GERD- gastroesophageal reflux disease

Pediatric Symptoms

Child reports burning or acidic taste in mouth
Child reports frequent "hot burps" or "baby vomit"
Child reports burning in the area of their heart or a stomach ache
Child has frequent belching after meals
Child displays neck stretching after eating – trying to prevent reflux (special needs patients)
Child's breath has an acidic odor
Child is continuously coughing during sleep (usually GERD, not Asthma)
Child has chronic hoarseness/ laryngitis/ pharyngitis
Child reports that is painful to swallow

Associated Conditions

Premature birth / Asthma / ADHD / Cerebral Palsy / Obesity / Failure to Thrive

Dental Manifestations

Enamel erosion (pot holes or moon craters) from the stomach acid washing over the teeth
Tooth sensitivity can develop once the enamel covering is gone
Acid reflux can make untreated cavities worse
Dental fillings (amalgams or resins) will start to appear taller than surrounding tooth structure
In severe cases of GERD, the tooth nerve can be exposed – OUCH!

Eliminate other potential causes of enamel erosion

Do not eat sour candies (sour skittles, sour gummies, sour patch kids, sour war heads, etc)

Suggested Dietary Changes to help reduce reflux

Avoid fried foods, spicy foods, acidic juices (OJ with pulp) and sodas
Avoid over eating (super sizing) and eating too fast --- enjoy every bite
Don't lie down after eating (takes 2 hours for the stomach to empty)
Don't eat close to bedtime
Place a 2x4 under the head of the bed vs. two pillows

Your Pediatrician may recommend -

Zantac, Prevacid, Prilosec, Reglan or Nexium (medications to prevent reflux)
Tums (sugar free) – dependent upon child's age
Referral to a Pediatric GI Specialist for diagnostic testing (endoscopy, 24 hour pH probe, etc)
Surgical correction – Nissen fundoplication / pyloroplasty

Long-term Dental Risks – if untreated, GERD can cause irreversible tooth structure loss

Long-term Medical Risks – chronic untreated GERD can lead to esophageal (throat) problems in adulthood

References:

Linnett V, Seow WWK: Dental erosion in children: A literature review. Pediatr Dent 23:37-43, 2001.

Laegergreen J, Bergstrom R, Lindgren A and Nyren O: Symptomatic gastroesophageal reflux as a risk factor for esophageal adenocarcinoma. N Engl J Med 340:825-831, 1999.

* more references on request

The Keels-Coffield Clinical Severity Scale of GERD Tooth Damage

			Suggest Treatments (specifically for GERD):
Level 0 NO EROSION			None
Level 1 MILD Only the cusp tips are affected; shallow "moon craters" are present			•If the child confirms a positive history of GERD symptoms, refer to his/her pediatrician or a GI specialist for testing and management. •If there is no dental sensitivity, routine fluoride applications and sealants may be adequate. •If dental sensitivity occurs, protect the teeth with occlusal composite resin build-ups. •Monitor and document the erosive lesions with photographs and/or casts (as tolerated by the child).
Level 2 MODERATE Deep "moon craters" or depressions are present and may coalesce			•Same recommendations as for MILD erosions, however, teeth with MODERATE erosions will require occlusal composite resin build-ups or SSC's to protect against further loss of tooth structure.
Level 3 SEVERE Teeth are slick with little or no anatomy present; possible pulpal exposures			•Same recommendations for MILD and MODERATE erosions, however teeth with SEVERE erosions may require pulp therapy or extraction (if non-restorable).