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Dental Prosthetic Status and Prosthetic Needs among Adults and Geriatric Patients Wearing Removable Dentures Visiting A Tertiary Dental Centre in Lagos, Nigeria

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Abstract

Aim: The aim of this study was to explore the association of Dental Prosthetic Status, Prosthetic Needs among adult patients wearing removable partial dentures visiting a Tertiary dental centre in Lagos, Nigeria

Methodology: This was a descriptive cross-sectional research design that was utilized, and a sample of consecutive participants who wore partial dentures were enlisted. Approval for this study was obtained from the Ethical Committee of Lagos State University Teaching Hospital (LASUTH) Ikeja.

A structured, interviewer-administered questionnaire was used to obtain the sociodemographic and other relevant data, including denture care and oral hygiene practices. Each participant received an intraoral examination, where their denture status and needs, oral hygiene and periodontal health status was assessed.

Results: The study population comprised of 125 participants, out of these 61(48.8%) were males and 64(51.2%) were females. Majority (24%) of them were in the age group of 60-69 years. The prosthetic status and prosthetic needs of participants were based among the age groups and gender. In the prosthetic status, majority of them had partial denture (70.8%) followed by no prosthesis (29%).The prosthetic needs showed that majority of the study population need one-unit prosthesis (75%) followed by a multi-prosthesis (42%), combination of one and/or a multiunit prosthesis (34%) and a full prosthesis (33%). Majority of the participants (65%) had Kennedy class 3 classification while the least (3.2%) was found in the complete edentulous participants. The age differences were statistically significant but the gender group for both the males and females were not statistically significant.

Data analysis was carried out using SPSS 24 (IBM SPSS Inc). Statistical significance was inferred at $p \leq 0.05$.

Conclusion: In this study, we found out that the prosthetic status of the participants was not satisfactory, making a high demand of prosthetic needs.

Keywords: Prosthetic status, Prosthetic needs, Adults, Geriatrics, Removable dentures

Introduction

Oral health is the absence of disease and is an integral part of general health. It is a state of being free from mouth and oro-facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking and psychosocial wellbeing. Lack of oral health is detrimental to general health and vice versa, and this is seen with presence of oral diseases such as caries, periodontal diseases, tooth wear and oral cancer which have systemic manifestations such as uncontrolled diabetes with periodontal diseases, and tooth wear with gastro-oesophageal reflux.

With increasing age, there are changes in the oral cavity both soft and hard tissues, and also due to certain diseases that are associated with age advances. [1]

Tooth loss is known to be a consequence of poor oral health, and this has adversely affected the nutritional status and dietary intake of individuals thereby compromising the general health and later results to poor quality of life. [2]

The loss of teeth can be very traumatic and upsetting and could be regarded as a serious life event that requires social and psychological readjustment.[3,4] In most developed countries, the accepted chronological age of the elderly people is 65 years, as a definition of the United Nations standard numerical criterion of 60 + years.[5] The elderly are therefore more prone to tooth loss since the likelihood of tooth loss increases with age as a result of the cumulative effects of caries, periodontal disease, trauma and dental treatment.

Periodontitis is a destructive inflammatory disease of the supporting tissues of the teeth and is caused either by group of specific microorganisms, resulting in progressive destruction of the periodontal ligament and alveolar bone resulting in periodontal pocket formation and/or gingival recession. [12]

Periodontal disease is major cause of tooth loss in the elderly in Nigeria. [6] It has also been noted that elderly people with poor oral health status leading to edentulousness, have problems with social situations and interpersonal contacts, which can lead to depression and affect their general well-being. [7]

The adverse effect of tooth loss without replacement includes, drifting and tilting of adjacent teeth, rotation of teeth, over eruption, loss of contact area with formation

of food traps. Others are faulty speech, changes in appearance and adverse psychological changes. [8]

The main purpose of replacement of missing teeth is to restore or improve appearance, ability to masticate, improve speech and to maintain the oral tissues in a healthy condition. [9] Teeth replacement options in Nigeria include over dentures, removable acrylic based dentures, implants and teeth supported (fixed) prosthesis. Fixed prostheses, though excellent options are quite expensive and may not be affordable options for most Nigerians. [9] In a study done among older adult living in Japan, the percentage of utilization of tooth replacement services was stated to be 68.2%. [9] Bassey [10] in a study on oral health needs, among geriatric patient in a tertiary hospital in Nigeria reported the utilization of tooth replacement services as 29.6%. However, this study was conducted in one tertiary hospital more than two decades ago, and only for a year. Akeredolu [11] in 2004 did a study in LUTH on anterior teeth replacement and noted an increase in tooth replacement among the elderly.

It has been found out that non-disease indicators such as socio-demographic and socio-economic factors, education, dental attitudes, dental utilization behaviours contribute to tooth mortality in addition to oral diseases.

