Letters to the editor

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Restorative dentistry

Other ways

Sir, I write in response to the Opinion article 'Occlusion: is there a third way?' (*BDJ* 2021; **231**: 160–162). After many years struggling with occlusion and occlusal concepts, it is with dismay that I read this paper.

Instead of encouraging learning in this fascinating and essential subject, the authors appear to signal another sad step towards the 'dumbing down' of standards as a convenient and easier path.

As a profession, are we sinking lower and giving up on excellent treatments? If this attitude is being instilled into undergraduates, it is even more worrisome. I wonder if the authors have given a thought as to how this paper might be used as supporting material for the hapless practitioner facing a GDC hearing for a case that went wrong? One can imagine counsel for the defence arguing that experience wasn't actually required and it is just unfortunate it went badly and the patient has been left in worse trouble than at the start.

To make it worse (as the authors admit in the paper), it is harder to remediate.

H. Stean, Kew, UK

Corresponding author Stephen Davies responds: I am grateful for the interest that Dr Stean has shown in our paper, and for his contribution to the debate. His is a valid view, and as we state in the paper comes from a direction in which we anticipated some criticism. Many of us, including he and I, have spent considerable energy and time studying occlusion.

My own view is that an occlusion can be judged only by the patient's reaction to it, rather than the didactic view of what is right or wrong. I hope that we made it clear, both in the title monitored developmental approach

[MDA] and in the text of the discussion paper, that it is the responsibility of the clinician to watch out for signs of a lack of adaptive capability in their patient.

I think the suggestion that we are 'dumbing down' the subject, or providing a defence for careless restorations, is a little harsh. On the contrary, adopting the MDA might be harder than following the script of either the conformative approach or the re-organised approach.

I am sorry if Dr Stean has mistaken our invitation for a discussion as the suggestion that the restoration of the worn dentition should be anything other than careful and thoughtful.

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Lacking useful detail

Sir, I was most interested to read 'Occlusion: is there a third way?' (*BDJ* 2021; **231**: 160–162). Whilst I actively encourage any discussion that broadens the general understanding of occlusion, being a card-carrying member of the composite reconstruction club, I feel the suggested approach lacks any useful detail for a dentist to follow. For example, no advice was given as to what one should do if the patient is suffering from TMD before the proposed treatment (very definitely make them a splint).

Following treatment, it was proposed that the direct composite restorations could be modified if problems arose which, though true, again gives no clue as to how this should be done. What it appears is being proposed is that teeth can be restored at a new OVD (which stands for occlusal vertical dimension and not overall vertical dimension as stated) with the condyles in an arbitrary position; if the patient then develops TMD or occlusal trauma (though interestingly, no mention is made of composite debond or bulk fracture),

the suggestion is to simply make the patient a splint, or carry out an unplanned occlusal equilibration. The fatal flaw in this approach is that a practitioner who lacks the skills to mount study models in centric relation (or more descriptively, retruded axis position [RAP]), at the proposed OVD, will lack the same skills required to make an effective splint or carry out an occlusal equilibration, both requiring an RAP recording. The other risk is that by carrying out these adjustments, the anterior teeth then lose contact and are therefore no longer able to guide excursive movement, thus unfavourably loading any posterior restorations. As an aside, opening the OVD on the articulator should only be performed if a very niche and arduous kinematic hinge axis recording is made. The sensible approach is to set the desired OVD using an anterior deprogrammer, then record the jaw relationship in RAP.

The good news, however, is that there is indeed a third way. If direct composite restorations are used to first restore the palatal surfaces of the upper anterior teeth, then you have in effect a fixed anterior deprogrammer, or Lucia jig. If there is also posterior occlusal wear to restore, then this can be completed at later visits once the mandible has taken up a new, more distal position in RAP. Because the patient now has their new intercuspal position coincident with their RAP, any adjustments to these restorations are well within the comfort zone of the uninitiated.

J. Baker, President of the British Society for Restorative Dentistry, London, UK

Corresponding author Stephen Davies responds: I am grateful for the opportunity to comment on Dr Baker's letter, although I hope he will forgive me for not entering into an argument on the best terminology in occlusion.