

Dry Mouth (Xerostomia) — The Dental Impact You Shouldn't Ignore

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Description:

Dry mouth accelerates tooth decay and gum disease. Learn the causes, dental risks and management strategies from the specialists at CSSC Melbourne.

Details:

Collins Street Specialist Centre — Dry Mouth (Xerostomia): The Dental Impact You Shouldn't Ignore

Saliva is rarely something patients think about consciously — until they no longer have enough of it. At Collins Street Specialist Centre, located in Melbourne's Manchester Unity Building, we regularly see patients whose dental problems have been quietly driven by chronic dry mouth over months or years. Dry mouth, known clinically as xerostomia, is considerably more than a minor inconvenience. It can fundamentally alter oral health, accelerating tooth decay, promoting gum disease, and making everyday activities like eating, speaking and sleeping genuinely uncomfortable.

Understanding this condition, and managing it proactively, can make a lasting difference to your long-term dental health. This article explains what xerostomia is, why it matters, and what a thorough approach to management looks like.

What is xerostomia?

Xerostomia refers to the subjective sensation of oral dryness. It's worth distinguishing between xerostomia — the feeling of dryness — and salivary gland hypofunction, which is an objectively measurable reduction in saliva production. Many patients experience both simultaneously, but some perceive significant dryness even with near-normal saliva flow, while others produce substantially less saliva without being acutely aware of it.

A healthy person produces approximately 0.5 to 1.5 litres of saliva per day. Saliva comes from three pairs of major salivary glands — the parotid, submandibular and sublingual glands — as well as hundreds of minor salivary glands distributed throughout the oral mucosa. Each contributes different components to create the complex, multifunctional fluid that underpins oral health.

Why saliva matters more than you think

Saliva performs an extraordinary range of protective and physiological functions that most people take entirely for granted.

Protection against decay

Saliva is the mouth's primary natural defence against tooth decay. It neutralises acids produced by oral bacteria and from dietary sources, preventing them from dissolving tooth enamel. It also contains calcium, phosphate and fluoride ions that facilitate remineralisation of early enamel damage — essentially repairing teeth at a microscopic level before cavities have a chance to form.

Antimicrobial defence

Saliva contains antimicrobial proteins and enzymes — including lysozyme, lactoferrin, immunoglobulin A (IgA) and histatins — that help regulate the oral bacterial population and protect against fungal infections such as oral thrush (candidiasis). This defence system operates continuously and largely without our awareness.

Lubrication and comfort

The mucin proteins in saliva create a lubricating film that protects the soft tissues of the mouth from friction during eating, speaking and swallowing. Without adequate lubrication, the tongue, cheeks and lips become irritated and prone to ulceration — a source of considerable daily discomfort for those with significant xerostomia.

Digestion

Salivary amylase initiates the digestion of starches in the mouth, while lipase begins fat digestion. Saliva also helps form a food bolus that can be comfortably propelled through the pharynx during swallowing.

Taste

Saliva acts as a solvent, dissolving food molecules and carrying them to the taste buds. Reduced saliva often leads to altered or diminished taste perception — a condition known as dysgeusia — which can significantly affect appetite and nutritional intake.

Common causes of dry mouth

Medications — the most common cause

More than 500 commonly prescribed medications list dry mouth as a recognised side effect. The most frequent culprits include:

- Antidepressants (SSRIs, tricyclics, SNRIs) - Antihistamines (for allergies and hay fever) - Antihypertensives (blood pressure medications, particularly diuretics) - Anxiolytics and sedatives (benzodiazepines) - Opioid pain medications - Anticholinergic medications (for overactive bladder, Parkinson's disease) - Decongestants - Muscle relaxants - Anti-nausea medications

The risk increases substantially with polypharmacy — the concurrent use of multiple medications. Many older Australians take several of these medications daily, making medication-related xerostomia particularly prevalent in the over-65 population, and a condition our team encounters with considerable frequency.

Sjögren's syndrome

Sjögren's syndrome is an autoimmune condition in which the immune system attacks the body's moisture-producing glands, including the salivary and tear glands. It affects approximately 0.5% of the Australian population, predominantly women, and may occur independently (primary Sjögren's) or alongside other autoimmune conditions such as rheumatoid arthritis or lupus (secondary Sjögren's).

