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 expensive 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 orthodontic needs involved to a distorted perception of their teeth seem to be easy victims.

"Smilexia" is the fanciful term I coined for this disorder, which appears to affect women more than men. If you open the pages of any journal published by the American Association of Cosmetic Dentistry, you will no doubt find at least one or two of these patients having extensive veneer 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 use of composites to restore 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.

Biggest bang for the buck—The STO combo

Let's cut to the chase: if you are a general dentist and want to knock 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 all ways trying to be faster because people hate being in braces, and aligners are often too slow or they do not give the dentist enough control of tooth movement.

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 (Dr斯Wain, Barr or De Paul) 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 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 use of composites to restore worn edges in combination with orthodontics to correct alignment.

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. Mandibles 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 competing with any rubbish from specialists who want to dictate what a general dentist can and 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 not 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 Litt, and you are insane not to take a series of oral rehabilitation courses from Dr Frank Spear or Dr John Kois.

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Too important to overlook. In fact, orthodontists have a very difficult time trying to treat adults with worn dentition, so I consider this a very good niche for doctors ready to invest in cross-training.

I have seen an orthodontist try to treat an advanced wear situation with full orthodontics, and the result was all wrong. Instead of allowing for the restorative material, the practitioner moved the short teeth into place as if they were full size, so when we took the cast to lengthen the worn incisors the result was a posterior open bite. The easier way to treat the case would have been to build up the teeth with composite prior to starting the orthodontics.

Cosmetic dentists have a tendency to veneer everything. They veneer teeth straight because they believe they claim to have three to four years. They veneer teeth to get rid of wrinkles and haziness. They do it to whiten and straighten them. They veneer teeth because the old veneers break. Exaggerated times in braces are often lies that patients do hate is composites that patients do not have muscular problems and headaches, there may be no need to say truth about orthodontics to get a bite change. Simply by looking at the effect on enamel replacement cement, orthodontists have on the lab and considering how orthodontics could manage the result may be sufficient without an articulator. A less deep overbite and a less trapped mandible appear to be achievable within most schools of training.

The cosmetic training really will begin to come into play with incisal displays, tooth proportions and fuller arches. The arch form after orthodontics usually is very pleasing and mimics the technique of overlying ceramic on the facial surfaces of the upper bicuspid. The term for this has faded from my memory because I tend to avoid courses that push the use of porcelain.

When I attended the UCLA Aesthetic Continuum, Dr Jimmy Kuban took a few moments to talk about a case in which a young teen had had her teeth disfigured with bulky veneers. He was forced to retreat her teeth but she had been compromised for life. As dentists, we are subject to many sales presentations disguised as courses and we rarely get the truth. The truth is dentistry is not easy and taking one weekend course will not be nearly enough. No guru is going to tell you all that you need to know. At a recent course on anterior aesthetics taught by Dr Gerald Chiche at the Seattle Study Club, I was forced to prepare a number of veneers on plastic teeth. The burning smell reminded me 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 decaying 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 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 “veneerial” 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.

**“I know, NOT ALL cosmetic dentists are Veneer Nazis...”**

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**Contact Info**

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