

Authors' response

Thank you for the interest in our article. We agree with the comment that cone-beam computed tomographic (CBCT) imaging provides more accurate information and we never contradicted that fact.

Radiation dosage with the use of x-rays should benefit the patient and simultaneously provide the dentist with accurate information, which is the reason for principles such as ALARA (as low as reasonably achievable) turning to ALADA (as low as diagnostically acceptable).¹ The purpose of our study was to examine to what extent angulation and sector position in palatally displaced canines (PDCs) differed between the panoramic radiograph and the CBCT image. We found that angulation and sector position deviated, but clinically the differences were modest. Overlap in frontal view to determine the sector position and angulation of PDC to midline was not hard to pin down in the panoramic radiographs, and these references have been used widely in the literature on interceptive treatment of PDCs. The lateral incisors near the PDC do not always have shorter roots.² The main conclusion to draw from the article is that CBCT should not be used routinely for diagnosis of PDC. The decision making regarding interceptive extraction of deciduous canines in PDC cases could be undertaken with the use of panoramic radiographs at an early age, around 10–11 years.³ There are cases, however, where CBCT is indicated, for example, if there is suspicion of root resorption or lesions that could result in a change of therapy.

Despite the shortcomings of a panoramic radiograph, it is a diagnostic tool that could be considered good enough for rendering PDC position when CBCT is not crucial for treatment planning, in line with the principle of ALADA.

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Importance of photographic standardization

We sincerely acknowledge the contribution of the authors for their study published in the January issue, "Resin-modified glass ionomer cement versus composite for orthodontic bonding: A multicenter, single-blind, randomized controlled trial" (Benson PE, Alexander-Abt J, Cotter S, Dyer FMV, Fenesha F, Patel A, Campbell C, Crowley N, Millett DT. *Am J Orthod Dentofacial Orthop* 2019;155:10-8).

It was a pleasure to read this article because currently, orthodontists have different alternatives of adhesion materials. One of these is the glass ionomer, which releases fluorine and does not have as strong adhesion as resin. It is also known that obvious lesions at the level of the tooth enamel after the cementation of the brackets are a problem that orthodontists face frequently in the dental office.

In current scientific articles, enamel lesions can be diagnosed photographically, but this requires a standardized protocol.¹ This recent article presents flaws in describing the method that can affect the results, because the authors did not report the technical characteristics of the camera or illumination conditions.² It is also unknown if the diagnosis was made on a computer screen or on photographic paper, and not finding these specific conditions could lead to a diagnostic error.³

The photographs presented in the article show different color contrasts, and this condition could modify the results.² Furthermore, a nondetailed photographic record does not allow the description of future investigations. On the other hand, a process of calibration of the observers that is not detailed can also affect the results because there may be errors in the diagnosis. These aspects must be taken into account by the readers, and a response clarifying these topics from the authors is necessary. Our intention is not to criticize the methodology of the article, but to draw attention to the use of standardized protocols to ensure a correct diagnosis.

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