

## Review Article

# The Influence of Oral Health Factors on the Quality of Life in Older People: A Systematic Review

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## Abstract

**Background and Objectives:** The number of people aged 65 years or older is growing substantially. As a result of increased health burden and tooth retention, more oral health problems are expected in this age group. A poor oral health-related quality of life (OHQoL) can compromise a person's psychological state, social relationships, personal beliefs, and physical health. The aim of this systematic review was to identify oral health factors associated with OHQoL in people aged 65 years or older and to give a comprehensive overview of the body of literature for each oral health factor separately.

**Research Design and Methods:** A comprehensive search was performed in five databases. The following terms were used as index terms or free-text words: "Oral Health," "Quality of Life," "Older People." Two researchers independently assessed studies for eligibility based on predefined criteria.

**Results:** Of 3,702 references retrieved from the databases, 68 studies were eligible and included (9 randomized clinical trials, 6 cohort studies, and 53 cross-sectional studies). All results were reported descriptively. OHQoL in people aged 65 years or older is positively associated with higher number of teeth, higher number of occluding pairs, implant-retained overdentures, and the shortened dental arch concept and negatively associated with xerostomia, orofacial pain, and poor chewing ability. In the current literature, there is no consensus on the association between edentulism, caries, and periodontal conditions and OHQoL.

**Discussion and Implications:** Having a functional dentition (either natural or prosthetic) is important for a good OHQoL, whereas painful or functional complaints are associated with impaired OHQoL.

**Keywords:** Oral health-related quality of life, Dental status, Dentition

In 2017, the United Nations published a report about global aging, showing that the older population is expected to increase substantially (United Nations, 2017).

Not only will the numbers of older people increase, but as older people are more likely to have comorbid disease

(Kassebaum et al., 2017), aging of the world population will lead to an increased number of people with multiple comorbid diseases (Kassebaum et al., 2017). Nowadays, due to improved dental care during the life span, older people tend to retain more natural teeth (Petersen, 2003).

Because impaired general health has a negative effect on oral health, and more older people have natural teeth, more oral health problems are expected in this population (Kassebaum et al., 2017).

Appropriate access to oral health care can improve the overall quality of life, even in older people with multimorbidity (Locker, Matear, Stephens, & Jokovic, 2002). The World Health Organization defines quality of life as “an individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (Gift, Atchison, & Dayton, 1997). Impaired quality of life can compromise a person’s psychological well-being, social relationships, personal beliefs, and physical health (Gift et al., 1997). To focus on how to improve the quality of life of an older person in dental care, it is important to know which oral health factors contribute to improved quality of life. Only a few previous reviews have reported on oral health factors influencing quality of life in adults (Ferreira, Dias-Pereira, Branco-de-Almeida, Martins, & Paiva, 2017; Gerritsen, Allen, Witter, Bronkhorst, & Creugers, 2010; Ilhan, Cal, Dundar, Guneri, & Daghan, 2015; Tan, Peres, & Peres, 2016). Strikingly, with the exception of a single article, there are no systematic reviews in the existing literature, which comprehensively synthesize the associations of oral health factors with quality of life in older people (Cunha et al., 2014). A person more than 65 years old may have different values and perspectives than an 18-year-old adult.

The concept of oral health-related quality of life (OHQoL) is based on the perspective that oral health conditions and diseases can undermine someone’s self-esteem and self-image, can cause other health problems, can discourage social interaction, and can lead to pain, stress, or depression (Bennadi & Reddy, 2013). Furthermore, it could influence vital functions, such as swallowing, speaking, and breathing (Rozier & Pahel, 2008). The most widely used method to assess OHQoL is multiple items questionnaires (Bennadi & Reddy, 2013). They often contain questions regarding a person’s perception on physical health, psychological status, and functional capacity (McGrath, Broder, & Wilson-Genderson, 2004).

One of the goals in dental care is to improve OHQoL of patients, which requires an understanding of which factors contribute to OHQoL (O’Boyle, 1997). In adults, OHQoL is affected by impaired oral health (Ilhan et al., 2015), including the number of remaining natural teeth, the number of occluding pairs, and the location of remaining teeth (Gerritsen et al., 2010; Tan et al., 2016), and periodontal disease (Ferreira et al., 2017).

A systematic review conducted in 2013 on the influence of oral health and literacy on OHQoL concluded that there is a negative impact of edentulism on OHQoL in people aged 65 years or older (Cunha et al., 2014). However, in this systematic review, the results of the 11 included studies were summarized separately, and the results were not

systematically reported for each oral health factor. With the exception of this single article, there are no other systematic reviews that describe the associations of oral health factors with OHQoL in older people. Because of global aging, the proportion of people aged 65 years or older attending dental care clinics will increase substantially. For dental care professionals, it is important to know which factors contribute to improved OHQoL, and what they should focus on when treating this specific population. Therefore, the aim of this systematic review was to identify oral health factors associated with OHQoL in people aged 65 years or older and to give a comprehensive overview of the body of literature for each oral health factor separately.

## Research Design and Methods

### Search Strategy

A review protocol was developed based on the Preferred Reporting Items for Systematic Reviews and Meta-Analysis-statement ([www.prisma-statement.org](http://www.prisma-statement.org)). A comprehensive search was performed in the bibliographic databases PubMed, Embase, EBSCO/CINAHL, EBSCO/PsycINFO, and Wiley/Cochrane Library from inception up to April 3, 2019, in collaboration with a medical librarian. The following terms were used (including synonyms and closely related words) as index terms or free-text words: “Oral Health,” “Quality of Life,” “Older People.” The search was performed without date or language restriction. After deduplication, all titles were screened and appropriate abstracts reviewed. The full search strategies for all databases can be found in Appendix 1 of the [Supplementary Material](#).

### Inclusion and Exclusion Criteria

The titles, abstracts, and full texts were reviewed according to the following inclusion and exclusion criteria. The inclusion criteria were as follows:

- randomized clinical trial (RCT) studies, cross-sectional studies, case-control studies, or cohort studies
- people aged 65 years or older
- participants stratified for oral health factor (eg, healthy vs. control)
- validated measurement tool for quality of life

Exclusion criteria were as follows:

- age below 65 years
- age not specified
- participants not stratified for oral health factors
- case report or review
- no usable data (eg, qualitative studies)

### Study Selection

Titles, abstracts, and full texts were independently screened by a dentist (L. R., MSc) and a dental master student (C. S., BSc). Conflicts were resolved by consensus meetings

between L. R., C. S., and R. W. (neurobiologist, PhD). Two articles were in other languages than English and were screened and assessed by a native speaker and dentist. The reference lists of all included studies were screened for additional relevant studies, but none were found.

