normal pulp cavities exclude dentinogenesis imperfecta'.

In the dentine abnormalities that may be associated with osteogenesis imperfecta, the pulp chambers and root canals are either progressively obliterated by the continuous deposition of highly disorganised dentine, or the pulp chambers are larger than normal by a failure of deposition. It is not possible to ascertain whether or not the pulp chambers are in fact enlarged, or to measure the amount of obliteration without taking periapical radiographs and comparing them with age matched controls.

There is also no mention in the article about tooth crown morphology or if, in fact, the teeth are smaller with cusp tips closer together than normal. Nor is there any reference to the presence or absence of short tapering roots.

Although discoloration and opalescence are the more easily observed signs of abnormality, they are not the only criteria for the classification of dentinogenesis imperfecta.

FIG 1 Clinical appearance of patient showing apparently normal teeth morphology and colour.

J P GAGE
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Oxford OX3 7LD.

This letter was shown to Dr Nicholls and colleagues, who reply as follows:

Sir,

We note Mr Gage's comments with interest and fully accept that the diagnosis of dentinogenesis imperfecta can be difficult, especially for non-dentists. Undoubtedly the assessment of the finer details of pulp cavity and root canal morphology is the province of dental expertise and well beyond the abilities of the casual observer. Yet most clinicians in the field rely upon tooth colour to diagnose dentinogenesis perhaps more than they ought.

Unfortunately panorthotomograms were not available from our patient and we have been unable to obtain a tooth for histological examination (which would settle matters beyond dispute). We therefore showed the clinical morphology of our patient's teeth and their appearance on skull x-rays to established dental experts interested in dentinogenesis in the London region. In their opinion neither the clinical appearance (fig 1) nor the tooth radiographs (fig 2) show any evidence of dentinogenesis imperfecta in this patient.

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HLA antigens in South African Afrikaners with heterozygous familial hypercholesterolaemia

Sir,

Familial hypercholesterolaemia (FH) is inherited as an autosomal dominant disorder. The prevalence of FH heterozygotes in the white Afrikaner population of South Africa is 1 in 100 or more and is the highest ever recorded. We have investigated the distribution of HLA antigens in 82 unrelated

FIG 2 A, P, and lateral views of patient's dentition enlarged from original skull x-ray.