Presence of Gingival Recession or Noncarious Cervical Lesions on Teeth under Occlusal Trauma: A Systematic Review

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Abstract

The goal of this research was to carry out a systematic review to verify the possible influence of occlusal factors on the occurrence of gingival recession and noncarious cervical lesions. To answer the specific research question—whether gingival recession or noncarious cervical lesions on teeth are present under occlusal trauma—a bibliographic search was conducted at MEDLINE/PubMed, Web of Science, and Gray Literature databases focusing on articles published, following strict inclusion criteria based on randomized clinical trials, controlled clinical studies, and case series, with restricted language (English) and publication date between March 2010 and March 2020, considering patients with occlusal trauma and gingival recession/noncarious cervical injuries. Questionnaires, animal or laboratory studies, case reports, and interviews were excluded. First, the title and/or abstract of the articles obtained were analyzed and, finally, a full-text reading was performed. Given the amount and diversity of the final studies, a qualitative analysis was made. Based on the established criteria, it was possible to obtain an initial 757 articles. After screening, five articles were included, and then qualitative analysis was performed. The results described in the articles were different, given the heterogeneity of the articles subjected to analysis. A few studies were published in the past 10 years, suggesting that the traumatic occlusion seems to be associated with the occurrence of the noncarious cervical lesion while it is not possible to arrive at a conclusion with regard to the association of gingival recession and occlusal trauma.

Keywords
► dental occlusion
► gingival recessions
► noncarious cervical lesions
► occlusal trauma
► systematic review

Key Message: Even though many professionals have categorically affirmed that there is a relation between trauma occlusal and gingival recession/noncarious cervical lesion, this systematic review found the absence of strong literature to really prove it. Once defined, it allows the therapeutic focus to centre on the causal or contributing factors and preventing or reducing future recurrence.
Introduction

Gingival recession (GR) is defined as the migration of the marginal gingiva to an apical level, using as reference the cementoenamel junction (CEJ), exposing the root surface and involving loss of periodontal attachment apparatus. Multiple factors can be involved causing or aggravating the GR, which can be divided into three groups: anatomical factors (dehiscence of the alveolar bone and abnormal position of the teeth), physiological factors (orthodontic movements), and pathological factors (abrasive and traumatic brushing, intra- and perioral piercing, tooth mobility, partial denture, deficient dental restorations [mainly with subgingival margins], bacterial plaque, periodontal diseases, damages resulting from iatrogenesis and use of tobacco [smoking], and occlusal trauma). Consequently, bone resorption may occur, normally, in the tooth’s cervical region due to forces that are concentrated in a few points of the tooth, characterizing a pathological occlusion.

Hence, occlusal disturb may increase inflammation of the periodontal structures and destruction of the collagen matrix, enhancing the osteoclasts activities, and causing GRs, which may cause greater susceptibility to the occurrence of root caries and root abrasion, jeopardizing esthetic, dentin hypersensitivity, reduction of keratinized tissue, and disharmony of the gingival margin. However, it should also be noted that the occurrence of a traumatic occlusal force depends on factors such as magnitude, direction, duration, and frequency. Therefore, the relation between GR and occlusal trauma needs to be clarified.

Another factor related to occlusal trauma is the presence of noncarious cervical lesions (NCCLs). Abrasion (abnormal frictional biomechanical process), erosion (mainly due to acidic dissolution), and abfraction (pathological loss of dental hard tissues due to biomechanical occlusal forces) was suggested, based in a little evidence existent, as a hypothetical component of cervical wear and could also be associated with periodontal disease. A study of NCCL pointed to abrasive toothpaste and traumatic brushing as the main causes of their occurrence. However, Lee and Eakle proposed that the occlusal forces with relevant cervical stress, resulting in the breaking of the enamel hydroxyapatite bonds and the consequent microfracture, chipping, and loss of structure, could play a major role in the NCCL etiology.

Since it was suggested, several laboratory studies of finite elements and in vivo have emerged. Bernhardt et al considered that this association exists, although other clinical researches studied individuals with a parafunctional habit of bruxism who had an even greater number of NCCL than subjects without any habit. Thereby, occlusal adjustments to eliminate interferences have not decreased the progression of NCCL. Furthermore, in a 3-year follow-up study, it was suggested that the facets consequent of occlusal wear was associated with a higher incidence of NCCL. Although the NCCL etiology is currently supported by the biomechanical concept of distribution of occlusal forces, there is a lack of scientific evidence. Then, it is wrong to restrict only one mechanism responsible for the occurrence of any NCCL type.

