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New Outstanding Service From N.A.O.L. *Should G.P.s Be Doing Orthodontics?* *The Twin Block™ - Appliance and Its Adjustment*

New Outstanding Service From N.A.O.L.

North American Orthodontic Laboratory takes great pride in announcing its new crown and bridge laboratory service. Due to our world wide facilities we are now able to offer you the highest quality workmanship at international off shore prices. This service includes inlays, crowns, bridges, laminate veneers, and composite inlays all for just \$5900 per unit, excluding any precious metal charges. In addition we will have the case back to you within fourteen days from the time that we receive it.

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Ian Walters

Should G.P.s Be Doing Orthodontics?

Dr. Walters is the immediate past president of the Australian Association of Orthopedics and Orthodontics. He is actively engaged in the practice of Maxillofacial Orthopedics in Sydney Australia.

That this question can be legitimately asked reflects on the priorities of undergraduate and postgraduate dental education. This is common throughout the world. Hopefully, from what I hear, some of my critical comments may not apply to all graduate schools.

Since Angle decided that orthodontics could never prosper within the confines of the formal dental teaching institutions and set up the first school of orthodontia independently of academia, orthodontists have tended to become increasingly isolated from general dentistry in terms of interchange of information. This has proved to be as detrimental to themselves as it has to general dentistry and the community it serves.

The teaching of craniofacial biology and the treatment of malocclusions and aberrations of orofacial development and craniocervical and craniomandibular dysfunction is rudimentary at the undergraduate level.

Thus it is almost impossible for dentists anywhere in the world to include the management of these conditions within the ambit of general practice. This is so if reliance is placed upon information received during undergraduate education or through any postgraduate programme currently available through the dental faculties.

However, an increasing number general practitioners, by structuring their own international educational network, have succeeded in acquiring the necessary biological knowledge and clinical expertise to do so. This knowledge includes a wide understanding of the use and limitations of functional orthopedic appliance~s, together with familiarity and facility with various fixed

appliances.

Thus, in orthodontics, a new and more formidable class of general dentist is emerging. As a class they command the flexibility of multi-appliance systems and familiarity with a variety of cephalometric analysis, such as those of Sassouni, Bimler and Ricketts. These are far richer in structural information than those of Steiner, so favored by orthodontists. These dentists can show treatment results, and debate this subject, in any company, at any level. These are the practitioners who have immersed themselves in the study of craniofacial biology and have explored with Moss, Petrovic, McNamarra, Harvold and Vargervik, Woodside, Bimler, Frankel, Truitt, Ricketts, Enlow and others, the field of orofacial growth, and to a surprising extent, its clinical control and management. Those general practitioners around the world who have combined the best features of the European inspired orthopaedics using mainly removable appliances with the American fixed appliances, have for the time being, seized the leadership in this area. They are making greater advances in the field of orofacial orthopaedics and orthodontics than their specialist colleagues. The latter must now reassess their position and strive by clinical expertise, rather than political muscle, to regain the lost respect of a significant section of the profession, and of an increasingly disenchanted public.

What, then, are the criteria for deciding on whether a dentist should be including orthopaedics and orthodontics within his or her general practice?

Firstly, the general dentist must be certain of possessing the necessary information and skills to properly diagnose and treat a malocclusion successfully and comprehensively in terms of the skeletal relations, muscular function, and dentoalveolar compensation.

The general practitioner's expertise must be such that the level of care is equal, or preferably superior to, that which is currently achieved by the majority of specialist orthodontists. This is not to deny that the specialty has within its ranks practitioners of exemplary and exceptional skill.

To be justified in treating malocclusion, the general dentist must be able to assess and address the patient's problem at the skeletal level as well as making the dentoalveolar adjustments necessary to detail a functional and mutually protected occlusion. One where the muscles and joints have a dental and facial milieu in which health and harmony of the masticatory system is coupled with enhanced overall aesthetics, or at worst, exhibits the least possible compromise.

Hopefully, treatment will be provided at the most appropriate stage of development rather than at the one most convenient to the practitioner. The practitioner will need broad knowledge of the biology involved and a wide armamentarium from which to select. No one appliance or treatment system will provide adequate care for all patients, whatever the virtuosity of the operator or the sophistication of the appliance. Perhaps it will become apparent to more clinicians that the time of most rapid growth is not the time of greatest biological adaptability.

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THE TWIN BLOCK™ APPLIANCE AND ITS ADJUSTMENTS



John W. Witzig, D.D.S.

Dr Witzig received his pre-dental education at the College of St. Thomas, St. Paul, Minnesota. Upon graduating from Marquette University Dental School in 1962, he established a dental practice in Minneapolis. Dr. Witzig was chosen the outstanding clinician of the year by the American Association of Functional Orthodontics in 1984. He is the honorary president of the Asian-American Association of

European orthodontists now choose the Twin Block™ for orthodontic and orthopedic treatment for these reasons: Eight Advantages:

1. The Twin Block™ is now recognized as the most comfortable and the most aesthetic of all the functional appliances.
2. Patients wear the appliance 24 hours a day (even while eating).
3. Patient can not remove the appliance if the doctor desires it not to be removed. (Construct with crown contours or Clark Clasps.)
4. The doctor removes the appliance, for the first time, two or three days after the insertion appointment.
5. Excellent appliance to increase the vertical in deep bite cases.
6. Appliance will close open bites, with proper adjustments and one proper treatment plan.
7. Mandibular repositioning and vertical results accomplished rapidly, because of 24 hour wear, even while eating.
8. By placement of screws in the appliances, lateral development or sagittal movement is readily accomplished.

Patient cooperation is excellent, because the tongue has freedom for speech. In most cases, the final detailing of the teeth is accomplished with six months of fixed appliances.

The Europeans are now using the Twin Block™ for TMJ

Functional Orthodontics and TMJ. Dr Witzig has co-authored with Dr Spahl: Orthodontic Mechanics, Volume L 1986. Dr Witzig and Dr Spahl have since authored Orthodontic Diagnostics, Volume IL 1989, and The Temporomandibular Joint, Volume III 1991.



treatment, with great results. The Twin Block™ is excellent for:

1. Relieving pain.
2. Decompressing the TM joints.
3. Permanently increasing the vertical in deep bite cases.
4. Repositioning the Mandible.
5. Easy for the patient to wear.

The Twin Block™ appliance was developed by European orthodontist Dr. William Clark, of Fife, Scotland.

CASE REPORT: This male patient, age 11 years and 4 months, Minneapolis, Minnesota, has a severe Class II/division 1 malocclusion, with an 11mm overjet. His lower incisors, bite into the soft tissues in the palate, with his deep overbite.

The patient has a very narrow upper arch, so I had a lateral development screw placed in the upper appliance. In the lower arch, the screw was not necessary. By using the Twin Block™, it is not necessary to widen the upper arch first, as maxillary development is accomplished simultaneously with the mandibular repositioning and vertical correction.

The patient was wearing the Twin Block™ 24 hours a day. We have begun the adjustments for increasing vertical dimension, for correcting the patients deep overbite. With 24 hour appliance wear, including while eating, the results will be rapid.

After the Twin Block™ treatment, which achieves excellent vertical correction and a Class I uncrowded dentition, I will finish the final detailing with six months of straightwire appliance therapy. The patient has worn the appliance 24 hours a day since I inserted the Twin Block™. After wearing the appliance full time, 24 hours a day, I showed him how to remove the appliance after the first two or three days.

I have the patient open the screw one turn (900), once a week, in the upper appliance. At the end of one month of wear 24 hours a day, the patient's mandible was totally repositioned forward.

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