

Dental and Oral Health Challenges in Patients with Eating Disorders: An Updated Review

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Abstract

Eating disorders are complicated psychiatric disorders with profound systemic and oral health implications that are often not identified in clinical practice. Dietary restriction, binge eating, and self-induced vomiting are disorders eating behavior that negatively impact the oral cavity via nutritional deficiency, exposure to acid, malfunction of salivary activities, and changes in immune and microbial. These processes lead to a wide spectrum of oral and dental effects such as dental erosion, caries, periodontal disease, mucosal lesions, alterations in salivary glands and temporomandibular complications that may compromise functionality, aesthetics, and the quality of life. The role of dental professionals in ensuring that eating disorders are detected at an early stage is of great significance because the oral manifestations can be realized prior to diagnosis. The most effective dental management in terms of prevention, conservation, and sensitive communication and multidisciplinary referral on time is of utmost importance. Incorporating oral health services into the overall medical and mental health systems can help decrease the burden of oral diseases and aid in the general recovery. In order to enhance oral and systemic results among people with eating disorders, this review highlights the necessity of early identification, ethical care, and team management.

Keywords: Dental erosion, dental health, early detection, eating disorders, multidisciplinary care

INTRODUCTION

Eating disorders (EDs) are severe and multidimensional psychiatric disorders that are associated with chronic disturbances in eating habits, which negatively impact physical, psychological, and social functioning. Anorexia nervosa, bulimia nervosa, binge eating disorder, and similar disorders have become widely known as significant health issues of the population as they have become more prevalent, start at an early age, have a chronic progression, and are associated with high morbidity. In addition to systemic effects, which are well documented and which comprise metabolic imbalance, cardiovascular complications, gastrointestinal dysfunction, and endocrine disturbances, the effects of eating disorders on oral health are far-reaching and under-evaluated [1]. The oral cavity is the most susceptible since it is in direct contact with behavioural and physiological ramifications of disordered eating, including chronic nutritional deficiencies, chronic intake of acidic food, and compensatory mechanisms such as self-induced vomiting or laxative abuse. All these conditions lead to a vast range of oral presentations with dental erosion, caries predisposition, periodontal disease, salivary gland dysfunction, xerostomia, mucosal lesions, and orofacial pain, which can substantially decrease mastication, speech, aesthetics, and the quality of life. Notably, oral manifestations are potentially some of the first and most easily apparent clinical signs of a psychiatric or medical

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underlying eating disorder and may in many instances come before formal medical or psychiatric diagnosis [2]. Therefore, the oral health status has significant clinical consequences since unchecked dental and oral complications might augment nutritional losses, support disordered eating patterns, and adversely affect psychological healing. The importance of early recognition, preventive intervention and interdisciplinary collaboration is also crucial and highlighted in recent literature as oral health is a part of overall care in patients with eating disorders (Table 1) [3].

Table 1. Types I–IV hypersensitivity reactions and their key features.

Type of hypersensitivity	Alternative name	Primary immune mediators	Underlying mechanism	Time of onset	Common clinical examples	Pharmaceutical relevance
Type I	Immediate Anaphylactic	IgE antibodies, mast cells, basophils	Allergen-induced cross-linking of IgE on mast cells leads to release of histamine and other mediators	Seconds to minutes	Allergic rhinitis, asthma, urticaria, anaphylaxis	Drug allergies (penicillin), vaccine reactions, biologic-induced anaphylaxis.
Type II	Antibody-mediated cytotoxic	IgG or IgM antibodies, the complement system	Antibodies bind to cell-surface antigens, causing complement activation or ADCC	Minutes to hours	Hemolytic anemia, blood transfusion reactions, Goodpasture syndrome	Drug-induced hemolysis, transfusion incompatibility.
Type III	Immune complex-mediated	IgG/IgM immune complexes, complement	Deposition of antigen-antibody complexes in tissues causing inflammation	Hours to days	Serum sickness, systemic lupus erythematosus, glomerulonephritis	Immune complex reactions to biologics and antitoxins.
Type IV	Delayed-type hypersensitivity	Sensitized T lymphocytes (Th1, CTLs)	T-cell-mediated inflammation and cytotoxicity	24–72 hours	Contact dermatitis, tuberculin reaction, chronic transplant rejection	Delayed drug hypersensitivity, topical agent reactions.

