**Prevalence and Clinical Parameters of Cervical Abrasion as a Function of Population, Age, Gender, and Toothbrushing Habits: A Systematic Review**

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**ABSTRACT**

Aim: To determine specific differences in prevalence and etiology of cervical abrasion (CA) related to age, gender, and population and to recommend optimal management protocols.

Background: Cervical abrasion is a part of a spectrum of regressive changes in teeth called noncarious cervical lesions (NCCLs). These are physiological or pathological alterations as a function of time, related to physical and/or chemical factors. There are multiple variables involved in the pathogenesis and management of these lesions. There may be age-, gender-, and population-based differences in prevalence and clinical parameters of CA.

Results: Our review selected 24 studies from an initial 3,876 titles. We found significant differences in prevalence of CA in relation to age, toothbrushing frequency, brush type, and brushing technique. There were definite conclusion regarding type of teeth affected and appropriate management to enhance quality of life of the patients. Data on CA are inconsistent and need standardization.

Conclusion: Cervical abrasion varies in prevalence across countries. However, it exhibits definite age-related increase. There is no gender predilection. The frequency of toothbrushing, type of brush, brushing technique, and use of dentifrice influences the prevalence. Certain teeth are more susceptible to abrasion than others. Resin-modified glass ionomers were reported to be better for treating this condition.

Clinical significance: There is no standardized methodology to diagnose the presence and clinical severity of dental abrasion. This affects data on prevalence, habits, and management. Standardized protocol and tools may be developed for the same, and would improve outcomes particularly in vulnerable groups like geriatric populations, which are mainly affected by this condition.

Keywords: Dental diseases, Prophylaxis, Systematic review, Tooth abrasion, Tooth wear.

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**INTRODUCTION**

Dental abrasion or cervical abrasion (CA) is the pathological wear of tooth substance due to abnormal mechanical processes not directly related to mastication. It is seen mainly on exposed root surfaces of teeth especially on the facial surfaces, but rarely seen even on incisal and proximal surfaces. Improper toothbrushing combined with injudicious use of abrasive dentifrices is accepted by most researchers to be the central cause of abrasion. The enamel being relatively resistant to wear is usually spared but the cementum and dentin are affected. Conventional knowledge holds that use of a hard or medium toothbrush with vigorous force is associated with CA. More frequent brushing of teeth may also be a causative. The technique of toothbrushing is important. Recommended techniques like the Bass method and Roll method appear to be safer, while horizontal toothbrushing is especially implicated in increased prevalence of CA.¹ ²

Abrasion is usually seen as a sharp-angled wedge or V-shaped defect in the root side of the facial cervical line and is associated with gingival recession. Its relation with toothbrushing is exemplified by the fact that it is observed to affect the contralateral quadrants depending on the left or right handedness of the individual. Toothpastes with higher abrasive content seem to be associated with higher CA. Even the use of toothpicks and strenuous flossing has been associated. There are some other uncommon association of CA related to habits and occupation. Pipe smokers, tailors, and carpenters, etc., have distinct patterns of abrasion based on their activity. However, these other causes are a miniscule proportion of the cases of abrasion.³

Cervical abrasion belongs to a group of lesions termed noncarious cervical lesions (NCCLs) that also include erosion and abfraction. There is usually more than one particular type of NCCL in every affected individual. In recent years, it is increasingly clear that abrasion, erosion, and abfraction may not be mutually exclusive and may develop in the same individual synchronously.

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or metachronously. The etiology of such lesions may also not be as clear-cut as previously believed. The multifactorial nature of these lesions makes it difficult for clinicians to manage due to variability in pathogeneses and individual characteristics that may depend on age, type of teeth, relevant habits, and occlusal patterns.  

Since the abrasive process is rather slow, there is formation of secondary and tertiary dentin to protect the pulp. Sclerotic dentin is another protective response that has treatment implications. Retention of dental plaque, sensitivity, pulp damage, and periodontal disease progression are few of the undesirable effects of CA. Treatment is aimed toward managing the symptoms, restoring the morphology of the teeth, and treating soft tissue pathology. If untreated, pulpal exposure and infection, as well as periodontal deterioration are possible. Therefore, CA must be managed appropriately with suitable restorative procedures.  

There is a public health incentive to assessing the demographic parameters related to CA including population, age, and gender, etc., to determine if there are significant differences in prevalence, risk factors, symptoms, measurements, and treatment outcomes. A thorough review of clinical studies needs to be performed to address these critical issues related to lesion management.

