

Dietary habits, eating practices and DMFT index among adults attending dental clinics in Amman, Jordan

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Recibido: 30/julio/2021. Aceptado: 9/noviembre/2021.

ABSTRACT

Introduction: There is a few studies regarding problems of oral health especially among adult groups in Jordan. This study was designed to use the Decayed, Missing and Filled Teeth (DMFT) index as an indicator for dental health status. Moreover, this index was used to find out the association between dietary habits, eating practices and the dental health status among Jordanians patients who had high DMFT index.

Methods: A private clinic-based cross-sectional study was conducted on 204 patients aged 18-64 years who visited eleven private dental clinics in Jordan. DMFT index was the examination tool of oral health status among the patients. A questionnaire was used during face-to-face interviews to collect data regarding socio-demographic characteristics, anthropometric data, dental behavior, and dietary data. SPSS (version 23) was used to conduct the statistical analysis and the statistical significance set at p-value <0.05.

Results: The mean (SD) values DMFT index in the patients was 14.8 ± 1.3 . About (62.25%) of the patients was classified as "High DMFT index" group which reflects index values higher than 13.9. Variables including age, gender, educational status, frequency of tooth brushing per day, frequency of using mouthwash per day, and smoking, were all used to adjust the relative risk between dietary habits, eating practices and being classified within "High DMFT index" group. It was noticed that the higher frequency intake of soft drinks, candies, chocolate, citric juices, junk foods, Arabic sweets, and sweetened juices, the higher the odds of being classified within "High DMFT index" group.

Conclusion: Unfortunately, our study revealed that the average DMFT index was very high. It is well-known that dental problems may affect patients throughout their lifetime. Therefore, the oral health status among Jordanians should be enhanced through making significant modifications in their dental behavior, dietary habits, and eating practices.

KEY WORDS

Dental behavior, Caries, DMFT index, Dietary habits.

INTRODUCTION

Dental caries is the disease that affecting the teeth of almost every individual during their adult life with an average ranges between 5 and 10 teeth per each individual¹. Actually, dental caries is a global indicator of oral health² and its effect on the quality of life is highly strong³. This disease through its ability in demineralizing and destructing the teeth will cause cavitation of the teeth⁴. In severe cases, dental caries can cause eating difficulty⁵ and also can bad breath⁶. Furthermore, an infection can spread to the surrounding soft tissues of the tooth and this may cause inflammation of these tissues and even may cause tooth loss⁵.

Dental caries measurement is calculated by the sum of the number of decayed (D) teeth, number of missed (M) teeth, and the number of filled (F) teeth (DMFT index)⁷. The Decayed, Missing and Filled Teeth (DMFT) index has is a global index that used in epidemiological studies for assessing the status of oral, dental health, and health status of the community⁸. Moreover, this remarkable index is used in community studies for the evaluation and monitoring of oral health interventions related to this area⁹.

One of the crucial organs of the body that impact people health is the oral cavity which cooperate greatly with different organs in the body¹⁰. Daily activities of people affected by ap-

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appropriate health of this cavity and these activities may include eating, talking, and people appearances and social relationships¹¹. Some practices such as poor tooth brushing habits, increased intake of fermentable carbohydrates, and low level of awareness about oral health are all possible factors for the prevalence of dental caries¹. Likewise, some of the sociodemographic factors and eating habits, also increase the prevalence of dental caries¹².

The prevalence of dental caries varies from country to country but an increased prevalence of dental caries is noticed in developing countries⁷. This is highly attributed to the, socioeconomic conditions in addition to dietary habits and a lack of education¹³. To date, there is a few studies that focused on the oral health especially among adult groups in Jordan. For this reason, the present the aim of the study was to evaluate the DMFT index and the level of severity of the disease among patients attended dentist clinics in Jordan and to study the association of this remarkable index with dietary habits and eating practices of Jordanian people.

MATERIALS AND METHODS

Study Design and Participants

This was a cross sectional study involving a total of 204 patients aged 18-64 years consist of 134 males and 70 females. They were recruited randomly between Jan 2021 to May 2021, from eleven private dental clinics in Amman, Jordan. To calculate the sample size, the following formula was used:

$$n = Z^2_{1-\alpha/2} P(1-P)/e^2$$

Where n is the number of participants, $Z^2 = (1.96)^2$ for 95% confidence, e is the maximum tolerable error for the prevalence estimate (0.05), and P is the "best guess" was estimated as 85%, as was estimated India¹⁴.

