

Fig. 1. Cephalometric study of a 2-year-old with Beckwith–Wiedemann syndrome and severe macroglossia. The mandible has been rotated down and back. In addition, the maxilla has been rotated superiorly and shortened vertically.

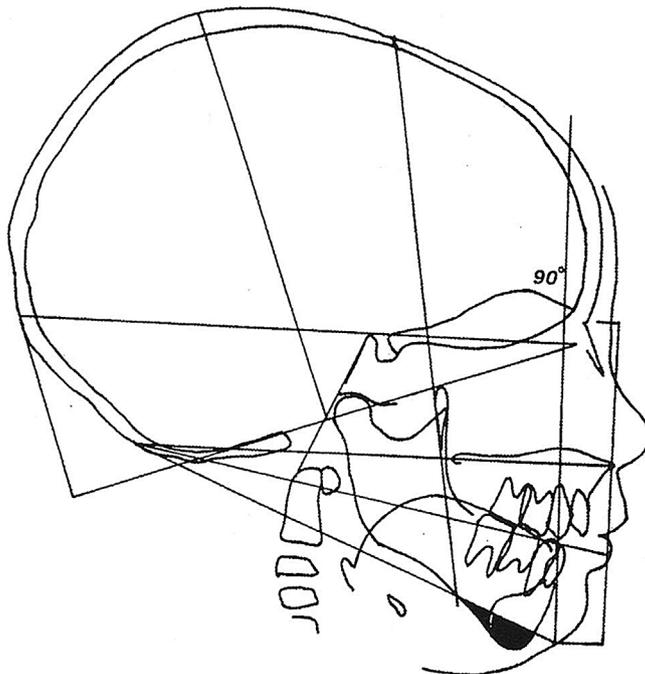


Fig. 2. Cephalometric study of the same child as in Fig. 1 at 5 years of age, following a partial glossectomy at 2 and 1/2 years of age. The mandible has rotated superiorly and the maxilla has elongated vertically, resulting in a more normal dentofacial skeleton.

Ethical approval

Not required.

Patient consent

Not required.

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Response to the Letter to the Editor in response to the publication “Tongue reduction in Beckwith–Wiedemann syndrome: outcome and treatment algorithm”

We are very grateful that our publication “Tongue reduction in Beckwith–Wiedemann syndrome: outcome and treatment algorithm”, published in January 2019 (Epub July 2018)¹, has aroused attention and interest.

Having received the ‘Letter to the Editor’, we appreciate their endorsement of our article. We are also grateful for the supplementary cephalometric data from the 1995 publication. Based on the cephalometric data, the authors conclude that the abnormal growth is mainly caused by the macroglossia, as proven by the normalizing post-surgical changes. We agree, as our data also show that surgical tongue reduction exerts a positive influence on skeletal, dentoalveolar, and functional development, with a satisfactory long-term outcome in the majority of patients. Macroglossia is thought to be one of the main factors. However, taking all data into account, one must conclude that cephalometric development seems to be more complex and not solely influenced by the hyperplastic tongue. In our cohort, one of the largest examined so far, 42% of the patients received orthodontic treatment over the course of time and 8% required combined orthodontic–orthognathic interventions, despite a previous sufficient reduction of the tongue.

We hope that the published treatment algorithm, as well as the supplementary cephalometric data in this correspondence, will encourage many more practitioners to focus on improving the treatment of Beckwith–Wiedemann syndrome in order to achieve optimal results and positive dentofacial development.

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Competing interests

None.

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Patient consent

Not required.

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Danger of highlighting the use of coxibs in daily dental practice

We read the valuable research by Isola et al. on the efficacy of celecoxib and ibuprofen for postoperative pain, swelling, and mouth opening after the surgical removal of impacted third molars with great interest¹. Nevertheless, we have some concerns regarding the cardiovascular adverse effects of COX-2 inhibitors.

As mentioned by Isola et al.¹, the surgical removal of third molars is one of the most common surgeries in daily dental practice. Pain, swelling, and restriction in mouth opening are the main problems in the postoperative period that the dental practitioner has to deal with. Considering the gastrointestinal, hematopoietic, and renal adverse effect profile of COX-1 inhibition, the formulation of non-steroidal anti-inflammatory drugs with relative COX-2 selectivity became a highly desirable target during the 1990s². However, studies in the first half of this decade revealed adverse effects of COX-2 inhibition on the cardiovascular system, includ-

ing an increased risk of myocardial infarction, exacerbation of stable congestive heart failure, and worsening high blood pressure³. Randomized trials and meta-analyses confirmed these findings, triggering a red flag for a potential cardiovascular safety issue with coxibs; this also led to the withdrawal of some of the COX-2 inhibitors from the market by the US Food and Drug Administration⁴. Recent studies have also recommended caution in prescribing COX-1 and 2 inhibitors for patients with existing cardiovascular conditions, until more evidence for safety via randomized trials is available⁵.

As suggested by Isola et al.¹, the most remarkable finding of their study is that treatment with celecoxib decreased the incidence and severity of postoperative pain following third molar surgery. This conclusion is very important and could affect the clinical behaviour of dental clinicians. We believe that when selecting celecoxib after dental surgery, its adverse effects must be considered. Therefore, the possible side effects of COX-2 inhibitors should have been emphasized in the text by the authors.

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Competing interests

None.

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Patient consent

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In response to Letter to the Editor “Danger of highlighting the use of coxibs in daily dental practice”

We appreciate the Letter to the Editor by Gülses et al. in response to our article entitled “Evaluation of the efficacy of celecoxib and ibuprofen on postoperative pain, swelling, and mouth opening after surgical removal of impacted third molars: a randomized, controlled clinical trial”¹. We also thank these authors for their recognition of the results of our randomized controlled clinical trial.

The comments raised by these authors regarding the adverse effects of COX-2 inhibition on the cardiovascular system, including the increased risks of myocardial infarction and disturbance of blood pressure, are well taken. However, some elaboration is in order.

The surgical removal of third molars is one of the most common surgical interventions in daily dental practice. Previous studies have demonstrated that celecoxib used at a dose ranging between 120 mg and 200 mg is efficient in the reduction of early stage acute pain and perioperative symptoms following third molar surgery^{2,3}.

During the last few decades, COX-2 selective inhibitors were introduced to provide the anti-inflammatory effects of non-steroidal anti-inflammatory drugs (NSAIDs) with less gastrointestinal toxicity. However, the first studies on COX-2 inhibitors, used for a wide range of conditions such as osteoarthritis and rheumatoid arthritis, found an increased risk of cardiovascular disease (CVD)