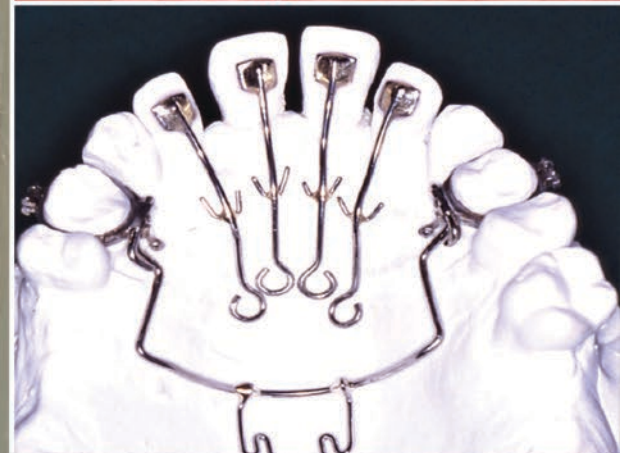


Second Edition

Adult Orthodontics

Edited by **Birte Melsen** | **Cesare Luzi**



WILEY Blackwell

Adult Orthodontics

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Second Edition

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Dedicate to all the people who helped us during the process

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About the Companion Website

This book is accompanied by a companion website for instructors:

<http://www.wiley.com/go/melsen-adult-orthodontics>

The website includes the following resources:

- PowerPoint slides
- Tables

Introduction

Working with the update of the book on adult orthodontics, I had to look back on the development within our discipline. In 1998 Carine Carels organised a symposium ‘The future of orthodontics.’

The lectures given in that symposium were focused on research related to the influence of genetics and environmental factors two aspects are dominating over; TADS and Clear Aligners.

Another part of the symposium brought the attention to the increasing difficulties in using animal models when testing various treatment approaches.

The pro et contra related to randomised control trials was discussed and an attempt to quantify the need for treatment and to choose the optimal timing for treatment was elucidated.

Altogether, the spirit was high, but when looking at the developments occurring since the symposium in Leuven, they have deviated from the prediction with respect to several aspects. The development of orthodontics has, as most other disciplines, been fractioned and more parts have been outsourced. The companies have taken over. Orthodontists are no longer wire-benders the first, second and third order corrections are taken care of when buying the right preformed bracket. Given the current trends, many patients will receive orthodontic treatment by non-specialist dentists or without dentists at all. The number of adult and elderly patients is growing and one could envision orthodontists treating mostly patients with severe or complex malocclusions, with iatrogenic damages, or in need of re-treatment.

There are several reasons for bending; to lower the force level, to control the first, second and third order corrections and to achieve the correct force system. While the force level can be lowered when choosing a different material and the prescription brackets can take care of the final position,

there is still a need for bending in order to obtain the correct force system. The latter is still valid.

Since the first version of Adult Orthodontics especially; TADS and Clear Aligners. But are they a blessing or a curse? However, the same development that has been taking over the medical world as orthodontics today “reification” in other words treating cases not patients. The number of publications with the keyword orthodontics are growing exponentially and the authors are paying to get published moving money from research to publishing. In the new version, we have chosen to present a survey of different TADS and aligners.

The advantages and disadvantages will be stressed. The definition of the treatment another topic that has been focussed on over the last decennia treatment should be individualised to achieve the goals.

The chapter on aligners is now including a history of the aligners and a description of the different types. We have focussed more on the possibility the mandibular repositioning and added a chapter on acceleration of tooth movement, another topic that has been focussed on over the last decennia. The number of Clear Aligner companies are growing every month and the different authors vary with respect to what problems they can solve.

Are we, maybe, focussing too much of the “hard” tissue and forgetting about the soft tissues, the muscle matrix and the tongue posture?

Just before submitting the book Sheldon Peck, who wrote the former introduction passed away. His interest reached from the history of orthodontics over clinical research. Let us recall a great colleague when we read the introduction to the first version.

I have been fortunate to have Dr Cesare Luzi as my co-editor. He has kept track on the delayed delivery from

the co-authors who all have been overloaded with problems related to COVID-19. Some people manage to be present both for their family, their patients and their colleagues. He is one of those. Without him I would not have been able to

complete this version in a period of a World dominated by lock-downs due to the pandemic COVID-19.

I thank all my co-authors for their contribution during these difficult times.

Introduction: More than a Century of Progress in Adult Orthodontic Treatment

Orthodontics for adults is not new. A hundred years ago and earlier, orthodontics was considered a division of prosthetics in the minds of most dentists. The problems related to the common loss of permanent teeth from uncontrolled caries were among the most frequent chief complaints of adult patients evaluated for 'orthodontia'. Unwitting extraction of posterior teeth during youth allowed adjacent teeth to tip into the spaces over time. Often, orthodontic uprighting of tipped teeth in adult patients was performed by the same doctor who afterwards prepared the teeth as anchor units for fixed or removable dental prostheses.

