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

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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

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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

not concerned with their health' needs to be approached with due care and appropriate understanding of human physiology – I'm sure we may all have come across obese or overweight individuals who may not necessarily agree with such generalised statements.

As your keen readers would have spotted in issue 10 (214: 489), the British Society of Periodontology is embarking upon a large campaign to raise awareness of periodontal diseases for both clinicians and patients, with particular emphasis on the systemic links. A recent joint workshop between leading world-renowned clinicians and researchers of the European Federation of Periodontology and the American Academy of Periodontology evaluated the entire evidence base in a systematic way (see www.efp.org for a comprehensive summary).

The *association* is indeed modest, with an Odds Ratio of 1.81,¹ but the biological plausibility is valid – obese patients are at a heightened constant state of systemic inflammation as well as at a high risk of insulin resistance, both of which we know can impact host immune responses hence its association with periodontal disease.²

When researchers started noticing a link between smoking and periodontal diseases,³ the association was put down to the assumption of poor oral hygiene, just as suggested here by C. Marks. Well-conducted research by Bergström⁴ finally proved smoking as its own risk factor, and the rest, as they say, is history.

Therefore, may we suggest to our colleagues living in this world of evidence-based medicine and dentistry, that we allow our dedicated researchers to do what they do best, and await for further definitive research to give clinicians the fully-informed guidance we need on the management of periodontitis in overweight and obese patients.

M. Tank, O. Patel, S. Boghani, A. Al-Omar
London

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BIZARRE METAL SPLINT

Sir, I recently saw a 64-year-old male patient who presented with pain from the lower left quadrant and requested an extraction of a retained root in this region.

On intraoral examination, to my amazement there was a bizarre metal splint covering all the teeth in both the upper and lower arches (Figs 1–2). This had been in place for over a year, as confirmed by the patient and judging by the amount of calculus visible.

The splints were constructed by the

Figs 1–2 An engineer's home-made 'precious splint'

patient, a 'former engineer who was quite good with his hands'. He claimed the splints had helped to stabilise his mobile teeth, enabling him to chew food much better.

The retained root was not visible in the oral cavity, but an OPG X-ray revealed a retained root in the region of the 36 and the splints firmly secured in place (Fig. 3).

The irony of it all was that the patient

Fig. 3 The OPG revealed a retained root and the splints firmly secured in place

wanted the retained root removed, but his 'precious splint' kept intact at all times. The patient also failed to mention if he had attempted an extraction himself leaving a retained root behind.

We agreed that a hospital referral was in the patient's best interest, in case of any other underlying pathology.

Hopefully the hospital may have persuaded the patient to have the splints removed, which may have resulted in the removal of the underlying teeth, as the splints seemed firmly secured with some sort of strong cement.

The end result may be the provision of a denture after the extraction of the mobile teeth, unless the patient decides to construct a DIY implant himself!

Though homemade devices are rare in the UK this is an example of one such rare case.

V. Egemonye
London

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NOT AN IANB

Sir, I have been successfully using a local anaesthetic (LA) technique introduced to me by Professor Brian Millar (King's Dental Institute, London) which is reliable, predictable and gives far greater patient comfort than inferior alveolar nerve blocks (IANBs). Painless IANBs are not always achievable, quick in onset or capable of achieving profound anaesthesia.¹ There is also the potential for nerve damage independent of the LA used but especially associated with the use of articaine.^{2,3}

Initially, I apply topical anaesthetic gel and give a buccal infiltration alongside the tooth I intend to anaesthetise. After waiting for onset of anaesthesia from the infiltration, I administer 0.1 ml articaine 4% with 1:100,000 adrenaline (Septanest), both mesially and distally of the tooth to be treated,