International Journal of Nursing Research (IJNR)
International Peer Reviewed Journal

Research Article

A Correlational Study on Oral Health and Oral Health-Related Quality of Life among Older Adults Attending Dental Outpatient Department of Selected Community Health Center of D and Nh

Dharini Parmar[1], Priya Sharma[1], Sujeeta Malik[2]

[1]Department of Community Health Nursing, Shri Vinoba Bhave College of Nursing, Silvassa, Dadra and Nagar Haveli, India, [2]Department of Community Health Nursing, Maharaja Agrasen Nursing College, Bahadurgarh, Haryana, India

ABSTRACT

Introduction: Oral health is a key indicator of overall health, well-being, and quality of life (QoL). It encompasses a range of diseases and conditions that include dental caries, periodontal disease, tooth loss, oral cancer, oral manifestations of HIV infection, and orodental trauma. **Aim:** The aim of the study was to correlate oral health and oral health-related QoL among older adults attending dental outpatient department of selected community health center of Dadra and Nagar Haveli. **Materials and Methods:** Survey approach was used to determine the correlation between oral health and oral health-related QoL among older adults. A descriptive correlational study design was adopted for conducting the study. The sample for the study was 165 older adults aged 50 years and above who have oral diseases/problem which were selected by non-probability purposive sampling technique. Structured Questionnaire on Demographic characteristics was developed by investigator for the purpose of collecting background information of the sample. Observational checklist was used to assess oral health status of older adults. Oral health impact profile (OHIP-14) tool was adopted to assess behavior on oral health status. **Results:** A total of 165 subjects were interviewed and examined. All were favorable to participate in this research study on level of oral health. There is low impact profile on level of oral health-related QoL. There is highly significant ($P < 0.001$***) correlation between oral health and oral health-related QoL among older adults with r-value of 0.4176. **Conclusion:** Hence, the study concludes that OHIP-14 was highly significance correlation between oral health and oral health-related QoL among older adults.

Keywords: Older adults, Oral health-related quality of life, Oral health

Address for Correspondence: Sujeeta Malik, Department of Community Health Nursing, Maharaja Agrasen Nursing College, Bahadurgarh, Haryana, India. E-mail: Sujitarmalik@gmail.com

Introduction

In the preamble of its constitution, the World Health Organization states that "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity."[1] Recent developments in the definition of health and measurement of health status have little impact on dentistry. The dental profession has remained narrowly clinical in its approach to oral health equating health with disease. This is the reason why dentistry has remained immune to this broadening concept of health. So now, it is important to know that quality of life (QoL) measures are not a substitute of measuring outcomes associated with the disease, but are adjunct to them.[2] Oral health-related QoL (OHRQoL) is a multidimensional concept used to assess people's comfort when eating, sleeping, and engaging in social interaction, self-esteem, and their satisfaction with respect to their oral health.[3] Epidemiologic studies have shown that factors such as age, gender, loss of teeth, the socioeconomic status, cultural

Access this article online

Website:www.innovationalpublishers.com/journal/ijnr | e-ISSN: 2456-1320

DOI: 10.31690/ijnr.2020.v06i04.010

How to cite this article: Parmar D, Sharma P, Malik S. A Correlational Study on Oral Health and Oral Health-Related Quality of Life among Older Adults Attending Dental Outpatient Department of Selected Community Health Center of D and Nh. Int J Nur Res. 2020; 6(4): 169-176.

