DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta, Georgia 30333

June 1987

Dear Colleague:

This letter will cover a broad spectrum of topics in the areas of smokeless tobacco, infection control, fluoridation, sealants, Baby Bottle Tooth Decay, plus other areas of interest.

With regard to smokeless tobacco, we report data on the use of smokeless tobacco among American Indian/Alaskan Native children in rural Alaska and pre-adolescent and adolescent youth in Wisconsin; enactment of new tobacco and smokeless tobacco laws in California; an opinion on dentists' duties to disclose the use of smokeless tobacco by minors; and smokeless tobacco-related bills enacted by various States in 1986.

A number of topics are covered in the area of infection control, including the prevalence of antibodies to HTLV-III/LAV among dental professionals; a study on the lack of antibodies to HTLV-III/LAV among Danish dentists; immunization information for dental care professionals and patients; and other pertinent information.

In the area of fluoridation, we present a synopsis of CDC's recommendations to the water supply industry concerning fluoride chemical shortages; a study on the mutagenicity of sodium fluoride to mouse lymphoma cells; and available new publications and materials.

Also included is general information on dental health, including Baby Bottle Tooth Decay, sealants, dental care for older people, and school-based preventive dental programs.

We welcome any contributions and/or comments you may have with regard to this letter. With your assistance, we can continue to provide the most current information concerning the prevention of oral diseases and the promotion of oral health.

Sincerely yours,

Lawrence J. Furman

Lawrence J. Furman, D.D.S., M.P.H.
Chief, Dental Disease Prevention
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SMOKELESS TOBACCO

USE OF SMOKELESS TOBACCO IN RURAL ALASKA

Reported rates of smokeless tobacco use have been consistently much lower for females than for males. Approximately 2% of females of all ages are estimated to have used smokeless tobacco in the last year. However, among American Indian/Alaskan Native (AI/AN) children, female and males usage rates are similar. Additionally, the reported number of smokeless tobacco users in this population is substantially higher than in the general U.S. population. The following is a partial excerpt taken from a 1986 Indian Health Service (IHS) survey conducted in Alaska.

Data collected from this survey showed that almost as many Alaskan school-aged girls are using smokeless tobacco products as school-aged boys. Data were collected in the spring of 1986 from voluntary respondents, both Alaskan Natives and non-Natives, in eight rural regions of Alaska. A nine-question, self-administered survey was distributed by IHS dental staff to students in grades K-12 who had volunteered to participate in the survey. The number of girls and boys responding was 2,454 and 2,511 respectively; they ranged from 5 to 18 years of age. Results indicated that 27.5% of girls and 33.7% of boys who responded use smokeless tobacco products. A user was defined as anyone who responded "yes" to the question, "Do you use smokeless tobacco products?" For 5-year-olds, 16.9% of girls and 9.8% of boys reported using smokeless tobacco products.

Data from the survey in Alaska, as well as other AI/AN surveys, report high usage rates for boys and girls and an early age of initiation for smokeless tobacco use. While P.L. 99-252 may have an impact on AI/AN children, it is important that primary prevention and cessation programs be developed and implemented for these special populations. A 5-year-old who uses smokeless tobacco until he or she is 18 years of age will be exposed to a number of health risk factors for 13 years. To be effective, smokeless tobacco intervention programs need to be implemented in preschool and kindergarten.

Reference:

CDC. Smokeless Tobacco Use in Rural Alaska. MMWR 1987;36:140-3.

USE OF SMOKELESS TOBACCO BY PRE-ADOLESCENT AND ADOLESCENT YOUTH IN WISCONSIN

The recent marked increase in smokeless tobacco use, predominantly by pre-adolescent and adolescent males, has prompted action at local, State, and Federal levels. Smokeless tobacco products have apparently become popular among students in schools across the United States. Data from various regions of the country indicate that 8 to 36 percent of male high school- and college-age students use smokeless tobacco products regularly. Data on smokeless tobacco usage among Wisconsin school-age children reflect national trends. A 1985 Dane County youth survey of students in grades 7-12 showed that more males used smokeless tobacco

than smoked cigarettes. For example, 45 percent of 8th-grade boys reported that they had tried smokeless tobacco at least once. Regular use of smokeless tobacco products increased from 9 percent of 7th-grade boys to 22 percent of 12th-grade boys. Fifteen percent of 12th-grade boys were daily users.

