ACCIDENTAL DISPLACEMENT OF LOWER WISDOM TOOTH DURING EXTRACTION: A CASE REPORT

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ABSTRACT

A case of accidental displacement of the lower third molar during extraction is reported. Factors predisposing to this complication, and the management of such a case discussed.

INTRODUCTION

Infrequently the lower third molar is displaced lingually during attempts at removal. Although few such cases have been reported, such a complication is more common than the rarity of case reports would imply as many cases probably go unreported. In such cases a portion of or the entire tooth may be involved. The clinician is then faced with several treatment options.

CASE REPORT

A fit 28 year-old Malay male patient was referred for management of a displaced lower left wisdom tooth. Earlier in the day he underwent extraction of this tooth. The referring dental officer allegedly attempted removing the tooth using Couplands straight elevator. He managed to loosen but not elevate the tooth. Subsequent elevation of the tooth were made using cryers buccally and apparently the tooth was displaced lingually during this time. Further attempts were not made as the patient started gagging and felt pain and tenderness in the region. The patient was subsequently referred to the visiting oral surgeon.

On examination the left submandibular region was swollen and palpation was difficult due to pain, swelling and tenderness. Intraorally the tooth was not visible and several sutures had been placed across the socket. Extraoral radiographs were requested to supplement the periapical radiograph taken by the officer. The patient was then prescribed a course of antibiotics and discharged to be reviewed at the next visit by the oral surgeon.

At the next visit the swelling and pain were reduced but trismus was present. On extraoral palpation the tooth could be felt lingual to the mandible. Orthopantomograph and submentovertex radiographs (Figs. 1 and 2) confirmed the presence and location of the tooth in the lingual pouch. The displaced tooth was removed under general anaesthesia two weeks after the incident. At operation a 6cm long submandibular incision was made and dissection carried down to the level of the mylohyoid muscle. The muscle was then incised over the site of the displaced tooth as finger pressure was applied intraorally to prevent further displacement. When the third molar became visible it was retrieved with an artery forcep whilst maintaining finger pressure on the tooth. Although the lingual cortical plate was palpable it was left in situ to avoid possible damage to the lingual nerve by its removal. The

Fig. 1. Orthopantomograph showing the displaced lower left wisdom tooth.
Fig. 2 Submentovertex radiograph showing the position of the displaced tooth.

wound was then irrigated and closed in layers. No sensory and motor deficits were noted in the mylohyoid and inferior dental nerves postoperatively. However a small area of hypoesthesia was noted in the dorsum of the tongue near the midline.

DISCUSSION

Adequate pre-operative assessment is important to avoid or to decrease the possibility of a failed extraction due to lingual displacement. For example by probing the distal of the crown of the lower third molar and combining this with radiographic examination the clinician can assess the amount of bone distal to the lower third molar and take appropriate steps to avoid deflection of the tooth linguually by bone distal to the said tooth.

Thinness or absence of lingual cortical bone in the region of the lower third molar further predisposes to lingual displacement of the tooth during extraction. Lingual displacement is also more likely if flap retraction is inadequate, the tooth lingually biased, partly or completely unerupted and buccally applied force is used for elevating an impacted lower third molar. When pre-operative clinical and radiographic assessment indicates that resistance to elevation would be encountered extraction is made easier by relieving the tooth of the overlying gingival pad as suggested by Killey and Kay. This would reduce resistance to upward movement and discourage lingual deflection. They also recommend placing a finger over the lingual aspect of the third molar tooth during elevation as a preventive measure but if soft tissue relief is inadequate for elevation, removal of distal bone should be performed.

If such an accident has taken place then the options available are whether to remove the displaced tooth or not and whether to do so immediately or to delay removal. Displaced lower third molar may remain asymptomatic and thus a clinician may well decide not to operate and review the patient periodically after prescribing a course of antibiotics and analgesics. However delayed infection can set in many months later and when this occurs infection is unlikely to settle unless the offending tooth is removed.

Clinicians differ as to when is the best time to operate. Delaying the operation will allow a foreign body induced fibrous tissue reaction to immobilise the tooth, later facilitating location and removal of the tooth. However if the tooth is accessible immediate removal would spare the patient the agony of a chronic infection and a second operation later.

The surgeon must also decide on the most suitable route of removing the displaced tooth. Location and accessibility, the degree of trismus present at the time of surgery and the surgeon’s preference would decide between the intraoral or extraoral route for removing the tooth. In this case the submandibular approach was chosen due to the presence of trismus, the posterior location of the tooth and the fear of driving the tooth further posteriorly during retrieval.

REFERENCES:


