

THE READERS' CORNER

[JOHN L. SHERIDAN, DDS, MSD](#)

1. When a patient comes to you for a second opinion on an orthodontic diagnosis, how do you proceed?

There was a broad consensus on second opinion consultations. Ninety-two percent of the respondents mentioned all, or a combination of, the following factors:

- A completely independent evaluation of the patient's condition, without being influenced by the initial clinician's findings. Most respondents did not want to know the details of the previous treatment plan—treatment of choice, fee, or projected length of treatment.
- Appropriate diagnostic records (requesting that they be forwarded, if taken by the doctor giving the initial opinion).
- Full discussion of the reasons expressed by the patient for seeking a second opinion.
- An effort to preserve the professional reputation of the initial orthodontist. Twenty-two percent said they would mention that the previous clinician was ethical and capable.

What do you do if you disagree with the original diagnosis?

There was nearly unanimous agreement that neither the findings of the original diagnosis nor the proposed treatment plan should be criticized. The common theme was that there are various valid treatment options for any particular case, and that clinicians tend to choose the method they are most comfortable with.

Some specific comments were:

- "If the approaches have similar goals, but vary in mechanics (Herbst vs. cervical headgear and Class II elastics), then we say that it's like taking two different roads to get to the same place, but each clinician prefers their own route. If there is a treatment decision that I believe may have a negative effect on the patient, I am a bit more direct and tell the patient that such an approach does not coincide with my treatment philosophy. But still, overt criticism is not called for."
- "Since most of the orthodontists in my relatively small town have similar training, there's not that much difference in treatment plans. It's usually personality or a breakdown in communications that causes the patient to seek a second opinion."
- "Most of my second opinions are due to problems in the initial consult. The reason patients seek a second opinion is that, for whatever reason, they don't have faith in the original doctor's treatment plan or office demeanor. Consequently, we go overboard to project our sincerity, competency, and commitment to patient care."

After you give a second opinion, what percentage of patients start treatment with you, rather than with the original orthodontist?

The responses to this question generally ranged from 50-90%, with the majority reporting a 60-80% acceptance of their second opinions. The second clinician was seen as having the advantage of knowing why the patient was dissatisfied with the visit to the initial orthodontist, and thus being able to achieve more positive rapport.

One respondent noted:

- "If a sincere patient seeks a second opinion in our office and then decides to go back to the original orthodontist, or perhaps seeks a third opinion, we want to know why. Other than price shopping, how did we fail to communicate our commitment to patient care and technical excellence? It gives us the impetus to review and improve our patient contact procedures."

What percentages of patients seeking second opinions do you believe are shopping for lower fees, are looking for different treatment options, or have other reasons?

The replies varied markedly. Although the average respondent felt that 34% of second opinions were motivated by fee shopping, 61% of second opinions were believed to be sought because of discomfort with the initial treatment options, a compatibility problem with the first office, or a combination of these factors. A few of the respondents noted that some insurance companies require second opinions.

Additional comments on second-opinion consultations were:

- "I never rush anyone into treatment. I do not believe in the 'one-step' when separators are placed at the first appointment. I believe that this is why many patients seek second opinions."
- "I think it's unfortunate that some orthodontists do not give an alternative treatment plan— the 'my way is the best and only way' attitude. It really confuses patients to be so dogmatic. For example, 'surgery is the only way', or 'headgear is barbaric'. Aren't we supposed to give the patient alternative treatment plans and discuss the pros and cons?"
- "If a patient has a bad attitude or a complex or hopeless case (as multiple-opinion patients sometimes do) I might undersell my service and indirectly (or directly!) guide them back to the previous orthodontist. Life is short!"

2. What are your criteria for using cervical headgear, high-pull headgear, chin cups, and protraction headgear?

Ninety-one percent of the respondents used cervical headgear, with most applications directed at the low-angle, Class II growing patient with maxillary protrusion. One-fourth of the clinicians said they used it to gain arch length by distalizing molars in the permanent or mixed dentition. However, another one-fourth said they were moving away from using cervical headgear, replacing it with other biomechanical systems such as Herbst appliances or twin block devices.

A notable percentage of the respondents (22%) did not use high-pull headgear at all, or used it infrequently. When used, it was primarily for the Class II patient displaying a high mandibular plane angle with maxillary protrusion and a tendency for vertical growth.

