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A view of Chicago. (Photo/stock.xchng)

AAO heads to Chicago

Early registration for this year's annual session ends April 8

If you haven't registered yet for the 2011 AAO Annual Session, taking place in Chicago from May 13–17, you might want to do it soon. Early registration closes Friday, April 8, at 5 p.m. (CDT).

This year's AAO Annual Session promises a variety of educational and social events that will be fitting for the whole team. Some of the highlights include:

- *The 2011 Orthodontic Staff program.* This program has been developed to address the most urgent and complex challenges facing today's orthodontic team members, both on the business side and on the clinical side. To

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The Quick Fix device for pseudo-Class III

Resolving anterior crossbites with the Quick Fix device

By S. Jay Bowman, DMD, MSD

(This is Part 2 of a two-part series)

The Quick Fix® device is based on a typical 2 x 4 edgewise appliance and was designed for effective and efficient advancement of the maxillary incisors.[24] The appliance consists of a rectangular stainless-steel arch wire, open coil springs, arch locks and Side Swipe auxiliaries.

Installation of the Quick Fix

Correction of a pseudo-Class III malocclusion in the transitional dentition is initiated by placement of an upper 2 x 4 appliance (e.g., two banded or bonded first molar tubes and pre-adjusted Butterfly Bracket™ brackets on the central and lateral incisors).

Leveling and alignment of the incisors using round superelastic wire typically requires two to five months before placing the rectangular wire of the Quick Fix device.

Next, Side Swipe auxiliaries are inserted into the molar tubes and may be tied back (Fig. 5). The Side Swipe will permit an additional arch wire length of 4–5 mm without that extra wire extending distal to the molar tube and poking the buccal mucosa of the cheek.

Universal arch locks are placed about 16–17 mm from the midline mark on the right and left side of a .0175-inch x .025-inch stainless-steel arch (Fig. 6).

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Illustrations of the quick-fix device. (Photos/Provided by Dr. S. Jay Bowman)

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We are who we choose to be

By Dennis J. Tartakow, DMD, MEd, EdD, PhD, Editor in Chief

With the 21st Century well into its second decade, new scientific technology, industrial integration and greater knowledge and skills are essential in order to move forward. Even with all elements and factors already in place, IT and administrative staff members, faculty members and orthodontic educators must develop new skills as technology advances.

For those individuals who are in, or have moved into, new careers in education, it is never without need for change, modification, training or learning new job skills. Career changes, such as from clinician to educator, must include reflection and reconsideration of attitudes and behaviors.

It's a new ball game with new rules, policies and conditions. We must glean greater understanding in order to assess the requirements and develop a plan for greater educational growth. This requires a strategic development plan that includes many essential factors, i.e. critical decisions for future growth, development, expansion of institutions, supportive companies, etc.

The "renaissance orthodontists" involved might require greater thought and consideration to experience future success in such a career change. In the educational milieu, this strategic development plan might serve as a tool for (a) exploration of goals, (b) determination of skill levels requiring different faculty expertise and (c) appreciation of faculty needs that have exploded since the computer age commencement.

Setting direction and planning are two separated activities. A necessary function of leadership is to produce change and set a new direction of that change. We must devote time and interest to such a strategic plan in order to (a) synchronize visions and aspirations, (b) provide a blueprint for a viable future to anticipate change and (c) hold constant the reason for being — the education of our students.

An assessment of strengths, weaknesses, opportunities and threats are also important in order to develop a strategic development plan. Such assessments could provide valuable reflections and analyses for yielding priorities that will be essential and critical for future success; such priorities will allow progression to the next or higher level.

Historically, reduced recruitment and retention and increased faculty vacancies have been becoming emergent problems in orthodontic education since the early 1990s, impacting people, communities and society. These issues have led to a daunting outlook for the future of orthodontic education.