background, dental stress, and smoking can affect the OHRQoL.[4] The continuous growth of elderly populations is evident around the world and is wisely attributed to the longer life expectancy today. The most important challenge today is to improve the QoL of the elderly, and oral health seems to play an important role in improving their general well-being. Oral health is closely related to several aspects of patients' general health and well-being.[5] The mouth is referred to as a mirror of overall health, reinforcing that oral health is an integral part of general health. In elderly population, poor oral health has been considered a risk factor for general health problems. On the other hand, older adults are more susceptible to oral conditions or diseases due to an increase in chronic conditions and physical/mental disabilities. Thus, old people form a distinct group in terms of provision of care.[6] Oral diseases are the most common of the chronic diseases and are important public health problems because of their prevalence, their impact on individuals and society, and the expense of their treatment. Oral health is their social functions and daily activities without physical, psychological, or social inconveniences.[7] According to Population Census 201, in India, 8.6% of population belong to old age group whereas in DNH, 4% of population are elderly.[8] A study was conducted to assess the relationship between oral health and oral health-related QoL among elderly people in the United Kingdom. The objective was to identify the determinants of OHRQoL among older people. OHRQoL was assessed by means of the Oral Health Impact Profile (OHIP)-14 additive score. They used multivariate zero-inflated poisson regression analysis was performed using R-project statistical software. The total 1277 elderly participants were included. The result shows that the weighted means (SE) OHIP-14 score of these participants were 2.95 (0.17) and having active caries (incidence rate ratio [IRR] = 1.37, confidence interval [CI] = 1.25; 1.50), polyunsaturated fatty acids >0 (IRR = 1.17, CI = 1.05; 1.31), dental pain (IRR = 1.34, CI = 1.20; 1.50), and wearing dentures (IRR = 1.30, CI = 1.17; 1.44) was significantly positively associated with OHIP-14 score. Having periodontal pocket >4 mm, at least one bleeding site, and anterior tooth wear were not significantly associated with the OHIP-14 score.[9] Thus, this study aimed to correlate oral health and oral health-related QoL among older adults attending dental outpatient department (OPD) of selected community health center of Dadra and Nagar Haveli.

Objectives

The objectives of the study were to:

- Assess the oral health and oral health-related QoL among older adults.
- Determine the relationship between oral health and oral health-related QoL among older adults.
- Find the association between oral health and demographic variables.
- Find the association between oral health-related QoL and demographic variables.

Hypotheses

All hypotheses were tested at 0.05 level of significance.
H_1: There will be a significant relationship among oral health and oral health-related quality of life.
H_2: There will be a significant association between oral health and oral health-related QoL with the demographic variables.
$H_{2.1}$: There will be a significant association between oral health and demographic variables such as age, gender, education, habits, family income, subjective health status, and subjective oral health status, presence of other diseases, dental status, and missing teeth.
$H_{2.2}$: There will be a significant association between oral health-related QoL and demographic variables such as age, gender, education, habits, family income, subjective health status, subjective oral health status, presence of other diseases, dental status, and missing teeth.

Conceptual framework

Conceptual framework is defined as a written or visual presentation that explains the main things to be studied in either graphically or narrative form the key factors, concepts, or variables and presumed relationship among them (Miles and Huberman, 1994). This study aimed at determining the oral health, its determining factors, and their impact on oral health-related QoL. A revised version of Wilson and Cleary's (1995) model for health-related QoL (Ferrans *et al*., 2005) was used to guide this study.

Materials and Methods

Research approach

The present study was aimed to assess the relationship between oral health and oral health-related QoL among older adults. In view of accomplishing the research objectives, a survey approach was considered.

Research design

Since the study aimed at determining the relationship between oral health and oral health-related QoL, a descriptive correlational survey design was found to be appropriate and employed in this study.

Variables

1. Primary outcome variable – Oral health and oral health-related QoL
2. Selected demographic variable – Age, sex, religion, education, family income, habit, presence of other

diseases, health status, oral health status, dental status, and missing teeth/tooth.

Research setting

In this study, research setting for pilot study was community health center, Dadra, and for conducting main study community health center, Rakholi, was selected.

Population

In this study, population consists of older adults aged 50 years and above and who have oral health problems.

Target population

In this study, target population consists of older adults aged 50 years and above who have oral diseases/problem and residing in Dadra and Nagar Haveli.

Accessible population

In this present study, the accessible population consists of older adults aged 50 years and above who have oral diseases/problem and coming to community health center of Rakholi.

Sample and sampling technique

Sample

In this study, samples were the older adults aged 50 years and above who have oral diseases/problem and coming to community health center of Rakholi.

Sample size

In this study, sample size consists of 165 older adults aged 50 years and above who have oral diseases/problem and coming to community health center of Rakholi.

Sampling technique

The present study adopted a non-probability purposive sampling technique.