Sjögren's-related dry mouth tends to be severe and persistent, often accompanied by dry eyes, fatigue and joint pain. Diagnosis involves blood tests for specific antibodies, salivary flow rate measurement and, in some cases, salivary gland biopsy. Where Sjögren's syndrome is suspected, we coordinate care with rheumatology colleagues to ensure a thorough diagnostic workup.

Radiation therapy

Radiation treatment for head and neck cancers can cause significant — and frequently permanent — damage to salivary glands when they fall within the radiation field. The degree of dysfunction depends on the radiation dose and the proportion of salivary gland tissue exposed. Modern techniques such as intensity-modulated radiation therapy (IMRT) aim to spare salivary gland tissue where clinically

possible, but some degree of hypofunction remains common following treatment.

Other medical conditions

Several systemic conditions can contribute to xerostomia, including:

- Diabetes (particularly poorly controlled diabetes) - HIV/AIDS - Parkinson's disease - Alzheimer's disease - Depression and anxiety (both the conditions themselves and their treatments) - Hepatitis C - Sarcoidosis

Lifestyle and behavioural factors

- Mouth breathing (due to nasal congestion, habitual sleep patterns or exercise) - Smoking and tobacco use - Alcohol consumption (including alcohol-based mouthwashes) - Caffeine (mild diuretic effect) - Cannabis use - Dehydration - Snoring and obstructive sleep apnoea (airflow through an open mouth dries the oral mucosa overnight)

The dental consequences of chronic dry mouth

Rampant tooth decay

Without saliva's buffering and remineralising effects, tooth decay can accelerate dramatically and in patterns quite distinct from typical caries. Xerostomia-related decay characteristically affects unusual locations — the smooth surfaces of teeth, root surfaces and even the margins of existing restorations such as fillings and crowns. Patients who previously had few cavities may suddenly develop multiple areas of decay across many teeth simultaneously.

This pattern, sometimes termed "radiation caries" when caused by radiotherapy, can be genuinely devastating. Teeth that have remained healthy for decades may deteriorate rapidly within one to two years of significant dry mouth developing — a clinical reality our team works hard to help patients understand and prevent.

Gum disease

Saliva helps flush food debris and bacteria from around the gum line. When salivary flow is reduced, bacterial plaque accumulates more readily, increasing the risk of gingivitis (gum inflammation) and periodontitis — the more serious form of gum disease involving bone loss around teeth. The antimicrobial components of saliva also play a meaningful protective role, and their reduction leaves the gingival tissues more vulnerable to infection.

Oral thrush (candidiasis)

The antifungal properties of saliva help maintain *Candida* yeast at controlled levels. When saliva is insufficient, *Candida* can overgrow, causing oral thrush — characterised by white patches on the tongue and inner cheeks, redness, soreness and a persistent cotton-like sensation in the mouth. Denture wearers with dry mouth are particularly susceptible to this complication.

Difficulty with dentures

Saliva creates a thin fluid film between the denture base and the underlying gum tissue that assists with retention, comfort and function. Xerostomia makes dentures significantly more difficult to wear — they tend to displace more readily, cause friction-related sore spots and interfere with chewing. This is a common presentation among patients who seek assessment at Collins Street Specialist Centre.

Eating and nutritional impact

Difficulty chewing dry or fibrous foods, altered taste perception and problems with swallowing can lead to meaningful dietary changes — often towards softer, more processed foods that may be nutritionally suboptimal. This impact on diet and nutrition can compound other health concerns, particularly in older

adults or those managing systemic illness.

Bad breath (halitosis)

Saliva helps wash away food particles and the bacteria responsible for malodour. Reduced salivary flow allows these to accumulate, often producing persistent halitosis that doesn't respond to standard oral hygiene measures — a source of considerable social distress for many patients.

Oral discomfort

Chronic dry mouth can produce a burning or tingling sensation throughout the mouth — sometimes referred to as burning mouth syndrome — as well as cracked and peeling lips, a sore or fissured tongue, and difficulty sustaining speech for extended periods. These symptoms, while not immediately visible, significantly affect quality of life.

Diagnosing dry mouth

A thorough assessment for xerostomia should encompass the following:

- **Medical and medication history:** Identifying potential contributing causes and reviewing the medication list in detail
- **Salivary flow rate testing:** Measuring resting and stimulated saliva production to quantify the degree of hypofunction
- **Oral examination:** Assessing for clinical signs including reduced saliva pooling, dry and sticky mucosa, atypical decay patterns and candidiasis
- **Blood tests:** Where Sjögren's syndrome or another systemic condition is clinically suspected
- **Specialist referral:** To rheumatology (for Sjögren's), ear nose and throat, or other relevant medical specialists as indicated by the clinical picture

Managing dry mouth — a comprehensive approach

Effective management of xerostomia requires a strategy that addresses both the underlying cause and its dental consequences. There is rarely a single solution; a combination of measures tailored to the individual patient tends to yield the best outcomes.