EATING DISORDERS: TYPES AND ORAL HEALTH RELEVANCE

The eating disorders are a continuum of psychiatric disorders characterized by maladaptive eating habits that have major and disorder-specific impacts on oral health, and therefore, it is clinically relevant to classify them in dental terms as a risk factor and their management. The wide categories are anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified feeding and eating disorders, each of which has specific behavioural patterns that translate into varying oral health risk factors. Anorexia nervosa is mostly linked with lifelong dietary restrictions and gross malnutrition, resulting in a compromised mucosal structure and salivary gland functions, leading to dental caries, periodontal disease, mucosal atrophy, cheilitis, and delaying wound healing [4]. Conversely, bulimia nervosa is closely associated with the frequent binge-purge cycles, and self-induced vomiting exposes the teeth and oral soft tissues to gastric acid, leading to typical patterns of dental erosion, dentin hypersensitivity, enamel surficiality, and an increased risk of caries caused by diminished salivary buffering capacity. The binge eating disorder, in the absence of compensatory purging, is linked to a high intake of high sugar food and acidic food, abnormal eating habits, and poor oral hygiene habits, which all increase the probability of dental caries, gingivitis, and halitosis. In all types of eating disorders, other oral health risk factors would include xerostomia due to dehydration or medications or dysfunction of salivary

glands, immunological impairment that increases susceptibility to oral infections, and behavioural aspects such as not brushing their teeth regularly and irregular oral hygiene [5]. In recent literature, the use of these oral manifestations is not just a secondary complication, but a clinically significant feature that can even precede medical diagnosis, impact nutritional intake, increase pain and discomfort, and have a negative impact on quality of life and adherence to treatment. It is thus vital to learn how certain eating disorder habits and oral disease patterns are correlated to detect them early and prevent them specifically. An organized review of the types of eating disorders and their risks to oral health is summarized in Table 2, confirming the necessity to consider dental examination as part of the multidisciplinary model of care of a patient with an eating disorder [6].

Table 2. Types of eating disorders and associated oral health risks.

Type of eating disorder	Key behavioural features	Major oral health risks
Anorexia nervosa	Severe dietary restriction, malnutrition	Dental caries, periodontal disease, mucosal atrophy, xerostomia.
Bulimia nervosa	Binge eating with self-induced vomiting	Dental erosion, dentin hypersensitivity, enamel loss, caries.
Binge eating disorder	Recurrent binge eating without purging	Dental caries, gingivitis, halitosis.
Other specified feeding and eating disorders	Mixed or atypical behaviours	Variable oral manifestations depending on behaviours.

MECHANISMS OF ORAL AND DENTAL DAMAGE

Oral and dental damage in eating disorders results from inter-religious biological and behavioural processes that together affect the integrity and resistance of the oral cavity. Among the main pathways, there is a role of nutritional deficiency, especially the lack of proteins, calcium, phosphorus, vitamins A, C, D, and B-complex, which are necessary in the process of mineralizing the enamel, producing collagen, maintaining immunity, and the integrity of the mucous. Ongoing malnutrition makes the hard and soft tissues weak, resulting in more enamel porosity, slows tissue repair, causes gingival inflammation, and increases vulnerability to dental caries and periodontal disease [7]. Simultaneously, acid exposure is a prevailing agent of harm, particularly in those patients who undergo frequent self-induced vomiting or excessive intake of acidic substances and drinks. Preexposure to gastric acid leads to the progressive demineralization and erosive wear on the teeth, especially palatal and occlusal, and mucosal irritation of the oral mucosa and changes in the oral pH environment. Such effects are also enhanced by salivary dysfunction since eating disorders are often related to the presence of hyposalivation or xerostomia caused by dehydration, electrolyte imbalance, pathology of the salivary glands, or the presence of psychotropic medications. A decrease in the flow of saliva decreases the buffering capacity, antimicrobial effect, and the potential remineralization, thus enhancing the rate of enamel loss, caries, and mucosal discomfort. Moreover, immune and microbial changes have a significant part in the oral pathology because malnutrition and chronic stress suppress the functioning of host immune processes and allow the oral microbiota to the more cariogenic and periodontopathogen species. This dysbiosis facilitates the formation of biofilms, gingivitis, opportunistic infections, such as oral candidiasis, and delayed oral lesion healing [8].

