THE 16th NATIONAL CONGRESS &
THE 3rd INTERNATIONAL SCIENTIFIC MEETING (TINI III) OF
THE INDONESIAN CONSERVATIVE DENTISTRY ASSOCIATION

Theme:
Revolutionizing Endo Restorations in
Global Community

Proceeding

November 27-29th, 2014
Shangri-La Hotel
Surabaya

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PROSIDING
TEMU ILMIAH NASIONAL
IKORGI III (TINI III)

Surabaya, 27 – 29 Nopember 2014

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Direct veneer in maxillary incisor with enamel hypoplasia: a case report

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Abstract

Background: Enamel hypoplasia is a defect in tooth enamel that results in less quantity of enamel. This condition can make teeth sensitive, also can make aesthetic interference because of its yellow to brown defect and its rough tooth surface, especially if it's happened in maxillary incisor. Tooth with enamel hypoplasia can be corrected with a variety of treatment options, one of them is direct veneer. Purpose: This case report will presents the procedures of direct veneer in tooth with enamel hypoplasia. Case: A 13 years old girl, feeling uncomfortable with her maxillary anterior incisor which is look rough on its labial surface and has brown defect. She wants her tooth to be repaired. Management: Direct veneer in one visit treatment has applied to the maxillary incisor with enamel hypoplasia. After the treatment, a satisfactory result has been achieved. Conclusion: Direct veneer is one kind of treatment choice for maxillary incisor with enamel hypoplasia to correct the aesthetic problem of its tooth.

Key words: enamel hypoplasia, aesthetic, direct veneer

INTRODUCTION

Enamel Hypoplasia

Enamel hypoplasia is a defect in the enamel surface that result in a decrease of the quantity of enamel. Defects in enamel hypoplasia may be a small hole or cavity in the tooth or may be amorphous defects widespread on the tooth surface. The defect can result the tooth become more sensitivity, not aesthetic, and even can cause the formation of cavities on the tooth. Some genetic diseases can lead the tooth to have an enamel hypoplasia.1,2

Enamel hypoplasia can occur multiple in any tooth. Tooth with enamel hypoplasia has presented clinical experience of white, yellow, to brown patches, with a rough surface or a cavity. In some cases, the quality of enamel influenced by the quantity of those enamel, so if there is interference on the quantity of enamel, it will affect the quality of those enamel.1,2

Tooth with enamel hypoplasia can be corrected with a variety of treatment options. Tooth bleaching treatment and microabrasion are very minimally invasive treatment options. Then, restorative treatment by layering the labial surface of the tooth using a resin composite or known as direct veneer, become a treatment options that can provide the best aesthetic results in tooth with enamel hypoplasia, but in cases with severe enamel hypoplasia, indirect veneer treatment with the porcelain material is the most preferred treatment.2,3

This case report will presents the procedures of direct veneer on the tooth with enamel hypoplasia.

Direct Veneer

Veneer is a layer of material that has the same color with tooth, which is layering on the labial surface to restored tooth with defect or cavity. Based on the type of the material, veneer can be made by composite materials or ceramic porcelain.5,6

Generally, the indications for the veneer on the tooth surface are malformation, discoloration, abrasion, erosion, or a failed restoration. In addition, several other factors are important to consider before deciding on veneer treatment, include the patient's age, occlusion factors, the health of the tissues around the tooth,
the position of the tooth and oral hygiene of the patient.4,5
1. Based on the aesthetic factor, veneers is divided into two types:
a. Partial Veneer, which is indicated on the teeth with a defect in some of the side;
b. Full Veneer, which is indicated on the teeth with larger defects.
2. Based on the material used, veneers can be divided:
a. Direct Veneer, using a composite material which is applied directly in a single visit;
b. Indirect Veneer, using porcelain or composite materials that are processed in the laboratory, so it takes more than one visit.
According to Heymann, et al., design of veneer preparation can be divided into:
1. "Window" preparation;
2. "Butt-joint incisal" preparation;

![Figure 1. Design of veneer preparation. A) Facial view of partial veneer that does not extend to the subgingival or involve incisal angle. B) Full veneer with "window" preparation design that extends to gingival crest and terminates at the facio-incisal angle. C) Full veneer with "but-joint" or "incisal-lapping" preparation design that extends to involve subgingivally surfaces and incisal. D) Partial veneer. E) Full veneer with "window" design. F) Full veneer with "but-joint incisal" design. G) Full veneer with "incisal-lapping" design.]

