

Success Rate and Risk Factors Associated with Mini-Implants Reinstalled in the Maxilla

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ABSTRACT

Objective: To determine the difference in the success rate for two types of oral installed mini-implants (OMIs): one type of initially installed OMI and a new implant of the same type that is reinstalled.

Materials and Methods: The subjects consisted of 58 patients (19 male, 39 female; mean age = 21.78 ± 5.85 years) who had received at least one OMI (self-drilling type, conical shape with 2.0-mm upper diameter and 5-mm length) in the attached gingiva of the upper buccal posterior regions for maximum anchorage during en masse retraction. If an OMI failed, a new one was immediately installed in the same area after 4 to 6 weeks or in an adjacent area immediately. The total number of initially installed OMIs (II-OMI) was 109 and the total number of reinstalled OMIs (RI-OMI) was 34. Statistical analysis was performed using χ^2 test, Kaplan-Meier method, log-rank test, and Cox proportional hazards regression model.

Results: The success rate and mean duration were 75.2% and 10.0 months, respectively, for II-OMI and 66.7% and 6.4 months, respectively, for RI-OMI. Age, vertical skeletal pattern, and site and side of implantation were not related to the success rates of II-OMI and RI-OMI. Log-rank test showed that II-OMI in males and Class III malocclusions were more prone to failure. The relative risk of II-OMI failure in Class III malocclusions as opposed to Class I malocclusions was 5.36 (95% confidence interval, 2.008 to 14.31, $P = .001$).

Conclusion: The success rate of the II-OMI was not statistically different from that of the RI-OMI. Sex and ANB angle might be more important factors for better II-OMI results.

KEY WORDS: Success rate; Risk factor; Orthodontic mini-implant; Reinstallation

INTRODUCTION

Recently, there has been a dramatic increase in the use of orthodontic mini-implants (OMIs; also known as

micro screws or mini screws) to allow maximum anchorage, decrease the need for patient compliance, and further simplify the treatment procedure.¹⁻⁵

According to experimental and clinical studies, OMIs can provide sufficient and stable anchorage for orthodontic treatment.^{2,6-10} However, the success rates of OMIs have been reported to range from 37% to 97%.¹¹⁻²² Studies have found that the stability of OMIs is affected by age, sex, craniofacial skeletal pattern, site and side of implantation, latent period, loading protocol, dimension of OMI, angulation of OMI to bone, insertion torque, degree of OMI-bone contact, quality and quantity of the cortical bone, degree of inflammation of the peri-OMI tissue, thickness and mobility of the soft tissue, and root proximity.^{6,14,15,19-21,23-26}

If an OMI fails, there are two options: reinstall a new one in the same area after 4 to 6 weeks or install a new one in an adjacent area immediately.⁵ However, few studies have focused on the fate of the reinstalled OMI (RI-OMI).

To determine objectively the success rate of RI-OMI, it is necessary to confine the sample to the same

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Figure 1. The orthodontic mini-implant used in this study (2005H, ORTHOplant, BioMaterials Korea, Seoul, Korea; self-drilling type, conical shape with 2.0-mm upper diameter, 5-mm length).

type of OMI from one manufacturer with the same implantation protocol and purpose. Also, to determine the risk factors associated with the failure rate, clinical characteristics, including sex, age, craniofacial skeletal pattern, and site and side of implantation, have to be examined. Most OMIs are used in the upper arch for the maximum posterior anchorage during retraction of the upper anterior teeth. Therefore, the purpose of this study was to assess the success rate and the risk factors associated with RI-OMIs placed in the upper buccal attached gingiva (BAG) after initial failure.

MATERIALS AND METHODS

Subjects were 58 patients (19 male, 39 female; mean age = 21.78 ± 5.85 years; range = 12.5 to 42.7 years) who received at least one OMI (2005H, ORTHOplant, Biomaterials Korea, Seoul, South Korea; self-drilling type, conical shape with 2.0-mm upper diameter and 5-mm length, Figure 1) in the upper BAG for the purpose of maximum posterior anchorage during en masse retraction of the upper anterior teeth.

The total number of initially installed OMI (II-OMI) was 109 (37 males, 72 females; 28 young patients (<18 years), 81 adult patients (>18 years); 55 on the right side, 54 on the left side; 1 in the area between the upper first and second premolars (Mx1), 73 between the upper second premolar and first molar (Mx2), and 35 between the upper first and second molars (Mx3); Tables 1 and 2). Craniofacial skeletal variables are listed in Table 3.

