A History and Update of Fluoride Dentifrices

J. S. Wefel, PhD
Continuing Education Units: 2 hours

This continuing education course is intended for general dentists, hygienists, and dental assistants. This course is a review and update of cosmetic and therapeutic dentifrices, their impact on market shares and the development of multi-benefit dentifrice technologies.

Overview
This course is a review and update of cosmetic and therapeutic dentifrices, their impact on market shares and the development of multi-benefit dentifrice technologies. The first therapeutic dentifrice contained fluoride and entered into the market place in the mid 1950's. The public was not convinced of the importance of such a product until the American Dental Association (ADA) Seal of Acceptance was awarded to a product in 1964. Both public and market pressures have resulted in a continued development of new and improved products which not only have therapeutic value but also cosmetic value. These developments have led to the use of various fluoride agents, abrasives, and additives as well as new technologies. The most recent fluoride dentifrice to receive the ADA seal provides almost all benefits available from dentifrice in one formulation.

Learning Objectives
Upon the completion of this course, the dental professional should be able to:
• Understand the history and development of modern day dentifrices.
• Discuss the changes from dentifrices that delivered only cosmetic benefits dentifrices to those that focused on therapeutic benefits; and then back to products that deliver a combination of both.
• Discuss the changes in ingredients and actives, and describe new technologies.
• Help the dental professional talk to their patients from a position of knowledge about the variety of fluoride dentifrices available in the current marketplace.
Course Contents

- Tooth Cleaning
- Caries Prevention
- Fluoride Dentifrices
- Public Acceptance of Therapeutic Dentifrices
- Mechanism of Action of Fluoride
- Differences in Active Agents
- Continued Development of Therapeutic Dentifrices
- Using Dentifrices as a Delivery System
- Course Test
- References
- About the Author

Tooth Cleaning

The ancient chewing or cleaning sticks probably represent the forerunners of today's toothbrushes. Descriptions of their use can be found in both the gospel of Buddha and ancient Egyptian writings. The concoctions used to clean the mouth, decrease mal-odor and treat the gums in early writings often were more detrimental than preventive. For example, in the writings of Piny (23–79 AD) several remedies are mentioned: burnt nitre to restore whiteness; goat's milk to sweeten the breath; burnt stag's horn and ashes of various animals for strengthening the gums, etc.¹ Many different remedies have been proposed for improving the conditions found in the oral environment, and one may even go so far as to call these unpleasant concoctions the first dentifrices. Two basic components of oral hygiene have passed the test of time and, although modified and improved, have their roots in ancient times. These components are both the bristle toothbrush and the dentifrice used in conjunction with the brush. Primitive cleaning sticks of different types still exist today and are the brush of choice in some cultures; although the modern day brush has evolved into a skillfully designed multi-tufted product. The manual brush continues to be improved and now there are power versions that move the bristles in many directions. These include versions with either oscillating-rotating or sonic movements. Dentifrices have also changed dramatically from the predominantly acid concoctions of the past to more basic or neutral products. This was the result of the acceptance of Miller's acidogenic theory of caries formation which helped promote the change from acidic to basic formulations.²

