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Short Communcation

Early Childhood Carie (ECC): Between Politics And Primary Private Care

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Oral health is a decisive indicator of the quality life in children [1]. The cranio-oro-facial complex allows the child to spell, talk, read, smile, laugh, kiss, touch, smell, taste, chew... to cry and guarantees protection against microbial infections and environmental threats too. The oral cavity and dental condition represent the mirror for general health and their examination has a screening value for nutritional deficiencies and/or general diseases such as: celiac disease, gastroesophageal reflux, diabetes, autoimmune diseases, oral cancer, etc. Saliva investigations can provide – as an investigation of blood-important information about general health.

On the other hand-early impairment of oral health through carious disease unintercepted in time and treated late or untreated has a biopsychosocial impact that can affect the growth, development and general health of the child. Children with ECC (early childhood decay) grow at a slower rate than children free from caries. In addition-the non esthetic appearance of decay or absent teeth for any person – whether adult or child-has an important negative connotation-in European culture being associated with the non-hygienic, undesirable lifestyle or the poorness from the edge of society.

It is true that during the last 30 years -the scourge of dental caries has recorded a continuous decline at international level. International level of oral health for children 0 - 12 years expressed by the DMFT/DMFT index has improved in the last 30 years and that is due – experts say-access to toothpastes with fluoride. It is also true that the "fluoride" manufacturing industry has developed extensively and that marketing and more or less free distribution campaigns of toothpaste and toothbrush and other dental hygiene accessories have developed to a higher profitability and have secured their sales [2].

And yet – vulnerable groups-especially children and adolescents-suffer from a high prevalence and severity of dental caries. A report on oral health in USA states that children's oral problems are 5 times more frequent than asthma and about 7 times more common than febrile states. Thus this index in 1992 was for children 6 - 8 and 11 - 13 years of 5.3 and 4.1 decreased in 2011 to 4.4 and 3.4 respectively. However a child who at 6 years old has 5 teeth affected (carious, extracted or treated) or at 11 years 3 affected teeth – reflects not only a health condition away from WHO's goals but also a serious medical and community management problem. Untreated caries in deciduous teeth peaked among children aged 1 - 4 years in 2015 [3].

As for the vulnerability of young people (children or teenagers)-this consists not only in their inability to identify, express and address their own needs. Children are addicted to adults acting on behalf of their rights. The vulnerability of children and adolescents also consists in the fact that their young (temporary or permanent) teeth are poorly mineralized and need a post-eruptive maturation. Fortunately, dental Enamel is endowed with an extraordinary potential 10 times higher than adults ' enamel to absorb minerals (PO4, fluoride, Ca, etc) from the oral environment and to complete its mineralization. Hygiene and nutrition behaviours may favour or accelerate the process of post-eruptive mineralization or may block/reverse (in which case it is installed dental caries).

Question

In Pediatric Dentistry– which operates predominantly -all over the world-in the private regime, the procedures for prevention, interception and monitoring of the dental caries of the paediatric population is possible and effective? Can Pediatric Dentistry, mostly private – alone – to make this scoured?

The answer is

No! Because the scourge of dental caries in children is a complex structural problem requiring political, social, education-behavioral,comprehensive-medical involvement and last but not least stomatological.

Political involvement

Because Isolated interventions focused on the implementation of dental behaviours just in dental offices is valuable but will not be effective in optimising the national or international oral health. It is because Prevention Programmes need to identify, change and reorganise political values and priorities. International public health organisations are- for example – long ago-increasingly concerned with the implementation of measures, guidelines and nutritional recommendations – among them recently and those limiting the consumption of sugar added-especially for children and teenagers [4,5].

Societal involvement

Because the phenomenon can only be controlled by understanding the dynamic changes that occur in society, especially with regard to family structure, growth and nutrition of children and socio-economic status, and because with the polarization of society in two layers of rich and poor the prevalence of social problems grows and dental decay focuses on the disadvantaged members of society. Children's oral health is not a priority for families living in economic insecurity [6].

