Un-cosmetic dentistry

Are you ready to reduce your dependence on porcelain restorations?

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While there are some occasional references to concerns about the overuse of porcelain, many articles in dental trade publications show off before and after dental makeovers that from my perspective were quite satisfactory prior to expensive intervention. I will not argue that there are people who truly have displeasing smiles and they can benefit greatly from cosmetic dentistry, but all too often people with bodys image issues related to a distorted perception of their teeth seem to be easy victims.

“Smilexenia” is the fanciful term I coined for this disorder, which appears to affect some young women more than others. If you open the pages of any journal published by the American Association of Cosmetic Dentistry, you will no doubt find at least one or two of these patients having extensive veneer treatment that could easily have been avoided with unbiased professional advice. The problem is that too many dentists have dedicated their lives to pure cosmetic dentistry, which is often based on using porcelain as a cure-all.

There are many of the cosmetic dentists recognized as the top tier appear to use their standing as a licence to drill. It is time to adopt a significant change in philosophy if the dental profession wishes to maintain any level of integrity. Lip service to conservative cosmetic dentistry means nothing. To truly practise “un-cosmetic dentistry”, a dentist must back away from ceramics and make use of composite to restore worn edges in combination with orthodontics to correct alignment.

This style of treatment does not have to be unprofitable. It does not have to be only for the simplest of cases either; actually, very complex cases can be treated to a high standard when multiple disciplines are employed together. The collaboration of specialists can be one alternative, but for patients on a budget or in areas with lower access, a general dentist trained in advanced therapies can offer comparable results for a fraction of the fee.

Biggest bang for the buck—STO combo

Let’s cut to the chase: if you are a general dentist and want to knock your practice out of the park with new opportunities, look at venturing into the realm of advanced shorter-term braces. I specifically say “shorter” because your goal needs to be always trying to be faster because people hate being in braces, and aligners are often too slow or they do not give the dentist enough control of tooth movement.

There are a number of dentists who promote STO, but I developed my own system before I had heard of any others so I have some different ideas. Frankly, levelling and aligning simple orthodontic cases is easy and can be learned through just a short course, which these-dentists (Drs Swain, Barr or De Paul) appear to teach very well. I would rather remain on the fringe of even these trend-setters, and offer my twisted perspective with less corporate influence.

As hugely popular as these STO courses are, there is however some potential for abuse by dentists who simply have a weekend course and no other training in orthodontics. While I would rather see a dentist do more orthodontics than veneering, orthodontists are partially justified for their concerns about GP orthodontics.

Taking courses alongside orthodontists and reading their journals, it is apparent that there is negative sentiment directed towards general practitioners who dare to bracket teeth. I do feel that a united profession is a favourable concept but, having experienced extreme levels of sabotage in my local area, I now refer less than in the past. Some other general dentists have mentioned similar problems (on online forums) with turf protection that appears oddly focused on orthodontics.

An article recently used the term “soft science” to describe orthodontics, and I would certainly agree that it is difficult to claim that orthodontists know the “right way to straighten teeth”, since few of them agree on anything. The reality is that the schools of thought in orthodontics are as polarised as the holy war between the myo-centric doctors and the centric relation believers.

As an example, the use of the Herbst appliance forces the TMJ forward, in an attempt to correct a deficient mandible. This is like someone standing on the balls of her feet to be taller. While the data, but the device has been used for almost 100 years already. Mandibles are not stimulated to grow after all, and patients may be holding their jaw forward in a Sunday bite simply to get their uncomfortable braces off.

Orthognathic surgery may be vastly underutilised in some cases and overused in others. The use of TADS appears to offer some promise, and while an oral surgeon may find it a nuisance to bother with placing them, a general dentist may be able to get them in place with little difficulty. Orthodontists often tremble at the thought of using a needle (like I did in dental school), so the price goes up as the patient heads to the oral surgeon.

BIAS: A particular tendency or inclination, especially one that prevents unprejudiced consideration of a question; prejudice

So this article is obviously biased towards expanded skills for the general dentist, but I do respect the need to pick your battles in treatment and refer when the case demands it. I essentially do not believe in slavishly following any rubbish from specialists who want to dictate what a general dentist should and cannot do. If you do not like my ideas, tough luck because the ones you may not stand up under close scrutiny. I do not want to waste my time justifying anything I choose to do and if I am taking a course beside an orthodontist who is snivelling that he will start doing fillings and extractions, that is awesome; I may have an opening for an associate.

As excited as I am about STO, I think a two-day course is only a taste of what you need to know. It is like taking a two-day self defence class and then thinking you can enter mixed martial arts. The problem is not what you learn, but the cases that you attempt that are actually much more complex than you realise (you will be defeated!). You MUST take a full orthodontic course such as the one taught by Dr Richard Litt, and you are insane not to take a series of oral rehabilitation courses from Dr Frank Spear or Dr John Koos.

