

Transverse skeletal deficiencies in orthodontics: etiology, consequences and treatment approaches

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Abstract

Aim: This paper explores the etiology, consequences, and treatment strategies for transverse skeletal deficiencies in orthodontics, focusing on treatment duration and growth prediction models. **Materials and Methods:** A comprehensive literature review encompassed embryological development, environmental factors, clinical presentations, and treatment strategies for transverse skeletal deficiencies. Studies on craniofacial growth, orthodontic interventions, surgical approaches, and Elastodontic therapy were analyzed. **Results:** Transverse skeletal deficiencies arise from genetic, intrauterine, and postnatal factors such as pacifier use, thumb-sucking, mouth breathing, and insufficient maxillary expansion during childhood. These deficiencies commonly lead to dental malocclusions, posterior crossbites, and airway issues, including sleep-disordered breathing. Traditional treatments like rapid maxillary expansion (RME) and surgical-assisted rapid palatal expansion (SARPE) are effective for younger and older patients. In addition, Elastodontic therapy, which utilizes elastic-based appliances to improve the alignment and function of the maxilla, offers a non-invasive, patient-friendly alternative for

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managing transverse deficiencies. This approach benefits cases requiring slower, more gradual expansion, providing better long-term stability than other methods. Treatment duration typically ranges from three to six months for younger patients, with more extended retention periods in older patients to prevent relapse. **Conclusions:** Transverse skeletal deficiencies are influenced by genetic, intrauterine, and environmental factors, leading to functional and aesthetic concerns, such as malocclusions and compromised airway function. Early intervention, including methods like orthopedic expansion and Elastodontic therapy, offers promising results, while surgical approaches are necessary for more severe cases. Understanding the developmental trajectory of these deficiencies is essential for tailoring treatment plans and ensuring both functional and aesthetic improvements. Future research should refine growth prediction models and evaluate the long-term effectiveness and stability of Elastodontic therapy in managing transverse skeletal deficiencies.

Keywords: Transversal Skeletal Defects, Maxillary Deficiency, Crossbite, Skeletal Malocclusion, Orthodontic Expansion Therapy, Elastodontic Therapy

Introduction

Transverse skeletal deficiencies represent a critical aspect of orthodontic and craniofacial development, arising from multiple etiological factors that trace back to intrauterine life and extend into postnatal growth (1–9). Understanding the origins and causes of these deficiencies is essential for developing effective treatment strategies and preventing malocclusions that can significantly impact oral health and overall well-being (10–18). Beyond the clinical and biological implications, the study of transverse deficiencies holds substantial importance in social education and public health awareness (19–28). Misusing certain oral habits and devices, such as pacifiers, prolonged bottle-feeding, and inadequate chewing patterns due to a soft diet, can contribute to improper skeletal development (29–38). Educating parents, caregivers, and healthcare professionals about these risk factors minimizes preventable malformations and ensures timely intervention (39). Scientific research is pivotal in advancing our understanding of skeletal deficiencies, allowing the development of more precise diagnostic methods and innovative treatment approaches (40–51). However, despite significant advancements, research in this field faces several limitations (52–58). Longitudinal studies are often required to track growth patterns and treatment outcomes over extended periods, which can be costly and time-consuming (41–51,59,60). Additionally, individual variations in genetic and environmental influences complicate the establishment of standardized treatment protocols (59–68). Therefore, while research continues to provide invaluable insights, there remains a need for ongoing exploration and refinement in orthodontics (69–78). However, the

introduction of Elastodontic therapy has revolutionized the treatment of these problems, as it offers a less invasive solution, reducing the risk of tissue damage and promoting better long-term stabilization (79–88). This approach represents a viable alternative, especially in less severe cases and patients who need gradual expansion without rigid devices (21,22,26,28,89–96). This paper aims to explore etiology, consequences, and therapeutic approaches (19,97–106) to transverse skeletal deficiencies, emphasizing treatment duration and growth prediction models (20,23,29,51,85,107–118).

Materials and Methods

A comprehensive literature review focused on embryological development, environmental factors, clinical presentations, and treatment strategies for transverse skeletal deficiencies (88,113,119–126). Studies on craniofacial growth, orthodontic interventions, and surgical approaches were analyzed. Clinical cases were also examined to assess treatment outcomes and predict growth patterns in different age groups (52–54,57,69,71,77,78,91,91,95,96,98–101,103,107–109,111,114–116,120,126–128).

