

today

94th EOS Congress • Edinburgh, 17–21 June 2018

	Virtual reality Dr Yassine Harichane from Canada explains that orthodontics is entering into a 360° revolution focused on the patient experience. » page 4		GDP orthodontics Dr James Forshaw about an intuitive pathway for acquisition, improvement and, if desired, mastery of general dental practitioner (GDP) orthodontics. » page 6f.		Interview The inventor of both the Carriere SLX Self-Ligating Bracket System and the Carriere Motion 3D Appliance, Dr Luis Carrière, shares his thoughts and visions. » page 10
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Edinburgh hosts European Orthodontic Society Congress this week

Ninety-fourth edition being held at Edinburgh International Conference Centre.



■ The 2018 European Orthodontic Society Congress is taking place from 17 to 21 June and promises to be another event to remember, the congress organiser said. Thousands of specialists from all over Europe are expected to attend the five-day congress. The last edition, which was held in Montreux in Switzerland in 2017, attracted over 2,000 visitors,

including a large number of post-graduates. According to European Orthodontic Society President Dr Dirk Bister, a London-based consultant in orthodontics, the programme for this year's congress will cover a wide range of contemporary orthodontic topics, including treatment mechanics, unwanted side effects of ortho-

dontic treatment, and lingual orthodontics. Interdisciplinary orthodontics and patient-centred research will also be discussed, he said. The Sheldon Friel Memorial Lecture will be held by Dean of the Faculty of Dental Surgery of the Royal College of Surgeons of Edinburgh Prof. Fraser McDonald, who will be

discussing the value of statistics in reporting scientific data and the relevance of this to clinical practice, together with the necessary caution. Bister stressed, however, that a large number of presentations are related to practical orthodontics. "They are ideally suited for colleagues who have just started their specialty practice and trainees," he said.

A postgraduate course will also be offered during the week. It will focus on evidence-based treatment of Class II malocclusions. In addition to the scientific presentations, over 40 sponsors, including DW Lingual Systems and Henry Schein Orthodontics, have announced that they will be introducing and showcasing the latest products, materials and technologies for orthodontic treatment. On 18 June, a symposium presented by French orthodontist Dr Waddah Sabouni will discuss the treatment of teenagers with the Invisalign system. The event will take place at the Lennox Suite (Level 2) and is sponsored by Align Technology. During the congress networking events to be held in the Usher Hall, Scotland's only five-star concert venue, as well as the Royal College of Surgeons of Edinburgh building, Bister added that participants are invited to immerse themselves in Edinburgh's culture, history and sights. "It is the ideal location for this event," he said. More information about the 94th congress is available at www.eos2018.com. ◀

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Registration for BOC 2018 in London now open

■ The biggest event for all UK dental professionals with an interest in the orthodontic specialty will be held in the heart of the capital this year at the Queen Elizabeth II Centre in Westminster. The theme for the

2018 British Orthodontic Conference (BOC), which is taking place from 27 to 29 September, is "Orthodontics 360". The programme promises to provide a focus on every aspect of orthodontics, including interdisciplinary care.



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Lined up for 2018 are highly rated international and UK speakers, including Dr David Sarver, Dr Elizabeth Menzel, Prof. Federico Hernández Alfaro, Dr David Birnie and Dr Nicola Attack. Also topping the bill is Prof. Martyn Cobourne, who will be giving the prestigious Northcroft Memorial Lecture. An exciting new addition, the OrthoTED session (Technology, Education and Design), will offer a range of dynamic 15-minute presentations.

The BOC social events are always very popular, and this year the gala reception, which is free to all congress registrants, will be held at Church House in Westminster. Each year, the conference is organised by a committee of British Orthodontic Society members, and this year, Director of Professional Development Dr Richard Jones is heading the team for the third time. "The three-day conference reflecting orthodontics in its entirety is ambitious, but we are aiming high. We have a host of renowned international and UK speakers, a pre-conference course focusing on the core CPD [continuing professional development] topic of cross-infection control, exciting social events, a two-day programme dedicated to our DCP [dental care professional] colleagues and a practice development day," he said.

To benefit from the early bird discount of up to £110, dental professionals should book by 15 July at <https://www.bos.org.uk/News-and-Events/Events/BOC-London-2018>.



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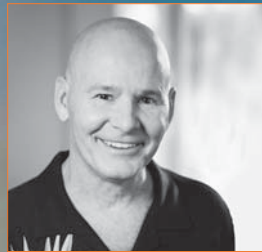
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and potentially in Spanish and Italian.



