

GUIDANCE FOR MANAGEMENT OF PATIENTS REQUIRING COMBINED ORTHODONTIC/RESTORATIVE TREATMENT IN PRIMARY CARE

Multidisciplinary treatments

Cases involving both orthodontics and a procedure in an associated discipline need particular care. Ideally a joint consultation should take place, so that the patient has the opportunity to discuss the risks and benefits of the overall plan before either treatment is started.

If this is not possible, the orthodontist should outline the overall plan and then ask the other clinicians involved to agree the plan before treatment commences.

Where extensive restorative procedures are planned, the patient must be fully aware of the long-term implications, including the possibility of costs. A consultation with the clinician who will be undertaking the restorative procedures is recommended and reflects best practice. Individual clinicians should obtain consent for their part of treatment.

A relevant and common example of this in primary care is the management of congenitally absent upper lateral incisors. There are two possible solutions – full orthodontic space closure with approximation of the upper canines next to the central incisors, followed by restorative camouflage of the lateral incisors. This is often perceived as the ‘healthier’ option but may be cosmetically inferior, depending on the colour and shape of the canines and the underlying occlusion. In some clinical situations this may not be achievable by orthodontic means.

The other solution is to open/maintain the space for subsequent restorative replacement of the missing tooth/teeth. Cosmetically this may be better where the canine is of a more bulbous shape or darker colour. It does, however, potentially mean that the patient will have ongoing maintenance and cost issues associated with the restorative solution. The orthodontist can help in this situation by tipping adjacent roots away from possible implant sites, if this is planned.

Every single patient/clinical situation is different and the decision process is a multi-factorial one. Critical to the outcome is the communication between the patient, referring dentist and orthodontist. The plan should be agreed by all parties before treatment starts, and it is useful if the referring dentist indicates on the referral letter that they have had a preliminary discussion with the patient regarding possible solutions and their preference.

In situations where the referring dentist has left the practice before the orthodontic treatment is finished, it would be expected that the referring practice would still support the proposed treatment.

It would be good practice for the orthodontist to ask the dentist to review the patient prior to orthodontic debond to ensure the clinical situation is viable for the proposed restorative care. Retainers can then be planned to facilitate this, usually placed to hold orthodontic outcome for a period of time prior to restorative care. Retainers may need to be replaced once restorative treatment is done and, again, the patient should be aware of any ongoing costs, if any, for this.

Drafted by BCUHB Orthodontic Clinical Management Network and approved by North Wales Local Dental Committee, March 2026

Based on British Orthodontic Society guidelines 'Consent in orthodontics 2024'