Application of AMCOP® elastodontic device for early orthodontic management of class III malocclusion in pediatric patients

Grazia Marinelli[1†]
Lucia Memè[8]
Angelo Michele Inchingolo[1†]
Filippo Cardarelli[1]
Laura Ferrante[1]
Elisabetta de Ruvo[1]
Francesco Inchingolo[1]
Massimo Corsalini[1]
Vito Crincoli[1]
Giuseppe Minervini[2]
Andrea Palermo[3]
Marco Farronato[4,5]
Cinzia Maria Norma Maspero[4,5]
Ana Júlia de Paula Guerra[6]
Sabina Saccomanno[7]
Alessio Danilo Inchingolo[1††]
Gianna Dipalma[1††]

[1] Interdisciplinary Department of Medicine, University of Bari "Aldo Moro", Bari, Italy.
[2] Multidisciplinary Department of Medical-Surgical and Odontostomatological Specialties, University of Campania "Luigi Vanvitelli," Naples, Italy.
[3] Department of Experimental Medicine, University of Salento, Lecce, Italy.
[4] Department of Biomedical, Surgical and Dental Sciences, School of Dentistry, University of Milan, Milan, Italy.
[5] Fondazione IRCCS Cà Granda, Ospedale Maggiore Policlinico, Milan, Italy.
[6] São José do Rio Preto, Brazil.
[7] Department of Life Science, Health and Health Professsions, Link University Italy
[8] Università degli Studi Link Campus University, Roma, Italy

[†] These authors contributed equally to this work as co-first.
[††] These authors contributed equally to this work as co-last.

Corresponding author: Alessio Danilo Inchingolo
email: ad.inchingolo@libero.it

Abstract

Introduction: Managing Class III malocclusions remains a complex issue in orthodontics today. While traditional functional approaches have often led to favorable outcomes, newer alternatives such as elastodontic devices have recently gained attention as a more advanced iteration of conventional methods. These appliances may offer a promising early intervention strategy for growing patients presenting with Class III malocclusions. Aim: This retrospective study aims to investigate the clinical effectiveness of the AMCOP® TC bioactivator in addressing dento-skeletal Class III malocclusions. Additionally, the study presents four selected clinical cases to illustrate the outcomes.
Materials and Methods: A total of 11 pediatric patients (5 boys and 6 girls) aged between 6 and 12 years were included in the study. All patients exhibited Class III malocclusion and were treated with the AMCOP® TC elastodontic appliance. The device was worn for two hours in the afternoon and overnight for an initial period of 6–8 months, followed by exclusive nighttime wear. Lateral cephalometric radiographs were taken at the start (T0) and end (T1) of the treatment. All radiographic data were evaluated using DeltaDent® software. Conclusions: The AMCOP® TC elastodontic device effectively contributed to the correction of dento-skeletal Class III malocclusion and supported the postural improvement of the cervical spine, specifically the first vertebra. Despite the need for additional clinical studies, the results suggest that this treatment may serve as a non-invasive and well-tolerated option for interceptive orthodontic care.

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Introduction

Class III malocclusion is a complex condition involving an abnormal sagittal relationship between the maxilla and mandible, where the lower jaw is positioned ahead of the upper jaw (1-10). This discrepancy may be purely dental or skeletal in nature (11-29) (30-41). Dental Class III can be identified through clinical assessment, while skeletal Class III requires cephalometric analysis, particularly evaluating the ANB angle on lateral cephalograms (42-50). An ANB angle below 0° indicates Class III, whereas angles between 0°–4° and over 4° denote Class I and Class II, respectively (38-46).

The malocclusion may stem from mandibular overgrowth, maxillary underdevelopment, or both (60-68). Genetics often play a significant role, with Class III traits frequently observed within families (69-75). Environmental and epigenetic factors, such as mouth breathing, abnormal swallowing, short lingual frenulum, or cleft palate, can also contribute, mainly by disrupting tongue posture and jaw development (76-91). Class III can present alongside different vertical patterns: a normal vertical dimension (normo-bite), a reduced dimension (deep bite), or an increased one (open bite), the latter generally indicating a poorer prognosis (92-103). Clinically, signs include forward positioning of the lower dental arch, a concave facial profile, and alterations in lip posture (104-127). The condition may be linked with other health issues such as sleep apnea, joint pain, speech disorders, reflux, and psychological effects (128-149). Orthopedic treatment, especially during growth phases, is a preferred intervention (150-159). One such method involves elastodontic therapy using AMCOP® TC bioactivators, which are functional appliances designed to correct dento-cranio-facial anomalies through neuromuscular re-education (160-169). These devices act on both jaw alignment and posture by engaging the first cervical vertebrae (170-186). The AMCOP® system includes various components: vestibular and lingual flanges that create a balanced pressure zone for proper tooth positioning; a lip bumper effect for muscular detachment and bone stimulation; a tongue ramp and button to encourage correct tongue placement; and design elements accommodating oral anatomy (187-200). Their flexibility is enhanced by thermoplastic materials of variable hardness, which can be softened in hot water for better fit (Figure 1) (201-212).

AMCOP® devices are classified based on malocclusion type—first class for transverse/vertical disharmonies, SC for Class II, and TC for Class III (213-219). The TC model aims to limit mandibular growth and restore physiological tongue function (69-75) (220-223). Specific models also exist for primary dentition and sleep-related breathing disorders (224-246).

This retrospective experimental study investigates the effectiveness of AMCOP® TC bioactivators in treating growing patients with Class III dento-skeletal malocclusions, illustrating the outcomes through four clinical case studies (247-261).

Material and methods

Sample Selection

The study included 11 patients (5 males, 6 females), aged between 6 and 12 years, who were treated with the AMCOP® TC bioactivator at the Orthodontic Department of Bari Polyclinic and a private practice. Inclusion criteria required skeletal Class III malocclusion (ANB < 0°), noticeable improvement in facial profile, and availability of lateral cephalometric radiographs before and after treatment. Patients were excluded if they had prior orthodontic treatment or craniofacial syndromes. Informed consent was obtained. Collected records included extra-oral and intra-oral photos, panoramic and lateral cephalometric X-rays, taken at the start (T0) and end (T1) of treatment.

Treatment Protocol

Treatment involved using the AMCOP® TC bioactivator, designed for Class III cases in primary, mixed, or permanent dentition. The device features a maxillary sliding plane and a mandibular stop. Patients wore the appliance for two hours in the afternoon and overnight for 6–8 months, followed by night-time use only. Treatment success was assessed by comparing cephalometric values (SNA, SNB, ANB) and observing clinical improvements.

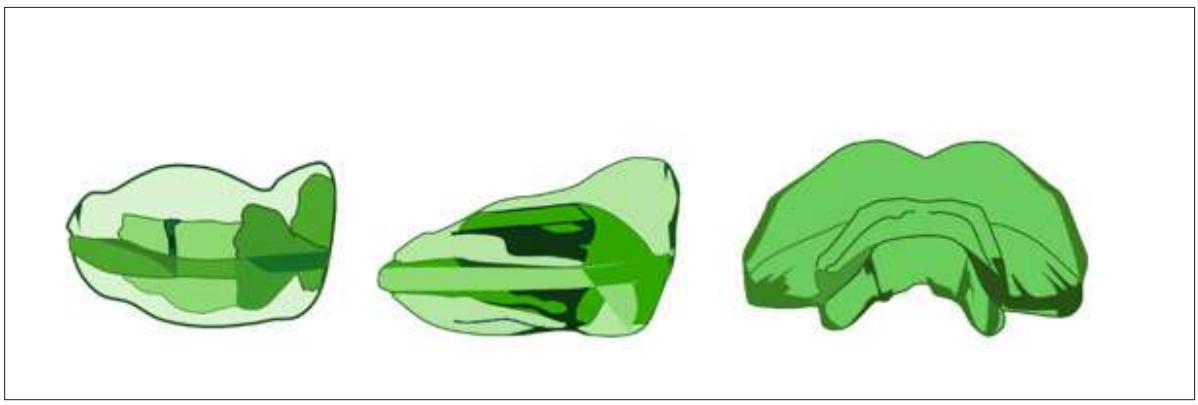


Figure 1. AMCOP® TC

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Cephalometric Analysis

Lateral cephalograms were analyzed at T0 and T1 using DeltaDent® software to measure treatment outcomes.