Tool for data collection

Part 1: Sociodemographic characteristics

Demographic characteristics will be developed by the investigator for the purpose of collecting background information of the sample. It consists of 14 items such as age, gender, religion, education, family income, habit, presence of other diseases, health status, oral health status, dental status, and missing teeth.

Part 2: Observational checklist on oral health assessment

It contains the oral health assessment observational checklist. The tool has 10 items. The scale had 2 points, that is, normal and abnormal. All the clinical features were observed by the researcher and were given score accordingly. The scoring for the patients with absent dentures, question numbers 5 and 6 are not applicable, for patients with partial dentures, question numbers 4 and 6 are not applicable and for patients with complete dentures, and question numbers 4 and 5 are not applicable. Hence, maximum score was 40 that indicates poor oral health and minimum score was 0 indicates good oral health.

Part 3: OHIP-14

It contains standardized tool developed by Slade and Spencer that consist of 14 items organized in seven subscales. The response will be a 5-point Likert format (0–4) from never (0) to very often (4). Scores will range from 0 to 56.
Arbitrarily classified as:

- Low impact – 0–18
- Moderate impact – 19–37
- High impact – 38–56.

Results

Table 1 depicts the sociodemographic characteristics of the sample. According to age (in years) wise distribution, majority of the subjects of 61% belongs to the age group between 50 and 59 years and 2% belongs to the age group between 80 and above years, whereas majority of the subjects of 64% were male and 36% were female. Mostly (99.4% of subjects have no history of smoking only 0.6% of subjects have history of smoking.
Table 2 depicts the area wise mean, SD, and mean% of 15.75, 3.65, and 32, accordingly. Overall maximum score was 40 and range from 25 to 7.
Table 3 depicts the area wise mean, SD, and mean% of 13.52, 3.01, and 24, accordingly. Overall maximum score was 56 and range from 23 to 6.
Table 4 depicts the frequency and percentage wise distribution of level of oral health. All the subjects of 100% were favorable. Most of the patients were suffer from problem with gingiva (99.39%) and other problems such as halitosis, dry mouth, calculus formation, and normal mouth opening (99.39%). About 96.97% of patient had no dentures whereas only 3.03% of patients had partial dentures and no patients had complete dentures. Patients have problems with lips (58.18%), mucous membrane (47.27%), tongue (72.73%), hard palate (64.24%), and soft palate (2.42%).
Table 5 depicts the frequency and percentage wise distribution of level of oral health-related QoL. Most of 94.55% of subjects have low impact and only 5.45% of subjects have moderate impact.

Table 1: Frequency and percentage wise distribution to correlational study on oral health and oral health-related quality of life among older adults attending dental OPD in selected community health center of D and NH according to their demographic data (*n*=165)

Demographic variables	Frequency	%
1. Age (in years)		
• 50–59	101	61
• 60–69	47	28
• 70–79	14	9
• 80 and above	3	2
2. Sex		
• Male	106	64
• Female	59	36
3. Religion		
• Hindu	161	97.6
• Christian	0	0
• Muslim	4	2.4
• Others	0	0
4. Education		
• Illiterate	70	42
• Primary education	57	35
• Middle school	29	17.6
• High school	7	4.2
• PUC	1	0.6
• Graduation and above	1	0.6
5. Family income		
• <1500	0	0
• 1501–3000	0	0
• 3001–4500	0	0
• 4501–6000	0	0
• 6001–10,000	34	20.6
• >10,001	131	79.4
6. Smoking habit		
• Yes	5	3
• No	160	97
7. History of smoking		
• Yes	1	0.6
• No	164	99.4
8. Chewing tobacco		
• Yes	27	16.3
• No	138	83.7
9. History of chewing tobacco		
• Yes	2	1.2
• No	163	98.8
10. Any other disease		
• No	159	96.4
• Diabetes	1	0.6
• Hypertension	5	3
• Heart disease	0	0
• COPD	0	0
• Asthma	0	0
11. Health status		
• Very healthy	0	0
• Healthy	33	20
• Neither healthy/unhealthy	128	77.5
• Unhealthy	4	2.5
• Very unhealthy	0	0
12. Oral health status		
• Very healthy	0	0
• Healthy	0	0
• Neither healthy/unhealthy	129	78.1
• Unhealthy	36	21.9
• Very unhealthy	0	0
13. Dental status		
• Natural teeth	159	96.4
• Partial dentures	6	3.6
• Full dentures	0	0
14. Missing teeth		
• Yes	144	87.3
• No	21	12.7

(*Contd*...)

