

Case report

Long-term use of ill-fitting dentures and its oral consequences in an elderly patient: a case report

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Summary

Introduction. This case report aims to present the comprehensive management of an elderly long-term denture wearer, document oral tissue alterations associated with prolonged use of ill-fitting dentures, and discuss the role of preventive care and patient education in geriatric prosthodontics.

Case report. A 76-year-old female patient presented to the Specialist Center for Dentistry at the Faculty of Medicine in Foča for complete denture fabrication. She wore an interim removable partial denture for approximately 40 years and complained of poor stability and unsatisfactory aesthetics. Over time, the remaining upper teeth were lost without subsequent interventions on the existing denture. Clinical examination revealed a completely inadequate existing denture. In the maxilla, a posterior flabby alveolar ridge bilaterally, a coronally positioned labial frenulum, and inflammatory fibrous hyperplasia of the palatal mucosa were observed. In the mandible, seven mobile teeth were affected by periodontitis and covered with hard dental deposits. Orthopantomographic findings revealed advanced maxillary alveolar ridge resorption, predominantly in the posterior region, generalized periodontitis of the mandibular teeth, and periapical lesions associated with teeth 32 and 33. Following a comprehensive clinical evaluation, the patient was informed of her condition, and the available treatment options were discussed. After acceptance, she signed a written informed consent form. Pre-prosthodontic surgical management was performed, and new complete dentures were fabricated after adequate healing. A six-month follow-up schedule was set and implemented. At the 12-month follow-up, oral ulceration was noted and promptly managed.

Conclusion. Dental professionals and healthcare policymakers should actively promote preventive oral health measures and support their implementation in geriatric populations.

Key words: removable partial denture, complete denture, oral mucosa, dental care for elderly, ill-fitting denture, flabby ridge

Introduction

Rapid demographic changes worldwide have led to a substantial increase in the elderly population. Approximately 23% of population in Bosnia and Herzegovina is aged 65 or older [1].

According to the World Health Organization (WHO), by 2030, one in six people globally will be aged 60 or older, and the total number of people aged 60 and older is projected to reach approximately 2 billion by 2050. Moreover, the population aged ≥ 80 years is expected to increase to 426 million between 2020 and 2050 [2].

Oral health is a fundamental component of overall health and well-being; however, it remains insufficiently addressed in the global health agenda. Although most oral diseases are preventable, their prevalence among older adults remains unacceptably high, representing a growing global health challenge [3]. Oral disorders constitute a substantial public health burden in aging populations, contributing significantly to disability-adjusted life years and healthcare costs worldwide, thereby underscoring the need for effective preventive policies and equitable access to oral healthcare for older adults [4]. The public health significance of oral health in older adults is increasingly recognized, as impaired oral function contributes to malnutrition, frailty, and a reduced quality of life. Recent evidence demonstrates that oral health challenges in older adults, including reduced dentition, chewing and swallowing difficulties, and xerostomia, are closely associated with malnutrition and impaired oral function, underscoring the importance of functional rehabilitation and preventive care in this population [5–9].

The use of removable dentures is highly prevalent among geriatric patients. However, prolonged denture wear without regular dental follow-up may lead to significant oral complications, including soft tissue alterations, inadequate denture fit, and functional discomfort. Continuous mechanical pressure and friction from ill-fitting dentures can induce chronic mucosal irritation and inflammation, potentially leading to pathological changes, such as flabby ridge formation or inflammatory fibrous hyperplasia [10]. These conditions compromise oral mucosal integrity and adversely affect denture

stability and function by directly influencing impression techniques, jaw relation records, and long-term denture success.

This report aims to present the comprehensive management of an elderly long-term interim removable partial denture (RPD) wearer, document the clinical consequences of prolonged use of ill-fitting dentures, and discuss the role of preventive care and patient education in geriatric prosthodontics.

Case report

The Ethics Committee of the Faculty of Medicine Foča, University of East Sarajevo approved the study (Approval No. 01-2-4), and it was conducted in accordance with the Declaration of Helsinki. Written informed consent was obtained from the patient for the use of clinical photographs and relevant clinical information for publication of this manuscript.

