DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta GA 30333

April 1986

Dear Colleague:

This issue covers a number of topics on fluoridation: an update on the fluoride chemical shortage; two items on fluoridation's relation to aging (from Finland and the National Institute on Aging); a new statement from the American Dental Association (ADA); 1985 referenda results; a school curriculum from Texas; the latest information on the Maximum Contaminant Level (EPA); a proposed bill in England; litigation in Portland; a new pamphlet from the American Association of Public Health Dentistry; and the latest periodic memorandum from DDPA refuting opponent charges from New Zealand.

Also included is information on smokeless tobacco education resources and the National Institutes of Health Consensus Development Conference, "Health Implications of Smokeless Tobacco Use," held in January. We also report on an infection control course for dental laboratory managers, developed by the National Association of Dental Laboratories, Inc., and there are items covering AIDS in saliva and the prevention of bacterial endocarditis. Of general interest are items on a sealant resources list; a non-chew cookbook; dental health education for the hearing impaired; and a Public Service Announcement from The American Dental Association on Baby Bottle Tooth Decay.

As always, we appreciate your contributions to this letter. With your input, we can continue to provide the most current information concerning the prevention of oral diseases and the promotion of oral health.

Stephen B. Corbin

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Chief, Dental Disease Prevention Activity
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FLUORIDATION

UPDATE AND SEMINAR ON FLUORIDE CHEMICAL SHORTAGE

The water supply industry recently experienced a fluoride chemical shortage which resulted in the curtailment of water fluoridation in several major cities. The shortage was brought on by a decrease in the manufacture of phosphate fertilizer, of which all three fluoride chemicals--sodium fluoride, sodium silicofluoride, and hydrofluosilicic acid--are produced as byproducts. Only the acid was affected by this particular shortage. On February 7, CDC issued a letter to all State dental directors and engineering personnel apprising them of the situation and offering answers to questions which had arisen.

While the present shortage is almost over, concern exists over possible future shortages. On June 17, the Dental Disease Prevention Activity will sponsor a 1-day seminar in Atlanta to discuss the issue and what steps can be taken to avoid the problem in the future. Participants will include individuals from the phosphate fertilizer industry, the water supply field, and areas of public health. Anyone interested in obtaining more information should contact Mr. Tom Reeves at (404) 329-1833, FTS 236-1833, before May 15.

PERSPECTIVES ON FLUORIDE AND AGING

The Centers for Disease Control continues to receive numerous inquiries from congressional offices and private citizens regarding an alleged role between fluoride and the process of aging as reported in Fluoride: The Aging Factor by John Yiamouyiannis, Ph.D. Recent information reported in the Lancet, as well as evidence cited by the National Institute of Aging, is offered as further corroboration of the lack of a demonstrated fluoride-aging effect.

Finnish Study Reports Community Water Fluoridation Helps Prevent Osteoporosis

Because bone fragility in elderly people is a serious public health problem, fluorides have been used for the treatment of osteoporosis and osteoporotic hip fracture.

A study undertaken in Finland (1967-1978) examined the possible association between the incidence of femoral-neck fractures in the population aged 50 and over and the presence of fluoride in the drinking water.

Two towns of similar economic structure, Kuopio and Jyvaskyla, were selected for the study. The number of inhabitants aged 50 and over and age and sex distribution during the study period were similar in the two towns. Both towns have trace quantities of fluoride in their natural drinking water supplies (0-0.1 mg/l), but Kuopio has fluoridated its drinking water since 1959 to the level of 1 mg/l.

All hospital-recorded cases of femoral-neck fracture were collected for residents of Kuopio and Jyvaskyla, regardless of where they were treated, for the study period 1967-1978. The individual patient's age at first hospital admission was reported as the patient's age in the authors' calculations.

The authors found that the incidence of femoral-neck fracture was greater in Jyvaskyla than in Kuopio and support the hypothesis that the lower incidence of femoral neck fracture in Kuopio is associated with a fluoride content of 1 mg/l in the drinking water. The lower incidence of fracture in Kuopio suggests that fluoride is an essential mineral for the strengthening of bone tissue, and that it is possible to reduce osteoporotic fracture with the use of fluorides.

Reference: Simonen, O., Laitinen, O., Does fluoridation of drinking water prevent bone fragility and osteoporosis?, Lancet, Aug. 24, 1985, p. 432-5.

