

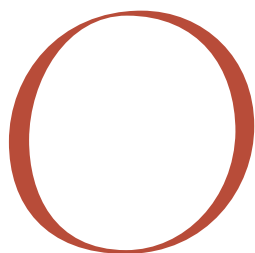


The Esthetic Correction of Anterior Dental Mal-alignment Conventional vs. Instant (Restorative) Orthodontics

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ABSTRACT

Creating a flow sheet may assist in the decision whether to use conventional orthodontics and what the limitations of treating the patient will be if treatment is performed without any orthodontics. The decision process can be viewed as a series of questions, and depending upon the answer to the questions, the practitioner and patient can decide on whether to involve orthodontics or not. Questions can create a framework to help separate the patients who would benefit from orthodontic intervention from those we all enjoy treating who can be managed with purely restorative care.



Over the last two decades, nothing has changed the way dentistry is practiced as much as endosseous root form implants and adhesive dentistry.¹⁻⁶ When introduced to the profession, both technologies provided the ability to restore patients in more conservative ways, leaving more natural teeth minimally altered. Over the 20 years that have followed their introduction, both technologies have suffered from, at times, overuse. With therapists deciding that implants were so successful, why not remove more teeth and use more implants. To the extent that on occasion patients who would routinely have been treated with periodontics and restorative dentistry in the past now are being treated with full mouth extractions and implant reconstructions.

This same phenomenon has also been applied to adhesive dentistry, particularly bonded porcelain, and especially in patients with problems of mal-alignment where conventional orthodontics would have been used in the past. Now “instant orthodontics” is being performed routinely with bonded porcelain. In fact, in every major city in the country, one can look in the Yellow Pages and find a dentist offering “Two

appointment orthodontics.”

It is now commonplace to have at least one publication a month arrive at the office showing a patient with unrestored teeth receiving 10 or 20 bonded porcelain restorations correcting a problem of alignment.

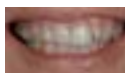
The purpose of this paper is not to judge whether all of these treatment plans are right or wrong, as I spend the majority of my practice time performing bonded porcelain restorations to alter patients appearance, but to create a flow sheet to aid in making the decision on whether conventional orthodontics should be used, and what the limitations of treating the patient will be if treatment is performed without any orthodontics.

The decision process can be viewed as a series of questions, and depending upon the answer to the questions, the practitioner and patient can decide on whether to involve orthodontics or not.

■ **Question 1. Will the teeth need to be restored to satisfy the patient’s esthetic desires whether orthodontics is performed or not?**



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Figures 1 and 2. A patient who desired an esthetic correction of her smile. Even if orthodontics had been performed to correct alignment, the teeth would still have needed restorations to improve their appearance and condition.



Figure 3. The completed restorations on the patient in Figures 1 and 2. Because all the other considerations were acceptable, the alignment correction was managed with the restorations.



Figure 4. An adult who required restorations on her peg-shaped lateral incisors and had impacted permanent canines. The maxillary esthetics and canine replacement could be managed restoratively, but the occlusal relationship, particularly the anterior crossbite and natural canine guidance, could only be corrected with orthodontics.



Figure 5. The patient from Figure 4 following exposure of the impacted canines and orthodontics to bring them into correct alignment and correct occlusion. (Orthodontics courtesy of Dr. Vince Kokich.)

tionship of the anterior teeth (**Figures 4 and 5**). This is especially true of patients with inadequate or excessive overbite or overjet or single tooth anterior crossbites.

For the restorative dentist, the most common occlusal problems encountered when desiring to restore the maxillary anterior teeth to a new length are a lack of room due to inadequate overjet, particularly in cases of excessive wear or a concern that the new longer restorations will create an excessively deep overbite that may result in fracture of the porcelain.

Equally common is the restorative dentist's thought process in solving these problems of space, which typically involves a desire to increase the vertical dimension of the occlusion. Often a measurement is made from the CEJ's or gingival margins of the maxillary central incisors to the mandibular central incisors, to determine if this distance is decreased below the average of 18 to 20 mm to decide if a vertical opening is required to regain lost vertical dimension.^{10,11} Unfortunately, all that this measurement evaluates is the state of eruption of the maxillary and mandibular anterior teeth, not the vertical dimension of occlusion. Unless the posterior teeth, particularly the molars, show significant wear or are lost, it is highly unlikely that the patient has lost vertical dimension.

