



Complete Summary

GUIDELINE TITLE

Recommendations on selected interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries.

BIBLIOGRAPHIC SOURCE(S)

Recommendations on selected interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. Am J Prev Med 2002 Jul; 23(1 Suppl): 16-20. [22 references] [PubMed](#)

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

- Dental caries
- Oral and pharyngeal cancers
- Sports-related craniofacial injuries (e.g., bone fractures, tooth loss, concussions, brain damage)

GUIDELINE CATEGORY

Prevention

CLINICAL SPECIALTY

Dentistry
Preventive Medicine

INTENDED USERS

Dentists
Health Care Providers
Health Plans
Managed Care Organizations
Public Health Departments
Utilization Management

GUIDELINE OBJECTIVE(S)

To provide recommendations on community interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries

TARGET POPULATION

Schools, communities, and populations in the United States

INTERVENTIONS AND PRACTICES CONSIDERED

Interventions to Prevent or Control Dental Caries

1. Community water fluoridation
2. School-based or school-linked pit and fissure sealant delivery programs

Note: Guideline developers considered statewide or community-wide sealant promotion programs; however, no recommendations were offered because of insufficient evidence.

Interventions to Prevent or Control Oral and Pharyngeal Cancers

Note: Guideline developers considered population-based interventions to prevent and control oral and pharyngeal cancers, specifically to improve stage distribution, morbidity, mortality or quality of life; however, no recommendations were offered because of insufficient evidence.

Interventions to Prevent or Control Sports-related Craniofacial Injuries

Note: Guideline developers considered population-based interventions to encourage use of helmets, facemasks, and mouthguards in contact sports; however, no recommendations were offered because of insufficient evidence.

MAJOR OUTCOMES CONSIDERED

Incidence or occurrence of:

- Dental caries
- Oral cancers or precancers
- Sports-related craniofacial injuries

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline was searched from 1966 through December 2000. In addition, members of the development team manually searched reference lists and consulted with specialists in the field to identify other relevant citations, including reports on studies of the economics of the interventions being examined.

To be included in the review of effectiveness of an intervention, a study had to (a) involve primary investigation of an intervention selected for evaluation; (b) be published in English on or before December 31, 2000, (c) be conducted in established market economies (unless such studies were unavailable or scarce, in which case, relevant studies conducted in other countries were included); and (d) compare outcomes among persons exposed to the intervention with outcomes among groups of persons not exposed or less exposed to the intervention.

NUMBER OF SOURCE DOCUMENTS

- 130 papers met the inclusion criteria and were abstracted, 94 of which were excluded because of limitations in their execution or design.
- 36 papers were considered qualifying studies.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Studies are categorized as having good, fair, or limited quality of execution based on the number of limitations (i.e., threats to validity) noted. Studies with limited quality of execution were not included in the summary effect of the intervention.

Good: 0 to 1 study limitations

Fair: 2 to 4 study limitations

Limited: 5 or more study limitations

Studies were evaluated for limitations in execution with respect to the following six categories (a total of 9 limitations are possible):

- Study population and intervention descriptions

- Sampling
- Exposure and outcome measurement
- Data analysis
- Interpretation of results (including follow-up, bias, and confounding)
- Other

In addition, the body of evidence of effectiveness is characterized as strong, sufficient, or insufficient based on the number of available studies, the suitability of their design and quality of execution, and the size and consistency of reported effects.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

For each intervention reviewed, the team developed an analytic framework indicating possible causal links between the intervention under study and predefined outcomes of interest. These outcomes included dental caries, oral cancers or precancers, and sports-related craniofacial injuries.

Studies that met the inclusion criteria also had to meet the quality criteria. Each study was evaluated using a standardized abstraction form and assessed for suitability of the study design and threats to validity. On the basis of the number of threats to validity, studies were characterized as having good, fair, or limited execution. The strength of the body of evidence of effectiveness was characterized as strong, sufficient, or insufficient on the basis of the number of available studies, the suitability of study designs for evaluating effectiveness, the quality of execution of the studies, the consistency of the results, and the effect size.

