PROGRESSIVE
ORTHODONTIC SEMINARS

TOP 10 MISCONCEPTIONS ABOUT ORTHODONTICS

Debunking the myths that plague dentistry

There are many myths about orthodontics

that confuse dentists and interfere with their ability to best treat patients. Many of these misconceptions just aren't true, aren't true anymore, or have only some partial truth.

We've studied the literature and research of this specialty throughout the past 40 years. We've created our own scientific studies and looked over tens of thousands of diverse cases from our global orthodontic network. Our research findings debunk many of the most common misconceptions about orthodontics.

Discover the truth about orthodontics and gain expert tips to be successful in the real world of orthodontics.



MYTH #1
Orthodontics, headgear, and rubber bands often cause TMD or TMJ

REALITY

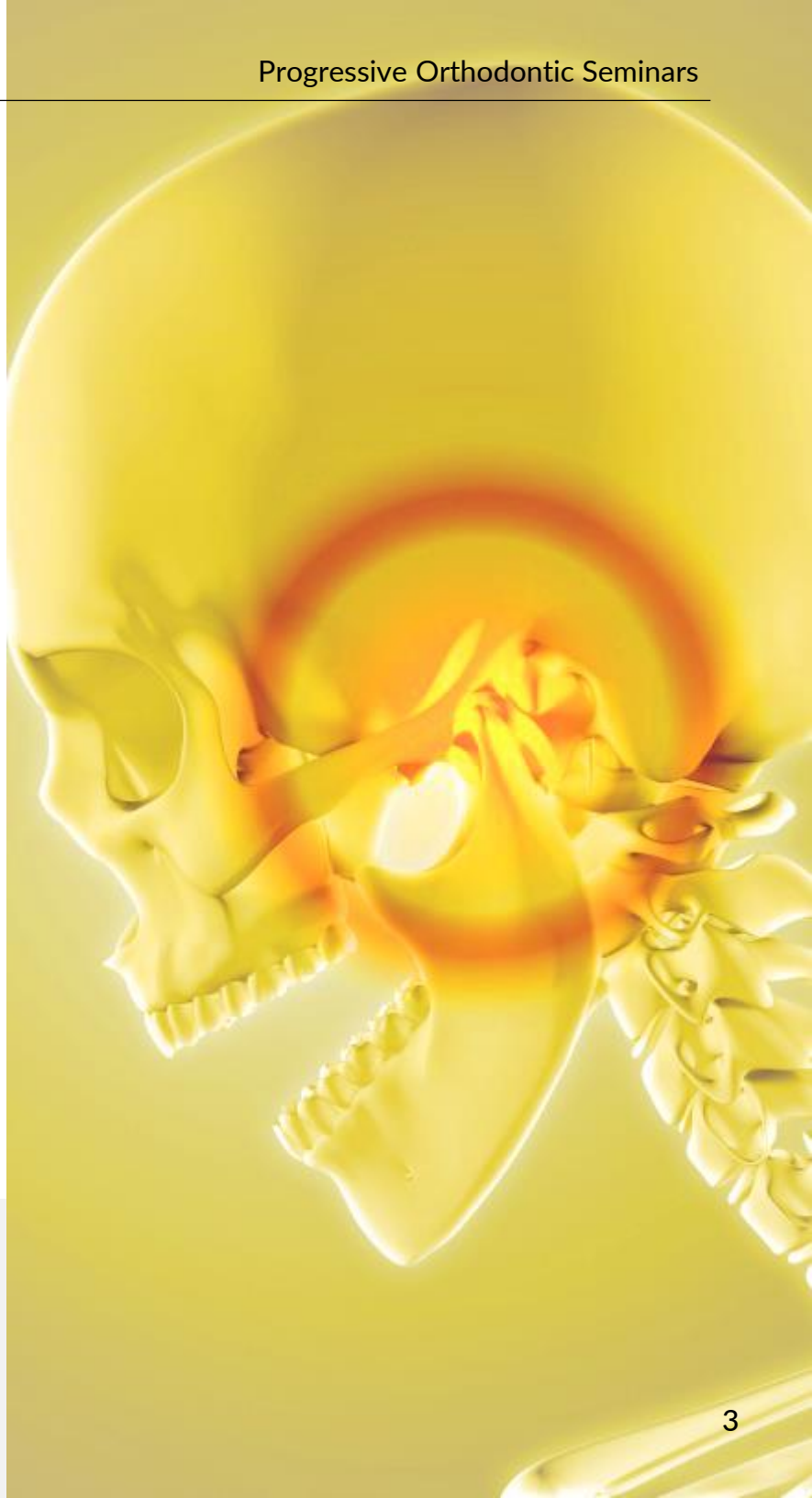
It's true that some orthodontic patients develop TMJ symptoms, but this is not a common result. In fact, a thorough evaluation and proper treatment plan can help you *improve* your patients' alignment and preexisting TMJ symptoms. We have seen dentofacial pain eliminated in many patients after getting orthodontic care.

