EDITORIAL

The value of oral rehabilitation

The prevention of any oral disease, including caries and periodontal disease (and the tooth loss that can follow), is highly desirable. Nonetheless, it seems unlikely that any of these chronic conditions will be eradicated in the near future. Although restorative disciplines have received criticism for a lack of commitment to prevention, the critique isn't always fair: The introduction of synoptic treatment concepts include extensive pretreatment and focus on oral hygiene and dietary counseling. Still, the central task of oral rehabilitation is to replace structures that have been lost due to caries, periodontal disease, or trauma.

Today's oral rehabilitation offers many options. But how do we distinguish between what's good and what's not? There are basically 2 concurrent types of outcomes used in clinical trials: (*1*) *longevity and survival* (survival of teeth, implants, restorations), and (*2*) *psychosocial parameters* (treatment satisfaction, quality of life).

Further, survival (of the restorations) is one of the most measured outcomes of dental clinical trials. But we shouldn't have to talk about survival. Patients expect that what we provide will last—patients generally aren't concerned with failure until it happens. And we do deliver quality service: Survival of fixed restorations, including implants, is in the high 80% range over 5 to 10 years.[1]

We are left to determine which differences matter to patients and how to make patients understand the variances among treatment options. Patients must understand that restorative treatment doesn't cure disease. After the primary healing of an injury, there is usually no difference in organ function and therefore no impact on daily activity. Oral rehabilitation is comparable to hip replacement or cataract surgery. Nobody will dispute the immense benefits of these treatments: They offer a dramatic increase of quality of life. Likewise is the case with oral rehabilitative treatment. None cure disease; they are symptomatic—or palliative.

The WHO defines palliative care as "an approach that improves the quality of life of patients [...] facing the problems associated with life-threatening illness." Tooth loss has also been identified as a chronic condition by the WHO. The negative impact of tooth loss on oral health and quality of life has been shown in many publications.

The main goal of palliative treatment is symptom relief. Modern oral rehabilitation provides relief from pain and other symptoms; integrates the psychological, social, and spiritual aspects of care; and will ultimately enhance quality of life. Synoptically, it may also positively influence the course of an illness and prevent further tooth loss or bone resorption. The measurement of treatment success requires benchmarks besides the existing clinical measures. A variety of patient-based outcome measures are available, mostly in the form of questionnaires intended for use in clinical research. The inventories are not yet ready for everyday use. Still, we can reliably measure the impact of conventional prostheses, implant-retained dentures, and fixed implant restorations: We can estimate satisfaction related to esthetics, ease of cleaning, comfort, and speech.[2] We can measure oral health–related quality of life with sufficient validity and reliability; even the impact of oral conditions and specific restorations on general health has been shown.[3,4] These data have initiated a movement toward a change in standards of care.[5]

With the data from the aforementioned and future studies, we can offer patients information on the differences among treatments gathered from patients' perspectives. When purchasing kitchen appliances, for example, the attached energy ratings help consumers compare products. We should be able to use the results from clinical trials to attach similar data to treatments. However, this is a far-off goal. Relatively few prosthodontic methodologies have been tested for quality of life or satisfaction outcomes. The development of outcome measures is dynamic, and no universal measures currently exist. More user-friendly and shorter measures are under development,[6] and they may bring us closer to such simple, universal measures.

Treatment for chronic conditions is about choice. With all the restorative options, and within a patient-centered approach, we need to provide our patients with information that includes input on the expected symptom relief to come to joint treatment decisions. Patient-based outcomes provide the basis for such an approach.

Guido Heydecke, DDS, Dr Med Dent Habil
Professor and Chair, Department of Prosthodontics
University Medical Center Hamburg-Eppendorf, Germany
E-mail: g.heydecke@uke.de

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