

Guideline on Fluoride Therapy

Originating Committee

Liaison with Other Groups Committee

Review Council

Council on Clinical Affairs

Adopted

1967

Revised

1978, 1995, 2000, 2003, 2007, 2008, 2012, 2013, 2014*

Reaffirmed

1972, 1977

* The 2014 revision was limited to use of fluoridated toothpaste in young children.

Purpose

The American Academy of Pediatric Dentistry (AAPD) intends this guideline to help practitioners and parents make decisions concerning appropriate use of fluoride as part of the comprehensive oral health care for infants, children, adolescents, and persons with special health care needs.

Methods

A thorough review of the scientific literature in the English language pertaining to the use of systemic and topical fluoride was completed to revise and update this guideline. Database searches were conducted using the terms “fluoride”, “fluoridation”, “fluoride gel”, “fluoride varnish”, “fluoride toothpaste”, “fluoride therapy”, and “topical fluoride”. Because over two million papers were identified through electronic searches, alternate strategies such as appraisal of references from recent evidence-based reviews and meta-analyses, as well as hand searches, were performed. This strategy yielded 105 manuscripts, primarily related to randomized clinical trials and evidence-based reviews, that were evaluated further by abstract. Of those, 45 manuscripts each had full examination and analysis in order to revise this guideline. Expert opinions and best current practices also were relied upon for this guideline.

Background

Widespread use of fluoride has been a major factor in the decline in prevalence and severity of dental caries in the US and other economically developed countries. When used appropriately, fluoride is both safe and effective in preventing and controlling dental caries.¹ Decisions concerning the administration of fluoride are based on the unique needs of each patient, including the risks and benefits (ie, risk of mild or moderate fluorosis versus the benefits of decreasing caries increment and, in some cases preventing, devastating dental disease).

Fluoride has several caries-protective mechanisms of action. Topically, low levels of fluoride in plaque and saliva inhibit the demineralization of sound enamel and enhance the remineralization of demineralized enamel. Fluoride also inhibits dental caries by affecting the metabolic activity of cariogenic bacteria. High levels of fluoride, such as those attained with the use of topical gels or varnishes, produce a temporary layer of calcium fluoride-like material on the enamel surface. The fluoride is released when the pH drops in response to acid production and becomes available to remineralize enamel or affect bacterial metabolism.¹ The original belief was that fluoride’s primary action was to inhibit dental caries when incorporated into developing dental enamel (ie, the systemic route), but the fluoride concentration in sound enamel does not fully explain the marked reduction in dental caries. It is oversimplification to designate fluoride simply as “systemic” or “topical”. Fluoride that is swallowed, such as fluoridated water and dietary supplements, may contribute to a topical effect on erupted teeth (before swallowed, as well as a topical effect due to increasing salivary and gingival crevicular fluoride levels). Additionally, elevated plasma fluoride levels can treat the outer surface of fully mineralized, but unerupted, teeth topically. Similarly, topical fluoride that is swallowed may have a systemic effect.²

Fluoridation of community drinking water is the most equitable and cost-effective method of delivering fluoride to all members of most communities.³ Water fluoridation at the level of 0.7-1.2 mg fluoride ion/L (ppm F) was introduced in the US in the 1940s. Since fluoride from water supplies is now one of several sources of fluoride, the Department of Health and Human Services recently has proposed to not have a fluoride range, but rather to limit the recommendation to the lower limit of 0.7 ppm F. The rationale is to balance the benefits of preventing dental caries while reducing the chance of fluorosis.⁴

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Table 1. DIETARY FLUORIDE SUPPLEMENTATION SCHEDULE

Age	<0.3 ppm F	0.3 to 0.6 ppm F	>0.6 ppm F
Birth to 6 months	0	0	0
6 mo to 3 years	0.25 mg	0	0
3 to 6 years	0.50 mg	0.25 mg	0
6 to at least 16 years	1.00 mg	0.50 mg	0

Fluoride supplements also are effective in reducing prevalence of dental caries and should be considered for children at high caries risk who drink fluoride-deficient (less than 0.6 ppm F) water (see Table 1).⁵ Determination of dietary fluoride before prescribing supplements can help reduce intake of excess fluoride. Sources of dietary fluoride may include drinking water from home, day care, and school; beverages such as soda⁶, juice⁷, and infant formula^{8,9}; prepared food¹⁰; and toothpaste. Infant formulas, especially powdered formulas that have been reconstituted with fluoridated water, have been associated with an increased risk of fluorosis.¹¹ Infants may be particularly susceptible because of the large consumption of such liquid in the first year of life, while the body weight is relatively low.² However, a recent evidence-based review suggests that reducing fluoride intake from reconstituted infant formula alone will not eliminate the risk of fluorosis development.¹² Fluorosis is associated with cumulative fluoride intake during enamel development, with the severity dependent on the dose, duration, and timing of intake.¹ Findings from a national survey report that eight percent of 12-15 year-olds have mild fluorosis and five percent have moderate fluorosis.¹³

