

A descriptive review of managing Anterior Open Bite across the deciduous, mixed, and permanent dentition stages

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Abstract

Anterior open bite is a malocclusion with a vertical gap between the upper and lower incisors when the posterior teeth are in occlusion. This condition can affect children and adults and has a multifactorial etiology, including functional habits, environmental factors, and genetic predisposition. Common causes include thumb sucking, mouth breathing, and skeletal growth discrepancies. Diagnosis involves clinical examination, radiographic imaging, and three-dimensional imaging to assess the severity and causes of the condition.

Anterior open bites are classified into dentoalveolar open bites, related to dental and functional issues, and skeletal open bites, caused by skeletal discrepancies. The severity, ranging from mild to extreme, influences treatment. Mild cases are treated with orthodontic appliances, while more severe cases may require a combination of orthodontics and surgery.

Early intervention, including habit modification, appliances, and orofacial myofunctional therapy, is crucial to preventing progression in children. Treatment may involve more complex orthodontic approaches or orthognathic surgery for severe skeletal open bites in adults. A comprehensive diagnosis and tailored treatment are essential for optimal functional and aesthetic outcomes.



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Introduction

Anterior open bite (AOB) is a malocclusion characterized by the lack of vertical overlap between the upper and lower incisors when the posterior teeth are occluded (1-12). When a person closes their mouth, they may see the apparent vertical space between their anterior teeth caused by this problem (13-24). This malocclusion may impact both adults and children (23-26)

AOB has a complex etiology and may include a mix of functional, environmental, and genetic variables (37-48). It could be brought on by behaviors that alter the way the teeth and jaw are positioned, like thumb sucking or long-term pacifier use (49-60). An AOB can also arise due to skeletal characteristics, such as a vertical difference in the mandibular and maxillary growth patterns (61-72).

To use AOB, a clinical examination, radiographic imaging, and occasionally three-dimensional imaging are used to evaluate the alignment and structure of the jaws and teeth (73-84).

Different treatment approaches are used for AOB, depending on the patient's age and the severity of the ailment (85-96). Orthodontic appliances (OA) like braces or aligners can treat mild cases, whereas a combination of orthodontics and surgery may be necessary for more severe cases (97-107). Early intervention is essential to getting the best results.

Classification of AOB

AOB, a complicated malocclusion, can be categorized in several ways (108-115) based on the underlying origin and severity of the disorder. Classification is essential because it directs the proper treatment strategy, which differs greatly depending on the kind and severity of the open bite (116-125). Dento-alveolar open bite (DAO) and skeletal open bite (SOB) are the two broad categories into which AOB can be divided, with other subcategories dependent on the patient's age, functional habits, and craniofacial growth patterns (126-135).

DAO

DAO is a malocclusion that is more commonly linked to problems with functional habits and tooth eruption patterns than to skeletal abnormalities (136-140). The maxilla and mandible are craniofacial structures that usually develop within standard growth patterns. Still, the teeth and alveolar bone are the main contributors to the open bite in this group (141-146). This open bite is frequently observed when aberrant oral habits significantly disrupt improper dental alignment (Figure 1).

Thumb sucking, tongue thrusting, mouth breathing, and other behaviors that might move teeth, especially incisors, are common contributing factors (147-150). For example, early childhood thumb sucking can put pressure on the upper and lower teeth, causing misalignment and an open bite (151-155). The anterior teeth may also move forward, creating a gap due



Figure 1. Dento-alveolar open bite.

to tongue thrusting, which occurs when the tongue presses against the teeth when speaking or swallowing (156-161). Furthermore, mouth breathing, which is frequently brought on by allergies or congestion in the nose, can alter how the tongue rests in the mouth and exacerbate tooth misalignment (162-165). Since the teeth are the leading cause of the issue, DAO may frequently be fixed with OA, such as braces (166-170).

SOB

Vertical differences in the growth and development of the maxilla (upper jaw) or mandible (lower jaw) are the cause of SOB (171-177). These differences could result from early developmental abnormalities, aberrant craniofacial growth patterns, or hereditary causes (178-183). Because the problem with SOB stems from the bone structure rather than the tooth positions, the ailment is more complicated and frequently necessitates a multidisciplinary approach to therapy (184-188).

Numerous factors can lead to SOB. A disparity between the maxilla and mandible's vertical growth—for example, the upper jaw growing too short vertically or the lower jaw growing too long—is one of the most frequent reasons (189-196). On the other hand, SOB is frequently congenital or associated with aberrant craniofacial development, which results in uneven jaw growth (197-201). Usually more difficult to correct, this open bite may necessitate orthodontic therapy (OT) and surgery, especially in extreme situations. Although OTs can assist with teeth alignment, surgery could be required to address the underlying bone imbalance (202-206).