Clinical examination (intra-oral examination)

Prior to our visits to the private dental clinics; an agreement was done with an experienced dentist to perform oral examination to determine DMFT index (decayed, missing and filled teeth index) using the procedures determined by the WHO Basic Oral Health Survey¹⁵ method which classify the DMFT index into four categories as shown in (Figure 1). Within the study period, every

patient visited the private dental clinic had signed an informed consent form of the study. Ethical approval was given by Ethics Committee of the Faculty of Agriculture/ Mu'tah University.

Data Collection

Face-to-face interview was performed by with each patient to collect data using questionnaire composed of four sections. The first section included socio-demographic characteristics of the patients. The second part included anthropometric data to determine body mass index (BMI) using the formula: $BMI = \text{weight in kg} / (\text{height in m})^2$. The classification was according to WHO¹⁶ classification in which underweight ($<18.5 \text{ kg/m}^2$), normal ($18.5\text{--}24.9 \text{ kg/m}^2$), overweight ($25.0\text{--}29.9 \text{ kg/m}^2$), and obese ($\geq 30.0 \text{ kg/m}^2$). The third section, which was reviewed by the experienced dentist, included data reacted to dental behavior which investigated frequency of the tooth brushing, the frequency of use mouthwash, and the frequency of dental visit. The last section was validated food frequency questionnaire (FFQ) included questions related to frequency intake of main food groups (fruits, vegetables, milk, grains) in addition to questions related to some unhealthy foods and drinks including (soft drink, candies, chocolate, citric juices, caffeinated drinks, junk foods, Arabic sweets, and sweetened juices). The reliability of the FFQ was calculated using test-retest procedure on a sample of 40 subjects. The value of Spearman's correlation coefficient of reliability was ($r = 0.812$).

Statistical analysis

The statistical analysis of data was performed by using the Graduate Pack SPSS 23.0 for windows 2010. Frequencies and percentages were calculated for the socio-demographic characteristics, oral hygiene habits, smoking, and BMI variables. Differences among subjects within different groups of DMFT index were examined using chi-square test (χ^2) for categorical variables. Adjusted Odds ratios (AOR) were obtained from binary logistic regression test and 95% confidence interval (95% CI) was also determined to find out the dietary habits as predictors for increased DMFT index. The cutoff point was the score of patients within the group of "High DMFT index" (> 13.9).

RESULTS

Socio-demographic characteristics are shown in (Table 1). The patients' age ranged between 18 and 64 years. Most of the patients were higher than 45 years. Regarding gender, males patients were approximately twice of the females patients. Moreover, higher percentages were shown for divorced patients (45.1%), patients with low education level (57.8%), smoker patients (74.5%), and patients with higher monthly income (53.4%) in comparison with other groups within each variable. Surprisingly, the majority of the patients had normal BMI with a percentage of (41.2%). According to our results, most of the patients had negative oral hygiene habits. Most of the patient had never brush

Figure 1. DMFT index Classifications, (WHO, 2013).

DMFT index	Classification
< 5.0	Very low
5.0–8.9	Low
9.0–13.9	Moderate
> 13.9	High

Table 1. Socio-demographic characteristics, oral hygiene habits, smoking, and BMI of the patients attended private dentist clinics (n=204).

Variables		N (%)
Age (years)	18-24	42 (20.6)
	25-34	44 (21.6)
	35-44	57 (27.9)
	45-64	61 (29.9)
Gender	Male	134 (65.7)
	Female	70 (34.3)
Marital status	Single	34 (16.7)
	Married	78 (38.2)
	Divorced	92 (45.1)
Educational status	Low	118 (57.8)
	Moderate	49 (24.0)
	High	37 (18.2)
Frequency of tooth brushing per day	0	121 (59.3)
	1	72 (35.3)
	≥ 2	11 (5.4)
Frequency of using mouthwash per day	0	132 (64.7)
	1	63 (30.9)
	≥ 2	9 (4.4)
Smoking	Yes	152 (74.5)
	No	52 (25.5)
BMI	Underweight	22 (10.8)
	Normal	84 (41.2)
	Overweight	46 (22.5)
	Obese	52 (25.5)
Total income	> 500 JOD	109 (53.4)
	< 500 JOD	95 (46.6)

their teeth or use mouthwash with a percentages of (59.3%) and (64.7), respectively.

