Iatrogenic damage in restorative tooth preparation and management

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INTRODUCTION
Iatrogenic damage in restorative teeth preparation and management constitute a significant issue that dentists and surgeons might face during and after restoration procedures. Moreover, previous studies have demonstrated that adjacent damage is inevitable during class II and conventional full-crown preparations.1-3 Previous investigations have reported that the risk of

ABSTRACT
Iatrogenic damage in restorative teeth preparation and management constitute a significant issue that dentists and surgeons might face during and after restoration procedures. Many presentations can be observed for the injured enamel following iatrogenic damage as the presence of fine scratches, 1 mm wide vertical grooves, extensive damage and indentations. Following the occurrence of such complications, subsequent changes to the properties of the affected areas can significantly increase the risk of developing dental caries. It is essential to shedding more light on such phenomena to increase awareness among dentists and physicians and to enhance the potential outcomes. Accordingly, in this literature review, the aim was to discuss the iatrogenic damage in restorative teeth preparation and management as per evidence from the current studies in the literature. At first, the discussion was around the different types of iatrogenic injuries based on the affected regions and the incidence of adjacent teeth injury during restoration was high. Moreover, it had been discussed the potential mechanisms and contributing factors that might flare up the injury and increase the risk of significant damage induction. Hypersensitivity and using rough materials are two common factors that may induce inflammation and induce damage. Further investigations might be needed for the implication of safe practices for surgeons and dentists to enhance the outcomes.

Keywords: Iatrogenic, Damage, Dentistry, Restoration

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adjacent dental injuries is hugely variable and can range between 49-97% among previous in vivo and in vitro investigations. Many presentations can be observed for the injured enamel following iatrogenic damage as the presence of fine scratches, 1 mm wide vertical grooves, extensive damage and indentations. Following the occurrence of such complications, subsequent changes to the properties of the affected areas can significantly increase the risk of developing dental caries. Besides, it was also reported that removal of the outer parts of the affected enamels and their potential exposure can also significantly be associated with more frequent solubility of water-soluble and acid-like substances that can also lead to the development of further complications.

Moreover, it has been reported that many factors can contribute to the potential iatrogenic damage during restoration. However, it appears that the factors are mainly related to the performing surgeons and their experience in performing successful procedures. Therefore, it was essential to shedding more light on such phenomena to increase awareness among dentists and physicians and enhance the potential outcomes. Accordingly, in this literature review, the aim was to discuss the iatrogenic damage in restorative teeth preparation and management as per evidence from the current studies in the literature.

**METHODS**

This literature review was based on an extensive literature search in Medline, Cochrane and Embase databases on 15 May 2021 by using the medical subject headings (MeSH) or a combination of all possible related terms. This was followed by the manual search for papers in Google Scholar and the reference lists are included at the end of this paper. Papers are around the discussion of the iatrogenic damage in restorative teeth that were screened for relevant information. There were no limits on date, language, age of participants or publication type.

**DISCUSSION**

**Incidence of iatrogenic damage**

**Adjacent teeth**

Many previous investigations have reported on the iatrogenic damage in restorative tooth preparation and management procedures. An old investigation by Moopnar et al previously reported the incidence of adjacent tooth damage during crown-prepared abutments to be 73.8% among a total of 652 in vivo tooth surfaces that were observed and examined in the study period, which was early strong evidence about the potential damage that can happen to these teeth during these preparations. Following this investigation, another one was published by Long et al in 1988 and included 45 extracted teeth from crown-related and MOD cavity-related preparations to find that all of these teeth were significantly damaged following the procedure. Moreover, the observed damage that was done to these teeth was classified into three categories including score lines, abrasions and nicks. Based on the findings of this investigation, the authors concluded that it is recommended that dentists and surgeons should care for proximal teeth during restorative preparations and management procedures. In a more recent investigation by Meideros et al the authors reported that among the teeth of 26 that were retrospectively included in their study, up to 60% of them showed significant degrees of iatrogenic damage to the underlying and adjacent teeth when performing class II restoration procedures. Another investigation by Lussi et al also reported that conventional instruments were used for class II preparations in 134 procedures to find that all of the examined teeth within the intervention group were subjected to deep damage which was also noticed to be less severe and less frequent than other control groups. In 1992, Qvist et al also reported that the incidence of iatrogenic tooth damage following class II preparation procedures in 190 proximal teeth was 64% and 69% for the observed primary and permanent teeth, respectively. Moreover, the authors reported that such iatrogenic damage can significantly increase the risk of requiring future procedures for these teeth by 3.5 and 2.5 folds for primary and permanent teeth more than the non-damaged ones. During class V composite restorations, the damage was also reported to be significant for the adjacent teeth.

**Pulp**

Many studies have previously reported that pulp damage is a potentiality that might occur as a result of many reasons during or after management and preparation of teeth-related preparation procedures. Complete crown preparation has been previously reported to significantly contribute to the damage of the pulp. Following teeth preparation by multiple years, previous studies have also demonstrated that pulp degeneration is a potential event. Accordingly, dentists and surgeons should care for such events by adequate considerations during such procedures. Reducing the risk can be done by rather using suitable materials and techniques that have been reported to pose less potentiality to cause damage over other modalities. Moreover, considering the morphology of the pulp can also decrease the risk of inducing damage to the pulp, as it has been previously reported that old aging is associated with reduced sizes of the pulp chambers. Insertion within the sublingual boundaries can significantly increase the risk of inducing damage because of the difficult management of such regions.

