



good PRACTICE

Perspectives and Insights for the Orthodontic Profession

VOLUME 1 NO. 1

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AMERICAN ORTHODONTICS

Alternatives after Molar Distalization

S. Jay Bowman, DMD, MSD

Rationale for Molar Distalization

A popular strategy for treating some Class II malocclusions involves the distalization of maxillary first molars. Molar distalization is typically complete prior to mid treatment, producing an easily resolvable Class I spacing problem. Consequently, Class II molar correction is achieved at an earlier stage of treatment in contrast to most traditional Class II treatment mechanics. In addition, many methods of distalization utilize continuous forces and are, therefore, not compliance-dependent.

Contraindications to distalization would be those cases exhibiting one or more of the following: severe overjet, significant crowding, bimaxillary protrusion, openbite, or a high mandibular plane angle. Several techniques for molar distalization have been described in the literature; however, it is the purpose of this communication to discuss alternative mechanics to complete treatment once the molars have been distalized.

Maxillary Anchorage Considerations

It has been recommended that the molars should be overcorrected by 30% (or about

2 mm) during distalization to compensate for some distal tipping of the molars or expected anchorage loss during retraction of the remaining maxillary teeth. After distalization, the molars must be held in their new position, as there is a significant tendency for mesial relapse. The molars may be maintained with a Nance holding arch (an acrylic palatal button that is fabricated from the lingual of the maxillary molars), a cervical headgear, or a transpalatal arch. One appliance, the Distal Jet™, not only serves to distalize molars, it may also be converted directly to a Nance holding arch (**Fig. 1 and 2**) without removal of the device from the patient's mouth.

Buccal Segment Retraction

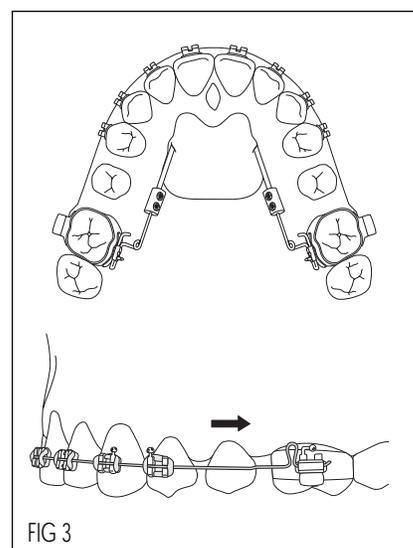
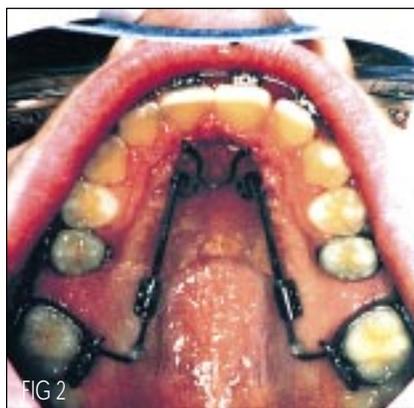
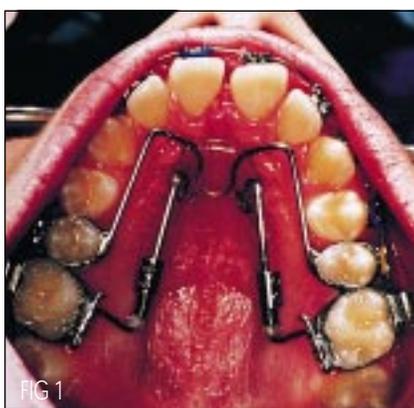
It has been recommended that the maxillary canines and premolars be permitted to passively drift for 4-5 months after distalization (**Fig. 3**) due to the traction of the transseptal fibers. Regardless of the timing of mechanical retraction of the remaining maxillary teeth, the Nance holding arch alone is not expected to provide sufficient anchorage support for the distalized molars. Additional anchorage (ie., stopped arch wires, headgear, and/or intermaxillary elastics) is recommended, however, unpredictable compliance may



Dr. Bowman has a private orthodontic practice in Portage, Michigan.

