Commentary

Early orthodontic treatment and interceptive treatment strategies

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SUMMARY Orthodontics as health care is sometimes at odds with modern marketing with its strong focus on aesthetics. In this commentary, I highlight how important it is that research of orthodontic treatment as a value for the entire community is performed and published.

The paper by Kerosuo et al. (2012) in this issue of the European Journal of Orthodontics has a health care approach to orthodontics that makes interesting reading. In a long term project, a small community has been followed. The treatment approach has been interceptive treatment in close collaboration between trained general practitioners and an orthodontist. The intention has been that everybody should have an opportunity for treatment, not only those who ask for treatment. A requirement is that the general practitioners have to be trained and have a certain volume of treatments for this model to be applicable. The authors show that great results can be attained with this approach. The studies of class II treatment have come to the conclusion that it is beneficial to postpone treatment and do treatment with fixed appliances (Tulloch et al., 2004; Harrison et al., 2007; O’Brien et al., 2009). These studies might lead to the opinion that all early and minor corrective efforts are of no use. Therefore, the present work is important as it shows that good results can be achieved including interceptive treatment strategies. This of course does not have to be contradictory to the results of the cited class II studies as the aims and treated malocclusions are different. The studies of class II treatment also had a small proportion of patients (15%) that did not receive further treatment (O’Brien et al., 2009). It is feasible that a trained dentist has better prerequisites to select these patients.

With regard to the study by Kerosuo et al., as always one could ask for a larger study group. The authors have followed one age group in a small community. The group appears consistent, and the drop-out rate at 20 years of age is acceptable. The treatment rate was high, 54%, but it includes all orthodontic corrections during this time span. Treatment need varies over time and also between populations, but high prevalence are usually found (Thilander et al., 2001; Alhaija et al., 2004; Tausche et al., 2004; Josefsson et al., 2007). In societies where subsidized treatment is offered, the use of index for treatment selection is needed. Another important concern is to ensure best value for money. The presented model appears to fulfill those aims. It is a model that contrasts to the idea that the malocclusion should evolve in full maturation to be clearly visible to the patient. On the other hand, this health care approach has an inherent drawback. The society and its decision-makers seldom see untreated malocclusion and can have difficulties to justify the treatment costs. This is a problem for all health care and of course the cost to society has to be monitored continuously. Kerosuo et al. should be credited for their comprehensive view of orthodontic care.

References


