

incisor and review of his radiographic records showed a long diodontic implant (material unknown) in place, retaining the crown, and extending almost to the base of the nasal cavity. Surprising is the appearance on the radiograph (Fig. 1), showing extensive root fracturing in the mid and coronal portions. Despite this, there is no evidence of bone loss, resorption or ankylosis radiographically. The tooth presents no associated soft tissue abnormality, mobility or periodontal pocketing clinically.

As to the history of this tooth, the patient reported having clashed heads during a rugby match aged nine, and this tooth being subluxed well into the palate, with the crown sheared off 'almost to gum level'. The first attendant dentist reduced the luxation on the day, and used the recovered natural coronal portion as a temporary restoration. The patient's own dentist placed the implant a week later, again using the natural tooth as a temporary restoration. The existing crown was placed ten years ago once the natural tooth had become discoloured. The patient's main recollection of the event was that his mother dropped him at the surgery and went shopping for the hour required to complete the procedure.

The endodontic-endosseous (EE, diodontic, or trans-radicular) implant has been in reported use as far back as Pharaonic times. Modern history shows this modality gaining popularity in the 1960s, particularly in the USA.<sup>1</sup>

For reasons including poor case selection, improper use of materials and poor bone bed preparation for the implant,

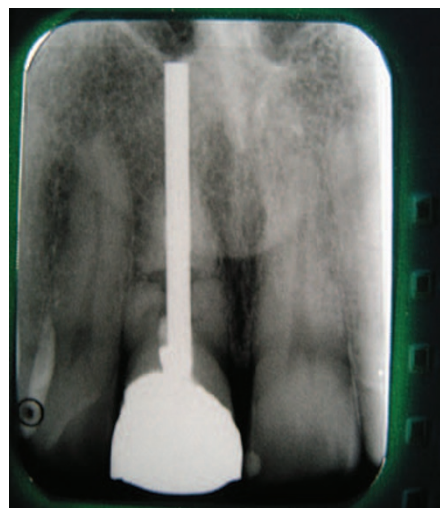


Fig. 1 Long diodontic implant

as well as post operative infection, this treatment modality suffered high failure rates. Common materials used for the implant post were steel, cobalt chrome, vitallium alloy, titanium, as well as hydroxyapatite-surfaced metals.<sup>2</sup>

The procedure fell into disuse, largely due to the predictability of osseo-integrated endosseous implants, in the West at least. Although the conventionally published literature (mostly case reports and commentaries) peters out for EE implants during the early 1990s<sup>3</sup> it seems from wider online searches that this is still very much in use in developing parts of the world including Egypt!

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DOI: 10.1038/sj.bdj.2013.798

## DEATH OF A PASTRY CHEF

Sir, the recent forensic anthropological examination of the skull of Marie-Antoine Carême (1784–1833) brought to light a clear cause of death directly related to poor dental status.

Carême, a nineteenth century French *pâtissier*, is considered the first internationally renowned celebrity chef, and the creator of the standard chef's hat, the *toque*.<sup>1</sup> He served as a *chef de cuisine* to Talleyrand, Napoléon, Tsar Alexander I and banker James Mayer Rothschild. He published several books on cookery, above all the encyclopaedic *Art of French cookery*, translated in London in 1836.<sup>2</sup> He died in Paris at the age of 48. The cause of death was considered to be chronic carbon monoxide intoxication and/or anthracosis (due to too many years inhaling the toxic fumes of the charcoal on which he cooked).<sup>1</sup>

Carême's skull is preserved in the National Museum of Natural History (Paris, France), as a part of the phrenological collection of Dumoutier (MNHN-HA-29888).<sup>3</sup> Its state of preservation is perfect (Fig. 1). The rest of the body (including the mandible) has been buried and remain, to date, non-observable.

The external examination of the maxillary shows the persistence of only one



Fig. 1 Carême's skull (picture by MNHN, anthropological collections)

tooth (14), and an extensive ante-mortem and post-mortem tooth loss (respectively: 11, 12, 13, 15, 16, 17, 18, 21, 22, 23, 24, 25, 26, 27). 5 mm- and 8 mm-length abscesses existed directly related to teeth 16 and 27, this last communicating with the maxillary sinus through a bone opening of 3 mm. Only a fragment of the 16 was still present at the time of death, inserted in the maxillary bone, maybe as a result of an incomplete tooth extraction during dental surgery.

This poor dental status is directly related to the occupational activities of Carême, ie the professional confection of pastries. Previous studies have shown the implication of personal and professional factors in the development of sugar caries, such as manipulation of sugars, frequent tasting of sweet dishes, sieving of icing sugar, etc.<sup>4–7</sup> Local infectious complications (maxillary sinusitis) may have played a direct role in the cause of death of the first celebrity chef.

C. Philippe, Paris

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DOI: 10.1038/sj.bdj.2013.799