British Journal of Oral and Maxillofacial Surgery (2003) **41**, 201–207
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BRITISH Journal of Oral and Maxillofacial Surgery

Letters to the Editor

doi:10.1016/S0266-4356(03)00044-5,
available online at www.sciencedirect.com SCIENCE DIRECT®

LINGUAL TRAUMATIC ULCERATION (RIGA-FEDE DISEASE)

Sir,

Riga-Fede disease is rare. There have been only 11 cases reported, including one from us.[1] It is a traumatic ulceration on the tongue in neonates and infants,[2] in association with natal or neonatal teeth. Ventral lesions result from contact with mandibular anterior incisors; rarer lesions on the dorsal surface are associated with the maxillary incisors.

A 6-year-old girl was brought to us. She had habitually bitten her tongue since she was 9 months old, resulting in sublingual ulceration from fraction against two lower central incisors. Her parents were advised to allow extraction of the neonatal teeth, but refused. The ulcerated area healed within a year, resulting in a cleft deformity (Fig. 1)

Trauma to the oral mucosa may result in surface ulceration, but most heal within days. The ulcerations in Riga-Fede disease may remain for a long time, resulting in inadequate food intake and retardation of growth.

The treatment of Riga-Fede disease is extraction of the teeth.

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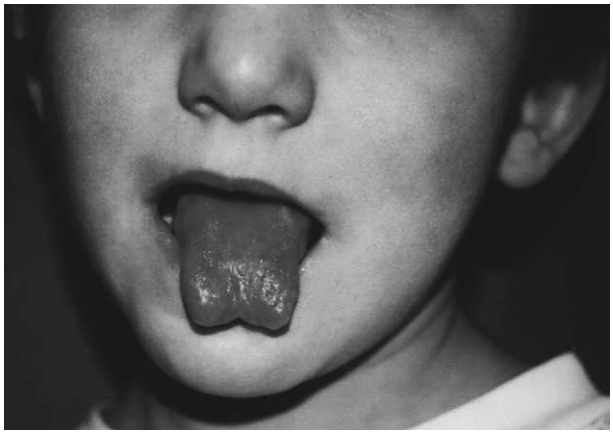

Fig. 1 View of the lingual deformity.

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doi:10.1016/S0266-4356(03)00067-6,
available online at www.sciencedirect.com SCIENCE DIRECT®

Re: Prolonged paraesthesia following inferior alveolar nerve block using articaine

Sir,

I was interested to read the letter by van Eeden and Patel (BJOMS, Vol. 40, pp 519–520) concerning ‘Prolonged paraesthesia following inferior alveolar nerve block using articaine’. This is not the first report of an association between articaine and long-standing altered sensation following intraoral injection. In 1995, Haas and Lennon (J Can Dent Assoc, Vol. 61, pp 319–330) reported that articaine was more likely to produce non-surgical paraesthesia following intraoral injection than other commonly used dental local anaesthetics. This may be due to the relatively high concentration of articaine in solution as the other drug which was shown in the Haas and Lennon study to produce significant incidences of paraesthesia was 4% prilocaine.

Kind regards.
Yours faithfully,

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doi:10.1016/S0266-4356(03)00028-7,
available online at www.sciencedirect.com SCIENCE DIRECT®

Re: A prospective randomised trial of the benefits of a sternocleidomastoid flap after superficial parotidectomy

We read with interest the recent paper by Kerawala *et al.*[1] reporting a clinical trial to determine the benefits of a sternomastoid flap after superficial parotidectiomy. As a result of similar cosmetic findings with this type of reconstruction following parotidectomy, we abandoned this technique several years ago in favour of a dermal fat inter-positional autologous graft. We found that the main problem with the sternomastoid