Screening and Interventions to Prevent Dental Caries in Children Younger Than Age Five Years: A Systematic Review for the U.S. Preventive Services Task Force

Prepared by:
Pacific Northwest Evidence-Based Practice Center
Oregon Health & Science University
Mail Code: BICC
3181 SW Sam Jackson Park Road
Portland, OR 97239
www.ohsu.edu/epc

Investigators:
Roger Chou, MD, FACP
Miranda Pappas, MA
Tracy Dana, MLS
Shelley Selph, MD, MPH
Erica Hart, MBS
Rongwei F. Fu, PhD
Eli Schwarz, DDS, PhD, MPH

AHRQ Publication No. 21-05279-EF-1
December 2021
This report is based on research conducted by the Pacific Northwest Evidence-based Practice Center (EPC) under contract to the Agency for Healthcare Research and Quality (AHRQ), Rockville, MD (Contract No. HHSA-290-2015-00009-I, Prism Order No. HHSA29032014T). The findings and conclusions in this document are those of the authors, who are responsible for its contents, and do not necessarily represent the views of AHRQ. Therefore, no statement in this report should be construed as an official position of AHRQ or of the U.S. Department of Health and Human Services.

The information in this report is intended to help healthcare decisionmakers—patients and clinicians, health system leaders, and policymakers, among others—make well-informed decisions and thereby improve the quality of healthcare services. This report is not intended to be a substitute for the application of clinical judgment. Anyone who makes decisions concerning the provision of clinical care should consider this report in the same way as any medical reference and in conjunction with all other pertinent information (i.e., in the context of available resources and circumstances presented by individual patients).

This report may be used, in whole or in part, as the basis for development of clinical practice guidelines and other quality enhancement tools, or as a basis for reimbursement and coverage policies. AHRQ or U.S. Department of Health and Human Services endorsement of such derivative products may not be stated or implied.

None of the investigators have any affiliations or financial involvement that conflicts with the material presented in this report.

Acknowledgments

The authors thank AHRQ Medical Officer Iris Mabry-Hernandez, MD, MPH, as well as members of the U.S. Preventive Services Task Force.

Suggested Citation

Structured Abstract

Background: In 2014, the U.S. Preventive Services Task Force (USPSTF) found insufficient evidence to assess the benefits and harms of screening for dental caries, but recommended that primary care clinicians prescribe oral fluoride supplementation to preschool children starting at age 6 months whose primary water source is deficient in fluoride and apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

Purpose: To systematically review the current evidence on primary care screening for and prevention of dental caries in children younger than 5 years old.

Data Sources: We searched the Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews (through April, 2021), and MEDLINE (2013 to April, 2021); with surveillance through July 23, 2021, and manually reviewed reference lists.

Study Selection: Randomized controlled trials (RCTs) and controlled observational studies on benefits and harms of screening versus no screening and referral to dental care from primary care versus no referral; studies on the diagnostic accuracy of oral examination and risk assessment by primary care clinicians; RCTs on benefits and harms of oral health education and preventive interventions; and systematic reviews on risk of fluorosis associated with early childhood ingestion of dietary fluoride supplements.

Data Extraction: One investigator abstracted data and a second investigator checked data abstraction for accuracy. Two investigators independently assessed study quality using methods developed by the USPSTF.

Data Synthesis (Results): Thirty-three studies (reported in 36 publications) were included in this update (19 RCTs, four non-randomized trials, nine observational studies, and one systematic review [19 studies]). Seventeen studies were newly identified as part of this update and 16 studies (including the systematic review) were carried forward from the previous review. No randomized trial or observational study compared clinical outcomes between children younger than 5 years of age screened and not screened by primary care clinicians for dental caries. One good-quality cohort study (n=258) found primary care pediatrician examination following 2 hours of training associated with a sensitivity of 0.76 (95% confidence interval [CI], 0.55 to 0.91) for identifying a child with one or more cavities and 0.63 (95% CI, 0.42 to 0.81) for identifying children younger than 36 months of age in need of a dental referral, compared with a pediatric dentist evaluation. One study (n=697) found a novel risk assessment tool administered by home visitor nurses associated with suboptimal accuracy for predicting future caries in children 1 year of age. The prior USPSTF review found oral fluoride supplementation associated with reduced caries incidence versus no supplementation in children younger than 5 years of age in settings with inadequate water fluoridation, though only one trial was randomized; we identified no new trials. The prior USPSTF review included a systematic review of observational studies which found an association between early childhood ingestion of systemic fluoride and enamel fluorosis. Topical fluoride (all trials except for one evaluated varnish) associated with decreased caries increment (13 trials in updated meta-analysis, N=5733, mean difference in decayed, missing, and filled teeth or surfaces -0.94, 95% CI, -1.74 to -0.34) and decreased
likelihood of incident caries (12 trials, N=8177, RR 0.80, 95% CI, 0.66 to 0.95; absolute risk difference -7%, 95% CI, -12% to -2%) versus placebo or no varnish, with no increase in risk of fluorosis or other adverse events. Almost all trials of topical fluoride were conducted in higher risk populations or settings. Evidence on other preventive interventions was limited (xylitol) or unavailable (silver diamine fluoride). Evidence on educational or counseling interventions is very sparse and no studies directly evaluated the effectiveness of primary care referral to a dentist versus no referral.

**Limitations:** Only English-language articles were included. Graphical methods were not used to assess for publication bias, due to diversity in populations, settings, and outcomes, and substantial statistical heterogeneity. Statistical heterogeneity was present in pooled analyses of fluoride varnish and not explained by stratification on a variety of factors. Studies conducted in resource-poor settings may be of limited applicability to screening in the United States. Most studies had methodological limitations.

**Conclusions:** Dietary fluoride supplementation and fluoride varnish appear to be effective at preventing caries outcomes in higher risk children younger than 5 years of age. Dietary fluoride supplementation in early childhood is associated with risk of enamel fluorosis, which is usually not severe. More research is needed to understand the accuracy of oral health examination and caries risk assessment by primary care clinicians, primary care referral for dental care, and effective parental and caregiver/guardian educational and counseling interventions.
# Table of Contents

## Chapter 1. Introduction and Background
- Purpose .............................................................................................................. 1
- Condition Background ...................................................................................... 1
- Condition Definition .......................................................................................... 1
- Prevalence and Burden of Disease/Illness .......................................................... 1
- Etiology and Natural History .............................................................................. 2
- Risk Factors ....................................................................................................... 3
- Rationale for Screening/Screening Strategies ...................................................... 3
- Preventive Interventions ...................................................................................... 3
- Current Clinical Practice/Recommendations of Other Groups ......................... 5

## Chapter 2. Methods
- Key Questions and Analytic Framework ............................................................ 6
- Strategies ........................................................................................................... 6
- Study Selection .................................................................................................. 7
- Data Abstraction and Quality Rating .................................................................. 8
- Data Synthesis ................................................................................................... 8
- USPSTF Involvement ......................................................................................... 9
- Expert Review and Public Comment .................................................................. 9

## Chapter 3. Results
- Screening for Dental Caries in Children Younger Than Age 5 Years .................. 10
- Key Question 1. How Effective Is Oral Screening (Including Risk Assessment) Performed by a Primary Care Clinician in Preventing Dental Caries in Children Younger Than Age 5 Years? ......................................................................................................................... 10
- Key Question 2a. How Accurate Is Screening Performed by a Primary Care Clinician in Identifying Children Younger Than Age 5 Years Who Have Cavitated or Noncavitated Caries Lesions? .................................................. 10
- Summary .......................................................................................................... 10
- Evidence ............................................................................................................ 11
- Key Question 2b. How Accurate Is Screening Performed by a Primary Care Clinician in Identifying Children Younger Than Age 5 Years Who Are at Increased Risk for Future Dental Caries? ........................................................................................................ 11
- Summary .......................................................................................................... 11
- Evidence ............................................................................................................ 11
- Key Question 3. What Are the Harms of Oral Health Screening Performed by a Primary Care Clinician in Children Younger Than Age 5 Years? ........................................................................................................ 12
- Interventions to Prevent Dental Caries in Children Younger Than Age 5 Years ................................................................................................................ 12
- Key Question 1. How Accurate Is Screening Performed by a Primary Care Clinician in Identifying Children Younger Than Age 5 Years Who Are at Increased Risk of Future Dental Caries? ........................................................................................................ 12
- Key Question 2. How Effective Is Parental or Caregiver/Guardian Oral Health Education Provided by a Primary Care Clinician in Preventing Dental Caries in Children Younger Than Age 5 Years? ........................................................................................................ 13
- Summary .......................................................................................................... 13
- Evidence ............................................................................................................ 13
Key Question 3. How Effective Is Referral by a Primary Care Clinician to a Dental Health Care Professional in Preventing Dental Caries in Children Younger Than Age 5 Years?

Summary.................................................................................................................................14
Evidence.................................................................................................................................14

Key Question 4. How Effective Are Preventive Interventions (Dietary Fluoride Supplementation, Topical Fluoride Application, Silver Diamine Fluoride, or Xylitol) in Preventing Dental Caries in Children Younger Than Age 5 Years?

Dietary Fluoride Supplementation.........................................................................................15
Summary.................................................................................................................................15
Evidence.................................................................................................................................15
Topical Fluoride Application.................................................................................................16
Summary.................................................................................................................................16
Evidence.................................................................................................................................16
Xylitol..................................................................................................................................18
Summary.................................................................................................................................18
Evidence.................................................................................................................................19
Silver Diamine Fluoride.........................................................................................................19

Key Question 5. What Are the Harms of Specific Oral Health Interventions to Prevent Dental Caries in Children Younger Than Age 5 Years (Parental or Caregiver/Guardian Oral Health Education, Referral to a Dental Health Care Professional, and Preventive Interventions)?

Summary.................................................................................................................................20
Evidence.................................................................................................................................20

Contextual Question. 1. How Effective Is Silver Diamine Fluoride in Preventing Dental Caries in Children Age 5 Years or Older?

Chapter 4. Discussion ...........................................................................................................23

Summary of Review Findings ...............................................................................................23
Limitations..............................................................................................................................25
Emerging Issues/Next Steps .................................................................................................25
Relevance for Priority Populations.......................................................................................25
Future Research ....................................................................................................................26
Conclusions...........................................................................................................................26

Figures

Figure 1. Analytic Framework: Screening for Dental Caries in Children Younger Than Age 5 Years
Figure 2. Analytic Framework: Interventions to Prevent Dental Caries in Children Younger Than Age 5 Years
Figure 3. Pooled Analysis of Topical Fluoride vs. Placebo or No Topical Fluoride on Mean Change in Number of Caries at Followup, by Fluoridation Status
Figure 4. Pooled Analysis of Topical Fluoride vs. Placebo or No Topical Fluoride on Caries Development at Followup, by Fluoridation Status
Tables
Table 1. Pooled Analyses of Mean Change in Number of Caries at Followup, Topical Fluoride vs. Placebo or No Topical Fluoride
Table 2. Pooled Analyses of Risk of Caries Development at Followup, Topical Fluoride vs. Placebo or No Topical Fluoride
Table 3. Summary of Evidence

Appendixes
Appendix A. Detailed Methods
  Appendix A1. Search Strategies
  Appendix A2. Inclusion and Exclusion Criteria
  Appendix A3. Literature Flow Diagram
  Appendix A4. List of Included Studies
  Appendix A5. List of Excluded Studies With Reasons for Exclusion
  Appendix A6. Criteria for Assessing Internal Validity of Individual Studies
  Appendix A7. Expert and Federal Reviewers
Appendix B. Evidence Tables and Quality Tables
  Appendix B1. Diagnostic Accuracy Studies for the Prevention of Dental Caries
  Appendix B2. Quality Ratings for Diagnostic Accuracy Studies
  Appendix B3. Trials of Educational Interventions for the Prevention of Dental Caries
  Appendix B4. Quality Ratings of Randomized, Controlled Trials of Topical Fluoride
  Appendix B5. Cohort Studies of Dental Referral From a Primary Care Clinician for the Prevention of Dental Caries
  Appendix B6. Quality Ratings of Included Cohort Studies
  Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries
  Appendix B8. Trials of Xylitol for the Prevention of Dental Caries
  Appendix B9. Systematic Review of Fluorosis Due to Fluoride Supplements
  Appendix B10. Quality Ratings of Systematic Reviews
Chapter 1. Introduction and Background

Purpose

This report will be used by the U.S. Preventive Services Task Force (USPSTF) to update its 2014 recommendation on the prevention of dental caries in children younger than 5 years of age.¹ In 2014, the USPSTF recommended that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride (B recommendation) and that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (B recommendation).² The recommendation was based on evidence from randomized trials that fluoride varnish is more effective than placebo or no varnish in preventing caries, and evidence previously reviewed by the USPSTF on the effectiveness of oral fluoride.³,⁴ The USPSTF found insufficient evidence to assess the balance of benefits and harms of routine screening examinations for dental caries performed by primary care clinicians in children younger than 5 years of age (I recommendation). The 2014 recommendation expanded on the 2004 USPSTF recommendation, which also recommended fluoride supplementation and found insufficient evidence on screening by primary care clinicians, but did not address use of fluoride varnish.⁵

Condition Background

Condition Definition

Dental caries, or tooth decay, is a common chronic disease that can cause pain and diminished function and quality of life throughout one’s lifespan.⁶ Caries lesions form in teeth through a complex interaction among cariogenic, acid-producing bacteria in combination with fermentable carbohydrates and other dietary, genetic, behavioral, social, and cultural factors.⁷⁻⁹

Children are susceptible to caries as soon as the first teeth appear, which usually occurs at about 6 months of age. Early childhood caries is defined as the presence of one or more decayed (noncavitated or cavitated), missing (due to caries), or filled tooth surfaces in any primary tooth in a preschool-age child between birth and 71 months of age.¹⁰ Early childhood caries is often measured using the dmfs index for decayed, missing, or filled primary tooth surfaces, and dmft for decayed, missing, or filled primary teeth. In a particular child, the number of dmfs can be higher than the number of dmft because one tooth may have more than one affected surface. Over the years the dental research and practice communities have developed and used different dental caries classification systems to describe the degree of decay, such as describing the progression of decay through the tooth tissues from the dentin to the pulp (d₁⁻d₄ lesions), the International Caries Detection and Assessment System (ICDAS)¹¹ and the American Dental Association Caries Classification System.¹² The American Dental Association Council on Scientific Affairs has published a comparative overview of these classifications.¹¹

Prevalence and Burden of Disease/Illness

Dental caries is the most common chronic disease of children in the United States.¹³,¹⁴ The National Health and Nutrition Examination Study (NHANES) found that among 2 to 5 year olds,
the prevalence of dental caries in primary teeth increased from approximately 24 percent between 1988 to 1994 to 28 percent between 1999 to 2004, with a subsequent decrease in caries prevalence to approximately 23 percent in 2011 to 2016. In 2011 to 2016, approximately 10 percent of children 2 to 5 years of age had untreated dental caries and in 2011 to 2014, approximately 4.6 percent had severe caries (defined as 3 or more decayed surfaces).

Dental caries disproportionately affects minority and economically disadvantaged children. NHANES data indicate that in 2011 to 2016, the prevalence of caries in children 2 to 5 years of age was 34 percent in those living in households below the federal poverty guidelines, compared with 16 percent in children from households at 200 percent or greater of the federal poverty guidelines; the proportion with untreated caries was 17 percent versus 6.02 percent. The prevalence of caries among children aged 2 to 5 years was higher in Mexican American children (33%) and black non-Hispanic children (28%) than white non-Hispanic children (18%). Dental caries were also more likely to be untreated in black non-Hispanic (15%) and Mexican American (15%) than white non-Hispanic children (6.7%).

Early childhood caries is associated with pain and loss of teeth, as well as impaired growth, decreased weight gain, and negative effects on quality of life. Filling placement or extractions of carious teeth can be traumatic experiences for young children, and occasionally result in serious complications. Early childhood caries is also associated with failure to thrive and can affect appearance, self-esteem, speech, and school performance, and is associated with future caries in both the primary and permanent dentitions. A systematic review found poor oral health associated with significantly increased risk of poor academic performance (pooled odds ratio [OR] 1.5, 95% confidence interval [CI], 1.20 to 1.83) and school absenteeism (pooled OR 1.43, 95% CI, 1.24 to 1.63). Premature loss of primary molars due to early childhood caries can result in loss of arch space, leading to crowding of the permanent teeth, affecting esthetics and potentially requiring orthodontic correction. In 2000, the U.S. Surgeon General estimated that over 50 million school hours are lost each year nationally due to dental related concerns. In the state of North Carolina, a study based on 2008 data estimated that more than 4 million school hours are lost each year due to poor oral health status, with over 700,000 of these hours lost due to dental pain or infection.

Etiology and Natural History

Dental caries is a disease process during which various strains of bacteria colonize the tooth surface and metabolize dietary carbohydrates (especially refined sugars) to produce lactic and other acids, resulting in demineralization of teeth. In children ages 12 to 30 months, caries typically initially affects the maxillary primary incisors and first primary molars, reflecting the pattern of eruption. Dental caries first manifests as white spot lesions, which are small areas of demineralization under the enamel surface. At this stage, the caries lesion is usually reversible, if appropriate preventive action is taken (e.g., change in dietary behaviors or application of fluoride varnish). If oral conditions do not improve, demineralization progresses, and eventually results in irreversible cavities, with a loss of the normal tooth shape and contour. Continued progression of the caries process leads to pulpitis (inflammation due to bacterial infection of the dental pulp, or soft tissue in the center of a tooth) and tooth loss, and can be associated with complications such as facial cellulitis and systemic infections.
Risk Factors

Risk factors for dental caries in young children are multifactorial comprising biological as well as non-biological factors/social determinants of health. Biological factors include high levels of cariogenic bacterial colonization, low saliva flow rates, developmental defects of tooth enamel, and high maternal levels of cariogenic bacteria. Non-biological/social determinants of health factors include, frequent exposure to dietary sugar and refined carbohydrates, inappropriate bottle feeding (e.g., child put to sleep with a bottle containing something other than water), low socioeconomic status, previous caries, maternal caries, and poor maternal oral hygiene. Other risk factors include lack of access to dental care, low community water fluoride levels, inadequate tooth brushing/use of fluoride-containing toothpastes, and lack of parental knowledge regarding oral health.

Rationale for Screening/Screening Strategies

Screening for dental caries and caries risk factors in young children prior to school entry could identify caries lesions at an earlier and reversible stage and lead to interventions to treat existing caries lesions, prevent progression of caries lesions, and reduce incidence of future lesions, including lesions in the permanent dentition. Screening strategies typically include oral health risk assessment and visual examination to identify high-risk children, including those already with caries. Primary care clinicians can play an important role in screening for dental caries because many young children routinely see a primary care clinician starting shortly after birth, but do not see a dental health care professional until they are older. Approximately three-quarters of children under 6 years of age did not have even one visit to a dental health care professional in the previous year, though the proportion with a visit increased from 21 percent in 1996 to 25 percent in 2004. Access to dental care is impacted by many factors, including social determinants of health and shortages in dental health care professionals treating young children, particularly for children who are not insured or who are publicly insured. Once children enter school, there are additional opportunities for screening and treatment.

Preventive Interventions

In young children at risk for dental caries, interventions to prevent development of caries lesions focus on reducing the burden of bacteria, reducing the intake of refined sugars, and increasing the resistance of teeth to caries development. Strategies to reduce the burden of bacteria include the use of fluoride, parental counseling to improve oral hygiene, xylitol, and topical antimicrobials such as chlorhexidine or povidone-iodine. Educational and behavioral interventions can also address reduced intake of refined sugars through changes in diet and feeding practices. Children with caries or at risk of caries can also be referred for needed dental care.

Use of fluorides primarily focuses on promoting remineralization of the enamel. Fluoride exposure can be topical (fluoride dentifrices, rinses, gels, foams, varnishes) or systemic (dietary fluoride supplements). Fluoridated water has topical as well as systemic effects. The main effect, however, is now believed to be topical. Fluoride is incorporated into the biofilm (dental plaque), saliva and tooth enamel and increases tooth resistance to acid decay, acts as a reservoir for remineralization of caries lesions, and inhibits cariogenic bacteria. A potential harm of
excessive systemic fluoride exposure is enamel fluorosis, a visible change in enamel opacity due to altered mineralization. The severity of enamel fluorosis depends on the dose, duration and timing of fluoride intake, and is most strongly associated with cumulative intake during enamel development; risk of fluorosis is related to exposure from birth to 6 to 8 years of age, though children are most susceptible between 15 to 30 months of age.\textsuperscript{27,28} Mild fluorosis manifests as small opaque white streaks or specks in the tooth enamel.\textsuperscript{29} Severe fluorosis results in discoloration and pitted or rough enamel.\textsuperscript{31} In 1999 to 2004, the prevalence of severe enamel fluorosis in the United States was estimated at less than 1 percent.\textsuperscript{29,30}

Topical fluoride is typically applied as a varnish with a small brush in young children. Unlike fluoride gels, which are more commonly used in older, school-aged children, fluoride varnish does not require specialized dental devices or equipment and can be applied quickly by both dental professional and non-dental health professionals in a variety of settings without the risk of the child swallowing large amounts, which can cause transient gastric irritation.\textsuperscript{7,31} Compared with other topical fluoride application methods (such as acidulated phosphate fluoride or sodium fluoride gel), systemic exposure to fluoride is low following application of fluoride varnish.\textsuperscript{32,33} The varnish results in prolonged contact time between the fluoride and the tooth surface, which maintains a higher level of the calcium fluoride in the biofilm; later the released fluoride promotes remineralization. Fluoride varnish is typically available in the United States as 5 percent sodium fluoride (2.26\% F). Fluoride varnish is cleared for marketing by the U.S. Food and Drug Administration (FDA) as a cavity liner and tooth desensitizer; its use for prevention of caries is off-label.\textsuperscript{34}

Silver diamine fluoride (SDF) is a topical medication that is noninvasive, relatively inexpensive, and easy to apply.\textsuperscript{35} The most common concentration is 38 percent, though it has been evaluated in 10 percent to 38 percent formulations. SDF was cleared for marketing by the FDA in 2014 as a desensitizing agent in adults, similar to fluoride varnish 20 years earlier;\textsuperscript{36} it has long been used in other parts of the world to arrest progression of existing caries lesions and avoid restorative treatment. SDF works by the combined effects of silver and fluoride on promoting remineralization, as a short-term germicide, and inhibits enzymes involved in collagen degradation, all of which result in an arrest of the carious process;\textsuperscript{35,37} SDF is also being evaluated for preventing future caries in school-age children.\textsuperscript{38,39} A potential disadvantage of SDF is cosmetic concerns, due to the permanent dark discoloration of active caries lesions by the silver component. However, SDF will not discolor healthy enamel, caries lesions themselves cause discoloration, and in young children discoloration would impact primary (non-permanent) teeth. Based on its potential as a caries treatment, SDF has been granted “breakthrough therapy” designation by the FDA, providing the opportunity for expedited approval for this indication, and a number of clinical trials of SDF for treating caries are in progress.

