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ortho

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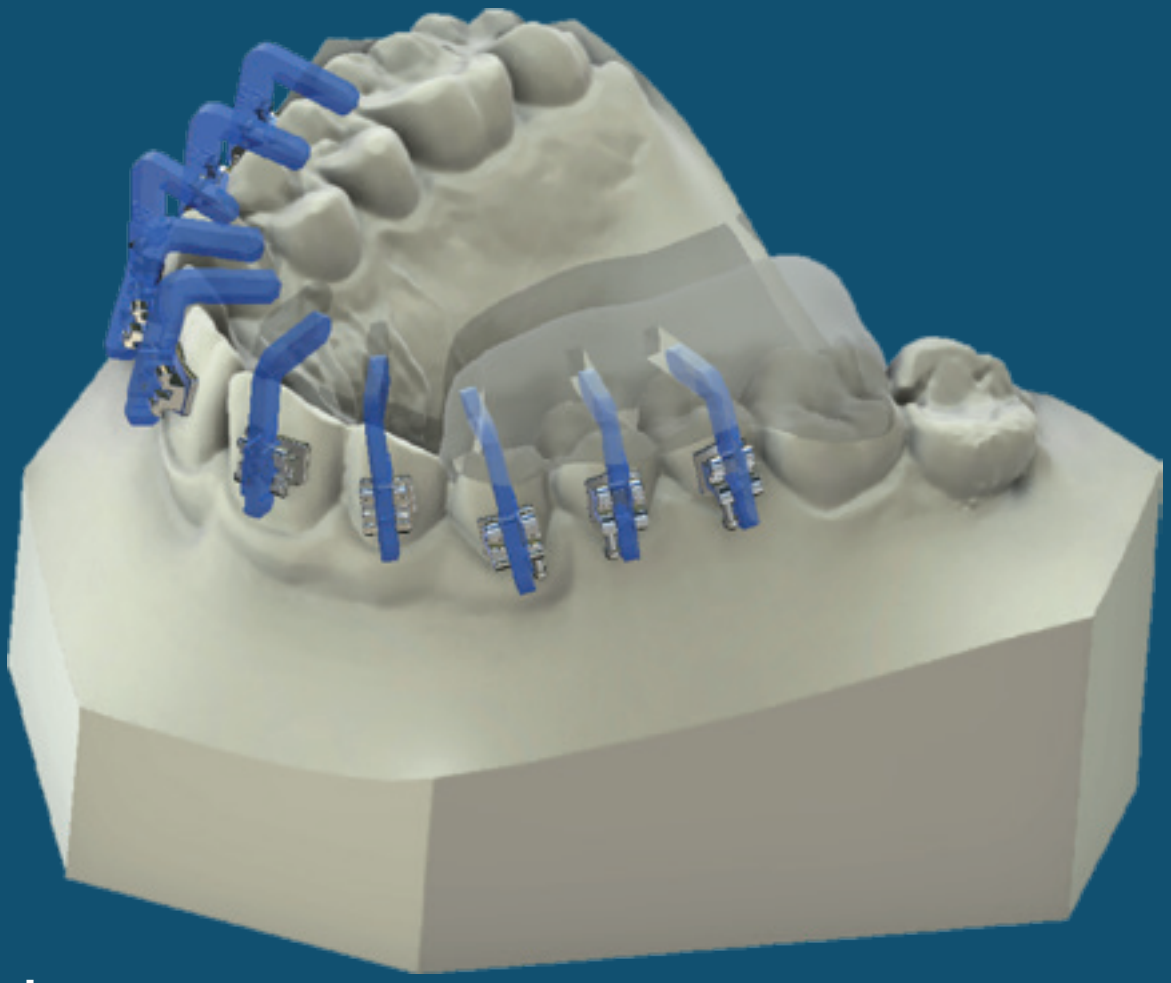

interview
Orthodontics and restorative dentistry are far more interlinked than we think

feature
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Prof. Bärbel Kahl-Nieke

EOS president 2020

Dear readers and colleagues,

The offer to write an editorial for the *ortho* magazine is an ideal opportunity for me as president, to invite you to the Congress of the European Orthodontic Society (EOS) that will be held in June 2020 in Hamburg. First of all, I would like to spread the good news that the early bird registration deadline is 1 April, and I highly recommend you all plan to be in Hamburg during this exciting week for the orthodontic community.