TIP

Do a thorough orthodontic and TMJ evaluation before presenting your orthodontic treatment plan and placing any brackets. You must first check where the symptom (or potential symptom) is coming from. Does the patient have dental or skeletal asymmetry, open bite, a constricted airway, myofunctional habits, or a malocclusion? Document any clicking, soreness, or pain (no matter how small) before starting treatment. This will help you achieve orthodontic success, as well as protect you legally. Don't forget to keep an open discussion before and during treatment, in case your patient starts seeing any new symptoms. Our tenured instructor Dr. David Dana gives a good tip on what to do if this happens,

"Incorrect bracket placement is the most common cause of TMD symptoms in orthodontic treatment. If a bracket is placed too gingivally, it can change the patient's bite. But this can be easily reversed! If you fix the bracket position, TMD symptoms can often be improved by the next appointment."

Dr. David Dana



MYTH #2
Root resorption commonly results from the heavy torque and traumatic forces needed to move teeth

REALITY

Severe apical root resorption is an uncommon condition that has been studied greatly, but is still not fully understood. Unfortunately, it is almost impossible to predict who will get a problematic amount of root resorption. After treating thousands of conventional orthodontic patients, Dr. Dana has only seen a handful that had root resorption during treatment, of which none lost a tooth.

With the great advances of dental technology in the past three decades, root shortening during orthodontics is much less common. In the 1970s, Dr. George F. Andreasen developed gentler, light force orthodontic wires. These “magic” Memory Wires—nickel-titanium (Nitinol, NiTi) archwires—were developed from naval and aerospace technology and are now widely used throughout the industry.

TIP

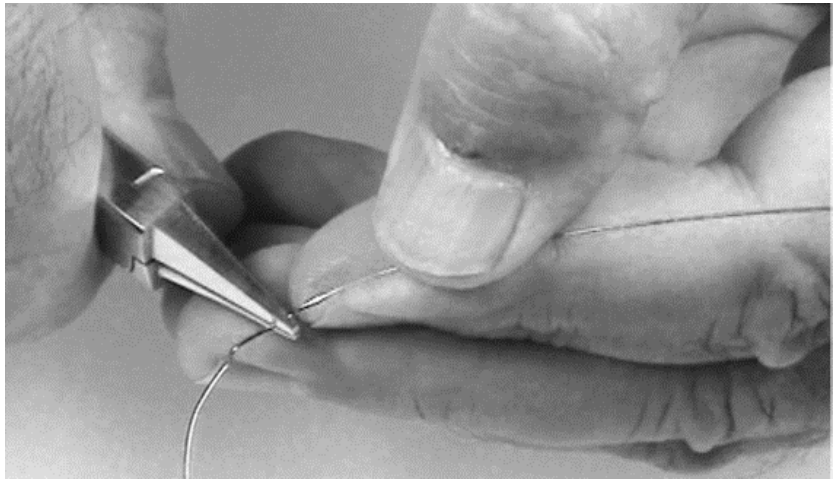
Be diligent in looking at the roots before, during, and after treatment. Take panoramic x-rays before treatment, every 6 months, and at debond. If you see the roots shortening, eliminate all forces so the cell system can reorganize. After 3 months, restart treatment with close supervision by taking regular x-rays every 3 months. If the roots are still shortening, consider changing your treatment plan.

