

# Examiners' Observations

## Key Insights for Accreditation Case Type III

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Illustrations by Dave Mazierski



In Case Type III, the candidate is challenged to replace a missing maxillary incisor or cuspid to a level of Accreditation excellence. The operator is given the option of replacing the missing dental components with either a bridge or an implant. If a bridge is selected, the accepted standard of excellence is the use of an ovate pontic (Figs 1-4). Replacement of a crown on a pre-existing implant is not acceptable for Case Type III.

The edentulous space must be documented pre-operatively with a radiograph (Figs 5a & 5b).<sup>1</sup> The examiners' focus is limited by definition to the replacement tooth and any areas that the candidate has treated. It is not necessarily a case type in which comprehensive smile design criteria are heavily weighed, unless the treatment rendered encompasses a broader field in the smile zone. The candidate must keep in mind that if a limited scope of treatment is selected, the balance of the smile zone should not be visually distracting, as it might indicate the need for additional management. A common problem in this case type is underestimating the time required to establish ideal tissue architecture.

The candidate's case selection and ability to treatment plan are particularly magnified in this case type. It is in the candidate's best interest to find a patient with reasonable periodontal architecture that presents the optimal environment to create excellence. Our goal is to achieve a result so natural-looking it is hard to discern that a natural tooth does not occupy the edentulous space. It is strongly recommended that candidates for every Accreditation case type work with a mentor, especially one who has been calibrated as an examiner.

Successful management and treatment planning demands mastery not only of prosthetic concepts,



**Figures 1-4:** An ovate pontic design presents the illusion that the missing tooth is actually erupting from the tissue.



**Figures 5a & 5b:** Preoperative and postoperative radiographs must document the edentulous space or failing tooth to be replaced.

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but also of the parameters of health imposed by the periodontal architecture.<sup>2</sup> Although some restorative dentists may provide advanced surgical procedures to their patients, in many cases effective treatment involves an interdisciplinary team. This team typically consists of the restorative dentist and the surgeon, who may be involved in site development or the placement of the implant. Regardless of who performs the surgery (if it is indicated), the key responsibility remains the orchestration of the treatment planning by the restorative dentist with a protocol that will provide predictable, durable, and esthetic results.<sup>3,4</sup>

A predictable protocol begins with a complete understanding of the options to restore the patient's health and function. This protocol starts with a visualization of the desired solution; this is then studied and modulated in three dimensions through the use of diagnostic models and a wax-up of the intended result. From this dental "blueprint,"

stents can be fabricated and utilized in both the surgical and restorative phases to effectively reproduce the anticipated results.<sup>5</sup> The restorative dentist will find great value in methodically and patiently manipulating the prototype restorations to help establish the best possible periodontal architecture.<sup>6,7</sup>

Dr. Chan should be commended for his fine demonstration of each of these elements of case management and the final result. His conservative approach in limiting the treatment to the edentulous areas of ##6-11 was well within the parameters of this case type (Fig 6). His model analysis and diagnostic wax-up allowed him to make key decisions in managing the spaces and developing the appropriate stents to be used during treatment. His understanding of the biology of the system facilitated his planning in the ideal placement of the implant in three dimensions. His attention to detail in managing the prototype ensured the predictability of the

tissue architecture and what appears to be a healthy and sustained result. His keen eye identified those elements of macro- and micro-esthetics that allow the restorations to "disappear" into the surrounding dentition.

The examiners as a group identified very limited criteria that had faults. Most examiners awarded the case a plus one because of the excellence that was demonstrated. The case passed unanimously. Those criteria that accounted for minor deductions included:

**Criterion 53:** The opacity was slightly high in the cervical one-third of the cuspids.

**Criterion 87:** Minor asymmetries were noticed in the contralateral teeth #6 & #11

The Accreditation process represents the ultimate challenge in the mastery of dental esthetics. Achievement of this gold standard of excellence will provide immeasurable rewards for you and your patients.

## References

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**Figure 6:** Although smile design deficiencies existed in the balance of the patient's smile, these criteria were not judged because they are not the primary focus of this case type, they were not treated, and they represented a normal state of health.



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