Why should you come to Hamburg in the second week of June this year? There are several reasons: the keynote speakers will cover a wide range of contemporary orthodontics and dentofacial orthopaedics and their scientific basis, promising an exciting mix of subjects that will be of interest to practitioners as well as the scientifically orientated orthodontic audience.

Before the first day of the scientific programme on 11 June with a European update on the role of orthodontics and dentofacial orthopaedics in oral health, you are all invited to the opening ceremony, where numerous cultural highlights and a really first-class address on a contemporary topic await you. During the welcome reception, which will take place in the trade exhibition area immediately after the opening ceremony, you will have the opportunity to meet with all the participants from all over the world.

The second main topic on Friday morning focuses on bone in orthodontics, and on Saturday, well-known speakers and experts in their fields will complete the scientific programme.

Every evening, there will be various options for enjoying Hamburg. For example, on 11 June, a reception with the Senator for Science, Research and Equality will be hosted in the town hall, followed by Postgraduate Disco Night at the 150-year-old former machine factory "Die Fabrik". The next evening, a ferry will take you to the President's Reception, to be held at a historic monument on the other side of the Elbe river, and the gala dinner will take place on the Friday night in the heart of the warehouse district, a UNESCO World Heritage Site. If you are interested in the whole programme, please come and join us for the Silver Mill Competition on a beach on the Elbe river on Sunday morning.

Please do register on **www.eos-congress-2020.com** before 1 April. This will enable you to save money and us to plan more optimally.

I am looking forward to welcoming you to the city of Hamburg from 10 to 14 June.

Prof. Bärbel Kahl-Nieke
EOS president 2020

EOS 2020
96th Congress of the European Orthodontic Society
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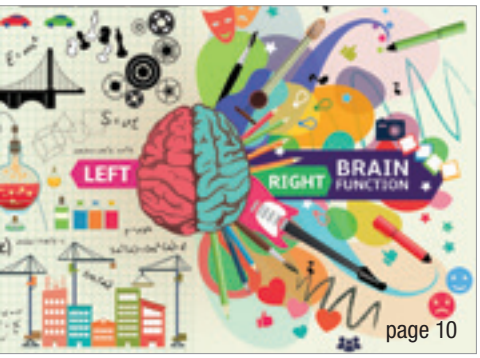

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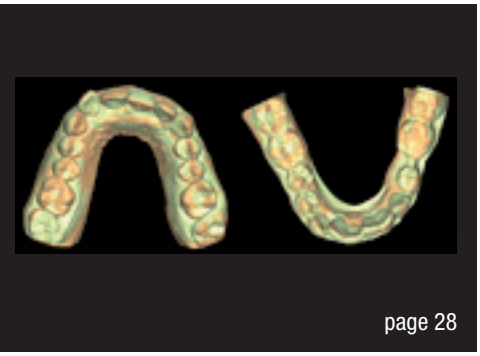
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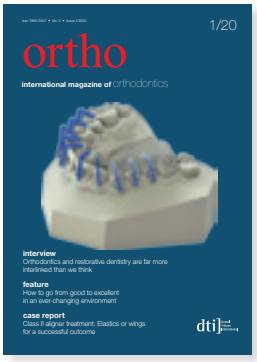

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Interview with Dr Tif Qureshi: Orthodontics and restorative dentistry are far more interlinked than we think

Nathalie Schüller, DTI

Dr Tif Qureshi

Dr Qureshi, what would you say is different about the IAS Academy compared with other teaching academies?
We are actually an orthodontic and restorative academy that mentors and supports our members. That means that IAS members can always consult with academy trainers and mentors for assistance with treatment planning, checking assessments, photos and treatment progression. Our goal is always to make sure our members practise safely, ensure that their records are complete and treat cases that are appropriate to their skill set.

There is nothing quite like it in the world, and we are very proud of what we have achieved. Our business may seem quite niched, but we think it should be global just purely because of what we are actually doing with the process of teaching orthodontics, restorative dentistry, occlusion and function as one approach.