Table 2: Area wise mean, SD, and mean% to correlational study on oral health among older adults attending dental OPD in selected community health center of D and NH (*n*=165)

	Max. score	Range	Mean	SD	Mean%
Overall	40	25-7	15.75	3.65	32

Table 3: Area wise mean, SD, and mean % to correlational study on oral health-related quality of life among older adults attending dental OPD in selected community health center of D and NH (*n*=165)

	Max. score	Range	Mean	SD	Mean%
Overall	56	23-6	13.52	3.01	24

Table 4: Frequency and percentage wise distribution to correlational study on oral health among older adults attending dental OPD in selected community health center of D and NH (*n*=165)

Oral health	Frequency	Percentage
Lips	96	58.18
Mucous membrane	78	47.27
Tongue	120	72.73
Patients with no dentures	160	96.97
Patients with partial dentures	05	3.03
Patients with complete dentures	00	00
Gingiva	164	99.39
Hard palate	106	64.24
Soft palate	4	2.42
Others	164	99.39

Table 5: Frequency and percentage wise distribution to correlational study on oral health-related quality of life among older adults attending dental OPD in selected community health center of D and NH (*n*=165)

Level of oral health-related quality of life	Score	
	F	%
Low impact	156	94.55
Moderate impact	9	5.45
High impact	0	0
Total	165	100

Table 6 depicts that the association between level of oral health with selected demographic data, that is, sex (χ^2 = 3.81, P = 0.078), religion (χ^2 = 0.65, P = 0.419), education (χ^2 = 3.46, P = 0.628), family income (χ^2 = 0.085, P = 0.771), smoking habit (χ^2 = 2.57, P = 0.109), history

Table 6: Association for level of oral health and selected demographic variables (*n*=165)

Demographic variables	≤ Median		>Median		χ^2-value	*P*-value
	F	%	F	%		
1. Age (in years)					12.47	0.006**
• 50–59	65	39.3	36	21.8	(df=3)	HS
• 60–69	22	13.3	25	15.1		
• 70–79	4	2.42	10	6.06		
• 80 and above	0	0	3	1.82		
2. Sex	53	32.1	53	32.1	3.81	0.078
• Male	38	23.0	21	12.7	(df=1)	NS
• Female						
3. Religion					0.6	0.419
• Hindu	88	53.3	73	44.2	(df=1)	NS
• Christian	0	0	0	0		
• Muslim	3	1.82	1	0.61		
• Others	0	0	0	0		
4. Education					3.46	0.628
• Illiterate	37	22.4	33	20	(df=5)	NS
• Primary education	29	17.5	28	16.9		
• Middle school	19	11.5	10	6.06		
• High school	4	2.42	3	1.82		
• PUC	1	0.6	0	0		
• Graduation and above	1	0.6	0	0		
5. Family income					0.085	0.771
• <1500	0	0	0	0	(df=1)	NS
• 1501–3000	0	0	0	0		
• 3001–4500	0	0	0	0		
• 4501–6000	0	0	0	0		
• 6001–10,000	18	10.9	16	9.7		
• >10,001	73	44.2	58	35.1		
6. Smoking habit						
• Yes	1	0.61	4	2.42	2.57	0.109
• No	90	54.5	70	42.4	(df=1)	NS
7. History of smoking						
• Yes	0	0	1	0.6	1.237	0.266
• No	91	55.1	73	44.2	(df=1)	NS
8. Chewing tobacco						0.013*
• Yes	9	5.45	18	10.9	6.21	S
• No	82	49.7	56	33.9	(df=1)	
9. History of chewing tobacco						
• Yes	0	0	2	1.2	2.48	0.115
• No	91	55.1	72	43.6	(df=1)	NS
10. Any other diseases						
• No	89	53.9	70	42.4		
• Diabetes	1	0.6	0	0	3.35	
• Hypertension	1	0.6	4	2.42	(df=2)	0.187
• Heart disease	0	0	0	0		NS
• COPD	0	0	0	0		
• Asthma	0	0	0	0		
11. Health status						
• Very healthy	0	0	0	0		
• Healthy	13	7.88	20	12.1		
• Neither healthy /unhealthy	78	47.2	50	30.3	9.96 (df=2)	0.007** HS
• Unhealthy	0	0	4	2.42		
• Very unhealthy	0	0	0	0		
12. Oral health status						
• Very healthy	0	0	0	0		
• Healthy	0	0	0	0		
• Neither healthy /unhealthy	73	44.2	56	33.9	0.494 (df=1)	0.484 NS
• Unhealthy	18	10.9	18	10.9		
• Very unhealthy	0	0	0	0		

