POLICY STATEMENT ON INTRAORAL/PERIORAL PIERCING
AND TONGUE SPLITTING

Background:
MDA current policy on intraoral/perioral piercing is Resolution 10H-01, which was ADA policy at the time. Since adopted by the MDA House this policy was revised by the ADA in 2004 and again in 2012.

The following edits to MDA policy are based on the ADA’s current policy (adopted by the ADA House in October 2012). It is recommended that MDA’s policy be updated.

Resolutions


09. Resolved, that Resolution 10H-01 regarding intraoral/perioral piercing be rescinded and removed from the Association Policy Manual.

VOTE REQUIRED: Majority of delegates present and voting

VOLUNTEER RESOURCE: Dr. Mark Johnston, secretary

STAFF RESOURCE: Mr. Bill Sullivan
Resolution 10H-01: 
Resolved, that the Michigan Dental Association adopts the American Dental Association policy entitled “Statement on Intraoral/Perioral Piercing.”

**ADA Statement on Intraoral/Perioral Piercing**

Piercing is becoming a more prevalent form of body art and self-expression in today’s society. However, oral piercings, which involve the tongue (the most common site), lips, cheeks, uvula or a combination of sites, have been implicated in a number of adverse oral and systemic conditions.

Patients typically undergo piercing procedures without anesthetic. In tongue piercing, for example, a barbell-shaped piece of jewelry typically is placed to transverse the thickness of the tongue at the midline in its anterior one-third using a needle. Initially, a temporary device longer than jewelry of choice is placed to accommodate post-piercing swelling. The free end of the barbell stem then is inserted into the hole in a ventral-dorsal direction. The recipient grasps the free end of the shank between the maxillary and mandibular anterior teeth and screws the ball onto the stem. The barbell also can be placed laterally, with the studs on the dorsolateral lingual surface. In the absence of complications, healing takes four to six weeks.

In lip or cheek piercing, jewelry position (usually a labret) is determined primarily by aesthetics with consideration to where the jewelry will rest intraorally. Once position is determined, a cork is usually placed inside the mouth to support the tissue as it is pierced with a needle. The needle is inserted through the tissue and into the cork backing. The needle then is replaced with the labret stud, and the disc backing is screwed into place. Healing time can range from weeks to months.

Common symptoms following piercing include pain, swelling, infection and increased salivary flow. Potential complications of intraoral and perioral piercings are numerous, although available scientific literature is rather limited and consists mainly of case reports. Possible adverse outcomes secondary to oral piercing include increased salivary flow; gingival injury or recession; damage to teeth, restorations and fixed porcelain prostheses; interference with speech, mastication or deglutition; scar tissue formation; and development of metal hypersensitivities. Because of the tongue’s vascular nature, prolonged bleeding can result if vessels are punctured during the piercing procedure. In addition, the technique for inserting tongue jewelry may abrade or fracture anterior dentition, and digital manipulation of the jewelry can significantly increase the potential for infection. Airway obstruction due to pronounced edema or aspiration of jewelry could present a hazard to respiratory or digestive organs. In addition, oral ornaments can compromise dental diagnosis by obscuring anatomy and defects in x-rays. It also has been speculated that galvanic currents from stainless-steel oral jewelry in contact with other intraoral metals could result in pulpal sensitivity.

The National Institutes of Health has identified piercing as a possible vector for bloodborne hepatitis (hepatitis B, C, D and G) transmission. Disease transmission (e.g., hepatitis B, tetanus, localized tuberculosis) has been associated with ear piercing, and cases of endocarditis have been linked to both nose and ear piercing.
Secondary infection from oral piercing can be serious. A recent article in the *British Dental Journal* reported a case of Ludwig’s angina, a rapidly spreading cellulites involving the submandibular, sublingual and submental fascial spaces bilaterally, that manifested four days after the 25-year old patient had her tongue pierced. Intubation was necessary to secure the airway. When antibiotic therapy failed to resolve the condition, surgical intervention was required to remove the barbell-shaped jewelry and decompress the swelling in the floor of the mouth.

Because of its potential for numerous negative sequelae, the ADA opposes the practice of intraoral/perioral piercing.
Council on Scientific Affairs Resolution 54—Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting

Resolved, that the “Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting” (Trans.1998:743; 2000:481; 2004:309) be amended by deletion and addition as presented in Appendix 2 of this annual report.

Policy Statement on Intraoral/Perioral Piercing and Tongue Splitting

Piercing and tongue splitting are forms of body art and self-expression in today’s society. However, oral piercings, which involve the tongue (the most common site),1-3 lips, cheeks, uvula or a combination of sites, and tongue splitting can be associated with a number of adverse oral and systemic conditions.

As with any puncture wound or incision, piercing and tongue splitting can cause pain,3-5 swelling,2-6 and infection.4,5,7 Potential complications of intraoral and perioral piercings specifically are numerous, although available scientific literature is rather limited and consists mainly of case reports. Possible adverse outcomes secondary to oral piercing include increased salivary flow;5,8 gingival injury or recession;2,6,9-13 damage to teeth;1,2,5,6,14 restorations and fixed porcelain prostheses; interference with speech;1,3,4 mastication5,4 or deglutition;4 scar-tissue formation;8 and development of metal hypersensitivities.15,16 Because of the tongue’s vascular nature, prolonged bleeding can result if vessels are punctured during the piercing procedure.17 In addition, the technique for inserting tongue jewelry may abrade or fracture anterior dentition,1,2,5,7,14 and digital manipulation of the jewelry can significantly increase the potential for infection.4-7 Airway obstruction due to pronounced edema2-5 or aspiration of jewelry poses another risk, and aspirated or ingested jewelry could present a hazard to respiratory or digestive organs.3,6 In addition, oral ornaments can compromise dental diagnosis by obscuring anatomy and defects in radiographs. There have been reports of the jewelry becoming embedded in surrounding tissue, requiring surgical removal.6,5 It also has been speculated that galvanic currents from stainless-steel oral jewelry in contact with other intraoral metals could result in pulpal sensitivity.18

Secondary infection from oral piercing can be serious. Piercing has been identified as a possible vector for bloodborne hepatitis (hepatitis B, C, D and G) transmission.19,20 Cases of endocarditis also have been linked to oral piercing.21,22 In addition, the British Dental Journal reported a case of Ludwig’s angina, a rapidly spreading cellulitis involving the submandibular, sublingual and submental fascial spaces bilaterally, that manifested four days after a 25-year-old patient had her tongue pierced.23 Intubation was necessary to secure the airway. When antibiotic therapy failed to resolve the condition, surgical intervention was required to remove the barbell-shaped jewelry and decompress the swelling in the floor of the mouth. In another case, a healthy 19-year-old woman contracted herpes simplex virus, presumably through a recent tongue piercing. The infection progressed to fulminant hepatitis and subsequent death.24

Although reports describing the morbidity and mortality associated with tongue splitting are currently not available in the literature, the risk of complications secondary to surgical procedures (including pain, swelling and infection) is well known. Therefore, the Association recommends that its members discourage patients who request the procedure by educating them of the risks associated with this surgery.

Because of its potential for numerous negative sequelae, the American Dental Association opposes the practice of intraoral/perioral piercing and tongue splitting.
References

New Proposed Policy

ADA Statement on Intraoral/Perioral Piercing and Tongue Splitting

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