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Clinical Epidemiological Concerns and the Geriatric Prosthodontic Patient

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Abstract---Investigations into the oral health of the elderly leave little doubt that disease and dysfunction galore, though there is some disagreement about how clinical findings translate into treatment needs. The disabled and the institutionalised appear to be the most vulnerable, whereas dentists appear to be uninterested in providing services outside the scope of traditional dental practice. As a result, the oral health concerns of the elderly, particularly those relating to prosthodontic treatment, remain largely unaddressed.

Keywords---prosthodontic treatment, geriatric prosthodontics, clinical epidemiological

Introduction

Age and health are two critical considerations in any treatment. The primary goal of this article has been to discuss the importance of replacing missing teeth in the frail elderly. There are no dependable definitions of acceptable oral function or the need for tooth replacement. Nonetheless, the dentist must understand these concepts. «The Shortened Dental Arch Concept» demonstrates that even with severely reduced dentitions, acceptable oral function in the elderly can be obtained. Consent after being informed.

Consent is only given when the elderly person has been fully informed of all acceptable treatments. Treatment can be hampered by a reduced ability to

tolerate long-term, multiple appointments, motor diseases, or financial constraints. Some simplified prosthetic treatments with reduced longevity can be justified; others are not recommended due to tissue harm. Even if oral diseases are poorly controlled, prosthodontics may be justified in some cases for the elderly. It is difficult to decide whether to repair or renew prostheses, and each case must be evaluated individually. Small fixed dental prostheses (bridges) are simple to make, usually provide better oral function, are less expensive than partial removable dental prostheses, are preferred by the elderly, and should never be ruled out as an option. The need to replace missing teeth in the elderly will continue, but only after careful individual evaluations.

This article's main focus is on the replacement of missing teeth in the elderly. Any dental treatment aims to maintain or even improve oral function. Prosthodontics restores oral functions such as mastication, speaking, appearance, and oral comfort when teeth are missing. What constitutes acceptable levels for these functions is rather vague, and there are no well-founded criteria for the need to replace teeth. Furthermore, oral function has recently been linked to oral health-related quality of life. As a result, the current task raises a number of difficult questions. Some of these may appear simple.

What is the purpose and impact of public guidelines?

Official guidelines and regulations continue to be influenced by traditional “thinking” about prosthodontics and decision making. Establishing adequate oral function, including mastication, speech, and aesthetics, is a standard requirement for prosthetic rehabilitation. The Norwegian Health Authority (1) has issued guidelines for the replacement of missing teeth, stating that «individual evaluations must be made about acceptable masticatory function and what is required for the individual to be able to communicate and have social relationships without hindrances related to teeth. Furthermore, the term «aesthetic zone» refers to teeth that the individual patient (our emphasis) considers necessary to be able to have normal social interaction without teeth problems.

Clinical considerations

The following factors are usually relevant and should be taken into account: Patients cannot be expected to express their true needs and how they can be met unless they have a thorough understanding of the available treatment options. Following a thorough clinical examination, the dentist determines these. It should be noted that many elderly people regard the dentist as an authority figure whose concept of optimal prosthodontic treatment based on the dentist's superior knowledge and experience may be difficult to challenge. However, several treatments are usually available, and it is critical that the dentist's preference is not presented so strongly that the patient's subjective need is obscured. The clinical experience that the subjective needs of the elderly may be less demanding than those of younger patients, and deviate significantly from more objective optimal treatments suggested by the dentist, is relevant to this discussion. In contrast, some patients may insist on restorations that do not meet generally accepted standards.

Conclusion

Identifying what constitutes necessary and reasonable treatment in a clinical setting is critical and necessitates a high level of knowledge, empathy, and patient-centered respect. Despite the fact that aspects of OHRQoL have been the subject of increasing research over the last decade, no simple and reliable test exists. The use of evidence-based dentistry, a popular guideline nowadays, appears to be of little or no use in such basic, but also complex diagnostics.

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