

Update of the S2k guideline

Surgical removal of wisdom teeth

The second update of the S2k guideline „Surgical removal of wisdom teeth“ was completed in August 2019. It was originally one of the three pilot guidelines of the German Medical Association (BZÄK) and has now been revised in collaboration with the German Society of Dentistry and Oral Medicine (DGZMK) and the German Association for Oral and Maxillofacial Surgery (DGMKG).

The revision of the guideline was previously added to the list of priority topics by the quality task force, consisting of representatives from the DGZMK, KZBV and BZÄK. Findings from the literature from 2012 to June 2017, the results of an interdisciplinary consensus conference of the various associations (see box on page 235) in Bochum on December 13, 2017, and additional contributions from a Delphi procedure from February 2018 to April 2019 have been included. The guideline updates the status of the recommendations in the following specific areas:

- Indications for removing wisdom teeth and for leaving them in situ
- Significance of CB-CT diagnostics
- Significance of perioperative antibiotic prophylaxis
- Significance of piezosurgery
- Significance of coronectomy
- Selecting the time for extracting the tooth

As in the previous version, the principles for selection of the recommendations are explained in background text, which is included in the long version of the guideline. The text is reproduced here for information.

Indications for extraction and preserving teeth

The second update still retains basically unchanged the core statement of the guideline, particularly with reference to (dental) medical indi-

cations, possible indications and contraindications with reference to the scientific literature of the period to June 2017.

However, the structured consensus of the expert group has made the following changes:

- a) The „Exposure of pulp by caries“ has been deleted from the group of „Indications for removal of wisdom teeth“ and transferred to the „Possible indications for removal of wisdom teeth“. This has made it correspond to the option of retaining the tooth by endodontic treatment as an alternative.
- b) „Halitosis requiring treatment“ has been added to the possible indications if other treatments for retention of teeth were not successful.
- c) Similar to the indications for removal, the indications for leaving wisdom teeth are classified as indications and possible indications (see box on page 80).

Background: indications

Traditionally a distinction has been made between clinically or radiologically symptomless and symptomatic teeth in the indications for treatment. While the removal of clinically or radiologically symptomatic teeth is generally approved in the literature, a general recommendation for the removal of clinically symptomless wisdom teeth cannot be justified based on scientific evidence.

However, following more recent investigations the strict division by clinical symptoms cannot be justified without further study. Regardless of the presence of a clinically detectable pericoronitis and radiologically confirmed pericoronal radiolucency, a relevant proportion of wisdom teeth (20 to 60 percent) show pathological changes [Baycul et al., 2005; Blakey et al., 2002; Simsek-Kaya et al., 2011; Yildirim et al., 2008], which may affect the periodontal situation of the adjacent molars and may also have further effects [Blakey et al., 2010]. In addition, a high rate of distal caries must also be expected in adjacent 12-year molars (in the range of 50 percent) as a result of a close spatial relationship to the wisdom teeth [McArdle et al., 2016; Kang et al., 2016]. As a result, a fundamental distinction between removal of wisdom teeth for prophylactic and therapeutic reasons does no longer appear to be justified.

Longitudinal studies show that around 30 percent of wisdom teeth planned for removal at the age of 18 tend to become a regular part of the dentition by the age of 30 [Kruger et al., 2001]. On the other hand, two developments in opposing directions show themselves with increasing age. While the frequency of inflammatory complications reaches a maximum in the age group between 18 and 35 years and then decreases with age

[Fernandes et al., 2009], simultaneously with increasing age complications with surgical extraction tend to increase [Chuang et al., 2007; Baensch et al., 2017].

The benefit of removing wisdom teeth to prevent a tertiary crowding of the anterior teeth in the mandible on conclusion of the orthodontic treatment has been a subject of controversy for a longtime [Linguist & Thilander, 1982; Ades et al., 1990] and is still not fully clarified. A prospective, randomized study did not show a significant influence on tertiary crowding, but the length of the anterior dental arch was significantly reduced if the wisdom teeth were left in place [Harradine et al., 1998]. However, because more than 50 percent of the patients in this study had premolars extracted beforehand, the results cannot be applied to patients with complete dentition.