Discussion

Traditional Functional Therapy

Class III malocclusions are among the most difficult to manage in orthodontics (262-265). Functional or interceptive treatments are often used for growing patients (266-273). Functional orthodontics, first introduced in Europe in the early 20th century, employs various appliances that influence jaw growth and occlusion (274-279). These devices are most effective during late mixed dentition (280-289). They are typically removable and encourage muscle reprogramming by prompting tongue and lip function, ultimately improving occlusal relationships (290-294).

Functional appliances are grouped into activators and morphoconformers (295-297) (298-308). The latter, such as Fränkel function regulators, act on soft tissues to guide skeletal growth by reducing abnormal muscular forces (309-312). For optimal effects, appliances are worn overnight and for 1–2 hours during the day (313-315). Nocturnal use engages involuntary reflexes like swallowing and breathing, while daytime use reinforces the response at the cortical level (316-318).

However, discomfort and lack of cooperation can lead to high failure rates (up to 34%). To address this, fixed appliances like the Herbst or Forsus are used for Class II malocclusions (319, 320). For Class III, treatments often include maxillary expansion to correct transverse discrepancies using devices such as rapid palatal expander or Transverse Sagittal Maxillary Expander (TSME) (321, 322). Research has shown similar improvements from both devices, though TSME offers superior maxillary arch perimeter gains (323-325). Alternative protocols like Reverse Twin Block with Lip Pads-Rapid Maxillary Expander (RTBLP-RME) and Face Mask-Rapid Maxillary Expander (FM-RME) have also proven effective in improving skeletal and dental relationships (326-328). RTBLP-RME showed more favorable skeletal changes (329). Bone anchored maxillary protraction has demonstrated superior forward movement of the maxilla compared to FM-RME, though it is more invasive due to surgical anchor placement (330-332). In contrast, FM-RME is simpler but requires longer usage (333). Another study compared face masks with and without anterior protrusion devices (DPA), showing that DPA can limit unwanted mandibular rotation (334, 335).

Elastodontic Therapy

Elastodontic therapy represents a modern advancement of traditional functional orthodontics (336). It uses soft, elastic forces to promote skeletal and dental corrections, especially in growing children with mixed dentition (337, 338). Known also as myofunctional therapy, this approach corrects dysfunctional muscle patterns—restoring nasal breathing, lip seal, proper tongue posture, and correct swallowing (339, 340). Patients are also instructed to do home exercises to support proper tongue and breathing habits (341). Elastodontic appliances are pre-formed and may include additional elements depending on the case (342, 343). They are typically made of soft silicones or polymers that provide gentle force without causing trauma (344). The best timing for elastodontic treatment is during early or mixed dentition to ensure orthopedic and orthodontic results (345, 346). These appliances are used during early treatment phases and for long-term retention (347, 348). Well-known elastodontic devices include Éducation Fonctionnelle, Myobrace®, LM-Activator, Multi-Function System, Muppy®, Occlus-o-Guide®, and AMCOP®. AMCOP® bioactivators offer neuromuscular, orthopedic, and orthodontic benefits (349-351). Their ease of use and good patient tolerance make them effective, with notable clinical and radiographic improvements seen after 16–20 months (325-355). A review by Ureni et al. confirmed that elastodontic therapy improves sagittal relationships and tooth alignment, especially in patients with oral dysfunctions (356-360). However, it may be less effective than conventional appliances in producing skeletal changes (361-364). Ciavarella et al. found that elastodontic appliances enhanced mandibular growth but had limited effect on tooth inclinations (365-367).



Figure 2. Orthopantomography before treatment

Similarly, Ronsivalle et al. noted both elastodontics and bi-maxillary plates improved Class III malocclusion, though elastodontics yielded better transverse palatal development (368-370).

Clinical cases

Case 1

The patient was a young female presenting with a Class III dento-skeletal malocclusion, which was treated using the AMCOP® TC appliance. A comprehensive diagnostic protocol was carried out both before and after treatment, including orthopantomography (Figure 2-3), postero-anterior teleradiography (Figures 4, 5), latero-lateral cephalometric radiography (Figures 6, 7), cephalometric analysis (Tables 1, 2), as well as extraoral (Figures 8, 9) and intraoral photographs (Figures 10, 11). The extraoral examination revealed an edge-to-edge incisal relationship and the presence of a midline diastema. Pre-treatment cephalometric analysis (Deltadent® Lana, Bolzano, Italy) confirmed the diagnosis of a skeletal Class III malocclusion. The treatment plan involved the use of the AMCOP® TC appliance. The patient was instructed to wear the device for two hours in the afternoon and throughout the night for the first six months, followed by nighttime use only for an additional six months. Upon completion of the treatment, the patient achieved a Class I occlusion, with correction of both overjet and overbite. Additionally, the device facilitated tongue re-education and contributed to the postural realignment of the first cervical vertebra.



Figure 3. Orthopantomography after treatment



Figure 4. Teleradiography antero-posterior before treatment



Figure 5. Teleradiography antero-posterior after treatment

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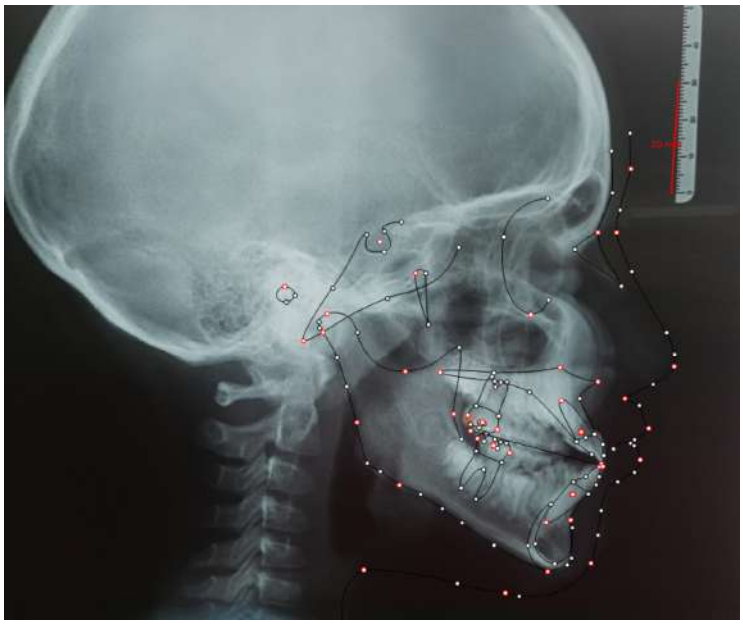


