

Quality Resource Guide

Making Pediatric Dentistry Part of General Practice

Author Acknowledgements

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Educational Objectives

Following this unit of instruction, the learner should be able to:

1. Differentiate shared decision-making between patient and provider versus informed consent.
2. Describe methods that can be used to enhance communication with a child.
3. List those preventive strategies that should be included in a treatment plan of a child with moderate caries risk.
4. Describe features in a primary or mixed dentition that are developmentally normal, but could be interpreted by parents as a problem.
5. List those items derived from a history and clinical examination of a child that enables assessment of caries risk.
6. Describe the difference in caries removal on the peripheral walls versus the pulpal floor in teeth with extensive lesions.
7. Differentiate between reversible and irreversible pulpitis in primary teeth.

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The following commentary highlights fundamental and commonly accepted practices on the subject matter. The information is intended as a general overview and is for educational purposes only. This information does not constitute legal advice, which can only be provided by an attorney.

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Introduction

The purpose of this guide is to review current basic concepts of Pediatric Dentistry that will enable general practitioners to provide oral health care to children as part of their practice. Topics covered will include shared decision-making, care pathways, child management, caries prevention, growth and development, restorative care, and pulp therapy. It is hoped that the adoption of these clinical concepts will allow the general practitioner to be more confident and comfortable when treating children.

Shared Decision-Making

There is a progressing shift from providing acute problem-focused health interventions to more sustainable, holistic preventive healthcare. Such care implies that, besides focusing on the child/caregivers main complaint, their physical, social, emotional, and cultural needs are taken into account. It requires the oral healthcare provider and the patient/caregiver have a discussion, and mutual agreement for care after the treatment options, probable outcomes and patient preferences are fully considered. Share decision-making is inseparable from informed consent/assent, but refers more to the process of optimizing patient-provider interaction to improve patient experience, and having a greater probability of success, and fewer complications.

Care Pathways

An important standard of oral health care is following a specific evidence-based care pathway for the child. An essential aspect of a specific care pathway is to evaluate the child's risk for future disease, which guides preventive and restorative therapies. Currently, there is not enough data to allow for a numerical model that can categorize a child's risk; however, practitioners can nonetheless have good estimates of risk, include factors such as a child's current number of carious and filled teeth, change of number of lesions since the past recall, number of white spot lesions, socioeconomic status of the family, caries status of the mother, frequency of sugar consumption, whether there are appliances in the mouth, and if a child lives in a fluoridated community.

Children at high caries risk require more intense preventive approaches to reduce caries initiation and to arrest caries progression. Conversely, risk-based therapy assumes that there will be less benefit of preventive therapies for those children who are at low risk for dental caries. Risk assessment also encourages treatment of the carious process, not just the filling cavities, as well as "active surveillance", *i.e.* the monitoring of caries progression and adherence to a preventive program, instead of definitive decisions regarding the treatment of a lesion at the first sign of disease. A complete description of caries risk assessment can be found in the MetLife Quality Resource Guide, *Clinical Decision-Making for Caries Management in Children 7th Ed.*

Generally, the restorative aspect of the care pathway is organized by both visits and quadrants; and integrates prevention, restorative and orthodontics aspects of the care. For example, a seven-year-old child's first visit may list: examination, Panorex and bitewings, oral hygiene instruction, topical fluoride treatment and discussion of the child's thumb sucking habit. The second visit may list: checking oral hygiene, checking compliance with reducing thumb habit, sealant "14", occlusal composite "a", occlusal composite "b".

Child Management

The majority of children coming for a dental visit exhibit good behavior, with some having apprehensions that are controlled because of the desire to please. However, a few children have a fear of dental procedures that may have been instilled in the child before the visit. These fears are intensified because of a desire to avoid pain, or evasion of what is interpreted as a threat to their well-being. Besides the child's fears and anxieties, past parental approaches to their child's behaviors often will affect behavior in the dental office. For example, if a child has found that "acting out" will allow him to get his way at home, such behavior may be used in the dental office.

There are several approaches commonly used by dental teams to make appointments more enjoyable and productive, no matter the age of the child or their behavior. Most importantly, the dental team needs

to communicate effectively with the child, by giving the child undivided attention and always addressing the child by first name using correct pronunciation. Conversation should be directed specifically to the child by literally and figuratively getting at the child's level. Excellent rapport can be established by making conversation in the child's world -- names and ages of the child's siblings, school and grade the child is in, the child's favorite activity or favorite pet. The dental team also needs to be empathetic, acknowledging the child's feelings and fears.