These biological vulnerabilities are further complicated by behavioural factors, such as poor oral hygiene practices and not attending to dental care regularly. These interacting systems all make up a vicious cycle where behavioural tendencies and physiological dysfunctions exacerbate the progression of oral diseases and increase the severity of symptoms [9]. The interrelation between nutritional compromise, acid-mediated damage, salivary impairment, and immune-microbial imbalance can be schematically represented in Figure 1, which depicts the pathophysiological processes through which eating disorder behaviours are related to oral and dental tissue destruction. The knowledge of these mechanisms is essential to detect them early and to have a specific approach to prevent them and elaborate on the coordination of overall management plans that take into account the oral presentation and the pathology of the underlying system disorder [10].

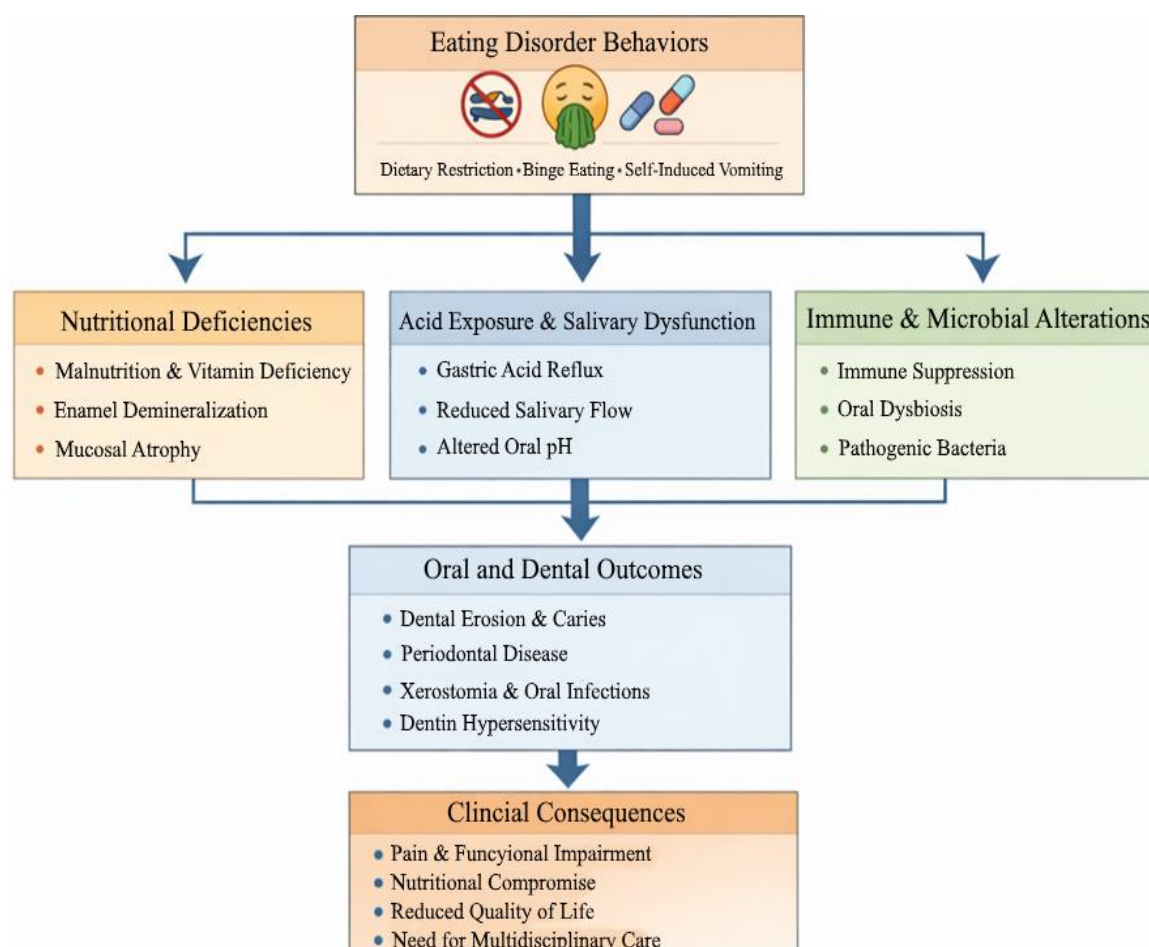


Figure 1. Pathophysiological link between eating disorder behaviors and oral health outcomes.

