Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS E-mail bdj@bda.org
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Research governance

Sir, our thanks to Dr Fiske for an interesting and thought-provoking editorial on the above subject (*BDJ* 2007; **203:** 117). We found her example of ethical practice in authorship of research papers interesting. It was ironic that in the same journal there were two papers, one with seven authors and another with an astonishing nine authors.

Is this as a result of the *BDJ*'s guidance for authors? The guidance states that authors '*should have some involvement* in at least one of the following: the design of the study, the collection of data and/or the analysis and interpretation of data, the drafting and editing of the manuscript, the statistical analysis of the manuscript, substantial involvement in obtaining funding, administrative and/or technical support or supervision of the study.'[1]

This guidance does not appear to be as robust as that of the *BMJ*, as discussed in the editorial. Will the *BDJ* editorial board adopt a similar rigorous policy on authorship and contributorship?

We believe it is important that readers of the journal and the scientific community should be under no illusion as to the contribution of authors. This could be made clear by requiring a statement of the exact contribution of each of the authors to both the research and the writing of the paper. We would urge the *BDJ* to follow the example of other international journals in publishing this information alongside the paper.

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1. British Dental Journal guidelines for authors. http://www.nature.com/bdj/authors/guidelines/index.html

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Virtually impossible

Sir, I read with great interest the unusual case of double teeth which was presented in your esteemed journal (*BDJ* 2007; **202:** 508-509). I also read the letter on another case report of double teeth by E. Grammatopoulos in response to the previously mentioned case (*BDJ* 2007; **203:** 119-120). I would like to share with your readers another very unusual case of double teeth (*J Esthet Restor Dent* 2006; **18:** 13-18). In this case it was very difficult for us to diagnose whether the double tooth was due to fusion of a supernumerary tooth with the central incisor (11) or was due to the gemination of the central incisor itself (Figs 1-2). I would agree with the comment made by E. Grammatopoulos that it is virtually impossible to differentiate gemination from fusion in certain cases. Hence whatever is the diagnosis, a definitive treatment plan of endodontics, exodontia or aesthetics should be considered.

N. Vasudev Ballal
Manipal

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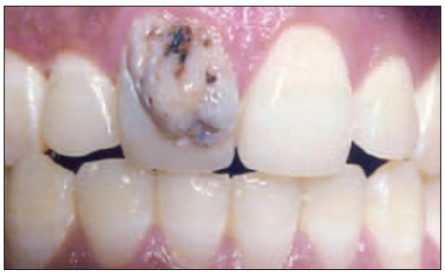

Fig. 1 Clinical view of double tooth

Fig. 2 Radiographic view of double tooth

Updated guidelines

Sir, a recent audit carried out within the Gwent Community Dental Service regarding medicaments used for pulp treatment in deciduous molar teeth, highlighted a wide variation in medicaments used by the clinicians. The Gold Standard used was the updated guidelines advocated by the British Society of Paediatric Dentistry[1] and published in the *International Journal of Paediatric Dentistry.*[2] Reasons for the variation would be lack of awareness of current guidelines which highlight the potential carcinogenic properties of formaldehyde containing medicaments as well as the clinicians' own success and experiences with various medicaments.

We would like to suggest that the *BDJ* creates a section in the journal where readers are made aware of guidelines that have been formulated or updated recently. We feel that the *BDJ* with such a wide audience of clinicians within the primary, secondary and tertiary dental sectors can help increase our awareness of guidelines which may only be published in specialist journals or made available on the website of special interest societies.

This can be explored one step further, by the BDA Website Focus Group, and a section on 'Updates' included on the BDA's new website, when it is launched in the future.

A. Gopakumar
K. Hughes
Tredegar

1. http://www.bspd.co.uk/publication-9.pdf
2. Rodd H D, Waterhouse P J, Fuks A B, Fayle S A, Moffat M A. UK National Clinical Guidelines in Paediatric Dentistry: pulp therapy for primary molars. *Int J Paediatr Dent* 1997; **7:** 267-268.

DOI: 10.1038/bdj.2007.1102

Destructive dentistry

Sir, when is the increasing tendency for the destruction of sound tooth to enable the achievement of the 'perfect smile' going to stop?

