



Prevalence Of Tobacco Associated Oral Mucosal Lesions In A Private Hospital - A Retrospective Study

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ABSTRACT

Aim: The present study was conducted to assess the prevalence and distribution of tobacco associated oral mucosal lesions in a private hospital and the effect of tobacco usage on the mucosal changes.

Background: Prevalence study of oral mucosal lesions in the Chennai population is important to assess their current distribution status. Oral mucosal lesions usually present as abnormal alterations in colour, surface texture, or loss of integrity of the oral mucosa. Oral potentially malignant disorders are of particular importance as they may progress into malignancy.

Materials And Methods: A retrospective study of all cases of oral mucosal lesions seen between 2019 and 2021. Demographic data, clinical data and tobacco habits were retrieved. Statistical analysis was performed using IBM SPSS version 20, and the mean, frequency, and percentage were calculated.

Results: Among 71807 outpatients who reported to the dental college, 28863 (40.19%) patients were diagnosed with oral mucosal lesions. Out of all the oral mucosal lesions, tobacco associated lesions were 28.81% (8314) and were most common in males. The most common tobacco related oral lesions in males were leukoplakia (37.29%) followed by oral submucous fibrosis (30.08%). The most common tobacco associated lesions in females were oral submucous fibrosis (3.01%).

Conclusion: We conclude that the dental practitioner should have adequate awareness and knowledge about the diagnosis and management of oral lesions. 37.85% of oral mucosal lesions were potentially malignant disorders and use of tobacco products increased the risk for oral mucosal changes.

Keywords: *Chennai, Leukoplakia, Lichen Planus, Oral Potentially Malignant Disorders, Oral Submucous Fibrosis, Precancerous lesion*

INTRODUCTION

Oral health plays an important role in improving the general health and quality of life. The oral mucosa includes the soft tissue lining of the oral

cavity, the buccal mucosa and the gingivae.[1] It comprises a distinct layered structure that is similar to the structure and function of skin. These layers protect it from bacterial infection,

and work to regulate temperature and water balance, much like the skin. The oral mucosa offers first line protection against trauma, potential pathogens, and carcinogenic agents.[2] Oral mucosal changes can be divided by clinical features into normal variations and oral mucosal lesions. Oral mucosal lesion is known as any abnormal alteration in colour, surface aspect, swelling or loss of integrity of the oral mucosal surface.[3] Oral potentially malignant disorders have significant concern as they may progress into malignancy.

Infections like bacterial, fungal or viral, local trauma or irritation, systemic diseases and excessive consumption of tobacco, betel quid and alcohol are the main cause for oral mucosal lesions. Tobacco use is one of the most important risk factors for the development of oral mucosal lesions including oral pre-cancer and cancer.[4] Over the last few years, various commercial chewable tobacco products such as pan masala and gutkha have become popular in India and in many parts of Asia. The increasing incidence of OPMD in India is due to the WHO data that says, India is the second largest consumer of tobacco products and third largest manufacturer of tobacco products.[5] Areca nut and tobacco are present in most of the products and both of which have been associated with the occurrence of oral cancer. The investigators have also observed that smoking and chewing of tobacco and betel quid act synergistically in oral carcinogenesis and that persons with mixed habits form a substantially high-risk population.[6]

Bidi is the most popular form of tobacco product in India.[7] Reverse smoking is a type of smoking where tobacco is smoked with the lighted end inside the mouth. Air is supplied to the burning zone through the unlighted end of the cigarette and smoke is expelled through the cigarette or through the mouth. The various forms of smoking tobacco products seen in India are Bidi, Chillum, Chutta, Cigarettes, Dhumti, Hookah and Hookli. The most common smokeless tobacco product used in India is Gutka and it has now been banned all over India.[8] It is alkaline in nature and causes chronic alteration to the oral mucosa in habitual paan chewers because of the pH alteration, due to slaked lime usage many times a day.[9] The buccal mucosa loses its

smoothness and the rough areas retain the quid for sometime which gradually shows discolouration. The various forms of smokeless tobacco used in India are Khaini, Mainpuri tobacco, Mawa, Mishri/Masheri, Paan, Snuff, Zarda, Gutka, Pan masala and Gudakhu.

