

Knowledge and Perception about Wisdom Teeth among Dentists

Agisha Raaje .P

Saveetha Dental College, Chennai

Abstract: *One of the complex topics in Dentistry is the management of third molar. Appropriate treatment options include removal, partial removal (coronectomy), or retention with subsequent clinical and radiographic surveillance and hygiene maintenance. There is general agreement in the medical and dental profession that the removal of third molar teeth is always appropriate when there is evidence of pathological changes such as periodontal disease, non-restorable carious lesions, infections, cysts, tumors, and damage to adjacent teeth. There is also general agreement that third molar teeth that are completely erupted and functional, painless, free of caries, in hygienic position with a healthy periodontium, without other associated pathologic conditions, are disease-free teeth that may not require extraction but do require hygiene maintenance and periodic clinical and radiographic surveillance if retained. (1)*

Keywords: wisdom teeth, knowledge

1. Introduction

The objective of the study was to learn the awareness among the general public about the presence of wisdom teeth, and their attitude towards prophylactic (asymptomatic) and symptomatic removal of wisdom teeth, and also to assess the difficulties faced by a dentist counselling the patients about the wisdom teeth, and the importance of its removal for general dental health.

2. Materials and Methods

A random sample of 140 dentists was taken. A short pre-tested questionnaire of 15 questions was given to the dentists. The questionnaire was designed with the aim of collecting information about the impaction of wisdom teeth, diagnostic aids used, patient symptoms, patient attitude towards symptomatic and prophylactic removal, dentist counselling to patients on the importance of its removal.

The questionnaire requested respondents to provide demographic data about age, qualification, speciality, practice and years of practice. The researcher conducting the survey personally visited the participating dental practitioners and the questionnaire was completed by the practitioner in her presence in the surgery.

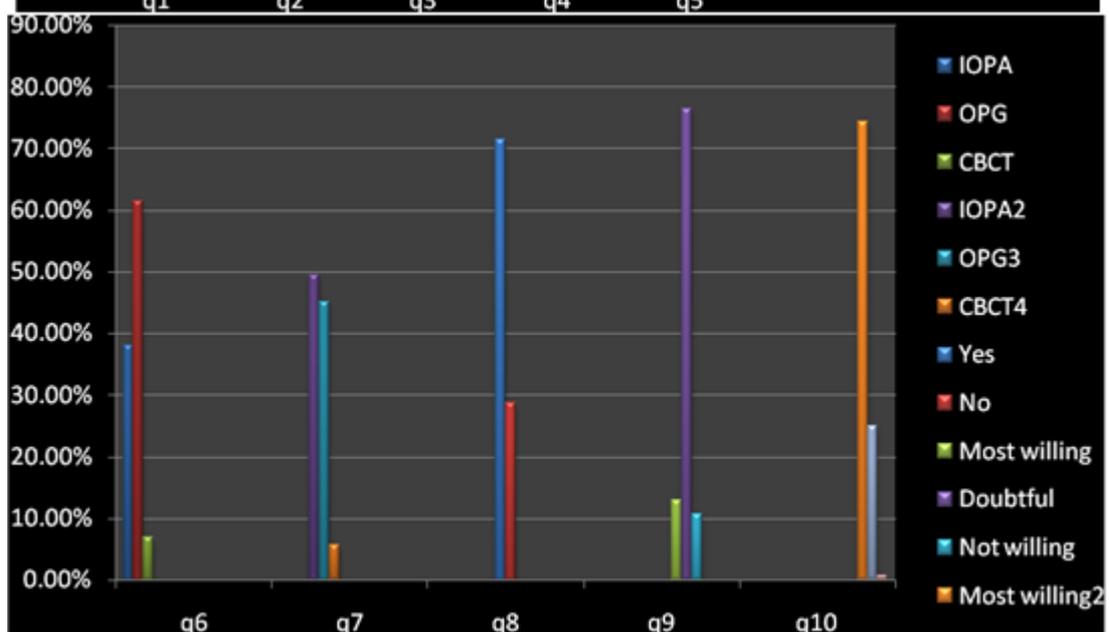
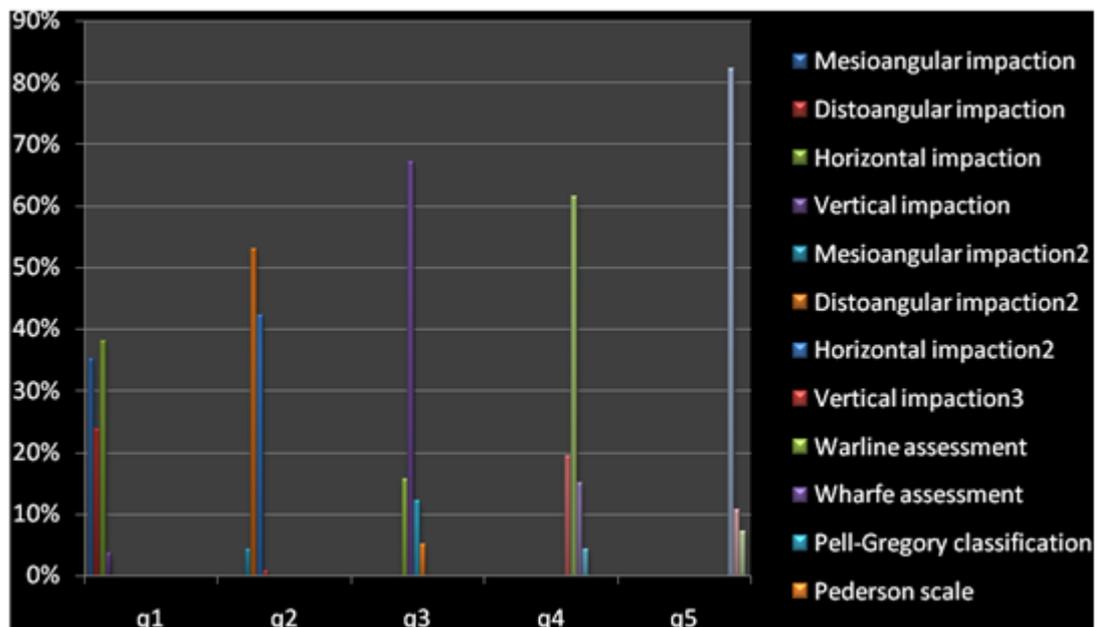
3. Results

