Patients with malocclusions associated with developing skeletal discrepancies: Making false promises.

Sir,

It is not uncommon for dental practitioners to see adolescent patients in whom there is either a developing or established malocclusion associated with a significant underlying skeletal discrepancy. This may result in any combination of a marked Class II or III incisor relationship, significant facial asymmetry, and/or problems in the vertical dimension leading to a deep overbite or anterior open bite. These conditions may prompt the practitioner, quite rightly, to refer the patient to a specialist orthodontist or directly to the consultant led hospital service for advice and/or treatment. In some cases, orthognathic treatment, combining orthodontics with orthognathic surgery, may be included in the treatment considerations, leading to onward referral to a hospital multidisciplinary team (MDT).

At the multidisciplinary clinic, the team must weigh up all the treatment options and whether or not the various approaches would satisfy the patient's motivations and expectations. Fundamental to this process is a consideration of the risks and benefits associated with each approach before putting these to the patient.

Unfortunately, it is our experience that an increasing number of patients are being referred where there are significant risks of providing orthodontic treatment (for example poor oral health), or surgery (for example, adverse soft tissue factors and/or potential for relapse) or where there are unproven health benefits (e.g. correction of speech problems or TMJ disorders) and these concerns mean that acceptance for this form of treatment cannot be justified. Explaining this to patients who have been told, or even promised, by previous clinicians that they need orthognathic treatment once they have stopped growing in order to satisfactorily treat their problem, can and does lead to extremely distressing situations for all concerned.

Whilst some patients will accept the decision, a significant number become distraught or aggressive, citing previous clinician's promises as the basis for these feelings. Patient complaints are increasing and of serious concern.

Good communication with patients and their parents is paramount at every patient contact and sometimes we fail to appreciate how simple comments or suggestions can have long-lasting effects on patients. It is our belief that clinicians should be reminded that, when faced with these clinical problems, carefully worded advice to patients is vital – patients and parents can be advised that orthognathic treatment is a potential treatment option but should be advised that no decision can be made as to the appropriateness of this until the patient has been fully assessed by the MDT and on no-account should promises for future treatment be made. Of course what patients and parents might hear from a consultation may differ from what clinicians have actually said; so it is important to emphasise that no future treatment is guaranteed at this stage.

Whilst forming only part of the overall diagnosis and assessment of patients, referring general practitioners and specialists may find the Index of Orthognathic Functional Treatment Need (Ireland et al. 2014) helpful when considering whether to refer a patient for consideration for treatment. This is based on a risk/benefit analysis and operates in a similar way to the Index of Orthodontic Treatment Need (IOTN) with which referrers will already be familiar.

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Ref: An index of orthognathic functional treatment need (IOFTN).

Ireland AJ, Cunningham SJ, Petrie A, Cobourne MT, Acharya P, Sandy JR, Hunt NP.

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