Observing the aforementioned facts, the aim of this systematic review (SR) was identifying the relationship between GR and NCCL on teeth under occlusal trauma, providing a scientific answer for the existent problem.

Material and Methods

This SR was conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analysis guidelines. The protocol for this study was registered on PROSPERO (CRD42020183268). The focused question for the present review was as follows: “Is there a relation between the presence of occlusal trauma and the appearance of GRs or noncarious abfraction lesions?”

Information Sources and Search Strategy


The used terms were “Non-carious lesions” OR “Noncarious lesions” OR “Cervical lesions” OR “Abfraction” OR “Gingival recession” OR “Gingival retraction” OR “Gum recession” OR “Gum retraction” AND “occlusal trauma” OR “traumatic occlusion” OR “excessive occlusal force” OR “pathologic occlusion” OR “dysfunctional occlusion.” The research was performed combining the previous terms (Supplementary Table S1), applying the filters described in Supplementary Table S2. An additional manual search was performed on the references of included articles to identify relevant publications.

Inclusion Criteria

This study was conducted based on randomized clinical trials, controlled clinical studies, and case series. The mandatory simultaneous criteria used were: clinical studies; studies published in English; publication date from March 2010 to March 2020; human studies; and articles that have the search terms in the title or abstract. Nonsimultaneous criteria were also applied, such as patients with occlusal trauma and GR (with detailed information about the type of GR); patients with occlusal trauma and noncarious cervical injuries (with detailed information about the type of noncarious cervical injury).

Exclusion Criteria

Clinical studies that did not fully meet the inclusion criteria, studies based on questionnaires, case reports, editorial letters, SRs, and meta-analysis, laboratory and animal studies, and interviews.
Study Selection and Quality Assessment

After the bibliographic search, two independent researchers (P.M.B.P.S.T. and T.R.S.) proceeded to filter relevant articles that fitted the study by analyzing the title and abstract for study selection. Any disagreement between the reviewers was discussed with a third author (G.V.O.F.). Cohen’s kappa test was performed to assess the reviewers’ agreement. Assessment of risk of bias and study quality of the included studies were performed independently by two reviewers (P.M.B.P.S.T. and G.V.O.F.), where the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement was applied. It featured 18 items that were answered with one of four options: 1—yes, 2—no, 3—cannot answer, and 4—not applicable. Only items with option 1 generated the score. Therefore, each article could obtain a score between 0 (no criteria fulfilled) and 18 (all criteria fulfilled).

The data collected using the STROBE statement was rated in a total of 18 points, among the 22 topics, as low quality (scored 0–6 out of a total of 18 points), as moderate quality (7–12), or as high quality (13–18). The ratings obtained were verified by a third reviewer (T.R.S.) and any discrepancy was resolved by discussion with another reviewer (P.A.B.F.).

Data Extraction

Reviewers extracted the data independently from the selected articles for further analysis using data extraction tables, which included the following parameters: author(s), year of publication, study design, main goal, the number of participants, systemic condition, exclusion criteria, and occlusal assessment method. All values and details were reported.

Results

Study Selection, Characteristics, and Description/Quality Assessment and Heterogeneity

The study selection is described in the flow diagram (Fig. 1). A total of 757 articles were obtained, of which 83 were duplicate, thus resulting in 674 final articles from MEDLINE/PubMed (n = 371), Web of Science (n = 294), and Gray Literature (n = 9). After reading the title and abstract of these articles, 19 articles were chosen to be read full text, PubMed (n = 12), Web of Science (n = 6), and Gray Literature (n = 1). Afterward, 14 were excluded with justification described in Table 1, the remaining 5 articles were chosen for inclusion (1 case–control and 4 cross-sectional studies). The agreement value between examiners was respectively 90.61 and 92.4%.

A summary was made about the articles included in this study (Table 2), containing the journal, the year of publication, the type of study, objective, inserted and excluded patients, and method used for assessing occlusal trauma. However, Table 3 refers to the detailed results relevant to this study and the conclusions of each article.