"There is no doubt that dedicated orthodontic educators have been critical to the development of the specialty. The question is whether the faculty will be there in the future to continue this history of strong education" (Larson, 1998, p. 122). This is the essence of a force for change that is necessary in our specialty.

Our responsibilities as educators are to educate our students to be professional and the best orthodontists they can be; teach them how to be experts; prepare them to speak before groups of individuals or to address a judge and jury in the courtroom; and most important — impress upon them the importance to write precisely, accurately and legibly.

Writing is one of the most important methods of communicating our thoughts, especially regarding treatment plans and projected patient outcomes, which can make a big difference years later when we are asked to defend ourselves and we cannot even remember the patient's name, let alone how we treated them.

Ask any malpractice attorney about how well orthodontists communicate his or her thoughts on a patient chart. Many do not write adequate notes in his or her patient's treatment chart to explain problems or elaborate treatment issues, and much writing is so poor that whatever is written makes little or no sense.

As educators, this is a poor reflection on us personally. Not only are most notations illegible, using shortcuts, abbreviations and hieroglyphics that are difficult to decipher, but most chart entries are way too short, incomplete and unacceptably inadequate. These are egregious situations and occur too often.

Orthodontic education is in need of fresh blood; this dilemma of full-time faculty member reduction resonates with inadequacies and consequences for today and tomorrow. Ultimately the financial obligation made it difficult, if not impossible, to attract young doctors to consider a career in postgraduate orthodontic education.

As a social justice concern, there may be a huge impact on the survival of the profession, especially the ability to serve the individual and address community needs. The price tag most likely may prohibit low-income students from pursuing the degree and also may have a negative impact on serving society as a whole.

We as clinicians, researchers or educators must be responsible and accountable for helping our present and future residents benefit from our armamentarium of skills, proficiency and expertise. Whether it be through the Socratic method, a form of inquiry and debate between individuals possibly with opposing viewpoints based on asking and answering questions to stimulate

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OT Corrections

Ortho Tribune strives to maintain the utmost accuracy in its news and clinical reports. If you find a factual error or content that requires clarification, please report the details to Managing Editor Kristine Colker at *k.colker@dental-tribune.com*.

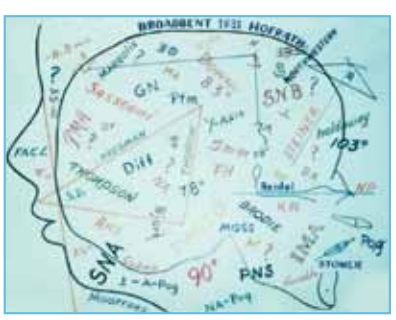

Image courtesy of Dr. Earl Broker.

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Are kids taking unnecessary risks?

In a matter of seconds, a sports injury can occur to the face or the mouth. Young children ages 5 to 14 are especially vulnerable, accounting for more than 80 percent of all sports-related emergency room visits, according to the Centers for Disease Control. Because many sports injuries can be prevented by wearing the proper protective gear, why aren't more parents, coaches and kids getting the message?

Each April during National Facial Protection Month, the American Association of Orthodontists urges athletes to "play it safe" by wearing mouth guards and other appropriate protective gear when participating in many sports and activities. According to a survey* taken by the AAO:

- 67 percent of parents surveyed said their child does not wear a mouth guard. 52 percent said that it was because their child "doesn't need that level of protection."
- 96 percent of parents surveyed believed their child's coaches' role on the use/promotion of protective sports gear was "important," "very important" or "extremely important," yet parents surveyed reported that only 36 percent of coaches actually recommended mouth guards during competitions while 34 percent recommend them during practice.
- According to parents surveyed, the most popular sports that children wear mouth guards while playing include football (42 percent), ice hockey (32 percent) and martial arts (13 percent).
- Of the parents surveyed, the most popular form of protective sports gear for children participating in organized sports include shoes/cleats (67 percent), helmet/headgear (51 percent), shin guards (48 percent) and knee pads (34 percent).

