Bilateral Posterior Maxillary Natal Teeth with Associated Tongue Ulcers: A Rare Clinical Case

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ABSTRACT

Background: Natal teeth are teeth present at birth, while neonatal teeth erupt within the first 30 days of life. This premature eruption has been associated with factors such as the superficial position of the tooth germ, infection or malnutrition, febrile illness, hypovitaminosis, and genetic predisposition. Natal/neonatal teeth are mostly found in the anterior mandibular region. The occurrence of posterior natal teeth, particularly in the maxillary molar region, is extremely rare.

Case presentation: We report a rare case of a 6-week-old male child who presented on account of bilateral posterior maxillary teeth noticed at birth, associated with ulceration of the dorsal surface of the tongue and discomfort during breastfeeding. Examination revealed two white, tooth-like structures, one on each posterior maxillary ridge. The teeth were quite loose. There were painful ulcerations on the right and left borders of the dorsum of the tongue. Ulcers were oval, measuring about 0.5cm by 0.3cm in dimension with a yellowish floor and raised borders. An assessment of bilateral posterior maxillary natal teeth with associated tongue ulcerations was made.

Due to the degree of mobility of the natal teeth, with a possible risk of aspiration and the discomfort experienced by the mother when breastfeeding, the decision to extract the teeth was made. The teeth were extracted under topical anaesthesia, and there were no associated complications. At one-week postoperative review, the baby and mother were comfortable during breastfeeding, and there was good healing of the tongue lesions.

Conclusion: This case report presented a rare condition of bilateral posterior maxillary natal teeth in an infant, with associated tongue ulceration, discomfort during breastfeeding, and possible aspiration risk of the mobile teeth. These challenges are crucial in managing the condition, and patient follow-up is essential in preventing potential malocclusion.

Key Words: Natal teeth, Neonatal teeth, Tongue ulcers, Posterior maxillary teeth

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INTRODUCTION

Natal teeth are defined as teeth present in the oral cavity at birth, while neonatal teeth erupt within the first 30 days of life.[1] Other terminologies have also been used in the past, such as congenital teeth, fetal teeth, pre-deciduous teeth, and praecox dentition (or dentitia praecox).[2] Natal teeth have been reported to be more common than neonatal teeth, with a ratio of 3:1.[3] These phenomena are rare, with an estimated incidence of 1 in every 2,000 to 3,000 live births.[2] In most cases, over 85% of natal teeth are in the mandibular anterior region, especially the central incisors, the maxillary anterior region (11%), and the posterior region (4%). Posterior natal teeth are reported to be more common in the mandible compared to the maxilla.[3]

The majority (over 90%) of natal teeth and neonatal teeth are primary teeth of normal dentition, while 1-10% are supernumerary teeth.[3,4] The prevalence of natal and neonatal teeth in male and female infants remains a subject of debate. While some systematic reviews suggest no significant differences between the sexes, other studies have indicated that females exhibit a higher occurrence of natal teeth with a ratio of 2:1.[3-6]

The aetiology of natal and neonatal teeth has been inconclusive;[7] however, the condition has been linked to some factors, including superficial position of the tooth germ, infection or malnutrition, febrile illness, hypovitaminosis, as well as genetic predisposition[7-9]. A positive family history has been reported in 8-62% of cases, and the mode of inheritance is suggestive to be autosomal dominant gene[4,10].

Another aetiologic factor that has been implicated is the environmental exposure of pregnant women to some highly unstable chemical substances like polychlorinated biphenyls (PCBs), polychlorinated dibenzo-p-dioxins (PCDDs) and polychlorinated dibenzofurans (PCDFs). These chemicals have been found to cross the placenta and are found in breast milk and adipose tissues of newborns.[3,7,11]

Natal and neonatal teeth have been associated with developmental abnormalities and syndromes such as histiocytosis X, cleft lip and palate, Pfeiffer syndrome, ectodermal dysplasia, Ellis-van Creveld, Hallerman-Streiff, and Sotos syndrome.[3-6]

