Letters to the Editor

Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London, W1G 8YS
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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.

SMOKELESS EVIDENCE

Sir, I write further to the news item (*BDJ* 2012; **212:** 310) and draft guidance by the National Institute for Health and Clinical Excellence recommending a greater role for dental professionals in smokeless tobacco cessation.[1] While this is a welcome move, making the guideline to specifically target the South Asian population is unjustified because smokeless tobacco (ST) use is prevalent in all communities and also globally eg Sudan (*toombak*), Sweden and other European countries (*snus*) and even in the USA where about 3.5% of the population currently uses ST.[2]

Secondly, there are issues regarding effectiveness and cost-effectiveness of tobacco cessation interventions pertaining to ST use. The evidence available for the efficacy and cost-effectiveness of pharmacotherapy for ST is highly inadequate as compared to that for smokeable tobacco. A recent Cochrane review on the effectiveness of available pharmacotherapy on ST use concluded that there is inadequate evidence to comment upon the efficacy of these interventions.[3] The dose of nicotine absorbed per use of ST, the physical sensations, reinforcement, ease of availability and the level of societal acceptance are different for the two habits, and there is also no separate model to assess cost-effectiveness of tobacco cessation medications for ST. The most commonly used BENESCO model used for measuring cost-effectiveness for smokeable tobacco is not recommended because it takes into consideration only four tobacco-related diseases, not including dental problems, oro-naso-pharyngeal cancers and pre-cancerous lesions like oral submucous fibrosis.[4]

Many questions therefore still need to be answered.

B. Chatterjee, New Delhi

1. National Institute for Health and Clinical Excellence. Public Health Draft Guidance. *Tobacco: helping people of South Asian origin to stop using smokeless tobacco.* UK: NICE, February 2012. Available from: www.nice.org.uk/nicemedia/live/12999/58278/58278.pdf (accessed Sept 2012).
2. US Department of Health and Human Services. *Results from the 2008 National Survey on Drug Use and Health: National Findings.* Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2009. http://oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.pdf (accessed August 2012).
3. Ebbert J, Montori V M, Erwin P J, Stead L F. Interventions for smokeless tobacco use cessation. *Cochrane Database Syst Rev* 2011; CD004306.
4. Critchley J A, Unal B. Health effects associated with smokeless tobacco: a systematic review. *Thorax* 2003; **58:** 435–443.

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BANANA ROOT FRACTURE

Sir, a 92-year-old male patient attended as an emergency stating that his bridge and a tooth had fallen out that morning whilst eating breakfast. He was in no pain and reported that he was medically fit and well. Examination revealed a 23-year-old avulsed three unit fixed-fixed bridge retained from a maxillary left canine and metal post in the left central. The patient also presented a tooth-like item measuring approximately 15 mm by 8 mm by 6 mm with signs of apex, root groove and potential root fracture all being noted. Intra-oral clinical examination revealed abutments without signs of significant damage but no sign of the loss of any tooth and absolutely no signs of soft tissue abnormality. The reason for the tooth-like structure remained a mystery and manipulation of the apical crack revealed a potential root canal space and further speculation that a tooth root had indeed been lost. Without evidence of any tooth avulsion the differential diagnosis of the foreign body was nothing more than conjectural and mysterious; odontome, salivary calculus? Only further and detailed questioning as to the contents of the patient's breakfast elucidated that he had indeed been eating a bran based product supplemented with dried fruit...the mystery was solved...dried banana! The perils of a healthy breakfast led to much merriment for all and a lesson learned on the need for a detailed diet analysis on occasion.

R. McAndrew, A. Bowkett
By email

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STEP IN THE RIGHT DIRECTION

Sir, I read with interest the news article published in the *BDJ*, *Microscope created for early oral cancer diagnosis* (2012; **213:** 9). I am of the opinion that Britain is playing second fiddle to the Americans when it comes to oral cancer screening in general practice and this is something we should encourage our practitioners to pay more attention to on a daily basis.

The above article highlights that the invention was conceived at the University of Texas and this should come as no real surprise. During my recent visits to the United States where I was shadowing a variety of dentists throughout the Carolinas, I was in awe as to the effort spent per patient on oral cancer screening. Every patient was routinely given a standard visual oral cancer screening followed by the use of a solution called ViziLite. For your readers who may not be aware, Vizilite is a solution the patient uses to rinse their mouth, after which the dentist performs an oral inspection using a disposable handheld light source to pick up any potential dysplastic areas.