

381 Oral Health Conditions

Definition/Cut-off Value

Oral health conditions include, but are not limited to:

- Dental caries, often referred to as “cavities” or “tooth decay”, is a common chronic, infectious, transmissible disease resulting from tooth-adherent specific bacteria, that metabolize sugars to produce acid which, over time, demineralizes tooth structure (1).
- Periodontal diseases are infections that affect the tissues and bone that support the teeth. Periodontal diseases are classified according to the severity of the disease. The two major stages are gingivitis and periodontitis. Gingivitis is a milder and reversible form of periodontal disease that only affects the gums. Gingivitis may lead to more serious, destructive forms of periodontal disease called periodontitis.(2)

More information on types of periodontal disease is available at:

<http://www.perio.org/consumer/2a.html>.

- Tooth loss, ineffectively replaced teeth or oral infections which impair the ability to ingest food in adequate quantity or quality

Presence of oral health conditions diagnosed, documented, or reported by a physician, dentist, or someone working under a physician’s orders, or as self reported by applicant/participant/caregiver. See Clarification for more information about self-reporting a diagnosis.

Participant Category and Priority Level

Category	Priority
Pregnant Women	I
Breastfeeding Women	I
Non-Breastfeeding Women	III, IV, V or VI
Infants	I
Children	III

Justification

Oral health reflects and influences general health and well being. Good oral health care and nutrition during pregnancy, infancy and childhood are often overlooked factors in the growth and development of the teeth and oral cavity.

Infants and Children

The Centers for Disease Control and Prevention (CDC) reports that dental caries may be the most prevalent infectious disease in U.S. children. More than 40% of children have tooth decay by the time they reach kindergarten. Infants that consume sugary foods, are of low socioeconomic status, and whose mothers have a low education level, are 32 times more likely to have caries at the age of 3 years than children who

do not have those risk factors. Despite its high prevalence, early childhood caries (ECC) is a preventable disease. (3)

ECC may develop as soon as teeth erupt. Bacteria, predominantly mutans streptococci (MS), metabolize simple sugars to produce acid that demineralizes teeth, resulting in cavities. The exact age at which MS colonization occurs in children is controversial, but it does not happen until teeth erupt. The earlier colonization occurs, the greater the risk of caries. MS typically originates in the mother and is transmitted to the child via saliva (often through cup and utensil sharing). Elevated maternal levels of MS, due to active or untreated caries and frequent sugar consumption, increase the risk of transmission. In addition, recent evidence suggests that exposure to environmental tobacco smoke increases the likelihood of MS colonization in children. (4)

Historically, ECC has been attributed to inappropriate and prolonged bottle use; formally called “baby bottle tooth decay.” However, recent studies indicate that the disease is multifactorial, which suggests any feeding practice that allows frequent sugar consumption in the presence of MS may result in caries formation: propped bottles containing sweetened liquids or formula, frequent consumption of juice or sweetened liquids from infant and “sippy” cups, and frequent snacking of high cariogenic foods. (4)

The frequency of sugar consumption is the main dietary variable in caries etiology. After bacteria metabolize sugar into acid, it takes 20-40 minutes for the acid to be neutralized or washed away by saliva. Therefore, if sugars are frequently consumed, the potential for demineralization is greater. Although MS can metabolize many different carbohydrates, they produce acid most efficiently from sugars, especially sucrose. Sugars within the cellular structure of food (such as fructose in whole fruit) are thought to be less cariogenic than sugars intentionally added to foods. (4) See [Table 1](#) for more information on the cariogenic potential of children’s foods and snacks.