Caries Prevention

Initial fluoride incorporation into dental preparations and research into the fluoride content of teeth, gave conflicting results. The "Brown Stain" associated with too much fluoride ingestion was thought to be "typical caries" in a paper presented in 1904 before the German Society for Surgery.³ McKay and Black investigated what had been termed Colorado Brown Stain as early as 1916 and found it was present in other communities and associated with the communal water supply, although they were not sure of the cause.⁴ These and other findings led the United States Public Health Service to do extensive epidemiological surveys to study dental caries and fluorosis in the late 1930's.⁵ When it was recognized that fluoride intake from water was associated with the prevalence of dental fluorosis and dental caries, many delivery systems and strategies were investigated to optimize the benefit of fluorides at the community level as well as the individual level. In 1937, a dental preparation claiming to prevent decay was not looked on very favorably by the American Dental Association's (ADA) Council on Dental Therapeutics. The possibility of toxicity, conditions of usage and absorption questions led to the ADA's conclusion that "The use of fluoride in dentifrices is unscientific and irrational, and therefore should not be permitted."⁶ At this time dental problems were considered to be a personal matter. The finding that the single greatest reason for rejecting people from the military in World War II was oral health changed this sentiment. Very quickly, oral health became a national security issue and was recognized as a public health problem. Fluoridation of the community water supply has been said to be an ideal public health measure and was first introduced in Grand Rapids, MI in 1945, with Muskegon acting as the control city. Other sister city studies were also begun in different countries and the overall results were a significant reduction in dental caries without cosmetically displeasing dental fluorosis, when the fluoride concentration was maintained at about 1 ppm.⁷ The mechanism of action was thought to be mainly the incorporation of fluoride into the enamel structure, thereby, reducing the solubility of the enamel.
Fluoride Dentifrices

With the success of water fluoridation, it was reasoned the topical application of fluoride might also result in fluoride uptake and incorporation into the teeth; and that some benefit may also be achieved with less frequent applications of higher concentrations of fluoride. Bibby initiated the early studies on both dentifrices and topical fluorides but was not entirely successful. A review of these and many other dentifrice studies was published by GK Stookey in a paper presented at a conference entitled "Clinical Use of Fluorides." There were about eight early studies using sodium fluoride and calcium abrasive systems, but none of them resulted in significant reductions in dental caries. The most likely explanation was the incompatibility of the abrasive system and the added fluoride, since it could react with the calcium of the abrasives and form calcium fluoride. This form of fluoride is not reactive with the enamel surface, and this lack of reactive ionic fluoride most probably resulted in the failure of these early formulations to prevent caries. In 1954, the first report of a clinically effective fluoride dentifrice was made. This dentifrice contained stannous fluoride combined with a heat-treated calcium phosphate abrasive system. This SnF$_2$ –Ca$_3$P$_2$O$_7$ combination was provisionally accepted by the ADA's Council on Dental Therapeutics with category B classification in 1960. Upon completion of additional studies showing its therapeutic effect, the dentifrice was given a category A classification in 1964. This recognition of preventive value led to continued investigations for improved formulations with different active agents and abrasive systems. The search for more effective products continues to this day.

Public Acceptance of Therapeutic Dentifrices

An interesting perspective on the public awareness and acceptance of a therapeutic dentifrice comes from an article published by the Harvard Business School. A detailed report by Unilever in 1959 made the observation: "Unfortunately, the true therapeutic dentifrice giving a high degree of protection against dental caries still remains a dream, one which seems unlikely to come true for some time. If this problem could be solved it might give us a world leader." The development and testing of Crest toothpaste in the late 50's seemed to be just such a dream product, but a market survey in 1958 showed this therapeutic dentifrice had had little effect on market shares. It wasn't until Crest was granted the ADA Seal of Acceptance that it was able to set itself apart from all other toothpastes. A total of over 40 clinical trials have been conducted with the original stannous fluoride and various abrasive formulations that have verified its efficacy. The combined importance of ADA acceptance plus no comparable therapeutic rival gave the Crest brand a chance to become a market leader. In 1969, Colgate also received endorsement for a therapeutic dentifrice. This shifted toothpastes from delivering merely cosmetic benefits to those focused on more therapeutic benefits, and the entire market began to change. A look at market shares shows toothpastes focused on delivering cosmetic benefits in the US had almost 70% of the market in 1960 but only 11% in 1985. Likewise, the therapeutically focused brands had only 14% of the market in 1960 but jumped to 60% in 1985, with another 19% in combination products. This shift in market shares shows the tremendous public acceptance and demand for therapeutic dentifrices that continues today. European markets were soon to follow, although it was Colgate's shift to a therapeutic dentifrice that led the way in that geography. Of equal interest seemed to be the gum health sector as opposed to the anti-caries sector. The primary mover in the "gum health" sector of the toothpaste market was the German firm Blendax. Similar to the shift in market shares in the US, the European cosmetic brands constituted only 10% of the market in 1985.