NIA Refutes Link Between Fluoride and Aging

The following is excerpted from a statement written by T. Franklin Williams, M.D., Director, National Institute on Aging (NIA), in response to a request from the Center for Prevention Services, CDC:

"The National Institute on Aging (NIA) has no clear evidence regarding the relationship between fluoride and accelerated aging. The information we have available is very specific and stems from research currently supported by NIA on the "Relationship of Hip Fractures to Fluoride in Water" conducted by Dr. George Everett, University of Iowa. This study, a retrospective analysis of age- and sex-specific hip fracture rates and specific water mineral concentrations, including fluoride, suggests that fluoride concentrations are inversely related to hip fracture rates for men over the age of 65 years...."

This response provides evidence contrary to a statement made in the book, Fluoride: The Aging Factor by John Yiamouyiannis, "fluoride has been found to contribute to and speed up virtually all the symptoms and biological effects associated with the aging process."

ADA REAFFIRMS EFFECTIVENESS OF WATER FLUORIDATION

The Council on Dental Health and Health Planning submitted a statement commemorating the 40th anniversary of water fluoridation to the American Dental Association's House of Delegates, which met November 3-7, 1985 in San Francisco. That statement, which is reprinted here, was accepted by the House and confirms the Association's unreserved endorsement of water fluoridation as the most effective and economical public health measure for the prevention of dental caries.

ADA Statement: "The year 1985 marks the 40th anniversary of the practice of community water fluoridation. Implementation of this measure has dramatically improved the public's oral health status. Dental caries prevalence among schoolchildren is currently lower than ever before. Increasing numbers of adults now retain their teeth throughout their lifetimes. Innumerable hours of needless pain and suffering have been avoided.

"Despite this unsurpassed record of effectiveness and safety, less than 55 percent of the United States population regularly receives water containing adequate levels of fluoride. Unfortunately many people continue to be misled by unfounded allegations about the measure. Since the inception of water fluoridation, the American Dental Association has carefully monitored scientific research regarding its safety and efficacy. Based on that review, the Association once again reconfirms water fluoridation as the most effective public health measure for the prevention of dental caries and strongly urges that its benefits be extended to all those served by communal water systems.

"The Association, through the Council on Dental Health and Health Planning, maintains a strong focus on the promotion of water fluoridation in the form of staff and technical support. Further, the Association takes this opportunity to commend those individuals who over the years have devoted countless hours to insure that their communities have access to optimally fluoridated water for the betterment of the public's oral health."

1985 FLUORIDATION REFERENDA RESULTS
(As reported to DDPA)

Date	City	For	Against	Outcome	Population of City
3-23	Duxbury, MA	991	969	Yes	11,807
5- 1	Millis, MA	737	359	Yes	6,908
8- 6	Glenwood Springs, CO	589	438	Yes	7,350
10-19	Monroe, LA	2,418	2,431	No	56,000
11- 5	San Antonio, TX	39,048	42,141	No	1,000,000
11- 5	Westfield, MA	4,536	6,633	No	35,465
11- 5	Leominister, MA	3,558	3,596	No	34,508
11- 5	Renton, WA	2,903	2,140	Yes	33,000
12- 3	Belleair, FL	707	635	Yes	3,984
12-10	Crystal River, FL	456	248	Yes	3,522

Although San Antonio lost its fluoridation referendum, 6 of the 10 reported referenda held in 1985 were favorable. After over 2 years of community fluoridation education in San Antonio, the referendum lost by 4 percent of the vote. Factors which contributed to the defeat include low voter turnout (19 percent of the registered voters) and a special election being held for the referendum rather than its being included as part of a general election. Over 24,000 voters representing all precincts in San Antonio were polled by telephone before the referendum; 73 percent indicated they were in favor of fluoridation. It was stated by the "Yes on Our Children's Health Committee" of San Antonio that the necessary groundwork has been established for fluoridation to succeed one day. In 1966, the issue was defeated at a referendum by a two to one margin.

EPA ANNOUNCES WATER STANDARDS AND MONITORING REQUIREMENT FOR FLUORIDE

The U.S. Environmental Protection Agency has announced a number of related actions which will lead to Revised Drinking Water Standards for fluoride.

First, the agency has issued its final Recommended Maximum Contaminant Level (RMCL) for fluoride. The RMCL for fluoride is 4 milligrams per liter. The agency has also proposed a Maximum Contaminant Level (MCL) for fluoride. This level is also 4 milligrams per liter. Finally, the agency proposes to amend the present Interim MCL for fluoride, changing that level to 4 milligrams per liter.