## Quality Assessment

The quality of the included studies was assessed by one reviewer (L. R.). The quality of the included RCT studies was assessed by one reviewer with the Cochrane Risk of Bias Tool, which assesses RCT studies on selection bias, performance bias, detection bias, attrition bias, reporting bias, and other bias (Savović et al., 2014). The quality of the cohort studies was assessed with the Newcastle Ottawa Scale (NOS), which assesses cohort studies on selection, comparability, and outcome (Wells G, 2000). Furthermore, the quality of the included cross-sectional studies was assessed with the Appraisal tool for Cross-Sectional Studies (AXIS tool), which assesses cross-sectional studies on reliability and relevance (eg, selection bias, response bias, and internal consistency; Downes, Brennan, Williams, & Dean, 2016).

## Data Extraction

Two researchers extracted and reviewed the data from the eligible studies (L. R., C. S.). The following characteristics were extracted from the included studies: (i) design, (ii) country, (iii) age, (iv) population, (v) oral health factor, and (vi) outcome tool (validated instrument for quality of life).

The included studies were categorized according to the following oral health factors domains, which were predefined based on the literature (Gil-Montoya, de Mello, Barrios, Gonzalez-Moles, & Bravo, 2015; Turner & Ship, 2007; Ying Joanna & Thomson, 2015): (i) natural dentition, (ii) caries, (iii) periodontal conditions, (iv) prosthetic status, and (v) other oral health-related factors.

## Analysis

All results were reported descriptively and tabulated. Meta-analysis was considered. However, the studies and results were too heterogeneous (eg, different study designs and populations, different assessments of the measurements, and different outcome tools) to conduct meaningful meta-analysis.

## Results

### Study Selection and Characteristics

Of the 3,702 references retrieved from the databases, 68 studies were eligible and included (Figure 1). From the

68 studies, 9 were RCTs, 6 were cohort studies, and 53 were cross-sectional studies. Of the included studies, one was in Korean and one was in Portuguese (Park & Ryu, 2010; Rodrigues Gomes, Teixeira, & Pimenta Paço, 2015). Characteristics of included studies are described in Table 1. The included articles were published from 30 different countries with 49 conducted in community, 9 in institutional care, and 2 in both. Four studies included older people with dementia.

## Quality Ratings

Quality ratings are described separately for RCTs, cohort studies, and cross-sectional studies in Appendices 2, 3, and 4, respectively. In all RCTs, some sort of bias was present, five of six cohort studies were of poor quality according to the NOS, and the quality of the cross-sectional studies ranged from 10 to 20 criteria of the AXIS tool.

## Quality-of-Life Outcome Tools

Of the 68 included articles, 38 used the Oral Health Impact Profile (OHIP), or a variety of the OHIP, to measure OHQoL (Allen & Locker, 1997). Nineteen articles used the Geriatric Oral Health Assessment Index and nine articles used the Oral Impact on Daily Performance questionnaire to measure OHQoL (Adulyanon, 1997; Archison & Dolan, 1990). Furthermore, four articles used the Euroqol 5 Dimension to measure general quality of life (Krabbe, Stouthard, Essink-Bot, & Bonsel, 1999).

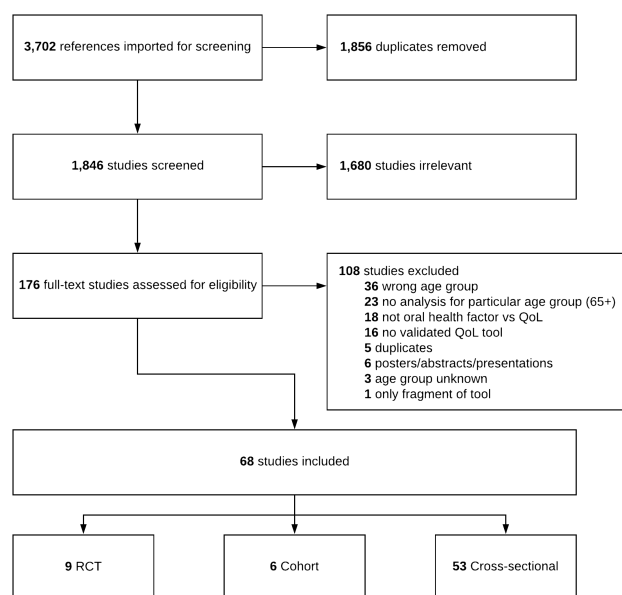


Figure 1. Flow diagram of study selection.