Initial consultation and diagnostics

A 76-year-old female patient, fully independent in her daily activities, presented to the Department of Prosthodontics at the Specialist Center for Dentistry, Faculty of Medicine Foča, University of East Sarajevo, with complaints of functional impairment and dissatisfaction with her maxillary interim RPD. The patient reported difficulty chewing, denture instability, and aesthetic concerns, primarily due to age and discoloration of dentures.

Medical history revealed no systemic diseases or ongoing pharmacological therapy. The dental history indicated long-term use of a maxillary interim RPD without regular follow-ups. The denture had been in continuous use for approximately 40 years, during which no replacement, relining, or adjustment was performed despite progressive tooth loss.

Inspection revealed a maxillary interim RPD, tissue-supported, with a reduced base

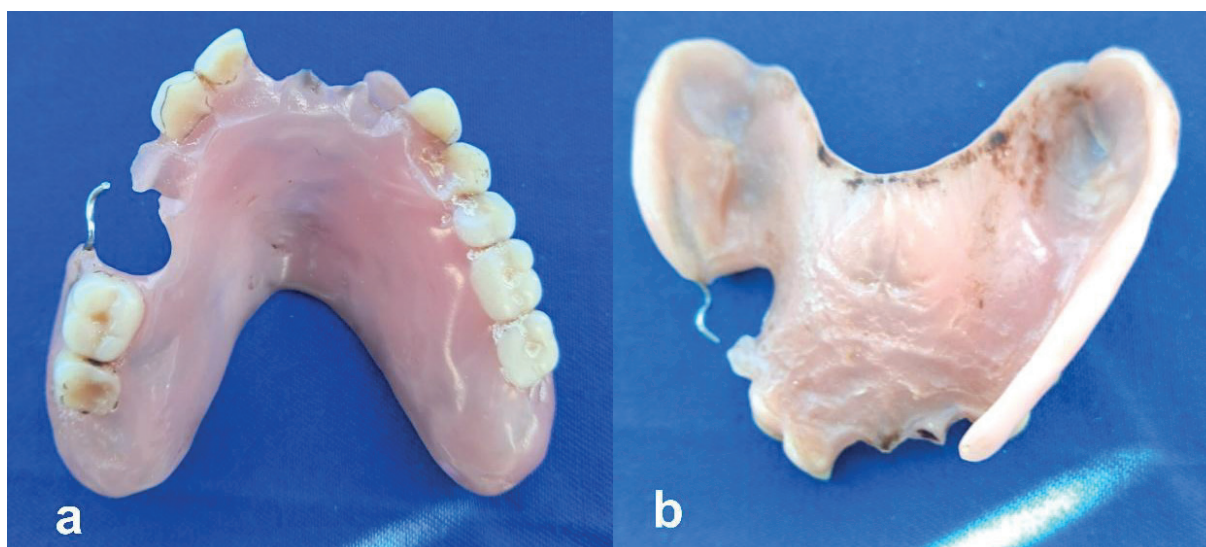


Figure 1. Maxillary interim removable partial denture used for approximately 40 years, showing severe wear and discoloration (a-mucosal side; b-occlusal side)

and severe abrasion of the artificial acrylic teeth, resulting in a reduced vertical dimension of occlusion. Denture hygiene was poor, with extensive surface discoloration and pigmentation (Figure 1). Intraoral examination revealed moist oral mucosa and a complete absence of the maxillary teeth, which had previously provided retention of the denture. The mucosa of the residual maxillary alveolar ridge was hypertrophic, and the ridge was bilaterally flabby in the distal parts (Figure 2). The enlargement of the mucosa was so significant that it compromised the proper positioning of the future occlusal plane and new dentures, and the left tuberosity contacted the mandibular residual alveolar ridge. The anterior segment of the ridge had a coronally positioned maxillary labial frenulum. Additionally, an inflammatory fibrous hyperplasia of the palatal mucosa was identified; it was irregular in shape and measured approximately 2.5 cm in length and 0.7 cm in width (Figure 2). Examination of the mandible revealed several mobile teeth severely affected by periodontitis and partially covered with hard dental deposits. The remaining oral mucosa and supporting tissues showed no pathological changes.



