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Integrating Oral Health and Pharmacotherapy in Stroke Rehabilitation: An Interprofessional Approach

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Abstract:- Stroke is a major cause of long-term disability across the world, requiring thorough rehabilitation strategies. This review discusses the combination of oral health management and pharmacotherapy in stroke neurorehabilitation. We cover the neurological basis of stroke recovery, including the concepts of neuroplasticity, mechanisms of motor recovery, and neuromodulation approaches, as well as the frequently neglected oral health problems associated with stroke survivors, including dysphagia, poor oral health, and risk of aspiration pneumonia. An interprofessional model between neurologists and dental professionals is presented as a way to enhance patient outcomes. Evidence shows that the collaborative provision of oral care can help minimize complications (e.g., pneumonia) and improve quality of life in stroke patients. Key pharmaceutical therapeutic interventions to improve post-stroke recovery (including neuroplasticity-enhancing drugs) and their oral health implications are also summarized. The conclusion presents the importance of the role of a neurologist-dentist to work in a complementary manner, incorporating oral health protocols and judicious pharmacotherapy in order to help provide optimal rehabilitation outcomes in patients with stroke.

Keywords: *Stroke Rehabilitation, Oral Health, Neuroplasticity, Dysphagia, Interprofessional Collaboration, Pharmacotherapy.*

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I. INTRODUCTION

Stroke is one of the major global health burdens. It is the second leading cause of death and a major cause of disability, and the number of people living with impairments related to stroke has been increasing in recent decades [1]. Advances in acute stroke care have led to an increase in survival, and as a result, the growing population of survivors of stroke has required massive effort in neurorehabilitation to regain function and independence. Neurorehabilitation is concerned with using the brain's ability to recover through neuroplastic changes and intensive therapy to enhance motor, cognitive, and daily living skills after stroke. Given the high prevalence of residual deficits, it is important to have comprehensive rehabilitation strategies to reduce the degree of long-term disability and quality of life following stroke.

Amid the focus on recovery of motor and cognitive functioning, oral health is one area of post-stroke care that has received less attention over the years. There is sufficient rationale for oral health to be incorporated into stroke recovery plans. Stroke-related neurological deficits can impair the ability of a survivor to maintain oral hygiene because of hemiparesis (one-sided weakness), sensory loss, or cognitive dysfunction [2]. Consequently, stroke survivors tend to have considerably worse oral health status (increased incidence of tooth loss, dental caries, and periodontal disease) and less frequent dental attendance than the general population [2]. Dysphagia (difficulty swallowing) is another common stroke complication, as it affects up to half of acute stroke patients [3]. Dysphagic stroke patients are at increased risk of aspirating bacteria that is carried in the mouth, which leads to pneumonia; in fact, improper oral hygiene and difficulty swallowing are risk factors for stroke-associated aspiration pneumonia [2]. For example, one controlled trial showed that early dysphagia screening and intensified oral hygiene care for the individual helped to reduce the incidence of post-stroke pneumonia from around 27% of people in usual care to only 7% in the intervention group [3]. These results highlight the importance of preserving the cleanliness of the oral space as well as regulating swallowing difficulties, something that was undervalued as a comfort measure and could be a lifesaving intervention in stroke rehabilitation.

Recognizing these risks, stroke care guidelines in a number of countries now include the routine care of the mouth of stroke patients as part of a best practice for stroke care. International stroke guidelines (e.g., in Australia, Canada, and the UK) contain very specific recommendations in relation to implementing oral hygiene protocols and dysphagia-specific oral care, aimed at improving the oral health and comfort of patients [2]. However, despite such recommendations, oral care is often low on the priority list in practice and may be neglected in the recovery from stroke [2]. Interdisciplinary approaches that ensure the integration of dental expertise in teams of stroke rehabilitation professionals may be able to close this gap. The neurobiological basis of stroke recovery and motor rehabilitation is discussed in the following sections (Section I), oral health considerations for stroke survivors are presented (Section II), and models for incorporating dentistry and neurology in stroke care are proposed (Section III). A brief description of important pharmacotherapies as they pertain to neurorecovery and oral health is also included (Section IV). Through this interprofessional lens, we hope to present some of the ways that care and interventions in neurology and dentistry and between these two groups can be coordinated to improve outcomes of stroke survivors.

