

“COMPARATIVE STUDY OF ERUPTION PATTERN OF PERMANENT DENTITION IN RURAL AND URBAN CHILDREN WITH RESPECT TO *PRAKRITI*”

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Abstract:

Impacted teeth / Unerupted teeth or malalignment of teeth are common problems seen in the children, lack of awareness on dental care is a serious issue in India. As compared to the urban population, the unawareness is significantly observed in the rural population. Also the environmental factors, nutritional status & socioeconomic condition may be the predisposing factors in permanent dentition. While doing the Prakritiparikshan under various aspects, Danta is also considered for deciding the prakriti i.e Vataj, Pittaj and Kaphaj. However, there is mention of relation of eruption pattern of Danta and Prakriti. Objective : Comparison of the eruption pattern of permanent dentition in rural and urban children with respect to Prakriti. Material and Method : A cross sectional observational study was conducted wherein total 210 participants were taken, which included 105 participants each from rural and urban region. As mentioned in methodology, obtained data through observational study was statistically analysed for comparison of eruption pattern of permanent dentition in rural and urban children with respect to Prakriti. Result: The results were interpreted and it was found that no significant difference was found between the eruption pattern of permanent dentition. No association was found with respect to Prakriti in rural an urban area. Conclusion : It is concluded that, no significant difference was observed in the rural and urban children in regard to the eruption of permanent dentition. No association between eruption pattern of permanent dentition and Prakriti was established.

Key words : Danta, , Permanent dentition, Eruption time, rural , urban Prakriti

Introduction:

The prime motto of *Ayurveda* is preserving the health of those who are hale and hearty in order to lay the foundation of a disease free society. *Ayurveda* advocates the maintenance of a healthy life by one's own right action.[1] The healthy status has to be ensured right from the cradle to the grave, from pediatric to geriatric age (*Balyaawastha* to *Jaraawastha*). *Ahar* is one of the *Upstambh* for maintaining health as it aids *Dhatuposhan*.[2] *Ahar* taken is converted into the *Ahara Rasa* after proper digestion. The process of digestion initiates at the oral cavity where the *Dant* (teeth) plays a significant role in chewing. Oral health is very important and critical for one's overall health. Yet it is often neglected. Though there is a special mention about *Dantangatrogas* by *Acharya Sushrut*.[3] the structural aspect is not elaborated in *Ayurved* text except for description by *Acharya Kashyapa*. The permanent dentition is of utmost importance not only for the aesthetic purpose but more importantly for chewing and pronunciation of consonants. Impacted teeth / Unerupted teeth or malalignment of teeth are common problems seen in the children, lack of awareness on dental care is a serious issue in India. As compared to the urban population, the unawareness is significantly observed in the rural population. Also the environmental factors, nutritional status & socioeconomic condition may be the predisposing factors in permanent dentition.[4]

In *Ayurveda* *Acharya* has explained many fundamental concepts like *Marma*, *Angapratyanga* and *Prakriti*. With respect to present era there are many more evidences connecting the concepts of *prakriti* of *Tridosha* with chronic diseases, metabolic pathways, , and various genotypes.[5] *Prakriti* is hereditary feature of person which reflects anatomical, physiological and psychological aspect of that person. *Prakriti* is decided at the time of birth by dominance of *Dosha* in *Shukra* and *Shonita* and remain same till death. Different physical properties of individual changes as per dominance of *Dosha* in *Prakriti*.[6] *Prakriti Parikshan* is helpful in preventive and curative aspect of diseases. Depending on accuracy of diagnosis and severity of disease, it becomes easier to treat the disease considering the

