Association of tobacco dependence and oral hygiene status

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ABSTRACT
Tobacco use has a major public health concern that results in significant morbidity and mortality. Tobacco use has an injurious effect on oral health such as oral cancer and potentially malignant disorders like leukoplakia, oral submucous fibrosis. Tobacco use has been found to have a strong, chronic and dose dependent effect on periodontal tissues due to poor oral hygiene caused by increased deposit of debris and calculus among tobacco users. This study aimed to find the association between oral hygiene status and tobacco dependence. A retrospective study was conducted using the case records of patients in University hospital. Data on tobacco dependence and oral hygiene status from 150 patient records were collected and analysed for association. Descriptive statistics and chi-square association was done. The mean age of patients in the records was 35 ± 12.44 years and males (14%) had severe tobacco dependence. The mean Oral Hygiene Index Simplified (OHIS) score was found to be 2.03 ± 1.009 which is interpreted as fair. There was no statistically significant association between oral hygiene status and tobacco dependence (p = 0.157). Tobacco dependence has no role in the oral hygiene status of an individual.

INTRODUCTION
Tobacco belongs to the family Solanaceae of genus Nicotiana, which is a powerful addictive substance which is harmful to health (Tushingham et al., 2018). The two common forms consumed in India, smoking (cigarettes, Bidis) and smokeless forms (gutka, pan masala, areca nuts). Tobacco has been estimated to cause premature death worldwide (Ministry of Health and Family Welfare, 2007). According to WHO, in India 94 million men and 45 million women used tobacco in smoke or smokeless form (WHO, 2020). Tobacco smoking is linked to many serious illnesses such as cancer, cardio pulmonary disease and many adverse health problems (Wald and Hackshaw, 1996).

One of the important components of tobacco is nicotine. Nicotine has been associated with neurotransmitters release, which leads to arousal, mood modulation, performance enhancement, analgesic, weight loss in tobacco users. Over the time of tobacco usage triggers the neural adaptation to homeostasis and leads to craving for the drug or drug seeking behaviour in the form of smoking, alcohol (Brand-
Studies have reported higher likelihood of psychiatric disorder in individuals with high dependence on tobacco (Glassman, 1990).

Tobacco consumption causes a variety of oral manifestations due to presence of toxins and carcinogens present in smoke emitted from tobacco such as pH change (Pratha and Prabakar, 2019), alteration in immune response, halitosis, plaque accumulation (Mathew et al., 2020) and staining of teeth (Asmussen and Hansen, 1986; Kumar and Vijayalakshmi, 2017). Tobacco has an increased risk for development of potentially malignant disorders such as oral submucous fibrosis, leukoplakia and palatal keratosis which has a higher chance of developing into malignant condition (Amagasa et al., 2011). Tobacco has been found to have positive correlation with many oral diseases such as dental caries (Prabakar et al., 2016; Samuel et al., 2020) and periodontal disease (Nivedita et al., 2018). Oral health is an important aspect in terms of the magnitude of dental problems and morbidity associated with it, the people in most parts of the world are not aware of the impact of tobacco on oral health (Fakhfakh et al., 2002; Pavithra and Jayashri, 2019). Smokeless tobacco usage has been associated with increased caries prevalence due to presence of sweeteners present in chewing tobacco. Thus caries prevention in tobacco users can be prevented by use of sealants in the younger age group (Khatri et al., 2019; Prabakar et al., 2018b,a,c), fluoride application (Kumar and Preethi, 2017) nutritional counselling (Neralla et al., 2019), remineralising dentifrice (Mohapatra et al., 2019; Prabakar et al., 2018b) and regular dental visits (Kumar and Preethi, 2017; Kannan et al., 2017). With this background the present study intended to find the association of tobacco dependence and oral hygiene status.

MATERIALS AND METHODS

Study setting and design

A retrospective study was conducted to find out the association between tobacco dependence (smoking and smokeless) and oral hygiene status. The study was conducted using case reports of patients visiting the author’s University hospital.

