Adverse Incident Reports to BOS

Since the last edition of CEB two incidents have been reported to the Society through our confidential reporting system.

The first of these was in December 2017. A 16 year old girl ingested a single use debonding bur during a routine orthodontic appointment (DB Orthodontics RA 1172) when it was lost from the handpiece in the mouth (Optima handpiece BA 611074). The clinician referred the patient for a chest Xray at the local district hospital. On attendance she was transferred to a teaching hospital and admitted. Further imaging located the bur within the bowel. She was kept in hospital for 2 nights, but subsequently discharged without surgery as the bur was expected to be passed naturally.

The second report was received in February 2018. A 13 year old girl in the early stages of orthodontic treatment attended the orthodontic department as an emergency. The previous evening her lower nickel titanium archwire had been displaced out of the lower molar whilst eating. The adjacent coilspring had been lost and the family were concerned that she may have inhaled or swallowed it. The archwire was replaced with an 018 stainless steel and the ends cinched. A chest Xray revealed that there was no foreign body and the family were reassured that the lost coil would probably be passed naturally.
This incident occurred despite the ends of the NiTi archwire being annealed and cinched. It serves as a reminder that supplementals can be lost from a flexible wire and present an airway hazard.

Maren Gaukroger
Consultant Orthodontist
United Lincolnshire Hospitals Trust

Adverse Incidents Officer
BOS