Other preliminary data from the Wisconsin Division of Health's Project Model Health for rural Wisconsin schools demonstrate the following: 22 percent of 8th-grade boys in specific schools are regular users of smokeless tobacco; 35 percent of 8th-grade girls have tried smokeless tobacco; 12 years is the mean age of initiating smokeless tobacco use; among regular users, the students chew or dip smokeless tobacco an average of six times/day, with 25 percent chewing or dipping over 10 times/day; the average duration time per dip or chew is 1 hour. On the basis of these data, the Wisconsin Division of Health has projected that one in five pre-adolescent and adolescent males is a regular smokeless tobacco user in specific Wisconsin communities.

The Division of Health, Wisconsin Department of Health and Social Services, has suggested (1) that preventive and regulatory actions are needed to offset a trend in smokeless tobacco use that may produce increased oral cancer death rates for this generation of young people; and (2) has proposed the following measures:

- Educational campaigns to increase public awareness of the possible adverse health effects caused by smokeless tobacco use. Students, school officials, coaches, and parents should be informed of these health effects.

- State laws to prohibit sales to minors. Presently, 14 States have no such law.

- Additional excise taxes levied on smokeless tobacco products. Presently, 28 States tax smokeless tobacco products.

- State laws enacted to prohibit free distribution. Only two States have such a law.

- A ban placed on media advertising.

- A requirement for strong health-warning labels.

- Increased awareness of health professionals concerning the effects of smokeless tobacco use. Because a substantial number of pre-adolescent and adolescent males may be regular smokeless tobacco users, oral examinations should be carried out to detect oral lesions.

- Primary prevention programs, as well as cessation programs, need to be developed and implemented.

Reference:

CDC. Use of Smokeless Tobacco - Wisconsin. MMWR 1986;35:641-4.

CALIFORNIA ENACTS NEW TOBACCO/SMOKELESS TOBACCO LAWS

Two bills related to tobacco and smokeless tobacco were recently enacted in California. AB 4085 repeals the existing law that allows high school district school boards to allow principals to designate places in schools where tobacco may be used. Under the new law, principals will be allowed to expel students who use tobacco products in school, or on their way to or from school.

AB 4214 prohibits promotional offers of smokeless tobacco requiring proof of purchase unless the offer states it is not available to persons under age 18. Such offers would require purchasers to verify their age as 18 or older. The law also prohibits the free distribution of smokeless tobacco products within two blocks of a facility whose primary purpose is directed toward persons under age 18, and prohibits distribution of unsolicited smokeless tobacco samples through the mail.

DENTIST'S DUTIES TO DISCLOSE A MINOR'S USE OF SMOKELESS TOBACCO

The following is excerpted from an opinion letter outlining the duties of a dentist to disclose a minor's use of smokeless tobacco to his or her parents. The legal opinion was prepared by the law firm of Pepper, Hamilton, and Scheetz (California) and is based on statutory directives and case precedents under California law. While the opinion focuses upon California law, it is hoped that additional publication of its conclusions will alert practitioners in other jurisdictions to similar duties that may exist under the law of their home States.

> The increase in the use of smokeless tobacco by minors has raised concerns in the dental community not only as to the negative health implications, but also the duties the dentist may have when he believes that a minor patient uses smokeless tobacco. Specifically, may the dentist disclose the observation that the minor uses smokeless tobacco to the parent?
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> If the dentist may disclose the information to the parent, the next question that must be addressed is whether or not the dentist is obligated to make the disclosure. While there appear to be no cases specifically addressing the issue, the cases (which do exist) suggest that the dentist should disclose the condition to the parent, as the parent is legally charged with caring for the child and must consent to any treatment.
>
> With respect to each of these questions, we conclude that the answer is in the affirmative, the dentist may, and must make, that disclosure to the parent.

