Integrative Health and Sciences. 2026; 3(2):101
doi: 10.63688/ihs.v3.i2.101

REVISIÓN

Incidental finding of erupted distomolars with bilateral maxillomandibular localization: report of an unusual clinical case of nonsyndromic hyperdontia

Hallazgo incidental de distomolares erupcionados con localización bilateral maxilomandibular: reporte de un caso clínico inusual de hiperdoncia no sindrómica

Ruth Shirley Lavadenz Pérez[1]
William José Arrazola Pozo[1]
Verónica Quiñones-Lazcano[1]

[1] Universidad Mayor de San Andrés, Facultad de Odontología. La Paz, Bolivia.

Submitted: 04-07-2026 | Revised: 10-07-2026 | Accepted: 25-09-2026 | Published: 27-09-2026

Corresponding Author: Ruth Shirley Lavadenz Pérez

ABSTRACT

Introduction: Hyperdontia is a numerical developmental anomaly of the dentition with a multifactorial etiology. Distomolars, or fourth molars, have a low prevalence, and their bilateral and bimaxillary occurrence in nonsyndromic patients represents an uncommon clinical finding. Objective: To characterize the incidental finding of erupted distomolars using a diagnostic protocol based on advanced imaging and 3D biomodeling to guide therapeutic planning. Case presentation: A 42-year-old systemically healthy male attended the Diagnostic and Admission Clinic of the Faculty of Dentistry at Universidad Mayor de San Andrés for a general dental evaluation, reporting food impaction in the left posterior mandibular region. Clinical examination identified dysmorphic and rudimentary supernumerary teeth located distal to teeth 1.8 and 3.8. Cone-beam computed tomography (CBCT) and three-dimensional biomodels produced with Elegoo Standard White resin made it possible to rule out dental fusion and analyze their spatial relationship with the third molars in greater anatomical detail. Conclusions: Erupted distomolars located in both the maxilla and mandible in nonsyndromic patients are uncommon. CBCT allowed precise assessment of their morphology, position, relationship with the third molars, and possible associated root alterations. Three-dimensional biomodeling complemented the diagnosis by providing a clear spatial representation of the structures involved and supporting interpretation of the case. The integration of clinical examination, CBCT, and 3D biomodeling enabled an accurate diagnosis and supported an individualized therapeutic approach consistent with the anatomical findings observed.

Keywords: Supernumerary teeth, Maxilla, Mandible, Cone beam computed tomography (CBCT).

RESUMEN

Introducción: La hiperdoncia es una anomalía numérica del desarrollo dental de etiología multifactorial. Los distomolares o cuartos molares presentan baja prevalencia, y su aparición bilateral y bimaxilar en pacientes no sindrómicos constituye un hallazgo clínico poco habitual. Objetivo: Caracterizar el hallazgo incidental de distomolares erupcionados mediante un protocolo diagnóstico basado en imagenología avanzada y biomodelado 3D para orientar la planificación terapéutica. Presentación del caso: Paciente masculino de 42 años, sistémicamente sano, acudió a la Clínica de Diagnóstico y Admisión de la Facultad de Odontología de la Universidad Mayor de San Andrés para valoración odontológica general, refiriendo empaquetamiento de alimentos en el sector posteroinferior izquierdo. La exploración clínica identificó piezas supernumerarias dismórficas y rudimentarias, ubicadas distalmente a las piezas 1.8 y 3.8. La tomografía computarizada de haz cónico (CBCT) y los biomodelos tridimensionales elaborados con resina Elegoo Standard White permitieron descartar fusión dentaria y analizar su relación espacial con los terceros molares. Conclusiones: Los distomolares erupcionados con localización maxilar y mandibular en pacientes no sindrómicos son infrecuentes. La CBCT permitió precisar su morfología, posición, relación con los terceros molares y posibles alteraciones radiculares asociadas. El biomodelado 3D complementó el diagnóstico al ofrecer una representación espacial de las estructuras involucradas. La integración del examen clínico, la CBCT y el biomodelado permitió establecer un diagnóstico preciso y proponer una conducta terapéutica individualizada acorde con los hallazgos anatómicos.

Palabras clave: Dientes supernumerarios, Maxilar superior, Mandíbula, Tomografía computarizada de haz cónico (CBCT).

© 2026, The Authors. This is an open access article distributed under the terms of the Creative Commons Attribution License (CC BY 4.0).

INTRODUCTION

Supernumerary teeth are characterized by an increase in the number of dental elements relative to the normal number of teeth. This condition is known as hyperdontia (1), also called hypergenesis (2).

Different theories have been proposed to explain the origin of supernumerary teeth; however, their exact etiology has not yet been fully established. Among the most widely accepted hypotheses is the phylogenetic or atavism theory, according to which this condition would represent a regression toward ancestral dental patterns characterized by a greater number of teeth (2, 3).