Sample selection and criteria

This retrospective study was employed by reviewing 86,000 records of patients visiting the University hospital from June 2019 to March 2020. A total of 1283 records with signed informed consent were sorted. Of which 150 case records containing infor-
mation on tobacco dependence and oral hygiene status of current smokers aged above 18 years were retrieved. We made an effort that all the 150 (148 males and 2 females) retrieved case records had all the information needed for the study with no duplicates. No gender restriction placed. We made an effort to remove all duplicates and incomplete case records with the help of an external reviewer.

Ethical approval
Prior permission to utilize the data was obtained from the University and was approved under ethical approval number SDC/SIHEC/2020/DIASDATA/0619-0320.

Instruments
Tobacco dependence recorded in the case sheets were done using Fagerstrom nicotine dependence scale. The instrument includes a separate set of questions for smoking and smokeless. A score of 0-2 represents mild dependence, 3-6 represents moderate dependence, score >6 represents severe dependence (Parmar et al., 2008). The oral hygiene status of patients in the case records was measured using Green and Vermillion Oral Hygiene Index - Simplified (OHIS) which determines debris and calculus grades on six indexed teeth (16/17, 11/21, 26/27, 36/37, 31/41, 46/47) separately. A total oral hygiene score is the sum of debris and calculus score. A total score of 0-1.2 represents good oral hygiene, 1.3-3 represents fair oral hygiene and score 3-6 represents poor oral hygiene.

Data collection
Data on patients’ age, gender, tobacco dependence and oral hygiene status was collected and tabulated in Microsoft Excel and imported to SPSS statistical analysis of version 23.0. The age of the patients in the case records was categorized for the convenience of statistical analysis such as 15-30 years, 31-45 years, 46-60 years, 61-75 years.

Statistical analysis
The collected data was analysed using Statistical Package for Social Sciences (SPSS) version 23.0. Descriptive statistics were used to present the prevalence of tobacco dependence and oral hygiene status and a chi-square association test was done to find the association between tobacco dependence and oral hygiene status. A statistical significance p value <0.05 was considered.

RESULTS AND DISCUSSION
From the total of 150 subjects the following results were observed. The mean age of tobacco users was found to be 35 ± 12.4 years.
Figure 1 shows the frequency distribution of age. About 48% were in the age group of 18 - 30 years. The X-axis shows age groups. Y-axis shows the number of patients. Most of the tobacco users were in the age group 18-30 years.

Figure 2 shows the frequency distribution of gender. The were about 98.97% of males and 1.3% of females. The X-axis represents gender distribution. Y-axis represents the number of patients. Males dominate the study population.

Figure 3 shows the association of tobacco dependency based on gender. 14% males had severe dependency, 34.67% had moderate dependency and 50% had low dependency. Females had moderate and low tobacco dependency. There was no statistically significant association between gender and tobacco dependency (p=0.816). The X-axis shows the dichotomized variables of gender. Y-axis shows the number of patients with tobacco dependence, where violet represents mild tobacco dependence, yellow represents moderate tobacco dependence and blue colour represents severe tobacco dependence. Association between gender and tobacco dependency (Pearson Chi-square value -0.407, p =0.816) (p>0.05, not significant). Tobacco dependency is high among males.

Figure 4 shows high tobacco dependency was more (6%) in the age group of 31-45 years & 18-30 years and 46-60 years (2%). On total 79.01% of patients had mild dependency, 11.3% had high dependency and 9.69% had moderate dependency. The X-axis shows age groups in years, Y-axis shows a number of patients with tobacco dependence, where violet represents mild tobacco dependence, green colour represents moderate tobacco dependence and blue colour represents severe tobacco dependence. No significant association between age and nicotine dependence (Pearson’s chi-square value: 0.789; p-value =0.267). Severe tobacco dependence was seen in the age group of 18-45 years.

