

# 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.

LETTERS

## 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.<sup>1-4</sup> 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.<sup>5</sup> 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

location of the eruption adjacent to the site of exposure imply a causal link, rather than just coincidence.

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## THE SHORT STRAW

Sir, a 3-year-old girl attended our clinic complaining of 'bleeding and painful gums'. The patient's mother reported that the child's gums at the front had looked sore for more than a year, with some kind of build up around a tooth which she was unable to clean by brushing. They had reported the problem a year ago to their previous dentist who suggested that it might be abnormal gum tissue growth that had formed around the tooth. No further advice or intervention occurred.

The mother tried to keep the area as clean as possible but became worried in the last three months when a gap started to appear between the front teeth and the tooth concerned.

Examination revealed adequate oral hygiene apart from moderate gingival inflammation around the LLA. The LLA was grade II mobile, supra-erupted and distobuccally rotated with a yellowish calculus-like covering over the gingival third of the tooth (Fig. 1). The yellow film seemed to be locked in place due to the tight mesial contact with the LRA. There was a build-up of plaque underneath and over the film covering the tooth, suggesting a foreign body.

Radiographically horizontal bone loss was observed around the LLA, but there were no signs of the film covering the tooth on the radiograph (Fig. 2).

A vertical cut was made along the length of the film labially using a scalpel and the object was slid out through the



Fig. 1 The affected tooth with its calculus-like covering



Fig. 2 Radiograph showing horizontal bone loss



Fig. 3 The foreign body removed from the tooth

contact point. Examination of the object revealed some kind of plastic straw like tubing around 4 mm long and 5 mm in diameter (Fig. 3).

Questioning of the mother and child did not reveal how the foreign object came to be lodged adjacent to the child's tooth.

N. Joshi, I. Al-Hadad, Z. Ullah

By email

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## CONSISTENTLY AMAZED

Sir, in the *BDJ* of 8 January a short abstract was provided of a study on the role of anxiety and depression in patients with temporomandibular pains (TMD).<sup>1</sup> It is no surprise that depression plays a role in TMDs as there is also ample evidence in the chronic pain

literature to show that depression is common in these groups of patients and affects outcomes. TMD in many instances is associated with other chronic pain as it appears these patients have an increased vulnerability to pain as shown by case control studies linking TMDs with migraines, fibromyalgia, post traumatic stress and back pain.<sup>2</sup> Prognostic studies have shown that poor outcomes are to be expected in patients with concomitant psychological factors.<sup>2</sup> However, in the recent article in the *BDJ* in the series on risk management in clinical practice on TMDs<sup>3</sup> there is no mention either of the importance of eliciting co-morbidities and psychological factors in the history, or highlighting the role of psychosocial techniques in management. Gray's and Al-Ani's article<sup>3</sup> continues to stress a mechanical approach to a problem which has genetic, environmental, behavioural and psychological risk factors. As Stoher<sup>4</sup> points out, splints need to be regarded as placebos but patients cling to them as they have few adverse effects and it seems dentists tend to prefer a mechanical rather than a biopsychosocial approach. I am consistently amazed at patients' (who have been wearing splints for months) complete lack of knowledge about the anatomy and functioning of the masticatory apparatus and their relief when this is explained through the use of a model. It is precisely because these broader issues are not taken into account that patients fail to improve and then instigate complaints. Ohrbach has recently extensively reviewed how disability should be assessed in patients with TMDs which is achievable in general practice.<sup>4</sup>

On behalf of facial pain unit

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