Letters to the Editor

Dear Sir,

Re: A Life Threatening Complication of Removable Appliance Therapy?

Iatrogenic damage occurring during orthodontic treatment is a fact of life and well documented in the literature. Recently, our attention has been drawn in particular to the very real risks of Headgear Therapy and many of us in clinical practice have greatly limited our use of this type of appliance as a result.

In contrast damage from removable appliances has been regarded as being minimal and certainly not associated with morbidity. However, a patient who recently atttended the orthodontic department at Guy's has made me consider these appliances in a new light!

The patient in question was undergoing a short course of simple upper removable appliance treatment in the mixed dentition to push an incisor tooth over the bite. Treatment seemed to be progressing well until one day he attended having not worn his appliance. On questioning the patient, who was of above average intelligence for his age, he said that he had been running home from school when his brace became displaced. On further investigation, it appeared that the appliance had become 'hooked around his uvula'.

Arriving home his parents could see the respiratory distress that their son was in and rushed him to their local casualty unit. There the duty S.H.O. gave the lad a local anaesthetic in the soft palate so he could disimpact the appliance. In the words of the Consultant Casualty Officer with whom I have been in correspondence—'A rather brave procedure in a patient who is a Haemophiliac!'

Fortunately, the patient made an uneventful recovery but perhaps we should in future treat the so called 'Cinderella' of British Orthodontics with a little more caution.

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Dear Sir,

Re: Risk Assessment

As clinicians we have to make risk assessments which are continually having to be revised. Witness the soul searching with regard to EOT and the change to disposable impression trays, etc. For many years, due to the risk of causing lung abcess, I have always tied bands/brackets into an archwire. Most often I use 0·015 braided sectional arch, with small circular loops distally, tied into all brackets whilst awaiting separation. I was delighted, therefore, to learn from 'The Effect of Timing Archwire Placement on *In Vivo* Bond Failure', (*BJO*, 1997, **24**, 243–245) that I have not been compromising bracket failure rate in choosing this particular risk avoidance, assuming, of course, that Concise behaves like Right-On in this respect.

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