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# Providing excellence in the care of children affected by decay

A quick reference guide for the dental team

# Foreword

Good oral health is an important part of wellbeing. In children, it contributes to physical, educational and social development. A third of 5 year olds in 2015 - 16 had experienced tooth decay. Despite recent improvements in children's oral health thanks to programmes such as Designed to Smile many children in Wales are not being taken for routine dental care.

The aim of the guide is to support primary care clinical dental teams manage and treat children with decay effectively. In doing so they will contribute to reducing the number of children requiring general anaesthetic for the extractions of teeth in Wales.

We hope you find this book useful.

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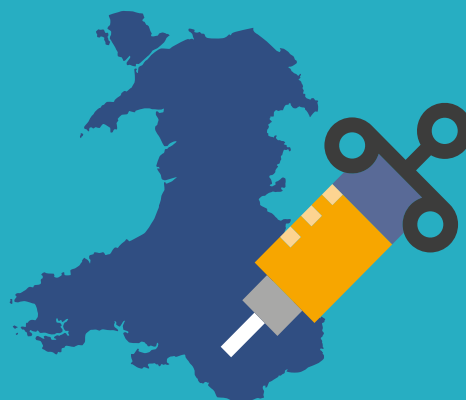


# Context

By the time children reach school age in Wales almost a third are affected by decay, a preventable disease. The disease starts early and in some communities 20% of 3 year olds already have childhood decay.



A total of 6,582 dental general anaesthetics (DGA) were performed in Wales during 2018-19. That equates to one in every 111 children across Wales<sup>1</sup>.



We understand the barriers to managing paediatric patients in primary care, however you will see from this guide that there are multiple caries management options and with the correct technique and appropriate patient selection, most children can be treated successfully in primary care.

Our intentions are to bridge the divide between the primary, secondary and tertiary care setting and to support each other in our collaborative role in improving oral health in children.

This booklet contains the most relevant recommendations from up to date evidence-based guidelines (see references). The main guidance and images used to develop this booklet are from the Scottish Dental Clinical Effectiveness Program Guideline (SDCEP) on the Prevention and Management of Caries in Children (2010 and 2018). Within this booklet readers are advised to read the full guidance<sup>2</sup> for further information.

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# 1 Providing excellence in the provision of dental treatment to children with decay

**Dental decay is largely preventable however many children continue to be affected and when this occurs it needs to be managed proactively and treated effectively.**

We aim to encourage routine and regular contact with primary care dental teams to prevent disease.

## **Priorities of care:**

- Create a positive child friendly environment

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- Manage pain

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- Prevent and manage decay in the permanent dentition

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- Reduce the risk of decay in the primary dentition causing pain or sepsis before the tooth exfoliates

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- If possible, maintain second primary molars in order to retain space.

# 2 Annual Assessment of need and risk (ACORN)

**All children should have a comprehensive examination at least once annually and a personalised plan for the year agreed. Don't overlook the fact that plaque is a significant indicator of future decay.**

## **During examination:**

- Clean and dry tooth surfaces
- Examine every tooth surface individually
- Reserve probing for exposed carious dentine not intact pits and fissures.

## **Record impact of disease such as pain and days off school:**

- Involve the parents and ask about difficulty eating, drinking and sleeping.

**Assess the risk of pain and sepsis developing before the tooth exfoliates.**



# 3 Sepsis in primary teeth

## Signs of sepsis:

- Alveolar tenderness

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- Sinus

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- Swelling

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- Non-physiological mobility compared to healthy contralateral tooth

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- Inter-radicular radiolucency.



Sinus associated with URD



Inter-radicular radiolucency LRD

## 4 Assessing the risk of pain or sepsis developing before exfoliation

**Assessing the risk of pain or sepsis occurring will aid your decision on the most appropriate management option for primary carious lesions.**

Operative management is not always necessary (see pages 20, 22-23) and therefore the clinician should assess whether the carious lesions diagnosed are low or high risk of causing pain and sepsis.