The Community Guide systematically links evidence to recommendations. The strength of evidence of effectiveness corresponds directly to the strength of recommendations (e.g., strong evidence of effectiveness corresponds to an intervention being strongly recommended, and sufficient evidence corresponds to an intervention being recommended). Other types of evidence also can affect a recommendation. For example, evidence of harms resulting from an intervention might lead to a recommendation that the intervention not be used, even if it is effective in improving certain outcomes.

A finding of insufficient evidence of effectiveness does not result in recommendations for or against an intervention's use but is important for identifying areas of uncertainty and continuing research needs. In contrast, sufficient or strong evidence of ineffectiveness leads to a recommendation that the intervention not be used. Although the option exists, the Task Force has yet to use economic information to modify recommendations.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Other

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Task Force recommendations are based primarily on the effectiveness of interventions as determined by the systematic literature review process. In making recommendations, the Task Force balances information about the effectiveness of an intervention with information about other potential benefits and potential harms. To determine how widely a recommendation should apply, the Task Force also considers the applicability of the intervention in various settings and populations. Finally, the Task Force reviews economic analyses of those interventions found to be effective and summarizes applicable barriers to intervention implementation. Economic information is provided to assist the reader with decision making but generally does not affect the Task Force's recommendation.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Strength of Evidence of Effectiveness = Strength of Recommendation

Strongly recommended: Strong evidence of effectiveness was found.

Recommended: Sufficient evidence of effectiveness was found.

Insufficient evidence: The available studies provided insufficient evidence to assess the effectiveness of the intervention.

Not recommended: The available studies provided sufficient evidence that the intervention is ineffective or that harms exceed benefits.

COST ANALYSIS

Each of the "Recommended" or "Strongly Recommended" interventions included a systematic review of information from economic evaluations.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline was submitted for extensive peer review, including review at various stages by a "consultation team", a team of national and regional subject matter and methodologic experts, and peer review of the finished product by selected external experts, agencies, and professional groups.

The Task Force also reviewed selected guidelines and other evidence reviews on prevention of dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. The reader is directed to the full publication: Gooch BF, Truman BI, Griffin SO, et al. A comparison of selected evidence reviews and

recommendations on interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. Am J Prev Med. 2002 Jul; 23(1 Suppl): 55-80.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The relationship between the strength of evidence of effectiveness and the strength of the recommendation is defined at the end of the "Major Recommendations" field.

Intervention Recommendations

The Task Force evaluated the evidence of effectiveness of five interventions in the following areas: (1) strategies to prevent or control dental caries; (2) strategies to prevent or control oral and pharyngeal cancers; and (3) strategies to prevent or control sports-related craniofacial injuries.

Interventions to Prevent or Control Dental Caries

Comprehensive population-based interventions to prevent or control dental caries aim to (1) increase public and professional awareness of opportunities for organized action, (2) promote practices that improve the oral environment (e.g., reducing consumption of refined sugar and brushing with fluoride toothpaste), (3) ensure optimal exposure to fluoride from all sources (including community water fluoridation), and (4) assure access to and efficient use of regular dental care, both preventive and restorative, including optimal use of sealants delivered in school-based or school-linked settings. This report examines the evidence of the effectiveness of three interventions to prevent and control dental caries at the community level: community water fluoridation, school-based or school-linked pit and fissure sealant delivery programs, and statewide or community-wide sealant promotion programs.

Community water fluoridation: strongly recommended. Community water fluoridation (CWF) is the controlled addition of a fluoride compound to a public water supply to achieve an optimal fluoride concentration. Since 1962, the U.S. Public Health Service has recommended that community drinking waters contain 0.7 pm to 1.2 pm of fluoride. *In 2000, more than 162 million people in the United States (57.6% of the population and 65.8% of those receiving municipal water supplies) were being supplied with water containing enough fluoride to protect teeth from caries. In 2000, a total of 38 states and the District of Columbia provided access to fluoridated public water supplies to $\geq 50\%$ of their populations. A national objective aims to ensure that at least 75% of the population will be served by community water systems providing optimal levels of fluoride by the year 2010.

