

When should my Child first visit his Pediatric Dentist?

According to guidelines from the American Academy of Pediatric Dentistry (AAPD), your child should be seen by his/her pediatric dentist no later than six months after the eruption of the first tooth. This visit mainly will involve counseling on oral hygiene, habits and on the effects that diet can have on his/her teeth. It is NOT recommended to wait until age 3 to visit your dentist and as a general rule, the earlier the dental visit, the better the chance of preventing dental problems. Children with healthy teeth chew food easily, learn to speak clearly, and smile with confidence. Start your child now on a lifetime of good dental habits. The AAPD also recommends a dental check-up at least twice a year; however some children that may be at a higher-than-average caries risk may need to be seen more often.

My child has “Gaps” between his baby teeth, is that ok?

It is normal and even “ideal” for baby teeth to have spacing between each other. Keep in mind that when permanent teeth erupt, their size will be considerably larger than that of baby teeth. As the baby teeth are lost, the erupting permanent tooth will quickly take advantage of this excess space. Children who do not have spacing in their primary dentition can have a higher incidence of crowding (crooked teeth) in the permanent dentition.

Which is the best tooth paste for my child?

There is not such a thing as the best toothpaste. We recommend ONLY products that have been ADA (American Dental Association) accepted or approved. The selection is usually made on a case-by-case basis; however the main consideration when selecting toothpaste is your child’s age. This is due to the risk of fluorosis in younger children that swallow toothpaste during regular brushing. A child may face the condition called enamel fluorosis if he or she gets too much fluoride during the years of tooth development. Too much fluoride can result in defects in tooth enamel.

Q: Why is enamel fluorosis a concern?

A: In severe cases of enamel fluorosis, the appearance of the teeth is marred by discoloration or brown markings. The enamel may be pitted, rough, and hard to clean. In mild cases of fluorosis, the tiny white specks or streaks are often unnoticeable.

Q: How does a child get enamel fluorosis?

A: By swallowing too much fluoride for the child's size and weight during the years of tooth development. This can happen in several different ways. First, a child may take more of a fluoride supplement than the amount prescribed. Second, the child may take a fluoride supplement when there is already an optimal amount of fluoride in the drinking water. Third, some children simply like the taste of fluoridated toothpaste. They may use too much toothpaste, and then swallow it instead of spitting it out.

Why do you need to place “silver caps” on my child’s teeth?

Recent controversy regarding the use of Stainless Steel Crowns (SSCs) in some states have led some parents to question dental care providers more thoroughly on their use and on other alternatives. SSCs have been used in dentistry for over 50 years for primary and permanent dentition. For primary teeth, SSCs are usually placed on teeth that have extensive caries (where two or more surfaces are extensively involved), or teeth that have pulp treatment (such as pulpotomy or pulpectomy). We also use them in teeth that will remain on the mouth for a considerably long period of time; where other materials will not last long enough. SSCs become loose and come out of the mouth just like normal primary teeth. They work just like normal teeth do, and require the same care. Alternatives to Stainless Steel Crowns do exist, particularly for front teeth. Usually these can be one of the following:

- A prefabricated SSC that has a white facing bonded to it on the front (Commonly we use the Nu-Smile brand www.nusmilecrowns.com)
- A white cap fabricated with a white filling material (Usually we call these strip crowns). We have photos available at our office if you have more questions.
- A normal SSC that we modify by building a window in the front of it, which we later fill with a white filling material.

My Child has to have his/her front baby teeth “pulled”. How is that going to affect him/her?

Children require extraction of one or more primary teeth in certain situations. These situations may include extensive decay on their front teeth, and/or localized infection (for example an abscess or a gumboil). Extractions are also necessary in cases of trauma, where the baby teeth have been pushed back, pushed forward, broken, or simply knocked out. Parents are obviously concerned of the esthetic and functional effects (on speech, feeding, and breathing) of removing one or more front baby teeth. There is good evidence that has shown NO long-term speech impediments on these cases. We also know from our professional experience that once the gums heal, children will be able to eat almost anything, since they can still bite-and-cut with the remaining teeth. As far as esthetics is concerned, Doctor Dorantes can offer you information on fixed appliances that can replace the missing tooth/teeth, assuming your child meets the right criteria.