The primary influences on the likelihood of eruption of wisdom teeth are the retromolar space and premolar extraction [Artun et al., 2005; Kim et al., 2003].

Longitudinal data from the „Veterans Affairs Normative Aging Study“ show a relevant, unfavorable influence of impacted wisdom teeth on the prognosis of adjacent molars over a period of up to 25 years and in particular an unfavorable influence on the distal periodontal situation [Nunn et al., 2013]. The current Cochrane Review (CD003879: Surgical removal versus retention for the management of asymptomatic disease-free impacted wisdom teeth) with reference to inadequate „evidence“ according to the criteria of the Cochrane methodology refers to consulting with the patient to reach a decision subject to clinical experience.

Tooth resorption:

The evaluation of resorption at the distal radix of second molars is extremely uncertain due to the superimposition by impacted teeth in the conventional panoramic image. The increased use of DVT imaging means that resorptions on 12-year molars are likely to be detected more often and will have to be considered when deciding whether to remove wisdom

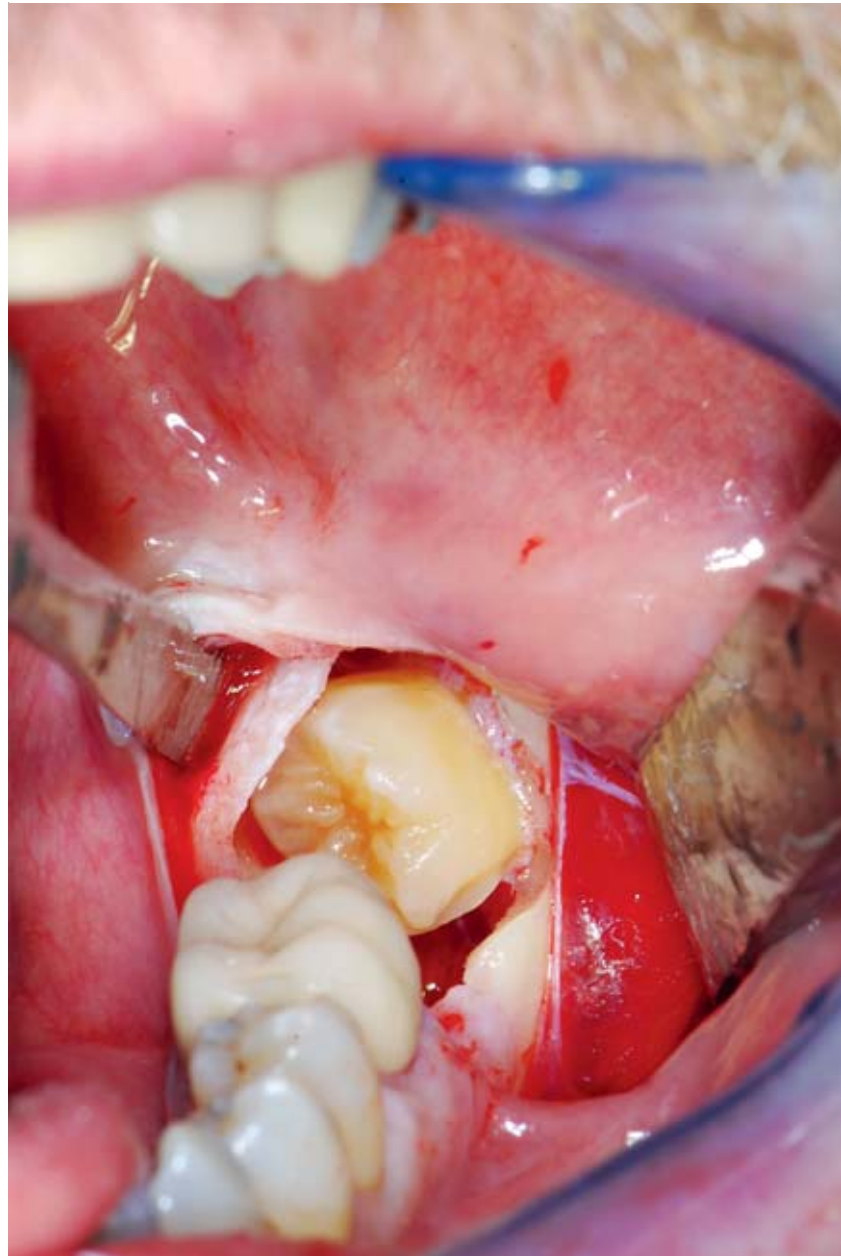


Photo: M. Kunkel

Figure 1 Surgical site after uncovering of a wisdom tooth surrounded by pericoronal cysts