Prakriti. It exhibits attribute of the prevailing *Dosha* in physiological physical, as well as psychological characteristics.[7] Thus, *Prakritiparikshan* is one of essential criteria for examination with respect to prevention and management of diseases. While doing the *Prakritiparikshan* under various aspects, *Danta* is also considered for deciding the *prakriti* i.e *Vataj*, *Pittaj* and *Kaphaj*. *Danta* is unique structure with the predominance of *Prithavi Mahabhuta*. [8] *Danta* is type of *Ruchakasthi* and is considered as *Updhatu* of *Asthi* by *Sharangdhara*. [9] *Kashyapa* has described the *Dantasampat Lakshane* means properties of ideal teeth. According to Ayurveda, tooth erupt in normal healthy child 8th months onward and *Asthi* and *Majja Dhatu* are primarily involved in *Dantotpatti*. (eruption of tooth) [10] Information regarding *Danta* that is teeth is available in Ayurvedic text but is present in scattered manner. [11] *Danta* characteristics also varies with respect to different *Prakriti*. For example, in *Vata* dominant *Prakriti*, *Danta* are *Parusha*, *Tanu*, *Ruksha* and *Alpa*. However, there is no mention of relation of eruption pattern of *Danta* and *Prakriti*. The study is a humble effort to study eruption pattern of permanent dentition in rural and urban children with respect to *Prakriti*

Material And Methodology :

Present study was done in Wardha region for the period of 24 months. The data was collected through health check up camps from Pre-primary, Primary schools and Dental outpatient department representing subjects within age group of 6-13 yrs old. Subjects were selected randomly. Informed consent was taken from authority of institute through proper channel and from parents whoever concerned. Total 210 subjects, which included 105 children from rural area and 105 from urban area. Each group of 105 children comprised of seven subgroups with a class interval of one year ranging from 6 to 13 years. Children suffering from any disease or malnutrition were excluded. All the children were subjected to dental examination before recruitment and those whose crown of teeth was fully erupted i.e. completely seen in oral cavity after penetrating the gingiva were included in the study. The researcher had undergone training for dental examination at the department of Pedodontics at the constituent Dental college of the university.

Method of collection of data:

The observations were recorded in the case record form, which comprised of three parts, first included the demographic profile, Second consisted of data regarding, eruption pattern of permanent dentition and clinical examination of teeth and third regarding *Prakriti parikshan*.. On examination the eruption pattern, colour of tooth, shape of tooth, duration of dentition were observed.

Statistical analysis :

As mentioned in methodology, obtained data was statistically analysed by searching for Comparison of the eruption pattern of permanent dentition in rural and urban children with respect to *Prakriti*. Statistical analysis was done by using chi square test and software used in the analysis was SPSS 22.0 version and GraphPad Prism 7.0 version and $p < 0.05$ is considered as level of significance.

Observation and results:

In the seven subgroups in rural area, participants were maximum female except for age group 11 to 12 years. However in urban area the male participants exceeded the females except for age group 12-13 years. (Table no. 1). The participants in the rural area were from middle and low income group whereas in urban they were from upper and middle income group

(Table 2). In regard to consumption of milk, which is a source of calcium, strongly recommended for appropriate development of teeth, maximum children in rural and urban area in the age group of 6 to 10 years were taking *dughdahar*, however this number decreased from 10 years onwards in both the groups, more in the rural area. (Table no. 3). Maximum participants were following mixed type of diet. (Table no. 4). On observation of eruption of teeth, it was observed that in almost all participants from both rural and urban area, the eruption of specific teeth was as per the age mentioned for its eruption. (Table no. 5) In the assessment of prakriti more than 60% were of kaphapittaj prakriti followed by vata pittaj and kapha vataj prakriti. (Table no. 6). No association was found with eruption of permanent dentition with prakriti in both rural and urban children (Table no. 7)

Discussion :

Gender: Out of 210 children 105 from rural area and 105 from urban area. In the rural area, there were more female as compared to that of male whereas in urban area, males exceeded the female. (Table no. 1) Kashyapa has described that early eruption of teeth occurs in female as compared to male. [12] Contrast to our findings and similar to the statement of Kashyapa, study by Lorey R, Cecers S, Lesaffre E Declerck D. reported early eruption in female as compared to male. [13] However, no such findings were observed in our study. No significant difference was found in relation to gender. There is no significant result for rural and urban area individually and also there is no significant result for comparison of eruption pattern of dentition with reference to gender in the given age group. Thus we did not find any difference in tooth eruption in rural and urban area as per gender.

Socio economic status : Children from higher socio economic backgrounds show earlier tooth emergence as compared to that of lower. [14] But, in present study we found there is no difference in tooth eruption in rural and urban area as per socioeconomic status.

