

4. Prior knowledge, which should literally be shared with the patient via articles and images, can be a very interesting strategy for clarification and persuasion. Also, in special situations as described above, unbroken teeth can be monitored via clinical and imaging control and, in these situations, prior knowledge of the reasons is critical for the patient, their family and the professional.

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The bare truth about Instagram Here we are for one more issue.

I should confess that I am, and we all are, very happy about this Journal's repercussion, with its honest and reliable contents, whose clear and objective aim is to be shared with you and to support your clinical applications. In this issue, you will find some more cases - this time we imagine that Instagram feeds, which do not openly display the number of "likes" that a post has received, may have made many people unhappy for having paid for "likes" and followers...

Anyway, here we go. For you who has just subscribed and is getting to know it now, our column describes cases before and after treatment in a page in Instagram. The photos, however, are published the way they come out of the camera, with no edition. The purpose is to show real cases the way we see them in the Instagram of numerous dentists, without resorting to manipulation to make images perfect, to the point that we deceive colleagues and patients.

THIAGO OTTOBONI and RICARDO PIMENTEL

This patient had a tooth fracture due to trauma. Procedures included lingual matrix manufacture (technique modified by Bertholdo, Ricci and Barrotte) to fabricate the lingual mock-up; shade selection according to composite buttons and stratification; production of a thin palatal layer with AT-3M; dentin opacity with OPA2 Estelite Omega, slightly raising at the bevel; opaque halo effect with addition of yellow Ivoclar stain, so that light passage between the halo and the lobes was improved; and A2E Estelite omega as enamel shade.





EDIT



COLOR CORRECTION



SATURATION



BRIGHTNESS



WARMTH



CONTRAST



CRISTIAN HIGASHI

Composites may mimic natural materials as long as they are used correctly. Attention to layer thicknesses and knowledge of dental anatomy make all the difference. In this case, we used opaque composites to make the incisal edge and the body of the restoration; an opalescent composite between lobes; a white dye for the reproduction of enamel hypoplasia; translucent and achromatic resins for the incisal third and interproximal areas; and fine Arkansas stones for texture.





EDIT



COLOR CORRECTION



SATURATION



BRIGHTNESS



WARMTH



CONTRAST



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CHANE WITINSCKI

A 26-year-old healthy woman was seen in the office immediately after a fall from the same level. Clinical examination and radiographic images showed an enamel and dentin fracture (Class IV) in the distal area of tooth #11, without any pulp exposure. As the patient brought the tooth fragment, our choice of an immediate treatment was bonding the fragment using a composite and restoring the tooth. A follow-up visit was conducted 15 days later.



-  EDIT
-  COLOR CORRECTION
-  SATURATION
-  BRIGHTNESS
-  WARMTH
-  CONTRAST
-  ROTATION



EDUARDO GROISMANN

Report of case of a central incisor (#11) to be extracted because of a root fracture treated using immediate osseointegrated implant placement and provisionalization.

The buccal bone plate was partially missing because of chronic inflammation associated with that tooth fracture.

For a long time, buccal bone plate integrity was seen as a pre-requisite for immediate implant placement. The technique then recommended included the elevation of a mucoperiosteal flap. Currently, as clinical and scientific knowledge has advanced, the use of the flapless technique should be the choice for immediate implant placement under similar clinical conditions.

The protocol used in our case was based on the availability of residual palatal bone. In addition, the gingival margin of the extracted tooth should be similar to that of its contralateral tooth. The implant should be positioned as recommended by Saadoum et al.¹ Primary stability is also a critical factor.

After implant placement, provisional retention followed the concepts defined by Suh et al.² A positioning guide prepared before the surgery was used for the impression of the critical margin of the provisional using Flow A2 composite. For the case described here, the crown of the extracted tooth was used as provisional.

After the impression of the critical margin, the prosthesis was sent to the laboratory, and the remaining gap between the provisional margin and the abutment collar was filled.

A concave area was created in the buccal aspect of the subcritical margin of the provisional.² At the same time, the surgery went on, and the bone xenograft was placed between the implant and the lingual aspect of the tissues in the region of the buccal contour.

To compensate for the remodeling that takes place after extractions, we chose a subepithelial connective tissue graft, which was elevated using the linear technique in the left lingual area, because the gingival margin was at the same level as its reference.

We chose a mixed flap, divided coronally (keep supply in the region) and beyond the mucogingival junction (flap mobility). Total thickness started below the keratinized tissue, especially in the area of the fistula. After the preparation of the seating area, positioning sutures and stabilization were used to keep the connective tissue graft stable, which promoted its integration.

The provisional was then positioned, and occlusion was adjusted. At this point, whenever possible, there should be no occlusal contacts, to avoid implant function during occlusion and disocclusion.

After surgery, the patient should be followed up during healing. Sutures are removed 7 to 14 days later. The interval for impressions of the emergence profile for the definitive prosthesis is three months.

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