OMIs were installed by one operator without a soft-

Table 1. Demographic Data of the Initial Installation of Orthodontic Mini-implants (OMIs)

	Young Patients (<18 years old)		Adult Patients (>18 years old)		Sum	
	No. of Subjects	No. of OMIs	No. of Subjects	No. of OMIs	No. of Subjects	No. of OMIs
	15.07 ± 2.11 years		24.34 ± 4.65 years		21.78 ± 5.85 years	
Male	6	12	13	25	19	37
Female	10	16	29	56	39	72
Sum	16	28	42	81	58	109

Table 2. Number of Orthodontic Mini-implants According to Side and Site of Implantation of the Initial Installation

Side and Site of Implantation ^a	Young Patients (<18 years old)		Adult Patients (>18 years old)		Subtotal		Total
	Right	Left	Right	Left	Right	Left	
	Mx1	0	0	1	0	1	
Mx2	14	11	23	25	37	36	73
Mx3	2	1	15	17	17	18	35
Subtotal	16	12	39	42			
Total	28		81		109		

^a Mx1 indicates area between the upper first and second premolars; Mx2, area between the upper second premolar and first molar; Mx3, area between the upper first and second molars.

Table 3. Definition and Mean and Standard Deviation of the Craniofacial Skeletal Variables

	Subgroup (No. of Patients)		Definition	Mean \pm SD
ANB ($^{\circ}$)	1 (28)	>0, <4	2.31 \pm 1.04	
	2 (18)	>4	6.05 \pm 5.74	
	3 (12)	<0	-3.31 \pm 3.68	
FMA ($^{\circ}$)	1 (13)	<25	19.31 \pm 3.79	
	2 (30)	>25, <35	28.96 \pm 2.95	
	3 (15)	>35	40.05 \pm 5.85	

tissue incision or pilot drilling. They were placed in the BAG just adjacent to the mucogingival junction of MX1, Mx2, and MX3 with a 90 $^{\circ}$ angle to the long axis of the teeth after leveling and alignment.

A 0.0220-in straight wire appliance was used. The orthodontic force of less than 200 g was applied to the OMI 2–3 weeks after placement using elastic chains or nickel-titanium closed-coil springs (medium, 9 mm, Ormco, Glendora, Calif), which stretched from the OMI head to the crimpable hook between the upper lateral incisor and canine in 0.019 \times 0.025-in stainless steel archwire.

The criteria for success of an OMI were absence of inflammation, absence of clinically detectable mobility, and capability of sustaining the anchorage function throughout the course of orthodontic treatment (more than 8 months or until completion of treatment purposes). Failure was defined as mobility or loss of OMI

Table 4. Success Rate of the Initially Installed Orthodontic Mini-implants (OMIs)^a and Reinstalled OMIs

		Initially Installed OMIs			Reinstalled OMIs			
		Success Number	Success Rate	<i>P</i>	Success Number	Success Rate	<i>P</i>	<i>P</i>
Sex	Male	23/37	62.2%	.0235*	11/17	64.7%	.7242	.0344*
	Female	59/72	81.9%		10/17	58.8%		
Age	Young	20/28	71.4%	.5889	7/9	77.8%	.4267	.4057
	Adult	62/81	76.5%		14/25	56.0%		
Site of implantation	Mx1	1/1	100.0%	.5528 [#]	1/1	100.0%	.9481	.1267 [#]
	Mx2	56/73	76.7%		9/15	60.0%		
	Mx3	25/35	71.4%		11/18	61.1%		
Side of implantation	Right	39/57	76.7%	.2917	12/23	52.2%	.1398	.4333
	Left	43/64	67.2%		9/11	81.8%		
ANB	1 [§]	45/51 ^{†††}	88.2%	.0010 ^{**}	4/8	50.0%	.1365	.0000 ^{***}
	2	26/35 [†]	74.3%		5/11	45.5%		
	3 [§]	11/23	47.8%		12/15	80.0%		
FMA	1	19/26	73.1%	.9230	6/8	75.0%	.5665	.8758
	2	42/56	75.0%		10/19	52.6%		
	3	21/27	77.8%		5/7	71.4%		
Area of reimplantation	Same place	—	—	—	13/19	68.4%	.3687	—
	Adjacent place	—	—		8/15	53.3%		
Total		82/109	75.2%	—	21/34	66.7%	—	.1267
Mean and SD (months)			10.03 ± 5.64			6.44 ± 3.69		.0000 ^{***}

^a χ^2 test; Mx1 indicates area between the upper first and second premolars; Mx2, area between the upper second premolar and first molar; Mx3, area between the upper first and second molars.

