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Review Article

Soft Tissue Analysis – A Review Article

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ABSTRACT:

One of the primary goals of orthodontic treatment is to attain and preserve optimal facial attractiveness. To accomplish this, it is important that the orthodontist conduct a thorough facial examination so that the orthodontic correction will not adversely affect the normal facial trait, for achieving this an accurate diagnosis and treatment planning is necessary. So, in this article a review of some of the soft tissue analysis is discussed.

Keywords: Soft tissue analysis, orthodontic, diagnosis, facial examination & treatment planning.

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INTRODUCTION

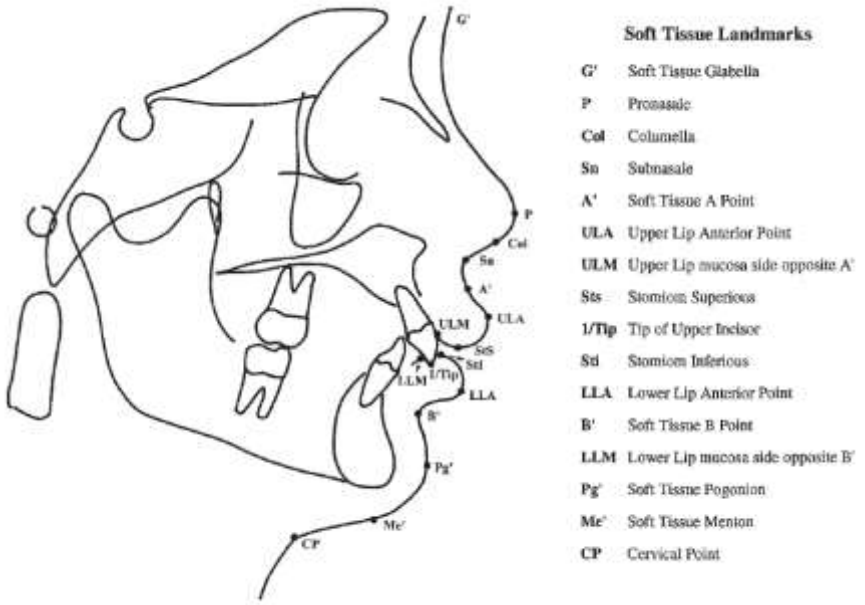
Facial esthetics is one of the main goals of orthodontic treatment and increased emphasis has been placed on it in recent years by both patients and orthodontists.[11] The famous Greek philosophers Plato and Aristotle introduced the term "aesthetics", which means the study of beauty and philosophy of art.[1] Aesthetics not only includes physical and natural beauty but also the beauties of human emotion and experience.

The orthodontists then rightfully streamlined "aesthetics" to "esthetics" and limited its scope to only those criteria easily manageable by objective analysis.[7] Facial profiles and facial balance is a constant, continuous study and learning process for orthodontists. Tooth movement and proper positioning of the teeth to ensure favourable facial changes and to avoid unfavourable changes should be in the orthodontist's "diagnostic" mind from the very first examination.[4]

Considerations of facial esthetics always have been an inseparable part of the principles and practice of orthodontics. The soft tissue profile has been studied extensively in orthodontics, primarily from lateral cephalometric radiographs, under the assumption that the form of soft tissue outline largely determines the esthetics of the face.

CEPHALOMETRIC SOFT TISSUE LANDMARKS[5,8]

One of the most important components of orthodontic diagnosis and treatment planning is the evaluation of the patient's facial soft tissue. Since the shape of the human face depends on both the structure of the hard tissue (bone) and the soft tissue that covers it, soft tissue should be analysed for the correct evaluation of an underlying skeletal discrepancy because of individual differences in soft tissue thickness.[5]



G-glabella	**most anterior point on the soft tissue forehead**
Li-labrale inferius	**most anterior point on the convexity of lower lip**
Ls-labrale superius	**most anterior point on the convexity of upper lip**
Ms-menton soft tissue	**most inferior point of the soft-tissue outline of the chin**
Ns-nasion soft tissue	**most concave point of the soft tissue on the frontal aspect of the bridge of the nose**
Pn-pronasale	**most anterior point of the nose**
SBN-Subnasale	**point at which the columella merges with the upper cutaneous lip**
Cm-Columella	**most anterior and inferior point of the nose**
Pog-pogonion soft tissue	**most anterior point on the convexity of the soft tissue chin**
Sls-superior labial sulcus	**most posterior point on the concavity between the upper lip and nose**
Stm-stomion	**midpoint of the labial fissure when the lips are closed naturally**
Sti-stomion inferior	**superior point of the lower lip**
Sts-stomion superior	**inferior point of the upper lip**

Various Soft Tissue Analysis:

1) Holdaway Soft Tissue Analysis[3]

Holdaway outlined 11 soft tissue parameters for soft tissue balance & the H-line or harmony line was formed by drawing tangent to the soft-tissue chin and the upper lip;

i) Facial angle formed by intersection of FH plane with line joining N to Pog. Average value 90^0 - 92^0. Used to measure the degree of protrusion (increase facial angle) or retrusion (decrease facial angle) of lower jaw.