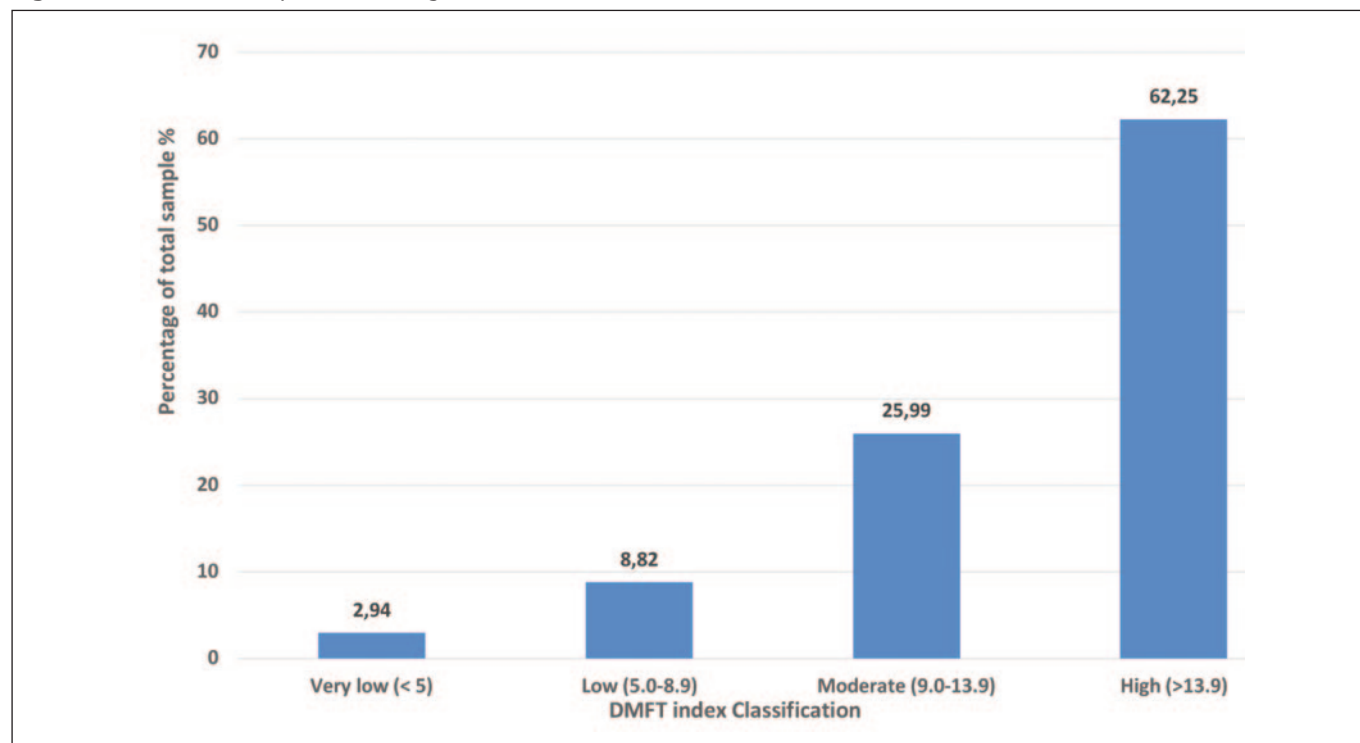
Mean of DMFT index for all participants was 14.8 ± 1.3 . The results as shown in (Figure 2) illustrated that (62.25%) of the patients were within the "High DMFT index" group according to of DMFT index classification with a score (>13.9). The percentages of patients were lower in the other groups with the lowest percentage was among the "very low DMFT index" group (2.94%).

