Dental Hospital Admissions in the Children of Mothers with an Alcohol-Related Diagnosis: A Population-Based, Data-Linkage Study

Colleen M. O’Leary, BSc, MPH, PhD1, and Linda M. Slack-Smith, BSc, Grad Dip(Med Tech), MSc, PhD2

Objective To investigate the relationship between maternal alcohol-use disorder and dental hospital admissions in children up to 5 years of age.

Study design Mothers with an International Classification of Diseases, 9th revision/10th revision alcohol-related diagnosis, a proxy for alcohol-use disorder, were identified through the Western Australian data-linkage system. Exposed mothers were frequency-matched by maternal age, Aboriginal status, and child’s birth year to randomly selected comparison mothers without an alcohol diagnosis. Linkage with the Midwives Notification System (1983-2002) identified all births of these mothers; “exposed” (non-Aboriginal, n = 11 171; Aboriginal, n = 8145) and comparison cohorts (non-Aboriginal, n = 32 508; Aboriginal, n = 16 719). Dental hospital admissions were identified through linkage with Hospital Morbidity Data (1983-2007) (3.2% exposed; 3.0% comparison) and cases of fetal alcohol syndrome (n = 84) through linkage with the Western Australian Register of Developmental Anomalies. ORs and 95% CIs for having a dental admission (International Classification of Diseases, 9th revision: 520-529; International Classification of Diseases, 10th revision: K0-K14.9) were generated by the use of generalized estimating equations, which we adjusted for potential confounding factors (aOR).

Results Children of mothers with an alcohol-related diagnosis had increased adjusted odds of gingivitis and periodontal diseases (aOR 1.67; 95% CI 1.12-2.51) and “other” diseases of the lip and oral mucosa (aOR 1.56; 95% CI 1.21-2.01). Diseases of the salivary glands were increased only in Aboriginal children of mothers with an alcohol-related diagnosis (aOR 2.65; 95% CI 1.09-6.44). Children diagnosed with fetal alcohol syndrome had increased ORs of any dental admission (aOR 2.58; 95% CI 1.30-5.11).

Conclusions Maternal alcohol-use disorder was associated with dental admissions related to disorders of the soft tissues, but questions remain regarding perinatal influences on dental admissions and disease. (J Pediatr 2013;163:515-20).

Fetal exposure to teratogens such as alcohol have been associated with many poor health outcomes.1 Such studies support the Barker hypothesis, which states circumstances in utero “program” later disease risk,3 and the “life-course approach,” which suggests that adverse factors accumulate across the lifespan.4 Exposure to alcohol during pregnancy increases the risk of a distinct range of characteristics known as fetal alcohol syndrome (FAS). Characteristics of FAS include facial dysmorphology, impaired growth, and neurodevelopmental disorders.2 Across the life-course, exposure to environmental risk factors associated with heavy maternal alcohol use can also indirectly increase the risk of harm to the child.5 Animal models indicate a relationship between fetal alcohol exposure and variations in tooth development and immune receptor changes.6 It has been suggested that alcohol exposure affects epidermal growth factor receptors, which in turn may have an impact on dental proliferation and differentiation.6 However, these results may not readily translate to humans. Potential models for an association between pregnant women with heavy alcohol use and their child requiring a dental admission include: (1) direct teratogenic effect of alcohol on tooth development, particularly enamel, leaving the tooth more vulnerable to dental caries or via growth effects7; (2) effect of facial deformity, which can lead to mouth breathing and increased risk of caries8; (3) effect of alcohol on immune system,6,9 impacting dental infections and disease processes such as periodontitis10; or (4) factors associated with socioeconomic status, because exposed mothers tend to have low incomes, have their children at a younger age, have poorer hygiene, be poorly nourished, and to be exposed to other drugs and substances.11 There has been limited research on the influence of fetal exposures on the etiology of dental caries and other disorders of the oral cavity in humans. Research on perinatal influences may offer prevention options in oral health,12 particularly given the inadequate dental workforce.13

Dental hospital admissions are the result of many factors representing the severe spectrum of dental caries and related disorders of the oral cavity14 and will be...
affected by service availability, professional practice at the time, and other factors such as the cost of private dental services. In Australia, 85% of dental care is provided through the private system, the majority of dental practices (75%) are located within the metropolitan area, and few Western Australian children (approximately 40%) younger than 5 years of age visit a dental professional.

