

Wearing Away; Causes, Diagnosis, Prevention and Management: A Review

Review Article

Volume 2 Issue 1- 2022

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Article History

Received: March 11, 2022 Accepted: March 23, 2022 Published: April 25, 2022

Abstract

Tooth surface loss or tooth wear is the diminution of hard tissues of the tooth including enamel and dentin caused by factors barring dental caries. Tooth wear is the consequence of attrition, abrasion, erosion or abfraction or a combination of these. The pathological wear of tooth surface can be caused by bruxism, which is clenching and grinding of teeth. This can also lead to dental hypersensitivity, compromise in function, forfeiture of esthetics due to loss of vertical dimension. Attrition is the aftermath of tooth to tooth grinding due to functional and para-functional habit. This review article predominantly focusses on dental attrition as the cause of tooth wear and also emphasize on the etiology, incidence, clinical features, diagnosis, significance of differential diagnosis, management and prevention.

keywords: Attrition; Tooth wear; Bruxism; Parafunctional habit; Wear facets

Introduction

Tooth surface loss or tooth wear is an irreversible loss of dental hard tissues. In addition to carious process, non carious processes such as attrition, abrasion, erosion, and abfraction also destruct tooth structure [1].

Historically, dental caries was the leading cause of tooth loss and dental hard tissue loss. Fluoride introduced in the 1930s has significantly reduced the incidence, prevalence and severity of dental caries [2]. Tooth wear is another stereotypical cause of tooth loss. Tooth surface loss or tooth wear is an irreversible, non carious and destructive process which results in a functional loss of dental hard tissue. Tooth wear can be clinically observed as attrition, abrasion, erosion and abfraction [1].

The term “tooth wear” also refers to tooth surface loss. Dental attrition refers to the wearing of dental hard tissues caused by tooth-to-tooth contact without any foreign substances interfering [3].

Classification of Tooth Surface Loss

Mechanical loss

Attrition: Dental attrition is the loss of tooth substance occurring as the result of tooth to tooth contact or mechanical wear between the antagonistic surfaces of teeth during mastication or parafunctional movements of the mandible [4].

Abrasion: From the Latin verb “abrasum”(to scrape off) comes the word “abrasion”[5].It means wearing away of the substance or structure through mechanical process.Abrasion is pathological wearing of teeth as a result of another process,abrasive substances or habits [6].

Chemical loss

4.2.1. Erosion: Dental erosion can be defined as the loss of hard tooth structure by chemical means, notably acids. The acids involved in the erosive process may be intrinsic or extrinsic which are of non-carious origin [7].



Biomechanical loss

Abfraction: The term abfraction, derived from the Latin verb *frangere* (to break), describes a wedge shaped defect at the cement enamel junction of a tooth.

According to The Glossary of Prosthodontic Terms (2017), abfraction is defined as “the pathologic loss of hard tooth substance caused by biomechanical loading forces; such loss is thought to be the result of flexure and chemical fatigue degradation of enamel and/or dentin at some location distant from the actual point of loading” [8]

From the Latin verb ‘*attritum*’, comes the word ‘*attrition*’ which means the action of rubbing against something. Attrition is most frequently encountered on incisal surfaces of the anterior teeth and occlusal surface of posterior teeth. Contact points on the proximal surfaces transmute into contact areas predominantly as a consequence of this mechanical wear. The restorations at the same time wears the adjacent tooth structure at the same rate in mechanical wear [9].

Attrition is one of the most commonly seen non carious lesion. It is also the main cause of debilitation of natural dentition and subsequent degradation of occlusion. It is important to differentiate attrition from other types of tooth surface loss for easy understanding of etiology of tooth wear. Thus, this article revolve around the causes, etiopathogenesis, incidence, clinical features, diagnosis, significance of differential diagnosis, management and prevention of attrition

Etiology of Attrition

Dental attrition is considered to have multifactorial etiology characterized by musculoskeletal, craniofacial and stomatognathic inter-relationship.

Physiologic process

Attrition is considered as a normal physiologic process with age but however several other factors may also cause exorbitant and pathological wear of teeth [10].

