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Evaluation of sensitivity of teeth after mandibular fractures

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Abstract

The sensitivity of teeth affected anterior to a fracture between the mental and mandibular foramina has been tested and followed up until either reinnervation or a period of three years has passed. The purpose of this study was to determine the reinnervation period, the number of denervated teeth, and the clinical importance of these measures. The investigation included a sensitivity test by electrical stimuli, clinical examination, and radiological findings. Fifty patients were examined; a total of 459 teeth were tested, and 273 of these were affected and thus had potentially impaired innervation. Tests after injury showed non-responsive teeth in 81.3% (222/273) of affected teeth. Six weeks after injury, 18.9% of teeth were reinnervated; by 1 year after injury, 92.3% of initially non-responsive affected teeth were reinnervated. The majority of teeth (33.8%) were reinnervated in the period from 6 weeks to 3 months. All 23/186 initially non-responsive, unaffected, contralateral corresponding teeth were reinnervated within the first 6 weeks. In the second and third years, none of the teeth were reinnervated. A year after injury, 95.3% of the incisors, 91.1% of the canines, 93.8% of the premolars, and 81.5% of the molars were reinnervated. Three years after injury, 7.6% of teeth remain denervated. During the second and third years, no reinnervation occurred; however, clinical signs of pulp devitalisation of denervated teeth occurred in 17.6% (3/17) or 1.3% of the initially non-responsive affected teeth. The results of this investigation revealed the stability of the pulp one year after injury. Denervated teeth should not be treated if no clinical or radiological signs of devitalisation exist.

Introduction

Mandibular nerve injury is a common complication of mandibular fractures between the mental and mandibular foramina. As a consequence of nerve injury, disturbances of the skin and mucous membrane as well as teeth sensitivity occur¹⁶. Patients feel such disturbances subjectively with various intensities, but clinical experience shows that this condition gradually improves after a certain period of time. Although it is known from clinical experience that teeth anterior to a fracture line can demonstrate disturbed sensitivity, the problem has not been addressed sufficiently in the literature²⁷.

Tooth sensitivity testing methods are based on pain, so it is impossible to differentiate vitality (a function of pulp vascularisation) from sensitivity (a function of innervation)^{1,4}. Using the information provided by recent findings, however, scientists have succeeded in using modern technology to detect tissue blood perfusion of the oral area via laser Doppler flowmetry (LDF)^{12,14} and pulse oximetry⁸. Therefore, the use of these physiometric tests for tooth vitality detection is a valuable resource¹⁵. Calil et al.⁸ concluded that further studies are required to assess the effectiveness and validity in determining pulp vitality in traumatised teeth. If the injury causes an interruption in pulp vascularisation, the result will be pulp tissue death (including the nerve); if only a nerve injury occurs, the vitality of the pulp will not be impaired. It is obvious that some injuries damage the nerve without influencing the survival of the pulp. Because terminal and electrical stimuli assess only the sensitivity of the pulp, they are not indicated for the direct evaluation of vitality. A tooth that does not change colour and lacks necrotised pulp is vascularised; the innervation is thus of secondary importance. It is

known from clinical experience that teeth anterior to the fracture line primarily demonstrate temporary disturbed sensitivity.

The incidence and natural history of post-traumatic sensory disturbances in the distribution of the inferior alveolar nerve (IAN) are insufficiently documented in the literature. This problem has been recognised previously^{16,25} and published studies include fractures and osteotomies that may or may not involve the mandibular canal in relation to specific methods and periods of fracture reduction⁵. There are only a few studies that evaluate IAN disturbances by examining tooth sensitivity³³.

In tooth vitality investigations, there have been various attitudes regarding the value of different stimuli in the detection of tooth vitality. Some studies report electric stimuli to be 100% precise, although these cannot distinguish the quality of the detected vitality³⁵. Other reports consider such stimuli to be unreliable²¹. Still others prefer vitality tests that measure electric amplitude without power²⁸, whereas some prefer a thermal vitality meter¹³. It is appropriate to conclude that the thermal and electric "vitality" tests, history, and clinical and radiological findings should be secondary methods for pulp status detection. Such status depends on many things, including age, general status, tooth size, past injuries, and pathologic pulp changes⁹.

The aims of this investigation were 1) to evaluate IAN disturbances by assessing tooth sensitivity after mandibular fracture with the use of an electric tester and 2) to determine the number of denervated teeth and the time period in which normalisation of tooth sensitivity or devitalisation occurred.

