Correction Of An Adult Skeletal Class III Malocclusion Utilizing A Restorative Approach

Edward H. Angle described class III malocclusion as one in which the mandibular first molar is positioned mesially relative to the maxillary first molar.¹ A class III skeletal relationship can occur as a result of a normal maxilla with mandibular protrusion, maxillary retrusion with a normal mandible, or a combination of maxillary retrusion and mandibular protrusion. A class III dental relationship can exist when the maxillary/mandibular relationship is normal.

A pseudo class III malocclusion is caused by a forward shift of the mandible to avoid incisal interferences.² For many class III malocclusions, both surgical and orthodontic treatment are required. Depending on the amount of skeletal discrepancy, surgical correction may consist of mandibular retraction, maxillary protraction, or a combination of both procedures. For some minor class III malocclusions, or in the case of a pseudo class III malocclusion, surgical intervention may not be necessary.

Treatment objectives, whether utilizing surgery, orthodontic treatment, or restorative treatment, are the same: to correct the class III crossbite, create an ideal overjet/overbite relationship, achieve a dental class I occlusion, correct the occlusal/incisal plane, correct the midline, and restore the teeth to proper size and proportion. The objective is to provide the patient with an acceptable functional-occlusal relationship and an aesthetic dental/facial appearance.

Malocclusions are common. Patients with crowded and rotated teeth, spacing, or a crossbite who are unsatisfied with their appearance may not be interested in traditional orthodontic treatment or surgical correction. Their objections can be related to the length of time needed to complete treatment, or fear of extensive surgery with extended recuperation. When deciding upon treatment, the clinician must understand how the malocclusion affects the patient aesthetically, functionally, and biologically, and the long-term impact of treatment. Many patients may not require treatment. Others may need treatment to improve functions as well as improve the long-term prognosis of the teeth and stomatognathic system. Still others may request treatment based solely on the desire to improve aesthetics. The practitioner must determine the benefits and consequences of each treatment option. It is important to speak with the patient, and determine when a noninvasive treatment plan may be optimal.

Once the patient understands and is fully informed of the treatment options, their benefits, and disadvantages, some individuals may desire treatment that does not involve orthodontics. In some cases, restorative techniques with veneers, crowns, or fixed prosthetics can provide exceptional strength, function, and aesthetics. The decision to proceed with restorative alignment of the teeth rather than orthodontic alignment is dependent on full disclosure and understanding of the treatment options, and the clinician’s understanding of preparation design, aesthetics, and occlusion.

CASE REPORT

History

A 47-year-old man presented with multiple dental problems ranging from recurrent caries, compromised periodontal health, occlusal trauma, and aesthetic concerns. He had begun to experience discomfort and had become concerned about the health of his teeth. In his 20s the patient had discussed orthodontic treatment and jaw surgery to correct his malocclusion, but elected not to receive treatment. Now in his 40s, the patient was unhappy with the appearance of his teeth and was interested in restoring his mouth to proper health without orthognathic surgery and orthodontics.

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Clinical Data

The patient was seen for a comprehensive examination including a full set of radiographs and digital photographs (Figures 1 to 7). The medical history was noncontributory. Evaluation of the temporomandibular joint revealed no history of previous problems and no current pathology. Jaw opening and range of motion were within normal limits. No joint sounds, signs, or symptoms of instability were evident. Head and neck, and muscles of mastication, were normal to palpation. Hard tissue examination revealed multiple restorations with recurrent caries. Tooth wear was evident throughout both arches. Occlusal examination revealed an anterior crossbite extending to a posterior crossbite on the left side. A class III cuspid and first molar relationship was present. Skeletal examination revealed a retrusive maxilla and protruded mandible (Figures 1 to 4). Examination of the face and profile revealed a shortened mid-face height and longer lower face length suggestive of a class III malocclusion.

