I would like to invite our dear readers to enjoy the knowledge – resulting from his clinical experience and scientific fundamentals – of an icon of Brazilian orthodontics. Prof. Roberto Carlos Bodart Brandão demonstrated, in his answers to the interviewers, profound knowledge and unique confidence while discussing the issues of disjunction, finalization, aesthetic excellence, occlusion, selective grinding and retaining. A sports fanatic, particularly nautical sports, Prof. Roberto regularly goes deep sea fishing, in addition to occasionally practicing windsurf and tennis. Restless, curious and very critical – especially of himself – he looks for his mistakes every day in order not to repeat them. He enjoys technology, but believes his profession is art and background. He also enjoys cooking, especially for family and friends, who are, according to him, his “greatest wealth”. He is the son of Aloadyr da Silva Brandão and Wilda Bodart Brandão (he, a general dentist, retired, one of those who worked from 7 am to 9 pm with two jobs and a private practice – tireless; she, a retired grade school teacher, who rose rapidly to become principal of a public school, through her competence and seriousness, a charismatic leader). Dr. Roberto works from his private clinic, located in Vitória/ES, where he works alongside his wife Larissa – also an orthodontist, a graduate from Universidade Federal Fluminense. I wish you all an excellent scientific contact with this five-star orthodontist.

Telma Martins de Araujo
Do you employ expansion followed by contraction – O senhor emprega a expansão seguida de contração, tão defendida na actualidade, como auxiliar na maxillary protraction? Telma Martins de Araujo

The results of the studies have been positive, and I have included this practice in my cases of Class III malocclusion with maxillary retraction, stimulated especially by the studies of Dr. Liou, who pioneered the technique. As I do not have access to the double-hinged expander developed by the author, I use the conventional Haas expander. After the expansion and contraction period (seven weekly cycles), I begin protraction using an orthopedic facemask. The casuistry, while still limited, is positive for this protocol, but we need more long-term studies to consider the stability of those results. The early treatment of Class III is one of the greatest accomplishments of orthodontics, and all effort and knowledge must be applied to correct and control growth, even when we know many cases will end up in surgical procedures, which should be clearly explained to patients and guardians.

What is your experience with non-surgical expansion in adult patients? Telma Martins de Araujo

Scientific evidence shows that closure of the midpalatal suture occurs around the age of 16 for girls and 18 for boys; in the same study, however, open sutures were found in cadavers up to 27 years of age. Based on these findings, I adopt a rather uncommon clinical approach for some cases of transverse maxillary deficiency. I usually attempt rapid maxillary expansion in patients up to 23 years old, depending on their individual characteristics. In these patients with posterior crossbite, I evaluate the thickness of the buccal bone plate in the maxillary arch, which should not feature salient root contours to the touch, and check the degree of synostosis of the midpalatal suture, which can be evaluated using occlusal radiography, or even better, through volumetric tomography. I use Dolphin Imaging software to reconstruct tomographic images; I believe in an improvement in the resolution of these images in the short-term, as they have not yet proven to be reliable. In the cases where the images suggest the suture has not fully closed, I make use of the Hyrax appliance activated four times a day during four or five days. I then reevaluate the patient, and if a diastema has developed between the maxillary central incisors (a clinical sign of expansion), I move on to activation twice a day, following the conventional protocol, until achieving overcorrection of the transverse problem (Fig. 1). I regard late expansion as a valid attempt, with which I have achieved a lot of success, but I know I have not reached the best possible scientific evidence for that practice. If expansion does not occur, the patient is previously informed of the need for surgically assisted rapid maxillary expansion (SARMA). Most patients prefer the clinical treatment, if possible, before the surgical solution.

How do you evaluate the incorporation of torque in posterior teeth, during the initial or advanced stages of treatment, using the same prescription of pre-adjusted brackets or the same pattern of bends on orthodontic arch wires for all patients? Jonas Capelli Junior

This question requires a reflection, and I shall divide the answer into two parts. First, I will discuss the concerns I have with torque during orthodontic treatment. I am very self-critical, and I believe I learn more from my mistakes than with my successes. During my practice, I have observed that incorporating undesirable torques leads to significant delays in treatment, as well as potential iatrogeny. In that context, I recommend all clinicians observe the torques in the posterior teeth of their patients prior to treatment and also after the leveling phase using round arch wires. The torques of posterior teeth are normally just fine in both cases. Therefore, there is no need, in most patients, to incorporate torques, but there is a need to control them. Therefore, we would make a mistake if we incorporated...
FIGURE 1 - A, B, C, D) 23-year-old patient, with posterior bilateral crossbite associated with a Class II division 1 malocclusion, anterior open bite. E, F) Correction of transverse problem through late maxillary disjunction, without surgical assistance, using the Hyrax. G, H, I) Result of the disjunction, with bite opening, temporary. J, K, L) Final result obtained with fixed appliances. In order to correct the Class II, the maxillary first premolars and mandibular second premolars were extracted for a camouflage effect. M, N, O, P) Smile comparison, before and after correction, purely clinical.
root movements where they are not necessary. This observation is far from forgoing the use of rectangular arch wires in treatments, but it defines that their use should be preceded by an important judgment. Prior to setting a rectangular arch, one should question whether there is the need to make root movements in posterior teeth. As the answer is usually no, the arch should be passive in those teeth. This is only effectively achieved if an “arch reading” is done prior to setting. The worst could happen if the torque indicated for a molar were the opposite of that resulting of standard Edgewise bend or a Straigh-wire prescription. This simple procedure, of “arch reading”, avoids two serious problems: (1) by incorporating an undesirable buccal root movement in posterior maxillary teeth, this leads to a reduction in periodontal thickness, adding a risk of periodontal recession, and at the same time, contraction of the maxillary arch, possibly resulting in a posterior crossbite; (2) if the movement is lingual by the root of the same teeth, there will be extrusion of the palatal cusp, and consequently an open bite (Fig. 2). For any of these situations, a problem is added or aggravated in the malocclusion, demanding time and mechanical effort that were previously unnecessary.²

