I'll try to spell out in writing what I would call the 3 most outrageous ploys used by fluoridation promoters:

1) To sell fluoridation, they always use photographs of the front teeth of very young minority children who suffer from baby bottle/sippy cup tooth decay. This is a condition that is endemic in low socio-economic populations wherein parents are not taught to avoid putting their babies/toddlers to bed at night, or to nap-time, or to car-seat time, with a bottle or sippy cup that contains milk-sugar, juice-sugar, and soda-sugar, the result of which is black stumps for the upper front teeth which require silver crowns from ear to ear and the crowns may even be proceeded by root canals on every one of those teeth in a single visit! The visible clue for this ploy is that the lower teeth are seldom affected by this horrific bacteria-rot. The cause is the acid waste of strep mutan bacteria that drip-drips over the upper teeth for extended time. The solution to the problem is to train toddlers to use a real cup that sends all fluids quickly past the teeth so that the saliva can quickly recover the proper PH.

Another thing - that same bacteria on baby-teeth will easily travel to become colonies on the permanent teeth! To use these minority pre-school children to sell water fluoridation is nothing short of criminal. They are being set up for years of tooth decay. See my 8th attachment for proof from the published dental literature that water fluoridation is beyond worthless to mitigate BB/SCup tooth decay. P.S. The CDC wrote in their April 30, 2007 News Release that the only age group for which tooth decay increased in years 1999-2004 was in the primary (baby) teeth of children aged 2 to 5 years. It increased from 24 percent to 28 percent between 1988-1994 and 1999-2004. These figures would be far higher if they were just looking at decay rates of low SE children in Headstart programs.

2) Dental Fluorosis has now increased well beyond the previous 2004 figure of 41% for teens age 12 to 19. DF is now up to 58%. DF is the visible harm from ingested fluoride. DF is called a cosmetic issue even though it literally alters and embrittles the protein of the outer dental enamel. Fluoride was identified in the 1990's as the only contaminant of EPA's 84 identified contaminants for which they are supposed to perform a risk analysis every three years. Using DF as a marker, there has never ever been a study looking for the internal effects (such as bone studies) of fluoride in children who have already suffered visible fluoride overdose. Both Poland and Mexico have looked at bone effects in children with DF and did report alteration of density and increased bone fractures. See the 5th attachment re Blacks.

3) Comparative toxicity of ingested fluoride compounds: The toxicity of all three fluoridation compounds is shockingly higher than the toxicity of naturally occurring calcium fluoride. Studies conducted in the 1930', (long before water fluoridation) including the 78 page Kick et al study by the Ohio Department of
Agriculture in 1936, show that the key factor for differences of toxicity is the degree of solubility. The more soluble the fluoride compounds, as in all three compounds used for artificial fluoridation, the higher the degree of toxicity. Far more insoluble calcium fluoride tends to pass through the system without being as absorbed into the blood.

The first paragraph of the Preface of the 2006 National Research Council report entitled Fluoride In Drinking Water, describes that in 1986, the USEPA established a maximum-contaminant-level goal (MCLG) of 4 milligrams per liter for fluoride in drinking water. This exposure value is not (I repeat, NOT) a recommendation for the artificial fluoridation of drinking water!! It is a guideline for concentrations of naturally occurring calcium fluoride!! SO WHERE IS THE MCLG FOR THE THREE FAR MORE TOXIC ARTIFICIAL FLUORIDATION CHEMICALS, I ASK???
When water fluoridation first began in the 1940s, dentists believed that fluoride’s main benefit to teeth came from being swallowed during the tooth-forming years. This belief that fluoride’s primary benefit was “systemic” and “pre-eruptive.” A “systemic” benefit is one that comes from ingesting fluoride, and a “pre-eruptive” benefit is one that occurs by swallowing fluoride before the teeth erupt into the mouth. The premise underlying this belief was that, since ingesting fluoride increased the fluoride content of the teeth, the teeth would be more resistant to decay for life.

Although this “systemic” paradigm was the premise that launched water fluoridation and fluoride supplementation programs, it has now been discarded by the dental research community. Today, as noted by the following studies, the overwhelming consensus by dental researchers is that fluoride’s primary effect is topical, not systemic, and that this topical effect occurs after the teeth have erupted into the mouth (i.e., post-eruptive), not before.

There is no need, therefore, to swallow fluoride, especially during infancy and early childhood.

As the Centers for Disease Control (CDC) stated in 1999 “fluoride prevents dental caries predominately after eruption of the tooth into the mouth, and its actions primarily are topical for both adults and children.”

The National Research Council has concurred, stating in 2006 that “the major anticaries benefit of fluoride is topical and not systemic.”

EXCERPTS FROM THE SCIENTIFIC LITERATURE

“it is widely recognized that the mechanism of action of F for caries control occurs essentially through its topical contact with the teeth. In other words, it is not necessary to ingest F to have F protection against caries.” SOURCE: Charone S, et al. (2012). Fluoride 45:133-37.

“Fluoride is most effective when used topically, after the teeth have erupted.”


“Since the current scientific thought is that the cariostatic activity of fluoride is mainly due to its topical effects, the need to provide systemic fluoride supplementation for caries prevention is questionable.” SOURCE: European Commission. (2005). The Safety of Fluorine Compounds in Oral Hygiene Products for Children Under the Age of 6 Years. European Commission, Health & Consumer Protection Directorate-General, Scientific Committee on Consumer Products, September 20.


“When it was thought that fluoride had to be present during tooth mineralisation to ‘improve’ the biological apatite and the ‘caries resistance’ of the teeth, systemic fluoride administration was necessary for maximum benefit. Caries reduction therefore had to be balanced against increasing dental fluorosis. The ‘caries resistance’ concept was shown to be erroneous 25 years ago, but the new paradigm is not yet fully adopted in public health dentistry, so we still await real breakthroughs in more effective use of fluorides for caries prevention.” SOURCE: Fejerskov O. (2004). Changing paradigms in concepts on dental caries: consequences for oral health care. Caries Research 38: 182-91.