ORAL AND DENTAL MANIFESTATIONS

Oral and dental conditions are among the most easily noticeable and clinically practicable implications of eating disorders that is the result of the combined impact of nutritional compromise, exposure to acid, salivary malfunction, and immune malfunction. One of the most notable symptoms is dental erosion especially in people with purging behaviors, in which the recurrent exposure to gastric acid results in the systematic demineralization of enamel, thinning of the tooth structure, dentin exposure, and even hypersensitivity, most often on the palatal surfaces of maxillary teeth. In addition to erosion, dental caries is also common in all types of eating disorders because of decreased salivary flow, compromised buffering ability, high consumption of cariogenic foods during the binge period and irregular oral hygiene habits [11]. Periodontal disease has also been common which is triggered by the buildup of plaque, inflammation of the gums, and the loss of immune defense, and chronic malnutrition reduces the ability to produce collagen and heal wounds, thus promoting the breakdown of periodontium. The involvement of soft tissue is also considerable with the presence of lesions of oral mucosa, including angular cheilitis, glossitis, aphthous ulcers, and mucosal atrophy in general, often being associated with iron deficiencies, vitamin B-complex deficiencies, and vitamin C deficiency, along with dehydration and mechanical irritation. Changes in salivary glands, such as enlargement of parotid glands, xerostomia, and alteration of salivary composition, are common in vomiting and dehydration and use of psychotropic medications, which also lead to complications in mastication, swallowing, and speech, further predisposing them to caries and mouth infections [12]. Moreover, the repetition of vomiting, the overload of the masticatory muscle, bruxism, and psychological stress can cause the development of the temporomandibular joint complications and orofacial pain, which consequently result in the tenderness of the joint, the limitation of its opening, and functional impairment. These together largely lead to poor oral functioning, aesthetics, nutrition, and life quality,

which underlines the need to identify and manage oral manifestations in a multidisciplinary environment early; a concise summary of oral manifestations, mechanisms, and clinical implications is provided in Table 3 [13].

Table 3. Oral manifestations, underlying mechanisms, and clinical implications.

Oral manifestation	Underlying mechanisms	Clinical implications
Dental erosion	Repeated exposure to gastric acid from vomiting, lowered oral pH, and reduced salivary buffering capacity	Enamel loss, dentin exposure, hypersensitivity, aesthetic compromise, increased fracture risk.
Dental caries	Xerostomia, frequent intake of cariogenic foods during binge episodes, and poor oral hygiene	Tooth decay, pain, infection risk, impaired mastication.
Periodontal disease	Plaque accumulation, immune suppression, and nutritional deficiencies affect collagen synthesis	Gingival inflammation, attachment loss, tooth mobility, and eventual tooth loss.
Oral mucosal lesions (cheilitis, glossitis, ulcers)	Deficiencies of iron, vitamin B-complex, vitamin C; dehydration; mechanical irritation	Oral pain, ulceration, difficulty in eating and speaking.
Salivary gland changes (xerostomia, parotid enlargement)	Vomiting behaviors, dehydration, electrolyte imbalance, and medication effects	Dry mouth, increased caries risk, swallowing difficulty, and oral infections.
Temporomandibular joint disorders	Repetitive vomiting, excessive muscle activity, bruxism, and psychological stress	Orofacial pain, joint tenderness, limited mouth opening, functional impairment.