MYTH #3
Dentists are not smart enough or skilled enough to treat orthodontics properly

REALITY

With large advances in technology, orthodontics has become much easier to provide. Great orthodontic work no longer needs a lot of hand skills and wire bending practice. In fact, some cases don't even need a single wire bend! With custom diagnosis, smarter appliances, and the ability to reposition brackets, more professionals are able to provide high level orthodontic care.

Of course, providing quality orthodontics is not "easy". While any dentist can provide quality orthodontics, it does take training, a supportive team, and dedication to be successful.



MYTH #4
The best time to put on braces is when a patient is in their adolescent growth stage

REALITY

Don't wait until a patient is in their teens to consider orthodontics! The American Dental Association (ADA) and the American Association of Orthodontists (AAO) recommend that young patients should get an orthodontic evaluation at 6 or 7 years of age.[1,2] An early orthodontic check-up enables clinicians to spot current or potential problems with their patient's occlusion and jaw growth.

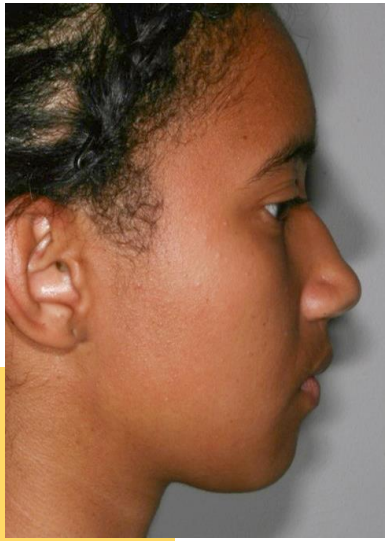
TIP

If you see orthodontic issues like Class III, posterior crossbite, open bite, deep bite, and oral habits early, provide (or refer out) interceptive orthodontic treatment to guide proper craniofacial development.

Since interceptive orthodontics can be less invasive, faster, and cheaper for the clinician and the patient, you should have an understanding of what to look for in your young patients to provide the best level of care.

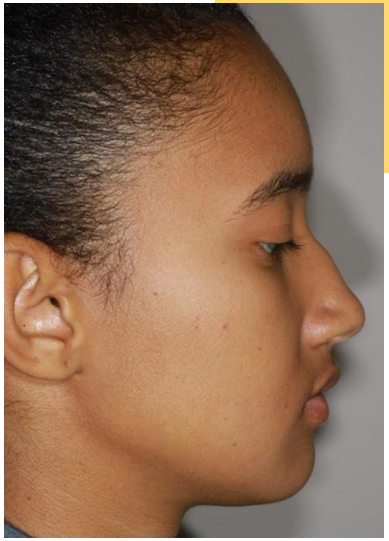
MYTH #5
Taking out teeth causes your patient's face to sink in, making them look concave and older

BEFORE



PREDICTION

AFTER



VTO prediction (and actual results) of this crowding case show a similar profile after extracting her upper and lower 4s.

REALITY

While you can use extractions to help reduce protrusion, extracting teeth does not mean your patient's profile will necessarily get flatter. Instead, you can use orthodontic mechanics to flatten a patient's profile or to make it look fuller. Those who understand orthodontics well can use their treatment tools (like torque, tooth positioning, and types of anchorage) to create a better dentofacial balance and give their patients the profiles they want.