Xylitol is a naturally occurring sugar that cannot be metabolized by the oral microflora and thus has the potential to reduce levels of caries-forming mutans streptococci in the plaque and saliva.\textsuperscript{40} In young children, xylitol can be administered as a syrup or topically via wipes. In older children, xylitol can also be administered in gum, lozenges, or snack foods. FDA allows foods (including chewing gums) that contain xylitol to make the following statement: “Xylitol may reduce the risk of tooth decay”.\textsuperscript{41} Other topical antimicrobials such as chlorhexidine varnish or gel and povidone-iodine rinses are not commonly used in the United States in young children or
are not available, as in the case of chlorhexidine varnish. Neither chlorhexidine nor povidone iodine has been approved by FDA to be used for caries reduction or prevention.42

**Current Clinical Practice/Recommendations of Other Groups**

Since the publication of the Surgeon General’s Report on Oral Health in 2000,14 many organizations (see below) have emphasized the importance of preventive oral health care for young children, particularly in the primary care setting. The American Academy of Pediatrics (AAP) has developed an oral health risk assessment tool for use in primary care settings starting at the 6 month visit, along with suggested interventions for children at risk.43 The American Academy of Pediatric Dentistry (AAPD) developed the Caries-risk Assessment Tool (CAT), designed for use by dental and non-dental personnel.44 Although the vast majority of pediatricians agree with recommendations on oral health screening, only about half report examining the teeth of more than half of their 0 to 3 year old patients, and few (4%) reported regularly applying fluoride varnish.25 Data on rates of SDF use in primary care settings are not available.
Chapter 2. Methods

Key Questions and Analytic Framework

Using the methods developed by the USPSTF, the USPSTF and the Agency for Healthcare Research and Quality (AHRQ) determined the scope and key questions for this review. Investigators created two analytic frameworks with the key questions and the patient populations, interventions, and outcomes reviewed (Figures 1 and 2). Screening and preventive interventions were addressed in a single analytic framework in the prior USPSTF review. For this update, screening and preventive interventions have been split into separate analytic frameworks to more clearly distinguish treatment of children with existing caries identified on screening (screening analytic framework) from treatment of children without caries to prevent the development of future caries (interventions to prevent dental caries analytic framework).

Key Questions

Screening for Dental Caries in Children Younger Than Age 5 Years

1. How effective is oral screening (including risk assessment) performed by a primary care clinician in preventing dental caries in children younger than age 5 years?
2. How accurate is screening performed by a primary care clinician in identifying children younger than age 5 years who:
   a. Have cavitated or noncavitated caries lesions?
   b. Are at increased risk for future dental caries?
3. What are the harms of oral health screening performed by a primary care clinician in children younger than age 5 years?

Interventions to Prevent Dental Caries in Children Younger Than Age 5 Years

1. How accurate is screening performed by a primary care clinician in identifying children younger than age 5 years who are at increased risk of future dental caries*?
2. How effective is parental or caregiver/guardian oral health education provided by a primary care clinician in preventing dental caries in children younger than age 5 years?
3. How effective is referral by a primary care clinician to a dental health care professional in preventing dental caries in children younger than age 5 years?
4. How effective are preventive interventions (dietary fluoride supplementation, topical fluoride application, silver diamine fluoride, or xylitol) in preventing dental caries in children younger than age 5 years?
5. What are the harms of specific oral health interventions to prevent dental caries in children younger than age 5 years (parental or caregiver/guardian oral health education, referral to a dental health care professional, and preventive interventions)?

*This is the same question as Screening Key Question 2b.
Contextual Question

One Contextual Question was also requested by the USPSTF to help inform the report. Contextual Questions are not reviewed using systematic review methodology.

1. How effective is silver diamine fluoride in preventing dental caries in children age 5 years or older?

Strategies

We searched the Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews (through April, 2021), and Ovid MEDLINE (2013 through April, 2021) for relevant studies and systematic reviews. Search strategies are available in Appendix A1. We also reviewed reference lists of relevant articles. Ongoing surveillance was conducted to identify major studies published since April 2021 that may affect the conclusions or understanding of the evidence and the related USPSTF recommendation. The last surveillance was conducted on July 23, 2021 and identified no studies affecting review conclusions.

Study Selection

At least two reviewers independently evaluated each study to determine inclusion eligibility. We selected studies on the basis of inclusion and exclusion criteria developed for each key question (Appendix A2). Articles were selected for full review if they were about dental caries in preschool children (younger than 5 years old), were relevant to a key question, and met the predefined inclusion criteria. We restricted inclusion to English-language articles and excluded studies only published as abstracts. Studies of non-human subjects were also excluded, and studies had to report original data. We included an update46 to a systematic review28 included in the prior USPSTF report on risk of fluorosis; otherwise, inclusion was restricted to primary studies and systematic reviews were used as source of potentially eligible studies.

For all key questions, we included studies of children younger than 5 years of age, including those with dental caries at baseline. We focused on studies of screening or diagnostic accuracy performed in primary care settings for identifying caries or children at increased risk of caries. For preventive treatments, we included studies of primary care feasible treatments (not requiring extensive dental specific training) administered in primary care or non-primary care settings (e.g., daycare or preschool), but noted the setting and whether the treatment was administered by persons with dental training. Interventions were parental or caregiver education, referral to a dentist by a primary care clinician, and preventive treatments including dietary fluoride supplementation, topical fluoride application (varnish, foam, or gel), xylitol, and SDF; the comparison for each was no intervention or placebo. Antimicrobial rinses and antimicrobial varnishes, which were included in the prior USPSTF review, were not included in this update because they are not widely used in children or not available in the United States. Outcomes were decreased incidence of dental caries, morbidity, quality of life, function, and associated harms, including dental fluorosis. The selection of literature is summarized in the literature flow diagram (Appendix A3). Appendix A4 lists the included studies, and Appendix A5 lists the excluded studies with reasons for exclusion.
Data Abstraction and Quality Rating

For studies meeting inclusion criteria, we created data abstraction forms to summarize characteristics of study populations, interventions, comparators, outcomes, study designs, settings (including human development index classification, preschool or daycare, and community fluoridation level) and methods. One investigator conducted data abstraction, which was reviewed for completeness and accuracy by another team member.

Predefined criteria were used to assess the quality of individual controlled trials, systematic reviews, and observational studies by using criteria developed by the USPSTF; studies were rated as “good,” “fair,” or “poor” per USPSTF criteria, depending on the seriousness of the methodological shortcomings (Appendix A6). For each study, quality assessment was performed by two team members. Disagreements were resolved by consensus.

Data Synthesis

We performed a random effects meta-analysis using the profile likelihood model to summarize the effects of topical fluoride versus placebo or no fluoride on likelihood of developing caries (dichotomous outcome) or caries burden (continuous outcome, measured based on the number of decayed, missing, or filled teeth [dmft] or surfaces [dmfs]). Effects on caries burden were based on mean difference in followup caries index if available; otherwise difference in change from baseline caries index (caries increment) was used. Adjusted differences were utilized when reported. For caries burden, we used dmfs when available and otherwise used dmft. Data for dentin caries were used if available; otherwise data for any (enamel or dentin) caries were used. We combined arms of comparable interventions within the same study in the primary analysis, so each study was represented once in a meta-analysis, in order to avoid overweighting. For cluster randomized trials, we used treatment differences that accounted for the intracluster correlation, if reported. Otherwise, we corrected for clustering using the intracluster correlation by calculating the design effect and the effective sample sizes before combining with individually randomized trials. If the intracluster correlation was not reported, we imputed it based on the intracluster correlation reported in the other cluster trials. We conducted prespecified study-level subgroup analyses on the following factors: use of cluster design (yes or no), varnish frequency (every 4, 6, or 12 months), trial conducted in very high human development index (HDI) setting (yes or no, based on a United Nations Development Programme HDI score of 0.800 or higher for the country or geographic setting), trial conducted in preschool or daycare setting (yes or no), high-risk population (yes or no; high-risk defined as high baseline caries, high community caries burden, low socioeconomic status, or low rates of oral health behaviors [e.g., brushing with fluoridated toothpaste]), mean age (<2 vs. ≥2 years), enrollment restricted to caries-free children at baseline (yes or no), adequate water fluoridation (yes or no; adequate fluoridation defined as ≥0.7 parts per million [ppm] F), use of additional oral health measures (yes or no; additional oral health measures defined as education and/or provision of toothbrush and toothpaste), followup duration (1 vs. <1 year), and risk of bias (fair vs. good). We also conducted a sensitivity analysis excluding a trial that used acidulated phosphate fluoride foam instead of fluoride varnish.
For all meta-analyses, statistical heterogeneity was assessed using the Cochran Q-test and $I^2$ statistic.\textsuperscript{48} All meta-analyses were conducted using Stata/SE 16.1 (StataCorp, College Station, TX).

For all key questions, the overall quality of evidence was determined using the approach described in the USPSTF Procedure Manual.\textsuperscript{45} Evidence was rated “good”, “fair”, or “poor” based on study quality, consistency of results between studies, precision of estimates, study limitations, risk of reporting bias, and applicability.\textsuperscript{45}

**USPSTF Involvement**

This review was funded by AHRQ. AHRQ staff and USPSTF members participated in developing the scope of the work and reviewed draft reports, but the authors are solely responsible for the content.

**Expert Review and Public Comment**

The draft Research Plan was posted for public comment on the USPSTF website from September 19 to October 16, 2019. The comments were reviewed and the Research Plan was revised by adding a footnote to clarify that in the screening analytic framework interventions are provided to children found to have caries on screening and in the prevention analytic framework interventions are provided to children without caries; changed “dentist” to “dental health care professional”; and revised the exclusion criteria to clarify that dental clinics providing interventions not available in primary care clinics are excluded from the review (interventions that can be provided in primary care practices are included even if they were administered in other settings). Also, the Research Plan was revised to clarify that information regarding the skill level or training of primary care clinicians participating in studies of screening and preventive interventions would be abstracted, and effects of skill level/training on effectiveness analyzed (data permitting).

A draft version of this report has been reviewed by content experts and representatives of Federal partners (Appendix A7), USPSTF members, and AHRQ Project Officers, and edits were made for clarity. The draft report was posted for public comment from May 11 to June 7, 2021, and minor edits were made for clarity, prior to finalization.
Chapter 3. Results

A total of 2674 new references from electronic database searches and manual searches of recently published studies were reviewed and 368 full-text papers were evaluated for inclusion. We included a total of 33 studies (reported in 36 publications). Seventeen trials were newly identified as part of this update and 16 studies (in 17 publications) were carried forward from the previous review. We excluded 16 studies (in 17 publications) that were included in the prior review; one was excluded for not being an included preventive intervention, two for including children 5 years and older, two for treatment of existing caries, four for comparing active interventions, and eight for being poor-quality. Included studies and quality ratings are described in Appendix B.

Screening for Dental Caries in Children Younger Than Age 5 Years

Key Question 1. How Effective Is Oral Screening (Including Risk Assessment) Performed by a Primary Care Clinician in Preventing Dental Caries in Children Younger Than Age 5 Years?

No study compared clinical outcomes between children younger than 5 years of age screened and not screened by primary care clinicians.

Key Question 2a. How Accurate Is Screening Performed by a Primary Care Clinician in Identifying Children Younger Than Age 5 Years Who Have Cavitated or Noncavitated Caries Lesions?

Summary

- One study (n=258) included in the prior USPSTF review found a pediatrician oral examination of children younger than 36 months of age associated with a sensitivity of 0.76 and specificity of 0.95 for identifying a child with one or more cavities, a sensitivity of 0.49 and specificity of 0.99 for identifying a tooth with a cavity, and a sensitivity of 0.63 and specificity of 0.98 for identifying children in need of a dental referral, compared with a pediatric dentist evaluation.
- One study included in the prior USPSTF review found a pediatrician oral health examination of children 18 to 36 months of age associated with a sensitivity of 1.0 and specificity of 0.87 for identifying nursing caries (n=61) compared with a pediatric dentist examination.
- No new studies on the accuracy of screening performed by a primary care clinician for identifying children younger than 5 years of age were identified.

Evidence

The prior USPSTF review included two studies on the accuracy of screening by a primary care clinician for identifying children with cavitated or noncavitated caries lesions (Appendix B1). In
both studies, screening was based on examination of the dentition for caries lesions. One good-quality study (n=258) evaluated the accuracy of caries screening of children younger than 36 months of age by primary care pediatricians following 2 hours of oral health education. The study enrolled Medicaid-eligible children (9.7% with a cavity, mean 0.3 cavities/child) attending a private pediatric group practice in North Carolina. Compared with a pediatric dentist evaluation, it found a pediatrician oral examination associated with sensitivity of 0.76 (95% CI, 0.55 to 0.91) and specificity of 0.95 (95% CI, 0.92 to 0.98) for identifying a child with one or more cavities, a sensitivity of 0.49 (95% CI, 0.37 to 0.60) and specificity of 0.99 (95% CI, 0.99 to 0.99) for identifying a tooth with a cavity, and a sensitivity of 0.63 (95% CI, 0.42 to 0.81) and specificity of 0.98 (95% CI, 0.95 to 0.99) for identifying children in need of a dental referral. The need for referral was based on the presence of a cavity, soft tissue pathology, or evidence of tooth or mouth trauma. A fair-quality study found a pediatrician oral health exam of children 18 to 36 months of age following 4 hours of training associated with a sensitivity of 1.0 and specificity of 0.87 for identifying nursing caries compared with a pediatric dentist exam (n=61, CIs not reported and could not be calculated). The number of true positives, true negatives, false positives, and false negatives were not reported and could not be calculated. Nursing caries were defined as caries involving one or more of the maxillary central or lateral incisors of the primary molars, but excluding the mandibular incisors. Methodological limitations of this study were unclear application of the reference standard to all patients and unclear inclusion of all patients in the analysis (Appendix B2).

No new study evaluated the accuracy of primary care clinician screening for carious lesions in children younger than 5 years of age.

**Key Question 2b. How Accurate Is Screening Performed by a Primary Care Clinician in Identifying Children Younger Than Age 5 Years Who Are at Increased Risk for Future Dental Caries?**

**Summary**

- One new study found a novel caries risk assessment tool administered by health visitor nurses in children 1 year of age associated with sensitivity of 0.53 and specificity of 0.77 (n=697) for predicting any d3mft lesion at age 4 years and sensitivity of 0.65 and specificity of 0.69 (n=784) for predicting presence of three or more d3mft lesions.

**Evidence**

One new study (n=1681) reported on the development and testing of a novel caries risk assessment tool (Dundee Caries Risk Assessment Model) administered by health visitors (registered nurses of midwives in Scotland with Masters level training who provide services to families with young children by visiting them in their homes) (Appendix B1). The cohort consisted of all children born and resident in Dundee, Scotland in one calendar year. The study examined 56 potential risk factors evaluated at age 1 year for prediction of caries at age 4 years, using a prediction tree-based analysis. The prevalence of any d1 (enamel or dentin) caries at baseline was 3 percent and the prevalence of any d3 (enamel of dentin) caries was 0.4 percent. At 4 years, the respective prevalence were 49 and 33 percent. Separate models were developed for prediction of any or at least three d1 or d3 caries. The final models included two to five risk factors...
factors, including health visitor assessment of risk, socioeconomic status, parental smoking status, being breast fed, use of a pacifier, housing type, use of vitamins, and food or drink intake at night. For predicting presence of any $d_3mft$ lesion at age 4 years, the sensitivity of the model was 0.53 and specificity 0.77 (n=697, CIs not reported), based on three risk factors (health visitor assessment of risk, parental smoking, and food or drink intake at night). For predicting presence of at least three $d_3mft$ lesions at age 4 years, the sensitivity of the model was 0.65 and specificity was 0.69 (n=784, CIs not reported), based on three risk factors (type of housing, health visitor assessment of risk, and use of vitamins). Results were similar for prediction of any or at least three $d_3mft$ lesions. The study was rated fair-quality because it was unclear if the reference standard was assessed independent from the screening test and the risk factors selected for the models were not predefined (Appendix B2). We identified no study with independent validation of the Dundee Caries Risk Assessment Model.

**Key Question 3. What Are the Harms of Oral Health Screening Performed by a Primary Care Clinician in Children Younger Than Age 5 Years?**

No study reported harms of children younger than 5 years of age screened and not screened by primary care clinicians.

**Interventions to Prevent Dental Caries in Children Younger Than Age 5 Years**

**Key Question 1. How Accurate Is Screening Performed by a Primary Care Clinician in Identifying Children Younger Than Age 5 Years Who Are at Increased Risk of Future Dental Caries?**

See Key Question 2b for Screening for Dental Caries in Children Younger Than Age 5 Years, which addresses the same question.

**Key Question 2. How Effective Is Parental or Caregiver/Guardian Oral Health Education Provided by a Primary Care Clinician in Preventing Dental Caries in Children Younger Than Age 5 Years?**

**Summary**

- The prior USPSTF review included two trials on effects of oral health education in preventing dental caries; however, the trials were rated poor-quality (not truly randomized) and not carried forward in the current review.
- One new fair-quality trial (n=104) found oral health education for mothers of caries-free children 12 to 36 months of age associated with reduced risk of incident dental caries versus usual care at 6 months (13.5% vs. 34.7%, RR 0.39, 95% CI, 0.18 to 0.85).
Evidence

The 2014 USPSTF review\(^3,4\) included two trials (in 3 publications) of multicomponent health interventions that included an oral health education component targeted at medically underserved children younger than 5 years.\(^5,8,9,62\) Both trials found the intervention associated with decreased caries incidence at 1 to 4 years. However, both trials were rated poor-quality and were not carried forward in the current review. Neither trial was truly randomized; both utilized cluster allocation, but there were only two clusters. In addition, one of the trials had high attrition and did not adjust for confounders.\(^5,8,9\)

One new, randomized trial conducted in Ahvaz, Iran (fluoride level in drinking water 0.31 to 0.51 ppm)\(^69\) compared provision of oral health education to mothers (n=104) of children age 12 to 36 months versus usual care without specific oral health education (Appendix B3).\(^70\) Children (mean age 18 months) were caries-free at the time of enrollment, with at least eight erupted teeth. The oral health education was delivered by a dental student at a well-child visit and included an oral health pamphlet, a brief individual session, a group session, and text message reminders every 2 weeks for 6 months. Dental health behaviors were not reported at baseline or followup. The study was open-label and rated fair-quality (Appendix B4).

At 6 months, oral health education was associated with decreased incidence of dental caries based on World Health Organization criteria (including white spot lesions noncavitated and categorized as D1) versus usual care (13.5% [7/52] vs. 34.7% [17/49]; risk ratio [RR] 0.39, 95% CI, 0.18 to 0.85). Harms were not reported.

Key Question 3. How Effective Is Referral by a Primary Care Clinician to a Dental Health Care Professional in Preventing Dental Caries in Children Younger Than Age 5 Years?

Summary

- No study directly evaluated the effects of referral by a primary care clinician to a dentist on caries incidence.
- Four new additional observational studies (N=61,194) of children enrolled in Medicaid found receiving a preventive dental visit from a dentist versus primary care clinician associated with increased likelihood of subsequent caries-related treatment, though findings are susceptible to confounding by indication. The studies were not designed to determine the referral source or effects of dental referral from primary care versus no referral.
- One study included in the prior USPSTF review (n=19,888) and one additional study (n=11,394) of children enrolled in Medicaid found an earlier (versus later) first preventive dental visit associated with no difference in subsequent dental procedures among treatment in children without caries at baseline; an earlier visit was associated with higher caries burden when assessed in kindergarten, but lower likelihood of untreated caries.
Evidence

No study directly evaluated referral of children younger than 5 years of age by a primary care clinician to a dental care professional versus no referral and effects on caries incidence or other dental outcomes. One retrospective cohort study included in the prior USPSTF report (n=19,888)\textsuperscript{71} and five subsequent retrospective cohort studies (N=72,588)\textsuperscript{72-76} evaluated outcomes associated with earlier versus later timing of preventive visits or primary care clinician versus dental provision of preventive dental visits (Appendix B5). All of the studies were conducted in Medicaid populations in North Carolina or Alabama; populations overlapped for studies conducted in the same state. The studies did not directly address the key question because they were not designed to determine the referral source or effects of dental referral from primary care versus no referral. In addition, although all studies controlled for confounders (including demographic factors, socioeconomic factors, and risk factors for caries), findings are susceptible to confounding by indication related to the need for dental services. All studies were rated fair-quality (Appendix B6).

