

## **Dr. Gary Alex (drgaryalex.com)**

### **EXAMPLE OF CASE WORK UP (from case that was treated)**

The patient, a 52 year old male in apparent good health, is interested in restoring his debilitated dentition and in improving the appearance of his teeth and smile. He states he is very self conscious of his teeth and often avoids smiling in photographs. He has recently finished orthodontics with Dr. XXXXX and is now in retainers. He has seen a number of restorative dentists but has “not found a good fit” or anyone he feels “completely confident in”. He would like “longer teeth and a white bright smile” but also wants his new teeth to “look natural”. He is aware of grinding and/or clenching at times and has been told by other dentists that he appears to have a “grinding habit”. He reports he drinks “a lot” of diet coke is also a heavy coffee drinker. He states he does not bite his fingernails or cuticles. He has no TMD type symptoms. He reports thermal sensitivity (especially lower left) and mentions his teeth are VERY sensitive to cleanings (ultrasonic instrumentation). There are no medical contraindications to treatment.

On 8/2/10 full upper and lower alginate impressions were taken along with diagnostic photographs, a full set of digital x-rays, earbow transfer, and CR and MIP bite record. A TMJ/muscle screening exam was performed. The impressions were poured in stone and the models mounted on a Denar Anamark Plus articulator.

#### **CLINICAL FINDINGS:**

- 1) ROM is WNL.
- 2) Well-developed strong facial musculature.
- 3) No clicks/pops at this time on straight opening but patient can induce click in right TMJ on lateral excursion.
- 4) Joints can be comfortably loaded.
- 5) Moderate “Hit and Slide” CR to MIP. First point of contact right posterior (DL cusp #2). Also first point of contact on mounted models in CR (good record).
- 6) Generally acceptable bone levels with areas of slight to moderate bone loss.
- 7) Generalized cervical plaque (oral hygiene needs improvement).
- 8) Heavily restored dentition (especially posterior) with mix of crowns, amalgams, and composites. Some of the restorations are defective and/or breaking down.
- 9) Severe wear upper and lower anterior teeth (less wear posterior). Wear pattern is consistent with protrusive type of parafunctional habit. May be chemical component as well.
- 10) Generally flat posterior tooth anatomy and loss of anterior guidance.
- 11) Existing teeth dark and discolored.
- 12) Length of existing upper central incisors is 6 and 8mm (average length 10-12mm).

- 13) Twelve upper teeth visible in full smile.
- 14) No teeth visible with lips in rest position.



I believe a dramatic change in the patient's smile and dentition is possible in this case. This will entail the treatment of multiple teeth in a logical and systematic fashion. The existing occlusal scheme is pathologic and there is a loss of "anterior guidance". The patient can expect further tooth destruction without treatment. There are also indications of an acidic component to the excessive wear. This could be from a naturally low mouth pH, the soda habit the patient has, or undiagnosed conditions such as GERD. The roots and bony support of the teeth are acceptable and should be able to support a reconstruction.

This is a high-risk occlusal case and this needs to be considered in the design and material choice in any restorative/cosmetic treatment. The patient appears to have a bruxing and/or clenching type parafunctional habit. Patients in this occlusal risk category have a greater chance of fracturing and/or dislodging restorative/cosmetic dentistry. Even if nothing is done a nightguard type appliance is strongly advised as this may help attenuate further tooth destruction.

We need space in the anterior in order to restore this dentition properly. This will require opening of the anterior "vertical dimension" slightly to provide adequate room to restore these teeth. It appears that the CR position of the teeth (see mounted models) may give us enough room in the anterior to meet treatment goals and requirements. The patient has also expressed a reasonable desire to "crown as few teeth as possible". We may have to only treat six of the lower teeth (22-27) and twelve upper teeth (3-14) to meet the treatment goals. We can confirm this in the waxup.

We also need to decide whether to place implants in the 6 and 11 positions versus making a bridge of some type (possibly an 8-unit bridge 5-12) to replace the missing teeth. My feeling is that implants are a better alternative in this case. The sites look very favorable

for implants. The only real disadvantages would be the extra cost and time the case might require. Also, the placement of implants, while routine, is still an invasive procedure. Advantages of implants include; help to preserve the bone, easier to clean than bridgework, breaks up case into individual units, no stress on abutment teeth. A bridge would be quicker and less expensive but would require splinting of individual teeth.