Discussion

Origin and Causes of Transverse Skeletal Deficiencies

Transverse skeletal deficiencies can originate in the prenatal stage, where genetic factors and intrauterine conditions influence craniofacial development (70,104,129–137). Malformations or restrictive intrauterine positioning may lead to asymmetries or underdevelopment of the maxilla. Postnatally, prolonged pacifier use, thumb-sucking, mouth breathing, and early loss of deciduous teeth can exacerbate skeletal discrepancies (138–147). Growth deficiencies in the maxilla often result from insufficient transverse palatal expansion during childhood, leading to posterior crossbites and dental crowding. The mandible may also exhibit transverse deficiencies less frequently than the maxilla. These conditions are exacerbated by altered muscle function, abnormal tongue posture, and nasal obstruction, which limit natural maxillary expansion (63,110,113,128,148,149, 380).

Consequences of Transverse Skeletal Deficiencies

The most common consequence of transverse skeletal deficiency is dental malocclusion, particularly unilateral or bilateral posterior crossbite. These malocclusions can lead to asymmetrical mandibular growth, temporomandibular joint dysfunction (TMD), and compromised airway function. Additionally, transverse deficiencies contribute to improper occlusal relationships, leading to excessive wear on specific teeth and potential periodontal complications. The long-term effects of untreated transverse skeletal deficiencies include impaired facial esthetics, speech difficulties, and altered mastication patterns. Furthermore, compromised airway function due to a narrow maxilla can result in sleep-disordered breathing, including obstructive sleep apnea (OSA) in severe

cases (93,102,149–153).

Beyond these localized effects, transverse skeletal deficiencies have significant repercussions on the functional and postural balance of the entire organism. When the maxilla is narrow, it affects the teeth and alters the overall craniofacial posture. The misalignment of the upper and lower arches can lead to altered muscle function and result in muscle imbalances within the craniofacial complex. These imbalances can extend to the cervical and upper thoracic regions, creating compensatory adjustments that affect the entire body's posture. This results in functional compromises in the body's position, leading to discomfort, pain, and a risk of more systemic postural issues (10,24,90,154–157). The muscular chains that control movement and posture become distorted in response to the initial skeletal discrepancies. For instance, the masticatory muscles, including the masseter and temporalis, may become overactive or underactive, depending on the degree of the skeletal deficiency. Similarly, muscles in the neck and shoulders may engage in a compensatory pattern to stabilize the head and jaw, leading to tension and discomfort in these areas. Over time, these adaptive mechanisms may contribute to chronic musculoskeletal pain and postural misalignments, potentially resulting in conditions such as headaches, neck pain, and even back pain (158–162,162–165).

Furthermore, transverse skeletal deficiencies can also cause an alteration of tongue posture. The narrow maxilla limits the available space for the tongue, forcing it to rest in a lower and more anterior position. This improper tongue posture can impede the normal functioning of the oropharyngeal muscles and may result in swallowing difficulties, speech problems, and even oral breathing habits. The tongue's altered posture can also interfere with proper oral rest position, which can, in turn, exacerbate airway obstruction and disrupt normal nasal breathing, contributing to further airway issues (166–180).

The interconnectedness of the oral cavity, craniofacial structures, and postural system means that correcting transverse skeletal deficiencies involves more than just addressing dental alignment. It requires a holistic approach that considers the occlusal relationship and the functional integration of muscles, posture, and breathing (181–197).

In summary, transverse skeletal deficiencies lead to a cascade of functional disruptions that impact dental health and the entire musculoskeletal and postural system. Early intervention is crucial to prevent these secondary effects and ensure proper development of the craniofacial structure and the body's overall posture (130,198–203).

Treatment Approaches

Treatment modalities for transverse skeletal deficiencies vary depending on the patient's age, severity of the deficiency, and skeletal maturity. The primary treatment approaches include:

- Orthopedic Expansion (Early Treatment): In growing children, RME is preferred. RME utilizes a fixed appliance, such as a Hyrax or Haas expander, to separate the mid-palatal suture and induce new bone

formation. This approach is most effective before the mid-palatal suture fuses, typically around puberty. Slow maxillary expansion is another alternative, often used when patient compliance is a concern. This method applies gradual forces, reducing the risk of tissue damage and increasing stability.

