

PROCEEDINGS OF THE WORKSHOP DISCUSSIONS ON EARLY TREATMENT

*Held by the College of Diplomates of the American
Board of Orthodontics in Quebec City, Canada on July
13-17, 1997*

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Iowa City, Iowa, Mexico City, Mexico, and Chicago, Ill.

Of 159 Diplomates who attended the meeting, 96 (60%) participated in the discussion groups on Wednesday, July 15, 1997. Dr. Terry Guenther divided the participants into five discussion groups led by the following chairs/co-chairs: S. Dugoni/K. Wass, P. Opitz/R. Staley, L. Sadowsky/R. Nemeth, H. Sather/S. Heckler, and C. Tulloch/B. Larson.

The various discussion groups considered the same series of questions and included the following:

- What is early treatment?
- Do you perform early treatment? If yes, how often?
- What type of cases do you treat early?
- What are the benefits of early treatment to the patient?
- What are the benefits of early treatment to the orthodontist?
- In your opinion, is the total treatment time longer, same, or shorter for early treatment?
- Is the quality of treatment better, same, or worse in cases treated early?

The leaders of each discussion group summarized the consensus of the workshop participants to these various questions. The summaries were then amalgamated into a consensus paper by Drs. S. Bishara, T. M. Graber, and R. Justus. Their report was the basis for the panel and group discussion on Thursday, July 17, 1997.

CONSENSUS SUMMARY OF THE WORKSHOP DISCUSSIONS

The present summary is not meant to reflect all the opinions that were expressed by each participant rather it reflects those points of general agreement.

• What is early treatment?

It was defined as treatment started in either the primary or mixed dentitions that is performed to enhance the dental and skeletal development before the eruption of the permanent dentition. Its purpose is to either correct or intercept a malocclusion and to reduce the need or the time for treatment in the permanent dentition.

There was also a consensus that in most cases there will be a need for a second phase of treatment after the eruption of the permanent teeth.

• Do you perform early treatment?

All participants agreed that they are involved in such a treatment approach.

• If yes, how often?

The majority of the participants estimated that 30% to 50% of their practice deals with patients who need an early phase of treatment. There was still significant variation among the participants regarding the extent they are involved in early treatment with a range between 5% and 100%.

• What type of cases do you treat early?

The reasons for providing treatment includes: Class II and III malocclusions, openbite, deep overbite with palatal impingement, transverse problems, and asymmetries with and without a functional shift, habits, congenital abnormalities, ectopic eruption of molars and canines, moderate to severe crowding, large overjet, and large diastema between the max-

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illary central incisors. In addition, patients with psychological problems related to self-esteem might be candidates for early treatment as well as patients with "gummy smiles" and lip incompetence.

● **What are the benefits of early treatment to the patient?**

The participants listed a number of benefits for early treatment. It needs to be remembered that this list is primarily based on the perception of the participants. The perceived benefits included improvement in the patient's self-esteem and parent satisfaction, greater ability to modify the growth process, earlier resolution or interception of the developing malocclusion, greater patient compliance, higher quality, i.e., more stable results are achievable, less extensive therapy, and shorter treatment time in the permanent dentition. There is also lesser potential for iatrogenic damage such as tooth fracture, root resorption, decalcification, and periodontal problems.

In the discussion, the participants pointed to the need to guard against the potential iatrogenic problems that may occur with early treatment such as dilaceration of roots, decalcification under bands left for too long, impaction of maxillary canines by prematurely uprighting the roots of the lateral incisors, impaction of maxillary second molars from distalizing first molars, and patient "burnout."

● **What are the benefits of early treatment to the orthodontist?**

The benefits suggested by the participants included the following: early treatment provides the orthodontists with more treatment options, better use of the growth potential, reduced need for extraction, better patient compliance, more satisfaction, and better final results. Because of the length of the observation period, when necessary, the clinician would have two "shots" at solving difficult or complex problems. There will be less need for "en masse" tooth movement, torque, and dental compensations in the second phase of treatment. As a result, the treatment mechanics in the second phase are simpler, less involved, needing less chair time, and have greater stability.

● **In your opinion, is the total treatment time shorter, the same or longer for early treatment?**

There was agreement that the total treatment time is longer when considering the observation period between the two stages. On the other hand, the observational continuum has the advantage of

intercepting potential developmental problems that in turn improves the stability of the results achieved.

● **Is the quality of treatment better, the same, or worse in cases treated early?**

The consensus was that the final result is better; a minority said that they did not observe a significant difference.

OTHER COMMENTS

The participants made numerous comments and raised a number of questions, a few are listed here.

1. Early treatment involves three stages, the first stage of treatment with specific objectives, an observation stage, and a late stage of treatment in the permanent dentition. The parents and patients need to be made aware that this is not one long (6 to 8 years) continuum of treatment.
2. With any treatment approach, the clinician has to consider the uniqueness of each individual patient.
3. Early treatment may have its own unfavorable sequelae, and no approach is perfect.
4. The ethics involving early correction versus late treatment that may require more complex orthodontic or surgical treatment.
5. Treatment ethics should take precedence to economic considerations if better results can be achieved.
6. How would the new systems of health care delivery handle the economics (approval) of early treatment?
7. The effect of treatment on self-esteem. Parents, teachers, and peers respond more positively to attractive versus unattractive children. Children by age 8 to 10 years recognize that they have "functional" problems and that orthodontic treatment can improve these problems.
8. Whatever treatment approach is adopted, the clinician should always strive for achieving results that are consistent with optimum tissue health and stability.

A great expression of thanks is due to the Diplomates who participated in the five workshops as well as the leaders of these workshops. The interactions between the participants make the meetings of the College a unique and enriching experience.