II. SECTION I: NEUROLOGICAL FOUNDATIONS OF STROKE REHABILITATION

Stroke rehabilitation is based on the science of neuroplasticity and the built-in ability of the central nervous system to reorganize itself in the face of damage [4]. Neural plasticity, the ability of the brain to establish new neuronal links, reorganize the pre-existing networks, and adjust the

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function in response to training and experience [5]. Motor recovery after stroke depends largely on such plastic reorganization because motor recovery requires "relearning" of motor skills and recruitment of alternate neural pathways to compensate for damaged brain regions [5]. Of particular note, spontaneous processes of biological recovery are most active in the early hours after the stroke, which is often described as a critical window of increased biological plasticity [6]. During this subacute phase, synaptic plasticity is increased, so early intervention is highly effective to drive recovery.

In order to take advantage of the power of neuroplasticity, stroke rehabilitation programs focus on high-intensity, repetitive, task-specific practice. Clinical and research evidence supports the view that meaningful, goal-directed movement training, when performed in an enhanced environment intensively and repetitively, leads to cortical reorganization and improvements in motor function [5]. For example, constraint-induced movement therapy and robotic-assisted training, which are task-specific exercises, can encourage motor relearning through use-reliance plasticity in affected limbs [7]. Rehabilitation is not a passive process, but active participation of the survivor in therapy is essential to success because motor recovery gains are very much related to the amount of practice and sensory feedback that the nervous system receives.

In addition to behavioral training, several different techniques of neuromodulation have risen to help supplement neural recovery. Neuromodulation is the term used to describe interventions that directly enhance or directly modify excitability in the brain or in neural networks in order to create plasticity and improve function [8]. Non-invasive brain stimulation modalities, including repetitive transcranial magnetic stimulation (rTMS) and transcranial direct current stimulation (tDCS), have had some success in improving motor recovery by making the cortex of the lesioned hemisphere more excitable or by modifying interhemispheric inhibition [9, 10]. Likewise, invasive approaches to neuromodulation are being investigated: one particular example is vagus nerve stimulation (VNS) combined with rehabilitation exercises. In an important randomized trial, active VNS of stroke patients undergoing rehab of the upper limbs resulted in nearly twice the improvement in clinically meaningful arm function compared with patients receiving rehab with sham stimulation [11]. About 50% of patients receiving VNS had a significant improvement in motor scores in the arm compared to about 25% of the control group [11]. These benefits continued at follow-up and resulted in the regulatory approval of VNS as an adjuvant therapy for chronic stroke rehabilitation [11]. Such findings demonstrate the possibilities of neuromodulation (either by external therapy or implanted devices) to enhance the effects of conventional therapy by engaging plasticity mechanisms.

Underpinning all these neurorehabilitation strategies is the aim of neuromodulating neural circuits in order to promote adaptive reorganization (functional plasticity) and prevent maladaptive changes (e.g., learning to non-use or spastic synergies). Importantly, recovery of the neurological function is heterogeneous; factors such as the severity of the stroke, location, and patient comorbidities affect the species of plastic change and motor return [9]. Neuroimaging and neurophysiological examinations (e.g., functional MRI, transcranial magnetic mapping) are becoming increasingly used to individualize rehabilitation and track changes in the nervous system and predict recovery trajectories [12]. In summary, the neurological basis for stroke rehabilitation is for driving neuroplasticity through intensive training and, in some circumstances, adjuvant neuromodulatory therapies. This provides the foundation for optimization of motor outcomes, which, as we discuss further, must be supplemented by attention to the oral health and general medical management of the patient.

III. SECTION II: ORAL HEALTH CONSIDERATIONS IN STROKE SURVIVORS

Oral health is an important and also frequently neglected part of treatment for stroke survivors. The aftereffects of stroke pose many challenges to preserving good oral hygiene and function. Neurological deficits like hemiplegia (paralysis on one side) may affect the patient's ability to brush teeth or carry out any basic oral care, especially when their dominant hand is affected. Cognitive and perceptual impairments may also cause less attention to be paid to oral hygiene. As a result,

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stroke survivors tend to have much worse oral health outcomes than their non-stroke counterparts [2]. Studies have found increased prevalence of dental caries, periodontal disease, and tooth loss in post-stroke populations, together with the decreased frequency of professional dental visits [2]. This deterioration in oral health status can happen rapidly during the period of hospitalization and rehabilitation, especially since no targeted oral care plan is in place.

