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<tr>
<td><strong>Author(s)</strong></td>
<td>Goh, V; Corbet, EF; Leung, WK</td>
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<tr>
<td><strong>Citation</strong></td>
<td>Journal of Clinical Periodontology, 2016, v. 43 n. 7, p. 595-602</td>
</tr>
<tr>
<td><strong>Issued Date</strong></td>
<td>2016</td>
</tr>
<tr>
<td><strong>URL</strong></td>
<td><a href="http://hdl.handle.net/10722/239524">http://hdl.handle.net/10722/239524</a></td>
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</table>
Impact of dentine hypersensitivity on oral health-related quality of life in individuals receiving supportive periodontal care

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Running title: dentine hypersensitivity in SPC subjects

Key words: dentine sensitivity; oral health; periodontal diseases; periodontitis; quality of life

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Date of resubmission: February 5, 2016

Conflict of Interest and sources of funding statement
The authors declare that they have no conflict of interests. The work described in this paper was substantially supported by a grant from the Research Grants Council of the Hong Kong Special Administrative Region, China (HKU 772110M).

Abstract

Aim: To determine the prevalence and impact of dentine hypersensitivity (DH) on oral health-related quality of life (OHRQoL) in individuals receiving supportive periodontal care (SPC).

Materials and Methods: One hundred and two adults receiving SPC were recruited for a cross-sectional study. Subjects were categorized into those who self-reported DH (DH1) or did not (DH0). Impact of DH on OHRQoL was assessed using the Chinese Condition-Specific Oral Impact on Daily Performance questionnaire (CS-OIDP). Evaluation of DH included tactile-stimulation followed by air-blast, and recorded using a Visual Analogue Scale (VAS).

Results: Sixty-one (59.8%) subjects self-reported DH with mean air-blast VAS score of 29.4 ± 21.3mm and mean tactile-stimulation VAS score of 10.9 ± 14.7mm. Fifty (49%) subjects reported impact on OHRQoL (mean CS-OIDP score = 4.7 ± 6.3). The most affected performance was cleaning the mouth (35.3%). Positive expression of DH and worse OHRQoL were associated with higher air-blast and tactile-stimulation VAS scores, and use of desensitizing agents. The minimally important difference (MID) in CS-OIDP scores was 2.0 points. Approximately 30% of subjects reported CS-OIDP scores above the MID.

Conclusions: Dentine hypersensitivity affects OHRQoL in patients undergoing SPC. The extent of impact was associated with severity of DH.
Dentine hypersensitivity (DH) is defined as a transient pain arising from denuded dentine, usually in response to tactile, thermal, chemical or osmotic stimulation that cannot be explained as arising from any other form of dental deformity or pathology (Dowell & Addy, 1983). DH is one of the most common complaints reported among dental patients (Irwin & McCusker, 1997, Bekes et al., 2009) especially after periodontal treatment (Tammaro et al., 2000, Rees et al., 2003, Lin & Gillam, 2012) occurring in more than half after non-surgical periodontal therapy (Chabanski et al., 1997, von Troil et al., 2002, Lin & Gillam, 2012), and more common after surgical procedures (Lin & Gillam, 2012). In a Chinese community, the prevalence of DH was 67.7% among patients from a hospital periodontology clinic in Hong Kong (Rees et al., 2003).

Previous studies on DH were often aimed at recording patient’s response to stimuli in terms of quantifiable results such as a global visual analogue scale (VAS) score (Al-Wahadni & Linden 2002, Rees & Addy 2002), and these may have evaluated a situation in which DH was artificially stimulated and was not a patient complaint. Patient-centred outcome measures such as oral health-related quality of life (OHRQoL) may offer additional information when used in conjunction with clinical evaluations to estimate the impact of DH on daily function (Bekes et al., 2009, Goh et al., 2015).

Studies on the effects of DH on OHRQoL are lacking (Boiko et al., 2010, Lin & Gillam, 2012, Bekes & Hirsch, 2013). One clinical study observed that most patients seeking treatment for DH reported substantial impact on their OHRQoL and were often limited in eating, drinking and oral hygiene habits (Bekes et al., 2009). DH has been shown to increase immediately after periodontal therapy and gradually reduce over time (Lin & Gillam, 2012, Mantzourani & Sharma, 2013). However, the long term impact of DH on the OHRQoL of treated periodontitis patients remains unclear. The aim of this study was to determine the
impact of DH on the OHRQoL of patients undergoing supportive periodontal care (SPC). The null hypothesis was that DH would have no effect on the OHRQoL of patients under SPC.

4 Materials and Methods

5 Study design

6 The study design was a convenient sample cross-sectional study.

7 Subjects

8 A target of 100 individuals undergoing SPC at the Periodontology Clinic, Prince Philip Dental Hospital (PPDH), The University of Hong Kong was set. Convenient sampling was carried out over 18 months (May 2013 - October 2014). Records of subjects scheduled for SPC were screened with assent from the clinician prior to their appointments.

