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

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.

A. W. Barrett, West Sussex
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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.

J. Limeres, M. Diniz, P. Diz Spain

1. Mew J. Glove wearing: an assessment of the evidence. *Br Dent J* 2015; **218**: 451-452.
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 Gastrointest 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.

4. Martin M V. Glove wearing necessary? *Br Dent J* 2002; **193**: 609.

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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

Fig. 1 A ranula

have had to be performed in the operating room under general anesthesia. Three weeks after the initial visit, the vesicle suddenly increased in size after a dinner and caused significant discomfort, so I performed an incision and drainage by myself using a fine needle to alleviate the symptom. One day after incision, the lesion became whitish and solid with no accumulated mucus, and then the lesion started to decrease in size and was completely resolved at two months after incision. No recurrence of ranula has been shown since the incision procedure.

Recent studies have shown that excision of the ranula and the sublingual gland is the standard and radical treatment for a ranula and yields the least possibility of recurrence.¹⁻³ Incision and drainage are only performed in infants and should be avoided in adults since they result in a rapid closure of the wound and a quick recurrence usually occurs.^{1,4,5} My experience indicated that a small superficial ranula may completely resolve after incision and drainage, probably because it is originated from minor salivary glands at this location rather than the sublingual gland.⁴ Therefore, incision and drainage can still be attempted to achieve a better cost-benefit in treatment of first-onset superficial ranula, especially in some situations like the shortage of medical resources or poor candidates for surgery. If the ranula recurs after incision and drainage, then excision of the ranula and the sublingual gland is recommended.

Wenjia Xie, China

- 1 Lee D H, Yoon T M, Lee J K, Lim S C. Treatment outcomes of the intraoral approach for a simple ranula. *Oral Surg Oral Med Oral Pathol Oral Radiol* 2015; **119**: e223-225.
- 2 Zhi K, Gao L, Ren W. What is new in management of pediatric ranula? *Curr Opin Otolaryngol Head Neck Surg* 2014; **22**: 525-529.
- 3 Patel M R, Deal A M, Shockley W W. Oral and plunging ranulas: What is the most effective treatment? *Laryngoscope* 2009; **119**: 1501-1509.

- 4 Albsoul N M, Obeidat F O, Altaher R N, Jubouri S A, Hadidy A M. Recurrent right sublingual ranula, concomitant with ipsilateral submandibular salivary gland aplasia. *Int J Surg Case Rep* 2013; **4**: 229-231.
- 5 Zhi K, Wen Y, Ren W, Zhang Y. Management of infant ranula. *Int J Pediatr Otorhino laryngol* 2008; **72**: 823-826.

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COMMUNICATION

Naming names

Sir, I thank Stephen Hancocks for stressing the urgent need for the institutionalisation of efficacious health communication strategies, harnessing the power of words in the delivery of healthcare and health promotion.¹ We live in truly cosmopolitan and multicultural societies. Patients, healthcare providers, nurses and physicians come from diverse political, gender, marital status, cultural, ideological, religious, economic and linguistic hues and cues, and hence is the need to advance global citizenship and nurture interpersonal and inter-institutional communications in an increasingly transnational work environment. The word is mightier than the sword, and if swords can coerce us into submission, nothing seems to be more powerful than the words that can shape our opinions, foster cultural, religious and social diversity, and promote tolerance, harmonious coexistence and mutual understanding; all lie at the heart of our ethos to promote scientific, educational and research collaboration across and between societies.

Munjed Farid Al Qutob, London

- 1 Hancocks S. Naming names. *Br Dent J* 2015; **219**: 193.

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RIGHT OF REPLY

Stereopsis

Sir, Syrimi and Ali wrote on the need for stereopsis in dentists (*Br Dent J* 2015; **218**: 597-598). The paper is an interesting one, but I believe their conclusion to be stronger than that represented in the few papers that were available for review. All the articles used the TNO test which uses 3-D pictograms to decide whether a student could see stereoscopically. The point in dentistry however is not whether one can see stereoscopically, but rather the ability to place an instrument close to, or on, a tooth. This is stereo perception and is important in avoiding erroneously placing a bur and causing damage. Subjects with poor stereo perception are considerably aided by visual clues such as objects lying in front or behind other objects.

Miller commented on this paper by saying 'that if one uses a mirror to view the operative field then one is using monocular

vision....' I am surprised by this remark as stereoscopic binocular vision is most certainly used for example when shaving or putting on make-up with a mirror. Indeed, Wheatstone invented the earliest (mirror) stereoscope in 1838¹ and similar mirror stereoscopes were used to view and measure stereopair photographs in surveying and photogrammetry until the recent advent of digital methods.

P. Howell, London

- 1 Stereoscope. Wikipedia. Available online at <https://en.wikipedia.org/wiki/Stereoscope> (accessed October 2015).

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Discrepancy in guidelines in periodontal examination

Sir, I want to share with the readers the discrepancy that I have noted in the recommendation in the basic periodontal examination and its implications.

According to the British Society of Periodontology,¹ if a score of three noted when recording basic periodontal examination (BPE), full pocket charting should be done for the sextants with score three, irrespective of the number of sextants with the score three; however, according to the Scottish Dental Clinical Effectiveness Programme (SDCEP)² the recommendation is that for patients with a BPE score of three in more than one sextant, a six point periodontal charting should be done throughout the entire dentition.

This has led to confusion in students while doing a periodontal examination here at the University of Dundee. I hope this discrepancy is addressed sooner rather than later.

Z. Imran, Dundee

- 1 British Society of Periodontology TBSo. Basic periodontal examination (BPE) 2011. Available Online at: http://www.bsperio.org.uk/publications/downloads/39_143748_bpe2011.pdf (Accessed October 2015).
- 2 SDCEP. Prevention and treatment of periodontal diseases in primary care, guidance in brief 2014. Available online at: <http://www.sdcep.org.uk/wpcontent/uploads/2015/01/SDCEP+Periodontal+Disease+Guidance+in+Brief.pdf> (Accessed October 2015).

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ERRATUM

Letter *British Dental Journal* 2015; **219**: 245-246, 'Cochlear implant update'

In the above letter we stated the sole author was V Kumar. We wish to clarify that the author's name should have read Vagish Kumar L S.

We apologise for any inconvenience caused.

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