is gradually stretched and elongated without complication in mandibular distraction osteogenesis?

Secondly, when the root migrates without deficit to the IAN, but later needs to be removed because of root eruption and exposure, does it mean that the IAN-endangering removal was only delayed?

Thirdly, when a "coronectomised" root is removed several years later in a different practice, maybe even in a different country, will their risk-assesment evaluate the circumstances correctly? Is cone-beam computed tomography recommended for migrated root removals that are still superimposed?

Finally, should we use guided bony regeneration routinely for such cases to reduce migration of the roots appreciably?

It would be interesting to read experts' opinions and experiences, or study results concerning such cases, to help assess what to expect when the IAN is located inter-radicularly, and surrounded completely or almost completely by the tips of the roots. Or is it all only theoretical?

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patient's permission

The study was approved by the Regional and Institutional Research Ethical Committee of University of Pécs [7920/PTE/2019] and the patient's consent was obtained.

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Efficacy of a plastic clothes peg in the management of trismus

Sir,

Trismus, or restricted mouth opening, is a well-documented complication after dentoalveolar or maxillofacial surgery that is daunting not only for the patient but also for clinicians to treat. It is usually caused by inflammation and spasms of the masticatory muscle postoperatively, or unyielding scarring. The limited opening of the mouth may cause problems with chewing, speech, and oral hygiene, and may cause pain.[1]

Usually trismus will resolve with time, and treatments include the use of physical therapy, active jaw exercises, the application of warmth, and medications such as nonsteroidal anti-inflammatory drugs, muscle relaxants, and steroids.[2] A number of techniques include the use of commercially-available jaw-stretching tools such as TheraBite® (Atos Medical AB),[3] less expensive stacked tongue blades, or tapered corks. Persistent trismus with an unknown cause may also be treated surgically with bilateral coronoidectomies.[4]

We have successfully used plastic clothes pegs (Fig. 1) for active jaw exercises in a patient who had postoperative trismus after the extraction of a third molar. The pegs were inserted between the teeth to increase the interincisal distance until slight pain was felt. The exercises were done for about two minutes every two hours to increase the interincisal distance and to stretch the muscles of mastication, and normal mouth opening was achieved within ten days (Fig. 2). The advantages of using clothes pegs are that they are cost-effective, improve compliance, and do not require multiple visits to the clinic. In a country such as India, where ankylosis

Fig. 1. Plastic clothes peg.

Fig. 2. Before and after exercises using the plastic clothes peg.

is prevalent in the lower socioeconomic strata where active jaw exercises are not often complied with, we recommend this alternative, cost-effective method.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patient's permission

Ethics approval was given. Informed consent has been obtained from the patient.

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Inadvertent entrapment of nasotracheal tube with a screw during bimaxillary osteotomy

Sir,

Damage to the endotracheal tube in orthognathic surgery is not uncommon. Inadvertent tearing of the tube by a reciprocating saw has been experienced in many centres.[1–3] This kind of damage is usually immediately obvious, as bubbling and problems with ventilation mean that the tube must be replaced.[3] Some of these cases may also present with difficulties in extubation.[4,5] Here we present a patient who had a double-jaw operation in which the nasotracheal tube was found to be stuck during awakening in the recovery room, and which was managed by an immediate return to theatre.

A 30-year-old man, who was having maxillary advancement and mandibular setback, was intubated through the left nostril with a 7F, cuffed, spiral-embedded endotracheal tube. Mini-plates were being fixed to the maxilla, with the screw holes drilled bicortically at the bilateral maxillary buttresses and pyriform aperture. There were no bubbles or other visible signs of air leakage, and no abnormalities were noted on oxygen monitoring at any time during the operation.

The nasotracheal tube was aspirated at the end of the operation with a nasogastric cannula, which glided effortlessly and brought out clear secretions only. The patient was brought to the recovery room, breathing spontaneously. Soon, the surgical team was informed that the tube was entrapped and he was taken back to theatre. As he was still breathing spontaneously, a flexible endoscope was introduced into the nasotracheal tube, and showed that the tip of a screw had punctured it (Supplemental Figure 1), and a free-floating spi-