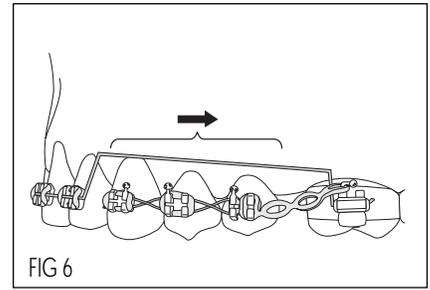
be problematic with these devices. Consequently, a fixed intermaxillary force may be more reliable. Fixed functional appliances (e.g. Herbst or Jasper Jumper) provide continuous support for the molars during retraction and these appliances are not completely dependent upon patient cooperation (**Fig. 4 and 5**).

The maxillary buccal segments (ie. canines, first and second premolars) are actively retracted to the distalized molars using segmental or continuous-arch wire mechanics. If segmental mechanics are selected, a utility arch wire is fabricated to avoid the brackets on the teeth in the buccal segments. The three teeth of each



Figures 1 and 2: After maxillary molar distalization, the Distal Jet appliance is converted to a Nance holding arch; the Nance holding arch alone is insufficient support for retraction of the remaining maxillary teeth.

Figures 3: After molar distalization, premolars may be permitted to drift distally due to the influence of transseptal fibers.



buccal segment are consolidated together by lacing a steel ligature around the brackets. They are then "floated back," without the frictional constraints of an arch wire, by connecting an elastic thread or chain from the second premolars to the molars (Fig. 6). Any rotations or tipping of these teeth that may result during retraction are subsequently resolved using a light continuous arch wire.

If sliding mechanics are selected, several options are available. One technique is to acid-reduce a full-size rectangular arch wire distal to the lateral incisors. The larger anterior portion of the wire provides torque control while the reduced size of the posterior dimension decreases sliding friction. A second option employs .018 slot maxillary anterior brackets and .022 slot posterior brackets. "Filling the anterior slot" with a continuous rectangular arch wire (.018 x .025) maintains anterior torque control while the larger posterior bracket dimensions produce less sliding friction during retraction. A third option is to place 90° bends mesial to the lateral incisors in a .018 x .022 arch wire. The .022 dimension of this rectan-

Figures 5 and 6: Segmental retraction mechanics: The three teeth of each buccal segment are tied together with ligature wire and "floated back" with elastic thread or chain. Anchorage support is derived from a utility arch wire, Nance holding arch, and the optional use of a J-hook or cervical headgear, Class II elastics, and/or Jasper Jumpers.

gular wire is used to control anterior torque in a .022 slot appliance while the distal .018 portion slides through the larger dimension posterior brackets during sliding space-closure. For each of the previous options, the maxillary central and lateral incisors are consolidated together with a ligature wire. The buccal

segments are then tied together and retracted along the arch wire with traction from coil springs, elastic thread, or chain elastic (Fig. 7).

Anterior Retraction

Once the buccal segments have been retracted, the incisors are retracted as a unit. Closed-loop retraction (Fig. 8) or continuous arch sliding mechanics may be employed (ie. elastic chain applied from molar to molar Fig. 9). An advantage of sliding mechanics is that a single arch wire may be used for both buccal segment and anterior retraction.

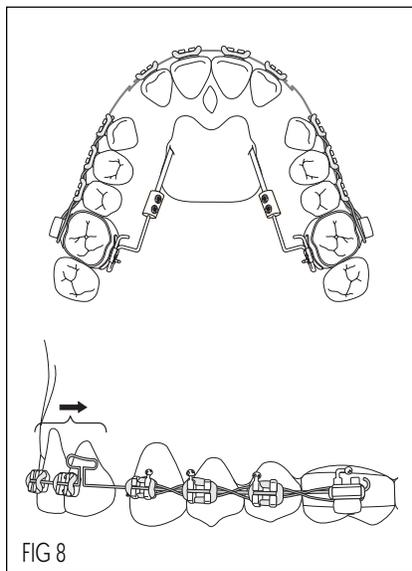
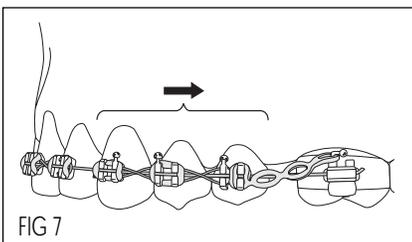


Figure 8: Continuous-arch mechanics: Maxillary incisors are laced together with stainless steel ligature wire. Buccal segments are also consolidated with ligature wire and then retracted along a continuous arch wire. Distalized molars are supported by a Nance holding arch, Jasper Jumpers, and possibly Class II elastics and/or headgear.