A fact that was verified in all five included studies was the detailed description of the occlusal factors and its assessment method. The factors analyzed were different in each study, integrating the panoply of analyzed factors were the following: prematurity in centric relation and excursive movements,33 prematurity at maximum intercuspation and on the nonwork side,32,33 guides and occlusal contacts,32,33 and interferences in centric relation, maximum intercuspation, and excursive movements.33 The articular-paper used (Accufilm II, Parkell, Edgewood, New York, United States) for evaluation was the same in four of the five articles,31,32,34,35 contrasting with the only study34 in which it was used a distinct type of articular-paper (Bausch Arti-Check, Bausch Articulating Papers Inc., Nashua, New Hampshire, United States).

Four articles31,32,34,35 described the method used in the NCCL and GR diagnosis although heterogeneity has been observed, and only one article32 did not describe the method applied. Teixeira et al,31 Yoshizaki et al,32 and Brandini et al35 developed all analyses with only one examiner, while in Alvarez-Arenal et al study,34 six researchers (one of each university included) performed the diagnosis. It is also worth mentioning that Smith and Knight Dental Wear Classification36 were used to classify NCCL.

Teixeira et al31 classified the lesions according to their morphology (concave or wedge shapes) and the depth (superficial: 0–0.9 mm, medium: 1.0–1.9 mm, deep: >2.0 mm), for which, impressions with an elastomeric material was used and, for GRs, Miller’s classification was applied. Yoshizaki et al32 and Brandini et al35 studies described that any discrepancy resulting from tooth structure loss at the level of the CEJ, not resulting from caries, was considered as NCCL. Despite these similarities, it is important to note that a classification regarding the lesions form was performed by Yoshizaki et al.32
Table 1 Articles excluded from the study, authors, and the reason for exclusion

