Techniques to solve posterior troubles like deep margin elevation are today more and more often performed in clinical situations in which you would otherwise need resective bone surgery, with lengthening of the clinical crown. The Deep Margin Elevation procedure recently introduced by Prof. Pascal Magne, Dr. Didier Dietschi and Dr. Roberto Spreafico is not an alternative procedure to surgery, but should be used in borderline clinical situations in which isolation with a rubber dam is difficult but still possible, meaning the periodontal biological width allows it, so you can facilitate the impression maneuvers and subsequent isolation for bonding. The concept of biological width postulated by Gargiulo et al in 1961 is a major requirement in restorative dentistry and prosthodontics. The biological width must be respected, both in restorative procedures and in prosthetic ones otherwise we’d create iatrogenic periodontal pockets. This article wants to illustrate a very simple and repeatable procedure which ideal starts with the cleaning of caries and the preparation of a cervical margin, which then must no longer be displaced apically; then the surgery to lower the bone crest to 3 mm from the already prepared cervical margin, and finally the restorative maneuvers. It is a huge mistake to perform the surgery procedures before preparing the cervical margin, as you can end up missing 1 mm or so hence also performing a Deep Margin Elevation later, which is a contradiction in terms.
The pre-operative bitewing shows a big decay on the distal, cervical side of 16
Fig. 2 Pre-operative picture
Fig. 3  After removal of the old filling, it’s pretty clear that the situation will require a crown lengthening procedure.
Fig. 4  The cleaning of the decay and the preparation of the distal cervical margin, and the crown lengthening procedure
Tip: It's mandatory to put the bone crest at 3 mm of distance from the prepared and clean, final cavity margin.
The stitches in place
Fig. 7 In the same session the rubber dam is put back in place, and the mesial decay is cleaned too. Note the good isolation obtained thanks to the surgical procedure.
Details after cleaning, the disto-palatal cusp was removed as it was too thin. In fact, we reduce all the cusps that are less than 2 mm. **Tip:** for composite onlay we need to reduce 2 mm in height too, for lithium disilicate 1 mm is enough.
A build-up is performed, sealing of the dentinal tubules, and preparing the cavity for an onlay.

**Tip:** Clean the dentin with glycine powder and decontaminate it with 2% chlorhexidine, then etch the enamel for 20 seconds, and apply a universal adhesive agent on the dentin and on the enamel, in a self etching mode. It works and performs very well and it prevents post operative sensitivity.
Only at this point we can clean the decay on 15 and 17 and do the direct fillings on them. **Tip:** don’t do them before not to damage them during the preparation of the onlay.
Fig. 11 Details of the placement of the sectional matrices and of the wooden wedges.
The direct restorations on 15 and 17 are done with only one body shade (A2 in this case) and brown stains to increase the perception of depth, and it's finished and polished under dam isolation.

**Tip:** use again a universal adhesive in a self etching mode, with the selective etching technique to have the best performance without post operative sensitivity.

**Tip:** finish and polish the restorations under the dam so to have the perfect control without blood and saliva and tissues to move away.
Before taking impressions we check the occlusion of the restorations. No corrections are needed.
Details of the impression taken with the stitches in place.

**Tip:** take a one step two paste impression to get the best performance of the impression materials with the less distortions.
The composite onlay, on the plaster model.

Fig. 15
After 48 hours the indirect restoration is tried in, with the stitches still in place. Tip: this will reduce the time of the provisionals and the discomfort of the patient.
We proceed with the occlusal check.
The rubber dam’s put in place again and the onlay’s tried in with the rubber dam too, before the bonding procedures.

**Tip:** check it back with the rubber dam in place as it could interfere with the restoration seating.
Finishing and polishing under the dam
The occlusal check at the end of the bonding procedure shows no need for correction.
Final check of the three restorations.
Two weeks post operative, there’s a good integration of the restorations of 15, 16, and 17.
Details of the morphology and anatomy of 15, 16, 17.
Details of the restorations. The tissues after two weeks are still healing.
To restore means to give function and esthetics back to our patients’ teeth. This must be done with accuracy and must last in the long run. We have to follow simple rules and protocols to obtain these goals, with no flight of fancy. As much as these steps can be feasible, predictable and applicable as much we’d reach the results required. Universal adhesives nowadays work and perform really well, clinically speaking, and can be used by everyone in the same way. They are not only the future of adhesion but they’re also the present, so use them without fear or doubt. The author wants to thank Dr. Paolo Marchetti for the surgical procedures and Mr. Sebastiano Nardo for the lab work.