# ADVANCED INTERDISCIPLINARY TREATMENT FOR ESTHETIC REHABILITATION OF CONGENITALLY MISSING MAXILLARY LATERAL INCISORS:

## *A Case Report*

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## Abstract

This case report explores the oral rehabilitation of a young patient with congenitally missing maxillary lateral incisors. An interdisciplinary approach involving digital planning, orthodontics, gingivoplasty, and minimally invasive adhesive dentistry procedures, such as injectable direct composite resin restorations and resin-bonded fixed dental prostheses (Maryland bridges), was employed to address both esthetic and functional concerns. Advanced computer-aided design/computer-aided manufacturing technology was instrumental in ensuring predictable results. The patient reported high satisfaction, demonstrating the success of integrated treatment planning and execution.



**Key Words: esthetic rehabilitation, Maryland bridge, RBFDP, digital dentistry, orthodontics, minimally invasive dentistry**

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## LEARNING OBJECTIVES

**After reading this article, the participant should be able to:**

1. Develop a treatment sequence for replacing a missing tooth.
2. Ascertain the most appropriate modality for treating missing lateral incisors.
3. Determine the type of treatment best suited for various conditions involving hypodontia.

Disclosures: *The authors declare no conflicts of interest.*

## Introduction

### Maxillary Lateral Incisor Agenesis

Congenitally missing teeth, or tooth agenesis, is considered one of the most common anomalies in dental development. According to the literature, certain genetic and environmental factors can contribute to hypodontia, with the permanent dentition being more frequently affected than the primary dentition.[1-3] According to some studies, agenesis of the maxillary lateral incisors is the second most common type of agenesis, while other articles describe it as the third most common.[1-4] It is prevalent in approximately 1% to 2% of the population, occurs bilaterally more often than unilaterally, and has been shown to be more common in women than in men.[2-5]

### Importance of Early Diagnosis

It is important to note that patients with congenitally missing maxillary lateral incisors face an esthetic problem that can impact their self-esteem.[2,3,5] Clinicians should be aware of clinical signs that indicate agenesis to make an early diagnosis (ideally, when the patient is 8 or 9 years old).[1,3] A delay of more than 1 year beyond the expected eruption time of the permanent tooth, or more than 6 months after eruption of the contralateral tooth, may suggest that the permanent tooth is absent.[1,3] Other signs of maxillary lateral incisor agenesis include the presence of generally narrower teeth, deviation of the maxillary dental midline, palatal displacement of canines, and peg-shaped maxillary lateral incisors.[1]

### Interdisciplinary Treatment

Treatment of maxillary lateral incisor agenesis requires an interdisciplinary approach. The treatment choice is based on a complex decision-making process.[1,6] A balanced, symmetrical smile line is considered essential for facial esthetics, which influences facial expression, overall physical appearance, and psychological well-being.[5] Ideally, the treatment selected should be the least invasive option that satisfies the case's esthetic and functional objectives.[7] Orthodontic treatment will usually be required to either open space for the missing teeth, with subsequent prosthetic replacement, or to close the space, followed by canine substitution (reshaping the tooth to resemble a lateral incisor).[2,4,5,7]

Regarding prosthodontic interventions, the following treatment options should be considered:

- implant-supported restorations
- resin-bonded prostheses
- fixed partial denture (FPD) prostheses (full-coverage two- or three-unit prostheses).[1]

Several studies have compared the long-term cost-effectiveness of these different prosthetic treatment approaches and found that the least cost-effective modality was the full-coverage FPD, while resin-bonded prostheses were considered more cost-effective than single-implant crowns.[1]

### Findings in the Literature

One of the most controversial topics in the literature regarding treatment of maxillary lateral incisor agenesis is whether to open or close the space with orthodontic intervention. According to a systematic review, the indications for both treatment modalities are supported mainly by the patient's oral

*"Clinicians should be aware of clinical signs that indicate agenesis to make an early diagnosis."*

characteristics.[8] Different factors can help clinicians make the proper treatment decision, such as the patient's lip and smile lines, facial profile, amount of space available, molar and incisal relationships, and characteristics of the canine and its relationship to the central incisor.[1,4,7,9] According to some authors, when both orthodontic space closure and opening interventions are possible, space closure is preferable due to its superiority in ensuring periodontal health, the likely absence of long-term biological and technical complications, and the ability to complete the treatment during early adolescence.[1,3,7-9] However, the esthetic outcome of this treatment approach may not be suitable for every patient.[3,4] In fact, several studies have reported difficulty obtaining adequate esthetics when substituting the canine for the lateral incisor because of differences in color, shape, and root volume.[8] Moreover, many patients do not meet the specific requirements necessary to be considered optimal candidates for space closure with canine substitution; for example, patients with a moderately convex profile, retrusive mandible, and/or a deficient chin. In these cases, an alternative form of treatment must be considered.[1,3,6] Space opening with prosthodontic replacement of the lateral incisors is indicated in cases of a Class I molar relationship, a Class III malocclusion with a concave facial profile, and cases in which canine recontouring is not recommended.[1] In addition, some authors have stated that prosthetic lateral incisors have superior esthetics when compared to camouflaged canines.[7] For more favorable outcomes with space opening, the advantageous situations include sufficient enamel on the abutment tooth for bonding (if an adhesive bridge is planned), the presence of a spaced dentition, and a Class III skeletal profile.[7]

### Importance of Conservative Treatment

The increasing demand for minimally invasive treatments has led clinicians and the dental industry to develop ultraconservative techniques and highly precise, resilient materials. Dentists and patients understand the importance of conserving as much sound dental structure as possible, both for the longevity of the treatment and for general dental health. Following this principle, resin-bonded fixed dental prostheses (RBFDPs) have gained popularity due to their noninvasive nature. According to several studies, RBFDPs offer a simple, inexpensive, and esthetic solution for replacing congenitally missing maxillary lateral incisors.[1,3,4] A systematic review published in 2008 regarding the survival and complications of resin-bonded prostheses demonstrated a 5-year survival rate of 87.7%.[10] Today, notable advances in restorative dentistry and dental adhesion have led to an increase in the survival rates of RBFDPs. Finally, the biological cost of an RBFDP is much less compared to conventional two- or three-unit fixed dental prostheses, which require extensive reduction of the adjacent teeth.[1,3]

When treating patients with congenitally missing maxillary lateral incisors, the orthodontist and prosthodontist should collaborate closely to ensure that the patient's biological, functional, and esthetic needs are met. The orthodontist should be aware of the final treatment plan in order to position the adjacent teeth properly and facilitate the subsequent restorative work.[1,6,7] The treatment philosophy of the present authors goes beyond excellent esthetics and function—their perspective is that conservative treatment should be a significant goal of any intervention, especially for young patients. Given this, the present clinical case will elaborate on a minimally invasive treatment approach to address congenitally missing maxillary lateral incisors.

