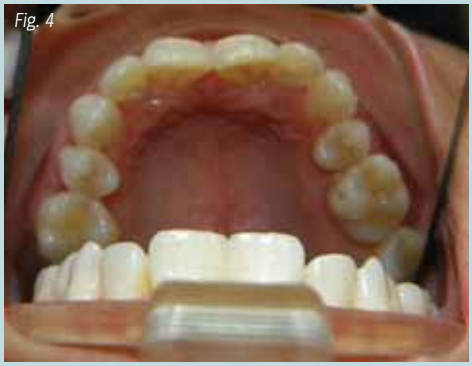
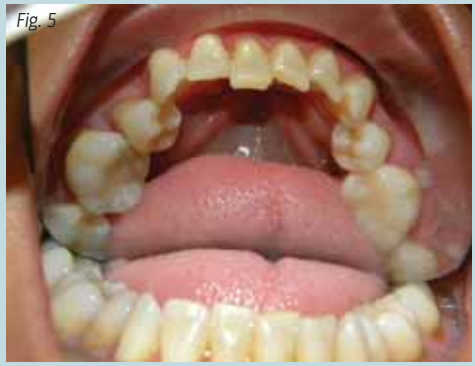
Would You Treat with This Resorption?

Have you ever had a case where you were concerned with increasing the root resorption? This Townie does, and his gut is saying don't do it.

charlestonbraces
Member Since: 06/05/09
Post: 1 of 22

Figs. 1-3: Forty-six year old female (mother of two twins I am treating), 4 bi-ext ortho as teenager, significant root resorption, significant incisor rotations. I am concerned about not only increasing the root resorption (and worsening the long-term prognosis for the incisors), but also the biomechanics we encounter when we move teeth with an altered center of rotation. My gut is telling me not to do this, but the mother is very unhappy with the appearance of her maxillary incisors and I really want to help. But, if I decide to play hero, of course I don't want to ruin her dentition or lessen the longevity of what she has left.





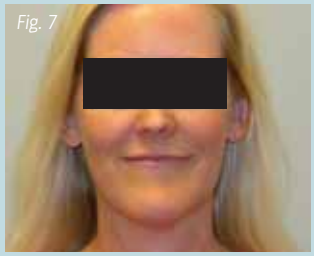


Fig. 4: Mirror image – not flipped

Fig. 5: Mirror image - not flipped

Fig. 9: This is a duplicate pan I held up to a white computer screen.

Fig. 10: This is my interpretation of where I think her bone level is and her incisor apices.

I guess veneers (instant orthodontics) would be a compromise worth entertaining, but that treatment option is not good for the perio health. If you did decide to take the chance and treat, would you go with fixed upper (get in and get out with light forces) or spring

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Adult with Root Resorption, How Much Resorption is Too Much to Retreat??
Search: Adult Resorption

retainer? The problem with the spring retainer is that she could not use it during the day because she does public speaking. So, then I would worry about the start, stop, go back, start, stop, go back… and what that would do for the teeth.

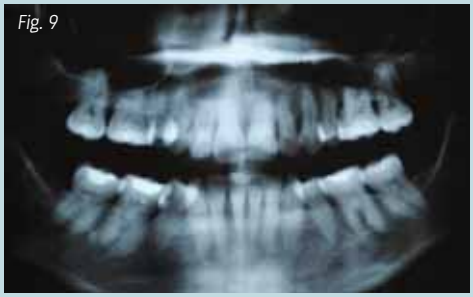
Fig. 9

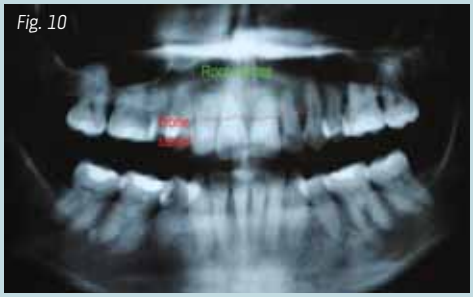
Fig. 10

Thoughts? ■

NOV 4 2011

Petertphan
Member Since: 10/13/03
Post: 2 of 22

It looks like she was treated with Tweed mechanics. So, they took out 4 bis, and got the teeth back and flattened that profile by means of J-hooks and a high-pull headgear. Notice how it's only the upper 2-2 that's got the ARR.

If that's the case, root resorption was way more a result of biomechanics than genetics. Light forces for a short period of time shouldn't worsen the situation. However, that's a Div II end on bite. I'm going to guess a quick fix would leave some noticeable overjet… maybe slight, since the lowers are crowded enough to roll forward. I wouldn't use any elastics in this case, though.