The agency is also proposing a Secondary Maximum Contaminant Level (SMCL) for fluoride of 2 milligrams per liter. The SMCL is not a federally enforceable standard but is intended to provide guidance to States and communities for limiting the occurrence of dental fluorosis while still permitting optimal fluoride levels for the reduction of dental caries.

Fluoride occurs naturally at elevated levels in drinking water in a number of States. At levels of 1 to 2 milligrams per liter, it helps to protect against tooth decay. Above this range it can cause dental fluorosis, which results in some discoloration and pitting of teeth. At 4 milligrams per liter and above, it can cause radiologically detectable changes in bone density with no clinically detectable adverse health effects. At 10 milligrams per liter, long-term exposures can cause skeletal disorders similar to arthritis. This, however, has not been observed with any frequency in this country.

The RMCL is a nonenforceable health goal. Under the Safe Drinking Water Act this is the first step in setting final enforceable standards.

The proposed MCL will lead to enforceable standards. The MCL is set as close to the RMCLs as possible based on health considerations, treatment technologies, cost, and other factors. The MCL for fluoride is designed to protect the consumer from the adverse skeletal effects of excessive fluoride.

The Interim MCL is the standard for fluoride that the agency adopted from the Public Health Service in 1977 when the Safe Drinking Water Act was passed. The current Interim MCL for fluoride is in the range of 1.4 to 2.4 milligrams per liter. The proposed amendment to the Interim MCL of 4 milligrams per liter, when promulgated, will be consistent with the agency's proposed MCL for fluoride.

Since the October 31, 1985 EPA announcement of the new standards, the South Carolina Department of Health and Environmental Control has filed a lawsuit in district court, Washington, DC, that asks for a review of the new standards set by EPA. The National Resource Defense Council, which is thought to favor lowering the standards, has filed a similar suit.

LESSON PLANS ON WATER FLUORIDATION AVAILABLE FROM TEXAS

Lesson plans on water fluoridation for grades kindergarten through 12 have been developed for San Antonio schools by Cheryl Aiello, Director of Dental Health Education in the Texas Department of Health. The lesson plans will be incorporated into the Bureau of Dental Health's Tattletooth school program.

Lesson plans for each grade level include objectives, teacher preparation, background information, instructions to the teacher, activities, lesson review, and handouts (coloring pages, parent letter, diagrams, graphs, information charts, and fact sheets). Of 274 San Antonio public schools, 45 percent, or 123 schools, have requested copies of the plan. In addition, all Catholic schools received copies of the curriculum.

For more information, contact:

Linda S. Crossett, R.D.H.
Administrator, Texas Fluoridation Project
Bureau of Dental Health
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199

512/458-7323

FLUORIDATION OF GREAT BRITAIN'S WATER SUPPLY APPROVED

Fluoridation of Great Britain's water supply was approved in late October, 30 years after the fluoridation bill was first introduced, according to The Observer.

The newspaper reports that the successful passage through Parliament last week of the Water Fluoridation Bill means that the number of people drinking fluoridated water could triple -to 15 million- within the next 2 years.

But 8 million Londoners may not benefit from the new law since the Thames Water Authority says its implementation would be prohibitively difficult.

"Although the latest opinion poll shows 69 percent of Londoners in favor of fluoridation," the newspaper article states, "Thames Water Authority said it would require another Act of Parliament to force it to act. The practical problems involved were more or less insurmountable, the authority claimed."

Areas which appear likely to get fluoride include Wolverhampton and other parts of the Black Country (2 million people), Manchester and the North-West (4.3 million people) and Strathclyde, Scotland (2.5 million). Merseyside may soon follow.

The Water Fluoridation Bill allows water suppliers to adjust the level of fluoride when requested to do so by local health authorities.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH ISSUES NEW BROCHURE

As part of its continuing efforts to inform the public about the benefits of fluoridation, The Massachusetts Department of Public Health (DPH) has published a new, free brochure, "Fluoridation: Nature's Tooth Protector."

"This brochure explains why community water fluoridation is important for good dental health," said Dr. Gregory N. Connolly, Director of DPH's Dental Health Division. "We know that scientific research throughout the world has proven that fluoridation is safe and effective. In fact, this brochure lists 100 State, national, and international organizations which support fluoridation."