Various studies in the past have revealed that socioeconomic status and education level have a strong association with oral health. Dental health has improved considerably over the past century, being considerably better among the people belonging to high socioeconomic status. Findings from recent studies show that people with low and very low incomes are 5 times more likely to have a poor oral health status compared to those with high incomes. In addition, a higher level of education is commonly related to better oral health and quality of life. Higher level of education also ensures the possibility to attain and understand information regarding oral health.

As per the prevalence of tooth loss in Nigeria among the adults and geriatric population (>65years old), information in the published national data on oral health status of adults and older people are lacking. This is in contrast to findings seen in other countries such as in Ghana (a low -middle income country in West Africa) was projected to increase from 5.3% of the total population in 2014 to 8.9% by 2050, and in India where the geriatric population (people above the age of 60 years) in 2016 was 8.9% and expected to rise to 21% by 2050.

Prosthodontic rehabilitation is very important in patients with post endodontic therapy and who are completely or partially edentulous, because it improves their chewing ability, digestion, aesthetics, and as a result, their quality of life.

In order to promote oral health of a population, it is imperative to know their prosthetic status and needs. However, there is a major discrepancy between prosthetic need and their fulfilment via treatment. This issue needs to be addressed and calls for a thorough assessment of the current prosthetic status and a proper healthcare plan accordingly.

This study aims to determine the Dental Prosthetic Status and Prosthetic Needs among the adult and geriatric ‘removable dentures wearers visiting a Tertiary dental centre in Lagos, Nigeria.

Materials and Methods

Study Design

A cross-sectional descriptive study was carried out in the outpatient department of Prosthodontics unit of the restorative departmental at the dental centre of the Lagos State University Teaching Hospital, Ikeja, Lagos. The

duration of the study was for a period of two months from Sept 2024 to November 2024.

One hundred and twenty-five patients were examined between September 2024 to November 2024. The sample was randomly selected and weighted to represent the 20 – 70 years and above in the hospital.

The sample size was obtained allowing 10% sampling error. The sample size was determined by using the formula for sample size calculation for descriptive studies as stated below: [18]

$n = z^2 P q/d^2$

(n = Sample size, z = Standard normal deviation = 1.96 at 95% Confidence limit,

P = Prevalence rate = 7.69%, q = 1 – P, = 1–7.69% = 1-0.0769 = 0.9231,

d = Error margin = 5%). No response or drop-outs rate =10%

Documented brushing for the remaining natural teeth twice daily was 7.69% from a previous study. (19) This was substituted in the above equation giving a minimum sample size of 109. Therefore, from the above sample size is n=109+11=120.

Inclusion criteria

The population was composed of patients who attended the Prosthetic clinic, regardless of sex, aged 18 years old or older. They included partial denture wearers who informed consent will be obtained after screening.

Exclusion criteria

Those who denied giving consent were excluded from the study, likewise any patient below 18 years old. Also, full dentate patients were excluded from the study.

Clinical examination

The research instruments consisted of structured oral interviews and oral clinical examinations. Oral interviews included the recording of participants' sociodemographic characteristics, dental visitations habits, oral and denture hygiene habits, and information about daily oral hygiene. Dentate/edentulism status and the presence of removable prostheses were recorded. The participants were asked whether they had undergone periodontal treatment before the date of this study.

The participants were examined seated in a dental chair with mouth mirror and explorer under natural light. Armamentarium used included plane mouth mirrors, explorers, tweezers, kidney trays, sterilized Cotton / gauze pieces, disposable mouth masks, disposable gloves, torch, hand towels, data collecting sheet, pen, pencil.

The prosthetic status and needs were recorded by a single examiner based on WHO Oral health assessment form. [21]

Prosthetic status

Code 0: No prosthesis

Code 1: Bridge

Code 2: More than one bridge

Code 3: Partial denture

Code 4: Both bridge(s) and partial denture(s)

Code 5: Full removable denture

Prosthetic need

Code 0: No prosthesis needed

Code 1: Need for one-unit prosthesis

Code 2: Need for multi-unit prosthesis

Code 3: Need for a combination of one –and/or multi-unit prosthesis

Code 4: Need for full prosthesis (replacement of all teeth)

Data Analysis

Data analysis was carried out using SPSS 24(IBM). Descriptive statistics was carried out for socio-demographic variables such as age, marital status, occupation, and educational status. For descriptive variables that are categorical, simple frequency and

percentages were determined. The statistical significance was determined using Pearson's chi square and Fisher's exact as appropriate. Statistical significance was inferred at $p < 0.05$.

