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**Compare Two Methods of Dental Arch Length Measurements on Digital Dental Models**

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Compare Two Methods of Dental Arch Length Measurements on Digital Dental Models

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ABSTRACT

Purpose: Accurate space discrepancy evaluation is important in treatment planning. Straight-line segments and brass wire method are the most common methods in arch length assessment. However, using segments causes underestimation, while more reliable brass wire method shows lower reproducibility. The aim of our study is (1) to compare the difference between conventional segmental distance method (SD) and a new method, ideal arch form (IA), and (2) to assess the reproducibility and reliability of two methods by means of digital models.

Materials and methods: Thirty sets of digital dental models presented full permanent dentition and Angle’s Class III malocclusion were included. The dental arch length was assessed with two methods: SD method and IA method. Paired-t test was used to compare two methods; Pearson’s correlation coefficient was used to analyze the correlated variables with inter-group difference; and interclass correlation coefficient was used to evaluate the reproducibility.

Result: Arch length in IA group was 1.86 and 0.86 mm larger than SD group in upper and lower arch, respectively (p < 0.05). The upper arch inter-group difference was negatively correlated to arch length (r = −0.39, p < 0.05) and lower arch inter-group difference was positively correlated to space deficiency (r = 0.40, p < 0.05). Both SD and IA method showed excellent reproducibility.

Conclusion: The SD method showed high consistency but low reliability in short upper arches and crowding lower arches. On the other hand, the IA method can represent the real arch length regarding to the basal bone, and simply be constructed and measured with digital software with high reproducibility. Taiwanese Journal of Orthodontics 2021;33(1):19–25

Keywords: Digital dental model; Dental arch length; Tooth-arch length discrepancy; Ideal arch form

INTRODUCTION

To achieve a better treatment plan, an accurate evaluation of tooth-arch length discrepancy (TALD), which calculate the difference between space required and space available, is important. To evaluate TALD in plaster model, clear ruler, divider, or digital caliper are used to measure the mesiodistal width of each tooth for space required.1-9 Previous studies have described several methods to measure the available space, including individualized arch form graphing,1 clear plastic arch form ruler,2 arcogramme,3 4- or 6- segment arch length,4,5 and direct wire measurement.6-8 Among these methods, straight-line segments and brass wire method are the most common methods nowadays. For the segmental lines, even though the method is simple, reduction of the round arch perimeter into straight-line segments will result in underestimation of the space available.9 On the other hand, in the brass wire method, a 0.020-inch brass wire was applied smoothly passing through the contact points between every tooth, from mesial side of first molar on the one side to the opposite side. Then the wire length will be...
measured. Although the brass wire method follows the arch form of basal bone, it is more time consuming than segmental length measurement and the reproducibility is low.10

To standardized the method, the ideal arch form correlated to the scheme of skeletal base might be a solution for space available measurement.7 In the previous studies, some methods to construct the ideal arch form were introduced, including geometric graphing,12-13 mathematical equation model14-16 and cast-CBCT image method.17

The first description based on the geometric rules was introduced by Bonwill and Hawley.12-13 They constructed an arch form with a circle of which radius is the combination of the width of six anterior teeth, and an equilateral triangle represents the intercondylar width. Recently, with the growing of technology and mathematics, the length and the curve of arch form are calculated with a formula or regression.14-16 Noroozi utilize the beta function formula to develop an accurate curve of equation based on inter-second-molar width, inter-canine width, second molar depth and canine depth.14 However, for the clinical practice, the geometric graphic method and the mathematical equation model are not feasible. According to Andrew's six elements orthodontic philosophy, the anterior and lateral border of mandibular dental arch will follow the rule from WALA ridge, which is defined as the most prominent portion of mandible’s mucogingival junction.17 The distance from second premolar cusp tip, first premolar cusp tip, canine cusp tip to the WALA ridge are 4 mm, 3 mm, and 2 mm respectively.17-20 The study of Ronay et al.23 revealed the strong correlation of WALA ridge and tooth position, proving that WALA ridge is capable to predict the tooth position in the concept of apical basal bone. In addition, the tooth to basal bone relation was also described in the CBCT image research and confirmed the dental-to-skeletal relation.20