"Fluoridation prevents two out of three cavities during a person's life," Dr. Connolly said. "Children in fluoridated communities have up to 65 percent fewer cavities, up to 90 percent fewer tooth extractions, and fewer crooked teeth caused by premature tooth loss. Up to 20 percent of all teenagers who have lived in fluoridated communities all their lives have no cavities at all."

The brochure notes that fluoridation saves money. "Fewer cavities result in lower dental bills for families and lower tax bills for publicly-supported dental programs. It is estimated that for every dollar spent on fluoridation, $50 is saved in potential dental bills."

In addition to the prevention of tooth decay, fluoridation may aid in the reduction of the incidence of osteoporosis, a degenerative condition which causes brittle bones. Fluoride binds the calcium in bones and teeth.

Copies of the brochure are available by writing FLUORIDE, Dental Health Division, Massachusetts Department of Public Health; 150 Tremont Street, Boston, MA 02111, or by calling (617) 727-0732.

NEW FLUORIDATION BROCHURE AVAILABLE FROM AAPHD

An 8-page illustrated brochure developed by the American Association of Public Health Dentistry is designed to help communities attain or retain water fluoridation. The brochure describes the health benefits of community water fluoridation to children and adults, explains why the procedure is an ideal public health method, details the extent of support for the procedure and its current status, and provides information to consumers on how to determine if their community is fluoridated and where to get additional information about community water fluoridation.

Price List

No. of copies	Costs per copy*
1-99	25 cents
100-499	24 cents
500-999	23 cents
1,000-9,999	22 cents
10,000-49,999	20 cents
50,000 or more	18 cents

*Includes postage in U.S.A.
Sample copy available from AAPHD National Office: 10619 Jousting Lane, Richmond, Virginia 23235

PORTLAND FLUORIDATION SUIT DISMISSED

On December 16, 1985, the Multnomah County Circuit Court in Portland, Oregon, dismissed a suit filed against six former county officials by a local group of fluoridation opponents. The suit had alleged that grant funds from one of the CDC categorical fluoridation grants had been spent for political, rather than educational, purposes. Oregon law and a Multnomah County ordinance prohibit political activity by public employees during working hours.

Attorneys for the defendants filed a motion to dismiss the case based on the fact that the state Tort Claims Act requires notice to be given within 180 days of the event that gives rise to the liability. The Court agreed with the defense and so dismissed the case. Plaintiffs have appealed the dismissal.

RESPONSE TO CLAIMS BY JOHN COLQUHOUN, NEW ZEALAND, OF NEW EVIDENCE ABOUT FLUORIDATION

A two-part paper, "Fluoridation in New Zealand: New Evidence," by John Colquhoun, was published in American Laboratory, May and June 1985. The paper stated that water fluoridation provides no dental benefits, is harmful to health, and damages children's teeth. Because Mr. Colquhoun served as

Principal Dental Officer, Auckland Health District, New Zealand, for 12 years, these articles have caused much concern about fluoridation. The following statements have been excerpted from a letter written in response to Colquhoun's claims by Peter B. V. Hunter, Principal Dental Officer (Research), for the Director, Division of Dental Health, Head Office, Wellington, New Zealand:

"There is a substantial body of evidence to demonstrate the dental benefits of fluoridation in New Zealand. The erroneous conclusions Colquhoun reaches result from his use of unsatisfactory measures of dental disease and an inadequate assessment of socio-economic status. He also makes inappropriate comparisons.

"Colquhoun bases his claims of damage to children's teeth on a survey he carried out in Auckland. Unfortunately, no protocol was prepared for the study and it is not possible to reconcile the discrepancies. However, some of the defects in the study design are as follows: selection of the schools in the fluoridated area was not random; residential history was not established for the children so the history of exposure to fluoridation was not accurately established; and no attempt was made to bring the children from the fluoridated and nonfluoridated areas to a central examination site to ensure that the examiners were unaware of the place of residence of the children. An independent scientific study by the Medical Research Council of New Zealand has shown that children from the fluoridated parts of Auckland do not have significantly more disfiguring tooth defects that those from nonfluoridated areas.

"The other measure used by Colquhoun, the 'percentage caries free,' is a useful measure to differentiate between groups of young children. However, as children get older the stage is reached where most have some fillings or dental decay and the proportion 'caries free' is smaller. The 'percentage caries free' is then no longer such a useful measure to differentiate between groups since it can be markedly influenced by a single treatment planning decision. This is the situation for 12- to 13-year-old New Zealand children.