Mechanism of Action of Fluoride

The development of newer dentifrice formulations has paralleled the increased understanding of the caries process and how fluoride works. The original belief of a continual dissolution of tooth surface has been replaced by the acceptance of subsurface demineralization, and the maintenance of a relatively intact surface layer (probably by remineralization). Demineralization occurs when there is an imbalance between processes of mineral gain and loss. Fluoride may interact with these processes in several ways. It is now widely accepted fluoride has both a systemic and topical mode of action. The
interaction of fluoride with the mineral component of tooth produces a fluorohydroxyapatite (FHA) by substitution of F\textsuperscript{−} for OH\textsuperscript{−}. This results in increased hydrogen bonding, smaller crystal lattice, and an overall decrease in solubility. The incorporation of fluoride into the hydroxyapatite (HA) lattice may occur while the tooth is forming or by ion exchange after it has erupted. A decrease in solubility increases with greater amounts of fluoride incorporation, but rarely do we exceed several thousand ppm of fluoride in the outer enamel.\textsuperscript{23} Thus, only limited protection from fluoride substitution would be expected as compared to FAP that has 40,000 ppm fluoride. Another means of acquiring fluoride into the enamel is from topical applications and ion exchange. This surface oriented exchange could also affect the solubility of the bulk solid. The exception to limited protection may be the crystallite surface, where a thin coating of pure FAP would make the bulk solid appear to be less soluble than the degree of substitution would predict. Therefore, a limited incorporation of fluoride into the crystal lattice or on the surface may have a significant impact on solubility.\textsuperscript{24} The systemic "solubility reduction effect" was thought to be the only mechanism of action until studies revealed a significant topical effect on mineralization as well as a bacterial effect.

Fluoride found in solution can also affect the dissolution rate without changing the solubility. As little as 0.5 mg/L in acidic solutions causes a reduction in the dissolution rate of apatite.\textsuperscript{25} This mechanism also involves absorption and/or ion exchange at the crystal surface. Thus, the surface may act more like FAP than HAP and have a different dissolution rate. When the enamel dissolves, it may also contribute fluoride to the solution. Under sink conditions this would not have much of an effect, but the solutions normally bathing the teeth are always partially saturated with respect to apatite. Fluoride levels as low as 230ug/g have been shown to reduce dissolution rate significantly.\textsuperscript{26} Thus, both the concentration of fluoride at the crystal surfaces and the fluoride concentration in the liquid phase during a cariogenic challenge are important.\textsuperscript{27}

In addition to protecting against demineralization, another way in which fluoride interacts with enamel to reduce dissolution is through remineralization. This is a process in which partially dissolved enamel crystals act as a substrate for mineral deposition from the solution phase that enables partial repair of the damaged crystals. Therefore, remineralization will counteract some of the demineralization and an equilibrium will develop between the two processes. The carious lesion is the result of demineralization outweighing remineralization. One of the benefits of the demineralization/remineralization interplay is the creation of less soluble mineral in enamel.\textsuperscript{28} This occurs by dissolution of the more soluble calcium deficient magnesium containing carbonated apatite which makes up enamel when first formed. The remineralization process results in formation of a less soluble form of apatite. When fluoride is also present, formation of FAP or at least fluorohydroxyapatite (FHAP) results in a mineral with even greater acid resistance. The remineralization process is one controlled by the supersaturation of fluids bathing the teeth – plaque fluid or saliva. The degree of supersaturation will, in part, determine the rate of precipitation of minerals from the solution.\textsuperscript{29} Too high of a supersaturation will result in the rapid formation of calcium phosphate and block the surface pores of enamel. This precipitation then limits the diffusion of calcium, phosphate and fluoride into the interior of the lesion resulting in lesion arrestment but not also lesion repair.\textsuperscript{30} The interior of the lesion is partially saturated with respect to HAP and can become supersaturated with respect to FAP if small levels of fluoride are present or diffuse into the lesion. The use of low concentration fluoride products, such as dentifrices on a daily basis, will help maintain this favorable saturation. Thus, remineralization of the lesion may result in the repair of the existing lesion with less soluble mineral and render this portion of the tooth less susceptible to future episodes of demineralization. This is probably one of the most important modes of action of fluoride.

