

- **Linking Orthodontics with Periodontal Health**
Linking Orthodontics with Periodontal Health Coordinating with Oral Surgeons for Jaw Corrections Integrating Pediatric Dentistry for Early Intervention Combining Endodontic Care in Complex Cases Collaborative Planning with Prosthodontists Sharing Diagnostic Data Across Multiple Specialists Addressing Aesthetic and Functional Goals Together Communication Strategies Among Dental Teams Balancing Orthodontic Solutions and Restorative Needs Encouraging Holistic Treatment Approaches Managing Patients with Special Medical Conditions Efficient Referrals That Improve Patient Outcomes
- **AI Driven Aligners That Predict Movement**
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- **About Us**



Okay, let's talk about why having all the information – the *whole* picture – is just so crucial when we're dealing with kids and their teeth and jaws. I mean, we're talking about pediatric orthodontics here, and getting it right early can make a world of difference. And a big part of "getting it right" is sharing all that diagnostic data – the X-rays, the models, the photos, the whole shebang – between different specialists.

Think of it like this: you wouldn't want a mechanic to only look at your car's engine when trying to figure out why your brakes are squealing, right? Same thing applies to a child's mouth. Orthodontists specialize in correcting dental irregularities in kids Child-friendly orthodontic solutions thumb sucking. An orthodontist is primarily focused on alignment, but the way teeth fit together, the shape of the jaw, the health of the gums, even breathing patterns – it's all interconnected.

So, when a pediatric orthodontist has access to comprehensive data and *then* shares it with, say, a pediatric dentist, an ENT (ear, nose, and throat doctor), or even a speech therapist, that's when the magic happens. The pediatric dentist might spot early signs of decay that could impact orthodontic treatment. The ENT might identify airway restrictions affecting jaw development. The speech therapist might notice tongue thrusting habits that are throwing off the alignment.

Having all that information available allows everyone involved to develop a truly coordinated and holistic treatment plan. We can address the *root* causes of problems, not just the symptoms. It helps us avoid conflicting treatments, unnecessary procedures, and ultimately leads to better, more stable, and longer-lasting results for the child.

Plus, think about the parents. They want the best for their kids, and they want everyone on the team to be on the same page. Sharing diagnostic data just builds trust and confidence that everyone is working together towards the same goal: a healthy, happy smile and a well-functioning mouth for the child. It's simply the smart, collaborative, and ultimately, the *right* way to approach pediatric orthodontic care.

*** Common periodontal issues in children undergoing orthodontic**

treatment. —

- * The interplay between orthodontic forces and periodontal tissues in young patients.
- * Common periodontal issues in children undergoing orthodontic treatment.
- * Preventive measures to maintain periodontal health during orthodontic treatment.
- * The role of oral hygiene instructions for children and parental involvement.
- * Early detection and management of periodontal problems during orthodontic care.
- * Collaboration between orthodontists and periodontists for optimal outcomes.

Sharing Diagnostic Data Across Multiple Specialists: Current Challenges

Okay, so picture this: you're a patient, right? You've got a thorny health issue, and you're bouncing between a cardiologist for your heart, a neurologist for those weird headaches, and maybe even a rheumatologist because your joints are acting up. Each of these specialists is brilliant in their own field, armed with cutting-edge diagnostic tools and a wealth of knowledge. Great, right? Except...are they actually talking to each other? Are they seeing the *whole* picture, or just their little corner of the puzzle?

That's where the current challenges in sharing patient information between specialists really hit home. We're not living in the paper-chart era anymore, thankfully. Most practices have embraced electronic health records (EHRs). But simply *having* an EHR doesn't magically solve everything. The big problem is often interoperability – or rather, the *lack* thereof. Different systems might not "speak" the same language, making it difficult to seamlessly transfer imaging studies, lab results, or even just basic notes. It's like trying to translate a complex scientific paper without a proper dictionary.

Then there's the issue of privacy and security. We all want our medical information protected, and rightly so. HIPAA is there for a reason. But sometimes, those very regulations, while crucial, can create hurdles. Specialists might be hesitant to share information, fearing they're inadvertently violating a privacy rule, even if it's in the patient's best interest. It adds another layer of complexity.

And let's not forget the human element. Time is precious for everyone, especially busy specialists. Hunting down records, deciphering someone else's notes, and figuring out how to integrate that information into their own workflow can be a real time-suck. It's an extra burden that can unfortunately discourage thorough collaborative efforts.

Finally, access plays a role. Not all specialists are part of the same hospital network or affiliated group. Getting access to records from an outside practice can sometimes feel like pulling teeth. There might be administrative hoops to jump through, faxes to send (yes, faxes still exist in healthcare!), and delays that can impact the speed and quality of care.

So, while we've made strides in medical diagnostics and technology, the simple act of sharing that diagnostic data effectively and efficiently between specialists remains a significant challenge. It's a challenge we need to tackle head-on, because ultimately, it's about ensuring that patients receive the most comprehensive and coordinated care possible.

*** Preventive measures to maintain periodontal health during orthodontic treatment.**

Okay, let's talk about sharing diagnostic data, like x-rays, lab results, and scans, between specialists. It's a real game-changer when it's done right, and a centralized data platform is often the key to making it work smoothly. Think about it: without a central hub, you're relying on faxes, CDs, maybe even just verbal handoffs of critical information. That's slow, prone to errors, and frankly, frustrating for everyone involved, especially the patient.

The beauty of a centralized platform is that it creates a single source of truth. All the diagnostic data, neatly organized and accessible, lives in one place. Specialist A, looking at a patient's MRI, can instantly see the results of Specialist B's blood work. No more waiting, no more chasing down reports, just instant access to the full picture.

This has huge benefits for collaborative care. It empowers specialists to make more informed decisions, faster. They can spot potential interactions between medications, identify subtle changes over time, and ultimately, develop a more comprehensive and effective treatment plan. It also facilitates better communication. Instead of playing phone tag, specialists can review the same data together, discuss nuances, and arrive at a shared understanding of the patient's condition.

Beyond efficiency and accuracy, a centralized platform can also significantly improve the patient experience. Imagine not having to retell your medical history to every new doctor, or not having to undergo the same tests multiple times because the results are lost in the shuffle. A centralized system reduces redundancy, minimizes delays, and empowers patients to feel more confident in their care.

Of course, security and privacy are paramount. Any centralized platform needs robust safeguards to protect sensitive patient data. But when done responsibly, the benefits of sharing diagnostic data across multiple specialists through a centralized system are undeniable. It's about creating a more connected, coordinated, and ultimately, more effective healthcare system for everyone.

*** The role of oral hygiene instructions for children and parental involvement.**

Okay, so we're talking about sharing diagnostic data between doctors, right? And the thing is, what one specialist considers vital might be totally different from what another one focuses on. It's not like everyone's looking at the same picture. So, what kind of diagnostic records are we *actually* talking about that are relevant to, say, a cardiologist *and* a rheumatologist?