There is great advantage in having the child's first dental visit before there is an acute problem so that the child can become familiar with a relaxed dental environment. Appointments should be no more than one-hour in length and not close to naptime. An approach that often has value for a new patient is for the child to observe dental procedures being performed on an older sibling or another well behaving child. Of course, such modeling experiences should avoid crying children, or sharp instruments, or any situation that may evoke alarm.

It is important to be honest with the child and describe exactly what will be felt and experienced, using a "Tell, Show, Do" approach. For instance, before a procedure is performed the child should be shown instruments that will be used, and perhaps a demonstration of what it will feel like on a finger (**Figure 1**). Finally, the procedure is performed, "Do",

Figure 1



"Tell, Show, Do" approach to familiarize the child with exactly what will happen in the dental appointment.

with the dentist reciting that it is exactly what was described. Words that do not evoke concern and that the child can understand (“tooth feeler” instead of “explorer”) should be used.

During procedures it is helpful to have repetitive, one-way conversations with the child, such as, “That is very good”, “We are doing such a good job fixing your teeth”, and “We are going to make your tooth look much better”. Good behavior, therefore, should be positively reinforced and should be offered throughout the visit perhaps by telling the child that “he/ she is a good helper”. Statements should be avoided that personalize children’s behavior to their self-worth, such as saying “you are good/bad”. Nitrous oxide analgesia significantly relaxes and aids in this verbal communication. It can be utilized for most restorative

Table 1 - Positive Measures Regarding Child Behavior Management

- Speak to the child, not at him.
- Be empathetic to the child’s concerns.
- Use words that are friendly and understandable.
- Gain child’s confidence by always being honest.
- Make use of good behaving children as a model.
- Employ “Tell, Show, Do” techniques.
- During procedures, talk to the child with constant, repetitious conversation.
- Use nitrous oxide analgesia for most preschool children with restorative procedures.
- Always give the child your undivided attention.

Table 2 - What to Avoid When Treating Children

- Using derisive or belittling language when a child is uncooperative.
- Having the child see other children that are crying, blood or sharp objects.
- Having appointments longer than one hour.
- Personalizing child’s behavior.
- Avoiding or delaying necessary procedures.

procedures in preschool children, even though there is no behavior problem. Children look forward to rewards at the end of the visit and small toys and stickers will be warmly accepted. **Tables 1 and 2** list positive measures and things to avoid with regard to child behavior management.

Dentists often fear giving local anesthetic to a child. Not anesthetizing a tooth that potentially will become painful always is a mistake. There is nothing worse than having a child experience continuous pain while a procedure is being performed. Therefore, if there is any doubt that the procedure may be uncomfortable, the dentist should give local anesthesia and ensure that the area is completely without sensation. When administering local anesthesia, always have an assistant with you to unobtrusively pass the syringe, and if necessary, hold the child’s hands. One should always prepare the area with topical or pressure anesthesia so that the initial needle insertion has little discomfort. Never let the child see the uncapped syringe. Always use distraction, such as mild shaking the child’s head when administering the anesthetic. Procrastination on the dentist part before administering local anesthesia does a great deal to increase a child’s fear (**Table 3**).

Table 3 - Strategies for Administering Local Anesthesia in Children

- Prepare area well with topical anesthesia or pressure.
- Give at least 1 carpule of 2% lidocaine, with maximum dose = child’s weight (lbs) X 2 = maximum mg of 2% lidocaine.
- Assure that the area is completely without sensation. With a mandibular block make sure there is a lip sign.
- Do not hesitate to give local anesthesia.
- Do not hesitate when giving local anesthesia.
- Use distraction, such as shaking techniques.
- Be honest with the child regarding possible discomfort (e.g., “you may feel a pinch”).

Caries Preventive Strategies

Education

The customary preventive dentistry program for children often involves education of the patient and parent regarding ways to prevent dental caries. These educational messages attempt to convince the child or parent to reduce high frequency sugar consumption, and to brush their teeth at least daily with fluoridated toothpaste. However, several studies suggest that educational programs improve knowledge, but only have a temporary effect on plaque levels, and have no discernible effect on caries experience. Behavioral change may be more successful when the parent is more engaged using techniques (e.g. motivational interviewing) in which the parent identifies the problem and subsequently offers approaches that they feel are achievable to change a behavior.

