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Does Smoking Cessation Improve Oral Health-related Quality of Life? A Pilot Study

Raha Habibagahi[1], Nader Navabi[2], Maryam Alsadat Hashemipour[2], Atefeh Hashemzehi[2]

Original Article

Abstract

Background: Smoking tobacco is a significant health problem for humankind. Cigarettes could affect people's life from socioeconomic and psychosomatic aspects. The oral cavity is the first orifice through which cigarette smoke enters the body. Thus, it is directly exposed to cigarettes and their harmful ingredients. This study aimed to determine the effects of smoking cessation on oral health-related quality of life (OHRQoL).

Methods: The subjects in the present observational study consisted of individuals visiting a specialized smoking cessation clinic in Tehran, Iran, to give up their smoking habit. After documentation of the subjects' demographic data, the questionnaire [Oral Health Impact Profile (OHIP-14)] was completed twice in three months (before giving up smoking and three months after initiating the program to quit smoking). Data analysis was performed using Sig. (2-tailed), paired t-test, and one-way analysis of variance (ANOVA) at a confidence interval (CI) of 95%.

Findings: Thirty-one subjects (29 men, 2 women) participated in this study. The mean age of the subjects was 37.03 ± 11.30 years. Although OHRQoL scores were increasing as to some parameters, including food tastes, anxiety, and a feeling of shame in the subjects after giving up smoking, it was not statistically significant ($P > 0.050$). On the other hand, the relationship between the quality of life (QoL) (before and after stopping smoking) and age was significant ($P = 0.001$ before quitting and $P = 0.050$ after quitting).

Conclusion: For a better understanding of the relationship between quitting smoking and an improvement in OHRQoL, it is necessary to perform more extensive studies in this field. The present study was a pilot study, which shed some light on the relationships between these parameters.

Keyword: Smoking; Oral health; Quality of life; Smoking cessation

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1- Orthodontic Research Center, School of Dentistry, Shiraz University of Medical Sciences, Shiraz, Iran
2- Department of Oral Medicine, School of Dentistry, Kerman University of Medical Sciences, Kerman, Iran
Correspondence to: Nader Navabi; Department of Oral Medicine, School of Dentistry, Kerman University of Medical Sciences, Kerman, Iran; Email: n_navabi@kmu.ac.ir

Introduction

Cigarette smoking affects the oral cavity adversely, similar to that in other body parts. Oral and esophageal cancers are the sixth most prevalent cancers in both men and women worldwide; however, they are the third most common cancers in men in some countries. The oral cavity is the first part of the body that is directly exposed to cigarette smoke and its noxious ingredients. Cigarette smoking gives rise to benign and sometimes malignant changes in the oral cavity.[1-4]

Some of the side effects of cigarette smoking in the oral cavity include the hairy tongue, leukoedema, melanin pigmentation, tooth discoloration, cervical caries, periodontal diseases, decrease in the sensation of taste, halitosis, nicotinic stomatitis, xerostomia, candida infections, premalignant lesions, and oral cancers.[5-9] Some studies have shown that dental caries is more common in children with smoking parents compared to those with non-smoking parents. In addition, smoking has a negative effect on the outcome of implant treatment.[10,11] Therefore, increasing evidence suggests that smoking has a negative effect on the oral health-related quality of life (OHRQoL), and people who break this habit are expected to avoid such side effects. As a result, this study aimed to evaluate the effect of breaking smoking habits on the OHRQoL.

Methods

The participants in the present observational study consisted of adults referring to a specialty smoking cessation clinic in Tehran, Iran, to break their smoking habits. People smoked cigrattes regularly and had decided to break the habit.

The inclusion criteria consisted of age > 18 years, no history of any known systemic condition, no daily use of medications, no other smoking habits, and no use of alcohol or opioid agents other than cigarettes.

The exclusion criteria consisted of giving up the process of quitting smoking habit before the end of the process and a lack of interest in continuing the cooperation.