Two new studies compared children enrolled in North Carolina Medicaid who had preventive oral health visits from a primary care clinician versus a dentist (Appendix B5).\textsuperscript{74,75} In both analyses, children who received oral health visits from a primary care clinician were less likely to receive caries-related treatment compared with those who received oral health visits from a dentist, likely because those who saw a dentist had greater dental health needs. In the larger study (n=41,453), the likelihood of receiving any caries-related treatment between 3 to 5 years of age was 26.7 percent among children who received preventive oral health visits from a primary care clinician, 51.8 percent among children who received preventive oral health visits from a dentist, and 47.6 percent among children who received preventive health visits from both.\textsuperscript{74} However, among children at risk for caries, another analysis (n=5235) found receiving preventive health visits from a primary care clinician associated with higher likelihood of untreated decayed teeth than receiving preventive health visits from a dentist (OR 2.05, 95% CI, 1.28 to 3.30).\textsuperscript{75}

Two new studies conducted among children enrolled in Alabama Medicaid reported similar results (Appendix B5).\textsuperscript{73,76} One study (n=9732) found children who had at least one preventive dental visit by a dentist were more likely to receive any caries-related treatment (20.6% vs. 11.3%, p<0.001) than those without a preventive dental visit.\textsuperscript{73} In the other study, children with at least one preventive dental visit by a dentist had more restorative dental visits (difference 11.1%, p<0.05) and emergency dental visits (difference 1.9%, p<0.05) than those without a preventive visit.\textsuperscript{76}

Two studies compared children with a first earlier versus later preventive dental visit. A study included in the prior USPSTF report evaluated children enrolled in North Carolina Medicaid (n=19,888) (Appendix B5).\textsuperscript{71} It found having a first tertiary (dental caries present at baseline) preventive dental visit after 18 months of age associated with increased risk of subsequent dental procedures between 43 and 72 months of age compared with having an earlier (before 18 months of age) first visit (incidence density ratio ranged from 1.1 to 1.4). Among children without dental disease at baseline, there was no difference in risk of subsequent dental procedures by timing of initial preventive dental visit. A subsequent, new study of children also enrolled in North Carolina Medicaid (n=11,394) found a first preventive visit by 37 to 48 or 49 to 60 months of
age associated with higher dmft index when assessed in kindergarten compared with first visit by 24 months of age, a finding likely related to children with more severe dental issues receiving earlier preventive visits. However, a later first visit was associated with decreased likelihood of having untreated caries.

**Key Question 4. How Effective Are Preventive Interventions (Dietary Fluoride Supplementation, Topical Fluoride Application, Silver Diamine Fluoride, or Xylitol) in Preventing Dental Caries in Children Younger Than Age 5 Years?**

**Dietary Fluoride Supplementation**

**Summary**

- We identified no new trials published since the 2004 USPSTF review.
- One randomized and four nonrandomized studies included in the 2004 review found dietary fluoride supplementation in settings with water fluoridation levels below 0.6 ppm F associated with decreased caries incidence versus no fluoridation.

**Evidence**

We identified no trials published since the 2004 USPSTF review of the effectiveness of fluoride supplementation on preventing dental caries in children younger than 5 years old. One randomized trial and four nonrandomized studies included in the 2004 USPSTF review found dietary fluoride supplementation in settings with water fluoridation levels below 0.6 ppm F associated with decreased caries incidence versus no fluoridation. The randomized trial (n=140, fluoridation <0.1 ppm F) found use of 0.25 mg fluoride drops or chews associated with decreased incidence of caries versus no fluoride supplementation in Taiwanese children with cleft lip who were 2 years of age at enrollment. The percent reduction in caries incidence ranged from 52 to 72 percent for dmft and from 51 to 81 percent for dmfs. In the nonrandomized trials (N=2,273), the reduction in caries incidence versus no fluoride supplementation ranged from mean dmft reduction of 32% to 69%, and decreased likelihood of incident caries (reductions ranged from 33% to 80%).

**Topical Fluoride Application**

**Summary**

- Based on 15 trials (5 trials in the prior USPSTF review and 10 new trials), topical fluoride (administered as fluoride varnish in all trials except for one) was associated with decreased caries increment (13 trials, N=5733, mean difference -0.94, 95% CI, -1.74 to -0.34, I²=86%) and decreased likelihood of incident caries (12 trials, N=8177, RR 0.80, 95% CI, 0.66 to 0.95, I²=79%; absolute risk difference [ARD] -7%, 95% CI, -12% to -2%) versus placebo or no varnish. Almost all trials were conducted in children at higher risk of caries.
• No trial evaluated effects of topical fluoride on quality of life, function, or other noncaries outcomes.

Evidence

The 2014 USPSTF review included three randomized trials that found fluoride varnish in children younger than 5 years of age more effective than no varnish (reduction in caries increment 18% to 59% and absolute mean reduction in the number of surfaces of 1.0 to 2.4). The trials enrolled children at high-risk of caries, based on low socioeconomic status, inadequate community fluoridation, or high baseline caries incidence. Two of the trials were conducted in Aboriginal communities in Canada or Australia and one trial was conducted in disadvantaged children in San Francisco. Results were consistent with findings from the 2004 USPSTF review, which found fluoride varnish associated with a percent reduction in incident caries lesions that ranged from 37 to 63 percent (absolute reduction in the mean number of cavities per child of 0.67 to 1.24 per year), based on three trials (two randomized and one with alternate allocation). One other randomized trial in the 2014 USPSTF review evaluated topical fluoride administered as acidulated phosphate fluoride foam rather than as a varnish; fluoride foam was associated with decreased risk of caries versus placebo (dmfs increment 3.8 vs. 5.0, p=0.03; reduction in caries increment 24%). Meta-analysis on the effects of topical fluoride on caries incidence was not conducted for the prior USPSTF review.

Five trials (N=2616) previously reviewed by the USPSTF on topical fluoride versus no varnish or placebo were carried forward for this update. As indicated above, four trials evaluated fluoride varnish and one trial evaluated fluoride administered as a foam. Eight trials of fluoride varnish included in prior USPSTF reviews were excluded due to poor-quality (non-randomized, including use of alternating allocation), age older than 5 years, evaluation of topical fluoride for treatment of existing caries, or comparisons of different frequencies of varnish application, without a no varnish or placebo control.

Ten additional trials (in 12 publications) of topical fluoride (N=6925) versus no treatment or placebo were added for this update (Table 1, Appendix B). All of the new trials evaluated fluoride varnish.

Across all 15 trials (previously reviewed by the USPSTF and added for this update), sample sizes ranged from 123 to 2536 (total N=9541) (Table 1, Appendix B). One trial was conducted in the United States, six in Europe, one in Brazil, one in Chile, two in China, two in Iran, and two in Aboriginal communities in Australia and Canada. Trials conducted in Kosovo, Iran, China, and the Aboriginal communities were not classified as “very high” on the human development index; the other trials were conducted in very high human development index countries. The mean age of enrolled children was 1 year to younger than 2 years in six trials and 2 years to younger than 5 years in nine trials; one trial did not report mean age but enrolled children 6 months to 5 years of age and was grouped with the trials of children 2 years to younger than 5 years. Five trials were conducted in preschool or daycare settings and the others were conducted in clinics. Seven trials enrolled children who were caries-free at baseline; five trials reported the proportion of children with caries at baseline, ranging from 17 to 100 percent, the trials with the highest...
proportion of children with caries at baseline (72% and 100%) were conducted in Aboriginal communities in Canada and Australia. All trials except for one evaluated children classified as being at higher risk, based on low socioeconomic status, high community prevalence of caries, high baseline caries burden, or low rates of oral health behaviors (e.g., tooth brushing with fluoride toothpaste).

Five trials were cluster randomized and the rest were individually randomized. Fluoride varnish was most commonly administered as 5 percent sodium fluoride varnish; single trials evaluated 1.5 percent ammonium fluoride, 0.2 ml 0.9 difluorosilane fluoride varnish, or 1.23 percent acidulated phosphate fluoride foam. Topical fluoride was administered every 6 months, with the exception of two trials which administered varnish every 3 or 4 months. One trial evaluated fluoride varnish every 6 or 12 months. Topical fluoride was administered by a dental health professional in all trials in which this information was reported. Three trials did not describe provision of oral health education; in the other trials, oral health education was provided in addition to the randomized intervention. The duration of followup ranged from 1 to 3 years. The trials focused on effects of topical fluoride on caries increment (reported as a continuous outcomes for number of incident caries surfaces or teeth) or on likelihood of a child developing incident caries (reported as a dichotomous outcome). No trial evaluated effects of fluoride varnish on quality of life, function, or other non-caries health outcomes.

Three trials were rated good-quality and the rest were rated fair-quality (Appendix B4). Methodological limitations in the fair-quality trials included unclear randomization or allocation concealment methods, open-label design, or high attrition.

In a meta-analysis, topical fluoride was associated with decreased caries increment versus placebo or no topical fluoride at 1 to 3 years followup (13 trials, N=5733, mean difference -0.94, 95% CI, -1.74 to -0.34, I²=86%; Figure 3). All trials reported caries increment as dmfs except for three, which only reported dmft. Statistical heterogeneity was substantial (I²=86%). Results consistently favored topical fluoride in analyses stratified according to use of cluster randomization, application frequency, classification as very high human development index setting, preschool setting, mean age (<2 years vs. ≥2 years), enrollment restricted to caries-free children at baseline, adequate community water fluoridation, provision of additional oral health measures, risk of bias, or duration of followup (1 vs. 2 vs. 3 years) (Table 1). Stratification on these factors had little effect on statistical heterogeneity and no statistically significant interactions between these factors and effects on caries increment were observed. Results were also similar when the trial that evaluated fluoride foam or the trial that was not conducted in a high-risk population was excluded from the analysis.

Topical fluoride was also associated with decreased likelihood of incident caries versus placebo or no topical fluoride (12 trials, N=8177, RR 0.80, 95% CI, 0.66 to 0.95; ARD -7%, 95% CI, -12% to -2%; Figure 4). Statistical heterogeneity was high (I²=79%). Definitions for incident caries included any caries lesion or development of ICDAS 5 to 6 (distinct dentine cavity) lesions (Table 2, Appendix B7). Results were similar when the trial of fluoride foam or the trial conducted in a nonhigh-risk population was excluded from the analysis (Table 2). There were no statistically significant interactions between use of cluster design, very high human...
development index setting, varnish frequency, preschool setting, all children caries-free at baseline, adequate community fluoridation, provision of additional oral health measures, risk of bias, or duration of followup, and statistical heterogeneity remained present in the stratified analyses (Table 2). There was a statistically significant interaction between age and effects of fluoride varnish on likelihood of incident caries (p for interaction=0.008). In trials in which the mean age was younger than 2 years, fluoride varnish was associated with decreased likelihood of incident caries (5 trials, N=3669, RR 0.60, 95% CI, 0.39 to 1.03, I²=49%), but there was no effect in trials in which the mean age of children was 2 years or older (7 trials, N=4508, RR 0.92, 95% CI, 0.81 to 1.01, I²=42%).

Xylitol

Summary

- One fair-quality trial (n=115) included in the prior USPSTF review found xylitol tablets associated with lower dmfs increment versus no xylitol in children 2 years of age (mean reduction 0.42, but the difference was not statistically significant.
- One small (n=44), fair-quality trial included in the prior USPSTF review found xylitol wipes associated with markedly decreased risk of having incident caries versus placebo wipes in children 6 to 35 months of age (5% vs. 32%, RR 0.14, 95% CI, 0.02 to 1.07), but the difference was not statistically significant.
- No new trials of xylitol versus no xylitol were identified.

Evidence

The 2014 USPSTF review included three trials of xylitol versus no xylitol, however, one of the trials was poor-quality (non-randomized) and excluded from this update. The other two trials were carried forward (Appendix B8); both were rated fair-quality. Methodological limitations included unclear randomization and/or allocation concealment, not blinding care providers or patients, and differences in attrition between groups (Appendix B4).

One trial (n=115) compared xylitol tablets versus no xylitol in Swedish children 2 years of age. Baseline caries prevalence was 6 percent and the proportion of children that brushed their teeth one to two times a day was 79 percent; water is not fluoridated in Sweden. Xylitol was administered as one 0.5 mg tablet at bedtime for 6 months, followed by two tablets daily. Xylitol was associated with lower dmfs increment versus no xylitol after 2 years, but the difference was not statistically significant (mean percent reduction 52%, mean dmfs reduction 0.42).

The other, smaller (n=44) trial compared xylitol wipes versus placebo wipes in U.S. (San Francisco) children 6 to 35 months of age (mean 17.3 months). Most children attending the clinic at which recruitment took place were of low socioeconomic status. The proportion of children with caries at baseline was 7 percent, the proportion that brushed their teeth daily was 68 percent, and the proportion that used fluoride toothpaste was 32 percent. The San Francisco water supply is generally fluoridated to 1.0 mg/l. Xylitol was administered as a topical wipe to the teeth three times per day for 1 year. Xylitol wipes were associated with markedly decreased risk of having incident caries versus placebo, though the difference was not statistically significant (5% [1/22] vs. 32% [7/22], RR 0.14, 95% CI 0.02 to 1.07). In an on-treatment
analysis of 37 children who completed the study, xylitol was associated with decreased risk of incident caries versus placebo (5% vs. 40%, p=0.03) and deceased dmfs increment (0.05 vs. 0.53, p=0.01); dmfs increment was not reported in the intention-to-treat population.

Silver Diamine Fluoride

We identified no trial meeting inclusion criteria of SDF versus placebo or no SDF for prevention of caries in children younger than 5 years of age. One trial\textsuperscript{101} was excluded because of non-English language, but a systematic review\textsuperscript{102} noted that methods and results were reported poorly and excluded the trial from meta-analysis. Evidence on SDF for prevention of caries in children 5 years of age or older is addressed in the Contextual Question.

Key Question 5. What Are the Harms of Specific Oral Health Interventions to Prevent Dental Caries in Children Younger Than Age 5 Years (Parental or Caregiver/Guardian Oral Health Education, Referral to a Dental Health Care Professional, and Preventive Interventions)?

Summary

- The prior USPSTF review included a systematic review of 19 studies which found an association between early childhood ingestion of systemic fluoride and enamel fluorosis of the permanent dentition. Studies were observational and had methodological shortcomings, including use of retrospective recall to determine exposures.
- Four new trials (N=4141) reported no differences between fluoride varnish versus placebo or no varnish in risk of fluorosis or the likelihood of any adverse event. Two studies reported children did not like the smell of the fluoride varnish and one study reported that a few children vomited due to the smell, texture, or taste.

Evidence

Dietary Fluoride Supplementation

No trial reported risk of dental fluorosis associated with early childhood ingestion of dietary fluoride supplements.

The prior USPSTF included a systematic review of 19 observational studies on the association between early childhood intake of fluoride supplements and risk of fluorosis, based on searches conducted through June 2006 (Appendix B9 and B10).\textsuperscript{46} Early childhood exposures were based on retrospective parental recall in 15 studies and on supplement use recorded at the time of exposure in four studies. Fluorosis was assessed at 8 to 14 years of age. The prevalence of fluorosis ranged from 10 to 67 percent. The review found intake of fluoride supplements prior to 7 years of age (primarily before 3 years of age) associated with increased risk of mild to moderate fluorosis. The ORs for dental fluorosis ranged from 1.1 to 10.8 in the studies that relied on retrospective recall and ranged from 4.2 to 15.6 in the studies that recorded supplement use at the time of exposure. We identified no new study on the association between early childhood intake of dietary fluoride supplements and risk of enamel fluorosis.
Topical Fluoride Application

The prior report included one trial of fluoride varnish that reported one child with an allergy to lanolin experienced an adverse event. The other studies did not report adverse events or reported that no adverse events were detected.

Four new trials (in 6 publications, N=4141) reported adverse events associated with fluoride varnish versus placebo or no varnish (Appendix B4 and B7).87-89,97,98,103

One trial (n=181) that followed children for 4 years reported no differences in the risk of fluorosis associated with the use of fluoride varnish compared with placebo (27% vs. 35%, p=0.44).103 There was also no difference in esthetically objectionable fluorosis (4.8% vs. 8.3%, p=0.48). No other trial reported risk of fluorosis. However, the degree of systemic exposure following application of fluoride varnish is believed to be low.

One trial (n=1096) reported no difference in the rate of adverse events between fluoride varnish and no fluoride varnish (7.2% vs. 5.9%; RR 1.22, 95% CI, 0.80 to 1.85).97,98 Two trials (N=2864) reported child complaints about varnish odor,87,89 with one reporting a few children vomited directly after application.88,89

Xylitol

Trials of xylitol did not report rates of diarrhea, and either did not report adverse events or stated none were reported.99,100

Contextual Question. 1. How Effective Is Silver Diamine Fluoride in Preventing Dental Caries in Children Age 5 Years or Older?

SDF has primarily been evaluated as a treatment for arresting existing cavitated caries lesions. Systematic reviews have found SDF effective for arresting caries in primary teeth of children, though methodological limitations have been noted.104,105 Evidence on the effectiveness of SDF for preventing caries in children is very limited. As described in the Results, we identified no trials on the effectiveness of SDF in preventing dental caries in children younger than 5 years of age. One trial (n=704) conducted in the Philippines allocated first graders in six schools based on class registration number to single application of SDF (administered by school nurses) or atraumatic restorative treatment (ART) sealants (administered by dentists).106 Children in two other schools served as no-treatment controls. The proportion of children with D3 caries at baseline was 13.3 percent. All of the schools were supposed to provide an ongoing oral health care program that included daily school-based tooth brushing with fluoride toothpaste, but three schools were not in compliance with the program. Therefore, analyses were stratified according to school compliance with the tooth brushing program. There were no statistically significant differences between SDF versus controls in caries increment in children in the brushing schools (hazard ratio [HR] 1.16, 95% CI, 0.51 to 2.63) or nonbrushing schools (HR 0.71, 95% CI 0.45 to 1.11), though estimates were imprecise. Staining and other harms were not reported.

We identified no other completed trials of SDF for preventing dental caries in children older than 5 years of age. Two similarly designed ongoing trials in the United States are currently in
progress, with expected completion in 2023. Both are cluster randomized trials in elementary school children and compare a single application of SDF (administered by dental hygienists or registered nurses) versus glass ionomer sealants (administered by dental hygienists). All children will receive toothbrushes, fluoride toothpaste, and oral hygiene instruction. The trial will evaluate caries arrest after 2 years and prevalence of new caries after 4 years. The primary difference between trials is that one is focused on children in low-income rural settings and in the other trial the primary study population is low-income urban Hispanic/Latino children.

One other randomized trial (n=452) of 6 year old children found 38 percent SDF every 6 months associated with fewer new decayed surfaces in primary teeth and first permanent molars versus no SDF at 36 months (0.29 vs. 1.43 and 0.37 vs. 1.06, respectively). However, applicability of this trial to prevention is uncertain, as SDF was used for caries arrest in deciduous teeth and baseline caries status in first permanent molars was unclear.
Chapter 4. Discussion

Summary of Review Findings

Table 3 summarizes the evidence reviewed for this update. Dental caries is highly prevalent in children younger than 5 years of age. A high proportion of children in this age group do not receive recommended dental care and important disparities in oral health and access to care exist, suggesting a potential role for primary care clinicians in dental caries screening and prevention. This report builds upon prior reviews conducted for the USPSTF. A difference between this report and the prior USPSTF reviews is that it utilizes separate analytic frameworks for screening and prevention, to more clearly distinguish treatment of children with existing caries identified on screening (screening analytic framework) from treatment of children without caries to prevent the development of future caries (interventions to prevent dental caries analytic framework).

Nonetheless, the main findings of this report are consistent with the prior USPSTF review. With regard to screening, we found no direct evidence on the effects of screening for dental caries by primary care clinicians in children younger than 5 years of age versus no screening on caries incidence and related outcomes. Some interventions, in particular fluoride supplementation in children and fluoride varnish, appear to be effective in preventing caries, though findings appear most applicable to higher risk children.

Evidence remains limited on the accuracy of primary care clinicians in identifying caries lesions or predicting caries incidence in children younger than 5 years of age. Compared with a pediatric dentist examination, one study in the prior USPSTF review found low sensitivity of primary care pediatricians for identifying children in need of a dental referral or with caries and another study in the prior review found high accuracy of a pediatrician oral examination for identifying nursing caries. One new study found a novel caries risk assessment tool administered by health visitor nurses in 1 year old children associated with suboptimal diagnostic accuracy for predicting future caries. Other studies have assessed caries risk assessment instruments in young children, but did not meet inclusion criteria because the instruments were not administered by primary care clinicians or in primary care settings. These instruments often incorporate findings from an oral examination by a dental health professional and include tests not commonly obtained or available in primary care (such as mutans streptococci levels, saliva secretion level, or saliva buffer capacity), potentially limiting applicability of findings to primary care settings.

Evidence on the effectiveness of parental or caregiver/guardian oral health education on caries outcomes also remains very limited. Two trials included in the prior USPSTF review were rated poor-quality (non-randomized) and not carried forward. One new trial found oral health education for mothers of caries-free children associated with reduced risk of incident dental caries versus usual care, but the study was relatively small and it was conducted in Iran, potentially reducing applicability to the United States. As in the prior USPSTF review, we identified no direct evidence on the effects of referral by a primary care clinician to a dentist on caries incidence. Observational studies of children enrolled
in Medicaid found receiving a preventive dental visit from a dentist (vs. a primary care clinician) associated with increased likelihood of subsequent caries-related treatment compared with a primary dental visit.\textsuperscript{73-76} However, these findings are difficult to interpret because of susceptibility to confounding by indication related to greater need for dental services in children who have a dental visit and variation in provision of caries-related treatment. Two observational studies compared an earlier versus later first preventive dental visit in early childhood but are also difficult to interpret. None of the studies were designed to determine referral source to dental services or to compare effects of dental referral from primary care versus no referral.