“For a long time, the systemic effect of fluoride was regarded to be most important, resulting in recommendations to use fluoride supplements such as tablets or drops. However, there is increasing evidence that the local effect of fluoride at the surface of the erupted teeth is by far more important.” **SOURCE:** Zimmer S, et al. (2003). *Recommendations for the Use of Fluoride in Caries Prevention.* Oral Health & Preventive Dentistry 1: 45-51.

“By 1981, it was therefore possible to propose a paradigm shift concerning the cariostatic mechanisms of fluorides in which it was argued that the predominant, if not the entire, explanation for how fluoride controls caries lesion development lies in its topical effect on de- and remineralization processes taking place at the interface between the tooth surface and the oral fluids. This concept has gained wide acceptance… With today’s knowledge about the mechanisms of fluoride action, it is important to appreciate that, as fluoride exerts its predominant effect… at the tooth/oral fluid interface, it is possible for maximum caries protection to be obtained without the ingestion of fluorides to any significant extent.” **SOURCE:** Aoba T, Fejerskov O. (2002). *Dental fluorosis: chemistry and biology.* Critical Review of Oral Biology and Medicine 13: 155-70.


“Fluoride supplementation regimens suffer from several shortcomings, the first of
which may be their derivation from a time when the major effect of fluoride was thought to be systemic. Although evidence that fluoride exerts its effects mainly through topical contact is great, supplementation schemes still focus on the ingestion of fluoride.”  

“The case is essentially a risk-benefit issue – fluoride has little pre-eruptive impact on caries prevention, but presents a clear risk of fluorosis.”  

“Until recently the major caries-inhibitory effect of fluoride was thought to be due to its incorporation in tooth mineral during the development of the tooth prior to eruption...There is now overwhelming evidence that the primary caries-preventive mechanisms of action of fluoride are post-eruptive through ‘topical’ effects for both children and adults.”  

“[L]aboratory and epidemiologic research suggests that fluoride prevents dental caries predominately after eruption of the tooth into the mouth, and its actions primarily are topical for both adults and children.”  

“[R]esearchers are discovering that the topical effects of fluoride are likely to mask any benefits that ingesting fluoride might have... This has obvious implications for the use of systemic fluorides to prevent dental caries.”  

“Although it was initially thought that the main mode of action of fluoride was through its incorporation into enamel, thereby reducing the solubility of the enamel, this pre-eruptive effect is likely to be minor. The evidence for a post-eruptive effect, particularly its role in inhibiting demineralization and promoting remineralization, is much stronger.”  
“Recent research on the mechanism of action of fluoride in reducing the prevalence of dental caries (tooth decay) in humans shows that fluoride acts topically (at the surface of the teeth) and that there is negligible benefit in ingesting it.” **SOURCE:** Diesendorf, M. et al. (1997). *New Evidence on Fluoridation*. Australian and New Zealand Journal of Public Health 21 : 187-190.

“On the basis of the belief that an adequate intake of fluoride in early life is protective against caries in later life, fluoride supplements are recommended for infants and children living in areas in which the fluoride content of the drinking water is low. However, critical reviews of the evidence have led to the conclusion that the effect of fluoride in decreasing the prevalence and severity of dental caries is not primarily systemic but exerted locally within the oral cavity. Because fluoride supplements are quickly cleared from the mouth, the possibility must be considered that they may contribute to enamel fluorosis, which is unquestionably a systemic effect, while providing relatively little protection against dental caries.” **SOURCE:** Ekstrand J, et al. (1994). *Fluoride pharmacokinetics in infancy*. Pediatric Research 35:157–163.

“It is now well-accepted that the primary anti-caries activity of fluoride is via topical action.” **SOURCE:** Zero DT, et al. (1992). *Fluoride concentrations in plaque, whole saliva, and ductal saliva after application of home-use topical fluorides*. Journal of Dental Research 71:1768-1775.

“I have argued in this paper that desirable effects of systemically administered fluoride are quite minimal or perhaps even absent altogether.” **SOURCE:** Leverett DH. (1991). *Appropriate uses of systemic fluoride: considerations for the '90s*. Journal of Public Health Dentistry 51: 42-7.

“It, therefore, becomes evident that a shift in thinking has taken place in terms of the mode of action of fluorides. Greater emphasis is now placed on topical rather than on systemic mechanisms…” **SOURCE:** Wefel JS. (1990). *Effects of fluoride on caries development and progression using intra-oral models*. Journal of Dental Research 69(Spec No):626-33;

“[E]vidence has continued to accumulate to support the hypothesis that the anti-caries mechanism of fluoride is mainly a topical one.” **SOURCE:** Carlos JP. (1983) *Comments on Fluoride*. Journal of Pedodontics Winter. 135-136.

“Until recently most caries preventive programs using fluoride have aimed at incorporating fluoride into the dental enamel. The relative role of enamel fluoride in caries prevention is now increasingly questioned, and based on rat experiments and reevaluation of human clinical data, it appears to be of minor
importance… Any method which places particular emphasis on incorporation of bound fluoride into dental enamel during formation may be of limited importance.”  

Healthy primary (baby) teeth

Mild decay

Moderate decay

Severe decay
The fluoride ion and hydrogen bonding:

1. Hydrogen bonding is a weak interaction that holds molecules together. They make and break easily and this is what makes them so versatile - indeed the hydrogen bonds formed between amides (the links between amino acids) are the most important weak hydrogen bonds in biological systems. That these can be disrupted by fluoride in the formation of much stronger bonds may explain how the chemically inert fluoride ion could interfere in the healthy operation of living systems. Thus some of the serious charges that are being laid at its door - genetic damage, birth defects, cancer and allergy response - may arise from fluoride interference after all.


