

# Performing Orthodontics Within the Framework of the General Dental Practice



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**M**ost of what I learned about orthodontics in dental school involved simple wire bending and very minor treatment. I do not think I am alone—it seems as though many dentists find that orthodontics seems totally foreign to them only after they have graduated and started their practices.

Fortunately, there are several well-known courses of study to take the dentist through diagnosis, cephalometric tracing, treatment planning, and case finishing that help impart some ability to treat the average orthodontic patient. Some of these courses are taught by such renowned clinicians and teachers as Drs. Jay Gerber and Brock Rossouw. The United States Dental Institute also offers an excellent series of orthodontic courses. The advantage for general dentists is being familiar with orthodontics is that many cases can be treated earlier in the patient's development with interceptive orthodontic treatment. In my practice, my team has found that referring the most difficult cases can still be a vital adjunct to patient care. Our relationship with our referring orthodontic practice is mutually beneficial—we can share with them a basic knowledge of restorative dentistry, and they are a resource for us to

help with our own orthodontic treatments.

After graduating from dental school and opening a private practice, it became very apparent that while most of the orthodontic treatment I saw took into account the general alignment of the dentition, it always seemed that less attention was paid to achieving a stable, long-term occlusal result. As a student of orthodontics, I know that it is paramount to the long-

term success of any treatment to have a minimal amount of interdental pressure between the teeth and, more importantly, a stable and well-balanced occlusion and comfortable musculature, with particular attention paid to the establishment of a cuspal-protected final result.<sup>1</sup> The experienced clinician realizes that orthodontic treatment may not be ideal in all cases because of arch or tooth size discrepancies,

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What seems to be simple treatment in initial stages of a case often ends up becoming very difficult during the final stages because of unforeseen problems. However, with proper guidance from reputable orthodontic instruction and case selection within the abilities of the general dentist, many cases that would otherwise be referred out of the office can be treated easily in the general practice. As the general dentist gains experience and the

parameters of what makes a case treatable become clear, it becomes more rewarding to tackle the more advanced malocclusions.

accompany any remaining growth at the condyle. In addition, straight wire appliances were used to align the dentition to complement the orthopedic treatment component. Figure 2 shows a successful outcome. The patient's self-confidence was improved with a new, enhanced smile.

With more complex multidisciplinary dental treatment, orthodontic care can be a great help in correcting a crowded dentition before prosthetic, restorative, or esthetic work is performed. The restorative dentist who provides quality orthodontic care has direct control over the entire case, thus allowing more ideal outcomes through occlusal setups that can provide adequate room for restorative materials and prosthetics. I believe that when a case is referred, it is the communication between what the restorative dentist wants and what the orthodontic specialist can or is able to provide that can make or break the case.

## Case No. 2

In this case, the patient lost tooth structure from the combination of bracket positioning and tooth contact (Figure 3). We sent this digital image to the treating orthodontic specialist to assess the problem. This type of communication truly helps



Figure 1—Preoperative anterior close-up view of class II, division 2 case.



Figure 2—Posttreatment anterior close-up view of completed case.



Figure 3—Image of damage from brackets and perforation used to communicate with orthodontic specialist.



Figure 4—Preoperative panoramic radiograph illustrating resorptive mandibular right condyle.