SMOKELESS TOBACCO-RELATED BILLS - 1986

Six types of tobacco-related laws were enacted by States during 1986, including some which deal with smokeless tobacco. The following is a summary of what action was taken by specific States:

- California restricted the distribution and advertising of smokeless tobacco.

- Delaware placed restrictions on the sale of smokeless tobacco products.

- Maine prohibits the selling of smokeless tobacco to persons under 16 years of age.

- Massachusetts and Minnesota passed laws requiring warning labels on smokeless tobacco products.

- Utah passed laws requiring labels on smokeless tobacco products and banning the free distribution of smokeless tobacco products.

INFECTION CONTROL

PREVALENCE OF ANTIBODIES TO HTLV-III/LAV AMONG DENTAL PROFESSIONALS

To assess the risk of transmission, Dr. Robert Klein and others studied the prevalence of antibodies to HTLV-III/LAV among dental professionals in the New York area. None of the 220 subjects who treat AIDS and high-risk patients had antibodies to HTLV-III/LAV confirmed by Western blot.

Ninety-three percent (204) of the subjects received accidental inoculation with sharp needles. The median number of accidental inoculations received was one within a month; in the preceding 5 years, the median was 10 (range 1-1,000).

Reference:

"Prevalence of Antibodies to HTLV-III/LAV Among Dental Professionals," Robert S. Klein, et al., Montefiore Medical Center and CDC.

LACK OF ANTIBODIES TO HTLV-III/LAV IN DANISH DENTISTS

The following is a recent letter sent to the Editor, Journal of the American Medical Association:

> Dentists often work without wearing surgeon's gloves. Their hands are therefore regularly contaminated with blood and saliva from patients. Furthermore, they may inhale aerosols from patients' saliva mixed with blood. Human T-cell lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) can be present in both blood and saliva. To determine whether this exposure represents a job-related hazard, a cross-sectional study was carried out on Danish dentists attending the Annual National Dental Association Convention, April 1985.
>
> Nine hundred sixty-one persons representing 22.9% of all Danish dentists gave blood and completed questionnaires. These 961 dentists represented 78.6% of the total number of registered dentists at the convention. Their distribution according to type of job, geography, and sex is similar to that of all Danish dentists. Of the 545 males enrolled, 18.8% were never married. All serum samples were tested for antibodies to HTLV-III/LAV by enzyme-linked immunosorbent assay (ELISA) tests. Results showing levels above the average from ten positive controls infected with acquired immunodeficiency syndrome (AIDS) were considered positive. Readings from 80% to 100% of the positive control value were scored as borderline positive. Serum samples that scored positive or borderline on ELISA screening were further tested by Western blot analysis, twice at the Institute of Cancer Research, Arhus, Denmark, and twice more at Biotech Research, Inc., Rockville, Maryland, using purified, disrupted HTLV-III/LAV grown in H9 cell lines as the antigens.

Serum samples from nine persons were borderline positive, and 12 persons had positive responses, but Western blot analysis in both Danish and American laboratories failed to confirm any. A finding of zero seropositivity among the 951 tested is consistent with the presence of, at the most, 11 seropositives (upper confidence limit, P=05) among the nontested dentists working with adult patients (0.2%).

Denmark has the highest prevalence of AIDS in Europe and a high prevalence of seropositive persons among risk group members. As of 1984, 26% of male homosexuals and more than 60% of Danish hemophiliacs using factor VIII have been found to be HTLV-III seropositive. There is a dentist-patient ratio of 1:1000 in Denmark and 82% of the dentists work primarily with adult patients. As a conservative estimate, homosexual men make up at least 2% of the total adult population of Denmark. The fact that many of our dentists were most probably in contact with seropositive clients but remained seronegative indicates that transmission of HTLV-III/LAV virus through dental work does not appear to be common. However, percutaneous occupational exposure must still be considered a potential risk factor, because medical professionals who are exposed by needlestick to AIDS cases may occasionally seroconvert. Thus, guidelines for preventing the spread of HTLV-III/LAV in dentistry should be followed.

