

Improve Your Clinical Pain Practice With Children

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The following true-or-false questions will introduce you to the articles in this issue of *Journal of the California Dental Association*. They are designed to test your knowledge of clinical pain concepts. The answers are provided below.

1. If an infant or very young child does not consciously remember a brief but acute encounter with procedure pain, there is no lasting “sensitizing” harm to the child.
2. An acceptable way to clinically estimate the amount of pain a child is actually experiencing for a given stimulus intensity is to compare their reactions to the reactions of other children in similar circumstances.
3. The subjective, emotional dimension of pain expression is a false contribution to pain experience.
4. The child’s mother is generally better than the dentist at determining the amount of pain a child is experiencing.
5. Under conditions of tissue trauma, a patient’s behavioral or self-report of pain is superior to any clinician assessment of pain.
6. “Behavior management” confounds the operation of pain assessment-intervention dynamics and should be abandoned.
7. There is no reliable, objective measure of pediatric pain.
8. Caries prevention methods have the greatest chance of being effective when implemented prior to the age of 12 months.
9. Research reveals that between 1960 and 2000, total sugar consumption among American families increased by 33 percent.
10. At-risk children who do not receive fluoride varnish and caregiver education twice a year have a fourfold increased chance of developing decay.

This month’s issue of *Journal of the California Dental Association* challenges conventional thought in the performance of clinical pain practice for children in dentistry. Although the pain principles advocated in these articles have been derived for pediatric procedure pain, they have relevance and applicability to adult pain as well.

Among the pain strategies suggested is one to preferentially reduce, defer, or prevent the procedural stimulation of very young children or children with an elevated “affective” dimension of pain so that they may develop more pain inhibitory controls. This will allow them to tolerate a more invasive procedure later. Among the advantages of this approach is that it will minimize the technical barriers to the early treatment of these children by nonspecialists.

Drs. Huston and Wood suggest we collaborate in this early treatment with our medical colleagues and thereby enable an important expansion in the access to dental care for underserved pediatric populations. Over time, early intervention

and prevention should reduce the dental restorative procedures that contribute to the sensitizing pain inventory that children experience.

Answers:

1. *False.* The dorsal horn of the spinal cord “implicitly” remembers pain and amplifies future pain signaling.

2. *False.* There is no uniform pain response for a given stimulus intensity. It is the child’s behavioral or self-report of pain that determines the intensity of their pain experience.

3. *False.* The emotional dimension of pain is integral to pain’s subjective experience.

4. *True.* Dentists, physicians, and nurses all tend to underestimate pediatric pain.

5. *True.* In the case of procedure pain, unless it is clear that nociceptive input has not occurred, the patient’s behavioral or self-report is the best evidence.

6. *True.* Assessment-intervention dynamics that target behavior make the assessment-intervention dynamic for pain susceptible to evaluator tendencies that deny the authenticity of children’s pain reports and underestimate pain. Targeting pain, not behavior, will allow clinicians to develop and improve upon intervention strategies that are effective in controlling pain in all of its dimensions.

7. *True.* Objective measures of pain, such as heart rate or galvanic skin response, are not reliable.

8. *True.* This is one reason why

physicians need to be counseled to lift the upper lip when doing their oral health exams to check for enamel integrity problems and assist in intercepting early white or brown spot lesions before cavitation occurs.

9. *True.* The increased risk of a prolonged sensitization injury from childhood dental procedure pain now places a higher value on dietary prevention messages.

10. *True.* Demonstrating that given the proper frequency, this noninvasive intervention will assist in stabilizing dental caries until children have developed increased pain inhibitory controls to better tolerate the invasiveness of dental procedures. ■■■■