The dichotomous theory has also been proposed, according to which a supernumerary tooth would originate from the division of the dental germ. Another widely accepted hypothesis is hyperactivity of the dental lamina, an odontogenic structure that could generate additional dental buds and give rise to two teeth of similar size or to a normal tooth accompanied by another dysmorphic tooth. The involvement of genetic and hereditary factors (3) has also been suggested, as well as trauma or local injuries, as possible elements associated with the development of this condition (4).

According to the literature, supernumerary teeth are uncommon in the third molar region and show a greater predilection for the maxilla (5). They can be observed both in adults with permanent dentition and in children with primary dentition, more frequently in men than in women (6). It has been reported that approximately 25% of supernumerary teeth erupt, while 75% remain impacted (2).

Supernumerary teeth are classified, according to their location in the dental arches, into mesiodens, paramolars, distomolars, and parapremolars and, according to their morphology, into rudimentary and supplementary (7).

The most frequent regions for the location of supernumerary teeth include, first, the maxillary incisor region, followed by the maxillary and mandibular molars, the premolars and, less frequently, the canines and lateral incisors (4).

Supernumerary teeth located in the anterior region of the maxilla are called mesiodens (7) and represent approximately 80% of cases. Supernumerary molars are mainly classified into distomolars and paramolars (8). These alterations usually occur individually and are rarely observed bilaterally (9).

The paramolar is a posterior supernumerary tooth that may be located buccally, lingually, or palatally, or in the interproximal space between two molars. Its presence is usually evident through radiographic studies. In contrast, the distomolar is located distal or distolingually to the third molar, which is why it is also called the fourth molar. It is usually unilateral, with a conical, rudimentary, or dysmorphic morphology and smaller than the third molar (9). Its morphology can vary from a well-developed crown, associated with a single root, to configurations different from conventional dental anatomy (10).

Hyperdontia has also been described in association with various syndromes and developmental disorders, including cleft lip and palate, cleidocranial dysplasia, Ehlers-Danlos syndrome type III, Goldenhar syndrome, Hallermann syndrome, Fabry-Anderson syndrome, Ellis-van Creveld syndrome, Streiff syndrome, orofaciodigital syndrome type I, incontinentia pigmenti, Marfan syndrome, Nance-Horan syndrome, and trichorhinophalangeal syndrome (11, 12).

Among the main differential diagnoses are:

- Dental fusion: It can be observed in posterior teeth associated with supernumerary teeth and corresponds to a developmental anomaly caused by the union of two dental germs, possibly related to physical, hereditary, or racial factors (13).
- Concrescence: It consists of the union of two teeth exclusively by root cementum. It is observed more frequently in posterior teeth, and its exact etiology is not completely established. Among the related factors that have been proposed are trauma, local infection, space restriction during development, masticatory changes after tooth loss, and interdental bone loss (14).

METHODS

Male patient, 42 years old, born in and resident of the city of Oruro, Bolivia, an industrial welder by occupation, attended the Outpatient Clinic of the Diagnostic and Admission Clinic (afternoon shift) of the Chair of Stomatological Semiology (Parallel B) of the Faculty of Dentistry of the Universidad Mayor de San Andrés (UMSA), La Paz, Bolivia. The patient requested a comprehensive

dental evaluation and reported as his main reason for consultation a "permanent discomfort due to food debris impaction in the left posterior region of the mandible." On history taking, he reported no spontaneous or provoked pain, neuralgia, or history of acute infectious episodes in the area.

As a first diagnostic approach, standardized periapical radiographs were obtained using the paralleling technique.

Given the limitations of planar evaluation for ruling out dental union anomalies, such as fusion or concrescence, and for precisely defining root topography, one study using cone-beam computed tomography (CBCT) was indicated.

The tridimensional volumetric study was performed with an Instrumentarium Dental OP300 tomography unit (Tuusula, Finland). Acquisition parameters were 89 kVp and 10 mA, with an isotropic voxel size of 0,125 mm and a field of view (FOV) optimized to encompass both dental arches. DICOM (Digital Imaging and Communications in Medicine) images were processed and analyzed using the OnDemand3D™ multiplanar reconstruction software.

To complement the three-dimensional analysis and facilitate the understanding of the anatomical relationship between the distomolars and the third molars, 3D anatomical biomodels were developed at a 1:1 scale from the data obtained by cone beam computed tomography (CBCT).

The digital workflow for biomodels began with the acquisition and export of volumetric data in DICOM format. Segmentation and generation of the tridimensional model were performed using OnDemand3D™ software, from which the file in STL (Standard Tessellation Language) format was obtained. Subsequently, the STL file was processed in Autodesk Meshmixer®, where cropping of the region of interest, cleaning and optimization of the tridimensional mesh, surface smoothing, closing of discontinuities, and correction of non-manifold geometries were performed.