We identified no new trials published since the 2004 USPSTF review on the effectiveness of dietary fluoride supplementation in children younger than 5 years of age. The 2004 USPSTF review found dietary fluoride supplementation to be effective at reducing caries incidence in children younger than 5 years of age in settings primarily with water fluoridation levels less than 0.6 ppm F, though conclusions were mostly based on non-randomized trials.\textsuperscript{7} We also found no new evidence on the association between early childhood intake of dietary fluoride supplementation and risk of enamel fluorosis. A systematic review included in the prior USPSTF review found an association between early childhood ingestion of systemic fluoride and enamel fluorosis of the permanent dentition.\textsuperscript{46} Risk of enamel fluorosis appears to be impacted by total intake of fluoride (from supplements, drinking water, other dietary sources, and dentifrices), as well as age at intake, with intake before 2 to 3 years of age appearing to confer highest risk.\textsuperscript{116} Although the prevalence of fluorosis may have increased among U.S. adolescents,\textsuperscript{117,118} observed trends could be related to variability in the accuracy or reliability of methods used to assess fluorosis.\textsuperscript{119} Regardless, severe fluorosis remains uncommon, with a prevalence of less than 2 percent.\textsuperscript{117}

Our findings on the effectiveness of topical fluoride were also consistent with the prior USPSTF review, based on ten new trials, and five trials carried forward from the prior USPTF review. Seven of the ten new trials were conducted in very high human development index settings (compared to two of five prior trials), potentially increasing applicability of findings to U.S. primary care settings. A meta-analysis found topical fluoride associated with decreased caries increment (mean difference -0.94, 95% CI, -1.74 to -0.34) and decreased likelihood of experiencing incident caries (RR 0.80, 95% CI, 0.66 to 0.95). The number needed to treat to prevent one child with incident caries was about 14. Topical fluoride was administered as a varnish in all trials except for one,\textsuperscript{47} which used acidulated phosphate fluoride foam. Although pooled analyses were characterized by substantial statistical heterogeneity, results were consistent in stratified analyses based on a number of factors, including use of cluster randomization, varnish frequency, setting, baseline caries status, community water fluoridation status, provision of additional oral health measures, risk of bias, and followup duration. Although there was an interaction between younger age and greater effectiveness of topical fluoride in reducing the likelihood of experiencing incident caries, there was no interaction between age and mean caries increment. Because almost all trials were conducted in higher risk children (based on low socioeconomic status, high community caries burden, high baseline caries burden, or low rate of oral health behaviors), the applicability of findings to children not at increased risk may be reduced. Although some studies were conducted in countries and settings in which sources of fluoride and oral health behaviors differ markedly from the United States, findings were similar when trials were stratified according to whether they were conducting in very high human development index settings or not. In all trials the varnish was applied by dental personnel,
though fluoride varnish is believed to be easily applied with minimal training.\textsuperscript{120,121} Evidence on harms associated with topical fluoride was limited but indicated no increased risk of fluorosis\textsuperscript{103} or adverse events\textsuperscript{97,98} versus placebo; serious adverse events were not reported though some children had difficulty tolerating varnish due to the odor.

Evidence on other preventive interventions was limited or unavailable. There were no new trials of xylitol in children younger than 5 years of age and evidence in the prior USPSTF review was limited to two trials with imprecise estimates.\textsuperscript{99,100} No trial evaluated SDF for prevention of caries in children younger than five years of age.

\textbf{Limitations}

Our review had limitations. First, we excluded non-English language articles, which could result in language bias. However, we did not identify non-English language articles that appeared likely to impact conclusions. Although one non-English language trial\textsuperscript{101} evaluated SDF versus no treatment for prevention of caries in children younger than 5 years of age, a systematic review\textsuperscript{102} that included this trial noted that methods and results were reported poorly and excluded it from meta-analysis. Second, we did not search for studies published only as abstracts. Third, we did not assess for publication bias with graphical or statistical methods because of differences in study design, populations, and outcomes assessed, with substantial statistical heterogeneity. Fourth, statistical heterogeneity was substantial in meta-analyses of topical fluoride. Results were consistent in prespecified stratified analyses based on factors related to study design, population characteristics, intervention characteristics, and setting, though stratification did not explain the heterogeneity. Fifth, some trials were conducted in countries and settings in which oral health care and behaviors may differ substantially from typical U.S. primary care settings, potentially reducing applicability. Sixth, most studies had methodological limitations, reducing certainty in findings, and some key questions and interventions were addressed by little or no evidence.

\textbf{Emerging Issues/Next Steps}

SDF was cleared for U.S. marketing by the FDA in 2014 as a desensitizing agent in adults.\textsuperscript{36} Although it has been evaluated for effectiveness in arresting existing caries, this use is off-label. There is also interest in using SDF off-label for prevention of caries. Two U.S. trials in elementary school-aged children are ongoing\textsuperscript{39,107} and could inform future trials in younger children. A potential disadvantage of SDF is permanent dark discoloration of active caries lesions by the silver component, which may impact acceptability, though this may be of less concern when applied prior to eruption of permanent teeth. In addition, active caries lesions themselves cause discoloration.

\textbf{Relevance for Priority Populations}

Dental caries disproportionately affects minority children and economically disadvantaged children. Contributing factors include lack of access to dental health services or insurance and suboptimal oral health behaviors. Recent data indicate that the largest improvements in burden of caries in children 2 to 5 years of age have occurred in those below the federal poverty threshold,
though significant disparities remain. In children below the federal poverty threshold, 17.6 percent had untreated caries in 2011 to 2014 compared with 6.2 percent at 200 percent or more above the threshold; corresponding rates for severe caries were 7.0 percent and 3.2 percent.\textsuperscript{15} Trials showing effectiveness of fluoride supplementation and topical fluoride have primarily been conducted in higher risk populations based on low socioeconomic status, caries burden, or low rates of oral health behaviors, indicating that increasing access and use of preventive treatments in disadvantaged populations could reduce disparities. Provision of oral care in primary care settings is considered an important strategy for improving access for vulnerable and underserved populations, because children who lack access to a dentist often have multiple encounters with a primary care clinician.\textsuperscript{122-124} For children enrolled in Medicaid or the Children’s Health Insurance Program (36 million as of May 2020), these programs are the primary source of dental coverage. In young children, receipt of preventive oral health services by nondental providers in medical settings is associated with reduced caries experience.\textsuperscript{125} State Medicaid policies to support primary care clinicians’ application of fluoride varnish to children expanded to all states following the publication of the 2014 USPSTF recommendation. Data indicate an association between implementation of such policies and increased likelihood of good or excellent teeth in this population.\textsuperscript{126}

**Future Research**

Research is needed to identify effective oral health educational and counseling interventions for parents and caregiver/guardians of young children. Research is also needed to validate the accuracy and utility of caries risk assessment instruments for use in primary care settings, and to determine how referral by primary care clinicians of young children for dental care affects caries outcomes. Additional trials would strengthen conclusions regarding the effectiveness of dietary fluoride supplementation in young children, especially in the current U.S. context of exposure to multiple sources of fluoride. Trials of fluoride varnish administered in primary care settings would be useful for confirming that effectiveness of fluoride varnish are reproducible in primary care settings and trials of varnish in lower-risk children and settings would be useful for determining applicability of findings. Studies on the effectiveness of SDF will clarify usefulness for prevention (rather than caries arrest) in young children; trials of SDF for prevention of caries in school-age children are expected to be completed in 2023.\textsuperscript{107,108}

**Conclusions**

Dietary fluoride supplementation and fluoride varnish appear to be effective at preventing caries outcomes in higher risk children younger than 5 years of age. Dietary fluoride supplementation in early childhood is associated with risk of enamel fluorosis, which is usually mild. More research is needed to understand the accuracy of oral health examination and caries risk assessment by primary care clinicians, primary care referral for dental care, and effective parental and caregiver/guardian educational and counseling interventions.
References


Anderson M, Dahllof G, Twetman S, et al. Effectiveness of early preventive intervention with semiannual fluoride varnish application in toddlers living in high-risk areas: A


Figure 1. Analytic Framework: Screening for Dental Caries in Children Younger Than Age 5 Years*

*The numbers in the analytic framework correspond to the Key Question numbers on page 9 in the report.
†Interventions are provided to children found to have caries on screening.
Figure 2. Analytic Framework: Interventions to Prevent Dental Caries in Children Younger Than Age 5 Years*

*The numbers in the analytic framework correspond to the Key Question numbers on page 9 in the report.
†Interventions are provided to children without caries.
### Figure 3. Pooled Analysis of Topical Fluoride vs. Placebo or No Topical Fluoride on Mean Change in Number of Caries at Followup, by Fluoridation Status

<table>
<thead>
<tr>
<th>Adequate fluoridation and Author, Year</th>
<th>Mean age of followup</th>
<th>Baseline caries</th>
<th>Continuous caries measured</th>
<th>N, Mean(SD) of Treatment</th>
<th>N, Mean(SD) of Control</th>
<th>Mean Difference (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>4</td>
<td>2 years</td>
<td>Mean dmfs; 4.79; dmfs-</td>
<td>93, 6.6(11.2)</td>
<td>113, 8.7(12.3)</td>
<td>-2.12 (-5.53 to 1.09)</td>
</tr>
<tr>
<td>Fratocelli, 1991*</td>
<td>3.5</td>
<td>2 years</td>
<td>Mean dmft; 1.6-1.7</td>
<td>167, 3.8(0.9)</td>
<td>151, 5.0(1.0)</td>
<td>-1.20 (-2.24 to -0.16)</td>
</tr>
<tr>
<td>Lawrence, 2006*</td>
<td>0.5-6†</td>
<td>2 years</td>
<td>dmft &gt;0: 72%</td>
<td>832, 17.9(14.4)</td>
<td>328, 13.5(16.3)</td>
<td>-2.80 (-6.94 to 1.34)</td>
</tr>
<tr>
<td>Slade, 2011*</td>
<td>2.8</td>
<td>2 years</td>
<td>≥1 carious surface</td>
<td>344, 7.3(13.4)</td>
<td>322, 9.6(10.1)</td>
<td>-2.30 (-3.75 to -0.85)</td>
</tr>
<tr>
<td>Aguirre-Lopez, 2014†</td>
<td>3.4</td>
<td>2 years</td>
<td>dmft &gt;0: 36%</td>
<td>175, 5.8(9.5)</td>
<td>154, 5.6(8.9)</td>
<td>0.30 (-1.88 to 2.28)</td>
</tr>
<tr>
<td>Jiang, 2014*</td>
<td>1.3</td>
<td>2 years</td>
<td>Mean dmft; 9.03</td>
<td>137, 5.2(0.5)</td>
<td>144, 9.0(10.5)</td>
<td>0.10 (-0.97 to 0.27)</td>
</tr>
<tr>
<td>Oliveira, 2012*</td>
<td>2.4</td>
<td>2 years</td>
<td>Dentine caries; 24% dmfs</td>
<td>85, 7.8(3.9)</td>
<td>92, 2.5(4.0)</td>
<td>-0.70 (-1.85 to 0.45)</td>
</tr>
<tr>
<td>Memarzadeh, 2016*</td>
<td>1.6</td>
<td>1 year</td>
<td>0</td>
<td>29, 0.3(0.9)</td>
<td>31, 0.4(1.0)</td>
<td>-0.12 (-0.56 to 0.38)</td>
</tr>
<tr>
<td>Muller-Millan, 2017*</td>
<td>2.7</td>
<td>2 years</td>
<td>dmft</td>
<td>131, 1.8(2.0)</td>
<td>144, 1.1(2.6)</td>
<td>-0.50 (-1.05 to 0.05)</td>
</tr>
<tr>
<td>Lattik-Xhemajli, 2019*</td>
<td>1.2</td>
<td>2 years</td>
<td>Mean dmfs; 1.1</td>
<td>218, 5.2(10.5)</td>
<td>209, 10.1(12.9)</td>
<td>-0.90 (-1.74 to -2.66)</td>
</tr>
<tr>
<td>McMahon, 2003*</td>
<td>3.5</td>
<td>2 years</td>
<td>Caries; 17%</td>
<td>577, 3.5(5.9)</td>
<td>573, 3.0(4.9)</td>
<td>0.00 (-0.83 to 0.63)</td>
</tr>
<tr>
<td>Subgroup (I² = 87.2%, p = 0.000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.8</td>
<td>2 years</td>
<td>0</td>
<td>187, 0.7(1.9)</td>
<td>93, 1.7(3.1)</td>
<td>-1.00 (-1.69 to -0.31)</td>
</tr>
<tr>
<td>Weintraub, 2006*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ticka, 2017*</td>
<td>3.1</td>
<td>3 years</td>
<td>0</td>
<td>187, 7.2(6.0)</td>
<td>213, 9.8(8.8)</td>
<td>-2.29 (-3.95 to -0.63)</td>
</tr>
<tr>
<td>Subgroup (I² = 0.0%, p = 0.159)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity between groups: p = 0.54  
Overall (I² = 85.7%, p = 0.006)  

- *Studies adjusted for clustering design or other confounding variables.
- †Range of age.

Abbreviations: CI=confidence interval; DMFS=decayed, missing, and filled surfaces; DMFT=decayed, missing, and filled teeth; ICDAS=International Caries Detection and Assessment System.
Figure 4. Pooled Analysis of Topical Fluoride vs. Placebo or No Topical Fluoride on Caries Development at Followup, by Fluoridation Status

<table>
<thead>
<tr>
<th>Adequate fluoridation and Author, Year</th>
<th>Mean age (years)</th>
<th>Duration of followup</th>
<th>Baseline caries</th>
<th>Outcome Definition</th>
<th>Treatment, Control, n/N</th>
<th>Risk Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jiang, 2005*</td>
<td>3.5</td>
<td>2 years</td>
<td>Mean dmft 1.6-1.7 dmfs increase &gt;6</td>
<td>47/167 53/151</td>
<td>0.80 (0.54 to 1.19)</td>
<td></td>
</tr>
<tr>
<td>Lawrence, 2008†</td>
<td>0.5-5†</td>
<td>2 years</td>
<td>dmft &gt;0: 72% New dmfs ≥1</td>
<td>595/832 247/328</td>
<td>1.07 (0.96 to 1.19)</td>
<td></td>
</tr>
<tr>
<td>Aggouropoulos, 2014†</td>
<td>3.4</td>
<td>2 years</td>
<td>dmfs &gt;0: 36% dmfs &gt;0</td>
<td>113/174 101/154</td>
<td>0.99 (0.85 to 1.16)</td>
<td></td>
</tr>
<tr>
<td>Jiang, 2014‡</td>
<td>1.3</td>
<td>2 years</td>
<td>Mean dmft: 0.03 Incident caries</td>
<td>14/137 10/144</td>
<td>1.47 (0.68 to 3.20)</td>
<td></td>
</tr>
<tr>
<td>Oliveira, 2014§</td>
<td>2.4</td>
<td>2 years</td>
<td>Dentine caries: 24%; New caries lesion</td>
<td>32/89 43/92</td>
<td>0.77 (0.54 to 1.09)</td>
<td></td>
</tr>
<tr>
<td>Anderson, 2015*</td>
<td>3</td>
<td>3 years</td>
<td>ICDAS 5-6: 5.2% ICDAS 5 to 6</td>
<td>75/1231 99/1305</td>
<td>0.78 (0.43 to 1.44)</td>
<td></td>
</tr>
<tr>
<td>Memarespou, 2016§</td>
<td>1.7</td>
<td>1 year</td>
<td>dmf &lt;0</td>
<td>1/87 4/85</td>
<td>0.24 (0.03 to 2.14)</td>
<td></td>
</tr>
<tr>
<td>Mroz-Miller, 2017*</td>
<td>2.7</td>
<td>2 years</td>
<td>Cavitated caries</td>
<td>59/131 89/144</td>
<td>0.31 (0.54 to 1.03)</td>
<td></td>
</tr>
<tr>
<td>Latifi-Xhemajli, 2019†</td>
<td>1.8</td>
<td>2 years</td>
<td>Mean dmfs: 1.1 ICDAS 5 or 6</td>
<td>48/218 100/209</td>
<td>0.46 (0.35 to 0.61)</td>
<td></td>
</tr>
<tr>
<td>McMahon, 2020‡</td>
<td>3.5</td>
<td>2 years</td>
<td>Caries: 17% d,ns increment &gt;0</td>
<td>165/577 193/573</td>
<td>0.85 (0.71 to 1.01)</td>
<td></td>
</tr>
<tr>
<td>Subgroup (I² = 75.4%, p = 0.000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weintraub, 2006§</td>
<td>1.8</td>
<td>2 years</td>
<td>Incident caries</td>
<td>37/163 42/92</td>
<td>0.49 (0.34 to 0.75)</td>
<td></td>
</tr>
<tr>
<td>Tidke, 2017§</td>
<td>3.1</td>
<td>3 years</td>
<td>Became caries active167/549 213/547</td>
<td>0.87 (0.75 to 1.02)</td>
<td>0.68 (0.33 to 1.33)</td>
<td></td>
</tr>
<tr>
<td>Subgroup (I² = 76.2%, p = 0.003)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogeneity between groups: p = 0.43
Overall (I² = 79.3%, p = 0.000)

*Studies adjusted for clustering design or other confounding variables.
†Range of age.

Abbreviations: CI=confidence interval; DMFS=decayed, missing, and filled surfaces; DMFT=decayed, missing, and filled teeth; ICDAS=International Caries Detection and Assessment System.
Table 1. Pooled Analyses of Mean Change in Number of Caries at Followup, Topical Fluoride vs. Placebo or No Topical Fluoride

<table>
<thead>
<tr>
<th></th>
<th>Number of trials</th>
<th>MD (95% CI)</th>
<th>I²</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>All trials</td>
<td>13</td>
<td>-0.94 (-1.74 to -0.34)</td>
<td>86%</td>
<td>--</td>
</tr>
<tr>
<td>** Fluoride type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 5% NaF varnish</td>
<td>10</td>
<td>-0.62 (-1.35 to -0.16)</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>• Other varnish</td>
<td>2</td>
<td>-2.24 (-8.56 to 3.98)</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>• Foam</td>
<td>1</td>
<td>-1.20 (-2.24 to -0.16)</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>** Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Good-quality trials</td>
<td>3</td>
<td>0.08 (-0.28 to 0.27)</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>• Fair-quality trials</td>
<td>10</td>
<td>-1.33 (-2.36 to -0.54)</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>** Fluoridation status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adequate</td>
<td>2</td>
<td>-1.19 (-2.81 to -0.29)</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>• Not adequate</td>
<td>11</td>
<td>-0.85 (-1.81 to -0.16)</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>** Cluster RCT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>3</td>
<td>-1.63 (-3.04 to -0.64)</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>• No</td>
<td>10</td>
<td>-0.72 (-1.66 to -0.09)</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>** Setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preschool</td>
<td>5</td>
<td>-1.04 (-2.90 to 0.57)</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>• Other</td>
<td>8</td>
<td>-0.89 (-1.86 to -0.21)</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>** Mean age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• &lt;2 years old</td>
<td>4</td>
<td>-1.26 (-3.24 to 0.74)</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>• ≥2 years old</td>
<td>9</td>
<td>-0.89 (-1.70 to -0.30)</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>** High-risk of caries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>12</td>
<td>-0.81 (-1.64 to -0.24)</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>• No</td>
<td>1</td>
<td>-2.29 (-3.95 to -0.63)</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>** Caries free at baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>5</td>
<td>-0.43 (-1.24 to 0.06)</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>• No</td>
<td>8</td>
<td>-1.40 (-2.74 to -0.29)</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>** High human development index</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>7</td>
<td>-0.43 (-1.16 to 0.06)</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td>• No</td>
<td>6</td>
<td>-1.62 (-3.26 to -0.33)</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>** Additional oral health measures used</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>10</td>
<td>-0.53 (-1.18 to -0.10)</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td>• No</td>
<td>3</td>
<td>-2.57 (-5.45 to 0.03)</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td>** Duration of followup</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1 year</td>
<td>2</td>
<td>-0.09 (-0.73 to 0.71)</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>• 2 years</td>
<td>11</td>
<td>-0.95 (-1.87 to -0.28)</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>• 3 years</td>
<td>1</td>
<td>-2.29 (-3.95 to -0.63)</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>** Application Frequency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Every 3 months</td>
<td>1</td>
<td>-4.90 (-7.14 to -2.66)</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>• Every 4 months</td>
<td>1</td>
<td>-0.12 (-0.60 to 0.36)</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>• Every 6 months</td>
<td>11</td>
<td>-0.73 (-1.40 to -0.24)</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>• Every 12 months</td>
<td>1</td>
<td>-1.00 (-1.72 to -0.28)</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

*p value for interaction.

Abbreviations: CI=confidence interval; MD=mean difference; NaF=sodium fluoride; RCT=randomized controlled trial.
Table 2. Pooled Analyses of Risk of Caries Development at Followup, Topical Fluoride vs. Placebo or No Topical Fluoride

<table>
<thead>
<tr>
<th></th>
<th>Number of trials</th>
<th>RR (95% CI)</th>
<th>I²</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>All trials</td>
<td>12</td>
<td>0.80 (0.66 to 0.95)</td>
<td>79%</td>
<td>--</td>
</tr>
<tr>
<td><strong>Fluoride type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 5% NaF varnish</td>
<td>11</td>
<td>0.84 (0.69 to 0.99)</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>• Other varnish</td>
<td>257,91</td>
<td>0.69 (0.27 to 1.71)</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>• Foam</td>
<td>1,17</td>
<td>0.80 (0.54 to 1.19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Good-quality trials</td>
<td>30,92,96</td>
<td>0.85 (0.71 to 1.08)</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>• Fair-quality trials</td>
<td>9,37,83,85,89,91,93,95,96,98</td>
<td>0.77 (0.60 to 0.96)</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td><strong>Fluoridation status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adequate</td>
<td>255,96</td>
<td>0.68 (0.33 to 1.33)</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>• Not adequate</td>
<td>10</td>
<td>0.83 (0.68 to 1.00)</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td><strong>Cluster RCT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>317,83,89</td>
<td>1.04 (0.74 to 1.17)</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>• No</td>
<td>9,37,83,90,91,93,95,96,98</td>
<td>0.76 (0.60 to 0.95)</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preschool</td>
<td>5,117,87,91,92</td>
<td>0.77 (0.58 to 1.01)</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>• Other</td>
<td>7,37,83,85,90,91,93,95,96,98</td>
<td>0.83 (0.61 to 1.08)</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td><strong>Mean age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• &lt;2 years old</td>
<td>5,37,83,90,91,93</td>
<td>0.60 (0.39 to 1.03)</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>• ≥2 years old</td>
<td>7,37,83,90,91,93,95,96,98</td>
<td>0.92 (0.81 to 1.01)</td>
<td>42%</td>
<td></td>
</tr>
<tr>
<td><strong>High-risk of caries</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>11</td>
<td>0.79 (0.64 to 0.96)</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>• No</td>
<td>1,98</td>
<td>0.87 (0.75 to 1.02)</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td><strong>Caries free at baseline</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>6,37,83,85,90,91,93,95,98</td>
<td>0.77 (0.57 to 1.04)</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>• No</td>
<td>6,37,83,85,90,91,92,96</td>
<td>0.82 (0.62 to 1.05)</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td><strong>High human development index</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>7,37,83,85,90,91,92,95,98</td>
<td>0.84 (0.69 to 1.00)</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>• No</td>
<td>5,37,83,91,93,96</td>
<td>0.74 (0.47 to 1.07)</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td><strong>Additional oral health measures used</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>10</td>
<td>0.86 (0.73 to 1.00)</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td>• No</td>
<td>2,37,91</td>
<td>0.59 (0.31 to 1.18)</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td><strong>Duration of followup</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1 year</td>
<td>3,37,85,93</td>
<td>0.71 (0.27 to 1.29)</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td>• 2 years</td>
<td>9,37,83,85,90,92,95,96</td>
<td>0.79 (0.63 to 0.99)</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>• 3 years</td>
<td>2,37,91</td>
<td>0.87 (0.67 to 1.07)</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td><strong>Application Frequency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Every 3 months</td>
<td>1,17</td>
<td>0.46 (0.35 to 0.61)</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>• Every 6 months</td>
<td>1,37,83,85,87,89,90,92,93,95,96,98</td>
<td>0.88 (0.74 to 0.98)</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>• Every 12 months</td>
<td>1,153</td>
<td>0.60 (0.40 to 0.91)</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

*p value for interaction.

