

ROMANIAN CHILDREN'S PERCEPTION OF DENTAL CAVITIES AND GINGIVAL BLEEDING IN CORRELATION WITH PERSONAL ORAL BEHAVIOURS – A CROSS SECTIONAL STUDY

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ABSTRACT

Aim of the study. The aim of the study was to evaluate the Romanian children's perception regarding 2 of the most common oral pathologies, dental caries and gingivitis in correlation with oral health behaviours. **Methods.** This was a cross-sectional study. The answers to 2 questionnaires distributed to children 12-15 years old from 2 schools in Bucharest, Romania were analyzed. One questionnaire included questions related to oral pathology, and the other to oral health maintenance behaviour. In our dental research study we made use of descriptive statistics in order to summarize continuous and categorical variables. The test used to examine relationship between children's perceptions and their behaviours was Roa-Scott chi-square test **Results.** All 137 children who participated in the study completed both questionnaires. Among them, 62% considered that a broken tooth is not a form of disease, but still 94.8% of them would go to the dentist. Regarding gingival bleeding, even if its presence as a sign of illness was not conclusive, most children (78.8%) considered that this sign requires medical attention. The frequency of sugar consumption in our study was low in 80.3% of children, and the frequency of brushing was more than once a day for 77.4% of subjects. **Conclusions.** Although most children perceived dental cavity as a disease and, gingival bleeding as not a sign of illness., there was a consensus regarding both conditions, that is, the necessity of dental treatment. Awareness of the need for dental treatment in case of signs for these two diseases is very important for promoting preventive dental programs for children.

Key words: caries, gingival bleeding, dental treatment, brushing, questionnaires.

INTRODUCTION

Oral cavity is most frequently affected by carious lesions and periodontitis, both with a bacterial starting point, but with etiopathogenesis specific to the structural particularities of the affected entities, the tooth its supporting tissues respectively [1].

Periodontal diseases (gingivitis and periodontitis) are considered inflammatory

chronic diseases of the supporting structure of the teeth. The determining factor in the appearance of these diseases is the accumulation of bacterial plaque above and below the gingiva, associated with an inadequate inflammatory immune response [2]. Along with the determining factor, a favorable role is played by certain oral and systemic circumstances. The American

Academy of Pediatrics Dentistry (AAPD) states that "gingivitis is nearly universal in children and adolescents, it usually responds to through removal of bacterial deposits and improved oral hygiene and the self-administered plaque control programs without periodic professional reinforcement are inconsistent in providing long-term inhibition of gingivitis"[3]. Thus, it was clearly demonstrated that gingivitis induced by bacterial plaque is present at all ages [4],[5] and that it is also the most common condition among children and adolescents, reaching a maximum prevalence of 80% at 11-13 years of age [6]. Superficial forms of periodontopathie called gingivitis are found both in children and in adults, and can evolve into deep forms with resorption of the alveolar bone, going up to the avulsion of the tooth [7],[8].

Epidemiological studies show that in children and adolescents the most common form of gingivitis is that induced by bacterial plaque, which has the advantage of being reversible and non-destructive of the periodontal tissues [9]. A study conducted by Ullah in 2002 on 12-year-old children found that 44.3% of them had poor hygiene and gingival bleeding [10]. Additional studies indicate that professional control and self-control of bacterial plaque in combination with fluoride has reduced the development of carious lesions in children and adolescents and has also led to the inactivation of root carious lesions in the elderly [11],[12].

Cariou lesions are presented as an ubiquitous process, and defined as the result of a chemical dissolution located on the surface of the teeth, caused by the acid produced by specific bacterial dental biofilm exposed frequently to sugars [13]. Dental caries is one of the most common diseases of the oral cavity, with a high prevalence throughout the world [14]. This is not a condition encountered only in childhood, it can also appear in adulthood [15].

Correlating these two etiopathological mechanisms it was asserted that emerging bacteria in the bacterial plaque, becomes a determining biological factor, in the appearance of periodontal diseases and carious lesions [16]. Consequently, multiple studies have underscored the importance of mechanical removal of dental plaque by correct tooth brushing [17],[18],[19] and also through the use of secondary means of hygiene [20].

Adolescence is a period of transition from childhood to adulthood and is characterized by physical, psychological and social transformations and can represent a favorable period for the formation of healthy oral concepts and behaviours [21],[22].