Milk is widely consumed, especially by children, and thus the interaction between different kinds of milk consumed and caries development has been a research topic of interest. Lactose is one of the least cariogenic sugars because it is poorly metabolized by MS. Researchers have reported cows’ milk to be a protective, anticariogenic agent due to its high concentration of calcium and phosphate. The buffering activity of proteins present in cows’ milk also might allow the formation of very stable complexes of calcium phosphate. Other anticariogenic properties in cows’ milk include antibacterial enzymes, vitamin D and fluoride. (4,5)

Infant formulas, on the other hand, have a high potential for inducing caries due to their high carbohydrate variability. The cariogenic potential of human milk is inconclusive. Human milk has been found to contain more lactose (8.3%) than cows’ milk (4.9%). A higher human milk lactose concentration and the possibility that lactose fermentation of cows’ milk is slower than in human milk, may make human milk caries risk slightly higher. Some evidence indicates that breastfeeding for over 1 year during the night after tooth eruption might be associated with ECC, however other investigations showed no relationship between prevalence of caries and breastfeeding. Regardless of the type of milk consumed, sufficient dental care and cleaning after drinking milk/formula and breastfeeding can help prevent ECC. Avoiding inappropriate dietary practices, such as frequent juice consumption or snacking on highly cariogenic foods also remain important ECC preventive practices. (4,5)

Table 1. Cariogenic Potential of Children's Foods and Snacks

Noncariogenic	Low Cariogenicity	High Cariogenicity
Cheese	Flavored Milk	Breakfast Bars
Chicken	Fresh fruits	Cake
Cottage Cheese	Whole grain products	Candies**
Eggs		Cookies
Flavored Club Soda		Doughnuts
Nuts and seeds*		Granola bars
Plain Cow's Milk (unflavored)		Pretzels
Plain Yogurt		Raisins and other dried fruits
Popcorn*		Soda crackers
Seltzer		Sweetened beverages (including fruit juice)
Vegetables		Sweetened dry cereals

*Not appropriate for infants and toddlers due to potential choking problems.

**Sticky candy and/or slowly eaten candy are extremely cariogenic.

Adapted from: Faine, MP. Nutrition and oral health. In: Proceedings of Promoting Oral Health of Children with Neurodevelopmental Disabilities and Other Special Health Care Needs. May 4-5, 2001. Seattle, WA.

Women

Maternal periodontal disease and dental caries may impact pregnancy outcome, and the offspring's risk of developing early and severe dental caries. Periodontal disease and caries may also increase the women's risk of atherosclerosis, rheumatoid arthritis and diabetes. These oral health problems are highly prevalent in women of childbearing age, particularly among low-income women and members of racial and ethnic minority groups. Socioeconomic factors, lack of resources to pay for care, barriers to access care, lack of public understanding of the importance of oral health and effective self-care practices all represent underlying reasons cited for observed inadequacies in oral health. (6)

Maternal periodontal disease, a chronic infection of the gingiva (gums) and supporting tooth structures, has been associated with preterm birth, low birthweight and development of preeclampsia (6, 7). Studies indicate that periodontal infection can result in placental-fetal exposure and, when coupled with a fetal inflammatory response, can lead to preterm delivery (7). Additionally, in a cohort of 164 young, minority, pregnant and postpartum women, the preterm/low birthweight rate was 5.4% lower among women who received periodontal treatment than those who did not receive treatment (7). In a case-control study, researchers found that preeclamptic patients were 3.5 times more likely to have periodontal disease than normotensive patients (6). (See nutrition risk criterion #304 [History of Preeclampsia](#) for more information.)

Fluoride and Fluorosis

Use of fluorides for the prevention and control of caries is documented to be both safe and highly effective. Fluoride, a naturally occurring substance, has several caries-protective mechanisms of action, including enamel remineralization and altering bacterial metabolism to help prevent caries. Excessive intake of fluoride can cause dental fluorosis which is a change in the appearance of the tooth's enamel. In the U.S., fluorosis appears mostly in the very mild or mild form - as barely visible lacy white markings or spots. The severe form of dental fluorosis, staining and pitting of the tooth surface, is rare in the U.S. The CDC reports that 32% of American children have some form of dental fluorosis, with 2.45% of children having the moderate to severe stages. (8, 9, 10, 11)

Parents and caregivers may have questions and concerns about fluoride content in water supplies and in infant formula. Fluoridated water can be found in communities that supplement tap water with fluoride and it may also be found in well water. The CDC's *My Water's Fluoride* website: <http://apps.nccd.cdc.gov/MWF/index.asp>, allows consumers in currently participating States to learn the fluoridation status of their water system.