After explaining the objectives of the study and obtaining informed consent, the individuals were included in the study. The subjects were assured that all their data would be kept confidential and only the results of the study would be reported.

The Ethics Committee of Kerman University of Medical Sciences, Kerman, Iran, approved the protocol of the study (code: 97000734). First, a last-year dental student filled out the Oral Health Impact Profile (OHIP-14) questionnaire for all the subjects through an interview.

The standard version of the Persian questionnaire was used, which includes 14 questions, and the respondents answered each question on one of the problems related to the condition of their mouth, teeth, or dentures during the past 12 months. These problems were people's experiences about physical, psychological, emotional, and social variables that are manifested as pain, discomfort, or disability. The answers were obtained according to the Likert scale as follows: a score of 4 for always, 3 for mostly, 2 for sometimes, 1 for seldom, and 0 for never. Therefore, the questionnaire's score range for OHRQoL was 0-56, with lower scores indicating a higher level of OHRQoL.[12] In addition, the OHIP-14 questionnaire evaluates seven aspects classified as follows: Questions 1 and 2: performance limitations, questions 3 and 4: physical discomfort, questions 5 and 6: psychological discomfort, questions 7 and 8: physical inability, questions 9 and 10: psychological inability, questions 11 and 12: social inability, and questions 13 and 14: complete inability. Demographic information (age, sex, educational level, and number of cigarettes smoked per day) was also recorded.

Then, people who had begun the process of breaking the habit of smoking were evaluated for a period of three months. After three months, the questionnaires were filled out again for the subjects. The sample size was estimated at n = 30, similar to previous studies. Descriptive statistics [frequencies, percentages, means, and standard deviations (SDs)] were used to report descriptive variables. Two-tailed paired t-test and one-way analysis of variance (ANOVA) [at a 95% confidence interval (CI)] were used with SPSS software (version 21, IBM Corporation, Armonk, NY, USA) to compare the subjects' scores on the questionnaires before and after breaking the cigarette smoking habit.

Results

Thirty-one subjects were included and evaluated in the present study with an age range of 22-58 years. Most of the subjects smoked less than a pack of cigarettes a day before deciding to break the habit. Combination technique (medications and

counseling) was performed for most of the subjects to break the habit of smoking (Table 1). The medications used to this end were Valerian, Zyban, Bupropion, nicotine glue, and chewing gums.

Table 1. Demographic characteristics of the subjects

Value	Item	Variable
Gender	Male	29 (93.5)
	Female	2 (6.5)
Age (year)		30.37 ± 3.11
Educational level	Illiterate	1 (3.2)
	School	4 (12.9)
	Diploma	4 (12.9)
	Academic	22 (71.0)
Cigarette smoking/day	< 20	20 (64.5)
	≥ 20	11 (35.5)
Methods of quitting	Drugs	3 (9.7)
	Counseling	7 (22.6)
	Combination	21 (67.7)

Data are presented as mean ± standard deviation (SD) or number and percentage

Table 2 presents the frequency distributions of the responses of 31 subjects to the questions on the OHIP-14 questionnaire before and after enrolling in this challenge. For example, Q1a and Q1b indicated the subjects' response to question 1 after and before breaking the habit.

The results showed significant changes in answers before and after breaking the habit to questions 2, 3, 4, 6, and 10 (about understanding the taste of food, oral pain, discomfort during eating, anger about the dental problems, and embarrassment about the oral cavity). However, no significant differences were observed in all 14 cases before and after breaking the smoking habit ($P > 0.05$). Table 3 shows the score changes in the OHIP-14 questionnaire before and after the attempt to break the habit using one-way ANOVA and paired t-test. Based on the P-values, none of the score changes were significant ($P > 0.05$).

