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THE EDITOR'S CORNER

The Importance of Class III Overcorrection

Class III treatment has long been the subject of heated debate and considerable frustration among orthodontists. In the adult dentition, generally all but the mildest of Class III malocclusions need to be addressed with orthognathic surgery in conjunction with orthodontics. In the deciduous, mixed, or adolescent dentitions, more options are available, many involving simultaneous or sequential transverse expansion coupled with anterior advancement of the maxilla. In recent years, we have seen the development of miniscrews or miniplates as anchorage for maxillary expansion and forward movement with a protraction headgear—generally referred to as an orthopedic facial mask or, more simply, a facemask. Other skeletal-anchorage options involve the use of miniplates for the application of intraoral Class III elastics or the combination of miniscrews with the Hybrid Rapid Palatal Expansion Advancer.

Initial and short-term results of Class III treatment using rapid palatal expansion and facial-mask therapy (RPE/FM) can be quite impressive. I remember how thrilled I was during my specialty training when my first RPE/FM patient came in for a one-month follow-up. It appeared at that appointment that the malocclusion was well on the way to complete resolution, and the change in the patient's appearance was gratifying. I followed that case throughout my first year, at the end of which the patient was transferred to an incoming student. The thrill I got from the initial results was more than matched, however, by the disappointment I felt when I saw the patient a year and a half later for a last follow-up visit prior to my graduation. The Class III malocclusion, along with its accompanying anterior crossbite, had returned. I learned the hard way about the strong tendency for further facial growth to counteract any corrections made in the short term, and thus about the importance of overcorrection in such cases.

Over the years, a number of strategies have been proposed to enhance the effectiveness, efficiency, and stability of RPE-FM treatment. Special efforts have been devoted to addressing the long-term tendency for unfavorable

skeletal growth that might negate the improvements achieved by such therapy. Strategies include the utilization of Class III removable functional appliances as transitional retainers between Phase I and Phase II treatments, or the incorporation of facemask hooks in the interphase retainers. Whatever the method, studies have shown that overcorrection of the Class III is an important factor associated with long-term success.

In this issue of JCO, a team of authors from the University of Florence, Italy—Drs. Lorenzo Franchi, Tiziano Baccetti, Caterina Masucci, and Efisio Defraia—present a modification of Liou's technique, in which the RPE is first used to expand the maxillary sutures and then reversed to constrict the maxilla back to its original starting width. This process of alternate rapid maxillary expansion and constriction (Alt-RAMEC) is repeated several times, with the aim of loosening up the sutures and thereby enhancing and accelerating the skeletal advancement of the maxilla once the facemask is applied. Although the technique has been widely used since its introduction in 2005, it does have the potential to cause deleterious periodontal effects on the permanent abutment teeth.

In the modification by Dr. Franchi and colleagues, using a bonded, full-occlusal-splint version of the RPE, facemask hooks are applied to the deciduous dentition to avoid any periodontal issues with the first premolars or first permanent molars. The short-term results, as demonstrated here in two patients, are eye-opening. In each case, a significant amount of overcorrection was achieved, which bodes well for the long-term stability of the skeletal Class III correction. The treatments were efficient, and no periodontal problems were noted. While I agree with the authors that more studies with larger sample sizes are needed to validate their results, I have little doubt that such studies would confirm the present findings. See if you agree.

It is with great sadness that we must report that Tiziano Baccetti, one of the authors of this article and a Contributing Editor of JCO, died in a tragic accident following his keynote lecture to the International Orthodontic Symposium in November. Dr. Baccetti fell from the Charles Bridge in Prague while taking a photograph of himself for his father. He was regarded by his peers as a "rising star" and a "superman" in orthodontics, as many e-mails to our office and comments on our Facebook page have affirmed. The loss of Dr. Baccetti at age 45 is truly a catastrophe for our specialty. All of us who knew him marveled at his ability to do so many things so very well. We will all miss him, and I know you will join me in sending heartfelt condolences to his family at via E. Pistelli 11, 50135 Florence, Italy. In addition, his colleagues have asked that we publish the following note: "The authors would like to dedicate this article to the memory of their beloved friend, Tiziano Baccetti, who was taken prematurely from us."

RGK