## Tips

| BEGINNER | INTERMEDIATE | ADVANCED |
|---|---|---|
| • Focus on clear communication with patients to align treatment goals with their expectations. | • Invest time in mastering digital tools such as CAD/CAM for treatment planning and execution. | • Prioritize interdisciplinary collaboration for complex cases involving multiple specialties. |

**Figure 1:** Initial extraoral photographs.

**Figure 2:** Facial analysis (initial situation).

**Figure 3:** Initial intraoral photographs: frontal, lateral, and occlusal views.

## Case Description

### Patient Overview and Initial Assessment

A 13-year-old patient presented with the chief complaint of being self-conscious about the appearance of his teeth. The patient's medical history was unremarkable (American Society of Anesthesiologists [ASA] Class I). His dental history revealed moderate oral hygiene with congenitally missing maxillary lateral incisors (teeth #7 and #10). The patient's teeth were also narrow and had incorrect proportions. The clinical assessment included extraoral and intraoral examinations, as well as a facial and smile analysis. Radiographic imaging, including panoramic radiographs, confirmed the absence of #7 and #10. The facial analysis revealed a convex profile angle, a retruded chin, and an obtuse nasolabial angle.

### Treatment Plan

A comprehensive treatment plan was designed to restore both esthetics and function. The main steps included the following:

**Prophylaxis:** Initial cleaning was performed to optimize oral hygiene.

**Digital planning and mock-up:** 2D and 3D computer-aided design (CAD) programs were used to optimize esthetics and functional visualization.

**Direct composite restorations:** An injectable composite resin restorative technique was employed on the maxillary central incisors to guide orthodontic treatment.

**Orthodontic treatment:** A conventional fixed appliance was used, followed by orthodontic aligners, to create adequate space for the lateral incisors and for general tooth alignment.

**Pontic site development:** The orthodontic aligners and direct composite were used to optimize the gingival architecture on the pontic site.

**RBFDPs:** RBFDPs (Maryland bridges) were utilized for the final prosthetic restorations for teeth #7 and #10.

### Treatment

**Diagnostics:** Following the initial assessment, comprehensive diagnostics were conducted, aided by extraoral and intraoral photographs **(Figs 1-3)**, panoramic radiographs **(Fig 4)**, intraoral scans **(Fig 5)**, and 2D planning and smile simulation **(Figs 6-9)**. The 2D smile simulation was then translated into a 3D wax-up using a dental CAD software program (exocad America; Wakefield, MA) **(Fig 10)**. A 3D printer (Pro2, SprintRay; Los Angeles, CA) was used to produce the 3D models of the smile simulation, as well as a 3D guide for gingivoplasty **(Figs 11 & 12)**. A silicone index (Zetalabor, Zhermack; Badia Polesine [RO], Italy) was made from the 3D model of the wax-up to fabricate the mock-up, which was created by injecting bisacryl material (Structur 3, A1, VOCO America; Fort Mill, SC) onto the silicone index and firmly placing the index over the patient's teeth intraorally.

**Restorative work:** After excess material was removed, multiple-view photographs were taken **(Fig 13)**. The patient, his parents, and the clinician approved the mock-up. Afterward, a transparent silicone index (ExaClear, GC America; Alsip, IL) was created by taking an impression of the wax-up to produce direct injectable composite resin restorations for the maxillary central incisors. Then, small perforations were created with diamond burs to fit the tip of the flowable composite resin. Gingival retraction cords #000 (Ultrapak, Ultradent; South Jordan, UT) were placed, and a fluoride-free prophylactic paste was applied to clean the tooth surfaces. The teeth were isolated and separated using a polytetrafluoroethylene band. The enamel was treated with 35% phosphoric acid (Ultra-Etch, Ultradent) for 30 seconds, then washed with water and air-dried. The adhesive system (3M ScotchBond Universal Plus, Solventum; Maplewood, MN) was applied actively for 20 seconds and lightly air-dried. The adhesive layer was polymerized for 20 seconds. Then,

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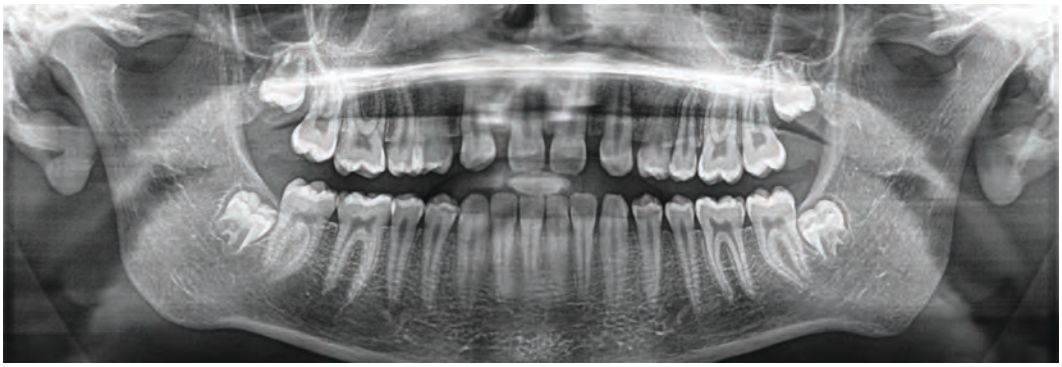


