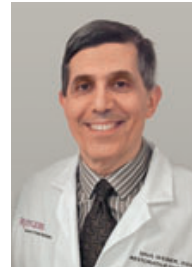




Geriatric dentistry: A changing paradigm



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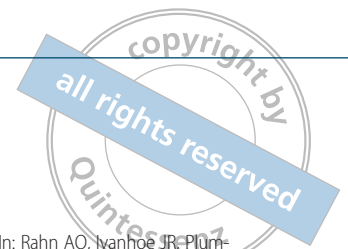
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The practice of dentistry has changed dramatically. Technology, patient expectations, life expectancy, dental therapy, and the internet have had a profound impact on the dentistry of today. Baby boomers are living longer and are more affluent, better educated, and living healthier and more productive lives. Unlike previous generations, they have benefitted from the advances in oral care, preventive dentistry, and diet, and consequently have retained their teeth. This population continues to seek quality and often complex dental therapies. Implants are commonly placed in individuals aged 60 and over.

The management of the aged population has received little attention. As stated by Dr Muller deVan, "We must meet the mind of the patient before we meet the mouth."¹ We must develop more objective and patient-centered evaluation criteria to meet their treatment needs. The geriatric patient may have psychological and physical challenges unrelated to dental and oral conditions which require creative solutions to meet their needs and create a sense of well-being. The infirmities of age may also be exacerbated by the presenting oral conditions. Complex treatments that require greater effort on the part of the patient for home care and management may not be appropriate. The prognoses for restorative therapies for the geriatric patient, which range from the simple Class 2 composites to the full mouth rehabilitation, require reevaluation. More objective and patient-based evaluation criteria must be applied² because the impact of restorative procedures on quality of life is an important consideration for the geriatric patient.³

For the geriatric patient, some of the available evidence-based literature suggests that the use of individual implants, small span fixed partial dentures, and implant-supported overdentures are often more predictable and effective than long-span complex restorations that are more difficult to maintain and manage.³ The elimination of biofilms for oral health requires explanation by the practitioner and understanding on the part of the patient or caregiver greater than that suggested by the term "oral hygiene". Conservative prevention of root caries, common in the geriatric patient, with sealants and bonding agents, should be addressed with long-term studies. Composite posts, with dentin bonding, enable reinforcement of endodontically treated teeth. Minimal tooth preparations eliminate the undermining of cusps and the fatigue fractures so often seen in extensively restored molars and premolars. Tooth wear and abrasion require a more efficient and creative approach to management as opposed to full coverage crown restorations.

A careful perusal of the clinical literature suggests that while for implants, survival and success have been thoroughly documented, differential diagnoses and treatment planning with regard to restorative prognosis are not sufficiently emphasized. Multiple treatment plans are feasible for the geriatric patient with some missing teeth, loss of vertical dimension of occlusion, or teeth with a poor prognosis.⁴ While the clinician and the patient recognize particular physical and financial limitations that govern treatment options, the importance of management of oral conditions, the dentition, and the long-term prognosis of particular restorative procedures are not often adequately presented or dis-



cussed.⁵ The overall health and physical and mental status of the patient must also be taken into consideration.

This area of dental practice will continue to grow as the world population ages with improved standards of healthcare. The need for predictable, standardized treatment protocols which support the esthetic and functional needs of the geriatric patient must be addressed by the dental community to include generalists and specialists alike.

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