Interdisciplinary Sequencing of Aesthetic Treatment

Michael Apa, DDS[a,b,*], Brian Chadroff, DDS[c]

KEYWORDS

• Facial analysis • Implant • Facial dehiscence

KEY POINTS

- Communication is important to achieve the ultimate perio-restorative interface.
- Facial aesthetic design was used to aid in the development of an aesthetic blueprint, so that soft and hard tissue discrepancies could be eliminated to improve the restorative aesthetic outcome and minimize patients' facial asymmetry.
- The team approach is essential in achieving ideal aesthetics for an interdisciplinary treatment plan.
- When communication occurs properly, the aesthetic surgery can be considered a surgical component of the restorative therapy.

BACKGROUND

A 40-year-old female patient presented to our office with a chief complaint of pain above the upper right central incisor. Her medical history was noncontributory. On radiographic examination it was determined than an endodontic failure existed including periapical pathology and a buccal fistula (**Fig. 1**). Full mouth charting revealed a stable periodontal status with a localized 8-mm midfacial probing approximating the apex of tooth number 8. Dental examination revealed porcelain laminate veneers on teeth numbers 4 to 13, which had been placed approximately 14 years prior.

AESTHETIC EVALUATION

Traditionally we evaluate patients from the facial perspective, then the smile perspective. Finally, we evaluate individual tooth anatomy for proper aesthetics. Before comprehensive evaluation and esthetic treatment planning, we took digital photographs per the

The authors have nothing to disclose.
[a] Rosenthal Apa Group, New York, NY, USA; [b] Department of Cariology and Comprehensive Care, New York University College of Dentistry, New York, NY, USA; [c] Department of Periodontics and Implant Dentistry, New York University College of Dentistry, New York, NY, USA
* Corresponding author.
E-mail address: doctorapa@yahoo.com

Dent Clin N Am 59 (2015) 717–732
http://dx.doi.org/10.1016/j.cden.2015.04.002 **dental.theclinics.com**
0011-8532/15/$ – see front matter

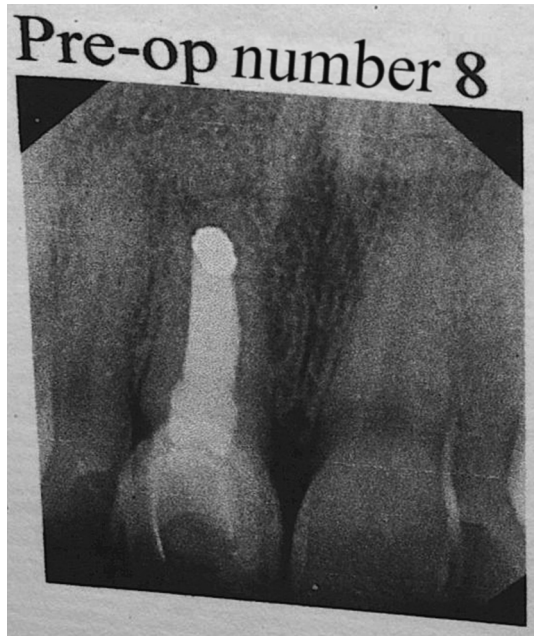

Fig. 1. Initial radiograph of patient.

American Academy of Cosmetic Dentistry's guidelines, and we also took a full mouth series of x-rays, made study models, and performed intraoral charting.

Facial

The patient's facial form is dolichocephalic on visual examination (Fig. 2). Both the bridge of the nose and the chin favor the patient's left side. The lower third of the face is the dominant third.

Smile

The patient has existing maxillary veneers from the second premolar to the second premolar (Fig. 3). At a full smile the patient shows excessive gingival display with a canting from right to left of the midline (Fig. 4). More gingival tissue is shown on the patient's right side than on the left as well as a canting of the existing veneers 4 to 8 to the patient's left. Asymmetrical tissue heights exist both from right of midline to left. Additionally, an asymmetry in tissue height is present between the maxillary centrals. The gingival margin on 8 is approximately 1.5 mm apical to the margin on tooth 9. Convexities appear to be present in the buccal corridor apical to the gingival margins of teeth 3 to 5 and 12 to 14.

Tooth

The narrowness of the patient's facial features dictated that the teeth, especially the central incisors, not be made any longer (Fig. 5). However, the angularity of the patient's facial features made it desirable to keep the angular anatomy in the teeth.[1]

PERIODONTAL CONSIDERATIONS

The patient had a chronic endodontic failure of tooth 8, with an existing buccal fistula. From a periodontal perspective, there was minimal overall probing depth except for a