

local constituents. Let them know your feelings.

Your constituent officers were elected to represent you (the grassroots members). Communicate with them. Bylaws can be changed (as you have recently found out). Even recently changed bylaws can be changed back.

Your voice is important—use it!

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POST-TREATMENT BACTEREMIA

The article "Preventing Post-Treatment Bacteremia: Comparing Topical Povidone-Iodine and Chlorhexidine" by Rainer Rahn and others (August JADA) was of particular interest to me. I have been advocating the "sanitization" or gingival degerming procedure since 1956.¹ Although I am in accord with their recommendations, I wish to call attention to some flaws in their investigation.

■ They should have separated their results into separate categories: incidence of bacteremia following extraction of a molar and incidence of bacteremia following interligamental injection. I am aware that they had 60 of each. The separation of the results would have added another dimension to our knowledge since there are no bacteremia studies associated with interligamental injections to my knowledge. Unfortunately, they lumped the results together. Moreover, the title of the paper suggests that the study is more inclusive than just one treatment procedure.

■ Another criticism for consideration is the difference in the degree of trauma between extraction of a molar and an interligamental injection.

Studies have shown that the magnitude, incidence and duration of dental bacteremia are related to the degree of trauma.²⁻⁴ Certainly, the procedure of extracting a molar opens many more blood vessels, for bacteria in the gingival sulcus, to gain intravascular entry, than the trauma of an interligamental injection. Although molars were designated as the teeth for extraction, there was no designation as to where the ligamental injection was administered. Was it only in the molar region? There may be differences in the incidence of bacteremia.

Furthermore, the extraction of a lower first molar with the widespread roots is more traumatic than the extraction of a lower second molar whose roots are more often fused and conical in shape, requiring a lesser rocking motion. The same may be said for the upper second molar.

Although the authors carefully took into account the oral hygiene and periodontal scores, the trauma scores were neglected. There is a statistically significant difference in bacteremias between heavy and mild trauma in the exodontic group.² Perhaps chlorhexidine is only effective in cases of mild trauma.

Finally, what was the basis of selecting the two drugs, at their respective concentrations, for the comparative study? Also, why was no discussion offered concerning differences in previous chlorhexidine studies? Their conclusion, gingival sulcus irrigation with povidone-

iodine, only confirms the result of other investigators.⁴

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1. Bender IB, Pressman RS. Antibiotic treatment of the gingival sulcus in prevention of postextraction bacteremia. *J Oral Surg* 1956;14:20.

2. Bender IB, et al. Bacterial endocarditis: a consideration for physician and dentist. *JADA* 1984;109:415-20.

3. Bender IB, Pressman RS. Factors in dental bacteremia. *JADA* 1945;32:836-53.

4. Bender IB, Montgomery S. Nonsurgical endodontic procedures for the patient at risk for infective endocarditis and other systemic disorders. *J Endod* 1986;12:400-7.

Author's response: I agree with Dr. Bender in principle that it would better to separate the different categories of treatment. On the other hand, a study I performed 10 years ago demonstrated clearly that the incidence of bacteremia following intraligamentary injection is approximately 60 to 70 percent.

It is well-known (from studies of Dr. Bender, but also from my own studies) that incidence of bacteremia is related to the trauma. I concluded from my own studies that traumatization during extraction of teeth may have the same intensity as traumatization by intraligamentary injection. I think that incidence of bacteremia does not only depend on the number of blood vessels that are opened during a treatment but also the hydrostatic pressure of the syringe. I can imagine that this hydrostatic pressure (we measured values up to 400 newtons) may open many blood vessels and press bacteria

from the gingival sulcus into these vessels.

In our study, all treatment (extraction as well as intraligamentary injection) was performed in the molar region.

The two drugs used in our study were selected as the only drugs that are approved in Germany for use in the oral cavity and that have shown an antiseptic effect in the oral cavity in vivo, which is statistically different from the control substance (water).

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PREFABRICATED OVERDENTURES

I must take exception to a statement that appeared in "Adjunctive Caries Control in Overdenture Abutment Teeth: A New Modality" by Kenneth S. Kurtz (February). The author states in the abstract that "in the ideal situation, the overdenture abutment is restored with a cast coping, but economic constraints may rule this out in favor of a prefabricated overdenture attachment."

The author reviews a case using two 0 degree prefabricated Extracoronary Resilient Attachments (APM-Sterngold) retaining a maxillary overdenture. After attachment placement, the author's technique for sealing the abutment dentin and suggestion for fluoride protection are noteworthy. The residual exposed dentin should be protected. However, I cannot accept the notion that prefabricated attachments are universally of economic savings.

I called APM-Sterngold and

was quoted \$194 for the master kit used in the placement of these attachments. This kit enables the dentist to prepare the abutment sites and seat the attachments. Additional attachments may be purchased for approximately \$110 per pair.

After discussing the pricing issue with AMP-Sterngold, I called a long-established crown and bridge laboratory in Kansas City, Mo. The chief technician informed me that the fabrication of two Type III gold copings with O-SO attachments would be approximately \$130 to \$140. This fee includes the cost of gold. The use of O-SO-style gold copings for overdenture retention is well-accepted in the prosthodontic community. Currently this technique is taught in the undergraduate dental curriculum at the University of Colorado dental school. Therefore, I submit that the rationale for using prefabricated overdenture attachments based on economics does not withstand careful scrutiny. Notwithstanding potential regional variations in laboratory costs, it seems clear that whatever advantages a prefabricated attachment may offer, they do not include significant cost savings.

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Author's response: It is my opinion that it is less expensive to place prefabricated overdenture attachments than custom cast overdenture attachments. Dr. Astroth is correct in that the ERA overdenture starter kit is \$194. This kit contains five overdenture attachments and the necessary installation ar-

mamentarium. However, a pair costs \$72. His laboratory fee comparison is unfair as it compares two different attachments. My local lab survey yields a range of \$160 to \$200 for each casting, O-SO or ERA. Dr. Astroth goes on to state that O-SO attachments are "well-accepted in the prosthodontic community." I submit that the ERA is equally well-accepted, and could be considered more versatile across a wide range of prosthetic possibilities: direct/indirect overdentures, fixed/removable casework and implant-retained overdentures. If Dr. Astroth has any input into the prosthetic curriculum at this dental school, perhaps he would consider teaching proper utilization of the ERA attachment to the undergraduate dental students. This knowledge may provide future clinicians with a viable alternative to the O-SO.

Economic constraints placed by the patient's budget are barriers to ideal treatment. The issue of chairtime is wholly neglected in Dr. Astroth's letter. Preparation, anesthetic administration, cord placement, impression, provisionalization, try-in and final cementation would take a minimum of two visits. By my estimate, approximately triple the amount of chairtime is necessary for placement of cast vs. prefabricated attachments. As you know, the patient pays for this time and expertise. Despite Dr. Astroth's beliefs to the contrary, it seems clear to me that prefabricated attachments are, in fact, significantly less costly than custom cast attachments for both the clinician and the patient.

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