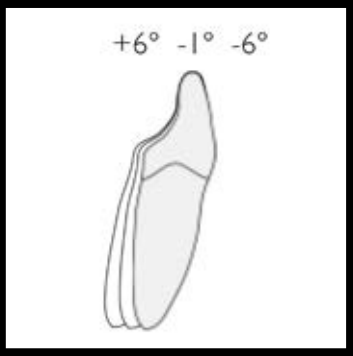
McLaughlin Bennett 5.0

with FORESTADENT



A bracket selection guide

with Dr. John Bennett and Dr. Rick McLaughlin

John Bennett & Rick McLaughlin

“I only want the very best.”

César Ritz 1850–1918

Contents:

– A big step forward –

Dear Colleagues,

For the first time we have brackets and arch wires which have been specifically designed for our current treatment method. They are ideal for our mechanics and we believe these are the finest available in today's market place.

The technical experts at Forestadent are among the best in the world, and we chose to work with them during the past four years. Together we have created a state-of-the-art set of brackets, with multiple refinements and improvements, based on a lifetime of experience. They have been designed by orthodontists for orthodontists and are a big step forward.

During four years of clinical testing the latest brackets have been delivering the very best for our patients, and in the following pages we highlight the clinical advantages of this new generation of brackets. There is a focus on using the .0227 slot size with .019/.025 working wires, but everything is available in .018 slot size, if this is your preference.

The arch wires were developed before the brackets, and they have made a big difference since 2014. They are are more effective with overbite control and sliding mechanics, because they have improved metal quality and superior hooks. What's more, they are exactly correct for the three shapes we advocate – ovoid, tapered, and square.

We hope you share our excitement as we move into the 2020s. The future is bright!

Sincerely,

John Bennett & Rick McLaughlin

Dr. Andrews

The work of Dr. Lawrence Andrews in the late 1960s and 1970s provides the science for the modern era of pre-adjusted edgewise. He defined ideal occlusion in his famous 'Six Keys' paper. Then he took the traditional .022 edgewise bracket and changed it completely, based on his findings. This became the Straight Wire Appliance or SWA.

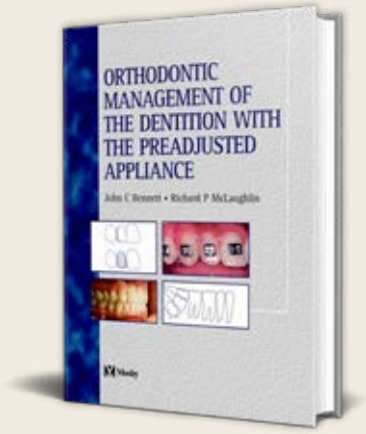
The orthodontic specialty owes a huge debt of gratitude to this man of genius. His work is completely valid today, and continues to provide the scientific basis for our current bracket designs. For seven years Dr. McLaughlin worked part-time with Dr. Andrews in his practice in San Diego.

Dr. Lawrence F. Andrews

Re-designing the brackets – the 1997 prescription

In many areas of medical and dental care, patient treatment comes from a combination of three components – science, tradition, and experience. The 1970s provided the science and the tradition, and by the mid-1990s we had 20 years of experience with SWA, based on hundreds of treated cases, and work with Dr. Hugo Trevisi.

It was time to move ahead, and in our 1997 book 'Orthodontic Management of the Dentition' we recommended a modified prescription and an entirely re-designed series of brackets. The 1997 prescription later became known as MBT™. It 'kept the best features of SWA and improved the rest' and was ideally suited to our mechanics. It has stood the test of time and is the most widely used prescription in the world today.



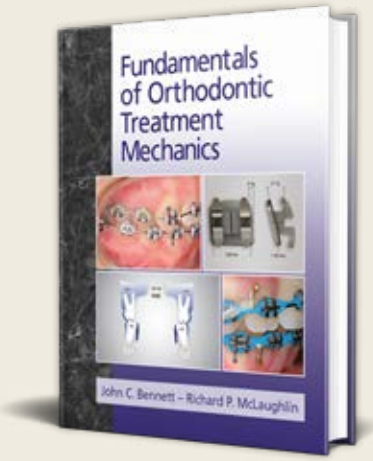
'Orthodontic Management of the Dentition' which is known as Book 2.

