

Letters to the Editor

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

DIFFERENTIAL DIAGNOSIS

Sir, following the 'numb chin syndrome' series of articles^{1,2} we would like to share our findings of the following case which was recently referred to the Oral Medicine Department at University of Manchester Dental Hospital.

A 37-year-old female patient presented to her general dental practitioner complaining of a numb lower right lip. She had a history of metastatic breast cancer affecting the liver which alerted a prompt referral to the Oral Medicine Department. Recent bone scans performed by the oncologist did not reveal any bony metastases in the pelvis and limbs. However, the bone scan failed to include the head and neck region. Dental radiographic examination (Fig. 1) confirmed the presence of a bony metastasis in the ramus of the mandible affecting the inferior alveolar nerve and lower right third molar. To confirm the radiological findings, she was referred to the maxillofacial department for a biopsy.



Fig. 1 Arrows indicate the presence of a bony metastasis in the ramus of the mandible

The case demonstrates the importance of including metastatic disease in the list of differential diagnosis of a numb lip as failure to recognise such a finding will not only have serious impact on the prognosis of a disease but

can lead to medico-legal consequences.

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1. Divya K, Moran N, Atkin P. Numb chin syndrome: a case series and discussion. *Br Dent J* 2010; **208**: 157-160.
2. Ryba F, Rice S, Hutchison I. Numb chin syndrome: an ominous clinical sign. *Br Dent J* 2010; **208**: 283-285.

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THE FULL EXTENT

Sir, we would like to highlight a case of interest that recently presented to our maxillofacial surgery outpatient clinic.

Patient A had originally undergone extraction of a lower third molar tooth as this was grade III mobile. A periapical radiograph had been taken as part of the assessment of this tooth prior to its extraction indicating localised pathology. The tooth was extracted uneventfully in general practice by his GDP.

Six months later, the patient then attended an emergency dental service complaining of pain in the extraction site with a non-healed socket. The patient was then subsequently referred to our clinic for further investigation.

At this visit an orthopantomogram XR revealed an extensive multilocular cystic lesion associated with the extraction socket (Fig. 1). Tissue diagnosis revealed a follicular ameloblastoma.

The patient has since undergone excision and reconstruction with an osteocutaneous fibular free flap. He has made a good post-operative recovery.

This case highlights the possibility that there may be occasions when intraoral periapical radiographs may not adequately define the full extent of any periapical pathology associated with third molar teeth.

In these cases we would recommend that further radiographic imaging should

be sought initially in the form of an OPG X-ray. This would enable better visualisation of any pathology, when more detailed CT studies may then be indicated.



Fig. 1 Extensive multilocular cystic lesion associated with the extraction socket

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1. Cankurtaran C Z, Branstetter B F IV, Chiosea S I, Barnes E L Jr. Best cases from the AFIP: ameloblastoma and dentigerous cyst associated with impacted mandibular third molar tooth. *Radiographics* 2010; **30**: 1415-1420.
2. Kotrashetti V S, Kale A D, Bhalaerao S S, Hallikeremath S R. Histopathologic changes in soft tissue associated with radiographically normal impacted third molars. *Indian J Dent Res* 2010; **21**: 385-390.
3. Flygare L, Ohman A. Preoperative imaging procedures for lower wisdom teeth removal. *Clin Oral Investig* 2008; **12**: 291-302.

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PERSONAL DIATRIBE

Sir, I write regarding *Unethical aspects of homeopathic dentistry* (*BDJ* 2010; **209**: 493-496). We are surprised that such a respected dental research journal with a hard earned impact factor should lend its columns to a personal diatribe of no scientific content. We always considered the *BDJ* to be an academic research and reference platform for original work. Mr Shaw's non-dental article is clearly not of this calibre.

We wish to address some of the fallacious, inappropriate and unsubstantiated remarks made in this article in order to set the record straight.

Dental therapeutics form a very small part of dental treatment and should only be used when a mechanistic approach no