* $P < .05$; ** $P < .01$; *** $P < .001$; # comparison between Mx2 and Mx3; ††† comparison between subgroup 1 and 3 in initially installed OMI, $P < .001$; †† comparison between subgroup 2 and 3 in initially installed OMI, $P < .05$; § comparison between initially installed OMI and reinstalled OMI in subgroup 1, $P < .01$; § comparison between initially installed OMI and reinstalled OMI in subgroup 3, $P < .05$.

in less than 8 months or before completion of treatment. If the OMI failed, the new one was installed at the same area after 4 to 6 weeks or at the adjacent area of the same side immediately. The total number of RI-OMIs was 34.

The variables were age, sex, ANB angle, FMA angle, site and side of implantation and area of implantation. The success rates of II-OMI and RI-OMI were calculated according to variables. A χ^2 test or Fisher exact test was used to estimate differences in the success rate. Cumulative survivals of the II-OMI and RI-OMI over time were analyzed using the Kaplan-Meier method. Comparison of cumulative survival between groups was performed using the log-rank test. Risk factors affecting survival were assessed by a Cox proportional hazards regression model.

RESULTS

Female patients were more common regardless of the age group (Table 1). The majority of the II-OMIs were placed at Mx2 followed by Mx3. Only one OMI in this series was placed in Mx1 (Table 2). However, Mx3 was advocated less frequently in young patients ($n = 3$) than in adult patients ($n = 32$) ($P < .05$, Table 2).

The success rate for II-OMIs (75.2%) was not statistically different from the success rate for RI-OMIs (66.7%). However, the mean duration of II-OMI use

(10.0 months) was significantly longer than the mean duration of RI-OMI use (6.4 months) ($P < .001$, Table 4).

There was no significant difference in age, side of implantation, and FMA in II-OMI versus RI-OMI. However, in II-OMIs, significantly higher success rates were found for females versus males ($P < .05$) and Class I and II malocclusions versus Class III malocclusions ($P < .01$) (Table 4). On the contrary, in RI-OMIs, significantly higher success rates were found for males versus females ($P < .05$) and Class III malocclusions versus Class I and II malocclusions ($P < .001$) (Table 4). When the success rate for II-OMIs was compared between angle classifications, there was a significant difference between Class I and III malocclusions ($P < .001$) and Class II and III malocclusions ($P < .05$) (Table 4). Compared with the success rate between II-OMIs and RI-OMIs, there was a significant difference in Class I malocclusions ($P < .01$) versus Class III malocclusions ($P < .05$) (Table 4).

The success rates in II-OMIs and RI-OMIs showed a significant difference in sex ($P < .05$) and ANB ($P < .001$) (Table 4). Other variables, such as age and side of implantation, also showed an opposite tendency for II-OMIs versus RI-OMIs, although there was no significant difference (Table 4).

The number of OMIs at Mx1 was too small to com-

Table 5. Distribution of Failure Time of the Initially Installed and Reinstalled Orthodontic Mini-implants (OMIs)

Failure Time (months)	Number	Percentage	Accumulation Percentage	Mean \pm SD of failure time (months)	<i>P</i>
Initially installed OMI					
≤ 1	7	25.93%	25.93%	2.85 \pm 1.90	.0268*
$> 1 \sim \leq 2$	8	29.63%	55.56%		
$> 2 \sim \leq 3$	6	22.22%	77.78%		
$> 3 \sim \leq 4$	0	0%	77.78%		
$> 4 \sim \leq 5$	2	7.41%	85.19%		
$> 5 \sim \leq 6$	2	7.41%	92.59%		
$> 6 \sim \leq 7$	2	7.41%	100.00%		
sum	27	100%			
Reinstalled OMI					
≤ 1	3	13.64	13.64	4.14 \pm 2.03	
$> 1 \sim \leq 2$	3	13.64	27.27		
$> 2 \sim \leq 3$	2	9.09	36.36		
$> 3 \sim \leq 4$	3	13.64	50.00		
$> 4 \sim \leq 5$	6	27.27	77.27		
$> 5 \sim \leq 6$	1	4.55	81.82		
$> 6 \sim \leq 7$	4	18.18	100.00		
sum	22	100.00			

* Independent *t*-test.

pare the success rate according to site of implantation. Therefore, implants at Mx2 and Mx3 were compared. Implants at Mx2 and Mx3 did not show any significant differences for II-OMIs versus RI-OMIs (Table 4). Although II-OMIs had a higher success rate than RI-OMIs, there was no significant difference according to site of implantation (Table 4). Also, there was no difference in the success rate for RI-OMIs between the same place and adjacent places (Table 4).

