Letters to the Editor

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OLD GOLD

Sir, we report an interesting case of a 70-year-old male who consulted us for the extraction of the mandibular right posterior teeth. Intra-oral examination revealed a long-span crown and bridge prosthesis extending from 33-38, made up of Japanese gold (yellow metal/technique alloy) (Fig. 1), which was used as an economical substitute for gold alloys in preclinical teaching situations.[1] The patient gave a history of fabrication of the prosthesis in 1973, which in our practice is probably the longest serving functional example for the last 40 years. It seems from wider online searches that this material is still very much in use in developing parts of world including India.

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Fig. 1 Gold prosthesis

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ROOT SURFACE CARIES

Sir, a recent clinical case prompted me to undertake a search for current literature relating to root caries progression rates. However, the published research on root surface caries appears to be very limited (data on occlusal, free smooth surface and dentine lesions are also reported to be sparse).[1] Only approximal lesion progression rates in children and young adults appear to be moderately well researched.

It is obvious that potential root lesion progression studies are frustrated by overriding ethical considerations to an extent which would effectively limit non-intervention research to retrospective studies.

When considering the matter, it occurred to me that the combined clinical experience of a significant number of colleagues might provide a useful pointer to the highest rate of lesion progression. To this end I submitted a post and attached questionnaire (poll) on the main forum of www.gdpuk.com which asked 'What is the fastest rate of root surface caries you believe you have probably seen clinically?' Each response option read 'X mm deep progression over 6 months (or pro-rata equivalent)'. The questionnaire received 16 responses (votes) and ranges for 'X' and the corresponding number of votes (in brackets) were 0.5 to <1.0 mm (2); 1.0 to <1.5 mm (2); 1.5 to <2.0 mm (3); 2.0 to <2.5 mm (0); 2.5 to <3.0 mm (4); 3.0 to <4.0 mm (2); >4.0 mm (3). The average maximum rate was approximately (as no >4 mm limit) 2.5 mm/6 months, with the median and modal ranges of 2.5 to <3.0 mm. It is likely that the responses were based upon new lesions which were identified at a recall visit and for which treatment was provided. Factors likely to have impacted on the estimates include the recall period, accuracy of depth estimation and extent of caries removal. A brief review of tooth morphology data[2,3] suggests that rapidly progressing root caries could readily result in pulpal exposure within six months based upon the values reported above. It is reported that 8.2% of individuals in a community-dwelling population could be expected to develop one or more new root lesions in any year.[4] Therefore, there appear to be grounds for consideration including immediate dental referrals for examination and dental health education for all patients receiving elective medical (single/multiple) therapies which suppress salivary gland function, particularly elderly patients and those with other caries risk factors.[5]

P. Mc Crory

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2. Sterrett J D, Pelletier H, Russell C M. Tooth thickness at the furcation entrance of lower molars. *J Clin Periodontol* 1996; **23:** 621–627.
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ANCIENT CALCULUS EGG

Sir, optical microscope examination of dental calculus deposits (DCD) has recently proven its importance for both ancient and recent populations in order to describe the pathological background of individuals.[1-3]

In the DCD of an individual from the ninth century AD, discovered buried in a silo (Villiers-le-Bel S1441, close to Paris, France), was identified a *Schistosoma mansoni* egg of 100 mm maximal length, with its characteristic lateral spine (HES coloration, magnification