The aim of this study was to use linked population-based data to investigate dental hospital admissions for childhood dental caries and other diseases of the oral cavity in children of mothers with an alcohol-related diagnosis. On the basis of the literature, we hypothesized that children of mothers with an alcohol-related diagnosis would have more dental hospital admissions than children of mothers without this diagnosis.

Methods

All women with a live birth recorded on the Western Australian Midwives Notification System (1983-2007) were eligible for selection into the total-population cohort study. Mothers with an alcohol-related diagnosis, a proxy for maternal alcohol-use disorder indicating heavy alcohol consumption, and a comparison cohort of mothers without an alcohol-related diagnosis were identified through record linkage of routinely collected population-based birth, hospital, mental health outpatient, and drug and alcohol services data. The data linkage was undertaken through the Western Australian Data Linkage Unit with the use of probabilistic matching. After linkage, a unique identifier replaces identifying information, and deidentified data files were provided to the researchers.

All mothers and their infants of at least 20 weeks’ gestation or 400 g of birthweight born in Western Australia 1983-2007 were identified through the Midwives Notification System, a statutory population-based system. Birth information on maternal demographic characteristics, maternal health, and pregnancy, labor, delivery, and infant outcomes is forwarded to the Western Australian Department of Health within 2 days after birth (statutory notification) and collated with the Hospital Morbidity Dataset and the Registry of Births, Deaths, and Marriages to ensure complete ascertainment.

The Hospital Morbidity Data System collects data on all hospital admissions in Western Australia, including demographic and clinical information. Trained data coders classify diseases and other health problems recorded by the attending medical officer(s) on the patient’s medical record. There are up to 21 diagnoses recorded for each hospital admission according to the International Classification of Diseases, 9th revision (ICD-9) and International Classification of Diseases, 10th revision (ICD-10) and one diagnostic code for the Mental Health Outpatient system, which collects data on mental health outpatient contacts. The Drug and Alcohol Office collects data on Perth-based treatment services and collects information on the 4 licit/illicit drugs of concern for the client.

Cases of FAS were identified through linkage of the birth data with data from the Western Australian Register of Developmental Anomalies. The Register of Developmental Anomalies collects information for the Western Australian population on birth defects diagnosed in stillbirths, terminations of pregnancy, and live births up to 6 years of age via multiple sources of ascertainment. Each birth defect is coded according to the British Paediatric Association International Classification of Diseases, 9th revision. Cases of FAS reported to the Register are diagnosed by individual clinicians, not through a centralized clinic.

Ethics approval for the conduct of this study was granted by the Princess Margaret Hospital Research Ethics Committee, the Human Research Ethics Committee, Western Australia Department of Health, the Western Australian Aboriginal Health Information Ethics Committee, and the Curtin Human Research Ethics Committee; Western Australian ethics committees do not allow researchers who use linked data to report numbers in which the number of cases within a stratum is <5 to prevent the likelihood of identification of individuals.

The exposed cohort are all mothers with an alcohol-related diagnosis (ICD-9 and/or ICD-10) recorded on one or more of the Western Australian birth, hospital, mental health outpatient, and drug and alcohol services datasets (1983-2007). The ICD-9 and/or ICD-10 codes within the categories of: (1) mental and behavioral disorder (alcohol-related); (2) an alcohol-related disease with a 100% attributable fraction; and (3) other alcohol codes were used and have previously been published.

The comparison cohort comprises mothers with a birth recorded on the Midwives Notification System (1983-2007) who did not have an alcohol-related diagnosis identified on the datasets described previously. A random selection of comparison mothers were frequency matched to mothers with an alcohol diagnosis on maternal age at the birth of the child within maternal Aboriginal status and year of birth at a ratio of approximately 4 non-Aboriginal comparison mothers to every exposed non-Aboriginal mother and 2 Aboriginal comparison mothers to every exposed Aboriginal mother. For this study, we restricted the cohorts to live births occurring between 1983 and 2002 to ensure that all children had turned 5 years of age by December 2007, the most recent year of our hospital data.

