

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. Are you currently using self-ligating brackets?

Three-quarters of the respondents were currently using self-ligating brackets. The remaining clinicians indicated that they were not using these brackets, but 14% said they would consider them in the future.

If you are currently using self-ligating brackets, what types have you tried, and which type do you prefer?

Just about all current brands of self-ligating brackets had been tried by at least some of the respondents. The most common appeared to be In-Ovation (GAC), Damon (Ormco), and SmartClip (Unitek), followed by SPEED (Strite Industries), Time (American Orthodontics), Carrière (ClassOne) and Synergy R (RMO). Although many respondents did not indicate their preferred brackets, those who did greatly preferred In-Ovation, Damon, or SmartClip.

What slot size do you use, and why?

Three-fourths of the clinicians who were using self-ligating brackets preferred .022" slots, which they felt provided greater stability with the

necessarily larger archwires. Some added that more wire options were available with this slot size, and that bite-opening forces would be stronger with larger wires.

Those who used .018" slots believed that lighter wires produced lighter and more physiologically acceptable force levels when the slots were filled with full-size archwires. A number of clinicians preferred working with a Bidimensional system, usually involving a combination of .018" slots in the maxillary and mandibular anterior regions for greater torque control and .022" slots in the posterior regions to facilitate sliding mechanics.

Representative comments included:

- "I was trained with .022", and it has always worked for me."
- "The increase in adult patients with edentulous spaces requires stiffer archwires to span those areas."
- "An .018" controls torque like I want for incisors and molars; .022" on cuspids and bicuspid allows freedom for sliding mechanics. Maybe I can't position brackets well enough, but .022" helps slight errors."

On what kinds of cases do you use self-ligating brackets?

Many respondents used self-ligating brackets in all (33%) or most (11%) of their cases. The self-ligating brackets were employed more commonly in adults than in adolescents. They were used about equally in mild-, moderate-, and severe-crowding cases, but were preferred in cases that could be treated without extractions.

Some specific comments were:

- "I use self-ligating brackets on just about all



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full orthodontic cases. But for Phase I treatment, especially 2 × 4s, I use twin brackets because the kids like colored ties.”

- “I use self-ligating brackets on nearly all cases, with the exception of surgical cases, as removal and placement of postsurgical archwires becomes more difficult due to the patient’s limited opening.”

What do you believe are the advantages of self-ligating brackets?

The most frequently mentioned advantage was that placement and removal of archwires was much faster and simpler with self-ligating brackets. Coupled with the improved efficiency of the assistants was a reduction in chairtime.

There was also a strong belief that the initial leveling and alignment phase would be faster when self-ligating brackets were used in combination with contemporary elastic, superelastic, or heat-activated archwires. Archwire engagement was reported to be more complete and predictable.

Many respondents noted that self-ligating brackets produced less friction and were therefore more efficient with sliding mechanics. Forces could thus be restricted to lighter, more physiologically acceptable levels.

A few typical comments:

- “Self-ligating are more hygienic, the initial phase of leveling and aligning is faster, you can schedule longer periods between appointments, and they are more comfortable for the patient.”
- “There is less friction in small round wires, which allows longer treatment intervals, and there are no nasty elastomeric Os to change. There is shorter chairtime, decreased treatment time, and less training for staff, which could mean less need for staff for my office.”
- “There’s much less need for elastomeric ligature inventory.”

What are the disadvantages?

The most frequent comment involved the frustration of failed clips that, in turn, necessitated the replacement of brackets. There were qualifying remarks, however, that better engineering and manufacturing standards have ameliorated these concerns in recent years.

A repeated concern was whether the cost of self-ligating brackets justified the purported increase in clinical efficiency. Although this currently appears to be a matter of opinion, some clinicians called for more research and clinically focused data on self-ligating brackets.

Another issue was patient preference: many children and adolescents want the colored ligatures that can be more easily placed on conventional edgewise brackets. Other respondents noted that the increased size of self-ligating brackets could promote patient discomfort and excessive plaque accumulation and that rotational control was somewhat compromised, especially during detailed finishing.

