Discussion of Dr. Bull's Paper

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Dr. Bull's paper is a careful and sincere presentation of a method of correcting Class II, Div. 1, which supposedly avoids the undesirable results which follow the older, more orthodox methods. A careful examination of the assumptions which underly the claims made in this paper, however, brings to light many controversial points which need clarification.

Dr. Krogman's report stating that 5% of Class II cases attain self correction without orthodontic intervention will come as a surprise to many of us. In a clinical experience of over 19 years, I have not observed any self correction in Class II cases. Moreover, inquiry among my colleagues has failed to elicit any evidence of self correction. Perhaps the cases cited were not true Class II cases.

In the absence of more accurate information to substantiate Dr. Bull's assertion that "little better than 5% of Class II Div. 1 cases arrive at successful outcome", one would do well to question such unscientific statements. Bull should specifically tell what he means by "successful outcome". The quoted statement may be true by Dr. Bull's standards; it hardly jibes with the experience of most practitioners.

Long before the era of extractions, treatment of Class II Div. 1 had a high percentage of success. In those days we gauged a successful result by the stability of the treated denture, by the health of the tissues. But to Dr. Bull, no case is treated properly unless it exhibits the upright mandibular incisor. All other considerations and standards of successful treatment are subservient to this principle.

Turning now to the dual bites, we assert that anyone who has practiced dentistry knows that one can find cases with dual bites that never had orthodontic treatment. I agree with Dr. Bull that one of the dangers of Class II treatment is obtaining a dual bite following the use of Class II elastics. Since Dr. Bull has not discarded elastics, he runs the same risk. In my orthodontic practice, I know of only two of my cases which ended as dual bites, and I have seen a good many subsequent to treatment. Discussion with some able dentists reveals that they occasionally see Class II untreated cases with dual bite.

We cannot agree that placing the jaws in Class I relation by jumping the bite is not successful. Cases involving mandibular displacements are readily and successfully treated by unlocking the occlusion and placing the mandible in its normal functional position. Kingsley had success with jumping the bite as far back as the 80's; he erred only in supposing this treatment would work for the true Class II cases. The mandibular displacement type of Class II readily responds to elastic therapy.

Dr. Bull divides the 95% of unsuccessfully treated cases into dual bites and double protrusions. The dual bites we have discussed. But what of the Double Protrusions? What constitutes a double protrusion is, of course, a matter of individual taste, subject to individual reaction and variation. Some there are who may bow to the fetish of upright mandibular incisors, and in their myopia may class every case not adhering to this rigid, brittle standard as a double protrusion. Others may see the inclination of the mandibular incisors as part of a spatial configuration,

a morphological pattern. They may note the tendency of uprighted incisors to return to their original inclinations, and in their treatment-planning take this fact into consideraion.

Dr. Bull maintains that his plan avoids double protrusions, and dual bites. His plan calls for the removal of four first bicuspids as a rountine procedure. To the severe punishment to the tissues entailed by closure of spaces — in itself a drastic procedure, one must add the further punishment aggravated by extensive wearing of elastics.

For any one to say that all four first bicuspids should be extracted routinely in the treatment of these cases is to throw reason to the winds. I say this emphatically because by the removal of the bicuspids, one does not bring back the incisors as much as one might think; many cases have been treated successfully in the past without any extractions. Those cases that were difficult to treat by the usual means could be treated by the removal of upper first bicuspids, and only a relatively small percentage of bimaxillary cases required the extraction of all four first bicuspids. The removal of four bicuspids may occasionally result in a situation where the normal mesio-distal relationship cannot be obtained. Should Dr. Bull continue this plan of treatment, he may eventually encounter such cases.

An examination of the clinical material supporting Dr. Bull's paper leads one to question whether or not all orthodontists would consider his cases typical of "Class II, div. 1." While they may be well treated, they do not all conform entirely with the reviewers concept of this class of malocclusion. The wisdom of extending to all cases of Class II, div. 1 the procedures which worked well in these particular cases is open to question.

Regarding treatment, Dr. Bull has devoted nearly half the paper to a description of technical procedures involved in the manipulation of the arches used in his method of treatment. To me the whole purpose of the technique seems to be that extraordinary precautions are being taken to prevent forward displacement of the mandibular incisors. Is this maneuver contributed to stability it would be commendable; but regrettably, evidence to the contrary is abundantly present. Uprighting of incisors is an ideal which should be kept before us to be sought when it can be realized, but which is undesirable in many cases. In those cases a slight forward inclination of incisors or a slight fulness of lips is a small price to pay for a more biologically acceptable result.

A full knowledge of growth and development potentialities inherent with the tissues, and sound diagnostic judgment are prime factors, in the final analysis, for the successful treatment of these malocclusions. Facial esthetics is still a moot subject and is strongly influenced by individual tastes and reactions.

That method of correction of Class II malocclusion which establishes the best balance and permanence after removal of retention, with the least loss of dental units and tissue is the method of choice. If the treatment suggested by Dr. Bull is accepted as routine procedure, then we have graduated into a robot group of wire benders, blindly following a single dictum, wantonly destroying tooth material and throwing overboard everything that Orthodontics stands for.

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