Classification of Dental Hospital Admissions

The outcomes under investigation were having any dental admission by the child’s fifth birthday (ICD-9: 520-529; ICD-10: K0-K14.9) or admission for one of the individual dental diagnoses: disorders of tooth development, dental caries, diseases of hard tissues of teeth, diseases of pulp and periapical tissues, gingivitis and periodontal diseases, other diseases of the lip and oral mucosa, dentoanomalies, other disorders of teeth and supporting structures, oral cysts, diseases of the jaw, diseases of the salivary glands, stomatitis and related lesions, and diseases of the tongue. Dental admissions resulting from trauma were not examined in this study.
The ICD-9/ICD-10 codes used to identify each dental diagnosis are listed in Table I (available at www.jpeds.com).

Statistical Analyses
Maternal alcohol diagnosis was coded as a binary “any” alcohol diagnosis (yes/no). The net excess proportions of dental admissions were calculated per 1000 live births, for significant results. Logistic regression incorporating generalized estimating equations, which takes into account the correlation between pregnancies to the same mother, was used to examine the association between any maternal alcohol diagnosis and any dental admission and each of the individual diagnostic classifications. We were unable to separately examine the association between dental admissions and alcohol diagnoses recorded during pregnancy because of small numbers. Generalized estimating equation analyses were conducted with SPSS version 19.0 (SPSS Inc, Chicago, Illinois). Results are presented as aOR with 95% CIs. Analyses were conducted for 3 categories: (1) any dental admission and each individual dental diagnosis; (2) dental admissions for non-Aboriginal and Aboriginal children; and (3) children with FAS. All analyses were adjusted for the factors used in frequency matching; maternal age and year of birth and maternal Aboriginal status, which were obtained from the Midwives Notification System and were available for all mothers. We also examined maternal illicit drug use, maternal depression (any ICD-9/ICD-10 code for either of these or a record of illicit drug use on the Drug and Alcohol Office dataset), and socioeconomic status as potential confounders. Socioeconomic status at the birth of the child was obtained through linkage with Australian Bureau of Statistics data; missing data were classified as “unknown.” Illicit drug use did not alter the OR by 20% or greater in any analyses so was not included in the final models. Maternal depression and socioeconomic status were included in the final model for “other” diseases of lip and oral mucosa for non-Aboriginal children because they reduced the OR by 20%. When there were fewer than 5 cases, the numbers were not reported and analyses not conducted.

Results
The cohort comprised 68,543 children born between 1983 and 2002, of whom 19,316 (28.2%) were born to mothers with an alcohol diagnosis recorded on the health datasets. There were 11,171 (57.8%) non-Aboriginal and 8,145 (42.2%) Aboriginal births (Table II). Mothers with an alcohol-related diagnosis were more likely to be of lower or unknown socioeconomic status at the birth of their children than comparison mothers. Exposed mothers were more likely to have diagnoses recorded in the health datasets for illicit drug use (38.3% non-Aboriginal and 21.5% Aboriginal) than comparison mothers (1.4% and 4.4%, respectively) and/or depression (non-Aboriginal 30.3% vs 3.1%; Aboriginal 12.5% vs 4.8%).

There were 2,609 children with a dental admission occurring by 5 years of age; 4.0% of exposed and 3.7% of comparison children (Table III). The majority of these children (98%) had only one dental admission. There were 3,156 dental diagnoses in total; 951 (30.1%) in exposed and 2,205 (69.9%) in comparison children. Dental caries was the most frequently occurring diagnosis, occurring in 52.9% of exposed and 61.5% of comparison children, followed by diseases of pulp and periodontal diseases (19.5%; 18.6%), “other” diseases of the lip and oral mucosa (13.1%; 7.6%), gingivitis and periodontal diseases (4.3%; 2.5%), and diseases of the salivary glands (1.7%; 0.8%), respectively. The numbers of admissions were too low to examine for diseases of hard tissues of teeth, dentofacial anomalies,
Children with a dental diagnosis (n)