Specific comments included:

- “The two primary reasons I discontinued self-ligating brackets were due to the poor final finishing results and door failure.”
- “They don’t produce faster results and are more difficult to work with.”
- “Clips or doors on the brackets can get embedded with plaque, impairing bracket performance.”
- “Calculus forms on the lower incisors and the tissues puff up on the bicuspid, making it harder to access the clips to open and close.”



2. What is your usual annual amount of vacation time, and how does this compare to five years ago? If there is a difference, to what do you attribute the change?

About 90% of the respondents to this question were solo practitioners; another 7% reported having two full-time orthodontists, a smattering listed three full-time orthodontists, and only a single respondent had four.

Nearly half of the clinicians reported taking more than four weeks of annual vacation time; 22% took four weeks, 19% took three weeks, and 10% took two weeks. One orthodontist-owner took only one week of annual vacation.

More than 65% reported that their usual vacation time had stayed constant over the last five years, but 25% said they were taking more vacation time since then. Only 4% were taking

less vacation time than they had five years ago; these doctors had either recently purchased or expanded their practices.

Longer vacations were largely attributed to improved office and clinical technology, to a more pragmatic consideration of life values, and occasionally to a lessening of financial burdens since paying off student loans.

Some typical remarks were:

- "The efficiency of contemporary archwires coupled with self-ligating brackets has given me the opportunity to have more vacation time."
- "I attribute the extended vacation time to my new associate and the desire to enjoy life as much as possible as I am growing appreciably older."
- "My life is getting shorter every year."

What are the most common uses of your vacation time?

The most common uses were for travel (86%), recreation (83%), and orthodontic courses or meetings (57%). Less vacation time was devoted to catching up on office work (11%), self-improvement (11%), or family time (9%).

Do you use vacation time for philanthropic work? If so, describe any philanthropic work you do during vacation time in your community or elsewhere.

Seventy-one percent of the respondents indicated that they never used their vacation time for philanthropic work. Many did note, however, that they regularly did pro bono work or treated cases at reduced fees for patients in distress. There were also many who said they were actively involved in their religious communities, fund raising, and various educational activities, but that these activities were curtailed during vacations. Still, 23% of the respondents indicated that they occasionally used some of their vacation time for philanthropic work, and 5% frequently used vacation time for humanitarian purposes.

Representative comments included:

- "I utilize vacation time for family activities, but I donate my time after work and on weekends to local service organizations, school functions, and community foundation."

- "I figure the best thing I can do is orthodontic care for free or greatly reduced fees. Vacation time is for my family and me."

- "I take trips to Tonga for dental humanitarian work, and I go to Honduras for educational work."

- "I work as a steward for a local community conservation district site and maintain a conservation resource property adjacent to my farm."

- "I do cleft care in the Third World."

- "I contribute time with a non-governmental organization out of London that works with disadvantaged youth in the Middle East."

- "I volunteer at Good Samaritan Clinic, a Christian medical-dental clinic that treats indigent patients, and also go on week-long trips doing extractions in Central America and Africa. I had to relearn how to extract teeth, but it has been fantastic. I also treat the 'Lost Boys of Sudan'."

What recreational activities do you enjoy on vacation?

Orthodontists enjoyed a variety of activities on vacation. The most prevalent, in decreasing order of popularity, were hiking, skiing/snowboarding, swimming, golf, tennis, and sailing. Other frequently mentioned recreational activities were sightseeing, running, hunting, boating, and camping, with a single vote each for auto racing, wine tasting, and skydiving.

Do you routinely close the office while on vacation, and if you do, who covers the office for emergencies while you are away?

There was an even split between those who routinely closed the office and those who did not. The clear majority of clinicians had the office staff cover while they were away. The next most common coverage was provided by neighboring orthodontists, followed by practice associates. Only a few reported having their patients' family dentists supervise emergency visits, and one respondent said that no one covered the office for emergency treatment.

An interesting comment was:

- "I hire an orthodontist to work with my staff so my practice is still functional while I am on vacation."

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