The Prophylactic Extraction of Third Molars: A Public Health Hazard

| Jay W. Friedman, DDS, MPH

Ten million third molars (wisdom teeth) are extracted from approximately 5 million people in the United States each year at an annual cost of over $3 billion.

In addition, more than 11 million patient days of “standard discomfort or disability”—pain, swelling, bruising, and malaise—result postoperatively, and more than 11,000 people suffer permanent paresthesia—numbness of the lip, tongue, and cheek—as a consequence of nerve injury during the surgery. At least two thirds of these extractions, associated costs, and injuries are unnecessary, constituting a silent epidemic of iatrogenic injury that afflicts tens of thousands of people with lifelong discomfort and disability.


IN THE UNITED STATES, prophylactic removal of third molars (wisdom teeth) is advocated by almost all oral and maxillofacial surgeons and many general dentists. According to the American Association of Oral and Maxillofacial Surgeons, “if there is insufficient anatomical space to accommodate normal eruption...removal of such teeth at an early age is a valid and scientifically sound treatment rationale based on medical necessity.”¹ As a result, 10 million teeth classified as impactions (teeth that fail to erupt into normal position but remain fully or partially embedded and covered by jawbone or gum tissue) are removed every year from mostly healthy young people.²

There is no evidence of widespread third-molar infection and pathology or of medical necessity to justify so much surgery. In fact, 50% of upper third molars classified as impactions are normally developing teeth, most of which will erupt with minimal discomfort if not extracted prematurely. Only 12% of truly impacted teeth are associated with pathological conditions such as cysts and damage to adjacent teeth.³,⁴ Most discomfort of erupting wisdom teeth is equivalent to teething and disappears on full eruption. Most infection of the gum tissue around the erupting or partially erupted teeth can be prevented by good oral hygiene, including toothbrushing. Infection occurs in fewer than 10% of third molars, most of which can be cured with antibiotics, oral rinsing, or removal of excess tissue (the hypercementum) around the tooth, without requiring removal of the tooth itself.⁵ Most of the pain and illness attributed to third molars is caused by the surgery, not the teeth.

Third-molar surgery is a multibillion-dollar industry that generates significant income for the dental profession, particularly oral and maxillofacial surgeons. It is driven by misinformation and myths that have been exposed before but that continue to be promulgated by the profession.⁶

THE MYTHOLOGY OF WISDOM TEETH

Myth Number 1—Third Molars Have a High Incidence of Pathology

Not more than 12% of impacted teeth have associated pathology (Table 1). This incidence is the same as for appendicitis (10%) and cholecystitis (12%), yet prophylactic appendectomies and cholecystectomies are not the standard of care.⁴ Why then prophylactic third-molar extractions?

What about pericoronitis, the pain and infection of the gum tissue surrounding a partially
prevalence of third-molar pathology in the population, removal of asymptomatic, nonpathologic third molars does not meet the standard of evidence-based practice.

Myth Number 2—Early Removal of Third Molars Is Less Traumatic

The American Association of Oral and Maxillofacial Surgeons states that “about 85% of third molars will eventually need to be removed.”\(^{10}\) The association recommends extraction of all 4 third molars by young adulthood—preferably in adolescence, before the roots are fully formed—to minimize complications such as postextraction pain and infection.

Adding an average of 8% incidence of pericoronitis to the 12% pathology listed in Table 1 brings the maximum pathology associated with third molars to 20%. However, a single episode of pericoronitis is not a reason to remove a third molar; this should be considered only if the problem fails to respond to conservative treatment or recurs.\(^9\)

Myth Number 3—Pressure of Erupting Third Molars Causes Crowding of Anterior Teeth

It is not possible for lower third molars, which develop in the spongy interior cancellous tissue of bone with no firm support, to push 14 other teeth with roots implanted vertically like the pegs of a picket fence so that the incisors in the middle twist and overlap. Yet that is the reason often given for removal of third molars, even though studies have produced...
TABLE 3—Estimated Annual Reduction of Cost and Disability From Performing Only Needed Third-Molar Extractions: United States