ii) Soft tissue Subnasale to H line measured as the distance of perpendicular made from subnasale to H line. Average 3 to 7mm, ideal 5mm

iii) Skeletal convexity point A is measured from N – Pog line to point A. Average value 2 to -2

iv) Upper sulcus depth measured from Subspinale to H line average value 5mm

v) Lower sulcus depth is measured from deepest point in the curvature between lower lip and the chin and the H line. Average value 5mm

vi) Lower lip to H line the ideal position of the lower lip to H line is 0 - 0.5mm anterior, but individual variations from 1mm behind to 2mm in front of the H line are considered to be in a good range.

vii)The H angle Formed between H line & line joining N to Pog. Average value 7-15mm

viii) Nose tip to H - line average value 12mm max

ix) Upper lip thickness is measured horizontally from point 2mm below point A to outer border of upper lip, average value 15mm

x) Upper lip strain is measured from vermilion border of upper lip to the labial surface of maxillary central incisor. If upper lip thickness is greater than upper lip strain then it indicates strain in upper lip

xi) Soft tissue chin thickness is measured from hard tissue Pogonion to soft tissue Pogonion. Average value 10 to 12 mm

Convexity Point A to N - Pog (in mm)	H angle (Degree)
-5	5
-4	6
-3	7
-2	8
-1	9
0	10
1	11
2	12
3	13
4	14
5	15
6	16
7	17
8	18
9	19
10	20

Best Range

Values of skeletal convexity with relation to H angle

2) Merrifield Z angle[5]

Formed by FH plane (Frankfort Horizontal Plane) & Profile line by drawing a line tangent to the soft-tissue chin and to the most anterior point of either the lower or upper lip, whichever was most protruding, and extending it upward to Frankfort plane, this is a modification of the H line used by Holdaway. Normal range $70^0 – 80^0$ Ideal $75^0 – 78^0$.

3) E line[9,10]

Also called as esthetic line, described by Ricketts. It is formed by joining tip of nose and soft tissue pogonion.

4) S line[12,13]

Steiners S line is drawn from midpoint between Sub-Nasale (Sn) and Pronasale (Pn) to Soft Tissue Pogonion (Pog) and lip prominence with reference to this line is assessed. Its cephalometric norms are as follows:

- Upper lip to S Line (0 ± 2mm)
- Lower lip to S Line (0 ± 2mm)

5) COGS analysis (cephalometrics for orthognathic surgery)[2]

The analysis was developed by Charles J. Burstone in 1978. In this analysis, Burstone et al. used a plane called horizontal plane, which was constructed of Frankfurt Horizontal Plane.

Landmark Name	Landmark Symbol	Description	Normal
Facial forms analysis			
Facial convexity/Contour angle	G-Sn-Pog	Increased +ve value – Convex Profile Increased -ve value – Concave Profile	$12^0 \pm 4^0$
Maxillary Prognathism	G-Sn	+ve Prognathism -ve Retrognathism	6 ± 3 mm
Mandibular Prognathism	G-Pog	Increased -ve Mandible Retrognathism	0 ± 4 mm
Vertical Height Ratio	G-Sn / Sn-Me	Ratio of Middle 3rd to Lower 3rd Facial height	1 : 1
Lower Face Throat Angle	Sn-Gn-C	Helpful in correcting antero -posterior facial dysplasias	$100^0 \pm 7^0$
Lower Vertical Height Depth Ratio	Sn-Gn / C-Gn	Determining the feasibility of reducing/increasing chin prominence (if ratio is >1 short neck)	1.2 : 1
Lip position and form			
Nasolabial Angle	Cm-Sn-Ls	Assessing the anteroposterior maxillary dysplasias	$102^0 \pm 8^0$
Upper Lip Protrusion	Ls to Sn-Pog	Abnormality treated by retracting/protracting incisors, surgically or orthodontically advancing or retracting the maxilla	3±1 mm

Lower Lip Protrusion	Li to Sn-Pog	Abnormality treated by retracting/protracting incisors, surgically or orthodontically advancing or chin prominence	2±1 mm
Mentolabial Sulcus Depth	Li-Pog'	Sulcus of 4mm provides a pleasing lower lip to chin contour	4±2 mm
Vertical Lip Chin Ratio	Sn -Stms / Stmi-Me	If ratio less than normal - vertical reduction genioplasty is recommended	1 : 2
Maxillary Incisor Exposure	tip of upper central incisor to Stms	Increased due to vertical maxillary excess or short upper lip Decreased due to vertical maxillary deficiency or larger upper lip	2±2 mm
Interlabial Gap	Stms-Stmi	Vertical maxillary excess – larger gap & lip incompetency Vertical maxillary deficiency – no gap & lip redundancy	2±2 mm

CONCLUSION

Today, more so than at any other time in our specialty, we have the ability to provide esthetic results to our patients. We have a good understanding of the changes that occur in the soft tissues with growth and the changes produced by our treatment. Comprehensive cephalometric and facial analyses allow us to identify the structural etiology of the malocclusion. Careful examination and documentation of soft tissue features will permit the reversal of negative traits and the maintenance of positive features in individuals, thereby enhancing clinical treatment.

As computer technology has become more sophisticated it has become possible to combine and integrate the benefits of cephalogram, patient photos and study models into one diagnostic package. Computerized cephalometry will continue to evolve rapidly, presenting both a challenge and an opportunity to the dental profession to improve visualization of the esthetic and functional impact of treatment plans.

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