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Research Paper

Gingival Veneers-The Esthetic Camoflauge for Gingival Recession

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ABSTRACT
The unesthetic appearance of maxillary and mandibular anteriors is considered to be one of the distressing aspect for any individual. The increased spacing between teeth root exposure leads to unesthetic appearance. Surgical procedures for gingival recession coverage do not have acceptable results in cases of severe gingival recession. So nonsurgical methods like gingival veneers should be considered as a treatment modality in such cases. This case report describes the fabrication and various merits of using gingival veneer prosthesis in a patient with exposed roots and interdental spacing.This offers a good interim solution for patients who may wish to have time to consider their options of more advanced and complex treatment.

KEYWORDS: *Esthetic, Gingival veneers,Prosthesis*

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I.INTRODUCTION

The dental appearance is associate integral part of facial beauty. Oral health is not only the sole absence of oral malady , it is additionally a great impact on individuals social life and self worth. The dental esthetics is confined to the tooth as well as the gingival component. To enhance the patient's appearance by improving the "pink component of smile" is the final aim of esthetics[1]. However due to the presence of periodontal disease there is loss of periodontal support by means of accelerated bone loss , apical migration of gingival margin, produces open interdental space, elongated clinical crowns, altered labio-dental and linguo-alveolar consonants production , sensitivity of teeth and most significantly black triangles. Black triangles are considered to be the foremost disliked esthetic issue after caries and crown margins[2]. The gingival recession is also another esthetic drawback which gives an unpleasantappearance .Root coverage procedures are done to treat gingival recession on isolated tooth but when there is gingival recession involving multiple teeth , these regenerative procedures don't seem to be attainable[3]. In these situations, gingival veneers to simulate missing gingival tissue comes as a rescue treatment possibility.

II.GINGIVAL VENEERS

Gingival veneer is outlined as a prosthesis within the labial aspect of dental arch, that aims to restore the muco-gingival contour and esthetics in areas, where periodontal tissues are deficient. It had been 1st introduced by Emslie in the year 1955, to mask the unesthetic appearance of gingival recession in a patient who underwent gingivectomy surgical procedure. Gingival veneer, traditionally were used as a carrier for periodontal

dressings and as a vehicle for delivering topical medications such as topical fluoride and topical steroids like triamcinolone for the prevention of desquamative gingivitis .

III.OTHER NAMES[4,5]

- Gingival masks
- Flange prosthetic device
- Removable gingival prosthesis
- Party gums.

IV.INDICATIONS[6]

- Gingival recession with root exposure.
- In tooth with exposed crown margins leading to root sensitivity .
- Open interdental spaces which are greater than 5mm , that is black triangles and food getting entrapped into those interdental spaces leading to major discomfort and pain to the patient.
- When there is mild gingival recession noted due to proclination of teeth.
- In cases of impaired phonation due to air escape through wide embrasure spaces.
- To enhance lip support and cheek support in needed cases.
- In patients with gummy smile and high lip lines who have been treated with osseointegrated implants before.

V.CONTRA-INDICATIONS[6]

- When there is poor oral hygiene due to inadequate plaque control and presence of gingival inflammation.
- In patients with increased risk of dentalcaries.
- In limited manual dexterity patients , when there is risk of aspiration.
- In heavy smokers.
- In patients with allergic reactions to fabrication materials.
- When there is repeated failure of restorations with microleakage present.
- When the periodontal therapy done is adequately not sufficient .

VI.CASE REPORT

A 48-year-old female patient with a non-contributory medical history presented with the chief complaint of bleeding gums and complaints of gaps between upper front teeth and elongated lower front teeth. Periodontal assessment revealed increased probing depths ranging from 4 to 5 mm with loss of interdental papilla present between maxillary central incisors and gingival recession of average 2 mm was present in mandibular anterior teeth. Radiographic examination demonstrated generalized horizontal bone loss in both arches. The diagnosis of chronic periodontitis was made after reviewing the clinical and radiographic findings. Complete preliminary periodontal treatment was performed. The treatment included oral hygiene instructions, supragingival plaque removal, and subgingival scaling and root planing using conventional hand instruments. After periodontal treatment, the patient maintained good plaque control to a level. At three months following nonsurgical periodontal treatment, probing depths were less than 4 mm. However, despite an improved periodontal condition, the patient expressed her concern over unsatisfactory aesthetic result and increased teeth sensitivity.Since the patient's gingival condition was not suitable for treatment with surgical root coverage techniques and moreover patient was concerned for esthetics, the decision was made to fabricate a gingival veneer in the both the arches. The patient was explained about the treatment and a written informed consent was obtained.

