

THE PATIENTS' POINT OF VIEW ON THE KNOWLEDGE OF FACTORS, WHICH AFFECT HEALTH IN THE ORAL CAVITY AFTER SURGERY OF CANCER IN THE MOUTH

Vlasta Kraševc¹, Danica Železnik², Uroš Železnik^{2,3}

¹University Clinical Center Ljubljana, Zaloška cesta 7, 1000 Ljubljana, Slovenia,

²University College of Health Sciences Slovenj Gradec, Glavni trg 1, 2380 Slovenj Gradec, Slovenia

³Health Center Ptuj, Potrčeva cesta 19a, 2250 Ptuj, Slovenia

Rad je primljen 12.8.2017. Rad je recenziran 21.9.2017. Rad je prihvačen 8.10.2017

ABSTRACT

INTRODUCTION: Raising awareness about oral hygiene is essential in every life stage. It is especially important to know the risk factors, which affect health in the oral cavity after oral cancer surgery.

OBJECTIVE: The objective of this article is to present the patients' point of view on the knowledge of factors, which affect health in the oral cavity after oral cancer surgery.

METHODS AND SUBJECTS: A quantitative non experimental descriptive research was conducted. The questionnaire containing special questions related to patient attitude after oral cancer surgery about basic demographics (age, gender, lifestyle, level of education) and questions about the information obtained by nurses. The research included 112 randomly chosen patients on their follow-up exams after an oral cavity surgery at the Clinic for oral and maxillofacial surgery, University Clinical Center in Ljubljana.

RESULTS: The research showed that most of the interviewed patients smoked, drank alcohol and had a low education. The patients know the risk factors after oral cancer surgery, but only a few changed their lifestyle.

DISCUSSION AND CONCLUSIONS: Patient education is an integral part of the treatment and should include a discussion of potential oral complications. It is very important that the dental team impress on the patient that optimal oral hygiene during treatment adequate nutrition and avoiding tobacco and alcohol can prevent or minimize oral complications.

Key words: risk factors, oral cavity, cancer, patient, knowledge

Correspondence:

Professor Danica Zeleznik, PhD

E-mail: zeleznik.danica@gmail.com

INTRODUCTION

Caring for one's health includes oral hygiene for all categories of the population. We often say that health starts in the mouth, therefore raising awareness about oral hygiene is of the utmost importance at every period in life. Oral health is being free of chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the mouth and oral cavity (1).

Oral hygiene has important effects on health and food, her effectiveness lowers infections and

increases health (2). Health promotion and illness prevention, especially through education, can be a long-term investment into one's health. The results of which can be achieved only through well aimed health-educating goals, education and utilising knowledge and experiences.

The effectiveness of health education can be measured with indicators that show behavioural and lifestyle changes. The wrong evaluation of the oral situation and insufficient knowledge lead to wrong equipment and techniques regarding oral hygiene (2-4). On the other hand, early detection

and intervention lower the appearance of infections and complications in the mouth. Healthy food and a healthy oral cavity are the basic factors for maintaining health, wellbeing and quality of life (5,6). Because of multiple combined risk factors, that attribute to the development of the most common oral cavity diseases, a person can get oral cavity cancer.

Most of these malign diseases in the region of the head and neck are alcohol and tobacco related squamous-cell carcinoma of the upper aero digestive tract and just like other body parts, cancer can also affect the oral cavity, or specifically the lips, tongue, oral mucosa and oral oesophagus (7,8).

Cancer of the oral cavity in the initial stage does not hurt and does not cause any problems, that's why it is important to pay attention to infiltrations (indurations of the mucous membrane of the oral cavity that we can feel, but we can't see, they are normally soft and elastic), ulcers, white or red changes of the mucous membrane. In most cases the initial changes are limited and painless; cancer in the mouth doesn't hurt until it hits a nerve or causes a larger inflammation. It is painless for a long time and it grows slow. The duty of the health care workers is to teach the patients about the harmful factors, which cause cancer in the mouth, as well as check their acquired knowledge.

In Slovenia there are yearly 250 new patients diagnosed with cancer of the oral cavity, of those 50 die (9). The occurrence of oral cavity cancer is growing. In its early phases oral cavity cancer is a well manageable disease that can be successfully healed without significant consequences. But when it isn't diagnosed early enough it quickly spreads onto lymph nodes in the neck, and gradually onto other organs.