Bracket and arch wire quality – the final challenge

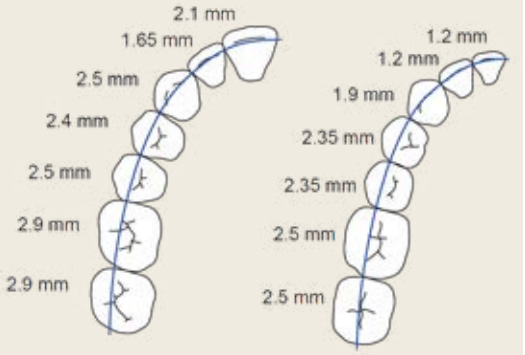
As we moved into the 2000s we were confident with our mechanics and our 1997 prescription. However, we needed better brackets and wires to achieve ideal results. The original MBT brackets were full size and milled. They worked well, but the specialty preferred smaller brackets and production changed to metal injection moulding (MIM). Accuracy was all-important if we were to avoid wire bending.

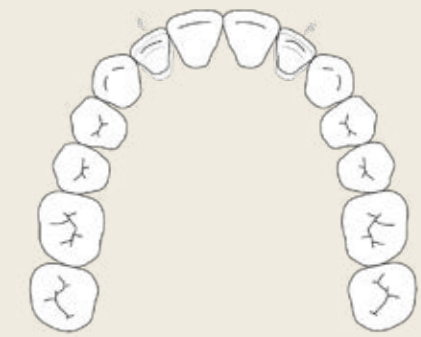
In summary, going into the 2000s we were not happy with the bracket quality or the wires (which came from the 1970s, and were also under-performing).

We have now overcome this final challenge. The last pieces of the puzzle are falling into place and we feel our life's work is almost complete. We have teamed up with a world class manufacturer to create a series of high performance brackets which really do the job. These are being accurately produced, exactly to our prescription, and as 2019 comes to an end the full range is available to the specialty. Additionally, we continue to enjoy using the superb set of wires, which were developed with Opal, but are now available from Forestadent.



'Fundamentals of Orthodontic Treatment Mechanics'.
ISBN 978-0-9564555-2-9
This is known as Book 4 and is available in English, Chinese, Italian, Japanese, Korean, Polish, Russian, Spanish, Turkish and Ukrainian.





The importance of in-out

Over the years there has been a focus on angulation and torque, but regrettably less attention has been given to in-out.
Perhaps it was felt that in-out is not important, or maybe it has been assumed by doctors that it is correct anyway in the brackets they use. Unfortunately, it is not safe to make these assumptions. In-out certainly is important (otherwise we have to start wire bending) and regrettably it has been wrong on many brackets in the past.

The work of Dr. Andrews

In his research Dr. Andrews used the term 'prominence' to describe what is commonly known as 'in-out'. He measured it from an imaginary line known as the 'embrasure line', shown here in blue for the upper and lower arches. This illustration is redrawn from Dr. Andrews' book pages 32 & 33.

Andrews LF 1989 Straight Wire - The concept and appliance.
LA Wells Co. ISBN 0-9616256-0-0

Bennett JC, McLaughlin RP, Fundamentals of orthodontic treatment mechanics. 2014 ISBN978-0-9564555-2-9 Page 44

One significant improvement

Care has been taken to have the correct in-out on the entire Mini Sprint II bracket range. However, the science from Andrews' research sample found that the labial surface of upper lateral incisors was inset by 0.55mm compared with the centrals. Experience has shown that this amount of inset (although it is scientifically correct) does not give ideal aesthetics from the point of view of our patients! Accordingly, a reduced inset on upper laterals is now a key feature, because we have found it provides better smile aesthetics. (See also page 7).

Slot size and bracket hooks

The average slot size

Sliding mechanics is a key part of our philosophy. Ideally, the preferred arch wire is .019 / .025 and the slot size needs to be slightly larger than 0.022. Bracket production at Forestadent offers new levels of precision, and we have been able to design the Mini Sprint II range with an average slot size of 0.0227, which we feel is ideal. It is preferable to 0.0220, which we have found can cause overtorquing of incisors and less effective sliding mechanics.
The 3% increase in slot size from .0220 to .0227 works really well and it has been a big improvement during prolonged testing on our patients.