### **Lesions in primary teeth at low risk of causing pain or sepsis**

None of the following lesions have clinically evident signs or symptoms of pain or sepsis, and it is likely that they will proceed to exfoliation without causing further problems, provided they are closely monitored and the patient is given Enhanced Prevention (see section 6 for details).



Pulp polyp URE



Retained roots LLD



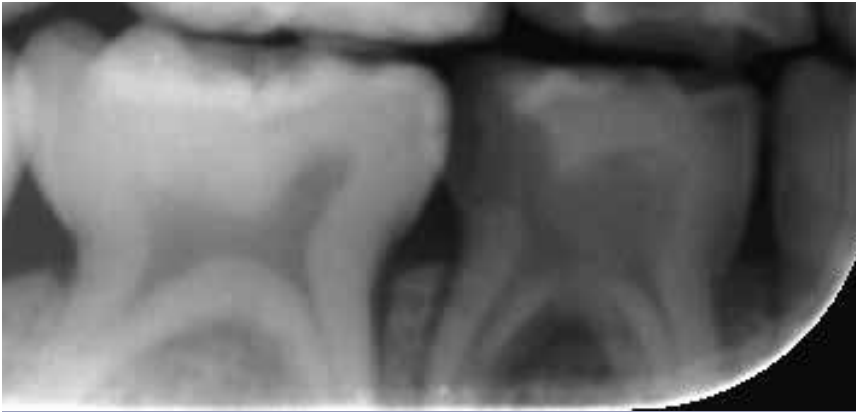
Arrested caries URE.  
(Dark colour but hard)



Arrested caries URD.  
(Light coloured but hard)

### Lesions in primary teeth with high risk of causing pain or sepsis

None of the following lesions have clinically evident signs or symptoms of pain or sepsis, but are likely to be associated with pain or sepsis before exfoliation if left unmanaged.



Radiographic exposure of the pulp LRD



Large active lesion LLE with several years before exfoliation and pulp exposure



Early distal lesion URD and deep occlusal lesion URE in a young patient



# 5 Radiographic assessment

## Indications for bitewings: children age 4+ if cooperative

- FGDP radiography guidelines<sup>3</sup> on frequency of bitewings:

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- **High risk:** 6 - 12 months

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- **All children:** 24 months

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- **Contraindications:**

- Lack of compliance, spaced dentition

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- **Of note:**

- Broad contact points make clinical diagnosis of interproximal lesions more difficult
- Distance between pulp horn and enamel is smaller than in permanent teeth so caries reaches the pulp more quickly
- Watch for triangle-shaped radiolucencies (mesial of Es and 6s) as these can be due to anatomical anomalies such as a cusp of Carabelli rather than caries.



Notice the mesial radiolucency of the ULE indicates an anatomical anomaly rather than caries

# 6 Decay risk indicators

**Main evidence-based indicators of a child being at increased risk of developing caries within the next 3 years are previous decay experience, being resident in an area of deprivation and the dental professional's opinion.**

As part of the contract reform process in Wales a need and risk assessment tool has been developed and is an example of best practice clinical assessment. You don't need to be part of the programme to access the resources.

**ACORN (Assessment of Clinical Oral Risks and Needs)** is a tool used to determine a patient's clinical needs based on patient complexity, exposure to risk and clinical findings. It includes the following indicators that may change your management of patients and identify those giving concern who will require more intervention.

• **Medical history:**

Conditions that will put a patient at risk of developing dental disease e.g. poorly controlled diabetes.

Conditions that will put a patient at risk when receiving dental treatment e.g. cardiac condition.

• **Social history:**

Care needs that could put a child at increased risk such as a child over 7 years of age who is not able to carry out oral hygiene practices without assistance.

Social issues causing complexity in providing dental care such as a 'looked after child'.

• **Dental history:**

Severe dental phobia or anxiety affecting attendance.

At assessment confirm if any of the above categories have positive findings. This indicates complexity.