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The Institute of Cancer Research
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Flemming Schultz
The Royal Dental College
Arhus, Denmark

Anne J. Bodner, M.D.
Biotech Research Laboratories, Inc.
Rockville, Maryland

Robert J. Biggar, M.D.
National Cancer Institute
Bethesda, Maryland

Reference:

Journal of the American Medical Association, October 24/31, 1986, Vol. 256, No. 16.

IMMUNIZATION INFORMATION FOR DENTAL CARE PROFESSIONALS AND PATIENTS

Dental Care Professionals:

Dental care professionals (and any staff with possible exposure to blood or blood products) are at especially high risk of contracting

hepatitis B, a dangerous and potentially fatal disease. These workers should receive a three-dose series of hepatitis B vaccine over a period of 6 months. It is recommended that vaccination be completed during training in schools of dentistry, nursing, laboratory technology, and other allied health professions, or as soon as possible following training.

All adults, including dental care professionals, should be immune to (and know their immune status against) measles, rubella, tetanus, and diphtheria. Measles and rubella can be prevented with one combined shot ("M-R). It is recommended for those persons who know or who suspect they have never had the diseases or the immunizations. Both diseases are highly contagious and can spread rapidly, sometime after only one exposure between patient and provider. Tetanus and diphtheria are no longer common in this country, but continued protection depends upon receiving a combined booster ("Td") at least every 10 years, beginning about age 15.

Patients:

Adolescent and adult patients should also be immune and have documentation of their immune status against measles, rubella, tetanus, and diphtheria. Preschool patients should have completed the primary series of childhood immunizations (polio, diphtheria, tetanus, pertussis, measles, mumps, rubella, and Haemophilus influenzae type b disease) prior to their second birthday. Booster doses of polio and diphtheria-tetanus-pertussis (DTP) vaccines are administered just prior to entry to kindergarten or first grade. Most State health departments issue standardized records to parents to help them track their children's immunizations.

General Information:

As with most medicines, vaccines carry some small risk of adverse effects. Most are mild and temporary, although the possibility for more severe reactions does exist. Some individuals should not receive vaccines of any type without being evaluated by a physician. These individuals include, but are not limited to, pregnant females, anyone sick with anything more serious than a cold, persons with compromised immune systems, and those with certain severe allergies. For more information on immunizations, contact your State or local health department.

Recommendations on vaccines and diseases are made by the Immunization Practices Advisory Committee (ACIP). These recommendations are reviewed frequently and revisions or updates are published in the CDC Morbidity and Mortality Weekly Report (MMWR). Examples of some diseases covered are: Recommendations for Protection Against Viral Hepatitis; Prevention and Control of Influenza; Mumps Vaccine; Poliomyelitis Prevention; and Meningococcal Vaccine.

DENTAL PROFESSIONALS AT LOW RISK OF AIDS

Preliminary results of the study "Prevalence of Antibodies to HTLV-III/LAV Among Dental Professionals" by Robert S. Klein, J. Phelan, G.H. Friedland, C. Schable, N. Trieger, and N.H. Steigbigel are reported.

Of the first 220 dental health care workers who treated AIDS patients or patients at risk of AIDS, 200 (91%) were dentists, 14 were dental hygienists, and 6 were dental assistants. Of those tested, none demonstrated antibodies to HTLV-III/LAV confirmed by Western blot. This group reported using the following infection control barrier measures in the provision of care: 47% always used gloves, 27% always wore masks, and 61% always wore protective eyewear.