For orthodontists, it requires the accurate replicas of oral dentition from patients to make ideal diagnosis and treatment plan. Although conventional plaster dental models can provide sufficient information that professionals required, the general disadvantages are their physical weight, time consuming, the need for storage space, and the risk of wearing and fracture. In pace with the emergence of computed technology, digital dental model become an efficient material for clinical practice. Nowadays, digital dental models can also assist space analysis and several studies were released to compare conventional and digital methods of measurement. Leifert et al.10 in 2009 used plaster models as control group comparing with digital models, and the result shows digital model is a reliable material to analyze arch length discrepancies. For the accuracy assessment, Quimby's research showed the digital models appeal great reproducibility.22 Controversially, the research from Sjögren revealed lower inter-examiner repeatability while using digital model and higher intra-examiner reproducibility for experienced examiner.11

In the past, it is difficult to assess the measurement on the imaginary line. However, by the assistance of digital analyze software, ideal arch form can be created on the virtual occlusal plane and measured with virtual rulers. Therefore, the purpose of this study is (1) to assess the reproducibility and reliability of a new method, ideal arch form (IA), and (2) to compare the difference between conventional segmental distance method (SD) and IA method by means of digital model measurement.

MATERIALS AND METHODS

The study was undertaken as an experimental approach. Thirty sets of maxillary and mandibular dental models were selected with criteria as following: Class III malocclusion patients before orthodontic treatment, absence of positive or negative bubbles, complete anatomical structure of the teeth without morphological defect, such as poor qualified restorations or large decays, and presence of full dentition from first molar on one side to first molar to the opposite side. The cases with obviously excessive space available were excluded. The present study followed the Declaration of Helsinki on medical protocols and ethics, and the Institutional Review Board of Chang Gung Memorial Hospital approved this study.

**Digital cast Obtaining**

The dental models were obtained by oral impression with Alginate (Cavex CA37®, Holland). After trimming the excess material to avoid occlusion and scan interference, the plaster casts were captured with an extraoral scanner, 3 shape R700™ (3Shape, Copenhagen, Denmark). The scanner contains 2-camera and 3-axis motion system which could capture full undercuts and reduce the interference. The Standard Tessellation Language (STL) files of the images were transferred to OrthoAnalyzer™ software (3Shape, Copenhagen, Denmark) for virtual cast analysis.
Preparation and orientation

The occlusal plane was defined as the plane passing through the mesiobuccal cusp of bilateral first molars and the most extruded point on the incisal edge of central incisors.

Measurements

Space required

The teeth were separated one by one to measure the tooth size from the most convex contour of both mesial and distal surface of the tooth. The cutting planes were parallel to the long axis of the tooth.

Space available (Arch length)

Two methods of arch length measurements were conducted.

1) Measurement method of segmental distance (SD group): The cast was oriented according the occlusal plane to which the visual angle is perpendicular. The segments were measured by connecting the points, including contact point of: right first molar and second premolar, right canine and lateral incisor, central incisors, left canine and lateral incisor, and left first molar and second premolar (Figure 1). However, most of the cases might show the teeth contacting with a contact area instead of a contact point. When encountering this situation, we would indicate the segmentation point in the middle of the area. In the canine completely blocked-out cases, the segmentation point will be adjusted to the most convex contour on the mesial side of the first premolar instead of the contact point of first premolar and the blocked-out canine.

Similarly, the adjustment could be applied in severely malaligned lateral incisor and premolars.

2) Measurement method of individualized arch form (IA group): The casts were oriented according the occlusal plane to which the visual angle is perpendicular. First of all, the arch form was first selected as symmetric ellipse arch which passes through the anterior contour of the alveolar ridge or incisal edge, and the endpoints were on the most mesial contour of first molars on both sides. According to Andrew’s measurement, the projection distances of the incisor tips to mucogingival junction are about 0 mm. We registered the center of the ellipse curve on the midpoint between the “midpoint of two central incisors edge” and the “anterior contour of the alveolar ridge” in the occlusal view. The previous measurement was more related to conventional brass wire technique and the later one was more related to WALA ridge rule of Andrew. While moving the tip of ellipse within the range, the curve passing through posterior teeth could fit the WALA ridge well for final determination of the individual arch form.