I was horrified to see in a recent edition of a dental newspaper a piece about a 25-year-old man with perfectly sound unrestored teeth, but slight imperfections in the shape and alignment of the upper labial segment, having ten veneers placed on the premolars, canines and incisors. Is there no consideration of the ten, 20, 30, 40 year, and

more, results of this wilful iatrogenic destruction?

Even the *BDJ* is not immune from portraying this destructive dentistry. In the recent articles about lasers there was a series of photographs showing a lower labial segment with slight crowding, a tooth was extracted and a three unit bridge constructed, on perfectly sound teeth!

When are these practitioners going to realise that unadulterated enamel and dentine are the gold standard materials, not porcelain?

The profession is creating a lot of problems for itself and patients in the future. Still, never mind, when the teeth and restorations fail, replace them with implants, so all is not lost!

C. Mortimer
Leicester
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Hidden pathology

Sir, teeth in excess of the normal number are referred to as 'supernumerary teeth'. Those that occur in the molar area are known as 'paramolar teeth'. More specifically, those that erupt distally to the third molar are 'distomolar teeth'.[1] Supernumerary teeth are more common in the permanent dentition and their prevalence ranges from 0.1% to 3.4%.[2] Hyperactivity of the permanent or deciduous dental lamina is believed to be the cause of supernumerary teeth[3] and certain diseases like Cleidocranial dysplasia and Gardner's Disease are associated with supernumerary teeth.[4] Supernumerary molars appear to occur less frequently compared to other supernumerary teeth and it is rare for patients to present with impacted fourth molars bilaterally.

A 27-year-old female was referred to the Department of Oral and Maxillofacial Surgery, with a chief complaint of pain in the lower left molar area for the past few days. On clinical examination, a pulpally involved lower left third molar was observed. The periapical radiograph ordered by her dental physician revealed widening of the periodontal ligament of this tooth and a diagnosis of acute periapical periodontitis of the lower left third molar was reached. A panoramic radiograph, however, revealed the presence of bilateral impacted mandibular fourth molars along with an impacted maxillary right fourth molar and left third molar (Fig. 1). All impacted supernumerary teeth were located posterior to the third molars. The mandibular fourth molars appeared to have a normal crown-root morphology, but smaller in size. The root pattern of the maxillary fourth molar could not be clearly discerned. A physician was consulted to rule out any associated syndrome. The initial treatment plan proposed the surgical removal of the offending lower third molar surgically along with simultaneous removal of all supernumerary teeth under general anaesthesia. However, the refusal of the patient to undergo simultaneous removal of these teeth under general anaesthesia and the fact that no evidence of pathology was associated with these supernumerary teeth prompted a change in the treatment plan. The lower third molar was removed surgically under local anaesthesia with vasoconstrictor. The postoperative period was uneventful and the patient reported complete relief from pain.

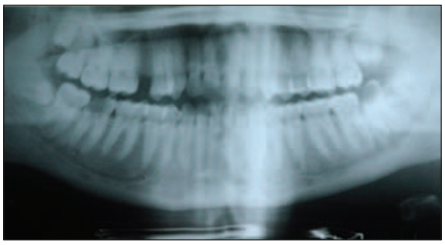

Fig. 1 Panoramic radiograph showing the presence of bilateral impacted fourth molars

The patient has been advised to undergo bi-annual radiographic examinations to rule out any bony pathology associated with these teeth. This case demonstrates the prudence of obtaining a panoramic radiographic prior to surgical removal of third molars to detect any hidden pathology/lesion.

B. Krishnan
India

1. Garvey M T, Barry H J, Blake M. Supernumerary teeth. An overview of classification, diagnosis and management. *J Can Dent Assoc* 1999; **65:** 612-616.
2. Kokten G, Balcioglu H, Buyukertan M. Supernumerary fourth and fifth molars: a report of two cases. *J Contemp Dent Pract* 2003; **4:** 67-76.
3. Regezi J A, Sciubba J J, Jordan R C K. *Oral pathology. Clinical pathologic correlations*, 4th ed. Philadelphia: WB Saunders, 2003.
4. Field A, Longman L. Disorders of teeth and bone. *In* Field A, Longman L, Tyldesley W R (eds). *Tyldesley's oral medicine*, 5th ed. pp 220-221. Oxford University Press, 2003.

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