Clinical Study

A New Total Digital Smile Planning Technique (3D-DSP) to Fabricate CAD-CAM Mockups for Esthetic Crowns and Veneers

F. Cattoni, F. Mastrangelo, E. F. Gherlone, and G. Gastaldi

1 Dental School, Vita Salute University, 20132 Milan, Italy
2 Dental and Maxillofacial Surgery Unit, San Rocco Clinical Institute, Ome, 25050 Brescia, Italy

Correspondence should be addressed to F. Cattoni; cattonif@tiscalinet.it

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1. Introduction

In recent years, the concept of what makes a smile beautiful has changed significantly [1, 2]. Nowadays, patients expect complex functional rehabilitations that are esthetically appealing [2–5]. An important goal in prosthodontics is to use minimally invasive treatment to improve the appearance of the smile [3–6] as a way to valorize the entire image of the patient [7] while maintaining the health and function of teeth and soft tissue [8, 9].

Porcelain laminate veneers (PLVs), minimally invasive solutions to dental esthetic problems, have the most long-term success [7, 10–14]. There are a number of stages in rehabilitative dental treatment, from making the impression and developing the model to creating the diagnostic wax-up and to constructing the laboratory mockup. The planning associated with creating a mockup is a very important as it affects patients’ understanding of the expected result [15, 16]. Whether the patient is happy with the overall treatment depends on how similar the prosthesis is to the mockup [17, 18]. The shape of the teeth, the adaptation of the prosthesis, and the size and the color of the new elements in relation to the soft tissue, lips, and the whole face are very important in the decision-making [19].

A large number of errors can occur at the various stages of the traditional prosthetic workflow, each stage requires a transfer of two-dimensional and three-dimensional (3D) data between operators. As computer-aided design and computer-aided manufacturing (CAD/CAM) and new materials are leading to a paradigm shift in what many practitioners regard as standard care for patients, a priority is to drastically reduce operator error [20].

The aim of this research was to evaluate new total 3D digital smile planning technique (3D-DSP) used in the previsionalization stage prior to milling poly(methyl methacrylate) (PMMA) mockups in the process of creating PLVs using a CAD/CAM system.
Table 1: Number of the patient veneers restorations.

<table>
<thead>
<tr>
<th></th>
<th>Number of treated patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>9</td>
<td>32.2</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>67.8</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 2: Distribution of porcelain laminate veneers according to location.

<table>
<thead>
<tr>
<th>Veneers</th>
<th>Number (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maxilla</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anterior</td>
<td>54</td>
<td>50</td>
</tr>
<tr>
<td>Posterior</td>
<td>30</td>
<td>27.8</td>
</tr>
<tr>
<td>Total</td>
<td>84</td>
<td>77.8</td>
</tr>
<tr>
<td>Mandible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anterior</td>
<td>10</td>
<td>9.3</td>
</tr>
<tr>
<td>Posterior</td>
<td>14</td>
<td>12.9</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>22.2</td>
</tr>
<tr>
<td>Total</td>
<td>108</td>
<td>100</td>
</tr>
</tbody>
</table>

2. Materials and Methods

Between September 2012 and July 2015, 28 patients (9 male and 19 female) aged 19 to 53 years (mean age of 36 years) took part in this study at the dental clinic at San Raffaele University, Milan, Italy. None of the patients had any oral, periodontal, or systemic diseases (Tables 1 and 2).

After radiological, phonetic, and static and dynamic occlusal evaluation, each patient had three intra- and extraoral digital images taken while wearing special eyewear (Digital Smile System Srl, Italy) (Figures 1 and 2). An intraoral scanner (Scanner 3D Progress, MHT, Italy) was used to get intraoral digital impressions of the maxilla and mandible arches in open and occlusal states. All the digital images, obtained from the processing of the pictures into the software 2D-Digital Smile System (Digital Smile System Srl, Italy) (Figure 3) and the STL file from the intraoral scans, were combined into the 3D-Digital Smile System (EGS Srl, Italy) to display the patient’s teeth and, from this, a virtual design of the potential dental prosthesis was created. When the patient agreed to this virtual 3D view of their planned-for prosthetics, a PMMA mockup (Bredent Srl, Italy) was milled using a CAM system (Zirkonzahn Srl, Italy) (Figure 4). Each mockup was tested in the patient’s oral cavity to make sure they would consent to the esthetic therapy and be satisfied with the end result (Figure 5). The newly milled mockups, cemented using spot-etch technique [21, 22], were used to guide the position of the prosthetics and maintain the margins on the enamel surface of the teeth [23–25] (Figure 6). The double cord techniques with the intraoral scanner (Scanner 3D Progress, MHT, Italy) was used to make all the definitive impression of the prepared teeth (Figure 7). The PLVs (IPS e.max System, Ivoclar Vivadent Srl, Italy) were produced using CAD/CAM technique (Zirkonzahn Srl, Italy). A total of 78 Variolink veneers (Ivoclar Vivadent Corp., Liechtenstein) and 30 Clearfil Esthetic Cement veneers (Kuraray America Inc., USA) were cemented onto vital teeth (Table 3) (Figure 8).