**Figure 4:** Initial panoramic radiograph.

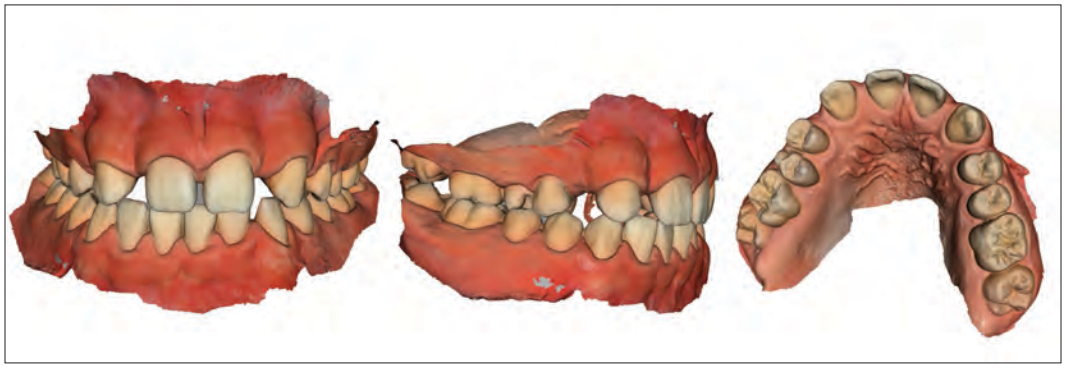


**Figure 5:** Initial intraoral scan.

a flowable composite resin with a high filler load (G-aenial Universal Flow, A1, GC America) was used to produce the injectable direct restorations. Finally, the restorations were finished and polished, and a glycerin gel was applied to the surface **(Figs 14-16)**. This restorative step of the treatment was extremely important to help guide future orthodontic treatment by establishing the ideal dimensions of the maxillary central incisors.

**Orthodontics:** The orthodontic treatment was performed in two phases. First, a self-ligating fixed appliance was used to open the spaces for the maxillary lateral incisors via distalization of the canines and premolars. When sufficient space was obtained, provisional crowns were placed on the lateral incisors and bonded to the central incisors, with the fixed appliance still in place **(Figs 17-19)**. After the conclusion of the first phase, the fixed appliance was removed. Invisible aligners (Smilers, Biotech Dental; Salon-de-Provence, France) were used for the second phase, which involved finishing and detailing. To help with pontic site development, each aligner was filled in with composite resin at the position of the lateral incisors. The invisible aligners allowed for easy try-in and soft tissue remodeling, as well as greater control and precision for the final movements **(Figs 20 & 21)**.

**Rehabilitating the edentulous spaces:** The final step of the treatment involved rehabilitating the edentulous spaces at teeth #7 and #10 with RBFDPs and direct composite restorations on the maxillary canines to achieve more harmonious shapes and proportions. The final impression was created digitally with an intraoral scanner (Medit i700, Medit USA; Newport Beach, CA) **(Fig 22)**. The RBFDPs were then fabricated through a full digital workflow that incorporated CAD/CAM technology. They were first designed in dental software (exocad) and then milled in a five-axis milling machine (model R5, vhf camfacture; Hauppauge, NY) from a lithium disilicate block **(Figs 23 & 24)**. The ceramic RBFDPs were tried in to evaluate esthetics, proximal contacts, occlusion, and color.

**Bonding the RBFDPs:** After the patient and his parents approved the esthetics, the bonding surfaces of the RBFDPs were treated according to the following sequence: etching with 5% hydrofluoric acid (Porcelain Etch, Ultradent) for 20 seconds, followed by rinsing and drying; washing in an ultrasonic bath for 2 minutes with alcohol to clean off etching remnants; and treating with silane (Monobond S, Ivoclar; Amherst, NY) **(Figs 25 & 26)**. The enamel on the palatal surfaces of #7 and #10 was treated with 35% phosphoric acid for 30 seconds, washed in water, and air-dried. Then, adhesive (OptiBond FL, Kerr; Orange, FL) was applied actively for 20 seconds, air-dried, and polymerized for 20 seconds **(Fig 27)**. The RBFDPs were then bonded with heated composite resin (3M Filtek Z100). Finally, the excess was removed, and occlusion was verified. The final result achieved a natural appearance characterized by tooth position and shape, gingival margin symmetry, papilla location, and color **(Figs 28-36)**.

