

physiologically. Their reference did not determine the amines in mouth air but determined salivary amines, which produce almost no volatiles in mouth air.⁴

Their proposed criteria are not realistic for dental practitioners, since medical specialists must always be present to make the multiple diagnoses.

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E. G. Winkel, the Netherlands;
M. Quirynen, Belgium;
R. Seemann, Switzerland

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The authors of Halitosis: a new definition and classification, M. Aydin and C. N. Harvey-Woodworth, respond: Thank you to Winkel et al. for paying attention to our work. This definition and classification paper is a part of our work. As we have previously explained to the reviewers of the BDJ, we are currently preparing one more manuscript on gas measurement method in halitosis patients to estimate the exact location(s) of the major halitosis gases emitted from the patient. Therefore, the diagnosis, treatment of halitosis and patient management protocol according to this new scheme will be discussed in a separate publication. We have emphasised this condition in the first page of our manuscript (see the last sentence of the 'previous definitions' section).

Almost every dentist in the world has been sufficiently trained and has the capacity to manage/refer a halitosis case. Our classification scheme and gas measurement method (not yet published) do not require specific skills, any medical licence or involvement of medical specialists.

In our manuscript, we have: 1) defined, 2) aetiologically classified halitosis by explaining its mechanisms, and 3) revised its terminology but never described any clinical application that may potentially cause malpractice.

Furthermore, as a general rule, every pathologic condition (including halitosis) must be systematically classified according to its aetiology or according to its mechanism but not according to practitioners' capabilities nor according to any particular medical branch.

On the other hand, amines are found in the composition of saliva, and vaporise when saliva dries. They are detectable by gas detectors or organoleptically, known as 'amine breath' or indole breath,¹ nitrogen-containing volatile amines^{2,3} and more.⁴

The classification made by Miyazaki et al. in 1999 does not reflect the multifactorial nature of halitosis and does not clearly cover every clinical situation. There are a lot of logic and terminological problems with their classification but these are not the main topic of this letter. The old classification does not meet the needs of our new gas measurement method. This is the reason why we need to re-classify halitosis before we declare our new gas measurement method in a separate publication.

Our classification has already been widely used by practitioners and patients. It is more logical, memorable, flexible, clear, concise and precise than the old classification. It permits multiple diagnoses, prevents terminological confusion, and is a unique classification that is mechanistic and aetiological!

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ORTHODONTICS

Misleading focus

Sir, as long as we continue to treat malocclusion as if it has no effect on the rest of the body, and as long as we believe teeth just are crooked and don't become crooked because of things we do, and as long as we let children grow up (dentally) deformed before we begin to intervene, and until we see that the maxilla collapses in all three dimensions of space even if there is a Class II malocclusion... then we'll never be free.

For the first 25 years of my career as an orthodontist, I too thought I had an open mind. But it was my eyes that were closed. Once you begin to look at the changes to the modern human face that have been amply documented, you will see what the Drs Mew see, and you will be freed of the narrow and misleading focus of the Angle Classification. Not only freed, but empowered to influence the growth of the child's face in ways you've never imagined. We need to look again, not for research, but at the faces you see every day.

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