Virtual reality and orthodontics: A new patient experience

By Dr Yassine Harichane, Canada

■ Imagine the following scenario: your patient arrives, both relaxed and calm, at your practice. Although the patient is visiting the practice for the first time, he is familiar with it and knows its interior well. Without further introduction, the patient takes a seat in the dental chair, and the orthodontic procedure is performed quickly and comfortably with patient compliance. There are no complications or tension, and the treatment is easily achieved. Imagine such a soothing and comfortable environment in which to treat patients. Now imagine this very same scenario through the eyes of the patient. One can see that it could actually be a comfortable experience. This is not some hypothetical futuristic utopia; this is actually happening now, and the aforementioned points are some of the many benefits of virtual reality (VR).

VR is a process that entails immersing the viewer in a 360° environment. By turning his head left, right, up or down, the patient can visualise a real or an artificial environment. The spectator could be immersed in the Caribbean Sea surrounded by corals or in a Canadian forest. The operation is simple: the participant wears a lightweight and comfortable headset in which a smartphone is inserted (Fig. 1). Owing to the gyroscopic sensors, the smartphone will project a matching image corresponding to the movements. If the patient raises his head, he will see the sky or the ceiling, and if he lowers his head he will see his feet. This technique is made possible



1



2



3

*Fig. 1: VR headset. *Fig. 2: Nikon KeyMission 360°. *Fig. 3: Nikon KeyMission Utility. *Fig. 4: Operatory room in VR. *Fig. 5: Scan this QR code for a VR lecture.

by a 360° shot using a dedicated camera (Fig. 2) and simple editing software (Fig. 3). The result is simply astonishing as we find ourselves projected into a place that may vary from actual tourist sites to virtual scenarios as in video games.

The applications in orthodontics are numerous and at present we are exploiting only a tiny part of its potential functions. The possibilities might be endless. Hence, it might become possible for the patient to visit the dental office from his home, where he can visualise the front desk, admire the treatment rooms or view the cleanliness of the sterilisation room (Fig. 4). The aim is to offer a virtual visit of the practice to allow the patient to choose a quality clinic, as well as familiarise himself with the space before his first appointment. Once physically seated in the chair, the patient can wear the VR headset during

the treatment and visualise a restful environment of his choosing. From here on, it is solely a matter of preference, as the patient might enjoy the beach, a VR video of Honolulu, or maybe even climbing a mountain. Any VR video is acceptable, as long as it achieves its purpose: calming the patient during a treatment session. Thus, everything becomes less tense, and the patient is relaxed. This might also be convenient for the dentist, as he can then execute whatever treatment is necessary as quickly and efficiently as possible.

Convincing the patient to undertake an orthodontic treatment is one thing, convincing him to follow the relevant recommendations is another. Obtaining patient compliance is not easy, especially in the case of younger patients. Furthermore, dentists have an unfortunate notorious association with pain and suffering, which might



induce anxiety in a patient. Again, VR can be applied here to divert the attention of the most dynamic patients. Another aspect worthy of mention regarding the benefits is the intellectual retention of instructions on hygiene procedures, for example, which might be dependent on support. It is plausible to assume that verbal instructions on hygiene may be forgotten once the patient has left the clinic. Most orthodontic practices provide only leaflets, but few patients retain these or follow their recommendations. A VR video featuring the practitioner or team members might have a much greater impact on follow-up care at home. The message could be pre-recorded and viewed on demand by the patient. The aims of this format is that it can provide different intellectual integration between information, which is connected to a stream of visual and auditory stimuli. The clinician might wish to promote the patient retaining the provided information in an easier way to achieve greater clinical success. For example, youngsters might remember their favourite movie line by heart, as opposed to information provided by their dentist. This is because it demands less of youngsters to remember words that are connected with pictures.

For the health practitioner, VR may yield an unexpected, but welcome, advantage in terms of professional education (Fig. 6). Many of us have not been able to attend a conference on the other side of the world for logistical reasons. In the near future, it will be possible to attend an orthodontic congress and listen to international speakers while sitting comfortably at home. Similarly, the demonstration of a new therapeutic technique will be easier with a VR video rather than plunging into a detailed explanation in an article without any illustration. The trainer can record his or her procedures with a 360° camera to allow the student to learn through immersion the technical movements

and ergonomics of the technique being taught.

