CALIFORNIA SOCIETY OF PEDIATRIC DENTISTS

Bulletin

Winter 2000 Vol. XXVII No. 3

President's Message

Dr. Larry Luke

I have chosen to speak in this issue on a sensitive subject in pediatric dentistry. When I first started to practice in the middle sixties, pediatric dentistry was still in its relative infancy. I practiced as an associate in Bakersfield, next door to an elementary school and the post office. At that time it seemed that every child had multiple carious lesions and quite frequently, abscessed teeth. When a child was difficult to manage, we gave them a cocktail consisting of sodium nembutal and demerol.

I look back at that time today and wonder how many bullets I must have dodged. I'm sure that our office was not unique and that there must have been sedation tragedies, but if so, the incidents were not widely circulated among our members. On occasion, we heard about poor anesthesia outcomes at ASDC chapter meetings held in Los Angeles.

Today, the caries rate is greatly reduced and I suspect the use of deep sedation is used less often as well. Yet, we seem to hear too frequently about another sedation tragedy. The latest was a few weeks ago when a three-year-old in Texas died after being sedated by a pediatric dentist. With ready access to the Internet, tragedies in far off lands become known overnight throughout the world.

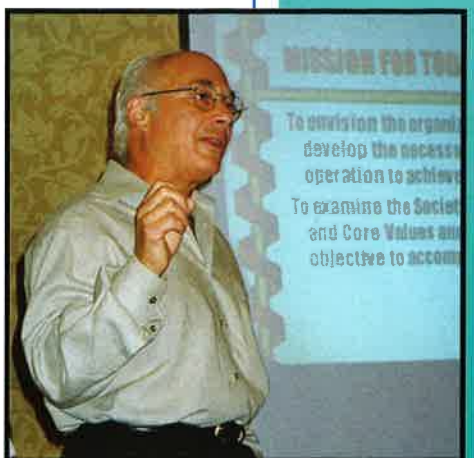
I have often wondered how I would handle my emotions if I contributed to the disablement or death of a child. Even in the best-managed case, I know that there is a chance that something could go wrong. When I observe my own children and grandchild, I think I understand how horrible it must be for the involved family.

So what is the answer? Should all in-office sedations, be abandoned? In England, the General Dental Council reached that conclusion. They have passed a law stating that after December 31, 2001, all dental treatment requiring general anesthesia must be performed in a hospital. They are already feeling the effect of this law that reduces access to care for children and adults who are unable to accept care without deep sedation. Prior to 1996, dentists in England were unlikely to have training. Since the government started requiring such training, the incidence of deaths has decreased significantly.

What happens when the AAPD guidelines are observed? There has been no reported significant morbidity or mortality related to sedation of patients when the AAPD guidelines have been followed scrupulously. This means limiting treatment to patients who are ASA Class I or 11. It means having the proper equipment such as a positive pressure oxygen delivery system, a functional suction apparatus, and fail-safe inhalation sedation equipment that is maintained and checked annually. It means having a readily accessible and appropriate emergency kit that is regularly checked and maintained. The office has an operational emergency protocol that can be immediately deployed. In my opinion this should be practiced through simulated exercises. Pulse oximetry, a blood pressure cuff and a precordial stethoscope is used depending on the level of sedation and consideration given to use of capnography. Drug dosage is carefully and individually determined and the patient monitored continuously until discharge. Careful records of drugs given, the time of administration and vital signs must be maintained.

If you are unable or unwilling to follow these guidelines, don't put yourself or your patients at risk by using conscious sedation in your office. When we have not had any negative consequences in our past usage, we tend to become nonchalant and careless. When disaster strikes, we must deal with the emotional and physical consequences to the victim, their family, our staff and ourselves. Our reputation is frequently destroyed, our right to practice may be revoked and our malpractice insurance taxed. Those using chloral hydrate alone or in combination with other drugs should be aware that most of the recent incidents in pediatric dentistry have involved this drug and should exercise special care when using it. There is a very small margin of safety with some drugs, especially when administered as part of a cocktail formula.

I plead with all of you to improve your training by frequently attending update courses on sedation and CPR, follow the AAPD guidelines to the letter, and don't let yourself become complacent. Access to care for children and special patients is at stake. The lives and happiness of our patients and their families are at stake. And, finally, your own livelihood and happiness are at stake.



Dr. Sig Abelson, Facilitator for the Strategic Planning Session held in Santa Monica.

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Fluoridation Facts

Content in this issue of the Bulletin is taken from Fluoridation Facts
Published by the American Dental Association
Council on Access, Prevention and Interprofessional Relations

Question

How much fluoride should an individual consume each day to reduce the occurrence of dental decay?

Answer

The appropriate amount of daily fluoride intake varies with age and body weight. As with other nutrients, fluoride is safe and effective when used and consumed properly.

In 1997, the Food and Nutrition Board of the Institute of Medicine developed a comprehensive set of reference values for dietary nutrient intakes. These new reference values, the Dietary Reference Intakes (DRI), replace the Recommended Dietary Allowances (RDA) which had been set by the National Academy of Sciences since 1941. The new values present nutrient requirements to optimize health and, for the first time, set maximum-level guidelines to reduce the risk of adverse effects from excessive consumption of a nutrient. Along with calcium, phosphorous, magnesium and vitamin D, DRIs for fluoride were established because of its proven effect on tooth decay. Fluoride intake in the United States has a large range of safety.

Tooth decay is an infectious disease that continues to be a significant oral health problem.

The first DRI reference value is the Adequate Intake (AI) which establishes a goal for intake to sustain a desired indicator of health without causing side effects. In the case of fluoride, the AI is the daily intake level required to reduce tooth decay without causing moderate dental fluorosis. The AI for fluoride from all sources (fluoridated water, food, beverages, fluoride dental products and dietary fluoride supplements) is set at 0.05 mg/kg/day (milligram per kilogram of body weight per day).

Using the established AI of 0.05 mg/kg, the amount of fluoride for optimal health to be consumed each day has been calculated by gender and age group (expressed as average weight).

The DRIs also established a second reference value for maximum-level guidelines called tolerable upper intake levels (UL). The UL is higher than the AI and is not the recommended level of intake. The UL is the estimated maximum intake level that should not produce unwanted effects on health. The UL for fluoride from all sources (fluoridated water, food, beverages, fluoride dental products and dietary fluoride supplements) is set at 0.10 mg/kg/day (milligram per kilogram of body weight per day) for infants, toddlers, and children through eight years of age. For older children and adults, who are no longer at risk for dental fluorosis, the UL for fluoride is set at 10 mg/day regardless of weight.

Using the established ULs for fuoride, the amount of fluoride that may be consumed each day to reduce the risk of moderate dental fluorosis for children under eight, has been calculated by gender and age group (expressed as average weight).