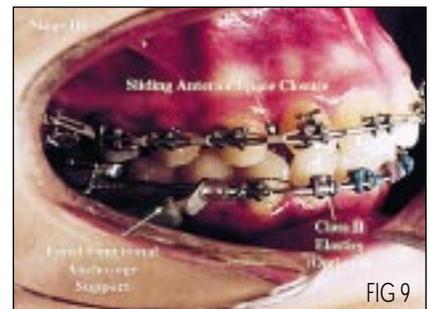


Figure 9: A summation of various finishing options

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TIPS & TORQUES

Rock and Roll bands

I was having a problem at my office with Herbst appliances coming loose. The heavy forces exerted by these appliances were causing the molar bands to loosen. I wasn't getting enough retention in the band cement to consistently secure the metal surface of the bands to the molars. I wanted another option, but I preferred not to use crowns.

We started using Maximum Retention (MR) bands and now we rarely have any loose Herbst bands. The photo-etched pockets in the MR bands have helped us get the retention we need on molars when multi-directional forces apply stress to the adhesion at the metal and enamel surfaces.

Patients are much happier now and our morale at the office is up. Switching bands has also helped reduce our overhead costs now that we have fewer emergencies.

*Byron W. Scott, DDS
Grand Rapids, MI*

Radiographic fogging gremlin[®]

Many years ago, an article extolled the virtue of directing the darkroom safety light towards the ceiling to minimize the direct concentration of light and give better overall working visibility. This proved to be so.

Almost ten years later, a problem arose with fogging of radiographic films. The building had moved due to a hot dry summer and much effort was spent trying to find the suspected light crack... to no avail. The door hinges were tightened, towels were packed around the darkroom corners, etc., and frustratingly, the fogging persisted. Eventually, the safety light itself was inspected – with difficulty – since it was facing, and very near, the ceiling. Thereupon it was noted that the red plastic safety filter had minute cracks that were letting white light through. Obviously, the heat from the bulb had caused the cracks in the plastic cover over the years. This was not previously obvious from below because the red light overpowered it when bounced off the ceiling. When the safety plastic cover was replaced with a new intact one, the fogging disappeared.

*Dr Barry Mollenhauer
Victoria, Australia*

"Cementing" our relationship

We have found a new product that has made our band insertions much easier. The MR Lock band cement is cleaner to use and less sticky than what we were using before. Clean-up is a breeze with a scaler and cotton roll.

We also like the delivery system for MR Lock LC because it will not continue to express after use. The carpule gun is real handy and we aren't wasting cement like before. Changing to a light cured, no mix band cement has really saved us a lot of time. The bands seem more secure too.

*Pam Otto & Marty Van Dalsen
Chairside assistants for Larry Majznerski, DDS, MSD
Grand Rapids, MI*

Gag me with a . . . tray?

The gag reflex that occurs with hypersensitive patients can become, well, a messy problem. I have found some simple techniques that reduce patient discomfort, yet allow for good impressions to be taken almost every time.

I always do the lower arch first if I am taking impressions for both arches. The lower arch does not initiate as much gag reflex, so patients are more relaxed than they would be if they had just had a bad experience with the upper impression tray. Then patients are more likely to keep their tongues properly positioned during the lower impression.

When inserting the impression tray, I ask the patient to sit upright and breathe through his or her nose. I seat the back of the tray first and then press down on the anterior teeth allowing all excess material and saliva to flow into a rubber bowl below the patient's mouth.

The key to minimizing the gag reflex is to divert attention on to something else. If I know it's a hypersensitive patient, I tell them to lift their leg. The muscle strain focuses their attention away from the discomfort at their mouth and tongue. Another cue that helps them divert their attention is counting while they squeeze a racquetball.