Figure 2. Maxilla showing a flabby ridge bilaterally, coronal insertion of the maxillary labial frenulum, and inflammatory fibrous hyperplasia extending from the hard palate

Orthopantomographic image confirmed advanced resorption of the maxillary alveolar ridge, predominantly in the posterior region, periodontitis affecting the remaining mandibular teeth, and periapical lesions associated with teeth 32 and 33 (Figure 3).

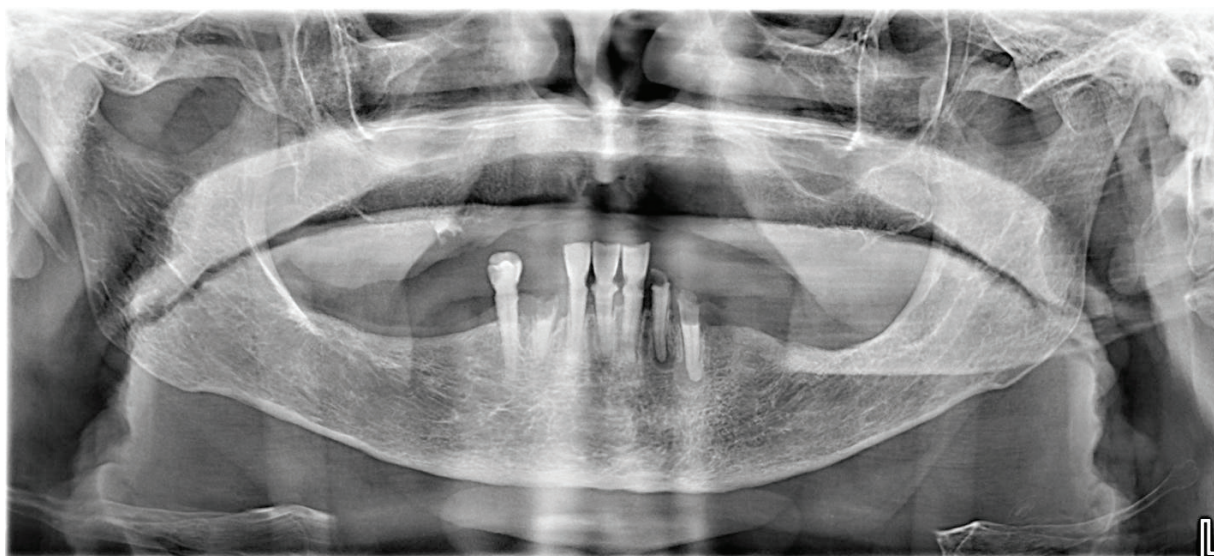


Figure 3. Orthopantomographic image showing severe maxillary alveolar ridge resorption, periodontally compromised mandibular teeth, and periapical lesions associated with teeth 32 and 33

Following a comprehensive extraoral and intraoral examination and radiographic assessment, the patient was informed of her clinical condition, and the available treatment options were discussed. The proposed treatment plan included extraction of periodontally compromised mandibular teeth, surgical correction of the maxillary labial frenulum, excision of flabby alveolar ridges, removal of palatal fibrous tissue, and subsequent fabrication of new complete dentures. After acceptance, written informed consent was obtained prior to all procedures.

Pre-prosthetic surgical phase and healing period

All surgical procedures were performed under local anesthesia. To minimize surgical trauma and accommodate the elderly patient's preference, excision of the flabby maxillary ridges was performed in two separate appointments, addressing one side per visit. The surgical intervention consisted of two elliptical V-shaped incisions along the poste-

rior maxillary alveolar ridge. The procedure was performed in the suprapariosteal plane while preserving the periosteum. The excessive hyperplastic soft tissue was carefully excised, and hemostasis was achieved. Primary wound closure was achieved using 4-0 silk sutures. During subsequent follow-up examinations, satisfactory healing was observed, and the tissues demonstrated increased firmness and stability. The coronally positioned maxillary labial frenulum was surgically removed, and the palatal fibrous tissue enlargement was excised and submitted for histopathological analysis. The surgical procedure achieved primary wound closure using 4-0 silk sutures, which were removed seven days postoperatively. Postoperative care included analgesics, cold compresses, and hyaluronic acid spray to support mucosal healing. Histopathological analysis (Figure 4) of the palatal fibrous enlargement confirmed a diagnosis of inflammatory fibrous hyperplasia, consistent with the clinical presentation. The remaining mandibular teeth were extracted under local anesthesia. The postoperative healing period was uneventful (Figure 5).

