

Original Research Article

A comparative evaluation of toothpaste tablets and a conventional toothpaste in assessing supragingival plaque and gingivitis among patients in Nellore city, Andhra Pradesh: a randomized clinical trial

Vimalakshi Devangam*, R. V. S. Krishna Kumar, Srinivasulu Gomasani,
Punamalli Symon Prasanth

Department of Public Health Dentistry, Narayana Dental College, Nellore, Andhra Pradesh, India

Received: 10 August 2026

Revised: 04 October 2026

Accepted: 07 October 2026

*Correspondence:

Dr. Vimalakshi Devangam,

E-mail: devangamvimalakshi@gmail.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Toothpaste tablets have emerged as a sustainable alternative to conventional toothpaste by reducing plastic waste. However, evidence regarding their effectiveness in controlling supragingival plaque accumulation and gingival inflammation remains limited, particularly among Indian adults. This study aimed to compare the effectiveness of toothpaste tablets and conventional toothpaste in reducing supragingival plaque accumulation and gingival inflammation among adults.

Methods: A parallel-arm, randomized, open-label clinical trial was conducted among 60 adults attending Narayana Dental College and Hospital, Nellore, Andhra Pradesh. Following baseline assessment using the O'Leary Plaque Control Record and the Loe and Silness Gingival Index, all participants underwent oral prophylaxis and were randomly allocated to the toothpaste tablet group (n=30) or the conventional toothpaste group (n=30). Participants brushed twice daily using the modified bass technique for four weeks. Intragroup and intergroup comparisons were performed using the Wilcoxon Signed-Rank Test and Mann-Whitney U test, respectively, with statistical significance set at $p < 0.05$.

Results: Both intervention groups demonstrated significant reductions in plaque control record and Gingival Index scores after four weeks ($p < 0.001$). No statistically significant differences were observed between groups for plaque control ($p = 0.847$) or gingival health ($p = 0.629$).

Conclusions: Toothpaste tablets demonstrated clinical effectiveness comparable to conventional toothpaste in reducing supragingival plaque accumulation and gingival inflammation after four weeks. These findings suggest that toothpaste tablets may serve as a sustainable alternative to conventional dentifrices without compromising clinical outcomes. Further randomized clinical trials with larger sample sizes and longer follow-up are recommended.

Keywords: Conventional toothpaste, Dental plaque, Gingival index, Plaque control record, Toothpaste tablets

INTRODUCTION

Oral health is an integral component of general health and well-being and significantly influences an individual's quality of life, functional capacity, and psychosocial health. Oral diseases affect an estimated 3.5 billion people worldwide, with untreated dental caries and periodontal diseases ranking among the most prevalent

chronic conditions globally. These diseases impose a substantial burden on individuals and healthcare systems by impairing mastication, communication, aesthetics, and overall quality of life while contributing to increased healthcare expenditure. Consequently, prevention of oral diseases through effective plaque control remains a fundamental objective of contemporary preventive dentistry.^{1,2}

Dental plaque is a structured microbial biofilm that forms on tooth surfaces and is recognized as the primary etiological factor in the initiation of gingivitis and the progression of periodontal disease. If not adequately removed, plaque undergoes maturation, resulting in an inflammatory response within the gingival tissues that may eventually progress to irreversible periodontal destruction in susceptible individuals. Decades of experimental and clinical research have consistently demonstrated that regular disruption of dental plaque through effective mechanical plaque control is the most predictable strategy for maintaining gingival and periodontal health.³

Mechanical plaque control is principally achieved through toothbrushing supplemented by interdental cleaning aids and the use of dentifrices. Toothpaste not only facilitates the mechanical removal of plaque but also acts as a vehicle for therapeutic agents such as fluoride, antimicrobial agents, desensitizing compounds, and remineralizing agents that enhance oral health. Fluoridated toothpaste has been widely recognized as one of the most successful public health interventions for the prevention of dental caries and remains an indispensable component of routine oral hygiene practices.⁴

Despite continuous advances in dentifrice formulations, growing concern has emerged regarding the environmental impact of conventional toothpaste packaging. Most commercially available toothpastes are packaged in multilayer plastic tubes that are difficult to recycle because of their composite structure. It is estimated that nearly 1.5 billion toothpaste tubes are discarded globally each year, contributing substantially to plastic pollution and long-term landfill accumulation. Increasing environmental awareness and the global movement toward sustainable healthcare have therefore stimulated the development of environmentally responsible alternatives that can minimize ecological impact without compromising clinical effectiveness.⁵

