Patient did not like the bridge that was done more than 10 years ago. Just wanted the bridge redone. I followed Stephen Phelan’s protocol for reconstruction. Not a very big smile. Patient has a very atrophic lip. Plan included the lowers but right now we are just rebasing and redoing the teeth on the partial and altering the incisors of the lower anterior.

Patient did not like the bridge that was done 10 years ago… I wonder why, Nathan? Stephen Phelan’s video tutorials are top notch. I have not purchased them yet but he has me thinking I should.

Figs. 12 & 13: Wax-up
Fig. 14: Reduction splint
Fig. 15: Putty of the wax-up
Fig. 16: This did not work at all and I wasted money on it.
Figs. 17, 18 & 19: Temps were a bit rough on the front teeth. This is after two months in the new VDO.
Fig. 20: These are temps that I made.

I had a very hard time telling they were restored, even with loupes and a headlight. My wife is considering veneers and I insisted that she see him for her treatment (we are not allowed to treat spouses in Canada).
Check out his website at www.occlusiondesign.com.

Fig. 21: All PFM. I did not have to worry about a high smile line and I trust the strength with long-span bridges and I figured it would be easier to match color with all PFM. We did framework and coping try-ins and I am glad we did as I had to section and index the bridge.
Fig. 22: Basically the entire left side is a bridge.
Figs 23 & 24: His lip was numb here, so I brought him back…
Fig. 25: Mr. Atrophic lip has been smiling more and it is not so atrophic anymore!
Very rewarding case. I can’t wait to do the lowers.
Lab work done by Van Hook Dental Studio in Tempe, Arizona.
[Posted: March 31, 2014]
I took his yearlong online course (still in it for another month). I would not have been able to attempt a case like this without his system and training. It took me to the next level. I have two other cases starting and I swear four more in the hopper while they save up the money.
Stephen is the bomb. Are people still saying that?

Stephen is the bomb. If I did not already have lots of experience treating cases like this I would jump at the opportunity to purchase his program. I still may to get some new ideas I have not thought of or been exposed to.

Nice case and nice result! What took him 10 years to get it done? Can you walk me through your reduction guide? What do you use all the perforations for? Thanks for sharing!
Great job Nathan! I think the choice of PFMs is a good one... it sucks so bad to bond a full mouth of e.max. I think he is a very easy going guy. When the last dentist did this he did it three times. I think he felt bad for him so he did not complain. I believe it took him so long because he lost trust in dentists after that... not in an angry way.

His bridge was failing, when I first prepared the case I had a plan to go to partials that he had accepted in case I could not do the bridge. With the functional analysis exam and the cosmetic imaging, I built the trust and he accepted—full price, no insurance.

The reduction guides include:

- An incisal reduction guide made from the wax-up.
- A sectional putty made from the wax-up. I cut it as I go and look at each tooth. The clear suckdown with holes drilled in the incisal, mid and cervical regions in all three vertical planes. I put this on and measure each hole to ensure proper reduction from the wax up for the restorative material planned.

I think I have pictures of this—I will look.

Can you walk me through your reduction guide? What do you use all the perforations for? Thanks for sharing!

Preston J., “A systematic approach to the control of aesthetic form.” What’s “new” was once old. All of us owe a great thanks to Jack Preston for laying the foundation of maintaining treatment goals from the wax up to the final restorations. His concepts are taught with minor variations by several clinicians (including me).

You did a very nice job following a well accepted algorithm. And I know your patient must be very pleased. I’d like to get your thoughts about frame work design and the decision not to cross arch splint.
Does Stephen Phelan only offer webinars courses?

He has an online course as well as a live weekend seminar. The seminar is very good, but it is a very large group and lecture style, not hands-on or interactive. I found that the seminar was a good overview of the subject, but a lot of things flew right over my head since it was my first exposure to FMR. The online course is the perfect complement to fill in the missing pieces.

Great result, well done. Were there mobilities amongst the abutments?

Do you have any concerns about the final posterior crown positions in relation to the roots or alveolus? Did you and your lab discuss the possibility of building in a posterior cross bite?

Well, you do not see the value of doing some bonding on the lower anterior and a treatment lower partial at least? I have the same question as Lane as well, given the drifting of the maxillary teeth, why cross arch stabilization was not considered or chosen, especially when one side was missing a canine. Phelan's stuff looks cool, kudos for someone who shoots with a full-frame DSLR.

I would have to research the reasons why I would cross arch splint. This was a long span bridge with multiple abutments anyway, I did not want to make the bridge any longer than absolute necessary in case it ever needs to be replaced… hopefully not. Maybe give me your thoughts on framework design and I can explain why I thought the way I did.

Surprisingly everything is solid as a rock. I was sure that I was going to find a lot of decay and problems but when everything was removed and cleaned up it was very clean and good. As awful as his teeth looked, they were rather clean.

The partial is in the lab right now being rebased and getting new teeth on it. I could have done it earlier but I decided to do it after I had the finals done on the upper and had worked out the occlusion. I adjusted the partial to fit the new upper occlusal scheme.

The plan included both arches, however the patient did not accept any of the lower treatment plan right now—he wanted to start on the uppers. I did alter the plane of the lower incisors to even them out.

That bridge did not drift. It was put in that way. It may have drifted some but I was told that it was like that from day one. So, cross arch stabilization, do you mean extending the bridge abutments past the midline?

Or do you mean building the posterior in cross bite in order to provide forces that "push" the upper bridge to the midline to compensate for drifting? I have to admit that the concept of cross arch stabilization is in my blind spot right now.

Think about your current case design, then think about the forces acting on the segments during masticatory function, particularly working movements.
My comments are based on what I see. In the initial photo, if you draw a perpendicular to the incisal edge it looks like the segment is pushed out to the buccal, and the space under the cuspid pontic adds to my concern.

At your two month provisional picture, did you fabricate your provisional with equal incisal edges and the contact closed? My additional concern is it has opened in response to the functional forces.

OK, I understand what you are saying. I would agree with you if I thought that this bridge was pushed out that way. It was not. It was made that way. I know that it seems hard to believe but when you take that bridge and hold it you see how it twists. The front tooth was not angled that way at all which was quite a surprise.

The space between 8 and 9 did not open up, the initial temp bridge that the lab made did not fit on the preps at all and I had to cut it into sections. I then remade the temps in sections and there was that gap in between 8 and 9. I was not happy with it but you could not see it without pulling up his lip a lot so I left it rather then try ad close it with flowable.

So, in a case where these forces were the reason for the splaying of the teeth, you mentioned building in crossbite in the posterior... could you explain that concept a little for me?

Does anyone have suggestions for where I could learn more about evaluating and establishing the proper occlusion for a full rehab case like this? I feel comfortable with most of the steps involved with a full rehab case, but I lack the confidence when it comes to establishing the proper guidance and knowing what adjustments to make at delivery. I plan on eventually taking one of the big name occlusion courses, but I probably won’t be able to afford it for another few years.

Crossarch splinting is creating resistance against dislodging or rotational forces obtained by using the natural teeth on the opposite side of the dental arch from the edentulous space to assist in stabilization.

Let’s look at what you have.

By fabricating an FPD that ends at the central your fulcrum line (green) is between the bi and the lateral. The dislodging force (blue arrow) is 90 degrees to the fulcrum line and movement in this direction will put the lateral under compression and the central under tension. Without a cuspid, this is not an ideal situation. Just by splinting across the midline to the opposing cuspid, look how the fulcrum line (orange) and the force to dislodgment (red arrow) changes, all the teeth are now under compression.