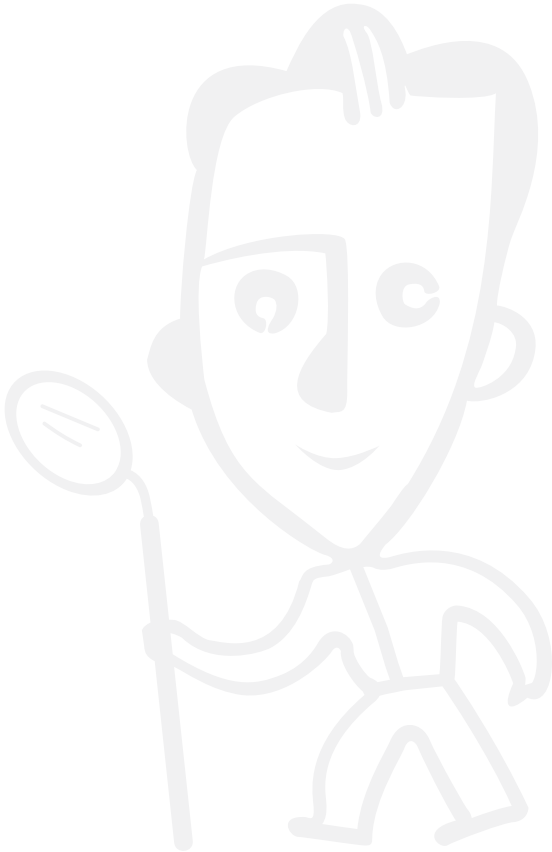


# A Patient's Guide to Treatment

by Dr John Flutter BDS (London)

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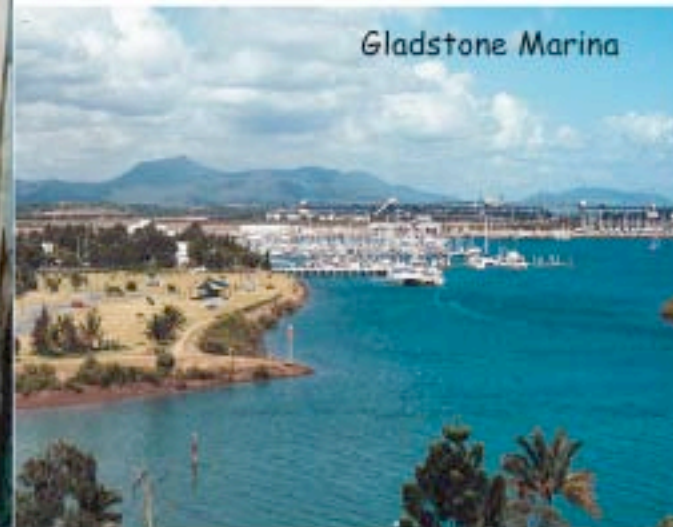




Qualified in London  
 Worked in Australia since 1979  
 Dentistry now limited to orthodontics  
 Works in Gladstone and Brisbane



The tooth fairies house



## About Dr John Flutter

I was born in England and went to university in London.

I qualified as a dentist in 1972 and worked in general practice in London for five years.

From the first day in general practice I started to provide orthodontic care for my patients. In those days I worked under the National Health Service and patients who required orthodontic treatment could be referred to a specialist orthodontist for diagnosis and a treatment plan. The specialist then advised on treatment and I could refer the patient back at any time later if I needed help. In this way I developed my treatment skills and gained experience.

After five years of working in London I sold my house and practice and bought a Landrover and drove to Australia.

After a short period of work in Melbourne and Seymour in Victoria I moved to Gladstone, Queensland in 1979. I started a new practice in Gladstone and continued to provide some orthodontic care. At that time there were no orthodontic specialists in Gladstone. Many of my patients were asking for orthodontic treatment in Gladstone so I started to attend courses to improve my orthodontic skills. As my skills and knowledge improved I started treating more orthodontic patients until it became a large part of my practice. Today I do no other treatment at all.

I completed numerous courses in Australia, Europe and the United States. I spent many hours studying. I spent time with specialist orthodontists to learn more. I passed an examination with the International Association of Orthodontics in Hawaii in 1995.