ROLE OF DENTAL PROFESSIONALS IN EARLY DETECTION

Dental practitioners are very important in overseeing the early detection of eating disorders because there are usually characteristic alterations on the oral cavity prior to the official diagnosis of the medical or psychiatric situation, making regular visits to the dentist an effective entry point of an early intervention. One can be suspicious of disordered eating behaviors by clinical findings of unexplained palatal or occlusal tooth erosion, diffuse enamel thinning, dentin hypersensitivity, frequent dental caries despite sufficient restorative treatment, or indications of xerostomia or a change in the salivary flow [14]. There are other warning signs such as an enlargement of parotid glands, angular cheilitis, atrophy of mucosas, lesions of erythematous/ulcerative

lesions and periodontal inflammation that seems disproportionate to the amount of plaque, temporary mandibular joint tenderness, masticatory muscle fatigue and bruxism can also be additional indicators of clinical concern. Such oral results, especially in the context of behavioral indicators, such as repeated cancellations of appointments, excessive concern about body weight or appearance, aversion to discussing dietary patterns, etc., must be interpreted as a potential underlying cause by clinicians, not as an independent dental pathology, as Figure 2 depicts. In addition to identification, there is the ethical communication and referral which are inseparable with the professional responsibility of the dentist and must be done with nonjudgmental and sensitive words that respect patient autonomy and are not accusatory of diagnostic description [15].

Some of the questions that can be used to encourage disclosure and ensure the preservation of trust include open-ended, patient-centered questions that touch on oral symptoms, general health, and well-being, guided by confidentiality and informed consent. When the clinical concern is proven, it is necessary to refer suitable medical, nutritional, or mental health providers in the framework of multidisciplinary care in time. Dental practitioners can make a significant contribution to the early diagnosis, reduce the development of oral diseases, and contribute to better overall results of people with eating disorders by positioning themselves as supportive participants in the overall healthcare system, focusing on oral health preservation and patient safety instead of weight and appearance [16].

