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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OVERSWUNG PENDULUM

Sir, I read the paper by Saund and Dietrich[1] with interest as their findings coincide closely with my personal observations. The original concept behind the NICE guidelines for the removal of impacted third molars was that the post-operative morbidity, particularly in terms of lingual and inferior dental nerve damage, outweighed any advantage of interceptive surgery. It now seems pretty clear that the guidelines have had little effect other than to shift wisdom tooth removal to an older age group.

Since retiring from clinical surgical practice I have been triaging referral letters for my local dental referral management service (someone has to do it!). Naturally many of these referrals request the removal of impacted wisdom teeth and I was immediately struck by the number of patients in the 30-50 age group with distal caries in a second molar in association with a mesioangular, part-erupted wisdom tooth. In most cases the decay is so advanced or inaccessible that root treatment or extraction of the second molar is the only option. This does not seem to be a common problem with horizontal or, of course, distoangular impactions – in which periodontal problems predominate.

Out of personal interest I kept a tally of the reasons for removal of all mesioangular, part-erupted third molars referred over a five-week period last year. The findings were as follows:

- Total = 120
- Second molar distal caries = 76 (63%)
- Other indications = 44 (37%).

It is common for the referring dentist to mention that this is a re-referral and removal of the offending wisdom tooth has been refused some years previously because it did not conform to the NICE guidelines. Occasionally a symptomatic contralateral wisdom tooth has been removed under general anaesthetic, leaving this one *in situ*!

Clearly this is a very selective study but nevertheless it reveals a disturbing trend which has been confirmed more elegantly by Saund and Dietrich. It appears that the NICE guidelines have swung the pendulum much too far away from pro-active surgical intervention, at least with regard to mesioangular, part-erupted impactions, and this is resulting in the premature loss of far too many second molars. It is time for a radical review of the NICE guidelines.

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1. Saund D, Dietrich T. The effects of NICE guidelines on the management of third molar teeth. *Br Dent J* 2012; **213:** 230–231.

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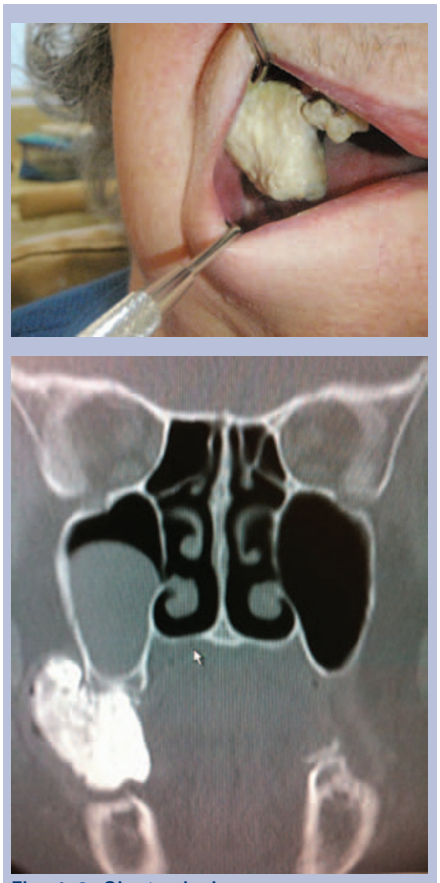
GIANT CALCULUS

Sir, we would like to share with you and your readers an unusual case of a giant calculus mimicking a neoplasm of the maxilla on computed tomography.

An 82-year-old lady presented to her local emergency department with facial injuries which she sustained following a fall at home. Plane radiographs revealed no fractures, but a suspicious radiopacity of her right maxilla was seen. A CT was arranged and the report described an exophytic dense ossification in the right maxilla representing a neoplastic lesion (Figs 1-2). An urgent referral to the Oral & Maxillofacial Unit was made. On clinical examination a giant calculus in the upper right quadrant was identified. The calculus and associated teeth were removed and the patient discharged.



Figs 1–2 Giant calculus

Intraoral examination is important in the assessment of maxillofacial trauma, and in this case may have prevented further unnecessary investigations.

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POST PLACEMENT

Sir, a 29-year-old woman was referred to her local oral surgery department for the extraction of her lower right six due to it being extensively broken down and