Functional & Cosmetic Excellence: Revitalization of a Proven Treatment Philosophy

By Dr. Straty Righelli, USA & L Douglas Knight, USA

Functional and Cosmetic Excellence (FACE Tx)® is an approach to orthodontic treatment that establishes measurable treatment goals for six elements that form the basis of comprehensive, interdisciplinary, high-quality orthodontic care:

• Functional occlusion
• TMJ health
• Facial balance
• Optimal dento-gingival esthetics
• Periodontal health
• Stability

For each of these goals, the original teaching staff of the FACE Tx has defined specific elements that create a framework for the systematic evaluation of the esthetic and functional needs of each patient and a method to assess treatment results. These treatment goals are supported by reputable studies published in well-respected, peer-reviewed journals. Sharing these goals and the means to achieve them with an interdisciplinary team—the orthodontist, the dentist and/or other specialists—provides you, the orthodontist, an opportunity to work with esteemed colleagues to create outstanding results for beauty, health and function.

Building successful practices is an important side benefit of this approach. Developing the skills required to manage and function within FACE Tx interdisciplinary treatment teams increases the complexity of cases one can treat. The collaborative interaction with experts in their respective fields (prosthodontists, periodontists, cosmetic and general dentists and surgeons), who ascribe to the same principles of tooth positioning and jaw function, creates a knowledge base to treat to predictable, on-time, optimal results while meeting and/or exceeding patients’ expectations. As a result, one’s referral network expands with r
cultus to use that will offer patients choices that the FACE Tx teaching faculty shares general techniques about how to adapt course instruction to clinical practice. There are several keys to successful treatment outcomes:

1) See everything before you begin

Figure 1a-d. The elements of a mutually protected occlusion: (a) optimal overjet and overbite in centric occlusion; (b) right working excision; (c) right balancing excision; (d) right protrusive excision

Worldwide Program of Instruction

FACE Tx offers one of the world’s only postgraduate interdisciplinary continuing educational programs. Offered in numerous countries to university-trained orthodontists, it provides didactic instruction and hands-on experience. Through a series of 5 to 7 one-week sessions, a team of established educators and practitioners convey this unique curriculum. The associated FACE Tx fraternity incorporates a lifetime learning forum for thousands of doctors who have adopted FACE Tx principles to their practices.

The FACE Tx teaching staff builds on each participating clinician’s knowledge base. The full-time faculty—Dr. Jorge Ayala (Santiago, Chile), Jeffrey McDonald (New York, USA), Straty Righelli (California, USA), and Carl Roy (Virginia, USA)—will manage active private practices and have extensive educational and clinical experience. The teaching faculty composes considerable years of skills and knowledge to formulate the FACE Tx approach to diagnosis, treatment planning and execution.

Defining Functional Occlusion, Smile Esthetics and Facial Balance

A number of orthodontic disciplines specify functional occlusion as a primary treatment goal, but few articulate its measurement or, for that matter, incorporate gnathological measurement protocols. Dr. Domingo Martin defines functional occlusion by what it is as well as what it is not. (See above.)

While functional occlusion serves as the foundation for the FACE Tx approach, the discipline further differentiates itself by integrating facial balance with dento-gingival esthetics for a comprehensive approach to diagnosis, treatment planning and execution. Dr. Renato Cocconi and surgeon, Dr. Micro Raffani, have analyzed the standards for optimal facial balance and dento-gingival esthetics and have quantified the relationship of the maxilla and the mandible to the facial profile. These elements are important diagnostic findings for the development of specific treatment goals and metrics to assess the esthetic quality of treatment results. Dr. Jorge Ayala has quantified the range of optimal facial balancing elements of various ethnicities, which is essential to strengthening our ability to apply the highest standards of care across various cultures. From this data, he developed the first VTO and STO-based orthodontic and orthognathic surgery treatment planning systems that incorporate soft tissue. From this research and the practicing orthodontists, along with the other clinicians in the group, comes a refreshing approach to lifelong learning that is not only didactic, but clinically realistic. It can be readily applied to one’s day-to-day practice.

