

# Letters to the Editor

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LETTERS

## WHAT LIES BENEATH

Sir, a 29-year-old male went to see his usual dentist one morning after discovering a large left sided facial swelling on awakening. He had a history of toothache of a throbbing nature from the lower left quadrant of his jaw which had been affecting him for the past three days.

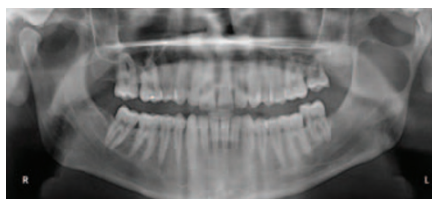
His past dental history demonstrated him to be a regular attendee at his dental practice undergoing routine check-ups every six months. His oral hygiene was found to be remarkable on previous visits and no signs of caries or periodontal disease had previously been noted. His dental records indicated previous radiographs were last taken over four years ago.

Extra-oral examination revealed a firm, tender swelling in the pre-auricular region of the left side of his face and mouth opening was found to be limited to approximately 13 mm. Tooth 37 was found to be significantly tender on percussion. No obvious caries was noted clinically and no soft tissue swelling could be palpated intra-orally. His airway was not compromised at this time.

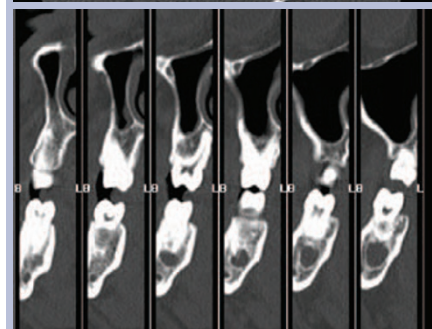
An orthopantomogram radiograph was taken showing a large, well defined unilocular radiolucency within the left ascending ramus of the mandible. Tooth 37 was also found to have mesial caries present with evidence of periapical pathology. This tooth further appeared to be displaced superiorly above the occlusal plane (Fig. 1).

The patient was sent to the nearest maxillofacial surgery unit where he was admitted and placed on intravenous antibiotics and analgesia.

A CT Dentascan was taken showing the location and extent of bone loss (Figs 2a-c).



**Fig. 1** Orthopantomogram radiograph showing a large, well defined unilocular radiolucency within the left ascending ramus of the mandible



**Figs 2a-c** CT Dentascan showing the location and extent of bone loss

Extraction of tooth 37 was later carried out under general anaesthetic, as well as marsupialisation and a soft tissue biopsy of the lesion. Histopathology results revealed that of a radicular cyst. The patient has since undergone continuous decompression of the cystic cavity. He has made good post-operative progress.

In this case, more recent radiographs may have picked up signs of early caries or dental pathology. General dental practitioners should ensure appropriate radiographic recall in all patients, including those that are asymptomatic and who may clinically appear dentally fit. Such radiographs might be in the form of bitewings which can reveal early dental caries allowing for intervention to be carried out, or similarly may indicate the need for further radiographic investigations such as long cone periapicals, a full mouth orthopantomogram or CT scan.

A. Puri

Middlesbrough

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## LACKING FOUNDATION

Sir, having specialised in periodontics for the last 28 years, during that time, like most periodontists, I have either been trying to create recession as the pockets heal or, rather less frequently, correct its outcome! We may be the one discipline in dentistry which welcomes recession in difficult financial times!

The paper regarding the origins and management of gingival recession, in a recent issue (*BDJ* 2011; 211: 251-254) by Patel *et al.*, provides a welcome reminder of this much misunderstood topic, but in my opinion fails to stress one fundamental point.