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Oral health in the ageing population

Older Adults Oral Health Issues

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Professor of Public Health Dentistry
The University of Manchester

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Special Edition 2014

Your tips to Current Oral Care Issues

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Introduction

There has been much emphasis on the challenges faced by children and their parents in securing optimal oral health. Indeed, the research base for fluoride interventions is largely centered on school age children. With policies and public health groups firmly focused on this population its easy to forget the other end of the life line – the so called "elderly" where there has been little attention paid to challenges and barriers to maintaining and securing good oral health.

This gap in both research and practice is all the more poignant given the recognised demographic shift that is occurring in Western populations – a move to a decreased birth rate and an ageing population that represent a significant challenge to health care systems world wide.

In 2013 Colgate-Palmolive supported a conference in Seattle, Washington that aimed to investigate the challenges of this important group of patients and develop a care pathway to integrate evidence-based interventions to ensure that best practice was employed in the management of older adults. This article highlights some of the findings from this meeting.

Who are the elderly?

One of the key outcomes of the meeting was that age is no indicator of oral health status – rather dentists should look to an individual's level of dependency – be this on supportive services, medication or social care. The impact of dependency – sometimes referred to as frailty within medical research – is a far better indicator of risk to oral health than simply chronological age.

What are the issues faced by this group?

Caries and periodontal disease are, as in younger populations, the major challenge for this group. However they often present with complex restorations that have required significant investment over time and must be maintained throughout life. While root caries is often considered one of the defining characteristics of older adults, coronal caries still accounts for the significant caries increment in this group – around 0.8 surfaces per year – with root caries being largely confined to those individuals living in institutional care. Periodontal disease is largely driven by a decreasing ability to maintain satisfactory levels of oral hygiene, with large accumulations of plaque seen in those whose physical or cognitive abilities have decreased over time.

What are the solutions?

A review of the scientific literature demonstrated that much of the evidence for prevention is based on studies in younger groups, but not exclusively so. There was good support for the use of high fluoride applications in this population as well as mouthrinses and gels. There is a clear need to help these individuals "protect the investment" in their oral health as well as recognising that many older adults without significant dependency are interested in health and beauty – particularly tooth whitening and other aesthetic treatments. The group considered a trigger age of 55 years at which point practitioners should begin to consider the presence of any dependency and how this might impact on their professional interventions as well as home care solutions. Recognising that dry mouth is an important confounder to oral care in this group; medicine reviews should be considered a crucial element in any oral care examination.

The working group also recognised the need for education and work force development in this area – highlighting that many practitioners felt ill equipped to deal with older patients and their sometimes complex needs. However, given the demographic shift such patients will become increasing common in primary care dentistry and thus skills in this area need to be developed.

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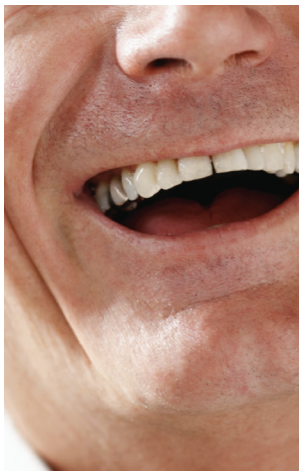

What should I do?

The group has developed a care pathway for older patients and this will shortly be available online, with free access for all, via the Gerodontology Journal (simply search for Gerodontology online). As well as the pathway document there are also a collection of articles that examine the epidemiology, aetiology and evidence base for securing oral health in these groups.

To make the pathway accessible a number of clinical scenarios were developed to try and place the evidence in to real life context. Two examples are included here.

Patient Scenario 1 - Ravi

Ravi, 68 years old, lives alone but his two children live nearby and visit him regularly. He can walk with the aid of a stick and is currently on medications that successfully control his high blood pressure and diabetes. He noticed recently, after losing two upper molars, that his lower removable partial denture is uncomfortable when chewing hard foods. He lives close to a dentist and has sought advice on how to improve the comfort of the denture.

The recommended oral care

Ravi's diabetes and high blood pressure if they become unstable could disturb his oral health. His request for help to enhance the comfort of the denture relates not only to his quality of life but also to his nutritional status. The dentist should inform him about the potential risk of caries and periodontal disease, and make a special assessment of salivary-flow that might be disturbed by his medication for blood pressure. Ravi needs an oral healthcare plan for self-care and professional management. He should be informed about the risk to oral health from diabetes and multiple medications (polypharmacy), placed on a more frequent recall schedule, and prescribed a high-fluoride toothpaste along with a professional applied fluoridated varnish to lower his risk of caries. The dentist should know how to contact Ravi's children in case Ravi fails to attend his recall appointments.

Older adults need an oral healthcare plan for self-care and professional management.

Patient Scenario 2 - Crisanna

Crisanna is 71 years old and lives in an assisted-care facility about 20 minutes by car from a dental clinic. She used to attend a dentist every 6 months but she has difficulty arranging transport to the dental clinic since she moved into the facility. She takes multiple medications for rheumatoid arthritis and chronic obstructive pulmonary disease, and steroids for a dermatological disorder. She can walk a short distance aided by a walker but over the last year she feels breathless when reclining in a dental chair. She has most of her natural teeth but there are numerous carious lesions associated with existing dental restorations, and she has newly exposed root-surfaces on her canines and premolars. She complains that her mouth is dry quite often but has not mentioned this to her dentist, physician or pharmacist.

The recommended oral care

Crisanna is a patient with chronic disorders that have increased her risk of caries and periodontal disease. A support network must be identified to enable her to visit the dentist on a regular schedule to stabilise the effect of the systemic disorders and the polypharmacy. Contact between the dentist and other healthcare personnel supplemented by the care of her family are essential to maintaining her oral health. In addition, she must be prescribed a high-fluoride toothpaste to reduce the risk of caries and ease the dry mouth, and given special instructions on how to remove plaque from the root-surfaces of the canines and premolars. The teeth with carious lesions might need fluoride-releasing restorations to prevent further demineralisation within the cavities. She needs also a fluoride varnish applied to all tooth surfaces, especially the newly exposed roots. The nursing staff providing her daily care must be advised about her unstable oral condition and shown how to assist her with oral care procedures. Any additional restorative treatment should be designed for easy maintenance.

Conclusions

There is a clear need to use a predictable and evidence based approach to the dental management of older adults. This should be based on an assessment of dependency rather than simply age. A clear focus on prevention is essential, not least given the caries increment in this group and the ability to recommend evidence based high fluoride treatments for use both professionally and as part of a home care plan.