Results of chi-square analysis as shown in Table 2 indicated that the subgroups within each variables either made significant difference within different groups of DMFT index or didn't make any significant differences. Subgroups within the variables of age, gender, educational status, frequency of tooth brushing per day, frequency of using mouthwash per day, and smoking, had all significant differences within groups of DMFT index. Within high DMFT index group, patients with an age 45-64 had a higher prevalence (34.7%) than other groups. Also, males had higher prevalence (73.2%) than females. Likewise, the prevalence was high in a patients with low education status (66.2%), patients who didn't brush their teeth (65.4%), patients who didn't use mouthwash (72.4%), and patients who were smoking (79.5%). On the other hand, subgroups within the rest of the variables including marital status, BMI, and total income, didn't have any significant differences within groups of DMFT index.

Table 3 depicts the dietary habits and eating practices as predictors for increased DMFT index among patients of high DMFT index group. The odds of having higher score of DMFT decreased with higher intake of vegetables, fruits, milk products, and grains, indicating their roles as a protective factors for increased score of DMFT index. In contrast, a higher risk of having higher score of DMFT increased with higher intake of soft drinks, candies, chocolate, citric juices, junk foods, Arabic sweets, and sweetened juices.

DISCUSSION

In our study we used the DMFT index which is a significant tool that is most often used to calculate the level of caries index among different communities¹⁷. Patients in our study were categorized into four groups according to their age. Most of the patients with "High DMFT index" were from elderly participants (45-64) yr old, followed by patients of (35-44) yr old. In comparison to other studies, the DMFT index in people aged 35 to 45 yr old was in Iran, Japan, Malaysia, South Korea, and in Turkey was 14.8%, 12.28%, 12.10%, 5.2%, and 10.8%, respectively¹⁸. The mean value of DMFT index was higher than that found by the National Institute of Dental and Craniofacial Research¹⁹ which indicated that the mean number of DMFT is 10.7 among females between 20 and 64 years of age. Likewise, our results was higher than that found by Liu et al.²⁰ in the study conducted in the Northeast China. The later study indicated that the DMFT index was 13.9.

Figura 2. Distribution of patients among DMFT index classification.

Results of our study showed a significant increase of DMFT with age and this was in accordance with results carried out in Australia²¹. According to gender variable, our results were consistent with that found by a study conducted by Henriksen et al.²² which revealed that a significant increase in decayed teeth in males. Regarding educational level, our results showed inverse correlations between education levels and DMFT and these results reinforce those found by Tafere et al.²³. The findings of this study showed that brushing and using mouthwash enhance the DMFT index. These results are similar to a study carried by Melo et al.²⁴ who reported that regular tooth brushing and using oral mouth washing improved the oral health. Higher percentage of Smokers among Jordanian population was the reason beyond our investigating of its effect on oral health. Our results were in agreement with that found by a study conducted by Golmohamadi et al.²⁵; which concluded that the increased number of smoked cigarettes was associated with higher DMFT index.

Dietary habits are important predictors for oral health. Our results send a warning to people who prefer processed or ready foods more than natural foods. Generally talking, between meals, the consumption of sweetened foods and drinks leads to the development of caries in children and unfortunately is associated with obesity in adults²⁶. In our study, it was found that DMFT index increased with higher intake of soft drinks, candies, chocolate, citric juices, junk foods, Arabic sweets, and sweetened juices. This is in agreement with results of a study conducted by Jones et al.²⁷, which indicated

the presence of significant correlation between the consumption of soft drink and DMFT index. Moreover, many previous studies which revealed a correlation between sugar consumption and caries incidence and in children²⁸ and in adults²⁹. On the other side, our results indicated the protective role of vegetables, fruits, and milk products as higher consumption of these natural foods was associated with lower DMFT index. Actually, these results were in accordance regarding vegetables but was contradicted regarding fruits with a recent study conducted by Tenelanda-López et al.³⁰ in Ecuador, which showed that higher the consumption of vegetables was associated with the lower the levels of caries and that higher risk of having cavities was associated with higher fruit consumption. In addition to that the former study also revealed that Milk consumption was not associated with the caries index.