Among these innovations, toothpaste tablets have emerged as a promising water-free alternative to conventional dentifrices. These compressed formulations are chewed before brushing and rapidly disintegrate in the presence of saliva to produce a paste-like consistency suitable for tooth cleaning. Their compact design permits packaging in reusable or biodegradable containers, thereby eliminating conventional plastic tubes and reducing packaging waste. In addition to their environmental advantages, toothpaste tablets offer improved portability, convenience during travel, longer shelf life, and reduced dependence on preservatives because of their water-free formulation. These characteristics have positioned toothpaste tablets as an attractive option within the growing concept of sustainable dentistry.⁶

Although consumer interest in toothpaste tablets has increased considerably over recent years, clinical

evidence supporting their effectiveness remains limited. Available randomized clinical trials have generally demonstrated that toothpaste tablets provide plaque control and gingival health outcomes comparable to those achieved with conventional fluoridated toothpaste. Clinical studies conducted among both children and adults have reported significant reductions in supragingival plaque accumulation and gingival inflammation following regular use of toothpaste tablets, with no clinically meaningful differences when compared with conventional dentifrices.

Beyond their clinical performance, recent investigations have demonstrated favourable physicochemical properties and consumer acceptance of toothpaste tablets. Experimental studies have reported satisfactory hardness, rapid disintegration, acceptable foaming characteristics, and anti-demineralization potential comparable with conventional fluoride dentifrices. Likewise, consumer-based studies have shown positive perceptions regarding their ease of use, portability, cleanliness after brushing, and environmental sustainability, although texture and foaming characteristics continue to influence user preference.⁷

Despite these encouraging findings, the available evidence is characterized by relatively small sample sizes, short follow-up periods, methodological heterogeneity, and limited representation of Indian adult populations. Differences in oral hygiene practices, dietary habits, socioeconomic conditions, and behavioural characteristics may influence the effectiveness and acceptability of toothpaste tablets across different populations. Therefore, well-designed randomized clinical trials conducted in diverse clinical settings are essential to strengthen the existing evidence base and facilitate evidence-based recommendations regarding their routine use.

Therefore, the present randomized clinical trial was undertaken to compare the effectiveness of toothpaste tablets and conventional toothpaste in reducing supragingival plaque accumulation and gingival inflammation among adults attending a tertiary dental care institution in Nellore, Andhra Pradesh.

The null hypothesis (H_0) stated that there would be no statistically significant difference between toothpaste tablets and conventional toothpaste in reducing supragingival plaque accumulation and gingival inflammation after four weeks of use.

METHODS

Study design

A parallel-arm, randomized open-label clinical trial was conducted to compare the effectiveness of toothpaste tablets and conventional toothpaste in reducing supragingival plaque accumulation and gingival inflammation among adults. The study was designed and

reported in accordance with the Consolidated Standards of Reporting Trials (CONSORT) guidelines.

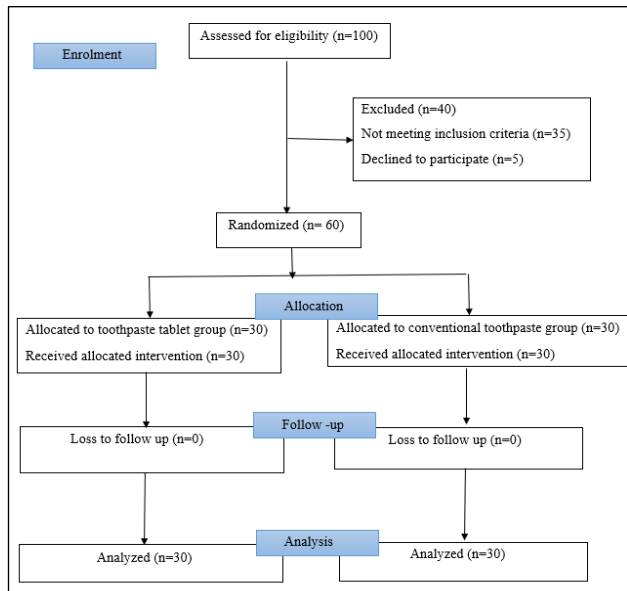


Figure 1: CONSORT flowchart.

Study setting and study period

The study was conducted in the Department of Public Health Dentistry, Narayana Dental College and Hospital, Nellore, Andhra Pradesh, India, from January 2026 to March 2026. Adult patients attending the outpatient department who fulfilled the eligibility criteria were recruited for the study.