*Updated numbers are based on: Populations Receiving Optimally Fluoridated Public Drinking Water -- United States, 2000. MMWR Morbid Mortal Wkly Rep 2002 Feb 22; 51(7):144-7.

CWF is strongly recommended based on its effectiveness in reducing the occurrence of dental caries within communities. Other positive effects mentioned, but not systematically evaluated, include (1) reducing disparities in caries risk and experience across subgroups defined by socioeconomic status, race or ethnicity, and other predictors of caries risk and (2) the "halo" or "diffusion" benefits to residents of nonfluoridated communities by means of exposure to processed food and beverages made from fluoridated water.

The safety of fluoride is well documented and has been reviewed comprehensively. Enamel fluorosis (visible discoloration of tooth enamel) is one of the potential adverse effects seen in children who ingest too much fluoride from any and all sources while tooth enamel is forming. Most cases of enamel fluorosis seen today are of the mildest form, which does not affect esthetics or function. The most recent review of potential adverse effects of CWF showed no clear association between water fluoridation and incidence of mortality from bone cancers, thyroid cancer, or all cancers.

Program costs of CWF are affordable. Median cost per person per year ranges from \$2.70 among 19 public water systems serving ≤ 5000 people to \$0.40 among 35 systems serving populations $\geq 20,000$. Estimated cost-effectiveness ratios (i.e., net cost per tooth surface spared from decay) indicate that community water fluoridation is cost saving (i.e., saves money from a societal perspective and also reduces caries).

School-based or School-linked Pit and Fissure Sealant Delivery Programs: strongly recommended. School-based or school-linked pit and fissure sealant delivery programs directly provide pit and fissure sealants to children unlikely to receive them otherwise. School-based programs are conducted entirely in the school setting, and school-linked programs are conducted in both schools and clinic settings outside schools. Such programs define a target population within a school district; verify unmet need for sealants (by conducting surveys); get financial, material, and policy support; apply rules for selecting schools and students; screen and enroll students at school; and apply sealant at school or offsite in clinics. Many programs target what are referred to as high-risk children with high-risk teeth. High-risk children include vulnerable populations less likely to receive private dental care, such as children eligible for free or reduced-cost lunch programs. High-risk teeth (i.e., those with deep pits and fissures) are the first and second permanent molars that erupt into the mouth around the ages of 6 and 12 years, respectively. School-based and school-linked sealant delivery programs are strongly recommended on the basis of strong evidence of effectiveness in reducing caries on occlusal surfaces of posterior teeth among children.

Other potential positive and negative effects of school-based or school-linked sealant delivery programs have been mentioned but remain unsupported by empirical evidence of effectiveness. For example, successful programs may lead to the positive effects of (1) increased support for coordinated school-based programs to address related dental and nondental needs of children from low-income families (e.g., immunization and better nutrition) and (2) increased willingness of third-party insurers to pay for sealants applied in all settings. Potential negative effects are expressed in concerns that (1) sealants containing Bisphenol-A may have estrogenic effects in the recipient and (2) effective delivery

of sealants (from all sources) might encourage recipients to ignore other anti-carries interventions (e.g., use of fluorides).

Economic evaluation studies reported sealant program costs per person served ranging from \$18.50 to \$59.83 (median = \$39.10). The cost effectiveness ratios (adjusted cost per averted decayed surface) ranged from cost saving (<\$0) to \$487. A hypothetical school-based sealant program that sealed first permanent molars would be cost saving if unsealed molars were decaying at the average rate of >0.47 surfaces per year.

