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. What amount of gingival display do you consider a "gummy smile"?

More than 80% of the respondents believed that a gummy smile would be evidenced by a gingival display in the 4-6mm range. There were a few observations that any amount of excessive gingival display constituted a gummy smile. Other clinicians noted that differences in facial type should be considered when evaluating the severity of the gingival display.

A typical comment was:

• "It's difficult to give a definite number because there are too many other factors. For instance, it depends on their typical smile as compared to the broadest smile."

What amount of smiling gingival display do you normally seek to correct?

Most clinicians usually sought to correct or improve as much of the gummy display as they could, with an emphasis on patients in the 4-6mm range. Several respondents commented that a gummy smile is difficult to correct by biomechanical intervention alone, and that the patient's esthetic perception should be factored into the treatment plan—in other words, an excessive gingival display noted by the orthodontist might not be a particular concern of the patient.

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Which methods of correction do you use to treat the gummy smile?

Most clinicians used more than one method to correct gummy smiles. Reverse-curve archwires were used by far the most routinely. A raised anterior section with loops was used occasionally by 31% of the respondents and routinely by 19%; about half the respondents, however, indicated that they would never use this method. Only two clinicians used skeletal anchorage routinely to treat gummy smiles, but many indicated that they planned to become more familiar with the possibilities of skeletal anchorage. Surgical intervention was recommended occasionally by almost every respondent; as one said, "Orthodontics is not a surgical specialty."

Other methods of gummy-smile correction included Burstone intrusion mechanics, Ricketts or Bioprogressive utility arches, J-hook headgear, and 2×4 strap-ups with gable bends mesial to the upper first molars.

Following correction of a gummy smile, how often do you find gingival surgery necessary to lengthen the incisor crowns, and how is this surgery performed?

The vast majority of respondents used crown-lengthening gingival surgery on an occasional basis. Only one clinician reported using the technique routinely, while 9% said they never used the technique. Although most of the respondents referred crown-lengthening surgery to periodontists, a few preferred to use oral sur-

geons. In-office laser surgery and electrosurgery were infrequently cited as other methods for lengthening incisor crowns.

How often do you see relapse of a gummy-smile correction?

None of the respondents said they routinely observed gummy-smile relapse. More than three-quarters reported occasional relapse, and about 20% indicated that they never saw relapse.

Has your opinion of what constitutes a gummy smile changed in recent years? If so, how?

The replies suggested that the clinicians' opinion of what constitutes a gummy smile has not changed, but that our perception of its esthetic impact has been modified in recent years. Many of the orthodontists noted that it may be acceptable to leave more gingival display than we previously thought appropriate, while still complying with the patient's esthetic goals. With more adult patients being treated, clinicians are aware that the upper lip lengthens with age, thus reducing excessive gingival display. Therefore, absolute correction of a gummy smile may not be necessary in older patients. The esthetics of a gummy smile can also be sex-related; there were numerous remarks that a slightly excessive gingival display contributes to a youthful appearance in females, but not in males.

Some specific comments were:

- "Laser technology has improved the possibility of making the gummy smile look much better."
- "My opinion hasn't changed; however, I see more models and celebrities that have gummy smiles and yet do not appear unattractive."
- "Vertical control is tough. Sometimes I feel I'm lucky to hold my own and not make it worse. Compliance with high-pull headgear has always been a battle, but the miniscrews should certainly make a difference."
- "I tolerate more gingival display now than I did a few years ago, but I'm more likely to seek help with increasing clinical crown heights to decrease a gummy smile."

2. Indicate your normal office communication procedures for new patients.

Sixty-five percent of the respondents used the mail for sending greetings and practice information prior to the first visit, while 20% used the telephone for initial contact. E-mail was the least favored method.

A first-visit reminder was delivered by phone by more than two-thirds of the respondents; the remainder were equally divided between surface mail and e-mail. A thank-you note to the referrer was nearly always sent by mail.

The medical/dental history was usually completed at home. Other options, in descending order of frequency, were completion at the first visit by the patient, completion by a staff member, and completion by the orthodontist.

Most offices used front-desk staff to greet patients on their first visits, followed by the treatment coordinator and then, in only a few practices, by the orthodontist.

Two-thirds of the respondents limited their first-visit diagnostic records to panorex films. The other clinicians preferred to obtain full records at the first visit, but there were many notations to the effect that comprehensive records were taken only when deemed necessary.

The case presentation was usually made by the orthodontist during the first visit or, more frequently, at a subsequent visit. Few respondents assigned their case presentations to staff members. The clear majority of respondents were comfortable giving the case presentation to one parent only; a much lower percentage preferred to have both parents present.

Financial arrangements were nearly always presented by a staff member, usually at the first visit, but less often at the second or subsequent visits. Rarely were financial arrangements presented by the orthodontist.

After case acceptance, treatment was generally initiated at the second patient visit. A substantial number of clinicians, however, said they would initiate treatment at the first visit, depending on circumstances such as the severity of the case, or at the third or subsequent visits.

Communication with referring dentists was

usually done by mail, with only a handful of offices using e-mail or telephone. The diagnosis and treatment plan were by far the most essential elements of this communication. Copies of x-rays were forwarded by 30% of the respondents, but cephalometric tracings were usually not sent or discussed. Few orthodontists communicated with referring dentists in person.

Do you have a practice website, and if so, do you use it for new patients?

Sixty-five percent of the clinicians reported having practice websites, and many of the rest said they were investigating the possibility of establishing their own websites.

Many innovative methods were reported for utilizing a practice website to familiarize patients with the office, augment internal marketing, and improve practice efficiency. The most common usage was to offer general information about the practice, such as hours of operation, directions to the office, and qualifications of the orthodontist and staff. Other website applications included appointment reminders, online payments, answers to frequently asked insurance questions, "braces troubleshooting" guides, new-patient medical/dental history forms, and interactive games. One clinician had even set up a virtual tour of his office.

Some respondents noted that there was a cost involved in setting up a website, along with a learning curve in figuring out how to promote it, but that this was more than compensated for by having such a powerful, contemporary tool for practice management.

Interesting remarks included:

• "We are fully informative with new patients, but I do not believe orthodontists should be pushy salespeople."

• "Patients expect contemporary offices to have an informative website. This is a standard, not something unique."

• "Our welcome letter encourages patients to use our website."

• "Establishing a website was one of the best things I have done for overall professional communication."

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