The children first visit to the dentist is recommended to be in the first year of life or when the first tooth erupts [23],[24]. In reality, most children have their first visit to the dentist at the age of 3-6 years, many of them for dental care, such as caries or its complications and less for prevention [25].

Public health departments around the world are seeking to develop various prevention programs to address poor oral health and its subsequent effects on the overall health and quality of life [26]. Oral health education and oral promotion can be provided through several means: pediatricians (who are the first that interact with parents and children), hospitals, care centers, private dental clinics, as well as kindergartens and schools [27]. Schools are perhaps the best place to promote oral health because school years cover a period that runs from childhood to adolescence [28]. Children are extremely receptive during this period and the earlier the oral habits are established, the longer the impact will last. Even more, these messages can be reinforced regularly during the kindergartens and then in the school years when the children tend to be independent, for a better fixation of habits [29]. Also, regular visits to the dentist are

extremely important because they can offer prevention and treatment measures for children, and also can guide them to a correct attitude regarding oral health [30].

This study aims to evaluate the perception and behaviours of the Romanian pupils, aged 12 to 15 in terms of oral health and oral hygiene habits.

MATERIALS AND METHODS

Study population

This cross-sectional study took place between January 2022 and April 2022 and targeted 137 children aged 12-15 years old, attending two secondary schools located in Bucharest. The respondents were requested to fill out two questionnaires, one related to their perception of oral disease, and the other addressing their oral health behaviour. All the 137 children answered completely to the two proposed questionnaires.

The questionnaires included a small number of suggestive questions that have been used in published studies and that have proven to meet the applicability and understanding criteria of 12-15 years old children.

The study was approved by the Scientific Research Ethics Committee of "Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania (Protocol No. 28447/18.10.2021).

Questionnaire

The two validated questionnaires were adapted, with author permission Mohamed Eaisalhy, in Romanian language [31].

For the translation of the original questionnaires were used two English language teachers who translated from English into Romanian. After the adaptation and completed results, the questionnaires were retranslated into English by two Romanian doctors with Canadian and British citizenship (Appendix A, Appendix B).

Following the translation, a version was built as simple as possible, with questions that should be at the level of knowledge and understanding of 12-15-year-old children, and with most of the answers with Yes/No/I don't know in order not to put them in difficulty.

Questionnaire components

In the questionnaire related to the perception of oral disease, children were asked to answer 8 questions about the severity and the presence of signs of illness in terms of carious lesions and gingivitis, well as concerning the importance of brushing and addressability to the dentist, and they were included in Table 1.

For the carious pathology were used the terms of broken tooth, and for periodontal pathology the term of the major sign: gingival bleeding.

The other questionnaire was focused on the oral health behaviour by answering to 5 questions related to the consumption of sweets and soft drinks, tooth brushing and visits to the dentist also including the frequency of the behaviours Table 2.

Statistical analysis

The data analysis was carried out using the excel program, and the associations between children's perception and behaviours were analyzed using IBM SPSS.

In our dental research study we made use of descriptive statistics in order to summarize continuous and categorical variables. We estimated the means (SD) for continuous variables and frequencies for categorical ones. We considered some key outcomes about children's oral health behaviours such as frequency of sugar intake, brushing habit, using fluoride toothpaste and regular visit to dentist.

The test used to examine relationship between children's perceptions and their behaviours was Roa-Scott chi-square test. In

addition, multivariate logistic regression analyses were conducted for each behaviour by creating new dependent variable in turn which were dichotomized into 'good' or 'not good'. Good behaviours included low frequency of taking sugars (0–3 times), brushing twice or more per day, consistent use of fluoridated toothpaste and regular dental attendance.

Various perception-related factors were taken as independent variables. Mixed effect logistic regression was used to take care of possible clustering effects. Statistically significant level was set at $p < 0.05$. P-values were also adjusted for multiple comparisons using false-discovery rate method with alpha level of 0.05.

RESULTS AND DISCUSSIONS

Results

From the analysis of the answers, it is found that all the questions were completed, which means that they were understood by the respondents.

Out of 137 children who answered our questionnaires, 58 were boys (42.34%), and 79 were girls (57.66%), with an average age of 12.8 years, (SD=1.05 years).

Questionnaire on children's perception

Regarding the decay pathology, 62% of children considered that a broken tooth is not a disease, more than half of them (60.6%) agreed that people with a broken tooth are sick. Among the respondents, 94.8% would visit the dentist when they notice the presence of a carious lesion.

