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SSP Position Paper: The Influence of Nutrition on Active and Supportive Periodontal Therapy

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Keywords

Periodontitis, Nutrition, Diet, Prevention, Periodontal Therapy

Abstract

Periodontitis is currently understood as a multifactorial, biofilm-associated, and immunoinflammatory disease. Modern dietary patterns, often characterized by a high intake of free sugars and ultra-processed foods, deviate from evolutionary adaptations and are frequently associated with systemic inflammatory processes. This position paper by the Swiss Society of Periodontology (SSP) evaluates the role of nutrition as a modifiable risk factor and integrates nutritional considerations across all phases of periodontal therapy. Available evidence suggests that a plant-based, fiber-rich, and low-sugar diet can reduce gingival inflammation and support microbial homeostasis in prevention (Stage 1). During the active therapy phases (Stages 2 and 3), the modulation of the host response by nutrients may be clinically relevant. Adjunctive intake of omega-3 fatty acids and antioxidants appears to positively influence the outcomes of non-surgical therapy, while an adequate supply of proteins and vitamin D is discussed as a supportive factor for wound healing following surgical interventions. In supportive periodontal care (SPC/ Stage 4), a sustained anti-inflammatory dietary pattern may support long-term stability. Consequently, nutrition should be considered an integral, modifying component of periodontal care that meaningfully complements mechanical therapy.

Introduction

This position paper by the Swiss Society of Periodontology (SSP) describes the importance of nutrition as a modifiable factor in the prevention, therapy, and long-term management of periodontal diseases. The aim is to concisely categorize the current state of knowledge regarding the role of nutrition in biofilm ecology, host response, and metabolic cofactors, and to derive practice-oriented statements for the periodontal therapy phases.

The presentation follows a question-and-answer format based on the stages of care. Each section is structured into the categories: research question, biological background, state of science, and recommendation. At the end of each question or section, a key message is provided. This summarizes the most important clinical statement in a single sentence and indicates the quality of evidence and strength of recommendation:

Quality of Evidence:

- **High** = Consistent RCTs/meta-analyses with clinical endpoints
- **Moderate** = Individual RCTs and/or consistent observational data; clinical endpoints available but heterogeneous
- **Limited** = Predominantly observational/preclinical data, short follow-ups, inconsistent results
- **Very Limited** = Primarily biological plausibility/expert consensus/process recommendation

Strength of Recommendation:

- **Strong** = Clear benefit with low risk and high feasibility
- **Conditional** = Benefit likely, but evidence/transferability is limited or heterogeneous
- **Good Practice Statement** = Process- or implementation-related recommendation based primarily on consensus, plausibility, and clinical practicality

Materials and methods

Study Design and Objectives

This work is a thematic position paper based on a narrative review of the evidence. The objective was to summarize the current state of knowledge regarding the influence of nutrition on the prevention, therapy, and long-term management of periodontal diseases and to derive practice-oriented statements aligned with the periodontal therapy phases.

Literature Search

A structured literature search was conducted, though not in the form of a formal systematic review. Relevant publications up to and including 2025 were identified in the PubMed/MEDLINE and Web of Science databases. The search strategy combined terms related to periodontal diseases (e.g. "periodontitis", "periodontal therapy") with terms related to nutrition and supplementation (e.g., "nutrition", "dietary supplements", "adjunctive therapy"). Primarily original research articles, systematic reviews, and meta-analyses in English were included. In addition, the reference lists of relevant review articles and meta-analyses were screened.

Data Extraction and Evidence Categorization

The selected publications were evaluated according to their study design, the nutritional factors investigated, clinical endpoints (e.g., gingival inflammation, probing pocket depth, clinical attachment loss, wound healing), and their transferability to daily clinical practice. No quantitative synthesis of the results was performed. The evidence was qualitatively categorized and presented systematically according to the stages of care within the periodontal therapy phases.

Assessment of Evidence Quality and Strength of Recommendation

The assessment of evidence quality and the strength of recommendation was conducted as a guiding orientation and did not formally follow a specific guideline instrument. This categorization serves to provide a transparent weighting of the statements and does not claim to represent a formal clinical guideline.

Fundamentals

How does nutrition influence periodontitis?