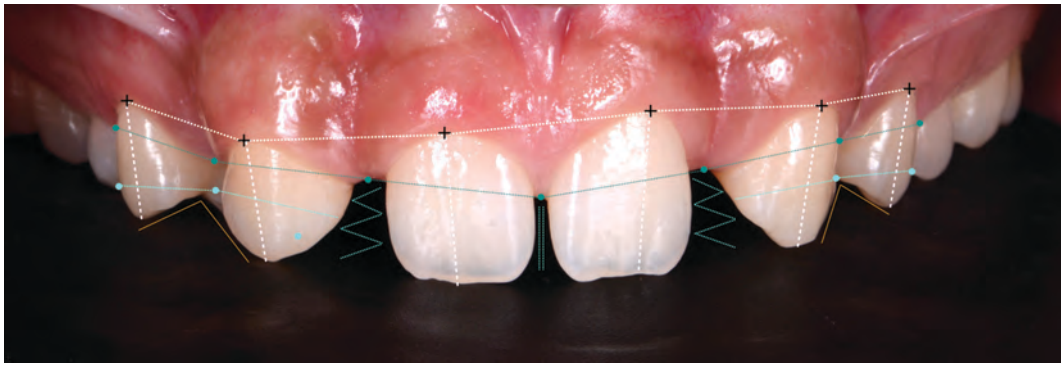
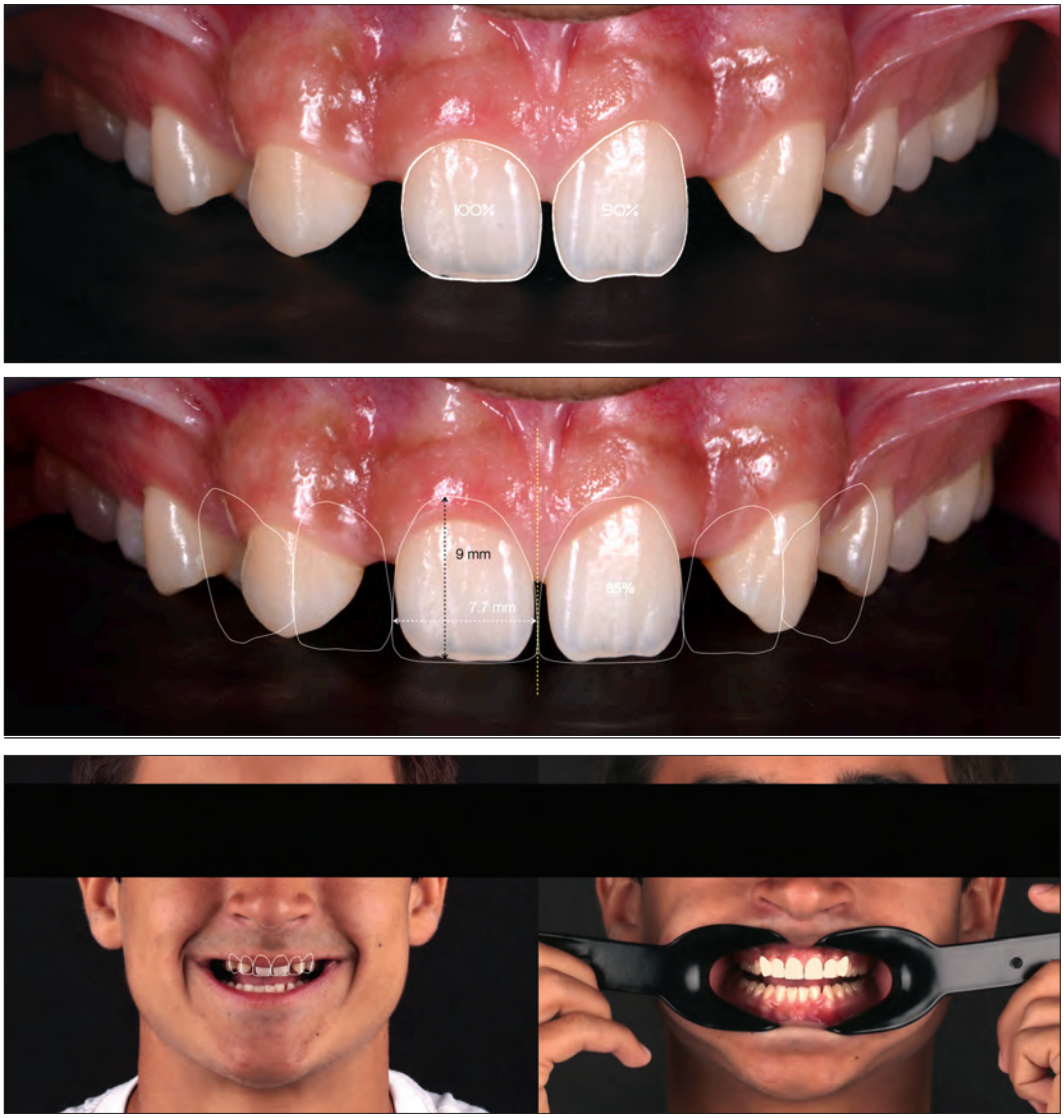


**Figure 6:** Smile analysis.




**Figures 7-9:** 2D treatment planning.

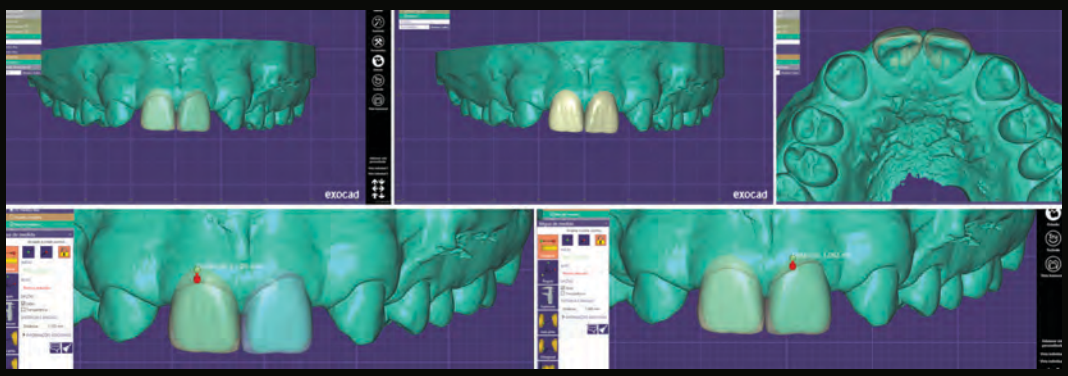



**Figure 10:** 3D treatment planning in dental CAD software.

**Figure 11:** 3D-printed model and guide for gingivoplasty.

**Figure 12:** Intraoral view of 3D-printed guide for gingivoplasty.

**Figure 13:** Facial photograph and close-up smile views of mock-up.

**Figure 14:** Guide for injectable direct composite resin restorations.

**Figure 15:** Sequence of clinical steps for the injectable direct composite restorations on the maxillary central incisors (#8 and #9).

