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THE EDITOR'S CORNER

Who Places Miniscrews?

There can be no doubt remaining in anyone's mind that temporary anchorage devices—miniscrews—have become mainstream adjuncts to comprehensive orthodontic therapy. Skeletal anchorage has given us a number of treatment options that in the past demanded either surgical intervention or cumbersome extraoral devices. Few orthodontists I know today practice without at least the occasional use of TADs; those who choose not to have made the decision out of personal preference, based either on cost-efficiency or on a confidence in their own ability to accomplish their treatment goals through other means. To each his own, but it seems that the number of clinicians who fall into this latter category goes down every day.

Lately, a vigorous point of discussion in JCO's Online Forum and elsewhere has been the topic of just who places the miniscrews. Many orthodontists, myself included, prefer to place their own. Others refer the procedure out to oral surgeons, periodontists, or general dentists with oral-surgery experience. In this issue of JCO, Dr. Peter Buschang and colleagues present the results of a worldwide survey addressing that topic, and we also offer the views of a number of leading orthodontists around the world in our own informal poll.

One of the themes emphasized in both reports is that the number of years in practice seems to be the most important factor in determining who places miniscrews. Recent graduates almost invariably choose to place the screws themselves, while those who have been in practice for a while—the threshold seems to be around 15 years—choose to refer the procedure out. The doctor's comfort level with using local anesthesia and with performing invasive procedures seems to be the major issue. Young graduates are not far removed from the rigors of dental school, in which injections and other invasive procedures are the rule rather than the exception. They see the placement of miniscrews as only minimally invasive—perhaps only slightly more than fitting a molar band. Doctors who have been in the exclusive practice of orthodontics for many years tend to feel more removed from general den-

tistry, and many are hesitant to utilize local anesthetics or to purchase the equipment and supplies necessary to do so. Others believe that oral surgeons or periodontists have a better knowledge of the osseous anatomy of the oral cavity, are more experienced in surgical procedures, and are better prepared to handle any complications that may arise.

Perhaps the most important reason for placing miniscrews in-house is that because the orthodontist knows exactly where the screws should be placed, there is no chance for miscommunication. This is certainly why I choose to place my own TADs: based on my knowledge of the forces I intend to apply throughout treatment, I know precisely where I want the miniscrews to be placed. Other considerations involve time and money. Many see a referral as involving an extra step, or two or three, prior to the initiation of actual orthodontic therapy. The surgeon or periodontist usually wants an initial consultation visit. It is not uncommon for that practitioner to take his or her own radiographs, thus involving more radiation exposure beyond the routine orthodontic diagnostic films, and then to set up another appointment for the actual surgery. A post-surgical follow-up visit is often requested, and the surgeon later needs yet another appointment to remove the devices. And of course, when oral surgeons or periodontists place miniscrews, they expect to be paid for their work. Sometimes the cost seems excessive to the patient—I have heard fees as high as $500 per screw—and the patient chooses not to pursue the treatment. I can't speak for others, but if I place my own miniscrews, I build the cost associated with the procedure into the fee I quote for my orthodontic services. That cost is much less than $500 per screw. Several orthodontists have reported that they have a difficult time "selling" the procedure, but I have not found this to be a problem in my own practice.

The procedure itself is certainly no more technically demanding then most of the other techniques that we perform on a day-to-day basis. I use a self-tapping miniscrew system, so that predrilling is not necessary. Only an overabundance of relatively loose mucosa will cause me to open the soft tissue, and then only to prevent the mucosa from wrapping around the rotating screw during insertion. Overall, the procedure is so simple that every time I do it, I am reminded of placing a self-tapping wood screw into soft pine. It is extraordinarily simple. The incidence of morbidity is so low that it's a non-issue.

For those who are still a little uncertain about precisely where to place miniscrews, various placement guides have been introduced to minimize the guesswork involved. And for those who still prefer to refer the procedure to a surgical specialist, several different protocols have been proposed to improve communication between the orthodontist and whoever is selected to do the surgery.

Miniscrew placement is certainly within the scope of orthodontic practice for doctors who want to pursue the training needed to perform it in-house. On the other hand, those who choose to refer the procedure out unquestionably have the right to do so. If you have yet to formulate a policy in your own practice, perhaps the surveys published in this issue will help you reach a decision. RGK