

disorders, oral mucosal disease, and medically complex conditions, because these patients cannot find dental providers who have the knowledge, skill, and experience to manage their conditions. Clearly there is unmet need. The implication that oral and maxillofacial pathologists are providing care to these patients is grossly exaggerated, because current evidence shows that over 95% of all clinically based income for oral and maxillofacial pathologists is derived from histopathology services, not from direct patient care (unpublished data).

Dr. Vincent also takes issue with the lawsuit involving the Texas Dental Board and claims that such action can “dilute the integrity of the dental health care profession.” Here, we believe that Dr. Vincent fails to appreciate the growth that the profession requires, which can only come from a hard look internally at the ADA specialty recognition process and the need for improvements in self-regulation. He expresses concern that the public is at risk with such a plan; however, he provides no justification of how the public would be harmed if the knowledge and skills in new dental fields available to the general public were to be expanded. Consistent with this, in U.S. District Court, Judge Sam Sparks noted that consumers would not be harmed by the court’s decision.⁶

In closing, the repetitive actions and decisions of the ADA have forced emerging specialties to go outside of the ADA. The American Board of Dental Specialties has been specifically developed to transcend this longstanding political process in order to achieve an objective process in approving dental specialties. While some may consider this as unfortunate, we believe that the public will benefit from more dental specialties with dental professionals who have advanced knowledge and skills in these exciting emerging fields. This clearly contrasts with Dr. Vincent’s opinion and is another example of how oral medicine is different from oral and maxillofacial pathology.

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Disclosure: Dr. Miller has served as chairman of the Specialty Recognition Committee for the American Academy of Oral Medicine since 1988. He is a member of the founding Board of Directors and currently serves as a director of the American Board of Dental Specialties. Dr. Friction has served as chairman of the Specialty Recognition Committee for the American Academy of Orofacial Pain since 1988. He is a member of the founding Board of Directors and currently serves as a director of the American Board of Dental Specialties.

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Mandibular changes on panoramic imaging after head and neck radiotherapy: a commentary



To the Editor:

We read with great interest the recently published article by Chan et al. titled “Mandibular changes on panoramic imaging after head and neck radiotherapy.”¹ We would like to congratulate the authors for their original study, as there are no published case series that characterize the different types of radiographic changes in the jaws post radiotherapy. However, we had a few queries and would appreciate if the authors could provide further clarification:

1. It is not clear why patients with osteoradionecrosis were excluded from the study, as it was not defined in the study’s exclusion criteria.
2. We had a little difficulty understanding how the bone changes can be attributed to radiotherapy alone. In the study there is no clinical correlation with the periodontal health status of the patient postradiotherapy,

and there is no mention of oral hygiene practices. Postradiotherapy oral mucositis can be a hindrance in the maintenance of regular oral hygiene,² which can lead to poor periodontal health and subsequent bone changes.

3. We are curious about the quality of the stored panoramic images, especially of the 204 film-based images, as there is no mention of any images excluded due to poor image quality.

We take this opportunity to record our appreciation of the efforts put forth by the authors in conducting this study, which will definitely facilitate further research in this field.

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“A randomized double-blind, multiple-arm trial comparing the efficacy of submucosal injections of hyaluronidase, dexamethasone, and combination of dexamethasone and hyaluronidase in the management of oral submucous fibrosis”—a commentary



To the Editor:

We congratulate the authors on the report of their randomized, double-blind, multiple-arm clinical trial.¹ The article is very informative for clinicians encountering oral submucous fibrosis. We have a few queries for which we seek clarifications from the authors. We request the authors respond to the following questions:

1. Without an intragroup analysis, can we conclude that there was significant reduction in tightness of mucosa in all the three groups?

2. The total improvement in burning sensation and tightness of mucosa does not appear to match with the total aggregate of baseline—week 2, week 2 to month 1, months 1 to 2, months 2 to 3, and months 3 to 6 for group 1.
3. With regard to tightness of mucosa and mouth opening (months 3-6), is it valid to include the group comparisons when one or more groups had mean and standard deviation of 0?

Thank you.

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Comparison of the performance of intraoral X-ray sensors using objective image quality assessment



In reply:

This letter is in response to the comments from Drs. Mah and Udupa regarding our article “Comparison of the performance of intraoral X-ray sensors using objective image quality assessment.” We are grateful for their comments and appreciate their careful reading of our paper.