FIGHTING FOR ORTHO

WHY GENERAL DENTISTS SHOULD OFFER ORTHODONTIC SERVICES FOR THEIR PATIENTS

Can Your Practice Afford to Refer Out Fifty Orthodontic Patients Per Year at $3,500 Per Case?

COVER STORY

by Brock Rondeau, D.D.S.

At the present time in many parts of the world there is a turf battle between general dentists and orthodontists not only due to the financial aspect but also due to the vast difference in treatment philosophy. Many orthodontists are trained with the conventional fixed philosophy which involves the extraction of bicuspids and the prevalent use of cervical facebow headgear which results in a retraction and compression of the maxilla. Many general dentists have been trained in the functional jaws, orthopedic philosophy which is a non-extraction early treatment, non-surgical approach.

The conventional approach prefers to wait until all the permanent teeth have erupted before commencing treatment whereas the functional philosophy suggests starting treatment as soon as the problems have been identified in either the deciduous or mixed dentition. 'This perception has been substantiated by Dr. Peter Sinclair in the January 1993 issue of the *Journal of Clinical Orthodontics*, when he states that the orthodontists interviewed said they used functional appliances in 5 percent to 10 percent of their cases. Also, the general dentists who have attended my courses over the past 15 years have indicated that they are constantly asked by orthodontists to extract bicuspids for their patients.

Many general dentists, pediatric dentists and parents have been frustrated with the response of some orthodontists upon observing certain malocclusions. "No treatment is indicated at this time, the patient is too young, the malocclusion will be observed and treated when the permanent teeth erupt." For practitioners trained with a preventive philosophy, this approach seems very irrational when statistics prove that malocclusions left untreated continue to worsen with time. Since research clearly shows that the clinician will obtain the greatest orthopedic response while the patient is actively growing, one wonders why the majority of patients are left untreated in the mixed dentition. The term "supervised neglect" seems appropriate.

I recommend two phase orthodontic treatment.

Phase I	Orthopedic phase utilizing functional jaw orthopedic appliances in the mixed dentition.
Phase 2	Orthodontic phase utilizing fixed braces in the permanent dentition.

In the mixed dentition, 80 percent of the transverse (constricted arches), sagittal (overjet), and vertical (overbite) problems are solved non-extraction and non-surgically. When all the permanent teeth erupt the last 20 percent of the treatment is accomplished with braces to fine tune the occlusion. Clinicians must learn to solve the functional and skeletal problems in the mixed dentition with functional orthopedic appliances.

Two prominent orthodontic clinicians, Dr. James McNamara and Dr. Robert Moyers, made the startling revelation that 80 percent of all Class II malocclusions have retrognathic mandibles. McNamara has further stated that less than 5 percent of the maxillas are truly prognathic. In light of these facts most general dentists find it hard to accept when orthodontic clinicians continue to apply retractive forces to the maxilla utilizing upper bicuspid extraction, cervical facebow headgear and the Wilson Distalizing Arch.

If 80 percent of the mandibles are retrognathic it would appear that this is an orthopedic or structural problem which would necessitate the utilization of a mandibular advancement appliance such as a Twin Block or Rick-A-Nator to correct the problem. Orthopedic-functional appliances consistently improve the health of the TMJ as well as dramatically improve the profile. Orthodontic clinicians must constantly arrive to achieve a stable joint relationship, good looking face and straight profile.

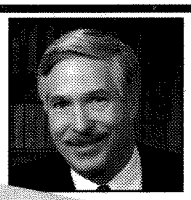
It his been estimated that 60 percent of children in the mixed dentition have some form of malocclusion. This represents a tremendous number of patients who need orthopedic-orthodontic treatment. As mentioned previously, many orthodontists have not been trained nor motivated to treat the vast majority of patients in mixed dentition. If this is so, then I respectfully submit that the general and pediatric dentists have a responsibility as well as a golden opportunity to increase their knowledge of orthodontics and orthopedics and become the treatment specialists of the mixed dentition.