For the study group, gingival bleeding was a less important clinical sign. Even if 73.7% of them considered that a medical treatment is necessary in case of gingival bleeding, and 78.8% would go to the dentist due to this manifestation, only 33.5% believed that gingival bleeding is a sign of disease.

Regarding tooth brushing, 66.4% of

children considered that it is necessary to be performed twice a day. With regard to use of dental floss as a secondary means of oral hygiene, 65.7% of them believed that it should be used to remove blocked food between the teeth, and only 3.6% considered that it is useful for removing bacterial plaque. All participants' answers to perception questions are presented in Table 1.

Questionnaire on children's behaviours

The responses related to the frequency of sweets' ingestion showed in our group that the majority of children (80.3%) have a low consumption of sweets (0-3 times/day), the percentage of those who consume more frequently being 6-12 times higher.

Dental brushing was performed more than once a day by the majority 77.4% of children, and only 2.9% of them didn't perform daily tooth brushing.

Regarding the type of toothpaste, 57.6% of the respondents knew the active compound of the toothpaste, and the majority of them (76.04%) used a fluoride toothpaste, but the rest of 42.4% did not know if their toothpaste contains or not fluoride.

Addressability to the dentist showed that most of the children (57.7%) go to the dentist when needed, and that 72.3% of them never missed a dental appointment. Regarding the reasons for which they went to the doctor, they were closely divided between pain (24.8%), control (37.9%), and other reasons (37.3%). All participants' answers to behaviours questions are presented in Table 2.

Table 1. Children answers to the first questionnaire related to the perception

Question	N*	%**
1. Persons with a broken tooth are:		
Healthy	54	39.4
Ill	83	60.6
2. Does a broken tooth represent a disease/an illness?		
Yes	24	17.5
No	85	62.0
I don't know	28	20.5
3. If you have cavities, do you have to go to the dentist?	130	94.8
Yes	3	2.3
No	4	2.9
I don't know		
4. Is gingival bleeding a disease?		
Yes	130	94.8
No	3	2.3
I don't know	4	2.9
5. Does gingival bleeding require treatment?		
Yes	101	73.7
No	16	11.7
I don't know	20	14.6
6. What should you do in case your gums bleed?		
Go to a nurse	5	3.6
Go to the dentist	108	78.8
Use mouthwash	8	5.8
Stop brushing your teeth	2	1.5
Continue brushing	11	8.0
Something else/other option	3	2.3
7. Should a person brush his/her teeth?		
Once a week	2	1.5
Once a day	4	2.9
Twice a day	91	66.4
More than twice a day	40	29.2
8. Dental floss is used for:		
Removing food stuck between teeth	90	65.7
Extra cleaning the teeth	26	18.9
Cleaning the tongue	6	4.4
Removing dental plaque	5	3.6
I don't know	10	7.4

*Number of cases **Percentages

Table 2. Children answers to the second questionnaire related to behaviours

Question	N*	%**
1. Frequency of sweets/juices a day:		
0-3 times a day	110	80.3
4-5 times a day	18	13.1
more than 6 times a day	9	6.6
2. Frequency of dental brush:		
Less than once a day	4	2.9
Once a day	27	19.7
More than once a day	106	77.4
3. Do you use a fluoride toothpaste?		
Yes	60	43.8
No	19	13.8
I don't know	58	42.4
4. How often do you go to the dentist?		
When needed	79	57.7
Regularly	47	34.3
Irregularly	11	8.0
5. Have you ever missed an appointment before?		
Never	99	72.3
Sometimes	30	21.9
Always	8	5.8
6. Why did you go to the dentist the last time?		
Pain	34	24.8
Check up	52	37.9
Something else	51	37.3

*Number of cases **Percentages

Associations between perceptions and behaviours.

Daily sugary intake habit was significantly associated with the awareness that people need to visit the dentist even they do not have cavities ($P=0.018$), awareness that gum bleeding is a sign of disease ($P<0.001$), correct knowledge of brushing frequency ($P<0.001$), and dental floss usage ($P<0.001$). Also, daily toothbrushing habit was significantly associated with the awareness that people need to visit the dentist even they do not have cavities ($P=0.041$), awareness that gum bleeding is a sign of disease ($P<0.001$), correct knowledge of brushing frequency ($P<0.001$) and dental floss usage ($P=0.011$).

None of the examined knowledge and perceptions was significantly associated with the usage of fluoridated toothpaste.