Of the 220 respondents to the survey, 204 reported accidental parenteral puncture wounds by instruments or needles within the preceding 5 years; the median number of incidents per subject over the preceding 5 years was 10 (range of 1-1,000). These preliminary results suggest that dental professionals are at low risk of infection from treating patients with or at risk of AIDS, even with intermittent compliance with infection control guidelines and frequent accidental injuries with sharp instruments.

SURGEON GENERAL'S REPORT ON AIDS

A 36-page booklet, "Surgeon General's Report on Acquired Immune Deficiency Syndrome," is now available. The booklet provides extensive information about AIDS, including how it is transmitted, the relative risks of infection, and how to prevent it. Copies may be obtained from:

Inter America Research
1200 E. North Henry Street
Alexandria, Virginia 22314
Attention: Clint Jones

AMERICAN RED CROSS VIDEOTAPE ON AIDS

The American Red Cross has produced a videotape about AIDS entitled "Beyond Fear." The tape consists of three parts: the Virus, the Individual, and the Community, and is available free of charge from individual Red Cross districts or by contacting Modern Talking Picture Services at (813) 541-7571.

VIDEOTAPE: "WHAT IF THE PATIENT HAS AIDS?"

A 22-minute videotape, "What if the Patient Has AIDS?" is available for health care personnel to describe precautions when caring for those patients with AIDS or AIDS-Related Complex (ARC).

The cost of the videotape is $55.00 and is available in the following sizes:

3/4" Video, No. A15093/GA

BETA 2 Video, No. A15095/GA

VHS Video, No. A15094/GA

The tape may be obtained from:

National Audiovisual Center
Order Section GA
8700 Edgeworth Drive
Capitol Heights, Maryland 20743-3701
Telephone: (800) 638-1000

Purchase orders, checks, or money orders should be made out to the National Archive Trust Fund. Invoice or credit card orders have a $5.00 handling fee.

FLUORIDATION

CDC RECOMMENDATIONS TO WATER SUPPLY INDUSTRY CONCERNING FLUORIDE CHEMICAL SHORTAGES

In the summer of 1986, the Centers for Disease Control (CDC) sponsored a Fluoride Chemical Shortage Seminar for the purpose of evaluating the most recent fluoride chemical shortage and to propose recommendations to keep the problem from recurring. The meeting included representatives from Federal, State, and local governments, public health officials, representatives of most major manufacturers of fluoride chemicals, and other interested parties. After evaluating all ideas and suggestions provided by these individuals, CDC prepared a summation of all comments made at the seminar and has made recommendations concerning any possible future shortages. The following is a summary of these recommendations:

1. It is recommended that all municipal fluoridated water systems using sodium silicofluoride and/or hydrofluosilicic acid maintain, at a minimum, a 3 months' supply of chemicals (in other words, never let the supply on hand fall below 3 months).

2. Municipalities' water systems should always try to obtain the maximum quantity of hydrofluosilicic acid possible. This may mean ordering the chemical in conjunction with other water systems, or increasing storage capacity. Larger orders generally mean lower prices per pound because of lower transportation costs.

3. Medium- to large-size water systems that fluoridate should be encouraged to obtain multi-year contracts (1- or 2-year contracts with extensions) for their supply of fluoride chemicals. This will help ensure the availability of supplies.

4. All fluoridated water systems (both municipal and schools) should use only fluoride chemicals that meet standards set by the American Water Works Association (CDC has maintained this recommendation for some time).

If you wish to obtain a copy of the entire report of the seminar proceedings, please contact:

Thomas G. Reeves, P.E.
Fluoridation Engineer
Dental Disease Prevention Activity
Freeway Park, Room 424
Centers for Disease Control
Atlanta, Georgia 30333
Telephone: (404) 329-1833
FTS: 236-1833

MUTAGENICITY OF SODIUM FLUORIDE TO MOUSE LYMPHOMA CELLS

The following is taken from the article, "The Mutagenicity of Sodium Fluoride to L5178Y [Wild-Type and $TK^{+}/-$ (3.7.2c)] Mouse Lymphoma Cells:"

The general population is widely exposed to inorganic fluorides because of their natural occurrence in water, soil, and food, as well as their use in water fluoridation and dental products for the prevention of dental caries. Significant occupational exposure and some industrial emission also exists--e.g., from power stations and foundries. Many epidemiological studies of populations exposed to both natural fluoride and fluoridated water have shown no association with an increase in cancer mortality.

