Non-extraction treatment of a Class II case with a missing mandibular central incisor using a CAD/CAM lingual orthodontic system

Author: Khaled Abouseada

Adult orthodontic patients insist on aesthetic treatment options that have the least possible impact on their work and life. Clear aligners are an excellent treatment option that is well suited to many comprehensive orthodontic treatment plans. You may have already figured out that case selection is essential, and some movements are more difficult to perform well with removable aligners.

Incognito lingual braces (SM ESPR) are an ideal treatment option for adult patients who are best treated with a fixed system and who are looking for invisible orthodontics. They are also perfect for patients who are not committed to dealing with removable aligners. Lingual braces are an exciting advancement in orthodontic care, and many patients are thrilled. I would like to present a brief background on the Incognito lingual braces system, followed by a discussion of a case I treated with lingual braces and why I chose this system.

The Incognito appliance is manufactured using state-of-the-art CAD/CAM technology. The first step in the fabrication process is taking accurate polyvinyl siloxane impressions and bite registration using polyvinyl siloxane, and then creating a model in plaster and a diagnostic wax-up thereafter (according to my direct instructions). The final model is then sent to me digitally for feedback, and I can make a series of changes until I am satisfied with the final result. The final model is then scanned with a 3D scanner and the brackets are designed on the computer.

The bracket and archwire system consists entirely of individualised components. The bracket bases and bodies, the position of the bracket body on the bases, the bracket-slot orientation (ribbonwise), the direction of the archwire insertion (vertical or horizontal) and the archwire geometry are all individually adjusted to each tooth, according to malocclusion and the orthodontist's instructions. Rapid prototyping technology is used for the manufacturing of the lingual brackets.

The braces are then cast from gold alloy, mounted in a flexible indirect bonding tray, and shipped out ready to be bonded. Direct bonding is feasible too, owing to the extended individualised components. The system consists entirely of individualised components. The brackets are designed on the computer digitally for feedback, and I can make a series of changes until I am satisfied with the final result. The final model is then scanned with a 3D scanner and the brackets are designed on the computer.

The Class II malocclusion was corrected by non-extraction orthodontic treatment with a CAD/CAM fixed lingual appliance (Incognito). The Class III molar relationship had not changed at the end of treatment, but a Class I canine relationship was achieved and the facial profile improved owing to improvement in the position of the mandibular incisor in relation to the mandibular plane, which affects the position of the lower lip.

Diagnosis and aetiology
The patient was male, aged 25 years and nine months, and had the chief complaint of crowding of the maxillary and mandibular anterior teeth. He had Class III canine and molar relationships on both sides, a 2mm overbite, a missing mandibular left central incisor, the maxillary midline was coincident with the midsagittal plane, the mandibular midline was shifted to the left, the maxillary dental arch had about 7mm of crowding and lower dental arch had 8mm of crowding, excluding the width of the missing mandibular incisor, and the maxillary lateral incisors were in crossbite (Fig 2).

According to cephalometric analysis, there was a Class II jaw relationship and normal vertical facial height. The patient was in good health and his medical history showed no contra-indications to orthodontic therapy (Fig 5).

Treatment objectives
The treatment objectives included correction of the maxillary and mandibular crowding, improvement of the dento-alveolar and maxilla-mandibular relationships, improvement of facial aesthetics, and establishment of a stable occlusion and better smile.

Treatment alternatives
Three treatment options were suggested to the patient. The first alternative entailed labial orthodontics using either metal or clear brackets. The second option entailed lingual orthodontics, as the aesthetic demand was very high for the patient and clear aligners would not have been able to achieve the needed results. Both Options one and two were non-extraction.

The third option was to extract all four first premolars but this would have affected the facial profile negatively. After detailed discussion with the patient, we chose Option two, non-extraction using a lingual appliance.

Treatment progress
Treatment began with customised, pre-adjusted, CAD/CAM fixed lingual appliances (0.550mm slots) placed on both the maxillary and man-

Fig. 1 Different steps of manufacturing of Incognito System

Fig. 2 Extraoral and intraoral photographs before treatment showing severe upper and lower crowding and retruded lower lip.