I was elected president of the Australian Association of Orofacial Orthopaedics and I am still the Queensland president of the same association.

In 1996 I was asked to lecture at the first Australian Symposium on Dentofacial Orthopaedics. The lecture was well received and as a result, over the next three years, I was asked to lecture in London, Canada, Spain, Malaysia and again in Australia. I enjoyed teaching and I was told that I had skills in this area that I also developed. In particular I was one of the first dentists to use computer generated presentations and use video images.

In 1999 after a lecture in Spain I was approached to lecture for Myofunctional Research Company initially in Europe. I agreed and as a result I have now visited 46 different countries (some many times) throughout the world lecturing to dentists and orthodontists. The material is generally very well

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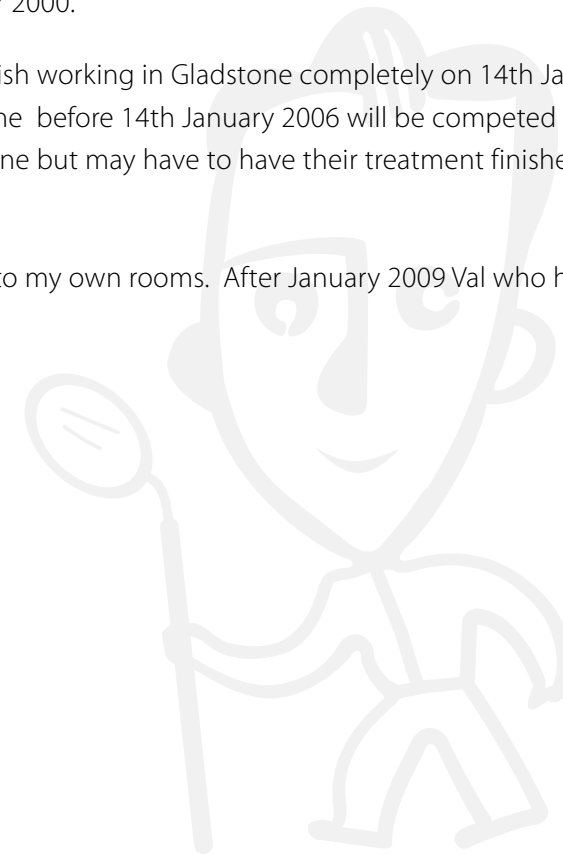
received. At two conferences I have been voted the best presentation at the conference by the delegates. I received the highest score ever at one meeting in the US in 2003.

I spent most of 2001 writing and producing a DVD to help dentists to review the material in my lectures. I have sold over 1500 of them. The DVD was produced for dentists but recently I have had very good feedback from non dentists. I have now reduced the cost of the DVD and made it available to the general public through my website [www.jfdental.com](http://www.jfdental.com).

In July 2002 I sold my general practice in Gladstone and now I work six days a month in Gladstone providing only orthodontic care. The remainder of the month I travel and lecture. I have made an overseas trip almost every month since October 2000.

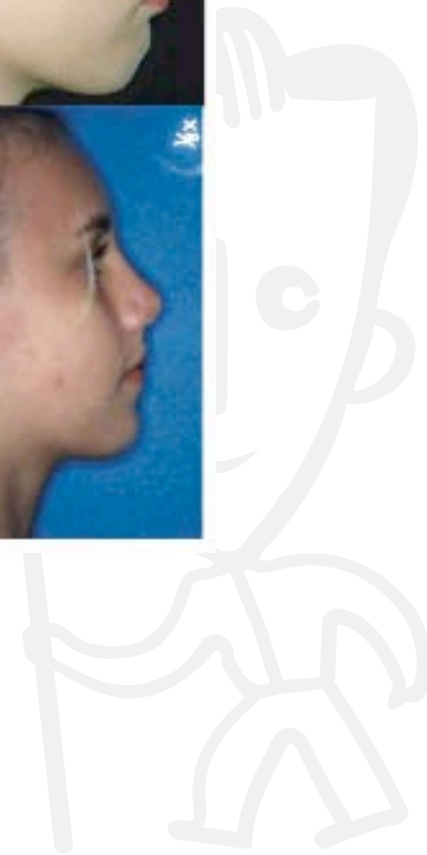
I am now moving to Brisbane to work and will see patients in Gladstone and Brisbane. I will finish working in Gladstone completely on 14th January 2009. After that I will see patients only in Brisbane. All patients who start treatment in Gladstone before 14th January 2006 will be completed in Gladstone. All patients who start treatment after 14th January 2006 may be finished in Gladstone but may have to have their treatment finished in Brisbane if they wish me to complete it.