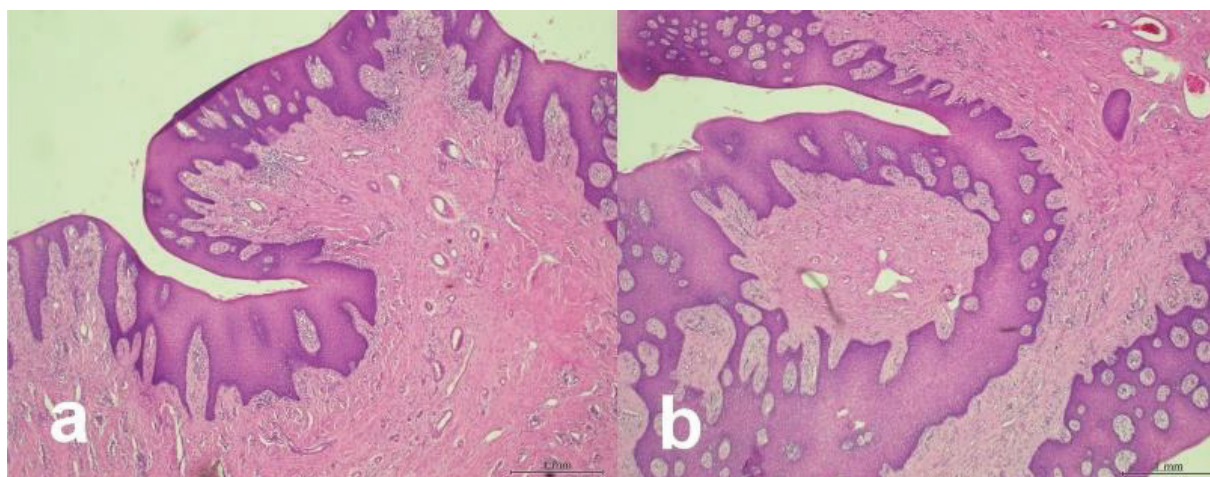


Figure 4. Histopathological specimen showing Inflammatory fibrous hyperplasia (a, b)

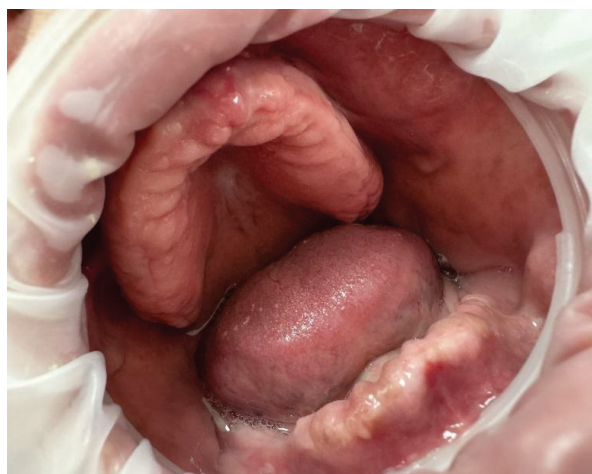


Figure 5. Intraoral tissues after pre-prosthetic surgical preparation

Prosthetic rehabilitation phase

One month after the surgical procedures, prosthetic rehabilitation was initiated. A preliminary impression was obtained using alginate with a standard tray. Based on postoperative clinical findings, selective compression was not needed. The borders of the custom tray were marked on the impression and transferred to the cast. The custom tray was fabricated using self-curing methacrylate resin. Subsequently, a final impression was

