

- computed tomography images in the preoperative assessment of impacted mandibular third molars. *J Oral Maxillofac Surg* 2002; **60**: 979–984.
7. Freisfeld M, Drescher D, Kobe D, Schüller H. Assessment of the space for the lower wisdom teeth. Panoramic radiography in comparison with computed tomography. *J Orofac Orthop* 1998; **59**: 17–28.
 8. Knutsson K, Lysell L, Rohlin M. Postoperative status after partial removal of the mandibular third molar. *Swed Dent J* 1989; **13**: 15–22.
 9. Rood JP, Shehab BA. The radiological prediction of inferior alveolar nerve injury during third molar surgery. *Br J Oral Maxillofac Surg* 1990; **28**: 20–25.
 10. O’Riordan B. Uneasy lies the head that wears a crown. *Br J Oral Maxillofac Surg* 1997; **35**: 209–212.
 11. Zola MB. Avoiding anaesthesia by root retention. *J Oral Maxillofac Surg* 1992; **50**: 419–421.
 12. Pogrel MA, Lee JS, Muff DF. Coronectomy: a technique to protect the inferior alveolar nerve. *J Oral Maxillofac Surg* 2004; **62**: 1447–1452.
 13. Hatano Y, Kurita K, Kuroiwa Y, Yuasa H, Ariji E. Clinical evaluations of coronectomy (intentional partial odontectomy) for mandibular third molars using dental computed tomography: a case-control study. *J Oral Maxillofac Surg* 2009; **67**: 1806–1814.
 14. Leung YY, Cheung LK. Safety of coronectomy versus excision of wisdom teeth: a randomized controlled trial. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2009; **108**: 821–827.
 15. Poe GS, Johnson DL, Hillebrand DG. *Vital Root Retention in Dogs*. 1971 NDS-TR-019 July 1, National Dental Center, Bethesda, Md.
 16. Johnson DL, Kelly JF, Flinton RJ, Cornell MJ. Histological evaluation of vital root retention. *J Oral Surg* 1974; **32**: 829–833.
 17. Whitaker DD, Shankle RJ. A study of the histological reaction of submerged root segments. *Oral Surg* 1974; **37**: 919–935.
 18. Plata RL, Kelln EE, Linda L. Intentional retention of vital submerged roots in dogs. *Oral Surg* 1976; **42**: 100–108.
 19. Cook RT, Hutchens LH, Burkes EJ. Periodontal osseous defects associated with vitally submerged roots. *J Periodontol* 1977; **48**: 249–260.
 20. O’Riordan BC. Coronectomy (intentional partial odontectomy of lower third molars). *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2004; **98**: 274–280.
 21. Pogrel MA. Coronectomy to prevent damage to the inferior alveolar nerve. *Alpha Omegan* 2009; **102**: 61–67.
 22. Freedman GL. Intentional partial odontectomy. *J Oral Maxillofac Surg* 1997; **55**: 524–526.
 23. Dolanmaz D, Yildirim G, Isik K, Kucuk K, Ozturk A. A preferable technique for protecting the inferior alveolar nerve: coronectomy. *J Oral Maxillofac Surg* 2009; **67**: 1234–1238.

Abstracts

IMPLANT RETAINED OVERDENTURES – IS LESS MORE?

Fracture incidence in mandibular overdentures retained by one or two implants. Gonda T, Maeda Y, Walton JN and MacEntee MI. *J Prosthet Dent* 2010; **103**: 178–181.

Many implant practitioners consider that, while two implants are the minimum required for a stable overdenture, more may be preferable for strength and support. In this novel piece of research, the authors randomly selected 85 patients who had their dentures supported either by two implants placed conventionally, bilaterally in the canine regions, or one implant placed centrally in the mandibular midline. The patients were monitored for up to five years.

It was found that there was no statistically significant difference in the incidence of fracture of the prosthesis between the two groups. Where fracture did occur it was related to the concentration of stresses around the support in both groups. It is suggested that reinforcing this area may be beneficial in either case.

It was stated in the paper that the goal of the research was to compare patient satisfaction, component costs, and treatment and maintenance time associated with mandibular overdentures retained by one or two implants. Although this paper merely reports the findings related to fracture incidence, it may well be that a single implant could prove to be an affordable treatment option for a patient who is unable to tolerate the mucosal support of a complete lower denture.

COULD YOU QUOTE THIS ACT AND DOES YOU PRACTICE COMPLY?

The *Mental Capacity Act 2005*: its significance for Special Care Dentistry and patient care. Kaul A, Mudie D and Berman S. *J Disabil Oral Hlth* 2010; **11**: 21–24.

Whilst this paper is aimed primarily at those practitioners working in the field of special care dentistry who can expect a significant proportion of their case-load to comprise vulnerable adults who lack decision-making capacity, we all see such patients from time to time and it is essential that we comply with the relevant legislation. This paper presents three scenarios, based on the

authors’ experiences, to illustrate some of the situations which may be encountered. The scenarios may make an interesting exercise for a staff-training session under professional CPD. The actual relevant legislation was set out in two preceding papers in this edition of the journal, and all three together may prove a useful practice resource.

For example, the legislation provides for those patients at risk to be provided with a capacity assessment. However, suggesting that this be implemented may leave these patients feeling threatened, angry or aggrieved, and it is how these situations are dealt with that is addressed in this paper. All too often practitioners are familiar with the word of the Law but have never been called upon to apply it in a clinical situation. The experience of the authors presented in this paper would provide valuable lessons for those who may find themselves in this position. The legislation must be complied with and wider dissemination to patients, carers and clinicians can only improve the care of vulnerable adult patients.

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