The preponderance of clinicians (83%) did not use chin cups. Those who did limited their application to Class III skeletal conditions in the mixed or early permanent dentition. There was a smattering of replies indicating chin cups were helpful in controlling the anterior vertical dimension when bite-opening mechanics were used.

Only 5% of the respondents used protraction headgear. These appliances were limited to patients displaying maxillary deficiency to the degree that there was a Class III incisal relationship. The consistent reason for not using protraction headgear was non-cooperation with instructions.

How do you check patient cooperation with headgear treatment?

All respondents who used headgear verified compliance by direct observation—signs of wear on the headgear, mobility of the molars, space opening mesial to the molars, changes in the occlusion, and the patient's ease of placing the headgear during a routine visit. Only 2% relied on verbal assurances from the patient or parent.

About half of the clinicians had their patients keep charts of headgear wear. Nearly all involved the parents in encouraging compliance. When asked about the effectiveness of these methods, approximately half of the respondents thought they were effective.

What do you do about lack of cooperation?

A majority of orthodontists indicated that a change in treatment methods would be necessary, involving the use of a fixed bite corrector such as a Jasper Jumper, Herbst, Distal Jet, or distalizing magnets to take compliance out of the patient's hands. One-third of the respondents mentioned extraction of maxillary first premolars as an alternative method to resolve a Class II case when cooperation was lacking. Additionally, most clinicians advised the patient and parents that treatment goals could be compromised by the lack of cooperation, and placed notations to that effect in the patient's chart. Six percent said they would inform the patient that if cooperation was not forthcoming, a surgical resolution of the Class II situation might be involved.

Do you find that the lack of progress is always related to non-cooperation?

Sixty-three percent of the clinicians said "yes". Those who said "no" usually attributed the lack of progress to variances in growth. Nine percent thought that, in addition to non-cooperation, poor diagnosis and treatment planning were contributing factors.

Some specific comments were:

- "Some growth patterns don't respond to our mechanics, or sometimes we are treating during a period of minimal growth where little changes can occur."
- "Possible discomfort or the inability to adapt to headgear—even when sleeping."
- "The results are consistent with the severity of the case. The worse the skeletal problem, the worse the progress and prognosis."
- "You know you're in trouble when the patient is reluctant to talk about their cooperation and appears disinterested when you're giving them an inspirational pep talk."

Under what circumstances do you discontinue headgear?

The majority (57%) used a treatment time standard, noting that they would discontinue headgear use after four to six months if there were no observable effect. Most clinicians said they would also discontinue headgear treatment if the patient protested against it.

Some specific remarks were:

- "After six months of pep talks, I quit. No alternatives –I just discontinue treatment."
- "I don't hesitate to discontinue headgear treatment if the patient throws a fit. I'd probably do the same if I had to wear one."
- "With a total lack of cooperation, the alternatives are extractions, heavy Class II elastics, surgery,

or debond and dismiss."

- "If it's Phase I of a two-phase treatment, I'll discontinue treatment until the patient is a bit older, and hopefully more responsible."

How do you insure patient safety with headgear?

Ninety-two percent of the respondents used some type of safety headgear involving breakaway straps or hooks. The vast majority also gave instructions, both written and verbal, to the patient and parents.

Individual comments included:

- "The ends of the hooks are rounded, and we stress that it's to be used only during quiet times. No slumber parties or rough-housing while in headgear."
- "We use a rubber stamp in the chart that says in bold letters, 'Headgear safety instructions given'. We also highlight the safety instructions on the patient's scorecard."