Although the success rate for RI-OMIs was not significantly different from the success rate for II-OMIs (Table 4), mean failure time was significantly longer for RI-OMIs than for II-OMIs ($P < .05$, Table 5). Most of the II-OMIs were lost within the first 3 months (77.78%) whereas most of the RI-OMIs were lost within 5 months (77.27%; Table 5).

A Kaplan-Meier analysis and log-rank test showed that failure was more likely in II-OMIs in males ($P = .018$; Figure 2) and Class III malocclusions ($P = .037$; Figure 3). The Cox proportional hazards regression model was used to assess the prognostic value of II-OMI failure. The risk ratio for failure of II-OMIs in Class III malocclusion versus Class I malocclusion was 5.36 (95% confidence interval, 2.008 to 14.31; $P = .001$, Table 6). However, neither method revealed any significant difference or a prognostic factor for RI-OMIs.

DISCUSSION

Success Rate

The success rate for II-OMIs in this study (75.2%, Table 4) was lower than that reported in some studies (80 to $\sim 90\%$),^{14,19,20} higher than that reported in another

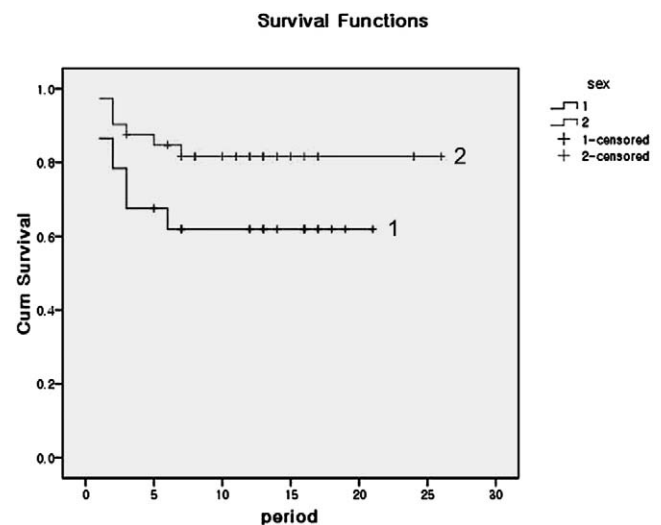


Figure 2. Kaplan-Meier analysis of failure of the initially installed orthodontic mini-implant (OMI) according to sex. Duration of survival was measured from OMI placement to the time of failure (complete) or to the last follow-up or completion of treatment (censored). Cumulative survival for OMIs in females (group 1, blue) was significantly longer than for those in males (group 2, green) ($P = .018$; log-rank test).

er study (37.0%),¹¹ and similar to that reported in yet another (78.6%).¹² The OMI used in this study was the first version of ORTHOplant (2005H, BioMaterials Korea, Seoul), which was self-drilling type and conical shape with 2.0 mm upper diameter and 5 mm length. To increase the success rate, the design was changed to increase the upper diameter to 2.5 mm (model number 2505P).

