Review

Probiotics, Prebiotics, Synbiotics and Dental Caries. New Perspectives, Suggestions, and Patient Coaching Approach for a Cavity-Free Mouth

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Abstract: Probiotic therapy forms a new strategy for dental caries prevention. Probiotic microorganisms possess the ability to displace cariogenic microorganisms and colonize the oral cavity. They can produce various antimicrobial substances such as bacteriocins, bacteriocin-like peptides, lactic acid, and hydrogen peroxide. Dairy products may be ideal for probiotic administration in dental patients. Many other means have been proposed, primarily for those allergic to dairy components, such as capsules, liquid form, tablets, drops, lozenges, sweetened cakes, and ice creams. The last two forms can be used in a coaching approach for children and elderly patients who find it difficult to avoid sugary beverages in their daily routine and benefit from the suggestion of easy, cheap, and common forms of delicacies. In caries prevention, the concept of the effector strain is already considered an integral part of the contemporary caries cure or prevention strategy in adults. Adults, though, seem not to be favored as much as children at early ages by using probiotics primarily due to their oral microbiome’s stability. In this non-systematic review we describe the modes of action of probiotics, their use in the cariology field, their clinical potential, and propose options to prevent caries through a patient coaching approach for the daily dental practice.

Keywords: probiotics; prebiotics; synbiotics; dental caries; effector strain; prevention; oral health

1. Introduction

Dental caries is a multifactorial disease that occurs because of the ecological imbalance between the inorganic components of the hard dental tissues and biofilms [1]. It is the most widespread disease worldwide, with a prevalence approaching 91% of the adult population [2–5]. This trend is depicted particularly in USA’s national expenditures on oral biofilm-associated diseases, which have surpassed the corresponding expenditures for heart conditions since 2006 [3]. In general, the human microbiome is in balance—symbiosis—with its host, the human body. However, the use of antibiotics seems to cause serious adverse effects, such as damage to the desired oral microbiome, pathogen resistance, and oral cavities more prone to dental caries, among other things [6,7]. For this reason, a newly derived and preventively oriented method, probiotic therapy (i.e., the use of desired and harmless microorganisms) has been gaining ground for the past few years. These facts requisite to form new strategies for dental caries prevention, especially in the post-COVID-19 pandemic recession-era worldwide.

In dentistry, probiotics utilization is being focused on advancing oral health by forestalling caries’ and periodontal diseases’ establishment [8]. In caries management, probiotics’ rationale is that probiotic microorganisms possess the ability to displace cariogenic microorganisms and colonize the oral cavity [9,10]. In this review study, we focus our interest on the modes of action of probiotics as much as on the scientific effort from the
advent of probiotics in cariology, until today. We also highlight some considerations regarding their clinical potential in daily use and propose simple options to prevent caries experience or aggravation through a patient coaching approach for the daily practice.

2. Nomenclature

Probiotics were discovered in 1907, from the observation of the Nobel laureate in Immunology and Russian bacteriologist Ilya Ilyich Metchnikoff, that certain bacteria promote human intestinal health [11]. Since then, much has changed in probiotic nomenclature and its perspectives [12–16]. Today, probiotics are defined as “live microorganisms, which when administered in adequate amounts, confer a health benefit on the host” by the World Health Organization (WHO) and the United Nations Food and Agriculture Organization (FAO) (2002) [17]. The term ‘prebiotics’, on the contrary, is used to describe “a selectively fermented ingredient that allows specific changes, both in the composition and/or activity in the resident microflora, that confers benefits upon host wellbeing and health” [18]. The term ‘synbiotic’ is applied to products containing probiotics and prebiotics (Figure 1) [19].

![Synbiotics](image)

**Figure 1.** Synbiotics are products containing both probiotics and prebiotics.

It should be noted that fermented foods, although consisting of many microorganisms serving as probiotics, do not follow the cause explained for probiotics [10]. Fermented foods comprise edible products in which microbial activity is necessary to acquire stability, safety, and sensory properties. This is accomplished due to the ability of certain microorganisms (i.e., fermentation microorganisms/microbiomes) to decompose carbohydrates, thereby producing metabolites, such as lactic acid (lactic acid bacteria and Enterobacteriaceae), acetic acid (Acetobacter spp., Gluconobacter spp., Bacillus subtilis and yeasts), ethanol (heterofermentative lactic acid bacteria, Enterobacteriaceae, yeasts etc.), carbon dioxide, hydrogen peroxide, bacteriocins and antimicrobial peptides, which act alone or collectively to inhibit spoilage and the growth of several pathogens. Therefore, the microbiomes used for fermentation do not aim primarily to alter a human’s microflora, even though many probiotic strains (e.g., Lactobacilli spp.) utilized in general medicine and dentistry have been derived from the fermentation industry.
3. Modes of Action of Oral Probiotics

Several microorganisms serve as oral probiotics. Probiotics that have been used in clinical trials are classified regarding the genus, the species, and the strain (Table 1).

<table>
<thead>
<tr>
<th>Genus</th>
<th>Species</th>
<th>Strain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactobacillus</td>
<td>rhamnosus</td>
<td>GG (ATCC 53103) [20–23], hct 70 [24], LB21 [25], LC 705 [22]</td>
</tr>
<tr>
<td></td>
<td>reuteri</td>
<td>ATCC 55,730 (SD2112) [26–28], ATCC PTA 5289 [29–32], DSM 17,938 [29–32]</td>
</tr>
<tr>
<td></td>
<td>casei</td>
<td>Shirota [33]</td>
</tr>
<tr>
<td></td>
<td>paracasei</td>
<td>F19 [34], GMNL-33 [35], SD1 [36–38]</td>
</tr>
<tr>
<td></td>
<td>acidophilus</td>
<td>ATCC 4356 [39], La-5 [40]</td>
</tr>
<tr>
<td></td>
<td>salivarius</td>
<td>TI 2711 [41], WB21 [41]</td>
</tr>
<tr>
<td></td>
<td>brevis</td>
<td>CD2 [42]</td>
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<tr>
<td></td>
<td>bifidum</td>
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<td></td>
<td>bulgaricus</td>
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<td></td>
<td>sporogens</td>
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<td></td>
<td>thermophilus</td>
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<td></td>
<td>Bifidobacterium animalis lactis</td>
<td>BB-12 (ATCC 27536) [40,44–46], DN-173010 [47,48]</td>
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<tr>
<td></td>
<td>bifidum</td>
<td>ATCC 29,521 [39]</td>
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<tr>
<td></td>
<td>longum</td>
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<tr>
<td>Streptococi</td>
<td>mutans</td>
<td>A2JM [50]</td>
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<tr>
<td></td>
<td>rattus</td>
<td>JH145™ [51,52]</td>
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<td></td>
<td>oralis</td>
<td>KJ3™ [52]</td>
</tr>
<tr>
<td></td>
<td>uberis</td>
<td>KJ2™ [52]</td>
</tr>
<tr>
<td></td>
<td>dentisani</td>
<td>CECT7746 [53]</td>
</tr>
<tr>
<td></td>
<td>salivarius</td>
<td>M18 [54]</td>
</tr>
<tr>
<td>Bacillus</td>
<td>coagulans</td>
<td></td>
</tr>
</tbody>
</table>

The probiotics’ mechanisms of action generally have not been precisely determined [56]. Nevertheless, in general, the three main modes through which probiotics exert their action are (a) modulation of host’s defense (b) direct destruction of pathogens, and (c) indirect removal of pathogens.

