DIGITAL VS. ANALOG WORKFLOW ON TEN CERAMIC VENEERS IN THE MAXILLA: A case report

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Background and aim

Different materials and treatment options are available in esthetic and restorative dentistry for the anterior region. The conventional protocol, including an analog impression with polyether or polyvinylsloxane, a master cast and die fabrication, waxing and pressing of ceramic materials, requires exceptional skills and is technique-sensitive. Intraoral scanning and digital impression taking provide an accurate alternative method for transferring information from the mouth to the dental laboratory. The digital file is always on the computer and can be immediately processed or at any time, unlike with the conventional procedure.

Regarding materials, various newer products, such as pressed or milled ceramics, offer enhanced strength and functionality; however, in thinner dimensions, they lack the inherent esthetic beauty of conventional materials such as feldspathic porcelain. As patient demand for better esthetics has increased in recent years so too has the need for restorative materials that closely mimic the patient’s natural dentition. Initially used for the creation of porcelain dentures, feldspathic porcelain has emerged as the premier esthetic material for custom veneer restorations. In recent years, the use of hand-layered powder/liquid feldspathic porcelain has been revived based on its highly esthetic values and little to no preparation requirements. By keeping preparation to a minimum, less tooth structure is removed and procedures are much less invasive, which is exactly what patients desire. In contrast, the conventional methods of ceramic fabrication have been described as time-consuming, technique-sensitive and unpredictable owing to the many variables, and thus CAD/CAM may be a good alternative for both dentists and laboratories. CAD/CAM may also reduce the fabrication time of high-strength ceramics by up to 90%. Furthermore, industrially fabricated blocks are more homogenous, with minimal flaws, and CAD/CAM restorations have been found to compare favorably with other restorative options.

As far as optical properties and CAD/CAM are concerned, the fact of complex optical illusion phenomena in anterior esthetics cannot always be met with monochromatic esthetic materials without the need for final characterization by a dental technician. In order to overcome such esthetic disadvantages of a monochromatic restoration, multichromatic ceramic blocks have been developed to create a 3-D layered structure. These ceramic blocks offer a gradient of chroma from the cervical to the incisal areas that replicate dentin and enamel in the same block.

The aim of this case report is to compare the analog versus the digital workflow on ten ceramic veneers in the maxilla, in terms of esthetic outcome, length of procedures and technical sensitivity for both the dentist and the dental technician.

Methods and materials

A 35-year-old patient presented at the office with the chief desire that the esthetics in the anterior region be changed (Fig. 1). A diagnostic wax-up was performed, followed by mock-up fabrication, in order to obtain a preliminary visualization of the final outcome. Orthodontic treatment was proposed in order to align the teeth in a more favorable position for veneers requiring minimal preparation and to reduce the overbite. One year after treatment, the patient returned for the final prosthetic rehabilitation (Figs. 2a & b). Digital smile design according to Coachman and Calamita
Fig. 1
Initial photograph of the anterior teeth prior to orthodontic treatment.

Fig. 2a
Anterior teeth after orthodontic treatment.

Fig. 2b
Extraoral photographs after orthodontic treatment.

Fig. 3
Digital smile design indicating crown lengthening of teeth #13, 12, 11 and 21 and restorative treatment of the ten anterior teeth.

Fig. 4
Wax-up on the stone model concerning the restorative treatment of the ten anterior teeth.

Fig. 5
Three-dimensionally printed model of the digital smile design planning, bearing a mock-up shell. A cervical opening was introduced for surgical access and guidance for crown lengthening.

Figs. 6a & b
Intraoral fit of the surgical guide for crown lengthening.

Fig. 7
Periodontal tissue of the anterior teeth six months after crown lengthening.

Fig. 8a
Mock-up silicone index.

Fig. 8b
Intraoral photograph of the mock-up.

Fig. 9a
Preparation through the mock-up.

Fig. 9b
Check of the preparation depth, with the use of the silicone guide, palatal aspect.

