Great expectations: treating both a colleague and a friend

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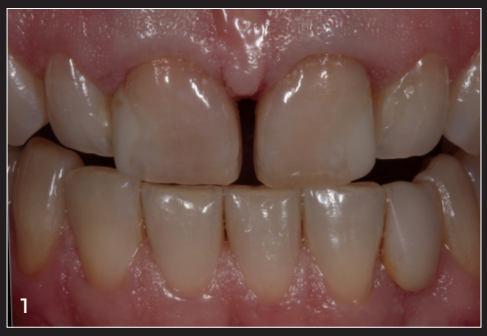
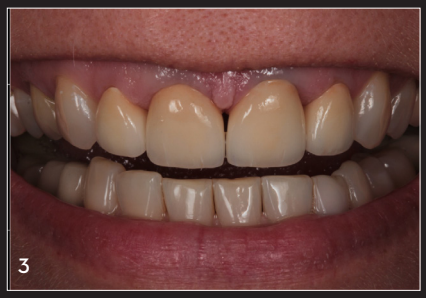
Every dentist knows that there exists an implicit emotional danger/uncertainty when it comes to treating family and friends. The gravity of these situations becomes amplified, exponentially, when the patient being treated also happens to be employed at the same workplace as the treatment provider.

So then, in these circumstances, what becomes of a definitive treatment that fails to live up to the expectations of the associate and friend that is under our care? As prosthodontists, we often continue to see our patients on a limited, long-term basis. The aphorism that we are "married to our patients with difficult/complicated situations" oozes sardonic humor when that discontented patient is also on the same payroll and works in the operatory down the hall.

Dental specialists tend to garner new patients based off colleague referrals and by word of mouth recommendations from existing patients. It is not altogether uncommon, however, to receive voluntary requests for treatment from in-house staff, hygienists, or even other dentists. While completing the final leg of my active duty service agreement in the U.S. Army, the dental assistant for my periodontist presented to me with just such a request. She indicated that she would soon be attending a family wedding in her home country of Poland, and that she was extremely self-conscious about the unesthetic appearance of her 'maxillary lateral and central incisors' (Figure 1).

During the initial examination, it was noted that teeth #8 and #9 had both undergone non-surgical root canal therapy many years prior, following a traumatic injury. Additionally, the existing composite restorations on





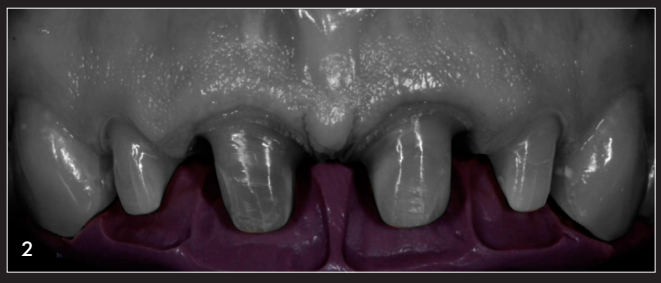


Fig. 1: Patient's initial presentation – discoloration of maxillary centrals resulting from trauma, non-surgical root canal therapy, and unesthetic composite resin restorations.

Fig. 2: Tooth preparations within vinyl polysiloxane "putty" matrix reduction guide fabricated from diagnostic wax patterns of teeth #7-#10.

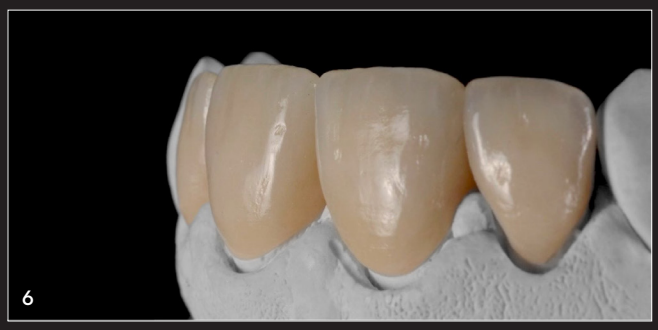
Fig. 3: Definitive full-contour porcelain fused to zirconia (PFZ) restorations, teeth #7-#10, demonstrating inappropriate opacity and value.

all four teeth had recurrent caries present. Treatment planning ensued, and considering the patient's parafunctional habits, compromised resin restorations, short clinical crowns, and high esthetic expectations outlined in her chief complaint, recommendations for a surgical crown lengthening procedure and full-coverage layered zirconia crowns were made.

All too often, financial issues, apprehension, and/or haste find a way to add a wrinkle into the best-intentioned treatment plans. The imminent overseas wedding celebration resulted in the patient deciding to forgo the recommended crown lengthening procedure for her case. Following diagnostic waxing, teeth #7-#10 were prepared for full-coverage crowns using a silicone template as a reduction guide (Figure 2). Poly(vinyl siloxane) final impressions were made, sent to the ceramist, and the crowns were then fabricated and returned for placement.

