Unusual orthodontic approach to a maxillary canine-premolar transposition and a missing lateral incisor with long-term follow-up

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In this case report, we present an unusual approach that was used to treat a 14-year-old patient with a bilateral canine-premolar transposition and a missing maxillary lateral incisor. The orthodontic treatment involved maintaining the transposition and creating a space for lateral incisor replacement. Toward the end of the treatment, accentuated buccal root torque was performed, and lateral group function was established to improve the treatment outcome. Finally, an ideal esthetic and functional occlusion was achieved. The 8-year posttreatment follow-up records show the stability of this treatment. (Am J Orthod Dentofacial Orthop 2012;142:690-7)

Tooth transposition is a relatively rare condition in which a permanent tooth develops and erupts in a position normally occupied by another permanent tooth. 1-6 Maxillary canine-premolar transposition is the most frequent type of tooth transposition, and several theories have been proposed to explain this condition. Genetic origin, 2,4-9 prolonged retention of deciduous teeth, supernumerary teeth, and local pathologic processes are some reported causes. 3,6-8,10

Transpositions in the mixed dentition are usually corrected when the dentoalveolar process has adequate width, the canine involved in the transposition has not completely erupted, and the transposition is not yet completed. 1,11-13 However, when the teeth involved have fully erupted and are almost aligned, and the dentoalveolar process is narrow, a satisfactory result can be obtained by maintaining the transposed teeth, preventing root resorption and gingival recession, and avoiding prolonged orthodontic treatment. 12-14

Here, we present a patient with bilateral maxillary canine-premolar transposition and a missing maxillary lateral incisor, who was treated by maintaining the transposed tooth positions with particular attention to function and esthetics. We also present the long-term follow-up findings.

DIAGNOSIS AND ETIOLOGY

A healthy 14-year-old girl came to us with her parents for the treatment of crowding of the teeth in both arches and the absent maxillary right permanent lateral incisor and left permanent canine. She had a straight profile and symmetric facial development (Fig 1). The intraoral clinical examination showed an Angle Class II malocclusion with left subdivision. We observed prolonged retention of both maxillary deciduous canines, absence of the right lateral incisor, and complete transposition of the right permanent canine with the first premolar. In addition, a unilateral posterior crossbite on the left side was observed (Fig 2).

The radiographic examination showed complete transposition on the right side and impaction of the maxillary left permanent canine with accentuated mesial inclination and incomplete transposition with the first premolar. Moreover, the absence of the maxillary right lateral incisor was confirmed (Fig 3). Cephalometrically, she had a good facial pattern with the mandibular incisors in a good position and the maxillary incisors slightly retroclined (Fig 4; Table).
**TREATMENT OBJECTIVES**

The treatment objectives for this patient were to (1) correct the posterior crossbite on the left side, (2) establish a Class I molar relationship on the left side, (3) extract the maxillary deciduous teeth, (4) maintain the maxillary canine-premolar transposition on the right side and perform a prosthetic replacement of the permanent lateral incisor, (5) move the impacted canine on the left side while maintaining the transposition, and (6) establish ideal overbite, overjet, and adequate occlusion with group function in lateral excursion.

**TREATMENT ALTERNATIVES**

Three treatment options were available for this patient. The first was corrective positioning of the transposed teeth to their normal positions in the arch. However, the dentoalveolar width was too narrow to permit the movement of these 2 teeth through the bone, so this treatment option was rejected. The second option was extraction of the maxillary first premolars to establish Class I canine and Class II molar relationships; this option was also discarded, because the maxillary left permanent canine was positioned in an accentuated distal position and would require orthodontic movement over a large area to establish the Class I relationship.

The third option considered was to maintain the transposition, moving the right first premolar to the position of the lateral incisor on the right side to achieve a Class I relationship and, on the left side, leaving the premolar in the position of the canine. This alternative was considered esthetically harmful, because of the change it would cause in the gingival contour and tooth shape and color. Moreover, after the treatment, the
lateral function on the right side would be canine disclusion, whereas on the left side it would be group function.

TREATMENT PROGRESS

Initially, bonded buttons were placed on the lingual surfaces of the maxillary left second premolar and first molar and on the buccal surfaces of the mandibular left second premolar and first molar. Subsequently, elastics were used over 2 months to correct the crossbite. In the third month, a standard edgewise appliance, 0.022 × 0.028 in, was bonded on the mandibular arch. In the following months, the teeth in the maxillary arch were sequentially bonded, and the deciduous teeth were extracted to permit appropriate aligning and leveling of the arch. To provide adequate area for this, both maxillary canines were not bonded during the initial period, when the first premolars were moved toward the mesial aspect. On the left side, the first premolar was moved until it established contact with the lateral incisor, and then the canine naturally occupied a favorable position in the arch, as seen in the radiographs (Fig 5).