In Sept 2004 I am starting to see patients Brisbane. Within the next two years I will be moving to my own rooms. After January 2009 Val who has been working with me in Gladstone since 1991 will move to Brisbane and work with me there.





- ▶ Four years after start of treatment
- ▶ No braces or extractions
- ▶ Improved jaw relationship, muscle function and head posture
- ▶ Notice the strain needed to bring the lips together at the start of treatment



## Non Extraction Orthodontics

### Whole Body Orthodontics

Before I start to move teeth I like to look at the cause of the problem.

Research has shown that over 90% of all orthodontic cases relapse unless they have permanent retention or the patient corrects the original cause of the crooked teeth.

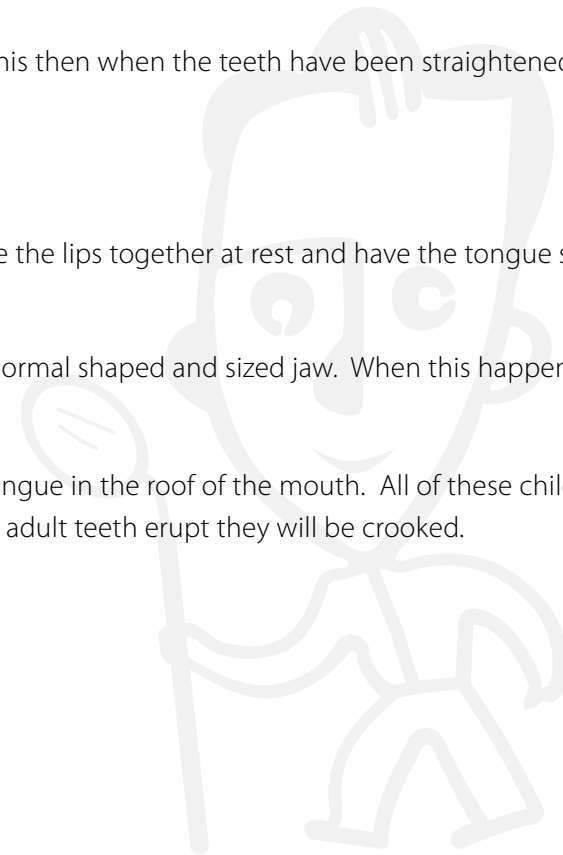
In addition to moving the teeth we need to address the cause of the problem. If we fail to do this then when the teeth have been straightened either we need to have permanent retention or the teeth will relapse towards the original position.

So why do some children develop crooked teeth and some children develop straight teeth?

For normal growth and development the growing child needs to breathe through the nose, have the lips together at rest and have the tongue sitting in the roof of the mouth.

When the tongue rests in the roof of the mouth the teeth erupt around the tongue forming a normal shaped and sized jaw. When this happens the teeth will erupt into a straight line.

Those children who breathe through the mouth or have the lips apart at rest will not have the tongue in the roof of the mouth. All of these children will have an underdeveloped upper jaw. It will not be big enough for all of the teeth and when the adult teeth erupt they will be crooked.





Eight years later the teeth are still straight

A series of photographs showing the expansion of the upper jaw, the bite closing and the teeth all fitting together well over a two-year period and eight years later.

- ▶ No extractions and no braces used
- ▶ The teeth stayed straight
- ▶ Sometimes the teeth look worse before they start to look better



The lower jaw should fit inside the upper jaw. In a normal bite the upper teeth are outside the lower teeth. If the upper jaw is small then there will not be enough room for the lower teeth to erupt without crowding and the lower teeth are also crooked.