(*Contd...*)

Table 6: (*Continued*)

Demographic variables	≤ Median		>Median		χ^2-value	*P*-value
	F	%	F	%		
13. Dental status						
• Natural teeth	89	53.9	70	42.4	1.19	0.274
• Partial dentures	2	1.2	4	2.4	(df=1)	NS
• Full dentures	0	0	0	0		
14. Missing teeth						
• Yes	73	44.2	71	43.0	2.88	0. 08
• No	18	10.9	3	1.8	(df=1)	NS

*P<0.05 significant, **P<0.01 and ***P 0.001 highly significant

of smoking (χ^2 = 1.237, P = 0.266), history of chewing tobacco (χ^2 = 2.48, P = 0.115), any other diseases (χ^2 = 3.35, P = 0.187), oral health status (χ^2 = 0.494, P = 0.484), dental status (χ^2 = 1.19, P = 0.274), and missing teeth (χ^2 = 2.88, P = 0.08) has shown non-significance between the level of oral health and selected demographic data. Thus, the stated research hypothesis, "There is a significant association between oral health and demographic variables at 0.05 level of significance," is rejected. And only the area of age (in year) (χ^2 = 12.47, P = 0.006), health status (χ^2 = 9.96, P = 0.007), and habit of chewing tobacco (χ^2 = 6.21, P = 0.013) have highly significant and significant association between oral health and demographic data. Thus, the stated research hypothesis, "There is a significant association between oral health and demographic variables at 0.05 level of significance," is accepted.

Table 7 depicts the association between the level of oral health-related QoL with selected demographic data. Association test obtained a level of oral health-related QoL with the area of education (χ^2 = 19.09, P = 0.002), history of tobacco chewing (χ^2 = 7.78, P = 0.005), and health status (χ^2 = 7.59, P = 0.022) has highly significant and significant association between the level of oral health-related QoL and selected demographic data. Thus, stated research hypothesis, "There is a significant association between oral health-related QoL with the selected demographic variables at 0.05 level of significance," is accepted.

Table 8 depicts that $P < 0.001$ was considered and the result is significant at $P < 0.05$. Therefore, p-value indicates highly significant relationship between oral health and oral health-related QoL and the research hypothesis stated that "There is a significant relationship among oral health and oral health-related QoL" is accepted.

DISCUSSION

In the present study, the majority of the subjects belong to the age group of between 50 and 59 years. About 64% and 36% are male and female participants, respectively. About 97.6% and 2.4% belongs to Hindu religion and Muslim religion, respectively. Most of them are illiterate with high family income. Most of them are having bad habits of smoking and tobacco chewing. Among them, 96.4% are with no other diseases, 0.6% are with diabetes, and 3% are with hypertension. About 77.5% and 78.1% are having average health status and oral health status, respectively. Most of them are having natural teeth. About 87.3% are having missing teeth. Our study finding was slightly similar to the study conducted by Murariu and Hanganu on oral health and QoL. Among 45–64 years old patients attend a clinic in Isai, Romania. The most affected QoL dimensions were physical disability (56%) and physical pain (41%). The next most commonly reported dimensions were psychological disability (24%), especially embarrassment (24%) and social disability (23%). Only 7% of the respondents reported functional limitations. Significant correlations were found between several oral health indicators and the OHIP-14 scores such as between the indicators "partial denture used" and "physical disability" (r = 0.42), "physical pain" (r = 0.32), "psychological disability" (r = -0.31), and between the oral health indicator "emergency treatment needed" and the "social disability" index (r = 0.44).[10]

