

Letters to the Editor

key - advised - always inform patient about
pulpitis on ~~front~~ anterior canines
may not be able to regenerate.

alendronic acid

Send your letters to the Editor,
British Dental Journal,
64 Wimpole Street,
London
W1G 8YS
E-mail bdj@bda.org

Priority will be given to letters less
than 500 words long.
Authors must sign the letter, which
may be edited for reasons of space.

LETTERS

EXTRACTION VENUE

Sir, I write in response to G. Kini's letter (*BDJ* 2007; 203: 440), regarding consensus on the most appropriate venue for extractions in bisphosphonate patients. I would firstly like to recommend the Australia paper¹ which I have found helpful in the informed consent process for these patients. The paper also suggests that almost 10% of Australian adults have an extraction of a tooth per year. Are UK figures comparable? In Lothian and Borders we have a population of just over one million of whom 6,000 adults received alendronic acid last year. If the Australian figures are comparable then this will equate to 600 extractions in this bisphosphonate group per year. Although our department could conceivably absorb a new patient group of this magnitude we would prefer to keep it in the primary sector and I would put forward three arguments to support this:

1. The extraction protocol is relatively simple
2. The risk of developing BONJ is usually low
3. When BONJ develops it is usually of a less aggressive nature and generally responds to treatment (exceptions exist).

My advice to practitioners considering straightforward extraction in the uncomplicated alendronic case is to: i) improve periodontal health where possible, ii) to provide pre- and post-operative chlorhexidine mouth rinsing and iii) to follow up and observe healing of the socket. If healing is not observed within three to four weeks we would welcome a referral. In a complicated alendronic acid or risendronate case, ie where the drug has been taken for a long period, concurrent use

of corticoid steroids, in the smoker and the elderly, outcomes are less certain and informed consent becomes more difficult. We would in these cases be happy to give case by case guidance or accept management. In the ibandronic acid, pamidronate and zoledronic acid cases a high incidence and severity of BONJ is accepted. Most specialist units would I am sure be keen to be involved with the management of this group at an early stage. The number of patients is relatively small but the severity of possible complications is great.

In summary I would suggest that it falls to Dr Kini and colleagues (who will ultimately be asked to deal with the severe jaw complications associated with bisphosphonate use) to consider the universally accessible literature and to draw up treatment protocols and referral pathways to guide their primary care colleagues at a local or regional level.

I would be happy to share our efforts at developing such a protocol and those interested can request *Bisphos Protocol* from me by emailing nick.malden@lpct.scot.nhs.uk.

N. Malden
By email

1. Mavrokokki T, Cheng A, Stein B, Goss A. Nature and frequency of bisphosphonate-associated osteonecrosis of the jaws in Australia. *J Oral Maxillofac Surg* 2007; 65: 415-423

DOI: 10.1038/bdj.2007.1193

IMPLANTS NO NEED FOR GRAFTING

Sir, in regard to the recent *BDJ* article,¹ I would like to ask if you could put my technique of removing fractured or misplaced, very well integrated dental implants before the authors of the article and all of your readers as well.

First, I detach the overlying mucosa or surrounding gingiva from the implant

neck and keep them away. Then I attach one pole of the electrocautery to the platform or body of the implant while the other pole is attached to the patient's leg or hand. I put the electrocautery on coagulation mode for five seconds. This procedure will cauterise and necrotise the layer of bone which is in close proximity, or integrated to the implant. I then suture the mucosa, prescribe some analgesics and dismiss the patient.

After seven days the patient comes back to the office and we unscrew the implant out of the bone very easily, even without the need for anaesthetic injection. It has worked for me over the years and in three cases when I had to remove the osseointegrated implants because the prosthodontist was not satisfied with the position or angulation. In most cases when only 1 mm or 1.5 mm of bone is left at the buccal and lingual side of the implant and the practitioner has decided to remove it, creating a through and through bone defect is what really happens when a trephine is used to remove the implant and its surrounding bone from the jaw. Then we have to go through the very difficult and timely/costly process of repairing or reconstructing the alveolus. With my technique, there will be no need for future grafting or any kind of reconstruction. The socket will heal by itself.

M. Jafari
By email

1. Virdee P, Bishop K. A review of the aetiology and management of fractured dental implants and a case report. *Br Dent J* 2007; 203: 461-466.

DOI: 10.1038/bdj.2007.1194

TECHNIQUE SENSITIVE

Sir, some of the materials we use in the mouth can be harmful when used inappropriately. Your recent article on bony necrosis following the use of