Professionally-applied topical fluoride treatments are efficacious in reducing prevalence of dental caries. The most commonly used agents for professionally-applied fluoride treatments are five percent sodium fluoride varnish (NaFV; 22,500 ppm F) and 1.23 percent acidulated phosphate fluoride (APF; 12,300 ppm F). The efficacy of fluoride varnish in primary teeth when used at least twice a year has been reported in at least four randomized controlled trials.¹⁵⁻¹⁸ The efficacy of fluoride varnish in permanent teeth, applied at three or six month intervals, also has been reported in at least four randomized controlled trials.¹⁹⁻²² Meta-analyses of 14 placebo-controlled trials show that fluoride gels, applied at three month to one year intervals, are efficacious in permanent teeth.²³ Some topical fluoride gel and foam products are marketed with recommended treatment times of less than four minutes, but there are no clinical trials showing efficacy of shorter than four-minute application times.¹⁴ There also is limited evidence that topical fluoride foams are efficacious.^{24,25} Children at increased caries risk should receive a professional fluoride treatment at least every six months.¹⁴ As the risk categories may change over time, the type and frequency of preventive interventions should be adjusted.¹

Other topical fluoride products, such as 0.2 percent sodium fluoride (NaF) mouthrinse (900 ppm F)^{26,27,28} and brush-on gels/pastes (eg, 1.1 percent NaF; 5,000 ppm F) also have been shown to be effective in reducing dental caries in permanent teeth.^{29,30} Home use of fluoride products for children should focus on regimens that maximize topical contact, in lower-dose higher-frequency approaches.³¹ Meta-analyses of more than 70 randomized or quasi-randomized controlled clinical trials show that fluoride toothpaste is efficacious in reducing prevalence of dental caries in permanent teeth, with the effect increased in children with higher baseline level of caries and by higher concentration of fluoride in the toothpaste, greater frequency of use, and supervision of brushing.^{32,33} A meta-analysis of eight clinical trials on caries increment in preschool children also shows that tooth brushing with fluoridated toothpaste significantly reduces dental caries prevalence in the primary dentition.³⁴ Using no more than a 'smear' or 'rice-size' amount of fluoridated toothpaste for children less than three years of age may decrease risk of fluorosis. Using no more than a 'pea-size' amount of fluoridated toothpaste is appropriate for children aged three to six (see Figure).^{35,36} To maximize the beneficial effect of fluoride in the toothpaste, teeth should be brushed twice a day³⁶ and rinsing after brushing should be kept to a minimum or eliminated altogether.^{34,37}

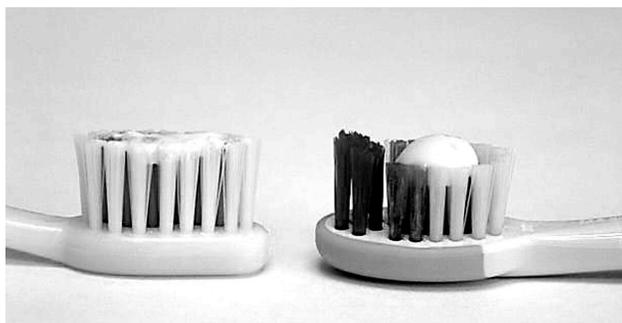


Figure. Comparison of a smear (left) with a pea-sized (right) amount of toothpaste.

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Recommendations

1. There is confirmation from evidence-based reviews that fluoride use for the prevention and control of caries is both safe and highly effective in reducing dental caries prevalence.
2. There is evidence from randomized clinical trials and evidence-based reviews that fluoride dietary supplements are effective in reducing dental caries and should be considered for children at caries risk who drink fluoride-deficient (less than 0.6 ppm) water.
3. There is evidence from randomized controlled trials and meta-analyses that professionally applied topical fluoride treatments as five percent NaFV or 1.23 per-cent F gel preparations are efficacious in reducing caries in children at caries risk.
4. There is evidence from meta-analyses that fluoridated toothpaste is effective in reducing dental caries in children with the effect increased in children with higher baseline level of caries, higher concentration of fluoride in the toothpaste, greater frequency in use, and supervision. Using no more than a 'smear' or 'rice-size' amount of fluoridated toothpaste for children less than three years of age may decrease risk of fluorosis. Using no more than a 'pea-size' amount of fluoridated toothpaste is appropriate for children aged three to six.
5. There is evidence from randomized clinical trials that 0.2 percent NaF mouthrinse and 1.1 percent NaF brush-on gels/pastes also are effective in reducing dental caries in children.

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