"Another serious flaw in Colquhoun's comparisons is a failure to clearly establish the place of residence of children and hence, fluoride exposure. Examination of the dental history charts of the 325 12- to 13-year-olds classified by Colquhoun in the nonfluoridated part of the Auckland Health District has revealed that 123 (38 percent) attended school in the nonfluoridated area but actually lived in the fluoridated area.

"The Department of Health continues to endorse the fluoridation of public water supplies as a proven health measure and the single most effective known means to preventing dental caries on a community basis."

References

Colquhoun, J. Fluoridation in New Zealand: new evidence, Part One. Am. Lab., 66-72, May 1985.

Colquhoun, J. Fluoridation in New Zealand: new evidence, Part Two. Am. Lab., 98-109, June 1985.

Hunter, Peter B.V. Principal Dental Officer (Research), Division of Dental Health, Head Office, Wellington, New Zealand. Personal correspondence, August 21, 1985.

SMOKELESS TOBACCO

SMOKELESS TOBACCO EDUCATION RESOURCES

The National Cancer Institute (NCI), National Institutes of Health, in cooperation with the Dental Disease Prevention Activity (DDPA), Centers for Disease Control, has developed a smokeless tobacco education resources list. Included in the list are descriptions of each item, contact source, cost, and availability.

The list is being sent to all secondary school principals by NCI. If your agency or organization has developed any smokeless tobacco education materials not included in the list, or if you would like a copy of the list, please contact either DDPA or NCI.

Dental Disease Prevention Activity
Center for Prevention Services
Centers for Disease Control
1600 Clifton Road
Atlanta, Georgia 30333
(404) 329-1830
FTS 236-1830

Coordinator: Smokeless Tobacco
Education Program
National Cancer Institute
National Institutes of Health
Bldg. 31, Room 4B41
Bethesda, Maryland 20205

SMOKELESS TOBACCO CONSENSUS DEVELOPMENT CONFERENCE

A Consensus Development Conference, "Health Implications of Smokeless Tobacco Use," was held at the National Institutes of Health, January 13-15, and was cosponsored by the National Cancer Institute, the National Institute of Dental Research, and the Office of Medical Applications of Research. A statement linking smokeless tobacco products to oral cancer was issued by the panel.

The statement reads, in part: "Our conclusion with respect to oral cancer is supported by multiple studies showing a relationship between oral cancer and chewing of betel quid containing tobacco in India and Southeast Asia. Furthermore, this view is consistent with the judgment of a recent working group of the International Agency for Research on Cancer, which reported that the evidence associating snuff with oral cancer is 'sufficient' to indicate a causal relationship.

"The risk of oral cancer in the United States is small among those who do not smoke, drink alcoholic beverages, or use smokeless tobacco. The data considered here, however, raise the concern that regular users of snuff, especially children, may develop oral cancer later in life. The panel believes that the public should be warned that the use of smokeless tobacco, particularly snuff, when started in childhood, increases the risk of oral cancer.

"Smokeless tobacco use increases the frequency of localized gum recession and leukoplakia where the snuff is usually placed, but evidence on its relationship to other diseases of the oral cavity is inadequate. The presence of lead in smokeless tobacco may pose a special risk for the developing fetus. Use of smokeless tobacco releases nicotine into the bloodstream and produces blood levels of nicotine comparable to those produced by smoking tobacco. The primary behavioral consequence of regular use of smokeless tobacco is long-term nicotine dependence and its associated health risks."

The statement concludes: "Use of smokeless tobacco has a long history in the United States, but trends in recent years, in particular the increasing use of snuff by children and young adults, have led to concerns about possible health consequences. National data suggest that at least 10 million persons have used smokeless tobacco of one kind or another within the past year. Patterns of use by age, sex, and type of product vary across the country.

"The human evidence that use of snuff causes cancer of the mouth is strong. Risk is particularly high for parts of the mouth where snuff is usually placed. Data are currently insufficient to come to any conclusions regarding the relationship of smokeless tobacco use to cancers at other sites. Repeated experimental studies in animals have failed to provide adequate evidence that chewing tobacco, snuff, or extracts derived from them induce cancer. However, nitrosamines chemically related to nicotine occur at high levels in snuff and, generally, at lower levels in chewing tobacco. These compounds are highly carcinogenic in animals. The concentrations of nitrosamines in smokeless tobacco are far higher than the levels of these compounds allowed in any U.S. food or beverage.