All formula, including powdered, concentrate and ready-to-feed, contain fluoride, but most infant formula manufacturers ensure low levels of fluoride (8). WIC State and local agencies should refer caregivers of formula fed infants with questions regarding the use of fluoridated vs. non-fluoridated water to prepare infant formula to the infants' health care provider.

Dental Care and Anxiety

It is reported that 50% of the U.S. population does not seek regular dental care. Of the entire U.S. population, 8-15% has dental phobias. Dental fear can be directly learned from previous painful or negative experiences or indirectly learned from family, friends and the media. Negative portrayal of dentistry by these sources adds to an individual's anxiety. Anxiety and/or fear of dental procedures may prevent participants from seeking necessary dental care during high risk periods of the life cycle (e.g., pregnancy). Dental providers are learning to understand the causes of dental fear, have techniques to assess the level of fear and have modified treatments to accommodate patients with high anxiety levels. (12)

Oral Health Problems and Special Health Care Needs

The following special health care needs can increase the risk for oral health problems and can also make the overall effects of poor oral health more severe (13):

- **Prematurity and intrauterine malnutrition**- can have adverse effects on an individual's oral health. A study of infants who weighed <2000g at birth indicated more porous dental enamel and subsurface lesions. Infants with very low birthweights (<1500g) are more apt to have enamel

defects of the primary teeth. Malnutrition in the first few months of life (when oral structures develop) can increase the risk for oral problems.

- **Gastroesophageal Reflux Disease (GERD)**- common among children with cerebral palsy, Down syndrome and other conditions. GERD can contribute to oral health problems. As acidic gastric contents are regurgitated, primary and permanent teeth can be eroded.
- **Failure to thrive and other problems with weight gain and growth**- frequent meals and snacks (which may contribute to caries development) may be needed to maintain an adequate energy intake, or if mealtime is longer than usual, the demineralization period may exceed remineralization. Delayed weaning and children sipping on a bottle throughout the day, could also contribute to oral health problems.
- **Craniofacial malformations**- individuals with these malformations are at higher risk of developing oral problems. For example, children with cleft lip/palate disorders have more decayed, missing, and filled teeth than children without.
- **Compromised immune function**- individuals with AIDS or those who take immunosuppressive medications are more susceptible to oral infections such as candidiasis, viral infections, dental caries, and periodontal disease.
- **Down syndrome (Trisomy 21)**- individuals with Down syndrome often have delayed dental development*, may be missing permanent teeth, and may have under-developed teeth or teeth with thin enamel. In addition, the potential for eating problems and GERD make oral care for individuals with Down's especially important. (13)

*Delayed Tooth Eruption (DTE) is the emergence of a tooth into the oral cavity at a time that deviates significantly from norms established for different races, ethnicities, and sexes. Variation in the normal eruption of teeth is a common finding, but significant deviations from established norms should alert the clinician to further investigate the patient's health and development. Eruption depends on genetics, growth of the jaw, muscular action and other factors. DTE is seen in children with certain genetic disorders, particularly Down syndrome, and in children with general developmental delays that involve the oral musculature. Whenever DTE is generalized, the child should be examined for systemic diseases affecting eruption, such as endocrine disorders, organ failures, metabolic disorders, drugs and inherited disorders. (14) Additional information about tooth eruption is available at: <http://www.ada.org/2930.aspx>.

Dentate Status, Diet Quality and General Health

By the time individuals reach adulthood, the human mouth has progressed from 20 primary teeth to 32 permanent (adult) teeth (2). The extent to which tooth loss can adversely affect nutritional status is not completely known. However, diet quality tends to decline as the degree of dental impairment increases. Studies have shown that intake of vitamin A, fiber, calcium and other key nutrients decline as the number of teeth decline. In The Health Professionals study, participants without teeth had diets that contained fewer vegetables, less carotene and fiber, and more cholesterol, saturated fat, and calories than persons with 25 teeth or more (15). Despite the trend toward increased tooth retention throughout adult life in developed countries, 11% of adults aged 25 and older have lost all of their natural teeth. This number increases to 30% for people over age 65 and is even higher in those living in poverty. Loss of teeth is not a normal result of the aging process; the major cause of tooth loss is extractions resulting from dental caries and/or periodontal disease. (15)