Abbreviations: CI=confidence interval; NaF=sodium fluoride; RCT=randomized controlled trial; RR=relative risk.
### Table 3. Summary of Evidence

<table>
<thead>
<tr>
<th>Key Question</th>
<th>Studies (k)</th>
<th>Observations (n)</th>
<th>Summary of Findings</th>
<th>Consistency and Precision</th>
<th>Other Limitations</th>
<th>Strength of Evidence</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening KQ 1 and 3. Effectiveness and harms of screening by PCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening KQ 2a. Accuracy of screening by PCP: Identifying caries lesion</td>
<td>k=2 (N=368) diagnostic accuracy studies (both in prior USPSTF review)</td>
<td></td>
<td>• Sensitivity of 0.76 and specificity of 0.95 for identifying a child with one or more cavities and sensitivity of 0.63 and specificity of 0.98 for identifying a child in need of a dental referral (1 study) • Sensitivity of 1.0 and specificity of 0.87 for identifying nursing caries (1 study)</td>
<td>Unable to assess consistency due to differences between studies Precision low to moderate</td>
<td>Nursing caries study rated fair-quality</td>
<td>Low</td>
<td>Primary care examiners underwent 2 or 4 hours of training; both studies conducted in the United States</td>
</tr>
<tr>
<td>Screening KQ 2b. Accuracy of screening by PCP: Predicting future caries</td>
<td>k=1 (n=1681) diagnostic accuracy study (new)</td>
<td>Dundee Caries Risk Assessment Model associated with sensitivity of 0.53 and specificity of 0.77 for predicting future dentin caries in children 1 year of age</td>
<td>Unable to assess consistency (single study) Precise</td>
<td>Fair-quality; factors selected for model not predefined; no validation available</td>
<td>Low</td>
<td>Administered by health visitor nurses in Scotland</td>
<td></td>
</tr>
<tr>
<td>Prevention KQ 1. Accuracy of screening by PCP*</td>
<td>See Screening KQ 2b</td>
<td>See Screening KQ 2b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention KQ 2. Educational interventions</td>
<td>k=1 (n=104) RCT (new)</td>
<td>1 RCT found oral health education for mothers of caries-free children 12 to 36 months of age associated with reduced risk of incident dental caries vs. usual care at 6 months (RR 0.39, 95% CI, 0.18 to 0.85).</td>
<td>Unable to assess consistency (1 study) Precise</td>
<td>Fair-quality; dental health behaviors not reported at baseline or followup</td>
<td>Low</td>
<td>Conducted in Iran in region with inadequate fluoridation of drinking water</td>
<td></td>
</tr>
<tr>
<td>Key Question</td>
<td>Studies (k)</td>
<td>Observations (n)</td>
<td>Study Designs</td>
<td>Summary of Findings</td>
<td>Consistency and Precision</td>
<td>Other Limitations</td>
<td>Strength of Evidence</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>-----------------</td>
<td>--------------</td>
<td>---------------------</td>
<td>--------------------------</td>
<td>-----------------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>
| Prevention KQ 3. Referral to a dentist by a PCP | k=6 (N=92,476) observational studies; 1 study in prior review and 5 new | | | • No study directly compared referral by primary care clinician to a dentist vs. no referral  
• Receiving a dental visit from a dentist associated with increased likelihood of subsequent caries-related treatment versus a dental visit from a primary care provider (4 studies)  
• Earlier versus later first preventive dental visit associated with no difference in rate of subsequent dental procedures, higher subsequent caries burden, and lower rates of untreated caries | Consistent  
Precise | Observational studies; fair quality; studies not designed to determine referral source or compare effects of referral vs. no referral; findings susceptible to confounding by indication | Low | All studies conducted in U.S. children enrolled in Medicaid; some overlap in study populations conducted within the same state |
| Prevention KQ 4. Preventive interventions: Dietary fluoride supplementation | k=1 (n=140) RCT and k=4 (N=3172) non-randomized trials (all in prior USPSTF review) | | | Dietary fluoride supplementation in settings with water fluoridation levels below 0.6 ppm fluoride associated with decreased caries incidence versus no fluoridation (percentage reduction ranged from 48% to 72% for primary teeth and 51% to 81% for primary tooth surfaces) | Consistent  
Precise | 4 of 5 trials were non-randomized | Moderate | 2 trials conducted in Asia; 1 trial conducted in children with cleft lip; 3 trials conducted between 1967 and 1972 |
<table>
<thead>
<tr>
<th>Key Question</th>
<th>Studies (k) Observations (n) Study Designs</th>
<th>Summary of Findings</th>
<th>Consistency and Precision</th>
<th>Other Limitations</th>
<th>Strength of Evidence</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention KQ 4. Preventive interventions: Topical fluoride</td>
<td>k=15 (N=9541) RCTs (5 in prior USPSTF review and 10 new)</td>
<td>Topical fluoride associated with decreased caries increment (13 trials, mean difference -0.94, 95% CI -1.74 to -0.34) and decreased likelihood of incident caries (12 trials, RR 0.80, 95% CI 0.66 to 0.95) vs. placebo or no varnish</td>
<td>Inconsistent (high statistical heterogeneity) Precise</td>
<td>11 trials rated fair quality (2 rated good quality); open-label design in some trials</td>
<td>Moderate</td>
<td>Almost all trials conducted in higher risk children or settings; almost all trials evaluated fluoride varnish; varnish applied by persons with dental training; some trials conducted in preschool or daycare setting; some trials conducted in non-very high human development index settings; some trials included children with high baseline caries burden</td>
</tr>
<tr>
<td>Prevention KQ 4. Preventive interventions: Xylitol</td>
<td>k=2 (N=159) RCTs (both in prior USPSTF review)</td>
<td>Estimates imprecise from 2 trials, but favored xylitol over placebo for caries outcomes</td>
<td>Consistent Imprecise</td>
<td>Trials rated fair-quality</td>
<td>Low</td>
<td>Trials conducted in U.S. and Sweden; 1 trial conducted in low socioeconomic status setting; xylitol administered as tablet or wipe</td>
</tr>
<tr>
<td>Prevention KQ 4. Preventive interventions: Silver diamine fluoride</td>
<td>No studies</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Prevention KQ 5. Harms of interventions: Dietary fluoride supplements</td>
<td>k=1 SR of 19 observational studies (in prior USPSTF review)</td>
<td>Intake of fluoride supplements prior to 7 years of age (primarily before 3 years of age) associated with increased risk of mild to moderate fluorosis; odds ratio ranged from 1.1 to 10.8 in the studies that relied on retrospective recall and from 4.2 to 15.6 in the studies that recorded supplement use at the time of exposure</td>
<td>Consistent Precise</td>
<td>Observational studies; most studies relied on retrospective recall to determine fluoride exposure</td>
<td>Low-moderate</td>
<td>Studies conducted in a variety of settings and countries, variability in recommended levels of fluoride supplementation and water fluoridation levels</td>
</tr>
</tbody>
</table>
### Table 3. Summary of Evidence

<table>
<thead>
<tr>
<th>Key Question</th>
<th>Studies (k) Observations (n) Study Designs</th>
<th>Summary of Findings</th>
<th>Consistency and Precision</th>
<th>Other Limitations</th>
<th>Strength of Evidence</th>
<th>Applicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention KQ 5. Harms of interventions</td>
<td>k=4 (N=4141) RCTs (all new)</td>
<td>No difference in risk of fluorosis or esthetically objectionable fluorosis (1 trial); no difference in risk of adverse events (1 trial); reports of complaints about odor</td>
<td>Consistency cannot be determined (single trials reported different adverse events) Precise</td>
<td>Harms not reported or suboptimal reporting in most trials</td>
<td>Low-moderate</td>
<td>See KQ 4</td>
</tr>
<tr>
<td>Prevention KQ 5. Harms of interventions</td>
<td>No studies</td>
<td>RCTs of xylitol vs. placebo or no xylitol did not report harms</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

*This is the same question as Screening KQ 2b.*

Abbreviations: CI=confidence interval; KQ=key question; PCP=primary care physician; ppm=parts per million; RCT=randomized controlled trial; RR=relative risk; SR=systematic review; USPSTF=United States Preventive Services Task Force.
Appendix A1. Search Strategies

**Database: OVID MEDLINE®**

Search Strategy:

1. `exp Dental Caries/` (43963)
2. limit 1 to ("newborn infant (birth to 1 month)" or "infant (1 to 23 months)" or "preschool child (2 to 5 years)") (8321)
3. limit 2 to `yr="2014 -Current"` (1368)
4. limit 3 to `(meta analysis or "systematic review")` (36)
5. from 4 keep 11,13,18,20-22,24,31 (8)
6. limit 3 to `randomized controlled trial` (121)
8. 5 or 7 (56)

**Database: EBM Reviews - Cochrane Database of Systematic Reviews**

Search Strategy:

1. `dental caries.mp. [mp=title, short title, abstract, full text, keywords, caption text]` (113)
2. limit 1 to `full systematic reviews` (87)
3. 2 and `prevention.mp. [mp=title, short title, abstract, full text, keywords, caption text]` (62)
4. 3 and `children.mp. [mp=title, short title, abstract, full text, keywords, caption text]` (51)
5. from 4 keep 1,6,8,23,30,32-35,41-42 (11)
## Appendix A2. Inclusion and Exclusion Criteria

<table>
<thead>
<tr>
<th>Category</th>
<th>Included</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Populations</strong></td>
<td>Asymptomatic children younger than age 5 years</td>
<td>Animal studies, adults, children older than preschool age (≥5 years), and children who are symptomatic for dental caries</td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
<td><strong>KQs 1–3 (screening) and KQ 1 (preventive interventions):</strong> Oral screening and risk factor assessment performed by a primary care clinician</td>
<td><strong>KQs 1–3 (screening) and KQ 1 (preventive interventions):</strong> Community- or school-based screening interventions</td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
<td><strong>KQs 2, 3, 5 (preventive interventions):</strong> Parent/caregiver/guardian oral health education and/or referral to dental health care provider</td>
<td><strong>KQs 2, 3 (preventive interventions):</strong> Education or referral not performed in primary care settings; education or referral for existing caries</td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
<td><strong>KQs 4, 5 (preventive interventions):</strong> Preventive interventions: oral fluoride supplementation, topical fluoride application, silver diamine fluoride, or xylitol (including xylitol given to the child or mother)</td>
<td><strong>KQs 4, 5 (preventive interventions):</strong> Interventions not available for preschool children or not available in the United States; treatment for existing caries</td>
</tr>
<tr>
<td><strong>Comparisons</strong></td>
<td>No intervention or placebo</td>
<td>Active treatment</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td><strong>KQs 1, 3 (screening) and KQs 2–5 (preventive interventions):</strong> Dental caries, morbidity, quality of life, and function</td>
<td>Cost effectiveness</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td><strong>KQ 2 (screening) and KQ 1 (preventive interventions):</strong> Diagnostic accuracy and measures of risk prediction</td>
<td></td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td><strong>KQ 3 (screening) and KQ 5 (preventive interventions):</strong> Dental fluorosis, tooth staining, emotional stress, acute toxicity, and other associated complications</td>
<td></td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Applicable to U.S. primary care practice</td>
<td>Schools; dental clinics providing interventions not available in primary care settings</td>
</tr>
<tr>
<td><strong>Study Design</strong></td>
<td><strong>KQ 1 (screening) and KQs 2–4 (preventive interventions):</strong> Randomized, controlled trials; nonrandomized, controlled clinical trials; and cohort studies</td>
<td><strong>KQs 1, 2 (screening) and KQs 1–4 (preventive interventions):</strong> Case-control studies; uncontrolled intervention studies</td>
</tr>
<tr>
<td><strong>Study Design</strong></td>
<td><strong>KQ 2 (screening) and KQ 1 (preventive interventions):</strong> Studies of diagnostic accuracy or risk prediction</td>
<td><strong>All KQs:</strong> Opinions, editorials, or case reports</td>
</tr>
<tr>
<td><strong>Study Design</strong></td>
<td><strong>KQ 3 (screening) and KQ 5 (preventive interventions):</strong> Randomized, controlled trials; nonrandomized, controlled clinical trials; cohort studies or case-control studies (if data from randomized trials are lacking); and systematic reviews</td>
<td></td>
</tr>
<tr>
<td><strong>Study Quality</strong></td>
<td>Good or fair quality</td>
<td>Poor quality</td>
</tr>
</tbody>
</table>
Appendix A3. Literature Flow Diagram

**Abbreviations:** CQ=Contextual question; KQ=Key question.

*Identified from reference lists, hand searching, suggested by experts, etc.

†We included 36 publications of 33 studies. See Appendix A5 for the list of excluded studies and Appendix A2 for the list of exclusion criteria.

‡Studies that provided data and contributed to the body of evidence were considered ‘included’.

§Studies may have contributed data for more than one key question.
Appendix A4. List of Included Studies


Appendix A4. List of Included Studies


Appendix A4. List of Included Studies


Appendix A5. List of Excluded Studies With Reasons for Exclusion

**Exclusion key:** 2: background information only; 3: contextual information only; 4: ineligible population; 5: ineligible intervention; 6: ineligible publication type; 7: ineligible outcome; 8: ineligible setting; 9: not applicable to U.S. population; 10: non-English paper; 11: outdated and/or non-systematic review; 12: ineligible comparison; 13: poor-quality study.

**Full-text papers excluded from the prior review**


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Full-text papers excluded from update searches


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


### Appendices A5: List of Excluded Studies With Reasons for Exclusion

<table>
<thead>
<tr>
<th>Study Reference</th>
<th>Exclusion Reason</th>
<th>PMID</th>
<th>Exclusion</th>
</tr>
</thead>
</table>
Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A5. List of Excluded Studies With Reasons for Exclusion


Appendix A6. Criteria for Assessing Internal Validity of Individual Studies*

**Systematic Reviews**

Criteria:
- Comprehensiveness of sources considered/search strategy used
- Standard appraisal of included studies
- Validity of conclusions
- Recency and relevance (especially important for systematic reviews)

Definition of ratings based on above criteria:

**Good:** Recent, relevant review with comprehensive sources and search strategies; explicit and relevant selection criteria; standard appraisal of included studies; and valid conclusions.

**Fair:** Recent, relevant review that is not clearly biased but lacks comprehensive sources and search strategies.

**Poor:** Outdated, irrelevant, or biased review without systematic search for studies, explicit selection criteria, or standard appraisal of studies.

**Case-Control Studies**

Criteria:
- Accurate ascertainment of cases
- Nonbiased selection of cases/controls, with exclusion criteria applied equally to both
- Response rate
- Diagnostic testing procedures applied equally to each group
- Measurement of exposure accurate and applied equally to each group
- Appropriate attention to potential confounding variables

Definition of ratings based on above criteria:

**Good:** Appropriate ascertainment of cases and nonbiased selection of case and control participants; exclusion criteria applied equally to cases and controls; response rate equal to or greater than 80%; accurate diagnostic procedures and measurements applied equally to cases and controls; and appropriate attention to confounding variables.

**Fair:** Recent, relevant, and without major apparent selection or diagnostic workup bias, but response rate less than 80% or attention to some but not all important confounding variables.

**Poor:** Major selection or diagnostic workup bias, response rate less than 50%, or inattention to confounding variables.

**RCTs and Cohort Studies**

Criteria:
- Initial assembly of comparable groups:
  - For RCTs: adequate randomization, including first concealment and whether potential confounders were distributed equally among groups.
  - For cohort studies: consideration of potential confounders, with either restriction or measurement for adjustment in the analysis; consideration of inception cohorts.
- Maintenance of comparable groups (includes attrition, cross-overs, adherence, contamination)
- Important differential loss to followup or overall high loss to followup
- Measurements: equal, reliable, and valid (includes masking of outcome assessment)
- Clear definition of interventions
Appendix A6. Criteria for Assessing Internal Validity of Individual Studies*

- All important outcomes considered
- Analysis: adjustment for potential confounders for cohort studies or intention-to-treat analysis for RCTs

Definition of ratings based on above criteria:
**Good:** Meets all criteria: comparable groups are assembled initially and maintained throughout the study (followup greater than or equal to 80%); reliable and valid measurement instruments are used and applied equally to all groups; interventions are spelled out clearly; all important outcomes are considered; and appropriate attention to confounders in analysis. In addition, intention-to-treat analysis is used for RCTs.

**Fair:** Studies are graded "fair" if any or all of the following problems occur, without the fatal flaws noted in the "poor" category below: generally comparable groups are assembled initially, but some question remains whether some (although not major) differences occurred with followup; measurement instruments are acceptable (although not the best) and generally applied equally; some but not all important outcomes are considered; and some but not all potential confounders are accounted for. Intention-to-treat analysis is used for RCTs.

**Poor:** Studies are graded "poor" if any of the following fatal flaws exists: groups assembled initially are not close to being comparable or maintained throughout the study; unreliable or invalid measurement instruments are used or not applied equally among groups (including not masking outcome assessment); and key confounders are given little or no attention. Intention-to-treat analysis is lacking for RCTs.

**Diagnostic Accuracy Studies**
Criteria:
- Screening test relevant, available for primary care, and adequately described
- Credible reference standard, performed regardless of test results
- Reference standard interpreted independently of screening test
- Indeterminate results handled in a reasonable manner
- Spectrum of patients included in study
- Sample size
- Reliable screening test

Definition of ratings based on above criteria:
**Good:** Evaluates relevant available screening test; uses a credible reference standard; interprets reference standard independently of screening test; assesses reliability of test; has few or handles indeterminate results in a reasonable manner; includes large number (greater than 100) of broad-spectrum patients with and without disease.

**Fair:** Evaluates relevant available screening test; uses reasonable although not best standard; interprets reference standard independent of screening test; has moderate sample size (50 to 100 subjects) and a "medium" spectrum of patients.

**Poor:** Has a fatal flaw, such as: uses inappropriate reference standard; improperly administers screening test; biased ascertainment of reference standard; has very small sample size or very narrow selected spectrum of patients.

Appendix A6. Criteria for Assessing Internal Validity of Individual Studies*

Appendix A7. Expert and Federal Reviewers

Expert Reviewers

Edward Chin Man Lo, BDS, MDS, PhD
Professor, Division of Applied Oral Sciences & Community Dental Care
Faculty of Dentistry at The University of Hong Kong

Steven M. Levy, DDS, MPH
Professor of Research, Department of Preventive & Community Dentistry
College of Dentistry and Dental Clinics
The University of Iowa

David M. Kroll, MD, MPH
Medical Director
Connecticut Children’s Care Network

Hugh Silk, MD, MPH
Professor
University of Massachusetts Medical School

Steven M. Levy, DDS, MPH
Professor of Research, Department of Preventive & Community Dentistry
College of Dentistry and Dental Clinics
The University of Iowa

Margherita Fontana, DDS, PhD
Professor of Dentistry
University of Michigan School of Dentistry

Federal Reviewers

Erin M. Abramsohn, DrPH, MPH
Office of the Associate Director for Policy and Strategy
Centers for Disease Control and Prevention

Frederick Hyman, DDS, MPH
Dental Officer
U.S. Food and Drug Administration

Darien Weatherspoon, DDS, MPH
National Institutes of Health/National Institute of Dental and Craniofacial Research

Benyam Hailu, MD, MPH
Medical Officer
National Institute on Minority Health and Health Disparities
<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Screening test</th>
<th>Reference standard</th>
<th>Country Setting Screener</th>
<th>Population</th>
<th>Sample size</th>
<th>Definition of a positive screening exam</th>
<th>Proportion unexaminable by screening test</th>
<th>Analysis of screening failures</th>
<th>Proportion who underwent reference standard and included in analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pierce et al., 2002</td>
<td>Primary care pediatrician exam following 2 hours of training</td>
<td>Pediatric dentist exam</td>
<td>United States Pediatric group practice Primary care pediatrician</td>
<td>Children &lt;36 months of age with erupted teeth participating in the &quot;Into the Mouths of Babes&quot; program. Excluded if they had received fluoride varnish and oral screening within 3 months or were very ill</td>
<td>n=258 children Cavitated lesions: 9.7% (mean 0.3/child)</td>
<td>Identification of a cavitated lesion Identification of need for referral</td>
<td>Appears to be none</td>
<td>Not applicable</td>
<td>Appears to be all</td>
</tr>
<tr>
<td>Serwint et al., 1993</td>
<td>Pediatrician exam (not primary care provider) following 4 hours of training</td>
<td>Pediatric dentist exam</td>
<td>United States General pediatric clinic Pediatrician</td>
<td>Children 18 to 36 months of age, mother primary caretaker. Excluded for developmental delay or facial abnormalities</td>
<td>n=110 children Nursing caries (caries involving ≥1 teeth including the maxillary central or lateral incisors or the primary molars but sparing the mandibular incisors): 20% (22/110)</td>
<td>Identification of nursing caries</td>
<td>Not reported</td>
<td>Not reported</td>
<td>55% (61/110)</td>
</tr>
</tbody>
</table>
## Appendix B1. Diagnostic Accuracy Studies for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Screening test</th>
<th>Reference standard</th>
<th>Country Setting Screener</th>
<th>Population</th>
<th>Sample size</th>
<th>Proportion with condition</th>
<th>Definition of a positive screening exam</th>
<th>Proportion unexamínable by screening test</th>
<th>Analysis of screening failures</th>
<th>Proportion who underwent reference standard and included in analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>MacRitchie et al., 2012</td>
<td>DCRAM</td>
<td>Dental exam following criteria developed for the Dundee selective threshold methods for caries detection.</td>
<td>Scotland Setting unclear, likely home-based Screening by nurse ‘health visitor’</td>
<td>Children born and resident in Dundee, Scotland, in 1 complete calendar year and followed longitudinally for 4 years.</td>
<td>n=1681</td>
<td>Any d₁ at year 1: 3% Any d₃ at year 1: 0.4% Any d₁ at year 4: 49% Any d₃ at year 4: 33%</td>
<td>At age 4 years: d₁mft ≥1 or ≥3 d₃mft ≥1 or ≥3</td>
<td>Appears to be none</td>
<td>Not applicable</td>
<td>99.8%</td>
</tr>
</tbody>
</table>
### Appendix B1. Diagnostic Accuracy Studies for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive predictive value</th>
<th>Negative predictive value</th>
<th>AUC (95% CI)</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pierce et al., 2002</td>
<td>Patient-level analysis: 0.76 (19/25), 95% CI, 0.55 to 0.91</td>
<td>Patient-level analysis: 0.95 (222/233), 95% CI, 0.92 to 0.98</td>
<td>Patient-level analysis: 0.63 (19/30), 95% CI, 0.48 to 0.76</td>
<td>Patient-level analysis: 0.95 (222/228), 95% CI, 0.95 to 0.99</td>
<td>NR</td>
<td>Good</td>
</tr>
<tr>
<td></td>
<td>Tooth-level analysis: 0.49 (39/80), 95% CI, 0.37 to 0.60</td>
<td>Tooth-level analysis: 0.99 (3210/3235), 95% CI, 0.99 to 0.99</td>
<td>Tooth-level analysis: 0.61 (39/64), 95% CI, 0.50 to 0.71</td>
<td>Tooth-level analysis: 0.99 (3210/3251), 95% CI, 0.98 to 0.99</td>
<td>NR</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td>Need for referral: 0.63 (17/27), 95% CI, 0.42 to 0.81</td>
<td>Need for referral: 0.98 (225/231), 95% CI, 0.95 to 0.99</td>
<td>Need for referral: 0.74 (17/23), 95% CI, 0.55 to 0.87</td>
<td>Need for referral: 0.96 (225/235), 95% CI, 0.93 to 0.97</td>
<td>NR</td>
<td>Fair</td>
</tr>
<tr>
<td>Serwint et al., 1993</td>
<td>1.0 (n/N not calculable)</td>
<td>0.87 (n/N not calculable)</td>
<td>Not calculable</td>
<td>Not calculable</td>
<td>NR</td>
<td>Fair</td>
</tr>
<tr>
<td>Current review</td>
<td>d₁mft &gt;0: 0.67</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Fair</td>
</tr>
<tr>
<td>MacRitchie et al., 2012</td>
<td>d₁mft &gt;0: 0.53</td>
<td>d₁mft &gt;0: 0.57</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Fair</td>
</tr>
<tr>
<td></td>
<td>d₁mft ≥3: 0.69</td>
<td>d₁mft ≥3: 0.77</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d₃mft ≥3: 0.65</td>
<td>d₃mft ≥3: 0.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>d₃mft ≥3: 0.69</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See Appendix A4 for full citations of included studies.

