

# 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.)*

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*1. On what percentage of your patients do you perform enamel reproximation?*

All the respondents performed at least some enamel reproximation, usually in about 20% of their cases. A few of the clinicians reported more frequent reproximation, in at least 50% of their cases; conversely, a few said they reproximated in less than 5% of their cases.

*What are your most common reasons for using the technique?*

Every respondent gave more than one answer to this question. The most common reason, mentioned by more than 65% of the clinicians, was to adjust for tooth-size discrepancies. This response was closely followed, however, by anterior crowding, dental esthetics, and borderline extraction cases. Only 15% said they used reproximation to resolve posterior crowding.

*How often do you perform enamel reproximation on anterior teeth, posterior teeth, or both sections in a single patient?*

The vast majority of respondents either "frequently" or "sometimes" reproximated the

anterior teeth. Only two clinicians reported reproximating "frequently" in the posterior segments; the remainder of the respondents were equally divided between the "sometimes" and "rarely/never" categories. No one "frequently" reproximated in both sections in a single patient, with the replies equally divided between the "sometimes" and "rarely/never" categories.

*At what stage of treatment do you usually perform enamel reproximation?*

More than two-thirds of the practitioners normally did enamel reproximation during tooth movement. Of the rest, about equal numbers performed enamel reproximation before and after tooth movement.

*Which methods and products have you tried that have worked the best, and why?*

Most respondents used more than one method and product. Nearly 90% used abrasive strips for interproximal reduction, closely followed by diamond disks, and more than 50% used burs. The abrasive strips and diamond disks were more likely to be used on the anterior teeth, while burs were more commonly employed for the posterior teeth.

Many clinicians who used abrasive strips did so because, with direct manual control, they could remove proximal enamel more conservatively. It was also noted, however, that abrasive strips could be time-consuming if multiple sites were involved. Diamond disks and burs were often preferred because they could rapidly reduce the interdental enamel, especially in situations with thicker proximal walls.

Because abrasive strips of various grit sizes



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can be obtained from virtually any supplier, no particular favorite was consistently noted. Braseler diamond disks were preferred by some clinicians, while others favored the burs from Rain-tree Essix or GAC. A few respondents mentioned using the mechanical-shuttle-action Dome Stripper for minor reductions.

Typical comments included:

- "I prefer abrasive strips because they are easier to control. The disks can rapidly remove tooth structure or ledge if not careful. On the other hand, strips are very slow."
- "Diamond disks anterior and burs in the posterior. I'll generally reproximate posterior teeth in borderline extraction cases. The bur is more efficient for greater amounts of reproximation."
- "I am comfortable with abrasive strips. I would like to do more posterior reduction, but I don't have the armamentarium or the courage to do it for the first time."

*Do you believe enamel reproximation helps prevent relapse? Please elaborate.*

Two-thirds of the respondents felt that reproximation did help prevent relapse. Their rationale was that the squared-off contact points produced by stripping could keep rotations from recurring. Another observation was that reproximation could reduce flaring of the incisors and consequently improve anteroposterior stability.

Some interesting responses:

- "No, I believe it masks relapse."
- "I haven't seen any solid research to support prevention of relapse. Reproximation is simply a way to resolve mild crowding and arch-length discrepancies."
- "Reproximation establishes flat interproximal contact points and reduces tooth-size, jaw-size disharmony."

*What problems, if any, have you experienced with patient acceptance of the technique?*

More than two-thirds of the clinicians reported either no problems or minimal difficulties. Patient concerns included the potential for caries, increased sensitivity of the teeth, and space re-opening. Several respondents observed that pa-

tient acceptance could be improved by education—in other words, by explaining that reproximation is essentially pathology- and pain-free.

Pertinent comments included:

- "I have had no problems, but the patients don't enjoy having it done."
- "My patients have been concerned with removing good tooth structure and are concerned there will be gaps after treatment."
- "The concept of enamel reduction is threatening to patients/parents until they understand that proper technique will prevent any of their fears from becoming reality."