Probiotics and their extracellular products are found to interact with the host’s mucous cells, determining in a strain-specific manner the cytokines’ and chemokine’s production, which leads to the enhanced phagocytic activity of macrophages, neutrophils, and Natural Killer (NK) cells [57]. For example, *B. lactis* Bb-12, *L. rhamnosus* GG, and *L. acidophilus* L41 increase the phagocytic capacity of leukocytes [58–61]. Probiotics, however, manipulate not only innate immunity but also stimulate adaptive immunity by increasing IgA levels in the serum and regulating the development of T helper cells and the proportion of Th1/Th2 cells [57,62–64]. In the oral environment, much less has been elucidated [56]. Indeed, specific probiotics inhibit the interleukin-8 (IL-8) response of the oral mucous cells caused by some periodontal pathogens as much as other inflammatory biomarkers, such as prostaglandin E2 (PGE2) [65–67]. Still, no alteration in salivary IgA levels has been observed [68]. Additionally, *L. paracasei* has been proved to augment the detectable counts of a defensin [69], salivary human neutrophil peptide 1–3 [70].

Probiotic bacteria can produce various antimicrobial substances, such as bacteriocins, bacteriocin-like peptides, lactic acid, and hydrogen peroxide. All of the above have an immediate effect on the host’s microbiome, as they preconceive the death of specific pathogens, while the producer strains survive [71–73]. For example, *L. rhamnosus* GG secretes...
a broad-spectrum antimicrobial substance affecting many Gram-positive (Streptococci, Lactobacilli, Clostridium spp.) and Gram-negative bacteria (E. coli, Bacillus fragilis) [74]. L. reuteri produces reuterin and reutericyclin [75,76], which exert their antimicrobial properties by inducing oxidative stress and altering the transmembrane ΔpH in target cells [77,78], respectively.

The indirect effects of probiotic microorganisms on the host’s microbiome have to do with the phenomenon of competing with the pathogenic bacteria either for an adhesion niche or for essential nutrients [79–82]. Whenever salutary strains preoccupy potential sites of pathogens’ adhesion, disease establishment is subverted [56]. The same happens when probiotic organisms excrete certain bio-surfactants that impede pathogenic bacteria’s adhesion or when they modify the salivary pellicle per se [82,83]. The previous adhesion sites are altered in a direction rendering them not probable for pathogens to establish.

4. Caries Pathogenesis

For a thorough perception of the role of probiotics in caries prevention and therapy, an analysis of the mechanism via which caries lesions develop is imperative. The oral cavity constitutes a habitat for a wide variety of microorganisms [84]. The latter are found to colonize both the oral mucosa and stable surfaces, such as teeth, fixed and removable prosthodontic appliances, etc. It is those microorganisms that colonize tooth surfaces to which dental caries is attributed. These microorganisms conglomerate, thereby constituting a complex, tolerant antimicrobial agent mass called ‘oral biofilm’ or ‘dental plaque’.

Oral biofilms are made up of a plethora of microorganisms. Some of them are harmless when present in the oral cavity, and some others possess a facultative pathogenic potential, which is called ‘opportunist pathogens’ [85]. According to the ‘Ecological Plaque Hypothesis’, in the presence of health, all of them are in a state of symbiosis with each other as much as with the host. In fact, they play a crucial role in the host’s health. Caries disease results from this symbiotic relationship’s subversion, where a shift toward pathogens occurs, a state characterized as dysbiosis. In that case, sugars consumed through diet are taken up by pathogenic bacteria and are metabolized to lactic acid. Acids produced by dental plaque solubilize apatite crystals of the hard dental tissues (i.e., demineralization). Once acidic residues are removed, remineralization occurs (Figure 2).

Figure 2. The process of caries development.

However, caries onset is not as simple as presented above. Many factors interplay among the host (salivary flow, apatite solubility), its oral microbiome synthesis, and the
type of nutrients being taken up (high/low-sugar diet) [86]. Thus, the effects of acids produced during a sugar-rich diet of low frequency can be neutralized by saliva or alkali produced in the dental plaque, meaning that demineralization and remineralization phenomena are in equilibrium. In the case that a sugar-abundant diet is consumed more frequently, the constant low-pH conditions exert evolutionary pressure toward acid-adapted and acidogenic bacteria, such as *Streptococci* and *Actinomyces*. If this frequency is even higher, the most efficient acid-tolerating and acid-producing bacteria dominate. In the last two cases, demineralization of the tooth surfaces prevails at the expense of remineralization [85].

Several microorganisms have been correlated with different types, stages, and sites of cariogenesis [84]. The complex microbial composition of cavities at various stages is not consistent with the specific plaque hypothesis and supports a polymicrobial origin. Nowadays, dental caries cannot be considered a classical infectious disease that follows the conventional Koch's model. The microbial ‘players’ involved change through time depending on the tissue affected, and multiple species are responsible for the progressing lesion at different stages of the caries process [87].

5. Caries Management with Probiotics

Today, probiotics seem to be a salutary, newly derived method to control dental caries [9,10]. The rationale of probiotics use in caries management is that probiotic microorganisms can expel cariogenic microorganisms and colonize the oral cavity. A wide variety of clinical trials have been conducted to examine probiotics’ effect on dental caries and oral microflora. These studies are summarized in Table 2.

**Table 2.** Clinical trials around oral probiotics utilized without aiming to preemptively colonize the oral cavity of subject.

<table>
<thead>
<tr>
<th>Baseline Condition</th>
<th>Type of Study</th>
<th>Patient Type</th>
<th>Baseline Condition</th>
<th>Study Groups</th>
<th>Treatment</th>
<th>Probiotic Strains</th>
<th>Strain Concentration</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meurman et al. (1994) [20]</td>
<td>Cohort study</td>
<td>Dental students (mean age 25 years)</td>
<td>Healthy</td>
<td>1 test group (n = 9)</td>
<td>2 × 250 g of probiotic yoghurt/day</td>
<td><em>Lactobacillus rhamnosus</em> ATCC 53103</td>
<td>1 × 10⁸ CFU/mL</td>
<td>LGG showed distinct growth in 8 of 9 subjects 2 weeks after treatment discontinuation.</td>
</tr>
<tr>
<td>Näse et al. (2001) [21]</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Daycare children (1–6 years old)</td>
<td>Healthy Caries</td>
<td>Test (n = 231)</td>
<td>5 × (±250 mL) of probiotic milk/week during a 7-month period</td>
<td><em>Lactobacillus rhamnosus</em> ATCC 53103</td>
<td>5–10 × 10⁵ CFU/mL</td>
<td>No significant differences in caries and MS scores. Significantly reduced caries-risk in the probiotic group, especially in the 3- to 4-year-old children.</td>
</tr>
<tr>
<td>Ahola et al. (2002) [22]</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Young adults (18–35 years old)</td>
<td>Healthy</td>
<td>Test (n = 38)</td>
<td>5 × 15 g of probiotic cheese/day for 3 weeks</td>
<td><em>Lactobacillus rhamnosus</em> ATCC 53103</td>
<td>1.9 × 10⁷ CFU/g</td>
<td>No significant difference in MS and yeast counts during intervention. Significantly reduced MS scores and a tendency toward fewer patients with high Lactobacilli counts in the pro-</td>
</tr>
</tbody>
</table>

