Letters to the Editor

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LETTERS

OUTWITH UTOPIA

Sir, I was delighted to read Professor Renton's excellent paper on coronectomy (*BDJ* 2012; 212: 323–326). In it, she emphasised the invaluable aid of cone beam computed tomography (CBCT) in accurately assessing third molars which appeared to be high risk on an OPT radiograph. I work in an excellent primary care oral surgery service and consider coronectomy an indispensable part of my armamentarium when treating patients with high risk third molars (as shown in the OPT, Fig. 1). I follow Professor Renton's method for carrying out the surgery but do not have access to CBCT. Even if I did, scanning these patients would simply not be financially viable. Local referral for CBCT is not an option either. I therefore elect to coronect these teeth purely from the radiographic appearance subject to their roots not being mobilised during the surgical procedure (as advocated by Professor Renton). I am aware this is a compromise but feel that it is in the patients' best interest to do so rather than putting them at unnecessary risk of a life-long dysaesthesia. In our rapidly changing oral surgery environment of increasing volumes of work (quite correctly) being carried out in primary care, I expect coronectomies without CBCT will become

Fig. 1 OPT showing a high risk third molar

more commonplace. I would be very interested to hear Professor Renton's views on this – in particular, whether she feels this is acceptable practice outwith the Utopian world of the teaching hospital?

R. Hierons
Darlington

Professor Tara Renton responds: May I thank Dr Hierons for her positive feedback regarding this technique paper on coronectomy. As a fellow oral surgery specialist who also works in both primary and secondary care I understand the potential issues regarding access to CBCT for thorough assessment of healthy patients with high risk vital third molars (or any other high risk vital tooth) for proposed coronectomy surgery.

However, since the original paper by this author in 2005 the development and evidence for CBCT assessment in these cases is indisputable. Without the CBCT assessment, 98% of cases undergoing coronectomy based on plain films alone are undergoing inappropriate coronectomy treatment rather than extraction (as it is well evidenced that only 2% of cases are at risk of permanent inferior alveolar nerve injury). Even using CBCT for assessment we still 'over-coronectomy' patients in approximately 5–10% of cases.

Thus with most dental schools and many private implant clinics having available CBCT I would highly recommend referring patients for this service on the NHS. Where accessibility to CBCT is an issue the NHS commissioners must be made aware and suitable provision of the service implemented.

In addition if the high risk tooth in a

tooth requires removal (as coronectomy is contraindicated) then again this CBCT service is essential to minimise morbidity and optimise patient care.

I do hope that this attends to Dr Hierons' concerns.

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RELIES ON EXPERIENCE

Sir, I write in response to the paper by Renton (*BDJ* 2012; 212: 323–326) on the topic of coronectomy. There is a resurgence of interest in this technique and two teams at GKT Dental Institute are proponents of the idea. The relevance of coronectomy is that it seems to reduce the risk of inferior dental nerve (IDN) injury to near zero and although potentially important clinically the main reverberation lies in the medico-legal arena. Already expert reports are claiming this technique is the treatment of choice for high-risk third molars (with roots that cross the IDN). Professor Renton is very knowledgeable on the topic of coronectomy and her article points out how very little has been written on the topic and even less scientific analysis undertaken to validate the technique and its use with CBCT. The current information on the appropriate use of coronectomy and CBCT really relies on experience and seems insufficient to form a balanced medico-legal argument. A national prospective randomised trial has been designed that should answer these questions and clearly establish what surgical technique should be used and when. Only then will the true place of coronectomy in a surgeon's armamentarium be known.

M. McGurk
By email

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