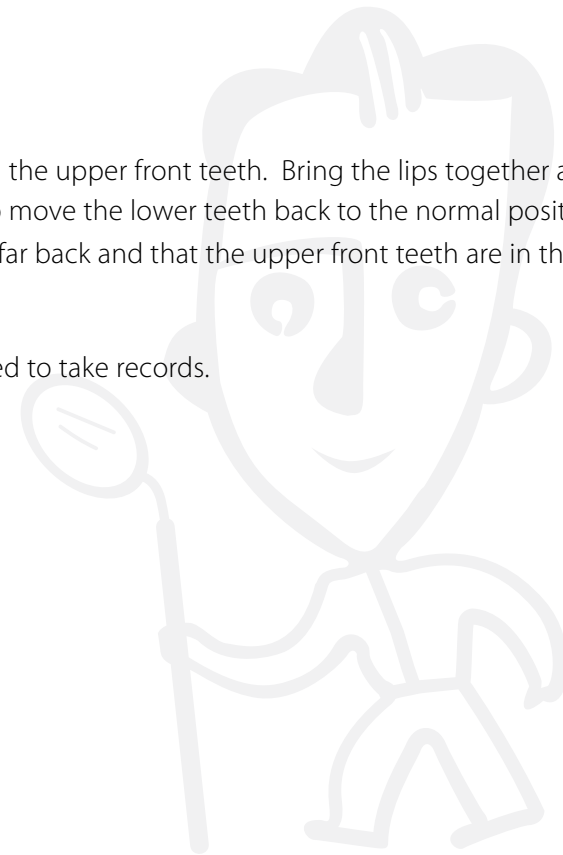
We all swallow about two thousand times a day. Once a minute when asleep and twice a minute when awake. In a normal healthy swallow there should be no movement of the lips at all. If the child has a habit of keeping the lips apart at rest or has a low tongue posture then the lower lip is active on the swallow. This has several effects. It causes the lower front teeth to crowd and it can result in the lower jaw failing to develop fully.

When we see children with "buck teeth" we tend to think that the front teeth are too far forward. This is rarely the case. Most children and adults with "buck teeth" have a lower jaw that is too far back.

## A simple test to check "buck teeth"

If your child has buck teeth ask them to bring the lower teeth forward until they are just behind the upper front teeth. Bring the lips together and then look at the child's profile. Does the profile look normal? With the lips together ask your child to move the lower teeth back to the normal position. Does the profile now look better or worse? If it looks worse it is a sign that the lower jaw is too far back and that the upper front teeth are in the correct position.

This is a simple test. In order to be sure where the upper jaw is in relation to the lower jaw I need to take records.





Establishing nasal breathing was an important part of the orthodontic treatment.

The Breathing Well Programme is used to help children establish nasal breathing.

- ▶ Dental pattern associated with mouth breathing
- ▶ Narrow upper dental arch
- ▶ The tongue never rests and functions in the palate
- ▶ Small upper jaw set back in the cranium
- ▶ Mouth breathing children often have straight lower teeth



- ▶ Nasal breathing restored
- ▶ No treatment in the lower jaw
- ▶ If mouth breathing persists after treatment significant relapse is likely



## Establishing Nasal Breathing

Why do children breath through the nose or have a poor lip seal?

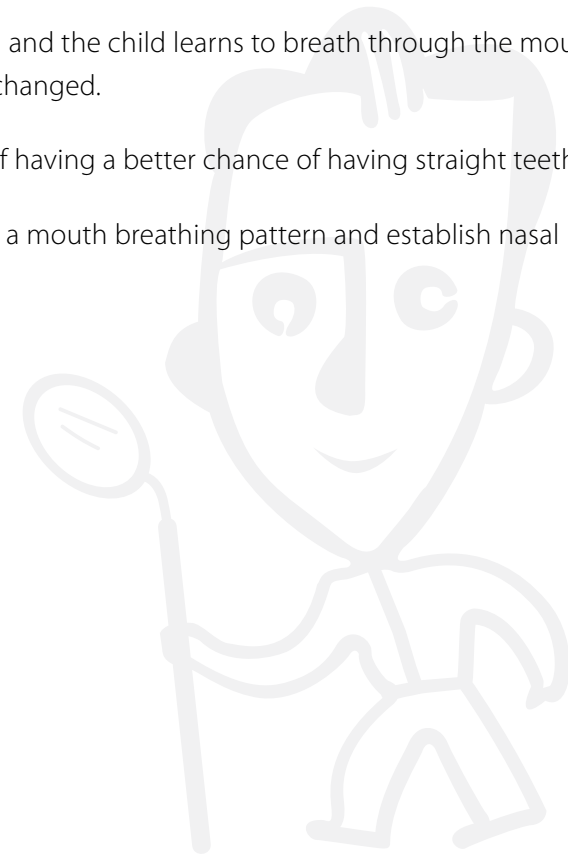
For most children mouth breathing is a habit which can be broken.

