INTRODUCTION

Decades ago the WHO developed oral disease surveillance systems to monitor dental caries in children. The first global map with DMFT data on 12-year-olds was presented in 1969. This map indicated high prevalence of caries in industrialized countries and generally low values in the developing countries [1].

It is an infectious-contagious disease implying an imbalance of normal molecular interactions between the teeth’s surface/subsurface and the adjacent microbial biofilm. It becomes expressed during a certain period of time as an accumulative demineralization which, if not treated, has the potential for producing cavities in the enamel and collateral damage in dentine and pulpar tissues [2]. The DMFT index was created to express carries experience. The D component is for untreated carries, M for missing teeth due to carries, and F for filling (dental restorations for carries treatment). The T means index per tooth (as opposed to S per surface). The recommended protocol for oral health surveys is based only on clinical examinations and excludes dental radiographs [11]. Most of the dental decay remains untreated with significant impacts on general health, quality of life, productivity, development and educational performance [3, 4, 5, 6].

It is crucial to control the disease process by assessing and rendering the treatment required along with spreading awareness regarding prevention. Several prevalence studies have been conducted and reported on different occasions on the dental carries and the treatment needs in developing countries such as India. However, not much data is available on the prevalence of dental carries and the treatment needs in rural areas of Chennai, India. Clinical indicators are important for the assessment of oral health and treatment needs, nevertheless their limitations must be considered. [12] The associated clinical and subjective indicators define a multidimensional assessment of the oral health condition. [13] The quality of life indicators related to oral health were defined as the measurements of how dental problems and oral disorders interfere in the normal functioning of an individual’s life. [14]

Hence, identifying this disease and determining its magnitude and distribution in populations is a major step in controlling or maintaining it at acceptable levels. [15]

MATERIALS AND METHODS

Sample Collection: The study was conducted in the Thiruvallur region of Chennai, Tamilnadu. The area is considered a rural area. All the people conducted in the study were between the ages of 10-60 years and were selected at random which gave a sample size of 100 participants. All the participants were included in the study after obtaining informed consent.
METHODOLOGY
Apart from this, we recorded basic oral hygiene practices which included frequency of cleaning and materials used to clean the teeth were recorded. The data regarding dental caries experience was recorded using DMFT index for permanent dentition on a structured format. The tooth was considered carious (D) if there was visible evidence of caries or decay, including untreated dental caries. The missing (M component) included teeth with indications for extractions or teeth extracted due to caries. The filled (F component) included filled teeth. Scores were recorded based on their oral health statuses. Finally, the average was calculated, to find the mean DMFT score of the entire study population. Average=Total DFMT/Total number of samples

RESULTS
Among the TOTAL number of participants involved in this study, 53% of them were males and 47% were females. The mean DMFT of participants was 2.58. It was observed that 41% of the participants had decayed teeth, 52% of the participants had missing teeth and only 7% of the participants had filled teeth.

DISCUSSION
 Majority of the participants were male. 53% of the study population was male and 47% were female. The DMFT score was the highest between the age groups of 31-40 with prevalence of high dental caries. This study inferred increased prevalence among the study groups and DMFT status is high. Hence meticulous oral hygiene awareness programs and caries prevention programs need to be done.

The present study showed that these formulas could be useful in studies of larger samples in areas with low prevalence of caries, as they can provide input to support oral health service planning and monitoring.

CONCLUSION
Proper application of preventive methods can reduce incidence of dental caries. This can be possible from the experience derived from the countries where the disease is in decline and it is the right time to get basic information about the disease pattern all over the country, its exact nature, degree of severity and to understand its association with specific factors. Thus, the knowledge of oral health at all ages and in different contexts is vital for decision-making in regard to preventive dental care.[7]

Despite incredible scientific advances and the fact that caries is preventable, the disease continues to be a major public health problem.[16] The World Health Organization (WHO) has ranked dental caries, as number three among all chronic noncommunicable diseases that require worldwide attention for prevention and treatment. [17]

