

Letters

Impacted canines

I was interested in the Case Report in Volume 65(1) about two girls who had impacted canines. (Turpin DL, Woloshyn H. Two patients with severely displaced maxillary canines respond differently to treatment. 65(1):13-22.) It might interest your readers to know that, as a matter of principal, I expand all undersized arches in the early mixed dentition. I have now been using this procedure for about 25 years and in the whole of this period cannot remember a single incidence of impacted canines, although I have had my usual share of impacted canines in patients first referred at an older age.

Unfortunately, I am not in the position to be able to justify this statement as the records are largely unavailable. Nevertheless, I am quite happy to make the definitive statement that permanent canines will almost never become impacted provided the maxilla is expanded while the child is in the early mixed dentition.

Although proof may be far away, I consider this to be a safe empirical treatment.

John Mew
Surrey, U.K.

Author's response

While your first reaction to the etiology of palatally impacted maxillary canines seems logical and will draw support from many clinicians, it flies in the face of recent findings by Peck et al. (Angle Orthod 1994;64(4):249-256). They found no association between transverse problems and the incidence of palatally displaced canines. According to Peck, "the data almost showed a negative correlation when attempting to relate the lack of adequate maxillary width to the incidence of impactions. For instance, many of the palatally displaced canines were found in very broad palates with no maxillary transverse problems."

Nevertheless, clinical solutions to the vexing problems created by palatally displaced canines

will continue to be in great demand. The more I see in my practice, the more humble I become.

David L. Turpin
Auburn, Wash.

Follow up

I would like to correct your impression that I provide expansion with the specific intention of correcting impacted canines. In the 1930s my father used expansion routinely for any young children who demonstrated a space deficiency. This was common practice in England at the time.

My father died suddenly in 1955 and I took over a practice that was full of expanded patients. I had been taught that expansion always relapsed and was surprised to find that many patients were stable. I spent the next few years trying to establish what caused or prevented stability, and since the early 1960s have routinely treated all young patients who were short of space using a specific rate and degree of expansion, ensuring that the patients were trained to keep their mouths closed afterwards. I have published several papers on the subject which showed that remarkable stability could be achieved in consecutive cases if these routines were followed. However, others have been unable to repeat my results and the general unpopularity of expansion and early treatment at that time prevented any acceptance of these concepts.

John Mew

Correction

The author information for An evaluation of a new spring design for segmented space closure (Angle Orthod 1995;65(3):187-198) contained a typographical error. It should have read:

T.C. Rinaldi, BS Civil Engineering, University of Illinois, 1989; DDS, University of Missouri at Kansas City, 1995; and MS Oral Biology, University of Louisville, 1995.

The Angle Orthodontist regrets the error.