<table>
<thead>
<tr>
<th>No. of Extractions</th>
<th>Cost, $</th>
<th>Savings, $*</th>
<th>No. of Patients</th>
<th>Patient Days of Standard Discomfort or Disability</th>
<th>Reduction of Patient Days of Standard Discomfort or Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral and maxillofacial surgeons</td>
<td>2 310 000</td>
<td>941 325 000</td>
<td>1 911 175 000</td>
<td>1 160 000</td>
<td>2 630 000</td>
</tr>
<tr>
<td>General practitioners</td>
<td>1 000 000</td>
<td>150 000 000</td>
<td>300 000 000</td>
<td>500 000</td>
<td>1 130 000</td>
</tr>
<tr>
<td>Total</td>
<td>3 310 000</td>
<td>1 091 325 000</td>
<td>2 211 175 000</td>
<td>1 660 000</td>
<td>3 760 000</td>
</tr>
</tbody>
</table>

Source. See reference 2.

Note. Extractions because of pathological conditions are estimated to represent 33% of current annual third-molar extractions.20,21

*Savings are calculated by subtracting the estimated cost of third-molar extractions performed only in cases in which pathology is present from the estimated cost of extractions currently performed per year.

Myth Number 4—The Risk of Pathology in Impacted Third Molars Increases With Age

The American Association of Oral and Maxillofacial Surgeons states, without substantiation, “Pathologic conditions [of impacted third molars] are generally more common with an increase in age.”1516 A study of more than 1756 patients who had retained more than 2000 mandibular impactions for an average of 27 years found that only 0.81% experienced cystic formation. There is no evidence of a significant increase in third-molar pathology with age.3 Of course, teeth that become repeatedly symptomatic or develop associated pathology should be removed.15,16

Myth Number 5—There is Little Risk of Harm in the Removal of Third Molars

Given the low incidence of pathology, it is specious to contend that less than 3 days of temporary discomfort or disability is a small price to pay to avoid the future risks of root resorption, serious infections, and cysts. Also ignored is the risk of incidental injury such as broken jaws, fractured teeth, damage to the temporomandibular joints, temporary and, especially, permanent paresthesia or dysthesia (numbness and dysfunction of the lower lip and the tongue). The box on the following page lists the complications that can occur with the removal of wisdom teeth.

Complications of Third-Molar Extractions

- Pain
- Swelling
- Trismus
- Hemorrhage
- Alveolar osteitis (dry socket)
- Periodontal damage
- Soft-tissue infection
- Injury to temporomandibular joint
- Malaise
- Temporary paresthesia (numbness of the lips, tongue, and cheek)
- Permanent paresthesia
- Fracture of adjacent teeth
- Fracture of the mandible
- Fracture of the maxilla
- Sinus exposure or infection
- Anesthetic complications

Data on the number of fractured jaws and damaged teeth are lacking. Fractures occur but are uncommon. There is little data on temporary and permanent temporomandibular joint injury after third-molar surgery, although a recent study of patients aged 15 to 20 years reported an incidence of 1.6%, which translates to thousands of such injuries each year.17

However, mandibular and lingual nerve injury resulting from third-molar surgery has been more widely reported. Because the percentages of incidental (unavoidable) and iatrogenic (avoidable) injury are small, no one has previously performed the simple task of applying these figures to the entire population exposed to surgery.

Reports on the incidence of mandibular (lower jaw) nerve paresthesia vary from a low of 1.3% for temporary and 0.33% for permanent paresthesia to a high of 4.4% for temporary and 1% for permanent paresthesia.18,19 Small figures, indeed! But if 3.5 million lower third molars are removed from 3.5 million persons by oral and maxillofacial surgeons (Table 2), the incidence of permanent paresthesia ranges from a low of more than 11 500 to a high of 35 000. Two thirds of these patients had no present or previous symptoms to warrant extraction.20,21 If 67% of the surgery is unnecessary, then between 7739 and 23 450 people are afflicted with permanent paresthesia unnecessarily each year (Table 4).