obtained using a custom tray with a two-step procedure: active border molding with a thermoplastic impression compound, followed by a final impression with zinc oxide-eugenol paste, which provided satisfactory retention and stabilization for future dentures. Definitive casts were made using dental stones, and occlusion rims were produced. Occlusion rims supported the lips and cheeks, and the position of the occlusal plane was defined using extraoral parameters: bipupillary and Camper lines. Adequate vertical and horizontal jaw relations were established and recorded, as well as the midline, canine line, high lip line, and low lip line. The acrylic artificial teeth set was selected based on the patient's anatomical guidelines. After setting the teeth, a clinical try-in was performed. The clinician verified jaw relations and preliminary occlusion. The patient was satisfied with the size, shape, and color of teeth. At denture delivery, the clinician checked the dentures for border extension, occlusion, and aesthetics. The patient received comprehensive verbal and written instructions on denture hygiene, proper use, and recognizing potential mucosal changes, and was advised not to wear dentures overnight.

Early post-delivery follow-up

Follow-up visits were scheduled at 1, 3, and 7 days post-delivery. During these visits, only minor adjustments were made to improve comfort and function. No mucosal trauma, erosion, or ulceration was observed. The patient reported satisfactory adaptation to the new dentures, wearing them throughout the day and avoiding overnight use (Figure 6).



Figure 6. Maxillary and mandibular complete dentures at delivery

Six-month follow-up

A six-month follow-up schedule was established, and the Department of Prosthodontics at the Specialist Center for Dentistry, Faculty of Medicine Foča, contacted the patient to arrange the recall appointment. The six-month follow-up visit was satisfactory, demonstrating adequate denture retention and stability, appropriate oral and denture hygiene practices, and healthy oral mucosa without signs of inflammation or trauma.

Twelve-month follow-up

At the 12-month follow-up visit, an ulceration was observed in the left mandibular vestibule that the patient had not reported. The lesion measured approximately 1 cm in length and 1–2 mm in width (Figure 7) and corresponded anatomically to the denture border. No additional mucosal alterations were detected. The denture was adjusted by carefully modifying the border area in contact with the ulceration

to eliminate mechanical irritation (Figure 8). Upon evaluation at the 7-day follow-up visit, the mucosal ulceration had completely healed with no remaining signs of irritation. At this visit, the dentures were clean and well-maintained, indicating satisfactory adherence to oral and denture hygiene instructions (Figure 9). The remaining oral mucosa was moist, intact, and free of pathological changes. The maxillary alveolar ridge was firm and stable (Figure 10). The patient reported overall satisfaction with the esthetics and comfort of the complete dentures (Figure 11). The patient was advised to continue established oral health practices and was scheduled for future regular follow-up visits to support long-term oral health and prosthetic function.



Figure 7. At the twelve-month follow-up, an ulceration was observed in the left mandibular vestibule, measuring approximately 1 cm in length and 1–2 mm in width

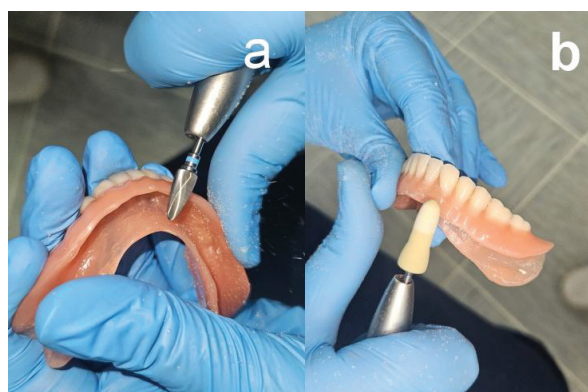


Figure 8. Denture adjustment by modifying the border area that is in contact with the oral ulceration at the twelve-month follow-up

