- Facial midline
- Skeletal midline
- Maxillary apical base midlines
- Mandibular apical base midlines
- Maxillary dental midlines
- Mandibular dental midlines

DETERMINATION OF TREATMENT PLANNING

The first thing to be done in planning the treatment and mechanics is selection of a treatment midline. The final goal is represented by this midline. The treatment midline may coincide with either the upper or lower dental midlines or in sudden instances both upper and lower midlines may have to be moved to make them coincident with the facial midline [17].

In cases where both upper and lower dental midlines are coincident but the upper and lower soft tissue/skeletal midlines are not then the treatment midline should be assessed along with surgical alternatives [17].

Often apical base discrepancies are associated with asymmetric left and right molar occlusion so the apical base midline asymmetries require careful attention during the treatment planning process. If the apical base discrepancy is up to 2.0 mm; it is advisable to select either the upper or lower midline; whichever is closest to the facial midline as a treatment midline for larger apical base discrepancies; both upper and lower midlines may need correction [18].

Apical base midline discrepancy may be present with or without tipping of the incisors if both apical base midline discrepancy and tipped incisors are involved; the treatment mechanics should make adjustments for the treatment of two separate problems [18,19].

CONCLUSION

- Possibility of each type of treatment is not symmetric with respect to plane of space. For example tooth movement by orthodontic means alone is more possible antero-posteriorly than vertical direction.
- Growth modification is more effective in mandibular deficiency (10 mm) than mandibular excess (5 mm).

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