Dysphagia (difficulty swallowing) is a common complication of stroke, which has a direct link with oral health [13]. Stroke-related dysphagia does not only affect nutrition and swallowing safety but also may cause stagnation of food debris and saliva within the oral cavity [13]. Patients with dysphagia often have impaired clearance of oral secretions and may have pockets of food in their mouth, which is a breeding ground for bacteria in the mouth and oropharynx [2]. This is of great concern, as aspiration of oral contents is a well-known way for pneumonia in stroke patients. Stroke survivors who have poor oral hygiene are at increased risk of aspiration pneumonia, which happens when pathogenic oral bacteria or food particles are inhaled into the lungs [2]. Aspiration pneumonia is a serious complication that prolongs mortality and hospital stay in stroke patients [3]. Improving oral health is thus one of the important preventative measures. For example, the implementation of strict oral care has proven effective in minimizing pneumonia: in one study, in patients with stroke receiving an oral hygiene intervention (along with a swallowing screening), pneumonia incidence was only 7%, whereas in control groups without the intensified oral care, pneumonia rates were 27-28% [3]. This is a stunning decrease underscoring the importance of maintaining oral cleanliness and control of dysphagia on the medical outcome of stroke rehabilitation.

In addition to pneumonia, stroke survivors who do not take care of their teeth may develop other health problems [14]. Oral infections (such as periodontal disease) and poor dentition may cause systemic inflammation, and this may have adverse effects on recovery or risk for vascular disease [15]. Pain resulting from dental problems can result in reduced nutritional intake and poor concentration on rehabilitation efforts. Moreover, oral discomfort or halitosis (bad breath) resulting from poor hygiene can be a factor that affects the patient's dignity, social interaction, and willingness to participate in therapy [16]. Stroke patients may also have difficulty with xerostomia (dry mouth), either from the direct effects of the neurological damage or as a side effect of medications given; less saliva flow also means that there is a greater opportunity for dental decay and mucosal infections [17]. If the stroke survivor wears dentures, the facial muscle weakness or change in anatomy may cause the dentures to fit poorly, causing sore spots or less use of dentures and thus a decreased nutritional intake [18]. Each of these factors proves why oral health needs should be addressed during stroke recovery and not deferred.

Implementing good oral hygiene for stroke patients is difficult and necessary. Normally, nurses or caregivers need to help the patients with functional limitations in self-care. Unfortunately, studies suggest that oral care does not receive a high priority compared with other tasks in stroke units [2]. When relying on others for oral care, patients often receive suboptimal cleaning—teeth and tongue might be insufficiently brushed, and oral examinations might be inconsistent. Some of the barriers healthcare staff identified are lack of time, inadequate training or confidence in providing oral care, unavailability of appropriate oral care tools, and patient resistance caused by cognitive issues or lack of understanding [2]. Caregivers may also be uncomfortable with performing oral hygiene for patients, particularly for those who have swallowing difficulties or behavioral problems. Overcoming these barriers needs education, resources, and system-level protocols. For example, training programs for nurses and nursing aides have been shown to increase knowledge and skills in oral care, and that results in cleaner mouths with fewer oral health complications in stroke wards [2]. Simple interventions such as the introduction of a standardized oral care toolkit (soft toothbrushes, toothpaste, chlorhexidine mouthwash, and suction devices for those at risk of aspiration) and the establishment of twice-daily oral care routines can make a big difference. Indeed, clinical guidelines recommend that all patients with stroke, especially those with dysphagia or who are tube-fed, should have assisted oral hygiene carried out a minimum of 2 times daily, including thorough brushing of teeth and oral mucosa with suitable cleaning agents

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(fluoridated toothpaste and/or antiseptic chlorhexidine gel) [2]. In case of severe dysphagia, it is recommended to use antiseptic mouth rinse (e.g., chlorhexidine 0.12%) to decrease the oral bacterial load [2]. Following such protocols helps to keep the mouth clean, moist, and intact with regard to the integrity of the oral tissues.

In summary, there are several oral health issues that stroke survivors encounter: physical and cognitive impairments that make it difficult to routinely take care of one's own body, dysphagia that puts patients at risk of aspiration infections, and oral neglect that can result in systemic complications such as aspiration pneumonia. However, with good oral hygiene practices and specific actions, a number of these risks can be avoided. A clean and healthy mouth not only helps to prevent medical complications, but it also plays a part in the comfort, nutrition, and overall rehabilitation progress. The evidence is clear that oral care forms a part of post-stroke care. This recognition is the setting for closer collaboration between neurological and dental professionals, discussed in the next section.