<p>| Control (n = 36) | 5 × 15 g of placebo cheese/day for 3 weeks | <em>Lactobacillus rhamnosus</em> ATCC 53103 | 1.2 × 10⁷ CFU/g |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Participants</th>
<th>Intervention</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montalto et al.</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Young adults (23–37 years old)</td>
<td>Capsuled probiotics + Liquid placebo/day for 45 days</td>
<td>L. sporogenes 16% L. bifidum 12% L. bulgaricus 12% L. thermophilus 18% L. acidophilus 20% L. casei 10% L. rhamnosus 12%</td>
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<td></td>
<td>(Liquid probiotics + capsuled placebo)/day for 45 days</td>
<td>Significant increase in Lactobacilli groups in both probiotic groups. No change in MS counts in all groups.</td>
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<td></td>
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<td></td>
<td>(Liquid and capsuled placebo)/day for 45 days</td>
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<tr>
<td>Nikawa et al.</td>
<td>Double-blind, placebo-controlled</td>
<td>Female dental hygienist students (20 years old)</td>
<td>95 g of placebo yoghurt/day for 2 weeks + 95 g of probiotic yoghurt/day for 2 weeks</td>
<td>L. reuteri SD2112 Data not provided</td>
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<td></td>
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<td></td>
<td>95 g of probiotic yoghurt/day for 2 weeks + 95 g of placebo yoghurt/day for 2 weeks</td>
<td>Probiotic yoghurt compared to the placebo yoghurt significantly reduced MS counts.</td>
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<tr>
<td>Caglar et al.</td>
<td>Randomized, double-blind crossover</td>
<td>Young adults (21–24 years old)</td>
<td>Test (n = 21)</td>
<td>Bifidobacterium animalis 7 × 10⁷ CFU/g</td>
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<td>Control (n = 21)</td>
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<td></td>
<td>Group A (n = 30)</td>
<td>200 mL of water/day through probiotic straw for 3 weeks</td>
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<td>Group B (n = 30)</td>
<td>200 mL of water/day through placebo straw for 3 weeks</td>
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<td>Group C (n = 30)</td>
<td>1 probiotic tablet/day for 3 weeks</td>
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<td>Group D (n = 30)</td>
<td>1 placebo tablet/day for 3 weeks</td>
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<td>Test (n = 23)</td>
<td>B. animalis lactis Bb-12 1 × 10⁷ CFU/g</td>
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<td>Control (n = 24)</td>
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<td></td>
<td></td>
<td></td>
<td>Periods 1,3: run-in and wash-out, respectively</td>
<td>Significant decrease in MS counts and tendency toward Lactobacilli reduction due to probiotic yoghurt consumption.</td>
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<tr>
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<td>Periods 2,4 (2 weeks each): 1 × 200 g of probiotic or placebo yoghurt/day</td>
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<td></td>
<td>L. reuteri ATCC 55730</td>
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<td></td>
<td>1 probiotic tablet/day for 3 weeks</td>
<td>Significant decrease in MS counts and tendency toward reduction of Lactobacilli scores in both probiotic groups.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1 placebo tablet/day for 3 weeks</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Participants</td>
<td>Intervention</td>
<td>Probiotic (n = 110)</td>
</tr>
<tr>
<td>------------------------------------------</td>
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<td>---------------------------------------------------------------------------------</td>
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<tr>
<td>Stecksen-Blicks et al. (2009) [25]</td>
<td>Clustered, double-blind, placebo-controlled, preschool children (1–5 years old)</td>
<td>Healthy Caries</td>
<td>1 × 150 mL probiotic milk (supplemented with 2.5 mg fluoride/L)/day for 21 months</td>
<td>L. rhamnosus LB21 1 × 10⁷ CFU/mL</td>
</tr>
<tr>
<td>Singh et al. (2011) [40]</td>
<td>Randomized, double-blind, placebo-controlled, crossover, children (12–14 years old)</td>
<td>Healthy</td>
<td>1-week run-in, 54 g of placebo ice-cream/day for 10 days, 2-week wash out, 54 g of probiotic ice-cream/day for 10 days</td>
<td>B. animalis lactis BB-12 1 × 10⁸ CFU/g ATCC27536</td>
</tr>
<tr>
<td>Chuang et al. (2011) [35]</td>
<td>Randomized, double-blind, placebo-controlled, young adults (20–26 years old)</td>
<td>Healthy</td>
<td>3 probiotic (+11% xylitol) tablets/day for 2 weeks</td>
<td>L. paracasei GMMNL-33 3 × 10⁷ cells/tablet</td>
</tr>
<tr>
<td>Kavaloglu-Cildir et al. (2011) [29]</td>
<td>Randomized, double-blind, placebo-controlled, crossover, children (4–12 years old)</td>
<td>Healthy Cleft Lip/Palate</td>
<td>Periods 1,3: run-in and wash-out, respectively Periods 2,4 (25 days each): 5 probiotics or placebo drops/day</td>
<td>L. reuteri DSM 17938 ≥1 × 10⁸ CFU/5 drops</td>
</tr>
<tr>
<td>Juneja et al. (2012) [24]</td>
<td>Randomized, double-blind, placebo-controlled, children (12–15 years old)</td>
<td>Healthy Caries</td>
<td>Group I (n = 18) 2 × 150 mL of standard milk/day for 3 weeks</td>
<td>L. rhamnosus hct 70 2.34 × 10⁸ CFU/day</td>
</tr>
</tbody>
</table>
Burton et al. (2013) [54] Randomized, double-blind, placebo-controlled Schoolchildren (5–10 years old) Healthy Caries

Test (n = 40) 2 probiotic lozenges/day for 3 months
Control (n = 43) 2 placebo lozenges/day for 3 months

S. salivarius M18 3.6 × 10^9 CFU/lozenge

Significant reduction of plaque scores in the probiotic group. Children who presented a distinct oral colonization by M18 tended to possess lower counts of MS.

Teanpaisan et al. (2013) [36] Randomized, double-blind, placebo-controlled Young adults (18–25 years old) Healthy Caries

Group A (n = 20) 1 × 10 g reconstituted probiotic milk powder in 50 mL of water/day for 4 weeks
Group B (n = 17) 1 × 10 g reconstituted placebo milk powder in 50 mL of water/day for 4 weeks

L. paracasei SD1 ≥ 10^7 CFU/g or mL

Significant decrease of MS levels and increase of Lactobacilli levels after probiotic milk powder consumption. The probiotic could be detected up to 4 weeks after the discontinuation of the intervention.

Yadav et al. (2014) [33] Randomized, double-blind, placebo-controlled, crossover Children (6–8 years old) Healthy Caries

Test (n = 31) Periods 1,3: run-in (7 days) and wash-out (30 days), respectively
Control (n = 31) Periods 2,4 (10 days each): 1 × 10 mL of probiotic or placebo milk/day

L. casei Shirota Data not provided

Significant reduction of MS counts after the intake of probiotic milk.

