Clinical Case Presentations

C1

Retarded eruption of all permanent teeth. An extreme case report

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Presenting problem: A 14 year old male patient with delayed eruption of all permanent teeth with the exception of maxillary first permanent molars was referred to our clinic. The clinical examination of the patient showed no signs of abnormality. Mental and physical development was normal for his age and there were no signs or symptoms supporting the presence of syndromes related to eruption problems. Blood tests were within normal limits and there was no history of such a problem in the family. Radiological examination showed that all permanent first molars were present but only the maxillary first molars had erupted. In order to achieve spontaneous eruption of their permanent successors a general practitioner extracted the central primary mandibular incisors. However no eruption of the permanent successors was observed over a period of two years.
Clinical management: A decision was made to surgically expose the crowns of the permanent central incisors in the lower jaw in order to promote spontaneous eruption. A year after the operation these teeth together with the mandibular third molars were partially erupted. No other teeth had erupted at this stage.
Discussion: A case of delayed eruption of all permanent teeth is very rare, especially when it is not related to any known syndrome. The pathogenesis is a diagnostic riddle and the treatment demands a very careful approach.

C2

Management of a patient exhibiting concomitant supernumerary teeth and hypodontia

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Presenting problem: A 9-year-old boy was referred by his General Dental Practitioner for the management of supernumerary teeth in the anterior maxilla. The child had little experience of dental treatment but was concerned with the aesthetics of his teeth. He was medically fit and well. Clinical and radiographic examination revealed the presence of a supplemental megadont tooth in the position of 11, an erupted palatal tuberculate supernumerary tooth causing displacement on closure and hypodontia of 35 and 45 with infraocclusion of 75. Orthodontically, the patient had a Class II division 1 incisal relationship on a mild Class II skeletal base. He was severely crowded in the upper arch but the lower arch was well aligned. Oral hygiene was noted to be poor.
Clinical management: All treatment was provided under the close supervision of an Associate Specialist in Orthodontics and initially involved extraction of 53 and the palatal supernumerary tooth and thorough oral hygiene instruction and preventive advice. Following further dental development, the megadont tooth and 24 were extracted to facilitate orthodontic alignment with an upper fixed appliance. A heat-treated gold onlay has been provided for 75 and 85 is currently monitored for signs of infraocclusion.
Discussion: There are few reported cases in the literature of concomitant supernumerary teeth and hypodontia. This case describes the multi-disciplinary management of a child with a complex dental problem.

C3

Undiagnosed cardiomyopathy in a child with features of Papillon Lefevre syndrome

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Presenting problem: We report on a child under long-term dental care for prepubertal periodontitis, premature root resorption of primary teeth, granulomatous, furrowed cobblestone oral mucosa and gingivae, hypodontia and peg shaped lateral incisors, caries and angular cheilitis who suffered a sudden unexpected death. Subsequent post mortem confirmed an undiagnosed dilated cardiomyopathy. This may have triggered ventricular fibrillation, which caused her death. Prior to her death, she had also been seen by several dermatologists with respect to palmar plantar hyperkeratosis, striae keratoderma, wiry hair and abnormal finger nails.
Discussion: In spite of being seen by a number of clinicians in several centres in the UK a satisfactory clinical diagnosis was never established. A detailed search of the literature revealed no previously reported link between Papillon Lefevre syndrome and cardiac pathology. This case report details the patient's specific clinical presentation, which included features similar to ectodermal dysplasia, Papillon Lefevre or oral Crohn's associated with skin pathology. Possible diagnoses are suggested. Clinicians seeing similar features in future should send the child for cardiac screening to rule out any potentially life threatening pathology.

C4

Staphylococcus aureus infection associated with orofacial granulomatosis

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Presenting problem: A 6-year-old girl attended the Department of Paediatric Dentistry at Edinburgh Dental Institute complaining of swelling and blistering of her upper lips and adjacent gingivae, which had been present for approximately 1 month. The patient had an unremarkable medical history.
Clinical management: Examination revealed submandibular lymphadenopathy with vesiculation and erythema in the upper incisor region. There was swelling and crusting of the upper lip with slight swelling of the lower lip. Foetor oris was evident. An initial diagnosis of primary herpetic gingivostomatitis was made. Despite treatment the lesions did not resolve. At review, the patient's mother stated that the patient was now suffering abdominal pain and diarrhoea. Haematological investigations revealed no abnormalities. Punch biopsies of the lips carried out under general anaesthesia showed lymphoedema but no granulomata. It was felt by the pathologist that the appearance was of a secondarily infected lesion with an underlying allergic component, most likely to be orofacial granulomatosis (OFG). Swabs sent for bacterial and fungal culture identified no fungal species but