Think about it. Imaging is huge. X-rays, MRIs, CT scans – they're almost universally useful. A cardiologist might be looking at the heart's structure and function, while a rheumatologist might be scrutinizing the same images for signs of inflammation in the joints or potential complications arising from autoimmune diseases affecting the heart. Then you've got lab tests. Blood counts, inflammatory markers, genetic tests... these can tell a story that resonates across multiple specialties. Elevated inflammatory markers, for example, could signal a heart condition or an autoimmune flare-up. Genetic predispositions for certain conditions, like familial hypercholesterolemia or specific types of arthritis, are obviously relevant to both.

Beyond that, there are more specialized tests that become important depending on the specific clinical scenario. An echocardiogram, primarily used by cardiologists, could reveal clues about systemic diseases that affect the heart muscle. Conversely, a muscle biopsy, typically within the realm of

rheumatology or neurology, might offer valuable insights into cardiac conditions linked to muscular dystrophies or inflammatory myopathies.

Electrocardiograms (EKGs) are pretty universally useful, too. While obviously key for cardiologists, the patterns on an EKG might flag up electrolyte imbalances or other systemic issues that are relevant to, say, an endocrinologist managing diabetes. And don't forget the patient's history! A detailed account of symptoms, past illnesses, and family history is often the most crucial diagnostic record of all, providing context for all the other tests and guiding specialists toward the right diagnoses, regardless of their individual areas of expertise. Because at the end of the day, it's all about piecing together the puzzle to see the whole picture of the patient.

*** Early detection and management of periodontal problems during orthodontic care.**

Sharing diagnostic data between specialists shouldn't feel like navigating a bureaucratic maze. Imagine a scenario: a patient needs input from a cardiologist, neurologist, and endocrinologist. Each specialist runs their own tests, generating valuable data. But if this data is trapped in different systems, speaking different "languages," the process becomes clunky and inefficient. That's where streamlining comes in.

Think of interoperability as the universal translator. It's the ability of different systems – different electronic health records, imaging software, lab databases – to seamlessly exchange and use information. Standards are the common grammar and vocabulary that enable this translation. They ensure that everyone understands the data in the same way, regardless of the system that generated it.

By embracing interoperability and adhering to established standards, we can break down data silos. Specialists can access a comprehensive view of the patient's diagnostic history, leading to more informed decisions, reduced redundancy in testing (saving time and money!), and ultimately, better patient care. It means the cardiologist can easily review the neurologist's MRI results, and the endocrinologist can understand the cardiologist's EKG findings, all without having to request and manually review paper reports.

This isn't just about technology; it's about improving collaboration and communication among healthcare professionals. It's about putting the patient at the center and empowering clinicians with the information they need to provide the best possible care. Streamlining data sharing through interoperability and standards is essential for a more efficient, effective, and patient-centered healthcare system.

*** Collaboration between orthodontists and periodontists for optimal outcomes.**

Okay, let's talk about something that's genuinely exciting in the world of medicine: how sharing diagnostic data between specialists can actually lead to better outcomes for patients. Think of it as a team effort, where everyone's got a piece of the puzzle, but only by putting those pieces together do you get the full picture. And that full picture? That's what leads to improved outcomes.

We've all heard horror stories, or maybe even experienced them ourselves, where a doctor only sees a tiny fraction of the information. They might focus on one specific test, or one particular symptom, without realizing it's connected to something else entirely. Now, imagine a scenario where a radiologist's report, a cardiologist's findings, and a neurologist's observations are all instantly available to each other. Suddenly, patterns emerge. Subtle clues become glaringly obvious. The 'aha!' moment becomes more frequent.

These "aha!" moments are the foundation for case studies highlighting improved outcomes through shared diagnostic insights. Consider a patient presenting with seemingly unrelated symptoms: fatigue, dizziness, and intermittent chest pain. Individually, these could point to a dozen different conditions. But by sharing the data – perhaps an abnormal EKG reading alongside an MRI showing subtle neurological changes – specialists can collaboratively identify a rare autoimmune disorder affecting both the heart and nervous system. This faster, more accurate diagnosis allows for earlier intervention and significantly improves the patient's prognosis.

These aren't just hypothetical situations; they're real-world examples of how breaking down the silos in healthcare can revolutionize patient care. The key is creating systems and protocols that facilitate secure, efficient, and standardized data sharing. It's about making it easier for specialists to connect the dots, to build a complete and accurate picture of the patient's health. The result? Fewer diagnostic delays, more personalized treatment plans, and, ultimately, better lives for the patients we serve. The beauty of sharing diagnostic data is that it amplifies the expertise of each specialist, creating a collective intelligence that's far greater than the sum of its parts. And that's something worth getting excited about.

Sharing diagnostic data between specialists sounds like a no-brainer, right? More eyes, better insights, faster diagnosis – everyone wins! But before we start flinging around sensitive patient information like confetti, we *have* to talk about privacy and security. It's not just a legal requirement, it's about respecting the people behind the data.

Think about it. That MRI scan, those lab results, that doctor's note – that's incredibly personal stuff. We need to make sure it's only being seen by the people who *need* to see it, and that it's being protected from prying eyes, whether those eyes belong to malicious hackers or just someone who's a bit too curious.

So how do we do that? Well, for starters, we need strong encryption. Basically, scrambling the data so that if it *does* fall into the wrong hands, it's just gibberish. We also need strict access controls, meaning

only authorized specialists can access the data, and maybe even only specific parts of it. Think need-to-know basis, like a super secret mission.

And then there's the human element. Training for everyone involved is crucial. They need to understand the importance of privacy, the potential consequences of a breach, and how to use the security systems properly. It's like teaching them how to handle fragile glass – carefully and with respect.

Finally, we need to be transparent with patients. Let them know *why* their data is being shared, *who* it's being shared with, and give them the option to opt-out if they're not comfortable. It's about building trust and empowering them to be in control of their own health information. Because at the end of the day, it's *their* data, and we need to treat it with the care and respect it deserves. Sharing diagnostic data can do a world of good, but only if we prioritize privacy and security every step of the way.

Future Directions: AI and Machine Learning in Diagnostic Data Integration. Sharing Diagnostic Data Across Multiple Specialists

Imagine a future where your entire medical history, all those scans, lab results, and doctor's notes, are seamlessly and securely accessible to every specialist involved in your care. No more fax machines, no more frantic calls chasing down reports. That's the promise of integrated diagnostic data, and AI and machine learning are poised to make that promise a reality.

Right now, sharing diagnostic data across specialists can be a real headache. Information silos are everywhere. A cardiologist might not have easy access to the detailed neurological assessment that a neurologist performed, even though both impact the patient's overall health. This lack of integration can lead to delayed diagnoses, redundant testing, and even conflicting treatment plans. It wastes time, costs money, and, most importantly, can negatively impact patient outcomes.

AI offers some exciting solutions. Machine learning algorithms can be trained to identify relevant information within vast datasets of diagnostic data. Think about it: a machine learning model could sift through hundreds of pages of medical records, highlighting key findings from different specialists that might be relevant to a new consult. This would drastically reduce the burden on the specialist, allowing them to focus on interpreting the data and making informed decisions.

