COMMENT

Letters to the editor

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Referrals

Apicectomy

Sir, as a specialist endodontist I am disappointed when my non-surgical root canal treatments are not successful. But I can accept that a slightly sub-100% success rate is in line with evidence-based literature and because I possess the confidence, skills and equipment to subsequently resolve the issue via a surgical approach. What I find harder to accept is that in the Wessex area where I work, all NHS apicectomy referrals are directed only to specialist oral surgeons.

Perhaps whether apicectomy should be considered endodontics or oral surgery depends on interpretation but good agreement exists across these two disciplines about what constitutes the 'Gold standard' best practice in apicectomy.[1-3] Recently published (in both the endodontic and the oral surgery literature) guidelines state that a modern[1,3] apicectomy requires magnification. It recommends cutting the affected root end with no bevel, curetting out the granulation tissue and preparing a retro cavity with ultrasonic-powered, angled cutting tips. After inspection of the cut root end with micromirrors, a root end filling (not amalgam) is placed. The wound is closed with non-resorbable sutures which ought to be removed at a review appointment after four days. Modern apicectomies performed in this way carry a significantly better chance of success (circa five times) compared to procedures attempted under more traditional, now outdated approaches.[4,5]

I am familiar with this modern protocol and with this armamentarium but in recent weeks I have seen a few patients with symptomatic infected teeth that have histories of prior 'apicectomy'. None of them demonstrated any signs of a retrograde filling yet these 'apicectomies' were performed within the last few months and years by oral surgeons. Inevitably I got to wondering if oral surgeons are aware of/adhere to best practice protocol and whether they are sufficiently equipped to do so?

For what little it is worth I have worked in environments where I have shared space with oral surgeons where there was not a single ultrasonic-powered, angled cutting tip in the oral surgery department.

Since we would all agree that NHS commissioning of apicectomy provision with public money ought to get a service that is being delivered along modern proven approaches, would they then feel it appropriate that specialist endodontists were also approved for apicectomy referrals?

P. Raftery, Havant

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4. Kruse C, Spin-Neto R, Christiansen R, Wenzel A, Kirkevang L L. Periapical bone healing after apicectomy with and without retrograde root filling with Mineral Trioxide Aggregate: A 6-year follow-up of a randomized controlled trial. *J Endod* 2016; **42:** 533–537.
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Impacted canines

Sir, it was with interest and a degree of disappointment that I read the paper by Patel and Taylor (*BDJ* 2016: **221:** 561–564) regarding the late referral of impacted canines.

I have been working part time in general dental practice in Surrey for 35 years. Over the last ten years I have been to numerous postgraduate courses and BDA meetings throughout the region when orthodontic consultants have preached the importance of detecting and not only referring cases of impacted canines but also the benefit of extracting the deciduous canine illustrated by dramatic serial radiographs. I am sure that this is also included in their lectures to F1 (vocational training) courses (indeed in the MOS course that I give each year to an F1 contingent I mention the benefit that can often be had by extraction of the deciduous canine in my section on surgical exposure of ectopic canines!).

I note in the article that much of the blame was placed on specialist orthodontists, probably due to their very long waiting lists. Having said that, I would assume that whilst a child was on the specialist orthodontist's waiting list he or she would still be attending their own general dental practitioner for routine check-ups. In my opinion I consider it is incumbent on a general practitioner who feels that the opportunity for this simple interceptive measure is running out that he or she should carry on and extract the deciduous canine. If they are not sure there is always the opportunity to show the radiograph to a local orthodontic consultant to confirm the treatment plan.

M. Wardle, by email

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Regulation

Bureaucratic behemoth

Sir, I hope you don't mind me contacting you in this way, but I have an issue that I feel is a widespread threat to our profession. I have been a caring, ethical, preventive, minimally invasive practitioner for many years now without having had a single complaint made against me. I have spent thousands of pounds and thousands of hours (!) training with Mike Wise, The American Academy and many other leading clinicians over the years to ensure that my knowledge and skill base is of the highest order and that I am practising up to date evidence-based dentistry. Three years ago after one complaint, from one patient about one tooth and one bad outcome, and initially one set of (admittedly 'old-fashioned' handwritten) records, the GDC launched an