What is an “Oral Sedation” and what are the risks associated with it?

A conscious oral sedation is a procedure in which a child is given an oral medication that causes a depressed level of consciousness. Our academy (AAPD) has clearly defined the indications for this procedure, and these are as follows:

- a. Preschool children who cannot understand or cooperate for definitive treatment.
- b. Patients requiring dental care who cannot cooperate due to a lack of psychological or emotional maturity.
- c. Patients requiring dental treatment, and who cannot cooperate due to a cognitive, physical or medical disability.

- d. Patients who require dental care but are fearful and anxious, and cannot cooperate for treatment.

As with any procedure in which a child's conscious state is altered, there are some risks involved. The main risks (serious complications) associated with conscious sedation include, but are not limited to: Aspiration, respiratory arrest, cardiac arrest, and death. Because your child will be partially awake, local dental anesthesia (a lidocaine shot) is still needed, and this may limit the extent of work that we can provide. Sedations are also an option in cases of accidents or trauma, but in these situations, the decision to administer the medication must take into consideration the risk of aspiration (breathing vomit into the lungs) and any head trauma that may have occurred. If your child is a candidate for a conscious sedation, please make sure you follow the instructions provided by Doctor Dorantes and his staff.

Can you do all the work at once with a Sedation?

In cases with extensive decay, we are limited by the maximum dosage of local anesthetic that we can use. As a rule we also consider your child's comfort after he/she leaves the clinic, in order to determine how much local anesthetic we can use. Very young children are at high risk of "biting" their lips or chewing on the inside part of their cheeks after they receive local anesthetic (a lidocaine shot). This usually happens because of their natural curiosity they try to feel the area or areas that are numb. For these and other reasons it is unlikely that we could work on all of your child's teeth at once.

What is a General Anesthesia appointment and how safe is it?

The use of general anesthesia for dental work in children is sometimes necessary in order to provide safe, efficient, and predictable care. Our academy (AAPD) recognizes the need for general anesthesia in certain situations where challenges relating to the child's age, behavior, medical conditions, developmental disabilities, intellectual limitations, or special treatment needs may warrant it. General Anesthesia is given to your child by a specialist (anesthesiologist) and our office is the only pediatric dental practice in Yakima using MD trained anesthesiologist for our in-office services. Doctor Dorantes is also on Staff at Yakima Memorial Hospital and this allows him to treat your child in a hospital setting if he/she so requires.

Pediatric dentists are, by virtue of training and experience, qualified to recognize the indications for such an approach and to render such care. Doctor Dorantes and his staff will discuss all the necessary steps that must be taken in order to promptly and safely complete your child's dental treatment after this treatment option has been chosen.

A natural concern of any parent or guardian whose child is having an operation is whether the anesthesia will cause any harm. Even though anesthesia today is much safer than it has ever been, all anesthesia has an element of risk. In fact, sometimes it is difficult to separate the risks of anesthesia from the risks of the operation itself. Anesthesia aims to take away the pain and discomfort of surgery

and make it easier for a procedure to be accomplished optimally, and these benefits must be weighed against the risks of anesthesia itself.

The specific risks of anesthesia will vary with the type of operation and whether it is an emergency, the age of the child, and any other problems or illnesses that exist. In cases of Dental Surgery we plan ahead so these surgeries are NOT considered emergency procedures.

According to the Society of Pediatric Anesthesia, The risks of general anesthesia may be considered in terms of **side effects** and **adverse effects**.