It would be an understatement to claim that VR provides an alternative to conventional styles of learning. Although it is far from perfect, it allows a wider spread of knowledge and a totally immersive pedagogy. VR is changing the way we work, learn and treat our patients. We have seen over time an evolution of orthodontic care by improving patient comfort. We are not just dealing with a set of teeth fixed into a bone mass appended to a skull, but with a person whose positive experience will inevitably lead to clinical success. Similarly, orthodontic education has evolved over time, since the transmission of knowledge is no longer done with a Kodak Carousel slide projector, but with sophisticated presentation software, incorporating photographs and clinical videos. VR is paving the way to a higher degree of evolution regarding how to understand our environment, whether it is an environment of care or work. As with tourism or cinema, VR offers many opportunities in the field of health. Orthodontics is entering into a 360° revolution focused on the patient experience.

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graduated from the Paris Descartes University in France and completed his MSc and PhD on dental pulp stem cells. He maintains a private practice in Canada and can be contacted at yassine.harichane@gmail.com.

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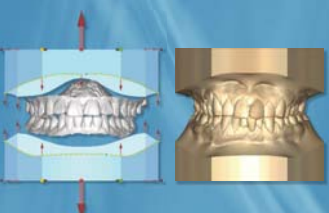
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Getting to grips with general dental practitioner orthodontics

By Dr James Forshaw, UK

■ My learning pathway with the IAS Academy was slightly different from the normal route in that I took the ClearSmile Aligner course first, then the ClearSmile Inman Aligner one and then the ClearSmile Brace course. I trained with aligners first by shadowing my former principal, who used a different clear aligner system to great effect.

I have been nothing but impressed with the ethos of the IAS Academy. There are three main factors of why I believe that its courses are superior to other orthodontic courses. Everything is under one roof. While planning a case, if one particular treatment modality or even a combination is preferable, one can be sure that it will be suggested. All cases go to the same laboratory, so mixed modalities are no problem. The leading figures running the courses I took were Drs Tif Qureshi, Anoop Maini and Jorge Perez. They are very dynamic, inspiring dentists, also fully engaged in social media, and expand the knowledge base of and equip dentists with the skills to perform what I believe is conservative, safe and, above all, ethical treatment. In addition, the number of orthodontic cases course presenter Dr Ross Hobson has completed is still beyond comprehension. Overall, the IAS Academy presents an intuitive pathway for acquisition, improvement and, if desired, mastery of general dental practitioner (GDP) orthodontics.

Case presentation

A 32-year-old male patient presented to our practice after he saw that we provide GDP orthodontics on

Skeletal pattern	Class II	
Frankfort-mandibular plane angle	Average	
Lower face height	Increased	
Facial asymmetry	Symmetrical	
Soft tissue	Competent lips at rest, average smile line	
Incisor relationship	Class II, Division I	
Overjet	3 mm	
Overbite	20 %	
Displacement on closure	No	
Molar relationship	Class III, ½ unit	Class III, ¼ unit
Canine relationship	Class II, ½ unit	Class II, full unit
Teeth present	All except mandibular second premolars	
Centre line	Dental centre line approx. 2 mm right	

Table 1

our website. He came from an NHS practice and it was agreed that he would remain with that practice for his routine care. He was fit and well, took no medication, had no allergies and was a non-smoker. However, he was struggling with his oral hygiene and did not like the appearance of his maxillary teeth, specifically the colour and the alignment. He was not keen on the idea of fixed orthodontic appliances, but had heard about clear aligners.

My examination revealed nothing abnormal with his extra- or intra-oral soft tissue, temporomandibular joint or range of motion. However, his oral hygiene was poor, which was not helped by the crowding of his maxillary anterior segment. In addition, tooth #48 was carious. I carried out a full orthodontic assessment (Table 1) and took photographs.

I explained that the maxillary teeth could and should be aligned, as this would likely result in easier cleaning of the teeth, plus it would improve the appearance. The patient and I agreed that the mandibular teeth could remain untouched, as this would keep the cost down, but mainly because they did not bother him. The

priority was to stabilise his periodontal condition. A basic periodontal examination Code 3 and heavy bleeding were recorded in each sextant. At that visit, I performed a gross scaling using the ultrasonic scaler and used a model to demonstrate both the use of flossettes and an oscillating toothbrush.

Twenty days later, tooth #48 was restored and I was pleased to find the patient's cleaning had clearly been consistent and diligent. The improvement was extremely impressive and exceeded my expectations. A fine scaling was carried out with further encouragement to maintain this level of home care.

Two weeks later, the colour and contour of the patient's gingival margins were as healthy as could be considering the crowding of the teeth. We discussed what treatment with ClearSmile Aligners would involve, such as interproximal reduction (IPR), compliance and risks, and a referral for specialist orthodontics was offered. Preferring to proceed with clear aligners, the patient signed off his full consent, and a two-stage putty impression was taken using a separation wafer. The Archwize digital plan-

ning software was used to predict tooth movement and necessary IPR throughout treatment. It suggested that 18 maxillary aligners would be needed.

