

Prescribing Dental Radiographs for Infants, Children, Adolescents, and Individuals with Special Health Care Needs

Latest Revision

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Purpose

The American Academy of Pediatric Dentistry (AAPD) intends these recommendations to help practitioners make clinical decisions concerning appropriate selection of dental radiographs as part of an oral evaluation of infants, children, adolescents, and individuals with special health care needs. The recommendations can be used to optimize patient care, minimize radiation burden, and allocate health care resources responsibly.

Methods

In 1981, the Ad Hoc Committee on Pedodontic Radiology of the American Academy of Pedodontics developed guidance on radiographic examination of pediatric dental patients.¹ Six years later, the U.S. Food and Drug Administration (FDA) published recommendations² developed by an expert dental panel, which included a representative of the AAPD, convened “to reach a consensus on standardizing dental radiographic procedures.”³ In 2002, the American Dental Association (ADA) initiated a review of that document. The AAPD, along with other dental specialty organizations, participated in the review and revision of those guidelines. The FDA accepted the revision in November 2004,⁴ and the AAPD endorsed it the following Spring. This review includes a new search of the PubMed®/MEDLINE database using the terms: dental radiology, dental radiographs, dental radiography, cone-beam computed tomography AND guidelines, recommendations; fields: all; limits: within the last 10 years, humans, and English. The ADA Council on Scientific Affairs has published updates to their recommendations for dental radiographs.^{5,6} The AAPD’s Council of Clinical Affairs has developed these best practices and continues to endorse the ADA/FDA’s recommendations.

Background

Radiographs are valuable aids in the oral health care of infants, children, adolescents, and individuals with special health care needs. They are used to diagnose and monitor oral diseases, evaluate dentoalveolar trauma, as well as monitor dentofacial development and the progress of therapy. The recommendations in the ADA/FDA guidelines were developed to serve as an adjunct to the dentist’s professional judgment. The timing

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of the initial radiographic examination should not be based upon the patient’s age, but upon each child’s individual circumstances. Radiographic screening for the purpose of detecting disease before clinical examination should not be performed.⁶ Because each patient is unique, the need for dental radiographs can be determined only after consideration of the patient’s medical and dental histories, completion of a thorough clinical examination, and assessment of the patient’s vulnerability to environmental factors that affect oral health. AAPD’s recommendations for assessing risk for caries development in children ages 0-5 years and ≥ 6 years can be found in *Caries-risk Assessment and Management for Infants, Children, and Adolescents*.⁷ Review of prior radiographs, when available from within the same practice or through record transfer, also contributes to the decision of radiographic necessity.

Radiographs should be taken only when there is an expectation that the diagnostic yield will affect patient care. The AAPD recognizes that there may be clinical circumstances for which a radiograph is indicated, but a diagnostic image cannot be obtained. For example, the patient may be unable to cooperate or the dentist may have privileges in a health care facility lacking intraoral radiographic capabilities. If radiographs of diagnostic quality are unobtainable, the dentist should confer with the parent to determine appropriate management techniques (e.g., preventive/restorative interventions, advanced behavior guidance modalities, deferral, referral), giving consideration to the relative risks and benefits of the various treatment options for the patient.

Because the effects of radiation exposure accumulate over time, every effort must be made to minimize the patient’s exposure. Good radiological practices are important in minimizing or eliminating unnecessary radiation in diagnostic dental imaging. Examples of good radiologic practice include:

ABBREVIATIONS

AAOMR: American Academy of Oral and Maxillofacial Radiology.
AAPD: American Academy of Pediatric Dentistry. **ADA:** American Dental Association. **CBCT:** Cone-beam computed tomography.
FDA: U.S. Food and Drug Administration.

1) use of the fastest image receptor compatible with the diagnostic task (F-speed film or digital), 2) collimation of the beam to the size of the receptor whenever feasible, 3) proper film exposure and processing techniques, 4) use of protective aprons and thyroid collars, when appropriate, and 5) limiting the number of images to the minimum necessary to obtain essential diagnostic information.⁶ The dentist must weigh the benefits of obtaining radiographs against the patient's risk of radiation exposure.