Ethical considerations

The study protocol was reviewed and approved by the Institutional Ethics Committee of Narayana Dental College and Hospital before commencement of the study. Written informed consent was obtained from all participants prior to enrolment. The study was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki. The trial was prospectively registered with the Clinical Trials Registry-India (CTRI/2026/01/100743).

Study population

The study population comprised systemically healthy adults aged 18-45 years attending the outpatient department of Public Health Dentistry. Eligible participants were screened according to predefined inclusion and exclusion criteria before enrolment.

Inclusion criteria

Adults aged 18-45 years, adult with presence of at least 20 natural teeth, and adult with willingness to participate and provide written informed consent.

Exclusion criteria

Individuals with systemic diseases affecting the periodontium, participants undergoing orthodontic treatment, history of antibiotic therapy during the preceding three months, and pregnant or lactating women.

Sample size estimation

The sample size was estimated using G*Power software with an effect size of 0.80, an alpha error of 5%, and a study power of 80%. The calculated minimum sample size was 52 participants. To compensate for potential dropouts and enhance statistical power, the sample size was increased to 60 participants, who were equally allocated into two study groups (30 participants per group).

Examiner calibration

Prior to the commencement of the study, the principal investigator underwent training and calibration for the assessment of supragingival plaque and gingival inflammation using the selected clinical indices. Calibration was performed under the supervision of a faculty member from the Department of Public Health Dentistry to ensure consistency and reproducibility of clinical recordings throughout the study.

Baseline examination and oral prophylaxis

After obtaining informed consent, baseline demographic information was recorded, and clinical examination was performed to assess supragingival plaque accumulation and gingival inflammation. Supragingival plaque was recorded using the O'Leary Plaque Control Record (1972), while gingival health was assessed using the Loe and Silness Gingival Index (1963).

Immediately following baseline assessment, all participants underwent full-mouth oral prophylaxis (scaling and polishing) to establish a standardized plaque-free baseline before initiation of the intervention.

Randomization

Following oral prophylaxis, participants were randomly allocated into two equal groups using a lottery method with an allocation ratio of 1:1. Sixty identical folded paper slips representing the two intervention groups were prepared, thoroughly mixed, and placed in an opaque container. Each participant selected one slip, and the allocation indicated on the slip determined the intervention group. Thirty participants were assigned to the toothpaste tablet group (Group I) and thirty to the conventional toothpaste group (Group II). Because of the nature of the intervention, blinding of the participants and investigator was not feasible.

Intervention

Participants in Group I received toothpaste tablets, while participants in Group II received conventional fluoridated toothpaste. All participants received standardized oral hygiene instructions and were trained individually in the Modified Bass toothbrushing technique. They were instructed to brush twice daily, once in the morning and once before bedtime, using only the allocated dentifrice for a period of four weeks. Participants were advised to avoid the use of any additional dentifrices, medicated mouth rinses, or other adjunctive oral hygiene aids during the study period while maintaining their usual dietary habits.

Compliance monitoring

Participant compliance was monitored throughout the four-week intervention period. Weekly reminders regarding the prescribed brushing regimen and study instructions were provided through telephone calls made by the investigator and WhatsApp messages. Participants were encouraged to report any difficulties encountered during the intervention period and were reminded to use only the assigned dentifrice.

Outcome measures

The primary outcome measures were Supragingival plaque accumulation, assessed using the O'Leary Plaque Control Record (1972) and Gingival inflammation, assessed using the Löe and Silness Gingival Index (1963).

Clinical examinations were performed at baseline and after four weeks by the same calibrated examiner using a mouth mirror and Community Periodontal Index (CPI) probe under adequate illumination.

Statistical analysis

The collected data were entered into Microsoft Excel and analyzed using IBM Statistical Package for the Social Sciences (SPSS) software, Version 20.0 (IBM Corp., Armonk, NY, USA). Descriptive statistics were expressed as frequencies, percentages, means, and standard deviations. The distribution of continuous variables was

assessed for normality using the Shapiro–Wilk test. Intragroup comparisons between baseline and four-week follow-up were performed using the Wilcoxon Signed-Rank Test, while intergroup comparisons were carried out using the Mann–Whitney U test. A p value of <0.05 was considered statistically significant.

RESULTS

A total of 60 participants were enrolled in the study and randomly allocated into two equal groups (30 participants each). Group I comprised 14 (46.7%) males and 16 (53.3%) females, whereas Group II included 12 (40.0%) males and 18 (60.0%) females. The mean age of participants was 31.8 ± 5.92 years in Group I and 33.7 ± 6.42 years in Group II. The demographic characteristics of the participants are presented in Table 1.

