



## Impact of Removable Partial Denture on Quality-of-life of Sudanese Adults in Khartoum State

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### ABSTRACT

**Introduction:** Tooth loss can affect a patient's quality-of-life (QoL), impacting on aspects, such as nutritional intake, psychological status, self-image, and daily engaging in social interaction. The purpose of this study was to assess the oral health-related QoL (OHRQoL) among adult Sudanese patients wearing removable partial dentures (RPDs) by utilizing oral health impact profile-14 (OHIP-14) to assess patient satisfaction with their dentures.

**Materials and methods:** The study population included 370 adult patients wearing RPDs. Of these, 99 were males and 271 females with the age range of 35 to above 60 years. Self-reported questionnaires were distributed randomly to be completed by the participants from each health sector after having read a consent letter. Two measures interpreting the OHIP-14 scales (sum and prevalence) were utilized for data collection. The relationship of patients' demographic characteristics, general and oral health status, and denture characteristics with their OHRQoL was investigated. The data were processed and analyzed by means of Statistical Package for the Social Sciences (SPSS).

**Results:** The means of OHIP-14 sum and OHIP-14 prevalence of partial denture wearers were 10.9 + 7.8 and 18.9% respectively. The most problematic aspects of OHIP-14 were functional limitation and psychological disability. On the contrary, the participants had little problem as a handicap and social disability aspects. The self-reported oral health, regular follow-up, denture satisfaction, duration of denture wearing use of the denture while eating, and frequency of denture cleaning positively contribute to oral health-related quality.

**Conclusion:** Loss of teeth and use of RPD significantly affect patients' oral health status and QoL. Patients who are satisfied with their dentures have a better QoL than their unsatisfied counterparts.

**Keywords:** Oral health, Quality-of-life, Removable partial denture, Tooth loss.

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### INTRODUCTION

Tooth loss is the outcome of various factors, namely, as a sequel of caries and periodontal diseases, trauma, congenital tooth loss, and oral cancer. Other factors have also been implicated like the tooth loss associated with sociodemographic, behavioral, or medical factors.<sup>1-3</sup> Edentulous state is a debilitating and irreversible condition and described as the final marker of disease burden for oral health.<sup>4</sup> Studies have shown that tooth loss can affect a patient's QoL, impacting on aspects, such as nutritional intake,<sup>5</sup> psychological status, self-image, and daily engaging in social interaction.<sup>6</sup> Tooth loss was listed as the second most frequent cause of disability among the elderly after cataract in a study in the Indian population.<sup>7</sup> A finding in a survey of a population having fewer than nine teeth showed that it had more impact on health-related QoL than having cancer, hypertension, or allergy.<sup>8</sup>

Several treatment options can be proposed to replace the missing teeth, such as implants and fixed or removable prostheses. Many previous studies have shown that implant-supported dentures can substantially improve the wearer's QoL.<sup>9</sup> Failure of the government to provide funding for implant prosthetic therapy, lack of insurance coverage for dental implant, financial limitations on the

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part of the patient, and the presence of contraindication for implants make the RPD as the treatment of choice and continues to be widely provided as a treatment option for replacing missing teeth.<sup>10</sup> Loss of teeth and wearing an RPD significantly affect patients' perception of oral health and QoL.<sup>11-13</sup> Nowadays, there is growing interest in recognizing oral health as a component of QoL.<sup>14</sup> The provision of RPDs and their impact on OHRQoL have been the subject of recent attention.<sup>15</sup> It is expected that the demand for prosthodontic treatment in developing countries would increase in the future due to a large percentage of the elderly within the population and also due to an increase in dental awareness. There is equally increasing emphasis attributed to the impact of these prosthodontic treatments on the QoL.<sup>10</sup> Therefore, it is important to consider an edentulous patient's needs and factors that influence their QoL.<sup>15</sup> There is relative lack of data pertaining to evaluate the OHRQoL in adult population in the developing world, in general, and particularly in the Sudanese population.<sup>16</sup> Therefore, this study was undertaken to assess the impact of RPDs on the QoL of Sudanese adults to improve and maintain their OHRQoL.

## MATERIALS AND METHODS

This cross-sectional hospital-based study was conducted in the dental departments of Khartoum State present in hospitals and dental clinics in educational institutions. The study population comprised adult patients wearing RPD (acrylic or chrome cobalt type), who are attending dental departments in hospitals and dental clinics in educational institutions for follow-up in Khartoum state. The population size is estimated at 3,500. The inclusion criteria were adult patients wearing RPD (either single or double) for at least 4 weeks. Subjects not completing the questionnaire and with intellectual impairment were excluded from the study.

