

# Letters to the Editor

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## OBSERVE THE HEALING PROCESS

Sir, I have read with interest the paper by L. Tolstunov in a recent edition.<sup>1</sup> It is important to continue the research related to prevention and management of alveolar osteitis (AO). During my on-calls as a dental foundation trainee in a busy oral & maxillofacial department, I received a lot of referrals from the accident & emergency department, where patients presented with severe post-operative pain or AO following dental extractions. Most patients I saw had already received treatment for AO by their dentist or their local emergency dental clinic. I noticed that a high number of patients who eventually presented to A&E developed an infection of the extraction socket following placement of Alvogyl. In most cases this could be managed with the removal of the dressing, irrigation of the socket and a short course of antibiotics. However, one patient developed severe facial cellulitis as a result of an Alvogyl dressing that was left *in situ* for over three weeks and caused infection of the socket. She had to be admitted for intravenous antibiotics and underwent extraoral drainage and debridement of the socket under general anaesthesia.

The dressing of a socket with Alvogyl is a very safe and effective management of AO.<sup>2</sup> It is an antiseptic and analgesic paste containing butamben, iodoform and eugenol. A recent study carried out by Ryalat *et al.* showed that Alvogyl reduced postoperative pain at the extraction site, but a higher incidence of both alveolar osteitis and local operative site infection had been encountered.<sup>3</sup> According to the manufacturer Alvogyl easily adheres to the alveolus and assisted by the patient's

tongue movements, it gradually self-eliminates.<sup>4</sup> This is not synonymous with self-dissolving, which is the impression frequently given to patients.

I acknowledge that the lady's case I have described is rare but it is an important reminder that the dressing is to be treated as an undissolvable foreign body and it cannot be assumed that 'self-elimination' takes place in every case. Good practice is to review patients who received treatment for AO to observe the healing process.

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2. Bowe D C, Rogers S, Stassen L. The management of dry socket/alveolar osteitis. *J Ir Dent Assoc* 2011; **57**: 305–310.
3. Ryalat S T, Al-Shayyab M H, Marmash A, Sawair F A, Baqain Z H, Khraisat A S. The effect of Alvogyl™ when used as a post extraction packing. *Jordan J Pharm Sci* 2011; **4**: 149–153.
4. Septodont. Periodontology and surgical/bone treatment: Alvogyl. Available at: [www.septodont.co.uk/products/alvogyl/?from=250&cat=](http://www.septodont.co.uk/products/alvogyl/?from=250&cat=) (accessed 12 February 2013).

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## PERSISTENT METALLIC TASTE

Sir, in a patient with the complaint of a strange or bad taste, the cause is typically difficult to diagnose, and treatment challenging. As always, the history is of paramount importance to diagnosis, and must always include exploration of lifestyle and environmental factors. A 70-year-old British woman complained of a strange persistent metallic taste since her summer holiday in Thailand 2012, although it was slowly spontaneously resolving. The medical history was non-contributory, except that she had

contracted dengue haemorrhagic fever (DHF) in 2012 and been hospitalised; further questioning revealed this was just before the onset of the oral complaint. Extraoral and oral examinations revealed nothing of significance. The taste perversion was attributed to the dengue and treated with reassurance and B complex vitamins. Taste abnormalities in dengue, though unmentioned in most publications on dengue or oral disease, were first reported after the Second World War<sup>1</sup> with sparse reports thereafter.<sup>2,3</sup> Dengue fever has re-emerged since 1950 with an ever expanding geographic distribution of both the viruses (dengue virus [DENV] serotypes 1–4) and the mosquito vectors (*Aedes aegypti* and *Aedes albopictus*), and the emergence of DHF in new geographic regions. It is currently the most important tropical infectious disease after malaria. About 40% of the world's population live in areas at risk for dengue transmission, such as endemic areas which include many popular tourist destinations in at least 100 countries in Asia, the Pacific, the Americas, Africa, and the Caribbean – though the mosquitoes can be found worldwide. Most cases seen in the developed world have been acquired elsewhere, by travellers or immigrants. The principal features of dengue fever are fever, headache, retro-ocular pain, joint pain, muscle and bone pain, rashes, and mild bleeding (eg from nose or gingivae) and easy bruising. DHF is a more severe form of infection, which can be fatal if unrecognised and not properly treated. There is, however, no specific treatment, only symptomatic care and attention to fluids and haemostasis. The most effective