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Letters to the Editor

Keratocystic odontogenic tumour (KCOT) has again been renamed odontogenic keratocyst (OKC)

In the recent World Health Organization classification of tumours of the head and neck[1], the name keratocystic odontogenic tumour (KCOT) has been changed again to odontogenic keratocyst (OKC). This decision has caused some confusion and has undoubtedly lessened alertness regarding this potentially very aggressive lesion. Apart from the known tendency of OKCs to recur, their potential aggressiveness has been well documented by Emerson et al.[2], who described the extension of two recurrent OKCs in the mediastinum, extended via the neck. Worral[3] and Abé et al.[4] reported OKCs penetrating into the temporalis muscle, while Makaria et al.[5] and Yamamoto et al.[6] found the same in the masseter muscle. Liu et al.[7] described a recurring OKC in an autogenous lyophilized bone graft, with extension into the masseter muscle. It is clear that extension into the soft tissues makes it very hard to remove this lesion in one piece. There will be a considerable risk of leaving some cells behind; thus, recurrences are almost unavoidable. Jackson et al.[8], Franc et al.[9], and Soost et al.[10] have described the extension of an OKC into the base of the skull. The potential danger of this phenomenon does not require further elaboration.

The presence of clusters of epithelial cell nests, also called basal cell hamartias[11], in a high percentage of OKCs, often accompanied by microcysts in the mucosa overlying the OKC, has been unequivocally proven by Stoelinga et al.[12–15]. Over the last 50 years, numerous studies have been reported that show the high tendency for OKCs to recur after surgical treatment, be it marsupialization with or without secondary enucleation, enucleation with or without additional treatment, or even segmental resections. Five case reports have been published showing recurrent OKCs in a bone graft[7,16–19]. The latter phenomenon almost proves that the source of some of these newly developing cysts is located in the mucosa covering the area where the OKC has been removed.

In light of the facts stated above, the decision to change the name back to OKC seems somewhat strange, denying its behaviour as a benign but aggressive tumour.

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Competing interests

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Ethical approval

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Patient consent

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Re: ''Comparison between flapless and open-flap implant placement: a systematic review and meta-analysis''

We read with great interest the article ''Comparison between flapless and open-flap implant placement: a systematic review and meta-analysis'' by Lemos et al., published in the April 2018 edition of the journal[1]. The review aimed to assess the difference between two techniques of implant placement using data extracted from several studies. However it appears that there may have been some inaccuracy in the data extraction.

The data extracted from the studies included had a direct influence on the forest plots and the Discussion section. The authors stated that two of them mainly worked on the data collection process. However, there are some errors in Table 2: (1) For the study by Bomicke et al. (2017), the authors noted an implant survival rate of 19/19 (100%) in the flap group; however the article by Bomicke et al. states: ''3 participants lost to follow-up in 3-year follow-up and 16 participants were analyzed in two-piece implants group''. (2) For the study by Cannizzaro et al. (2011), the authors noted that the mean (standard deviation (SD)) marginal bone loss was 0.43 (0.40) in the flap group and 0.38 (0.42) in the flapless group; however the table in the article by Cannizzaro et al. shows that the data mentioned in the review were used to evaluate the marginal bone level rather than bone loss, and the mean (SD) of marginal bone loss was 0.33 (0.50) in the flap group and 0.24 (0.29) in the flapless group. (3) For the study by Van de Velde et al. (2010), the authors noted that the mean (SD) of marginal bone loss was 1.93 (0.42) in the flap group and 1.95 (0.7) in the flapless group; however the table in the article by Van de Velde et al. shows that the data mentioned in the review were used to evaluate the marginal bone level rather than bone loss at the 18-month follow-up, and the mean (SD) marginal bone loss was 0.77 (0.39) in the flap group and 1 (0.58) in the flapless group.

The implant survival rate and marginal bone loss outcomes are important when making decisions regarding the choice of surgical method for implant placement. A meta-analysis is required to be rigorous, and this review with data errors could mislead readers or change opinion on non-conventional methods.

To conclude, the comparison of a variety of surgical methods using an ethical design is needed. Those methods associated with low success rates, multiple complications, etc., will cease to be used, and ultimately the methods of choice will have benefits for both the clinician and the patient.

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Competing interests

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Ethical approval

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Patient consent

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Response to the Letter to the Editor on ''Comparison between flapless and open-flap implant placement: a systematic review and meta-analysis''

Thank you for giving us the opportunity to reply to the Letter to the Editor in response to our manuscript ''Comparison between flapless and open-flap implant placement: a systematic review and meta-analysis''[1]. We would like thank the authors of the letter for the time taken and care with which they verified the data tabulated in this work. However, the claims made are refuted in the points described below.

All tabulated data were obtained from the selected studies. We opted to consider the initial data about the patients because not all studies were clear regarding drop-outs and/or withdrawals. For the study of Bomicke et al.[2], we tabulated the data for the patients initially recruited (19 patients, without considering the three patients who dropped out). However, we performed the analysis again taking into consideration the dropouts for the all selected studies that reported this information and found that this minor fact was not relevant to the final analysis as stated by the authors of the letter. Thus, there remained no significant difference in implant survival rate between flapless and open-flap surgery (Fig. 1).

Regarding the marginal bone loss outcome, both studies highlighted by the authors of the letter reported the data tabulated in our manuscript[3,4]. For these studies we considered the final value of the bone level reported by the authors. The data reported by the letter refer to the difference between the baseline value and that obtained at the last available follow-up. Thus, we performed the analy-