Fig. 3 Final photographs show normal overbite and overjet.
maxillary and mandibular first premolars. However, this was not a favourable treatment alternative owing to its negative effect on the facial profile.

Performing lingual orthodontic treatment for each patient in the average orthodontic office is now a reality. The treatment results are of a high level, and all our patients may benefit from an invisible appliance. Former problems, such as discomfort, speech alteration, finishing inaccuracies, and particular tooth anatomy, can be overcome in this manner.

The extraction of the mandibular incisors constitutes a therapeutic alternative in treating certain anomalies. It is not a standard approach to symmetrically treating most malocclusions, but the therapeutic aims must be adjusted in certain clinical situations to individual patient needs, even when this means that the final occlusion achieved is not ideal. The deliberate extraction of a mandibular incisor in certain cases allows the orthodontist to improve occlusion and dental aesthetics with minimal orthodontic treatment. In all cases, however, a diagnostic cast is required to predetermine the occlusal possibilities precisely.

Conclusion
The key to success in lingual orthodontics in terms of both professional and patient satisfaction is practice and training. The Incognito system can be used for all types of malocclusions with the same precision as labial braces. The possibility of incisor extraction should be a part of every clinician’s portfolio of treatment techniques. If it is planned carefully and executed properly, incisor extraction can be an effective way of satisfying a particular set of treatment objectives.

Discussion
The treatment objectives were attained with the non-extraction treatment protocol using a CAD/CAM lingual system. Obviously, the results reflect the effects of not only the proximation of the mandibular anterior teeth, but also the relief of crowding in both arches and the correction of the mandible incisors constitutes a therapeutic alternative in treating certain anomalies. It is not a standard approach to symmetrically treating most malocclusions, but the therapeutic aims must be adjusted in certain clinical situations to individual patient needs, even when this means that the final occlusion achieved is not ideal. The deliberate extraction of a mandibular incisor in certain cases allows the orthodontist to improve occlusion and dental aesthetics with minimal orthodontic treatment. In all cases, however, a diagnostic cast is required to predetermine the occlusal possibilities precisely.

Conclusion
The key to success in lingual orthodontics in terms of both professional and patient satisfaction is practice and training. The Incognito system can be used for all types of malocclusions with the same precision as labial braces. The possibility of incisor extraction should be a part of every clinician’s portfolio of treatment techniques. If it is planned carefully and executed properly, incisor extraction can be an effective way of satisfying a particular set of treatment objectives.

Fig. 3 Final photographs show normal overbite and overjet standard E fitting connection, speed up to 18.2 Beta III Titanium Archwire. stainless-steel wire and 18.2 x 18.2 Beta III Titanium Archwire. The total active treatment time was 17 months. Patient compliance was good. For retention, fixed maxillary and mandibular retainers were provided, as well as an Essix retainer at night.

Treatment results
The post-treatment extra-oral photographs showed general improvement in the facial profile. The post-treatment intra-oral photographs showed satisfactory dental alignment, Class I canine and Class III molar relationships, and a normal overbite and overjet. In addition, the maxillary and mandibular incisors had a normal inter-incisal angle due to the interproximal reduction in the maxillary arch.

In Figure 4, we can see how accurate the model was compared with the final treatment outcome for both arches. At the end of treatment, a normal morphological and functional occlusion was obtained, with anterior guidance in lateral and protrusive excursions. Class I canine relationships were obtained on both sides. The good interdental relationship also provided a well-balanced facial profile with lip competence.

Another treatment option would have been to extract the mandibular arches using an indirect bonding technique. Levelling, alignment and expansion of the arch were achieved using heat-activated, super-elastic, customised wire (14, 16, 18 x 22, and 18 x 25). Detailing and finishing were performed using 16 x 22 stainless-steel wire and 18.2 x 18.2 Beta III Titanium Archwire. The total active treatment time was 17 months. Patient compliance was good. For retention, fixed maxillary and mandibular retainers were provided, as well as an Essix retainer at night.

