diabetes mellitus’ [2], rightly points out that the extraction of teeth that cannot be conserved because of terminal periodontal infection and/or periapical infection could help to lower the burden of chronic infection/inflammation. This is not the first time that Prof. Friedlander has insisted on this point; readers interested in the subject will already have read a similar letter sent to the editor of the Journal of Clinical Periodontology in May 2007 [3].

We must admit that we did not consider the extraction of non-restorable teeth as an analysis criterion in the meta-analysis. The explanation for this is simple: the intervention studied in our meta-analysis was periodontal treatment. We defined such treatment as any therapy including at least one of the following: scaling/root surfacing; and/or antibiotherapy (local or general) intended for periodontal treatment; and/or prescription of oral antiseptics; and/or instruction/motivation in oral hygiene. This choice was guided by a literature search aimed at determining a consensual point of view on the procedures that constitute periodontal therapy [4,5]. We agree, of course, that taking charge of the full, overall oral–dental health of patients affected by periodontitis often requires a much broader treatment approach than simple periodontal therapy (removal of non-restorable teeth, but also endodontic treatment, adequate prosthetic rehabilitation, occlusal adjustments, orthodontic treatment and suitable periodontal maintenance). All these procedures are also potentially capable of reducing certain forms of oral inflammation and could, therefore, contribute to a reduction in glycated haemoglobin (HbA1c) levels in diabetic patients. However, to the best of our knowledge, no controlled clinical trial has specifically evaluated the effectiveness of such procedures in lowering HbA1c levels. Of these procedures, the extraction of non-restorable teeth is certainly among those that would best help to obtain a lower burden of chronic infection/inflammation.

Prof. Friedlander suggests that we should analyze the nine clinical trials included in the meta-analysis, taking account of dental extractions in the original studies. As tooth extraction is not recognized by the scientific community as a means of periodontal treatment in itself, and as our literature-search strategy was centred on periodontal treatment, such a subgroup analysis would, by definition, prove to be imperfect. Also, as mentioned above, we do not know of any clinical trial assessing the effect of tooth extraction on reducing HbA1c levels.

Nevertheless, we have reexamined the nine clinical trials included in the meta-analysis [2,6–12]. Seven of them [6–8,10–12] did not directly mention tooth extraction (whether in terms of criteria for inclusion, non-inclusion, exclusion or type of therapy). In addition, three of the trials included subjects with only moderate forms of periodontitis [6,8,12]. The trial conducted by Promsudthi et al. [11] did not include subjects who had periapical infection.

Finally, and interestingly, the two studies that reported extraction of non-restorable teeth were also the two that obtained the greatest treatment effect [2,9]. In a way, this proves Prof. Friedlander right, and opens up an interesting avenue for research. However, our opinion is that this consideration could not, on its own, explain the observed difference in treatment effects. The selection bias of the study by Friedlander et al. is also an important – even preponderant – factor that must be taken into consideration when interpreting the results. The absence of randomization in the study may indeed have been the source of the greater treatment effect observed.

In conclusion, taking the removal of non-restorable teeth into account in one way or another is a crucial element when the effect of periodontal treatment on a general pathology is studied. In the DIAPERIO clinical trial that is currently ongoing [13], we chose to include subjects only after the extraction of non-restorable teeth and treatment of periapical lesions, considering this phase to be a precondition for standard periodontal treatment.

Conflicts of interest

No conflicts of interest.

References

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