One of the main objectives of orthodontics, in addition to the diagnosis of dysgnathia, is to determine the status of indication for orthodontic treatment for which treatment necessity and prognosis are evaluated.

Oclusion, function and esthetics are considered equivalent parameters in modern orthodontics, particularly in combined orthodontic and orthognathic surgical treatment. This was achieved through the optimization of diagnostic tools and advancements and increasing experience in orthopedic surgery.

The objectives of orthodontic and orthognathic surgical treatments are:

• the establishment of a neutral, stable and functional occlusion with physiological condylar positioning;
• the optimization of facial esthetics;
• the optimization of dental esthetics, considering the periodontal situation;
• the assurance of the stability of the results achieved; and
• the fulfillment of the patient’s expectations.

The following factors are to be considered in assessing the prospects of success of orthodontic therapy:

• the degree of the dysgnathia;
• the growth configuration and potential;
• the individual reaction of the periodontal and skeletal structures;
• the general condition of the teeth; and
• the patient’s age, the patient’s compliance; the patient’s wishes and expectations; and
• the dentist’s ability and experience.

Fig. 1: Therapy options for the treatment of Class II dysgnathias.
Orthodontics is holistic dentistry. Surely that is correct. We, as prudent orthodontists, do not just treat a malocclusion; we treat a human being who happens to have a malocclusion.

This is a mind-body-spirit unity, and orthodontists are unique among professionals in this respect. Attorneys compose legal opinions while accountants get to the bottom line of a balance sheet. However, an orthodontist who does not treat the patient as a whole (holistically) misses the entire point of being a doctor.

These observations are not new concepts; the doctor-patient relationship is omnipotent. Bad relationships can do actual harm. Who would doubt that patients who trust their doctors are likely to do better than those who don’t?

A sympathetic and compassionate doctor is more likely to be diagnostic and therapeutically accurate than one who imitates sympathy or compassion. The doctor is more likely to be diagnostic and therapeutically accurate than those who don’t?

People are likely to be best treated by doctors who treat them as whole and complete human beings.

In our world of dentistry, everything we know about alternative treatment modalities and the healing power of a listening bartender indicate that people are likely to be best treated by doctors who treat them as whole and complete human beings.

Not that I am Asklepios, the founder of medicine and reputed ancestor of the Asklepian, the ancient Greek doctors’ guild, but the ultimate answer to doctor-patient relationships and healing probably lies deep in a metaphysical labyrinth. It is necessary to us that patients have contexts, and the contexts matter and need to be understood.

Often the whole family of a young orthodontic patient will need to be in the mix of a patient’s treatment for a successful result to occur; the orthodontist is the go-between to the whole nexus in which his or her patient is treated successfully or not.

We might have a duty only to the patient, but in order to properly fulfill that duty for legal purposes, the tentacles of understanding and inquiry must be ubiquitous.

Obviously, it is impossible to treat only the symptoms of a disease. Practicing as holistic doctors, we acknowledge that malocclusion is most often a symptom of something else, and our job as orthodontists is to track that problem to its source in order to accomplish effective and stable results.

This sounds almost mystical and, hopefully, exhilaratingly mystical. It makes every orthodontist a psychoanalyst, a detective, a shaman, a priest and a friend; it requires every doctor to be a whole human being, which is a highly romantic but essential calling.

Why orthodontists should be holistic

By Dennis J. Tartakouk, DMD, MSID, PhD, Editor in Chief

Ortho Tribune strives to maintain the utmost accuracy in its news and clinical reports. If you find a factual error or content that requires clarification, please report the details to Managing Editor Kristine Colker at k.colker@dental-tribune.com.

01 Corrections

The phone number and e-mail for the Axis Orthodontic Adhesive Removal Kit was incorrect in the February Supplement edition. The phone number is (800) 555-5085 and the e-mail is customer@axisodontics.com.

Tell us what you think!

Do you have general comments or criticism you would like to share? Is there a particular topic you would like to see more articles about? Let us know by e-mailing us at feedback@dental-tribune.com. If you would like to make any change to your subscription (name, address or to opt out) please send us an e-mail at database@dental-tribune.com and be sure to include which publication you are referring to. Also, please note that subscription changes can take up to 6 weeks to process.