Statistics show that 90 percent of the face is developed

COVER PROFILE

The Rondeau File

Brock Rondeau, D.D.S.



FAMILY PROFILE: Joey—the love of my life who constantly supports and inspires me. Scott—Son, age 25, attending college in Toronto, specializing in event marketing.

PROFESSIONAL ACCOMPLISHMENTS: General Dentist Practicing Orthodontics, Orthopedics, TMJ, 21 years; Past President, International Association for Orthodontics; Diplomate, International Board of Orthodontics; AAFO Clinician of the Year, 1993; Contributing Editor, *Journal of Clinical Pediatric Dentistry*; Awarded IAO's Highest Honor, Leon Pinsker Award; Duane Stanford Award

GRADUATE: Dalhousie University, Halifax, Nova Scotia, Canada, 1966

PROFESSIONAL AFFILIATIONS: International Association for Orthodontics, American Association for Functional Orthodontics, Academy of General Dentistry, American Academy of Head, Neck and Facial Pain, Canadian Dental Association, Ontario Dental Association, London & District Dental Society.

PUBLICATIONS & EDUCATIONAL MATERIAL: Orthodontic Course Manual, 650 pages; *Straight Wire & Functional (Orthopedic Appliances)*; "Twin Block Appliance, Part II," *The Functional Orthodontist*, March-April 1996; "Twin Block Appliance, Part I," *The Functional Orthodontist*, March-April 1995; "Class II Malocclusion in Mixed Dentition," *The Journal of Clinical Pediatric Dentistry*, September, 1994; "The Pendulum Appliance," *The Functional Orthodontist* January-February 1994; and dozens of other articles in several journals. (*Editor's Note: A complete list is available from* The Farran Report *on request.)*

SPECIAL DENTAL INTERESTS: Teaching orthodontics-orthopedics-TMJ to general dentists, pediatric dentists and orthodontists. I want to be part of the change that must occur within the orthodontic profession. Our children must be treated early in mixed dentition, with a non-extraction, nonsurgical functional jaw orthopedic approach.

DENTAL HEROES: Leaders in the Field of Functional

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by age twelve so it is vital that the orthopedic problem be treated early in order to guide the growth of our younger patients. Parents are very receptive to early treatment. They realize that problems treated early can prevent more serious and perhaps more expensive problems later on. Parents want what is best for their children which includes straight teeth, proper size jaws, properly aligned maxillas and mandibles, straight profiles and beautiful similes.

Dr. Howard Farran, one of North America's top practice management consultants, while attending my orthodontic course in Phoenix, said recently, "When was the last time a patient asked for a bridge? Mothers ask every day about their children's crooked teeth and crooked jaws. It is time that general dentists take courses on how to fulfill the needs of their patients and fill their appointment books."

Many new graduates as well as experienced practitioners are experiencing problems due to lack of new patients. If you want to increase your income you must first increase your knowledge and the services that you offer your patients. Most general dentists agree that the information they received in dental school was inadequate in several areas, including practice management, orthodontics, and TMJ.

One way to help practitioners thrive and survive in the 90's is to take continuing education courses in these subjects and incorporate them into their general practices Can your dental practice really afford to refer out fifty orthodontic cases every year at $3,500 per case? Most practice management experts think not!

While lecturing last year in Atlanta, I had an orthodontist from Brazil, Dr. Nelson Jose Rossi, attend my course. He has written three textbooks on orthodontics and he informed me that general dentists were taught functional jaw orthopedics in dental school and routinely treated the functional and skeletal problems of these patients in mixed dentition including the airway problems, facial asymmetries, posterior crossbites, ear problems and habits involving tongue thrusting and thumb sucking. In permanent dentition if the malocclusion still needed further treatment the patient would he referred to an orthodontist for fixed braces.

Contrast this situation to the one that exists in North America where the general dentist receives inadequate training in dental school and is, at times, harassed if he or she attempts to either take courses in or practice orthopedics or orthodontics. While the turf battle rages the real loser is the patient, particularly the one in mixed dentition.

