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Assessment Of Knowledge, Perceptions, And Clinical Practices Regarding Molar-Incisor Hypomineralisation Among Saudi Dental Professionals: A Cross-Sectional Study

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ABSTRACT

Background: *The increasing incidence and clinical importance of molar-incisor hypomineralization (MIH), a developmental enamel deficiency, make it an important issue in dentistry that is acknowledged as a worldwide public health concern. Although MIH is becoming more well known around the world, very little is known about how Saudi dentistry practitioners understand and use this concept.*

Aim: *This survey is needed to find out what dentists know about MIH, how they feel about it, and their clinical experiences with it.*

Methods: *A nationwide, cross-sectional study was conducted from September to December 2024 via a structured online questionnaire distributed via professional forums and social media platforms. The survey assessed sociodemographic information, MIH-related knowledge, clinical experience, and management strategies. A modified knowledge score (KS) model was applied. The data were analysed via descriptive statistics, chi-square tests, and Kruskal–Wallis tests to identify intergroup differences.*

Results: *Out of 257 respondents, 24 were pediatric dentists, 130 were general dental practitioners, and 103 were other dental specialists. While 89.5% of all participants and 100% of paediatric dentist correctly identified MIH as a developmental anomaly, knowledge scores were generally lower than international benchmarks. Significant differences were found in clinical experience and treatment approaches across groups. Fluoride varnish was the most commonly used preventive measure (64.2%), whereas composite resin and glass ionomer cement were the predominant restorative materials. Dental professionals preferred prefabricated crowns, whereas general dental practitioner and other dental specialist were more reliant on composite restorations.*

Conclusion: *This study highlights a substantial gap in MIH-related education among Saudi dental professionals, especially those outside of pediatric dentistry. Enhancing training through curriculum changes and continued professional development leads to early diagnosis, better treatment, and improved patient outcomes. A coordinated, multidisciplinary approach is recommended to address MIH as a pressing oral health issue in Saudi Arabia.*

Keywords: *Molar-Incisor Hypomineralization, MIH, paediatric dentistry, dental education, enamel defect, Saudi, clinical management, knowledge assessment*

INTRODUCTION

There has been research on early permanent molar opacities since the late 1970s, but the term "molar incisor hypomineralisation" (MIH) was not used until 2001 by the European Academy of Pediatric Dentistry (EAPD) (1, 2). The assessment, mitigation, and treatment of MIH are the primary foci of numerous studies (3, 4). One or more first permanent molars, but seldom upper permanent incisors, might experience molar incisor hypomineralisation (MIH), a qualitative developmental enamel abnormality initially documented by Weerheijm et al. (5) in 2001. Extreme cases of this condition present defined opacities with structural loss and a white-creamy or yellow–brown color, a condition known as posteruptive enamel breakdown (PEB) (6).

Currently, MIH is a progressively prevalent dental anomaly in clinical practice. The global prevalence is estimated at 13.5%, with impacted incisors in 36.6% of cases, and approximately 27.4% of patients (7) necessitate treatment interventions (8). Clinically, MIH is distinguished by enamel translucency accompanied by a colouration that ranges from white to yellowish-brown, contingent upon severity (9,

10). As a result, hypomineralised enamel is hypersensitive and deteriorates after eruption; it can also develop carious lesions and cause pain (11). Research on medical professionals' knowledge and training in MIH dates back to the turn of the century. Knowledge, opinions, and clinical experiences are the subjects of a plethora of studies spanning several nations (12).

Given that MIH is presently acknowledged globally as a public health issue (13, 14) with a rising incidence and a worldwide prevalence of approximately 13.1% (18), coupled with the dearth of research in Saudi Arabia concerning paediatric dentists' perceptions in both public and private sectors regarding the factors linked to the condition's development and clinical features, it is critical to improve dental treatment for children with MIH by studying paediatric dentists' understanding of the condition and their perspectives on it.

METHODOLOGY

This cross-sectional study focused on dentists registered with the Saudi Dental Council. A systematic, online questionnaire was disseminated nationally via Google Forms from September to December 2024. The survey was disseminated via professional dental forums, WhatsApp groups, and social media platforms, including Facebook and LinkedIn, to augment participation.

