How Do You Handle Broken Fixed Retainers?

Do you charge when patients need to have their fixed retainer rebonded or replaced?

I have a love/hate relationship with fixed lingual retainers. They are so good at keeping the teeth straight, but annoying when they come loose/debond.

For my current retention protocol, I usually give parents and patients the option of a fixed lower lingual retainer and I’ll also go ahead and make upper and lower Hawleys. My assistants also let them know that the lingual retainer doesn’t always last forever and like shoes, toothbrushes, clothes, etc. will wear out over time, especially in the oral environment and might need to be replaced. I will repair loose fixed retainers for free for a year, but have been charging patients after a year should they become loose or debond. I work in a corporate group practice, so I don’t feel (too) guilty about doing this. But I am human, and a part of me certainly does feel like I’m overcharging the patient. Yet, I also do not want to have a life-long retention patient who I am indebted to simply because mom wanted a fixed retainer.

What protocol do you use for handling your broken fixed retainers? And what composite do you use? I’m thinking maybe my flowable isn’t as robust as it could be.

Thanks!

I agree with your frustration. We always make a clear overlay retainer for patients to wear at night, so they have a backup if the bonded retainer comes loose. We include a year of retention visits as part of their fee and charge an office visit after that, although I will admit I have waived the office visit several times.

We find the flowable composites do wear quickly. We are trying some restorative composite from Ivoclar (also starting to use for Invisalign attachments) as it supposedly is more durable. I am about to order some of the mini-molds to use for placing the composite.

Our practice is near a university and we get several calls a month to repair bonded retainers that were placed in the students’ hometowns... so you are not the only one with these issues.

Communication of your retention protocol (by your office manager) at the time of retainer placement goes a long way to staving off frustration, fee, no fee, costs and options.

It depends on whether you are talking about upper or lower fixed retainers.

In my opinion, lower fixed retention is absolutely the way to go in 99 percent of cases. Lower front teeth move. Always. Forever. In everyone. Of course, that is not strictly true, but no one has any way of determining in advance who has teeth that will move and who has teeth that will stay stable.
On the other hand, upper fixed retention is very rarely a good idea. They are a hygiene nightmare, they come off monthly, you have to bond every tooth, they are hard to form properly, etc.

So our policy for lower fixed retainers is:

1. If they come off within the first six months and the patient brings back the wire, the retainer is rebonded at no charge.
2. After the first six months, if the retainer is only off on one side, we will rebond it for free for a lifetime. We want to encourage them to come back immediately once they notice it is loose.
3. After the first six months, if the retainer is off on both sides and the patient brings back the wire, we charge $49 for the rebond.
4. At any time, if they come back without the wire, it is $104 (in one office) or $175 (in the other office) for a new bonded retainer. Then the clock resets.

For upper fixed retainers, I will do 1-1s for stubborn diastemas at no charge. If they knock them off, the policy is the same as for lower lingual retainers.

Any other fixed upper retainer is only when a patient/parent insists on it; we try to talk them out of it. Then it is $250 for the retainer and $100 for any rebonds, which happen all the time.

The key is to inform patients and parents of these facts all along. You should not feel guilty about charging for these things. Almost everything in life requires maintenance; retainers are no exception. ■ Diane

Diane, on your lower do you bond every tooth or just 3s? If you are just bonding to 3s, do you find some rotations/relapse on the incisors? If you bond every tooth, do you get one tooth debonded without the patient noticing until it moves significantly? What wire do you use? Do you make an overlay Essix?

I feel that there is a million ways to approach retention and if one way was best we would all do it, so I like to hear about what others do. ■

Generally, I offer patients upper and lower Essix retainers (day of deband) and Hawleys (a few weeks later). I will bond 1-1 or 2-2 if there was a diastema to begin with. If parents request a bonded 3-3, I will do those in addition to the Essix and Hawleys – and my assistants inform parents that after a year, broken fixed retainers will be charged a fee to replace.

In the past, I bent a TMA wire and bonded to just the 3s on the lower, but found that despite that, incisors would often rotate facially. I do agree that finishing with proper overbite and overjet helps keep the upper and lower incisors somewhat in alignment, but let’s face it, a lot of cases don’t finish ideally due to lack of compliance, poor oral hygiene (and you have to get out), etc.

While we’re also on retention, I am having a tough time keeping extraction spaces closed on adults. Regardless if patients wear their Essixs/Hawleys 24/7, it seems that a millimeter or two of space is always opening up. I’ve also used wrap-around upper and lower Hawleys to address this problem, but the fit is never spectacular and the contacts are still very light, if that. Any suggestions or tips? ■

Hoodortho, So they wouldn’t brush their teeth or wear their elastics, but you think they will wear a removable lower retainer for the rest of their life? I find that to be unlikely.
Obviously what you are saying is that if you give them a removable retainer, and they don’t wear it then it is “their fault.” Then their teeth get really crooked again and they need to be completely retreated. But if they had a bonded retainer, then the teeth would only be able to move a little, and the fix would be relatively cheap and easy. And somehow the movement of their teeth is their fault in the first example, but your fault in the second example? I don’t really think that is true.

