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Parent Instructions: Managing Congenitally Missing Maxillary Lateral Incisors in Your Child

Introduction:

This handout is designed to guide you as parents through the journey of treating your child's congenitally missing maxillary lateral incisors (#7 and #10) from initial diagnosis to final dental implant placement. Congenitally missing teeth occur when permanent teeth fail to develop, affecting about 1-2% of children, and the maxillary lateral incisors are commonly involved. The goal is to maintain space, esthetics, and function while your child grows, ultimately replacing the missing teeth with implants once skeletal maturity is reached. This process involves a team of specialists: restorative dentist, orthodontist, and oral surgeon. Treatment can span 10+ years, requiring patience and compliance. We'll cover key ages, treatments, and care instructions to help you support your child.

Regular communication with the dental team is essential. Educate your child about the process in age-appropriate ways, and monitor for any self-esteem issues related to appearance—psychological support might be beneficial if gaps affect confidence.

1. Proper Age for Initial Diagnosis:

The ideal time to diagnose congenitally missing maxillary lateral incisors is during the early mixed dentition phase, typically between ages 7 and 9 years. This is when primary (baby) lateral incisors naturally exfoliate (fall out), and permanent ones are expected to erupt around age 8-9. If there's no sign of eruption or



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if primary teeth are retained longer than usual, schedule a dental visit promptly.

- **What to Expect:** Your pediatric dentist will perform a clinical exam and take radiographs (e.g., panoramic X-ray) to confirm the absence of the teeth and assess adjacent tooth development.
- **Parent Actions:** Bring your child for routine dental check-ups starting at age 7. Report any delayed tooth loss or gaps to the dentist immediately. Early diagnosis allows better planning and more treatment options, preventing complications like space closure or shifting teeth.

2. Proper Age for Initial Orthodontic Treatment:

Orthodontic intervention typically begins around ages 7-10 for initial planning and space management, with comprehensive treatment (e.g., braces) starting between ages 10 and 13, often aligning with the pubertal growth spurt. The focus is on creating or maintaining adequate space (6-7 mm per side) for future implants while monitoring eruption of nearby teeth like canines.

- **What to Expect:** If canines erupt into the lateral spaces, orthodontics may distalize (move) them. Treatment lasts 18-24 months. Space maintainers (e.g., lingual arch) may be used if full orthodontics is delayed.
- **Parent Actions:** Ensure your child attends orthodontic appointments. Supervise oral hygiene around braces to prevent decay. Encourage compliance with elastics or retainers—non-compliance can lead to space loss. Discuss esthetic concerns; temporary pontics (fake teeth) on braces can help during treatment.



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3. Usual Gap in Time from Final Orthodontics to Implants (Male vs. Female):

Orthodontic treatment usually completes by ages 13-15. However, dental implants cannot be placed until skeletal growth is complete to avoid complications like implant misalignment or bone changes. This creates a gap of several years for interim management.

- Males: Growth typically ceases around ages 18-21, leading to a 5-8 year gap from ortho completion.
- Females: Growth often ends earlier, around ages 16-18, resulting in a 3-5 year gap.
- What to Expect: During this period, retainers or provisional restorations maintain space and esthetics.
- Parent Actions: Track your child's growth (e.g., height, secondary sexual characteristics like facial hair in boys). Inform the team of rapid changes. Maintain regular check-ups to adjust retainers as needed.

4. Need for Maryland Bridge Retainers to Prevent Root Movement, with Precautions:

After orthodontics, a Maryland bridge (a fixed resin-bonded prosthesis) is often used as an interim restoration to prevent root movement of adjacent teeth, space collapse, or supraeruption of opposing teeth. It's preferred for adolescents (age 12+) due to its conservative nature—no extensive tooth preparation required. The bridge uses wings bonded to the backs of central incisors and canines, with pontics (fake teeth) filling the gaps.



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- Precautions: Avoid sticky or hard foods that could debond the bridge. Floss under pontics daily using floss threaders. Watch for wear or loosening—report immediately to avoid tooth shifting.
- Parent Actions: Supervise hygiene; schedule replacements every 1-2 years as growth alters fit. Monitor for gum irritation or decay around bonded areas. This bridge is temporary; it's removed before implants.

5. Determination of Final Growth with Comparative Cephalometrics (Male vs. Female):

Skeletal maturity must be confirmed before implant placement to ensure stability. This is assessed using comparative cephalometric radiographs (side-view X-rays of the head), taken serially every 6-12 months starting around age 14. Superimposition of images checks for stability in cranial base and jaw length. Other methods include hand-wrist X-rays (Fishman indicators) and cervical vertebral maturation (CVM stages 5-6).

- Male vs. Female Differences: Males mature later (full epiphyseal plate fusion around 18-21), while females reach maturity earlier (16-18). Cephalometrics show mandibular growth correlating with vertebral changes, with males exhibiting stronger correlations in some studies.
- Parent Actions: Attend monitoring appointments. If growth is delayed, a bone age assessment by an endocrinologist may be needed. Avoid habits like thumb-sucking that could affect jaw development.



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6. Need for Possible Bone Grafts Before or During Implant Placement:

Congenitally missing laterals often result in deficient alveolar bone width or height, requiring bone grafts in many cases to provide a stable foundation for implants. Grafts may use autogenous bone (from your child's jaw, e.g., ramus) or synthetic materials. This is evaluated via CBCT scans annually during monitoring.

- **Timing:** Grafts are typically done 3-6 months before implant surgery or simultaneously if minor.
- **Parent Actions:** Encourage a diet rich in calcium and vitamin D for bone health. Discuss risks (e.g., swelling, infection) with the surgeon. Post-graft care includes soft foods and antibiotics if prescribed.

7. Need for Provisionals During Implant Integration:

After implant placement (once growth is complete), osseointegration (bone fusing to implant) takes 3-6 months. During this time, provisional (temporary) restorations are essential for esthetics, function, and soft tissue shaping, especially in the esthetic anterior zone. These may be immediate (placed same day) if stability allows, or transitional implants for adolescents.

- **What to Expect:** Provisionals could be bonded bridges or implant-supported temporaries. Avoid loading them heavily.
- **Parent Actions:** Ensure a soft diet post-surgery. Clean gently around provisionals. Report any looseness or discomfort. Transition care responsibility to your child as they mature.



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8. Need to Monitor Implants for Hygiene, Occlusion, etc., Indefinitely:

Dental implants have a high success rate (>95%), but require lifelong monitoring to prevent complications like peri-implantitis (inflammation around the implant). Annual visits include checking hygiene, occlusion (bite), bone levels via radiographs, and esthetics.

- Key Areas: Brush/floss daily; use interdental brushes for implants. Monitor for gum bleeding or bite changes. Professional cleanings every 6 months.
- Parent Actions: Initially supervise hygiene; teach your child proper techniques. Attend all follow-ups. Provide a nightguard if grinding occurs. Report issues like pain or mobility immediately—early intervention ensures longevity.

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