Non-nutritive sucking with a pacifier: Pros and cons

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The detrimental effects of prolonged pacifier use on the developing oral structures are often the primary focus of dental professionals; however, non-nutritive sucking with a pacifier has other consequences that include not only harmful effect but positive influences as well. This article will address some of the issues for consideration regarding the use of pacifiers and provide information for appropriate recommendations to parents of infants and toddlers regarding the use and cessation of non-nutritive sucking with a pacifier.

At birth, survival depends on instinctive sucking that occurs with stimulation of the lips and tongue. In addition to nourishment, sucking soothes infants, providing both physical and psychological comfort. The need for sucking is very strong during the first three months of life but it decreases around a infant’s seventh month; by this time, the neuromuscular structures of the oral cavity are prepared for eating, drinking, and, ultimately, mastication. To allow for the infant’s need for sucking while allowing for timely intervention prior to a malocclusion developing, the ideal time for cessation of non-nutritive sucking is during the second or third year of life; after this time, non-nutritive sucking is considered to be a prolonged sucking habit. Because of the adverse effect of unbalanced muscle activity on dental arch development, the continuation of a pacifier habit beyond what is considered to be a normal developmental stage is discouraged. Parents may question whether pacifier use or digit sucking is preferable in terms of the effect on the dentition and the ability to discontinue the habit. In a 2002 study by Warren and Bishara, pacifier and digit habits produced different malocclusions. Although both habits were associated with an increase in open bite, pacifier habits were associated more often with posterior crossbite, while digit habits were associated with greater overjet, higher palatal vaults, and more diminished maxillary arch widths.

In the primary dentition, a pacifier habit often leads to an increase in overjet with anterior openbite, a prevalence of edge-to-edge primary canines, and distal step primary molar relationship with posterior crossbite. The pacifier nipple displaces the tongue to the floor of the mouth, placing a lateral force on the mandibular primary molars. This lateral pressure tips the mandibular primary molars laterally, widening the lower arch. When the tongue cannot provide palatal support for the maxillary primary molars, palatal tipping of the maxillary primary molars and canines results. A second component adds to palatal constriction at this age: the mid-palatal suture is open and pressure from the buccinator muscles during sucking enhances the maxillary arch constriction. The narrowed arch causes interference of the maxillary primary canines (Fig. 1) and a lateral slide into a functional crossbite (Fig. 2). With continued sucking and palatal constriction, one or both maxillary posterior segments move into a crossbite occlusion. The habitual protruded tongue position and pacifier nipple create an anterior open bite and overjet. Pressure against the teeth must exist for at least six hours a day to cause tooth movement. Variations in terms of the amount of the time spent with a pacifier in the mouth (and the intensity of the child’s sucking) may explain why some children do not develop a posterior crossbite.

Pacifier use should be discouraged as soon as canine interference is noted. A 2001 study of 310 3-year-old children found that pacifier use led to a Class II canine relationship. Ultimately, the effects of a sustained pacifier habit beyond 24–47 months of age may extend into the mixed dentition, contributing to a Class II molar relationship and an anterior open bite. In addition to the difference between a pacifier and digit habit, the design of the pacifier may be included in information provided to a parent. Manufacturers have created pacifiers that are designed to imitate a mother’s breast, purporting that the muscular movements of sucking simulate those of nursing and that this, in turn, encourages normal arch development in the primary dentition. The nipple of the conventional pacifier has a cherry-like shape and is thicker than the physiological pacifiers. Adair et al tested two physiological pacifiers against a conventional pacifier and found that they offered no significant advantage in terms of protection against a malocclusion. This finding was confirmed by a 2002 study that found no significant difference between the physiological and conventional pacifier uses in terms of overjet, mean open bite, and posterior crossbite.

When Viggiano et al compared the effects of breastfeeding, bottle feeding, and non-nutritive sucking, non-nutritive sucking was the main risk factor in terms of malocclusion and open bite developing in the primary dentition. Bottle feeding infants instead of breastfeeding them between birth and six months of age has been associated with the development of a pacifier habit. It has been speculated that infants learn to suck differently with a bottle nipple compared with the breast nipple, which may predispose children to prefer the stimulus of a pacifier as they grow older. There appears to be no association between bottle feeding and digit sucking habits.

Multiple studies have noted another possible detrimental effect concerning pacifier introduction and breastfeeding: pacifier use during the first week of life has been shown to reduce exclusive and overall time spent breastfeeding by a significant amount. Howard et al
recommended delaying use of a pacifier until the infant was at least one month old. A 2003 study by Ullah and Griffiths reported that infants who did not use a pacifier had an overall breastfeeding duration of 10 months, compared to 7.5 months for infants who used pacifiers; however, they concluded that occasional pacifier use could not be blamed definitively for reducing the duration of breastfeeding among infants. In 2001, Kramer et al concluded that pacifier use may merely be an indicator of breastfeeding difficulties or a lack of motivation on the mother’s part to breastfeed instead of the pacifier being the cause of earlier weaning; a 2002 study by Benis supported these findings. Viktora et al also reported that mothers who are less confident with breastfeeding or who were having difficulties in breastfeeding use pacifiers more often to wean infants. Another investigation adjusted for breastfeeding problems and determined that reduced breast stimulation may have shortened the duration of breastfeeding, with a reduction in the number of times the infant was fed each day when a pacifier was introduced at two weeks of age.