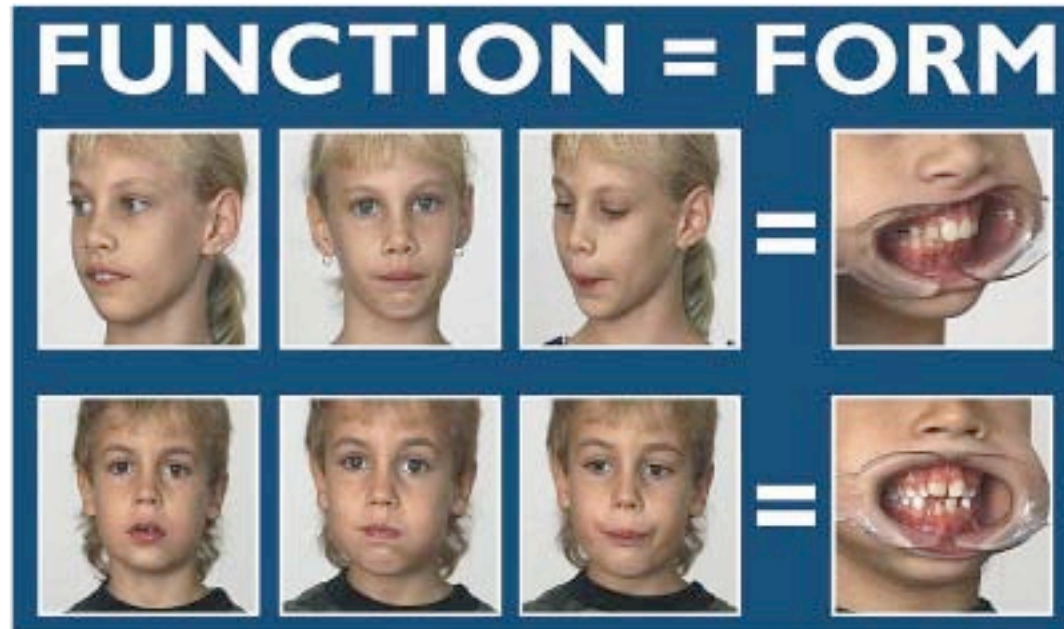
This pattern usually starts very early in life. All new born children breathe through the nose with a lip seal. Children who are breast fed are less likely to develop mouth breathing patterns. The thrust of the tongue forwards to suckle at the breast is a strong driving force to develop the upper jaw.

There are many factors involved. Allergies and air-borne particles can cause an allergic reaction and the child learns to breath through the mouth. Once a mouth breathing pattern is established it becomes a habit and it is a habit that can be changed.

There are many reasons to establish nasal breathing in a growing child apart from the benefit of having a better chance of having straight teeth.

The Breathing Well Programme is a three month programme which I use to help children break a mouth breathing pattern and establish nasal breathing.





- ▶ Jaw shape and size and tooth position is determined by muscles.
- ▶ Light forces are required to move teeth.
- ▶ Large forces are exerted by the muscles.
- ▶ The lip and tongue push on teeth every time we swallow and in speech.
- ▶ These two children have completely different muscle patterns and completely different types of irregular teeth.



## Improving lip seal and swallowing patterns

No child who has the lips apart at rest or who moves the lower lip when they swallow unconsciously will have straight teeth.

