Regardless of the type of the clinical situation, major flaws can strongly impact on the quality of life of a person.

The use of direct composite veneers as a treatment option should be considered the first choice in order to recover the aesthetic appearance of damaged teeth, especially because indirect techniques have a higher biological and economical cost. Composite direct veneering is also the first choice when we think in a minimal invasive way.

A large number of studies have demonstrated long lasting good results for composite restorations in posterior teeth. A recent meta-analysis of prospective studies on anterior composite restorations showed a median overall estimated survival of 95% for class III and 90% for class IV, after 10 years.

When composite veneering was used, the studies showed a satisfactory clinical performance and the survival rate of 80.1% after 3.5 years. Direct composite veneers performed in vital teeth showed a better performance compared to those in non-vital teeth for colour match, fracture and retention outcomes. The same retrospective clinical evaluation (1) showed that veneers in non-vital teeth have two times higher risk of failure than the veneers placed in vital teeth and that was no difference in survival rate between veneers placed with micro-filled or universal composites.

Based on scientific statistics and clinical data, composite veneers could be an option to enhance the aesthetic appearance of our patients' smiles. Of course composite veneers do not exclude the use of indirect restorations such as crowns or ceramic veneers.

In this article, three non vital teeth and one vital tooth were restored with composite to improve the aesthetic appearance. In my clinical practice I call this an "aesthetic emergency" before a long lasting treatment option will be done.

Also, I would like to demonstrate a workflow option that we can use when we want to restore both proximal and vestibular parts of the teeth in the same session. As a basic guideline to follow each time, at first we should concentrate on the restoration of the "frame" of the tooth (proximal and incisal) and after that, we can better focus on the facial aspect of the tooth. Regarding this hypothesis, the steps that are presented in this article have the purpose of enhancing the efficiency of the procedure and spending less time chair side with more predictable aesthetic outcome for the patient.
This patient required aesthetic improvement; restorations with a minimal invasive approach were chosen. After he was informed that he already had invasive restorations, we decided together to improve the aesthetics with composite restorations in one session.

This is the aspect of the teeth after isolation, when the composite in excess can be observed most of the times.
The first thing we do is to remove the old composite restorations and to clean the proximal area – old composite, adhesive in excess, calculus, plaque. Also the width of the central incisors was slightly different and we always should take this into consideration during our restorative procedures.
The main challenge in these situations is to evenly split the space between the centrals. Mylar strips are not very helpful in this step, but two metal matrices (MyCustomRings Kit, Polydentia) can help the dental practitioner to better see where the midline is placed.
Fig. 5  With both matrices in place I have restored 11.

Fig. 6  After applying the composite on the mesial part of 11, I removed both matrices and started contouring the restoration. For a nice outcome, it is critical that the mesial part of 11 has the right shape.
Then, the mesial wall of 21 was restored using only one metal matrix and, after that, both distal walls were built. To check the width of the central, we can use a periodontal probe to measure. In this step, I am not focusing on the vestibular part yet.
Fig. 8  Now, my concern is to have the proximal walls in the right position and to have as much as possible the equal width.

Fig. 9  Next, I have restored the laterals just the proximal walls.
After this step, in order to have a better control over the limits of the restorations on the cervical area, I prefer to do a split of the rubber dam and to place a continuous retraction cord. Then I prepared the vestibular part of the teeth leaving enough space for the composite.
Starting all over the adhesive procedure, I restored the vestibular part of the teeth one by one, beginning with the centrals.

After each reconstruction, I prefer to adjust it as a reference for the next one. Also at this moment you can adjust the length and the morphology of the incisal margin.
If the proximal limits of the veneer are placed in an area where the spatula or the instruments have no access, the metal matrices can be used again.
All four veneers were reconstructed. As a composite material I used Brilliant OA2 for proximal and for the last composite layer A2 Brilliant Ever Glow, Coltene.

After rubber dam was removed, I performed an initial finishing and polishing of the reconstructions. This session took 2.5 hours: anesthesia, isolation, cavity preparation, proximal reconstruction, vestibular reconstruction, and initial finishing procedure.
During the next session, I checked the colour and the composite integration and after that I did the final finishing and polishing procedure.
The main step at this stage is to work with the transition lines. If this step is properly carried out, the composite veneers will have a visual appearance that will please the patient.

The final aspect after finishing and polishing. Also we can see the nice improvement of the gingival aspect only after a few days.
This second appointment was about 1 hour, so the whole procedure took 3.5 hours, divided in two sessions.
1. Composite veneers can be a nice option for vital and non vital teeth.
2. Composite veneers are the less invasive procedures.
3. In case we have to restore both proximal and vestibular parts of a tooth, starting with the proximal walls may prove to be more efficient.