The study followed ethical guidelines, with the principles outlined in the Helsinki Declaration assuring the research process's integrity. Before participating in the study, all participants were informed of its purpose and provided their consent to participate. The participants voluntarily and anonymously completed the questionnaire, which permitted flexibility in response time and reduced the likelihood of response bias. The questionnaire was modified from previously validated tools utilised by Gambetta-Tessini et al. (15) and Gamboa et al. (16) and was tailored to the Saudi clinical situation. It was organised into three primary sections:

1. Sociodemographic Data

Each participant's age, sex, and years of clinical practice were categorised as follows: 5–10 years, 11–20 years, or more than 21 years. Degrees such as BDS, master's, PhD, postgraduate diplomas, or specialized certifications were considered acceptable. On the basis of their main area of practice, dentists are divided into three groups: general dental practitioners (GDPs), paediatric dentists (PDs), and other dental specialists (ODSs).

2. Evaluation of knowledge

The understanding of molar-incisor hypomineralisation (MIH) was evaluated via a knowledge score (KS) model modified from Gambetta-Tessini et al. (15). The discussion encompassed the etiology, developmental time, and clinical signs of MIH, along with the typical distribution of caries. The grading criteria for KS are specified in the Statistical Analysis section.

3. Perceptions, Clinical Experience, and Confidence in the Management of MIH

This part evaluated respondents' self-reported exposure to MIH cases, their diagnostic and treatment experiences, and their confidence in managing such cases. Preferences for professional development in MIH, such as workshops, webinars, and CME sessions, were documented. Stainless steel crowns, extractions, microabrasion, resin infiltration, glass ionomer cement, composite resin, and fluoride varnish were among the management options that were evaluated. Owing to the lack of national MIH prevalence data in Saudi Arabia, the global prevalence statistics provided by Schwendicke et al. (2018) (8) were utilised for contextual comparison.

Pilot Testing and Validation of the Questionnaire

The questionnaire was pilot tested with a convenience sample of 15 dentists (5 PDs, 5 GDPs, and 5 ODSs) from various regions of Saudi Arabia. The participants (8 women and 7 men, aged 27–52 years) had clinical experience ranging from less than 5 years to 25 years. Feedback was utilised to enhance terminology and contextual references for clarity and pertinence to Saudi dental practice. The English-language version of the questionnaire was implemented via Google Forms.

Statistical Examination

All replies were automatically recorded in a Google Sheets database and subsequently exported for analysis with R statistical software. Descriptive statistics, including frequencies, means, and percentages, were computed for sociodemographic and practice-related factors. The Shapiro–Wilk test was employed

to assess data normality, and homoscedasticity was evaluated before performing group comparisons. The disparities among GDPs, PDs, and ODSs were evaluated as follows: Kruskal–Wallis tests for continuous variables ▪ Chi-square analyses for categorical variables. Calculation of the knowledge score (KS): Responses in the knowledge section were evaluated according to the revised KS framework established by Gambetta–Tessini et al. (15) (scoring rubric outlined in Supplementary Annex S1). KS was regarded as a continuous variable, with potential scores ranging from 20 to 60. A p-value less than 0.05 was deemed statistically significant for all inferential analyses.