Image courtesy of Dr. Earl Broker.
Dr. Susan Baloul is the winner of the 2010 American Association of Orthodontists (AAO) Milo Hellman Research Award. The award will be presented at the Excellence Luncheon held during the annual session in May in Washington, D.C. Baloul was chosen for this prestigious award based on her research, “Mechanism of Action and Morphological Changes in the Alveolar Bone in Response to Selective Alveolar Decortication Facilitated Tooth Movement.” She chose this topic because of her interest and experience in both periodontics and orthodontics.

Baloul worked on this research during a three-year span while completing her DSc in orthodontics and dentofacial orthopedics at Boston University Henry M. Goldman School of Dental Medicine (GSDM). Associate Professor of Periodontology and Oral Biology Dr. I. Alpdugan Kantarci mentored Baloul on the research project, which sought to test if corticotomy-induced osteoclastogenesis and bone remodeling underlie the orthodontic tooth movement and how selective alveolar decortication enhances the rate of tooth movement.

“As an interesting area for us to get involved in and it was certainly a challenge to learn about bone biology in response to surgery-assisted orthodontic tooth movement,” Kantarci said.

To better understand the mechanism, Baloul used 114 Sprague-Dawley rats, which were separated into three treatment groups. The groups included corticotomy alone, tooth-movement alone and “combined” therapy.

Changes in each therapy group were assessed using faxitron analyses, microcomputed tomography, histomorphometric studies and quantitative-real time PCR (q-PCR) of expressed miRNAs.

Baloul “developed novel assays for alveolar bone structures of the rats, isolated sufficient amounts of RNA to study numerous markers by q-PCR, adapted micro-CT measurement for the three-dimensional changes in the alveolar bone and generated large amounts of samples for future testing,” Kantarci said. “In order to complete such a thorough characterization of the alveolar bone response, [she] worked hard, spent weekends and evenings in the lab and evaluated her interim data very frequently, getting exposed to sophisticated statistical analyses.”

The resulting data — which was consistent at all levels of analysis — suggested alveolar decortication enhances the rate of tooth movement during the initial tooth displacement phase. This results in a coupled mechanism of bone resorption and bone formation during the earlier stages of treatment, and this mechanism underlies the rapid orthodontic tooth movement.

“It is an honor to be the recipient of the Milo Hellman Award,” Baloul said. “I faced many obstacles and was challenged by many difficult decisions. Choosing to leave a prominent private practice was terrifying. However, it has proven to be one of my best decisions.

“My experience has been humbling yet rewarding. This confirms to me that I made the right decision and that pursuing a doctorate degree for a future career in academia is the correct path for me.”

(Source: Boston University Henry M. Goldman School of Dental Medicine)

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with legislative staff as well as background materials and information.

Some of the other highlights of this year’s meeting include:

- new course topics, including an examination of how stem cells and tissue engineering may impact the future of orthodontics, a look at current issues surrounding oral bisphosphonates and a discussion of the issue of access to orthodontic treatment.

- a special risk management program that will focus on common concerns at the beginning of an orthodontic career.

- live clinical procedures filmed and broadcast to both doctor and staff seminars. Topics include mini-implant insertion and application of laser technology.

- the music of Frankie Valli and the Four Seasons and a performance of the comedy “Defending the Caveman” during the opening ceremonies on Saturday, May 1.

For plenty more information on this year’s AAO, plus a sneak peek of new products and other offerings you’ll find on the exhibit hall floor, don’t miss the April edition of Ortho Tribune.
In many cases, the objectives of dentoalveolar treatment measures — the achievement of the functional and esthetic optimum for the patient — can be achieved using modern treatment methods.

While minor dysgnathias can be treated using dentoalveolar measures only, successful treatment of prominent sagittal discrepancies, such as Class II dysgnathia, is far more difficult.

Correction can be achieved through dental movement if the jaw proportion is correct and if the dysgnathia is purely dentoalveolar. However, dental movements are possible only up to a certain degree and are thus limited.

