Virtual reality and orthodontics: A new patient experience

By Dr Yassine Harichane, Canada

Imagine the following scenario: your patient arrives, both relaxed and calm, at your practice. Although the patient is visiting the practice for the first time, he is familiar with it and knows its interior well. Without further introduction, the patient takes a seat in the dental chair, and the orthodontic procedure is performed quickly and comfortably with patient compliance. There are no complications or tension, and the treatment is easily achieved. Imagine such a soothing and comfortable environment in which to treat patients. Now imagine this very same scenario through the eyes of the patient. One can see that it could actually be a comfortable experience. This is not some hypothetical futuristic utopia; this is actually happening now, and the aforementioned points are some of the many benefits of virtual reality (VR).

VR is a process that entails immersing the viewer in a 360° environment. By turning his head left, right, up or down, the patient can visualise a real or an artificial environment. The spectator could be immersed in the Caribbean Sea surrounded by corals or in a Canadian forest (Fig. 1). The operation is simple: the participant wears a lightweight and comfortable headset in which a smartphone is inserted (Fig. 2). Owing to the gyroscopic sensors, the smartphone will project a matching image corresponding to the movements. If the patient raises his head, he will see the sky or the ceiling, and if he lowers his head he will see his feet. This technique is made possible by a 360° shot using a dedicated camera (Fig. 3) and simple editing software (Fig. 4). The result is simply astonishing as we find ourselves projected into a place that may vary from actual tourist sites to virtual scenarios as in video games. The applications in orthodontics are numerous and at present we are exploiting only a tiny part of its potential functions. The possibilities might be endless. Hence, it might become possible for the patient to visit the dental office from his home, where he can visualise the front desk, admire the treatments rooms or view the cleanliness of the sterilisation room (Fig. 5). The aim is to offer a virtual visit of the practice to allow the patient to choose a quality clinic, as well as familiarise himself with the space before his first appointment. Once physically seated in the chair, the patient can wear the VR headset during the treatment and visualise a restful environment of his choosing. From
Use of diode laser in the treatment of gingival enlargement during orthodontic treatment

Case report

By Prof. Carlo Fornaini, Dr. Aldo Oppio, Luigi Cella & Elisabetta Menigo, Italy

Introduction

In recent decades, we have witnessed the substantial development and expansion of the use of fixed orthodontic appliances. While their application has many advantages, several problems related to the health of the soft tissue may sometimes appear during treatment. In fact, the use of fixed orthodontic appliances may provoke labial desquamation, erythema multiforme, gingivitis and gingival enlargement.1

Gingival enlargement is a very common complication during orthodontic treatment, but fortunately, it seems to be transitory and generally resolves after orthodontic therapy, even if sometimes incompletely. Gingival overgrowth induced by orthodontic treatment shows a specific fibrous and thickened gingival appearance, different from fragile gingiva with marginal gingival redness common in allergic or inflammatory gingival lesions.2

Several clinical studies suggest that orthodontic treatment may be associated with a decrease in periodontal health, causing a hypertrophic form of gingivitis. However, the actual pathogenesis of gingival enlargement is not yet completely understood, although probably involves increased production by fibroblasts of amorphous ground substance with a high level of glycosaminoglycans. Increases in mRNA expression of Type I collagen and up-regulation of keratinocyte growth factor receptor could play an important role in excessive proliferation of epithelial cells and increased development of keratinocyte proliferation.

Fig. 1: Clinical view, showing gingival enlargement, just before the debonding procedure.

Fig. 2: Application of a topical anaesthetic.

Fig. 3: Surgical laser-assisted treatment via laser gingivectomy.

Fig. 4: Clinical view just after surgery.

Fig. 5: Healing five days after surgery.

Fig. 6: One month follow-up.

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The role of 3-D imaging systems in present orthodontics

By Dr Enrique Gonzalez Garcia, Mexico

Abstract

Traditionally, the diagnosis in orthodontics gives a lot of importance to cephalometry and the analysis of the dental casts. The development of new technologies does not intend to discard traditional concepts, in fact, it intends to provide more information allowing a wider approach of our patients and resulting in a more thorough diagnosis.