Addressing the cause

- **Medication review:** Discuss with your treating doctor whether alternative medications with fewer xerostomic side effects are available. Never stop or adjust medications without medical guidance — but raising the issue is entirely appropriate, as alternatives frequently exist and prescribers may not be aware of the oral health impact.
- **Medical management:** Treating underlying conditions such as reflux, diabetes or Sjögren's syndrome can improve salivary gland function over time.
- **Lifestyle modifications:** Addressing mouth breathing (including management of nasal congestion), ceasing smoking, limiting alcohol consumption and maintaining adequate hydration all contribute meaningfully to symptom reduction.

Stimulating saliva production

For patients who retain residual salivary gland function, strategies to encourage saliva production include:

- **Sugar-free chewing gum:** Masticatory stimulation reliably increases salivary flow. Products containing xylitol offer the additional benefit of inhibiting cariogenic bacteria.
- **Sugar-free lozenges or mints:** Another practical means of stimulating flow, again preferably xylitol-containing.
- **Prescription sialagogues:** Medications such as pilocarpine (Salagen) or cevimeline can pharmacologically stimulate salivary gland output. These require a medical prescription and aren't appropriate for all patients, but can be highly effective in suitable cases.
- **Adequate hydration:** Sipping water consistently throughout the day assists with comfort and food clearance, though it doesn't replicate saliva's complex protective chemistry.

Saliva substitutes and oral moisturisers

Where salivary glands are unable to produce sufficient saliva — as is frequently the case following radiation therapy — artificial saliva products and oral moisturisers provide meaningful symptom relief:

- **Saliva substitute sprays and gels:** Products containing carboxymethylcellulose or mucin-based formulations replicate some of saliva's lubricating properties and are available without prescription
- **Oral moisturising gels:** Applied to the gums and palate, particularly at bedtime to assist with overnight comfort
- **Specialised toothpastes and mouthwashes:** Formulated specifically for dry mouth, these products avoid sodium lauryl sulphate (which can irritate already-vulnerable tissues) and alcohol (which worsens dryness)

Dental care adjustments

Patients with xerostomia require a modified preventive dental care regimen:

- **Fluoride supplementation:** High-concentration prescription fluoride toothpaste (5000 ppm) used daily is a cornerstone of caries prevention in this group. Custom fluoride trays for home application may also be recommended.
- **More frequent dental reviews:** Three to four-monthly check-ups rather than the standard six-monthly schedule, enabling early detection and prompt treatment of developing decay.
- **Remineralising agents:** Casein phosphopeptide-amorphous calcium phosphate (CPP-ACP) products such as Tooth Mousse can help strengthen enamel between appointments.
- **Gentle oral hygiene products:** Alcohol-free mouthwash, a soft-bristled toothbrush and non-abrasive toothpaste are all preferable for patients with dry mouth.
- **Dietary counselling:** Reducing the frequency of sugar exposure, avoiding acidic beverages, and recognising that xerostomia substantially amplifies the erosive and cariogenic potential of dietary acids.
- **Prompt intervention for decay:** Because caries progresses more rapidly in a dry oral environment, early treatment is essential to preserve tooth structure.

Living well with dry mouth

Proactive management makes a measurable difference to both comfort and oral health outcomes. The following practical measures are worth incorporating into daily life:

- Carry water wherever you go and sip regularly throughout the day
- Keep lip balm accessible to prevent cracked and uncomfortable lips
- Avoid salty, spicy or very dry foods that worsen mucosal discomfort
- Use a humidifier in your bedroom overnight to reduce oral dryness during sleep
- Sip water during meals to assist with chewing and swallowing
- Avoid alcohol-based mouthwashes — they worsen dryness and can irritate vulnerable tissues
- Chew sugar-free gum after meals where practical
- Keep your dental appointments without delay — they carry greater importance than ever when dry mouth is present

When to seek specialist assessment

Seek professional assessment promptly if you experience any of the following:

- Persistent dry mouth lasting more than a few weeks
- A sudden increase in tooth decay or dental sensitivity
- White patches, redness or soreness within the mouth
- Difficulty eating, speaking or swallowing
- Dentures that have become uncomfortable, unstable or difficult to wear
- Dry mouth accompanied by dry eyes, joint pain or persistent fatigue, which may indicate Sjögren's syndrome and warrants investigation

How Collins Street Specialist Centre can help

At Collins Street Specialist Centre, our specialist team is well equipped to assess and manage the dental consequences of xerostomia. Our prosthodontists can restore teeth damaged by decay, our periodontists can treat associated gum disease, and our team works collaboratively to develop a personalised preventive plan designed to protect your remaining dentition over the long term.

