Letters to the Editor

Comment (May) – Perhaps the thumb technique wasn’t so bad!

I would like, if I may, to add some personal comments to the excellent editorial on the ‘thumb technique’ in the May issue.

The late and inspirational Bernie Kieser is mentioned and I, no doubt along with all of his past students, remember Bernie quoting these papers purporting to show how restoration overhangs, and other so-called plaque retention factors, led to worsening periodontal conditions, and then showing us radiographs of such overhangs with no bone loss, while elsewhere in the same mouth there was bone loss around teeth which had no restorations! As Bernie used to say, a plaque retention factor is only a problem if the patient can’t clean it; it’s not a plaque retention factor if there is no plaque on it. As you rightly point out, in this respect a lump of calculus is no different from an amalgam overhang but, of course, Bernie was always misquoted in this respect, as you also mention.

Another late, great and inspirational clinician was Bernie’s compatriot Aubrey Sheiham, who died suddenly in 2015; Aubrey was also a notorious challenger of received wisdom and he, in fact, published a study way back in 1971 showing that there were no significant differences in gingivitis at sites with and without restoration overhangs,¹ as did Leon in 1976² and Grasso et al in 1985.¹

I guess I would be looking at trying a lot harder with my bleaching techniques – both inside and outside bleaching, before hastening the destruction of the crown of this vulnerable tooth. Certainly the final crown looks great, but does it improve the longevity of the tooth to iatrogenically remove most of the remaining coronal tooth structure in the name of aesthetics?

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Letter 2

I’m a bit confused over the (I feel) slightly contradictory message from Dental Update May 2018 Volume 45. On page 382 there is a review of a textbook on minimal intervention dentistry – which is something that Dental Update is usually very enthusiastic about and rightly so.

However, there is then an article on ‘A Single Crown on a Maxillary Incisor’. The end result in this article is excellent but surely the article would have benefited from more discussion as to why such an aggressive preparation of the central incisor tooth was carried out? There is a very brief sentence on previous unsuccessful bleaching but no clue as to whether this was internal or external, what materials were used and why the bleaching did not work. There is no radiograph of the tooth, although it is mentioned that ‘incomplete bone consolidation’ of the apical area exists. Does this mean incomplete healing?

I remain unsure as to why a veneer was not feasible, although this is briefly explained. I’m also unsure about the slightly excellent, comprehensive articles on this important subject.

Could I suggest another action that the dental surgeon (or therapist) might take in respect of helping their patients quit? I know that part one ended with the conclusion that sheer will power is insufficient alone to result in a successful quit. However, I am aware of a number of people who have been able to stop smoking merely after reading a book, that of Allen Carr’s Easy Way To Stop Smoking (ISBN 978-0-718-19455-0). I first became aware of this book following a conversation a few years ago with one of my patients, and have recommended it on a number of occasions since (it being part of my smoking cessation toolkit!)

For those unfamiliar with the author, he had previously been a very heavy smoker. He asks that readers continue to smoke as they read through the book, that they take their time, and that, by the end of the book, they will want to give up forever. Hard to believe, I know, but it does work for some (and is worth considering, especially when other methods do not appeal to the patient). Although now deceased, clinics dedicated to his system exist all over the world, with information available via audio, DVD, etc. The book has been translated into at least 36 languages in over 50 countries, so I guess it has helped a number of people.

The ultimate aesthetic challenge in dentistry: a single crown on a maxillary central incisor

(Dent Update 2018; 45: 415–424)

I read this article with a sense of dismay, particularly the sequential photos of the crown preparation, and was forced to wonder whether it would pass the ‘daughter test’. (I have a beautiful 26-year old daughter myself!)

Given the initial extensive treatment the tooth has already received, and that in such a young patient, the long-term prognosis for the tooth is already guarded. If my daughter had such a heavily restored central incisor (and there were no supporting radiographs showing this, but the text mentioned root treatment, apical surgery and a large palatal composite) would I consider turning, what at least appears to be, a whole tooth into a small peg on the basis of an aesthetic problem? Especially as that small peg presumably has a significant hole down the middle of it (where the RCT was done).

I guess I would be looking at trying a lot harder with my bleaching techniques – both inside and outside bleaching, before hastening the destruction of the crown of this vulnerable tooth. Certainly the final crown looks great, but does it improve the longevity of the tooth to iatrogenically remove most of the remaining coronal tooth structure in the name of aesthetics?

Professor Graham R Ogden
Head of Oral & Maxillofacial Clinical Sciences
University of Dundee Dental Hospital and School

The dentist’s role in smoking cessation management parts 1 and 2 (Dent Update 2018; 45: 197-206 and 298-309)

Thank you for publishing these two

References

Philip Ower
Specialist in Periodontics

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odd ‘warm and big smile’ photos at the end but that’s just personal opinion!
Anyone agree or is it just me?

