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Dr. Friedman is correct that pathology associated with 2nd molars adjacent to erupted and partially erupted 3rd molars is well known (Garaas *et al.*, 2011; Falci *et al.*, 2012; Friedman, 2014). Our article sought to categorically define the risk posed to adjacent 2nd molars by unerupted, erupted, or absent 3rd molars (Nunn *et al.*, 2013). Previously, the most comprehensive study was The Third Molar Clinical Trials (White, 2007). However, these included only patients with 4 retained asymptomatic 3rd molars and adjacent 2nd molars. Our study included participants with any retained asymptomatic 3rd molars and adjacent 2nd molars and also those with absent 3rd molars. Inclusion of these additional categories allowed for comparison of bony-impacted, soft-tissue-impacted, erupted, and absent 3rd molars on the risk of 2nd molar pathology, which is a novel contribution of our study.

Dr. Friedman is also correct about the low prevalence of soft-tissue-impacted 3rd molars in our study cohort. Nevertheless, the associated absolute risks for 2nd molar tooth loss and 2nd molar pathology are substantial (Table). Importantly, we found that bony-impacted 3rd molars posed no more risk to adjacent 2nd molars than did erupted 3rd molars. This information may be useful in guiding decision-making by patients with various types of unerupted 3rd molars. Analysis of our data clearly indicates that any potential benefit to 2nd molars of prophylactic removal of 3rd molars is related to the type of 3rd molar status. Last, our findings should not be inferred as justifying the prophylactic removal of

Response to Letter to the Editor, “Retained Asymptomatic Third Molars and Risk for Second Molar Pathology”

Table. Absolute Risk over Course of Study

3rd Molar Status	2nd Molar Loss (entire study)	2nd Molar Pathology (entire study)
Absent	0.0%	39.6%
Erupted	3.8%	52.8%
Soft-tissue impaction	39.1%	81.6%
Bony impaction	14.6%	56.5%

asymptomatic 3rd molars. Rather, these findings are consistent with the approach of ‘watchful waiting’.

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