My treatment philosophy is to solve the functional and skeletal problems in mixed dentition and the dental problems in permanent dentition. Research has shown that condylar changes occur in growing individuals is well as the fact that malocclusions untreated actually worsen with time. Therefore it is in the patients' best interests to treat their problems as early as they are diagnosed.

The degree of cooperation achieved is much higher when patients are ages 8 to 11 (mixed dentition) rather than waiting until all the permanent teeth erupt in permanent dentition. Functional jaw orthopedic appliances are growth modeling appliances and are most effective in the mixed dentition. Treatment in the mixed dentition ensures that most patients can be treated non-extraction and non-surgically.

My clinical experience during the past twenty years of treating thousands of patients with orthopedic and orthodontic problems as well as TM dysfunction has convinced me that functional jaw orthopedics is the key to successful treatment for many patients. The TMJ has been described as the great impostor. If there is a structural problem as a result of the mandible not being in a correct relationship with the maxilla either transversely, sagittally or vertically, this can cause the condyles to become anteriorly displaced and the disc anteriorly or anteromedially displaced. This results in an internal derangement and the patient can exhibit any of the following symptoms including headaches, neck aches, dizziness, fainting, restricted jaw opening, clicking, jaw locking, ear aches, pain around the eyes or shoulder pain.

The general dentist is the primary care provider for these patients. Clinicians must learn to properly diagnose these problems and treat the underlying structural problems by orthopedically repositioning the mandible to its correct forward position. The objective is to move the condyle down and forward and allow the disc to assume its correct position on the head of the condyle. Functional clinicians have found that this treatment consistently reduces the incidence of TMJ signs and symptoms as listed above.

The majority of these patients do not seek the services of a dentist since they regard these symptoms as a medical problem and therefore go to medical doctors, E.N.T. specialists, chiropractors, physical therapists, neurologists, and in some cases, psychiatrists. However, if there is a structural problem and if an internal derangement exists, the dentist must be considered the primary care provider.

The conservative treatment of many patients suffering from TM dysfunction is to learn to diagnose the problem utilizing a TMJ Health Questionnaire, TMJ exam, muscle palpation, TMJ x-rays, and then to become proficient in the use of splints and functional appliances such as the Twin Block. This appliance was developed by an orthodontist, Dr. William Clark, Fife, Scotland, and is essentially just two blocks, upper and lower, which interlock at 70 degrees. It is the interlocking bite blocks which reposition the mandible forward. Since approximately 67 percent of the malocclusions are Class II and 80 percent of these have retrognathic mandibles, this is one of the most important appliances utilized today.

Patients presenting with large overbites, receding mandibles and receding profiles are orthopedically corrected in seven to nine months. The Twin Block is extremely patient friendly, unlike some of the older functional appliances, and enjoys a high rate of success.

With an estimated 44 million people in North America suffering from chronic headaches and 60 percent of children in mixed dentition having some form of malocclusion, it is time that the dental profession makes more of an effort to help these patients. The head and neck are our areas of specialty and we should be involved in helping these patients.

A few years ago the American Association of Orthodontics changed its name to the American Association of Orthodontics and Dentofacial Orthopedics. I think it is time that the entire profession, including general den-

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tists, pediatric dentists and orthodontists start taking the subject of Dentofacial Orthopedics seriously. Our younger patients are depending on all professionals to start considering the well being of the patient and to treat the patient in mixed dentition utilizing functional jaw orthopedic appliances.

In the August 1996 issue of the *American Journal of Orthodontics and Dentofacial Orthopedics*, Shari Wolsky and James McNamara wrote an article entitled "Orthodontic Services Provided by General Dentists." They indicate that 76.3 percent of general dentists in Michigan provide orthodontic services for their patients. This is a significant number and it would seem that, in light of this fact, it would be extremely counter-productive for the orthodontic profession to continue their harassment of general and pediatric dentists. It is surprising that some members of the orthodontic profession seem intent on alienating their chief referral sources, namely the general and pediatric dentists. If this attitude continues, I predict serious problems in the future for both groups. It is important that the orthodontic profession realize that the enemy is malocclusion and not the other practitioners who practice with a functional jaw orthopedic philosophy. General dentists were given the right to practice orthodontics by nature of their dental degree and then, will not accept the fact that a specialty group is trying to take away that right.