Pinto et al. (2014) [48] Randomized, double-blind, placebo-controlled, crossover Orthodontic patients (median age 15 years) Healthy Caries

Group 1 (n = 15) 1-week run-in, 200 g of probiotic yoghurt/day for 2 weeks, 4-week wash out, 1 × 200 g of placebo yoghurt/day for 2 weeks
Group 2 (n = 15) 1-week run-in, 200 g of placebo yoghurt/day for 2 weeks, 4-week wash out, 200 g of placebo ice-cream/day for 2 weeks

B. animalis lactis DN-173010 Data not provided

No significant difference in MS, Lactobacilli and total cultivable microorganisms counts after both yoghurts. Both yoghurts were equally efficient at reducing total cultivable microorganisms isolated from dental plaque.

Nishihara et al. (2014) [41] Randomized, double-blind, placebo-controlled with 4 parallel arms Sixth-year dental students (mean age 24.8 years) Healthy Caries

Group 1 (n = 17) 1 probiotic (+280 mg xylitol) tablet for 1 month
Group 2 (n = 16) 1 probiotic (+450 mg xylitol) tablet for 1 month

L. salivarius WB21 6.7 × 10^8 CFU/tablet
L. salivarius TI 2711 2.8 × 10^8 CFU/tablet

No significant change in MS levels. Significant increase in Lactobacilli counts in the two probiotic groups and enhanced buffering capacity.
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Age</th>
<th>Treatment</th>
<th>Lactic Acid Bacteria</th>
<th>CFU/Tablet</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keller et al. (2014) [30]</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Adolescents (12–17 years old)</td>
<td>Test (n = 19)</td>
<td>2 probiotic tablets/day for 12 weeks</td>
<td>L. reuteri DSM 17938 L. reuteri ATCC PTA 5289</td>
<td>≥ 10^8 CFU/tablet ≥ 10^8 CFU/lozenge</td>
</tr>
<tr>
<td>Gizani et al. (2016) [31]</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Adolescents and young adults (mean age 15.9 years)</td>
<td>Test (n = 42)</td>
<td>1 probiotic lozenge/day for 17 months</td>
<td>L. reuteri DSM 17938 L. reuteri ATCC PTA 5289</td>
<td>≥ 10^8 total CFU/g</td>
</tr>
<tr>
<td>Ghasemi et al. (2017) [39]</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Female students (19–27 years old)</td>
<td>Group 1 (n = 25)</td>
<td>200 g of probiotic yoghurt/day for 3 weeks</td>
<td>L. acidophilus ATCC 4356 B. bifidum ATCC 29521</td>
<td>1.5 × 10^8 total CFU/g</td>
</tr>
<tr>
<td>Koopaie et al. (2019) [55]</td>
<td>Randomized, double-blind, placebo-controlled, crossover</td>
<td>Adolescents and adults (mean age 41.67 years)</td>
<td>Group 1 (n = 20)</td>
<td>70 g of probiotic cake/day for 1 week, 4-week wash-out period, 70 g of regular cake/day for 1 week</td>
<td>B. coagulans Data not provided</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Participants</td>
<td>Intervention</td>
<td>Outcome</td>
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<tr>
<td>Javid et al.</td>
<td>Randomized, double-blind,</td>
<td>Students (18–30 years old)</td>
<td>Test: 300 g of probiotic yoghurt/day for 2 weeks, 300 g of placebo yoghurt/day for 2 weeks</td>
<td>Significant reduction in MS and Lactobacilli levels in the probiotic group.</td>
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<tr>
<td>(2020) [46]</td>
<td>placebo-controlled</td>
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<td>B. lactis Bb-12 10^6 CFU/ml</td>
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<td>Control: 300 g of placebo yoghurt/day for 2 weeks</td>
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<tr>
<td>Ferrer et al.</td>
<td>Prospective, mechanistic</td>
<td>Adults (25–35 years old)</td>
<td>Group 1: 7 vials (multidose) containing the probiotic strain, 5.5 × 10^9 CFU/vial</td>
<td>Significant decrease of MS and significant increase in S. dentisani levels and salivary pH.</td>
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<tr>
<td>(2020) [53]</td>
<td>pilot with two parallel</td>
<td></td>
<td>Group 2: 2 vial (monodose) containing the probiotic strain, 4 × 10^{10} CFU/vial</td>
<td>The latter was stronger in the multi-dose schedule.</td>
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<td>follow-up groups</td>
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</table>

Among most of these trials, dairy products remained a common denominator as an administration milieu [46–48]. Milk’s colloidal nature seems to be enamel protective [88], as it contains organic and inorganic compounds assisting in compensating cariogenic challenges [89]. Another substrate of dairy formulations, calcium lactate, also possesses anti-cariogenic properties [90]. Therefore, dairy products may be ideal for probiotic administration. However, many other means have been proposed to serve as probiotic administration agents, especially for those allergic to dairy components. Among those means stand capsules or liquid form [43], specially prepared straws or tablets [27,35,41], drops [29], lozenges [54], and even sweetened cakes [55] and ice creams [44].

The first-ever study introducing probiotics to dental clinical practice was that of Meurman and his colleagues [20]. They suggested that Lactobacillus Gorbach-Goldin (GG) – LGG, a strain earlier isolated by Gorbach and Goldin [91], can colonize the human oral cavity. Nonetheless, its long-term beneficial effect on oral health and the resulting alterations in oral microflora remained unilluminated. Näse et al. investigated L. rhamnosus GG for its in vivo long-term effect (7-month period) on dental caries [21,92]. They reported no significant changes in S. mutans salivary counts and caries prevalence occurred, but a significantly lower caries-risk than in the control group.

Following these results, Ahola et al. investigated the short-term anticaries effect of a cheese containing the same Lactobacillus rhamnosus strain plus L. rhamnosus LC 705 [22]. After a 3-week period, no statistically significant difference in S. mutans counts between the intervention and the control group occurred. However, the probiotic-containing cheese was found to exert its enhanced anticaries potential during the post-treatment period, as the S. mutans levels in saliva were significantly reduced.

In 2003, Montalto et al. examined two extra facets of probiotics intended for oral administration [43]. Probiotic species tested in this study were L. sporogens 16%, L. bifidum 12%, L. bulgaricus 12%, L. thermophilus 18%, L. acidophilus 20%, L. casei 10%, and L. rhamnosus 12%. The probiotics used, independently of the administration’s milieu, were found to increase Lactobacilli salivary counts in contrast to S. mutans. In fact, capsule and liquid forms were found to lead to equivalent results. The only practical difference between these two types of administration is that Lactobacilli strains diffused into the oral cavity in the liquid state. Thus, a systemic effect of oral probiotics was suggested.

In 2004, Nikawa et al. highlighted the selective bactericidal influence of L. reuteri SD2112 (ATCC55730) on S. mutans in vitro and in vivo [26]. The individuals consumed a cup (95 g) of placebo yoghurt (S. thermophilus and L. bulgaris) once a day for two weeks during lunchtime in the first group. The following 2 weeks, a probiotic yoghurt containing L. reuteri and S. thermophilus was administrated in the same terms. In the second group,
the opposite regimen was followed. Ultimately, both types of treatment significantly reduced the \textit{S. mutans} salivary carriage, compared to its baseline values for each group.

