COMMENT

Letters to the editor

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Dental trauma

Smartphone hazards

Sir, most teenagers are inseparable from their smartphones and dropping one certainly would be a disaster. A 17-year-old female presented for a second opinion complaining of persistent painful symptoms associated with a traumatised upper central incisor.

Clinical examination revealed a repaired incisal edge to 11 with visible fracture lines to the coronal enamel extending toward the root surface. Sensitivity testing was hyper-responsive to both ethyl chloride and electric pulp testing. Digital pressure to the tooth yielded a painful response to lateral forces. Radiographs showed an oblique root fracture in the mid to apical third of the root. A diagnosis was made of complicated crown and root fracture and irreversible pulpitis. The extent of this injury we found to be surprising given the description of the injury by the patient being the result of her rapidly turning her head to engage in conversation and hitting her tooth against the side of the phone being held by her boyfriend.

The tooth was considered to be of poor long-term prognosis but an initial decision was made to attempt root canal therapy to maintain bone and crucially soft tissues over the medium term. Unfortunately, symptoms did not resolve following pulp extirpation and subsequent redressing of the root canal system on multiple occasions. In view of the complexity of the fracture and ongoing symptoms the patient ultimately requested extraction. An immediate denture has been provided with a view to longer term options in the near future.

With the ever increasing use of smartphones in society with the trend for 'selfies' we wonder whether these devices will become a more prevalent factor to be considered in dental trauma.

V. Wilson, S Stone, G. McCracken, Newcastle

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Accidental ice-burn

Sir, we wish to present a case of an 8-year-old boy who presented with his father following extractions of deciduous teeth in general practice the previous day.

Although the extractions had reportedly been simple and straightforward his parents were keen to avoid pain, discomfort and any swelling that might ensue. His mother had suggested he wrap 'some ice in a clear sandwich bag' and place it over the side of his face where the teeth had been removed. Unfortunately, this resulted in a substantial ice-burn to the lip (Fig. 1). The parents were incredibly upset given their good intentions and the subsequent outcome. Conservative advice was given with regards to managing the traumatised area.

The use of ice is not unusual and the principles of managing many soft-tissue injuries revolve around the stalwarts of RICE (Rest, Ice, Compression, Elevation). Injuries following the application of cold in dentistry or oral and maxillofacial surgery could not be identified in reviewing the literature. It would stand to reason that if advising patients to manage swelling with ice, care is taken to warn the patient of potential risks such as direct contact of soft tissue with ice over prolonged periods.

S. Stagnell, G. Burrows, by email

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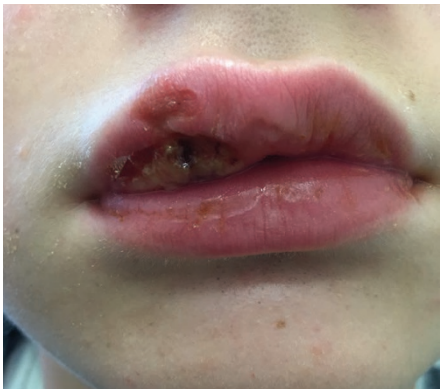

Fig. 1 Burn to the lip caused by ice

Medical emergencies

Trivialising the dentist

Sir, I am very concerned at the article in the *BDJ* on 24 June 2016 (Volume 220, issue 12) by Dr Jevon regarding first aid. The advice given in this paper is clear and concise. Surely patients (and others) should expect a level of response to medical emergency above that of first aid to be provided by a dentist in their dental practice. The dentist has after all completed a degree incorporating training and examination in 'medicine for dentistry'. I feel the article would be more applicable to the staff working in roadside service stations (with no disrespect to their level of medical training intended). I could go on but feel that I may be in need of first aid.

R. Kerr, Exeter

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Orthodontics

Allergic to the orthodontist?

Sir, we write to present an unusual case of a 14-year-old child presenting with angioedema with breathing difficulty during orthodontic treatment, resulting in an emergency hospital admission. This was preceded by three other episodes of angioedema during orthodontic treatment. The patient reported 15 episodes of angioedema in the past year; the majority were not associated with dental treatment.

The patient was seen by the immunology team who diagnosed her with non-allergic idiopathic angioedema, after excluding allergy to latex and local anaesthetic and hereditary angioedema. Idiopathic angioedema is defined as at least three episodes of angioedema within 6 to 12 months without clear aetiology.[1]

The patient was referred to Bristol Dental Hospital by the local orthodontist due to