**Clinical Tips and Extracts**

**Ectopic maxillary first molars: please do not extract the E!**

By Dr Nour Eldin Tarraf

Often in the early mixed dentition a maxillary first permanent molar erupts ectopically and is locked or impacted under the deciduous second molar. Too often those patients are referred after the deciduous second molar has been extracted because it is deemed “too badly” damaged. The first molar then erupts mesially taking up most of the space for the second premolar. We are then left with the dilemma of opening space and maintaining it for four to five years until eruption of the second premolar or planning for later complicated treatment with potential extraction of the second premolar. This is almost always avoidable if the 6s are managed correctly and timely. Ectopic eruption of first molars is fairly common and it can self-correct in many cases. However, extraction of the E (deciduous second molar) is almost never a good idea. Studies show that the E will survive till the normal shedding time even with advanced resorption of the distal root, if the 6s are distempered with an appropriate treatment in a timely manner.

The management will depend on the degree of impaction, presence or absence of the 5s, crowding and other factors. Management can be as simple as placement of an elastomeric or metallic separator, which can be enough to disimpact the 6, all the way up to a sectional fixed appliance to push the 6s distally.

Early detection and management is key. Children should be monitored for the timely eruption of the first permanent molars between 5-7 years old. If ectopic first molars are detected early management can save a lot of treatment time and cost in trying to regain space and then maintain it until the eruption of the second premolar.

**References**


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Dr Tarraf is presenting Understanding Orthodontics at the ADA NSW Centre for Professional Development on 30 May, 9.00am-4.30pm, 1 Atchison Street, St Leonards. Book online at www.adansw.com.au/CPD

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**Packing retraction cord**

by Dr Michael Mandikos

Too many clinicians have trouble placing retraction cord before taking their impression. However, placing a cord is very simple if done correctly. The three factors to consider are the size of the cord for the size/depth of the sulcus, the size of the packing instrument, and realizing that the cord is being packed into a circular shape - the circumference around a tooth root.

In regards to cord size, it is important to remember that the gingival sulcus in health is only about 0.7mm deep. So there is very little room in it for a big cord. I prefer to use Ultratrand Size #0 cord, or Premier Size 800 cord for most clinical situations (See Image 1). These are fine cords, but they fit into the fine space that is most gingival sulcuses. The cords are placed "just" into the sulcus, so they are level with the prepared margin of the tooth, and not pushed too far apically into the sulcus. This keeps the cord within the sulcus and prevents it pushing deeper into the epithelial attachment, or worse, into the connective tissue attachment zone. There is certainly no space in a sulcus for routine use of a double cord technique in my experience.

The cord placement instrument needs to be equally as fine as the cord. I like the American Eagle IPC or PPC-F fine flat plastics as placement instruments (See Image 2), although there are other dedicated placement instruments on the market. A regular flat plastic instrument will not do the job as it is too thick. The gingival sulcus is quite shallow as we already said, and a cord will enter it more readily if it is gently pressed in with a very fine placement instrument.

Lastly, it is also important to realise that the cord has a round profile, and it is being tucked into a round shaped sulcus. If one thinks of the analogy of coiling up a garden hose, they will realise that as they coil the hose, the hose itself is rotating as it assumes its round, coiled up position on the hose reel or in a big circle on the ground. The same applies to the cord being tucked into the round sulcus around a tooth. It will rotate as it goes around the tooth and if the clinician uses a fine placement instrument and gently presses on the inner aspect of the cord as they tuck it into the sulcus, it will rotate on itself and fall into the sulcus more readily. (See Image 3)

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Dr Mandikos is presenting Current Concepts in Cementation at the ADA NSW Centre for Professional Development on 16 May, 9.00am-4.30pm, 1 Atchison Street, St Leonards. Book online at www.adansw.com.au/CPD

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**Dentures and Dry Mouth**

By Professor Ian Myers OAM

Chief Executive Officer, Australian Dental Association (Queensland Branch)

Many patients who have hypo-salivation or recurrent dry mouth will complain they have difficulty with retention and comfort of their dentures. While a number of denture adhesive powders and pastes are available, these adhesives often produce a very sticky and gummy mass under the denture which can make denture hygiene and oral hygiene very difficult. An alternative approach is to use an oral lubricant or saliva replacement gel to assist with denture retention and comfort. This can be applied as needed and in many cases is much more comfortable and easier to maintain than other gum based denture adhesives.

The added moisture from the oral Lubricant under the denture increases retention and can minimise abrasions and ulcerations of the oral mucosa.

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