<table>
<thead>
<tr>
<th>Oral diagnoses</th>
<th>Any alcohol diagnosis, n = 19316 (n (%))</th>
<th>No alcohol diagnosis, n = 49227 (n (%))</th>
<th>Net excess proportion per 1000 live births (95% CI)</th>
<th>OR (95% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>18536 (96.0)</td>
<td>47398 (96.3)</td>
<td>-</td>
<td>Referent</td>
</tr>
<tr>
<td>1</td>
<td>619 (3.2)</td>
<td>1471 (3.0)</td>
<td>2.2 (–0.7; 5.1)</td>
<td>1.07 (0.97-1.18)</td>
</tr>
<tr>
<td>2+</td>
<td>161 (0.8)</td>
<td>358 (0.7)</td>
<td>1.1 (–0.4; 2.6)</td>
<td>1.12 (0.93-1.36)</td>
</tr>
</tbody>
</table>

Disease of hard tissues of teeth

<table>
<thead>
<tr>
<th>Disease of hard tissues of teeth</th>
<th>Any alcohol diagnosis, n = 951†</th>
<th>No alcohol diagnosis, n = 2205†</th>
<th>OR (95% CI)†</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5</td>
<td>11 (0.5)</td>
<td>12 (0.5)</td>
<td></td>
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<tr>
<td>5</td>
<td>7 (0.8)</td>
<td>17 (0.8)</td>
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</table>

Other disorders of teeth and supporting structures

<table>
<thead>
<tr>
<th>Other disorders of teeth and supporting structures</th>
<th>Any alcohol diagnosis, n = 19316 (n (%))</th>
<th>No alcohol diagnosis, n = 49227 (n (%))</th>
<th>Net excess proportion per 1000 live births (95% CI)</th>
<th>OR (95% CI)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental caries</td>
<td>503 (52.9)</td>
<td>1356 (61.5)</td>
<td>1.5 (–4.1; 1.2)</td>
<td>0.97 (0.87-1.09)</td>
</tr>
<tr>
<td>Disease of the jaw</td>
<td>161 (8.4)</td>
<td>358 (0.7)</td>
<td>2.2 (–0.7; 5.1)</td>
<td>1.07 (0.97-1.18)</td>
</tr>
<tr>
<td>Diseases of cysts of oral region</td>
<td>161 (8.4)</td>
<td>358 (0.7)</td>
<td>2.2 (–0.7; 5.1)</td>
<td>1.07 (0.97-1.18)</td>
</tr>
<tr>
<td>Other diseases of the jaw and stomatitis</td>
<td>161 (8.4)</td>
<td>358 (0.7)</td>
<td>2.2 (–0.7; 5.1)</td>
<td>1.07 (0.97-1.18)</td>
</tr>
<tr>
<td>Diseases of the tongue</td>
<td>161 (8.4)</td>
<td>358 (0.7)</td>
<td>2.2 (–0.7; 5.1)</td>
<td>1.07 (0.97-1.18)</td>
</tr>
</tbody>
</table>

Cysts of the oral region, diseases of the jaw and stomatitis, and related lesions (Table III).

Children of mothers with an alcohol diagnosis had increased odds of gingivitis and periodontal diseases (aOR 1.67; 95% CI 1.12-2.51), “other” diseases of the lip and oral mucosa (aOR 1.56; 95% CI 1.21-2.01), and diseases of the salivary glands (aOR 2.06; 95% CI 1.05-4.03) (Table III). The net excess proportions for children of mothers with an alcohol-use disorder were 1.0 per 1000 (95% CI 0.4-1.8) for gingivitis and periodontal diseases, 3.1 per 1000 (95% CI 1.9-4.4) for other diseases of the lip and oral mucosa, and 0.5 per 1000 (95% CI 0.1-1.0) for diseases of the salivary glands (Table III).