Severity of Open Bite

- The vertical distance between the patient's mandibular (lower) and maxillary (upper) incisors as they bite down determines the severity of an AOB. Since more severe open bites frequently require more involved or extensive treatment, the severity of the condition dramatically influences the treatment strategy (207-211).
- Mild Open Bite (0-2 mm): There is typically less than 2 mm of space between the upper and lower incisors (212,213) in mild cases. Non-invasive treatments like orthodontic braces or aligners can commonly address these situations, and patients may only need

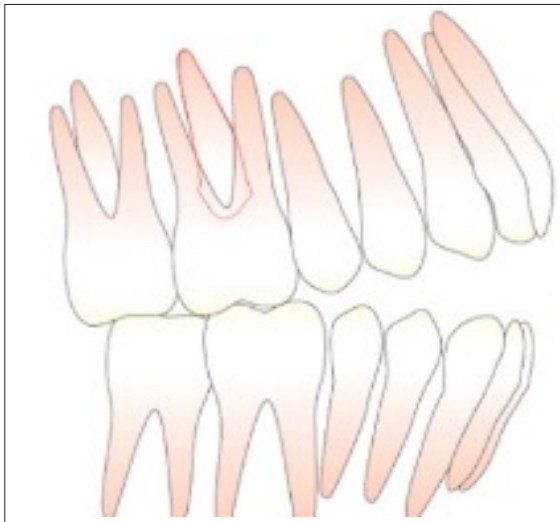


Figure 2. Severe Open Bite

to make minor changes to their oral hygiene practices (214–219).

- **Moderate Open Bite (2-4 mm):** Although OA may still cure this type of bite, it manifests as a more pronounced space between the incisors. Additional functional therapy may be necessary to treat oral habits such as tongue pushing caused by an open bite (220–224).
- **Severe Open Bite (4->6 mm):** Treatment for a severe open bite usually entails a more comprehensive approach that may involve both orthodontic and surgical procedures (225–234). The vertical jaw disparity is more noticeable in these situations, and the tooth alignment and the underlying skeletal issue require extensive surgery (235–239) (Figure 2).

Etiology of AOB

- AOB has a complex etiology that includes both environmental and genetic components. The open bite may occur due to skeletal, habitual, and functional problems (240–246). The following are some of the leading causes:
- **Non-Nutritive Sucking Habits:** Children who use pacifiers or thumb suckers for extended periods may experience an open bite as a result of the teeth's regular emergence (247–252). The maxillary incisors are under pressure from these behaviors, ultimately preventing them from emerging and separating the top and lower teeth. The issue can also be made worse by behaviors like tongue pushing, which is when the tongue pushes forward against the teeth during swallowing (253–257).
- **Mouth Breathing:** Mouth breathing can result in an open bite and irregular tongue position, which is frequently linked to persistent nasal congestion (258–264). There may be a lack of vertical overlap between the upper and lower teeth in mouth breathers due to the tongue, which normally rests on the roof of the mouth during breathing, falling forward (265–269).
- **Hereditary Factors:** In certain instances, an AOB

may be caused by a hereditary predisposition in which improper development of the craniofacial features results in skeletal abnormalities(270–273). An open bite may stem from some skeletal issues that impede appropriate dental occlusion (274–278).

- **Craniofacial Growth Abnormalities:** A SOB may develop as a result of abnormalities in the growth of the maxilla or mandible. In some situations, the upper and lower incisors may not meet due to either insufficient or excessive vertical growth of the jaw or maxilla (279–283).

Diagnosis

Diagnosing AOB involves a comprehensive evaluation that includes a detailed patient history, clinical examination, and imaging studies.

- **Clinical Examination:** The main methods used to diagnose AOB are visual examination and jaw and tooth palpation. A dentist will examine the connection between the upper and lower incisors (284–288)in both centric occlusion and other functional postures. This can assist in identifying the kind and extent of the open bite. To better understand the origin of the open bite, the doctor will also search for additional symptoms, such as incorrect tongue posture, lip incompetence, or facial asymmetry (289–296).
- **Radiographic Imaging:** The skeletal and dental structures may be evaluated using diagnostic imaging techniques such as cone-beam computed tomography (CBCT), panoramic radiography, and cephalometric X-rays (297–302). These pictures cover the relationship between the maxilla and mandible, the position of the teeth, and any underlying skeletal abnormalities that might be causing the open bite (303–307).
- **Functional Assessment:** The patient's oral behaviors, including mouth breathing, tongue thrusting, and non-nutritive sucking, are evaluated as part of a functional assessment. This can direct the course of treatment and assist in determining possible causes of the malocclusion. In cases with DAO, evaluating the patient's eating habits and tongue posture is especially crucial because aberrant tongue motions might exacerbate the illness (313–318).
- **3D Imaging and Computerized Models:** More and more people are using modern diagnostic methods, like 3D imaging and computerized digital models, better to understand the patient's craniofacial anatomy and occlusion (319–325). These technologies allow for a more precise evaluation of the open bite's severity and more accurate treatment strategy planning (326–330).