Data were collected by using questionnaires, which were filled by interviewing each patient. The questionnaire consists of four parts. The first part comprised the patients' demographic characteristics (sex, age, occupation, education, and income). The second part comprised the general health status (self-reported general health and use of medication due to medical problem), oral health status, and dental-related factors (number of healthy tooth, number of decayed tooth, dental visits, frequency of brushing, bleeding gums during brushing, and self-reported oral health). Teeth that were sound, decayed, filled or filled, but decayed were marked as natural teeth. Teeth with grade 111 mobility, retained roots, or extensive crown destruction were marked as decayed teeth. The third part comprised the denture characteristics: RPD wearing experience (number of years/months), denture

material (acrylic or chrome cobalt), satisfaction with denture, hours of wear per day, denture usage (wear dentures when eating and sleeping), cleaning frequency, and reasons for prescription. The fourth part is the OHIP-14. This questionnaire consists of 14 questions explaining the positive and negative effects on the health of the oral cavity in seven different subscales, namely, functional limitation, physical pain, psychological discomfort, physical disability, psychological disability, social disability, and handicap. The responses were made on a 5-point Likert scale (0—never, 1—almost never, 2—sometime, 3—fairly often, and 4—very often). The main reason for using OHIP short form was to ease the burden on the patient and clinician.

## Data Analysis

Data were analyzed in statistical software SPSS version 20. Frequency and percentage were computed for categorical variable, such as patient demographic characteristics (sex, age, occupation, education, and income), general health status, oral health status, dental-related factors, and denture-related factors with their OHRQoL. Chi-squared test was used for associations between characteristics and OHIP. Furthermore, t-test and analysis of variance (ANOVA) were used to test if there was a significant difference between some categories in OHIP. For all tests, a  $p < 0.05$  is considered statistically significant. In this study, two measures of interpreting the OHIP-14 scales were utilized to describe the prevalence and severity of OHRQoL. The OHIP-14 prevalence was defined as the percentage of people who reported one or more OHIP-14 items, with often and very often response. The OHIP-14 sum was calculated as a simple nonweighted summation of impact scores after assigning numbers to each OHIP-14 scale as follows: Zero for never, 1 for hardly ever, 2 for occasionally, 3 for fairly often, and 4 for very often. The scores had a possible range of 0 to 56, the higher scores representing the worse OHRQoL.

## RESULTS

A total of 370 patients wearing RPD agreed to participate in the study. Nearly three-quarters of the sample were female (73.2%). The ages of the participants ranged between 35 years and above 60 years, of which 38.1% were in the age group between 45 and 50 years. The distribution of the sociodemographic characteristics of study subjects is presented in Table 1. About 61% of the participant described their general health status as fair. About 16.5% described their general health as good as summarized in Table 2. About 82% described their oral health as fair, 11% described it as poor, and only about 7% described that they had good oral health as summarized

**Table 1:** Sociodemographic characteristics of RPD wearers (n = 370)

	Frequency (%)
<i>Gender</i>	
Male	99 (26.8)
Female	271 (73.2)
<i>Age (years)</i>	
35–40	26 (7)
40–45	113 (30.5)
45–50	141 (38.1)
Above 50	90 (24.3)
<i>Marital status</i>	
Single	35 (9.5)
Married	265 (71.6)
Divorced	24 (6.5)
Widowed	46 (12.4)
<i>Living area</i>	
Rural area	133 (35.9)
Urban area	237 (64.1)
<i>Education</i>	
Less than high school	140 (37.8)
High school and above	230 (62.2)
<i>Income</i>	
Low	74 (20)
Medium	263 (71.1)
High	33 (8.9)
Total	370 (100)

**Table 3:** Oral health-related characteristics of studied partial denture wearers (n = 370)

	Frequency (%)
<i>Perceived oral health</i>	
Good	25 (6.8)
Fair	303 (81.9)
Poor	42 (11.4)
<i>Brushing</i>	
Sometimes	79 (21.4)
Always	286 (77.3)
Never	5 (1.4)
<i>Bleeding gum</i>	
Sometimes	177 (47.8)
Always	93 (25.1)
Never	100 (27)
<i>Regular visits to dentist</i>	
Yes	194 (52.4)
No	176 (47.6)
Total	370 (100)

