

A Survey To Assess The Knowledge Regarding The Extraoral Factors Associated With Halitosis Among Female College Students.

Prof Dr.Nisha M.D

Vice Principal ,Poyanil College of Nursing ,Kerala

Date of Submission: 20-07-2021

Date of Acceptance: 04-08-2021

I. INTRODUCTION

Most people suffer from foul breath. It's not uncommon for halitosis to be discovered in patients and dentists due to the increasing media exposure. While, it must be said, it is still regarded highly taboo. When in doubt, have a nurse examine the patient for halitosis. Patients who are looking to try to treat their halitosis before coming to the clinic may be found at the halitosis clinic. Some of the most often used products for fighting halitosis are chewing gum, candy, and mouth rinse. However, this is known to be the case, as the items are understood to serve only to conceal the true cause of foul breath, and so they have no effect on it.

Over half of the patients have previously consulted a general practitioner or a specialist with regards to their breath odor. Many individuals have suffered with halitosis for years, and research reveals that this has contributed to an enormous amount of emotional stress. These are some of the more prevalent reasons of poor breath: periodontal problems, tongue coating, cavities, and impaired salivary flow. Halitosis has a big impact on one's whole well-being, social and psychological. Inhalants which have a distinctive, unpleasant odor have been found to be associated to a variety of psychological disorders, including anxiety, depression, major worry, and behavioral changes, as well as making the user feel sad and anxious.

Methods and instruments

To design a cross-sectional study, a random sample was used. Colleges in Kerala provided their students with anonymous questionnaires for distribution. The purpose of the research was to highlight the results of the study, as well as any possible problems that surfaced. The number of women who received the questionnaire was 197, and 99 percent of them completed it. Three participants had difficulty because of a lack of time. To ensure that the survey questions were

appropriate, the survey was developed using a questionnaire that was then tested using a pilot study.

In the questionnaire, we collected information on our target audience, such as age, gender, and geographic location, as well as numerous other questions that probed our research target's knowledge of halitosis and their abilities to help identify possible causes and treatments.

Using the latest version of SPSS 22, the data were examined.

II. RESULTS

Out of 88.1% of the population, 87.5% answered Students who were between the ages of 18 and 25, with an average age of 21, comprised the participation pool. According to the results, 78% of participants reported they were not suffering with halitosis. About 18.9% of the individuals who stated they have found their own halitosis admitted to having it.

Halitosis originated in the majority of the responders' stomachs. The periodontal pocket (36.5%) and the tongue were the next most-cited locations (23.5 percent). around 34.7% More over eight in ten (78.9%) said bad breath was linked to a lack of brushing, with dry mouth (32.3%), smoking (20.5%), and ear infections (18.5%) completing the top four (27.9 percent). Diarrhea and many other gastrointestinal disorders came in first, accounting for about 89% of systemic illnesses like Crohn's disease, intestinal obstructions, and other conditions. Respiratory diseases followed next, and diabetes ranked last.

About 68% of participants believe that a plan to combat foul breath can be implemented by using goods like mouthwash. Among the entire group, 32.1% answered that they would consult their dentist when making decisions about this subject.

The results showed that individuals without braces believed that poor breath was caused by not

brushing (a p-value of 0.011) and were more inclined to see a dentist (a p-value of 0.020). Overall, those with SPH had far less to fear in terms of poor breath or dental brushing. There were significant variations between age groups in the sense of bad breath (p=0.032), according to a multiple regression analysis. There was a post hoc Tukey test that showed the percentage of individuals that perceived halitosis under the age of 22 was significantly higher than those who were over the age of 22 (p=0.027). The perception that halitosis starts in the stomach is held by respondents aged 21–23 (at a p value of 0.033) as much as those aged 18–20 (with a p value of 0.072). In the 18- to 20-year-old age group, ENT disease was found to be less frequently the cause of bad breath than those over 22 (p=0.031). People in the 21- to 22-year-old age group were far more likely to reject the method for treating halitosis than were other age groups (p=0.004).

III. DISCUSSION

Bad breath is a problem affecting everyone, from personal relationships to international connections. Periodontal disorders, gastrointestinal problems, and tongue covering are some of the major reasons of foul breath. The difference between these findings could be attributed to age inequalities. While those studying in the health sciences had a larger preference for the tongue as the main source, this may be related to the respondents' understanding of the issue.

