



Management of Third Molar Teeth

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The American Association of Oral and Maxillofacial Surgeons believes the best approach to any clinical dilemma is to employ “evidence based practice.” This process merges the best available clinically relevant evidence with the results of a comprehensive and focused clinical and imaging examination to formulate recommendations that can be discussed with the individual patient.

A common clinical dilemma faced by patients today is what to do about their third molars. Areas of concern include determining when surgical management is indicated (particularly in the case of “asymptomatic” teeth), the risks associated with either removal or retention of third molars, the optimal timing for treatment, the cost of treatment as well as the cost of retention, and how to best develop a plan for follow-up when a decision is made to retain a third molar.

There are a variety of recognized management choices for third molars, including removal, partial removal (coronectomy), retention with active clinical and radiographic surveillance, surgical exposure, tooth repositioning, transplantation, surgical periodontics, and marsupialization of associated soft tissue pathology with observation and possible secondary treatment.

When considering possible management choices, the clinician should also consider the likelihood that disease will develop. Further, since evidence clearly indicates that

surgery is more difficult as patients age; therefore given the desire to achieve therapeutic goals, obtain positive outcomes, and avoid known risks and complications, a decision should be made before the middle of the patient’s third decade to remove or continue to observe third molars, with the knowledge that future treatment may be necessary based on the clinical situation. Finally, the AAOMS also recognizes the oral and maxillofacial surgeon as the clinician qualified to determine a surgical treatment plan and care for the individual patient.

AAOMS Position Statement on Third Molar Management

As a means of helping to clarify what is known with respect to third molar management, the AAOMS offers the following position statement:

Predicated on the best evidence-based data, third molar teeth that are associated with disease, or are at high risk of developing disease, should be surgically managed. In the absence of disease or significant risk of disease, active clinical and radiographic surveillance is indicated.

This statement clearly recognizes that while not all third molars require surgical management, given the documented high incidence of problems associated with third molars over time, all patients should be evaluated by someone experienced and expert in third molar management.

Approach to the Patient with Third Molars

The approach to third molar management begins with a thorough medical and dental history, with attention paid to any symptoms that may be associated with the patient's wisdom teeth. The clinician should ascertain whether symptoms are present and if so, whether they are related to the patient's third molars or another source. Physical examinations should include the eruption status and position of the tooth in the jaws/oral cavity, functionality, and periodontal and caries status. Imaging allows determination of the presence or absence of the tooth, presence or absence of disease, anatomy of the tooth and its root system, as well as the tooth's relationship to important structures such as the inferior alveolar nerve, adjacent second molar, maxillary sinus, etc. In addition, imaging can detect significant associated and non-associated disease, such as cysts or tumors.

Where there is evidence of disease, management is generally straightforward. When tissue associated with a third molar is suspected to be pathologic in nature, it should be submitted for histologic examination. When symptoms are present, it is important to identify the source with subsequent management focused on removal or control of the etiology.

Uncertainty is more explicit in the case of patients who have asymptomatic disease-free third molars. Given that we cannot confidently predict what the future holds for all patients with asymptomatic, disease-free teeth, we must rely on the clinician's experience and expertise in recognizing the likelihood that pathology will develop and his or her ability to communicate this in realistic terms to the patient.

White Paper



In the absence of evidence regarding current associated symptoms or disease to support surgical management, the surgeon should review the likelihood of pathology developing in the future, functionality, risks of removal, risks of retention, and protocol for active surveillance. Removal should be favored when the third molar is currently or likely to be non-functional, there is an overlying removable prosthesis, orthodontic removal is justified (such as when the tooth is preventing the eruption of the second molar) and in the case of planned orthognathic surgery. Patients should also be informed of the greater difficulty and increased rate of complications associated with third molar removal as they age. When appropriate, patients should be advised that if they retain their disease-free wisdom teeth, it is possible they could live their entire lives without problems.

The AAOMS offers the above recommendations based on the best available clinically relevant literature and is committed to a process of constant re-evaluation of new information.

For relevant sources and resource material, please see [Supporting Information to the Management of Patients with Third Molar Teeth](#) available on [aaoms.org](#).

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