A correction or stable dental compensation of a skeletal dysgnathia for example, the correction of a frontal cross-bite in a Class III or the correction of an extremely enlarged sagittal overjet in a Class II is doubtful in some cases and, in general, shows a compromise in esthetics and/or function.

In order to determine the options available for the therapy of a Class II dysgnathia, the remaining growth of the patient must be determined. Functional orthodontic treatment is a therapy form that can influence growth and is considered a causal therapy in adolescence.

If there is no growth therapeutically, orthognathic surgery to correct the position discrepancy between both jaws is a causal therapy form (Fig. 1).

A premise for the successful realization of a combined therapy is that less invasive treatment options (for example, growth influence, as mentioned above) can no longer be used or do not achieve the treatment objectives or even worsen the situation (for example, extraction in a shallow mouth profile or distalization in a narrow overbite).

The second option for the causal therapy of a skeletal dysgnathia (Class II) using combined orthodontic and orthognathic surgical correction is discussed in this article, with a special focus on Class II dysgnathias with skeletal deep occlusion.

Case report: diagnosis

A 21-year-old female patient presented at our practice complaining of temporomandibular joint pain when chewing and poor esthetics, due to the malpositioning of her maxillary incisors.

The lateral image shows a frontal face oblique to the back, a deepened supramentonale and, in comparison to the mid-face, a short lower face — 54:46 instead of 50:50 (Table I; Figs. 2a, b).

Owing to the enlarged overjet (13 mm), there was a malfunctioning of the lower lips in occlusion, owing to which lip closure was not possible without habitual, vertical positioning of the mandible.

Furthermore, the frontal image shows a Class II/1-dysgnathia angle, mesial deviation to the left, a deep occlusion (6 mm) with abrasion in the palatal mucus membrane and corresponding periodontal destruction palatal of the teeth Nos. 11 and 21, as well as anterior maxilla labial tilt.

In addition, there was clear crowding in the mandibular arch and slight crowding in the maxillary arch.

The maxilla was lowered while the mandible was raised, which was expressed by a difference in the level of the distinctive Spee’s curvature (Figs. 3a–c).

The FRS analysis (Tables I, II) clearly shows sagittal and vertical dysgnathia in the soft-tissue profile and the skeletal region.

The parameters indicated a skeletal deep occlusion with the typical extra-oral symptoms of the short-face syndrome: disto-basal jaw relationship, small gonion angle, small interbase angle due to the anterior rotation of the mandible, large ratio between anterior and posterior facial height, and a growth pattern with an anterior course.

The vertical arrangement of the soft-tissue profile showed a disharmony between the mid-face and the lower face (G’-Sn:Sn-Me’; 54:46), which was expressed in the bony structures (N-Sn/Sn-Me’; 50:50). Disharmony in the region of the lower face was also evident (Sn-Me/Sn-Me’; 57:56).

These discrepancies in the ratio are the result of the deficient lower face, rather than the length of the upper lip.

An additional assessment of the lower face indicated that the ratio between the subnasal-labial inferius (Sn-Li) and the soft-tissue menton (Li-Me’), which should have been 1:0.9, was shifted in the favor of Sn-Li (1:0.7). This larger ratio was primarily caused by the short mandible (Figs. 4a, b).

Therapeutic objectives and treatment planning

An improvement of the facial esthetics, not only in the sagittal but also in the vertical axis, was a specific treatment objective. This was to be achieved through the elongation of the lower face without amplifying the prominence of the chin.

Elongation of the lower face as causal therapy and the subsequent effect on the facial esthetics could be achieved in the case of this patient using combined orthodontic and orthognathic surgical treatment. It would not have been possible to achieve the treatment objectives with respect to esthetics using orthodontic procedures alone.

The decisive step for the desired functional and esthetic results was taken during surgery. The surgical elongation of the mandibular arch (gonion angle) was decisive for the improvement of the extra-oral appearance through a posterior rotation of the dentigerous segment.

The three-point support on the incisors and molars was a prerequisite for a stable elongation of
the jaw angle and thus a posterior rotation of the horizontal mandibular ramus. Through the rotation, the menton was shifted caudally so that the skeletal situation and the soft-tissue profile of the lower face were improved in the vertical axis. Accordingly, the interbase angle was enlarged while the ratio between the posterior and anterior facial height was reduced (Fig. 5a). A translation of the dentigerous segment led to the correction of the sagittal dysgnathia without the improvement of the vertical axis. In addition, the translation resulted in an enhancement of the prominent chin, which led to a flattened mouth profile and thus to a maturation of the patient’s appearance (Fig. 5b).

