Letters to Editor

An ultrasound examination in such case pre-operatively would have been helpful in diagnosis and we suggest to do this in all cases of triggering with unusual presentation like post-traumatic triggering and with associated diffuse synovitis. A surgeon aware of such possibility can avoid inappropriate and incomplete release while managing this common and seemingly minor condition.

Role of dental impression compound in plastic surgery: Know more about it

Sir,

I read with much interest an article entitled ‘dental impression compound as an effective splint for maintenance of ear elevation in microtia reconstruction’[1] published in your esteemed journal. I was elated to know that the impression compound material, which we routinely use in dentistry to make preliminary intraoral impressions of edentulous jaws;
has its valuable application in the field of plastic surgery as well. My inquisitiveness led me to explore more about its uses in plastic surgery. A thorough PubMed search with the keyword dental impression compound revealed 85 articles that included articles from journals of numerous medical disciplines such as plastic surgery, cardiology, radiology, rheumatology, and so on, other than dentistry.

Thadani and Ladani in their article entitled ‘a new method for training of ear framework creation by silicon dental impression material’ published in your journal; have prepared a three-dimensional model of harvested costal cartilage with impression compound cake.[3] The usefulness of this thermoplastic material in the field of oculoplasty was reported in 1990 by Betharia et al. who successfully used compound as a postsurgical intraocular stent in the socket reconstruction surgery for maintenance of the proper apposition of the split thickness skin graft to the tissue bed, which besides eliminating the dead space, also gave desired shape to the socket.[3] Seitchik advocated the use of impression compound as a safe method for external splinting following a rhinoplasty or nasal fracture reduction.[4] Impression compound is also used as a bite registration material for face-bow mounting to record the spatial orientation of jaws for performing mock surgery prior to orthognathic surgery. Pani and Hedge described a two stage technique utilizing greenstick compound and addition silicone impression material to provide a safe, economical, and accurate method for recording impressions in children with cleft lip and palate.[5] Bhattacharya et al. have used this material to document the first web space angle in patients with adduction contracture thumb.[6] The above examples illustrate the versatility of dental impression compound (popularly known as compo or stent’s compound) in regard to its multiple uses in the field of plastic surgery, mandating the need to have a workable knowledge about this material.

Impression compound is a mucocompressive, thermoplastic (i.e., it softens when heated and hardens when cooled) and rigid impression material that was invented by British dentist Charles. T. Stent in 1856. Later, a Viennese surgeon, Johannes F. S. Esser (1877-1946) used it in plastic surgery as a matrix to form tissue in the process of rebuilding a shattered face and popularized it as Stent’s mould or Stent’s compound.[7] It is made up of three constituents that include resins (e.g., wax), filler (e.g., talc or soapstone) and lubricants (stearic acid or stearin). Two types of impression compounds are available - Type 1 which is low fusing with a fusion temperature of approximately. Above 45°C and Type 2 which is high fusing with a fusion temperature of approximately above 70°C. It is manipulated in a temperature controlled water bath or air bath or open flame. When the compound is heated, the outside part always softens first and inside part softens last. Adequate time must be allowed for the material to be uniformly heated throughout its mass. Higher the temperature, greater is the flow. However if the temperature is quite high, leaching of plasticizers causes it to become grainy and sticky. Although reusable, it cannot be sterilized and tends to become unhygienic and should not be reused ideally. It is nontoxic and nonirritant to the tissues.

It is available in different colours such as brown, grey, green, red, black and white and is dispensed in many forms such as sheets, cakes, cones, sticks etc., [Figure 1]. It satisfies all the criteria for the ideal soft tissue substitute.[8] However, it can be a potential cause of iatrogenic burn injury if used carelessly and if Bhandari and Singh[1] would have known that the impression compound is also available in brown (skin shade), they would have definitely used the brown coloured cake instead of red cake, so as to provide better aesthetics in 6 months postoperative period.

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Value for money in attending conferences:

Sir,

Bhattacharya has created an excellent guide on how to get the best value for money out of conference attendance. The article is particularly timely as individuals and funders seek to ensure that money on medical education is money well spent. The article is also reflective of a growing interest in cost and value in medical education more broadly. Any cost-value analysis is fundamentally dependent on two components — first a comprehensive account of the costs and second a comprehensive account of benefits or utility accrued.

Bhattacharya's account of the cost of conference attendance is comprehensive — apart from one component that is missing — that is the payment of locum fees that are often necessary.

To change tack and to look at things from a completely different perspective, perhaps the fee could be picked up by someone else - thus rendering the attendance free of charge. A delegate’s employer may pick up the fee as may a commercial sponsor. However, the commercial sponsor may want something in return and thus a free ticket may in the long run cause more problems than it solves. If an employer pays then, the employer will expect the attendance at the conference to result in an improvement in clinical care at the home institution — which is a perfectly reasonable expectation.

In terms of benefits from attendance at conferences, some benefits as the author suggests are non-tangible and difficult to quantify. However, some benefits are more explicit. Conference attendance might enable a delegate to learn how to shorten patients’ length of stay for certain procedures. This will result in real cost savings for the home institution. Conference attendance may enable a delegate to learn how prevent adverse events, and preventing such adverse events may once again result in a tangible monetary saving to the institution. When these things do occur, it is certainly worth reporting them back to the institution. The institution in question will them realise the benefits of sending its doctors to conferences.

Finally and importantly conference delegates should think not only about the monetary cost of attendance, but also the cost in terms of climate change. Reducing carbon footprint is vital, and healthcare professionals undoubtedly have role to play in this regard also.

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