Furthermore, AI can play a crucial role in standardizing data formats. Different hospitals and labs often use different systems and terminologies, making it difficult to share data seamlessly. AI can help

translate and harmonize this data, ensuring that information is consistent and understandable, regardless of its source. Imagine an AI-powered "translator" that automatically converts data from one format to another, paving the way for truly interoperable systems.

The future also holds the potential for AI to proactively identify potential problems based on integrated diagnostic data. By analyzing patterns and correlations across multiple specialists' findings, AI could flag subtle indicators of disease that might otherwise be missed, leading to earlier and more effective interventions.

Of course, there are challenges to overcome. We need to address concerns about data privacy and security, ensuring that patient information is protected. We also need to ensure that AI algorithms are fair and unbiased, avoiding perpetuation of existing health disparities. And perhaps most importantly, we need to build trust in these technologies, demonstrating their accuracy and reliability to both clinicians and patients.

Despite these challenges, the potential benefits of AI and machine learning in diagnostic data integration are immense. By breaking down data silos and empowering specialists with comprehensive, readily accessible information, we can create a healthcare system that is more efficient, more effective, and ultimately, more patient-centered. The future of diagnostic data sharing is bright, and AI is the key to unlocking its full potential.

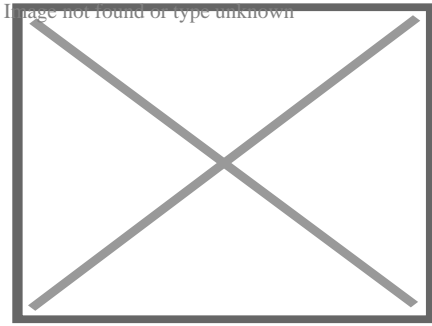
About dental caries

Redirect to:

- Tooth decay
- **From a page move:** This is a redirect from a page that has been moved (renamed). This page was kept as a redirect to avoid breaking links, both internal and external, that may have been made to the old page name.

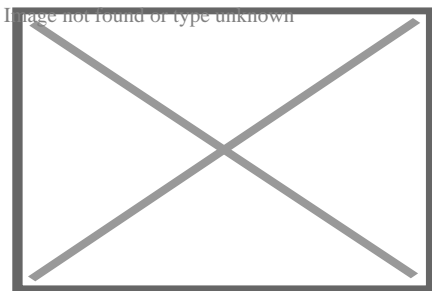
About thumb sucking

For other uses, see Thumbsucker (disambiguation).



Infants may use pacifiers or their thumb or fingers to soothe themselves

Newborn baby thumb sucking



A bonnet macaque thumb sucking

Thumb sucking is a behavior found in humans, chimpanzees, captive ring-tailed lemurs,^[1] and other primates.^[2] It usually involves placing the thumb into the mouth and rhythmically repeating sucking contact for a prolonged duration. It can also be accomplished with any organ within reach (such as other fingers and toes) and is considered to be soothing and therapeutic for the person. As a child develops the habit, it will usually develop a "favourite" finger to suck on.

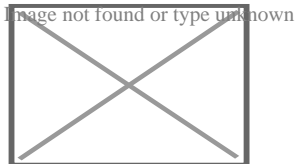
At birth, a baby will reflexively suck any object placed in its mouth; this is the sucking reflex responsible for breastfeeding. From the first time they engage in nutritive feeding, infants learn that the habit can not only provide valuable nourishment, but also a great deal of pleasure, comfort, and warmth. Whether from a mother, bottle, or pacifier, this behavior, over time, begins to become associated with a very strong, self-soothing, and pleasurable oral sensation. As the child grows older, and is eventually weaned off the nutritional sucking, they can either develop alternative means for receiving those same feelings of physical and emotional fulfillment, or they can continue experiencing those pleasantly soothing experiences by beginning to suck their thumbs or fingers.^[3] This reflex disappears at about 4 months of age; thumb sucking is not purely an instinctive behavior and therefore can last much longer.^[4] Moreover, ultrasound scans have revealed that thumb sucking can start before birth, as early as 15 weeks from conception; whether this behavior is voluntary or due to random movements of the fetus in the womb is not conclusively known.

Thumb sucking generally stops by the age of 4 years. Some older children will retain the habit, which can cause severe dental problems.^[5] While most dentists would recommend breaking the habit as early as possible, it has been shown that as long as the habit is broken

before the onset of permanent teeth, at around 5 years old, the damage is reversible. [6] Thumb sucking is sometimes retained into adulthood and may be due to simply habit continuation. Using anatomical and neurophysiological data a study has found that sucking the thumb is said to stimulate receptors within the brain which cause the release of mental and physical tension. [7]

Dental problems and prevention

[edit]



Alveolar prognathism, caused by thumb sucking and tongue thrusting in a 7-year-old girl.

Percentage of children who suck their thumbs (data from two researchers)

Age	Kantorowicz ^[4]	Brückl ^[8]
0–1	92%	
1–2	93%	66%
2–3	87%	—
3–4	86%	
4–5	85%	25%
5–6	76%	
Over 6	—	9%

Most children stop sucking on thumbs, pacifiers or other objects on their own between 2 and 4 years of age. No harm is done to their teeth or jaws until permanent teeth start to erupt. The only time it might cause concern is if it goes on beyond 6 to 8 years of age. At this time, it may affect the shape of the oral cavity or dentition. [9] During thumbsucking the tongue sits in a lowered position and so no longer balances the forces from the buccal group of musculature. This results in narrowing of the upper arch and a posterior crossbite. Thumbsucking can also cause the maxillary central incisors to tip labially and the mandibular incisors to tip lingually, resulting in an increased overjet and anterior open bite malocclusion, as the thumb rests on them during the course of sucking. In addition to proclination of the maxillary incisors, mandibular incisors retrusion will also happen. Transverse maxillary deficiency gives rise to posterior crossbite, ultimately leading to a Class II malocclusion. [10]

Children may experience difficulty in swallowing and speech patterns due to the adverse changes. Aside from the damaging physical aspects of thumb sucking, there are also additional risks, which unfortunately, are present at all ages. These include increased risk of infection from communicable diseases, due to the simple fact that non-sterile thumbs are covered with infectious agents, as well as many social implications. Some children experience social difficulties, as often children are taunted by their peers for engaging in what they can consider to be an “immature” habit. This taunting often results the child being rejected by the group or being subjected to ridicule by their peers, which can cause understandable psychological stress.[¹¹]

Methods to stop sucking habits are divided into 2 categories: Preventive Therapy and Appliance Therapy.[¹⁰]

Examples to prevent their children from sucking their thumbs include the use of bitterants or piquant substances on their child's hands—although this is not a procedure encouraged by the American Dental Association[⁹] or the Association of Pediatric Dentists. Some suggest that positive reinforcements or calendar rewards be given to encourage the child to stop sucking their thumb.