<table>
<thead>
<tr>
<th>Title</th>
<th>Authors</th>
<th>Exclusion motive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary trauma from occlusion and periodontitis</td>
<td>Mark Branschofsky, Thomas Bieler, Ralf Schafer, Thomas F Flemming, Herman Lang</td>
<td>Factors associated with NCCL/GR are not included in the research strategy</td>
</tr>
<tr>
<td>Clinical evaluation of the association of noncarious cervical lesions, parafunctional habits, and TMD diagnosis</td>
<td>Daniela Attili Brandini, Sônia Regina Panzarini, Igor Mariotto Benete, Carolina Lunardelli Trevisan</td>
<td>Factors associated with NCCL/GR are not included in the research strategy</td>
</tr>
<tr>
<td>Factors influencing the progression of noncarious cervical lesions: A 5-year prospective clinical evaluation</td>
<td>Kanchan Sawlani, Nathaniel C. Lawson, John O. Burgess, Jack E. Lemons, Keith E. Kindernecht, Daniel A. Givan, Lance Ramp</td>
<td>Factors associated with NCCL/GR are not included in the research strategy</td>
</tr>
<tr>
<td>Noncarious cervical lesions (NCCLs) in a random sampling community population and the association of NCCLs with occlusive wear</td>
<td>J. Yang, D. Cai, F. Wang, D. He, L. Ma, Y. Jin, K. Que</td>
<td>Factors associated with NCCL/GR are not included in the research strategy</td>
</tr>
<tr>
<td>The role of occlusal loading in the pathogenesis of noncarious cervical lesions</td>
<td>John R. Antonelli, Timothy L. Hottel, Robert Brandt, Mark Scarbeec, Tejas Patel</td>
<td>Factors associated with NCCL/GR are not included in the research strategy</td>
</tr>
<tr>
<td>Association of noncarious cervical lesions with oral hygiene habits and dynamic occlusal parameters</td>
<td>Satheesh B. Hararul, Abdulrahman Saad Alqahtani, Mohammed Shaya AlMazni, Mohammad Khalid Alqahtani</td>
<td>Factors associated with NCCL/GR are not included in the research strategy</td>
</tr>
<tr>
<td>New insights in the link between malocclusion and periodontal disease</td>
<td>Olaf Bernhardt, Karl-Friedrich Krey, Amro Davoul, Henry Volzke, Stefan Kindler, Thomas Kocher, Christian Schwahn</td>
<td>Factors associated with NCCL/GR are not included in the research strategy</td>
</tr>
<tr>
<td>Relationship between self-reported bruxism and periodontal status: Findings from a cross-sectional study</td>
<td>João Botelho, Vanessa Machado, Luís Proença, JoãoRua, Leonardo Martins, Ricardo Alves, Maria Alzira Cavacas, Daniele Manfredini, José João Mendes</td>
<td>Factors associated with NCCL/GR are not included in the research strategy</td>
</tr>
<tr>
<td>Noncarious cervical lesions: why on the facial? A theory</td>
<td>W. Dan Sneed</td>
<td>No assessment for etiology of NCCL</td>
</tr>
<tr>
<td>Erosive tooth wear and wedge-shaped defects in 1996 and 2006: cross-sectional surveys of Swiss army recruits</td>
<td>Adrian Lussi, Matthias Strub, Ernst Schurch, Markus Schaffner, Walter Burgen, Thomas Jaeggi</td>
<td>No assessment for etiology of NCCL</td>
</tr>
<tr>
<td>Abfraction, abrasion, biocorrosion, and the enigma of noncarious cervical lesions: a 20-year perspective</td>
<td>John O. Grippo, Marvin Simring, Thomas A. Coleman</td>
<td>No assessment for etiology of NCCL</td>
</tr>
<tr>
<td>Biomechanics of noncarious cervical lesions</td>
<td>G. Beresescu, L.C. Brezeanu</td>
<td>Laboratorial study</td>
</tr>
<tr>
<td>Effects of occlusal loads in the genesis of noncarious cervical lesions - a finite element study</td>
<td>Andreea Stanusi, Veronica Mercut, Monica Scricciu, Mihaela Sanda Popescu, Monica Mihaela Craitoiu Iacob, Luminita Daguici, Stefan Castravete, Daniela Doina Vintila, Mihaela Vatu</td>
<td>Laboratorial study</td>
</tr>
<tr>
<td>The role of occlusal factors in the presence of noncarious cervical lesions in young people: a case-control study</td>
<td>A. Alvarez-Arenal, L. Alvarez-Menendez, I. Gonzales-Gonzalez, E. Jiménez-Castellanos, M García-Gonzalez, H deLlanos-Lanchares</td>
<td>Same data/patients used in two different articles</td>
</tr>
</tbody>
</table>

Abbreviations: GR, gingival recession; NCCL, noncarious cervical lesion; TMD, temporomandibular disorder.

The quality assessment of all studies included was considered high, considering them as low risk of bias (▶Fig. 2), with the following results: Teixeira et al., Alvarez-Arenal et al., and Brandini et al. with score of 16, and Yoshizaki et al. and Figueiredo et al. with score of 15.

Participants
Heterogeneity was observed across all the studies. In three studies, the participants were patients from the services of each institution; in one, the population was students; and, in the another, the population was patients, students, and employees of the institution. All studies were conducted in dental clinics at educational institutions (4 in Brazil and 1 in Spain). Besides, three studies detailed the number of teeth analyzed and the age was considered a possible etiological factor by three out of five studies which had a reduced average rating between 39 and 41 years, and in two there was a positive association between the increased prevalence of NCCL and age. Only Yoshizaki et al. found a higher prevalence of NCCL in the group of patients aged 31 to 50 years and not in the group corresponding with more advanced age (> 50 years). Only Teixeira et al. observed an association between age and GR.