![Figure 2. Clinical feature of the lateral incisor before treatment. (Source: Private collection operator)]

CASE REPORT

In July 2013, a 13-year-old teenage came to the Department of Conservative Dentistry in Hasanuddin University with chief complaints feel not confident with her maxillary incisor which looks rough with brown patches on its labial surface.

From the results of anamnesis, patient reported that the condition has been experienced for a long time, but she did not feel disturbed yet. She starts not confident when she enters adolescence age. She did not feel pain. The patient, who was accompanied by her sister, came to tell that she has a history of taking antibiotics since childhood. She wants her tooth to be repaired, so that she can get her confidence again.

On clinical examination, looks a rough defect with brown patches on the labial surface of her lateral incisor #22 (Figure 2). Gingival tissue around the teeth is normal and showed no signs of inflammation.

Her lateral incisor #22 then are summed has enamel hypoplasia condition and will be treated with direct composite veneer.

CASE MANAGEMENT

Before the treatment on #22, the first is we clean the tooth’s surface using a brush and pulp, then captured it before the treatment, and determined the colour of #22 with a shade guide from the composite materials which we used (Figure 3), which is adapted to the natural tooth colour.

Having obtained the appropriate colour, then we made preparations to clean up the defect formation on the labial surface of #22. Gingiva in the cervical area of #22 was retraction by using retraction cord to open the gingival sulcus to facilitate the formation of a mixture endings in the cervical area. Furthermore, the preparation is done with "window" preparation design (Figure 4) using a diamond-bur.
After the tooth is prepared, it is cleaned with water and dried, then isolated for subsequent etching and bonding material applied. Etching material is 35% phosphoric acid, which is applied to the entire surface of the enamel and dentin of the teeth that have been prepared. Etching applied using microbrush. Etching allowed to stand for 15 seconds, then rinsed with water and dried. After that, the bonding material as the adhesive material agent, also applied on the labial surface of the tooth using microbrush, then irradiated with light cured for 10 seconds (Figure 5).

And then, the composite is applied layer by layer on the labial surface of #22 and its carved anatomically. Previously, on the mesial and distal sides of #22, we placed celluloid strip to prevent overcontour proximal restoration (Figure 6).

After the composite is applied and sculpted according to its anatomy, and then we giving way to the end of the procedure, called finishing and polishing. Finishing procedure performed to remove the sharp contours of the tooth and form appropriate its anatomy, while polishing restoration aims to smooth and polish the surface of the restoration (Figure 7).

Figure 3. Determination of the tooth colour with shade guide. a) shade guide A2 match with its natural tooth colour; b) shade guide A3 looks darker than its natural tooth colour. (Source: Private collection operator)

Figure 4. Clinical condition of the tooth after preparation. a) #22 after preparation looks from the front; b) #22 after preparation looks from the proximal side. (Source: Private collection operator)

Figure 5. Etching and bonding procedures. a) the application of etching to the #22; b) etching was applied for 15 seconds; c) application of bonding agent on #22; d) application light cured at #22 who has dental bonding agent for 10 seconds. (Source: Private Collection operator)

Figure 6. a) composite application on #22; b) light cured on the composites that have been carved for 20 seconds. (Source: Private collection operator)

Figure 7. Finishing and polishing procedures. a) using a needle-shaped finishing bur; b) using an aluminum-oxide.
After all the procedures completed, we recaptured clinical images of #22 after direct composite veneer treatment (Figure 8) and matched its colour to shade guide A2 that have been adjusted before.

![Figure 8. Clinical feature of lateral incisor #22. A) before direct composite veneer; b) after direct composite veneer. (Source: Private collection operator)](image)

**DISCUSSION**

Disruption due to the aesthetic condition of incisor with enamel hypoplasia may result in a decrease in confidence for patients, especially in women and adolescent patients. Enamel hypoplasia resulting yellow to brown spots with defects on the surface of the tooth, so the tooth feels rough and looks not aesthetic.1,2

Generally, there are several types of dental treatment options for tooth with enamel hypoplasia.1,2,3 One of them is direct veneer. Some of the advantages and disadvantages of the treatment options with direct veneer is:3,6-7,9:

- **Advantages of direct composite veneer:**
  1. Conservative with minimally invasive;
  2. Provide maximum aesthetic results;
  3. Provide a good adaptation of the supporting tissues of the tooth;
  4. Easy to applied, but it takes skill to adjust the colour;
  5. Need short visit time with a cheap price relatively.

