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Periodontal Disease and Oral Health Literacy in Primary Care Patients

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Abstract

The cross-sectional analytical study included adult and senior participants who were drawn from Family Health Clinics in Piracicaba, So Paulo State, Brazil. A questionnaire was used to collect sociodemographic data (sex, age, skin colour, and education), behavioural data (brushing and flossing), health determinants (type and frequency of dental health services), and clinical data (pain). Intraoral examination of visible dental biofilm and the community Pediodontal Index were used to obtain data on mouth conditions. From the medical records, the systemic clinical conditions (blood glucose, glycated haemoglobin, and blood pressure) were extracted. The explanatory variable was the Health Literacy Scale (HL) (low, medium, and high). Health literacy is defined as "the ability of individuals to receive, process, and comprehend fundamental health information and services required to make good health decisions."

Keywords: Periodontal disease • Oral health literacy • Care patients

Introduction

This involves the ability to read and comprehend written content, transmit health-related information effectively, navigate the healthcare system, and achieve and maintain good health. Education influences an individual's health literacy capacity, which is influenced by culture, language, and the peculiarities of health-related situations. Health literacy has been demonstrated to be a powerful predictor of a person's health, health behaviour, and health outcomes. Limited health literacy is connected with poor health self-ratings, poor adherence to medical instructions, poor self-management abilities, increased mortality risks, poor health outcomes, and higher death rates [1].

Health literacy is increasingly recognised as a root cause of health disparities and has been designated as a national public health priority. Health literacy is also listed as one of the five important tracks for improving health in the World Health Organization's (WHO) 7th Global Conference on Health Promotion. In the last decade, oral health literacy (OHL) has acquired importance in the dentistry literature. OHL, like health literacy, has been shown to be crucial in minimising inequities in oral health and promoting oral health. Individuals with limited OHL have been found to be more vulnerable to oral illnesses and their complications. Lower literacy has been associated to issues with preventative services, delayed medical diagnosis, and poor adherence. The proportion of older adults (40.2%) who reported at least one missing tooth due to discomfort or caries was significantly lower than the prevalence rate of missing teeth (77% in the 2015 So Paulo Oral Health Survey among adults aged 35-44 years). These disparities could be ascribed to different sample characteristics as well as methodological differences in how the result was assessed. The proportion of participants who had their previous dental visit owing to pain or caries (36.2%) in our study was consistent with the findings in the United States and National Oral Health Survey, 37% of Brazilian adults cited pain or extraction as the reason for their previous dental visits [2].

Description

According to our findings, among users of primary healthcare services, low OHL was substantially related with missing at least one tooth due to discomfort or caries. Similar results have been observed in investigations with people from the United States and Belarus. Because untreated dental caries and periodontal disease are the leading causes of tooth loss globally, early treatment is the most effective way to halt the progression of these illnesses and prevent tooth loss. Individuals with low OHL, on the other hand, may lack the skills needed to grasp and apply health information, recognise the need for early treatment, and navigate the frequently complex health-care systems. Individuals with adequate levels of OHL may be able to detect early indications of oral diseases. Most people in India believe that dentistry is a costly endeavour, which keeps them away from registered experts on the one hand, while turning them into hostages to the services of unregistered lay practitioners on the streets on the other. The main cause for this is a lack of understanding about oral health and cleanliness. While much is known about health literacy in the medical environment, little is known about oral health literacy (OHL). Every individual should gain a complete understanding of oral health and hygiene practises in order to improve his or her own oral health. Oral health literacy could be a key component in increasing the utilisation of oral health care by marginalised populations. The most significant risk factors include unhealthy lifestyles and a lack of availability and accessibility of oral health care. Poor communication is viewed as one of the causes of this failure. It is common knowledge that an individual's literacy level has a substantial impact on dentist-patient communication. As a result, individuals with inadequate reading skills have a weaker grasp of the necessity of prevention and maintenance, resulting in poor health [3].

The majority of the study subjects, 50%, were from rural areas, which is lower than in a study done in Bangladesh (85%).This disparity could be explained by the fact that in Bangladesh, the majority of people in rural areas have low incomes and have limited access to oral health care facilities. As a result, a free dental check-up in their community is likely to have enhanced their active participation in similar outreach programmes. The current study found that half of the study population (50%) had inadequate oral health literacy, which found that approximately 60.4% of adult patients seeking oral health care in a private setting had inadequate oral health literacy. Female individuals had somewhat higher levels of appropriate oral health literacy (30.8%) than men (16.2%), but there was no significant difference between the two groups

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(P value 0.159), which is comparable to research done in Tamil Nadu Virajpet India. In contrast, studies in Pakistan Mangalore and the United States found a substantial difference between male and female oral health literacy levels. The most likely explanation for this is that female respondents were more aware of their oral health than male subjects. One of the most powerful risk factors for oral health literacy and poor oral health outcomes is socioeconomic status. The majority of the study respondents in the current study who had poor oral health literacy levels were from the lower socioeconomic class (64.5%) and higher lower class (82.11%), as determined by evaluating the people' education, occupation, and income scale. This is comparable to a study conducted in Brazil where study subjects from the lower classes showed lower levels of oral health literacy [4,5].

Conclusion

There were no extra-oral alterations observed in our study individuals. Only 5.3% of individuals had tooth erosion, and 3.83% used partial dentures. Only 1% (6 participants) had a history of traumatic injuries in the past. In the study, the prevalence of oral mucosal lesions was comparably low. The frequency of tobacco pouch keratosis was 3%, and some patients had periapical abscesses (3.34%). OSMF and leukoplakia were found in 0.67% and 1.33%, respectively. The prevalence of fluorosis was much greater (16%) among the Ghaziabad research respondents. According to a study of the Bureau of Indian Standards 2012 of the Ghaziabad district, this could be due to the presence of fluoride beyond the maximum allowable limit of 1.5 ppm in the subterranean water. As a result, the study discusses a strong relationship.

Acknowledgement

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Conflict of Interest

None.

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