The two main risk factors leading to oral cancer are smoking and drinking alcohol (8). Both can be cancer genic, but a combination of both doubles the chances of getting cancer. Oral cancers usually occurs at the bottom of the oral cavity and on the edge of the tongue, where cancer genic substances combined with saliva stay over the longest period of time (10). Besides smoking and drinking alcohol, bad oral hygiene and tooth decay can attribute to

cancer. They cause local infections and add to the cell damage (10,11).

Cancer in the mouth presents a large medical problem all over the world. The purpose of treating malign tumours of the oral cavity is first and foremost the removal of cancerous tissue and preventing the illness from repeating itself. If it is possible, only one form of treatment is being used and usually this treatment is surgical (7). For a successful treatment of oral cavity cancer, the most important factor is the stage of the disease at the time of the diagnosis. Unfortunately, a carcinoma is recognised too late in 50 % of the cases (stage III, IV) presuming that dentists, hygienists, dental prosthetists, maxillofacial and oral surgeons play a very important role at early diagnosing cancer in the mouth. One of the reasons for the late diagnosis lies in the behaviour of certain individuals – those who smoke and drink regularly, are only rarely or never visiting the dentist. For these people individual plans have to be made that include caring for oral health (12).

With the help of primary preventive the exposure to factors that attribute to cancer is being lowered or removed completely. Amongst primary preventive activities factors of behavioural patterns living environment and infections associated with cancer, are being monitored with different indicators. Here the role of the nurse is extremely important, especially regarding work in health education, counselling and providing moral support to the patients and their relatives (13, 14).

Patients receiving oral cancer treatment are faced with multiple questions before, during and after treatment. For them working with the medical staff is of key importance, especially for maintaining oral health, where nurses play a very important role. Patients in the process of oral cancer treatment are very vulnerable, because their basic life activities are affected, including breathing, eating, verbal communication. The period of postoperative treatment and rehabilitation process are demanding. The patient is faced with being dependant on other people and learning to adjust to different circumstances in life that he has to learn to manage, while at the same time accepting his changed self-image, which can

often prove to be a great challenge. Patient cooperation is very important, this includes understanding instructions and advices, as well as their willingness to give up risk factors that they have been prone to before. Acute and long-lasting effects that patients are exposed to, have to be lowered, so that their quality of life can increase.

The aim of this article is to present the patients' point of view on the knowledge of factors, which affect health in the oral cavity after oral cancer surgery.

METHODS AND SUBJECTS

A non-experimental, quantitative research method was used. Data was gathered through a questionnaire.

A non-coincidental, purpose sample was used. The research included patients on their follow-up exams after an oral cavity surgery at the Clinic for oral and maxillofacial surgery in Ljubljana.

For the purpose of the research a measuring instrument was developed, which included statements and a level of agreement, expressed with a nominal increase level scale. A five-level Likert scale of opinions was being used. Number 1 means strong disagreement and number 5 strong agreements. The used instrument was a questionnaire, designed with the help of comparing literature and the experience of the researcher (23,25). It contains questions about demographic data, data regarding the education of the interviewee and claims about information gathered during hospitalisation, information regarding risk factors attributing to diseases in the oral cavity, occurrences of risk factors before surgery, information provided by the nurses at the release from the hospital, the occurrence of risk factors after surgery, the frequency of dentist appointments, the frequency of performing oral care.

The data processing was made with the help of statistical analysis, with the program IBM SPSS 20.0 (IBM Corp., Armonk, NY). Categorical data were presented by absolute and relative frequencies. Numerical data are described as mean and standard deviation. In case of asymmetric distribution of data, the median and the limits of interquartile range were used to assess mean and the variability of numerical

data. Internal consistency of used questionnaire was assessed by the Cronbach alpha coefficient. Differences between numerical variables were tested by t-test for independent samples. Bivariate correlation of total scores was assessed by Spearman coefficient ρ . The level of significance was set at $p < 0.05$.

RESULTS

112 patients took part in this research, of those, 73 (65.2%) were male and 39 (34.8 %) were female. The highest percentage of the questioned 37.5% had a vocational education. The average age was 61.6 years; half of those were 60 years old or younger.

Table 1. Knowledge of the factors that affect health of the oral cavity

	Min	Max	AS	SD	n
Factors that affect health of the oral cavity	2	5	3.94	0.85	112

On average the patients rank their knowledge of factors that affect health of the oral cavity after oral cancer surgery as high (Table 1).

Table 2. Testing the differences between sexes on the level of awareness about oral hygiene after surgery.