**Table 2:** General health characteristic of studied partial denture wearers (n = 370)

	Frequency (%)
<i>General health</i>	
Good	61 (16.5)
Fair	252 (68.1)
Poor	57 (15.4)
<i>Medical problems</i>	
Yes	215 (58.1)
No	155 (41.9)
Total	370 (100)

**Table 4:** Distribution of patients according to denture-related factors

	Frequency (%)
<i>RPD age (months)</i>	
<6	144 (38.9)
6–12	167 (45.1)
More than 12	59 (15.9)
<i>Denture material</i>	
Acrylic	352 (95.1)
Chrome-cobalt	18 (4.9)
<i>Denture status</i>	
Single partial denture	173 (46.8)
Full mouth partial denture	197 (53.2)
<i>Satisfied with your denture</i>	
Yes	288 (77.8)
No	82 (22.2)
<i>Denture wearing time (hours)</i>	
0	2 (0.5)
Up to 8	114 (30.8)
8–16	163 (44.1)
More than 16	91 (24.6)
<i>Eating with dentures</i>	
Yes	270 (73)
No	100 (27)
<i>Sleeping with dentures</i>	
Yes	62 (16.8)
No	308 (83.2)
Never	27 (7.3)
Up to 7 times per week	264 (71.4)
More than 7 times a week	79 (21.4)
<i>Reason for making denture</i>	
Patients' request	220 (59.5)
Clinician recommendation	150 (40.5)
Total	370 (100)

in Table 3. More than two-thirds of the patients (77.8%) were satisfied with their dentures as shown in Table 4. Both OHIP-14 sum and prevalence were significantly associated with self-reported oral health and regular visits to dentists. Similarly, these two measures of OHRQoL were significantly associated with satisfaction with the denture and denture-related variables, such as denture usage time, eating with denture, and frequency of denture cleaning. There was a statistically significant relationship

between denture satisfaction and eating with denture and OHIP-14 prevalence and OHIP-14 sum, so that the participants who are satisfied with their dentures and who were using it while eating had the lowest scores in both measures (improved OHRQoL) with  $p = 0.01$ . Likewise, a significant association was found between the OHIP-14 sum and OHIP-14 prevalence and frequency of denture cleaning with  $p = 0.002$  and  $p = 0.001$  respectively. The more the RPD wearer cleaned the denture, the lower the

**Table 5:** Distribution of OHIP-14 for each single item

	Never (0)	Hardly ever (1)	Occasionally (2)	Fairly often (3)	Very often (4)
<i>Functional limitation, n (%)</i>					
Pronunciation	89 (24.1)	150 (40.5)	111 (30)	16 (4.3)	4 (1.1)
Taste	124 (33.5)	152 (41.1)	77 (20.8)	13 (3.5)	4 (1.1)
<i>Physical pain, n (%)</i>					
Painful aching	137 (37)	155 (41.9)	59 (15.9)	14 (3.8)	5 (1.4)
Uncomfortable to eat	128 (34.6)	147 (39.7)	71 (19.2)	16 (4.3)	8 (2.2)
<i>Psychological discomfort, n (%)</i>					
Self-conscious	167 (45.1)	116 (31.4)	75 (20.3)	9 (2.4)	3 (0.8)
Feel tense	139 (37.6)	139 (37.6)	74 (20)	11 (3)	7 (1.9)
<i>Physical disability, n (%)</i>					
Unsatisfactory diet	148 (40)	129 (34.9)	72 (19.5)	15 (4.1)	6 (1.6)
Interrupted meals	188 (50.8)	112 (30.3)	55 (14.9)	12 (3.2)	3 (0.8)
<i>Psychological disability, n (%)</i>					
Relaxation	113 (30.5)	149 (40.3)	92 (24.9)	13 (3.5)	3 (0.8)
Embarrassment	168 (45.4)	127 (34.3)	65 (17.6)	8 (2.2)	2 (0.5)
<i>Social disability, n (%)</i>					
Irritable by people	213 (57.6)	114 (30.8)	27 (7.3)	10 (2.7)	6 (1.6)
Difficulty in usual jobs	234 (63.2)	103 (27.8)	22 (5.9)	8 (2.2)	3 (0.8)
<i>Handicap, n (%)</i>					
Life is less satisfying	281 (75.9)	70 (18.9)	14 (3.8)	4 (1.1)	1 (0.3)
Unable to function	303 (81.9)	53 (14.3)	11 (3)	1 (0.3)	2 (0.5)

OHIP-14 scores (better OHRQoL) detected as shown in Tables 5 to 6.