As a practical example, daily intake of 2 mg of fluoride is adequate for a nine to 13-year-old child weighing 88 pounds (40 kg). This was calculated by multiplying 0.05 mg/kg/day (AI) times 40 kg (weight) to equal 2 mg. At the same time, that 88 pound (40kg) child could consume 10 mg of fluoride a day as a tolerable upper intake level.

Children living in a community with water fluoridation get a portion of their daily fluoride intake from fluoridated water and a portion from dietary sources that would include food and other beverages. When considering water fluoridation, an individual must consume one liter of water fluoridated at 1 part per million (1 ppm) to receive 1 milligram (1 mg) of fluoride. Children under six years of age, on average, consume less than one-half liter of drinking water a day. Therefore, children under six years of age would consume, on average, less than 0.5 mg of fluoride a day from drinking optimally fluoridated water (at 1 ppm).

If a child lives in a non-fluoridated area, the dentist or physician may prescribe dietary fluoride supplements. As shown in the table "Dietary Fluoride Supplement Schedule 1994", the current dosage schedule recommends supplemental fluoride amounts that are below the AI for each age group. The dosage schedule was designed to offer the benefit of decay reduction with margin of safety to prevent mild to moderate dental fluorosis. For example, the AI for a child 3 years of age is 0.7 mg/day. The recommended dietary fluoride supplement dosage for a child 3 years of age in a nonfluoridated community is 0.5 mg/day. This provides leeway for some fluoride intake from processed food and beverages, and other sources.

Decay rates are declining in many population groups because children today are being exposed to fluoride from a wider variety of sources than decades ago. Many of these sources are intended for topical use only; however, some fluoride is inadvertently ingested by children. Inappropriate ingestion of fluoride can be prevented, thus reducing the risk for dental fluorosis without jeopardizing the benefits to oral health.

For example, it has been reported in a number of studies that young children inappropriately swallow an average of 0.30 mg of fluoride from fluoride toothpaste at each brushing. If a child brushes twice a day, 0.60 mg may be inappropriately ingested. This may slightly exceed the Adequate Intake (AI) values. The 0.60 mg consumption is 0. 10 mg over the AI value for children 6 to 12 months and is 0.10 mg under the AI for children from 1-3 years of age. Although toothpaste is not meant to be swallowed, children may consume the daily recommended adequate intake amount of fluoride from toothpaste alone. In order to decrease the risk of dental fluorosis, the American Dental Association has since 1992 recommended that parents and caregivers put only one pea-sized amount of fluoride toothpaste on a young child's toothbrush at each brushing. Also, young children should be supervised while brushing and taught to spit out, rather than swallow the toothpaste.

It should be noted that the amounts of fluoride discussed here are intake, or ingested amounts. When fluoride is ingested, a portion is retained in the body and a portion is excreted.

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California Society of Pediatric Dentists
BULLETIN

CSPD members are encouraged to contribute to the Bulletin. Articles, Letters to the Editor, or other items of interest are welcome. Items for publication may be submitted by e-mail (rhansen@cspd.org), in computer format on a 3.5" disk or typewritten in double space format.

Product and informational content presented in the Bulletin by contributing authors is not necessarily endorsed by the Executive Board of CSPD.

Published 4 times annually
Editor
Roland Hansen, DDS, MS

MISSION OF THE BULLETIN

The Bulletin of the California Society of Pediatric Dentists shall be to examine and identify the issues that affect the specialty of Pediatric Dentistry and the oral health of teenagers and children. All of our readers should remain informed and participate in the formulation of public policy and personal leadership to advance the purposes of the Society. The Bulletin is not a political publication and does not knowingly promote the specific views at the expense of others. The views and opinions expressed in the Bulletin do not necessarily represent those of the California Society of Pediatric Dentists.

The National Fluoridation Summit

The National Fluoridation Summit was held at the DoubleTree Resort in Sacramento on September 8-10, 2000. The keynote address was delivered by Dr. Harold Slavkin, Dean of the University of Southern California School of Dentistry and former Director of the National Institute of Dental and Craniofacial Research. The meeting opened with a welcoming videotape presentation by the Surgeon General, Dr. David Satcher. Caswell Evans, DDS, MPH delivered a message on the Surgeon General's Report on Oral Health of America.

Sessions on Current Science and Technology included Fluoridation Benefits, Reducing Disparities, Engineering, and Modern Fluoridation Systems. Day 1 sessions also included an Overview of Fluorosis - Allegation vs. Evidence, Recent Studies of Cost Efficiency. Day 2 concentrated on Legislative Issues, Coalition Building, Public Relations/Media, and Community Efforts in cities throughout the nation. Day 3 activities found the attendees learning how to "Counter the Opposition." The Summit concluded with an Open Forum that included Future Recommendations, Consensus Recommendation, and a Summit Summary.

The conference was attended by 106 fluoridation workers who were treated to a comprehensive discourse on the varied aspects of community water fluoridation. Among the notable presenters was David Heumann, PE for the Los Angeles Department of Water and Power who delivered a comprehensive plan to achieve optimum levels of fluoride in the water of Los Angeles. Michael Easley, DDS, MPH, the Director of the National Center for Fluoridation Policy and Research (http://fluoride.oralhealth.org) presented an outstanding Power Point slide lecture that defined the position of national authorities on the benefits of fluoridation.

CSPD members in attendance included Drs. Mark Lisagor, Andy Soderstrom and Roland Hansen. Several reference pamphlets were delivered to those in attendance and will be made available to CSPD members, including: Water Fluoridation - A Manual for Water Plant Operators, Engineers and Technicians, Engineering and Administrative Recommendations for Water Fluoridation, Review of Fluoride - Benefits and Risks,

A cadre of antifluoridationists received a permit to march on the sidewalk in protest to our efforts; however, they illegally entered the lobby of the hotel and abruptly dispersed prior to the arrival of the Sacramento police.

The Public Health Outreach Van - Sutter County Human Services.

Fluorides and Community Water Fluoridation

- Fluoridation is considered beneficial by the overwhelming majority of the health and scientific communities as well as the general public.
- Fluoride helps prevent tooth decay. All ground and surface water in the U.S. contains some naturally occurring fluoride. If a community's water supply is fluoride-deficient (less than 0.7 parts fluoride per million parts water) fluoridation simply adjusts the fluoride's natural level, bringing it to the level recommended for decay prevention (0.7-1.2 parts per million).
- Fluoridation is a community health measure that benefits children and adults. Simply by drinking optimally fluoridated water, members of a community benefit, regardless of income, education or ethnicity - not just those with access to dental care.
- Fluoridation protects over 360 million people in approximately 60 countries worldwide, with over 10,000 communities and 145 million people in the United States alone.
- As with other nutrients, fluoride is safe and effective when used and consumed properly. From time to time, opponents of fluoridation have questioned its safety and effectiveness. None of these charges has ever been substantiated by generally accepted science. After 50 years of research and practical experience, the overwhelming weight of scientific evidence indicates that fluoridation of community water supplies is both safe and effective.
- Just fifty cents per person per year covers the cost of fluoridation in an average community. Over a lifetime, that is the approximate price of one dental filling, making fluoridation very cost effective.
- Time and time again, public opinion polls show an overwhelming majority of Americans support water fluoridation.