TIP

Use a good prediction software to help you plan the bite and soft tissue placement so you don't have surprises at the end of your treatment. VTOs are great tools to help you compare non-extraction and extraction plans. You can even see what the patient will look like if you extract their 4s versus their 5s, etc. Diagnostic software can help you visualize potential treatment results with both the tooth and soft tissue positioning.

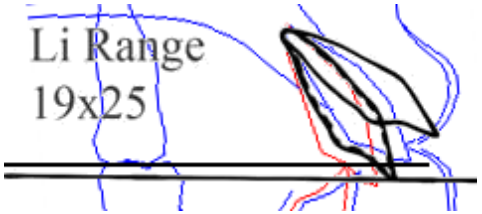
MYTH #6
Orthodontic patients get receding gums and their teeth can come out of the tissue or bone

REALITY

If you plan and manage your orthodontic patients well, teeth should never come out of the gum or bone.

TIP When you do your orthodontic evaluation, evaluate the thinness of the gum tissue and bone. If the tissue is too thin, do not start orthodontics yet.

There are a few ways to manage thin gums. For example, you can provide a gingival graft, move roots away from the gums, and change the position of the teeth. You should do a comprehensive evaluation before putting on any brackets to prevent unwanted tooth movement. With a good analysis you can see the skeletal resistance and adjust your treatment planning and appliance design to compensate any thin tissue or bone.



In your orthodontic analysis, make sure to look at skeletal resistance when comparing treatment options. In this example, a Li 19x25 bracket and archwire combination will move the tooth beyond the retraction limit, causing skeletal resistance.

MYTH #7
Braces cause cavities and decalcification

REALITY

Braces don't cause cavities or decalcification, poor hygiene and dental habits do. While braces may make it harder to brush and floss, the majority of orthodontic patients finish with no new cavities or discolorations on their teeth.

TIP

If you have a patient with bad hygiene, do not start orthodontic treatment until they prove that they've fixed their brushing and flossing routine. Before putting on brackets, make sure your patients know how to clean their teeth properly, avoid drinking dark sodas, and understand what happens if they don't follow your guidance.

If you have an orthodontic patient with declining hygiene, apply fluoride and provide an extra cleaning (for a fee, of course). Let them know that if they don't fix their hygiene that you will take off the braces and hold treatment. If they have bad hygiene after your warning, take off their brackets until their gums have less swelling or bleeding and rebracket when hygiene improves.

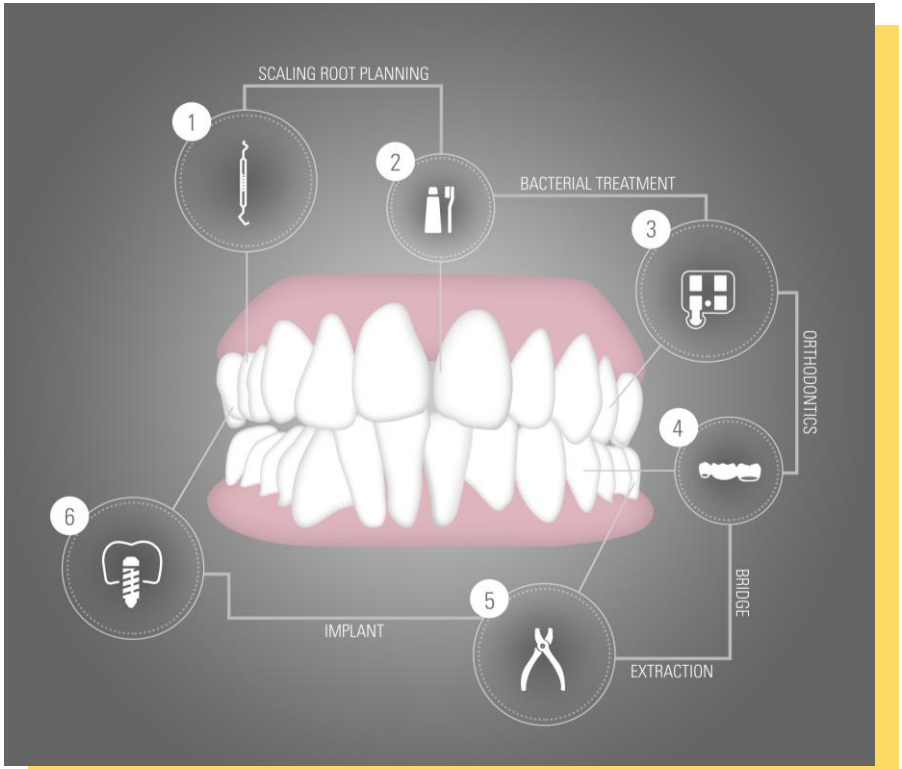
MYTH #8
Only orthodontists can provide braces