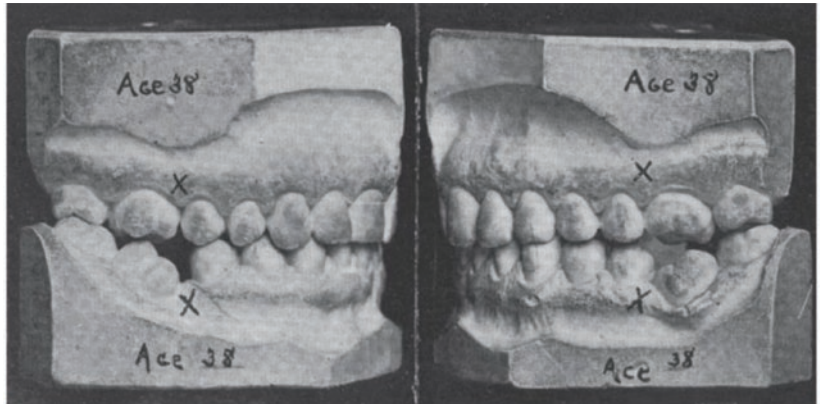
We are fortunate to have details of an adult orthodontic treatment performed by Edward H. Angle, MD, DDS (1855–1930), the man acknowledged worldwide as the first specialist in orthodontics. In addition to his skill at creating ingenious 'tooth-regulating' appliances, Angle was a bold and talented clinician. In 1901, a 38-year-old woman, Mrs A, came to him from Louisville, Kentucky, referred by her dentist. She was from a leading Kentucky family and she travelled 400 kilometres to Dr Angle's office in St. Louis, Missouri, because of his reputation as the 'world's best' clinical orthodontist.

Mrs A's four permanent first molars, all healthy, were 'sacrificed' at nine years of age by a dentist who said this course of action would prevent the development of malocclusion of the other teeth. She came to Dr Angle three decades later with severe tipping of the mandibular molars into the extraction sites (Figure 0.1a,b). In the maxillary dental arch, complete closure of the first molar sites had occurred with associated retroclination of the anterior teeth and loss of lip support. Furthermore, Angle reported that 'not only have the remaining teeth been rendered almost useless for mastication, but in recent years there has been chronic pericementitis, resulting from wrongly directed force from the molars in their tipped and abnormal positions' (Angle 1903, 1907).

A century ago, orthodontic treatment was not frequently undertaken for adult patients. Dentists perceived grave uncertainties of response and outcome associated with orthodontic tooth movement in adults, regardless of their absolute need for improved dental health. Even the great Dr Angle was doubtful in his prognosis for Mrs A, saying her age was 'the most advanced age recorded for such an extensive operation' (Angle 1903, 1907).

Nonetheless, Angle commenced a pre-prosthetic orthodontic treatment for his patient. He used his own design of nickel–silver fixed appliances to regain the lost spaces of the four first molars in preparation for fixed bridgework. First, Angle placed bands with buccal tubes (his 'D-bands') on the second molars. He then fabricated heavy labial arches ('E' arches) for insertion into the tubes to provide three-dimensional expansion of both dental arcades. In addition to regaining the lost molar spaces, he wanted to procline the anterior teeth, 'lengthen the bite' and give Mrs A's lips more support for better facial aesthetics. She was a very cooperative patient and all objectives were met within six months of treatment (Figure 0.2a,b). Angle was elated that her 'teeth were moved as easily and as rapidly as is usual in the case of a miss of eighteen, and with no unfavourable symptoms following the movement of any of the teeth' (Angle 1903, 1907). After active treatment, vulcanite removable plates were fitted for an additional six months of retention, until the teeth were set firmly enough in their new positions to receive space-filling bridgework from her dentist in Louisville.

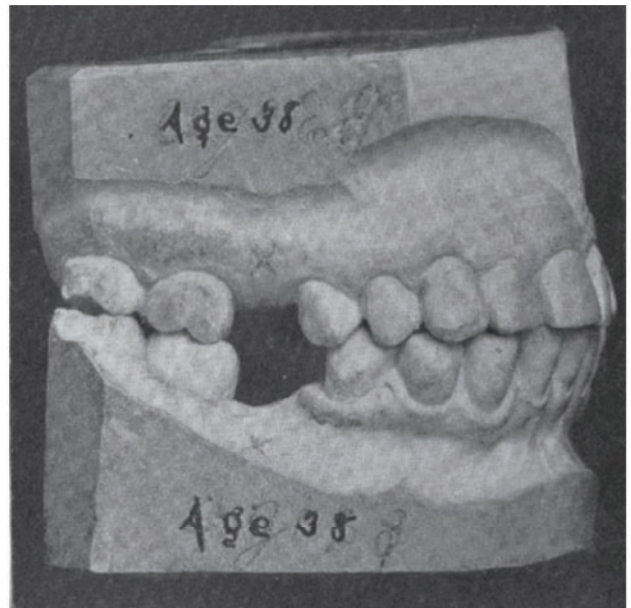
Dr Angle was proud of Mrs A's treatment results and included her case in his published lectures and textbook (Angle 1903, 1907). In these written accounts, he described Mrs A as 38 years old. But in his private correspondence from 1899 to 1910 – recently available to us (Peck 2007) – he consistently referred to her as a woman aged 42 years.



(1)

(2)

Fig. 0.1



(1)

(2)

Fig. 0.2

Perhaps a sympathetic Angle made her appear four years younger in his professional publications as a concession to the vanity of this charming adult patient, whom his letters show he held in high esteem.

