Sheet#10

Prevention In Elderly Patients

Protocol for high risk elderly patients

Clinically:

• Baseline radiographs

• Prophylaxis application of chlorhexidine for 1 minute followed by rinsing.

• Apply sealant to pits and fissures, which must be checked for integrity at recall.

• Fluoride varnish application.

Patient should be advised not to brush, eat hard foods or rinse for 10 hours

Three applications of fluoride varnish are recommended over a 3-month

At home care:

• Brushing twice a day with fluoridated toothpaste containing high percentage of fluoride.(there is special toothpaste for elderly pt especially pt with dry mouth the fluoride level up to 5000 ;this type of toothpaste need description to buy it

• Rinsing daily for 1 minute with a fluoride mouthwash (0.05% NaF) at bedtime.

• Then Rinse weekly rather than daily with a chlorhexidine solution for 6 weeks

Note: There is disadvantage of chlorhexidine such as staining ,depapillation ,sensitivity some few record report almost death in pt highly sensitive to chx that's why apply chx clinically or at home weekly not daily

• After 6 months, recall repeat baseline radiographs to compare if there are any progressing lesions, to monitor proximal lesions and to restore any lesions which have reached the middle third of dentine.

• Oral hygiene instruction and dietary counseling are required to ensure success

• If the pt stable we start to see them at 6 month interval

Protocol for moderate risk elderly patients

in this group we skip baseline radiographs , chlorhexidine , pit and fissure sealants and we start with fluoride varnish application.

• Prophylaxis followed by fluoride varnish application.

Patient should be advised not to brush or eat hard foods for 10 hours.

Three applications of fluoride varnish are recommended 3 times over a 3-month period for every year the patient remains at moderate risk.

• Brushing twice a day with a fluoridated toothpaste

• Rinsing daily for 1 minute with a fluoride mouthwash (0.05% NaF) at bedtime .

Note: no need to use chlorhxidine weekly at home

recall every 6 months if they are stable we start to see them every 6-12 months.

Protocol for low risk elderly patients

-Prevention is limited to brushing twice a day with fluoridated toothpaste.

Reviews at 12–18 month intervals to check for white spot formation and any proximal radiolucency by bitewing radiographs

PRESERVING TOOTH TISSUE

Besides caries we should consider preserving the tooth structure in

Elderly patients .

-In young patients as soon as caries advance from enamel to dentine we restore the tooth but in the elderly patients we prefer to preserve what is left rather than restore.

- Elderly patients who were prone to caries in their youth are highly likely to have relatively large restorations as a consequence of the restorative cycle or staircase, and these teeth will be prone to eventual failure.

What we mean is that when we do a restoration and we face recurrent caries and restore the tooth again each time we will remove more tooth structure so you are going down the stairs of losing that tooth - it’s actually not a cycle but rather a staircase-

Newer elderly cohorts will have progressively more sound teeth, as operative intervention will have been restricted to where indicated. With minimal preparations and where modern adhesive materials will have been used.

So if we do more prevention and less operative work the whole population will have less amount of fillings, crowns and chances of tooth loss with time.

These patients will require different management strategies and this will pose a challenge for practitioners in the future.

looking ten years from now all the protocols that we are talking about will not be valid anymore and we have to find new guidelines

Currently on average 60% of restorations placed by practitioners are replacements of restorations that are deemed to have failed in clinical service.

The most common reason cited for replacing restorations is secondary caries.

-Marginal defects are often misdiagnosed as secondary caries and restorations replaced needlessly.

Similarly restorations are frequently replaced that could have been repaired, refurbished or simply monitored.

For example an 80 year old patient came to our clinic with a nice class 2 amalgam on the upper left 7 with just a chipped margin of the amalgam .

Should we remover the filling and risk the need of an endo treatment? or should we polish it ?

so go with this thought process .. we always prefer preventive rather than operative work

NON-CARIOUS TOOTH TISSUE LOSS .. ( abrasion , erosion , attrition)

Elderly patients frequently exhibit the effects of non-carious tooth tissue loss (NCTTL).

For Tx plane we need study cast , diet analysis to know if the erosion whether extrinsic or intrinsic dose the pt have problem with acid reflex to refer them to physician ,once we know the diagnosis to treat them according to it,

sever attrition pt we need to provide them with bite guard, so taking impression ,study cast,face bow transfer ,bite registration then fabrication of occlusal splint(either on upper or lower arch )usually upper is better, check fit on pt mouth in centric only the cusp tip touch the occlusal splint(centric there is dot( functional cusp), eccentric(lateral ,protrusive there is one line canine guidance , Anterior teeth in contact while posteriors are separated in protrusive

note:

* type of occlusal splint :soft( vacuum sheet) hard(acrylic ,transparent)
* bruxism pt we prefer soft splint
* occlusal splint it's device between upper and lower jaw that have certain thickness to open bite, any producer in dentistry that include raising vertical dimension and opening of the bite it need face bow transfer
* The idea behind the bite guard : when the mandibular teeth hits the flat acrylic this deprograms the proprioception and prevents the muscle of mastication from biting in full form as in bruxism .

follow up of occlusal splint usually in 2 week , then after 6 month, every year each visit we need to check the splint

every 2-3 year we need to change the occlusal splint due to wear

Clenching the pt bite strongly without moving the teeth(less damade to teeth) opposite to bruxism it move while bite in centric

Dry mouth

It’s a myth that salivary flow reduces with aging ; it is mainly due to the medications that our elderly patients use due to autoimmune/autonomic effects rather than direct effect on saliva reduction . offer for them salivary substitute we follow the same protocol as high risk pt