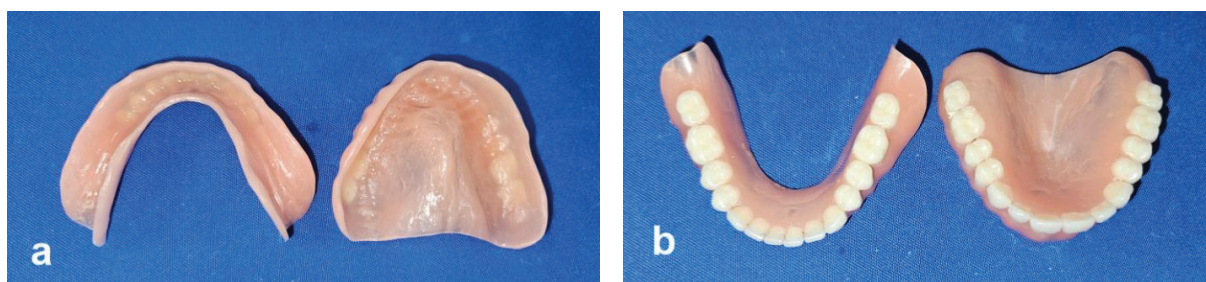


Figure 9. At the twelve-month follow-up, dentures were clean, indicating satisfactory oral and denture hygiene (a - mucosal side; b - occlusal side)



Figure 10. At the twelve-month follow-up, the maxillary alveolar ridge was firm and stable



Figure 11. Follow-up appearance twelve months after denture delivery

Discussion

The present case demonstrates the cumulative oral tissue changes associated with prolonged use of an ill-fitting interim RPD in an elderly patient, complicated by progressive tooth loss and the absence of regular prosthodontic follow-up. Although flabby ridges, inflammatory fibrous hyperplasia, alveolar ridge resorption, periapical lesions, and periodontitis are common findings in geriatric dentistry, their coexistence in this patient posed a clinically challenging scenario requiring a carefully staged treatment approach. Despite her advanced age, the patient in this case was systemically healthy and fully independent, allowing for comprehensive pre-prosthodontic surgery and complete denture rehabilitation.

Removable dentures are subject to progressive material degradation, artificial tooth wear, and loss of fit over time [11, 12]. According to the American College of Prosthodontists (ACP) position statement, removable complete and partial dental prostheses are medical devices with limited lifespans rather than permanent restorations and should be evaluated for replacement after more than five years of function [12]. The patient in this report continuously wore an interim RPD for approximately four decades without professional relining, occlusal adjustment, or replacement. Over time, progressive abrasion of the acrylic teeth markedly reduced the vertical dimension of occlusion. As residual alveolar bone undergoes continuous, lifelong resorption while the acrylic denture base remains unchanged, an increasing biomechanical misfit develops [11, 13, 14]. Unfavorable force distribution and constant tipping movements under occlusal loading subject the underlying tissues to chronic mechanical trauma, accelerating residual bone resorption and inducing compensatory soft-tissue changes [14–17].

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A prominent clinical finding in our patient was the presence of extensive flabby ridges located bilaterally in the posterior maxilla. The flabby ridge develops when residual alveolar bone undergoes progressive resorption and is subsequently replaced by mobile, hypertrophic fibrous connective tissue [15, 16]. Published studies indicate that displaceable ridges occur in up to 24% of edentulous maxillae and approximately 5% of edentulous mandibles [14, 16, 18]. While flabby ridges are most classically documented in the anterior maxilla, their occurrence in the posterior maxilla is strongly associated with prolonged denture-induced trauma, excessive occlusal overload, and advanced residual ridge resorption [14]. In our patient, this excessive movable tissue extended below the optimal occlusal plane, with the hypertrophic tuberosities encroaching upon the interarch space, presenting a major mechanical barrier to proper occlusal plane orientation and denture stability [16, 19].

The available literature describes two primary approaches for managing flabby ridges: conservative prosthodontic techniques using modified impression methods and surgical excision [15, 16, 18, 20]. Conservative impression techniques, such as the window technique or selective-pressure methods using low-viscosity materials, are widely advocated because surgical excision of mobile tissue often may carry significant drawbacks [15, 18, 19]. Specifically, excising the movable tissue over an already severely resorbed ridge can obliterate the vestibular depth, lead to a flat, shallow ridge, and bring muscle and frenal attachments unfavorably close to the crest of the ridge [15, 16, 18, 21]. This resulting muscle pull and loss of sulcular depth can severely destabilize the future dentures or necessitate secondary pre-prosthodontic surgeries such as vestibuloplasty [16, 21]. Furthermore, replacing lost tissue volume requires thickening the acrylic denture base, which increases prosthesis weight and bulk [16].