Fig. 9c
Final preparation of the teeth.
Fig. 10 Analog impression with polyvinylsiloxane.

Fig. 11 Digital impression with TRIOS.

Fig. 12a Digital planning of the provisional restorations.

Fig. 12b Provisional restorations intraorally (Telio CAD).

Fig. 13 Analog workflow (refractory dies, built-up veneers, adjustments, staining/glazing).

Fig. 14 Digital workflow (3-D printed model, CAD/CAM veneers, adjustments, staining/glazing).

Fig. 15a Feldspathic veneers with try-in paste.

Fig. 15b CAD/CAM veneers with try-in paste.

Fig. 15c First quadrant feldspathic veneers and second quadrant CAD/CAM veneers simultaneously with try-in paste.

Fig. 16a Isolation field and try-in of the fit of the veneers on teeth #11 and 21.

Fig. 16b Etching of the enamel for 30 seconds with a 32% orthophosphoric acid.

Fig. 16c Application of the bonding agent.

Fig. 16d Final polymerization of the veneers.

Fig. 16e Veneers in situ before finishing and polishing procedures.

Fig. 16f Final outcome immediately after removal of the rubber dam.
was performed, from which a treatment plan of crown lengthening and veneers on teeth #15–25 (Fig. 3) was proposed. A conventional diagnostic wax-up was also produced (Fig. 4). Both digital and conventional mock-ups were applied, and agreement was attained concerning tooth shapes and proportions. Crown lengthening was performed, guided by the digital mock-up, with the use of an acrylic transparent double crown lengthening guide that indicated the borders of the gingivectomy and alveolectomy needed in periodontal surgery for esthetic rehabilitation (Figs. 5, 6a & b).

After six months of tissue stabilization (Fig. 7), a mock-up was produced with Telio CS C&B (Ivoclar Vivadent) chairside (Figs. 8a & b), and tooth preparations with silicone guides were performed (Figs. 9a–c). Both conventional impressions with polyvinylsiloxane (Fig. 10) and digital impressions (TRIOS, 3Shape) were taken (Fig. 11).

Provisionalization was executed digitally, using Telio CAD (Ivoclar Vivadent) in the Wieland Select CNC milling machine. The design was performed with the 3Shape DentalDesigner 2015 software (Figs. 12a & b). Two sets of final restorations were fabricated. The set of feldspathic veneers was fabricated on a stone model using IPS Style (Ivoclar Vivadent), while IPS Empress CAD Multi (Ivoclar Vivadent) was used for the digital set (Figs. 13 & 14). Both sets were examined intraorally with a try-in paste to compare the optical properties of the feldspathic and the CAD/CAM veneers (Figs. 15a–c).

The subjective decision of the clinician and the patient was to cement the feldspathic veneers, owing to slight differences in the length of the central incisors between the two sets. Adhesive procedures followed (Figs. 16a–f), and final intraoral and extraoral photographs were captured one week later (Figs. 17a–e).

Results

Intraoral digital scanning is a perfect alternative clinical procedure compared with the conventional impression technique. The digital planning and mock-up procedure is a powerful communication tool for the dentist, although special skills in using computer software are required. Regarding the laboratory workflow, most of the analog procedures require more time (refractory dies, built-up veneers, adjustments), except the staining/glazing (Figs. 18a & b).

Although the esthetic outcome of the feldspathic veneers was subjectively chosen in this case, the analog workflow is much more demanding. The digital approach, because of the reduced difficulty, speed, complexity and patient discomfort, tends to be preferable (Figs. 18a & b).

Conclusion

Knowledge and application of virtual smile design procedures, coupled with innovative dental laboratory technologies, allow dentists to diagnose, plan, create and deliver esthetically pleasing new dental compositions. Furthermore, advances in CAD/CAM technology have catalyzed the development of esthetic veneer restorations with industrially produced materials possessing superior biomechanical properties and good esthetics.

Editorial note: A list of references is available from the publisher.