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Prevalence of Oral Diseases and Assessment of Quality of Life in Geriatric patients with and without comorbidities – A Systematic Review

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ABSTRACT

Background: The global rise in the ageing population has increased the burden of chronic oral diseases among older adults, particularly in regions with limited geriatric-focused healthcare resources. Age-related physiological decline, multimorbidity, and polypharmacy collectively heightened susceptibility to dental caries, periodontal disease, tooth loss, xerostomia, and prosthetic complications. Despite this growing concern, evidence on how comorbidities influence oral health and quality of life among geriatric individuals remained fragmented.

Aim: This systematic review aimed to determine the prevalence of oral diseases among geriatric adults and to assess oral health-related quality of life (OHRQoL), while examining the impact of comorbidities, multimorbidity, and polypharmacy.

Materials and Methods: The review was conducted according to PRISMA 2020 guidelines and was prospectively registered in PROSPERO [CRD420251232457]. A comprehensive search of PubMed, Scopus, Web of Science, Cochrane Library, and Google Scholar was performed for studies published from January 2000 up to date. Observational studies involving adults aged ≥60 years that reported oral health indicators and OHRQoL using validated instruments (GOHAI, OHIP) were included. Data extraction and quality appraisal were carried out independently by two reviewers using the Joanna Briggs Institute (JBI) checklist. Due to heterogeneity across populations and assessment tools, a narrative synthesis was employed.

Results: Five studies met the eligibility criteria, representing institutionalized Italian elders, tribal elders in Kerala and Tamil Nadu, dental outpatients in Delhi, and community-dwelling older adults in Iran. Across all settings, high levels of dental caries, periodontal destruction, tooth loss, and inadequate prosthetic rehabilitation were observed. OHRQoL was consistently reduced, with the poorest scores among individuals with multimorbidity and functional impairment. Comorbidities and polypharmacy showed strong associations with compromised oral health and diminished OHRQoL.

Conclusion: Oral diseases remained a major public-health concern among geriatric adults. The strong influence of comorbidities, multimorbidity, and polypharmacy on oral health underscored the need for integrating oral healthcare into routine geriatric services. Targeted preventive strategies, improved accessibility, and interdisciplinary care

approaches are essential to enhance functional well-being and quality of life in ageing populations.

Keywords: ageing population, comorbidities, dental caries, elderly populations, GOHAI, geriatric oral health, multimorbidity, OHIP, older adults, oral health-related quality of life (ohrqol), periodontal disease, polypharmacy, prosthetic status, quality of life, systemic diseases, tooth loss.

INTRODUCTION

The global demographic transition toward an ageing population has emerged as one of the defining public health challenges of the twenty-first century. Improvements in increasing life expectancy, declining fertility rates, and improvements in medical care have collectively increased the proportion of adults aged 60 years and above in nearly every region of the world[1,2,3]. This demographic shift holds significant implications for health care systems, particularly in low and middle income countries, where resources remain strained and geriatric-specific services are limited. As older adults increasingly represent a higher proportion of primary healthcare utilization understanding the multiple dimensions of their health particularly oral health has become essential.[4,5]

Ageing is accompanied by a gradual decline in physiological resilience, immune competence and tissue repair capacity. These changes increase susceptibility to a wide range of oral diseases including dental caries, root caries, periodontal disease, tooth loss, mucosal lesions, xerostomia and prosthetic complications.[6,7] These conditions accumulate progressively across the lifespan and when untreated can profoundly impair chewing efficiency, dietary adequacy, communication, and social participation. Consequently, oral health is now recognized as a critical determinant of general health, functional independence, nutritional status, psychological well-being, and overall quality of life in older adults.[8,9,10]

The oral health needs of older individuals rarely exist in isolation. Instead, they are deeply intertwined with the presence of systemic diseases, which are increasingly prevalent with advancing age.[7,11,12] Chronic conditions such as diabetes mellitus, hypertension, cardiovascular disease, arthritis, respiratory disorders, thyroid dysfunction and cognitive impairment are highly prevalent among older adults and often have direct or indirect implications for oral health.[13,14,15] For example, uncontrolled diabetes is linked with increased periodontal destruction[16,17], arthritis limits manual dexterity and reduces the effectiveness of oral hygiene[18] and chronic respiratory conditions or cardiac medications frequently cause salivary gland dysfunction.[19] These complex interactions underscore that oral health cannot be addressed independently of the broader medical context of ageing individuals.

