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Authors' response

We thank the reader for her interest in our article and for the comments regarding the standardization of the clinical photographs used in the study. As we stated in the Methods section, all clinicians involved were trained and experienced in the routine use of clinical photography. We think that this was sufficient to produce images that, when viewed by the assessors on a computer screen, allowed them to make judgements about the presence or absence of new demineralized lesions (DLs) and, if present, whether these DLs would be considered unesthetic. The use of multiple assessors allowed disagreements between assessors to be resolved through a majority consensus opinion. We think that these are the most relevant and clinically useful outcomes in the assessment of demineralization during orthodontic treatment.

Other researchers might consider the size or "whiteness" of DLs to be important outcomes. If so, then we agree that more rigorous standardization, including a calibration scale in each image, would be required to ensure that comparable measurements could be achieved across all images. We would suggest that the use of quantitative light-induced fluorescence (QLF) would be a more appropriate method of obtaining images for these outcomes.[1] QLF is capable of producing standardized images, with more accurate positioning over the long periods required when following participants for the full length of orthodontic treatment. However, we consider that, although QLF no doubt increases the precision and reproducibility (as well as the cost) of recording demineralization, the outcomes are not as clinically relevant as a straightforward visual assessment of the presence or absence of new DLs.

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A case for invincible first premolar extraction

The December 2018 Clinician's Corner article by James L. Vaden et al on Class II correction is a treat for any orthodontist.[1] The cases shown in the article align with the notion that correction was achieved by a deliberate conscious effort and laser-sharp focus from the very start and throughout the entire treatment, while adapting and adjusting for multiple variables along the way toward an excellent finish. But I was left with a few questions and judgments.

The authors propounded that the maxillary first premolar and mandibular second premolar extraction protocol is an acceptable method of gaining the required space for patients with moderate to low mandibular plane angle in Class II management. Was this a formula or a clinical judgment? The notion is not new and has existed since the extraction modality came into effect.

I love the ancient Indian story of 6 blind men and an elephant. Any time I find myself struggling with something I know I am capable of handling, this is the story that pops into my mind: each of us doing what we think will move us along, though each of us is only partially right. The story illustrates an extreme case of differing viewpoints that is not very different from what exists in our profession. When it comes to treating a certain patient, some would treat teeth and others would treat the face. Some would postpone a treatment and others would start immediately. Some would retract and others might advance. Some would extract and others would preserve a full set of teeth.

Let me come straight to the point: After 18 years of orthodontic management of patients, it is still perplexing for me to plan on extraction of second premolars for a borderline discrepancy or Class II malocclusion. I often realized that when minimal retraction of lower