Introduction

Adapting to new three-dimensional concepts is not an easy task and is even harder considering that the information is so vast that it can result overwhelming. That is why when evaluating a patient for orthodontic treatment, it is intended to use a systematic method so that we can obtain the most essential information that these methods provide.

Case report

A 14-year-old female patient was referred to our department by the orthodontics unit because, at the end of fixed orthodontic treatment, she had developed gingival enlargement in the upper arch (Fig. 1), related to the fast closure of the spaces associated with very poor oral hygiene due to bleeding during toothbrushing. Just after the removal of the appliance, a topical anaesthetic (EMLA, AstraZeneca) was applied to the gingiva (Fig. 2) and a gingivectomy was performed using a diode laser (XD-2, Fotona) according to the technique of removal of the inner dental papilla (Fig. 3). The parameters used were as follows: a wavelength of 980 nm, continuous wave, a 500 μm fibre in contact mode. The intervention had a duration of 475 seconds, and the patient did not feel any pain (Fig. 4). After the intervention, the patient did not take any kind of pain medication, and the healing process was completed in five days (Fig. 5).

Discussion

The first laser appliance was built by Maiman in 1960, and some years later, it was successfully employed in medicine and in oral surgery with several advantages. It may provide excellent incision performance with sealing of small blood and lymphatic vessels, resulting in haemostasis and reduced postoperative oedema. Furthermore, target tissues are disinfected as a result of local heating and production of an eschar layer, which results in a decreased amount of scarring owing to decreased postoperative tissue shrinkage, allowing one to avoid the use of sutures.

Diodes, the last generation of laser used in dentistry, have several advantages, such as reduced cost and size, and offer the operator the possibility to work both in continuous and chopped mode. Based on our experience, we can confirm that this technology may represent a new approach to the resolution of gingival enlargement during orthodontic treatment, with better comfort for the patient during and after surgery.

General visualisations

To perform a general exploration, it is necessary to know the three anatomical planes: coronal plane, sagittal plane and axial plane.

Coronal plane (Figs. 1 & 2)

The coronal plane is located in the anterior part of the face, approximately parallel to the buccal surfaces of the anterior teeth. It divides the skull in two, anterior and posterior structures.

Sagittal plane (Figs. 3 & 4)

The sagittal plane divides the skull in two symmetrical parts. It has a transversal orientation allowing examining two segments: right and left.

Axial plane (Figs. 5 & 6)

The axial plane is parallel to the floor and the occlusal plane. It divides the skull in two equal parts: superior and inferior, allowing the view of structures from top to bottom and bottom to top. The overview of these three anatomical planes should give the specialist a complete exploration of the 3D anatomy. The result is a deeper knowledge of the anatomy of the patient or, like in some cases, a number of findings that might result in the modification of our treatment plan.

Teeth and surrounding bone structures

For obvious reasons, one of the main areas to check is the dental zone. Images that allow to check the teeth that are present and the ones in process of eruption, if that is the case, should be generated. As well as the characteristics of the adjacent bone and even take some numeric references.

Airways and paranasal sinuses

Breathing is the foundation of life. CBCT scans offer a precise visual of the airways and surrounding craniofacial structures that influence them, such as the mandible, palate, paranasal sinuses, facial relations, adenoid
Tissue, tonsils and more. This view of the airway completely changes the perception of the specialist and, most important, the life of the patients.

Soft tissues

The evaluation of the soft tissues in a three-dimensional system and without magnification is ideal for the orthodontist because he/she can now evaluate the patient fully with one exam, completely changing his perspective. Previously, with 2-D images we only had the possibility of making an unilateral evaluation of the skull and structures unless, of course, several X-rays were taken and complementary analysis in each of them. The other option was performing photographic analysis to see the facial aesthetic from different photographic angles and requiring a major number of shots that surely resulted difficult for the patient. The diagnostic evaluation with 3-D systems allows in one exam to evaluate the patient from the angles necessary as well as evaluating the soft and hard-tissues resulting visually stunning and attractive for the patient, being this extremely positive considering that the patient has a better understanding of his/her aesthetic problems and how the specialist will proceed to eliminate them.

