Future clinical trials in prosthodontics should focus on patient-centred outcomes and use study designs that take into account patient and clinician treatment preferences.[7] Moreover, when calculating study power, it is necessary to allow for the not-insignificant proportion of patients who will refuse to be allocated to one or other arms of a trial.

Asbjørn Jokstad
Department of Prosthodontics, University of Toronto Faculty of Dentistry, Toronto, Canada

1. Zelen M. A new design for randomized clinical trials. N Engl J Med 1979; 300:1242–1245.
2. Adamson J, Cockayne S, Puffer S, Torgerson DJ. Review of randomised trials using the post-randomised consent (Zelen's) design. Contemp Clin Trials 2006; 27:305–319.
3. Verheggen FW, Nieman FH, Reerink E, Kok GJ. Patient satisfaction with clinical trial participation. Int J Qual Health Care 1998; 10:319–330.
4. Feine JS, Awad MA, Lund JP. Rejoinder to Bradley: Patient preferences and clinical trial design and appreciation and critique of a paper by Feine, Awad and Lund. Community Dent Oral Epidemiol 1999; 27:89–92.
5. Walton JN, MacEntee MI. Choosing or refusing oral implants: a prospective study of edentulous volunteers for a clinical trial. Int J Prosthodont 2005; 18:483–488.
6. Kronstrom M, Palmqvist S, Soderfeldt B, Vigild M. Utilization of dental health services among middle-aged people in Sweden and Denmark. Acta Odontol Scand 2002; 60:276–280.
7. King M, Nazareth I, Lampe F, et al. Conceptual framework and systematic review of the effects of participants' and professionals' preferences in randomised controlled trials. Health Technol Assess 2005; 9 (35).

Evidence-Based Dentistry (2006) **7**, 81-82. doi:10.1038/sj.ebd.6400446

EDITOR'S NOTE

Mineral trioxide aggregate in primary molar pulpotomies

In their commentary on the paper by Holan et al.,[1] Duggal and Al Ansary[2] indicated that, "In addition to including teeth with pulp exposure, asymptomatic teeth with deep carious lesions were also included in the study". This interpretation of the study is in keeping with the listing of symptomless primary molars with deep carious lesions as one of the inclusion criteria in the original paper. The inclusion criteria as listed in the article were: 1) symptomless primary molars with a deep carious lesion; 2) exposure of a vital pulp by caries; 3) no clinical or radiographic evidence of pulp degeneration, such as excessive bleeding from the root canal, internal root resorption, inter-radicular and/or periapical bone destruction, swelling or sinus tract; and 4) the possibility of proper restoration of the teeth. The authors clarified that only teeth that met all four criteria were included in the study. Thus, teeth with deep carious lesions were but without pulp exposure were not included in the study.

1. Holan G, Eidelman E, Fuks AB. Long-term evaluation of pulpotomy in primary molars using mineral trioxide aggregate or formocresol. Pediatr Dent 2005; 27:129–136.
2. Duggal M, Al Ansary M. Mineral trioxide aggregate in primary molar pulpotomies. Evid Based Dent 7:35–36.