9 The subjects’ inclusion criteria, modified from guidelines by Holland et al. (1997), were: (1) treated periodontitis subjects aged 18-75 years under SPC with at least 4 standing non-molar teeth, (2) subjects with no remaining pockets ≥ 6mm, (3) no suppuration, (4) bleeding on probing (BOP) ≤ 25% sites, (5) plaque accumulation (measured as plaque index, PI) ≤ 30% sites, (6) satisfactory oral function. The exclusion criteria were: (1) medical and pharmacotherapeutic histories that may alter the response to pain stimuli, (2) expectant mothers, (3) history of eating or systemic disorders predisposing to DH, (4) evidence of increased dietary exposure to acids (assessed with a diet sheet and intra-oral examination for dental erosion), (5) having received root surface debridement or periodontal surgery within the past six months. Subject recruitment procedure is summarized in Figure 1.

13 Further details regarding sample size determination, personal data protection, clinical examination, selection of teeth for assessment of DH, and the OIDP index are shown in Appendix S1.
Assessment of DH

From each subject, two closely matched non-molar teeth were selected for tactile-stimulation and air-blast test.

Tactile-stimulation was carried out with a standard periodontal probe tip (Williams probe, Hu Friedy®, Chicago, IL, USA) directly connected to an electronic pressure sensor. The probe tip was run perpendicular across the CEJ until the subject experienced discomfort, or when a 70g load was reached. Discomfort at a pressure more than 70g was not considered DH and not recorded. This cut-off point has not been confirmed by any studies but follows previous research (Ide et al., 2001). No attempt was made to record the specific load at which the stimulus was triggered. Due to the design of the customized pressure sensitive probe, which needed the probe and sensor to be perpendicular to the tooth, molars had to be excluded.

Air-blast test was carried out with a standard dental triple syringe at a maximal pressure of 90psi and at environmental temperature of 19.5-25.1 (mean 21.6 ± 1.3) degrees Celsius. A one-second air current was applied perpendicular to the buccal root surface 5mm away, as measured with a periodontal probe. Adjacent teeth were shielded with rubber dam strips.

The interval between both tests was set at five minutes though an appropriate time frame has yet to be confirmed (Holland et al., 1997). Subjects scored pain intensity for both tests on a 100mm Visual Analogue Scale (VAS) ranging from 0 mm = ”no pain” to 100 mm = “agonizing pain” immediately after pain was triggered (Ide et al., 2001).

As the sampling unit was at a subject level, average of each DH test per subject was calculated by summation of the VAS scores from the two teeth evaluated then divided by two.
No cut-off point for DH was set as the aim of this study was to evaluate the impact of DH on OHRQoL regardless of DH severity.

**OHRQoL assessment**

OHRQoL was assessed using the validated Chinese version of the Oral Impact on Daily Performances (OIDP) index (Zeng et al., 2010) in a condition-specific form (CS-OIDP). Calculation of CS-OIDP scores, extent and intensity follows the previous reported standard protocol (Tsakos et al., 2010, Zeng et al., 2010).

**Data analysis**

Data were analyzed using the statistical package SPSS 22.0 (SPSS, Chicago, IL, USA). Subjects were categorized into those who complained of DH (DH1) and those who did not (DH0). Standard statistical analyses were conducted to compare subject’s demographic and clinical data. A $p < 0.05$ was considered statistically significant.

Effect size (ES) and the systemic error of measurements (SEM) were calculated to estimate the minimally important difference (MID) for CS-OIDP scores using a distribution-based approached (Tsakos et al., 2012). The ES was expressed as a ratio and interpreted through benchmark values of small (0.2), moderate (0.5) and large (0.8) effect (Cohen, 1988). The SEM was calculated through multiplying the standard deviation of the mean CS-OIDP score by the square root of one minus the reliability of the OIDP index. A difference in score less than the SEM is probably a measurement error. The SEM value is taken as the MID (Tsakos et al., 2010), and scores above the SEM/MID are regarded as clinically meaningful.

Backward stepwise logistic regression was performed to determine any associations between: whether a subject complained of DH, and 14 independent variables. The independent variables were: (i) continuous data – age, remaining standing teeth, mean full-
mouth PPD, REC, CAL, Pl%, BOP%, CS-OIDP score, SPC duration, air-blast and tactile-stimulation VAS; (ii) categorical data – gender, tooth brushing frequency and use of desensitizing toothpaste. The significance level for retention of a variable in the model was 0.05. Associations between CS-OIDP and the aforementioned independent variables were determined through analysis of covariance (ANCOVA).

**Ethics**

The study protocol was approved by the Institutional Review Board of the University of Hong Kong/Hospital Authority Hong Kong West Cluster (IRB reference number: UW 13-228).

**Results**

A total of 102 subjects completed all evaluations. Demographic and clinical data of 102 subjects are summarized in Table 1. Sixty-one (59.8%) subjects self-reported DH (DH1). Subjects who did not report DH (DH0) were slightly older (Table 1). No significant differences were detected between groups in terms of gender distribution, plaque (Pl)%, bleeding on probing (BOP)%, mean full-mouth clinical attachment level (CAL), probing pocket depth (PPD), recession (REC), SPC duration and number of standing teeth. The mean full-mouth CAL for the study population was 3.0 ± 0.6mm, indicating moderate attachment loss (Genco et al., 1999, Ng & Leung, 2006).