CONCLUSION

This study revealed that high percentage of dental patients in Amman, Jordan are classified as with "High DMFT index group" and this reflected an alarming issue regarding oral health status. It was obviously noted that the patients with high DMFT index were having higher intake of cariogenic foods such as soft drinks, candies, chocolate, citric juices, junk foods, Arabic sweets, and sweetened juices. In contrast, those patients were not aware of the protective role of some foods that protect them from cavities. Further studies should be conducted to find out more associations with other factors

Table 2. Distribution of patients within different groups of DMFT index in relation to Socio-demographic characteristics, oral hygiene habits, smoking, and BMI variables.

Variables		Very low DMFT index N (%)	Low DMFT index N (%)	Moderate DMFT index N (%)	High DMFT index N (%)	p-value ^a
Age (years)	18-24	3 (50.0)	9 (50.0)	8 (15.1)	22 (17.3)	0.017*
	25-34	1 (16.7)	3 (16.7)	11 (20.8)	29 (22.8)	
	35-44	2 (33.3)	4 (22.2)	19 (35.8)	32 (25.2)	
	45-64	0 (0.0)	2 (11.1)	15 (28.3)	44 (34.7)	
Gender	Male	1(16.7)	7 (38.9)	33 (62.3)	93 (73.2)	0.033*
	Female	5 (83.3)	11 (61.1)	20 (37.7)	34 (26.8)	
Marital status	Single	0 (0.0)	8 (44.4)	9 (17.0)	17 (13.4)	0.779
	Married	3 (50.0)	6 (33.3)	29 (54.7)	40 (31.5)	
	Divorced	3 (50.0)	4 (22.2)	15 (28.3)	70 (55.1)	
Educational status	Low	1(16.7)	3 (16.7)	30 (56.6)	84 (66.2)	0.042*
	Moderate	2 (33.3)	9 (50.0)	9 (17.0)	29 (22.8)	
	High	3 (50.0)	6 (33.3)	14 (26.4)	14 (11.0)	
Frequency of tooth brushing per day	0	5 (83.3)	14 (77.8)	19 (35.9)	83 (65.4)	< 0.001*
	1	1 (16.7)	4 (22.2)	28 (52.8)	39 (30.7)	
	≥ 2	0 (0.0)	0 (0.0)	6 (11.3)	5 (3.9)	
Frequency of using mouthwash per day	0	4 (66.7)	14 (77.8)	22 (41.6)	92 (72.4)	< 0.001*
	1	2 (33.3)	2 (11.1)	28 (52.8)	31 (34.4)	
	≥ 2	0 (0.0)	2 (11.1)	3 (5.6)	4 (3.2)	
Smoking	Yes	2 (33.3)	6 (33.3)	43 (81.1)	101 (79.5)	0.008*
	No	4 (66.7)	12 (66.7)	10 (18.9)	26 (20.5)	
BMI	Underweight	1 (16.7)	5 (27.8)	11 (20.8)	5 (4.0)	0.766
	Normal	2 (33.3)	6 (33.3)	18 (34.0)	58 (45.7)	
	Overweight	2 (33.3)	4 (22.2)	12 (22.6)	28 (22.0)	
	Obese	1 (16.7)	3 (16.7)	12 (22.6)	36 (28.3)	
Total income	> 500 JOD	3 (50.0)	10 (55.6)	29 (54.7)	67 (52.8)	0.494
	< 500 JOD	3 (50.0)	8 (44.4)	24 (45.3)	60 (47.2)	

^a: p- value of chi-square test.

*: Statistical significance at p-value ≤ 0.05.

Table 3. Dietary habits and eating practices as predictors for increased DMFT index.