So why not increase the vertical restoratively? Primarily because of the cost to the patient and the need to re-

This is a critical question to answer. If the teeth will need to be restored because of existing restorations, poor tooth size or shape, or color problems uncorrectable with bleaching, then orthodontics will have to provide some other significant benefits in order to be chosen to correct mal-alignment. If, on the other hand, the teeth would not require restorative treatment other than perhaps bleaching and re-contouring following orthodontic treatment, there are compelling reasons to do conventional orthodontics and leave the teeth unrestored.

As good as our current techniques and materials are, there is certainly no evidence that restorations will survive a lifetime when placed in young individuals.⁷⁻⁹ Because of this, the expediency of the quick fix must be weighed against the long-term consequences of preparing teeth in patients who would not require restorations if convention-

al orthodontics was performed.

On the other hand, if the teeth need restorations even after orthodontics, the treatment planning process becomes an issue of whether an acceptable result can be achieved by the restoration alone, or if it will be necessary to utilize both orthodontics and restorative dentistry to create the desired esthetic outcome.

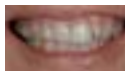
Will the teeth need to be restored whether orthodontics is performed or not?

Yes? Go to Question 2 (**Figures 1 through 3**).

No? Orthodontics is the preferred treatment plan.

■ **Question 2. Can the occlusion be managed without orthodontics but with restorative dentistry?**

Often times restorative dentistry can solve the esthetic problems of maxillary and mandibular anterior teeth but cannot correct the occlusal rela-



Figures 6 and 7. A patient with severe attrition of his mandibular anterior teeth and what appeared to be a loss of vertical dimension of occlusion.



Figure 8. A measurement made from the CEJ's or gingival margins of the maxillary to mandibular centrals, showed a distance of only 10 mm, appearing as a significant loss of vertical dimension. Examination of the posterior teeth showed no wear and an acceptable occlusion. Measuring from the gingival margins of maxillary to mandibular first molars revealed a normal vertical dimension of occlusion, the anterior measurement simply reflected secondary eruption of the anterior teeth due to severe wear.



Figure 9. Orthodontics was performed to intrude the lower incisors and level the lower arch after they were first built up. The upper arch was also leveled.



Figure 10. Final restorations consisted of four maxillary anterior restorations and four mandibular anterior restorations. The posterior teeth and vertical dimension remained unchanged. (Restorations courtesy of Dr. Gregg Kinzer.)

store posterior teeth which otherwise would require no treatment. How can orthodontics overcome the problem? If the problem is one of excessive overbite due to wear and anterior eruption, orthodontics can level the arches intruding the anterior teeth allowing the restoring dentist the ability to restore the anterior teeth and leaving the patients posterior teeth unrestored (Figures 6 through 10). If the problem is one of inadequate overjet, as in an end to end occlusion, the orthodontist can strip or extract mandibular teeth creating room for the mandibular anteriors to be retracted, creating a nor-

mal overjet to properly position or restore the anterior teeth, leaving vertical dimension unchanged. Another occlusal issue found commonly in cases of severe crowding is the inability to create any type of normal canine relationship in the occlusion even with full coverage restorations. Again, orthodontics cannot only resolve the canine relationship, but allow the restorative dentist to change from a very aggressive restoration to a conservative veneer, or no restoration at all.

Can an acceptable occlusal relationship be created with restorative dentistry alone?

Yes? Go to Question 3.

No? Orthodontics is preferred.

■ **Question 3. Is the most apical free gingival margin level esthetically acceptable?**

With the emphasis on esthetics that has occurred over the last 25 years, the relationship of gingival levels to appearance is now well accepted.¹² What does not seem to be as well understood, however, is why aberrations in gingival margin levels occur. That is, why are the free gingival margins at different levels on two central incisors in the same patient? What we know biologically is that in most patients the biologic width is constant for that patient around all teeth.^{13,14} Therefore, variations in gingival margin height must be due to differences in bone level or sulcus depth between teeth in the same patient. If recession of facial bone on one central has occurred so that its bone level is 3 mm apical to the adjacent centrals, it would not be surprising to see the gingival margin on the central with the bony recession also recede. What also can happen however, is to have the bone levels vary not because of bony recession, but because of differences in tooth eruption.