Compounding this complexity is the widespread phenomenon of multimorbidity, defined as the coexistence of multiple chronic conditions within a single individual.[20] Multimorbidity often necessitates long-term use of multiple medications, leading to polypharmacy which introduces additional oral health complications such as xerostomia, altered taste, oral burning sensations, and increased caries risk.[21,22,23] Polypharmacy also places older adults at greater risk of drug interactions, adverse effects and reduced adherence to both medical and dental care regimens. In the presence of such intersecting factors, oral diseases may progress rapidly, remain untreated or further contribute to systemic decline.[24,25]

As the clinical manifestations of oral disease interact with systemic disease burden, their impact extends beyond physical symptoms to influence daily functioning and social engagement. This has led to increasing emphasis on oral health-related quality of life (OHRQoL), a multidimensional construct that captures the functional, emotional, and psychosocial consequences of oral conditions.[26] Instruments such as the General Oral Health Assessment Index (GOHAI)[27] and the Oral Health Impact Profile (OHIP)[28,29] have become central to geriatric oral health research providing insight into how older adults perceive and experience the effects of oral disease. These measures offer valuable information that complements clinical findings, particularly given that older adults may adapt to long-standing oral conditions or underreport symptoms due to low expectations of oral health in old age.[30]

Despite growing recognition of the significance of geriatric oral health, existing literature remains fragmented and context specific. Oral disease patterns vary widely across geographic, socioeconomic and cultural groups with marginalized communities such as tribal populations, low-income rural elders and institutionalized older adults often experiencing the highest burden of unmet needs. Additionally, while individual studies have described associations between systemic comorbidities and poor OHRQoL, a consolidated understanding of how multimorbidity and polypharmacy influence oral health outcomes is still lacking. This gap is particularly evident in low-resource settings and developing regions, where research data are sparse and geriatric oral health services remain underdeveloped.

The present systematic review seeks to integrate evidence across diverse populations to provide a comprehensive evaluation of oral disease burden and OHRQoL in geriatric individuals with specific focus on the influence of comorbidities, multimorbidity and polypharmacy.

Accordingly, the primary objectives of this review are to:

- Describe the prevalence and distribution of major oral diseases among geriatric adults
- Evaluate OHRQoL outcomes using validated assessment tools
- Examine the association of comorbidities, multimorbidity, and polypharmacy with oral health status and OHRQoL
- Provide evidence-based recommendations for integrating oral health into geriatric and primary-care frameworks.

Through this comprehensive examination, the review underscores the pressing need to recognize oral health as an essential component of holistic geriatric care and highlights opportunities to enhance functional well-being and quality of life among older adults.

MATERIALS AND METHODS

Protocol

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) guidelines.[31] The review protocol was prospectively registered in the PROSPERO International Prospective Register of Systematic Reviews[32] (Registration ID: CRD420251232457).

Search Strategy

A comprehensive literature search was performed across multiple electronic databases to identify studies reporting oral health status and oral health-related quality of life among geriatric individuals with and without comorbidities. The following databases were searched:

• PubMed/MEDLINE
• Scopus
• Web of Science
• Google Scholar
• Cochrane Library

The search included publications from January 2000 up to date.

Search Terms

A combination of Medical Subject Headings (MeSH) and free-text keywords was used. Search strings included:

"geriatric" OR "elderly" OR "older adults" OR "senior citizens"
"oral health" OR "dental caries" OR "periodontal disease" OR "tooth loss"
"oral health related quality of life" OR "OHRQoL" OR "GOHAI" OR "OHIP"
"comorbidity" OR "multimorbidity" OR "polypharmacy" OR "systemic diseases"

Boolean operators (AND/OR), phrase matching and appropriate database specific filters were applied to refine searches.

Additional Search Methods

• Manual searching of reference lists of relevant articles
• Screening of gray literature sources, including WHO and government health reports
• Cross-checking citations using Google Scholar's "cited by" feature

All identified records were imported into a reference manager and duplicate records were removed.

Study Selection

A two-stage screening process was employed:

Stage 1: Title and Abstract Screening

Two reviewers independently screened the titles and abstracts of all retrieved records. Studies clearly not related to geriatric oral health or quality of life were removed.