The average slot size is 0.0227, which is 3% larger than the classical 0.022, and works ideally with System 5.0 sliding mechanics.

Improved hook design

The new series of brackets has an improved design of hook, which is lower profile and much better for patients.
Integral bracket hooks are available as an option on all premolar and canine brackets. However, not all orthodontists use hooks on canines and premolars, and in the past there have been concerns about discomfort and plaque control.

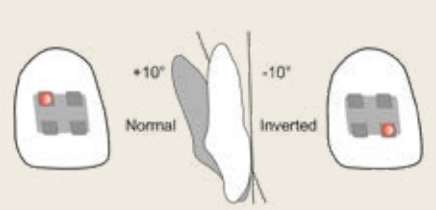
The improved design of bracket hook with Mini Sprint II is lower profile and better for patients.

Bracket hooks or no hooks?

There are differences of opinion about hooks.
Some orthodontists feel they are essential on all cases for proper treatment mechanics, particularly up-and-down elastics at the end of treatment.
Others believe they are serious plaque traps and cause needless discomfort to the patient for the duration of the treatment, although they may only be used for a few weeks or not at all.
As they developed their technique the authors chose not to use hooks, and the published cases in their second and third books were successfully treated mostly without hooks. When needed, Kobyashi ties were added for a short period.
Brackets without hooks was a cleaner and more comfortable experience for the patient than having hooks in the mouth for 18 to 24 months.
The latest book shows cases with bracket hooks, because the authors were evaluating this option. Where possible, one author (RPM) generally prefers to have hooks only on canine brackets, but not premolars. The other author (JB) has reverted to having no hooks, as previously.

In the past there have been concerns that hooks are uncomfortable for the patient and bring an added risk of decalcification due to plaque accumulation at the gingival margin. For those colleagues who use hooks, it is hoped that the new low-profile design will be a big step forward.

Upper incisor brackets



Inverted upper lateral incisor brackets give -10° torque and +8° angulation in cases with in-standing laterals.

In cases with instanding upper lateral incisors it is often helpful if the bracket is inverted.

An occlusal view of a case, close to completion. It shows the slightly increased prominence of the upper lateral incisors, resulting from the reduced in-out on the brackets. This gives better smile aesthetics, which is much appreciated by patients.

Tip, angulation, and in-out

Centrals have +17° torque and +4° angulation.
Laterals have +10° torque and +8° angulation.
Upper laterals have reduced in-out compared with the research figures (please see below and page 5).

The -10° torque option for upper laterals

In cases with in-standing upper lateral incisors it is often helpful if the bracket is inverted. This gives -10° torque instead of +10°.
The displaced lateral incisor carries the normal bracket, but it is rotated through 180°. The angulation (tip) stays the same at 8° but the torque becomes -10°. It is not correct to switch sides. The left bracket goes on to the left incisor and the right bracket on to the right incisor. Inverting the bracket in this way applies effective labial root torque at the rectangular wire stage, for easy root correction.
It is normally better to achieve correct incisor and canine torque from bracket versatility. The alternative is wire bending, but it is difficult and time consuming to introduce the exact amount of torque needed into rectangular wire. Inverting the bracket is more precise and easier. The authors recommended this in 1997. They showed a published case in their second book (p. 98–104) and a treatment sequence in the third book (p.43).
If wire bending is to be minimised it is essential to use accurate brackets and to bond them correctly.

Reduced in-out for upper laterals

As discussed on page 5, the upper lateral incisor brackets have reduced in-out compared with the research figures, because this gives better smile aesthetics.
Andrews' research found that the upper lateral incisor inset was 0.55mm compared with the centrals. However, in many cases this amount of inset is not pleasing for the patient. The reduced inset on upper laterals is now a key feature, and popular with patients.

Lower incisors

Lower incisor tip, angulation, and in-out

Lower centrals and laterals have -6° torque and zero angulation. The authors have recommended and used the -6° lower incisor bracket for more than 20 years and it continues to be the bracket of choice for most cases. The in-out is based on Andrews' research finding of -1°, with additional control due to the .019/.025 wire not being a precise fit in the slot. The bracket delivers an ideal relationship with the lower canines, provided bracket positioning is accurate. This avoids the need for wire bending.

