

Case Report *

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HISTORY OF PATIENT: This patient was a well developed girl of fifteen years who was in good health. She was bottle-fed in infancy, and has had only mild children's diseases to date. No tonsilectomy or adenoidectomy was ever performed. The father's teeth were good although the mother's were poor and very irregular. The child was high strung and nervous with a tendency to twitch and jerk. Her facial musculature was under a state of hypertonicity and her mentalis and buccinator muscles were overactive. In addition she had a faulty swallowing habit.



Fig. 1.—Photographs of patient before treatment.

Case Analysis: The case was considered a Class I bordering on Class III malocclusion due to a slightly overdeveloped mandible. It was characterized by a mesial drift of the buccal segments of both upper and lower arches. The maxillary buccal segments were in lingual occlusion and there was a faulty mesial axial tipping of the maxillary canines. The upper arch mid-line was found to be shifted about one millimeter to the right. The maxillary laterals were in lingual occlusion due to lack of normal intercuspis width. In addition to the mesial drift of the buccal segments, there was overlapping and lingual tipping of the crowns of the incisors and canines in the lower arch and a noticeable flattening in that area. The canine roots were also carried too far labially.

Treatment: All of the teeth were banded and the Edgewise arch mechanism was employed. The arch was expanded in the maxilla and the maxillary molars and premolars were carried distally. Subsequently the canines were

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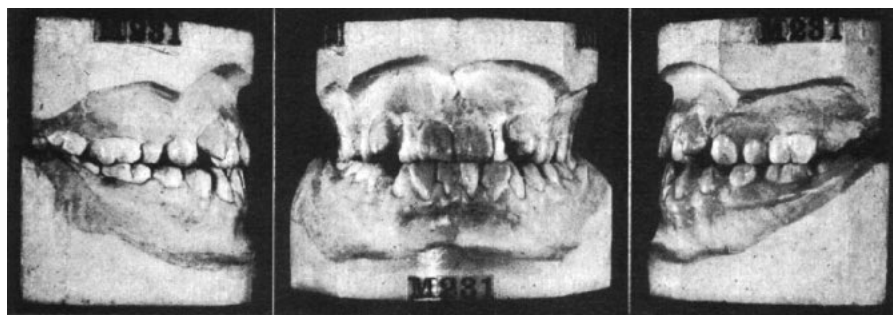


Fig. 2.—Casts of patient before treatment.

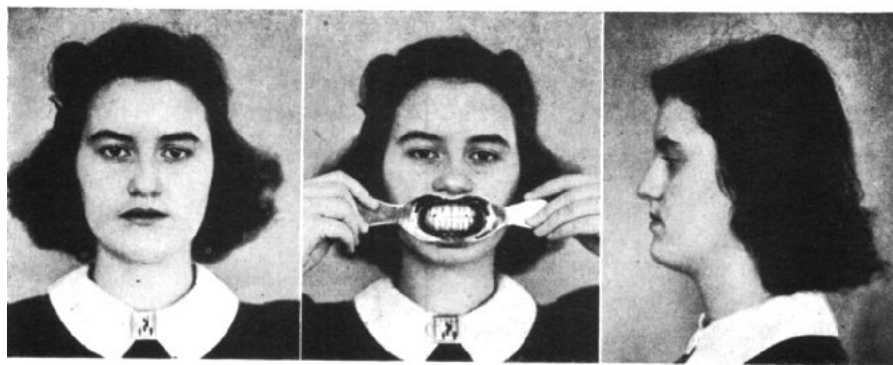


Fig. 3.—Photographs of patient following treatment.

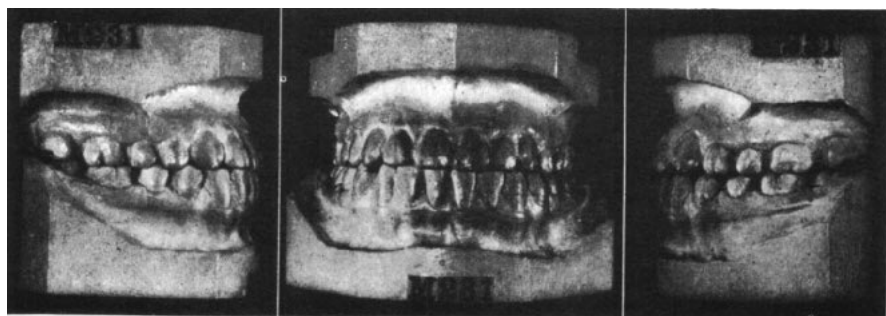


Fig. 4.—Casts of patient following treatment.

moved distally. These distal movements were accomplished by means of vertical loops and coiled springs in conjunction with occipital anchorage and intermaxillary elastics. Passive swallowing exercises were employed. In the mandible a distal movement of the molars and premolars was found necessary as well as a correction of the lingual tipping and rotations of the canines and incisors.

Occipital anchorage was used on both the upper and lower arches to

produce actual tooth movement, reinforce intermaxillary elastics and relieve the strain of the elastics. It was found to be extremely helpful in this case. Two years were required for treatment.

Retention: Hawley plate retainer was used on the upper arch. On the lower arch the cuspids were banded and connected by a lingual wire.

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