Considering the socioeconomic status of the rural and urban population P value was found to be significant in the rural area. This may be due to no participant in the rural area belonged to the upper socioeconomic status and only 1/4th them belonging to middle socioeconomic status and maximum 3/4th population belonging to lower socioeconomic status. This may be due to no participant in the urban area belonged to the lower socioeconomic status and only 1/2th them belonging to middle socioeconomic status. In urban area, the observations were totally contrast with no participant in lower socio economic group. Result was significant in rural area and non significant in urban area. Comparative result for eruption pattern according to socio-economic status of rural and urban area was not significant. (table 2)

Dugdhahar : Dugdhahar means inclusion of milk and milk products in diet. Milk is rich source of calcium and proteins. It is one of the essential factor for teeth remineralization. [15] In present study we found that there is no difference in tooth eruption in rural and urban area as per *Dugdhahar* as children in both the groups were taking *Dugdhahar* which is one of the source of calcium. We observed number of children taking *Dugdhahar* decreased with increasing age. This may be due to as they prefer to take full diet as compared to milk. In present study we found there is no difference in tooth eruption in rural and urban area as per *Dugdhahar*. It was hypothesized that the children in rural area may not taking milk due to low socioeconomic status. However it was found that the socioeconomic status did not affect the nutrition of the children from rural area.

Type of Diet : Diet play important role in the eruption pattern of teeth in children. In present study, we found children taking purely veg and mix diet, in age group taken for study in both rural and urban area. In our study it was observed that in rural area the participants consuming

mixed diet (80%) exceeded the children consuming pure vegetarian food. The same was observed in urban area, the percent of pure veg was 40% and mixed veg was 60%.

There was not significant result with respect to diet in rural and urban area individually and also there was not significant result in comparison between rural and urban area. This may be due to smaller sample size of each group. In present study we found there is no difference in tooth eruption in rural and urban area as per diet. (Table no. 4)

Type of prakriti : Maximum number of participants belonged to *Kapha pittaj prakriti* followed by *Kapha vataj prakriti* and *vata pittaj prakriti*. No participants with dominance of *Pitta* i.e, *Pittavataj* and *Pittakaphaj* were found. Also no children *Vatakaphaj prakriti* were found.

In present study we found there is no difference in tooth eruption in rural and urban area as per type of *prakriti*. (Table no. 5)

Correlation of eruption pattern of permanent dentition with prakriti : Prakriti is a phenotypic phenomenon. It results from a typical genotype.[16] Few of the related studies were reviewed[17,18]. On observation of eruption of permanent dentition in rural and urban population in relation to *prakriti*, no association was observed. In our study maximum number of participant belonged to *Kapha pittaj prakriti* followed by *Kapha vataj prakriti* and *Vata pittaj prakriti* respectively. No specific observation in regards to eruption of permanent teeth in relation to *prakriti* was found. This may be due to very small sample size in each group. In present study Comparison of eruption pattern of permanent dentition with respect to *prakriti* in between rural and urban area is significant in *Kapha pittaj prakriti*.(Table no. 6)

Eruption of teeth : In present study we found proper eruption of all types of teeth occurred at the given ages in both rural and urban area, there was no as such difference in eruption of teeth in rural and urban area. In present study Comparison of eruption of teeth in between rural and urban area is found to be non-significant. (table 7)

Conclusion:

Based on the observations of our study, it is concluded that, no significant difference was observed in the rural and urban children in regard to the eruption of permanent dentition.

No association between eruption pattern of permanent dentition and *prakriti* was established.

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Table no. 1: Distribution of children in rural and urban area according to gender

Age Group	Rural Area		Urban Area	
	Male	Female	Male	Female
6-7 yrs	6(40%)	9(60%)	12(80%)	3(20%)
7-8 yrs	4(26.67%)	11(73.33%)	10(66.67%)	5(33.33%)
8-9 yrs	6(40%)	9(60%)	11(73.33%)	4(26.67%)
9-10 yrs	6(40%)	9(60%)	7(46.67%)	8(53.33%)
10-11 yrs	7(46.67%)	8(53.33%)	9(60%)	6(40%)
11-12 yrs	9(60%)	6(40%)	12(80%)	3(20%)
12-13 yrs	2(13.33%)	13(86.67%)	5(33.33%)	10(66.67%)

- X²-Value =8.31,p-value=0.21,NS,p>0.05

Table no. 2: Distribution of children in rural and urban area according to socio-economic status.