Temporomandibular joint

The TMJ is, by definition, a ginglymus diarthrodial complex joint. This complexity is reflected in the knowledge and importance that each professional gives it. There are a number of specialists for who the TMJ is remote from the teeth and does not interfere with orthodontic treatment. On the extreme opposite side, for the other group of specialists, the TMJ is the foundation on where they base all their treatments. Whichever concept the doctor has on this, the evaluation of the TMJ should be included in the diagnosis.

Conclusion

The specialist cannot be unaware of the constant advances in technology. Of course, these developments have to be taken in moderation and with responsibility because it does not substitute the knowledge acquired during ones professional training and even less the experience obtained from treating patients. Needless to say, an effort is required for the training and understanding of these new systems but such systems are every time easier and perceptibles and the quality, quantity and usefulness of the information it generates is unquestionable. It is important to remember the concept that we are healthcare providers and our goal is more than to just straighten teeth. Therefore, it is mandatory to diagnose our patients fully and when necessary, seek consultation from other specialists, since nowadays a great number of our patients require multidisciplinary treatments.

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Can we treat patients in fewer visits?

By Dr Skander Ellouze, Tunisia

“We live very far away, in the Congo, but we come to Tunis twice a year, in December and August. We would like you to be our children’s orthodontist, and sincerely hope that you will accept them as your patients.”

After a review of the patient’s records and a brief period of reflection, I decided to begin treatment for T., aged 13 (the youngest sibling required no treatment at that time). The patient would be seen only twice a year during his holidays in December and August.

What was the total length of treatment?
The treatment lasted 22 months and required 5 visits, including the bonding and debonding appointments. In modern orthodontics, we are continuously striving to adapt to a changing world and to respond to emerging needs (comfort, esthetics, hygiene, etc.). Minimizing time commitments during the treatment process (shorter treatment duration, fewer visits) is an important part of this development. Aligner treatments have already started to emerge in this trend, sometimes limiting patient visits to those required to begin and end treatment. Is it possible to monitor long-distance patients undergoing multi-band treatments?
The light, passive force of the Damon System brackets has helped to move the industry forward in this direction. In fact, with the Damon System, increasing the time between appointments is strongly recommended during the alignment/levelling phases. This enables the force system to act “gently” on the periodontal complex.

This raises two key questions:
Is it possible to take this concept even further?
Imagine being able to provide treatment to patients in just a few appointments, with the added benefit of:
• enabling patients (children and adults) to reduce the number of visits to the office to just 4 to 5 over the course of their treatment.
• reducing wait times as well as the number of calls and reminders managed by office staff.

How do we keep this approach from having a negative impact on the quality of treatment?
This article offers ideas and provides a starting point. It introduces the possibility of rethinking the appoint ment schedule for orthodontic treatments, which—in addition to saving time—opens up new opportunities:
• for patients, by more easily offering them a greater choice of practitioners (Patients would no longer have to choose a less favorable practitioner based simply on the proximity of his or her office in order to make it to monthly appointments)
• for practitioners, by enabling them to more confidently take on a growing number of long-distance patients.

Combining these new fixed appliance treatment modalities could establish an entirely new standard.

My thoughts
We now have the possibility of managing our offices based on this “spreadout” scheduling, with fewer visits to the chair. It can be implemented in the majority of cases, with a few minor exceptions such as those involving impacted teeth. Without this possibility, we would be forced to turn away patients, with whom a good relationship had already been established, and to make sometimes risky patient referrals.

Such a treatment is typically completed in 4 to 6 appointments spread over 6 to 12 months, without having a negative impact on the final outcome. In fact, these long breaks between visits can even be beneficial in terms of tissue integrity.

CASE NO 1
T.F. was 13 years old at the time of his first visit

Diagnosis
Class I inci-cal-canine crowding in both arches
Class II long face syndrome, hypodivergent
Retrusion chin
Presence of wisdom teeth buds

Treatment Plan
Non-extraction treatment
Alignment - levelling
Obtain a functional occlusion and accentuate the smile arc.
VISIT NO 1
Both appliances bonded on the same day.
SAP bracket placement

Torque Selection
Maxilla: Super low torque on the incisors – super torque on the canines.
Mandible: Low torque on the incisors – super torque on the canines.