Material and methods

This prospective study used a sample derived from the population of patients with mandibular fractures treated at the Department of Oral and Maxillofacial Surgery in Zagreb between 2006 and 2009. Inclusion criteria were 1) the presence of a minimally displaced (< 3 mm) mandibular fracture between the mental and mandibular foramina because these fractures place the IAN at direct risk for injury¹⁶, 2) treatment with closed reduction and maxillomandibular fixation with elastics because late deleterious effects on the teeth and periodontal tissues from interdental wiring are uncommon 1 year after the removal of the interdental wiring⁴⁵, 3) preoperative and postoperative panoramic radiographs as a routine imaging, although it is possible to diagnose the interruption of IAN continuity with MR imaging²², and 4) patients who accepted more follow-up examinations and pulp testing. The investigation included 50 patients with fractures between the mental and mandibular foramina. Anterior to the fracture line, these patients had affected teeth that initially seemed to be avital but actually were not, and they had potentially impaired innervation. We assumed that the lack of responsiveness to electric pulp testing was due to inferior dental nerve injury because there was no evidence of direct tooth trauma. Complete documentation of patients was obtained, and complete follow-up until reinnervation or the passing of a three-year period (in patients for whom reinnervation of all teeth did not occur) was performed. Patients with parasymphiseal fractures, teeth involved in the fracture line, carious teeth, teeth with prosthetic restorations, previously devitalised teeth, and teeth injured in the fractures were excluded from the study.

An electric vitality tester was used for sensitivity testing (Digitest model No.D626D, Parkell). It consisted of an instrument casing with a battery. The tester contained a digital electric stimulus slide ranging from 0-64, with electrodes patched for

examining tooth surface sensitivity and a connection cable applied to the patient's lip. Teeth were dried and isolated with cotton, electrodes were moistened, and the lowest intensity stimulus that caused a reaction was marked as the level of sensitivity. In this investigation, initially sensitive teeth were noted as vital from this time onward, regardless of the presence of a later reaction. The eventual change in the level of sensitivity was not analysed here. Teeth that did not react even at the highest level of electric stimulus were considered to be denervated.

Teeth were considered vital if they did not have any clear signs of avitality (e.g., colour change, pathologic mobility, percutory sensitivity, radiological periapical transparency, root resorption, or other clinical indicators and process symptoms). Teeth were selected for placement in the avital group due to clinical signs, not because of a negative electric test.

The sensitivity of all potentially endangered teeth was examined on admission (prior to therapy). We performed electric pulp testing on contralateral, corresponding, unaffected teeth for control purposes. The sensitivity of all initially non-responsive teeth was examined one and a half, three, four, six, and twelve months after jaw fracture treatment. The teeth for which sensitivity was not verified (even twelve months after therapy) underwent an additional two years of testing as long as they did not show clear clinical signs of avitality.

Results

We tested the sensitivity of a total of 459 teeth. Of these, 273 (59.5%) were affected anterior to the mandibular fracture between the mental and mandibular foramina and thus had potentially impaired innervation. Of the 459 teeth, 186 (40.5%)

were unaffected, contralateral, corresponding teeth for control purposes. A total of 222/273 (81.3%) of the affected and 23/186 of the unaffected, contralateral, corresponding teeth were initially non-responsive.

The number of reinnervated teeth increased with time. Six weeks after the injury, 19% were reinnervated. Roughly 85% of teeth were reinnervated after six months, and 92% of teeth were reinnervated one year after the injury. No reinnervation occurred later than one year following the injury (Table 1).

When we analysed the reinnervation of teeth in a determined time period, we noticed that most of the teeth were reinnervated in the one and a half- to three-month period after the injury (33.8%). Fewer teeth were reinnervated in the period from the seventh to the twelfth month after the injury (7.7%), whereas no teeth were reinnervated in the period from one to three years after the injury.

Because of the rather small number of samples for particular teeth, the results were analysed for groups of teeth. A year after injury, 95.2% of incisors, 91.1% of canines, 93.8% of premolars, and 81% of molars were reinnervated (Table 2).

Most medial incisors (30.9%) were reinnervated by one and a half months after injury or between one and a half and three months (30.9%). Only 7.1% of medial incisors were reinnervated between the seventh and twelfth months. Most lateral incisors (45.5%), canines (35.5%), second premolars (31%), first molars (33.3%), and second molars (36.4%) were reinnervated in the period between one and a half and three months. The same number of first premolars (25.7%) was reinnervated during the period from one and a half to three months and the period from the fifth to sixth month. Most wisdom teeth were reinnervated during the fifth and sixth months. None of the second molars were reinnervated until one and a half months after injury, but the same

number was reinnervated during the fifth and sixth months as well as from seven to twelve months (1/11).

Three years after the injury, 17 out of 222 teeth (7.6%) remained denervated. The most frequently denervated teeth were molars (18.5%), while the least frequently denervated teeth were the incisors (4.6%). Canines (4/45) and first premolars (3/35) were numerically the most frequently denervated teeth; as a percentage, however, third molars (28.6%) were the most frequently denervated teeth.