Figure 6. Cephalometric analysis before treatment

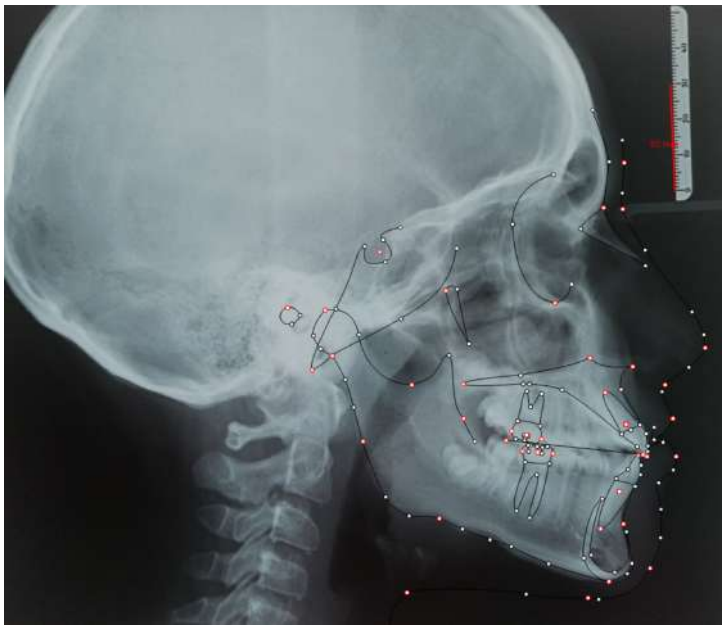


Figure 7. Cephalometric analysis on teleradiography after treatment

Table 1. Cephalometric values after treatment

Cephalometric Analysis before Treatment	Values (°)	Normal Values (°)
SNA	81,3	82 ± 3
SNB	82,9	80 ± 3
ANB	-1,6	2 ± 2
OVJ	3.5	3.5 ± 2,5
OVB	0.6	2 ± 2,5
CoGoMe	136,0	128,8 ± 4
Is^Ans-Pns	126,4	110 ± 6
Li^GoGn	106	94 ± 7
Apg-Li	3,6	2 ± 2

Table 2. Cephalometric values after treatment

Cephalometric Analysis after Treatment	Values (°)	Normal Values (°)
SNA	83,0	82 ± 3
SNB	84,0	80 ± 3
ANB	1,0	2 ± 2
OVJ	2,5	3.5 ± 2,5
OVB	1,5	2 ± 2,5
CoGoMe	128,0	128,8 ± 4
Is^Ans-Pns	115,4	110 ± 6
Li^GoGn	99,7	94 ± 7
Apg-Li	2,0	2 ± 2



Figure 8. Frontal extraoral before treatment



Figure 9. Frontal extraoral after treatment



Figure 10. Intraoral before treatment



Figure11. Intraoral after treatment

Case 2

The patient was a growing female child who presented during early mixed dentition with an anterior crossbite associated with a deep overbite and a marked sagittal discrepancy (Figures 12-19). The initial clinical examination revealed a negative overjet, complete anterior deep bite, and a functional Class III occlusal pattern. Extraoral assessment showed a flattened

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Figure 12. Orthopantomography before treatment



