Sir,

Gingival recession makes a challenging state of affairs in the anterior region as the loss of interdental papillae leaves unappealing black triangles between the teeth.\(^1\) A suitable option in cases of mild to moderate cases of gingival recession is to do mucogingival surgery. However, when the condition is advanced and severe, mucogingival surgeries will carry the risks of relapse.\(^2\) In such case an alternative option is gingival replacement with a gingival veneer also known as flange prosthesis, party prosthesis, gingival slip, gingival mask, gingival replacement unit and artificial gingiva.\(^3\) The gingival veneer is a thin, lightweight design, held in place by extension between the teeth. It can be made as thin acrylic or silicon mask that is worn to cover the exposed root surface and mimic the missing gum. Thus, it improves the aesthetics by masking the tissue loss. When in place it conceals exposed root surfaces, enhances esthetics, prevents food impaction, and improves speech.\(^4\) Occasionally, this can also be done by clever use of white fillings to close the gaps between teeth.

A 28-year female reported with complaint of gum recession and dissatisfaction with enlarged spaces between her maxillary anterior teeth. On examination, she was diagnosed with aggressive periodontitis. Oral examination revealed open interdental embrasures and exposed root surfaces localized to maxillary central incisors and left lateral incisor (Figure 1).

Patient was managed with phase-I therapy, which included oral-hygiene instructions, scaling, and root planning. Both ultrasonic and hand instrumentation was used. One-month follow-up showed patient compliance in maintaining oral hygiene. The patient had time constraints and expressed hesitation over surgical intervention. It was decided to refer her to the Prosthodontics Department.

An esthetic gingival veneer was chosen to camouflage the defect. Informed consent was taken after educating the patient of the pros and cons of the prosthesis. A perforated metallic stock tray with irreversible hydrocolloid impression material (Alginate) was used to make the impression. Proper size impression tray was selected and tray adhesive was applied. Care was taken to record the entire functional details of buccal vestibule from premolar to premolar by direct application of impression material with finger in the labial sulcus before seating the impression tray. The tray was removed from the mouth taking great care not to tear the inter-dental tags, which represented the embrasure spaces and the cast was poured. Severe undercuts were blocked interproximally with wax from the lingual aspect so that the acrylic resin gingival veneer would only cover the labial and buccal embrasures. The gingival veneer was waxed up and heat processed. After curing, veneer was removed from flask, trimmed, finished and polished. It was tried in the mouth and required adjustments were made (Figure 2). The veneer was to be stored in water during night to prevent detrimental effect on the acrylic prosthesis. This would also ensure adequate rest to the gingival tissues. The importance of persistent plaque control in the ongoing prevention of both caries and periodontal disease was emphasized. Patient was satisfied as this was a minimally invasive and cost effective option.

Patients with advanced periodontitis often experience open gingival embrasures (black triangles). Surgical treatment may be deficient in restoring ideal aesthetics.\(^5\) Prosthetic gingival restoration with gingival veneers can replace large volumes of receded soft tissues, fill the interproximal spaces to eliminate black triangles and improve esthetics. Good esthetic results have been achieved using gingival veneers renewing the patient’s self-confidence. Their aim is to restore the mucogingival contour and improve the compromised appearance associated with lost periodontal tissues.

REFERENCES


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Letter to the editor

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