

Letters to the editor*

Case reports display the finest type of orthodontics

As an orthodontist retired from private practice and university teaching, I enjoy reading the monthly journal to help me stay in the game and be better able to interact with colleagues and former students. I especially enjoy the case reports section, as I can relate to the very practical side of these articles. Two case reports in the June issue, "A novel approach of torque control for maxillary displaced incisors"¹ and "A simple approach to correct ectopic eruption of maxillary canines"² were some all-time favorites. These cases are sourced from practitioners and schools around the world and exemplify some of the best attributes of the enlightened orthodontist (I considered "renaissance", but that would be too old-school). The treatments devised and displayed in these cases represent creativity and ingenuity bolstered by a sound knowledge of biological and mechanical principles. These qualities were integrated by each practitioner and team member to formulate and execute a novel and simple treatment approach to complex problems unique to each patient. To those who are wary of the future of orthodontics, concerned about corporate, systematized, do-it-yourself, and teleorthodontics, look to these cases and the untold numbers like them being treated across the world as the finest type of orthodontics, destined to thrive and prosper.

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What seems to be the latest will never replace the need to apply sound biomechanics

I read with interest the case report by Jiang et al in the June 2019 issue (Jiang Q, Yang R, Mei L, Ma Q, Wu T, Li H. A novel approach of torque control for maxillary displaced incisors. *Am J Orthod Dentofac Orthop* 2019;155:860-70). The treatment presentation of the patient with palatally blocked incisors was extensive and accurate. However, I wish to express some concerns pertaining to the comparison of the effectiveness of the promoted torquing technique vis-à-vis traditional mechanics.

The authors reported that the required opposite torque on the maxillary incisors could not be achieved with conventional torque management techniques such as Warren springs and torque bends or with the use of inverted brackets. Clinically effective and efficient torque control in the maxillary anterior teeth was achieved instead using a simple approach by bonding a second row of brackets cervically on the compromised teeth and engaging nickel-titanium archwires.

Preadjusted orthodontic brackets have in-built prescriptions of torque, tip, and in-out that are optimized for average patients. Maxillary incisor bracket torque prescriptions vary between 0° and 22°, with bracket placement at the center of the crown.

Torque expression may be influenced by other factors as well. The labial contour of the crown surface differs at different heights on the crown of the same tooth. Placement of the same bracket at different heights will result in important differences in the amount of root torque because of variable labial crown morphology and a varying crown-root angle.¹

In a finite element study, Papageorgiou et al² found that palatal crown displacement was significantly affected by bracket positioning in the apical third of the crown (up to 94%), in teeth with average crown-root angle. On the other hand, buccal apex displacement was affected both by bracket prescription (up to 42%) and bracket positioning (up to 23%).

The bonding of upper brackets gingivally to protect or enhance the smile arc was introduced by Pitts,³ and it is referred to as "SAP bracket positioning." It can lower the effective torque prescription. Palatal crown torque can be controlled even more by inverting all anterior