

**EDITOR**

Robert G. Keim, DDS, EdD, PhD

**SENIOR EDITOR**

Eugene L. Gottlieb, DDS

**ASSOCIATE EDITORS**

Birte Melsen, DDS, DO (Aarhus, Denmark)

Ravindra Nanda, BDS, MDS, PhD  
(Farmington, CT)

John J. Sheridan, DDS, MSD (Jacksonville, FL)

Peter M. Sinclair, DDS, MSD (Los Angeles, CA)

Bjorn U. Zachrisson, DDS, MSD, PhD  
(Oslo, Norway)**TECHNOLOGY EDITOR**W. Ronald Redmond, DDS, MS (San  
Clemente, CA)**CONTRIBUTING EDITORS**

R.G. Alexander, DDS, MSD (Arlington, TX)

Tiziano Baccetti, DDS, PhD (Florence, Italy)

Jeff Berger, BDS, DO (Windsor, Canada)

S. Jay Bowman, DMD, MSD (Portage, MI)

Robert L. Boyd, DDS, MEd (San Francisco, CA)

Vittorio Cacciafesta, DDS, MSC, PhD (Milan,  
Italy)José Carrière, DDS, MD, PhD (Barcelona,  
Spain)

Jorge Fastlicht, DDS, MS (Mexico City, Mexico)

John W. Graham, DDS, MD (Litchfield Park, AZ)

Robert S. Haeger, DDS, MS (Kent, WA)

Warren Hamula, DDS, MSD (Monument, CO)

James J. Hilgers, DDS, MS (Mission Viejo, CA)

Masatada Koga, DDS, PhD (Tokyo, Japan)

Björn Ludwig, DMD, MSD (Traben-Trarbach,  
Germany)

James Mah, DDS, MS, DMS (Los Angeles, CA)

Melvin Mayerson, DDS, MSD (Kettering, OH)

Richard P. McLaughlin, DDS (San Diego, CA)

James A. McNamara, DDS, PhD (Ann Arbor, MI)

Elliott M. Moskowitz, DDS, MS (New York, NY)

Jonathan Sandler, BDS, MSC, FDS RCPS,  
MOrth RCS (Chesterfield, United Kingdom)Georges L.S. Skinazi, DDS, DSO, DCD  
(Paris, France)

Michael L. Swartz, DDS (Encino, CA)

Flavio Uribe, DDS, MDS (Farmington, CT)

**EXECUTIVE EDITOR**

David S. Vogels III

**MANAGING EDITOR**

Wendy L. Osterman

**EDITORIAL ASSISTANT**

Heidi Reese

**BUSINESS MANAGER**

Lynn M. Bollinger

**CIRCULATION MANAGER**

Carol S. Varsos

**GRAPHIC DESIGNER**

Jennifer Johnson

Address all communications to *Journal of Clinical Orthodontics*, 1828 Pearl St., Boulder, CO 80302. Phone: (303) 443-1720; fax: (303) 443-9356; e-mail: info@jco-online.com. See our website at www.jco-online.com.

# THE EDITOR'S CORNER

## Some Thoughts on Appointment Intervals

The length of time between orthodontic appointments, generally called the "appointment interval", has been the subject of debate for years. Various reasons have been given for selecting one interval over another. Doctors all have their own preferences, based either on what they were taught in their orthodontic specialty programs or on community norms. Little evidence has been presented in the orthodontic literature to support those biases.

Ideally, any practice decision that influences patient treatment should be made with the patient's best interest in mind. That doesn't necessarily mean there is only one *right* way; the concept of "best interest" may comprise multiple possibilities. In a situation where various options could be considered equal for the patient, then it only makes good sense to select the one that maximizes the efficiency of the orthodontic practice. Decisions about appointment intervals generally fall into this category.

In the early days of the specialty, archwires were made of precious metals, similar to those used by restorative dentists. The time between appointments had to be relatively short because of the limited working range of materials such as gold. Because of the malleability of these metals, deflections had to be minimized to avoid permanent deformation. Furthermore, the wire ligatures used in those days did not have the properties of elastomeric ligatures, which can effectively extend the working range of archwires. As a result, patients had to be seen as often as every few days, or at least every couple of weeks, to reactivate the treatment bends in the wires.

Over the past few decades, archwires have become more and more elastic, beginning with stainless steel and continuing through beta titanium and various nickel titanium materials. Today's superelastic, thermally activated copper nickel titanium wires have extraordinary working ranges. Extending appointment intervals has been in both the patient's best interest, with respect to optimal tooth movement, and the practice's best interest, with respect to chairtime optimization.

In reality, the orthodontic appointment interval has

always been determined by practical as well as treatment-related considerations. When fees were open-ended and paid on a monthly basis, a monthly visit was the usual way to associate the monthly payment with a treatment visit. As fixed fees became the norm, patients were still billed monthly to dissociate fee payment from the number of visits. If a patient could be scheduled on the same day every month, it was more convenient for the parents to budget their monthly payments. It was also easier to arrange time out of school to see the orthodontist on a regular basis.

With the treatment options available to orthodontists nowadays, it is more than a little naïve to take a one-size-fits-all attitude when it comes to appointment intervals. The routine monthly appointment is an anachronism. As always, however, the patient's best interest must be the determining factor. That includes an optimal rate of tooth movement and tissue response, which may, in turn, depend on optimizing the biomechanical properties of orthodontic biomaterials. Assuming that the patient's oral health is of primary concern, secondary factors in the patient's best interest may include treatment financing, scheduling convenience, and monitoring of compliance-dependent appliances.

All in all, the determination of appointment intervals involves a complex decision tree that

can be difficult for any practitioner to diagram. Although a number of published articles have dealt with individual facets of this decision—such as the optimal time between appointments for particular appliances or archwire materials—few have attempted to put all the pieces of the puzzle together.

In this issue of JCO, Drs. Laurance Jerrold and Nona Naghavi try to bridge that gap in the literature. After reviewing a wide range of articles on the subject, the authors have identified nine major considerations that can guide the clinician in determining appointment intervals. I found that their suggestions make eminent sense in specific situations and are readily implemented in a busy practice. I trust you will agree with me.

RGK

---

## **CORRECTION**

In the article by Dr. K. Hero Breuning, "Efficient Tooth Movement with Early Full-Size Archwires" (JCO, April 2011), the archwire and bracket sizes listed for the Damon system in the text (p. 207) and in Figure 2 are incorrect. The maxillary archwire should be .020" square, and the bracket slot size should be .022".