procedures they are comfortable with irrespective of single or dual registration. Curriculum specifications cannot be prescriptive in nature for any surgeon whether singly or doubly qualified.

Many oral surgeons carry out extended competencies despite having had very limited formal training availability since 1984 (none outside of AACOMS). This lack of training opportunities is an issue and BAOS fully endorses the urgent setting up of training programmes to address this.

BAOS recognises the value of this paper in highlighting the need to increase competency based postgraduate training opportunities in oral surgery that will ensure those gaining a CCST will be appropriately trained to sustain the valuable workforce that will be required in the future.

R. Bunyan
President BAOS

1. The European Primary and Specialist Dental Qualifications Regulations 1998.
2. PMETB report on training in OMFS. paras 106, 112 and 115.

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INAPPROPRIATE REFERRALS

Sir, despite the NICE guidance on the removal of impacted wisdom teeth laid out ten years ago we are still receiving a large volume of inappropriate referrals for the removal of wisdom teeth. An audit of referral letters was carried out and new referral guidelines disseminated which resulted in an overall improvement in the standard of the referrals received by our Oral and Maxillofacial Surgery (OMFS) department.

However, there still remains a large number of patients referred that do not comply with NICE guidelines. As a reminder, 'the routine practice of prophylactic removal of pathology-free impacted third molars should be discontinued by the NHS'.[1] Surgical removal should only be embarked upon in patients with evidence of pathology. Such pathologies include:

1. Two or more episodes of pericornitis
2. Unrestorable caries
3. Non-treatable pulpal or periapical pathology
4. Cellulitis
5. Abscess
6. Osteomyelitis
7. Internal or external resorption of the tooth or adjacent teeth
8. Fracture of the tooth
9. Disease of the follicle including a cyst or tumour
10. Tooth or teeth impeding surgery or reconstructive jaw surgery
11. When a tooth is in or within the field of tumour resection.

I urge readers to re-familiarise themselves with this guidance as it is imperative that clinicians refer only those patients with a recognised clinical treatment need. Compliance with this should help to reduce the numbers of patients on OMFS out-patient and surgical waiting lists, avoid patient confusion relating to wisdom tooth extraction and maintain a high standard of evidence-based clinical practice.

R. O'Brien
London

1. National Institute for Clinical Excellence. Guidance on the Removal of Wisdom Teeth – Technology Appraisal Guidance No 1, March 2000. http://www.nice.org.uk/nice-web/Embcat.asp?page=oldsite/appraisals/wis_guide.htm

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RETAINED TOOTH FRAGMENT

Sir, we recently encountered this case and wish to share the findings with your readers.

A 46-year-old man, who was fit and well, presented to the emergency department complaining of a swelling of the left side of the lower lip (mucosal aspect), which had been present for three months. It was gradually increasing in size, sometimes painful and occasionally infected. Three months ago he was involved in a motorcycle accident in Greece in which his upper and lower lips were lacerated and also several of the upper and lower anterior teeth were fractured. His lips were sutured in Greece. Upon return to the UK he saw his GDP on numerous occasions for the extraction of necessary teeth and construction of dentures. The patient mentioned about the lower lip swelling but was reassured that it was probably a traumatic extravasation mucocele. He then consulted his GMP who said that the swelling was probably due to his dentures. The patient then resorted to attending the emergency department as above and on examination a firm lower lip mass, 0.5 cm in length, was identified, which was not currently infected. A lower lip soft tissue lateral radiograph was taken which shows a piece of tooth embedded in the substance of the lower lip (Fig. 1). The plan is for removal of this tooth fragment, under a local anaesthetic, via a trans-mucosal approach.

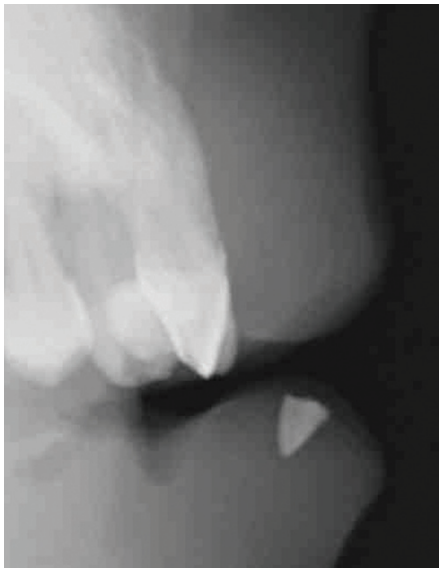

Fig. 1 Radiograph showing a piece of tooth embedded in the lower lip

This case demonstrates the value of taking a social and recreational history and also demonstrates the utility of soft tissue radiographic views in confirming the diagnosis, which have been recommended in such cases.[1]

In such cases, tooth fragments will most commonly be found in the lips (as opposed to other sites of the oral cavity); rarely, such fragments will spontaneously erupt from the mucosa[2] but the usual recommendation is that such fragments should be removed to prevent any undesirable foreign-body reactions and scarring.[1]

P. Gill
K. Fleming
By email

1. da Silva A C, de Moraes M, Bastos E G, Moreira R W, Passeri L A. Tooth fragment embedded in the lower lip after dental trauma: case reports. *Dent Traumatol* 2005; **21:** 115-120.
2. Roth J S, Walczyk J S. Occult tooth fragments spontaneously extruded after six months. *Cutis* 1994; **54:** 253-254.

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SUFFICIENT RETENTION

Sir, a 9-year-old boy who was undergoing orthodontic treatment with a