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Natal Tooth: A Case Report highlighting Clinical Management and association with Maternal Risk Factors

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Abstract

Natal teeth are uncommon developmental findings present at birth and may cause functional and clinical concerns for both the infant and caregiver. These teeth may interfere with feeding, result in maternal discomfort during breastfeeding, and pose a potential risk of aspiration when excessively mobile. Early diagnosis and appropriate management are therefore essential. This report describes the case of a 23-day-old female infant presenting with a natal tooth in the mandibular anterior region. Maternal history was significant for gestational diabetes mellitus, anemia, and hypothyroidism, although any association with natal teeth remains speculative. Clinical examination revealed a conical, whitish-opaque crown with Grade III mobility, indicating inadequate attachment and increased aspiration risk. Based on the clinical findings and mobility, extraction was planned following confirmation of adequate vitamin K prophylaxis. The tooth was extracted atraumatically under topical anesthesia, and hemostasis was achieved successfully. Postoperative healing was uneventful, with satisfactory healing observed at one-week follow-up. This case highlights the importance of careful clinical assessment, risk evaluation, and timely intervention in the management of natal teeth.

Keywords: Natal teeth, Riga-Fede disease, Vitamin K prophylaxis, Gestational diabetes, Infant oral health, Pediatric dentistry.

Introduction

Eruption of primary teeth is an important developmental milestone that typically begins around six months of age, most commonly involving the mandibular central incisors. Occasionally, teeth may erupt at birth or within the first month of life because of variations in eruption timing. Teeth present at birth are termed natal teeth, whereas teeth erupting within the first 30 days after birth are termed neonatal teeth [1].

Natal and neonatal teeth are rare findings, with a reported prevalence ranging from 1 in 2,000 to 1 in 3,500 live births. Natal teeth occur more frequently than neonatal teeth and most commonly involve the mandibular central incisors. In most cases, these teeth belong to the normal primary dentition rather than representing supernumerary teeth [2,3]. Clinically, they often exhibit poor root formation, enamel hypoplasia, and increased mobility due to inadequate attachment to the alveolar bone.

Natal teeth may lead to several complications including feeding difficulties, maternal discomfort during breastfeeding, traumatic ulceration of the ventral tongue (Riga-Fede disease), and aspiration risk in cases with excessive mobility [4].

Management depends on multiple factors including mobility, feeding interference, soft tissue trauma, and risk of aspiration. While conservative management may be considered for asymptomatic stable teeth, extraction may be indicated when mobility or associated complications are significant. Pediatric dentists play an essential role in diagnosis, treatment planning, behavior guidance, dose calculation for medications, and postoperative monitoring in neonates. Appropriate interdisciplinary care and timely intervention contribute to favorable clinical outcomes [5].

Case Presentation

A 23-day-old female infant was referred to the Department of Pediatric Dentistry, Thai Moogambigai Dental College and Hospital, Chennai, with a tooth-like structure present in the mandibular anterior region since birth.

The infant was born at 37 weeks and 5 days of gestation through normal vaginal delivery with a birth weight of 3.24 kg. Apgar scores were eight and nine at one and five minutes, respectively. The infant cried immediately after birth but was admitted briefly to the neonatal intensive care unit because of

mild tachypnea and was discharged in stable condition.

Maternal history revealed gestational diabetes mellitus diagnosed during pregnancy, anemia treated with iron supplementation, and hypothyroidism managed with thyroxine therapy. There was no history of teratogenic exposure during pregnancy. Family history revealed neonatal seizures in the father, although documentation was unavailable.

Intraoral examination revealed a tooth-like structure in the mandibular anterior region corresponding to the location of primary mandibular central incisors 71 and 81, as shown in Figure 1(A). The crown appeared small, conical, and whitish-opaque with Grade III mobility according to Miller's classification. Mild gingival swelling was present without associated inflammation. The tongue, floor of the mouth, buccal mucosa, and remaining oral structures appeared clinically normal. No ulceration of the ventral tongue was observed.

The differential diagnosis included supernumerary tooth, dental lamina cyst, Bohn's nodules, and eruption cyst; however, the location and morphology were consistent with a natal tooth. Based on the anatomical position corresponding to the primary mandibular incisors, the tooth was considered part of the normal primary dentition rather than a supernumerary tooth. No syndromic features or congenital abnormalities were identified.