Materials and Methods

Research Question

A research question was formulated as far as possible adhering to the PICOS (population, intervention, control, and outcomes) format. This was aimed at determining if there are significant differences in prevalence, risk factors, symptoms, measurements, and treatment outcomes of dental abrasion with respect to population, age, and gender.  

“Are there significant differences in prevalence, risk factors, symptoms, measurements, and treatment outcomes of dental abrasion with respect to population, age, and gender?”

Sources, Search, and Study Selection

Electronic literature searches of Pubmed/Medline database and the Cochrane Study register, and other online sources were undertaken. Keywords applied include “dental abrasion,” “CA,” and “NCCLs,” etc. Original articles in journals with adequate impact and citation were preferred. The literature search was done until December 2018. Published European language articles in scientific journals were selected with year range from January 1970 to December 2018. As would be mentioned in results, the majority of the articles were dated from January 1974 to December 2018. Inclusion and exclusion criteria were formulated and applied (Table 1). Major inclusion criteria included clinical studies with good metrics and standard study design with adequate data items required in the analysis. English language or translated versions were acceptable. Human studies in persons with permanent dentition and good periodontal status (not beyond gingival recession related to CA), with acceptable neuromuscular coordination were selected. Studies without proper study design, inadequate data, untranslatable scripts, and dated earlier than 1970 were excluded.

Data Collection

A customized data extraction form was generated for this review. Basic information, important details, outcomes, and other measures were included. Two independent observers collated the data and filled the forms. In case of disagreement, a consensus was reached.

| Table 1: Inclusion and exclusion criteria |
|------------------------------------------|
| **Inclusion criteria** | **Exclusion criteria** |
| Clinical human studies in Cochrane Library and Pubmed listing of acceptable quality | Trials deemed to be unsuitable for our analysis due to lack of adequate information and major deficits in study design and methods, etc. |
| Studies that specifically mention the prevalence, clinical parameters, and treatment protocol of cervical abrasion and noncarious cervical lesions in general | Studies that do not reference cervical abrasion in main title or text or include only cervical erosion, attrition, and abfraction as stand-alone lesions |
| Studies that factor in toothbrushing as an integral component of the pathogenesis of cervical lesions | Studies that do not adequately include data on toothbrushing |
| Publications ranging from year January 1970 to December 2018 | Studies earlier than 1970 |
| English and European language articles (including translations) | Languages without translated versions |
| Studies in healthy human participants with permanent dentition and otherwise healthy periodontal status | Studies of people with periodontal disease, and disabilities that prevent proper coordination required for toothbrushing |

Data Items

The variables for data collection were tabulated. The included variables were setting/country, sample size, and demographic characteristics including age, gender, socioeconomic status, symptoms, toothbrushing parameters (brush type, technique, and frequency), number and type of teeth commonly affected, the index of tooth wear employed, and other relevant analyses.

Quality Assessment

Assessment of quality is critical to the validity of any review process. There are numerous procedures and guidelines available. The present review planned to employ the methodological quality assessment using the Cochrane tool for risk of bias, with seven major criteria. Each selected study was assessed in order to gather clear evidence of quality research and elimination of all possible biases. This was done by assessing the following:

- Selection bias (which includes randomization and allocation concealment),
- performance bias (blinding of personnel and participants),
- detection bias (blinding of assessment),
- attrition bias (incomplete outcome data),
- reporting bias (selective reporting), and
- other causes of possible bias.

Two researchers independently assessed these criteria and gave judgment of “high risk,” “unclear risk,” or “low risk.”

Qualitative and Quantitative Syntheses

Depending upon the characteristics of the selected studies and the various data items retrievable from these studies, qualitative and quantitative syntheses of the collated data was performed.
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Results and Analysis

Search Details

Electronic search of the literature showed a total of 3,961 titles. Researching after removal of duplicate titles reduced the number to 3,876. Careful visual identification of relevant articles and filtering of titles reduced the results to 63. By applying all inclusion and exclusion criteria, the total number of studies selected for the review was 24. Table 1 illustrates the inclusion and exclusion criteria. Flowchart 1 shows the preferred reporting items for systematic reviews and meta analyses (PRISMA)-based selection process.