**Table 1.** Characteristics of Included Studies

Paper	Design	Country	N	Age mean (SD)	Population	Oral health factor(s)	Outcome (tool)
Alshammari et al., 2018	CS	Saudi Arabia	200	69.26 (SE 0.34)	Elderly patients aged 65+ attending dental clinics	NT, prosthetic status, pain	GOHAI-Ar
Astrom et al., 2018	Co-hort	Sweden	3,585	70	Swedish people born in 1942	Persistent tooth loss, FT	OIDP
Awad et al., 2003	RCT	Canada	60	65; 75	Persons between the ages 65 and 75 who wished to replace their dentures	IOD	OHIP, OHIP-EDENT
Campos et al., 2018	Co-hort	Brazil	32	76.7 (SD 6.3); 75.23 (SD 4.4)	Partially or completely edentulous elderly individuals with AD and without AD	New CD	GOHAI
Castrejon-Perez et al., 2017	CS	Mexico	655	70+	Home dwelling elders 70+	Xerostomia, prosthetic status, periodontal conditions	OHIP-14-SP
Chen et al., 2012	CS	Taiwan	400	77	Denture recipients under a new welfare and public health policy	Complete dentures	OHIP-14
Cho et al., 2019	CS	Korea	3,034	65+	Elderly people	Function	EQ-5D
Cicciù et al., 2013	CS	Italy	158	65–87	Dentate older people with AD	Periodontal conditions	OHIP-14
Cornejo et al., 2013	CS	Spain	194	65+	People aged 65 or older in long-stay centers	D vs ED, NT, DMFT, periodontal conditions, prosthetic status, dental appearance	GOHAI
da Silva et al., 2011	CS	Brazil	876	72.8	Elderly people	NT, AOM, prosthetic status	GOHAI
Dahl et al., 2011	CS	Norway	151	72.1 (68–77)	Adults of 68–77 years old	D vs ED, NT, DT	OHIP-14
Emami, 2009	RCT	Canada	255	70.0 (SD 4.8)	Edentulous elders (65+)	IOD	OHIP-20
Emami et al., 2010	RCT	Canada	173	66–88	Edentulous elders (65+)	IOD	OHIP-20
Eric et al., 2012	CS	Bosnia and Herzegovina	261	65+	Community-dwelling adults 65+	NT, NOP	OIDP
Eric et al., 2017	CS	Bosnia and Herzegovina	120	65+	Community-dwelling edentulous adults 65+	New CD	OIDP
Geckili et al., 2011	Co-hort	Turkey	78	65–82	Edentulous complete denture wearers seeking IOD	IOD	OHIP-14
Gerdin et al., 2005	CS	Sweden	41	83–91	Old people living at service homes	Xerostomia, hyposalivation	OHIP-14
Göktürk et al., 2018	CS	Turkey	110	72.1 (SD 4.33)	Elderly patients from the periodontology department	Periodontal conditions	GOHAI
Ha et al., 2012	Co-hort	Korea	439	65–93	Elderly, who were basic livelihood security recipients (65+)	Prosthetic status	OHIP-14
Hassel et al., 2007	CS	Germany	36	75+	Patients wearing FPD or RPD	Prosthetic status	OHIP-SUM
Heydecke et al., 2003	RCT	Canada	55	69.4; 68.9	Older people seeking denture replacement	IOD, new CD	OHIP-20
Hoeksema et al., 2017	CS	Netherlands	1,026	80 (IQR 77–84)	Community-living elderly participating in “samen ouder” program	Dentate, CD, IOD	EQ-5D

Table 1. Continued

Paper	Design	Country	N	Age mean (SD)	Population	Oral health factor(s)	Outcome (tool)
Hoeksema et al., 2018	CS	Netherlands	103	79 (72–85)	Community living older people	D vs ED	OHIP-14
Hsu et al., 2014	CS	Taiwan	332	76.0 (SD 0.4)	Community-dwelling, independently living elderly adults	NT, NOP, prosthetic status, function	GOHAI-T
Jabbour et al., 2012	RCT	Canada	172	71 (SD 4.5)	Edentulous females and males aged 65+	IOD, new CD	OHIP-20
Jensen et al., 2008	CS	USA	641	79.1	Community-dwelling elderly persons with disabilities	NT, xerostomia, CTN	OHIP-14
Johansson et al., 2012	CS	Sweden	9,813	65; 75	All 65 and 75 years of age	Xerostomia	OIDP
Jung et al., 2008	CS	Korea	268	72.27 (SD 5.22)	Community-dwelling older adults	NT, orofacial pain	OHIP-K
Kato et al., 2018	CS	Sweden	804	70, 78, 82, 86, 92	Men aged 70, women aged 70, 78, 82, 86 and 92	NT, periodontal conditions	OHIP-14
Klotz et al., 2017	CS	Germany	169	82.9 (SD 8.9)	Nursing home residents with or without dementia	NT, prosthetic status	GOHAI
Klotz et al., 2018	Co-hort	Germany	152	73.9 (SD 0.9)	people born in 1930–1932	Prosthetic status	GOHAI
Kohli et al., 2017	CS	USA	177	65+	institutionalized and community-dwelling older adults	D vs ED	OHIP-14
Komagamine et al., 2012	Co-hort	Japan	122	74.4	Edentulous patients requiring new CD	New CD	OHIP-EDENT
Lee et al., 2012	CS	Taiwan	947	65+	All elderly over the age of 65	D vs ED, prosthetic status, function	OHIP
Ling et al., 2014	CS	New Zealand	162	82.6 (SD 6.6)	Older people admitted to older persons' hospital wards	D vs ED, root DT	OHIP-20
Masood et al., 2017	CS	UK	1,277	65+	Older people	NMT, DT, root DT, PUFA, periodontal conditions, orofacial pain, prosthetic status	OHIP-14
McKenna et al., 2015	RCT	Ireland	89	65+	Partially dentate older patients	SDA, RPD	OHIP-14
McKenna et al., 2018	RCT	Ireland	89	65+	Partially dentate older patients	SDA, RPD	OHIP-14
Meneses-Gómez et al., 2016	CS	Colombia	342	72.6 (SD 5.9)	Elderly population receiving health care at the public hospital network	AOM, TMJ, prosthetic status	GOHAI
Mihara et al., 2018	CS	Japan	1,969	69–71, 79–81	Community-dwelling elderly residents	NT, function, prosthetic status	GOHAI
Motallebnejad et al., 2015	CS	Iran	300	71.4 (SD 5.6)	Elderly population	D vs ED, prosthetic status, CTN	OHIP-14
Müller et al., 2013	RCT	Switzerland	34	85.0 (SD 6.19); 84.1 (SD 5.55)	Very old edentulous patients who depend on help for activities of daily living	IOD	OHIP-EDENT
Nielsen et al., 2016	CS	Netherlands	235	73.1 (SD 5.4); 85.4 (SD 7.1)	Care-independent and care-dependent older population	DT, prosthetic status, CTN	GOHAI
Noguchi et al., 2017	CS	Japan	187	77.9 (SD 3.0)	Elderly 75+ who have pain in general	NT, DT, FT, periodontal conditions	GOHAI