014 CN archwires were placed along both arches, from the 1st molar to the 1st molar, without stops.
Bite turbos were bonded to 13 – 23 in order to unlock the occlusion, promote leveling, and protect the brackets on the lower arch.

VISIT NO 2: 4 MONTHS
The patient returned 4 months later. The arches showed excellent initial progress in terms of leveling.

New 014 archwires were placed to continue the leveling-alignment process. Anterior stops were placed on both arches.

VISIT NO 3: 10 MONTHS
Ten months into the treatment, the 014 archwires were kept on, and both arches showed excellent progress in terms of leveling-alignment. Crowding was fully resolved.

A panorex was done to confirm the proper placement of the initial brackets.

Only the maxillary central incisors (whose roots showed significant proclination) were rebonded with standard torque brackets.

Both arches were fitted with 16x25 CN archwires, and the bite turbos were gradually reduced.

VISIT NO 4: 14 MONTHS
It was as if time was doing the work for us. After just 2 visits over 14 months, a remarkable correction was observed in all 3 orders.

Nonetheless, 13 was repositioned to provide a more gingival placement and to correct tipping (see the panorex taken 4 months earlier, which shows an excessive tip-back of this tooth).

For the maxillary arch, the 16x25 CN archwire was replaced with an 18x25 CN archwire, and the mandibular arch was fitted with a 17x25 TMA archwire. The patient was also required to wear vertical intercuspation elastics on the upper canines.

The bite turbos were removed completely during this appointment.
VISIT NO 5: 21 MONTHS
Seven months later, the family returned to the office over the summer break.
A long appointment was scheduled to—if all went well—remove the appliances
and put a retainer in place. The day of the visit, the decision was made to proceed.
When I announced that the treatment would be completed that day, the patient
and his parents had quite a memorable reaction: “Already? It went so fast! Thank
you! He is going to have the best summer break!”
The results, although not perfect, were remarkable. The end-of-treatment re-
cords clearly show good tissue quality (periodontal and root integrity), undoubt-
edly thanks to the use of minimal force with long rest periods, a minimal number
of archwires, and bonding which allowed for continuous improvement through-
out the entire treatment, from beginning to end.
That same day, we began treatment for the youngest sibling, using the same
protocol.

VISIT NO 6: POST-RETENTION PHOTOS +12 MONTHS
Today, 37% of my patients fitted with multibracket appliances are non-residents,
meaning they live in another country, or even on another continent. These treat-
ments would be impossible without this new flexible scheduling.
Even with these new treatment modalities, a certain level of precaution and or-
ganization is required in order to ensure continuous improvement (the promise
touted by each new system on the market today):
• An appropriate prescription for the anterior torques.
• A SOLID bonding protocol (brackets and bite turbos) that eliminates the risk of
bond failure almost entirely.
• Extremely precise brackets placement, reducing the need for repositioning.
• Biomechanical foreplanning: sufficient wire supply for leveling – proper place-
ment of stops – lasting activation devices (coils, for example, rather than power
chains) – anticipating biomechanical effects with the use of mini-screws, etc.

CASE NO 2
This patient, aged 15 years, was treated in 5 visits spread over 31 months.
These photos show the treatment stages and the intervals between appoint-
ments. A Damon System was used to treat this case of a Class III malocclusion,
with incredible results observed in the teeth and facial features.

CASE NO 3
This “spread-out” scheduling approach can also be applied to treatments involving extractions. In this case, the patient
moved to Canada in the middle of her treatment (at 11 months), still with several spaces left to be closed. Having already
undergone an initial 3 year treatment (see photos), the patient wanted to remain with the same orthodontist and agreed
to travel from Canada every 6 months to continue her treatment.
After moving away, she was seen just 3 more times, including the debonding appointment.
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- Orthognathic Patients
- Digital Analysis & Treatment of sleep apnea cases

KEYNOTE SPEAKERS

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