The rising occurrences of Xerostomia (dry mouth) in patients was one of the most talked-about issues at the International Symposium on Dental Hygiene, recently held at the Scottish Exhibition and Conference Centre in Glasgow. So it was unsurprising that it was a packed room for Prof. Michael Lewis' presentation The role of the dental hygienist in the diagnosis and management of dry mouth in association with GSK.

Lewis is Professor of Oral Medicine in the School of Dentistry, Associate Dean for Postgraduate Studies and Dean of the Dental Faculty at Cardiff University. He is also Vice-President of the Royal College of Physicians and Surgeons of Glasgow.

The lecture began with Prof. Lewis setting the scene for the lecture with his alternative title Unlocking the secrets of saliva. His aim was to inform delegates of the production of saliva, its components, the effects of reduced salivary production, and what can be done to help patients with this condition.

Prof. Lewis explained that there are three major paired glands that produce 95 per cent of saliva: the parotid (60 per cent), the submandibular (30 per cent) and the sublingual (5 per cent). The rest is produced by more than 600 minor or accessory glands mainly found in the lips, cheek and palate.

The lecture moved on to the role of the dental hygienist in the diagnosis and management of dry mouth in association with GSK. Prof. Lewis detailed the manner in which salivary flow rate is neurally controlled—it is excited by taste and mechanical stimuli but inhibited by feelings such as anxiety. Owing to its importance in speech, as a buffer against acid attack, cleansing antimicrobial actions etc., a reduced flow rate soon manifests as a problem. Symptoms often mentioned by patients include a lack of taste, difficulty in swallowing, and increased effort when speaking. Immediate signs in the mouth observed by clinicians include no saliva pooling in the mouth, frothy or cloudy saliva, sticky/erythematous mucosa, atrophic tongue dorsum, candidosis, and angular cheilitis. One big marker for xerostomia, explained Prof. Lewis, is the occurrence of cervical caries and failed restorations.

Moving from theory to practice, Prof. Lewis then discussed what clinicians can do for patients presenting with dry mouth. He stressed the importance of investigation into the causes of dry mouth for each patient, to ensure any underlying condition has been identified and medication use explored.

Means of investigation can include clinical exam (discussion with patient; appearance of patient, i.e. face, hands, gait; appearance of saliva; ‘mirror sticks test’—a dental mirror will often stick to the buccal mucosa if there is reduced saliva), salivary flow rate tests, haematological tests, sialography and labial gland biopsy.

Once the cause of the condition has been identified, both the clinician and patient can focus on the way in which to manage it, commented Prof. Lewis. For example, it may be possible to suggest a change in medication to one that does not list dry mouth as a side effect; or a diagnosis of diabetes should see improved glycaemic control on behalf of the patient and subsequent resolution of dry mouth symptoms.

There are many salivary substitutes that can be recommended. Prof. Lewis described a few of these, as well as the benefits and disadvantages of using them. The most graphic disadvantage was of Salinum, described as "like licking a cricket bat!" Owing to their formulation and ease of use, oral care systems such as the Biotène range have proved very popular with patients.

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