Letters to the Editor

A PRACTICAL GUIDE FOR PATIENTS UNDERGOING EXODONTIALS FOLLOWING RADIOTHERAPY TO THE ORAL CAVITY

Sir, I refer to the above article in the December 2002 issue of Dental Update by Kanatas et al. No doubt it has been proven that hyperbaric oxygen therapy is the best means to prevent and treat osteoradionecrosis. However, it is costly and not easily available. Thus, I would like to bring to the attention of the authors of the availability of ultrasound as an alternative mode of prevention and for treatment of osteoradionecrosis.

Harris (1992) has proven that ultrasound has a role to play in the treatment of osteoradionecrosis.1 In fact, in view of the facility and economy of ultrasound, Reher and Harris (1997) strongly recommended a prophylactic regime in heavily irradiated mandibles, especially those exposed to brachytherapy or a combination of teletherapy and chemotherapy.2 I hope the authors can consider incorporating ultrasound in their ‘Best approach’.

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References:

Sir, I refer to the article in the December 2002 issue by Kanatas et al. (Dent Update 2002; 29: 498–503). I hope it is not too late to make a comment as we get Dental Update late in this part of the world. I just want to highlight the problem with dental extractions for patients with nasopharyngeal carcinoma following radiation therapy.

Nasopharyngeal carcinoma is seen commonly in South China and South East Asia, mainly in patients of Chinese ethnic. With globalization, I would not be surprised to see an increasing number of the patients in the United Kingdom and western world. The mode of treatment is mainly radiation therapy.

My personal experience is that this group of patients, unfortunately, will develop complications, either delayed wound healing or osteoradionecrosis, following extraction of their maxillary molars (as opposed to the mandibular molars in irradiated oral cancer patients). Tong et al. had highlighted this problem in the Australian Dental Journal in 1999.3 This is because the dose to the nasopharynx is normally between 6250 to 7000 cGy, delivered over 30 treatments in daily fractions of 200 to 225 cGy. The customary field set-up employed leads to high-dose bilateral exposure of the molar teeth in the maxilla and mandible, and all the major salivary glands.

So, even though the tumour is not located in the oral cavity, extreme precaution should be employed when treating this group of patients. As a matter of fact, Tong et al. claimed that extraction of maxillary and mandibular anterior teeth can be safely done without any precautions.

Extractions of the premolars and mandibular molars similarly were not associated with significant risk, provided that an atraumatic technique and antibiotic cover were used.4 Problems arising from these extractions were manageable with relatively simple measures of wound debridement and closure. They emphasized that careful follow-up until completed healing was necessary.

They suggested that, when extraction of maxillary posterior teeth was necessary, prophylactic antibiotics were not sufficient to prevent the complication of delayed healing (though this has been recommended in the ‘best approach’ by Kanatas et al.). The risk of ONN was 10.5% within the field of maximal radiation dose of NPC. They suggested that the protocol of Marx for giving hyperbaric oxygen (HBO) should be considered, even though they did not agree with wholesale prescription of HBO therapy.4

I hope this little additional information will be useful to all general dental surgeons when dealing which head and neck cancer patients, especially those suffering from nasopharyngeal carcinoma.

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Reference:

STICKING TO FACTS

Sir, In the March 2003 copy of Dental Update I read with interest the comment by F. J. T. Burke, ‘Sticking to facts’.

The article suggested that the clinician would need to read approximately 416 articles per year. In the guidelines for authors at the back of the same issue, I noted the request for an article to be no longer than approximately six normal reading pages. All things considered, this amounts to approximately 2496 pages of reading material each year and increasing by the hour, not to mention Dental CDs, Dental TV, etc. and the minefield of text that comes from the Dental Organizations, Government and Health Boards. Naturally common sense will tell anyone that it is a total waste of time because no-one can possibly have the time or ability to absorb it all.

Clinicians like myself are hungry for up-to-date information that will improve our skills and make us practice better dentistry, but authors need to be told that we have a serious negative equity of