

Post-Traumatic Taste Problems

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We tend to consider taste to be a minor sense, although gustatory perception is highly refined. Its physiology is poorly understood and the little is known about the symptoms of pathological conditions affecting taste. Taste is essentially an oral sense, and it is now widely accepted that we can perceive seven different basic tastes: sweet, salty, bitter, sour, umami, astringent and metallic. Taste is also linked to olfaction (the sense of smell) and salivation. Patients experiencing taste problems should undergo a detailed interview with their doctor, with the aim of identifying the cause of the problem.

Buccal, ear-nose-and-throat and neurological examinations should be carried out and chemical or electrical stimulation tests can also be very useful. Taste problems may have many different causes.

They affect quality of life, reduce appetite and constitute a risk factor for undernutrition. These conditions are difficult to treat, requiring elimination of the cause, the use of flavor enhancers or a change in diet according to the advice of a dietician. Any associated undernutrition must be dealt with.

This article focuses on post-traumatic dysgeusia and its management in affected workers.

The gustation establishes probably with the olfaction one of the most former sensibilities of the human beings. The loss of the taste is considered as a "invisible handicap", which strikes the individual in an important way in term of quality of life without being perceived outside. In an inconvenient way, direction of the taste, which seems anatomically very complex and still incompletely

Clarified, is considered as "minor" with regard to the others.

Cicéron argued that "non sequitur ut, cui cor sapiat, non sapiat palatus" (The one who has the wise heart, also has the wise palace). The disturbances of the taste are considered dysfunctions of secondary interest today. It may be necessary to impute the reason to the philosophers who, as Kant, established a hierarchy of the senses and relegated taste and olfaction to the rank of the senses animal, primitive, less noble than the view and the hearing, who characterize the refined man. The disorders of the taste, only or in association with the dysosmie, are particularly invalidating symptoms because of the profound repercussions on the personal and relational life of the reached subject. They can have grave consequences inherent to the incapacity to recognize possible substances. They can have serious consequences inherent to the inability to recognize any harmful substances. This also causes changes gradual dietary attitudes with possible onset or aggravation of problems nutritional. Finally, there is the increase in stress and the possibility of anorexia and depression.

In the professional field, an alteration of this type for a cook, a sommelier or an olive oil taster induces incapacity and incapacity to work economic and personal plans. The pathologies of taste have many causes: periodontal disease, prosthesis and amalgam dentistry, poor dental hygiene, Sjogren's syndrome, mycosis, smoking, alcoholism, ENT viral infections, diabetes by neuropathy, drug effects, hypothyroidism, tumor of nerves of taste, radiotherapy and chemotherapy, epilepsy, psychic disorders, depression, family dysfunction, aging, pregnancy or menopause, vitamin deficiencies or trace elements, etc.

The purpose of this article will be on post-traumatic dysgeusia.

The first description of a case of anosmia and ageusia after head trauma is reported in 1870 by Ogle. The oldest case of "pure" post-traumatic ageusia is notified in 1876 by Ferrier. At Deems and coll. 1991, 132 cases of cranial trauma were estimated with 46 cases of dysgeusia's listed.

In most of the situations, a mitigation of the symptomatology is indicated in time.

No relation between the gravity of the hurts in the head, and the appearance or the duration of the loss of the taste is brought back until now (Sumner, on 1967). Although the bibliography mentions only a low(weak) percentage of case, the demand of recognition of the symptomatology is in fact not insignificant.

The not yet completely codified objective methods, are expensive, concentrated in few universities and require of the particularly qualified staff.

The demonstration of the relationship of causality does not seem still easy.

The care of a patient suffering from disorders of the Taste still very complex taste, especially in the suites of a traumatic brain injury where we are symptom neglected by the person himself, here him worries rather vital questions taste and here often convinced of the temporary nature of the phenomenon. The long time interval before the awareness of the disease prevents a rapid treatment.

For the doctors, the more urgent the anamnesis. It is necessary to speak with the patients not only of the trauma, but also of the problems encountered in the hospital, the return to the home, to look for possible weight loss, changes of fashions of streets, disorders of the mood. With the identified symptoms, the disease has to be clinically and paraclinically confirmed.

Unfortunately, the objective methods are still largely experimental and have not been still not enough validity, reproducibility, sensitivity, specificity, reliability. They are not yet standardized, are too expensive and are still underdeveloped.

Subjective tests, even if they have many limitations, give at least a perception approximate problem. The attending physician, although very involved, will invite the patient to consult a specialist.

The same attention must also be paid to returning to work.

The problem directly concerns the few professionals (sommeliers, olive oil tasters, cooks, tasters and food sales employees), who will significant harm in the course of their work.

But there is also an "indirect" problem: these workers, over a longer period, can have weight loss, metabolic disorders and depression. The occupational doctor must know these problems so that you can intervene in time if the situation demands it. He is legitimate to hope that this long course will be taken in hand by specialists who will work in synergy.

A final point concerns the revision of the amount of compensation. The scales in Italy range from 1 to 5%.

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