Data Customization and Compilation

Tables 2 to 5 record the concise and categorized information compiled after comprehensive evaluation of the 24 studies that had been selected after applying all criteria. The order of the evaluation had been randomized and performed by two independent evaluators in order to eliminate timeline and interobserver bias. These data were based upon a summation of the evaluator reports after discussion on conflicting findings and achieving consensus. The 24 studies have been reported between 1976 and 2018. Most of the studies are cross-sectional in nature. They had good representation from countries all over the world. Sample sizes ranged from a minimum of 32 to a maximum of 2,707. The total number of samples in the 24 studies totaled 11,401 participants. Most studies had adequate data on most of the parameters that had been agreed upon by the researchers. Key exclusions from further analysis were socioeconomic status and symptoms, since there was negligible data on these two parameters. A separate analysis of treatment of CA was included separately.

Quality Assessment

Applying the Cochrane risk of bias tool, assessment of the selected studies revealed that overall the significant risk of bias was low. Randomization and allocation concealment were not applicable in these studies since most of the studies were cross-sectional in nature. Many authors did not explicitly include the key terms in their methodology, which is a requirement in many methodological assessments. However, further analysis of the methodology revealed that they had adhered to the required guidelines and omitted to report as such. Most of the studies stated blinding of assessment and observer independence. There were no reports of incomplete data or dropouts. All the data were reported and compiled in the studies, and no evidence of selective reporting was found.

Consensus opinion and judgment of two observers were required to classify the studies in each of the seven criteria as “low risk,” “unclear risk,” or “high risk.” Analysis showed that two studies achieved the acceptable “low-risk or unclear” judgment in 6 criteria, three studies achieved it in 5 criteria, six studies scored 4, and seven studies scored 3. Six studies had achieved acceptable judgment in 2 criteria. A majority of 75% of the selected studies had acceptable judgment in 3 or more criteria. Therefore, the overall quality assessment was found to be acceptable to conduct qualitative syntheses of the 24 studies. However, quantitative synthesis was not deemed possible due to the lack of adequate controlling and standardization among the different studies. The parameter-wise observations based on exhaustive analysis of 24 studies are presented in the succeeding section.

Qualitative Synthesis

Geographic, Sample, and Prevalence Data

The region-wise analysis of the studies reveals that the European region has the highest number of selected studies (7) and samples (5,314) compared to five from the US, four from Brazil, three from China, two each from Africa and Pakistan, and one from India. Country-wise China has the highest number of participants at 3,502, followed by Germany (2,707). Romania has the least number of participants (50). Regarding the time period, six studies were from the years 1976 to 2000, nine studies from 2001 to 2010, and nine studies from 2011 to 2018. Most of the studies were cross-sectional.
| Author                  | Year | Country | Setting       | Samples | Gender           | Important findings | Toothbrushing data | Main cause | Prevalence | TWI | Teeth most affected | Mean number of teeth |
|-------------------------|------|---------|---------------|---------|------------------|--------------------|--------------------|------------|------------|-----|---------------------|----------------------|
| Hand et al.              | 1986 | US      | Elder         | 520     | No data reported | No data reported   | No data reported   | No data reported | Vigorous brushing | 56% | 30% have more than 1 | No data reported      |
| Radentz et al.           | 1976 | US      | Army          | 80      | No data reported | Higher hygiene in abrasion cases | No data reported | No data reported | Vigorous brushing | No data reported | No data reported | No data reported |
| Piotrowski et al.        | 2001 | US      | Army veterans | 32      | No data reported | No significant related to firm brushing | No data reported | No data reported | Firm brushing | No data reported | No data reported | No data reported |
| Aw et al.                | 2002 | US      | General       | 57      | No data reported | No data reported   | No data reported   | No data reported | Older people, no sex difference | No data reported | 91% had index of 3 | 70% on posterior teeth, 65% on maxillary teeth, and 46% on premolars. |
| Bader et al.             | 1996 | US      | Dental patients | 264    | No data reported | Technique is significant | 3×/day more lesions | Hard More in people with lower arch first and facial first brushing | No data reported | No data reported | No data reported | No data reported |