**Following clinical examination record the dental status:**

**Red** Active disease

**Amber** At risk behaviours or context that places children at risk

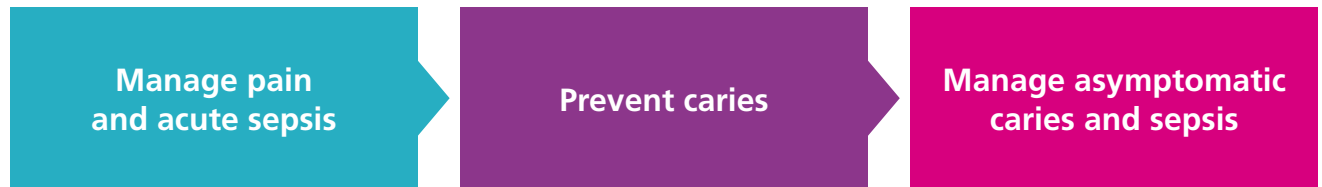
**Green** No clinical need low risk

Record in clinical notes and use when planning preventive care for patients and deciding on radiograph frequency and dental recall intervals<sup>4</sup>.



# 7 Care sequence

Once the child has been assessed, the care sequence outlined below should be followed.



# 8 Managing pain and acute sepsis: Care pathway

Manage pain and acute sepsis

Prevent caries

Manage asymptomatic caries and sepsis

## Reversible pulpitis

Pain to cold/sweet, poorly localised, pain resolves on removal of stimulus

Pre-cooperative child\*

Cooperative child

Excavate caries and dress. Not all caries has to be removed. Avoid exposure and ensure that the restoration has a good seal.

Give LA, remove caries and restore.

Pain relief and review in 7 days.

## Irreversible pulpitis

Spontaneous pain, wakens child at night, pain to hot/cold, not resolved on removal of stimulus

Pre-cooperative child/multiple abscesses

Cooperative child

Attempt partial caries excavation, and apply a corticosteroid-antibiotic paste e.g. Odontopaste, cotton wool and a glass ionomer restoration.\* Refer for extraction with inhalation sedation or GA.

Give LA, remove caries and apply a corticosteroid-antibiotic paste lining, cotton wool and a glass ionomer restoration or XLA.

Pain relief and review in 7 days.

## Dental abscess

Spontaneous pain, wakens child at night, tooth tender to percussion, swelling, malaise

Pre-cooperative child

Cooperative child

Refer for extraction with inhalation sedation or GA. If indicated prescribe antibiotics and pain relief.

Excavate caries to access pulp chamber and commence drainage, place cortico-steroid antibiotic paste e.g. Odontopaste in pulp chamber, cotton wool and plain ZOE. If indicated prescribe antibiotics (Section 10). Prescribe pain relief (Section 9), review 2/7 and 7/7.

Pulp therapy extraction or referral.

\*Option also suitable for a cooperative child on emergency visit.

# 9 Pain relief for children

- Paracetamol and Ibuprofen are recommended for pain relief in children. Aspirin should be avoided in patients under 16 due to risk of Reye's syndrome. Avoid NSAIDs in children with asthma, known allergy, peptic ulcer disease, those on oral anticoagulants or those who have an inherited bleeding disorder. Use NSAIDs with caution in patients with renal, cardiac or hepatic impairment
- Pain relief should be prescribed only as a temporary measure. Ensure that the underlying cause of the pain is managed
- If the following regime is ineffective refer the patient to the general medical practitioner.



## For mild to moderate odontogenic or post-operative pain, an appropriate 5-day regimen is:

For children	
Paracetamol Tablets or Soluble Tablets, 500mg, or Oral Suspension*, 120mg/5ml or 250mg/5ml	
6 months - 1 year	120mg four times daily (max. 4 doses in 24 hours)
2 - 3 years	180mg four times daily (max. 4 doses in 24 hours)
4 - 5 years	240mg four times daily (max. 4 doses in 24 hours)
6 - 7 years	240-250mg four times daily (max. 4 doses in 24 hours)
8 - 9 years	360-375mg four times daily (max. 4 doses in 24 hours)
10 - 11 years	480-500mg four times daily (max. 4 doses in 24 hours)
12 - 15 years	480-750mg four times daily (max. 4 doses in 24 hours)
16 - 17 years	500mg-1g four times daily (max. 4 doses in 24 hours)