**Figure 16:** Intraoral photographs following the injectable direct composite restorations.

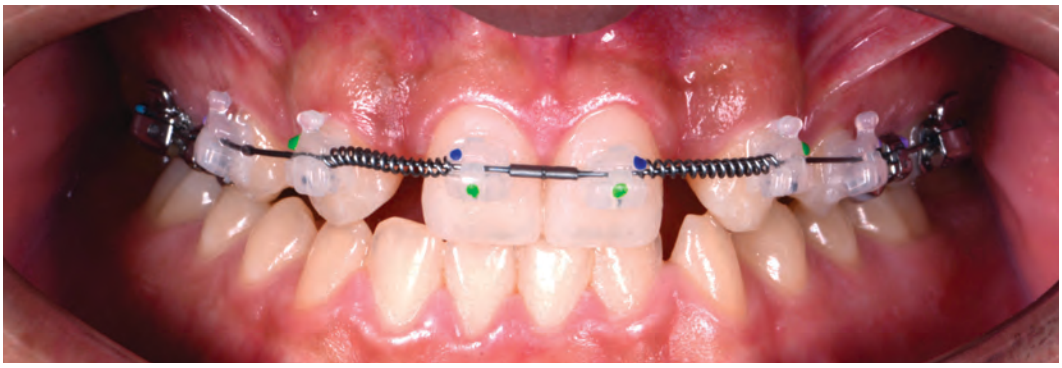
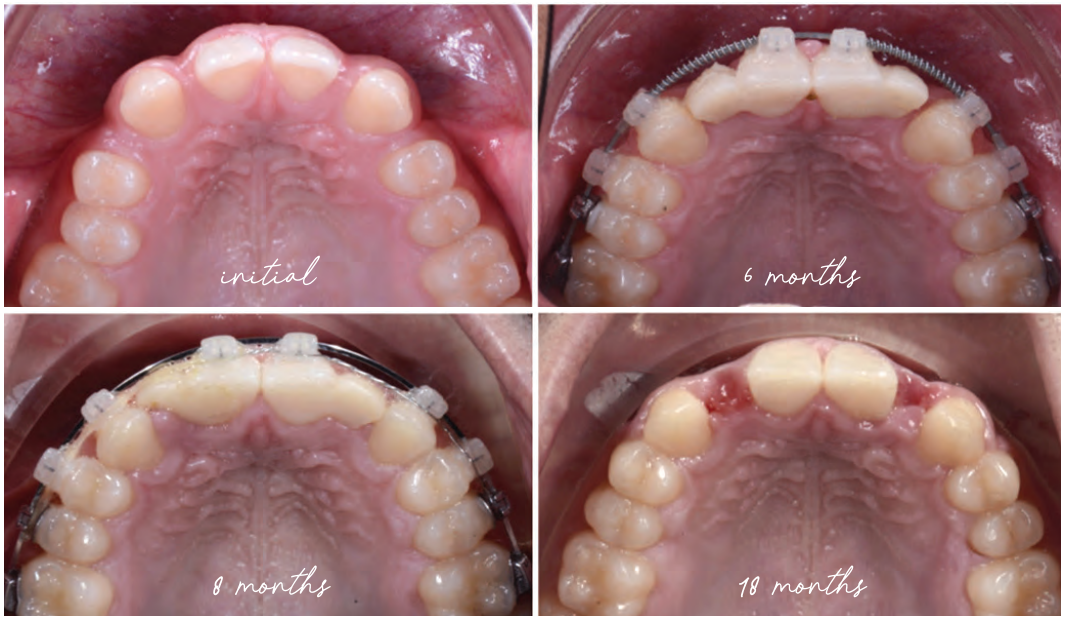


**Figure 17:** Self-ligating fixed appliance (beginning of treatment).




**Figures 18** & **19**: Treatment progression with self-ligating fixed appliance: frontal, lateral, and occlusal views.

**Figure 20:** Occlusal view following removal of the fixed orthodontic appliance.

**Figure 21:** 3D treatment planning of invisible aligner treatment and close-up view of the patient wearing the invisible aligners.