Dry mouth is frequently a chronic condition requiring ongoing management rather than a single intervention. We work alongside you and your medical practitioners to achieve the best possible outcomes for your oral health and overall wellbeing.

****If dry mouth is affecting your dental health or quality of life, call Collins Street Specialist Centre on (03) 9654 5705**** to arrange a consultation. Located in Melbourne's Manchester Unity Building at 220 Collins Street, our team is here to help you protect your smile for the long term.

Frequently asked questions

****What is xerostomia?**** The clinical term for dry mouth.

****Is xerostomia the same as salivary gland hypofunction?**** No, they are distinct conditions. Xerostomia is the subjective feeling of dryness; salivary gland hypofunction is an objectively measurable reduction in saliva production.

****Can you have xerostomia with normal saliva flow?**** Yes, some patients feel dry with near-normal flow. Conversely, some patients with significantly reduced saliva production aren't acutely aware of it.

****How much saliva does a healthy person produce daily?**** Approximately 0.5 to 1.5 litres.

****How many major salivary gland pairs exist?**** Three — the parotid, submandibular and sublingual glands — plus hundreds of minor salivary glands distributed throughout the oral mucosa.

****How does saliva protect against tooth decay?**** It neutralises acids that dissolve enamel and contains calcium, phosphate and fluoride ions that facilitate remineralisation of early enamel damage.

****Does saliva have antimicrobial properties?**** Yes. It contains proteins including lysozyme, lactoferrin, IgA and histatins that help regulate oral bacteria and protect against fungal infections such as oral thrush.

****What is dysgeusia?**** Altered or diminished taste perception, which can result from reduced saliva.

****Does saliva assist digestion?**** Yes. Salivary amylase initiates starch digestion and salivary lipase begins fat digestion.

****What is the most common cause of dry mouth?**** Medications. More than 500 commonly prescribed drugs list dry mouth as a recognised side effect, including antidepressants, antihistamines, diuretics, opioids and anticholinergics.

****Does polypharmacy increase dry mouth risk?**** Yes, substantially. The risk increases with each additional medication.

****Is dry mouth more common in older Australians?**** Yes, due to higher rates of polypharmacy in this group.

****What is Sjögren's syndrome?**** An autoimmune condition in which the immune system attacks moisture-producing glands, including the salivary and tear glands. It affects approximately 0.5% of the Australian population, predominantly women, and can occur independently (primary Sjögren's) or alongside conditions such as rheumatoid arthritis or lupus (secondary Sjögren's).

****Does radiation therapy cause dry mouth?**** Yes, and the damage is frequently permanent. The degree of dysfunction depends on the radiation dose and the proportion of salivary gland tissue exposed.

****Does diabetes contribute to dry mouth?**** Yes, particularly poorly controlled diabetes.

****What lifestyle factors worsen dry mouth?**** Mouth breathing, smoking, alcohol consumption (including alcohol-based mouthwashes), caffeine, cannabis use, dehydration and obstructive sleep apnoea.

****How does dry mouth damage teeth?**** Without saliva's buffering and remineralising effects, decay can accelerate dramatically. It characteristically affects smooth surfaces, root surfaces and restoration margins — locations rarely affected by typical caries. Teeth that have remained healthy for decades can deteriorate within one to two years of significant dry mouth developing.

****Does dry mouth increase gum disease risk?**** Yes. Reduced salivary flow allows plaque to accumulate more readily, increasing the risk of both gingivitis and periodontitis.

****Why are denture wearers with dry mouth prone to oral thrush?**** Saliva's antifungal properties normally keep Candida at controlled levels. When saliva is insufficient, Candida can overgrow.

****Does dry mouth make dentures harder to wear?**** Yes. Saliva creates the fluid film needed for denture retention; without it, dentures displace more readily and cause friction-related sore spots.