IV. SECTION III: INTEGRATING DENTISTRY AND NEUROLOGY

Given the complexity of the interrelations between oral health and outcomes in stroke, an interprofessional approach that bridges neurology and dentistry is extremely beneficial. Integrating dental care in stroke rehabilitation requires a team of collaborators, such as neurologists, rehabilitation physicians, nurses, speech therapists, and dental professionals (dentists or dental hygienists), to meet the oral health needs of stroke patients in parallel with neurological rehabilitation. Such collaboration may be of different sorts, from engagement of dental consultants in stroke unit rounds or multidisciplinary team meetings to regular dental evaluation of in- and outpatients during rehab to training of rehabilitation staff in oral care techniques and when to make referrals to dental services.

The role of the dental team in stroke care has been emphasized by expert guidelines. The British Society of Gerodontology, for example, issued guidelines that note that the dental team has a role not only in prevention but also in rehabilitation for stroke survivors [19]. They recognized that dentistry is frequently 'left out of the equation' in the planning of stroke care, as even national stroke strategies may not explicitly mention oral health [19]. To remedy this, the onus is on the "stroke-skilled dental team" to assert their role as part of the multidisciplinary network of care [19]. In practice, this means dental professionals who have expertise in special care dentistry (the branch dealing with patients with special needs or medical complexities) should be involved soon after the acute phase of the stroke. Early involvement can include giving advice to the hospital staff regarding oral hygiene care during acute care (when patients might be intubated or have impaired consciousness) as well as continuation of preventive and restorative dental care during the rehabilitation phase [19]. By being a part of the stroke rehab team, dental professionals can make sure to address issues such as painful teeth or oral infections or ill-fitting dentures in a timely manner, thus helping to eliminate potential barriers to recovery, such as pain or malnutrition.

Interprofessional collaboration models between dentistry and neurology have shown definite benefits. A transdisciplinary team approach was studied in an acute stroke unit in Japan in which dentists and dental hygienists worked with doctors, nurses, and speech therapists to provide oral care to patients with stroke [20]. The results were compelling: patients who received collaborative oral health care had significantly improved their oral health status upon discharge as determined by improvements in oral plaque and debris scores [20]. In that study, the prevalence of oral problems (such as tongue coating, denture plaque, and poor oral cleanliness) was high upon admission, but with intensive team-based oral hygiene interventions, these problems greatly diminished [20]. The conclusion was that the oral health of the stroke patients in the acute phase can be considerably expressed by integrating dental professionals into the care team [20]. Another recent systematic review (2025) regarding oral health care in post-stroke patients reiterated this approach, concluding that regular oral care, including support from a dental hygienist in stroke units, is necessary for prevention of oral health-related diseases and an overall improved quality of life for stroke survivors [21]. In other words, implementing

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dental care as a regular component of stroke rehabilitation can prove helpful not only in the mouth but also has the potential to improve nutritional status, comfort, and willingness to participate in therapy.

Successful integration requires well-defined protocols and communication pathways. One of the ways this can be done practically is through an oral care protocol in the stroke rehabilitation setting. For instance, the nursing staff can be taught to conduct daily oral examinations and cleanings and make referrals to a dentist for any acute findings such as loose teeth, thrush, and periodontal abscesses. Dental professionals can conduct rounds once a week or on an on-demand basis for patients with difficult needs (e.g., those requiring extraction or denture adjustments before they can safely resume a regular diet). Some stroke rehabilitation centers have developed either on-site dental services or partnerships with dental schools to help in providing prompt care. The literature documents that structured oral hygiene programs throughout inpatient rehabilitation have improved outcomes: in one trial, a program comprising patient education on toothbrushing and professional dental cleanings twice per week had a significant impact on oral hygiene indices in stroke patients during a 6-week rehabilitation period [22]. Another study introduced an advanced oral hygiene care program (including the use of power toothbrushes and chlorhexidine mouthwash) among outpatients with stroke and found that their plaque control and oral health behaviors were improved [23]. These programs emphasize that, with the systematization of oral care with the help of professionals, stroke survivors can maintain or even improve their oral health despite the physical limitations.

