Ayurvedic Oral Health Practices in Preventive Dentistry: Triphala Mouthrinse, Oil Pulling and Community Gingivitis Care

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ABSTRACT

Preventive dentistry increasingly encounters patient interest in Ayurvedic oral practices such as Triphala mouthrinse, herbal dentifrices, tongue cleaning, Kavala, Gandusha, and oil pulling. While systematic reviews suggest possible plaque and gingivitis benefits from selected herbal agents, these practices should supplement rather than replace brushing with fluoride toothpaste, interdental cleaning, periodontal assessment, and dental treatment. This paper presents a community gingivitis-care model for Ayurveda-informed oral health promotion. Classical oral hygiene concepts were synthesized with systematic reviews of Triphala mouthrinse, Ayurvedic plaque-control agents, and oil pulling. A synthetic school-adult community audit of 96 participants illustrates plaque-control education, mouthrinse adherence, oil-pulling tolerance, and dental referral triggers. The paper highlights dosing clarity, allergy screening, aspiration caution, oral lesion assessment, and avoidance of exaggerated claims. It concludes that Ayurvedic oral practices can be responsibly included in preventive dentistry when they are documented as adjuncts, when dental red flags prompt referral, and when patient education remains anchored in conventional oral hygiene standards.

KEYWORDS: *Triphala mouthrinse; oil pulling; Ayurvedic dentistry; gingivitis; Gandusha; community oral health*

INTRODUCTION

Ayurvedic oral care is familiar to many households through tongue cleaning, herbal tooth powders, Kavala, Gandusha, chewing sticks, and oil pulling. In contemporary dentistry, these practices attract interest because patients often seek low-cost, culturally acceptable methods to reduce plaque, gingival bleeding, halitosis, or mouth dryness. Ayurveda discusses oral health within daily regimen and Shalakya Tantra, while preventive dentistry emphasizes plaque control, fluoride, diet, and regular examination (1, 2, 3).

The overlap is promising but also vulnerable to exaggeration. A mouthrinse may reduce gingival inflammation in a trial, yet it cannot replace scaling when calculus is present, restore caries, treat abscess, or substitute for periodontal diagnosis. Oil pulling may be low risk for many adults, but it can be time-consuming, unpleasant, or unsafe if swallowed or aspirated. Patients also vary in allergies, gag reflex, oral lesions, and medication use.

This paper develops a community oral health model that places Triphala mouthrinse and oil pulling within an adjunctive prevention framework. It draws on systematic review evidence while preserving dental referral pathways. The approach is designed for Ayurveda colleges, dental outreach camps, and community clinics where oral hygiene advice can be culturally grounded without compromising dental standards (6, 7, 8).

LITERATURE REVIEW

Classical Ayurveda emphasizes daily oral cleanliness, scraping of the tongue, use of suitable herbal sticks or powders, mouth holding, gargling, and attention to diet and digestion (1, 2). These practices are embedded in Dinacharya rather than isolated product use. Their preventive logic includes mechanical cleansing, stimulation of oral tissues, taste normalization, and reduction of foul smell or coating.

Modern evidence is strongest for selected herbal mouthrinses and plaque-control agents rather than for broad oral-systemic claims. A systematic review of Ayurvedic and herbal plaque-control agents concluded that such agents may help reduce plaque and gingival inflammation as adjuncts (6). A review focused on Triphala mouthrinse found it may perform comparably to chlorhexidine for some gingival inflammatory outcomes, although evidence quality and heterogeneity limit certainty (7). A 2024 comparison of Triphala and curcumin

mouthwashes similarly supports cautious adjunctive use rather than replacement of standard care (8).

Oil pulling literature is more mixed. Reviews describe possible reductions in oral bacterial counts, plaque, or gingivitis, but many studies are small and short-term (9, 10, 11). Dental counseling should therefore present oil pulling as optional and supplementary. It should never displace brushing, interdental cleaning, fluoride exposure, treatment of caries, or periodontal therapy.

ADJUNCTIVE ORAL CARE PRINCIPLES

A responsible Ayurveda-informed dental model can be built around a few practical principles.

- Position Triphala mouthrinse and oil pulling as adjuncts to brushing, interdental cleaning, professional scaling, and dental diagnosis.
- Screen for oral ulcers, abscess, loose teeth, bleeding severity, allergy, gagging, aspiration risk, pregnancy concerns, and pediatric unsupervised use.
- Document frequency, duration, tolerance, taste acceptability, and whether participants continued conventional oral hygiene.

