The efficacy of EMG, jaw tracking, and joint sound recording technologies in the evaluation of TMD

To the Editor:

After some years of quiescence, Dr. Charles Greene and associates have once again taken up the battle against the use of modern technology as aids in evaluating occlusion and temporomandibular disorder (TMD).1

Your respected journal, which has a reputation for fairness, did not meet its journalistic standards by allowing Dr. Greene to use the Editorial section as a platform to disparage our devices while presenting an Association’s policy statement that he has coauthored. Dr. Greene has been at the forefront of a 25-year campaign against the use of our devices. In his letter of August 10, 1994, to the U.S. Food and Drug Administration (FDA), Dr. Greene warns of “potential dangers of such devices” and demands the FDA’s “attention to this most important public health issue.” As a result, an FDA panel was assembled before which Dr. Greene testified against the use of our devices. Reporting on the conclusions of a subsequent government investigation, Dickinson’s FDA review called this panel a “rigged FDA panel.” Furthermore, Dr. Greene has written reports against the use of our devices as an employee of American Dental Examiners, a company that consults with insurance companies. Dr. Greene has also testified against clinicians who have used our devices (Esser v. Shapira and Illinois, 1995).

In his editorial, Dr. Greene states that a “central issue” that must be addressed regarding these “diagnostic devices” is the matter of sensitivity and specificity. Simply stated, the fallacy in Dr. Greene’s statement about sensitivity and specificity lies in the fact that the devices in question do not make diagnoses (i.e., rule-in or rule-out TMD).

Along with history, visual examination, and imaging, the data produced simply provide more knowledge for the dentist in making his or her diagnosis or evaluating treatment progress of a given patient.

A significant body of literature published in peer-reviewed journals over the past 40 years has documented the efficacy of electromyography, jaw tracking, and joint sound recording as valuable aids in the evaluation of TMD patients’ status, for planning effective treatment, and for evaluating patients’ response to treatment.2-6 (Only 5 references are listed to meet the requirements of the Letter to the Editor format.) Despite the efforts of these few individuals, the FDA has reaffirmed the intended uses of our k7 and the value of neuromuscular instrumentation in the dental practice has been evidenced by the dramatic growth in use of this technology by clinicians in over 35 countries and by ≥90 medical and dental schools worldwide.

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HIV infection and tooth loss

To the Editor:

In the course of our current study on HIV infection and associated oral health issues, we came upon the fascinating article “HIV infection and tooth loss” in the March 2008 Journal.1

In that article, a group of HIV-positive dental patients were studied retrospectively, in a 2-year period, and compared with an age-, race-, and gender-matched group of HIV-negative dental patients, which structur-
ally is consistent with the criteria of a typical case-control study.

However, to our surprise, the study method was described as “a retrospective cross-sectional chart study.” Cross-sectional studies are designated to observe a sample of population at just 1 particular point of time. They are thus fundamentally different from longitudinal studies.2

We would appreciate if the respected journal could clarify our confusion by a brief note of explanation.

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HIV and tooth loss

In reply:

I reviewed the comments in the recent letter to the editor regarding our paper “HIV and tooth loss.” Our work has both cross-sectional and longitudinal elements, because we compared the HIV-infected individuals with control subjects at a single initial time point as well as examined the changes over time in the 2 groups.

As such, the author of the letter makes a good point that we did not indicate the longitudinal nature of the study when we called it a “cross-sectional study.” We did, however, describe accurately what we did in the methods, including examining the data at different time points. Our failure to refer to the study as a “longitudinal study” does not change the validity of the data nor the conclusions expressed in the paper.

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