Among the 61 DH1 subjects, 59 (96.7%) reported discomfort from the air-blast test with a mean VAS score of 30.4 ± 21.0mm while only 44 (72.1%) responded to the tactile-stimulation test with a mean VAS score of 15.1 ± 15.4mm. Two DH1 subjects reported DH only on their molars and did not respond when non-molar teeth were tested. However, they
reported impacts on OHRQoL. Nine (22.0%) DH0 subjects reported discomfort from the air-blast test with a mean VAS score of 11.4 ± 15.3mm, while four (9.8%) responded to tactile-stimulation test with a mean VAS score of 6.5 ± 5.3mm. All tactile-stimulation test positive subjects were air-blast test positive.

Oral impacts due to DH were common, 50 (82.0%) of the 61 DH1 subjects reported impacts (mean CS-OIDP score = 5.7 ± 6.6) while 11 (18%) did not report any impact. The mean air-blast VAS score for those reporting impacts was 31.3 ± 21.6mm, mean tactile-stimulation VAS score was 11.6 ± 15.6mm. The mean air-blast VAS score for the 11 subjects who reported no impacts was 21.0 ± 18.6mm, mean tactile-stimulation VAS score was 7.6 ± 9.2mm, difference in mean air-blast VAS scores ($p = 0.15$) and mean tactile-stimulation scores ($p = 0.42$) between both groups were not statistically significant. No DH0 subjects reported impact on OHRQoL.

Of the 50 DH1 subjects who reported impacts, cleaning the mouth was the most common daily performance affected (n = 36, 35.3%), followed by eating (n = 35, 34.3%), emotional stability (n = 11, 10.8%), social contact (n = 6, 5.9%), going out (n = 5, 4.9%), sleeping/relaxing (n = 2, 2.0%), smiling (n = 2, 2.0 %) and speaking (n = 2, 2.0%) (Figure 2).

None reported impact upon doing light physical activities. Among reported impacts, 17.2% scored an intensity of “very little”, 50.5% scored an intensity of “little”, 25.2% scored “moderate”, and 7.1% scored “severe”. None reported intensity of “very severe”. Nineteen (18.6%) subjects reported one impact, 19 (18.6%) reported two impacts, six (5.9%) reported three impacts and six (5.9%) reported four impacts. None reported more than four impacts.

The ES was determined at 0.75 which showed a moderate effect size and the SEM/MID was determined as 2.0 points. Thirty-one (30.4%) subjects had CS-OIDP scores above the MID with mean score of 8.4 ± 7.1. This group of subjects showed a slightly different prevalence in impacts with 25 (80.6%) reporting impact on eating, 22 (71.0%)
cleaning the mouth, 10 (32.3%) emotional stability, six (19.4%) social contact, five (16.1%) going out, two (6.5%) speaking, two (6.5%) smiling, two (6.5%) sleeping/relaxing.

Due to inability to effectively assess the air-blast and tactile-stimulation VAS scores of two DH1 subjects with DH only on molars, they were excluded from multivariate analyses.

Results of the logistic regression analysis are summarized in Table 2. When considering factors that influenced whether a subject complained of DH, only three independent variables remained in the final model. These were air-blast VAS score, tactile-stimulation VAS score and the use of desensitizing agent. Higher CS-OIDP score was associated with higher air-blast and tactile-stimulation VAS score, age and using desensitizing agents (Table 3).

For patients identified as possible subjects through clinical records, 45 upon contact had just received root surface debridement and could not partake in the study. Thirty-three could not attend the clinical examination or reschedule their SPC to fit our data collection, of these, 26 (78.8%) agreed to answer questions regarding their DH status over the phone (Figure 1). Fourteen (53.8%) did not experience DH while 12 (46.2%) did. Of the 12 subjects that complained of DH, 11 (91.7%) had DH for more than six months, of these, two (18.2%) reported impacts on daily performances due to DH with mean CS-OIDP score of 8.9 ± 7.6. Both subjects reported difficulty in cleaning the mouth due to DH, one reported impact on relaxing, none reported impacts on any other daily performances.

Discussion

Prevalence, severity and impact of DH on subjects under SPC have so far remained unreported. Though DH may be moderate in intensity and transient in duration (Tammaro et al., 2000, von Troil et al., 2002, Lin & Gillam, 2012), this present study found 59.8% of subjects who have been undergoing SPC for a mean duration of 53.0 ± 57.3 months had a complaint of DH. Similarly, previous research within general Chinese communities found
subjects having endured DH for five years or more (Liu et al., 1998, Wang et al., 2012). A high prevalence of DH in Chinese SPC patients may be due to considerable attachment loss, frequent scaling during SPC, long-term retention of DH prone periodontitis affected anterior teeth, differences in cultural norms and a highly erosive diet (Taani & Awartani, 2002, Rees et al., 2003, Chu et al., 2010, Wang et al., 2012).

The mean age of the present study population was 52.1 ± 10.9 years, and the SPC subjects complaining of DH over the past six months were relatively younger. Earlier studies reported a peak in DH between 40 and 50 years of age, with DH reducing after the fifth decade (Rees et al., 2003, Chu et al., 2011). This may be attributed to age-related alterations within the pulpal space in particular, degeneration of odontoblasts, calcifications, and formation of reactionary dentine (Morse et al., 1993, Espina et al., 2003, Bartold, 2006).

