

Pediatric Molar Hyperdontia: A Descriptive Case Report

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ABSTRACT

Background: Hypergenetic molars are uncommon in children and adolescents. Furthermore, the presence of multiple eumorphic supernumerary molars (SNMs) in children is sporadic. The author, therefore, reports a nonsyndromic case of multiple supplemental SNMs in a child.

Case description: A ten year old boy primarily complaining of cheek biting was found to have six molars on the maxillary left quadrant. Following investigations and case discussion, four molars and fibroma were surgically removed under general anesthesia.

Discussion: This paper discusses the prevalence and management of SNMs in the pediatric population while documenting the first case of multiple eumorphic SNMs in the mixed dentition.

Keywords: Case report, Distomolar, Fibroma, Paramolar, Primary molars, Supernumerary molars.

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INTRODUCTION

Supernumeraries (SPNs) in the molar region are called supernumerary molars (SNMs). SNMs are uncommon, solitary, unilateral, and rudimentary structures. The SNM may appear as a tooth fused with the wisdom tooth or its additional cusp in its residual form. However, eumorphic SNMs are rare. Furthermore, multiple SNMs in the supplemental form are extremely rare.¹

Supernumerary molars (SNMs) are of two types—paramolars and distomolars. Paramolars are usually located buccal or palatal or in the interproximal space of the molars.² While the distomolar (fourth molar/retromolar) is distal or distolingual to the third molar.³ Nevertheless, reports of the fifth, sixth, and seventh SNMs are published.⁴⁻⁷

Supernumerary molars (SNMs) are uncommon in the pediatric population. Trenouth and Bedi,⁸ Park et al.,⁹ and Shimizu et al.¹⁰ have documented SNMs in the primary dentition, and El-Bahannasawy¹¹ reported a case of concomitant hypo-hyperdontia (CHH) with SNM in the mixed dentition. However, the permanent dentition of adolescents exhibits more SNMs than the primary and mixed dentition¹² (Tables 1 and 2).

Only one case of nonsyndromic sporadic multiple eumorphic SNMs in the mandibular left quadrant is documented in the pediatric age group.⁷ Hence, the authors report a sporadic case of multiple supplemental SNMs in the maxillary left quadrant of a 10-year-old male child, who primarily reported cheek biting of a left buccal swelling. This article tabulates the prevalence of pediatric molar hyperdontia.

CASE DESCRIPTION

Case Presentation

A 10-year-old boy and his father sought treatment at the Department of Dentistry for extra growth on the left cheek inside the mouth. The child complained that the growth was interfering with his bite. Medical, family, and social histories were noncontributory.

Clinical Assessment

An intraoral, nonpainful, and moderate solitary pedunculated growth was observed at the occlusal level of the left cheek. The left maxillary posterior sextant was crowded with three molars

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morphologically similar to the permanent first molar—a molar in buccal conversion, a molar palatal, and a molar distal to them. Extraoral findings were not relevant (Figs 1A and B).

Radiographic Assessment

An orthopantomogram (OPG) (Fig. 2A) revealed six permanent molars in the left maxillary sextant; three erupted and three unerupted. The dental development in all other quadrants was appropriate for the child's chronologic and dental age. A cone-beam CT was ordered to evaluate the accurate locations of supernumerary teeth and their spatial relationships with neighboring structures and adjacent teeth (Figs 2A and B).

Treatment Plan

Extraction of all three erupted molars and one unerupted (most accessible and displaced) molar was planned under general anesthesia. Parental consent was obtained for the treatment.

Treatment and Follow-up

All three erupted molars and one unerupted molar distal to the last erupted molar were extracted, and the fibroma was excised under general anesthesia. Postoperative recovery was uneventful. After 2 years, OPG was repeated (Fig. 3).