Since the days of the SWA, the correct in-out has resulted in lower incisor brackets which appear rather 'thick'. Some doctors who are new to the philosophy comment on this feature, but most find it is easily manageable with the System 5.0 mechanics. The lower incisor brackets are fully interchangeable, left and right, and between centrals and laterals.

Lower incisor brackets. The in-out delivers an ideal relationship with the lower canines at the end of treatment, provided there has been correct bracket positioning and good mechanics. They are fully interchangeable, left and right, and between centrals and laterals.

The +6° torque option

In some situations lower incisor brackets can be inverted, which gives +6° torque and zero angulation. This can avoid wire bending and help the mechanics in some Class III cases or in situations where there is a need to 'burn' lower anchorage without retroclining the lower incisors. Also if a single lower incisor is proclined, inversion of the bracket can help to bring the root into bone, but care is needed. This is discussed on page 56 of 'Fundamentals of Orthodontic Treatment Mechanics'.

There is some increased prominence of the bracket tie-wings after inversion. However, this is seldom an issue because appropriate cases normally have a Class III incisor relationship with a reduced overbite.

These lower left incisor brackets have been inverted to give +6° torque and zero angulation.

The -1° torque lower incisor bracket

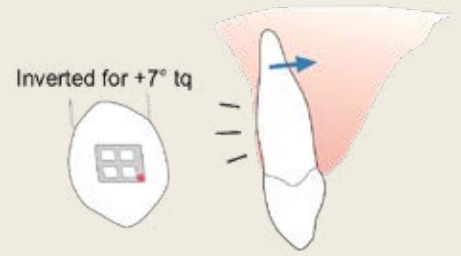
The -6° torque prescription for lower incisors has been superb since the authors started using it in the mid-1990s and it remains the 'go-to' preference for most cases.

However, it is necessary to respect the anatomy of the alveolar bone, which can be narrow and challenging in the lower incisor region. For a small number of cases the authors have found it useful to have a -1° torque and zero angulation bracket available.

Thus, System 5.0 has three torque options for the lower incisors and great versatility when managing the lower anterior segment.

The System 5.0 treatment method has three torque options for the lower incisors. This provides great versatility when managing the lower anteriors, and minimises wire bending. The -6° remains the ideal bracket in most cases. (Not to scale).

The upper left canine bracket and premolar brackets. The -7° torque bracket can be inverted to give +7° and guide the root into cancellous bone, depending on the needs of the case. The canine bracket is available with or without a hook. If it has a hook this needs to be removed if it is planned to invert the bracket.



In cases with buccally ectopic canines the -7° torque bracket is often inverted to give +7° and guide the root into cancellous bone. Inversion is also helpful where there is lateral incisor agenesis and it is planned to close space, bringing the canine into contact with the central incisor.

The System 5.0 treatment method has three torque options for the upper canines. This provides great versatility when managing the upper anteriors, but the -7° is the bracket of choice in most cases. (Not to scale).

The science of bracket bases

The canines are the longest teeth in the human dentition and good control is essential. After a computer analysis of enamel anatomy, all the bases have been re-designed for the Mini Sprint II range. This is of particular importance for canines, which have a curved labial surface. The new bases are a big advantage, because the snug fit helps to express the prescription accurately, and ensures better retention.

Upper canine tip, angulation, and in-out

The routine upper canines have -7° torque and +8° angulation. Canines should be and are the thinnest brackets in the upper arch. This minimal dimension is essential to avoid excess thickness of brackets on other teeth, which reduces tooth control.
The -7° upper canine bracket has been a cornerstone of our treatment method since 1997 and is the bracket of choice for most cases. After rapid maxillary expansion (RME) it is helpful to use -7° torque brackets to achieve good root correction without wire bending. („Fundamentals" book page 59).

The +7° torque option

The upper canine bracket can be inverted, which gives +7° torque and +8° angulation. In cases with buccally ectopic canines this is a useful option to guide the root into cancellous bone without wire bending. The +7° torque is also used in cases where there is agenesis of the upper lateral and the space is to be closed, bringing the canine into contact with the upper central.