Having good mixing materials, preparing the impression trays with posterior dams, and loading and inserting the tray properly all contribute to a better experience for your patient when models are taken. The only thing worse than having a bad experience with a gagging patient is having to repeat it all over again five minutes later.

*Darrell G. Smith, DDS
Roy, UT*

Good Practice welcomes your tips and ideas. Please address correspondence to: Jeffrey D. Smith, American Orthodontics, P.O. Box 1048, Sheboygan, WI 53082-1048. Fax to: 920-457-1485, or e-mail to jsmith@americanortho.com. Submissions, which are subject to editing, must include the author's name, address and phone number for verification.

It's About TIME

John Valant, DDS, MSD

Q: Dr. Valant, how would you describe the changes in orthodontics over the last 25 years?

A: Orthodontists have witnessed dramatic improvements in office efficiency over the last 25 years. Many of these improvements have involved the business aspects of our practices. Long gone are the paper appointment books, pegboards and 3 x 5 finance cards. Through computerization we now enjoy paperless offices that are more efficient and accurate than before. In my office imaging software has improved our ability to communicate better with our patients. Soon, digital radiography will save us time and eliminate x-ray developers altogether, and in the long run, will be much more cost effective. Yet, with all this new computerized technology, it seems that little progress has been made toward dramatically increasing the efficiency of orthodontic treatment.

Q: What about straight wire appliances and nickel titanium wire?

A: Straight wire appliances and nickel titanium wires have helped our clinical efficiency, but we still place elastomeric O's that stain, deform, and collect plaque. Wire ligations are time consuming to place and often cause unnecessary discomfort and emergencies when they are displaced.

Q: Do you believe that self-ligating brackets are a good alternative to straight wire appliances?

A: Self-ligating brackets were developed about 20 years ago to address the issues that I just mentioned. The evolution of the design of these brackets since 1980 has been dramatic. TIME brackets were developed by Dr. Wolfgang Heiser and Klaus Farber in 1993. These two innovators addressed many of the issues that plagued earlier designs. Its small mesial-

distal width enables it to be placed in the most severely crowded lower anterior cases. This is the result of its one piece design. The door, or engaging clip mechanism, is also one piece making it very simple to open and close. A simple instrument (**Fig. 1**) engages the middle of the clip mechanism and rotates the clip open and closed.

Q: How would you describe the TIME bracket?

A: The overall bracket is simply a conventional twin straight wire bracket with a self-engaging clip. This conventional design enables clinicians to utilize their current treatment techniques and philosophies. Bracket bases are tooth specific ensuring good adaptation and consistent treatment results. Hooks are not required as the gingival undercut is more than sufficient to allow for co-ligation, placement of elastomeric chain, or placement of elastics in any force direction. The elimination of cast hooks or tied-on Kobayashi hooks facilitates better oral hygiene and reduces the chances of decalcification.

Q: Do you view the TIME bracket as an active or passive appliance?

A: Companies manufacturing self-ligating brackets will promote "active" versus "passive" as one being superior to the other. The TIME bracket has been designed to be both passive and active. It is passive when small round flexible initial wires are placed to correct rotations and leveling (**Fig. 2**). But, when a larger rect-



Dr. Valant has a private orthodontic practice in Cedar Hill, Texas and is Assistant Professor of Orthodontics at Baylor University.



angular wire is placed in the slot, the unique design of the clip creates an active 200-400 gram force that fully seats the wire in the slot and, therefore, expresses the desired torque (**Fig. 3**).

Q: What is your archwire sequence when using TIME brackets?

A: The wire sequence that I utilize in my practice is, using a .018 slot:
Initial : .012 or .014 nickel titanium
8 - 10 weeks: Upper .018 x .025, Lower .016 x .025 heat activated nickel titanium
8 - 10 weeks: Upper .0175 x .025 stainless steel
8 - 10 weeks: Lower .016 x .025 stainless steel
I use elastics as necessary. This appliance can also be used with headgear, distalizing



I have seen treatment times reduced by 4 to 6 months, but it is the consistency of the treatment outcomes that has made me appreciate how technology can dramatically effect the way I practice orthodontics.

appliances, power chain, or any other treatment modality.

