Author’s response to reviews

Title: Treatment decisions regarding caries and dental developmental defects in children – a questionnaire-based study among Norwegian dentists

Authors:

Marte-Mari Uhlen (martemau@ostfoldfk.no; martemari@gmail.com)
Håkon Valen (hakon.valen@niom.no)
Line Schrøder Karlsen (linkar5@ostfoldfk.no)
Anne Skaare (anne.skaare@odont.uio.no)
Athanasia Bletsas (athanasia.bletsa@ostfoldfk.no)
Vibeke Ansteinsson (vibekean@ostfoldfk.no)
Aida Mulic (aida.mulic@niom.no)

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Author’s response to reviews:

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Dear reviewers

Thank you for your positive response and for giving us the opportunity to submit our revised manuscript OHEA-D-18-00635 “Treatment decisions regarding caries and dental developmental defects in children and adolescents - a questionnaire-based study among Norwegian dentists.” The authors are very grateful for all the valuable comments and recommendations given, and we have amended the manuscript accordingly.

All remarks made by the reviewers have been taken into consideration, and are commented point by point below. All revisions in the manuscript are highlighted in red (Track Changes).

Reviewer 1

Abstract

Aim
Should be more informative indicating options in children and adolescents as in title, and use "treatment decisions" rather than “treatment strategies” as in intro part.

The aim has now been changed (p.2, lines 31-33) from: “Therefore, the aim was to investigate Norwegian dentists´ treatment strategies and reasons for treatment choice when dealing with deep caries and severe DDDs.” to: “Therefore, the aim was to investigate Norwegian dentists’ treatment decisions and reasons for treatment choice when dealing with deep caries in primary teeth and severe DDDs in permanent teeth in children.”

Results

Please mention a brief description about the profile of the surveyed dentists. And indicate that most of the dentists surveyed worked as general practitioners. This is important as it reflects the rather non-ideal restorative options chosen, that wouldn't otherwise be chosen by a pediatric dentist. A pediatric dentist would rather put a SSC.

The profile of the responders (including that they were mostly general practitioners) has now been added to the abstract (p. 2, lines 42-44).

Please indicate the main reasons for their restorative choices.

The main reasons for the treatment decisions are now added in the abstract (p. 2, lines 57-58).

Please indicate how the background characteristics did not significantly affect the choices.

This is now added in the abstract (p. 2, lines 55-56).

Keywords

Rather than "Questionnaire study"- please add MIH, also useful to add “restorative options”, “deep caries”....
The keyword “Questionnaire study” has been omitted from the list, while “MIH” and “restorative options” are included (p. 2, lines 64-65).

Introduction

Informative, however lengthy. I suggest delete the second paragraph. Try to make it no longer then 1.5-2 pages.

The introduction has now been shortened by deleting the second paragraph.

Would be clearer for the reader if you indicate from the introduction whether in the PDS: are the dentists general dentists or specialists?

This has now been added to the introduction (p. 6, lines 113-114).

Aim- needs to be re-written to indicate children & adolescents as in title.

The title is now changed to only “children”, and the word “adolescents” has now been omitted as the questionnaire and patient cases are on primary teeth and young permanent teeth (p.1, line 2 and p. 6, line 121).

Methods

Adequate, however, in the questionnaire, "Background characteristics of dentists: what is meant by main occupation? Aren't they dentists?"

By main occupation is meant the main (≥ 50%) workplace; whether the dentists work at the PDS or other institutions. This is now added to the manuscript (p. 7, lines 133-134), and is also explained/changed in the Table 1.
What were the inclusion/exclusion criteria for participants, eg dentists who do not treat children were excluded later.

All dentists working in the PDS were included in the study; however, when analyzing the results, dentists who did not treat children nor working clinically were excluded (n=40). We have now added “all dentists” in the manuscript (p. 6, line 126) and in the abstract (p. 2, line 35), while dentists who were excluded are described in the manuscript (p. 8, lines 158-159).

Please attach the questionnaire to show how the questions about the cases were addressed. I am concerned about giving ZOE as a restorative option, the reader must know in which context this option was given, or how was the question addressed to the participants.

The patient cases used in the present study are given in Figure 1, and the questions used in the questionnaire are described in the material and method part. Since the questionnaire is in Norwegian language, we are considering it as irrelevant for the reader to have access to the original questionnaire.

However, it is worthy to mention that ZOE based materials are frequently used for stepwise excavation and to postpone the final restoration, and is a frequent choice, especially in primary teeth. Therefore the alternative was given to the responders.