Today, adult orthodontics involves much more than regaining lost arch space. The enlightening chapters in this book demonstrate an unrestricted range of orthodontic problems and solutions for the adult patient that more than match those associated with conventional adolescent treatments. Adult orthodontics demands additional skills, such as the ability to work with compromised dentitions and to accept less-than-ideal results as the best possible outcome in many cases.

We often have several choices in adult treatment plans. Sometimes financial cost becomes a significant factor from the adult patient's point of view. We must seriously attempt to weigh the costs of various treatment alternatives against the technical virtues of each. As socially sensitive clinicians, we must acknowledge differences within each society and between societies in the ability to absorb escalating costs of certain procedures. For example, consider the problem of a space resulting from the loss or absence of a tooth, which can be managed by either space-reopening or space-closing methods. Within a free-market healthcare system, the combined costs of pre-prosthetic orthodontics and a dental implant with crown are often greater than a full-treatment orthodontics fee. Thus, it may be economically prudent to manage the space in this instance with orthodontic closure rather than with a multidisciplinary prosthetic solution.

If we may speculate based on the historical record, Edward H. Angle would likely be very pleased with this elaborately designed book on adult orthodontics. It contains the elements he considered essential for solid scientific problem-solving. First, the diagnostic aspects and problems

are clearly defined. Then, various solutions and limitations are elucidated in the simplest terms possible, using case studies. Beautifully illustrated case reports are featured in a supplemental CD disk which is conveniently provided in a pocket on this book's inside cover. And finally, Angle greatly respected those who explained and thoughtfully encouraged new and promising materials, methods and techniques.

Birte Melsen is exceptionally well-suited to the task of orchestrating the production of a state-of-the-art text on adult orthodontics. She is both a biologic researcher and a talented, experienced clinician. She knows how to plan practical, biologically sound treatments and she has pioneered innovative therapeutic pathways. Dr Melsen, with the contributed expertise of her extremely capable team of hands-on authorities, has given us a book that will surely extend the boundaries of the specialist's abilities and vision in the management of complex adult orthodontic problems.

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1

Potential Adult Orthodontic Patients – Who Are They?

Birte Melsen

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Introduction

The number of adult patients receiving orthodontic treatment is increasing worldwide. According to the editor of the *Journal of Clinical Orthodontics*, the time when orthodontics was just for children is definitely over (Keim et al. 2005a, 2005b). The increase in the number of adult patients requesting orthodontic treatment is also reflected in European countries (Burgersdijk et al. 1991; Stenvik et al. 1996; Kerosuo et al. 2000). Vanarsdall and Musich (1994) listed five reasons for this change. Three concerned the improved capacity of the profession to treat problems in adult patients either only orthodontically or in combination with orthognathic surgery. Two points referred to the patient's desire to maintain their natural teeth.

Proffit (2000) explained that the increase in the number of adult patients seeking treatment was due to greater availability of information, and analysed the motivation necessary to seek orthodontic treatment as an adult. However, the patients referred to by Proffit are mostly well informed about the possibilities and limitations of orthodontic treatment, and while this assertion may be valid within certain socioeconomic groups in the USA, it is rarely the case in Europe. A possible explanation of this

difference between the USA and Europe could be the marketing of orthodontics in the USA. In Europe, it is often ignorance and insecurity that characterise the adult patients seen in the orthodontist's office. Patients may come on their own initiative because they are dissatisfied with either the appearance of their teeth or their ability to chew, or due to a combination of both, or they may have been referred by their family dentist.

Who are the patients?

How can we characterise the adult population presenting to an orthodontic office? Adult patients can be classified according to several criteria. While they all share the fact that they are no longer growing, we must differentiate between young adults, who have recently stopped growing, and older adults, who have experienced deterioration of their dentition and changes in their occlusion over time (Figures 1.1 and 1.2).

Young adult patients are those who, from a professional point of view, should have been treated earlier, or those in whom optimal treatment can be carried out only after cessation of growth. Based on the importance of the impact of genetics on the final skeletal morphology (Savoye et al. 1998), it is frequently considered desirable to postpone treatment of severe skeletal deviations that can be recognised in other members of the family until adulthood, at which time surgical treatment can be carried out (Figure 1.3).

Some young adult patients with severe malocclusions should, however, have been treated earlier. Their malocclusion, which was not considered as an indication for treatment when younger, worsens with time and leads them to seek treatment as adults (Figures 1.2 and 1.4). Proffit (2006) diagrammatically illustrated where tooth movement alone can solve the problem, where tooth

movements combined with growth modification are needed and where surgery is considered necessary. However, the lines indicating the limits should not be considered as sharp cut-off points, but rather as indicative of a 'grey zone' in which more than one treatment option can be considered (Figure 1.5). Cassidy et al. (1993) discussed making a decision about surgery based on the advantages and disadvantages of surgical and orthodontic approaches to the treatment of these patients. On the basis of analysis of post-treatment changes and a risk analysis, they concluded that conventional orthodontic treatment is a better choice in borderline cases.

