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Dr. Robert Boyd: **Why Do Early Treatment If It Is Less Efficient?** page 32

December 2010 – Volume 3, Issue 11

# orthotown

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# Social Media
## & Professional Practice

by Dr. Donald E. Machen & Hollie A. Bernstein Machen, Esq.


**Associate Recruitment 101**
What success factors will lead to your desired result? page 23

**Technology Case Report**
Class I with deep bite and crowding treated with lingual, CBCT and SureSmile, page 29

Message Board: **"Patients brought their own brackets and asked me to do the treatment,"** page 10



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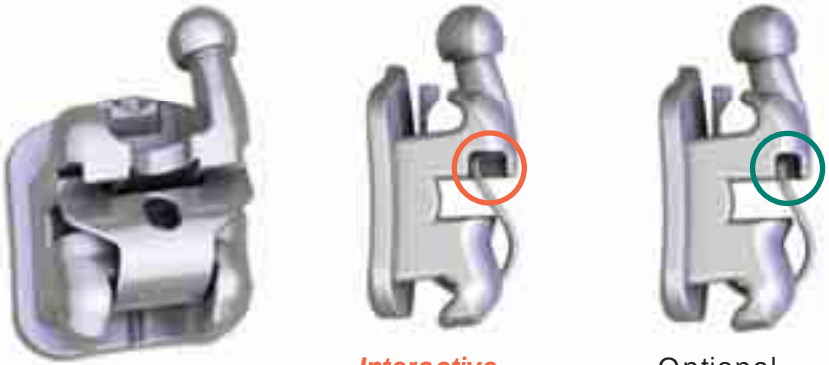

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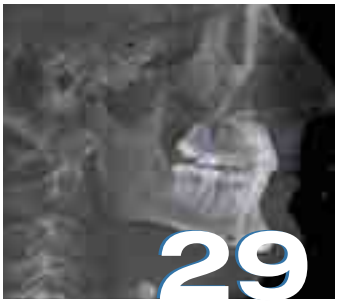



## Articles



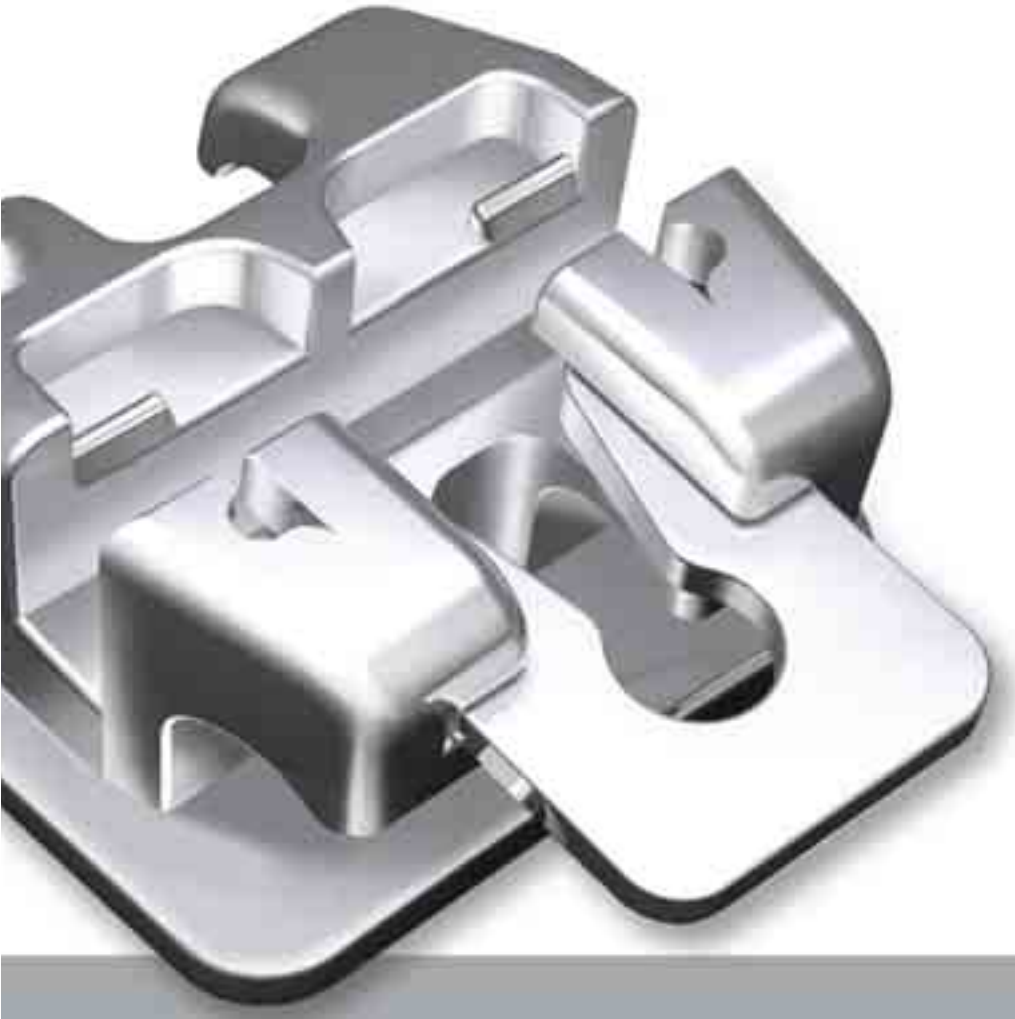
## Townie Clinicals



## Message Boards



## In This Issue



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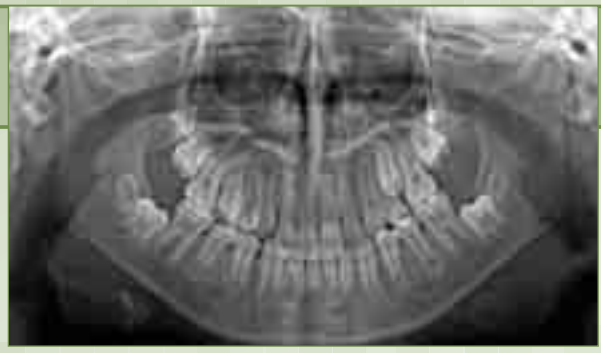

### Help Distalize This Molar (Without TADs)

Since the 7s aren't in yet on this 10-year-old patient, this Townie was hoping to use some type of a bonded appliance to attempt tipping/distalization of the UL6 and eruption of UL5. Any suggestions?

Distalize This Molar Search

## Message Boards

**Lack of Payment**

Does anyone have a good standard protocol for when patients (parents) quit making payments?

Lack of Payment Search

**Former Partner Just Opened Down the Street...**

Anyone else have this happen to them? What would you do in this situation?

Former Partner Search

### ONLINE CE

**Exceptional Service – Contagious Passion by Jeff Behan**

You never get a second chance to make a first impression, right? Learn tips on providing exceptional customer service, with a special emphasis on how front office staff can succeed in making the right first impression every time.

### MONTHLY POLL

**Marketing/New Patients**

Do you send out direct mailers?

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b. No

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Throughout *Orthotown Magazine,* you can scan tag codes to access information directly from your smartphone. To scan these codes, visit **http://gettag.mobi/** to download the free barcode reader to your mobile device. Then scan every code you see in *Orthotown Magazine* to access additional information, enter contests, link to message boards, comment on articles and more!

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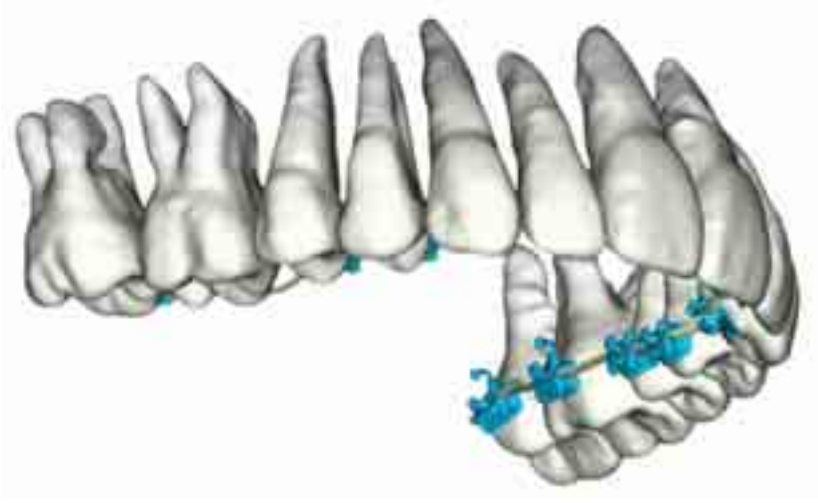

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# Statistics and Milestones

by Wm. Randol Womack, DDS, Board Certified Orthodontist
Editorial Director, *Orthotown Magazine*

December signifies many milestones for *Orthotown Magazine.* First of all, it is the end of our second full year of publications exclusively for the orthodontic profession. I feel so blessed to hear positive responses about the magazine from friends and colleagues at meetings I attend. Last month I attended the Invisalign Summit in Las Vegas and received many compliments about Orthotown.

*"To those of you who took the time to respond, we thank you very much. The feedback on* Orthotown Magazine *and Orthotown.com is sincerely appreciated."*

At the Invisalign Summit, Dr. Robert Boyd received the equivalent of a Lifetime Achievement Award from Align Technology for his dedication and contribution to the development of the Invisalign System and the advancement of Invisalign education over the past 12 years. Dr. Boyd was not only instrumental in the early development of the aligner system, but he persisted through the early years of questions and criticisms from colleagues and administrators about being involved with this "questionable orthodontic project" called Invisalign. His commitment to a vision to make Invisalign a viable option for excellent orthodontic treatment, in spite of having his judgment and his reputation questioned, is something quite extraordinary. If you know Dr. Boyd or have heard him lecture, you can understand why he deserved this honor. Visionaries like Dr. Boyd are what keep the content of *Orthotown Magazine* exciting and new.

