

# Comparative effectiveness of orthopedic devices for treating skeletal class III malocclusion in growing patients

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## Abstract

**Aim:** Skeletal Class III malocclusion (CI III) presents a significant orthodontic challenge, particularly in growing patients requiring interceptive treatment to achieve effective functional and aesthetic correction. This review compares various orthopedic devices and therapeutic protocols used in CI III correction, identifying the most effective options in an interceptive context.

**Materials and methods:** We searched the PubMed, Scopus, and Web of Science databases for studies published in English, human studies, open-access studies, and studies addressing CI III correction with interceptive orthopedic devices.

**Results:** Exclusions included in vitro animal studies, off-topic studies, reviews, meta-analyses, and articles in languages other than English.

**Conclusions:** The application of orthopedic devices in growing patients can rapidly improve CI III malocclusion, although each device has specific effects on the surrounding skeletal structure.

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## Introduction

Skeletal Class III is a complex craniofacial anomaly characterized by an imbalance in the sagittal relationship between the maxilla and mandible. This condition is typically marked by mandibular protrusion and/or hypermandibulism, which may or may not be accompanied by retrusion or underdevelopment of the upper jaw (1–15). Such an imbalance can lead to significant functional and aesthetic concerns, making early diagnosis and appropriate treatment crucial for long-term stability and facial harmony (16–48). The etiology of Class III malocclusion is multifactorial, involving genetic and environmental factors. Genetic predisposition plays a significant role, as evidenced by familial clustering and higher prevalence in specific ethnic groups. Studies have shown that Class III malocclusion is more common in Asian populations, with reported prevalence rates reaching up to 14% in Chinese and Japanese individuals, compared to approximately 5% in Caucasians, such as in Italy. This suggests a strong hereditary component, with genes influencing maxillary deficiency, mandibular prognathism, or a combination of both. Additionally, specific craniofacial syndromes, such as Crouzon syndrome and Treacher-Collins syndrome, have been associated with Class III skeletal patterns, further emphasizing the genetic basis of this condition. Environmental influences also contribute to the development and severity of Class III malocclusion (49–79). Habitual behaviors, such as mouth breathing, improper tongue posture, and early loss of primary teeth, can exacerbate existing skeletal discrepancies by altering standard growth patterns. Factors like premature fusion of cranial sutures or postural habits related to sleeping position may further impact the anteroposterior relationship between the jaws (4,15,80–143). Cephalometric analysis is a fundamental tool in diagnosing and classifying Class III malocclusion. The most critical measurements include the SNA, SNB, and ANB angles, which help assess the anteroposterior skeletal relationships. In a regular skeletal pattern, the ANB angle typically falls within the range of  $2 \pm 2$  degrees, with deviations indicating Class II ( $>4$  degrees) or Class III ( $<0$  degrees) malocclusions (144–157). The Wits appraisal provides insight into skeletal divergence and jaw positioning, with typical values ranging from  $-1 \text{ mm} \pm 2 \text{ mm}$ . A more negative Wits value suggests increased skeletal divergence, often linked to a steeper occlusal plane. From a dental perspective, Edward Angle's classification system, established in 1907, remains a cornerstone in occlusal diagnosis. According to this classification, Class III malocclusion occurs when the mesiobuccal cusp of the maxillary first molar occludes distal to the buccal groove of the mandibular first molar. To compensate for the reverse bite, patients may develop dental modifications, including upper dentoalveolar protrusion and lower retrusion, which can result in frontal or lateral

crossbite (158–182). Over time, these compensatory mechanisms can contribute to functional difficulties, such as masticatory inefficiencies, speech alterations, and temporomandibular joint (TMJ) disorders. A concave facial profile often characterizes the clinical presentation of Class III malocclusion due to midfacial deficiency. This leads to an increased nasolabial angle, a protrusive lower lip, and excessive exposure of the lower incisors (183–214). Additional features may include macroglossia, a low tongue posture, and an increased tendency toward mouth breathing. The severity of these features can vary based on whether the malocclusion is primarily skeletal or dentoalveolar in origin. Overall, Class III skeletal malocclusion represents a significant orthodontic challenge, requiring a comprehensive approach to diagnosis and treatment. Due to its progressive nature, early identification and intervention are essential in guiding maxillary and mandibular growth toward a more favorable alignment. Advances in cephalometric assessment, three-dimensional imaging, and genetic research continue to enhance our understanding of this condition, allowing for more precise treatment planning and improved patient outcomes (215–250).

