

Letters to the Editor

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Priority will be given to letters less than 500 words long.
Authors must sign the letter, which may be edited for reasons of space.

CRB TRAINING

Sir, I write in reference to CRB and C. Zane's letter concerning post offices (*BDJ* 2011; 210: 3). I duly took all my information (October) to Colchester Crown Post Office and a very efficiently run place it was with a doorman asking my purpose and inviting me to a seat when my number should be called for the appropriate section. All very painless. However, I asked the clerk how many she had done; 'about ten' was the reply. She had a great wad of notes and no training. I was not surprised when I received my forms back from CQC saying they were filled in incorrectly (by the clerk) and they would have to be resubmitted. I still have not received the appropriate certificate. You are supposed to be able to track its progress online, but who has the inclination when we are pursued by red tape from every direction!

S. Bazlinton
By email

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HERPES ZOSTER REACTIVATION

Sir, reactivation of the herpes zoster virus in the ophthalmic division of the trigeminal nerve is common in adults over 50 years of age. Left untreated, herpes zoster ophthalmicus (HZO) may lead to chronic and debilitating complications such as post herpetic neuralgia and blindness.

We would like to share a case of HZO with anterior uveitis which occurred after treatment with a CU-80 visible curing light system (wavelength 410-501 nm; Jovident International, Duisburg, Germany) and successfully managed with topical corticosteroids and mydriatics. This is the first description of HZO reactivation following

treatment with dental curing light units. This previously unreported case highlights the need to recognise the manifestations of herpetic ocular and periocular disease during routine dental practice.

Herpes zoster ophthalmicus (HZO) is caused by reactivation of latent Varicella zoster virus (VZV) in the ophthalmic division of the fifth cranial nerve. Approximately 1% of the general population develop HZO at some point in their lifetime. Risk factors for reactivation include increasing age, trauma, chronic corticosteroid use, post-surgery – eg following laser *in situ* keratomileusis, and decreased immunity correlating with a specific decline in cell-mediated immunity to the virus.¹⁻⁴ Although ultraviolet light has been shown to precipitate reactivation, light within the visible spectrum is not a recognised risk factor. We present a report of HZO with anterior uveitis occurring after dental treatment involving use of a CU-80 visible curing light system (wavelength 410-501 nm; Jovident International, Duisburg, Germany).

A 58-year-old woman presented three days after undergoing filling treatment for a tooth cavity with a CU-80 visible curing light system with a new onset, painful rash on the left side of her forehead and associated fever and malaise. The left eye was painful and photophobic.

On examination, a marked left-sided papulo-vesicular eruption was noted in the distribution of the ophthalmic division of the trigeminal nerve (Fig. 1). Visual acuity measured 6/6 bilaterally. Anterior segment examination revealed conjunctival injection and anterior chamber inflammation with

no evidence of keratitis. The intraocular pressures were normal and fundus examination was unremarkable. With a diagnosis of HZO and anterior uveitis, the patient made an uneventful recovery following treatment with oral acyclovir and topical dexamethasone 0.1% with cyclopentolate 1%.



Fig. 1 Papulo-vesicular eruption along the distribution of the ophthalmic division of the trigeminal nerve

Visible light-cured composite systems have widespread use in restorative, orthodontic and cosmetic dentistry due to their ease of use, short application time, and excellent safety profile. However, there is some evidence that these photocuring sources pose some risk of irreversibly disrupting cellular function *in vivo* due to a photochemical reaction. The degree of damage appears to be light dose dependent and independent of temperature.⁵ Although little is understood about the mechanism of VZV reactivation, one plausible explanation in this case is that virus reactivation occurred secondary to localised immunosuppression from cellular dysfunction due to the curing light system. The onset of symptoms shortly following the dental curing light system treatment and the