There were various reasons why porcelain veneers were requested, but one of the most common was crowding in the anterior segment. Frequently this involved people who had worn fixed orthodontics as teenagers, but relapse had set in and a quick fix was requested and, a lot of the time, guess what was carried out... yes, veneers. Even in a recession, there still remains the substantial demand for cosmetic dentistry.

Although I believe that tooth whitening can be considered as a scalpel-free face-lift, porcelain veneers are definitely not - and that includes the thin or prepless variety.

Back then, adult orthodontics was not what it is today. Lingual braces were in their infancy and in the realm of the very few specialist orthodontists that had the skill and the will to carry out this innovative but tricky treatment.

There were various reasons why porcelain veneers were requested, but one of the most common in my experience was crowding in the anterior segment. Frequently this involved people who had worn fixed orthodontics as teenagers, but relapse had set in and a quick fix was requested and, a lot of the time, guess what was carried out... yes, veneers. Even in a recession, there still remains the substantial demand for cosmetic dentistry.
the crowded anterior segment? A few years ago I attended the Straight Talk Seminars hands-on Inman Aligner course, and I would now like to share with you my first ever case.

The patient was a 45-year-old gentleman who was enquiring about the options to improve the look of his lower anterior teeth that had... yes, you guessed it, relapsed after fixed orthodontics as a teenager. Admittedly he blamed himself for this, as he had stopped wearing his retainer. He presented with mild to moderate crowding in the upper anterior segment and moderate crowding in the lower anterior segment. It was, however, only the lower incisors that concerned him.

Over the years he was given various options for treating this from various dentists. These included the quick fix porcelain veneers, fixed orthodontics and Invisalign. Luckily, he had always declined the veneer option and didn't want the fixed orthodontic option. I made him aware of lingual orthodontics but due to costs and length of treatment time, this was declined. Although Invisalign was a viable option, it was twice as costly and would have taken twice as long as what I proposed... the Inman Aligner. He hadn't heard of it before but really liked the fact that not only was it removable but it was also quick, usually taking three-four months and was cost effective.

Good case selection is essential and a parallel technique digital long cone periapical radiograph was taken of the lower incisors. This is essential not only to assess whether any apical pathology is present but also to assess the spacing between the roots. If the roots are as crowded as the crowns, then this may be a difficult case and you should proceed with caution. This case exhibited no pathology and some spacing between the roots. The patient therefore went ahead with impressions at his consultation appointment. This is quickly done in alginate using metal Rimlock trays and an alginate finger sweep lingually and labially for accurate bubble-free impressions.

The fit appointment was two weeks later and took 15 minutes. Lingual and labial composite attachments were placed to engage the palatal bow and prevent the labial bow from slipping towards the gingiva respectively. Some selective and progressive interproximal reduction (IPR) was carried out. The patient received instructions as well as demonstrations of insertion and removal of the appliance. It was emphasised that both nocturnal and day-time wear is essential in Inman cases, with an average of 18 hours of wear per day.

Figure 1. Preoperative 1:2 Anterior Retracted View showing lower anterior segment crowding. Note how much lower down the LL1 tooth was compared with the other incisors.

Figure 2. Postoperative 1:2 Anterior Retracted View at 13 weeks. Whitening and incisal edge bonding was offered to the patient but was declined as he was so happy with the end result as it was.

Figure 3. Preoperative 1:2 Retracted Right Lateral View. Note degree of lower incisal crowding.

Figure 4. Postoperative 1:2 Retracted Right Lateral View. Note good incisal alignment.

Figure 5. Preoperative 1:2 Retracted Left Lateral View.

Figure 6. Postoperative 1:2 Retracted Left Lateral View.

Figure 7. Preoperative 1:1 Anterior Close Up View.

Figure 8. Postoperative 1:1 Anterior Close Up View. Bonding was offered to level incisal edges but was declined.

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It may be tempting to carry out IPR in the region of most crowding, in this case LL1. However, if IPR had been carried out mesial and distal to the LL1, this would have created ledges, poor contact areas, a far from ideal contour and final result. It is important to remember the ‘Domino Effect’ with these cases. IPR in this case is done remote to the site of most imbrications or crowding, namely distal of the LL2 and LR2 and can even be done distal to the LL3 and LR3 (and in certain situations distal to the first premolars). Further down the line once the crowded incisors begin to ‘unravel’, IPR can be carried out in the LL1 region.

IPR is best carried out using Brasseler VisionFlex metal perforated polishing strips in the following sequence (depending on space required and if need-ed): Yellow (Extra fine, 15µ), Red (Fine, 50µ) and Blue (Medium, 50µ). You must always go back the other way and finish off with the extra fine yellow strip to ensure a smooth enamel surface. A fluoride mouthwash is also recommended.

The patient was reviewed every two-three weeks, depending on progress, and 15 weeks later he was delighted with the result. The patient was given the option of bonding to level the incisal edges off but he was happy to accept the final result as it was. The composite attachments were polished off and a wire retainer fitted. A 0.5mm Equis style clear retainer was made to fit over the wire retainer. This acts as a good back up in case the wire comes away, however the patient is instructed to wear this every night for the initial three months, reducing this to every other night and then once a week after the first year.

There has been much debate about whether ‘simple’ orthodontics can or should be carried out by GDPs. In my view, the key word here is ‘simple’. We are not reorganising the occlusal scheme, we are not moving molars and we are not extracting teeth. In fact, I see no downside to providing this treatment. Whether the Inman Aligner is used as a standalone treatment, before whitening, bonding or even veneers, one thing is for sure, it simplifies treatment and allows minimal preparation or no preparation at all. Not offering tooth alignment, in my opinion, verges on negligence. It is not a question of ‘should we be providing this treatment option?’ We must provide it.

So is the Inman Aligner the Real Deal? It sure is.

About the author

Dr Dominique Kanaan achieved a Diploma in Hypnotherapy and most recently she has become a Licentiate of the Faculty of Homeopathy. She explores all aspects of dentistry but, after working in a leading flagship cosmetic dental clinic in Selfridges, has focused her interests in the field of cosmetic dentistry. She is well known in the cosmetic dental arena and to keep up-to-date with the very latest techniques, attends courses both national and internationally and is a full member of the British Academy of Cosmetic Dentistry. Dr Kanaan has also teamed up with her husband Zak and is a Clinical Director of K2 Dental Seminars, running a renowned whitening course in particularly team dentists, hygienists and therapists in the latest tooth-whitening techniques.

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Figure 9. Preoperative Lower Occlusal View with bonded wire retainer in place.

Figure 10. Postoperative Lower Occlusal View with bonded wire retainer in place.