In the last year, I have diagnosed and am in the process of treating 3 patients who exhibited idiopathic external resorption of mandibular cuspids. For two of the patients it involved both lower cuspids and for one patient it involved a single cuspid.

Prior to the symptoms and diagnosis, these teeth remained healthy well into their middle-aged years.

In one case, orthodontics had been done as a child but that was 50 years prior. In the other two cases, there was no evidence of trauma, orthodontics or any other etiology that could explain the extreme resorption noted.

In all cases, the teeth have been ultimately extracted.

**Case #1:**
A dentist’s wife, with a history of orthodontics as a teenager and has been maintained for 35 years, presented with a pink spot on the facial of the lower cuspid. When examining it, we discovered the enamel was easily penetrated and a resumptive lesion was observed radiographically.

The lesion was asymptomatic but ultimately removed and grafted for a future implant site.

Please note x-ray taken previously on 8/20/2001 and then x-ray taken subsequently on 5/17/2012.

I have also included a preop photo taken on 5/23/2012 and intraoperative photo taken on 8/23/2012.

**Case #2:**
For this case, treatment had been attempted at a local dental school where the tissue was surgically elevated and amalgam restorations were placed lingually.
Unfortunately, the resorptive lesions continued and the teeth were recently removed and the sites subsequently grafted.

Photo taken 9/10/12

Photo taken 9/10/12

X-Ray 26-27 taken 6/21/12

X-Ray 22-23 taken 6/21/12

Case #3:
This case involves a 65-year-old neurosurgeon who suddenly developed discomfort. Radiographs revealed resorption bilaterally and the teeth are in the process of being removed and ultimately restored.

X-Ray Tooth #22 taken 10/27/2011

X-Ray Teeth #26-28 taken 11/17/2011
In all of the cases, removal of the teeth was extremely difficult because of ankylosis occurring either along the entire length of the root or in the areas of the resorptive lesion.

The teeth had to be sectioned, and in many cases, removed assiduously in order to carefully preserve as much of the buccal-lingual plate as possible to allow for replacement with an implant. In some cases, the root segments had to actually be drilled out.

The etiology of this resorptive, as I mentioned, is unknown. People have spoken of trauma as a predisposing factor. There seems to be a number of cases associated with orthodontic treatment at an earlier point in life. In these cases, only one of the three patients had that in their history.

This external resorption is associated with a localized ankylosis of the tooth where the periodontal ligament has been invaded by bone. Osteoclasts confuse the tooth with bone and resorb the cementum and dentine. Occasionally, the bone will actually invade the resorbed portion of the tooth. These teeth will often present with symptoms pulpally but in one of the cases, it was picked up completely asymptomatically.

Attempts to treat with restorations have been, to date, unsuccessful since the resorptive process continues despite restorations at the point of resorption. In addition, trying to treat these areas by removing the resorptive lesion and restoring it is fraught with difficulty because access is very difficult. Bone must be removed and restorations often become nonphysiological due to their placements so far below the crest of the adjacent teeth.

Unfortunately, removal of these teeth becomes the only alternative with all of the difficulties aforementioned.