As is often the case for patients receiving esthetic anterior restorations, the initial trial placement of the crowns was unacceptable and required refinement. After further refinement, a second attempt was made during the following weeks, which again, resulted in another unacceptable result. The third and final visit was also marked by significant disappointment, and out of desperation (due to the time factor), the patient finally conceded/agreed to the process and allowed the four crowns to be cemented, noting that the restorations were "…at least better than what (she) had" (Figure 3). The high hopes that the patient held for the dentist (me) treating her ran parallel to the expectations that the dentist held for the ceramist fabricating the restorations: the result would be nothing short of spectacular. The final photographs and a frustrated patient are a clear testament to the fact that this expected end was not achieved.

In defense of all dentists who have ever endeavored to restore anterior teeth, not every case turns out to be worthy of being shown on the 'lecture circuit' or to be reported in peer-reviewed periodicals. And if we are being honest with ourselves, most treatments actually don't become showcase material. Humans, however, have a tendency to record the hits, and not the misses. Our assistants and colleagues recall the great cases, because after all, those are the special ones that we talk



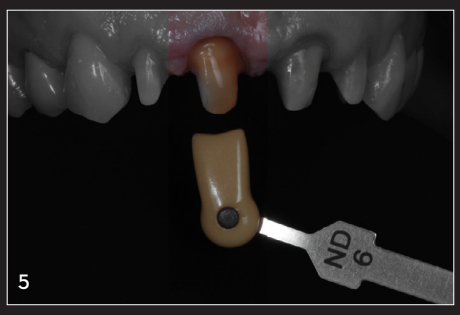


Fig. 4: Surgical crown-lengthening procedure being completed in anticipation of replacing the existing PFZ restorations with an improved esthetic result.

Fig. 5: Stumpf shade recording following tooth preparation.

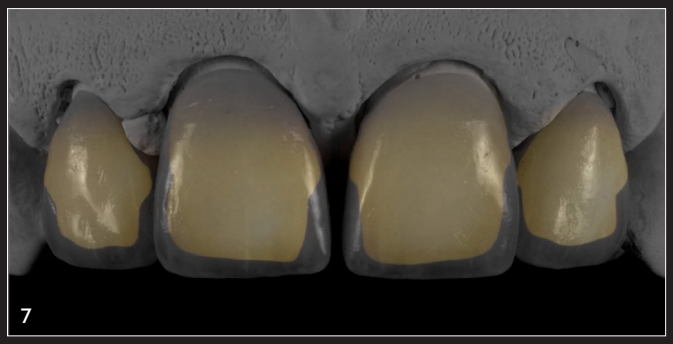
Fig. 6: New, definitive porcelain veneered to zirconia restorations on solid cast.

about over and over again, those are the ones that go in the smile gallery on the office webpage, those are the pictures that get framed and receive a place on the wall in the laboratory or the break room. Managing patient expectations is a skill in and of itself – in the same manner that administering anesthesia without discomfort is a skill or border molding a custom tray for a denture is a skill. It takes practice and experience to truly master – LOTS of practice and experience.

Fast-forward through four months of awkward interactions in the hallways and avoiding eye contact during clinic meetings, a message was received from a good friend and ceramist in Switzerland with whom I had confided my disappointment, offering to redo the crowns for the patient at no charge. The patient eagerly agreed, this time following through with the initial recommendations to crown lengthen her teeth (Figure 4). After a healing phase of six months, the initial crowns were sectioned off and the stumpf shades evaluated for each tooth (Figure 5). The proposed treatment the second time around remained the same: zirconia copings layered with feldspathic ceramic (Figures 6-7). The reason that a stumpf shade was indicated, despite the material selection, is due to the improvement in light transmission and the increased translucency of the zirconia used for this situation.

At the placement appointment for the new crowns, the patient was extremely pleased with the improved esthetic result (Figures 8, 9), and the potentially disastrous ramifications of a failed treatment existing between colleagues and friends were avoided. ■

Special thanks and appreciation in recognition of the dedication and charitable contributions made by my friend and master ceramist on this case, Mr. Djemal Ibraimi at i-Tech Dental Laboratory (Bulle, Switzerland), and also by my very skilled periodontist, Dr. Sheldon Lu at OC Perio Specialists (Orange, CA).



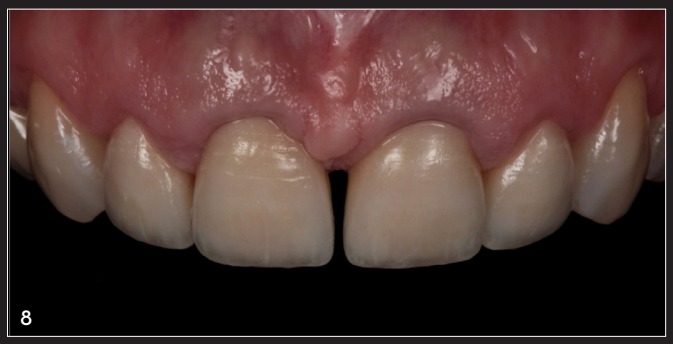


Fig. 7: Transparent overlay illustrating the zirconia core substructure and veneering ceramic of each crown.

Fig. 8: Retracted anterior view of definitive PFZ restorations #7-#10 following placement.

Fig. 9: Left lateral view of patient in repose following delivery of PFZ restorations teeth #7-#10.

Figures 6 and 7 are courtesy of Mr. Djemal Ibraimi.