

Our colleagues' letter in response to our paper, however, did not discuss the abovementioned findings, but discussed another very interesting and important topic in orthognathic surgery: the removal of third molars before or during BSSO. In our current retrospective study, our clinical protocol was to remove third molars at least six months before orthognathic surgery. It was valuable to have a study group without third molars during BSSO, to measure the volume of cortical and cancellous bone without interference of impacted third molars in the mandibular ramus.

The timing of third molar removal in orthognathic surgery is debatable.² Our earlier research has shown that removal of third molars during BSSO increases the risk of a bad split, but not the risk of other complications (infection, removal of osteosynthesis material, or neurosensory disturbances).³ We agree that the presence of third molars during BSSO increases the difficulty of the procedure, especially when a surgeon strives for bicortical screw fixation, for example. This can make the surgical procedure more challenging and more time-consuming. A possible bad split can furthermore complicate both the surgical procedure and postoperative healing. Long-term consequences of bad splits are rare, but not impossible. We therefore think that third molar removal concomitant with BSSO is possible, but is associated with these disadvantages.

On the other hand, preoperative removal of third molars does present its own disadvantages. As our colleagues state, patients suffer the surgical implications (pain and swelling) and social implications (time off work) for each separate procedure.⁴ If complications (such as infection) occur after preoperative third molar removal, this is especially unfortunate in patients who need to undergo orthognathic surgery later on. And last but not least, there is no literature available regarding the effect of preoperative third molar removal on the risk of bad splits during BSSO. The fact that the presence of third molars during BSSO increases the risk of a bad split does not guarantee that the removal of third molars before surgery reduces this risk.

We therefore believe that the exact role of third molars during BSSO and the role of third molar removal before BSSO needs further research in a well-designed randomised-controlled prospective study. Until such a study is performed, we agree that the timing of third molar removal in orthognathic surgery remains dependant on the clinical circumstances, the surgeon's preference, and the patient's choice.

Conflict of interests

We have no conflicts of interest.

Ethics statement/confirmation of patients' permission

Not applicable.

Reference

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Re: Testing recommendation for COVID-19 and planned surgery

Sir,

We found that the publication on “Testing recommendation for COVID-19 (SARS-CoV-2) in patients planned for surgery - continuing the service and “suppressing” the pandemic” is very interesting.¹ Al-Muharraqi noted that “*The aforementioned recommendations may be expensive, but they can mitigate the risks to patients, staff, and public.*”¹ In

fact, surgeons are at a high risk of contracting COVID-19 in clinical practice. The COVID-19 patient might be asymptomatic and COVID-19 transmission to surgeon is possible.² The concept to apply preoperative testing for COVID-19 is interesting. It might help screen for asymptomatic COVID-19. Nevertheless, it has to recognise that the PCR test might have a false negative result. The detection rate of COVID-19 is different in different types of specimens.³ The quality of available diagnostic tests is also important.⁴ It is necessary to have a good quality control of the test for preoperative testing. Regardless of preoperative testing for COVID-19, universal precautions for all patients are necessary.

Ethics statement/confirmation of patients' permission

Not applicable.

Conflict of interest

We have no conflicts of interest.

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