Editorial

The dentulous, aging patient: What should we do?

I am the dental consultant for a small long-term care facility. It's sad for me to admit, but the truth is the patients with the best oral health are those with no teeth at all. Patients with teeth have extensive caries, broken teeth, and very advanced periodontal disease. These patients are unable to perform their own oral hygiene and are uncooperative to let the staff do so for them. These patients, in my opinion, would be best served by full-mouth extractions, but due to cooperation, transportation, economic and mainly medical problems, this is not a practical option. . . . So what do you do for them, is my question? What is my moral obligation? Professional obligation?

—An e-mail inquiry

It is not enough for a great nation to have added new years to life. Our objective must be to add new life to those years.

—John F. Kennedy

It is clear that all over the world, people reaching their later years have saved more of their teeth than did their ancestors. The quality of life in those later years is immeasurably improved because of that fact. It's a wonderful gift dentistry has made available to people, and all of us take justifiable pride in being part of this beneficent profession. These dentulous, aging patients are better for their exposure to our dental therapies . . . until they become incapacitated and are no longer able to maintain basic oral hygiene.

Aging patients who become unable to perform basic oral care rapidly succumb to the maladies described in the e-mail message quoted above. Unless there is a constant, loving caregiver who does not grow weary of tending to basic hygienic needs of the incapacitated, the conditions worsen. Unless we can create preventive protocols that will protect the incapacitated patient, some of our patients will be *worse* because of our dental therapies. Unless we act against the omnipresent bacterial mass patiently awaiting a diminished level of hygiene or a break in immunological defenses, pain and infection will surely afflict this patient cohort.

It is a massive cohort. In the United States alone, it is projected that up to 40% of the population (significantly more than 100 million individuals) will be over 65 years of age by 2020. Similar patterns exist around the world. Demands on the respective health care systems will grow apace as the "geriatric imperative" expands.

But what are we to do in the meantime? How do we counsel our patients? Our families? Our friends? We will likely ALL have our turns as caregivers and as care receivers. The answers we devise and promulgate will affect everyone.

I believe it is important to recognize that for this cohort of compromised individuals, complex dental care that requires high compliance levels *is not indicated*. The major components of care for these special patients are palliative, preventive, emergency, and removable prosthodontic services. Education and preparation is critical for both patient and family members. Attending dentists must keep a wary eye on the potential future of their patients and be prepared to render common-sense care and support early in the course of the numerous maladies that afflict an aging population.

From the dental standpoint, those maladies are primarily caries and periodontal disease. Both maladies are prevented by rigorous plaque control, selective chemotherapeutic interventions, and adequate host resistance.

Root caries, like other forms, is a function of the tooth, microorganisms, and diet. Prevention is by mechanical and chemical intervention. Mechanical includes brushing, wiping, and flossing the bacterial plaque away. Chemical intervention is considered a supplement to mechanical, and attending dentists should determine on a case-by-case basis when to intervene chemically. *Inadequate* hygiene by a patient can be supplemented with a daily 10-cc rinse of 0.05% cetylpyridinium chloride or 0.06% thymol solution and a 0.2% NaF rinse. *Inability* to perform oral hygiene is treated by daily rinse or brushing with 15 cc of 0.2% chlorhexidine gluconate and daily 0.2% NaF rinse. Quarterly 5.0%-NaF varnish applications are also helpful.

Periodontal disease, like caries, is controlled by mechanical cleaning of bacterial plaque and various chemotherapeutic agents such as fluorides, antiplaque agents, and salivary substitutes. In addition to the substances listed above for caries, Listerine antiseptic has shown antiplaque and antigingivitis properties. Various salivary substitutes are currently available on world markets.

Education, preparation, common sense, and a relentless interest in the patient's best interest will be the foundations of our approach to the aging, dentulous patient. We need to devise our strategies for dealing with these important patients.

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