Occlusal Factors and Characteristics
After analysis of the different occlusal factors was conducted, the report of its influence on the occurrence of the injury was transversal to all the five studies. In two, it was found that prematurity at maximum intercuspation and on the nonwork side were factors associated with the occurrence of...
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<tr>
<td>Teixeira et al, 2018</td>
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<td>2018</td>
<td>Brazil/English</td>
<td>Cross-sectional</td>
<td>Evaluate the risk factors associated with NCCL and cervical hydration (CDH) and gingival recession (GR), besides to the relationship between them in a specific Brazilian population</td>
<td>&gt; 18 years old and present at least one of the three changes, alone or in combination</td>
<td>Initial - 185 patients: Male = 85,56% Female = 0,68% Age average: 41,9</td>
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<td>&gt; 18 years old and good systemic health</td>
<td>Initial - 118 patients: Male - 50% Female - 68%</td>
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<td>Initial - 280 patients: Male - 106% Female - 174</td>
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<td>Brandini et al, 2012</td>
<td>Journal of Prosthetic Dentistry, 2.787</td>
<td>2012</td>
<td>Brazil/English</td>
<td>Cross-sectional</td>
<td>Assess the potential relationship between oral factors and the occurrence of NCCL</td>
<td>No reference is made</td>
<td>Initial - 111 patients: Male - 30% Female - 81%</td>
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<td>Figueiredo et al, 2015</td>
<td>Revista de Odontologia, 0.033</td>
<td>2015</td>
<td>Brazil/English</td>
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<td>Observe the occlusal aspects of patients with and without NCCL and identify their risk factors</td>
<td>No reference is made</td>
<td>Initial - 88 patients: Male - 36.64% Female - 63.36%</td>
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**Table 2 Brief description of included articles in the study**

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Abbreviations: GR, gingival recession; IF, impact factor; NCCL, noncarious cervical lesion.
### Table 3 Description of included articles in the study (results and conclusion)

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<th>Relevant results to the study</th>
<th>Conclusion</th>
</tr>
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<tr>
<td>Brandini et al, 2012</td>
<td>46 patients with NCCL (171 teeth with lesions) Of 1,296 teeth examined: • NCCL: 171 Teeth with NCCL and maxillary position when occlusal trauma occurs: • MIP: n = 61; p-value ≤ 0.001 • Centric relation: n = 59; p-value ≤ 0.001 • Working side: n = 80; p-value ≤ 0.001 • Nonworking side: n = 24; p-value ≤ 0.001 • Protrusion: n = 14; p-value = 0.002</td>
<td>Although the etiology of NCCL is multifactorial, the results of this study indicate that the direction and intensity of forces applied to teeth are important contributions to the occurrence of NCCL.</td>
</tr>
<tr>
<td>Figueiredo et al, 2015</td>
<td>Descriptive and inferential statistics: • Interferences in maximum intercuspatation (Present): Not NCCL (F) - 1; Yes NCCL (%) - 1.1; Reference values (F) - 45**; Reference values (%) - 51.1% • Interferences on the nonworking side (Present): Not NCCL (F) - 5; Yes NCCL (%) - 5.7; Reference values (F) - 28**; Reference values (%) - 31.8% Relative risk of developing NCCL: • Higher number of NCCL (OR): Interferences in maximum intercuspatation - 26.640*; Interferences on the nonworking side - 3.789*; • Presence of NCCL (95% CI): Interferences in MIP - 8.289–85.61; Interferences on the nonworking side - 1.521–9.438; • Presence of NCCL (OR): Interferences in MIP - 100.385**; Interferences on the nonworking side - 4.667%; • 95% CI: Interferences in MIP - 12.45–809.0; Interferences on the nonworking side - 1.570–13.87</td>
<td>Occlusal interference in maximum intercuspatation and on the nonworking side are risk factors for a greater number of injuries and their development.</td>
</tr>
<tr>
<td>Yoshizaki et al, 2017</td>
<td>80 patients with NCCL Of 2,902 teeth examined: • NCCL - 280 Poisson analysis of the association between independent variables and the presence of NCCL: Premature contacts: MIP: Adjusted prevalence ratio = 3.68; 95% CI = 2.43–5.59; p-value ≤ 0.0001 Nonworking side: Adjusted prevalence ratio = 2.76; 95% CI = 1.27–5.99; p-value ≤ 0.010</td>
<td>Factors associated with NCCL were • Age; • Presence of interferences at maximum intercuspatation and on the nonworking side; • Consumption of wine and alcoholic beverages.</td>
</tr>
<tr>
<td>Teixeira et al, 2018</td>
<td>163 patients with NCCL 110 patients with RG Of 5,180 teeth examined: • NCCL – 1,308 • GR – 1.334 • NCCL, GR, and CDH – 479 Bivariate analysis: Premature contacts (Yes): • NCCL – Mean = 7.42; SE = 0.42; p-value = 0.008 • GR – Mean = 7.68; SE = 0.54; p-value = 0.008 Multivariate analysis: Premature contacts (Yes): • NCCL – Estimate = 2.999; 95% CI = 0.774–5.223; p-value = 0.009 • GR – Estimate = 3.956; 95% CI = 1.072–8.440; p-value = 0.007</td>
<td>• Confirms, within limitations, that NCCL and GR increase with age; • NCCL, CDH, and GR have a positive correlation; • Lesion depth and morphology contribute to different levels of recession; • Age, gender, gastric diseases, and occlusal trauma were relevant factors for the occurrence of NCCL, CDH, and GR.</td>
</tr>
<tr>
<td>Alvarez-Arenal et al, 2019</td>
<td>Univariate logistic regression: • Protrusive interferences (Yes): Total - 59; OR – 1.82; 95% CI - 1.11–2.99; p-value - 0.018 • Right laterally interferences (Working side): Total - 19; OR – 1.21; 95% CI - 0.59–2.43; p-value - 0.598 • Right laterally interferences (Nonworking side): Total - 34; OR – 1.96; 95% CI - 1.06–3.65; p-value - 0.033 • Right laterally interferences (Both sides): Total - 17; OR – 2.40; 95% CI - 1.01–5.71; p-value - 0.048 • Left laterally interferences (Working side): Total - 16; OR – 1.18; 95% CI - 0.56–2.51; p-value - 0.661 • Left laterally interferences (Nonworking side): Total - 38; OR – 1.82; 95% CI - 1.02–3.31; p-value - 0.043 • Left laterally interferences (Both sides): Total - 16; OR – 2.23; 95% CI - 0.93–5.36; p-value - 0.072</td>
<td>• NCCL probably have a multifactorial etiology; • The risk factors contained in this predictive model are not enough to explain the presence of NCCL; • Protrusive and nonworking side interferences are significant for the occurrence of NCCL, in univariate or isolated analysis, but not in multivariate analysis.</td>
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Abbreviations: CDH, cervical dentin hypersensitivity; CI, confidence interval; GR, gingival recession; MIP, maximum intercuspation position; NCCL, noncarious cervical lesion; OR, odds ratio; SE, standard error.