Age Group	Rural Area			Urban Area		
	Upper	Middle	Low	Upper	Middle	Low
6-7 yrs	0(0%)	4(26.67%)	11(73.33%)	5(33.33%)	10(66.67%)	0(0%)
7-8 yrs	0(0%)	3(20%)	12(80%)	5(33.33%)	10(66.67%)	0(0%)
8-9 yrs	0(0%)	2(13.33%)	13(86.67%)	6(40%)	9(60%)	0(0%)
9-10 yrs	0(0%)	4(26.67%)	11(73.33%)	7(46.67%)	8(53.33%)	0(0%)
10-11 yrs	0(0%)	4(26.67%)	11(73.33%)	7(46.67%)	8(53.33%)	0(0%)
11-12 yrs	0(0%)	8(53.33%)	7(46.67%)	6(40%)	9(60%)	0(0%)
12-13 yrs	0(0%)	0(0%)	15(100%)	5(33.33%)	10(66.67%)	0(0%)

- X²-Value =13.13,p-value=0.0411,S,p<0.05

Table no. 3 : Distribution of children in rural and urban area according to *Dugdहार*

Age Group	Rural Area		Urban Area	
	Yes	No	Yes	No
6-7 yrs	14(93.33%)	1(6.67%)	15(100%)	0(0%)
7-8 yrs	10(66.67%)	5(33.33%)	15(100%)	0(0%)
8-9 yrs	12(80%)	3(20%)	14(93.33%)	1(6.67%)
9-10 yrs	10(66.67%)	5(33.33%)	13(86.67%)	2(13.33%)
10-11 yrs	9(60%)	6(40%)	11(73.33%)	4(26.67%)
11-12 yrs	7(46.67%)	8(53.33%)	12(80%)	3(20%)
12-13 yrs	8(53.33%)	7(46.67%)	10(66.67%)	5(33.33%)

- X²-Value =10.20,p-value=0.06,NS,p>0.05

Table no. 4 : Graphical distribution of children in rural and urban area according to type of diet.

Age Group	Rural Area		Urban Area	
	Vegetarian	Mixed Vegetarian	Vegetarian	Mixed Vegetarian
6-7 yrs	5(33.33%)	10(66.67%)	6(40%)	9(60%)
7-8 yrs	2(13.33%)	13(86.67%)	5(33.33%)	10(66.67%)
8-9 yrs	4(26.67%)	11(73.33%)	4(26.67%)	11(73.33%)
9-10 yrs	3(20%)	12(80%)	5(33.33%)	10(66.67%)
10-11 yrs	2(13.33%)	13(86.67%)	7(46.67%)	8(53.33%)
11-12 yrs	2(13.33%)	13(86.67%)	6(40%)	9(60%)
12-13 yrs	1(6.67%)	14(93.33%)	3(20%)	12(80%)

- X²-Value =5.12,p-value=0.52,NS,p>0.05

Table no. 5: Distribution of children in rural and urban area according to *Prakriti*.

Age Group	Rural Area			Urban Area		
	Vata pittaj	Kapha Pittaj	Kapha vataj	Vata pittaj	Kapha Pittaj	Kapha vataj
6-7 yrs	1(6.67%)	12(80%)	2(13.33%)	2(13.33%)	11(73.33%)	2(13.33%)
7-8 yrs	2(13.33%)	10(66.67%)	3(20%)	2(13.33%)	8(53.33%)	5(33.33%)
8-9 yrs	3(20%)	10(66.67%)	2(13.33%)	1(6.67%)	10(66.67%)	4(26.67%)
9-10 yrs	3(20%)	5(33.33%)	7(46.67%)	3(20%)	10(66.67%)	2(13.33%)
10-11 yrs	2(13.33%)	10(66.67%)	3(20%)	2(13.33%)	12(80%)	1(6.67%)
11-12 yrs	4(26.67%)	6(40%)	5(33.33%)	4(26.67%)	7(46.67%)	4(26.67%)
12-13 yrs	5(33.33%)	8(53.33%)	2(13.33%)	2(13.33%)	9(60%)	4(26.67%)

- X2-Value =8.31,p-value=0.75,NS,p>0.05

Table no. 6: Correlation of eruption pattern of permanent dentition with prakriti :

Following table shows the distribution of children in rural and urban area according to eruption pattern of permanent dentition with prakriti according to age group.

