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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LETTERS

TREATING THE WHOLE PATIENT

Sir, I recently attended a six-week, half-day course in Leeds aimed at creating a new generation of patients empowered to take action of their healthcare needs in partnership with their healthcare professionals (the Expert Patients Programme – EPP) and must recommend it.

It is a lay-led, self-management course for people with long-term health conditions to take an active role in the management of their lives. It covers pain reduction, improved use of medication, managing common symptoms, using your mind, exercise, communication, healthy eating, making treatment decisions and making your wishes known and planning for the future ie advance directives for healthcare – fears and reality.

I am now a certified expert patient and self-manager, and wholeheartedly encourage those practitioners and/or patients living with a long-term health condition to sign up. There is no fee and the free textbook after the course is invaluable. All transport/childcare/healthcare etc can be claimed back in full.

As dentists, we are interested in treating the whole patient and understand the impact that chronic medical conditions can have on our patients' oral needs. Conversely, it may help patients with chronic oro-facial conditions eg pain, ulcers, cancer, to cope better long term, reducing the need for surgery visits and medication.

The EPP originates in the USA and since 2004 has also led a coalition of organisations across the NHS and voluntary sector to develop Stepping Stones to Quality (SS2Q) as a straightforward and practical assurance frame-

work. It is a non-profit organisation and works in partnership with other providers across the NHS, voluntary sector and social care to ensure equitable provision of lay-led self-management across England to all people living with long-term conditions.

Nobody wants to have a long-term illness but if we do, we can learn to live the healthiest and fullest life possible. Dentists can be part of this holistic healthcare. (Contact on: tel: 0113 843 4548; email: epp.account@nhsleeds.nhs.uk.)

H. Tawfik

Leeds

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SCANT EVIDENCE

Sir, I agree with Dr Ghaeminia's commentary on *Coronectomy may be a way of managing impacted third molars* and consider it to be essential reading.¹

I am concerned coronectomy that can be undertaken by all is possibly being promoted as an alternative to extraction of third molars with scant evidence of patient benefit. NICE guidelines stipulate those impacted third molars suitable for extraction in the UK yet there is no mention of them in the published papers.

Following a coronectomy of an impacted third molar that satisfied NICE criteria for its extraction, would it be deemed a failure of the duty of care if the tooth remnants later became symptomatic? Would the surgery be considered inadequate² should a patient suffer inferior dental (ID) nerve damage from the coronectomy surgical technique (undertaken to prevent it)? Should a root that is unnoticed to have been inadvertently loosened in the procedure later become symptomatic

soon after the coronectomy also be a failure of the duty of care?

Cone beam CT investigation has been suggested as essential to confirm the third molar root relation to an 'at risk inferior dental nerve'³ prior to coronectomy. Does this radiation hazard negate any benefit from protection to the ID nerve by the technique? What of the risks to the lingual nerve from the surgical technique? Importantly, should research using the technique be submitted for scrutiny by an ethics committee?

G. D. Wood

By email

1. Ghaeminia H. Coronectomy may be a way of managing impacted third molars. *Evid Based Dent* 2013; **14**: 57–58.
2. Gleeson C F, Patel V, Kwok J, Sproat C. Coronectomy practice. Paper 1. Technique and trouble-shooting. *Br J Oral Maxillofac Surg* 2012; **50**: 739–744.
3. Renton T. Notes on coronectomy. *Br Dent J* 2012; **212**: 323–326.

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ANTICOAGULANT UPDATE

Sir, anticoagulation therapy produces an increased risk of bleeding. The common anticoagulant is the coumarin warfarin – a vitamin K antagonist (VKA). Anticoagulants that may replace warfarin are new oral anticoagulants (NOACs) and include dabigatran etexilate (NICE recommended) and rivaroxaban (US Food and Drug Administration approved).^{1,2} Dabigatran and rivaroxaban are quickly absorbed and, in the event of excessive anticoagulant activity, discontinuing the drug is usually sufficient.

Guidelines for dental surgery in patients on NOACs have recently been published in the *BDJ* and elsewhere.^{3,4} The guidance is similar to that recommended for patients on treatment with

other agents producing a bleeding tendency, and suggests reducing trauma, restricting tooth extraction to a maximum of four teeth at any single visit, and using local haemostasis (sutures, packs and pressure). For VKAs, the standard advice on pre-operative checking of the INR within 24 hours to ensure a level of <4 is advised. No pre-operative blood testing or dose adjustment is recommended for NOACs. Dentists should seek advice from a senior dental or medical colleague in any patients with another clotting defect, recently placed stent, liver or kidney functional impairment, alcohol problems and in patients under treatment with cytotoxic agents.

The anticoagulant effect can if necessary be reversed in emergency situations when VKAs are used, using vitamin K, fresh-frozen plasma, prothrombin complex concentrate, or recombinant factor VIIa. However, no antagonists have been available thus far for NOACs. Compared with VKAs, the NOACs have a shorter half life and shorter duration of anticoagulant effect. If reversal of NOACs is essential, haemodialysis has been recommended to eliminate dabigatran and there is some evidence that coagulation factor concentrates may be effective.⁵⁻⁷ Now there is new evidence that an antibody fragment which binds dabigatran (aDabi-Fab) can reverse its anticoagulant effects⁸ and, if substantiated, this may prove a major advance for the emergency reversal of dabigatran.