To cover the lack of knowledge about \textit{L. reuteri}’s effect on Lactobacilli salivary counts in humans, after the introduction of the strain \textit{Bifidobacterium} DN-173 010 to the oral probiotic armamentarium \cite{47}, Caglar et al. selected \textit{L. reuteri} ATCC 55,730 as intervention strain to illuminate this unknown aspect \cite{27}. As concluded, probiotic-containing straws and tablets could be beneficial to \textit{S. mutans} confinement. Two years later, Caglar and his affiliates presented the strain \textit{Bifidobacterium lactis} Bb-12 as an anticaries-competent probiotic strain \cite{44}. This study introduced a novel probiotic strain into the race against caries and suggested ice-cream as a possible means for probiotics administration.

Given the previous studies about probiotics’ role in caries management, Stecksen-Blicks et al., came up with the highly promising idea of combining probiotic bacteria with fluoride \cite{25}. This idea was based on the hypothesis that these two agents would act synergistically. Children in both the probiotic and placebo group consumed 150 mL of medium-fat milk at lunch for 21 months. As the results indicated, caries incidence increment was statistically significantly lower in the intervention group than in the control children. In contrast, salivary counts of caries-associated \textit{S. mutans} and Lactobacilli were not affected.

With time passing by, innovative probiotic strains have been proposed for the fight against dental caries. For instance, \textit{L. acidophilus} La5 combined with \textit{B. lactis} Bb-12 \cite{40}, \textit{L. paracasei} GMNL-33 \cite{35}, \textit{L. rhamnosus} hct 70 \cite{24}, \textit{S. salivarius} M18 \cite{54}, \textit{L. paracasei} SD1 \cite{36}, \textit{L. casei} Shirota \cite{33}, \textit{L. acidophilus} ATCC 4356 combined with \textit{B. bifidum} ATCC 29,521 \cite{39} dismiss \textit{S. mutans} from the oral cavity. Moreover, \textit{L. paracasei} SD1, when being received once a day for 4 weeks can be retained in the oral cavity of healthy young adults for 4 additional weeks by the time the regimen has been interrupted \cite{36}. Lately, a shift towards the study of the host-specific alterations caused by probiotics has been recorded. Remarkably, the potential of specific probiotics to decrease caries risk has been correlated with their property to increase saliva’s buffering capacity \cite{41,53}, although no probiotic tested for an immediate anticaries ability has been shown to invert early caries development per se \cite{30,31}.

It is worth mentioning that in 2019, a highly promising study was conducted \cite{55}. This trial investigated the effect of a \textit{Bacillus coagulans}-abundant cake on \textit{S. mutans} levels and salivary pH. It pointed out that the sweetened probiotic cake can keep \textit{S. mutans} amounts low and comparable to those surveyed before cake consumption. Hence, it was proposed that cakes carrying probiotic flora may comprise a novel strategy against \textit{S. mutans} \cite{92}. This proposal is the modern trend in food policy \cite{93}.

6. Clinical Considerations on Probiotics’ Effectiveness

In general, for a strain to serve as a probiotic, it should be capable of firmly attaching to the oral surfaces \cite{94}. However, Lactobacilli, present weak adhesiveness on the tooth structure \cite{95}. The latter raises a variety of speculations around their long-term restraint in retention sites. Data from research studying the effect of probiotics on their saliva concentration and their tooth structure content are limited. However, according to Meurman et al., during the second week after the discontinuation of probiotic treatment with a yoghurt supplemented with LGG, LGG’s salivary counts show a decrease in subjects who were following the treatment \cite{20}.

Likewise, Busscher et al. investigated LGG, \textit{L. acidophilus} and \textit{B. bifidum}’s ability of adhesiveness on the tooth structure in vitro and in vivo \cite{96}. In vitro data suggested that LGG possesses a by far inferior ability of adhesion to the clear enamel (without salivary pellicle) and the pellicle-coated enamel compared to the corresponding ability \textit{L. acidophilus}. This difference was attributed to the hydrophilic character of LGG. Salivary samples collected from individuals who were subjected to the daily intake of these bacteria through a bio-yoghurt were free of Lactobacilli. It was concluded that the ecological conditions in the oral cavity of test persons were unfavorable for Lactobacilli to
grow, as temporary colonization could not be achieved even in individuals without any evincible amounts of Lactobacilli.

Another study demonstrating the temporary colonization of the oral cavity by probiotic Lactobacilli is Petti et al. [97]. The authors investigated if *S. thermophilus* and *L. bulgaricus*-containing yoghurt presented any activity against the oral microbiome regarding whether these probiotics could colonize the human oral cavity. Some activity against oral Streptococci was detected, but this has not resulted from the probiotics’ colonization because it elapsed once the treatment was discontinued.

Yli-Knuuttila et al., except for demonstrating LGG’s inability to colonize young adults’ oral cavity, signalized that permanent LGG colonization is possible, providing that early administration in childhood has taken place [98]. Devine and Marsh [99] explained that the latter finding was correlated with the instability of the resident microbiota in children [100]. After that, many studies were conducted to examine the possible long-term effect of probiotics in the child population. These trials are synopsized in Table 3.

