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A Message Bearing on the Treatment of Class II, Division I Malocclusion

(*Extracts from Dr. Edward H. Angle's correspondence*)

Dr. Angle's last written words concerning his principles of treatment of Class II, Division I malocclusion are found, according to Mrs. Angle, in a letter to his friend and former student, Albin Oppenheim.

In the October 1931 and January 1932 issues of the *Angle Orthodontist,* appear two exhaustive articles on this particular group of cases. These were prepared by Allan G. Brodie and Cecil C. Steiner and clearly describe the Angle concept and the Angle principles of treatment of Class II, Division I malocclusion. It seems most fitting to supplement these discussions with a few paragraphs from the master teacher himself. Any comment relative to the meaning that Dr. Angle, in this correspondence, desired to convey is unnecessary, indeed it would almost be sacrilegious to attempt collaboration. Therefore quotations from Dr. Oppenheim's letter of inquiry and from Dr. Angle's letter of reply will complete the article.

Quotation from a letter of Albin Oppenheim, dated April 4th, 1929.

"Now, dear Dr. Angle, can you answer me one question? When we were in America and spoke about treatment of Class II cases, you insisted, because of your convincement, that the upper teeth must be brought back and in going forward again they take with them the lower teeth or the mandible itself. In your article "the Latest and Best" you do not mention this idea, you say only the upper teeth must be brought back. In my article I show cases treated by bringing the mandible forward, because the mandible, the retarded chin, is the weak point in Class II cases, and this way of treatment is demanded on account of my research work conducted on many skulls (Dental Cosmos, Nov., Dec., '28) which also showed that the mandible is not enough developed in Class II. What will also be right; you move the upper teeth back, I, as one of your good pupils, shift the mandible forward; *you* try not to influence the mandible forward, *I* reinforce the anchorage in the upper jaw, that its teeth may not go back, only the mandible forward; what will be now? I really am quite perplexed."

Dr. Angle's reply, in a letter dated, November 12th, 1929.

"I think you have stated my views on the treatment of Class II, Division I, quite comprehensively, namely, that, in the main, I believe the upper teeth should be moved distally. Of course, there is a great variety of these cases, and for this reason I think they will have to be arranged and classified so that there will be a clearer understanding of what is needed in degree of tooth movement in their treatment. I think we will agree, however, that in a large majority of cases of Class II, Division 1, the mandible is underveloped and distal to its normal position, or in its relation to the skull and the upper teeth. Yet in some cases the mandible seems to be not materially underveloped. In the average typical case I do not think the upper molars are farther mesially than they should be, especially in the early stages of development of the malocclusion, say up to eight years of age. So the question arises, why move the upper molars back in order to have them occlude with the lower teeth? The reason is, it seems to me, that, unfortunately, through various causes, the lower molars erupt and lock in distal relations with the uppers, or at least are forced into distal occlusion as the eruption of the teeth proceeds. This applies to both dentures. But the lowers, being hopelessly locked in distal occlusion, the mandible is prevented from normal forward growth such as it would have, had the lower molars succeeded in locking normally. A study of the muscles thus preverted shows this condition to be inevitable.

Of course, as the years go on, the natural struggle in the mandible for normality of bone growth naturally causes, through the malocclusion, more or less mesial movement of the upper teeth. The degree of this is to be quite accurately noted by the inclination of the upper cuspids, in many cases, as well as by the positions of the upper molars.

Now, it seems to me that in treatment the upper teeth should be moved distally, whether they need it (in young cases) or not, in order to help to establish the proper axial force relations so that these may, through function, assist in pulling the lower teeth forward as well as to produce growth in a forward direction in the mandible.

With young patients I have had the best success following this plan. In other words, to try to establish proper cusp relations and, gradually, normal function and proper axial force relations, (even though temporarily disturbing the normal relations of the upper molars to the skull), and I have seen the upper teeth gradually regain their proper axial relations with the skull and line of occlusion, at the same time bringing the lower teeth forward and lengthening and developing the mandible. Such a case, you will remember, is shown on page 469 of my seventh edition.

Now the degree to which the upper teeth, and even the lower teeth, are to be pushed backward, depends wholly on the conditions in each individual case. Therein lies the necessity for good judgment and skill.

So I do not think that you and I are so far apart in our conclusions after all. You would drag the lower teeth forward and develop the mandible through mechanical devices. I would do this partially, and partially through the instrumentality of the upper teeth, as above outlined.

These cases are simple when taken young, provided, of course, the abnormal habits are overcome and normal muscular functions established to assist in gaining or in reestablishing the normal, beautiful balance of mechanical forces in the denture.

Of course there is much, very much, more that might be said with regard to this subject, but much more would be out of the question in a letter. But in the main I hope that I have made my position clear.

One thing that I certainly now believe is that the tempero-mandibular articulation should not be disturbed, but the proper placing of the teeth, plus normal growth through reestablished normal functions of teeth, muscles, etc."