Of the 61 subjects who had a complaint of DH, 59 had clinically detectable DH with the air-blast test while only 44 responded to the tactile-stimulation test. When factors that potentiated DH clinically were evaluated, evaporative stimuli was found to be the most effective stimulus for DH, while a lower percentage of sensitive teeth responded to tactile stimuli (Chabanski et al., 1997, Rees et al., 2003). Among the 41 DH0 subjects, nine (22.0%) responded to the air-blast test and four (9.8%) responded to the tactile-stimulation test. These subjects, though having experienced DH before, may have become accustomed to DH over time and did not register having a problem until tested. This observation points toward the differences in individual pain perception and tolerance which may influence DH experience (Bekes & Hirsch, 2013). A previous study had reported that subjects respond to DH test even when their teeth were completely obscured (Addy et al., 2007). Since subjects in this study could hear the air-blast and see the probe being used, they may have anticipated pain and responded reflexly. Such phenomenon may be true across the entire sample in any DH study,
which reflects the importance of including patient-centered outcome measures in assessing DH. CS-OIDP of zero for DH0 subjects indicate that they were not affected by DH.

Analyzing the impact of DH on OHRQoL can be complex, with limited studies having addressed the impact of DH on OHRQoL (Bekes et al., 2009, Boiko et al., 2010). DH is highly prevalent among periodontitis patients; therefore a condition-specific questionnaire, the OIDP (Adulyanon et al., 1996, Bernabe et al., 2009a&b, Tsakos et al., 2010) translated into the Chinese language (Zeng et al., 2010), was selected for the current study. Condition-specific OHRQoL measures have narrower focuses which increase acceptability by including only important dimensions. A focussed instrument may provide more insights into the consequences of specific oral conditions rather than evaluating overall quality of life in relation to general oral health (Bernabe et al., 2009a, Tsakos et al., 2010, Hvaring et al., 2014). Though a Dentine Hypersensitivity Experience Questionnaire has been developed (Boiko et al., 2010), and translated into the Chinese language (He et al., 2012), it was not available at the start of this study and has not been as widely used as the CS-OIDP.

This study found that the overall mean CS-OIDP score of DH1 subjects was 4.7 ± 6.3. Fifty (82.0%) DH1 subjects reported experiencing impacts while 11 (18.0%) did not. Though all 11 responded to the air-blast test and nine responded to the tactile-stimulation test, they seemed to have become adapted to DH. Adaptation was described as an attempt to normalize the effects of extreme and continuous stimuli (Allison et al., 1997). The effects of a stimulus (DH) are lessened in the short term and reduced in the long term (Allison et al., 1997). The three most reported impacts due to DH were cleaning the mouth (35.3%), eating (34.3%), followed by emotional stability (10.8%), all of which affected subjects from an intensity of “very little” to “severe”. Impacts on social contact, going out, relaxing, smiling and speaking were lesser. While DH exerts significant hindrance on the physical performances of the oral structures and influences an individual’s emotional state, the impact on other daily functions
appears less pronounced. Results from a previous study employing the generic-OIDP within a Chinese population (Zeng et al., 2010) differed slightly from the current observations. That study found that eating was the most prevalent daily performance affected (Zeng et al., 2010). This is similar for other OIDP studies where eating was the most affected performance (Gherunpong et al., 2004, Kida et al., 2006). Though the difference between number of subjects complaining of difficulty in cleaning the mouth and eating in this study was not extensive, no other studies employing the OIDP had, to the extent of our knowledge, reported difficulty in cleaning the mouth to be the most prevalent oral impact. This observation was true even for two non-participating subjects contacted by phone who reported impacts, on whom cleaning the mouth was the most frequent complaint due to DH. This reflects the minor yet significant difference between using a generic-OIDP and a CS-OIDP. Indeed, cleaning the mouth would be a major concern among this group of subjects and the use of the CS-OIDP indicated as such.

Description of the intensity and extent of impacts have previously been used to report oral impacts using the OIDP (Gherunpong et al., 2004, Kida et al., 2006, Zeng et al., 2010). Intensity refers to the highest severity score on any performances which does not consider the aggregate score of all performances but concentrates on the performances that had been most severely affected. Extent of impacts refers to the number of daily performances affected by oral conditions. Such indicators allow differentiation between subjects with a similar overall OIDP score but distinct patterns of impacts on OHRQoL (Zeng et al., 2010). Among the 50 subjects who reported impacts, the most reported intensities were “little” (50.5%) and “moderate” (25.2%). Most subjects reported only one or two impacts on their daily lives, with none reporting effects on more than four performances.

To date there are no guidelines to determine whether a subject with a specific OHRQoL-outcome pattern or score is mildly, moderately or severely compromised by his /
her condition (Tsakos et al., 2012). The MID may provide better interpretability for the
results gathered. The MID is the smallest score or difference in score that is considered
important from the patient’s or the clinician’s point of view (Tsakos et al., 2010). In the
context of this study, the difference in mean CS-OIDP score between the two groups was 4.7.
The ES for this difference was 0.75, which was moderate; while the SEM/MID was
approximately 2.0 points. The difference in CS-OIDP scores between groups exceeded the
SEM/MID considerably and this was considered clinically meaningful (Tsakos et al., 2012).