Ethical Approval

The study was aware of the Code of Ethics of the World Medical Association (Declaration of Helsinki) and it received the ethical approval from the Health and Research Ethics Committee of the Lagos State University Teaching Hospital (LREC/06/10/2635)

The examinations were undertaken with the understanding and informed consent obtained from each patient on the subject. Confidentiality was assured to all participants and all recording forms were numbered but not named.

Results

The study population comprised of 125 participants, out of these 61(48.8%) were males and 64(51.2%) were females. Majority (24%) of them were in the age group of 60-69 years (Table 1). With reference to educational status of the participants, very few are illiterate (0.8%) and over 9% are literate with higher percentage in tertiary or higher education. The occupation varies among the participants from being unemployed to a professional. Majority of them 24% were retirees and the least ones were from the labour (2%) and the housewife (2%) classes. (Table 1).

In the consideration of both the prosthetic status and prosthetic needs of participants, these were based among the age groups and gender. In the prosthetic status, majority of them had partial denture (70.8%) followed by no prosthesis (29%), while other types of prosthesis including full denture, bridge and implant were not available. The prevalence of partial denture (70.8%) was found to be higher among the more than 70 years' age group. (Table 2).

An insight into the prosthetic needs showed that majority of the study population need one-unit prosthesis (75%) followed by a multi-prosthesis (42%), combination of one and/or a multiunit prosthesis (34%) and a full prosthesis (33%). The needs for one-unit prosthesis were relatively higher in females than males, also for the number with no prosthesis (12%). The number for multi-unit prosthesis higher among the males (26%) compared to the female gender who had (21%).In the study, it was found that majority of the participants had removable partial dentures and therefore, it was believed to consider the use of Kennedy classification to determine type and grade of partial denture which would be useful in the management of the participants with reference to aesthetics, function, occlusion and preservation of tissues. Majority of the participants (65%) had Kennedy class 3 classification which is a tooth bounded saddle type of partial denture, while the least (3.2%) was found in the complete edentulous participants (Table 3).

The age differences were statistically significant but the gender group as both the males and females were not statistically significant.

Discussion

In the present study, when the prosthetic status of the participants, it was observed that only 35% wore no prosthesis and 65% wore removable partial dentures and none for removable full dentures. These figures are in conformity with previous studies[22,23,24] except the low percentage recorded in participants with no prosthesis or no full dentures. These can be attributed to general attitude and behaviour towards receiving oral health care[25] especially among the geriatric age group where there is fear of not being able to adapt to dentures. This geriatric group is negatively inclined to wearing complete dentures but showed positive attitude in wearing partial dentures compared to younger patients.

This might be due to improved masticatory and aesthetic functions.

Moreover, the geriatric group do not think that dentures are important. They incur medical treatment expenses already and do not want to spend on dental treatment. Previous studies showed that replacement of missing teeth is correlated with high social-economic status and educational status.[26] It was found that participants with higher educational attainments have greater health concerns and seek prosthodontic care more often than those with lower educational status.[27]

Contrary to our study, it was observed that the socio-economic status was very poor which led to unmet prosthetic needs with reference to their literacy level, education status and occupation[28]. However, in our study the prosthetic needs were demanding ranges from one-unit prosthesis (44.8%), two-unit prosthesis (24%), one or multi-unit prosthesis (20%) and full dentures (4%) which brought the total prosthetic needs to 92,8%, similar to a representative German sample with 81%. [29]This is evidenced in the criteria used in the assessment for prosthetic needs between the studies[29]

However, it was found in another study that people with edentulousness might be left unaware of treatment needs and finances,[30] fear of dental treatment and time constraints to treatment[31] if no prosthetic rehabilitation. The illiterate population, from educational level of the study group in Jizan[32] was 30%. This could have had an impact on prosthetic rehabilitation as they could not afford the treatment options available, unlike in another study in Saudi where free dental care treatments are provided to the people.[32] In our study, the participants were able to utilise the treatments.

The conventional removable dentures continue to represent the first rehabilitative treatment option offered to many edentate patients around the world[33]. In our study, we found out more requests for partial dentures (44.8%) than complete dentures (4%). This is traceable to the lifestyle, educational status, occupation and age groups of the participants who on the average are motivated towards maintaining good oral health and preserve tendencies to losing teeth.

In our study it was observed that different treatment options were given to the participants but since it was patient driven decision, majority of them chose conventional acrylic dentures than other options based on their finances, awareness, age, and ability to come to receive treatment at further visits. This was in contrast to actual prosthetic treatment to replace missing teeth being decided by the clinician as opposed to patient desires[34]

In addition, it was found that the decision to proceed with prosthodontic treatment or not belongs to the patient, who when highly educated about their decisions can best weigh his or her priorities[35]. This is similar to our study where the retirees, graduates, professionals and service participants were knowledgeable to make decisions on their prosthodontic treatment without financial constraints.