Table 1: Baseline demographic characteristics of study participants in the two intervention groups.

Demographics		Group 1 (toothpaste tablets group), N (%)	Group 2 (toothpaste group), N (%)
Gender	Males	14 (46.7)	12 (40)
	Females	16 (53.3)	18 (60)
Age in years		31.8 ± 5.92	33.7 ± 6.42

The mean Plaque Control Record (PCR) score in Group I decreased from 71.3 ± 5.50 at baseline to 29.3 ± 5.77 after four weeks, with a mean reduction of 41.9. Similarly, Group II demonstrated a reduction in mean PCR score from 70.9 ± 4.55 at baseline to 28.9 ± 5.14 at the end of the study, with a mean reduction of 42.0. The reduction in plaque scores within both groups was statistically significant (Wilcoxon Signed-Rank Test, $p < 0.001$).

Intergroup comparison using the Mann-Whitney U test demonstrated no statistically significant difference between the two groups either at baseline ($p = 0.882$) or after four weeks of intervention ($p = 0.847$), indicating that toothpaste tablets and conventional toothpaste were equally effective in reducing supragingival plaque accumulation (Table 2).

Table 2: Intra- and intergroup comparison of plaque control record scores at baseline and after four weeks.

Groups	Before (at baseline)	After (4 -weeks)	Mean difference	Wilcoxon sign rank test p value
Group 1	71.3 (5.5)	29.3 (5.77)	41.9	<0.001*
Group 2	70.9 (4.55)	28.9 (5.14)	42.0	<0.001*
Mann-Whitney U test	0.882 (NS)	0.847 (NS)		

*Significant at $p < 0.05$; NS = Not statistically significant

The mean Gingival Index (GI) score in Group I decreased from 1.357 ± 0.150 at baseline to 0.863 ± 0.138 after four weeks, with a mean reduction of 0.493. In Group II, the mean GI score decreased from 1.330 ± 0.137 to 0.800 ± 0.128 , corresponding to a mean reduction of 0.483.

The reduction in gingival scores within both groups was statistically significant (Wilcoxon Signed-Rank Test, $p < 0.001$).

Intergroup comparison revealed no statistically significant difference in Gingival Index scores either before the

intervention ($p=0.475$) or after four weeks ($p=0.629$), suggesting that both toothpaste tablets and conventional

toothpaste produced comparable improvements in gingival health (Table 3).

Table 3: Intra- and intergroup comparison of Gingival Index scores at baseline and after four weeks.

Groups	Before (baseline)	After (4 weeks)	Mean difference	Wilcoxon sign rank test p value
Group 1	1.357 (0.150)	0.863 (0.138)	0.493	<0.001*
Group 2	1.33 (0.137)	0.8 (0.128)	0.483	<0.001*
Mann-Whitney U test	0.475 (NS)	0.629 (NS)		

*Significant at $p<0.05$; NS = Not statistically significant

Both toothpaste tablets and conventional toothpaste resulted in statistically significant reductions in supragingival plaque accumulation and gingival inflammation after four weeks of use. However, no statistically significant differences were observed between the two intervention groups, indicating that toothpaste tablets demonstrated clinical effectiveness comparable to conventional fluoridated toothpaste.

DISCUSSION

The present randomized clinical trial compared the effectiveness of toothpaste tablets and conventional fluoridated toothpaste in reducing supragingival plaque accumulation and gingival inflammation among adults over a four-week period.

The present study demonstrated a significant reduction in supragingival plaque accumulation following four weeks of twice-daily brushing in both intervention groups. The mean Plaque Control Record score decreased from 71.3 ± 5.50 to 29.3 ± 5.77 in the toothpaste tablet group and from 70.9 ± 4.55 to 28.9 ± 5.14 in the conventional toothpaste group, with statistically significant intragroup improvements ($p<0.001$). However, intergroup comparison revealed no statistically significant difference between the two dentifrices, suggesting that toothpaste tablets were as effective as conventional toothpaste in controlling supragingival plaque.

These findings are consistent with those reported by Martinez et al, who compared toothpaste tablets with conventional sodium fluoride toothpaste in a randomized clinical trial and observed significant reductions in plaque scores within both groups without any statistically significant difference between the interventions.⁸ The authors concluded that toothpaste tablets could provide plaque control comparable to conventional dentifrices when used as part of routine oral hygiene practices.

