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Editor's response

Before we received the response from the authors of the "Clinician's corner" article (Bisinelli JC, Ioshii S, Retamoso LB, Moysés ST, Moysés SJ, Tanaka OM. Conservative treatment of unicystic ameloblastoma. Am J Orthod Dentofacial Orthop 2010;137:396-400) to Dr Ide's letter, I consulted with two reviewers with expertise in maxillofacial radiology and oral pathology. After reading the original article and the letter to the editor, the maxillofacial radiologist noted that, "from the radiographs, the lesion is not a typical unicystic ameloblastoma. I think Dr Ide has provided the evidence to support his points in the letter." The oral pathologist reviewed the histologic photographs, Figure 2, *C* and *D*, confirming that "they are most consistent with an adenomatoid odontogenic tumor."

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Stability of lateral open bite and myofunctional therapy

I read with interest the case report in the May issue (Cabrera MC, Cabrera CAG, de Freitas KMS, Janson G, de Freitas MR. Lateral open bite: treatment and stability. Am J Orthod Dentofacial Orthop 2010;137:701-11). This article reported the nonextraction treatment of an adult with a lateral open bite and a unilateral posterior crossbite. The lateral open bite was closed with intermaxillary elastics to obtain dentoalveolar extrusion in the region of the lateral open bite. After 2 years, the results were successful and remained stable. To enhance the stability, myofunctional therapy was used. The treatment results were excellent at the end of 2 years. Although the manuscript was well written, from the clinician's point of view, clarification on some points would have been useful.

First, this was a case of dentoalveolar lateral open bite, and the patient was not a vertical grower; hence, consideration of posterior tooth intrusion was not needed. I think the only possible option was extrusion of the affected dentoalveolar segments.

Second, the tongue as a causative factor for malocclusion development has been debated from the last century, and still there is no consensus on this topic.[1] However, for this patient, there was no obvious reason for the lateral open bite other than lateral tongue thrusting. Thus, myofunctional therapy for correction of tongue function seems appropriate. But clarification on the type of therapy used would be useful for clinicians. In an interesting article, Alexander[2] suggested some functional exercises and a retention methodology for modification of tongue function and stability of the open bite. Were such methods used?

Third, in the retention phase, a modified Hawley plate was used. How about using a retention plate with a lateral tongue crib or shield? Such a shielding method could also be used during treatment.[3]

This is one of very few articles on lateral open bite reported in the orthodontic literature. Importantly, this report mentions the role of functional therapy for open-bite stability. Again, I praise the authors for their interesting and thought-provoking article.

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