A smile that is perceived as unattractive mars confidence, sociability and self-regard. For some patients, the lack of visual appeal stems in large part from a gummy smile, which a layperson begins to consider disharmonious when there is 3 to 4 mm of gingiva displayed. Management of such a complaint often entails both periodontal and restorative therapy, if not also orthognathic surgery and facial plastic procedures.

The following report showcases two-stage esthetic crown lengthening and prosthetic rehabilitation for the treatment of a gummy smile.

Patient history

A medically and periodontally stable 40-year-old female presented with excessive, asymmetric gingival display of 5 to 7 mm upon smiling, short clinical crowns and incisal wear from tooth #4 to #13 (Figs. 1, 2). Due to attrition and the relationship between the dentition and periodontal drape, the anterior teeth appear square-shaped and “masculine.” Diagnoses included: (1) Coslet Type IA altered passive eruption, evidenced by a wider-than-customary dimension of keratinized gingiva and an alveolar crest at least 1.5 apical to the cementoenamel junction (CEJ), and (2) vertical maxillary excess. The patient also shows a thick tissue biotype.

Treatment plan

- Consult with oral and maxillofacial surgeon regarding orthognathic surgery
- Consult with facial plastic surgeon regarding lip lowering therapy
- Consult with restorative dentist regarding ideal tooth shape setup and fabrication of surgical guide
- Two-stage esthetic crown lengthening from tooth #4 to #13
  - First stage: osseous recontouring
    - Six-week healing period
  - Second stage: gingivectomy
    - Three-month healing period
- Final porcelain veneer restorations for teeth #4 through #13
- Delivery of maxillary occlusal bite guard

Treatment plan rationale

Ideal treatment for the patient with vertical maxillary excess embraces a host of dental and medical specialties. In such a case as this, in which the patient demonstrates up to 7 mm of gingival display, LeFort I maxillary impaction may further refine results if conventional crown lengthening insufficiently elevates the periodontal margin, creates an unacceptable crown-to-root ratio
or precludes achievement of a natural-seeming emergence profile due to exposure of excessive radicular structure.³

Likewise, neuromuscular relaxation of the upper lip by botulinum toxin type A (BTX-A) depresses the lip, and thus masks any mucosal surplus left after periodontal surgery.⁴

As the patient declined orthognathic and facial plastic therapy, the treatment rendered to alleviate her gummy smile and re-establish tissue and dental symmetry included a two-stage crown lengthening procedure followed by delivery of porcelain veneers from tooth #4 to #13.

A biphasic crown lengthening approach minimizes the 1 to 3 mm coronal gingival shifts common after one-stage procedures detected especially in patients with thick soft-tissue biotypes (such as the patient featured in this report).⁵

By first reshaping only the osseous crest and letting healing commence, it is possible to correct any coronal rebound of the soft tissue seen after healing at the second, gingivectomy-only, surgery.

Once the attachment apparatus fully remodels post-gingivectomy, which takes roughly three months, final restorations may be cemented.

**_Restorative consult_**

From the diagnostic models, the patient’s prosthodontist created an ideal dental wax-up, upon which a vacuform matrix was applied to generate a surgical guide (Figs. 3, 4).

**_Osseous recontouring (first stage)_**

The first stage of biphasic crown lengthening of teeth #4 through #13 involved only osseous resection. The patient took 0.25 mg oral triazolam and 600 mg ibuprofen one hour before surgery. Anesthesia with 2 percent lidocaine with 1:100,000 epinephrine and 0.5 percent bupivicaine with 1:200,000 epinephrine was given via local infiltration.

A buccal sulcular incision was made extending from tooth #4 to #13, and vertical incisions were dropped at the mesio-buccal and disto-buccal line angles of teeth #4 and #13. A full-thickness flap was elevated (Fig. 5).

Osteectomy was performed using an Ochsenbein chisel, carbide finishing bur and Neumeyer bur to position the alveolar crest at least 3 mm from the anticipated restorative margin at each site, as verified by the surgical guide (Fig. 6).

The bone was gradualized such that no sharp edges or bulbous areas existed, and positive architecture was preserved.

The flaps were replaced and sutured in sling fashion with 4-0 expanded polytetrafluoroethylene (ePTFE) (Fig. 7). The gingival height and shape post-surgery appeared similar to that found before surgery, even 10 days after intervention (Fig. 8).
Once the soft tissue resettled six weeks post-os
tectomy (Fig. 9), the second stage of biphasic crown
lengthening of teeth #4 through #13 was executed.
The patient was sedated and anesthetized as above.
A definitive external bevel gingivectomy of teeth
#4 through #13 was performed with a #15 scalpel
utilizing the surgical template to delineate the
desired tooth contours (Fig. 10). The papillae were
left intact and no sutures were required. Healing four
weeks after the gingivectomy revealed a harmoni-
ous gingival drape (Fig. 11).

**Final prosthetics**

Placement of final veneers on teeth #4 through
#13 occurred three months post-gingivectomy
(Fig. 12). An occlusal bite guard was delivered to
protect the restorations. In order to correct lip line
asymmetry and further diminish gingival display,
neuromuscular lip correction (lowering) with BTX-A
was reconsidered, but the patient did not pursue
treatment.

Six years after veneer placement, the patient
remained satisfied with the functional and esthetic
result achieved solely through periodontal surgery
and prosthetic rehabilitation (Figs. 13, 14).

**Postoperative instructions**

After each surgical procedure, the patient was
instructed to take 600 mg of ibuprofen every four to
six hours, hydrocodone 7.5 mg/acetaminophen 750
mg every four to six hours as needed for pain and
100 mg of doxycycline a day for 10 days.

The patient was instructed not to brush at or
near the surgical site but instead to rinse with 0.12
percent chlorhexidine or warm saline twice daily.
The patient was also directed not to chew in the affected
area for at least two weeks. Suture removal occurred
at 10 to 14 days post-surgery._

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**Periodontal surgeon:** Michael Sonick, DMD  
**Restorative dentist:** Stephen Rothenberg, DMD

Dr. Michael Sonick is a full-time practicing periodontist and implant surgeon in Fairfield, Conn. He is on the editorial boards of many journals and is co-editor of the textbook “Implant Site Development.” He is currently a guest lecturer at New York University School of Dentistry and is director of Sonick Seminars, in Fairfield, Conn. You may contact Dr. Sonick at mike@drsonickdmd.com.

**Fig. 13a** Smile pre-treatment.  
**Fig. 13b** Smile six years post-treatment.  
**Fig. 14** Facial view six years post-treatment.