Statewide or Community-wide Sealant Promotion Programs: insufficient evidence. Statewide or community-wide sealant promotion programs encourage sealant use among private practitioners and through community-based programs. Program activities include continuing education courses for dental health professionals; educational campaigns for consumers, community leaders, and third-party payers; and efforts to promote school-based or school-linked sealant delivery programs. Statewide or community-wide sealant promotion programs aim to increase public and professional awareness of the health benefits of sealants, encourage third-party reimbursement for sealant application, increase appropriate use of sealants by practitioners, and increase access to sealants for disadvantaged populations who might not get them otherwise (e.g., through school-based programs). The one available study that evaluated a statewide sealant promotion campaign provided insufficient evidence to assess the program's effectiveness in changing public or professional behavior or in reducing dental caries statewide. The evidence was insufficient because of limitations in study design and execution, which did not allow valid attribution of reported changes in sealant use to the intervention.

Interventions to Prevent or Control Oral and Pharyngeal Cancers

Since 1992, organized efforts to develop and implement a national strategic plan for preventing and controlling oral and pharyngeal cancers have been gaining momentum in the United States. In 1996, a coalition of national, state, and local health agencies began promoting coordinated strategies in five areas: (1) advocacy, collaboration, and coalition building; (2) public health policy; (3) public education; (4) professional education and practice; and (5) data collection, evaluation, and research. Despite the organized efforts described above, the effectiveness of population-based interventions to prevent and control oral and pharyngeal cancers, specifically to reduce mortality or improve quality of life, remains unknown.

Population-based interventions for early detection of pre-cancers and cancers: insufficient evidence. Population-based interventions for early detection of pre-cancers and cancers educate the public about risk factors, symptoms, signs, and the value of early detection; encourage high-risk or symptomatic individuals to examine themselves for suspicious lesions and to seek out a source of professional examination and follow-up; train health workers to detect suspicious lesions; examine people at the workplace, home, health fairs, field clinics, or the usual source of care; and refer eligible people with suspicious lesions (e.g., leukoplakia, erythroplakia, lichen planus, submucous fibrosis, and oral cancer) for follow-up and treatment.

The Task Force identified 19 studies with limited quality of execution. Those studies provide insufficient evidence of the effectiveness of early detection programs in improving stage distribution, morbidity, mortality, or quality of life at the population level.

Interventions to Prevent or Control Sports-related Craniofacial Injuries

The consequences of sports-related injuries (e.g., bone fractures, tooth loss, concussions, brain damage) range from something as simple yet frustrating as a loss of game time to the much more serious events of paralysis and death. Helmets, facemasks, and mouthguards protect users from injuries to the head, face, and mouth. Protective equipment is mandatory in some professional sports: baseball requires use of helmets, football requires helmets and facemasks, ice hockey requires helmets, and boxing requires mouthguards. In amateur sports, helmets, facemasks, and mouthguards are mandatory in boxing, football, ice hockey, and men's lacrosse, and mouthguards are mandatory in women's field hockey. Healthy People 2010 established a developmental objective to increase the proportion of public and private schools that require use of appropriate head, face, eye, and mouth protection for students participating in school-sponsored physical activities.

Population-based interventions to encourage use of helmets, facemasks, and mouthguards in contact sports: insufficient evidence. Population-based interventions to encourage the use of helmets, facemasks, and mouthguards in contact sports aim to prevent injuries to the head, face, and mouth. Rules of play involving use of helmets, facemasks, goggles, and mouthguards vary by sport and position played. Intervention programs educate health professionals, parents, coaches, players, and officials of organized sports about the risks of injury and the potential benefits of protective equipment; offer incentives for regular use of protective equipment at both practice and formal competition; and encourage the enforcement of rules of play involving use of safety equipment. The Task Force identified four qualifying studies that evaluated the effectiveness of intervention programs in (1) increasing the frequency of correct and incorrect use of helmets, facemasks, and mouthguards and (2) reducing the incidence, prevalence, or recurrence and type and severity of sports-related injuries to the head, face, and mouth. Those studies provide insufficient evidence of the effectiveness of such programs in changing the behavior of players or in reducing the frequency of sports-related injuries to the head, face, and mouth. Although effectiveness could not be established, mainly because of inadequate number, design, or execution of studies, readers are reminded that the use of helmets, facemasks, and mouthguards is mandatory in many sports and encouraged by a Healthy People 2010 objective.