Surgery should not be a substitute for orthodontic treatment, but when treatment is delayed beyond the time when growth modification is possible, surgery is often the only possible solution. A lack of treatment at the most convenient time thus adds to the number of surgical

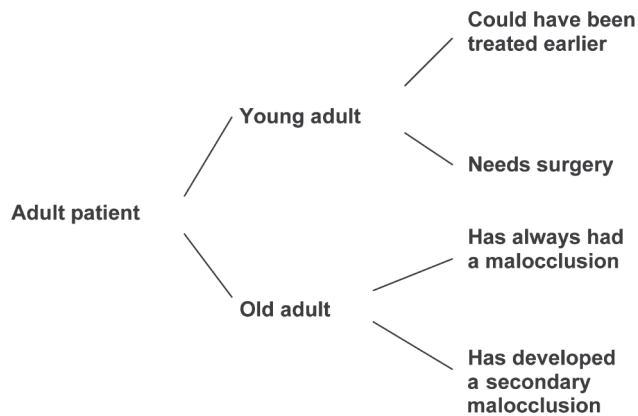


Fig. 1.1 Classification of adult patients.



Fig. 1.3 Extraoral photograph of a young woman whose treatment was postponed until adulthood as a surgical solution was foreseen. The malocclusion had worsened over puberty, but since it was reflecting a family facial pattern, treatment was delayed until cessation of growth.



Fig. 1.2 (1)–(3) An adult patient demonstrating a gradual increase in overjet over time.



(1)



(2)



(3)



(4)

Fig. 1.4 (1)–(3) A slight increase in overjet which did not qualify for publicly funded treatment. The overjet increased over the years and a medial diastema developed, leading to a more severe malocclusion. (4) In addition to the increased overjet, there was extrusion of the upper incisors.

candidates. Another factor contributing to the increased demand for orthognathic surgery is the simplification of orthodontic techniques. The use of pre-adjusted brackets and the ‘Straight-Wire Appliance’ (SWA) has certain limitations and may contribute to the increased indication for orthognathic surgery. When the available mechanics are limited to ‘straight wires’ only, however, for patients in ‘grey zone’, the most suitable treatment option seems to be leaning more and more towards surgery (Burstone 1991).

Lack of availability or financial considerations may also be a reason for not having orthodontics at the optimal time. Third-party payments may have an impact on which children will be offered orthodontic treatment, and in several countries such as Denmark, the percentage of children who will be offered conventional orthodontic treatment is politically determined. Orthodontic treatment will not be performed if the severity of the malocclusion is below the criteria established by law (National Board of

Health 2003), and as a consequence the patient in Figure 1.4 might not be offered treatment today either.

Very few features of malocclusion reduce with time (Harris and Behrents 1988), with both Class II and Class III malocclusions becoming more severe (Figure 1.6). Therefore, if a skeletal deviation which could have been handled by growth modification is left to worsen until growth ceases, the only possible treatment may be a combination of orthodontics and surgery. A reason, although not acceptable, for the increase in the number of patients receiving orthognathic surgery is the fact that treatment comprising orthognathic surgery is frequently paid for by a third party, that is, insurance or public funds. This has led to a preference for a surgical solution in borderline patients who could be treated either with or without surgery. Third-party involvement in orthodontic services may thus result in the unfortunate development of an increase in the number of adult patients needing

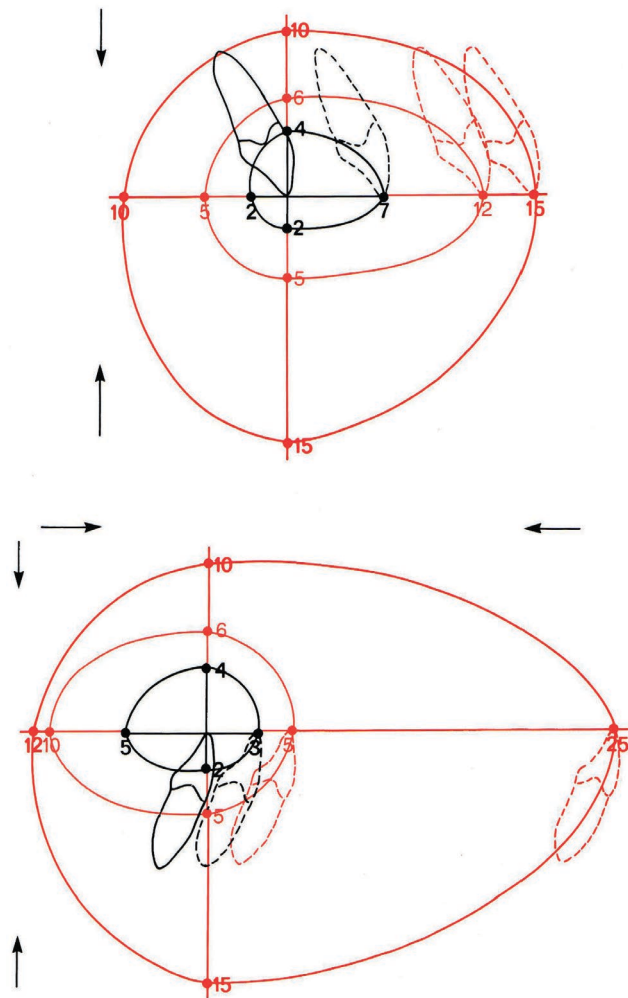


Fig. 1.5 Diagrammatic illustration of the changes in incisor position in growing and non-growing individuals that are possible with orthodontic tooth movement, growth adaptation and orthognathic surgery. The teeth in the centre of the coordinate system illustrate the ideal position. The inner envelope of each diagram illustrates the possible correction that can be obtained by tooth movements alone. It should be noted that the envelope is elliptical in shape, as the limits of movement in the labial and lingual directions are not the same. Labial movement is easier in the maxilla, and lingual movement is easier in the mandible. The middle envelope indicates what can be achieved if orthodontic tooth movement is combined with growth modification. The outer envelope indicates the possibilities of treatment when surgery is performed. (From Proffit [2006], with permission from Elsevier.)