Developmental defects/anomalies

Developmental anomalies such amelogenesis imperfecta, dentinogenesis imperfecta causes rapid wear of the teeth because of very thin and friable enamel as in former and weak enamel and dentin attachment which results in easy separation as in latter [11].

Psychological factors and parafunctional habits

Though attrition is common in older individuals, numerous studies have reported attrition to be more and more seen in children and young adults and is typically linked to bruxism. There is possibility that stress and anger experienced by young individuals might cause dental attrition [12].

Bruxism, grinding habits.

Pencil/pen biting, Pipe smoking and holding object between teeth accelerates attrition [13].

Bruxism is a parafunctional and non-productive practice of clenching or grinding the antagonist surfaces of the teeth which is catastrophic in nature.

Bruxism has been defined by the American Academy of Sleep Medicine as the “repetitive jaw muscle activity characterized by the clenching or grinding of teeth and/or bracing or thrusting of the mandible” [14]. Bruxism is conventionally a retaliation of increased stress and anger as shown in flowchart

Bruxism can be broadly classified into

Sleep Bruxism (SB)

Awake Bruxism (AB) [15].

Iatrogenic causes

Faulty restoration, coarse porcelain restoration.

Improper interocclusal relationship due to failure orthodontic rehabilitation [16,17].

Other causes

TMJ disorders: Most patients with TMD showed posterior teeth wear (61%) than generalized teeth wear. Thus, association was present between occlusal teeth wear and TMD patients especially in the age group of 26-40 years [18].

Coarse and non-refined diet.

Other adverse habits.

Systemic health – GERD (Gastroesophageal REFLUX DISEASE): Attrition-corrosion is the loss of tooth substance due to the action of a corroding agent in areas in which tooth-to-tooth wear occurs. This process may steer to a loss of vertical dimension, substantially in patients with GERD or gastric regurgitation [19].

Xerostomia.

Medications: In particular, the use of antipsychotics and selective serotonin re-uptake inhibitors has been associated with bruxism, which is a relatively seldom reported side effect. A recent systematic review of case reports found it was most commonly reported with fluoxetine, venlafaxine and sertraline. Inhibition of dopamine-2 receptors by antipsychotics contributes to the association with bruxism as well [20].

Aggravating factors

Poor-quality of enamel or absence of enamel (e.g., fluorosis, environmental or hereditary enamel hypoplasia or dentinogenesis imperfecta)

Premature contacts (edge-to-edge occlusion)

Erosion [9].

Incidence

According to current data, severe tooth wear is most common among those over 70 years old. It generally begins at an early age of 3 percent among young adults and reaches 17% by middle age. An age-related survey on middle aged adults revealed an increase in wear on teeth's incisal surfaces and occlusal surfaces with increasing acuity [21].

Several epidemiological surveys and studies report that the tooth wear is prevalent among young adults ranging from 6 to 45%, whereas the tooth wear severity in older adults has shown to be consistent. The dental health survey of children in 1993 first noted that the children aged 5 or below, in particular those consuming soft drinks or carbonated drinks unveiled signs of abnormal erosion [22].

Attrition is more common in males than in females [M>F]. There are several reasons for this, including strong masseter muscle activity, larger muscle fiber mass, and stronger ligaments in males compared with females. Males also demonstrated more adverse habits, potentially contributing to attrition [12].

It was found that male subjects showed more attrition than female subjects in a previous study. Male subjects of all the age groups showed higher attrition than female subjects of all the age groups. Similar results were seen in earlier studies of Hugosan et al., Seligman Et al. and Donachie et al.

Attrition can transpire in both deciduous as well as the permanent dentition. Surfaces that contact opposing teeth are disproportionately affected, as might be expected. Oftentimes, the incisal and occlusal surfaces, furthermore the lingual surface of the maxillary anteriors and the labial surface of the mandibular anteriors are involved



Different tooth show tooth wear or attrition of tooth at different rates

Incisors-97%

Molars - 85%

Canine - 74%

Premolar (least affected)-60% [23,24,25].

The phenomenon of dental wear and attrition is associated to both clinical dentistry and comparative odontology. The paradigm of tooth wear is one of the clinical perturb in the current practice of dentistry and also of interest in the field of forensic odontology [26].

