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Letter to Editor

Dentistry Section

Impacted Love: Mandibular Kissing Molars Advisable to Remove or Not

JIGAR M. DHUVAD[1], RAJESH A. KSHIRSAGAR[2]

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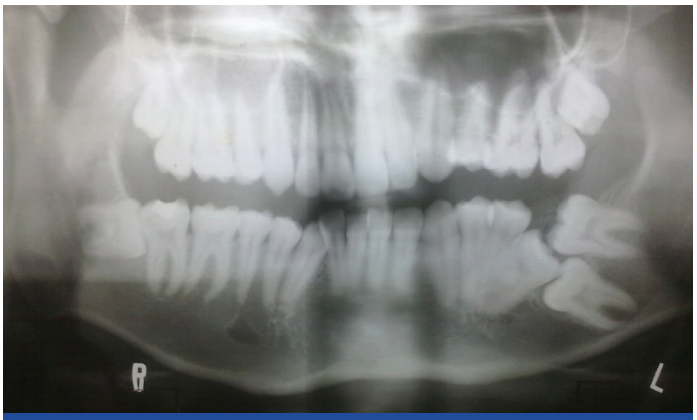
Sir,

The permanent teeth most often affected by eruption problems are the mandibular and maxillary third molars, maxillary canines, central incisors, second mandibular premolars and, more rarely, second molars (0.03-0.04% of all impacted teeth) [1]. The term "kissing molars" (KM) or "rosette formation" refers to impacted mandibular second and third molars, which have occlusal surfaces contacting each other in a single follicular space and roots pointing in opposite directions [2]. However, this term has also been used to describe a similar appearance with other impacted molars [2]. We searched the Pubmed and Medline databases for non-syndromic multiple impacted mandibular molars published since 1975 and to the best of our knowledge, this is the first reported kissing molars case primarily involving all the mandibular molars.

A 28-year-old male came to us with a complaint of lower left posterior teeth missing since 20 years and wanted replacement of the teeth in the same. The intra oral examination revealed the edentulous area in left posterior area of lower jaw with all molars missing with healthy overlying mucosa. Panoramic radiograph revealed horizontally impacted mandibular third molar on the right side, and the first; second and third mandibular molars on the left side were impacted. There was no bony pathology and the panoramic view showed normal trabecular pattern [Table/Fig-1]. Then several clinical examinations were performed to rule out any systemic pathology, and they all had normal results. Finally, based on clinical and radiological findings, diagnosis of kissing molars was done. The treatment options for impacted molar include observation, removal of the obstacle, surgical exposure, luxation, and extraction of the unerupted molar [3]. After considering all the factors, we authors have stipulated the treatment plan with the surgical removal of kissing molars followed by rehabilitation by dental implants. However, patient didn't turn up for the treatment so, no treatment was provided.

To achieve optimum function and aesthetics, an interdisciplinary cooperation between the oral surgeon, endodontist, orthodontist and prosthodontist should be required for the management of the case [4]. Studies based on biomechanical models show that, the external oblique ridge provides strength to the angle area of the mandible. If a wisdom tooth is present in oral cavity, the most of the tooth portion supports the mandibular forces and allows the external oblique ridge to remain intact. While, wisdom tooth is impacted (not in the oral cavity), the resultant tension line gets interrupted and the bony mandibular angle becomes weak [4].

Preservation of the impacted teeth can create the complications such as reduction of mandible bony tissue; which increases the chances of mandible fracture, root resorption of adjacent teeth, local pain or pathologic changes [5]. In order to reduce or even prevent these complications, it becomes necessary the prior surgical planning, as well as the knowledge of the professionals and patients concerning the potential risks of this surgical intervention like [4,5]: displaced teeth in the soft tissue, mandibular fractures during the surgery or postoperatory dry socket, damage to the inferior alveolar nerve (0.5 to 5%); lingual nerve (0.2 to 2%); adjacent teeth, osteomyelitis, Temporomandibular joint (TMJ) disorders, particularly internal derangements.



[Table/Fig-1]: OPG shows the impacted mandibular molars on the right and left side

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PARTICULARS OF CONTRIBUTORS:
1. Assistant Professor, Department of Oral and Maxillofacial Surgery and Implantology, Government Dental College and Hospital, Ahmeadabad, India.
2. Professor and Head, Department of Oral and Maxillofacial Surgery and Implantology, Bharati Vidyapeeth Dental College and Hospital, Pune, India.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:
Dr. Jigar M. Dhuvad,
D-34, Ishan-1, Behind Seema Hall, Satellite, Ahmeadabad, Gujarat-380015, India.
E-mail : drjigardhuvad1981@gmail.com

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