**Soft tissues**

The term biologic width refers to an important regional market for dentists and surgeons to consider to help them avoid the development of dental damage and induction of complications and adverse events. However, the
definition and width of this region are still controversial among studies in the literature. For instance, a previous investigation by Gargiulo et al previously reported that the biological width is equal to 2.04 mm.25 A previous investigation by Vacek et al also reported that the average biological width for their population was similar to that reported by the previous study.26 Nevertheless, they also reported that some of the patients had different measurements. Therefore, dentists should consider such phenomena when dealing with their patients. Additionally, previous studies have also demonstrated that the biological width can be hugely variable depending on the morphology of the patient, as it has been observed that the estimated width can range from 0.75–4.3 mm.27,28 Bone loss and inflammation can be significantly observed if the performing surgeon violated the biologic width and the restorative margin has been mistakenly placed within the area of the attachment when the restoration is aimed (Figure 1). Soft tissue damage can also be present and can lead to unpleasant events for the patient. Cheeks and tongue can both be affected during restoration. While preparing for the labial and buccal surfaces, damage to the lips and cheeks can be associated. In addition, when preparing the mandibular molars and lingual surfaces are approached, damage to the tongue can be significantly observed. Careful retraction, aspirator tip, ejection of the flanged saliva and using a mouth mirror can all aid in the risk reduction of tongue damage during restoration procedures. Carefully approaching the preparation of the mandibular molars is recommended to avoid the development of complications and not to represent any damage on the tongue of the patient.29

![Image](93x243 to 242x378)

Figure 1: Bone loss and inflammation secondary to violation of the biological width.29

Mechanism and contributing events

Many contributing factors have been previously reported among studies in the literature to contribute to the development of iatrogenic damage and impact the prognosis. Tooth hypersensitivity to the applied dental materials has been previously reported to occur secondary to the application and use of cheap dental alloys when performing restoration procedures.30 Previous studies have also expressed that nickel, which is used in alloys, is the main substance that contributes to the underlying inflammation. However, the frequency of inflammation following the use of nickel is still controversial among studies in the literature.31 On the other hand, using precious alloys has been reported to be associated with fewer complications secondary to the development of potential hypersensitivity. Furthermore, it has also been reported that the roughness of the used material is a more significant contributor to the development of a hypersensitivity reaction more than the material of the applied alloy.32 Gingival inflammation and plaque formation can be significantly associated with the application of rough alloys. Therefore, it can contribute to the development of related complications.32 Accordingly, subgingival roughness of the surfaces should be avoided to obtain better outcomes, as evidence also shows that gold and resin were also associated with similar rates of plaque formation and similar frequencies of complications. During restoration, inadequate cleaning of any underlying debris can lead to the development of negative periodontal responses.32 Many sources have been found as major contributors to the underlying debris as impression materials, retraction cord, permanent or temporary cement and provisional materials. Adequate examination and diagnosis of the secondary underlying inflammation are essential with rapid removal of any detected foreign bodies to avoid the development of further adverse events. Besides, anesthesia should be considered when patients are not comfortable during the procedure and tissue response should be adequately monitored to ensure that the enhanced outcomes have been achieved. Preservation of the safety of the periodontium has also been previously correlated with the applied crown contour for the restorative procedures.33 The proper use of efficacious contours can significantly lead to enhanced outcomes, such as enhancing the gingival form, maintaining adequate hygiene, and providing adequate visual on the tooth in the anesthetized areas. Previous in vivo and in vitro investigations have indicated that over contouring is significantly associated with the development of inflammation and teeth damage during restoration while it has also been reported that under contouring is not associated with such adverse events.34 Inadequate tooth restoration has been reported to be the most common factor that can significantly lead to over contouring as a result of the bulk formation to provide enough room for the restoration material. It has also been previously recommended that using flatter contours should be used when anesthetic decisions are not critical. Many other factors have also been reported to be associated with the development of iatrogenic damage as factors related to applying a rubber dam, placing the matrix, cavity preparation, marginal fit and provisional restoration.30,35-37

Subsequent events to the iatrogenic damage

As it is widely known that tooth restoration can be associated with significant damage to the teeth where the procedures were performed and with the significant
increase in the accumulation of caries. Many concerns have been aroused that such events might further add to the damage of the adjacent teeth and contribute to the development of significant damage to them. In a long-term follow-up prospective investigation for four years, Vanderas et al reported that the presence of interproximal caries primary second molars and the permanent first molars was significantly associated with an elevated risk of increased mesial caries lesions on the latter teeth, being adjacent to the primary second molars that underwent restorative procedures. A previous investigation by Xue et al. also previously reported that the natural presence of dental enamels on the surface of the teeth at risk can significantly act as a protection against the development of caries and other related adverse events. Moreover, the authors also reported that in vitro demineralization of the teeth can significantly be correlated with the features of the naturally developed white spot lesions.

CONCLUSION

We have discussed the iatrogenic damage during and after restorative tooth preparation and management procedures. At first, it has been discussed the different types of iatrogenic injuries based on the affected regions and the incidence of adjacent teeth injury during restoration is high. Moreover, we have discussed the potential mechanisms and contributing factors that might flare up the injury and increase the risk of significant damage induction. Hypersensitivity and using rough materials are the two most common factors that may induce inflammation and induce damage. Further investigations might be needed for the implication of safe practices for surgeons and dentists to enhance the outcomes.

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REFERENCES