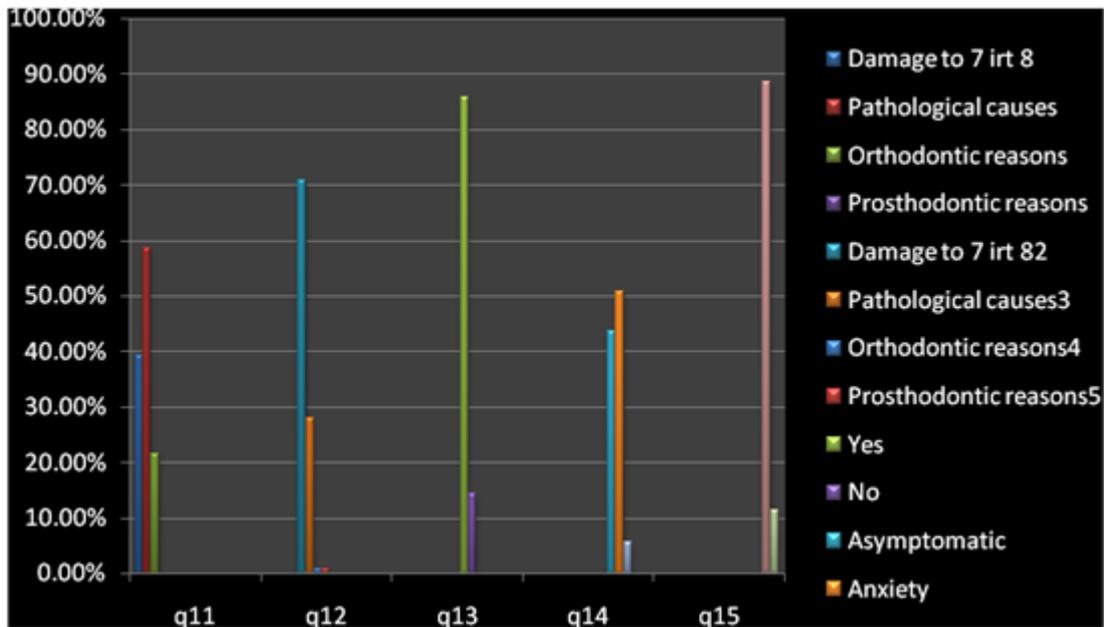
37.9% of the dentists said that the most common type of impaction that they see among their patients is horizontal