Abbreviations: AUC=area under the curve; DCRAM=Dundee Caries Risk Assessment Model; CI=confidence interval; NR=not reported.
## Appendix B2. Quality Ratings for Diagnostic Accuracy Studies

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Representative spectrum</th>
<th>Random or consecutive sample</th>
<th>Screening test adequately described</th>
<th>Screening cutoffs predefined</th>
<th>Credible reference standard</th>
<th>Reference standard applied to all screened patients</th>
<th>Same reference standard applied to all patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>MacRitchie, 2012</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes (99%)</td>
<td>Yes</td>
</tr>
<tr>
<td>Serwint, 1993</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
</tr>
<tr>
<td>Pierce, 2002</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Appendix B2. Quality Ratings for Diagnostic Accuracy Studies

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Reference standard and screening examination interpreted independently</th>
<th>Reference standard assessed by blinded assessor</th>
<th>Screening test assessed by blinded assessor</th>
<th>High rate of uninterpretable results, noncompliance with screening test, or attrition</th>
<th>Analysis includes patients with uninterpretable results or noncompliance</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>MacRitchie, 2012</td>
<td>Yes</td>
<td>Unclear</td>
<td>Unclear</td>
<td>No</td>
<td>No</td>
<td>Fair</td>
</tr>
<tr>
<td>Serwint, 1993</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td>Unclear</td>
<td>Fair</td>
</tr>
<tr>
<td>Pierce, 2002</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Not applicable</td>
<td>Good</td>
</tr>
</tbody>
</table>

*See Appendix A4 for full citations of included studies.
## Appendix B3. Trials of Educational Interventions for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Study Design</th>
<th>Interventions</th>
<th>Baseline population characteristics</th>
<th>Eligibility criteria</th>
<th>Number approached, eligible, enrolled, analyzed</th>
<th>Country Setting</th>
<th>Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basir et al., 2017</td>
<td>RCT</td>
<td>A. 2 brief in-person sessions (1 individual, 1 group; ≤30 minutes each), text message reminders every 2 weeks for 6 months, and pamphlet containing tips on the promotion of educational items and the need for oral health care for their children B. Usual well baby visit care without an oral health component</td>
<td>A vs. B  Mean child age (SD): 1.5 (0.6) years  Mean maternal age (SD): 31 (6.7) years  Female: 50%  Race/ethnicity: NR  No prior dental visit: 71% vs. 73%  Education &gt;high school: 90%  Caries at baseline: NR  Toothbrushing: NR</td>
<td>Mothers of children age 12 to 36 months without caries and with ≥8 completely erupted teeth, 4 maxillary anteriors, and 4 mandibular anteriors</td>
<td>Approached: 140  Eligible: 107  Enrolled: 104 (52 vs. 52)  Analyzed: 104 (52 vs. 52)</td>
<td>Iran  Maternal-child health wards  Water fluoridation: NR</td>
<td>No external funding</td>
</tr>
</tbody>
</table>
## Appendix B3. Trials of Educational Interventions for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Duration of followup</th>
<th>Confounders adjusted for in analysis</th>
<th>Outcomes</th>
<th>Adverse events/harms</th>
<th>Attrition</th>
<th>Quality rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basir et al., 2017</td>
<td>6 months</td>
<td>NA</td>
<td>A vs. B Caries incidence (WHO criteria, including white spot lesions non-cavitated and categorized as D1): 13.5% (7/52) vs. 34.7% (17/49); RR 0.39 (95% CI, 0.18 to 0.85)</td>
<td>Not reported</td>
<td>Unclear</td>
<td>Fair</td>
<td>Fig 1 show all pts were analyzed at followup but that math doesn’t work for the reported caries incidence (35% of 52=18). I calculated the N based on an n=17 and incidence of 35%.</td>
</tr>
</tbody>
</table>

*See Appendix A4 for full citations of included studies.

Abbreviations: CI=confidence interval; NA=not applicable; NR=not reported; RCT=randomized controlled trial; RR=relative risk; SD=standard deviation; WHO=World Health Organization.
### Appendix B4. Quality Ratings of Randomized, Controlled Trials of Topical Fluoride

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agouropoulos et al., 2014</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Anderson et al., 2016 Anderson et al., 2017</td>
<td>Unclear</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Basir et al., 2017</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Frostell et al., 1991</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Unclear</td>
<td>No</td>
<td>No</td>
<td>Unclear</td>
<td>No</td>
</tr>
<tr>
<td>Jiang et al., 2005</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Jiang et al., 2014</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Latifi-Xhemajli et al., 2019</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Lawrence et al., 2008</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>Unclear</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>McMahon et al., 2020</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Memarpour et al., 2015</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Memarpour et al., 2016</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td>Unclear</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Muñoz-Millán, 2018</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Oliveira et al., 2014 dos Santos et al., 2016</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Oscarson et al., 2006</td>
<td>NR</td>
<td>NR</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Siade et al, 2011</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tickle et al., 2016 Tickle et al., 2017</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td>Unclear</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Weintraub et al., 2006</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Zhan et al., 2012</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Appendix B4. Quality Ratings of Randomized, Controlled Trials of Topical Fluoride

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Acceptable levels of overall attrition and between-group differences in attrition?</th>
<th>Post-randomization exclusions</th>
<th>Avoidance of selective outcomes reporting</th>
<th>Adjusted for cluster correlation?</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agouropoulos et al., 2014</td>
<td>No/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Anderson et al., 2016</td>
<td>No/Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
</tr>
<tr>
<td>Anderson et al., 2017</td>
<td>No/Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
</tr>
<tr>
<td>Basir et al., 2017</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Frostell et al., 1991</td>
<td>Unclear</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Jiang et al., 2005</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
</tr>
<tr>
<td>Jiang et al., 2014</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Good</td>
</tr>
<tr>
<td>Latifi-Xhemajli et al., 2019</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Lawrence et al., 2008</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
</tr>
<tr>
<td>McMahon et al., 2020</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Good</td>
</tr>
<tr>
<td>Memarpour et al., 2015</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Memarpour et al., 2016</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Muñoz-Milán, 2018</td>
<td>No/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Oliveira et al., 2014</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Good</td>
</tr>
<tr>
<td>dos Santos et al., 2016</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Oscarson et al., 2006</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Slade et al., 2011</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
</tr>
<tr>
<td>Tickle et al., 2016</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Tickle et al., 2017</td>
<td>Yes/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Weintraub et al., 2006</td>
<td>No/Yes</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
<tr>
<td>Zhan et al., 2012</td>
<td>Yes/No (10% vs. 23%)</td>
<td>No</td>
<td>Yes</td>
<td>NA</td>
<td>Fair</td>
</tr>
</tbody>
</table>

*See Appendix A4 for full citations of included studies.

Abbreviations: NA=not applicable; NR=not reported.
## Appendix B5. Cohort Studies of Dental Referral From a Primary Care Clinician for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Type of study</th>
<th>Interventions</th>
<th>Population characteristics</th>
<th>Eligibility criteria</th>
<th>Number approached, eligible, enrolled, analyzed</th>
<th>Country</th>
<th>Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior Report</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beil et al., 2012</td>
<td>Cohort</td>
<td>A: First preventive dental visit by age 18 months</td>
<td>A vs. B Female: 46% vs. 48-51% Non-white race: 67% vs. 66-67% Number of well-child visits: 1.8 vs. 1.4-1.7 Percent of population in county under 18 months of age enrolled in Medicaid: 30% vs. 31-33% Dentists per capita in county: 5.1 vs. 4.5-4.9</td>
<td>Children enrolled in North Carolina Medicaid prior to first birthday, enrolled for at least 12 months, with a paid claim for dental care (1999-2006) Excluded if they received dental services in medical office as part of the Into the Mouths of Babes fluoride varnish program.</td>
<td>Approached: 165,383 Eligible: 19,888 Enrolled: 19,888 Analyzed: 19,888</td>
<td>United States</td>
<td>AHRQ and NIDCR</td>
</tr>
<tr>
<td><strong>Current Report</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beil et al., 2014</td>
<td>Cohort</td>
<td>A: First preventive dental visit by age 24 months B: First preventive dental visit at age 24 to 36 months C: First preventive dental visit at age 37 to 48 months D: First preventive dental visit at 49 to 60 months</td>
<td>A vs. B vs. C vs. D Female: 47.5% vs. 50.6% vs. 49.5% vs. 48.2% White: 42.0% vs. 38.7% vs. 36.6% vs. 39.2% Black: 44.0% vs. 48.4% vs. 51.6% vs. 46.0% Hispanic: 11.6% vs. 11.4% vs. 9.7% vs. 12.1% Other race: 2.4% vs. 1.5% vs. 2.0% vs. 2.7% Mean (SD) number of well-child visits: 1.68 (1.13) vs. 1.34 (1.11) vs. 1.24 (1.12) vs. 1.15 (1.09) Medicaid enrollees under age 18 years in county of residence: 34.8% vs. 34.7% vs. 36.0% vs. 35.8% Mean (SD) number of dentists per 10,000 population: 4.11 (2.04) vs. 4.10 (2.01) vs. 3.83 (1.97) vs. 3.79 (1.91)</td>
<td>Children enrolled in North Carolina Medicaid prior to first birthday, still enrolled after turning 1 year, and did not receive preventive dental services in a medical office (2005-2006)</td>
<td>Approached: NR Eligible: 11,394 Enrolled: 11,394 Analyzed: 11,394</td>
<td>United States</td>
<td>AHRQ and NIDCR</td>
</tr>
</tbody>
</table>
## Appendix B5. Cohort Studies of Dental Referral From a Primary Care Clinician for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Type of study</th>
<th>Interventions</th>
<th>Population characteristics</th>
<th>Eligibility criteria</th>
<th>Number approached, eligible, enrolled, analyzed</th>
<th>Country</th>
<th>Sponsor</th>
</tr>
</thead>
</table>
| Blackburn et al, 2017 | Cohort | A: ≥1 preventive dental visit delivered by dental health care professional  
B: No preventive dental visits | A vs. B  
Female: 50.9% vs. 50.7%  
Black: 44.0% vs. 43.4%  
White: 37.6% vs. 38.3%  
Hispanic: 16.3% vs. 16.5%  
Other race: 2.0% vs. 1.8% | Children enrolled in Alabama's Medicaid program from birth for 3 or more years (2008-2012) | Approached: NR  
Eligible: NR  
Enrolled: 9732  
Analyzed: 9732 | United States | Lister Hill Center for Health Policy at the University of Alabama at Birmingham School of Public Health |
| Kranz, et al., 2014a | Cohort | A: Received ≥2 preventive oral health visits from a PCC  
B: Received ≥2 preventive oral health visits from a dental health care professional  
C: Received ≥2 preventive oral health visits from a PCC and a dental health care professional | A vs. B vs. C  
Female: 48.4% vs. 50% vs. 46.6%  
White: 39.4% vs. 34.4% vs. 36.4%  
Black: 41.6% vs. 42.1% vs. 42.7%  
Hispanic: 7.0% vs. 14.2% vs. 11.9%  
Mean (SD) number of well-child visits before age 3 years: 5.0 (1.4) vs. 4.0 (2.2) vs. 4.9 (1.6)  
Medicaid eligible people under 18 years old per 10,000 people: 511.2 (SD 144.0) vs. 417.7 (SD 123.5) vs. 452.8 (SD 124.4)  
Mean (SD) number of dentists per 10,000 people: 3.3 (1.4) 4.6 (1.7) vs. 3.8 (1.7) | Children enrolled in North Carolina Medicaid prior to first birthday, still enrolled after turning 1 year, and received preventive dental services before the age of 3 years (2005-2006) | Approached: NR  
Eligible: 5235  
Enrolled: 5235  
Analyzed: 5235 | United States | AHRQ and NIDCR |
### Appendix B5. Cohort Studies of Dental Referral From a Primary Care Clinician for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Type of study</th>
<th>Interventions</th>
<th>Population characteristics</th>
<th>Eligibility criteria</th>
<th>Number approached, eligible, enrolled, analyzed</th>
<th>Country</th>
<th>Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kranz, et al., 2014b</td>
<td>Cohort</td>
<td>A: Received preventive oral health visits from a PCC</td>
<td>Age: 3-5 years overall</td>
<td>Children enrolled in North Carolina Medicaid prior to first birthday, enrolled for ≥12 months before age 3 years, enrolled for ≥7 months after turning 3 years, with &gt;1 visit to PCPs, dentists, or both before age 3 years (2000-2006)</td>
<td>Approached: NR Eligible: 41,453 Enrolled: 41,453 Analyzed: 41,453</td>
<td>United States</td>
<td>AHRQ and NIDCR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B: Received preventive oral health visits from a dental health care professional</td>
<td>Female: 48.7% vs. 48.9% vs. 47.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>C: Received preventive oral health visits from a PCC and a dental health care professional</td>
<td>White: 37.8% vs. 29.4% vs. 33.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Black: 39.1% vs. 39.3% vs. 39.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hispanic: 12.6% vs. 20.1% vs. 18.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mean (SD) number of well-child visits before age 3 years: 4.8 (1.3) vs. 3.9 (1.9) vs. 4.6 (1.4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medicaid eligible people &lt;18 years old per 10,000 people: 0.2 (SD 0.1) vs. 0.2 (SD 0.1) vs. 0.2 (SD 0.1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mean (SD) number of dentists per 10,000 people: 43.6 (1.6) vs. 5.2 (1.8) vs. 4.3 (1.9)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sen et al., 2016</td>
<td>Cohort</td>
<td>A: ≥1 preventive dental visit</td>
<td>Age, mean (SD), years: 4.5 (0.7) vs. 4.0 (0.8)</td>
<td>Children enrolled in Alabama's CHIP program from birth to 4 years old (1996-2012)</td>
<td>Approached: NR Eligible: NR Enrolled: 4774 Analyzed: 4774</td>
<td>United States</td>
<td>Alabama Department of Public Health and Alabama Children's Health Insurance Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B: No preventive dental visits</td>
<td>Female: 49.5% vs. 47.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>White: 67.2% vs. 72.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Black: 23.6% vs. 17.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other race: 9.2% vs. 10.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Well-child visits by 3 years, mean (SD) per child: 6.1 (3.7) vs. 6.6 (3.7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix B5. Cohort Studies of Dental Referral From a Primary Care Clinician for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Duration of followup</th>
<th>Confounders adjusted for in analysis</th>
<th>Outcomes</th>
<th>Adverse events/ harms</th>
<th>Attrition</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beil et al., 2012</td>
<td>Through 72 months of age</td>
<td>Age, race/ethnicity, caregiver employment, caregiver education, language spoken at home, diet score, hygiene score, tooth monitoring score</td>
<td>Subsequent dental treatment, first preventive visit at 18-24, 25-30, 31-36, or 37-42 months vs. &lt;18 months (reference) Primary or secondary preventive visit: incidence density ratio 0.98 (0.87-1.1), 1.1 (0.94-1.2), 1.1 (0.96-1.2), and 1.1 (0.95-1.2) Tertiary preventive visit: Incidence density ratio 1.2 (1.0-1.4), 1.2 (1.1-1.4), 1.1 (0.99-1.3), and 1.4 (1.2-1.6)</td>
<td>Not reported</td>
<td>None reported</td>
<td>Fair</td>
</tr>
<tr>
<td>Current Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beil et al., 2014</td>
<td>Up to 5 years of age (assessment in kindergarten)</td>
<td>Child-level: gender, race, number of well-child visits from age 12 to 24 months, and whether child was continuously enrolled in Medicaid County-level: % of population under age 18 enrolled in Medicaid, metropolitan status, and number of dentists per 10,000 population</td>
<td>A vs. B vs. C vs. D Any with untreated caries among those with caries (n=6749): 41.3% vs. 33.9% vs. 38.8% vs. 42.2%, p&lt;0.01 for B vs. others B vs. C vs. D (reference A) Adjusted IRR (95% CI) for dmft index: 0.98 (0.90 to 1.07) vs. 0.88 (0.81 to 0.95) vs. 0.75 (0.69 to 0.82); p=0.05 for A vs. C and D Adjusted OR (95% CI) for having any untreated dental disease among children with any dental disease (n=6749): 0.71 (0.56 to 0.90) vs. 0.82 (0.66 to 1.03) vs. 0.97 (0.77 to 1.22), p&lt;0.01 for A vs. B</td>
<td>Not reported</td>
<td>None reported</td>
<td>Fair</td>
</tr>
<tr>
<td>Blackburn et al, 2017</td>
<td>3 years</td>
<td>Propensity score matching of health services utilization, race, rural-urban community, age, fluoridation level</td>
<td>A vs. B Received any caries-related treatment visit: 20.6% vs. 11.3%, p&lt;0.001 Any annual dental visit: 80.1% vs. 42.8%, p&lt;0.001 Received fluoride varnish during the first 2 years of life: 84.3% vs. NA Number of fluoride varnishes received, mean (SD): 1.1 (0.7) vs. NA Difference in number of annual caries-related visits: 0.15 (95% CI, 0.11 to 0.16) Difference in caries-related expenditures: -0.01 (95% CI, -0.13 to 0.12) Different in annual dental expenditures: 0.03 (95% CI, -0.06 to 0.13)</td>
<td>Not reported</td>
<td>None reported</td>
<td>Fair</td>
</tr>
</tbody>
</table>
## Appendix B5. Cohort Studies of Dental Referral From a Primary Care Clinician for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Duration of followup</th>
<th>Confounders adjusted for in analysis</th>
<th>Outcomes</th>
<th>Adverse events/harms</th>
<th>Attrition</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kranz, et al., 2014a</td>
<td>Up to 3 years of age</td>
<td>Propensity score matching of sex, race, Hispanic ethnicity, total number of months enrolled in Medicaid, number of well-child visits, indicators of special health care needs, receipt of caries-related treatment, whether any preventive oral health services were received in a federally qualified health center, health department, or rural health clinic, proportion of population with access to fluoridated public drinking water, rural or urban status, number of dentists, pediatricians, and family practice physicians per 10,000, and Medicaid-eligible children younger than 18 years</td>
<td>A vs. B vs. C Received any caries-related treatment before age 3 years: 24.0% vs. 39.2% vs. 31.0% A vs. C (reference B) OR (95% CI) of &gt;0 dmft: 1.06 (0.78 to 1.46) vs. 0.77 (0.52 to 1.14) IRR (95% CI) of expected number of dmft for children at risk for dmft (n=2521): 0.95 (0.82 to 1.09) vs. 0.94 (0.82 to 1.08) OR (95% CI) of untreated decayed teeth of those at risk for dmft (n=2521): 2.05 (1.28 to 3.30) vs. 1.34 (0.82 to 2.19), p&lt;0.01 for A vs. B</td>
<td>Not reported</td>
<td>None reported</td>
<td>Fair</td>
</tr>
<tr>
<td>Kranz, et al., 2014b</td>
<td>Up to 5 years of age</td>
<td>Child-level: sex, race, Hispanic ethnicity, months enrolled in Medicaid per year, number of well-child visits, indicators of special health care needs, whether any preventive oral health services were received in a public clinic, year that treatment was received County-level: proportion of population with access to fluoridated drinking water; rural or urban status; and the number of dentists, pediatricians, and family practice physicians, and Medicaid-eligible children under 18 years per 10,000 population</td>
<td>A vs. B vs. C Received any caries-related treatment between ages 3 to 5 years: 26.7% vs. 51.8% vs. 47.6%</td>
<td>Not reported</td>
<td>None reported</td>
<td>Fair</td>
</tr>
<tr>
<td>Sen et al., 2016</td>
<td>3 years</td>
<td>Propensity score matching of health services utilization, race, rural-urban community, age, fluoridation level</td>
<td>A vs. B Difference in number of restorative dental visits (adjusted): 11.1%, p&lt;0.001 Difference in number of emergency dental visits (adjusted): 1.9%, p&lt;0.05</td>
<td>Not reported</td>
<td>None reported</td>
<td>Fair</td>
</tr>
</tbody>
</table>