RESEARCH GAP

The literature often evaluates a product but not the community education system around it. In real settings, patients may use an herbal mouthrinse irregularly, dilute it incorrectly, discontinue brushing, or assume that reduced bleeding means periodontal disease has resolved. Research therefore needs to study counseling, adherence, dental referral, and behavior maintenance, not merely the antimicrobial effect of a formulation.

Another gap is the limited integration between Ayurveda practitioners and dentists. Ayurveda clinics may advise Gandusha or Triphala without periodontal charting, while dental clinics may dismiss traditional practices without asking what the patient is already using. A shared documentation template could reduce misunderstanding and make community oral health more patient-centered.

OBJECTIVES

- To propose a community preventive dentistry model for Triphala mouthrinse, oil pulling, and oral hygiene education.
- To identify safety, referral, and adherence fields needed for Ayurveda-informed oral care documentation.
- To present synthetic audit data illustrating plaque-control behavior and gingival comfort trends without claiming clinical efficacy.

METHODOLOGY

1. Community Model Design

The model was developed from classical oral hygiene concepts and contemporary systematic reviews of Triphala, herbal plaque-control agents, and oil pulling (1, 6, 7, 9, 10). It includes a baseline oral screening, dental referral checklist, education session, optional adjunct selection, and follow-up. Participants with abscess, severe mobility, deep caries pain, suspicious lesions, uncontrolled bleeding, or need for scaling were referred for dental management.

The synthetic audit represented 96 adults from school-parent and village outreach settings. Participants were grouped by preferred adjunct: Triphala mouthrinse, sesame or coconut oil pulling, or education-only oral hygiene support. The dataset was created to illustrate documentation and should not be interpreted as a trial.

Table 1. Oral health screening and referral triggers in community Ayurveda-dental outreach

Observation	Action	Reason
Spontaneous pain or swelling	Dental referral	Possible infection or abscess
Generalized mild gingival bleeding	Education plus adjunct if appropriate	Preventive plaque-control focus
Suspicious oral lesion	Urgent dental/oral medicine referral	Requires diagnosis
Gagging or aspiration concern	Avoid oil pulling	Safety and tolerance issue

2. Measures And Follow-Up

Outcome fields included self-reported gum bleeding, plaque-control behavior, mouth freshness, taste acceptability, adherence, and dental referral completion. Where dental staff were available, simplified plaque and gingival scores were recorded. Adverse event fields included nausea, mouth ulcer irritation, tooth sensitivity, allergic response, and accidental swallowing.

Education stressed that herbal adjuncts do not replace brushing twice daily with suitable toothpaste, interdental cleaning, diet moderation, and professional care. Participants were asked to bring all oral products used at home so that counseling could be personalized rather than generic.

Table 2. Adjunctive oral practices and documentation requirements

Practice	Typical Documentation	Caution
Triphala mouthrinse	Preparation, frequency, duration, taste, tolerance	Avoid claims of replacing chlorhexidine or dental therapy
Oil pulling	Oil type, duration, swallowing avoidance, gag reflex	Avoid in aspiration risk or unsupervised children
Tongue cleaning	Device, pressure, frequency	Avoid trauma and excessive scraping
Herbal powder	Ingredients, abrasiveness, frequency	Check enamel sensitivity and unknown additives

RESULTS AND FINDINGS

In the synthetic audit, oral hygiene adherence improved most when counseling was practical and culturally familiar. Triphala mouthrinse users reported higher taste acceptability than oil-pulling users, while oil pulling had more discontinuation due to time burden. Education-only participants still showed behavior gains, highlighting that instruction itself is an active component of community prevention.