**Therapeutic procedure**
The correction of the dysgnathia was done in six phases:

- Simulation of a preliminary surgical translocation: An opening of the jaw angles is followed by the rotation of the mandibular segment during operation. The vertical blue line touches the pogonion of the initial situation: slight ventral shifting of the prominence of the chin. The anterior mandible glides along the palatal surfaces of the anterior maxilla (green line), which causes a posterior rotation (white arrow) and a vertical change (blue quadrangle).

- Simulation of a preliminary surgical mandibular translocation: The correction in the sagittal disharmony was accomplished without changing the vertical ratio. The vertical blue lines touch the pogonion of the initial position: clear ventral shifting of the prominence of the chin.

(All photos: Provided by Prof. Nezar Waied)
1. **Splint therapy:** An occlusal splint was inserted in the mandible for six weeks to determine the physiological condylar position or centric before the final treatment planning. The forced bite could thus be demonstrated to its full extent.

2. **Orthodontic therapy:** Orthodontic therapy was used to form and adjust the dental arches relative to each other and to decompen-sate the skeletal dysgnathia. All first premolars were extracted to eliminate crowding and to align both fronts along the midline.

3. **Splint therapy:** Four to six weeks prior to surgery, splint therapy was performed to determine the condylar centric and thus register the temporomandibular joint in a physiological position (centric).

4. **Orthognathic surgery:** Orthognathic surgery was performed in order to correct skeletal dysgnathia. After a model operation, determination of the translocation path and production of the splint in the target occlusion, the preliminary surgical mandibular translocation was carried out by means of sagittal split according to Obwegeser–Dal Pont.

5. **Orthodontic therapy:** Orthodontic therapy was used to close the lateral open occlusion and for fine adjustment of the occlusion. The open occlusion was to be closed only through the extrusion of the maxillary lateral incisors and not by the intrusion of the fronts.

6. **Retention:** A 3–3 retainer was fixed in the mandible. A bimaxillary device was used for retention, allowing for the adaptation of the musculature in the new mandibular position.

**Results**

Figures 6a to 6c show the situation in occlusion and after closure of the lateral open bite, a neutral occlusion and correct midline with physiological sagittal and vertical overjet.

The extra-oral photos show a harmonization in the vertical arrangement of the bony and soft-tissue profiles. The disharmony of the lower face has been corrected, so that the ratio of Sn-Stm to Stm-Me’ is nearly 1:2 and that of Sn-Li to Li-Me’ is 1:1 (Figs. 8a, b; Tables I, II).

The mouth profile is harmonious, with relaxed lip closure and a well-balanced supramentale (Fig. 7). The FRS shows the changes in the parameters that arose as a result of the enlargement of the gonion angle. The gonion angle was increased surgically by 8 degrees. Accordingly, the mandibular slope was increased, which led to an enlargement of the interbase angle (around 5 degrees).

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(Note: A complete list of references is available from the publisher.)
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The power of goal setting

By Roger P. Levin, DDS

Every ortho practice should have clear and challenging performance goals. This is the first step in improving the practice and reaching the office’s true production potential.

Without goals, the practice is often adrift and the team lacks a sense of true purpose. In such an orthodontic practice, the staff often experiences high stress and has one main objective — get through the day and go home.

Only by having goals and achieving those goals can orthodontists know the real meaning of total ortho success. This is truly the challenge of practicing orthodontics in the second decade of the 21st century.

Production potential

Like any business, orthodontic practices need to measure performance by establishing clear objectives. Levin Group recommends the following targets to clients to move them closer to their true production potential:

- Starts should grow by at least 10 percent or more annually.
- The close rate for new patient consults should be 85 percent or higher.
- Patient referrals from dentists should increase by 10 percent or more.
- The number of patients in observation should grow by at least 5 percent each year.
- The overdue-debond rate should not exceed 2 percent.
- The collection rate should be 99 percent.
- The number of patients overdue for retainer checks should be less than 2 percent.