California's Children

- Only 30% of Californians receive the benefits of fluoridated drinking water
- More than 25% of preschool children do not have dental insurance
- More than 40% of high school students do not have dental insurance
- Between 50% and 75% of "Minority high school students" need dental care
- California's children have twice as much untreated tooth decay (dental caries) as the national average
- Children living in poverty have increased in number with attendant increases in disease; especially "minority children."

The meeting opened with a welcoming videotape presentation by the Surgeon General, Dr. David Satcher.

The Proposition 10 legislation presents an unusual opportunity to improve the oral health of the children in California.

PROPOSITION 10

An opportunity to improve the oral health of young children in California

by Rick Udin

We need your help!

The California Children and Families First Act of 1998 (Proposition 10) increased the tax on cigarettes and tobacco products. Enacted under this bill is the collection of a tax of fifty cents per pack on cigarettes. The receipts are directed into the new California Children and Families First Trust Fund to improve early childhood development from the prenatal stage to age five. A new state commission and individual county commissions were created to oversee the expenditure of this money with the state commission responsible for spending 20 percent and the county commissions responsible for the remaining 80 percent. The money can be spent in the areas of parental education and support services, high-quality affordable child care, and child/maternal health-care services emphasizing prevention, diagnostic screenings and treatment not covered by other programs.

County commissions were organized to allocate funds designated for local programs. Money is allocated to each county based on the number of births in the county as a percentage of the statewide total. The amounts range from about $7,000 for Alpine County to over $166 million for Los Angeles County. Each county commission decides how to spend its allocation, with interested parties invited to submit proposals for consideration.

The Proposition 10 bill presents an unusual opportunity to improve the oral health of the children in California who need the most assistance. Money allocated to date by county commissions are funds to help in water fluoridation, payment for preventive services, and funding for the provision of oral health care for young children by dental students and pediatric dentistry residents.

Pediatric Dentistry in general has been late in submitting proposals to channel some of these funds to the oral health needs of children at risk. Our members have been actively involved in participating in selected counties, including Monterey, Ventura, San Francisco, San Luis Obispo, Sacramento and Alameda. However, there are many counties that do not have input by our members and most likely dentistry is not a priority of the respective commissions. The following is a list of the counties in the state having individual county commissions.

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DIETARY REFERENCE INTAKES FOR FLUORIDE

FOOD AND NUTRITION BOARD OF THE INSTITUTE OF MEDICINE 1997

AGE GROUP	REFERENCE WEIGHTS * KG (LBS)	ADEQUATE INTAKE (MG/DAY)	TOLERABLE UPPER INTAKE (MG/DAY)
Infants 0-6 months	7 (16)	0.01	0.7
Infants 6-12 months	9 (20)	0.5	0.9
Children 1-3 years	13 (29)	0.7	1.3
Children 4-8 years	22 (48)	1.0	2.0
Children 9-13 years	40 (88)	2.0	10
Boys 14-18 years	64 (142)	3.0	10
Girls 14-18 years	57 (125)	3.0	10
Males 19 years and over	76 (166)	4.0	10
Females 19 years and over	61 (133)	3.0	10

Value base on data collected during 1988-94 as part of the Third National Health and Nutrition Examination Survey (NHANES III) in the United States.

Surgeon General's Report & Prop 10 Put Infant Oral Health in the Spotlight

by Mark Lisagor

Proposition 10, which imposed a 50 cent tax on every pack of cigarettes sold in California, mandates that the funds received (hundreds of millions each year) be spent exclusively in promoting the health and wellbeing of infants and children from birth to age five.

The idea is to promote, support and improve early childhood development by enhancing the intellectual, social, emotional, and physical development of young children in California, making them better prepared to enter the public school system

At a time when the Surgeon General's Report on Oral Health has created a heightened awareness about dental caries prevalence ("the silent epidemic") and the severe access to care problem which many Americans face, there is a unique opportunity to lay claim to a great deal of this funding for issues in oral health in California.

Most of the money is given to individual counties (for example, Ventura County received approximately eleven million dollars in the first year) with great latitude on exactly how the money must be spent. In each county, special Commissions have been formed to develop strategies and to receive proposals from various organizations in the community for funding of programs meeting the Proposition's objectives and guidelines.

In several counties, coalitions concerned with improving infant and oral health have been meeting and are developing plans and proposals to address the issues of barriers to access to care for many children to whom our offices are often unavailable. Programs often focus on prevention, with a wide range of proposals being considered and funded, ranging from early identification and education of "high risk" mothers of infants with early childhood caries, to training programs for public health nurses and educators in risk assessment and parent education, to fluoride varnish programs, to coalition-building for community water fluoridation campaigns. Other counties have funded significant projects for direct treatment costs associated with early childhood caries, especially for children with special needs.

In Ventura County two "high impact" grants were recently funded: one to pay for the cost of anesthesia services for children requiring general anesthesia for dental care, where this is an economic barrier to access; a second grant funds the development of a "narrow casting" educational program; aimed at low income mothers of high risk infants- included in the project is development of entertaining videos which are distributed to new mothers in county hospitals and other public agencies, which focus on basic preventive behaviors related to infant oral health.

CSPD members are encouraged to contact the Proposition X Commissions in their counties to begin to develop oral health components and grant proposals on the local level. Many dental societies and county departments of public health are already involved and would undoubtedly welcome pediatric dentists' involvement and input.

Members are also asked to share information, copies of grant proposals, details about grants which have been funded, and other insights to Rick Udin at rudin@hsc.usc.edu.

News Briefs

Executive Director, Dr. Mel Rowan reports an address and telephone change.

California Society of Pediatric Dentists
PO Box 4977
Palos Verdes, CA 90274
Phone 310-465-1580
FAX 310-465-1590

Mailing address for larger items including an 8 1/2X 11 envelope is:

1120 Via Mirabel
Palos Verdes Estates, CA 90274

Oral Conscious Sedation Course

Healthcare. education specialists, CME Associates, based out of Orange County, California, announces a training program that has been approved by the Board of Dental Examiners for oral conscious sedation for pediatric patients. Completion of this course will satisfy the requirements set forth by the California Board of Dental Examiners to obtain a certification to administer oral conscious sedation per section 1647.12. The student will also be issued an American Heart Association Pediatric Advanced Life Support (PALS) certificate upon completion. This course will be conducted at the Long Beach Airport Marriott, 4700 Airport Plaza Drive, Long Beach on December 1-3, 2000. The program is a twenty-five hour course which utilizes didactic material, case presentations and clinical lab teaching sessions. Topics covered include pharmacology of drugs used for conscious sedation, safety in use of oral sedation in a clinical setting, protocol for management of emergencies in the dental office, evaluation of the pediatric airway and Pediatric Advanced Life Support. For more information and registration, please contact CME Associates at (714) 998-2208.

