The three-day event is shaping up to be different from most other conventions out there, including giving attendees more time in the exhibit hall without having to worry about conflicting educational sessions, a new generation of speakers who haven’t yet shared their stories with meeting attendees and a simple way to have dinner at some great restaurants and meet some new friends.

“I’ve been to several orthodontic meetings around the world and seen the different ways people have presented academic programs,” said Dr. Clarke Stevens, the man behind OrthoVOICE. “European meetings often have more people involved than the regular list of speakers. We thought it would be interesting and creative to invite different types of people.”

Some of these people include Dr. Scott Law, a practicing orthodontist in Killeen, Texas, who just finished his residency in 2009. He will speak on “Hit the Ground Running While Training for a Marathon — Know When to Pass the Baton and Win the Relay.”

It also includes Dr. Jennifer J. Garza, who started her career as an orthodontic assistant and now has her own paperless practice and is a biologic orthodontist. She will share how her experiences have shaped the philosophies she is determined to uphold in her practice.

Each day of the meeting, there will be sessions for orthodontists and sessions for staff, with two to three tracks going at the same time. However, attendees aren’t limited by their job descriptions — if an orthodontist wants to attend a staff-focused presentation or vice versa, he or she is more than welcome to do so.

Another idea taken from European meetings, Stevens said, will be a more creative use of exhibit hall space. Not only will attendees have one-hour breaks to explore the exhibits, but vendors are encouraged to have entertainment or themes in their booths. One exhibitor, Stevens said, is considering offering a coffee bar in the morning with pastries.

Of course, a meeting is never complete without an array of social activities, and OrthoVOICE has plenty of those. A cocktail party kicks off the first night with entertainment, while a cocktail party the second night is more of a wine-and-cheese affair.

Two unique events are the breakfast roundtable and Dinner With Strangers. For breakfast, every table will have a moderator and a topic, from how one conducts a new patient exam to how one closes spaces where there’s been an extraction. Orthodontists and staff are encouraged to pick a topic they want to discuss and spend their meal sharing information with others.

For Dinner With Strangers, attendees will find a list in their registration materials of various restaurants around Las Vegas where OrthoVOICE has made reservations for eight to 10 people.

Attendees will pick a restaurant they would like to go to and will then show up for dinner with other attendees who they haven’t yet met.

“Sometimes I go to a meeting alone, and I wonder what I’m going to eat,” Stevens said. “But this way, you can go to a great restaurant and have a great evening with some new friends.”

Stevens said he likes that OrthoVOICE is being held in Las Vegas and plans to keep it there every fall.

“It’s also nice to have stability and have a meeting in one place every year, so if someone can’t make it to the AAO one year, they know they will have this nice alternative.”

**Take Your Practice to the Next Level**

The majority of children from six years of age will show signs of malocclusion. In many cases, the underlying causes are never addressed. Just treating malocclusion with either a fixed or functional appliance does not address these problems.

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Once educated, most parents and their children would prefer this approach – less braces, better facial development and a stable result without retainers.
At the same time, a second force element can be applied with the aid of a miniscrew and an uprighting spring (Figs. 1b–d). This avoids the loss of anchorage that inevitably occurs when only an uprighting spring is fixed to the multi-bracket appliance (Fig. 2).

The straightening of an individual tooth may become necessary for periodontological, prosthetic or orthodontic reasons. This is a very simple procedure if a miniscrew and uprighting spring are used and the appliance remains invisible to the observer. The tooth need only be fitted with an appropriate attachment system that makes it possible to fix this to the uprighting spring.

Depending on how the spring is set, it is even possible to achieve intrusion or extrusion of the tooth. This form of treatment is inexpensive for the patient and the orthodontist will find it highly effective.

Alignment of retained teeth

The alignment of retained or displaced teeth, particularly in the case of canines, is one of the most common forms of surgical intervention in the field of orthodontic techniques. Numerous appliances are available — rubber bands, springs, orthodontic chains — that are effective to a greater or lesser extent.

All these mechanisms have the same underlying problem: the neighboring teeth must be used — directly or indirectly — to provide an anchorage so that the required traction forces can be applied.

Ideally, the neighboring teeth will offer the greater resistance so that only the retained tooth moves. Realistically, however, both components tend to move toward each other. In the worst-case scenario, only the group providing anchorage is displaced from its original position. This can occur if there is anklylosis of the retinated tooth, something that is difficult to evaluate during initial examination.

If an attempt is made to move an anklyosed canine toward insufficient dental anchorage, the result will be the worst-case scenario. This can lead to an open bite in the region of the anterior teeth and premolars.

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stable methods of acquiring more transverse space in the upper jaw. The targeted screw rate should be in the range of 0.2 to 0.6 mm/day.

As a rule, the appliance is fixed by means of bands to the molars and premolars. The desired transverse width can generally be achieved within 10 to 20 days. Thereafter, a three-month stabilization phase should be observed, in order to allow ossification of the ruptured palatine suture.

