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THE EDITOR'S CORNER

Our Expanding Role

In the past, the term "interdisciplinary orthodontics" generally referred to the preparation of patients for definitive restorative and/or prosthodontic rehabilitation. Such treatment could include molar uprighting to provide more physiologic bridge abutments, distribution of spacing across the upper anterior teeth prior to crowning, cosmetic bonding or veneering if such spaces resulted from maxillary anterior deficiency, or vertical extrusion of key teeth to allow more esthetic gingival contouring in the finished fixed prosthodontic case. The orthodontic armamentarium and skill sets were not all that different from routine tools and procedures; they were just applied in a slightly different manner.

Of late, however, the sphere of activities associated with "interdisciplinary orthodontics" has expanded considerably. It used to be that if the orthodontist did any surgery at all, it was the simple "fingertip" extraction of baby teeth that were ready to fall out anyway. Only five or six years ago, if you had suggested to me that I would be handling surgical lasers as part of my daily routine, I would have thought you a hopeless Star Wars futurist. But today, in many orthodontic offices worldwide, clinicians have assumed the responsibility for dealing with the redundant soft tissues that occasionally arise secondary to tooth movement and minor periodontal surgeries. The surgical laser is a remarkable tool for addressing these cases.

With more and more orthodontists including skeletal anchorage devices in their professional bags of tricks, the idea of performing minor surgical procedures is gaining widespread acceptance. When miniscrews first came out, there was a minor controversy over who should be placing them—oral surgeons, periodontists, or the orthodontists themselves? In fact, I posed that very question in one of my early editorials on the subject. Most orthodontists I know now place their own miniscrews, and the aura of mystery and exclusivity has gone out of the procedure. A miniscrew generally takes less time to insert than to tell or write about.

Of course, performing minor surgery implies the need for suitable anesthesia. I remember being told during my residency that "shots and needles are something we leave behind" when we enter the specialty of orthodontics. I never really bought into that dictum, probably because I spent eight years as a general dentist in a remote practice that, by geographic necessity, involved a lot of surgery—everything from routine extractions and wisdom teeth to setting broken jaws. I figured it was a waste of good training to let the simple skills associated with providing local anesthesia, generally acquired in the second year of dental school, go to waste simply because I had "specialized". My orthodontic armamentarium has always included the equipment and supplies necessary to render adequate local anesthesia when the need arose. Still, I fully respect the opinions of other orthodontists who do not wish to keep syringes and needles in their offices. Last week, I was supervising one of my second-year residents in the placement of a miniscrew to provide anchorage for a molar intrusion. While this particular resident has outstanding orthodontic ability and an extraordinary dental-school background, she was clearly reluctant to administer the shots needed for anesthesia. Once I had "numbed up" the patient, the resident placed the miniscrew without incident. Out of curiosity, I subsequently asked several orthodontists and residents for their views on the matter, and many of them responded that they, too, would prefer not to give shots if any alternative were available.

In the October 2006 issue of JCO, Drs. Neal Kravitz and Budi Kusnoto described how they used a potent topical anesthetic agent on one side and injected a local anesthetic on the other for the insertion of two miniscrews in a single patient. They achieved acceptable levels of anesthesia with both procedures. In our current issue, Dr. John Graham describes two techniques for providing anesthesia sufficient for soft-tissue laser surgery and miniscrew placement without the need for hypodermic needles. One involves a compounded topical anesthetic agent applied in an aqueous gel, and the other is a device that uses pneumatic pressure to deliver anesthetics submucosally. Adoption of these anesthetic techniques will help us further expand our interdisciplinary abilities.

Another topic that was never considered an orthodontic subject in the past is the area of sleep disorders, reviewed in this issue by Dr. Sarah Shoaf. In the past, specialists from a number of different disciplines, including oral surgery, otorhinolaryngology, general surgery, and sleep therapy, have dealt with obstructive sleep apnea, with varying degrees of success. Surgical techniques generally involved enhancing the airway by means of veloplasty, a procedure that works well for some, but not so well for others. The patients I have known who have undergone this procedure have invariably reported painful postoperative healing periods. Another technique frequently employed to address sleep apnea is the application of positive-pressure oxygen to keep the airway from collapsing on expiration. This requires the patient to wear a contraption that always reminds me of an underwater breathing apparatus. Although some people can tolerate these quite well, I know I would not sleep a wink if I were hooked up to one.

Recently, however, a number of orthodontists have shown promising results in treating mild-to-moderate cases of sleep apnea with devices that are simply modifications of standard functional appliances. In many such cases, the obstruction of the airway that induces sleep apnea results from the position of the mandible. Mandibular advancement appliances are a logical solution, but as Dr. Shoaf reminds us, this idea is not new: repositioning the mandible to open the airway is one of the first steps in standard CPR.

Clearly, the entire concept of interdisciplinary orthodontics is undergoing an acute redefinition. It's no longer a matter of simply getting the mouth ready for other dental disciplines to provide a definitive rehabilitation of the occlusion and facial esthetics. As the scope of what constitutes orthodontic treatment continues to broaden, it should be interesting to see where this leads.

RGK