Dental visit frequency was significantly associated with the awareness that tooth decay is a disease ($P=0.019$), awareness that gum bleeding requires treatment ($P=0.002$).

The addressability to the dentist was significantly associated with the awareness that people need to visit the dentist even if they do not have cavities ($P<0.001$), awareness that gum bleeding is a sign of disease ($P=0.006$) and dental floss usage ($P<0.001$). The relationships between perceptions and behaviours are presented in Table 3.

Discussion

Both periodontal disease and carious disease have a bacterial etiology, with the starting point being the bacterial plaque associated with the dental surface and the epithelium of the gingival sulcus [32]. Thus, both pathologies have means of primary and secondary prophylaxis, the effectiveness of which can lead to a decrease in the incidence and prevalence of these diseases [33].

In the literature, there are few studies on the perception of oral diseases addressed directly to younger children, most of them are addressed to their parents, so that the choice of similar questionnaires has a value of comparison and awareness of the two oral pathologies [34]. Also, in the age group of 12-15 years, parental control tends to decrease both on the achievement of oral hygiene and on food control, especially on the consumption of sweets or even on some vicious habits.

It is obvious that oral education among children is very important because the good health habits acquired at an early age can be maintained in adulthood [35]. This is important not only for the oral health but also to maintain an adequate general health [21]. This is also supported by the study conducted by previous study which shows the importance

of an oral health program in schools in order to develop children's skills in terms of oral hygiene [36].

The accessibility and availability of oral health services as well as the level of education of the parents are very important for the control of dental caries and gingival inflammation [30]. In developing countries 18-38.8% of children aged 12 have never been seen by a dentist or do not visit a dentist regularly, while in developed countries the percentage rises slightly to 44% [14]. In our study, most of the children answered that they go to the dentist only when needed (57.7%) and only 34.3% visit the dentist regularly, which corresponds, although in a smaller percentage, to the results of another study, carried out on 434 children ages between 11 and 14 [31].

Albeit the study was conducted on schoolchildren from the urban environment of an European capital, there is still a small percentage, under 3%, of children who do not brush daily their teeth, a percentage that is 4 times lower than that reported by Eaisalhy et al. [31], in a study also performed in urban environment.

From the analysis of the responses related to carious lesions (questions 1 and 2 from Table 1), it appears that the presence of carious lesions is not perceived by the participating children as a pathology that can also have an influence on general health. A number of 60% of children consider that a person with broken teeth is sick, perhaps more related to the aesthetic aspect, while 62% of the children do not consider dental caries to be a disease. The same contradiction is noticed by Eaisalhy et al. [31], concluding that although the presence of caries affects the quality of life, it is not perceived by children as a threat to general health that requires a change of objections as in other systemic disease.

