# Policy on Tobacco Use


## Originating Council
Council on Clinical Affairs

## Review Council
Council on Clinical Affairs

## Adopted
2000

## Revised
2003, 2006, 2010


## Purpose
The American Academy of Pediatric Dentistry (**AAPD**), in order to reduce pain, disability, and death caused by nicotine addiction, recommends routine screening for tobacco use, treating tobacco dependence, preventing tobacco use among children and adolescents, and educating the public on the enormous health and societal costs of tobacco.

## Methods
This policy revision is based upon a review of current dental, medical, and public health literature related to tobacco use. An electronic search was conducted using the following parameters: Terms: "tobacco", "teen tobacco use", "tobacco use in children", "smoking", "smokeless tobacco", "smokeless tobacco and oral disease", "pregnancy and tobacco", "secondhand smoke", and "caries and smoking"; Field: all fields; Limits: within the last 10 years; humans, English; clinical trials; birth through age 19. Three hundred sixteen articles matched these criteria. Web sites for the American Lung Association, American Cancer Society, Centers for Disease Control and Prevention, Environmental Protection Agency, Campaign for Tobacco Free Kids, and US Department of Health and Human Services were reviewed. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

## Background
Tobacco is a risk factor for 6 of the 8 leading causes of deaths in the world and kills up to one-half of its users.[1] In the US, the Surgeon General's report states that smoking is the single greatest avoidable cause of death.[2] This report concludes that even in nonsmokers, secondhand smoke exposure causes disease and death.

The Centers for Disease Control and Prevention (CDC) has conducted a National Youth Tobacco Survey (NYTS) for the years 1999, 2000, 2002, 2004 and 2006 as part of the Healthy People 2010 objectives on tobacco use.[3] While middle school students showed a decrease in the use of cigarettes, cigars, and bidis (unfiltered cigarettes from India)[4], they did not show a change in the use of smokeless tobacco, pipes, or kreteks (unfiltered cigarettes from India)[4] between 2004 and 2006.[4,5] Unfortunately during this same period, no significant change was seen in the tobacco use of high school students.[4,5] Tobacco use among high school students is 20.0% or 3.5 million, while 19.8% of adults smoke.[5,6] Smokeless tobacco use is seen in 13.4% of male high school students and 2.3% of females.[5,6] Each day approximately 3,600 youth between 12-17 years of age try smoking with 1,100 a day becoming regular daily users.[6,7]

Signficant health consequences for tobacco use include 440,000 deaths per year from smoking and an additional 50,000 deaths per year from secondhand smoke.[5,6] Other catastrophic sequelae are cardiovascular disease; reproductive effects; pulmonary disease; cancers of the cervix, kidney, pancreas, stomach, lung, larynx, bladder and esophagus; leukemia; cataracts; abdominal aortic aneurysm; bronchitis; and other lung diseases including pneumonia.[7,8]

Secondhand exposure to tobacco smoke imposes significant risks as well. Cardiovascular disease and lung cancer are increased by 25-30% in nonsmokers who inhale secondhand smoke.[9] Infants and children who are exposed to smoke are at risk for sudden infant death syndrome (SIDS), acute respiratory infections, middle ear infections, bronchitis, pneumonia, asthma[10], allergies[11,12], and infections during infancy.[13] Caries in the primary dentition also is related to secondhand smoke exposure.[14-16] Enamel hypoplasia in both the primary and permanent dentition also is seen in children exposed to cigarette smoke.[17]

A new term, "thirdhand" smoke, has been proposed to describe the particulate residual toxins that are deposited in layers all over the home after a cigarette has been extinguished.[18] These volatile compounds are deposited and "off gas" into the air over months.[19,20] Since children inhabit these low-lying contaminated areas and because the dust ingestion rate in infants is more than twice that of an adult, they are even more susceptible to thirdhand smoke. Studies have shown that these children have associated cognitive defects in addition to the other associated risks of secondhand smoke exposure.[21]