"Use of smokeless tobacco is one of the number of health-endangering behaviors which frequently coincide with the clear potential for long-term and serious consequences."

INFECTION CONTROL

GLOVE USE SUBJECT OF CRA NEWSLETTER

The September 1985 issue of Clinical Research Associates Newsletter is devoted to the use of gloves in dentistry.

Among the subjects covered in the newsletter are the relevance of gloves in dentistry, fit and cost of gloves, problems associates with glove purchase, comparative evaluation of latex gloves, reuse of gloves, and treatment of hands before and after glove use.

For more information, contact Clinical Research Associates, 3707 North Canyon Road, Suite 6, Provo, Utah 84604. The telephone number is 801/226-2121.

NADL DEVELOPS INFECTION CONTROL COURSE FOR DENTAL LABORATORY MANAGERS

The National Association of Dental Laboratories (NADL) and University Education Courses have developed a self-instructional course on infection control for dental laboratory owners and managers. "Infection Control in the Dental Laboratory," prepared by Dr. Robert R. Runnells, clinical assistant professor at the University of Utah School of Medicine-Dental Education, is a complete self-instructional course designed for laboratory use, but aimed at the entire dental team.

"NADL strongly encourages dental laboratory owners and managers to study this course, and to adopt at least the minimum program outlined in the course for limiting the risk of cross-contamination among patients, dentists, and dental technicians," said Robert W. Stanley, NADL executive director.

"We are living in an age when new and deadly diseases, like AIDS and hepatitis, can spring up overnight and travel from country to country, coast to coast, and from doctors' and dentists' offices into laboratories and back to patients," said Dr. Runnells, who is also the course instructor. "This course is a step-by-step program that offers practical methods and techniques to limit the risk of infection and cross-contamination."

The course includes:

* "Infection Control in the Dental Laboratory," a study guide which introduces the reader to the topic of infection control in general and provides instruction on methods and procedures to be followed in the laboratory

* Two 60-Minute Audio Tapes to be used in conjunction with the study guide

* Three Reminder Wall Charts for display in the dental laboratory

* Review Exercises, which are completed and returned to University Educational Courses for a certificate upon course completion

The Infection Control Course has been recognized by the National Board for Certification (NBC) for continuing education credits for Certified Dental Technicians (CDTs) and Recognized Graduates (RGs). In addition, NADL and University Educational Courses provide dental laboratory managers who complete and return the review exercises a Certificate of Course Completion for prominent display in the laboratory. This program also includes academic continuing education credits from the University of Utah.

In conjunction with this course, Dr. Runnells offers, through NADL, instructional materials and seminars for laboratory owners and managers, dentists, and auxiliaries.

"Infection Control in the Dental Laboratory" retails for $34.95, including postage and shipping, but is available to NADL members, Certified Dental Laboratories (CDLs), CDTs and RGs for $24.95. Quantity discounts are available for educational institutions and related nonprofit organizations. For more information write to: Infection Control Course, NADL, 3801 Mt. Vernon Avenue, Alexandria, VA 22305.

INFREQUENCY OF ISOLATION OF HTLV-III VIRUS FROM SALIVA

A study of 71 homosexual men who were seropositive with HTLV-III/LAV demonstrates the infrequency of HTLV-III/LAV in the saliva of infected persons. The study, titled "Infrequency of Isolation of HTLV-III/LAV Virus from Saliva in AIDS," was published in the New England Journal of Medicine, December 19, 1985. Virus was detected in saliva of only 1.3 percent of the 83 samples, while the virus was recovered in 56 percent of blood samples from these individuals.

Number of Patients	No. Positive for HTLV-III/LAV in Saliva Samples	No. Positive for HTLV-III/LAV in Blood Samples
Healthy seropositive (20)	0/20	7/17
AIDS-related complex (32)	0/38	14/21
AIDS (19)	1/25	7/12
Total (71)	1/83 (1.29%)	28/50 (56.0%)

These findings are consistent with data that indicate that transmission of HTLV-III does not occur through casual contact.

PREVENTION OF BACTERIAL ENDOCARDITIS

The following recommendations are from the Committee on Rheumatic Fever and Infective Endocarditis of the Council on Cardiovascular Disease in the Young:

TABLE I

Procedures for Which Endocarditis Prophylaxis Is Indicated

All dental procedures likely to induce gingival bleeding (not simple adjustment of orthodontic appliances or shedding of deciduous teeth)
Tonsillectomy and/or adenoidectomy
Surgical procedures or biopsy involving respiratory mucosa
Bronchoscopy, especially with a rigid bronchoscope*
Incision and drainage of infected tissue
Genitourinary and gastrointestinal procedures as listed in text

*The risk with flexible bronchoscopy is low, but the necessity for prophylaxis is not yet defined.