Helen Peppiatt
General Dental Practitioner, Norfolk and Masters student in Advanced General Dental Practice, Birmingham

Author’s Response

Thank you very much for carefully reading the article. I can understand, if bleaching the reported tooth is considered least invasive. However, as mentioned, a preceding bleaching therapy by another dentist did not result in the desired whitening effect, leaving the tooth still darkly discoloured (a bleaching result would also not be stable in the long term). Now you can accept this and just replace the incisal composite or you can discuss together with the patient the remaining options. Of course, all of these will be more invasive. A ceramic veneer would principally be a restorative option, however, with the tooth already being restored with a large palatal composite restoration after root canal treatment, I considered the remaining stiffness of the tooth at least problematic, considerably increasing the risk of static fractures of a potential ceramic veneer. Then, not many options are left and you have to decide: ‘To prepare, or not to prepare (a complete crown), that is the question.’ This is the most invasive approach, but results in a predictable outcome in terms of requested aesthetic appearance as well as restorative success. All aforementioned facts with pros and cons were discussed with the patient who decided in favour of the glass ceramic crown.

Prof Dr Juergen Manhart
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A forehead haematoma with an important diagnosis

Patients with undiagnosed bleeding disorders can present with varying clinical features ranging from innocuous bruising to life-threatening haemorrhage. Haemophilia is an X-linked recessive bleeding disorder causing a disruption within the intrinsic clotting pathway. After trauma, patients with Haemophilia experience an increased bleeding time with excessive bleeding into mucosal tissue, muscles and joints, which carries a significant risk of morbidity and mortality. The authors highlight the diagnostic and management actions undertaken for a paediatric patient, in whom Haemophilia A was an incidental finding, who suffered a craniofacial injury.

An 18-month-old child presented with his parents to the Emergency Department following a mechanical fall with a persistent and expanding forehead swelling. Clinically, a 5 x 4 cm firm swelling over the left frontal region was noted (Figure 1). There was no family history of bleeding disorders.

An urgent CT head was requested to rule out intracranial haemorrhage and fractures, which returned as normal (Figure 2). Haematological investigations revealed a factor VIII deficiency (< 0.01) indicating severe Haemophilia A. The haematoma was surgically drained under a general anaesthetic and the patient referred to a tertiary haematology centre for ongoing management.

The severity of Haemophilia is dependent upon the levels of remaining factor VIII and < 1% of the population suffer with severe Haemophilia. The usual presentation time for Haemophilia is during infancy after a traumatic event, as noted in this case. Emphasis should be placed upon obtaining a comprehensive history, examination and focused haematological investigations.

Undiagnosed paediatric cases of Haemophilia A can present to the Oral and Maxillofacial Surgery department with abnormal bleeding following trauma. This stresses the importance of screening appropriate patients to diagnose this lifelong bleeding disorder and liaising with haematologists as necessary.

This case highlights the need for clinical vigilance in a child presenting with an inconsistent injury pattern following a perceived trivial injury. Optimum lifelong management of this patient was ensured.

References

Additional facts on the distance of mandibular posterior teeth to the inferior dental canal

I read with interest the excellent and comprehensive article entitled ‘Trigeminal nerve injuries related to restorative treatment’ by Professor Tara Renton (Dent Update 2018; 45: 522–540). In Table 2, Professor Renton summarizes the findings of several researches that studied the relationship between mandibular premolar apices and the mental foramen, highlighting the close proximity of the mental foramen with the first premolar apex and the second premolar apex.1–3 One example of overextrusion of root canal filling material involving the premolar is shown in Figure 3. My personal experience with the Asian population has shown that, because of the variability in the location of the foramen relative to the apex, there seems to be no ‘absolute safety zone’ in the premolar region if accidental extrusion of endodontic files and materials occurs.4 I share with you the observation of the apex of a second premolar that literally ‘sits’ on top of the inferior dental canal (IDC) just next to the mental canal (Figure 1).

I noticed that Figures 2 and 4 showed overextrusion of filling material involving the first and second molars. However, the morphometric distance between the apices of these teeth and the IDC was not provided in Table 2. I believe it would be good to remind the readers that for the mandibular first molar, although 3.5–6.9 mm is the generally acknowledged range of distance,2,5 this distance in fact can be as little as 1 mm.6 Tilotta-Yasukawa et al reported that the second molar too can be less than 1 mm from the inferior dental canal. This, again, is in contrast with the range of 3.5–4.5 mm distance reported earlier by Denio et al7 and Littner et al.3 The risk of endodontic overextrusion will increase if these teeth have wide apical foramina or when the apical constriction has been destroyed during root canal preparation or by resorption. The loss of bony barrier between the IDC and apices, eg in cases where a pathological lesion such as periapical granuloma is present, will even make it riskier to perform safe root canal treatment.8 In fact, Professor Renton and her team had earlier shown that periapical lesions of mandibular teeth itself can cause trigeminal nerve injuries.9

I hope the additional information is useful.

References
4. Ngeow WC. Is there a “safety zone” in the mandibular premolar region where damage to the mental nerve can be avoided if periapical extrusion occurs? J Can Dent Assoc 2010; 76: a61.

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CPD ANSWERS
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1. C
2. B
3. C
4. B
5. C
6. C
7. C
8. D
9. B
10. B

Carly Marples, DCT2 O&M Surgery
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Letters