There are several features on presentation which influence the treatment choice: the degree of mobility, interference with breastfeeding, presence of traumatic injury to the nipples and tongue (ulceration of the ventral surface of the tongue, known as Riga-Fede disease), pain, bleeding, and the possibility of aspiration of the teeth.[4,6,7,9]

Various cultural beliefs are linked to the presence of natal or neonatal teeth. However, there are notable gaps in understanding and misconceptions among mothers, nurses, and traditional birth attendants, which often promote stigma, fear, and harmful practices instead of supporting factual information.[12,13] Due to its clinical rarity, we present a case of bilateral posterior maxillary natal teeth with associated tongue ulcers in a Nigerian child.

Case Presentation

A 6-week-old male infant presented to the Peadiatric Dental clinic with bilateral maxillary posterior teeth noticed at birth. Patient's mother reported the presence of tongue ulcerations, which she had noticed about 2 weeks after birth. She complained of difficulty and discomfort during breastfeeding.

The patient was delivered vaginally at 38 weeks of gestation with a birth weight of 3.2 kg. The pregnancy was mostly uneventful. Although the mother reported a febrile illness during the first trimester, for which she took unspecified medications, no prenatal complications or genetic abnormalities were noted. The parents reported no family history of natal or neonatal teeth.

At birth, some tooth-like structures were noticed bilaterally in the posterior maxillary region.

Intraoral examination revealed two upright, white, tooth-like structures on the left and right maxillary posterior ridges in the region of teeth 55 and 65, with associated grade 3 mobility. Bilateral ulcerations were noticed on the left and right lateral surfaces of the dorsum of the tongue, measuring approximately 0.5cm by 0.3cm on each side. The ulcers were oval with irregular margins, yellowish-white fibrinous bases, and erythematous borders. No other oral anomalies were noted.

Intraoral radiographs were not obtained because the infant could not tolerate the procedure. Due to the possible risk of aspiration of these highly mobile teeth and the associated traumatic tongue ulceration and discomfort during breastfeeding, a decision was made to extract the teeth.

The mother was counselled that the prematurely erupted natal teeth may be part of the primary dentition series, potentially leaving a gap until the eruption of the permanent successors. Verbal consent was obtained from the patient's mother.

Both natal teeth were extracted under topical anaesthesia. The sockets were curetted to ensure

removal of odontogenic cellular remnants, hence preventing development and eruption of residual tooth-like structures from the extraction site. Minimal bleeding occurred, which was controlled by digital pressure. The infant tolerated the procedure well and resumed breastfeeding soon after.

At one-week post-extraction review, the extraction sites and tongue ulcers were fully healed and no feeding issues were reported.

At 6 months follow-up, the baby appeared healthy and had erupted his lower central incisors (71, 81), which the mother reported to have erupted at 4 months of age.

Fig 1. Preoperative clinical picture showing the posterior maxillary natal teeth.

Fig 2. Clinical picture showing tongue ulcerations

Fig 3. Post extraction clinical picture

Fig 4. Extracted Natal teeth

Fig 5. Six months review visit showing erupted lower central incisors

DISCUSSION

Natal and neonatal teeth are rare dental anomalies, and their presence in the posterior maxillary region, as seen in this case, is extremely uncommon. Most natal teeth are found in the mandibular anterior region, particularly the central incisors, accounting for over 85% of cases.[11] The presence of bilateral posterior maxillary natal teeth in a neonate without syndromic features is clinically significant and contributes valuable insight to the limited literature.

Aetiology and Clinical Presentation

The exact aetiology of natal and neonatal teeth remains unclear, though several factors have been implicated including superficial positioning of tooth germs, genetic predisposition, nutritional deficiencies, febrile illnesses, and endocrine disturbances.[7,8] In our case, the mother experienced a febrile illness during the first trimester of pregnancy, which is one of the etiologic factors that have been implicated in this condition. This is because febrile illnesses during pregnancy are thought to induce metabolic disturbances that can accelerate eruption process. The absence of family history in this case suggests that sporadic factors rather than hereditary transmission may have played a role.

