Oral Health Status in the Elderly Priests in Bangkok

Prapatsorn Ploysangngam DDS*,
Sermsiri Subhakorn MSc* Nucharee Pongnarisorn MSc*,
Saeng Jaturanon DDS*, Somchai Chaisupamongkollarp DDS*

** Dental Department, Priest Hospital*

***Objective**: To describe the oral health status of the elderly priests in Bangkok.*
***Material and Method:** The elderly priests aged 60 and over in Bangkok were clinically examined at Priest Hospital using methods recommended by the World Health Organization. Information on oral health behavior was obtained via questionnaires.*
***Results**: A totally of 714 elderly aged 60 years and above (mean =69.5 ± 6.7) were examined. About 13.2% were edentulous. The mean DMFT score was 16.9 (DT=2.6, MT= 13.2, FT= 1.0). The mean number of DMFT and MT increased according to age, with MT dominating in the DMFT index. The prevalence of decayed and filled root among the elderly priests was 10.6 with the mean DFT-root at 0.3. The percentage of the elderly priests with shallow and deep periodontal pockets decreased with age from 42.5% to 21.2% among the elderly aged 60-74 and 75 and above, respectively. Obviously, tooth loss became a problem among the elderly priest. 13.2% of the participated priests were edentulous. The mean number of remaining teeth was 18.6 teeth person. This figure decreased with age. Only half of the elderly aged 60-74 and one-third of the older aged 75 years and more had functional teeth at least 20 natural teeth. In addition, the elderly priest needed more extraction for 2.2 teeth per person.*
***Conclusion:** Tooth loss or tooth mortality amongst the elderly priest in Bangkok should be a concern in the situation where the elderly has a trend to live longer. To manage tooth loss problem, prevention and treatment of dental caries and periodontal disease were needed. Effective oral health education and regular dental checkups should be emphasized.*

***Keywords:** oral health, DMFT, CPITN, priest, elderly*

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With advances in medicine and prolonged life expectancy, the rapid growth of the number of aging people throughout the world becomes an important public health issue and a growing burden to countries worldwide[1,2]. According to the National Statistical Organization of Thailand, it is reported that the elderly proportion increases continuously higher than any other countries in this region. The population structure has been changed towards an aging population structure. The percentage of elderly Thais aged 60 and over grew from 4.4 in 1970 to 6.8 in 1995 and 10.7 in 2007. This figure is projected to 14.6 in 2025 and to 22.7 in 2050 [3,4]. To prevent on-coming health burdens on the country, it is very important that the elderly are as healthy as possible. However, some evidences revealed that as people age, the elderly are more susceptible to chronic and life-threatening diseases as well as acute infections. Not only general health problem but also poor oral health are more prevalent among this age group[1]. Due to sharing common risk factors, it was shown that poor oral health can increase the risks in general health. It affects nutritional intake with compromised chewing and eating abilities. Similarly, systemic diseases and their adverse effects of treatment can lead to increased risks of oral disease[5].

Globally, poor oral health among older people has particularly been seen in a high level of tooth loss,

Correspondence to: Ploysangngam P, Dental Department, Priest Hospital, 445 Sri Ayudhya Rd, Ratchathevi, Bangkok 10400, Thailand. Phone: 0-2354-4310. E-mail: prapatsorn_moo @yahoo.com

dental caries experience, and high prevalence rates of periodontal disease, xerostomia, and oral pre-cancer/ cancer[6]. According to the Thailand national oral health survey, the trend of oral health status of the elderly Thais has continued to improve over two decades[7-9]. In the year 2000, the old Bangkokian had the mean number of teeth present at 15.16. Caries experience, as measured by Decayed, Missing and Filled Tooth (DMFT) was 18.51 with 15.99 of missing tooth. About 41.4% had shallow and deep periodontal pockets and 15.5% were edentulous[9].

In Thailand society, the Buddhist priest serves as an officiant on ceremonial occasions, as well as being responsible for preserving and conveying the teachings of the Buddha. However, when they get old, they live independently under monastic life with no family support. There is no idea how the oral health status of the elderly priest is. To promote oral health for the elderly priest, the oral health status of the elderly priest should be clearly understood. Therefore, the purpose of the present study was to describe the oral health status of the elderly priests in Bangkok.

