Lastly, all the studies we have reviewed were intervention studies in the format of *in vitro* or *ex vivo*, thus 'one's behaviour, lifestyle, diet, genetic make-up, oral hygiene, and access to professional dental care' could not have affected the results. In addition, there is overwhelming evidence that industrial exposure to acid fumes causes dental erosion.^{6,7} Therefore, it is transparent that exposure to acids is a risk factor for dental erosion.^{8,9}

In conclusion, we do not discount the benefits of polyols on dental caries but acidic additives should be avoided and long term safety of polyols should be studied in humans. The objective of our review was to raise awareness of the risk hidden under the false security of 'sugar-free' dental health claims.

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DOI: 10.1038/sj.bdj.2011.1059

ASTONISHING DENIAL

Sir, I would like to draw readers' attention to the serious issue of 'big' corporate takeover of dentistry. In my opinion, the denial of the profession and the BDA to confront this matter is astonishing. My personal experience when discussing the topic with the colleagues who had the pleasure of working for the major corporates is that it has been overwhelmingly negative.

Please let's not fool ourselves: a corporate's main function is to generate money for its shareholders. It is not the principal dentist safeguarding the patients' best interests or introducing the latest and the best for 'his or her' practice.

With regard to the free market, there is no free market regulating the market. Currently there are few estate agents dealing with dental practice sales. Incidentally these agents deal initially with the best rewarding clients.

Of course the NHS has a fair tendering procedure for its allocation of new contracts. However, corporate resources will employ full-time staff to deal with tendering. Can 'Dr Smith' who has dedicated his life to NHS dentistry publish a 100 page tendering proposal? Not to mention the bank and the new CQC with its 'register first before buying' ingenious policy.

We may all be comfortable burying our heads in the sand for now. But be aware of the future. Would the strategy of a large supermarket chain entering dentistry be unusual for a corporate? Not at all. It is part of a genuine and legal growth strategy: squeeze suppliers and wages. What income would be allocated to a self-employed dentist working in such circumstances? I suppose a hard working farmer will be able to answer this with some degree of passion. And imagine if that chain owned and supplied all other small practices with dental material and other services.

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DOI: 10.1038/sj.bdj.2011.1060

SCURVY AND THE AGEING POPULATION

Sir, we write to you about two cases of scurvy which recently presented to our unit. Despite a great reduction in its prevalence, this ancient disease still affects people in our developed world today. It is noteworthy that the Care Quality Commission has recently published a report showing 17% of hospitals investigated were not compliant in meeting the nutritional needs of patients.¹ Furthermore, studies have shown that high proportions of elderly people already have low vitamin C levels on medical admission.²

The earliest symptom of scurvy, occurring only after many weeks of deficient intake, is fatigue. The most common cutaneous findings are perifollicular haemorrhages, ecchymoses, leg oedema, poor wound healing, and coiled body hairs. Gingival abnormalities include gingival swelling, purplish discoloration, and haemorrhages. Pain in the back and joints is common. Syncope and sudden death may occur.³ Scurvy is easily treated with vitamin C supplements and the inclusion of fresh fruit and vegetables in a daily diet.⁴

An 83-year-old female who lived in a care home was referred regarding 'erosions' in her mouth with associated difficulty in maintaining adequate nutritional intake. The patient's medical history included coronary artery bypass graft, stroke, nephrectomy, anaemia, osteoarthritis and dementia. There were no known allergies or use of alcohol and the patient had stopped smoking 40 years ago.

Clinical examination revealed blood crusted lips and generalised confluent ulceration affecting the buccal mucosa which also involved the gingiva. An elevated blood urea was noted, suggestive of renal dysfunction or poor fluid intake and her vitamin C levels were low. Clinical symptoms coupled with low ascorbic acid levels led to a diagnosis of scurvy. The patient was started on vitamin C supplements and a review a week later showed complete resolution of the oral lesions.

In another case, a 63-year-old female presented reporting a one month history of poor eating with reported weight loss due to swollen and bleeding gums. There was no relevant medical or social history except for a diet consisting mainly of plain pasta, devoid of fresh fruit and vegetables.

Clinical examination revealed the gingiva were swollen and bled spontaneously or on minor trauma (Fig. 1). All teeth were mobile. Initial blood tests revealed a Hb 7.9/dl and an otherwise normal FBP and coagulation screen. Medical examination revealed dependent oedema of the lower legs with bruising, perifollicular haemorrhaging and corkscrew hairs, (Fig. 2). A diagnosis of scurvy with secondary anaemia