THE READERS' CORNER

JOHN J. SHERIDAN, DDS, MSD

(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.)

1. What are your treatment goals for adult patients, and how do they differ from those for adolescents?

The prevailing attitude among the respondents was to strive for similar treatment goals for adults as with adolescents. Compromise was often deemed necessary in adult treatment, however, because of the lack of growth potential, periodontal implications, the presence of restorations, and time restraints. Limiting the correction to the chief concerns of an adult patient was frequently mentioned, especially when surgery was suggested but refused by the patient. An extended period of retention was often thought necessary for adults.

Typical comments were:

• "For adults, my treatment goal is to choose the best option for them individually."

• "For adults, I concentrate on esthetics, a supported occlusion, and preprosthetic needs. Overall, there is not a significant difference in treatment goals for adults. If possible, I want to finish them to ABO specifications."

• "My treatment goals for adults tend to be compromised from ideal, and I rely heavily on what the patient wants corrected."

• "For adult patients, I am willing, when indicated, to compromise on my ideal treatment goals. Esthetics is very important to the adult patient. For instance, I may leave the molars slightly Class II, and some will finish with the midline slightly off."

• "If possible, I avoid extractions on an adult patient. My goals do not differ from adolescent patients, but there are limits, especially if they could benefit from a surgical procedure and they decline it."

Dr. Sheridan is an Associate Editor of the *Journal of Clinical Orthodontics* and a Professor of Orthodontics, Jacksonville University, 2800 University Blvd. N., Jacksonville, FL 32211.

In an adult premolar extraction case, do you try to parallel the roots of the teeth on either side of the extraction sites?

Paralleling the roots on either side of an extraction site appeared to be the accepted standard. Fully 98% of the respondents said they always tried to parallel the roots, while only 2% did so occasionally. No clinician reported never seeking root parallelism.

Do you try to correct posterior tooth rotations in adults?

Seventy-eight percent said they always corrected posterior rotations, and 21% sometimes corrected them.

Do you attempt to orthodontically correct a gummy smile or orthodontically correct an open bite in an adult?

Fifty-six percent of the respondents reported that they would attempt to orthodontically correct a gummy smile in an adult, while 41% said they would not. A more substantial majority—83%—indicated they would try to orthodon-

tically correct an adult open bite, while 17% would not.

Do you ever use rapid palatal expansion in an adult? If so, do you attempt to split the maxillary suture? Do you ever use slow palatal expansion in adults?

Rapid palatal expansion was used in adults by roughly half the respondents. Thirty-two percent always attempted to split the maxillary suture, but 39% did so only occasionally. A slight majority of clinicians (51%) said they had tried slow palatal expansion in adults.

How effective have you found palatal expansion in adult patients?

There was a general consensus that adult expansion was not particularly effective or stable, since it was attributed primarily to dental tipping within the alveolus rather than to actual palatal expansion. Still, many respondents endorsed adult palatal expansion with surgical assistance. Expansion was also felt to be beneficial when used orthodontically to upright lingually inclined buccal segments.

Representative remarks included:

• "Very iffy results with rapid expansion. With slow expansion, I've had better results, but stability is still questionable. I suggest lifetime retention."
• "I have had great success in conjunction with surgical separation of the midpalatal suture and limited success without surgical assistance."
• "I've witnessed, all too often, the buccal roots going through the cortex. 3D imaging has been invaluable in assessing this."
• "Very slow expansion in adults with tapered archforms is simply another way of achieving orthodontic tooth movement to improve the archform."

In what kinds of adult cases do you use skeletal anchorage? What degree of success have you had?

In order of preference, the types of adult cases in which respondents said they would use skeletal anchorage were: extraction cases (75%), overerupted molars (74%), open bite (60%), bimaxillary protrusion (40%), gummy smile (32%), and crossbite (4%). The success rate, taking into account the occasional failure of a temporary anchorage device (TAD), was believed to be distinctly favorable; the clinicians perceived that their treatment goals would be difficult, if not impossible, to achieve without the skeletal anchorage.

Some individual remarks were:

• "They can be used for about anything, with usually good success."
• "The ultimate success rate of what I set out to accomplish has been very high. I am very pleased with the new clinical abilities I have using TADs."
• "I give my patients three options: surgery, headgear, or TADs. I have had about a 95% success rate with TADs."
• "I have had mixed success. Several TADs became loose during treatment, and I could not move some molars despite using TADs due to alveolar housing constraints."

In what kinds of adult cases do you recommend surgical orthodontics?

An overwhelming majority of the respondents (at least 97%) felt that severe mandibular deficiency or severe prognathism were indications for surgical correction. About half the clinicians said they would recommend surgery for moderate mandibular deficiency or prognathism, but only a few would suggest surgery for mild discrepancies. Eighty-three percent of the orthodontists said they would recommend surgical orthodontics in open-bite cases, but only 11% suggested surgical resolution of closed bites.

Do you recommend permanent retention for adult patients?

There was a strong indication that permanent retention is an essential component of adult treatment planning. Virtually all the respondents indicated that they always (58%) or sometimes (40%) recommended permanent retention for adult patients. Only 2% of the respondents indicated that they would never advise adults to have permanent retention.

2. *What do you do to stay in shape?*

About 80% of the respondents to this question were male. Most were in their 40s and 50s, with a substantial group in their 60s and only a few in their 30s or 70s.

How often do you exercise, and where do you work out?

A majority of the orthodontists (57%) said they exercised several times a week. This was followed, in decreasing frequency, by working out daily, weekly, and on an irregular basis. Only 3% of the respondents indicated they did not exercise at all. The favorite workout locations, about equally popular, were at home or outdoors; fewer clinicians went to gyms.