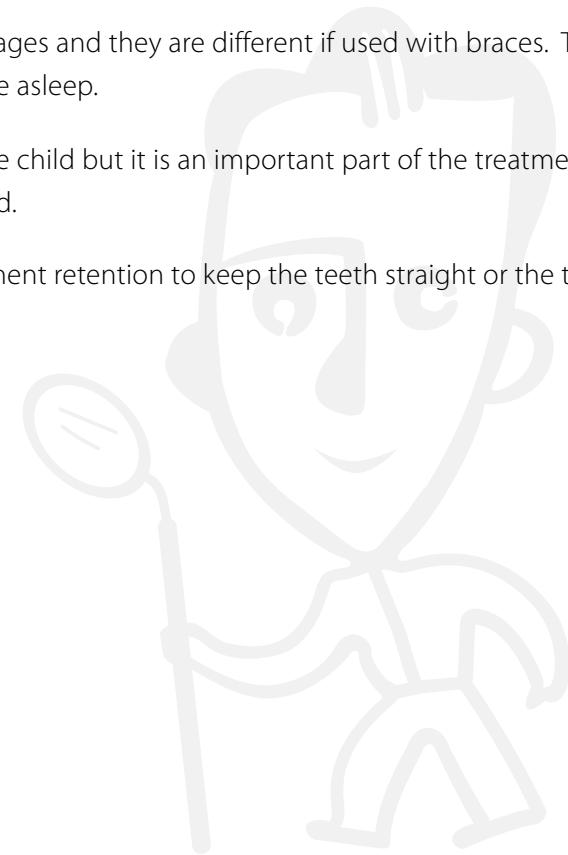
For most children who have straight teeth as well as putting the teeth into a new position we need to change the muscle patterns that put them in the crooked position to start with.

The child needs to do some muscle training.

For this we use a removable appliance called a Trainer. There are different Trainers for different ages and they are different if used with braces. They are all worn for a minimum of one hour a day while awake with the lips together and all night while asleep.

For daytime wear, the child can neither talk nor eat. This is a big commitment on the part of the child but it is an important part of the treatment. If the Trainer is not worn as instructed it will mean that the cause of the problem will not be corrected.

If the cause has not been corrected when we finish treatment the child will either need permanent retention to keep the teeth straight or the teeth will relapse towards the original position.





A research project, in conjunction with the University of Belfast, ten children treated with only a Trainer.

- ▶ Changes in jaw size were measured with laser scanning of models.
- ▶ Photographs evaluated to show facial change.
- ▶ Results to be published later.

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- ▶ Significant changes in shape and size of the jaws in most cases
- ▶ The teeth were less crowded in all children after one year

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are still straight

A series of photographs showing the expansion of the upper jaw, the bite closing and the teeth all fitting together well over a two-year period and eight years later.

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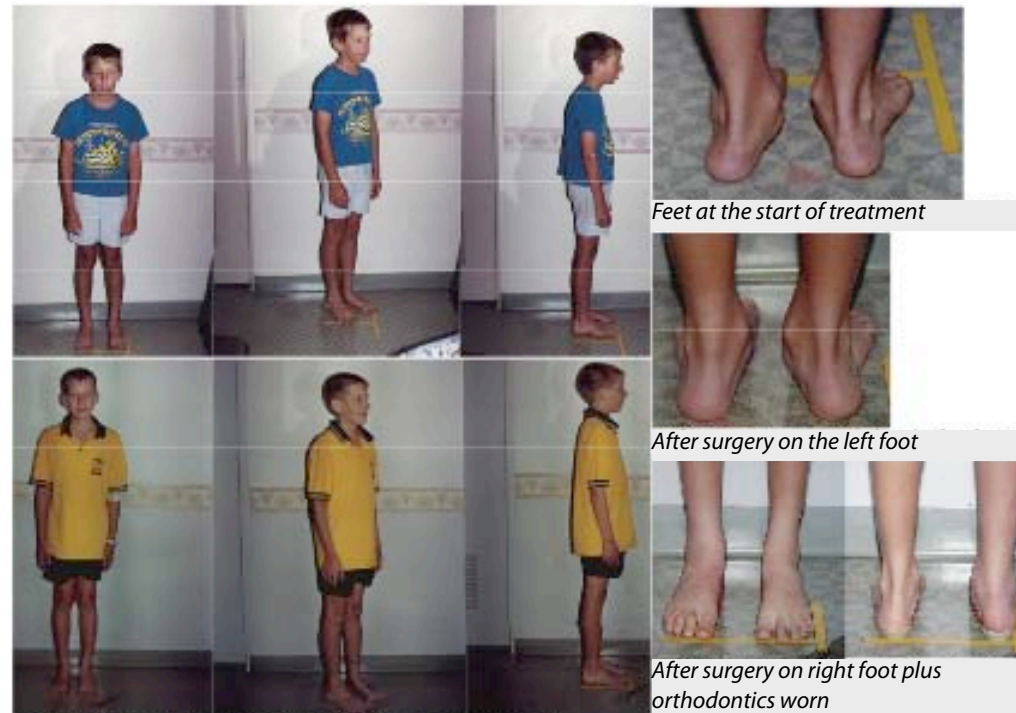
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## Upper Jaw Development