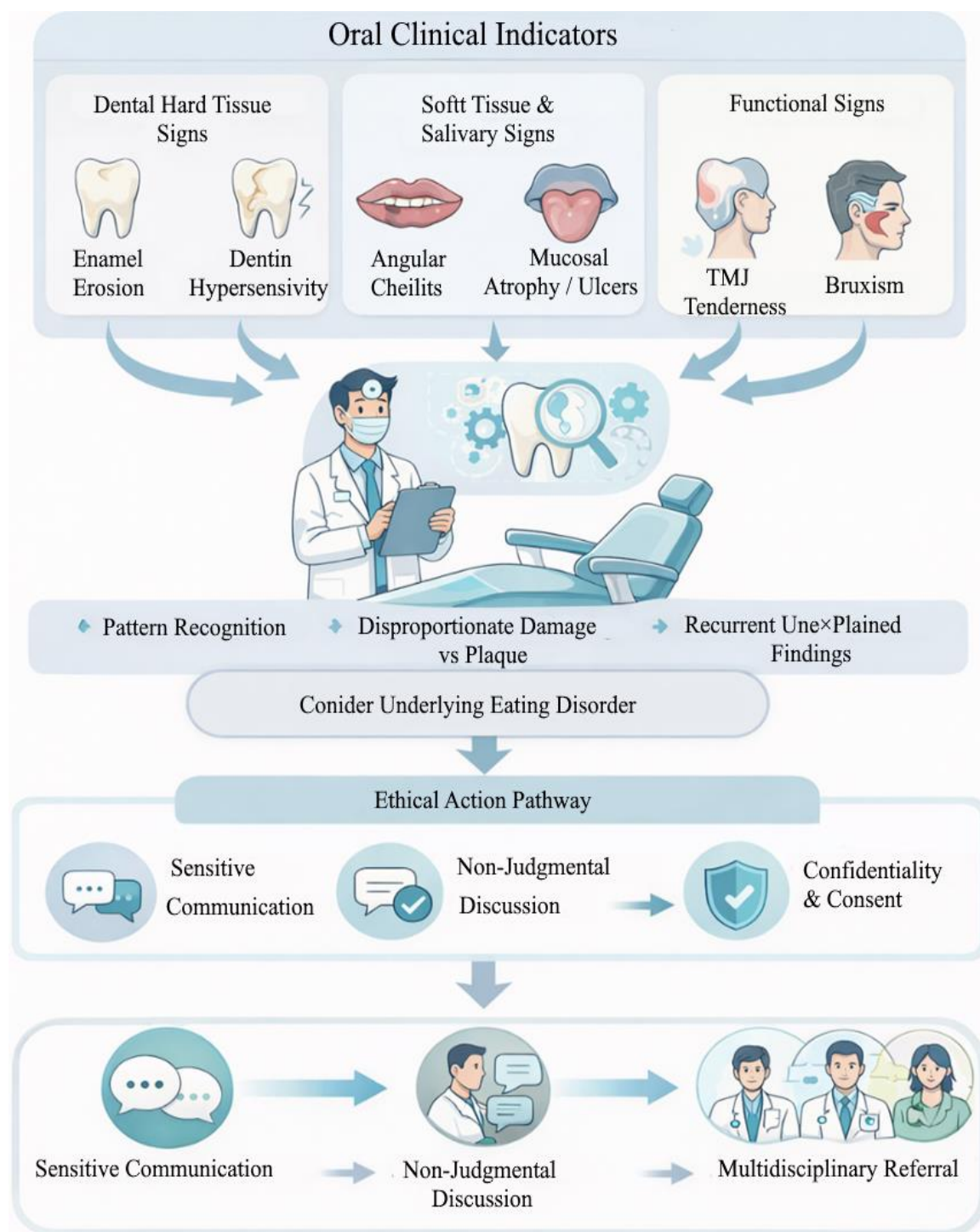


Figure 2. Oral clinical indicator.

CLINICAL MANAGEMENT AND PREVENTIVE CARE

Treatment and prevention of eating disorders in patients needs a relatively simple, yet comprehensive and individual approach to clinical management and prevention, which focuses on the protection of oral tissue and supplements the entire recovery process. Prevention methods are the main part of the care and must be directed at minimizing the additional harm related to acid exposure, xerostomia, and cariogenic issues. Patients are supposed to be taught about not brushing their teeth immediately after vomiting or eating acidic foods to avoid the loss of erosive enamel but instead they should rinse their mouths with water, bicarbonate, or fluoride-containing mouth rinses to normalize oral pH [17]. With

the help of regular use of high-fluoride toothpaste, topical fluoride treatments, and remineralizing fluoride agents like calcium based and phosphate based products, weakened enamel can be strengthened and hypersensitivity can be lessened. Treatment of xerostomia with sufficient hydration, chewing gums, sugar-free, salivation substitutes, and (when necessary) salivary stimulants is required to provide oral lubrication and buffering. Patient education needs to be presented in an empathetic way with an emphasis on oral health maintenance and not on dietary management or weight management discussions, the reinforcement of mild oral hygiene routines, the need to exhibit regular dental check-ups, and the significance of oral health in comfort, functionality, and quality of life [18].

The restorative and supportive dental care should be conservative and symptom-based along with prevention, especially in the active stage of the eating disorder. To treat dentin hypersensitivity and early erosive lesions, desensitization of dentin and protective resin sealants, and minimally invasive restorations can be implemented whereas large-scale rehabilitative treatment of erosion should be avoided until the disease is stabilized to prevent restoration breakdown. Non-surgical management, control of plaque, and maintenance therapy should be considered as the ideas of periodontal therapy, and it should be acknowledged that impaired healing and immune response may have an impact [19]. The fabrication of occlusal splints to treat bruxism and temporomandibular discomfort may also be considered as supportive care, or frequent evaluations of the progression of erosion or caries. Notably, the clinical dental management is to be incorporated into a multidisciplinary model, and there should be a close interaction between the dental practitioners, the physicians, the nutritionists and the mental health specialists to maintain a consistent flow of care and patient safety. With the integration of focused preventive care, limited restorative care, and focused patient care education, dentists can reduce the risk of oral complications, provide relief, and play a significant role in the overall therapeutic objectives of patients with eating disorders [20].

MULTIDISCIPLINARY MANAGEMENT APPROACH

A *multidisciplinary management approach* is essential for the effective care of patients with eating disorders, as these conditions involve complex interactions between psychological, nutritional, and physical health that cannot be adequately addressed by a single discipline. Integrated care models emphasize close collaboration between *dental professionals, mental health specialists, physicians, and nutritionists*, ensuring that oral health management aligns with the broader therapeutic goals of medical stabilization and psychological recovery. Within this framework, dental professionals serve not only as providers of preventive and restorative care but also as key contributors to early identification and ongoing monitoring of oral complications associated with eating disorders [11].

