THE READERS' CORNER

JOHN J. SHERIDAN, DDS, MSD

(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. Do you analyze the patient's smile as part of your diagnosis? If so, briefly describe your method.

The overwhelming majority of respondents said they did analyze patients' smiles. This was usually done according to the orthodontist's judgment, however, rather than by following specific formulas. Establishing a pleasant smile usually involved a combination of factors, such as the amount of gingival display, the presence of buccal corridors, the position and width of the smile line, and the esthetic alignment of the incisors, midline, and occlusal plane.

Some specific comments were:

- "In smile evaluation, I have started to use video clips of the patient for unusual cases. I plan on using more of this technology in the future."
- "While talking to the patient initially, the conversation usually results in a natural smile from the patient, and that is my baseline to work with."

Which of the following do you include in your treatment plan: the vertical position of the upper incisors, the curve of the incisal line, the upper canine position, the upper premolar width?

All the clinicians used multiple treatment objectives, but the vertical position of the upper incisors was the most frequently cited standard. This, in turn, was directly related to the common concern of creating an esthetic balance between the display of the teeth and the amount of exposed gingiva.

Establishing a harmonious curve of the incisal line in relation to the lip line was also a major issue; most orthodontists used bracket positioning to parallel the smile line to the curvature of the lower lip, as recommended by Sarver. Several respondents noted that proper intercuspation should not be ignored, and that the esthetic position of the upper canine had to be coupled with a canine-protected occlusion.

Upper premolar width, another commonly mentioned criterion, was usually associated with providing the esthetic effect of buccal corridors while maintaining an efficient occlusion.

Interesting remarks included:

- "The patient, family, and friends will judge the result by the smile, not by the molar intercuspation. A mismatched incisor curve and lip line is jarring."
- "I like to see the upper incisors rest gently on the lower lip when smiling and have the upper incisor cementoenamel junction barely exposed by the upper lip."
- "The smile needs to harmonize with the face. My idea of a perfect result is one in which you notice the patient's eyes first, not their teeth."

What other factors do you consider when analyzing a patient's smile: age, sex, malocclusion, other?

Dr. Sheridan is an Associate Editor of the *Journal of Clinical Orthodontics* and a Professor of Orthodontics, Jacksonville University, 2800 University Blvd. N., Jacksonville, FL 32211.

There was a broad consensus that younger patients should have fuller, slightly more procumbent smiles—not only because the slightly protrusive smile is thought to be more attractive on younger patients, but because it will diminish the impact of the physiological changes that occur over time. It was noted that as a patient ages, the profile becomes flatter, and the lips lengthen and become somewhat thinner, leading to a reduced crown display. The clinicians felt that any treatment that would accentuate this process in older patients should be avoided.

Many respondents noted that females generally benefit from a slightly more protrusive smile, more open buccal corridors, and more tooth display than in males.

Although the patient's malocclusion was less of a concern, it was still significant. Several respondents mentioned that it would be difficult to fully appreciate a pleasant smile if it were superimposed on a malocclusion that affected facial form.

Another factor listed was the patient's individual desires, which had to be balanced with the clinician's treatment goals. As an adjunct to creating a more brilliant smile, many clinicians advised post-treatment bleaching, especially in older patients.

Typical comments were:

• "Age is a significant factor. The upper incisors tend to disappear with age."

• "I like to see more teeth and slightly more curve to the smile of a female patient."

• "I believe it's important that the patient's concerns and expectations be discussed. If incisal position, gummy smile, or dental shapes are a concern, then the patient needs to know the limitations I have to work with."

What mechanics do you use to treat a gummy smile? Under what circumstances would you resort to gingival surgery to treat a gummy smile?

The most frequently cited treatment methods were orthodontic intrusion of the upper incisors, gingival surgery for older patients, anterior high-pull headgear for younger patients, and anterior miniscrew anchorage in support of incisor intrusion. When a gummy smile was attributable to an obvious maxillary vertical excess, respondents felt orthognathic surgery should be considered.

The condition that would most often indicate gingival surgery was excessive or hypertrophic gingivae, closely followed by short teeth or crown heights, passive or delayed eruption, and variable gingival margins that would benefit from alteration of their height and contour. Many clinicians said they would refer to and consult with a periodontist prior to gingival surgery. The diode laser was cited as the most effective instrument for performing gingival surgery in the orthodontic office.

Individual responses included:

• "Gummy smiles have historically been a difficult problem that would require orthognathic surgery for correction. Now I believe that temporary anchorage devices will allow for some impressive results."

• "I allow a reasonable time for post-treatment gingival shrinkage to occur. If that does not occur, then I refer the patient to a periodontist for a gingivectomy."

2. How many emergency appointments do you see on an average day, and what are your most common emergencies?

Replies ranged from one or fewer to six or more emergency visits on an average day, with the average at around one to three visits.

By far the most common emergency was sticking wires. This was followed, in decreasing order of frequency, by loose, broken, or lost brackets; missing ligatures; missing separators; missing Kobayashi hooks; lost or broken retainers; and lost or broken power chains.

Do you build time into your appointment schedule for emergencies? Do you routinely keep a chair free for emergencies?

More than 70% of the respondents built time into their schedules for emergencies. On the

other hand, about the same number of offices did not routinely keep chairs free for these emergency visits.

A typical comment was:

• "We build time into our schedule for emergencies, 30 minutes in the a.m. and 30 minutes in the p.m."

On average, how quickly do you see an emergency patient?

The majority of respondents said they would see an emergency patient immediately or as soon as possible. If this was not feasible, seeing the patient on the same day was the preferred alternative. Only one reply indicated that the emergency patient would be seen the next day, and there were no reports of appointing these patients at longer intervals.

Which emergencies are likely to be seen sooner than others?

Patients in pain, usually from poking wires, were the most likely to be seen immediately. Another priority was a patient reporting trauma, especially involving displaced teeth. A patient's perception that something was going wrong would also trigger most clinicians' apprehension. Included on the emergency priority list was the tightening or replacement of auxiliary appliances such as transpalatal arches, Hyrax or Quad Helix devices, Herbst appliances, and Nance buttons.

Some individual remarks:

• "It's less work, in the long run, to immediately fix the problem than to repair the damage at a future appointment."

• "We have no priority for emergencies. If the patient feels there is an emergency, we see them as soon as possible."

How do you handle emergency calls after hours?

The most prevalent methods were responding to messages on the answering machine and giving patients the doctor's private phone number or pager number. Much less common was giving out a staff member's or covering doctor's private number. The least popular method was an answering service.

Who is the first person called to see an emergency if you are out of town or otherwise unavailable?

Most respondents had more than one procedure for dealing with such emergencies. A senior staff member or other employee was the usual contact—generally on a rotational basis, with a cell phone dedicated for that purpose. Local colleagues and practice associates were less frequently used. A few respondents remarked that the family dentist can be a source of help, especially in a small town where no other orthodontist is available.

One specific comment:

• "During office hours, my senior staff person screens the patient's emergency calls. After hours, my colleague's name and number are left on my voice mail."

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