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# "Grow old along with me!"

Grow old along with me!
The best is yet to be
The last of life, for which the first was made.
*–Robert Browning (1812–1889)*

United Nations population studies continue to confirm that increasing numbers of people are reaching age 65, particularly in the more industrialized countries of the world, and life expectancy has risen from 45 in 1900 to 75 today. More of that cohort are retaining most of their natural teeth, with expectations of better oral appearance, function, and comfort as they age.

Dentistry is proud of having participated in reducing edentulism, and indeed, for about 70% of the so-called "functionally independent elderly," aggressive preventive and intelligent therapeutic efforts will help assure continuing health, function, and appearance.

Of the rest of the elderly population, about 20% are classified as "frail elderly" (individuals who have lost a degree of independence, but who can still live in the community if support services are available to them), and the remaining 10% are the "functionally dependent elderly" who cannot live independently and are either homebound or institutionalized.

These percentages skew dramatically toward oral disaster among the poor in industrialized societies and among many in less industrialized countries, where preventive and therapeutic knowledge and services are more difficult to obtain, and the percentages of frail and functionally dependent elderly are relatively larger.

We in the profession should consider what we will be faced with in the future. It seems very clear that tomorrow's elderly patient will be quite different from today's, particularly regarding the number of retained functional teeth. However, dentate individuals are at increasing risk of oral disease as they age, because common dental diseases are largely opportunistic entities that explode into catastrophic manifestation if an individual's will or ability to control plaque diminishes.

Caries and periodontal diseases are lifelong threats to dentate individuals. How will we manage our dentate patients as they age and become more infirm? Frail and functionally dependent adults tend to be female, widowed, and over 80 years of age, and take an average of 3 drugs per day (many of which cause diminished salivary flow, hence increased caries and periodontal disease). Nearly half are without any close relatives or relations. As they enter various care-receiving relationships, from home care to institutional care, they become increasingly dependent on their caregiver(s) for basic daily activities and hygiene. Relatively few of these caregivers are knowledgeable about oral hygiene, and the risk of oral infection and pain increases.

For the most part, those who are 80 years of age and older wear dentures, and their care is relatively simple: preventing denture stomatitis and other *C albicans* manifestations per aggressive oral hygiene and denture maintenance, converting existing partials into transitional dentures, and adjusting dentures and relining as needed. The new generation of patients, however, has a different idea about dentures, appearance, and comfort. We can maintain healthy mouths with cooperative patients, but when do we make the decision to manage catastrophe by multiple extractions and placement of dentures? If we attempt to intervene too early, we stand to lose the patient's trust and confidence. If we wait too long, the patient may be unable to tolerate and adjust to the prostheses.

An enduring principle of ethical dentistry is that the ideal treatment for any patient is the simplest intervention(s) that adequately meets the patient's needs, wants, and abilities for health, comfort, function, and appearance. Therefore, our first obligation, especially with the frail and dependent patient, is to do what we can to stop disease progression and to attend to the patient's chief complaint. A "loose upper denture" should not necessarily equate to new full dentures. A labial frenum ulceration should not necessarily indicate an occlusal reconstruction. And how do we handle unrequested treatment? What if economic necessity eliminates certain treatments we feel are necessary? There are many legal and ethical dilemmas to consider if one wishes to care for this population of patients.

At the same time, there is no greater satisfaction than helping those who cannot help themselves. The dominant reason for doing our part should be to ensure that the members of our respective communities fully participate in "... the best (which) is yet to be."

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