In addition, a coil spring was used between the first and second premolars to widen the space,
and elastomeric chains were used between the central or lateral incisor and the first premolars to improve the anterior movement. To maintain the space for prosthetic replacement, a compressed coil spring was also placed between the right central incisor and first premolar. Toward the end of the treatment, a 0.021 × 0.025-in stainless steel archwire was inserted to establish optimal torque of the anterior teeth. For the first premolars, accentuated buccal torque was used to the roots to simulate canine prominence and give the required support to the lips.

Accentuated lingual torque of the canine roots was used to prevent too much prominence on both sides. Vertical elastics were used for the subsequent 2 months to improve intercuspatation of the teeth, and then the appliances were removed. A circumferential maxillary retainer with a provisional right lateral incisor was used in the maxillary arch, whereas a bonded canine-to-canine retainer was placed in the mandibular arch.

### TREATMENT RESULTS

The facial pattern was maintained (Fig 6), and the treatment provided the following outcomes: Class I molar relationships on both sides, maxillary first premolars performing the function of the canines in a Class I relationship with the mandibular canines, and adequate overbite and overjet. Lateral group function was established to prevent overload on the first premolars. The maxillary and mandibular midlines remained mismatched even at the end of treatment, with a 1.0-mm deviation between them, and a space of 0.5 mm remained between the left lateral incisor and the first premolar; this was filled with composite resin after the retention period.

The lateral incisor space was restored with a bonded restoration, because the patient was too

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**Table. Cephalometric summary**

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Norm</th>
<th>Pretreatment*</th>
<th>Posttreatment†</th>
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<td>Lower lip-S line (mm)</td>
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<td>-2</td>
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</table>

*Pretreatment records at age 14 years 2 months; †Posttreatment records at age 17 years 9 months.
young to receive an implant immediately after orthodontic treatment (Fig 7). The posttreatment panoramic radiograph showed good parallelism of the roots and no root resorption. An accentuated root curvature of the left first premolar root could be seen (Fig 8). Cephalometrically, the patient had
a similar pattern as in the beginning of the treatment as seen in the final cephalogram and the superimposition (Figs 9 and 10). The 8-year posttreatment (6 years postretention) records showed that the occlusion remained stable over the years, and that the conditions of the hard and soft tissues were also maintained (Fig 11).

DISCUSSION

Maxillary canine-premolar transposition is the most frequent type of transposition treated by orthodontists, and is frequently associated with other dental anomalies such as absence of teeth, as seen in this patient. The etiologic factors for transposition are variable; in this patient, the cause probably was the prolonged retention of the deciduous teeth, which is considered one of the most common causes for transpositions.

There are several treatment options available for canine-premolar transpositions that might or might not involve extraction of permanent teeth. In the nonextraction treatment option with narrow dentoalveolar bone, it is preferable to maintain the transposition, because attempts to restore the normal tooth positions could lead to a prolonged treatment period along with irreversible consequences such as root resorption and gingival recession.

The orthodontic treatment option of maintaining the canine-premolar transposition has limitations with respect to esthetic and functional rehabilitation. There are differences in size, shape, and color between the teeth involved, and this can occasionally create esthetic problems with the patient’s smile. Furthermore, the gingival margin of the premolar is positioned more occlusally relative to the canine. Therefore, it could require gingival recontouring after treatment, or extrusion of the canine and equilibration of the cusp. In our
patient, the amount of equilibration would have been too extensive if the canines were extruded, so we preferred gingival surgery. However, the patient and her parents believed that periodontal surgery was not necessary. Therefore, the gingival level discrepancy remained and affected the overall esthetics.

In our patient, stripping was performed on the mesial and distal surfaces of the canines to reduce the mesiodistal width and to achieve a better functional relationship with the mandibular canine. Another important issue to be considered was the interference between the palatal cusps of the transposed premolar and the mandibular canine that normally occurs in transpositions. However, in our patient, an accentuated buccal root torque was accomplished; consequently, lateral group function was established. Thereafter, no interference was observed between the cusps at the end of treatment, and reshaping was not necessary.

CONCLUSIONS

Such unusual treatment should be accompanied by long-term follow-up to observe the stability and the condition of the occlusion. In our patient, the reevaluation conducted 8 years after treatment and 6 years after retention showed an optimal functional occlusion with good stability of the tooth positions.

This type of treatment is not the conventional protocol for tooth transpositions. The appropriate treatment should be selected only after careful diagnosis, which can vary from patient to patient.
REFERENCES


Fig 11. Facial and intraoral photographs 8 years after the end of treatment (6 years postretention).