These figures are based on simple extrapolations from studies by...
Table 4—Estimated Annual Incidence of Paresthesia of the Mandibular Nerve Following Third-Molar Extractions by Oral and Maxillofacial Surgeons: United States

<table>
<thead>
<tr>
<th>Persons with Paresthesia</th>
<th>Minimum No</th>
<th>Maximum No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extraction of 3.5 million lower third molars</td>
<td>45,500</td>
<td>154,000</td>
</tr>
<tr>
<td>Temporary</td>
<td>45,500</td>
<td>154,000</td>
</tr>
<tr>
<td>Permanent</td>
<td>11,550</td>
<td>35,000</td>
</tr>
<tr>
<td>Extraction of the 33% of third molars with symptoms or pathology</td>
<td>15,015</td>
<td>50,820</td>
</tr>
<tr>
<td>Temporary</td>
<td>15,015</td>
<td>50,820</td>
</tr>
<tr>
<td>Permanent</td>
<td>3,811</td>
<td>11,550</td>
</tr>
<tr>
<td>Incidence of iatrogenic paresthesia if 67% of the extractions are unnecessary</td>
<td>30,485</td>
<td>103,180</td>
</tr>
<tr>
<td>Temporary</td>
<td>30,485</td>
<td>103,180</td>
</tr>
<tr>
<td>Permanent</td>
<td>7,739</td>
<td>23,450</td>
</tr>
<tr>
<td>Incidence of iatrogenic paresthesia if 50% of the extractions are unnecessary</td>
<td>22,750</td>
<td>77,000</td>
</tr>
<tr>
<td>Temporary</td>
<td>22,750</td>
<td>77,000</td>
</tr>
<tr>
<td>Permanent</td>
<td>5,775</td>
<td>17,500</td>
</tr>
</tbody>
</table>

Note: Paresthesia is numbness of the lips, tongue, and cheek. The estimated minimum percentage of temporary cases of paresthesia is 1.3% and of permanent cases is 0.33%—the maximum is 4.4% temporary and 1% permanent.

Paresthesia

How is it possible that so much harm is done and so little is heard of it? The answer is that paresthesia of the lips and tongue is not deadly. Although it is one of the most common reasons that patients sue oral and maxillofacial surgeons, most judges and jurors do not fault the surgeons, because the patients consented to surgery, thereby assuming the risk. That patients are given unsubstantiated information that would, in just circumstances, invalidate their informed consent is rarely convincing to a court.24,25 Patients who might have avoided the surgery in the absence of confirmed pathology are consigned to a numb jaw or lip or tongue for the rest of their lives. Symptoms include frequent drooling, biting of the lip or the inside of the cheek or the side of the tongue, and paralytic disfigurement or drooping of the lip. The sense of taste, the facility of speech, and the sensory pleasure of kissing are diminished. When bilateral paresthesia occurs, the anguish, discomfort, and disability are more than doubled. To be sure, the degree of paresthesia varies, from mild to severe. Constant tingling numbness is the most common feature, but some patients experience frequent shooting pains much like neuralgia. Those suffering from severe paresthesia may be driven to near hysteria by a loss of sensory functions that affects all aspects of their lives.

The risk of paresthesia is not the same for all extractions. It is highest for the mesioangular impaction, in which the tooth is positioned at a 30–45° angle toward or actually against the distal, or back, surface of the second molar (Figure 1). When fully formed, the roots frequently lie close to the right and left mandibular nerves, which run along the jaw beneath or between the roots. The risk of permanent paresthesia following extraction of a mesioangular impaction is as high as 6.8%, much higher than for other types of unerupted or impacted teeth.6 More than 95% of these teeth will never cause any problem. As many as
three fourths of the developing third molars classified as mesioangular impactions at the time of extraction are not impacted at all, but would continue to erupt into normal position in the mouth if left alone.²⁶

There can be no excuse for tolerating so many unnecessary extractions on millions of unsuspecting and misled people and putting them at risk of so much iatrogenic nerve injury. This is a public health hazard.