Awareness	Sex	n	AS	SD	t	sp	p
I received verbal instructions from the nurses about oral cavity care.	male	73	4.08	1.21	0.33	110	0.742
	female	39	4.00	1.34			
I received written instructions from the nurses about oral cavity care.	male	73	3.19	1.45	0.66	110	0.512
	female	39	3.00	1.50			

It has been determined that there are no statistically significant differences in the awareness of patients about oral cavity care after oral cancer surgery regarding sex (Table 2).

Table 3. Pearson's correlation coefficient between age and awareness about oral cavity care after surgery

	Age	
	r	0.18
I received verbal instructions from the nurses about oral cavity care.	p	0.061
	n	112
	r	-0.02
I received written instructions from the nurses about oral cavity care.	p	0.91
	n	112

Table 3 is showing that there is a weak positive correlation between age and verbal, but not written awareness of the patient about oral cavity care after oral cancer surgery, correlation is not statistically significant ($r=0.18$; $p=0.061$).

We researched the influence education has on the awareness of patients regarding principles of a healthy diet after oral cancer surgery. Regarding the influence of age, we didn't find significant differences ($r=0.03$; $p=0.76$), similarly the differences weren't significant among different levels of education (neither with men nor with women).

Table 4. Intensity of risk factors before and after oral cancer surgery and the result of the paired t-test

		AS	SD	t	sp	p
Regular smoking	Before procedure	3.48	1.82	6.76	111	<0.001
	After procedure	2.21	1.65			
Regular drinking	Before procedure	2.63	1.65	7.25	111	< 0.001
	After procedure	1.46	0.99			
Psychological stress	Before procedure	3.57	1.53	1.26	111	0.212
	After procedure	3.38	1.49			
Unhealthy diet	Before procedure	2.72	1.42	0.42	111	0.672
	After procedure	2.64	1.28			

It is evident from table 4 that the intensity of regular smoking ($t=6.76$) and regular drinking of alcohol ($t=7.25$), has lessened, meanwhile the psychological stress and unhealthy diet didn't change significantly after oral cancer surgery in comparison with the situation before. Certain aspects of healthy lifestyle are being observed after surgery.

Table 5. Paying attention to oral hygiene regarding sex

	n	AS	SD	t	sp	p
Men	73	2.26	1.422	-1.72	110	0.04
Women	39	2.72	1.191			

Leven's test shows that the difference of variances in groups is not statistically significant ($F=1.61$; $p=0.207$). The conditions for the use of a t-test are therefore met. Because the hypothesis also assumes the direction of the difference, women should wash their teeth more often than men, the testing had to be one-directional. The t-test shows us that women brush their teeth significantly ($p=0.04$) more often than men, the hypothesis is therefore accepted (Table 5).

Table 6. Spearman's correlation coefficient between intensity of risk factors after surgery and education

	Education					
	All		Men		Women	
	r	p	r	p	r	p
I smoke regularly (two or more cigarettes a day).	-0.15	0.125	-0.25	0.033	-0.04	0.814
I smoke occasionally (several times a week).	0.04	0.650	0.06	0.610	-0.10	0.559
I drink alcohol every day.	-0.01	0.943	-0.10	0.413	0.11	0.505
I drink alcohol several times a week.	-0.10	0.318	-0.18	0.132	-0.03	0.853
I eat healthy.	0.01	0.933	0.02	0.885	0.04	0.819
I'm under psychological stress.	0.01	0.945	-0.13	0.287	0.22	0.181

It is evident from table 6 that, regarding the entire sample, education is not correlated to intensity of risk factors after surgery. But there is a weak negative correlation between regular smoking after surgery and the level of education in men. The number of higher educated men that smoke regularly after surgery is smaller. Before surgery the correlation between regular smoking and education in men was statistically insignificant ($r=-0.13$; $p=0.284$).

Table 7. Pearson's correlation coefficient between age and the intensity of risk factors after surgery

	Age	
	r	p
I smoke regularly (two or more cigarettes a day)	0.04	0.683
I smoke occasionally (several times a week)	-0.01	0.906
I drink alcohol every day	0.10	0.299
I drink alcohol several times a week	0.04	0.659
I eat healthy	0.03	0.763
I'm under psychological stress	-0.02	0.824

Assertions, measured with a 5 level scale, are being treated as interval, while age is measured with a ratio measurement scale. None of Pearson's correlation coefficients between age and the intensity of risk factors after surgery is statistically significantly different than 0, as evident in table 7.

