

Tongue Stud Damage - A Case Study

Oral piercings are becoming more common and so are the problems they create. Remind patients of the dangers of oral piercings.

periopeak

Posted: 7/16/2011

Post: 1 of 49



This female patient in her early 50s had a tongue stud for 10 years. Check out the damage it caused.

Class I mobility on 24 and 25, both are non-vital. Her periodontist recommended extraction of 24 and 25. Notice lack of attached gingiva. Endo was performed, then regenerative periodontal endoscopy (RPE) the same day with Emdogain. Limiting factor here will be the attached gingiva on the lingual. Buccal is all WNL with beautiful tissues.



Patient was prescribed metronidazole 500mg BID for eight days. DNA test revealed high level of *T. denticola*. She is PST negative, smokes half a pack daily and eats very well. Periogain was recommended, two caps twice daily for host modulated therapy. Do you think she has a chance of keeping these teeth? ■

lindadouglas

Posted: 7/16/2011

Post: 2 of 49



Judging by those periapical lesions I would have said the prognosis was hopeless, especially because she is a smoker, but I have seen your work before, so I would love to see the outcome after you work on this patient. I usually see tongue piercings on the young and foolish, but not on the middle-aged! I once read about someone who got a brain abscess after a tongue piercing. ■

JERSEY DEVIL

Posted: 7/17/2011

Post: 6 of 49



Unbelievable the damage she was doing and didn't even know it! ■

JGonzalesRDH

Posted: 7/17/2011

Post: 7 of 49



Absolutely savable! Expensive, but she could have these teeth for another 10 years I bet. If mobility remains after RPE, what are they considering for restorative options? Did they take #24/25 out of occlusion? Would be interesting to see a full arch photo as well if you have one... doesn't look like she has a lot of incisal wear, which is good. Great case study! Thanks for sharing. ■

Just for your general information, when considering treating this area with a CT graft I am mostly looking for the following:

drtoast
 Posted: 8/3/2011
 Post: 43 of 49

Is there adequate depth to the floor of the mouth? Does the remaining gingiva have some thickness to it so when I reflect it back I won't wind up perforating through the tissue? (When this happens, you are in really bad shape, and you have now most likely made things worse than they were before.) Will the patient's tongue allow me adequate access to do the surgery? And lastly, am I dealing with a highly compliant patient?

I know that recession on the lingual aspect of lower anterior teeth is an extremely prevalent problem, and many of these patients would benefit significantly if they could have soft tissue augmentation procedures. I am definitely very careful and cautious when I decide to treat one of these problems. I think a very appropriate area to treat is when a patient has only his lower six anterior teeth present and there is significant recession on the lingual of a canine, which happens so often as the lingual bar of the partial has settled. This can be a very nice service to a patient, helping her so she doesn't lose either the canine or worse still, the lower partial. (I am still a big believer in trying to preserve our own natural teeth where possible.) ■



periopeak
 Posted: 8/4/2011
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Here are some three-week post-op photos; nice tight tissue. ■



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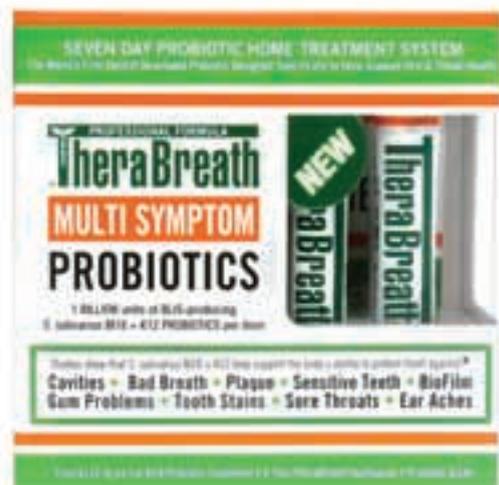
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