treatment when the indication for treatment depends on the severity of the malocclusion as based on static morphological criteria. Where the percentage of children who can be offered publicly funded treatment is determined politically, the orthodontist has only limited freedom in determining how the resources available should be used in the most efficient way (National Board of Health 2003). As a result, the orthodontist may opt not to treat the most

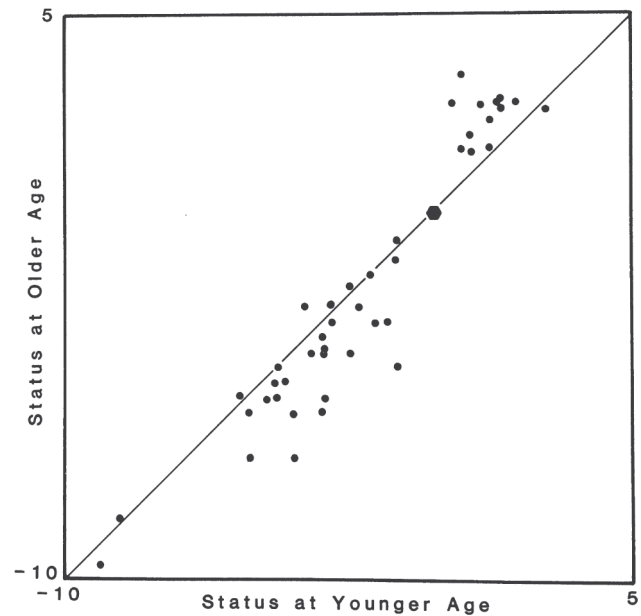


Fig. 1.6 Graphic illustration of the development of occlusion with age. Note that the Class II and Class III malocclusions have worsened. (Redrawn from Harris and Behrents 1988, with permission from Elsevier.)

difficult cases but refer them to surgery, thus shifting the responsibility for these cases to another part of the health service. Excessive tightening of the criteria for reimbursing treatment costs may therefore increase rather than reduce the total costs for the 'third party' in the long run (Mavreas and Melsen 1995).

Older adult patients, over age 40, present with signs of ageing, deterioration or a dentition often characterised by extensive rehabilitation (Proffit 2000). The number of these patients is also increasing and the patients often present with a 'secondary malocclusion', that is, malocclusion that has developed or has worsened in adulthood. This may occur as a result of deterioration of the dentition and the periodontium due to poor dental care. The aetiology of these malocclusions will be dealt with in more detail in Chapter 3.

In addition to age, adult patients can also be classified based on reasons for the first consultation. Some patients may come on their own intuition; others are referred by family or friends or a general dentist. Family and friends may hear about the possible treatments offered by orthodontists or they may have noted an ongoing deterioration in the patient's occlusion, for example, increasing spacing or crowding. Aesthetics plays a major role as a motive for treatment among these patients (Figure 1.7). Functional problems related to speaking (Figure 1.8), chewing or temporomandibular disorder (TMD) symptoms are other motives for seeking orthodontic treatment. The family dentist may also refer a patient because he or she considers orthodontic treatment necessary in order to halt



Fig. 1.7 This patient came with a photograph taken at home and declared, 'I was not aware that my teeth were sticking out that much'.

ongoing deterioration of a dentition or because the present tooth position and/or occlusion do not provide a satisfactory basis for planned prosthodontic rehabilitation (Figure 1.9).

An alternative classification of adult patients could therefore also be based on the chief complaint: aesthetics, function or difficulty in achieving suitable occlusal rehabilitation due to, for example, tooth malposition (Melsen and Agerbaek 1994).

Malocclusions detected by adult patients are generally confined to the anterior teeth and comprise spacing or crowding, often related to changes in the overjet and overbite. Factors of importance for development of secondary malocclusion within the masticatory apparatus are, among others, loss of one or more teeth in the buccal segments and periodontal disease. Both factors influence the internal balance (Figure 1.10).



(1)



(2)



(3)



(4)



(5)

Fig. 1.8 (1) As a young person, this patient had been a singer. (2) With the increase in overjet, this was no longer possible, but it was not until she saw a periodontist that she became aware that something could be done about her occlusion. (3)–(5) The intraoral photographs demonstrated extreme periodontal involvement, elongated clinical crowns following periodontal surgery, flaring of the upper incisors and crowding of the lower incisors.

Box 1.1 Problem list for the patient in Figure 1.8

Chief complaint:

- 'I used to sing, this is not possible anymore. My top teeth are moving.
I do not bite very well'.

History:

- Previous orthodontic treatment with a removable appliance to align the upper incisors.