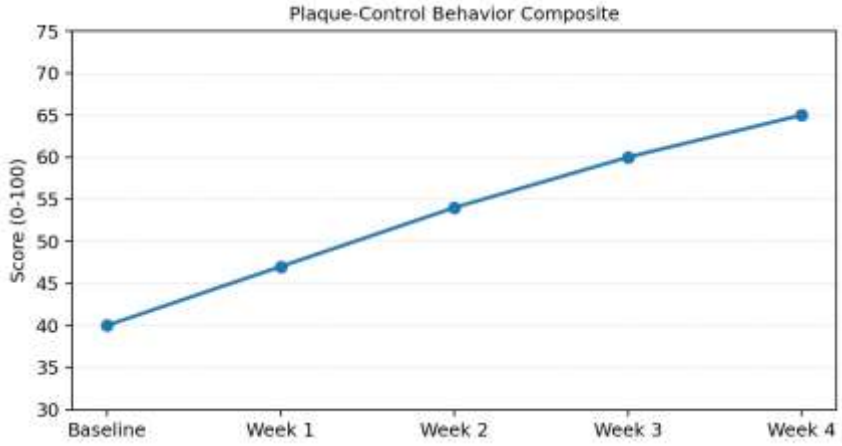

Figure 1: Synthetic plaque-control behavior score during adjunctive Ayurvedic oral care follow-up

The illustrative plaque-control composite improved over four weeks, but the model deliberately avoids attributing change to a single product. Participants often changed brushing technique, tongue cleaning, sugar frequency, and dental referral behavior at the same time. A community study that ignores these co-interventions would overstate the apparent effect of the herbal adjunct.

Table 3: Synthetic oral health audit findings

Domain	Pattern	Interpretation
Gum bleeding	Self-reported bleeding decreased	Could reflect brushing improvement and adjunct use
Taste acceptability	Triphala rated more acceptable than oil pulling	Palatability influences adherence
Dental referral	Referral completion was incomplete	Outreach must include follow-up support
Adverse effects	Mild nausea occurred with oil pulling	Tolerance screening is necessary

DISCUSSION

Ayurvedic oral health practices have a plausible place in preventive dentistry when they are presented with restraint. Systematic reviews support possible adjunctive benefits for herbal mouthrinses and Triphala in plaque-induced gingivitis, but the quality and comparability of

studies vary (6, 7, 8). This means community programs should avoid language suggesting that herbal rinses replace professional periodontal care.

Oil pulling requires even more careful counseling. Reviews report potential reductions in oral bacterial counts or gingival measures, but evidence is limited and practice burden is substantial (9, 10, 11). A patient who dislikes oil pulling may still benefit from better brushing, tongue cleaning, diet changes, and dental visits and professional counseling standards (12). A successful Ayurveda-dental program should therefore be flexible rather than product-centered.

The model also clarifies the ethical role of Ayurveda practitioners. They can improve oral health literacy, identify dental red flags, and support culturally acceptable routines, but they should refer disease requiring dental intervention. This aligns with global traditional medicine strategy and pharmacovigilance principles: traditional practices should be safe, documented, evidence-aware, and integrated without misleading claims (4, 5).

The most useful role of Ayurveda may be motivational rather than pharmacological. Many participants accept oral hygiene advice more readily when it is connected with familiar ideas such as daily regimen, tongue cleanliness, suitable diet, and mouth freshness. Preventive dentistry can use that cultural entry point while still insisting on fluoride exposure, interdental cleaning, scaling when indicated, and dental referral for pain, swelling, suspicious lesions, or mobility. The integration is strongest when each system contributes its safest strengths.

A community oral-health program must also address product variability. Herbal powders and mouthrinses differ in particle size, storage, concentration, preservatives, and household preparation. If these details are not recorded, a positive or negative outcome cannot be interpreted. The proposed model therefore asks participants to describe or bring their products, records taste and tolerance, and warns against abrasive or unknown mixtures. This is especially relevant where commercial claims travel faster than dental advice.

CONCLUSION

Triphala mouthrinse, oil pulling, tongue cleaning, and related Ayurvedic oral practices can be integrated into preventive dentistry as adjuncts when education, screening, and referral are

robust. The community model proposed here emphasizes behavior change, product tolerance, and dental co-care rather than isolated claims. Future pragmatic studies should measure plaque, gingival bleeding, adherence, adverse events, and referral completion together.

LIMITATIONS

- The audit data are synthetic and do not prove the effectiveness of Triphala, oil pulling, or herbal dentifrices.
- Objective periodontal measures were simplified and may not reflect full dental diagnosis.
- The model does not address advanced periodontitis, caries treatment, oral cancer diagnosis, or pediatric unsupervised use.

FUTURE SCOPE

- Conduct community trials comparing education-only, Triphala adjunct, and oil-pulling adjunct groups.
- Develop Ayurveda-dental referral cards for outreach camps.
- Analyze long-term adherence and product safety across different age and risk groups.

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