teeth. Epidemiological data on the frequency are still not available, but patient series with a prevalence of 20 % with horizontal and mesioangular inclined third molars lead to the expectation that the problem of external resorption will have a more prominent place in deciding the treatment in future [Oenning et al., 2014; Oenning et al., 2014; Wang et al., 2017]. For example, in the case of resorption at the distal root of the 12-year molar, it would be possible to remove or if applicable reposition the wisdom tooth by orthodontic treatment.

DVT diagnostics

In spite of the wide range of new publications on DVT diagnostics, there have been no relevant changes to the indications for three-dimensional imaging. The guideline shows this in a statement and a recommendation:

Statement.

Three-dimensional imaging before removing a wisdom tooth is not required if conventional two-dimensional imaging shows no indication of any specific risks.

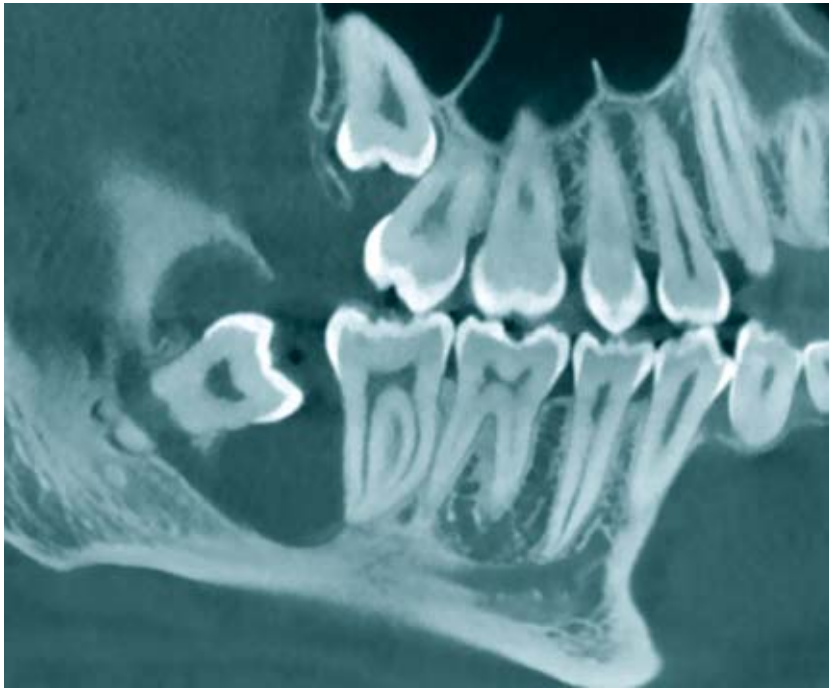


Figure 2a Course of the inferior alveolar nerve in the root region (sagittal reconstruction)

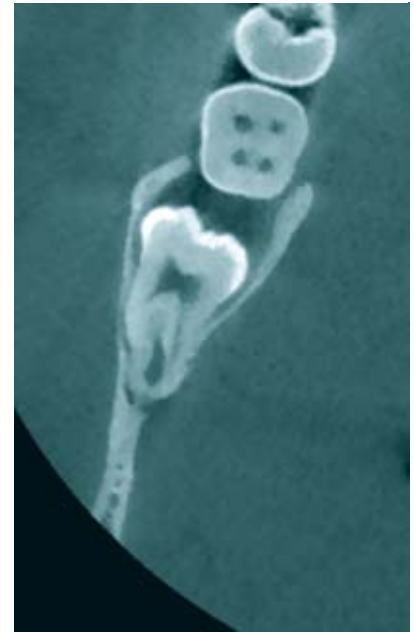


Figure 2b The frontal reconstruction shows the very unusual intraradicular course of the inferior alveolar nerve

