

THE EDITOR'S CORNER

The Toughest Cases

In every one of my 40 years teaching orthodontic diagnosis and treatment planning to graduate specialty students, I have invariably been asked by some enthusiastic first-year resident which cases are the most difficult to treat. Tough question. My initial response is always something like “the spoiled brat, screaming, non-cooperator.” Most of us simply dismiss such patients, telling their parents to bring them back when they grow up a bit and are able to be polite and civil and follow instructions. Once in a great while, I find they actually do come back; generally, though, the parents get miffed and take the kid somewhere else—which was my covert goal in the first place. Most new orthodontic students don’t even consider behavioral issues to be problems, but they soon learn that behavioral issues are the biggest problems in clinical practice because they are so hard to resolve.

Returning to the residents’ question, what these students really want to know is what anatomical types are the most difficult to treat. Having spent the early part of my career researching and treating craniofacial anomalies along with cleft lip and palate cases, my inclination is to identify these cases as the most difficult, since each patient presents a unique set of problems. But such severe cases are generally handled by university-based craniofacial anomalies teams or multidisciplinary cleft palate teams, and I don’t want to answer the residents’ question with a type of case they are unlikely to see much throughout their careers. Therefore, I (and many of my academic colleagues) usually reply, “High-angle anterior open-bite cases.” These are frequently complicated by severe TMJ problems, which makes matters even more difficult. Now, the orthodontist is faced not only with having to correct a malocclusion, but with treating a dys-

functional and deranged TMJ.

Management of these cases involves all the routine issues of orthodontic treatment: planning how to obtain adequate space to align all the “crooked” teeth, carrying out such alignment, correcting the sagittal discrepancies, controlling any vertical issues, finishing and detailing, and, finally, retention. With a high-angle anterior open bite, however, all this seems at least a bit more difficult to accomplish, and vertical control is exponentially more difficult. Strategies range from transpalatal and lower lingual holding arches to high-pull headgear, fixed or removable bite blocks, and unusual (and often creative) extraction patterns. In some cases, all these strategies may need to be employed. Fortunately, the advent of skeletal anchorage devices has added a new dimension to vertical control in high-angle and all other types of cases. Today’s orthodontist has more options than ever for vertical control.

In this issue of JCO, our own Contributing Editor, Dr. Jae Park, and a team of co-authors from South Korea describe a remarkably difficult high-angle anterior open-bite case presenting with severe TMD. Diagnosis and treatment planning for this patient were unquestionably complex and difficult. Execution of the treatment plan, while challenging, was remarkable. In the end, the authors used many of the techniques I just mentioned, plus a few more. Occlusal, TMJ, and functional issues were all corrected, and the facial result was beautiful.

The next time an enthusiastic young orthodontic graduate student asks me what type of case is the most difficult to treat, I am going to refer to this article. Congratulations to Dr. Park and his colleagues on a job well done. RGK