

Table 1 Mean OHIP summary scores (x) by diagnosis and number of appointments (n)

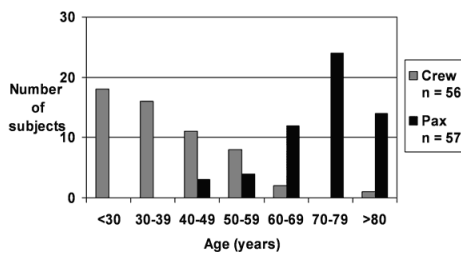


Figure 3 Patients' age distribution (%) of crew and passengers

The vessel in Hong Kong

Conclusions

Differences seen between the two groups are not exclusively attributable to the age factor but represent differing backgrounds in home countries. Socioeconomic factors serve to explain the high standard of prosthetic care in passengers. Crew in general present with less sophisticated prosthetic devices. This is in line with their different socioeconomic status and origin from developing countries. The level of dental fees aboard in comparison to treatment costs in home countries may explain some of the differences in attendance. British officers would find subsidised crew treatment rates low in comparison to private rates at home. Filipino cabin stewards in turn would still receive basic treatment in their home country (extractions) substantially cheaper than on board. Passengers have enjoyed high standards of prosthetic care in the past and will expect a similarly high standard from ship based facilities. The ease of access to quality dental care may explain the relatively low level of perceived problems as characterised by oral health-related quality of life scores. The dental officer aboard has to be prepared to care for very varied diagnostic and treatment needs.

Literature

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DENTAL PRACTICE DURING A WORLD CRUISE: CHARACTERISATION OF ORAL HEALTH AT SEA

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Background

More than 100 million passengers, mostly from industrialised nations, have taken a cruise since 1980. The growing fleet of cruise ships is manned by ever increasing numbers of crew, the majority of whom

come from developing nations. Despite the large numbers of both, crew and passengers involved, little is known about oral health of these two distinctly different populations at sea.

Methods

In a retrospective, descriptive epidemiologic study design the routine documentation of all dental treatment provided on a cruise ship during two months at sea in 2006 was analysed after the voyage. Subjects were $n = 57$ passengers (3.5 % of 1619) with a mean age of 71 (± 9.8) years and $n = 56$ crew (5.6 % of 999) with a mean age of 37 (± 12.0) years. Age, gender, nationality, number of natural teeth

and implants were extracted. The prosthetic status was described by recording the number of teeth replaced by fixed prosthesis and number of teeth replaced by removable prosthesis. Oral health-related quality of life (OHRoL) was measured using the 14-item Oral Health Impact Profile (OHIP-14) and characterised by the OHIP sum score.

Results

Figure 1 Patients prosthetic status (%) and mean number of teeth

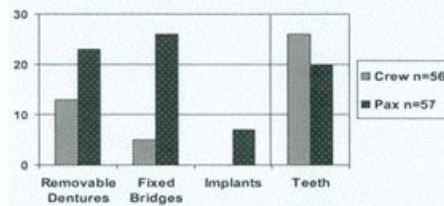


Figure 2 Crew nationality (%) n= 999

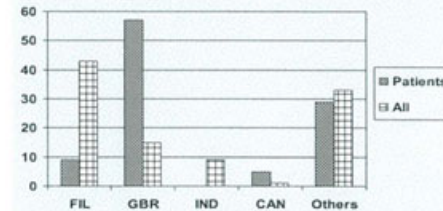
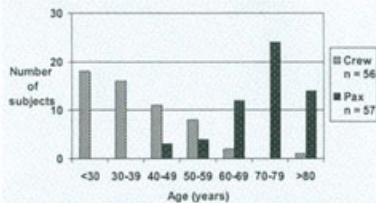


Table 1 Mean OHIP summary scores (x) by diagnosis and number of appointments (n)

Diagnosis	Emergency treatment		Routine treatment			
	Passenger n	Crew n	Passenger n	Crew n	Passenger n	Crew n
Trauma	7	-	-	-	-	-
Pericoronitis	-	1	-	-	-	-
Pulpal disease	14	7	7	22.3 (4.8)	2	0.0
Periodontal disease	3	3	8.0 (5.3)	-	2	1.5 (0.7)
Caries	8	10	20.9 (19.5)	-	16	3.0 (5.9)
Defective restoration	25	5	3.4 (5.5)	1	0.0	4
Defective prosthesis	8	-	-	-	-	-
Others	5	1	8.0 (-)	1	5.0 (-)	30
Mean	7.6 (9.1)	12.3 (11.1)	2.0 (1.9)	3.3 (5.9)		

Figure 3 Patients' age distribution of crew and passengers



Women attended for treatment more often than men. Passengers had a mean number of 20 natural teeth plus substantial fixed and removable prosthodontics. Crew had a mean of 26 teeth. Differences seen between the two groups are not exclusively attributable to the age factor but represent differing backgrounds in home countries. Socioeconomic factors serve to explain the high standard of prosthetic care in passengers. Crew in general present with less sophisticated prosthetic devices.



Conclusion

Passengers have enjoyed high standards of prosthetic care in the past and will expect a similarly high standard from ship based facilities. The dental officer aboard has to be prepared to care for

very varied diagnostic and treatment needs. The ease of access to quality dental care may explain the relatively low level of perceived problems as characterised by oral health-related quality of life scores.