THE EDITOR'S CORNER

Dental Team Spirit

This summer, for the first time, I was honored to be one of the four invited speakers at the University of Southern California's Annual Review of Dentistry—an exclusive lecture series, consisting of four days each on two different islands of Hawaii, that has been conducted for 30 years. The coordinators go out of their way to ensure that the content of the courses is top-notch, independent of the tropical paradise setting.

The topics and speakers are always focused on areas of particular interest to general dentists. This year's subject was dentofacial esthetics, and since that has been of primary concern to orthodontists since the inception of the specialty, it was deemed appropriate that an orthodontist be on the panel. The other speakers included a world-renowned prosthodontist and dental materials specialist with an interest in indirect-bonded anterior restoratives, an accomplished restorative dentist who also specializes in indirect-bonded restoratives, and a periodontist who focused on the importance of gingival esthetics to the overall appearance of the smile. The conference was coordinated by an endodontist, so with the notable exception of an oral surgeon, we had the interdisciplinary bases covered. This combination of speakers lent a unique dynamic and provided a profound learning experience for me, the likes of which I had not seen since my residency.

When I took straw polls of our audiences, there was no other orthodontist at the first four-day series, on Maui, and only one on the big island of Hawaii. This was a little disappointing to me, because I was impressed by the orthodontic savvy and sophistication of the other attendees. All of them knew what I was talking about when I presented some clinical slides illustrating specific biomechanical techniques for addressing such interdisciplinary problems as lip support and incisal edge position. In fact, their understanding of orthodontics was substantially more sophisticated than my own knowledge of current cosmetic restorative techniques. Like many practicing orthodontists, I spent a number of years as a general den-

tist before returning to school for specialty training. I left general dentistry just as implants, direct-bonded restoratives, and indirect veneers were coming on the scene. Over the 20 years since, I have made what I thought was an adequate effort to keep abreast of developments in the rest of dentistry, but what I learned in Hawaii showed me otherwise. Perhaps this will serve as a wake-up call to me and to my orthodontic colleagues who might have let our baseline education slip a little.

Although the audience seemed to enjoy the couple of hours I spent on the social psychology of facial appearance, it really responded to my discussion of orthodontics as a means to regenerate alveolar bone prior to implant placement. We have been experimenting with forced eruption of hopeless teeth to raise the alveolar levels prior to implant placement for about a decade now at USC, but our efforts have been largely restricted to vertical alveolar development. Last year, JCO published an article that described the orthodontic movement of hopeless teeth to regenerate bone in both the vertical and horizontal planes (Zuccati, G. and Bocchieri, A.: Implant site development by orthodontic extrusion of teeth with poor prognosis, J. Clin. Orthod. 37:307-311, 2003). At this year's AAO annual session, Bjorn Zachrisson presented a more definitive paper on the use of orthodontics to develop alveolar bone and keratinized gingiva in both planes. His sample size was a good deal larger than that of Zuccati and Bocchieri, and the study built nicely on their ideas. Dr. Zachrisson's cases displayed a superb orchestration of efforts involving himself as the orthodontist, along with oral surgeons, periodontists, prosthodontists, and restorative dentists. My audience in Hawaii, made up mostly of general dentists, seemed as enthralled as his AAO audience in Orlando with this "new" application of orthodontics: moving teeth not only to enhance facial appearance, improve occlusion, and promote the health of the temporomandibular joints, but also to develop alveolar bone for implant placement, improve periodontal health and osseous support of threatened dentition prior to prosthetic restoration, and relocate gingival crests for optimal esthetics.

This opens an entirely new horizon for the application of orthodontics to the interdisciplinary dental team, and we need to spread the word to the other team members. In Hawaii, I found that my personal efforts at keeping abreast of what the rest of the team has been doing might have fallen a little behind. I also learned that other dentists might not be aware of how much more we as orthodontists can contribute to a complicated interdisciplinary case than simply repositioning teeth for esthetics and function. It became especially clear to me that all members of the dental team can benefit tremendously from interacting with one another in the learning environment of an interdisciplinary continuing education forum. RGK