New imaging technology (i.e., cone beam computed tomography [CBCT]) has added three-dimensional capabilities that have many applications in dentistry. The use of CBCT has been valuable as an adjunct diagnostic tool in assessing periapical pathosis in endodontics, oral pathology, anomalies in the developing dentition (e.g., impacted, ectopic, or supernumerary teeth), oral maxillofacial surgery (e.g., cleft palate), dental and facial trauma, and orthodontic and surgical preparation for orthognathic surgery. The American Academy of

Table. RECOMMENDATIONS FOR PRESCRIBING DENTAL RADIOGRAPHS⁶

Patient Age and Dental Developmental Stage				
Type of Encounter	Child with Primary Dentition (prior to eruption of first permanent tooth)	Child with Transitional Dentition (after eruption of first permanent tooth)	Adolescent with Permanent Dentition (prior to eruption of third molars)	Adult, Dentate or Partially Edentulous
New Patient* being evaluated for oral diseases.	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.	
Recall Patient* with clinical caries or at increased risk for caries.**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe.			Posterior bitewing exam at 6-18 month intervals.
Recall Patient* with no clinical caries and not at increased risk for caries.**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe.		Posterior bitewing exam at 18-36 month intervals.	Posterior bitewing exam at 24-36 month intervals.
Patient (New and Recall) for monitoring of dentofacial growth and development, and/or assessment of dental/skeletal relationships.	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships.		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars.	Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/endodontic needs, treated periodontal disease and caries remineralization.	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these conditions.			

* Clinical situations for which radiographs may be indicated include, but are not limited to:

A. Positive Historical Findings

1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies
4. Postoperative evaluation of healing
5. Remineralization monitoring
6. Presence of implants, previous implant-related pathosis or evaluation for implant placement

B. Positive Clinical Signs/Symptoms

1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract ("fistula")
9. Clinically suspected sinus pathosis
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical tooth erosion
23. Peri-implantitis

** Factors increasing risk for caries may be assessed using the ADA Caries Risk Assessment forms (0–6 years of age⁸ and over 6 years of age⁹).

Oral and Maxillofacial Radiology (AAOMR) has published position statements which summarize the potential benefits and risks of maxillofacial CBCT use in orthodontic and endodontic diagnosis, treatment, and outcomes and provides clinical guidance to dental practitioners.^{10,11} The AAOMR's position statements support and affirm the position of the ADA Council on Scientific Affairs in that the selection of CBCT imaging must be justified based on individual need.¹⁰⁻¹² Because this technology has potential to produce vast amounts of data and imaging information beyond initial intentions, it is important to interpret all information obtained, including that which may be beyond the immediate diagnostic needs or abilities of the practitioner.

Recommendations

The recommendations of the ADA/FDA guidelines are contained within the accompanying Table. "These recommendations are subject to clinical judgment and may not apply to every patient. They are to be used by dentists only after reviewing the patient's health history and completing a clinical examination. Even though radiation exposure from dental radiographs is low, once a decision to obtain radiographs is made it is the dentist's responsibility to follow the as low as reasonably achievable (ALARA principle) to minimize the patient's exposure."⁶

Intraoral imaging should be maintained as the standard diagnostic tool. The use of CBCT should be considered when conventional radiographs are inadequate to complete diagnosis and treatment planning and the potential benefits outweigh the risk of additional radiation dose. It must not be routinely prescribed for diagnosis or screening purposes in the absence of clinical indication. Basic principles and guidelines for the use of CBCT include: 1) use of appropriate image size or field of view, 2) assess the radiation dose risk, 3) minimize patient radiation exposure and, 4) maintain professional competency in performing and interpreting CBCT studies.¹⁰⁻¹³ When using CBCT, the resulting imaging is required to be supplemented with a written report placed in the patient's records that includes full interpretation of the findings.

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