DifferentialPremolar (4s/5s)

- Upper 4s and lower 5s -
allow correction of Class II molars

- Upper 5s and lower 4s -
allow correction of Class III
molars

- Asymmetrical extraction of 4s
and 5s -
allow to correct centrelines

First Molars (6s)

Often done due to poor prognosis of these teeth in the long term due to gross caries, heavily restored.

-Prolongs the orthodontic treatment (can double the treatment time)

-Prognosis !?patient compliance with long fixed appliance treatment is poor

LOWER ARCH

- Achieving a good occlusion is more dependent upon the timing of the FPM extraction. Lower FPM should only be extracted when bifurcations of the lower permanent second molar starts to calcify, usually at the age of 8½ – 9½ year

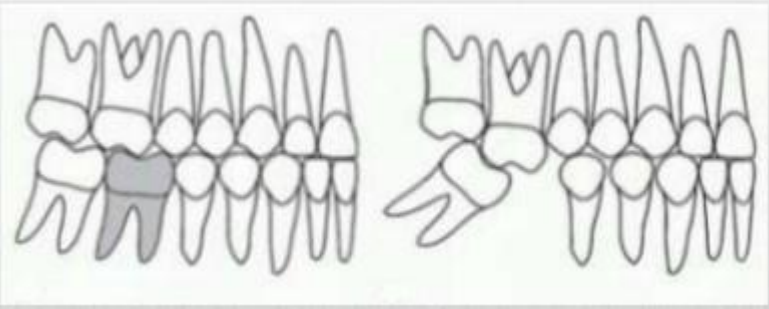
The loss of only a lower first permanent molar after the eruption of the lower second permanent molar (> 8 years) may result in :

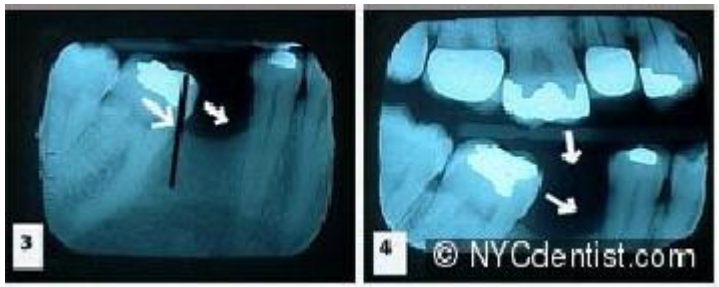
(A) Severe mesial tipping of the lower second permanent molar

(B) Supra-eruption / over eruption of the upper first molar.

permanent molar

(C) Migration or distal tipping of the lower second premolar.





“Compensating Extractions”

- Used with 6s
- When you extract a lower 6 you will extract the upper 6 to stop it over erupting and compromising the occlusion
- When you extract (upper 6) you do not necessarily extract a lower 6 (unless it is poor prognosis) as the lower 6 will not over erupt
- You do not need to balance 6s extractions

Upper Incisors (1s and 2s)

- Rarely chosen due to poor aesthetics
- Poor prognosis due to severe trauma or perio support
- Root resorptionof lateral or central incisors due to ectopic canines
- Developmental malformations: dilaceration, dens in dente,fusion/gemination, macrodont

Lower Incisors (1s or 2s)

- Easy to relieve crowding in cases where the buccal segments are Class I but there is lower incisor crowding
- Useful in adult patients as it is a small space to close who are Class III and want to retract LLS
- Main disadvantage is that crowding re-appears around the remaining incisors and it increases the overbite
- Must have a bonded retainer afterwards

Canines (3s)

- Important teeth as the cornerstone of the arch and needed in canine guidance
- Severely ectopic tooth unsuitable for exposure and bonding or autotransplantation
- Good lateral incisor to first premolar contact in achieved with fixed appliances
- First premolar can be masked as a canine through its rotation with the appliance

Second Molars (7s)

- Rarely the tooth of choice due to its position so far posteriorly
- Aid distal movement of the upper buccal segments
- Relief of very mild lower premolar crowding
- Provides additional space for third molars to avoid their impaction -no guarantee they will erupt!

3rd molar

Guidance

1.1 The practice of prophylactic removal of pathology-free impacted third molars should be discontinued in the NHS.

1.2 The standard routine programme of dental care by dental practitioners and/or paraprofessional staff, need be no different, in general, for pathology free impacted third molars (those requiring no additional investigations or procedures).

1.3 Surgical removal of impacted third molars should be limited to patients with evidence of pathology. Such pathology includes unrestorable caries, non-treatable pulpal and/or periapical pathology, cellulitis, abscess and osteomyelitis, internal/external resorption of the tooth or adjacent teeth, fracture of tooth, disease of follicle including cyst/tumour, tooth/teeth impeding surgery or reconstructive jaw surgery, and when a tooth is involved in or within the field of tumour resection.

Specific attention is drawn to plaque formation and pericoronitis. Plaque formation is a risk factor but is not in itself an indication for surgery. The degree to which the severity or recurrence rate of pericoronitis should influence the decision for surgical removal of a third molar remains unclear. The evidence suggests that a first episode of pericoronitis, unless particularly severe, should not be considered an indication for surgery. Second or subsequent episodes should be considered the appropriate indication for surgery.

NonExtraction Cases

- Very mild cases of crowding
- Will involve arch expansion or arch lengthening to accommodate all the teeth
- Shorter treatment times (if fixed appliance treatment only)
- Often used in Class II/2 cases or in combination with functional appliances
- No guarantee it will be orthodontically stable!