December also is the time of year when we complete our annual Orthotown survey. To those of you who took the time to respond, we thank you very much. The feedback on *Orthotown Magazine* and Orthotown.com is sincerely appreciated. Here is a sampling of some of the positive responses we received:

*"A good source of timely clinical information."*

*"Great forum for discussion of clinical and management issues."*

*"Great way to get feedback from colleagues."*

*"Very current, amazing insights from dedicated doctors; a great resource."*

*"Great clinical case discussions. Excellent CE courses. Some very good clinical articles."*

*"It's like a study group on paper and/or computer."*

And one that really caught my eye:

*"A help site for beginners."*

Other interesting statistics:

- 72 percent of responders knew that Orthotown.com membership is limited to orthodontists.
- 69 percent did not agree for vendors to be involved in discussions.
- 85 percent of responders read *Orthotown Magazine.*
- 44 percent of responders have posted a case or comment on Orthotown.com message boards.
- 37 percent of responders prefer to obtain the majority of CE credits online.

Of course, we had negative comments as well, but they were "politely" negative with a tone for constructive criticism. Frankly, we learn the most from these very welcome responses.

So, I and the very competent and fantastic staff at Orthotown, sincerely thank all of our responders for taking time to participate in our survey and for letting us know that we are providing cutting edge, up-to-speed, valuable and interesting articles and discussions to our orthodontic profession.

One final statistic: 61.4 percent of the survey responders plan to attend the 2011 AAO meeting in Chicago. Therefore, we extend a sincere invitation to you responders, and to all our readers, to stop at our booth so we can personally express our appreciation for your support over the past two-and-a-half years. ■

For the Next

# BIG THING

in Orthodontics


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*— Dr. William R. Womack, DDS, Editorial Director, Orthotown Magazine*

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# Patients Brought Their Own Brackets and Asked Me To Do the Treatment...

*Ever had patients bring in their own hardware and ask you to put it on their teeth? Do you think it's a legitimate or ridiculous request?*

**krismadental**
Posted: 9/24/2010
Post: 1 of 18

Hello. Just want to share.

Lately I have found a lot of patients who have brought their own brackets (usually straight wire brackets) and also O-ring elastics and have asked me to do ortho treatment for them.

They tell me that they bought them online.

I refused them, and am still feeling upset until now.

This month there have been six patients who contacted me to do so.

I wonder if it is happening in other countries.

The craziest thing is that there are also a lot of patients who get their brackets on by some dental lab technicians and ask me to correct their previous treatments.

The world is crazy nowadays. ■ [krismadental practices in Indonesia]

**like2drill**
Posted: 9/24/2010
Post: 2 of 18

That is quite unusual.

I probably would offer to do the ortho, but only discount my cost of the brackets.

What most patients don't get is the cost isn't in just the brackets alone. You need at least eight to 12 years of college and a dental license to use them legally on real people.

I would tell them I order my brackets in bulk at $2.35 a bracket, and the O-ties are free for me. Multiply that times an average of 32 brackets a case (including debond/replacements). I might give them $200 just to be sporting.

The three degrees you see on my wall are the expensive part, not these things you bought off the Internet made in China.

Would they bring in a box of car parts to a dealership and say, "I don't want to buy a car, but can you put this one together for me?" ■

**krismadental**
Posted: 9/24/2010
Post: 3 of 18

When I told them no, the patients just say, "OK if you don't want to help me, I'll just go to another dentist or find a technician, and ask him/her to put these things on my teeth."

It really upset me.

Is it happening in the U.S., too? ■

**mkbark**
Posted: 9/24/2010
Post: 4 of 18

You might also mention that used brackets can be reconditioned and resold. There's no guarantee of how the reconditioning was done, and whether the properties of the brackets were affected. Also, do they want the O-ties, etc. sterilized before you use them in their mouth? That will certainly affect their treatment fee. ■

I think I would just refuse to use their brackets, ask how much they paid for them, and give them double that amount off the cost of the case. I wouldn't dare bring my own sutures to the dermatologist when he is removing a mole or something... weird. ■

**Wired**
Posted: 9/24/2010
Post: 5 of 18

Wired, I think that's a bad policy to set, since krismadental says he's had six calls this month with the same request. I would just refuse to use appliances which nothing is known about the provenance. And no, I've never had such a request! And I like the analogy of taking the parts of the car to the mechanic. ■

**mkbark**
Posted: 9/24/2010
Post: 6 of 18

Mkbark, holy cow! You are right. I missed the part about six patients in a month who had made this request. Forget it! I thought it might just be a single patient here and there. Give me a break, what are these folks thinking? Imagine someone walking into a plastic surgeons office with their implants from eBay... What about going to the periodontist with an implant in hand? ■

**Wired**
Posted: 9/24/2010
Post: 7 of 18

I have never heard of it happening in the U.S. – not to say that it hasn't happened.

Practicing without a dental or medical license is a felony in the U.S. Go to jail for a few years if caught and convicted. Every few years you will hear something on the national news about someone practicing medicine without a license and defrauding people. ■

**like2drill**
Posted: 9/24/2010
Post: 8 of 18

I'm speaking from experience – years ago, I worked in a practice that reconditioned the brackets so many times that the brackets would frequently spontaneously separate from the pad during treatment. ■

**mkbark**
Posted: 9/27/2010
Post: 11 of 18

My policy is: If you bring in your own brackets, you also have to bring in your own assistant.

I'm not too far from Mexico, and have (thankfully) never had a patient bring in their own brackets.

What I see far too often are patients who get bonded down in Mexico, and then come here for adjustments. They are told by their dentist/ortho in Mexico that "anyone can see them in the U.S. for an adjustment."

I had a family with three kids just bracketed down in Mexico, who showed up for their first "adjustment." Imagine their frustration when I told them we don't work like that here. ■

**njtxortho**
Posted: 9/27/2010
Post: 12 of 18

I live in California, but not close to the border. I also see people that get braces on in Mexico (and often dirt cheap). Usually the bracket position is awful, and it does not help me at all that their braces were put on elsewhere, as I need to reposition most of the brackets.

Is it that orthodontists typically charge a quarter to a third of the total treatment fee as a down payment before bonding, that people think they are getting a super deal by getting the brackets poorly placed in Mexico? Should any discount be given to someone who shows up with braces placed in Mexico (just to get them on), and how much if so? ■

**sharperdds**
Posted: 9/27/2010
Post: 13 of 18

*continued on page 12*

continued from page 11

**swamp fox**
Posted: 9/28/2010
Post: 14 of 18

What the hell is going on!

Here are my brackets, can you stick 'em on? I live in Australia and have never heard of it happening. I would charge the same as for any patient, plus a few hundred more for being disrespectful to the profession.

We are close to Asia, so a few go there and get banded up. I charge them a full fee and take off the crappy fake brackets and replace them with real ones.

I like the idea of sterilization for Hepatitis, HIV, etc. – they need to be aware of the risks.

The other question is: Are these the patients you really want in your practice? ■

**caortho**
Posted: 9/28/2010
Post: 15 of 18

I was laughing at the whole ridiculous situation until I remembered that I just had a mother of a patient ask me to glue back on some of the crappy brackets that have come off since they were put on in the Philippines last year. She planned to go back every six months (nice recall system), but "something came up." It's now dragged on for a year, and she's never been seen by "her doctor."

I considered being nice for a few seconds and then looked in her mouth at the brackets that remained, the missing teeth, the crowding, rotations, bite collapse, etc. and realized she needs to be stripped and to have records.

She declined.

Not my problem. ■ CA

**krismadental**
Posted: 9/29/2010
Post: 17 of 18

It seems that the parents want to do the best for his/her children, but unfortunately their economical state is limited. So the parent goes to an "alternative" orthodontist to treat their children. ■

**umngmc**
Posted: 10/7/2010
Post: 18 of 18

I've had one guy from the Philippines come in with Damon braces on and some Damon brackets that his orthodontist gave to him knowing that he was coming to the States to resume his treatment. I thought that was really nice of the ortho in the Philippines. Too bad his brackets were all over the place in his mouth.

The funniest case for me is the patient who came from India with "pin and tube-like" braces on his teeth and demanded I use the existing fixed appliances because his ortho in India told him he only had a few months of treatment left. I had no idea what kind of appliances they were! I had to look up online the closest resemblance and my first thoughts were Johnson twin wire or pin and tube. Anyways, to make a long story short, it was my way or the highway and the patient took the highway.

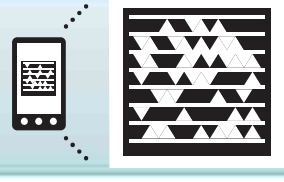
Five percent of your patients cause 95 percent of your problems. Weed out that five percent and life is bliss. What happens if he loses a bracket? What happens if a bracket becomes damaged? You then have to substitute one of your own with a different prescription? All problems I don't want to deal with, no thanks.

Deduct the cost he spent on those brackets off his treatment fee. Problem solved.

Still laughing from your dilemma.