Evolutionary perspective on nutrition and oral diseases

The metabolism and microbiome of Homo sapiens are adapted to long-term evolutionary processes and natural dietary environments. Paleomicrobiological data suggest that the oral microbiome main-

tained a certain degree of stability over millennia (1). It was not until fundamental changes in lifestyle and diet occurred - particularly with the transition to sedentarism and the onset of agriculture approximately 12,000 years ago, as well as during the Industrial Revolution with the increasing availability of refined sugars and white flour - that a significant shift in microbial balance took place. These developments were accompanied by an increase in caries and periodontal diseases, as well as an increase in potentially pathogenic species and a decrease in microbial diversity (1–3). The processes of sedentarism and the Industrial Revolution led, among other things, to a dramatic increase in the consumption of processed carbohydrates such as sugar. In Switzerland, sugar consumption ranges between 32 and 43 kg per capita per year and is frequently associated with an insufficient intake of dietary fiber and micronutrients. Such dietary patterns deviate from human biological adaptation - as our metabolism remains genetically programmed for the natural diet of our ancestors - and promote chronic inflammation (4–6). Accordingly, many non-communicable diseases are understood as "mismatch diseases," in which living conditions no longer align with the biological requirements for health. Evolutionary and animal studies suggest that diet strongly influences the pathogenicity of the biofilm (2,7,8). Non-human primates exhibit a healthier oral microbiome under species-appropriate conditions than modern humans (9).

Etiological models of periodontal disease development

Periodontitis is described as a multifactorial, biofilm-associated, immunoinflammatory disease (10). Depending on the etiological model, periodontal inflammation is based on dysbiotic biofilms and/or immune system dysregulation. Both systems are modulated by individual risk factors.

According to the non-specific and specific plaque hypotheses, the quantity and quality of the biofilm are decisive for disease development, with certain keystone pathogens (such as P. gingivalis, T. forsythia, and T. denticola) being associated with the disease (11–14). According to the ecological plaque hypothesis, the dysbiotic shift of the biofilm is based on local and systemic influencing factors (such as pH value, oxygen saturation, microbial nutrition, and inflammatory processes) (15). Consequently, certain microorganisms have a colonization advantage under specific environmental conditions. In the case of periodontitis-associated pathogens, these include inflammatory processes, elevated temperature, protein supply as a nutrient source, and anaerobic, tendentially alkaline environments. Based on the further development of the keystone pathogen concept, periodontitis is the result of a synergistic community of microorganisms and a disrupted host response (16). Inflammation is seen as a driver of dysbiosis, and dysbiosis, in a self-reinforcing cycle, further promotes inflammation (17).

Based on these etiological models, nutritional factors influencing the microbiome, the bacterial metabolome, and the immune system can affect periodontal inflammation. Regarding the biofilm, nutrition can significantly influence its growth, provide or withhold nutritive foundations (most notably through sugar in the caries process), and affect the biofilm's metabolome. Regarding the immune system, nutrition can either promote or inhibit inflammatory processes.

To ensure terminological consistency, this paper distinguishes between three overlapping patterns:

- **Whole-foods plant-based diet**: Focuses on whole plant foods (vegetables, fruits, legumes) with no or only minimal processing.
- **Mediterranean diet**: A specific pattern high in vegetables, fruits, olive oil, moderate fish, and low red meat intake.
- **Anti-inflammatory diet**: A functional term for patterns aimed at reducing systemic inflammation by reducing free sugar intake, processed carbohydrates, and saturated fatty acids, optimizing the omega-3 to omega-6 ratio and maximizing antioxidant and fiber intake.

Periodontal inflammation-modulating nutritional factors

Ultra-processed carbohydrates, sugar, and dietary fiber

An excess of sugar and refined carbohydrates (ultra-processed foods, UPF) combined with an insufficient intake of dietary fiber can lead to metabolic dysregulation. Locally, these factors promote biofilm growth; the production of pro-inflammatory carboxylic acids is discussed as a modulator for the development of gingivitis (18), which can occur alongside the development of caries (19,20). Systemically, this can result in blood sugar fluctuations, dyslipidemia, and chronic inflammatory processes, which in turn favor periodontal inflammation and

other sugar-associated diseases (5,19,21–23). The WHO recommends reducing free sugars to below 10% of total energy intake, with a further reduction to below 5% (approx. 25 g/day) cited as a target value with potential additional benefits for oral health. A fiber-rich diet can counteract this by lowering systemic inflammatory markers and reducing periodontal inflammatory activity (24,25). A frequent consequence of high processed carbohydrate consumption and fiber deficiency is obesity. Adipose tissue acts as an inflammatory endocrine organ and amplifies local and systemic inflammatory processes through the release of pro-inflammatory mediators. These include classical cytokines (such as interleukins or TNF-α) as well as specific adipokines formed in adipose tissue (e.g., leptin). Simultaneously, the concentration of protective, anti-inflammatory mediators such as adiponectin decreases. These mediators dysregulate the immune response, reduce the efficiency of antigen presentation, and prevent adequate control of pathogenic bacteria such as P. gingivalis (26).