RESULTS

This study examined dental professionals' knowledge of and attitudes toward MIH to enhance oral care for affected children. Table 1 shows the demographics and professional characteristics of 257 Saudi dentists, divided into general dental practitioners (GDPs, n=130), paediatric dentists (PDs, n=24), and other dental specialists (ODSs, n=103). Overall, 66.1% of the respondents were female, with more PDs (95.8%) than GDPs (73.8%) and ODSs (49.5%) ($p < 0.001$). The age distribution differed considerably among the groups ($p < 0.001$), with GDPs being younger (53.8% ≤ 30 years) and PDs being evenly distributed between 31–40 and 41–50 years. In the 31–50 age range, ODSs were most prevalent. Only a small percentage of the dentists in all the groups were over 51. The groups differed significantly in years of professional experience ($p < 0.001$). The GDP practitioners had fewer than 5 years of experience (42.3%), whereas the PD practitioners had 5–10 years (41.7%). Most ODS (41.7%) had 11–20 years of experience. Educational credentials differed considerably among groups (p 0.001): GDPs mostly held basic dental degrees or MSc/PhDs (23.9%), whereas ODSs favoured speciality degrees with MSc/PhDs (8.2%). PDs were evenly distributed by qualification level, with a minor preference for specialty training. These data revealed statistically significant demographic and professional differences among the dental subgroups. Different dental practitioner groups answered knowledge-based questions about molar-incisor hypomineralization (MIH), as shown in Table 2. In total, 89.5% of the participants and 100% of the paediatric dentists correctly identified MIH as a developmental abnormality separate from amelogenesis and hypoplasia. The group differences were not statistically significant ($p^* = 0.185$). The most prevalent estimate of MIH incidence was 5–10% (31.1%), whereas 21% were unclear, notably PDs (41.7%). MIH can develop from pregnancy to the third year of life, according to 38.5% of respondents, especially PDs (50%). None of the knowledge questions showed statistically significant differences between groups ($*p^* > 0.05$), indicating that general, pediatric, and specialty dental practitioners comprehend the nature, prevalence, and etiological window of MIH similarly.
Most participants (83.7%) reported experiencing MIH cases in their practice, with 100% of paediatric dentists (PDs) reporting clinical experience ($p = 0.060$) (Table 3). However, the most prevalent developmental abnormalities were significantly different ($p < 0.001$). GDPs (38.5%) and PDs (33.3%) reported yellow/brown opacities the most (38.5%), whereas ODSs reported both white and yellow/brown opacities (76.7%). Only 15.6% of the respondents experienced posteruptive fractures or opacities. Fluoride varnish was the most popular preventative measure (64.2%), especially among GDPs (72.3%) and PDs (66.7%), with substantial intergroup differences ($p = 0.001$). Fewer CPP-ACP and fissure sealants were used, with more GDPs using them more. Most restorative treatments were composite (52.1%) and glass ionomer cement (GIC; 38.5%), with GDPs and ODSs preferring composites. Compared with the other groups, the PD group chose prefabricated crowns (20.8%) more because of their clinical exposure to paediatric patients. Extraction was infrequently used (2.7%), indicating a preference for cautious treatment. These findings show that dental specialities recognise and treat MIH differently.

DISCUSSION

Given that MIH constitutes a global concern and that developing nations bear the majority of the cost, addressing the existing knowledge gaps in these countries is imperative (5). This study was the first to examine Saudi paediatric dentists' understanding of MIH and their attitudes towards the topic. In areas where precise population estimates of this abnormality are scarce or nonexistent, it is especially important for paediatric dentists to recognise MIH as a clinical concern to handle this condition. To develop treatment plans that provide children with efficient and high-quality oral health care, it is essential to

study dentists' knowledge and awareness of MIH. In the present study, 89.5% of the participants and 100% of the paediatric dentists accurately recognised MIH as a distinct developmental anomaly, independent of amelogenesis and hypoplasia. A comparable study by Neves et al. (13) revealed that nearly all respondents (98%) recognised MIH; however, it did not delineate the proportion of participants or paediatric dentists who classified MIH as a distinct developmental anomaly from amelogenesis and hypoplasia.

The mean knowledge score (KS) in this study was inferior to those reported in prior research conducted in Australia (15), Chile (15), and Hong Kong (16). The KS metric introduced by Gambetta-Tessini (15) facilitates cross-group comparisons on the basis of geographic location and specialty while monitoring advancements in education, including continuing education initiatives or curriculum enhancements in paediatric dentistry. These findings highlight the necessity of rigorously assessing MIH-related curricular content in dental institutions at both the undergraduate and specialty training stages and of creating specialised courses designed for professional career advancement.

The current investigation revealed a statistically significant difference in the identification of the most prevalent developmental anomaly ($p < 0.001$). The GDPs (38.5%) and PDs (33.3%) predominantly presented yellow/brown opacities (38.5%), whereas the ODSs presented both white and yellow/brown opacities (76.7%). Only 15.6% of the participants experienced posteruptive fractures or opacities. Dummer et al. (17) noted that 48.9% of children exhibited enamel abnormalities, with a greater prevalence of yellow opacities observed in boys.

