

# THE READERS' CORNER

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*(Editor's Note: The Readers' Corner is a quarterly feature of JCO in which orthodontists share their experiences and opinions about treatment and practice management. Pairs of questions are mailed periodically to JCO subscribers selected at random, and the responses are summarized in this column.)*

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*1. What is the most efficient method you have used to distalize upper molars?*

There was no broad consensus on any particular device, but the most commonly mentioned was the Herbst appliance. This was closely followed by the Distal Jet, the Pendulum, coil springs, and headgear. Incidentally mentioned were miniscrews, the Pend-X, and the Jones Jig.

The most important consideration with all these systems was to move the molars without excessive flaring of the anterior teeth. For example, a Nance button might be attached to the premolars in conjunction with a coil spring that would generate the distal molar movement. Many clinicians favored the extraction of second or third molars to provide distal space for the molars.

*What is the most efficient method you have used to distalize lower molars?*

The most prevalent device used to distalize lower molars was the lip bumper. Next most popular were compressed nickel titanium coil springs, which were usually used in conjunction with some mechanism to control flaring of the

anterior teeth. Also mentioned, to a much lesser extent, were tip-back auxiliary springs, miniscrews, and Class III elastics. Lower second molars were sometimes extracted prior to distalization of the lower first molars.

*What is the most efficient method you have used to distalize cuspids in extraction cases?*

A third of the respondents said they preferred to distalize cuspids with coil springs. This was followed in popularity by elastomeric power chain. A few clinicians indicated that they preferred to place sectional arches with low-friction brackets, wires, and ligature ties. Others said they did not distalize the cuspids separately, but used sliding mechanics for en masse movement of the anterior segment. Other techniques included gable bends, power thread, and Damon mechanics coupled with Class II or III elastics.

*What is the most efficient method you have used to close extraction spaces?*

The three methods most commonly used to close extraction spaces were closing loops, elastomeric chain, and nickel titanium springs. Some clinicians preferred to work with sectional archwires, while others used Damon mechanics. No respondent mentioned the use of skeletal anchorage to close extraction spaces.

*What is the most efficient method you have used to rapidly expand the palate?*

Nearly every clinician employed some kind of screw, either fixed or removable, for rapid palatal expansion. The Hyrax-type screw was by far the most popular, followed by the Haas device and the Dentaurum expansion screw. One respon-



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dent used a miniscrew to anchor the expansion mechanism. A Quad Helix was occasionally used to expand the palate in mixed or early permanent dentition patients.

*What is the most efficient method you have used to bring impacted cuspids into the arch?*

The most frequently mentioned method was a gold chain from the cuspid to a stabilizing archwire. The gold chain was usually placed by an oral surgeon after the crown, or a portion of it, was exposed. Several respondents noted that, if possible, the crown of the cuspid should be moved through the attached gingiva.

Less common techniques involved elastic thread, an auxiliary wire soldered to the main archwire, extrusion loops bent into the archwire, or nickel titanium coil springs. Some clinicians said they preferred not to use any attachment if conditions were favorable; in such a case, the cuspid would be surgically uncovered and allowed to erupt naturally into the arch.

*What is the most efficient method you have used to upright mesially inclined molars?*

Most of the systems listed for uprighting mesially inclined molars were designed to tip the crown distally rather than to move the root mesially. Options included nickel titanium or stainless steel springs, lingual arches with distal hook extensions, tip-back bends, bracket positioning, sectional archwires, and multiloop wires. One respondent reported using miniscrew anchorage. Several clinicians observed that the initial molar correction could be facilitated by slightly opening the bite with anterior turbos prior to the uprighting mechanics and by removing the third molars before distalizing the mesially inclined molars.

*What is the most efficient method you have used to control rotations?*

Many methods were used to control rotations, the most common being bracket positioning or the use of offset brackets. Additionally, many clinicians used stainless steel ligatures or self-ligating brackets to firmly ligate the archwire

into the bracket slot for a constant antirotational force. Other techniques included the attachment of an elastomeric chain to a bonded lingual button for severe rotations, the initial full engagement of a small-diameter nickel titanium wire, and the placement of a removable lingual arch for molar rotations.

There were numerous comments to the effect that effective retention was necessary to ensure the stabilization of corrected rotations. Bonded cuspid-to-cuspid lingual wires and Essix removable retainers were the most frequently mentioned methods.

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 2. *How often do you perform cosmetic finishing?*

Every respondent performed some amount of cosmetic finishing—the vast majority either “routinely” or “as needed”. Only a few clinicians said they did cosmetic finishing “as requested”.

*Which cosmetic finishing measures do you use? Do you present these options using digital enhancement of patient records?*

Two-thirds of the clinicians never bonded porcelain veneers to upper incisors, with the remainder using the procedure “sometimes”. On the other hand, the vast majority of respondents said they reshaped teeth “frequently”, with only two replies of “sometimes”. Nearly twice as many respondents “frequently” rebuilt small upper lateral incisors as those who did so “sometimes” or “never”. Only a few reported using gingival contouring on a frequent basis; 32% said they would do it “sometimes”, but 48% reported that they never did gingival contouring. Fully 90% of the respondents did not yet use digital enhancement of the patient’s records to present cosmetic finishing options.

*How often do you perform in-office bleaching? If you do not perform in-office bleaching, do you refer patients out for bleaching, or do you recommend or prescribe home bleaching?*

No one reported doing in-office bleaching “routinely”, although several respondents said

they would bleach teeth on an "as needed" or "as requested" basis. Ninety percent indicated that they did not do it at all.

Three-fourths of the respondents said they referred patients out, usually to the referring dentists. About the same number, however, reported that they sometimes recommended commercially available home bleaching products.

*How do you determine fees for the above cosmetic procedures?*

A solid majority did not charge separately for ancillary cosmetic procedures, especially reshaping of teeth. Some respondents said they charged separate fees for composite build-ups, according to the time involved in placing the composite. One clinician indicated that he asked approximately the same fee as would be charged by a restorative dentist.

*How does your use of cosmetic finishing differ between adult and adolescent patients?*

Many of the clinicians saw no difference between adult and adolescent patients in regard to cosmetic finishing procedures. The major differences noted were that adults usually required more careful treatment planning for cosmetic finishing, that bleaching and veneer build-ups were not recommended for adolescents, that crown lengthening was more frequently performed in adults, and that interproximal reduction was more often indicated for adults.

*To what extent is archform a factor in your cosmetic finishing?*

Thirty percent of the respondents indicated that archform was not a limiting factor in cosmetic finishing, but others said they would prefer to work within the parameters of the patient's existing archform. Several clinicians mentioned altering an archform to establish buccal corridors or to compensate for a tapered arch or large teeth.

*What periodontal considerations enter into your cosmetic finishing?*

The most common periodontal concern focused on establishing proper gingival contour

and height. Related to this were considerations of crown length and interdental tissue loss associated with black triangles. Concern was also expressed over fibrotic gingival hyperplasia, the intrusion of teeth with periodontal pockets, and the periodontal ramifications of overly aggressive interdental reduction. One clinician took the precaution of requiring a specialist's periodontal evaluation before treating an adult or older teen-ager.

*Are there other considerations in your cosmetic finishing?*

The most frequently mentioned additional consideration was that in a case requiring future veneers, crowns, or implants, appropriate space had to be established for the restorative dentist. This, in turn, required consulting with the restorative dentist prior to definitive treatment. Other concerns were the vertical symmetry of the canines, the cant of the occlusal plane, the need for interproximal reduction to reduce or eliminate interdental black triangles, and the establishment of esthetic torque for the anterior teeth.

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