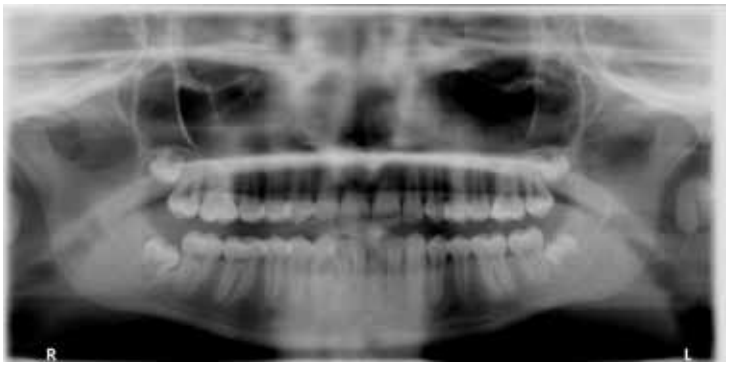
57 Graham Road
Cuyahoga Falls, OH 44223

Tel: 330-929-2808
www.fallsoralsurgery.com

Do These Wisdom Teeth Need to be Removed?

Third Molars and Your Patients

At our office, we routinely see patients of all ages for evaluations of both symptomatic and asymptomatic third molars. More often than not, many of our referred "older" patients are having signs or symptoms while the younger patients may or may not. Many patients and dentists wonder, ***"Do these wisdom teeth need to be removed ?"*** In our practice, we treat our patients based on sound surgical judgement, and ***evidence based research*** guides us in our decision making.



Ideally a panorex should be taken to determine the root development of the wisdom teeth. Once there is evidence of 1/3-1/2 root development, these teeth are optimal for removal.

"The AAOMS White Paper"

Here is a summary of the findings:

- **The presence of visible third molars is *associated with overall elevated levels of periodontitis.***
- **There is i*ncreased difficulty and risk of complications* associated with removal of impacted teeth if deferred until later in life.**
- **Third molars *play a role in the etiology of dental crowding*, however they are only one factor to consider in dental crowding. This dental crowding is likely multifactorial.**
- ***Patients over 25 years of age were 1.5x more likely to experience complications* with third molar removal, and the risk is generally increasing with increasing age over 25 years.**
- ***Eruption to the occlusal plane does not imply a good state of health,* particularly with respect to soft tissue support.**
- **The incidence of numbness to lip/chin/tongue increases from *1-2% in patients under 25, to well over that number with increasing age.***
- **Impacted third molars adversely *disrupt the periodontal ligament* of the second molar, can cause *root resorption,* and lead to *pocket depths* .**

To view the White Paper in its entirety, please visit: http:www.aaoms.org/docs/third_molar_white_paper.pdf

Here's some advice on answering the famous question……

"Do My Son's/Daughter's wisdom teeth need to be removed?"

About 98% of patients have insufficient room for meaningful eruption of their wisdom teeth. Your son/daughter has inadequate space for the eruption of his/her wisdom teeth. If we leave them in place, he/she will likely develop gum tissue infections, decay, loss of bone support to the adjacent teeth, ongoing infections and pain.

In 2007, the **American Association of Oral and Maxillofacial Surgeons** (AAOMS) performed a multicentered, review of the disease processes caused and contributed by the presence of third molars. This paper was spearheaded by Dr. Raymond White from the University of North Carolina, but involved the aid of 7 other academic institutions throughout the country. This groundbreaking study has since been known as the:

"AAOMS White Paper"

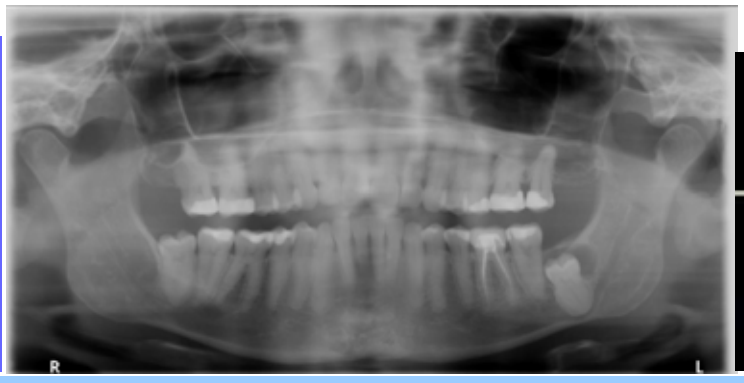
The paper has eloquently detailed indications, and ***evidence based reasons*** for how, why and when we treat 3rd molars on our patients.

We'd like to present a case of a patient who unfortunately, has been the recipient of 'conservative' wisdom tooth management as a teen. This hits really close to home, as this is my mother's case…

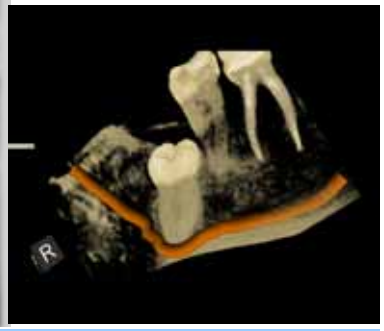
History:

My mother is a 61 year old who had a partially erupted tooth #32 and full bony impacted tooth #17. Both of these areas have had episodic pericoronitis with on/off pain. She was told by her dentist as a child, "wait until there are problems, they may come into occlusion." She presented for evaluation of her ongoing gum tissue infections. A panorex determined a significant pericoronal radiolucency around #17 with displacement of the IAN (Inferior Alveolar Nerve) inferiorly. #32 had distal bone present with an operculum, decay, periodontal inflammation and probing depths greater than 5mm with bleeding. She otherwise had meticulous oral hygiene. A CT scan in our office was obtained to locate the dimensions of the cyst and location of the IAN in #17.

- ***Patients over 25 years of age were 1.5x more likely to experience complications* with third molar removal, and the risk is generally increasing with increasing age over 25 years.**



3D CT Scan lingual view of #17



Treatment:

Under general anesthesia, teeth #17 and #32 were removed, the associated cyst around #17 was enucleated and sent for biopsy. The osseous defect in #17 was grafted at the time of surgery. Given her age and the presence of the cyst, her postoperative course was prolonged with discomfort and frequent dressing changes to help with pain control. The final biopsy results reported a dentigerous cyst, with virtually no chance of recurrence. If we had waited, this cyst would have inevitably involved tooth #18, and as it grew would have predisposed her to a pathologic jaw fracture. Moreover, this cyst could have just as easily been an odontogenic keratocyst, an ameloblastoma or another invasive, recurrent tumor.

As we know from the AAOMS White Paper, she was projected to incur these problems and **this was projected even as a late teenager**. Her cyst, grafting, periodontal issues, and prolonged pain could have easily been avoided if treated appropriately at an earlier age in life.

Stephen Barnes, DMD

As Always, if we can be of any service to you or your patients, please don't hesitate to call on us.

Warmly,
The Doctors and Staff at Falls Oral Surgery

ORAL SURGERY & Falls DENTAL IMPLANT CENTER

330.929.2808