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.[1] 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.[2] 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.[3] According to the manufacturer Alvogyl easily adheres to the alveolus and assisted by the patient's tongue movements, it gradually self-eliminates.[4] 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.

S. Wegenast
Derby

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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[1] with sparse reports thereafter.[2,3] 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

protective measures for dengue are those that avoid mosquito bites.[4] The case illustrates the importance to dental professionals of taking a full travel and lifestyle history, and using the literature; and, to the public, due consideration of both the opportunities and potential challenges of global travel.

C. Scully CBE, by email

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A TOPICAL TOPICAL

Sir, I read with interest your recent News item proposing use of Nisin food preservative for preventive management of head and neck carcincoma.[1] Another potentially very valuable, somewhat overlooked, yet accepted and safe, natural health aid is green tea extract (GTE) from the leaves of *Camellia sinensis*. GTE is available over-the-counter and possesses potent antioxidants called catechins of which the chief active ingredient is epigallocatechin gallate (EGCG). Its stability in hot water is good with minimal activity loss and it is naturally water soluble. At and above physiological pH the catechins are unstable. So EGCG may present with somewhat compromised systemic bioavailability – but this does not at all rule out its topical benefits. EGCG is anticancer and also has other benefits such as cardioprotection.[2] In fact, green tea has antibacterial and antiinflammatory[3] and antiviral[4] in addition to cancer chemopreventive capabilities.[5,6] A controlled clinical trial of GTE showed a trend towards a dose-response effect for green tea exposure in patients with premalignancy of the mouth.[6] The authors summarise that these results support the longer-term clinical testing of green tea extract for oral cancer prevention. Green tea is thus a *topical* 'topical'!

J. Loudon
Sydney

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DEMISE OF THE SINGLE HANDED PRACTITIONER

Sir, on the cusp of retirement I would like to reflect on two of the changes in dentistry over the last 40 years, using the issue of the *BDJ* (Volume 214 No. 1, 12 January 2013) as an *aide memoire*.

My entering general dental practice in 1973 and starting as a single handed practitioner consisted of automatically obtaining a Family Practitioner Committee number and setting up practice in a Grade II listed town house with a brass plate outside. This contrasts today with Dr J. R. Mackay's lament in Letters to the Editor of his 'non-job' (*BDJ* 2013; **214:** 6) trying to comply with the plethora of bodies regulating the practice of dentistry. Forty years ago my job description was dental surgeon; today my job title is performer and provider of primary dental care for the local PCT, lead in child protection, lead for cross-infection control, radiological protection supervisor, health and safety supervisor, fire warden, lead for information governance, lead for staff training, and environmental cleaning operative. I have probably left a few out. As a single handed practitioner I would not be able to carry these duties out unless I saw patients part-time, therefore reducing my income. Furthermore, I would now not be able to afford the installation, maintenance and certification of complex and sometimes unreliable items of equipment seemingly necessary such as vacuum autoclaves, washer-disinfectors and computerised records.

The second major change is highlighted in your current journal under Product News: *End of an era for historic practices* (*BDJ* 2013; **214:** 37). The majority of dental practices 40 years ago were set up in former private residences in town centres which now, because of the incompatibility of the Disability Discrimination Act and HTM 01-05 with listed building consent, conservation area consent and planning permission are deemed no longer fit for purpose and will soon be unviable.

Both these changes may be seen as progress, but put together with the retirement of dentists who were of the baby boomer generation, this can only contribute to the demise of the single handed practitioner who once formed the majority provider of primary dental care in the UK. Farewell!

M. Austin, Hove

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NEW PROTOCOL NEED

Sir, D. Howarth makes a fair point about the maintenance of implants in dementia patients but the same problems occur in crown and bridge patients or indeed any patient with standing teeth.

Dementia, serious strokes or any serious brain injury render the patient unable to look after their mouths and it is almost impossible for carers to assist them. Many have multiple other problems requiring attention and time. The speed with which decay destroys teeth renders anything but extractions pointless. Add to this the number of patients taking bisphosphonate drugs with their attendant risk of osteonecrosis post extraction and the need for a new protocol for treating the elderly and infirm becomes evident.

Maybe the denture wearers of the past who drifted into full dentures over the years didn't have such a bad deal after all.

I. A. Inglis, Plymouth

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