

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.)

1. Do you attempt adult maxillary expansion? If so, do you customarily use a surgical or non-surgical technique? What do you feel are the advantages and disadvantages of each technique?

Two-thirds of the respondents said they did expand adult maxillae, but nearly all of them coupled the procedure with surgical assistance, either immediately or when it became obvious that there was dental movement rather than palatal shelf movement.

The principal advantages cited for surgically assisted adult maxillary expansion were the likelihood of a more predictable bodily movement of the buccal segments due to true palatal shelf expansion, less dental tipping that could complicate the case, less soft-tissue recession, and improved stability. Most respondents felt that the main disadvantage of surgically assisted expansion was the surgery itself—it was costly, inconvenient, and traumatic, and there was the risk of tissue dehiscence and perhaps morbidity. When these factors were explained to the patient, there was a tendency to reject treatment.

The advantages given for a non-surgical technique centered around the simplicity of the

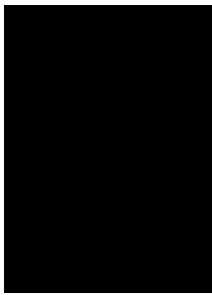
procedure—it could be done in the office, with minimal expense, and was essentially non-traumatic. The main drawback was that it might not achieve the treatment objective of efficiently expanding the maxilla without excessive tipping of the buccal teeth. With excessive tipping came the danger of moving the teeth out of cervical alveolar bone.

What do you feel are the advantages and disadvantages of slow and rapid adult maxillary expansion?

A slight majority of the clinicians preferred to use rapid palatal expansion with surgically assisted procedures, because they believed there would be less dental tipping and better stability. In general, however, most respondents favored rapid maxillary expansion in patients up to age 18-20 and slow maxillary expansion thereafter. One reason given was that adults seemed to tolerate slow maxillary expansion better than rapid. A few clinicians remarked that the palatal suture could be opened in adults over 20 without surgery, and that while it was unpredictable, it was well worth trying in selected cases.

One comment:

- “I will utilize rapid palatal expansion (one turn every day) in combination with surgery in my adult patients to achieve skeletal expansion and minimal crown tipping. The expander is placed prior to surgery and actively adjusted in the operating room to verify that the proper surgical cuts have been adequately completed. I use slow palatal expansion (one turn every other day) in those patients who are in their late teens. I find there is less discomfort associated with slow expansion in these patients. I have had much suc-



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cess with opening the midpalatal suture with minimal tipping (verified by occlusal x-rays) up to age 18 years.”

What expansion appliance(s) do you use for adults, and why?

The majority of respondents used a Hyrax-type appliance with a wire framework and no acrylic pads that might irritate the palatal mucosa. For stability, many clinicians augmented the wireborne appliance with a lingual bar and/or multiple bands. A few respondents used other expansion devices, including Quad Helix appliances for non-surgical expansion and bonded appliances. Only one respondent reported using a removable device for adult maxillary expansion.

A representative comment was:

- “An attempt is made to expand without surgery using a Hyrax-type appliance. The expansion appliance is turned two times a day (1/2mm each). If expansion occurs, it is evident within several days. If no expansion is occurring, the patient will be unable to turn the expansion screw due to discomfort. Then surgical intervention is indicated.

How long do you retain adult maxillary expansion?

A significant majority said they retained adult maxillary expansion for as long as possible. This was followed by those who retained the corrections for at least four to six months, or sometimes as long as a year. No clinician reported retaining adult expansion cases for less than three months.

Do you feel you can always achieve your expansion goals in adults?

Most of the respondents believed they could achieve their expansion goals in adults, but maintaining the results was an altogether different matter. Approximately equal numbers of clinicians thought results could be maintained as thought not.

How much relapse do you expect in your adult maxillary expansion cases?

There was a wide variation in the estimates of relapse, but the consensus was that adult maxillary expansion is inherently unstable. The least amount of relapse reported was “not much with a good diagnosis and treatment plan”. This was balanced by another clinician who believed there would be 100% relapse unless the expansion were surgically assisted. The remainder of the replies ranged from 15% to 50%. Only a few clinicians indicated that they overexpanded adult patients to reduce the degree of anticipated relapse.

There was general agreement that surgically assisted expansion was more stable than non-surgical, but that the results were still unpredictable for any given case. Reasons given for this were that adult surgical expansion could induce alveolar ridge distortion that was prone to relapse, that there is always some degree of reboundable tipping in any expansion procedure, and that the concomitant alteration of the periodontium and cortical plate could affect the ultimate stability of the case.

Some interesting responses:

- “Why correct a constricted maxilla, as evidenced by a buccal section crossbite in the adult, if there is no functional or esthetic problem? I believe many of my colleagues are correcting situations that, in reality, are nothing more than innocuous, aberrant anatomical occurrences that do not require therapy, but rather the common sense to leave well enough alone.”
- “Goals must be practical. Sometimes no expansion is attempted if periodontal problems are evident in the buccal sections. It might be better to leave the crossbite in these situations.”

2. *Do you have a website? If not, do you expect to have one in the future?*

Sixty-two percent of the respondents reported that they had websites or were in the process of obtaining them. Furthermore, 78% of the rest were planning to incorporate websites into their practices at some future point.

If you do not plan to have a website, why not?

The primary reason given for not having a website was that the orthodontist was unable to see any particular benefit from that technology. Among the explanations for this attitude were that the practice was rural and a website would not be useful, that maintaining the website was just another duty for an already overburdened administrative staff, and that the clinician was planning to retire in the near future.

Comments included:

- "I don't see the need for one other than the AAO website."
- "I provide a very specialized service, not simply orthodontics. We build relationships, have superb staff with excellent abilities, and feel that a website would trivialize this high-end service. We rely on direct GP and patient referrals, and so far that has served us just fine."
- "Presently, a website is not necessary in a small community. However, to maintain a technological edge, I may pursue this in the future."

If you currently have a website, what uses do you make of it? If you plan to have a website, what do you plan to use it for?

The primary uses listed for a website were for marketing the practice and educating patients or prospective patients about the hours of the practice, the location, the qualifications of the doctor and staff, orthodontics in general, emergency instructions, pager numbers, and frequently asked questions. Some clinicians said they also used their websites for interacting with their patients and referring dentists. Following this, in decreasing order of usage, were requests for information about the practice, appointment re-

quests, and changing appointments. The least mentioned usage was for outlining basic orthodontic fee structures.

One interesting comment:

- "I use my website for patient or prospective patient information. This tool gives the impression that my practice is 'high tech', and I believe that is valuable. However, I do not believe the Web will be an appreciable source of new patients."

What are your monthly averages for: the number of visits (hits), number who requested an appointment, number of initial appointments kept, number converted to starts, and percentage of adult starts?

Because the technology is relatively new, many of the clinicians did not have this data available. Those who did reported a wide range of monthly hits—one more than 1,000, but most less than 50. Numbers of patients obtained through website contacts were also quite variable, but with few exceptions were surprisingly low.

Who in the office manages the website? What outside services do you use?

Most of the websites were designed and structured by professionals such as graphic designers or Internet Service Providers, and then monitored either by the doctor or by the doctor and the office manager. A few of the respondents used outside companies to maintain and manage their sites.

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