Not such a dry subject

Dental Tribune details the opening plenary session, Xerostomia and Hyposalivation: Mechanisms and solutions, at this year’s meeting of the European Association of Oral Medicine

The 10th Biannual Meeting of the European Association of Oral Medicine, held in London, was a truly collaborative effort. Organised by the EAOM and the three London dental schools (King’s College London, Queen Mary University of London and the Eastman Dental Institute of University College London) and supported by GSK, the conference highlighted the importance of oral medicine in diagnosing and treating conditions such as xerostomia and hyposalivation.

The opening plenary session of the main part of the conference was dedicated to this topic. After opening remarks by Baroness Gardner of Parkes and Chief Dental Officer for England Dr Barry Cockcroft, it was time to turn over the session to the two Chairs, Prof Isaac van der Waal (head of the Department of Oral and Maxillofacial Surgery and Oral Pathology of the VU University Medical Center/ACTA Dental School, Amsterdam) and Prof Crispian Scully CBE (director of Special Projects at the UCL Eastman Dental Institute (EDI); Professor of Special Care Dentistry, University College London). After setting the scene for the session, they introduced the first speaker, Prof Stephen Porter.

Prevalence

Prof Porter is Director and Professor of Oral Medicine of UCL Eastman Dental Institute. His presentation, Hyposalivation: Prevalence, assessment, differential diagnosis and quality of life impact, gave a general overview of the problem of xerostomia in terms of prevalence. He discussed the age factor in the condition, as well as issues such as immuno-suppressant disease and drug/radiotherapy treatments. He also looked at the issue from the point of view of the patient, whose quality of life can be affected because of reduced sleep and impaired eating function.

Next to speak was Dr Jackie Brown, specialist in Oral & Maxillofacial Radiology. She is Consultant in Dental & Maxillofacial Radiology at Guy’s & St Thomas’ Hospitals Foundation Trust, and is Senior Lecturer at King’s College London Dental Institute of Guy’s, King’s College & St Thomas’ Hospitals and at the Eastman Dental Institute. Dr Brown’s presentation, Contemporary imaging in salivary gland disease diagnosis, looked at the role of imaging in the distinguishing and identifying diseases affecting the salivary glands. She discussed the various imaging equipment.
available, including ultrasound and Cone Beam Computed Tomography (CBCT), and their advantages and disadvantages.

Then it was the turn of Prof Gordon Proctor, Professor of Salivary Biology; Head of Salivary Research Unit; Department of Clinical Diagnostic Sciences, King’s College London Dental Institute. He discussed Drug related hyposalivation: a review of physiology and sites of drug action. Prof Proctor highlighted the relationship between drug therapy and salivary flow rates. He discussed the findings from various studies looking at this relationship, including one specific paper by Wolff et al. Major salivary gland output differs between users and non-users of specific medication categories (published in Gerodontology in Feb 2008).

Viral Infection Speaking just before the coffee break was Prof Jennifer Webster-Cyrilcave, Associate Professor, Departments of Dental Ecology and Microbiology and Immunology, University of North Carolina Chapel Hill Schools of Dentistry and Medicine. Viral infections of salivary glands resulting in hyposalivation took a look at various viral infections that can affect saliva production, including HIV, Herpes and Polyomaviruses including BKV. One of the main challenges, said Prof Webster-Cyrilcave, is determining how viruses get into and infect the salivary cells.

Following the coffee break, where there was a chance to network and discuss the morning’s presentations, came Prof Roland Jonsson, Vice-chairman of the Gade Institute at the University of Bergen. His lecture dealt with Immunopathology resulting in hyposalivation. He mainly focused on Sjogren’s Syndrome, where there was a chance to network and discuss the relationship between drug therapy and salivary flow rates. He discussed the findings from various studies looking at this relationship, including one specific paper by Wolff et al. Major salivary gland output differs between users and non-users of specific medication categories (published in Gerodontology in Feb 2008).

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Next, Prof Sue Lightman, MRC Senior Clinical Fellow/ Senior Lecturer at the Institute of Ophthalmology and Consultant Ophthalmologist at Moorfields Eye Hospital in London, looked at Ocular associations of hyposalivation. She detailed how quickly dry eyes can occur and how the treatment of patients suffering with xerostomia. The first thing clinicians have to remember, said Dr Fox, is at the end of the day we have to treat patients. One thing clinicians have to remember, said Dr Fox, is at the end of the day we have to treat patients. One thing clinicians have to remember, said Dr Fox, is at the end of the day we have to treat patients. One thing clinicians have to remember, said Dr Fox, is at the end of the day we have to treat patients. One thing clinicians have to remember, said Dr Fox, is at the end of the day we have to treat patients.

Time to talk about dry mouth?

Approximately 20% of people suffer symptoms of dry mouth, primarily related to disease and medication use. More than 400 medicines are associated with dry mouth, especially if 3 or more are used together.1

Ask your patients Some patients develop advanced coping strategies for dealing with dry mouth, unaware that there are products available that can help to provide protection against dry mouth, like the Biotène system.

Diagnosing dry mouth Four key questions have been validated to help determine the subjective evaluation of a patient’s dry mouth:
1. Do you have any difficulty swallowing any foods?
2. Does your mouth feel dry when eating a meal?
3. Do you spill liquids to aid in swallowing dry food?
4. Does the amount of saliva in your mouth seem to be too little, too much or you do not notice?

Clinical evaluations can also help to pick up on the condition, in particular:

• Use of the mirror ‘stick’ test – place the mirror against the buccal mucosa and tongue. If it adheres to the tissues, then salivary secretion may be reduced.
• Checking for saliva pooling – is there saliva pooling in the floor of the mouth?
• Determining changes in caries rates and presentation, looking for unusual sites, e.g. incisal, cuspal and cervical caries.

Dry mouth can be a leading cause of bad breath and may lead to caries or gum disease.

Detailed look This session was a very detailed investigation at some of the causes of xerostomia and hyposalivation and allowed delegates to get a better understanding of how these conditions affect salivary flow; as well as get an update on the treatment behind many of the products clinicians can recommend to patients for relief.

The Biotène System The Biotène formulations supplement natural saliva, providing some of the missing salivary enzymes and proteins in patients with xerostomia and hyposalivation to replenish dry mouths. The Biotène system allows patients to choose appropriate products to suit in with their lifestyles.

Products specially formulated for dry mouth:
• Biotène Orabalance Saliva Replacement Gel – For relief of dry mouth
• Biotène Orabalance Liquid

Hygiene Products:
• Biotène Fluoride Toothpaste
• Biotène Moisturising Mouthwash

The range is specially formulated for individuals experiencing dry mouth or related oral irritations:

• Alcohol free
• Methyl Salicylate

The Biotène range:
• Helps maintain the oral environment and provide protection against dry mouth
• Helps supplement saliva’s natural defences

Dry mouth can be a leading cause of bad breath and may lead to caries or gum disease.