operator is not tempted to reuse gloves in the treatment of more than one patient, a procedure practised by 77% of routine glove-wearing respondents in a survey in England and Wales in 1992.3

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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;6:157 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 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 (i.e., cost-benefit analysis, cost-effectiveness analysis or cost-minimization analysis) that supports the theses 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 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 unforeseen 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.