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.)

What percentage of your active patients are adults? What percentage of your adult patients are female?

The respondents' mean percentage of adult patients was 25%, with a low of around 20% and a high of 35%. The vast majority of these patients were women, with a mean percentage of 75% and a high of about 90%.

When do you typically schedule adult patients?

About half of the respondents scheduled their adult patients at the same times as their child and adolescent patients. Eleven percent scheduled adult patients during particular time blocks for the office's convenience; the same percentage scheduled adults during the early morning hours, and 5% scheduled adults during the late afternoon hours. Only 3% said they scheduled adults in the evening, and 1% on weekends. A few practices indicated that adults were scheduled in the late morning or early evening, or that they were scheduled at the patient's convenience. An interesting comment was:

• "On the first and last week of school we try to schedule more adults."

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How do your initial examination, case presentation, and fee presentation for adult patients differ from those for child patients?

Sixty-two percent of the clinicians reported that there was no difference in their initial examination, case presentation, or fee presentation, but 24% said that adults required more time and, in many cases, consultation with other specialists. Some remarked that the same information was presented to the adult patient as to the parents of the child or adolescent patient, but that the presentation tended to be more time-consuming because of questions and explanations.

Representative answers included:

• "We focus more on periodontal concerns and a full understanding of what the patient desires from treatment. The case presentation sometimes takes a little longer because the adult patient wants more detailed information. The fees are higher and rarely covered by insurance."

• "More time is allocated for the adult patient because of the need for more explanations, due to more questions from the patient, and the need to gain their confidence and to reassure the patient."

• "The presentations are the same, except I take more time with the adult patients to let them know that they will have more discomfort than children. I go out of my way to make sure they are self-motivated. I don't want to talk an adult into braces and then have to hear them asking at every visit, 'Why am I doing this?'"

How do your fees and fee payment arrangements for adult patients differ from those for child patients?

Fifty-four percent replied that their fees were 10-20% higher for adults than for children,

while another 23% indicated that their fees were significantly higher for the adult population. The difference ranged from about $500 to $2,000. The remainder of the respondents indicated that their fees were approximately the same for both groups. A few clinicians reported that their fees for adults were correlated with treatment time. A typical response was:

• "My fees for adults, on average, are higher. The fee arrangement is the same, depending on the circumstances."

How do your informed consent and educational methods for adult patients differ from those for child patients?

About 80% of the respondents said their informed consent and educational procedures were the same for adults as for child or adolescent patients. Many did note that treatment limitations, relapse potential, compromises, and periodontal or TMJ issues were more emphasized with adults. A few clinicians reported that their educational methods were tailored to mature patients.

Specific comments were:

• "We focus more on periodontal concerns, need for grafts, more frequent cleanings, etc. Also, we emphasize the harmful effects of smoking and how it relates to their dental and orthodontic health."

• "No difference, since we are always communicating with adults (parents). They always want to know everything, and that takes good software like Vistadent to explain all the details."

Do you have a separate waiting room or reception area for adult patients?

All but three respondents indicated that they did not have separate reception areas for their adult patients.

Replies included:

• "I have separate rooms. The kids' room is soundproof and has video games. The adult room is next to the reception desk and has a coffee area."

• "Children go to the on-deck bench or PacMan machine. Adults remain in the reception room until called."

Where do you treat adult patients?

The substantial majority of clinicians reported that they treated their adult patients in an open bay or private operatory, depending on availability, with most using the open bay. Twelve percent indicated that they had private operatories dedicated exclusively to adult patients.

If you treat adults in an open bay, do you mix adults with children?

All the respondents who had open bays indicated that they mixed adults with children unless an adult patient requested otherwise, which was a rare occurrence.

Some comments were:

• "Most adults don't mind. We do have some teachers that see their students, past and present, here. They usually prefer more privacy. Also, we usually don't take adult impressions in the open bay."

• "Most adults are asked on the first few visits if they prefer privacy, and almost 100% say no."

Do you assign specific staff members to adult patients?

The vast majority, 87%, replied that they did not assign specific staff members to their adult patients, and those who did often indicated that it was because of a good relationship between a patient and a particular staff member.

Specific answers included:

• "It depends on the patient. If they 'click' with one assistant, we make an effort to keep them with that staff member as much as possible."

• "Our more experienced assistants work with adult patients."

• "A staff member is assigned to each patient, child or adult, to follow that patient through treatment. That assistant, whenever possible, will see that patient."

What treatment methods do you use for adult patients that you do not typically use for children, and vice versa?

It was evident from the replies that there were many treatment methods that were considered specific to adults. Only 6% of the respondents indicated that their techniques were the same for adults and children.

