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CASE STUDY

GAGGING: GIVE THE MESS A MISS - CASE REPORTS

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ABSTRACT

Very often we come across patients who have an excessive gag reflex. Gagging in dental patients can lead to avoidance of dental treatment and hence hinder the patient care. It can compromise the treatment at every stage, starting from diagnosis to rendering active treatment to the patient. Etiology and Management of gagging have been dealt with in the previous articles in this series. We hereby present cases where severe gaggers were managed and their orthodontic treatment carried out with appliance modification and other gagging control techniques.

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INTRODUCTION

Case I

A 12 year old male patient walked into our clinic with the chief complaint of protruded upper front teeth. Case history revealed the patient had taken an orthodontic consultation in the past with another orthodontist and was given an orthodontic appliance for the correction of his malocclusion but he could not continue with the treatment due to excessive gag reflex. On clinical examination, the patient was diagnosed as having Angle's class II malocclusion, with bimaxillary proclination and mild spacing in the upper and lower anteriors on a Class II skeletal base, mild vertical growth pattern, potentially competent lips and a deep mentolabial sulcus. Based on the clinical and cephalometric findings, a functional appliance therapy to redirect the mandibular growth was planned. A sudden and progressive increase in the weight and height in the past few months suggested the patient going through the pubertal growth spurt further indicating immediate start of the functional appliance treatment. Keeping his excessive gag reflex in mind, a modified fixed twin block was planned for the patient.

Case II

A 12 year old male patient walked into our clinic with the chief complaint of protruded upper front teeth. Case history revealed an excessive gag reflex. During clinical examination, the patient was found to be very sensitive and gagging even with the placement of mouth mirror in his mouth. The clinical examination also revealed Angle's class II malocclusion, on a Class II skeletal base, mild horizontal growth pattern, potentially competent lips and a deep mentolabial sulcus. In this case, desensitization method was followed. After initial examination and impression making using distraction method, the patient was sent home with a mouth mirror and was advised to keep it in the mouth and also touch it to the lateral borders of the tongue, for a few seconds to start with but slowly increasing the time and depth each time the act was repeated. The patient was recalled after a week and the progress analysed. Tremendous improvement was seen at this appointment with patient allowing the intraoral photographs to be taken with a little use of distraction method. He was later called after a week and construction bite recorded without any difficulty. After 3 days, patient was given a removable twin block for his skeletal Class II correction. The appliance was worn for a period of 9 months without any discomfort or difficulty.

DISCUSSION

Gagging patients as we see are not limited to any one specialty. It is important for the treating clinician to classify their patients and hence initiate appropriate management techniques. Needless to mention, if the cause of gagging is not analyzed, any attempt on the clinician's part to manage gagging will fail and hence either the treatment will not be possible or the quality of treatment rendered may be compromised.

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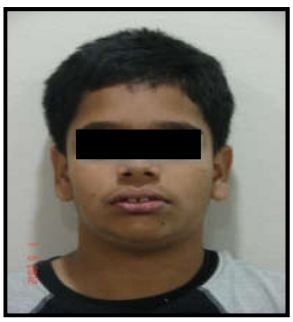
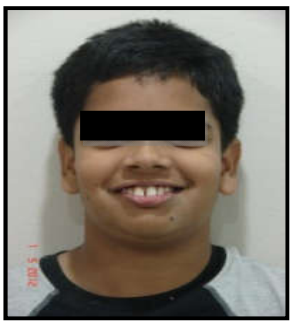
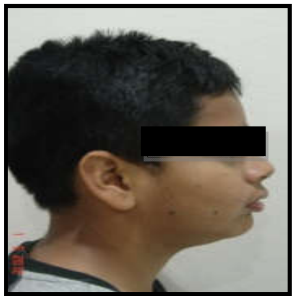
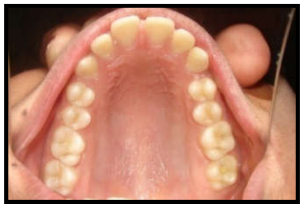
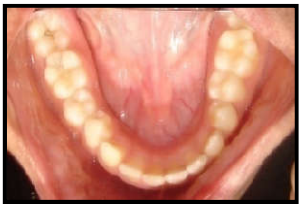
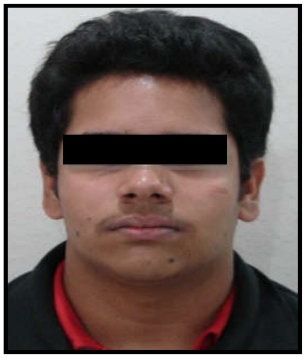
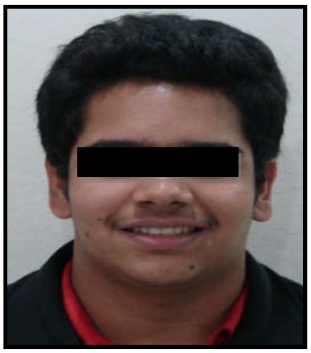
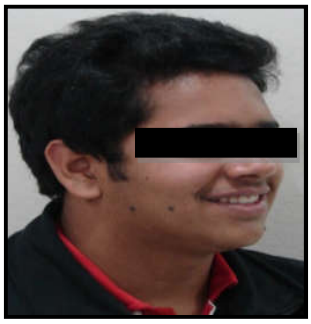
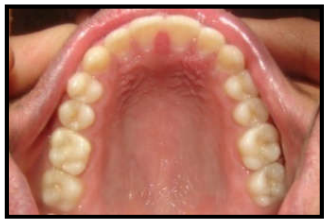
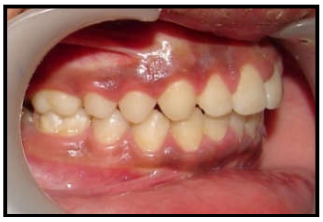
Pre Treatment (Case I)