National Survey of the Prevalence of Dental Caries

Among School Children (Ages 5-17 Years) in California, Oregon and Washington.

* With no exposure to fluoride, 3.61 mean DMF (decayed, missing and filled) surfaces.

* Age and sex matched children exposed to water fluoridation presented a 1.42 DMF, or a 60% reduction in tooth decay.

Attention CSPD Members

Those members who have office web sites will be provided a link to their site on the CSPD web site. Addresses should be mailed to Steve Niethamer at sniethamer@compuserve.com

CSPD Membership Hits 500

The addition of eleven new members in CSPD brings our membership total to 500, an all-time high.

The new members are:

Drs. Todd L. Hilliard, Michael J. Amodeo, Lance C. Bautista, Catherine M. Kruljac, Anne R. Lee, Ameneh Khosrovani, Paul J. Morris, Janet Y. Lee, Kathy Ying, Khanh D. Le, Reinaldo J. Negron.

Dr. Negron was reported to be the 500tth member.

Did you Know?

You can access the website of the National Institute of Dental and Craniofacial Research to find a precise description of Amelogenesis Imperfecta, Dentinogenisis Imperfecta and other oral/craniofacial disease including the Syndrome, Gene Name, Gene Symbol, OMIM Number, Chromosomal Location, Molecule, Inheritance, and the Description of Craniofacial Features. Log on to the NIDCR website at:

http://www.nidcr.nih.gov/cranio/index.htm

A Multimedia CD-ROM hosted by Dr. John Featherstone, UCSF entitled "The Science and Practice of Caries Prevention was viewed prior to the Strategic Planning session held on Sunday after their fall Board Meeting. The CSPD Board and Officers viewed a portion of the multimedia CD-ROM that was created under the sponsorship of Delta Dental of California, CDA, AAPD and CSPD. Dr. John Featherstone of UCSF hosted the 55-minute presentation entitled "The Science and Practice of Caries Prevention". The subject material included the following titles:

The Science and Practice of Caries Prevention
- What is Dental Caries?
- First Mechanism of Action of Fluoride
- Subsurface Demineralization
- What is the Relevance?
- Second Mechanism of Action of Fluoride
- What Does it Mean?
- Conclusions
- Remineralization
- Remineralization Process
- Important Components of Saliva
- The Caries Balance
- Caries Intervention (1)
- Conservative Caries Management
- Caries Management by Risk Assessment
- High Risk Subjects
- Fluoride Concentrations
- Fluoride Sources
- Caries Prevention for Orthodontic Patients
- Caries Intervention (2)

The CD-ROM delivery was chosen because on-demand eLearning solutions using proprietary software enables the delivery of new media over the Internet, Intranets, or a CD-ROM. The delivery of realistic streaming video and audio, as well as an intuitive interface, delivers an on demand personal presentation with greater impact and retention.

The software can link a transcript to each published video clip and scroll the text as the video plays. Text scrolling breaks down communication barriers by allowing non-English speaking viewers and others to understand the lecturer more clearly. A second text track in Spanish may be used at the discretion of the viewer.

Educational information delivered via streaming video can also be searched for those portions that have relevancy to the viewer. Review of those sections of most interest is easily accomplished by clicking on the Play List (a Table of Contents) or clicking on a line of text.

This method of delivering streaming video to the desktop allows the user to navigate through a video sequence using familiar VCR controls, a playlist, or textual notes that are synchronized with the video. Users can also create a custom playlist... thus turning Real Video and other formats into a more user-friendly form of information exchange.

Rich media is finding it way into the marketplace because it offers considerable promise and potential for applications in the area of training and distance learning. The application of streaming media in the distance learning arena is compelling since these applications harness the functionality of video by combining it with data and presenting it in a manner that facilitates self-paced learning.

This initial effort using CD-ROM delivery is currently under evaluation by the sponsoring organizations.

Our Public Health Attitude

"The moral test of government and all of society is how we treat those who are at the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadow of life, the needy, and the handicapped or disabled."

Hubert H. Humphrey (1962)

"The moral test of government and all of society is how we treat those who are at the dawn of life, the children..."

Drs. Mel Rowan and Nord Nation (M.D.) the brother of the late Wil Nation at a meeting of the Children's Dental Foundation at Long Beach Memorial Medical Center.

At the present time, only 62.2% of the population served by public water systems have access to fluoridated water.

Why does community water fluoridation sometimes lose when it is put to a public vote?

Answer

Voter apathy, blurring of scientific issues, lack of leadership by elected officials and a lack of political campaign skills among health professionals are some of the reason fluoridation votes are sometimes unsuccessful.

Fact

Despite the continuing growth of fluoridation in this country during the past decades, millions of Americans do not yet receive the protective benefits of fluoride in their drinking water. At the present time, only 62.2% of the population served by public water systems have access to fluoridated water. In 1992, approximately 70% of all U.S. cities with populations of more than 100,000 fluoridated their water, including 42 of the 50 largest cities. In 1998, the U.S. Public Health Service revised national health objectives to be achieved by the year 2010. Oral Health Objective 10 deals specifically with community water fluoridation and states that at least 85% of the population served by community water systems should be receiving the benefits of optimally fluoridated water by the year 2000.1 At the time the objectives were revised, less than half of the states met the 85% goal.

The adoption of fluoridation by communities has slowed during the past several decades. Social scientists have conducted numerous studies to determine why this phenomenon has occurred. Among the factors noted are lack of funding, public and professional apathy, the failure of many legislators and community leaders to take a stand because of perceived controversy, low voter turnout and the difficulty faced by an electorate in evaluating scientific information in the midst of emotional charges by opponents. Unfortunately, citizens may mistakenly believe their water contains optimal levels of fluoride when, in fact, it does not.

Clever use of emotionally charged "scare" propaganda by fluoride opponents creates fear, confusion and doubt within a community when voters consider the use of fluoridation. Defeats of referenda or the discontinuance of fluoridation have occurred most often when a small, vocal and well-organized group has used a barrage of fear-inspiring allegations designed to confuse the electorate. In addition to attempts to influence voters, opponents have also threatened community leaders with personal litigation. While no court of last resort has ever ruled against fluoridation, community leaders may be swayed by the threat of litigation due to the cost and time involved in defending even a groundless suit. In no instance has fluoridation been discontinued because it was proven harmful in any way. Adoption of fluoridation is ultimately a decision of state or local decision-makers, whether determined by elected officials, health officers or the voting public. Fluoridation can be enacted through state legislation, administrative regulation or a public referendum. Fluoridation is not legislated at the federal level and is perceived in most states as a local issue. From 1989-94, 318 communities authorized fluoridation by administrative governmental action. In the same time period, 32 referenda were held with fluoridation authorization approved in 19 and defeated in 13. As noted above, referenda can be unsuccessful for a variety of reasons. Nonetheless, a community's decision to protect the oral health and welfare of its citizens must, in some cases, override individual objections to implement appropriate public health measures.

