Editor's Corner
Dr. Kirt E. Simmons

To screw or not to screw, what is the question?

How many of you are "screwing" your patients with mini-/micro-/etc. screws these days?

Have you jumped on this latest orthodontic "fad" yet? I have heard some doctors say they expect to use these on most of their patients one of these days. Right now I find mini-/micro- screws where distraction was just 5-10 years ago. Remember those days? Distraction was the wave of the future and conventional orthognathic procedures and extraction of lower teeth for crowding were things of the past. Certain persons were recommending them and performing them on every patient they could possibly rationalize might need them. I fear this is the case with mini-/micro-screws for some people. If most patients could really benefit from their unique capabilities now, how did we adequately treat all those patients who came before?

When I sponsored the first CE course on skeletal anchorage at the University of North Carolina 13 years ago, we had precious few registrants and most doctors came out of that course saying it was great, but really only necessary for a few patients and not worth their time/trouble to incorporate into their practices. Of course, in those days it was the surgeons screwing them in our patients and it could be argued the cost to benefit ratio was simply not worth it for all but a select few patients. Perhaps the doctors of 13 years ago just "didn't get it" and now they do. Or perhaps the marketing of the idea/concept just finally reached the "tipping" point so it has gone from a largely maligned procedure only of value in the institutional setting to one agreeable, acceptable and "necessary" for any "up to date" practitioner to utilize to the utmost. Perhaps it's a case of perception and frame of reference. When I returned to the University of North Carolina and introduced skeletal anchorage to the implant team 15 years ago none of the other specialists on the team (surgeons and prosthodontists) really believed it was possible to orthodontically reposition teeth in the ways I suggested I could if I had skeletal anchorage. I remember vividly an early case in which the maxillary molars were supraerupted by several millimeters due to loss of the opposing molars. Although I suggested a treatment plan involving skeletal anchorage and intrusion of the molars this was discounted and the molars were removed, the bone recontoured, sinuses grafted and upper implants placed as none of the other specialists really believed intrusion of those teeth were possible. By three years later, after seeing the results of several cases I did manage to treat, I remember the referral of a patient with a molar extruded about 20mm for me to intrude!

Obviously, as someone who has been doing this since I worked with Dr. Eugene Roberts nearly 20 years ago, I am aware of the great potential of skeletal and mini-/micro- screw anchorage to provide alternative treatment options and outcomes for our patients. But it should be just that- just another special tool in our tool box to be used only when warranted and when the cost to benefit ratio is clearly in their favor and the alternatives have been provided to the patient. Now, about self-ligating brackets…….