The second part of the answer concerns the use of pre-adjusted appliances, using an author’s judgment as a finished solution. We need only observe the countless number of appliances available in the market, and each author’s declarations favoring their own product and pointing out the problems with the competition, to suspect these ready-made solutions. The search for the perfect appliance is limited by the diversity in tooth shapes and dental arches that can be considered normal. A geometric progression would explain the variety of situations and the impossibility of finding a solution that could fit perfectly into a single case. Variation in human occlusion is the rule, and not a given average applied to determine the torque and angling of a prescription. Additionally, there is the variation in the torque result whenever the height in which a bracket is bonded is changed (Fig. 2). The idea of perfect techniques only find space when there is no scientific basis – and that goes both for pre-adjusted appliances and conventional techniques (Edgewise, Ricketts), when critical thinking is not used before

![Figure 2](image-url)

**FIGURE 2** - A) Bonding of two same prescription brackets at different heights on a premolar crown. B) Verify the opposite effects of root torques when wires are placed orthogonally to the brackets. C) Root buccal torque effect in the more apical bracket, with a potential contraction of the arch and risk of periodontal recession. D) Opposite effect on the occlusal-bonded bracket, root lingual torque, creating premature contact and potential open bite. Although they represent extremes, these figures show how much the effect of torque incorporated into the brackets is dependent on tooth morphology.
any procedure. It is certainly easier to win the lottery than find an appliance that can treat a malocclusion, with quality, in the hands of an orthodontist without the proper qualifications. Professional qualification demands hard training, obtained only is specialization courses with at least 2,000 hours in the classroom. Unfortunately, the lack of management in Brazilian orthodontics has led many to consider normal specialization courses with three days a month, with a class load that until recently would not even be acceptable for refresher courses. What has changed? In the rest of the world, nothing – the number of courses has decreased, with only those with higher quality remaining, prioritizing critical thinking by the orthodontist, and not the technique. In Brazil, there is desperation, excess of dentists, lack of patients, the low compensation and low quality in education… in short, lack of management. That is the great challenge of ABOR – to take the responsibility of managing the field of orthodontics, as happens with medicine in Brazil and orthodontics in the United States, where organized specialists are the managers of their specialties. It is a battle that should be fought by all orthodontists, organized, giving support to ABOR and BBO, as that is the only solution.

Your training was in “standard Edgewise” and, after a few years, you migrated to “Straight-wire”. What you would say to orthodontists who still practice only “standard Edgewise” and, likewise, to schools and orthodontists who are educated only in straight-wire? Luiz G. Gandini Junior

Indeed, my initial education was at UFRJ, which has a curriculum based on the Edgewise technique, intensively and extensively reviewed and revised. I believe that is one of the main reasons I am in this privileged position, answering questions made by prominent professionals in Brazilian orthodontics. I have a visceral bond with my professors at UFRJ, of whom I would highlight four names: Professor Alderico Artese, for his innovative and sagacious spirit; Professor Carlos Teles, for his straight conduct; Professor Ana Maria Bolognese, for her determination towards scientific evidence; and lastly, Professor Nelson Mucha, who is an icon of excellence, who has inspired an entire generation of orthodontists. I definitely believe that students need guidance, a consistent education that combines critical thinking, knowledge and training, aiming for the best possible professional judgment. As such, building an orthodontic plan based on consistent techniques, which require great control over the wire and dental accessories – such as the Edgewise, Ricketts and Segmented Arch techniques – is precious and essential in the education of an orthodontist. In fact, the solution for each problem in orthodontics should lie within the orthodontist, and, to that end, there is the need for a long and thorough education, in addition to dominating a technique, and not being a hostage to it. Unfortunately, recent graduates seek the shortest route, and are led to specialization courses, even Master’s degrees, in which they are trained like technicians of a straight-wire factory. When faced with the reality of clinical practice, they discover that, without a solid basis, it is not possible to build a career, and they lose themselves in more courses and new techniques. Five years ago, after 15 years in orthodontics, I opted for the use of pre-adjusted brackets. I don’t consider I have changed techniques, as I continue to use loops and resources based on Edgewise. I consider all prescriptions of what is known as “Straight-wire” to be, in fact, variation of the Edgewise technique. With the use of pre-adjusted appliances, I believe I made my clinical life easier, especially in the early stages of treatment, and I have noticed, more than ever, that any prescription has its limits. Certainly, one who is trained only in Edgewise and masters the technique, is able to use any straight wire prescription. The opposite is not true. For all that, I consider it absolutely essential that an orthodontist’s initiation be through techniques featuring a scientific basis, exhaustive training and a long history of success, such as the Edgewise technique.