Maxillary and mandibular alginate impression was made and cast was prepared using dental stone . A wax pattern was prepared involving the undercuts toaccurately reproducethe interdental open gingival embrasures. The gingival veneer was fabricated using heat curing acrylic resin. Then the gingival veneer was adapted to the maxillary and mandibular teeth during an insertion visit.Theveneer was engaged into the interdental open gingival embrasures to obtainadequate retention. Patient was instructed to clean veneer each day. Also instructions were given to clean it every time after having food. The veneer has to be stored in water during night to prevent warpage of the prosthesis to ensure adequate rest to the gingival tissues. The importance of persistent plaque control in the ongoing prevention of both caries and periodontal disease was emphasized. The veneer was well tolerated by the patient, and satisfactory aesthetics were also obtained .

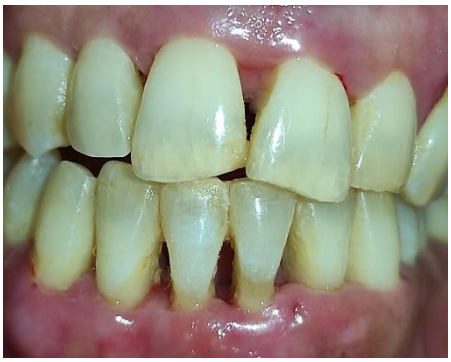

Figure 1 : Pre-operativephotograph showing gingival recession

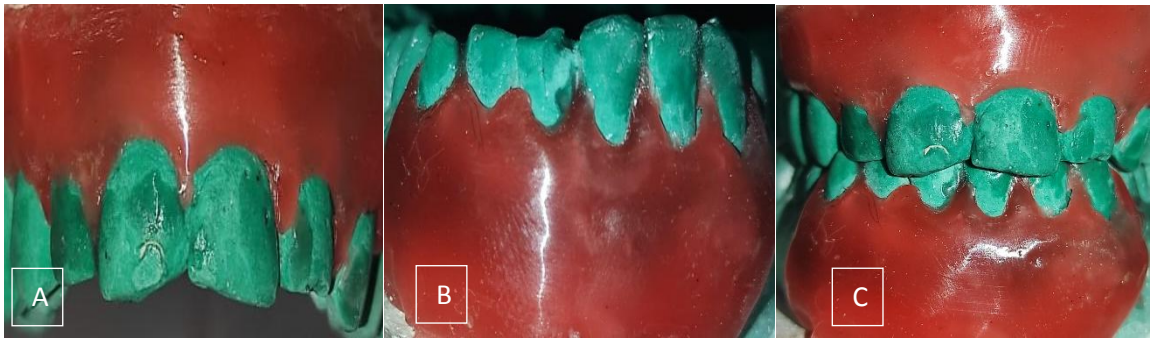

Figure 2A and 2B- Wax pattern of maxillary and mandibular gingival veneer prepared on the cast.

Figure 2C- Wax pattern of Maxillary and Mandibular gingival veneer in occlusion

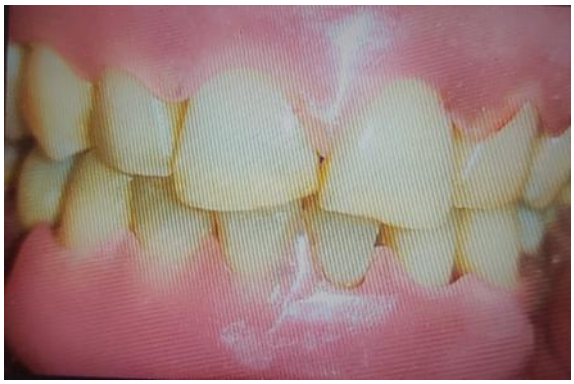

Figure 3 -Insertion of maxillary and mandibular gingival veneer

VII.DISCUSSION

Many factors influences the development of gingival recession which includes abnormal tooth positioning in the arch, plaque-induced inflammation, traumatic toothbrushing, orthodontic treatment, and restorative procedures [7]. Gingival recession leads to many functional, esthetic, and phonetic complications.It can be treated by periodontal plastic surgery or nonsurgical approaches. Many surgical procedures are available in literature for the augmentation of soft tissue structures and reconstruction of the interdental papillae [8,9]. Gingival veneers are usually preferred in cases where the hard and soft tissue augmentation have failed, and the patient prefers a non surgical approach. This prosthesis is generally used to correct deformities remaining after periodontal disease and effective in solving phonetic problems. The process of fabrication is also simple and it is comfortable to wear.But anyhow the disadvantages are difficulty in obtaining retention,and difficulty in cleaning procedures, staining and plaque accumulation.

VIII.CONCLUSION

Since esthetics is the growing priority for both the patient and the clinician, in cases of severe recession where surgical treatment is considered invasive and unpredictable, gingival veneers have become an effective alternative since it is economical and comfortable to the patient.A greater sense of psychological satisfaction can also be obtained as the patient can smile without the fear of 'black triangles'.

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