The CS-OIDP scores for the DH0 group were consistently zero, as such, it can be interpreted
that those reporting a CS-OIDP score above 2.0 (n = 31, 30.4%) had indeed experienced
worse OHRQoL due to DH compared to those who did not. However, this group of subjects
reported eating to be the most affected daily performance, an observation that was somewhat
different from the entire subject pool. A reason for this finding cannot be explained from the
current data. Perhaps future research may shed some light on such results.

Factors that select for experiencing DH are unclear (Tammaro et al., 2000, Al-
Wahadni & Linden, 2002, Amarasena et al., 2010, West et al., 2013). Meticulous oral
hygiene before periodontal therapy significantly reduced DH (Tammaro et al., 2000) and
more tubular openings were found to be occluded when plaque control was good (Suge et al.,
2006). Conversely, increase in prevalence of DH was associated with tooth brushing with
toothpaste due to removal of the smear layer (Addy & West, 2013). When subjects with
periodontal disease were studied, DH was associated with increased gingival recession (Rees
& Addy, 2002, Costa et al., 2014) and radiographic bone loss (Fischer et al., 1991). In the
SPC patients studied having a high prevalence of DH, the distribution of DH appeared to be
unaffected by these aforementioned parameters. Both groups (DH0 and DH1) showed no
differences in full-mouth plaque accumulation, gingival bleeding, oral hygiene habits,
gingival recession and attachment loss, but reported different DH experiences, reinforcing the
assumption that causes of DH are multi-factorial and complex (Al-Wahadni & Linden, 2002, Taani & Awar-tani, 2002, West et al., 2013). From the logistic regression analysis, reporting DH was associated with greater discomfort from the air-blast and tactile-stimulation tests, which was unsurprising. Though the higher percentage of subjects in DH1 using desensitising agents was understandable, the relatively high odds ratio (17.8) for experiencing DH if using desensitizing agents was quite unexpected. However, since subjects in both groups reported using a variety of self-applied desensitizing agents, no definite conclusion could be drawn from this observation. The CS-OIDP scores give a quantitative estimate of how DH undermines OHRQoL. Factors that were found to be associated with the severity of impact on subjects’ daily lives were air-blast VAS score, tactile-stimulation VAS score, age and the use of desensitizing toothpaste. Increases in air-blast and tactile-stimulation VAS scores were associated with corresponding increases in CS-OIDP scores, suggesting that the severity of clinically tested DH was linked to worse OHRQoL. Though both the air-blast and tactile-stimulation tests may be used to estimate the impact of DH on OHRQoL, results must be interpreted with caution as the increases in CS-OIDP scores were minimal. Increasing age was associated with greater impact on OHRQoL due to DH. This was similar to a previous research which found older adults reporting worse OHRQoL due to DH (Bekes et al., 2009). The use of desensitizing agents also predicted higher CS-OIDP scores. When the results of this study are viewed in their entirety, subjects with greater severity of DH clinically and using desensitizing products had a greater tendency to report DH and experienced worse OHRQoL.

Due to the cross-sectional design of this study, certain factors (e.g. previous periodontal treatment, desensitizing therapy, SPC duration) could not be controlled. A longitudinal study with subjects grouped according to type of periodontal therapy received, evaluated for DH and monitored for an appropriate period may be able to reduce such
Another limitation of this study was difficulty in subject recruitment. Within the confines of the selection criteria, subjects suitable for the study were constrained. Many potential subjects who showed recurrent periodontal disease and insufficient oral hygiene through their records and during examination were excluded from the study. This may be due to the fact that patients recommended for regular SPC in a teaching-hospital usually have higher periodontal disease risk (Leung et al., 2006). A longer duration for subject recruitment in future research might prove beneficial. As molars were excluded in the DH test, use of alternative DH assessment procedures to allow evaluation of molars may be considered. However, to date, control and reproducibility of many DH assessment methods are limited (Holland et al., 1997, Ide et al., 2001).

**Conclusion**

This study evaluated the impact of DH on OHRQoL among patients receiving SPC. Within the limits of this study, DH appears to undermine the OHRQoL of patients who had completed periodontal treatment. The extent of impact is positively associated with the clinical severity of DH. The minimally important difference in CS-OIDP scores was 2.0 points, with approximately one third of patients experiencing poorer OHRQoL due to DH. The most affected daily performance was cleaning the mouth, an observation that is pertinent in the delivery of SPC care for treated patients. Though DH tends to reduce in intensity after periodontal treatment, its mild but prolonged presence may negatively affect the daily lives of patients. More research is warranted to clarify this relationship and identify the best therapeutic protocol to minimize negative effects of DH.

**Acknowledgement**
The work described in this paper was substantially supported by a grant from the Research Grants Council of the Hong Kong Special Administrative Region, China (HKU 772110M).

We acknowledge Dr. Xiaojuan Zeng who provided us with the Chinese version of the OIDP questionnaire.

Words count (except Acknowledgement): 4026

Supporting Information

Additional Supporting Information may be found in the online version of this article:

AppendixS1. Materials and Methods; The Oral Impact on Daily Performances (OIDP) index

Clinical Relevance

Scientific rationale for the study: Prevalence and impact of DH on OHRQoL in patients under SPC remains unreported.

