

operator is not tempted to reuse gloves in the treatment of more than one patient, a procedure practiced by 77% of routine glove-wearing respondents to a survey in England and Wales in 1992.⁵

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Crown and bridge removal

My compliments on the excellent results of your stewardship of *QI*. I have great respect for your professional acumen and clinical talents. *QI* is a better journal because of your efforts.

I am concerned with the message of an article in the January 1995 issue. This well-written and beautifully illustrated article on "Methods for removing crowns and bridges: Preserving the restoration" by William Liebenberg (*Quintessence Int* 1995;26:7-14) has great potential for harm to the patients of your readership. Dr Liebenberg was careful to stress the concept of proceeding with caution. I want to reinforce that idea.

My admonition to all who read this article is, "Don't do it!" The printed word has the aura of "gospel" about it. Many young and inexperienced dentists will read this article and be eager to try to resurrect a bridge or crown for a variety of reasons. The most common reason is usually economic. Where is the economy when an abutment or abutments are fractured and then endodontic therapy is necessary—if the patient is lucky? What happens when a vertical fracture is induced and then the abutment tooth or crown is no longer salvageable? It is a given, that if crowns and/or bridges are removed with

any of the techniques described, bad things will certainly ultimately happen.

My advice, which has stood the test of time, when in doubt—cut it off as well described in the beginning of the article. Sure it takes time, effort and expense. Such an approach will help to insure the Hippocratic concept of, "First, do no harm."

I do not mean to impugn the professional integrity of the author. I am sure that in his skilled and capable hands, these techniques are highly successful. Every dentist who is exposed to these ideas, however, is not that proficient. We all have a responsibility to our patients and each other. We are all always students.

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Move over amalgam—at last

I am a subscriber to *Quintessence International* and regular reader of your editorial. I find your editorials well thought out, insightful, thought provoking and at times controversial. But, I find your March editorial "Move over amalgam—at last" (*Quintessence Int* 1995;26:157) to be so controversial to my philosophy that it is deserving of this letter.

Although I agree that the technology of composite resins and dentin bonding agents has advanced leaps and bounds from just a decade ago, I still think it is premature to declare that "Amalgam should never be used as a first-time restorative material."

Composite resin restorations (PCR) may be appropriate for conservative carious lesions (Class I or Class II lesions), but I would be reluctant to place them in interproximal preparations where the gingival floor is subgingival and/or bleeding and moisture control is unreliable. The issue with PCR is not so much to do with wear than it has to do with reliable and predictable marginal seals. Resins do not have the bulk like amalgam and handling properties that allow it to be intimately condensed against the cavity wall. As such, I have seen many voids at the gingival floor area on a radiograph of teeth that appear to be clinically sound.

Also, I take exception to your second declaration, "Amalgam should never be used as a restorative material in pediatric

dentistry." I assume that you are referring to restorations of deciduous molars. I do not know of a more cost-effective restorative material to use in teeth designed to maintain oral integrity until 10 years of age. I challenge you to find me anything in the literature with an economic analysis (ie, cost-benefit analysis, cost-effectiveness analysis or cost-minimization analysis) that supports the thesis that a conventional single or two-surface cavity prep on a deciduous molar is better served with a PCR than an amalgam.

Until then, I will continue to judge the appropriateness of which restorative material to use on the individual clinical factors presented while taking into account the economical analysis I mentioned prior.

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Editor's note:

I thank Dr Balevi for his insightful comments. He brings up two very good points—the first deals with a deep interproximal restoration. I agree that this is not an ideal place for present-day resin composites, however, it may be a place to consider a resin-modified glass-ionomer material. My challenging statement, "amalgam should never be used as a first-time restorative material," was not intended to cover the unlikely occurrence that a deep interproximal lesion would be an initial carious lesion in a tooth. More than likely a small occlusal or interproximal lesion would be the first requiring restoration—a deep interproximal lesion is more likely to occur later, under a restoration in place, which excludes it from my "first-time restorative" category.

Regarding Dr Balevi's second point—I agree. There is nothing that I am aware of in the literature to show cost-benefit of a nonamalgam material over amalgam. However, the converse is also true. While unproven cost-benefit is important, equally important is retention, longevity, sealed margins, fluoride-release potential, and even ease of use and esthetics, all of which favor the resin-modified glass-ionomer material as having at this time the most promise for use as the ideal restorative material in pediatric dentistry. Undoubtedly, however, amalgam will continue to be used for some years by those who prefer peace of mind from long experience with the use of amalgam to the risk of testing the limits of new materials.