

Poor Dental Health as leading Risk Factor for noninfectious Diseases: One of major WHO Concerns in 21st Century (note)

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Original Article

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Source: *Clinical Social Work and Health Intervention*
Pages: 42 – 44

Volume: 13
Cited references: 13

Issue: 5

Reviewers:

Yanna Trilisinskaya
Bujumbura, BI
Joseph Hasto
Trencin, SK

Keywords:

Dental. Health.

Publisher:

International Society of Applied Preventive Medicine i-gap

CSWHI 2022; 13(5): 42 – 44; DOI: 10.22359/cswhi_13_5_08 © Clinical Social Work and Health Intervention

Abstract:

Poor dental health in a known risk factor for cardiovascular and cancer portality in long term horizon. In Acute cases, infectious endocarditis with 10% mortality attributable directly to poor dental health, caries dentis, and dental surgery or napropriate implantation are classical examples of infectious diseases related mortality, and chronic inflammation for head and neck neoplasia, and systemic arteriosclerosis.

Introduction

Poor dental health is still one of the major WHO concerns. The commonest infection is dental caries causing chronic inflammatory syndrome leading to accelerated atherosclerosis and hypoxia of important systems such as the immune and cardiovascular. Therefore, access to dental practice in acute cases for free and for implantology and chronic care covered by Health Maintenance Organisations from the public health point of view are crucial for a decrease of cancer and cardiovascular complications, morbidity and mortality.

Acute and chronic infectious diseases consequences

Chronic caries, gingivostomatitis, are known risk factors for immune system activation and acceleration of chronic immune organ disorders including chronic glomerulonephritis and arthritis. Severe orofacial infection may cause acute or subacute meningitis and endocarditis, with 10-13% mortality (1-2)

Noninfectious diseases

Infections and mechanical irritation in the oral cavity may cause long term consequences of oral neoplasia, as a cause of mechanical and local irritation and inflammation. In addition,

one or other great WHO concern are chronic dental cares and gingivostomatitis related inflammatory syndrome leading to accelerated atherosclerosis. Therefore, death due to cardiovascular and cerebrovascular diseases is significantly up to two times higher in countries not covering long term health care. (34)

Oral symptoms of other chronic diseases

Apart of precancerosis such as leukoplakia, and chronic ulcers leading to head and neck cancers, many other neoplasms are manifested firstly in the oral cavity. Therefore, not only doctors but also other staff including nurses, etc., may play when properly trained for early diagnosis of localized neoplasia, in Sub-saharan Africa, eg., for Kaposi sarcoma or other lymphoma related with HIV. In addition many infections including omikron variant based COVID first start with symptoms in the oral cavity. (56)

Conclusion

Dental technology, dental technics, oral health and hygiene, are scientifically known, and available in most EU, US and other higher income countries. However, most third world countries, with lower income, have virtually no access either to regular prophylactic nor to acute healthcare. In addition, past COVID pandemics, war conflicts, separate completely huge numbers of patients or potential patients from any kind of dental care apart from plastic surgery and traumatology. (1-6)

Therefore, all efforts leading to better access to acute and chronic healthcare are emerging tasks from WHO for those countries which have capacities to serve in dental health not only for their local patients, but once or twice a year, during their holidays, go to countries during post war rehabilitation, currently Iraq, Sudan, Syria, Rwanda etc, and in future to Ukraine, not only to help suffering patients and victims of war, but also to help to secure better cardiovascular health for all, as WHO underlines in their strategy until 2030.

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