Letters to the Editor

Dear Sir,

Re: Forestadent Travel Award

I would like to congratulate Mr Moseley on winning the Forestadent Travel Award, and on the excellent standard of presentation and treatment of the three cases presented. However, I note that none of the cases are shown at any length of time out of retention. This is not in any way meant as a criticism. I appreciate how hard it is to meet a deadline. Nevertheless, it is always interesting to see cases out of retention. Relapse can occur and I would think that the third case presented would be prone to relapse.

Let us hope none of the cases have relapsed, but either way it would be very interesting to know, since Mr Moseley has clearly done everything in his power to make a success of treatment. Can we have an update please.

Yours sincerely

J. D. ATHERTON
56 Rodney Street
Liverpool L1 9AD, U.K.

Dear Sir,

I would like to thank Dr Atherton for his interest and observations concerning the treatment of the cases presented for this award. I am assuming that the comment stating the possibility of future relapse of the result obtained for the third case relates to either:

(1) changes in incisor alignment; or
(2) stability of the open bite closure, achieved by a combination of second molar extraction, vertical growth modification, and a small amount of lower incisor extrusion.

At the most recent review of this patient, aged 17 years, the open bite had remained stable. She was continuing to wear removable retainers on a part-time basis to maintain incisor alignment. This decision reflected her excellent compliance with regard to appliance wear during active treatment and, ideally, should continue at least until third molars have completed eruption. I appreciate that this level of co-operation may not be achievable for all patients presenting with a similar malocclusion. My clinical impression was that facial growth was complete at the end of active treatment.

A variable degree of post-treatment change in alignment and occlusal relationships can be identified in the majority of cases that present with a significant malocclusion. If the long-term result following treatment is a stable occlusion that is aesthetically acceptable, I would not consider that this constitutes post-treatment relapse.

H. C. MOSELEY

Dear Sir,

Re: Orthologic 'A' Company Award for 1997

I was most impressed by the cases treated by Ian Lund which justifiably won the Orthologic 'A' Company Award for 1997 (*BJO*, **26,** 1–8, 1999). To see such difficult cases treated to such a standard leaves most of us feeling rather humble and should help to motivate all of us to improve out own standards.

However, the presentation raises further questions. Will the right mechanics always get results like these? If not why not? We all know that some cases grow favourable and some do not. Is this the luck of the draw or are there hidden factors which we do not yet understand? What do we actually learn from seeing successfully treated cases? Many would admit to learning more from our failures than our successes and some might be tempted to mutter 'He was lucky with that case, it will probably relapse later'. In our efforts to demonstrate the potential of orthodontic treatment, could we be misleading not only the public, but also ourselves?

Unfortunately, most results do not reach this standard, and many leave much to be desired. Even the more successful cases may raise uncomfortable issues, such as root damage, decalcification, facial aesthetics, and long-term stability.

While it is good to be inspired, we are unlikely to learn very much from cases that grow favorably. We might learn more if only we had the courage to survey blocks of consecutive patients 10 years after treatment and show our failures as often as our successes.

Yours sincerely,

JOHN MEW
Braylsham Castle,
Broad Oak, Heathfield,
Sussex TN21 8TY, U.K.

Dear Sir,

First, I would like to thank Dr Mew for his interest in the Orthologic 'A' Company award for 1997 (*BJO* **26,** 1–8, 1999) and for his generous comments upon the results.

The editorial policy of the *BJO* and the criteria which are set down by the examiners of the Membership of Orthodontics for which these cases were originally presented, and the criteria for the Award itself are not for my comment. However, as an orthodontist who has recently completed a 3-year postgraduate course, I feel that case reports published within the *BJO* are of considerable interest and contributed to my overall training.

It is now generally accepted that the gold standard for any orthodontic research is a prospective randomized controlled trial. However, case reports are recognized as having a part to play in the hierarchy of evidence and are often of educational value.

Cases submitted by 25 registrars from units throughout the country were all treated to a high standard, a tribute to

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those clinicians and also to their clinical trainers. I was fortunate in receiving this award and do not feel that these cases are necessarily strokes of luck as Dr Mew implies. I believe that the majority of my colleagues would aim to treat these cases in the manner described. There is certainly a consensus among our trainers with regard to treatment philosophy in orthodontics.

Orthodontists acknowledge the contribution of favourable growth to the outcome of cases and wish that there were more in our power to predict those cases which will not grow favourable. I feel, however, that it is all too easy to blame unfavourable growth when perhaps in fact it may be due to other factors.

Yours sincerely,

DR D. IAN LUND
67 Woodland Rd,
Darlington.
Co. Durham DL3 8BQ, U.K.