2. American chemists (Edwards, Poulos and Kraut authors of #3 below) have now used X-ray analysis to study a fluoridated enzyme, and a disturbing picture emerges. For the first time, the crystal structure of a fluoride-inhibited peroxidase enzyme shows that the fluoride ion attaches itself to the iron atom at the heart of the enzyme and then disrupts the active site by attracting groups that can form strong hydrogen bonds to itself. Ultimately, this inactivates the enzyme by changing its shape, or molecular conformation. These changes are small but highly significant. Fluoride might begin the process of cancer by interfering with the hydrogen bonding of DNA, as it does to peroxidase. Suddenly there is proof positive of what fluoride does to the hydrogen bonding of one vital component of a living cell.

Reference: New Scientist Feb 28, 1985

3. "Fluoride binding induces significant perturbations of the enzyme structure of the distal side of the heme. The major effect occurs at the active-site arginine residue (Arg-48) which moves about 2 A in order to optimize hydrogen-bonded interactions with the fluorine atom. A small readjustment of the distal histidine (His-52) about 0.5 A, is also seen upon fluoride binding. Additionally, a hydrogen-bonded network of 4 water molecules at the active site is reorganized. ....These observations imply that movement of the Arg-48 side chain may play a key role in the enzymic mechanism of cytochrome c peroxidase."


X-ray analysis shows the fluoride ion attaches itself to the iron atom at the heart of the peroxidase enzyme and disrupts the active site by attracting groups that can form strong hydrogen bonds to itself. This inactivates the enzyme by changing its shape, or molecular conformation. Fluoride might begin the process of cancer by interfering with the hydrogen bonding of DNA. Edwards et al. J of Biological Chemistry, 1984.
$200,000: ADA to CDA

Exact quotes:

January 12, 2010: Of the 4 page CDA Executive Bulletin, page 1 lists 8 items of News. The third item is: CDA Receives ADA State Public Affairs Program Grants. (CA Dental Asso. and American Dental Asso.)

Pages 2 and 3:
"We are pleased to report that the ADA's State Public Affairs Program has granted a total of $300,000 to assist CDA in its public policy work in 2010.

Specifically, ADA granted CDA $200,000 to assist in our effort to prevent the placement of "fluoride and its salts" on the List of Chemicals Known to the State to Cause Cancer or Reproductive Toxicity that is produced by the State of California, Environmental Protection Agency, Office of Environmental Health Hazard Assessment (OEHHA). The Safe Drinking Water and Toxic Enforcement Act of 1986 (Proposition 65) requires the governor to publish this list of toxic chemicals each year. OEHHA is currently considering fluoride and its salts for inclusion in the Proposition 65 listing. A determination is expected within the next 13 months.

The ADA also granted $100,000 to CDA to support our public affairs activities related to supporting children's oral health programs. This is a continuation of an effort partially funded by the ADA Public Affairs Program last year."

Note: Re: the $200,000- as you may know, Fluoride was not placed on the Prop. 65 list. They dismissed the Bassin study without consideration that it was the FIRST age-specific study - i.e. a brilliant study design because osteosarcoma only happens to GROWING bone with the growth plates are exposed to fluoride. Age 7, the first growth spurt for boys was the biggest window of injury!
Brain damage in rats from fluoridated water

An animal study links low levels of fluoride in water to brain damage [Brain Res.. 784, 284 (1998)]. The research was a collaboration among a chemist and two psychologists (including lead author Julie A. Varner) at Binghamton University, Binghamton, N.Y., and an EPA neurotoxicologist. Twenty-seven rats were divided into three groups and for one year were given either distilled water, distilled water with 2.1 ppm NaF—the same concentration of fluoride normally used in fluoridated drinking water—or distilled water with 0.5 ppm AlF3. In both treated groups, the aluminum levels in the brain were elevated relative to controls. The researchers speculate that fluoride in water may complex with the aluminum in food and enable it to cross the blood-brain barrier. Both treated groups also suffered neural injury and showed increased deposits of B-amyloid protein in the brain, similar to those seen in humans with Alzheimer’s disease. “While the small amount of AlF3 . . . required for neurotoxic effects is surprising, perhaps even more surprising are the neurotoxic effects of NaF” at 2.1 ppm, the authors write.
Hydrogen bonding is a weak interaction that holds molecules together. They make and break easily and this is what makes them so versatile - indeed the hydrogen bonds formed between amides (the links between amino acids) are the most important weak hydrogen bonds in biological systems. That these can be disrupted by fluoride in the formation of much stronger bonds may explain how the chemically inert fluoride ion could interfere in the healthy operation of living systems. Thus some of the serious charges that are being laid at its door - genetic damage, birth defects, cancer and allergy response - may arise from fluoride interference after all.

Does fluoridated water reduce tooth decay for US Head Start children? Turns out that water fluoridation is statistically worthless for: Baby Bottle/Sippy Cup tooth decay (11 references below) and for Pit and Fissure tooth decay (13 references below).

Baby Bottle/Sippy Cup Tooth Decay

1) “Sippy cups are the worst invention in history. The problem is parents’ propensity to let toddlers bed down with the cups, filled with juice or milk. The result is a sort of sleep-over party for mouth bacteria,” said pediatric dentist Dr. Barbara Hymer as she applied $5,000 worth of silver caps onto a 6-year-old with decayed upper teeth. Dr. Brad Smith, a Denver pediatric dentist estimates that his practice treats up to 300 cases a year of what dentists call Early Childhood Caries. Last year, Children’s Hospital did 2,100 dental surgeries, many of which stemmed from the condition, Smith said. The condition crosses economic boundaries, but Smith said it is especially pervasive among children in poor families. (Caries means cavities)
Source: Auge, K. Denver Post Medical Writer. Doctors donate services to restore little girl’s smile. The Denver Post, April 13, 2004. (Denver has been fluoridated since 1954.)