The American Dental Association recommends:

- Praise children for not sucking, instead of scolding them when they do.
- If a child is sucking their thumb when feeling insecure or needing comfort, focus instead on correcting the cause of the anxiety and provide comfort to your child.
- If a child is sucking on their thumb because of boredom, try getting the child's attention with a fun activity.
- Involve older children in the selection of a means to cease thumb sucking.
- The pediatric dentist can offer encouragement to the child and explain what could happen to the child's teeth if he/she does not stop sucking.
- Only if these tips are ineffective, remind the child of the habit by bandaging the thumb or putting a sock/glove on the hand at night.
- Other orthodontics[¹²] for appliances are available.

The British Orthodontic Society recommends the same advice as ADA.[¹³]

A Cochrane review was conducted to review the effectiveness of a variety of clinical interventions for stopping thumb-sucking. The study showed that orthodontic appliances and psychological interventions (positive and negative reinforcement) were successful at preventing thumb sucking in both the short and long term, compared to no treatment.[¹⁴]
Psychological interventions such as habit reversal training and decoupling have also proven useful in body focused repetitive behaviors.[¹⁵]

Clinical studies have shown that appliances such as TGuards can be 90% effective in breaking the thumb or finger sucking habit. Rather than use bitterants or piquants, which are not endorsed by the ADA due to their causing of discomfort or pain, TGuards break the habit

simply by removing the suction responsible for generating the feelings of comfort and nurture. [16] Other appliances are available, such as fabric thumb guards, each having their own benefits and features depending on the child's age, willpower and motivation. Fixed intraoral appliances have been known to create problems during eating as children when removing their appliances may have a risk of breaking them. Children with mental illness may have reduced compliance.[10]

Some studies mention the use of extra-oral habit reminder appliance to treat thumb sucking. An alarm is triggered when the child tries to suck the thumb to stop the child from this habit. [10][17] However, more studies are required to prove the effectiveness of external devices on thumb sucking.

Children's books

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- In Heinrich Hoffmann's *Struwwelpeter*, the "thumb-sucker" Konrad is punished by having both of his thumbs cut off.
- There are several children's books on the market with the intention to help the child break the habit of thumb sucking. Most of them provide a story the child can relate to and some coping strategies.[18] Experts recommend to use only books in which the topic of thumb sucking is shown in a positive and respectful way.[19]

See also

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- Stereotypic movement disorder
- Prognathism

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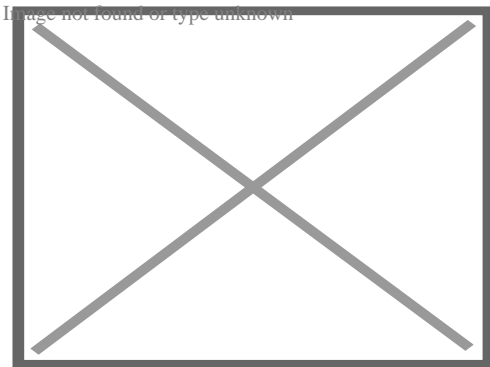
External links

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- "Pacifiers & Thumb Sucking". Canadian Dental Association.

About orthodontics

Orthodontics



Connecting the arch-wire on brackets with wire

Occupation

Names Orthodontist

Occupation type Specialty

Activity sectors Dentistry

Description

Education required Dental degree, specialty training

Fields of employment Private practices, hospitals

Orthodontics^{[a][b]} is a dentistry specialty that addresses the diagnosis, prevention, management, and correction of mal-positioned teeth and jaws, as well as misaligned bite patterns.^[2] It may also address the modification of facial growth, known as **dentofacial orthopedics**.

Abnormal alignment of the teeth and jaws is very common. The approximate worldwide prevalence of malocclusion was as high as 56%.^[3] However, conclusive scientific evidence for the health benefits of orthodontic treatment is lacking, although patients with completed treatment have reported a higher quality of life than that of untreated patients undergoing orthodontic treatment.^{[4][5]} The main reason for the prevalence of these malocclusions is diets with less fresh fruit and vegetables and overall softer foods in childhood, causing smaller jaws with less room for the teeth to erupt.^[6] Treatment may require several months to a few years and entails using dental braces and other appliances to gradually adjust tooth position and jaw alignment. In cases where the malocclusion is severe, jaw surgery may be incorporated into the treatment plan. Treatment usually begins before a person reaches adulthood, insofar as pre-adult bones may be adjusted more easily before adulthood.

History

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Though it was rare until the Industrial Revolution,^[7] there is evidence of the issue of overcrowded, irregular, and protruding teeth afflicting individuals. Evidence from Greek and Etruscan materials suggests that attempts to treat this disorder date back to 1000 BC, showcasing primitive yet impressively well-crafted orthodontic appliances. In the 18th and 19th centuries, a range of devices for the "regulation" of teeth were described by various dentistry authors who occasionally put them into practice.^[8] As a modern science, orthodontics dates back to the mid-1800s.^[9] The field's influential contributors include Norman William Kingsley^[9] (1829–1913) and Edward Angle^[10] (1855–1930). Angle created the first basic system for classifying malocclusions, a system that remains in use today.^[9]

Beginning in the mid-1800s, Norman Kingsley published *Oral Deformities*, which is now credited as one of the first works to begin systematically documenting orthodontics. Being a major presence in American dentistry during the latter half of the 19th century, not only was Kingsley one of the early users of extraoral force to correct protruding teeth, but he was also one of the pioneers for treating cleft palates and associated issues. During the era of orthodontics under Kingsley and his colleagues, the treatment was focused on straightening teeth and creating facial harmony. Ignoring occlusal relationships, it was typical to remove teeth for a variety of dental issues, such as malalignment or overcrowding. The concept of an intact dentition was not widely appreciated in those days, making bite correlations seem irrelevant.^[8]

In the late 1800s, the concept of occlusion was essential for creating reliable prosthetic replacement teeth. This idea was further refined and ultimately applied in various ways when

dealing with healthy dental structures as well. As these concepts of prosthetic occlusion progressed, it became an invaluable tool for dentistry.^[8]

It was in 1890 that the work and impact of Dr. Edwards H. Angle began to be felt, with his contribution to modern orthodontics particularly noteworthy. Initially focused on prosthodontics, he taught in Pennsylvania and Minnesota before directing his attention towards dental occlusion and the treatments needed to maintain it as a normal condition, thus becoming known as the "father of modern orthodontics".^[8]

By the beginning of the 20th century, orthodontics had become more than just the straightening of crooked teeth. The concept of ideal occlusion, as postulated by Angle and incorporated into a classification system, enabled a shift towards treating malocclusion, which is any deviation from normal occlusion.^[8] Having a full set of teeth on both arches was highly sought after in orthodontic treatment due to the need for exact relationships between them. Extraction as an orthodontic procedure was heavily opposed by Angle and those who followed him. As occlusion became the key priority, facial proportions and aesthetics were neglected. To achieve ideal occlusals without using external forces, Angle postulated that having perfect occlusion was the best way to gain optimum facial aesthetics.^[8]

With the passing of time, it became quite evident that even an exceptional occlusion was not suitable when considered from an aesthetic point of view. Not only were there issues related to aesthetics, but it usually proved impossible to keep a precise occlusal relationship achieved by forcing teeth together over extended durations with the use of robust elastics, something Angle and his students had previously suggested. Charles Tweed^[11] in America and Raymond Begg^[12] in Australia (who both studied under Angle) re-introduced dentistry extraction into orthodontics during the 1940s and 1950s so they could improve facial esthetics while also ensuring better stability concerning occlusal relationships.^[13]