Material and Method

Data were collected as a part of the Sustained and Holistic Health Care Program for the priests Commemoration of His Majesty the King's 60 years Accession to the Throne (Phase 1 and 2) from February 2006 to July 2007. The subject was the elderly priest

Table 1. Mean number of teeth present, prevalence of priests with tooth loss/ dental prosthesis, by ages

	60-74 years	75 years and older	Total
Number of subjects	549	165	714
Mean tooth present	19.4	15.8	18.6
Mean functional teeth present	17.3	13.4	16.4
% priests with edentulous	11.1	20.0	13.2
% priests with at least 20 functional teeth	49.9	35.2	46.5
% priests having upper prosthesis	37.5	48.1	40.0
% priests having lower prosthesis	33.1	45.3	35.9

Table 2. Level and prevalence of caries experience of the elderly priest, by ages

	60-74 years	75 years and older	Total
Crown			
DT	2.7	2.5	2.6
MT	12.4	15.9	13.2
FT	1.1	0.9	1.0
DMFT	16.2	19.3	16.9
% priest with DMFT	96.9	98.8	97.3
Root			
DT-root	0.3	0.2	0.2
FT-root	0.1	0.0	0.1
DFT-root	0.4	0.3	0.3
% priest with DFT-root	11.7	7.3	10.6

Table 3. Percentage distribution of all subjects, according to their highest CPITN score

	60-74 years	75 years and older	Total
Score 0 (healthy)	3.5	8.5	4.6
Score 1 (bleeding)	1.5	3.0	1.8
Score 2 (calculus)	30.4	30.9	30.5
Score 3 (4-5 mm pocket)	23.0	11.5	20.3
Score 4 (≥6 mm pocket)	19.5	9.7	17.2
Score 9 (excluded)	22.2	36.4	25.5

Table 4. Percentage of the elderly priests with dentition, periodontal and prosthesis treatment needs

	60-74 years	75 years and older	Total
%priests with untreated caries	63.2	55.8	61.5
%priests with dentition treatment needs			
- 1-surface filling	3.7	2.8	3.5
- 2-surface filling	0.7	0.5	0.7
- Root canal treatment	0.1	0.1	0.1
- Extraction	2.1	2.4	2.2
%priests with periodontal treatment needs			
- No treatment needs (score 0, 9)	25.7	44.9	30.1
- Self care practice (score 1)	1.5	3.0	1.8
- Scaling (score 2,3)	53.4	42.4	50.8
- Root-planning (score 4)	19.5	9.7	17.2
%priests with prosthesis needs			
- Upper prosthesis	50.3	52.2	50.7
- Lower prosthesis	58.1	57.9	58.0
- Complete prosthesis	5.8	17.0	8.4

who was 60 years or older and currently resided in Bangkok. The examination procedures, instruments and diag-nostic criteria followed those recommended by the World Health Organization[10]. The examinations were carried out by ten dentists. Tooth status was recorded using the DMFT index. The community periodontal index for treatment needs (CPITN) was used to assess the periodontal status. In addition, prosthetic status and treatment needs were also recorded. Then, each priest was asked to complete a short questionnaire self-perception of oral health, oral hygiene practice and utilization of oral health services. As the subject aged 60 and over, a dental personnel was at hand to assist with completion of the questionnaire if needed. Analyses were carried out by using SPSS version13.

Results

Totally, 714 priests aged 60 years and older in 272 out of 447 temples were included in the study. All were male with the average age of 69.5 $\pm$ 6.7.

Table 1 showed the mean number of teeth present, prevalence of priests with tooth loss/dental prosthesis, by ages. It was found that 13.2% of all subjects were edentulous in both jaws and its prevalence increased with age. The average number of teeth present of the old (aged 60-74) and the very old (aged 75 and over) were 19.4 and 15.8 teeth/ person, respectively. Less than half had at least 20 functional teeth.

Table 2 illustrated prevalence and level of caries experiences among subjects. The overall DMFT score was 16.9. The mean number of MT increased with age and dominated in the DMFT scores in both groups. The prevalence of decayed and filled root among the elderly priests was 10.6 with the mean DFT-root at 0.3.