Moreover, collaboration goes both ways in terms of mutual education: neurologists and rehabilitation teams are able to gain training on the importance of oral health red flags and basic oral care, while dental professionals will gain an understanding of the special needs of stroke patients (e.g., how to deal with patients with unilateral neglect or cognitive impairment in the dental chair). Speech-language pathologists, who frequently manage therapy for dysphagia, are another important link—they can liaise and work with dental colleagues to ensure that oral sensitivity and safety of swallowing are optimized (perhaps by suggesting certain oral exercises or prosthetic devices, such as palatal lifts, where appropriate). Pharmacists on the team can also play a role in the team by reviewing medications for oral side effects (such as dry mouth or risk of bleeding, as discussed in the next section) and making recommendations for mitigations such as saliva substitutes or going through medications around the time of dental procedures.

In essence, the integration of dentistry and neurology in stroke rehabilitation is about being able to look at the patient holistically. The neurological and oral aspects of health are interrelated, as improving oral health can prevent medical setbacks and improve rehabilitation participation, while neurological recovery promotes better self-care, including oral hygiene. An interprofessional, collaborative framework—with common goals and open communication—ensures that stroke survivors get comprehensive care. By implementing such a model, rehabilitation teams will be able to minimize complications such as aspiration pneumonia, increase patient comfort and nutritional intake, and ultimately aid better functional recovery for stroke survivors [3, 20].

V. SECTION IV: PHARMACOTHERAPY HIGHLIGHTS

While rehabilitation therapies and supportive care are the mainstay of stroke recovery, pharmacotherapy can play a complementary role in this process to enhance neurorecovery and manage stroke complications. Several classes of medications have been explored as having the potential to foster a post-stroke neurological improvement. Serotonergic and dopaminergic agents are chief among them and regulate neurotransmitters that are implicated in motor learning and cortical plasticity [24]. Indeed, present evidence indicates that the best pharmacological support for recovery of movement has been seen with drugs that interfere with the actions of the neurotransmitters serotonin and dopamine [24]. For example, selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine have been studied for post-stroke motor recovery: fluoxetine started in the subacute phase improved motor function in patients with stroke in early trials (e.g., the FLAME study), a hypothesis based on the ability of SSRIs to improve neuroplasticity and cortical excitability [25]. However, larger

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multicenter trials in the last several years have shown mixed results, and the routine use of SSRIs for motor recovery is still debated [26]. On the dopaminergic side, various drugs such as levodopa, which is typically used in the rehabilitation of Parkinson's, have been piloted for use in stroke rehabilitation in the hope of using dopamine's role in motor learning. There are some reports of small improvements in motor outcomes with levodopa or dopamine agonists combined with physical therapy, which may imply its benefits by providing better engagement and reward feedback of the relearned movements [24]. Another area of interest is psychostimulants (such as amphetamines or methylphenidate), which have been trialed to increase general arousal and make rehabilitation participation easier. Although initial animal studies have been promising, the clinical results have been variable, and they are not standard care given the possible side effects [27]. Overall, the concept of restorative pharmacotherapy is to use drugs favoring brain repair processes (different from acute phase drugs, which act on the stroke cause, such as thrombolytics or thrombectomy). These restorative agents usually have a therapeutic window of days to weeks after the stroke, which coincides with the plastic period of the brain [24]. It is important to note that any kind of pharmacological enhancement of recovery should be coupled with active rehabilitation—drugs do not retrain the brain, but they may provide a more favorable internal environment for plasticity if the patient engages in therapy [24].

Beyond medications focused on neurorecovery, most stroke survivors are taking several medications for secondary prevention and symptom management with implications for oral health and dental care. These medications increase propensity for bleeding, which is directly relevant for any dental interventions. A simple extraction of a tooth or even a vigorous dental cleaning can result in prolonged bleeding in the patient who is on blood thinners. However, it is generally not safe to stop these medications arbitrarily because of the high risk of recurrent stroke. Therefore, communication between healthcare providers and dental professionals is so important. Patients and clinicians should communicate with dentists about anticoagulants, and dentists can liaise with physicians if there is a need for a temporary adjustment for an invasive procedure. Dental work may be continued with precautions (e.g., local hemostatic measures) in most instances without halting antithrombotics. For routine dental cleansing it is usually sufficient to use a careful method, but for major oral operations the neurologist or main care supplier may be consulted to consider the thrombotic risk versus the risk of bleeding.