Caswell Evans, DDS, MPH opens the Press Conference at the National Fluoridation Summit Meeting.

Website Activity Report

Requests from Tuesday 13-Jun-2000 10:38 to Thursday 14-Sep-2000 23:34 (93. 5 days).

General Summary

(Figures in parentheses refer to the last 7 days).

Successful requests: 28,518 (2,000)
Average successful requests per day: 304 (285)
Successful requests for pages: 7,667 (565)
Average successful requests for pages per day: 81 (80)
Failed requests: 1,123 (73)
Distinct flies requested: 118 (91)
Distinct hosts served: 2,177 (278)
Data transferred: 172,875 kbytes (10,036 kbytes)
Average data transferred per day: 1,848 kbytes (1,433 kbytes)

DIETARY FLUORIDE SUPPLEMENT SCHEDULE 1994

Approved by the
- American Dental Association
- American Academy of Pediatrics
- American Academy of Pediatric Dentistry

Fluoride ion level in drinking water (ppm)*

Age	<0.3 ppm	0.3-0.6 ppm	>0.6 ppm
Birth - 6 months	None	None	None
6 months - 3 years	0.25 mg/day**	None	None
3 - 6 years	0.50 mg/day	0.25 mg/day	None
6 - 16 years	1.0 mg/day	0.50 mg/day	None

* 1.0 part per million (ppm) = 1 milligram/liter (mg/L)
** 2.2 mg sodium fluoride contains 1 mg fluoride ion.

Annual Meetings

2001

March 29 - April 1
Sacramento Hyatt Regency at Capital Park
Sacramento, CA

2002

Anaheim Disneyland

2003

April 3 - April 6
Empress Hotel Victoria,
British Columbia, Canada

2004

Yosemite National Park

Officers and members of the Board of Directors for CSPD meet quarterly. The membership of CSPD is encouraged to provide input to the leadership. Our next regularly scheduled meeting will beheld in San Francisco. Board meetings are open to the membership, and you are welcome to attend. Address your written intention to attend to President, Dr. Larry Luke.

District VI AAPD Trustee

by Ray Stewart

In his Board report, Dr. Stewart stated, "the ongoing issue of regulation or in some cases legislation involving Oral Conscious Sedation in dental offices continues to be of great concern. The recent effort by the State Board of Dental Examiners in Florida to require the presence of EKG monitors and defibrillators in any office or facility where oral conscious sedation is provided to children is an example of how things can get out of hand unless pediatric dentists are "at the table." The AAPD is actively opposing the adoption and remains in negotiation.

The negotiations between the AAPD and the American Board of Pediatric Dentistry concerning the need for reforms in the process of achieving Diplomat status continue. ADA responded to AAPD's request for clarification of its policy on limiting the time period of eligibility for certification. The ADA response that "there is a no time limit Policy" will hopefully lead to an immediate change in American Board policy on time limits.

AAPD is in the planning stages of a "Consensus Conference on Restorative Materials." It will be chaired by Dr. Kevin Donly and held in Texas in the fall of 2001. The conference arose because of outside "experts" expressing their views as to what was and was not appropriate restorative and treatment strategies for children. The conference will be held on a yearly basis. The membership will be invited to attend as observers not attendees

Dr. Stewart reported that he will be contacting each of the State Component Presidents in District VI to begin work toward a formal District VI structure. The goal will be to establish a District Unit, which will adopt a Constitution and By-Laws delineating how it will function to elect a District VI Trustee, advance names for AAPD Council appointments and elect District representatives to the AAPD Nominating Committee. Dr. Stewart requested CSPD input regarding how the Board wants to be represented. Two possibilities were offered.

a. Each state component with single vote and trustee on district board. If this option came into effect, all the other states would have equal voting power with CSPD.

b. Each state or component would have votes proportional to membership in that state.

Community Water Fluoridation

• Fluoridation is considered beneficial by the overwhelming majority of the health and scientific communities as well as the general public.

• Fluoride helps prevent tooth decay. All ground and surface water in the U.S. contains some naturally occurring fluoride. If a community's water supply is fluoride-deficient (less than 0.7 parts fluoride per million parts water) fluoridation simply adjusts the fluoride's natural level, bringing it to the level recommended for decay prevention (0.7-1.2 parts per million).

• Fluoridation is a community health measure that benefits children and adults. Simply by drinking optimally fluoridated water, members of a community benefit, regardless of income, education or ethnicity - not just those with access to dental care.

• Fluoridation protects over 360 million people in approximately 60 countries worldwide, with over 10,000 communities and 145 million people in the United States alone.

• As with other nutrients, fluoride is safe and effective when used and consumed properly. From time to time, opponents of fluoridation have questioned its safety and effectiveness. None of these charges has ever been substantiated by generally accepted science. After 50 years of research and practical experience, the overwhelming weight of scientific evidence indicates that fluoridation of community water supplies is both safe and effective.

• Just fifty cents per person per year covers the cost of fluoridation in an average community. Over a lifetime, that is the approximate price of one dental filling, making fluoridation very cost effective.

• Time and time again, public opinion polls show an overwhelming majority of Americans support water fluoridation.

The adoption of fluoridation by communities has slowed during the past several decades.

Proposition 10... Continued from pg. 4

PROPOSITION 10 COUNTIES

Alameda	Kings	Placer	Sierra
Alpine	Lake	Plumas	Siskiyou
Amador	Lassen	Riverside	Solano
Butte	Los Angeles	Sacramento	Sonoma
Calaveras	Madera	San Benito	Stanislaus
Colusa	Marin	San Bernardino	Sutter
Contra Costa	Mariposa	San Diego	Tehama
Del Norte	Mendocino	San Francisco	Trinity
El Dorado	Merced	San Joaquin	Tulare
Fresno	Modoc	San Luis Obispo	Tuolumne
Glenn	Mono	San Mateo	Ventura
Humboldt	Monterey	Santa Barbara	Yolo
Imperial	Napa	Santa Clara	Yuba
Inyo	Nevada	Santa Cruz	
Kern	Orange	Shasta	

We are calling on interested CSPD members who live/work in one of the counties listed above) for help. We are looking for members willing to put in some time and energy to work with their county commission to develop worthy projects to improve the oral health of the children in their county. The Child Advocacy Committees; created a clearinghouse of materials that are available to interested CSPD members. These materials provide information describing the problems of early childhood caries and access to care for many of the children nationally as well as in California, and provide strategies in helping to improve efforts towards prevention and early intervention. The Child Advocacy Committee can also provide guidance in making the necessary local contacts and serve to put you in touch with CSPD members who have been successful in obtaining funding for proposals in their local counties.

Please contact Rick Udin at rudin@hsc.usc.edu. or (213) 740-2679 for additional information.

Dental problems result in pain, infection, and millions of lost school days and workdays each year.