**Table 3.** Clinical trials investigating probiotics ability to colonize the oral cavity of children preemptively.

<table>
<thead>
<tr>
<th>Baseline Condition</th>
<th>Type of Study</th>
<th>Patient Type</th>
<th>Baseline Condition</th>
<th>Study Groups</th>
<th>Treatment</th>
<th>Probiotic Strains</th>
<th>Strain Concentration</th>
<th>Results</th>
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<tbody>
<tr>
<td>Aminabadi et al. (2011) [23]</td>
<td>Randomized, double-blind with 4 parallel arms</td>
<td>Children (6–12 years old)</td>
<td>Healthy</td>
<td>Group A (n = 35)</td>
<td>2 × 5 mL of 0.12% chlorhexidine/day for 2 weeks</td>
<td><em>L. rhamnosus</em> GG</td>
<td>$2 \times 10^8$ CFU/g</td>
<td>Significant decrease in MS counts in all groups; only in groups A and C it was persisted for 5 weeks after the end of treatment. In group C LGG levels were more prominent than in group B.</td>
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<td>Taipale et al. (2012) [45]</td>
<td>Randomized, double-blind, placebo-controlled with 3 parallel arms</td>
<td>Infants (1–2 months old)</td>
<td>Healthy</td>
<td>Group B (n = 35)</td>
<td>2 × 5 mL of 0.12% chlorhexidine/day for 2 weeks + 15–20 mL of probiotic yoghurt for 3 weeks</td>
<td><em>B. animalis lactis</em> BB-12</td>
<td>$5 \times 10^8$ CFU/tablet</td>
<td>Significant decrease in MS counts in the probiotic and the sorbitol groups at the age of 2 years. No observed permanent oral colonization of BB-12. Lactobacilli were unaffected.</td>
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<td>Hasslöf et al. (2013) [34]</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Infants (4 months old)</td>
<td>Healthy</td>
<td>Group C (n = 35)</td>
<td>2 probiotics-tablets/day</td>
<td><em>L. paracasei</em> F19</td>
<td>$1 \times 10^8$ CFU/serving</td>
<td>No significant difference in MS counts and caries experience between the two groups. No</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>Participants</td>
<td>Intervention</td>
<td>Outcome</td>
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<td>Stensson et al. (2014) [28]</td>
<td>Randomized, single-blind, placebo-controlled</td>
<td>Mothers (during the last month of gestation) + Infants (through the 1st year of life)</td>
<td>5 drop of probiotic-oil/day (last month of gestation and 1st year of life)</td>
<td>Significant decrease in caries prevalence in the probiotic group. No significant intergroup differences in L. reuteri, MS, Lactobacilli and sIgA counts.</td>
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<tr>
<td>Hedayati-Hajikand et al. (2015) [52]</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Preschool children (2–3 years old)</td>
<td>1 chewing probiotic-tablet/day S. uberis KJ2™ S. oralis KJ3™ S. rattus JH145™ ≥1 x 10⁸ total CFU/tablet</td>
<td>Significantly lower caries increment in the probiotic group.</td>
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<td>Villavicencio et al. (2017) [49]</td>
<td>Randomized, triple-blind, placebo-controlled</td>
<td>Preschool children (3–4 months old)</td>
<td>200 mL of reconstituted probiotic milk/day for 5 days a week during a 9-month period L. rhamnosus 5 x 10⁸ CFU/g of powdered milk B. longum 3 x 10⁶ CFU/g of powdered milk</td>
<td>Significantly lower counts of Lactobacilli count and higher buffering capacity in the test group. No significant difference in caries prevalence, MS counts, salivary pH and dental plaque between the groups.</td>
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<td>Pahumunto et al. (2018) [37]</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Preschool children (1.5–5 years old)</td>
<td>5 g of probiotic milk powder in 50 mL of water/day for 3 months L. paracasei SD1 ≥1 x 10⁷ CFU/g</td>
<td>Significantly lower risk of MS levels increases and of caries development in the test group.</td>
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<td>Alamoudi et al. (2018) [32]</td>
<td>Randomized, double-blind, placebo-controlled</td>
<td>Children (3–6 years old)</td>
<td>2 probiotic lozenges/day for 28 days L. reuteri DSM 17938 L. reuteri ATCC PTA 5289 ≥2 x 10⁸ total CFU/lozenge</td>
<td>Significant decrease in MS and Lactobacilli counts in the probiotic group. No statistical difference in</td>
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<tr>
<th>Group I (n = 86)</th>
<th>1 × 3 g of placebo milk powder in 50 mL of milk for 7 days/week for 6 months</th>
<th>L. paracasei SD1</th>
<th>1.8 × 10^7 total CFU/mL</th>
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<tr>
<td>Group II (n = 89)</td>
<td>1 × 3 g of probiotic milk powder in 50 mL of milk for 7 days/week for 6 months</td>
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<td>Group III (n = 93)</td>
<td>1 × 3 g of probiotic milk powder in 50 mL of milk for 3 days/week + 3 g of placebo milk powder in 50 mL of milk for 4 days/week for 6 months</td>
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Significantly lower counts of MS and higher levels of Lactobacilli in saliva in both probiotic groups than in the placebo group. No difference regarding these alterations between the probiotic groups.

One study mentioned above evaluated the possible correlation between probiotic use in combination with an agent controlling the oral microbiota [23]. Aminabadi et al. tested this eventuality by combining the salutary advantages of chlorhexidine (CHX) in oral microbiome control using LGG. They concluded that CHX increases—at least 5 weeks after ceasing the regimen—the stability of LGG oral colonization.

Taipale et al. evaluated the influence of B. animalis lactis Bb-12 (Bb-12) early administration on S. mutans and Bb-12 oral colonization [45]. Subjects 1–2 months old in the test group received tablets with the probiotic strain, whereas control groups consumed xylitol (X) and sorbitol (S) in the same manner. The whole regimen lasted until the infants became 2 years old. Qualitative PCR showed bare and no Bb-12 oral colonization at 8-month-old and 2-year-old children, respectively, significantly reduced S. mutans levels, and had no effect on Lactobacilli. Such results were extracted in a study carried out one year later for the strain L. paracasei F19 [34].

In 2014, Stensson and his team studied whether caries prevalence could be subverted through oral probiotic administration before establishing the oral microflora [28]. It is worth mentioning that although a significant reduction in caries incidence was reported, no caries-associated microbiological alterations were observed. Other strains of L. reuteri
(DSM 17,938 and ATCC PTA 5289), when administered through lozenges twice a day, prevail against MS and Lactobacilli and benefit the salivary buffer capacity [32].

Hedayati-Hajikand et al., in turn, evaluated the effect of a commercially known probiotic product (ProBiora3 TM) filled with the strains S. uberis KJ2, S. oralis KJ3, S. rattus JH145 as an adjunct to the everyday oral hygiene of 2/3-year-old children [52]. Thus, ProBiora3 TM chewing tablets benefit early childhood caries increment when used in children’s daily oral care.

More recent studies suggest that L. rhamnosus combined with B. longum, L. paracasei SD1, and L. brevis CD2 could also assist in attenuating the range of dental caries from early ages [37,38,42,49]. More specifically, L. rhamnosus combined with B. longum, despite being incapable of reducing S. mutans salivary levels, they do so as far as Lactobacilli are concerned and enhance the buffering capacity of saliva [49]. On the other hand, L. paracasei SD1 affects MS levels and inhibits caries development [37,38]. Finally, the latest research in the field suggests that L. brevis CD2 is competent for diabetic children because it improves some caries risk factors (e.g., reduction in salivary MS and maximum plaque pH fall, increase in lowest plaque pH) and gingival health [42].

7. The Concept of the ‘Effector Strain’

Generally, the ‘effector strain’ is a microorganism with zero pathogenic potential that can persistently colonize infection-susceptible host tissues and prevent tissues conquest by pathogens. This mechanism has been described as ‘replacement therapy’. This method could be used for prevention, as much as for the cure of disease, and potentially could lead to ‘herd protection’ through effector strain’s transmission from one individual to another [101]. In the case of dental caries, the use of certain S. mutans strains as ‘effector strains’ has been proposed by Hillman [102]. Specific S. mutans strains with low acidogenic potential due to a lactate dehydrogenase (LDH) deficiency and the ability to produce particular bacteriocins could be mobilized to serve as ‘effector strains’ [102–104]. LDH is an enzyme that plays a pivotal role in pyruvate to lactic acid conversion during the catabolism process of glucose by cariogenic bacteria [105]. On the other hand, bacteriocins possess antimicrobial properties against strains or species in close relativity with the producer one [106].

A series of S. mutans strains, JH1000, JH1001, JH1005, JH1010 have been found to produce a specific bacteriocin (‘mutacin 1140’ or ‘MU1140’), a lantibiotic, in particular, with close relativity to nisin’s structure [104,107], as the latter has been determined by Hurst [108]. Mutacin 1140 is highly bactericidal against a wide range of microorganisms, primarily Gram-positive (e.g., Streptococcus sanguis, Streptococcus salivarius, Streptococcus pyogenes, Streptococcus mitis, Lactobacillus salivarius, oxacillin—and vancomycin-resistant Staphylococcus aureus and Actinomyces species), and Gram-negative bacteria as well [104,109,110]. This is attributed to its ability to powerfully connect with lipid II [111,112], which is a crucial element in bacterial wall synthesis [113] and is targeted by a variety of antibiotics [114]. No adaptive resistance to MU1140 has been presented [109]. JH1000 and its close relatives JH1001, JH1005, and JH1010 were also tested for their ability to colonize rats’ oral cavity [104]. JH1001 and JH1005 strains were significantly more competent to displace indigenous S.mutans strains and, conversely, to a lesser extent, displaced by extrinsic bacteria (e.g., S. mutans Ingbritt) than JH1010 strains. The strong correlation between the bacteriocin production and the producer strain’s ability to preemptively infect the rodents’ oral cavity indicated that JH1001 and its successor, JH1005, could be used as human probiotic strains in the future. The finding reinforced this thesis that JH1001 strain was indeed superinfecting and could displace indigenous S. mutans to a great extent in humans, but a minimal infection dose (MID) was not determined [115]. Two years later, JH1005’s ability to superinfect the human oral cavity was examined [116]. The results were more than encouraging, as S. mutans levels significantly decreased 7- and 38-fold in the post-treatment period. In contrast, the rest of the subjects’ oral ecological flora remained unaffected, thereby satisfying an excellent precondition for a successful
replacement therapy that in no way should effector strains unsettle human oral ecological balance to the extent that predisposition to other diseases is possible.