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Jaw Orthopedics—Dr. Merle Bean Dr. Grant Bowbeer, Dr. Jim Broadbent, Dr. Bill Clark, Dr. Ralph Garcia, Dr. Jay Gerber, Dr. Duane Keller, Dr. Terry Spahl, Dr. Brendan Stack, Dr. Craig Stoner, Dr. John Witzig.

INTERESTS OUTSIDE OF DENTISTRY: Golf, Skiing and Travel.

BEST THING ABOUT BEING A DENTIST: To help patients achieve a beautiful smile, straight profile and healthy TMJ so they can lead successful, pain-free lives.

WORST THING ABOUT BEING A DENTIST: Hassle from some members of the profession because they have a different philosophy of treatment.

LAST BOOK I READ: *Golf My Way*, by Jack Nicklaus

WHAT NOBODY KNOWS ABOUT ME: I plan to spend more time with my family and friends in the future.

FAVORITE DISH AND DRINK: Italian Pasta and Beer.

TRAVELS: Teach 42 weekends per year. Recently returned from teaching in England. Played golf in Scotland. Planning a trip to Australia and Taiwan in 1997.

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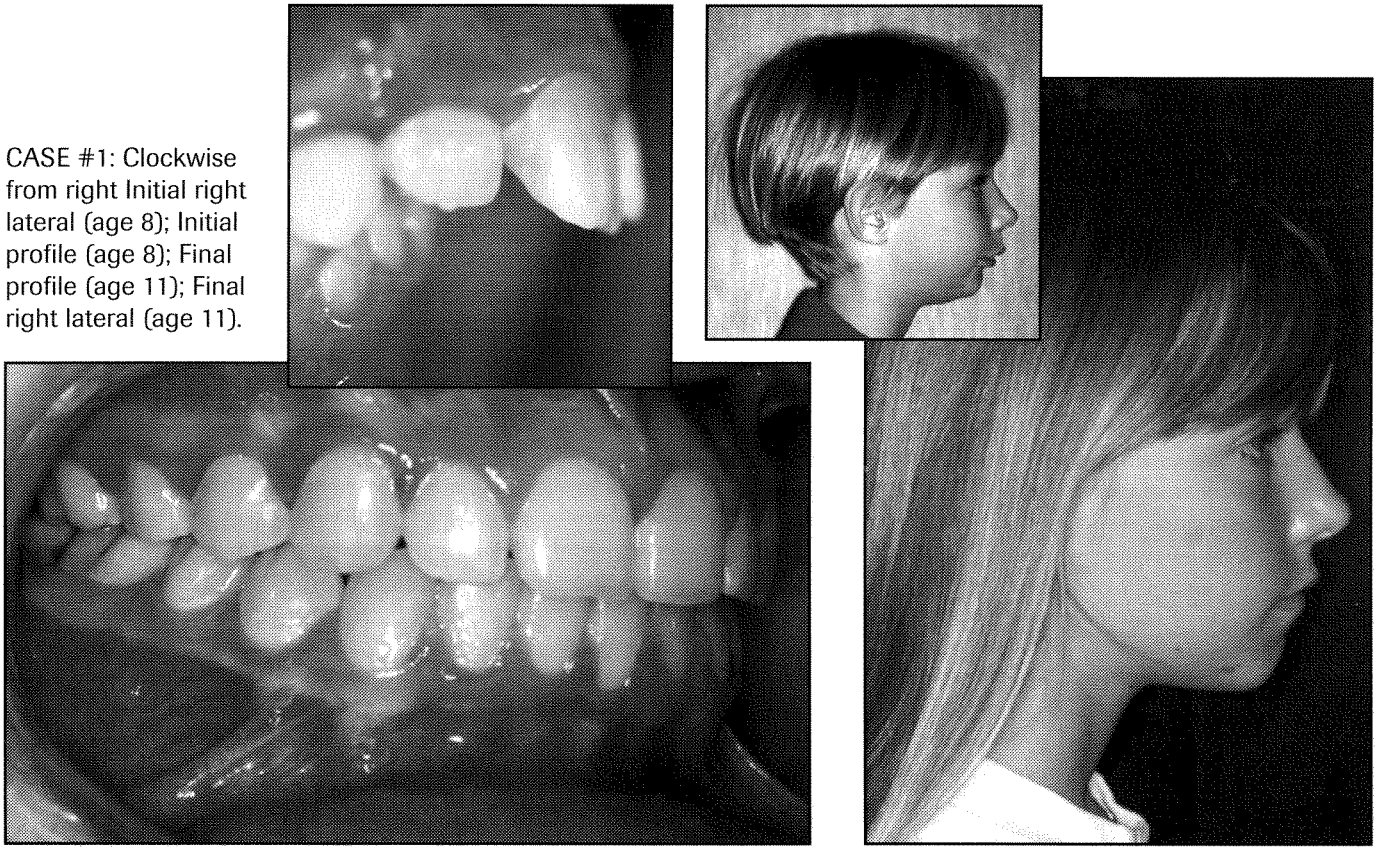
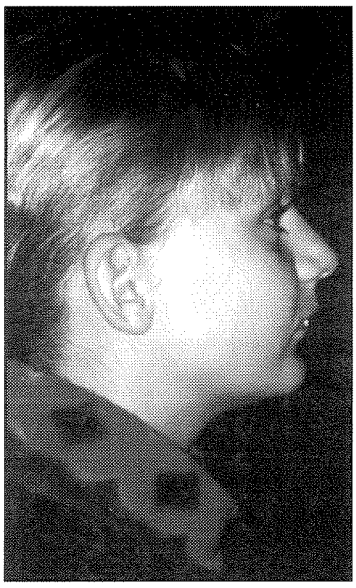
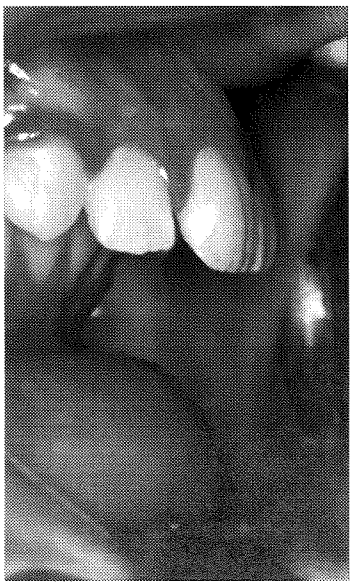
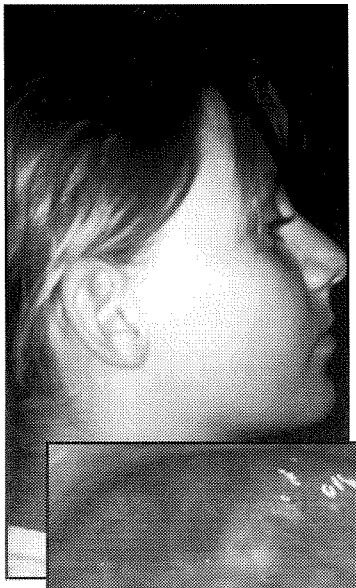
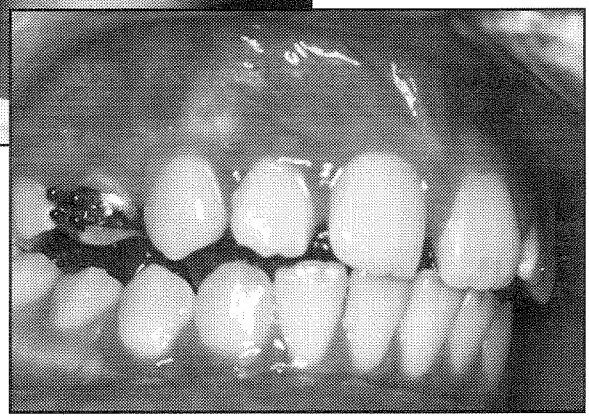


CASE #1: Clockwise from right Initial right lateral (age 8); Initial profile (age 8); Final profile (age 11); Final right lateral (age 11).