An example would be two overlapped central incisors, one to the lingual and one to the facial. The tooth to the lingual will always wear more than the one to the facial. And as it does, it will erupt bringing the bone coronally with it and resulting in a coronally placed gingival margin. Another possibility which can lead to aberrations in gingival margin heights, is to have the bone levels correct, but variations in sulcus depth between the centrals. The tooth with the shallower sulcus will have a more apically positioned gingival margin than the one with a deeper sulcus. This variation in sulcus depth is very common in cases of anterior tooth malposition. The more labially inclined teeth having thinner gingiva and a shallow sulcus, and the more lingually placed teeth

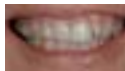


Figure 11. A patient sought esthetic correction of her anterior teeth. The central incisors and left lateral would require some restorative treatment whether orthodontics is performed or not. The occlusion is acceptable and the most apical free gingival margin, which is on the left central, is acceptable. The tissue on the right central and left lateral is coronally positioned relative to ideal.



Figure 12. Note, in the incisal view, how the free gingival margin levels correspond to the labial lingual position of the teeth in the alveolus. The right central having tissue more coronal due to its lingual position and the left lateral having more coronal tissue than the right lateral, even though it has had a crown placed which attempted to correct the lingually positioned root.



Figure 13. A gingivectomy was performed on the right central and left lateral to correct their tissue levels esthetically. Whether or not bone removal will also be necessary will depend upon whether the tissue levels were incorrect, due to variations in the vertical eruption of the teeth which created discrepancies in the bone, or if the bone levels are correct and the variations in tissue existed due to differences in the sulcus depth due to labiolingual differences.



Figure 14. To determine whether variations in the bone or sulcus depth created the original discrepancies in tissue level, sounding with a probe to bone can be performed. Note on the left central incisor, which had the more labial position and did not have a gingivectomy, that the tissue is 3 mm coronal to bone which would be normal for most patients.



Figure 15. On the right central, 1 mm of tissue was excised to correct tissue level, yet sounding reveals a 3 mm depth. This means that prior to the gingivectomy, the tissue was 4 mm coronal to the bone and had a 2 mm sulcus as opposed to the 1 mm sulcus of the left central. This variation in tissue height above bone can be explained by the differences in labiolingual position.



Figure 16. On the left lateral, 3 mm of tissue was removed to correct the gingival level. Sounding depth still reveals 3 mm of tissue coronal to bone. This means that prior to the gingivectomy there was 6 mm of tissue coronal to the bone and 4 mm sulcus due to the lingual root position.



Figure 17. This photo is of a patient following gingivectomy, tooth preparation and provisionalization. The challenge, however, remains root position. The restorations have corrected the coronal alignment, but the roots of the right central and left lateral are still lingually positioned. This has a high potential for the gingiva to rebound coronally negating the esthetic benefits the gingivectomy has provided, and may require that periodically the tissue on the right central and left lateral will need to be excised to maintain pleasing esthetics for the patient. While this is not a biologic problem, it is certainly an annoyance for the patient. Orthodontically aligning the teeth prior to the restorations would have eliminated this problem.

having thicker gingiva and a deeper sulcus (Figures 11 through 17).

So what does all of this have to do with whether I use orthodontics or not? We all know periodontal surgery can alter gingival margins, and we also know it is much easier to remove tissue or bone than create it.¹⁵⁻¹⁷ So the critical question is, is the most apical free gingival margin level an acceptable one? Because if it is, then it will be possible to use either gingivectomies or osseous surgery to apically position the gingival margin heights on all the other teeth relative to the most apical tissue. If however doing that creates excessively long and thin looking teeth, then a new problem exists. While connective tissue grafting is very predictable and effective at covering exposed root surfaces, it is far less predictable at moving tissue coronally to cover enamel or ceramic on labially positioned teeth. So if the patient has a high smile line and the most apically positioned free gingival margin is unacceptable due to a labially positioned tooth, orthodontics to reposition the teeth and tissue is the most predictable solution.

Orthodontics can also be used to correct the other situations described. A coronally positioned gingival margin due to a lingually positioned tooth and deep sulcus can have the tooth correctly positioned and the gingiva will thin to a normal thickness sulcus depth and



Figure 18. This patient presented after reading about cosmetic dentistry and desired the restoration of all her maxillary teeth to change their appearance. She also made it clear she desired a near-perfect final result. Her left central was the only anterior tooth that would require restoration, other than some incisal bonding on the right lateral and central, if she did orthodontics. A review of her papilla levels however quickly changed her mind. Due to the rotated left lateral, the papilla between the lateral and central is apically positioned due to the small gingival embrasure. Restoring the teeth cannot move the papilla coronally and will result in a very long contact.