The most problematic aspects were functional limitation and psychological disability so that 30 and 24.9% of the participants very often and fairly often had problems with pronunciation and function respectively. On the contrary, the participants had little problem in handicap and social disability aspects so that only 3% of them were unable to function and 5.9% had difficulty doing usual jobs. A total of 70 individuals answered at least one item as fairly often and very often, OHIP-14 prevalence = 18.9%, and the mean of OHIP-14 sum was  $10.9 \pm 7.8$ .

## DISCUSSION

Data on the impact of partial denture on OHRQoL of adult Sudanese partial denture wearers have not previously been published online. The present survey was, therefore, undertaken to gather such information from them to aid the establishment of oral health education programs. Thus, the present study utilized OHIP-14 as a measurement of OHRQoL to assess the impact of RPD on the QoL. Our study shows that the OHIP-14 prevalence as well as the sum were lower than that found in other studies.<sup>10</sup> This may indicate that Sudanese adults have higher impact with RPD wearing in OHRQoL. Studies have indicated that the elderly patients have less scores of the OHIP-14 sum than younger patients. Our study, however, showed that male patients with younger age (35–45 years) have less score of OHIP sum. Such findings could be attributed to self-concern with esthetics and

oral function in comparison with older patients. On the contrary, older patients are more experienced to function with missing teeth, and they might have less esthetic and social demands and more impaired neuromuscular control, which could make them more indifferent to the treatment. Concerning the gender differences, female patients have higher social demands and self-concerns with esthetics and are difficult to be satisfied that result in lower OHRQoL. Other studies have shown that sex and age do not have a significant association with OHRQoL.<sup>10</sup>

The results of the study also show that single and married participants have less OHIP sum, but there is no significant association between marital status and OHRQoL. This may be because they are more concerned about their looks and esthetics. In our results, the education level has a significant association with the OHIP prevalence. Patients with high education maintained good oral hygiene with lower grades. This finding can be interpreted by the fact that better-educated patients are more realistic in their judgment. Another possible explanation of this trend may be related to a person's expectations.

Subjects with a lower level of education may have lower standards or expectations in their evaluation of health satisfaction or life satisfaction, and accordingly, are more likely to be satisfied than those more educated. Subjects with a higher education level may be more concerned about having oral health and esthetics problems than those with a lower education level, as this may be less accepted in their social circles. Therefore, those with

**Table 6:** Bivariate analysis showing factors affecting OHRQoL of RPD wearers (n = 370)

	OHIP sum		OHIP prevalence	
	Mean ± SD	p-value	n (%)	p-value
<i>Gender</i>				
Male	9.1 ± 8.7	0.007*	25 (25.3)	0.084***
Female	11.6 ± 7.4		45 (16.6)	
<i>Age (years)</i>				
35–40	10 ± 6.4	0.272**	5 (19.2)	0.008***
40–45	9.9 ± 8.4		17 (15)	
45–50	11.5 ± 7.4		20 (14.2)	
Above 50	11.6 ± 8		28 (31.1)	
<i>Marital status</i>				
Single	10.9 ± 7.4	0.209**	4 (11.4)	0.657***
Married	10.5 ± 7.6		53 (20)	
Divorced	11.1 ± 6.3		5 (20.8)	
Widowed	13.2 ± 9.5		8 (17.4)	
<i>Living area</i>				
Rural area	9.4 ± 9.2	0.011*	32 (24.1)	0.08***
Urban area	11.8 ± 6.8		38 (16)	
<i>Education</i>				
Less than high school	11.2 ± 8.6	0.642*	35 (25)	0.028***
High school and above	10.8 ± 7.3		35 (15.2)	
<i>Income</i>				
Low	9.5 ± 8.4	0.061**	23 (31.1)	0.011***
Medium	11 ± 7.5		41 (15.6)	
High	13.4 ± 7.9		6 (18.2)	
<i>General health</i>				
Good	7.5 ± 8	0.001**	15 (24.6)	0.164***
Fair	11.3 ± 7.8		41 (16.3)	
Poor	13 ± 6.2		14 (24.6)	
<i>Medical problem</i>				
Yes	12.8 ± 7.5	0.001*	43 (20)	0.624***
No	8.3 ± 7.4		27 (17.4)	
<i>Oral health</i>				
Good	6.2 ± 6.8	0.004**	5 (20)	0.001***
Fair	11.1 ± 7.7		46 (15.2)	
Poor	12.2 ± 7.9		19 (45.2)	
<i>Tooth number remained</i>				
<15 teeth	11.29 ± 8.81	0.606*	22 (23.9)	0.209***
15 teeth and more	10.81 ± 7.45		48 (17.3)	
<i>Brushing</i>				
Sometimes	11.3 ± 7.4	0.795**	10 (12.7)	0.137***
Always	10.8 ± 7.9		60 (21)	
Never	12.6 ± 8.3		0 (0)	
<i>Bleeding gum</i>				
Sometimes	11.2 ± 8.4	0.006**	32 (18.1)	0.919***
Always	12.5 ± 6.2		18 (19.4)	
Never	9.0 ± 7.8		20 (20)	
<i>Regular visits</i>				
Yes	12.0 ± 7.1	0.005*	21 (10.8)	0.001***
No	9.8 ± 8.3		49 (27.8)	
<i>RPD age (months)</i>				
<6	11.2 ± 7.9	0.041**	31 (21.5)	0.199***
6–12	11.5 ± 7.7		25 (15)	
More than 12	8.6 ± 7.7		14 (23.7)	