## For mild to moderate odontogenic or post-operative or inflammatory pain, an appropriate 5-day regimen is:

For children	
Ibuprofen Oral Suspension*, 100mg/5ml or Ibuprofen Tablets, 200mg	
6 - 11 months	50mg four times daily, preferably after food
1 - 3 years	100mg three times daily, preferably after food
4 - 6 years	150mg three times daily, preferably after food
7 - 9 years	200mg three times daily, preferably after food
10 - 11 years	300mg three times daily, preferably after food
12 - 17 years	300-400mg four times daily, preferably after food

\*Prescribe sugar-free forms.

# 10 Antibiotics for children

**Indications:** Systemic signs of infection (<36°C and >38°C), spreading infection, unable to achieve drainage.

First-line antibiotics	
Amoxicillin Capsules, 250mg, Oral Suspension*, 125mg/5ml, or 250mg/5ml	

6 - 11 months	125mg three times daily
1 - 4 years	250mg three times daily
5 - 11 years	500mg three times daily
12 - 17 years	500mg three times daily

Metronidazole Tablets, 200mg, or Oral Suspension, 200mg/5ml	
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1 - 2 years	50mg three times daily
3 - 6 years	100mg three times daily
7 - 9 years	100mg three times daily
10 - 17 years	200mg three times daily

- Above regimens are for 5 days
- **In cases of severe infection for:**
  - **Children up to age 11:** Can increase dose of amoxicillin to 30mg/kg (max 1g) TDS and dose of metronidazole to 7.5mg/kg (max 400mg) TDS
  - **Children age 12 - 17:** Can double dose of amoxicillin and metronidazole
- Can use metronidazole as an alternative in penicillin allergic patients or as an adjunct in severe infections.

Second-line antibiotics	
Clarithromycin Tablets, 250mg or Oral Suspension 15mg/5mL or 250mg/5mL	

1 - 11 years Body weight 8-11kg	62.5mg two times daily
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1 - 11 years Body weight 12-19kg	125mg two times daily
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1 - 11 years Body weight 20-29kg	187.5mg two times daily
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1 - 11 years Body weight 30-40kg	250mg two times daily
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12 - 17 years	250mg two times daily
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**Clindamycin** 12 - 17 years:  
150mg four times daily for 5 days

**Co-amoxiclav 250/125** 12 - 17 years:  
1 tablet three times daily for 5 days

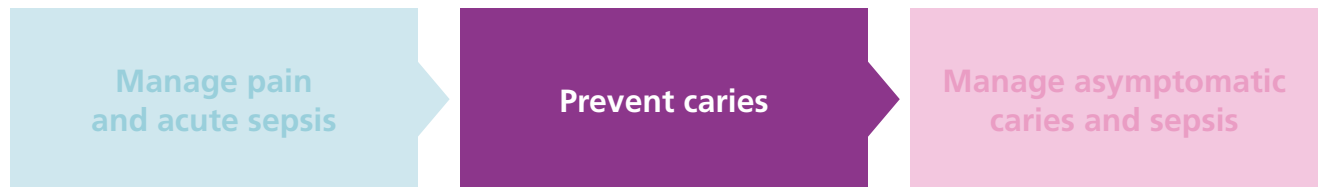
- Above regimens are for 7 days
- To be prescribed only if the patient does not respond to first line antibiotics. Consider referring or speaking to a specialist before prescribing.

\*Prescribe sugar-free forms.

# 11

## Consistent proactive prevention

Despite careful assessment and history taking dental teams cannot always predict *all* children at risk. Therefore the approach is to offer *all* children preventive intervention and advice. Those who are giving concern need to receive more.



# 12 Don't forget diet advice

- Maximum of 4 sugar hits/day

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- Keep sugar to mealtimes whenever possible

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- Avoid hidden sugars

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- Water/milk only between meals

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- Use sugar free snacks and alternatives

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- Avoid sugary snacks and drinks within an hour of bed time

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- Only water in a bottle at bedtime

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- Brushing last thing before bed.