Although feeding difficulty was not significant, the marked mobility of the tooth posed a potential aspiration risk. No history of aspiration, choking episodes, or respiratory distress associated with tooth mobility was reported by the parents. Considering the young age of the infant and limited cooperation, radiographic examination was deferred. After obtaining medical clearance and confirming vitamin K prophylaxis, extraction was planned. Parents were instructed to feed the infant approximately 30–45 minutes prior to the procedure to improve comfort during treatment.

The procedure was carried out under aseptic conditions using a knee-to-knee position involving both the parent and operator. The infant was positioned in a semi-recumbent posture on the dentist's lap. The oral cavity was gently cleaned using sterile gauze before the procedure. Topical anesthetic gel was applied over the mucosa using cotton applicators and allowed to act for approximately one minute, as shown in Figure 1(B). Due to the marked mobility of the tooth, extraction was performed atraumatically using sterile gauze with gentle rotational movement. The extracted specimen demonstrated a conical crown with minimal root formation, as shown in Figure 1(C). Socket curettage was performed to remove remnants of dental papilla and Hertwig's epithelial root sheath. Hemostasis was achieved with sterile gauze pressure, and the immediate postoperative condition

is shown in Figure 1(D). The infant tolerated the procedure well.

Parents were advised regarding postoperative feeding instructions, oral hygiene maintenance, and monitoring for bleeding or discomfort. Paracetamol drops were prescribed in an appropriate pediatric dosage if required. The patient was reviewed after one week.

Follow-up examination demonstrated satisfactory healing without signs of infection or complications, as shown in Figure 1(E). The infant resumed normal feeding, and the parents reported complete resolution of their concerns.

Discussion

The exact cause of natal and neonatal teeth is not clearly understood and is believed to be multifactorial. Some of the suggested contributing factors are superficial location of the developing tooth germ, genetic predisposition often followed an autosomal dominant pattern, endocrine disturbances, nutritional deficiencies, and environmental influences [6]. Additionally, maternal conditions such as infections, fever, malnutrition, exposure to toxins, systemic disorders like gestational diabetes, anemia, and hormonal imbalances during pregnancy have been proposed as possible contributors. In the present case, the mother's history of gestational diabetes mellitus and hypothyroidism may have played a role in the premature eruption of teeth.

Complications such as feeding difficulties, maternal discomfort during breastfeeding, and traumatic ulceration of tongue's ventral surface, known as Riga-Fede disease. In addition, highly mobile teeth pose a potential risk of aspiration, necessitating prompt clinical evaluation.

Natal teeth have also been reported in association with certain syndromes, such as Ellis-van Creveld syndrome, Hallermann-Streiff syndrome, Pierre-Robin sequence, ectodermal dysplasia, and Soto's syndrome, indicating a possible genetic predisposition in some cases. However, no syndromic features were observed in the present case.

Natal teeth can exhibit a broad spectrum of clinical presentations, ranging from well-developed crowns resembling normal primary teeth to small, conical, hypoplastic structures with minimal or no root formation. They often appear yellowish or opaque and may be loosely attached to the underlying structures, sometimes connected only by soft tissue. The absence of adequate root development contributes to increased mobility, which plays a crucial role in guiding management decisions.

Hebling (1997) classified these teeth into four categories based on their clinical presentation [7].

CLASS	DESCRIPTION
Type I:	Shell-shaped crown poorly fixed to the alveolus by the gingival tissue and absence of a root.
Type II:	Solid crown poorly fixed to the alveolus by the gingiva and little or no root.
Type III:	Eruption of the incisal margin of the crown through the gingiva.
Type IV:	Edema of the gingiva with an unerupted but palpable tooth.

TABLE 1: Classification of Natal and Neonatal Teeth

This table presents the clinical classification of natal teeth based on crown morphology, degree of fixation to the alveolus, and root development.