REALITY

General dentists are able to provide orthodontics as long as they treat to the standard of care. We are confident in saying this since we have looked into various state and country regulations, and also have a network of graduates who provide orthodontics in 80 countries around the world from every continent (except Antarctica).

Although dentists can legally do orthodontics, there are a few countries like Russia, Sweden and Norway that make it more difficult with an extra hurdle of regulation, registration, or national health insurance coverage.

Dentists can do great orthodontics. GPs also have an extra advantage in providing orthodontic care to multidisciplinary cases since they have a knowledge of working with patients in all aspects of dentistry.



Orthodontics can be one step in your comprehensive treatment map.

MYTH #9
Doing orthodontics will get me into trouble

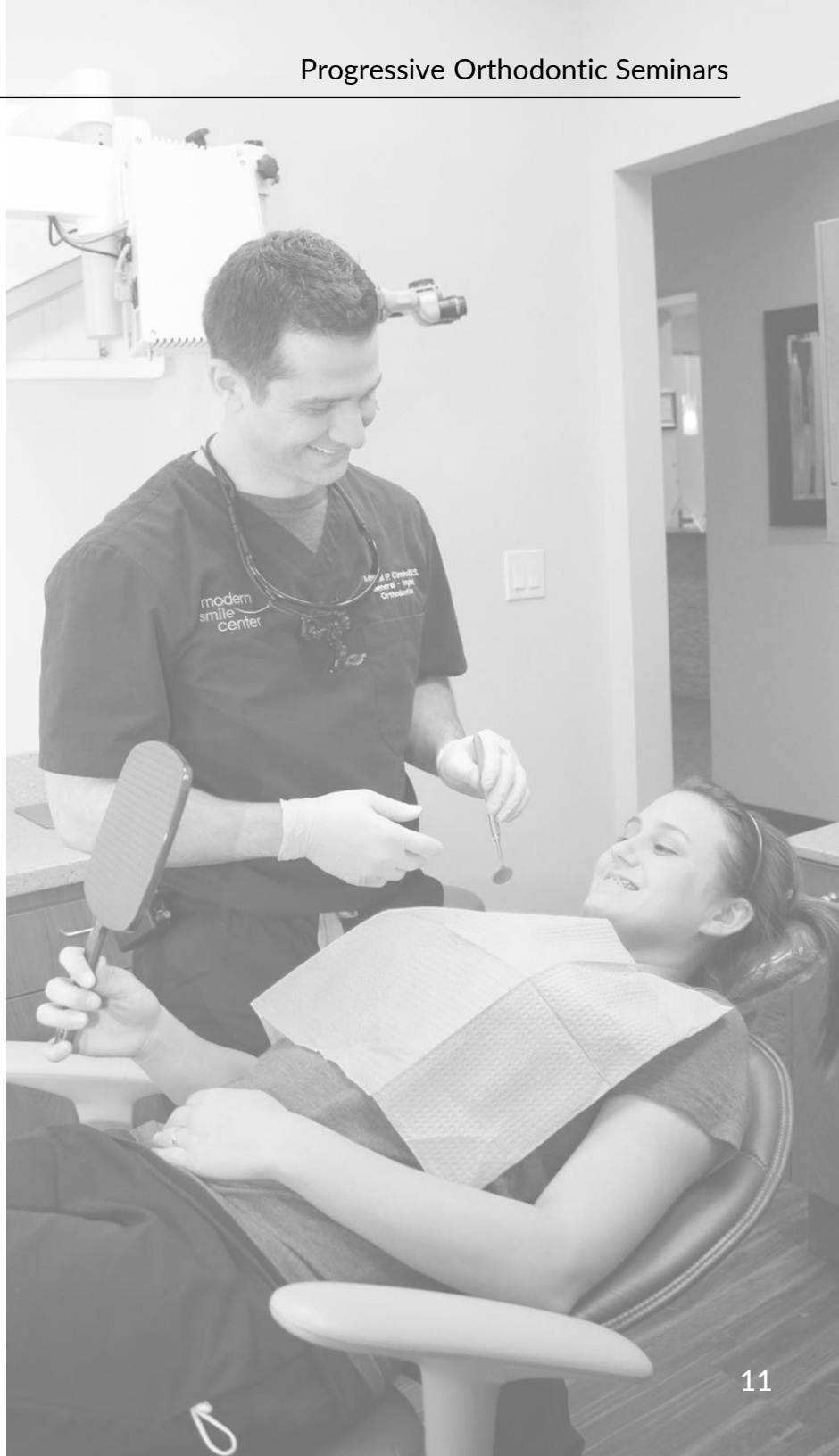
REALITY

As a general dentist, if you provide high-quality orthodontics, you are within your professional rights and will not lose your dental license. If you're in a community that has a highly guarded orthodontic specialty, please contact us. We have several services that can help you stay protected. We have many graduates in places like these who still choose to help their patients with in-house orthodontic care. We can help look over your marketing and cases and double check that things are in order.

TIP

Make sure to take full records and evaluate and plan your orthodontic cases comprehensively before starting treatment. Document treatment alternatives and limitations, and communicate honestly to patients.

Good training programs will help you to provide the highest level of care, avoid missteps (or fix them quickly), and protect yourself. Learn a few ways that you can protect yourself in this article: 6 Ways to Avoid Trouble with Your Ortho Cases