Since she's concerned about the public speaking aspect, why not try Invisalign with about 25-50 percent reduced movement programmed in? Lighter forces per tray, and as "invisible" as can be. You can also be like a hawk and take PAs every few months. ■

NOV 4 2011

flybywire
Member Since: 06/28/04
Post: 3 of 22

Agree with Invisalign suggestion! ■

NOV 4 2011

sharperdds
Member Since: 05/01/05
Post: 4 of 22

+1 on the Invisalign. The research I've seen shows much less risk of EARR (External Apical Root Resorption) with Invisalign. This should work OK with public speaking as well. ■

NOV 4 2011

dhmjdds
Member Since: 11/16/04
Post: 5 of 22

+2. Seems like an ideal Invisalign case. I agree with the suggestion to slow down tooth movement even more (i.e., this is not an express case).

The toughest thing should not be getting the rotations out, but getting decent root/crown torque to improve that pushed-in appearance. She'll have overjet at the end – make sure you, she and her GP are OK with that. Upper and lower fixed retainers plus overlay removable retainers or she'll be back where she is now in a couple of years.

And don't begin any treatment without a full set of PAs and perio clearance. ■ Diane

NOV 7 2011

bracingU
Member Since: 01/11/08
Post: 6 of 22

I got as far as the photos and thought I would only do this with Invisalign. It seems to be the consensus with the others as well. In adults with crowding and bone loss, make sure that you include a discussion about black triangles and program some IPR in for the upper and lower anteriors. ■

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tom525
Member Since: 06/18/08
Post: 7 of 22

This patient should be treated by a periodontist first, then consult with a prosthodontist. A ceph would be a good idea. She appears to have a skeletal pattern indicating non-extraction. Work with a team. I have a hard enough time treating these cases with fixed appliances. Does anyone have a similar case treated with Invisalign? Maybe Invisalign combined with fixed? I would not be surprised to find that she has a severe parafunctional habit. So TMJ consult might be necessary as well. I don't think this patient should have to live the rest of her life with this occlusion, and I would not be afraid to help her, as long as she is prepared to accept the risks. ■

NOV 14 2011

kpacker
Member Since: 03/24/10
Post: 8 of 22

I just started a case with short roots and that was my only suggestion to the patient – Invisalign. It will slow the Tx progression and lengthen overall time. I could assure no extrusion of incisors as well in the ClinCheck and maybe intrude them, which Invisalign is good at doing. I also have the need to correct a mild Cl II dentition, which I felt better about doing wearing elastics with the trays. That way forces are minimized, tooth movement is slow and the elastics aren't hooked to one tooth but exerting their force on the whole arch. And I also figured that, if needed, we could continue elastic wear even if tooth movement is done while staying in final trays. We also planned more frequent progress panos to monitor roots. Again, compromises exist and I make sure informed consent is given and that it's their decision if they want to do it or not. Not an amazing answer by any means, just my thought process for a similar case.

It's a case I'm curious to see the outcome of and how well it progresses. ■

NOV 14 2011

pshannon
Member Since: 07/26/11
Post: 9 of 22

Bone loss as well as root resorption disturbs me. This could go south in a hurry. I would probably not get involved as the last guy can be the villain. ■ PShannon

NOV 14 2011

jcquintero
Member Since: 12/28/09
Post: 10 of 22

I wouldn't use Clear Aligner Therapy (CAT). Rotating maxillary incisors can be very inefficient and frustrating with removable appliances, especially laterals. Been there done that. Refine, refine, refine… Expectations and fees would be too high for it not to work. They always say, "I'm not looking for perfection," but they are in the end. What CAT would take eight months to do 80 percent of the way, fixed appliances could do 80 percent in three months. I would treat with light wires, say .012nt and 0.14nt all the way. She probably has a posterior-positioned condyle too with a likelihood of an anterior displaced disk, so she might come forward a little as you unlock and open her bite. I would treat with fixed and take PAs frequently. By the way, that study about Invisalign and less EARR was done by a researcher who is on the payroll for the company. ■

NOV 15 2011

dhmjdds
Member Since: 11/16/04
Post: 11 of 22

I would have to respectfully disagree with the previous poster. There is little lateral incisor rotation that is needed in this case, and the central incisors are wide and long, so rotation should not be a problem with Invisalign trays at all. Can't speak for using other manufacturers. I still think that the main thing you need is torque, so a .012Ni isn't going to give you anything there. ■

NOV 15 2011

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