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Learning Objectives

After completion of this exercise, the participant will be able to:

1. Contrast in-house aligners (IHAs) with commercial systems in terms of costs and benefits.
2. Describe a technique for temporary camouflage of an extraction space during forced eruption of an impacted maxillary canine.
3. Compare various protocols for splint management with the "surgery first" approach.
4. Discuss the anchorage alternatives for retraction of severely proclined upper anterior teeth in a Class II, division 1 case.

Article 1

Nisco, P.M.: *Integration of In-House Aligner Therapy in Private Practice* (pp. 450-459)

1. The total cost of producing an IHA, including equipment, is typically about:
   a) $2-3
   b) $5-8
   c) $10-12
   d) $20-25
2. Advantages of sequential aligner staging over refinements to an ideal setup include all of the following except:
   a) built-in compensations for system algorithms
   b) ability to include multiple stages in the initial treatment plan
   c) ability to optimize treatment efficiency
   d) features of being orthodontist-directed rather than appliance-directed
3. Orchestrate 3D software was developed by:
   a) Dr. Matt Nisco
   b) Dr. Lloyd Truax
   c) Dr. Michael Rains
   d) Dr. Todd Ehrler
4. For long-distance IHA treatment, the author uses the:
   a) Orchestrate 3D app
   b) Dental Monitoring ScanBox
   c) Drufomat Scan system
   d) CandidMonitoring tech

Article 2

Harrison, S.D. and Park, J.H.: *A Modified Pontic Appliance for Treatment of Impacted Maxillary Canines* (pp. 460-462)

5. An adult patient with an impacted maxillary canine and retained deciduous canine may be reluctant to have the deciduous tooth extracted because of the:
   a) possibility that the impacted tooth cannot be successfully erupted
   b) dark, edentulous space left by the extraction
   c) risk of root resorption
   d) instability of orthodontic attachments
6. The authors' modified pontic is attached to:
   a) an .036" lingual arch
   b) an .018" × .025" stainless steel archwire
   c) a cantilever from the main archwire
   d) the buccal first-molar tubes
7. To adjust the pontic's location:
   a) appropriate hooks are soldered to the main archwire
   b) a distal-loop transpalatal arch is inserted
   c) U-loops are added to the lingual arch
   d) the pontic is trimmed with a carbide taper bur

8. To create a distal molar tip that counteracts the mesial tip induced by the cantilever used for eruption of the impacted tooth:
   a) appropriate hooks are soldered to the main archwire
   b) a distal-loop transpalatal arch is inserted
   c) U-loops are added to the lingual arch
   d) the length of the cantilever wire is adjusted

Article 3

Pelo, S.; Moro, A.; Soverina, D.; De Nuccio, F.; Maselli, A.; and Gasparini, G.: *Indications and Management Protocol for the Use of Splints with the "Surgery First" Approach* (pp. 463-484)

9. A major contraindication to the "surgery first" approach is:
   a) the presence of mildly proclined or retroclined incisors
   b) a Class III malocclusion
   c) the need for orthodontic extractions
   d) the presence of premature occlusal contacts

10. An intermediate splint is particularly recommended for:
   a) maxillomandibular fixation
   b) bilateral sagittal split osteotomy
   c) one-jaw surgery
   d) two-jaw surgery

11. A dynamic splint:
   a) can turn a "surgery early" case into a "surgery first" case
   b) takes full advantage of the regional acceleratory phenomenon
   c) can be used an as an occlusal build-up to avoid interferences
   d) all of the above

12. The digital file for production of an intermediate splint is obtained by:
   a) eliminating all surgical movements of the mandible
   b) estimating the required surgical expansion of the maxilla
   c) copying the movements of the maxilla from the two-dimensional visual prediction tracings
   d) establishing the postsurgical occlusion with virtual models

Article 4

Sutthiprapaporn, P.; Thittiwong, R.; and Pisek, P.: *Miniscrew Anchorage for Treatment of Severely Proclined Upper Anterior Teeth in a Class II, Division 1 Malocclusion* (pp. 485-494)

13. In a Class II, division 1 case, excessive upper lip procumbency is typically associated with a:
   a) lower anterior tooth-size excess
   b) canted occlusal plane
   c) protrusive maxillary dentition
   d) tapered maxillary archform

14. Common categories of Class II, division 1 treatment include all of the following except:
   a) growth modification
   b) early intervention
   c) orthodontic camouflage
   d) surgical-orthodontic therapy

15. Safe interradicular miniscrew insertion requires a space of at least:
   a) 3mm
   b) 5mm
   c) 8mm
   d) 12mm

16. Janson and colleagues observed similar soft-tissue effects from Class II, division 1 treatment with fixed functional appliances as compared with:
   a) the combination of a Pendulum with a Nance appliance and headgear
   b) clear aligner therapy using elastics
   c) nonextraction fixed appliance treatment
   d) fixed appliance treatment involving two maxillary premolar extractions