Figure 5 shows oral hygiene status of the patients which was fair in about 61.3% patients, poor in 17.3% patients and good in 21.3% patients. The X-axis shows ordinal variables of oral hygiene status. Y-axis shows the number of patients. Most of the patients had a fair score for oral hygiene.

Figure 6 shows distribution of tobacco dependence and oral hygiene status. About 32% of patients with mild tobacco dependency had fair oral hygiene and 6% had poor oral hygiene. Among moderate tobacco dependency 19.33% of patients had fair oral hygiene, 8% had poor oral hygiene. In high tobacco dependency, 10% had fair oral hygiene and 3.33% had poor oral hygiene. There was no statistically significant association between tobacco dependence and oral hygiene status (p=0.157). The X-axis shows tobacco dependency. Y-axis shows the number of patients with oral hygiene status within each nicotine dependence. Where pink colour represents good oral hygiene, red colour represents fair oral and orange colour represents poor oral hygiene. No significant association between tobacco dependency and OHIs (Fisher’s exact test value = 6.525; p = 0.157). Most of the patients with nicotine dependency have fair oral hygiene status.

Tobacco use has been reported to cause various health manifestations and higher morbidity and mortality rate (Ministry of Health and Family Welfare, 2007). The present study findings showed that tobacco use has been significantly higher in males 98.7% as compared to females 1.3%. Similar findings have been reported by (Ahsan et al., 2020), where the prevalence rate of tobacco usage among males was 89.8% (Ahsan et al., 2020). (Dsouza, 2005), in his study reported 75% prevalence rate of smoking among males (Dsouza, 2005). There were no contradictory findings to the present results, this could be due to smoking prevalence being higher among males due to autonomous lifestyle, while females do not accept the fact of tobacco consumption socially (Pampel, 2006).

In the present study, the majority of tobacco use is in adults between 18 to 30 years of age. Similarly Biener at al, reported young adults as vulnerable targets of tobacco, as they are exposed and initiated to tobacco at this age (Biener and Albers, 2004). In contrast, Souza et al found higher tobacco usage and poor hygiene among the older age group above 50 years, suggestive of many years of tobacco usage which gradually leads to poor oral hygiene (Dsouza, 2005).

The present study findings show patients with high and moderate tobacco dependency had higher fair oral hygiene status compared to mild dependency. Similar findings (Nwhator et al., 2010), found higher mean oral hygiene index score with poor oral hygiene in smokers than non-smokers (Nwhator et al., 2010). (Dsouza, 2005), reported 13.43% of smokers had poor oral hygiene status (Dsouza, 2005) which is in consistency with the present study.

However potential limitations may interrupt our results, the study lacked in assessing the other factors such as socio-economic, literacy rates, oral hygiene practices which contribute to oral hygiene status of an individual. Also, due to cultural and ethical variation in knowledge and attitude towards oral health the study results cannot be extrapolated to
other populations. Further prospective cohort studies with snowball sampling will be needed to find the strength and magnitude of association.

CONCLUSIONS

Within the limitations of the study, there is significant association between tobacco dependence and oral hygiene status. Individuals with moderate and high tobacco dependence have fair to poor oral hygiene status. Innovations on tobacco cessation should be promoted to create awareness among the general population to curb oral diseases.

Authors contribution

First author (Kiruthika Patturaja) performed the analysis, interpretation and wrote the manuscript. Second author (Arthi Balsubramaniam) contributed to conception, data design, analysis, interpretation and critically revised the manuscript. Third author (Iffat Nasim) participated in the study and revised the manuscript. All the three authors have discussed the results and contributed to the final manuscript.

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Conflict of Interest

The authors declare that they have no conflict of interest for this study.

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REFERENCES


D’Souza, V. M. 2005. A correliative study on oral health status and knowledge on oral health hazards among adults consuming tobacco of selected communities of Managlore. RUGHS.


