THE READERS' CORNER

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(Editor's Note: The Readers' Corner is a quarterly feature of JCO in which orthodontists share their experiences and opinions about treatment and practice management. Pairs of questions are mailed periodically to JCO subscribers selected at random, and the responses are summarized in this column.)

1. We generally flatten the curve of Spee. Does a flat curve of Spee afford good functioning occlusion?

Eighty-three percent of the respondents believed that flattening the curve of Spee provided a good functioning occlusion. Twelve percent thought it did not contribute, and the rest were not sure. The most common rationale for those who felt that flattening the curve was beneficial was that it would be easier to obtain an acceptable Class I buccal occlusion. Another reason given was that when the curve of Spee was leveled, the occlusion could settle and a more functional, cuspid-protected occlusion could be established without posterior balancing side interferences.

Some specific comments were:

• "I think the more important consideration would be the overbite and overjet and proper buccal section interdigitation. If flattening the curve of Spee will help me achieve these treatment goals, there should be no problem."

• "Flattening the curve of Spee does not guarantee a functioning occlusion. We flatten the curve for efficient orthodontic tooth movement. The curve of Spee will establish itself when the patient is out of appliances, when diet, lifestyle, aging, and stress affect the occlusion."

• "The curve of Spee is a variable. Most of the time it should be flattened to finish the case with acceptable incisal coupling. But there are times when it should be accentuated, and there are times when it should be deemphasized. It depends on the specifics of the case."

Should a curve of Spee be built into cases presenting with minimal or no overbite?

Three times as many clinicians believed that a curve of Spee should be built into such cases as those who did not. Respondents who favored adding the curve of Spee indicated that establishing anterior disclusion would facilitate the eventual achievement of a Class I occlusion, and that the settling occlusion would result in an effective overbite. There were many comments, however, that building in the curve of Spee would depend on other factors such as the mandibular plane angle, the age of the patient, the perceived degree of patient cooperation, and the etiology of the minimal overbite.

Specific remarks included:

• "In these cases one should slightly alter the bracket position gingivally to assist in deepening the bite."

• "We, of course, don't initially flatten the curve in high-angle, open-bite situations. Why aggravate an already difficult situation?"

• "I am very cautious about flattening the curve of Spee in these cases. It's hard enough to establish incisal guidance with minimal or no over-

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bite. Flattening the curve can aggravate this situation."
• "Fortunately, in these type cases, there is very little curve of Spee to flatten. That's why there is little or no overbite. Excessive curves of Spee are usually correlated with deep bite, not tendency to open bite. However, in these type cases, I induce the curve of Spee after I have the anterior relationships under control, because you still need incisal guidance in the finished case."

Do you examine the curve of Wilson or the curve of Monson in your diagnosis and treatment planning, and if so, what do you look for?

Two-thirds of the respondents said they routinely evaluated the curve of Wilson, but only 22% used the curve of Monson. Those who examined the curve of Wilson were concerned about molar tipping and torque when contemplating arch expansion, uprighting of lingually tipped lower posterior teeth, or correction of plunging cusps. With the curve of Monson, interest was focused on the vertical molar position. The overriding concern with either of these curves, however, was a perceived deviation from the normal range.

Some individual remarks:
• "Lingually tipped posterior teeth may be candidates for uprighting, which can help with a nonextraction approach."
• "I look for posterior crown torque as an indicator of the curve of Wilson."
• "I am very aware of the curve of Wilson, especially in transverse discrepancy cases and for surgical setups; also, in cases with crossbite correction utilizing crossbite elastics. I think it's important to attempt to get forces through the long axis."
• "If the curve of Wilson is deep, the lower molars are tipped lingually. The upper arch may need expansion to accommodate the lower molar uprighting, and this, in turn, would generate more room in the arches to correct crowding."
• "For the curve of Wilson, I look at the molar torque. For the curve of Monson, I look at the upper molar vertical position."

2. In presenting your treatment plan, do you present more than one way of treating the case?

One-third of the respondents reported that they frequently presented more than one way of treating a specific case, while two-thirds reported that they sometimes did so. No clinicians said they never presented more than one treatment option, but a few respondents indicated that they did so only rarely.

If you present more than one treatment option, why do you do so?

Every respondent listed more than one reason for presenting alternative treatment plans. One hundred percent believed that it was the patient's right to be informed. Next in frequency of response, 43% felt that presenting different treatment options engendered better patient cooperation, and 18% thought it improved case acceptance. Fourteen percent said they presented more than one treatment option because of uncertainty about the best course of action—in other words, in borderline cases. The least common rationale was that there would be less chance of the patient seeking a second opinion.

In case of a child or adolescent patient, whose decision do you seek?

A significant majority of respondents indicated that they sought the decisions of both the parents and the patient. About one-fourth of the clinicians said they sought only the parent's decision, but only a few reported that they would abide by the decision of the child or adolescent patient.

If the patient or parent chooses an option that is not your first choice, how often do you go along with that decision?

About 40% of the clinicians said they frequently acceded to an option that was not their first choice, and the remaining 60% indicated that they sometimes did so. Many of the respondents added that they would go along with an alternative as long as it did not violate the overall treatment goals. A typical response was:

• "As long as the patient understands the overall treatment goals and the compromises that may be evident in their treatment choice, I will go along."

What would influence you to agree to a treatment plan that was not your first choice?

Nearly all the respondents checked off more than one category. By far the most frequent answer was "the patient's objection to surgery", followed by "the patient's objection to extractions", "cost", and "length of treatment". The least frequently cited, although still with a significant number of responses, was "simplicity of treatment".

How much time do you allot for a case presentation?

Only 15% of the clinicians said they had an open-ended schedule for case presentations. For the rest, the normal time allotment varied from eight minutes to 70 minutes. The vast majority, however, indicated that they spent 20 to 30 minutes in a case presentation. There were many remarks that the time allotted depended on the complexity of the case.

Who is responsible for the case presentation, and how much does the doctor participate?

Two-thirds of the respondents indicated that the case presentation was a joint effort between the doctor and the treatment coordinator. There was some variation in the proportion of time allotted between the two, but most clinicians said they presented the clinical aspects and potential or actual treatment complexities themselves, while the treatment coordinator presented the fee structure, office policies, and appointment protocols.

Typical comments included:

• "My treatment coordinator does most consultations and case presentations. I present the more difficult cases such as surgery."

• "The doctor presents the treatment plan and appliance options, if any, and answers questions specific to treatment. The patient coordinator then presents the fee and payment options, and closes by setting up the next appointment."

• "The doctor and the treatment coordinator are involved in the case presentation. For particularly difficult cases, it is done at the end of the day or lunch to allow for extra time."

• "In my office, case presentations are scheduled at the end of the day. This allows me to spend as much time as needed to discuss case diagnosis, proposed treatment, length of treatment, and financial obligations."

• "The doctor does the initial case presentation over the telephone. If the case is complicated or many questions are asked, we bring them into the office for more in-depth consultation. We try to begin the case presentation from the initial consult. Educating the patient and family from the beginning makes it easier to do a phone consult. They already have heard most of the diagnosis and treatment plan before taking records."

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