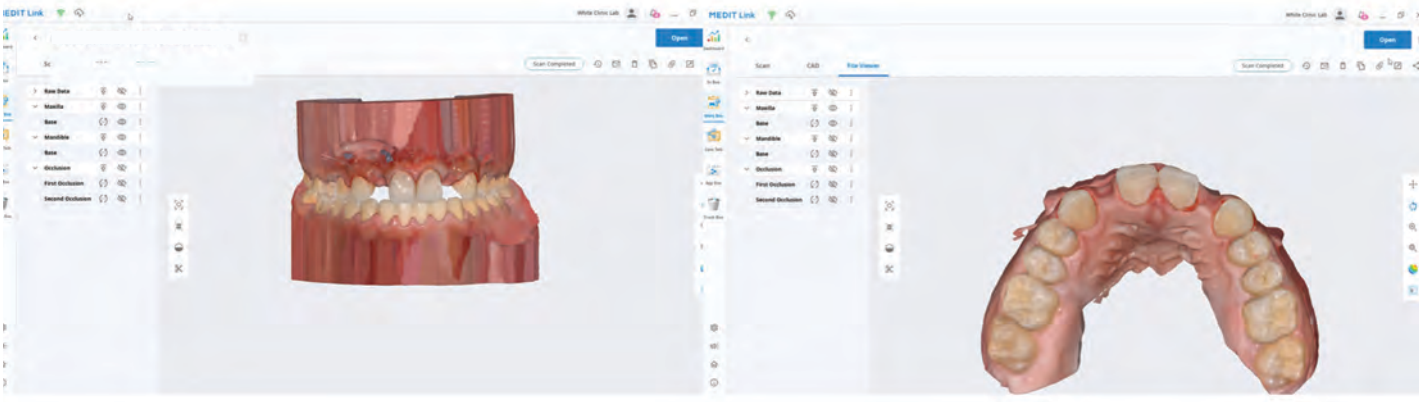


**Figure 22:** Final impression with intraoral scanner.

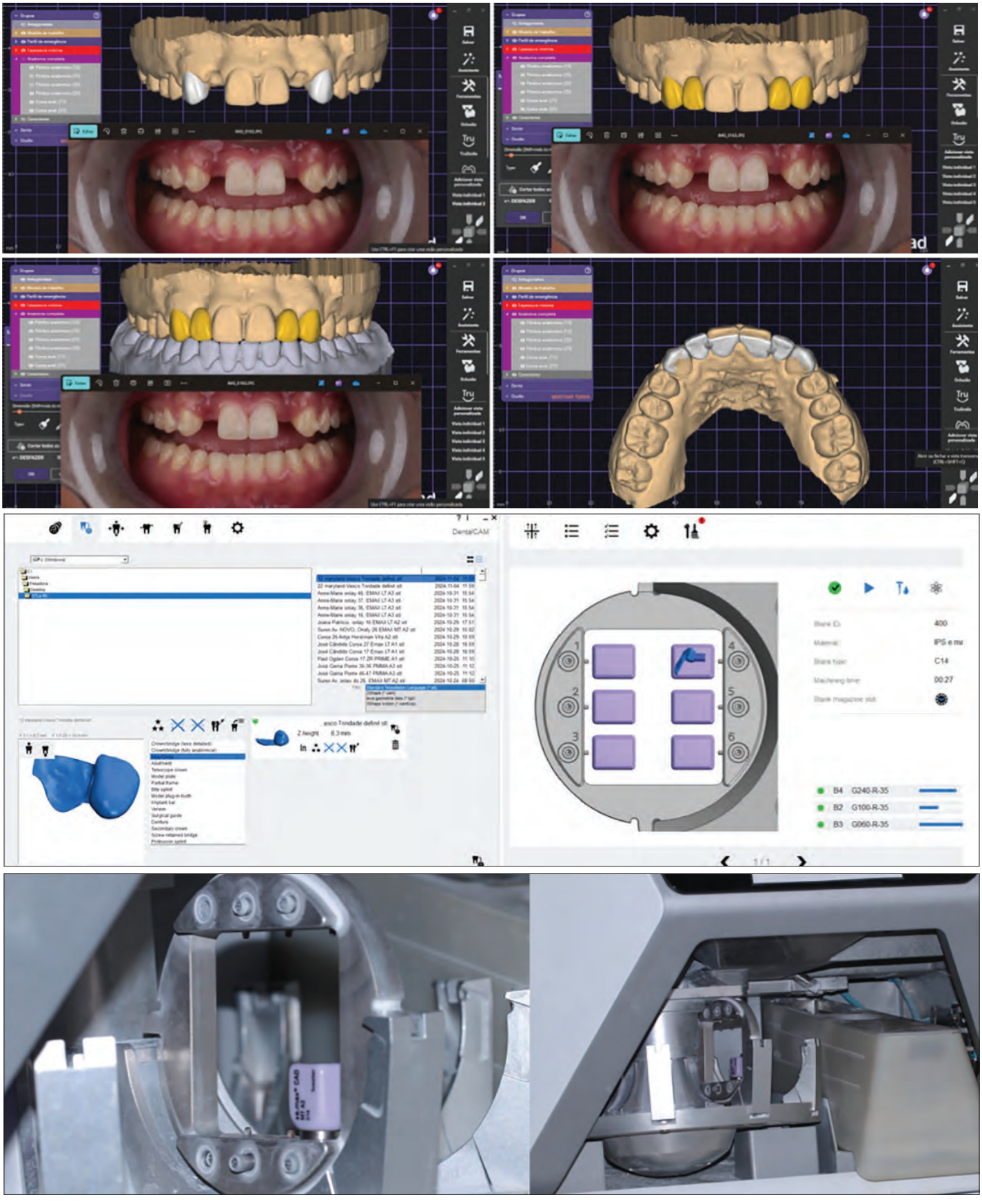



**Figure 23:** CAD/CAM workflow to obtain the RBFDPs.

## Discussion

### Orthodontic Space Closure and Opening

According to various studies, the management of patients with maxillary lateral incisor agenesis involves either space closure with canine substitution or space opening with prosthetic replacement of the lateral incisors. Neither approach has been found to be universally superior to the other. Given this, there is consensus that the type of treatment chosen should be dependent on the patient's individual oral characteristics.[1-8]

**Space closure:** The main advantages of orthodontic space closure include the longevity of the treatment, the ability to complete it during the patient's early adolescence, the potential to avoid prosthodontic interventions, and, typically, the lower costs involved.[1,6,7] Clear indications for this treatment approach are a Class I malocclusion with severe crowding in the anterior region of the mandible or a Class II malocclusion without crowding or dental protrusion in the anterior segment of the mandible.[1,2,6,7] It is also important to consider the relative sizes of the anterior teeth when the plan is to substitute a canine for a lateral incisor. The ideal canine for substitution should have similar proportions in width and convexity as the lateral incisor, which is not often the case.[2,6,7] If the canine is relatively large, reshaping it will require a significant amount of tooth reduction to appropriately position these teeth esthetically and functionally in the three planes of space. This amount of crown reduction can be excessive, which is not ideal, especially in young individuals.[1,3,6,7]

**Space opening:** In the present clinical case, the patient presented with a convex profile and a deficient chin prominence. Additionally, the maxillary arch was already narrower than the mandibular arch, and the teeth in general had small dimensions that did not match the size of the dental arch. In this specific situation, closing the spaces would further collapse the maxilla, creating both esthetic and functional issues. For this reason, the orthodontist and prosthodontist decided to open the space for the missing lateral incisors. To optimize the final outcome, two different types of orthodontic appliances were used: a self-ligating fixed appliance in the first 18 months of treatment, and invisible aligners for the last 4 months of treatment. It was decided to use invisible aligners during the final part of treatment for finishing and detailing, and because this method facilitates the process of gum modulation on the pontic site as well as the try-in appointments for the RBFDP.