Do you mean with the Inman Aligner or another tool as well?
The Inman Aligner is just one of the tools employed. I am a pioneer of the Inman Aligner and my name is associated with it. We've actually applied the occlusal and functional planning protocols I developed for the Inman Aligner to clear aligners, fixed appliances and comprehensive orthodontic treatment—and that's actually more interesting because it is applicable across the spectrum and it's enabled me to show general dentists that they should be doing orthodontic treatment for functional and restorative reasons. When one understands how teeth can move throughout life,[1] it is clear that, for the general dentist who does not do orthodontic treatment, he or she is working in a continually compromised environment. It is almost impossible to do all restorative dentistry well without some orthodontic thinking included.

To what extent do you feel a general practitioner should perform more orthodontic treatment, and when is it then necessary for him or her to refer patients to a specialist?
When the patient needs comprehensive orthodontic treatment, a referral should be made to a specialist. However, if a patient only has a small degree of anterior tooth crowding and has a stable posterior occlusion and a well-aligned posterior arch, it may well be appropriate for the general dentist to treat.

What is missing across the profession is the understanding that anterior tooth crowding will nearly always become worse. What that means is that as the anterior teeth start to change, they start to interact differently, the occlusion changes, the teeth start to chip, they start to wear, and these things are very preventable early on if the dentist identifies the problem, and he or she will be able to align these teeth very simply. This is what general dentists could be doing, simple movements anteriorly to help avoid problems developing later.

The driving factor for the patient may be aesthetic—and it often is—but actually, it is not just cosmetic orthodontic treatment; it is actually aesthetic and functional orthodontic treatment, which is quite different. When patients understand the effects of continued crowding and the wear and occlusal changes that can occur as a result, they often want to undergo treatment.

Our goal is not just to move teeth, but to move them carefully. We also want to teach how to restore them post-orthodontic treatment, how to develop a plan for that restoration, and how to maintain and retain the results so that they endure for life, because it will have a long-term functional advantage for the patient, rather than allowing his or her teeth to crowd and continue to change.

I think the reason dentists have missed that continual crowding is not just a cosmetic problem, but results in problems with function, anterior tooth grinding, tooth wear, chipping and so on is that orthodontics and restorative dentistry have been kept apart as completely different subjects and they should not be.

This highlights the growing realisation of the importance of an interdisciplinary approach to treating patients. Do you agree?
Absolutely, you have to have broad knowledge. If you don't do or at least understand a little bit of everything, you cannot give the best options to your patient. If a general dentist does not do a bit of orthodontic treatment, for example, when a patient comes in with an anterior tooth chipped in several places which has repeatedly chipped several times, it is very common for that tooth to end up with a veneer or a crown. This is a common mistake. One reason that tooth keeps chipping is because the patient's teeth are moving as the teeth crowd, causing interference. A general dentist should be able to see that and fix these tiny movements. If he or she cannot, then the risk is that a crown or veneer will be used for the wrong reason.

There is the need to consider the situation holistically, to see that the problem is not only aesthetic, to question why the problem came about in the first place, don't you think?
Exactly, this is part of the process and how our orthodontic training is driven. It is not driven by pure orthodontics; it is driven by the functional and aesthetic benefits to the patient. Furthermore, we use whatever is right for each patient; we don't focus on using one system. We diagnose a patient to determine what is best for him or her, which appliance is more appropriate for him or her.

I treat many cases with clear aligners, but I am worried that many dentists are becoming blind to anything else except clear aligners and that this will get them into trouble eventually. Many orthodontic companies are just trying to sell one product. Our goal as practitioners is, and should always be, to do what is right for each patient, and I strive to help the dentist understand what the right choice is. It might be clear aligners, it might be fixed appliances, it might be no orthodontic treatment, just restorative treatment. So, our concept with teaching at the IAS Academy is a little different.

Can you tell me more about that concept then?
I try to help dentists understand that, while there are cosmetic benefits to using the concept of align, bleach and bond, which is a simple solution compared with veneers, there are also functional benefits to that process. We try to help them see how this treatment is not just for a few people, but for a much wider demographic.