* p < 0.05
** p < 0.01

NCCL. As for the study developed by Alvarez-Arenal et al.,
interferences during protrusive movements and on the
non-work side were statistically significant when the univariate
analysis was conducted, but not in the multivariate analy-
sis. Brandini et al. also concluded, more generally, that the
direction and intensity of forces, due to occlusal trauma, is an
important factor for the occurrence of NCCL. Teixeira et al.
were not objective in the conclusion, reporting several
factors, including occlusal trauma, associated with the
development of both NCCL and GR, not specifying whether
it was related to both or just one of the types of injuries,
although it was verified in both, with presence of statistical
significances ($p < 0.05$).

The occlusal scheme with the development of NCCL was
studied only by Brandini et al. A positive association was
obtained between the occurrence of NCCL and the presence
of group function during left (63%) and right (54%) laterality
movements.
NCCL and GR Location and Etiology

The analysis of the role of occlusal trauma as an etiological factor in the presence of NCCL and GR was performed in all the studies. NCCL location was not performed by one study, while Alvarez-Arenal et al. reported the GR preferential location of NCCL on the right side and 20% at maxillary on the left side. Furthermore, it was the only study that focused on the relationship between occlusal trauma and the occurrence of GR.

After analysis, it was concluded in three articles that NCCLs were more prevalent in the maxillary premolars. Yoshizaki et al. had 57% of incidence in premolars, while Brandini et al. detailed this issue, affirming more presence in first premolars (23.1% of the total NCCL on the right side and 20% at maxillary on the left side). Teixeira et al. and Figueiredo et al. concluded that this type of lesions appeared exponentially in maxillary premolars.

Nonocclusal Factors Causing NCCL and GR

Abrasive/traumatic brushing and parafunctional habits were reported in the articles and included as etiological causal factor of NCCL and GR. The abrasive/traumatic brushing had contradictory results and did not present a statistical significance, but it can be considered a contributing factor. Only one study considered it as a risk factor for NCCL.

Another variable reported was the acidic activity and its influence on the development of NCCL. It is worth to be noted that a positive correlation associated with the presence of gastroesophageal diseases but not significant. Similarly, a relationship was found between the consumption of alcoholic beverages and consumption of exogenous acid with the occurrence of NCCL.

