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, where mature patients present with a history of malalignment, it equally benefi cial and fulfi ling results can be achieved. In government-funded systems, patients with congenital abnormalities receive treatment that is essential to their ongoing oral health. Restorative dentists work closely with orthodontists, who can appreciate how small de tails can aid in achieving positive restorative outcomes.

As a young dentist, I corrected a tooth in crossbite with a simple T-spring appliance. It was enjoya ble and brought a diferent type of delayed-growth1 satisfactory to the more cerebral but sensuous molar endodontics or the more artistic and align composite build-up. I was not a specialist, but I managed to do some orthodontics. In contrast to my experience, gen eral dental practitioners are now more routinely providing tooth movement with the emergence of short-term orthodontics (STO). This has resulted in some conjecture as to the methods of achieving “straighter” teeth. Indeed, some may consider STO as an emerging entity competing with specialist orthodontists, but should it be?

The specialist training path way for orthodontics involves a competitive-entry three-year full-time course linked with the achievement of a master’s level qualifi cation that many may feel daunted by. Indeed, navigating the pathway from start to fi nish can be diffi cult academically and fi nancially when factoring in fees and loss of earnings during train ing. Once quali ed, 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 orthodonti c care.

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 fi rst 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 treatment need. There will be an obvious shortfall of adults or adolescent patients with minor malocclu sions 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 diferent settings utilising various techniques with the advent of STO. This may have resulted in some territorial par anesia between the two camps of traditional orthodontics versus STO systems. Conversely, it may be that diferencing scientifi c, techni cal and ethical ethos on managing the same problem is the source of the debate.

Quick and easy?

Commercialisation has modi fi ed the provision of orthodontics in the UK. Indeed, there are now orthodontic brands with courses attached and a faculty of individ uals who promote their particular product. Companies tend to boast that their product is the best with limited complications and treat ment 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 inter ested observers.

The rapid development of STO has not escaped the venture (or some may say vulture) capitalists. In the same vein as DIY 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 middle man (i.e. the dentist). To my knowl edge, STO has yet to make it on to the price list of Samantha’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 conversion may detract from the real reasons we are providing the treatment. The risk and benefit of treatment must remain balanced or be rebalanced in favour of the patient.

The best things in life are rarely quick, easy and without refl ection. 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. Becoming an expert in many a field requires time, effort and experience.

Orthodontics is a complicated discipline that is difficult to deliver optimally and efficiently. Treatment planning should be performed in person not only to ap preciate 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 opt-timal results to a spe cialist orthodontist utilizing traditional methods?

In any case, placing a time limit on any treatment could be considered contentious. Patients ask me all the time “How long is this treatment going to take Doc?” I always reply “I’ll tell you when it’s finished.” As such I am rarely wrong.

Advertising cosmetic treatments the fair dinkum way

The Australian health ministry—recently examined the pros and cons of cosmetic procedures and in particular the modes of promoting the treatments. The working group found that advertising and promotion more often than not focused on the benefits to the consumer, downplaying or not al ways mentioning risks. The group went on to identify advertising practices that were not driven by medical need and where there was signifi cant opportunity for fi nancial gain by those promoting them. They identifi ed the need to

DT launches new international ortho mag

By DTI

HONK KONG: The orthodontic segment has grown signifi cantly within the past 20 years owing to new technologies and products, as well as an increase in adult patients requesting orthodontic treatment. In response to this trend and to update dentists on the most signifi cant developments in the fi eld, Dental Tribune International (DTI) has added ortho—international magazine of orthodontics to its portfolio. The 2016 issue includes articles on clear aligners, vibration therapy and rapid maxillary expansion, as well as the latest product infor mation and event previews.

The high-gloss English-language magazine adopts an interdisciplinary approach involving orthodontics, oral surgery, periodontics and restorative dentistry, and aims to serve as an educational tool, providing comprehensive knowledge and information on the newest technology that can pro fi tably be in tegrated into treatment concepts. The publication, which will be dis tributed at all major international orthodontic congresses and exhibitions, presents the latest research and case studies, as well as trends in procedures and tech niques.

In order to connect with orthodontic specialists, the DTI team is scheduled to attend a number of orthodontic events around the globe in 2016, including the 24th Congress of the European Orthodontic Society, which will take place between 11 and 16 June in Stockholm in Sweden, and the Fourth Scientifi c Congress for Alliger Orthodontics, to be held on 18 and 19 November in Cologne in Germany. DTI will be providing comprehensive live coverage of these and other events on its website. In addition, e-newsletters about the respective events will be sent to orthodontists worldwide.