Fluoride, at a relatively low concentration, may also interact with the oral bacteria to reduce plaque acid production at a relatively low concentration. Several mechanisms have been proposed to account for this end result. One is the well known interaction of fluoride with the enzyme enolase which could reduce acid
The predominance of NaF and Na₂FPO₄ as the active agents in most toothpastes also led to the inevitable question "Are all fluoride dentifrices the same?" This question was addressed by Stookey in 1984 after a review of over 140 articles on fluoride dentifrices. It was found that a number of dentifrices with various active ingredients (NaF, SnF₂, amine F, and Na₂FPO₄) and abrasive system combinations provided significant cariostatic benefits. The major systems approved for use in the US were sodium fluoride (NaF) and sodium monofluorophosphate (Na₂FPO₄). The majority of active agents used in topical preparations normally dissociate to give fluoride ion and the companion cation. The cation may have some interactions on its own, such as Sn or Ti, but the main effects on caries are associated with fluoride. The application of these agents results in the dissociation of the salts and the presence of F⁻ and cation, except in the case of FPO₄⁻. In this case, the fluoride source is in a different form and requires enzymatic hydrolysis to cleave the covalent bond between the phosphate molecule and fluoride. Studies of FPO₄⁻ have shown it is more compatible with dentifrice abrasives, but it may differ in its mode of action from the fluoride ion. Early work showed the FPO₄⁻ ion could react with the apatite surface and reduce dissolution, and it was thought to be retained in the oral environment as the whole molecule. Later, studies by Pearce and Moore were unable to confirm this mechanism; and it was felt that most of the activity of this agent was due to fluoride ion present as an impurity. It is commonly felt FPO₄⁻ is a useful agent since it may hydrolyze and release fluoride ions that will interact in the oral environment as described in the previous section.

Unfortunately, most studies were not designed to test these active ingredients in head-to-head comparative clinical trials, since they contained different abrasives and levels of fluoride. Dr. Stookey did make several observations from the data reviewed and stated the MFP formulations gave comparable results to the old SnF₂ dentifrices, but the NaF dentifrices with compatible silica abrasive systems were better in reducing caries than the old SnF₂ products. Four out of five clinical trials also resulted in numerically greater effectiveness for the sodium

Differences in Active Agents
The desire to find a more effective dentifrice and the ideal active ingredient and abrasive system spurred continued research in the development of therapeutic dentifrices. Monofluorophosphate (MFP) actives were introduced and found to be compatible with a variety of abrasive systems, and the combination demonstrated positive caries benefits in most studies. The search for a more stable formulation and greater caries effectiveness also led to the introduction of a sodium fluoride (NaF) formulation, which eventually replaced the original stannous fluoride (SnF₂) active ingredient. This new product used the advertising phrase of "Fluoristat" and combined NaF with a silica abrasive system that proved more effective against caries than the previous "Fluoristan" formulation. This change in active agents occurred in 1981 when the silica abrasive systems were found to be compatible for most active agents. All of the fluoride actives have been shown to be successful, to some extent, in preventing dental caries when used in a regular program of oral hygiene. The highly competitive toothpaste market has been a factor in the development of more effective products as well as improving flavor and increasing worldwide usage. This has been a great benefit to public dental health, as evidenced by the decline in the prevalence of dental caries over the past several decades in most developed countries.
Continued Development of Therapeutic Dentifrices