Patients who play sports such as hockey should be encouraged to wear mouth guards. (Photo/stock.xchng)

The AAO recommends that mouth guards be worn for contact sports. Such sports include, but are not limited to, football, wrestling, basketball, baseball, volleyball, lacrosse, ice and field hockey, softball and soccer. Mouth guards also should be worn when participating in any activity where the mouth might come into contact with a hard object or the ground. Mouth guards can help prevent jaw, mouth and teeth injuries and are less costly than repairing an injury.

"I've seen too many children and adults ruin their healthy, beautiful smiles — or worse — because they fail to wear a mouth guard during practices and games," says William Gaylord, DDS, MSD, orthodontist. "Precaution and common sense are key to preventing injuries."

Mouth guards are one of the least expensive pieces of protective equipment available. An orthodontist can recommend the best mouth guard for an athlete who wears braces. OT

(The AAO commissioned Impulse Research Corp. to conduct the AAO 2008 Protective Sports Gear Survey. The survey was conducted in February 2008 online with a random sample of 1,049 men and women, ages 18 years old or older, from the United States and Canada. Survey participants are representative of American and Canadian men and women 18 years old or older who have children between the ages of 8 and 18 who participate in organized sports.)*

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critical thinking, or to simply illuminate ideas, these residents must carry the torch of learning that we were so blessed to have received from our mentors; the future of orthodontics depends on our efforts. Where is Socrates when he is needed the most?

Aristotle (384-322) articulated it quite well: "The educated differ from the uneducated as much as the living from the dead" (Howe, 2003, p. 19). OT

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This position will permit seating of the arch wire into the incisor brackets with the arch locks distal to the lateral incisors. Sections of open coil spring are slid onto the wire, up to the arch locks. These parts are pre-assembled and stored in anticipation of their future use.

After installation of the Side Swipes, the arch wire of the Quick Fix assembly is inserted into the edgewise tubes of the Side Swipe, not in the molar or headgear tube (Fig. 5). The excess wire now lays adjacent to the molar tube.

The arch wire is then seated into the incisor bracket slots and a stainless-steel ligature is laced, e.g., "figure-8," (Fig. 5) across to consolidate the incisors together so as to prevent opening space between the teeth. The arch locks are loosened with the wrench, and they are slid distally along the wire to compress the open coil spring (Fig. 7).

Once the locks are positioned between the first and second primary molar, compression is typically sufficient, and the locks are tightened. A distal end cutting pliers are used to cut the arch wire flush to the end of the molar tube, not the Side Swipe tube (Fig. 8).

This will leave about 4–5 mm of wire distal to the Side Swipe next to the molar tube to provide for advancement of the incisors; a process that requires about two to three months.

The Quick Fix device is self-limiting. In other words, should a patient not return within four to five weeks after installation, incisor advancement would only progress until the distal portion of the arch wire slips out of the Side Swipe tube (Fig. 5).

Simple case reports demonstrate the progression of treatment and correction of typical pseudo-Class III anterior crossbites using the Quick Fix device (Figs. 9–13). Other appliances and devices may be combined with the Quick Fix device such as palatal expanders, e.g. MIA Quad Helix,*[26] (Fig. 13), reverse pull facemask, lower 2 x 4 and Class III elastics.

After the desired amount of advancement is achieved, then the appliances may be removed and retention initiated as desired.

Fig. 5: Right and left Side Swipe auxiliaries are placed into typical bonded or banded first molar tubes. The wire segment of the Side Swipe is inserted into the molar tube from the mesial, with the rectangular tube of that auxiliary oriented to the buccal. The Side Swipe is secured to the molar tube by tying a stainless or alastic ligature from the hook on the auxiliary to a hook on the molar tube. The Quick Fix wire assembly (stainless-steel wire, arch locks, open coil springs) is then inserted into the Side Swipe tube where the distal part of this "traveling" arch wire is positioned adjacent to the molar tube. The rectangular arch wire is seated into the brackets on the incisors and ligated into place using a stainless ligature lacing to prevent unwanted space opening.