**One change at a time  
don't overwhelm parents  
with advice**

- Start with 'golden' hour before bed
- Encourage patients and parents to look at food labels. They are colour coded. You can look at per 100g to compare different products
- The scientific advisory committee on nutrition now advises that free sugars should make up a maximum of 5% of daily energy intake (6 teaspoons of sugar/day).



# 13 Action planning

**Action planning is a simple technique that makes preventive advice achievable, less time consuming for the clinical team and more specific to the patient and family. Use the skills and capacity of the whole team to deliver this.**

It's about identifying barriers to undertaking good oral hygiene and dietary practices. The steps involved are:

- Identify the barrier by asking simple questions. Examples of barriers: child forgets to brush teeth, doesn't like the taste of toothpaste, grandparents buy child sweets everyday.
- 
- Make an action plan. Emphasise one key point per contact so that it's achievable.  
For example choose from:
    - Prioritise bedtime tooth brushing
    - Use a family fluoride toothpaste
    - Nothing sweet to eat or drink in the hour before bed.
- 
- Agree the personal prevention plan with the family for them to take away and record it in the clinical records.



# 14 Topical fluoride

## Prevention (for those with active decay or at risk):

- Apply sodium fluoride varnish (5%) 4 times per year to children over 2 years of age and earlier if signs of decay
- Design to Smile doesn't apply fluoride varnish to all school children and if applying will only apply once or twice a year. For children having this done in school, fluoride varnish should still be applied twice a year.

**Duraphat contains 22,600 ppm**

Manufacturer recommends:

2 - 5 years: 0.25ml

6+ years: 0.4ml

## Contraindications:

- Allergy to colophony
- Allergy to sticking plasters
- Child who has been hospitalised for severe asthma in the last 12 months.



# 15 Fissure sealants

- Permanent teeth are most at risk of decay during and immediately following eruption
- Fissure sealants are an effective intervention that should be considered for children with active decay in deciduous and permanent teeth or who are at increased risk
- Resin-based sealants are the preferred choice of sealant
- Glass ionomer cement can be used on partially erupted permanent molars or in pre-cooperative children as a temporary measure using the 'finger press technique' as described below.

## Finger press technique

- 1 Place a small amount of glass ionomer on one finger tip, and vaseline on the adjacent finger.
- 2 If possible wipe the tooth surface with a cotton wool roll. Firmly apply the finger tip with glass ionomer to the tooth surface to be sealed. Keep finger in place for 2 minutes.
- 3 Place the second finger in the mouth, and rapidly switch fingers, to allow coverage of the glass ionomer with vaseline before moisture contamination. Fuji Triage can be used in these case.



- Remember to seal buccal and palatal pits of molars
- Other teeth such as Es, 4s and 5s and palatal pits of upper lateral incisors can be sealed
- Always check the integrity of existing fissure sealants at recall intervals and top up worn sealants if needed.

# 16 Managing asymptomatic primary caries and chronic sepsis: Care pathway

Manage pain and acute sepsis

Prevent caries

Manage asymptomatic caries and sepsis

- This pathway is recommended for children with no medical problems
- Managing caries in the primary dentition is best undertaken without inducing dental treatment anxiety
- Leaving acute sepsis untreated is not an option, however you can leave asymptomatic sepsis for up to 3 months in order to acclimatise the child for definitive treatment.

Caries into enamel

Caries into dentine

Caries into pulp/chronic sepsis

## Enhanced prevention

Apply fluoride to enamel lesions if not contraindicated

**Select most appropriate management option subject to patient cooperation**

**Cooperative:** Pulp treat and restore if < 3 pulpally involved teeth or XLA (see section 19)

**Pre-cooperative:** stabilise with temporary restorations and acclimatise child for definitive treatment (up to a maximum of 3 months), consider extraction (LA/IHS/GA)

**If > 3 pulpally involved teeth:** consider extraction (LA/IHS/GA)

## Local anaesthetic options

- 1 Conventional local anaesthetic.
- 2 The Wand Local Anaesthetic delivery system. This is a computerised LA delivery device, which can be used for buccal infiltrations, ID blocks and for intraligamental injections. It delivers anaesthetic at a slow speed to improve patient comfort and is routinely used by Specialists in Paediatric Dentistry.



