The sterile water we use for the autoclave is provided in one litre plastic bottles, of which we use four each day, draining 3.5 litres off at the end of the day. Following the above assumptions, a total of 40,250 litres would go down the drain, and 46,000 bottles used each day. The cost in energy in production of the sterile water: to extract water from the ground, to distil it, and fill the bottles; and the energy required to produce the plastic, convert it into a bottle, transport it, and sterilise its contents, are substantial. Further the 46,000 bottles per day, will require collecting and recycling, or will end up being transported and taking up space in a land fill site.

Although my calculations may be well wide of the mark, hopefully they provide further food for thought. However it is undoubtedly true that HTM 01-05 has greatly increased dentistry's carbon footprint in this country.

C. Dugmore
Leicester
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POSITIVE SPUTUM

Sir, we read with interest the paper *Primary tuberculosis masquerading as gingival enlargement* (*BDJ* 2010; **208:** 343-345).

Tuberculosis has a very high incidence in developing countries. According to WHO estimates 9.27 million new cases of tuberculosis (TB) occurred in 2007 with around 55% of global cases arising in Asia (South East Asia and Western Pacific regions), which is attributed to poor hygiene conditions.[1]

The authors of the paper presented a case of primary tuberculosis of the gingiva. Such a condition is considered a rare entity affecting approximately 0.05-5.00% of patients with TB[2] as the oral cavity is considered to be immune due to local immunity of the mucous membrane.[3] However, an increasing incidence of TB (due to Aids and emerging multidrug resistant strains) means that we are likely to see many cases of tuberculosis in the oral cavity in future, so that TB should be considered as a differential diagnosis. The most usual presentation is as an ulcer on the tongue, gingival or buccal mucosa and as a radiolucency when bone is affected. Since the ulcers usually mimic squamous cell carcinoma, a diagnosis becomes more challenging.[4] Mechanical tears and trauma in the oral cavity are considered one of the aetiological factors for inoculation of bacteria in the oral tissue from sputum. But surprisingly, there are very few cases of secondary tuberculosis in spite of a high incidence of sputum positive cases.

The authors have found positive sputum in their case. Acid fast bacilli can be found in saliva in a case of primary tuberculosis of the oral cavity but not in sputum. Positive sputum points to TB of pulmonary origin although sometimes, TB of the bronchioles is not evident on radiographs. To rule out that possibility, bronchoscopy or CT scan is mandatory. We therefore believe that the presented case is of secondary tuberculosis of the oral cavity.

S. Gandhi, N. Gandhi, S. Bither
By email

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DENIED A REPLY

Sir, I read with interest the letter *Anonymity rights* (*BDJ* 2010; **209:** 105), recounting a false allegation of molestation from a female patient. I have been in general practice since 1986 and I always work with my door open and a nurse in the surgery. Five years ago a female patient had a lengthy crown prep procedure during which the surgery door was open and my nurse was present. This lady waited for one month and then reported to the police that she had been raped whilst in the chair. She took two days of their time and her story was so garbled that they refused to take the matter any further. My frustration was and still remains that I was advised that I must not contact her at all costs and I had no right of reply. She did not, as far as I know, broadcast her allegations more widely. She has now five years later sent a letter threatening to end my career as she has found a retired journalist who is going to champion her cause, and signed her letter 'one of your victims'. Throughout the time I have had to live under the threat of her 'going public'. I suppose it is the risk we take donning a white coat, and I was relieved that she had chosen something so extreme to fantasise about. The local police were quite supportive and wanted to prosecute her for wasting police time, however, they are not allowed to unless she withdraws her allegation, which she refuses to do.

There is no way I can prove nothing happened or prevent someone else doing something similar. I could install a video recorder to tape every working session, but I would have hours of tape to catalogue and keep forever. Anonymity for the accused is viewed as unnecessary by our law makers because the rates of false accusation for rape and sexual offences is no higher than for any other crime. The stress that such an accusation causes cannot be described or the sense of how unjust it is when we are denied a right of reply.

Name and address supplied
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SILLY SEASON

Sir, well the 'silly season' must be upon us! So I gather the GDC is considering removing our right to use the courtesy title 'Dr'. I think there are some very important comments to make on this issue.

First the GDC should not be wasting their time and resources over an issue that was sorted out after decades of debate 14 years ago. I gather that the excuse for this 'debate' is that the courtesy title 'Dr' can confuse the public and mislead them into believing dentists are medically qualified!

So, have there been any issues where a member of the public has been misled by this courtesy title in the last 14 years? NO.

The courtesy 'Dr' title for dentists is used by the majority of countries in the world. The people in these countries do not seem to have any problems over this, and there do not appear to have been any issues of the international or EU public being misled in any way. The GDC is implying that the British public are stupid - or certainly not as discerning as the rest of the world!

The majority of countries in the EEC refer to their dentists as 'Dr'. The dental qualifications of EU countries are