Oral Potentially Malignant Disorders refers to all epithelial lesions or conditions with an increased risk for malignant transformation.[10] Oral Potentially Malignant Disorders include oral leukoplakia, erythroplakia, erythroleukoplakia, oral submucous fibrosis, palatal lesions in reverse smokers, erosive lichen planus, oral lichenoid reactions, graft-versus-host disease, oral lupus erythematosus, actinic cheilitis of the lower lip and hereditary conditions, such as dyskeratosis congenita and epidermolysis bullosa. Most of the oral potentially malignant disorders are asymptomatic in the early stages and are usually detected by practitioners on routine oral examination. It is noteworthy that many oral squamous cell carcinomas develop from potentially malignant disorders.[11]

Correct diagnosis and timely treatment of Oral Potentially Malignant Disorders may help prevent malignant transformation in oral lesions.[12]

The prevalence, incidence, and severity of oral mucosal lesions in a particular population could be evaluated through epidemiologic studies,[13] but the results of such studies have hardly ever been published globally. Important information from these prevalence studies will be useful in formulating plans for the administration of health services.[14] They help us to learn about the pattern of local disease occurrence and subsequently contribute toward the understanding of the natural history of a disease.[15]

The cardinal feature of conducting a prevalence study of oral mucosal lesion in a population is to understand its extension and characteristics. These studies may make a pavement for formulating prevention programmes that improve oral health promotion. Nevertheless, epidemiological data of the changing trends of these oral mucosal lesions are lacking. Our research and knowledge have resulted in high-quality publications from our team [16–30]

Hence, the present study was carried out to assess the prevalence of different types of OMLs in a general population in patients visiting private hospitals in Chennai, Tamilnadu, India.

MATERIALS AND METHODS

A retrospective analysis of dental health and clinical examination records of 71807 patients visiting a private hospital for multidisciplinary dental procedures between 2019 and 2021 was conducted. Ethical clearance was obtained from the Saveetha Institute of Medical and Technical Science (SIMATS) Scientific Review Board. Undergraduate student performs the general and clinical examination and fills the findings in an electronic database and then it is evaluated and cross checked by a faculty from the Department of Oral Medicine. All the patient’s were examined on a dental chair with a mouth mirror, probe and gauze under good artificial illumination.

Patient’s demographic data, chief complaint, past medical history, past dental history, medications taken, habit history, extraoral and intraoral clinical examination are noted in the patient's file. Habits such as smoking, paan chewing and alcohol intake, and frequency, duration, site of placement in oral cavity, duration of contact with mucosa and discontinuation of habits were also noted. Oral mucosal lesions were categorized according to the WHO criteria. The cases which lacked written information dental examination records or if it was not assessed by a faculty, then those data were excluded from the study.

General built, age, gender, systemic illness, drug history, and habit history are the components to be evaluated in each record. Clinical examinations for all the patients were carried out according to the WHO guideline. Extraoral examination including facial symmetry, developmental abnormalities, temporomandibular joint, and lymph nodes were recorded. In intraoral examination the size of the mouth, shape, mouth opening, anatomical variation on the oral mucosa, presence of any lesions and features of the lesion, location, extension, size, colour, consistency, etiological or related factors, and dental status were noted. The patients were classified into groups based on the forms of tobacco used smoke, smokeless or mixed categories. The patients were educated about the harmful effect of tobacco and encouraged to cease the habit.

The collected data were tabulated and frequency & distribution statistical analysis was done using IBM SPSS version 20. The chi-square test and Fisher’s exact test were applied to find the significance of study parameters. A value less than 0.05 was considered statistically significant.

RESULTS

Among 71807 outpatients who reported to the dental college, 28863 (40.19%) patients were diagnosed with oral mucosal lesions. Out of all the oral mucosal lesions, tobacco associated lesions were 28.81% (Figure 1). Study participants were of the age group between 17 and 90 years with an average age of 42 years.

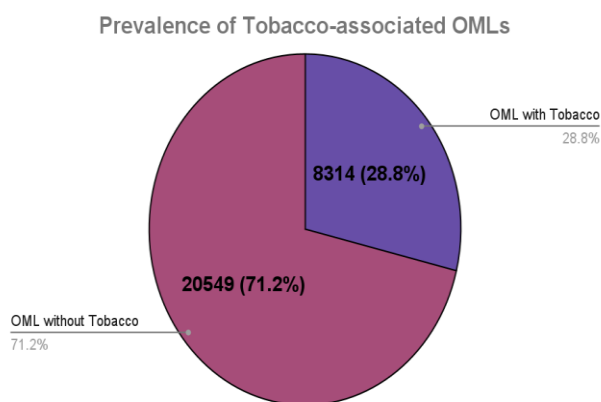


FIGURE 1: Prevalence of Oral mucosal lesions with and without tobacco association

Figure 1 shows prevalence of oral mucosal lesions among patients with tobacco association or without tobacco association Of the 28863 patients, 10972 (38.01%) consumed tobacco in one or another form of tobacco and 8314 patients

(28.80%) of these clinically presented with oral mucosal lesions. Out of 10972 tobacco users, 10114 (92.18%) belonged to male population and 858 (7.8%) belonged to the female population (Figure 2).

