COMPROMISE TREATMENT*

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ABOUT two years ago, I gave a paper before this society on the subject of "Compromise Treatment."† Some of the most interesting cases under treatment at that time, have since been completed, and it might be of interest to you to know just what results have been accomplished.

I believe that compromise treatment should always be used conservatively. Not every case of missing teeth, either congenitally or by accident or disease, will profit by this method, and judgment and discretion are needed to determine just what cases can successfully undergo this form of treatment. Generally speaking, compromise treatment should be advocated only during the years of greatest bone development, especially if much destruction and building of bone is necessary.

Substitution for missing teeth has long been a source of study, but I will venture to say, that if the case is taken early enough, compromise treatment offers the most effective solution to the problem. In the case of missing teeth, congenitally or otherwise, the natural procedure would be to move the remaining teeth back to their normal positions, which would be absolutely correct from the standpoint of normal mesiodistal relation of the teeth, but what advantage is there in having the teeth in normal mesiodistal relation and supplying the missing tooth with one of porcelain, causing mutilation of the teeth on either side of the space and future trouble. What orthodontic treatment really means in cases of this sort, is, I think, not always a normal mesiodistal relation, but the conservation of sound, live tooth tissue. It is either a case of normal occlusion with artificial restoration, or a compromise occlusion without mutilation and artificial substitutes. By this form of treatment, missing teeth can be provided for, and give, it seems to me, as good and often a better appearance than any substitute that might be supplied in the space opened to the normal tooth size, and in many cases the operation would be simpler, provided the conditions were the same. In the case of a child, you can readily see that it would almost be out of the question to successfully place an artificial tooth in a space opened to the required size, for the pulps of the teeth are large as a rule and should we wish to make restoration for the missing one, the substitute must be so constructed that it will not endanger the life of the other teeth. Temporary replacement would be the only solution to the problem. By compromising, we can avoid this difficulty, and it is one reason why I am so strongly in favor of this treatment for missing teeth. It would not be so difficult to successfully replace a missing tooth with a substitute, if we could do it ourselves, for we know

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what we want and what the results must eventually be so far as the physiologic tooth movement and occlusion are concerned. The general practitioner and crown and bridge man also have their ideas, and occasionally disagreements arise and we do not get exactly what we want. If, however, we are to follow some fixed rule, as has been the custom with a great many men in our specialty, we can, of course, resort only to the placing of some sort of artificial substitute.

The illustrations I showed at another meeting were of cases that had not progressed to the stage where you would have any inkling of what I consider a successful compromise. Some of these cases have since been completed and I shall show you in the accompanying illustrations, the results which have been accomplished.

Fig. 3.

Fig. 4.

CASE 1.—This case (Figs. 1 and 2) has a lateral missing upon the left side, caused by an accident some three months before this model was made. Nature was trying to put the teeth in approximal contact and the space left by the tooth was closing. As the patient was only eleven years old, do you think it would have been good policy to have regained the space? The ideal conservation and compromise is shown in the next picture.

CASE 2.—The next slide shows a congenitally missing lateral upon the right side (Fig. 3). The model shows the upper right posterior teeth just one cusp

mesial to the normal and the upper anterior teeth in labioversion. To have tried to place the molars in their normal mesiodistal relation would have required the moving of the right upper posterior teeth distally and that seemed to me unnecessary and an impractical way of treating the case especially as the lateral would have had to have been replaced. Fig. 4 will show the completed case. The canine has not made the very best lateral, but is it not better than a porcelain one? I am sure it will be more serviceable than any substitute that could have been used.

CASE 3.—We have here a case of congenitally missing laterals on each side. The radiogram showed no teeth in process. (Fig. 5.) This was a hard case to treat as one may imagine, for I believe that the teeth should be moved singly

Fig. 5.

Fig. 6.

and bodily. The left canine being in torsion and having a very large root was especially obstinate to treatment. By carrying out my ideas I finally attained the results that are shown in Fig. 6. Some may not believe that this is the plan that should have been followed, but to the conservative mind it will not fall short of ideal results, for I know of no other treatment that would have produced any better.

CASE 4.—In this case (Fig. 7) you will notice that the canines are missing. History gives us the extraction of these teeth when they came in labial to the rest of the teeth. The facial deformity can well be imagined. The young man was nineteen at the time of the application of the appliances, but before I had

finished the case he enlisted for service. The model in Fig. 8 was taken on the day before he left. In the treatment of this case, I proceeded as if it were a regular mesioclusal type. The results I was striving for are plainly shown in the second model of this case.

CASE 5.—Fig. 9 shows the second upper premolars missing on both sides.

Fig. 7.

Fig. 8.

Fig. 9-A.

Fig. 9-B.

Fig. 10.

At the time the first model was made, the patient was only ten years old and I decided that it would be most advantageous from all viewpoints, to move all of the upper teeth forward by intermaxillary elastics, rather than leave the first molars in their normal mesiodistal relation and open the space for the missing

Fig. 11.