The zero torque canine bracket

The zero torque option is often helpful after premolar extractions. These cases may have slightly narrow or small maxillas and the treatment often involves correction of canine root tip, or bodily retraction of canines. The canine roots need to be in cancellous bone for effective movement. The zero torque bracket, or sometimes the +7° option, are helpful to achieve this without wire bending.

Lower canines

Lower canine tip, angulation, and in-out

The routine lower canines have -6° torque and +3° angulation. As in the upper, the lower canines are the thinnest brackets in the lower arch, which is important to minimise wire bending. The -6° lower canine bracket is preferred for most cases.

The lower right canine bracket is shown here without a hook. These are available with hooks if required.

The +6° torque option

The normal lower canine bracket can be inverted, which gives +6° torque and +3° angulation.
In cases with buccally ectopic canines this is helpful in positioning the root into cancellous bone, reducing the risk of gingival recession or periodontal breakdown.

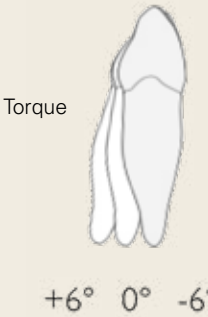
The lower left canine bracket has been inverted to give +6° torque. A zero torque lower canine bracket is also available.

The zero torque canine bracket

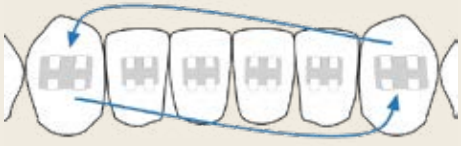
As in the upper arch, a zero torque option is often helpful in premolar extraction cases. This can assist with correction of canine root tip, or bodily retraction of canines, guiding the canine roots into cancellous bone for effective movement.

Left / right switch in some Class III cases

Most non-surgical Class III cases have dental compensation at the end of treatment.The lower incisors tend to be retroclined, the upper incisors proclined, and the lower canines are often tipped a little distally.
In some Class III treatments we can anticipate this, and switching left and right canine brackets helps the mechanics. This changes the tip from +3° to -3° and provides the required tip compensation without the need for wire bending. It reduces anchorage needs in the lower arch.



As with the uppers, there are three torque options for the lower canines. The options are used less in the lower arch, but are still important in a few cases. The -6° is the bracket of choice in most cases.
(Not to scale).

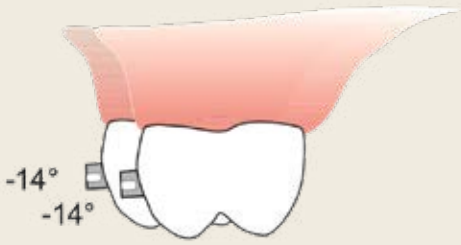


In some Class III treatments it is helpful to anticipate dental compensation, and to switch left and right canine brackets. This changes the tip from +3° to -3° and reduces anchorage needs in the lower arch.

Upper first and second premolar brackets are shown here without hooks, but are also available with hooks. They are interchangeable, first and second and left and right.

Lower left first and second premolar brackets are shown here without hooks, but are also available with hooks.

Full size upper left first and second molar tubes. A mini second molar tube became available in late 2018.



The authors' 1997 values for torque were based on Andrews' research findings, and continue to be recommended. They included extra torque control compared with the research values, because torque is not well expressed by the pre-adjusted appliance, and a .019 / .025 working wire does not completely fill the .0227 slot.

Upper premolars

The upper first and second premolars have -7° torque and zero angulation. They are interchangeable, first and second and left and right. They are shown here without hooks, but they are available with hooks.

Lower first and second premolars

The lower first premolar has -12° of torque and the lower second has -17° of torque. They have 2° of tip. Unlike upper premolars they are not interchangeable, first and second or left and right. They are shown here without hooks, but they are available with hooks.

Upper first and second molar tubes

The specification for upper first and second molar tubes is -14° torque and 10° of offset, with zero angulation, which is the same as the 1997 prescription. Andrews' findings gave a figure of -9° torque but experience showed that during treatment the extra torque figure of -14° helps to prevent the palatal cusps of the upper molars from hanging down, which can cause functional interferences. The full sized second molar tube is shown, but a mini version became available in late 2018. Full size tubes are useful when molars require a lot of tooth movement, but in most cases the authors find that a mini tube works well.

