

# Letters to the Editor

## Oral haemangiomas

I recently commenced work in an Oral Medicine department at a Dental Hospital and it has struck me just how common vascular lesions, in particular haemangioma referrals, are. I would like, therefore, to provide a short review of the intra-oral haemangioma.

A haemangioma is a benign, vascular malformation which is usually a small isolated developmental abnormality.<sup>1</sup> They are normally flat lesions which are described as red, red/blue or blue and can occur anywhere within the oral cavity. They are more common on the tongue and lips and, while they are usually asymptomatic, they can bleed with trauma.

Potential differential diagnoses (but not exhaustive) include: varicosity; amalgam tattoo; mucocele; naevi; telangiectasia; melanotic macule; haematoma; eruption cyst; Kaposi sarcoma; and salivary gland tumour. A useful diagnostic tool is the placement of a glass slide to compress a haemangioma; it will blanch and lose its colour.<sup>2</sup>

Unless there is diagnostic uncertainty, treatment of haemangiomas is not usually indicated and an explanation, along with reassurance, is sufficient. Treatment is reserved for patients with aesthetic concerns, or where the lesion is at risk of repeat trauma likely to induce bleeding, for example a shaving injury. Increasing size may also warrant an excisional biopsy.

Treatment options may include no treatment, spontaneous involution and resolution, excisional biopsy, laser ablation or cryosurgery, as determined by secondary care and on discussion with the patient.

Most importantly, referrals to secondary care are fundamental when there are concerns about the lesion demonstrating any sinister features, or for a second opinion. Of note, within the literature there have been 11 reported cases describing angiosarcomas arising from benign haemangiomas in the absence of irradiation.<sup>3</sup> If the patient has aesthetic concerns, or the lesion is vulnerable to repeat trauma, this may also warrant a referral. Finally, for the GDP, the use of a diagnostic glass slide and repeat photographs of the lesion are invaluable diagnostic tools to help in identifying and reviewing an intra-oral haemangioma and may negate a long wait for a referral and reassurance.

## References

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3. Nathenson MJ, Molavi D, Aboulafia A. Angiosarcoma arising in a patient with a 10-year old haemangioma. *Case Rep Oncol Med* 2014; **1**: 185323.

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## Root displacement into the lingual space: a rare occurrence

I wish to report a rare but clinically important risk during removal of lower third molar teeth. A 71-year-old female attended surgery for the removal of the lower left wisdom tooth (LL8) under local anaesthesia. The tooth had a history of pain and unrestorable subgingival caries. There was no relevant medical history. A pre-operative periapical radiograph was used to plan removal (Figure 1).

### Procedure

Routine simple elevation was carried out on the mesial aspect of the LL8. The majority of the tooth was removed, however, a third, lingually positioned root had separated and remained mobile in the socket. A curved clip was used to attempt retrieval but became caught on septal bone, which broke away, leading to the root disappearing into the lingual space. The socket was rechecked following copious irrigation confirming no root in sight.

The procedure was stopped immediately, haemostasis achieved and the patient informed in an open and honest manner. OPG facility allowed approximation of the position of the root (Figure 2). A maxillofacial on-call DCT was called for further management, who advised sending an urgent referral via FDS to an OMFS outpatient unit, antibiotic prophylaxis and monitoring following discharge. The patient was called in the afternoon. She explained that she was completely asymptomatic and had regained feeling following anaesthesia. A follow-up appointment found no complaints or signs of infection or swelling in surrounding tissues. The patient was assessed in an OMFS



**Figure 1.** Pre-operative periapical radiograph of the lower left wisdom tooth. Distally curved root(s) noted.



**Figure 2.** Post-operative sectional orthopantomogram of the displaced root at a position lingual and parallel to the tooth socket.

outpatient setting one week later and awaits a CT scan for locating the root.

### Immediate management

Primarily management is based on symptoms. If the root remains asymptomatic, and is not at risk of travelling between spaces, then it can be left for long-term review, with the patient's consent. In cases of persistent symptoms, such as pain, infection and swelling, a plan for retrieval is required. Following appropriate high quality imaging, CBCT, CT, OPG, or occlusal views, the location of the root can be estimated. Poor visualization and limited access are key considerations for planning surgical exploration. Intra- vs extra-oral approaches have been defined in case reports.<sup>1,2</sup> Careful retrieval is carried out following discussion of risks and benefits, primarily including failure to retrieve the root fragment and lingual nerve injury.

### Clinical significance

Root displacement is considered to be associated with various risk factors, including: patient age, tooth position, presence of a lingual plate fracture, abnormal lingual plate thickness, excessive or uncontrolled force, lack of operator expertise, and poor clinical and radiological assessment.<sup>3,4</sup> It is important for the practitioner