Table 2. Frequencies (percentages) of answers to the Oral Health Impact Profile (OHIP-14) before and three months after quitting

Questions	Seldom	Sometimes	Fairly often	Very often	All the time
Q1b	21 (67.7)	5 (16.1)	3 (9.7)	2 (6.5)	0 (0)
Q1a	21 (67.7)	7 (22.6)	1 (3.2)	2 (6.5)	0 (0)
Q2b	6 (19.4)	10 (32.3)	7 (22.6)	8 (25.8)	0 (0)
Q2a	2 (6.5)	21 (67.7)	8 (25.8)	0 (0)	0 (0)
Q3b	5 (16.1)	9 (29.0)	13 (41.9)	4 (12.9)	0 (0)
Q3a	1 (3.2)	3 (9.7)	25 (80.6)	2 (6.5)	0 (0)
Q4b	3 (9.7)	14 (45.2)	9 (29.0)	4 (12.9)	1 (3.2)
Q4a	3 (9.7)	8 (25.8)	16 (51.6)	4 (12.9)	0 (0)
Q5b	2 (6.5)	6 (19.4)	12 (38.7)	10 (32.2)	1 (3.2)
Q5a	3 (9.7)	2 (6.5)	15 (48.4)	11 (35.5)	0 (0)
Q6b	12 (38.7)	8 (25.8)	8 (25.8)	3 (9.7)	0 (0)
Q6a	11 (35.5)	16 (51.6)	3 (9.7)	1 (3.2)	0 (0)
Q7b	7 (22.6)	12 (38.7)	11 (35.5)	1 (3.2)	0 (0)
Q7a	6 (19.4)	17 (54.8)	6 (19.4)	2 (6.5)	0 (0)
Q8b	10 (32.3)	9 (29.0)	11 (35.5)	1 (3.2)	0 (0)
Q8a	10 (32.3)	10 (32.3)	11 (35.5)	0 (0)	0 (0)
Q9b	13 (41.9)	5 (16.1)	7 (22.6)	6 (19.4)	0 (0)
Q9a	11 (35.5)	10 (32.3)	8 (25.8)	2 (6.5)	0 (0)
Q10b	7 (22.6)	8 (25.8)	10 (32.3)	4 (12.9)	2 (6.5)
Q10a	2 (6.5)	15 (48.4)	13 (41.9)	1 (3.2)	0 (0)
Q11b	3 (9.7)	7 (22.6)	10 (32.3)	10 (32.3)	1 (3.2)
Q11a	3 (9.7)	2 (6.5)	16 (51.6)	10 (32.3)	0 (0)
Q12b	16 (51.6)	11 (35.5)	4 (12.9)	0 (0)	0 (0)
Q12a	16 (51.6)	13 (41.9)	2 (6.5)	0 (0)	0 (0)
Q13b	17 (54.8)	6 (19.4)	8 (25.8)	0 (0)	0 (0)
Q13a	17 (54.8)	9 (29.0)	4 (12.9)	1 (3.2)	0 (0)
Q14b	26 (83.9)	5 (16.1)	0 (0)	0 (0)	0 (0)
Q14a	28 (90.3)	3 (9.7)	0 (0)	0 (0)	0 (0)

Data are presented as number and percentage

Table 3. Correlation between different domains of the Oral Health Impact Profile (OHIP-14) and mean scores (before and after quitting)

Domains of OHIP-14	Score (before quitting)	Score (after quitting)	P
Functional limitation	2.096 ± 1.680	1.677 ± 1.248	0.085
Functional disorder	3.064 ± 1.691	3.580 ± 1.176	0.081
Psychological disorder	3.129 ± 1.688	2.903 ± 1.220	0.472
Functional disability	2.290 ± 1.595	2.161 ± 1.416	0.630
Psychological disability	2.741 ± 2.128	2.451 ± 1.362	0.300
Social disability	2.580 ± 1.432	2.612 ± 1.202	0.901
Total disability	0.871 ± 1.117	0.741 ± 0.998	0.354