Fats and proteins

An imbalance favoring pro-inflammatory omega-6 fatty acids and saturated fats can intensify periodontal inflammatory processes, while omega-3 fatty acids (EPA/DHA) appear to have anti-inflammatory and pro-resolving effects (27,28). Trans fats and saturated fatty acids promote bone loss and amplify the local inflammatory response (29–31). Animal protein sources contain higher proportions of saturated fats, heme iron, and advanced glycation end products (AGEs), which promote systemic and local inflammatory reactions and can accelerate periodontal destruction processes (32–34). Plant-based or Mediterranean dietary patterns often show lower periodontal inflammatory activity (35–37). Since plant-based foods contain almost no Vitamin B_{12}, supplementation is necessary for predominantly plant-based diets. Adequate Vitamin B_{12} supply supports central processes such as cell proliferation, collagen synthesis, and immune function, thereby contributing to the maintenance of periodontal tissue integrity.

Micronutrients, phytochemicals, and plant-based nitrates

Vitamins (A, B, C, D, E), minerals (zinc, magnesium, calcium, selenium), coenzyme Q10, and polyphenols (e.g., flavonoids, phenolic acids, lignans) have antioxidant, immunomodulatory, and anti-inflammatory effects. Terpenoids (β-carotene, lycopene), alkaloids, glucosinolates, and melanoidins further contribute to the reduction of oxidative stress (38–41). Studies indicate that dietary nitrates from plant sources have the potential to lower gingival inflammation parameters, although the degree of independence from plaque changes is still debated in the literature (42). This effect is attributed to improved local microcirculation, inhibition of pro-inflammatory cytokine expression, and the potent antioxidant properties of nitric oxide. Comparable antibacterial, anti-inflammatory, and antioxidant effects are also described for phytochemicals found in green tea, pepper, saffron, ginger, and turmeric (43–45).

To assist clinicians in providing concrete guidance, the following table summarizes key nutrients and their common food sources:

Table 1. Key nutrients, possible food sources, and their periodontal relevance.

Nutrient	Possible Food Sources	Periodontal Relevance
Omega-3 (EPA/DHA)	Fatty fish (salmon, mackerel), algae oil, walnuts, flaxseeds	Support for inflammatory resolution (Resolvins)
Vitamin C	Bell peppers, citrus fruits, berries, broccoli, kale	Collagen synthesis; antioxidant protection
Vitamin D	Fatty fish, egg yolk, (sunlight/supplementation)	Bone metabolism; immune modulation
Fiber	Legumes, whole grains, vegetables	Reduction of systemic inflammatory markers
Polyphenols	Green tea, turmeric, berries, dark chocolate	Inhibition of pro-inflammatory signaling pathways

Results

What is the current knowledge regarding the influence of nutrition in therapy? (Nutrition as an adjunctive?)

Prevention and Early Intervention (Stage 1)

Research question: What role does nutrition play in the prevention and early intervention of periodontal diseases?

Biological Background: In the preclinical phase, nutrition is a primary factor associated with the stability of the oral micro-ecosystem. Based on biological plausibility, a whole-food plant-based, fiber-rich, and low-sugar diet supports a diverse oral microbiota and an anti-inflammatory microenvironment. Mechanistically, antioxidants and omega-3 fatty ac-

ids (as described in section 3.1.3) are proposed to modulate the initial host response to the biofilm.

State of the Science: Controlled studies demonstrate that balanced dietary patterns correlate with reduced gingival inflammation. In specific randomized settings, diets low in carbohydrates and rich in omega-3 fa[y acids and fiber led to a decrease in gingivitis parameters (46). While some data suggest these effects may occur partially independent of mechanical plaque control, the available evidence is primarily associative or based on small-scale experimental models. A study saw that adherence to a Mediterranean diet can correlate with lower Bleeding on Probing (47). Meta-analyses additionally indicate a tendentially protective association between Mediterranean diet adherence and periodontitis prevalence (48).

