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Dr. Michael DiTolla practices in two locations, both of which emphasize esthetic dentistry and orthodontics, an essential component of esthetic dentistry. He is a nationally recognized lecturer on practice management for esthetic practices, and he serves on the editorial board of Contemporary Esthetics and Restorative Practice. *He also lectures regularly for P.A.C.-live, a hands-on esthetic program, which allows dentists to treat live patients.*

Dr. Pinero has taken on a case that many general practitioners would shy away from, probably telling the patient that there was nothing that could be done to improve the patient's appearance. In fact, six other talented dentists did refuse treatment to this patient.

Fees for Challenging Cases

If you decide to accept a challenging case like this, one of the difficulties is determining a fee. In addition to the typical fee for the specific restorations and procedures, there should be a 20% to 30% rehabilitation fee to encompass all the unknowns. I prefer to use a floating fee structure for a case like this. I give the patient a range for final fee, based on complexity, additional procedures, and additional laboratory needs. Attempting to set a flat fee for a case this complex, as you might for a typical veneer case, makes it far too easy to either undercharge or overcharge the patient. Patients who will accept treatment at $22,000 will also accept treatment at $28,000, but it is better to present the fee as a range, rather than quoting $22,000 and having to ask for an additional $6,000 later.

In this case, the use of an orthodontic orthotic in conjunction with occlusal equilibration, laser-assisted crown lengthening, gingival shaded composite on the provisionals, and the need for a bisque bake try-in to check occlusion and gingival shade, all justified quoting a fee range.

Solve the Occlusal Problem First

As Dr. Pinero mentioned, if he hadn't solved the occlusal problems first, he would have set himself up for esthetic failure. The eight maxillary anterior veneers placed on this patient would have been doomed to early failure if his occlusal scheme had not been corrected. Many dentists incorrectly believe that they have had bond failures when anterior restorations have failed, when in reality the failure was the result of ignoring the function of the tooth before making the esthetic change. In addition, had Dr. Pinero not addressed the occlusal problems first, the patient would have continued to have gingival recession in the absence of periodontal disease, which almost certainly would have led to an esthetic failure down the road.

Orthodontics for Prevention

This patient's occlusal problems remind me of why we provide early orthodontic treatment in our office; we want to prevent these types of cases from getting this advanced. If this patient's maxilla had been properly developed and other functional problems addressed while he was young, it is safe to assume that his mandible would not have been restricted or trapped posteriorly. (In fact, it's amazing that this patient did not developed temporomandibular joint symptoms, which would have further complicated treatment.) In addition, with a more harmonious occlusion, the patient probably would not have developed this amount of gingival recession or all of that parafunctional wear.

Arch and skeletal discrepancies are often corrected routinely if treated while the patient is still growing. Even if you do not plan on providing orthodontic and orthopedic services to your patients, you owe it to them to take a course that allows you to accurately diagnose, treat, and refer patients appropriately. Dr. Pinero was able to treat the occlusal problems with an orthotic repositioning appliance, to find the position for the mandible in which the patient's occlusion and musculature became asymptomatic, and then adjust the occlusal scheme to allow the patient to keep his mandible in that position. Only then could Dr. Pinero begin the restorative phase of this case.

Patient Involvement

I applaud Dr. Pinero for involving his patient in the decision about using mucogingival grafting to improve the final esthetic result, which the patient declined. When an optional procedure can effect the overall esthetic outcome of a case, it is absolutely essential that the patient make the decision. Dr. Pinero also did his overhead a favor when he and the patient decided to do all the restorations in one appointment. Obviously, with a case this complex and a fee this high, it is perfectly acceptable to reschedule other patients and make this the only patient you see that day.

Technique Gems

Dr. Pinero gives us two real gems in this article. The first is his use of a gingival-shaded flowable hybrid composite on the directly fabricated provisional restorations. If you have always hated the provisionalization of anterior cases, try Dr. Pinero's Revolution technique™, which uses a vaccuform splint. This technique not only prevents having to reline lab-fabricated temps, which may or may not adapt well to the preps, but it also gives you the great esthetics of composite as opposed to acrylic.

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The second gem concerns a problem nearly all of us have had: gingival bleeding after etching the enamel margins of the prep. This can happen just as easily on veneer cases as it can on proximal boxes in the posterior. Dr. Pinero uses a spray-on thrombin solution to stop the bleeding, and in Dr. Pinero's own words: "This solution has revolutionized the luting phase in my practice." I can't wait to try it before impressions as well, providing it doesn't interfere with the setting of vinyl polysiloxane materials. It is critical to control moisture during the luting phase because one speck of blood can contaminate a margin and lead to staining, microleakage, and marginal discoloration in a relatively short period.

Making the Impossible Possible

Dr. Pinero uses a multidisciplinary approach to tackle one of the toughest esthetic cases this journal has ever presented. I particularly appreciate his patience in treating the occlusal problems definitively before tackling the restorative aspects of the case. His use of gingival shading both in the provisional and final restorations as a solution for a patient who refused periodontal grafting is a great example of how with enough planning, skill, and patience, the impossible can be made possible. ■