

Reader Disappointed in Pediatric Issue

The articles in the October 2009 issue of the *Journal of the California Dental Association* “Good, Clinical Pain Practice for Pediatric Procedure Pain: Target Considerations” (pages 719-722) and “Good, Clinical Pain Practice for Pediatric Procedure Pain: Iatrogenic Considerations” (pages 713-718), by Dennis Nutter, DDS, were very disappointing. I am a board-certified pediatric dentist and I found both pieces offensive.

There are numerous statements made that are not supported by references. These all should be interpreted as options and not supported facts.

The author contradicted himself when he pointed out in “Iatrogenic Considerations” that “there does not yet exist reliable, objective, measure of pediatric pain.” Yet, in “Target Considerations” he stated, “When pain is a possibility, it should be measured.”

He complained about the use of restraints, voice control, and hand over mouth. Hand over mouth has been out of use for a number of years. The use of restraints is slowly falling to the wayside as pediatric dentists are using sedation methods more. I find it interesting that I have read complaints in the *Journal of the American Academy of Pediatric Dentistry* that pediatric dentists have gotten away from behavior management methods and depend on pharmaceutical methods more. The author quoted a paper citing a very low number of pediatric dentists using sedation methods, yet everyone I know of uses nitrous oxide/oxygen on a daily basis. For the more uncooperative children, they use oral sedation and/or intravenous sedation administered by an anesthesiologist. These two methods can be quite stressful, but there are children who are untreatable with less invasive methods.

Which brings up another point. What about those patients who enter your office screaming and crying for their first dental appointment anywhere? Did their parent’s car inflict pediatric pain? The parking lot? A good rule of thumb is, if the patient can sit for a haircut then he/she will sit for a dental exam. I have had numerous patients cry because they are scared then tell me they did not feel a thing when they were done.

The author quoted a 1994 study where “11 percent of practicing Seattle-area dentists strongly agreed with denying the pain reports of children.” This means that 89 percent did not agree. He went on to say “and a large majority of the dentists in the study doubted that authenticity of children’s behavioral pain reports issuing during invasive procedures.” What was the percentage for this statement? A large majority can be interpreted numerous ways, 51 percent or 90 percent, depending on the individual.

Let’s be realistic. Some children cry for dental procedures, no matter what the dentist does. Just like there are adults who complain of everything a dentist may do. I am sure there is a percentage of children who do experience pain, but most will tell you versus becoming unruly. Good communication is very important when treating children.

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Dr. Nutter Responds

The focus of Dr. Ripley’s letter is a rejection of the first principle of good clinical pain practice that compels clinicians to treat a child’s pain reports as credible under conditions of tissue trauma or as clinical pain authority Patricia McGrath put it, “that only the



child can know how much pain they are experiencing.” This is not a point that I will concede. How much pain a clinician chooses to justify hinges on who is deciding that question — the clinician or the child. I have amply documented my reasons for agreeing with Patricia McGrath, Donald Price, and others that it is the child who must decide how much pain they are experiencing.

The writer’s confusion about pain measurement is understandable given the scant training that most dental clinicians receive in this area. Clinician estimations of pain intensity are influenced by subjective bias and the patient’s own pain reports are themselves reflections of the subjective nature of pain. This subject deserves further study in greater detail.

The writer contends that since the 1994 Milgrom and Weinstein et al. study found that “11 percent of practicing Seattle-area dentists strongly agree with denying the pain reports of children,” then “this means that 89 percent did not agree.” Not exactly. This question item was paired with a seven-point Likert scale to give respondents a means to specify their level of agreement with the

statement. Ten percent of the respondents strongly disagreed with denying a child's pain report while, on the other end of the spectrum, 11 percent strongly agreed. Each of the five-scale points in between represent an area that I have interpreted as indicating some degree of "doubt." Hence, my statement regarding the number of dentists who "doubted the authenticity of children's behavioral pain reports issuing during invasive procedures" referenced a "large majority."

During invasive treatment, clinicians cannot know if a child's pain reports are

authentic. If we guess wrong and disbelieve their pain reports, besides causing suffering and distrust, we may also harm the child with a sensitization injury that can debilitate their reactions to future necessary medical treatments. Therefore, we must derive our treatment strategies as if they are credible. Clinicians must tread cautiously when deriving treatment strategies for those children who "cry for dental procedures no matter what the dentist does." Good clinical, pediatric pain practice requires that the assessment intervention dynamics of dentists

treating children be oriented toward pain, not behavior. Measuring pain will allow clinicians to develop and improve upon intervention strategies that are effective in controlling pain in all of its dimensions.

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