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DOI: 10.1038/sj.bdj.2019.54

The following two letters are in response to a letter 'Tobacco control: Safer without snus' published in the *BDJ* on 26 October 2018.

Snus

Swedish snus is different

Sir, recently, a letter by Shanahan raised some concerns about a recent report by the Science and Technology Committee (STC) suggesting the discontinuation of the ban on snus.¹

However, I believe there are some inaccuracies in the letter that I would like to address. The letter cited a study by Warnakulasuriya² in associating snus with an increased risk for oral cancer. However, that study was mainly referring to oral tobacco products used in Asia, most of which are particularly harmful and associated with elevated risk for oral cancer.

Swedish snus is a very different product. Despite the high rate of snus use among Swedish men, the prevalence of oral cancer in Sweden is among the lowest in the European Union.³

There is strong epidemiological evidence that snus use is not associated with a demonstrable increase in oral cancer risk.^{4,5}

Therefore, it is particularly important to distinguish Swedish snus from other forms of oral tobacco products which have different toxic potential and substantially elevate the risk for disease.

While correctly mentioned by Shanahan that smoking cessation pharmacotherapies are available and safe, their popularity is limited and they are not used as alternatives by smokers unable or unwilling to quit smoking with the use of approved methods.

For the latter, snus and other tobacco harm-reduction products have a role in substituting for smoking and represent

a reasonable option considering that the alternative is to continue to smoke.

Tobacco harm-reduction products do not substitute but supplement other existing tobacco control measures, in an effort to rapidly reduce smoking prevalence and smoking-related disease and death.

Considering that Swedish snus has a long history of strong epidemiological evidence, the suggestion by the STC to review the ban seems reasonable and in fact should be followed by other authorities such as the European Union.

K. Farsalinos, by email

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DOI: 10.1038/sj.bdj.2019.55

Much safer with snus

Sir, I was alarmed to see that poor acquaintance with current oral cancer evidence can lead to backward conclusions as stated in the letter by Dr D. Shanahan.

The referenced study by Foulds *et al.* was a relevant piece when published 15 years ago, but today several later studies provide much more robust data on the public health benefits that have been reaped from snus use in Sweden.^{1,2}

The study by Warnakulasuriya *et al.* is not only highly outdated but is totally irrelevant with respect to Swedish snus, since it is based on Indian smokeless tobacco products with totally different characteristics. Modern Indian researchers do make the appropriate distinctions resulting in summary statements such as: 'Nasal snuff and snus were not associated with oral cancer risk.'³

The most comprehensive modern summary has been given by the Global Burden of Disease Study 2016 by stating: 'Based on available evidence, for chewing tobacco RRs were significantly higher than one for oral cancer and oesophageal cancer, while for snus or snuff we did not find sufficient evidence of a RR greater than one for any health outcome.'⁴

The suggestions by the Science and Technology Committee (17 August 2018) are actually well supported by the available scientific evidence.

L. M. Ramström, by email

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DOI: 10.1038/sj.bdj.2019.56

Adrenaline use

The use of pre-filled adrenaline syringes in anaphylaxis kits

Sir, I am writing with regards to the recent correspondence by the Office of Chief Dental Officer England (OCDO) titled 'Adrenaline for anaphylaxis kits – a reminder to health care professionals.'¹

This document highlighted the current supply disruption of EpiPen and EpiPen Junior adrenaline auto-injectors (AAIs) and therefore guided dental practitioners and dental care professionals to stock and use adrenaline ampoules in the management of anaphylaxis in order to help preserve national stock of AAIs.

This reminder failed to fully appreciate the use of adrenaline 1:1000 1 mg/1 ml pre-filled syringes when stocking medical emergency kits and their use in the management of anaphylaxis. The use of pre-filled syringes negates the need to stock adrenaline ampoules and to complete the drawing up process.

Reference to pre-filled syringe use is seen in SDCEP guidance and should be more greatly acknowledged as a viable and suitable alternative to stocking adrenaline ampoules in the reminder sent by the OCDO.²

Dental professionals are expected to have competency in the use of ampoules and drawing up solutions, however, medical emergencies are rare occurrences, with anaphylaxis accounting for only 1% of emergencies encountered in the dental setting.³

Therefore, the completion of administering adrenaline with the use of ampoules is rarely practiced in real-life emergency situations. We are unaware of any current national