From one to three years after injury, 14/17 (82.4%) non-responsive teeth were denervated. This represents 6.3% of the initially non-responsive teeth (14/222). A total of 3/17 (17.6%) of denervated teeth were devitalised from one to three years after injury. Therefore, only three out of 222 (1.35%) of the initially non-responsive teeth remained devitalised three years after the injury. The teeth that were devitalised included one lateral incisor from the 44 initially denervated lateral incisors (2.3%), one canine from the 45 initially denervated canines (2.2%), and one wisdom tooth from the 35 initially denervated wisdom teeth (2.8%).

Discussion

In this investigation, the number of reinnervated teeth increased with time after the injury. One year after injury, 92.3% of teeth were reinnervated. Only Ferdousi¹¹ analysed vitality changes of teeth after mandibular fractures in addition to other changes after n. alveolaris inferior damage. In his investigation, all teeth responded in vitality tests six months after injury.

A question remains regarding which part of the tooth reacts to the stimulus. In 1967, Mumford²⁹ suggested that periodontal tissue reacts to the stimulus. Although the weakest electric stimulus can produce a periodontal tissue reaction and produce false information regarding tooth sensitivity and/or vitality, Närhi³⁰ concluded that the stimulus necessary for a periodontal tissue reaction is much higher and that the monopolar vitality-meter is safe when used with careful handling. Tooth innervation is much less important than vascularisation and the pulp integrity depends on the blood supply⁴⁶.

Although parasymphyseal fractures were excluded from this study, affected teeth with potentially impaired sensitivity are all from the fracture line between the mental and mandibular foramina to the midline of the mandible. Thus a question remains regarding crossover sensation from the contralateral side. The most interesting time periods regarding reinnervation were suggested by Machida²⁶ and Robinson³⁶. Machida²⁶ concluded that reinnervation starts four weeks after cutting of the nerve and that revascularisation starts five days after arteria alveolaris inferior binding. In cats, Robinson³⁶ found that pulp reinnervation starts 3–9 weeks after nervus alveolaris inferior cutting due to the ipsilateral mylohyoid, ipsilateral and contralateral lingual, and contralateral alveolar nerves that enter the pulp. Except for the ipsilateral lingual nerve, these do not normally innervate the pulp. Mucosal and skin re-innervation crossing the mid-line has not been demonstrated elsewhere¹⁸. If the original innervation is allowed to regenerate after such a collateral reinnervation has been formed, the collateral innervation is not withdrawn³⁷. When the injury is extended to mimic some aspects of reconstructive jaw surgery, the sources of reinnervation of tooth pulp are the recovering ipsilateral IAN, the contralateral IAN, and the mental and lingual nerves on both sides³⁸.

Robinson³⁹ also studied twenty-one adult patients with unilateral inferior alveolar or mental nerve lesions. They were divided into three groups on the basis of the type of nerve injury. Among other tests, he carried out tooth pulp sensation using a monopolar electric pulp tester. The vitality of all of the lower teeth on the side of the injury, which had not been crowned or root-filled, was recorded. When nerve compression occurred tooth pulp sensation appeared to return to normal by 1 day to 4 months post-injury. When nerve section occurred tooth pulp sensation was normal by 3, 6 and 11 months post-injury. Fifteen months post-injury one patient reported having had two restorations on the side of the injury, painlessly without local anaesthesia, despite the teeth responding normally to electric pulp testing. After nerve section and regeneration block (resected mandible and reconstructed defect), tooth pulp sensation returned in one patient in the ipsilateral incisors, canine and both premolars between 6 and 9 months post-injury. The results of pulp testing suggested the development of a collateral reinnervation of the teeth. _Robinson said that the false localisation of stimuli on the side of injury to a position near to the midline on the contralateral side would be consistent with the development of a collateral reinnervation across the midline. His previous researches demonstrated collateral reinnervation after IAN injuries in the cat, after tooth reimplantation and after segmental osteotomy. Trigeminal nerve fibres are able to sprout across the midline into the pulps of denervated contralateral teeth⁴⁰. It is initiated by a peripheral stimulus, probably a trophic factor in the denervated tissue³⁸. A similar pattern of recovery has been described after IAN injuries^{11,41}. Owen et al.³² suggested that nerve growth factor plays an important role in collateral reinnervation from high-threshold sensory nerves.

Studies of denervated or poorly innervated teeth have identified contributions of the nerve fibres to tooth repair⁶. The incidence of tooth necrosis increases after injury when nerve fibres are missing³. The location and the size of the injury⁷ and the rate of infection²⁰ determine the extent to which the injury of denervated teeth leads to irreversible pulpitis.

The greatest number of teeth remaining denervated after three years post fracture, in this investigation were canines (4/45), but percentage-wise wisdom teeth exhibited the highest frequency (2/7, 28.6%). The most frequently denervated group of teeth was the molars (18.5%). The reason for this may lie in the fact that these teeth have few roots therefore their potential for damage is higher. Because canines have longer roots, the canine area is at a higher risk for fracture and damage²³.