From 2017, a new issue of the ortho magazine will be published twice a year with a print run of 4,000 copies. An e-paper edition of the magazine is available free of charge via the DTI online print archive.
Regulate promotion and advertising ethically with factual, easily understood information from a source that is independent of practitioners and 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 adverts, 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 end 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 practice as loss leading, one could ask who is losing and who is gaining and at what price?

One important aspect of the report identified the wider social impact of cosmetic procedures in that people may become increasingly dissatisfied with themselves and their appearance, culminating in deeper concerns for the person and reducing scope for individuality. Many dentists throughout the country may have a slipped contact here, a rotation there or a space distal to a canine who are unlikely to be waiting in earnest for the next voucher deal alert on their iPhones. Inducing misgivings or raising concerns about the patient’s teeth position where the teeth are otherwise healthy and the patient presents with no concerns could be considered unethical and worryingly dishonourable.

Relapse of confidence

In a recent publication from an indemnity provider, orthodontics was identified as an emerging area for claims against their clients. This is likely to be the tip of the iceberg, whose size will probably continually grow as more and more orthodontics is provided and the repercussions of which may only become apparent gradually in the future.

In the now highly litigious area 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 labial 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.

Clear steps to business building

A cornerstone of a successful business is the repeat customer who values the dentist and his or her service and returns with no qualms or misgivings about what the dentist feels should be provided. A successful business relies on patients returning in the long term owing to their positive experiences. Focusing on short-term gains without due consideration of quality or reliability of the treatment provided has potential repercussions for patients, the business of dentistry and perception of the profession.
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Individuals play the game, but teams win championships

What it takes to build the ultimate practice unit

By Lina Craven, UK

It is said that all teams are groups, but not all groups are teams. What separates the two is interdependence. A true team is focused on a common purpose; team members support one another and enhance each other’s work and contribution. Andrew Carnegie captured this accurately when he said, “Teamwork is the ability to work together toward a common vision. It is the fuel that allows common people to attain uncommon results.”

I knew that achieving the ultimate team is possible, because when I was a dental nurse many years ago in America, I was part of an ultimate team. What made us great was our leader, Dr Derrick Tagawa. He and his partner had a very clear vision and they knew exactly what was needed from each one of us to ensure the practice achieved its desired results. In turn, each one of us knew that every challenge we faced was an opportunity for personal, professional and practice growth.

Practices with a motivated, focused and empowered team produce excellent results; consequently, patient satisfaction is high and practitioners realise increased financial rewards. Achieving such a team is not pie in the sky but it does require complete commitment from the whole team. Based on my own experience of being a part of a high-performing team and my observations as a consultant to practices, here are my key principles for the creation of an ultimate team.

Do not confuse being the boss with being a leader. Leaders set the tone for the practice. They lead by positive example. Successful teamwork starts at the top with leaders who provide strategic vision and establish team goals. Effective leaders clearly define their vision and share it with their team to establish a common purpose.

Any successful relationship can only survive if values are shared, believed and agreed upon; values like honesty, respect, integrity, commitment to each other, commitment to the practice success. Shared values help to build an effective team and to establish its culture, conduct, rules and policies. The key is to ensure the entire team agrees on the same values and is prepared to work by them. According to the world’s finest flight demonstration team (the Blue Angels, US Navy), “without shared values, peak performance isn’t possible” and “a team’s values must align with its purpose, mission, and actions.”

Every team member, from the leader to the cleaner, must learn to communicate clearly and effectively. Successful relationships are built on positive, honest and open feedback. Is information shared openly and honestly in your team? Does gossip or negative chatter exist in your practice? Team members must learn to address concerns, deal with conflict and accept responsibility for the success of other team members. When conflict occurs, it must be dealt with honestly, directly and openly as soon as possible and in line with the team’s adopted values. Foster positive attitudes and creative thinking — attitudes can either make or break the team dynamics, so there is no place for negative people.

Do all your team members have a clear and up-to-date job description? Are they all qualified to undertake their roles? Are there written procedures for every area of the practice? Often team members say they are not sure who is responsible for something, or they do not have a job description, or they were promised training when they started, but have not yet received any owing to the practice being too busy. Cross-training increases efficiency and thus becomes bored or complacent. Dr Tagawa believed in providing the best training for his staff. He also recognised that he may lose some individuals who desired greater career progression than the practice could offer. He knew nevertheless that those who remained would perform at their peak and more than justify his investment.

Each team member is a cog in the practice’s wheel of success. However, many are often underutilised in their or her full potential and make each person more productive and valuable to the team.

Each team member is a cog in the practice’s wheel of success. However, many are often underutilised in their or her full potential and make each person more productive and valuable to the team.

