

LETTERS TO THE EDITOR

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DENTAL RADIOGRAPHY

Gold thread therapy

Sir, a 58-year-old woman presented for prosthodontic treatment. Her medical history revealed only previous breast and head and neck cancers.

Extraoral and intraoral examination revealed no unusual findings apart from her partially edentulous state and extensive restorations but, in the course of investigation, multiple unusual linear radio-opacities were evident over a wide area on pantomography (Fig. 1). On further questioning the patient revealed she had undergone 'gold thread therapy' for facial 'rejuvenation'.



Fig. 1 Pantomography revealed multiple unusual linear radio-opacities

It is recognised that some 'cosmetic' procedures can be demonstrated radiographically^{1,2} but we are unaware of other reports on gold thread.

The technique (Gold Filament, Gold Lift; Remaillage; Gold Reinforcement; Gold Silk) involves the implantation of a 99.99% pure gold thread of diameter 0.1 mm to 0.5 mm into the sub-dermal skin, the concept being that gold promotes angiogenesis, as the immediate area surrounding the thread is richer in blood vessels, and the mast cells numbers around the gold thread increase over time,³ which, it is suggested, may result in skin 'rejuvenation'. The latest Gold Thread Implantation™ is performed with 0.1 mm gold thread and purportedly requires no anaesthesia, and is associated with no pain, no haemorrhage, and no scars – and

lasts 8–15 years.⁴ It is occasionally used in chronic diseases (eg sinusitis, arthritis, rheumatism)⁵ and in acupuncture.

The evidence base for any therapeutic efficacy, however, is slender.⁶

B. Mizrahi, C. Scully

By email

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2. Alsaadi G, Jacobs R, Quiryren M, van Steenberghe D. Soft tissue augmentation of the cheeks detected on intra- and extraoral radiographs: a case report. *Dentomaxillofac Radiol* 2008; **37**: 117–120.
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4. Gold thread rejuvenation technology description. Available at: <http://www.gold-thread.com/technology> (accessed 8 May 2014).
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DENTAL INSTRUMENTS

Operating otoscope

Sir, oral examination for patients with limited oral opening presents considerable technical challenges to the examiner and can be an uncomfortable process for both examiner and patient. Most overhead or floor lights do not permit adequate examination, and headlights and mirrors, while offering more positioning flexibility and preserving hands-free feature, do not accommodate patients with more challenging oral features. Penlights can be helpful, but most are too dim and do not direct light well enough for considerable clinical use. Some clinicians have seen the benefits of using diagnostic otoscopes, which solve many of the above technical problems of examination and have the added benefit of magnification (Fenton S A. Personal communication. July 2009). Use of diagnostic otoscopes, which have a closed head not that does not permit bi-directional airflow, is limited by fogging of the lens.

Use of an operating otoscope, which has an open head and is less prone to fogging,

eliminates all of the above challenges. Operating otoscopes may be used for oral examination with or without speculum attached (Figs 1 and 2). If hands-free use is required and the patient is to remain in one position for a prolonged period, a vice clamp and c-arm extension could also be used, but we have not found this necessary. Use of an operating otoscope for oral examination is the standard technique employed for all patients in our group, irrespective of oral opening.



Fig. 1 Operating otoscope with speculum attached. While the light distribution is narrow, light is sufficient when using the magnification lens and if doing ear examination, there is no interruption of the examination process to remove the speculum



Fig. 2 Operating otoscope without speculum attached. Without the speculum attached, the entire oral cavity is easily illuminated

R. J. McCormick, M. I. Poling
Buckhannon, USA

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EVIDENCE-BASED DENTISTRY

More than just P values

Sir, as dental clinicians, we should be all aware of the increased effort to incorporate an evidence-based approach