Good luck! ■





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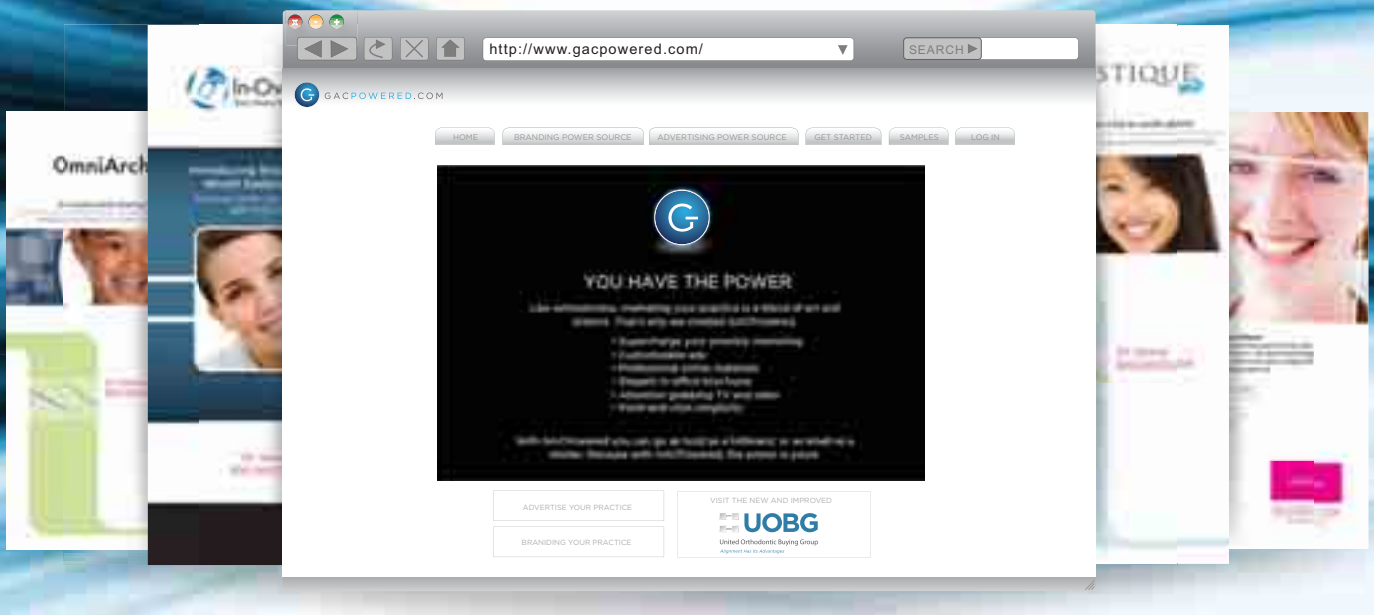


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# How Would You Treat This Case?

*Everyone has a different opinion about how to treat this unique case. Put in your two cents.*

**drmithuna**
Posted: 8/12/2010
Post: 1 of 19

A 12-year-old came for a second opinion.
Impacted upper second premolars.
Still sucks her arm at night...
How would you treat this case?
Thank you! ■

**charlestonbraces**
Posted: 8/12/2010
Post: 2 of 19

Is she Sunday biting? The OJ in the ceph and the lateral photos don't jive. ■

**jwkortho**
Posted: 8/14/2010
Posts: 3 & 4 of 19

I agree. There is a discrepancy in the lateral photos and the ceph. The ceph also does not appear parallel with FH. With that being said, this would be a simple choice for me of extracting the impacted maxillary second premolars, the mandibular first premolars, followed by RME.

I'm not sure that I would include many other options.

*[Posted: 8/14/2010]*

In reviewing the case one more time, I might include a surgical option of a mandibular advancement, if the parents/patient were interested. ■

**dhmjdds**
Posted: 8/16/2010
Post: 5 of 19

The left quad photo and the ceph are probably close to correct. She is definitely not biting on her back teeth in the right quad or the anterior teeth photo. I recommend retraining your staff on both lateral cephs and photos!

I agree with the four bicuspid extraction and expander then braces plan. Surgical correction seems like way overkill to me.

You could take out the erupted upper bis and allow the blocked out teeth to erupt; this would save her from expensive surgical extractions. ■ Diane

**ahayes**
Posted: 8/16/2010
Post: 6 of 19

My brain couldn't figure out the ceph. Makes more sense to me like this.

Normally, I'd like to expand before extracting anything, but I'd be in favor of extracting the teeth in the palate now. There's no place to put the jack-screw with the palatal teeth acting like huge tori. I'd also use a bonded RPE or a Hyrax with a posterior coverage splint on the lower together. Then re-evaluate for bracketing and/or lower extractions. My hunch is that I'd probably be treating this case as a uni-arch extraction. ■ andy

**SylvainChamberland**
Posted: 8/16/2010
Post: 7 of 19

Extraction of all 5s (second premolars) would be easier than 5/4.

You need to protract lower 6 to obtain Class I molar relationship and minimize lower anterior retraction. As you protract lower 6s, you bring them in a narrower part of the arch and this will help to correct the transverse discrepancy. RPE would cause the bite to open more. Good luck. ■

**ahayes**
Posted: 8/16/2010
Post: 9 of 19

Sylvain, then why extract at all? To protract a molar?

The above makes little sense to me. How will bringing the lower first molar into the second bicuspid spot (a narrower part of the arch) fix the transverse problem? Also, isn't the second molar in the first molar spot the same thing? ■ andy

**SylvainChamberland**
Posted: 8/17/2010
Post: 10 of 19

Andy, why extract at all? Because of the crowding of tooth 3.3.

Because alignment in a non-extraction approach will procline lower incisor and it will adversely affect the OJ and OB. This will increase lip incompetency, procline lower lip.

To obtain Class I molar relationship.

Upper first molar is mesially rotated and only mesiobuccal cusp are in crossbite. If you de-rotate the molar it will look not as constricted as it looks.

Width across lower second premolar is narrower than the width across the first molar. Therefore extraction of the premolars will result in a narrower width across the first molar. In a study (accepted for publication in a referee journal but not yet published) it has been shown that the inner first molar width decreased by a mean 1.9mm.

Yes, the second molar in the first molar spot is the same thing. If you look at an arch form which is a parabolic form, the closer you are to the front, the narrower it is. If a tooth is missing on both sides, chances are that molar will be in a narrower part of the arch form. ■

**Wired**
Posted: 8/17/2010
Post: 11 of 19

Hey Andy, if you use a Hyrax with the lower full coverage splint, how is the lower splint designed? Is it removable or fixed? I like the idea of bonded RPEs, but I hate the removal and oral hygiene problems with them. But I have no experience with the Hyrax and lower splint setup and thought it might be better. ■

*continued on page 16*

continued from page 15

**ahayes**
Posted: 8/17/2010
Post: 12 of 19

Wired, it would be removable. It's nothing elaborate. Usually, just a lingual wire with a ball clasp or two. Kind of like the Gelb splint below.

I've also just used an Essix made out of some thicker material and it worked fine. ■ andy

**jwkortho**
Posted: 8/17/2010
Posts: 13 & 14 of 19

So, Andy, what is the purpose of this removable lower splint, especially if this is an extraction case?

*[Posted: 8/17/2010]*

This case is a good example of why it's risky to treatment plan from just photos (like some of my orthodontist friends).

I measured the ANB from this ceph as seven degrees with an IMPA of 89 and U1/NA of 23.8.

None of the photos jive with the ceph.

I'm thinking non-extraction in the lower arch to help compensate for the Class II skeletal along with advancement mechanics (like Fosus).

I'd even consider postponing the decision about upper extractions until I've expanded, de-rotated the upper 6s and consolidated any space gain into the second premolar areas... using a quad.

You might be surprised how much less crowded the 5s become after achieving these goals. ■ JG

**ahayes**
Posted: 8/17/2010
Post: 15 of 19

jwkortho, the patient is already an open-bite and near the hypodivergent side with the mandibular plane angle. Like with a bonded RPE, the idea is to disclude the teeth and guard against bite opening with expansion. Ideally, the Gelb-type splint would have the side effect of some molar intrusion but that's hard to count on when you desire that side effect. ■ andy

**BRACESBED**
Posted: 8/30/2010
Post: 16 of 19

Extract teeth 4 and 13
Palatal Expansion
Extract teeth 21 and 28
Vertical elastics ■

**tom525**
Posted: 8/30/2010
Post: 17 of 19

1. ENT consult
2. Extraction of premolars
3. Bite closing Herbst appliance with palatal expansion and SWA
4. Prepare family for the possibility of surgical correction if growth correction is limited ■

# Class II, Bi-lateral Brodie Bite

*Patient with a brodie bite has this Townie questioning his technique and seeking advice for next time.*

**ahayes**
Posted: 5/25/2010
Post: 1 of 33

**Case: Beginning Images**

This is a case that I've just debonded. It's not your run-of-the-mill case.

I thought this might be a good discussion because this patient got several differing opinions about treatment prior to starting with me. I'm going to leave it open for comments and interpretation before going through with the progress and final records.

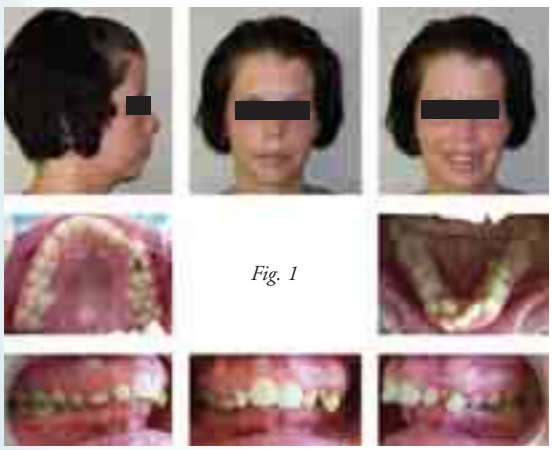


*Fig. 1*

*Fig. 2*

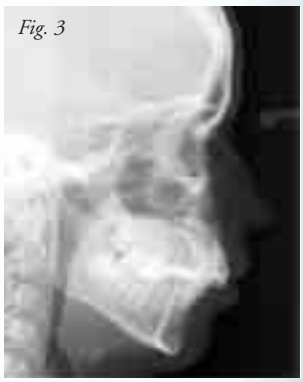


*Fig. 3*

Some things of interest:

- The patient is in her mid-20s at the start.
- Bi-lateral buccal crossbites.
- She comes from over an hour and a half away.
- There were some large gaps in treatment due to serious illness of her child... aka treatment time was long and it was not all my fault.

This is not my best case or finish. Looking back, there are a lot of things I've learned from and would have done differently here. Feel free to educate me further!

