### Letters to the Editor

fractured permanent teeth treated in a pediatric dentistry clinic' (1). The article troubles me because of the extremely high reported incidence of complications requiring endodontic treatment. When I look at the data, I can see that the authors have not taken concomitant luxation injuries into consideration. This in my opinion is a gross error in method. My own published research has demonstrated that this factor alone will significantly influence the final outcome (in my data: approx. 1% PN and 3% PCO). And it is this factor alone - ignoring concomitant luxations – that makes crown fractures (alongside root fractures) one of the most overtreated injury types. I think it is unfortunate that the reviewer did not pick up on this. But publication of such data promotes the misconception that crown fractures require endodontic therapy, when in fact it is the luxation injury that necessitates this treatment.

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### Reference

1. Güngör HC, Uysal S, Altay N. A retrospective evaluation of crown-fractured permanent teeth treated in a pediatric dentistry clinic. Dent Traumatol 2007;23:211–7.

# Response to A retrospective evaluation of crown-fractured permanent teeth treated in a pediatric dentistry clinic

I would like to express our gratitude to Dr Andreasen for her interest in our recent article (1). Dr Andreasen emphasizes on concomitant luxation injuries and expresses her concerns that these injuries have not been taken into consideration in the study protocol. In fact, as it is written in the 'Patients and methods' section of the article, 'only' uncomplicated (enamel-dentine) and complicated crown-fractured teeth were included in the study. However, this sentence could have been written more clearly to avoid misconceptions as stated by Dr Andreasen. The results of our study indicate a dramatic late referral rate. Only 53% of the study samples were referred to our clinics in less than 7 days after the traumatic injury. The delay in seeking dental care after a traumatic injury might have masked underlying concomitant luxation injury. Although the possibility of existing concomitant injury cannot be ruled out, it is sometimes impossible to make an accurate diagnosis of the exact clinical situation with respect to luxation injury especially in a late presenting case. This condition has been discussed as a contributing factor for the high rate of pulp necrosis observed in the study. I hope this information is useful to satisfy Dr Andreasen's concerns.

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1. Güngör HC, Uysal S, Altay N. A retrospective evaluation of crown-fractured permanent teeth treated in a pediatric dentistry clinic. Dent Traumatol 2007;23:211–7.

# Development of Ankylosis in permanent incisors following delayed replantation and severe intrusion

Dear Editor,

The subject addressed in the article 'Development of ankylosis in permanent incisors following delayed replantation and severe intrusion' by Campbell et al. (1) is of extreme relevance as dental traumas are more likely to occur in children, and the practitioners should be able to treat such injuries. However, some questions have been raised.

We believe that the diagnostic methods used in that article, namely, Periotest<sup>®</sup> and Miller's index could be cited in the *objective* section. It seemed to us that the authors aimed to propose different and efficient methods for diagnosing those cases of trauma resulting in dental ankylosis and then compare them.

Regarding the first case report, however, it was not mentioned where the tooth had been stored during the extra-oral period, thus raising questions on both prognosis and indication for replantation. It is possible that ankylosis was an outcome expected by the authors, since teeth kept out of aqueous medium are more likely to be ankylosed (2).

Regarding the second case report, the authors had mentioned that they would await a further improvement of the periodontal ligament so that the root canal could be filled later. According to the literature (3, 4), however, dental ankylosis is well known to have no improvement process, thus making it difficult to identify when the root canals would be filled (5).

Finally, the device suggested by the authors for diagnosing ankylosis, namely, Periotest<sup>®</sup>, is contraindicated in those cases of acute pulpitis, acute pericoronaritis, and dental traumas (6). Therefore, we have raised questions on its use in the two cases reported by that article.

Although such a subject is of great interest for both clinicians and child dentists, the results should be cautiously viewed because there are doubts as to whether the diagnostic methods were reliable and efficient as well as whether the clinical procedures and treatment proposed were adequate.

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# Response to Development of Ankylosis in permanent incisors following delayed replantation and severe intrusion

An objective measurement technique requires that measurements are produced independently of the individual performing the measurement. By this definition, the Miller Index is not an objective measure of tooth mobility as the assessor provides both the physical stimulus to the tooth and assessment of the magnitude of tooth movement that is produced. The Periotest<sup>®</sup> is an objective measure of tooth mobility but a weak method for diagnosis of ankylosis (1).

In the first case presented the avulsed central incisors were replanted after a delay of approximately 180 min by a dentist in the community. The patient then presented to our hospital clinic for follow-up and additional treatment. As extraoral time is the most significant predictive factor for ankylosis after replantation, it was anticipated that ankylosis would occur (2). The intent of the case report was not to determine whether ankylosis would occur but when ankylosis would occur.

Our paper states that the community-based endodontist who was providing care for the patient described in case 2 anticipated that a normal periodontal ligament would be established in 3 months to 1 year and that he intended to obturate the canals with gutta-percha at that time. This information was provided to highlight misconceptions about the potential for reversal of ankylosis that are widely held within the dental community. As to the use of the Periotest<sup>®</sup> for dental trauma,

As to the use of the Periotest<sup>®</sup> for dental trauma, we refer the authors of the above letter to our earlier publication that assessed the efficacy of Periotest<sup>®</sup> diagnosis of post-traumatic ankylosis (1).

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# Use of hydroxyapatite in tooth replantation radiographically followed up for 14 years

Dear Editor,

The article 'Use of hydroxyapatite in tooth replantation radiographically followed up for 14 years: a case report' by Baldissera et al., which was published in your journal (1), has caused concern amongst us. We know that *Dental Trauma-tology* has a strong clinical character, and the presentation of the method described in that paper could be mistakenly taken by careless readers. Ethical aspects are, in contrast to the opinion of the authors, of extreme importance and must be taken into account even when it is 'not the focus of the report'.

The authors justify the use of hydroxyapatite because it is a 'biocompatible, osteoconductive material primarily used for bone reconstruction', which does not endorse its use for pulpectomies of This document is a scanned copy of a printed document. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material.