Percentage distribution of all elderly priests

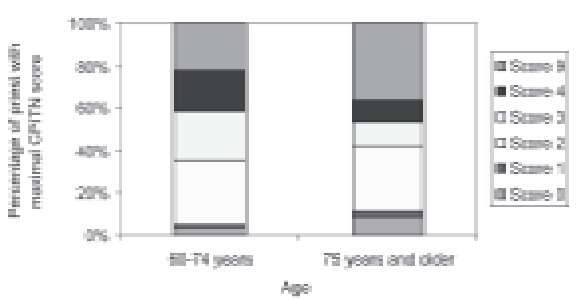

Fig. 1 Percentage of the elderly priest with highest CPI score, by ages

Table 5. Percentage of the elderly priests according to the questionnaires

	60-74 years	75 years and older	Total
1. Do you have any oral health problems?			
- Yes	75.0	65.6	72.9
- No	21.6	31.2	23.7
- Don't know	3.4	3.2	3.4
2. What kinds of problems do you have?			
- Food retention	79.9	57.4	75.4
- Caries	70.9	58.7	68.3
- Calculus	70.5	53.6	67.0
- Chewing hard food	69.2	48.3	64.6
- Tooth mobility	67.2	56.1	64.7
- Halitosis	66.8	51.7	63.6
- Tooth sensitivity	62.7	47.6	59.0
- Gingivitis	56.0	30.4	50.2
- Toothache	54.6	49.1	53.2
- Poor denture	45.8	38.0	43.6
- Others	33.6	25.6	31.3
3. How do you clean your mouth?			
- None	3.4	4.9	3.8
- Tooth brushing	97.5	96.4	97.2
- Flossing	26.5	2.5	20.3
- Proxabrush	54.3	36.2	49.5
- Toothpick	73.8	45.5	67.7
- Others	16.7	13.3	15.6
4. How often do you visit dentists a year?			
- Once a year or lesser	75.7	77.3	76.0
- At least twice a year	24.3	22.7	24.0
5. Where do you usually see a dentist?			
- Dental clinic/ private hospital	52.0	47.7	51.0
- PH	24.7	31.2	26.1
- Other public dental service facilities	21.8	19.3	21.2
- Temple	1.6	1.8	1.6
6. Why not going to PH*?			
- Too far	72.4	55.4	68.7
- No time	50.0	47.8	49.4
- No oral health problems	53.2	47.4	51.7
- Waiting for worse problems	53.0	34.2	48.4
- Do not know PH	38.3	33.3	37.1
- No one took me to PH	34.7	35.1	34.8
- No money	23.6	10.0	20.2

* PH - Priest Hospital

according to their highest CPITN score was shown in Table 3. About one-third of them had score 2 (calculus) as the highest CPITN score. The prevalence of the old with shallow and deep periodontal pockets was 23.0% and 19.5%, respectively. Correspondingly, these figures dropped to 11.5 and 9.7 in the very old group and the mean number of sextants with pockets was 1.1 and 0.6 (data not shown).

Table 4 demonstrated the percentage of the elderly priests with dentition, periodontal and prosthesis treatment needs. It was shown that 61.5% had untreated caries. 50.8% needed scaling and 17.2% required complex treatment for managing deep periodontal pocket. About half (50.7-58.0%) needed upper or lower dental prosthesis and 8.4% needed completed denture.

Table 5 revealed the information from questionnaires. It was shown that about 72.9% had self-perception of their own oral health problem. The top-three common problems among the elderly were food retention, dental caries and calculus. On the other hand, those among the very old concerned about dental caries, food retention and tooth mobility. Regarding their oral hygiene practice, 97.2% brushed their teeth and 67.7% used toothpick as an extra-cleaning method. About three-fourth subjects visited dentists not more than once a year. Just above half usually went to private offices. A quarter went to the Priest Hospital. For those who did not seek dental services at Priest Hospital reported the reasons of long distance (68.7%), no current problems (51.7%) and no time (49.4%).

Bivariate correlation revealed that positive correlation between those whose treatment needs were extraction and those who reported as 'never seen dentists before' ($p < 0.05$), and also between needed extraction and those who visited dentists not more than once a year ($p < 0.01$) (data not shown).

Discussion

The present study used the method recommended by the World Health Organization, except for an examination site which was not performed under daylight[10]. The examination under clinical setting would provide higher figures than that under daylight one due to clearer view.

DMFT

Regarding dental caries experience, the mean DMFT score of the priest increased with age from 16.2 among the old to 19.3 among the very old. Tooth loss was predominantly high with MT-component accounting for 78% of the index. Compared to the other studies, the DMFT of the old priest was between 14.37 of Thais and 18.51 of Bangkokian among similar ages[9]. Internationally, the DMFT of the elderly priest was lower than 22.8 of the male elderly in South Australia and 20.2 of 65-74-year-olds in Madagascar, but higher than 12.4 of 65-74-year-olds Chinese in the second national oral health survey in China[11-13]. Not only coronal part but also root was affected by dental caries. The prevalence of decayed and filled root among the elderly priests was 10.6 with the mean DFT-root at 0.3, showing lower than 19.6% and 0.56 of the elderly Thais, respectively[9].