In the questionnaire, the section about how often the respondents registered DDDs in their patients, were there types of DDDs suggested or given to them?

Three different alternatives of DDD were given to the respondents: molar incisor hypomineralisation (MIH), dental fluorosis (DF) or other DDDs. This is now added to the manuscript (p. 7, lines 137-139).

For case 2- please indicate the grading of the molar according to the MIH treatment need index by Stephen et al, 2017 (EAPD); I suggest its a (4c) score.
We have decided not to include the present reference in the manuscript as the MIH-TI score have not been used in our questionnaire.

Results

Line 163- "nearly half 257 (44.8%), registered other DDDs frequently"- what are the other types?

The respondents were given three different alternatives for dental developmental defects (DDD) when asked how often they registered the defects: molar incisor hypomineralisation (MIH), dental fluorosis (DF) and other DDDs. Previous publications have shown that the prevalence of MIH and DF are relatively common in Nordic countries, after enamel hypoplasia and opacities. With other DDD is meant all other DDD, except for MIH and DF.

Discussion

Are general dentists allowed/ do they have access to treating children under GA in Norway? Please discuss this point.

All general dentists with access to GA are allowed to treat the patients under GA. For GPs working in the PDS they may refer their patients to hospitals for treatment under GA.

The discussion is lengthy. I suggest, lines 201-211 to be summarized in a few lines, likewise, lines 212-229 be removed or summarized in a few lines, as they are well-known facts.

These paragraphs have now been compromised (p. 11-12, lines 231-257).

Lines 232-237 should be the first paragraph as an explanation for the response rate, starting from "It can be argued that ....", this should be followed by a brief description of the profile of the dentists surveyed with regards to their age experience...etc and whether there were any significant differences present/not present that could affect the choices.
Dentists’ background characteristics have now been added to the manuscript (p. 14, lines 294-295).

Lines 230-232- should be considered a limitation, mentioned just before the conclusion (end of discussion).

This paragraph, as well as the paragraph mentioned above (“It can be argued…”), has now been moved at the end of the manuscript (p. 14, lines 291-301).

Conclusion

There is a mention of “There were no statistically significant associations between background characteristics and reasons for treatment choices.” This was not mentioned in results, or discussion, and suddenly it's in the conclusion. Please check this point, and adjust accordingly.

The sentence is now omitted from the manuscript, p. 14, lines 304-305.

Tables

Table 1- Please indicate that there were general dentists (indicate prevalence) and specialists. For age, please indicate the age ranges, it’s interesting to see the youngest & oldest to compare experience.

The prevalence of general practitioners and age ranges are now added to the table 1, p.22.

Table 2- Why is esthetics given as a reason for extraction (case 1a), and ZOE (case 1b)??

It is difficult to assume reason why esthetics was chosen by dentists for the extraction and ZOE. However, it should be kept in mind that only 3 dentist chose esthetics when considering
extraction. And only 3 dentists chose number of affected molars/materials available/aesthetics for ZOE.

Figure

As indicated above, for case 2, please mention the MIH-TNI score in the legend (case description).

We have decided not to include the present reference in the manuscript as the MIH-TI score have not been used in our questionnaire.

Reviewer 2

I wonder if the use of rubberdam/cofferdam is common in Norway and how this can possible influence the treatment decisions made.

Use of rubberdam/cofferdam is taught at dental schools; however, use is not mandatory.

At the dental schools in Norway, what is the advice to use as a restauration material in primary teeth?

There are no national guidelines on choice of restorative material used for restoration of primary teeth in Norway. The choice of restorative materials is therefore done by the dentist.

There are many young women in your study. That is possibly do to the fact that you only included PDS-employed dentists. Is this true or is there another explanation?

It is correct that the majority of our sample is women, and the main reason for that is that the majority of the employees at the PDS are females: of 1407 dentists in the PDS in 2017, 1059 are
females and 348 are males (www.ssb.no). In contrast, in the private practice, most of the dentists are males (1698 males vs. 1395 females).

And how many percent of the total dentist works for PDS?

Recent data shows that 1407 dentists work at the PDS, while 3093 dentists are in the private sector (www.ssb.no).

Question with table 1: why did you choose 41 to split the age groups? Does this have something to do with the date amalgam was banned at the universities?

The main reason why the age selection was done on 41 years of age is due to the teaching reform introduced in 1996 in Norway. In 1996, 22 years ago, individuals who were approximately 41 years old in 2018 were 19 in 1996, and the first year student at the University. By selecting this age as a cut-off make it possible to compare students with an old and new reform.