*See Appendix A4 for full citations of included studies.*
Appendix B5. Cohort Studies of Dental Referral From a Primary Care Clinician for the Prevention of Dental Caries

Abbreviations: AHRQ=Agency for Healthcare Research and Quality; CHIP=Children's Health Insurance Program; CI=confidence interval; IRR=incidence rate ratio; NIDCR=National Institute of Dental and Craniofacial Research; NA=not applicable; NR=not reported; OR=odds ratio; PCC=primary care clinician; SD=standard deviation.
Appendix B6. Quality Ratings of Included Cohort Studies

<table>
<thead>
<tr>
<th>Author, year* Country</th>
<th>Did the study attempt to enroll all (or a random sample of) patients meeting inclusion criteria (inception cohort)?</th>
<th>Were the groups comparable at baseline on key prognostic factors (e.g., age, sex, other medications)?</th>
<th>Did the study use accurate methods for ascertaining exposures and potential confounders (i.e., age, sex, other medications)?</th>
<th>Were outcome assessors and/or data analysts blinded to exposure being studied?</th>
<th>Did the article report attrition or missing data?</th>
<th>Is there important differential loss to followup or overall high loss to followup or missing data?</th>
<th>Were appropriate confounders analyzed (i.e., age, sex, other medications)?</th>
<th>Were outcomes pre-specified and defined, and ascertained using accurate methods?</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beil et al., 2012 United States</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
<td></td>
</tr>
<tr>
<td>Beil et al., 2014 United States</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
<td></td>
</tr>
<tr>
<td>Blackburn et al., 2017 United States</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
<td></td>
</tr>
<tr>
<td>Kranz, et al., 2014a United States</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
<td></td>
</tr>
<tr>
<td>Kranz, et al., 2014b United States</td>
<td>Yes</td>
<td>Mostly</td>
<td>Unclear</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
<td></td>
</tr>
<tr>
<td>Sen et al, 2016 United States</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Fair</td>
<td></td>
</tr>
</tbody>
</table>

*See Appendix A4 for full citations of included studies.
### Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Type of study</th>
<th>Interventions</th>
<th>Baseline population characteristics</th>
<th>Eligibility criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Frostell et al., 1991 | RCT | A: Duraphat treatment twice a year  
B: No treatment  
Most children were exposed to fluoride toothpaste and some use fluoride tablets and mouth rinse solutions.  
Interventionist: NR | Age: 4 years  
Female: NR  
Race: NR  
Mean dmfs: 4.79 | 4 year old children  
Excluded: Those who developed ≥10 caries between 3 and 4 years of age. |
| Jiang et al., 2005 | Cluster RCT (15 clusters) | A: 0.6 to 0.8 g of 1.23% acidulated phosphate fluoride foam applied every 6 months, max 4 applications  
B: Placebo foam  
No oral health education described  
Interventionist: 2 dental health care professionals and 2 assistants | Age, mean (SD): 3.6 (0.6) years  
Female: 46%  
Race: NR  
dmft, mean (SD): 1.6 (2.5)  
dmfs, mean (SD): 2.6 (4.3)  
Use of fluoride toothpaste: 22%  
Daily toothbrushing: 46% | Children 3 to 4 years of age  
Excluded: Not reported |
| Lawrence et al., 2008 | Cluster RCT (20 clusters) | A: 0.3 to 0.5 ml 5% sodium fluoride varnish (Duraflor) applied every 6 months  
B: No fluoride varnish  
All children: Parental oral health education at baseline, 12 and 24 months  
Interventionist: dental health care professionals | Age, mean (SD): 2.5 (1.2) years  
Female: 51%  
Race: 100% aboriginal  
dmft, mean (SD): 7.0 (6.2)  
dmfs >0: 72%  
Daily toothbrushing: NR | Children 6 month to 5 years of age, with at least one primary tooth  
Excluded: No teeth, stainless steel crowns only, ulcerative gingivitis, stomatitis or allergy to colophony component. |
| Slade et al., 2011 | Cluster RCT (30 clusters) | A: 0.25 ml 5% sodium fluoride varnish (Duraphat) every 6 months, parental oral health education and provision of toothbrush and toothpaste (low concentration fluoride)  
B: No interventions  
Interventionist: dental health care professionals | Age, mean: 2.8 years  
Female: 49%  
Race: All aboriginal  
dmfs >0: 62.5%  
dmfs, mean: 4.7  
Daily toothbrushing: NR | Aboriginal identity, 18 to 48 months of age  
Excluded: Asthma |
## Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Type of study</th>
<th>Interventions</th>
<th>Baseline population characteristics</th>
<th>Eligibility criteria</th>
</tr>
</thead>
</table>
| Weintraub et al., 2006 | RCT | A: 0.1 mL 5% sodium fluoride varnish (Duraphat) applied at 6 month intervals with 4 intended applications  
B: 0.1 mL 5% sodium fluoride varnish (Duraphat) applied once per year with 2 intended applications  
C: No fluoride varnish (gauze dipped in varnish, then folded and dry area applied to teeth)  
All children: Parental oral health education annually  
Interventionist: dental health care professionals | Age, mean (SD): 1.8 (0.6) years  
Female: 53%  
Hispanic: 47%  
Asian: 46%  
Other race/ethnicity: 7%  
dmfs: 0 (excluded)  
Daily toothbrushing: NR | 6 to 44 months if age, 4 erupted maxillary incisors, caries-free without demineralized white spots  
Excluded: Medical problems or medications affecting oral health e.g. cleft lip/palate |
| Current Report | | | | |
| Agouropoulos et al., 2014 | Cluster RCT (10 clusters) | A: 0.2 ml 0.9% difluorosilane (1000 ppm fluoride) at 6 month intervals  
B: Placebo varnish without fluoride at 6 month intervals  
All children: Supervised toothbrushing at school with fluoride toothpaste, parental oral health education, and toothbrushing instructions  
Interventionist: dental health care professionals | Age, mean (SD): 3.4 (0.8) years  
Female: 49.6%  
Race: NR  
dmfs, mean (SD): 2.8 (6.4)  
Caries: 37.5%  
Daily toothbrushing: NR | Children ages 2 to 5 years attending one of the preselected public preschools.  
Excluded: Born outside of Greece, antibiotics within the last 2 weeks |
| Anderson et al., 2016 | Same as Anderson et al., 2017 | Cluster RCT (23 clusters) | A: 0.25 ml sodium fluoride varnish (5.65 mg Duraphat) on the buccal surface of teeth every 6 months  
B: No fluoride varnish  
All children: Parental oral health education, toothpaste, and toothbrush at 12, 24, and 36 months  
Interventionist: examiner, not specified, or dental assistant | Age: 1 year  
Female: 51.5%  
Race: NR  
ICDAS 1-6: 5.2%  
ICDAS 3-6: 0.6%  
ICDAS 5-6: 0.2%  
Daily toothbrushing: 55.1% | All children born in 2010 and living in the selected areas.  
Excluded: Not reported |
## Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Type of study</th>
<th>Interventions</th>
<th>Baseline population characteristics</th>
<th>Eligibility criteria</th>
</tr>
</thead>
</table>
| Anderson et al., 2017 Same as Anderson et al., 2016 | Cluster RCT (23 clusters) | A: 0.25 ml sodium fluoride varnish (Duraphat) on the buccal surface of teeth every 6 months  
B: No fluoride varnish  
All children: Parental oral health education, toothpaste, and toothbrush at 12, 24, and 36 months  
Interventionist: examiner, not specified, or dental assistant | Age: 1 year old  
Female: 53%  
ICDAS 3-6 score: 3%  
Daily toothbrushing: 50% | Children enrolled in “Stop Caries Stockholm” (see Anderson et al., 2016) who developed caries between 1 and 3 years of the study period. |
| Jiang et al., 2014 | RCT | A. 5% sodium fluoride varnish (Clinpro White Varnish) at 6 month intervals, also hands-on training on brushing child’s teeth at baseline and toothbrush provided at 6 month intervals  
B: Hands-on training on brushing child’s teeth at baseline; toothbrush provided and toothpaste without fluoride (placebo) administered at 6 month intervals  
C. No additional intervention  
All children: Parental health education at baseline  
Interventionist: dental health care professionals | Age, mean (SD): 1.3 (0.3) years  
Female: 56%  
dmft, mean (SD): 0.03 (0.24)  
Daily toothbrushing: 12% | Children 8 to 23 months of age Excluded: Major systemic disease or on long-term medication; not cooperative and refused examination |
| Latifi-Xhemajli et al., 2019 | RCT | A: 1.5% (7700 ppm) ammonium fluoride (Fluor Protector S) applied every 3 months for 2 years  
B: Usual care (control group had no F-varnish applied, unless their parents were advised for their child’s basic oral health care)  
Interventionist: 2 pediatric dental health care professionals | Age, mean: 21 months  
Female: NR  
Race: NR  
dmfs, mean (SD): 1.1 (2.9)  
Daily toothbrushing: NR | Children 6 to 30 months with parental permission. |
| McMahon et al., 2020 | RCT | A: Duraphat 50 mg/mL applied every 6 months  
B: Placebo varnish applied every 6 months  
All children: daily supervised toothbrushing  
Interventionist: dental health care professionals | Age, mean: 3.53 years (SD 0.24)  
Female: 50%  
Race: NR  
Caries at baseline: 17%  
Mean dmfs: 1.1 (SD 3.5)  
SIMD 1 (most deprived): 21% | 3 year old children attending their first year of education in nursery schools. Excluded: Those with contraindications for fluoride varnish, history of bronchial asthma requiring hospitalization, history of allergic episodes requiring hospital admission, showing signs of distress on |
### Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Type of study</th>
<th>Interventions</th>
<th>Baseline population characteristics</th>
<th>Eligibility criteria</th>
</tr>
</thead>
</table>
| Memarpour et al., 2015 | RCT           | A. 5% (22,600 ppm) sodium fluoride varnish (DuraShield) and parental oral health education every 4 months  
B: Educational pamphlet and motivational oral health counseling every 4 months  
C: CPP-ACP twice a day after teeth brushing and information on oral hygiene  
D: Dental examination only  
Interventionist: dental health care professionals | Age, mean (SD): 1.8 (0.6) years  
Female: NR  
Race: NR  
dmft: 0 (excluded)  
Daily toothbrushing: NR | the day of baseline inspection, or showing signs of verbal or nonverbal reluctance.  
Children 12 to 36 months, having lived since birth in towns with a similar water fluoridation level (<0.7 ppm) and at least 4 erupted maxillary primary incisors with at least 2 white spot lesions  
Excluded: Those who showed signs of cavitated caries or who did not use any oral hygiene methods, fluoride-containing products, or other preventive measures at home or at dental clinics; history of systemic disease, congenital physical or mental disability, oral or dental anomalies or disabilities, a history of drug allergies, allergies to milk protein or benzoate preservatives. |
| Memarpour et al., 2016 | RCT           | A. 5% sodium fluoride varnish at 6 month intervals; parental oral health education and training on proper toothbrushing at baseline  
B: Placebo varnish at 6 month intervals; parental oral health education and training on proper toothbrushing at baseline  
C. Placebo varnish at 6 month intervals without oral health education or training  
Interventionist: dental health care professionals | Age, mean (SD): 1.7 (0.7) years  
Female: 46%  
Race: NR  
Maternal high school diploma or higher: 55%  
dmft: 0 (excluded)  
Daily toothbrushing: 0% | Children age 12 to 24 months  
Excluded: Systemic diseases, drug allergies, congenital physical or mental disabilities, oral or dental anomalies or disabilities |
| Muñoz-Millán et al., 2018 | RCT           | A. 0.5 mL of fluoride varnish (Profluorid Varnish®) every 6 months  
B. 0.5 mL innocuous placebo varnish every 6 months  
All children: twice a year received a toothbrush and a tube of children’s 500 ppm fluoride toothpaste, and supervised daily toothbrushing  
Interventionist: not described | Age, mean (SD): 32.9 (6.2) months  
Female: 54%  
Race: NR  
Daily toothbrushing: 100%  
-Brushing ≥2/day: 72%  
Good to fair oral hygiene index: 58%  
Visible plaque: 76% | 2 to 3 year old children without cavitated carious lesions or previous dental treatments  
Excluded: Children with systemic diseases, disabilities or developmental enamel defects, and those with temporary residences. |
## Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Type of study</th>
<th>Interventions</th>
<th>Baseline population characteristics</th>
<th>Eligibility criteria</th>
</tr>
</thead>
</table>
| Oliveira et al., dos Santos et al., 2014 | RCT | A: 5% (22,600 ppm) sodium fluoride varnish at 6 month intervals  
B: Placebo varnish  
All children: Parental oral health education, free toothpaste and toothbrush at baseline  
Interventionist: trained undergraduate or graduate dental students | Age, mean (SD): 2.4 (0.9) years  
Female: 47%  
Race: NR  
d2mfs, mean (SD): 0.9 (2.1)  
d1mfs, mean (SD): 0.8 (1.9)  
Caries: 23.5%  
Daily toothbrushing: 80% | 1 to 4 years of age  
Excluded: Fluoride application in the previous 6 months, >10 dental surfaces with dentine caries lesions, dental abscess, or systemic disease that could be aggravated by a dental problem. |
| Tickle et al., 2016  
Tickle et al., 2017 | RCT | A: 22,600 ppm fluoride varnish at 6 month intervals; also provided toothbrush and 50 mL tube of 1,450 ppm fluoride toothpaste  
B: No fluoride intervention  
All children: Parental oral health education every 6 months  
Interventionist: dental health care professionals | Age, mean (SD): 3.1 (0.53) years  
Female: 54%  
Race: NR  
dmft: 0 (excluded)  
Daily toothbrushing: NR | 2 to 3 years of age  
Excluded: Dentin caries, history of fillings or extractions due to caries, fissure sealants on primary molar teeth, and/or a history of severe allergic reactions requiring hospitalization. |
## Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Number approached, eligible, enrolled, analyzed</th>
<th>Country Setting</th>
<th>Sponsor</th>
<th>Duration of followup</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior Report</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Frostell et al., 1991 | Approached: NR  
Eligible: NR  
Enrolled: 206  
Analyzed: 206 (113 vs. 93) | Sweden  
Suburban areas  
Fluoridation status NR | Swedish Sugar Company, Swedish Odonatological Patents Revenue Research Fund | 2 years |
| Jiang et al., 2005 | Approached: NR  
Eligible: NR  
Enrolled: 392 (209 vs. 183)  
Analyzed: 318 (167 vs. 151) at 2 years | China  
Recruitment setting: Kindergarten  
Water fluoridation status: 0.1 to 0.3 ppm | National Key Technologies R&D Program of the Tenth-five Year Plan, Ministry of Science and Technology China | 2 years |
| Lawrence et al., 2008 | Approached: 1,793  
Eligible: 1,275  
Enrolled: 1,275 (915 vs. 360)  
Analyzed: 1,146 (818 vs. 328) | Canada  
Recruitment setting: Rural Aboriginal communities  
Water fluoridation status: No fluoridation | Institute of Aboriginal Peoples’ Health/Canadian Institutes of Health Research; Toronto Hospital for Sick Children Foundation | 2 years |
| Slade et al., 2011 | Approached: 685  
Eligible: 666  
Enrolled: 666 (344 vs. 322)  
Analyzed: 666 (344 vs. 322) | Australia  
Recruitment setting: Rural Aboriginal communities  
Water fluoridation status: See population characteristics  
Water fluoride concentration <0.6 ppm: 87% | Australian National Health and Medical Research Council | 2 years |
| Weintraub et al., 2006 | Approached: NR  
Eligible: NR  
Enrolled: 376 (126 vs. 124 vs. 126)  
Analyzed: 280 (87 vs. 93 vs. 100) | U.S.  
Recruitment setting: Family dental center and public health center serving primarily low-income, underserved Hispanic and Chinese populations  
Water fluoridation status: ~1 ppm | National Institute of Dental and Craniofacial Research; the National Center for Minority Health and Health Disparities; UCSF Department of Preventive and Restorative Dental Sciences | 2 years |
| **Current Report** | | | | |
| Agouropoulos et al., 2014 | Approached: NR  
Eligible: 424  
Enrolled: 409 (216 vs. 193)  
Analyzed: 328 (181 vs. 162) | Greece  
Recruitment setting: Public preschools located in medium and low socioeconomic areas of Athens, Greece  
Water fluoridation: NR (no fluoridated water in Greece) | "Live.Learn.Laugh" programme by FDI/Unilever and by Ivoclar-Vivadent | 2 years |
| Anderson et al., 2016 | Same as Anderson et al., 2017 | Sweden  
Recruitment setting: Dental clinics located in areas with a multicultural population and families predominantly of medium or low socioeconomic status | Stockholm County Council and Karolinska Institute | 2 years |
### Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Number approached, eligible, enrolled, analyzed</th>
<th>Country and Setting</th>
<th>Sponsor</th>
<th>Duration of followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson et al., 2017 Same as Anderson et al., 2016</td>
<td>Approach: NR Eligible: 3403 Enrolled: 801 Analyzed: 664 (314 vs. 350)</td>
<td>Sweden Recruitment setting: Dental clinics located in areas with a multicultural population and families predominantly of medium or low socioeconomic status Water fluoridation: NR</td>
<td>Stockholm County Council and Karolinska Institute</td>
<td>3 years</td>
</tr>
<tr>
<td>Jiang et al., 2014</td>
<td>Approach: 512 Eligible: 483 Enrolled: 450 (149 vs. 152 vs. 149) Analyzed: 415 (137 vs. 144 vs. 134)</td>
<td>China Recruited from parenting education centers and child day care centers Water fluoridation: 0.5 ppm</td>
<td>Hong Kong Research Grant Council</td>
<td>2 years</td>
</tr>
<tr>
<td>Latifi-Xhemajli et al., 2019</td>
<td>Approach: NR Eligible: NR Enrolled: 504 (255 vs. 249) Analyzed: 427 (218 vs. 209)</td>
<td>Kosovo Recruited from 11 preschools in the Pristina area Water fluoridation: NR</td>
<td>None</td>
<td>2 years</td>
</tr>
<tr>
<td>McMahon et al., 2020</td>
<td>Approach: 1,916 Eligible: 1284 Enrolled: 1284 (643 vs. 641) Analyzed: 1150 (577 vs. 573)</td>
<td>Scotland Recruited from 4 NHS Health Board areas Water fluoridation: NR</td>
<td>Scottish Government</td>
<td>2 years</td>
</tr>
<tr>
<td>Memarpour et al., 2015</td>
<td>Approach: NR Eligible: 220 Enrolled: 140 Analyzed: 123 (32 vs. 31 vs. 29 vs. 30)</td>
<td>Iran Recruitment setting: Public health care centers Water fluoridation status: &lt;0.7 ppm</td>
<td>Vice-Chancellor of Research of the Shiraz University of Medical Science</td>
<td>12 months</td>
</tr>
<tr>
<td>Memarpour et al., 2016</td>
<td>Approach: NR Eligible: NR Enrolled: 300 (100 vs. 100 vs. 100) Analyzed: 260 (87 vs. 85 vs. 88) at 12 months</td>
<td>Iran Public health care centers Water fluoridation: &lt;0.7 ppm</td>
<td>Shiraz University of Medical Sciences</td>
<td>1 year</td>
</tr>
<tr>
<td>Oliveira et al., 2014 dos Santos et al., 2016</td>
<td>Approach: NR Eligible: 310 Enrolled: 200 Analyzed: 181 (89 vs. 92); 123 in nested-cohort (63 vs. 60)</td>
<td>Brazil Low-income families recruited at a pediatric ambulatory clinic located in a public health center &quot;Access to fluoridated water&quot;, fluoridation status otherwise not reported</td>
<td>Colgate-Palmolive provided free supplies</td>
<td>24 months, 4 years for nested-cohort</td>
</tr>
</tbody>
</table>
Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Number approached, eligible, enrolled, analyzed</th>
<th>Country Setting</th>
<th>Sponsor</th>
<th>Duration of followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tickle et al., 2016</td>
<td>Approached: 2455&lt;br&gt;Eligible: 1248&lt;br&gt;Enrolled: 1248&lt;br&gt; Analyzed: 1096 (549 vs. 547)</td>
<td>Ireland&lt;br&gt;National Health Services dental practices in Norther Ireland&lt;br&gt;Fluoridation status not reported (national policy of mandatory water fluoridation at 0.6 to 0.8 ppm)</td>
<td>National Institute for Health Research Health Technology Assessment program</td>
<td>3 years</td>
</tr>
<tr>
<td>Tickle et al., 2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Outcomes</th>
<th>Adverse events/harms</th>
<th>Attrition</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior Report</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frostell et al., 1991</td>
<td>A vs. B</td>
<td>Mean dmfs₁: 2.26 vs. 3.60, p&lt;0.01; Mean dmfs₂: 2.86 vs. 4.10, p=NS; Mean dmft: 1.09 vs. 1.32, p=NS</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>Jiang et al., 2005</td>
<td>A vs. B</td>
<td>dmfs increase &gt;0: 61.7% (103/167) vs. 73.5% (111/151); RR 0.84 (95% CI, 0.72 to 0.98); dmfs increase ≥6: 28.1% (47/167) vs. 35.1% (53/151), RR 0.80 (95% CI, 0.58 to 1.11); dmfs increase ≥11: 11.4% (19/167) vs. 17.2% (26/151), RR 0.66 (95% CI, 0.38 to 1.14); dmfs increment (SD): 3.8 (0.9) vs. 5.0 (1.0); p=0.03; reduction in caries increment 24%</td>
<td>No adverse events detected</td>
<td>A vs. B: 20% (42/209) vs. 17% (32/183)</td>
</tr>
<tr>
<td>Lawrence et al., 2008</td>
<td>A vs. B</td>
<td>Incident caries:† 71.5% (595/832) vs. 75.3% (247/328), adjusted OR 0.72 (95% CI, 0.42 to 1.25); -caries free at baseline:‡ 44.4% (157/354) vs. 57.9% (73/126), adjusted OR 0.63 (95% CI, 0.33 to 1.1); -0 to 1 years:‡ 61.1% (209/342) vs. 69.4% (84/121), adjusted OR 0.52 (95% CI, 0.23 to 1.19); -2 to 3 years:‡ 75.5% (336/445) vs. 82.0% (132/161), adjusted OR 0.52 (95% CI, 0.24 to 1.10); dmfs increment, adjusted mean (SD):† 11.0 (15.0) vs. 13.5 (15.0); adjusted mean difference -2.4 (SE 2.0), p=0.24, prevented fraction 18%; -caries free at baseline, adjusted mean (SD):‡ 4.3 (8.5) vs. 6.1 (9.4); adjusted mean difference -1.7 (SE 1.3), p=0.18; -0 to 1 year, adjusted mean (SD): 8.1 (10.5) vs. 11.2 (14.1); adjusted mean difference -3.1 (SE 2.4), p=0.10; -2 to 3 years: 13.6 (16.0) vs. 16.6 (17.5); adjusted mean difference -3.7 (SE 3.0), p=0.22</td>
<td>One child allergic to lanolin experienced an adverse event</td>
<td>A vs. B: 11% (96/915) vs. 9% (32/360)</td>
</tr>
<tr>
<td>Slade et al., 2011</td>
<td>A vs. B</td>
<td>dmfs increment, adjusted mean (SD): 7.3 (10.4) vs. 9.6 (10.1), difference -2.3 (95% CI, -3.7 to -0.8), prevented fraction 24%; -effect of additional 1 ppm F: -4.3 (95% CI, -7.0 to -1.6); -effect of age (years): -0.3 (95% CI, -0.3 to -0.2)</td>
<td>No adverse events detected</td>
<td>A vs. B: 19% (60/322) vs. 18% (63/344)</td>
</tr>
</tbody>
</table>
## Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Outcomes</th>
<th>Adverse events/harms</th>
<th>Attrition</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weintraub et al., 2006</td>
<td>A vs. B vs. C</td>
<td>Incident caries (dmfs &gt;0): 13.2% (11/83) vs. 15.1% (13/86) vs. 29.3% (27/92) at 12 months, RR 0.45 (95% CI, 0.24 to 0.83) A vs. C and RR 0.52 (95% CI, 0.28 to 0.93) for B vs. C; 17.3% (14/81) vs. 28.0% (23/82) vs. 46.7% (42/90) at 24 months, RR 0.37 (95% CI 0.22 to 0.63) for A vs. C and 0.60 (95% CI 0.40 to 0.91) for B vs. C</td>
<td>No adverse events detected</td>
<td>A vs. B vs. C: 31% (39/126) vs. 25% (31/124) vs. 21% (26/126)</td>
</tr>
<tr>
<td>Current Report</td>
<td>A vs. B</td>
<td>Caries prevalence (dmfs&gt;0): 63.0% (110/174) vs. 64.8% (100/154) at 1 year, RR 0.97 (95% CI, 0.83 to 1.14); 64.8% (113/174) vs. 65.8% (101/154) at 2 years, RR 0.99 (95% CI, 0.85 to 1.16)</td>
<td>No serious adverse events were noted, in some cases, the smell of the varnish was unpleasant to the younger children</td>
<td>A vs. B: 19.5% (42/216) vs. 20.2% (39/193)</td>
</tr>
<tr>
<td>Agouropoulos et al., 2014</td>
<td>A vs. B</td>
<td>Caries increment (change in dmfs), mean (SD): 2.1 (4.5) vs. 2.3 (4.7) from baseline to 1 year; 0.8 (2.2) vs. 1.1 (2.3) from 1 to 2 years; 2.9 (5.3) vs. 3.0 (5.2) from baseline to 2 years</td>
<td>No serious adverse events were noted, a few children vomited directly after application due to the smell, texture, or taste of the varnish</td>
<td>A vs. B: 25.5% (421/1652) vs. 25.5% (446/1751)</td>
</tr>
<tr>
<td>Anderson et al., 2016 Same as Anderson et al., 2017</td>
<td>A vs. B</td>
<td>Scores at 24 months ICDAS 1-2: 6.8% (83/1223) vs. 6.2% (90/1452), RR 1.09 (95% CI 0.82 to 1.46) ICDAS 3-6: 3.4% (42/1223) vs. 4.3% (63/1452), RR 0.79 (95% CI 0.54 to 1.16) ICDAS 5-6: 2.5% (30/1223) vs. 2.5% (37/1452), RR 0.96 (95% CI 0.60 to 1.55) ICDAS 1-6: 10.2% (125/1223) vs. 10.5% (153/1452), RR 0.96 (95% CI 0.77 to 1.20) Scores at 36 months ICDAS 1-2: 11.5% (141/1231) vs. 9.6% (125/1305), RR 1.20 (95% CI 0.95 to 1.50) ICDAS 3-6: 10.4% (128/1231) vs. 13.7% (179/1305), RR 0.76 (95% CI 0.61 to 0.94) ICDAS 5-6: 6.1% (75/1231) vs. 7.6% (99/1305), RR 0.80 (95% CI 0.60 to 1.07) ICDAS 1-6: 21.9% (269/1231) vs. 23.3% (304/1305), RR 0.94 (95% CI 0.81 to 1.08)</td>
<td>No serious adverse events were noted, a few children vomited directly after application due to the smell, texture, or taste of the varnish</td>
<td>A vs. B: 25.5% (421/1652) vs. 25.5% (446/1751)</td>
</tr>
</tbody>
</table>
## Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Outcomes</th>
<th>Adverse events/harms</th>
<th>Attrition</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson et al., 2017</td>
<td>A vs. B</td>
<td>No progression of caries between 12 and 24 months: 71.1% vs. 76.8%, p=0.002</td>
<td>NR</td>
<td>A vs. B: 26.3% (112/426) vs. 6.7% (25/375)</td>
</tr>
<tr>
<td>Same as Anderson et al., 2016</td>
<td></td>
<td>No progression of caries between 24 and 36 months: 79.0% vs. 79.0%, p=0.912</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Progression from a healthy or initial stage occlusal surface (ICDAS 0 to 2) to a moderate to an extensive decayed surface (ICDAS 3 to 6): 6.0% vs. 7.3%, p=0.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jiang et al., 2014</td>
<td>A vs. B vs. C</td>
<td>Incident cavitated caries lesions: 10.2% (14/137) vs. 6.9% (10/144) vs. 8.2% (11/134); RR 0.68 (95% CI, 0.31 to 1.48) for A vs. B, RR 1.24 (95% CI, 0.59 to 2.64) for A vs. C, RR 0.85 (95% CI, 0.37 to 1.93) for B vs. C; RR 1.48 (95% CI, 0.83 to 2.64) for A vs. B, RR 1.47 (95% CI, 0.82 to 2.64), RR 0.99 (95% CI, 0.52 to 1.88) for B vs. C</td>
<td>NR</td>
<td>8% (23/301)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incident cavitated and noncavitated caries lesions: 17.5% (24/137) vs. 11.8% (17/144) vs. 11.9% (16/134); RR dmfs, mean (SD): 0.2 (0.9) vs. 0.1 (0.5) vs. 0.2 (1.0); MD -0.1 (95% CI, -0.27 to 0.07) for A vs. B, MD 0.00 (95% CI, -0.23 to 0.23) for A vs. C, MD -0.1 (95% CI, -0.29 to 0.09) for B vs. C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latifi-Xhemajli et al., 2019</td>
<td>A vs. B at endpoint</td>
<td>dmfs, mean (SD): 5.2 (10.5) vs. 10.1 (12.9), p&lt;0.001</td>
<td>NR</td>
<td>15.3% (77/504)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dmfs &gt;0: 30.6% vs. 60.0%; RR 1.81 (95% CI, 1.49 to 2.20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ICDAS 5-6: 22.0% vs. 47.7%; RR 1.49 (95% CI, 1.29 to 1.73)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>McMahon et al., 2020</td>
<td>A vs. B</td>
<td>Mean dmufs: 3.5 (5.9) vs. 3.5 (4.9)</td>
<td>NR</td>
<td>A vs. B: 10% (66/643) vs. 11% (68/641)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Worse dmufs: 27% (155/577) vs. 32% (181/573), OR 0.80 (95% CI, 0.62 to 1.03)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Worse d3mfts: 29% (165/577) vs. 34% (193/573), OR 0.79 (95% CI, 0.61 to 1.01)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Worse d3mfs: 21% (119/577) vs. 26% (147/573), OR 0.75 (95% CI, 0.57 to 0.99)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Worse mt: 5% (28/577) vs. 4% (21/573), OR 1.34 (95% CI, 0.75 to 2.39)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Worse ft: 9% (52/577) vs. 11% (65/573), OR 0.77 (95% CI, 0.53 to 1.14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extraction: 2% (11/577) vs. 1% (8/573), OR 1.37 (95% CI, 0.55 to 3.44)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fillings: 10% (55/577) vs. 11% (61/573), OR 0.88 (95% CI, 0.60 to 1.30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pulpotomy: 1% (4/577) vs. 1% (3/573), OR 1.33 (95% CI, 0.30 to 5.95)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preformed metal crowns: 2% (13/577) vs. 2% (10/573), OR 1.30 (95% CI, 0.56 to 2.98)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extraction of deciduous teeth: 0% (1/577) vs. 0% (0/573)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NNT to prevent 1 child from having a worsening of d3mft: 21</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Outcomes</th>
<th>Adverse events/harms</th>
<th>Attrition</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memarpour et al., 2015</td>
<td>A vs. B vs. C vs. D dfmft at 12 months, mean (SD): 0.3 (0.90) vs. 0.42 (0.99) vs. 0.17 (0.53) vs. 2.0 (2.0); p&lt;0.001 for C vs. others</td>
<td>NR</td>
<td>A vs. B vs. C: 82.9% (29/35) vs. 88.6% (31/35) vs. 85.7% (30/35) vs. 91.4% (32/35)</td>
<td>Fair</td>
</tr>
<tr>
<td>Memarpour et al., 2016</td>
<td>A vs. B vs. C</td>
<td>Incident caries (dmft &gt;0) At 4 months: 1.0% (1/95) vs. 2.1% (2/97) vs. 3.1% (3/96); RR 1.96 (95% CI, 0.18 to 21.24) for A vs. B, RR 0.34 (95% CI, 0.04 to 3.18) for A vs. C, RR 0.66 (95% CI, 0.11 to 3.86) for B vs. C At 8 months: 1.1% (1/93) vs. 3.2% (3/94) vs. 16.0% (15/94); RR 2.97 (95% CI, 0.31 to 28.02) for A vs. B, RR 0.07 (95% CI, 0.01 to 0.50) for A vs. C, RR 0.20 (95% CI, 0.06 to 0.67) for B vs. C At 12 months: 1.1% (1/87) vs. 4.7% (4/93) vs. 33.0% (30/90); RR 4.09 (95% CI, 0.47 to 35.89) for A vs. B, RR 0.03 (95% CI, 0.005 to 0.25) for A vs. C, RR 0.14 (95% CI, 0.05 to 0.39) for B vs. C</td>
<td>NR</td>
<td>13% (40/260)</td>
</tr>
<tr>
<td>Muñoz-Millán et al., 2018</td>
<td>A vs. B</td>
<td>Incidence of caries: 45% (59/131) vs. 55.5% (80/144), p=0.081 Mean (95% CI) incremental caries difference: -0.5 (-1.1 to 0.1) Mean (SD) dfmft: 1.6 (2.0) vs. 2.1 (2.6) Preventive fraction: 18.9% (95% CI, -2.9% to 36.2%)</td>
<td>None reported by parents</td>
<td>A vs. B: 32% (42/131) vs. 30% (44/144)</td>
</tr>
<tr>
<td>Oliveira et al., 2014 dos Santos et al., 2016</td>
<td>A vs. B</td>
<td>Children with new dentine caries lesions: 35.9% (32/89) vs. 46.7% (43/92); RR 0.77 (95% CI, 0.54 to 1.09), ARD 11% (95% CI, -3.5 to 25.0%) d2mfs, mean (SD): 2.0 (4.0) vs. 2.8 (4.2), difference -0.8 (95% CI, -1.9 to 0.4) d3mfs, mean (SD): 1.8 (3.9) vs. 2.5 (4.0), difference -0.7 (95% CI, -2.0 to 0.4)</td>
<td>2 complaints reported; 1 child's mother was bothered by the color of the child's teeth after fluoride varnish application and 1 child's mother reported the child complained of a burning sensation in her mouth on the first day of placebo varnish application No withdrawals due to AEs, and of 11 (8 vs. 3) children with asthma at baseline none reported any AEs Followup for subgroup evaluated at 4 years (n=123) Fluorosis: 27% (17/63) vs. 35% (21/60); p=0.44</td>
<td>A vs. B: 11% (11/100) vs. 8% (8/100)</td>
</tr>
</tbody>
</table>
## Appendix B7. Trials of Topical Fluoride for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Outcomes</th>
<th>Adverse events/harms</th>
<th>Attrition</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tickle et al., 2016</td>
<td>A vs. B</td>
<td><strong>Converted from caries free to caries active:</strong> 34% (187/549) vs. 39% (213/547); adjusted OR 0.81 (95% CI, 0.64 to 1.04); p=0.11&lt;br&gt;<strong>dMfs affected by caries in children who developed caries, mean (SD):</strong> 7.18 (7.99) vs. 9.61 (8.75); adjusted mean difference -2.29 (95% CI, -3.96 to -0.63); p=0.007&lt;br&gt;<strong>Teeth extraction, among those developing caries:</strong> 11.2% (11/187) vs. 13.1% (28/547)</td>
<td>A vs. B</td>
<td>Any AE: 7.2% (45/624) vs. 5.9% (37/624); RR 1.22 (95% CI 0.80 to 1.85)</td>
</tr>
</tbody>
</table>