Recommendation:

- **Good Practice Statement**: Assessment of dietary habits as part of the periodontal risk analysis.
- **Conditional Recommendation**: Recommendation of a whole-food plant-based, fiber and polyphenol-rich diet to support gingival health
- **Conditional Recommendation**: Prioritizing fresh, unprocessed foods to ensure
- adequate intake of micronutrients

Key Message: A low-sugar, fiber- and micronutrient-rich diet is associated with lower, plant-gingival inflammatory parameters; however, large-scale causal evidence remains limited.

Quality of Evidence: Moderate
Strength of Recommendation: Conditional

Non-surgical Therapy (Stage 2)

Research question: What influence does nutritional intervention have on the outcomes of non-surgical periodontal therapy (subgingival instrumentation (SI))?

Biological Background: Following instrumentation, the host response is a determinant of tissue resolution. Mechanistically, omega-3 fatty acids and antioxidants are thought to support the resolution of inflammation (see 3.1.3).

State of the Science: Systematic reviews suggest, including a comprehensive analysis of 87 studies, suggest that an adjunctive intake of micronutrients, antioxidants, omega-3 fatty acids, green/oolong tea, as well as polyphenols and flavonoids may be associated with moderate improvements in PPD and CAL (19,49,50). While intervention studies (51,52) reported more pronounced reductions in inflammation, it is important to distinguish between these biological effects and clinically significant “hard” endpoints, which often show high heterogeneity. Studies by Glavin et al. (2025) and Doshi et al. (2025) showed a possible positive influence of adequate micronutrient intake on clinical healing parameters (53,54). The role of diet independent of plaque control remains a subject of debate. The evidence for probiotics is currently too inconsistent for a routine recommendation.

Recommendation:

- **Good Practice Statement**: Discussing nutritional habits as a supportive element of SI.
- **Conditional Recommendation**: Avoiding free sugars and ensuring an adequate supply of anti-inflammatory nutrients including micronutrients and polyphenols as listed in Table 1 to support healing dynamics.

Key Message: Adjunctive nutritional support is associated with improved healing parameters a\er subgingival instrumentation; however, the clinical effect size is subject to study heterogeneity.

Quality of Evidence: Moderate
Strength of Recommendation: Conditional

Surgical Therapy (Stage 3)

Research Question: How does nutrition influence wound healing and regeneration following periodontal
surgery?

Biological Background: The postoperative phase involves high metabolic demands for tissue synthesis. Biologically, proteins and Vitamin C are essential for collagen formations while Vitamin D and omega-3 fatty acids are cofactors for bone metabolism and angiogenesis.

State of the Science: Preclinical and animal studies suggest that micronutrient and protein availability can improve healing (55). However, clinical data regarding hard endpoints (PPD/ CAL) following human surgery remain limited and inconsistent. While ac-

celerated tissue regeneration is biologically plausible with adequate Vitamin D and omega-3 levels (56,57), a direct causal link between perioperative supplementation and superior long-term surgical success is not yet robustly established.

Recommendation:

- **Good Practice Statement**: Preoperative assessment of nutritional status and Vitamin D levels, particularly before regenerative procedures.
- **Conditional recommendation**: Ensuring a nutrient-dense, perioperative diet (Proteins, Vit. C/D/E, Omega-3) to support physiological regeneration.
- **Good Practice Statement**: Maintaining adequate hydration and a soft, nutrient-rich diet postoperatively.

Key Message: While the availability of specific nutrients is biologically plausible for surgical healing, clinical evidence regarding superior hard endpoints remains limited.

Quality of Evidence: Limited
Strength of Recommendation: Conditional / Good Practice Statement

Supportive Periodontal Care (SPC) (Stage 4)

Research Question: How can nutrition contribute to the long-term stabilization of periodontal status during supportive care?

Biological Background: Maintaining a low-inflammatory environment is essential for long-term success. A sustained anti-inflammatory diet is proposed to stabilize tissue homeostasis and counteract systemic risk factors like dyslipidemia.

State of the Science: Reviews indicate that micronutrient-rich diets may promote periodontal stability (19,40,56). Digital tools (apps) have shown potential to improve adherence to these dietary pa[erns, which correlate with lower BOP and PPD during SPC (58). However, robust long-term data regarding the prevention of recurrence through diet alone are lacking.