Stage 2: Full Text Review

Full-text articles that met initial screening criteria were assessed. Any disagreement between reviewers was resolved through consensus.

The PRISMA flow process i.e. identification, screening, eligibility, and final inclusion was followed throughout the selection procedure (Figure 1).

Figure 1: PRISMA Flowchart

Eligibility Criteria

Inclusion Criteria

Studies were included if they met the following criteria:

- Population: Geriatric individuals aged ≥60 years.
- Design: Observational studies (cross-sectional, case–control or cohort).
- Outcomes:
  - Oral health parameters including DMFT, periodontal status, edentulism, mucosal lesions, prosthetic needs.
  - OHRQoL outcomes measured using validated tools (GOHAI, OHIP).
- Exposure Variables: Presence and reporting of comorbidities, multimorbidity or polypharmacy.
- Publication: Full-text articles published in English.

Exclusion Criteria

Studies were excluded if they:

- included participants <60 years;
- lacked oral health assessments;

- did not evaluate OHRQoL;
- were interventional studies, reviews, case reports, theses, or abstracts;
- acked extractable numerical or descriptive data.

Data Extraction

A standardized data extraction sheet was used. The following information was collected from each eligible study:

- Study characteristics: country, setting, design, sampling method, sample size, demographic profile.
- Oral health findings: DMFT scores, caries prevalence, periodontal status, attachment loss, edentulism, prosthetic status and needs.
- Systemic health profile: type and prevalence of comorbidities, presence of multimorbidity, medication use, polypharmacy.
- OHRQoL data: instrument used, mean and domain-specific scores.
- Statistical results: regression findings, odds ratios, p-values, associations between comorbidities and oral health or OHRQoL.

Data extraction was conducted independently by two reviewers and cross-verified to ensure accuracy.

Quality Assessment

The methodological quality of included studies was assessed using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist[33] for analytical cross-sectional studies.

Domains assessed included:

- clarity of inclusion criteria;
- sample representativeness;
- measurement reliability of oral health indicators;
- validity and consistency of OHRQoL instruments;
- adequacy of statistical analysis;
- control of confounding factors.

Each study was categorized as low, moderate or high risk of bias, and discrepancies were resolved through reviewer consensus (Table 5).

Outcome Measures

Primary Outcomes

- Prevalence of oral diseases in elderly individuals.
- Oral health related quality of life scores (overall and domain-specific).
- Secondary Outcomes
- Impact of systemic comorbidities and multimorbidity on oral health and OHRQoL.
- Effect of polypharmacy on oral conditions and quality of life.
- Predictors of poor oral health and reduced OHRQoL.

Data Synthesis

Owing to heterogeneity across study populations, assessment tools and reporting formats, meta-analysis was not appropriate. A descriptive narrative synthesis was performed instead. Findings were organized under the following themes:

- Study characteristics
- Oral disease burden
- OHRQoL outcomes
- Influence of comorbidities and multimorbidity
- Determinants of low OHRQoL

Patterns were compared across different socioeconomic and clinical contexts to identify common trends and variations.

RESULTS

Five studies met the inclusion criteria.

Author (Year)	Study	Country / Setting	Sample Size	Age (Mean / Range)	Key Population Features
Sukumar et al. (2025) [34]	Tooth morbidity and its impact on oral related quality of life in elderly tribal population-The Irula experience.	Tamil Nadu, India (Irula tribal elderly)	881	Majority 60–69 yrs	Severe oral disease burden; 61.9% illiterate; 76.4% female
Rezaei Majd et al. (2025) [35]	Multimorbidity and polypharmacy in older adults, and their impact on oral health-related quality of life.	Iran (Community-dwelling elderly)	800	69.30 ± 7.03	High multimorbidity (66.1%); low literacy (57.7% illiterate)
Bianco et al. (2021)[36]	Oral Health Status and the Impact on Oral Health-Related Quality of Life among the Institutionalized Elderly Population: A Cross-Sectional Study in an Area of Southern Italy	Italy (Institutionalized elderly)	288	Mostly 65–79 yrs	High tooth loss; low denture use; institutionalized adults
Neelamana et al. (2020) [37]	Oral health status and related quality of life among elderly tribes in India	Kerala, India (Tribal elderly)	310	≥60 yrs	47.5% attachment loss; poor access to dental care
Chahar et al. (2019)[38]	Oral health-related quality of life among elderly patients visiting special clinics in public hospitals in Delhi, India: A cross-sectional study.	Delhi, India (Dental OPD)	400	~65–75 yrs	High untreated caries, periodontal disease