Problem list:

- Extraoral: Insufficient lip closure, prominent lower lip.
- Function: Lip pressure during swallowing, hyperactive mentalis muscle, inactive upper lip, unstable occlusion, dual bite.
- Dental status: Heavily restored permanent dentition with temporary fillings in some teeth, endodontic treatment of 16 and 25.
- Periodontal status: 30–40% bone loss, but following periodontal surgery, no pathological pockets.
- Tooth position anomalies: Mesial rotation: 16, 17, 23, 25, 27; distal rotation: 24.
- Occlusion: Distal relationship of canines and molars bilaterally, 14 mm overjet, 2.5 mm overbite, scissor bite corresponding to 24, 34; dental midline discrepancy, with the lower incisors off the midline compared with the upper.
- Space relationship: upper arch: spacing of 4 mm; lower arch: crowding of 3 mm; deep curve of Spee.

Box 1.2 Treatment goal for patient in Figure 1.8

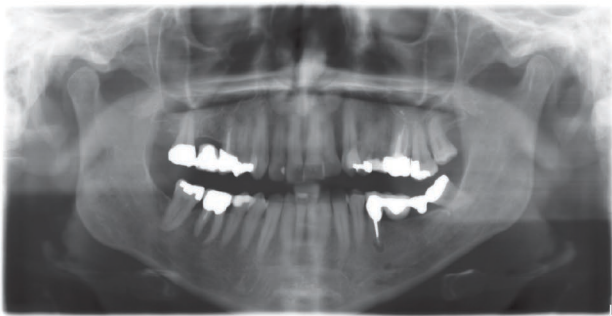
Treatment goal

- Function: To find the structural position of the mandible, prepare for occlusal onlays to facilitate lip closure, making it possible for the patient to sing again.
- Occlusion: Close spaces in the upper arch by retraction and intrusion of the incisors, expand sagittally to align in the lower arch. Reduction of the overjet to achieve incisal contact. Correction of scissor bite by buccal movement of 44 and of the midline discrepancy by differential space closure.
- Maintenance: Cast upper retainer optimising the load transfer to the upper anterior teeth.

How do the patients express their needs?

Some adult patients indicate that they have desired treatment for some time, but for various reasons, it had not been possible – some would have grown up in areas where orthodontic services were not available; others would not have received treatment for financial reasons. With increasing availability of orthodontic services, the first type of adult patient may be less prevalent in the future. The increased sensitivity to deviation in appearance within many societies will eventually lead some patients to seek treatment (Lazaridou-Terzoudi et al. 2003). Appearance is becoming increasingly more important and the level of deviation from socially determined norms is reducing. This tendency is reflected in the increased desire for aesthetic treatment, including cosmetic surgery, orthodontics and aesthetic dentistry (Schweitzer 1989a, 1989b; Nathanson 1991; Matarasso 1997; Figueroa 2003).

Some patients who did not perceive a need for treatment earlier will, as a result of continuing deterioration of the dentition, find themselves no longer satisfied with the function or the appearance of their dentition. Some of these patients may have been treated earlier, but were not aware of the possibility for treatment or did not perceive a need for it until recently (Figure 1.11). The individual level of acceptance varies greatly. The mere thought of having to wear braces keeps some patients from consulting the orthodontist. Awareness of this problem within the profession has led to the development of various attempts to reduce or even totally avoid visibility of the necessary appliances. Placement of the appliances on the lingual side has been one way of preventing their being seen. Smaller-sized or transparent brackets have also made labial appliances more acceptable. The introduction of Invisalign® reflects the desire to develop and use orthodontic appliances that are not seen while in the mouth (Smith et al. 1986a, 1986b; Fontenelle 1991; Bishara and Fehr 1997; Sinha and



(1)



(2)

Fig. 1.9 (1) and (2) This patient had a bridge to replace the left first and second lower molars. The bridge was made after the upper molar had overerupted and the third molar had tipped mesially. The adverse direction of loading of the bridge led to fracture of the second premolar. The patient then required orthodontic treatment in addition to three implants. This could have been avoided had the bridge been fitted soon after the extraction.



(1)



(2)

Fig. 1.10 (1) Patient who had 'always' had a diastema. However, it increased in size following the extraction of two lower molars. (2) Situation 2 years later.



(1)



(2)



(3)

Fig. 1.11 (1)–(3) This patient brought in a series of personal photographs clearly demonstrating the development of a malocclusion. It was, however, not until the dentist explained that an incisor was at risk, but no replacement was possible due to the diastema that the patient requested treatment.

Nanda 1997; Norris et al. 2002; Vlaskalic and Boyd 2002; Wong 2002; Bollen et al. 2003; Joffe 2003; Wiechmann 2003; Wiechmann et al. 2003; Wheeler 2004; Eliades and Bourauel 2005; Nedwed and Miethke 2005; Turpin 2005). It is well known that most minor malocclusions become more pronounced with increasing age (Harris and Behrents 1988; Baumrind 1991).

The first visit

At the first consultation, on the one hand, adult patients may seem insecure due to lack of knowledge regarding the aetiology of their malocclusion and the available treatment alternatives. They are, on the other hand, conscious regarding their desire to improve the appearance or function of their teeth, but there may be some doubts and even a reluctance to undergo orthodontic treatment.

