Letters to the editor*

“Painless” Parker

The October editorial on Dr Edgar R. R. Parker evoked memories of our dental history course at McGill University in Montreal (Behrents RG. Dr Edgar R. R. Parker: his time and now. Am J Orthod Dentofacial Orthop 2015;148: 521-4).

“Painless” Parker did some remarkable things right here in Montreal, Canada. On St. Catherine Street, a main thoroughfare in Montreal, he had a tightrope wire installed from a second-story window on one side of the street to a window on the other side of the street. He engaged a tightrope walker to cross the street. When the walker emerged from the first window to begin his walk, he cried out to the people below, “I am going to the office of Painless Parker because he extracts teeth painlessly.” For the return trip, he would yell to the people below he had just had his tooth removed painlessly at Dr Parker’s office. Sometimes, as a further marketing tool, the tightrope walker would release a bag of nickels in the middle of his walk, causing pandemonium as people rushed to pick up the change in the middle of the street—blocking traffic in the midst of all the mayhem.

When the circus came to town, articles and a picture in the newspaper reported on how Parker, fearlessly, had removed a lion’s tooth. According to the legend, most people were unaware that the lion was very old and already toothless.

In Quebec and other provinces to which Painless Parker migrated, he was thrown out or forced to leave because the government and dental societies legislated against his marketing practices. The basic ethics of dental practice, incorporated in dental provincial legislation, still stand today. I believe this to be true in the U.S. as well. This was an important point not mentioned in the editorial.

I have practiced orthodontics for the last 48 years and taught the Practice Management course at the University of Montreal, Orthodontic Section, for the last 31 years, and my view is that new graduates today are challenged by the same factors listed in the editorial. The United States has always been 15 years ahead of Canada in orthodontic practice trends. Markets were much more open in Canada for young orthodontists in the past. My advice has been to practice where you want to live, treat people fairly, and do excellent work. Canadian orthodontists have managed to escape Health Maintenance Organizations, Medicaid, and much of corporate orthodontics. A new graduate today will most likely become an associate or open several satellite offices, compared with the graduates of the 1960s through the 1990s. Others will opt to purchase an existing practice.

Now, at age 74, I practice part-time with the young orthodontist to whom I sold my practice and I teach part-time, all with abundant passion. I tell the new residents that they have made a choice to join the best profession in the world despite all the changes occurring around them. Your editorial was “bang on.” Keep up the excellent work.

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Bone contribution in corticotomy-assisted rapid maxillary expansion


As shown in Table III, both buccal alveolar bone and palatal alveolar bone thicknesses were increased at the root apex level and at the middle of the root level. Could the authors explain how to determine whether the plane was comparable between pretreatment and posttreatment? Since both buccal and palatal alveolar bone thicknesses increased, did the total alveolar bone volume also increase after treatment? Another concern was maxillary posterior tooth buccal inclination. The maxillary posterior tooth had about a 10° average buccal inclination between pretreatment and posttreatment, as described in Table IV. Both the maxillary posterior tooth inclination changes and the alveolar bone expansion contributed to the maxillary arch expansion. What proportion of each factor contributed to the maxillary arch expansion?

*The viewpoints expressed are solely those of the author(s) and do not reflect those of the editor(s), publisher(s), or Association.
Which contributed more in this case? We appreciate the authors’ efforts to share the experience with the readers.

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Authors’ response

We thank the readers for their comments regarding our article (Echchadi ME, Benchikh B, Bellamine M, Kim SH. Corticotomy-assisted rapid maxillary expansion: a novel approach with a 3-year follow-up. Am J Orthod Dentofacial Orthop 2015;148:138-53). We also thank the editor for allowing us to reply to the letter.

In the methodology we used for the computed tomography scans, the standardization of the equipment, the image-acquisition settings, and the patient’s head posture position in all 3 planes allowed comparison of the images before and after expansion. The pretreatment buccal cusp tips of the maxillary first molars and premolars were at the same level, and our reference plane was an axial section parallel to the palatal plane, at the level of maxillary first molar furcation (Fs). Since the roots had about 11 mm in average length and the slice thickness was about 1 mm, the alveolar bone thickness measurements were made at the middle of the root at Fs + 14 mm, and for the root apex at Fs + 9 mm. However, to obtain a proper occlusion, the canines were extruded; hence, we used the buccolingual root diameter as a reference for the canines to obtain comparable sections between pretreatment and posttreatment.

Superimposition of the computed tomography scans showed noticeable increases in bone thickness, especially in the canine and premolar areas. Also, the alignment of the 4 maxillary incisors resulted in an increase of the interradicular bone volume.

The comparison of pretreatment and posttreatment maxillary posterior tooth inclinations showed increases in the axial inclinations of the premolars and right molars, which had a significant impact on the transverse linear dimensions. In addition, the use of fixed appliances simultaneously with the expander offered overcorrection control. Moreover, tooth movement occurred with the alveolar bone and not through it.

In this patient, alveolar bone regeneration and posterior tooth inclinations contributed in the same way to the maxillary arch expansion. However, buccal bone apposition, observed in this patient, cannot necessarily be extrapolated for other patients.

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Reduction in incidence of white spot lesions with lingual appliances

I want to make a few comments on the article “Lingual appliances reduce the incidence of white spot lesions during orthodontic multibracket treatment,” in the September issue (Wiechmann D, Klang E, Helms HJ, Knösel M. Am J Orthod Dentofacial Orthop 2015;148:414-22). This retrospective study analyzed a huge sample of patients, who were treated in one of the world’s leading lingual orthodontic practices.

Some important factors that affect the etiology of white spot lesions (WSLs) should have been reported, including the ligature type (continuous stainless steel or elastomeric power chain). This has been found to influence not only the archwire replacement speed, but also the plaque accumulation rate. Furthermore, the use of vestibular buttons for intra-arch and interarch elastics can facilitate the onset of labial WSLs.1,2

An important difference in the sample size between the preadolescent (90% of the sample) and adolescent (10% of the sample) groups means that every comparison between them is influenced by this. Furthermore, the period of adolescence is closely associated with the teenage years; therefore, using 13 or 14 years as the cutoff between preadolescence and adolescence would have obtained more balanced groups and probably different results of a statistical comparison.

The influence of further possible confounding factors, such as oral hygiene status, nutritional habits, and fluoridation exposure, was also not considered, although this was declared in the Discussion section.3,4 A control group treated in the same clinic with a labial technique could have limited the impact of these confounding factors.5

Finally, with regard to the bracketing procedure, the application of a thin extra layer of a fluoride-releasing bonding resin should have been more emphasized.