For digital slicing, the processed STL file was imported into CHITUBOX Basic software, which was used to configure the printing parameters. The biomodel was oriented at approximately 45° relative to the print platform, and medium-density supports were configured, with 0.4 mm contact points located in areas that would not compromise the anatomical structures of interest. The layer height was set at 50 µm (0.05 mm), with an exposure time of 2.5 seconds per layer and 35 seconds for the initial adhesion layers.

The sliced file was transferred to an Elegoo Mars 5 3D printer, and Elegoo Standard White photopolymerizable resin was used. Printing was performed via UV light photopolymerization and lasted approximately 2 hours and 15 minutes.

After printing was completed, the biomodel was washed in 99% isopropyl alcohol (IPA) for 20 minutes to remove any unpolymerized resin residues. Subsequently, it was allowed to dry for approximately 15 minutes and then subjected to post-curing in an Elegoo Mercury UV chamber at a wavelength of 405 nm for 10 minutes. Finally, the supports were removed and localized finishing of their insertion points was performed using fine rotary instruments.

RESULTS

In the systemic anamnesis, the patient did not report metabolic, cardiovascular, or endocrine diseases, nor genetic or syndromic disorders associated with multiple hyperdontia. His only relevant surgical history was a laparoscopic cholecystectomy performed 6 years earlier, without intraoperative or postoperative complications. He denied pharmacological treatment and reported no known allergies to medications, local anesthetics, or dental antiseptics.

Extraoral physical examination revealed a symmetric, mesofacial facial appearance, with no palpable lymphadenopathy or alterations in temporomandibular joint (TMJ) movements. Intraoral examination showed that the buccal mucosa, hard and soft palate, floor of the mouth, lips, and oropharynx were clinically healthy, pink, firm in consistency, and without evidence of lesions. Poor oral hygiene was observed, with generalized bacterial plaque accumulation, supra- and subgingival calculus, and mild marginal gingival inflammation.

Clinical inspection of the dental arches revealed an incomplete permanent dentition due to previous unrehabilitated extractions, multiple carious lesions, and defective or ill-fitting amalgam and resin restorations. The patient reported not having undergone regular dental check-ups in the past.

In the detailed examination of the retromolar regions, in quadrant I, immediately distal to tooth 1.8, an erupted supernumerary tooth was identified; it was microdontic, with rudimentary and conical morphology, and located toward the vestibular aspect relative to the longitudinal axis of the third molar. In quadrant III, distal to tooth 3.8, a second erupted supernumerary tooth was observed, also microdontic and rudimentary, located toward the lingual aspect of the arch.

Both distomolars were completely erupted with preserved coronal integrity, although they constituted plaque retention niches that favored food packing.

In the right maxillary region, the crown of the distomolar was observed adjacent to the distal surface of tooth 1.8; however, superimposition of the zygomatic process of the maxilla, the posterior wall of the maxillary sinus, and the tuberosity made it difficult to delineate the periodontal ligament space, root anatomy, and apex of the supernumerary tooth.

In the left mandibular region, the distomolar was observed distal to tooth 3.8. In this sector, superimposition of the external oblique line of the mandible and high cortical density hindered assessment of the root configuration and its relationship with the inferior alveolar nerve canal.

Panoramic reconstruction confirmed the presence of two mesioangulated distomolars in opposite arches, establishing a condition of asymmetric bilateral hyperdontia associated with teeth 1.8 and 3.8. No other retained supernumerary tooth germs were identified in the rest of the maxillofacial complex.

In the analysis of the maxillary distomolar associated with tooth 1.8, the axial section showed the crown and root located in a distobuccal position relative to the third molar. A continuous periodontal space of approximately 0.4 mm was observed, with no evidence of cemental union or concrescence. In the sagittal section, complete root formation was identified, with a single root with relatively straight walls. The root apex was located approximately 2.8 mm from the floor of the maxillary sinus. The coronal section allowed assessment of the buccal cortical plate covering the root of the distomolar.

In the analysis of the mandibular distomolar associated with tooth 3.8, the axial slice showed its distolingual location. The lingual bone plate was observed to be fenestrated in the coronal third, with the crown in close proximity to the soft tissues of the floor of the mouth. The sagittal slice revealed complete root formation and marked bayonet-shaped apical dilaceration, with double curvature in the vestibulolingual and distomesial directions. The coronal slice made it possible to observe the transverse misalignment of the distomolar axis relative to the mandibular body and confirmed its anatomical independence from tooth 3.8.