The line medially to the WALA ridge of 4 mm and 3 mm on second premolars and first premolars respectively were connected (Figure 2). The adjusted line represents the optimal arch form which would pass through the buccal cusp of mandibular premolars and incisal edge of the mandibular incisors. Ultimately, the maxillary ellipse arch form would be coordinated according to the mandibular arch, for about 2 to 3 mm wider than the mandibular arch.

Figure 1. Segmental distance method. After orienting the digital models, the segments were obtained by connecting the points together: contact point of the right first molar and second premolar, the contact point of right canine and lateral incisor, the contact point of central incisors, the contact point of left canine and lateral incisor, and then the left first molar and second premolar.
Space deficiency

Tooth size-arch length discrepancy was defined as space available minus space required.

Measuring time

The time for space available measurement were recorded. For the SD group, the measure time included point marking and segmental distances calculation. For the IA group, the measure time included only arch form development, and the length will be calculated by the software automatically.

Consistency of the methods

All measurements were conducted by a single examiner (Y.C.C). For intra-observer consistency, 10 digital casts were randomly selected to conduct a re-examination after an interval of 2 weeks. The validation of segmentation consistency and arch form development were assessed.

Statistical analysis

Statistical analysis was carried out with SPSS 22.0 application (IBM, Chicago, IL, USA). The difference of space available acquired form two methods was assessed with paired-t test. Besides, the difference of discrepancy in SD group and IA group was also compared with paired-t test. To analyze the correlated variables with inter-group difference, Pearson’s correlation coefficient was utilized. To test the intra-observer consistency, the validation of segmentation consistency and arch form development were assessed with interclass correlation coefficient. P-value < 0.05 was considered statistically significant.

RESULT

The statistical analysis showed there was significant difference between SD group and IA group. In average, the space available in IA group was 1.86 mm longer in maxillary model and 0.86 mm longer in mandibular model (Table 1).

In the upper models, the inter-group difference showed statistically significant correlation with arch length with IA method (UIA) (Pearson’s correlation coefficient $r = -0.39, p < 0.05$). The result indicated the longer the upper arch, the smaller the difference between groups. On the other hand, the difference between two methods in the lower arch showed significant correlation to space deficiency with the SD method (LSDD) (Pearson’s correlation coefficient $r = 0.40, p < 0.05$), indicating the more space deficiency noted with SD method, the more difference between two methods (Table 2). The time required to perform the two methods showed no statistically significant difference while 111.6 and 126.7 seconds were taken in SD and IA method, respectively. After the interclass correlation coefficient (ICC) test, both

| Table 1. Space deficiency measured with two different methods. |
|------------------|------------------|------------------|------------------|------------------|
|                  | Ideal Arch form (IA) | Segmental distance (SD) | Inter-group difference (SD-IA) |                  |
|                  | n = 30 | Mean | SD | n = 30 | Mean | SD | Mean |
| Upper arch       |          |       |    |          |       |    |      |
| Space available  | 75.4    | 5.74  | 73.6 | 5.29    | -1.86 | 2.06 | <0.001$^1$ |
| Space deficiency | -2.38   | 5.33  | -4.70 | 5.11    |          |      |       |
| Lower arch       |          |       |    |          |       |    |      |
| Space available  | 65.48   | 3.89  | 64.62 | 4.07    | -0.86 | 1.53 | <0.005$^2$ |
| Space deficiency | -2.77   | 4.04  | -3.64 | 4.4     |          |      | <0.005$^2$ |

$^1$p-value <0.01. $^2$p-value <0.05.
Table 2. Correlation of inter-group difference and other measurements.