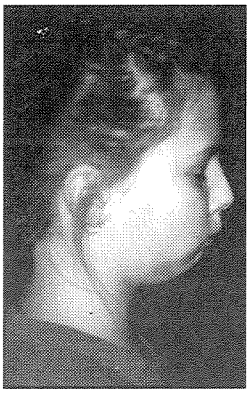


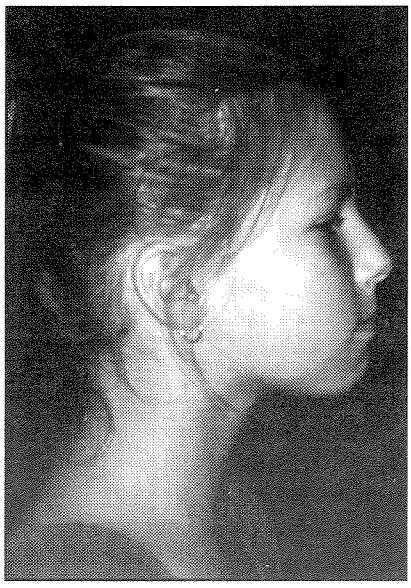


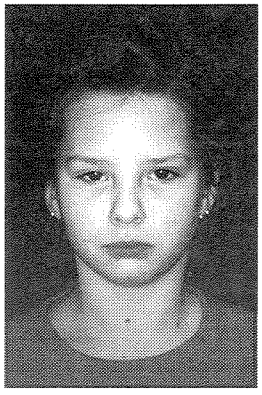


CASE #2: Clockwise, from left Initial profile 15mm overjet (10/93); Insert twin block 15mm overjet (12/93); Progress profile twin block 7 months (4/94); Insert Rick-A-Nator normal overjet (9/94).

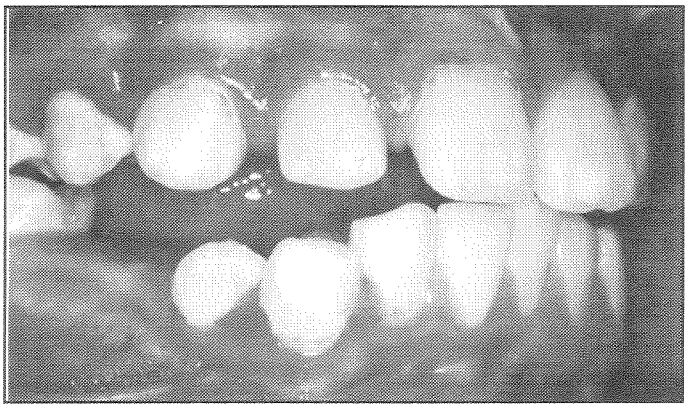
All Photos Courtesy of Dr. Brock Rondeau