A greater proportion of Aboriginal children had a dental admission than non-Aboriginal children (Table IV). Similar point estimates were observed for gingivitis and periodontal diseases for both non-Aboriginal (aOR 1.76; 95% CI 0.77-4.02) and Aboriginal children (aOR 1.64; 95% CI 1.03-2.60) (Table IV). However, the reduction in number of cases for non-Aboriginal children resulted in imprecise estimates. There was a 60% increase in the odds of Aboriginal children having a dental admission for gingivitis and periodontal...
diseases (aOR 1.64; 95% CI 1.03–2.60) and for other diseases of lip and oral mucosa (aOR 1.61; 95% CI 1.22–2.12; Table IV). Salivary gland diseases in Aboriginal children were increased more than 2.5 times (aOR 2.65; 95% CI 1.09–6.44), and there were fewer than 5 cases in the non-Aboriginal exposed cohort (Table IV). The net excess proportions for dental admissions in Aboriginal children were 1.5 per 1000 live births for gingivitis and periodontal diseases, 5.6 per 1000 (95% CI 2.8–8.6) for other diseases of lip and oral mucosa, and 0.9 per 1000 (95% CI 0.1–2.1) for salivary gland diseases (data not shown).

There were 84 children diagnosed with FAS, of whom 9 (10.7%) had one or more dental admissions by their fifth birthday (data not shown). The OR for children with FAS having any dental admission by 5 years of age was 2.58 (95% CI 1.30–5.11), with a net excess proportion of 70.0 per 1000 (95% CI 20.2–154.1). The numbers of children with FAS were too small to examine each of the individual dental diagnoses separately.

## Discussion

Hospital admissions for disorders of the soft tissues were increased for children of mothers with an alcohol-use disorder. Our results showed that children of mothers with an alcohol-related diagnosis were 50% to 67% more likely to have hospital admissions up to 5 years of age for gingivitis and periodontal diseases or diseases of the lip and oral mucosa, and twice as likely to have an admission for diseases of the salivary glands, than children of comparison mothers. However, the net excess proportion for hospital admissions for each of these diagnoses was relatively small, ranging from 0.5 to 3.1 per 1000 live births. When we examined dental admissions separately for non-Aboriginal and Aboriginal children, increased odds of diseases of the lip and oral mucosa and diseases of salivary glands were observed only for Aboriginal children, with net excess proportions of 5.6 and 0.9 per 1000 live births, respectively. High rates of admissions for diseases of the soft tissues and salivary glands were observed previously in an article in which authors investigated hospital admissions for diagnoses related to the oral cavity in Aboriginal children; however, the association with maternal alcohol-use disorder was not investigated in that study.

The association between dental hospital admissions for diagnoses related to disorders of the soft tissues is consistent with the research evidence on the risk to the fetus from prenatal alcohol exposure. Prenatal alcohol exposure has been shown to adversely affect immune functioning, and to impact on dental infections and disease process such as periodontitis. The finding that 10.7% of children with FAS had a dental admission compared with approximately 3% of other exposed children and comparison children is also suggestive of the effects of prenatal alcohol exposure. Although there was no indication of an association between prenatal alcohol exposure and hospitalizations for tooth development or facial deformity, the small numbers of children with FAS prevented examination of the type of diagnoses in this high-risk group. Given the relatively strong association for children diagnosed with FAS having some form of dental admission, this warrants further investigation when larger databases become available.

However, the finding that increased ORs for other diseases of the lip and oral mucosa and diseases of the salivary glands were observed only in exposed Aboriginal children may indicate unmeasured confounding by factors such as nutrition and poor hygiene. The majority of Aboriginal mothers in this study were in the lowest socioeconomic bands, so adjusting for socioeconomic status may not have fully accounted for confounding from the level of disadvantage and poor health found in Australian Aboriginal people. Adding weight to this assumption was the finding that maternal depression and socioeconomic status were important confounding factors in the regression analyses for non-Aboriginal children admitted to hospital for “other” diseases of the lip and oral mucosa. This was not the case for the analyses for Aboriginal children, and this difference may reflect underascertainment of depression in Aboriginal mothers by mainstream health services or the myriad of other environmental risk factors present in the lives of Aboriginal children.

Overall, the small numbers of dental admissions in children whose mothers had an alcohol-related diagnosis recorded during pregnancy precluded any firm conclusion about the relative impact of prenatal alcohol exposure and environmental factors. Although admissions for dental caries contributed less to dental admissions than expected, the study only investigated admissions primarily concerned with deciduous teeth and does not explore the relationship of maternal alcohol-use disorder with permanent teeth.

