Un-cosmetic dentistry

Are you ready to reduce your dependence on porcelain restorations?

While there are some occasional references to concern about the overuse of porcelain, many articles in dental trade publications show off before and after dental makeovers that from my perspective were quite satisfactory prior to extensive intervention. I will not argue that there are people who truly have displeasing smiles and they can benefit greatly from cosmetic dentistry, but all too often people with underlying issues related to a distorted perception of their teeth seem to be easy victims.

“Smilexenia” is the fanciful term I coined for this disorder, which appears to affect mostly young women more than others. If you open the pages of any journal published by the American Association of Cosmetic Dentistry, you will find no one mentioning porcelain veneers as a frequent treatment that could easily have been avoided with unbiased professional advice. The problem is that too many dentists have dedicated their lives to pure cosmetic dentistry, which is often based on using porcelain as a cure-all.

Sadly, many of the cosmetic dentists recognised as the top tier appear to use their standing as a licence to drill. It is time to adopt a significant change in philosophy if the dental profession wishes to maintain any level of integrity. Lip service to conservative cosmetic dentistry means nothing. To truly practise “un-cosmetic dentistry”, a dentist must back away from ceramics and move in a direction to remove worn edges in combination with orthodontics to correct alignment.

This style of treatment does not have to be unprofitable. It does not have to be only for the simplest of cases either; actually, very complex cases can be treated to a high standard when multiple disciplines are employed together. The collaboration of specialists can be one alternative, but for patients on a budget or in areas with lower access, a general dentist trained in advanced therapies can offer comparable results for a fraction of the fee.

“Before-and-after” – The STO combo

Let’s cut to the chase: if you are a general dentist and want to shock your practice out of the park with new opportunities, look at venturing into the realm of advanced shorter-term braces. I specifically say “shorter” because your goal needs to be at least one or two of these patients having extensive veneer treatment that could easily have been avoided with unbiased professional advice. There is no need to drill on patients who dare to bracket teeth. I do not want to waste my time, and patients may be holding their jaw forward in a Sunday bite simply to get their uncomfortable braces off.

There are a number of dentists who promote STO, but I developed my own system before I had heard of any others so I have some different ideas. Frankly, levelling and aligning simple orthodontic cases is easy and can be learned through just a short course, which these dentists (Drs Swain, Barr or De Paoli) appear to teach very well. I would rather remain on the fringe of even these trend-setters, and offer my twisted perspective with less corporate influence.

As hugely popular as these STO courses are, there is however some potential for abuse by dentists who simply have a weekend course and no other training in orthodontics. While I would rather see a dentist do more orthodontics than veneering, orthodontists are partially justified for their concerns about GP orthodontics.

Taking courses alongside orthodontists and reading their journals, it is apparent that there is negative sentiment directed towards general practitioners who dare to bracket teeth. I do feel that a united profession is a favourable concept but, having experienced extreme levels of sabotage in my local area, I now refer less than in the past. Some other general dentists have mentioned similar problems (on online forums) with turf protection that appears oddly focused on orthodontics.

An article recently used the term “soft science” to describe orthodontics, and I would certainly agree that it is difficult to claim that orthodontists know the “right way to straighten teeth”, since few of them agree on anything. The reality is that the schools of thought in orthodontics are as polarised as the holy war between the myo-centric doctors and the centric relation believers.

As an example, the use of the Herbst appliance forces the TMJ forward, in an attempt to correct a deficient mandible. This is like someone standing on the balls of her feet to be taller. While the data, but the device has been used for 100 years already. Mandibular teeth are not stimulated to grow after all, and patients may be holding their jaw forward in a Sunday bite simply to get their uncomfortable braces off.

Orthognathic surgery may be vastly underutilised in some cases and overused in others. The use of TADS appears to offer some promise, and while an oral surgeon may find it a nuisance to bother with placing them, a general dentist may be able to get them in place with little difficulty. Orthodontists often tremble at the thought of using a needle (like I did in dental school), so the price goes up as the patient heads to the oral surgeon.

BIAS: A particular tendency or inclination, especially one that prevents unprejudiced consideration of a question; prejudice

So this article is obviously biased towards expanded skills for the general dentist, but I do respect the need to pick your battles in treatment and refer when the case demands it. I essentially do not believe in learning with any rubbish from specialists who want to dictate what a general dentist and implant cannot do. If you do not like my ideas, tough luck because the ones you have may not stand up under close scrutiny. I do not want to waste my time justifying anything I choose to do and if I am taking a course beside an orthodontist who is snivelling that he will start doing fillings and extractions, that is awesome; I may have an opening for an associate.

As excited as I am about STO, I think a two-day course is only a taste of what you need to know. It is like taking a two-day self-defence class and then thinking you can enter mixed martial arts. The problem is that what you learn, but the cases that you attempt that are actually much more complex than you realise (you will be defeated). You MUST take a full orthodontic course such as the one taught by Dr Richard Luft, and you are insane not to take a series of oral rehabilitation courses from Dr Frank Spear or Dr John Kois.

Adult orthodontics is full-mouth reconstruction, and the treatment of worn dentition is
Cosmetic dentists have a tendency to veneer everything. They veneer teeth straight because they think they can. They claim they can do that three to four years. They veneer teeth to get rid of wrinkles and holes. They will do 16 veneers and white them to whiten and straighten them. They veneer teeth because the old, worn dentition is so tender and sensitive.

My suggestion for breaking an aesthetic obsession is “cosmetic training really warped your thinking. You will find some dentists who do not have loupes or want to pay double for advanced microscopy. What patients do hate is composites that chip/stain. This brings me to use Clearfil AP-X PLT (Kuraray—no endorsement money yet). Free-hand composite bonding is the best way to be able to follow the contours of the teeth, so scrape the idea of using a wax-up as an instant makeover if orthodontics would be helpful.

The Clearfil shade XL appears to have a chamelion effect that works for most shades of teeth. If a lighter shade is desired, then a cut-back technique can be employed to modify the final appearance with another shade/materiel like 3M Supreme (5M ESPE).

From my review of the CRA/Clinicians Report literature, this brand of composite is particularly strong in clinical use, and I have heavily restored cases that were broken. I consider this a very good niche treatment. I have seen an orthodontist who was forced to retreat her teeth because of dental school, which brought back mixed emotions. I took away the idea of additive cosmetic strategies and the use of minimal reduction if choosing to use ceramic. Bonding to enamel instead of dentine still seems to be the better plan. (I also gave Dr Chiche a few photographs of John Lennon’s decayed molar and he shared the fact that he had an original photo of the Beatles that was lost in Katrina—I hope he finds the copy sometime soon!) As one of the first dentists to combine STO concepts with advanced treatment planning of the worn dentition, I can honestly say that if you can set aside the use of porcelain veneers and substitute some of the treatment modalities mentioned in this article, you will eventually find a way back to ceramic usage with a better empathy for patient care. The public is becoming wiser and the market is shifting towards dentists who are ready to mix up their training.

As my UK dentist colleague Dr Martin Kelleher, who lectures on “veneering” disease, would say, use the daughter test before you do anything irreversible.

I would add that you owe it to your patients to learn from the best in the game. Cross-training in continuing education may be the best investment you can make in dental practice.

### Contact Info
Dr Michael Zuk is the author of the book "Confessions of a Former Cosmetic Dentist." As a consultant to several marketing programmes, including Highspeed Braces.org and Aller Toothache.com, the dentist has cultivated unique niches as alternative to the veneer-based practice model. He can be contacted at drmichaelzuk.com.

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