Q: *What other reasons are there for using self-ligating brackets such as TIME?*

A: Some Canadian provinces have mandated that only licensed dentists and registered hygienists perform procedures on their patients—chair-side assistants cannot place ligatures or elastomeric ties! This regulation has forced our Canadian colleagues to become more efficient with their chair-side operations. The use of self-ligating systems in Canada are more prevalent than in the U.S., but I think it's time for us to learn what they were forced to learn—that we can more efficiently utilize our chair-side assistants using self-ligating and self-engaging brackets.

Q: *Do self-ligating brackets really save you that much time?*

A: A time management study in 1990 by Majjer and Smith found that 7.3 minutes were saved per patient appointment when a self-ligating bracket was used versus a conventional twin bracket. I estimate that if my practice schedules 20 archwire changes a day and I work an average of 16 days per month, then I would save about 39 hours of chair-time per month. This is about 5 days of chair-time per month that I can use for other things! I can internally market my practice to existing patients, or I can work to add additional patients to my practice, or I can just take more time off to enjoy my family and the fruits of my labor.

Q: *I have heard that it is difficult for patients to accept longer treatment intervals. How do you address this issue in your practice?*

A: Our patients have readily accepted longer treatment intervals once they understand why they are being seen less often. We live in a society where oftentimes both parents work outside the home and children are involved in many activities in and outside their schools. Parents don't want to miss work and they don't want their kids to miss school. Once we educate them that this approach to their treatment involves today's latest technology in orthodontics, they have no problems accepting 8 to 10 week intervals between office visits. In fact, we have found that explaining the benefits of self-ligating brackets has become an important marketing tool for us.

Q: *What about monthly payments? Do you have problems collecting fees from your patients on the months that they are not visiting your office?*

A: Those who justify monthly appoint-

ments to collect patients' monthly checks are letting financial arrangements dictate their treatment schedules. We explain that the treatment fee is being financed over the treatment time, but has nothing to do with the frequency of their office visits. Our office offers a variety of financial arrangements to help with our monthly collections. One of which is an electronic auto-draft of their checking account. This inexpensive alternative, which costs about \$10.00 per patient over the entire treatment time, enables us to collect monthly fees yet maintain 8 to 10 week intervals between office visits.

Q: *Overall, how happy have you been with TIME brackets?*

A: Clinically, TIME brackets have been a win-win for our patients and our practice. I have seen treatment times reduced by 4 to 6 months, but it is the consistency of the treatment outcomes that has made me appreciate how technology can dramatically effect the way I practice orthodontics. My staff and I are very glad we made the switch to TIME brackets. 

Did you know that . . .

A typical bracket requires about 40 seconds bonding time with a standard halogen curing light. The PowerPAC™, a plasma arc curing light, achieves a secure bond in less than 10 seconds. Those extra 30 seconds per tooth add up to 10 minutes per patient once 20 teeth are bonded.

The average practice starts about 220 new patients per year and grosses around \$800,000. So, those additional ten minutes per patient add up to an extra 37 hours per year of wasted productivity.

The average practice is open 150 days per year, or 1,200 hours if the practice is open for eight hours per day. Amazingly, those extra 10 minutes per patient cost the average practice 3% (37 hours/1,200 hours) or \$24,667 worth of production. Over a period of five years, which is the duration of the warranty of the PowerPAC™, the average practice can actually save about \$123,000 in wasted production time. And you thought halogen light bulbs were expensive!

Isn't it amazing the difference just 30 seconds can make?

To analyze the potential productivity savings of PowerPAC™ at your practice, use the following formula:

1. To calculate hours per year of wasted productivity, multiply 10 minutes by the number of annual starts and then divide by 60.
2. To calculate wasted productivity as a percentage of total office time, divide the hours calculated in Line 1 by total office hours (hours open per day multiplied by days open per year).
3. Multiply the percentage in Line 2 by your annual production and you will discover the cost per year of using an additional 30 seconds to bond each tooth.