The biomodel obtained allowed the dentoalveolar anatomy and the spatial relationship of the distomolars with the third molars to be represented tridimensionally, complementing the interpretation of the CBCT, therapeutic planning, and explanation of the case to the patient.

Based on the integration of the clinical findings, periapical radiographic examination, volumetric interpretation using CBCT, and 3D biomodeling, the diagnosis of multiple asymmetric bilateral hyperdontia was established, characterized by the presence of erupted distomolars of rudimentary and microdontic type, located in quadrant I, distovestibularly to tooth 1.8, and in quadrant III, distolingually to tooth 3.8.

Additional findings included marked apical root dilaceration of the mandibular distomolar, carious lesions, defective restorations in multiple teeth, and plaque-induced marginal gingivitis.

The therapeutic prognosis of distomolars was considered unfavorable due to their lack of masticatory function, their role as niches for plaque retention and food packing, and the potential risk of compromise of adjacent dental structures.

The prognosis of the adjacent third molars, teeth 1.8 and 3.8, was considered favorable, since they did not present signs of external root resorption or significant loss of interproximal bone support.

The prognosis of overall pulpal and periodontal health was considered favorable, contingent upon bacterial plaque control, scaling, prophylaxis, restoration of carious lesions, and oral health education.

The design of the treatment plan was structured in an interdisciplinary manner, considering the elimination of etiological factors, the preservation of noble anatomical structures, and the functional and aesthetic restoration of the oral cavity.

For this purpose, an initial approach was proposed consisting of ultrasonic scaling, professional prophylaxis, oral hygiene instruction, and bacterial plaque control. Regarding hyperdontia, the therapeutic approach proposed was simple extraction of the maxillary distomolar associated with tooth 1.8 and surgical extraction of the mandibular distomolar associated with tooth 3.8, considering the observed apical dilaceration. Likewise, removal of carious lesions, replacement of defective restorations, and subsequent prosthetic planning for the missing teeth were recommended.

Although the distomolars were erupted and asymptomatic from a pain perspective, the proposal for extraction was based on preventive criteria related to the risk of periodontal disease, due to the recurrent food packing reported by the patient in the region of tooth 3.8, a condition that favored plaque retention and could compromise the periodontal tissues of the distal surface of the third molar. Likewise, the difficulty in performing adequate hygiene at the distomolar-third

molar interface constituted a risk factor for the development of carious lesions. In the case of the mandibular distomolar, its proximity to the inferior alveolar nerve was also considered, so its removal was proposed as a preventive therapeutic alternative. However, the surgical procedure was not performed at the institution.

Upon completion of the case assessment, the patient's usual residence in the city of Oruro and the need for subsequent follow-up conditioned the execution of the surgical plan at the institution. The patient was temporarily in the city of La Paz for work reasons, which made it difficult to ensure adequate clinical follow-up.

Because care at the Diagnosis and Admission Clinic of the Chair of Stomatological Semiology of UMSA was limited to the diagnostic phase, which included imaging studies, 3D biomodeling, and therapeutic planning, it was considered necessary to ensure adequate postoperative follow-up. The potential surgical extraction required subsequent follow-up to assess healing and promptly detect possible complications.

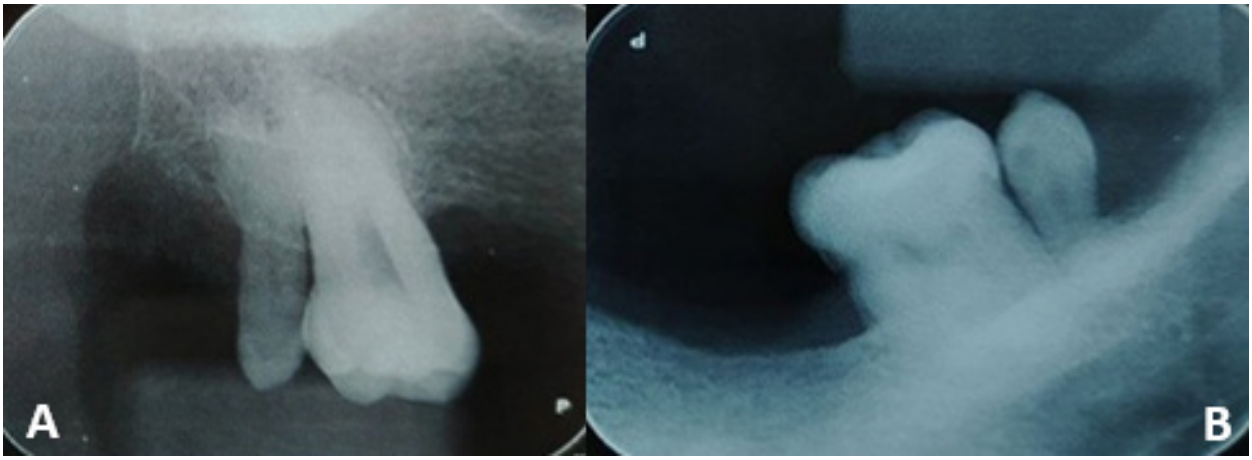
For this reason, a counseling session was conducted using the 3D biomodel as an educational resource. The patient's anatomical condition, the presence of root dilaceration, and the proposed therapeutic alternatives were explained to the patient. The patient received a clinical-imaging report, the DICOM file, and the physical 3D biomodel, and was referred to a center specialized in oral and maxillofacial surgery in the city of Oruro for assessment, potential treatment, and follow-up at the patient's usual place of residence.

