Composite resins are excellent materials available to all clinicians. The evolution of their mechanical and optical properties, as well as the curing lights that achieve an effective conversion make them an excellent choice, not only when we restore cavities or small parts of a tooth, but also when we have to perform in large dental reconstructions. All this combined with a good polishing and occlusal adjustment enables good functional and aesthetic results, with a relatively low cost, when compared to laboratory work.

In this case a male patient, 32 years old, heavy smoker, was searching to a treatment that could change his smile, without provisionals or any kind of lab work.
Fig. 1  — Initial aspect of the smile, showing discoloration, large restorations and an inverted curve of the smile.

Fig. 2  — Close-up view of the anterior teeth. The extension of restorations can be perceived. The 1.1 has a root canal treatment performed.
Fig. 3  
Img. 3 – A direct mock-up, with an easy handling composite resin, was performed in the same appointment to motivate and to help communication with the patient.

Fig. 4  
Img. 4 – Frontal view in occlusion with retractors.
Fig. 5  Img. 5 – 4 sessions of in-office whitening were performed, then after 2 weeks all the restorations were removed.

Fig. 6  Img. 6 – After the etchant and the adhesive application (Ultraetch-Ultradent / Single Bond – 3M), the palatal shelf (Renamell OW-Cosmedent) and the first layer of dentin was applied (Herculite A2 – Kerr). At that time, the incisal edge of the lateral incisor is a reference to the length. For large reconstructions, it’s better to start by the hardest tooth.
Fig. 7 – The second layer of dentin (Herculite A1 – Kerr) and the third layer (Tetric-Ceram A1 – IvoclarVivadent) were applied reproducing mamelons and leaving the space for the opalescent layer.

Fig. 8 – The opalescent enamel (Vitalescence TB – Ultradent) and the first enamel layer (Durafill B2 – Heraeus Kulzer) were applied.
Fig. 9 – A little palatal chamfer was performed on the canines to get strength for the excursive guidances. The marginal ridges, the incisal edge and palatal enamel were built with Vitalescence PF – Ultradent. The artificial dentin was built on the histological space with TetricCeram A1.

Fig. 10 – The incisors and canines received the same restorative sequence, respecting the differences between the extensions of the cavities and thickness of the composite resins. The final enamel layer for the incisors was Renamell IL-Cosmedent and Durafill A1 – Heraeus Kulzer. This is the end of main restorative appointment. Just create the basic, primary, geometry and don't worry about refinements or embrasures first.
Fig. 11 - Img. 11 – 1 year follow-up – frontal view

Fig. 12 - Img. 12 – 1 year follow-up – Lateral view
Fig. 13 — Palatal view
Fig. 15 – Frontal aspect of the smile – 1 year after the procedure
Fig. 16 – Frontal aspect of the smile – 4 years follow-up
In this article we can see the possibility of large, simultaneous reconstructions with a free hand bonding approach. Composite
resin can provide durability and aesthetics, as long as we know how to explore the characteristics of the composite resins commonly found on the market. Associated to the knowledge of dental anatomy and occlusion, composite resins are an excellent option to solve complex cases in the daily routine.