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THE EDITOR'S CORNER

Our Favorite Cases

Over years of orthodontic practice, each of us develops a repertoire of case types we prefer to treat—in effect, a kind of personal sub-specialty in which we are particularly proficient. For example, I have always enjoyed working with cleft-palate cases, so much so that I eventually decided to treat them for free if the financial strain would overly burden a needy family's resources. I enjoy the challenges presented by clefts, and the long-term positive effect on kids' lives is payment enough for me. A good friend and colleague of mine is a long-time devotee and instructor of the Tweed technique, as taught at the Tweed Study Course in Tucson, Arizona. Consequently, the cases he enjoys treating most are severe Class II patients who refuse surgery for whatever reason. His finished nonsurgical Class II cases never fail to impress me; that he can accomplish such superb outcomes using what many of today's orthodontists would consider primitive treatment modalities—stainless steel archwires, J-hook headgear, chin cups, and the like—is especially remarkable. Another friend of mine actually likes to treat Class IIIs, also nonsurgically, whereas most of us wince at the thought of dealing with such cases.

Naturally, if we each have a favorite type of malocclusion to treat, we also have our least favorites. My biggest headache would have to be a non-growing Class II, division 2. Other clinicians have expressed to me their dislike of generalized-spacing cases, skeletal deep bites, and particularly high-angle cases. Of course, our favorite or least favorite type of case doesn't have to be a diagnostic classification. All of us like cooperative patients who follow instructions well and those who are "good growers". All of us dislike cases in which patient behavior is an issue—although there are those who excel at and sincerely enjoy working with patients who are developmentally, intellectually, or emotionally challenged. I consider these doctors to be very special people, some of the most exemplary humanitarians in our profession. Other categories that might elicit emotions of favor or disfavor are those defined by patient age or stage of physiological develop-

ment. I know orthodontists who treat adults exclusively, as well as those who will accept only patients who are still actively growing.

One type of case that always causes me to cringe when it comes along is a retreatment in which the patient is unhappy with the original results for one reason or another. Such cases have several strikes against them from the outset. First of all, the patient has already expressed dissatisfaction with a treatment outcome and is, more than likely, distrustful of the entire orthodontic process. The second doctor has to go out of his or her way to prove acceptable to the patient. Secondly, there are physiological considerations involved in retreatment. If the patient has a potential for root resorption, as most do, some of that potential will already have been expressed, and you won't have as much root to work with to finish the case.

All of us have had to retreat various cases to the best of our abilities. In fact, one of the defining episodes in the history of orthodontics occurred when Tweed decided to retreat a number of patients he had originally treated without extractions, extracting four premolars the second time around. The improved facial esthetics and occlusal function that he achieved and presented to the profession changed the course of orthodontic diagnosis and treatment planning and, coincidentally, started a debate about extractions that goes on to this day.

In the current issue of JCO, Dr. Márlio Vinícius de Oliveira and his Brazilian colleagues present a retreatment case that, like Tweed's, seemed to require premolar extractions to address the patient's concerns about esthetics and function. While Dr. Oliveira's team had more contemporary modalities such as skeletal anchorage devices at their disposal, their overall treatment goals and subsequent outcomes are still reminiscent of those sought and achieved by Dr. Tweed, including a much-enhanced facial profile and a substantially improved occlusion.

While I seriously doubt there are many of us who would consider retreatment cases to be among our favorites, the approach taken by Dr. Oliveira and colleagues and the results they achieved should serve as an example to every orthodontist. RGK