In the postwar period, cephalometric radiography^[14] started to be used by orthodontists for measuring changes in tooth and jaw position caused by growth and treatment.^[15] The x-rays showed that many Class II and III malocclusions were due to improper jaw relations as opposed to misaligned teeth. It became evident that orthodontic therapy could adjust mandibular development, leading to the formation of functional jaw orthopedics in Europe and extraoral force measures in the US. These days, both functional appliances and extraoral devices are applied around the globe with the aim of amending growth patterns and forms. Consequently, pursuing true, or at least improved, jaw relationships had become the main objective of treatment by the mid-20th century.^[8]

At the beginning of the twentieth century, orthodontics was in need of an upgrade. The American Journal of Orthodontics was created for this purpose in 1915; before it, there were no scientific objectives to follow, nor any precise classification system and brackets that lacked features.^[16]

Until the mid-1970s, braces were made by wrapping metal around each tooth.^[9] With advancements in adhesives, it became possible to instead bond metal brackets to the teeth.^[9]

In 1972, Lawrence F. Andrews gave an insightful definition of the ideal occlusion in permanent teeth. This has had meaningful effects on orthodontic treatments that are administered regularly,^[16] and these are: 1. Correct interarchal relationships 2. Correct crown angulation (tip) 3. Correct crown inclination (torque) 4. No rotations 5. Tight contact points 6. Flat Curve of Spee (0.0–2.5 mm),^[17] and based on these principles, he discovered a treatment system called the straight-wire appliance system, or the pre-adjusted edgewise system. Introduced in 1976, Larry Andrews' pre-adjusted edgewise appliance, more commonly known as the straight wire appliance, has since revolutionized fixed orthodontic treatment. The advantage of the design lies in its bracket and archwire combination, which requires only minimal wire bending from the orthodontist or clinician. It's aptly named after this feature: the angle of the slot and thickness of the bracket base ultimately determine where each tooth is situated with little need for extra manipulation.^{[18][19][20]}

Prior to the invention of a straight wire appliance, orthodontists were utilizing a non-programmed standard edgewise fixed appliance system, or Begg's pin and tube system. Both of these systems employed identical brackets for each tooth and necessitated the bending of an archwire in three planes for locating teeth in their desired positions, with these bends dictating ultimate placements.^[18]

Evolution of the current orthodontic appliances

[edit]

When it comes to orthodontic appliances, they are divided into two types: removable and fixed. Removable appliances can be taken on and off by the patient as required. On the other hand, fixed appliances cannot be taken off as they remain bonded to the teeth during treatment.

Fixed appliances

[edit]

Fixed orthodontic appliances are predominantly derived from the edgewise appliance approach, which typically begins with round wires before transitioning to rectangular archwires for improving tooth alignment. These rectangular wires promote precision in the positioning of teeth following initial treatment. In contrast to the Begg appliance, which was based solely on round wires and auxiliary springs, the Tip-Edge system emerged in the early 21st century. This innovative technology allowed for the utilization of rectangular archwires to precisely control tooth movement during the finishing stages after initial treatment with round wires.

Thus, almost all modern fixed appliances can be considered variations on this edgewise appliance system.

Early 20th-century orthodontist Edward Angle made a major contribution to the world of dentistry. He created four distinct appliance systems that have been used as the basis for many orthodontic treatments today, barring a few exceptions. They are E-arch, pin and tube, ribbon arch, and edgewise systems.

E-arch

[edit]

Edward H. Angle made a significant contribution to the dental field when he released the 7th edition of his book in 1907, which outlined his theories and detailed his technique. This approach was founded upon the iconic "E-Arch" or 'the-arch' shape as well as inter-maxillary elastics.^[21] This device was different from any other appliance of its period as it featured a rigid framework to which teeth could be tied effectively in order to recreate an arch form that followed pre-defined dimensions.^[22] Molars were fitted with braces, and a powerful labial archwire was positioned around the arch. The wire ended in a thread, and to move it forward, an adjustable nut was used, which allowed for an increase in circumference. By ligation, each individual tooth was attached to this expansive archwire.^[8]

Pin and tube appliance

[edit]

Due to its limited range of motion, Angle was unable to achieve precise tooth positioning with an E-arch. In order to bypass this issue, he started using bands on other teeth combined with a vertical tube for each individual tooth. These tubes held a soldered pin, which could be repositioned at each appointment in order to move them in place.^[8] Dubbed the "bone-growing appliance", this contraption was theorized to encourage healthier bone growth due to its potential for transferring force directly to the roots.^[23] However, implementing it proved troublesome in reality.

Ribbon arch

[edit]

Realizing that the pin and tube appliance was not easy to control, Angle developed a better option, the ribbon arch, which was much simpler to use. Most of its components were already prepared by the manufacturer, so it was significantly easier to manage than before. In order to

attach the ribbon arch, the occlusal area of the bracket was opened. Brackets were only added to eight incisors and mandibular canines, as it would be impossible to insert the arch into both horizontal molar tubes and the vertical brackets of adjacent premolars. This lack of understanding posed a considerable challenge to dental professionals; they were unable to make corrections to an excessive Spee curve in bicuspid teeth.^[24] Despite the complexity of the situation, it was necessary for practitioners to find a resolution. Unparalleled to its counterparts, what made the ribbon arch instantly popular was that its archwire had remarkable spring qualities and could be utilized to accurately align teeth that were misaligned. However, a major drawback of this device was its inability to effectively control root position since it did not have enough resilience to generate the torque movements required for setting roots in their new place.^[8]

Edgewise appliance

[edit]

In an effort to rectify the issues with the ribbon arch, Angle shifted the orientation of its slot from vertical, instead making it horizontal. In addition, he swapped out the wire and replaced it with a precious metal wire that was rotated by 90 degrees in relation—henceforth known as Edgewise.^[25] Following extensive trials, it was concluded that dimensions of 22 × 28 mils were optimal for obtaining excellent control over crown and root positioning across all three planes of space.^[26] After debuting in 1928, this appliance quickly became one of the mainstays for multibanded fixed therapy, although ribbon arches continued to be utilized for another decade or so beyond this point too.^[8]

Labiolingual

[edit]

Prior to Angle, the idea of fitting attachments on individual teeth had not been thought of, and in his lifetime, his concern for precisely positioning each tooth was not highly appraised. In addition to using fingersprings for repositioning teeth with a range of removable devices, two main appliance systems were very popular in the early part of the 20th century. Labiolingual appliances use bands on the first molars joined with heavy lingual and labial archwires affixed with soldered fingersprings to shift single teeth.

Twin wire

[edit]

Utilizing bands around both incisors and molars, a twin-wire appliance was designed to provide alignment between these teeth. Constructed with two 10-mil steel archwires, its delicate features were safeguarded by lengthy tubes stretching from molars towards canines. Despite its efforts, it had limited capacity for movement without further modifications, rendering it obsolete in modern orthodontic practice.