- **Disadvantage of direct composite veneer:**
  1. Preparation technique is quite difficult;
  2. Requires a lots clinical experience;
  3. Tooth can become more sensitive;
  4. Unable applied to tooth with severe discoloration or severe defects.

Returns aesthetic from tooth with enamel hypoplasia by direct veneer treatment, either to improving the aesthetic condition of the tooth, also improve the quality of the enamel, due to the clean up and closure of the defect by restoration materials that help tooth become more strength. The tooth will become stronger and aesthetic, and patient’s confidence will increase.1,2

In addition to the direct veneer, tooth with enamel hypoplasia can also be corrected with tooth bleaching treatment or with indirect veneer.1,2,3 However, in this case, tooth bleaching is not recommended due to defects that occur already formed a shallow cavity that even been done tooth bleaching, still require additional treatment in the form of restoration of the cavity to cover the defect. In fact, the patient in this case want to get her tooth repaired immediately with a minimum visits. Meanwhile, treatment with tooth bleaching or indirect veneer is a treatment option that requires more than one visit.

Each steps in the procedure of direct veneer treatment in this case is done by a variety of considerations. Selection procedure of shade guide tooth colour, for example, this procedure is done by involving the patient to assess the suitability of the colour of her tooth. The colour selection is done together with the patient and performed when tooth are not in the dry condition. Some of the colours chosen approach is compared with each other for the closest colour of natural teeth. As a result, we choose shade guide colour A2 which is thought to correspond to the natural colour of the patient’s tooth.3,10

Furthermore, the selection of "window" preparation design in the direct veneer in this case based on the defect is localized in the central region of the labial surface of the #22, which has not reached the incisal edge, so it is considered do not need to prepared the incisal edge of the area. Tooth then prepared carefully with minimum tooth prepared. Preparation of the tooth structure needs only limited enamel retrieval and does not exceed 0.5 mm, so that no difficulty in adjusting the colour, because the structure of enamel retrieval will cause the tooth structure becomes darker due to the structure of dentin increasingly imagined. Preparation of the tooth structure for incisors is maximum of 0.5 mm and for canines is maximum 0.75 mm. To controlling the preparation of tooth structure can be used depth-cutting diamond bur 0.5 mm as the initial
or guiding bur, followed by fissure diamond bur or diamond needle to smooth the tooth surface preparation and finishing tooth with a defect.5,9,10

As in the composite restoration procedure, in the direct composite veneer is also worth the things that can affect the adhesion strength of the composite to tooth structure, including cleaning the enamel before applying appropriate etching and bonding agent as manufacturer's instructions. Cleaning enamel can be done using alcohol or water from the three-way syringe, to improve adhesion bonding, because saliva, debris, and oil derived from the handpiece can hinder the process of etching and bonding. When the tooth surface is clean, then acid etching by phosphoric acid 35% - 37% be applied to the entire surface using microbrush on labial #22 for 15 seconds, then rinsed and dried. And then, the adhesive material applied as a bonding agent also to the entire labial surface of #22 evenly using microbrush and then irradiated with light cured for 10 seconds.11,12,14

Composite was applied to the labial surface of the teeth layer by layer until the teeth are formed in accordance with its anatomy. Good contact between the composite with the gingival tissue around the tooth are maximized, especially in embrasure area because of the the overcontour restoration and the presence of a thin composite layer in the composite margin will lead to easy fracture and gingival irritation. So that, to prevent that problems, we placed celloidin strips on the mesial and distal sides of the #22. Checking existence of the overcontour restoration can also be done by passing dental floss without wax on the proximal area.11,12,13,15

The end of treatment procedures in this case of direct veneer is finishing and polishing. This procedure is important to get the maximum direct veneer treatment. Finishing and polishing procedure performed with a variety of tools and materials such as finishing burs, an aluminum oxide discs, and an aluminum-silicon-oxide point to maximize the anatomical contours of the tooth, so that it looks more natural, throwing and smooth restoration which is sharp and rough to prevent retention of food and debris, as well to get shiny restoration results.12,13,15

CONCLUSION

In the case of tooth with enamel hypoplasia, treatment with direct composite veneer may be appropriate treatment options to restore and improve the aesthetic condition of the tooth damaged by the existing defects. Besides easy to apply, relatively low cost, and short in visits, treatment with direct composite veneer are also promising a very satisfying aesthetic results for patients.

SUGGESTION

In this case, direct composite veneers in tooth with enamel hypoplasia gives satisfactory results for the patient. However, along with the development of knowledge and dental materials, the direct treatment of the veneer may be getting attention for continuously modified to obtain a new technique or other material better.

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