Table 1. Continued

Paper	Design	Country	N	Age mean (SD)	Population	Oral health factor(s)	Outcome (tool)
Östberg et al., 2011	CS	Sweden	186	80+	People with pain problems	Function, dental appearance	OHIP-14
Paredes-Rodríguez et al., 2016	CS	Spain	30	80.50 (SD 8.93)	Nursing home residents with or without dementia	NT, xerostomia	OHIP-14
Park et al., 2010	CS	Korea	156	77.4 (SD 6.53)	Community-dwelling elders	NT, xerostomia, prosthetic status	OHIP-14
Pearson et al., 2007	RCT	UK	133	80.7; 79.5	Older patients requiring CD	New CD	OIDP
Porter et al., 2015	CS	UK	179	65–100	Older residents of nursing homes	Periodontal conditions, sensitive teeth, orofacial pain, xerostomia	OIDP
Rebello et al., 2016	CS	Brazil	613	69.27 (SD 3.01)	Elderly people	D vs ED, DMFT, prosthetic status	GOHAI
Rodrigues Gomes et al., 2015	CS	Portugal	207	65+	Older adults with diabetes	NT, DT, periodontal conditions, xerostomia	OHIP-14
Sáez-Prado et al., 2016	CS	Spain	202	65+	Elderly people aged 65 years or more	NT, NMT, DT, DMFT, FT	OHIP-14, EQ-5D
Santucci et al., 2015	CS	Malta	278	83.5 (SD 6.5)	State institutionalized older adults	NT, NMT, NOP, DT, DMFT, FT, periodontal conditions	OHIP-14, GOHAI
Shao et al., 2018	CS	China	744	69.3 (65–74)	Elders	NT, DMFT, root DT, periodontal conditions, prosthetic status	GOHAI
Sheiham et al., 2001	CS	UK	202	65+	Population aged 65 years and older	D vs ED, NT	OIDP
Skoskiewicz-Malinowska et al., 2019	CS	Poland	500	73 (65–99)	Urban residents at the age of 65+	Oral dryness	OHIP-14
Slade et al., 1996	CS	Australia, Canada, USA	1,642	65+	People aged 65 and older	NMT, root DT, RR, periodontal conditions	OHIP
Souza et al., 2017	CS	Brazil	7,619	69.09	Older people	D vs ED, prosthetic status, dental appearance	OIDP
Stenman et al., 2012	CS	Sweden	561	70	Elderly individuals	NT, burning mouth	OHIP-14
Strömberg et al., 2013	CS	Sweden	302	65–101	Homebound elderly	D vs ED, NT, DT, RR, periodontal conditions, prosthetic status	GOHAI
Tsakos et al., 2004	CS	Greece	681	71.4 (SD 5.4); 74.5 (SD 6.9)	Elderly population	NT, NOP, DT, root DT, periodontal conditions, prosthetic status	OIDP
Wu et al., 2017	CS	Hong Kong	195	75.3 (SD 6.7)	Community-dwelling elders	NT, NOP, DT, periodontal conditions	GOHAI
Yen et al., 2015	CS	Taiwan	277	76.0	Elderly individuals	NT, AOM, orofacial pain, halitosis, xerostomia, prosthetic status	GOHAI-T
Yoon et al., 2013	CS	Korea	479	74.6	Community-dwelling elders aged 65 years or above	NMT	OHIP-14



Table 1. Continued

Paper	Design	Country	N	Age mean (SD)	Population	Oral health factor(s)	Outcome (tool)
Yu et al., 2008	CS	China	155	80.0 (SD 7.2)	Hospitalised geriatric patients	D vs ED, NOP, periodontal conditions, xerostomia	GOHAI
Zhou et al., 2012	CS	China	913	73 (SD 6)	Older adults	prosthetic status	OHIP-14
Zuluaga et al., 2012	CS	Spain	215	82.9 (SD 7.6)	Institutionalized elderly	D vs ED, NT, NOP, DT	GOHAI
Zusman et al., 2016	CS	Israel	987	65+	Elderly	Prosthetic status, dental appearance	OHIP-14

Note. RCT = randomized controlled trial, CS = cross-sectional, USA = United States of America, UK = United Kingdom, SD = standard deviation, IQR = interquartile range, AD = Alzheimer's Disease, IOD = implant overdenture, FPD = fixed partial denture, RPD = removable partial denture, CD = conventional denture, D = dentate, ED = edentate, NT = number of teeth, NMT = number of missing teeth, DMFT = decayed missing and filled teeth, DT = decayed teeth, NOP = number of occlusal pairs, CTN = clinically assessed treatment need, PUFA = Presence of severely decayed teeth with visible pulpal involvement, Ulceration caused by dislocated tooth fragments, Fistula and Abscess, SDA = shortened dental arch, AOM = abnormalities oral mucosa, TMJ = temporomandibular joint, FT = filled teeth, RR = retained roots, OHIP = Oral Health Impact Profile, GOHAI = Geriatric Oral Health Assessment Index, ODP = Oral Impact on Daily Performance.

## Results Categorized in Domains

### Natural dentition

All reported associations regarding edentulism, number of teeth, number of missing teeth, and number of occluding pairs are shown in Table 2. Five studies reported significantly lower OHQoL in edentulous participants than in dentate participants (Hoeksema et al., 2017; Hoeksema et al., 2018; Motalebnejad, Mehdizadeh, Najafi, & Sayyadi, 2015; Stromberg, Holmen, Hagman-Gustafsson, Gabre, & Wardh, 2013; Zuluaga, Montoya, Contreras, & Herrera, 2012), two studies demonstrated a positive association between edentate patients in comparison to dentate patients and OHQoL (Lee, Yang, Ho, & Lee, 2012; Souza, Costa Oliveira, & Martins, 2017), and seven studies reported no significant association between edentulism and OHQoL (Alshammari, Baseer, Ingle, Assery, & Al Khadhari, 2018; Cornejo, Perez, de Lima, Casals-Pedro, & Borrell, 2013; Dahl, Wang, Holst, & Ohrn, 2011; Kohli, Sehgal, Nelson, & Schwarz, 2017; Rebelo, Cardoso, Robinson, & Vettore, 2016; Sheiham et al., 2001; Yu, Lee, Hong, Lau, & Leung, 2008). All studies regarding edentulism were cross-sectional studies. Only two studies, showing either no significant association or a negative association between edentulism and OHQoL, met all quality criteria of the AXIS tool (Hoeksema et al. 2018; Rebelo et al., 2016). One cohort study of poor quality showed that participants with permanent tooth loss were most likely to both worsen and improve OHQoL (Astrom, Ekback, Ordell, & Gulcan, 2018).

