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Timing of treatment for orthodontic problems varies

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“Is it possible to predict whether my child will need braces?” asks a mom at her child’s routine pediatric visit. “Will prolonged thumb-sucking affect the teeth? Is my child predisposed to injuries because of protruding teeth? Can a child’s self image be damaged by the unaesthetic appearance of the teeth?”

Parents may ask their pediatricians questions concerning the need for orthodontic appliances (braces). Many of these inquiries are concerns regarding normal and abnormal primary, mixed and permanent dentitions. Due to time constraints in the medical school resident curriculum, physicians rarely receive the education to address these dental health concerns.

The Academy has developed a comprehensive Oral Health Risk Assessment Training for Pediatricians and Other Health Professionals (www.aap.org/compeds/dochs/oralhealth/training.cfm) to address such concerns.

Pediatric dentists and orthodontists are trained to recognize, diagnose and treat dento-facial abnormalities. It is recommended that an orthodontic screening be done no later than age 7. This age coincides with the complete eruption of the permanent first molars (six-year molars). Concomitantly, the permanent incisors have initiated their eruption, and an evaluation of the antero-posterior and transverse dimensions can be made.

The appropriate timing of treatment for a variety of orthodontic problems is multidimensional. Intervention must be

considered in the context of an overall oral health care treatment plan. Successful treatment depends on the doctor obtaining parental support as well as patient cooperation. Treatment may have to be delayed until the child is more receptive to care.

Treatment philosophies continue to evolve, and many pediatric patients are receiving two phases of orthodontics care. Treatment is initiated earlier, but in separate stages for limited periods of time. The phases may be separated by intervals of no treatment.

Mixed dentition Phase I treatment often focuses on skeletal problems, rather than dental corrections (i.e., rapid palatal expansion and headgear). As a result of earlier intervention and expansion techniques, fewer permanent teeth are being extracted.

The goal of interceptive orthodontic treatment is to correct a skeletal, dento-alveolar or muscular disharmony. This can be accomplished by altering the oral environment prior to the eruption of the adult dentition with a variety of biomechanical appliances.

There is much debate within the orthodontic and pediatric dental community as to the long-term benefit of early and protracted treatment. Long-term treatment outcomes in randomized clinical trials have not proven

either of these to be clinically superior. This lack of consensus contributes to the confusion among pediatricians and parents.

There are clear indications for early treatment for the following



When orthodontic treatment is needed, it should be considered within the context of the overall oral health care treatment plan. Recommendations call for an orthodontic screening no later than age 7 years.

dental problems: prolonged thumb and tongue thrusting habits, facial asymmetries, space loss, severely protrusive anterior teeth, ectopic eruptions, anterior and posterior crossbites, and poor aesthetics.

Many orthodontic problems simply should be monitored and eventually treated when there is nearly a full complement of teeth. Growth variability and treatment response are highly individual. Hence, accurately predicting a child’s maturation is a challenge and must be given careful consideration.

Early treatment goals should be delineated clearly at a specific growth and maturational stage. Prior to initiating any orthodontic treatment, diagnostic records (i.e., radiographs, photographs, study models, etc.) are needed to formulate a comprehensive treatment plan. Sometimes, even the smallest tooth movement, such as correcting a crossbite, can enhance a child’s self-esteem. Pediatric dental professionals and orthodontists need to work together to achieve the best possible outcome.

Dr. Jaffe is an AAP associate member and a member of the AAP Section on Pediatric Dentistry.

RESOURCE

For information about the latest oral health policies and clinical guidelines, visit the American Academy of Pediatric Dentistry’s Web page, www.aapd.org/media/policies.asp.