Recommendation:

- **Conditional Recommendation**: Long-term adherence to a nutrient-dense, anti-inflammatory diet.
- **Good Practice Statement**: Utilizing digital aids and regular motivational counselling during SPC appointments to support lifestyle changes.

Key Message: A sustained anti-inflammatory diet may support long-term periodontal stability, primarily through favorable e9ects on metabolic cofactors.

Quality of Evidence: Limited
Strength of Recommendation: Good Practice Statement

Summary, Concept, and Future Prospects

Summary

Periodontitis is a biofilm-associated, immunoinflammatory disease of the periodontium that stands in close interaction with dietary habits and metabolic factors. The available evidence demonstrates that nutrition can modulate both the composition and metabolism of the oral biofilm, as well as systemic inflammatory predisposition and the local host response. Across all stages of periodontal therapy, an anti-inflammatory, nutrient-dense diet is associated with more favorable inflammatory parameters, supported healing dynamics, and improved long-term stability.

These correlations can be integrated into a holistic nutritional concept based on a predominantly plant-forward, whole-food diet. Such a pattern is characterized by a high intake of dietary fiber, phytochemicals, and essential micronutrients, which support periodontal tissue homeostasis and positively influence systemic inflammatory processes. Additionally, ensuring a requirement-based supply of micronutrients such as Vitamin D and Vitamin B_{12} plays a vital role in immune regulation and tissue healing; however, supplementation should primarily occur in cases of proven deficiency or for specific dietary patterns (e.g., vegan diets).

Concept

Based on the current data, nutrition should be understood as a complementary, cross-stage component of the periodontal care regimen. This position paper describes a practice-oriented nutritional concept that can be implemented throughout the various stages of care. The early assessment of relevant dietary habits as part of the periodontal risk analysis is central. Building on this, patient-specific recommendations can be made, particularly regarding the

reduction of pro-inflammatory dietary factors—such as free sugars and ultra-processed foods—and the promotion of an anti-inflammatory, micronutrient-rich diet.
During the active therapy phases (Stages 2 and 3), nutrition can serve as an adjunctive measure to support healing dynamics, particularly through an adequate supply of protein, omega-3 fatty acids, and selected vitamins. In supportive periodontal care (SPC), nutrition primarily serves the long-term stabilization of the periodontal status and the reduction of the risk of recurrence. The integration of simple screening instruments, standardized counseling elements, and digital support services can facilitate implementation in daily practice and promote sustainable patient adherence.

To facilitate implementation in daily practice, a structured "Screen-Advise-Refer" workflow is proposed:

1. **Screen**: Identify nutritional risks (e.g., high sugar intake, low fiber) during history taking.
2. **Advise**: Provide simple, actionable advice (e.g., "Increase vegetable intake to 3 portions/day" or "Prefer fatty fish/walnuts for omega-3").
3. **Refer**: Collaborate with registered dietitians for patients with severe metabolic comorbidities (e.g., BMI >30 or uncontrolled diabetes).

Future Prospects

Despite increasing evidence, relevant research gaps remain. Future studies should incorporate clearly defined nutritional interventions, standardized clinical endpoints, and longer observation periods. Of particular interest are dose-response relationships of individual nutrients and the influence of complex dietary patterns on periodontal stability and recurrence rates.

Furthermore, new insights into the interaction between nutrition, the oral microbiome, and host immunity open perspectives for personalized nutritional concepts in periodontology. Digital applications for recording dietary habits, self-monitoring, and supporting recall management could play a significant role in supportive care in the future.

In the long term, it is advisable to integrate nutritional medicine content more deeply into periodontal continuing education and to expand interdisciplinary collaborations with nutritional professionals to further establish nutrition as an evidence-based component of periodontal care.

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Zusammenfassung

Einleitung

Parodontitis ist eine multifaktorielle, biofilm-assoziierte und immunentzündliche Erkrankung des Zahnhalteapparates. Moderne Ernährungsmuster, die oft durch einen hohen Konsum von freiem Zucker und hochverarbeiteten Lebensmitteln geprägt sind, weichen von biologischen Anpassungen ab und sind häufig mit systemischen Entzündungsprozessen assoziiert. Dieses Positionspapier der Schweizerischen Gesellschaft für Parodontologie (SSP) evaluiert die Rolle der Ernährung als modifizierbaren Risikofaktor über alle Phasen der parodontalen Betreuung hinweg.