Figure 19. From the incisal, the rotation of the lateral and the narrowing of the embrasure is obvious.



Figure 20. Because the bone level was correct, when orthodontics corrected the rotation following placement of a correctly shaped temporary on the left central, the papilla returned to its normal level. Following orthodontics the only restoration placed was the replacement crown on the left central and direct bonding the incisal edges of the right lateral and central.

level. Finally, a tooth in labial version with slightly apical thin tissue and a shallow sulcus can be correctly positioned with the gingiva thickening, getting a normal sulcus depth and level.

As an aside, it currently is very popular to sculpt the free gingival margins using a laser or electro surge to ideal levels during cosmetic restorative procedures.¹⁸ This results in a far more pleasing final result esthetically. However, the practitioner must identify the cause of the gingival aberration prior to selecting the mode of treatment for the gingival levels. If the problem is one of bony levels, then flap surgery and osseous re-contouring will be necessary to provide biologic health and tissue stability. If the problem is excessive sulcus depth due to a lingually positioned tooth, then sculpting the tissue will be biologically acceptable. But since the tooth is in lingual version a significant amount of tissue re-growth may occur, and it may be necessary to periodically re-trim the

tissue to maintain the ideal appearance. Orthodontically repositioning the same tooth can alleviate the problem (Figures 11 through 17).

Is the most apical free gingival margin level acceptable?

Yes? Perform surgery to correct tissue and go to Question 4.

No? Can it be covered with grafting? No? Orthodontics is preferred.

■ **Question 4. Are the papilla levels harmonious?**

Similar to free gingival margin levels, the papilla levels are critical to the overall esthetics of anterior teeth.¹² Papilla that are too far apically positioned either result in an open gingival embrasure (black space) or the development of an excessively long contact and subsequent rectangular looking teeth. Three factors come into play in establishing papilla levels. Underlying bone level, the patient's biologic width, and the gingival embrasure form and size. Of these, the patient's biologic width will be relatively constant for

them, but bone level and embrasure form can vary dramatically with tooth eruption. This can create a significant esthetic challenge for the restorative dentist. In general, unless the patient has had wear or excessive overjet and secondary eruption, the bone interproximally is rarely positioned too far coronally. And, unless the patient has had periodontal disease, the interproximal bone is rarely too far apical. This means that in most cases which present for cosmetic procedures, variations in papilla level will be related to embrasure form. The interesting thing to note, is excessively large embrasures, as in the presence of diastemas, can result in papillae that are apically positioned.

Excessively small embrasures, as can happen in overlapped or rotated teeth, can also result in papillae that are apically positioned. The key question then becomes, is the most apically positioned papillae acceptable? That is, will its position result in an excessively long contact and disharmony of coronal form which is esthetically displeasing? If the answer is yes, then orthodontics is the only option to correct it.

Currently there are no periodontal surgery procedures which can increase the height of interproximal bone, or grow predictable interproximal soft tissue. But, orthodontics can erupt teeth to move interproximal bone coronally, close diastemas to move soft tissue papillae height coronally, or align overlapped teeth allowing the papillae to move to the normal coronal position above the bone. Of these examples, the case of significantly mal-aligned overlapped teeth is the one most often benefiting from orthodontics to correct papillae levels. Typically, cases of multiple diastema may not have normal papilla heights, but heights of all the papillae are even. Therefore, the final result is harmonious, just with slightly larger contacts than if the diastema were closed.

Mal-aligned teeth however, are a significantly different problem. Some embrasures are normal with normal papillae height, others are very small



Figure 21. This patient, a dentist, desired the restorative correction of his teeth mal-alignment rather than orthodontics. The teeth would need restoration to achieve his esthetic goals whether orthodontics was completed or not. The occlusion could be managed without orthodontics. His high lip line didn't show the discrepancies in free gingival margin levels, and the papilla levels, which did show, were acceptable. However, to bring the left lateral into alignment would virtually guarantee pulpal involvement during tooth preparation, and subsequent endodontics.



Figure 22. This occlusal view shows the labial positioning of the left lateral. When presented with the option of endodontics versus short-term orthodontics, the patient chose orthodontics.



Figure 23. Following stripping of the teeth, five months of orthodontics achieved the alignment shown.



