

Letters to the Editor

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LETTERS

FLAPLESS SECTIONING

Sir, teeth requiring surgical extractions are commonplace in the dental surgery. Extracting teeth via sectioning of the crown and roots is a well-recognised surgical technique.¹ This method frequently requires buccal bone removal to identify the root bifurcation in order for the tooth to be sectioned in an upwards direction. However, bone removal can delay healing and cause an increased risk of postoperative complications.^{2,3}

An alternative and more conservative approach is to use the pulp chamber which is exposed following sectioning of the crown of the tooth with a fissure bur (Figs 1-2). Removal of the contents of the pulp chamber will help to identify the position of the root canals. This axial view of the root anatomy of the tooth can then be used to determine the location and angulation of the bucco-lingual cut needed to accurately section the roots (Fig. 3). Starting from within the tooth, a surgical fissure bur can precisely section the tooth downwards to separate the roots for elevation and delivery (Figs 4-5). Third molars may require a mucoperiosteal flap to be raised in order to visualise root sectioning whereas in general this described technique should enable flapless sectioning to be performed. We believe that this method is a quick and easy approach for the surgical removal of teeth, which avoids further buccal bone removal and improves accuracy in root sectioning. This technique also enables the conservation of buccal bone and therefore minimises postoperative pain and swelling.

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Figs 1-2 The pulp chamber exposed following sectioning of the crown of the tooth with a fissure bur



Fig. 3 This axial view of the root anatomy of the tooth can be used to determine the location and angulation of the bucco-lingual cut needed to accurately section the roots



Figs 4-5 A surgical fissure bur can accurately section the tooth downwards to separate the roots for elevation and delivery

1. Farish S E, Bouloux G F. General technique of third molar removal. *Oral Maxillofac Surg Clin North Am* 2007; **19**: 23-43.
2. Figueiredo R, Valmaseda-Castellón E, Berini-Aytés L, Gay-Escoda C. Incidence and clinical features of delayed-onset infections after extraction of lower third molars. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2005; **99**: 265-269.
3. Marciani R D. Third molar removal: an overview of indications, imaging, evaluation, and assessment of risk. *Oral Maxillofac Surg Clin North Am* 2007; **19**: 1-13.

DOI: 10.1038/sj.bdj.2013486

WRONG MESSAGE

Sir, we write with reference to the recent paper by Dr Tolstunov¹ and feel drawn to suggest that the inclusion of this study in the research section of the journal may have conveyed the wrong message. This cross arch study may be of some merit but the absence of statistical analysis raises questions. When statistical analysis is attempted on the data presented, these questions are answered in that the study is too small (low powered) to generate meaningful statistical results. The impressive difference in the dry socket rates observed between the experimental 22% and control 78% has in fact a high probability of having happened by chance. To shed further light on the intriguing question, 'to irrigate a post extraction socket or not irrigate', a much larger study would be required with perhaps five times the number of subjects contained in this study. It therefore could be a little premature to change practice on the strength of this present pilot study alone.

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1. Tolstunov L. Influence of immediate post-extraction socket irrigation on development of alveolar osteitis after mandibular third molar removal: a prospective split-mouth study, preliminary report. *Br Dent J* 2012; **213**: 597-601.

DOI: 10.1038/sj.bdj.2013.487