

Letters to the Editor

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CHOKING IN PERSPECTIVE

Sir, regarding the letter *Malteser compromise* (*BDJ* 2012; 213: 197); although I empathise with the parent of the child who choked on the Malteser this is an anecdote that has no place in a professional journal.

To answer the question 'do we need to give additional warnings of choking hazard during the period of adaption to fixed braces?'; I would answer no and that we should all exercise a little more common sense.

Should the parent not have been present and serious harm had come of the child, would clinical records need to be investigated to determine whether such warnings were given?

Please, let's keep things in perspective.

S. Fletcher, Plymouth

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ADEQUATE KNOWLEDGE

Sir, I write in response to the letter *Inadequate knowledge*.¹ I am unsure why Professor Renton is under the impression that the dental profession has inadequate knowledge in relation to local anaesthetic (LA)-related nerve injuries.

LA-related nerve injuries are rare and thankfully are not complaints that dentists deal with on a regular basis. The process of obtaining consent from patients requires consideration of two important aspects: firstly the probability of a particular risk arising and secondly the seriousness of possible injury. This risk of nerve damage associated with IAN blocks is very low. Professor Renton published an article in *Dental Update* in June 2010: *Prevention of iatrogenic inferior alveolar nerve injuries in relation to dental procedures*.² This article cites the incidence of local

anaesthetic related nerve injury to be '1:588,000 for prilocaine and 1:440,000 for articaine, which is 20-21 times greater than for lidocaine injections'. As lidocaine is the gold standard for IAN blocks in the United Kingdom, the assumed risk in these cases is very low. Also, this article states that recovery takes place at eight weeks in 85-94% of cases. Therefore in the majority of patients that are unfortunate enough to sustain nerve damage following IAN block, the symptoms are insignificant and fade over time. Bearing the above points in mind, I think that the risks associated with IAN block LA are unlikely to change the patient's decision to proceed with treatment, even if explained in full to patients. To expand upon the potential risk of nerve damage to each patient receiving treatment under local anaesthetic would be unnecessarily pedantic.

By comparison the risk of permanent harm associated with spinal nerve blocks, as reported by the Royal College of Anaesthetists, is considered to be one in 23,500 to 50,500 and the risk of paraplegia or death one in 54,500 to one in 141,500.³ The potential consequences associated with this technique are substantially more significant and warrant mentioning.

To conclude, in my opinion the dental profession has adequate knowledge of the incidence and nature of these injuries and this knowledge has been enhanced by the regular publications by Professor Renton on this topic.^{1,2,4-6}

N. O'Connor, Edinburgh

1. Renton R. Inadequate knowledge. *Br Dent J* 2012; 213: 197.
2. Renton T. Prevention of iatrogenic inferior alveolar nerve injuries in relation to dental procedures. *Dent Update* 2010; 37: 350-352, 354-356, 358-360.

3. Information for Patients: The Royal College of Anaesthetists. *Risks associated with your anaesthetic. Section 11: Nerve damage associated with a spinal or epidural injection*. Revised. The Royal College of Anaesthetists, 2009. www.rcoa.ac.uk/system/files/PI-Risk11.pdf.
4. Renton T, Adey-Viscuso D, Meechan J G, Yilmaz Z. Trigeminal nerve injuries in relation to the local anaesthesia in mandibular injections. *Br Dent J* 2010; 209: E15.
5. Renton T, Yilmaz Z. Profiling of patients presenting with posttraumatic neuropathy of the trigeminal nerve. *J Orofac Pain* 2011 Fall; 25: 333-344.
6. Renton T. Minimising and managing nerve injuries in dental surgical procedures. *Faculty Dent J* 2011; 2: 164-171.

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A SENSIBLE PROTOCOL

Sir, Professor Renton makes some very important and pertinent points in her letter published in the *BDJ* (*Inadequate knowledge*; *BDJ* 2012; 213: 197). The direct inferior alveolar nerve block (IANB) has been the corner stone of mandibular anaesthesia in dentistry for over 80 years but we do have a problem with it, as evidenced by the 63 patients with neuropathic injuries (NIs) resulting from IANB injections, seen on her clinic. The morbidity of prolonged anaesthesia or paraesthesia in the lingual nerve or inferior alveolar nerve has been highlighted by Professor Renton and it is sobering that over a dentist's working life, statistics suggest he or she may be responsible for 1-3 permanent NIs in their patients.

My feeling is that we need to look closely at the direct IANB and to see if we can minimise the risk of this injection leading to NI. Professor Renton mentions the increasing use of articaine as a buccal infiltration in the mandible for routine conservation or even extractions and the placement of implant fixtures. This technique obviates the need for an IANB altogether and so should be used wherever possible. There are two