

FEATURES SECTION

Letters to the Editor

Dear Editor

The article on 'Choosing a pre-adjusted orthodontic appliance prescription for anterior teeth' by E. Thickett, N. G. Taylor, and T. Hodge,¹ is a well thought out and of value to all orthodontists who use pre-adjusted edgewise systems. The authors have 'thought out of the box' and have nicely elucidated various modifications of bracket positioning to tackle certain tricky clinical situations that an orthodontist routinely encounters.

Although we agree with most of the modifications mentioned in the article (and were already using some of them), we wish to share our approach to handling some of the situations cited, and to seek clarification on certain points.

1. (i) When an upper central incisor is missing and the treatment plan involves moving a lateral incisor into the former's space, the authors mention that they bond a contralateral central incisor bracket onto the lateral incisor in such a fashion that the tooth's root moves mesially and the crown distally (Thickett *et al.*, Figure 6).¹ The authors claim that this provides an optimal emergence profile and avoids the problem of retention from a mesioingival margin of a restoration.

However, we feel that the traditional method of centring the lateral incisor in the space of the central incisor (without changing the angulation) is better than the authors' modification. If the lateral incisor assumes the angulation that the authors suggest, the occlusal forces will not be transmitted along its long axis and a large distal restoration will be more prone to failure than small restorations on its mesial and distal aspects.

(ii) On closer observation of Thickett *et al.* Figure 6,¹ we suspect that the bracket on the lateral incisor is not of a contralateral central incisor but of a contralateral lateral incisor. We wish to know which bracket exactly the authors have used.

2. In the case of Class III camouflage (Thickett *et al.*, Figure 4),¹ the authors suggest the use of contralateral canine brackets to tip the canine crowns distally. To achieve the same objective, we prefer to use the designated bracket on the designated canine but slightly angulating it to get the desired amount of crown tipping. This method will leave the power arm distally which will be better from a biomechanical point of view, if we need to use it.

3. In the case of Class III camouflage, the authors suggest inverting the incisor bracket for labial root torquing. Although Subtelny,² Catania,³ and Goldin⁴ advocated this kind of labial root torque in Class III patients, they have used it for skeletal correction (maxillary protraction) in growing individuals, and not for camouflage. We think that if we invert the brackets on upper central incisors, especially MBT brackets, we get an effective torque of -17° . We suspect that inducing such an amount of negative torque may cause root resorption and dehiscence. So, we would like to know if the authors have used these MBT brackets without any problems.

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References

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3. Catania JA, Cohen BD, Deeney MR. The use of labial root torque and the tie-forward technique in the treatment of maxillary skeletal retrusion and severe arch length discrepancy. *Am J Orthod Dentofacial Orthop* 1990; **98**: 12–18.
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Dear Editor

Thank you for forwarding the letter regarding our article. We were very interested to receive these constructive comments. We appreciate that many of the modifications are not original and although in common use thought it appropriate to indicate the effects of using different bracket prescriptions.

Question 1 relates to absence of an upper central incisor where mesial movement of an adjacent maxillary lateral incisor is carried out to replace the absent central incisor. We have found it helpful to place a contralateral incisor bracket on the lateral incisor tooth to position the mesial aspect of the lateral incisor against

the adjacent central incisor. Our restorative colleagues have found it easier to build up the distal profile of the incisor; however, we fully accept the comments regarding occlusal forces transmitting along the long axis and appreciate that crown morphology of the lateral incisor will determine optimum tooth position.

We congratulate the authors on identifying our typographical error which should, of course, read 'contralateral, lateral incisor' which does not read as well as 'contralateral central' but is nevertheless correct. Only a true orthodontist would identify this error which has been missed by three authors and the editorial review.

We note that the suggestion is made to use a canine bracket slightly angulated to achieve the desired amount of crown tip. We appreciate that this will leave the power arm distally, but the compound contoured base

of preadjusted brackets may result in a poor fit and could at least in theory alter the pre-adjustment in the bracket. Our preferred approach is, therefore, to place contralateral canine brackets where we feel it is appropriate to angulate the canine distally.

We fully appreciate the concern that placing inverted brackets on upper central incisors, especially MBT brackets, could lead to root resorption and dehiscence. We have not personally tried inverting brackets but are aware that this has been discussed in the literature and thought it appropriate to indicate the potential effect of inverting brackets. On reflection the article would have been improved by emphasizing the selected cases where this may be beneficial which are limited to those where growth modification is still a possibility.

We thank the authors for their comments.

E. Thickett, N. G. Taylor, T. Hodge