Until recently, fluoride mutagenicity data (in various in vitro and in vivo test systems) had resulted in largely negative findings although some results were ambiguous. Tsutsui, et al., reported that sodium fluoride induced unscheduled DNA synthesis (UDS) in cultured human oral keratinocytes, UDS and chromosome aberrations (CA) in cultured human diploid fibroblasts (Tsutsui et al., 1984b), and UDS, CA, sister chromatid exchanges (SCF) and morphological and neoplastic transformation in cultured Syrian hamster embryo cells (Tsutsui et al., 1984a).

Cole, et al., conducted animal studies using L5178Y wild-type and $TK^{+}/-$ (3.7.2c) cells treated with sodium fluoride over a range of concentrations (10-500 g ml^{-1}) and treatment times (4, 16 and 48 h) covering a 10-100% survival. The mutant frequency at five genetic loci (resistance to ouabain, 6-thioguanine, excess thymidine, methotrexate and 1-B-D-arabinofuranosyl cytosine) was assayed in wild-type cells and trifluorothymidine in $TK^{+}/-$ cells. Observation of and an analysis of the colony size of trifluorothymidine-resistant mutants in $TK^{+}/-$ cells suggest that sodium fluoride is clastogenic to dividing cultured mammalian cells at high, toxic concentrations.

Further work is desirable to investigate the mechanism by which chromosomes are damaged at high concentrations of fluoride. Nevertheless, the authors concluded that ". . .the knowledge available at present gives no reason to expect any genotoxic effects in human tissues at levels of fluoride ions to which they are currently exposed in the general population."

Reference:

Cole, J., Muriel, W.J., Bridges, B.A., "The Mutagenicity of Sodium Fluoride to L5178Y [Wild-Type and $TK^{+}/-$ (3.7.2c)] Mouse Lymphoma Cells," Mutagenesis, Vol. 1, 1986, IRL Press Limited, Oxford, England.

"FLUORIDES AND DENTAL CARIES," 1986

The third edition (1986) of "Fluorides and Dental Caries" is now available. This publication has been an invaluable resource over the years for many individuals involved in water fluoridation. The current volume is edited by Dr. Ernest Newbrun, Professor of Oral Biology and Periodontology, Department of Stomatology, School of Dentistry, University of California, San Francisco. The contents include: water

fluoridation and dietary fluoride; fluoride supplements; fluoride dentifrices; topically applied fluorides; legal, social, and economic aspects of fluoridation; mechanism of fluoride action in caries prevention; fluoride metabolism; fluoride toxicology; evaluation of some objections to water fluoridation; and promoting the use of fluorides in a community.

The cost of the book is $32.50 (Illinois residents add 6% sales tax) and may be obtained from:

Charles C. Thomas, Publisher
2600 S. First Street
P.O. Box 4709
Springfield, Illinois 62708-4709

NEW FLUORIDATION BROCHURE FROM MAINE

A newly revised and published brochure, "Community Water Fluoridation: The Natural Solution to Tooth Decay," has been prepared by the Maine Department of Human Services, Office of Dental Health, to explain water fluoridation and its benefits to the general public in a straightforward and informational way.