# 17 The Hall Technique

## Effective restoration for deciduous teeth

- 1** Ensure that the parents and patient are aware of the fact the crown is metal. Useful terminology for children are 'pirate teeth' or 'princess teeth'.
- 2** Assess need for separators (place 3 - 5 days before fit appointment). Topical anaesthetic can be applied to the gingivae when placing separators to reduce discomfort.
- 3** Sit the child upright and use gauze to protect airway.
- 4** Select the correct size. There should be 'spring back' at the contact points.
- 5** Avoid seating fully at this can be difficult to remove.
- 6** Use a glass ionomer luting cement such as Ketac Cem (3M ESPE).
- 7** Seat the crown down over the tooth. You can use cotton wool rolls to assist with seating the crown or ask the child to bite down.
- 8** Remove excess cement and floss the contact points.



# 18 Management options for primary caries

## Complete caries removal and restoration/crown

- Gold standard
- Conventional restoration placed under local anaesthetic
- **Recommended materials:** Composite e.g. Dentsply Sply Spectrum, resin modified glass ionomer e.g. GC Fuji LL LC, GC Fuji VIII, 3M Photac FIL Quick, Compomer e.g. Dyract flow.

## Selective caries removal and restoration

- Partial caries removal only
- Remove sufficient carious tooth tissue to enable an effective marginal seal when using an adhesive restorative material
- No LA needed
- Reduces risk of pulp exposure
- **Recommended materials:** Adhesive material such as resin modified glass ionomer e.g. GC Fuji II LC, GC Fuji VIII, 3M Photac Fil Quick, Compomer e.g. Dyract flow plus fissure sealant (class I) or Hall Crowns (class II).

## No caries removal, seal with restoration

- Aims to seal carious lesion from oral environment to stop progression
- **Clinical indications:** non-cavitated occlusal lesions (fissure sealant) or class II lesions with no pulpal involvement (Hall crown)
- Can use the finger press technique (page 19).

## Non-restorative cavity control

- Aims to reduce the cariogenic potential of the lesion by altering the environment of the plaque biofilm overlying the lesion
- Suitable for primary teeth with arrested caries or where the tooth is unrestorable and close to exfoliation
- Suitable for primary teeth with advanced lesions and where alternative methods are not feasible
- The lesion should be made self-cleansing by removal of plaque retentive areas such as enamel overhangs
- Must be used in conjunction with site-specific prevention.

## Site-specific prevention

- Suitable for asymptomatic lesions in pre-cooperative children
- Demonstrate tooth brushing
- Give dietary advice
- Apply fluoride varnish four times/year
- Record the size, colour and consistency of lesions in the clinical notes.

## Extraction

- Avoid at first visit if possible
- Consider dressing symptomatic lesions with odontopaste, cotton wool and a temporary filling such as kalzinol or glass ionomer
- Referral can be made for extraction under inhalation sedation or GA (page 25) if child will not accept this under LA.

**Your choice will depend on patient cooperation. All options are appropriate so long as you can justify your decision and document this in the clinical records.**

**For children with no medical problems, the preferred treatment options are indicated.**

Technique		Site-specific prevention	No caries removal and seal using the Hall Technique	No caries removal and seal with fissure sealant (or infiltration)	Selective caries removal and restoration	Non-restorative cavity control	Complete caries removal and restoration/crown	Extraction
Tooth/Lesion								
Tooth near to exfoliation		✓				✓		
Any tooth with arrested caries - aesthetics not a priority*		✓				✓		
Occlusal	Initial	✓		✓				
	Advanced				✓			
Proximal	Initial	✓						
	Advanced		✓					
Anterior	Initial	✓						
	Advanced				✓		✓	
Unrestorable tooth (pain/infection free)						✓		✓

# 19 Pulp treatment (SDCEP)

## Vital pulp therapy

Indications = irreversible pulpitis or radiographic signs of pulpal involvement.