In the present study, assessment of oral health and oral health-related QoL is mean % of 32 and 24, respectively. The study was supported by Chalmers *et al.*, conducted on caring for oral health in Australian residential care. The OHAT was evaluated as being a reliable and valid screening tool for use among residents in Australian residential care facilities, including those with cognitive impairments.[11]

In the present study, correlation of oral health and oral health-related QoL among older adults is with 94.55% and 5.45% with low impact and medium impact, respectively. No high impact was observed. The result findings of the study were consistent with a study conducted by Paredes-Rodríguez *et al*. on QoL and oral health in the elderly. The average QoL according to the OHIP rate is 19.23 (Dt = 10.58), being 56 the worst QoL. The Pearson correlation coefficient indicates that QoL is not related to the number of remaining teeth (r = -0.046; P = 0.810) nor the number of ingested drugs (r = 0.226; P = 0.23) but a greater sensation of dry mouth is related to a poorer QoL (r = 0.678; P = 0.230). There is no association between the number of ingested drugs and the xerostomia index (r = 0.144; P = 0.447). The most frequently measures used against dry mouth were drinking water (21 subjects) and sugarless candies (15 subjects).[12]

Table 7: Association for level of oral health-related quality of life and selected demographic variables (***n***=165)

Demographic variables	Low		Moderate		χ^2-value	*P*-value
	F	%	F	%		
1. Age (in years)						
• 50–59	98	59.3	3	1.82	3.91	0.272
• 60–69	42	25.4	5	3.03	(df=3)	NS
• 70–79	13	7.8	1	0.61		
• 80 and above	3	1.82	0	0		
2. Sex						
• Male	99	60	7	4.24	0.759	0.384
• Female	57	34.5	2	1.21	(df=1)	NS
3. Religion						
• Hindu	152	92.1	9	5.45	0.236	0.627
• Christian	0	0	0	0	(df=1)	NS
• Muslim	4	2.42	0	0		
• Others	0	0	0	0		
4. Education						
• Illiterate	68	41.2	2	1.2		
• Primary education	53	32.1	4	2.4	19.09	0.002** HS
• Middle school	27	16.36	2	1.2	(df=5)	
• High school	7	4.24	0	0		
• PUC	1	0.61	0	0		
• Graduation and above	0	0	1	1.2		
5. Family income						
• <1500	0	0	0	0		
• 1501–3000	0	0	0	0	0.01	0.902
• 3001–4500	0	0	0	0	(df=1)	NS
• 4501–6000	0	0	0	0		
• 6001–10,000	32	19.3	2	1.2		
• >10,001	124	75.1	7	4.2		
6. Smoking habit						
• Yes	5	3.03	0	0	0.29	0.585
• No	151	91.5	9	5.45	(df=1)	NS
7. History of smoking						
• Yes	1	0.6	0	0	0.05	0.810
• No	155	93.9	9	5.4	(df=1)	NS
8. Chewing tobacco						
• Yes	26	15.7	1	0.6	0.19	0.661
• No	130	78.7	8	4.85	(df=1)	NS
9. History of chewing tobacco						
• Yes	1	0.6	1	0.6	7.78	
• No	155	93.9	8	4.85	(df=1)	0.005** HS
10. Any other disease						
• No	151	91.5	8	4.85		
• Diabetes	1	0.6	0	0	2.16	0.339
• Hypertension	4	2.42	1	0.6	(df=2)	NS
• Heart disease	0	0	0	0		
• COPD	0	0	0	0		
• Asthma	0	0	0	0		
11. Health status						
• Very healthy	0	0	0	0		
• Healthy	28	16.9	5	3.03	7.59	0.022* S
• Neither healthy /unhealthy	124	75.1	4	2.42	(df=2)	
• Unhealthy	4	2.42	0	0		
• Very unhealthy	0	0	0	0		
12. Oral health status						
• Very healthy	0	0	0	0	0.009	0.974
• Healthy	0	0	0	0	(df=1)	NS
• Neither healthy /unhealthy	122	73.9	7	4.24		
• Unhealthy	34	20.6	2	1.21		
• Very unhealthy	0	0	0	0		

(*Contd*...)