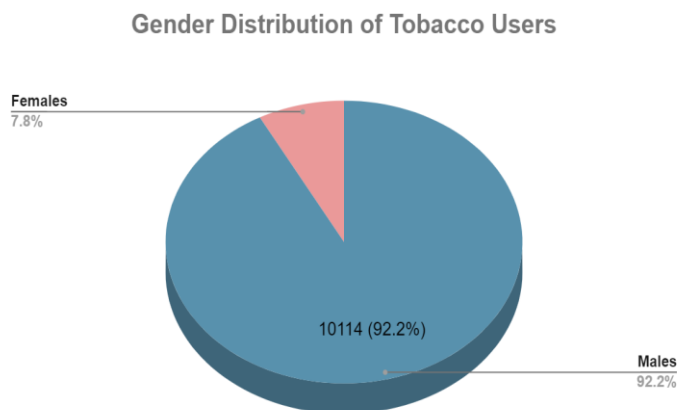


FIGURE 2: Distribution of Tobacco users among males and females

Figure 2 shows distribution of tobacco habits among males and females

3615 (32.94%) and mixed tobacco consumption 2769 (25.23%) shown in Figure 3. Most of the females were chewers (65.76%). The most common tobacco habit practiced among males was smoking followed by chewing.

The most prevalent form of tobacco used was smoking 4588 (41.81%), followed by chewing

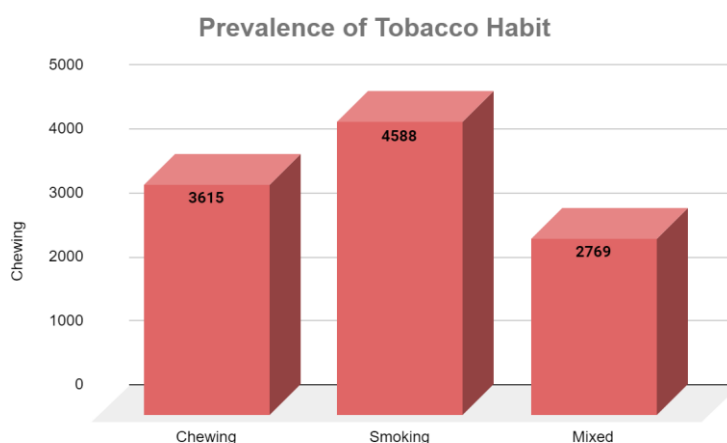


FIGURE 3: Prevalence of Tobacco Habits

Figure 3 shows prevalence of chewing, smoking and mixed tobacco habits among study participants

The prevalence and severity of oral mucosal lesions were directly proportional to the time span and frequency of tobacco use, although

there were few contradictions. The most common tobacco associated lesions were leukoplakia (39.28%), oral submucous fibrosis (33.10%), tobacco pouch keratosis (25.87%) and smokers palate (2.46%).(Figure 4)

The most common tobacco associated lesions in

males were leukoplakia (37.29%), oral submucous fibrosis (30.08%), tobacco pouch keratosis (25.07%) and smokers palate (2.46%). The most common tobacco associated lesions in females were oral submucous fibrosis (3.01%), leukoplakia (1.98%) and tobacco pouch keratosis (0.79%).

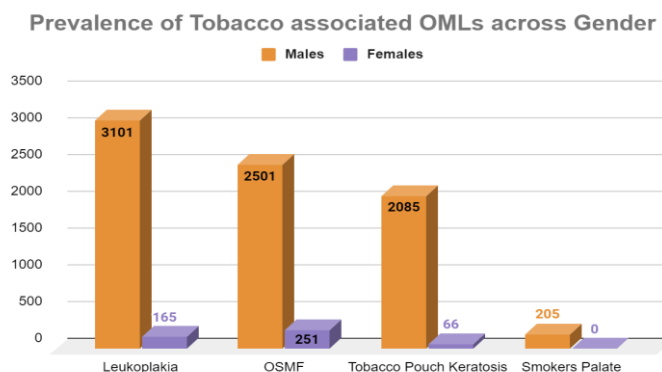


FIGURE 4: Prevalence of Tobacco Habits

Figure 4 shows prevalence Leukoplakia, OSMF, Tobacco pouch keratosis and smokers palate among males and females

DISCUSSION

Consumption of various forms of tobacco is emerging as a significant, and growing threat to health. Tobacco products consist of 7000 different chemicals and among these more than 60 are considered carcinogenic.[31] Bulk of tobacco products are frequently utilized in the form of cigarettes or bidis.[32] Among the smokeless form, commercially available paan masala are becoming more common, especially among teenagers and young adults than in the older age group. A definite association has been recorded between tobacco habit and oral potentially malignant disorders and oral cancer.