*What disappointing outcomes have you experienced with enamel reproximation?*

Eighty-five percent of the respondents reported little to no disappointing results. Those with negative experiences mentioned difficulty in obtaining the desired morphology, ledging or scarring of the proximal enamel walls, flat contact points, occasional caries, and patient apprehension about the procedure.

Some specific remarks:

- "Knock on wood, none to date. I have been using air-rotor stripping for 15 years."
- "Occasionally I have seen caries develop when fluoride rinse was not used."

*What are your contraindications for enamel reproximation?*

Contraindications centered around poor oral hygiene, especially when coupled with hypocalcification. Also frequently mentioned were thin enamel walls, sensitive teeth, inadequate proximal surface access because of overlapping contacts, and poor morphology of the teeth to be stripped. A substantial number of clinicians, however, reported no contraindications for enamel reproximation.

*Do you routinely prescribe fluoride treatment after reproximation, and, if so, what is your usual regimen for in-office and home treatment?*

Only 40% of the respondents routinely prescribed fluoride treatment after reproximation, which is somewhat surprising considering that

the contemporary literature advises the immediate use of fluoride. Those who did prescribe fluoride treatment usually recommended a commercially available fluoride rinse or augmented this with an in-office application by either the orthodontist or the family dentist.

Individual comments were:

- "I advise the use of Gel-Kam and a fluoridated dentifrice. In certain cases I refer to the family dentist for fluoride treatment."
- "I paint Remin solution in the office and advise the use of the fluoride rinse ACT at home."
- "We give all of our patients brush-on fluoride."

2. *Have you employed one or more practice management consultants?*

A slight majority of responding practices (58%) had employed management consultants.

*If you employ a consultant, is the service ongoing, one-time, or as-needed?*

There was a fairly even distribution of replies, with a few more in the "as-needed" category than in the "ongoing" or "one-time" groups.

*How do you normally work with the consultant, in your office, by telephone, or online?*

Some two-thirds of the respondents worked with the consultants in their offices, about one-third by telephone, and only a few online.

*In which areas was the consultant helpful?*

Consultants were found to be most helpful in improving practice efficiency. Other areas mentioned, in descending order of frequency, were staff management, practice building, scheduling, record keeping, external marketing, and patient referrals. The least important categories were office technology and dentist referrals.

*What percentage increase in practice income do you attribute to consultant services?*

A substantial majority of respondents reported a 15-20% increase in practice income. Only three practitioners cited more than a 30% income boost.

*In what areas was the consultant unsuccessful, and to what do you attribute this lack of success?*

Many areas were listed as unsuccessful, including scheduling and staff stability, although 5% of the respondents indicated that their consultants were not deficient in any aspects. Among the reasons given for lack of success were inadequate experience in orthodontic specialty practice and failure to give follow-up advice. Other respondents mentioned that there were too many new policies to implement, that the staff resisted implementing the new ideas, or that it was too difficult to maintain the initial enthusiasm.

Remarks included:

- "The consultant gets the staff pumped up, but this surge in energy is difficult to maintain without constant follow-up."
- "The cost of the services and disruption of established practice guidelines over a long period of time tend to discourage continued consultation."
- "The problem is finding the time in a busy practice to implement recommended changes."

*If you have never employed a practice consultant, what factors would make you consider doing so?*

The three most common reasons given were lack of busyness, negative growth, and declining profits, especially when associated with a decrease in referrals. Other situations in which consultants might be considered were practices with excessive overhead, orthodontists needing an assessment of practice value when contemplating a sale or taking on an associate, and offices where the doctor and staff were getting burned out. Seven percent of the respondents said they would not consider hiring consultants because their practices were doing well enough as they were.

Some typical comments were:

- "If I found that my statistics were falling behind the industry average (as indicated by the JCO Practice Survey) and I could not determine why, I would consider a consultant."
- "I don't ever see myself hiring a practice consultant. I've been in a private solo practice for 22 years and have been very successful."

## READERS' CORNER

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