Every morning in Dr Tagawa’s practice as part of our commitment to the team, we would meet 10 minutes prior to the start of the day to prepare for the show. The head receptionist had a simple but effective system for updating us with vital information, including how many patients we would be seeing, special recognitions (like patients’ birthdays), identifying difficult patients, where staff were expected to be (from the rota) and anyone off that day. It only took 5 minutes for the update and 5 minutes more to review the day before regarding what had worked well and what had not. It helped us to focus on the day ahead.

Consistency is critical to creating the ultimate team, it fosters credibility and trust. Ken Blanchard and Sheldon Bowles wrote in their book Raving Fans, “customers allow themselves to be seduced into becoming raving fans only when they know they can count on you time and time again.” This is also true for teams; just replace the word “customers” with “team members.” I often hear people say things like “one day we’re instructed to something and the next day it becomes something else.” If you want to be part of the ultimate team, be consistent.

It is said that what motivates individuals the most is recognition — a pat on the back or a word of praise here and the job is well done. Embrace this principle and, although it may feel awkward at first, if it is done often enough it becomes a habit. Sam Walton, founder of Wal-Mart Stores, said: “Appreciate everything your associates do for the business. Nothing else can quite substitute for a few well-chosen, well-timed, sincere words of praise. They are absolutely free and worth a fortune.”

Building the ultimate team does represent a challenge, but once achieved it is hugely rewarding. There is no point implement- ing one principle in isolation. It is like baking a cake without the eggs.

“Successful leaders embrace the power of teamwork by tapping into the innate strengths each person brings to the table.”

Blue Angels, US Navy

Lina Craven is founder and Director of Dynamic Perceptions, an orthodontic management consultancy and training firm in Stone in the UK, and has many years of practice-based experience. She can be contacted at info@linacraven.com
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Conservative smile design for the general dentist

By Dr Rami Chayah, Lebanon

Abstract

This article discusses the advantages of short-term anterior tooth alignment using the Inman Aligner system, particularly for general dentists. The article will give a brief description of the Inman Aligner appliance and its use in short-term orthodontics, and it will answer three major questions the general dentist should ask himself/herself during the treatment planning process. In support of this treatment modality, three case scenarios general dentists see daily will be given as examples.

Introduction

General dentists face the daily challenge of performing cosmetic veneers for patients with misaligned anterior teeth who refuse orthodontic treatment, many of whom regard fixed orthodontic treatment as too long a commitment for achieving their desired aesthetic results. In today’s fast-paced life, some patients are not prepared to wait or to go through long treatments. One of the greatest benefits of short-term anterior alignment is that many people who would refuse comprehensive orthodontic treatment may accept short-term removable alignment techniques such as the Inman Aligner system.

The Inman Aligner is a simple removable appliance; a modification of the removable spring retainer. It uses super elastic coil springs to apply highly efficient light and consistent forces on both the labial and lingual surfaces of the anterior teeth (Figs. 1 & 4). The appliance is fabricated on a cast on which, based on a surgical model, the anterior teeth need correction have been removed and reset in the ideal position in wax on the working cast. When the patient wears the appliance, the built-in forces generated by the spring coils will correct the misaligned anterior teeth (Fig. 9).

What distinguishes the Inman Aligner appliance from other short-term orthodontic systems such as Invisalign (Align Technology) and Six Month Smiles is its low cost, low risk and short learning curve for general practitioners. Only one appliance is used from the start to the end of the treatment. Sometimes, several clear aligners may be used to rotate resistant canines. The system is well received by patients because it is fast and relatively cheap. It also accommodates today’s active lifestyle. Usually, most cases take from six to 16 weeks. Patients can take the appliance out during meals or work meetings.

As with any other treatment technique, the Inman Aligner has its limitations. Hence, case selection is imperative, as the Inman Aligner is not suitable for posterior orthodontic treatment or Class II or III treatment. Only certain types of movements are possible and some patients will still need conventional orthodontic treatment or indirect restorations. Certain criteria should be met before treatment proceeds. At consultation, other orthodontic alternatives should be offered. The dentist must quote for the long-term retention maintenance and should look for any skeletal discrepancies. Compromises must be signed off.

Treatment concept and case presentation

Dentists need to consider three questions about treatment during the treatment planning process. The first question: can the patient’s teeth be
fixed without orthodontic treatment in a very short period. In order for the general practitioner to answer this question, he or she should first establish whether the patient does not wish to pursue orthodontic treatment because of the time commitment and cost. Would he or she also refuse short-term anterior tooth alignment? Would the occlusion be improved even though a Class I molar or Class I canine relationship may not be achieved? Patients may prefer short-term alignment techniques because of the shorter treatment time and the lower cost.

