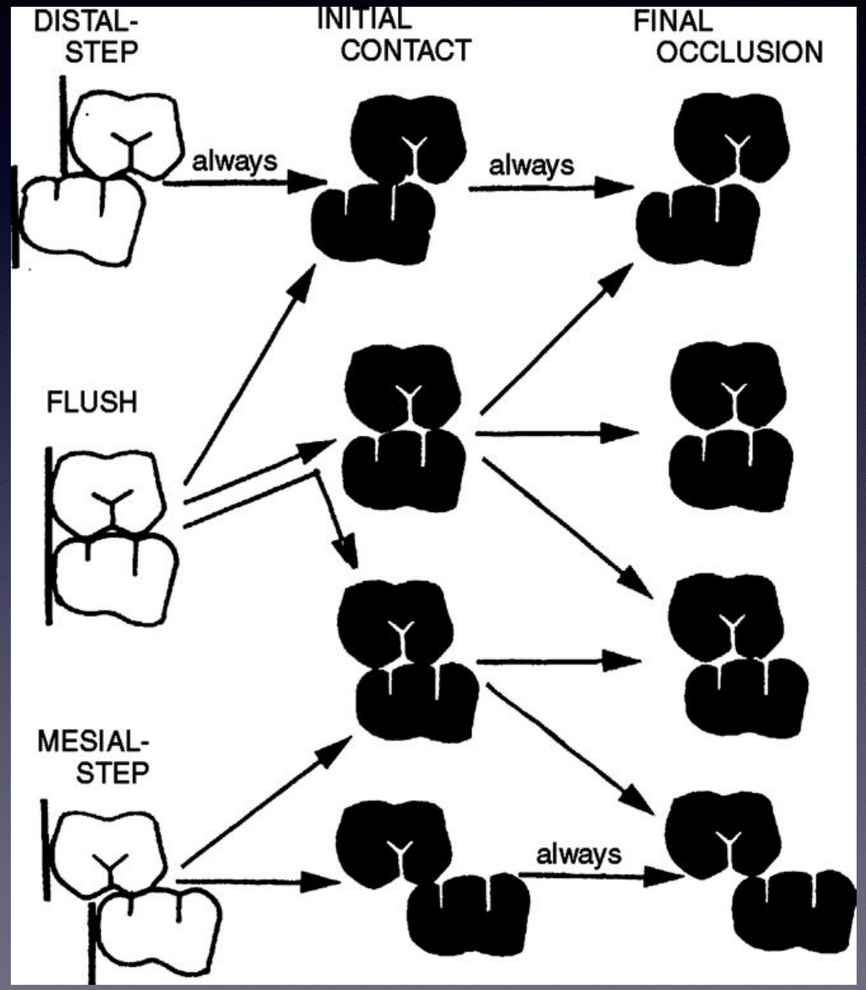
Occlusal Assessment

- Hope to get Ortho to give a lecture

Primate Space/Anterior Crowding

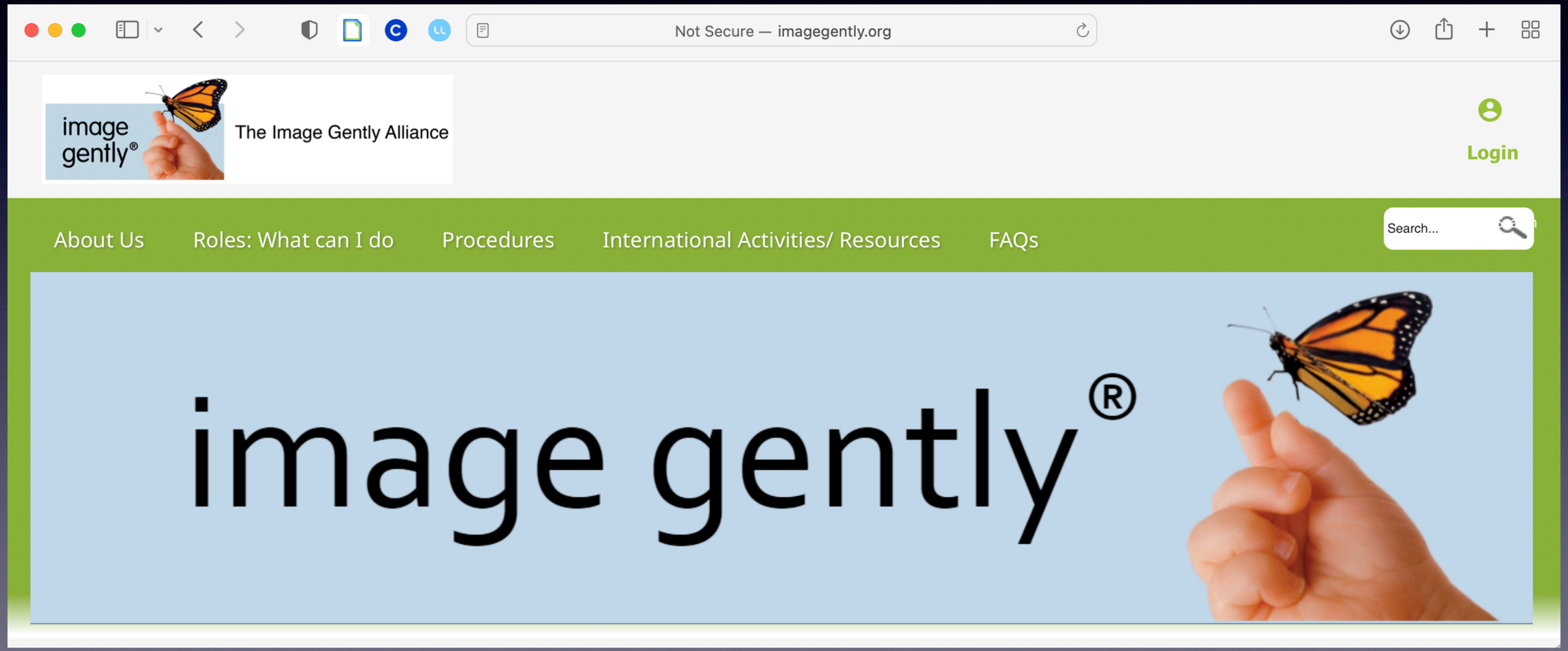
- Lack primate space almost always indicates there will be crowding.
- Anterior crowding in primary teeth indicates there will be crowding in the permanent anteriors.
- If you don’t remember were primate space is look it up

Description of Occlusion



(Fig. 20-14, McDonald and Avery's)

Minimize Use of Radiographs



Minimize Use of Radiographs

- Always have a reason for taking an X-ray.
- Adjust to caries risk level
- Optimize conditions to get clinically useful images

Child Abuse

- You are obligated to report suspicions of child abuse
  - You will not be held responsible if it turns out no abuse was occurring if report was made in good faith
  - A more common finding in very young children is torn frenums from forced feeding.

Not on the exam but
might aid in understanding

Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

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 emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references. Refer to the text in the Recommendations on the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents (*www.aapd.org/policies/*) for supporting information and references.

AMERICA'S PEDIATRIC DENTISTS THE BIG AUTHORITY on little teeth®	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [8]	•	•	•	•	•
Injury prevention counseling [9]	•	•	•	•	•
Counseling for nonnutritive habits [10]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants [11]			•	•	•
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment and/or removal of third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

9 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.

10 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.

11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

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

Factors	High risk	Moderate risk	Low risk
Risk factors, social/biological			
