

therapeutic system should be established according to the intra-articular pathologic status and executed appropriately with orthodontic approaches to produce stable occlusion at splint-induced condylar position, which is speculated to produce optimal intra-articular environment leading to functional remodeling of the condyle with bone resorption regarded as TMJ-OA.

OP-10 구연

Effect of high-pull headgear and Class III elastics on non-surgical treatment for adult open bite

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Orthodontists are often faced with various types of an anterior open bite in adults. If an open bite case shows neither severe skeletal problems nor remarkably imbalanced facial profile, we'll try to treat them without surgery. The morphological indications of an anterior open bite include a steep mandibular plane and increased anterior facial height, both of which reflect mainly downward and backward rotation of the mandible. In some cases, an anterior open bite can be also attributed to excessive proclination of the dental arch with mesial inclination of the posterior teeth. Therefore, we have to make an effort not to cause mandibular further rotation and molar extrusion while active treatment. High-pull headgear to the upper molars may be one of the best approaches to improve an anterior open bite without remarkable extrusion of the upper molars. Class III intermaxillary elastics combined with high-pull headgear are also helpful in uprighting the lower molars and in correcting the lower occlusal plane. In this presentation, I'm going to introduce two open bite cases non-surgically treated by the standard edgewise appliance along with high-pull headgear and Class III elastics, and to describe the effect of this mechanics on non-surgical treatment of open bite. Case 1 : 19 years and 1 month old female showing slight skeletal Class II open bite but Angle Class III dental relationship. Case 2 : 20 years and 4 months old female showing severe skeletal Class II open bite without increased lower facial height.

OP-11 구연

Orthopedic versus surgically assisted maxillary expansion – Which cases & when? (악정형력에 의한 상악골 확장과 외과적 술식을 동반한 상악골 확장 – 어떤 경우에 언제?)

박종욱 | 박종욱치과의원

The envelope of change in the transverse dimension is significant in the growing patient where orthopedic expansion can be done. In the non-growing patient, mild alveolar bone remodeling can accomplish half of that change. Beyond that, surgery is needed for correction of deficient maxillary arch width. Two different techniques, multi-segmented maxillary surgery or surgically assisted rapid maxillary expansion (RME), can be used for surgical palatal expansion. If surgery is needed, I prefer surgically assisted RME, which I feel is more stable. To support this portion, I like to cite an article by Dr. Proffit at UNC published in 1996 in International Journal of Adult Orthodontics and Orthognathic Surgery. In this study, the most stable maxillary surgery was a maxillary impaction, and the least was a segmental upper jaw used to widen the maxilla. Indications for surgically assisted RME are

1) Expansions greater than 5mm, assuming normal inclinations of the posterior teeth; 2) History of buccal gingival recession in the maxilla; 3) Vertical facial patterns where tipping of posterior teeth could not be tolerated; 4) Unilateral crossbites or asymmetries; 5) Failed or relapsed orthopedic expansions; and 6) Orthognathic cases that require a large increase in maxillary width (this is a separate procedure done prior to the main surgery and allowed to heal). Clinical case reports comparing two approaches (orthopedic vs. surgically assisted RME on adults) will be presented to discuss the benefits and morbidity of each.

OP-12

Management of double horizontal impacted second and third molars

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Although impaction of the mandibular second molar is not a common clinical problem. A treatment of this anomaly is more complicated especially when the third molar develops too early and competes for space above the second molar. The impacted second molar is always associated with arch length deficiency and its mesial inclination varies from oblique to horizontal position. The objective of the presentation was to describe the biomechanics for correction of the impacted second molar. Removal of the impacted second molar is recommended upon the assumption that extraction of the second molar allows the third molar to erupt simultaneously in a satisfactory occlusal relation. This procedure is performed when crown formation of the third molar is complete with minor amount of root formation. Anyhow eruption of the third molar with favorable inclination is unpredictable. Therefore, uprighting the second molar is advocated when proper biomechanics can be prescribed. The treatment comprises surgical uncovering followed by orthodontic uprighting. Since most of the uprighting springs produce both moment and extrusive force on the impacted molar, success of the treatment requires proper design of the uprighting spring and anchorage preparation to minimize the side effect of the uprighting mechanics on the adjacent teeth.

OP-13 구연

Communication in orthodontic practice (교정임상에서의 커뮤니케이션)

손우성 | 부산대 교정과

병원을 이용하는 환자의 만족도는 의료서비스의 질과 시설, 장비 외에도 의료진의 의사소통 능력에 큰 영향을 받는다. 따라서 환자-치과의사-직원과의 효과적인 커뮤니케이션은 교정치료의 또 다른 핵심 포인트라고 할 수 있을 것이다. 원활한 커뮤니케이션은 보다 정확한 진단을 위해, 시간 절약, 높은 환자 유지율, 환자의 만족을 통한 의료진의 자기 만족, 환자의 치료 동의율과 지시 이행율 증가, 치료 결과의 향상 뿐 아니라 의료소송의 위험을 줄여 준다. 실제 의료분쟁의 과정을 분석해 보면 치료결과에 불만족보다도 평소의 의사소통의 미숙, 특히 고객 불만에 대한 대응이 적절하지 못한 경우가 많은 것을 알 수 있다. 본 발표에서는 효율적인 상담을 위한 방법, 고객의 불만에 대한 잘못된 대응과 적절한 대응, 의료분쟁을 예방하기 위한 커뮤니케이션의 구체적인 원칙, 특히 설명의무에 대하여 정보를 제공하고 의료의 효율성과 질 관리를 추구하는 경영공학인 Clinical Pathway의 개념을 소개하고자 한다.