Although the success rate for II-OMIs was not sta-

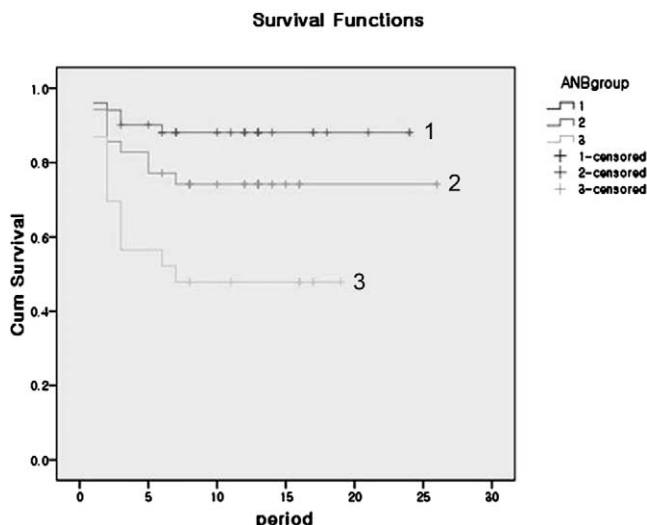


Figure 3. Kaplan-Meier analysis of failure of the initially installed orthodontic mini-implant (OMI) according to ANB group. Duration of survival was measured from OMI placement to the time of failure (complete) or to the last follow-up or completion of treatment (censored). Cumulative survivals for OMIs of Class I malocclusion (group 1, blue, $P = .000$; log-rank test) and Class II malocclusion (group 2, green, $P = .037$; log-rank test) were significantly longer than for Class III malocclusion (group 3, brown).

tistically different from the success rate for RI-OMIs, the success rate for RI-OMIs (66.7%) was lower than that for II-OMIs (75.2%, Table 4). Because the host factors such as age, sex, and craniofacial skeletal pattern were the same, the degree of bone remodeling at the same area and the bone density and thickness of the adjacent area in the same side before reinstallation could affect this difference.

Sex and Success rate

In II-OMIs, the females showed a higher success rate than the males ($P < .05$, Table 4), which did not agree with other results.^{14,19} However, RI-OMIs showed the opposite tendency. The reason for the difference in success rate for females between II-OMIs and RI-OMIs might be attributable to the conical shape of the OMI used in this study, which could produce higher insertion torque than other shapes. In female patients, the lower bone density and/or thin cortical bone, especially in young patients,²⁷ could be com-

pensated for by the higher value of insertion torque in the conical-shaped OMI. However, too strong an insertion torque could induce microfractures around the OMI in the cortical bone and eventually bone remodeling might loosen the OMI.¹⁶

Age and Success Rate

The criteria for age groups in this study was based on the fact that growth has ended in most girls boys at 18 years of age.²⁸ As the boundary for minimum age, Park et al²⁹ used 15 years and Park³⁰ used 20 years. Both studies reported that the older groups had higher success rates. However, the result in this study showed that there was no statistically significant difference in success rates between young (<18 years) and adult (>18 years) patients (Table 4). This is in accord with Miyawaki et al,¹⁴ who stated that there was no significant difference in the success rates of the under 20 age group, the 20 to 30 age group, and the over 30 age group.

Craniofacial Skeletal Pattern and Success Rate

The finding that vertical type (FMA) did not affect the success rate of II-OMIs and RI-OMIs among subgroups (Table 4) does not agree with the results of Miyawaki et al,¹⁴ who stated that patients with high mandibular plane angles were associated with OMI failure because of thin cortical bones. Other factors, such as soft-tissue thickness, oral hygiene, and root proximity, have been cited in the success of OMIs.^{20,31,32}

A striking finding of the present study is that Class III malocclusions showed the least success compared with Class I and II malocclusions in II-OMIs ($P < .01$, Table 4). This means that in Class III patients, the posterior maxilla might have a lower bone density and/or thin cortical bone, narrow BAG, deficient interradi- cular space, and differences in bite force that could affect the success rate. However, there was no statistically significant difference in RI-OMIs. Further study is needed to discover the reason.

Sidedness and Success Rate

There was no significant difference in the success rate between the right and left side (Table 4). This dis-

Table 6. Cox Proportional Hazards Regression Model for Overall Survival in the Initially Installed Orthodontic Mini-implant with Prognostic Factor (ANB)

ANB Group	B	SE	Wald	df	P	Risk Ratio: Exp(B)	95% CI for Exp(B)	
							Lower	Upper
Class I (reference)	—	—	11.741	2	.003	1	—	—
Class II	0.826	.527	2.453	1	.117	2.283	0.813	6.415
Class III	1.679	.501	11.234	1	.001	5.361	2.008	14.310

agrees with the results of Park et al,¹⁹ who reported that the right side had a significantly higher failure rate than the left side.

Site and Success Rate

The site of implantation differs, and the amount of interradicular space, cortical bone thickness and BAG can be changed. Therefore, it is necessary to consider the narrow interradicular space, thin cortical bone, and narrow BAG to prevent the failure of an OMI. In this study, after checking the root proximity, the OMIs were inserted at 90° angles to the long axis of the teeth. The horizontal insertion of the OMI with short length and conical shape could minimize problems such as root damage and/or periodontal ligament injury. In addition, Chen et al¹⁸ insisted that screw length did not influence the outcome of an OMI. With respect to the site of implantation, II-OMIs and RI-OMIs did not reveal any difference in success rate because of the same host factors (Table 4).