The periodontal examination revealed generalized inflammation. Much of the inflammation was associated with the failing restorations. Aesthetically, the central incisors were not visible with the resting lip position, but the mandibular teeth were evident. A flat to reverse smile line was present, with the incisal plane being shorter than the occlusal plane. The length of the central incisors was short (measuring approximately 8 to 9 mm), these teeth were misshapen from wear, and not commensurate with the golden proportion. The color of the teeth did not complement the smile and were of low value.

Diagnosis

The diagnosis was a mutilated class III malocclusion with an asymmetrical anterior crossbite, posterior crossbite, and recurrent restorations with recurrent caries that were in need of replacement, occlusal wear with possible loss of vertical dimension, and an unesthetic smile.

Treatment Approaches

Prior to development of the definitive treatment plan the benefits and limitations of the 2 main treatment options were discussed with the patient: 1. orthodontic treatment followed by restorative dentistry, or 2. restorative dentistry alone. The benefits of orthodontic treatment with a restorative component would include less invasive restoration of the teeth. Nevertheless, it was obvious that once orthodontic treatment was complete, the patient would still require considerable restorative dentistry, specifically addressing recurrent caries in all 4 posterior sextants. The anterior dentition would require restoration due to wear and need to re-establish anterior/cuspid guidance. Lastly, with orthodontic treatment the shape and color of the existing dentition would remain the same, therefore not addressing one of the patient’s main treatment goals—to improve the appearance of his smile. To achieve this goal the anterior teeth would require restoration, most likely porcelain veneers.

Orthodontic treatment would also require an extended treatment time of at least 9 to 12 months, and at that point the result would be limited to preprosthetic aesthetics.

The benefits of the restorative dentistry option would address the failing restorations in all 4 posterior sextants. It would also allow restoration of the worn anterior dentition, which would also re-establish the anterior/cuspid guidance. The color of the dentition could be improved, addressing the goal of improving the color and shape of the teeth, and thereby the patient’s smile. An extended treatment time would not be necessary with this option, with treatment completed in 3 to 6 weeks. The compromise with this treatment option would be the need for a more aggressive approach to tooth preparation, and all teeth would require restoration to correct the malocclusion. Financially, both options were equivalent, and therefore not an issue.

After consideration of both options, the patient elected to restore all teeth without orthodontic treatment.

Discussion

The treatment plan had 4 specific goals: 1. optimal oral health, 2. occlusal stability, 3. comfort when functioning, and 4. acceptable aesthetics. The relationship of the jaws and teeth should be analyzed to determine which segment/teeth is/are properly related to the cranial base and skeletal facial profile. The treatment goal is to maintain what is correctly aligned and change what is not. Analysis of the mounted casts is an important step. An important outcome is occlusal stability, with a focus on stable holding contacts for each tooth. Radiographic examination plays an important role as well, establishing biological health of the periodontium relative to pulpal, osseous, and structural concerns. Radiographic exam also provides analysis of skeletal relationships to aid in diagnosis and treatment.

When properly treated, crossbite relationships can be very stable, predictable, and maintainable. This is possible because the teeth are not being bodily moved through osseous tissue with retained memory of periodontal ligaments and other structures. Further, stability and maintainability are achieved through stable central occlusion contacts. Crossbites can be divided into 2 categories: anterior crossbite and posterior crossbite, each with a different set of challenges and considerations. They may or may not occur together, and should be analyzed separately. Anterior and posterior crossbites are analyzed separately because they are evaluated by different criteria. Anterior crossbites are evaluated with regard to aesthetics, anterior centric contacts, and anterior guidance. Posterior crossbites are evaluated based on the teeth in relationship to the bone, tongue, and cheeks, and the occlusal relationship of maxillary teeth to mandibular teeth. A posterior crossbite may be a functional, stable relationship similar to a normal arch relationship, and may not require treatment. Evaluating anterior and posterior crossbites separately may reveal situations where correction of the crossbite (anterior or posterior) is not necessary to achieve the desired goal.

The potential problems associated with anterior crossbites are: aesthetics, absence of centric contact on anterior teeth or reversed anterior contacts, and lack of anterior guidance. Anterior crossbites do not provide anterior guidance in protrusive or lateral excursions.