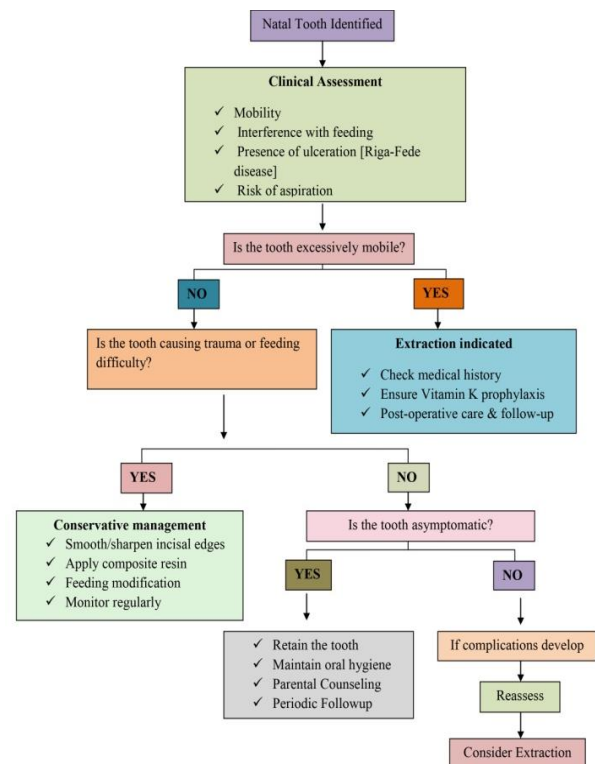
Radiographic examination is generally useful for differentiating natal teeth from supernumerary teeth; however, obtaining radiographs in neonates may not always be feasible because of age and cooperation limitations. In the present case, clinical findings strongly suggested that the tooth belonged to the normal primary dentition.

Management depends on clinical factors such as mobility, feeding interference, soft tissue trauma, and aspiration risk [8]. Stable asymptomatic teeth may be retained with regular observation; whereas extraction is indicated when excessive mobility increases the risk of aspiration. In the present case, extraction was considered necessary because of Grade III mobility despite the absence of significant feeding difficulty.

Timing of extraction is important because neonates are susceptible to vitamin K deficiency bleeding due to immature hepatic synthesis of vitamin K-dependent clotting factors [9]. Therefore, confirmation of vitamin K prophylaxis prior to extraction is essential. In the present case, medical clearance and vitamin K status were confirmed before treatment.

The American Academy of Pediatric Dentistry recommends curettage of the extraction socket to remove remnants of the dental papilla and Hertwig's epithelial root sheath in order to prevent continued odontogenic development [10]. This protocol was followed in the present case, and postoperative healing was uneventful.

Although natal teeth are uncommon but documented findings, this report emphasizes a structured clinical management approach involving aspiration risk assessment, confirmation of vitamin K status, atraumatic extraction, and postoperative follow-up. The proposed management given in Flowchart summarizes practical clinical decision-making criteria and may assist clinicians in selecting conservative management or extraction based on mobility, feeding interference, traumatic ulceration, and aspiration risk.



FLOWCHART 1: Clinical Assessment Criteria for Management of Natal Teeth

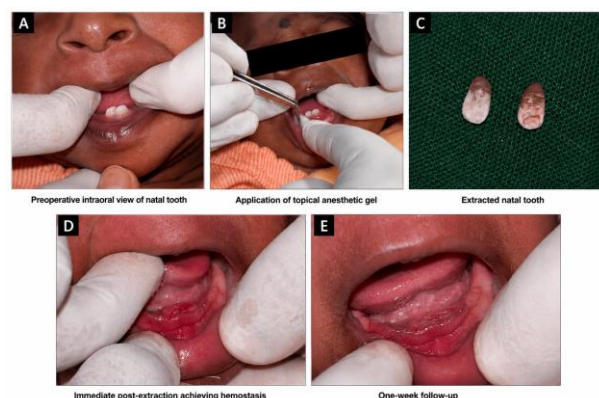


Figure 1: Clinical Presentation and Management of Natal Teeth

Conclusions

Natal teeth require prompt recognition and careful clinical evaluation because of the potential risk of aspiration, feeding difficulties, and soft tissue trauma. Management should be individualized based on clinical findings, especially tooth mobility and associated complications. Extraction can be performed safely when indicated, provided appropriate precautions such as assessment of vitamin K status are undertaken.

A multidisciplinary approach involving pediatricians and pediatric dentists is important for safe management and postoperative care. Early

diagnosis, parental counseling, and regular follow-up contribute significantly to favorable clinical outcomes in neonatal oral conditions.

Ethical Considerations

Ethical approval was not required for this case report as per institutional policy. Written informed consent for publication of clinical details and clinical photographs was obtained from the patient's parent.

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