Begg's Appliance

[edit]

Returning to Australia in the 1920s, the renowned orthodontist, Raymond Begg, applied his knowledge of ribbon arch appliances, which he had learned from the Angle School. On top of this, Begg recognized that extracting teeth was sometimes vital for successful outcomes and sought to modify the ribbon arch appliance to provide more control when dealing with root positioning. In the late 1930s, Begg developed his adaptation of the appliance, which took three forms. Firstly, a high-strength 16-mil round stainless steel wire replaced the original precious metal ribbon arch. Secondly, he kept the same ribbon arch bracket but inverted it so that it pointed toward the gums instead of away from them. Lastly, auxiliary springs were added to control root movement. This resulted in what would come to be known as the Begg Appliance. With this design, friction was decreased since contact between wire and bracket was minimal, and binding was minimized due to tipping and uprighting being used for anchorage control, which lessened contact angles between wires and corners of the bracket.

Tip-Edge System

[edit]

Begg's influence is still seen in modern appliances, such as Tip-Edge brackets. This type of bracket incorporates a rectangular slot cutaway on one side to allow for crown tipping with no incisal deflection of an archwire, allowing teeth to be tipped during space closure and then uprighted through auxiliary springs or even a rectangular wire for torque purposes in finishing. At the initial stages of treatment, small-diameter steel archwires should be used when working with Tip-Edge brackets.

Contemporary edgewise systems

[edit]

Throughout time, there has been a shift in which appliances are favored by dentists. In particular, during the 1960s, when it was introduced, the Begg appliance gained wide popularity due to its efficiency compared to edgewise appliances of that era; it could produce the same results with less investment on the dentist's part. Nevertheless, since then, there have been advances in technology and sophistication in edgewise appliances, which led to

the opposite conclusion: nowadays, edgewise appliances are more efficient than the Begg appliance, thus explaining why it is commonly used.

Automatic rotational control

[edit]

At the beginning, Angle attached eyelets to the edges of archwires so that they could be held with ligatures and help manage rotations. Now, however, no extra ligature is needed due to either twin brackets or single brackets that have added wings touching underneath the wire (Lewis or Lang brackets). Both types of brackets simplify the process of obtaining moments that control movements along a particular plane of space.

Alteration in bracket slot dimensions

[edit]

In modern dentistry, two types of edgewise appliances exist: the 18- and 22-slot varieties. While these appliances are used differently, the introduction of a 20-slot device with more precise features has been considered but not pursued yet.^[27]

Straight-wire bracket prescriptions

[edit]

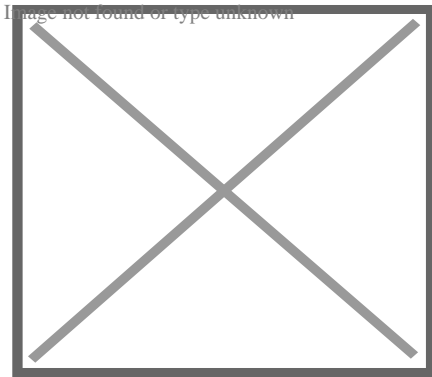
Rather than rely on the same bracket for all teeth, L.F. Andrews found a way to make different brackets for each tooth in the 1980s, thanks to the increased convenience of bonding.^[28] This adjustment enabled him to avoid having multiple bends in archwires that would have been needed to make up for variations in tooth anatomy. Ultimately, this led to what was termed a "straight-wire appliance" system – an edgewise appliance that greatly enhanced its efficiency.^[29] The modern edgewise appliance has slightly different construction than the original one. Instead of relying on faciolingual bends to accommodate variations among teeth, each bracket has a correspondingly varying base thickness depending on the tooth it is intended for. However, due to individual differences between teeth, this does not completely eliminate the need for compensating bends.^[30] Accurately placing the roots of many teeth requires angling brackets in relation to the long axis of the tooth. Traditionally, this mesiodistal root positioning necessitated using second-order, or tip, bends along the archwire. However, angling the bracket or bracket slot eliminates this need for bends.

Given the discrepancies in inclination of facial surfaces across individual teeth, placing a twist, otherwise known as third-order or torque bends, into segments of each rectangular archwire was initially required with the edgewise appliance. These bends were necessary for all patients and wires, not just to avoid any unintentional movement of suitably placed teeth or

when moving roots facially or lingually. Angulation of either brackets or slots can minimize the need for second-order or tip bends on archwires. Contemporary edgewise appliances come with brackets designed to adjust for any facial inclinations, thereby eliminating or reducing any third-order bends. These brackets already have angulation and torque values built in so that each rectangular archwire can be contorted to form a custom fit without inadvertently shifting any correctly positioned teeth. Without bracket angulation and torque, second-order or tip bends would still be required on each patient's archwire.

Methods

[edit]



Upper and lower jaw functional expanders

A typical treatment for incorrectly positioned teeth (malocclusion) takes from one to two years, with braces being adjusted every four to 10 weeks by orthodontists,^[31] while university-trained dental specialists are versed in the prevention, diagnosis, and treatment of dental and facial irregularities. Orthodontists offer a wide range of treatment options to straighten crooked teeth, fix irregular bites, and align the jaws correctly.^[32] There are many ways to adjust malocclusion. In growing patients, there are more options to treat skeletal discrepancies, either by promoting or restricting growth using functional appliances, orthodontic headgear, or a reverse pull facemask. Most orthodontic work begins in the early permanent dentition stage before skeletal growth is completed. If skeletal growth has completed, jaw surgery is an option. Sometimes teeth are extracted to aid the orthodontic treatment (teeth are extracted in about half of all the cases, most commonly the premolars).^[33]

Orthodontic therapy may include the use of fixed or removable appliances. Most orthodontic therapy is delivered using appliances that are fixed in place,^[34] for example, braces that are adhesively bonded to the teeth. Fixed appliances may provide greater mechanical control of the teeth; optimal treatment outcomes are improved by using fixed appliances.

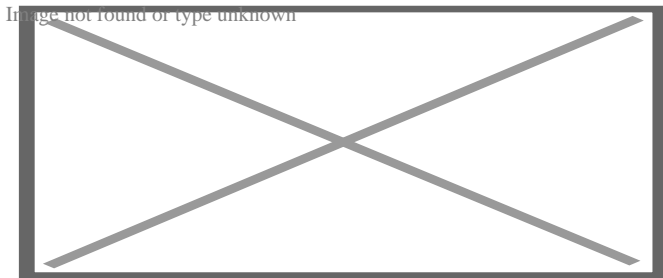
Fixed appliances may be used, for example, to rotate teeth if they do not fit the arch shape of the other teeth in the mouth, to adjust multiple teeth to different places, to change the tooth angle of teeth, or to change the position of a tooth's root. This treatment course is not preferred where a patient has poor oral hygiene, as decalcification, tooth decay, or other

complications may result. If a patient is unmotivated (insofar as treatment takes several months and requires commitment to oral hygiene), or if malocclusions are mild.