Data are presented as mean ± standard deviation (SD)
OHIP-14: Oral Health Impact Profile

The means and SDs of the total OHIP-14 questionnaire scores before and after attempting to break the habit were 16.774 ± 8.909 and 16.129 ± 6.286, respectively, indicating no significant difference despite an improvement in the OHRQoL of the subjects after breaking the smoking habit (P = 0.640). In addition, no significant relationships were observed between the OHRQoL before and after breaking the habit and the variables of gender, educational level, the number of daily cigarettes, and the technique used to break the smoking habit (P > 0.05). However, the relationship between the OHRQoL (before and after breaking the habit) and age was significant (P = 0.001 and P = 0.050 before and after breaking the habit, respectively), i.e., the OHRQoL decreased with age in both statuses.

Discussion

The present study evaluated the effect of smoking cessation on OHRQoL. Despite the lack of significant statistical results, OHRQoL has improved somewhat in some respects, including taste of foods, discomfort of eating, and the amount of anger and shyness about oral and dental issues.

Numerous studies have evaluated the effect of smoking and breaking this habit on general health and the OHRQoL. Studies by Schmitz et al.[13] and Guiterrez-Bedmar et al.[14] showed that non-smokers had better general health compared to smokers. Smoking individuals had lower OHRQoL compared to non-smoking individuals.[15,16] As for the effect of smoking cessation, similar to the natural effect of smoking on quality of life (QoL), the only available studies are on the effect on health-related QoL (HRQoL) rather than OHRQoL. In this context, Bolliger et al. evaluated the effect of breaking the cigarette smoking habit on cardiac markers as a factor affecting the general health.[17]

Kruskemper and Handschel evaluated the effect of breaking the cigarette smoking habit on the QoL of patients with oral squamous cell carcinoma (OSCC); however, they did not use any questionnaires such as OHIP-14.[18]

So far, no studies have examined the effect of smoking cessation on OHRQoL in the same way as the present study. Jensen et al.[19] and Morin et al.[20] have evaluated the effect of breaking the cigarette smoking habit on the patients' QoL; however, they had similar methodologies as the present study, but Jensen et al. used questionnaires for HRQoL, and Morin et al. only assessed the oral health descriptively.

The main focus of the present study is a relative improvement in the OHRQoL in some aspects. However, no significant difference was observed in the overall scores of the OHIP-14 questionnaire before and after breaking the habit. Nonetheless, Morin et al.[20] and Tomioka et al.[21] reported significant improvements in the patients' QoL after breaking the smoking habit. The use of special oral health questionnaires, such as OHIP-14, seems to make it somehow difficult to assess changes in OHRQoL after breaking the smoking habit, similar to what is in present study. This may be due to the fact that these questionnaires examine a limited number of aspects of QoL, while questionnaires such as the 36-Item Short Form Survey (SF-36) evaluate HRQoL. Following the cessation of smoking in the present study, there were improvements in functional limitations, physical discomfort, and mental and physical disability, the physical aspects of which are related to eating and the perception of food tastes and its psychological aspects are related to anger and shyness about the appearance of the teeth.

Disorders of the sense of taste is one of the

known side effects of smoking, and people are expected to report that they enjoy eating more after quitting smoking, which is similar to the results of our study. Lyons et al. reported significant differences between smokers and non-smokers, concerning the physical aspects of HRQoL.[22] However, Bellido et al. did not report any significant differences in the physical or psychological aspects between smokers and non-smokers, consistent with the results of the present study.[23] Concerning the psychological aspects of breaking the smoking habit and the OHRQoL, factors such as calculus and periodontal disease appear to be exacerbated by smoking, and the formation of dark pigments on the labial surfaces of teeth endangers facial beauty and has adverse effects, especially in women.

