We read with interest the article and wish to submit few of our observations in the reader’s forum.

Q1. There are some discrepancies in the literature review reported in the article.
a. According to Padwa et al., occlusal canting can be perceived by 90% of untrained observers if it exceeds 4°, and not 3° as reported by the authors. Further the untrained observers were members of the medical profession and not patients.
b. The statement regarding the study by Chu et al. that “asymmetry of the oral commissure measuring < 3 mm and eye canting were not recognized as clinically insignificant” is double negative and implies probably the opposite of what the authors want to convey.
c. Referring to the work of Song et al., the authors have stated that ”55.3% adults without facial asymmetry exhibit lip canting”. We could not locate this datum in the article. On the contrary, their study showed that 54.7% of the non-facial deformity patients had parallel (less than 1° angle) oral commissure and exocanthion lines implying no clinically significant lip canting.

Q2. The authors have used the mandibular symme-
try plane constructed from genial tubercle, menton and mid-incisor tip of mandible to represent the skeletal mid-sagittal plane of the lower face. Given that the dental midline can be frequently deviated, independent of the skeletal component, the use of mid incisor tip to create a skeletal mid-plane of reference appears inapt.

Q3. The section on analysis of intraobserver reproducibility is not clear. While the first line indicates the use of Pearson’s correlation coefficient, the last one states that there was no statistically significant difference between the two sets of measurements (without the mention of the test used). The actual statistics to be reported with these tests are missing. Further, the inappropriateness of correlation coefficient or t-test for evaluating method agreement is well recognized.

Q4. In the discussion, the authors have stated that ‘Ferrario et al. reported that lip canting of < 3° is generally difficult for people to perceive’ and hence used this to divide the sample into those with clinically prominent lip cant and those without. However, we could not find this information in the article.

Q5. The results of this study are based on the sample of Class III patients requiring surgical correction. Hence, they may not be generalizable to individuals with other and less severe malocclusions, an important limitation of the study.
A1. a. Thank you for pointing it out. We agree that the sentence should be changed to ‘Padwa et al. reported that when the frontal occlusal plane canting exceeds 4° on posteroanterior cephalograms, 90% of the untrained observer notices the cant.’
b. There were some incorrect expression. The sentence must be changed from ‘were not recognized’ to ‘were recognized’.
c. There were some confusing expression and numbers. In line with the suggestions, it would be better to say ‘45.3% of the asymmetric patients had larger than 1° of oral commissure and exocanthion line angle or 54.7 asymmetric patients had parallel oral commissure and exocanthion line’.

A2. We agree with your comments and it was discussed while reviewing the article. Subjects of this study were limited to patients who never underwent surgical treatment. We needed 3 points as reference of mandibular symmetry plane, which means we needed one more point except menton and genial tubercle. Even though some errors can be occurred by using mandible dental midline as a reference point, we thought it would be the best way to set mandibular symmetry plane. Your comment is insightful and pointed out important drawback of our study.

A3. We admit that the intraobserver reproducibility section could have been more clearly expressed. Paired t-test was used to compare results of number 2. We also believe statistical analysis need be modified. We thank you for listing the useful reference article.

A4. We appreciate your comments. Correct reference about lip canting degree is Lee et al’s paper published at 2019. In this article, we intended to say layperson easily recognize lip canting over 3.25°.

A5. Limitation of this study from sampling only Class III patients were discussed while reviewing the article. It is hard to use this research for Class I and Class II patients, and we admit that this is a major limitation of this study. Thank you for your questions.

Replied by
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