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Class III malocclusions do not have traditional anterior/cusp guide while class I and II occlusions do have this guidance. The class I patient does not use protrusive movements in a similar way to class I and class II patients who use these movements. Most class III patients limit their function to vertical movements and have a vertical functional pattern. They are vertical chews with a vertical envelope of function because the class III malocclusion does not allow forward movement. Most crossbite patients do not use lateral functional movements similar to class I and class II occlusions. Regarding vertical movement, the goal is to maintain the posterior centric stop position from the previous class III in the new class I position relative to the vertical axis of the root. After treatment, the new class I occlusion should be designed and restored with minimal overjet and overlap, and minimal anterior guidance.

Additional consideration must be given to changes that occur in proprioception of the teeth and lips. With an anterior crossbite, when moving maxillary anterior teeth forward, there must be sufficient alveolar bone to support the new tooth position. The stresses exerted support the new tooth position. The stresses exerted cause the mandibular anterior teeth to move down and away from the lingual of the maxillary anterior teeth along the arc of opening and closing path while the condyles are in centric relation. This will allow the mandibular incisors to be more in line with the maxillary anterior teeth, helping to correct the anterior crossbite. The second is improved aesthetics. Many patients with an anterior crossbite have short clinical crowns. By increasing the vertical dimension, room is created to lengthen the teeth and improve aesthetics. When establishing the occlusal plane it is better to keep the Curve of Wilson and Curve of Spee relatively flat and on an even plane (one that is more shallow).

**Treatment Plan**

The treatment plan would be a full-mouth restoration of all remaining teeth with crowns, bridges, onlays, onlay veneers, and porcelain veneers to correct the class III crossbite, restore carious and worn teeth, restore anterior/cusp guide and occlusion. Initial treatment would consist of a diagnostic workup, including models mounted by facebow transfer to a semi-adjustable articulator in centric relation. Occlusal analysis of the mounted models would be performed to identify the skeletal and dental relationship. This would allow determination of how much (if any) the vertical dimension of occlusion would need to be opened to restore the maxillary and mandibular arch form, and correct the crossbite.

**The Challenges**

The challenges discussed with the patient prior to treatment included: change in speech, change in sensation of the upper lip as a result of the new position of the teeth, the effect of the new jaw position on the TMJ and muscles of mastication, increased vertical dimension, and sensation of centric stops on the anterior teeth (the patient had never experienced these contacts). When treating any full mouth restorative case where vertical dimension is to be changed, caution should be made not to increase vertical dimension more than is necessary. In this case the goal was to increase the posterior vertical dimension no more than one mm. Opening the vertical dimension by this minimal amount should not have an adverse effect on the TMJ. If the joint is comfortable at the existing vertical dimension, it is unlikely that the joint will experience any discomfort at an altered vertical dimension. 

**Treatment Phase**

A complete pretreatment analysis is essential when restoring an anterior crossbite. A wax-up of all anterior teeth should be accomplished that represents the final contours and tooth position.

Instructions were forwarded to the laboratory with all diagnostic materials including photographs and mounted models in centric relation. The instructions included a description of soft tissue changes, desired length of the central incisors, maxillary and mandibular arch form changes, anterior tooth proportions, molar relationships, overjet and overbite dimensions, anterior/cusp guide requirements, and amount of increase in the vertical dimension (Figure 8). A diagnostic wax-up would be required to visualize the outcome (Figure 9). In addition to the diagnostic wax-up, fabrication of an acrylic anterior centric relation jig capturing the new vertical dimension of the maxillary and mandibular teeth was requested. This jig would become the pretreatment guide, providing a vertical stop at the new vertical dimension in centric relation (Figure 10). The diagnostic wax-up would serve as the restorative blueprint for progression of the case through the preparation, provisional, and restorative phases. A putty matrix of the diagnostic wax-up would be made of both arches, to be used in the fabrication of the provisional restorations. With the diagnostic wax-up, anterior vertical dimension/centric relation jig, and putty matrices fabricated, the patient could be appointed to prepare and provisionalize both the maxillary and mandibular arches simultaneously. The patient’s tolerance to the new vertical dimension and occlusal scheme would be evaluated, which would then be followed by the definitive restorative phase.