Copies of the brochure may be requested from:

Maine Department of Human Services
Office of Dental Health
State House, Station #11
Augusta, Maine 04333

NEW FLUORIDATION MATERIALS FROM ADA

The American Dental Association (ADA) has developed a videotape entitled "Fluoridation: The Facts and the Challenge." The tape features a number of health professionals and individuals who discuss the benefits of fluoridation and community approaches for fluoridation. Surgeon General C. Everett Koop states the U.S. Public Health Services's support for fluoridation and Henry Cisneros, Mayor of San Antonio, Texas, discusses his support as well as San Antonio's efforts to bring fluoridation to that city. Tom Reeves, Fluoridation Engineer, Dental Disease Prevention Activity, CDC, talks about the engineering aspects of fluoridation and Dr. Joel Boriskin, Chairman, Council of Community Health, Hospital, Institutional, and Medical Affairs, ADA, discusses dentistry's role in fluoridation. The tape is approximately 15 minutes long and is available in either 1/2" or 3/4" format for $12.50.

The ADA has also developed a water fluoridation campaign manual entitled "Nature's Idea: Fluoridation." This 35-page manual covers the following topics: (1) Why Fluoridation? (2) Researching the Community; (3) Timing a Fluoridation Campaign; (4) City Council Action Only; (5) City Council

Action with Anticipated Referendum; and (6) State Legislation. The manual is available from ADA at no charge.

These materials may be ordered from:

Ms. Nancy Fehrenbacher
Staff Associate
Council of Community Health, Hospital,
Institutional, and Medical Affairs
American Dental Association
211 E. Chicago Avenue, Suite 1648
Chicago, Illinois 60611

ADDITIONAL NOTEWORTHY ITEMS

PAMPHLET - "HEALTHY TEETH FOR HAPPY SMILES"

A new pamphlet entitled "Healthy Teeth for Happy Smiles" has been developed by the Wisconsin Division of Health. The pamphlet is a parent's guide to good dental health for infants and young children from birth through 6 years of age. Topics addressed in the pamphlet are fluorides and dental sealants, teething and tooth eruption sequence, Baby Bottle Tooth Decay, proper nutrition, and the necessity for early regular dental care.

Pamphlets may be ordered from:

Document Sales
P.O. Box 7840
Madison, Wisconsin 53707

Reference Order No. is 4078. Make checks payable to Document Sales. The cost of the pamphlet is:

1 copy	- free
50 copies	- $ 3.50
100 copies	- $ 5.40
500 copies	- $18.05

BABY BOTTLE TOOTH DECAY SLIDES/TAPES FROM WISCONSIN

Although the prevalence of Baby Bottle Tooth Decay (BBTD) has not been accurately established, there appears to be a greater prevalence of the condition among lower socio-economic status groups and certain ethnic subgroups. A general consensus prevails in Wisconsin that BBTD has become a serious problem for the Hmong population, some of whom have recently immigrated to the United States.

"Baby Bottle Tooth Decay," an 8-minute slide/tape program narrated in Hmong only (written script in both Hmong and English) has been developed by the Wisconsin Division of Health and WIC. The program was adopted from the D.C. Dental Society's award-winning program "Bright from the Start." The slide/tape program is available for $38.00 from:

Del Brown
Photographic Media Center
University of Wisconsin
45 N. Charter Street
Madison, Wisconsin
Telephone: (608) 262-2944

(Check or purchase order payable to Photographic Media Center.)

The program "Bright from the Start: The Story of the Nursing Bottle and Your Child's Teeth" is available in English, Spanish, and some dialects of Vietnamese and Cambodian from the following:

Nursing Bottle Caries
D.C. Dental Society
4300 Fordham Road, N.W.
Washington, D.C. 20016
Telephone: (202) 686-0817

PREVENTIVE DENTAL CARE FOR OLDER PEOPLE

Like the rest of the population, older people need dental services, including preventive dental care. Until recently, such care has been directed primarily toward younger people, but oral health care programs should also be aimed at the older population in order to prevent tooth decay and gum disease which may lead to tooth loss. Preventive care for older people should include screening for both oral cancers and systemic diseases with oral symptoms.

Today, 61 percent of those age 65 and older still have their own teeth, compared to only 44 percent in 1960. Unfortunately, older people do not seek dental care as frequently as the general population, even though they have a higher than average use of medical services. According to the 1981 National Health Interview Survey, 40 percent of the elderly have not been to a dentist for 5 or more years, compared to only 14 percent of the general population. In addition, 90 percent of older people incorrectly believe that it is not necessary to visit a dentist if they have lost all of their teeth. This is demonstrated by edentulous (without teeth) individuals reporting even less frequent dental visits.