Figure 13. Orthopantomography after treatment

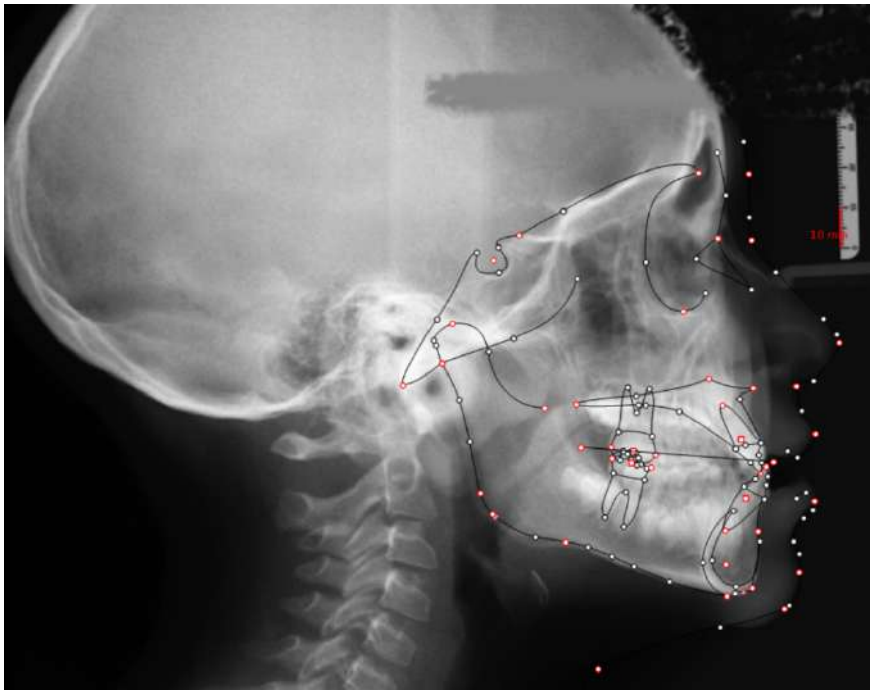


Figure 14. Cephalometric analysis on teleradiography before treatment

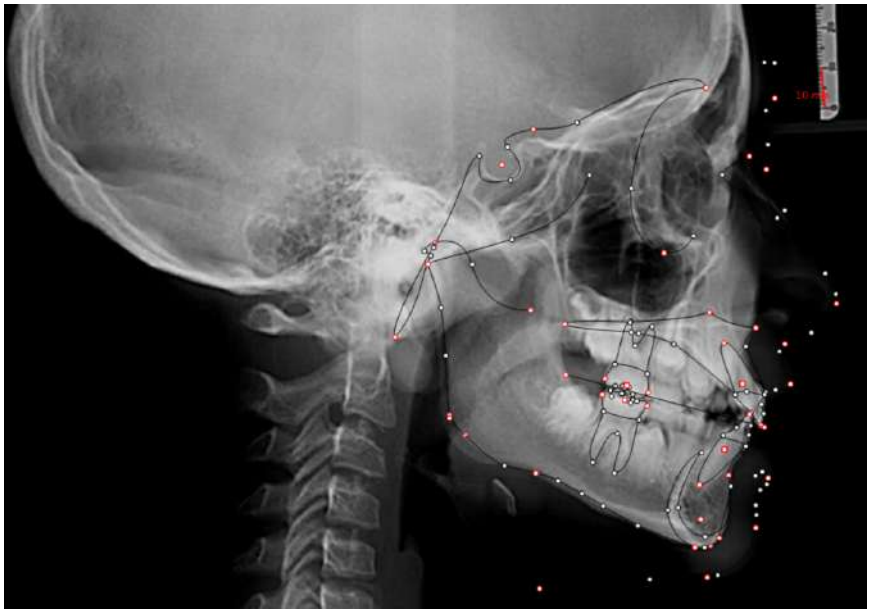


Figure 15. Cephalometric analysis on teleradiography after treatment

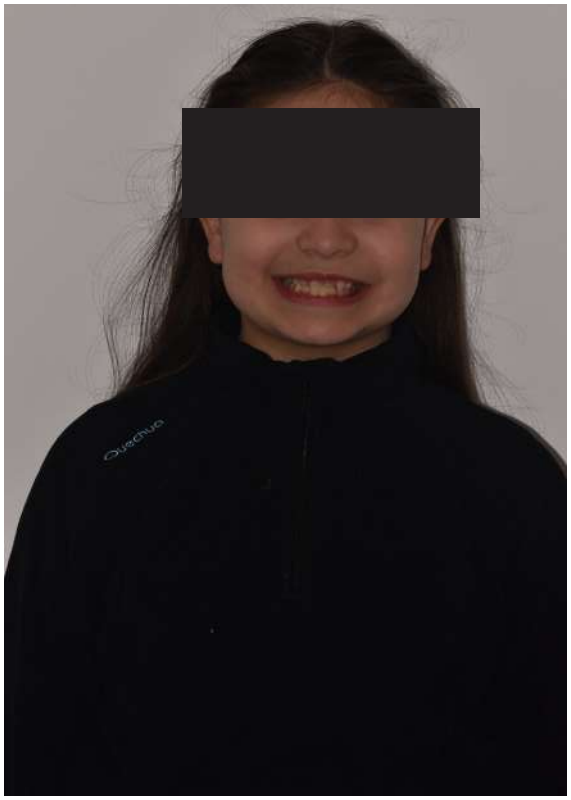


Figure 16. Frontal extraoral before treatment



Figure 17. Frontal extraoral after treatment

facial profile, while cephalometric analysis confirmed a skeletal imbalance characterized by increased SNA and SNB values, an ANB of 0°, negative Withs appraisal, and significant dentoalveolar compensations, including proclination of both upper and lower incisors (Table 3). The vertical pattern was predominantly hypodivergent, suggesting a high risk of unfavorable mandibular growth progression if left untreated. Given the patient's young age and growth potential, an early interceptive treatment was planned to use the AMCOP® TC appliance, with the aim of correcting the anterior crossbite, improving neuromuscular balance, and guiding sagittal and vertical development during growth. The appliance was worn nightly and for additional daytime hours, according to patient compliance.

After 18 months of treatment, a clear clinical improvement was observed. Intraoral examination demonstrated complete correction of the anterior

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Figure 18. Intraoral before treatment



Figure19. Intraoral after treatment

crossbite, with establishment of a positive overjet and normalization of the anterior occlusal relationship. The deep bite was reduced, allowing more functional anterior guidance. Occlusal relationships improved toward a stable dental Class I, and the need for excessive dentoalveolar compensation was reduced.
Cephalometric reassessment showed an overall improvement in sagittal relationships and incisor inclinations, with a trend toward normalization of the previously altered parameters. These findings indicate that early functional therapy with the AMCOP® TC appliance was effective in intercepting the developing Class III malocclusion, improving occlusal function, and potentially reducing the severity of future skeletal discrepancies (Table 4).

Table 3. Cephalometric values before treatment

Parameter	Values	Normal Values
SNA (°)	92.2°	82 ± 3
SNB (°)	92.2°	80 ± 3
ANB (°)	0.0°	2 ± 2
Overjet (OVJ)	–7.0 mm (Wits)	3.5 ± 2.5
Overbite (OVB)	~0 / reduced	2 ± 2.5
CoGoMe (°)	~126–128°*	128.8 ± 4
Upper incisor inclination (Is^Ans–Pns)	~113.4°	110 ± 6
Lower incisor inclination (Li^GoGn)	105.9°	94 ± 7
Lower incisor compensation (Apg–Li)	~4.4 mm	2 ± 2

Table 4. Cephalometric values after treatment

Parameter	Values	Normal Values
SNA (°)	86.9°	82 ± 3
SNB (°)	84.3°	80 ± 3
ANB (°)	2.6°	2 ± 2
Overjet (OVJ)	–4.1 mm (Wits)	3.5 ± 2.5
Overbite (OVB)	Deep bite (reduced)	2 ± 2.5
CoGoMe (°)	~128–130°*	128.8 ± 4
Upper incisor inclination (Is^Ans–Pns)	111.9°	110 ± 6
Lower incisor inclination (Li^GoGn)	101.0°	94 ± 7
Lower incisor compensation (Apg–Li)	~3.3 mm	2 ± 2

This case highlights the importance of early diagnosis and timely functional intervention in growing patients, demonstrating how interceptive treatment can favorably influence occlusal development and facial balance during critical growth phases.

Case 3

The patient was a 6-year-old female presenting with a Class III dento-skeletal malocclusion associated with anterior crossbite in the early mixed dentition (Figures 20-26). Baseline diagnostic records included orthopantomography, latero-lateral cephalometric radiography with cephalometric analysis, and extraoral and intraoral photographs. Clinical examination revealed a flat-to-slightly convex facial profile with sagittal skeletal discrepancy and negative overjet (Tables 5, 6). The treatment consisted exclusively of functional orthopedic therapy using the AMCOP® TC appliance, worn throughout the night and for one additional hour during the day, for a total duration of 24 months. At the end of active treatment, complete correction of the anterior crossbite was achieved, with normalization of overjet and overbite and establishment of a Class I dental relationship. A long-term follow-up evaluation performed at the age of 12 years, in complete permanent dentition, confirmed the stability of the results, showing a well-maintained anterior dental seal and a stable Class I occlusion. The AMCOP® TC appliance was continued as nighttime retention only, supporting neuromuscular balance and occlusal stability throughout growth.