Attrition to a great degree results from the contact between the antagonist teeth and well defined wear facets are seen in this condition. Attrition, solely eventuate on the complete occlusal and incisal surfaces as shown in Figure 1, but may also be seen on the buccal or palatal sides of maxillary and mandibular anterior teeth in deep bite relationship [27].

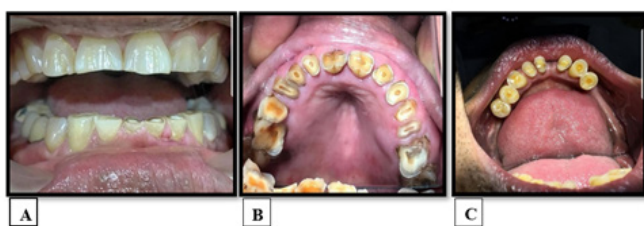


Figure 1: (A) frontal view, (B and C) occlusal view of maxillary and mandibular teeth respectively showing attrition.

Attrition usually appears as flat, glossy on the tooth surface and have distinct margins. This symmetrical pattern of occurrence does not occur in their habitual intercuspal position, but in their occurrence with a tooth opposite them [28].

In cases of bruxism sui generis or unique pattern of wear commensurate with where and how the patients bruxes their teeth forcibly against each other during the parafunction. The pattern of occlusal wear in ideal present day dentition shows an antero-posterior curvature of mandibular teeth (as described by Ferdinand Graf von-spee), in contrast to this, curve of Wilson was observed in the coronal plane which was an upward u-shaped curvature of the occlusal plane of the maxillomandibular relationship [29].

It is the temporalis and masseter muscles that provide the most favourable loading on the teeth that determine these wear patterns. This tooth wear due to attrition is well thought-out as a physiological phenomenon which crafts the monson curve of occlusion. Normal wear pattern differs from those of pathological causes.

Enamel is the tissue that is for the most part worn off due to attrition, the enamel wear accredited to attrition single-handedly is within the non -pathological range for healthy people. In patients with severe bruxism (bruxers), the occlusal load is 2-10 times superior to that of the ordinary people, and they endure longer time of tooth -tooth contact which results in superfluous enamel wear [30].

Diagnosis

Diagnosis of tooth loss is not easy because patient may actually not observe unless symptomatic. Etiology of attrition is multifactorial and making a diagnosis is often tricky, for example: erosion may cause softening of dentin and enamel which in turn undergo attrition of teeth. Hence the dental professionals should find out if the wear is physiological or pathological.

Diagnosis should include detailed case history and examination of the patient. Sequential diagnosis is essential as mentioned in Table 1.

Table 1: Sequential diagnosis of attrition.

1. Diagnose the cause of the wear
<ul style="list-style-type: none"> • Acid erosion – occlusal and incisal cupping, palatal wear on upper incisors, facial (buccal) changes on upper incisors • Bruxism – flat occlusal/incisal surfaces. Accurate inter-digitation of upper and lower teeth, masseteric hypertrophy • Abrasion – cervical wear lesions • Combination (the most common type) look for aspects from a, b and c
2. Check the diet for:
<ul style="list-style-type: none"> • The frequency and amount of acidic foods and drinks • The presence of any drinking habits • Historical dietary habits
3. Check for gastric causes
<ul style="list-style-type: none"> • Heartburn and other symptoms of reflux (epigastric pain, chronic cough, hoarseness) • Regurgitation • Rumination • Eating disorders
4. Classify the tooth wear into – mild, moderate or severe remembering the impact of age
5. Provide reasonable and achievable changes to the diet
<ul style="list-style-type: none"> • Do not attempt to radically change dietary habits as research has shown this not to be particularly realistic • Attempt to modify dietary patterns. Reducing frequency of acidic intake and stopping any dietary habits
6. Consider adapting oral hygiene habits such as using low abrasivity toothpastes with fluoride
7. Monitor tooth wear with study casts remembering that tooth wear is a relatively slow process and does not always require restorations

Intraoral evaluation should comprise radiographs, photographs, and salivary flow rate and study models. Study models may also help for future reference (if required). Location, extent and severity of tooth surface loss may help identify the primary reason although the surface changes of enamel and dentin will also play a part in corroborating the severity. Presence/absence of signs and symptoms like dentinal hypersensitivity or facial muscle tenderness will also help in pinpointing the cause.

