Letters to the Editor

PERIOPERATIVE CORTICOSTEROID SUPPLEMENTATION AND DENTAL-ALVEOLAR SURGERY

Sir, I read with interest the above-named article (Dent Update 2003; 30: 316–320). I agree with the author that this issue has always been confusing, not only to the junior staff, but even to those at higher level. It has been a general teaching in our unit that patients who need dental extractions/dento-alveolar surgery are told to double their dosage of steroid the morning of the procedure. However, I have not been able to find much scientific evidence to support this practice. As the authors did mention such a practice in their article but did not recommend it, I would be most grateful if they could confirm whether such empirical practice should be discontinued.

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Sir, I read with interest the above-named article and another one recently by Professor Seymour who touched upon the management of dental patients with corticosteroid. Professor Seymour has cautioned in his article that steroid cover, though overly stated, should be prescribed to patients with Addison’s disease. This fact has not been raised by Key et al., and I believe it is important to differentiate between the two main groups of patients on steroids: those needing it to replace a missing one, like in Addison’s disease, and those taking steroids to treat disease/suppress rejection, etc. It is most probable that patients with Addison’s disease would not be able to respond well to stress at all as they cannot produce any steroid, as compared to the latter group; those having their glands suppressed by long-term steroid usage, but may still be able to respond to stress.

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THE AUTHOR’S REPLY
I would like to thank the two previous correspondents for their comments. Our article highlighted the dilemma confronting practitioners when reviewing the literature on corticosteroid supplementation and aimed to provide a simplified guide to the clinical management of these patients, thus reducing the numbers of unnecessary hospital referrals. Differentiation of patients into primary hypoadrenalism and suppression of the hypothalamic-pituitary-adrenal axis due to long-term exogenous corticosteroid supplementation may be a valid argument, but it is not generally highlighted in the literature. Primary hypoadrenalism is a rare condition (0.8 cases per 100,000 population), whereas exogenous corticosteroid supplementation is commonplace. It would, however, seem logical to administer corticosteroids to patients with Addison’s disease.

The use of an intravenous route for corticosteroid administration is recommended as the delay in absorption from intramuscular deposition may be as much as 8–10 hours. Absorption from the oral route via the gastrointestinal tract can be rapid. However, the stress of anticipating a dental operation may delay absorption and lead to unpredictable levels of blood corticosteroid. Doubling the dosage of steroid on the morning of the procedure has been suggested, but there appears to be little scientific evidence to support this practice and it is not included in the present guidelines.

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DIRECT CORE MATERIALS
Sir, Wilson, Fisher and Bartlett (Dent Update 2003; 30: 362–368) reviewed materials available for use in direct placement cores. A significant omission from their table of material properties is Modulus of Elasticity. The ability of a material to resist deformation under load repeatedly is, arguably, as important a consideration for core materials as the compressive, flexural or tensile strengths but was not discussed in the paper.

In my opinion, the use of ultimate strength values (at the point where the material breaks in a laboratory test) could be misleading. Composite materials are relatively flexible and...