2) (Note: The mother is a major source of oral infection in her infant. ...When all carious lesions in pregnant women were restored and they followed good dietary practices, their salivary S. mutans counts decreased to low levels. When these low counts were maintained during their infants’ early lives, their salivary counts of S. mutans were also low and they acquired fewer carious lesions than other children of comparable age. When children in the same study became infected with S. mutans before the age of two years, they had approximately eight times as many carious lesions as children in whom S. mutans was not detected until the age of four.)

3) “Baby Bottle Tooth Decay (BBTD) is a severe form of early childhood caries caused by frequent or prolonged use of nursing bottles that contain liquids with natural or added sugars, e.g., milk, sugared water, fruit juices. The liquid pools around the upper front and back teeth, creating a perfect environment for bacteria to initiate tooth decay. Children with such an early onset of decay are more prone to developing dental caries in other teeth as they erupt.”
4) “Oral Disease is still a neglected epidemic in our country, despite improvements in oral health due to fluoridation, other forms of fluorides, and better access to dental care. Consider the following: 50 percent of Head Start children have had baby bottle tooth decay.”

5) 33% of Head Start children and 13% of non-Head Start preschool children had Early Childhood Caries/Baby Bottle Tooth Decay (BBTD).
1) In non-fluoridated urban regions, 40% of Hispanic preschool children had BBTD.
2) In fluoridated urban regions, 45% of Asian Head Start preschool children had BBTD.
Source: California Department of Health Services, Maternal and Child Health Branch, 1995; *Our Children's Teeth: Beyond Brushing and Braces*.

6) Among 2,520 children, the largest proportion with a history of falling asleep sipping milk/sweet substance was among Latinos/Hispanics (72% among Head Start and 65% among non-HS) and HS Asians (56%). Regarding the 30% and 33% resultant decay rates respectively; Our analysis did not appear to be affected by whether or not children lived in an area with fluoridated water.

7) By either of the two criterion i.e., two of the four maxillary incisors or three of the four maxillary incisors, the rate for 5-year-olds was significantly higher than for 3-year-olds. Children attending centers showed no significant differences based on fluoride status for the total sample or other variables.

8) The prevalence of BBTD in the 18 communities of Head Start children ranged from 17 to 85 percent with a mean of 53%. The surveyed communities had a
mixture of fluoridated and non fluoridated drinking water sources. Regardless of water fluoridation, the prevalence of BBTD remained high at all of the sites surveyed.


9) Overall, 37 of the 125 children (29.6 percent) were found to have BBTD. Compliance in putting fluoride drops in bottle once a day was identical between BBTD and non BBTD groups.


10) “Data from Head Start surveys show the prevalence of baby bottle tooth decay is about three times the national average among poor urban children, even in communities with a fluoridated water supply.”


11) A survey was administered to parents of 139 children diagnosed with early childhood caries (ECC) in 5 pediatric dentistry practices in Canada. The factors providing the most caries risk are: (1) being left with a bottle while sleeping; (2) parents having problems brushing the child’s teeth; (3) holding liquids in the mouth for prolonged times; and (4) ethnicity.


**Pit and Fissure Tooth Decay and Fluoridation**

1) “Fluoride primarily protects the smooth surfaces of teeth, and sealants protect the pits and fissures (grooves), mainly on the chewing surfaces of the back teeth. Although pit and fissure tooth surfaces only comprise about 15% of all permanent tooth surfaces, they were the site of 83% of tooth decay in U.S. children in 1986-87.”

2) “Because the surface-specific analysis was used, we learned that almost 90 percent of the remaining decay is found in the pits and fissures (chewing surfaces) of children’s teeth; those surfaces that are not as affected by the protective benefit of fluoride.”
Source: Letter, August 8, 2000, from Jeffrey P. Koplan, M.D., M.P.H. Director Centers for Disease Control and Prevention (CDC) Atlanta GA to Congressman Kenneth Calvert, Chair, Subcommittee on Energy and Environment, Committee on Science, Wash DC.

3) “Nearly 90 percent of cavities in school children occur in the surfaces of teeth with vulnerable pits and grooves, where fluoride is least effective.”

4) “Let me begin by saying that fluorides are most effective in preventing decay on the smooth surfaces of teeth. However, the chewing surfaces of posterior are not smooth. They have crevices and pits and it is our experience that fluorides don’t really get access to these pitted areas.”
Source: Hearings: Subcommittee of the Committee on Appropriations, House of Representatives. March 1984. Dr. Harald Loe, Director of the National Institute of Dental Research.

5) “Fluoridation and the use of other fluorides have been successful in decreasing the prevalence of dental caries on the smooth surfaces of teeth. Unfortunately, these efforts have much less effect on dental caries that occur in the pits and fissures of teeth (particularly on the biting surfaces of teeth) where more than 85 percent of dental caries now occur.”

6) “The program focused on four caries-prevention techniques: sealants, a plastic-like coating applied to the chewing surfaces of back teeth and to pits and fissures on the sides of teeth (these surfaces are most prone to decay and ones which fluorides cannot protect adequately).”
7) “It is estimated that 84% of the caries experience in the 5 to 17 year-old population involves tooth surfaces with pits and fissures. Although fluorides cannot be expected appreciably to reduce our incidence of caries on these surfaces, sealants can.”

8) “The type of caries now seen in British Columbia’s children of 13 years of age, is mostly the pit and fissure type. Knudsen in 1940, suggested that 70 percent of the caries in children was in pits and fissures. Recent reports indicate that today, 83 percent of all caries in North American children is of this type. Pit and fissure cavities aren’t considered to be preventable by fluorides, they are prevented by sealants.”

9) “Even though half of all kids are cavity-free today, 80% of the decay that does occur appears on the chewing surfaces of their back teeth, where fluoride isn’t as effective.”

10) “Although systemic and topical fluoride use has been shown to be highly effective in prevention of caries on smooth surfaces, enamel surfaces with pits and fissures receive minimal caries protection from either systemic or topical fluoride agents.”