Adult orthodontics is full mouth reconstruction, and the treatment of worn dentition is...
Cosmetic dentists have a tendency to veneer everything. They veneer teeth straight back because they claim that you only need three to four years. They veneer teeth to get rid of wrinkles and blemishes. They can wear them to whiten and straighten them. They veneer teeth because the old person really needs them. Times in braces are often liaisons that need to be corrected as soon as possible to stop the abuse that is going on. Cosmetic dentists need to reprogramme to back off and get some air. And orthodontists need to give a little elbow room to their referring dentists who want to offer some orthodontics. The smart ones maintain a positive relationship and often see referrals from the primary care dentists who claim that NOT ALL cosmetic dentists are Veneer Nazis, and NOT ALL orthodontists tell patients that GP orthodontics causes root resorption.

My suggestion for breaking an aesthetic obsession is “cosmetic, not cosmetic”, which has cultivated if you have focused your training on aesthetic dentistry. The easiest way to do this is to take porcelain veneers off the table in the treatment planning stage. Composite resin can be used conservatively with orthodontics to provide a near-complete medium- to long-term solution.

Any time you stick to a single series of training programmes, you start to pick up biases that war your thinking. You will find that the ideas within the dental profession are as extreme as the religious and political beliefs around the world. The champions of the various philosophies can be very convincing, but I think we need to take a step back and make up an individual philosophy that puts the patient first.

If you take the average patient, this means that you will offer fast, affordable, reversible and conservative treatment. Millions have been spent to make people think veneers are better than real teeth; I challenge that idea. Porcelain is not as good as healthy enamel and never has been, not if you consider it has 0.8-1% of water absorption.

The easiest way to do this is to use a series of training programmes, ideally taught by an orthodontist who has trained graduate students, take a full-mouth reconstruction programme (or at least a worn dentin component), then if you want you can take a composite technique course.

I personally do not get fancy with composite. Since my patients do not have loupes or want to pay double for advanced mi- cronize cosmetic. What patients do hate is composites that chip/stain. This brings me to use Clearfil APE. It’s a PES (Kuraray—no endorsement money yet). Free-hand composite bonding is the best way to be able to follow the contours of the teeth, so scrape the idea of using a wax-up as an instant mantra if ortodontics would be helpful.

The Clearfil shade XL appears to have a unique effect that works for most shades of teeth. If a lighter shade is de-sired, then a cut-back technique can be employed to modify the final appearance with another shade/material like 3M Supreme (5M ESPE).

From my review of the CRA/ Clinicians Report literature, this brand of composite is particularly strong in clinical practice. I have had heavily restored cases that are still holding up after five years of service. The composite does not polish very well, so I have started using G-foats as a final glaze, especially for smokers. I suggest getting the patient that he fills the fillings, there is a 50 per cent warranty for the first 12 months, regardless of how they were broken.

With orthodontic treatment, you should, as mentioned earlier, try to rebuild any worn teeth before you do anything irreversible. Simply by looking at the effect, enamel replacement is possible and have on the lat. Considering how orthodontics could manage the result may be sufficiently without an articulator. A less deep overbite and a less trapped mandible appear to be achievable within most schools of training.

The cosmetic training really will begin to come in to play with incisal displays, tooth proportions and fuller arches. The arch form after orthodontics usually is very pleasing and mimics the technology of overlying ceramic on the facial surfaces of the upper bicuspids. The term for this has faded from my memory because I tend to avoid courses that push the use of porcelain.

When I attended the UCLA Aesthetic Continuum, Dr Jimmy Kubank took a few moments to talk about a case in which a young teenager had her teeth disfigured with bulky veneers. He was forced to retreat her teeth but she had been compromised for life. As dentists, we are subject to many sales presentations disguised as courses and we rarely get the truth. The truth is dentistry is not easy and taking one weekend course will not nearly enough. No guru is going to tell you all that you need to know.

At a recent course on anterior aesthetics taught by Dr Gerald Chiche at the Seattle Study Club, I was forced to prepare a number of veneers on plastic teeth. The burning smell reminded me of dental school, which brought back mixed emotions. I took away the idea of additive cosmetic strategies and the use of minimal reduction if choosing to use ceramic. Bonding to enamel instead of dentine still seems to be the better plan. (I also gave Dr Chiche a few photographs of John Lennon’s decayed molar and he smiled the fact that he had realized that Beatle was lost in Katrina—I hope he finds the copy sometime soon!)

As one of the first dentists to combine STO concepts with advanced treatment planning of the worn dentition, I can honestly say that if you can set aside the use of porcelain veneers and substitute some of the treatment modalities mentioned in this article, you will eventually find a way back to ceramic usage with a better empathy for patient care. The public is becoming wiser and the market is shifting towards dentists who are ready to mix up their training.

As my UK dentist colleague Dr Martin Kelleher, who lectures on “veneering” disease, would say, use the daughter test before you do anything irreversible.

I would add that you owe it to your patients to learn from the best in the profession and, cross-training in continuing education may be the best investment you can make in dental practice. I have seen an orthodontist from a full orthodontic programme, take a composite technique with composite, since my patient was Veneer Nazis, ...