The biology of tooth movement and how advances in gene therapy and molecular biology technology may shape the future of orthodontic treatment. [35]

Braces

[edit]



Dental braces

Braces are usually placed on the front side of the teeth, but they may also be placed on the side facing the tongue (called lingual braces). Brackets made out of stainless steel or porcelain are bonded to the center of the teeth using an adhesive. Wires are placed in a slot in the brackets, which allows for controlled movement in all three dimensions.

Apart from wires, forces can be applied using elastic bands, [36] and springs may be used to push teeth apart or to close a gap. Several teeth may be tied together with ligatures, and different kinds of hooks can be placed to allow for connecting an elastic band. [37][36]

Clear aligners are an alternative to braces, but insufficient evidence exists to determine their effectiveness. [38]

Treatment duration

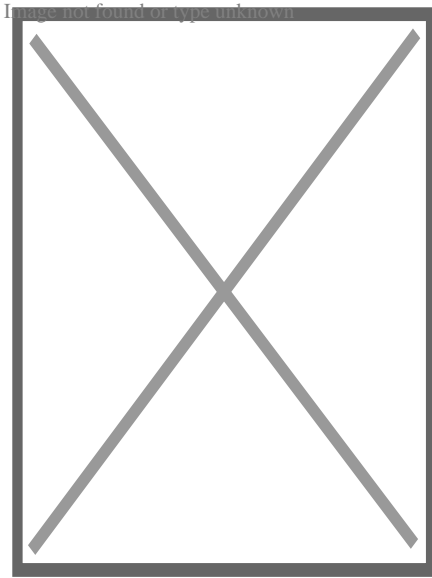
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The time required for braces varies from person to person as it depends on the severity of the problem, the amount of room available, the distance the teeth must travel, the health of the teeth, gums, and supporting bone, and how closely the patient follows instructions. On average, however, once the braces are put on, they usually remain in place for one to three years. After braces are removed, most patients will need to wear a retainer all the time for the first six months, then only during sleep for many years. [39]

Headgear

[edit]

Orthodontic headgear, sometimes referred to as an "extra-oral appliance", is a treatment approach that requires the patient to have a device strapped onto their head to help correct malocclusion—typically used when the teeth do not align properly. Headgear is most often used along with braces or other orthodontic appliances. While braces correct the position of teeth, orthodontic headgear—which, as the name suggests, is worn on or strapped onto the patient's head—is most often added to orthodontic treatment to help alter the alignment of the jaw, although there are some situations in which such an appliance can help move teeth, particularly molars.



Full orthodontic headgear with headcap, fitting straps, facebow, and elastics

Whatever the purpose, orthodontic headgear works by exerting tension on the braces via hooks, a facebow, coils, elastic bands, metal orthodontic bands, and other attachable appliances directly into the patient's mouth. It is most effective for children and teenagers because their jaws are still developing and can be easily manipulated. (If an adult is fitted with headgear, it is usually to help correct the position of teeth that have shifted after other teeth have been extracted.) Thus, headgear is typically used to treat a number of jaw alignment or bite problems, such as overbite and underbite.^[40]

Palatal expansion

[edit]

Palatal expansion can be best achieved using a fixed tissue-borne appliance. Removable appliances can push teeth outward but are less effective at maxillary sutural expansion. The

effects of a removable expander may look the same as they push teeth outward, but they should not be confused with actually expanding the palate. Proper palate expansion can create more space for teeth as well as improve both oral and nasal airflow.^[41]

Jaw surgery

[edit]

Jaw surgery may be required to fix severe malocclusions.^[42] The bone is broken during surgery and stabilized with titanium (or bioresorbable) plates and screws to allow for healing to take place.^[43] After surgery, regular orthodontic treatment is used to move the teeth into their final position.^[44]

During treatment

[edit]

To reduce pain during the orthodontic treatment, low-level laser therapy (LLLT), vibratory devices, chewing adjuncts, brainwave music, or cognitive behavioral therapy can be used. However, the supporting evidence is of low quality, and the results are inconclusive.^[45]

Post treatment

[edit]

After orthodontic treatment has been completed, there is a tendency for teeth to return, or relapse, back to their pre-treatment positions. Over 50% of patients have some reversion to pre-treatment positions within 10 years following treatment.^[46] To prevent relapse, the majority of patients will be offered a retainer once treatment has been completed and will benefit from wearing their retainers. Retainers can be either fixed or removable.

Removable retainers

[edit]

Removable retainers are made from clear plastic, and they are custom-fitted for the patient's mouth. It has a tight fit and holds all of the teeth in position. There are many types of brands for clear retainers, including Zendura Retainer, Essix Retainer, and Vivera Retainer.^[47] A Hawley retainer is also a removable orthodontic appliance made from a combination of plastic and metal that is custom-molded to fit the patient's mouth. Removable retainers will be worn for different periods of time, depending on the patient's need to stabilize the dentition.^[48]

Fixed retainers

[edit]

Fixed retainers are a simple wire fixed to the tongue-facing part of the incisors using dental adhesive and can be specifically useful to prevent rotation in incisors. Other types of fixed retainers can include labial or lingual braces, with brackets fixed to the teeth. ^[48]

Palatal expander

○

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Palatal expander
Orthodontic headgear

○

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Orthodontic headgear
An X-ray taken for skull analysis

○

Image not found or type unknown

An X-ray taken for skull
analysis
Top (left) and bottom retainers

○

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Top (left) and bottom retainers

Clear aligners

[edit]

Clear aligners are another form of orthodontics commonly used today, involving removable plastic trays. There has been controversy about the effectiveness of aligners such as Invisalign or Byte; some consider them to be faster and more freeing than the alternatives. ^[49]

Training

[edit]

There are several specialty areas in dentistry, but the specialty of orthodontics was the first to be recognized within dentistry.^[50] Specifically, the American Dental Association recognized orthodontics as a specialty in the 1950s.^[50] Each country has its own system for training and registering orthodontic specialists.

Australia

[edit]

In Australia, to obtain an accredited three-year full-time university degree in orthodontics, one will need to be a qualified dentist (complete an AHPRA-registered general dental degree) with a minimum of two years of clinical experience. There are several universities in Australia that offer orthodontic programs: the University of Adelaide, the University of Melbourne, the University of Sydney, the University of Queensland, the University of Western Australia, and the University of Otago.^[51] Orthodontic courses are accredited by the Australian Dental Council and reviewed by the Australian Society of Orthodontists (ASO). Prospective

applicants should obtain information from the relevant institution before applying for admission.^[52] After completing a degree in orthodontics, specialists are required to be registered with the Australian Health Practitioner Regulation Agency (AHPRA) in order to practice.^{[53][54]}

Bangladesh

[edit]

Dhaka Dental College in Bangladesh is one of the many schools recognized by the Bangladesh Medical and Dental Council (BM&DC) that offer post-graduation orthodontic courses.^{[55][56]} Before applying to any post-graduation training courses, an applicant must have completed the Bachelor of Dental Surgery (BDS) examination from any dental college. ^[55] After application, the applicant must take an admissions test held by the specific college. ^[55] If successful, selected candidates undergo training for six months.^[57]

Canada

[edit]

In Canada, obtaining a dental degree, such as a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD), would be required before being accepted by a school for orthodontic training.^[58] Currently, there are 10 schools in the country offering the orthodontic specialty. ^[58] Candidates should contact the individual school directly to obtain the most recent pre-requisites before entry.^[58] The Canadian Dental Association expects orthodontists to complete at least two years of post-doctoral, specialty training in orthodontics in an accredited program after graduating from their dental degree.