The changing market pressures led to continued investigations to develop improved products, leading to changes in toothpaste formulations and packaging of products. Some examples would be development of gels vs. pastes, pumps to deliver the products, dual tube reservoirs, and the addition of many cosmetic agents as well. One of the early improvements was the development of "tartar control" toothpastes in the mid 1980's, which proved to be quite successful in the market place. A pyrophosphate or zinc additive was found to be effective in reducing the growth of tartar and not allowing it to harden into a difficult to remove deposit. This made cleanings easier for the hygienist during routine dental visits. Another tartar control agent made use of a co-polymer of ether and maleic acid (PVM/MA) and pyrophosphate to reduce calculus formation. Not all people are troubled by excess tartar formation, but an increased public awareness of oral health has led to the addition of agents to not only clean the teeth and mouth but to improve the overall health. Thus, manufacturers have focused on the development of "multi-benefit" formulations capable of addressing more than a single need. An example is the combination of fluoride and potassium nitrate to simultaneously control both caries and dentinal hypersensitivity. We have also seen an increase in products that combine "cosmetic" and "therapeutic" agents into one. An example here would be the cleaning, tartar control, stain removal, or whitening ability of new formulations combined with fluoride to control caries.

Although fluoride dentifrices and improved oral health have greatly benefited the population by reducing caries incidence, surveys show a continued high prevalence of gingivitis and gingival recession among adults. The desire to treat both caries and gingivitis, coupled with the changing patterns in oral health, led to extensive research by the Procter & Gamble laboratories and the "return" to stannous fluoride as an active ingredient. This required the development of a stabilized formulation.
that would provide sufficient stannous fluoride for the anti-gingivitis benefit and sufficient reserves of stannous fluoride to provide a caries benefit. The stabilization system developed used sodium gluconate as a chelating agent to protect SnF$_2$ from hydrolysis. Stannous chloride was included as an anti-oxidant to protect SnF$_2$ from oxidation and as a stannous reservoir to reduce the SnF$_2$ loss onto the abrasive. The many other beneficial aspects of stannous fluoride, such as dentin desensitization and root surface reactivity, may hold promise for future improvements. A special issue of the Journal of Clinical Dentistry in 1995 was devoted to Stabilized Stannous Fluoride Dentifrice. Thus, the active agents most readily available in the US market once again include SnF$_2$ as well as NaF and some Na$_2$FPO$_4$. Unfortunately, the use of SnF$_2$ continued to be limited at that time largely due to poor taste, astringency, and potential for minor extrinsic stain. These challenges would take another decade to overcome.

**Using Dentifrices as a Delivery System**

The widespread acceptance of using toothpaste for improved oral health has resulted in the use of dentifrices as an effective delivery system for both cosmetic and therapeutic agents. This is evident by the myriad of dentifrice brands and types available at the local supermarket. One of the caveats to using proven caries preventive dentifrices to deliver additional oral health benefits is that we retain the original benefits of that product. This has meant significant testing is needed when formulating multi-benefit products to ensure that each ingredient is able to perform in light of the others. This is the exact same situation that faced NaF actives and calcium abrasives in the early dentifrices - compatibility of ingredients. In the development and marketing of new products, each manufacture has had to test their new formulations in order to ensure the new additive or ingredient did not interfere with the existing "active" while also providing a significant new benefit. Table 1 is a timeline of significant events in the development of cosmetic and therapeutic dentifrices combined. One of the more interesting developments was the addition of sodium bicarbonate dentifrices into the market. This product was introduced by Church & Dwight and included baking soda which was traditionally used by previous generations. The popularity