Intraoral photographs with occlusal view and facial views will help in appraising the areas of dentinal and pulpal exposure in that particular teeth.

Radiographs like orthopantomogram, intraoral periapical and bitewing radiographs help in identifying the remaining dentin and enamel thickness, involvement and location of furcation and presence of periapical pathosis conversely [31,32].

There are numerous scale to quantify the severity and progression of tooth structure loss

Crown height measurement

Area of wear facets

Depth of groove

Tooth Wear Index(TWI)

TWI (Tooth wear index)

Smith and knight introduced this index which uses the concept of measuring tooth wear as mentioned in Table 2.

It is a comprehensive approach whereby all four visible surfaces (buccal, cervical, lingual and occlusal, incisal) of all teeth present are scored for wear, irrespective of how it occurred.

For training and standardization with other investigators, the authors developed guidelines for using the criteria in a booklet; in cases of doubt, the lowest score should be used. Complete enamel loss (score 4) may, however, be ambiguous, as there is almost always a rim of enamel at the worn surface margins (the colloquial “enamel halo”) [33].



Significance of Differential Diagnosis

Dietary, medical, social, and dental histories are fundamental to delineate between the various clinical presentations. It is prime to discern erosion from attrition so that the tooth wear can be managed aptly, taking into account the diverse causes and their denouements

Once the etiology has been found out in detail, an exact diagnosis have to be made and the patient concerns have to be determined. The main aims of biologically sensible management are the following:

The preservation of the remaining tooth tissue,

A pragmatic improvement in aesthetics,

The restoration of patient confidence [34].

Treatment Planning

In flourishing a treatment plan the dentist should scrutinize the following factors:

Whether the wear is localized or generalized.

Factors which affect patient's speech, function and orofacial esthetics.

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient [35].

Figure 2 illustrates treatment modalities to be followed for patients with dental attrition.

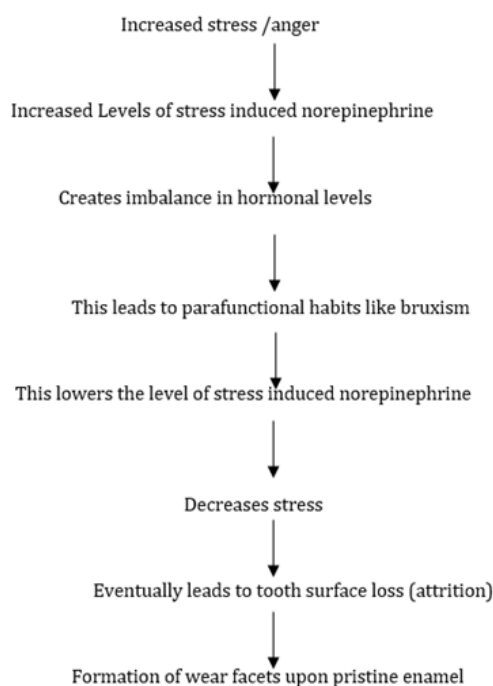


Figure 2: Etiopathogenesis of attrition caused due to stress or anger [4,16].

Palliative Treatment

They include various methods to treat the etiological factors of attrition.

Treatment of bruxism

It is recommended that patients consult a psychologist for help in learning to cope with the situations that cause anxiety leading to bruxism. Cognitive behavioral therapy is then used to help the patient's better deal with the anxiety that leads to bruxism [36]. Also meditation, yoga and deep breathing exercises are admonished to

man oeuvre stressful conditions. In order to check for the presence of bruxism, a hard acrylic resin occlusal splint should be prescribed when most of the teeth are present. The splint should cover the entire occlusal surface with multiple occlusal contacts on closure and provide anterior guidance [17,37].