Definitions:

Strength of Evidence of Effectiveness = Strength of Recommendation

In general, strength of evidence of effectiveness links directly to strength of recommendation as follows:

- Strong: Strongly recommended
- Sufficient: Recommended

- Insufficient: Available studies do not provide sufficient evidence to determine effectiveness
- Sufficient or strong evidence of ineffectiveness or harm: Recommend against

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are based on 36 qualifying studies, all of which had good or fair quality of execution. In general, the strength of evidence of effectiveness corresponds directly to the strength of recommendations (see the "Major Recommendations" field).

Detailed descriptions of the evidence are provided in the companion documents to the guideline:

- Truman BI, Gooch BF, Sulemana I, et al. Reviews of evidence on interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. *Am J Prev Med.* 2002 Jul;23(1 Suppl):21-54.
- Gooch BF, Truman BI, Griffin SO, et al. A comparison of selected evidence reviews and recommendations on interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. *Am J Prev Med.* 2002 Jul;23(1 Suppl):55-80.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- According to Community Guide rules of evidence, strong evidence shows that community water fluoridation is effective in reducing the cumulative experience of dental caries within communities.
- According to Community Guide rules of evidence, strong evidence shows that school-based and school-linked sealant delivery programs are effective in reducing decay in pits and fissures of children's teeth.

POTENTIAL HARMS

- Enamel fluorosis (visible discoloration of tooth enamel) is one of the potential adverse effects seen in children who ingest too much fluoride from any and all sources while tooth enamel is forming. Most cases of enamel fluorosis seen today are of the mildest form, which does not affect esthetics or function. The most recent review of potential adverse effects of community water fluoridation showed no clear association between water fluoridation and incidence of mortality from bone cancers, thyroid cancer, or all cancers.

- Potential negative effects of school-based or school-linked sealant delivery programs have been mentioned but remain unsupported by empirical evidence; (1) sealants containing Bisphenol-A may have estrogenic effects in the recipient and (2) effective delivery of sealants (from all sources) might encourage recipients to ignore other anti-caries interventions (e.g., use of fluorides).

Subgroups Most Likely to be Harmed:

Children whose tooth enamel is forming are at greatest risk for fluorosis.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Readers are cautioned not to confuse an assessment of insufficient evidence of effectiveness with evidence of ineffectiveness. In most cases, an assessment of insufficient evidence was based on an inadequate number of qualifying studies (i.e., studies meeting established criteria for study design and execution that allow reported changes in outcomes to be validly attributed to the intervention).
- The Task Force’s finding of insufficient evidence indicates the need for more research on intervention effectiveness. Until the results of such research become available, readers are encouraged to judge the usefulness of these intervention by other criteria.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Given that oral health conditions cause considerable morbidity and mortality, and that activities to promote oral health are ongoing throughout the United States, the recommendations in this report should be relevant to most communities.

Communities, school systems, healthcare systems, and oral health practitioners should consider starting program planning and implementation cycles by:

- Assessing their goals in light of national goals and objectives
- Assessing the current burden of oral health conditions in their populations
- Reviewing the current status and history of intervention activities
- Identifying opportunities for improving intervention effectiveness and oral health status

Subsequently, in deciding which combination of interventions is most likely to meet local objectives, decision makers should consider state and local laws and regulations, resource availability, administrative structures, economic and social environments of implementing organizations and practitioners, and recommendations and other evidence provided in this and other reports, including those of the U.S. Surgeon General; the National Health Service Centre for Reviews and Dissemination; University of York; the Centers for Disease Control

and Prevention (CDC); the Institute of Medicine; and the Canadian Task Force on Preventive Health Care.

