

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.

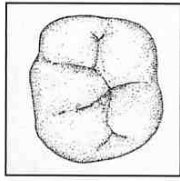
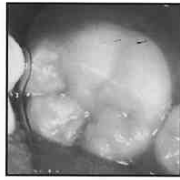
Laegergreen J, Bergstrom R, Lindgren A and Nyren O: Symptomatic gastroesophageal reflux as a risk factor for esophageal adenocarcinoma. N Engl J Med 340:825-831, 1999.

* more references on request

The Keels-Coffield Clinical Severity Scale of GERD Tooth Damage

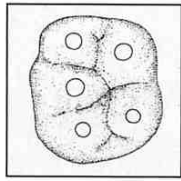
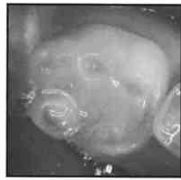
Suggest Treatments (specifically for GERD):

None

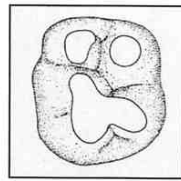
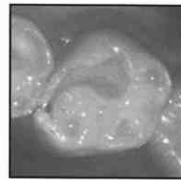


Level 0
NO EROSION

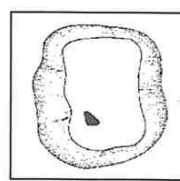
- If the child confirms a positive history of GERD symptoms, refer to his/her pediatrician or a GI specialist for testing and management.
- If there is no dental sensitivity, routine fluoride applications and sealants may be adequate.
- If dental sensitivity occurs, protect the teeth with occlusal composite resin build-ups.
- Monitor and document the erosive lesions with photographs and/or casts (as tolerated by the child).



Level 1
MILD
Only the cusp tips are affected; shallow "moon craters" are present



Level 2
MODERATE
Deep "moon craters" or depressions are present and may coalesce



Level 3
SEVERE
Teeth are slick with little or no anatomy present; possible pulpal exposures

- Same recommendations as for MILD and MODERATE erosions, however teeth with SEVERE erosions may require pulp therapy or extraction (if non-restorable).

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