As the name suggests, mandibular advancement devices are worn at night in order to prevent bruxism. They keep the lower jaw forward while sleeping helping to prevent teeth grinding. In contrast to occlusal splints, they are more painful to wear. Patients can be given habit breaking appliances. Chemotherapeutic agents which can be prescribed consist of muscle relaxants and non-steroidal anti-inflammatory drugs (NSAIDs) to relieve symptoms [38].

Occlusal prematurities have to be rectified. Removable partial dentures are suggested for patients with missing anterior teeth. Porcelain restorations which effectuate the wearing of opposing teeth have to be polished suitably which can lessen surface roughness. Orthodontic treatment to be considered for correction of Angle's class III and Angle's class II division 2 malocclusion [32].

Observation

In order to determine the rate of wear, serial casts can be used to observe at regular intervals and make comparisons for six months or more after initial casting. The rationale behind this is that wear is a slow process, with many patients never exhibiting overt symptoms. It is possible to come to a decision if any intervention is obligatory based on the evaluation of rate. When the patient's appearance, function, and occlusal stability meet the relevant objective and functional criteria, patient evaluation and monitoring are limited only to a recall schedule

Restorative Techniques

Restorative materials must have the same degree of wear resistance as the opposing structure, tooth or restorative material; they should be highly flexural, be cost effective. Diverse materials are utilized for different circumstances. To prevent wear of opposing natural dentition, metal occlusal surface and of high noble content, such as gold alloys are favored. The wear on the restoration itself and the opposing dentition is not the only factor to consider in cases of heavy bruxers, but also its ability to endure the severe load applied. Metal and metal-ceramic prosthesis are likely to be the safest choices in such cases [39].

Adhesive cements

In the treatment of worn dentition, composite restorations can be used as a less invasive option. However, the effectiveness of such restorations has not been demonstrated clinically. Study results concluded that the restorative approach is conservative, easily maintained and has a short to medium term survival rate [40]. Glass ionomer cement is another alternative for restoration.

Interdisciplinary Approach

Before restorative care can be provided, primary dental diseases such as dental plaque must be controlled. Overloading of the occlusal surfaces in cases of bruxism or teeth clenching would also be detrimental to the surface.

The factors to be evaluated in a patient preliminary to any treatment are biological, functional, aesthetic, periodontal, endodontic, coronal, occlusal, orthodontic and prosthodontic management.

Biological

Irregular tooth surfaces due to tooth substance loss leading to plaque retention.

Presence of pulpal exposure.

Weakening of tooth structure due to loss of tooth tissue.

Functional

Occlusal wear triggers dent alveolar compensation and reduces the efficiency of mastication.

Aesthetic

The appearance after tooth substance loss is unacceptable to the patient.

Periodontal assessment

Restorative care is contraindicated for people with uncontrolled periodontal disease, as loss of bone structure can impair restorations. A gingival and periodontal health assessment should be carried out to determine the state of the gum and periodontal tissues. Controlling dental plaque should also be part of treatment before beginning treatment, as inadequate bone support may lead to tooth movement [41,42].

Endodontic assessment

Clinical tests and radiographs should be used to determine whether pulpal and periapical problems exist. Rehabilitative procedures should be completed before endodontic procedures are performed, because performing endodontics after restorative procedures may compromise their structural integrity [17].

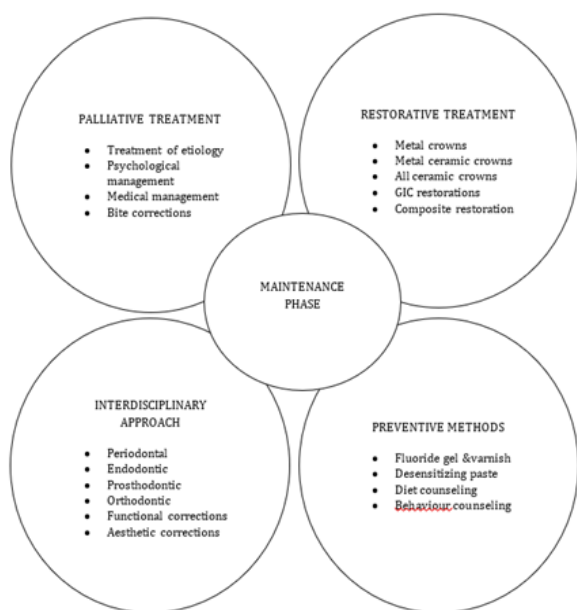


Figure 3: Schematic representation of treatment modalities to be followed for attrition.

