Miniscrews: a focal point in practice

Part 4 of 6: More clinical examples
By Dr. Björn Ludwig, Dr. Bettina Glasl, Dr. Thomas Lietz and Prof. Jörg A. Lisson

The straightening of mesially tipped (second) molars in a full dentition represents a therapeutic challenge. The treatment is further complicated if the tooth is not only tipped but also partly impacted.

The presence of a non-erupted third molar does not simplify the process (Fig. 1a). When planning the required appliance, it is important to consider whether it is necessary, for example, to reshape the entire dental arch (Figs. 1a–d) or just upright the tipped tooth.

If miniscrews with bracket heads are used, it is possible to employ a special NiTi uprighting spring (such as the Memory Titanol spring, FORESTADENT).

A standard multi-bracket appliance can be used to reshape the dental arch.
What does it mean to be scholarly?

By Dennis J. Tartakow, DDS, MSD, PhD
Editor in Chief

Q uoting Nathan Pusey’s “The Age of the Scholar” (1965), “We live in a time of such rapid change and growth of knowledge that only he who is in a fundamental sense a scholar — that is, a person who continues to learn and inquire — can hope to keep pace, let alone play the role of guide” (Howe, 2003, p. 19).

Dr. Pusey’s quote is almost 50 years old but is as important, if not more important, today as it was then. The concepts and principles for which his words stand for also apply to the goals and direction set forth by our orthodontic training programs.

To be scholarly and erudite requires a fundamental understanding of ethics or moral philosophy, which addresses questions about morality, justice and virtue.

These concepts are clearly not (a) a matter of following one’s feelings, (b) identified with religion, (c) morals and social norms that deviate from what is considered to be ethical. It is necessary to continually examine one’s standards to ensure they are well founded and reasonable. It also means the continuous effort of studying our own moral beliefs and social conduct, striving to ensure that we and the institutions we help to shape live up to standards that are reasonable and solidly based.

According to Webster’s Online Dictionary (2010), there are many other applied definitions, explanations and descriptions of scholarly communication. In general, scholarly communication is an umbrella term illustrating the process of academics, intellectuals and researchers publishing and contributing their findings to the wider academic community and beyond. It is simply the creation and dissemination of knowledge related to research, education and erudite endeavors.

There has been widespread belief that the dissemination of scholarship in the traditional system has reached a state of crisis in recent years, which has also been referred to as the publishing crisis (UConn Libraries Spring Forum, 2008).

Such concepts must be encouraged and promoted as goals and directions for all students in colleges and universities.

Our orthodontic residents in undergraduate, postgraduate or continuing education must also be encouraged to seek these principles of scholarship to maintain quality guidelines and to improve the standards of orthodontic education.

References


OT Corrections

“Mussews: a focal point in prac—” on Page 1 of the June/July issue of Ortho Tribune, was Part 5 in a series of 6.

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@dentaltribune.com.

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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 where 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.

“Vegas is a great place to have a meeting because it’s sort of an entertainment capital, and people love to come there,” he said.

“Vegas is great because it’s sort of an entertainment capital, and people love to come there,” he said. “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.”
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 retained tooth, something that is difficult to evaluate during initial examination.

If an attempt is made to move an anklylosed 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.

### Skeletal adjustments: palatine suture expansion

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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

In the case of patients with Class II malocclusion who have completed or are near completing their growth...

Figs. 6a, 6b: Bilateral cross-bite in a 7-year-old boy (a). X-ray of the hybrid RPE appliance in situ (b).

Fig. 6c, 6d: Status after 10 days’ use: cross-bite has disappeared and vertical bite has remained stable (c, d).

Figs. 7a–d: Anchorage of the canine using a miniscrew avoids protrusion of the anterior teeth when using a fixed Class II correction appliance (here: Williams appliance, FORESTADENT).

Figs. 8a, 8b: The miniscrew stabilizes the position of the molars to which the Kinzinger FMA is attached. This counteracts any protrusion of the premolars and anterior teeth (a). Class I dental status on completion of treatment (b).
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Orthodontics to position the teeth
It is the aim of pre-prosthetic procedures to reposition the teeth. Orthognathic surgery is the point of view of the patient. The advantage of the patient’s mental and physical well-being is considerably less restriction from the opposing jaw (Fig. 9), the same effect is achieved — but with considerably less restriction from the point of view of the patient.

Orthognathic surgery
After surgical intervention to 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 prosthesis. 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 (8 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.

Miniscrews have already shown, particularly the second canines, Fig. 10a)

Fig. 10a

Fig. 10b

Fig. 10c

Fig. 10d

(Edited 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.)

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Declines in ortho production are still a reality for many orthodontists across the country. Research from a first quarter ADA 2010 survey shows 44 percent of orthodontists reporting lower net income, 37 percent reporting lower gross billings and 41 percent with lower numbers of new patients. These results should come as no surprise to orthodontists.

From the patients’ perspective, orthodontics is increasingly viewed as a commodity. Competition increases every day. Recent advances, such as Invisalign®, have increased competition even more. There is no evidence to suggest this scenario will change anytime soon.

Yet, despite all of these potential obstacles, Levin Group ortho practices continue to grow by:
• Encouraging patient referrals through superior customer service,
• Turning occasional referring dentists into frequent referring dentists.

What is superior customer service?
The ortho practice needs to make certain it provides truly excellent customer service to ensure patients or parents would find it odd to even consider going elsewhere when another family member needs ortho treatment.