DISCUSSION

Different indicators show that the number of inflicted with cancer, will grow in the future this is why it is of extreme importance to equip people with knowledge of risk factors for its occurrence, as well as about maintaining health after surgery (15).

Patient education is an integral part of the pre-treatment evaluation and should include a discussion of potential oral complications. It is very important that the dental team impress on the patient that optimal oral hygiene during treatment adequate nutrition and avoiding tobacco and alcohol can prevent or minimize oral complications (16,17). To ensure that the patient fully understands what is required, provide detailed instructions on specific oral care practices, such as how and when to brush and floss, how to recognize signs of complications, and other instructions appropriate for the individual (16). Patients should understand that good oral care during cancer treatment contributes to its success.

Čižmarević states, that a patient has to be well acquainted with the expected development of the illness and the expected benefits of a surgery, which means that a patient with oral cancer also has to be well informed about the risk factors after surgery (18). The most important risk factors for development of oral cancer are certainly smoking and

alcohol. Many authors think that a whole medical team is involved in patient education and that nurses play an important role in this team (2-4, 11, 18-21).

After the cancer treatment complications in the mouth can improve, but it often happens, that they remain for months or years (22, 23). When the acute side effects are solved, a strict oral hygiene plan has to be upheld this is why patient education is an integral part of evaluation of treatment and has to include a discussion about possible complications in the mouth (22-26). Patients have to know the risk factors and have to understand, that with good oral hygiene, healthy eating and knowledge about risk factors, they can contribute to success and a better quality of life, during cancer treatment (27, 28).

Our research showed, with the help of the Spearman correlation coefficient, that less regular smoking and drinking alcohol occurred with patients after oral surgery, while there was no statistically significant difference in psychological strain and unhealthy eating habits. Some aspects of a healthy lifestyle are held after surgery. The research shows us that the level of knowledge about a healthy lifestyle and the level of education are not connected. Higher educated men smoke less after surgery, while there was no statistically significant correlation between regular smoking and education in men.

A research conducted in India where tobacco is also being chewed, showed that tobacco and alcohol are strong risk factors for cancer development, besides age, social status and long exposure, which is in a way comparable to our study. The true cause of oral cavity cancer is not known, but it is a fact that its development can be linked to smoking and alcohol. It is a fact that since the early beginnings of treating malign diseases and until today the situation got better (8, 15, 28-30).

Pearson's correlation coefficient between age and the intensity of risk factors after oral surgery, shows that there are no significant differences between age and exclusion of risk factors. Age doesn't play a role in giving up risk factors. Also the Spearman correlation coefficient shows us that knowing about a healthy lifestyle and education is not connected.

Oral cavity cancer is a disease; predominantly present with the male population, a small percentage of the afflicted are females. Social factors and lower education are also involved, which can be determined from our study (28). The study shows that care for oral health is connected both with the sex of the patients; women are known for more often visiting the dentist than men, as well as with the lifestyle (31). Like Premik explains, a healthy oral cavity guarantees quality of life and at the same time shows the welfare of the society one lives in. It is a basic human right and a part of general health, which starts in the mouth (32).

CONCLUSION

The questioned patients know the risk factors of their illness after surgery, but only a few changed their lifestyle in a sense, which would exclude those risk factors. Because there are sizeable deviations from the normal situation with patients after an oral cavity surgery, support from the whole medical staff is needed, especially from the nurses. The patients should be tracked in their home environment, so that lifestyle changes could be enforced and a sense of responsibility for one's health could be awoken. Early detection of anomalies in the oral cavity is crucial, especially among the risk groups of population, such as smokers and people consuming alcohol. Of course the greatest risk is among those who do both.

To lower smoking, harmful and risky drinking of alcoholic beverages and their aftereffects, the situation should be approached in its entirety. Actions should be directed especially towards younger population, because the understanding of the independent and joint effects of tobacco and alcohol could have important implications for prevention.