OK, it's on.

**Case: Progression Images**

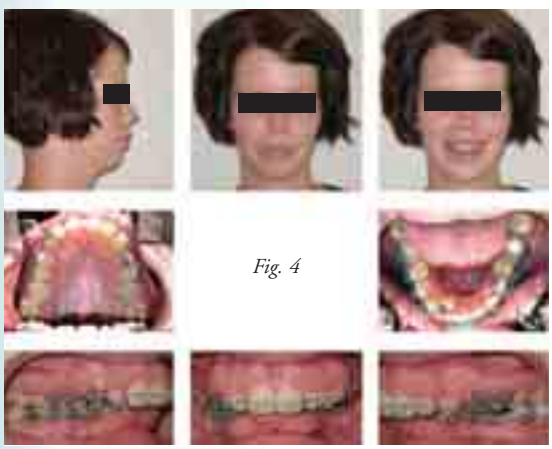


*Fig. 4*

**Fig. 4:** *Posted: 6/1/2010* in Post #15

**Figs. 5-6:** *Posted: 6/4/2010* in Post #21

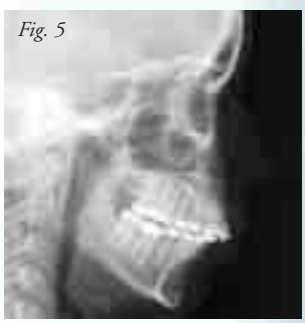


*Fig. 5*

*continued on page 18*

continued from page 17

Fig. 6

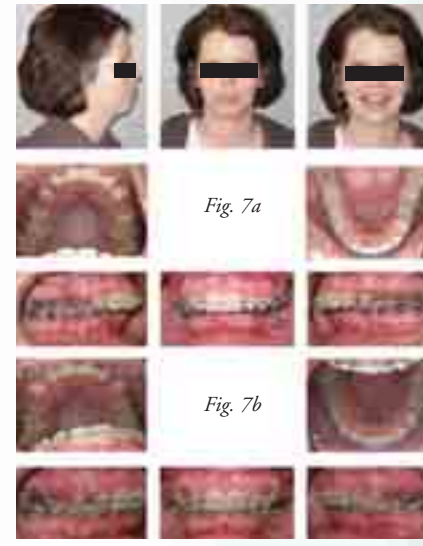


Fig. 7a

Fig. 7b

**Fig. 7:** T-loops activated for space closure, intrusion and palatal root movement.

**Case: Final Images**

**Figs. 8-11:** Here's the final. I've had mixed feelings about this case. Honestly, I was disappointed with the case initially. After I looked at the final composite images, I was almost embarrassed to have my name associated with it. Then I compared each of the before and after images and was relatively satisfied.

**Fig. 8:** Immediately after debonding and laser recontouring.

Fig. 8

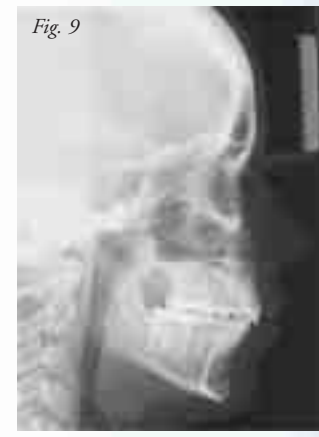


Fig. 9

Fig. 10

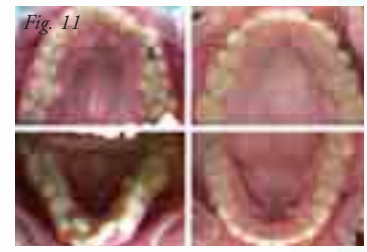
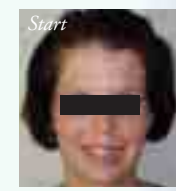


Fig. 11



Start

Finish

The total treatment time was every bit of three years and I feel like the debonding was still premature. Throughout the treatment she was very good about driving in from several hours away. There were a few periods of time where she wasn't able to come in for several months.

In reviewing this case, there's a list of things that I'd like to have done or taken back and done over. I'll add some of them when I get more time.

Shoot away! ■

I'm surprised the Cs are still there. Someone has done all these restorations, but it didn't occur to them to extract the Cs.

How about a lower Schwartz plate and see where you are at? Probably then extract 4s. TADS for anchorage on the upper 6s. This is a tough case. ■

**amalgamator22**
Posted: 5/25/2010
Post: 2 of 33

I had an adult patient who had a very similar lower jaw. I ended up placing a bi-helix and got great expansion.

Her upper incisors are already upright, so I would not think to extract upper bis.

She really looks like a surgical case, but I'm curious to see how she finished. ■

**njtxortho**
Posted: 5/25/2010
Post: 3 of 33

Amalgamator22, I think that is a nice conservative plan. ■ andy

**ahayes**
Posted: 5/26/2010
Post: 5 of 33

My vote is upper 4s and lower 5s. TADs as needed if things open up. Not sure why the gums seem so fibrotic. (Health history?)

Posed smile, probably more gingival display on natural smile.

Perio grafting as needed depending on hygiene.

Possibility of gingival embrasures.

Three-month hygiene recalls.

Functional shift?

Future consideration for surgical correction if there are remaining aesthetic issues beyond the help of orthodontics. ■

**catch-22**
Posted: 5/28/2010
Post: 7 of 33

This would be a great case for MSDO (mandibular symphyseal distraction osteogenesis), followed by a mandibular advancement. It appears that you would need 8-9mm of widening. Third molars are well developed with primary teeth remaining. How old is she? ■

**jwkortho**
Posted: 5/31/2010
Post: 9 of 33

I'd likely start with extracting upper Cs and a bi-helix on the lower and see if I could get any correction of the brodie bite. If I'm lucky enough to get some buccal occlusion then I can start thinking forward of what I can do to correct the AP discrepancy. Considering the patient's age and Class II relationship, it seems that without surgery we're going to end up with a compromise somewhere. Either the upper incisors are going to be over-retracted (extract U4s) or she'll end up with excessive overjet (nonextraction). ■

**OrthoUte**
Posted: 5/31/2010
Post: 11 of 33

# Lean and Mean Ortho: Cost Saving Measures in an Orthodontic Practice?

*Times are tight. What do you do to keep your practice running smoothly, but at better cost efficiency?*

**Wired**
Posted: 2/8/2010
Post: 1 of 48

As a newbie I have a lot of time to try to figure out how to stay lean and mean. I was wondering if anyone else would be willing to share any tips and tricks. Here are the things that I do.

- I use Safco Dental for supplies; compared to Schein they are about 20 percent cheaper on almost everything.
- Stainless impression trays so I don't throw away $0.50 every time I take an impression.
- OrthodonticStore.com for some things.
- American Grad deal right now so brackets and wires are pretty cheap.
- eBay curing lights – Woodpecker B. Great light!

That's all I can think of right now. ■

**fanasticsmiles**
Posted: 2/10/2010
Post: 4 of 48

How about saving money on software and annual fees to software companies by:

1. Using Microsoft Outlook for scheduling or Google Calendar for storing contact information.
2. Using QuickBooks or Office Accounting Pro for billing, accounting needs.
3. Using a free Web-based photo editor program – such as Picasa or Windows Live photo gallery.

Definitely some out-of-the-box ideas, but hasn't anyone tried this before?
I am starting an office this year and considering using the above for software. ■

**Wired**
Posted: 2/10/2010 ▪ Post: 5 of 48

Not sure that you can schedule multiple columns of patients on Google Calendar, but I do love some Google products! ■

**ucla98**
Posted: 2/10/2010
Post: 6 of 48

I've used a $10 appointment book to schedule my patients in multiple columns for years; 60-100 patients a day... no problem at all. Why do the appointments have to be made on the computer?

I bought Mathieu pliers from eBay for $7 each. And they're still in good working condition after three to four years of heavy usage. ■

**fanasticsmiles**
Posted: 2/15/2010
Post: 7 of 48

You can enter as many multiple appointments as needed in Google calendar... just need to click on the "day" view. The only problem that I can foresee with this is you can only do 30 appointments, unless you manually choose to edit each appointment time. I haven't tried this with Microsoft Outlook yet, but I am fairly sure it works as well.

The advantage of using an online calendar/appointment book is that you can view the calendar and appointments from any computer with internet access anywhere, you can make and change appointments from any Internet-enabled computer

as well, if your office is not open five days a week and you wanted to have an administrative assistant answer phones, this could be done at an out-of-office site with any Internet computer.

I definitely see the simplicity and efficiency of using an old fashioned written appointment book with a pencil, but if you are only doing this to save money then you can use Google calendar for free and have instant access to your appointment book and contacts from anywhere.

No one out there has attempted to use any Microsoft or Google products in their office? ■

**eggraid101**
Posted: 2/15/2010
Post: 8 of 48

I like using Google for spreadsheets and documents, but I really like the ortho software for everything we do in the office. I've never used Outlook (Macs only here for whatever that's worth) and it is interesting to think about cutting out practice software, but having everything right there, easy to find, easy to use is the best thing about software. Chart notes, X-rays, pictures, and also letters that we write to patients and GPs. Maybe you can create a letter template in one of those software programs, and the patient's info pops in there? It's a nice idea, and I bet there will be a way to do this without too much difficulty in the future. I have loved having TOPS in my office, though. ■

**nysent**
Posted: 2/15/2010
Post: 9 of 48

I can see using existing software for making appointments or billing and financial statements, but I can't think of a way to have paperless/digital charts without using some kind of formal dental program that backs up in a few different places daily. I'd love to improvise and use non-ortho programs to get things done, but I just physically don't have the space to have a wall of file folders, no matter how skinny the folder. Now someone once mentioned that back in the day ortho charts used to be able to fit on an index card, which I could accommodate, but I don't know if My malpractice carrier would like that so much. I think I will have to spring for an all-inclusive program just to keep my life simple and will cut back on the fancy chairs and cabinets to hopefully fit it in my budget. ■

**charlestonbraces**
Posted: 2/15/2010
Post: 10 of 48

For 30 months we have used Google calendar, but in addition to the practice management software. This was mainly used to note things such as "Hey, you have a lunch with Dr. So and So, don't forget." You can book multiple appointments at a given time, and the minute interval is 15 minutes, not 30. But as most have already mentioned, an ortho program or a good old fashioned calendar will do this better. If you are out of town working as an associate, I would just leave the appointment book with a spouse (or if unmarried, mom and dad or the assistant).