Tobacco use can result in oral disease. Oral cancer,[9] periodontitis,[22-25] compromised wound healing, a reduction in the ability to smell and taste, smoker's palate and melanosis, coated tongue, staining of teeth and restorations, implant failure, and leukoplakia[26,27] are all seen in tobacco users. Smokeless tobacco is a risk factor for periodontal conditions[28-30] and oral cancer.[31]

Initiation of tobacco use begins before age 19 for 90% of adult smokers.[32] In fact, most studies show that people who do not use tobacco as a teen never use it.[32] Aggressive marketing of tobacco products by manufacturers,[33,34] smoking by parents,[35] peer influence, a functional belief in the benefits and normalcy of tobacco,[36] availability and price of tobacco products, low socioeconomic status, low academic achievement, lower self image, and a lack of behavioral skills to resist tobacco offers all contribute to the initiation of tobacco use during childhood and adolescence.[37] Teens who use tobacco are more likely to use alcohol and other drugs and engage in high risk sexual behaviors.[38]

The monetary costs of this addiction and resultant morbidity and mortality is staggering. Annually, cigarette smoking costs the US $193 billion, based on lost productivity (more than $97 billion) and health care expenditures (more than $96 billion).[7] Health care cost from the exposure to secondhand smoke is about $10 billion annually.[7] Contrast this with tobacco industry expenditures on advertising and political influence of $13.11 billion in 2005.[7]

Current trends indicate that tobacco use will cause more than 8 million deaths a year by 2030.[39] It is incumbent on the healthcare community to reduce the burden of tobacco-related morbidity and mortality by supporting preventive measures, educating the public about the risks of tobacco, and screening for tobacco use and nicotine dependence.

## Policy statement

The AAPD opposes the use of all forms of tobacco including cigarettes, pipes, cigars, bidis, kreteks, and smokeless tobacco and alternative nicotine delivery systems (ANDS), such as tobacco lozenges, nicotine water, nicotine lollipops, or "heated tobacco" cigarette substitutes. The AAPD supports national, state, and local legislation that eliminates tobacco advertising and promotions that appeal to or influence children, adolescents, or special groups. The AAPD supports prevention efforts through merchant education and enforcement of state and local laws prohibiting tobacco sales to minors. As environmental tobacco smoke (**ETS**) is a "known human carcinogen" and there is no evidence to date of a "safe" exposure level to ETS (secondhand or passive smoke),[40] the AAPD also supports the enactment and enforcement of state and local clean indoor air and/or smoke-free policies or ordinances prohibiting smoking in public places.

Furthermore, the AAPD encourages its members to:

1. promote and establish policies that ensure dental offices, clinics, and/or health care facilities, including property grounds, are tobacco free;
2. support tobacco-free school laws and policies as advocated by the American Dental Association;[41,42]
3. serve as role models by not using tobacco and urging staff members who use tobacco to stop;
4. routinely examine patients for oral signs of and changes associated with tobacco use;
5. determine and document tobacco use by patients and smoking status of their parents, guardians, and caregivers;
6. educate patients, parents, and guardians on the serious health consequences of tobacco use and exposure to ETS in the home;
7. provide both prevention and cessation services using evidence-based interventions identified as "best practice" for treating tobacco use and nicotine addiction;
8. work to ensure all third-party payors include "best practice" tobacco cessation counseling and pharmacotherapeutic treatments as benefits in health packages;
9. work with school boards to increase tobacco-free environments for all school facilities, property, vehicles, and school events;
10. work on the national level and within their state and community to organize and support anti-tobacco campaigns and to prevent the initiation of tobacco use among children and adolescents, eliminate cigarette sales from vending machines, and increase excise tax on tobacco products to reduce demand;
11. work with legislators, community leaders, and health care organizations to ban tobacco advertising, promotion, and sponsorships;
12. organize and support efforts to pass national, state, and local legislation prohibiting smoking in businesses such as day-care centers where children routinely visit and other establishments where adolescents frequently are employed;
13. establish and support education/training activities and prevention/cessation services throughout the community;
14. recognize the US Public Health Service Clinical Practice Guideline "Treating Tobacco Use and Dependence"[43] as a valuable resource.

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