Parafunctional habits have been suggested as a factor that can play a major role in the development of NCCL. A positive correlation between the existence of parafunctional habits and NCCL occurrence was observed in two studies. On the other hand, one study did not verify statistically significant correlation between occlusal parafunctional and NCCL/GR.

Discussion

The role of occlusal trauma in the etiology of GR and NCCL is a topic of clinical relevance in dentistry. However, it remains a controversial subject due to the reduced current scientific evidence that supports its true relation.

Studies Quality

It is noteworthy that, from the selected studies, all are in the middle of the pyramid of quality of scientific evidence. STROBE Statement was used to assess the quality and risk of bias, which all achieved a high-quality classification. Despite, Alvarez-Arenal et al. study presented a somewhat compromising detail of the quality of the study.

Study Design, Population Characteristics, and Etiology

Regarding patients age, three studies had a reduced average age (39–41 years). So, the premise that the prevalence of NCCLs and GR increases with age becomes limited considering this aspect, particularly in the Brandini et al study. Yoshizaki et al. found a higher prevalence in patients aged 31 to 50 years, and another study had no conclusion regarding age. Only Teixeira et al. reported an association between age and GR, also it was the only study included to evaluate GR. It was suggested by two studies that age is an etiological factor due to the longer exposure to which an older individual is subjected, corroborating the information available in the study developed by Boricic et al.

For clinical diagnosis performed, if single or six uncalibrated examiners, there was a risk of bias and imprecision of the studies may increase, jeopardizing also the reproducibility. Also, no laboratory study was included in this SR, given the inherent limitations of finite element analysis (based on computer models, not completely representing teeth in vivo; most of the studies regarding NCCLs use two-dimensional models).

It is safe to say that NCCL occurred preferentially in upper premolars, which revealed to be in agreement with other previous studies. This prevalence is verified probably due to the lower capacity to absorb lateral forces observed in premolars when compared with canines, leading to cervical tension and a consequent occurrence of NCCL.

Three studies tested this etiological factor (parafunctional habits) and in two had a positive correlation with NCCL occurrence, despite being low. On the other hand, Teixeira et al. could not verify a significant correlation with NCCL or GR, suggesting it as an enhancer of tooth loss at a cervical level, when compared with physiological forces since the magnitude of forces during this type of habit greatly exceed loads during normal activity.

The acidic activity was another factor analyzed by three articles with no unanimous results, and was considered a contributing factor for the occurrence of NCCL but not GR. Also, the role that abrasive/traumatic brushing played in the development of both NCCL and GR, three studies considered it, nevertheless, in this SR the data verified was not enough to draw any conclusions about this topic. Regarding brushing, it is important to state that two studies described the existence of NCCL in populations that did not have brushing habits, in concordance with Teixeira et al. and an in vitro study, which has shown that the presence of this factor is not enough for the development of these NCCLs. On the other hand, Morocchi et al. reported higher occurrence of this lesion in the left hemi-arch in right-handed patients, suggesting the influence of the brushing method on the etiology of NCCL.

Then, the evidences presented here are in concordance with Fan and Cato’s study and are weak and not feasible to conclude occlusal trauma causes periodontal alterations. Conversely, a case report published by Ustun et al. affirmed, in a patient Angle Class III malocclusion and with deep bite, that the severe GR was occasioned by the traumatic occlusion, which is in agreement with Jati et al. who demonstrated bone dehiscence and V-shaped recession due to occlusal trauma. Therefore, Campos et al. in an experimental study,
concluded that occlusal trauma promoted bone resorption after 14 days of analyses, while it did not cause GR.

Within the limitation of this SR, it can be concluded that few studies were published in the past 10 years, highlighting that NCCL and GR present a multifactorial etiology. However, the traumatic occlusion with consequent exacerbated forces to which the teeth are subjected seem to be associated with the occurrence of NCCL. No conclusions regarding the association of GR with the presence of occlusal trauma were possible to be done. The few published studies showed a high degree of heterogeneity, which suggests new well-designed randomized controlled clinical studies on the subject.

Conflict of Interest
The authors declare no conflicts of interest with this study.

References