#### TREATMENT OPTION:

- 1) Complete prophylaxis and periodontal charting/evaluation. Evaluate lower anterior teeth 23-26 for clinical crown lengthening.
- 2) Send out models for full mouth diagnostic waxup in centric relation, matrix for temps, and preparation guides.
- 3) Appointment #1 (three-four hours): Prepare 3,4,5,12,13,14 for full coverage. All old restorations would be removed and the support teeth cleaned and built up as required. Take impressions for lab processed reinforce provisionals 3-14. Fabricate chair-side provisionals at existing vertical dimension.
- 4) Appointment #2 (two and one-half hours): Prepare 22-27 for full coverage restorations. All old restorations would be removed and the support teeth cleaned and built up as required. Take impressions for lab processed reinforce provisionals 22-27. Fabricate chair-side provisionals at existing vertical dimension.
- 5) Mount preparation models at new vertical dimension (open bite) and have lab do minimal preparations 7-10 and fabricate reinforced provisional restorations at new vertical dimension of occlusion. We would use diagnostic waxup as a guide in creating provisionals.
- 6) Appointment #3 (Three hours): Prepare 7,8,9,10 and deciduous canines for full coverage. Insert upper and lower provisionals and balance bite. At this point the patient will have a completely new smile, new occlusion, and "new look". The provisionals will serve as a guide to final case design. It is while in provisionals that deciduous canines would be extracted and implants placed (6 and 11).
- 7) After implant integration modify preparations as required and take final impressions.
- 8) Try in entire case in bisque bake (roughed out state) and make occlusal adjustments as required.
- 9) Place finished case (18 units in all). Impressions for Durasoft nightguard/retainer.
- 10) Insert Durasoft guard and adjustments as needed. Patient to be on 4 month recalls for hygiene.

In my opinion porcelain veneers are not predictable (long-term) in this case and I recommend full coverage restorations (crowns). A total of 18 teeth would be treated in this option. Upper arch: 3-14 Lower arch: 22-27. Other teeth can be treated if required or desired by the patient.

**CASE FEE: \$35,200 plus the lab fees for the diagnostic waxup, lab fees for any lab-processed provisionals, and lab fees for any implant supported crowns. This is a comprehensive fee that includes, prophylaxis and periodontal charting, removing all**

existing dentistry, cleaning and building up all support teeth, tissue sculpting where required, all tooth preparations, impressions mountings, and model work, all chair-side fabricated provisional restorations, eighteen units of high-end crowns/bridgework (may include cast gold, porcelain to gold, and/or all-ceramic restorations), night/guard at completion of case, case design, coordination, and artistry. Fee does not include endodontic procedures (if required), placement of implants, or any treatment by periodontist.

- Quoted fees are good for 12 months after date of case workup.
- Treatment plan is subject to change as the case progresses depending on what we find as treatment moves along.
- Preparation of teeth for crowns/bridgework and/or veneers requires the irreversible removal of tooth structure. The amount of tooth structure removed depends on the particulars of the case.
- There is a possibility that any of the teeth being treated could need endodontics (root canals) immediately or at any time in the future.
- TMD problems are possible anytime dental work is done and/or a bite relationship is changed.
- Ceramic crowns and/or veneers and/or bridgework repaired or replaced free of charge for period of two years after date of placement if any problems during normal use.
- Longevity of any dental restoration is highly dependent on patient home-care and regular maintenance. Proper oral hygiene is critical. Periodontal prophylaxis and maintenance is recommended at least two-four times a year depending on the case.
- If a retainer/mouth guard was made for you at the end of the treatment it **MUST** be worn every night or the restorations/teeth may move, chip, or break.
- I encourage patients to seek 2nd opinions in cases such as this.
- Case fee to be paid 1/4 upfront at start of case, 1/4 at second preparation appointment, 1/4 when lab provisionals placed, and 1/4 when final case inserted.

**The aforementioned has been explained to me in detail and I have received a copy of this report.**

Patient Signature: \_\_\_\_\_ Date:   /  /  .

I agree to allow Dr. Alex to use photographs (which may or may not include full facial views), models, and descriptions of my case, for consultation, educational, and presentation purposes. This release covers all photographs taken prior to, and after, the date of this release.

Patient Name: (please print) \_\_\_\_\_ Patient Signature: \_\_\_\_\_

**Pre-op**



**Finished Case**

