



## Author's reply to the letter to the editor of *Journal of the Korean Association of Oral and Maxillofacial Surgeons*

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Thank you for your considerate review<sup>1</sup> of this article<sup>2</sup>. Your feedback is greatly appreciated. Responses to your comments follow.

1) Of the 36 patients that the authors have enlisted in Table 1, two cases of bone tumor patients have been included with the rest being osteoporotic patients. Bone tumors cause aggressive resorption and should have been excluded from the study.

→ Clinical application of the drug is based on the type of lesion. The importance is the total concentration of the drug rather than its individual potency. We optimized the concentration of each drug for osteoporosis and tumor patients, justifying inclusion of both osteoporotic and tumor patients in our study.

2) The mandibular cortical index (MCI) which has excellent repeatability and reliability could have been taken instead of the panoramic mandibular index (PMI) in which, apart from the disadvantages mentioned in your paper, difficulty is encountered in identifying the mental foramen.

→ The MCI actually was included in the alpha stage of this study. However, unlike mathematical calculations such as MI (mental index) and PMI, our MCI values lacked consistency in measurement. Analysis of MCI should be performed only after proper training.

3) As per the data in Table 1 – all the bisphosphates (BPs) mentioned are nitrogen containing bisphosphonates with varying potencies and hence varied effects on the bone. For

e.g., Pamidronate's (which is a second-generation BP) relative potency is only 100 when compared to Zoledronate (3rd generation BP) whose relative potency is 10,000. Hence Zoledronate will cause a greater increase in the bone mineral density when compared to Pamidronate in a relatively short period of time. Also, Alendronate is given orally, whereas Zoledronate and Pamidronate are given intravenously. This again creates a disparity as the IV BPs are far more potent than oral BPs and known to cause osteonecrosis. Hence only same generation of BPs either oral (or) IV should have been included in the study in order to ensure homogeneity.

→ As you mentioned, patients in this study were not homogeneous. We could not unify the patient factors due to the small number of patients. Although a longitudinal study design would be optimal, research ethics prohibit such study.

4) Again, as per the data mentioned in Table 1, 15 patients were followed up to a duration of 18-24 months (T<sub>2</sub>), but in Tables 2, 3, 4, and 5 as well as in Fig. 2 it is mentioned that the size of the group T<sub>1</sub>- T<sub>2</sub> is 13. This discrepancy between the tables is confusing and needs clarification.

→ Follow-up duration was determined as the number of days between the first and last visits. Not all patients underwent the exam at the same interval. For example, 60 follow-up patients had data from 0, 12, and 60 months. Such data could be utilized for analysis of T<sub>0</sub> versus T<sub>1</sub> but not for that of T<sub>0</sub> versus T<sub>2</sub>.

### Author's Contributions

J.K.L. wrote this manuscript.

### Funding

No funding to declare.

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## Conflict of Interest

No potential conflict of interest relevant to this article was reported.

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**How to cite this article:** Lee JK. Author’s reply to the letter to the editor of *Journal of the Korean Association of Oral and Maxillofacial Surgeons*. J Korean Assoc Oral Maxillofac Surg 2023;49:57-58. <https://doi.org/10.5125/jkaoms.2023.49.1.57>