Case 1

The first case presented is a good example of a scenario relevant to the question above. The patient was a young woman at college who presented at my office requesting a full smile makeover of 20 veneers; she desired a “Hollywood smile” as expressed in her own words. Her complaint was the retracted maxillary right and left central incisors, the incisal edge wear on the maxillary central incisors and mandibular anterior teeth, the pinoy shape of the maxillary and mandibular canines, and the yellow colour of her teeth overall (Figs. 4 & 5). It could be argued that it would be highly unethical to prepare the sound enamel, transforming her ten maxillary teeth into stumps, for the rest of her life, especially at this young age. After long discussion and explanation of the disadvantages of the shortcut route of preparing her teeth for ceramic veneers, this option was excluded. Several other options were available and discussed with her, but because she wanted a smile enhancement in a short period of time, conventional fixed orthodontic treatment was also excluded. After checking her bite, it was observed that there was insufficient interocclusal space to shift the maxillary central incisors forwards without opening the bite. However, the patient accepted the removable Inman Aligner system to its short treatment time and flexibility regarding being able to take the appliance off during the day while eating.

The treatment plan was to follow the AABR protocol alignment, bleaching and bonding. This concept still constitutes a smile makeover but in a very conservative manner. Taking into consideration her age and her sound enamel issue, this was agreed to be the most progressive means of carrying out her smile enhancement. First, her maxillary teeth were aligned using the Inman Aligner with an expander for nine weeks. Two extra-clerar aligners were used in the last two weeks of treatment to de-rotate the maxillary left lateral. Once the maxillary teeth had been aligned and in the two weeks of treatment, the teeth were bleached with custom-fitted super-sealed trays (Fig. 6). Now the incisal edges had been stained and whitened, the patient became more aware of the differential wear on the incisal edges of her anterior maxillary and mandibular teeth. Incisal edge bonding using composite resin bonded using a simple direct technique. The patient was very happy with the final result (Figs. 7–9).

Case 2

The second question to be considered regarding treatment: would some of the teeth be aggressively prepared or end up with root canal treatment if treated with restorative dentistry without alignment and would the overall outcome be better with alignment rather than without? This question addresses the ethical dilemma general dentists face every day. We often have cases over- lapping anterior central incisors in our office.

The patient presented in this case was bothered by the look of his overlapping maxillary central incisors (Figs. 10 & 11). His mandibular teeth were also crowded, but for some reason, his concern was only with his maxillary teeth. He had started to hide his smile in front of his friends, feeling embarrassed to show his maxillary teeth. After the full orthodontic examination and discussion about all of the treatment options, including comprehensive orthodontic treatment, the patient chose the removable Inman Aligner system owing to its flexibility in that the wearer is able to remove the appliance off during the day while eating. Although left central incisor would have been aggressively prepared had it been treated restoratively by using a simple anterior alignment technique, the treatment took only eight weeks to straighten the teeth and a great deal of sound enamel tissue was preserved by conservatively resolving the unattractive appearance of the maxillary teeth (Figs. 12 & 13).

The treatment plan was to align the teeth first and then to reseal the restorative work needed (Fig. 16). The appliance was used for 12 weeks and only worn for 8 to 10 hours a day. During the last three weeks of alignment, the patient began to bleach his teeth. By week 12, the teeth were straight and the dentine of the incisal edges (Fig. 25). The patient initially requested Inman Aligner veneers to resolve his smile problem, but after mocking up the design directly in his mouth, he was discouraged from pursuing this option owing to the amount of tissue that would be lost. The aggressive preparation of the occlusal image of his maxillary teeth after alignment to assist the restorative work needed (Fig. 26). Natural-looking thin maxillary veneers owing to aligning the teeth first (Fig. 28).

Case 3

The third question to be considered: will the teeth require restorative work anyway, even after alignment?

The case presented serves to demonstrate the necessity of aligning the teeth even before placing ceramic veneers. The patient in this case exhibited moderate misalignment with major anterior edge wear due to occlusal trauma. In addition, the teeth were darkened through years of stains being absorbed through the wear (Fig. 27). At this point, a direct mock-up was done to show the patient the smile design that could be achieved with composite. He felt that the teeth were still flat and wanted a fuller smile. Because we had aligned the teeth, only minimal preparation was needed as evident from the wax-up and the decision was made to fabricate ceramic veneers instead (Fig. 28). This case shows that for complex situations and considering patients’ high aesthetic demands, pre-alignment is essential to produce minimally invasive veneers with minimal enamel loss.

This clinical approach guarantees that the strength of bonding to the enamel is much greater.

Conclusion

The goal of this article is to encourage general dentists to reflect on the importance of considering short-term tooth alignment alone or in conjunction with restorative dentistry when treating patients. Hopefully, these three questions and cases will prompt readers in thinking through the process of this treatment modality.

Disclosure: Dr Chayah is the trainer for Inman Aligner Training in the Middle East. He provides hands-on, full-day certificate courses to general practitioners.

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