3. Results

The preoperative patient parameters showed bruxism (22.2%), tooth trauma (14.8%), abrasion (11.2%), discoloration (22.2%), crowding (14.8%), diastema (7.4%), and caries (7.4%) (Table 4). The follow-up 2 years later revealed 1 total fracture, 2 sensitive teeth, and 1 gingival recession (0.9%). None of the 108 PLVs showed debonding,
chipping, microleakage, discoloration, or secondary caries, and no root canal therapy was necessary (Table 5).

Patients responded to a questionnaire to determine their satisfaction with the digital smile design planning and the test in the form of the mockup. They graded both the planning and the test as effective, very effective, or ineffective. For the digital smile design previsualization, with visual analogical scale (VAS scale), 18 (64%) of patients found it very effective and 10 (36%) effective; 24 (86%) found the milling mockup very effective and 4 (14%) effective (Table 6).

### 4. Discussion

In all prosthodontic aesthetic treatment, the accurate design planning and the basic communication phase with the patient play a crucial role in the therapy. The best previsual means most widely used as a measure of explanation with a patient is the therapeutic planning, associated with the creation of a mockup [17, 19]. With contemporary digitalized techniques, it is possible to redesign a patient’s smile [15, 16]. Effective previsualization followed by a mockup is the ideal way to explain changes to a patient and receive their approval [17–19]. Traditional “analogical techniques” are based on a planning process that involves radiological and clinical evaluation, intra- and extraoral photographic analysis, static and dynamic occlusal evaluation, and traditional impressions [21]. The more traditional techniques that use the free-hand “composite technique” before the wax-up do not evaluate the design of the smile [25, 26].

A secondary evolution of digital prosthetic planning is limited to bidimensional digital work flow [21] and requires, after digital smile design protocol, the stone model, the manual processing of a laboratory diagnostic wax-up, and the printing of the classic mockup in the patient's oral cavity through the use of silicone keys. In traditional planning techniques, the data transfer from virtual design to laboratory is difficult and potentially full of errors because it uses a manual process to obtain the computer design of canine zenith lines for the laboratory stone model [21]. This manual process is necessary to transfer all the measurements of the teeth to the new smile project design. Another difficult and unpredictable process is the mockup printing in the patient’s
CAD/CAM-milling mockup, to reduce the errors usually associated with the classical manual steps and to improve the accuracy of the prosthetic procedure. All digital data transfer from the clinical 3D planning to the laboratory CAD/CAM process is simpler, faster, and more predictable. However, having photographs plays a crucial role: the patient-approved virtual smile is used to guide the final design of the teeth, which are usually made with the CAD/CAM process.

5. Conclusions

A 2-year follow-up of prosthetic PLVs created using the new total digital smile planning technique in vital teeth in the esthetic zone showed that it is possible to obtain excellent results in both functional and esthetic rehabilitation and high patient satisfaction. The new procedure also reduces the amount of time spent in the clinic and laboratory, increases the predictability of data matching to build CAD/CAM-milling mockups, reduces trauma caused by handling hard dental tissues, and improves accuracy and reproducibility of the final mockup. The total new digital smile planning technique is minimally invasive and facilitates diagnosis, improves communication with the patient, reduces processing times, and increases predictability of the results with very little discomfort and very high esthetic final results. The present study has limits, such as the limited number of patients enrolled: further studies on a larger sample of patients are therefore needed to confirm our present results.

Competing Interests

The authors declare that they have no competing interests.

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References