Another pharmacotherapy consideration is the influence of side effects of common post-stroke medications on oral health. Many drugs used in patients with hypertension and anticholinergic drugs may cause xerostomia, with a decrease in saliva and an increase in the risk of development of cavities and mucosal lesions. For example, beta-blockers and diuretics (commonly used to regulate blood pressure after stroke) have dry mouth as a side effect [28]. Likewise, medication for bladder dysfunction or spasticity (e.g., oxybutynin or baclofen) has anticholinergic properties that reduce salivary flow [29, 30]. The result can be rampant dental caries or problems wearing dentures due to a dry oral cavity. To combat this, patients may try using saliva substitutes, make sure they are well-hydrated, or have more frequent dental check-ups to detect tooth decay while it is in its early stages. Anticonvulsants may be prescribed to patients who had a stroke and have seizures; in particular, the anti-seizure drug phenytoin may cause gingival overgrowth, which is an over-proliferation of gum tissue, making it more difficult for patients to maintain good oral hygiene and requiring periodontal intervention [31, 32]. Calcium channel blockers (similar to nifedipine for hypertension) have a similar side effect of gingival hyperplasia [33]. Awareness of these possible reactions means the care team can take steps to prevent these kinds of reactions by implementing preventive oral hygiene measures and consulting a dentist at the earliest sign of overgrowth. In addition, stroke patients with depression or emotional lability are treated with antidepressants (including SSRIs or tricyclics), which can have oral implications (such as bruxism, or teeth grinding, or dry mouth) [34]. Dentists may have to make mouthguards for bruxism or suggest topical fluoride for individuals that have dry mouth on these medications.

In summary, pharmacotherapy in stroke rehabilitation

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has two functions: 1) augmenting neurological recovery and 2) managing medical comorbidities and preventing complications, some of which have oral health ramifications. Clinicians should take both aspects into account. Drugs such as SSRIs and dopaminergic agents provide opportunities to increase neuroplasticity if used appropriately together with therapy [24]. At the same time, the medication regimen of a patient for stroke prevention or other conditions must be considered in the planning of dental care to ensure the provision of safe and effective oral health care. The interprofessional approach, therefore, extends to pharmacists and prescribing physicians that work with dental providers to optimize outcomes for stroke survivors.

VI. CONCLUSION

Stroke recovery is maximized when rehabilitation is holistic—looking at not only neurological deficits but also the oral and systemic health of a survivor. This review has cited the possibility of integrating oral health care and pharmacotherapy into stroke rehabilitation, which is both a pragmatic and beneficial strategy. A collaborative structure in which neurologists, dentists, nurses, speech therapists, pharmacists, and other members of the team coordinate their work can make a dramatic difference in outcome for the patients. By engaging dental professionals in the management of stroke, we can help prevent complications such as aspiration pneumonia, oral infection, and malnutrition that hinder recovery [3]. Research has shown that such interprofessional collaboration has led to concrete benefits such as better oral hygiene and lower infection rates in stroke patients if dental care is included in the rehabilitation plan [20]. Meanwhile, appropriate use of pharmacotherapy, from neuroplasticity-enhancing drugs to meticulous management of anticoagulants and side effects, serves to support the rehabilitation process on multiple fronts.

In practice, the implementation of the neurologist-dentist collaborative model could include joint protocols (e.g., oral care guidelines in stroke units), cross-disciplinary education, and mutual communication at key points of care (hospital discharge, outpatient follow-ups). Such initiatives will make oral health maintenance a part of the stroke recovery and not an afterthought. Attention to oral health not only prevents medical setbacks, but it also contributes to psychological well-being and social reintegration of stroke survivors because patients who are pain-free and are confident in their oral hygiene are more likely to eat well, communicate, and participate actively in therapy.

Stroke rehabilitation facilitated by integrating oral health and pharmacotherapy is an interprofessional best-practice strategy. It draws on the expertise of both the medical and dental professions to tackle the full range of problems encountered by stroke survivors. Such integration ultimately promotes more safety, efficacy, and patient-centeredness of stroke care. By considering oral health in addition to motor and cognitive recovery and managing medications with a look toward neurorecovery and dental implications, rehabilitation teams are able to support stroke survivors to have better functional outcomes, fewer complications, and an improved quality of life in the long journey of the recovery process [9, 10].

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