Morbidity associated with pacifier use has been evaluated in the literature. Castelo et al reported that pacifier use or other parafunctional sucking habits were not linked to temporomandibular joint dysfunction in the primary dentition. Pacifier use among infants and toddlers has been associated with an increase in the occurrence of otitis media. Pacifier use should be restricted to the time when the infant is falling asleep. Warren et al assessed pacifier use as a risk factor for otitis media from birth to 12 months of age and reported similar findings.

In general, the literature concludes that pacifier use is a modifiable risk factor for otitis media. To reduce the number of infections in those children who are most susceptible, it probably is most appropriate to give advice concerning the restricted use of pacifiers to parents of pacifier users who suffer from recurrent bouts of otitis media. In a 1997 study, Brook and Gober investigated the presence of aerobic and facultative anaerobic bacteria on the surface of pacifiers used by children during recent episodes of otitis media and found that pacifiers do not contain high colony counts of microorganisms; as a result, pacifiers cannot be considered to be a significant source for...
It has been recommended in 1992 that pacifiers not have a strong or consistent association with ECC; in fact, pacifiers offer a mildly protective effect. 20

Safety considerations for the use of pacifiers also should be included in the infant/toddler examination. Severe laceration could occur if the shield is held inside the lips, with the edges of the flanges touching the maxillary and mandibular mucobuccal folds. Pacifiers have been implicated in death from asphyxia, due to their becoming lodged in the pharynx. 21

Simkiss et al recommended pacifiers with ventilation holes in pacifier flanges, a minimum vertical and horizontal dimension of 43 mm, and a ring. 22 The holes permit air passage, the larger flanges inhibit the pacifier from lodging behind the soft palate, and the ring can be used to remove the pacifier from the pharynx in case of aspiration. Cords attached to a pacifier may cause strangulation. 23 A symmetrical nipple permits the pacifier to remain in the correct sucking position, while large shield vents with a textured inner surface help to prevent irritation and rashes that would result from trapped saliva.

Recently, pacifiers have been suggested as another measure to reduce the risk of sudden infant death syndrome (SIDS). Placing infants in a supine position for sleep has resulted in a significant decrease as another measure to reduce the risk of sudden infant death syndrome (SIDS). 24

Pacifier sucking in combination with sweet solutions has been shown to provide a synergistic analgesic effect in newborn infants during minor painful procedures. 28 The pacifier, in combination with sucrose solutions, has been determined to be a safe and effective method for relieving pain in neonates. 29 One 1999 study reported that pacifiers were found to be even more effective for pain relief than concentrated sucrose and glucose solutions. 30

Pacifier habits persist longer today than in the past and are considered to be socially acceptable into the preschool years. The appropriate time to discontinue a non-nutritive sucking habit varies, depending on such considerations as the developmental stage of the child, the harm or potential harm to the oral structures, whether any harmful results can resolve spontaneously, the availability of methods for stopping the habit, and the perceived need due to social or medical circumstances. With all issues considered, the time for intervention may be at approximately two years of age to minimize occlusal disharmonies. 31

The examination of a toddler or preschooler also should include a discussion regarding prolonged use of a pacifier and its harmful effects on the developing dentition. Dentists may demonstrate this effect to the parent(s) by placing the child in centric occlusion with the lips retracted manually (Fig. 3). This step is important to make the parent(s) aware of the pacifier’s detrimental effect and in motivating them to discontinue pacifier use. The crossbite usually will self-correct within six months after cessation of the habit (Fig. 4). Fifty percent of all children with a non-nutritive sucking habit will cease the habit without parental intervention by 24–28 months of age.

Digit habits may persist longer than pacifier sucking and may require appliance therapy for cessation. 32 Cessation of the habit usually is more of a challenge for the parent(s) than for the child. Parental withholding of the pacifier during the day may be a consideration but the parent’s perception that the child requires the pacifier to transition to sleep often is the final issue that must be overcome. Various methods may be suggested for ending the pacifier habit, including dipping the nipple in white vinegar, making it distaste-ful; piercing the nipple with an ice pick or cutting the nipple shorter to reduce sucking satisfaction; leaving it behind on a trip; or forcing the child to go “cold turkey.” 33 Professional explanation from a dentist and abrupt permanent removal by the parent(s) seem to be the most effective methods for eliminating the habit.

Discussion

Any consultation with parents regarding pacifier use should include the potential benefits as well as the risks and safety considerations. Harmful oral developmental effects can be avoided when cessation occurs while the child is approximately 2 years old. Delaying introduction until breastfeeding is firmly established and reducing pacifier use among children who suffer from recurrent incidences of otitis media can remove any negative effects in these areas. The proven value of pacifiers in reducing the incidence of SIDS, augmenting sucking satisfaction, and providing an undeniable source of comfort appear not only to justify their continued use in infants and toddlers but to support it.

Summary

Pacifier use should be continued for its physiological and psychological benefits, as long as the child receives an appropriate introduction and timely cessation. During the infant’s examination, dentists should include discussion regarding various considerations for pacifier use.

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References

3. Larsson E. Sucking, chewing, and feeding habits and the development of crossbite: A