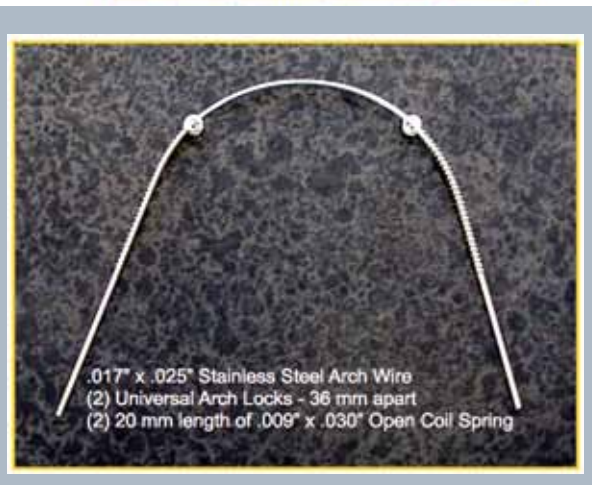


Fig. 6: The Quick Fix wire assembly consists of a .017-inch by .025-inch stainless-steel arch form, two universal arch locks positioned 36 mm apart (to position them distal to the maxillary lateral incisors and permit wire seating) and two 20 mm lengths of .009-inch by .030-inch open coil spring.

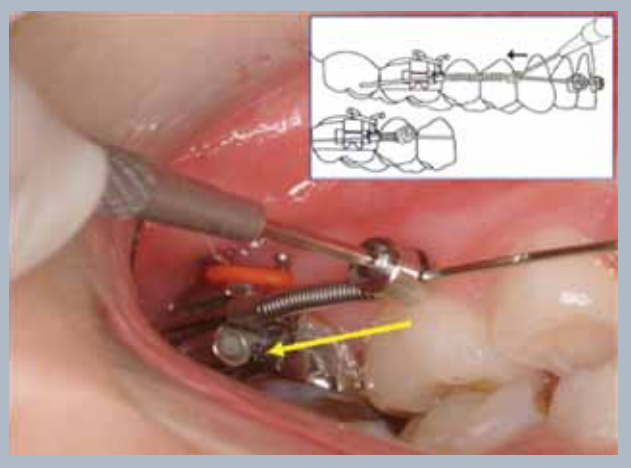


Fig. 7: The arch lock is loosened and slid to the distal to compress the open coil spring. The lock is tightened at a position between the first and second primary molar. (Note: the distal extension of the arch wire was inserted into the Side Swipe tube and the remaining portion lies adjacent to the molar tube.)

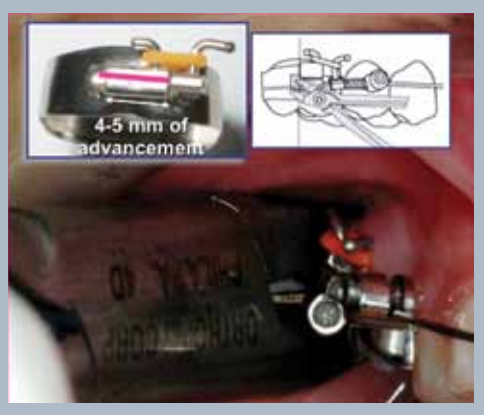


Fig. 8: After the open coil spring has been compressed, a distal end cutter is used to cut the distal extension of the arch wire just flush to the end of the molar tube, not the Side Swipe auxiliary. This provides for 4–5 mm of "traveling" arch wire to advance the incisors. The device is self-limiting as the wire will slip out of the Side Swipe after 4–5 mm of advancement.

Fig. 9: Resolution of an anterior crossbite in the transitional dentition for an 8-year old female. Leveling with 2X4 appliances required three months, followed by four months incisor advancement with the Quick Fix appliance.

