

The authors described their technique as novel, but we would like to bring to their notice some facts. A similar method for correction of Class II malocclusion was given by Pedro Planas of Spain in 1971 and was named Planas direct tracks (PDTs).¹ PDT has been used since then for early Class II malocclusion correction² and also for pseudo-Class III malocclusion correction.³ PDTs are prism-shaped blocks incorporating inclined planes of 45° made up of composite resin directly built or cemented onto the occlusal surfaces of premolars and molars.⁴ The mechanism of action of PDT is also the same as bonded inclined bite raisers elastics (ie, raising the bite to unlock the mandible and keep it in the desired position). In addition to bite raisers, El-Bokle and Abbas included a fixed appliance with short elastics. Apart from this, there is no other difference between these 2 methods. The authors should have included the history of this bite raiser to give due importance to the original work of Planas. As this method of mandibular positioning has been in use since 1971, it is not justified to call it a novel method.

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Authors' response

We read with so much interest the letter to the editor regarding our recent article, "A novel method for the treatment of Class II malocclusion."

The authors pointed out that we did not include the Planas direct tracks (PDT) introduced by Dr Planas¹ of Spain in 1971 in our references. We would like to draw the authors' attention to the fact that our article was a case report and not a literature review that would normally include all of the possible references regarding our work. In addition, we did mention that the introduction of inclined bite planes was as early as 1899.

The authors also claim that the mechanism of action of PDT is the same as our bonded inclined bite raisers elastics. We have to disagree because of the fundamental differences between the devices. First, the inclined raisers that we use are not merely prism in shape like the PDT. A plateau is intentionally added to make it difficult for the mandible to occlude more distally, which could worsen the Class II relationship (Fig 1 in our article). Second, elastics attached to an orthodontic appliance are a key factor in maintaining the advanced mandibular position, especially during sleep. Third, our technique is specific regarding the amount of advancement (2 mm) and gradual activation, whereas the article referenced by the authors for Class II treatment by Gribel and Gribel² was a case report on Class II treatment with PDT in the deciduous dentition in the absence of any orthodontic appliances. We do find their technique hard to implement at this young age and highly subject to relapse.

We hope that we have clarified the differences between our technique and the others, implying the novelty of our technique.

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Risk factors for maxillary impacted canine-linked severe lateral incisor root resorption

An article by Wang et al was published in 2020 with the purpose to investigate the risk factors for impacted maxillary canine-linked severe lateral incisor root resorption (Wang H, Li T, Lv C, Huang L, Zhang C, Tao G, et al. Risk factors for maxillary impacted canine-linked severe lateral incisor root resorption: a cone-beam computed tomography study. *Am J Orthod Dentofacial Orthop* 2020;158:410-9). Although the article was quite informative, we have some questions.

The legend for Figure 10 indicates $P < 0.1$ to be statistically significant for the chi-square or Wilcoxon test between the study group and the control group for each

variable. The same figure shows that the P value for age is 0.070, making it a significant variable. However, it was stated to be not significant in the Results section.

The article states that the study is a retrospective longitudinal design. Moreover, the cone-beam computed tomography (CBCT) images were retrospectively analyzed. However, the flowchart of the experimental design depicts the study as prospective because it starts with *Patients*, followed by *CBCT scanning at the Radiology Department* (Fig 2). Kindly explain the variation.

The Introduction states that lateral incisor root resorption could be detected 37% more by CBCT than with 2-dimensional radiographs; Ericson et al¹ was cited to justify this statement. However, the referred article does not report CBCT but rather describes radiographic examination and polytomography. Moreover, CBCT was introduced to dental offices in the late 1990s.²

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Author's response

Thank you for the insightful commentary on our manuscript. We appreciate this opportunity to explain some doubts raised in your letter.

The P value for age mentioned in Figure 10 ($P = 0.070$) was the result of the Wilcoxon test. This test suggested that age might be 1 possible risk factor for severe lateral incisor root resorption. Then, all the possible risk factors, including age, were tested with the binary logistic regression to screen the predictors for severe lateral incisor root resorption. The result of binary logistic regression for age was $P = 0.387$, which showed that no significant difference was found between the study group and the control group. Please note that age was stated to be not significant in the Results section, which represented the result of binary logistic regression.

The flowchart of the experimental design was added to elucidate the process of obtaining and analyzing clinical data. In fact, this study was designed and implemented in 2018 using cone-beam computed tomography (CBCT) images screened from 2016 to 2017, matching the definition of a retrospective study. Thank you for offering us an opportunity to clarify this point.

Regarding the third question raised in the letter, ever since a symposium on Craniofacial Imaging in the 21st Century was held in 2002 in Pacific Grove, Calif, CBCT technology has undergone a rapid evolution.¹ CBCT nowadays could provide accurate images and information about root morphology as the subjects could be observed at any angle using 3-dimensional reconstruction.² It is widely known as a reliable detector for craniomaxillofacial deformity. With good imaging quality and proper clinical skills, nearly all patients with root resorption can be observed by CBCT-based clinical examination. As for the referred literature in our article (Ericson et al),³ the researchers stated that 37% of the lateral incisors affected by root resorption appeared normal on the 2-dimensional radiographs. If CBCT had been introduced to dental offices at that time, these 37% neglected patients could have been treated earlier. We attempted to convey this understanding in the introduction of our article when we wrote that "lateral incisors root resorption could be detected 37% more by CBCT than with 2-dimensional radiographs."

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