Principal findings: A majority of patients under SPC experience DH and report worse OHRQoL. The MID for CS-OIDP scores was 2.0 points with approximately 30% of subjects reporting a higher value. The most affected performance was cleaning the mouth.

Practical implications: Patients may experience prolonged DH after periodontal treatment which impairs OHRQoL. Clinicians should pay attention towards patients who self-report such symptoms during SPC, apply and advise use of desensitizing agents, and develop better desensitizing strategies to counter such effects.

Words count: 98
References


Legend

Fig. 1. Flow chart on subject recruitment. All patients regardless of study participation, continued their SPC in the Periodontology Clinic.

Fig. 2. Frequency and intensity of oral impact on daily performances (n = 102)
Table 1. Characteristics of subjects, with (DH1) or without (DH0) a complaint of dentine hypersensitivity (n = 102)

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<td>No. of standing teeth</td>
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<td>61 (59.8)</td>
<td>38 (37.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used desensitizing agent (n)</td>
<td>Yes</td>
<td>41 (40.2%)</td>
<td>15 (14.7%)</td>
<td>χ²</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>20 (19.6%)</td>
<td>26 (25.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPC Duration (months)</td>
<td></td>
<td>57.3 ± 60.2</td>
<td>45.9 ± 52.4</td>
<td>t</td>
<td>0.419</td>
</tr>
<tr>
<td>Clinically detectable DH (n)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response to air-blast</td>
<td>Yes</td>
<td>59 (57.8)</td>
<td>9 (8.8)</td>
<td>Fisher</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2 (2.0)</td>
<td>32 (31.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAS score (mm)</td>
<td></td>
<td>29.4 ± 21.3</td>
<td>2.5 ± 8.3</td>
<td>t</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Response to tactile stimulation</td>
<td>Yes</td>
<td>44 (43.1)</td>
<td>4 (3.9)</td>
<td>Fisher</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>17 (16.7)</td>
<td>37 (36.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VAS score (mm)</td>
<td></td>
<td>10.9 ± 14.7</td>
<td>0.6 ± 2.4</td>
<td>t</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Affects OHRQOL (n)</td>
<td>Yes</td>
<td>50 (49.0)</td>
<td>0</td>
<td>Fisher</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----</td>
<td>-----------</td>
<td>---</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>No</td>
<td>11 (10.8)</td>
<td>41 (40.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CS-OIDP score</td>
<td>4.7 ± 6.3</td>
<td>0.0</td>
<td></td>
<td>t</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

Values are shown as mean ± SD; percentage in parenthesis unless stated otherwise; t: T-test, \(\chi^2\): Pearson’s Chi square test, Fisher: Fisher’s exact test; level of significance set at \(p < 0.05\).

VAS: Visual analogue scale; OHRQoL: Oral health-related quality of life; Affects OHRQoL: Subjects with CS-OIDP score > 0.
Table 2. Results of logistic regression analysis on factors affecting whether a subject does or does not complain of DH ($n = 100$)

<table>
<thead>
<tr>
<th>Factor</th>
<th>β (SE)</th>
<th>Odds Ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air-blast VAS score</td>
<td>0.20 (0.06)</td>
<td>1.22 (1.09-1.36)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Tactile-stimulation VAS score</td>
<td>0.24 (0.11)</td>
<td>1.27 (1.02-1.57)</td>
<td>0.034</td>
</tr>
<tr>
<td>Use of desensitizing agent$^a$</td>
<td>2.88 (0.99)</td>
<td>17.80 (2.56-123.52)</td>
<td>0.004</td>
</tr>
<tr>
<td>Constant</td>
<td>-3.99 (1.08)</td>
<td>0.019 (0.019-0.019)</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

$^a$Not using desensitizing agent as reference group
Table 3. Results of Analysis of Covariance on factors that affected CS-OIDP score (n = 100)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Estimate</th>
<th>SE</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air-blast VAS score</td>
<td>0.10</td>
<td>0.02</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Tactile-stimulation VAS score</td>
<td>0.13</td>
<td>0.03</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Use of desensitizing agent(^a)</td>
<td>1.77</td>
<td>0.66</td>
<td>0.009</td>
</tr>
<tr>
<td>Age</td>
<td>0.06</td>
<td>0.03</td>
<td>0.046</td>
</tr>
<tr>
<td>Intercept</td>
<td>-4.44</td>
<td>1.81</td>
<td>0.016</td>
</tr>
</tbody>
</table>

\(^a\)Adjusted \(R^2 = 0.476, F = 23.474, p < 0.001\)
\(^a\)Not using desensitizing agent as reference group
For Peer Review

Fig. 1. Flow chart on subject recruitment. All patients regardless of study participation, continued their SPC in the Periodontology Clinic.

163x232mm (300 x 300 DPI)
Fig. 2. Frequency and intensity of oral impact on daily performances (n = 102)
104x84mm (300 x 300 DPI)
Materials and Methods

Sample size determination

The sample size was estimated as follows: Based on an earlier report on OHRQoL in periodontitis patients (Aslund et al., 2008), 251 subjects were sufficient for a cross-sectional study using the Basic Periodontal Examination and a general OHRQoL questionnaire. Considering the more intricate data collection procedures, and that approximately 70% of the local periodontal clinic attendees were affected by DH (Rees et al., 2003), a cohort of 100 periodontitis subjects undergoing SPC was considered appropriate when confidence interval was set at ± 5%, with estimated error of 0.1%, and estimated prevalence of impact on OHRQoL of 50%.