11) “It has been recognized for years that fissured occlusal surfaces are the most vulnerable to caries. With the continuing caries decline among children, caries is becoming a disease of the fissured surfaces as the rate of approximal caries development continues to decline faster than that of overall caries experience. Occlusal surfaces are also those least protected by fluorides, so the case for sealant as a complementary procedure to fluoride is even stronger. As of the early 1990s, at least 83% of all decayed or filled surfaces in the permanent teeth of 5-17-year-olds were in pit-and-fissure surfaces.
12) “The most effective prevention of caries on the smooth surfaces of teeth is fluoride. However, the chewing surfaces of molars are most vulnerable to cavities because they can be hard to clean, and difficult for fluoride to penetrate. Dental sealants are the most effective means of caries prevention on these surfaces.”

13) “Regardless of the degree or perfection of calcification of the enamel of the teeth examined, the decays as found are practically limited to the pits and fissures; or, put in another way, to those areas upon which there are interruptions in the surface continuity.” Note: Of the 733 cavities counted and tabulated by McKay in Pima Indian School at Sacaton Arizona, Bruneau Idaho, and Towner Colorado, ninety five percent (95%) were in the pits and fissures.
Source: Frederick S. McKay, DDS. Original Communications, Dental Cosmos August 1929.

The Deception

Fluoridation has historically been “sold” to politicians and civic leaders by using photos of rampant Baby Bottle/Sippy Cup Tooth Decay (BBTD), a highly visible decay of the upper front teeth. The cause of the decay is high levels of strep mutan bacteria. Fluoridated water at 1 ppm does not kill this bacteria that, 1) colonize on tooth surfaces, 2) thrive and multiply on sugars, and 3) pass their acidic waste onto the dental enamel causing the damage we call tooth decay.

50 percent of U.S. Head Start children have Baby Bottle/Sippy Cup tooth decay from high levels of strep mutans bacteria. A steady source of sugar is supplied to the bacteria by sipping fluids rather than drinking fluids from a cup. The bacteria’s acidic waste first ravages the primary teeth and then continues on to decay the permanent teeth.

In January 2000, Dr. Kathleen Thiessen, Senior Risk Assessment Scientist at SENES Oak Ridge Inc. Center for Risk Analysis, reviewed the 1993-94 California Oral Health Needs Assessment for the City of Escondido (Keepers-of-the-Well.org, #17 Effectiveness) and stated in her critique:
1) For preschool children, ... any evaluation of the effectiveness of various measures (fluoridation) must control for the occurrence of BBTD and,

2) Any study of the effectiveness of a particular measure (fluoridation) in preventing dental caries must control for the presence of dental sealants, or the results will be meaningless. and,

3) In addition, if children with BBTD are thought to be more prone to developing caries in permanent teeth, then history of BBTD vs. caries incidence should be examined for both preschool and elementary children.

The dental literature is clear that elementary school children with a history of BBTD are indeed more prone to decay in permanent teeth. Therefore, controlling or adjusting for history of BBTD in elementary school children should be the norm but is never done! By not adjusting for BBTD history and sealants, dental studies of elementary school children can claim a (false) fluoridation benefit!
Subject: Fluoridation; Harm, Origin, and Failure of…..

Harm: Fluoridation and the Age-Specific Factor

“Overall, an average of 86.8% of the dose was retained by the infants, which is about 50% higher than would be expected for adults. They concluded that “…the pharmacokinetics of fluoride in infants reveal(s) a completely different pattern compared to what has been found in adults.” There is a clear need for more information about the renal handling and general metabolism of fluoride in young children and the elderly.”

Advances in Dental Research 8(1);5-14, June, 1994

Both osteosarcoma and hip fracture incidence are significantly linked to water fluoridated at the “optimal” 1 ppm. In three published studies, osteosarcoma is linked to rapidly growing bone of children rather than to adult bone.

1) Ph.D. dissertation student Elise Bassin, using the data collected by her Harvard professor Chester Douglass, first eliminated his data for adult males and females and then by looking at exposures for each year of age was able to uncover a 700% increased incidence of osteosarcoma for males exposed to fluoridated water (1 ppm) between age 5 and 10.

“The evaluation of age-specific effects distinguishes our study from the other investigations. Rothman (37) has warned that failure to identify the appropriate time window for exposure may result in misclassification which can adversely affect the ability to detect an association.”


2) Likewise, the Journal of American Medical Association, August 12, 1992, Brigham City, Utah hip fracture study showed in Figure 1 that the age specific window-of-injury for women is the approximately fifteen years (perimenopause) prior to menopause, a period of increased bone remodeling and uptake of embrittling fluoride. (To avert crippling skeletal fluorosis, the EPA’s Maximum Contaminant Level for fluoride in public water is 4 ppm.) This age specific window resulted in a 100% increase in hip fracture for women at age 75 and would most likely have been much higher had the women grown up on fluoridated water as well.

Maureen Jones, Archivist for 24 years
Citizens for Safe Drinking Water
FluorideAlert.org
Keepers-of-the-Well.org
1205 Sierra Ave.
San Jose, CA 95126
408 297-8487
Origin: Fluoride made the 1945 atomic bomb possible because fluoride is what enriches uranium. It is uranium-hexafluoride (WWII code name: “hex”) that, when heated to a gas, separates the uranium isotope 235 from 238 and then can enrich isotope 235 to a 90% bomb-grade level.

1995 declassified letters are available at: Deepwater New Jersey Lawsuit. “Visit” the spring 1946 meetings of the Manhattan Project's top military with Dupont's attorneys and the FDA wherein they determined they must create a strategy to avert the growing litigation problems due to fluoride gas escaping from Dupont's processing facility. The military feared that any additional lawsuits could end the atomic bomb project.