How can the orthodontist advise such patients?

Which malocclusions require orthodontic correction? Only scarce evidence indicates a relationship between the existence of a malocclusion and the prevalence of other dental

problems such as caries, periodontal disease and gnathological problems (Gher 1998).

On this basis, how can the orthodontist give appropriate advice to the patient? Recently Johnston (2000) proposed that a need for treatment in this group of adult patients is not identical to the demand for treatment, and that the demand for improved aesthetics would usually be the main reason for undertaking treatment. This implies that the priority given by an individual patient to aesthetics determines his or her need for treatment. The present author does not share this opinion. The reasons for seeking an orthodontic consultation are often: fear of losing teeth; lack of the possibility of a fixed prosthodontic solution or functional problems. In any case, it is important to inform the patient of the likelihood of further deterioration of the malocclusion if left untreated.

Even a patient given adequate information may refrain from having treatment. If the patient is in doubt, it may be advisable to produce a set of study casts, preferably digital, and then observe the changes over one or more years. Based on the changes seen, the patient can then reconsider whether to initiate orthodontic treatment (Figure 1.12). Another

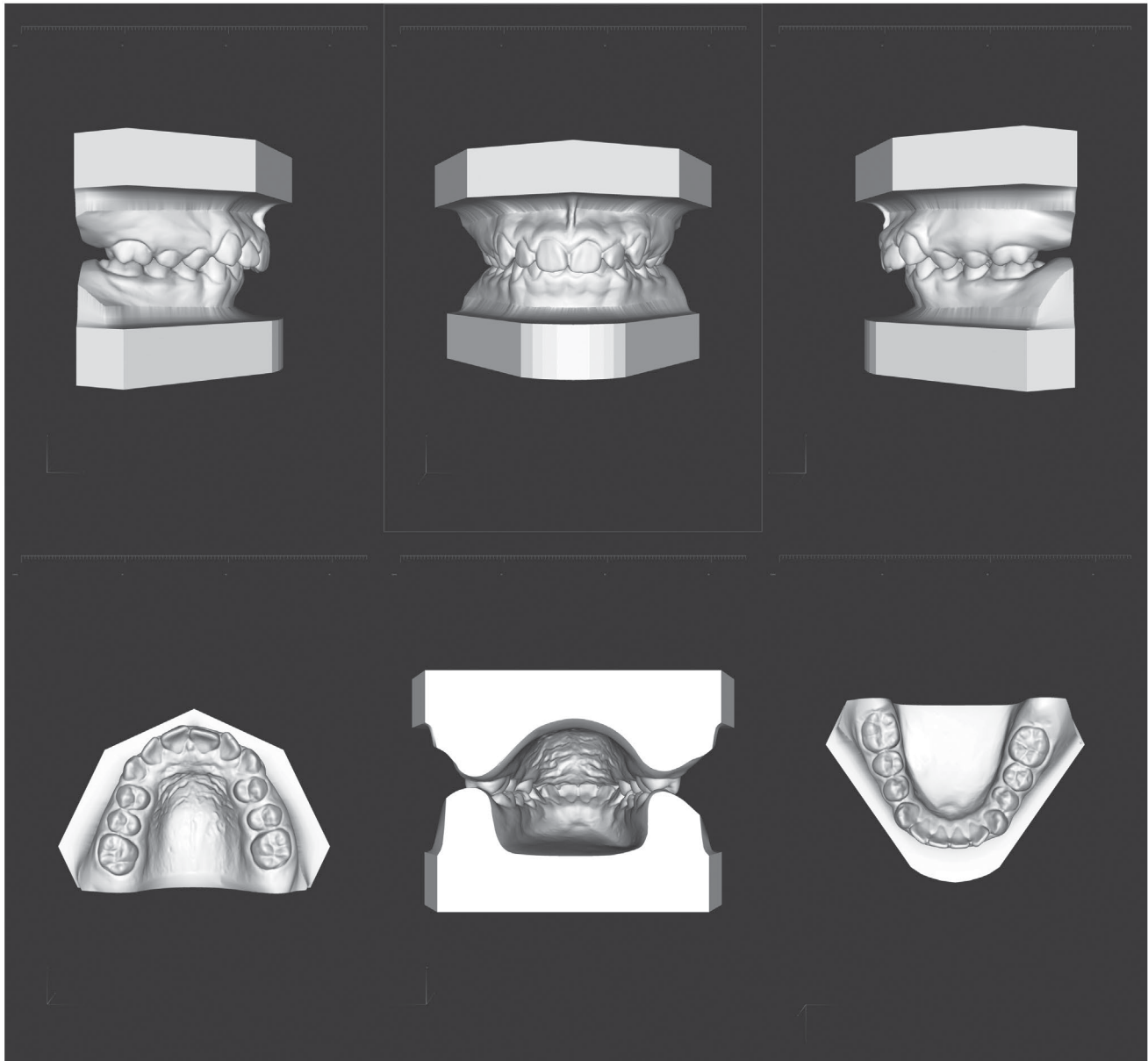


Fig. 1.12 Virtual models. Images can be printed or downloaded by the patient at home where she or he can discuss the problems with family and friends and also follow the eventual deterioration of the occlusion over time.

approach is to ask the patient to present with personal photographs from over his or her lifetime, which could illustrate the development of the malocclusion. Changes within the dentition occur slowly and it is often only when seeing together pictures taken after long intervals of time that patients realise what is happening.