## Contra-indications to pulp therapy

- Tooth close to exfoliation
- Multiple pulp therapies needed
- Unrestorable tooth
- Pre-cooperative child.

## Non-vital pulp therapy

Indications = dental abscess/ non-vital pulp.

**Give local anaesthetic, cut cavity and remove the roof of the pulp chamber.**

Remove contents of pulp chamber using a slow handpiece or excavator.

Remove contents of pulp chamber using a slow handpiece or excavator. Remove necrotic tissue from entrance of root canal using a straight probe.

Irrigate pulp chamber with water from 3-in-1 syringe (avoid using compressed air due to risk of surgical emphysema), if bleeding use cotton wool with ferric sulphate. Dry the chamber with cotton wool.

Irrigate pulp chamber with water from 3-in-1 syringe (avoid using compressed air due to risk of surgical emphysema). Local anaesthetic can be used to irrigate canals. Dry the chamber with cotton wool.

Place zinc oxide eugenol cement in the pulp chamber. Setting calcium hydroxide cement (e.g. Dycal) or MTA may first be placed on pulp stumps and the floor of the pulp. Restore with a preformed metal crown using a conventional preparation.

Place non-setting calcium hydroxide paste or MTA in the coronal section of the canals and fill the cavity with zinc oxide eugenol cement, place a preformed metal crown.

Annual radiographic review.

If tooth remains symptomatic or a sinus develops or is still present after 3 months, extract the tooth.



## 20 Referral for specialist care

- When it is not feasible to provide necessary treatment, a referral should be made to a more appropriate service. Remember that if the patient has been referred for a single course of treatment, it is important that you continue to see the patient for routine care and prevention.
- Some children are un or pre cooperative and will require behavioural or pharmacological support such as IV/IHS sedation or GA.
- **Decay alone or age is not an indication to refer a child for general anaesthetic. A child who presents with multiple carious lesions with low risk of developing pain or infection and who has difficulty accepting treatment could well be managed by a prevention only approach until they are more acclimatised to dental treatment.**
- Before making a referral, treat acute pain, provide prevention and attempt treatment using one of the management options outlined in conjunction with behavioural management techniques. If this fails then refer to a community or hospital dental service for assessment and justify the request for sedation or general anaesthesia.
- **Referral alone is not a management option for acute dental pain. The referring practitioner has a duty of care to manage this. It is good practice to dress open cavities to reduce risk of pain while the patient waits to be seen.**



### Inhalation sedation:

- Suitable for children over 5 years who understand the concept of nose breathing.

### Intravenous sedation:

- For teenage patients (over age 12).

### General anaesthetic:

- GA may be the most suitable option for pre-school children, those who require multiple extractions or those undergoing traumatic procedures, **however it is important to consider GA as the last resort.**

## Specialists in Paediatric Dentistry in your area:

Health Board	Community Specialist in Paediatric Dentistry	Referral address
Cardiff and Vale	Tracy Butler	Community Dental Service Riverside Health Centre Wellington Street Cardiff CF1 9SH
Aneurin Bevan	Tracy Butler Hannah Ilett	Vicki Jones Clinical Director of CDS Grange House Llanfrechfa Grange Cwmbran, Torfaen NP44 8YN
Cwm Taf	Lois Davies	Dental Department Keir Hardie Health Park Aberdare Road Merthyr Tydfil CF48 1BZ
Swansea Bay	Rohini Mohan	CDS appointments/waiting list coordinator Dental Department Central Clinic Orchard Street Swansea SA1 5AT
Hywel Dda	Rohini Mohan	Primary Dental Care Services Glangwili Hospital Carmarthen SA31 2AF
Betsi Cadwaladr (Bangor)	Paul Leach	Dental Office Bodfan Ysyty Eryri Caernarfon, Gwynedd LL55 2YE
Betsi Cadwaladr (Wrexham)	Janine Bailey	Wrexham Community Dental Clinic Grove Road Wrexham LL11 1DY

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## 22 Acknowledgements

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