Figure 20. Orthopantomography before treatment

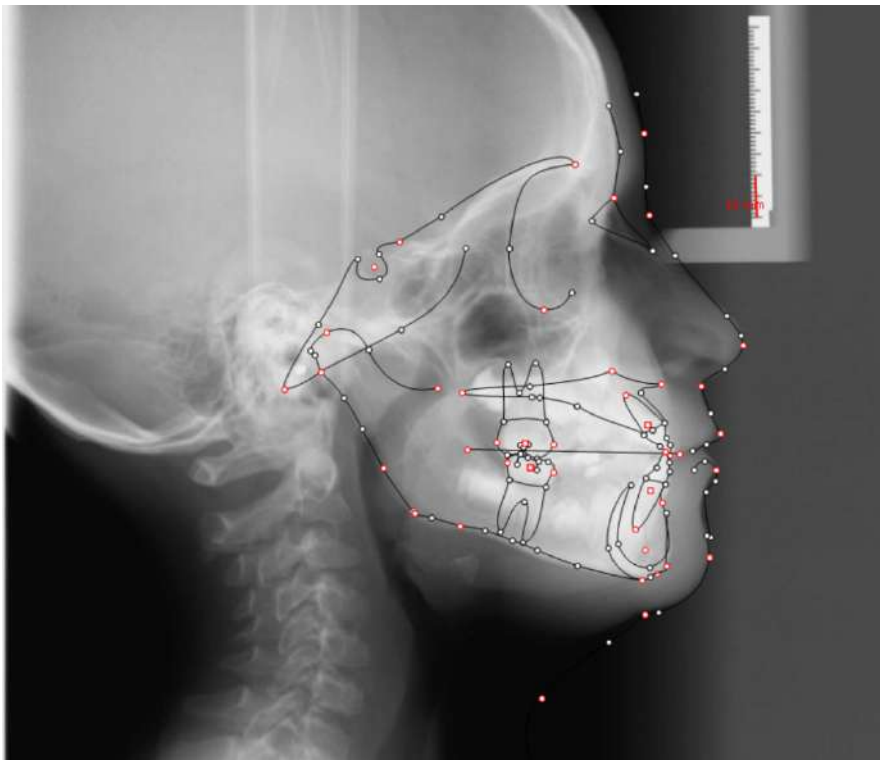


Figure 21. Cephalometric analysis before treatment

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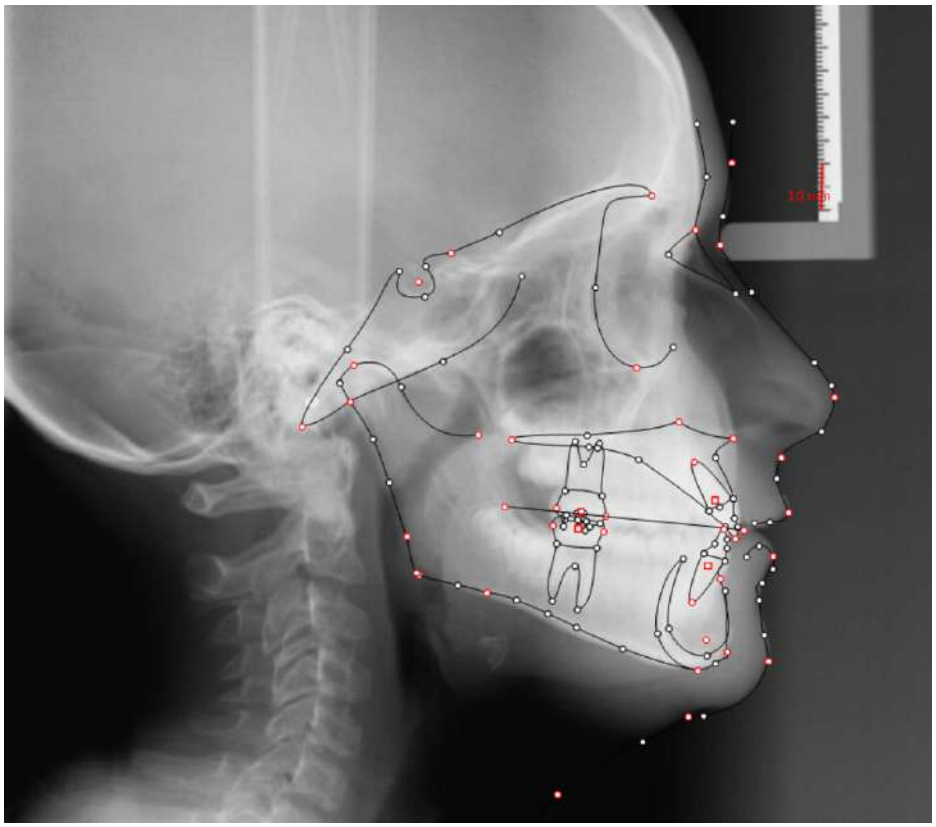


Figure 22. Cephalometric analysis after treatment



Figure 23. Frontal extraoral before treatment



Figure 24. Frontal extraoral after treatment



Figure 25. Intraoral before treatment



Figure 26. Intraoral after treatment

Table 5. Cephalometric values before treatment

Parameter	Values	Normal Values
SNA (°)	81.9°	82 ± 3
SNB (°)	83.0°	80 ± 3
ANB (°)	–1.2°	2 ± 2
Overjet (OVJ)	–5.7 mm (Wits)	3.5 ± 2.5
Overbite (OVB)	Deep bite	2 ± 2.5
CoGoMe (°)	~136°*	128.8 ± 4
Upper incisor inclination (Is^Ans–Pns)	110.2°	110 ± 6
Lower incisor inclination (Li^GoGn)	96.9°	94 ± 7
Lower incisor compensation (Apg–Li)	~2.6 mm	2 ± 2

Table 6. Cephalometric values after treatment

Parameter	Values	Normal Values
SNA (°)	84.4°	82 ± 3
SNB (°)	83.5°	80 ± 3
ANB (°)	1.0°	2 ± 2
Overjet (OVJ)	–3.6 mm (Wits)	3.5 ± 2.5
Overbite (OVB)	Deep bite	2 ± 2.5
CoGoMe (°)	~129–130°*	128.8 ± 4
Upper incisor inclination (Is^Ans–Pns)	107.7°	110 ± 6
Lower incisor inclination (Li^GoGn)	96.9°	94 ± 7
Lower incisor compensation (Apg–Li)	~0.7 mm	2 ± 2

Case 4

The patient presented in early mixed dentition with a complete anterior crossbite associated with a bilateral posterior crossbite, resulting in a functional mandibular shift and lower dental midline deviation (Figures 27-34) (Table 7). Extraoral examination revealed a flat facial profile with a tendency toward convexity, a long facial pattern, and mild facial asymmetry, consistent with a functional component superimposed on an underlying skeletal Class III tendency. The treatment protocol involved the use of an AMCOP TC appliance, designed to address the transverse maxillary deficiency and eliminate the functional shift. The appliance allowed progressive transverse development of the maxillary arch, promoting spontaneous mandibular repositioning and restoration of a more physiologic maxillomandibular relationship during growth. Following active treatment, a complete correction of both anterior and posterior crossbite was achieved. Transverse arch coordination was obtained, with elimination of the unilateral posterior crossbite and resolution of the functional mandibular deviation. The occlusion was stabilized in a dental Class I relationship, with normalization of overjet and overbite and centering of the lower dental midline relative to the maxillary midline. From a sagittal perspective, the correction of the functional shift contributed to an improvement in the intermaxillary relationship, with favorable dentoalveolar adaptation and reduction of compensatory incisor inclinations. Vertical relationships remained stable throughout

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Figure 27. Orthopantomography before treatment



Figure 28. Orthopantomography after treatment

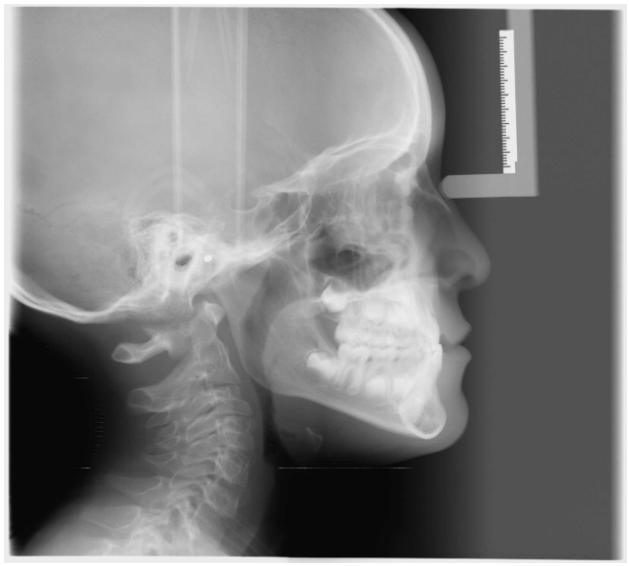


Figure 29. Cephalometric analysis before treatment

treatment, maintaining a normodivergent growth pattern. Extraoral assessment after treatment showed an improvement in facial balance and symmetry, with a more harmonious sagittal profile compared to baseline. The correction of occlusal relationships allowed a more stable mandibular posture, positively influencing soft tissue profile and facial proportions. The post-treatment lateral cephalogram (Table 8) and the clinical, occlusal, and photographic records clearly demonstrate total correction of the malocclusion, supporting the effectiveness of early interceptive treatment with AMCOP TC in patients with Class III malocclusion associated with transverse maxillary deficiency and functional mandibular displacement. Early orthopedic–orthodontic intervention appears to play a key role in restoring functional occlusion and guiding craniofacial development toward a more favorable pattern.