Class II correction with the Quick Fix device

Molar distalization: Class II elastics

If anchorage is applied to the Quick Fix mechanism to prevent "flaring" of the incisors, then distal movement of the molars can be achieved. Because this device is not inserted into a headgear tube (in contrast to the bimetric arch[22]), then a cervical headgear or Jasper Jumper[27] fixed functional could be added.

Another alternative would be the application of Class II elastics to support the incisor position. This requires fixed appliances on the lower arch, e.g. 2 x 4 and fixed lingual arch. Unfortunately, both headgear and elastics wear are dependent upon unpredictable patient compliance.

In contrast to the Distal Jet[28] (a device specifically designed for molar distalization), both the Quick Fix and bimetric produce force at the crown, rather than through a couple closer to the center of resistance of the molar.

As a consequence, they produce more molar tipping and may introduce unwanted labial tipping of the lower incisors from elastic wear. The use of a pre-adjusted appliance with lingual crown torque in the brackets on the lower incisors may reduce that incisor "flaring."[18]

Molar distalization: mini-screw supported

As an alternative distalization method for Class II patients, mini-screw anchorage can be added to provide indirect anchorage to the Quick Fix. Mini-screws can be inserted into the buccal alveolus, between the upper first molars and second premolars or in the infrazygomatic ridge.[30,32]

Stainless-steel ligature is then tied from the mini-screws to the incisors to support the distal-driving force from the Quick Fix.

An alternative miniscrew insertion location would be on the palatal alveolus between the roots of the first molar and second molar[30,31] with a steel ligature tied from the TAD to a button bonded on the lingual of the upper first premolar.

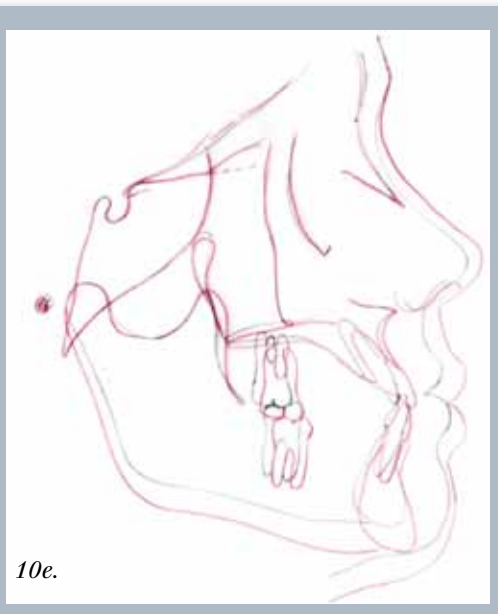
Once the molars have been overcorrected into a super-Class I (half-step Class III) relationship, then the mini-screws may need to be removed, and possibly re-positioned, if they are needed to provide anchorage support for retraction of the remaining maxillary teeth.


10a.


10b.


10c.


10d.


10e.

Figs. 10a–e: Anterior crossbite resolved in seven months with combination of upper 2 x 4 appliance and Quick Fix appliance for an 11-year old male. At age 13, the patient was ready for some limited treatment to close spaces using full fixed appliances.

Conclusions

Ismail and Bader[32] have suggested that, "In developing appropriate treatment plans, dentists should combine the patient's treatment needs and preferences with the best available scientific evidence, in conjunction with the dentist's clinical expertise."

Early correction of pseudo-Class III malocclusion has been demonstrated to provide simple, rapid (about six to eight months), efficient, reliable and stable resolution of anterior crossbite. In addition, this treatment reduces the risk of development of skeletal Class III malocclusions and may diminish the difficulty of, or occasionally eliminate the need for, any later comprehensive treatment.[5,6]

The Quick Fix device is a simple, predictable, and effective mechanism for achieving this correction for pseudo-Class IIIs,[33,34] and it can also be used for Class II patients to provide molar distalization using Class II elastic or mini-screw support.

