

Rostrally Displaced Maxillary Canine Teeth – Lance Effect

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Figure 1 showing a normal relationship of upper and lower canine teeth with the upper behind the lower with the mouth closed

Rostrally displaced maxillary canine teeth are a common occurrence in Sheltie dogs. It occurs in other breeds as well but the general principles of recognition, evaluation and treatment are the same. The upper canine tooth erupts in an abnormal direction and is pointing forward like a lance of a medieval knight who would be jousting. Figure 1 demonstrates normal positioning of the canine teeth. In the event of abnormal eruption and the malpositioning of the tooth, there are specific considerations such as gingival quality and attachment, crowding with the incisors, and trauma to and from other teeth that must be taken into account to determine the best course of action. There are occasional

instances where treatment is not needed, but this should only be determined after dental radiographs are taken in conjunction with a tooth-by-tooth examination and bite evaluation. The main focus should be a functional mouth that is free of pain and infection. We are essentially trying to make the best of a bad situation.

It is important to evaluate the mouth before intubation and get an idea of the relationship between upper and lower

teeth and how they fit together. I take closed-mouth pictures from many different angles for a more thorough evaluation. In Figure 2, we can see the upper canine tooth is in front (rostral) of the lower canine tooth with the mouth closed. The lower canine tooth is deviated toward the side (labioversion). This is functional and not causing any negative tooth-on-tooth contact. The problem, however, is the reduced amount of gingiva on the mesial (front) aspect of the upper canine tooth and the large amount of hair and debris that collects here (arrow). With homecare to keep the area free of plaque and debris, it is possible to manage this area as long as there is gingival attachment around the tooth. If there is no attachment of gingiva, the tooth would need to be surgically removed with successful closure to prevent a hole from forming into the nasal passage (oronasal fistula). Figures 3 and 4 show a more involved case but we were still



Figure 2 showing lance canine tooth with reduced gingiva in front of the tooth and also debris gathering

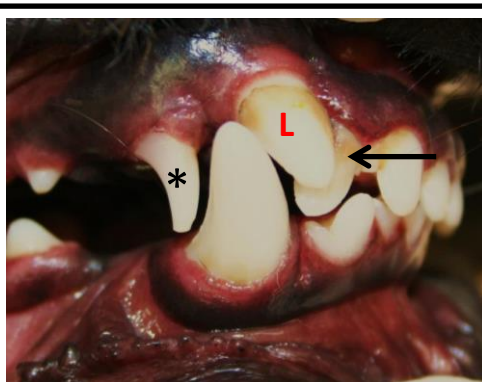


Figure 3 shows a retained deciduous (baby) tooth (*), lance upper canine tooth that is not fully erupted (L) and crowding of the upper canine with the 3rd incisor with significant periodontal bone loss (arrow)

able to keep the more important canine teeth by removing the retained deciduous (baby) tooth and the crowded 3rd incisor. We also removed a portion of the gingiva that was not attached. Homecare is important to maintain oral health.

We have shown cases where the teeth may be functional and free of infection with treatment & homecare. Some cases are best managed by surgical extraction. Occasionally, we can move the tooth with orthodontics to correct the position. This is the least predictable, most involved and most expensive method.



Figure 4 shows patient from figure 3 two weeks after removal of the retained baby tooth and 3rd incisor as well as removal of some unattached gingiva over the upper canine tooth