Quick question for the other practices, how do you keep track of GP lunches? Does your practice management software show a box today for "Lunch with Dr. Jones"? Do you have a paper calendar (or Google calendar), or do you rely on that fraught-with-danger sticky note stuck to the bottom edge of the computer monitor? ■

**drbecky**
Posted: 2/15/2010
Post: 11 of 48

Regarding GP lunches... We use a server-based electronic calendar through our e-mail client (called Thunderbird). It is really great; you can have multiple calendars accessible at any computer. We set reminders for each lunch. All of this is open-source software. If open-source software isn't your cup-o-tea, I believe you

*continued on page 22*

continued from page 21

can also do this with Outlook and you would need an exchange server to make it a network calendar.

We are thankful every day to have an electronic scheduling system. I can't believe how much time would be wasted flipping through a paper book to look up an existing appointment for someone on the phone. Or how my treatment coordinator could be scheduling a banding while my two front desk girls are scheduling appointments for other people. I think that the efficiency in my office far outweighs the cost of my system – especially if you get something basic. No idea about Google calendar, but some type of electronic system is very important, in my opinion. ■

**ucla98**
Posted: 2/15/2010
Post: 12 of 48

None of my three offices is open five days a week. My ortho manager carries the appointment book with her wherever she goes so she can add and delete the appointments when she is not at the office. All of the appointments are the same at my office. I don't demand long appointments for starts/final deband/bracket repair and short appointments for quick retie/retainer check. It doesn't matter if I have 60 or 80 patients a day... I show up for work at 2 p.m. and go home at 6 p.m.

I use a cheap appointment book not because I want to save money, but because it is so much easier to add/delete the appointments and move the patients around. Flipping a page is faster than moving a mouse cursor.

Last week, I helped out an office that uses digital X-rays. I had a horrible time there because it took forever for the assistant to upload digital radiographs. For me, it is much more efficient to use the paper chart with pan and ceph films, treatment plan notes and financial contract inside. ■

**drjoop**
Posted: 2/22/2010
Post: 30 of 48

Back on Google, I use it for my personal calendar, staff work schedule, lunches, meetings, etc. It syncs with android phones, so you always know about additions and changes. It is great. Plus I use it a lot for communication. Each staff member has a Gmail account as well. I also keep a lot of forms on Google documents, so they are accessible to staff when they need them.

I use ortho2 for scheduling/management. I can access this on my server remotely in satellite offices and work like I am right there in my main office. ■

**drjoop**
Posted: 2/22/2010
Post: 35 of 48

I did not mean to imply that you provide less than excellent quality of care.

I just find it easier to get information on my "business" with software. It makes things easier, and you get a lot of information from it.

I have paper charts for all my patients, not "paperless."

I think a grid system of scheduling would give you more flexibility with the time you give for your procedures. You can lock the grid in so that mistakes cannot be made, if that is a concern.

If it works for you, and you don't think it can improve with a different system, then keep things rolling the same. Different strokes for different folks! ■

# Associate Recruitment 101

by David Marks

Many articles and books have been written on the art of recruiting dental and medical professionals. I know, because I have authored a number of chapters and commentaries in industry "rags." When I think back to all the thoughts and suggestions I've shared throughout the years, I find a common thread. Successful recruitment ultimately comes down to one core idea: Be committed to succeed.

In other words, you need a steadfast desire to complete the task at hand, and that task is to find the associate – the right associate – who will provide the desired services to your practice. You might be looking for a future partner, a full-time associate to cover an additional office and expand hours, or a part-time associate to allow you to enjoy some time off each month. The specifics of your recruitment effort don't change the fact that there are certain "success factors" that will likely lead to your desired result. Here are some suggestions:

## 1. Once you start, have patience with the process.

Recruitment is not an overnight undertaking. There will likely be multiple candidates to consider, and each candidate takes time to process. It can take as long as a year or more to identify, screen, interview, reference, negotiate with and sign your top choice. So start the process well in advance of the date you want an associate to begin practice. A minimum of six to eight months is recommended. If a candidate rejects your offer, don't let it dampen your spirit. Persistence is the key.

## 2. Be committed to your goal.

If you are the least bit hesitant with your plans to add an associate, you will decrease your likelihood of success tenfold. Questioning yourself in the middle of a recruitment process will cause you to lose momentum. As a result, you might fail to send follow-up e-mails to residency programs, or you might put off calling potential candidates. You perhaps will not set up interviews in a timely fashion or find yourself unprepared to discuss hours, compensation and what the future holds for the associate. Losing momentum is by far the number-one "killer" of successful recruitment.

## 3. Plan the process.

- Ascertain the sources you will use to identify viable candidates and budget appropriately. The most utilized sources to obtain candidates include journal classified advertising, online career centers, recruitment firms, e-mail blasts, residency programs and direct mail to practicing orthodontists. Each avenue varies in cost and effectiveness so budgeting upfront is crucial. Don't allow the cost to be a momentum buster in midstream.
- Establish the process to screen potential candidates. Most processes begin with a telephone interview. Identify early on who will be making these initial calls and what questions you want to ask. Be sure to have a similar list of questions for all candidates, so it will be easy to rank them against each other once all initial phone interviews are concluded. To further define your rankings, after the phone interview you should also consider seeking either

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continued from page 23

*"Have patience, understand the timing and the process you will be going through and plan thoroughly."*

verbal or written references on candidates you consider viable. A number of practices are now using personality testing prior to an onsite formal interview.

- Create your formal interview process. Will it consist of one or two interviews? How many days will a candidate's interview last? If using a one-interview process, will you offer to have the candidate bring their spouse or significant other? Who will be interviewing the candidates, and how much weight will you afford their comments? Besides figuring out the answers to these questions, you should solicit external assistance with the process. The local chamber of commerce, a realtor and school administrators can be good resources. Lastly, decide upfront if you are paying the candidates' travel, food and hotel costs. Doing so will not give you an advantage, but not doing so will put you at a huge disadvantage.
- Don't be concerned with how many interviews you should plan for. This number is a moving target. Rather, plan to interview until you have two viable candidates for the position. With two candidates, you will have a back-up in case one says no, and you will also provide yourself leverage if a candidate negotiates unreasonable terms. If you only identify one viable candidate, be more flexible with your negotiations.
- Develop the terms of your offer prior to the phone interviews, and a written contract should be in order prior to the formal interview process. You will likely be asked about compensation, benefits and future partnership opportunities. Also be ready to address questions about moving expenses, house hunting trips, sign-on bonuses and other incentives (like country club initiation fees) you might offer to attract the perfect candidate.
- Lastly, determine who will negotiate the contract with the candidate. While most practice owners do this themselves, it can lead to issues, possibly even to a candidate walking away if negotiations get contentious. You might want to have your attorney handle the negotiations, so you can remain the "good guy." Put an end date on all offers. An end date puts pressure on both parties to work toward getting a deal done and eliminates the need for you to withdraw an offer if a candidate procrastinates.

### 4. Put your plan in motion.

Recruitment is a difficult undertaking. Chances are many of you have never previously been in the position of having to, or wanting to, recruit an associate. The fact that recruitment firms can do a brisk business charging up to $25,000 for each successfully placed candidate just confirms the difficulty and aggravation that goes along with the effort.

Have patience, understand the timing and the process you will be going through and plan thoroughly. Know your market and what offers will be competitive. Stay committed once you make the decision to recruit, and your new associate will be there sooner than you think. n


## Author's Bio

**David Marks** is the president and CEO for OrthoSynetics, Inc. (OSI), a business service company in the orthodontic industry that assists orthodontic practices utilizing a full service, turnkey management approach to address all non-clinical practice functions to gain better efficiencies and profitability. He has more than 30 years of experience in the health-care industry including the recruitment and hiring of health-care professionals. For more information, visit www.orthosynetics.com.

Which of these would you like

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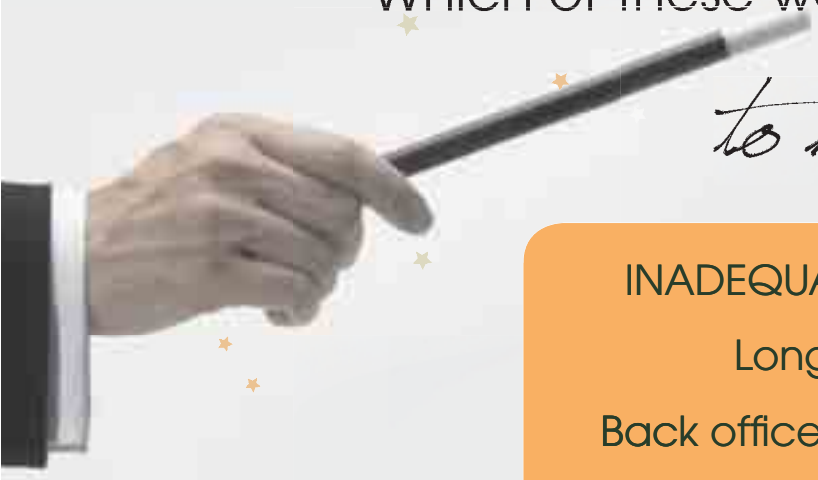
*to make disappear?*



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Back office DISTRACTIONS

Low CASH flow

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Scheduling INEFFICIENCIES

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Dr. Bill Pickard, Fayetteville, AR

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# Social Media & Professional Practice


by Donald E. Machen, DMD, MSD, MD, JD, MBA, CFA; and Hollie A. Bernstein Machen, Esq.