## Materials and Methods

This narrative review was conducted to evaluate the effectiveness of various orthopedic treatment modalities for Class III malocclusion. A comprehensive literature search was performed using three major electronic databases: PubMed, Scopus, and Web of Science. The search covered studies published in English, human studies, open-access articles, and research focusing on Class III malocclusion correction using interceptive orthopedic devices. Exclusion criteria included *in vitro* studies, animal studies, articles unrelated to Class III malocclusion treatment, reviews, meta-analyses, and publications in languages other than English. Data extraction focused on study design, patient demographics, treatment modalities, and reported outcomes. The selected studies were analyzed to compare the efficacy, stability, and side effects of different orthopedic treatment approaches. The findings were synthesized to provide a comprehensive overview of the current evidence on interceptive treatment strategies for Class III malocclusion.

## Discussion

### *Etiology of Class III Malocclusion*

Class III malocclusion is multifactorial, with genetic and environmental influences playing significant roles. Genetic factors contribute significantly to skeletal discrepancies, with hereditary traits influencing maxillary hypoplasia, mandibular prognathism, or a combination of both. Environmental factors, including mouth breathing, tongue posture, and early loss of primary teeth, can exacerbate skeletal imbalances. Epidemiological studies indicate that Class III malocclusion varies in prevalence across different ethnic groups, being more common in East Asian populations than in Caucasian or African populations. Understanding these etiological factors is crucial for

determining the appropriate intervention, timing, and modality (251–292).

### *Growth and Treatment Timing*

The success of interceptive orthopedic treatment for Class III malocclusion heavily depends on the timing of intervention. Growth modification is most effective when initiated during peak pubertal growth, as the craniofacial complex undergoes significant changes during this period. Skeletal maturity indicators such as cervical vertebral maturation (CVM) and hand-wrist radiographs can help determine the optimal time for treatment. Early intervention, typically between ages 6 and 10, allows for more excellent orthopedic effects on maxillary protraction and mandibular growth restriction. Delayed treatment may necessitate more invasive approaches, including orthognathic surgery (3,7,293–329, 533, 534).

### *Results and comparison of different orthopedic devices*

Several orthopedic devices have been developed to address Class III malocclusion in growing patients, and they can be broadly classified into extraoral and intraoral functional appliances. One of the most used extraoral devices is the Reverse-Pull Headgear, also known as the Facemask. This appliance promotes maxillary protraction by applying forward and downward forces to the maxilla through elastics attached to intraoral anchorage. Clinical studies have demonstrated its effectiveness in significantly improving cephalometric parameters such as the SNA angle and the ANB correction, making it a widely accepted approach in managing skeletal discrepancies associated with Class III malocclusion. Another extraoral treatment modality is Chin Cup Therapy, which has been extensively employed to manage maxillary deficiency (2,330–354). The inverted chin cap is particularly effective in cases where mandibular overgrowth needs to be controlled. Comparative studies analyzing the effects of the facemask and the reverse chin cap in growing patients with skeletal Class III patterns indicate that both devices contribute to advancing the upper jaw. Cephalometric evaluations have revealed similar outcomes between these methods, including an increase in the SNA angle and a decrease in the inclination of the lower mandibular incisors. However, concerns regarding long-term stability persist, as the effectiveness of mandibular growth inhibition remains variable. The Bionator III and Frankel III appliances are commonly used to modify mandibular growth among the intraoral devices. Removable functional appliances encourage favorable skeletal and dentoalveolar adaptations, although their impact on skeletal correction is generally considered less significant than that achieved with facemask therapy. Another intraoral approach is the use of the Double Plate Appliance (DPA), which contributes to improving vertical dimensions. The DPA is often employed with the facemask (DPA-FM) to enhance the effectiveness of maxillary protraction. Rapid Maxillary Expansion (RME) is another technique frequently combined with facemask therapy. By loosening the circummaxillary sutures, RME facilitates maxillary advancement and

