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LETTER TO THE EDITOR

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Allergic rhinitis and dental caries

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TO THE EDITOR:

I have read the review article titled “Allergic rhinitis (AR) and dental caries: A systematic review” by Calvo-Henriquez et al. with great interest.¹ After I carefully read this interesting article, I want to raise some points that require further explanation and briefly mention our study in this area.

Similar to this systematic review, the literature is currently controversial and it neither confirms nor denies the presence of a relationship between AR and dental caries.^{2,3} This valuable systematic review demonstrated that of the 3/8 included studies, of which 2/6 were performed in children, reported a statistically significant association between AR and caries.

Firstly, this systematic review stated that 3/8 included studies showed a statistically significant association between AR and caries. Did these AR patients in the three studies with this significant relationship also have asthma as a comorbidity? I did not see an explanation for this in the article. I think it is important and useful for the reader to clarify this. Because in the presence of this significant relationship, besides the contribution of asthma itself as a disease, it may be necessary to consider the contribution of medications used by asthmatic patients. If those AR patients do not have asthma, this is also very consistent with the literature.³

Second, I think that the meaning and results of the study by Herrström et al.⁴ have been interpreted somewhat in reverse, in a different way than was intended. Indeed, Herrström et al.⁴ studied the association between allergic diseases (eczema, allergic rhino-conjunctivitis, and asthma) and different types of dental restorative materials (amalgam, composite, and glass ionomer) in Swedish schoolchildren. Herrström et al.⁴ studied the effect of dental restorative materials on the prevalence of eczema, allergic rhino-conjunctivitis, and asthma in schoolchildren. It must have been difficult to establish the relationship between the material used in the dental repair and allergic disease and eczema. Observing the frequency of allergic diseases in those who have amalgam or tooth fillings is not the same thing as checking the frequency of dental caries in allergic diseases. I think that this has been misinterpreted by Calvo-Henriquez et al.¹ Those who have caries or other dental problems but do not have dental fillings (amalgam) should not be kept out of sight. Furthermore, in this study by Herrström et al.,⁴ dermatitis is referred to as atopic dermatitis or eczema. When dermatitis is mentioned in the article by Calvo-Henriquez et al.,¹ not this meaning, but other types of allergic dermatitis come to my mind as an allergist, and the meaning of the word has been deviated. This word ought to have been used as atopic dermatitis.

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Thirdly, in our thesis study, we also compared the oral or dental health of healthy children with that of those diagnosed with AR and asthma between 6 and 12 years of age. There was a significant difference between the decayed, missing, and filled teeth (DMFT) index measurements of the patient and the healthy group. Low DMFT index measurements were found in our overall AR+ asthma patient group. Especially, the significant decrease in the DMFT index in AR patients was seen as the duration of drug use increased.

In brief, we think that in allergy patients (allergic rhinitis and asthma cases) chronic mouth breathing, hyposialia, even medications (such as antihistamines) used, and other things play a joint role in the development of dental caries. Therefore, we agree with the authors that the inclusion of oral health or dental care screening in the otolaryngology, pulmonology, and allergy guidelines should be recommended.

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