Throughout the past several years, a significant number of orthodontists have contacted us about the use of social media networking and requested assistance with problems that have occurred. As a risk management protocol, having a business plan subsection devoted to both the positive aspects of these opportunities and a checklist of procedures when things go wrong, is a sound and prudent way to approach this.

Our experience with this has enabled us to prepare a list of suggestions that might save you a great deal of time and mental anguish. If the worst-case scenario occurs, the suggestions contained within this article might save your practice and your financial future. The horror stories of our consulting clients should be carefully considered before embarking on a campaign to market and establish a public relations effort via social media.

## Background

Worldwide, there are more than a half billion users of MySpace, Facebook, Twitter, LinkedIn and the other social networks, with approximately 40 percent of those in the United States, or roughly 200 million. The opportunities are unlimited. However, so are the potential problems that can be caused by disgruntled employees, patients and even jealous competitors. According to experts, social networking is and will continue to be the most influential and efficient manner with which to interact with the current and next generation.

## Protecting Your Valuable Reputation

You've heard the terms "goodwill" and "intangible assets." In valuing an orthodontic or other professional practice, a large portion of the value is often allocated to one or both of these categories. Imagine for a moment the precipitous drop in value if a barrage of negative comments is circulated through various social media portals. The speed at which this destructive and harmful information can go viral is astounding. For this and other reasons, a plan should be in place for both the appropriate strategic use of and tactical methods by which to handle any of these untoward occurrences. Just as you would handle an untoward consequence of a treatment plan, the orthodontist and his or her team, including advisors, must be ready to take action at the first sign of problems related to negative comments through any social networking outlet.

An example might help you to understand the scope and magnitude of the potential problems that can occur.

*An orthodontist with a large practice, starting approximately 300 patients per year, with a staff of 14, notices a drastic decline in new patient appointments. In addition, a number of scheduled new patient visits are cancelling. Along with these issues, calls are being received for records to be transferred to other orthodontists. After some review and contact with several individuals who are leaving, it is determined that someone sent e-mails to patients, referring dental offices and scheduled patients with both disparaging remarks and a link to a Web site with unflattering articles about the practice and the orthodontist.*

## What Action Should You Take?

The following protocols are suggested to incorporate into your practice business and marketing plan in order to be as alert and proactive as possible. By being alert and proactive you might be able to avoid such situations altogether; but if they occur, you will also be ready to move on them immediately. Left alone, in a very short time, an orthodontic practice could be destroyed by the actions of a vindictive present or former employee or patient, or regrettably, a former associate or competitor.

## Developing Your Plan

### 1. Due Diligence

A trusted and time-tested employee, a carefully selected consulting service that you retain, or you should regularly search the Internet under your name and the practice name. All major search engines (including, but not limited to, Google, Yahoo,

AskJeeves, AOL Search, Wikipedia, MSN Search, Digg, BX, Bing, etc.) should be scoured.

Additionally, the popular dentist and doctor-patient review Web sites (such as Dr. Oogle, Dentistreview, Vimo, etc.) need to be searched. We suggest you read up on risk management and reputation perception, including improving patient care, reducing lawsuits and increasing referrals. If you need direction in risk management, read our book *Managing Risk in Orthodontic Practice.*

### 2. Prevention

All patient information must be securely maintained, not only for compliance with confidentiality and privacy requirements, but also to limit access and be able to identify access to your vital and valuable patient computer records. In this regard, each employee must sign an employment contract (for new employees) and an addendum for current employees specifying their prohibition of use of confidential and private information, except as you specifically authorize. Specific language should reflect the obligations and responsibilities and what might happen in the event the policies are violated.

### 3. Action Plan

If you identify someone who has initiated a negative campaign against you or your practice, the following is a suggested plan of action:

a. Determine the extent of the dispersion and damage; identify the Web site(s) that are hosting this material or the offender by a quick search on www.whois.com or a similar site. This is a free service and is one of the quickest means to identify the provider and IP address of those hosting the disparaging material. On occasion, the person is computer/Internet savvy and you might need similar computer expertise or consultants to "reverse engineer" an e-mail, or a forensic specialist to assist you with these searches. Be prepared because it is much easier, quicker and less costly if you have arranged for this in advance. These methodologies will identify the perpetrator. As a legal matter, any person who would submit or disperse a malicious attack, especially if done so anonymously for the purpose of adversely affecting the practice might be subject to punitive damages, counsel fees and other damages depending on the jurisdiction.

b. Immediately file the proper complaint form. Each host has a form specific to their Web site which enables complaints to be filed. Merely having a lawyer send a letter, no matter how it is worded or how threatening the tone, might be inadequate and will likely be ignored. Our experience in this area has been that if this step isn't followed, no action will result from your request. Simply threatening a lawsuit is ineffective, unproductive and might waste valuable time. You must use the correct, site-specific complaint form. We suggest to our clients that they have complaint forms for each of the major Web sites on file with the proper filing instructions since the last thing you want to do is to try and locate one when the problem occurs.

c. Once the complaint form is filed, either the practitioner or their representative should follow up regularly and constantly with the legal representatives of the hosting facilities until the desired action is taken. Here is where you should be relentless and as aggressive as possible. Be prepared to offer whatever proof that you and your team can assemble to show that the statements or disparaging remarks are without basis, malicious or untrue, and that statements are being hosted in violation of the law, including but not limited to, the Digital Millennium Copyright Act. After proper notice, the host can be held liable in court for failing to remove this information which is being published.

d. Other possible bases or causes of action include: social media that use portions of your material, Web sites and other copyrighted or trademarked materials. Such action might include violations of federal or state copyright and trademark law, and subject the offenders to large fines and penalties. The preliminary requirement for this is that copyright and trademark protection be available. This is readily available, as we have arranged for many of our consulting clients.

e. Further, even if the negative commentary has some measure of truth, lawsuits for invasion of privacy and holding in a false light might be available. Such commentary often includes statements that are frequently misleading and just as damaging.

f. Finally, be prepared to file a lawsuit, obtain subpoenas and to request injunctive relief from the courts. There are specific requirements that must be met in order to obtain a temporary injunction. One important factor is the potential for "irreparable harm." It is likely that if a court is presented with the devastation that will occur to patient care from a disruption in that care caused by false and malicious statements as well as to the practice, the staff, their families and the reputation of the doctor, the court will agree that the harm is likely to be "irreparable."

Sometimes, the disparaging, negative and extremely harmful material is spread by mail or by word of mouth. Be diligent in tracking down the source. Enlisting the aid of experienced and trained professionals might be needed. This is not the time to be pennywise and dollar foolish. Above all else, have the mechanism in place for prompt and efficient action. Have this as part of your business plan along with a specific action plan and a detailed list of assignments.

## Reputation Management

Throughout the past several years, we have counseled our clients that a vital aspect of risk management in orthodontic practice is practice and doctor reputation management. Your reputation is an asset. It is critical that everyone in the practice

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directs his or her efforts to this most important endeavor. As mentioned before, reputation management requires its own section in your business and marketing plan, brand management and other practice development efforts. Part of this includes developing your own information dissemination program that can be accomplished in many forms of social networking, including blogs, Twitter, etc., which are frequently updated. These can be in-house or via subscription services. Spend some time and develop your plan. No matter how much time or effort you expend, it will pay dividends in the event that what is described herein happens to you. Think of it as another form of insurance, which you all have in the event of a casualty loss, accident or malpractice. We hope these events never occur, but we still insure against them.

## Some Final Thoughts About Social Networking Interaction

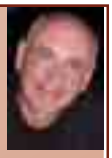
In your social media networking section of the business plan, we suggest a definite protocol be implemented and that any and all people who are employed by you and your practice or who represent you be trained to follow the guidelines that you establish. Specifically, patient and potential patient interactions should be limited to the rules that you establish. Failing to do so can lead to less than optimal results and set the stage for your removal from one or more of these opportunities or for negative and disparaging comments. Social media and networking offer many opportunities. However, be prepared because patients will let you and everyone else know if they are displeased with any aspects of their care or interpersonal relationship. Social networking sites offer an expanded public forum for commentary.

Additionally, it is important to educate the staff on how their personal social networking comments can adversely impact the practice. Even a tired, end-of-workday Facebook comment like "My boss was a jerk today!" can be used out of context and disseminated by others in a campaign against a practitioner. While you cannot restrict the staff's personal use of social media, educating the staff on the dangers should be enough for employees who share the goal of building a successful practice. (This is easily accomplished by a well-designed incentive compensation program which involves the staff in the practice's success.)

Take advantage of the training offered through the various social networking Web sites and for best results obtain additional training. Also, outsourcing of this aspect after thoroughly performing due diligence on the vendor can be another excellent option. In this regard, it is critical that each representative who will be accessing the various social media networking opportunities be completely familiar with their rules and requirements and agree to comply with those and with the rules established by you for your practice. This agreement should be part of their employment or consulting contract. No matter how you proceed, appropriate training, retraining and reviewing is an integral part of your continuing efforts. Make sure employees know that confidentiality and privacy of patient records are of the utmost importance and that they must comply with the requirements under HIPAA, state law and professional ethics, and also to insure that the records are not used for untoward purposes.