However, despite these well-recognized limitations of surgical management, conservative

impression techniques alone were unfeasible in our patient. The massive fibrous hyperplasia in the posterior maxilla physically interfered with the interarch space, contacting the opposing mandibular ridge and creating severe occlusal interferences that precluded denture fabrication [16]. To achieve a firm denture-bearing foundation without inducing vestibular obliteration or unfavorable muscle pull, a conservative, selective resection was performed rather than radical excision. By executing two elliptical V-shaped incisions strictly in the suprapariosteal plane [16], the underlying periosteum and a controlled layer of dense fibrous tissue were preserved. This approach eliminated excessive tissue mobility while retaining a firm, resilient mucosal foundation capable of withstanding functional occlusal loads, simultaneously promoting tension-free primary wound closure and uneventful healing.

In addition to soft-tissue hypermobility of the residual ridge, prominent mucogingival attachments represent a well-recognized obstacle to successful complete denture rehabilitation [10]. In our patient, a coronally inserted maxillary labial frenulum extended close to the crest of the resorbed alveolar ridge. Such coronal frenal attachments compromise the peripheral seal in the anterior vestibule and exert dynamic dislodging forces during speech and mastication [10, 15]. Accommodating a prominent frenulum by excessively notching the labial flange of the denture base not only disrupts the peripheral hermetic seal but also creates a major stress concentration zone, predisposing the maxillary complete denture to midline fatigue fracture [10]. Therefore, performing a pre-prosthodontic maxillary labial frenectomy was essential to eliminate unfavorable muscular tension, restore vestibular sulcus continuity, and facilitate effective border molding during final impression taking.

Following successful tissue stabilization and an uneventful healing period, definitive complete dentures were fabricated. Because the displaceable tissue mass had been surgically resolved, conventional mucostatic impression

modifications were unnecessary; instead, border molding and definitive impressions using custom trays successfully established a complete peripheral hermetic seal, optimal retention, and stability [10].

In geriatric prosthodontics, patient education regarding daily denture hygiene and nocturnal prosthesis removal is paramount [11]. Removing dentures at night relieves continuous mechanical compression, promotes mucosal capillary perfusion, and significantly decreases the risk of denture-related stomatitis [11, 22].

The global burden of oral disorders continues to rise substantially with rapid population aging, leaving conditions such as severe tooth loss and edentulism as major public health challenges [23, 4]. In older adults, dental service utilization is heavily constrained by socioeconomic disparities, limited access to dental services, lower educational levels, and limited oral health awareness [24], which often predispose vulnerable individuals to prolonged, unmonitored denture wear, as exemplified by our patient. Expert guidelines in geriatric dentistry note that although many oral conditions in older adults are preventable, they are often underdiagnosed because of access barriers and misconceptions, underscoring the need for proactive clinical and public health strategies [25]. Preventive oral health strategies that target modifiable risk factors and promote healthy behaviors can significantly lower the prevalence of oral diseases and their related complications. Routine dental follow-ups and simple interventions by dental professionals, such as denture adjustments and hygiene reinforcement, are crucial for reducing oral diseases and improving overall health outcomes [11, 26]. A six-month follow-up schedule was established and implemented for our patient to monitor denture function and oral mucosal health, enabling timely identification and management of potential complications [26]. The ulceration identified at the 12-month follow-up was promptly managed, further emphasizing the

value of regular clinical follow-up for the early detection and management of denture-related complications. In our patient, the complete resolution of the ulceration within seven days following border adjustment confirmed its purely traumatic etiology. While chronic mechanical irritation from ill-fitting dentures may harm oral tissues and has been reported to increase the risk of oral malignancy [27, 28], prompt clinical evaluation is essential, and persistent or non-healing oral lesions require appropriate clinical assessment and, when necessary, histopathological analysis.

