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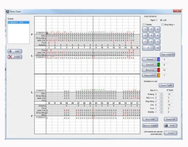

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Position Paper

Epidemiology of Periodontal Diseases*

This paper was prepared by the Research, Science and Therapy Committee of the American Academy of Periodontology and is intended for the information of the dental profession. It represents the position of the Academy in regard to the current state of knowledge about the epidemiology of periodontal diseases. This paper, with issues examined from the epidemiological viewpoint, is intended to give practitioners an epidemiological perspective on issues of interest to them. It replaces the version published in 1996. *J Periodontol 2005;76:1406-1419.*

Epidemiology is the study of health and disease in populations and of how these states are influenced by heredity, biology, physical environment, social environment, and personal behavior. Analytical epidemiology seeks to identify the risk factors associated with a disease, to quantify the strength of those associations, and to estimate whether an association is causal. An understanding of risk factors can lead to theories of causation and then to treatment protocols for clinicians to use with their patients. The essential features of epidemiology as a method of research, when compared to clinical research and case studies, are that 1) groups rather than individuals are the focus of study and 2) persons with and without a particular disease (e.g., periodontal diseases), and with and without the exposure of interest are included, rather than just patients. The study of population groups rather than individuals is to allow for valid estimates while accounting for normal biological variation (e.g., some individuals form plaque readily, others do not). Broadening a study to include those without disease, as well as those with it, provides a reference point against which to quantify risk.

Advances in research over recent years have led to a fundamental change in our understanding of the periodontal diseases. As recently as the mid-1960s, the prevailing model for the epidemiology of periodontal diseases included these precepts: 1) all individuals were considered more or less equally susceptible to severe periodontitis; 2) gingivitis usually progressed to periodontitis with consequent loss of bony support and eventually loss of teeth; and 3) susceptibility to periodontitis increased with age and was the main cause of tooth loss after age 35.[1-4] Advances in our understanding of periodontal diseases since that time have led to this old disease model being reevaluated.

This review concentrates on recent research in the epidemiology of chronic periodontitis. It will assess current knowledge on prevalence, incidence, severity, risk factors, and predicting disease risk. The review does not directly address microbial infection and host response mechanisms, modes of disease progression (i.e., bursts or linear), links between periodontitis and systemic diseases, the specifics of less common clinically-recognized conditions such as aggressive periodontitis, and conditions associated with hematological or genetic disorders.

GINGIVITIS: PREVALENCE AND DISTRIBUTION

National survey data show that gingivitis is found in early childhood, is more prevalent and severe in adolescence, and then tends to level off in older age groups.[5] The prevalence of gingivitis among schoolchildren in the United States has ranged from 40% to 60% in national surveys.[6,7] In the national survey of employed adults in 1985-86, 47% of males and 39% of females aged 18 to 64 exhibited at least one site which bled on probing.[8] The mean number of bleeding sites per person was higher in older than in younger males, but this was not seen in females. In the first U.S. national survey of adults in 1960-62, which scored gingivitis visually, 85% of men and 79% of women were found to have some degree of gingivitis.[9] In the third National Health and Nutrition Examination Survey (NHANES III, 1988-94), 50% of adults were found to have gingivitis on at least three or four teeth.[10] Even allowing for the differences in measurement techniques between the two surveys, there appears to have been an improvement in gingival health over that 25-year period.

Plaque deposits are closely correlated with gingivitis, a relationship long considered one of cause-and-effect. Longitudinal studies among Norwegian professionals and students, among whom oral hygiene was excellent, found no increase in prevalence and severity of gingivitis between the late teen years and age 40.[11] In a related study among Sri Lankan tea workers, both oral hygiene and the gingival condition were poorer at all ages.[12] Studies among other populations in developing

* This paper was revised under the direction of the Research, Science and Therapy Committee and approved by the Board of Trustees of the American Academy of Periodontology in May 2005.

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