Coronal assessment

This involves incorporating retentive features on the occlusal surface of posterior teeth for restorations [17].

Occlusal assessment

The vertical dimension at occlusion is determined and accustomed according to the requisite of rehabilitative procedure.

Functional assessment

There is still a dispute concerning the impact of tooth loss on the rest of the dentition. In the absence of posterior support, anterior teeth may have to bear an adverse amount of masticatory stress. However, many authors are of a different opinion.

Aesthetic assessment

This is mainly related to the anterior teeth. The assessment includes severity of tooth loss, location of gingival margin and lip line.

Orthodontic and Prosthodontic Management

Evaluation of vertical dimension at occlusion

Loss in vertical dimension at occlusion leads to aged appearance. In some cases, clinical crown length decreases within the clinical occlusion due to wear. If dent alveolar compensation occurs, Vertical Dimension of Occlusion (VDO) can remain constant or increase. The use of trial restorations is a reliable method to determine physiologic VDO. Initially, a removable splint made of heat polymerized resin is placed and observed periodically for 6-8 weeks. Fixed provisional restorations are then placed for the next 2-3 months, and followed by final restorations. In planning of final restorations, space is required for the restorative materials in the maximum intercuspal position. Space available makes the restoration straightforward. If the space is not available, the next step is to evaluate whether the wear is generalized or localized [42,43].

Anterior wear

There are quite a lot of techniques used to create interocclusal space for localized tooth wear. Dahl appliance works on the principle of selective intrusion of worn teeth and their counterparts, with continuous eruption of unaffected teeth. These methods are designed for localized wear only and have proven to withstand scrutiny over time using anterior cobalt-chromium removable splint, resin bonded casts, or composite palatal onlays/buildups [44].

Straight wire orthodontics

Proclination of anterior teeth or the intrusion of attrited teeth and their counterparts are methods used to create space.

Tooth preparation at existing intercuspal position to create space.

Occlusal adjustment

Generalized wear

It is generally recommended to maintain the VDO in cases where the VDO has reduced due to wear if the patient adapts well to the occlusion and there are no functional problems. In patients with TMD symptoms and signs, it should be prudently increased if the decreased VDO creates space problems or aesthetic concerns. This should be done cautiously in patients with temporomandibular disorders (TMD). Prosthetic rehabilitation only begins after reversible treatments have reduced the signs and symptoms of TMD [43,45].

Different treatment protocols can be determined based on the classification given by Turner and Missirlan. If a patient has excessive wear as well as loss of VDO, all teeth of one arch should be prepared at the same time, which prevents abrupt increases in VDO and permits better aesthetic control. The crown length might be shortened in other cases if VDO is not lost and room is available for the restorative material because of dent alveolar compensation. A gingivoplasty may be necessary in these situations. The creation of vertical space can be accomplished through orthodontic treatment, restorative repositioning and surgical relocation of segments in patients with a limited gap between teeth but not a loss of VDO [46].

Removable prosthodontic strategies

Having all the teeth extracted and getting a complete denture is the most popular treatment option in countries where removable means of treatment are more popular due to economic considerations [47]. Overlaying a bridge with single teeth is less harmful than a bridge with roots, but it will cause residual ridge resorption. To prevent progression of the resorption, using single teeth as overdenture abutments is better.

Finally, maintaining excellent oral hygiene is important in ensuring the restoration's long-term success.

Preventive Treatment

Preventive dentistry should be the primary approach to management of patients with tooth wear, attempting to prevent its progression and any worsening of the condition. The exposed dentin is desensitized or fluoridated to reduce sensitivity; glass ionomers can also be placed until a definitive restoration can be performed. In severe cases, where roots are exposed, root canal therapy might be needed.