Area of Reimplantation and Success Rate

The reason why there was no difference in the success rate of RI-OMIs between the same place and an adjacent place (Table 4) seems to be attributable to the absence of any difference in host factors such as age, sex, skeletal patterns, and side of implantation.

Failure Time

Because more than 77% of II-OMIs failed within first 3 months and more than 77% of RI-OMIs failed within the first 5 months in RI-OMI, the OMIs that withstand more than a 4–6 month period of force application can be considered successful and stable (Table 5). Although the average duration of failure in II-OMIs (2.85 months) was shorter than 3.40 months found by Park et al,¹⁹ the average duration in RI-OMIs (4.14 months) was longer than the duration reported by Park et al.¹⁹

A reason why the mean failure time for RI-OMIs was significantly longer than the failure time for II-OMIs ($P < .05$, Table 5) might be the use of a more cautious procedure during reinstallation and continuous bone remodeling around the OMI.

Survival Analysis

Kaplan-Meier analysis with log-rank test showed that sex and ANB angle had an effect on the failure rates of II-OMI (Figures 2 and 3). The Cox proportional hazards regression model showed that ANB could be a prognostic value of II-OMI failure (Table 6). Therefore, it is necessary to pay attention when installing OMIs in male patients with Class III malocclusion.

CONCLUSIONS

- The success rate of RI-OMIs was not statistically different from that of II-OMIs. Reinstalling the OMI immediately into the adjacent area after failure of the II-OMI will reduce the time lost for OMI usage.
- Age, vertical skeletal pattern, and site and side of implantation were not related to the success rates of II-OMIs and RI-OMIs.
- Sex and ANB might be considered important factors in achieving a better result for the II-OMIs.

REFERENCES

1. Kanomi R. Mini-implant for orthodontic anchorage. *J Clin Orthod.* 1997;31:763–767.
2. Umemori M, Sugawara J, Mitani H, Nagasaka H, Kawamura H. Skeletal anchorage system for open-bite correction. *Am J Orthod Dentofacial Orthop.* 1999;115:166–174.
3. Park HS, Bae SM, Kyung HM, Sung JH. Micro-implant anchorage for treatment of skeletal Class I bialveolar protrusion. *J Clin Orthod.* 2001;35:417–422.
4. Bae SM, Park HS, Kyung HM, Kwon OW, Sung JH. Clinical application of micro-implant anchorage. *J Clin Orthod.* 2002;36:298–302.
5. Baek SH, Moon CH, Sung SJ, et al. *Orthodontic Mini-implant: Various Treatment Strategies and Clinical Application.* Seoul, Korea: Jeeseung Publishing Co; 2007: 216–228.
6. Costa A, Raffaini M, Melsen B. Microscrews as orthodontic anchorage. A preliminary report. *Int J Adult Orthod Orthognath Surg.* 1998;13:201–209.
7. Melsen B, Lang NP. Biological reactions of alveolar bone to orthodontic loading of oral implants. *Clin Oral Implants Res.* 2001;12:144–152.
8. Freudenthaler JW, Haas R, Bantleon HP. Bicortical titanium screws for critical orthodontic anchorage in the mandible: a preliminary report on clinical application. *Clin Oral Implants Res.* 2001;12:358–363.
9. Herman RJ, Currier GF, Miyake A. Mini-implant anchorage for maxillary canine retraction: a pilot study. *Am J Orthod Dentofacial Orthop.* 2006;130:228–235.
10. Thiruvengkatachari B, Pavithranand A, Rajasigamani K, Kyung HM. Comparison and measurement of the amount of anchorage loss of the molars with and without the use of implant anchorage during canine retraction. *Am J Orthod Dentofacial Orthop.* 2006;129:551–554.
11. Kim YH, Choi JH. The study about retention of miniscrews used for intraoral anchorage. *J Korean Dent Assoc.* 2001;39:684–687.
12. Moon CH. The clinical use and failure of skeletal anchorage system. *J Korean Dent Assoc.* 2002;40:68–74.
13. Park HS. Clinical study on success rate of micro-screw implants for orthodontic anchorage. *Korea J Orthod.* 2003;33:151–156.
14. Miyawaki S, Koyama I, Inoue M, Mishima K, Sugahara T, Takano-Yamamoto T. Factors associated with the stability of titanium screw placed in the posterior region for orthodontic anchorage. *Am J Orthod Dentofacial Orthop.* 2003;124:373–378.
15. Cheng SJ, Tseng IY, Lee JJ, Kok SH. A prospective study of the risk factors associated with failure of mini-implants used for orthodontic anchorage. *Int J Oral Maxillofac Implants.* 2004;19:100–106.
16. Motoyoshi M, Hirabayashi M, Uemura M, Shimizu N. Rec-

