Foreword

Are we dominated by myths?

Writing an editorial for a young revue is not an easy task. Maybe it's more difficult if we are talking about oral health. That's why we are dealing with some dentistry "myths", which last over decades.

In the 19th century, P.P. Broca said, "The last questioned assumption is often the most questionable". Such pseudoscientific statements are accepted without question by large majority of dentists.

Myth no. 1. Sucking will dislodge the blood clot from the alveolus of an extracted tooth, conducting to an alveolitis.

Within the first day from the removal of a tooth, the fibrin-covered clot is held in position by gingival tissue. Unsupported gingival tissues collapse into the clot-filled alveolus, which helps keep the clot position. Within 48 hours, an in growth of fibroblasts and capillaries occurs, and epithelium migrates down the socket wall until it contacts granulation tissue. By the third day, fibroblasts have already proliferated and grown into the peripheral areas of the clot. So, the blood clot is mechanically secured within the first 24 to 48 hours after tooth removal.

There is no scientific evidence to support that the patient-induced oral vacuum has any relationship to post surgical sequels.

Myth no. 2. Menstruating women who undergo surgery will have significant post-operative bleeding.

Clinicians have believed that women should wait until menstrual bleeding has finished before undergoing dental surgery because they were at risk of postoperative hemorrhaging.

There is a lack of published studies that demonstrated clinically significant prolonged bleeding in women who undergo oral surgical procedures during the menstrual period.

Myth no. 3. Patients should never receive bilateral mandibular anesthetic blocks.

It might be some kind of extension to adults of the conventional wisdom to avoid such an anesthetic procedure in young children, to minimize the risk of the child's chewing on the lower tip while anesthetized.

The myth might have been perpetuated believing that bilateral blocks could generate a potential airway problem for patients. This belief is also not rational or scientific based.

So, bilateral mandibular anesthetic blocks are appropriate procedures, whenever the treatment plan and doctor's judgment state the need for them.

Myth no. 4. A pregnant woman should not receive surgical procedures in the first or third trimester.

Such concern is based generally on the fear of litigation if the fetus suffers any birth defects, the fear of spontaneous delivery, radiation and anesthesia exposure; there are also patient management and postoperative medication concerns. Such concerns have no more clinical signifi-cance that they would for any patient receiving treatment. Emergency surgery for the relief of infection or pain can be done at any time during pregnancy, but with appropriate precautions as follows: o Exposure to radiation of essential films only (with appropriate shielding); o Documented patient counseling and informed consent; o Obstetric consultation if indicated; o Medical consultation (if indicated) for possible anemia (=20% of pregnancies); o Use of appropriate medications intra-operatively and post-surgery.

Although surgical procedures are performed with the least risk during the middle trimester, there is no consistent reason to avoid essential, emergency surgery in a patient with an uncomplicated pregnancy, solely because of concerns for the fetus or the mother. Dentists should consult with the patient's obstetrician if management questions are rising.

Editor in chief
Prof. Dr. Dorin Bratu, D.D.S., PhD
Faculty of Dentistry, Timisoara, Romania