

Panel Discussion Summary
Drs. A. Kuijpers-Jagtman, D. Turpin, H. Legan, J. Cope
July 19, 2006
10:00-11:30 AM
Moderator: Dr. S. Bishara
Summary by: Dr. R. Hyduk

The audience asked a number of pertinent and interesting questions of the panel.

The initial question posed discussion of future evidence based research producing a definition of practice or an evidence-based practice. Multiple input, with final agreement that the goal at present is to produce guidelines, but not defining the way the orthodontist practices.

A follow up question related to the liability the doctor would find himself in if the evidence-based guidelines were not followed. The consensus was that the literature is used anyhow to promote a point for or against the doctor and therefore the trial attorney would say “evidence-based” isn’t changing anything in how they handle a case. The bottom line is you have to do the best thing for that patient that you are trained to do.

A question was posed concerning the age of the patient when using TADs. The response from Dr. Cope was his youngest patient was 12 years old and his oldest was 65 years old. Children pose additional concerns due to softer bone and unerupted teeth. More than age, he stressed taking a good medical history, especially with the number of middle-aged women taking medication for osteoporosis and men and women on anti-cancer meds, which complicates osteoblastic and osteoclastic bone activity. The anti-cancer medications can even cause osteonecrosis of the jaws, which further complicates screw devices.

Discussion followed on the subject of smoking and implant placement. Dr. Kuijpers-Jagtman asked if this was a contra-indication to their use. Dr. Cope stated that it is a relative contra indicator and his main concern is at the initial healing phase.

Dr. Bishara asked to Dr. Legan the number of obstructive sleep apnea patients he sees in his practice. Dr. Legan replied that he sees numerous patients with OSA, and approximately 70 have had bi-maxillary osteotomies in the last 5 years. On a follow up note, Dr. Bishara was concerned with the effects of this surgery on patients exhibiting normal facial morphology pre-surgically. Dr. Legan feels the profile always looks better, and again, the surgery is done for “life saving”, and not cosmetic in nature, even though this is a nice post surgery benefit. If anything, this profile situation may be a problem in the Asian population where a patient may present with mandibular prognathism and a small nasal projection. Dr. Legan also stressed that after the advancement of the maxilla of 10mm or more, no bone grafting is being done at the posterior aspect and this is not a problem at this time.

Dr. I. Kolin entertained the possibility of lower first bicuspid extractions with retraction of the anterior segment and limiting the surgery to a bilateral mandibular advancement procedure. Dr. Legan felt this can be evaluated on an individual basis, but at the present his team prefers two-jaw surgery when possible.

Dr. R. Nemeth questioned the incidence of infections especially with appliances placed intra-orally going through soft tissue in order to attach to bone. Dr. Legan says he stresses oral hygiene and addresses the problem when it arises. Dr. Cope addressed this from a TAD perspective saying he also stresses oral hygiene and cleans the device at every patient visit. He also recommends Chlorhexidene use prior and after screw/implant placement.

A question was posed concerning the use of intra-oral repositioning appliance for sleep disorders and the liability issue. Dr. Legan responded by stressing that the doctor inform the patient, cover all areas of patient concern and lastly, the doctor should align themselves with a sleep team in their geographic area.

It was asked to Dr. Cope if he had used implants for vertical cant discrepancies. Discussion ensued between Dr. Cope, Dr. Bishara and the questionnaire with Dr. Cope feeling that additional studies are necessary.

Varied questions and answers ensued regarding having a scientific meeting such as this available for review by a search. At that point, it was discussed in more detail by Dr. Kuijpers-Jagtman of how to follow a true search as outlined by the previous lectures and the hierarchy of evidence-based research.

Dr. Legan answered an audience member that the orthodontist is an integral component of the medical model protocol for the treatment of OSA.

A statement was made to Dr. Legan from the audience that maxillas in the majority of cases could benefit from expansion for a number of reasons. Dr. Legan agreed and also added that most Class III cases are better corrected with maxillary advancement and not mandibular setback procedures, especially in OSA cases.

Dr. Hyduk voiced his concern of the orthodontist doing procedures (implants, lasers, TADs) which would be better handled by other specialists such as oral-maxillofacial surgeons and/or periodontists. Dr. Cope feels that whoever does the procedure best should perform it. The orthodontist who is treating the patient knows best where the TADs should be located and what the final goals need to be in order to produce the desired results.

There was a general discussion between the panel, the moderator and the audience on the excitement and challenges ahead for all of us, as a group, and our implementation of an evidence-based practice model.