**Provisionalization**

The provisional restoration was fabricated utilizing a putty matrix made from the diagnostic wax-up. The provisional was removed from the matrix and separated into 2 posterior segments and 1 anterior segment for both the maxillary and mandibular arches, and trimmed appropriately. The maxillary and mandibular anterior segments were returned to the mouth. With
both segments in place, an initial equilibration was performed on the provisional. Adjustment in this way acts as an anterior jig, allowing the condyle to position in centric relation at this vertical dimension. Measurement with the digital caliper was made, verifying that the vertical dimension had remained the same. With the vertical dimension and centric relation verified, the maxillary and mandibular posterior provisional segments were tried in. The posterior provisional segments were equilibrated until equal centric holding contacts were recorded on all posterior and anterior teeth. Anterior and cuspid guidance were then established, which completed the occlusal adjustment.

All segments of the provisional restoration were removed and prepared for cementation. The maxillary and mandibular anterior veneer segments would be tacked by spot etching with 35% phosphoric acid, bonded with unfilled resin and flowable composite, cleaned to satisfaction, and light cured into place. The posterior provisional segments were cemented with provisional cement. With the occlusal adjustments complete, aesthetic re-contouring of the provisional was performed. The provisional was then polished and glazed to satisfaction (Figures 16 and 17). The provisional was dismissed and reappointed the next day for evaluation of the provisional restoration. The final impressions, facebow transfer, and bite registration were forwarded to the laboratory with instructions to create and mount the master models. The laboratory was advised that models and photographs of the provisional would be forwarded in the future, after patient acceptance of the new vertical dimension and occlusal scheme could be verified.

The patient was present for evaluation of the provisional in regard to aesthetics, phonetics, and function. The patient was very satisfied with the aesthetics. Regarding speech, the “S” position was verified and the patient was able to accommodate to the new incisal edge position with minimal phonetic problems. The patient was aware of the maxillary teeth against the inside of the upper lip, and accommodated well. The patient expressed that time was needed to adjust to the new vertical dimension and occlusal scheme, as this felt foreign. With the aesthetics and phonetics acceptable, the occlusion was re-evaluated utilizing the Tekscan. Adjustments were made with the Tekscan to provide equal intensity centric contacts. The patient was then released and scheduled for another evaluation in one week.

The patient presented for the one-week follow-up appointment. The vertical dimension was comfortable but the patient still expressed difficulty adjusting to the new occlusal scheme. The evaluation revealed that cuspid guidance was not comfortable. Adjustments were made, converting cuspid guidance to group function with lateral excursive movements distributed across the first molar, bicuspids, and cuspid. The Tekscan was utilized to assist with the occlusal adjustments. Once these adjustments were completed, the patient was comfortable. The patient was scheduled 2 weeks later to verify comfort with the new occlusion. This was accomplished and models and photographs of the provisional were forwarded to the laboratory with instructions for fabrication of the final restorations. Instruction included fabrication of porcelain to gold crowns for all molars, zirconia crowns for all bicuspids, and feldspathic porcelain veneers for all cuspsids and incisors. The decision to proceed with restorative alignment and occlusal contact is dependent on full disclosure to the patient and the clinician’s understanding of preparation design, aesthetics, and occlusion. As demonstrated in this Class III case, with proper examination, diagnosis, treatment planning, and communication, excellent aesthetic, phonetic, and functional results can be achieved and maintained. As with all full mouth restorative cases, periodic occlusal evaluation will be necessary at normal hygiene intervals.