- ▶ Plates are used to expand the upper jaw
- ▶ After expansion we sometimes hold the expansion with another plate
- ▶ The expansion will only stay stable in the long term if the tongue learns to rest and function in the palate.





Foot surgery and orthodontics improve foot support leading to improved cranial support and improved head posture.

- ▶ No orthodontic treatment at all.
- ▶ Photographs courtesy Dr Tony Simeone.

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## Posture or why do dentist need to look at the feet?

The teeth are a part of the body and the body in many ways acts as a single system.

In order to have straight teeth and well aligned jaws then we need a straight well aligned cranium or head.

The cranium sits on top of the spine which is supported by the shoulders and the pelvis. If the shoulders and the pelvis are not level the head will not be level.

In order to have a level pelvis we need good support from the feet.

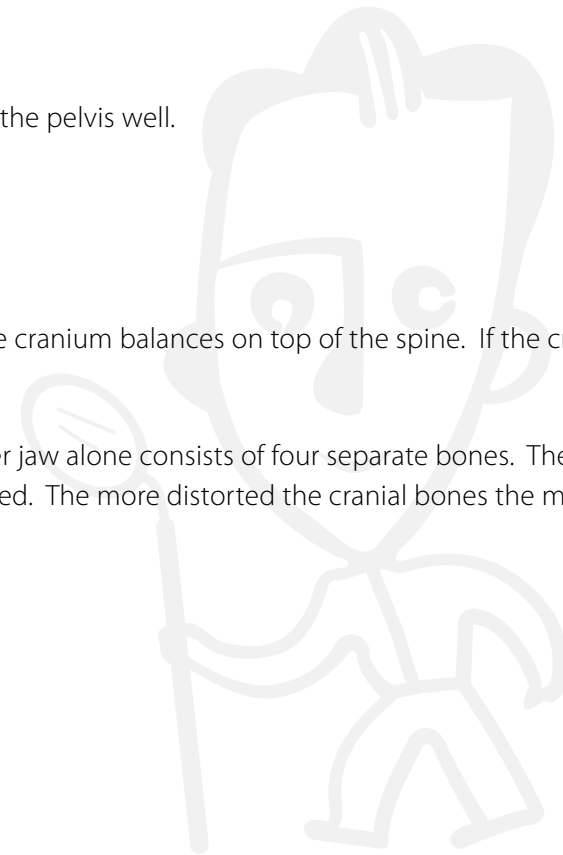
I do not treat peoples feet. I studied and trained enough to recognise feet that do not support the pelvis well.

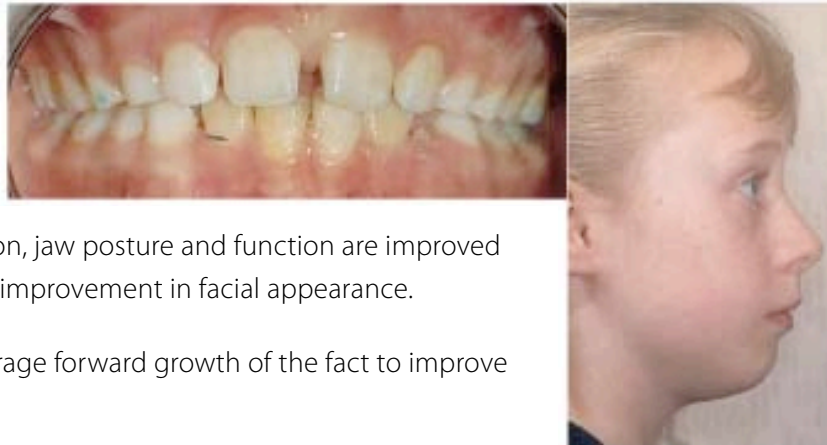
I know podiatrists who can help children with foot support.