Discussion
The treatment objectives were attained with the non-extraction treatment protocol using a CAD/CAM lingual system. Obviously, the results reflect the effects of not only the proximation of the mandibular anterior teeth, but also the relief of crowding in both arches and the accuracy of the model in reflecting the final result (Figs 5a–g). We still had to perform interproximal reduction in the maxillary arch to achieve a normal overbite and overjet, with the canines in a Class I relationship.

Another treatment option would have been to extract the mandibular arches using an indirect bonding technique. Levelling, alignment and expansion of the arch were achieved using heat-activated, super-elastic, customised wire (14, 16, 18 x 22, and 18 x 25). Detailing and finishing were performed using 16 x 22 stainless-steel wire and 18.2 x 18.2 Beta III Titanium Archwire. The total active treatment time was 17 months. Patient compliance was good. For retention, fixed maxillary and mandibular retainers were provided, as well as an Essix retainer at night.

Discussion
The treatment objectives were attained with the non-extraction treatment protocol using a CAD/CAM lingual system. Obviously, the results reflect the effects of not only the proximation of the mandibular anterior teeth, but also the relief of crowding in both arches and the accuracy of the model in reflecting the final result (Figs 5a–g). We still had to perform interproximal reduction in the maxillary arch to achieve a normal overbite and overjet, with the canines in a Class I relationship.

Another treatment option would have been to extract the mandibular arches using an indirect bonding technique. Levelling, alignment and expansion of the arch were achieved using heat-activated, super-elastic, customised wire (14, 16, 18 x 22, and 18 x 25). Detailing and finishing were performed using 16 x 22 stainless-steel wire and 18.2 x 18.2 Beta III Titanium Archwire. The total active treatment time was 17 months. Patient compliance was good. For retention, fixed maxillary and mandibular retainers were provided, as well as an Essix retainer at night.

Discussion
The treatment objectives were attained with the non-extraction treatment protocol using a CAD/CAM lingual system. Obviously, the results reflect the effects of not only the proximation of the mandibular anterior teeth, but also the relief of crowding in both arches and the accuracy of the model in reflecting the final result (Figs 5a–g). We still had to perform interproximal reduction in the maxillary arch to achieve a normal overbite and overjet, with the canines in a Class I relationship.

Another treatment option would have been to extract the mandibular arches using an indirect bonding technique. Levelling, alignment and expansion of the arch were achieved using heat-activated, super-elastic, customised wire (14, 16, 18 x 22, and 18 x 25). Detailing and finishing were performed using 16 x 22 stainless-steel wire and 18.2 x 18.2 Beta III Titanium Archwire. The total active treatment time was 17 months. Patient compliance was good. For retention, fixed maxillary and mandibular retainers were provided, as well as an Essix retainer at night.

Discussion
The treatment objectives were attained with the non-extraction treatment protocol using a CAD/CAM lingual system. Obviously, the results reflect the effects of not only the proximation of the mandibular anterior teeth, but also the relief of crowding in both arches and the accuracy of the model in reflecting the final result (Figs 5a–g). We still had to perform interproximal reduction in the maxillary arch to achieve a normal overbite and overjet, with the canines in a Class I relationship.
Author Info

Dr Khaled Abouseada is a consulting orthodontist involved in private practice in Saudi Arabia, Bahrain and Egypt. He lectures orthodontics at the Batterjee Medical College and Specialized Academy for Medical Training. He has lectured at many international dental and orthodontic forums. He is a certified trainer for CAD/CAM orthodontics and serves on the editorial board of Dental Tribune Middle East. He won the I Love My Dentist Award in 2010–2012 and the MENA Award for Orthodontic Best Case in 2010–2012.

Dr Khaled M. Abouseada
Asnani Dental Clinic
P.O. Box 122721
Jeddah 21332
Saudi Arabia
khaled@khaledabouseada.com

Editorial note: A complete list of references is available from the publisher.

Unique, original & clinically proven
The membrane you can trust

- THE WORLD’S NUMBER 1 MEMBRANE
- 17 years of successful clinical history
- More than 200 studies
- Early membrane vascularisation supports bone regeneration


Long-term results of 12–14 years

www.bio-gide.com

Fig. 5a-g Showing upper and lower initial and final comparing them to their corresponding set-up