Other preventive methods include:

Desensitizing agent

Application of 0.7% fluoride in the dental clinic followed by application of 0.4% stannous fluoride at home will decrease the sensitivity [49]. Potassium fluoride toothpaste can also help in treating sensitivity. Tooth mousse from GC is a valuable paste for managing sensitivity from TW which administered using bleaching tray [50]. Fluoride has been demonstrated to protect the teeth from further wear after a tooth has been stripped of its enamel. Munoz et al. found remineralizing toothpastes increased the hardness of the exposed surface to acids compared with conventional fluoride toothpastes. Individuals with suspected dentinal hypersensitivity can be treated professionally with a fluoride solution of 0.7%, followed by a dental professional applying stannous fluoride of 0.4% at home. These toothpastes are also considered to be suitable when it comes to managing dentinal sensitivity. They contain potassium which has been found to be beneficial in clinical trials. Topical fluoride applications protect against tooth wear after consumption of soft drinks by reducing their erosive characteristics. Fluoride mouth rinses have a 0.05% concentration and are alcohol free, helping to combat acidic damage to the teeth, and remineralizing toothpastes work to increase the hardness of teeth that are regularly exposed to acidic substances. Fluoride varnish may be applied to patients with hypersensitivity related to erosive lesions in the dental surgery, while using a toothpaste containing potassium may also relieve the symptoms [48].

Modification in beverages

Coca Cola can be reduced in erosive potential by adding calcium lactate. Patients who experience erosive wear in their mouth due to increased consumption of acids such as carbonated drinks, fruit juices, and any other acidic drink should be informed to reduce their consumption [50]. It is beneficial to change habits such as drinking acidic drinks with a straw and not swishing them around in the mouth. Stop doing things like nibbling on nails and using pens/pencils. It is often necessary to perform a thorough dietary investigation when a patient shows adverse eating habits, and any dietary changes made should be documented and adjusted accordingly. If there is a suspicion of an abnormal eating disorder, a thorough dietary investigation should be performed. If the patients have an abnormal diet and are suffering from severe tooth wear, a 3-day consecutive comprehensive diet diary is recommended. For such patients, it is frequently beneficial to reduce their consumption of acidic foods and beverages, such as fruits, fruit juices, carbonated drinks, etc. They should also be advised to avoid the consumption of erosive foods and beverages during meal times [50]. The dentist should refer patients to a medical doctor if he or she suspects that they have reflux disease or bulimia. The symptoms of gastric reflux can be reduced with the help of medications such as ranitidine and omeprazole [13,50].

Those with tooth wear benefit from splints to prevent further tooth loss, especially from attrition. Night guards are necessary for those with nocturnal bruxism. Patients with nocturnal bruxism may be prescribed a full coverage hard acrylic splint as a measure of prevention, such as a Michigan splint or a Tanner appliance, which provides an

ideal occlusion with centric stops, canine guidance and even anterior guidance. Patients with erosion must, however, take precautions when receiving stabilizing splints to prevent their condition from worsening, especially if they suffer from gastro reflux. This could be caused by the accumulation of acidic substances within the splint [13,50].

Maintenance Phase

Cases should be reviewed annually and study casts and photographs should be taken to assess long-term outcomes. Since long-term outcomes are unknown, there should be regular follow up of treated cases. During the clinical and radiographic examination of abutments, it is important to check for caries, failed retention and wear facets. Cementation failures can also be caused by differential wear, short clinical crowns and bruxism.

Conclusion

Tooth wear or tooth surface loss is a quotidian physiological condition occurring that occurs in multitude. Attrition which is one of the cause of tooth wear has a multifactorial etiology which envelops the portrayal of each etiology. Dental professionals should be acquainted with the etiology of tooth wear in order to put forward a successful diagnosis and to bestow exact management and treatment.

These etiologies masquerade concurrently or synchronously or may act conjointly with supplementary entities to camouflage or obscure the true character of tooth wear. The towering preponderance of attrition was seen in both younger age as well as the older age. The stress, pressure, burden in the present time is also a confederated factor. As age advances, the austerity of attrition will amplify. Attrition can turn pathologic when it influences the function of teeth or aesthetics. An expeditious investigation and diagnosis is indispensable to usher timely intervention in the form of palliative, restorative and preventive methods to halt the progression of the same. The order of treatment should be formulated according to the patient's needs, severity, aesthetics, function and the potential for progression.

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