The standard anchorage technique — with dental support only — has several disadvantages. The most significant is the risk of tipping the anchor teeth.

Many appliances have been described that distribute the force over more than one tooth. A further problem is apparent here: as it is necessary to leave the appliance in place for a longer period after the active phase, it is only possible to commence further corrective treatment for teeth in the anterior region.

It is possible to overcome these problems by using the hybrid RPE (Figs. 4–6).

Bands are employed as usual in the molar region. In the anterior region, the RPE appliance is fixed using two miniscrews. These should be placed on a notional transverse line connecting the canine/premolar contact points paramedially.

Distraction is achieved using the same method as in standard techniques.

There are several advantages to hybrid RPE. Preparation of the apparatus is much simpler and cheaper, whilst the dental arch, including the premolars, is accessible for additional tooth correction measures.

**Class II corrections**

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phase, simple techniques for the forward positioning of the lower jaw are usually ineffective.

Following a thorough initial examination and diagnosis, there are three possible therapeutic approaches: camouflage, fixed Class II correctional appliances (Herbst cant, Sabbagh Universal Spring, FMA, Jasper Jumper, etc.) or orthognathic surgery.

The patient must be informed of the advantages and disadvantages of each approach. All fixed Class II correctional appliances — irrespective of whether these use the Herbst splint or canted plane principle — have the same problem and the same undesirable side effects. There is a risk of protrusion of the lower frontal teeth and/or distalization of the upper molars.

By means of passive stabilization with the aid of two miniscrews (Figs. 7, 8), these effects can be readily avoided.

Orthognathic surgery

After surgical intervention to relocate or reposition the jaw (for orthodontic or traumatological reasons), it is important to maintain a stable correlation between the bone fragments and the jaw in the postoperative phase. This promotes healing and prevents relapse.

The occlusion appliance is fixed intraorally, using intermaxillary elastic or wire ligatures, depending on the situation. It is essential to use the appropriate fixing options, whether this is a splint (Schuchardt splint) or a multi-bracket appliance.

Where these are really only needed in one jaw or jaw section, the question arises of whether, in the era of the miniscrew, it is necessary to involve the other jaw in the stabilization of the surgical effect.

If miniscrews are used in the opposing jaw (Fig. 9), the same effect is achieved — but with considerably less restriction from the point of view of the patient.

Pre-prosthetics

It is the aim of pre-prosthetic orthodontics to position the teeth optimally for the subsequent prosthetics. This can include intrusion, uprighting and the opening or closing of gaps amongst other techniques.

As this series and many other publications have already shown, miniscrews are particularly useful in this context. Miniscrews can also be used as anchoring elements for a provisional prosthesis.

Where teeth are missing (particularly the second canines, Fig. 10a) and the growth phase is not yet completed, the fitting of an intermediate prosthesis is problematic.

As an alternative, particularly where additional anchorage is required, miniscrews can be used. A longer screw (9 or 10 mm) can be inserted in the center of the dental ridge (Fig. 10b).

There should be at least 1 mm of bone to the mesial and distal sides of the miniscrew.

The hole for the insertion of a miniscrew (1.6 mm) should thus be at least 2.6 mm. A provisional crown can then be mounted onto the head of the miniscrew. If necessary, a bracket can be fixed to this crown (Fig. 10c).

Outlook

The clinical use of miniscrews supports a wide range of tasks. Dental repositioning that was previously deemed impossible becomes achievable, whilst possible repositioning techniques are improved and supported.

In order to achieve this, miniscrews alone are not sufficient; an appropriate range of equipment is also necessary.

Several suppliers of miniscrews offer, in addition to screws and insertion tools, a number of devices that facilitate the use of miniscrews. The fifth part of this series will focus on the wide range of useful auxiliaries that are available.

(EDITORIAL NOTE: A complete list of references is available from the publisher. This article first appeared in Dental Tribune Asia Pacific, Vol. 7, No. 5, 2009. The next edition of Ortho Tribune will feature “Part V — Therapeutic auxiliary elements.” All photos were provided by the authors.)

Send us your case study!

Have an interesting ortho case you would like to share with your peers? To have your case study considered for publication in Ortho Tribune, send your 800- to 1,200-word case study and up to 12 high-resolution photos to Managing Editor Kristine Colker at k.colker@dental-tribune.com. Authors will be notified of publication and have an opportunity to review the designed case study prior to final publication. Cases will be published pending editor approval and space availability.

Fig. 9: The use of miniscrews to attach intermaxillary rubber traction bands means that no other attachments to the teeth are necessary.

Fig. 10a: Missing tooth #12 is to be replaced by an implant-based crown. The initial phase of treatment involves widening the gap (a). The head of the vertically inserted OrthoEasy screw (b,c) is used to anchor a provisional crown (including bracket), which serves to widen the gap further (d).