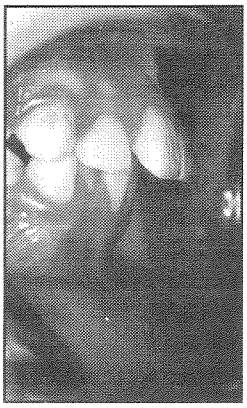


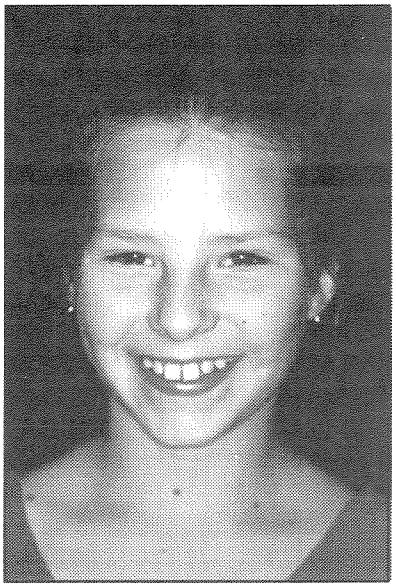


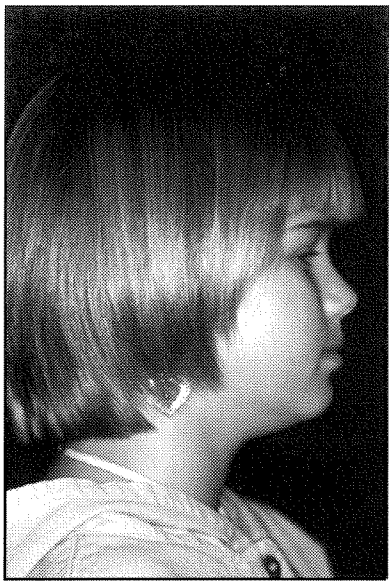


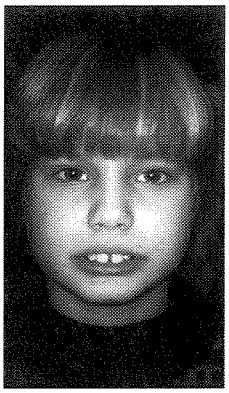
CASE #3: Clockwise from far left Initial profile (2/95); Progress profile (8/95); Initial frontal (2/95); Progress frontal (8/95); Initial right lateral overjet 9mm (2/95); Progress right lateral normal overjet (8/95–after twin block).

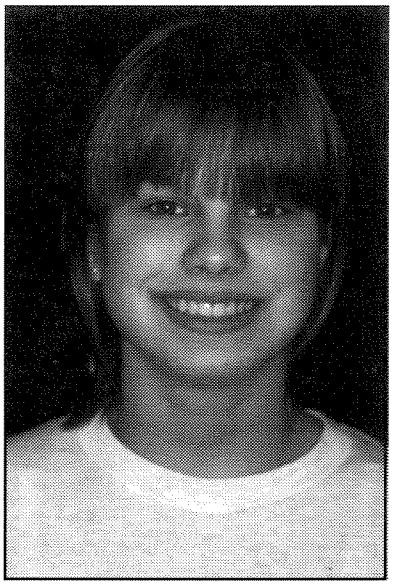


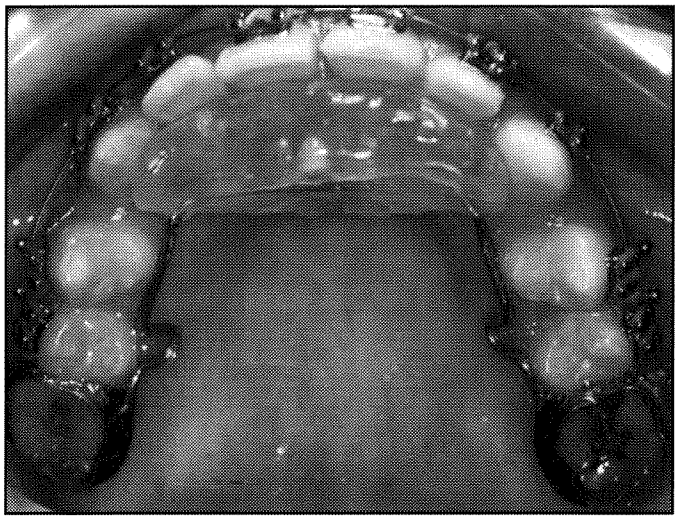












CASE #4:
Clockwise, from top left: Initial profile (12/91); Progress profile (4/94—after twin block); Initial frontal (12/91); Final frontal (2/96); Initial right lateral, overjet 11mm (12/91); Progress right lateral (4/94—after twin block); Final right lateral (2/96); Twin block; Twin block after 7 months; Rick-A-Nator