The General Accounting Office Replies to Inquiry

The General Accounting Office (GAO) is the investigative arm of Congress and this report was prepared at the request of Senators Bingaman, Feingold and Representatives Barrett and Obey. It takes on added significance when combined with the 1996 Inspector General's report and the 1999-2000 Surgeon General's Report. GAO staff is currently working to address the barriers that contribute to the problems identified in this report and identify areas that the states need to address to improve access and utilization. Jim Crall and Burt Edelstein contributed data to the GAO for the preparation of the second report. The full report in text or PDF format can be found on the GAO website at www.gao.gov (Report No. GAO/HEHS0-00-72, April 12, 2000)

Summary:

Pursuant to a congressional request, GAO provided information on the:

(1) dental health status of Medicaid beneficiaries and other vulnerable populations; and (2) extent to which these groups have dental coverage and use dental services.

GAO noted that: (1) dental disease is a chronic problem among many low-income and vulnerable populations; (2) GAO's analysis of the most recent national health surveys (1994-1997) showed that relative to more affluent segments of the population, low-income populations had a disproportionate level of dental disease; (3) for example, poor children had five times more untreated dental caries (cavities) than children in higher-income families, and poor adults were much more likely to have lost six or more teeth to decay and gum disease than higher-income adults; (4) minority populations also faced high levels of dental disease; (5) dental problems result in pain, infection, and millions of lost school days and workdays each year; (6) although every state Medicaid program offers dental coverage for children and most programs cover adults eligible for Medicaid, use of dental services by low-income people is low; (7) states are required to provide comprehensive dental benefits for children enrolled in Medicaid, and the State Children's Health Insurance Program provides variable but often substantial levels of dental coverage to eligible low-income children in all but two states; (8) adult dental services, although optional under Medicaid, are covered to some extent in about two-thirds of the states; (9) the availability of coverage does not, however, bridge the income gap to equalize the likelihood of visiting a dentist; (10) for example, GAO'S analysis of 1995 Medicaid claims data showed that only 29 percent of enrolled adults had visited the dentist in the preceding year, less than half the rate of higher-income adults; and (11) national survey data also showed that in 1996 poor children and adults visited the dentist at about half the rate of their higher-income counterparts—numbers that had stayed relatively unchanged since 1977.

Concluding Observations

Dental disease is a chronic problem among many low-income and vulnerable populations. Our analysis of the most recent national health surveys (1994-97) showed that relative to more affluent segments of the population, low-income populations had a disproportionate level of dental disease. For example, poor children had five times more untreated dental caries (cavities) than children in higher-income families, and poor adults were much more likely to have lost six or more teeth to decay and gum disease than higher-income adults. Minority populations also faced high levels of dental disease. Dental problems result in pain, infection, and millions of lost school days and workdays each year.

Although every state Medicaid program offers dental coverage for children and most programs cover adults eligible for Medicaid, use of dental services by low-income people is low. States are required to provide comprehensive dental benefits for children enrolled in Medicaid, and the State Children's Health Insurance Program (SCHIP) provides variable but often substantial levels of dental coverage to eligible low-income children in all but two states. Adult dental services, although optional under Medicaid, are covered to some extent in about two-thirds of the states. The availability of coverage does not, however, bridge the income gap to equalize the likelihood of visiting a dentist. For example, our analysis of 1995 Medicaid claims data showed that only 29 percent of enrolled adults had visited the dentist in the preceding year, less than half the rate of higher-income adults. National survey data also showed that in 1996 poor children and adults visited the dentist at about half the rate of their higher income counterparts-numbers that had stayed relatively unchanged since 1977.

Legislative Report

by Paul Reggiardo

The California legislature turned off the lights on the 2000 legislative session last month and the Governor has acted on those bills of interest to CSPD passing in the final hours of the session.

CSPD counted 16 bills potentially impacting pediatric oral health or delivery of oral health services, four of which passed the legislative, were signed by the Governor, and chaptered into law as follows:

AB 869 (Keeley) extends the implementation date of the provisions for the oral conscious sedation certificate (AB 2006) to January 1, 2001.

AB 497 (Gallegos) repeals current law requiring the dentist to be in attendance at each place of practice in which he or she has ownership interest at least 50% of the time that office is open.

AB 2394 (Firestone) will create a task force to evaluate the cultural and linguistic competency of California physicians and dentists and subcommittee of that task force to determine the feasibility of establishing a pilot project to allow Mexican and Caribbean licensed physicians and dentists to practice in nonprofit community health centers in the state's medically underserved areas.

AB 2611 (Gallegos) as introduced would have, among other provisions, permitted hospital to require emergency room coverage as a condition of hospital privileges even if the medical staff voted against regulating such mandatory call. The final version of the bill only requires the Senate Office of Research to conduct a study of emergency on-call coverage issues.

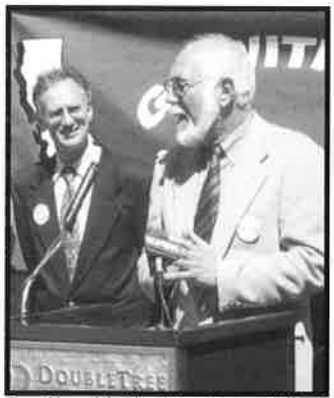
The 2001 legislative session convenes December 14, when the first of an estimated 3300 bills will be introduced.

Letter to the Editor

New Denti-Cal Rates

The new Denti-Cal rates will have an effective date of August 1, 2000. However, it may be several months before the new regulations are approved and Delta is geared up with their computers to process claims at the new rates.

Current regulations require dentists to bill at their usual and customary rates. Nevertheless, we are under the impression that some do not, i.e., they bill at what they know Denti-Cal will pay. For those dentists who bill at UCR, assuming that is higher than the new rates, any services provided on or after Aug 1 will eventually be paid at the higher revised rates. But dentists who bill at the current rates, assuming their UCR is higher, will NOT be paid at the higher revised rates, because it will be assumed that they are billing at UCR.



Dr. Harold Slavkin, Dean U.S.C. School Dentistry addresses the media at the National Fluoridation Summit Meeting.

The moral is: if you know of or work with dentists who bill at current Denti-Cal rates, it would be important to let them know that they will be losing money unless they bill at UCR.

Wayne Grossman, Past President

Flouridation Facts... Continued from pg. 2

Question

Is tooth decay still a serious problem?

Answer

Yes. Tooth decay or dental decay is an infectious disease that continues to be a significant oral health problem.

Fact

Tooth decay is, by far, the most common and costly oral health problem in all age groups. It is one of the principal causes of tooth loss from early childhood through middle age. A dramatic increase in tooth loss occurs among people 35 through 44 years of age. The two leading causes of tooth loss in this age group are dental decay and periodontal diseases. Decay continues to be problematic for middle-aged and older adults, particularly root decay because of receding gums. In addition to its effects in the mouth, dental decay can affect general well-being by interfering with an individual's ability to eat certain foods and by impacting an individual's emotional and social well-being by causing pain and discomfort. Tooth decay, particularly in the front teeth, can detract from appearance, thus affecting self-esteem.