The number of natural teeth was found to be positively associated with OHQoL in 21 studies (Cornejo et al., 2013; Dahl et al., 2011; Eric et al., 2012; Ha, Heo, Jin, Paik, & Bae, 2012; Jensen, Saunders, Thierer, & Friedman, 2008; Jung & Shin, 2008; Kato et al., 2018; Klotz, Hassel, Schroder, Rammelsberg, & Zenthofer, 2017; Mihara et al., 2018; Satoshi Noguchi, Michiko Makino, Satoru Haresaku, Kaoru Shimada, & Toru Naito, 2017; Paredes-Rodriguez et al., 2016; Rodrigues Gomes et al., 2015; Saez-Prado, Haya-Fernandez, & Sanz-Garcia, 2016; Shao et al., 2018; Sheiham

et al., 2001; Silva et al., 2011; Stromberg et al., 2013; Tsakos, Marcenés, & Sheiham, 2004; Wu, Cheung, Lam, & Gao, 2017; Yen et al., 2015; Zuluaga et al., 2012), with 4 studies finding no significant association between number of teeth and OHQoL (Hsu et al., 2014; Park & Ryu, 2010; Santucci & Attard, 2015; Stenman, Ahlqvist, Bjorkelund, & Hakeberg, 2012). Regarding number of missing teeth, four studies found a significant negative association between number of missing teeth and OHQoL (Masood, Newton, Bakri, Khalid, & Masood, 2017; Saez-Prado et al., 2016; Santucci & Attard, 2015; Slade et al., 1996), whereas one study reported no significant association (Yoon et al., 2013). The study of Santucci and colleagues was conducted in institutionalized older people, whereas the other studies were conducted in community-dwelling older people.

One study reported a negative association between unfilled anterior spaces (gap between front teeth) and OHQoL (Stenman et al., 2012). Regarding occluding pairs (ie, the number of pairs of opposing lower and upper teeth), six of eight studies concluded that there was a positive association between the number of occluding pairs and OHQoL (Eric et al., 2012; Shao et al., 2018; Tsakos et al., 2004; Wu et al., 2017; Yu et al., 2008; Zuluaga et al., 2012). The two studies that did not find an association between the number of occluding pairs and OHQoL were of poor quality, meeting only 14 and 12 of 20 criteria of the AXIS tool (Hsu et al., 2014; Santucci et al., 2015).

In summary, there is no consensus on the influence of edentulism on OHQoL in people aged 65 years or older. However, there is overall agreement that a higher number of natural teeth and a higher number of occluding pairs are positively associated with OHQoL.

### Caries

In Table 3, the associations between OHQoL and decayed teeth, Decayed Missing and Filled Teeth (DMFT), filled teeth, root caries, and retained roots are given. Seven studies

**Table 2.** Associations of Oral Health Factors in the Natural Dentition Domain With Oral Health-Related Quality of Life

Paper	D vs ED	NT	NMT	NOP
Alshammari et al., 2018	N.S.			
Cornejo et al., 2013	N.S.	+		
da Silva et al., 2011		+		
Dahl et al., 2011	N.S.	+		
Eric et al., 2012		+		+
Ha et al., 2012		+		
Lee et al., 2012	–			
Hoeksema et al., 2017	+			
Hoeksema et al., 2018	+			
Hsu et al., 2014		N.S.		N.S.
Jensen et al., 2008		+		
Jung et al., 2008		+		
Kato et al., 2018		+		
Klotz et al., 2017		+		
Kohli et al., 2017	N.S.			
Masood et al., 2017			–	
Mihara et al., 2018		+		
Motallebnejad et al., 2015	+			
Noguchi et al., 2017		+		
Paredes-Rodríguez et al., 2016		+		
Park et al., 2010		N.S.		
Rebelo et al., 2016	N.S.			
Rodrigues-Gomes et al., 2015		+		
Saez-Prado et al., 2016		+	–	
Santucci et al., 2015		N.S.	–	N.S.
Shao et al., 2018		+		+
Sheiham et al., 2001	N.S.	+		
Slade et al., 1996			–	
Souza et al., 2017	–			
Stenman et al., 2012		N.S.		
Strömberg et al., 2013	+	+		
Tsakos et al., 2004		+		+
Wu et al., 2017		+		+
Yen et al., 2015		+		
Yoon et al., 2013			N.S.	
Yu et al., 2008	N.S.			+
Zuluaga et al., 2012	+	+		+

Note. D = dentate, ED = edentate, NT = number of teeth, NMT = number of missing teeth, NOP = number of occluding pairs, + = positive association, – = negative association, N.S. = no significant association.

found no significant association between decayed teeth and OHQoL (Dahl et al., 2011; Niesten et al., 2016; Noguchi et al., 2017; Rodrigues Gomes et al., 2015; Saez-Prado et al., 2016; Tsakos et al., 2004; Zuluaga et al., 2012), whereas four studies found a negative association between decayed teeth and OHQoL (Masood et al., 2017; Santucci et al., 2015; Strömberg et al., 2013; Wu et al., 2017). Four of five studies reported a negative association between DMFT and OHQoL (Rebelo et al., 2016; Saez-Prado et al., 2016; Santucci et al., 2015; Shao et al., 2018). Regarding filled teeth, three studies reported a negative association with OHQoL (Noguchi et al., 2017; Saez-Prado et al.,

**Table 3.** Associations of Oral Health Factors in the Caries Domain With Oral Health-Related Quality of Life

Paper	DT	DMFT	FT	Root caries	RR
Astrom et al., 2018			+		
Cornejo et al., 2013		N.S.			
Dahl et al., 2011	N.S.				
Ling et al., 2014				–	
Masood et al., 2017	–			+	
Niesten et al., 2016	N.S.				
Noguchi et al., 2017	N.S.		–		
Rebelo et al., 2016		–			
Rodrigues-Gomes et al., 2015	N.S.				
Saez-Prado et al., 2016	N.S.	–	–		
Santucci et al., 2015	–	–	N.S.		
Shao et al., 2018		–		–	
Slade et al., 1996				–	–
Strömberg et al., 2013	–				–
Tsakos et al., 2004	N.S.		–	N.S.	
Wu et al., 2017	–				
Zuluaga et al., 2012	N.S.				

Note. DT = decayed teeth, DMFT = Decayed missing and filled teeth, FT = filled teeth, RR = retained roots, + = positive association, – = negative association, N.S. = no significant association.

2016; Tsakos et al., 2004), whereas one study reported no significant association (Santucci et al., 2015), and one study reported a positive association (Astrom et al., 2018).

The link between root caries (caries located on the root surface of a tooth) and OHQoL remains unclear: three studies reported a negative association between root caries and OHQoL (Ling et al., 2014; Shao et al., 2018; Slade et al., 1996), one study reported a positive association (Masood et al., 2017), and another one found no significant association between root caries and OHQoL (Tsakos et al., 2004). Retained roots (partial root structure that remains in the jaw following fracture or severely damage by caries) were negatively associated with OHQoL, according to two studies (Slade et al., 1996; Strömberg et al., 2013).

One study found a negative association between the presence of severely decayed teeth, ulceration caused by dislocated tooth fragments, fistula, and abscesses and OHQoL (Masood et al., 2017). All studies on the influence of caries on OHQoL were cross-sectional studies, varying with a quality rating from 12 to 20 on the AXIS tool. The different findings of the studies cannot be explained by the overall difference in quality.