LITERATURE

1. World Health Organization *What is Oral Health?* Factsheet. Geneva: WHO. 2007.
2. White R. Nurse assessment of oral health: a review of practice and education. *Br J Nurs*. 2000;9:260-6.
3. Cooley C. Oral health: basic or essential care? *Cancer Nurs Pract*. 2002;1:33-9.
4. Southern H. Oral care in cancer nursing: nurses knowledge and education. *J Adv Nurs* 2006;57:631-8.
5. Rotovnik Kozjek N. Pomen prehranjenosti pacientov pred in po operativnem posegu v ustni votlini. V D. Štromajer M., Mikulič, V., Česen in I. Trobec (ur.), Zbornik predavanj 3. strokovnega seminarja Uspešna komunikacija - zadovoljen pacient v maksilofacialni in oralno-kirurški obravnavi, Brdo pri Kranju, 27 november. Združenje za maksilofacialno in oralno kirurgijo Slovenije. Ljubljana. 2010: 77-80.
6. Zupanc V, Sedej I. Disfagija in prehrana: ko požiranje postane problem: informacije za bolnike in svojce. Ljubljana: Inštitut Persea. 2010.
7. Dovšak D. Rak ustne votline in ustnega dela žrela. *Radiother Oncol* 2006;40(Suppl1): 9-17.
8. Radoi L, Paget-Bailly S, Cyr D, Papadopoulos A, Guida F, Schmaus A, et al. Tobacco smoking, alcohol drinking and risk of oral cavity cancer by subsite: results of a French population-based case-control study, the ICARE study. *Eur J Cancer Prev*. 2013;22:268-76.
9. Zdravniška Zbornica Slovenije 2016. Rak ustne votline. Available <http://www.zdravniskazbornica.si/zs/1201/rak-ustne-votline>; accessed 18.6.2017.
10. Grošelj A. 2015. Rak ustne votline. Available <http://www.doktor24.si/revija-doktor/zdravniki-pisejo/327-rak-ustne-votline>; accessed 12.7.2017.
11. Fitzpatrick J. Oral health care needs of dependent older people: responsibilities of nurses and care staff. *J Adv Nurs*. 2000;32:1325-32.
12. Sieracki R, Voelz L, Johankin T, Kopaczewski D, Hubert K. Development and implementation of an oral care protocol for patients with cancer. *Clin J Oncol Nurs*. 2009;13:718-20.
13. Semple CJ, Dunwoody L, Kernohan WG, McCaughan E, Sullivan K. Changes and challenges to patients' lifestyle patterns following treatment for head and neck cancer. *J Adv Nurs*. 2008;6:85-93.
14. Bohak A. Zdravstvena nega pacienta s traheostomo – menjava trahealne kanile s tesnilko. V A. Trdin in M. Matjaž (ur.), Celostna obravnava pa-

- cienta obolelega za rakom grla in vratu: zbornik predavanj: II. strokovno izobraževanje, Maribor, 27. maj 2011 Ljubljana: Zbornica zdravstvene in babiške nege Slovenije – Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije. 2011: 71-7.
15. Marijanović I, Buhovac T. Onkologija jučer, danas, sutra. *Zdravstveni glasnik*. 2017;1:94-8.
 16. Schubert MM, Appelbaum FR, Peterson DE, Lloid ME. Oral complications. In: Blume KG, Forman SJ, eds.: *Thomas' Hematopoietic Cell-Transplantation*. 3rd ed. Malden, Mass: Blackwell Science Inc.. 2004:911-28.
 17. Rotovnik Kozjek N. Prehranska podpora bolnika z rakom. *Onkologija / šola: tumorji prebavil II*. 2014;56:56-9.
 18. Čižmarevič B. Kirurško zdravljenje raka ustne votline in ustnega dela žrela. V. A. Trdin in M. Matjaž (ur.), *Celostna obravnava pacienta obolelega za rakom grla in vratu: zbornik predavanj: II. strokovno izobraževanje*, Maribor, 27. maj 2011 Ljubljana: Zbornica zdravstvene in babiške nege Slovenije- Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije. 2011:11-5.
 19. Furr A, Binkley C, McCurren C, Carrico R. Factors affecting quality of oral care in intensive care units. *J Adv Nurs*. 2004;48:454-62.
 20. National Institute of Dental and Craniofacial Research. *Oral Complications of Cancer Treatment: What the Dental Team Can Do*. 2015. Available, <https://www.nidcr.nih.gov/OralHealth/Topics/CancerTreatment/OralComplicationsCancerOral.htm>; accessed: 20.7.2017.
 21. Kempainen V, Tossavhainen K, Turunen, A. Nurses' roles in health promotion practice: an integrative review. *Health Promot Int*. 2012;28:490-500.
 22. Binkley C, Furr L, Carrico R, McCurren C. Survey of Oral Care Practices in US Intensive Care Units. *Am J Infect Control*. 2004;32:161-9.
 23. Lin YS, Chang J, Chang TH, Lou MF. Critical-Care Nurses' Knowledge, Attitudes and Practices of Oral Care for Patients with Oral Endotracheal Intubation: A Questionnaire Survey. *J Clin Nurs*. 2011;20:3204-14.
 24. Farah CS, McCullough MJ. Oral cancer awareness for the general practitioner: new approaches to patient care. *Aust Dent J*. 2008;53:1-10.
 25. Mimović V. Dejavniki tveganja in njihov vpliv na zdravje ustne votline. Diplomsko delo, Maribor: Univerza v Mariboru, Fakulteta za zdravstvene vede. 2009.
 26. Malkin B. The importance of patients' oral health and nurses' role in assessing and maintaining it. *Nurs Times*. 2009;10:5-17, early online publication.
 27. Sultana N, Malik M. The Overview of Oral Cancer and Risk Factors in Bangladesh. *Int J Dent Res*. 2014;2:8-10.
 28. Kadashetti V, Chaudhary M, Patil S, Gawande M, Shivakumar KM, Patil S et al. Analysis of various risk factors affecting potentially malignant disorders and oral cancer patients of Central India. *J Can Res Ther*. 2015;11:280-6
 29. Johnson NW. Tobacco use and oral cancer: a global perspective. *J Dent Educ*. 2001; 65:328-39.
 30. Rahman M, Sakamoto J, Fukui T. Calculation of population attributable risk for bidi smoking and oral cancer in south Asia. *Prev Med*. 2005;40:510-4.
 31. Petti S. Lifestyle risk factors for oral cancer. *Oral Oncol*. 2009;45:340-50.
 32. Premik M. V ustih se skrivajo sprožilci vrste bolezni. 2013. Available <http://www.primorske.si/Priloge/Zdravje/V-ustih-se-skrivajo-sprozilci-vrste-bolezni.aspx>; accessed 30.7.2017.