An 8-page story, commissioned in 1997 by the Christian Science Monitor and based on the 1995 declassified documents, is available at: Fluoride, Teeth and The Atomic Bomb. One can see that water fluoridation, launched in 1945, was born of national security urgency at the highest level.

The University of California system has been the sole manager of Los Alamos National Laboratory since 1942, beginning with the Manhattan project. Currently, the American Dental Association's top spokesperson for water fluoridation, Dr. Howard Pollick, has long been employed at UC San Francisco.

Also, the net film, Fluoridegate is well worth watching, especially for Black Americans. Blacks have twice the incidence and twice the severity of dental fluorosis as white Americans. (1993, National Research Council Report, p. 45)

Failure: Baby Bottle Tooth Decay aka Early Childhood Caries:

After decades of fruitlessly promoting water fluoridation for the sake of disadvantaged children, the University of California San Francisco School of Dentistry announced on December 18, 2008 they had received a record $24.4 million from the National Institutes of Health to figure out how to fight early childhood caries, also known as "baby bottle tooth decay" or "nursing caries".

Published Dental Literature Has Long Noted Fluoridation's Failure:

1) Auge, K. Denver Post Medical Writer. Doctors donate services to restore little girl's smile. The Denver Post, April 13, 2004. (Note: Denver, CO has been fluoridated since 1954.)

"Sippy cups are the worst invention in history. The problem is parents' propensity to let toddlers bed down with the cups, filled with juice or milk. The result is a sort of sleep-over party for mouth bacteria," said pediatric dentist Dr. Barbara Hymer as she applied $5,000 worth of silver caps onto a 6-year-old with
decayed upper teeth. Dr. Brad Smith, a Denver pediatric dentist estimates that his practice treats up to 300 cases a year of what dentists call Early Childhood Caries. Last year, Children’s Hospital did 2,100 dental surgeries, many of which stemmed from the condition, Smith said, and it is especially pervasive among children in poor families.

2) Shiboski CH et al. The Association of Early Childhood Caries and Race/Ethnicity Among California Preschool Children. J Pub Health Dent; Vol 63, No 1, Winter 2003. Among 2,520 children, the largest proportion with a history of falling asleep sipping milk/sweet substance was among Latinos/Hispanics (72% among Head Start and 65% among non-HS) and HS Asians (56%). Regarding the 30% and 33% resultant decay rates respectively; Our analysis did not appear to be affected by whether or not children lived in an area with fluoridated water.

3) California Department of Health Services, Maternal and Child Health Branch, 1995; Our Children’s Teeth: Beyond Brushing and Braces. 33% of Head Start children and 13% of non-Head Start preschool children had Early Childhood Caries/Baby Bottle Tooth Decay (BBTD).
1) In non-fluoridated urban regions, 40% of Hispanic preschool children had BBTD.
2) In fluoridated urban regions, 45% of Asian Head Start preschool children had BBTD.


5) Barnes GP et al. Ethnicity, Location, Age, and Fluoridation Factors in Baby Bottle Tooth Decay and Caries Prevalence of Head Start Children. Public Health Reports; 107: 167-73, 1992. By either of the two criterion i.e., two of the four maxillary incisors or three of the four maxillary incisors, the rate for 5-year-olds was significantly higher than for 3-year-olds. Children attending centers showed no significant differences based on fluoride status for the total sample or other variables.

The finding of 47% of the children having experienced dental caries in their primary teeth does not differ greatly with other studies of low socioeconomic status and racial ethnic groups. *(Washington D.C. has been fluoridated since 1952.)*

Overall, 37 of the 125 children (29.6 percent) were found to have BBTD. **Compliance in putting fluoride drops in bottle once a day was identical between BBTD and non BBTD groups.**

In 1986, a program to prevent BBTD was implemented in 12 Head Start centers in 10 states. In three years BBTD decreased from 57% to 43%. **Funding was discontinued in 1990.**

“Data from Head Start surveys show the prevalence of baby bottle tooth decay is about three times the national average among poor urban children, **even in communities with a fluoridated water supply.**”

Of 369 children who attended the University of Texas-Houston Health Center (Houston is fluoridated), **56%** between 2 and 3 years old had decay. Among the 3 year olds, **46%** had more than three decayed teeth. **The children without decay were weaned from the bottle at an average age of 10 months. Those with severe decay were weaned at 16.9 months.**

12) Kong D. City to launch battle against dental 'crisis'. *Boston Globe, Nov. 27, 1999.*
18% of children 4 years old and younger seen in the pediatric program at Tufts University School of Dental Medicine in 1995 had baby bottle tooth decay. Treatment can cost up to $4,000 per child. **Boston was fluoridated in 1978.**

**In summary, initial primary incisor caries is a risk factor for developing future carious, extracted, and restored teeth.**

The primary precipitating factor for this 100 year old problem is prolonged use of the bottle or breast past 9 to 12 months of age. North American Indians have reported an incidence of 53 percent, Inuit (Eskimo) children have shown a 60%-65% incidence and Mexican American migrant farm workers, 30%.

Pit and Fissure Tooth Decay

“Fluoride primarily protects the smooth surfaces of teeth, and sealants protect the pits and fissures (grooves), mainly on the chewing surfaces of the back teeth. Although pit and fissure tooth surfaces only comprise about 15% of all permanent tooth surfaces, they were the site of 83% of tooth decay in U.S. children in 1986-87.” *Selected Findings and Recommendations from the 1993/94 California Oral Health Needs Assessment.*

“Because the surface-specific analysis was used, we learned that almost 90 percent of the remaining decay is found in the pits and fissures (chewing surfaces) of children’s teeth; those surfaces that are not as affected by the protective benefit of fluoride.”

*Letter, August 8, 2000, from Jeffrey P. Koplan, M.D., M.P.H., CDC Atlanta GA.*

“Nearly 90 percent of cavities in school children occur in the surfaces of teeth with vulnerable pits and grooves, where fluoride is least effective.”