Variables		High DMFT index	
		AOR ^a (95% CI)	
Frequency intake of Vegetables (serving /d)	> 5	0.48 (0.03-6.01)	< 0.001*
	2-4	0.59 (0.43-12.67)	< 0.001*
	<1	Reference	
Frequency intake of Fruits (serving /d)	> 5	0.81 (0.06-11.71)	0.011*
	2-4	0.98 (0.07-14.48)	0.041*
	<1	Reference	
Frequency intake of Soft drinks (times /week)	> 5	2.42 (1.91-6.67)	0.006*
	2-4	2.94 (2.83-8.82)	0.043*
	<1	Reference	
Frequency intake of Milk products (serving /d)	> 5	0.73 (0.06-8.95)	0.083
	2-4	0.81 (0.04-13.56)	0.071
	<1	Reference	
Frequency intake of Grains (serving /d)	> 5	0.32 (0.03-14.84)	< 0.001*
	2-4	0.41(0.03-9.05)	< 0.001*
	<1	Reference	
Frequency intake of Candies (times /week)	> 5	3.32 (1.09-8.74)	0.033*
	2-4	14.33 (4.01-40.93)	< 0.001*
	<1	Reference	
Frequency intake of Chocolate (times /week)	> 5	6.36 (2.82-19.31)	< 0.001*
	2-4	28.02 (10.77-69.39)	< 0.001*
	<1	Reference	
Frequency intake of Citric juices (times /week)	> 5	3.71 (1.16-11.48)	0.025*
	2-4	11.13 (3.02 -39.49)	< 0.001*
	<1	Reference	
Frequency intake of Caffeinated drinks (serving /d)	> 5	1.84 (0.81-4.93)	0.123
	2-4	1.98 (0.78-5.21)	0.174
	<1	Reference	
Frequency intake of junk foods (times /week)	> 5	4.66 (2.90-9.22)	< 0.001*
	2-4	7.36 (3.34-19.65)	< 0.001*
	<1	Reference	
Frequency intake of Arabic Sweets (times /week)	> 5	8.93 (3.44-23.39)	< 0.001*
	2-4	22.51 (6.73-69.61)	< 0.001*
	<1	Reference	
Frequency intake of sweetened juices (serving/d)	> 5	11.52 (5.08-33.18)	< 0.001*
	2-4	15.41 (22.78-42.57)	< 0.001*
	<1	Reference	

*: Statistical significance at p-value ≤ 0.05 .

^a: adjusted for (age, gender, educational status, frequency of tooth brushing per day, frequency of using mouthwash per day, and smoking).

that may affect oral health. Also, more awareness about appropriate dental behaviors and healthy eating habits are recommended through individual and community levels.

ACKNOWLEDGEMENTS

The author appreciates the efforts of Mu'tah University to give an ethical approval to conduct such crucial study. Moreover, the author thanks all physicians and patients for their cooperation during the time of interviews and examinations.

