

Letters to the editor

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Dental implants

Polisher protocol

I recently gave a webinar on 'Osseointegration – maintaining the balance', where I discussed in-depth the crucial role maintenance and monitoring has in maintaining peri-implant health. There were many questions at the end of the presentation around use of air polishers, and I highlighted the European Federation of Periodontology (EFP) position on the use of air polishers, in particular the excellent EFP infographics which provide an evidence-based approach to their use.¹

On reading the *British Dental Journal* the next day I found the publication by Mordi *et al.*² an extremely useful case study, which in my opinion makes essential reading for clinicians using air polishers, or those considering their use. The article explained the mechanism as to how a pneumomediastinum could result whilst using an air polisher. On a number of occasions the authors mentioned the need to develop protocols to ensure the safe use of air polishers and if iatrogenic events did unfortunately occur, appropriate protocols to manage these events.

Having found this an interesting and informative read, on scanning through the *BDJ* I noticed an advertisement for an air polisher with the strapline 'Free yourself from protocol'. Whilst the effective use of air polishers for supragingival plaque, stain, and calculus removal may be more time effective than traditional hand instrumentation (freeing clinicians from current hand instrumentation protocol), the article by Mordi *et al.* highlighted the need for other protocols for safe and effective use. As always prevention is better than cure, and protocols for safe and appropriate use will go some way to mitigate against untoward events, as highlighted by this case.

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References

1. European Federation of Periodontology. Guideline on treatment of peri-implant diseases. Available at <https://www.efp.org/education/continuing-education/clinical-guidelines/guideline-on-treatment-of-peri-implant-diseases/> (accessed 10 November 2025).
2. Mordi V, Leung B, Peyman A *et al.* An unsuspecting presentation of extensive pneumomediastinum following dental air-polishing. *Br Dent J* 2025; **239**: 549–553.

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Primary dental care

Emergency extractions in patients on antiplatelet/anticoagulant therapy

Emergency dental extractions in patients receiving antiplatelet or anticoagulant therapy are increasingly encountered in primary dental care. Historically, interruption of antithrombotic therapy was advised, but contemporary guidance discourages this due to the risk of thromboembolism. Current recommendations support proceeding with most minor oral surgical procedures without interruption of therapy, provided robust local haemostatic measures are used.^{1,2,3}

Antiplatelet agents (e.g., aspirin, clopidogrel, ticagrelor) inhibit platelet aggregation, while anticoagulants (warfarin; direct oral anticoagulants [DOACs] apixaban, rivaroxaban, edoxaban, dabigatran) target the coagulation cascade. DOACs offer predictable anticoagulation without INR [International Normalised Ratio] monitoring and are preferred for most patients with non-valvular atrial fibrillation, whereas warfarin remains indicated for mechanical heart valves or severe mitral stenosis.^{2,4}

For patients on warfarin, dental extractions can usually proceed without interrupting therapy, provided the INR – checked within 24 hours (or within 72 hours if previously stable) – is ≤ 3.5 in primary care; an INR around 2.7 provides an additional margin of safety, particularly in settings with limited

haemostatic support. If the INR exceeds this level or has been unstable, the patient should be referred for medical advice or secondary care management.³ Liaison with the patient's physician or haematologist is advised if multiple extractions or surgical complexity is anticipated.

For patients on DOAC therapy, schedule the procedure at trough plasma concentration to minimise bleeding risk: approximately 24 hours after the last dose for once-daily agents (rivaroxaban, edoxaban) and approximately 12 hours for twice-daily agents (apixaban, dabigatran).⁵ Dose omission is usually unnecessary for routine cases. Omitting a single pre-procedure dose may be considered in patients at higher bleeding risk or with significant renal impairment following individual risk assessment.^{3,4}

Effective local haemostasis should be achieved using the following first-line local measures: atraumatic technique and firm gauze pressure; suturing where indicated; local haemostatic agents (oxidised cellulose or absorbable gelatine sponge); and tranexamic acid 4.8% mouth rinse (10 mL gently swilled for two minutes, four times daily for 2–5 days).^{1,3,6} These measures align with national recommendations.^{3,7}

For post-operative care, prescribe paracetamol for analgesia and avoid non-steroidal anti-inflammatory drugs (NSAIDs) where possible. Anticipate occasional secondary bleeding at 24–48 hours and manage with repeat local haemostatic measures. Refer to secondary care if bleeding persists, surgical complexity is high, or there is severe renal impairment. Adherence to current clinical guidelines enables safe emergency extractions without interrupting antithrombotic therapy, thereby balancing haemorrhagic and thromboembolic risks.³

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