Diet

The role of sugar in promoting the dental caries process is well documented. High frequency sugar consumption is generally regarded as one of the important causative factor for caries. In toddlers, sugar containing drinks, especially juice, in bottles or sippy cups has been associated with early childhood dental caries. Most sugars (e.g., glucose, fructose, sucrose) are readily metabolized by *mutans streptococci* and other dental plaque bacteria, to produce acids that can demineralize tooth structure. High frequency sugar consumption sustains a low pH environment that demineralizes teeth. Furthermore, large consumption of sugar is not healthy for the body, in general, because it will substitute for the consumption of essential foods. For any individual at high risk for caries, controlling the frequency sugar consumption should be an important component of a caries prevention program.

Tooth Brushing

The role of tooth brushing in the prevention of tooth decay has long been considered self-evident. Yet, there is little evidence to support the belief that tooth brushing, *per se*, reduces caries. However, brushing with fluoridated toothpaste has shown to significantly reduced dental caries. Additionally, there is data

that suggests not rinsing the mouth after brushing with fluoridated toothpaste has additional benefit in reducing caries in children. To prevent fluorosis from excessive swallowing of toothpaste, children should use a “smear” of toothpaste for children under age three, and a “pea-sized” amount of toothpaste for preschoolers above age three.

Systemic Fluoride Dietary Supplements

If the fluoride content of the child’s drinking water is unknown, a sample of the water should be analyzed for fluoride content, and if the water is fluoride deficient, systemic fluoride supplementation can be recommended considering the fluoride content of the water, the child’s age, as well as the child’s caries risk (Table 4). Data from many clinical trials show caries reduction in primary teeth of 30-80% from fluoride supplements. However, there is literature showing that children, whether living in a fluoridated or non-fluoridated area, have a higher prevalence of dental fluorosis with fluoride supplement use. It is now recommended that fluoride supplements only should be prescribed to children residing in non- fluoridated communities, and who are identified as being at high caries risk.

Professional Topical Fluorides

Professional topical fluoride treatments, tray/brush-on or varnishes have had a long history of use in preventing dental caries. Fluoride varnishes have gained popularity, especially for preschool children, because the total amount of fluoride delivery can be better controlled. Fluoride varnishes are now generally sold as single dose containers, along with a brush, that dispense 0.25, 0.4 or 0.6 ml with the smaller dosages recommended for preschool children.

In 2014, 38% silver diamine fluoride (SDF) has been approved by the FDA for treating dentinal sensitivity in adults, but more frequently is being used “off label” to arrest carious lesions in children. In 2016, the FDA awarded SDF the designation as a “breakthrough therapy” based on its ability to arrest cavities. Studies have shown that the caries arrest with SDF is more effective on the anterior teeth and application frequency is optimal when done every six months. If SDF is being considered

to treat cavities in primary teeth, parents need to be informed that the product will impart a black stain on the cavities.

Dental Sealants

Numerous clinical trials during the past several decades have shown that dental sealants are safe and highly effective in preventing pit and fissure caries. Indications for sealants in primary and permanent molars include deep and stained fissure, history of caries, or the child has been identified as being at risk for caries. Most interesting is the ADA guideline that recommend placement of sealants even in those teeth that have non-cavitated enamel caries.

Table 4 - Supplemental Fluoride Dosage Schedule

Age	Fluoride in Home Water (ppm)		
	<0.3	0.3 - 0.6	>0.6
6 mo. - 3 yr.	0.25*	0	0
3 - 6 yr.	0.50	0.25	0
6 - 16 yr.	1.00	0.50	0

* mg fluoride supplement per day
 Note: Recommended for children at high caries risk