Fig. 12.

Fig. 13.

Fig. 14.

teeth. Fig. 10 shows the teeth in approximal contact, but not in as good occlusion as they are at the present time. At the time the last model was made, the teeth had not developed fully and consequently the force of the inclined

planes had not had an opportunity to act. At the time I last saw the patient I noticed a great improvement over this model.

CASE 6.—When the first molars have been lost by disease, if the patient is within the age of bone development, it behooves us to put the second molar in the place of the missing first molar (Fig. 11). It is so easy a matter to place the second molar in approximation with the second premolar in the treatment of cases that I see no reason for retaining the space. The second molar occludes very nicely in the place of the first molar, and when the third molar erupts, I believe it will be a better and a stronger tooth than it might otherwise have been. In fact, after a little while, I doubt very much whether the change will be noticed. This case needed considerable more treatment and Fig. 12 shows what has been accomplished.

CASE 7.—The case that is now shown has a missing premolar upon the right side. The left upper teeth were all one cusp mesial to the normal. The right is also somewhat mesial, but not, in this particular case, the desired distance. The upper teeth on the left, from central to second molar, were moved distally into normal occlusion, after the third molar was extracted, and after the supernumerary was (x) moved, the right half of the upper teeth were moved mesial enough to put all of the teeth in approximal contact. This seems to me logical and I believe I have produced a nice set of teeth without mutilation or an artificial substitute (Fig. 14).

I have only illustrated the use of compromise treatment in the cases of missing teeth, but there are many other ways by which we can compromise and extract a tooth occasionally without any undesirable results esthetically or from the standpoint of mastication. As I said before, one must use discretion in the treatment of cases by this method. The fixed plan of normal occlusion does not always give the results we are striving for, and a little compromise very often relieves our responsibility.

DISCUSSION

Dr. Burt Abell, Toledo, Ohio.—I do not believe I can add anything of value to what Dr. Gifford has said. I think he has gone to a lot of trouble in some of these cases to get better occlusion than I would feel justified in doing. While we take the short way out of it on the older cases, on the younger cases, we do every bit of work that is needed to be done. I do not feel that anybody is justified in so arranging teeth that a patient has to wear what I call a crippled tooth in the mouth. No bridge, or substitute can possibly take the place of the natural teeth. We can bridge to get normal occlusion but why should we make an effort to get normal occlusion if we have not the material there with which to get it? We never can move these teeth into a compromised position—I say that advisedly—and have all of them absolutely occlude as well as they would in the occlusion that was intended by nature. But it is a great deal better to mismatch teeth (I do not know that I want to be quoted on that term) to put them into other positions rather than to put them in normal positions and supply the missing teeth artificially. I am very much in favor of orthodontic compromise treatment if there are missing teeth rather than to put them in their normal positions and have to supply teeth artificially to hold them there permanently.

Dr. William C. Fisher, New York City.—I have nothing to defend. I admit I am guilty. I am very glad indeed that Dr. Abell took the stand he has so decidedly. In the last two years I have been in close touch with Dr. Dewey on almost the same subject, and he goes to the point of sacrificing a good tooth in order to get a compromise, so that he won't have to put in artificial substitutes. If the x-ray shows that a bicuspid is lack-

ing, I will sacrifice the bicuspid in the opposing arch on this side rather than open it up and put in a substitute if the upper teeth are sound and good and the patient is young.

I have one case (I call it a very sad case) that taught me the greatest lesson I ever had in orthodontia, and it taught me the lesson that every man has to have sooner or later, namely, that I did not know very much about orthodontia. That case came to me after it had been in the hands of a specialist in orthodontia, a man who has practiced it exclusively. He had the case for over two years. He had used several appliances, and the last appliance was pin and tube. There was lacking in the lower jaw a bicuspid on each side of that arch. In the upper arch the full complement of teeth was present. They were all inclined to decay. The girl was not strong. She was about twelve years of age. I decided to use Dr. Ellis' appliance, which you may have seen published two years ago, and open the space. When I got the space opened and decided to put in a substitute, I could not bring myself to devitalize the teeth and place in two artificial substitutes for the girl to wear during the rest of her life, neither could I bring myself to construct anything removable with clamps. I then concluded I would go all over my case again by extracting the bicuspids in the upper jaw. Then I had to close in my space, and I assure you that it closed in quicker than I opened it, but I had to use force. At last, after working on the case for over two years I concluded I had secured as fine a result as was possible in a girl now nearly sixteen years of age, and she had been wearing the orthodontic appliance for five years with a slight interval in between. I said to her father, "It is my opinion this child has had all the orthodontia she should ever have; we have not secured a perfect condition, but the removal of these two bicuspids did more for the child in six months than the exclusive orthodontist and general practitioner did in five years.