Personal data protection

The PPDH is a university affiliated teaching-hospital. All patients had during admission signed a consent form agreeing to have their records accessible for clinical training and research purposes. As such, access to patient records was pre-consented. Nevertheless, the study protocol including the periodontal patient records screening was approved by the appropriate Institutional Review Board. Collected data were all stripped of personal identifiers.

Clinical examination

Clinical assessment included an update on each subject’s medical, dental and treatment history, use of self-applied desensitizing agents, oral hygiene practices and DH experience within the previous six months. Clinical examination included number of standing teeth, PI%, BOP%, clinical attachment level (CAL), recession (REC) and probing pocket depth (PPD) measured at six sites (mesio-buccal, mid-buccal, disto-buccal, mesio-lingual, mid-lingual,
disto-lingual) on each tooth according to previous protocols (Wong et al., 2012). All
examinations were carried out by a single operator (VG).

Selection of teeth for assessment of DH
From each subject, two closely matched non-molar teeth were selected for tactile-stimulation
and air-blast test. Non-molar teeth directly identified by the subject as being sensitive were
given priority for testing. To reduce the chances of non-response being due to possible pulpal
causes, only teeth responding to pulp sensibility test were selected. The inclusion criteria for
teeth selection were: (1) non-molar teeth, (2) responsive to pulp sensibility test, (3) absence
of radiographic periapical pathology. Exclusion criteria were: (1) teeth or supporting
structures with potentially pain-related pathology e.g. caries, increased mobility, (2) teeth
with history of trauma, (3) abutments for fixed or removable prostheses, and (4) heavily
restored teeth. The teeth were selected from the upper or lower arch only (decided by a coin
toss; heads: maxilla, tails: mandible), from contralateral quadrants, with tooth type matched
as closely as possible. If more than one non-molar tooth was sensitive, the most severely
affected tooth was selected and matched with its contralateral counterpart. If the subject was
unable to pinpoint sensitive teeth or had no sensitive teeth, the test teeth were randomly
selected with a dice (e.g. dice roll of no. 5 = second premolars). This was performed until
suitable non-molar teeth were selected. Presence and location of any molar teeth with DH
were recorded as well.

The Oral Impact on Daily Performances (OIDP) index
The Oral Impact on Daily Performances (OIDP) evaluates oral impacts on nine basic daily
performances: (1) eating, (2) speaking, (3) cleaning the mouth, (4) light physical activities, (5)
going out, (6) sleeping/relaxing, (7) smiling, (8) emotional state, and (9) social contact. The
OIDP was designed to associate specific oral health problems with impacts on daily life, thereby linking such impacts to the specific oral condition of interest (Bernabe et al., 2009a). This has enabled the OIDP to be used as a condition-specific OHRQoL measure (Bernabe et al., 2009a&b, Tsakos et al., 2010, Hvaring et al., 2014).

Higher CS-OIDP scores represent worse OHRQoL. The CS-OIDP extent was calculated as the number of performances affected by impacts, ranging from none to nine. The CS-OIDP intensity was estimated as the highest severity of impact on any of the nine daily performances, ranging from none to very severe (Zeng et al., 2010).

References


dentine hypersensitivity in a hospital clinic population in Hong Kong. *Journal of

Tsakos, G., Bernabe, E., D’Aiuto, F., Pikhart, H., Tonetti, M., Sheiham, A. & Donos, N.
(2010) Assessing the minimally important difference in the oral impact on daily


STROBE Statement—Checklist of items that were included in the current cross-sectional study

<table>
<thead>
<tr>
<th>Item No</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Title and abstract | 1 (a) Study design  
Page 2, Abstract, under the heading: Materials and Methods, line 2: cross-sectional study  
(b) Balanced/informative abstract  
Page 2, Abstract given in the format of: 1) Aim, 2) Materials and Methods, 3) Results, 4) Conclusions |
| Introduction | 2 Explain the scientific background and rationale for the investigation being reported  
Definition and prevalence of dentine hypersensitivity as well as findings from previous studies explained under introductory paragraphs (See main text, paragraphs 1, 2 and first part of 3) on page 3.  
Rationale for study explained in paragraph 3, page 3&4. |
| Objectives | 3 State specific objectives, including any prespecified hypotheses  
See text, page 3, last line – page 4, lines 1-2. |
| Methods | 4 Present key elements of study design early in the paper  
See text, page 4, under Materials and Methods: Study Design |
| Setting | 5 Describe the setting, locations, and relevant dates, including periods of recruitment, and exposure  
See text, page 4, under Materials and Methods, Subjects  
Describe follow-up  
Cross sectional study, no follow up appointments were given. Subjects continued with scheduled SPC.  
Refer to: Figure 1. Flow chart on subject recruitment. All patients regardless of study participation, continued their SPC in the Periodontology Clinic. |
| Participants | 6 Eligibility criteria for participants  
See text, Materials and Methods, under the headings: 1) Subjects  
Sources and methods of selection of participants  
Please see text, Materials and Methods, under the headings: 1) Subjects |
| Variables | 7 Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers.  
Please see text, Materials and Methods, under the headings: 1) Subjects, 2) Assessment of DH, 3) OHRQoL assessment; and AppendixS1, under Materials and Methods, 1) Clinical examination, 2) Selection of teeth for assessment of DH |
| Data sources/ measurement | 8* For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group  
All demographic data, clinical variables, assessment protocols and measurements are...
described in detail under:

