Tongue piercing: Part II

Introduction

Mucogingival defects through intra- and peri-oral piercings

Many complications have recently been reported in medical and dental literature (1–5).

Dental hygienists should familiarize themselves with the possible oral and dental problems associated with piercing. They need to become more vocal in educating their patients about the medical and dental risks associated with oral piercing and oral jewelry. Attachment loss can be severe, even if gingival recession is slight. It is recommended to check the periodontium of patients with piercings regularly.

Case history

The patient is a healthy, non-smoking 22-year-old female. She is taking no medications and says her health is good. She has been coming in for regular maintenance every 6 months. She brushes two times per day and flosses once a day.

Mouth inspection

The examination reveals some 3-mm probing depths and 10% bleeding and the presence of a piercing in her lower lip that is held in place by a metal disk on her inner labial mucosa. She exhibits good plaque control ability and her gingival tissue is clinically healthy. However, on the buccal aspect of 41, the marginal gingiva showed a recession of 5 mm not associated with a plaque-induced inflammatory lesion. She had noticed the appearance of the recession 2 months after the insertion of the labial piercing and habitually 'liked to play with it'.

Questions

1 How can a gingival recession be defined?

2 What are the causes of gingival recession?

3 Why is it important to do an intensive periodontal examination in this patient?

4 The gingival recession of the 41 were clearly related to the labial piercing. You advised her to remove the stud but she did not agree with this. What is your treatment plan?

Answers

1 Reduction of the height of the marginal gingiva to a location apical to the cemento-enamel junction, resulting in root surface exposure; signifies attachment loss (6).

2(a) Anatomy of the labiate plate of the alveolar bone. A thin, fenestrated, or absent labial alveolar bone is a major predisposing factor to recession. Tooth anatomy and tooth position also affect the thickness of the labial plate.

(b) Oral hygiene status. Poor oral hygiene results in plaque-induced gingival disease. Therefore it would make sense that poor oral hygiene would lead to gingival recession. Research however shows that more recession is caused by meticulous oral hygiene.

(c) Acute or chronic trauma. Gingival trauma and injury caused by toothbrushing are significant risk factors. The technique, frequency, duration, and force of brushing and toothbrush filaments have been implicated in recession. Injury to the gingiva caused by foreign objects or damaging habits such as fingernail scratching also may cause recession.

(d) Frenal attachment at the gingival margin. Progressive recession may occur when the fibres of the frenum insert near the gingival margin and cause a tight frenal pull on the gingival tissues. Tissue movement as a result of speaking or chewing can pull the gingiva from the cemento-enamel junction, resulting in gingival recession.

(e) Occlusal trauma. Occlusal trauma that results in the movement of teeth can alter the attachment of the gingiva to the tooth (6).

3 Patients with intra-oral or peri-oral piercing may be at increased risk of developing significant periodontal attachment loss involving proximal teeth. In the absence of gingival recession, such attachment loss could escape detection without an appropriate periodontal examination. In general, the earlier the detection of the attachment loss and recession, the more amenable such periodontal defects are to treatment (1).

4 When she prefers to keep the labial piercing, the only option is to monitor her every six months when she comes for prophylaxis visits (2).

References

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