With the esthetic zone being absolutely critical to a patient’s external appearance and inner emotions, orchestrating a bioesthetic result is mandatory. Too often, this is complicated when esthetic desires infringe on the health of the periodontal complex. This is often true when biologic width violations have occurred iatrogenically.

Many factors may contribute to these failures; the two main culprits being intracrevicular margin location and overcontoured restorations. Not only is plaque accumulation problematic, but the supracrestal fibres also become interrupted, causing the tissues to become further inflamed and esthetically unmanageable. Kois’ landmark study defined the total dentogingival complex (DGC) as clinically predictable at 3mm on the direct facial aspect, and at 3mm-5mm interproximally when measured from the free gingival margin to the osseous crest.

It is critical anteriorly that the gingival margin mimics the osseous scallop while maintaining the DGC.1 Further complicating these complex situations is the degree of inflammation in the soft tissue, affecting the clinical development of health and esthetic symmetry.

Dental lasers have evolved considerably as an adjunctive and alternative treatment to safely, conservatively, and reliably decrease bacterial levels and improve the hard and soft tissue contours.

An ideal result

Often the patient is frustrated with his or her previous poor cosmetic results. However, to improve the periodontal framework in order to create an ideal result, they must be referred to yet another doctor. Even more challenging is the extended healing time created by restorative surgery. This not only affects the chronology of final restorative care, but also delays the patient’s ultimate satisfaction and happiness for a minimum of two to three months.

Fortunately, dental lasers have evolved considerably as an adjunctive and alternative treatment to safely, conservatively, and reliably decrease bacterial levels and improve the hard and soft tissue contours.

Studies of Er:YSGG lasers by Rizoiu and others have shown that thermal coagulative results, as well as bony ablation characteristics are similar to a dental bur.2 From a patient-friendly standpoint, less need for suturing and shorter healing times improves case acceptance for doing ideal dentistry. In selected cases, such as the one presented in this article, minimally invasive laser procedures, with precise restorative planning and technique, can satisfy esthetic and functional parameters. Furthermore, patients can enjoy optimal results more comfortably and efficiently.

A conservative strategy was devised that would allow us to correct the problems and causes in a “multi-tasking” manner.

Case Presentation

A 58-year-old female patient presented for correction of what she termed her “tilted smile” (Fig 1). Given that she was starting a new sales career, she also wanted to make her teeth brighter and her smile much broader. The patient shared her frustration about previous dental consultations that had focused solely on orthodontic or surgical solutions without considering a more practical approach that would fit her busy life.

Her smile analysis established that the esthetic zone being absolutely critical to a patient’s external appearance and inner emotions, orchestrating a bioesthetic result is mandatory. Too often, this is complicated when esthetic desires infringe on the health of the periodontal complex. This is often true when biologic width violations have occurred iatrogenically.

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lished a collapse of the buccalpits in the buccal corridor. Furthermore, the axial inclinations, irregular gingival margins, and incisal edges created a downward tilt to the patient's right due to tooth positioning. Close-up imaging showed healthy gingival tissues as well as a weakened right central incisor from a large composite (Fig 2).

Findings
A full clinical examination with radiographs and mounted models revealed the following:
• Biomechanically, the majority of her teeth remained strong despite previous dental care.
• Periodontally, soft and hard tissues were healthy.
• Occlusally, load testing was normal (after muscle relaxation) and there was obvious CR-CO anterior-vertical slide due to a premature contact at tooth #50.
• Esthetically, the width-to-length ratio of the upper centrals was 1:2, far from the ideal range of 0.75:1.0. Tooth shade was a Vita A2.

Treatment Plan
Given the patient's previous history and her desire for minimally invasive dental care, a conservative strategy was devised that would allow us to correct the problems and causes in a "multi-tasking" manner:
• Muscle and bite therapy with a Tanner appliance, followed by careful equilibration aided by the T-scan (Tekscan System; South Boston, MA).
• Three-dimensional wax-up on a Stratos articulator (Ivoclar Vident; Amherst, NY) (Fig 5)
• Home bleaching of the lower teeth with Opal (tradent; South Boston, MA)
• Home bleaching of the lower teeth with Oxy-fresh; Coeur d'Alene, ID) (Fig 8). Using a 7/8 curette (Fig 8). Using the resection was smoothed with a 7/8 curette (Fig 8).