What the FACE Tx Course Teaches

During the comprehensive one- to two-year FACE Tx program instruction, participants develop a solid foundation of knowledge and skills in the following areas that is clinically practical:

• In-depth evaluation of joint function and occlusion
• Mounting models with the most up-to-date instrumentation in simulating patients’ jaw movements
• Latest analytical techniques to assess facial balance and esthetic smile design
• Multidisciplinary case diagnosis and computer assisted treatment planning (VTO)
• Efficient and simple treatment mechanics with self-ligating appliances
• Establishing one’s own interdisciplinary treatment team
• Treatment and practice management strategies and marketing techniques to enhance one’s interdisciplinary network, and
• Knowledge of the type of patients one can treat successfully and language to use that will offer patients choices that the FACE Tx teaching faculty shares general techniques about how to adapt course instruction to clinical practice. There are several keys to successful treatment outcomes:

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Avoiding common problems in tooth extractions

By Dr Kamis Gaballah, UAE

The last two decades have seen significant advances in restorative techniques and materials for dentistry. The latter, along with community-based preventive measures that aim to reduce the incidence of caries, have resulted in many patients living with functional teeth for a longer period. Yet, extraction of teeth forms the considerable bulk of the workload in oral surgeries owing to several factors, including the late presentation of patients with advanced dental disease, the presence of symptomatic impacted teeth, such as third molars, and the need to extract teeth for orthodontic or orthognathic treatment.

The extraction of teeth varies greatly based on the type of patient who is undergoing the procedure. For example, elderly patients with significant co-morbidities and on a complex combination of medications as compared with young healthy individuals render the procedure complicated and require much more preparation with modifications during and after patient management. Additionally, extractions can range from a single, fully eruption tooth with favourable morphology to multiple misaligned, impacted teeth or teeth with challenging morphology. Local anatomy, such as tooth proximity to the nerve, maxillary sinus and tuberosity, also plays a significant role. These variations usually dictate who is to perform the extraction, as many general practitioners deal with less complicated cases of dental extraction in individuals regarded as healthy patients and may not feel comfortable operating on medically complex patients.

Complex extraction cases have been linked to a higher rate of postoperative complications; therefore, a cautious and systematic approach should be adopted that includes a detailed preoperative assessment to predict the potential difficulties that might arise during extraction. The documentation of all complicating risk factors along with their potential morbidity must be included in the informed consent. In the following article, other useful tips will be provided that are not usually included in traditional textbooks or lecture notes to help general practitioners to perform safer extractions.

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longer and more curved roots and be embedded in highly dense, compact alveolar bone, and thus sectioning of the bone may be required to use the resistance. Racial differences should also be taken into account, as extrac-
tions of teeth from individuals of Afro-Caribbean descent tend to be more difficult due to the hard-
ness of their bone and divergence of roots in their molars.

The resistance of hard tissue should be expected, particularly if maxil-
lar third molars are being extracted, as the potential force of the teeth is high and the tuberosity is relatively com-
mon when excessive force is applied with dental forceps. Fracture of the tuberosity may produce irregular sharp bony boundaries, significant soft tissue lacerations or potentially an oroantral fistula. If such risk fac-
tors are identified, tooth sectioning should be followed by elevation of roots with dental luxators instead of traditional elevators or forceps, which are known to deliver much higher force to the alveolar bone.

The indications for the extraction of impacted lower third molars (LM3) have been the subject of long-
term debate. Surgical procedures for the extraction of unerupted LM3 are associated with a potential of 4 % articaine and 3–4 % prilocaine. Although the percentage of injection with minimal doses of the operator achieve optimal pain control with minimal episodes of injection with minimal doses of anaesthetic agent.

The surgery should be planned ac-
cording to the information obtained from the preoperative assessment process. The procedure itself should aim to minimise the manipulation around the IDC. This should include the carefully planned access, tooth sectioning and elevation techniques. In many instances, the extraction of the whole tooth may carry an unavoidable risk of injury to the nerve, therefore intentional retention of the IDC and is certainly contra-indicated. It should be noted that the IDC is comparable to that observed after surgical extraction, except with a significantly low incidence of injury to the IDC.

It should be noted that both sec-
tioning and coronectomy can be performed with a shorter time than the amount of bone removal re-
quired is minimal, thus minimising of the postoperative morbidity. How-
ever, it cannot be performed in all cases in which the LM3 is close to the IDC and is certainly contra-indicated when the LM3 is decayed or its roots are fused or its crown is lined with a pathologic and should be considered with caution in severely inclined mesio-angular roots. In many instances, the extraction of the whole tooth was proposed via a planned procedure introduced around 20 years ago called coro-
nectomy. This is the removal of the crown of a tooth, leaving the root in situ. It is merely adopted to avoid or minimise damage to the IDC. The rate of complications after coro-
nectomy is comparable to that observed after surgical extraction, except with a significantly low incidence of injury to the IDC.
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