

Your practice is loaded with malocclusion and crooked teeth. In an earlier edition of Visions, I defined malocclusion as a misalignment of the maxilla and mandible, regardless of the position of the teeth. To emphasize, a patient can have a gross malocclusion even with perfectly straight, Angle Class I tooth relationships. On the converse, crooked teeth do not necessarily mean that the jaws are misaligned. So in the former situation, orthodontic treatment is necessary to functionally correct the malocclusion to a physiologic position. In the latter, orthodontic treatment is sought to cosmetically straighten the teeth, but care must be taken so as not to introduce a misalignment of the jaws. In other words, to not straighten the teeth and inadvertently create a malocclusion.

It goes against conventional wisdom with regard to what most of us have been taught since dental school, which is that straight teeth are equivalent to a good occlusion.

At LVI we teach that phase 1 treatment is complete when we have stabilized the occlusion with an orthotic and symptoms are reduced as much as possible. Depending on the extent of occlusal correction needed, phase 2 treatment can be completed with something as conservative as coronoplasty to something as involved as a full mouth prosthodontic reconstruction. But for everything in between, orthodontic treatment is the treatment of choice. Additionally, many cases can benefit from combination therapy whereby orthodontic treatment is followed by limited prosthetic procedures such as crowns and onlays for worn teeth. This results in a very stable occlusal scheme that is finished as conservatively as possible. Preparing teeth for crowns and onlays is second nature to dentists. We unholster the hand-piece and use it every day. Orthodontically moving teeth, however, is a much different discipline, unrelated technically to what we are comfortable with in a general dental practice. For that reason, the thought of providing orthodontic treatment can be unnecessarily intimidating. If you asked me when I finished dental school if I thought that I would be doing ortho in my office, my answer would have been a resounding "No!" Remarkably, that is the same answer I would give today if I were asked if there are any offices that should not offer orthodontic treatment in their practice. I will go so far as to say that delivering orthodontic care is an absolute necessity if you perform any amount of reconstructive treatment in your practice and if you have a successful basic restorative practice, you owe it to your patients to take orthodontic courses so that you recognize the need for orthodontics and refer appropriately. Every dentist needs to know what correct orthodontic treatment looks like just as they need to recognize when a good root canal has been done or a good implant placement has been done even if they don't perform the procedures. But why not add orthodontic treatment as an option in your practice?

## There are many great reasons to offer comprehensive orthodontic treatment in the general dental practice:

• Many adult patients prefer staying in your office rather than going to an orthodontist's office where the waiting room is filled with children and teenagers.

• When the economy is down parents may forgo their own dental treatment but they still make sure their children receive orthodontic care.

• When the economy is up, parents pursue orthodontic treatment themselves.

• For half the cost of a full mouth reconstruction, case acceptance is higher for patients who are offered a combination of orthodontics and prosthodontics to correct their occlusion.

• With proper training and just one operatory dedicated to orthodontics, practice production can dramatically increase with possibly as little as a total of two hours of doctor time per case for the entire duration of the treatment

There are so many patients in need of

orthodontic care that most dentists can get started inexpensively with marketing that is exclusively internal. Over the course of just one week, count the number of patients you see in your hygiene practice that can benefit from orthodontic treatment. If you can convert just one of those patients a week, you are looking at an increase in production of well over one hundred thousand dollars.



### FIGURE 1

This 11 year old male who presented for orthodontic consultation displayed open mouth habitus at rest as well as multiple other facial features indicating a chronically obstructed airway.



### **FIGURE 2**

High palatal vault, collapsed arch, and dental impaction in the same patient as figure 1 are more signs of a significant airway obstruction. In addition to tonsillectomy, adenoidectomy and growth directed physiologic orthodontics, myofunctional therapy is imperative to prevent orthodontic relapse.

# "The eye cannot see what the mind does not know."

The Beginners Orthodontics class at LVI is a great way to get started in Physiologic Orthodontics. It is designed for those dentists that have little to no experience with comprehensive orthodontics. The course covers all of the basics needed to get orthodontics up and running in your practice: diagnostics, instrumentation, mechanics and case finishing.

Diagnostics: It is important to not only evaluate the current clinical condition, but also determine the historical root cause of the malocclusion and teeth misalignment. Diagnostic information is gathered from cephalometric tracings and model analysis which measure vertical, transverse and sagittal space deficiency and availability. Models properly mounted to the hamular notch-incisive papilla plane (HIP) allow evaluation of maxillary cant. A basic photographic series helps determine postural discrepancies that not only contribute to malocclusion but also can compromise the stability of finished orthodontic cases. But there is no bigger risk for instability than airway and Myofunctional compromise. They are, in my opinion, THE ROOT CAUSE of malocclusion. A bad airway leads to a bad swallow which results in malocclusion. See Figures 1 and 2. Specifically, there are three conditions that must be evaluated before, during and after orthodontic treatment:

bracket design, wire metallurgy and a better understanding of controlled tooth movement and skeletal growth have streamlined treatment. Predictable case finishing is better than ever when basic protocols are understood and followed.

The best summary is the anonymous quote: "The eye cannot see what the mind does not know." Properly diagnosing a patient before any treatment is initiated is more critical to orthodontics than the appliances, brackets and wires. Too many finished cases have malocclusions camouflaged by very straight teeth with a midface that is still deficient, the maxillary arch still canted and the airway still corrupted. Getting started in orthodontics is easy. Look at every patient in your own practice and evaluate them with regard to "The Big Three." Those with dysfunction are your potential orthodontic patients. Look in your own practice and you will see hundreds of cases just waiting for treatment.

Beginner Orthodontics: Physiologic Orthodontics Level 1 May 12-14, 2016 www.lviqlobal.com/beginners-orthodontics-physiologic-orthodontics-level-1

1. Nasal patency with nasal breathing.

- 2. Proper lip seal
- 3. No tongue habits

These are "The Big Three" that must be addressed with Myofunctional therapy to ensure orthodontic success and to prevent orthodontic relapse. Dr. Heidi Dickerson's course, Orofacial Myofuntional Disorders and Myofunctional Therapy is an absolute necessity for anyone who has patients that breathe, and certainly for dentists that provide orthodontic care.

### Instrumentation, Mechanics and Case Finishing:

The days of two-year treatment plans with extractions, headgear, multiple removable appliances, and utilization of dozens of wires and changing and bending wires monthly are long gone. Innovations in Orofacial Myofunctional Disorders (OMD) and Myofunctional Therapy

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"We make a living by what we get, but we make a life by what we give." WINSTON CHURCHILL

