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Alveolar osteitis: What's in a name?

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COMMENT

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Alveolar osteitis

What's in a name?

Sir, alveolar osteitis (dry socket) is a well-recognised and frequently encountered post-extraction complication resulting from premature disintegration of a blood clot in the extraction socket. The clinical presentation of alveolar osteitis is typically marked by moderate to severe, throbbing pain on the 2nd to 4th day after an extraction; tender, exposed alveolar bone; and halitosis. It is best described as delayed healing and the therapeutic goal is to relieve the patient's pain. However, treatment does not hasten healing.[1] Alveolar osteitis should be managed with irrigation of the extraction socket with sterile saline to remove necrotic debris and placement of an appropriate medicated dressing like Alvogyl. Curettage of the socket needs to be avoided as it may expose the bone further. Persistence of pain may require replacement of the dressing every other day until the pain subsides.

Anecdotal evidence from general dental practice settings across the country suggests that dentists and nurses frequently tend to equate alveolar osteitis with an 'infected socket' and the same diagnosis is often communicated to the patients. This seems misleading and almost invariably prompts patients to request antibiotics. Although there is a small risk that alveolar osteitis may be complicated by secondary infection, this needs to be evaluated objectively rather than assumed by the dental clinicians. Establishing a diagnosis of an infected socket warrants clinical evidence of suppuration and/or soft tissue swelling and erythema, fever and lymphadenopathy. The Chief Medical Officer in England has repeatedly expressed serious concerns regarding widespread antibiotic resistance and has called upon NICE to develop guidance on antibiotic prescriptions.[2] More recently the WHO has also described a 'post antibiotic era' as a major global threat and there is a substantial risk of common infections proving to be fatal due to increasing resistance of microorganisms to available antibiotics.[3]

Given that dental practices also contribute to the heavy load of total antibiotic prescriptions across the country, it is imperative to revisit this issue to restrict the use of antibiotics only to clinical situations where absolutely indicated. Following routine extractions, dental practitioners are more likely to encounter alveolar osteitis than infection which precludes the need for antibiotic prescriptions.[4] Using your esteemed journal's platform I wish to re-emphasise that alveolar osteitis needs to be managed as delayed healing rather than an infection and this should be communicated accordingly to the patients. This will help reassure patients and minimise their demand (and potentially incorrect prescriptions) for antibiotics.

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1. Hupp J R, Tucker M R, Ellis III E. *Contemporary oral and maxillofacial surgery.* Elsevier Health Sciences, 2013.
2. Davies S C, Fowler T, Watson J, Livermore D M, Walker D. Annual Report of the Chief Medical Officer: infection and the rise of antimicrobial resistance. *Lancet* 2013; **381:** 1606–1609.
3. World Health Organization. Antimicrobial Resistance Global Report on surveillance 2014.
4. Lodi G, Figini L, Sardella A, Carrassi A, Del Fabbro M, Furness S. Antibiotics to prevent complications following tooth extractions. *Cochrane Database Syst Rev* 2012; **11:** CD003811.

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Dental education

Colour perception impairment

Sir, I am grateful to the authors of the opinion piece on screening dental students' deficiencies in colour perception (*BDJ* 2016; **221:** 227–228). Not because I agree with their thesis, but because the issue of colour perception impairment (CPI) needs to be aired and better understood. Importantly, proper adjustments should be made to accommodate such impairments. This applies equally to dentists in training and in employment, because their trainers and employers have a legal duty to do so.

There are very few professions that can genuinely claim such adjustments would be too expensive or onerous, or that their lack thereof would endanger the public. Such thinking is outmoded and very likely discriminatory. Nowadays, around one third of would-be-pilots with a CPI are deemed perfectly safe to fly thanks to new tests which can differentiate the types of CPI.[1,2] Of note, the blanket ban on 'colour-blindness' in the police force was deemed indirectly discriminatory on the grounds of sex, because its frequency in males is approximately ten times that in females.[3] Moreover, a blanket ban does not take into account that there are varying degrees of CPI.[4]

Returning to dentistry, I would take issue with the assertion that colour perception is a core dentistry skill, for several reasons. A skill is an ability that can be taught and learned – clearly not applicable to CPI. Colour-matching is a technical measurement that can be more accurately achieved with instrumentation rather than relying on the human eye (with or without CPI). I cringe that the authors compare impaired colour vision acuity with mental impairment in the debate about professional competence. Therefore, I categorically refute their assertion there is an urgent need to 'determine the relationship between colour vision deficit and dental competence'.

Seeking the wisdom and guidance of our dental regulator sadly does not provide any enlightenment on the subject of CPI, nor indeed the more general issue of adjustments for disabilities. COPDEND, on the other hand, does provide an equality impact assessment on foundation training wherein they assert the model of assessment is seen to be fair and equitable to all disability groups.[5] (However, I have advised COPDEND that their website system to deliver a written enquiry requires the enquirer to pick out