Table 5 - Calcification and Eruption Chart

		Tooth	First Evidence of Calcification	Eruption
PRIMARY Dentition	Maxilla	Central incisor	3-4 mos. <i>in utero</i>	7½ mos.
		Lateral incisor	4½ mos. <i>in utero</i>	8 mos.
	Canine	5½ mos. <i>in utero</i>	16 - 20 mos.	
	First molar	5 mos. <i>in utero</i>	12 - 16 mos.	
Mandible	Maxilla	Second molar	6 mos. <i>in utero</i>	20 - 30 mos.
		Central incisor	4½ mos. <i>in utero</i>	6½ mos.
	Lateral incisor	4½ mos. <i>in utero</i>	7 mos.	
	Canine	5 mos. <i>in utero</i>	16 - 20 mos.	
PERMANENT Dentition	Maxilla	First molar	5 mos. <i>in utero</i>	12 - 16 mos.
		Second premolar	6 mos. <i>in utero</i>	20 - 30 mos.
		Central incisor	3 - 4 mos.	7 - 8 yrs.
		Lateral incisor	10 mos.	8 - 9 yrs.
		Canine	4 - 5 mos.	11 - 12 yrs.
	Mandible	First premolar	1½ yrs.	10 - 11 yrs.
		Second premolar	2 yrs.	10 - 12 yrs.
		First molar	At birth	6 - 7 yrs.
		Second molar	2½ yrs.	12 - 13 yrs.
		Third molar	7 - 9 yrs.	17 - 21 yrs.

Adapted from Logan and Kronfeld, JADA, 1933

Sealants should be placed as soon as feasible in children who are at risk of caries. While most published data on the effectiveness of sealants refer to their use on permanent teeth, sealants on primary teeth also have shown value. There is sufficient need to seal primary molars as epidemiologic studies have shown that over 80% of caries in preschool children are found on the pit and fissure surfaces of primary molars.

Growth and Development

It is important for those practitioners who see children to know when teeth first start to develop and when they erupt. Not only is this a frequent question that parents ask, but also it is critical to understand developmental problems of teeth. **Table 5** gives estimates of mineralization and eruption of primary and permanent teeth. However, it should be recognized that these average values might vary greatly between children.

Normal Spacing Development

Most primary dentitions have generalized spacing, and frequently there are diastemas occurring between the mandibular primary canine and first primary molar, and between the maxillary lateral primary incisor and the maxillary primary canine, often referred to as primate spaces. The first permanent molars ordinarily erupt in an end-to-end relationship, but may also erupt into a Class I relationship (the mesial buccal cusp of the maxillary first permanent molar interdigitates in the buccal groove of the mandibular first molar), or a Class II relationship. If the mandibular arch contains primate spaces, the erupting first permanent molar may cause the second primary molar and the first primary molar to move forward, closing the primate space, and allowing the permanent molars to shift forward into Class I relationship. This sometimes is referred to as the first shift, which can occur between ages 6-8.

With the exfoliation of the primary molars and their replacement with the premolars, the first permanent molars may undergo another shift, the second shift or Leeway Shift. This shift is due to the larger size of the primary molars

compared to the succeeding premolars. The average leeway space (per side) of 1.7 mm exists in the mandible, and 0.9 mm in the maxilla. Therefore, permanent molars that are in end-to-end relationship in the mixed dentition can also shift to Class I relationship with the transition to the full permanent dentition.

Incisor Position

With the eruption of the lower permanent incisors, a 2.2 to 2.5 mm widening of the arches between the canines may occur, due to growth or to the distal migration of the primary canines. Other factors that allow the larger permanent teeth to erupt into the space occupied by the smaller primary incisors is the forward positioning and the angulation of the permanent incisors, as well as utilization of diastemas, if present in the primary incisor region. In general, the average child has some spacing in the primary incisor region, whereas, in the permanent incisor region there is often some crowding, especially in the mandible.

Another temporary developmental problem often exists during the eruption of the maxillary anterior segment, often called “the ugly ducking stage”. This is due to the maxillary permanent canines pressing on the developing roots of the lateral incisors, pushing the roots mesially and causing the crowns of the central and lateral incisors flare distally. With further eruption of the canines, the lateral incisors are pushed mesially, properly aligning the incisor crowns and closing of the diastema between the centrals.

Space Maintenance

Space maintainers are often indicated for the premature loss of primary molars due to dental caries. The early loss of second primary molars is especially critical because the first permanent molar will drift forward causing a shortage of the space needed for the premolars to erupt. This mesial shift of the first permanent molars most often will lead to a major crowding problem, often with blocked out premolars. However, if the

premolar under the primary tooth that is to be extracted will soon erupt, indicated by no bone over the crown of the erupting tooth or the root of the premolar is at least half formed, space maintenance is not indicated. The practitioner should recognize that space loss can occur very rapidly after tooth extraction. Consequently, space maintenance appliances should be placed as soon as possible, or the patient should be referred as soon as possible to a dentist who is comfortable with constructing the appliances.