Do you have a personal trainer, and if so, how often do you meet with him or her?

Eighty percent of the respondents did not have personal trainers. The 20% who did have trainers tended to see them at least weekly, with only a few meeting less often.

In what recreational activities do you engage for exercise?

The replies suggested that orthodontists participate in many types of activities. The most common was walking/hiking (72%), followed, in decreasing order of frequency, by golf, running/jogging, cycling, skiing/snowboarding, swimming, tennis, and weightlifting. A smattering of respondents were involved in basketball, yoga, Zumba body sculpting and other types of aerobics, and kayaking.

Do you encourage your staff to exercise regularly? Do you have any exercise equipment or facilities in your office building?

Fifty-six percent of the respondents said they encouraged their staff members to exercise regularly, but only 8% had exercise equipment or facilities in their office buildings.

A few comments:

• "Yes! We note increased energy for our busy work schedule and fewer sick days taken."
• "We've had an increase in office camaraderie, as my staff works out together at the gym across the street from our office. Also have seen an improvement in fitness and attitude."
• "You can lead a horse to water . . . . Some do exercise; some have very young children, and they are worn out."

Do you provide free or subsidized gym memberships to your staff? Describe any other incentives you have given to your staff to exercise.

Only 14% of the responding orthodontists provided free or subsidized gym memberships to their staffs. Other options provided for staff exercise included:

• "We have predictable lunch hours with time to exercise. We respect that time and see our staff participating in various noon-hour activities."
• "We tried offering health-club memberships, but had poor-to-no response."
• "We don't have an incentive for exercise per se, but we have a $500 bonus to stop smoking."
• "Constant information pertaining to exercise and health is given to the staff."
• "They hear me preach it all the time."
• "Reimbursement for any unused sick days."

Is your practice involved in any team sports or other fitness events, with or without patients?

About three-quarters of the respondents indicated that they were not involved in such activities. The remaining practices listed a variety of sports, however, including:

• "Curling!"
• "We participate in interoffice golf outings."
• "Some staff play women's volleyball or go bowling."
• "Some of the staff will participate in community charity fundraising run/walk events that we sponsor."
• "Our office does two or three walk-a-thons a year."
• "We sponsor swim, baseball, and softball teams. We just became a major sponsor for the only kids' cycling club in town, and my associate coaches them."
• "I sponsor more than 30 local sports teams a year, from hockey to baseball to skating."

JCO would like to thank the following contributors to this month's column:

Dr. David C. Adams, San Diego, CA
Dr. R. Craig Allen, Hopkinsville, KY
Dr. Elliot E. Angel, Sierra Vista, AZ
Dr. Jose M. Arango, Colorado Springs, CO
Dr. Richard B. Ballard, Sandpoint, ID
Dr. Lisa Banning, Tamaqua, PA
Dr. William Bausch, Davenport, IA
Dr. Edward S. Boim, Toms River, NJ
Dr. Bruce D. Burns, Kernersville, NC
Dr. Timothy Bussick, Fort Wayne, IN
Dr. Jonathan Chase, Stoneham, MA
Dr. Gary D. Cohen, Hendersonville, TN
Dr. Betty L. Cragg, Unionville, Ontario
Dr. Jennifer Eisenhuth, Eagan, MN
Dr. James G. Frazier, River Forest, IL
Dr. Renée E. Geran, South Lyon, MI
Dr. Chester S. Handelman, Chicago, IL
Dr. Barry D. Hoffman, Calgary, Alberta
Dr. Joe Hudgins, Carbondale, IL
Dr. Gary O. Inman, Elizabethtown, KY
Dr. Douglas A. Jolstad, Excelsior, MN
Dr. Alan F. Justin, Saratoga Springs, NY
Dr. Kenneth B. Kaplin, Arlington Heights, IL
Dr. Gerald Kinoshita, San Jose, CA
Dr. Rejean Labrie, St. Hyacinthe, Quebec
Dr. Robert Lokar, Novi, MI
Dr. Robert B. Lowthorp, Bishop, CA
Dr. James B. Macomson, Gastonia, NC
Dr. L. Donald Mayer, La Grange, TX
Dr. Jean Siebold McGill, Easton, PA
Dr. Robert E. Meister, Rancho Santa Margarita, CA
Dr. John Melling, Ashland, MA
Dr. David Meyer, Brookings, SD
Dr. Richard J. Mori, Dayton, OH
Dr. Gary D. Mundy, El Paso, TX
Dr. Paul Nelson, Seattle, WA
Dr. Jim O'Leary, Waterford, CT
Dr. Mitchell Pelsue, Janesville, WI
Dr. Mark J. Perelmuter, Louisville, KY
Dr. Steven Peterson, Madison, WI
Dr. Norman J. Pokley, Caro, MI
Dr. Bridget Powers, Walnut Creek, CA
Dr. Mark Rosenthall, Muncie, IN
Dr. Earl S. Sauget, Agana, Guam
Dr. Bruce W. Scarola, Brandon, FL
Dr. Bryan C. Scott, Vacaville, CA
Dr. Michael W. Scott, Longview, TX
Dr. Michael W. Sheets, Corvallis, OR
Dr. Edward M. Sheinis, Coral Springs, FL
Dr. Heidi Beth Starnes, Newport Beach, CA
Dr. Malcolm E. Steen, DeLand, FL
Dr. Bryan E. Taylor, Waco, TX
Dr. Stephen Tracey, Upland, CA
Dr. Andrew P. Trapani, Algonquin, IL
Dr. Camille VanDevanter, Federal Way, WA
Dr. Michael J. Wagner, Woodinville, WA
Dr. Kevin C. Walde, Washington, MO
Dr. Ronald P. Wolk, Calgary, Alberta