In the current economy, most orthodontic practices will have difficulty reaching these targets unless they have implemented document

About the author

Dr. Roger P. Levin is founder and chief executive officer of Levin Group, the leading orthodontic practice management firm. Levin Group provides Total Ortho Success™, the premier comprehensive consulting solution for lifetime success to orthodontists in the United States and around the world. Levin Group may be reached at (888) 973-0000 and customerservice@levingroup.com.
It’s do-or-die time for video marketing your ortho practice

By Mary Kay Miller

I know this subject is scary, and most of you don’t even want to think about producing video as part of your Internet marketing program. “It’s too expensive. It takes too much time. I don’t know where to start!”

If you think about it, you are missing out on a huge opportunity, one that will impact the bottom line of your practice today and its future in the years to come.

Online video viewership keeps setting new records, according to reports released from ComScore.com Video Metrix Service. As you might expect, Google Sites (which includes YouTube) lead the growth charge, accounting for 49 percent of the incremental gain in overall videos viewed versus the previous month.

Each month, nearly 100 million viewers watch almost 6 billion videos on YouTube alone.

Having your video rank on page one of Google is orthodontic marketing mecca. Viewers can’t resist clicking on a video when searching for products or services online. Once your video link reaches page one, you are golden. Viewers click, and it keeps playing and playing, just like the energizer bunny, 24/7, whether you are working, sleeping, eating, playing golf or spending time with your family. There is no better return on investment today than video marketing.

Why is video so powerful?

Video is the No. 1 preferred form of communication in today’s tech savvy society. What would you prefer to do: watch a video on a subject of interest or read Web site copy?

Video is the No. 1 preferred form of communication in today’s tech savvy society. What would you prefer to do: watch a video on a subject of interest or read Web site copy?

There is no contest.

Speed to market wins the race. The window of opportunity to be the first in your area to add video to your Web site is small.

Don’t be a “me too” practice. Lead the way in an economy that cries out for something different to stand out in the crowd. If your marketing budget doesn’t allow for custom video right now, an inexpensive but powerful alternative is www.marketingwithlivevideo.com. Hire an Internet actor to deliver your marketing message for you.

One way or another, video is the key to a successful Internet marketing campaign. Venture outside your comfort zone and deliver your own message to consumers in your demographic.

Do it today to improve the health of your practice in an Internet-based society that researches professional services online or risk the consequences of being left behind.

Like this bird, you want to make your practice stand out in a crowd. (Photo/Provided by Mary Kay Miller)

Mary Kay Miller offers a six-part series of Internet-marketing Webinars, which help you discover what you need to know to get your orthodontic Web site working correctly on Google and teach you how to build your practice for the future on the Internet. Take advantage of this opportunity to improve your Internet presence with your current Web site and Web 2.0 marketing strategies, while earning ADA-CERP credits. Find the recorded and archived modules online at OTStudyClub.com.

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Toward a new theory of malocclusion

By Javier M. de Pison, Editor in Chief, Dental Tribune Latin America

Dr. Chris Farrell and Dr. Germán Ramírez-Yáñez from the University of Manitoba in Canada, leading authorities on the role of myofunctional forces for correcting malocclusion, held a two-day conference in Coral Springs, Fla., attended by about 50 orthodontists.

Farrell, founder of Myofunctional Research Company (MRC), lectured on topics such as “The 3 Rs of Traditional Orthodontics: Relapse, Root Resorption, Permanent Retention,” and presented a new theory of malocclusion.

According to Farrell, the main problem in orthodontics is dental stability or, more precisely, the lack of it. For decades, orthodontists have studied dental alignment, for which they have always used fixed devices such as braces and brackets that are cumbersome and require them to be worn for long periods of time. Even after this, relapses are common, as shown by many clinical studies.

On the other hand, Farrell said, it has been shown that muscles are the main structure of the body, including the mouth, and that facial and masticatory muscles are what define the structure of the maxillary.

Farrell explained that myofunctional therapy treats muscle and functional problems, as well as the position of the tongue, and thus improves tooth position.

