LETTERS TO THE EDITOR

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IN PRACTICE

Glove wearing: new circumstances and many unknowns

Sir, we wish to comment on the article recently published in the *BDJ* suggesting that there are no logical reasons for using gloves in non-surgical procedures.[1]

Research focussing on blood-borne viruses has shown that the risk of their transmission in the dental setting is very low, although dental treatment is still considered to be a risk factor for HBV and HCV infection.[2] Additionally, the number of emerging viral diseases with repercussion in dentistry has increased dramatically in recent decades.[3] The risk of transmission can be reduced by taking routine precautionary measures such as glove wearing, as this practice significantly reduces the blood volume transferred during needlestick injuries.

Restricting glove use to surgical dental procedures underestimates the potential of saliva as a vehicle for the transmission of infectious diseases. Glove wearing prevents the transmission, via saliva, of infectious agents previously considered of lesser importance, such as herpetic whitlow,[4] though it is now known that some of these viruses may have oncogenic potential. Although this field has received little attention to date, we have shown, for example, that over 50% of HCV-infected patients have detectable levels of HCV-RNA in their saliva and that culture of the saliva from patients with confirmed tuberculosis is positive in almost 90% of cases.

Continuous stimulation of the immune system with small quantities of antigens to favour natural immunity is a delicate issue. The most radical proponents are the anti-vaccination movements, particularly active since Wakefield's study, linking vaccination and autism. Recently, in Spain, a 6-year-old child who had not been vaccinated against diphtheria died from this disease, which for the past 28 years has been considered to have been eradicated in that country. In an ever more global society, the arrival of refugees and immigrants (United Nations stated that in 2013 the United Kingdom was among the top 10 destinations for international migrants) requires us to maximise universal barrier measures, in particular to avoid the transmission of pathogenic organisms not recognised by our immune system.

In summary, we consider that glove wearing is a barrier measure of confirmed efficacy and that furthermore, the use of gloves only in the context of surgical procedures could be of medico-legal importance.

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2. Mahboobi N, Porter S R, Karayiannis P, Alavian S M. Dental treatment as a risk factor for hepatitis B and C viral infection. A review of the recent literature. *J Gastrointestin Liver Dis* 2013; **22:** 79-86.
3. Scully C, Samaranayake L P. Emerging and changing viral diseases in the new millennium. Oral Dis 2015; DOI: 10.1111/odi.12356.
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PATIENT CONFIDENTIALITY

A pertinent point

Sir, pertinent to Peter Ward's editorial (*Br Dent J* 2015; **219:** 145), Wood (*Br Dent J* 2015; **218:** 439) raises an important issue with regard to the disparity in guidelines on patient confidentiality issued by the GDC and GMC. Recently a (GMC-registered) consultant histopathologist from another hospital sent me (a GDC-registered oral pathologist) the histological sections of a gingival biopsy from a female patient aged 50 for a second opinion. The clinical diagnosis was of an epulis, but the histopathologist was concerned at the possibility of an odontogenic myxoma, a rare but destructive tumour of the jaws. Review of the histological sections showed non-specific microscopic features, but the differential diagnosis indeed included odontogenic myxoma. To establish a definitive diagnosis required further clinical information and access to the radiographs. Normally, this would be a simple matter of speaking to the clinician concerned (who, usually, is hospital-based) and requesting the radiographs from the referring hospital, which would then be electronically transferred via secure means. Had the patient had the biopsy in hospital, her consent to allow anybody involved in her management to view the radiographs would have been implicit when she consented to the biopsy procedure. However, on this occasion the biopsy had been taken by a dental surgeon in practice and sent to the referring hospital for diagnosis. The dental surgeon was contacted and asked to forward the radiographs, but refused to do so without the patient's written consent, citing GDC guidelines on patient confidentiality. Fortunately (though perhaps inconsistently), she was prepared to discuss the case on the telephone, and assured me that clinically the lesion was a typical epulis, that the radiographs did not show any evidence of a neoplasm, and that she would arrange appropriate follow-up. I, therefore, issued a histopathology report which included the rider that the radiographs were unavailable for examination. As I have heard nothing further in ten months I am hopeful the correct diagnosis was made. When it issued its guidelines on patient confidentiality, one imagines the GDC did not intend to frighten dentists into obstructing the diagnostic process, but that is what appears to have been achieved in this case.

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Incision and drainage can still be attempted for a superficial ranula

Sir, I am a 28-year-old ophthalmologist. Three months ago I visited the local dental clinic because I was bothered by a 0.7 x 0.5 cm fluid-filled and fluctuant vesicle located on the floor of the mouth (Fig 1) for one week. A diagnosis of ranula was made and the excision of the ranula with associated salivary glands was suggested if the ranula still existed after monitoring for three months. By considering the size and location of this lesion, the surgery may