Table 3. Associations between perceptions and behaviours

	Daily sugary intakes				Daily Toothbrushing				Use of fluoridated toothpaste				Dental visit frequency				Missed dental appointments			
	Low N (%)	Moderate N (%)	High N (%)	P-value*	More than once N (number)	Once N (number)	Less than once N (number)	P-value*	Yes N (number)	No N (number)	P-value*	As needed N (number)	Irregularly N (number)	Regularly N (number)	P-value*	Never N (number)	Sometimes N (number)	Always N (number)	P-value*	
1. A person with a decayed tooth is Healthy	42 (30.66)	7 (5.11)	5 (3.65)	0.59	41 (29.93)	12 (8.76)	1 (0.73)	0.72	21 (15.33)	33 (24.09)	0.581	37 (27)	6 (4.38)	11 (8.04)	0.019	41 (29.93)	9 (6.57)	4 (2.92)	0.437	
	68 (49.63)	11 (8.03)	4 (2.92)		65 (47.44)	15 (10.95)	3 (2.19)		39 (28.47)	44 (32.11)		42 (30.65)	5 (3.65)	36 (26.28)		58 (42.33)	21 (15.33)	4 (2.92)		
2. Tooth decay is a disease?	18 (13.14)	5 (3.65)	1 (0.73)	0.534	21 (15.33)	2 (1.46)	1 (0.73)	0.294	10 (7.3)	14 (10.22)	0.227	12 (8.76)	1 (0.73)	11 (8.04)	0.375	18 (13.14)	5 (3.65)	1 (0.73)	0.912	
Yes	92 (67.15)	13 (9.49)	8 (5.84)		85 (62.04)	25 (18.25)	3 (2.19)		50 (36.5)	63 (45.98)		67 (48.9)	10 (7.3)	36 (26.27)		81 (59.12)	25 (18.25)	7 (5.11)		
No/Don't know	107 (78.1)	16 (11.68)	7 (5.11)	0.018	103 (75.18)	24 (17.52)	3 (2.19)	0.041	58 (42.33)	72 (52.56)	0.075	74 (54.02)	11 (8.03)	45 (32.84)	0.636	97 (70.9)	28 (20.43)	5 (3.65)	<0.001	
Yes	3 (2.19)	2 (1.46)	2 (1.46)		3 (2.19)	3 (2.19)	1 (0.73)		2 (1.46)	5 (3.65)		5 (3.65)	0 (1.46)	2 (1.46)		2 (1.46)	2 (1.46)	3 (2.19)		
No/Don't know	2 (1.46)	1 (0.73)	1 (0.73)	0.018	2 (1.46)	2 (1.46)	2 (1.46)	0.041	17 (12.4)	29 (21.17)	0.075	22 (16.05)	4 (2.92)	20 (14.6)	0.636	33 (24.09)	10 (7.3)	3 (2.19)	<0.001	
Yes	34 (24.82)	7 (5.11)	5 (3.65)		38 (27.74)	6 (4.38)	2 (1.46)		17 (12.4)	29 (21.17)		22 (16.05)	4 (2.92)	20 (14.6)		33 (24.09)	10 (7.3)	3 (2.19)		
4. Gum bleeding is a disease?	76 (55.71)	11 (7.85)	4 (2.92)	0.018	68 (49.63)	21 (15.33)	2 (1.46)	0.041	43 (32.11)	48 (35.56)	0.075	57 (42.33)	7 (5.11)	27 (20.43)	0.636	66 (49.63)	20 (15.33)	5 (3.65)	<0.001	
Yes	3 (2.19)	2 (1.46)	2 (1.46)		3 (2.19)	3 (2.19)	1 (0.73)		2 (1.46)	5 (3.65)		5 (3.65)	0 (1.46)	2 (1.46)		2 (1.46)	2 (1.46)	3 (2.19)		
No/Don't know	2 (1.46)	1 (0.73)	1 (0.73)	0.018	2 (1.46)	2 (1.46)	2 (1.46)	0.041	17 (12.4)	29 (21.17)	0.075	22 (16.05)	4 (2.92)	20 (14.6)	0.636	33 (24.09)	10 (7.3)	3 (2.19)	<0.001	
Yes	34 (24.82)	7 (5.11)	5 (3.65)		38 (27.74)	6 (4.38)	2 (1.46)		17 (12.4)	29 (21.17)		22 (16.05)	4 (2.92)	20 (14.6)		33 (24.09)	10 (7.3)	3 (2.19)		
4. Gum bleeding is a disease?	76 (55.71)	11 (7.85)	4 (2.92)	0.018	68 (49.63)	21 (15.33)	2 (1.46)	0.041	43 (32.11)	48 (35.56)	0.075	57 (42.33)	7 (5.11)	27 (20.43)	0.636	66 (49.63)	20 (15.33)	5 (3.65)	<0.001	
Yes	3 (2.19)	2 (1.46)	2 (1.46)		3 (2.19)	3 (2.19)	1 (0.73)		2 (1.46)	5 (3.65)		5 (3.65)	0 (1.46)	2 (1.46)		2 (1.46)	2 (1.46)	3 (2.19)		
No/Don't know	2 (1.46)	1 (0.73)	1 (0.73)	0.018	2 (1.46)	2 (1.46)	2 (1.46)	0.041	17 (12.4)	29 (21.17)	0.075	22 (16.05)	4 (2.92)	20 (14.6)	0.636	33 (24.09)	10 (7.3)	3 (2.19)	<0.001	
Yes	34 (24.82)	7 (5.11)	5 (3.65)		38 (27.74)	6 (4.38)	2 (1.46)		17 (12.4)	29 (21.17)		22 (16.05)	4 (2.92)	20 (14.6)		33 (24.09)	10 (7.3)	3 (2.19)		

In terms of affecting the marginal periodontium, there is a contradiction between the recognition of gingival bleeding as a disease and the need for treatment. Although most children (66.5%) do not recognize gingival bleeding as a sign of disease, 73.7% assert that its presence requires treatment and that they must go to the dentist, a percentage double that reported Eaisalhy et al. [31]

The frequency of tooth brushing was found in similar percentages in many studies. In our study 77.4% of the children brush their teeth twice a day, a percentage close to that was found in Singh's study of 68.1% [37], but superior that founded by Eaisalhy et al. [31].

