INVESTIGATING THE IMPACT OF TOOTH WEAR

Interview with **Professor Andrew Eder**

Speaking exclusively to *Private Dentistry*, Professor Andrew Eder explores the current situation regarding tooth wear in the UK

PD: In your view, what do the Adult and Children's Dental Surveys indicate in terms of the situation regarding tooth wear in the UK?
Andrew Eder: In very broad terms, it's two fold. If you look at the last two surveys, with 10 years between, they essentially demonstrate that tooth wear is on the increase in both adults and children. Conversely, when considering tooth wear alongside tooth decay and gum disease, these have not shown the same increase and, in some cases, have even decreased.

PD: In real terms, what are you seeing in practice in relation to tooth wear?
AE: There are two elements of greatest concern to me at the moment. One is older patients who are living longer, and keeping their teeth for longer, but who are having problems with tooth wear (Figure 1). Some of their teeth are sharp, others are crumbling, fillings are falling out, and the dentition isn't as effective as it used to be. Managing those sorts of problems is quite challenging. I'm also seeing younger patients with a lot of enamel loss due to attrition or erosion (Figure 2); the latter due mainly to the consumption of carbonated drinks and alcohol, as well as stomach acid regurgitation in patients with eating disorders.

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PD: Is there anything about the pattern of tooth wear in the UK that surprises you?
AE: There is an issue that I'm keen to look into, so I don't have all the answers yet. Some reports have suggested that there is less erosive tooth wear in the US than in the UK. There is a suggestion that people in the US prefer their soft drinks much colder than we do in the in UK, normally putting ice in drinks or having them straight out of the fridge. When you do that, it may have a positive effect on the pH, in that it

Figure 1: 80-year-old male with missing teeth, erosion, abrasion and attrition

Figure 2: 30-year-old male with erosion and attrition

becomes less acidic. It's early days on this but something that I'm keen to explore to see how we might be able to influence the potentially damaging effects of acidic drinks.

PD: Are you seeing anything new in practice that dentists might not yet be very aware about when it comes to tooth wear?
AE: One thing that I'm seeing more of in recent years is tooth wear related to recreational drug use. That's most definitely something I'd like to make people more aware of. You'll often see unusual patterns of tooth wear, particularly attrition as a result of grinding and clenching, because users may hold their mouth and face in what appears to be a very strained position. Finger application of drugs can also cause significant ulceration of the soft tissues.

If an unusual case of tooth wear presents, colleagues should explore all options, and a frank and open discussion with the patient may be required. However, if they are under the age of consent sometimes it can be more tricky. There is obviously preventive advice to share regarding drug use, but if there is tooth grinding then a mouthguard may be helpful although compliance is questionable.

Involving other healthcare providers where appropriate will also be critical to provide comprehensive assistance.

PD: In general terms, what can dentists do to help their patients prevent further wear damage going forward?
AE: The most important elements are the professional awareness and the ability to diagnose the various types of tooth wear based on the presentation. It isn't uncommon for me to see a patient referred for an opinion and, on examination, it is clear that they present with a high level of tooth wear (Figures 3 and 4); and yet no-one at their dental practice has mentioned this previously.

Early diagnosis is key because the sooner you diagnose any tooth wear, the sooner you can offer preventive advice and limit further progression. Also, at this point and where appropriate, patients can often be provided with simple, adhesively retained restorations to protect areas of tooth wear without further removal of otherwise healthy enamel or dentine.

Building on this approach, we – the profession – need to encourage and foster a conservative approach to management.

PD: What might the future hold for people susceptible to tooth wear if this challenge is not addressed appropriately and quickly?
AE: If tooth wear is not managed at the most optimal time and allowed to deteriorate, we may be limited in the treatment options available to help these patients. As a result, this might impact negatively on the quality of life experienced by, particularly, our older patients. If the wear progresses deep into the tooth, then patients can suffer from sensitivity and pain leading, possibly, to root canal problems and even tooth loss. In summary, we must do everything possible to avoid reaching the point where only extensive and complex treatment at one end or extractions at the other remain as viable options. Looking to a healthier future, it's all about professional awareness, patient education, tackling the challenges of erosion in the young, and addressing wear and tear in the elderly. It's certainly an area in which the dental profession can make a big difference, and the sooner the better. ●

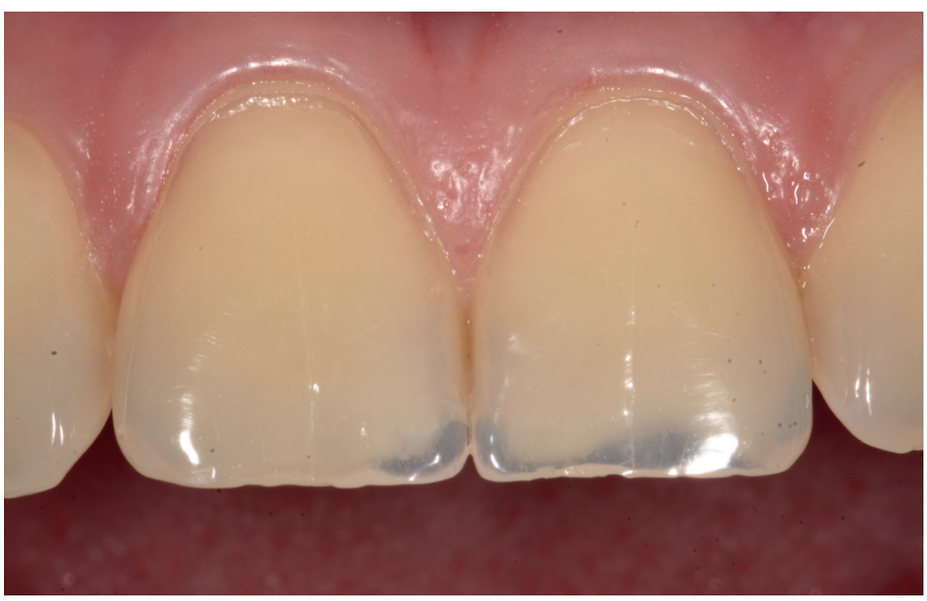

Figure 3: A 44-year-old male with erosion and incisal thinning

Figure 4: A 44-year-old male with palatal erosion

CPD

AIMS AND OBJECTIVES
To discuss the primary factors behind tooth wear in the UK today and how the issue might be addressed.

EXPECTED OUTCOMES
Correctly answering the CPD questions on page 74 shows the reader understands the impact of tooth wear and the main causes.

VERIFIABLE CPD HOURS: 1

THE LONDON TOOTH WEAR CENTRE
The London Tooth Wear Centre offers an evidence-based and comprehensive approach to managing tooth wear, using the latest clinical techniques and an holistic approach in a professional and friendly environment. For further information, please get in touch.

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