

# Implications of Parkinson Disease in oral health

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## INTRODUCTION

Parkinson's disease (PD), described for the first time 200 years ago, is the second most prevalent neurodegenerative disorder (1) and is increasing in developed and developing countries due to the increase of life expectancy.

This disease is characterized essentially by motor function disorders, such as resting tremor, muscular rigidity, bradykinesia and postural instability and has implications for performing daily life activities, namely, in oral hygiene (2).

Parkinson patients have dysphagia, sialorrhea, xerostomia, burning mouth syndrome, olfactory dysfunction, and difficulty in using and adapting to dental prosthesis worsen by cognitive impairment and dementia.

The dentist should have the knowledge and competence to identify all signs and symptoms that these patients can develop in their oral cavity in order to treat them properly. Furthermore, all the medications prescribed to these patients and their side effects on oral cavity must be acknowledged.

## METHODS

Concerning the collection of data for this review, the PubMed database of the U.S. National Library of Medicine was used as the main electronic database.

A systematic search of articles published up until 2016 was performed for the subjects: "Parkinson's Disease" AND "Oral health".

The Mendeley software was used for electronic title management. The obtained results were carefully evaluated and the most important findings related to the oral health alterations in PD are summarized below.

## RESULTS

9-77% of PD patients have dysphagia (2) which can result in sialorrhea in 32-74% of PD patients (3) due to an incapacity to maintain a closed mouth because of muscle hypotonia and oesophageal reflux enhancing dental erosion and angular cheilitis (4).

However xerostomia (dry mouth) is also frequent in PD patients, and facilitate dental caries, periodontal disease and oral discomfort (4).

The burning sensation is 5 times more prevalent in PD patients and is related to pharmacological treatment (levodopa). Others factors for bad oral hygiene is a loss of manual dexterity and cognitive dysfunction.



## CONCLUSION

The collaboration between the dentist and the caregiver (formal and/or non-formal) and his experience/skills is essential to obtain a cared supervision in oral and personal hygiene during the course of the disease. This team's work is crucial to maintain or improve the patient's quality of life.

### References:

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