

ACCIDENTAL THIRD MOLAR DISPLACEMENT INTO
THE LATERAL PHARYNGEAL SPACE

To the Editor:—A 28-year-old woman was referred to our clinic for the removal of distal-vertical impacted mandibular third molars. After a mucoperiosteal flap was reflected, the tooth was elevated with a Winter (Medicor, Tuttingen, Germany) elevator in its bifurcation. During elevation, the tooth suddenly jumped up toward the nasopharynx and disappeared. The patient was asked whether she swallowed the tooth. She explained that she did not swallow the tooth, but she had difficulty swallowing. At this time, it was noticed that there was a laceration at the pharyngeal space above the left tonsil. Immediately, a panoramic radiograph was taken (Fig 1). The radiograph showed displacement of the tooth into the superior aspect of the lateral pharyngeal space. Clinically, the tooth was not seen at the laceration site because it was fully lodged in soft tissue. Immediately after, the tooth was removed via the laceration with a hemostat. The laceration was sutured with 3-0 silk sutures. The healing period was uneventful.

Displacement of an entire tooth during extraction is rarely encountered. In the literature, it is reported that an entire tooth has been displaced to the lateral pharyngeal space,¹ the lateral region of neck,² and the infratemporal fossa.^{3,4} Anatomic considerations such as a distolingual angulation of the tooth, thin lingual cortical plate, excessive or uncontrolled force, and inadequate clinical and radiographic examination are important factors that can lead to tooth displacement.^{1,2,5} In the current case, although excessive force was not applied, the fact that the tooth was lodged in soft tissue was interesting.

Although some authors prefer to postpone surgery for several weeks so that fibrous inflammatory tissue reaction

immobilizes the tooth, others prefer to perform surgery at the time of tooth displacement, because delayed intervention may increase the risk of infection and foreign body reaction.^{2,6}

We believe, if it is possible, a displaced tooth should be removed immediately because delayed intervention may cause potential complications such as infection, foreign body reaction, or patient disturbance.

ÜMIT ERTAS, PhD
M. SELIM YARUZ, DDS
SINAN TOZOĞLU, DDS
Erzurum, Turkey

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FIGURE 1. Orthopantomography shows the displaced mandibular third molar in the area of the pharyngeal space.

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PREVENTING COMPLICATIONS ARISING IN
ALVEOLAR DISTRACTION OSTEOGENESIS

To the Editor:—I am writing in regard to the article "Minor Complications Arising in Alveolar Distraction Osteogenesis" by Drs Garcia et al (*J Oral Maxillofac Surg* 60:496-501, 2002). A complete understanding of the biology of formation and maintenance of the distraction regenerate does not mean technical or mechanical failure can be avoided.

Wound dehiscence, fenestration of the bone segment, segment malposition, fracture of the segment, technical difficulties with the device, or traumatic postsurgical loading can all affect regenerate healing. The remarkable ability for soft tissue wounds to heal in the oral cavity does not guarantee that the underlying bone will follow suit.

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Here are a few cautionary tips with regard to avoiding complications in the distraction of small segments of bone:

1. Do not make the segment too small. It may resorb away.
2. Make atraumatic saw cuts with cooling irrigation. Use fine osteotomes to free the bone flap, but not complete the lingual cut, because you cannot be sure you do not fracture the cortical bone near adjacent teeth.
3. Place the devices with minimal periosteal stripping.
4. Slow down the distraction rate. Small increments (0.4 mm twice per day) allow fibrillar collagen and vasculature, to maintain continuity in the regenerate.¹
5. Maintain the lingual periosteal integrity of the regenerate.²
6. If an untoward event occurs, such as tearing a flap, delay beginning the distraction (up to 3 weeks), or abort the surgery.³
7. Avoid cutting the flap on the crest. It will cause dehiscence.

It is good to recall that small orthognathic segment complications have been reported leading to loss of teeth or bone, even necrosis of the entire segment. This can surely occur in a distraction osteotomy as well.

We compliment the authors in taking the time to critically analyze a series of cases and provide a complications report. This is much needed in the scientific literature, which is too often unburdened by adverse outcomes. *From complication and failure we learn the most.*

OLE T. JENSEN, DDS, MS
Denver, CO

ZVI LASTER, DDS
Tiberrus, Israel

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NOTE FROM A FRIEND

To the Editor:—It was with much regret and sadness I heard of “Pete’s”—Larry Peterson’s—death. Many in the US may not appreciate the strong links he built with some colleagues in the UK. In the early 1980s I read a short letter that Stephen Schendel wrote to *JOMS* about the benefits of getting some training in Europe. At that time I had just been appointed as a consultant (full-time attending) and found myself 1 of 2 surgeons serving a population of 800,000. So I replied to Stephen’s letter about the benefits of training not only in France, but in Sunderland, my unit in the UK! Larry Peterson picked up on this, and despite the incomplete address with my letter, he contacted me and we started a rotation that has lasted nearly 20 years. From these contacts many trainees have learned both about each other’s surgical philosophies and culture. Most importantly, many long-lasting friendships were made. I hasten to add that these benefits of learning and friendship apply to me as well.

Without Pete’s drive and determination this rotation would never have lasted. The quality of his trainees was a tangible measure of his teaching skills. This combined with his organizational, research, and clinical skills made me appreciate what a formidable academic and trainer he was. He was also great fun and was a modest man, yet he believed passionately in his role as educator and maxillofacial surgeon.

It is indeed a tragedy that he has died so young. I was pleased to see that at my last meeting, about 2 years ago, I found him looking more contented and positive than ever. A recent e-mail showed his great strength, for although unwell, more than I appreciated at the time, he displayed no self pity or negative thinking. He will be sadly missed, and I extend my sympathy to Kit, his family, and friends.

PETER WARD BOOTH, FDS, FRCS
East Grinstead, United Kingdom

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