Total of 5 studies 953
| Author          | Year | Country | Setting | Samples | Gender | Important findings                                                                 | Toothbrushing data | Age factor | Main cause | Prevalence | Index (TWI) | Teeth most affected | Mean number of teeth |
|-----------------|------|---------|---------|---------|--------|------------------------------------------------------------------------------------|-------------------|------------|------------|------------|-------------|----------------------|----------------------|
| Borcic          | 2004 | Croatia | General | 555     | No data reported                                                                | No data reported  | No data reported | No data reported | Increased with age | No data reported | Lower premolars more than 1 | No data reported |
| Sangnes         | 1976 | Norway  | General | 533     | No data reported                                                                | Good hygiene       | 2/day reported   | No data reported | No data reported | No data reported | No data reported | No data reported |
| Bergström       | 1988 | Stockholm | General | 250     | No data reported                                                                | Does not influence | No data reported | No data reported | No data reported | No data reported | No data reported | No data reported |
| Bergström       | 1979 | Stockholm | General | 818     | No data reported                                                                | Bristle firmness   | 2x related to lesions | No data reported | Significant difference between horizontal and roll (lowest) technique | No data reported | No data reported | No data reported |
| Marinescu       | 2017 | Romania |         | 50      | 18 and 32, higher in males                                                       | Did not specify abrasion | No data reported | No data reported | 34% vertical, 52% circular, 14% horizontal | No data reported | No data reported | No data reported |
| Akgül et al.    | 2003 | Turkey  | Patients | 428     | 186 and 242                                                                     | More in old age, male gender, and frequency of brushing | Yes | No data reported | Not significant | 20+ | No data reported | No data reported |
| Bernhardt et al.| 2006 | Germany | General | 2,707   | No data reported                                                                | Mostly focused on abfractions | No data reported | No data reported | 20–59 | No data reported | No data reported | No data reported |
| **Total of 7 studies** | | | | | | | | | | | | | 5,341 |
### Table 4: Cervical abrasion data in South American/African region

| Author            | Year | Country | Setting          | Samples | Gender | Important findings                                                                 | Frequency | Type   | Technique     | Age factor | Main cause                  | Prevalence | Index (TWI) | Teeth most affected | Mean number of teeth |
|-------------------|------|---------|------------------|---------|--------|------------------------------------------------------------------------------------|-----------|--------|---------------|------------|---------------------------|------------|-------------|---------------------|---------------------|
| Pegoraro et al.   | 2005 | Brazil  | General          | 70      | No data reported | Occusal stress could also be a factor                                              | No data reported | No data reported | No data reported | 25–45 years | No data reported | 88%        | No data reported | No data reported | 5.61                |
| Telles et al.     | 2007 | Brazil  | Dental students  | 48      | 28 and 20 |                                                                  | No data reported | No data reported | No data reported | 16–24 years | No data reported | 17.23% of all teeth | No data reported | No data reported | 5.8                 |
| Faye et al.       | 2005 | Senegal |                  | 655     | No data reported | Horizontal brushing in 55% patients                                               | No data reported | No data reported | No data reported | 16–24 years | No data reported | 17.10% (112) NCCL of which 77% were CA | No data reported | No data reported | No data reported |
| Brandini et al.   | 2011 | Brazil  | Dental students  | 58      | 15 and 43 | Medium/hard brushing and higher force had greater NCCLs                            | Not significant | Med/hard | Not significant | 19–31 years | Hard brushing, toothpaste not significant | 53.50% | No data reported | 93% in post-sup quad, more in right |
| Bomfim et al.     | 2015 | Brazil  | Workers          | 100     | 55 and 45 | Age related increase, also with smoking                                            | No data reported | No data reported | No data reported | 20–68 years | No data reported | Total 19.4%. 5.03% in 18–34 years, 12.5% in 35–44 years, 28.5% in 45–68 years | No data reported | No data reported | No data reported |
| Oginni et al.     | 2003 | Nigeria | Patients         | 106     | No data reported | Use of local more abrasive dentifrices cause more prevalence                       | No data reported | No data reported | No data reported | 62.3%       | No data reported | 50.8% on left side in right-handed | No data reported | No data reported | 5.94                |