TABLE 1: Characteristics of Included Studies

Author	DMFT (Mean)	Decayed Teeth	Missing Teeth	Periodontitis	Edentulism	Prosthetic Status
Sukumar et al. (2025) [34]	ICDAS-based	38.5% caries prevalence	53.6% tooth loss	70.8% periodontitis	Not directly stated	Only 2.3% restorations present
Rezaei Majd et al. (2025)[35]	–	–	–	Not reported	–	–
Bianco et al. (2021) [36]	26.4 ± 7.5	3.5 ± 4.6	22.5 ± 9.5	High; GI = 1.77; PI = 2.23	31.9%	27.1% denture use; 26.1% edentulous w/o dentures
Neelamana et al. (2020)[37]	High missing teeth	High	>50% missing ≥20 teeth	47.5% attachment loss	~40%	Very limited prosthetic rehabilitation

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Chahar et al. (2019) [38]	High untreated caries	High	Common	Very high	~35%	Very low restorative care

TABLE 2: Oral Health Status of Geriatric Participants

Author	GOHAI Mean / Median	% Poor OHRQoL	Functional Limitation	Psychosocial Impact	Pain / Sensitivity
Sukumar et al. (2025) [34]	Median-based GOHAI	53% poor OHRQoL	20.7% always have chewing difficulty	18% limit social interaction	21.6% always sensitive
Rezaei Majd et al. (2025)[35]	51.36 ± 7.25	73.3%	Moderate limitation	–	–
Bianco et al. (2021) [36]	Moderate impairment	Not directly quantified	6.6% chewing difficulty	18% nervous/self-conscious	–
Neelamana et al. (2020)[37]	Lower scores	>60%	Chewing & food limitation common	Present	Moderate
Chahar et al. (2019) [38]	Low–moderate	High	High chewing difficulty	Present	Present

TABLE 3: OHRQoL (GOHAI) Scores and Functional Impacts

Author	Key Findings	Effect on Oral Health	Effect on OHRQoL	Statistics
Rezaei Majd et al. (2025) [35]	Multimorbidity = 66.1%; mean comorbidities = 3.74	More tooth loss, poorer periodontal status	Strong negative effect	AOR = 1.803, p=0.002; r = −0.163
Sukumar et al. (2025)[34]	High arthritis, hypertension; sensory issues	Higher caries & periodontal disease	Strong negative influence	Caries AOR = 1.369; Periodontitis AOR = 1.686; Tooth loss AOR = 2.752
Bianco et al. (2021)[36]	High frailty in institutional elders	Moderate gingival inflammation	Slight psychosocial impact	Not quantified
Neelamana et al. (2020)[37]	Undiagnosed systemic issues	Severe attachment loss	Lower OHRQoL	Not quantified
Chahar et al. (2019)[38]	High chronic disease load	Poor oral hygiene & caries	Moderate	Not reported

TABLE 4: Influence of Comorbidities, Multimorbidity & Polypharmacy

JBI Domain	Bianco (2021) [36]	Rezaei (2025) [35]	Chahar (2019) [38]	Neelamana (2020) [37]	Sukumar (2025) [34]	Overall
Inclusion criteria	Yes	Yes	Yes	Yes	Yes	Low
Sample frame appropriate	Yes	Yes	No	No	Yes	Moderate
Sampling method	Yes	Yes	No	No	Yes	Moderate
Sample size adequate	Yes	Yes	Yes	Yes	Yes	Low
Subject/setting description	Yes	Yes	Yes	Yes	Yes	Low
Valid oral health measures	Yes	Yes	Yes	Yes	Yes	Low
Valid OHRQoL measures	Yes	Yes	Yes	Yes	Yes	Low
Confounders identified	Yes	Yes	No	No	Yes	Moderate
Adjustment for confounders	Yes	Yes	No	No	Yes	Moderate
Appropriate statistics	Yes	Yes	Yes	Yes	Yes	Low
Response rate adequate	Yes	Yes	Not reported	Not reported	Yes	Moderate

TABLE 5: Risk of Bias Assessment (JBI Cross-Sectional)