Our findings also agree with those of Desai et al, who evaluated chewable toothpaste tablets in children using both manual and powered toothbrushes.⁹ Their study demonstrated comparable plaque removal efficacy between toothpaste tablets and conventional toothpaste following four weeks of supervised brushing, irrespective of the type of toothbrush used. Although that investigation was conducted in a pediatric population, the comparable outcomes observed in the present study

suggest that the effectiveness of toothpaste tablets is not limited to children and may also be applicable to adult populations.

Similarly, Padmanabh et al reported significant improvements in plaque control among children using chewable toothpaste tablets over a four-week period.¹⁰ While the authors observed slightly greater plaque reduction with toothpaste tablets, the overall findings supported their effectiveness as an alternative to conventional toothpaste. Differences between their findings and those of the present study may be attributed to variations in study population, plaque assessment indices, brushing supervision, toothpaste formulations, and participant compliance.

Srivastava et al reported significant plaque reduction following the use of chewable toothpaste tablets among young adults.¹¹ These findings are consistent with the present study and further support the potential of toothpaste tablets as an alternative to conventional toothpaste.

In addition to plaque reduction, the present study demonstrated a significant improvement in gingival health following the four-week intervention. The mean Gingival Index score decreased significantly within both the toothpaste tablet and conventional toothpaste groups ($p<0.001$), whereas no statistically significant difference was observed between the two groups after the intervention.

The present findings are in agreement with those of Martinez et al, who reported significant reductions in Gingival Index scores following the use of both toothpaste tablets and conventional sodium fluoride toothpaste, with no statistically significant differences between the intervention groups after two weeks of supervised brushing.⁸ The authors concluded that toothpaste tablets could maintain gingival health comparable to conventional dentifrices when used appropriately.

Similarly, Desai et al observed significant improvements in gingival health among children using chewable toothpaste tablets and conventional toothpaste over a four-week period.⁹ Their findings demonstrated that both dentifrices were equally effective in reducing gingival

inflammation irrespective of whether a manual or powered toothbrush was used.

The comparable clinical performance observed between toothpaste tablets and conventional toothpaste may be explained by the fact that the mechanical action of toothbrushing, rather than the physical form of the dentifrice itself.

All participants in the present study received standardized instructions in the Modified Bass technique, thereby minimizing variation in brushing technique between the two intervention groups. Evidence from systematic reviews indicates that toothbrushing remains a fundamental component of mechanical plaque control, although the superiority of one manual brushing technique over another is not consistently demonstrated.^{12,13}

In addition to their clinical effectiveness, toothpaste tablets offer several practical and environmental advantages. Their water-free formulation permits packaging in reusable or biodegradable containers, thereby reducing plastic waste associated with conventional toothpaste tubes. They are lightweight, travel-friendly, require fewer preservatives, and are increasingly being adopted as part of sustainable oral healthcare practices.

Recent consumer-based studies have also reported favourable perceptions regarding their portability, convenience, and environmental sustainability, although texture and foaming characteristics remain important determinants of user acceptance.⁵

The findings of the present study contribute to the emerging evidence supporting environmentally sustainable oral hygiene products by demonstrating that toothpaste tablets can achieve short-term clinical outcomes comparable to those of conventional fluoridated toothpaste.

The present study possesses several strengths. To our knowledge, it is among the few randomized clinical trials conducted in an Indian adult population comparing toothpaste tablets with conventional fluoridated toothpaste. Baseline oral prophylaxis was performed for all participants before the intervention, ensuring a standardized plaque-free starting point. Standardized brushing instructions using the Modified Bass technique, examiner calibration, and regular compliance monitoring through weekly telephone calls and WhatsApp reminders further strengthened the internal validity of the study. The use of validated clinical indices, namely the O'Leary Plaque Control Record and the Loe and Silness Gingival Index, provided objective and reproducible outcome measures.

Despite these strengths, certain limitations should be acknowledged. The study was conducted at a single

institution with a relatively small sample size and a follow-up period of only four weeks, limiting the generalizability of the findings and precluding assessment of long-term clinical outcomes. The open-label design introduced the possibility of performance bias, as blinding of participants and the investigator was not feasible owing to the obvious differences in the physical form of the dentifrices. In addition, patient-reported outcomes such as taste preference, ease of use, overall satisfaction, and long-term acceptability were not evaluated. Future multicentre randomized clinical trials with larger sample sizes, extended follow-up periods, assessment of participant-reported outcomes, and evaluation of additional clinical and microbiological parameters are recommended to further establish the long-term effectiveness and acceptability of toothpaste tablets.

