relieve colic. However, we need to bear in mind that these are gradual changes, as mentioned in our article.

In agreement with Cunha et al., we believe that it is crucial to promote actions to encourage pacifier nonuse, as well as pro-breastfeeding actions, within counseling practices, which do not impose such practices or make women feel guilty, but actually respect their individuality and provide relevant information to help them make informed decisions about their children’s care. That is to say that professionals and mother-child health policy-makers cannot play a neutral or passive role on the use of pacifiers, a practice associated with multiple negative outcomes on the nursing infant’s health and nutrition.

References


doi:10.2223/JPED.1939

Giuliana M. Parizoto
Mestre. Enfermeira. Banco de Leite de Bauru, Secretaria Municipal de Saúde de Bauru, Bauru, SP, Brazil.

Crístina M. G. de L. Parada
Livre-docente. Professora adjunta, Departamento de Enfermagem, Faculdade de Medicina de Botucatu, Universidade Estadual Paulista (UNESP), Botucatu, SP, Brazil.

Sônia I. Venâncio
Doutora. Pediatra, Instituto de Saúde, Secretaria de Estado da Saúde de São Paulo, São Paulo, SP, Brazil.

Maria Antonieta de B. L. Carvalhaes
Doutora. Professora assistente, Departamento de Enfermagem, Faculdade de medicina de Botucatu, UNESP, Botucatu, SP, Brazil. E-mail: carvalha@fmb.unesp.br

No conflicts of interest declared concerning the publication of this letter.

Breastfeeding and early childhood caries:

a myth that survives

Dear Editor,

The review article by Losso et al., which was recently published in this well respected journal, had the objective of informing the readers about the risk factors for caries in patients younger than 6 years old.1 Having read the manuscript with special interest, since one of our studies is cited among the references,2 we would like to make some remarks about it.

Our first comment is about the use of the term caries for this age group. The term early childhood caries (ECC), adopted by the American Academy of Pediatric Dentistry (AAPD), is aimed at emphasizing the presence of caries in deciduous teeth during the first 6 years of life. The translation of the term into Portuguese (cárie precoce na infância) used by Losso et al.,1 as well as other Brazilian authors, is inappropriate, can cause confusion regarding its correct meaning, and is not related to the concept proposed by the AAPD. Since the adjective precoce means something that is premature, taking place before the normal time or occurring before the expected age, the use of the term carie precoce na infância causes the misunderstanding that caries in the primary dentition is a disease that develops at a younger age than usual. Confusion is provoked by the meaning of the term early childhood, which designates the phase of human development encompassing the first years of life, that is, related to infants and preschoolers. Therefore, the term cárie do lactente e do pré-escolar (CLPE), used for the first time in Portuguese in our article,2 is the most exact and appropriate translation because it defines the presence of this pathology in children up to 6 years old in an unmistakable manner.

The second important aspect is that Losso et al. stated that our study would have reported conflicting information about the cariogenicity of maternal milk.1 Such statement is not correct, and the main conclusion of our study was not mentioned by these authors. In our review of the literature on the relationship between breastfeeding and ECC, we concluded that there is no evidence supporting the association between breastfeeding and development of caries. We also added that this relationship is complex and can be confounded by many variables, mainly infection with Streptococcus mutans, enamel hypoplasia, sugar intake, in its different forms, and social conditions, represented by parents’ educational level and socioeconomic status.2 We are proud to inform that our study has been recently considered by White3 as one of the five studies showing relevant scientific evidence on the association between breastfeeding and ECC. In this study, White3 clearly mentioned our conclusion and listed the possible limitations of our critical review. The author concluded that, due to the well-established benefits of breastfeeding and the lack of consistent evidence of its association with the occurrence of ECC, dentists should support the current recommendations of breastfeeding. The author also recommends that good dental hygiene practices should be emphasized after the eruption of the first tooth and that parents should be instructed to reduce the frequency of...
the consumption of food and beverages containing sugar by infants and preschoolers.³