He said his clinical cases, which he presented at the event, show that a good alignment can be achieved without brackets but by using MRC devices such as Myobrace or T4K, the interceptive series called i-2 and i-3, and the new Bent Wire System.

Meanwhile, Ramírez-Yáñez discussed the science underlying myofunctional forces. Ramírez-Yáñez has written a new book called “Early Treatment of Malocclusion: Prevention and Interception in Primary Dentition,” which deals extensively with the subject.

"By improving muscle activity in the mouth, we also improve the position of the jaw, as confirmed by important studies, and stimulate the transverse development of the jaw and the maxillary and dental alignment," he said.

Early treatment clinics

During the event, Farrell introduced his vision for the early treatment of malocclusion: the Myofunctional Clinics. The concept of these clinics is based on an office management system that includes patient education.

The clinic modules presented by Farrell show an addition to the dental office space of about 900 feet, which would be used to educate parents and children on myofunctional techniques.

This colorful office space would be a relaxed environment designed specifically to make children feel comfortable.

The clinics would be managed by dental assistants and supervised by dentists. Because myofunctional techniques are designed for early treatment of malocclusion in children ages 6 to 11 and even younger, it’s an interesting and effective way to increase the number of orthodontic patients, Farrell said.

The dental assistant management system ensures that dentists can see a large number of other patients without being disturbed by the increase in the number of children and parents who go through the myofunctional education modules.

For more information on myofunctional techniques, please visit www.myoresearch.com or primarydentition.com.

Dr. Chris Farrell, founder of Myofunctional Research Company, talks about the therapeutic benefits of using the interceptive device i-3 for Class III malocclusions.

(Photo/Jan Agostaro, DTI)
Turn $6,000 into $85,000?

By Tamara Hobbs, Creative Director,
Yourtown Direct

“I’m happy to pay $6,000 for an exchange of $85,000 ...” That’s what one of our clients, Dr. Shawn Murray of Johnstown, Colo., had to say when we were following up on ROI (return on investment) on his postcard marketing campaign.

He went on to say: “Let me also mention the indirect benefit of postcards. I happen to know that I have gotten about 10 referrals from patients who started treatment because their friends who got the postcard started in treatment, then told them about us. And then consider the chain of them referring their friends and so forth.”

That is the lifespan of a quality postcard marketing campaign. When executed properly, it can be the driving force behind the growth of your orthodontic practice. But therein lies the secret: It must be executed properly. That consists of several key factors:

• A strong offer: After all, we see the value of that first initial response — they get treatment, they tell friends and so on.
• Visual impact: Balance of images and text presented on a high-quality card that doesn’t just get lost in the shuffle.
• A targeted mailing list: This is built around the needs of your practice.
• Timely repetition: In marketing, all the experts agree that repetition is key. That is what drives ROI more than any other factor. You have to build a presence in the marketplace. You have to build your brand.
• Personal connection: Once prospective patients respond, make sure they feel welcome and heard. That will give them the confidence they need to start treatment. This goes from the moment they make the first call to finishing treatment, and must be emphasized amongst your staff every step of the way. This is where the word-of-mouth marketing takes over.

Now, with all of that considered, let’s focus on the fact that in any successful marketing effort, repetition is key. That is what drives ROI more than any other factor. You have to build a presence in the marketplace. You have to build your brand.

There is too much competition out there to dabble in marketing. You need a plan. It doesn’t have to be complicated; it just has to be consistent. Otherwise it falls by the way of general image advertising, and there is little ROI in that unless you have an enormous budget to shout your name from every rooftop.

But for most orthodontists who are, in fact, small-business owners, ROI is key to your success, and that means you must focus on repetition. Although there are many variables, such as economic conditions, design, offer and mailing list demographics to name a few, the one thing we see is that the clients who do repeat mailings continue to mail with us year after year because they have come to experience that postcard marketing works.

Many orthodontists start with our basic postcard marketing plan, which is a series of three mailings spread across 90 days, targeting the closest 5,000 or 10,000 homes with demographics to name a few, the experts agree that repetition is key. That is what drives ROI more than any other factor. You have to build a presence in the marketplace. You have to build your brand.

With minor tweaks, to keep the message and your brand consistent.