Education and promotion of health behaviour

It is Because decisions and nutritional actions or daily hygiene (or their lack) of mothers, vouchers, grandparents, educators or foster families are determinants for the oral health of children. Who monitors or intercepts the mother or grandmother giving to the child in repeated tea outlets sweetened with milk or honey? Who monitors the child's proper dental hygiene? Who counseles the mother who is breastfeeding often and nocturnal the child a long time after the age of one year? [7,8].

Primary oral care

Without the integration of oral care in primary medical assistance- early interception of dental caries cannot be effective. It is because the first preventive measures of dental caries must begin before the birth of the child and immediately after childbirth. Moreover- the concept of Dental home visits in the same sense as Medical home visits could be the subject of a new vision and framing of educated staff for this purpose. Taking long-term medication with sugar-sweetened medicines in children with chronic diseases is the risk factor for dental caries. Interception through the anamneosis and Dental Home monitoring and the enterprise of protective-preventive measures can protect the child from a future dental drama [9,10]. In the year 2013-The most important professional organization in the world for nutrition -the International Academy of Nutrition and Dietetics-published a position document from which we quote: "there is a close link between food and oral health... and a better dental health is a step towards a better general health". The Academy supports the integration of oral health in nutrition field, education and research services. The collaboration between dieticians and the professionals in the field of oral health is still the missing link in the circuit of promoting oral health [11].

Dental approach

Unfortunately- pediatric patients attend the first consultation late, inconstant and most of the time in emergency and in the stage of dental drama. In addition-the traditional approach of surgical curative type (drill, fill-in and PIN) din HighTech clinics around the World is the only therapeutic dominance that aims-only repairing the consequences but not eradicating carious disease. Not Incidentally-Children of young age with early caries and requiring complex oral rehabilitation need hospitalization and costly interventions in general anesthesia.

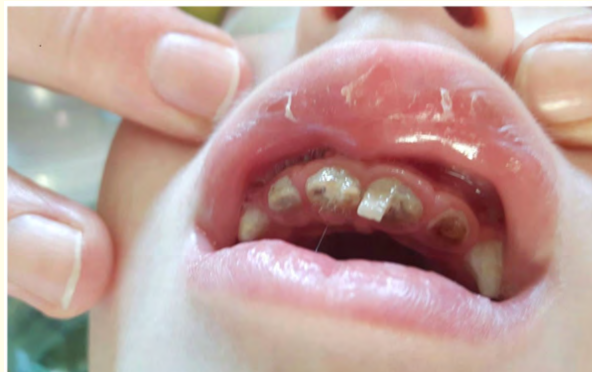

Figure 1

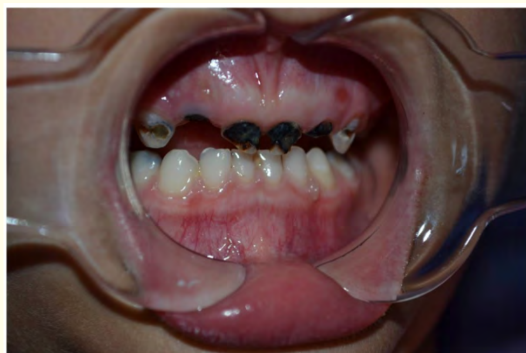

Figure 2

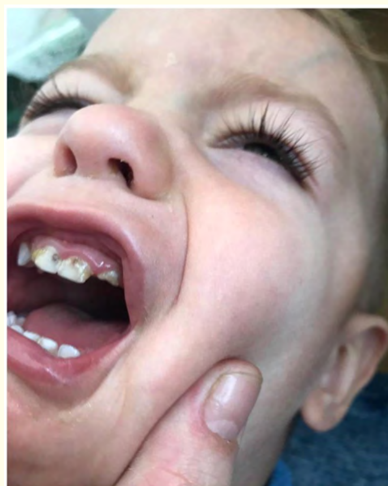

Figure 3

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