Material und Methoden

Es wurde eine strukturierte narrative Literaturrecherche bis zum Jahr 2025 in den Datenbanken PubMed/MEDLINE und Web of Science durchgeführt. Die ausgewählten Publikationen (Originalarbeiten, systematische Reviews und Meta-Analysen) wurden hinsichtlich ihrer Relevanz für das parodontale Betreuungsschema qualitativ evaluiert und in die entsprechenden Versorgungsstufen (Stufen 1–4) eingeordnet.

Resultate

Die Evidenz deutet darauf hin, dass eine vollwertige, pflanzenbetonte (whole-food plant-based), ballaststoffreiche und zuckerarme Ernährung in der Prävention (Stufe 1) mit geringeren gingivalen Entzündungsparametern assoziiert ist. Während der aktiven Therapiephasen (Stufen 2 und 3) kann eine adjuvante Zufuhr von Mikronährstoffen, Omega-3-Fettsäuren und Antioxidantien die Gewebeheilung und klinische Parameter (BOP, PPD) unterstützen, wenngleich klinische Studiendaten zu harten Endpunkten eine hohe Heterogenität aufweisen. In der unterstützenden Parodontalbetreuung (SPC / Stufe 4) wird ein dauerhaft antientzündliches Ernährungsmuster vorgeschlagen, um die langfristige Gewebehomöostase zu sichern.

Diskussion

Die Modulation der Wirtsantwort durch Ernährung ist biologisch plausibel, allerdings sind klinische Daten oft heterogen und weisen primär assoziative statt kausale Zusammenhänge auf. Die starke therapeutische Wirkung der mechanischen bzw. chirurgischen Therapie kann zudem subtilere ernährungsbedingte Effekte in Kurzzeitstudien maskieren. Dennoch rechtfertigen das minimale Risiko für Nebenwirkungen und der systemische Zusatznutzen die Implementierung in den Praxisalltag. Hierfür wird ein strukturierter „Screen-Advise-Refer“-Workflow empfohlen, um eine praxisnahe Ernährungsberatung effizient umzusetzen.

Résumé

Introduction

La parodontite est une maladie immunoinflammatoire multifactorielle associée au biofilm. Les modes d'alimentation modernes, souvent caractérisés par une consommation élevée de sucres libres et d'aliments ultra-transformés, s'écartent des adaptations biologiques et sont fréquemment associés à des processus inflammatoires systémiques. Ce document de position de la Société Suisse de Parodontologie (SSP) évalue le rôle de la nutrition en tant que facteur de risque modifiable à toutes les étapes de la prise en charge parodontale.

Matériels et méthodes

Une revue narrative et structurée de la littérature jusqu'en 2025 a été réalisée dans les bases de données PubMed/MEDLINE und Web of Science. Les publications sélectionnées (articles originaux, revues systématiques et méta-analyses) ont été évaluées qualitativement en fonction de leur pertinence pour le schéma de soins parodontaux et classées selon les stades de traitement correspondants (stades 1 à 4).

Résultats

Les données disponibles suggèrent qu'une alimentation non transformée d'origine végétale (whole-food plant-based), riche en fibres et pauvre en sucre, est associée à une réduction de l'inflammation gingivale en prévention (stade 1). Durant les phases de traitement actif (stades 2 et 3), un apport complémentaire en micronutriments, en acides gras oméga-3 et en antioxydants peut soutenir la résolution tissulaire et les paramètres cliniques (BOP, PPD), bien que les données des essais cliniques sur les critères de jugement stricts présentent une certaine hétérogénéité. Dans le cadre des soins parodontaux de soutien (SPC / stade 4), des habitudes alimentaires anti-inflammatoires durables sont proposées pour préserver l'homéostasie tissulaire à long terme.

Discussion

La modulation de la réponse de l'hôte par la nutrition est biologiquement plausible, mais les données cliniques sont souvent hétérogènes et révèlent principalement des liens associatifs plutôt que causaux. De plus, l'effet thérapeutique majeur du traitement mécanique ou chirurgical peut masquer les effets nutritionnels plus subtils dans les études à court terme. Néanmoins, le risque minimal d'effets secondaires et le bénéfice systémique additionnel justifient l'intégration de stratégies nutritionnelles dans la pratique quotidienne. À cet effet, un protocole structuré de type « Dépister-Conseiller-Orienter » (Screen-Advise-Refer) est recommandé pour guider les conseils diététiques de manière pragmatique.

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