Steps for inserting the Quick Fix Device

1. Placement of a maxillary 2 x 4 pre-adjusted appliance.
2. Initial alignment and leveling with .016 superelastic arch wire for two to five months.
3. Place appropriate right and left Side Swipes into the maxillary molar tubes: the segment of wire is inserted from the mesial into the molar tube with the Side Swipe tube positioned mesial and buccal to the molar tube.
4. Trim the excess wire of the Side Swipe just flush to the molar tube and tie back with an elastic or stainless-steel ligature tie (optional).
5. Place universal arch locks 36 mm apart (to fit distal to the maxillary lateral incisors) on a .0175-inch by .025-inch stainless-steel arch wire.
6. Slide two 20 mm open-coil springs on the arch wire up to each arch lock.

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7. Insert this Quick Fix wire assembly into the tube of the Side Swipes and seat the wire in the brackets on the incisors.
8. Consolidate the incisors with stainless-steel laced ligature to prevent unintended anterior space opening.
9. Slide the arch locks distally along the arch wire to compress the open coil springs until the arch locks are between the first and second primary molars. Then tighten the locks to maintain the spring activation for incisor advancement.
10. Cut the distal end of the arch wire flush to the distal end of the molar tube, *not* the Side Swipe tube. In this manner, about 4–5 mm of arch wire is adjacent to the molar tube and provides sufficient wire for incisor advancement. OT

(Editor's note: Bowman has a financial interest in the Butterfly System and Quick Fix Kit.)

*Quick Fix Kit™ with Side Swipes™ Ref #852-781, American Orthodontics, Inc., 1714 Cambridge Ave., Sheboygan, Wis. 53082-1048.
*MIA Quad Helix, AOA Laboratories, 13931 Spring St., Sturtevant, Wis. 53117.
**Butterfly Bracket System, American Orthodontics. 1714 Cambridge Ave., Sheboygan, Wis. 53082-1048

Fig. 11: An 8-year old male with a pseudo-Class III crossbite and associated functional shift, corrected by upper incisor advancement with a 2 x 4 and Quick Fix appliance in eight months. Five months of leveling and alignment was followed by three months of Quick Fix advancement.

Fig. 12a: Anterior crossbite resolved and arch length increased by simple advancement of the upper incisors using a combination of 2X4 and Quick Fix appliances in seven months (three months with the Quick Fix) for a 9-year-old female in the mixed dentition.

Fig. 13: Anterior crossbite and severe upper arch length discrepancy resolved using a combination of upper 2 x 4, MIA Quad Helix and Quick Fix appliance for an 8-year old male.

Fig. 12b: Note the improvement in upper lip support. Later correction in the permanent dentition will be relatively limited.

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Practice makeover update: ongoing transformation

This is the fifth in the Levin Group Total Ortho Success Practice Makeover series

By Jennifer Van Gramins and Cheri Bleyer

"We made great strides this past year, but our journey is still under way," said Dr. Michelle Gonzalez, winner of the 2010 Levin Group Total Ortho Success™ Practice Makeover. The San Rafael, Calif., orthodontist received year-long consulting programs in both orthodontic management and referral marketing.

Gonzalez, the owner and operator of a successful 15-year-old ortho practice in an affluent area, entered the contest because she wanted to take her practice to the next level.

The systems in the office hadn't been updated for a number of years, which is typical for many practices. Levin Group recommends redesigning practice systems every three to five years to keep pace with the changes taking place in the office, including the introduction of new technology, new services, new workflow and new personnel.

In addition, team members weren't always on the same page, which resulted in miscommunication and unnecessary stress. "It can be easy to focus on the day-to-day and lose sight of the big picture, which was starting to happen in my practice," said Gonzalez.

"The consulting experience really opened my eyes to my practice's full potential, and Levin Group helped me develop a roadmap to achieve ultimate success," she said.