DISCUSSION

Supernumeraries (SPNs), also known as hyperdontia, are developmental aberrations during odontogenesis. An excessive number of teeth, which may be normal or associated with coronary or radicular problems, characterizes it.¹³ They might appear

Table 1: Publications of SNMs in children/adolescents

Author	Year	Age/sex	Arch	Number	Morphology	Location
Trenouth and Bedi ⁸	1963	9/M	Mx	Solitary unilateral	Supplemental with successional unerupted supernumerary	Erupted
Scheiner and Sampson ⁴⁹	1996	16/M	Mx	Bilateral	Conical	Erupting
Shimizu et al. ¹⁰	2007	4.1/F	Mx	Solitary unilateral	Supplemental first primary molar with the permanent supernumerary successor	Primary second molar region
Harris and Clark ⁷²	2008	12–18 years; 11 M/ seven F	Mx/Md	20/8	Distomolars	–
Ferrés-Padró et al. ⁷⁴	2009	5–19 years; 51 M/28 F	Mx/Md	5/2	Distomolars/paramolars	–
Park et al. ⁹	2010	4.3 years/F	Mx	Solitary unilateral	Supplemental primary molar	
Nagaveni et al. ¹²	2010	11/F	Mx	Solitary unilateral	Rudimentary paramolar	Erupted buccally between first and second molar
Arikan et al. ⁷¹	2013	3–16 years; 48 M 3–16 years; 26 F	Md	Two unilateral Three bilateral	One conical; four tuberculate paramolar	Unerupted
Kariya et al. ⁷⁰	2014	15/M	Mx/Md	Bilateral	Paramolars and distomolars	Two erupted-Mx/two partially erupted-md
Vlaykov et al. ⁶⁹	2015	12/F	Md	Unilateral	Distomolar	Impacted
Nirmala and Tirupathi ⁴²	2016	13/F	Mx	Bilateral	Rudimentary paramolar (right) Distomolar (left)	Impacted
Singhal et al. ⁷	2017	12/F	Md	Unilateral multiple	Fourth, fifth, sixth, and seventh supplemental molars	Impacted
Ribeiro ⁷⁵	2017	13/F	Mx/Md	Bilateral multiple	Supplemental molar (one in each quadrant)	Impacted
Chandna et al. ⁷³	2017	15/F	Mx	Bilateral	Rudimentary paramolar	Erupted
Jaiyeoba and Ifesanya ⁶⁵	2018	15/M 14/M 12/F	Mx/Md Md Mx Mx	Four bilateral Bilateral Solitary Bilateral	Tuberculate distomolar Supplemental distomolar Supplemental distomolar	Unerupted Unerupted Unerupted

Table 2: Description of SNMs

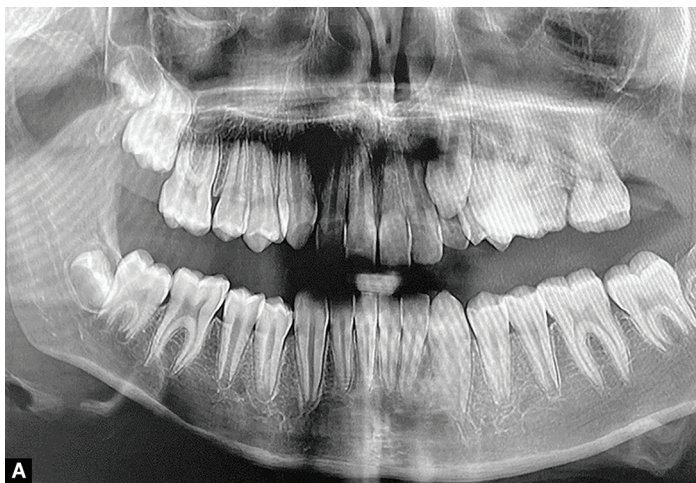
SNMs	Paramolars	Distomolars
Prevalence	0.036–0.13% ^{10,12,46–49} 0.09–0.29% ⁵⁰ Females > males ^{23,54}	0.03–2.1% ^{17,24,57–61} Males > females ^{17,57,59} Males = females ^{17,57}
Morphology	Heteromorphic > eumorphic ¹⁹ Conical > tuberculate > supplemental ^{23,46} Tuberculate > supplemental ^{54,56}	Heteromorphic > eumorphic ^{17,24,58} Peg, conical, tuberculate, molariform ^{57,59}
Location	Mandible > maxilla ^{48,49–52} Maxilla > mandible ^{23,53,54} Maxilla = mandible ⁵⁶	Maxilla > mandible ^{17,57}
Right/left	Right < left ^{23,54}	Right > left ⁵⁹ ; left < right; right = left ^{17,58,59,61}
Unilateral/bilateral	Unilateral > bilateral ^{23,55}	Unilateral > bilateral ^{17,57,58}
Solitary/multiple	Solitary > multiple ^{23,55}	Solitary > multiple ^{64,65}
Position in the arch	Between FPM and SPM < between SPM and TPM ^{12,47–49}	Distal or distolingual to TPM ^{64–68}
Eruption status	Erupted > partial/completely impacted ²³	Erupted < partial/completely impacted ^{17,43,57,58,62} Erupted > partial/completely impacted ^{24,63}