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1890</td>
<td>Colgate in Tubes</td>
</tr>
<tr>
<td>1955</td>
<td>Crest Markets first Therapeutic Dentifrice with SnF$_2$</td>
</tr>
<tr>
<td>1960</td>
<td>First ADA seal for Crest</td>
</tr>
<tr>
<td>1969</td>
<td>Colgate with MFP receives seal</td>
</tr>
<tr>
<td>1979</td>
<td>Aim receives seal</td>
</tr>
<tr>
<td>1980</td>
<td>Crest converts to Sodium Fluoride due to formulation challenges with SnF$_2$</td>
</tr>
<tr>
<td>1985</td>
<td>Crest introduces Tartar Control</td>
</tr>
<tr>
<td>1986</td>
<td>Colgate introduces Tartar Control with NaF active</td>
</tr>
<tr>
<td>1987</td>
<td>Aim Extra Strength (1500 ppm) introduced</td>
</tr>
<tr>
<td>1993</td>
<td>Mentadent with NaF + baking soda + peroxide</td>
</tr>
<tr>
<td>1995</td>
<td>Crest Gum Care (stabilized SnF$_2$)</td>
</tr>
<tr>
<td>1996</td>
<td>Colgate with tricosan and co-polymer</td>
</tr>
<tr>
<td>1998</td>
<td>Arm &amp; Hammer-baking soda- cleaning and stain</td>
</tr>
<tr>
<td>1999</td>
<td>Crest first seal for whitening dentifrice with soft silica</td>
</tr>
<tr>
<td>2001</td>
<td>Improved whitening—soft silica</td>
</tr>
<tr>
<td>2002</td>
<td>Colgate Total Plus Whitening receives ADA Seal</td>
</tr>
<tr>
<td>2002</td>
<td>Dual Action Whitening Technology with sodium hexametaphosphate</td>
</tr>
<tr>
<td>2004</td>
<td>Dual Action Chamber</td>
</tr>
<tr>
<td>2006</td>
<td>Crest Pro-Health with novel technology combining stannous fluoride and sodium hexametaphosphate receives ADA Seal</td>
</tr>
</tbody>
</table>
the market place. This cosmetic benefit has been a continuing consideration since the late 1990’s. The whitening effect encompasses the original cleaning function of dentifrices, such as tartar and stain removal, but may also include intrinsic stain removal by use of bleaching agents to change the clinical shade of the teeth. A dual action whitening technology evolved from these efforts as well. Table 2 lists the variety of dentifrice claims and the standard ingredients used to accomplish these claims.

Another product that seemed to shape the market for years came from the public’s desire for whiter teeth. Whitening agents were available in the dental office but not in the drugstore as an over-the-counter product. One of the first claims was the removal of extrinsic stains by existing tartar control agents. These formulas were optimized and tested for stain removal as well as tartar control. Intrinsic stains normally required the use of peroxides or carbamides which have the ability to bleach the teeth and increase “whiteness.” Crest Whitestrips marked the advent of consumer applied whitening agents and allowed the individual to brighten their smile at home. Toothpaste manufacturers were also aware of this public interest in a cosmetic benefit of oral health products and improved formulations for stain removal, stain prevention, tartar reduction, and whitening all became available in

<table>
<thead>
<tr>
<th>Table 2. Oral Health Claims of Dentifrice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decay Reduction</td>
</tr>
<tr>
<td>Anti-Calculus</td>
</tr>
<tr>
<td>Anti-Plaque/Gingivitis</td>
</tr>
<tr>
<td>Desensitizing</td>
</tr>
<tr>
<td>Whitening</td>
</tr>
</tbody>
</table>

of these products resulted in the production of baking soda products by all the other manufacturers as well. The dental care products from Church and Dwight had the greatest amount of baking soda (65%) compared to the Colgate and Crest products which were around 25%. Although it was commonly believed the baking soda abrasive was more aggressive, it ultimately proved to be milder than the more commonly used abrasive formulations.  