Figure 1. Intraoral clinical images



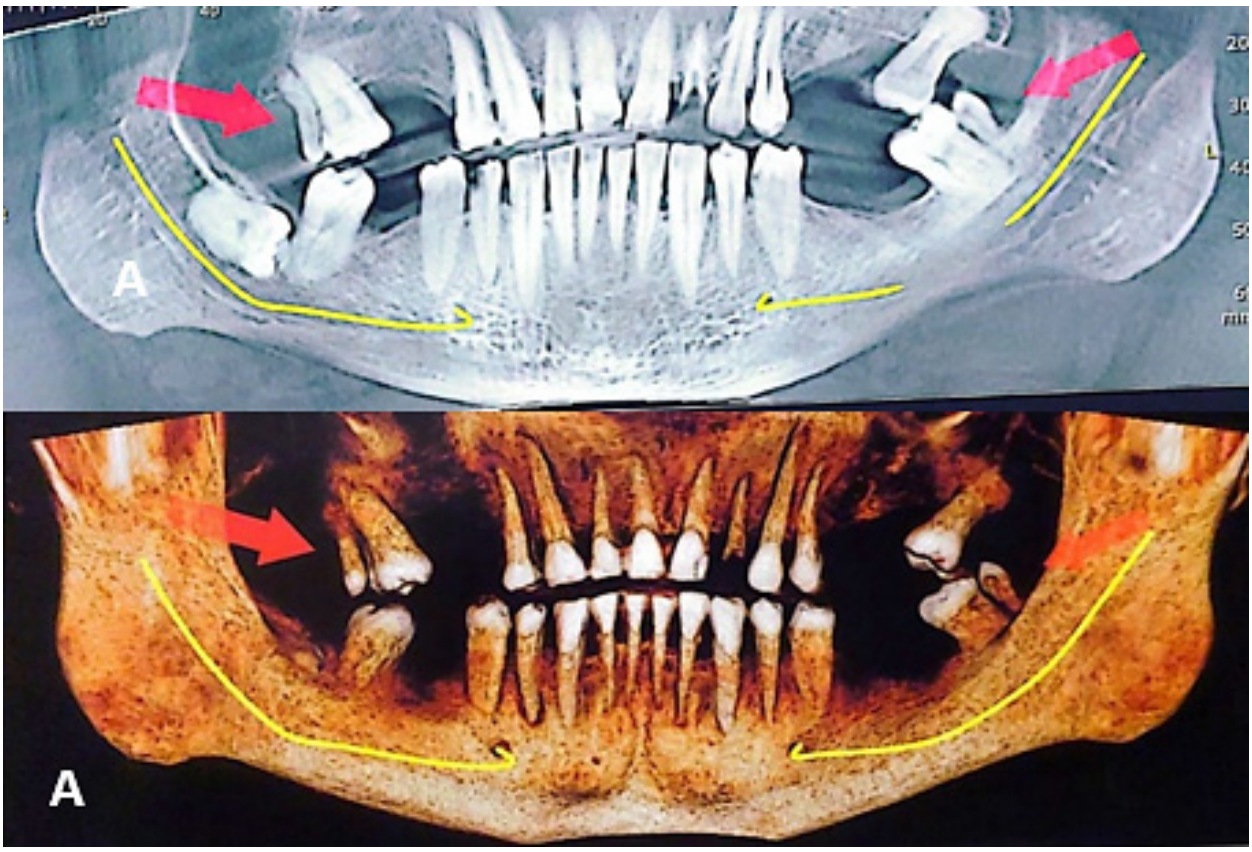
A) Erupted, dysmorphic, and rudimentary distomolar, located distal to tooth 1.8.
B) Erupted, dysmorphic, and rudimentary distomolar, located distal to tooth 3.8.