The situation is similar for devitalised teeth. One incisor, canine, and third molar became avital; however, when percentages are considered wisdom teeth (14.3 %) were the most frequent due to the small sample size in our investigation.

No teeth became reinnervated later than one year after the injury, and only 3 out of 222 initially non-responsive teeth (1.35 %) were devitalised during the one- to three-year period after the injury. Therefore, we can conclude that the pulp is vitally stable one year after the injury.

It is known from clinical experience that denervated teeth after segmental osteotomies regain their innervation and vascular supply¹⁰. This is supported by experimental micro-angiographic studies showing that, with few exceptions, the pulp does occur following experimental dentofacial surgery. Blood flow is present in the teeth at all times after posterior segmental osteotomy, but there is a risk of ischaemia²⁴.

Patients with mandibular fractures are a difficult population to study because of the non-elective nature of the fracture and the high incidence of accompanying injuries. The type of nerve injury varies greatly due to both fracture type and displacement. In most studies, these fractures are treated with miniplates, monocortical screws, and intermaxillary fixation³⁴. The incidence of IAN injury after mandibular fracture ranges from 46%³⁴ to 81%¹⁶ preoperatively, and 77%⁴² to 91%¹⁹ postoperatively; a 1 year follow-up shows an incidence of 0% to 45%¹⁹.

We can compare our results with those from recent investigations of sensitivity alterations after mandibular osteotomies and distraction osteogenesis². The incidence of IAN disturbances ranged from 10% to 94%, depending on the testing method used⁴⁴. The most pronounced nerve damage recovery occurred during the first 3 months⁴³, and the majority of patients declared their sensation to be "normal" 1 year after the operation⁴⁷. Recovery of neurosensory function of the IAN after a bilateral sagittal split osteotomy also varies from 2 months to 2.5 years, depending on the surgical technique, patient age, fixation method, and perioperative position of the nerve³¹. The highest rates of recovery after third molar surgery and iatrogenic injury to the IAN were observed during the 6 months after injury. The IAN cannot retract on transaction in a bony canal, and the canal wall may act as a conduit for sprouting axons¹⁷. Considering our results in relation to these investigations, it is obvious that the reinnervation of teeth and the recovery from IAN sensory disturbance starts between 6 weeks and 2 months after injury and can proceed for 2.5 to 3 years.

In conclusion, the current study clearly shows that denervation occurred in four fifths of the affected teeth and that 1 year after injury, 92.3% of the initially non-responsive, affected teeth were reinnervated. The pulp is vitally stable one year after the

injury, and denervated teeth should not be treated if neither clinical nor radiological signs of devitalisation are present.

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Table legend

Table I. Number of reinnervated affected initially non-responsive teeth in relation to the time period after the injury

| <i>Time (months)</i> | <i>No</i> | <i>%</i> |
|----------------------|-----------|----------|
| > 1.5 | 42 | 18.9 |
| > 3 | 117 | 52.7 |
| > 4 | 156 | 70.3 |
| > 6 | 188 | 84.7 |
| > 12 | 205 | 92.3 |
| > 36 | 205 | 92.3 |

TABLE II. Reinnervation of affected initially non-responsive teeth groups in determined time period.

| <i>Time (months)</i> | <i>Groups of teeth</i> | | | | | | | | | |
|----------------------|------------------------|-------------|---------------------|-------------|-----------------------|-------------|--------------------|-----------|--------------------|-------------|
| | <i>Incisors (86)</i> | | <i>Canines (45)</i> | | <i>Premolars (64)</i> | | <i>Molars (27)</i> | | <i>Total (222)</i> | |
| | <i>No</i> | <i>%</i> | <i>No</i> | <i>%</i> | <i>No</i> | <i>%</i> | <i>No</i> | <i>%</i> | <i>No</i> | <i>%</i> |
| > 1.5 | 21 | 24.4 | 10 | 22.2 | 8 | 12.5 | 3 | 11.1 | 42 | 18.9 |
| 1.5 - 3 | 33 | 38.4 | 16 | 35.5 | 18 | 28.1 | 8 | 29.6 | 75 | 33.8 |
| > 4 | 10 | 11.6 | 9 | 20.0 | 16 | 25.0 | 4 | 14.8 | 39 | 17.5 |
| 5 - 6 | 11 | 12.8 | 3 | 6.7 | 13 | 20.3 | 5 | 18.5 | 32 | 14.4 |
| 7 - 12 | 7 | 8.1 | 3 | 6.7 | 5 | 7.8 | 2 | 7.4 | 17 | 7.7 |
| 13 - 36 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 82 | 95.2 | 41 | 91.1 | 60 | 93.8 | 22 | 81 | 205 | 92.3 |