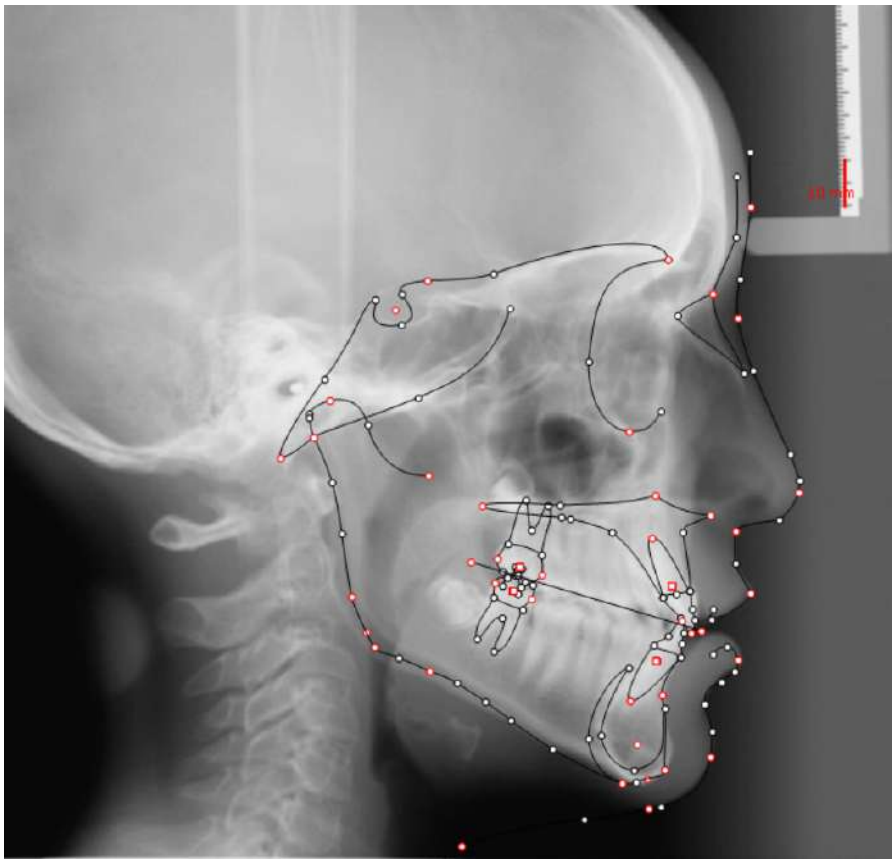


Figure 30. Cephalometric analysis after treatment



Figure 31. Frontal extraoral before treatment



Figure 32. Frontal extraoral after treatment

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Figure 33. Frontal intraoral before treatment



Figure 34. Frontal intraoral after treatment

Table 7. Cephalometric values before treatment

Cephalometric Analysis after Treatment	Values (°)	Normal Values (°)
SNA	79°	82 ± 3
SNB	78,5°	80 ± 3
ANB	0,5°	2 ± 2
OVJ	2,5	3.5 ± 2,5
OVB	1,5	2 ± 2,5
CoGoMe	131°	128,8 ± 4
Is^Ans-Pns	112°	110 ± 6
Li^GoGn	100°	94 ± 7
Apg-Li	2,0 mm	2 ± 2

Table 8. Cephalometric values after treatment

Parameter	Values	Normal Values
SNA (°)	80.0°	82 ± 3
SNB (°)	79.9°	80 ± 3
ANB (°)	0.0°	2 ± 2
Overjet (OVJ)	–5.4 mm (Wits)	3.5 ± 2.5
Overbite (OVB)	Deep bite	2 ± 2.5
CoGoMe (°)	~132–133°*	128.8 ± 4
Upper incisor inclination (Is^Ans–Pns)	109.4°	110 ± 6
Lower incisor inclination (Li^GoGn)	95.1°	94 ± 7
Lower incisor compensation (Apg–Li)	~1.5 mm	2 ± 2

Case 5

The patient was a 4-year-old male who began treatment during complete deciduous dentition, presenting at clinical examination with a tendency toward skeletal Class III malocclusion, characterized by anterior crossbite with 100% deep bite, deviated mandibular midline, and a flat facial profile (Figures 35-40). Initial intraoral documentation refers to this early age; however, radiographic records (orthopantomography and latero-lateral cephalometric radiography) were obtained only after 18 months of therapy, once parental consent was granted and the patient had entered the mixed dentition phase. Cephalometric analysis performed at that time confirmed a growth pattern unfavorable to skeletal Class III development (Table 9). The treatment protocol consisted exclusively



Figure 35. Orthopantomography before treatment

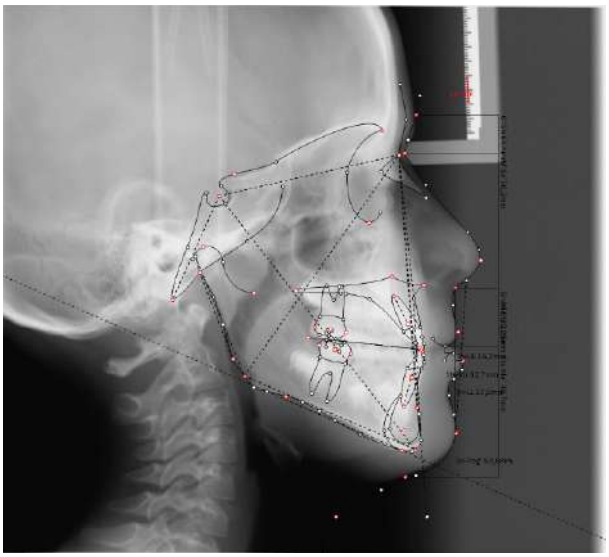


Figure 36. Cephalometric analysis before treatment

of functional orthopedic therapy using the AMCOP® TC appliance, initiated in early childhood and currently ongoing. At the 18-month clinical follow-up, significant improvements were observed, including anterior bite opening, transverse maxillary development favoring correction of the anterior crossbite, and improvement of the dental midline relationship. Given the patient's growth phase and skeletal pattern, the treatment is still in progress and requires continued monitoring over time to guide craniofacial development and assess long-term stability.



Figure 37. Frontal extraoral before treatment



Figure 38. Frontal extraoral after treatment

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Figure 39. Frontal intraoral before treatment



Figure 40. Frontal intraoral after treatment

Table 9. Cephalometric values before treatment

Parameter	Plausible Value	Normal Values
SNA (°)	78.0	82 ± 3
SNB (°)	82.5	80 ± 3
ANB (°)	–4.5	2 ± 2
Overjet (mm)	–2.0	3.5 ± 2.5
Overbite (mm)	1.0	2 ± 2.5
Wits (mm)	–5.0	0 ± 2
CoGoMe (°)	133.0	128.8 ± 4
Is^Ans–Pns (°)	116.0	110 ± 6
Li^GoGn (°)	88.0	94 ± 7
Apg–Li (mm)	–2.0	2 ± 2

Case 6

The patient presented for orthodontic evaluation in the early mixed dentition phase, with only the lower central incisors erupted (Figures 41-47). At the initial clinical examination, an anterior and unilateral posterior crossbite on the left side was observed, associated with a lower dental midline deviation to the left.

Extraoral examination revealed a flat facial profile with a tendency toward convexity, a long facial pattern, and facial asymmetry, likely related to the functional mandibular shift induced by the unilateral posterior crossbite. Cephalometric analysis performed before treatment (Table 10) showed a skeletal Class III relationship, characterized by reduced maxillary sagittal position (SNA 75.9°), mandibular retrusion (SNB 76.4°), and a negative ANB angle (–0.5°). Vertical relationships were within normal limits, with a normodivergent growth pattern (CoGoMe 130.7°). Dental compensation was evident, particularly at the mandibular level, with marked proclination of the lower incisors (Li^GoGn 110.6°) and reduced overjet and overbite (OVJ –0.9 mm; OVB –3.1 mm) (Table 10).