Implications for WIC Nutrition Services

To help prevent oral health problems from developing and ensure the best possible health and developmental outcomes, WIC staff can encourage participants and caregivers to:

Diet

- Breastfeed infants during the first year of life and beyond as mutually desired.
- Avoid having an infant/child sleep with a bottle. Any bottle taken to bed should contain only water. (See Risks 425.3 and 411.2)
- Gradually introduce a cup between 6 and 12 months of age, wean from the bottle by 12 months of age.
- Drink/provide only water and milk between meals.
- Limit sugary foods and drinks (if sweets are eaten, it's best to restrict to mealtimes.)
- Avoid carbonated beverages and juice drinks. (See Risk 425.2)
- Limit the intake of 100% fruit juice to no more than 4-6 ounces per day.
- Establish eating patterns that are consistent with the Dietary Guidelines for Americans and the infant feeding practice guidelines of the American Academy of Pediatrics.
- Consume/provide a varied, balanced diet during gestation and throughout childhood to set the stage for optimal oral health. (1,3,4,15)

Oral Hygiene

- Wipe the gums of even a very small infant with a soft washcloth or soft toothbrush, even prior to tooth eruption, to establish a daily oral hygiene routine (17, 18).
- Brush teeth (including an infant's, as soon as teeth erupt) thoroughly twice daily (morning and evening) and floss at least once every day.
- Minimize saliva sharing activities (i.e., sharing a drinking cup and utensils). (1,3,4,15)

Fluoride

- Use fluoride toothpaste approved by the American Dental Association ("pea-size" for 2-5 year olds and, "smear" for under the age of two and at moderate or high caries risk). (1)
- Rinse every night with an alcohol-free over-the-counter mouth rinse with 0.05% sodium fluoride (guidance for woman participant and caregiver only). (3)
- Contact the infant's (if formula fed) health care provider with questions regarding the use of local drinking water or bottled water to prepare infant formula. (3)
- Talk to the dentist about fluoride supplements. These may be of benefit in reducing dental decay for children living in fluoride-deficient areas (See Risk 411.11).
- Check if the public water systems have added fluoride at:
<http://apps.nccd.cdc.gov/MWF/Index.asp>.
- Access the following website for more information about fluoride:
<http://www.cdc.gov/fluoridation/safety.htm>.

Referrals

- Establish a dental home within 6 months of eruption of the first tooth and no later than 12 months of age. (3)
- See a dentist for examinations (every 6 months) and/or restoration of all active decay as soon as possible. (WIC staff should provide dental referrals as necessary.)

Oral Health Resources/Handouts

- Summary of Pediatric Oral Health Anticipatory Guidance:
<http://www.aafp.org/afp/2004/1201/p2113.html#afp20041201p2113-t2>.
- Table: Oral health and dietary management for mothers and children (see page 3 of pdf.)
<http://www.sciencedirect.com/science/article/pii/S0002822398000443>.
- Oral Health Care During Pregnancy: A National Consensus Statement:
http://www.mchoralhealth.org/materials/consensus_statement.html.
- *Your Baby's Teeth*: <http://www.aafp.org/afp/2004/1201/p2121.html>.
- *Two Healthy Smiles: Tips to Keep You and Your Baby Healthy*:
<http://www.mchoralhealth.org/PDFs/pregnancybrochure.pdf>.
- *Tips for Good Oral Health Care During Pregnancy*:
<http://www.mchoralhealth.org/PDFs/OralHealthPregnancyHandout.pdf>.
- *A Healthy Smile for Your Baby* (English): <http://www.mchoralhealth.org/PDFs/babybrochure.pdf>.
- *A Healthy Smile for Your Baby* (Spanish):
http://www.mchoralhealth.org/PDFs/babybrochure_sp.pdf.

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18. Holt K, et al. *Bright Futures Nutrition*, 3rd Edition. American Academy of Pediatrics, 2011.

Clarification

Self-reporting of a diagnosis by a medical professional should not be confused with self-diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. A self-reported medical diagnosis (“My doctor says that I have/my son or daughter has...”) should prompt the CPA to validate the presence of the condition by asking more pointed questions related to that diagnosis.