Mental health professionals address the underlying psychopathology and maladaptive behaviors, while physicians manage systemic complications and nutritionists guide safe nutritional rehabilitation, thereby reducing behaviors that perpetuate oral damage such as vomiting, dietary restriction, or binge eating. Effective communication and clearly defined referral pathways are critical to avoid fragmented care, ensure patient safety, and reinforce consistent health messaging [21].

Importantly, patient-centered coordination allows treatment plans to be adapted according to disease severity, stage of recovery, and individual psychosocial needs, with confidentiality and informed consent guiding information sharing across disciplines. Regular follow-up and feedback among team members help monitor both oral and systemic outcomes, enabling timely modification of preventive strategies, dental interventions, and behavioral therapies [22]. This collaborative approach not only minimizes the progression of oral disease but also supports adherence to treatment, improves quality of life, and enhances long-term recovery outcomes. The sequential and interconnected steps involved in coordinated multidisciplinary care – from dental screening and sensitive communication to referral, diagnosis, and integrated management – are outlined in Figure 3, which illustrates a structured pathway for managing patients with eating disorders within a collaborative healthcare model [23].

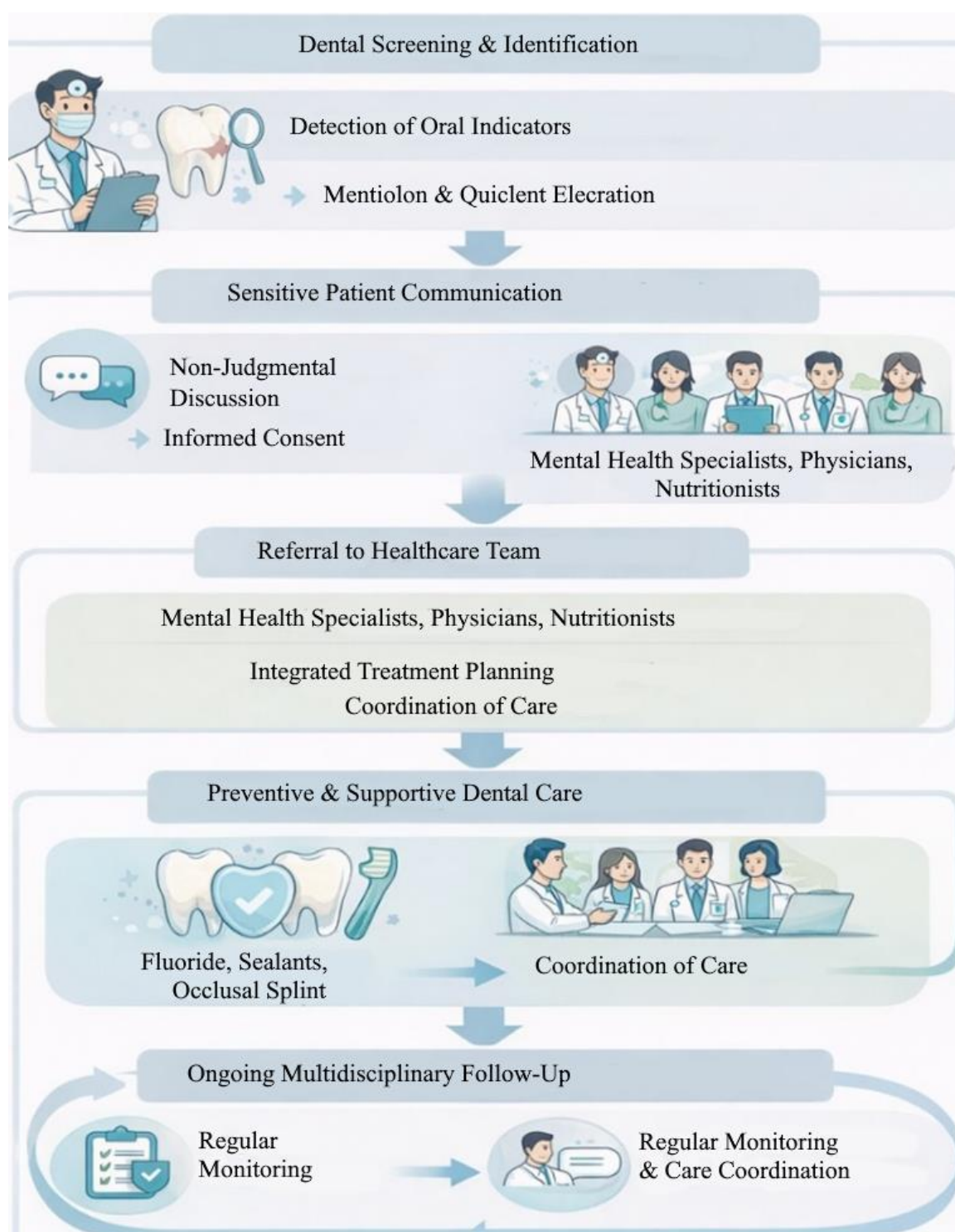


Figure 3. Dental screening & indentification.

CHALLENGES, LIMITATIONS, AND FUTURE DIRECTIONS

Treatment of eating disorders in oral health is linked to various clinical, ethical, and research related issues that inhibit the best prevention and treatment results. Clinically, due to the insidious and uncharacteristic nature of oral manifestations and the ordinarily hesitant nature of patients to report disordered eating habits, early identification continues to be tough and results in late-onset and absence of early oral disease diagnosis [24]. Multifactorial nature and complexity of the pathology of eating disorders compounds further the process of dental management as continuous actions like vomiting,

dietary cutback, and binge eating may nullify preventive and restorative interventions and leave the treatment vulnerable to failure. The ethical issues revolve around ensuring that there is a balance between autonomy and confidentiality of the patient, as well as the role of the clinician in making the right referral and multidisciplinary care, especially in stigmatized, judged, or denied cases [25]. Also, the lack of consistency in training dental practitioners on the identification of eating disorders and ethical involvement is a major constraint in the everyday practice. Research-wise, there exists a significant gap in