Table 7: (*Continued*)

Demographic variables	Low		Moderate		χ^2-value	*P*-value
	F	%	F	%		
13. Dental status						
• Natural teeth	150	90.91	9	5.45	0.359	*P*=0.549 NS
• Partial dentures	6	3.64	0	0	(df=1)	
• Full dentures	0	0	0	0		
14. Missing teeth						
• Yes	136	82.4	8	4.85	0.06	0.966
• No	20	12.1	1	0.61	(df=2)	NS

*P<0.05 significant, **P<0.01 and ***P<0.001 highly significant

Table 8: Correlation between oral health and oral health-related quality of life among older adults attending dental OPD in selected community health center of D and NH (n=165)

	"*r*"-value	*P*-value
Oral health and oral health-related quality of life	0.4176	*P*<0.001*** HS

*P<0.05 significant, **P<0.01 and ***P<0.001 highly significant

Association test obtained a level of oral health-related QoL with age, sex, religion, family income, smoking habit, history of smoking, chewing tobacco, any other diseases, oral health status, dental status, and missing teeth has shown non-significance between level of oral health-related QoL and selected demographic data. The area of education, history of tobacco chewing, and health status have highly significant and significant association between the levels of oral health-related QoL and selected demographic data.

$P < 0.001$ was considered and the result is significant at $P < 0.05$. Therefore, p-value indicates highly significant relationship between oral health and oral health-related QoL.

CONCLUSION

The findings of the study concluded that the oral health and oral health-related QoL gives a significant correlation through low impact profile among older adults. Thus, it can be concluded that oral care is must to improve the oral health status and oral health-related QoL among older adults.

REFERENCES

1. Bennadi D. Reddy C. Oral health related quality of life. J Int Soc Prev Community Dent 2013;3:1-6.
2. WHO. Definition of Oral Health. Available from: https://capp.mau.se/oral-health-promotion/ [last accessed on 2020 Dec16].
3. Braimoh OB. Alade GO. Oral health-related quality of life and associated factors of elderly population in Port Harcourt, Nigeria. Saudi J Oral Sci 2019;6:18-24.
4. Sanadhya S, Aapaliya P, Jain S, Sharma N, Choudhary G, Dobaria N. Assessment and comparison of clinical dental status and its impact on oral health-related quality of life among rural and urban adults of Udaipur. India: A cross-sectional study. J Basic Clin Pharma 2015;6:50-8.
5. Motallebnejad M, Mehdizadeh S, Najafi N, Sayyadi F. The evaluation of oral health-related factors on the quality of life of the elderly in Babol. Contemp Clin Dent 2015;6:313-7.
6. Bhardwaj VK. Gerodontology-orodental care for elderly. Eur J Gen Dent 2012;1:15-9.
7. Dos Santos MB, Montenegro FL, Arcas SP, Hiratsuka M, Consani RL, Marchini L. Oral health status, hygiene habits and treatment needs amongelderly brazilians: A cross-sectional study. World J Dent 2012;3:22-5.
8. Morowatisharifabad MA, Ravaei J, Haerian A, Shahi MA, Malekhosseni SV, Rezaeipandari H. Self-reported oral health and quality of life in theelderly. Elderly Health J 2016;2:56-61.
9. Naito M, Yuasa H, Nomura Y, Nakayama T, Hamajima N, Hanada N. Oral health status and health-related quality of life: A systemic review. J Oral Sci 2006;48:1-7.
10. Murariu A, Hanganu C. Oral health and quality of life among 45- to 64- year-old patients attending a clinic in Iasi, Romani. OHDMBSC 2009;8:7-11.
11. Chalmers JM, Spencer AJ, Carter KD, King PL, Wright C. Caring for Oral Health in Australian Residential Care. Dental Statistics and Research Series no. 48. Cat. no. DEN 193. Canberra: AIHW; 2009.
12. Paredes-Rodríguez VM, Torrijos-Gómez G, González-Serrano J, LópezPintor-Muñoz RM, López-Bermejo MA, Hernández-Vallejo G. Quality of life and oral health in elderly. J Clin Exp Dent 2016;8:e590-6.