Figure 24. The final result now consisted of conservative porcelain veneers from first premolar to first premolar except for the right lateral incisor, which had the pre-existing crown.

while this may be a useful tool for doing a wax up or set up, it can fall short of creating ideal esthetics in patients with diastemas or crowding. The reason for this is quite simple. The golden proportion creates a proportionate relationship of the teeth relative to their widths.

This seems logical, but the evidence is clear that different anterior teeth carry more weight in the patient's assessment of esthetics, particularly the maxillary central incisors. While conversely, the maxillary lateral incisors can have large variations in their width and still be judged esthetic as long as they are symmetrical. This concept is especially true in developing the plan for patients with an extreme amount of excessive space or crowding. In either case, the golden proportion will apportion the space to a percentage, which on one extreme may create very large centrals and on the other, very small centrals. It is esthetically more pleasing to create ideal proportion to the centrals for either case and allow the laterals to be wider or narrower than ideal. The proportionate centrals will create the illusion of a pleasing smile, while the misproportioned laterals will rarely be noticed if they are symmetrical to each other.¹²

Can an acceptable contour and arrangement be created?

Yes? Go to Question 6.

No? Orthodontics is preferred.

■ **Question 6. Are the structural compromises necessary to correct the alignment acceptable?**

due to overlap and with significantly apically positioned papillae. In these patients, if orthodontics is not performed, there is often significant disharmony of contact length and final coronal form (Figures 18 through 20).

Are the papilla levels harmonious?

Yes? Go to Question 5.

No? Orthodontics is preferred.

■ **Question 5. Can an acceptable contour and arrangement be created?**

This is really a question of coronal width and length. In my role as an educator, this is the question I get most often concerning instant orthodontics. A student will approach me carrying a photograph or model with either large diastemas or severe crowding, and say, "Do you think I need to send the patient to an orthodontist?" What they are really asking is, can I make these teeth look good given their existing position and alignment? My response to the question is always the same. That is, without drawing my desired tooth form on a photograph, or doing a diagnostic wax-up on the model, I don't know. Having said that, I believe a few comments are appropriate concerning

contour and arrangement.

First, let's start with patients with multiple diastemas. This occurs for two reasons. Inappropriately small natural anterior teeth or normal teeth with an excessively large arch form. The two may be very different to treat. The patient with diastemas due to small teeth, is almost always best treated with restorative dentistry whether any orthodontics is done or not. The patient with normal size teeth but a long arch form, can often be treated either way, with restorative alone or with orthodontics alone. The key to answering either question is to perform a diagnostic wax up or set up on mounted models. The other extreme is the patient with severely overlapped and crowded teeth. This patient commonly presents biologic and structural problems as well which we will address in the next question. The esthetic question that must be answered for both the patient with diastemas or crowding is, how will the teeth look if they are restored in their current position? It is common to read articles discussing the use of the "golden proportion" in planning treatment for patients with mal-alignment.^{19,20} And



One of the great strengths of bonded porcelain is its conservative nature compared to conventional full coverage restorations.⁴ When mal-alignment is being corrected, the tooth preparation must get significantly more aggressive and the labially positioned tooth having significant amounts of labial reduction done to bring it into line, sometimes requires a near amputation of the existing coronal form. The more lingually positioned teeth need significant lingual tooth preparation to avoid an excessively thick incisal edge and rotated teeth may need a combination of significant labial and lingual reduction on mesial and distal to accomplish the desired alignment. This issue of varying amounts of tooth preparation brings up an interesting challenge in determining what is or is not an acceptable treatment plan. Classically, dentistry has always espoused the most conservative

treatment possible for any tooth, yet there are not clear cut guidelines to suggest a particular preparations reduction will create "X" percentage change in success.

It does seem prudent however to add the patient's age and current dental condition into the equation when answering this question. The younger the patient and the fewer restorations currently, the more the desire to stay conservative with our tooth preparations.

Can an acceptable contour and arrangement be created?

Yes? Go to Question 7.

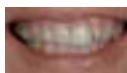
No? Orthodontics is preferred.

■ **Question 7. Are the biologic consequences of correcting the alignment restoratively acceptable?**

This question really has two components. The pulpal and the periodontal. If the desired contour will require a tooth preparation which exposes the pulp, or

amputates the pulp and coronal tooth structure, strong consideration must be given to treating the situation with orthodontics. As good as we believe our pulp caps or endodontics procedures are, they definitely are not 100 percent.²¹⁻²³ And, in a young individual, elective endodontic therapy and a foundation restoration may impact whether or not the tooth lasts for the patient's lifetime (**Figures 21 through 24**).