In summary, there is no consensus on the negative association between caries and OHQoL.

### Periodontal conditions

Associations between pocket depth, mobility, bleeding, gingivitis, periodontitis, and abnormalities of the oral mucosa and OHQoL are given in Table 4. Three studies reported



**Table 4.** Associations of Oral Health Factors in the Periodontal Conditions Domain With Oral Health-Related Quality of Life

Paper	Pocket depth	Mobility	Bleeding	Gingivitis	Periodontitis	AOM
Castrejon-Perez et al., 2017				N.S.	N.S.	
da Silva et al., 2011						–
Göktürk et al., 2018					–	
Kato et al., 2018					–	
Masood et al., 2017	N.S.		N.S.			
Meneses-Gomes et al., 2016						N.S.
Noguchi et al., 2017	N.S.					
Porter et al., 2015		–	–			
Rodrigues-Gomes et al., 2015					N.S.	
Santucci et al., 2015	–					
Shao et al., 2018	–					–
Slade et al., 1996	–					
Strömberg et al., 2013			+			
Tsakos et al., 2004		N.S.				
Wu et al., 2017	N.S.		N.S.			
Yu et al., 2008				–		

Note. AOM = abnormalities oral mucosa, + = positive association, – = negative association, N.S. = no significant association.

a negative association between pocket depth and OHQoL (Santucci et al., 2015; Shao et al., 2018; Slade et al., 1996), one study reported a negative association between mobility and bleeding and OHQoL (Porter et al., 2015), and one study reported a negative association between gingivitis and OHQoL (Yu et al., 2008). Two studies found a negative association between periodontitis and OHQoL (Göktürk & Uçan Yarkaç, 2018; Kato, Abrahamsson, Wide & Hakeberg, 2018). One study reported a positive association between a healthy periodontium and OHQoL (Cicciù et al., 2013).

On the other hand, more studies found no significant association between pocket depth (Masood et al., 2017; Noguchi et al., 2017; Wu et al., 2017), mobility (Tsakos et al., 2004), bleeding (Masood et al., 2017; Wu et al., 2017), gingivitis (Castrejon-Perez et al., 2017), or periodontitis (Castrejon-Perez et al., 2017; Rodrigues-Gomes et al., 2015) and OHQoL. In addition, two of three studies found a negative association between abnormalities of the oral mucosa (eg, ulcers, lichen planus, candidiasis) and OHQoL (da Silva et al., 2011; Shao et al., 2018).

Other studies found no significant association between periodontal inflammation (Yoon et al., 2013), and need for periodontal treatment and OHQoL (Cornejo et al., 2013). All studies regarding periodontal conditions were cross-sectional studies.

In summary, there is no consensus on the negative association between periodontal conditions and OHQoL. From the 18 included studies, 8 studies reported a negative association, 1 study reported a positive association, and 9 studies reported no significant association.

#### Prosthetic status

Table 5 shows the associations between the prosthetic status and OHQoL. Four studies found a positive association between the use of removable dentures and

OHQoL (Klotz et al., 2017; Motallebnejad et al., 2015; da Silva et al., 2011; Souza et al., 2017), six studies reported negative associations (Masood et al., 2017; Mihara et al., 2018; Stromberg et al., 2013; Yoon et al., 2013; Zhou, Zhang, Jiang, Wu, & Du, 2012; Zusman, Kushnir, Natapov, Goldsmith, & Dichtiar, 2016), and three other studies found no significant associations (Cornejo et al., 2013; Ha et al., 2012; Hsu et al., 2014). Only one of these studies, reporting no significant association, was a cohort study (Ha et al., 2012). All other studies were cross-sectional studies. A negative significant association between OHQoL and nonfunctional dentures (dentures without stability, retention, and extension) was reported by two studies (Castrejon-Perez et al., 2017; Klotz et al., 2017). Another cross-sectional study reported a negative association between OHQoL and dentures causing ulcers or bad breath (Alshammari et al., 2018).

One cohort study of good quality found an association between type of dental prosthesis and OHQoL, indicating a greater OHQoL in participants with a fixed dental prosthesis than those who wore removable dental prosthesis and conventional dentures (Klotz et al., 2018).

Moreover, after insertion of a new conventional denture, most studies, of which two RCTs, reported a positive association between new dentures and OHQoL (Campos, Ribeiro, & Rodrigues Garcia, 2018; Eric, Tihacek Sojic, Bjelovic, & Tsakos, 2017; Ha et al., 2012; Jabbour, Emami, de Grandmont, Rompre, & Feine, 2012; Komagamine et al., 2012; Pearson, Gibson, Davis, Gelbier, & Robinson, 2007), except for one RCT, which mentioned no significant association (Heydecke, Locker, Awad, Lund, & Feine, 2003).

Seven studies, of which five were RCTs, found statistically significant positive correlations between implant-retained overdentures in comparison with conventional dentures and OHQoL (Awad et al., 2003; Emami, 2009; Emami, Allison,

**Table 5.** Associations of Oral Health Factors in the Prosthetic Domain With Oral Health-Related Quality of Life

Paper	IOD vs CD	IOD vs new CD	Denture treatment need	PD vs CD	Using dentures	New CD
Awad et al., 2003	+					
Campos et al., 2018						+
Castrejon-Perez et al., 2017			–			
Cornejo et al., 2013			N.S./–		N.S.	
da Silva et al., 2011			–		+	
Emami et al., 2009	+					
Emami et al., 2010	+	+				
Eric et al., 2017						+
Geckili et al., 2011	+					
Ha et al., 2012				N.S.	N.S.	+
Heydecke et al., 2003	+					N.S.
Hoeksema et al., 2017	+					
Hsu et al., 2014					N.S.	
Jabbour et al., 2012	+					+
Klotz et al., 2017				N.S.	+	
Komagamine et al., 2012						+
Masood et al., 2017					–	
Mihara et al., 2018					–	
Meneses-Gomes et al., 2016			N.S.			
Motallebnejad et al., 2015					+	
Müller et al., 2013		+				
Nielsen et al., 2016				N.S.		
Park et al., 2010				N.S.		
Pearson et al., 2007						+
Rebello et al., 2016			–			
Shao et al., 2018			–			
Souza et al., 2017					+	
Strömberg et al., 2013					–	
Tsakos et al., 2004			–			
Yen et al., 2015			–	N.S. / –		
Yoon et al., 2013					–	
Zhou et al., 2012					–	
Zusman et al., 2016					–	

Note. IOD = implant-retained overdenture, CD = conventional denture, PD = partial denture, + = positive association, – = negative association, N.S. = no significant association.