**Invisible aligners:** Clear aligners have been described both in the literature and by patients as offering a more physically comfortable experience compared to traditional orthodontic treatments.[11] Other advantages include esthetics, easy oral hygiene maintenance, and less psychological discomfort.[11] In fact, a recent systematic review concluded that patients treated with clear aligners show higher oral health-related quality of life during orthodontic treatment than patients treated with conventional orthodontic appliances.[11] It has been frequently reported in the literature that one of the greatest limitations of clear aligners is their lower efficiency with respect to some types of orthodontic movements in comparison to traditional fixed appliances.[12] However, the technology behind invisible aligners has been improving continuously and significantly; today, a large number of cases, even moderate or very complex ones, can be managed with aligners.[13]

**Mock-up:** The correct way to assess the ideal width of missing lateral incisors is a diagnostic wax-up.[1,2] Thus, in the present clinical case, a mock-up was made before beginning the orthodontic treatment. This mock-up also served to establish the proper width for the maxillary central incisors prior to orthodontics and facilitated the treatment for both the orthodontist and the restorative dentist, as there was a reference to follow throughout the treatment. When space opening is the chosen modality, the space distribution of the edentulous regions mesial and distal to the canines and central incisors, as well as the occlusion and esthetics, will determine and guide the orthodontic treatment and posterior prosthodontic rehabilitation.[1]

*"When treating patients with congenitally missing maxillary lateral incisors, the orthodontist and prosthodontist should collaborate closely to ensure that the patient's biological, functional, and esthetic needs are met."*

**Figure 24:** Final ceramic RBFDP restorations on the 3D models.

**Figure 25:** Adhesion protocol for the RBFDPs consisted of etching with 5% hydrofluoric acid for 20 seconds, followed by rinsing and drying.

**Figure 26:** Adhesion protocol for the RBFDPs: silane.

**Figure 27:** Adhesion protocol for the RBFDPs: adhesive.

**Figures 28** & **29**: Intraoral photographs of the final restorations, frontal and occlusal views.

**Figure 30:** Final situation, close-up smile view.

### Prosthodontic Interventions

The prosthodontic interventions available to restore missing lateral incisors include single-tooth implants, full-coverage fixed dental prostheses, or RBFDPs.[1,7] The primary consideration when determining the best option for each case is the conservation of tooth structure. The treatment of choice should always be the least invasive option that still meets the case's functional objectives and esthetic requirements.[3,14]

**Single-tooth implants:** The single-tooth implant has become one of the most popular treatments for replacing missing teeth due to the high rates of successful osseointegration, the long-term function of implant-supported restorations, and the fact that it leaves the adjacent teeth untouched.[2,3,15] However, particularly for cases with congenitally missing lateral incisors, the clinician must consider important parameters, such as the time of implant placement (i.e., the patient's age), the amount of bone available, the space needed coronally (mesiodistally) and apically (interradicular spacing), the height of the gingiva, and retention of space needed before implant placement.[1,2,3,7,10,15] Regarding the timing of implant placement, studies have demonstrated that females complete their facial growth by 17 years of age, whereas males demonstrate facial growth up to age 25.[1,2,3,7] Implants cannot be placed before the completion of facial growth, as this can cause significant periodontal, occlusal, and esthetic problems.[3,7] The risk of infraocclusion of the implant-supported restorations may occur during mature adulthood due to continuous eruption of the teeth long after the completion of facial growth, whereas implants cannot erupt.[1,3,5,10] This means that loss of leveling between the implant crown and the adjacent teeth over time must be expected.[8]

Several studies have demonstrated that after completion of orthodontic treatment for space opening, patients exhibit a reduction in alveolar bone width and loss of ridge height. Additionally, without the development and eruption of the lateral incisors, the osseous ridge and soft tissue are typically deficient.[1,3,4] Given this, augmentative procedures (such as bone graft and connective tissue graft) may be necessary in most cases to guarantee enough bone for proper 3D positioning of the implant and for adequate esthetics.[1,2,3,4,7] Following these needs, the single-implant option to restore congenitally missing lateral incisors will often represent a high-cost and quite invasive treatment approach.

**Full-coverage fixed dental prostheses:** Regarding full-coverage fixed dental prostheses, two options are available: a conventional bridge and a cantilever bridge.[1] These types of restorations are considered to be the least conservative of all tooth-supported restorations, as the amount of tooth reduction required is extensive and can lead to pulpal trauma, especially in young patients. Given this, its use is quite rare in the treatment of tooth agenesis in the anterior region.[1,3,7,16] Possible indications for a full-coverage fixed dental prosthesis include the replacement of an existing bridge or the presence of adjacent teeth that require rehabilitation due to extensive caries, fractures, and/or discoloration.[1,2,3,7]

**RBFDPs:** The aforementioned information supports why the authors chose RBFDPs to restore the present patient's con-

genitally missing maxillary lateral incisors. Resin-bonded prostheses are considered to be the most conservative and most predictable treatment option. Since they rely on adhesion alone, the adjacent teeth are subject to minimal or no tooth preparation. In addition to avoiding pulpal trauma, RBFDPs involve lower costs and less chair time in comparison to conventional fixed prostheses.[1-3,7,14-19]

Regarding the longevity of RBFDPs, a systematic review published by Pjetursson et al. on earlier types of resin-bonded prostheses demonstrated a 5-year survival rate of 87.7%. The most frequent complication was debonding.[10] Today, the change in the prosthesis design from two retainers to a single retainer, as well as the use of all-ceramic restorations and precise adhesive techniques, has decreased the frequency of debondings and fractures, increasing the survival rates. In fact, the literature on single-retainer, all-ceramic resin-bonded prostheses describes survival rates ranging from 94% to 99% and finds that this treatment approach has been clinically demonstrated to have excellent esthetics and function.[1,14-19] Naenni et al. conducted an in vivo study to assess the clinical outcomes of single-retainer RBFDPs after a mean of 10 years (range 7.4 to 13.3 years) in function, and the survival rate was 100%. Neither technical failures nor biologic complications were reported.[16] In any case, it is widely stated in the literature that the most common type of failure with an RBFDP is debonding, which does not affect the adjacent teeth.[4,18,19]

To achieve optimal outcomes using RBFDPs, clinicians should consider the specific requirements of this treatment option. These include the position and mobility of the abutment teeth, as well as the overall occlusion. A shallow overbite is considered the ideal interincisal relationship, as it reduces excessive lateral forces on the abutments and allows sufficient tooth surface for bonding.[1,2,3,17] Deep overbites and proclined teeth are important contraindications for RBFDPs.[3]