The key to achieving a fabricated probiotic combining low acidogenicity and high colonizing capacity was introducing the mutant LDH gene into JH1000 strains [117]. Initially, a natural selection favored the wild-type S.mutans JH1000 occurred by eliminating the mutant gene, suggesting that the LDH gene’s mutation was lethal in JH1000 [117,118]. This problem could be overcome by limiting the glucose supply and by augmenting alcohol dehydrogenase (ADH) activity, which, as found, compensates for LDH deficiency in high sugar concentrations [119].

With the advent of the new millennium, Hillman et al. announced the construction of an effector strain, BCS3-L1, thanks to the insertion of the adh B gene of ADH (derived from Zymomonas mobilis) to the JH1140 strain (a mutant strain that produces two- to three-fold mutacin 1140 than JH1001) [120]. Animal studies highlighted that strain as ideal for replacement therapy inception, as it fulfilled all the prerequisites for an effector strain, which are the significantly reduced pathogenic potential, the selectivity in colonizing the tissues at risk of disease (i.e., the S.mutans niche), genetic stability, superinfecting competency, and prevention of pathogen outgrowth. Targeted mutations were introduced to BCS3-L1 through DNA recombination [50]. These mutations affected the genes dal and come. The dal participates in formation of the bacterial cell wall and the comE gene has a regulatory role in the uptake of exogenous DNA. To date, tests in rats foresee no harmful side effects of A2JM. Collectively, the A2JM strain has low acidogenicity, can colonize the oral cavity, produces high levels of MU1140, and is genetically stable.

Other strains are also under investigation. These include the LDH-deficient S. rattus JH145, which can displace S. mutans from the oral cavity of rats [121] and is included in the commercial ProBiora3 TM (Streptococcus uberis KJ2, Streptococcus oralis KJ3, Streptococcus rattus JH145) mouthwash, which is considered a safe and effective adjunct in maintaining dental health [51,122]. A new strategy for replacing dental caries places LDH- and gcrR-deficient and S. mutans in the foreground [123]. Hence, the deletion of this gene allows the LDH-deficient S. mutans to better adhere to tooth surfaces. This hypothesis has been confirmed both in vitro and in vivo [124].

At first, the concept of the effector strain constituted a radical notion in probiotic therapy. Now, it is considered an integral part of the contemporary caries cure or prevention strategy in adults. Moreover, the thorough study of the effector strain’s capacities and its safety guarantees its clinical effectiveness.

8. Synbiotics: A New Perspective in Caries Management

As previously mentioned, the term ‘synbiotic’ regards products that consist of both probiotics and prebiotics. Gibson and Roberfroid first proposed prebiotics in 1995 to promote symbiosis in gut microbiota [19]. Today, there is clear evidence that prebiotics enhances host’s immune function [125–128], selectively favoring health-promoting bacteria, such as Lactobacilli and Bifidobacteria [129–133], employing potential adhesion sites of pathogenic strains, thereby exerting anti-adhesive properties and repressing the virulence of human pathogens per se [130,132,134].

In dentistry, as in general medicine and the food industry [93], prebiotics are combined with probiotics to enhance the latter’s ability to “outgrow” pathogens. Until today, only five combinations have been tested; all of them are at pre-clinical stages [135–139]. Glucomannan hydrolysates (GMH) or 3% galactooligosaccharides (GOS) and 1% fructooligosaccharides (FOS), when combined with L. acidophilus, suppress S. mutans growth [135–138]. In 2015, Kojima et al. proposed specific probiotic and prebiotic candidates that could be combined to serve as synbiotics [136]. The corresponding probiotics were specific strains from the species L. fermentum, L. plantarum, and L. paracasei. The potential prebiotics were xylose, xylitol, and arabinose, which were the only
saccharides tested to simultaneously inhibit S. mutans growth and promote the survival of Lactobacilli.

Another strategy of synbiotics evolving in the past few years is incorporating probiotics-specific prebiotics known for their ability to maintain the oral environment’s pH at high levels when a cariogenic challenge occurs. These prebiotics are mainly urea and arginine [140]. Although urea benefits specific oral microorganisms [141–143], its anti-cariogenic effect is notable [144,145], no study about its potential use in synbiotics has been conducted. Arginine, an amino acid strongly positively correlated with caries absence in adults [146], is also well-documented [147]. In contrast to urea, arginine has found one application in synbiotics. This was accomplished by Bijle and his partners [139]. According to this study, arginine concentration is directly correlated with LGG’s viability, inhibition of S. mutans per se, biofilm, in general, and lactic acid production, thereby preserving plaque pH after the treatment application. Nonetheless, clinical trials must be carried out soon to verify their application in the complex oral environment.

Undoubtedly, the concept of synbiotics in caries management has high promise. For the moment, it is still in its infancy. Further clinical trials, which will investigate the in vivo effect of these formulations on the oral microenvironment, especially on dental plaque and its pH, are necessary to clarify whether synbiotics can facilitate our attempts to decrease caries incidence.

9. Patient Coaching Approach on the Use of Probiotics for Caries Prevention

Research around probiotics indicates that these may be a good tool in healthcare delivery. It is expected that they will be a cooperative agreement to the patient’s adjunct in oral health promotion, as probiotics are simple to consume and do not require any effort from the patients. The latter’s compliance to the treatment strongly depends on their attitude towards it and how the dentist could show the short and long-term benefits of following diet instructions. Inevitably, we should persuade dental patients that probiotics are meaningful. This will not be achieved through traditional standardized health advice. Current healthcare advances dictate that the patient should be put in the epicenter and gain an active role in the doctor-patient relationship [148,149]. The motivation provided should be based on patients’ customized needs and skills. A thorough understanding of the necessity of probiotics in the daily diet and the easy way of consumption they possess in contrast to more demanding oral hygiene practices will ensure their position in all dental patients’ diet.

Many alterations are observed from infancy to adolescence as far as oral microbiota and dietary habits are concerned. While the microbiota of children’s mouths are unstable, during puberty, they become consistent [100]. Infants and toddlers may be bottle-fed, whereas children and teenagers likely consume high-sugar- or high-starch-containing snacks and beverages [150,151]. Both habits favor caries establishment. In the case of infants, toddlers, and children, parents should be informed about the microbiological ‘open window’. In this context, milk would be the probiotic carrier of choice, given the fact that they daily consume milk at breakfast time. Teenagers and children also, considering that they may not manage to refrain from a high-sugar diet, should be suggested to prefer probiotic sweetened foods instead of regular ones, as the former are considered to confer health benefits on the consumers [40,44,55].

