LETTERS TO THE EDITOR

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
Email bdj@bda.org. Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space. Readers may now comment on letters via the *BDJ* website (www.bdj.co.uk). A 'Readers' Comments' section appears at the end of the full text of each letter online.

SMOKING CESSATION

Out with the new and in with the old?

Sir, we are repeatedly prompted to urge our patients to give up smoking and I have found a delightfully decorous way that seems to work which I would like to share with your readers.

Bludgeoning our patients with yet more scientific reasons to quit meets a fairly stony resistance as they have probably heard it all before. Instead of using that confrontational approach I tried working with them, and this gentler approach seems to be more effective.

I find that many patients who are trying to quit are smoking about 15 cigarettes per day and need a bit of help to cut down further. Reaching for 'just one more' from the packet is all too easy and so I have got my patients to visit local charity shops to buy themselves an old cigarette case (hopefully of a suitable style for them as the fabulous Fabergé ones are so difficult to find these days!). They then put that day's quota (eg 15 cigarettes) into the case and that has to last them for the day – no more sneaking another quick one in.

This helps them to eek out a bit more time between their fixes of nicotine as they know that they have a self-imposed, limited supply for the whole day. Also, the process of counting them into the case works in the same way as popping pills out of blister packs makes one realise exactly how many pills one is dispensing. If by the end of the day they find that they have one or more left over, they could even give themselves a sticker on some chart inside the kitchen cupboard.

The following week, they put one less cigarette into the case and so on until they have been able to wean themselves off the dreaded weed completely.

This method is proving to be quite successful and I commend it to your readers to try with their own patients. The charity shops then benefit again by the patient taking the now-redundant cigarette case back for resale!

C. Marks, Southampton

DOI: 10.1038/sj.bdj.2015.863

INFECTION CONTROL

Removing the sensation

Sir, it was interesting to read the letter to the editor in this Journal on gloves by J. Limeres, M. Diniz and P. Diz[1] and the original article, 'Glove wearing an assessment of evidence' also in the *British Dental Journal* by J Mew.[2]

Gloves are no different than condoms. They take the pleasure out of dentistry. Young people do not know anything better because they have never worked without gloves.

Specialisation in dentistry has increased because of loss of tactile sensation. The overall standard of dentistry has gone down. The number of gold and silver restorations has gone down because they require skill. The number of resin and glass-ionomer restorations has increased because these restorations are held in place by bonding techniques.

When the instruments are hot, gloves interfere with sense of touch and patients can be harmed. Because of lack of tactile sensation there is more chance of needle stick injury. The instruments and appliances like crowns and inlays can slip out of hand more easily while wearing gloves.

It is very difficult to use root canal instruments such as hand reamers and files with the gloves. Locating the apex while wearing gloves is very difficult. More and more patients are being referred to the specialist oral surgeons for extraction of teeth.

Recently there were headlines on the front page of *Sunday Express* dated 25 October, 2015, 'Fillings rot your teeth.' The original article on which the headlines were based was, 'Risk factors for caries development on tooth surfaces adjacent to newly placed class II composites – a practice based study'.[3] Most of the similar studies of damage to adjacent teeth have only been done since 1990. While preparing a class II cavity because of lack of tactile sensation while wearing gloves, it is easy to damage the adjacent tooth.

There was not a single study carried out comparing working with the gloves and working without the gloves.

L. K. Bandlish, London

1. Limeres J, Diniz M and Diz P. In practice: Glove wearing: new circumstances and many unknowns. *Br Dent J* 2015; **219:** 369.
2. Mew J. Glove wearing an assessment of evidence. *Br Dent J* 2015; **218**: 451–452.
3. Kopperud S E, Espelid I, Tveit A B and Skudutyte-Rysstad R. Risk factors for caries development on tooth surfaces adjacent to newly placed class II composites – a pragmatic, practice based study. *J Dent* 2015; **43**: 1323–1329.

DOI: 10.1038/sj.bdj.2015.864

CASE REPORT

Plastic canal?

Sir, an interesting case is presented of a 34-year-old gentleman referred into the restorative department at The Royal London Dental Hospital. He presented with chronic periapical periodontitis around the previously root filled and post crowned 11, the crown was loose but could not easily be removed with finger pressure.

At assessment there was a discussion of what material the post was made out of as it appears relatively radiolucent (Fig. 1a). Upon removing the crown to begin re-root canal treatment it was discovered that the post was in fact a plastic burn-out post (Fig. 1b) and the core was largely a zinc oxide-eugenol-based material. This type of post is, of course, designed to be used to create an intra oral wax/resin post and core which can then be cast by a technician. The patient recalled that the post and

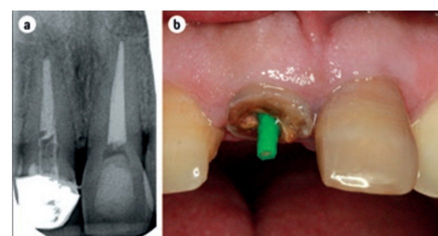

Fig. 1 (a) radiolucent post and (b) plastic burn-out post

© 2015 British Dental Association. All rights reserved