TRENDS & TECHNOLOGY



Where are you?

Being on the internet offers many advantages, but does your office really need a web site? Chances are your patients are already there. Your future patients are already there too. So, where are you?

The question of whether to be, or not be on the internet has emerged as one of the great questions facing orthodontists today. Many have jumped onto the internet with web sites designed for their patients; some are designed for prospective patients, yet others are still trying to figure out why they're online at all. Having a successful web site may not be as critical as getting patients to brush regularly or avoid sticky foods, but it is quickly emerging as a growing trend in the orthodontic profession.

So you decide to make the leap onto the internet. Now you are immediately faced with several burning questions. What do I want my patients, their parents and friends to see when they log onto my site? Is my web site for internal or external marketing, or both? How do I start? Where do I turn for help?

Certainly these questions need to be addressed by every clinician who desires to communicate better with his or her patients—and what about the multitude of prospective patients out there "surfing the net" looking for information about local orthodontists. The great challenge is that with today's technology just about anything and everything is possible, so where you begin often determines where you will end up. Looking at other web sites is helpful, but having a clear strategy is essential to creating the right web site for you.

Once you've decided to create a web site for your practice, you must select the right person for the job. You have several options available: hire a professional, hire a local talent (one of your patients, maybe), or do it yourself.

According to Dr. Doug Depew from Kennesaw, Georgia, who claims one of the longest running orthodontic web sites at www.depewsmiles.com, "If you are going to have it done professionally, ask for references and visit sites they have designed. As designers have more business than they can handle, some will take months to design a site that could be done in a matter of a couple of weeks, or even weekends, by a new start-up designer or a high school kid looking for a couple of extra bucks. Laying out a web site is not hard; it takes a little experience and a lot of creativity to do a decent job." Dr. Depew's other web site, www.orthoassisting.net, is a template design by one of these professional web site development companies, www.comercis.com.

Recently a variety of companies have emerged that specialize in developing and hosting web sites for professionals in the dental field. Two examples are www.dentalexchange.com and www.rdent.com. Although fees for developing a web site by a professional company will vary, a basic web site can be designed for less than \$500 with monthly hosting fees starting at \$20 per month.

After selecting the right individual to create your web site (and continually update it), the next task is to determine what to put on your web site and what to leave off. A good rule of thumb is to focus on your practice goals and especially the needs of your patients, both current and prospective. Anything you can do to help visitors get the information **they want** will translate into a successful web site. Remember, you are posting the information they want to read, not what you want to tell them.

Dr. John Kalbfleish of Village Centre Orthodontics in Ontario, Canada (www.VCOrthodontics.com) designed his own web site and recommends

several caveats for your web site layout and content. First, place all printed information that your office hands out on your web site such as oral hygiene instructions, introductory letters, etc. Second, get your patients interacting with your web site using contests, and displaying pictures, photos and presentations. For example, Village Centre Orthodontics ran a Valentine's Day contest where patients had to find the VCO logo that was displayed in seven places throughout the web site. This contest encouraged patients to visit all their web pages enabling them to become more familiar with the information that was available on the practice's web site.

Dr. Doug Depew also cites several Do's and Don'ts when designing a web site for your practice. First, make sure that your name, address and phone numbers are on the main page, and ensure that your name is on every page in case visitors forget whose site they are on. Second, do a fairly simple and straightforward main page, avoid wordiness, and let the main page guide your visitors to the information they want. Third, use caution when adding dated material to your web site, such as employee of the month, because it will require constant updating; and make sure to schedule updates periodically throughout the year. Fourth, don't get "graphic happy" because people are looking for information, not entertainment. Too many graphics make a page look busy and they lengthen download times. Fifth, create links with referring dentists and other specialists. Many items such as Frequently Asked Questions (FAQ's) can be linked instead of reproduced. Sites such as www.aaortho.org and www.bracesinfo.com are good examples of some helpful links.