Our third comment is related to the great concern of Losso et al. in emphasizing the fact that the AAPD does not recommend breastfeeding on demand after the eruption of the first deciduous tooth. Although the authors included the literature published during the past 25 years in their review article, they did not consider the current scientific evidence that is not in agreement with this recommendation, including many of the references cited in our study² and in White’s³ article. In addition, we detected an important and basic misconception in the article by Losso et al. with regards to the study by Plutzer & Spencer,⁴ which compromises their recommendations about breastfeeding. According to Losso et al., Plutzer & Spencer’s findings support the AAPD recommendations.⁴ However, when analyzing this study,⁴ we detected an important misinterpretation. Plutzer & Spencer tested the effectiveness of an oral health promotion program in nulliparas with the purpose of reducing the prevalence of ECC in their children at 18 months. The authors found that the children whose mothers were provided with information on oral health during pregnancy and when their children were 6 and 12 months old had a four-fold decrease in the prevalence of ECC. Plutzer & Spencer did not mention the AAPD recommendations in their study.⁴ On the contrary, the nutritional recommendations adopted by these authors were based on the official recommendations of the Australian government, which stimulate breastfeeding up to 1 year at least and do not suggest any type of restriction due to its low prevalence at 6 months (approximately 20%).⁵

Furthermore, another recent study has confirmed that maternal milk, in addition to not being cariogenic, is a protective factor against the occurrence of caries.⁶ Niemi et al. demonstrated that human milk components are able to inhibit adhesion of S. mutans to hydroxyapatite crystals in vitro.⁶ Based on the current scientific evidence, which supports the fact that maternal milk is not cariogenic, we disagree with the conclusions of Losso et al.¹ regarding any restrictions to breastfeeding due to pediatric oral health.

These authors’ point of view is in direct agreement with other information reported in our critical review: in spite of the fact that there is not scientific evidence confirming the association between breastfeeding and caries, many health professionals still do not believe that the human milk is not cariogenic, perpetuating the myth originated from this association.

We would like to emphasize the fact that our comments do not intend to deny the merit of the article as a whole and we hope we could contribute to this discussion.

References

doi:10.2223/JPED.1945

Nilza M. E. Ribeiro
Cirurgiã-dentista, odontopediatria. Mestranda, Saúde da Criança, Pontifícia Universidade Católica do Rio Grande do Sul (PUCRS), Porto Alegre, RS, Brazil. E-mail: anraquel@terra.com.br

Manoel A. S. Ribeiro
Pediatra, neonatologista. Mestre em Pediatria, PUCRS, Porto Alegre, RS, Brazil.

No conflicts of interest declared concerning the publication of this letter.

Authors’ reply

Dear Editor,

Initially, we would like to thank Ribeiro & Ribeiro for the attentive reading of our article entitled “Severe early childhood caries: an integral approach”¹ and for their comments. Our study is a broad approach of caries in childhood, including information on its prevalence, risk factors for its development, clinical aspects, local and systemic consequences, and prevention. Therefore, we did not intend to provide an exhaustive analysis of each topic approached in the article.

Regarding the terminology used, several different terms have been adopted throughout the years in the international literature to designate this topic.² Although the suggestion of the term cárie do lactente e do pré-escolar can be considered valid and interesting, the terms cárie precoce na infância and cárie de acometimento precoce are well-established in the Portuguese language and are used in dentistry articles in Brazil, being the most commonly adopted by dentists.²

We absolutely did not intend to reduce mothers’ motivation to breastfeed. On the contrary, we understand that it is a responsibility of the dentist to stimulate this practice, since, in addition to the undeniable benefits for the child’s physical and psychological health, breastfeeding favors normal face growth and prevents the development of abnormal swallowing and malocclusions.³

We reviewed the paragraph of our article where we cite your excellent review of the literature⁴ and in which we used the phrase “conflicting information on the cariogenicity of breastfeeding.”¹³ Regarding this phrase, we would like to clarify that it was a reference to your comment “The obtained results often are contradictory and the findings were not always reproduced,”¹⁴ what can be found in the original articles cited in your review article. We agree that you concluded that “there is no scientific