Funnel shaped tube entrances

The upper and lower molar tubes all have a funnel shaped entrance, which is helpful for wire placement, especially in the second molar region.

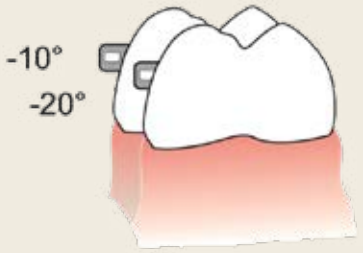
Lower first and second molar tubes

The lower first molar has -20° of torque and the lower second molar has -10° of torque. They have zero offset and zero angulation. As with the uppers, they have a funnel-shaped entrance, for easy wire placement.

Lower left first and second molar tubes. In many treatments the mini second molar tube is preferred.

Mini lower second molar tubes

Full size lower second molar tubes are used to correct difficult rotated or tipped teeth, but in many treatments the mini second molar tube is preferred. Despite its small size it provides good tooth control in routine cases. It is more comfortable for the patient than the full size tube, with fewer interferences and it became available in late 2018.



There is extra torque control compared with the research values, and this helps to prevent lower molars from rolling lingually and causing interferences.

Treating to a Class II molar relationship

When treating to a Class II molar relationship, the lower first molar tubes are often used in the upper arch on the contralateral side (see the „Fundamentals" book page 61). Thus the lower right tube can be used on the upper left molars, and the lower left tube can be used on the upper right molars. Some orthodontists use normal upper molar tubes to achieve most of the tooth movements, and then to switch to lower first molar tubes for finishing. Others use lower first or second molar tubes in the upper from the outset when treating to a Class II relationship.

When treating to a Class II molar relationship, the lower first molar tubes are often used in the upper arch on the contralateral side.

Authors' notes

Unrivalled tooth control

Since the days of Edward H. Angle, the edgewise bracket has been good at controlling angulation ('tip') and in-out. However, it is accepted that torque control is the difficulty with the edgewise bracket, and when we transitioned into the pre-adjusted era in the 1970s this continued to be true.

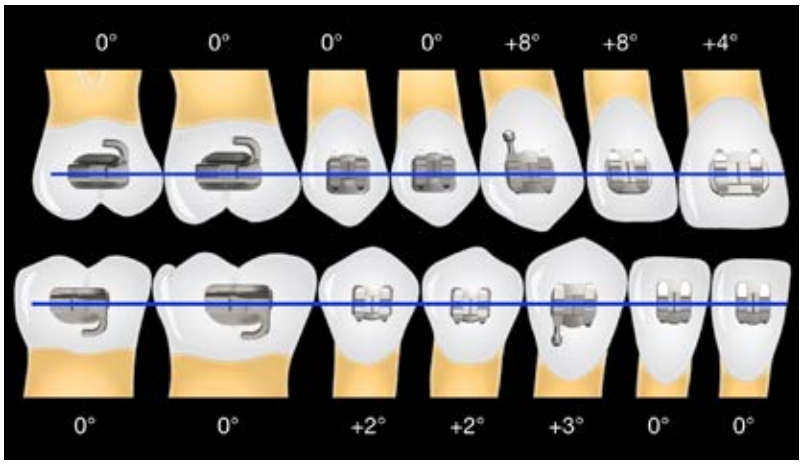
As the specialty moved away from standard edgewise, it entered an era when everything was built into the brackets. It soon became clear that bracket accuracy and positioning was all-important if wire bending was to be avoided.

Torque control by wire bending has to be avoided where possible in orthodontics because it is time-consuming and tends to be inaccurate.

Torque control (without wire bending) is easier and better with System 5.0 because (i) the brackets are more accurate, and (ii) there is a range of anterior options within the normal prescription (see below). With System 5.0 wire bending should be a thing of the past in most treatments, if bracket positioning is good and the correct mechanics are used.

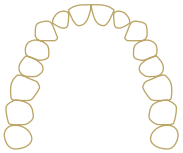
Torque

Tip



As discussed on page 4, our award-winning 1997 book 'Orthodontic Management of the Dentition' recommended a modified prescription, ideally suited to our mechanics. The prescription has stood the test of time and it remains unchanged. It has become the accepted ideal for the human dentition and it is the most widely used prescription in the world today. (This diagram is for illustration purposes and is not drawn to scale).