Management in the Deciduous Dentition

AOB is frequently linked to functional behaviors in children, especially those with deciduous (baby) teeth, like using a pacifier or sucking one's thumb. Treating these habits before the emergence of permanent teeth is the main objective of treatment (331–335)in these situations.

- **Behavioral Intervention:** Eliminating bad oral habits through behavioral treatments is one of the best strategies for treating AOB in young children. Motivational strategies to help kids quit using pacifiers or thumb-sucking are examples of this. Parental participation, incentives, and positive reinforcement can all effectively change these behaviors (336–340).
- **Use of Appliances:** In more severe situations, OA tools like habit breakers, thumb-sucking spurs, or lingual cribs can be utilized to stop harmful behaviors from continuing. Putting physical barriers in the mouth makes it harder for kids to thumb-suck, which helps discourage the habit (341–345).
- **Orofacial Myofunctional Therapy (OMT):** The goal of orofacial myofunctional therapy is to re-educate the face, mouth, and tongue muscles to support healthy function and enhance tongue posture (346–352). When tongue thrusting is causing the AOB, this treatment may be particularly beneficial. OMT can help stop the open bite from getting worse by treating the functional features of the malocclusion (353–357).
- **Management in the Mixed Dentition:** A youngster with primary and permanent teeth is said to be in the mixed dentition period (358–362). If AOB continues into this stage, early intervention may be required to prevent the condition from getting worse. The severity of the open bite and whether it is predominantly caused by skeletal or dental factors determine the potential treatment options in the mixed dentition (363–367).
- **OA: Functional appliances** like the Herbst appliance, which can assist in regulating the vertical dimension and promoting the appropriate eruption of the teeth, may be used in OT for children in the mixed dentition phase (368–373). Additional devices, such as bite blocks or headgear, may be employed to close the open bite and regulate the eruption of the posterior teeth.
- **Early Treatment with Braces:** Moving the teeth into better alignment may involve a brief period of braces or another OA. This is particularly true with DAOs when the skeletal structures are typical, and the primary issue is dental.

Management in the Permanent Dentition

AOB is usually more severe and may require more sophisticated treatment methods when it continues into the permanent dentition (374–379). Depending on the severity, treatment options might vary from orthodontic care to surgery.

- **OT: Braces, elastic bands, or other appliances** may be used in occupational therapy (OT) to seal the open bite and straighten teeth in adults and adolescents with mild to moderate AOB (308,380–383). Molar intrusion and anterior tooth extrusion are often employed tactics to accomplish this.
- **Temporary Anchorage Devices (TADs):** In orthodontics, mini-screws and other TADs are increasingly employed to offer a secure anchor for the molar incursion. Without depending on patient

compliance, these devices enable the application of forces to shift teeth (384–388). They are especially helpful in treating adult SOB.

- **Orthognathic Surgery:** Orthognathic surgery might be necessary for severe SOB patients who cannot be resolved with orthodontics alone. To fix the vertical disparity, the maxilla or mandible must be moved (389–394). Surgery is usually required when there is a substantial skeletal imbalance and orthodontics alone cannot straighten the bite (395–401, 402).

Conclusion

AOB is a complicated illness with a range of underlying causes and severity levels. Early management is essential for youngsters in the deciduous and mixed dentition phases to halt the condition's progression. Treatment for adults or patients with permanent dentition may be more involved and include a mix of appliances, orthodontic procedures, and possibly surgery. AOB can be successfully handled to enhance the patient's functional and aesthetic results with a thorough diagnosis and customized treatment plans. A comprehensive strategy that includes early intervention, habit modification, and applying orthodontic or surgical techniques is necessary for successful treatment.

Institutional review board statement

Not applicable.

Informed consent statement

Not applicable.

Data availability statement

Data are contained within the article.

Conflict of interest

The authors declare that they have no conflict of interest.

List of Abbreviation

Abbreviation	Meaning
AOB	Anterior Open Bite
CBCT	Cone-Beam Computed Tomography
DAO	Dento-Alveolar Open Bite
OA	Orthodontic Appliances
OMT	Orofacial Myofunctional Therapy
OT	Orthodontic Treatment
SOB	Skeletal Open Bite
TADs	Temporary Anchorage Devices

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