C. Scully
By email

1. Khoo C W, Tay K H, Shantsila E, Lip G Y H. Novel oral anticoagulants. *Int J Clin Pract* 2009; **63**: 630–641.
2. Griffiths M J, Scully C. New anticoagulants. *Br Dent J* 2012; **213**: 96.
3. Sime G. Dental management of patients taking oral anticoagulant drugs. April 2012. Available online at www.abaoms.org.uk/docs/Dental_management_anticoagulants.doc (accessed July 2013).
4. Kerr R, Ogden G, Sime G. Anticoagulant guidelines. *Br Dent J* 2013; **214**: 430.
5. van Ryn J, Stangier J, Haertter S *et al*. Dabigatran etexilate – a novel, reversible, oral direct thrombin inhibitor: interpretation of coagulation assays and reversal of anticoagulant activity. *Thromb Haemost* 2010; **103**: 1116–1127.
6. Zhou W, Schwarting S, Illanes S *et al*. Hemostatic therapy in experimental intracerebral hemorrhage associated with the direct thrombin inhibitor dabigatran. *Stroke* 2011; **42**: 3594–3599.
7. Pragst I, Zeitler S H, Doerr B *et al*. Reversal of dabigatran anticoagulation by prothrombin complex concentrate (Beriplex P/N) in a rabbit model. *J*

Thromb Haemost 2012; **10**: 1841–1848.

8. Schiele F, van Ryn J, Canada K *et al*. A specific antidote for dabigatran: functional and structural characterization. *Blood* 2013; **121**: 3554–3562.

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BLEEDING SOCKETS

Sir, many emergency department (ED) doctors have their first experience of managing a patient with a dental problem in the middle of the night. Most of the problems are either managed inappropriately or are immediately referred to their registrar or maxillofacial team.¹

Although it isn't the most common problem, bleeding post-dental extraction sockets can be frightening for the patient and the medical team due to the risks of airway compromise² and blood loss.³ Initial treatment in the ED usually involves pressing surgical gauze or a cotton roll into the socket with pressure applied by the patient biting on it. If this fails then the gum is anaesthetised and a horizontal mattress suture placed. These tasks are more difficult for molar sockets and especially in a distressed patient, when there is inadequate equipment and poor visualisation of the site, as often encountered by a junior doctor in the ED.

I have developed an instrument which has been successfully used on a number of occasions, avoiding more aggressive interventions. By using a small piece of Surgicel (haemostatic cellulose⁴) wrapped around a Toothette (a pink sponge on a stick used to provide moisture to patients who are unable to swallow), the haemostatic matrix can be delivered directly to a bleeding socket as it clings well to the sponge (Fig. 1). The sponge itself can then be easily bitten down on by the patient and moulds to the socket, in contrast to the uncomfortable bulkiness of gauze. An additional advantage of the Toothette is that it can be safely placed in the wound by the patient or clinician with the plastic handle held firmly in the adjacent teeth or lips to ensure the haemostatic agent is kept in place. This is an improvement of a previous design where Surgicel was wrapped around a cotton roll and maintained in the wound with some difficulty. Both products are cheap and readily available in EDs, and when used together

Fig. 1 A Toothette with a the Surgicel in place

provide an effective tool for stopping post-dental extraction haemorrhage.

D. McDonnell
Plymouth

1. Patel K K, Driscoll P. Dental knowledge of accident and emergency senior house officers. *Emerg Med J* 2002; **19**: 539–541.
2. Funayama M, Kumagai T, Saito K, Watanabe T. Asphyxial death caused by postextraction hematoma. *Am J Forensic Med Pathol* 1994; **15**: 87–90.
3. Moghadam H G, Caminiti M F. Life-threatening hemorrhage after extraction of third molars: case report and management protocol. *J Can Dent Assoc* 2002; **68**: 670–674.
4. Suleiman A M. Influence of Surgicel gauze on the incidence of dry socket after wisdom tooth extraction. *East Mediterr Health J* 2006; **12**: 440–445.

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PEJORATIVE STATEMENT

Sir, I was disappointed to read the letter by J. Critchley titled *Severe bilateral click* (BDJ 2013; **214**: 540) containing the pejorative statement 'As we often hear, her migraines began following the removal of all four first premolars and fixed orthodontics in her mid-teens'.

The reality is of course 'As we often hear, there is no evidence that extraction of first premolar teeth as part of orthodontic treatment results in TMD'. Silence is deafening.

G. McIntyre
Dundee

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PROOFLESS PUDDING

Sir, in response to the letter from C. Marks entitled *Grossly deformed bodies* (BDJ 2013; **214**: 433), we would like to present our thoughts as StRs in periodontology.

Marks writes, 'The causal link for this self-inflicted disease seems perfectly obvious: poor diet and oral hygiene.' This appears to be a rather gross and unfair generalisation of this group of patients without any evidence base whatsoever. Added to this, the statement 'anyone capable of allowing their body to become so grossly deformed is