Mini Sprint® II Brackets McLaughlin Bennett 5.0



Optimized arch form through clinically proven bracket values. Adjusted In/Out values for better clinical results.

Better comfort through lowered hooks with flatter design and increased space between tie wings and pad.

Anatomically curved hook base for optimal bonding results.

Maxillary						Slot .018"		Slot .022"	
Tooth		Torque	Angulation	In/Out	Rotation	Order No. Right	Left	Right	Left
1	Centrals	+17°	+4°	1,05	–	780T0103	779T0103	780T0101	779T0101
2	Laterals	+10°	+8°	1,25	–	780T0203	779T0203	780T0201	779T0201
3	Cuspids	-7°	+8°	0,6	–	780T0313	779T0313	780T0311	779T0311
	Cuspids + hook	-7°	+8°	0,6	–	780T0303	779T0303	780T0301	779T0301
3	Cuspids	0°	+8°	0,6	–	780T0333	779T0333	780T0331	779T0331
	Cuspids + hook	0°	+8°	0,6	–	780T0323	779T0323	780T0321	779T0321
4	Bicuspids	-7°	0°	0,8	–	780T0413	779T0413	780T0411	779T0411
	Bicuspids + hook	-7°	0°	0,8	–	780T0403	779T0403	780T0401	779T0401
5	Bicuspids	-7°	0°	0,8	–	780T0413	779T0413	780T0411	779T0411
	Bicuspids + hook	-7°	0°	0,8	–	780T0403	779T0403	780T0401	779T0401

Mandibular						Slot .018"		Slot .022"	
Tooth		Torque	Angulation	In/Out	Rotation	Order No. Right	Left	Right	Left
1	Centrals	-1°	0°	1,3	–	780T1223	780T1223	780T1221	780T1221
	Centrals	-6°	0°	1,3	–	780T1203	780T1203	780T1201	780T1201
2	Laterals	-1°	0°	1,3	–	780T1223	780T1223	780T1221	780T1221
	Laterals	-6°	0°	1,3	–	780T1203	780T1203	780T1201	780T1201
3	Cuspids	-6°	+3°	0,6	–	780T1413	779T1413	780T1411	779T1411
	Cuspids + hook	-6°	+3°	0,6	–	780T1403	779T1403	780T1401	779T1401
3	Cuspids	0°	+3°	0,6	–	780T1433	779T1433	780T1431	779T1431
	Cuspids + hook	0°	+3°	0,6	–	780T1423	779T1423	780T1421	779T1421
4	Bicuspids	-12°	+2°	0,65	–	780T1513	779T1513	780T1511	779T1511
	Bicuspids + hook	-12°	+2°	0,65	–	780T1503	779T1503	780T1501	779T1501
5	Bicuspids	-17°	+2°	0,65	–	780T1613	779T1613	780T1611	779T1611
	Bicuspids + hook	-17°	+2°	0,65	–	780T1603	779T1603	780T1601	779T1601

Cases

Max. Cuspids: -7° Torque; Mand. Centrals: -1° Torque, Cuspids: 0° Torque

Variation	Slot .018"			Slot .022"		
Cases	1	5	10	1	5	10
	706T1000	706T1001	706T1002	706T1009	706T1010	706T1011
3	706T1003	706T1004	706T1005	706T1012	706T1013	706T1014
3-5	706T1006	706T1007	706T1008	706T1015	706T1016	706T1017

Max. Cuspids: -7° Torque; Mand. Centrals and Cuspids: -6° Torque

Slot .018"			Slot .022"		
1	5	10	1	5	10
706T1031	706T1032	706T1033	706T1046	706T1047	706T1048
706T1036	706T1037	706T1038	706T1051	706T1052	706T1053
706T1041	706T1042	706T1043	706T1056	706T1057	706T1058

Mini buccal tubes McLaughlin Bennett 5.0

Maxillary	Tooth	Torque	Angulation	Distal Offset	.018"	.022"
	7	-14°	–	4°	728-0814	728-0812
	7	-14°	–	4°	727-0814	727-0812