The bilateral presentation of posterior maxillary natal teeth is particularly rare. While most reported cases involve unilateral or bilateral mandibular anterior teeth, few cases of maxillary posterior natal teeth have been documented. There have been reports of posterior natal teeth presenting as either unilateral[14-16] or bilateral [6,15,17]. Our study reports a case of bilateral posterior natal teeth in the maxilla, similar to these studies. The bilateral symmetry observed in our case further adds to the uniqueness of this presentation.

There is conflicting evidence regarding sex predilection in natal and neonatal teeth. In a retrospective study of 15 cases, there was no significant gender predilection amongst the cases studied. However, some studies have reported a female predilection in natal and neonatal teeth[17-20]. In our case, the affected infant was male, which is consistent with some other reports.[9,14,16]

Studies have reported that 90% of natal/neonatal teeth are part of the normal primary dentition, while about 10% are supernumerary teeth.[3,4] Differentiation typically relies on radiographic examination, though this may not always be feasible in young infants. In our case, a periapical radiograph could not be taken due to the infant's inability to cooperate with the radiographic procedure and the urgency of intervention required for the painful bilateral tongue ulcerations. It could not be ascertained whether the teeth were primary or supernumerary.

The complications associated with natal teeth in our case included traumatic ulceration of the tongue, feeding difficulties, and risk of aspiration. The grade 3 mobility of both teeth posed a significant aspiration hazard, which was a primary indication for extraction. The traumatic tongue ulcerations resulted from repeated trauma to the dorsal surface of the tongue against the sharp edges of the natal teeth during feeding and tongue movement. These ulcerations caused discomfort to the infant and interfered with effective breastfeeding.

Management of natal/neonatal teeth is influenced by several factors, including their mobility, potential to cause trauma to the child and mother, interference with feeding and parental/societal negative beliefs, which have also been reported to influence management of natal/neonatal teeth.[3,4,14,20,21] The treatment of choice ranges from leaving alone with close monitoring, smoothening and rounding off sharp edges of the tooth or extraction.[3,4,6,9,14,16] Furthermore, Iandolo et al[22] stated that ameloplasty and additive restoration with adhesive materials can be done on the natal or neonatal teeth when the teeth are associated with Riga-Fede disease to prevent further injury and encourage soft tissue healing.

In this case report, the treatment of choice was extraction, the decision was largely influenced by the degree of mobility (grade 3) of the natal teeth and the presence of tongue ulcerations.

The extraction was performed under topical anaesthesia with minimal bleeding controlled by digital pressure. The procedure was well tolerated, and immediate resumption of breastfeeding was possible. Complete healing of both the extraction sites and tongue ulcers was achieved within one week, with resolution of feeding difficulties. Close monitoring after extraction is essential because if the natal teeth are of the normal primary dentition, it would result in the premature loss of posterior primary teeth, leading to loss of space with the possibility of developing a malocclusion in the permanent dentition.[3-6]

The issue of cultural beliefs in relation to natal teeth, as reported by Bankole et al. [13] and Ogbeide[21,] had no influence on the treatment choice in this child because the parents were unaware of any

superstitious belief associated with this condition. It is important to note that the parents sought professional care for this condition rather than resorting to traditional practices. The fact that the teeth were left in place for 6 weeks before seeking treatment suggests that the natal teeth had minimal psychosocial impact on the family's wellbeing. They were further reassured and counselled on the need for follow-up review visits to monitor growth and development of the dentition.

CONCLUSION

Bilateral posterior maxillary natal teeth represent an extremely rare clinical presentation. They can present with several clinical challenges, ranging from trauma to the tongue, pain and discomfort during breastfeeding, as well as the risk of possible aspiration when they are mobile.

These clinical presentations are crucial in managing this condition, and optimal patient follow-up by a paediatric dentist is essential in preventing potential malocclusion.

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Conflict of interest

None declared

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