

As pointed out by Milnes<sup>2</sup> 'There can be no doubt that a reparative, biologic approach to pediatric pulp therapy is preferable to the absolutist, devitalization approach of formocresol pulpotomy' but although other protocols for managing deep caries in primary teeth are now in common use, Patchett *et al.*<sup>5</sup> noted that 'Presently, in Newcastle, the treatment of choice for non-vital primary molars is extraction since there is little evidence of an alternative medicament which is as effective as formocresol and which exhibits minimal technique sensitivity'.

Should we not balance the damage done from removing so many teeth from young children against the unproven damage done by formocresol pulpotomies?

Perhaps we should ask if we have thrown the baby out with the bathwater for no good reason?

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## TOOTH RELICS

Sir, I was most interested in the paper on St Apollonia's tooth by Skrobonja *et al.* (*BDJ* 2009; **207**: 499-502) in which a tooth relic in the cathedral treasury in Rab (Croatia) is described. Whilst it is possible that this tooth really is a relic of St Apollonia it must be recognised that, as the authors state, there are very many instances of fraud which occurred in mediaeval times when false claims were made about so called relics. There is no evidence that the *autentica* provides a guarantee that the relic is authentic, as claimed by the authors, since these

seals were not recognised until 1543, some 1,300 years after St Apollonia's martyrdom.

The authors cite the ten churches listed by Walsh as having relics of St Apollonia. There are, however, numerous other relics purported to be those of the saint. She must have been a remarkable person if even a small fraction of these are correct. It is said that Philip II of Spain, an avid collector of relics, managed 'to amass all 290 holy teeth from the mouth of Saint Apollonia'<sup>1</sup>.

I am aware of two existing relics in England attributed to St Apollonia, one in the Victoria and Albert Museum and the other at the Anglican Shrine at Walsingham. In both cases, unlike the Croatian one, the relic is a small fragment of tooth or bone. There was also a relic in the chapel at St Michael's Mount, Cornwall said to be from St Apollonia. That relic is no longer there.

The authors make much of the fact that it could be St Apollonia's tooth as it comes from a young person. However, there is considerable doubt as to the age of the saint when she was martyred. Although she is generally depicted as a young woman many versions of her history describe her as an aged virgin.

There are some 56 representations of St Apollonia in British churches, mainly in stained glass or painted on rood screens. All but one of these is described by Beal<sup>2</sup> but there is another one on a rood screen at Hennock, Devon which I found subsequent to preparing that list.

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## MAGNIFIED JOY

Sir, I can only be fully supportive of any recent discussion<sup>1</sup> and research<sup>2</sup> involving photography and dentistry but I would just like to add to the discussion and draw attention to the benefits of providing this through the use of an operating microscope.

Although microscopes were introduced not too long ago for use in endodontic

treatment, the joy of using magnification and illumination in this way extends to many aspects of dentistry. With experience and practice an operating microscope can be used routinely for much of the time in assessment, treatment and communication in general practice. Once a camera is set up to look through the microscope the image of what is seen through the microscope can be recorded consistently and hygienically at any stage of diagnosis, treatment and advice.

I use a miniDV camcorder that also takes excellent single 'photoshots'. My nurse uses a 'bagged' remote control to operate the camera. It is minimal interruption to our work pattern. Screens run from the same camera display 'real time' presentations of procedures for the benefit of support staff, colleagues and not least the patient if they would also like to watch. We can also video record at the same time.

Microscope dentistry takes commitment but it is achievable. Successful, ergonomic and routine application is very dependent on good nursing support, training and the selection of appropriate equipment and instrumentation. The logic of working this way, as in all surgical disciplines that have adopted magnification and illumination, is unbeatable. If you can see or see better you can do better. With the added benefit of applying photography and video 'on tap' it is a truly complete and satisfying way to work.

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