Adults also have unique dietary patterns which need to be considered [152]. Those between the ages of 18 to 30 years old exhibit no specific nutritional pattern associated with caries disease. Those older than 30 years of age seem to consume high portions of sweetened beverages, sandwiches, and bread, indicating caries prevalence and severity in this group. In high caries-risk adults, the application of the effector strain may be unavoidable.

Older adults often confront serious health and socio-psychological problems, such as obesity, malnutrition, memory lapses, low mood, reduced resilience, etc. [153,154]. Their oral health is also compromised [154]. Due to these problems and their advanced age, they
subconsciously resist changing their attitude and quit caring about themselves, thereby facing a vicious circle of constant health impairment. This obstacle could be overcome if the dentist learns to encourage such patients and maximize the potential of collaboration and, by extension, of treatment. Considering that probiotics’ daily intake does not require excellent skills or daily lives, they may consist of a minor, high profitable diet change for older patients. Again, in these people, the effector strain may have to be chosen for utilization.

People suffering from hyposalivation are vulnerable to oral diseases, including dental caries [155]. Diagnosed hyposalivation often comprises a sequela of severe systemic diseases, such as diabetes mellitus, Sjögren’s syndrome, or cancer during the phase of chemotherapy and radiotherapy or may be derived by age or certain drugs [156–162]. In this context, these patients need to be diet coached to admit probiotics into their daily routine. Probiotic lozenges in the daily diet may be the best choice, as lozenges confirmedly increase salivary flow [163]. The inclusion of probiotics will help them surpass the potential jeopardy of caries development or other oral infections. Notably, cancer patients are expected to strictly follow probiotic treatment because they are more receptive to new therapies [164]. During anticancer therapy, the instability of their physical body should need diet highlights to surpass the treatment’s stress. Nevertheless, cancer patients are surprisingly unwilling to follow diet recommendations for long; thus, probiotics could be an effective, cheap, and easy solution for positively affecting their oral condition at the first stages of treatment and the phase of maintenance [154].

10. Discussion

Dental caries is still a significant public health problem across the world. It has a multifactorial etiology. Health inequality influences general and oral health. In the early 1970s, Swedish children had some of the worst caries statistics in Europe. Accordingly, these inequalities were manifest between groups with lower and higher educational levels. Then, the Swedish government developed a national dental insurance system and proposed that all citizens be entitled to dental care on equal terms. At the same time, they organize public dental care, free of charge, for all children and adolescents up to and including 19 years of age. The result of this politics is the detrimental decline of the caries index. A decline in the incidence of dental caries is also observed in countries having established public health programs using fluoride for dental caries prevention, coupled with changing living conditions, healthier lifestyles, and improved self-care practices. Indeed, the use of fluoride is considered a public health benefit.

Diet also possesses a prominent place in caries establishment and prevention. The frequent consumption of sugars and starches in foods and beverages is the primary causative factor of cariogenesis [165–168]. This etiologic relationship can be mirrored through studies investigating dental caries incidence whenever sugar availability changes occurred [169,170]. A correlation of the types of sweetened foods with their cariogenicity does not express the precise action of sugars in the oral cavity in real-time, due to the interplay among sugars with the salivary flow and the preventive measures implemented [171]. Since sugars’ role in caries development is evident today, it is sensible to orientate toward their intake confinement. This could be achieved either by reducing sucrose intake (or intake frequency) or replacing sucrose in the diet with sugar substitutes, such as sorbitol and xylitol, or by adding to the diet various food factors, including phosphates [172]. It is not clear yet whether these measures are efficient.

Therefore, as we approach the new era of preventive dentistry, and given that fluoride intake is not a nostrum [173], we should seek contemporary methods that are highly efficient, cost-effective, safe, and necessitate the least involvement of our patients. In general, probiotic strains are considered safe, as most of them have been informally consumed in fermented foods and utilized in general medicine for several years [10,174]. Short-term and long-term clinical trials around oral probiotics confirm this, as they do not alter the oral microbial ecology in a direction prone to disease [22,27,28,45].
The effectiveness of the permanence of probiotics’ impact on the mouth’s microbial flora—and by extension, on oral health—strongly depends on the pre-existent microbial conditions prevailing in the oral cavity [99]. Adults seem not to be favored as much as children at early ages by using probiotics, primarily due to their oral microbiome’s stability. This is why we need to consider probiotics better as a preventive method rather than as a therapy per se, meaning that we can implant certain microbial strains in our patients’ mouth from an early age to augment the potential benefit to people’s oral health in the long-run. Yet, this is not always the case. As it is known, public health measures and pharmaceutical regimens have played a vital role in overall in the dental health improvement and the prolongation of life [175–178]. This, in conjunction with falling birth rates, leads to an aging population [175,179]. Given that more people are getting older and preserving their natural teeth than in the past and are more likely to develop caries lesions [180–182], we need to develop methods that are addressing such a population [183]. In these people, the effector strain concept seems to be critical, as it allows us to displace established pathogens at an advanced age, at which naturally significant alterations in oral microecology have not been feasible previously. Perhaps another adult-oriented method to prevent caries lesion in the future may be the autonomous use of mutacin 1140 (MU1140) or its analogues, to confine S. mutans carriage, followed by the treatment of simple probiotic strains, such as L. reuteri strains, to ensure that a desirable integration of theirs in the mouth is competent and durable. The last suggestion is since mutacin 1140 is highly bactericidal for S. mutans [104], this is an ability that can be technically improved [184]. Also, MU1140 is not connected with acquired resistance by pathogens [109], its pharmaco-kinetic and -dynamic properties are well-known [110,185,186], and its analogues can now be produced through laboratory biochemical processes [187].

The most significant advantage of probiotics is that they confer benefits to patients’ health through a minimal involvement of the latter. This will make them more acceptable as a new method. Furthermore, probiotics can now be contained in formulations, such as ice-creams and cakes [40,44,55], which contain high proportions of sugars, thereby promoting cariogenesis [171], and make those easily consumed, happy diet delicacies to work in favor of the good oral condition and not against it. The choice to entirely refrain from such products is not feasible, especially for children, who frequently consume a sugar-enriched diet [188]. Thus, the inclusion of probiotic strains in these products would be positive for preventing dental caries as they reduce S. mutans salivary levels. This will change in the future; the ways in which diet can benefit oral health, diminishing dental caries, through comfort in use and well-known products, will be accepted by everyone. It seems imperative that different probiotic formulas must be designed in the food industry in collaboration with dental professionals to make oral prevention and human sustainability a fact for future generations.

11. Conclusions

The introduction of probiotics to the field of cariology is auspicious for the decrease of caries prevalence. The most important fact of all is that they are addressing a broad spectrum of our patients’ ages and health status through multiple manners and they can be readily and safely incorporated into daily use with the application of general coaching models, without necessitating particular toil from the side of the patients. The latter is of great significance for older people. The knowledge around oral probiotics’ mechanisms of action, nonetheless, is still lacking. Further studies need to be conducted to understand their interaction with the host’s cells and microbiome. In the meantime, they should be used as a preventive method rather than as a caries therapy per se tool.

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