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Dr. Michael DiTolla practices in two locations, both of which emphasize esthetic dentistry and orthodontics. A nationally recognized lecturer on practice management for esthetic practices, and editorial board member for Contemporary Esthetics, he also lectures regularly for P.A.C.-live, a hands-on esthetic program that allows dentists to treat live patients.

In the early days of esthetic dentistry, the majority of anterior porcelain restorations were placed without too much thought given to the surrounding gingival tissues. A patient would come to us, interested in improving her smile, and to most of us that meant improving the appearance of her teeth. Periodontal surgery in general, specifically crown lengthening, was thought to be strictly a posterior procedure. For decades, the gingiva was thought of as a place to hide a metal margin. But, as we started to evaluate the before and after photos of our anterior cases, it became clear that we not only needed to pay attention to the gingiva, but that we also needed a predictable way to sculpt the tissue to achieve the optimal esthetic results desired by our patients.

The world's best looking crowns or veneers cannot make up for clinical crown lengths of the central incisors that are off by 1 mm as a result of a difference in gingival crest levels. In the past, at the try-in appointment, patients often would say that one central incisor looked shorter than the other central incisor, and many dentists would check the incisal edge position of the centrals and tell the patient that the teeth were the same length. In reality, the patient perceived the difference in the length of the clinical crown, and before we began recontouring gingiva, the only place to adjust the length of the tooth was at the incisal edge.

Today, we realize that there is much more to a pleasing esthetic smile than simply the teeth. Drs. Young and Margeas demonstrate this in their article. I have always noticed that the most stunning before and after esthetic changes tended to be those involving some degree of gingival recontouring—as in the gummy smile case. A patient who expresses dissatisfaction with his or her smile, saying that the teeth are too short, may in fact be complaining of a gummy smile. It bears repeating that even a perfect set of veneers cannot save an esthetic case in which the excess gingival tissue has not been adequately dealt with. On the other hand, correcting gingival problems to an ideal can make up for less than perfect veneers. One of the reasons we still love before and after albums is that they allow us to show patients how and why gingival recontouring can make all the difference in the world.

In our office, when we realize that a substantial amount of gingival recontouring will be required to satisfy both my esthetic requirements and the patient's, we will often ask the laboratory to make a composite stent at the new gingival level and shape. In other words, I will draw a line on the study model indicating where the new gingival heights and contours are expected to be. The laboratory then builds a facial composite stent that conforms to the new outline, and we try the stent into the patient's mouth to evaluate the new length of the teeth.

When the patient smiles with the stent in place, she can almost immediately see how nice her smile will look, once more tooth and less gingiva are visible. Often, we will take a picture of the patient smiling with the stent in place—for both our use and the patient's. If a periodontist is going to do anterior crown lengthening for you, send the composite stent to the periodontist so it can be tried on the patient's teeth during surgery to verify where to position the gingival margins.

Additionally, if there is a minor amount of gingival recontouring to be done, we will often perform this procedure at the preparation appointment and use the direct provisional technique to bring the margin of the provisional veneer to the new gingival margin, to help keep it in place during the 2 weeks of provisionalization. A simple case would involve 1 mm to 2 mm of reduction with no violation of the biological width, so osseous recontouring would not be necessary to achieve the desired gingival outline. If we perform the recontouring, we add that fee to the overall case fee, although it usually averages about $150 per tooth. If the recontouring is done by a periodontist, it is preferable to have that procedure done 3 to 4 weeks before the preparation appointment, to allow the gingival tissues to heal completely at their new levels. You may still need to do some very minor adjustments at the preparation date with either an electrosurgery unit or a laser.

There are few among us who can look back at many of our anterior cases and not see results that were compromised because little or no attention was paid to the gingiva. And, while some dentists might find it disturbing, I have enjoyed the few occasions on which a patient decided not to have veneers done after having gingival recontouring with a periodontist, as an increase in clinical crown length had been the main esthetic concern. Those cases, while few and far between, have always reinforced to me the importance of gingival levels to overall cosmetic success. When having your laboratory do the diagnostic wax-up for your veneer case, be sure to let them know about your plans to perform gingival recontouring, or they will be forced to add any necessary length to the incisal edge. The difference between ideally sized centrals with minimal gingival show, and unesthetic centrals growing from 4 mm of excess gingiva, truly can make all the difference in the world. ○

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