Although similar cases are common in everyday dental practice, their long-term consequences remain insufficiently recognized and addressed. Unlike our previous report on denture-induced fibromatous hyperplasia [29], this case illustrates the broader clinical implications of prolonged use of an ill-fitting denture and documents management of coexisting tissue changes through staged surgical preparation and complete denture rehabilitation, with follow-up extending to 12 months. This report highlights the importance of regular dental examinations, timely correction or replacement of ill-fitting dentures, and patient education as essential components of preventive care in geriatric prosthodontics.

Limitations

The main limitation of this report is that it describes a single clinical case; therefore, the findings cannot be generalized. Furthermore, clinical records from previous decades were unavailable, preventing direct longitudinal assessment of the onset and progression of the observed changes over the approximately 40-year period. Consequently, the contribution of prolonged denture use to the development of these conditions can only be discussed in the context of the clinical findings and the patient's history.

Conclusion

Prolonged use of ill-fitting dentures without regular professional follow-up may contribute to progressive oral tissue changes and functional deterioration. Regular prosthodontic examinations, early recognition of oral

mucosal changes, adequate denture hygiene, and timely correction or replacement of ill-fitting dentures are essential for maintaining oral health and prosthetic function in older adults. Dental professionals should promote these preventive measures through patient education and regular follow-up.

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Ethical approval. The Ethics Committee of the Faculty of Medicine Foča, University of East Sarajevo approved the study (No. 01-2-4) and informed consent was ob-

tained from all individual respondents. The research was conducted according to the Declaration of Helsinki.

Conflicts of interest. The authors declare no conflict of interest.

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Dugotrajna upotreba neadekvatnih zubnih proteza i njene oralne posljedice kod starijeg pacijenta: prikaz slučaja

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Uvod. Cilj prikaza slučaja je da predstavi sveobuhvatno liječenje osobe starijeg doba, dugogodišnjeg nosioca privremene pločaste parcijalne proteze, da ilustruje posljedice lošeg nalijeganja proteza na tkiva tokom produženog perioda upotrebe, te da naglasi važnost preventivne njege i edukacije gerodontoloških protetskih pacijenata.

Prikaz bolesnika. Pacijentkinja stara 76 godina javila se u Specijalistički centar za stomatologiju Medicinskog fakulteta Foča radi izrade totalnih proteza. Gornju parcijalnu pločastu protezu je nosila 40 godina, a kao glavne tegobe navela je nestabilnost proteze i lošu estetiku. Klinički pregled otkrio je neadekvatnu postojeću protezu. Vremenom je došlo do gubitka preostalih gornjih zuba bez naknadnih intervencija na postojećoj protezi. Bočni segmenti maksilarnog rezidualnog alveolarnog grebena bili su pokretni, gornji labijalni frenulum pozicioniran koronalno, na nepcu vidljivu inflamatornu fibrozu hiperplaziju. U donjoj vilici utvrđeno je prisustvo sedam pokretnih zuba, prekrivenih tvrdim zubnim naslagama. Ortopantomografski nalaz ukazao je na opsežan gubitak koštanog tkiva maksile, najizraženiji u bočnim segmentima, te generalizovanu parodontopatiju donjih zuba uz periapikalne lezije zuba 32 i 33. Nakon pregleda pacijentkinja je obavještena o nalazima i mogućnostima liječenja. Po prihvatanju terapije potpisala je obrazac za informisani pristanak. Izvršena je pretprotetska hirurška priprema, te po zarastanju izrađene totalne proteze. Utvrđen je i sproveden raspored kontrolnih pregleda na šest mjeseci. Na kontrolnom pregledu obavljenom dvanaest mjeseci po predaji totalnih proteza, primjećene su i blagovremeno liječene oralne ulceracije.

Zaključak. Stomatolozi i profesionalci koji učestvuju u kreiranju politike javnog zdravlja trebalo bi da aktivno promovišu preventivne oralnozdravstvene mjere i podržavaju njihovu primjenu kod gerijatrijske grupe pacijenata.

Ključne riječi: parcijalna proteza, totalna proteza, oralna mukoza, stomatološka njega za starije osobe, neadekvatna proteza, pokretni greben