

tural resistance, to the extent that it may sometimes break. If the transport plate were specifically designed for alveolar use (perhaps smaller, *and/or* more appropriately shaped, *and/or* more flexible?), these problems would be less important and we would be free to use thinner *transport segments*. Thin segments are easily cut with current instruments (notably ultrasonic *osteotomes*²), *and* would permit distraction in highly atrophic mandibles, so maintaining the existing mandibular architecture as much as possible and reducing the risk of fracture of the basal bone during or after operation.

Enislidis et al. concluded that *subperiosteal* distraction is not an effective technique for increasing the height of the alveolar ridge, in view of the high incidence of complications. However, I disagree with their conclusion: I think that their results are no worse than those obtained with other techniques such as onlay bone grafting. Certainly, though, I think that better results could be obtained if manufacturers started thinking about the design of distractors for alveolar use.

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Benign paroxysmal positional vertigo: An unusual complication of molar teeth extraction

Sir,

Benign paroxysmal positional vertigo is a common cause of vertigo, and makes up about 17% of all cases of dizziness. The incidence is about 10.7 to 17.3/100000, and it is equally common among men and women. It is caused by free-floating endolymph particles (otoliths) that come from

the otolithic membrane of the utricle macula and displaced into the posterior (90% of cases) or lateral (5–10%) semicircular canal of the vestibular apparatus. The otoliths alter the gravity-dependent endolymph system and cause abnormal neural firing from the hairy cell of the ampullae, that result in vertiginous attacks on moving the head. Primary or idiopathic positional vertigo comprises 50–70% of cases, while head injury is the most common cause of secondary benign paroxysmal positional vertigo (7–17%).¹ Surgical trauma not related to operations on the ear has been reported as a rare cause.^{2–5}

We recently saw a 28-year-old healthy woman who had had an operation for the extraction of four third molar teeth for severe dysodontiasis with an impacted wisdom tooth 28. She was operated on general anaesthesia with the patient supine. The head was not hyperextended during the operation. Immediately after recovery from the anaesthetic, the patient had intense vertigo accompanied by nausea on turning her head to the left; the vertigo recurred only when she moved her head towards the left, and did not occur when she sat upright or turned her head to the right. She had no previous history of dizziness. She was referred immediately to the ENT department. After history evaluation and clinical examination (Semont's diagnostic manoeuvre elicited a torsional nystagmus beating toward the affected site) a prompt diagnosis was made of benign paroxysmal positional vertigo associated with cupulolithiasis of the left posterior semicircular canal. She had an efficacious therapeutic cycle of Semont's liberatory manoeuvres with the aim of repositioning the otoliths from the posterior semicircular canal into the utricle.¹

Benign paroxysmal positional vertigo is characterised by short, recurrent episodes of vertigo triggered by movement of the head on the plane of the posterior or lateral semicircular canals of the vestibular organ.¹ The clinical features of benign paroxysmal positional vertigo make diagnosis relatively easy. Although secondary benign paroxysmal positional vertigo is more commonly related to operations on the ear, it has also been seen after nose, throat, and oral surgery. Bone drilling and the use of osteotomes and surgical hammers may be responsible for the transmission of percussive forces capable of detaching the otoliths from the otoconial layer of the utricular macula.^{2–5} Though benign and often self-limited, it can cause severe discomfort for patients and may become dangerous if not recognised. It should therefore be considered in all subjects with postoperative positional vertigo particularly after oral and maxillofacial procedures, and in those subjects with a previous history of dizzy spells. The risk of postoperative vertigo should be mentioned when obtaining the informed consent for maxillofacial operations.

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A safe and accurate technique for transbuccal incisions

The transbuccal approach for fixation of fractures of the mandibular angle and sagittal split osteotomy sites is standard practice in many centres.¹ Various techniques have been described to pinpoint the placement of the buccal incision: including the use of a finger, a curved clip, or toothed forceps to push the buccal skin and subcutaneous tissues outward.² However, this often distorts the point over the fracture site and also places the operator's finger at risk of injury.

We present another way of safely and accurately placing the buccal skin incision. The buccal retractor from the trocar set is placed with the internal limb lined up over the fracture site, and vertical and horizontal alignments are checked. The incision is made just through the skin, and the point for the incision is the centre of the circle within the external limb of



Fig. 1. Incision at the centre of the ring.

the retractor. This corresponds to the centre point of the trocar, enabling accurate fixation of screws at either side of the fracture site. This technique ensures safe and accurate placement of the trocar and we have used it with no deleterious effects (Fig. 1).

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