Regarding the composition of the toothpaste, almost half of the respondents (43.8%) use fluoride toothpaste, a significant percentage, but equal to that of those who do not know the composition of the toothpaste, which shows the important role that parents have in the control and awareness of oral hygiene in children aged 12-15 years old.

Also, regarding the most known secondary tool for oral hygiene, dental floss, this was used too little among children. Thus, 65.7% of the participants in this study use it only to remove food stuck between the teeth, similar to the one found by Eaisalhy et al. [31]. Only 3.6% of children responded that they use the dental floss to remove dental plaque, a percentage which is close to that found by Chen et al. [38] who had reported a percentage of 5.57% of frequent use of dental floss among 12-year-old children in China, but double compared to the one reported by Eaisalhy et al. 2015 [31]. Similar percentages were found regarding the fact that dental floss is an additional means of hygiene, but with little value in both studies, approximately 20%, which indicates insufficient information regarding its role.

The frequency of sugar consumption is also an important factor in the development of bacterial plaque and implicitly in affecting oral

health. Compared to other studies, in our study the sugar consumption can be considered low, with 80.3% of children consuming between 0-3 products with sugar daily, compared to the results of Eissalhy et al. [31] who reported that most children (52.4%) consumed 6 or more sweet products per day, or compared to other studies where the majority of children (63.3% and 59.7% respectively), have moderate sugar consumption [30],[38].

Although the studies were done in different geographical regions, even at different time intervals, almost a decade, the results are essentially similar, even if there are value differences. The questions were chosen to provide relevant data regarding the risk indicators for the two conditions: the carbohydrate-rich eating habit, recognized as a substrate for the development of bacterial plaque, as well as primary oral hygiene (dental brushing and its frequency) but also secondary (the composition of the toothpaste and the dental floss, best known among the auxiliary

Acknowledgements

All authors have accepted responsibility for the entire content of this manuscript and approved its submission.

Conflicts of Interest: There are no known conflicts of interest in the publication of this article. All authors have read and approved the manuscript.

means).

CONCLUSIONS

1. These results show that, although the degree of information about carious and periodontal pathology among children is still low, the need to be addressed to the dentist is known and this is where the parental role most likely comes into play, despite the fact that over a quarter of the respondents state that they do not respect treatment appointments.
2. If most children have perceived dental cavity as a disease, gingival bleeding was not as alarming and was not seen as a sign of illness.
3. Children awareness of the importance of oral hygiene in relation to general health must be achieved using several means. Skills start through education in the family but must be supported through attractive information programs for children in schools and also in social media.

Appendix A

Question	Questions and Romanian translations (italic)
Q1	Frequency of sugary food/drink intakes per day <i>Frecvența dulciurilor/sucurilor pe zi</i>
Q2	Frequency of toothbrushing per day <i>Frecvența periajului dentar</i>
Q3	Regular use of fluoridated toothpaste <i>Folosești o pasta de dinți cu fluor</i>
Q4	Dental attendance pattern <i>Cât de des mergi la dentist</i>
Q5	Missed a dental appointment before <i>Ai ratat o programare înainte</i>
Q6	Reason for last dental visit <i>De ce ai mers ultima oară la dentist</i>

Appendix B

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Question	Questions and Romanian translations (<i>italic</i>)
Q1	A person with a decayed tooth is <i>Persoanele cu un dinte stricat sunt</i>
Q2	Do you think tooth decay is a disease <i>Un dinte stricat reprezintă o boală</i>
Q3	Do you need to see the dentist if you do not have cavities <i>Dacă ai carii trebuie să mergi la dentist</i>
Q4	Do you think gum bleeding is a sign of disease <i>Sângerările gingivale sunt semn de boală</i>
Q5	Do you think gum bleeding requires treatment <i>Sângerările gingivale necesită tratament</i>
Q6	What should you do if your gum starts bleeding <i>Ce ar trebui să faci dacă îți sângerează gingiile</i>
Q7	A person should brush his teeth <i>O persoană trebuie să se spele pe dinți</i>
Q8	Dental floss used for <i>Ața dentară se folosește pentru</i>