Despite a decrease in the overall decay experience of U.S. schoolchildren over the past two decades, tooth decay is still a significant oral health problem, especially in certain segments of the population. The 1986-1987 National Institute of Dental Research (NIDR) survey of approximately 40,000 U.S. school children found that 25% of students ages 5 to 17 accounted for 75% of the decay experienced in permanent teeth. Some of the risk factors that increase an individual's risk for decay are irregular dental visits, deep pits and fissures in the chewing surfaces of teeth, inadequate saliva flow, frequent sugar intake and very high oral bacteria counts.

Because dental decay is so common, it mistakenly tends to be regarded as an inevitable part of life. Data from NHANES III collected on adults aged 18 and older revealed that 94% showed evidence of past or present decay in the crowns of teeth, and 22.5% had evidence of root surface decay.

In addition to impacting emotional and social well-being, the consequences of dental disease are reflected in the cost of its treatment. The nation's dental health bill in 1997 was $50.6 billion. Again, the goal must be prevention rather than repair. Fluoridation is presently the most cost-effective method for the prevention of tooth decay for residents of a community in the United-States.

The new Denti-Cal rates will have an effective date of August 1, 2000.

Dental Fluorosis

Classification by H. T. Dean - 1943

Classification

Criteria - Description of Enamel

Normal

Smooth, glossy, pale creamy—white translucent enamel

Questionable

A few white flecks or white spots

Very Mild

Small opaque, paper-white areas covering less than 25% of the tooth surface

Mild

Opaque white areas covering less than 25% of the tooth surface

Moderate

All surfaces affected, marked wear on biting surfaces, brown stain may be present

Severe

All tooth surfaces affected; discrete or confluent pitting; brown stain present

BOARD BRIEFS

CALIFORNIA SOCIETY OF PEDIATRIC DENTISTS MINUTES - BOARD OF DIRECTORS
DATE: SEPTEMBER 23, 2000 • DOUBLETREE GUEST SUITES, SANTA MONICA, CA

...the Governor recently signed the new budget with an estimated 80 million dollars to apply toward dental services in the Medi-Cal program.

The 106th meeting, of the Board of Directors of the California Society of Pediatric Dentists was called to order by Dr. Larry Luke on Saturday, September 23, 2000 at 9:25am.

In attendance were: Doctors Luke, Lovingier, Rowan, Perry, Hansen, Azama, Rothman, Soderstrom, Mungo, De Lorme, Stewart, Brennan, Christensen, Pederson, Udin, Grossman and Reggiardo. Also present were Dr. Sig Abelson (strategic plan facilitator) and Mrs. Marian (secretarial assistant)

CORRESPONDENCE

"The Legislative Process" - Dr Grossman reported that this news article is related to current state dental board matters and the treatment of dental practitioners accused of a wrongdoing. "Historically, other courts have put in place fair processes with many checks and balances. This has not been the case in the Administrative Law System." Over the years it has been difficult to find a case brought against a dentist that ended in the dentists favor. Dr. Reggiardo will investigate the matter more fully and file a report for the next Board meeting.

Report of the CSPD Delegation to DHS regarding DentiCal fee increases - Dr. Grossman reported that the Governor recently signed the new budget with an estimated 80 million dollars to apply toward dental services in the Medi-Cal program. Of the 80 million dollars, more than half has been earmarked to remedy two longtime deficiencies of the program:

1. Periodic exams will now be paid twice a year.
2. Prophylaxis and fluoride will now be paid twice a year.

Children's Dental Health Bill - Dr. Jac Pederson reported that Congresswoman Lois Capps has introduced legislation to promote children's dental health. Her bill - The Children's Dental Health Preservation Act - authorizes the Secretary of Health and Human services to fund grants to states for dental health programs for children and the bill has been endorsed by the ADA. Dr. Pederson asked the Board asking for a CSPD letter of commendation for Ms. Capps..

LEGISLATIVE AND GOVERNMENTAL AFFAIRS - DR. SODERSTROM

Drs. David Rothman, Larry Luke and Mel Rowan at the recent Los Angeles Board Meeting.

Highlighted the Keely bill (AB 869) which extended the implementation date of the provisions for the oral conscious sedation certificate to January 1, 2001.

Reported on the SB 111 program that added 3.4 million dollars to be allocated to 28 counties.

The Gallegos bill (AB 2229) would allow persons otherwise eligible for Healthy Families who have private medical insurance, but no dental or vision benefits, to separately purchase the dental or vision benefits of the Healthy Families program.

The waterline issue bill has been changed to a study. Currently it is on the Governor's desk.

SB 292 was revised to clarify existing law to specify that second opinions on dental decisions may be made by dentists and not physicians.

DENTAL BOARD OF CALIFORNIA - DR. REGGIARDO

The Board proposed adoption of regulation establishing the application and renewal fees for the Oral Conscious Sedation Certification to be $200.00 and $75.00 respectively.

The Board approved a course proposed by the University of California San Francisco School of Dentistry as meeting the requirements set forth in regulation for which the oral conscious sedation certification could be issued upon satisfactory completion. The Board previously approved similar courses proposed by Loma Linda University School of Dentistry and CME Associates, a health education provider. The Board has received about 900 applications.

The Board's Ad Hoc Sunset Review Committee released in preliminary draft version the second part of its proposed report to the Board. The report is due for release in October in its final form. It appears that the Sunset Report will contain language indicating that consideration of specialty licensure will be part of the Board's future agenda.

A letter from Dr. Steven Schoenfield from CDA was received asking for CSPD input regarding dental assisting duties and length of training for the dental assistant. CDA's goal is to incorporate all input into a draft proposal that will be submitted to COMDA by mid-October for inclusion in its November task force agenda packet. The timeline does not allow for comprehensive input but there will be additional opportunities to offer detailed input regarding duties for dental assistants at a later time. Right now they are only asking for general input regarding typical duties that auxiliaries would be able to perform in our specialty, for them to present the concept to the taskforce.

The task force approved 17 previously adopted proposals for regulatory duty changes and approved language for the justification statements that will be presented with each recommendation to COMDA. Regarding the proposal of CSPD to permit sealant placement, the following wording was approved. To the allowable duties of the Registered Dental Assistant under direct supervision would be added. Apply pit and fissure sealants. (Evidence of satisfactory completion of a Board-approved course of instruction or equivalent instruction in an approved RDA program in this function must be submitted to the board prior to any performance thereof). The task force agreed to solicit and evaluate proposals for the modification or revision of the entire regulatory scheme governing auxiliary duties. One proposal to be considered will be specialty tract auxiliary categories, which is a modular program for the assistants. Dr. Reggiardo's suggestion at the present time is for CSPD to respond to CDA with the proposal for Preventive Dental Assistant category. (The license could include the taking of radiographs, sealant placement, coronal polish, fluoride gel & varnish application, and mouth guard impressions.) This will help all auxiliary staff be uniform in their allowable duties. The DBC is looking to have all RDA's certified in coronal polish and radiographs uniformly.

