Many patients who present seeking cosmetic dentistry have underlying functional, structural and biological problems. If either the aesthetic desires or functional needs are not met, the sequelae can be extremely traumatic for all concerned. Typically these patients have been drilled and filled over the years and often exhibit signs of tooth surface loss (attrition, erosion, abrasion, for example). A more comprehensive approach is required than the single-tooth dentistry which is customary, but required than the single-tooth treatment is one that has been sold and never had a nice smile and if that was possible she would be very happy.

What Am I Trying to Achieve?

Accessing the patient’s wishes provides invaluable information in helping us determine what we are trying to achieve. Most importantly we need to have a vision of the desired result – what does a healthy, stable, attractive mouth look like?

Combining the patient’s desires with these goals will produce beautiful, long-lasting, comfortable, predictable results.

Start at the beginning

Whatever the presenting condition or our patient’s desires, it is essential that we have a records process in place that will allow us to carry out a comprehensive examination so that we may use that information to determine what problems the patient has and how we may help them. Digital photography is not only an essential record but also an excellent aid in coidagnosis, helping the patient see and understand the problems that they may have.

It is important to be consistent in the photographs that are taken and in the camera settings that are utilised. Additional shots may also be taken to help illustrate specific points.

Centric relation bite record

The last piece of information necessary to mount the casts to a semi-adjustable articulator is a bite record which relates the lower cast to the upper cast. Again binocular magnification is used to achieve centric relation (CR) and the record is taken with wax (Delar, Great Lakes Orthodontics) or vinyl polysiloxane (futar D, blue mousse). If it is difficult to manipulate the patient, a Lucia jig may be first used to programme the muscles. When the muscles have relaxed, it will be possible to record the bite utilizing the jig in combination with bimanual manipulation.

Biologic assessment

The periodontal condition is recorded and an oral cancer check performed. The teeth are examined for signs of decay and failing restorations. Any necessary radiographs are taken.

Case planning and delivery

Once the records have been gathered, we can now analyse the information and develop a treatment plan.

Visualisation

The first step in this process is to develop a mental image of our optimum result. It is important to focus on the possibilities and not be constrained by the restrictions that are often placed upon us.

Model work

Careful analysis and diagnosis of the mounted casts will produce the 3D image of the mental picture we developed above.

Temporisation

All lining stents and matrices from the diagnostic wax up will allow proper, but minimal preparation and allow chairside fabrication of temporary restorations that will require minimal alteration.

Final restorations

Once the temporary restorations have been perfected for function and aesthetics, the technician can copy this information to produce predictable, stress-free results.

Impressions are taken being careful to record all the teeth and sufficient tissue detail. Alginate is still an excellent material to use and will ensure the model is cast promptly. I will often use polyvinyl siloxane (PVS) materials in a quick two stage putty wash technique that I find help record all necessary information with the added advantages of stability and the potential to recast.

An earbow is taken so that the models can be mounted onto an articulator. This relates the upper cast to the condylo, records the occlusal/incisal plane and provides the correct arc of closure for the lower cast.

Once the temporary restorations are inserted, the lower teeth were whitened and reshaped/restored using composite.

Once the implants became integrated, the lower teeth were whitened. The lower anterior was restored and at the same time the upper teeth prepared and temporised according to the diagnostic wax up. The provisional restorations were adjusted for function and aesthetics.

Once all desired goals were met, photographs, impressions, bite record and earbow were taken. This stage is the final stage. The technician can then ‘reverse engineer’ the final restorations so that nothing is left to chance.

Richard’s case

Once the periodontal condition was stable, implants were placed in the upper left first molar and both lower first molar areas. Gingival recontouring was also carried out at this stage. The upper teeth had failing restorations, were structurally changed and needed to be reproposed slightly for functional and aesthetic improvement. To achieve our aims, it was decided that the upper teeth should be restored. The lower teeth were in generally good order but the patient wished for them to be whiter and the incisal edges of the lower anterior teeth needed to be reshaped to improve function and aesthetics. It was decided that the lower teeth should be whitened and reshaped/restored using composite.

Jenny’s case

Records were gathered as described above. The patient’s joints were stable and healthy. As signs of occlusal instability were present it was decided to work in centric relation. Preliminary mouth preparation involved extracting several teeth that were beyond redemption and intensive periodontal treatment. Two carious teeth were cleaned and temporised. An optimum result was visualised and then waxed up on the mousetrapped. The teeth are examined for signs of decay.
A PREDICTABLE APPROACH TO AESTHETIC DENTISTRY

Dr IAN BUCKLE

Excellence in aesthetic restorations can be achieved simply and predictably when you know what to do and how to do it. Following the Four Steps to Predictable Aesthetic Dentistry coupled with a clear understanding of the aesthetic and functional goals we wish to achieve will lead to beautiful, comfortable, long-lasting restorations. This in turn results in an efficient, productive Practice with decreased stress for all.

The fee per delegate is £345 and qualifies for 6.5 hours CPD.

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