- Why are we extracting so many wisdom teeth and premolars?
- Does permanently holding teeth out of their balance zone eventually compromise perio-support?

If there is an environmental influence, then there must be discernable pathological process. I proposed a hypothesis 'craniofacial dystrophy',¹ which suggests that environmental factors cause a downswing in facial form.

This, in turn, leads to malocclusion, by reducing the cross-sectional area to accommodate the adult teeth. It also increases the likelihood of developing sleep apnoea by moving the tongue closer to the airway. This suggests contemporary orthodontics, when retractive, may exacerbate sleep apnoea.

I am not the only professional to believe that changes in masticatory effort, swallowing patterns and oral posture are influencing facial growth. If we are right, malocclusion and its associated health problems are preventable lifestyle problems.

This has profound consequences for how and when we treat them because the best medicine identifies the cause and prevents the problem. Unfortunately, few within our profession are keen or willing to follow this realisation to its natural conclusion. My suspicion is that some fear upsetting the status quo or lucrative business models.

There is justification for fearing the consequences of speaking out. The BOS has reported me to the GDC for attempting to raise awareness and educate the general public through our YouTube channel orthotropics.

The BOS exists to serve its beneficiaries – the public – not its own profession.

It is scandalous that the BOS should try to control public access to intellectual debate and curb the freedom of speech of members.

The genie is out of the bottle. Around the world, professionals and patients asking these questions are finding one another and forming online communities demanding change. I have decided to respond by sponsoring a parliamentary petition to discuss this issue. To find out more please

visit <https://preventcrookedteeth.com>. It is supported by academics and medical professionals from five continents. My objective is to work together to find answers through the application of science and to transform people's lives for the better.

M. Mew, by email

1. Mew M. Craniofacial dystrophy. A possible syndrome? *Br Dent J* 2014; **216**: 555–558.

DOI: 10.1038/sj.bdj.2018.766

Correction

Coronectomy: Coronectomy & CBCT – A marriage of convenience!

Letter to the Editor *Br Dent J* 2018; **225**: 200

Table 2 listing the 'Homerton Coronectomy Criteria for Mandibular Third Molar teeth' and the citation to Table 2 were missing from the original letter. The missing table and paragraph citing Table 2 are provided below.

We apologise for any inconvenience this omission may have caused.

'Furthermore, in patients who had CBCT assessment, 21% (n = 12) were not adequately risk assessed in spite of availability of cross sectional imaging. This could have been due to a lack of general consensus in the use of CBCT for assessment of impacted M3M and understanding of the indications for coronectomy (Table 2).'

Table 2 Homerton Coronectomy Criteria for Mandibular Third Molar teeth

1	Tooth is intimate with IDN based on plain radiograph and/or higher imaging
2	Tooth is vital and has no or only initial caries
3	Tooth is not mobile or affected by periodontal disease
4	Tooth is not associated with any other pathology (cysts/tumours/fractures)
5	Patient is not diabetic/ immunocompromised/ undergoing or due to have radiotherapy/chemotherapy/anti-resorptive medication.
6	The risk of performing coronectomy should not outweigh the presumed benefits.
7	Patient is well aware of postoperative complications including dry socket, infection, root migration and possible repeat surgery.

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