The treatment protocol included the use of an AMCOP TC appliance, aimed at correcting the transverse discrepancy, eliminating the unilateral posterior crossbite, and resolving the functional mandibular deviation. Following therapy, a complete correction of the left posterior crossbite was achieved, along with re-centering of the lower dental midline and establishment of a dental Class I relationship.

The occlusion appeared stable, with improved transverse coordination of the arches and normalization of anterior relationships, as documented in the post-treatment intraoral records.

At present, a post-treatment lateral cephalogram is not available due to family-related constraints; therefore, cephalometric comparisons are limited to pre-treatment data. Nevertheless, clinical outcomes demonstrate effective interception of the transverse and functional components of the malocclusion, potentially reducing the risk of worsening skeletal discrepancies during growth.



Figure 41. Orthopantomography before treatment



Figure 42. Orthopantomography after treatment

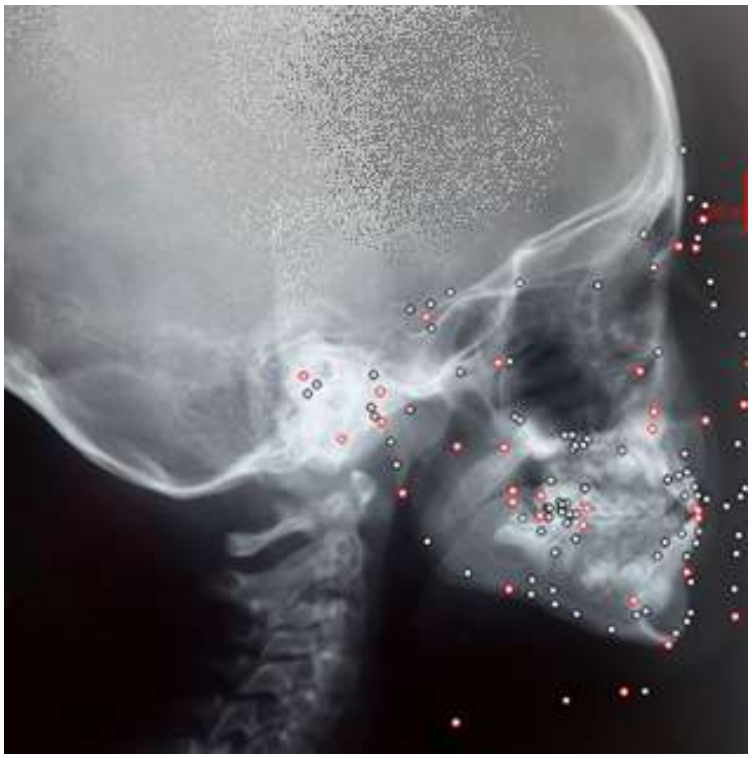


Figure 43. Cephalometric analysis before treatment

Table 10. Cephalometric value after treatment

Cephalometric Analysis before Treatment	Values (°)	Normal Values (°)
SNA	75,9	82 ± 3
SNB	76,4	80 ± 3
ANB	-0,5	2 ± 2
OVJ	-0,9	3.5 ± 2,5
OVB	-3,1	2 ± 2,5
CoGoMe	130,7°	128,8 ± 4
Is^Ans-Pns	111	110 ± 6
Li^GoGn	110,6°	94 ± 7
Apg-Li	-0,5	2 ± 2

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Figure 44. Frontal extraoral before treatment



Figure 45. Frontal extraoral after treatment



Figure 46. Frontal intraoral before treatment



Figure 47. Frontal intraoral after treatment

Case 7

The patient was a 7.5-year-old female in mixed dentition, presenting with a flat facial profile. Intraoral clinical examination revealed mandibular deviation to the right associated with unilateral posterior crossbite in the right molar region, lower dental midline deviation to the right, and a tendency toward dental Class III malocclusion (Figures 48-53) (Table 11). The maxillary arch appeared constricted, with evident space deficiency for the eruption of the permanent maxillary lateral incisors, while the permanent mandibular incisors showed retroinclination. The patient was treated with the AMCOP® TC appliance, and therapy is currently ongoing. At the 12-month follow-up, clinical evaluation demonstrated significant transverse maxillary expansion with correction of the unilateral posterior crossbite and improvement in maxillo-mandibular transverse relationships, as well as a favorable trend toward midline correction. Given the patient's growth phase and evolving dentition, treatment will be continued and closely monitored, with final radiographic assessments planned to evaluate skeletal relationships and long-term stability.

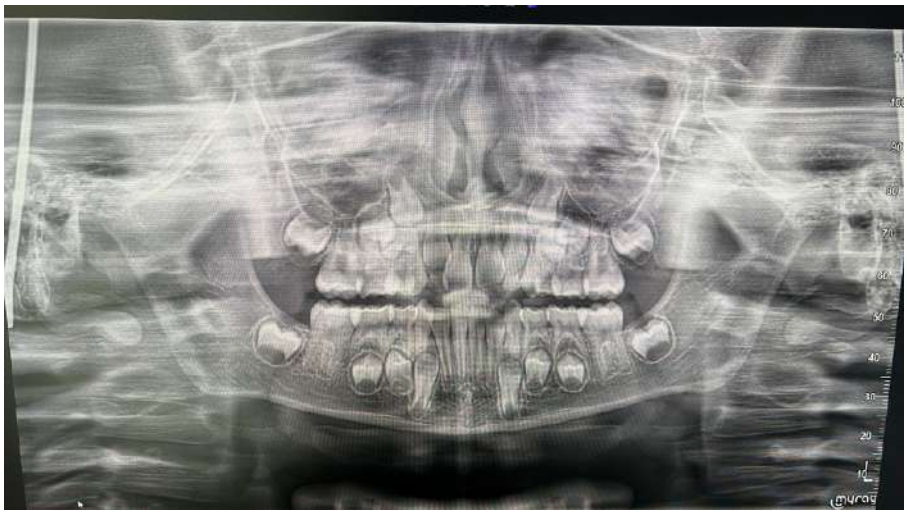


Figure 48. Orthopantomography before treatment

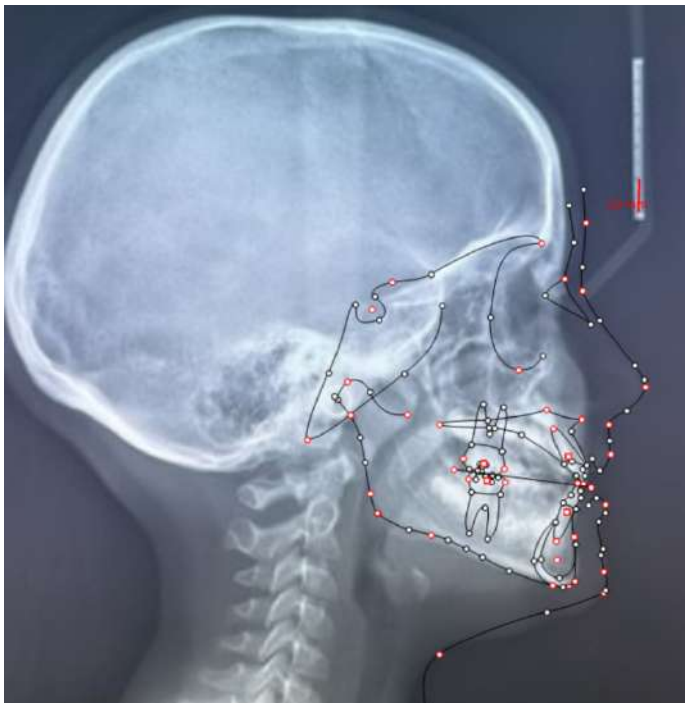


Figure 49. Cephalometric analysis before treatment



Figure 50. Frontal extraoral before treatment



Figure 51. Frontal extraoral after treatment

10.59987/ads/2026.1. 83-119



Figure 52. Frontal intraoral before treatment



Figure 53. Frontal intraoral after treatment

Table 11. Cephalometric value after treatment

Parameter	Values (°)	Normal Values (°)
SNA	74.6°	82 ± 3
SNB	74.9°	80 ± 3
ANB	–0.3°	2 ± 2
Overjet (OVJ)	–1.0 mm	3.5 ± 2.5
Overbite (OVB)	~0 / reduced	2 ± 2.5
CoGoMe (°)	≈130.7°	128.8 ± 4
Upper incisor inclination (Is^Ans–Pns)	~111°	110 ± 6
Lower incisor inclination (Li^GoGn)	~108–110°	94 ± 7
Lower incisor compensation (Apg–Li)	–0.5 mm	2 ± 2