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We bond only the 3s. Yes, the incisors might move slightly. Bonding them to the wire seems to help only a little, since as you pointed out, they can’t tell if they come loose and they always come loose from the incisors. If a tooth rotates, I IPR both sides of it slightly (with the wire in place) to free up the contacts and 90 percent of the time, it will move back into alignment just from lip pressure. I only make overlay Essixs if they are otherwise needed (bruxers); not routinely. They are not going to wear them. ■ Diane

I feel that at some point during treatment patients have to take responsibility for their teeth and the alignment of them. I prefer Hawleys, due to the ease of cleaning, longevity of use and for keeping the teeth aligned. We inform our patients that if not worn their teeth will likely get crooked. I can’t babysit them for the rest of their lives. These kids will be adults someday and I feel at some point should be held accountable. So yes, I do feel less responsibility should I see relapse in cases where removables were not worn. Which is why I also give patients Hawleys to overlay bonded lingual retainers. Should they come loose, I want them to have another back-up retainer to keep those teeth straight.

My problem with using bonded linguals (and I have since switched to bonding each tooth), is hygiene and maintenance and, really, not every patient or parent wants it. I certainly don’t mind rebonding those loose areas, however I don’t like hearing parents gripe about the cost to do it. As I posted earlier, we inform parents that like most things in life, these bonded linguals require maintenance and might become broken – and we charge a fee to fix/replace them. Of course, many of them don’t remember that or still gripe about it anyway.

When I did previously just bond to the 3s and noticed relapse, I would IPR the tooth and found that it didn’t really help with the rotation correcting. Maybe it was just my technique. And I do find that patients are cognizant of when a single bond becomes loose on a lingual wire that is bonded to each tooth.

The bottom line is, I hate seeing relapse and I want to do everything I can to prevent it. ■

I bought a practice two years ago. As a result, I am not overly confident in what the previous doc explained to patients and parents at debond, so I have eaten a lot of relapse and retainer costs over the past few years. I wish I could have bought everything but his retention patients.

This morning I have a mom with her daughter whose braces were removed three years ago. Her lower fixed retainer broke two months ago with slight relapse. She went to the dentist who recommended she have a removable retainer as her hygiene was not good and fixed retainers could break and were tough to clean around. Mom
was irate we did not give her a removable one to begin with as the teeth have shifted and the dentist told her she could not keep it clean. So I give a lower spring retainer with resets at no charge.

I move to the next chair and there is an irate mother whose daughters braces were removed three years ago. Her lower anterior teeth have shifted since braces were removed as a result of zero compliance with wearing her lower spring retainer. She tells me all her friends kids have fixed wires and never have to worry about retainers. I said I would align the lower teeth and place a fixed at no charge.

I pulled the two moms aside and asked them to tell each other why they were in the office. After five minutes of talking, the first mom asked for a permanent fixed again and the other mom asks for a new removable spring. I couldn’t believe it.

Fixed or removable... damned if you do and damned if you don’t. One of the best things I did when I started in the practice was implementing a retention agreement. The parents and kids sign this at debond and take it home after it is scanned into their chart. It also covers information about late jaw growth.

Parents and patients pick either a lower fixed or lower spring. I review the positives and negatives of both and inform them either way retention is for life since those lower teeth will shift. I much prefer the lower spring and I would say we use it 80 percent of the time. With this being their choice I don’t feel bad charging $100 when they come in a year later with a spot off and I don’t feel bad when the lower anteriors are crowded and need retreatment if they didn’t wear their spring. If there is ever an upset parent I pull up the agreement and ask if there is anything different we should have done on our end. They usually do not have much to say then.

Anyone have a “retention informed consent” in the office? I have been thinking of developing one and making it be signed by the patient or guardian before the brackets come off. So we are all clear on:
1) Retainer wear
2) Post-treatment checkup protocol and what happen if it’s not followed
3) Consequences of not wearing retainers
4) Financial responsibilities for retainer repair/loss/not fitting
5) Patient discharged
Any one heard of one?

We place fixed lower retainers in 99 percent of our patients, poor oral hygiene being the primary reason we do not prescribe one. Ours are placed indirectly using Anoop Sondhi’s technique. We have very little failure. We guarantee them for three months, after which there is a charge for repair or replacement if they lose it. We do give them an Essix overlay if they started with a severely rotated incisor. After one year, we also charge for a post-treatment visit. We do not have them sign an agreement but we do hand them a retention brochure and review it with them and the parents. This seems to be very effective.