Prolonged exposure of oral mucosa to tobacco products can induce changes which could be a protective mechanism of the oral cavity or attributed to the carcinogen itself.[33,34] Carcinoma related to tobacco usage accounts for nearly half of all malignancies in men and quarter of all cancers in women.[35] Analysing the data collected from our study, out of the 10972

patients with history of tobacco habit, 10114 (92.18%) were males and 858 (7.8%) were females. These variations between the distribution of oral mucosal lesions could be attributed to the higher tobacco used by male population and the easier access to tobacco products. On the contrary, due to social norms and cultural restrictions females tend to keep up a certain persona and as a consequence they are less likely to follow these deleterious habits.[36]

Smokeless tobacco products are used in forms of sucked as a quid, applied to gums, chewed or sniffed. Habitually placing tobacco in the mucobuccal fold in the mandibular anterior or posterior regions where the mucosa is in direct contact with snuff or chewing tobacco leads to

Tobacco Pouch Keratosis.[37] The prevalence of tobacco pouch keratosis was 25.87% with the highest prevalence rate in males (96.93%).

Smoker's melanosis or smoker's palate or nicotina stomatitis is caused due to the effects of nicotine on melanocytes to produce excess melanosomes, which results in basilar melanosis. It is usually seen in smokers characterized by whitish mucosa with a red central dot to high

temperature rather than the chemical composition of the smoke.[38]

Oral submucous fibrosis is "an insidious, chronic disease affecting any part of the oral cavity and sometimes the pharynx. Although occasionally preceded by and/or associated with vesicle formation, it is always associated with juxta-epithelial inflammatory reaction followed by fibro-elastic change of the lamina propria, with epithelial atrophy leading to stiffness of the oral mucosa and causing trismus and inability to eat." [39] The prevalence rate of OSMF in our study was 33.10% and most commonly found in males. The malignant transformation rate of OSMF was 5.1%.

Leukoplakia are potentially malignant disorders which are associated with both forms (smoking and smokeless) of tobacco, with malignant transformation rate of 9.5%. [40] In our study, the prevalence of leukoplakia (39.28%) was found most frequently among smokers.

The most prevalent tobacco habit among our study population was smoking followed by chewing and mixed tobacco consumption. [41] One study documented the association of higher level of chewers' mucosa and tobacco pouch keratosis among the tobacco chewers group. [42] Another Indian study reported leukoplakia (13.1%) and tobacco-induced keratosis (9.7%) in smokeless tobacco users. [43]

Patil et al. documented high prevalence of leukoplakia among mixed tobacco consumption habit and also reported that prevalence of oral mucosal lesion in males were higher than females. [44] Sinha et al. in their study stated that, the use of smokeless tobacco was found to be higher among males as compared to females in India, Myanmar, Nepal, and Sri Lanka. However, in Bangladesh, Indonesia, and Thailand, Smokeless tobacco use was higher among females as compared to males. [45] All these study results were in accordance with this study with little variation in occurrence of lesions. These discrepancies could be due to the ethnic and cultural variations and the accessibility of tobacco products in the particular regions. [46]

In older individuals the prevalence of oral mucosal lesions were higher when compared to

younger individuals, and it can be related to different habits acquired with age. [47] Chewing

tobacco, smoking, and consumption of alcoholic beverages have become a common social habit in India. [48,49]

The distribution pattern of oral mucosal lesions differed from one study to another as seen from our results. This may be due to the fact that with increasing age many alterations of the oral mucosa can be induced. Also, the type of participants included in the study can affect the distribution pattern of oral mucosal lesions. In order to compare prevalence rate across populations, they must have certain similarities like habits, form of tobacco used, mean age, and belong to the same age group. The limitations of this study is that it was of a retrospective nature where information and classification biases might exist and results cannot be generalized to the general population.

CONCLUSION

Cardinal information about the prevalence and distribution of oral mucosal lesions among patients seeking dental care in private hospitals has been provided in the results of this study. Based on the results from our study, we conclude that the greater prevalence of oral mucosal lesions calls for ample awareness and knowledge about the diagnosis and management of these lesions. The prevalence of oral mucosal lesions were relatively higher in older individuals when compared to younger age groups. With increase in age, habits such as smoking, chewing tobacco and alcohol consumption increases, which can also be the reason for this trend observed in our study. 37.85% of oral mucosal lesions were potentially malignant disorders and use of tobacco products increased the risk for oral mucosal changes. This emphasises the importance of routine examination of oral mucosa and the patients must be motivated to quit this deleterious habit. All the dental practitioners should be updated periodically on oral lesions which will enhance their diagnostic ability. It is important to create awareness among the general population on deleterious effects of tobacco use and to encourage them to quit the

habit for the benefit of improving their oral and general health.

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CONFLICT OF INTEREST

There are no conflicts of interest.

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