- See text, Materials and Methods 1) Subjects, 2) Assessment of DH, 3) OHRQoL assessment, 4) Data analysis (Pages 4-7); and
- AppendixS1, Materials and Methods, 1) Clinical examination, 2) Selection of teeth for assessment of DH, 3) The Oral Impact on Daily Performances Index (Page 1-3).

Grouping of subjects are explained in Data analysis; summarized in Table 1.

Bias 9

Describe any efforts to address potential sources of bias
- See text, Materials and Methods, under Subject selection, regarding explanation on inclusion and exclusion criteria to minimize confounding factors; the study followed specific published guidelines on dentine hypersensitivity research (Holland et al., 1997, Ide et al., 2001, Tsakos et al., 2010, Zeng et al., 2010).
- Also in AppendixS1, under the heading: Clinical examination (All examinations were carried out by a single operator: VG)
- Use of a condition-specific OHRQoL questionnaire may reduce potential bias due to effects from other conditions as discussed under: Discussion, page 11, lines 3-14
- Molar teeth were excluded (see text, Assessment of DH, page 5, lines 11-13)

Study size 10

Explain how the study size was arrived at
Please see AppendixS1, page 1, Materials and Methods, under the heading: Sample size determination

Quantitative variables 11

Explain how quantitative variables were handled in the analyses.
See main text, Materials and Methods, page 6, under the heading: Data analysis

If applicable, describe which groupings were chosen and why
See text, Materials and Methods, page 6, under the heading: Data analysis, first paragraph.
See also attached Table 1, for all variables assessed.

Statistical methods 12

(a) Describe all statistical methods, including those used to control for confounding
See text, Materials and Methods, page 6, under the heading: Data analysis

(b) Describe any methods used to examine subgroups and interactions
See text, Materials and Methods, page 6, under the heading: Data analysis; see also Tables 1, 2, 3

(c) Explain how missing data were addressed
Not applicable, no missing data from participating subjects.
26 dropout subjects were interviewed by phone (see text, page 9, lines 10-18). This data was not included in the analysis

(d) If applicable, describe analytical methods taking account of sampling strategy
Not applicable

(e) Describe any sensitivity analyses
Not applicable

Results

Participants 13*

(a) Report numbers of individuals at each stage of study—e.g. numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed
See text, Results, page 7, lines 13-15
See text, Results, page 9, lines 10-18 (Final paragraph for Results)
See also Figure 1. Flow chart on subject recruitment

(b) Give reasons for non-participation at each stage
See text, Results, page 9, lines 10-18 (Final paragraph for Results)
See also Figure 1. Flow chart on subject recruitment

(c) Consider use of a flow diagram
See Figure 1. Flow chart on subject recruitment
Descriptive data 14*

(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders.
See Table 1.

(b) Indicate number of participants with missing data for each variable of interest.

No missing data for participating subjects.

Outcome data 15*

Report numbers of outcome events or summary measures.
See Table 1.

Main results 16

(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (e.g., 95% confidence interval). Make clear which confounders were adjusted for and why they were included.
Not applicable.

(b) Report category boundaries when continuous variables were categorized.
See Table 1.

(c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period.
Not applicable.

Other analyses 17

Report other analyses done—e.g. analyses of subgroups and interactions, and sensitivity analyses.

Please see text, Materials and Methods, under the heading: Data analysis (page 6).
See Tables 1, 2, 3;
See also text, Results (page 9, lines 3-9) for explanation about the multivariate analyses and interactions between variables.

Discussion

Key results 18

Summarise key results with reference to study objectives.

See text, under: Discussion (page 9). All results are discussed with appropriate reference to study objectives/aim.
See page 11, line 3-25, page 12, line 1-23. Key results on impacts of DH on OHRQoL are discussed in detail.
See also Table 2. for results on factors influencing DH experiences.
See also Table 3. for results on factors affecting OHRQoL.

Limitations 19

Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias.

See text, page 14 lines 22-25, page 15, lines 1-10 (limitations discussed in detail).

Interpretation 20

Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence.

See text, under Discussion, page 9: All results are discussed and explained within the limits of this study with appropriate references as support (if available).
See text, under Conclusion, page 15: All results including prevalence of dentine hypersensitivity (DH), factors affecting a complaint of DH, factors affecting impairments in OHRQoL, severity and areas of OHRQoL affected by DH and generalization of results are given; See text, under Clinical Relevance, Practical implications, page 16.

Generalisability 21

Discuss the generalisability (external validity) of the study results.

See text, under Clinical Relevance, Practical implications, page 16.

Other information

Funding 22

See text, page 1, under: Conflict of interest and sources of funding statement.
See also main text, under Acknowledgement, page 15, line 24, page 16, lines 1-4.

*Give information separately for exposed and unexposed groups.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely