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THE EDITOR'S CORNER

The Challenge of Presurgical Orthodontics

The paired subjects of orthognathic surgery and surgical orthodontics routinely elicit both excitement and frustration among many clinicians. Combining oral surgery with orthodontic treatment allows us to achieve results that are much closer to ideal in even the most severe cases. On the other hand, learning to understand the complexities and subtleties of presurgical orthodontics can lead to a certain amount of aggravation. Post-surgical relapse is another source of exasperation for surgeon and orthodontist alike—to the point that many orthodontists refuse to treat cases requiring orthognathic surgery, and a few oral surgeons prefer to refer such patients to colleagues who have made the commitment to acquiring proficiency in the procedures involved, essentially becoming subspecialists in the field.

There can be no doubt that significant advances have been made over the past 75 years. Severe Class II and Class III malocclusions that, prior to the work of the Swiss oral and maxillofacial surgeon Dr. Hugo Obwegeser and other pioneers in the field, had to be handled with a "camouflage" approach are now treated to facial and occlusal standards that involve little or no compromise. The results of orthognathic surgery in conjunction with orthodontics have become highly predictable, and background training in these techniques is now mandatory in every orthodontic or oral and maxillofacial surgery graduate program. Unfortunately, the number of patients who not only need this kind of treatment, but who want it and can afford it, is so small that resident experience is often minimal at best. This is probably the most common concern voiced by orthodontic graduate students and residents about their specialty training programs.

The need for ongoing education in surgical orthodontics is met, in part, by articles such as the one published this month in JCO, in which Drs. G. William Arnett and Michael J. Gunson present a simple, three-step approach to their "Esthetic Treatment Planning for Orthognathic Surgery". Like Dr. Obwegeser, Dr. Arnett can be considered one of the true innovators in orthognathics, con-

tributing substantially to the body of literature in the field while promoting a holistic approach to treatment planning. In the Arnett-Gunson system, the old adage about "putting the plaster on the table" is only one part of the process. For too long, orthodontists have overemphasized correction of the occlusion as the primary consideration in surgical treatment planning. As Drs. Arnett and Gunson themselves state in a follow-up interview by Dr. Dipak Chudasama, to appear in next month's issue, "The scope of occlusal correction can be defined as a mission statement or set of goals that should guide bite correction. As the occlusion is corrected, other factors must be maintained if adequate, or even improved if inadequate. These factors include facial appearance, periodontal health, TMJ function, stability, airway expansion, and fulfilling the patient's wishes."

In this model, the role of the orthodontist becomes at once more critical and more complex. An in-depth understanding of the specific requirements of orthodontic preparation is essential for any orthodontist who wants to accept this exciting and engaging challenge. With an acknowledgment to JCO Contributing Editor Dr. Richard McLaughlin, Drs. Arnett and Gunson explain and illustrate the fundamental principles behind their holistic approach to treatment planning. They detail the steps involved in presurgical dental decompensation, extraction patterns, facial examination, and the use of segmental archwires to maximize the outcome of presurgical orthodontics.

Although Drs. Arnett and Gunson make the rather discouraging observation in their interview that "currently, on average, orthodontic and surgical bite-correction results are poor", they remain optimistic about the combined prospects of orthognathic surgery and surgical orthodontics. In their view, "The future of bite correction (orthodontics and orthognathic surgery), to a large extent, will depend on one thing: our ability to teach goal-oriented treatment." Their article and interview go a long way toward advancing that ideal. RGK