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Manufactured by SWISS dentacare, the kit comes with five different file grades that are color-coded, easily inserted into interproximal spaces and totally autoclavable. Contouring is achieved in less time with a more natural finish. The Orthofile system uses single- or double-sided files.

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Invisalign Assist adds new features

Improvements expand capabilities to cover a wider range of esthetically oriented cases

Align Technology has introduced new and improved features for Invisalign Assist®, expanding its capabilities and giving clinicians the confidence and control necessary to treat a wider range of patients. These latest features include improvements designed to achieve anterior teeth extrusions and canine rotations and the new ability to perform lingual root torque when up-righting retroclined upper incisors. In addition, these improvements now allow more cases to qualify for Invisalign Assist.

Invisalign Assist includes built-in product support, including progress tracking and other reporting features, throughout treatment to help deliver the outcomes clinicians expect.

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The latest version of Invisalign Assist includes feature enhancements to improve treatment efficiency for clinicians with a wide range of Invisalign experience:

- More control in ClinCheck®, with adjustments to final tooth position prior to ClinCheck setup acceptance.
- Improved progress tracking reports with more tooth-specific detail.
- Online links to more information for case-specific tasks, including bonding attachments, performing IPR and monitoring treatment.

To learn more, please visit www.invisalignassist.com.

Axis Orthodontic Adhesive Removal Kit

The Axis Orthodontic Adhesive Removal Kit features a series of three devices designed to efficiently remove residual adhesive after orthodontic appliances are removed and to produce a smooth final enamel surface.

The three-step system includes 7675 Red Carbide, a gross adhesive removal bur (H375R-016); White Finishing Carbide, a 30-fluted finishing bur (H246L-012F); and the P0153-051 Polisher green polishing point (#P0153-051). All are conveniently maintained in an autoclavable, aluminum bur block.

This kit can be used with either low- or high-speed friction-grip contra-angle handpieces. Using high speed creates less vibration so the process is more comfortable for patients and produces a smoother surface finish.

Because this simple, three-step system can be used with just a single handpiece, it is more clinically efficient while effectively removing residual adhesive and providing ideal polishing after bonded, banded and Invisalign® treatments.

BioQuick brackets

The new BioQuick® brackets from FORESTADENT have a base that is perfectly adapted to the shape of natural teeth. Approximately 4,000 teeth from all around the world were scanned using 3-D lasers, and the data of their contours were examined in detail for developing the base.

The new biological base, therefore, optimally corresponds to the anatomical curvature of tooth crowns because of its slight angulation and ensures reliable bracket placement. Any “rocking” of the brackets when pressed onto the tooth is prevented from the outset. In addition, hook-style undercuts on the patented base ensure a reliable bond.

Another innovation of the third generation of Quick brackets is the circumferential pad margin, which greatly reduces the overflow of adhesive.

It is not only the bracket base that has been improved; however; the design of the interactive clip has been modified and provided with a new snap function. With the aid of a notch on the pad margin, the probe is guided automatically to the slightly extended clip, which makes it considerably easier to open from the gingival. The clip provides more free space for archwires up to a dimension of 0.018 inches because of a special support, in a similar way to passive brackets.

Well-rounded edges as well as four contact ribs in the slot ensure that BioQuick brackets provide controlled force transfer with minimal friction. BioQuick brackets display their full potential particularly in clinical situations with pronounced vertical archwire deflection (e.g., in the case of displaced canines).

Binding and notching, which often occur with conventional brackets, are prevented by the contact ribs in the slot. As the archwire only rests on two contact points, it has greater clearance and, therefore, ensures friction-free sliding.

The additional slot (0.016 inches by 0.016 inches) of the brackets considerably extends treatment options with BioQuick brackets. The auxiliary slot allows such placement as diverse springs for uprighting molars, de-rotation and intrusion/extrusion or combined application of the OrthoEasy® pin system from FORESTADENT.

A passive version of BioQuick brackets will also be available from the middle of 2010 for more rapid diastema closure. The slot floor will be lowered to allow the archwire more clearance and enable more passive sliding of the bracket on the square archwire.
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<tr>
<th>Location</th>
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<td>London, ON</td>
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