Recommendation:

Three-dimensional imaging (such as DVT/CT) may be indicated if the conventional two-dimensional imaging suggests an immediate spatial relationship to risk structures or pathological changes and at the same time the dentist considers that additional spatial information may be required for the risk assessment of the patient, planning the procedure or also for orientation during the procedure.

Background:

Digital volume tomography (DVT) has become established as the three-dimensional imaging methodology used for indications and treatment in dentistry, oral surgery and maxillofa-

cial surgery. The advantages of DVT diagnostics with reference to topographical information, resolution and dimensional accuracy have been described in great detail in recent years. The availability of DVT has placed the question of the necessity of 3D diagnostics before surgical extraction of wisdom teeth in a central position.

A number of studies has shown that DVT is suitable for showing specific morphological features, positional anomalies and in particular the lack of a boundary between alveolus and nerve canal and thus can be used to assess the risk of nerve damage [Ghaeminia et al., 2009; Lübbers et al., 2011; Neugebauer et al., 2008; Suomalainen et al., 2010; Sursala and Dodson, 2007; Tant-anapornkul et al., 2007]. The authors therefore derive the indication of 3D imaging before surgery from the fact that these features are clearly shown in the 3D images. There are also preliminary indications that the surgical procedure may be changed in specific cases due to the inclusion of the DVT information [Ghaeminia et al., 2011]. Critical findings such as the resorption of 12-year molars by impacted wisdom teeth can also only be evaluated by three-dimensional imaging [Oenning et al., 2015].

However, it has so far not been possible to demonstrate that the increased information on the root morphology and topography found with the 3D diagnostics has actually resulted in changes to the surgical procedure and that this has resulted in a reduced rate of nerve damage. Due to the low frequency of such a result, confirmation of a reduction in the risk of nerve damage is practically impossible to obtain under the conditions of a randomized study, because plausible assumptions for the study parameters would result in a sample size of more than 150,000 patients [Roeder et al., 2012]. In practice, an evaluation of the necessity is possible only with the use of surrogate parameters, such as the display of risk indicators.

A prospective randomized study by Ghaeminia et al. contradicts this evaluation and reports of a sample size of 268 patients with 320 wisdom teeth [Ghaeminia et al., 2015]. However, the calculation of the sample size by this working group by implausible assumptions of basic frequencies of damage (12 percent) is not appropriate and is clearly faulty due to the actual frequency of nerve damage of 1.2 percent for the control group within the study population. In addition, the inclusion criteria for



Figure 3 Tooth resorption

the study (wisdom teeth with increased risk of nerve damage based on the panoramic image (PSA)) contradict the evaluation by the surgeons, who assessed the extraction as difficult in only 20 percent of cases. The times required for the operation (DVT group: 11.1 min versus PSA group: 11.9 min) were virtually the same in both study groups. It is not clear that the information derived from the DVT has influenced the surgical procedure.

The perioperative antibiotic prophylaxis

The recommendation for the perioperative antibiotic prophylaxis has been reduced from the clear endorsement („should“) to an open recommendation („may“).

Recommendation:

Perioperative antibiotic prophylaxis may be applied during removal of a wisdom tooth.

Background:

The discussion of the benefits of a prophylactic antibiotic therapy has been part of every surgical specialty since the beginning of the antibiotic era. The benefits of prophylactic antibiotic therapy have been a subject of dispute for a long time in the field of removal of wisdom teeth. Overall, a majority of methodologically high quality, systematic reviews confirm the benefits of prophylactic antibiotic therapy for the reduction of alveolar osteitis and also a reduction in infections from wounds [Ren and Malmstrom, 2007; Lodi et al., 2012; Ramos et al., 2016; Marcussen et al., 2016], but not all reviews show a significant therapeutic effect [Isiordia-Espinoza et al., 2015].