TABLE II

Cardiac Conditions[A] Which Require Endocarditis Prophylaxis

Endocarditis Prophylaxis Recommended:
Prosthetic cardiac valves (including biosynthetic valves)
Most congenital cardiac malformations
Surgically constructed systemic-pulmonary shunts
Rheumatic and other acquired valvular dysfunction
Idiopathic hypertrophic subaortic stenosis (IHSS)
Previous history of bacterial endocarditis
Mitral valve prolapse with insufficiency[B]
Endocarditis Prophylaxis Not Recommended:
Isolated secundum atrial septal defect
Secundum atrial septal defect repaired without a patch six or more months earlier
Patent ductus arterious ligated and divided six or more months earlier
Postoperative coronary artery bypass graft (CABG) surgery

[A]This table lists common conditions but is not meant to be all-inclusive.

[B]Definitive data to provide guidance in management of patients with mitral valve prolapse are particularly limited. It is clear that in general such patients are at low risk of development of endocarditis, but the risk-benefit ratio of prophylaxis in mitral prolapse is uncertain.

TABLE III

Summary of Recommended Antibiotic Regimens for Dental/Respiratory Tract Procedures

Standard Regimen	
For dental procedures that cause bleeding, and oral/ respiratory tract surgery	Penicillin V 2.0 g orally 1 hour before, then 1.0 g 6 hours later. For patients unable to take oral medication, 2 million units of aqueous penicillin G IV or IM 30-60 minutes before a procedure and 1 million units 6 hours later may be substituted
Special Regimens	
Parenteral regimen for use when maximal protection desired: e.g., for patients with prosthetic valves	Ampicillin 1.0-2.0 g IM or IV plus gentamicin 1.5 mg/kg IM or IV, one-half hour before procedure, followed by 1.0 g oral penicillin V 6 hours later. Alternatively, the parenteral regimen may be repeated once 8 hours later
Oral regimen for penicillin-allergic patients	Erythromycin 1.0 g orally 1 hour before, then 500 mg 6 hours later
Parenteral regimen for penicillin-allergic patients	Vancomycin 1.0 g IV slowly over 1 hour, starting 1 hour before. No repeat dose is necessary

Note: Pediatric doses: Ampicillin 50 mg/kg per dose; erythromycin 20 mg/kg for first dose, then 10 mg/kg; gentamicin 2.0 mg/kg per dose; penicillin V full adult dose if greater than 60 lb (27 kg), one-half adult dose if less than 50 lb (27 kg); aqueous penicillin G 50,000 units/kg (25,000 units/kg for follow-up); vancomycin 20 mg/kg per dose. The intervals between doses are the same as for adults. Total doses should not exceed adult doses.

The Committee also stated that: "Antibiotic regimens used to prevent recurrences of acute rheumatic fever are inadequate for the prevention of bacterial endocarditis. Appropriate additional antibiotics should be described at times of procedures associated with the risk of development of endocarditis.

"The Committee recognizes that it is not possible to make recommendations for all possible clinical situations. Practitioners must exercise their clinical judgment in determining the duration and choice of antibiotic when special circumstances apply. Furthermore, since endocarditis may occur despite antibiotic prophylaxis, physicians and dentists should maintain a high index of suspicion regarding any unusual clinical events following dental or surgical procedures."

Reference:

Shulman, ST, et al. Prevention of Bacterial Endocarditis: A Statement for Health Professionals by the Committee on Rheumatic Fever and Infective Endocarditis of the Council on Cardiovascular Disease in the Young. Circulation, 70:6, Dec 1984, p. 1123-7.

OTHER

SEALANT EDUCATIONAL MATERIALS

The Dental Disease Prevention Activity (DDPA), Centers for Disease Control, in cooperation with the Dental Health Section, American Public Health Association, has developed a sealant educational resources list. Each item is listed in one of six areas:

1. Pamphlets, Brochures, Booklets
2. Posters, Plaques, Charts
3. Audiovisuals
4. Fact Sheets
5. Other
6. Educational Materials from Manufacturers

The list includes the title of the item, publisher, address, phone number, publication date if available, appropriate audience code, cost, and availability.

