

# Aesthetic Correction for Severe Gum Recession

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**T**here are times when a patient presents in our practices with dental problems that may initially confuse us. How can a dentist restore a compromised dentition without disappointing the aesthetic aspirations of our patient?

Creative treatment planning using dental technologies from different dental specialties often leads to results that we wouldn't think possible just several years

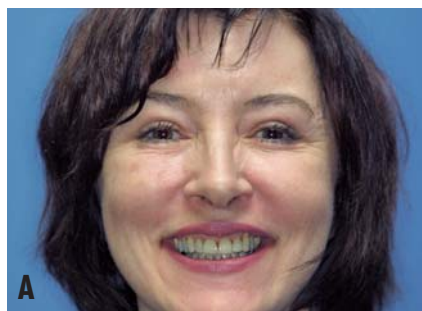
ago and make us proud of our restoration and what we have done to change someone's smile and self-confidence.

Our patient presented with generalized moderate periodontal bone loss, significant gingival recession on the upper right canine and a severe gingival recession on the upper left canine (Figs. 1A-C).

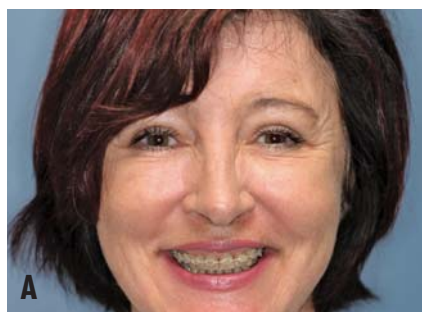
Although she accepted the fact

that her dental state was a result of her own neglect, at 50 years of age, she was mentally discouraged because the treatment plans she had been previously presented ranged from full mouth periodontal surgery and crown and bridge of the "piano key variety" to the extraction of all her upper teeth and a full upper denture.

Rather than do something she believed she would regret, she



**FIGURES 1A-C**—Patient presented with generalized moderate periodontal bone loss, significant gingival recession on the upper right canine and a severe gingival recession on the upper left canine.



**FIGURES 2A-C**—Illustrates the placement of the gingival grafts and the subsequent extrusion of the canines. It is important to create an adequate band of attached gingiva to aid in the orthodontic extrusion and to reposition both gingival and bone levels.

ected to do nothing up until this point. The breakdown of the interdental papilla and the beginning of the appearance of what is frequently referred to as the “black triangle” between the anterior incisors is an indication of underlying bone loss. A composite restoration was placed on the root surface of the upper left canine to further complicate the ability to achieve root coverage with gingival grafting.

Visually, the central incisors were short with a crown to root ratio of 1:1 (7.75mm x 7.75mm). We know a ratio of 70-75 percent to be ideal so if we use periodontal surgery creatively to raise our

gingival level, we begin to diminish the discrepancy between the anterior and cuspid gingival level. To reposition the gingival margins of the canines, we choose to initially place free gingival grafts and then use orthodontic extrusion to create gingival level harmony.

After four months of periodontal healing, final impressions were taken of our preparations and provisionals. The patient has now had several months to preview her new look and make any changes if needed. The laboratory will fabricate templates of the model of our provisional restoration so that the final all porcelain

restoration will duplicate the aesthetics, incisal embrasures, thickness and contours of the temporary. This will help to ensure that the patient will like the final restoration. They will just be a higher quality version of the provisionals. **OH**

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**FIGURE 3**—Once our canines are in a satisfactory position, we take study models and create a diagnostic waxup to serve as a template for our final projected restoration.



**FIGURES 4A-B**—We then prepare and temporize the teeth at the desired position specified by our waxup. We may use a laser, electrosurge or blade to place our margins where we want them irregardless of where the alveolar bone is. Aesthetics is the criteria and we can sculpt papilla in the gingival tissue, align gingival levels and place teeth in harmony within the golden proportions. Periodontal surgery is performed at this point and the periodontist utilizes the positioning of our temporaries to recreate biological width and repair bony defects according to the projected aesthetic results. If the periodontics was to have been performed before the temporization, we may have been left with a lack of interdental papilla, black triangles and irregular gingival architecture.



**FIGURES 5A-C**—The final Empress (Ivoclar, Amherst, NY) were then fabricated using a multilayering technique. A TC1 ingot was chosen for the basic shade as the patient’s teeth were in the Vida A range. Some neutral and clear porcelain was fired around the margin to make them appear invisible. The teeth were etched, bonded with Excite (Ivoclar, Amherst, NY) and Variolink (Ivoclar, Amherst, NY) was used to lute them. The occlusion was carefully adjusted, oral hygiene instructions were given and the patient was placed on three months maintenance.