United States

[edit]

Similar to Canada, there are several colleges and universities in the United States that offer orthodontic programs. Every school has a different enrollment process, but every applicant is required to have graduated with a DDS or DMD from an accredited dental school.^{[59][60]} Entrance into an accredited orthodontics program is extremely competitive and begins by passing a national or state licensing exam.^[61]

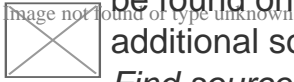
The program generally lasts for two to three years, and by the final year, graduates are required to complete the written American Board of Orthodontics (ABO) exam.^[61] This exam is also broken down into two components: a written exam and a clinical exam.^[61] The written exam is a comprehensive exam that tests for the applicant's knowledge of basic sciences and clinical concepts.^[61] The clinical exam, however, consists of a Board Case Oral Examination

(BCOE), a Case Report Examination (CRE), and a Case Report Oral Examination (CROE).^[61] Once certified, certification must then be renewed every ten years.^[61] Orthodontic programs can award a Master of Science degree, a Doctor of Science degree, or a Doctor of Philosophy degree, depending on the school and individual research requirements.^[62]

United Kingdom

[edit]

This section **relies largely or entirely on a single source**. Relevant discussion may be found on the talk page. Please help improve this article by introducing citations to additional sources.



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Throughout the United Kingdom, there are several Orthodontic Specialty Training Registrar posts available.^[63] The program is full-time for three years, and upon completion, trainees graduate with a degree at the Masters or Doctorate level.^[63] Training may take place within hospital departments that are linked to recognized dental schools.^[63] Obtaining a Certificate of Completion of Specialty Training (CCST) allows an orthodontic specialist to be registered under the General Dental Council (GDC).^[63] An orthodontic specialist can provide care within a primary care setting, but to work at a hospital as an orthodontic consultant, higher-level training is further required as a post-CCST trainee.^[63] To work within a university setting as an academic consultant, completing research toward obtaining a Ph.D. is also required.^[63]

See also

[edit]

- Orthodontic technology
- Orthodontic indices
- List of orthodontic functional appliances
- Molar distalization
- Mouth breathing
- Obligate nasal breathing

Notes

[edit]

- [^] Also referred to as *orthodontia*
- [^] "Orthodontics" comes from the Greek *orthos* ('correct, straight') and *-odont-* ('tooth').^[1]

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Orthodontics

Diagnosis

- Bolton analysis
- Cephalometric analysis
- Cephalometry
- Dentition analysis
- Failure of eruption of teeth
- Little's Irregularity Index
- Malocclusion
- Scissor bite
- Standard anatomical position
- Tooth ankylosis
- Tongue thrust

Conditions

- Overbite
- Overjet
- Open bite
- Crossbite
- Dental crowding
- Dental spacing
- Bimaxillary Protrusion
- Prognathism
- Retrognathism
- Maxillary hypoplasia
- Condylar hyperplasia
- Overeruption
- Mouth breathing
- Temporomandibular dysfunction

Appliances

- ACCO appliance
- Archwire
- Activator appliance
- Braces
- Damon system
- Elastics
- Frankel appliance
- Invisalign
- Lingual arch
- Lip bumper
- Herbst Appliance
- List of orthodontic functional appliances
- List of palatal expanders
- Lingual braces
- Headgear
- Orthodontic technology
- Orthodontic spacer
- Palatal lift prosthesis
- Palatal expander
- Quad helix
- Retainer
- SureSmile
- Self-ligating braces
- Splint activator
- Twin Block Appliance

Procedures

- Anchorage (orthodontics)
- Cantilever mechanics
- Fiberotomy
- Interproximal reduction
- Intrusion (orthodontics)
- Molar distalization
- SARPE
- Serial extraction

Materials

- Beta-titanium
- Nickel titanium
- Stainless steel
- TiMolium
- Elgiloy
- Ceramic
- Composite
- Dental elastics

- Edward Angle
- Spencer Atkinson
- Clifford Ballard
- Raymond Begg
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Organizations

- American Association of Orthodontists
- American Board of Orthodontics
- British Orthodontic Society
- Canadian Association of Orthodontists
- Indian Orthodontic Society
- Italian Academy of Orthodontic Technology
- Society for Orthodontic Dental Technology (Germany)

Journals

- American Journal of Orthodontics and Dentofacial Orthopedics
- The Angle Orthodontist
- Journal of Orthodontics

Institution

- Angle School of Orthodontia

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Dentistry

Specialties

- Endodontics
- Oral and maxillofacial pathology
- Oral and maxillofacial radiology
- Oral and maxillofacial surgery
- Orthodontics and dentofacial orthopedics
- Pediatric dentistry
- Periodontics
- Prosthodontics
- Dental public health
- Cosmetic dentistry
- Dental implantology
- Geriatric dentistry
- Restorative dentistry
- Forensic odontology
- Dental traumatology
- Holistic dentistry

Dental surgery

- Dental extraction
- Tooth filling
- Root canal therapy
- Root end surgery
- Scaling and root planing
- Teeth cleaning
- Dental bonding
- Tooth polishing
- Tooth bleaching
- Socket preservation
- Dental implant

Organisations

- American Association of Orthodontists
- British Dental Association
- British Dental Health Foundation
- British Orthodontic Society
- Canadian Association of Orthodontists
- Dental Technologists Association
- General Dental Council
- Indian Dental Association
- National Health Service

By country

- Canada
- Philippines
- Israel
- United Kingdom
- United States

See also

- Index of oral health and dental articles
- Outline of dentistry and oral health
- Dental fear
- Dental instruments
- Dental material
- History of dental treatments
 - Ancient Rome
- Infant oral mutilation
- Mouth assessment
- Oral hygiene

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Cleft lip and cleft palate

Related specialities

- Advance practice nursing
- Audiology
- Dentistry
- Dietetics
- Genetics
- Oral and maxillofacial surgery
- Orthodontics
- Orthodontic technology
- Otolaryngology
- Pediatrics
- Pediatric dentistry
- Physician
- Plastic surgery
- Psychiatry
- Psychology
- Respiratory therapy
- Social work
- Speech and language therapy

Related syndromes

- Hearing loss with craniofacial syndromes
- Pierre Robin syndrome
- Popliteal pterygium syndrome
- Van der Woude syndrome

National and international organisations

- Cleft Lip and Palate Association
- Craniofacial Society of Great Britain and Ireland
- Interplast
- North Thames Regional Cleft Lip and Palate Service
- Operation Smile
- Overseas Plastic Surgery Appeal
- Shriners Hospitals for Children
- Smile Train
- Transforming Faces Worldwide
- Smile Angel Foundation (China)

- Germany
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