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The return form should be received by our office before the deadline of **November 20, 2000**. If you have at least **12 correct answers**, verification of 3 hours credit will be sent to you.

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Learning Objectives

After completing this course, the participant will be able to:

1. Describe the effects of placing a fixed lingual arch in the transitional dentition.
2. Compare the stability of 2 methods of fixation after jaw surgery.
3. Describe the standards for performing a space assessment.
4. Discuss a space analysis not linked to a specific appliance or treatment philosophy.

Article 1. Longitudinal assessment of vertical and sagittal control in the mandibular arch by the mandibular fixed lingual arch. by Francisco J. Villalobos, Pramod K. Sinha, and Ram S. Nanda

1. How did change in mandibular molar position in the fixed lingual arch group compare with that of the control group?
   a. The molar tipped mesially in the lingual arch group but not in the control group.
   b. There was no difference in molar position between the lingual arch and the control group.
   c. Vertical and sagittal change of the molar was larger in the lingual arch group.
   d. Vertical and sagittal change of the molar was smaller in the lingual arch group.

2. Which measurement of mandibular incisor position was NOT different between the fixed lingual arch group and the control group?
   a. Angular change
   b. Axial change
   c. Horizontal change
   d. Vertical change

3. What was the difference between movement of the molars and incisors in the group with the fixed lingual arch?
   a. The incisors extruded 4 times the amount of the molars.
   b. The molars intruded twice as much as the incisors.
   c. The molars and the incisors intruded a similar amount.
   d. The incisors extruded less than the molars.

4. What is a possible disadvantage of using the fixed lingual arch in the transitional dentition?
   a. A cusp-to-cusp molar relation may not self-correct.
   b. A molar crossbite will develop.
   c. An opening rotation of the mandible may be enhanced.
   d. Distal tipping of the incisors increases overbite.

Article 2. Stability of bilateral sagittal split ramus osteotomy: Rigid fixation versus transosseous wiring. by Jeffrey L. Berger, Valmy Pangrazio-Kulbersh, Sven N. Bacchus, and Richard Kaczynski

5. How did the authors describe their findings?
   a. For the majority of values, skeletal relapse was an infrequent sequela of surgical correction.
   b. None of the changes were statistically significant.
   c. The extent and direction of skeletal change was not predictable for most of the variables.
   d. There were major differences in the amount of relapse between the 2 types of fixation.

6. How much did the overjet relapse in this group of mandibular advancement patients?
   a. The overjet relapsed 5% from the pretreatment value.
   b. The overjet relapsed 17% from the pretreatment value.
   c. The relapse was statistically insignificant but clinically important.
   d. There was no relapse in overjet.

7. Why did the authors suggest that relapse in vertical height of the ramus may have been due to changes at the gonial angle?
   a. Anterior facial height did not change.
   b. Remodeling changes were seen in the condylar head.
   c. The relapse only occurred in the transosseous wiring group.
   d. There was no horizontal loss in mandibular dimension.

8. The only practical method currently available for assuring maximum stability requires (1) prolonged skeletal stabilization and (2) control of the proximal segment.
   a. The first statement is true; the second is false.
   b. The first statement is false; the second is true.

Answers

	a	b	c	d		a	b	c	d
1	❑	❑	❑	❑	9	❑	❑	❑	❑
2	❑	❑	❑	❑	10	❑	❑	❑	❑
3	❑	❑	❑	❑	11	❑	❑	❑	❑
4	❑	❑	❑	❑	12	❑	❑	❑	❑
5	❑	❑	❑	❑	13	❑	❑	❑	❑
6	❑	❑	❑	❑	14	❑	❑	❑	❑
7	❑	❑	❑	❑	15	❑	❑	❑	❑
8	❑	❑	❑	❑	16	❑	❑	❑	❑

Program Evaluation

	Agree	Neutral	Disagree
1. The content was appropriate.	❑	❑	❑
2. The objectives were met.	❑	❑	❑
3. I will apply most of the information in my daily activities.	❑	❑	❑
4. This method of CE is effective.	❑	❑	❑

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c. Both statements are true.
d. Both statements are false.

Articles 3 and 4. The Royal London Space Planning: An integration of space analysis and treatment planning. Part I: Assessing the space required to meet treatment objectives. Part II: The effect of other treatment procedures on space. by Robert H. Kirschen, Elizabeth A. O'Higgins, and Robert T. Lee

9. What is the first stage in the process of space planning?
   a. An assessment of future growth
   b. An assessment of the space requirement
   c. The determination of molar movements required for occlusal correction
   d. The determination of space to be used during treatment

10. How is the archform dealt with in the assessment of crowding and spacing?
   a. The archform need not reflect the majority of teeth.
   b. The chosen archform becomes a treatment objective.
   c. The line of the arch must include the most prominent incisor.
   d. The points of reference must remain consistent for each case.

11. Which is correct with regard to the occlusal curve?
   a. For a depth of 4 mm, 1.5 mm should be allowed.
   b. One millimeter of space should be allowed for every millimeter of depth of curve.
   c. Parallel-sided teeth require more space.
   d. Second molars are used to assess the depth of the curve.

12. For the purpose of space planning, each millimeter of incisor retraction will consume 2 mm of space within the dental arch. The upper incisors are corrected in the analysis to an overjet of 2 to 3 mm in relation to the lower incisors.
   a. The first statement is true; the second is false.
   b. The first statement is false; the second is true.
   c. Both statements are true.
   d. Both statements are false.

13. How does molar expansion affect space?
   a. Approximately 0.5 mm is created by each millimeter of expansion.
   b. Buccal movement of a single tooth increases arch width.
   c. Expansion increases arch depth.
   d. Splitting the palatal suture creates less space than other methods of expansion.

14. Which factor in space analysis does NOT incorporate clinical treatment objectives?
   a. Arch width
   b. Correction of incisor angulation and inclination
   c. Crowding or spacing in the original malocclusion
   d. Incisor advancement or retraction

15. What determines the amount of space available from premolar extractions?
   a. Anchorage demands
   b. Location of the crowding in the arch
   c. Location of the teeth extracted
   d. Size of the teeth extracted

16. What was the value of Royal London Space Planning in the treatment planning of case 1?
   a. To determine that Class II elastics should be used to reduce the Class II molar relation
   b. To establish that headgear must be used to meet the anchorage demands
   c. To select which premolars must be extracted
   d. To establish that a functional appliance was indicated