Figure 2. Periapical radiographs



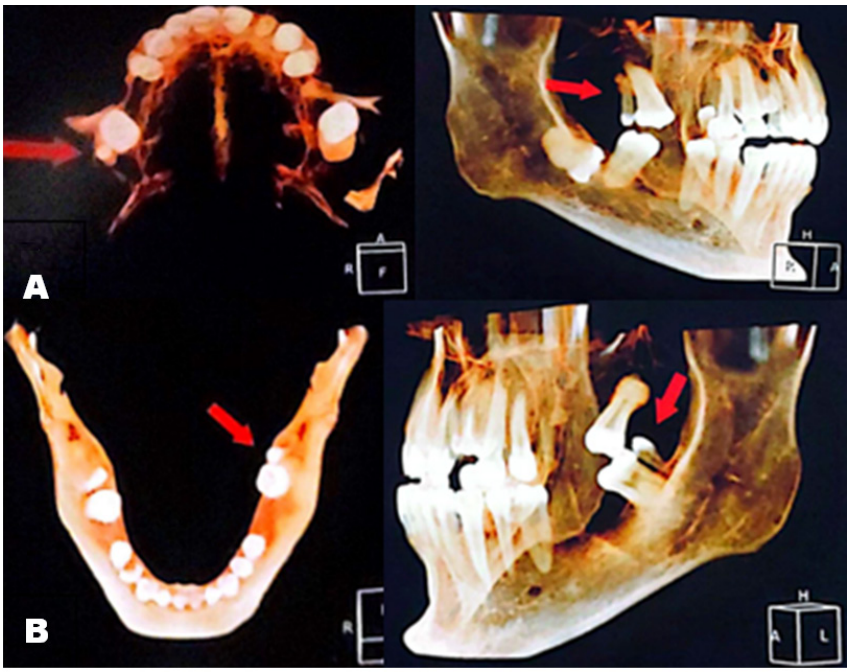
A) Microdontic and rudimentary distomolar, adjacent to tooth 1.8.
B) Microdontic and rudimentary distomolar, adjacent to tooth 3.8.

Figure 3. Cone beam computed tomography (CBCT): panoramic reconstruction



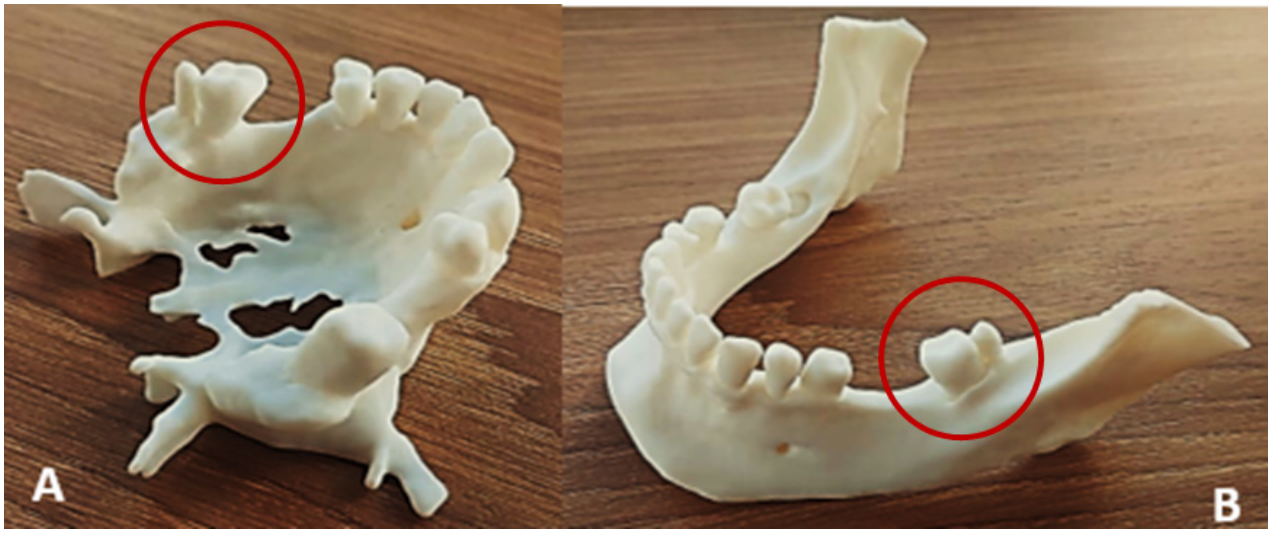
Mesioangulated distomolars associated with teeth 1.8 and 3.8 are observed, indicated by red arrows.

Figure 4. Cone-beam computed tomography (CBCT): tridimensional assessment of the maxilla and mandible



A) Distomolar located distal and buccally to tooth 1.8, observed in axial and sagittal sections. B) Distomolar located distal and lingually to tooth 3.8, observed in axial and sagittal sections.

Figure 5. Tridimensional biomodels



A) Posterior region of the maxilla with a distomolar located distal to tooth 1.8, indicated by a red circle. B) Posterior region of the mandible with a distomolar located distal to tooth 3.8, indicated by a red circle.