	OHIP sum		OHIP prevalence	
	Mean ± SD	p-value	n (%)	p-value
<i>Denture material</i>				
Acrylic	10.6 ± 7.5	0.001*	66 (18.8)	0.757***
Chrome-cobalt	17.2 ± 10.6		4 (22.2)	
<i>Denture status</i>				
Single partial denture	10.3 ± 8.1	0.125*	26 (15)	0.097***
Full mouth partial denture	11.5 ± 7.5		44 (22.3)	
<i>Satisfied with denture</i>				
Yes	9.9 ± 7.1	0.001*	35 (12.2)	0.001***
No	14.7 ± 8.9		35 (42.7)	
<i>Usage time (hours)</i>				
0	21.0 ± 24.0	0.001**	2 (100)	0.009***
Up to 8	12.7 ± 7.8		21 (18.4)	
8–16	11.7 ± 7.2		25 (15.3)	
More than 16	7.1 ± 7.1		22 (24.2)	
<i>Eating with dentures</i>				
Yes	10.1 ± 7.0	0.001*	37 (13.7)	0.001***
No	13.2 ± 9.4		33 (33)	
<i>Sleeping with dentures</i>				
Yes	8.6 ± 7.5	0.009*	12 (19.4)	1.0***
No	11.4 ± 7.8		58 (18.8)	
<i>Cleaning frequency of denture</i>				
Never	13.9 ± 10.7	0.002**	14 (51.9)	0.001***
Up to 7 times per week	11.3 ± 7.0		40 (15.2)	
More than 7 times a week	8.5 ± 8.5		16 (20.3)	
<i>Reason for prescription</i>				
Patients' request	10.3 ± 7.4	0.079*	35 (15.9)	0.098***
Clinician recommendation	11.8 ± 8.4		35 (23.3)	

\*Independent sample t-test; p<0.05 is significant; \*\*one-way ANOVA; \*\*\*Chi-square test; SD: Standard deviation

a lower education level and lower expectations may report better OHRQoL.<sup>9</sup> There was a significant association between living area and OHIP-14 sum in this study. Participants residing in a rural area had a lower OHIP sum and a higher OHRQoL. That can be explained by the fact that people who are living in rural areas are more satisfied with their treatment and they do not protest or ask for more. In previous studies, of the seven studies that evaluated OHRQoL impacts related to the residential area, four had no significant association with OHRQoL, two had reported more impact on rural area dwellers, and one more impact on urban residents.<sup>17</sup> Participants with high- and medium-income levels show better OHRQoL.