The Task Force has strongly recommended community water fluoridation and school-based or school-linked pit and fissure sealant delivery programs. Although the Task Force generally does not use economic information to modify recommendations, this information, provided in the accompanying article, can help local policymakers in the decision-making process. If local goals and resources permit, the use of these interventions should be initiated or increased. In addition, these particular interventions should be considered in the context of other community-wide, provider-based, and individual strategies for preventing or controlling dental caries in communities.

The Task Force's decision to make no recommendation for or against the use of three other reviewed interventions at the community level (statewide or community-wide sealant promotion programs, population-based interventions for early detection of pre-cancers and cancers, and population-based interventions to encourage use of helmets, facemasks, and mouthguards in contact sports) indicates the need for high quality research on their effectiveness. Until the results of such research become available, readers may judge the usefulness of these interventions based on other criteria. Although the effectiveness of community-wide sealant promotion programs remains unknown, the clinical safety and effectiveness of sealants have been established.

Where organized efforts are being considered to reduce the burden of oral cancer, the findings presented here should be considered together with recommendations of other groups. For example, more widespread use of effective strategies to reduce tobacco use, an important cause of oral and pharyngeal cancer, should be encouraged and periodic oral examinations of people engaging in risk behaviors (tobacco use or excessive alcohol consumption) or manifesting suspicious symptoms may be considered by clinicians.

Finally, in the absence of a community-wide recommendation on use of protective head and face equipment in contact sports, it should be noted that the frequency and severity of head, face, and oral injuries have decreased in some sports since the use of helmets, facemasks, and mouthguards became mandatory in selected organized contact sports (e.g., football and ice hockey).

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Recommendations on selected interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. Am J Prev Med 2002 Jul; 23(1 Suppl): 16-20. [22 references] [PubMed](#)

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2002 Jul

GUIDELINE DEVELOPER(S)

Task Force on Community Preventive Services - Independent Expert Panel

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

Task Force on Community Preventive Services

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Fielding, Jonathan, M.D., M.P.H., M.B.A. (Chairperson); Mullen, Patricia Dolan, Dr. P.H. (Vice Chairperson); Brownson, Ross, Ph.D.; Fullilove, Mindy, M.D.; Guerra, Fernando, M.D., M.P.H.; Hinman, Alan R., M.D., M.P.H.; Isham, George J., M.D.; Land, Garland H., M.P.H.; Mahan, Charles S., M.D.; Nolan, Patricia A., M.D., M.P.H.; Scrimshaw, Susan C., Ph.D.; Teutsch, Steven M., M.D., M.P.H.; Thompson, Robert S. (Tommy), M.D.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline is subject to periodic updates.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Task Force on Community Preventive Services Web site](#). Also available from the [National Library of Medicine's Health Services/Technology Assessment Text \(HSTAT\) Web site](#).

Print copies: Available from the Community Guide Branch, Epidemiology Program Office, Centers for Disease Control and Prevention, 4770 Buford Highway, Mailstop K-73, Atlanta, GA 30341.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Guideline Summary:

- Promoting oral health: interventions for preventing dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. A report on recommendations of the Task Force on Community Preventive Services. MMWR Recomm Rep. 2001 Nov 30; 50(RR-21): 1-13. Available from the Centers for Disease Control and Prevention (CDC) Web site: [Portable Document Format \(PDF\)](#); [HTML Format](#)

Evidence Reviews:

- Truman BI, Gooch BF, Sulemana I, et al. Reviews of evidence on interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. Am J Prev Med. 2002 Jul; 23(1 Suppl): 21-54.
- Gooch BF, Truman BI, Griffin SO, et al. A comparison of selected evidence reviews and recommendations on interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. Am J Prev Med. 2002 Jul; 23(1 Suppl): 55-80.