Treatment
At the initial closed periodontal lift, the ErCr:YSGG laser was used in three modes (gingival sculpting, osseous recontouring, and bio-stimulation). Prior to anesthesia, the desired framework was planned and outlined using a fine marker (Fig 4). Furthermore, a stick-bite was used, not only to establish an ideal incisal plane, but also to properly align the gingival margins (Fig 5).

With the settings at 2.0 Watts (W), 20 pulses per second, 20 per cent air, and 20 per cent water, a G-6 tip (600µ in diameter) was used to shape the labial gingival region. No tissue necrosis or significant bleeding occurred as a result of using the laser's relatively lower settings. All areas were "sounded" using a periodontal probe (Fig 6).

At the facial margins, osseous sculpting required great precision in order to maintain a 5-mm DGC. A specially tapered T4 tip (400µ in diameter) was used at a 25 per cent higher wattage of 2.5W. Prior to usage, the tip was measured and marked to 5 mm in order to maintain controlled adjustments within the gingival sulcus during periodontal probe movement of the tip (Fig 7). The resection was smoothed with a low-level laser therapy at a setting of 0.25 W, a decrease in the release of inflammatory histamine and increased fibroblasts for junctional epithelial growth was achieved by "frosting" the outer epithelium and injection sites (Fig 9). The patient was placed on a vigorous home-care regimen (Oxygel, Oxy-fresh; Coeur d'Alene, ID) and closely monitored for a period of 6 months, despite previous dental care. No tissue necrosis or significant bleeding occurred as a result of using the laser's relatively lower settings.

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NEW!

A conservative strategy was devised that would allow us to correct the problems and causes in a “multi-tasking” manner.
UCL Eastman graduate wins orthodontic prize

The UCL Eastman Dental Institute would like to congratulate Joanne Brethell, an orthodontic graduate student who recently won the prestigious JK Williams Medal.

The JK Williams medal is awarded annually in memory of John Williams, Consultant Orthodontist and outstanding teacher who was based at Wakefield and Leeds and a former Board member of the Faculty of Dental Surgery. The winner is the individual achieving the most outstanding overall examination performance in all the diets of the Intercollegiate Membership in Orthodontics examination of the Royal College of Surgeons of England and the Royal College of Surgeons and Physicians of Glasgow (IMOrth) held in the academic year.

Joanne is the 7th winner of the award to be trained at the UCL Eastman Dental Institute. The bi-collegiate award involves a three-hour written examination, followed by the presentation of a thesis as part of cases treated personally by the candidate, GDEs and structured clinical reasoning exercises enabling the assessment of clinical knowledge, skills and communication abilities.

Following completion of her third-year training, Joanne plans to continue pursuing a career as a hospital consultant, and is hoping to start a post-CCT training post in October 2010.

For more details about the UCL Eastman Dental Institute, please visit www.eastman.ucl.ac.uk or telephone 020 7915 1038.
month while occlusal therapy and bleaching procedures were performed.

Four weeks after surgery, the tissues had healed and restorative care could be initiated. The patient's teeth were prepared for veneers and a crown with mild soft tissue re-shaping, to fine-tune our previous treatment. After taking impressions and bite registrations, prototype provisionals (Luxatemp Plus, Zenith Dental, Englewood, NJ) were fabricated using the “shrink-wrap” technique. The patient was sent home with the same home-care regimen as mentioned previously, and instructed to “test-drive” her new smile for esthetics and function. She returned in a week to perfect the prototype's occlusion, color, and morphologic features. Photographs and models were sent to the laboratory, providing a final blueprint for the porcelain restorations (Fig 10).

Satisfied Patient

Four weeks later, the provisionals and cement were carefully removed from the teeth. All restorations were tried in individually and as a group to verify fit and esthetics. After the patient's enthusiastic approval, the porcelain was bonded using the two-by-two technique and isolation. Margins were smoothed and polished and occlusion balanced with the T-scan. A protective night-time appliance was created to add longevity to the rehabilitation. Very satisfied patient said that we had exceeded her expectations.

The use of a hard/soft tissue laser is a wonderful adjunctive tool for cosmetic and restorative dentistry. The case discussed here demonstrates that this type of laser technology gives dentists the ability to make significant soft and hard tissue changes while being minimally invasive. These changes not only improve the final esthetic outcome of the case but also provide the physiologic functional parameters required for successful dentistry.

Acknowledgments

The author thanks his office team and laboratory technician, Mr. Wayne Payne (Payne Dental Lab, San Clemente, CA), for continually enhancing the lives of many patients like the one presented here. He also is thankful to his family, who allow him to contribute to the education of other dentists and their teams.

References