In this study, fluoride varnish emerged as the predominant preventive measure (64.2%), particularly among general dental practitioners (72.3%) and paediatric dentists (66.7%), who exhibited significant intergroup disparities ($p = 0.001$). CPP-ACP and fissure sealants were utilised less frequently, with general dental practitioners employing them more extensively. The majority of restorative procedures consisted of composite materials (52.1%) and glass ionomer cement (GIC; 38.5%), with general dental practitioners (GDPs) and oral health care providers (ODPs) favouring composites. Dental professionals choose prefabricated crowns (20.8%) more frequently than other groups do owing to their clinical experience with patients. Extraction was rarely employed (2.7%), indicating a predilection for conservative interventions. Delgado et al. (1) reported that treatment techniques for PDs primarily favoured glass ionomers (75.0%), preformed crowns (70.8%), and composite resins (58.3%). Conversely, GDPs and ODSs favoured composite resins (54.6% and 57.3%, respectively), resin infiltration (39.2% and 29.1%), and glass ionomers (36.9% and 30.1%).

The results reveal a significant deficiency in MIH education among dentists. We have observed similar trends in Portugal, Malaysia, and Hong Kong, where dentists exhibit a lack of MIH training (16, 18). Improved access to information is crucial for the early identification of MIH and the appropriate care of patients. Timely diagnosis enables preventive interventions, reduces posteruptive fractures and sensitivity, and guarantees proper monitoring of afflicted teeth (16). Therefore, enhanced dissemination of MIH knowledge is essential for a unified public health response, necessitating interdisciplinary coordination among dental specialists.

This study, while pioneering in its focus on Saudi dental professionals knowledge and perceptions of molar-incisor hypomineralization (MIH), is not without limitations. First, the use of an online questionnaire and convenience sampling through social media and professional forums may have introduced selection bias, potentially excluding nontech-savvy professionals or those less engaged in digital platforms. Additionally, the relatively small number of paediatric dentists compared with other groups limits the statistical power to generalise subgroup-specific findings across the broader population of dental practitioners. Self-reported data also carry the risk of recall and social desirability biases, which may affect the accuracy of participants' responses regarding their clinical experiences and confidence levels.

CONCLUSION

Despite these limitations, the findings underscore a significant gap in MIH-related knowledge and clinical preparedness among Saudi dental professionals, particularly general dental practitioners and other specialists. While awareness of MIH as a distinct developmental condition is relatively high, practical

knowledge and confidence in diagnosis and management vary notably across specialties. This calls for the integration of comprehensive MIH-focused modules into undergraduate and postgraduate dental curricula, as well as the promotion of continuing professional development initiatives such as workshops and webinars. Addressing these educational gaps is critical for enhancing early diagnosis, guiding effective treatment, and ultimately improving oral health outcomes for children affected by MIH in Saudi Arabia.

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Table 1: Demographic distribution of study participants

Characteristics	Total N = 257 n (%)	GDPs N = 130 n (%)	PD N = 24 n (%)	ODS N = 103 n (%)	p value
Sex					
Female	170 (66.1)	96 (73.8)	23 (95.8)	51 (49.5)	<0.001
Male	87 (33.9)	34 (26.2)	1 (4.2)	52 (50.5)	
Age group					
≤ 30	98 (38.1)	70 (53.8)	5 (20.8)	23 (22.3)	<0.001

31–40	72 (28.0)	18 (13.8)	11 (45.8)	43 (41.7)	
41–50	78 (30.3)	35 (26.9)	6 (25.0)	37 (35.9)	
≥ 51	9 (3.6)	7 (5.5)	2 (8.3)	3(2.9)	
Years of practice					<0.001
< 5	73 (28.4)	55 (42.3)	2 (8.3)	16 (15.5)	
5–10	68 (26.5)	28 (21.5)	10 (41.7)	30 (29.1)	
11–20	89 (34.6)	37 (28.5)	9 (37.5)	43 (41.7)	
> 21	27 (10.5)	10 (7.7)	3 (12.5)	14 (13.6)	
Degree level					<0.001
DDS/MSc/PHD	110 (42.8)	62 (23.9)	7 (2.7)	41 (16.0)	
Postgraduation + MSc/PhD	125 (48.6)	65 (25.3)	9 (3.5)	51 (19.8)	
Specialty + MSc/PhD	32 (12.4)	3 (1.2)	8 (3.1)	21 (8.2)	