Total of 6 studies 1,037
## Table 5: Cervical abrasion data in South and Central Asian regions

| Author                  | Year | Country | Setting       | Samples | Gender | Important findings                                                                 | Toothbrushing data | Main cause | Prevalence | Index (TWI) | Teeth most affected | Mean number of teeth |
|-------------------------|------|---------|---------------|---------|--------|-------------------------------------------------------------------------------------|-------------------|-----------|------------|-------------|----------------------|-----------------------|
| Kumar et al.            | 2015 | India   | Special needs | 383     | 170 and 213 | Brush type, technique, frequency was significant                                    | Frequency: 23.8% 2x | Type: Hard 29% | Technique: Combination 27% and horizontal 26% | Age factor: 12–15 years | Main cause: Toothbrush | Prevalence: 19–25% | No data reported | No data reported | No data reported |
| Ahmed et al.            | 2009 | Pakistan | Patients      | 95      | 69 and 26 | Weak age correlation, no effect on occlusion, bruxism                              | No significant difference | No data reported | 50.3 mean | 73% horizontal brushing | No data reported | No data reported | All first premolars (molars least involved) | 7.06 |
| Sadaf and Ahmed         | 2014 | Pakistan | Patients      | 90      | 67 and 23 | No significant gender difference                                                   | 2/day not significant | Yes—hard | No data reported | No data reported | No data reported | No data reported | No data reported | No data reported | No data reported |
| Zhang et al.            | 2015 | China   | Students      | 720     | 360 each | Brushing less than 2x per day and duration less than 2 minutes increased tooth wear | No data reported | No data reported | No data reported | 15–19 years | No data reported | No data reported | No data reported | No data reported | No data reported |
| Zi Yun et al.           | 2015 | China   | General       | 1,759   | No data reported | Elderly group had more factors associated with lesions                         | No data reported | No data reported | Brushing method was significant in middle age group but not significant in older age group | 35–44 years and 65–74 years | No data reported | 76.8% and 81.3% | 82% middle age group had index of 2 and 64% of older group had index of 2. Index 4 was in 3.4% and 8%, respectively | See more in first premolars | 3.4 and 4.4 |
| Que et al.              | 2013 | China   | General       | 1,023   | No data reported | Lesions associated with age and periodontal status                             | Or 4.2 for 2x with horizontal compared to 1x vertical | Or 1.59 for horizontal vs vertical | 20–69 years highest in 60–69 years age group | No data reported | 61.70% | No data reported | Premolars | No data reported |

Total 6 studies: 4,070
Fifteen out of the 24 studies included prevalence rates. Only one of the five US studies explicitly noted the prevalence rate as 56%. Four EU studies noted the prevalence at 30%, 45%, 62%, and 85%. The four Brazilian prevalence rates ranged from 17% to a high of 88%. African rate was 17%. Chinese reported a high prevalence of 60–80% while India had a range of 19–25%. 8–8,10,13,17,19,21,22,23,24,26,28

**Age and Gender Data**

Seventeen studies had noted the age range of the participants. 8–8,10,11,13–17,19,21,22,24–26,28 The ages varied from schoolchildren (12–15 years) to middle age and elderly (60–69 years). Age-wise data agreed by our researchers suggested a gradual increase in prevalence with age. The 12–30 years age group had a rate of 19%, the 31–45 years group ranged from 30% to 60%, while the 46–69 years group ranged from 28% to 85%. Though there is much heterogeneity among the studies, the findings concur with the general opinion that CA and other noncarious lesions increase with age.

Gender specification was mentioned but had not been specifically assessed. Only two studies had reported higher prevalence in males. 8,22,24 One study did not find significant difference between the sexes. 26 Others did not report genderwise data.

**Toothbrushing Data**

Twelve out of the 24 studies had reported on the use of toothbrush with or without a dentifrice. The type of brush, the frequency of brushing, technique of brushing, and the frequency of brush change were also noted. 8–8,11,13,14,19,20,23,24,26,27

Six studies clearly state that brushing two or more times a day was significantly associated with CA. 8–10,14,20,29 Five studies did not report significant difference. 11,13,19,23,26 while the others had no data. The odds ratio of twice a day brushing was derived at 1.8 (Bernhardt et al.)–4.2 (Que et al.), compared to single daily use of toothbrush. Not surprisingly, studies reported a positive correlation between cervical lesions and good oral hygiene. 10,29

The type of toothbrush was mentioned in four studies. 8,19,20,26 All studies report that brushing with hard toothbrush was associated with higher lesion prevalence compared to medium and soft toothbrushes. The participants who reported using a high force for brushing were also associated with such lesions, though adequate information is scant in this aspect.

Technique of toothbrushing was reported in nine studies. 8–8,10,14,19,20,22,24,28 Overall, horizontal, circular, and mixed (horizontal–vertical and horizontal–circular) brushing techniques were associated with higher lesion prevalence compared to roll-type and vertical brushing. Three studies did not find significant differences in relation to brushing technique. 8,19,24 Que et al. found the odds ratio at 1.59 for horizontal vs vertical brushing. 10

A North American study found that brushing the facial surfaces first and lower arch first seemed to have a greater prevalence of lesions. 20 Comparing age groups, the significance of technique appeared to be lower in elderly people.