DISCUSSION

The present clinical case and the one reported by Rajaram Mohan et al. coincide in the usefulness of cone-beam computed tomography to characterize the morphology of distomolars and to assess possible phenomena of dental fusion (15). However, there are important differences between both reports: while the present case describes rudimentary, erupted, and independent distomolars in a 42-year-old male with maxillomandibular location, Rajaram Mohan et al. documented an impacted molariform double tooth in a 27-year-old female patient. Nevertheless, both reports coincide in considering food packing and dental caries as clinical factors that may justify the proposal of surgical treatment for these fourth molars.

In agreement with the findings of the present case, Zhang et al. (16) and Kose et al. (17) report a low prevalence of distomolars and a higher frequency in male patients. Unlike the epidemiological pattern described by Kose et al., who reported a higher frequency of distomolars in the maxilla (62.16%), the present case shows an erupted bilateral maxillomandibular presence. Likewise, these studies highlight the diagnostic utility of cone-beam computed tomography to assess the anatomical relationship of supernumerary teeth and reduce the risk of periodontal and occlusal complications.

The present report also agrees with the series by Ikeda et al. (18) in describing erupted bilateral posterior hyperdontia in non-syndromic male patients and highlighting the usefulness of cone-beam computed tomography to evaluate complex root anatomies. Unlike Ikeda et al. (18), who documented a maxillary association of distomolar and paramolar with an atavistic molar sequence, the present case reports rudimentary distomolars located in the maxillary and mandibular arches. Nevertheless, both reports consider extraction as a therapeutic alternative given the risk of caries and periodontal involvement associated with food impaction.

The present report shares similarities with the study by Shi et al. (19), in which erupted distomolars were described in male patients in the fourth decade of life, associated with food packing and evaluated by cone-beam computed tomography. However, Shi et al. documented greater anatomical complexity by identifying an impacted fifth molar in addition to the symmetric maxillary fourth molars. In contrast, the present case shows an asymmetric maxillomandibular distribution, with distomolars associated with teeth 1.8 and 3.8. Both reports agree in considering extraction as a therapeutic alternative given the risk of periodontal involvement and dental caries. In the present case, this approach was recommended, but it was not performed.

Finally, the present case and the case reported by Husain et al. (20) agree on the usefulness of cone-beam computed tomography for anatomical assessment and therapeutic planning of distomolars in non-syndromic patients. Husain et al. documented a complex arrangement of maxillary fourth and fifth molars with dental fusion in one female patient, whereas the present case corresponds to erupted and independent distomolars, with maxillomandibular distribution in one male patient. Both reports agree in considering extraction as a possible therapeutic approach in the presence of complications such as regional pressure sensation or recurrent food impaction. In the present case, extraction was proposed as the therapeutic approach; however, the procedure was not ultimately performed.

CONCLUSIONS

The presence of erupted distomolars with maxillary and mandibular location in one non-syndromic patient constitutes a rare clinical finding. Although their initial identification can be performed through conventional clinical and radiographic examination, cone-beam computed tomography (CBCT) allowed a more precise characterization of their morphology, position, and relationship with the third molars, as well as ruling out phenomena of dental fusion and assessing associated radicular and anatomical alterations.

Tridimensional biomodeling complemented the information obtained through CBCT by providing a spatial representation of the structures involved, facilitating the understanding of the case and the planning of the proposed treatment. The integration of clinical evaluation, CBCT, and 3D biomodeling made it possible to establish an accurate diagnosis and to propose an individualized therapeutic approach, supported by the anatomical characteristics observed.

This case demonstrates the value of 3D biomodeling as a complementary tool to CBCT for tangibly representing complex anatomical relationships, supporting patient explanation, and guiding the planning of possible surgical intervention in cases of distomolars with unusual anatomical characteristics.