On the other hand, some authors point to the problems of potential resistance and changes in the microbiome even with short-term administration of antibiotics [Zaura et al., 2015; Aragon-Martinez et al., 2016]. Against this background there are also reviews in which the authors do not advise prophylactic antibiotic therapy, in spite of significant reductions in infectious complications (even in their own meta-

Indications and possible indications for removing wisdom teeth and for leaving them in situ

Indications for removing wisdom teeth

One indication is present with:

- acute or chronic infections (dentitis difficilis)
- teeth destroyed by caries that cannot be restored or untreatable pulpitis
- in the case of patients with diffuse facial pain if there are indications that the wisdom tooth is a relevant cause of pain
- untreatable periapical changes
- manifest pathological structures in connection with tooth follicles (such as cysts, tumors) or suspicion of such changes
- in connection with the treatment of/ and limitation of the progress of periodontal diseases
- teeth that interfere with orthodontic and/or reconstructive surgery
- teeth in the fracture gap that interfere with treatment of a fracture
- use of the tooth for transplantation

Possible indications for removing wisdom teeth

One indication may be present:

- to simplify orthodontic tooth movements and/or to simplify orthodontic retention or to secure a completed orthodontic treatment.
- for prophylactic tooth extraction for higher-level reasons to improve quality of life (for example, poor availability of medical treatment, etc.)
- with resorption at neighboring teeth
- pulp exposed by caries

- Teeth that interfere with a planned prosthetic restoration, for example expected due to a secondary eruption due to continuing atrophy of the alveolar ridge or due to pressure from removable dentures
- if other measures are implemented under anesthesia and renewed anesthesia is required to remove a wisdom tooth
- if the elongated/tilted wisdom tooth interferes with the dynamic occlusion
- if the wisdom tooth is the cause of halitosis that requires treatment and other measures for retention of teeth were not successful.

Indications for leaving wisdom teeth in place

One indication for leaving wisdom teeth in place is present if:

- orthodontic treatment of the tooth is planned
- it is to be used for a prosthetic restoration

One indication for leaving wisdom teeth in place may be present if:

- a spontaneous regular setting of the wisdom teeth in the dental arch can be expected
- with deep impacted and displaced teeth without clinically or radiologically confirmed findings of a high risk of surgical complications.

Source: DGMKG, DGZMK: S2k guideline for surgical removal of wisdom teeth, 2019. AWMF register number: 007-003

analysis) [Lodi et al., 2012; Arteagoitia et al., 2016]. Although the overall data situation confirms the benefits of a prophylactic antibiotic therapy and in the meantime a methodologically acceptable cohort study on the benefits of a prophylactic antibiotic therapy under practice conditions is now available [Lang et al., 2017], the endorsement and also the rejection of prophylactic antibiotic therapy can both be scientifically supported.

Piezosurgery

The scientific evidence for piezosurgery has significantly increased in the last five years, with the result that the significance of this method will continue to increase. However, the data on relevant clinical conclusions are not yet so unified that application of

piezosurgery can be generally promoted.

Recommendation:

Piezo osteotomy can be used as an alternative or supplement to conventional osteotomy for removal of wisdom teeth where neighboring anatomical structures are in danger.

Background:

Piezosurgical applications have been described in recent years as an alternative for numerous types of procedures in maxillofacial surgery and dental surgery, because due to the technical principle the danger to neighboring structures is likely to be reduced. In the case of wisdom tooth removal a number of prospective randomized studies and also results from systematic reviews [Jiang et al., 2015;



Photo: Kunkel

Figure 4 Variations of tooth morphology

Moraissi et al., 2016; Badenoch-Jones et al., 2016] are now available. However, the selection of studies and parts of the evaluation methodology of Al-Moraissi et al. have been criticized in the literature [Badenoch-Jones et al., 2016]. The meta-analyses have consistently shown significant advantages with pain reduction, oral opening, swelling, but also significantly longer operation times compared to conventional osteotomy techniques. Initial evaluations for „nerve damage“ as the clinical outcome parameter [Badenoch-Jones et al., 2016] indicate that piezosurgery may also reduce the risk of nerve damage.