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 non-spill 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		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
Clinical findings			
Child has non-cavitated (incipient/white spot) caries or enamel defects	Yes		
Child has visible cavities or fillings or missing teeth due to caries	Yes		
Child has visible plaque on teeth	Yes		

Circling those conditions that apply to a specific patient helps the practitioner and parent understand the factors that contribute to or protect from caries. Risk assessment categorization of low, moderate, or high is based on preponderance of factors for the individual. However, clinical judgment may justify the use of one factor (e.g., frequent exposure to sugar-containing snacks or beverages, more than one decayed missing filled surfaces [dmfs]) in determining overall risk.

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

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

(For Dental Providers)

Factors	High risk	Moderate risk	Low risk
Risk factors, social/biological			
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 has special health care needs		Yes	
Protective factors			
Patient receives optimally-fluoridated drinking water			Yes
Patient brushes teeth daily with fluoridated toothpaste			Yes
Patient receives topical fluoride from health professional			Yes
Patient has dental home/regular dental care			Yes
Clinical findings			
Patient has ≥1 interproximal caries lesions	Yes		
Patient has active non-cavitated (white spot) caries lesions or enamel defects	Yes		
Patient has low salivary flow	Yes		
Patient has defective restorations		Yes	
Patient wears an intraoral appliance		Yes	

Circling those conditions that apply to a specific patient helps the practitioner and patient/parent understand the factors that contribute to or protect from caries. Risk assessment categorization of low, moderate, or high is based on preponderance of factors for the individual. However, clinical judgment may justify the use of one factor (e.g., interproximal lesions, low salivary flow) in determining overall risk.

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