*FPM, first permanent molar; SPM, second permanent molar; TPM, third permanent molar





Figs 1A and B: (A) Preoperative (pre-op)—buccal fibroma; (B) Pre-op—occlusal view of maxillary right quadrant



Figs 2A and B: (A) Orthopantomogram (2 years post-op OPG); (B) CBCT (pre-op)

before birth or as late as 10 years of age.¹⁴ In various groups, the prevalence of supernumerary teeth in permanent dentition ranges between 0.5 and 5.3%, and deciduous teeth range between 0.2 and 0.8%.^{15–17} The occurrence of supernumerary teeth was greater (approximately 1.28–2.4%) in studies that mainly included youngsters, primarily in the premaxillary region. However, a smaller percentage (1%) was reported in research that looked at older age groups (adults), which was mainly in the maxilla and posterior parts of the dental arch.¹⁸

Single or multiple SPNs are possible. A single SPN is found in 76–86% of instances and two SPNs in 12–23%. Despite this, only 1% of cases (that is, more than three) had multiple SPNs.^{19–21} Multiple hyperdontia is uncommon in people who have no other disorders or syndromes. The mandibular and premolar areas have the most nonsyndromic multiple SPNs, followed by the anterior and molar regions.^{4,22}

The prevalence of SNMs ranges from 0.18 to 0.33%.^{23,24} SNMs are of two types—paramolars and distomolars. They can be eumorphic or rudimentary. The eumorphic SNMs arise from the lingual extension of an additional tooth bud, while the rudimentary form occurs due to the proliferation of epithelial remnants of the



Fig. 3: Pre-op OPG

dental lamina that are, in turn, induced by the pressure of the complete dentition.^{25–27} The permanent supernumerary teeth developing as supplemental teeth after the permanent teeth are thought to represent a third dentition. Reduplication of SNPs yields their respective successors. SNMs can develop before the primary dentition (predeciduous), contemporary to the deciduous/mixed/

permanent teeth, or after the permanent dentition (postpermanent dentition, also called late-developing SPNs)¹⁴ (Table 2).

Ooe²⁷ reported a case of a tooth germ between the first and second primary molars of a 5-month-old fetus, but at this stage, it appeared only as a thickening of the dental lamina. Leche²⁸ reported a tooth germ in the cap stage in a 3-month-old infant located between the upper primary canine and the first primary molar. Whether this tooth would have developed into a primary canine or a first molar is unknown. To date, only two cases of primary SNM in the primary dentition. One case of primary SNM with reduplication in the mixed dentition has been reported.^{8–11} Only one case of nonsyndromic multiple eumorphic SNMs in the mandibular left quadrant in an adolescent is documented.⁷ Likewise, the current case has multiple SPN supplemental molars in the left maxillary quadrant.