A big part of that roadmap was creating a vision statement, which lays out where Gonzalez wants to take her practice in the next three to five years. She set challenging performance targets for the next three years and sees the practice achieving them with the help of her team and improved systems.

Orthodontist leadership

Leading a team can be extremely challenging due to the time constraints placed on orthodontists. As the practice's main producer, an orthodontist spends most of her or his day providing patient care, which leaves little time for coaching and mentoring the team.

In fact, compared to other dental professionals, orthodontists face far greater demands on their time because of the high volume of patients they see. For example, a GP may see on average 15 to 20 patients a day, whereas an orthodontist can easily see double or triple that number.

Handling that kind of patient volume requires incredible focus, which often leaves little time for team building and training. That's why Levin Group emphasizes the importance of implementing high-performance systems. When a quality team is trained on step-by-step systems, the practice almost runs by itself.

During the last phase of her management consulting program, Gonzalez visited the Levin Advanced Learning Institute in Phoenix for two days of intensive and interactive training on leadership. Along with a group of about a dozen other dental professionals who are also Levin Group clients, she learned topics such as:

- Guiding the team
- Enhancing time management
- Improving communication
- Achieving financial independence
- Managing people
- Achieving a vision

This peer-learning experience spurs insightful comments and feedback based on the participants' diverse backgrounds and leadership styles. Clinicians compare and contrast on what has and hasn't worked in their practices.

"As an orthodontist and solo practice owner, you often work in an insulated environment," Gonzalez said. "So it was especially helpful to hear how orthodontists from across the country are dealing with challenges and achieving success."

Two biggest wins

Gonzalez said the new scheduling system and a structured referral marketing program are the two biggest improvements since the makeover began.

"Previously, our schedule wasn't functioning at an optimal level. There was some confusion at times between the front office and back office staff regarding the schedule. Now everybody is on the same page," she said.

The practice conducted procedural time studies — a necessary step to creating an accurate schedule. Computers were installed in treatment rooms, allowing the clinical team to add notes to patient records and schedule the next appointment. In addition, processes were put in place to improve communication between administrative and clinical staff.

Dr. Michelle Gonzalez, clockwise from bottom left, and her team: Kris, Mary, Laurie and Irene. (Photo/Bruce Cook Photography, San Rafael, Calif.)

"When everybody on the team knows what's going on, then we all can be focused on providing patients and parents the best possible experience," the orthodontist said.

In the spring, the practice upgraded its referral marketing efforts. Gonzalez brought on a new employee, LeAnn, as a part-time practice coordinator (what Levin Group calls a professional relations coordinator) to consistently communicate with the practice's referral base and potential referrers. The results have been outstanding: stronger referral relationships, the addition of new referring doctors and increased referrals.

"In the past, I would personally do all office visits, but it wasn't consistent simply because of my busy schedule," she said. "Having a dedicated employee just makes more sense, and it's far more effective."

Final thoughts

"You can always get better," Gonzalez said. "And sometimes you need help to get better. That's probably the biggest lesson I learned during this makeover year."

The San Rafael orthodontist is looking forward to even more success in 2011 and the years ahead.

"My team and I have learned a lot from our consulting experience, and we are ready to keep building on those accomplishments. Full steam ahead!" OT

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OT About the authors

Cheri Bleyer, Levin Group senior consultant
Bleyer joined Levin Group in 2003 as a Levin Group orthodontic management and marketing consultant. As a senior consultant, Bleyer has played a key role in the development of Levin Group's ever-expanding marketing program, and she regularly lectures at the Levin Advanced Learning Institute.

Jen Van Gramins, Levin Group senior consultant
Van Gramins has spent the last four years working as a Levin Group orthodontic management consultant. Prior to that, she managed medical and dental practices for 12 years. She served as practice manager for the Oral Health Clinic at Loyola University Medical Center in Maywood, Ill.

Cheri Bleyer, left, and Jen Van Gramins

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