Table 2. lists the variety of dentifrice claims and the standard ingredients used to accomplish these claims.
Current dentifrice formulations often combine several ingredients and, therefore, become multi-benefit formulations. Recently, claims have been made for almost all of the benefits listed in Table 2. in a single product. For example, Colgate Total was introduced in the 1990’s with 0.3% Triclosan, 2% Gantrez, and 0.243% NaF with a silica abrasive. Extensive clinical testing was performed to receive the ADA Seal of Acceptance for protection against gingivitis, plaque, and caries. An improved version is Colgate Total Plus Whitening Toothpaste and it is described in a special issue of Journal of Clinical Dentistry, 2002. This formulation claims efficacy with caries, plaque, gingivitis, tooth whitening, and oral malodor. In contrast to using existing ingredients like the soft silica abrasives for whitening, Procter & Gamble developed a more efficient stain and tartar removal formulation by using sodium hexametaphosphate, a calcium surface active builder (CASAB). Earlier work to ensure no loss of effectiveness in relation to caries reduction with the new hexametaphosphate (it’s not abrasive) polymer was done in vitro, in situ, and then in clinical studies. One of the problems with CASAB agents is their hydrolytic stability in the aqueous phase of conventional dentifrices. The development of dual-phase packaging technology has permitted the use of polypyrophosphate ingredients such as sodium hexametaphosphate. This new product usage is also described in a special issue of the Journal of Clinical Dentistry, 2002.

Continued development of the dual whitening system has resulted in the use of a patented "Polyfluorite" System. The Polyfluorite System contains stabilized stannous fluoride combined with the cosmetic benefits of the sodium hexametaphosphate-CASAB. Thus, the CASAB is used to inhibit calculus, whiten by extrinsic stain removal, and prevent stain formation, while the stannous fluoride in the polyfluorite system fights plaque and gingivitis, provides long-lasting antibacterial action, protects against sensitivity, fights cavities, and helps freshen breath. This new formulation is called Crest PRO-HEALTH dentifrice. Over 70 studies have been performed to support the Polyfluorite System's ingredients benefits. A review of the new technology is found in the online Compendium journal. This new technology is the first to combine proven results in caries reduction, plaque reduction, less gingivitis, less sensitivity, and decreased tartar. The ADA granted its Seal of Acceptance to this multi-benefit product in 2006. As stated by the wording of the seal, "The ADA
Council on Scientific Affairs' Acceptance of Crest PRO-HEALTH Toothpaste is based on its finding the product is effective in helping to prevent and reduce tooth decay, gingivitis, and plaque above the gumline, to relieve sensitivity in otherwise normal teeth, and to whiten teeth by removing surface stains, when used as directed. In a single formulation, we now have the majority of claims positively affected by the new technologies and formulations developed.

This update has shown the market forces have continued to develop new and improved products for the consumer. The therapeutic dentifrices developed have been responsible for a large portion of the caries reduction in the industrialized world. What new technologies or use of existing ones awaits the consumer is open for speculation. Will nanotechnology become an important component in the future? Will the use of dentifrices as a delivery system increase and expand? Will oral cancer or other systemic diseases find a delivery system from the oral environment? We only have to wait to see what new systems may come to bear in this ever-changing market place.
To receive Continuing Education credit for this course, you must complete the online test. Please go to www.dentalcare.com and find this course in the Continuing Education section.

Course Test Preview

1. Community water fluoridation was first introduced in Grand Rapids, MI in what year?
   a. 1872
   b. 1905
   c. 1945
   d. 1957

2. The mechanism(s) of action of fluoride is (are):
   a. Disrupts cellular metabolism of the intra-oral bacteria that promote caries.
   b. Incorporation of fluoride into the surface crystals of the enamel, thereby reducing the solubility of the enamel.
   c. Enhances the remineralization process.
   d. All of the above
   e. A and C

3. The active ingredient in the first toothpaste approved by the ADA was:
   a. Sodium fluoride
   b. Calcium fluoride
   c. Monofluoro-phosphate
   d. Stannous fluoride

4. What concentration of fluoride in a municipal water supply is required to significantly reduce the caries incidence without causing dental fluorosis?
   a. 0.01ppm
   b. 1.0ppm
   c. 10ppm
   d. 100ppm

5. “Brown stain” was once used to describe a condition later known as:
   a. Goodpasture's Disease
   b. Acute iron toxicity
   c. Dental fluorosis
   d. Chronic retro-orbital dyspnea