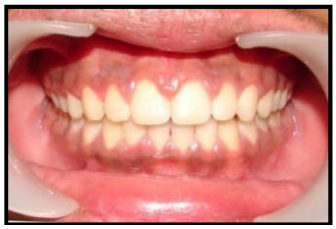
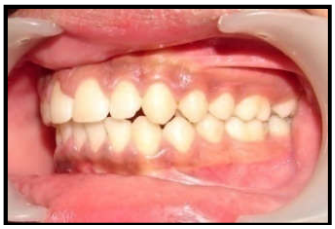
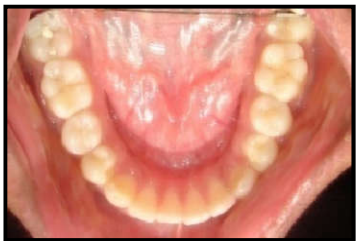



Post Treatment (Case I)

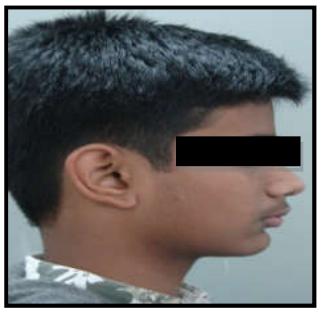
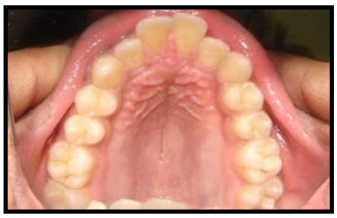
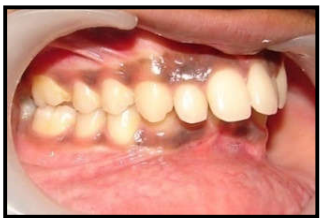
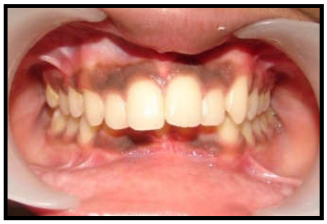
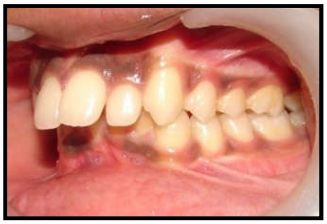
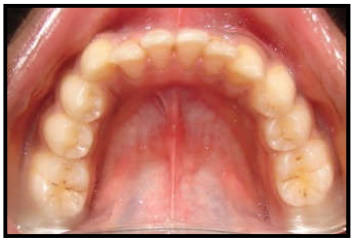