THE ECONOMICS OF THIRD-MOLAR SURGERY

Each of the approximately 5500 oral and maxillofacial surgeons in private practice averages nearly 53 third-molar cases a month, accounting for the removal of at least 7 of the 10 million “impacted” third molars extracted annually.²⁷ Most of these teeth are not impacted. Half are upper third molars, most of which can erupt normally, as will many, if not most, of the lower third molars (Figure 2). Removing these teeth while they are still developing in the jaw bone results in a higher fee: extraction when the tooth is embedded in soft tissue or bone is a more complex surgical procedure than a simple extraction after the tooth erupts. Even so, it seldom takes an oral and maxillofacial surgeon more than 8 minutes to extract an impacted tooth once the patient is anesthetized.²⁸

The average annual income of oral and maxillofacial surgeons from third-molar extractions alone is estimated at $518,636 (see footnote, Table 2). Even though only 20% of third molars have associated pathology or tissue inflammation, allowance should be made for the 33% that may cause some discomfort (Table 3), even if the condition might resolve later on without surgery. Two thirds of all third-molar extractions are unnecessary. Eliminating these extractions would reduce the oral and maxillofacial surgeon’s annual income by $347,486, resulting in an annual savings to patients of more than $1.9 billion, or $2.2 billion if extractions by general practitioners are included (Table 3).

A RATIONAL POLICY

The British National Institute for Clinical Excellence is unequivocal in its recommendation, adopted by the National Health Service: “The practice of prophylactic removal of pathology-free impacted third molars should be discontinued. . . . There is no reliable evidence to support a health benefit to patients from the prophylactic removal of pathology-free impacted teeth.”⁹(p1–2) The conditions for which extraction is justified include nonrestorable dental caries, pulpal infection, cellulitis, recurrent pericoronitis, abscesses, cysts, and fractures.

Government-funded programs in the United States are beginning to adopt similar policies; an example is the Healthy Kids Dental Program administered by Delta Dental of Michigan. Also needed is better education of dentists, beginning in dental school, and of the public on the reasons to avoid unnecessary extractions.

THE FALLACY OF TWO SCHOOLS OF THOUGHT

One school of thought is endorsed by oral and maxillofacial surgeons who contend that most third molars are potentially pathologic and should be removed. The other holds that only third molars with associated pathology should be removed. The legal system, in which decisions are generally based on norms of practice or local or regional standards of care, credits each school of thought as having equal merit, ignoring the scientific evidence base. That is why oral and maxillofacial surgeons usually prevail in malpractice suits when patients are injured during elective surgery. After all, if the expert oral and maxillofacial surgeon says the surgery is necessary, then it is necessary. The fact that most third molars, impacted or not, do not become diseased and that the risk of iatrogenic injury from such surgery is greater than the risk of leaving asymptomatic, nonpathologic teeth alone does not override the expert opinion of oral and maxillofacial surgeons. Thus, the prevalent practice of prophylactic third-molar extractions is ordained as the standard of care, even though that standard is based on an erroneous evaluation of all outcomes and costs.

Malpractice in dentistry is more common than is acknowledged, but the victim’s recourse to redress the physical and financial injury is severely limited.²⁵ The recovery amounts involved are usually too small to cover an attorney’s expenses. However, there is something the legal profession could do to protect the public: abolish the fallacy of the standard of care and 2 schools of thought as having equal merit, ignoring the scientific evidence base. That is why oral and maxillofacial surgeons usually prevail in malpractice suits when patients are injured during elective surgery. After all, if the expert oral and maxillofacial surgeon says the surgery is necessary, then it is necessary. The fact that most third molars, impacted or not, do not become diseased and that the risk of iatrogenic injury from such surgery is greater than the risk of leaving asymptomatic, nonpathologic teeth alone does not override the expert opinion of oral and maxillofacial surgeons. Thus, the prevalent practice of prophylactic third-molar extractions is ordained as the standard of care, even though that standard is based on an erroneous evaluation of all outcomes and costs.

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References