PATIENT SAFETY - DR. ROTHMAN:

Expressed his appreciation to the committee members for their hard work.

The charge to the committee is to identify and monitor issues and incidents related to patient safety in the dental office. Patient safety is limited to the areas of sedation and anesthesia delivered to infants, children and adolescents.

Please see page 11

Board Briefs... Continued from pg. 10

Dr. Rothman reported that all data retrieved is strictly confidential and the information gathered and analyzed is for the use of our members only for developing policies and guidelines.

The committee reviewed agencies and groups who they thought would have these policies in place. This is new territory; and most do not have this committee in their structure.

A data form will be developed which will allow consistent analysis of the data and reports will be made annually to our membership.

Officer's Reports

President - Dr. Luke

Correspondence

Dr. Luke sent a letter to Dr. Isman expressing CSPD's support for the DHS proposal to the Health Care Financing Administration for a grant to apply innovative methods of managing oral conditions among young children enrolled in Medi-Cal and the Healthy Families Program. Dr. Luke reported that the grant was approved.

A letter was written by Dr. Luke and addressed to Ms. Georgetta Coleman, Executive Officer, Dental Board of California. The purpose of the letter was to express CSPD's dismay over the recent ruling of the U. S. District Court in the case of Bingham v. Hamilton which, if left standing, appears to prohibit enforcement of a significant provision of Dental Board regulation governing the advertising of credentials by dentists. The board met in closed session and there is no public knowledge at this time as to the ultimate decision

A letter was drafted to Dr. Isman regarding the proposal of fluoride varnishing and the saliva testing of new mothers as added services for both the medical and the dental Medi-Cal programs. CSPD complimented the Office of Medi-Cal Services for their innovative thinking in their attempt to improve the dental health of our indigent population. The letter also posed some concerns with the proposal and some expectations if the services are approved.

PresidentElect - Dr. Perry

Strategic Plan Update - Dr. Perry went over the current strategic plan and "graded" the organization on each point. Overall success was achieved and he reported that he is hoping for the same for the next strategic planning session.

Vice President Report - Dr. Mungo

Dr. Mungo attended the AAPD legislative workshop for pediatric dentistry leaders that was held in Oakbrook, IL. He reported that the workshop was designed to enhance and build upon the skills of its attendees.

Executive Director - Dr. Rowan

Dr. Rowan requested a decision from the Board regarding a service contract for the copier that would cost $225 per year for quarterly servicing and full labor coverage for any repairs.

Dr. Rowan reported that the CSPD archive CD is complete and presented the President the first copy dated 1975-2000.

The President adjourned the meeting at 5:10 p.m.

Respectfully submitted by Lonnie Lovingier, DDS
Secretary

Web Notes

RECENT POSTING ON THE CSPD WEBSITE

WWW.CSPD.ORG

In What's New see:

Reprints from the Winter Bulletin

- **President's Message Winter 2000**
- **Board Briefs, Las Angeles**
- **News Briefs - Winter 2000**
- **Officers and Committees 2000-2001**
- **Sponsors 2000-2001**

The Surgeon General's Report on Oral Health the complete document in pdf format at http://silk.nih.gov/public/hck1ocv@www.surgeon.fullrpt.pdf

Sites related to the Surgeon General's Report on Oral Health

Centers for Disease Control - Oral Health Resources at http://www.cdc.gov/nccdphp/oh

You can download the GAO report in text or PDF format on the GAO website at www.gao.gov (Report No. GAO/HIEHS-00-72, April 12, 2000) or you can order a copy from the GAO's Document Distribution Center at 202-512-6000.

SELECTED WORLD WIDE WEBSITES WITH SCIENTIFICALLY VALID FLUORIDATION INFORMATION

CALIFORNIA SITES:

California Dental Association
http://www.cda.org/public/index.html

Califomia Fluoridation Now
http://www.deltadentalca.org/flo/flo/spr98.html

Delta Dental Plans of California
http://www.deltadentalca.org/sub/sub/fluor.html

Dental Health Foundation of California
http://www.dentathealthfoundation.org

Los Angeles Citizens for Better Dental Health
http://www.dhs.co.la.ca.us/phps/phwpost/watrfird.htm

Sacramento District Dental Society
http://wwwsdds.org/fluoride.htm

OTHER STATES'SITES:

Washington State Children's Alliance
http://www.childrensalliance.org/teeth/fluoride.htm

Washington State Dental Association
http://www.wsda.org/public/consumers/factsheets2.cfm?id=34

Washington State Oral Health Coalition
http://www.childrensalliance.org/teeth/washingt.htm

NATIONAL SITES:

American Academy of Family Physicians
http://www.aafp.org/policy/50.html

American Dental Association
http://www.ada.org/consumer/fluoride/fl-menu.html

American Society for Nutritional Sciences and the American Society for Clinical Nutrition
http://www.faseb.org/ain/fluoridation.html

National Center for Fluoridation Policy & Research
http://fluoride.oralhealth.org

U. S. Centers for Disease Control, Division of Oral Health
http://www.cdc.gov/nccdphp/oh

U. S. National Institutes of Health, National Center for Dental & Craniofacial Research
http://www.cyberdentist.com/fluoride.htm#q1
http://www.nidr.nih.gov

U. S. Public Health Service (Report on Fluoride Benefits & Risks)
http://www.cda.org/public/pubhsrvc.html

El Primer Informe Del Cirujano General Sobre Salud Oral Encuentra Disparidades Profundas Entre La Poblacion A Nivel Nacional
http://www.nidcr.nih/gov/news/052500spanish.htm

INTERNATIONAL SITES:

British Fluoridation Society
http://www.derweb.ac.uk/bfs/index.htm

Calgary (Alberta, Canada) Regional Health Authority
http://www.crha-health.ab.ca/pophlth/hp/fluoride

Note:
Sites "Not Found" can ordinarily be accessed if file extensions are deleted and the homepage address is inserted.

CALIFORNIA SOCIETY OF PEDIATRIC DENTISTS
P.O. BOX 6396
SAN PEDRO, CA 90734-6396

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Annual Meeting
2001 Sacramento ..... Richard Mungo
Annual Meeting 2002 Anaheim Lonnie Lovingier
Annual Meeting 2003 Victoria ..... Ann Azama
Annual Meeting 2004 Site Selection Ann Azama & Cathy Christensen
Mel Rowan

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Ad Hoc Committee on Improving Access to Care ..... David Perry
Mark Lisagor
Fred Coleman
Ray Stewart
Francisco Ramos-Gomez
Andrew Soderstrom
Richard Udin
Julie Jenks
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Ad Hoc Committee on Patient Safety ..... David Rothman
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