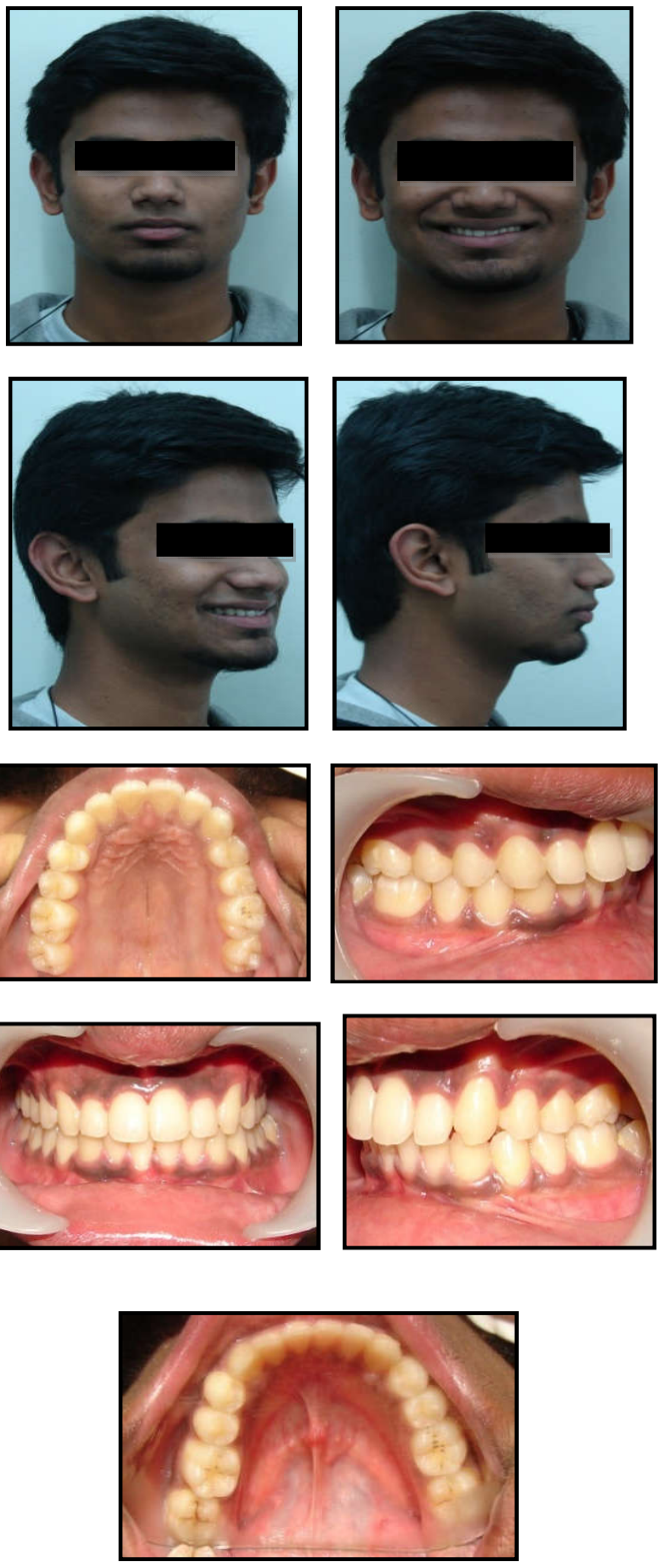




Pre Treatment (Case II)



Post Treatment (Case II)



Hence, etiology and management of gagging though underrated, plays a very crucial role. So, no matter how skillful the clinician is in his field, the treatment and hence the clinician may fail drastically if he is not knowledgeable enough in these aspects of gagging.

DISCUSSION

Gagging patients as we see are not limited to any one specialty. It is important for the treating clinician to classify their patients and hence initiate appropriate management techniques. Needless to mention, if the cause of gagging is not analyzed, any attempt on the clinician's part to manage gagging will fail and hence either the treatment will not be possible or the quality of treatment rendered may be compromised. We may come across a few patients where the appliance modification can be tried as in the first case. But there could be instances where the treatment cannot be rendered just by modifying the appliance. Hence it becomes extremely important for the physician to be very well versed with all possible management options. In both cases reported, we were successful in achieving Gagging Prevention Index score of I [1,2] as we did not encounter any problem during treatment after we followed the planned protocol for control of gag reflex and the treatment was successful**.**

Summary and Conclusion

Hence, etiology and management of gagging though underrated, plays a very crucial role. So, no matter how skillful the clinician is in his field, the treatment and hence the clinician may fail drastically if he is not knowledgeable enough in these aspects of gagging.

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