impaction and 52.9% of them feel that distoangular impaction is the most difficult type of impaction that they see. 67.1% of the dentists assess the difficulty of impaction using Wharfe assessment, whereas 61.4% think Wharfe assessment is the best assessment to use. 82.1% of the dentists reported that pain is the most common symptom that the patient complain in case of impacted wisdom tooth. 61.4% dentists reported that they use OPG for diagnosis of impaction, and 49.3% thought OPG was the best for diagnosis of impaction. 71.4% of the dentists said they advised prophylactic removal of wisdom teeth when the patient does not complain of any symptoms. 76.4% of the patients were doubtful towards removal of their wisdom teeth for prophylactic reasons, even after counselling from their dentists, and 74.3% of the patients were most willing for extraction of their wisdom teeth for symptomatic reasons. 58.6% of the dentists said that they advice their patients for compulsory removal of third molar, only for pathological reasons, but 70.7% of the dentists reported that the most common reason for the extraction of wisdom tooth was damage to 7 in relation to 8. 85.7% of the dentists reported that they counseled their patients about the presence and importance of the removal of third molars. 43.6% of the dentists reported that the common reasons for denial of treatment by patients is that they find it unnecessary to remove the tooth as they do not have any symptoms. And 88.6% of the dentists said that they advised the removal of maxillary third molar, when they perform removal of mandibular third molar.

The questionnaire is as follows:

- q1. What is the most common type of impaction that you see among your patients?
- q2. What is the most difficult type of impaction that you see among your patients?
- q3. How do you access difficulty?
- q4. Which assessment do you think is the best?
- q5. What are the most common symptoms that patients complain in case of an impacted wisdom tooth?
- q6. What are the radiographs that you use for diagnosis of impacted wisdom teeth?
- q7. Which do you think is the best?
- q8. Do you advice prophylactic removal of wisdom teeth even when the patient does not complain of any symptoms?
- q9. Patient attitude towards removal of his/her wisdom teeth for PROPHYLACTIC reasons?
- q10. Patient attitude towards removal of his/her wisdom teeth for SYMPTOMATIC reasons?
- q11. When do you advice the patient for compulsory and immediate removal of wisdom tooth?
- q12. Which is the most common reason for removal of wisdom teeth in your patients?
- q13. Do you counsel the patients about the presence and the importance of its prophylactic and symptomatic removal if impacted?
- q14. What are the common reasons for denial of treatment?
- q15. Do you advice removal of maxillary third molar, when you do removal of mandibular third molar?





4. Discussion

It is apparent that treatment decisions regarding why, when or how to treat third molar teeth are extremely complex. The presence of third molar teeth, their position within the jaws and/or dental arches, the condition of the teeth and associated teeth and structures, and the presence or potential for pathology associated with third molar teeth must be considered carefully. The risk of complications involved with early treatment of third molar teeth that are likely to cause problems versus the morbidity caused by retained third molar teeth and subsequent treatment in an older patient must be weighed.

For almost fifty years, studies have documented the presence of periodontal disease around asymptomatic third molars.(2) Two very large epidemiological studies show an association between third molar teeth and periodontal pathology in both younger and older patient populations.(3,4) Recently, the findings of a large scale, multidisciplinary, multiple site, prospective, longitudinal study have shown that a significant number—almost 25%—of patients with retained asymptomatic third molar teeth had baseline probing depths of 5mm or greater on the distal of a second molar or around a third molar tooth. If the probing depth in this area was equal to or greater than 5mm, there was also an associated attachment loss of greater than 2 mm in 80/82 patients. The same study reported that a higher proportion of patients with probing depths equal to or greater than 5mm were more than 25 years old.(5) Another study showed that for 38% of patients with probing depths of to 4mm in the second/third molar region upon enrolment in the study, the probing depths increased in a relatively short period of time with a mean follow up of 2.2 years. The study also concluded that contrary to the expectations of the public and clinicians, erupted third molar teeth are as likely to have increases in probing depths as impacted third molars.(6) In a previous study, The American Association of Oral and Maxillofacial Surgeons, firmly supports the surgical management of erupted and impacted third molar teeth, even if the teeth are asymptomatic, if there

is presence or reasonable potential that pathology may occur caused by or related to the third molar teeth.(7)