STAVOVI PACIJENATA O POZNAVANJU ČIMBENIKA KOJI UTJEČU NA ORALNO ZDRAVLJE NAKON OPERACIJE RAKA U USTIMA

Vlasta Kraševc¹, Danica Železnik², Uroš Železnik^{2,3}

¹ Sveučilišni klinički centar Ljubljana, Zaloška cesta 7, 1000 Ljubljana, Slovenija,

² Fakultet zdravstvenih studija Slovenj Gradec, Glavni trg 1, 2380 Slovenj Gradec, Slovenija

³ Dom zdravlja Ptuj, Potrčeva cesta 19a, 2250 Ptuj, Slovenija

SAŽETAK

UVOD: Podizanje svijesti o oralnoj higijeni je neophodno u svakoj životnoj fazi. Posebno je važno upoznati čimbenike rizika koji utječu na zdravlje u usnoj šupljini nakon operacije raka u ustima.

CILJ ovog rada je predstaviti stavove pacijenata o poznavanju čimbenika koji utječu na zdravlje u usnoj šupljini nakon operacije raka u ustima.

METODE I ISPITANICI: Izvršeno je kvantitativno neeksperimentalno deskriptivno istraživanje. Upitnik sadrži posebna pitanja vezana uz pacijentovo stajalište nakon operacije oralnog karcinoma sa osnovnim demografskim podacima (dob, spol, način života, razina obrazovanja) i pitanja vezana za informacije dobivene od strane medicinskih sestara. U istraživanju je sudjelovalo 112 slučajno odabranih bolesnika na kontrolnom pregledu nakon operacije usne šupljine na Klinici za oralnu i maksilofacijalnu kirurgiju Sveučilišnog kliničkog centra u Ljubljani.

REZULTATI: Istraživanje je pokazalo da je većina ispitanih pacijenata pušila, pila alkohol i imala nisko obrazovanje. Bolesnici poznaju čimbenike rizika nakon operacije, ali samo nekoliko njih promijenilo je svoj stil života.

RASPRAVA I ZAKLJUČCI: Obrazovanje pacijenata sastavni je dio liječenja i treba uključivati raspravu o mogućim oralnim komplikacijama. Vrlo je važno da zdravstveni tim utječe na pacijenta da optimalna oralna higijena tijekom liječenja, adekvatna prehrana i izbjegavanje duhana i alkohola može spriječiti ili minimizirati oralne komplikacije.

Cljučne riječi: faktori rizika, usna šupljina, rak, znanje, pacijent

Osoba za razmjenu informacija:

prof. dr. sc. Danica Železnik

E-adresa: zeleznik.danica@gmail.com