Table 2: Comparison of knowledge about MIH among study participants

Questions	Total N = 257 N (%)	GDPs N = 130 N (%)	PDs N = 24 N (%)	ODSs N = 103 N (%)	p value
It is known that MIH is a developmental defect that differs from amelogenesis and hypoplasia?					
Yes	230 (89.5)	118 (90.8)	24 (100.0)	88 (85.4)	0.185
No	27 (10.5)	12 (9.2)	0 (0.0)	15 (14.6)	
What is the prevalence of MIH in Portugal?					
< 5%	40 (15.6)	17 (13.1)	1 (4.2)	22 (21.4)	0.152
5–10%	80 (31.1)	39 (30.0)	6 (25.0)	35 (34.0)	
10–20%	48 (18.7)	25 (19.2)	6 (25.0)	17 (16.5)	
> 20%	35 (13.6)	18 (13.8)	1 (4.2)	16 (15.5)	
Not sure	54 (21.0)	31 (23.8)	10 (41.7)	13 (12.6)	
What is the period/duration that this occurrence can happen?					0.425
During the pregnancy	50 (19.5)	26 (20.0)	3 (12.5)	21 (20.4)	
First year of life	25 (9.7)	15 (11.5)	0 (0.0)	10 (9.7)	
Third year of life	13 (5.0)	8 (6.2)	0 (0.0)	6 (4.9)	
Pregnancy up to the first year of life	70 (27.2)	30 (23.1)	9 (37.5)	31 (30.1)	
Pregnancy up to the third year of life	99 (38.5)	51 (39.2)	12 (50.0)	36 (35.0)	
In your opinion, do you think the pattern of caries related to MIH is different from the classic caries pattern?					
Yes	226 (86.7)	118 (91)	25 (96.1)	87 (85.1)	0.4112
No	11 (4.1)	4 (2.8)	2 (4.9)	7 (6.3)	
Not sure	20 (7.8)	11 (7.9)	0 90.0)	10 (9.6)	
Knowledge score, mean (SD) [min–max]	40.1 (5.3)	42.3 ((6.3)	39.9 (5.2)	41.1 (3.9)	0.221

Table 3: Perception of study participants regarding MIH

Questions	Total N = 257 N (%)	GDPs N = 130 N (%)	PDs N = 24 N (%)	ODSs N = 103 N (%)	p value
In your clinical practice, do you find cases of MIH?					
Yes	215 (83.7)	106 (81.5)	24 (100.0)	85 (82.5)	0.060
No	42 (16.3)	24 (18.5)	0 (0.0)	18 (17.5)	
What is the most common type of dental development defect that you find in your clinical practice?					
White opacities	48 (19.2)	32 (25.1)	3 (8.9)	20 (19.1)	<0.001
Yellow/brown opacities	81 (30.9)	48 (35.6)	7 (21.9)	33 (32.4)	
Posteruptive fractures	5 (1.9)	2 (1.8)	3 (9.2)	2 (1.4)	
None	17 (6.8)	7 (5.8)	0 (0.0)	8 (8.1)	
Posteruptive fractures and Yellow/brown opacities	15 (5.6)	2 (1.8)	7 (22.3)	6 (6.6)	
White opacities and Yellow/brown opacities	76 (29.2)	41 (31.9)	6 (28.3)	27 (26.7).	
White opacities. Yellow/brown opacities and Posteruptive fractures	14 (5.1)	5 (3.8)	4 (13.7)	4 (4.2)	
What type of preventive treatment do you usually apply for these teeth?					
Fluor varnish	165 (64.2)	94 (72.3)	16 (66.7)	55 (53.4)	0.001
Diamino-fluoride of silver	14 (5.4)	5 (3.8)	1 (4.2)	8 (7.8)	
CCP-ACP or cracked amorphous casein phosphate	45 (17.5)	12 (9.2)	14 (58.3)	19 (18.4)	
Crack Sealant	102 (39.7)	60 (46.2)	4 (16.7)	38 (36.9)	
others	67 (26.1)	32 (24.6)	5 (20.8)	30 (29.1)	
What type of treatment do you usually apply for MIH?					
Microabrasion	49 (19.1)	25 (19.2)	6 (25.0)	18 (17.5)	
Infiltrating resin	89 (34.6)	53 (40.8)	5 (20.8)	31 (30.1)	
Glass ionomer	100 (38.9)	49 (37.7)	18 (75.0)	33 (32.0)	
Composite	148 (57.6)	72 (55.4)	14 (58.3)	62 (60.2)	
Amalgam	4 (2.2)	0 (0.0)	0 (0.0)	2 (1.9)	
Preformed crowns	75 (29.2)	28 (21.5)	17 (70.8)	30 (29.1)	
Extraction	7 (2.7)	2 (1.5)	3 (12.5)	2 (1.9)	