Treatment

IPR was carried out progressively over the first three visits, and yellow strip filing was performed for the remaining five appointments. All of the visits passed without problems. The patient was very diligent in his wearing and care of the aligners and reported no pain or difficulty.

At the end of the 18 planned aligners, there was still a central diastema of approximately 0.2 mm and tooth #23 had not rotated completely. The laboratory offered three (free) or six (for a fee) refinement aligners. The patient chose the latter, reasoning that as we had come this far, we should finish properly. He was charged the laboratory cost only.

As the refinement aligners were progressing, I took impressions for whitening trays, and the patient wore 16 % carbamide peroxide gel for three weeks between wearing his aligners. By the end, the diastema had closed and tooth #23 had improved a little but not entirely. However, the patient declared himself happy and elected for Essix retainers over a fixed wire, as he liked the idea of being able to floss all of his teeth, plus he was so used to wearing aligners that wearing retainers at night posed no problem.

Support

The IAS support forum helped me a great deal in my first case. When I was concerned about the midline diastema and the uprighting of tooth #23, I was advised by Dr Qureshi to obtain a leaf gauge, which I did, and I cannot now imagine working without it. Dr Perez also helped

me to understand that the anterior-posterior relationship was working against this case in uprighting tooth #23 completely. The mandibular teeth would have required aligning for this to be possible and now that I am more experienced I feel I could spot this from the beginning.

Dr Perez also helped improve the mid-treatment impressions stage, which included impression taking first then removal of the existing composite force drivers and replacement with the new drivers at the fit stage. I did not then realise this was the ideal sequence, as it is only something that one becomes aware of as treatment progresses. However, at no stage did I feel isolated or unsupported during this case.

Outcome

While the patient arrived with misaligned teeth that were difficult to clean and gingivae that reflected this, he left with clean, light teeth, pink gingivae and a much straighter smile. He was very pleased and expressed warm gratitude for his treatment. He practised every bit of advice given with conspicuous diligence and as a result he reaped the rewards.

I was even happy with this having been a compromised case. Of course, a comprehensive orthodontic treatment plan would have intruded the central incisors, de-rotated the canines further and closed the mandibular spaces, but this is not what the patient wanted. His molar relationships did not change, but we affordably and conservatively made his visible teeth straighter, whiter and easier to clean, and to me this is the very essence of what GDP orthodontics is.

Upon reflection, a leaf gauge is essential. Accurate IPR underpins aligner treatment and I should have been aware of the existence of these tools earlier. Also, I wish I had seen