This study is based on a total-population based cohort of high-risk mothers who have an alcohol-related diagnosis and all their births recorded on the Midwives Notification System. Data linkage reduces loss-to-follow-up and recruitment bias. The data-linkage system includes routinely collected data for all public and private hospital admissions, including day stays and the diagnoses are recorded in the patient’s medical record by the attending medical officer and then coded by trained data coders. The Western Australian data linkage system has been demonstrated as a valid means of identifying cases admitted to hospital for a health-related condition. Importantly, medical doctors would have recorded the diagnosis in the patient’s medical records and trained data coders are responsible for recording the ICD-9/ICD-10 codes for inclusion in the hospital morbidity dataset. These data are widely used for research and have previously been used to investigate the effects of maternal alcohol-use disorder on the offspring and dental hospital admissions.

Health professionals in Western Australia do not routinely question patients about their alcohol use, so women with an alcohol-related diagnosis in this study would have had overt alcohol-related problems in order for the alcohol diagnosis to have been recognized and recorded. The prevalence of alcohol-use disorders in non-Aboriginal women in this
study is lower than the reported population estimate of 5%, indicating underrecognition of alcohol-use disorders in comparison with women. Although we are not aware of any published estimates of alcohol-use disorders for Aboriginal women, it is likely that underrecognition of alcohol-related problems in Aboriginal mothers also occurred in this study as we were unable to access data from Aboriginal-specific health services. FAS is underrecognized in Australia, and in this study we have not identified all children diagnosed with FAS on the Western Australian Register of Developmental Anomalies. These factors would likely have reduced the strength of the associations and biased the estimates towards the null.

In conclusion, maternal alcohol diagnoses were associated with dental admissions for their children but with diagnoses related to disorders of the soft tissues rather than dental carries. Some of these associations were more pronounced in children with Aboriginal mothers. Understanding perinatal influences on dental disease is required for targeting prevention strategies. Identification of maternal alcohol-use disorders and early interventions to address maternal drinking and support the mother and child during the early years would help improve child health.

We thank the staff of the Western Australian Data Linkage Unit for access to the Western Australian Data Linkage System and for their assistance in obtaining the data and the Western Australia Health Data Custodians for access to the core health datasets.

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Reprint requests: Colleen M. O’Leary, BSc, MPH, PhD, Centre for Population Health Research, Curtin University, GPO Box U1987, Perth, Western Australia, 6845. E-mail: colleen.oleary@curtin.edu.au

References

Table I. ICD-9 and ICD-10 dental diagnosis codes

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10 code</th>
<th>ICD-9 code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disorders of tooth development</td>
<td>K0-K01.1</td>
<td>520.0-520.9</td>
</tr>
<tr>
<td>Dental caries</td>
<td>K02-K02.4; K02.8-.9</td>
<td>521.0</td>
</tr>
<tr>
<td>Disease of hard tissues of teeth</td>
<td>K03-K03.9</td>
<td>521.1-521.9</td>
</tr>
<tr>
<td>Diseases of pulp and periapical tissues</td>
<td>K04-K04.9</td>
<td>522.0-522.9</td>
</tr>
<tr>
<td>Gingivitis and periodontal diseases</td>
<td>K05-K06.9</td>
<td>523.0-523.9</td>
</tr>
<tr>
<td>Other diseases of the lip and oral mucosa</td>
<td>K13.0-K13.7</td>
<td>525.5-525.9</td>
</tr>
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<td>Dentofacial anomalies, including malocclusion</td>
<td>K07-K07.9</td>
<td>524.0-524.9</td>
</tr>
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<td>Other disorders of teeth and supporting structures</td>
<td>K08.0-K08.9</td>
<td>525.0-525.9</td>
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<td>Cysts of oral region</td>
<td>K09.0-K09.9</td>
<td>526.0-526.2</td>
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<td>Diseases of the jaw</td>
<td>K10.0-K10.9</td>
<td>525.3-525.9</td>
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<tr>
<td>Diseases of salivary glands</td>
<td>K11.0-K11.9</td>
<td>527.0-527.9</td>
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<tr>
<td>Stomatitis and related lesions</td>
<td>K12.0-K12.2</td>
<td>528.0-528.3</td>
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<td>Diseases of the tongue</td>
<td>K14.0-K14.9</td>
<td>529.0-529.9</td>
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