With the above in mind, implementing a social media networking program can become a critical component of your orthodontic practice growth strategy. n


## Author's Bio



**Donald E. Machen, DMD, MSD, MD, JD, MBA, CFA,** is the recognized authority on risk management in orthodontic practice having initiated the discipline in the mid-1980s. He developed, moderated and presented at the AAO's first national risk management telecast to more than 2,600 orthodontists. He has represented orthodontists, dental specialists, general dentists and physicians in malpractice lawsuits and other legal matters as a trial lawyer and currently is a trial court judge in Pennsylvania having served for more than 14 years. He is a board certified orthodontist maintaining a part-time practice and is on the orthodontic faculty of Case Western University Dental School and The University of Pittsburgh School of Dental Medicine. He is also an Adjunct Professor of Law at Duquesne University School of Law where is teaches malpractice litigation. Dr. Machen was the editor of the Legal Aspects of Orthodontic Practice column in the *AJO,* writing a monthly column and has authored columns in *JCO* and *Ortho Tribune.* He lectures extensively to orthodontic groups, both large and small, focusing on developing highly effective systems for eliminating lawsuits, optimizing patient care and increasing practice referrals. Dr. Machen is the author of *Managing Risk in Orthodontic Practice* and is managing director of Risk Management Consultants, LLC. He can be contacted at: drmachen@orthormc.com.

**Hollie A. Bernstein Machen, Esq. –** After graduating from the University of Pittsburgh School of Law, Hollie spent the early part of her legal career as a litigation associate and then partner of the Bernstein Law Firm, a multi-office firm specializing in creditors' rights. After leaving that firm to raise her three children, Daniel, Lindsey and Roxanne, she began focusing on legal research and writing as a judicial law clerk in Pennsylvania and has remained active in that endeavor for more than 13 years. Additionally, she spent more than five years counseling clients on financial issues as a wealth management advisor at PNC Bank and National City Bank, earning various designations in the financial services profession including that of Certified Retirement Planning Counselor. Presently, in addition to working with clients at Risk Management Consultants, she spends time teaching online legal research skills to attorneys and judges as a research specialist for Westlaw and acts as practice manager for Dr. Machen's part-time orthodontic practice.

# TECHNOLOGY CASE REPORT

## Class I with Deep Bite and Crowding Treated with Lingual, i-CAT & SureSmile

by Dr. Ed Lin

My first experience with lingual appliances came in the late 1990s, while I was an orthodontic resident at Northwestern University. The experience was enough to convince me that I never wanted to touch another lingual case again. However, when GAC came out with their self-ligating lingual brackets (Innovation-L), it definitely stirred my interest. When I saw how low-profile the Innovation-L brackets were and how easy they were to open and close, I was definitely open to trying out lingual again but only for anterior alignment cases. As I began treating several limited U3-3 and L3-3 lingual cases and began feeling more comfortable working with the Innovation-L appliances, I was one of several SureSmile orthodontists who began lobbying SureSmile to develop their software applications for lingual as well as for labial. For those of you who might be interested in learning more about SureSmile QT, SureSmile QT went into beta testing in January of 2009. At the 2010 AAO annual meeting, SureSmile released a limited launch of SureSmile QT that was only available to existing SureSmile customers who have demonstrated a proficiency in SureSmile's software applications. Having been actively involved with the development and testing of SureSmile QT, it is incredible for me to think how far they have come in only a little more than 18 months. I truly give the SureSmile team a great deal of credit in being able to develop such an incredible product in such a short period of time. As a result, I would like to share with all of you a SureSmile-Lingual case that I just completed last winter.

## Patient Information:

The patient presented at his new patient examination as a healthy 41-year-old adult male. He stated that his chief complaint was that he wanted to have a nicer smile. He also stated that he was a professional airline pilot and because of his profession he wanted to be treated with an aesthetic orthodontic treatment option in as short of treatment time as possible.

## Diagnosis and Etiology

Figure 1: Intraoral examination revealed a Class I molar and canine relationship on both sides. His overbite (OB) was deep at 60 percent and his overjet (OJ) was tight at 1mm. There was an increased lower curve of spee and excess upper and lower incisal wear due to his OB and OJ relationship. Arch length deficiencies were present in 7mm of his maxillary arch and 7mm in his mandibular arch. Both maxillary and mandibular arch forms were asymmetric and tapered. Periodontal evaluation revealed normal and healthy gingival tissue with no recession present.

Frontal facial evaluation revealed a symmetrical and balanced facial pattern. Profile facial evaluation revealed a straight profile with slightly prominent chin. His nasio-labial angle was 110 degrees and both upper and lower lips were normal and competent at repose. A frontal smile evaluation revealed acceptable upper and lower smile lines with buccal corridors present.

Figure 2: Cephalometric analysis revealed a Class I skeletal relationship with ANB=2. It also revealed a brachiocephalic facial pattern with a low MPA=26. His U1-SN=99 and IMPA=99 degrees were both within normal limits.

Figure 3: Panoramic evaluation revealed that all third molars had been extracted. Alveolar bone height in both maxillary and mandibular arches looked healthy and within normal limits. There were no other significant findings present.


Fig. 1

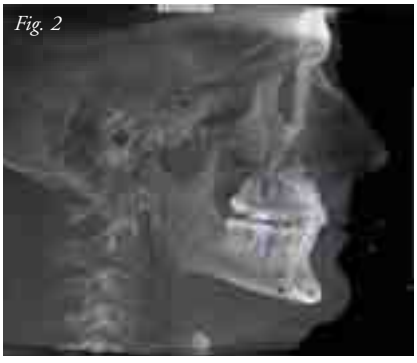


Fig. 2

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## Treatment Summary

The patient had requested to be treated with SureSmile and Innovation-L lingual fixed appliances due to his desires to be treated with an aesthetic orthodontic appliance and in the shortest treatment time possible. As a result, the lingual amalgam present for his UL2 needed to be replaced with a composite restoration by his general dentist prior to the placement of his Innovation-L brackets.

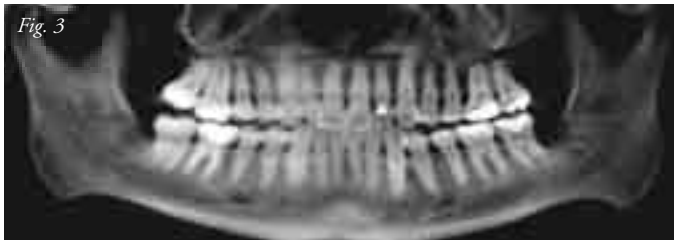
Fig. 3

On February 24, 2009, 0.018 Innovation-L (GAC) fixed appliances were placed for U7-7 and L7-7 using our practice's indirect bonding technique. The UR2, LL1 and LR3 were not bonded due to significant rotations. Lingual 0.016 CuNiTi wires (G&H) were placed in both maxillary and mandibular arches with open coil NiTi springs placed for his UR2, LL1 and LR3. Bite turbos were also placed utilizing Herculite for his LL4, LL3, LR3 and LR4. On April 25, the patient was seen for his regular appointment and a bracket was placed on his UR2 (not in an ideal position) and the open coil NiTi springs were activated for his LL1 and LR3 (Fig. 4). Lingual 0.016 CuNiTi wires were replaced in both maxillary and mandibular arches. On June 24, the bracket for his UR2 was repositioned to a more ideal position and the lower bite turbos were removed as his bite had opened significantly (Fig. 5). Lingual 0.016 CuNiTi wires were replaced in both maxillary and mandibular arches.


Fig. 4


Fig. 5

On July 28, the patient began the SureSmile process. His upper and lower arch wires were removed and the Innovation-L bracket doors were closed. Upper and lower incisal manicuring was performed to give balance and symmetry to his incisal edges. An i-CAT-SureSmile scan (8cm height at 0.2 voxel setting) was then taken with a wax bite with the condyle seated in the glenoid fossa and leaving the patient's bite open 3mm. Because of the amalgam restorations present in his upper right and upper left posterior quadrants, and the root canal in his lower right posterior quadrant, a supplemental SureSmile ora-scan was also necessary for these three quadrants due to concerns with scatter with the i-CAT. Lingual 0.016 CuNiTi wires were replaced in both maxillary and mandibular arches (Fig. 6). On August 8, the patient's SureSmile plan was completed and his wires were ordered to be bent utilizing SureSmile's proprietary software and robots (Fig. 7).


Fig. 6


Fig. 7

On September 14, 0.016x0.022 SureSmile CuNiTi wires were inserted in both maxillary and mandibular arches. Clear plastic buttons were bonded on his UR3, UL3, LL3 and LL3 and 3/16in, 3.5oz vertical elastics were given to the patient to be worn at nighttime. On November 7, the patient returned and photos were taken (Fig. 8). 0.017x0.025 SureSmile CuNiTi wires were inserted in both maxillary and mandibular arches. The same vertical elastics were continued at nighttime only.


Fig. 8


Fig. 9

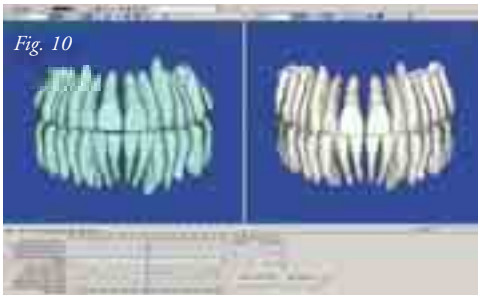
Fig. 10

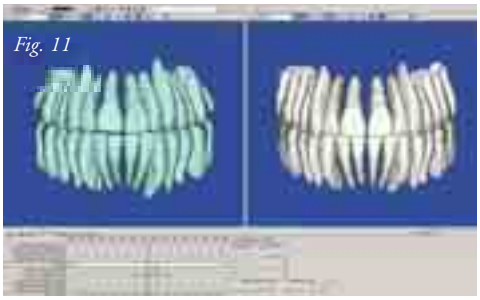
Fig. 11


Fig. 12

On January 5, 2010, photos were taken again to track treatment progress and virtual wire bends were ordered using SureSmile's proprietary software to address some minor tooth alignment issues (Figs. 9-11). The plastic buttons were removed and vertical elastics were discontinued. On January 26, the patient returned to have his .017x0.025 SureSmile CuNiTi finishing wires inserted. On March 9, the patient returned to have his Innovation-L lingual fixed appliances debonded and moved him into retention with an Essix ACE retainer with full-time wear and a L3-3 fixed lingual splint. On July 27, the patient returned for final records, and retention wear of his Essix ACE retainer was reduced to night-time only (Figs. 12-14).