“WOWing” your patients requires having the right systems in place. To do so, you should follow these steps:
• Establish operating procedures for customer service that every patient will experience.
• Survey your patients regularly to determine their satisfaction levels.
• Ask your referring dentists how they view customer service in your practice.
• Develop a system to handle any patient/parent concerns or complaints quickly and in a manner that achieves total patient satisfaction.

How do occasional referrers become frequent referrers?
Every ortho practice has one or two top referrers who contribute the bulk of referrals. However, if you lose one of these referring dentists, an extraordinary amount of revenue — possibly hundreds of thousands of dollars over time — could be lost.

Diversifying your referral sources begins by:
• Determining who refers
• Analyzing how many patients each of them refers
• Customizing marketing strategies to effectively get GPs to refer more patients
• Subsequently tracking each strategy for effectiveness and then making adjustments as needed

An effective referral marketing program will foster better relationships, generate more referrals and subsequently reduce or reverse the noticeable declines many orthodontists have experienced.

Conclusion
Now is not the time to adopt diminished expectations. Remember that ortho practices have incredible potential. By upgrading your customer service and referral marketing systems, ortho practices can grow exponentially.

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Dr. Roger P. Levin is chairman 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.
The most profitable way to run the business side of your orthodontic practice is to understand, define and know what your break-even number is for your business. Many orthodontists try to operate the business side of their practice on intuition: “I think we did really well this month,” “It feels like we started a ton of patients,” “The checking account looks good, our starts must be great.” Intuition does not provide feedback of real data for making knowledgeable decisions. Profits in a practice can greatly increase when the clinician has the ability to understand the business numbers, particularly the practice’s break-even point, and can monitor these numbers with a system to keep the team and practice on course.

The break-even number
The break-even number is the first and most important number an orthodontist and his staff should know. The break-even point number should provide enough revenue to meet the following goals:
- Clinician income
- Retirement contributions
- Overhead expenses
- Salary expenses
- Loan payments
- Increase in staff labor costs such as raises, benefits and skill levels
- Capital improvements such as equipment and office remodeling

The four keys to success
Profits in an orthodontic practice depend directly on four numbers: the break-even point, production, collection and overhead expenses. From the break-even point number, production and collection goal numbers and a budget for the practice can be calculated. Defining, monitoring and controlling all of these numbers each month will more likely result in the desired profits for the practice.

The game plan
1. The break-even point must be calculated and defined.
2. The orthodontist must determine what the practice will need to produce and collect each month to meet the break-even point number. The production goal must be defined and divided among the producers in the office. This is generally by the number of new patient exams, records and starts.
3. The scheduling coordinator must schedule all producers’ days to meet their individual production goals. It is important to remember that cancellations and changes in the schedule affect how much the orthodontist, the treatment coordinator and other staff members may be able to produce each day.
4. Have excellent financial arrangements and/or collection policies in the practice. Delinquencies should be no more than 3 percent of your total collections.
5. The orthodontist must have a defined budget for the overhead expenses of a practice. The budget should be divided among many areas: salary expenses, clinical supplies, lab costs, marketing, etc. These budgets should be monitored on a monthly basis. The clinician’s profit-and-loss statement will have the necessary information to monitor expenses.

The entire team can help the orthodontist control and monitor production, collection and the expenses. Each member should know what these numbers are, how accountable he or she is for meeting these numbers and how to monitor the numbers throughout the month.

Summary
It is well worth the time and effort to define and monitor the business numbers discussed: break-even point, production and collection goals and overhead expense budgets. This maximizes profits, gives the orthodontist and team more control and ends the guessing game of where you really are financially as a business.

About the author
Scarlett Thomas is an orthodontic practice consultant who has been in the field for more than 23 years, specializing in case acceptance, team building, office management and marketing. Contact her at (858) 455-2149, e-mail scarlett@orthoconsulting.com, or visit www.orthoconsulting.com.
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The ability of i-CATVision 1.9 to save and export scan data in DICOM allows clinicians to work within their 3-D planning software of choice. With improvements made to the DICOM component of this version, corporate practices, hospitals and universities will be better equipped to efficiently share large amounts of information.

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For more information on the i-CATVision 1.9 and Quantum IQ, call (800) 205-3570.

**New products arouse interest during AAO**

FORESTADENT presented several products at this year’s annual session of the American Association of Orthodontists, held in May in Washington, D.C.

One product on display was BioQuick®, the third generation of the self-ligating Quick bracket system. The most significant feature of BioQuick is a new base, which has been adapted to the anatomical contour of tooth crowns.

Another product on display was MiniAnts, a type of bracket with a reduced width, which complements the 2D® lingual bracket system. Until now, twinning brackets in the lower anterior region had to be placed close together because of their width, but there is much more space available with the mini anteriors. This facilitates compensation bends required mainly during the finishing phase.

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<td>November 1-12</td>
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<tr>
<td>Sioux Falls, SD</td>
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<td>Toronto, ON</td>
<td>October 15-16</td>
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<td>Palo Alto, CA</td>
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<td>Stockton, CA</td>
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<td>Moncton, NB</td>
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<td>Littleton, CO</td>
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<td>Kansas City, MO</td>
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<td>Minneapolis, MN</td>
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<td>Carlsbad, CA</td>
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<td>Pittsburgh, PA</td>
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<tr>
<td>Seattle, WA</td>
<td>November 19-20</td>
<td>November 1-12</td>
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<tr>
<td>Kitchener, ON</td>
<td>November 26-27</td>
<td>November 1-12</td>
</tr>
</tbody>
</table>

2011 Events

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