In the present study, age had a negative effect on the OHRQoL in both phases, i.e., before and after breaking the smoking habit, which might be explained by factors such as exacerbation of periodontal diseases, loss of the natural teeth, and use of removable dentures and their relevant problems. Gasperini et al. also reported that due to the effect of age factor on psychological aspects of the QoL in the adults who decided to quit smoking, age factor should always be considered as an effective factor in the QoL of these people.[24]

Numerous studies have evaluated the effect of smoking cessation on HRQoL, in which subjects with a chronic disease have been assessed. Russel et al.[25] and Deng et al. evaluated patients with chronic inflammatory diseases of the intestines and schizophrenia. It seems that chronic illness in an infected person can be an important and effective factor in quitting smoking and QoL. Since limited studies have been performed on OHRQoL, attention should be paid to periodontal diseases and other orodental problems in the subjects.[26]

Concerning improvements in the psychological aspects of OHRQoL, the results of the present study showed that it was necessary to be aware of the initial psychological state of individuals in the decision to quit smoking, because it is possible that people with stress and low self-esteem become dependent on nicotine. Such dependence can lead to a vicious circle, and the inability to break this habit can be stressful and cause anxiety in such cases. Laaksonen et al. reported that subjects with a smoking habit had lower psychological health compared to non-smokers.[27]

Becona et al. reported that the general psychological aspect in cigarette smokers was damaged at a higher rate compared to non-smokers.[16] After all, people with physical or psychological disorders may have lower QoL due to their specific medical conditions, and this has nothing to do with smoking and makes it difficult to accurately assess the relationship between smoking and QoL. Baiardini et al. believe that evaluation of changes in the QoL after breaking the cigarette-smoking habit should be accompanied by an assessment of the psychological characteristics of the subjects, including their anxiety and mood.[28] The present study did not show any significant relationship between the rate of cigarette smoking and changes in the OHRQoL; however, Erickson et al. reported that subjects with a low rate of cigarette smoking showed more changes in the HRQoL one week after quitting.[29]

Some of the limitations of such studies include:

1. The difficulty of breaking the cigarette smoking habit due to the association between the physical dependence on nicotine and psychological dependence, which leads to the patient's lack of cooperation during the study and withdrawal from the study. The problem with quitting smoking is due to the link between physical dependence on nicotine and psychological dependence.

2. Many smokers often hide their smoking habits due to social considerations and negative aspects of smoking, and this makes it difficult to access them.

3. A lack of general social awareness that it is possible to break the cigarette smoking habit by referring to relevant clinics.

Conclusion

It appears that breaking the cigarette smoking habit is effective in improving the OHRQoL (especially in the physical performance and psychological inability aspects); however, since statistically significant changes were not detected in the present study, it is suggested that the present study be considered a pilot study and in future studies:

1. Specific tools be compared with HRQoL tools (such as SF-36) in this field to achieve more definite results.
2. Larger sample sizes be used to compare the effects of different techniques for breaking the smoking habit.

3. Good and effective scientific techniques be provided for the general population to break the habit of smoking and specialized clinics for this purpose be available. The authorities of these clinics should be better engaged to consider a more active role for dentists in this field.
4. More information about the general public be provided. Officials at these clinics need to do better to play a more active role for dentists in this area.

Conflict of Interests

The authors have no conflict of interest.

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Authors' Contribution

Writing the manuscript and translation into English: RHA; Idea and managing the study, editing the manuscript: AA; Data analysis: MAH; Collection of data (doctoral thesis): AH.