*See Appendix A4 for full citations of included studies.
†Restricted to aboriginal children, including 14 non-randomized children who received fluoride varnish.
‡Includes 102 non-randomized children (88 nonaboriginal) who received fluoride varnish (or subgroup from this population).

Abbreviations: AE=adverse event; CI=confidence interval; CPP-ACP=casein phosphopeptide-amorphous calcium phosphate; ICDAS=international caries detection and assessment system; MD=mean difference; NR=not reported; NS=not significant; OR=odds ratio; RCT=randomized controlled trial; RR=relative risk; SD=standard deviation; SE=standard error; UCSF=University of California, San Francisco.
Appendix B8. Trials of Xylitol for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Type of study</th>
<th>Interventions</th>
<th>Population characteristics</th>
<th>Eligibility criteria</th>
<th>Number approached, eligible, enrolled, analyzed</th>
</tr>
</thead>
</table>
| Oscarson et al., 2006 | RCT | A: One 0.48 gram xylitol tablet at bedtime after brushing for 6 months; then one tablet twice daily to age 3 years and 6 months  
B: No tablets | Age: 25 vs. 25 months  
Female: 49% vs. 46% (p>0.05)  
Non-white: NR  
Seldom/irregular toothbrushing: 7% vs. 3% (p>0.05)  
High (>100 CFU) mutans streptococci counts: 11% vs. 6% (p>0.05)  
Daily sugary soft drinks: 17% vs. 27% (p>0.05)  
Daily sugars sweets: 0% vs. 2% (p>0.05) | Healthy 2 year old children. Excluded: Children with severe disabilities or uncooperative for oral exam | Number approached: NR  
Number eligible: NR  
Number enrolled: 132 (66 vs. 66)  
Number analyzed: 115 (55 vs. 63) |
| Zhan et al., 2012 | RCT | A: Xylitol wipes, two at a time, three times per day (estimated daily dosage 4.2 g) every 3 months  
B: Placebo wipes | Age: 6 to 35 months vs. 6 to 35 months  
Female: 36% vs. 40%  
Non-white: 90% vs. 95%  
Brush teeth daily: 68% vs. 68%  
Use fluoride toothpaste: 36% vs. 27% | Mothers with healthy children aged 6 to 35 months; mothers were primary care givers (>8 hours daily) and with minimum of one active caries lesion within a year; no children with oral or systemic diseases; no mothers or children who took antibiotics or other medication affecting oral flora in previous 3 months. | Number approached: 82  
Number eligible: 57  
Number enrolled: 44 (22 vs. 22)  
Number analyzed: 44 (22 vs. 22) ITT; 37 (20 vs. 17) on-treatment analysis |
## Appendix B8. Trials of Xylitol for the Prevention of Dental Caries

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Country Setting</th>
<th>Sponsor</th>
<th>Duration of followup</th>
<th>Outcomes</th>
<th>Adverse events/harms</th>
<th>Attrition</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oscarson et al., 2006</td>
<td>Sweden</td>
<td>Recruitment setting: Public dental clinic Water fluoridation status: Not reported</td>
<td>County of Vasterbotten, The Patent Revenue Fund for Dental Prophylaxis and Swedish Dental Society</td>
<td>2 years</td>
<td>A vs. B Dental caries: 18% (10/55) vs. 25% (16/63), OR 0.65 (95% CI 0.27 to 1.59) dmfs, mean: 0.38 vs. 0.80 (p&gt;0.05) Absolute reduction in caries increment: 0.42 Reduction in caries increment: 52%</td>
<td>A vs. B Withdrawals due to adverse events: NR</td>
<td>A vs. B: 16.7% (11/66) vs. 4.5% (3/66)</td>
</tr>
<tr>
<td>Zhan et al., 2012</td>
<td>United States</td>
<td>Recruitment setting: University pediatric clinic Water fluoridation status: Not reported</td>
<td>California Society of Pediatric Dentistry Foundation, a Graduate Scientific Research Award from American Academy of Pediatric Dentistry, and NIH/NIDCR grant U54 DEO19285</td>
<td>1 year</td>
<td>A vs. B Mean new decayed surfaces: 0.05 vs. 0.53 (p=0.01) New caries lesions at 1 year: 5% vs. 40% (p=0.03); NNT 3 ITT analysis of new caries lesions at 1 year: 5% vs. 32%; RR 0.14 (95% CI 0.02 to 1.07); NNT 4 Absolute reduction in caries increment: 0.48 Reduction in caries increment: 91%</td>
<td>None</td>
<td>A vs. B 9% (2/22) vs. 23% (5/22)</td>
</tr>
</tbody>
</table>

*See Appendix A4 for full citations of included studies.

Abbreviations: CFU=colony-forming unit; CI=confidence interval; ITT=intention to treat; NIDCR=National Institute of Dental and Craniofacial Research; NIH=National Institutes of Health; NNT=number needed to treat; NR=not reported; OR=odds ratio; RCT=randomized controlled trial; RR=relative risk.
## Appendix B9. Systematic Review of Fluorosis Due to Fluoride Supplements

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>Databases searched, date of last search</th>
<th>Number and type of studies</th>
<th>Methods for rating methodological quality of primary studies</th>
<th>Methods for synthesizing results of primary studies</th>
<th>Number of patients (treatment and control)</th>
<th>Adverse events</th>
<th>Quality rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ismail and Hasson, 2008</td>
<td>MEDLINE: 1966-June 2006 Cochrane: up to 2nd quarter 2006 EMBASE: 1974-2006</td>
<td>5 observational studies</td>
<td>Cochrane Handbook of Systematic Reviews</td>
<td>Qualitative analyses only, due to high heterogeneity of subjects, outcomes, and duration of followup</td>
<td>Not reported</td>
<td>5 observational studies reported fluorosis outcomes associated with early childhood use of fluoride supplementation - All studies found an association between fluoride supplementation in early childhood and risk of fluorosis - 1 study (n=383) found OR increased by 84% per year of use of fluoride supplements (95% CI, 1.4 to 2.5) - 1 study (n=188) OR 10.3 in children started on fluoride supplements within the first 2 years of life (95% CI, 1.9 to 61.6) - Largest study (n=3978) found slightly increased risk that ranged</td>
<td>Good</td>
</tr>
</tbody>
</table>
## Appendix B10. Quality Ratings of Systematic Reviews

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>1. Did the research questions and inclusion criteria for the review include the components of PICO?</th>
<th>2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol? (Critical Domain)</th>
<th>3. Did the review authors explain their selection of the study designs for inclusion in the review?</th>
<th>4. Did the review authors use a comprehensive literature search strategy? (Critical Domain)</th>
<th>5. Did the review authors perform study selection in duplicate?</th>
<th>6. Did the review authors perform data extraction in duplicate?</th>
<th>7. Did the review authors provide a list of excluded studies and justify the exclusions? (Critical Domain)</th>
<th>8. Did the review authors describe the included studies in adequate detail?</th>
<th>9a. Did the review authors use a satisfactory technique for assessing the RoB in individual studies that were included in the review? (Critical Domain)</th>
<th>9b. Did the review authors use a satisfactory technique for assessing the RoB in individual studies that were included in the review? (Critical Domain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ismail and Hasson, 2008</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not reported</td>
<td>Not reported</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Appendix B10. Quality Ratings of Systematic Reviews

<table>
<thead>
<tr>
<th>Author, year*</th>
<th>10. Did the review authors report on the sources of funding for the studies included in the review?</th>
<th>11a. If meta-analysis was performed did the review authors use appropriate methods for statistical combination of results? (Critical Domain)</th>
<th>11b. If meta-analysis was performed did the review authors use appropriate methods for statistical combination of results? (NRSI)</th>
<th>12. If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?</th>
<th>13. Did the review authors account for RoB in individual studies when interpreting/discussing the results of the review? (Critical Domain)</th>
<th>14. Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review? (Critical Domain)</th>
<th>15. If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review? (Critical Domain)</th>
<th>Overall rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ismail and Hasson, 2008</td>
<td>No</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Good</td>
</tr>
</tbody>
</table>