

Letters to the Editor

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Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

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TONGUE HOOK

Sir, we would like to present the case of a 15-year-old girl who presented in the outpatient clinic of the oral and maxillofacial surgery department with her tongue hooked palatally to the orthodontic appliance in the region of the upper left six (Fig. 1). She had been in this painful condition for almost two and a half hours and she was not able to release her tongue from the orthodontic appliance. We were able to release her tongue from the hook after injecting some local anaesthetic (Ultracain D-S forte) into it. The palatally impacted upper right canine was surgically exposed earlier.

Orthodontists should be aware of the potential traps of orthodontic appliances, especially those narrowing the tongue space. If the tongue space is narrowed, orthodontic appliances should be simply covered by small pieces of orthodontic wax. That way the patient may be spared painful eventualities.



Fig. 1 Patient with tongue hooked on orthodontic appliance

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COMPOSITE AND WIRE BRIDGES

Sir, a patient recently presented with an unusual bridge construction I thought would be of interest to my colleagues.

The patient reports having bridges originally placed 15 years ago. The most recent replacement was four years ago in Estonia and the patient noticed the bridges fracturing two months post placement.

On examination the patient had three fixed-fixed bridges replacing both mandibular second premolars and the maxillary left first premolar. The bridge construction was not ceramic or metal but appeared to be of a 'composite and wire' design. The composite appeared to be placed in a direct technique, simply being placed freehand around a wire. There were numerous fractures of the bridge with sections of the wire being exposed in several places. The pontic design was poor being non-cleansable and having significant plaque/calculus deposits and extensive gingivitis. There were several defective margins with significant positive ledges and frank recurrent caries. Periapical radiographs showed extensive caries affecting many of the root treated abutments and variable amounts of horizontal bone loss (Fig. 1).

The patient was informed of the problems and a treatment plan formulated which included dismantling the bridges and assessing the abutment restorability.

'Composite and wire' techniques are commonly used in several areas of dentistry including trauma splints, orthodontic retainers and periodontal splinting. However, 'composite and wire' bridges are something I was not taught in my BDS and after seeing this case I can see why.

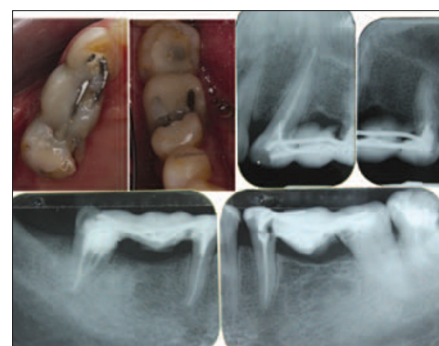


Fig. 1 Extensive caries affecting many root treated abutments and variable amounts of horizontal bone loss

Composite bridges are indeed an increasingly accepted treatment option; however, these are constructed from fibre-reinforced composite (laboratory composite reinforced with glass fibre). However, they suffer from several problems, including fracture (minor or catastrophic), debonding and discolouration, and currently lack the evidence base to act as permanent restorations.¹

There are many problems with the 'direct composite and wire bridge' design including: the difficulties in forming a hygienic, well-shaped pontic, the disparities in the flexural strength and lack of stable bonding between the metal wire and composite resin leading to poor fatigue resistance.

There has been much discussion in the *BDJ* recently regarding the immigration of EEA dentists and although this is only a single case, it perhaps illustrates some of the concerns regarding the differences in teaching across the member states.

R. Holliday, Newcastle

1. van Heumen C C, Kreulen C M, Creugers N H. Clinical studies of fiber-reinforced resin-bonded fixed partial dentures: a systematic review. *Eur J Oral Sci* 2009; 117: 1-6.

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