CURRENT CONCEPTS FOR IMPACTED THIRD MOLARS

MOHAMMAD SAJJAD AKHUND, BDS, MSc (Oral Surgery)

ABSTRACT

Wisdom teeth account for 98% of all impactions. They are the last teeth of permanent series to erupt. Mandibular third molar is the most commonly impacted tooth. It is in general agreement that symptomatic third molar that will not erupt normally should be removed. The retention of impacted third molar gives too many complications such as pain, swelling, pericoronitis, caries, neuralgias, pressure resorption of adjacent tooth and even may be a source of cyst and tumor formation. The treatment of choice for symptomatic impacted mandibular third molar remains its surgical removal.

INTRODUCTION

Mandibular third molars are of clinical interest as these teeth account for 98% of all impactions. They are the last teeth of permanent series to erupt. Mandibular third molar is the most commonly impacted tooth. It is in general agreement that symptomatic third molar that will not erupt normally should be removed.1 According to Mercier et al absolute indications and contraindications for removal of asymptomatic wisdom teeth can’t be established.2 The impacted mandibular third molar should be removed if eruption is not expected or when no further treatment is possible.2,3 Paterson advocate prophylactic extraction of third molar as soon as possible, in order to prevent the subsequent problems such as periodontal pocketing, caries, recurrent pericoronitis, pressure root resorption of adjacent tooth, odontogenic cyst or tumor formation, pain of unknown origin, fracture of mandible and even to facilitate the orthodontic treatment.

The impacted mandibular third molar should be removed if eruption is not expected or when no further treatment is possible.2,3 Paterson advocate prophylactic extraction of third molar as soon as possible, in order to prevent the subsequent problems such as periodontal pocketing, caries, recurrent pericoronitis, pressure root resorption of adjacent tooth, odontogenic cyst or tumor formation, pain of unknown origin, fracture of mandible and even to facilitate the orthodontic treatment.

The most common indication for removal of impacted third molar is pericoronitis. The vertically impacted third molar seems most likely to develop pericoronitis usually in third decade. The infection accounts for 25% of all pathology and is rare over the age of 40 years.4 The second most common indication for the removal of this tooth is when it causes pressure on the inferior alveolar nerve which may produce intermittent neuralgic symptoms, frontal and occipital headaches and obscure indefinite sense of pressure, otalgia dentalis and tinnitus5. Therefore, it should be removed during teens to decrease the incidence of postoperative morbidity. Osborn suggested that one should evaluate patients third molar removal by the time the skeletal growth is completed at 16 to 18 years of age.

The role of impacted mandibular third molars in the imbrication of lower incisor is extremely controversial.6 However, it becomes worst due to impacted third molars, therefore, removal is indicated in severe lower anterior crowding. Impacted mandibular third molar may be associated with an increased risk of angle fracture of mandible. When present in fracture line may cause complications in the treatment of fracture. Therefore, these teeth should be removed before reduction and fixation of fracture to prevent the subsequent complications.

When third molar eruption is low, cyst may develop. The incidence of cyst formation ranges between 0.001% and 11% and of odontogenic tumor is between 0.003-2%. These events have frequently been cited as a reason, for removal of asymptomatic teeth. In some instances, the impacted third molars may be the etiol-

* Prof & Incharge, Dept. of Oral Surgery, Liaquat Medical University Hyderabad, Sindh
ogy of TMJ dysfunction syndrome and removal of impacted third molar may eliminate the complaints”.

If orthognathic surgery is to be performed impacted third molar that exists within the path of proposed Sagittal split ramus osteotomy should be removed 6-12 months before surgery.

Retained impacted mandibular third molar may endanger the prosthetic work due to pressure of growth, so it should be removed before crowning of second molar. With increasing atrophy of alveolar crest retained teeth may become more superficial and may either interfere with the fit of a full lower denture or cause pain due to either caries or gum infection, therefore retained impacted mandibular third molar in an edentulous jaw should be considered for removal. In addition the retained wisdom teeth can influence the occlusion because of over eruption of antagonist and may cause disturbance in occlusal equilibrium. This complication is also possible due to mesial pressure of impacted mandibular third molar.

CONCLUSION

The impaction of tooth is as old as the dental medicine itself. The retention of impacted third molar gives too many complications such as pain, swelling, pericoronitis, caries, neuralgias, pressure resorption of adjacent tooth and even may be a source of cyst and tumor formation. The treatment of choice for symptomatic impacted mandibular third molar remains its surgical removal.

REFERENCES