Mandibular	Tooth	Torque	Angulation	Distal Offset	.018"	.022"
	7	-10°	–	0°	728-1814	728-1812
	7	-10°	–	0°	727-1814	727-1812

Tulip buccal tubes McLaughlin Bennett 5.0

Maxillary	Tooth	Torque	Angulation	Distal Offset	Slot	on large pad right	on large pad left
	76 | 67	-14°	–	10°	.018" x .028"	743T0744	742T0744
					.022" x .028"	743T0742	742T0742
Mandibular							
	6 | 6	-20°	–	0°	.018" x .028"	743T1714	742T1714
					.022" x .028"	743T1712	742T1712
	7 | 7	-10°	–	0°	.018" x .028"	742T0724	743T0724
					.022" x .028"	742T0722	743T0722

Archwires McLaughlin Bennett 5.0

	Tapered-form		**Ovoid-form**		**Square-form**			
description	Order No. Maxillary	Order No. Mandibular	Order No. Maxillary	Order No. Mandibular	Order No. Maxillary	Order No. Mandibular	profile	ø inch
McLaughlin Bennett 5.0 Nickel Titanium - Heat Activated	208H0835	208H0935	208H1835	208H1935	208H2835	208H2935	●	.014"
	208H0840	208H0940	208H1840	208H1940	208H2840	208H2940	●	.016"
	208H2040	208H2140	208H3040	208H3140	208H4040	208H4140		016" x .022"
	208H2044	208H2144	208H3044	208H3144	208H4044	208H4144	■	.017" x .025"
	208H2048	208H2148	208H3048	208H3148	208H4048	208H4148	■	.019" x .025"
McLaughlin Bennett 5.0 Stainless Steel	202-0835	202-0935	202-1835	202-1935	202-2835	202-2935	●	.014"
	202-0840	202-0940	202-1840	202-1940	202-2840	202-2940	●	.016"
McLaughlin Bennett 5.0 Stainless Steel Heat Treated	202H0845	202H0945	202H1845	202H1945	202H2845	202H2945	●	.018"
	202H0850	202H0950	202H1850	202H1950	202H2850	202H2950	●	.020"
	202H2048	202H2148	202H3048	202H3148	202H4048	202H4148	■	.019" x .025"

Archwires Ball Posted McLaughlin Bennett 5.0

	Tapered-form		**Ovoid-form**		**Square-form**				
description	Order No. Maxillary	Order No. Mandibular	Order No. Maxillary	Order No. Mandibular	Order No. Maxillary	Order No. Mandibular	mm	profile	ø inch
McLaughlin Bennett 5.0 Stainless Steel Ball Posted	-	209T2448	-	209O2448	-	209S2448	24	■	.019" x .025"
	-	209T2648	-	209O2648	-	209S2648	26	■	.019" x .025"
	-	209T2848	-	209O2848	-	209S2848	28	■	.019" x .025"
	209T3048	-	209O3048	-	209S3048	-	30	■	.019" x .025"
	209T3248	-	209O3248	-	209S3248	-	32	■	.019" x .025"
	209T3448	-	209O3448	-	209S3448	-	34	■	.019" x .025"
	209T3648	-	209O3648	-	209S3648	-	36	■	.019" x .025"
	209T3848	-	209O3848	-	209S3848	-	38	■	.019" x .025"
	209T4048	-	209O4048	-	209S4048	-	40	■	.019" x .025"
McLaughlin Bennett 5.0 Stainless Steel Ball Posted	-	209T2444	-	209O2444	-	209S2444	24	■	.017" x .025"
	-	209T2644	-	209O2644	-	209S2644	26	■	.017" x .025"
	-	209T2844	-	209O2844	-	209S2844	28	■	.017" x .025"
	209T3044	-	209O3044	-	209S3044	-	30	■	.017" x .025"
	209T3244	-	209O3244	-	209S3244	-	32	■	.017" x .025"
	209T3444	-	209O3444	-	209S3444	-	34	■	.017" x .025"
	209T3644	-	209O3644	-	209S3644	-	36	■	.017" x .025"
	209T3844	-	209O3844	-	209S3844	-	38	■	.017" x .025"
	209T4044	-	209O4044	-	209S4044	-	40	■	.017" x .025"

All archwires are supplied as package of 10 pieces.

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