Other patients will have noted changes in their dentition, and will describe either deterioration of a previously acceptable malocclusion or the development of a secondary malocclusion in relation to the loss of one or more teeth or periodontal disease. They may request intervention to prevent further development or treatment that can restore

the original occlusion. Should we fulfil this request or even establish an occlusion that is better than the original? Do these patients really need orthodontic treatment?

The event that triggers the patient to seek treatment may differ from patient to patient. The problems most frequently mentioned are related to flaring of the front teeth. A patient may have had an increased overjet as long as they can remember, but slow and gradual worsening, and the development of an anterior diastema, makes the situation unacceptable. A photograph taken at a social event may be the primary trigger (Figure 1.7). Comparison of this image with an earlier photograph would clearly demonstrate the

aggravation of the situation and the patient may decide to seek treatment to stop this, or they may at least seek advice from an orthodontist.

Communicating with the patient

The first visit to the orthodontist may result in conflict (Kalia and Melsen 2001) between the orthodontist and the general dentist, between the patient and the orthodontist or even between the patient and the general dentist. The orthodontist may wonder why the patient was not referred earlier and remark on the rehabilitation that has been done so far, and even indicate that this may interfere with the solution considered best by the orthodontist. If the orthodontist approaches the general dentist for information on the patient's dental care and recent development, the



Fig. 1.13 The patient's main problem was the flared incisor. The patient was not aware of the deep bite and the crowding in the lower teeth.

general dentist may well consider it undesirable interference, especially when the patient consults an orthodontist without a referral from their general dentist. It may, however, also occur if the patient is referred to the orthodontist from the general dentist, but without sufficient information of the situation. The general dentist may not have worked up a comprehensive problem list, but used a single symptom as the basis of referral to the orthodontist. If the patient also perceives the cause of referral as a minor problem, the orthodontist's explanation of the situation may generate a problem. The patient in Figure 1.13 was referred for flaring of a single incisor without their being aware that this may be related to crowding in the lower jaw and a deepening of the bite. The patient may react negatively to the information about the complexity of the problem and confront their general dentist with the new information; this may create conflict between the patient and dentist. The patient may feel that he or she has been misinformed by the general dentist and therefore even choose to change their family dentist, or the patient may perceive the complexity of the problem as an overreaction from the orthodontist's side. This is particularly difficult in cases where previous prosthodontic work has to be redone following the treatment suggested by the orthodontist (Figure 1.14).

An orthodontic consultation may thus result in problems between the colleagues involved in the treatment. This can be further aggravated when a third colleague is consulted, for example, a periodontist, who may find that insufficient periodontal maintenance has contributed to the present situation. Neglect on the part of a colleague who has been taking care of a patient in the period when a secondary malocclusion has developed may result in negative feelings between the patient and the involved dentist.



Fig. 1.14 A group of colleagues discussing possible treatment options with a patient.

The scenario that an apparently small problem can be a sign of a severe condition often occurs in other professions as well: 'The strange noise in my car proved to be the sign of a gearbox breaking down'. Pain in the arm can temporarily be alleviated with analgesics, but it may be a symptom of a severe heart condition. In the medical profession, it is not unusual to find patients with a simple problem where it turns out to be a symptom of a more complex disease. Why does it then seem so difficult for the dental profession to accept such a diagnosis?

In order to avoid conflicts related to adult patients, close teamwork between dental colleagues, maintaining a high level of communication, should be established. The information given to the patient by different colleagues should not be contradictory. The consequences of failing to give or giving insufficient information can lead to neglect on the patient's side; for instance, insufficient interest in replacing a tooth that was extracted.

A crucial requirement in relation to treatment planning where multiple disciplines are involved is agreeing on a common problem list and treatment plan in which there are no disagreements among the colleagues involved. Possible and unavoidable differences of opinion should be discussed, but never in front of the patient. The final problem list and the treatment plan agreed by all specialists should then be communicated to the patient and all dental colleagues involved.

The patient may desire a more detailed explanation of both the problem list and treatment plan (Boxes 1.1 and 1.2). This should be carried out by the team member who is in closest contact with the patient or by the one bringing the team together. The level of information must be the same among the team members and all data of importance for the treatment decision should be presented to the patient in a diplomatic way. When explaining the problem and possible treatment options to the patient, it is of the utmost importance also to explain the consequences of completing versus not completing the treatment.

Summary

Adult patients consulting the orthodontist present with a large variety of problems and a dentition often characterised by deterioration and extensive rehabilitation that may make treatment planning complicated. In most cases, the treatment will have to be done as a team approach because periodontal, functional and prosthodontic problems also have to be taken into consideration. The importance of good communication both between the involved team members and between the patient and the clinicians cannot be sufficiently stressed. Sharing information on the various treatment options with various specialities will improve the likelihood that patients receive the best possible outcome (Figure 1.14). It is, when explaining the treatment options to the patient, important to make it clear that all treatment

results have to be maintained. The patient should not expect stability, but be aware that maintenance is important.

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