The few studies that mention the use of toothpaste report that they do not significantly affect the prevalence of abrasion independent of the brush type or brushing technique. 11,14,25

Almost all the studies agree that vigorous brushing is a factor in development of CA.

**Tooth-related Data**

Ten studies specified the teeth most affected in abrasion. 8–8,10,18,19,23,25,28,29 Generally, posterior teeth, maxillary teeth, and premolars seem to be usually affected by CA. Premolars especially are the most affected teeth. Seven studies report that premolars are affected in almost all participants. Furthermore, first premolars and lower premolars are the maximum affected. Regarding the side of the arches, there are conflicting reports. Studies do not find a significant difference between the right and left sides. Most of the studies had not mentioned the handedness of the participants; therefore, it is not possible to make a cogent finding in this aspect. Most of the studies did not assess the extent of wear by standardized methods. Among the studies that did so, the tooth wear index (TWI) by Smith and Knight was preferred. 30

To summarize, the results indicated adequate prevalence data from studies across countries, with a wide range from 17% to 80%. Ages ranged from schoolchildren (12 years) to the elderly (69 years), with good evidence of age-related increase in abrasive lesions, while gender data are inadequate. Toothbrushing data were clear on the significant effects of brushing frequency and vigorous method on prevalence of abrasive lesions. Maxillary teeth and premolars seemed to be more vulnerable to dental abrasion.

**DISCUSSION**

Noncarious cervical lesions are one of the most common dental issues that affect a large section of the population. They include abrasion, abfraction, and erosion. Abrasion is due to the action of mechanical processes not related to physiological activities like mastication. It is mostly due to injudicious use of toothbrush and dentifrices. It is seen as a sharp wedge-shaped defect in the exposed root surface of the tooth. Abfraction is a type of lesion that is said to arise from flexural stresses to the tooth that can result from biomechanical loading factors. Erosion is due to chemical action not related to dental caries. 1,2

There are many theories of development of NCCLs. The abfraction theory (Lee and Eakle) suggests that biomechanical forces due to high occlusal loading cause flexure and tensile stress concentrations at the cervical region. This results in microcracks between hydroxypatite crystals. The abrasion theory suggests that soft tissue loss above the cementoenamel junction (gingival recession) causes exposure of cemental surface. This surface is susceptible to wear due to toothbrushing with abrasives. This accompanied by the aforementioned factors, which results in abrasive cervical defects. 3

There is a lot of confusion regarding the terminology among researchers over the world. Many researchers accept abfraction as not more than a theoretical concept. Others postulate that all NCCLs are abfractions and not due to abrasive action. Abrasion may be confusing to distinguish from cervical erosion if history and other factors are similar. There may be a higher incidence of cervical erosion in people consuming acidic drinks and simple carbohydrates. 4,5

Grippe et al. postulated a multifactorial illustration of NCCLs and categorized CA as both endogenous and exogenous defects due to friction. Endogenous causes were mastication and tongue activity, while exogenous causes were dental hygiene, habits, occupation, and presence of dental appliances. The author earlier (1991) first defined the term abfraction from “ab fractio” meaning to break away. They also proposed replacing the term erosion with the more appropriate “biocorrosion.” 1,2

A critical review by Bartlett and Shah in 2006 regarded abfraction as hypothetical and experimental, and opined that there is no conclusive evidence to backup the abfraction theory.
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Therefore essentially, the overwhelming proportion of NCCLs would appear to be abrasions.6

Abrasion has been reported by many authors to be mainly due to toothbrushing using a dentifrice. The dentifrice is regarded by some researchers to be important compared to using plain toothbrush, which does not seem to cause abrasion on its own. However, there are multiple factors involved in its pathogenesis, including salivary characteristics (pH, buffers, calcium–phosphate levels, and flow rate), tooth position, periodontal factors, type/composition of toothbrush, and toothpaste, etc. Use of drugs and occupational factors may also have to be accounted.5-6

A review by Wood et al. concluded that cervical lesions were multifactorial in etiology and proportional to age and were more common on the facial surfaces of teeth. The shape of the lesion does not correlate with etiology, and significantly, the long-term benefit of treatment is unclear.3

