Letters From Our Readers

To: Editor, *The Angle Orthodontist*

Re: Response to: The premature loss of primary first molars: space loss to molar occlusal relationships and facial patterns by Stanley A. Alexander, Marjan Askari, Patricia Lewis. *Angle Orthod.* 2015 Mar;85(2):218-223.

We want to thank Dr. Northway for his compliments and for his interest in our study which further expands his related and pivotal paper on the same topic., We will answer his observations in the order that they were presented.

Orthodontics is a clinical science and has a familial and historical relationship with physical anthropology. As such, we find the use of anthropometric and clinical terminologies as ''a vertical growing face'' or ''hyperdivergent'' interchangeable in the description of facial forms as was described in this study. We had no intention to apply ethnic differentials to this population sample. Upon clinical examination of the seven and eight year old patients, neither digit habits, nor respiratory problems, nor transverse implications were noted.

As discussed in the paper, all measurements were made directly on the patient, with an intact opposing arch serving as a reference point. Ideally and we agree, cephalometric and stone model measurements would have served as a stronger and more dynamic baseline from which deviations would be measured and quantitated; unfortunately, current institutional review boards of the 21st century in the United States rarely allow for clinical procedures, particularly radiographic, to be performed when clinical therapy does not follow as was the case in this study. If we were to repeat this investigation, our current options would be to digitally scan and measure the areas studied with a far less obtrusive method than to impression seven and eight year old children, and measure the results from stone models. The study time period was set at 9 months, since the majority of space loss occurs within a 6 month period after the premature loss of a primary tooth; space loss after this period is usually clinically insignificant, as long as other variables remain stable.

With regard to the impact of other components of premature loss of primary teeth as Dr. Northway mentions, (age at the time of extraction, which tooth, pre-existing conditions, carious condition, and the existing malocclusion), our inclusion criteria was exact in its description as to age of the patients represented, the absence of interproximal caries, and the molar relationships either being end-on or Class I. Any conclusions that are made based upon our result of facial form and the permanent first molar relationship, can only be interpreted to the population studied and therefore kept in its perspective. What we realize is that although the obvious conclusions are staring us in the face, they often go unnoticed.

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