Guideline-Specific Background Articles:

- Community preventive services and oral health: wishes for the future [Commentary]. Am J Prev Med. 2002 Jul; 23(1 Suppl): 3-5.
- Partnering to unlock the mysteries of oral diseases and injuries [Commentary]. Am J Prev Med. 2002 Jul; 23(1 Suppl): 6-7.
- Community-based oral health prevention. Issues and opportunities [Commentary]. Am J Prev Med. 2002 Jul; 23(1 Suppl): 8-12.
- The Robert Wood Johnson Foundation's response to improving the nation's oral health [Commentary]. Am J Prev Med. 2002 Jul; 23(1 Suppl): 13-5.
- Reviews and Recommendations to Prevent Dental Caries, Oral and Pharyngeal Cancers, and Sports-Related Craniofacial Injuries [Commentary]. Am J Prev Med. 2002 Jul; 23(1 Suppl): 81-2.

General Background Articles:

- Truman BI, Smith-Akin CK, Hinman AR, Gebbie KM, Brownson R, Novick LF, Lawrence RS, Pappaioanou M, Fielding J, Evans CA, Jr., Guerra F, Vogel-

- Taylor M, Mahan CS, Fullilove M, Zaza S, Task Force on Community Preventive Services. Developing the Guide to Community Preventive Services—overview and rationale. *Am J Prev Med* 2000 Jan; 18(1 Suppl): 18-26.
- Pappaioanou M, Evans CA, Jr. Development of the Guide to Community Preventive Services: A U.S. Public Health Service initiative. *J Public Health Manag Pract* 1998 Mar; 4(2): 48-54.
 - Zaza S, Lawrence RS, Mahan CS, Fullilove M, Fleming D, Isham GJ, Pappaioanou M, Task Force on Community Preventive Services. Scope and organization of the Guide to Community Preventive Services. *Am J Prev Med* 2000 Jan; 18(1 Suppl): 27-34.
 - Briss PA, Zaza S, Pappaioanou M, Fielding J, Wright-de Agüero L, Truman BI, Hopkins DP, Mullen PD, Thompson RS, et al, and the Task Force on Community Preventive Services. Developing an evidence-based Guide to Community Preventive Services—methods. *Am J Prev Med* 2000 Jan; 18(1 Suppl): 35-43.
 - Zaza S, Wright-de Agüero L, Briss PA, Truman BI, Hopkins DP, Hennessy MH, Sosin DM, Anderson L, Carande-Kulis VG, Teutsch SM, Pappaioanou M, Task Force on Community Preventive Services. Data collection instrument and procedure for systematic reviews in the Guide to Community Preventive Services. *Am J Prev Med* 2000 Jan; 18(1 Suppl): 44-74.
 - Carande-Kulis VG, Maciosek MV, Briss PA, Teutsch SM, Zaza S, Truman BI, Messonnier ML, Pappaioanou M, Harris J.R., Fielding J, Task Force on Community Preventive Services. Methods for systematic reviews of economic evaluations for the Guide to Community Preventive Services. *Am J Prev Med* 2000 Jan; 18(1 Suppl): 75-91.
 - Zaza S, Pickett JD. The Guide to Community Preventive Services: update on development and dissemination activities. *J Public Health Manag Pract* 2001 Jan; 7(1): 92-4.
 - Novick LF, Kelter A. The Guide to Community Preventive Services: a public health imperative. *Am J Prev Med*. 2001 Nov; 21(4 Suppl): 13-5.

Users can access the complete collection of companion documents at the [Task Force on Community Preventive Services Web site](#).

Print copies: Available from the Community Guide Branch, Epidemiology Program Office, Centers for Disease Control and Prevention, 4770 Buford Highway, Mailstop K-73, Atlanta, GA 30341.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on October 4, 2002.

COPYRIGHT STATEMENT

No copyright restrictions apply.

© 1998-2004 National Guideline Clearinghouse

Date Modified: 11/8/2004

FIRSTGOV