In dentistry, you sometimes see case presentations in which the patients being treated are clearly wealthy and for the treatment they need to spend an amount of money which is out of most patients' reach. I have always noticed that some dentists focus on selling big-ticket treatments, but really only a few can afford these. At the IAS Academy, we highlight treatments which are very aesthetic and affordable for everybody. In doing so, we are changing the demographics of who we are trying to treat.

With align, bleach and bond, we can treat a case without tooth preparation which in the past I would have treated with expensive veneers, costing maybe €10,000–€20,000. It will look just as good as veneers, will last ten years—the same lifespan as veneers—and will cost less than half the price. In ten years' time, when the patient needs something redone, it will be very simple to perform, requiring change of the bonding but no preparation, and be affordable still.

So, a treatment that is both minimally invasive and cheaper?
It is minimally invasive and cheaper, but I would even go as far as to say that it is virtually non-invasive. The most important thing with this approach is how we deal with what I call "the replacement event".

It is what many dentists don't often think about when they are selling a treatment; it is rare to consider the long-term replacement event. What I mean by that is that, when talking to their patients about veneers, I doubt many dentists ask themselves whether the patient will be able to afford the treatment again in ten or 15 years' time and whether in ten or 15 years the patient will be in a psychological state to want the treatment.

Another thing patients are not told regarding treatment with veneers is that they don't all drop off; sometimes, they partially break and it is very difficult to match single units that were made ten or fifteen years before.

The reason to align, bleach and bond is not just to be able to treat more people, but also because, when you have to repair or renew, it is much simpler to do so. One might think then that it would be the way to go, the treatment to choose, but what I am saying is still considered left-field, alternative, thinking in cosmetic dentistry.

There is evidence to show that a lot more people would have this treatment done because they could then afford it. For example, a survey done in the UK in 2008 among the public asked people what amount of money they would spend on their teeth, and the results were that only 0.5% of people would spend more than £5,000.

There are many advantages to align, bleach and bond, a simple treatment with functional benefits, and the study you just mentioned clearly showed that more people, whether they have the means or not, would choose the treatment. Are most practitioners you come in contact with convinced of the benefits and willing to give up or reduce the number of high-ticket treatments they offer?
Yes, definitely, especially once they see the concept presented. We have had many practices that focus heavily on high-ticket treatments come along to learn how to widen their demographic. It might not result in them necessarily losing patients, but most realise they will gain more. And the patients they are likely to treat more are the ones they already have sitting in their chairs.

I am aware that there is some resistance from some corners, where the smile design/ten veneer approach is seen as the only way to treat cases for the best cosmetic result, but this is decreasing, especially when one is honest enough to ask oneself what one would have done oneself.

When you look at both modalities, the cost, the intervention required, the risk, the replacement impact, the long-term maintainability, align, bleach and bond makes a strong case for itself. The fact that I have educated hundreds of dentists on this kind of treatment, and that this treatment approach is clearly among the biggest growing in the UK suggests that there is definitely room for this approach in any practice.

Dr Qureshi, thank you very much for your time.

Reference

1 Little RM. Stability and relapse of dental arch alignment. Br J Orthod. 1990 Aug;17(3):235-41.

about

Dr Tif Qureshi qualified from King's College London in 1992 and is a past president of the British Academy of Cosmetic Dentistry. He is a principal dentist at Dental Elegance in Sidcup in Kent in the UK, where he practises minimally invasive cosmetic and restorative dentistry.

Qureshi was the first dentist in the UK to pioneer the concept of progressive smile design through alignment, bleaching and bonding, which changed the face of cosmetic and aesthetic dentistry in the UK, many parts of Europe and around the world. He challenged the traditional approach cosmetic dentists used and introduced this simpler concept to revolutionise the way many dentists offer aesthetic dentistry, which allowed far more patients to have access to life-changing results without expensive and potentially damaging treatment. This has had a profound effect on many thousands of practices and millions of patients around the world, proving this option a viable treatment for many patients, instead of opting for veneers and crowns, and has created a paradigm shift in the perception of what treatment is truly minimally invasive.

Qureshi is founder and a clinical director of the IAS Academy. The academy is a global community of world-class teachers and colleagues that have one common goal: to empower dentists to confidently treat their patients with the best and most ethical treatment options available and focus on tooth preservation and lifetime patient care. The academy teaches, mentors and supports its members on a journey of orthodontics and restorative dentistry.

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