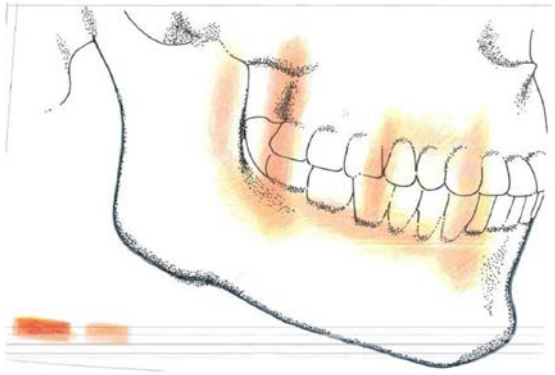

Fig. 1. Diagram showing facial pain in the mandibular division of the trigeminal nerve in our patient.

Pain diagrams are often used to assess musculoskeletal and chronic bodily pains,[1] but this has yet to be transferred into the management of facial or TMD pain. A cross-sectional study in 2016 found that drawings of sites of pain were simple adjunctive clinical and research tools for identifying comorbid pains in patients with TMD.[2] Geis et al[3] also found merit in these diagrams for detecting other conditions that coexisted with facial pain, and concluded that using them for diagnosis did not place excessive demands on patients.

Physical and psychological comorbidities have a large impact on treatment outcomes in orofacial pain. The use of localised, regional, or whole-body pain drawings could allow patients to convey their history and symptoms more effectively, and to improve the sharing of information between them and their surgeons to improve the planning of treatment.

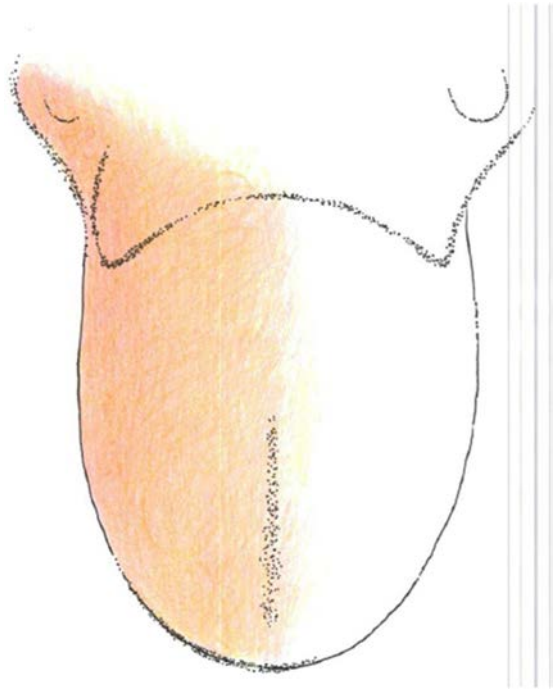

Fig. 2. Diagram showing the radiation of pain across our patient's tongue on the right side.

We consider patient-drawn pain diagrams to be of diagnostic value, as they may more accurately identify pain within a division or branch of the trigeminal nerve that may be amenable to a more localised procedure, particularly in those who struggle to portray their symptoms verbally.

Authors' contributions

Naeem Adam: Authorship of letter.
Emma Walshaw: Authorship of letter and submission.
Lachlan Carter: Authorship of letter and treating clinician.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patient's permission

No ethical approval required. No permission or consent was required from the patient.

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A timely reminder of the importance of follow up

Sir,

Alveolar osteitis is a common reason for dental emergencies after the extraction of teeth. Dentists are well-equipped

and educated to manage it and have a range of options with which to relieve the symptoms.

One of these involves the use of an Alvogyl™ (Septodont) dressing, which combines three key ingredients (iodoform, eugenol, and butamben) in a fibrous paste.[1] It has instant local anaesthetic and antiseptic effects, quickly manages discomfort, and is safe and effective, provided that it is removed from the socket once the underlying condition has resolved.[2] While the manufacturer's instructions state that Alvogyl™ spontaneously eliminates itself, its fibrous base is not resorbable. This can become a point of confusion for the dental practitioner.

Recently, a patient was referred to our unit from the Department of Infectious Diseases. She had a two-month history of a non-healing and infected extraction socket and had been given multiple courses of antibiotics orally by her dentist and general practitioner. At one stage she had spent a short time in a tertiary hospital having antibiotics intravenously, a lumbar puncture, and multiple blood cultures (as part of a septic screen for transient bacteraemia with streptococci). On thorough examination, the only potential infective source was the tender and suppurating socket 46.

Given the remarkable history, we were quick to biopsy and debride the area to rule out actinomycosis, or worse, malignancy. Histopathological examination, however, showed chronic inflammation surrounding a ". . .foreign material consistent with 'Alvogyl' ". After debridement her symptoms resolved and the site healed completely.

Alvogyl™, when used correctly, is a safe and effective method for managing this common presentation, and few other options provide such immediate results. As with all dressings and materials we use in dentistry, it is critical that dentists are fully aware of their biochemical properties. More importantly, this unusual case highlights the principle of practice that we often forget: a five-minute follow up appointment can prevent a whole lot of trouble.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patient's permission

No ethics approval required. The patient's permission has been obtained and all her details have been omitted from the paper.

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Novel cover plate

Sir,

We describe an unusual and ingenious patient-constructed cover plate. A 67-year-old patient with osteoradionecrosis of the right body of the mandible presented to the maxillofacial surgery clinic for review. He had exposed bone intraorally, and the severity of his disease was graded as Notani II.[1] He had difficulties with pain (mainly on the ipsilateral side of the tongue because of damage from the necrotic lingual bony plate), and with food being trapped around the exposed bone.

Before his review, he took it upon himself to construct a plate to cover the exposed area and ameliorate his symptoms (Fig. 1). He used a pair of scissors to cut the handle off a plastic 4-pint (2.27 L) milk bottle from a supermarket, then cut the tube in half longitudinally. He trimmed the edges to adapt it to the exposed bone and lined it with a thin sheet of wax from his dentist. On top of this, he added an adhesive denture strip to adapt it to the wound.

He found that the cover plate had good retention and eased his symptoms enough to improve his quality of life whilst awaiting further treatment. It minimised the amount of food that was trapped and the trauma to the tongue from the exposed bone (Fig. 2). The plate did not become dislodged or

Fig. 1. Exposed mandibular bone.