MYTH #10
Patients want to get braces from the orthodontist, not the dentist

REALITY

While it's true that some patients prefer a specialist that took 2-3 years of orthodontic residency, many patients will likely prefer to get treated by you. Patients often know and trust you and your staff and don't want to move. If they know that you're a kind, smart, and dedicated dentist that gives them great dental care, they'll probably think that you'll be dedicated to providing them great orthodontic care too.

READ ARTICLE: 4 Reasons Why Patients Prefer Their General Dentist for Orthodontic Treatment

TIP

Don't shortchange yourself with doubt. If you would like to help patients by providing excellent orthodontic care, see if you may have demand from existing patients.

When you see potential patients, ask them if there is anything they don't like about their teeth or smile. This opens the conversation. Many will tell you that they don't like their bite or crooked teeth and will ask if you could give them braces.

Conclusion

Now that you know more about the truth of orthodontics, we hope you can make more informed decisions for you and your patients.

Wondering if something you heard about orthodontics is true or not? Ask us at info@posortho.net

References
1. The Right Time for an Orthodontic Check-Up: No Later than Age 7. American Association of Orthodontists. https://aaoinfo.org/system/files/media/documents/Right_Time_for_Ortho-MLMS-hl.pdf. Accessed April 11, 2018.
2. When should I take my child to see an orthodontist? Sharecare.com. https://www.sharecare.com/health/orthodontic-braces/when-take-child-to-orthodontist. Accessed April 11, 2018.

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