enhances treatment efficiency. A variation of this method, known as the Alt-RAMEC (Alternating Rapid Maxillary Expansion and Constriction) protocol, involves sequential expansion and contraction phases to stimulate maxillary protraction further. Research suggests that Alt-RAMEC/FM achieves better skeletal advancement than conventional RME/FM combinations. Hybrid Skeletal Anchorage Techniques have emerged as an innovative advancement in orthopedic treatment. These methods incorporate temporary anchorage devices (TADs) to provide skeletal anchorage for maxillary protraction, thereby reducing unwanted dental side effects while enhancing skeletal response (1,5,8,11,14,355–389). A notable example is the Hybrid Hyrax, a palatal expansion appliance that integrates skeletal anchorage to minimize undesirable incisor inclination, a common concern with traditional RME approaches. In addition to these methods, other orthopedic approaches include the Reverse Twin Block (RTB), which primarily induces dentoalveolar changes rather than significant skeletal modifications. The Jasper Jumper is another functional appliance used in cases where improvement of molar relationships and overjet is required through a combination of skeletal and dental correction. The effectiveness of these devices varies, with some yielding more pronounced dental effects rather than skeletal improvements. One of the ongoing challenges in the orthopedic treatment of Class III malocclusion is balancing dental and skeletal anchorage (390–414,535). Skeletal anchorage, which involves mini-plates or appliances like the Hybrid Hyrax, offers superior control of jaw growth and minimizes side effects such as excessive tilting of the upper incisors. In contrast, traditional dental anchorage techniques can result in unwanted dental inclinations and increased facial height, which may compromise treatment outcomes. Side effects and treatment limitations must also be carefully considered. Some facemask treatments have been associated with posterior mandibular rotation, increasing lower facial height. Additionally, the proclination of upper incisors and retroclination of lower incisors are common effects observed with Reverse Twin Block therapy. Although these changes may initially appear beneficial, their long-term stability remains questionable. Furthermore, the excessive forward tilting of upper incisors, often caused by dental-anchored devices, can negatively impact facial aesthetics, requiring careful management during treatment planning (12,155,415–442). A crucial aspect of Class III orthopedic treatment is the long-term stability of results. Some studies indicate that while orthopedic interventions produce significant short-term improvements, their effects may diminish, particularly if mandibular growth persists into late adolescence. To optimize long-term outcomes, retention protocols are essential (13,443–477). Using fixed or removable retainers, including bonded lingual retainers and removable appliances, is critical in maintaining treatment results and preventing relapses. Factors such as residual mandibular growth, patient compliance, and selecting appropriate retention strategies significantly influence the stability of treatment outcomes. Early intervention is key to optimal results, especially when

using orthopedic devices to stimulate upper jaw growth. The combination of facemask therapy with rapid palatal expansion remains the gold standard for managing Class III malocclusion in growing patients. However, integrating newer skeletal anchorage techniques shows promising potential in improving treatment stability and minimizing unwanted dental effects. Future research should focus on long-term follow-up studies to evaluate the durability of these treatment modalities and determine the most effective strategies for ensuring stable outcomes in the correction of Class III malocclusion (478–532).

## Conclusion

Interceptive orthopedic treatment for Class III malocclusion offers significant benefits in growing patients, allowing for skeletal modifications that reduce the need for future surgical interventions. However, treatment outcomes depend on various factors, including patient age, compliance, and growth potential. Advancements in skeletal anchorage and digital treatment planning continue to refine therapeutic approaches, improving predictability and effectiveness. Further, longitudinal studies are required to assess the long-term stability of different treatment modalities.

## Abbreviations

Alt-RAMEC Alternate maxillary expansion and constriction  
 ANB Point A–Nasion–Point B  
 BAMP Bone anchored maxillary protraction  
 CBCT Cone beam computed tomography  
 CIII Class III  
 CIIIM Class III malocclusion  
 Co Condyle  
 DPA Double-plate appliance  
 FM Facemask  
 FM/BB Bite block and face mask  
 Gn Gnation  
 Go Gonion  
 Me Menton  
 MTTBA Modified tandem traction bow appliance  
 N Nasion  
 PFM Protraction face mask  
 PNS Posterior nasal spine  
 PS3 Pushing splits 3  
 RME Rapid maxillary expansion  
 RME/FM Rapid maxillary expansion and facial mask  
 RMR Removal mandibular Removal mandibular retractor  
 RTB Reverse twin block  
 RTBLP-RME Modified reverse twin block with rapid palate expansion  
 S Saddle  
 CI III Skeletal class III  
 CI III Skeletal class III malocclusion  
 SEC Splints, class III elastics, and chin cup  
 Sna Anterior nasal spine  
 SNA Saddle–Nasion–Point A  
 SNB Saddle–Nasion–Point B  
 TSME Transverse sagittal maxillary expander

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