Grandmont, Rompré, & Feine, 2010; Geckili, Bilhan, & Bilgin, 2011; Heydecke et al., 2003; Hoeksema et al., 2017; Jabbour et al., 2012). Also, implant-retained overdentures compared with new conventional prostheses showed positive correlations with OHQoL, according to two RCTs (Emami et al., 2010; Müller et al., 2013). One cross-sectional study reported no significant differences in OHQoL between patients with implant-retained overdentures and dentate patients (Hoeksema et al., 2017).

Furthermore, only one study reported positive associations between OHQoL and characteristics of the removable partial denture (RPD), such as esthetics, retention, and fit (Hassel, Rolko, Grossmann, Ohlmann, & Rammelsberg, 2007). This is in contrast with fixed partial dentures, where no significant association between OHQoL and esthetics was found (Hassel et al., 2007). One study found positive associations between OHQoL and the

esthetics and speech function of the conventional denture (Komagamine et al., 2012). For maxillary denture retention and mandibular denture stability, positive associations were found with OHQoL as well (Chen et al., 2012). McKenna and colleagues conducted an RCT, showing that, regarding tooth replacement strategies for partially dentate people, treatment according to the shortened dental arch (SDA) concept resulted in better OHQoL than treatment with RPD after 1-year and 2-year follow-up (McKenna et al., 2015; McKenna et al., 2018).

In summary, there is no consensus of the influence of the use of dentures on OHQoL. Being satisfied with the dentures, proper function of the dentures, and no need for denture treatment, were positively associated with OHQoL. Several RCTs show a positive effect of implant-retained overdentures on OHQoL, and one RCT shows a positive correlation of the SDA concept compared to RPD.

### Other oral health-related factors

The associations of other oral health factors that may have an influence on OHQoL are presented in Table 6. Most (8 of 10) included studies found statistically significant negative associations between xerostomia and OHQoL scores (Castrejon-Perez et al., 2017; Gerdin, Einarson, Jonsson, Aronsson, & Johansson, 2005; Johansson et al., 2012; Paredes-Rodriguez et al., 2016; Park & Ryu, 2010; Porter et al., 2015; Rodrigues Gomes et al., 2015). There was no statistically significant association between hyposalivation and OHQoL (Gerdin et al., 2005). One study found a significant negative association between OHQoL and clinical symptoms of oral dryness (Skoskiewicz-Malinowska, Malicka, Zietek, & Kaczmarek, 2019).

One study reported no significant associations between OHQoL and orofacial pain, in contrast to four other studies that found negative associations (Alshammari et al., 2018; Jung & Shin, 2008; Masood et al., 2017; Porter et al., 2015; Yen et al., 2015). The study that reported no significant association had the lowest quality rating (14/20; Yen et al., 2015).

Furthermore, negative associations between OHQoL and the following oral health factors were reported by cross-sectional studies: presence of symptoms in the temporomandibular joint (Meneses-Gomez et al., 2016), sensitive teeth (Porter et al., 2015), halitosis (Yen et al., 2015), clinically assessed treatment need (Jensen et al., 2008; Motallebnejad et al., 2015; Niesten et al., 2016), and a poor opinion of their dental appearance (Cornejo et al., 2013; Meneses-Gomez et al., 2016; Östberg & Hall-Lord, 2011; Souza et al., 2017; Stenman et al., 2012). There was no association between OHQoL and burning mouth (Stenman et al., 2012). Moreover, three studies found positive associations between OHQoL and chewing ability (Cho & Kim, 2019; Hsu et al., 2014; Östberg & Hall-Lord, 2011), but one study found no significant association (Lee et al., 2012). One study reported a significant positive association between occlusal force and OHQoL (Mihara et al., 2018).

In summary, OHQoL is associated with xerostomia, but no association was found with hyposalivation. Furthermore, orofacial pain and poor chewing ability were negatively associated with OHQoL.

### Discussion and Implications

The aim of this systematic review was to identify oral health factors associated with OHQoL in people aged 65 years or older and to give a comprehensive overview of the body of literature for each oral health factor separately. We found higher number of natural teeth, higher number of occluding pairs, being satisfied with dentures, proper function of dentures, and not having a need for denture treatment were positively associated with OHQoL. Implant-retained overdentures compared to conventional dentures, and SDA concept compared to RPD, resulted in a better OHQoL in people aged 65 years or older. Xerostomia, orofacial pain,

**Table 6.** Associations of Remaining Oral Health Factors With Oral Health-Related Quality of Life

Paper	Xerostomia	Orofacial pain	Chewing function
Alshammari et al., 2018		–	
Castrejon-Perez et al., 2017	–		
Cho et al., 2019			+
Gerdin et al., 2005	–		
Hsu et al., 2014			+
Jensen et al., 2008	N.S.		
Johansson et al., 2012	–		
Jung et al., 2008		–	
Masood et al., 2017		–	N.S.
Östberg et al., 2011			+
Paredes-Rodríguez et al., 2016	–		
Park et al., 2010	–		
Porter et al., 2015	–	–	
Rodrigues-Gomes et al., 2015	–		
Yen et al., 2015	N.S.	N.S.	
Yu et al., 2008	–		

Note. + = positive association, – = negative association, N.S. = no significant association.

and poor chewing ability were found to be negatively associated with OHQoL. There is no consensus in the current literature regarding the association between OHQoL and caries, periodontal conditions, and edentulism.

### Natural Dentition

Another systematic review concluded that edentulism in older people is associated with a poor quality of life (Cunha et al., 2014). However, they described the results of 11 articles separately, without clearly describing on what their final conclusion was based (Cunha et al., 2014). In our systematic search, it was found that most studies did not find a significant association between edentulism and OHQoL in people aged 65 years or older and that there were two studies that reported a better OHQoL in edentate participants, due to the absence of dental problems that can only occur in natural teeth (Lee et al., 2012; Souza et al., 2017). The overall consensus on the negative effect of tooth loss has also been reported in the adult population (Gerritsen et al., 2010; Tan et al., 2016). A systematic review on qualitative studies shows that tooth loss is not only associated with diminished oral function but is also associated with less self-esteem and loss of social status (Nordenram et al., 2013).