- Elastodontic therapy is a relatively recent methodology characterized by advanced elastic devices to correct malocclusions and manage skeletal deformities, mainly transverse deformities. This approach combines traditional orthodontics with electrotherapy, utilizing the ability of elastics to exert controlled and gradual forces over time to achieve changes in bone tissue and teeth.
- Orthodontic and Camouflage Treatment: Orthodontic approaches such as archwire expansion or dental tipping may compensate for mild transverse deficiencies. However, these methods do not address skeletal discrepancies and may lead to long-term relapse.
- SARPE: for adolescent and adult patients with closed midpalatal sutures, SARPE is a viable option. This procedure combines orthodontic expansion with surgical intervention to separate the suture and allow for transverse maxillary growth. Segmental LeFort I osteotomy may also be considered in severe cases requiring skeletal widening along with vertical or anteroposterior corrections.
- Mandibular Expansion Techniques: In extreme cases, mandibular transverse deficiencies can be treated with corticotomy-assisted expansion or distraction osteogenesis techniques. These procedures are less standard but can be effective when necessary (165,204–209).

Elastodontic therapy

It is based on elastic devices (often customized) that apply subtle and constant forces to stimulate bone remodeling and encourage tooth movement. Elastics can be placed on fixed or mobile devices, depending on the case, and are designed to slowly expand the dental arch, particularly to treat transverse defects, such as expansion of the upper jaw. This therapy is beneficial in skeletal transverse deficits, where the upper dental arch is too narrow about the jaw, causing malocclusions such as posterior crossbite. Elastics are used to apply forces that stimulate palatal expansion and tooth alignment correction more gradually than techniques such as the RME (210–216). As a non-surgical therapy, elastodontic therapy is less invasive than other options, such as surgery or rapid expansion appliances. Due to the gradualness of the forces exerted by the elastomers, patients may experience less discomfort during treatment (24,127,128,153,217–222, 381). The elastics and devices can be adapted to the patient's needs, offering a more targeted and precise treatment. In children and young patients, bone tissue is more plastic and responds better to elastic stimuli (223–228). Therapy may take several months to a year, with maintenance periods to ensure long-term stability (37,38,229–236). In more complex cases or for adult patients, elastodontic treatment can be combined with other orthodontic techniques, such as fixed braces or orthognathic surgery (237–256). Although elastodontic

therapy is still in the developmental stage, several clinical studies suggest that using specific elastomers to correct transverse malocclusions may be a viable alternative to more invasive techniques. Effectiveness depends on patient cooperation, as elastics must be worn for the recommended time to achieve optimal results (208,257–261).

Duration and Growth Predictions

The duration of treatment varies based on the severity of the deficiency and the patient's age (262–271). Orthopedic expansion in younger patients typically requires three to six months of active treatment, followed by retention to maintain the achieved expansion (262,272–286). Relapse potential is higher in older patients, necessitating extended retention periods or additional interventions (263,287–314). Predicting craniofacial growth is essential for long-term treatment stability. Growth modification is more effective in prepubertal patients, as their sutures remain responsive to orthopedic forces (258,270,315–367). In contrast, post-adolescent patients require more invasive approaches to achieve stable skeletal expansion (210,368–374). Regular follow-ups and cephalometric analysis help monitor treatment progress and anticipate further growth-related changes (74,93,110,219,375–379).

Conclusion

Transverse skeletal deficiencies originate from genetic, intrauterine, and postnatal factors. Left untreated, they lead to significant malocclusions and functional impairments. Early intervention using orthopedic expansion techniques offers the best prognosis, while surgical approaches provide solutions for adult patients. Elastodontic orthodontic therapy represents an innovative approach to managing transverse malocclusions, taking advantage of the gradualness and precision of elastics to correct skeletal defects without invasive intervention. Although less well-known than other orthodontic techniques, it is gaining popularity due to its advantages in terms of comfort and customization. It is also a promising option for treating skeletal defects in young and adult patients. Understanding the developmental trajectory of these deficiencies allows for tailored treatment planning, improving both esthetic and functional outcomes. Future research should focus on refining predictive models for growth and enhancing stability in non-surgical and surgical interventions.

Abbreviations

Obstructive sleep apnea (OSA)
 Rapid maxillary expansion (RME)
 Surgical-assisted rapid palatal expansion (SARPE)
 Temporomandibular joint dysfunction (TMD)

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