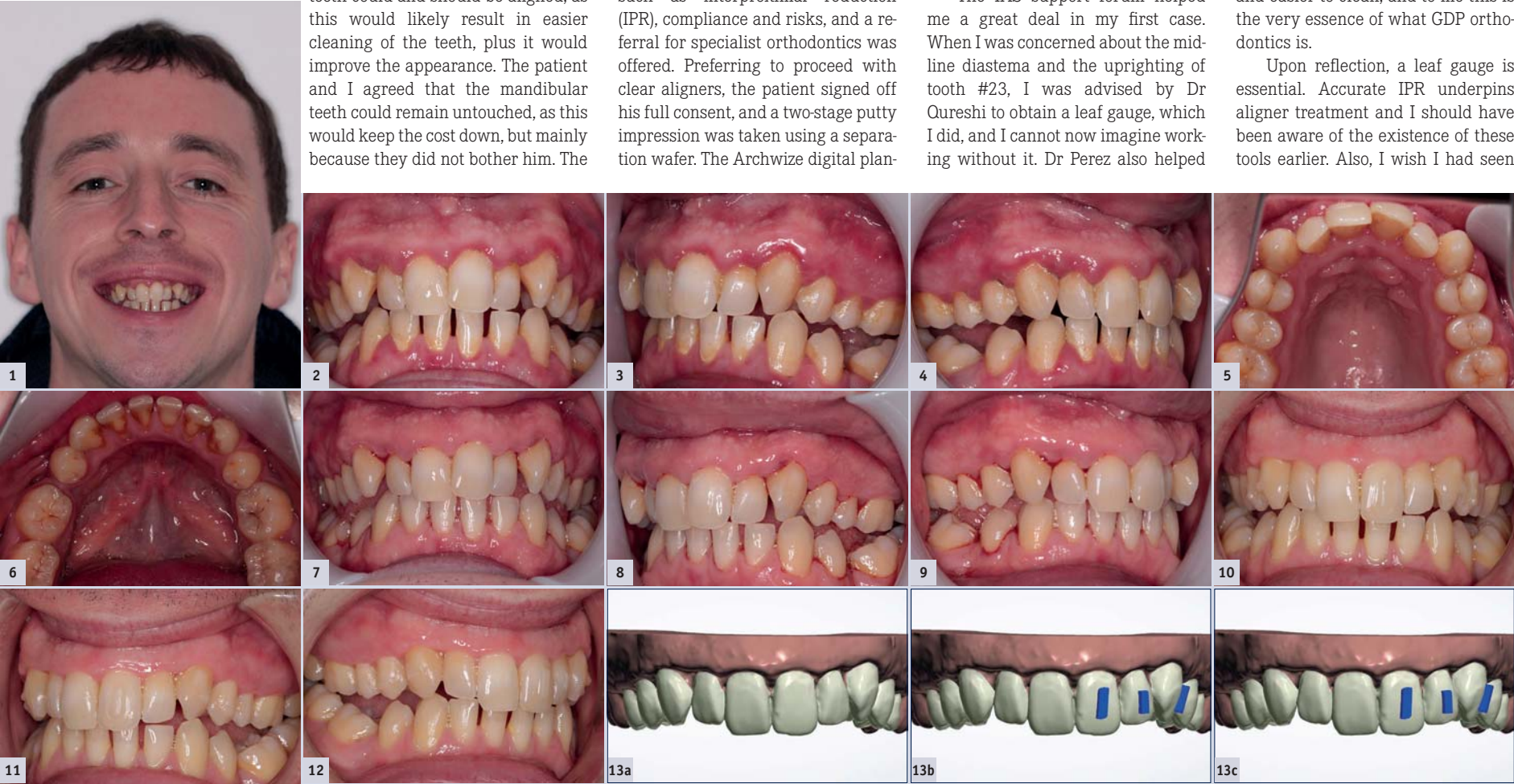


Fig. 1: Pre treatment. Fig. 2: Pre treatment smile. Fig. 3: Pre treatment left lateral. Fig. 4: Pre treatment right lateral. Fig. 5: Pre treatment upper occlusal view. Fig. 6: Pre treatment lower occlusal view. Fig. 7: Post scaling anterior view. Fig. 8: Post scaling right lateral view. Fig. 9: Post scaling left lateral view. Fig. 10: Post initial alignment, prior to refinement aligners anterior view. Fig. 11: Post initial alignment, prior to refinement aligners right lateral view. Fig. 12: Post initial alignment, prior to refinement aligners left lateral view. Fig. 13a: current position. Fig. 13b: Three refinement aligners. Fig. 13c: Six refinement aligners.

the interference of tooth #33 with tooth #23 sooner, instead of towards the end of treatment.

Looking back at this case, it is apparent that I had not quite mastered my photography, leading to darker before photographs. I steadily eliminated errors in my technique throughout the case by use of better mirrors, de-steaming, better retraction, greater knowledge of exposure and suchlike. This case just happened to be right at the start of the learning curve. I also wish I had taken more photographs during treatment.



*Fig. 14: Post treatment.
*Fig. 15: Post treatment smile.
*Fig. 16: Post treatment anterior view.
*Fig. 17: Post treatment upper occlusal view.
*Fig. 18: Post treatment lower occlusal view.

Dr James Forshaw

is a dentist practising in Bangor in the UK. His favourite aspects of dentistry include anterior alignment orthodontics, removable prosthodontics and converting nervous patients.



Finally, not something I would have changed, as it was a successful and calculated risk, but it is worth mentioning that orthodontics should not be carried out when the periodontium is not demonstrably stable. However, I knew that the tooth positions were getting in the way of this patient's oral hygiene and so took the decision to treat based on his initial response to treatment and the way he applied himself.

For other practitioners approaching their first anterior alignment orthodontic cases, I would encourage them and advise them not to let mental blocks stop them, because most of the time if one pushes past these, one will realise they did not really exist. At the very worst, one will make minor mistakes, but the IAS support forum and community exist to help identify issues early and correct them. One literally gains nothing

when things go perfectly. Mistakes are how improvement happens.

I would advise practitioners to consider the patients they see and just how many adults have crowded teeth. They should ask them if they know that they might be able to straighten their teeth without metal orthodontic appliances, and whether they had ever wondered why their anterior teeth are worn and chipped whereas their posterior teeth are not.

Also, they should ask whether they know why plaque builds up around their crowded teeth more than anywhere else. If they are interested and want to know more, the practitioner could consider providing a free consultation, including an orthodontic assessment. At the very least, he or she will gain useful practise and at most will gain a patient desiring an enjoyable, ethical and rewarding treatment. ◀

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