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THE EDITOR'S CORNER

Camouflage or Surgery?

Like most experienced orthodontists, when in the presence of other people, I'm in a continuous state of facial analysis—though it's usually subconscious on my part. My indulgent, long-suffering wife of 42 years has come to accept and understand this. In the early days of our relationship, when I was right out of orthodontic school, she would instinctively, out of minor jealousy, scold me for looking at another woman's face for what she considered to be too long a time. She eventually came to realize that the faces I seemed to be staring at were not necessarily the prettiest ones around. They were the ones that could have been made prettier by orthodontic treatment or by orthodontics in conjunction with orthognathic surgery. As our marital relationship matured along with our professional acumen, my wife came to realize that I was (usually) not just enamored by "another pretty face", but was asking myself how I could make that face even more attractive. A career elementary school-teacher and administrator, my wife has never had any formal training in dentistry or facial esthetics. But since she has gone through dental school, specialty training, private practice, academics, and an editorial career with me, she certainly knows the vernacular. Now, rather than scolding me for looking at a young lady's face for too long, my wife will chuckle and ask, "Upper 4s, lower 4s?" or "Three-piece maxilla with a BSSO?" If orthognathic surgery might be involved, she generally adds, "Let me guess, you and Duke could make her beautiful!"

The Duke in question is the long-time University of Southern California Chairman of Oral and Maxillofacial Surgery, Dr. Dennis-Duke Yamashita, the great oral surgeon with whom I worked closely for almost 20 years. The last time my wife commented along these lines, I was staring at the face of a young lady—we'll call her Becky—who had just finished her second year of dental school and whom I had taught the previous semester. We ran into her at a local grocery store during semester break and had a brief and pleasant chat. As my student walked away, my wife observed, "Let me guess, you and Duke could make

her beautiful, right? Simple mandibular advancement?" I should note that Becky had compromise "camouflage" treatment performed in her teens by an orthodontist from her hometown. Everything about Becky's face, teeth, and smile is already pretty. She is a beautiful young lady. She also has a noticeable skeletal Class II sagittal relationship, with a distinctly retrognathic mandible. There is nothing functionally, psychosocially, or physiologically wrong with her facial appearance or occlusion, yet every time I see Becky, the old instincts deep in my psyche scream silently to me, "You and Duke could make her prettier!"

The truth of the matter is that she is completely satisfied with her own facial appearance. When Becky first sought orthodontic care, I am sure she presented one of my least favorite clinical situations: a "borderline surgical case". When offered the option of orthognathic surgery, she and her parents declined, and she was successfully treated with orthodontic camouflage. While there is no formal definition of a "borderline case" or of "orthodontic camouflage", as the late Supreme Court Justice Potter Stewart said (in reference to obscenity), "I know it when I see it."

Knowing it when you see it and knowing what to do about it are two different things. Borderline cases are always difficult diagnostic calls to make. As long as the occlusion and mastication are within normal limits, I generally let the patient be the judge of his or her own facial esthetics. But if the patient is willing to undergo surgery, the decision is entirely up to the treating doctor or doctors. If you're like me, you always second-guess yourself, no matter which way you choose to go: surgical or camouflage. In a situation like this, I appreciate any additional help I can get.

The current issue of JCO includes an article in which Drs. Teresa Pinho and Rita Raposo of Portugal offer some welcome guidelines for deciding on orthodontic camouflage vs. surgical-orthodontic treatment of skeletal Class II malocclusions. Two detailed case presentations—one managed surgically, the other through camouflage treatment—serve to illustrate their approach. The way these patients were successfully handled may ease any pangs of second-guessing for those of us presented with such cases in the future. RGK