The self-perceived dental needs are culturally and behaviorally dependent and rely on the ability to allocate

time and money for this service, as well as priorities in terms of other needs that have a negative impact on activities of daily living. Various studies showed a positive association between degree of poverty and impact on OHRQoL.<sup>17</sup> In this study, there is a significant relationship between OHIP-14 sum, but not prevalence and self-reported general health. Participants who were free from medical problem have a significant association with the OHIP-14 sum. This is similar to the findings of other studies.<sup>18</sup> It has been demonstrated that there was a significant relationship between self-reported oral health and OHIP-14 prevalence and OHIP-14 sum, so that the participants with good oral health had the lowest scores (improved OHRQoL). Our study indicated that there is a significant association between bleeding gums and OHRQoL. Other studies have considered gingivitis as a worse part of OHRQoL in a wide age range of population.<sup>19</sup>

The present study showed that participants who always brush their teeth had lower OHIP sum and a better OHRQoL was associated with more frequent toothbrushing. The number of remaining teeth, which is considered to be the strongest factor of OHRQoL in the previous studies, is not evident in this study. There was no significant association between number of remaining teeth and OHIP sum and OHIP prevalence, but patients who have more remaining teeth had lower OHIP sum and their OHRQoL is generally better. This may be due to limited treatment possibilities, which are much more difficult to implement, with less remaining teeth, for functional and esthetically pleasing solutions.<sup>20</sup> This study showed that patients with acrylic dentures had higher OHRQoL than those wearing metal partial denture. This observation is the opposite to what many specialists would regularly recommend.<sup>10</sup> In many instances, acrylic denture was indicated for immediate esthetic restorations, which can solve major concern of the patients. Furthermore, acrylic dentures are generally cheaper, require less treatment time and are heavily used to restore missing anterior teeth. These factors could explain why the reported OHRQoL by patients wearing acrylic partial denture appears higher. On the contrary, other studies revealed no influence of denture material on patient comfort and satisfaction.<sup>2</sup> Our study also showed that denture status has no significant association with OHRQoL. Patients with one jaw partial denture showed higher OHRQoL than patients with upper and lower partial dentures. This finding is similar to a previous study, which shows that patients with partial prosthetic treatment in both arches had generally higher OHRQoL than those with a full denture treatment in one or more arches.<sup>21</sup>

Our results also show that an inverse relationship exists between RPD experience (years of denture use)

and OHIP. This might be explained by the phenomenon of adaptation. In a previous study, the RPD wearers experienced a more adverse impact of the dentures on the OHRQoL than complete denture wearers.<sup>22</sup> Thus, complete denture wearers might be more accepting to the limitations of denture functions than RPD wearers.<sup>9</sup> Participants with more cleaning frequency and more usage times of their dentures (eating with dentures, sleeping with dentures in their mouth) have lower scores of OHIP and better OHRQoL. This is similar to an Australian study, which showed a significant relationship between the frequency of use (hours/day) and OHIP-14. Decreased frequency of use is inversely proportional to the reported OHIP-14 prevalence, leading to lower OHRQoL. This reflects that acceptance of the RPDs is enhanced by the positive patient attitude toward his/her own oral health. Preshaw et al<sup>13</sup> noted the positive effect of RPD on patients' QoL and satisfaction. The longer the patients used their partial denture, the more the neuromuscular control of the appliance and improvement in their speaking ability. It was also noted that the pain and discomfort caused by using the appliance tended to decrease over time.<sup>10,13</sup> The findings of this study suggested that high satisfaction of removable dentures was significantly related to higher OHRQoL. The technical quality of dentures, technical advice and psychological and emotional factors play an important role in patients' adaptation to their denture. These are similar to other studies.<sup>23</sup>

In our study, it was found that the circumstances of provision for RPD, whether by dentist recommendation or patient perceived needs, were not significantly associated with the OHRQoL. Regular visits to the dentist have a significant relationship with OHRQoL. A patient who regularly visits the dentist had lower OHIP-14 prevalence than others and improved OHRQoL. It must be remembered that the patients' motivation for cleaning the denture decreases with time; therefore, subjects using RPDs should receive regular recalls with oral hygiene instructions. Our study shows that the most problematic aspects were functional limitation and psychological disability. This finding was a similar study of Pakistan.<sup>24</sup>

## CONCLUSION

- Loss of teeth and use of RPD significantly affect patients' oral health status and QoL.
- The self-reported oral health, regular follow-up, denture satisfaction, duration of denture wearing, using the denture while eating, and frequency of denture cleaning positively contribute to OHRQoL. These factors should be considered by the treating clinician and explained to the patient when RPD treatment is planned and executed.

- Dentists should spend more time counseling the edentulous patients before and during denture construction. It has been proved that patients who are satisfied have a better QoL than their unsatisfied counterparts.
- The most frequently reported oral health negative impacts were those related to functional limitation and psychological disability.

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