tumor thickness in the sentence, “In addition, all of the tumors that were positive for nodal metastasis had a depth of invasion >4 mm.” However, we do not see a need to go into the depth of correlating all the histologic features with the lymph node metastasis, because it is out of the scope of this study and only a single synchronous case out of 28 was positive for lymph node metastasis.

REFERENCES

The values of 5-year survival of synchronous and single primary OSCCs were based on references 1 and 4 of the article.

ARE THEY REALLY SYNCHRONOUS TUMORS?

We also agree that there is a possibility to have an underneath connection between 2 tumors of closely associated sites. However, we were meticulous in this aspect to include only lesions well apart from each other. Although commenters have proposed that “the histologic examination of normal tissue is mandatory to rule out any underneath connection between the synchronous OSCCs,” it is highly questionable whether it is ethically correct to section normal mucosa of a patient with 2 well-apart lesions with clear margins just to see whether the tumor is connected. It is automatically understood that when the excision margin is clear, there is no connection between 2 tumors. Further, most of the tumors in the study were either bilateral or from 2 different sites.

TNM, HABITS, DURATION

The clinical data such as relevant habits, TNM stage, and duration of the lesions could not be retrieved adequately as to present in the article because of the lack of access to patient records. As mentioned in the article, the lack of clinical and survival data was the major limitation of this study.

VALIDITY CONCLUSION

Because the given results cannot be explained by the prevailing knowledge, it may not be scientific to say that the results are incorrect. As we also have stated, the lack of survival data is a major limitation of this study. However, it does not negate the validity of the results, as there is a significant difference in histologic features. The question we have raised in the discussion, “whether the synchronous OSCCs behave in a different way clinically despite their less aggressive histological features or if some unknown factors affect the survival of these patients,” was just to emphasize the importance of further research in this context.

In summary, the lack of survival and clinical data to support the results of the study is a major limitation; however, this does not negate the fact that the histologic features of the synchronous lesions presented are less aggressive, because the criteria used were well defined and accepted.

We believe our explanations have answered the issues raised in the letter to editor regarding this article.

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Research and publication ethics: What have we learned thus far?

To the Editor:

It was not surprising that Dr. Spångberg, an OOOOE editor, recently showed possible radiographic “falsification” in a submitted manuscript.1 Indeed, several research and publication ethics standards have been set up since World War II. These include the Nuremberg Code, the Declaration of Helsinki, the International Committee of Medical Journal Editors’ Uniform Requirements for Manuscripts to Biomedical Journals, and recommendations by the World Association of Medical Editors and the Committee on Publication Ethics.2-7 However, many notorious experiments have still occurred, such as Japan’s Unit (late 1930s-1940s), malaria studies and mustard gas experiments (USA, 1940s), post–World War II experimentation with radiation (USA, 1950s-1960s), the Tuskegee syphilis study (USA; 1932-72), and studies of hepatitis transmission in Willowbrook State School (USA; 1950s).2,4,6,7

Recently, fabrication of the cloning research results by Woo Suk Hwang, a Korean professor; fraudulent nutritional researches by Ram B. Singh, an Indian physician; and a Chinese clinical trial on esophageal cancer without the patient’s consent were extensively criticized.2,4-7 There is much evidence that financial conflicts of interest are found with individual researchers, departmental chairs, Ethics Committee members, and even journal editors and peer reviewers. The financial interests are continuing unabated in a large proportion of medical researches and higher rates of research citations.5

As Altman and Bland8 remind us, “Absence of evidence is not evidence of absence,” the absence of ethical documentation does not mean that the study
complies with ethical standards or is ethically acceptable. Our investigative series revealed the lack of disclosures of human subject protection (obtaining ethical approval and subject’s consent), financial conflicts, and academic-industry relationship in oral-maxillofacial surgery (OMS) journals and innovations.\textsuperscript{2-5} Funding sources were disclosed in only 26.4\% of controlled trials published in OMS journals.\textsuperscript{4} Our recent studies (as yet unpublished) demonstrated that 9 of 29 clinical studies (31\%) on piezoelectric OMS procedures were dual or fragmented publications in journals of different disciplines or different languages and that OMS authors had a considerably different understanding of research ethics.

Multiple factors may contribute to such scientific misconduct. These include inadequate research experience, bias from career self-interest or financial gains, ignorance about research and publication ethics, or a combination of these.\textsuperscript{5-7} The shortage of experience, role models, encouragement, and mentorship/support increase unfamiliarity with research, lack of scientific works, and risks of research misconduct.\textsuperscript{4,9} It is probable that formal research education is not included during residency training. Once a trainee becomes a consultant or a faculty member, it may be difficult for him or her to serve as a good research worker and educator, because of the lack of research and pedagogic experiences. This leads to a vicious cycle of problems.