The Deception

Fluoridation has historically been “sold” to politicians and civic leaders by using photos of rampant Baby Bottle/Sippy Cup Tooth Decay (BBTD), a highly visible decay of the upper front teeth. The cause of the decay is high levels of strep mutan bacteria. Fluoridated water at 1 ppm does not kill this bacteria that, 1) colonize on tooth surfaces, 2) thrive and multiply on sugars, and 3) pass their acidic waste onto the dental enamel causing the damage we call tooth decay.

50 percent of U.S. Head Start children have Baby Bottle/Sippy Cup tooth decay from high levels of strep mutans bacteria. A steady source of sugar is supplied to the bacteria by sipping fluids rather than drinking fluids from a cup. The bacteria’s acidic waste first ravages the primary teeth and then continues on to decay the permanent teeth.

In January 2000, Dr. Kathleen Thiessen, Senior Risk Assessment Scientist at SENES Oak Ridge Inc. Center for Risk Analysis, reviewed the 1993-94 California Oral Health
Needs Assessment for the City of Escondido (Keepers-of-the-Well.org, #17 Effectiveness) and stated in her critique:

1) For preschool children, ... any evaluation of the effectiveness of various measures (fluoridation) must control for the occurrence of BBTD and,

2) Any study of the effectiveness of a particular measure (fluoridation) in preventing dental caries must control for the presence of dental sealants, or the results will be meaningless. and,

3) In addition, if children with BBTD are thought to be more prone to developing caries in permanent teeth, then history of BBTD vs. caries incidence should be examined for both preschool and elementary children.

The dental literature is clear that elementary school children with a history of BBTD are indeed more prone to decay in permanent teeth. Therefore, controlling or adjusting for history of BBTD in elementary school children should be the norm but is never done! By not adjusting for BBTD history and sealants, dental studies of elementary school children can claim a (false) fluoridation benefit!

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“The ADA’s recommendations were included in a July 21, 2011 email from Nadine Gracia in the Office of the U.S. Secretary of Health.”

FOR IMMEDIATE RELEASE

Fluoridgate: Dental Group Document Surfaces, Describes Extensive Water Fluoridation Safety Research Needed  
Kidney Patients, Diabetics and Seniors in Focus as Questions Swirl in Burgeoning Scandal

July 13, 2016 -- A Freedom of Information Act request has uncovered an explosive document from the American Dental Association (ADA) calling for research on the health effects of drinking fluoridated water.

The latest in a cascading series of adverse revelations about water fluoridation, the document appears at odds with years of public statements by dental groups assuring the public that fluoridation safety has been extensively researched.

The Campaign for Dental Health says on its website, “With over 3,000 studies or research papers published on the subject, few topics have been as thoroughly researched as water fluoridation.”

But newly obtained federal emails contain a statement from ADA calling for research on how fluoride ingestion and processing in the body is influenced by age, race, sex, nutritional status, medications, health conditions, and culture.

ADA also recommends research to determine how diabetics and kidney patients are affected by fluoridated water, and how age, sex, and race variables come into play.
Civil rights icon Andrew Young had spoken out against fluoridation in 2011, noting that “the story about fluorides keeps changing.” The new documents show that Andrew Young’s and Dr. Gerald Durley’s statements opposing fluoridation generated a whirlwind of meetings and correspondence in dental and government circles.

A letter emerged in which ADA voiced concern that Young’s and Durley’s statements about fluoridation harm to minorities had “the potential to gain traction.”

Other nationally known figures subsequently waded in, such as environmental activist Erin Brockovich who called for Fluoridegate scandal investigations.

Best-selling author and nationally known physician Dr. Mark Hyman issued this statement: “I support federal investigative hearings looking into why our cities and towns are allowed to continue to add fluoride to public water sources and why the whole story about fluorides is only just now coming out.”

The ADA research recommendation document also recommends examination of total fluoride intake from all sources, and research on how dental fluorosis impacts minority populations.

Dental fluorosis is a disfigurement of teeth caused by excessive childhood exposure to fluorides.

The ADA’s recommendations were included in a July 21, 2011 email from Nadine Gracia in the Office of the U.S. Secretary of Health.

“Why did ADA not publicly release its research recommendations? Why did promoters continue saying fluoridation had been extensively researched?” asks Daniel G. Stockin, a career public health professional known internationally for his work to end water fluoridation.
“Kidney patients, diabetics, seniors, and those with intersecting risks – such as seniors who are kidney patients or diabetics – are going to be outraged as the details of Fluoridegate emerge,” he says.

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Reference Links / Sources:

- Freedom of Information Act documents: see second page for ADA research recommendation: [http://nebula.wsimg.com/236932a4e7803225f908f5e3feee5d29?AccessKeyId=A4D71DDB38C1C74A9260&disposition=0&alloworigin=1](http://nebula.wsimg.com/236932a4e7803225f908f5e3feee5d29?AccessKeyId=A4D71DDB38C1C74A9260&disposition=0&alloworigin=1)
- Campaign for Dental Health statement on 3,000 studies: [http://ilikemyteeth.org/scientists/](http://ilikemyteeth.org/scientists/)

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Registered cancers for nine communities (including Seattle and San Francisco) in the USA (nearly 22 million inhabitants) were obtained from IARC, the WHO International Cancer Registry. The data was used for analysis of incidence rates of cancers at thirty-six sites of the body.

Using the CDC’s 1985 Fluoridation Census, of the 36 sites, 23 sites were significantly, positively, associated with fluoridated drinking water.
Although the subject has received little attention, some data suggest that dental fluorosis is more prevalent among African-Americans than among other races or ethnic groups in the same community. Russell (1962), in the Grand Rapids fluoridation study, noted that fluorosis was twice as prevalent among African-American children than white children. In the Texas surveys in the 1980s, the odds ratio for African-American children having dental fluorosis, compared with Hispanic and non-Hispanic white children, was 2.3 (Butler et al., 1985b). Dental fluorosis also tended to be more severe among African-American children than white children in the Georgia study (Williams and Zwemer, 1990), although the difference was not statistically significant. In Kenya, prevalence and number of severe cases were unexpectedly high when related to fluoride concentrations in drinking water (Manji et al., 1986c), although nutritional factors could have confounded these results. The reasons for these findings are unknown and do not appear to have been explored further.

