Dental Traumatology

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LETTER TO THE EDITOR

Dental Traumatology

Professor Lars Andersson, Editor-in-Chief

Re: Sönmez et al. Orthodontic extrusion of a traumatically intruded permanent incisor: a case report with a 5-year follow up. *Dent Traumatol* 2008;**24**:691–694.

Dear Lars,

I have just received the recent issue of *Dental Traumatology* and discovered a problem that is common to us all: focus on the most obviously traumatized tooth and neglect of less obvious problems. I'm referring to the

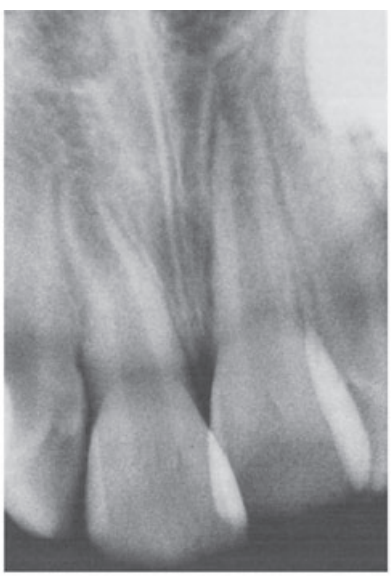


Fig. 2. Preoperative periapical radiograph of intruded permanent left maxillary central incisor.

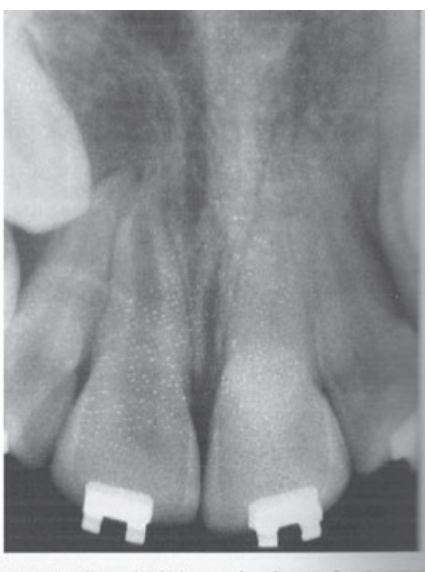
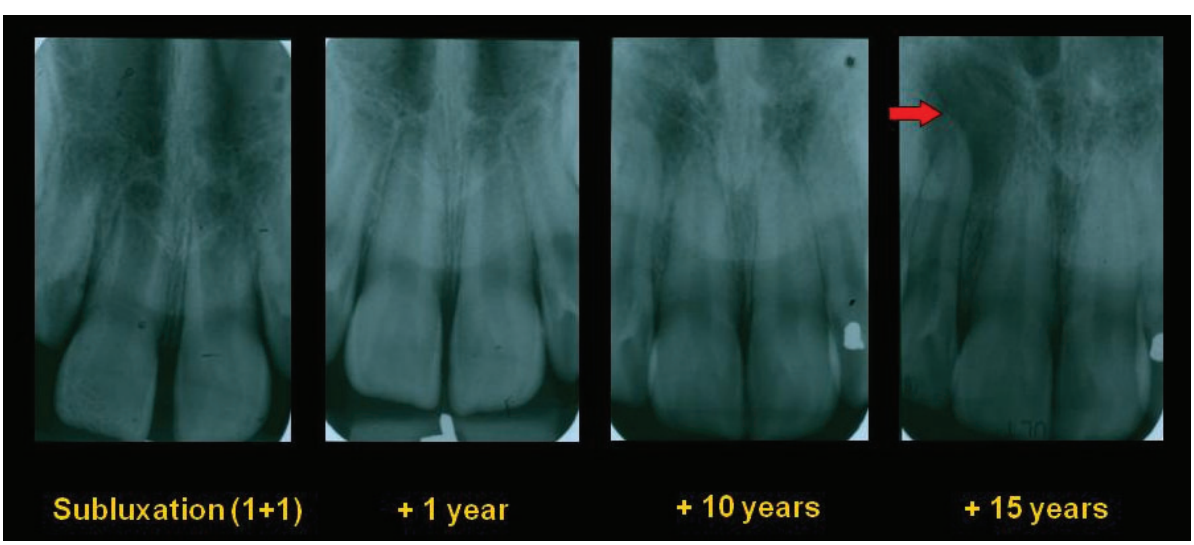


Fig. 4. A radiograph which was taken 5 years after the trauma, and in which pulp canal obliteration of the tooth can be clearly seen.



case report of orthodontic extrusion of an intruded incisor (Figures 2 and 4 reproduced on previous page).

Although the authors have successfully repositioned the intruded left central incisor, they seem to have neglected two critical signs of pulp necrosis of the right central incisor: (1) an apical radiolucency; (2) arrested root development – in this case, the lack of mineralization of the root canal. When comparing the radiograph at the 5-year follow up with the one from the time of injury, it can be seen that the root canal of the right lateral incisor has become obliterated – a sign of minor trauma and healing with a type of scar tissue. Thus what we are seeing is the result of injury to three incisors and not just the left central incisor.

I am certain that we all have made similar errors in clinical assessment. As proof of this, see the radiographs from one of my own cases.

The radiolucency seen here over the apex of a lateral incisor – 15 years after subluxation of both central – is the result of neglect to prophylactically treat a foramen coecum. However, the lesson is still the same: we as therapists should view the entire patient and not just the teeth most obvious in need of treatment.

Yours sincerely,

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