SUMMARY AND CONCLUSION

When determining if treatment for malocclusion is indicated, the clinician must understand how the malocclusion affects the patient aesthetically, functionally, and biologically, as well as any impact of treatment. It is important to consult the patient and advise when a less invasive orthodontic treatment plan may be optimal. Once the patient is fully informed of the treatment options and desires treatment without orthodontics, a restorative/prosthetic approach using veneers, crowns, or fixed prosthetics can provide exceptional strength, function, and aesthetics. As in all cases, thorough evaluation and planning are essential.

The decision to proceed with restorative alignment of the teeth rather than orthodontic alignement is dependent on full disclosure to the patient and the clinician’s understanding of preparation design, aesthetics, and occlusion. As demonstrated in this Class III case, with proper examination, diagnosis, treatment planning, and communication, excellent aesthetic, phonetic, and functional results can be achieved and maintained. As with all full mouth restorative cases, periodic occlusal evaluation will be necessary at normal hygiene intervals.

References
Figure 15. Posterior teeth seated into bite registration. An anterior bite registration is then created, indexing the prepared maxillary and mandibular teeth.

Figure 16. Provisional, frontal retracted view in occlusion.

Figure 17. Provisional, left lateral view in occlusion.

Figure 18. Final restoration, smile view.

Figure 19. Final restoration, retracted view.

Figure 20. Final restoration, retracted left lateral view.
Continuing Education
Test No. 98.#

To submit Continuing Education answers, use the answer sheet on page xx. On the answer sheet, identify the article (this one is Test 98.#), place an X in the box corresponding to the answer you believe is correct, detach the answer sheet from the magazine, and mail to Dentistry Today Department of Continuing Education.

The following 8 questions were derived from the article Correction Of An Adult Skeletal Class III Malocclusion Utilizing A Restorative Approach by Gerard J. Lemongello, DMD on pages xx through xx.

Learning Objectives

After reading this article, the individual will learn:

• The importance of understanding how malocclusion affects the patient aesthetically, functionally, and biologically, and the long-term impact of treatment.
• A treatment protocol that provided a patient with an acceptable functional-occlusal relationship and an aesthetic dental/facial appearance.

1. A class III skeletal relationship can occur as a result of:
   a. a normal maxilla with mandibular protrusion.
   b. maxillary retrusion with a normal mandible.
   c. a combination of maxillary retrusion and mandibular protrusion.
   d. all of the above.

2. The decision to proceed with restorative alignment of the teeth rather than orthodontic alignment is dependent on:
   a. full disclosure and understanding of the treatment options.
   b. the clinician’s understanding of preparation design.
   c. aesthetics, and occlusion.
   d. all of the above.

3. What compromise exists when utilizing a restorative option to correct a malocclusion vs. orthodontic treatment?
   a. the need for a more aggressive approach to tooth preparation.
   b. there is no compromise to restorative treatment.
   c. restorative treatment takes longer to complete.
   d. all of the above.

4. The treatment plan in this article had 4 specific goals: Which goal is NOT correct?
   a. optimal oral health.
   b. occlusal instability.
   c. comfort when functioning.
   d. acceptable aesthetics.

5. The potential problems associated with anterior crossbites are:
   a. aesthetics.
   b. absence of centric contact on anterior teeth, or reversed anterior contacts.
   c. lack of anterior guidance.
   d. all of the above.

6. When converting a class III malocclusion to a new class I the occlusion should be designed and restored with:
   a. minimal overjet and overbite.
   b. minimal anterior guidance.
   c. 5 mm of overjet and 90% overbite.
   d. a and b.

7. In the case presented, the challenges discussed with the patient prior to treatment included:
   a. change in speech.
   b. change in sensation of the upper lip as a result of the new position of the teeth.
   c. the effect of the new jaw position on the muscles of mastication, increased vertical dimension, and sensation of centric stops on the anterior teeth.
   d. all of the above.

8. Caution should be made not to increase vertical dimension more than is necessary. A 3 mm opening of the vertical in the anterior segment should:
   a. not have an adverse effect on the TMJ.
   b. not produce muscle tension.
   c. result in a 1 mm change in the length of the masseter muscles, which is well tolerated.
   d. all of the above.