The most common differences mentioned were that adults were more likely to be treated with esthetic brackets, lingual appliances, the Invisalign system, or Red White & Blue technology; that surgery was more often included in the treatment plan for facial balance; that air-rotor stripping and lower incisor extractions were more likely to be used for relief of crowding, to avoid bicuspid extractions; and that mechanical palatal expansion was less frequently used.

What are some of the particular challenges of adult treatment?

The major responses were that consultation and collaboration with a periodontist or multidisciplinary team was often necessary, and that due to the absence of growth, orthopedic appliances and headgear could not be used effectively in adult cases. Additionally, treatment could be influenced by restorations and tooth wear, and TMJ signs or symptoms had to be considered.

Other factors mentioned were that the maintenance of closed spaces was more unpredictable, chairtime was longer, the teeth moved more slowly, three-cornered spaces were more prevalent, and there was more discomfort from appliances among adult patients. Some clinicians noted that long-term retention was frequently indicated due to a potentially higher relapse tendency. Another common remark was that many adult patients had higher treatment expectations, but that treatment plans often had to involve compromise or camouflage.

What are some of the interdisciplinary challenges presented by adult patients?

The most prevalent challenge presented by the adult patient was thought to be working with a specialist to monitor periodontal status. Of equal concern was the necessity of putting an interdisciplinary team together that might include an oral surgeon, restorative dentist, endodontist, and TMJ specialist.

Specific comments were:

• "Adult patients present with periodontal problems, missing teeth, porcelain crowns, preparing for crown-and-bridge or implant, and other cosmetic dental treatment. Conferences with other specialists and the family dentist are important."

• "Perio, perio, perio, and not making the perio situation worse. Also, communicating with the restorative dentist to make sure I move the teeth where he wants me to."

Do you find adult patients more or less cooperative than child patients? Please elaborate.

Ninety-one percent of the respondents believed adult patients were more cooperative than children, 4% thought the cooperation level was the same, and only 2% felt children were more cooperative than adults. Adults were perceived to be more cooperative with elastic wear, hygiene instructions, and keeping their appointments. These observations were tempered, however, by comments that adult compliance often depended on the more well-defined personality of the individual patient—in other words, that adult patients were generally more cooperative, but could also be more irritatingly demanding.

Remarks included:

• "As a rule, most adults are more cooperative with brushing, elastic wear, and avoiding foods that cause loose brackets and prolonged treatment times."

• "I find that adults present with more medical concerns, have more emotional and psychological issues, and have less patience with treatment time."

In non-surgical adult cases, if there are no apparent occlusal difficulties, are you more willing to settle for the existing occlusion and direct your attention strictly to the patient's chief complaint?

Ninety-three percent of the respondents were willing to settle for an existing occlusion when occlusal difficulties were not evident. Some caveats were noted, however: the treatment plan would only be modified on a case-by-case basis, and only when the patient was aware of the

limitations of treatment.

Some specific replies:

• "I'm less heroic and adventurous with adults due to slow tooth movement. If the occlusion isn't perfect, but it has functioned fine for 30 years, then I'm not going to change it. If it ain't broke, don't fix it."

• "Crossbites in the posterior quadrants are stable and more difficult, if not unnecessary, to treat."

• "I can't count how many times an adult has come to me for a second opinion, frustrated and angry because they wanted one little thing fixed and they had a complete treatment plan thrown at them. I am more willing to address limited treatment desires with adults than with kids."

• "There are new multiple cosmetic modalities that are offered by the general dentist to address cosmetic/esthetic concerns. As orthodontists, we should address proper alignment and occlusion of the teeth. Only if the patient declines surgery will I accept the existing occlusion."

How does the length of treatment for adult patients differ from that for child patients?

About half of the respondents said their adult treatment times were longer than those for child patients; 41% believed the treatment times were about the same, and only 9% indicated that adult treatments were shorter.

Interesting observations included:

• "Adult treatment is usually the same as for an uncooperative child, or three to six months longer than a cooperative child."

• "For complex treatments, it takes time to coordinate with other specialists."

• "If tori are present, I always add six to 12 months. Sometimes, in nonextraction plans, treatment time may be very similar. But if it is an extraction case, it is usually six to 12 months longer because I want to move roots slowly and gently through bone."

How does your finishing protocol for adult patients differ from that for child patients?

The most consistent reply was that the treatment goals and finishing goals were the same, implying that orthodontists want to achieve the best possible results no matter what condition is presented. Many respondents noted that longer retention periods were required for adults, and that permanent retention was frequently recommended. Full-time, 24-hour retainer wear, however, was often replaced by night and/or evening wear. More fixed retention was prescribed for adults, but when removable retention was indicated, an Essix-type plastic retainer was commonly used. In addition, equilibration was frequently mentioned as an adult finishing procedure. A pertinent comment was:

• "Lots of tooth reshaping, incisal edge equilibration, and marginal ridge reduction. I use positioners with kids, but can't with adults because they are not as effective and the adults won't wear them to work."

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