REFERENCES

- Petersen PE, Bourgeois D, Ogawa H, Estupinan-Day S, Ndiaye C. The global burden of oral diseases and risks to oral health. *Bull. World Health Organ.* 2005; 83(9):661–669.
- Omitola OG, Arigbede AO. Prevalence of dental caries among adult patients attending a tertiary dental institution in South-South region of Nigeria. *P H Med J.* 2012; 6:52–58.
- Cantekin K, Yildirim MD, Cantekin I. As-sessing change in quality of life and dental anxiety in young children following dental re-habilitation under general anesthesia. *Pediatr Dent.* 2014; 36(1):12E-17E.
- Shafer AW, Hine MK, Levy BM, Rajendran R, Sivapathasundharam B. *Shafers textbook of oral pathology.* 6th ed. India: Elsevier India; 2009.
- Laudenbach, JM, Simon, Z. Common dental and periodontal diseases: evaluation and management. *Med Clin North Am.* 2014; 98 (6): 1239–60.
- Saini N, Ajwani P, Kaur K, Kumar A. Oral malodor: a common oral problem. *J Bioeng Biomed Sci.* 2011; 2(1): 1-7.
- Petersen, P.E. The World Oral Health Report 2003: Continuous improvement of oral health in the 21st century—The approach of the WHO Global Oral Health Program. *Commun. Dent. Oral Epidemiol.* 2003; 31 (Suppl. 1), 3–24.
- Broadbent JM, Thomson WM. For de-bate: Problems with the dmft index pertinent to dental caries data analysis. *Community Dent Oral Epidemiol.* 2005; 33(6):400-9.
- Marthaler TM. Changes in dental caries 1953-2003. *Caries Res.* 2004; 38(3): 173-81.
- Tohidast akrad Z, Beitollahi JM, Khajetorab AA. DMFT (Decayed, Missing, Filled, Teeth) Oral Health Index in Sweets and Cable Industry Workers. *Iran J Public Health.* 2006; 35(2):64-68.
- Parker EJ, Jamieson LM. Associations between indigenous Australian oral health litera-cy and self-reported oral health outcomes. *BMC Oral Health.* 2010; 10:3.
- Žemaitienė M, Grigalaukienė R, Vasiliauskienė I, et al. Prevalence and severity of dental caries among 18-year-old Lithuanian adolescents. *Medicina.* 2016; 52(1):54–60.
- Kulkarni SS, Deshpande SD: Caries prevalence and treatment needs in 11-15 year old children of Belgaum city. *J Indian Soc Pedod Prev Dent.* 2002; 20(1): 12–15.
- Patro BK, Ravi Kumar B, Goswami A, et al.: Prevalence of dental caries among adults and elderly in an urban resettlement colony of New Delhi. *Indian J Dent Res.* 2008; 19(2): 95–8.
- World Health Organization (WHO). *Oral health survey: basic method*, 5th ed. Geneva: World Health Organization, 2013.
- World Health Organization (WHO). *Physical status: the use and interpretation of anthropometry.* Report of a WHO expert committee. Technical report series no. 854. Geneva: World Health Organization; 1995 (http://whqlibdoc.who.int/trs/WHO_TRS_854.pdf).
- Wolgin M, Filina N, Shakavets N, Dvornyk V, Lynch E, Kielbassa AM. A systematic review of the caries prevalence among children living in Chernobyl fallout countries. *Sci. Rep.* 2019; 9, 1–10.
- Bernabé E, Sheiham A. Extent of differences in dental caries in permanent teeth between childhood and adulthood in 26 countries. *Int Dent J.* 2014; 64(5):241-5.
- National Institute of Dental and Craniofacial Research. *Dental Caries (Tooth Decay) in Adults (Age 20 to 64)*; 2018.
- Liu L, Zhang Y, Wu W, Cheng M, Li Y, Cheng R. Prevalence and correlates of dental caries in an elderly population in Northeast China. *PLOS-One.* 2013; 8(11):1-6.
- Brennan DS, Spencer AJ: Changes in caries experience among Australian public dental patients between 1995/96 and 2001/2. *Aust N Z J Public Health.* 2004; 28(6): 542–8.
- Henriksen BM, Ambjørnsen E, Axéll T: Dental caries among the elderly in Norway. *Acta Odontol Scand.* 2004; 62(2): 75–81.
- Tafere Y, Chanie S, Dessie T, et al.: Assessment of prevalence of dental caries and the associated factors among patients attending dental clinic in Debre Tabor general hospital: a hospital-based cross-sectional study. *BMC Oral Health.* 2018; 18(1): 119.
- Melo P, Marques S, Silva OM. Portuguese self-reported oral-hygiene habits and oral sta-tus. *Int Dent J.* 2017; 67(3):139-47.
- Golmohamadi MR, Abassi F, Esmaeili M, Jalayer Naderi N. Salivary pH and DMFT index in smokers and non-smokers: a comparative study based on the quantitative rate of smoking. *Avicenna J Dent Res.* 2018; 10(4):140-143.
- Matsuoka Y, Fukai K: Adult dental caries and sugar intake. *Health Sci Health Care.* 2015; 15(1): 22–9.
- Jones C, Woods K, Whittle G, et al.: Sugar, drinks, deprivation and dental caries in 14-year-old children in the north west of England in 1995. *Commun Dent Health.* 1999; 16(2): 68–71.
- Szpunar SM, Eklund SA, Burt BA: Sugar consumption and caries risk in school children with low caries experience. *Commun Dent Oral Epidemiol.* 1995; 23(3): 142–6.
- Ceylan S, Açikel CH, Okçu KM, et al.: Evaluation of the dental health of the young adult male population in Turkey. *Mil Med.* 2004; 169(11): 885–9.
- Tenelanda-López, D., Valdivia-Moral, P., & Castro-Sánchez, M. Eating Habits and Their Relationship to Oral Health. *Nutrients.* 2020; 12(9), 2619.