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Dr. Bruce A. Baker, Evansville, IN
Drs. Dan L. Blackwell and Elizabeth Blackwell Nill, Lee's Summit, MO
Dr. Paul N. Brown, Bloomfield Hills, MI
Dr. Jeffrey E. Burzin, Clinton, CT
Dr. Ralph Depee, Pampa, TX
Dr. Robert DeShields, Strongsville, OH
Dr. Todd E. Dickerson, Chandler, AZ
Dr. Floyd J. Dickson, Muskogee, OK
Dr. Thomas G. DiMassa, Lakewood, OH
Dr. John S. Disher, Greenville, SC
Dr. Vacharee B. Fell, Culver City, CA
Dr. Howard L. Friedman, Poughkeepsie, NY
Dr. Randy L. Gittess, Winter Springs, FL
Dr. William J. Glenos, St. Augustine, FL
Dr. Joseph Gray, Upland, CA
Dr. R.D. Jackson, Jr., Alexandria, LA
Dr. S. Meredith Johnson, Jr., Jeffersonville, IN
Dr. John T. Kalange, Boise, ID
Dr. Michael G. Kelley, Indianapolis, IN
Dr. Suhail A. Khouri, Chesterfield, MO
Drs. Peter H. Leonard and John D. Hiester, Columbus, IN
Dr. Craig C. Lewis, Kissimmee, FL
Dr. Thomas C. Lovlien, Ashland, WI
Dr. Rosario F. Mayro, Philadelphia, PA
Dr. James W. McDaniel, Chattanooga, TN
Dr. Dennis McKee, La Mesa, CA
Dr. Edward A. Myers, Middletown, NY
Dr. James R. Nicholson, Indianapolis, IN
Drs. T. Richard Perrine and Cynthia S. Wiley, Goldsboro, NC
Drs. Linda E. Rigali and Joan F. Walder, Northampton, MA
Dr. E.G. Righellis, Oakland, CA
Dr. Larry D. Roberts, Elkhart, IN
Dr. Richard A. Schechtman, Jefferson Valley, NY

Dr. Clifford C. Seran, Pitman, NJ
Dr. R.W. Shafer, Champaign, IL
Dr. William E. Silver, Miami, FL
Dr. E. John Strauss, Jr., Gallipolis, OH
Dr. Thomas F. Tilson, Olympia, WA
Dr. R. Thomas Tipton, Tempe, AZ
Dr. John Turchetta, Warwick, RI
Dr. Ronald Weiner, Parsippany, NJ
Dr. Richard B. Williams, Billings, MT
Dr. Harold P. Wittman, Alexandria, VA

FIGURES



Fig. 1 New molar attachment laser-welded to stainless steel bar.



Fig. 2 Molar attachment inserted into slot prepared in pontic.



Fig. 3 Two-piece intrusion arch in patient with bridge from mandibular right first bicuspid to second molar.



Fig. 4 40-year-old female with bridgework in mandibular right buccal quadrant.



Fig. 5 Patient after extraction of mandibular right lateral incisor, conventional separation of mandibular left first molar, and preparation of bridgework on opposite side for special attachment.



Fig. 6 Special attachment inserted into pontic and fixed with resin.



Fig. 7 Removable appliance with lateral support used to protrude maxillary right lateral incisor and allow correction of anterior crossbite.



Fig. 8 Multibacketed mandibular leveling arch in place.



Fig. 9 After correction of anterior crowding and crossbite. Horizontal bar in pontic slot was leveled off and polished, rather than being filled esthetically, because bridge needed to be replaced after

treatment due to poor marginal fit.

REFERENCES

- 1 Burstone, C.J.: Deep overbite correction by intrusion, *Am. J. Orthod.* 72:1-22, 1977.
- 2 Buyukyilmaz, T.; Zachrisson, Y.O.; and Zachrisson, B.U.: Improving orthodontic bonding to gold alloy, *Am. J. Orthod.* 108:508-510, 1995.
- 3 Cochran, D.; O'Keefe, K.L.; Turner, D.T.; and Powers, J.M.: Bond strength of orthodontic composite cement to treated porcelain, *Am. J. Orthod.* 111:297-300, 1997.
- 4 Whitlock, B.O. III; Eick, J.D.; Ackerman, R.J. Jr.; Glaros, A.G.; and Chappell, R.P.: Shear strength of ceramic brackets bonded to porcelain, *Am. J. Orthod.* 106:358-364, 1994.
- 5 Zachrisson, Y.O.; Zachrisson, B.U.; and Buyukyilmaz, T.: Surface preparation for orthodontic bonding to porcelain, *Am. J. Orthod.* 109:420-430, 1996.
- 6 Graber, T.M. and Swain, B.F.: *Orthodontics: Current Principles and Techniques*, C.V. Mosby Co., St. Louis, 1985.
- 7 Schwindling, F.P.: *Theorie und Praxis der Segmentbogentechnik nach Burstone*, Edition Schwindling, Merzig, Germany, 1991.
- 8 Burstone, C.J.: Rationale of the segmented arch technique, *Am. J. Orthod.* 48: 805-822, 1962.

FOOTNOTES

- 1 To be produced by Dentaaurum, Inc., 10 Pheasant Run, Newtown, PA 18940.
- 2 For example: Komet Model No. 1957, Brasseler GmbH, Lemgo, Germany.