Some other ideas for content that you should consider are:

1. Show photos of the different types of brackets and the assorted ligature colors available at your office.
2. Display the doctors' credentials, diplomas, special training, memberships and fellowships, and years of experience.
3. Introduce the members of your staff in a fun way using photos, personality descriptions, or lists of likes and dislikes.
4. Provide information about accepted insurance plans and show samples of financial payment plans that promote the affordability, not the price, of orthodontics at your practice.
5. Show maps and give directions to your office from local schools. Visit www.mapquest.com for easily copied maps for your web site.
6. Briefly detail the initial appointment for prospective patients, so they know what to expect upon their first visit.
7. Using photos, present the indications that warrant orthodontic treatment and show your results with before and after images.

The internet offers new opportunities for you to communicate better with your current patients, and allows you to give prospective patients the information they desire before picking up the telephone to schedule their first appointment. Yet, with all this new technology, nothing replaces the satisfaction your patients feel when they visit your office for the first time. If you cannot do this well, then even the best web site will offer you little in return. 


Editor



AAO 2000 Birthday Celebration

With so much to see and do –and eat!–in Chicago, we offer a short listing of some of our favorites:

Don't Miss...

- **Art Institute of Chicago:** 111 S. Michigan, Grant Park just east of the Loop. One of the World's finest art collections. \$8 artic.edu/aic/index.html
- **Chinatown:** Southwest of the Loop, five minutes west of the McCormick Center.
- **Sears Tower Skydeck:** Wacker & Jackson, just west of the Loop. 9:00 am to 11:00 pm. \$10. sears-tower.com
- **Hancock Observatory:** On top of John Hancock building, North Michigan Avenue & Chestnut. 9:00 am to midnight, Open air, other activities. \$8.50.

Worth a Visit...

- **DisneyQuest:** Rush & Ohio streets. Indoor, interactive theme park with virtual games, creative zones, arcade games. \$16 entrance fee, \$34 all day. disney.go.com/DisneyQuest/Chicago/home.html
- **ESPNzone:** Ohio & Wabash. Sports restaurant/bar. 220 TV monitors, 40 satellite dishes. Watch sports, listen to ESPN radio. espn.go.com/espninc/zone/chicago.html
- **Untouchable Tours:** 610 N. Clark Street. Two hour guided bus tour of Chicago mobster "hot spots & hit spots". Reservations required (773) 881-1195. \$22

- **Chicago Historical Society:** Clark Street & North Avenue (312)642-4600. Birth, growth and history of Chicago. \$5
- **Cubs Baseball:** Wrigley Field, 1060 West Addison. Tickets: (773) 404-CUBS, (404-2827) \$10-25 chicagocubs.com
Home games:
4-28 2:20 pm Arizona Cardinals
4-29 1:20 pm Arizona Cardinals
4-30 1:20 pm Arizona Cardinals
5-2 7:05 pm Houston Astros

Nightlife

Comedy

The Second City

1616 N. Wells Street (312) 337-3992, secondcity.com

Blues

Blue Chicago

736 N. Clark Street (312) 642-6261

Buddy Guy's Legends

754 S. Wabash (312) 661-1003

House of Blues

329 N. Dearborn Street (312) 923-2000, hob.com

Jazz

The Backroom

1007 N. Rush Street (312) 751-2433

The Jazz Showcase

59 W. Grand Avenue (312) 670-2473

Pops for Champagne

2934 N. Sheffield Avenue (773) 472-1000

Restaurants Near Downtown

American

Harry Caray's Sports Restaurant

Award winning sports themed bar/restaurant.

33 W. Kinzie (312) 828-0966

Green Dolphin Street Jazz theme

2200 N. Ashland Avenue (773) 395-0066

Italian

Spiaggia/Café Spiaggia Formal/Lighter menu

980 N. Michigan Avenue (312) 280-2755

Scooz!

410 W. Huron Street (312) 943-5900

Japanese

Hatsuhana

160 E. Ontario (312) 280-8808

Pizza

Pizzeria Uno

29 E. Ohio (312) 321-1000

Pizzeria Due

619 N. Wabash (312) 943-2400

Steak Houses

Gibsons Bar and Steakhouse

1028 N. Rush Street (312) 266-8999

Saloon

200 E. Chestnut (312) 280-5454

Ruth's Chris Steakhouse

431 N. Dearborn (312) 321-2725