Restorative Care

Two important principles for restorative care in children are having good local anesthesia and having good isolation on teeth that are being restored. There is no doubt that a child is a much better patient when they do not have pain during a procedure, when they do not have to deal with water in the back of their mouths, and when they do not experience tastes and objects that are part of restorative care. Furthermore, a rubber dam retracts soft tissues, provides contrast, reduces salivary contamination and protects the airway.

Although amalgam and composite are both good restorative materials for intracoronal restorations in children, there is a trend toward greater use of composites. Such a change is the result of better composite materials, patient preference and the political issues regarding mercury disposal. Disadvantages of composite materials, however, include the need for more rigorous techniques, requirement for absolute moisture control (especially for Class II restorations) and greater cost.

Preformed crowns are often indicated in the restoration of primary teeth that have large lesions with cusps in jeopardy. Additionally, crowns are generally indicated for teeth that have had pulp treatment or teeth with one or more interproximal lesions. The restoration of teeth with preformed crowns can be challenging, especially if two adjoining teeth need crowns, or if there is space loss due to advanced caries. It is often prudent to

refer such cases to Pediatric Dentists who have considerable experience with these situations.

Pulp Therapy for Primary Teeth

If a child presents with pain from a carious primary tooth, it is critical to determine whether the pulp has reversible or irreversible pulpitis. Those primary teeth with pain evoked by eating, but diminishes after the stimulus is removed and/or shows no signs of infection probably have reversible pulpitis and can be treated to preserve pulp vitality. Treatment for such deep caries in primary teeth involves “selective caries removal” where carious dentine is completely removed from the peripheral walls of the deep lesions, followed by careful/no removal of carious tissue on the pulpal floor. Glass ionomer cement generally is the material that is placed over the remaining dentine to enhance pulp healing and repair.

However, if excavation results in a pulp exposure, a pulpotomy procedure can be performed that includes complete removal of the coronal pulp with the remaining pulp in the canals treated best covered with mineral trioxide aggregate (MTA). In contrast, if a child presents with spontaneous pain, especially waking the child at night, or other signs of irreversible pulpitis, the treatment should be pulpectomy or extraction, depending on the importance of the tooth (*i.e.*, second primary molars that are not near exfoliation) and the desires of the parent (**Table 6**).

Summary

Treating children in a general dental practice should be rewarding and a pleasant experience for the dental team and the child, provided that a few basic concepts are considered. There is

a shift from providing acute problem-focused health interventions to more sustainable, holistic preventive healthcare. Shared decision-making includes patient preferences are fully considered and discussed in order to optimize patient-specific evidence-based care pathway. Managing child anxiety is accomplished by being empathetic to the child’s concerns, explaining what you want to do, and giving the child your full attention. Disease prevention includes reducing frequent sugar consumption, brushing the child’s teeth at least daily with fluoridated dentifrice, and professionally administered/prescribed topical fluoride. Treatment of dental caries involves using risk assessment methods, disease prevention, and when necessary, conservative restorative dentistry.

Table 6 - Pulp Therapy for Primary Teeth

Condition	Signs	Treatments
Reversible Pulpitis	<ul style="list-style-type: none"> • Pain evoked by eating • Pain can be relieved by brushing, analgesics • No radiolucencies or root resorption 	<ul style="list-style-type: none"> • If no exposure – selective carries removal followed by restoration. • If exposure – pulpotomy
Irreversible Pulpitis	<ul style="list-style-type: none"> • Spontaneous pain, often at night • Tooth mobility/sensitive to percussion fistula/abscess • Fever • Bifurcation radiolucency or root resorption 	<ul style="list-style-type: none"> • Pulpectomy or extraction, depending on critical nature of tooth and/or patient preferences.

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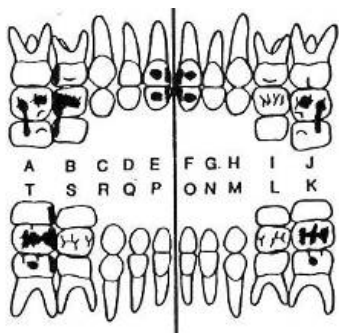
Sally presents for her first dental examination at age 4 years. She has never been hospitalized, takes no medications and review of systems is noncontributory.