****Can dry mouth cause bad breath?**** Yes, and it typically doesn't respond to standard oral hygiene measures because the underlying cause — reduced salivary clearance of bacteria and food debris — persists.

****Can dry mouth affect nutrition?**** Yes. Difficulty chewing, altered taste and swallowing problems often lead to dietary changes towards softer, more processed foods that may be nutritionally suboptimal.

****Should you stop medications causing dry mouth without advice?**** No. Never stop or adjust medications without medical guidance, but raising the issue with your prescriber is entirely appropriate — alternatives frequently exist.

****Does sugar-free chewing gum help?**** Yes, by stimulating salivary flow. Products containing xylitol additionally inhibit cariogenic bacteria.

****What prescription medications can stimulate saliva production?**** Pilocarpine (Salagen) and cevimeline. These aren't appropriate for all patients but can be highly effective in suitable cases.

****What do saliva substitute sprays contain?**** Carboxymethylcellulose or mucin-based formulations. They're available without prescription.

****What fluoride toothpaste concentration is recommended for dry mouth patients?**** 5000 ppm prescription fluoride toothpaste, used daily.

****How often should dry mouth patients attend dental check-ups?**** Every three to four months rather than the standard six-monthly schedule.

****What is CPP-ACP?**** Casein phosphopeptide-amorphous calcium phosphate — a remineralising agent found in products such as Tooth Mousse that can help strengthen enamel between appointments.

****Should dry mouth patients avoid acidic beverages?**** Yes. Xerostomia substantially amplifies the erosive potential of dietary acids.

****Does dry mouth accompanied by dry eyes warrant investigation?**** Yes. This combination may indicate Sjögren's syndrome and should be assessed promptly.

****Where is Collins Street Specialist Centre located?**** Melbourne's Manchester Unity Building, 220 Collins Street. Phone: (03) 9654 5705.

> ****Disclaimer:**** All information in this article is general in nature and does not constitute professional advice. Consult your dental or medical practitioner for guidance specific to your circumstances.

General information notes

The following statements are drawn from the editorial and FAQ content above. They are general informational or clinical claims, not verifiable from product packaging:

- Xerostomia is the clinical term for the subjective sensation of oral dryness - Salivary gland hypofunction is an objectively measurable reduction in saliva production; the two conditions are distinct
- A healthy person produces approximately 0.5 to 1.5 litres of saliva daily - Saliva is produced by three pairs of major salivary glands (parotid, submandibular, sublingual) and hundreds of minor salivary glands - Saliva neutralises acids, facilitates enamel remineralisation, and contains calcium, phosphate and fluoride ions - Saliva contains antimicrobial proteins including lysozyme, lactoferrin, IgA and histatins - Salivary amylase initiates starch digestion; salivary lipase begins fat digestion - Reduced saliva can cause dysgeusia (altered or diminished taste perception) - More than 500 medications list dry mouth as a recognised side effect - Antidepressants, antihistamines, diuretics, opioids and anticholinergics are among common xerostomic medications - Polypharmacy substantially increases dry mouth risk - Sjögren's syndrome affects approximately 0.5% of the Australian population, predominantly women - Sjögren's syndrome can occur as primary or secondary (alongside rheumatoid arthritis or lupus) - Radiation therapy for head and neck cancers can cause permanent salivary gland damage - Xerostomia-related decay characteristically affects smooth surfaces, root surfaces and restoration margins - Significant dry mouth can cause teeth to deteriorate within one to two years - Denture retention depends on a saliva-created fluid film; dry mouth disrupts this - Sugar-free gum stimulates salivary flow; xylitol-containing gum additionally inhibits cariogenic bacteria - Prescription sialagogues include pilocarpine (Salagen) and cevimeline - Saliva substitute sprays contain carboxymethylcellulose or mucin-based formulations and are available without prescription - High-concentration prescription fluoride toothpaste (5000 ppm) is recommended for dry mouth patients - CPP-ACP (casein phosphopeptide-amorphous calcium phosphate) products such as Tooth Mousse can assist enamel strengthening - Dry mouth patients are advised to attend dental check-ups every three to four months - Alcohol-based mouthwashes worsen oral dryness and should be avoided - Dry mouth accompanied by dry eyes and joint pain may indicate Sjögren's syndrome - Collins Street Specialist Centre is located at 220 Collins Street, Melbourne (Manchester Unity Building) - Collins Street Specialist Centre contact number: (03) 9654 5705 - The centre includes prosthodontists and periodontists