Those factors which contribute to the lower use of dental services by the elderly include lack of perceived need, the low priority the elderly assign to dental care, the high costs and relative inaccessibility of dental care, and the attitudes of some dentists toward elderly patients.

More detailed information about this problem may be obtained by requesting a copy of "Technical Review Notes," Healthy Older People, Office of Prevention and Health Promotion, Public Health Service, Department of Health and Human Services, telephone (800) 626-5433. This Technical Review Note discusses the dental problems frequently experienced by older people and the proper treatment and preventive services that can help prevent and control dental problems. It explains the roles of both the dentist and the dental hygienist. For assistance in carrying out dental care programs or in making referrals, the note also includes a description of available resources from national organizations.

SEALANTS PUBLICATION AVAILABLE

"Preventing Pit and Fissure Caries: A Guide to Sealant Use" has recently been published by the Massachusetts Department of Public Health, Division of Dental Health, in collaboration with the Massachusetts Health Research Institute, Inc.

The guide provides dentists, dental auxiliaries, and public health professionals with guidelines for sealant use in individual office settings and community preventive dentistry programs.

The guide was prepared by Louis W. Ripa, Harry M. Bohannan, Virginia A. Callanen, Gregory N. Connolly, Judith A. Disney, James R. Hardison, Alice M. Horowitz, and Richard J. Simonsen. The recommendations presented are based on an evaluation of consensus opinion developed by the committee.

DENTAL PROGRAM MATERIALS AVAILABLE FROM MICHIGAN

Dental Sealants:

Dental Sealant Program Planning Guide - This guide provides the organizational information necessary to plan and conduct a dental sealant program in the school setting. It is intended to supplement the technical materials available from other sources.

Dental Sealant Fact Sheet - This has been reprinted with permission from the Massachusetts Department of Public Health. The State of Michigan's name and logo have been added with space on the back for the name and address of the local agency conducting the program. These are intended to be sent to parents, with consent forms.

Dental Sealant/Fluoride Stickers - These are available for distribution to children participating in a dental sealant program. The logo was designed to not only promote the program but to educate the public that sealants and fluoride work together.

Periodontal Health Film for Teenagers and Adults

"Prescription for Periodontal Health" is a 12-minute film for teenagers and adults produced by the National Institute of Dental Research and funded by Procter and Gamble. The film is available for free loan from Modern Talking Pictures Service, 5000 Park Street North, St. Petersburg, Florida 33709. For information on purchasing the film, see below.

To order the above materials, contact:

Jacqueline Tallman, R.D.H., M.P.A.
Dental Program Coordinator
Bureau of Community Services
Department of Public Health
P.O. Box 30035
Lansing, Michigan 48909
Telephone: (517) 335-8898

CALIFORNIA INSTITUTIONALIZES SCHOOL-BASED PREVENTIVE DENTAL PROGRAMS

The Governor of California recently signed legislation (SB 111) that permanently establishes, in statute, the Children's Dental Disease Prevention Program, a school-based program that currently serves over 357,000 children in grades K-6. The program has been in operation since 1980 and would have terminated at the end of 1986 if new legislation had not been enacted to extend it. The new law has added children in pre-school and special education classes to those already eligible to participate.

FOR YOUR INFORMATION

The Dental Disease Prevention Activity (DDPA) "Dear Colleague" letter is developed by DDPA and produced by Technical Information Services, Center for Prevention Services, Centers for Disease Control, Atlanta, GA 30333. Articles and/or written comments should be sent to:

Ms. Betty Ballinger
Dental Disease Prevention Activity
Freeway Park, Room 424
Centers for Disease Control
Atlanta, Georgia 30333
Telephone: (404) 329-1830
FTS: 236-1830

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