<table>
<thead>
<tr>
<th></th>
<th>Pearson's correlation coefficient, r=</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper arch inter-group difference compared to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UIA</td>
<td>-0.39</td>
<td>0.03</td>
</tr>
<tr>
<td>USD</td>
<td>-0.33</td>
<td>0.86</td>
</tr>
<tr>
<td>UIAD</td>
<td>-0.30</td>
<td>0.11</td>
</tr>
<tr>
<td>USDD</td>
<td>0.09</td>
<td>0.62</td>
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<tr>
<td>Lower arch inter-group difference compared to</td>
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<td></td>
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<tr>
<td>LIA</td>
<td>0.08</td>
<td>0.69</td>
</tr>
<tr>
<td>LSD</td>
<td>0.30</td>
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<tr>
<td>LIAD</td>
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<td>0.76</td>
</tr>
<tr>
<td>LSDD</td>
<td>0.40</td>
<td>0.03</td>
</tr>
</tbody>
</table>

UIA, upper arch length using ideal arch form method; USD upper arch length using segmental distance method; UIAD, upper arch space deficiency using ideal arch form method; USDD, upper arch space deficiency using segmental distance method; LIA, lower arch length using ideal arch form method; LSD lower arch length using segmental distance method; LIAD, lower arch space deficiency using ideal arch form method; LSDD, lower arch space deficiency using segmental distance method.

*p-value<0.05.

Table 3. Interclass correlation coefficient (ICC) of reproducibility.

<table>
<thead>
<tr>
<th></th>
<th>Interclass correlation coefficient</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper arch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space required</td>
<td>0.95</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Space available (IA)</td>
<td>0.96</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Space available (SD)</td>
<td>0.97</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Lower arch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space required</td>
<td>0.97</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Space available (IA)</td>
<td>0.99</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Space available (SD)</td>
<td>1.00</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

Two-way mixed model was used. Type A interclass correlation coefficient using an absolute agreement definition.

*p-value<0.01.

Discussion

The result showed the difference in upper dental arch was only 1.86 mm difference between the two methods. The difference was statistically significant that indicates some underlying problems could be revealed when using segmental distance for arch length measurement. According to the result, we may pay more attention on the potential underestimation in upper arch length, especially in cases with shorter arch length as indicated in Table 2.

When it comes to time consumed in two methods, measuring with segmental distance method on plaster models is easier and faster than with curved
arch form length. Nevertheless, assisted with digital dental model, the ideal arch form length can be developed and measured efficiently and eliminate the difference of the time required between these two methods.

In the previous study, it was considered that the reproducibility is low when using curved arch length. Based on the consistency of tooth position and skeletal arch introduced by Andrew's six element philosophy and also confirm with CBCT image, WALA ridge provides a scheme for arch form development. In our study, although the reproducibility of ideal arch form is slightly lower than segmental distance, it is still excellent (ICC = 0.99 in lower arch, 0.96 in upper arch). Assisted with digital software, the measuring curves can be consistently processed on the occlusal plane, and the scale could facilitate calibrating the position of wire to WALA ridge, eventually generate a method with high reproducibility and reliability. For the upper arch, since the limitation of the software which can only reflex the lower ideal arch form to the upper arch but not allow moving them as a guide, there might be lower consistent in the upper ideal arch form development of the patients with severe asymmetry or anteroposterior skeletal discrepancy.

The case selection which only included Class III malocclusion patients because the present study is the pilot study of an undergoing research in our institution. The methods of arch length measurements need to be validated for evaluation of occlusion characteristics in Class III patients. Thus preliminary assessment might be constructive to decide a better solution. Besides, the arch form in Class III malocclusion already has wide diversity, not to mention in different classification of malocclusion. Therefore, to reduce the analysis discrepancy, only patients with Class III malocclusion were included.

To assess the tooth size arch length discrepancy, space available measurement is an important issue which affects the variable considerably. First of all, to reflect the real arch length, curved length is more ideal and reliable than the segmental lines. Furthermore, the measurement regarding to the basal bone could reveal the hidden space once taking narrow arch expansion into consideration, and disclose the overestimated space when taking tooth proclination into account.

CONCLUSION

As the technology developing, using digital dental model for space deficiency assessment is efficient. Segmental distance method shows high consistency but low reliability in short upper arches and arches with crowding dentition. On the other hand, ideal arch form method can represent the real arch length regarding to the basal bone, and simply be developed and measured with digital software.

FUNDING

None

Conflict of interest statement

The authors declare no conflicts of interest.

ETHICAL APPROVAL

This study was approved by the Institutional Review Board of Chang Gung Memorial Hospital (No. 2102180062).

PATIENT CONSENT

Not required.

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