- ommended placement torque when tightening an orthodontic mini-implant. *Clin Oral Implants Res.* 2006;17:109–114.
17. Tseng YC, Hsieh CH, Chen CH, Shen YS, Huang IY, Chen CM. The application of mini-implants for orthodontic anchorage. *Int J Oral Maxillofac Surg.* 2006;35:704–707.
 18. Chen CH, Chang CS, Hsieh CH, Tseng YC, Shen YS, Huang IY, Yang CF, Chen CM. The use of microimplants in orthodontic anchorage. *J Oral Maxillofac Surg.* 2006;64:1209–1213.
 19. Park HS, Jeong SH, Kwon OW. Factors affecting the clinical success of screw implants used as orthodontic anchorage. *Am J Orthod Dentofacial Orthop.* 2006;130:18–25.
 20. Kuroda S, Sugawara Y, Deguchi T, Kyung HM, Yamamoto TT. Clinical use of miniscrew implants as orthodontic anchorage: success rates and postoperative discomfort. *Am J Orthod Dentofacial Orthop.* 2007;131:9–15.
 21. Motoyoshi M, Matsuoka M, Shimizu N. Application of orthodontic mini-implants in adolescents. *Int J Oral Maxillofac Surg.* 2007;36:695–699.
 22. Wiechmann D, Meyer U, Büchter A. Success rate of mini- and micro-implants used for orthodontic anchorage: a prospective clinical study. *Clin Oral Implants Res.* 2007;18:263–267.
 23. Deguchi T, Takano-Yamamoto T, Kanomi R, Hartsfield JK Jr, Roberts WE, Garetto LP. The use of small titanium screws for orthodontic anchorage. *J Dent Res.* 2003;82:377–381.
 24. Kim JW, Ahn SJ, Chang YI. Histomorphometric and mechanical analyses of the drill-free screw as orthodontic anchorage. *Am J Orthod Dentofacial Orthop.* 2005;128:190–194.
 25. Cho HJ. Clinical applications of mini-implants as orthodontic anchorage and the peri-implant tissue reaction upon loading. *J Calif Dent Assoc.* 2006;34:813–820.
 26. Kuroda S, Yamada K, Deguchi T, Hashimoto T, Kyung HM, Takano-Yamamoto T. Root proximity is a major factor for screw failure in orthodontic anchorage. *Am J Orthod Dentofacial Orthop.* 2007;131(4 suppl):S68–S73.
 27. Dos Reis LM, Batalha JR, Munoz DR, Borelli A, Correa PH, Carvalho AB, Jorgetti V. Brazilian normal static bone histomorphometry: effects of age, sex, and race. *J Bone Miner Metab.* 2007;25:400–406.
 28. Huertas D, Ghafari J. New posteroanterior cephalometric norms: a comparison with craniofacial measures of children treated with palatal expansion. *Angle Orthod.* 2001;71:285–292.
 29. Park YC, Kim JK, Lee JS. *Atlas of Contemporary Orthodontics.* Seoul, Korea: Shin Hung International; 2005: 1–104, 145–161.
 30. Park HS. Clinical study on success rate of microscrew implants for orthodontic anchorage. *Korea J Orthod.* 2003;33:151–156.
 31. Kim HJ, Yun HS, Park HD, Kim DH, Park YC. Soft-tissue and cortical-bone thickness at orthodontic implant sites. *Am J Orthod Dentofacial Orthop.* 2006;130:177–182.
 32. Deguchi T, Nasu M, Murakami K, Yabuuchi T, Kamioka H, Takano-Yamamoto T. Quantitative evaluation of cortical bone thickness with computed tomographic scanning for orthodontic implants. *Am J Orthod Dentofacial Orthop.* 2006;129:721. e7–e12.