Commentary

Amelogenesis imperfecta: Newer rehabilitation approach

The case report 'Restoration of Functions and Esthetics in a Patient with an Amelogenesis Imperfecta' presents to us rare, inherited, autosomal-dominant, recessive or X-linked traits (X p22.3–p22.1), which manifest themselves as quantitative and qualitative tooth enamel defects, without any systemic manifestations.[1] The prevelance of this condition is expected to occur in one in 718 to one in 14,000. Of these, hypoplastic amelogenesis imperfecta (AI) represents around 73%, hypomaturation AI represents 40%, and hypocalcification AI represents 7%.[2,3]

The pathophysiology of AI, with its clinical manifestations, is well portrayed in this article. These conditions may also be seen in special children who have always compromised on oral hygiene status. Clinical manifestations of AI include thin tooth enamel, soft tooth enamel, pitted tooth enamel, rough tooth enamel, and yellow-brownish fragile teeth.

The treatment options for this severe disabling condition often pose a great challenge to the dental surgeon. Treatment modalities vary from oral prophylaxis and root planing, endodontic treatment for all required teeth, periodontal surgeries if required, and then restoring the teeth with tooth-colored restorative cements or polycarboxylate crowns.[4-6] Frequently, AI is seen in children belonging to the low socioeconomic status, hence, the uniqueness of this article lies in the use of minimally invasive, low-cost, and effective restorative composites. The need to correct these inherited defects requires early identification and intervention by a dental health care professional. Dental surgeons must consider the social implication of these patients in terms of esthetics and intervene to relieve the suffering of AI patients.

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