According to our study, gastrointestinal disorders apart, there is a paucity of information on extraoral factors, including breath odor, in the medical literature. Other causes of halitosis include chronic sinusitis, upper respiratory tract infections, diabetes, older age, being female, and poorer socioeconomic position. Inability to breathe correctly due to dry mouth could lead to this problem. Further attention should be placed on the usual causes of halitosis, such as ENT and pulmonary disease, metabolic disorders, and some medicines.

Of those who had malodorous breath, only five percent would urge that a friend notify them of it. Society's opinion of halitosis' impact on emotional states may influence people's responses to these issues. Other aspects of this view suggest that specialists who can diagnose and treat this issue have a greater duty of care. They demonstrate how crucial it is to incorporate such discussions in dental training programs.

REFERENCES

[1]. Quirynen M, Dadamio J, Van den Velde S, De Smit M, Dekeyser C, Van Tornout M, et

al. Characteristics of 2000 patients who visited a halitosis clinic. *J Clin Periodontol.* 2009;36:970–5.

- [2]. Zürcher A, Filippi A. Findings, diagnoses and results of a halitosis clinic over a seven year period. *Schweiz Monatsschr Zahnmed.* 2012;122:205–16. This is a retrospective study which analyzed data from 465 patients of the Halitosis Clinic at the University of Basel.
- [3]. Quirynen M, Zhao H, van Steenberghe D. Review of the treatment strategies for oral malodour. *Clin Oral Investig.* 2002;6:1–10
- [4]. Scully C, El-Maaytah M, Porter SR, Greenman J. Breath odor: etiopathogenesis, assessment and management. *Eur J Oral Sci.* 1997;105:287–93.
- [5]. Goldberg S, Kozlovsky A, Gordon D, Gelernter I, Sintov A, Rosenberg M. Cadaverine as a putative component of oral malodor. *J Dent Res.* 1994;73:1168–72.
- [6]. McDowell JD, Kassebaum DK. Diagnosing and treating halitosis. *J Am Dent Assoc.* 1993;124:55–64.
- [7]. Tessier JF, Kulkarni GV. Bad breath: etiology, diagnosis and treatment. *Oral Health.* 1991;81:19–22. 24.
- [8]. Seemann R, Conceicao MD, Filippi A, Greenman J, Lenton P, Nachnani S, et al. Halitosis management by the general dental practitioner—results of an international consensus workshop. *J Breath Res.* 2014;8:017101. This article summarizes the results of a consensus workshop of international authorities with the aim of reaching a consensus on general guidelines on how to assess and diagnose patients' breath odor and on the treatment of halitosis.
- [9]. Yaegaki K, Coil JM. Examination, classification, and treatment of halitosis; clinical perspectives. *J Can Dent Assoc.* 2000;66:257–61.
- [10]. Coil JM, Yaegaki K, Matsuo T, Miyazaki H. Treatment needs (TN) and practical remedies for halitosis. *Int Dent J.* 2002;52:187–91.
- [11]. Miyazaki H, Arao M, Okamura K, Kawaguchi Y, Toyofuku A, Hoshi K, et al. Tentative classification of halitosis and its treatment needs. *Niigata Dent J.* 1999;32:7–11.
- [12]. Krespi YP, Shrimel MG, Kacker A. The relationship between oral malodor and volatile sulfur compound-producing bacteria. *Otolaryngol Head Neck Surg.* 2006;135:671–6.
- [13]. Apatzidou AD, Bakirtzoglou E, Vouros I, Karagiannis V, Papa A, Konstantinidis A.

- Association between oral malodour and periodontal disease-related parameters in the general population. *Acta Odontol Scand.* 2013;71:189–95.
- [14]. Sterer N, Rosenberg M. Breath odors. Origin, diagnosis and management. Berlin: Springer; 2011. p. 5–75. CrossRefGoogle Scholar
- [15]. Delanghe G, Bollen C, Desloovere C. Halitosis-foetor ex ore. *Laryngorhinootologie.* 1999;78:521–4.
- [16]. Rosenberg M, Knaan T, Cohen D. Association among bad breath, body mass index, and alcohol intake. *J Dent Res.* 2007;86:997–1000.

Prof Dr.Nisha M.D. “R A Survey To Assess The Knowledge Regarding The Extraoral Factors Associated With Halitosis Among Female College Students.” *International Journal of Engineering Research and Applications (IJERA)*, vol.11 (8), 2021, pp 35-37.