Panoramic radiography has long been used to detect and diagnose extra teeth. These radiographic images do not assess the precise location of a supernumerary tooth and its spatial interactions with nearby structures and adjacent teeth, which is crucial for treatment planning. For determining, analyzing, and planning SPN treatment based on precise three-dimensional information about the type, shape, and position of the SPN and local aberrations and root resorption of adjacent permanent teeth, cone-beam computed tomography (CBCT) is recommended.¹² The radiation dose used in CBCT is frequently higher than that used in conventional radiography. This is a cause for concern among children, so ALADAIP principles should be prioritized in optimization (as low as diagnostically acceptable, indication-oriented, and patient-specific). This has prompted more efforts to adjust doses and justify using CBCT in pediatric dentistry. Hence, rational use of low-dose CBCT is being advocated in the pediatric population.^{29,30}

Supernumerary molars (SNMs)—like structures such as the paramolar tubercle/bolk cusp, formation supradentalis, formation paradentalis, and the fused supernumerary tooth should be ruled out in the differential diagnosis.^{12,31}

Supernumeraries (SPNs) with a normal orientation will usually erupt. Compared to 73% of primary SPNs, only 13–34% of all permanent SPNs erupt.²⁰ The position of impacted or erupted SPNs may remain unchanged for many years without causing any clinically discernible problems. SNMs may erupt normally, remain impacted, appear inverted, or assume an abnormal eruption path. However, they may cause carious and/or periodontal breakdown, impaction of permanent teeth, the delayed or ectopic eruption of adjacent teeth, dilaceration, delayed or abnormal root development of associated permanent teeth, and root resorption of adjacent teeth, pulp necrosis^{20,32–35} cyst formation with bone loss.^{20,36} The prevalence of dentigerous cysts with SPNs is 1–9.9%. Adenomatoid odontogenic tumor with multiple impacted SPNs is also reported. However, ameloblastoma with dental follicles of SPN is rare. To date, only four cases of dentigerous cysts associated with SNM are documented.³⁷

Supernumerary molars (SNMs) can migrate to the maxillary sinus or hard palate, may impinge on nerves, leading to paresthesia and/or pain, or reduplicate (late-forming SPNs).^{34,38,39} It can cause malocclusions like crowding or be an impediment in treatment like incomplete space closure during orthodontic treatment,^{40,41} jeopardizing the implant sites and complicating alveolar bone grafting. Buccally positioned SNMs cause traumatic bite with laceration of the buccal mucosa.⁴² Similarly, in the present case, the crowded left maxillary posterior quadrant had caused cheek

biting on the left side, resulting in traumatic/irritation fibroma at the line of occlusion.

The presence of SNMs in the developing occlusion of a child patient may make it difficult to intervene or call for aggressive treatment later. Surgical removal of impacted SPNs may not be required unless there is a risk of developing complications or is associated with a pathological condition. Proponents have advocated delayed surgical removal of SPNs within the proximity of permanent teeth as they can interfere with root development. However, if early removal is necessary, it must be accompanied by an adequate clinical and radiographic diagnosis and sound surgical intervention with effective behavior management. SPN management decision-making systems assist practitioners in making treatment decisions, such as removing the supernumerary tooth and, in some cases, the retention of impacted or erupted SPNs with no functional or esthetic complications.^{43,44}

When a supplemental tooth emerges, it may not be easy to distinguish which tooth is extra and which is of the regular dental series.⁴⁵ It is reasonable to remove the most displaced tooth from the line of the arch to alleviate crowding.⁴¹ In this case, all three erupted molars and one unerupted distomolar were extracted to avoid a future surgical procedure due to the potential reduplication of SNM. The fibroma was excised under general anesthesia with histopathological confirmation.

CONCLUSION

- Supernumerary molars (SNMs) are relatively uncommon clinical entities in the pediatric population.
- Majority of SNMs can cause clinical complications.
- A prompt diagnosis and rationally tailored treatment minimize complications.
- It is vital to reduce their impact as soon as possible and establish proper occlusion of adjacent permanent teeth.

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