sion and was positive to vitality testing. There was a small vertical crack running in the disto-lingual aspect of the tooth. A periapical radiograph was taken and is shown here (Fig. 1).

The lower right eight is impacted under the lower right seven, causing root resorption. There is loss of the lamina dura and therefore potential hindrance of the cushioning effects of the periodontal ligament. The lower right six is heavily restored, with radiolucencies associated with the distal root, and under the crown (likely radiolucent cement).

The prognosis of the lower right seven was poor, and after a full discussion with the patient it was decided that the best option was extraction.

As can be seen (Fig. 2), the vertical fracture has propogated down the length of the tooth. This may be attributed to the impacted eight and subsequent loss of the cushioning effect of the periodontal ligament.

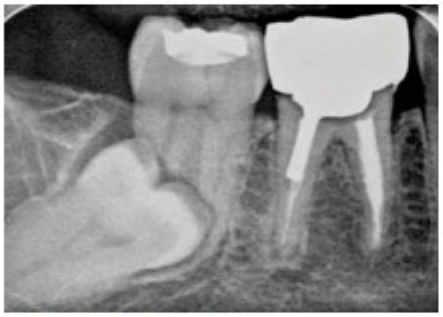

Fig. 1 Periapical radiograph

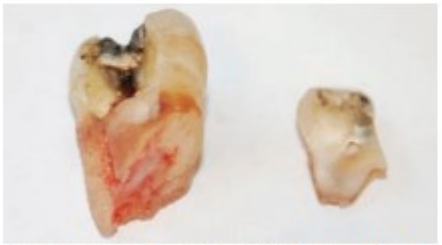

Fig. 2 Vertical fracture down the length of the tooth

P. Raval, J. Patel, London
DOI: 10.1038/sj.bdj.2010.1089

STRONG RESISTANCE

Sir, I write in response to Nigel Harradine's comments on a previous letter of mine (*BDJ* 2010; 209: 439). While I am grateful for his comments, with all due respect I disagree with the content: the speciality of orthodontics is treating malocclusion as if it were a genetic disease. If, as he states, orthodontics has 'found very little good evidence to identify the environmental factors', then treatments provided must be genetically based or guesses.

The cumulated efforts of the British Orthodontic Society's (and its predecessor's) 'research, publications and presentations at meetings and conferences' over the course of 100 years have failed to elucidate the aetiology, pathology or cure of malocclusion. When common sense and the weight of published scientific evidence could so obviously prove an environmental cause, the fact that it has not suggests a strong resistance to opening this Pandora's Box. Calling for more research or review articles asks for an unethical delay, for material that could also be ignored. I believe that only a forum of active participation will deliver the truth.

We have been granted a legal monopoly over dental care on the condition that we act professionally and in the best interests of our patients. I feel that we are falling short of this. If repeating the GDC's debate of 1936 is not acceptable, would an independent review be?

BDA members are encouraged to comment on the BDA web forum.

M. Mew, by email
DOI: 10.1038/sj.bdj.2010.1090

A SUBJECTIVE OPINION

Sir, I see that Michael Mew feels we lack foundation to explain the aetiology of malocclusion (*BDJ* 2010; 209: 439).

Nigel Harradine, Chairman of the British Orthodontic Society, has rightly refuted any conspiracy theory amongst specialist and academic orthodontists.

It remains to point out that 'malocclusion' is not a scientific term. It is a subjective opinion on how much a particular occlusion varies from the ideal. In fact the ideal is rare and variants are part of biological systems.

It is well recognised that heredity, development and environmental factors all play a part in a particular variant occlusion.

THERE IS NO ONE SIMPLISTIC CAUSE.

If Michael Mew has researched evidence for a new theory, it is very welcome. It is up to him to prove it, not for anyone else to disprove it.

T. Kolb, Cirencester
DOI: 10.1038/sj.bdj.2010.1091