I know chiropractors who can help with improving body posture.

Growing children need to stand and sit up straight. The better the child's posture the better the cranium balances on top of the spine. If the cranium is not well supported and balanced there will be distortions in the cranium.

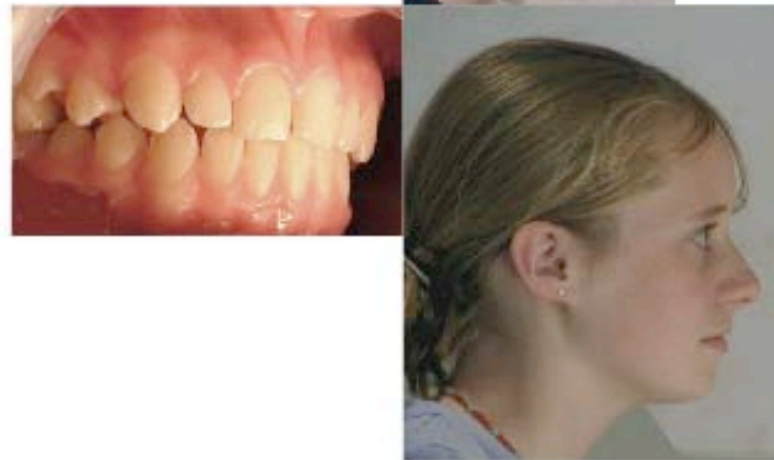
The cranium consists of 47 different bones including the upper and lower jaw bones. The upper jaw alone consists of four separate bones. These all fit together like a jig-saw puzzle. If any of these bones are distorted all of the bones will be distorted. The more distorted the cranial bones the more irregular the teeth.

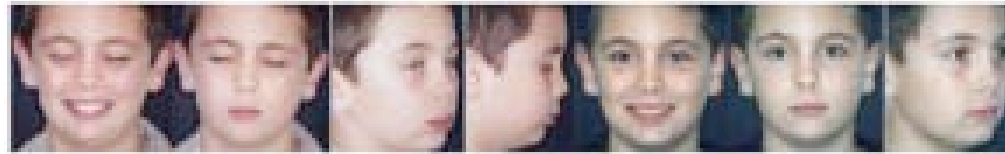




When tooth position, jaw posture and function are improved we need to see an improvement in facial appearance.

We need to encourage forward growth of the face to improve facial appearance.





- ▶ One year of treatment at age 8 using only a Trainer
- ▶ Improved shape of upper and lower jaws
- ▶ Improved relationship between the jaws
- ▶ The teeth are straighter
- ▶ Improved facial improvement
- ▶ The Trainer is worn all night, every night while the child is asleep
- ▶ Plus one hour a day, every day with the lips together



When we expand the jaws often the expansion relapses and returns back towards where we started. We need to look at the cause of the crooked teeth and correct the cause.

*Before we started treatment*



*After expanding the jaws and straightening the teeth and holding the teeth in position*



*Eight years later with no retention and the teeth have moved back towards where we started*



If we want the teeth to stay straight we need to change function and posture to match the new tooth position or the teeth will return towards the original position.



## A Full Set of Records

All children who are over six at the start of treatment will need a full set of records in order to have a complete diagnosis and treatment plan. All patients who are seeking orthodontic treatment will require this.

- ▶ A set of models of the upper and lower teeth.
- ▶ This involves taking an impression of the upper and lower jaws.
- ▶ Photographs of the teeth
- ▶ Photographs of the face
- ▶ Photographs of the whole body standing up without shoes (postural photographs)
- ▶ Photographs of the feet
- ▶ Three x-rays of the jaws and skull

Once I have the records I can complete the diagnosis and treatment options.

I then have a second consultation where I sit around the table with the family and explain to parent and child what will be involved if the child chooses to start treatment.

I will also give you a printed estimate of the times and costs involved if you choose to go ahead with treatment.