(Note: 2.3 means a risk ratio of 2.3 to 1)

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See also: Fluoride Action Network, Racial Disparities in Dental Fluorosis.
View 20 minute net film entitled, Our Daily Dose.
Fluorine Toxicity in Plants

J.W. Pscheidt, Extension Plant Pathology Specialist, OSU

Fluorine (F) occurs in the atmosphere as gaseous molecules (F₂) and in reduced form as particulate fluoride (F⁻). In water, inorganic fluorides usually remain in solution (as fluoride ions) under conditions of relatively low pH and hardness. Plants are exposed to fluoride through the air, soil, and water. Natural sources include weathering of fluoride minerals (such as cryolite, feldspar, mica, and apatite), volcanic gases, and marine aerosols. Aluminum smelting, brick, glass and ceramic manufacturing, and high phosphate fertilizers can also be important sources. Many municipal water sources inject fluorine (at 1 ppm) as an additive to prevent tooth decay. Use of this water for irrigation can result in toxicity symptoms on sensitive plants.

In general, soil fluoride is not available to plants. Roots take up small amounts of soil fluoride by diffusion, which results in a low background concentration in the plant foliage. There are exceptions such as tea plants that are natural accumulators of fluoride. Gaseous uptake of fluoride by leaves is rapid due to its high solubility.

Leaf spots due to fluorine toxicity.
Neil Bell, 2009.
Fluorine is an accumulative poison in plant foliage. Accumulation may be gradual over time. Fluoride strongly inhibits photosynthesis and other processes. It will move in the transpiration stream from roots or through stomata and accumulate in leaf margins. Typical fluorine injury symptoms on broadleaf plants include marginal and tip necrosis that spread inward. Conifer needles exhibit tip necrosis that spreads to the base. Drought stress or salt toxicity can have similar symptoms.

A wide variety of plants are sensitive to fluoride toxicity (Table 1). Typical indoor foliage plants include *Dracaena*, Tahitian Bridal Veil (*Gibasis pellucida*), and the spider plant (*Chlorophytum comosum*). Both *Dracaena deremensis* and *D. fragrans* (corn plant) are very sensitive to fluoride toxicity. Fruits such as apricot, blueberry, grape, peach, and plums are also sensitive. Conifers that are sensitive include Douglas-fir, western larch, most pines, and blue spruce. Sensitive flowering plants include gladiolus, lily, tulip, and yucca.

Avoiding fluorine toxicity starts with knowing which plants are sensitive. Avoid fluoridated water, high phosphate fertilizers, and low soil pH. An exception would be low pH-loving plants like blueberry. High calcium levels in the soil or rooting medium, such as use of dolomite, can help tie up fluoride and prevent injury.

<table>
<thead>
<tr>
<th>Common Name</th>
<th>Scientific Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apricot</td>
<td><em>Prunus armeniaca</em></td>
<td>Some cultivars are intermediate insensitivity.</td>
</tr>
<tr>
<td>Box Elder</td>
<td><em>Acer negundo</em></td>
<td></td>
</tr>
<tr>
<td>Blueberry</td>
<td><em>Vaccinium corymbosum</em></td>
<td></td>
</tr>
<tr>
<td>Sweet corn</td>
<td><em>Zea mays</em></td>
<td></td>
</tr>
<tr>
<td>Plant</td>
<td>Species</td>
<td>Injury</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Douglas-fir</td>
<td><em>Pseudotsuga menziesii</em></td>
<td></td>
</tr>
<tr>
<td>Gladiolus</td>
<td><em>Gladiolus</em> sp.</td>
<td>Bract and leaf injury.</td>
</tr>
<tr>
<td>Grape</td>
<td><em>Vitis vinifera</em></td>
<td>V. <em>labrusca</em> is intermediate.</td>
</tr>
<tr>
<td>Oregon Grape</td>
<td><em>Mahonia aquifolium</em></td>
<td></td>
</tr>
<tr>
<td>Western Larch</td>
<td><em>Larix occidentalis</em></td>
<td></td>
</tr>
<tr>
<td>Peach</td>
<td><em>Prunus persica</em></td>
<td>Soft suture or red suture disease of the fruit.</td>
</tr>
<tr>
<td>Pine</td>
<td><em>Pinus</em> sp.</td>
<td>Eastern white pine, lodgepole, scotch, Mugho, ponderosa</td>
</tr>
<tr>
<td>Plum</td>
<td><em>Prunus domestica</em></td>
<td>Flowering plums are resistant.</td>
</tr>
<tr>
<td>Blue Spruce</td>
<td><em>Pice pungens</em></td>
<td></td>
</tr>
<tr>
<td>Tulip</td>
<td><em>Tulipa</em> sp.</td>
<td></td>
</tr>
<tr>
<td>Corn plant</td>
<td><em>Dracaena</em> sp.</td>
<td>Most species and cultivars.</td>
</tr>
<tr>
<td>Yucca</td>
<td><em>Yucca</em> sp.</td>
<td></td>
</tr>
<tr>
<td>Spider plant</td>
<td><em>Chlorophytum comosum</em></td>
<td></td>
</tr>
<tr>
<td>Tahitian Bridal Veil</td>
<td><em>Gibasis pellucida</em></td>
<td></td>
</tr>
<tr>
<td>Lily</td>
<td><em>Lilium</em> spp.</td>
<td></td>
</tr>
</tbody>
</table>

* Plant are considered sensitive when injury has been observed on most of the species and when leaf analysis revealed a fluoride content less than 50 ppm.

References