Table 6: Correlation of eruption pattern of permanent dentition with prakriti

Age Group	Jaw	Standard Eruption	Rural Area			Urban Area		
			Vata pittaj	Kapha Pittaj	Kapha vataj	Vata pittaj	Kapha Pittaj	Kapha vataj
6-7	Upper jaw	1 st Molar (M1)	1(6.67%)	10(66.67%) 2-No	2(13.33%)	2(13.33%)	11(73.33%)	2(13.33%)
	Lower jaw	Central Incisor (I1)	1(6.67%)	12(80%)	2(13.33%)	2(13.33%)	11(73.33%)	2(13.33%)
		1 st Molar (MI)	1(6.67%)	10(66.67%) 3-No	1-No	2(13.33%)	11(73.33%)	2(13.33%)
7-8	Upper jaw	Central Incisor(I1)	1(6.67%) 1-No	9(60%) 1-No	3(20%)	2(13.33%)	8(53.33%)	4(26.67%) 1-No
	Lower jaw	Lateral Incisor(I2)	2(13.33%)	10(66.67%)	3(20%)	2(13.33%)	8(53.33%)	4(26.67%) 1-No
8-9	Upper jaw	Lateral Incisor(I2)	3(20%)	10(66.67%)	3(20%)	1(6.67%)	10(66.67%)	4(26.67%)
	Lower jaw	-						

9-10	Upper jaw	-						
	Lower jaw	Canine (C)	3(20%)	5(33.33%)	6(40%)	3(20%)	10(66.67%)	3(20%)
10-11	Upper jaw	First Premolar (P 1)	2(13.33%)	10(66.67%)	3(20%)	2(13.33%)	12(80%)	1(6.67%)
	Lower jaw	First Premolar (P 1)	1(6.67%)	10(66.67%)	3(20%)	2(13.33%)	12(80%)	1(6.67%)
11-12		Second Premolar (P2)	4(26.67%)	6(40%)	5(33.33%)	4(26.67%)	7(46.67%)	4(26.67%)
	Upper jaw	Canine (C)	2(13.33%)	6(40%)	5(33.33%)	4(26.67%)	7(46.67%)	4(26.67%)
	Lower jaw	Second Premolar (P2)	4(26.67%)	6(40%)	5(33.33%)	4(26.67%)	6(40%)	3(20%)
12-13	Upper jaw	Second Molar (M2)	4(26.67%)	8(53.33%)	2(13.33%)	2(13.33%)	9(60%)	4(26.67%)
	Lower jaw	Second Molar (M2)	4(26.67%)	8(53.33%)	2(13.33%)	2(13.33%)	9(60%)	4(26.67%)

Table no. 7: Distribution of children in rural and urban area according to eruption of teeth

Age Group	Jaw	Standard Eruption	Rural Area	Urban Area
6-7 yrs	Upper jaw	1 st Molar (M1)	15(100%)	15(100%)
	Lower jaw	Central Incisor (I 1)	15(100%)	15(100%)
		1 st Molar (M1)	15(100%)	15(100%)
7-8 yrs	Upper jaw	Central Incisor(I 1)	14(93.33%)	14(93.33%)
	Lower jaw	Lateral Incisor(I 2)	14(93.33%)	14(93.33%)
8-9 yrs	Upper jaw	Lateral Incisor(I 2)	15(100%)	15(100%)
	Lower jaw	-	-	-
9-10 yrs	Upper jaw	-	-	-
	Lower jaw	Canine (C)	15(100%)	15(100%)
10-11 yrs	Upper jaw	First Premolar (P 1)	15(100%)	15(100%)
	Lower jaw	First Premolar (P 1)	15(100%)	15(100%)

11-12 yrs	Upper jaw	Second Premolar (P2)	15(100%)	15(100%)
		Canine (C)	15(100%)	15(100%)
	Lower jaw	Second Premolar (P2)	15(100%)	15(100%)
12-13 yrs	Upper jaw	Second Molar (M2)	15(100%)	15(100%)
	Lower jaw	Second Molar (M2)	15(100%)	15(100%)