CONCLUSION

Within the limitations of the present study, toothpaste tablets demonstrated clinical performance comparable to that of conventional toothpaste in reducing supragingival plaque accumulation and gingival inflammation after four weeks of use. Considering their comparable effectiveness together with their environmental and practical advantages, toothpaste tablets may represent a promising sustainable alternative to conventional dentifrices. However, larger multicentre randomized clinical trials with longer follow-up are required before widespread clinical recommendations can be made.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee of Narayana Dental College and Hospital, Nellore, Andhra Pradesh, India (IEC/NDCH/2025/OCT-DEC/P-117)

REFERENCES

1. World Health Organization. Global oral health status report: towards universal health coverage for oral health by 2030, 2022. Available at: <https://www.who.int/publications/i/item/9789240061484>. Accessed 01 June 2026.
2. Peres MA, Macpherson LM, Weyant RJ, Daly B, Venturelli R, Mathur MR, et al. Oral diseases: a global public health challenge. *Lancet*. 2019;394(10194):249-60.
3. Marsh PD. Dental plaque as a biofilm and a microbial community-implications for health and disease. *BMC Oral Health*. 2006;6(Suppl 1):S14.
4. Olczak-Kowalczyk D, Mielczarek A, Jackowska T, Mielnik-Błaszczyk M, Turska-Szybka A, Opydo-Szymaczek J, et al. Fluoride agents in the prevention and treatment of dental caries and erosion in children, adolescents and adults—recommendations of Polish Experts. Update of recommendations: Individual fluoride prevention in children and

- adolescents–recommendations of Polish Experts. *Nowa Stomatologia*. 2023.
5. Sandhu J, Calderon B, Park B, Patel J, Garcia-Godoy F, Oyoyo U, et al. Zero waste: consumers' perception of the use of eco-friendly toothpaste tablets-a quasi-experimental study. *J Contemp Dent Pract*. 2025;26(4):333-8.
6. Amaechi BT, Kanthaiyah K, Farah R, Yang K, Obiefuna AC, Abdul-Azees PA, et al. Evaluation of the Efficacy of a Dentifrice Tablet to Prevent Dental Caries: A Microbial Study. *Dentist J*. 2025;13(5):201.
7. Baste N, Gundecha P. A comprehensive review on toothpaste tablets: formulation, benefits and future prospects. *Int J Sci Res Technol*. 2026;4(06):896-910.
8. Martinez A, Im J, Bezman E, Lee E, DeAnda D, Ree R, et al. A comparison of toothpaste tablets and a sodium fluoride dentifrice for the control of supragingival plaque and gingivitis: A 2-week randomized controlled trial. *Am J Dentis*. 2023;36(4):172-6.
9. Desai SS, Reddy GR, Varma SA, Devendrappa SN. A comparative evaluation of plaque removal efficacy of a chewable toothpaste tablet with conventional toothpaste using conventional toothbrush and powered toothbrush in children of age-group 8-12 years. *Int J Clin Pediatr Dentis*. 2026;19(4):464.
10. Padmanabh SK, Makhiya M, Mulchandani V, Jhamb V, Trivedi M, Upendrabhai MJ. A comparative clinical evaluation of plaque removal efficacy of a chewable toothpaste tablet with conventional toothpaste in children-A randomized clinical trial. *Saudi J Oral Sci*. 2022;9(3):185-9.
11. Srivastava H, Chhabra KG, S N, Chaudhary P, Dangi S, Srivastava N. Evaluation of the plaque removal efficacy of chewable toothpaste tablets—a randomized controlled crossover trial. *Frontiers in Oral Health*. 2026;7:1893652.
12. Deinzer R, Weik U, Eidenhardt Z, Leufkens D, Sälzer S. Manual toothbrushing techniques for plaque removal and the prevention of gingivitis-A systematic review with network meta-analysis. *Plos one*. 2024;19(7):e0306302.
13. Sälzer S, Graetz C, Dörfer CE, Slot DE, Van der Weijden FA. Contemporary practices for mechanical oral hygiene to prevent periodontal disease. *Periodontol*. 2020;84(1):35-44.

Cite this article as: Devangam V, Krishna Kumar RVS, Gomasani S, Prasanth PS. A comparative evaluation of toothpaste tablets and a conventional toothpaste in assessing supragingival plaque and gingivitis among patients in Nellore city, Andhra Pradesh: a randomized clinical trial. *Int J Community Med Public Health* 2026;13:6537-43.