The resource list is available from DDPA at the following address:

Dental Disease Prevention Activity
Center for Prevention Services
Centers for Disease Control
1600 Clifton Road
Atlanta, Georgia 30333

If your organization or agency has developed sealant educational materials and you are not included in the resource list, please contact Cathy Backinger at DDPA.

NON-CHEW COOKBOOK

A non-chew cookbook has been developed for persons recovering from oral surgery or otherwise suffering from conditions which prevent chewing.

A foreword written by Mark A. Piper, D.M.D., M.D., an oral surgeon from St. Petersburg, Florida, states: "This book addresses both the nutritional as well as the gustatory requirements of the individual on a soft or liquid diet. It is hoped that it will stimulate the palates of those who otherwise are bored by their chewing restrictions and, at the same time, improve or maintain the nutrition important for good health and recovery from surgery and disease."

The book contains 200 recipes on beverages, soups, main dishes, vegetables, and desserts, with a complete nutritional analysis of each recipe.

The retail price of the book is $14.95, plus $2.50 for postage and handling; wholesale price is $10.47 (available to medical professionals

and hospitals ordering in quantities of 10 or more). There is no postage charge on quantity orders.

For more information, write or call: Non-Chew Cookbook, P.O. Box 2190, Glenwood Springs, CO 81602; 303/945-5600.

FOR YOUR INFORMATION

The Dental Disease Prevention Activity "Dear Colleague" letter is developed and published by Technical Information Services and the Dental Disease Prevention Activity, Center for Prevention Services, Centers for Disease Control, Atlanta, GA 30333. Articles and/or written comments should be sent to this address. Telephone calls should be directed to Caffilene Allen at 404/329-1819 or FTS: 236-1819.

Use of trade names in this publication is for identification purposes only and does not represent endorsement by the Centers for Disease Control or the U.S. Public Health Service.

NEW DENTAL HEALTH EDUCATION MATERIALS FOR HEARING IMPAIRED PERSONS

These graphic, simply written materials will be applicable for the hearing impaired population as well as populations that use English as a second language and those with limited reading ability or reading skills. The materials have been developed in cooperation with specialists in education of hearing impaired persons at Gallaudet College in Washington, D.C., the world's only liberal arts college for deaf people. The project is supported by a grant from the American Fund for Dental Health.

These newly developed materials include:

Five graphically illustrated pamphlets with minimal use of written language: "Gum (Periodontal) Disease, "How You Can Have: Healthy Teeth and Gums," "Tooth Decay," "Root Canal Treatment," and "What To Do After A Tooth Extraction (Tooth Pulled)"

A captioned videocassette, "Fluoride: The Magnificent Mineral," (in cooperation with the National Institute of Dental Research)

A captioned slide series on oral health

A series of brief, simply written articles on oral health topics for publication in newsletters in the hearing impaired community

Suggestions for use of these materials in promoting oral health in the hearing impaired community, including how to use an interpreter

To obtain an introductory packet, including a fact sheet on the needs of persons who are hearing impaired, samples of the pamphlets, the post-operative instructions, suggestion sheet, and more information about the video and slide materials, return the request form below. The introductory packet will be provided at no cost.

REQUEST FOR INTRODUCTORY PACKET:
Dental Health Education Materials
for The Hearing Impaired

NAME_____

POSITION_____

ADDRESS_____

_____

_____

_____

For our information, please let us know reasons for your particular interest in these materials:

_____

_____

_____

_____

RETURN TO:

HI Dental Health
Department of Health Ecology
School of Dentistry, 15-136 Moos Tower
University of Minnesota
515 Delaware Street, S.E.
Minneapolis, MN 55455

AMERICAN DENTAL ASSOCIATION DEVELOPS PSA ON "BABY BOTTLE TOOTH DECAY"

The American Dental Association (ADA) has developed a 30-second Public Service Announcement (PSA) on Baby Bottle Tooth Decay entitled "Nursing Bottle Mouth." The PSA film depicts a baby girl at naptime with a nursing bottle. A spoken message aimed at parents points out that only water should be put in a baby's naptime bottle because sweetened formulas and juices remain in the mouth while the baby sleeps and can contribute to tooth decay.

The ADA has distributed the PSA to over 250 major television stations in the United States. In order to reach and inform as many parents as possible about this preventable disease, we encourage you to contact the television stations in your area and emphasize to them the importance of airing this PSA.

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