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DISCUSSION

The findings of this systematic review demonstrated that oral diseases remained highly prevalent among geriatric adults across diverse sociocultural and economic backgrounds. Although the included studies varied considerably ranging from institutionalized elders in Italy evaluated by Bianco et al. (2021)[36] to tribal elders in Kerala and Tamil Nadu examined by Neelamana et al. (2020)[37] and Sukumar et al. (2025)[38] a consistent pattern emerged. All studies reported substantial burdens of dental caries, periodontal destruction, tooth loss, unmet prosthetic needs and impaired oral health related quality of life (OHRQoL). These observations were in accordance with global epidemiological trends described by Kassebaum et al. (2014)[39] and aligned with the WHO geriatric oral health framework outlined by Petersen and Yamamoto (2005)[40].

A major recurring theme across the included studies was the high prevalence of tooth loss. Bianco et al. (2021)[36] reported elevated DMFT scores among institutionalized Italian elders reflecting cumulative disease experience and dependence on caregivers for oral hygiene. Similar long term tooth loss trends were documented in Swedish cohorts by Norderyd et al. (2015)[41]. The magnitude of tooth loss, however, was far greater among tribal elders with Neelamana et al. (2020)[37] in Kerala and Sukumar et al. (2025)[34] in the Irula community documenting very high edentulism rates. These disparities closely resembled patterns reported among Indigenous and socially marginalized populations globally as shown by Leake and Birch (2008)[42] and Adams et al. (2004)[43]. In contrast, Delhi elders assessed by Chahar et al. (2019)[38] exhibited high untreated caries yet comparatively lower complete edentulism supporting the observation by Thomson et al. (2010)[44] that even irregular dental visits can moderate cumulative tooth loss.

Periodontal disease severity also followed a distinct gradient. Neelamana et al. (2020)[37] and Sukumar et al. (2025)[34] reported profound periodontal destruction among tribal elders including deep pockets and extensive attachment loss. These findings corresponded with the Chinese National Oral Health Survey led by Jiao et al. (2021)[45] and caries periodontal epidemiology described by Gao et al. (2018)[46] both of whom identified low income limited education and limited access to oral healthcare as key determinants of periodontal disease in older adults. The biological vulnerability associated with ageing, highlighted by Ship and Crow (1994)[47] further explained the rapid progression observed among underserved elders. In contrast, institutionalized elders evaluated by Bianco et al. (2021)[36] showed moderate rather than severe breakdown likely due to some degree of caregiver supervision. The Iranian elders studied by Rezaei Majd et al. (2025)[35] experienced functional limitations primarily due to multimorbidity and polypharmacy aligning with the systemic interactions described by Casanova et al. (2014)[48].

Dental caries remained prevalent in all populations with particularly high levels of untreated decay reported by Chahar et al. (2019)[38] and among tribal communities in both Kerala and Tamil Nadu. These trends aligned with the near universal caries prevalence reported in older Chinese adults by Gao et al. (2018)[46]. Xerostomia related to polypharmacy, high dietary sugar, poor oral hygiene and limited access to restorative services were probable contributors. Low oral health literacy strikingly evident among tribal elders reinforced the findings of Parker et al. (2012)[49] who demonstrated the critical influence of health literacy on caries burden among Indigenous Australian communities.

Unmet prosthetic needs represented another consistent finding. Bianco et al. (2021)[36] noted low denture uptake despite institutional support reflecting barriers such as dependency, cognitive impairment and difficulty adapting to prostheses as similarly reported by Klotz et al. (2017)[50]. Among the tribal populations studied by Neelamana et al. (2020)[37] and Sukumar et al. (2025)[34], prosthetic rehabilitation was minimal due to cost barriers, poor accessibility and cultural acceptance of tooth loss. Even among urban elders in Delhi, Chahar et al. (2019)[38] described significant unmet prosthetic needs influenced by affordability and competing health priorities. These outcomes were consistent with the broader evidence cited by Walls and Steele (2004)[51] and Yoshida et al. (2011)[52] regarding the impact of inadequate prosthetic rehabilitation on masticatory function, nutritional status, frailty, and systemic decline. The association between tooth loss and cognitive impairment identified by Kato et al. (2019)[53] further highlighted the systemic consequences of untreated tooth loss.

