Oral Complications among Women during the Menopause Transition

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Introduction

Menopause is defined as the end of menstruation due to the reduction of ovarian follicular activity. A diagnosis of natural menopause is made retrospectively after 12 months of amenorrhea with no pathologic connection. Radiation, surgery, and chemotherapy can all be used to intentionally induce menopause. Menopause is a life-changing era for women, but it is also a particularly tough period marked by a slew of difficulties brought on by a variety of circumstances. The quality of life during menopause is influenced by a number of factors. Sugar consumption, diabetes mellitus, dental cavities, and smoking are some of the factors we looked at during the pre-menopausal era and post-menopause. It strikes at the age of 51 years and is caused by full or near complete ovarian follicular depletion resulting in hypoestrogenemia and elevated Follicle Stimulating Hormone (FSH) levels. Pre-menopause occurs after reproductive years but before menopause and is marked by irregular menstrual cycles, endocrine changes, and symptoms such as hot flashes.

Primary ovarian insufficiency is a phase of natural menopause that occurs between the ages of 40 and 45 years, whereas early menopause occurs below 40 years. Early menopause and primary ovarian insufficiency have both been linked to an increased risk of cardiovascular disease, bone loss, and cognitive impairment. The clinical aspects and diagnosis of the menopausal transition and menopause will be discussed in this topic, as well as the criteria for primary ovarian insufficiency and early menopause. Body Mass Index (BMI), family history, ethnic origin, parity, menarche, and previous oral contraceptive usage are all factors that influence the age at which menopause begins. Due to the availability of oestrogen in adipose tissues, obese or overweight women experience menopause later in life with fewer climacteric symptoms than thin women. Menopause is linked to a wide range of symptoms, both physical and psychological. These symptoms can have a negative impact on dental health and treatment needs. Thus, dentists should be aware of the symptoms and health-care needs of pre-menopausal, menopausal, and post-menopausal women.

Oral Changes at Menopause

Oral changes associated with menopause are often linked to hormonal changes, but physiological ageing of the oral tissues also plays a part. In addition to climacteric problems, many menopausal women experience oral irritation. Dry mouth, painful mouth for various reasons, and less frequently Burning Mouth Syndrome (BMS), are the most common pre-menopausal and post-menopausal oral symptoms.

Burning Mouth Syndrome

Burning Mouth Syndrome (BMS) is a frequent oral anomaly that develops as acute pain and a spontaneous burning sensation affecting diverse parts of the oral cavity in the absence of any recognisable biological abnormalities. It mostly affects the tongue, lips, palate, gingiva, and denture support areas and is bilateral. Hormonal alterations and small fibre sensory neuropathy of the oral mucosa have been hypothesised as possible reasons for the underlying aetiology.

Xerostomia

Another common symptom of menopausal women is hyposialia, often known as xerostomia or dry mouth. Although a few studies have found that salivary flow reduces in menopausal women when IgA and total protein levels rise, others have been unable to detect any changes in salivary volume or composition. Reduced salivary flow has also been linked to an increased incidence of root caries, oral pain, taste changes, oral candidiasis, and periodontal disease in post-menopausal women, according to certain research. In addition, menopausal women are more likely to develop Sjogren's syndrome, an autoimmune illness that causes xerostomia, keratoconjunctivitis sicca, vaginal dryness, and dyspareunia.

Mucosal Changes

The oral mucosa is similar to the vaginal mucosa in some aspects. The alterations in the oral mucosa might range from "menopausal gingivostomatitis" to atrophic pale mucosa. Gingiva that bleeds easily and has an excessively pale, dry, shiny, erythematous appearance is a sign of menopausal gingivostomatitis. Because of the atrophic mucosa, the denture should be made as smooth as possible to avoid hurting it. Other oral mucosal illnesses include candidiasis, pemphigus vulgaris, benign mucosal pemphigoid, lichen planus, and mouth ulcers caused by mechanical stress from bad habits or chronic denture irritation.

Neurological Disorders

Trigeminal neuralgia is also reported to be common in post-menopausal women due to compression of the superior cerebellar artery on either of the trigeminal nerve's branches. Severe unilateral, lancinating, "electric-shock" like pain, generally in the centre and lower third of the face, characterises the condition. Other neurological illnesses that may afflict post-menopausal women include Alzheimer's disease and atypical facial pain/neuralgia.

Osteoporosis and Periodontitis

Following menopause, the risk of developing periodontitis and osteoporosis increases. Although increased bacterial plaque accumulation and estrogen/serum osteocalcin insufficiency have been identified as etiological factors, the actual aetiology remains unknown. Advanced alveolar bone loss, decreased Bone Mineral Density (BMD) of alveolar crest/subcrestal

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alveolar bone, and to a lesser extent, ligamentous attachment loss may occur as a result of systemic osteoporosis, leading to widespread bone loss.

Eating Disorders

Menopausal women's psychological anguish might lead to eating disorders. Self-induced vomiting and the resulting regurgitation of gastrointestinal contents might cause oral alterations. Menopausal women with eating problems may experience smooth enamel erosion, perimolysis, enlarged parotid glands, trauma to the oral mucous membrane and pharynx caused by the use of fingers, combs, and pens to induce vomiting, angular cheilitis, dehydration, and erythema.