### Caries

In the current literature, there is no consensus on the influence of caries on OHQoL in people aged 65 years or older. Impaired OHQoL due to caries may be caused by pain, poor esthetics, or halitosis (Santucci & Attard, 2015). However,

it is important to acknowledge that carious lesions do not always cause pain or may not be in the esthetic zone, and as such, does not influence self-rated OHQoL.

### Periodontal Conditions

We found no consensus on the associations between periodontal conditions and OHQoL. Another systematic review found periodontal diseases have a negative impact on quality of life in adults, depending on the severity of the periodontal disease (Ferreira et al., 2017). However, periodontal disease is recognized as a “silent” disease, causing only a few or no symptoms, which could explain the results of the studies that did not find an association between periodontal conditions and OHQoL. Although periodontal disease may not directly lead to impaired OHQoL, it can ultimately lead to loss of teeth, and therefore have a negative impact on OHQoL in older people (Kato et al., 2018).

### Prosthetic Status

A previous review found a positive association between OHQoL and implant-retained overdentures compared to conventional dentures in the adult population (Strassburger, Kerschbaum, & Heydecke, 2006). We showed similar results for people aged 65 years or older. Implant-retained overdentures have better stability and retention, which supports patients’ satisfaction (Emami et al., 2010). This results in better chewing ability and improvement in esthetics, speech, food choice, and social activity (Heydecke et al., 2003). Dissatisfaction with conventional dentures is the most common reason to fit implant-retained overdentures, which could also explain the better OHQoL of implant-retained overdentures compared to conventional dentures (Geckili et al., 2011).

Furthermore, regarding tooth replacement strategies for partially dentate people, the SDA concept compared to RPDs resulted in a better OHQoL in people aged 65 years or older in this study. These results are in contrast with another review, which concluded that the SDA concept appears to be as feasible as RPD in terms of OHQoL in adults (Fueki & Baba, 2017). A recently conducted RCT showed no differences in chewing capacity between patients with SDA or RPD (Wallace et al., 2018). Besides, patients often indicate that they do not want to have removable dentures (Cronin, Meaney, Jepson, & Allen, 2009). The SDA concept can therefore be a good strategy to prevent overtreatment and discomfort of removable dentures while preserving a functional dentition (McKenna et al., 2015; McKenna et al., 2018).

### Other Oral Health-Related Factors

Xerostomia is negatively associated with OHQoL, according to a few reviews (Gil-Montoya et al., 2015). Xerostomia affects on difficulties in swallowing and chewing, burning

sensation, pain in salivary glands, and speech difficulties (Ying Joanna & Thomson, 2015).

Furthermore, our review shows that orofacial pain has a negative influence on OHQoL in people aged 65 years or older. In adults, besides dental pain, negative associations were reported between temporomandibular disorders and OHQoL (Dahlstrom & Carlsson, 2010). Pain is known to have a negative impact on a person’s physical and mental state, and social functioning (Sprangers et al., 2000).

Chewing ability has previously been reported as significantly related to lower OHQoL scores (Inukai, John, Igarashi, & Baba, 2010). In our review, poor chewing ability was also found to be negatively associated with OHQoL in people aged 65 years or older. This could be explained by diminished food intake and different food intake, which is caused by poor chewing ability (Hsu et al., 2014).

### Quality Assessment

From the 68 studies, 9 were RCTs, 6 were cohort studies, and 53 were cross-sectional studies. The RCT studies reported on the influence of implant-retained overdentures, conventional dentures, and the SDA concept on OHQoL, whereas the cohort studies reported on the influence of implant-retained overdentures, (new) conventional dentures, and fixed or removable dentures on OHQoL. All other oral health factors were described in cross-sectional studies. It is important to acknowledge that results reported by cross-sectional studies cannot be used to determine cause and effect. However, cross-sectional studies are commonly used to determine factors that associate with a certain health-related problem, in this case OHQoL. Most studies showed methodological flaws and some sort of bias. Performance and detection bias were often present in the RCT studies. According to the NOS, only one cohort study was of good quality and from the 53 cross-sectional studies, only three studies met all 20 criteria of the AXIS tool (Hoeksema et al., 2018; Porter et al., 2015; Rebelo et al., 2016).

### Strengths and Limitations

This is the first systematic review on OHQoL for people aged 65 years or older, including all oral health-related factors. Strengths include unrestricted literature searches, no language limitations, and study selection performed independently by two researchers.

Nonetheless, the sample size in each study varied greatly, from 32 participants in one study to a national survey (9,813 participants) study. Because of different study designs and populations, different assessments of the measurements, and different outcome tools, no meta-analysis could be performed. Furthermore, some studies did not adjust for confounders (eg, age, gender, educational level, frailty, and general health) and the nonresponse rate was often not described, resulting in an increased risk for



selection bias. In this review, we considered 65 years as the cutoff point for older people. It is important to acknowledge, however, that in other countries younger individuals could be considered as older people.

Most of the included studies were cross-sectional. Future research with longer follow-ups and RCTs are needed to understand causal associations.

## Clinical Implications

As people age, their perceptions and values with respect to quality of life may change (Stenman et al., 2012), and it is important to adjust the dental care accordingly. This review shows that to preserve a good OHQoL in dentate people aged 65 years or older, it is important to prevent tooth loss to preserve a good OHQoL. However, it should be acknowledged that more oral health problems can occur in dentate older people, due to impaired oral self-care and increased comorbid diseases (Kassebaum et al., 2017). This review shows that it remains unclear whether being dentate in people aged 65 years or older is preferable in terms of OHQoL than being edentate. People aged 65 years or older might benefit more from well-functioning dentures than from being dentate. More research is needed to determine at what point (eg, number of teeth, missing front teeth) having well-functioning dentures is preferred over being dentate in terms of OHQoL. Furthermore, dental care in this population must focus on being free of pain and retain proper chewing ability. The results of the included studies are at population level, which should not mask the diversity on individual level. It is therefore recommended to evaluate each person's perceptions and wishes separately, to achieve the best possible treatment choice.

## Conclusion

This is the first systematic review on OHQoL for people aged 65 years or older, including all oral health-related factors. Having a functional dentition (either natural or prosthetic) is important for a good OHQoL, whereas painful or functional complaints are associated with impaired OHQoL.

## Supplementary Material

Supplementary data are available at *The Gerontologist* online.

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## Conflict of Interest

The authors declare that there are no conflicts of interest.

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