6. What is required for the release the fluoride ion from the monofluorophosphate molecule?
   a. pH below 4.5
   b. Brushing
   c. Enzymes
   d. All of the above

7. Which of these compounds are used as actives in tartar control toothpastes?
   a. Pyrophosphate
   b. Zinc
   c. Polymer of ether and maleic acid (PVM/MA)
   d. All of the above
8. The first Category A classification for a fluoridated dentifrice was awarded by the American Dental Association in:
   a. 1947
   b. 1955
   c. 1964
   d. 1969

9. Which of these has never been an active ingredient in a fluoride dentifrice?
   a. NaF
   b. SnF₂
   c. Na₂FPO₄
   d. None of the above

10. Public acceptance of therapeutic dentifrice occurred after:
    a. The introduction of tartar control dentifrices
    b. The development of NaF products
    c. The ADA seal of acceptance was granted
    d. The introduction of MFP products

11. Remineralization of enamel requires:
    a. Fluoride
    b. Supersaturation
    c. Collagen
    d. pH < 5.0

12. Calcium surface active builders are a part of the new technologies and act to:
    a. Reduce caries
    b. Freshen breath
    c. Control Sensitivity
    d. Remove stain and whiten teeth

13. Fluorides main influence in the oral cavity is through:
    a. Systemic Incorporation
    b. Bactericidal Activity
    c. Preventing Demineralization/Enhancing Remineralization
    d. None of the above

14. The desire to improve current active agents resulted in:
    a. SnF₂ as the first active
    b. Fluoristat replacing Fluoristan
    c. The development of a stabilized Stannous Fluoride
    d. All of the above

15. When using a compatible abrasive system:
    a. NaF became the agent of choice
    b. NaFPO₄ performed as well as the original SnF₂
    c. NaF performed better than the original SnF₂
    d. Meta-analysis revealed a small but significant difference between NaF and NaFPO₄
    e. All of the above
References

About the Author

James S. Wefel, PhD

Dr. Wefel joined The University of Iowa College of Dentistry in 1973. He is director of the Dows Institute for Dental Research, administrative director of the Office of Clinical Research, and a professor in the Department of Pediatric Dentistry. Dr. Wefel's primary teaching responsibilities include the areas of graduate cariology, undergraduate cariology and preventive therapies, and undergraduate seminars in selective courses.

Dr. Wefel's areas of research include laser and tooth interactions, early caries detection, mechanisms of action of fluoride, topical fluorides, remineralization, kinetics of calcium phosphate crystal growth, secondary caries, oral fluoride kinetics, antimicrobials, and F-releasing materials. Specific research in the Dows Institute for Dental Research includes root surface caries, laser prevention of tooth demineralization, and F-releasing biomaterials and secondary caries. Activities include promotion of research from the laboratory to the clinical in the Center for Clinical Studies.

Currently, Dr. Wefel is a reviewer for The Journal of Clinical Dentistry; Journal of Dental Research; Caries Research; Calcified Tissue Research; Archives of Oral Biology; American Journal of Dentistry; Journal of Oral Pathology and Gerodontology; reviewer reserve for Oral Biology and Medicine II Study Section, National Institute of Dental and Craniofacial Research; outside reviewer for the National Science Foundation and American Fund for Dental Health; ad hoc reviewer for the Board of Scientific Counselors, NIDCR; former president of the Cariology Research Group, IADR (1990-1991); current consultant for the American Dental Association Council on Scientific Affairs; recipient of the IADR Distinguished Scientists Award; current member of the American Association for Dental Research; the International Association of Dental Research; the American Dental Education Association; and the European Association for Caries Research; and member of the College of Dentistry's Faculty Promotions Advisory Committee.

Dr. Wefel can be contacted at:

James S. Wefel, PhD
N413 DSB
University of Iowa
Iowa City, IA 52242
Fax: 319-335-8895
Office: 319-335-7376
Email: James-wefel@uiow.edu