She presents because her mother says that she has

been up at night for the past three days crying because of a toothache. The chart to the

right records the findings of the

clinical and radiographic examination: Large buccal, lingual and mesial lesions on the maxillary central incisors; a large lesion is evident on the distal & occlusal surface of the maxillary right first primary molar; a radiographic mesial carious lesion is evident on the mandibular right second molar; and small fissure carious lesions are evident on all the second primary molars. In addition, there is swelling of the buccal gingiva adjacent to the maxillary right first molar, and Sally points to this tooth when asked what tooth is bothering her.



1. Shared decision-making between oral health provider and patient includes:

- Mutual health approach after discussion of outcomes and preferences.
- Care pathways including risk-based preventive and restorative options.
- Understanding and care of the chief complaint.
- All are correct.

2. The chief complaint is tooth “b”. From the clinical symptoms what treatment should be considered:

- Selective caries removal, followed by composite restoration.
- Complete caries removal, followed by composite restoration.
- Pulpotomy
- Pulpectomy

3. What pertinent question(s) can you ask the mother regarding the reasons for dental caries in this child:

- Did your child sleep with a bottle?
- Does your family drink fluoridated city water or do you have your own well?
- How often does Sally brush her teeth?
- All are correct.

4. What risk factor is the most critical in classifying Sally’s caries risk?

- Sibling’s history of caries
- Reason for presenting for first visit
- Fluoride level of drinking water
- Number of carious lesions

5. Preventive therapy could include:

- Diet analysis
- Professional fluoride varnish treatment
- Sealants on those molars that are not carious
- Chlorhexidine

- 1, 2 and 3 are correct
- 1 and 3 are correct
- 2 and 4 are correct
- 4 is correct
- All are correct

6. Sally cries when she sees the dentist pick up the mirror and explorer. The best approach is to:

- Refer her to a pediatric dentist.
- Reappoint for a morning appointment.
- Show her on her finger nail what the explorer does.
- Tell her that after appointment prize requires a “good helper”.
- Tell her that that the needle will not hurt.

7. For local anesthesia associated with restorative care, what is the maximum amount of 2% lidocaine local anesthesia that should be given to this 40 pound child?

- 20 mg
- 40 mg
- 50 mg
- 80 mg

8. The emergency visit, and the diagnostic/preventive visits have been completed. The first restorative visit will be the caries excavation and restoration of tooth “t” (right mandibular second molar). Critical factors for the success of this treatment include:

- Choosing the correct matrix.
- Good anesthesia.
- Making sure that the child does not cry.
- Good isolation with a rubber dam.

- 1, 2 and 3 are correct
- 1 and 3 are correct
- 2 and 4 are correct
- 4 is correct
- All are correct

9. Tooth “t” has deep caries. Sally has said that sometimes it hurts when she eats candy. Treatment will include:

- Selective caries removal, followed by composite restoration.
- Complete caries removal, followed by composite restoration.
- Pulpotomy.
- Temporary restoration, followed by composite restoration in 6 months.

10. The initial preventive and restorative therapy has been successful, and you see Sally for 3, successive recall appointments. The most important factor for reassessing her future caries risk at this point would be:

- mother’s caries history
- sibling’s caries history
- original caries rate
- number of new lesions

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2. How would you rate the quality of the content?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Please rate the effectiveness of the author.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Please rate the written materials and visual aids used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. The use of evidence-based dentistry on the topic when applicable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
6. How relevant was the course material to your practice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. The extent to which the course enhanced your current knowledge or skill?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. The level to which your personal objectives were satisfied.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Please rate the administrative arrangements for this course.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

10. How likely are you to recommend MetLife's CE program to a friend or colleague? *(please circle one number below:)*

10
9
8
7
6
5
4
3
2
1
0

extremely likely
neutral
not likely at all

What is the primary reason for your 0-10 recommendation rating above?

11. Please identify future topics that you would like to see:

Thank you for your time and feedback.



To complete the program traditionally, please mail your post test and registration/evaluation form to:
MetLife Dental Quality Initiatives Program | 501 US Highway 22 | Bridgewater, NJ 08807