

# Letters to the Editor

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LETTERS

## 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.<sup>1</sup> 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.

R. S. Desai, P. Shirsat, A. P. Nehete



Fig. 1 Gold prosthesis

1. Kelsey W P 3rd, Franco S J, Barkmeier W W, Blankenau R J. Preclinical assessment of a technique alloy for teaching cast restorations. *J Dent Edu* 1982; **46**: 293–296.

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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).<sup>1</sup> 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](http://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<sup>2,3</sup> 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 indi-

viduals in a community-dwelling population could be expected to develop one or more new root lesions in any year.<sup>4</sup> 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.<sup>5</sup>

P. Mc Crory

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3. Magne P, Gallucci G O, Belser U C. Anatomic crown width/length ratios of unworn and worn maxillary teeth in white subjects. *J Prosthet Dent* 2003; **89**: 453–461.
4. Banting D W. The diagnosis of root caries. *J Dent Educ* 2001; **65**: 991–996.
5. National Collaborating Centre for Acute Care (UK). *Dental recall: recall interval between routine dental examinations*. NICE clinical guidelines, no. 19. London: NICE, 2004. Available at: [www.nice.org.uk/nicemedia/live/10952/29484/29484.pdf](http://www.nice.org.uk/nicemedia/live/10952/29484/29484.pdf) (accessed 5 November 2013).

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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.<sup>1–3</sup>

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 µm maximal length, with its characteristic lateral spine (HES coloration, magnification

× 200). Slight deformation is due to short-term decalcification by the acetic acid and rehydration process.

As for the previous diagnosis of comparable eggs from a French fifteenth–sixteenth century AD latrine (Montbéliard),<sup>4</sup> and because the parasite has an African origin,<sup>5</sup> our main hypothesis is of an imported case (slave? traveller? merchant?).

This case – the oldest evidence of the parasite in Europe – highlights the interest of such samples and microscope technique for retrospective diagnosis. Dental calculus represents a very informative sample for the reconstruction, not only of commensal microbes, but also the pathological background of individuals, including parasitological infections.

P. Charlier, I. Abadie, S. Cavard, L. Brun

By email

1. Charlier P, Huynh-Charlier I, Munoz O *et al.* The microscopic (optical and SEM) examination of dental calculus deposits (DCD). Potential interest in forensic anthropology of a bio-archaeology method. *Leg Med (Tokyo)* 2010; **12**: 163–171.
2. Adler C J, Dobney K, Weyrich L S *et al.* Sequencing ancient calcified dental plaque shows changes in oral microbiota with dietary shifts of the Neolithic and industrial revolutions. *Nat Genet* 2013; **45**: 450–455.
3. Piperno D R, Dillehay T D. Starch grains on human teeth reveal early broad crop diet in northern Peru. *Proc Natl Acad Sci U S A* 2008; **105**: 19622–19627.
4. Bouchet F, Harter S, Paicheler J C, Araujo A, Ferreira L F. First recovery of *Schistosoma mansoni* eggs from a latrine in Europe (15th–16th centuries). *J Parasitol* 2002; **88**: 404–405.
5. Morgan J A, Dejong R J, Adeoye G O *et al.* Origin and diversification of the human parasite *Schistosoma mansoni*. *Mol Ecol* 2005; **14**: 3889–3902.

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## INTRINSICALLY DISHONEST

Sir, having now read and tried to come to grips with the new GDC guidance, the profession needs to come off the fence and say that it fails to protect patients; it shows a deep mistrust of the profession, and it is essentially unworkable and intrinsically dishonest.

Where the guidance says that registrants must not accept payment that might affect or appear to affect their judgement, that describes the UDA system and probably most of the variations on it, or those so far proposed.

When I rang the GDC just before the

introduction of the 2006 contract to say it was unethical I was told that this was a political question not an ethical one.

We are told to note all the discussions on treatment when we recommend a crown. I could write an essay to describe the process each time (and each time it would be subtly different).

Even though a doctor or a care worker can be trusted to do a domiciliary visit on their own dentists no longer can be. All this does is give a field day to the lawyers who can always claim that we must be at fault because we failed to fulfil these well-meaning but ridiculous standards.

S. Des Clayes, Sawbridgeworth

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## WELCOME WISDOM

Sir, it is good to see further discussion and debate recently in the *BDJ* and *Faculty Dental Journal* with regard to the NICE guideline on the extraction of wisdom teeth.<sup>1</sup> The guideline has not been updated in 13 years and was originally developed for cost saving reasons as third molar surgery is one of the most commonly performed surgical dental procedures in the NHS. The SIGN guideline, management of unerupted and impacted third molar teeth,<sup>2</sup> published the same year, provides greater information about the levels of evidence available for each guideline statement and is more detailed. NICE have classified their guideline as ‘static’ since March 2010 but even if there is a lack of new evidence for the guideline surely it is prudent to update and re-evaluate the national guideline at timely intervals? The Cochrane collaboration update their reviews regularly and SDCEP update their guidelines regularly to allow further discussion of topics in a multidisciplinary setting and to ensure improvements in the quality of patient care. More information on the decision making process needs to be implemented into guidelines for the management of impacted wisdom teeth. Guidelines should be patient centred, individualised and take into account the multiple

dental and patient factors involved when making a decision on the extraction of an impacted wisdom tooth. This should include degree of impaction, patient age, position and location of the tooth, patient risk assessment for oral disease, patient medical history and most importantly patient preferences, not just simply whether the tooth is disease free or not.

J. Perry

By email

1. National Institute for Care and Excellence. *Guidance on the extraction of wisdom teeth*. March 2000.
2. Scottish Intercollegiate Guideline Network. *Management of unerupted and impacted third molar teeth*. SIGN Publication No. 43. March 2000.

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## MEDICINAL CONSTITUENTS

Sir, I am writing to highlight the importance of eliciting a comprehensive social history when managing a patient, to ensure care can be provided within which a patient's social and religious observances can be respected.

A maxillofacial oncology patient reviewed following surgery and radiotherapy complained of persistent and debilitating post-radiotherapy xerostomia. It was agreed that a combination of local artificial saliva replacement measures would be undertaken in the first instance to address this. One such supplement contains porcine mucin, which may be refused by patients observing meat-free diets or those of Muslim and Jewish faiths. In this case, upon informing the patient, the patient refused this supplementation on religious grounds and alternatives were identified.

The basic social history and patient bio data may not always identify such adherences and patients may be otherwise unaware of such ingredients within medicinal products. This demonstrates the importance for the clinician to understand the constituents of the products they use and inform the patient accordingly to ensure the patient's holistic needs are met.

Z. Mirza, London

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