Parents can be great allies

An interview with IDEM presenter Dr Tan Wee Kiat, Singapore

In a morning session on 10 April, Dr Tan Wee Kiat will be presenting a paper on paediatric dentistry as part of the Dental Hygienist and Therapist Forum at IDEM. In this interview, the head of the National Dental Centre of Singapore’s Paediatric Dentistry unit discusses important aspects of child treatment and how they affect treatment outcomes.

Dr Tan Wee Kiat: A paediatric dental healthcare team is no different from a general dental practice team. Both differ only in their training and their approach to patients. Furthermore, being a tertiary institution like the National Dental Care of Singapore, our team works closely with a wider range of health professionals like paediatricians, psychologists, speech therapists, medical social workers, and nurses.

Regardless of their respective fields of work within the dental unit, all members of the team have a common goal which is to deliver good treatment outcomes and to provide a experience that is as pleasant as possible for the child patient and the parent. Every principal of a practice has an image he or she wants to convey, for example the culture and philosophy of the practice, be it fun loving, professional, kind, etc. This must then be embodied and reflected at every customer contact from front line to support staff.

How can a dentist’s interaction with a child patient affect the success of their practice? Paediatric dentists know that successful patient dynamics involve effective communication not just with the child but also the parent. Parenting styles influence child behaviour in the operator. Behavioural management techniques require parental “buy in” and in many instances their consent. Life style changes that ought to have an impact on the child’s oral health depend on a parent or caregiver’s co-operation.

Gaining trust of both patient and parent is paramount. We are truthful in all interactions, and we do not say it does not hurt when it does, but we help the child cope.

You emphasised the importance of the parent. Outside the clinical environment, which other groups of people contribute to the management of a child’s oral health? Groups like school teachers are also important. For Singapore, I would also add maids and caregivers such as grandparents or baby sitters. In regard to teachers involved in early childhood education and staff of preschool centres are very important in helping to manage children’s oral health, in my opinion, but how can they look after the children if they feed them with unhealthy snacks and make them drink milk from a bottle, when these children have been weaned off the bottle? In fact, I would like to see a dental component included in early childhood education programmes.

What are some of the more common development defects of the human dentition amongst children? Enamel defects in the primary dentition associated with pre-, peri- and post-natal conditions such as low birth weight, children’s or mother’s illness are the most common. The incidence is from 13 to 39 per cent in full term infants. Children of low birth weight are more prone to enamel defects and these leave them vulnerable to decay.

Cleft lip and palate is not generally regarded as a defect of the dentition but a defect of fusion of embryonic lip and palatal structures. The position of teeth is affected because these components carry teeth buds in them. The teeth decay long before parents decide to seek help from a dentist. Preventive measures and risk assessment that could have been implemented are missed out because parents do not bring their child for the first dental assessment by embryology and oral pathology, they would just have to refresh their training by reading and have a high index of suspicion. Many atlases show oral conditions in pictures with great clarity and this is the next best thing to seeing a case in real life, especially if the condition is rare. Learning to think in a systematic and logical manner is what a good dental school teaches you.

Intervention will depend on the condition and the risk of complications, such as decay. This stays also true for the anticipative guidance they can give to parents. Conditions of genetic causes often have an inheritance pattern. Knowledge of how these conditions are inherited is useful in genetic counselling.

What are the different types of dental developmental problems that paediatric dentists may encounter and what is the difference between behavioural problems and dental anxiety? We shall confine this discussion to behavioural problems we encounter in normal children and not special needs children. Most behavioural problems stem from anxiety, and result in avoidance of treatment, or uncooperative behaviour in the dental clinic.

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Developmental dental anomalies in the primary dentition are rare, except for fusion (two primary teeth joined together) which can be found in around 1 per cent of children (Fig. 1). The implication of finding fused primary teeth is that there is a 50 per cent chance of having a missing permanent successor. Supernumeraries which are extra teeth beyond the normal complement, have an occurrence of 2.5 per cent (Fig. 2). These teeth may interfere or prevent the eruption of permanent teeth, or deflect them from the true eruption position.

incidence of cleft lip and palate in Singapore in a hospital based study was found to range between 1.7 and 2.07 per 1,000 births, much lower than enamel defects mentioned above. Developmental defects of enamel and dentine of genetic origin are extremely rare.

How can these developmental defects affect the physical and psychological health of children? Parents do not notice enamel defects unless they are very obvious. Oftentimes, these vulnerable age 1. Genetic defects of tooth structure have a greater impact as primary and permanent teeth are affected. Affected teeth may cause pain, be unesthetic, and need crowns later in life.

How can dental professionals identify children who deviate from normal dental development and what are appropriate interventions or counsel when identified? First, dentists must know what is “normal” in terms of dental development. If they have been trained in dental development,
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Behavioural problems in the dental clinic can manifest as crying, screaming, tantrums, refusal to open mouth, delaying tactics like coughing, vomiting, or extreme talkativeness.

How can paediatric dentists gain more behavioural knowledge about the child patient prior to any relevant treatment?

The training in dental schools provides a good basis in information gathering, such as taking a good medical and dental history. Listening to parents, for instance, what the child likes or dislikes about going to dentist, as well as knowledge of previous dental visits and what happened there can also serve as a guide for dentists. Paediatric dentists develop an understanding of the child’s personality whether he or she is introverted, shy, outgoing, or adventurous. In addition, assessing the dynamics between parent and child, gives a sense of the parenting style and the likelihood of which treatment modality is acceptable to parents, as well as what management technique is likely to succeed with a particular child.

What can paediatric dentists do to safeguard the interest of children with anomalous behavioural patterns during care?

Some questions to ask oneself would be: Can I do fairly good dentistry with this level of behaviour? If not, am I able to control or minimise the disruption so that I can still provide an acceptable standard of dentistry? Can I still do the job safely? How traumatic is this whole process to the child and parent and will I jeopardize future co-operation? Is this a one-off procedure which does not have to be repeated and hence have a likelihood of the child forgetting any trauma that is associated with it?

What strategies can the dental team employ to ensure positive behaviour in children?

There is no way to ensure positive behaviour. People who say there is have not worked with children enough. You can load the dice in your favour by being friendly, non-threatening, and showing genuine care to the child. You can also schedule appointments which do not conflict with nap times when children can get cranky. Furthermore, you can draw boundaries for acceptable behaviour, and you can enlist the parent in the strategies you will employ. Parents are a much underutilised resource, but when trained appropriately, they can be great allies. They serve as role models and they are the ones who will ultimately trust you with their child.

How common is the usage of restraints?

In our unit, we do not use restraints like papoose boards, or devices to strap children down. Restraint is usually done by parents, who help in holding the child. In America, paediatric dentists take consent for restraint, and show the devices they use to restrain children so that parents have a good idea of what they are consenting for. Restraint should be used cautiously as it can be taken as assault and liable to prosecution. In UK and Australia, restraint devices are seldom used by paediatric dentists and many schools do not teach this anymore.

Thank you very much for the interview."

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International Endodontic Congress April 18-21, Moscow

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The event will take place within the International Dental Exhibition Dental Salon 2016 which will allow the attendees to combine the participation in a scientific event with visiting the exhibition booths. Within the ENDODONTIC congress program there will be organized practical hands on courses (pre-congress April 18 and post congress, April 21). An official get together closing party of the congress (April 20), following the second day of the scientific program. The party is being organized in one of the most popular and modern restaurant bars of Moscow “Passagen” (Krousa City Hall).

ENDODONTIC congress committee is happy to offer optional excursions to visit the most exciting places of Moscow city.

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