The periodontium is a different issue. It has two distinct components to how it may be adversely affected with a restorative correction. First is the issue of gingival health and contour. Anytime a rotated or lingually positioned tooth is being corrected restoratively, there is the potential for significant alterations in emergence profile.²⁴ This may or may not have an impact on gingival health. What certainly has



the potential for negatively impacting the periodontium is the restorative alignment of severely overlapped teeth. As the teeth overlap, the contact moves apically. As the contact moves apically, the risk of violating the biologic width when preparing the teeth and getting subsequent inflammation increases. This occurs when we attempt to separate the contact cervically with our tooth preparation because the contact has moved apically due to the overlap. Simply separating it with a bur has a high likelihood of placing the margin in the attachment. Note the apical position of the contact between the left central and lateral in **Figures 18 and 19**, as an example.

Are the biologic consequences correcting the teeth restoratively acceptable?

Yes? Perform instant orthodontics using restorative dentistry.

No? Orthodontics is preferred.

So the ideal "Instant Ortho" patient would: Need the teeth restored whether ortho was done or not, will have an ideal occlusion without any orthodontics, has free gingival margin and papilla levels that are manageable non-orthodontically, can have a pleasing and esthetically acceptable contour and arrangement without orthodontics, and finally, the tooth preparations required wouldn't mutilate the teeth structurally or biologically. What is amazing is how many patients meet these requirements and truly are good candidates for a non-orthodontic esthetic correction. What is equally amazing is how often I see patient treatment where these parameters were violated and the patient or dentist are trying to figure out why the ceramic fractured, prep broke off, tissue got red, or overall esthetic result is mediocre and asymmetric following a restorative only correction.

The purpose of this paper has not been to condemn or promote the orthodontic or non-orthodontic approach, but rather to highlight the criteria by which we decide how to evaluate and proceed with the multiple treatment options

available. With the clinical parameters described above, I'd like to discuss the other non-clinical reason that dentists use for not performing orthodontics. "The patient didn't want orthodontics." As my orthodontic colleague Vince Kokich says, "Nobody wants orthodontics." And, I believe that this is absolutely true until the patient gets presented the legitimate benefits and consequences of each approach. I refer to this as the Pro vs. Con list for each method of treatment. And I would encourage you to create a written list and present it to the pa-

What is amazing is how many patients meet these requirements and truly are good candidates for a non-orthodontic esthetic correction.

tient detailing the risks and benefits of each method of treatment, orthodontic and non-orthodontic. Essentially, this list is an informed consent sheet for the purpose of treatment. An example may look like this:

Orthodontics

- Pro
 - Less money
 - Fewer restorations
 - No root canals
 - No perio surgery
 - Non-orthodontic

- Con
 - Time
 - Retainer after treatment

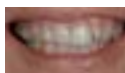
- Pro
 - Less time

Con

- More money
- More restorations
- Aggressive tooth preparations
- Perio surgery

I grant you the above example looks very biased toward orthodontics, and yet it is a very real example of what I commonly see in practice. I can tell you that after having the pros and cons outlined for them, patients who didn't want orthodontics suddenly decide it might not be so bad. And, after this presentation, an interesting secondary benefit occurs. The patient recognizes that you just presented to them a very honest assessment of what's possible and in some instances sold them on not having you do the treatment. That level of commitment to their well being creates a high level of respect toward you and the referral of everyone else they know who may be considering esthetic care. Among those people will be plenty who do need esthetic care without orthodontics and will trust what you tell them because of the reputation and integrity that you have developed within your community for putting their health above monetary gain. The great paradox is that as you seemingly send some treatment away, the ultimate gain is you get more treatment to do than you ever would have had by performing excessive or inappropriate treatment on one patient and having it fail. I'm not saying this occurs overnight, but practices are built over years by a clear sense of core values that are adhered to even when there is an initial desire to bring in more money.

In conclusion, this paper, as I stated in the beginning, was not written to condemn "Instant Orthodontics" as I enjoy performing it as much as anybody. But, in this author's opinion, it is being performed excessively in many patients' mouths who would need little or no restorative care with orthodontic intervention. Even worse, it is being performed unsuccessfully relative to the longevity or health of the result. It is my hope that the ques-



tions above can create a framework to help separate the patients who would benefit from orthodontic intervention from those we all enjoy treating who can be managed with purely restorative care. **CDA**

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