Furthermore, as the clinician explained the different treatment needs to the patient ranging from removable partial dentures, complete dentures and other prosthesis, the final treatment decision made by the patients fall within the age group for both male and female as seen in the findings in this study which were consistent and expected as in other studies[36] Tooth loss has been attributed to be complications from these two prevailing dental conditions, caries and periodontal disease. As a result of these cumulative effects of these two conditions, tooth loss increases with age.

In the analysis of the denture treatment needs in our study, it was noticed that there was no statistically significant difference between the denture needs for

males and females(P>005). Therefore, both males and females have almost same partial and complete denture needs. Though, the older age group showed more dentures need than the younger age group. The reason for this age difference is that the older age group suffer from chronic systemic disease s, which could affect their oral health. Also, another reason could contribute is the social aspect which is less valued by older people.

Recommendation: looking at the trend of edentulousness which become more significant as ageing take place, it would be more beneficial for older and elderly people to have a purpose built geriatric dental centre at various strategic locations to reduce burden of transportation costs and could serve as a place for social engagement with one another, and likewise to ease connection with other medical specialities where their services are needed.

Conclusion

In this study, we found out that the prosthetic status of the participants was not satisfactory, making a high demand of prosthetic needs. This might be due to lack of knowledge, lack of services and funding. The Dentist has a role to play to prevent tooth loss in the first instance by identifying the cause of tooth loss, preventive measures to eliminate the challenges and provide solutions to overcome the barriers meeting the unmet prosthetic needs. Such preventive measures include organising oral health programs, community engagements and mobilisation and provisions of oral health facilities most especially the elderly people. These services must be acceptable, accessible and affordable to the people. Such services must be delivered well, monitored, transparent in the discharge of the duties and accountable.

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Legend Tables

Table 1: The socio-demographic distribution of study participants

Variable	Frequency	Percentage
Gender		
Male	61	48.8
Female	64	51.2
Age group		
20-29	22	17.6
30-39	12	9.6
40-49	14	11.2
50-59	23	18.4
60-69	30	24.0
>70	24	19.2
Education		
illiterate	1	0.8
Primary	12	9.6

Secondary	32	25.6
Tertiary	59	47.2
Postgraduate	21	16.2
Occupation		
Unemployed	4	3.2
Labour class	3	2.4
Small merchant	14	11.2
Corporate	5	4.0
Retirees	30	24.0
Housewife	3	2.4
Business	19	15.2
Service	16	12.8
Professional	27	21.6
Total	125	100

Table 2: Prosthetic Status

Variables	No prosthesis Freq(%)	Partial denture Freq(%)	Full denture	Other prosthesis	P -value
Age Group					
20-29	8(36.3)	14(63.6)	0	0	
30-39	6(50.0)	6 (50.0)	0	0	
40-49	5(35.7)	9 (64.2)	0	0	0.001*
50-59	10(43.5)	13 (56.5)	0	0	
60-69	11(36.6)	19 (63.3)	0	0	
>70	7 (29.2)	17 (70.8)	0	0	
Total	47(37.6)	78(62.4)			
Gender					
Male	21(34.4)	40(65.5)	0	0	2.478
Female	24(37.5)	40(62.5)	0	0	
Total	45(35)	80 (64)	0	0	
Prosthetic needs					

Variables	No prosthesis	Need for 1-unit Prosthesis	Need for multi-unit prosthesis	Need for combination of 1 or multi-unit prosthesis	Need for full prosthesis
Age Group(Yrs)					
20-29	3 (13.6)	15(68.1)	2 (9.1)	1 (4.54)	0(0)
30-39	0 (0)	9 (75.0)	1 (8.3)	2 (16.6)	0(0)

40-49	1 (7.1)	6 (42.8)	6 (42.8)	1 (11.4)	0(0)
50-59	2 (8.7)	10 (43.5)	3 (13.0)	6 (26.1)	1(8.3)
60-69	2 (6.6)	9 (30.0)	10 (33.3)	7(23.3)	2 (6.6)
>70	0 (0)	8 (33.3)	8 (33.3)	8(34.2)	2(33.3)
Gender					
Male	0 (0)	25(41.0)	16(26.2)	19 (31.1)	1(1.6)
Female	8 (12.5)	31 (48.4)	14(21.8)	7(10.9)	4 (6.6)
Total	8 (6.4)	56 (44.8)	30 (24.0)	26(20.8)	5(4.0)

Table 3: Distribution of participants based on Edentulism

Edentulism	Frequency	Percentage
Dentate	4	3.2
Edentulous	4	3.2
Kennedy class 1	7	5.6
Kennedy class 11	5	4.0
Kennedy class 111	82	65.6
Kennedy class 1V	23	18.4