Short-term gains...long-term problems?
The emergence of STO and its future implications in general practice

By Aws Alani, UK

The provision of orthodontics can be a life-changing experience for young patients whose "crooked" teeth can affect their confidence and self-esteem. Indeed, mature patients whose "crooked" teeth can be a life-changing experience for young patients with congenital abnormalities receive results that are essential to their ongoing oral health. Restorative dentists work closely with orthodontists, who can appreciate how small details can aid in achieving positive restorative outcomes.

As a young dentist, I corrected a tooth in crossbite with a simple spring appliance. It was enjoyable and brought a different type of delayed gradual satisfaction to the more cerebral but tenuous molar endodontics or the more artistic and instant composite build-up. I was not a specialist, but I managed to do some orthodontics. In contrast to my experience, general dental practitioners are now more routinely providing teeth movement with the emergence of short-term orthodontics (STO). This has resulted in some controversy as to the methods of achieving "straighter" teeth. Indeed, some may consider STO as an emerging entity competing with specialist orthodontics, but should it be?

The specialist training pathway for orthodontics involves a competitive entry three-year full-time course linked with the achievement of a master’s level qualification that many may feel daunted by. Indeed, navigating the pathway from start to finish can be difficult academically and financially when factoring in fees and associated expenses during training. Once qualified, the majority of these specialists reside like the majority of all specialists, in the south-east of England. With this skewed distribution of specialists and assumed need for access, it might seem prudent for general dental practitioners to contribute to meeting the need for orthodontics.

Indeed, the long-cited managed clinical networks have yet to be fully realised, although all planning and documentation related to managed clinical networks identify general dental practitioners as integral to the function of the network. The number of orthodontic therapists has gradually increased over the last ten years or so since inception of the first courses in Wales and Leeds. Therapists are allegedly more cost-effective to train and employ in a large orthodontic practice; however, unlike their hygiene or therapy colleagues, they cannot practise without a specialist’s treatment plan and supervision.

Patients who qualify for orthodontic treatment under the UK government-funded system need to be assessed according to the index of orthodontic need. There will be an obvious shortfall of adults or adolescent patients with minor malocclusions who do not meet the criteria who would like their teeth straightened. This cohort may have to seek treatment privately from orthodontic specialists or general dental practitioners. As such, these minor or straightforward cases may be managed in a number of different settings utilising various techniques with the advent of STO. This may have resulted in some territorial paranoia between the two camps of traditional orthodontics versus STO systems. Conversely, it may be that differing scientific, technical and ethical ethos on managing the same problem is the source of the debate.

Quick and easy?

Commercialisation has modified the provision of orthodontics in the UK. Indeed, there are now orthodontic brands with courses attached and a
factor of individuals who promote their particular product. Companies tend to boost that their product is the best with limited complications and treatment being low risk, predictable and easy. Somewhat surprisingly, courses are being run on how to convert patients into orthodontic clients. There are books describing strategies on promoting and increasing revenue. They outline detailed strategies on attracting more patients than one’s local competitor—or is that colleague? Sounds more like capitalism than commercialism to many interested observers.

The rapid development of STO has not escaped the venture (or some may say vulture) capitalists. In the same vein as DIT Whitening and sports guards, one can now have one’s teeth straightened via online companies using products delivered by Her Majesty’s Royal Mail and so cut out the middleman (i.e. the dentist). To my knowledge, STO has yet to make it on to the price list of Samuel’s, a beauty salon in Peckham.

What may cause fear and worry is that the provision of tooth movement set against a backdrop of a focus on increasing revenue and patient convenience may detract from the real reasons we are providing the treatment. The risk and benefit of treatment must remain balanced or be re-balanced in favour of the patient.

The best things in life are rarely quick, easy and without reflection. While learning or training, one gains stature from one’s mistakes and learns by way of osmosis from those of individuals one hopes to emulate. Orthodontics is a complicated discipline that is difficult to deliver optimally and efficiently. Treatment planning should be performed in person not only to appreciate the challenges the patient presents with but also to develop a lasting patient rapport. Equally important, patients need to be diligent during treatment and forever more for purposes of retention. Is it possible that a one- or two-day course with a treatment plan lasting half a year or less can provide equally optimal results to a specialist orthodontist utilising traditional means? In any case, placing a time limit on orthodontics is a complicated discipline that requires time, effort and experience. Becoming an expert in many a field requires time, effort and experience. One important aspect of the report identified the need to regulate promoters. This is unfortunately not always readily available. In some Australian jurisdictions, there are specific guidelines that need to be adhered to for promotion of cosmetic treatments and they specifically cover before and after treatment advertising, which we know in the UK is a popular practice among the cosmetically driven. This is commonly one ideal, perfect case showcased on the front of the practice website with no mention of any problems, either acute or chronic. Another aspect of the report detailed prohibition of time-limited offers or inducing potential customers through free consultations for the purposes of treatment uptake. The latter is something that has seen STO promoted by way of voucher deals on the Internet or via smartphone applications. Others may consider such a practice as loss leading, one could ask who is losing and who is gaining and at what price.

In the now highly litigious arena of UK dentistry, the failure of orthodontic treatment against the backdrop of Montgomery V. Lanarkshire Health Board is likely to result in increased litigation. The movement of teeth into what the patient and the dentist feel is the correct position may be possible in the short term, but in the long term complications may arise owing to a variety of soft- and hard-tissue factors that cannot accommodate this new and supposedly “right” position. Indeed, orthodontics requires the appreciation of detail where symmetry and alignment are “king”, but long-term stability is the likely “empress”. Relapse of position is a common complaint and where patients have paid handsomely for a result they may have been happy with at the time of the cheque clearing, over time tiny tooth shuffles can result in disproportionate and vehement dissatisfaction. Where teeth are moved indiscriminately, recession in the lateral segment is a complication difficult to explain and remedy in the high lip line of a conscientious and ambitious corporate female patient. Indeed, more haste, less speed may result in a case being etched longer in the memory of the patient and the clinician for the wrong reasons.

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