Since the number of MT in the present study was large, it accounted for 78% of the score. According to Peter (2006), the DMFT index can be invalid in older adults due to unable to exclude reasons for extraction to dental caries only (Peter 2006). In other words, the MT-component of the DMFT index used in the elderly subjects should be considered an indicator both of previous periodontal disease and of caries.

Furthermore, the findings revealed that 61.5% of participating priests had untreated caries which required 1-2-surface filling at 4.2 teeth per person and extraction at 2.2 teeth per person. This indicated that prevention and treatment of dental caries in either the tooth crown or root were needed; otherwise tooth loss problem would be aggravated by untreatable dental caries.

CPITN

The periodontal condition was measured as the Community Periodontal Index Treatment Needs (CPITN). The findings revealed that most elderly priests had inflamed periodontal tissues. The improvement of periodontal status of the elderly priest depended much on dental personnel for professional cleaning and oral health education.

Half (50.8%) required professional cleaning and removing calculus and other plaque-retentive factors in order to reduce existing inflammation[14]. About 17.2% presented signs of deep periodontal pocket (CPITN = 4) which needed complex treatment by a periodontist. This was consistent with the global data which reported that the percentage of subjects with CPITN score 4 ranged from 5 to 70% among older people[2]. Compared with figures reported in other studies, the prevalence of the old priest with CPITN score 4 (17.2%) was higher than 12.3% of Bangkokian but lower than 25.7% of Thais aged 60-74 years old[9]. Similarly, the prevalence of having shallow and deep

periodontal pockets (score 3, 4) among the old priest, accounted for 37.5%, was twice as high as 17.1% of people aged 65-74 in Madagascar and 22.2% of Chinese elderly[12,13].

Furthermore, the prevalence of periodontitis decreased with age from 42.5% in the old to 21.2% in the very old priest. This was inconsistent with the previous studies which reported an increase in prevalence of periodontitis with age[15]. However, it was interesting to say that the percentage of priests with 'score 9', which representing the presence of less than two functional teeth left in an examined sextant, accounted for 22.2 among the old priest and 36.4% among the very old. This demonstrated an increase in the number of missing teeth and a decrease of functional teeth among the very old. Furthermore, it seemed that the decreased prevalence of periodontitis with age in the present study would result from increased number of missing teeth rather than improvement of periodontal disease. However, it is important to reinforce the concept that periodontal disease is not a consequence of age per se, but due to chronic expose to risk factors over a number of years[16].

Some epidemiological studies showed that high prevalence rates and severity of periodontal disease were associated with local factors such as poor oral hygiene and high levels of dental plaque[6]. Interesting, almost the entire participated priest claimed that they used tooth brushing to clean their own mouth. About 20.3% used dental floss and 49.5% used proxabrush. This indicated the ineffectiveness of oral hygiene practice of the elderly and oral health education by dental personnel needs to improve.

Tooth loss

Tooth loss compromised the integrity of the dentition and can lead to clinically significant deficits in masticatory function and nutrition[17]. Extensive tooth loss reduced chewing performance and affected food choice[18]. In the maintenance of satisfactory nutritional status, natural and functional dentition at least 20 teeth played an important role[19].

Overall, 13.2% of the participated priests were edentulous. The mean number of remaining teeth was 18.6 teeth person. This figure decreased with age from 19.4 among the old priest to 15.8 among the very old. Only half of the old and one-third of the very old had at least 20 functional teeth. In addition, the findings revealed that the elderly priest needed extraction, averaging at 2.2 teeth per person.

The prevalence of edentulism among the elderly priest was relatively low when compared with figures reported in other studies. The percentage of the Bangkokian-elderly aged 60-74 with at least 20 functional teeth and edentulism were 36.5 and 15.5% respectively[9]. Compared with the other countries in South East Asia, it was found that the figures were still relatively low. The prevalence of edentulousness of the elderly aged 65-74 reported were 19 in India, 24 in Indonesia and 37 in Sri Lanka[2]. However, a problem of tooth loss became worse when the priest got older. The average teeth present of the very old was 15.8. The percentage of priest with 20 and more functional teeth and edentulousness were 35.2 and 20.0%, respectively. For increasing chewing performance, 35.5-40% of 714 priests reported having upper and/or lower denture but 57.7% needed new dental prosthesis.

