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Letters to the Editor

Aid to positioning of patients

Sir,

We read the technical note by Michael, Walton, and Wake about the use of inflatable pressure bags to aid in positioning of patients with great interest.[1] As we described an identical device in 1999,[2] and have used it for over 16 years we can attest to its usefulness.

If one enters "aid to patient position" into a search engine such as PubMed our paper appears as number 111 of 198, and we imagine it is for this reason and because the title of our paper makes no reference to "inflatable bags" that neither the authors or indeed the reviewers were aware of our very similar article.

References

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Re: Root fragment in the ostium of the maxillary sinus [Br. J. Oral Maxillfac. Surg. 47 (2009) 572–573]

Sir,

We read with interest the short communication from Sethi, Cariappa and Chitra.[1] The authors demonstrated, via the use of a computed tomogram that a dental root fragment blocked the maxillary sinus ostium following failed dental extraction.

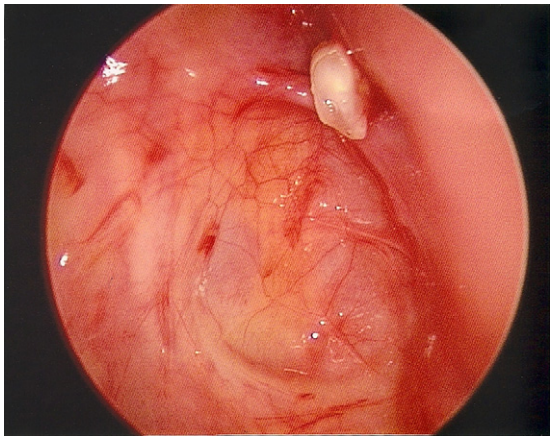

Fig. 1. Endoscopic view of right maxillary sinus.

We wish to add to this clinical scenario by presenting an endoscopic view (Fig. 1) showing a similar outcome following failed dental extraction.

Our patient was referred with a history of right sided maxillary sinusitis. She had a tooth extracted by her General Dental Practitioner three months previously at which point a root was displaced into the maxillary sinus. The endoscopic view shows the root fragment lodged within the maxillary ostium preventing functional drainage of the sinus. After the retrieval of the root via a Caldwell Luc procedure the patient made a full recovery.

We concur with the authors' suggestion that the beat of the cilia, posture of the head and negative aspiratory pressure moved the fragment into the ostium.

Conflict of interest

There is no conflict of interest.

Reference

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An end to the need for orthognathic surgery?

Sir,

We enclose a photograph, which was brought to our attention by a patient at one of our orthognathic clinics. This was taken on a visit to his optician (a well known high street chain).

The patient didn't agree, despite purchasing new spectacles, with the claim made although said the irony made him smile. Fortunately no claim is made with regard to jaw function—this being our reason for treatment of orthognathic patients. However we felt that colleagues may be interested in how other health professionals (or at least the advertising agencies they employ) view serious and, for some patients, very debilitating conditions as apparently minor and amusing problems. On the other hand should we invite a dispensing optician onto our orthognathic MDT?!!

Conflict of interest

The authors confirm they have no conflict of interest.

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Re "The need of postoperative radiographs in maxillofacial fractures—A prospective multicentric study" by M.K. Jain, M. Alexander [Br. J. Oral Maxillofac. Surg. 47 (2009) 525–529]

Sir,

I read with interest the above paper and would like to congratulate Jain and Alexander on their work. It adds to the increasing amount of evidence that questions the need for "routine" postoperative radiographs in our trauma patients.[1,2]

The authors are to be commended on their prospective study across multiple centres, accruing a substantial number of patients.

Regulations on ionising radiation clearly stipulate a principle of dose reduction, and the need to justify radiographic examination through clinical diagnostic yield.[3]

In addition to the patient's exposure to radiation, the routine practice of obtaining radiographs places a heavy demand on radiological resources including nursing staff, porters, and radiographers, and could possibly result in delayed discharge. Often the radiographs are not reviewed by senior staff, which negates their use.[1]

In the current climate of healthcare that is driven by evidence, this work in presenting sound level 2 evidence should add strength to the argument against obtaining routine postoperative films.

Clinical judgement alone is sufficient for the postoperative evaluation of most maxillofacial fractures, so radiographs in this setting should be obtained only when they can be individually justified, and will have a direct impact on further management of the patient.

In striving for better care for our patients, we should perhaps discard such an outdated, unnecessary practice that has no real clinical justification.

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