Ortho ,Sheet #17

we have to always make sure to gain enough data from the ptn in order to reach to the correct diagnosis , by accurate history taking ,examination, interviews,physical examination,analysis of the records ..etc)

* We have to put a good ,productive treatment plan
* Examination and treatment plan sheet is different than the one we use in our cons clinics ,,it has the age with years and months
* As we all know the chief complain must be in the ptns own words
* Any relevant medical history should be mentioned as well
* During the examination process we have to write down the class-facial symmetry-soft tissues /lip competency-smile line-habits/thumb sucking for example-TMJ function- and any obvious signs of systemic disease.
* Upon intraoral examination we have to look for caries,plaque,any perio problems,bridge, or fillings ,mention the general condition of the oral cavity,notice the oral hygiene level and plaque index,check the upper and lower arch ,each alone.
* Then put them in occlusion and record the molar and incisal realation (class what ?,,overjet and overbite ,center line )
* Record the general condition of the mouth ,teeth quality in details( decalcification for example ),perio conditions, presence of pockets,gingival recession ,gingival perio health,overgrowth of the gingiva, and traumatic bites, if present .
* In our examination sheets restorations must be recorded ,why is it important to record the teeth quality ? for, we do care about all teeth whether they’re ortho or not ,plus treating teeth under an ortho appliance is a difficult thing to do .
* Hypoplasia is very important to record, for example if the ptn noticed it on one of his teeth after the treatment ,this record would protect us legally .

We rarely extract the 6s for an ortho correction, for, by extracting it we lose one of the relations we have between the teeth.

We divide the arch into 3 segments from the canine to the canine on the other side (labial segment ),from the canineon the right side to the most posterior tooth (right posterior segment), from the canine on the left side to the most posterior tooth (left posterior segment)

We have to record the remaining teeth morphology , inclination and angulation , sometimes we might have supernumerary teeth ,hypodontia,impacted,delayed eruptions, asymmetrical eruptions of more than 6 to 9 months , retained deciduous teeth .

We have to know that missing canines is not common , and central incisors are more common to be missing in the lower arch ,,check missing teeth and supernumerary ones by taking radiographs .

Crowdings should be written down as well , osseous eruption of the canine , look at the contralateral side and compare

Obviously teeth differ in their sizes among ppl

Doctor presented a case of a 35 years old lady ,who had an impacted canine and a deciduous tooth in an area where a bridge has been constructed ,after a while the canine ,permenant one , started to erupt pushing the bridge outward , so this example is to show the importance of taking radiographs before treatment .

Impacted teeth like moving and wandering around the arch , that’s why annual radiographs are needed (OPGs) to check the current location of the tooth, transmigration of an impacted tooth might be common in old ppl (an impacted tooth crossing the midline ).

Another case showing a ptn having a missing 4 and 5 ,,its actually common to have a missing 5 but uncommon to have the 4, it seems that this ptn has a generalized delay in the eruption of the teeth.

We have to examine as well the space condition ,to decide whether the arch is well aligned crowded or spaced.

We mean by the space available the (space available-space required)

Space available is the space from the mesial side of the 6 on one side to the mesial side of the 6 on the other side .

Space required is the width of each tooth alone from the 5 on one side to the 5 on the other side , then we add them all together and then find the difference between the space available and the space required , if the difference is 0 then each contact point is attached to the one on the adjacent tooth and the arch is well aligned , if its negative then space is needed to properly align the arch , and if its positive then space is available, arch is spaced.

When the value of the space available is negative it might be a mild-moderate-or severe crowding

Less than 4 …mild crowding

4-8…..moderate crowding

More than 8….severe crowding

(knowing that all of which are negative values)

We do these measurements by either a S.S wire or a divider .

Describe the rotation of the tooth :

We describe the rotation of the tooth according to the contact point migration , and we usually refer to the side that is severely displaced .

Inclination and angulation of the teeth

,, we mean by inclination the buccolingual angle of the tooth in the arch , its sometimes called the torque.

Angulation is the mesiodistal angle of the tooth in the arch , sometimes called the mesiodistal tip of the tooth .

Remember that simple removable appliances cause tipping.

Disoccluded teeth should be recorded as well.

-we have to see how does the ptn translate from the maximum mouth opening position to max. intercuspation,, detect any deviation in this path , overjet ,overbite,incisal relation,molar relation,transverse discrepancy .

In class 1 incisal relationship,,,the lower incisal edge occludes at or immediately below the cingulum plateau of the upper incisor tooth.

In class 2 incisal relationship….the lower incisal edge occludes behind the cingulum plateau of the upper incisor tooth

Class 2 division 1 ,,,,proclined upper incisors ,,increased overjet

Class 2 division 2 ,,,retroclined or upright upper incisors ,,decreased overjet (sometime might have an increased overjet )

Class 3 incisal relationship ,,the lower incisal edge occludes anterior to the cingulum plateau of the upper incisor.

-so u have to look at the maximum intercuspation and see where the lower incisor edge occludes compared with the cingulum plateau of the upper incisors .

What is overjet ? it is the horizontal overlap between the lower incisor labial surface and the upper incisor edge ,,average value is usually 2-4mm

In some cases we might have a reversed overjet ,,negative value overjet

What is overbite ? it is the vertical overlap that describes how much the upper incisors are covering of the lower incisors ,,,on average its usually one –third the lower incisor

Overbite can be either complete or incomplete ,,,complete can be further classified into hard tissue or soft tissue contact

Complete overbite means that the lower incisal edge is in touch with the something either soft or hard tissue ,,and that’s how its classified into hard tissue and soft tissue contact according to the tissues in which the lower incisors are in touch with

Furthermore soft tissue contact is classified into traumatic and atraumatic contact according to the irritation and traumatization of the soft tissues caused by such contact .

-openbite : where the upper incisors are not covering the lower incisors ,,can be symmetrical or asymmetrical ,,measured in mm,,,,we have to describe its extent as well

We can have an anterior openbite or a posterior openbite

We have to check the center line of the upper teeth and compare it with the center line of the face.

So in this way we’ve located the upper center line , amd then we have to ask the ptn to go into occlusion in order to locate the lower center line

Molar relationship:

Class1 ,,where the mesio-buccal cusp of the upper molar is in the buccal groove of the lower molar

Class2 ,,,where this position is more anterior , can be half unit ,full unit , quarter unit, three-quarter unit .

Half unit for example: cusp to cusp relation

When the realtion jumps anteriorly a full cusp ,,this is full unit class 2

Posteriorly a whole cusp ,,full unit calss 3

Canine relationship:

Calss1 ,,,where the upper canine is in the embrasure between the lower canine and the lower 1st premolar.

Calss 2….when its anterior to this position

Class 3..when its posterior to this position

Crossbite : might be anterior crossbite or posterior crossbite ,,generalized or localized

Posterior crossbite can be lingual crossbite or buccal crossbite

-lingual crossbute is also called scissors bite ,,,localized or generalized

class 3,,,is also considered anterior crossbite ,,reverse overjet ,,

not every class 3 is an anterior crossbite ,,,yet every anterior crossbite is considered a class 3 relationship

radiographs , photographs and study models ,,,analyses of such information is essential

radiographs …ALARA(as low as reasonably achievable )

Supplementary teeth are similar in shape and form to the original teeth ,yet smaller in size

in case of facial asymmetry we have to consider taking a posterior-anterior cephalogram

skeletal discrepancy ,,lateral cephalogram

space analyses can be made more accurately on a study model

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