This indicated that a problem of tooth loss amongst the elderly priest in Bangkok should be a concern in the situation where the elderly trend to live longer. Tooth loss or dental mortality is recognized as the final outcome of a multi-factorial process that involves disease-related factors as well as health behaviors, patient preferences, and professional interventions[20]. The other studies reported that the major reasons for tooth extraction among the elderly are severe dental caries and periodontal problems[6,21,22]. The present data revealed that the number of teeth with its treatment needs as an extraction was higher among those who reported 'never seen dentists before' and 'fewer dental visits annually'. Regardless of disease-related factors, it seems that the problem of tooth loss in the present study was due to inability to access dental services provided which may result from insufficient dental manpower and poor patient's attitude on oral health care. In order to manage a problem effectively, further research is needed with respect to its risk factors among the elderly priest.

Conclusion

The oral health status of elderly priests examined was poor due to high level of tooth loss, caries experience and prevalence of periodontal pockets. 13.2% of the elderly were edentulous. About half of the elderly aged 60-74 and one-third of the very old aged 75 years and more had at least 20 functional teeth in order to maintain satisfactory nutritional status. Shortly, a problem of tooth loss amongst the elderly priest in Bangkok should be a concern in the situation where the elderly trend to live longer. There is a need to develop appropriate management to improve the oral health condition of this population.

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สภาวะทันตสุขภาพของพระสงฆ์สูงอายุในกรุงเทพมหานคร

ประภัสสร พลอยแสงงาม, เสริมศิริ สุภากรณ์, นุชจรี พงษ์นริศร, แสง จตุรานนท์, สมชัย ชัยศุภมงคลลาภ

วัตถุประสงค์: *เพื่อศึกษาสภาวะทันตสุขภาพของพระสงฆ์สูงอายุในกรุงเทพมหานคร*
วัสดุและวิธีการ: *พระสงฆ์ที่อายุมากกว่า 60 ปีจำนวน 714 รูป ได้รับการตรวจสภาพช่องปากตามเกณฑ์ขององค์การอนามัยโลก และตอบแบบสอบถามที่โรงพยาบาลสงฆ์*
ผลการศึกษา: *ค่าเฉลี่ยโรคฟันผุ DMFT เพิ่มตามอายุ และมีค่าประมาณ 16.9 ซี่ต่อคน (ผุ 2.6, ถอน 13.2 และ อุด 1.0 ซี่) ความชุกของผู้ที่มีการผุที่รากฟันเท่ากับร้อยละ 10.6 โดยผุเฉลี่ย 0.3 ซี่ต่อคน ความชุกของผู้มีกระเป๋าปริทันต์ลดลงจากร้อยละ 42.5 ในพระผู้สูงอายุ 60-74 ปี เป็นร้อยละ 21.2 ในกลุ่มพระอายุ 75 ปีหรือมากกว่า แต่ความชุกที่ลดลงน่าจะเป็นผลมาจากภาวะการสูญเสียฟันที่เพิ่มขึ้นมากกว่า จำนวนฟันแท้ที่เหลือของพระสงฆ์ที่ได้รับการตรวจเท่ากับ 18.6 ซี่ต่อคน และลดน้อยลงตามอายุ ร้อยละ 13.2 ไม่มีฟันเหลือในช่องปากเลย ร้อยละของพระสงฆ์ที่มีจำนวนฟันในช่องปากที่สามารถทำหน้าที่ได้เท่ากับ 49.9 ของพระสงฆ์อายุ 60-74 ปี และร้อยละ 35.2 ในกลุ่มพระสงฆ์อายุมากกว่า 75 ปีขึ้นไป นอกจากนี้ยังพบว่ามีฟันที่จำเป็นต้องได้รับการถอนอีก 2.2 ซี่ต่อคน ร้อยละ 13.2 ไม่มีฟันในช่องปากเลย*
สรุป: *ปัญหาการสูญเสียฟันของพระสงฆ์สูงอายุในกรุงเทพมหานครควรได้รับความสนใจเนื่องจากปัจจุบันพระสงฆ์มีอายุเฉลี่ยมากขึ้น สิ่งจำเป็นในการลดปัญหาการสูญเสียฟันในกลุ่มผู้สูงอายุต้องเน้นทั้งการป้องกันการเกิดรวมทั้งการรักษาโรคฟันผุและโรคปริทันต์ที่มีอยู่ไม่ให้ลุกลาม อีกทั้งควรมีการเน้นย้ำให้พระสงฆ์มีความรู้เกี่ยวกับการดูแลสภาวะช่องปากตนเองอย่างมีประสิทธิภาพ และควรสนับสนุนให้พระสงฆ์สูงอายุได้รับการตรวจฟันเป็นประจำ.*