Heasman et al. did a meta-analysis of the effect of toothbrushing (excluding toothpastes) on development of cervical lesions. They did not find conclusive evidence of toothbrushing due to conflicting results obtained by various studies. Furthermore, longitudinal studies were lacking in the analysis. They postulated that the frequency, method, and the hardness of bristles may be associated with more cervical lesions. Direct causative link is yet to be established.4

Litonjua et al. reported on the discrepancies in the prevalence data of NCCLs due to lack of standardization, resulting in confusion and subsequent misdiagnosis of these lesions over the world. Attrition, abrasion, and erosion can simultaneously occur and act sequentially, synergistically, or additively. Treatment planning is dependent upon the etiology and pathogenesis of each individual lesion. Another article by the authors advised that the single-etiologic terms like attrition and erosion may be replaced by the term NCCL since there is more and more evidence of multifactorial etiology of cervical lesions.31,32

An in vitro study by Bizhang et al. reported an unexpected finding that use of soft toothbrushes with dentifrice had higher number of dentinal loss compared to medium or hard brushes. The reason presumably was that soft brushes were more hemogenous and flexible with larger surface area resulting in greater dispersion of toothpaste on the dentinal surfaces. However, being an in vitro study, the various factors involved in the oral environment need to be considered in order to obtain a conclusive finding.33

Limitations of the Current Literature and Protocols—Future Trends

The present review concurs with the prevalent consensus that the etiology of CA is multifactorial; the occurrence of other cervical lesions simultaneously cannot be ruled out. The confusion in terminology and diagnosis confounds the proper analysis of purely abrasive lesions. There cannot be a completely foolproof method to segregate CAs from any of the NCCL studies. Moreover, studies that focus on CA alone are very rare and suffer from the same diagnostic issues. Furthermore, the prevalence ranges varied considerably within and across populations.

There was no consensus on the type of measurement indices that are to be followed. This resulted in a complete lack of quantifiable information as to the extent of the lesions. Therefore, there is need for a standardized tool to measure the extent of the CA lesions. A simple index of measurement is also necessary for uniformity of data compiled throughout the world. Such a reliable protocol can help in formulation of treatment plans.

Treatment Modalities

The objective of management of CA and other NCCLs is to arrest lesion progress, to strengthen the tooth to withstand functional stresses, to mitigate dentine hypersensitivity, to reduce likelihood of pulpal involvement, and also to enhance esthetics and prevent further retention of plaque and associated factors. In all restorations, the most important clinical complications were secondary caries, fracture and wear, marginal discoloration, and color mismatch, etc. NCCLs rarely occur without soft tissue lesions including gingival recession and periodontal disease, and therefore, it is imperative to sustain soft tissue health as part of a holistic management. The abfraction theory of flexural stress might also need to be considered in intransigent cases.34

Cervical abrasion is usually treated by surface preparation and restoration, with a suitable adhesive or micromechanical bond-based material. Additional retentive mechanisms like cavo-surface beveling have been discussed in many studies (systematic review by Schroeder et al.). Overall, many researchers are of the opinion that there is no conclusive evidence to suggest that beveling is critical to the success of the restorations. However, it does seem to have a positive effect in the retention of such restorations.35

Various studies had evaluated different materials and restorative techniques over the years. In the Brazilian study, the 2-year retention rate of composite cements for CA was 78.8%. The authors noted that variable 3-year retention rates ranging from 50% to 100% was reported by many studies. Resin-modified glass ionomer restorations (RMGICs) had a retention rate of 100%. This would indicate that RMGIC was a better alternative to composites, though both materials are acceptable to restore dental abrasion.36-45

Conclusion

Cervical abrasion has been established to be due to the vigorous use of toothbrush with or without an accompanying dentifrice. The prevalence varies and there is need to devise a standardized protocol for diagnosis. There is a significant correlation between prevalence and increasing age. There is no significant gender difference. Higher frequency and use of harder brush bristles were associated with higher prevalence of wear. Posterior and maxillary dentition is most affected by abrasion.

Cervical abrasion should be considered along with other NCCLs as a holistic approach. Soft tissue pathology like gingival recession and attachment loss should also be managed appropriately for the long-term success of treatment. There is a need to devise a standard index that is followed by all clinicians that should be simple and reliable. Future trends point to the development of reliable instruments and indices for clinical assessment and consequent formulation of appropriate treatment plans.

Ethics Statement

This systematic review is free from ethical concerns.

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