the form of strong, longitudinal research findings on how to guide standardized dental management treatment in patient with eating disorders and a small number of clinical trials assessing the effectiveness of preventive and restorative measures in patients with eating disorders [4]. New insights indicate that innovative interdisciplinary education, organized screening instruments, and integrated care models could have a positive impact on the process of early detection and treatment coordination. Innovations in digital health, salivary diagnostics, and oral microbiome studies can also be used to promote individual risk assessment and specific interventions. To mitigate the latter challenges, a stronger clinical awareness, ethical sensitivity, and research-backed approaches are required to maximize the outcomes of oral and systemic health and recovery in eating disorder survivors in the long run [26].

CONCLUSION

The close interactions between the personal disorders of the psyche, the overall physiology, and the oral setting make eating disorders an acute but under-acknowledged threat to the well-being of the oral and dental organs. This review highlights the far-reaching implications of behavioral aspects of eating disorders, including dietary restriction, binge eating, and purging, on oral tissues. These aspects cause nutritional deficits, exposure to acids, salivary dysfunction, and immune-microbial changes, leading to a broad range of dental and oral manifestations. Those complications not only damage oral functions and make it less aesthetically pleasing, but also may lead to nutritional depletion and have a deleterious effect on the overall quality of life and recovery outcomes. Dental practitioners are in an ideal place to detect cases of early diagnosis because when professionally approached, oral manifestations can show signs of medical diagnosis before it is formal, and thus early intervention is necessary. This would necessitate effective management with a preventive and minimally invasive approach to dental care, which is part of a multidisciplinary care model comprising of mental health, medical, and nutritional practitioners. Although awareness is increasing, there is still a problem with early diagnosis, patient disclosure, and ethical communication, as well as the absence of standardized and evidence-based dental management guidelines. The future development relies on the increased level of interdisciplinary cooperation, professional training improvement, and research aimed at prevention methods and long-term consequences. Considering oral health as a part of universal eating disorder management, healthcare professionals can prevent oral health complications, assist patients in recovery, and make their own contributions to better patient holism.

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