Case 8

The patient was a growing child presenting an anterior crossbite involving the permanent maxillary left incisor, associated with an early dental Class III pattern (Figures 54-60). The initial cephalometric analysis revealed a sagittal skeletal discrepancy characterized by reduced SNA and SNB values, a negative ANB (–0.3°), and a negative Wits appraisal (–5.3 mm), consistent with a developing Class III malocclusion (Table 12). Dentoalveolar compensation was also observed, with proclination of both upper and lower incisors and a negative overjet.

An interceptive orthodontic treatment was carried out using the AMCOP® TC appliance for a period of 12 months. The therapy resulted in complete clinical correction of the anterior crossbite, restoration of a positive overjet, and improvement of the dental Class III relationship. Clinical examination and photographic records documented favorable maxillary transverse development, contributing to improved occlusal relationships and anterior guidance. The vertical dimension remained well controlled throughout treatment. Post-treatment cephalometric radiographs were not available; therefore, treatment outcomes were evaluated on the basis of clinical findings and photographic documentation. Despite this limitation, the observed occlusal correction and transverse maxillary development suggest a positive orthopedic and dentoalveolar response to early functional therapy.



Figure 54. Orthopantomography before treatment



Figure 55. Teleradiography antero-posterior before treatment

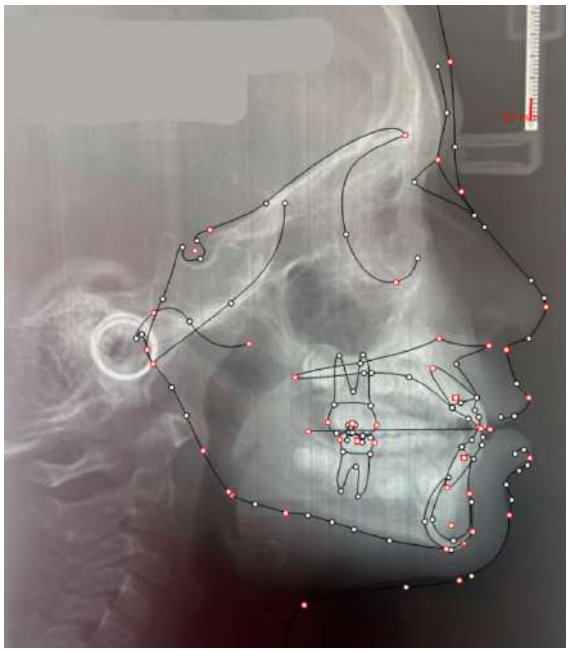


Figure 56. Cephalometric analysis before treatment



Figure 57. Frontal extraoral before treatment



Figure 58. Frontal extraoral after treatment



Figure 59. Frontal intraoral before treatment



Figure 60. Frontal intraoral after treatment

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Table 12. Cephalometric value after treatment

Parameter	Value	Normal Values
SNA (°)	74.6	82 ± 3
SNB (°)	74.9	80 ± 3
ANB (°)	–0.3	2 ± 2
Wits (mm)	–5.3	0 ± 2
CoGoMe (°)	129.0	128.8 ± 4
Is^Ans–Pns (°)	112.6	110 ± 6
Li^GoGn (°)	108.0	94 ± 7
Apg–Li (mm)	–3.5	2 ± 2
Overjet (mm)	–1.0	3.5 ± 2.5
Overbite (mm)	4.0	2 ± 2.5

Case 9

The patient (Figures 61-65) was a growing male child presenting with a dental Class III malocclusion characterized by an anterior crossbite and an altered incisal relationship, detected during the mixed dentition phase. The initial clinical examination revealed a negative overjet with reduced anterior guidance and an unstable anterior occlusal seal, consistent with a functional and dentoalveolar Class III pattern. Although lateral cephalometric radiographs (LL) were not available either before or after treatment due to parental reluctance to radiographic exposure, comprehensive clinical and photographic documentation was performed, supported by orthopantomography and serial intraoral and extraoral records.

The treatment plan consisted of an early orthopedic–functional approach using the AMCOP® TC appliance, prescribed with nighttime wear and additional daytime use according to patient compliance. The therapeutic goal was to intercept the Class III malocclusion by promoting favorable dentoalveolar adaptation and neuromuscular rebalancing during active growth, while improving anterior occlusal relationships.

At the 12-month follow-up, a marked clinical improvement was observed. Intraoral examination documented complete correction of the anterior crossbite, with restoration of a positive overjet and overbite and the achievement of a stable anterior occlusal seal. The molar and canine relationships evolved toward a dental Class I, indicating a favorable sagittal correction. Extraoral photographs showed an improvement in smile aesthetics and perioral balance, without signs of functional deviation. The panoramic radiograph confirmed harmonious dental eruption and alignment consistent with the patient's developmental stage.

Despite the absence of lateral cephalometric data, the consistency between clinical findings, photographic documentation, and occlusal outcomes supports the effectiveness of the AMCOP® TC appliance in the early treatment of dental Class III malocclusion. This case highlights the clinical relevance of early functional intervention in growing patients, demonstrating that significant occlusal correction and stabilization can be achieved within a relatively short treatment period when therapy is initiated during a favorable growth phase.



Figure 61. Orthopantomography before treatment



Figure 62. Frontal extraoral before treatment



Figure 63. Frontal extraoral after treatment



Figure 64. Frontal intraoral before treatment



Figure 65. Frontal intraoral after treatment

Conclusions

Patients treated with the AMCOP® TC elastodontic device wore it for two hours in the afternoon and overnight for 6–8 months, followed by nighttime use only. This approach led to correction of skeletal Class III malocclusion and improvement in cervical spine posture. Treatment lasted 16–24 months on average, with the appliance replaced every 6–8 months due to loss of elasticity. Typically, two to three devices were used per patient. Although promising for its minimal invasiveness and high patient compliance, further studies are needed to confirm the effectiveness of AMCOP® TC bioactivators in managing Class III malocclusions.

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Data availability statement

Not applicable.

Conflicts of interest

The authors declare no conflict of interest.

Abbreviations

AMCOP: Multifunctional Cranio-Occlusal-Postural Harmoniser
DPA: Anterior Protrusion Device

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FM-RME: Face Mask-Rapid Maxillary Expander
RTBLP-RME: Reverse Twin Block with Lip Pads-Rapid Maxillary Expander
SC: Second Class
TC: Third Class
TSME: Transverse Sagittal Maxillary Expander

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