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

**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 increasingly litigious age, meticulous record keeping is a must.

**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.

**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)

**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 anteriorly. 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.

**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)

**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.

**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 techni-
cian 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 diag-
nostic 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 can-
not 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
countoured as this can allow ‘gin-
gival growth’. (Fig 11-15)

10 Occlusion. An under-
standing 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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