**Present clinical case:** In this particular case, the patient was periodically evaluated by the restorative dentist, especially during the final part of the orthodontic treatment, to ensure that the occlusal requirements for the placement of the RBFDPs were met. Additionally, during the final stage of the orthodontic treatment, when the patient was using invisible aligners, the restorative dentist initiated the pre-prosthetic development of the pontic site. In this case, soft tissue augmentation was not considered due to the patient's age and low smile line. Pontic site development may be carried out before the final impressions or at the time of fitting the final prosthesis. When performed before the final impressions, it can be conducted with either a removable provisional prosthesis or a fixed prosthesis.[20,21] In the present clinical case, the restorative dentist used orthodontic aligners filled in with composite resin on the missing lateral incisor spots to augment the fitting surface of the pontic. The composite resin, with a shaped ovate pontic, compressed the gingival tissue and developed the pontic site. The goal of the ovate pontic is to create the illusion that the tooth is emerging from the mucosa, mimicking a natural tooth.[20,22]

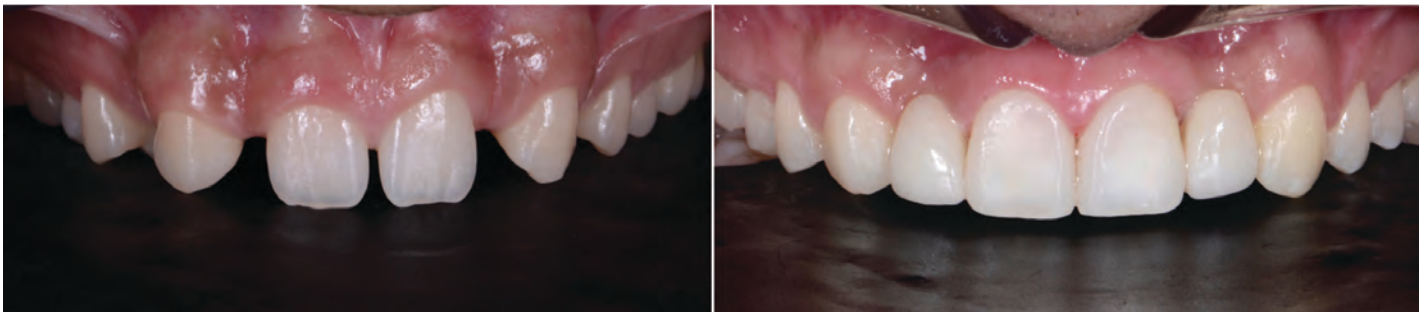


**Figure 31:** Before and after intraoral photographs of the maxillary arch.

**Figures 32** & **33**: Before and after photographs, occlusal and frontal views.

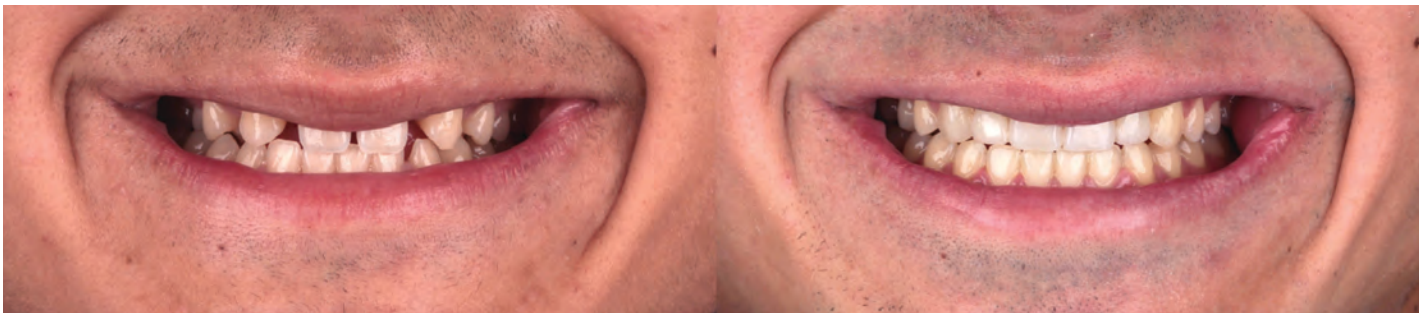


**Figure 34:** Before and after photographs, close-up smile view.

**Figure 35:** Before and after photographs, right lateral view.

**Figure 36:** Before and after photographs, left lateral view.

## Summary

The treatment of congenitally missing teeth requires an interdisciplinary approach. The use of advanced digital workflows is of great importance for the accuracy and precision of the treatment delivered. There are several restorative options for replacing congenitally missing lateral incisors. The lack of randomized controlled trials and the limited number of prospective and retrospective studies comparing the different treatment options make it difficult to draw definitive conclusions about the superiority of one option over the others. However, each restorative option can achieve a high degree of success when used in the appropriate clinical situation. This case demonstrates how modern techniques and collaborative planning can lead to good esthetic and functional results, significantly improving patient confidence and quality of life.

*"To achieve optimal outcomes using RBFDPs, clinicians should consider the specific requirements of this treatment option. These include the positions and mobility of the abutment teeth, as well as the overall occlusion."*

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## Keynote Speaker

### AACD 2026 Aventura

Dr. Miguel Stanley will headline the Scientific Session at AACD 2026 Aventura on Saturday, April 18, with his presentation, *Beyond Beauty: The Evolution of Modern Cosmetic Dentistry*. A global leader in cosmetic and interdisciplinary care, Dr. Stanley teaches that treatment must extend beyond enhancing esthetics to encompass longevity, biological safety, and systemic health. His approach integrates digital workflows, AI-driven planning, and biocompatible materials to ensure precision, predictability, and patient-centered outcomes while reducing biological risks. These same guiding principles are reflected in his contribution to this issue of the *jCD*. To learn more and to experience Dr. Stanley's insights live, join us at the AACD 2026 Aventura Scientific Session by registering at www.aacdconference.com

Dr. Rodrigues received her Master's degree from the Faculty of Dental Medicine at the University of Lisbon in Portugal. Her clinical practice in Lisbon is dedicated to restorative dentistry, esthetics. and prosthodontics.

Dr. Curto received her dental degree from the University of Bari in Bari, Italy. Her clinical practice in Lisbon, Portugal, is devoted exclusively to orthodontics.