10 Top tips on achieving great aesthetics

Drs David Bloom and Jay Padayachy discuss some practical advice on getting great aesthetic results for your restorative cases

1. **Photography.** When it comes to any form of restorative treatment, digital photography is an essential tool and will aid in treatment planning, discussion of the proposed treatment with the patient as well as a medicolegal record. In addition to pre-ops, take pictures of your provisional (if an aesthetic case) and don’t forget the post-op pictures as well. Intra-oral cameras are excellent for showing the tooth preparation especially if doing any posterior work as it will show up recurrent caries and any fracture lines present so that you can show the patient and warn them about any possible root treatment in the future being required for the tooth. This is especially valid if the tooth does become non-vital a few years later and they try and blame you for it. In this increas

2. **Wax-ups** for provisional restorations and visual diagnostic try-ins. Before embarking on any form of aesthetic work it is important to know where your end point is. Diagnostic wax-ups will help considerably with this in helping to visualise what you are trying to achieve and also gain acceptance from the patient before you actually start by enabling a visual diagnostic try-in. Wax-ups can range from full arches to single teeth to enable correct contouring for a fractured incisal edge, and for ideal implant placement via stents.

3. **Lab communication.** Any form of laboratory based restoration must be accurately communicated. Thus the appropriate lab slip needs to be fully completed and signed off by the dentist. This ensures that the prescription is carried out correctly by the technician. This includes information for both the wax-up and the final restorations. For aesthetic work, photography, as already discussed, is a given; the technician needs to see all the pre-op pictures, the pictures of the provisional restorations and it is also nice to send them a copy of the post-ops so they can see how beautiful their work looks in the mouth, a luxury they don’t usually experience. (fig 1)

4. **Whitening.** As part of your treatment planning for any restorative work, always ask the patient if they would like to have their teeth whitened first, particularly if doing anything anterior. Once the restorations are placed it will be too late unless you want to replace the work you have just fitted. We prefer not to whiten teeth we will be preparing for veneers so that their true foundation shade can be assessed. If they have been whitened first they will darken with time which may compromise the aesthetic outcome. Don’t forget to make new whitening home trays once the new restorations are fitted and build this into your treatment fees.

5. **Bonding.** In this porcelain veneer dominated world remember that conventional bonding with composite resin can give a great result. It is non-invasive of tooth tissue ensuring that the enamel is not violated. This works very well when building out buccal corridors in an otherwise intact dentition. (figs 2-7)

6. **Smile design.** An understanding of the principles of smile design is crucial in your treatment planning. Even if the case is not an aesthetic one, you need to be able to communicate what can be achieved by looking at the bigger picture rather than just necessarily the one tooth they are concerned about. They may not be interested but at least you will have covered it (and make a note of this in their records). Fortunately now we are going away from the mass produced standard American-style smile (unless you are using an American lab for some reason) to a more natural European beautiful form whereby the teeth do not all look the same but have a hint of individuality.

7. **Ovate pontic site.** This enables the pontic to look as though it is emerging from the gingiva similar to a natural tooth rather than just sitting on the ridge. Upon extraction of a tooth and the making of the provisional bridge ensure that the pontic is actually sitting down in the socket by at least three mm. If it is not doing this then it is easy to add flowable composite onto the temporary restoration to achieve this. If the ridge has healed and no site has been created then it is very easy to create it with a laser, electrosurgically, or large round bur; your impression can then be taken but ensure that your provisional restoration is
filling the newly created site. Communicate with your technician the depth of the ovated site, and ask them to scrape away a further mm on the master model so when the final bridge is seat-ed there is some blanching of the soft tissue which will help remodel the tissue further. (Figs 8-10)

8 Multi-disciplinary approach.
A dentist should no longer regard himself as an island but should utilise their specialist col-leagues to aid in the restorative treatment plan. This can range from orthodontic pre-alignment with Inman aligners to minimise the degree of tooth preparation required by getting the teeth in the ball park, to surgical crown lengthening based on the diagnostic wax up and appropriate stents or re root treating teeth to be restored if there are signs of apical pathology.

9 Tissue training for implants.
Historically implants were regarded as successful if they integrated fully. Patients were happy to have their space filled with something fixed and were less concerned by the aesthetics. Nowadays if the implant crown doesn’t look beautiful and the emergence profile and tissue height and contour doesn’t look natural, it would be regarded as a failure albeit aesthetically. The use of temporary crowns to train the tissue to correct contour cannot be underestimated. Time and care spent at this phase of treatment which can take any-thing from three to 12 months is of paramount importance in creating this effect. These tem-porary crowns should be under contoured as this can allow ‘gin-gival growth’. (Figs 11-15)

10 Occlusion. An understand-ing of the basics of occlusion is essential to ensure the longevity of your restorations. Ideally the occlusal form should include equal intensity contacts on all posterior teeth in a cusp tip to fossa relationship with a canine protected occlusion in lat-

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