Coronectomy

There have been no significant new insights into coronectomy over the period of this update. The scope of observations has certainly improved and post-operative observation periods over more than five years with low complications have been described. However, data on the longer-term effects over the life of patients are still not available, for example in the case of subsequent treatment with antiresorptives, immune suppression, diabetes, dialysis, tumor therapy and much more. To this extent coronectomy remains an alternative treatment with narrow limits in the indications.

Recommendation:

As an alternative to complete tooth extraction a coronectomy can be conducted in the case of restricted space to the inferior alveolar nerve where there is a high risk of damage.

Background:

In recent years the method of selectively removing the crown while leaving the root of the wisdom tooth has been revisited. This treatment concept is based on the fact that where the risk of injuring the inferior alveolar nerve is high, complete removal of the root can be avoided and only the crown and the follicular tissue of the wisdom tooth as a cause of pericoronitis are removed. In the meantime, some case series, a number of comparative cohort studies [Cilasun et al., 2011; Hatano et al., 2009; O’Riordan, 2004; Pogrel et al., 2004] and also prospective randomized studies [Leung and Cheung, 2009; Renton et al., 2005] have been published. These studies indicate that the risk of damage to the inferior alveolar nerve is reduced by the coronectomy. However, the long-term effects of leaving parts of the tooth, such as with reference to subsequent radiotherapy or antiresorptive treatment or even therapeutic immunosuppression, have not yet been adequately studied. Only very minor secondary complications were observed over a post-surgical observation period of up to five years [Leung and Cheung, 2016].

In addition to the classical coronectomy, modifications such as a planned two-stage removal after partial removal of the tooth crown [Landi et al., 2010], after partial removal of the bone [Tolstunov et al., 2011] or supplemented by orthodontic treatments [Wang et al., 2012] or Guided Bone Regeneration [Leung, 2016] have been described. So far, only results from small patient cohorts are available for the various modifications.

Preferred time for tooth removal

A recommendation for selecting the time for tooth removal has now been added. This recommendation is based primarily on the significantly in-

Involved professional bodies and associations

- German Association for Oral and Maxillofacial Surgery (DGMKG)
- German Society of Dentistry and Oral Medicine (DGZMK)
- German Association for Orthodontics (DGKFO)
- German Academy of Oral and Maxillofacial Surgery (AGKi)
- Professional Association of German Oral Surgeons (BDO)
- National Association for Patient Integration (BAGP)
- German Medical Association (BZÄK)
- Interdisciplinary Working Group for Oral Pathology and Oral Medicine (AKOPOM)
- Federal Association for Statutory Health Insurance Dentists (KZBV)

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creased perioperative morbidity/comorbidity and the poorer periodontal regeneration at neighboring 12-year molars in advanced age.

Recommendation:

If there is an indication for removal of the wisdom tooth or an indication is foreseeable and the time of tooth extraction can be planned, this wisdom tooth should be removed during the time of development of the root, preferably before the age of 25.

Background:

For the decision on the time of surgical removal, in addition to the option of regular setting in the dental arch [Kruger et al., 2001] the primary focus for consideration is the stage of development of the tooth root and its current and anticipated relation-

ship to the inferior alveolar nerve, the danger of resorption at neighboring teeth [Wang et al., 2017], the age-dependent local operational risk [Chuang et al., 2007; Baensch et al., 2017] and the age-dependent periodontal regeneration on the neighboring 12-year molar [Kugelberg et al., 1991].

In addition to the long version of the guideline, a detailed guideline report is also available as a source of information. The documents can be downloaded from the web sites of the German Medical Association, the DGZMK and the AWMF. The next revision of the guideline is planned for 2024.

The literature list can be found at www.zm-online.de or www.online-dzz.com.



(Photo: private)

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