A **side effect** is a secondary or unwanted effect of a drug or treatment. Many side effects of anesthesia drugs and techniques can be anticipated, but may be unavoidable. Although at times uncomfortable or distressing, most common side effects are not particularly dangerous. They will either wear off or can be treated easily. Examples of side effects are nausea, vomiting, drowsiness, dizziness, sore throat, shivering, aches and pains, discomfort during injection of drugs, and agitation upon awakening from anesthesia.

An **adverse effect** is a result of a drug or treatment that is neither intended nor expected. Adverse effects are very rare, but may occur. These may include dental trauma, croup (swelling of the windpipe), allergic reactions to drugs or latex products, wheezing, vocal cord spasm or injury, regurgitation of stomach contents with subsequent aspiration pneumonia, injury to arteries, veins or nerves, alterations in blood pressure, and/or irregular heart rhythms. Death and brain damage are the most feared of all anesthetic risks, but fortunately these complications are extremely rare. In the United States, the chance (risk) of a healthy child dying or sustaining a severe injury as a result of anesthesia is less than the risk of traveling in a car. If you have questions specific to general anesthesia, please refer to our anesthesiologist's website at : <http://www.m2anesthesia.com>

Will you need to give my child a "shot" to do the dental work?

This is the one of the most commonly asked questions that we get from our patient's parents. We try to minimize the discomfort of the injection by placing a gel that works as a local anesthetic and numbs the tissue where the injection will be administered. Profound local anesthesia is usually obtained five to ten minutes after the injection, depending on the area of the mouth where the anesthetic was placed. We always check to confirm that the area is numb before we begin to work. In cases of localized infection or trauma (like broken teeth) it is very difficult to obtain profound anesthesia, however we do have other means of supplementing the anesthetic (like conjoined use of nitrous-oxide gas, medications or conscious sedation). Younger children, particularly pre-schoolers may interpret the feeling of numbness as pain, and therefore cry. Please follow the postoperative instructions that we give you, in order to minimize complications such as lip biting.

My child's teeth have stains on them, are these cavities?

When a baby-tooth changes color, it can mean many things. Baby teeth can and do normally change in color, particularly close to the time that they become loose, however, this change is minimal and should not be confused with a carious lesion (cavity). The best way to determine if your child has a stain or a true cavity is to take him or her to a pediatric dentist.

Caries is an infectious disease; it progresses if left untreated, and usually is associated with pain (especially when the “cavities” are large). Teeth with cavities typically assume a darker (brown) discoloration, and depending on the extent, may exhibit loss of tooth structure. Teeth that have been previously “bumped” may also change in color. Traumatized baby teeth can assume a yellow or a dark discoloration, which may or may-not be associated with pain. Other less common causes of changes in color may be: Fluorosis, food staining (particularly tea or colas), systemic disease (hepatitis), etc.

My child is getting “shark teeth” on the bottom, what can I do?

One of our most common consults occurs when children around the age of six or seven begin to lose their lower front teeth. Many of our parents become overly worried about this phenomenon. It is VERY NORMAL for permanent lower incisors (front teeth) to erupt behind their predecessors (baby teeth), however if a baby tooth is not loose by the time half of the permanent incisor has erupted, it may be necessary to pull it.

My Child has crooked teeth. Will he/she need braces?

Crooked or crowded teeth are very common in the growing patient. Even patients that get braces may develop a minor degree of crooked (crowded) teeth, particularly in the front teeth of the jaw, as they grow old. The first step in determining the need for treatment is what we call an orthodontic consult. During this appointment we may obtain special records and special x-rays of your child’s jaws. This information will allow us to make a decision based on predicted growth patterns that your child may show later. In orthodontic terms we refer to this as Early Treatment.

Early treatment refers to ANY orthodontic (braces) or orthopedic (appliances like Head-gear) treatment that begins when the child is in primary dentition, or in early mixed dentition (when the first permanent teeth begin to erupt). Early treatment has been proven to be effective despite objections by some people in the orthodontic community. The AAPD recognizes that early diagnosis and successful treatment of developing malocclusions can have both short-term and long-term benefits, while achieving the goal of occlusal harmony, function, and facial esthetics.