Aesthetic Dentistry Made Easy

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With advances in science and technology, aesthetic dentistry continues to evolve. This is also a direct result of the advances in the abilities of the doctor-ceramist team, and what they can create together. The doctor-patient-laboratory relationship has become more clearly defined due to a better understanding of the limitations and expectations of what the ceramist can produce. New temporary materials, impression materials, cements, etc., have made attaining superior aesthetic results much more predictable. This article will demonstrate a step-by-step approach to creating the most naturally enhancing aesthetics in a very easy-to-follow format.

THE KEY TO PREDICTABLE AESTHETIC RESULTS

The most important part of predictable aesthetics is diagnosis (examination and case selection) and treatment planning. It is important to be able to visualize the final result in order to properly and accurately describe the proposed treatment to the patient. Listening to the patient's concerns and effectively communicating shape, size, and color are all significant factors in a successful result. One way that this can be accomplished is by doing a composite resin mock-up directly in the patient's mouth. Another way would be by using an accurate digital imaging program, such as Envision A Smile (envisionasmile.com). This software was designed by Dr. George E. Kirtley, who is an accredited member of the American Academy of Cosmetic Dentistry (AACD).

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CASE REPORT

First, we looked at the patient in her entirety. We examined how the teeth played within her face. While observing her speech and function, we were mentally visualizing how we could improve her overall appearance. Once we had formulated some thoughts regarding our treatment approach, we moved to the mouth to further visualize the possibilities. In looking at full-face pictures of our patient, we immediately decided to close the gap (Figure 1). We also noted that the position of tooth No. 6, as well as the appearance of a missing tooth in the upper left, were distractions to the eye. After examining the full-mouth radiographs, we found tooth "No. 13" to actually be a deciduous first molar. Next, we examined the patient intraorally to begin to finalize our treatment plan. Her existing tooth shades were flattering and worked well with her surrounding facial colors. By establishing a more uniform blend of color, the hypocalcifications were something that we could certainly improve upon aesthetically (Figures 2 and 3). To obtain one color, minimal preparation would be required. This was good for a couple of reasons: more conservative dentistry always reduces the chance for postoperative problems, and it allows our ceramists to create the most lifelike aesthetics by using the underlying natural tooth structure to illuminate vitality into the overlying porcelain veneer.

Our treatment goals were to close the diastema between teeth Nos. 8 and 9, and to create harmony from anterior to posterior by giving more width to our patient's smile. Not every patient needs to have his or her buccal corridor built out. However,

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Figure 1. Preoperative, full-face.

Figure 2. Preoperative, full-face, left lateral.

Figure 3. Preoperative, full-face, right lateral.

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