'Warfarin and Drug Interactions: Prescribing Vigilance' by Hook J *et al* (*Dent Update* 2016; **43**: 34–36) about warfarin and their drug interactions in dental management.[1]

Anticoagulation with low molecular weight heparin and vitamin K antagonists is the current standard of care for venous thrombo-embolism treatment and prevention. For the past decades, warfarin has been considered the mainstay of treatment, but its use is limited by a narrow therapeutic index that necessitates regular monitoring of the international normalized ratio (INR) and adjustments to the dose accordingly. Its use is also limited by drug interactions. Novel oral anticoagulants (dabigatran, rivaroxaban and apixaban) represent a new era in anticoagulation therapy. These novel oral anticoagulants have been developed and come in two categories: activated factor X inhibitors (rivaroxaban and apixaban) and a direct thrombin inhibitor (dabigatran). These new drugs do not require the INR to be monitored.[2]

There is little published in the current literature specific to professionals involved in oral health care. The degree of renal function, the complexity of the surgical procedure and the patient's risk of bleeding due to other concomitant causes are the most important factors to consider during surgical dental treatment of patients.[3,4]

As the number of patients taking these novel oral anticoagulants has been increasing, their use poses a number of challenges in dental management. The dentist must use caution and attention when treating patients taking dabigatran, rivaroxaban and apixaban. As healthcare professionals we should also be aware of how and when to report adverse drug reactions.

References

1. Hook J, Millsopp L, Field EA. Warfarin and drug interactions: prescribing vigilance. *Dent Update* 2016; **43**: 34–36.
2. Costantinides F, Rizzo R, Pascazio L, Maglione M. Managing patients taking novel oral anticoagulants (NOAs) in dentistry: a discussion paper on clinical implications. *BMC Oral Health* 2016; **16**(1): 5.
3. Curtin C, Hayes JM, Hayes SJ. Dental implications of new oral anticoagulants for atrial fibrillation. *Dent Update* 2014; **41**: 526–531.
4. Elad S, Marshall J, Meyerowitz C, Connolly G. Novel anticoagulants: general overview and practical considerations for dental practitioners. *Oral Dis* 2016; **22**: 23–32.

Adrian Curto
University of Salamanca, Spain

An interesting development

A fit and well 28-year-old gentleman was referred to the Oral Surgery department at Ealing Hospital by his general dental practitioner for a specialist opinion regarding his upper 2nd and 3rd molar teeth. His GDP had taken periapical radiographs during the root canal treatment of the 1st permanent molars and noted that the 2nd molars were in fact unerupted.

At presentation the patient's only complaint was of mild generalized temperature sensitivity and, upon examination, no abnormalities were detected extra- or intra-orally. Upon review of an OPG radiograph (Figures 1 and 2) it was noted that both upper 2nd molar teeth are fully formed and completely unerupted. Both 3rd molar teeth are fully erupted and mesially angulated to such a degree that they contact the upper 1st molars.

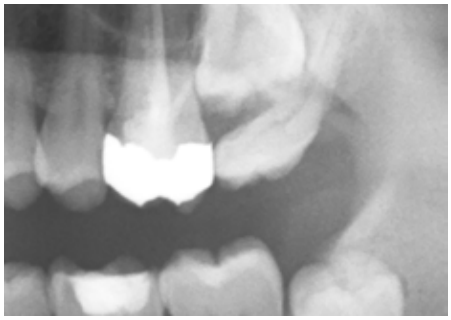

Figure 1.

A more focused clinical examination of the upper 3rd molars showed them to have good interproximal contacts with the upper 1st molars and good occlusal contacts with the lower 2nd molars by virtue of the selective attrition of the disto-occlusal surfaces, with exposed dentine, compensating for their mesial angulation. This wear, along with the wider than normal embrasures, were the only indication that the last standing molars were in fact 3rd molars.

Owing to the lack of any pathological or functional issues, the patient was keen to avoid treatment; the only treatment advised was topical fluoride preparations, desensitizing toothpastes and resin sealers to reduce the sensitivity of his exposed dentine. With regards to the elective extraction of his upper 3rd molars, the probability of spontaneous eruption of the upper 2nd molar teeth is very low; this is because of his age and the fact that the teeth are fully formed, which results in very little eruptive potential, but also because the most likely cause of their original absence, prior to their impaction against the upper 3rd molars, was primary failure of eruption.

It is important, upon the discovery of such an abnormality, that we remember always to act in our patient's best interests; however, with such an unusual presentation, seeking a second opinion about any possible intervention was appropriate.

Dr Martin James
DCT2 in Oral and Maxillofacial Surgery, London North West Healthcare NHS Trust

Figure 2.