All five included studies demonstrated compromised OHRQoL, though the underlying drivers varied. Iranian elders assessed by Rezaei Majd et al. (2025)[35] reported the poorest OHRQoL due to multimorbidity and mental-health burdens consistent with the Korean evidence presented by Park et al. (2023)[54]. Tribal elders experienced substantial functional impairments, including difficulty chewing, food avoidance and social withdrawal, echoing earlier work by Slade and Spencer (1994)[55] on the social impact of oral diseases. Institutionalized elders in Italy described psychosocial dissatisfaction rather than functional problems, a trend also observed in Japanese cohort by Yoshioka et al. (2013)[56]. Delhi elders reported moderate OHRQoL impairment, likely owing to partial but not sufficient access to dental care.

Comorbidities played a significant role in modifying oral health outcomes across the included studies. Both Rezaei Majd et al. (2025)[35] and Sukumar et al. (2025)[36] highlighted the impact of systemic conditions such as diabetes, hypertension, arthritis and sensory impairments on oral hygiene capability, periodontal status and OHRQoL. These findings were compatible with the reports of Casanova et al. (2014)[48] and Gil-Montoya et al. (2015)[57] who demonstrated the reciprocal influence of multimorbidity and oral disease in older adults.

Together, the included studies illustrated a clear inequality gradient in oral health among ageing populations:

- Bianco et al. (2021)[36]: Institutionalized elders with moderate disease but notable psychosocial burden
- Chahar et al. (2019)[38]: Urban elders with high untreated caries and moderate OHRQoL impairment
- Rezaei Majd et al. (2025)[35]: Multimorbid community elders with systemic disease driving oral functional decline
- Neelamana et al. (2020)[37]: Kerala tribal elders with extensive periodontal destruction and severe tooth loss
- Sukumar et al. (2025)[34]: Irula tribal elders with the highest cumulative disease burden and profound functional disability

This gradient reinforced global evidence indicating that oral health in older adults is not merely a function of biological ageing but is shaped by lifelong socioeconomic disadvantage, variable access to care, differing levels of oral-health literacy, and growing multimorbidity, as emphasized by Adams et al. (2004)[43], Steele et al. (2004)[51] and Gil-Montoya et al. (2015)[57].

Strengths

- Included studies represented diverse geriatric groups institutionalized, urban, community-dwelling, and tribal populations.
- Focused on multimorbidity and OHRQoL, areas often underrepresented in earlier reviews.
- All studies used validated indices (DMFT, ICDAS, CPI, GOHAI, OHIP), strengthening methodological robustness.
- Inclusion of datasets from Europe, South Asia, and the Middle East increased external validity.

Limitations

- All studies were cross-sectional, limiting causal inference.
- Methodological heterogeneity (different indices, varying diagnostic thresholds) impeded meta-analysis.
- Some studies had incomplete reporting, particularly for prosthetic status and effect sizes.
- Sociocultural differences potentially influenced self-reported OHRQoL.
- Possible publication bias toward studies reporting negative outcomes.

Future Research

- Conduct longitudinal cohort studies to map disease progression and multimorbidity interactions.
- Evaluate community-based and mobile geriatric dental interventions, especially in tribal regions.
- Develop integrated care models linking oral health with chronic disease clinics and nutrition programs.
- Promote standardized diagnostic and OHRQoL tools across global geriatric research.
- Explore sociocultural determinants and help-seeking behaviors through qualitative studies.

CONCLUSION

This systematic review demonstrates that oral diseases constitute a major and persistent public health burden among geriatric adults across diverse sociocultural settings with consistently high levels of tooth loss, periodontal destruction untreated caries and poor prosthetic rehabilitation contributing to significant functional limitations and impaired oral health related quality of life. The comparative analysis across institutionalized, urban, community-dwelling and tribal populations highlights a clear gradient of vulnerability wherein socioeconomic disadvantage, limited access to dental care, cultural barriers and multimorbidity intensify oral disease severity and functional decline. The strong associations between systemic comorbidities, polypharmacy and oral deterioration underscore the interconnected nature of oral and general health in later life. These findings collectively emphasize the urgent need to integrate oral health into geriatric and primary care frameworks through preventive strategies, early detection, rehabilitative care and targeted outreach for marginalized groups, in order to improve functional independence, nutritional well-being and overall quality of life in ageing populations.

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