On the other hand, research misconduct might go undetected or undertreated because of the journals themselves. Many journals fail to take immediate action to deal with the ethical burdens, especially when senior researchers are involved. A number of editors are unfamiliar with handling such situations and some are unaware of potential ethical problems that may arise.\textsuperscript{6,10,11} This may explain partly why retraction of articles owing to unintentional error occurred twice as often as retraction due to scientific misconduct.\textsuperscript{12} Moreover, guidelines for authors are usually limited and inconsistent among different journals.\textsuperscript{13,14} Recently, we found that although similar to those of plastic surgery and otolaryngology journals, ethical issues in the instructions to authors of leading OMS journals were incomplete.\textsuperscript{9}

Journal mechanisms against scientific misconduct remain variable. Plastic and Reconstructive Surgery and the International Journal of Oral and Maxillofacial Surgery have now followed longer-established medical journals’ policies. They will no longer accept any submission without statements on human subject protection, financial support, and potential conflicts of interests. The ethical statements are published regularly in every publication of both journals.\textsuperscript{4,6,12} The American Journal of Radiology and Chest sanction the submission of the author with redundant or repetitive publications for 3 and 5 years, respectively.\textsuperscript{7,16}

In a forceful effort, Editors-in-Chiefs of 13 leading otolaryngology journals created a consortium to maintain the integrity of the journals. They will share with each other the name of the author and details of ethical violation: plagiarism, duplicate publication, undisclosed conflicts of interest, inappropriate authorship, and breaches in research and publication ethics, including lack of human subject protection, fair and unbiased data presentation, and outright scientific fraud. The unethical author will be punished regarding future publication in these 13 journals for a specified period of time. Each editor could independently undertake other actions, including notification of the dean, departmental chair, or chair of the scientific integrity committee at the author’s institution.\textsuperscript{17,18} Unfortunately, a similar joint commitment is still lacking among dental journals’ editors.

Taken together, it is high time for dental journals to have appropriate oversight of ethical breaches and implement the measures as a standard in peer-review publishing. An author/investigator has to strictly adhere to ethical research guidance. Adequate research training would help reduce scientific malpractice, both intentional and unintentional.\textsuperscript{2,3,6,7} For details on research misconduct, please refer to Gilbert and Denison,\textsuperscript{16} and Pitak-Arnnop et al.\textsuperscript{7,19}

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\textbf{REFERENCES}

Association of oral lichen planus with thyroid disease in a Finnish population: A retrospective case-control study: “A different finding from a Mediterranean area”

To the Editor:

Siponen et al. report an association of oral lichen planus/oral lichenoid lesions (OLP/OLL) with thyroid disease in the Finnish population. As they point out, OLP has been associated with a number of systemic disorders, generally of autoimmune origin (myasthenia gravis, Sjögren’s syndrome, ulcerative colitis, psoriasis, celiac disease, some liver diseases, thymoma, and lupus erythematosus); however, only in a few conditions has this link been confirmed. For example, the correlation between chronic hepatitis C virus (HCV) infection and OLP would be one of these, even if many contrasting results have been published and the partial dependency on geographic factors as well as genetic differences has been focused. Furthermore, autoimmune conditions, such as systemic lupus erythematosus, rheumatoid arthritis, and celiac disease have also been simply found to be associated with autoimmunity thyroid diseases, but without great and definitive evidence.

Hence, the association between OLP/OLL and thyroid diseases/thyroid medication, in particular hypothyroidism, have been reported in some studies up to the recent study by Siponen et al., who analyzed retrospectively 222 OLP/OLL patients and 222 controls, with a marginal significant association (95% confidence interval [CI] = 1.03 to 4.90) between OLP/OLL and hypothyroidism (10% versus 5% in controls). Finally, the authors suggested that the association of OLP and hypothyroidism could be linked to a similar, but still unknown, immune-mediated mechanism, warranting further studies in a different population.

With this regard, we would like to share our findings from a cross-sectional study performed in Sicily (West Mediterranean area). We consecutively recruited 125 resident patients, of these 74 had Hashimoto’s thyroiditis or Graves disease (70 female and 4 male; mean age: 47 ± 15.2 years; range: 14 to 79 years; of which 58 patients had Hashimoto’s thyroiditis and 16 had Graves disease) as the test group; these 2 autoimmune pathologies share with OLP a common immune-mediated pathogenesis, causing hypothyroidism and hyperthyroidism, respectively. Controls were 51 patients (42 female; 9 male; mean age: 54.6 ± 11.5 years; range: 24 to 73 years) suffering from goiter, an endemic disease in Sicily without autoimmune pathogenesis, and were found to be matched for age and gender with the test group (P > .2 by Student t).

In all samples, thyroid diseases were diagnosed both serologically and histologically; all patients underwent total thyroidectomy and subsequent replacement with thyroxin medication. All patients underwent oral examination, independently, by 2 of the authors (C.D. and C. P.), both experts in oral medicine. In our study, all patients who were HCV-positive or with OLL potentially associated with drugs, amalgam fillings, or topical allergens were excluded, different from Siponen et al., to reduce biases on the final results.

One patient with Hashimoto’s thyroiditis showed oral lesions with a reticular aspect bilaterally on the buccal mucosa and atrophic/erosive features on the masticatory mucosa, compatible with the diagnosis of OLP. The patient underwent incisional oral biopsy and the subsequent histologic examination confirmed the diagnosis of OLP. None of the controls showed clinical signs of OLP/OLL.

Different from Siponen et al., we did not find any significant association between autoimmune thyroid...