## Summary and Conclusions

Total treatment time for this patient was 12.5 months. Total number of appointments from the initial bonding appointment to the debond appointment was 10, including one emergency appointment. I am truly amazed at the efficiencies of these phenomenal technologies of Innovation-L, SureSmile QT, and i-CAT and the fact that I can give my patients a completely aesthetic option for treatment in a significantly decreased treatment time.

I currently have approximately 75 SureSmile QT cases that are in treatment. Approximately two-thirds of my cases are in treatment with SureSmile QT in the upper arch and SureSmile for labial in the lower arch and approximately one-third of my cases are in treatment with SureSmile QT for both arches. I personally feel that SureSmile QT will be a great option for all of our patients, especially for those patients looking for a truly aesthetic option for orthodontic treatment and want to have their treatment completed in a shorter treatment time. Are there still lingual issues with SureSmile, such as inter-bracket distance? Absolutely. However, so far I have been impressed and what I do know is that technology only keeps getting better. n

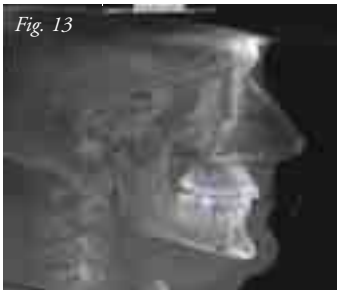
Fig. 13

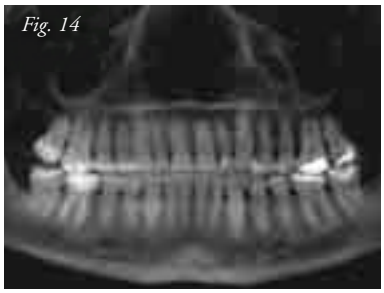
Fig. 14


## Author's Bio

Internationally recognized speaker, **Dr. Ed Lin,** is a full-time practicing orthodontist and partner at both Orthodontic Specialists of Green Bay (OSGB), in Green Bay, Wisconsin, and also Apple Creek Orthodontics (ACO) in Appleton, Wisconsin. Dr Lin received both his dental and orthodontic degrees from Northwestern University Dental School ('95 - DDS and '99 - MS).

# Why Do Early Treatment If It Is Less Efficient?

by Dr. Robert Boyd

One of the most debated issues within the orthodontic profession is whether to do early orthodontic treatment. From a health-care delivery point of view, this issue was significant enough that the U.S. National Institute of Health commissioned two prospective longitudinal controlled clinical trials (PLCCT) of early orthodontic treatment more than 15 years ago at the Universities of North Carolina and Florida. The study focused on two groups of matched Class II malocclusions with more than 5mm overjet. One group was started in the mixed dentition with treatment consisting of a headgear or functional appliance. The other group was deferred and treated later with a single phase in the early permanent dentition. The design was to evaluate the efficiency and effectiveness of the first phase in order to either eliminate a second phase or to create an improved second phase result after both groups had the second phase of treatment. These two studies (and one other study conducted later in the UK) showed no significant benefits from groups who received the early orthodontic treatment. Since these types of studies are considered the highest form of evidence to judge the efficacy of treatment, a logical conclusion is not to do early treatment if it involves more visits to get to the same result.

Early treatment is still a modality I employ in about 15 to 20 percent of the middle mixed dentition patients I see because the results from these studies really only apply to mild and moderate Class II malocclusions that are treated in a manner similar to the treatment techniques employed in these studies. I further believe that these studies' results have been over-generalized to include other forms of early orthodontic treatment such as Class I crowding, more severe Class II patients and even Class III treatment.

At our Arthur A. Dugoni School of Dentistry in San Francisco we have employed early orthodontic treatment techniques based on the approach developed by Dr. Arthur Dugoni which use more comprehensive treatment methods designed to treat moderate to severe Class I, II and III malocclusions in the transverse, vertical and anterior dimensions. We also have protocols that follow these early treatments with a more comprehensive retention program for all three planes of space until the permanent dentition is fully erupted (except for third molars).

Our analysis of these results throughout the years has found certain advantages of the Dugoni early treatment methods on select cases which include being much more likely to avoid extractions in the permanent dentition, entails less root resorption and significantly decreases the need for a second phase of treatment.

Patient and family concerns about early treatment are important to consider as well. I have found that many patients and parents do not want to wait until all permanent teeth have erupted because of aesthetic concerns in the eight- to 10-year-old age group. In addition, recent cross-sectional epidemiological studies by Jon Artun have shown significantly increased incisor trauma in mixed middle dentition ages that have overjet greater than 5mm. In general, one of the most difficult types of orthodontic treatments I have managed in my career is an ankylosed or missing upper incisor(s) which occurred as a result of anterior tooth trauma.

It is important to point out that a number of studies of efficacy of early treatment Class III treatments have shown more effective correction in these patients. However, recent studies of the use of titanium plates as anchorage for Class III treatment developed by De Clerk show excellent results when used in the adolescent permanent dentition.

In summary, we treat many different types of patients who present with very different concerns for aesthetics or functional issues. The over-generalizing of previous early treatment studies about treatment efficacy based on limited types of treatment can restrict our choices to find the common ground needed to create a treatment plan that is optimal for each patient. ■


## Author's Bio

**Dr. Boyd** received his DDS degree from Temple University, postgraduate certificates in periodontics and orthodontics from the University of Pennsylvania and a master's degree in education from the University of Florida. He is diplomate of the American Board of Orthodontics, a fellow of both the American and International College of Dentists and a member of the Pierre Fauchard Academy. He has published extensively in both periodontics and orthodontics. He was on the original research and development team for the Invisalign system and is on the Clinical Advisory Board. Dr. Boyd is currently the Frederick T. West endowed chair at the Arthur A. Dugoni, UOP Department of Orthodontics.

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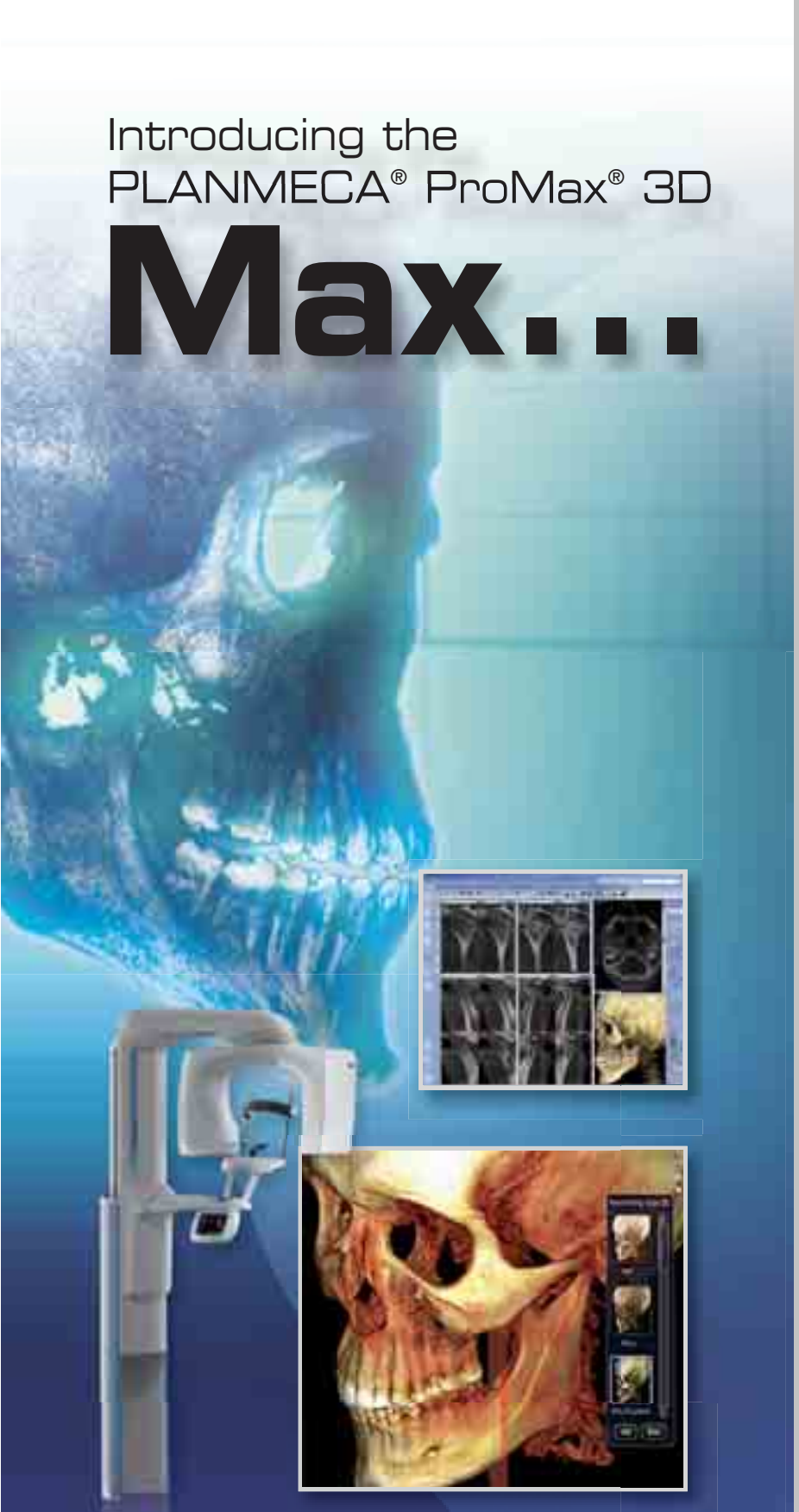

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