REFERENCES

1. Jahanimoghadam F, Mohammadi F, Aftabi R. Non-syndromic supernumerary fourth molar: a report of two cases and review of literature. J Oral Health Oral Epidemiol. 2024;13(2):78-84. https://doi.org/10.34172/johoe.2303.1545
2. Estévez Salazar AB. Hallazgo radiográfico de cuarto molar o distomolar supernumerario fusionado a tercer molar superior: reporte de caso [trabajo de titulación]. Ambato: Universidad Regional Autónoma de los Andes; 2020. Disponible en: http://dspace.uniandes.edu.ec/handle/123456789/11780
3. Li X, Gong X, Yu M, Gao X. Clinical features of non-syndromic late developing supernumerary teeth: a sign of the third dentition? BMC Oral Health. 2024;24:397. https://doi.org/10.1186/s12903-024-04155-3
4. Santo MS do Espírito. Dentes supranumerários na região de terceiros molares: uma revisão de literatura [trabajo de conclusión de curso]. Florianópolis: Universidade Federal de Santa Catarina; 2023. Disponible en: https://repositorio.ufsc.br/handle/123456789/252021
5. Nagaveni NB, Umashankar KV. Report of a rare odonto-stomatologic anomaly: maxillary paramolar. Series Clin Med Case Rep Rev. 2024;1(6):1-3. https://doi.org/10.54178/2993-3579.v1i6a2021
6. Lao A, Bi S, Cheng H, Lai T, Huang S, Zhao S. A combination of kissing molars, maxillary bilateral supernumerary teeth and macrodontia: a rare case report. BMC Oral Health. 2020;20:112. https://doi.org/10.1186/s12903-020-01092-9
7. Neville BW, Damm DD, Allen CM, Chi AC. Oral and maxillofacial pathology. 5th ed. St. Louis: Elsevier; 2024.
8. Woo SB. Oral pathology: a comprehensive atlas and text. 3rd ed. Philadelphia: Elsevier; 2024.
9. Khan TT, Erkin M, Ghaus S, Pasha M, Shahnawaz S. Combination of bilateral paramolar and distomolar supernumerary teeth in the maxillary arch: a rare case report. Merit Res J Med Med Sci. 2022;10(6):168-176. https://doi.org/10.5281/zenodo.6712359
10. Ozkan A, Dag H, Altug HA, Sencimen M. Bilateral double maxillary paramolars: a rare case report. J Clin Diagn Res. 2017;11(8):ZD04-ZD05. https://doi.org/10.7860/JCDR/2017/27393.10484
11. Mahto RK, Dixit S, Kafle D, Agarwal A, Bornstein MM, Dulal S. Nonsyndromic bilateral posterior maxillary supernumerary teeth: a report of two cases and review. Case Rep Dent. 2018;2018:5014179. https://doi.org/10.1155/2018/5014179
12. Tominaga K, Sasaki R, Okamoto T. Four erupted supernumerary teeth around the maxillary second molar. BMJ Case Rep. 2021;14(5):e241213. https://doi.org/10.1136/bcr-2020-241213
13. Odell EW. Cawson's essentials of oral pathology and oral medicine. 10th ed. Edinburgh: Elsevier; 2024.
14. Sivapathasundharam B. Shafer's textbook of oral pathology. 10th ed. New Delhi: Elsevier; 2024.
15. Rajaram Mohan K, Pethagounder Thangavelu R, Fenn SM. Impacted molariform distomolar double tooth: a case report. Cureus. 2022;14(4):e23780. https://doi.org/10.7759/cureus.23780
16. Zhang H, Gong X, Xu X, Wang X, Sun Y. Tooth number abnormality: from bench to bedside. Int J Oral Sci. 2023;15:5. https://doi.org/10.1038/s41368-022-00208-x
17. Kose MN, Ararat E. Prevalence and clinical significance of distomolar and paramolar teeth. BMC Oral Health. 2026;26:996. https://doi.org/10.1186/s12903-026-08299-2
18. Ikeda Y, Ogawa A, Takahashi N, Yamada H. Non-syndromic bilateral posterior maxillary supernumerary teeth: rare combination of paramolar and distomolar. Bull Tokyo Dent Coll. 2026;67(1):11-15. https://doi.org/10.2209/tdcpublication.2025-0016
19. Shi J, Bi Y, Wu Z. Symmetrically erupted upper fourth molars and an impacted fifth molar: a case report. Case Rep Dent. 2025;2025:3575942. https://doi.org/10.1155/crid/3575942
20. Al-Haj Husain A, Schönegg D, Bosshard FA, Valdec S. Bilateral supernumerary maxillary fourth and fifth molars: a clinical case report and literature review. Imaging Sci Dent. 2022;52(4):429-434. https://doi.org/10.5624/isd.20220124

FUNDING

No funding.

CONFLICT OF INTEREST

Does not exist.

AUTHORSHIP CONTRIBUTIONS

Conceptualization: Ruth Shirley Lavadenz Pérez, William José Arrazola Pozo, Verónica Quiñones-Lazcano.
Methodology: Ruth Shirley Lavadenz Pérez, William José Arrazola Pozo, Verónica Quiñones-Lazcano.
Research: Ruth Shirley Lavadenz Pérez, William José Arrazola Pozo, and Verónica Quiñones-Lazcano.
Writing – original draft: Ruth Shirley Lavadenz Pérez, William José Arrazola Pozo, and Verónica Quiñones-Lazcano.
Writing – review and editing: Ruth Shirley Lavadenz Pérez, William José Arrazola Pozo, and Verónica Quiñones-Lazcano.