Based on the findings of the present study, it can be concluded that frequency of brushing teeth twice daily was reported to be very low which reveals lacunae in the awareness of oral hygiene measures and its importance on oral health. This implies an urgent need for awareness initiative for preventive dental health behavior and attitudes, which is beneficial for the lifetime.[18]

References
1. Ditmyer, Marcia et al. "Inequalities Of Caries Experience In Nevada Youth Expressed By DMFT Index Vs. Significant Caries Index (Sic) Over Time". BMC Oral Health 11.1 (2011): n. pag. We
2. Pitts NB, Stamm JW. International Consensus Workshop on Caries Clinical Trials (ICW-CCT) - Final consensus statements: Agreeing where the evidence leads. J Dent Res 2004; 83(Spec Iss C):C125-8.
3. SladeGD: Epidemiology of dental pain and dental caries among children and adolescents. Community Dent Health. 2001, 18: 219-227.
4. Thomas CW, Primosch RE: Changes in incremental weight and well being of children with rampant caries following complete dental rehabilitation. Pediatric Dent. 2002, 24: 109-113.
5. Sheiham A: Dental caries affects body weight, growth and quality of life in pre-school children. Br Dent J 2006, 201: 625-626. 10.1038/sj.bdj.4814259.
6. Sheller B, Churchill SS, Williams BJ, Davidson B: Body mass index of children with severe early childhood caries. Pediatr Dent. 2009, 31: 216-221.
7. Pinto VG. A construção do Paradigma de Promoção de Saúde - um desafio para as novas gerações. In: Kriger L, organizador. Promoção da Saúde Bucal. São Paulo: Artes Médicas; 2003.
8. Ditmyer, Marcia et al. "Inequalities Of Caries Experience In Nevada Youth Expressed By DMFT Index Vs. Significant Caries Index (Sic) Over Time". BMC Oral Health 11.1 (2011): n. pag. We
9. U.S. Department of Health and Human Services, Public Health Service: Oral Health Progress Review. 2008, Accessed on February 20, 2011,
10. Dhar V, Jain A, Van Dyke T E, Kohli A. Prevalence of dental caries and treatment needs in the school-going children of rural areas in Udaipur district. J Indian Soc Pedod Prev Dent 2007;25:119-21
11. Becker, Tal, et al. "How much does the DMFT index underestimate the need for restorative care?" Journal of dental education 71.5 (2007): 677-681.
12. Locker D. Issues in measuring change in self-perceived oral health status. Community Dent Oral Epidemiol. 1998; 26(1):41-7. [Links]
13. Biazevic MGH. Indicadores subjetivos em saúde bucal: revisão sistemática [Dissertação de Mestrado]. São Paulo: Faculdade de Odontologia da USP; 2001. [Links]
14. Locker D, Miller Y. Subjectively reported oral health status in an adult population. Community Dent Oral Epidemiol. 1994;22(6):425-30
15. Rebelo, Maria Augusta Bessa et al. "Dental Caries And Gingivitis Among 15 To 19 Year-Old Students In Manaus, AM, Brazil". Brazilian Oral Research 23.3 (2009): n. pag. Web.
16. Sohi RK, Gambhir RS, Veeresha KL, Randhawa AK, Singh G. Assessment of prevalence of dental caries among 5 and 12-year-old schoolchildren in Chandigarh (U.T.), India. Arch Oral Res 2012; 8:39-45.
17. Marrs JA, Trumbley S, Malik G. Early childhood caries: Determining the risk factors and assessing the prevention strategies for nursing intervention. Pediatr Nurs 2011;37:9-15
18. Prabakar J, John J, Srisakthi D. Prevalence of dental caries and treatment needs among school going children of Chandigarh. Indian J Dent Res 2016;27:547-52

How to cite this article:
Noorul Huda Abdul Rahman and Anand (2017)'Dmft Index In Thiruvallur Poplation', International Journal of Current Advanced Research, 06(04), pp. 3368-3370.DOI: http://dx.doi.org/10.24327/ijcar.2017.3370.0275

*******