About 38 percent of the dentists said that the most common type of impaction that they see among their patients is horizontal impaction. A previous study states that distoangular impaction is the most difficult type of impaction that oral surgeons see in their day to day practice,(8) but our study states that only around 53 percent of them feel that distoangular impaction is the most difficult type of impaction that they see and the remaining people stated that found other types of impactions more difficult to perform. 67.1% of the dentists assess the difficulty of impaction using Wharfe assessment, whereas 61.4% think Wharfe assessment is the best assessment to use. 82.1% of the dentists reported that pain is the most common symptom that the patient complain in case of impacted wisdom tooth. A previous study states that CBCT is the best radiograph to diagnose the impacted third molars as it gives a three dimensional localization of the third molars as it relates to the inferior dental canal. But our study states that only around 61percent of the dentists used OPG for diagnosis of impaction, and only 0.7 percent used CBCT for the diagnosis and around 50 percent even thought that OPG was the best for diagnosis of impacted third molars.(9) Though the NICE guidelines for the removal of third molar, states that even third molar teeth that are impacted but are free from diseases should not be removed for prophylactic reasons, as the patients undergoing prophylactic removal of wisdom teeth are exposed to the risks of nerve damage, damage to other teeth, infection, bleeding and, rarely, death,(10) but a very high rate to about 72 percent of dentists stated that they advised prophylactic removal of wisdom teeth when the patient does not complain of any symptoms. 76.4% of the patients were doubtful towards removal of their wisdom teeth for prophylactic reasons, even after counselling from their dentists, and around 74 percent of the patients were most willing for extraction of their wisdom teeth for symptomatic reasons. A previous study states that not more than 12 percent of impacted teeth have associated pathology, the incidence of which is the same as that for appendicitis (105) and cholecystitis(12%) and yet

prophylactic appendectomies and cholecystectomies are not the standard of care,(11) but our study states that about 59 percent of the dentists advised their patients for compulsory removal of third molar, only for pathological reasons, incidence of which they said was of a very high rate, contrary to the mentioned study, and most of them reported that the most common reason for the extraction of wisdom tooth was damage to 7 in relation to 8. Around 86 percent of the dentists reported that they counseled their patients about the presence and importance of the removal of third molars and a lesser percent of dentists reported that the common reasons for denial of treatment by patients is that they find it unnecessary to remove the tooth as they do not have any symptoms. Around 89 percent of the dentists said that they advised the removal of maxillary third molar, when they perform removal of mandibular third molar, which is contrary to the guidance for extraction of third molar by NICE.

5. Conclusion

Third molars, also called the wisdom teeth, have long been identified as a source of problems. They are the most commonly impacted teeth, in the human mouth. A lack of room, to allow the teeth to erupt results in a risk of periodontal disease and dental caries, that only increases with age. Only a small minority (less than 2%) of adults of age 65 years or older, maintain the teeth without caries or periodontal disease and 13% maintain unimpacted wisdom teeth without caries or periodontal disease. Its increased significance in the oral health related quality of life has made it a subject that demands increased attention and awareness by individuals and dental practitioners. In this study a questionnaire was filled by dentists based on the awareness and willingness of their patients for the extraction of their wisdom teeth and the difficulties faced by them in the extraction of wisdom teeth.

References

- [1] American association of Oral and Maxillofacial surgeons; Evidence Based Third Molar Surgery; pg 1-5
- [2] Ash M. Costich ER, Hayward JR: A study of periodontal hazards of third molars. Journal of Periodontology 1962;33:209
- [3] Elter JR, Coumo CJ, Offenbacher S, *et.al.* Third molars associated with periodontal pathology in NHANES III. Journal of Oral and Maxillofacial Surgery, 2004; 62:440
- [4] Elter JR, Offenbacher S, White RP, *et.al.* Third molars associated with periodontal pathology in older Americans. Journal of Oral and Maxillofacial Surgery, 2005; 63:179
- [5] Blakey GH, Marciani RD, Haug RH, *et.al.*: Periodontal pathology associated with asymptomatic third molars; Journal of Oral and Maxillofacial Surgery. 2001;60:1227-1233
- [6] Blakey GH, Jacks MT, Offenbacher S, *et.al.* : Progression of periodontal disease in the second/third molar region in subjects with asymptomatic third molars. Journal of Oral and Maxillofacial Surgery; 2006; 64:189-193

- [7] The American Association of Oral and Maxillofacial Surgeons; Evidence Based Third Molar Surgery; 2013:1-5.
- [8] Srinivas M. Susarla, AB^{*}, Thomas B. Dodson, DMD, MPH[†]; Risk factors for third molar extraction difficulty; Journal of oral and maxillofacial surgery; Volume 62, Issue 11, November 2004, Pages 1363-1371.
- [9] Reyes Enciso^o, Robert A. Danforth, Emanuel S. Alexandroni, Ahmed Memon, James Mah; Third-molar impaction diagnostic with cone-beam computerized tomography; International Congress Series ; Volume 1281, May 2005, Pages 1196–1199.
- [10] Guidance on the Extraction of Wisdom Teeth; NICE technology appraisal guidance 1; Issued: March 2000; guidance.nice.org.uk/ta1.
- [11] Leonard MS. Removing third molars: a review for the general practitioner. J Am Dent Assoc. 1992; 123:77–92.