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آیا ترک سیگار به بهبود کیفیت زندگی مرتبط با سلامت دهان منجر می‌گردد؟ یک مطالعه مقدماتی

رها حبیب‌آگهی[۱]، نادر نوابی[۲]، مریم السادات هاشمی‌پور[۲]، عاطفه هاشم‌زهی[۲]

مقاله پژوهشی

چکیده

مقدمه: مصرف دخانیات، معضل بزرگی برای سلامت افراد بشر محسوب می‌گردد و کشیدن سیگار می‌تواند ابعاد اقتصادی، اجتماعی و روحی- روانی زندگی روزمره افراد را تحت تأثیر قرار دهد. حفره دهان، نخستین قسمتی از بدن است که در معرض مستقیم دود سیگار و ترکیبات مضر آن قرار دارد و سیگار کشیدن بر کیفیت زندگی مرتبط با سلامت دهان (Oral Health-related quality of life یا OHQoL) افراد تأثیرات منفی بر جای می‌گذارد. هدف از انجام پژوهش حاضر، بررسی تأثیر ترک سیگار بر OHQoL افراد بود.

روش‌ها: این مطالعه به روش مداخله‌ای (Interventional) صورت گرفت و جمعیت مورد نظر را افرادی تشکیل دادند که به یک کلینیک ترک سیگار در تهران مراجعه کرده بودند. پس از ثبت داده‌های دموگرافیک، پرسش‌نامه Oral Health Impact Profile (OHIP-۱۴) در دو مقطع زمانی (قبل از شروع به ترک و سه ماه پس از اقدام به ترک سیگار) برای شرکت‌کنندگان تکمیل گردید. داده‌ها به منظور مقایسه امتیاز پرسش‌نامه بیماران، قبل و پس از ترک سیگار با استفاده از آزمون‌های Paired t و One-way ANOVA با فاصله اطمینان (Confidence interval یا CI) ۹۵ درصد مورد تجزیه و تحلیل قرار گرفت.

یافته‌ها: ۳۱ نفر (۲۹ مرد و ۲ زن) با میانگین سنی ۱۱/۳۰ ± ۳۷/۰۳ سال در تحقیق حاضر شرکت نمودند. با وجود بهبود نمرات OHQoL در زمینه‌هایی مانند «حس کردن مزه غذاها و خجالت‌زده و عصبانی بودن از مسایل مربوط به دندان‌ها» پس از ترک سیگار، تغییر معنی‌داری مشاهده نگردید ($P > ۰/۰۵۰$)، اما ارتباط معنی‌داری میان کیفیت زندگی مرتبط با سلامت دهان (قبل و پس از اقدام به ترک سیگار) و متغیر سن وجود داشت ($P = ۰/۰۰۱$ برای قبل از ترک سیگار و $P = ۰/۰۵۰$ برای پس از ترک سیگار)..

نتیجه‌گیری: برای شفاف‌تر شدن رابطه میان ترک سیگار و بهبود OHQoL، به انجام مطالعات تکمیلی نیاز است و پژوهش حاضر را می‌توان در این حیطه به عنوان مطالعه مقدماتی (Pilot) تلقی نمود که نشانه‌هایی از وجود این ارتباط را نشان داد.

واژگان کلیدی: سیگارکشیدن؛ سلامت دهان؛ کیفیت زندگی؛ ترک سیگار

ارجاع: حبیب‌آگهی رها، نوابی نادر، هاشمی‌پور مریم السادات، هاشم‌زهی عاطفه. **آیا ترک سیگار به بهبود کیفیت زندگی مرتبط با سلامت دهان منجر می‌گردد؟ یک مطالعه مقدماتی.** مجله اعتیاد و سلامت ۱۳۹۹؛ ۱۲ (۳): ۷۴-۱۶۷.

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۱- مرکز تحقیقات ارتودنسی، دانشکده دندان‌پزشکی، دانشگاه علوم پزشکی شیراز، شیراز، ایران

۲- گروه بیماری‌های دهان، دانشکده دندان‌پزشکی، دانشگاه علوم پزشکی کرمان، کرمان، ایران

نویسنده مسؤول: نادر نوابی؛ گروه بیماری‌های دهان، دانشکده دندان‌پزشکی، دانشگاه علوم پزشکی کرمان، کرمان، ایران

Email: n_navabi@kmu.ac.ir