Patients’ satisfaction with different types of veneer restorations

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ABSTRACT

Objectives: The aim of this study was to measure the satisfaction of patients with respect to the aesthetics of veneer restorations (VRs) and to identify potential factors influencing their satisfaction.

Materials and Methods: One hundred and eighty VRs of three different types (direct composite, indirect composite and porcelain) were placed on anterior teeth. Patients were asked to fill in questionnaires at baseline and at one- and two-year recalls.

Results: At baseline the overall satisfaction was 76%, after two years this was 78%. The variable ‘type of VR’ was the only factor measured that had a significant influence on the satisfaction of the patient. At the two-year evaluation patients with porcelain VRs were more satisfied than those with direct composite VRs (P<0.05).

Conclusions: From the results of this study it is concluded that differences in clinical procedures had no effect on satisfaction. Also the number of VRs had not influenced the level of satisfaction. After two years a significant difference was observed for the variable ‘type of VR’, with the best results for porcelain.

KEY WORDS: Veneer restoration, Clinical evaluation, Satisfaction

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INTRODUCTION

About one third of the adult population in the USA is dissatisfied with the colour or shape of one or more of their natural or restored teeth¹. The same conclusion was found in the Dutch National Dental Survey which was performed in 1986²,³. The growing importance placed on aesthetics may result in an increased demand for cosmetic dental treatment. Cosmetic dentistry has the purpose to maintain or improve the aesthetic appearance of the teeth. A good option to restore unaesthetic anterior teeth is a veneer restoration (VR). Both direct and indirect bonding techniques can be used for this type of restoration. The technique of VR is not new, but the materials and preparation design have changed over time.

The clinical success of restorations depends on technical aspects, aesthetic result and performance in time. Most of the studies dealing with evaluations of VR have been performed by dentists⁴–⁷. These studies report the survival rate of VR with or without well described evaluation criteria. If evaluation criteria were used they often differ from standardized criteria, for example as in Quality Evaluation for Dental Care of the California Dental Association (CDA-rating) or United States Public Health Service Criteria (USPHS)⁸–¹⁰. The parameters employed were mostly surface characteristics, marginal integrity, anatomic form and the colour of the restoration. Except for the criterion ‘colour’ these are all objective parameters and the levels are relatively easy to quantify. The criterion ‘colour’ is difficult to
describe without the use of colorimetric devices\textsuperscript{11}. Also the criteria ‘aesthetic result’ and ‘satisfaction’ evaluated by dentists or patients are not objective but subjective criteria\textsuperscript{1,12,13}. Nevertheless, the judgement of the patient regarding aesthetic outcome and their satisfaction is most important to the success of aesthetic restorations. The aesthetic requirements of dentists are not the same as those of patients\textsuperscript{2}. They vary not only from person to person but are also dependent on professional interests. There is only one study performed to investigate the patients’ satisfaction with bonded restorations\textsuperscript{3}. This study showed a relative high level of satisfaction (96% satisfied). Nordbo\textsuperscript{4} reported that the acceptance of porcelain VRs were judged to be good.

The aim of this study was to investigate the patient satisfaction with VRs and to identify the factors influencing satisfaction.

\section*{MATERIALS AND METHODS}

This analysis was part of a clinical trial which was originally designed to test the influence of a number of clinical variables on the survival of VRs. This trial involved 180 VRs of three different materials using two preparation designs, one with and the other without incisal reduction. The VRs were placed by seven dentists in the Dental School of Nijmegen on maxillary central and lateral incisors for aesthetic reasons (62% discoloration, 24% deviation of position and 14% deviation of shape).

The three types of VR were:

1. Direct resin composite (DC; Silux Plus, 3M Co., St. Paul, MN, USA)
2. Indirect resin composite (IC; Dentacolor, Hereaus Kulzer GmbH, Wehrheim, Germany)

A factorial design of the different treatment combinations is presented in Table I. Details about the materials, operators, assigning of the experimental variables, preparation and clinical procedures for fabrication of the VR have been previously published\textsuperscript{14}.

The patients’ satisfaction with their VR was assessed using questionnaires with precoded categories. Patients were asked to fill in the questionnaires at baseline (one month after the placement of the VRs) and at recalls one and two years after placement of the VRs.

\begin{table}
\centering
\caption{Table I. Factorial design and sample sizes of the different treatment combinations}
\begin{tabular}{|c|c|c|c|}
\hline
Type & Type DC & Type IC & Type P \\
\hline
Prep. 1 & 60 & 30 & 30 \\
Prep. 2 & — & 30 & 30 \\
\hline
\end{tabular}
\end{table}

DC, direct resin composite; IC, indirect resin composite; P, porcelain; Prep. 1, no reduction of the incisal edge; Prep. 2, reduction of the incisal edge.

A number of patient-dependent and experimental variables were tested if they influenced the patients’ satisfaction. These factors, including levels and distributions, are presented in Table II.

\begin{table}
\centering
\caption{Table II. Factors tested for influence on the patients’ satisfaction, including different levels and distributions}
\begin{tabular}{|l|c|c|c|}
\hline
Factor & Type & Measurements & Description of variable/points number of patients (and VRs) \\
\hline
Type of VR & E & B, R1, R2 & 38 (60) \\
DC & P & B & 36 (61) \\
IC & — & B & 37 (58) \\
Preparation design (P, IC) & E & B & 50 (75) \\
No incisal reduction & IC & B & 23 (44) \\
Incisal reduction & Operator & E & 1–7 Operators \\
1 VR & P & B, R1, R2 & 43 (43) \\
2 VRs & — & B, R1, R2 & 34 (68) \\
>2 VRs & — & B, R1, R2 & 34 (68) \\
Tooth type & — & B & 108 (108) \\
Central incisor & Lateral incisor & — & 71 (71) \\
Reason of treatment & Discoloration & — & 74 (110) \\
Deviation of shape & Deviation of position & — & 15 (26) \\
Time of existing & — & B & 22 (43) \\
0–10 years & Female & — & 34 (34) \\
>10 years & Mean age & — & 39 (39) \\
Congenital & Procedure problems & — & 38 (38) \\
Gender & Male & — & 31 (31) \\
Female & — & B & 80 (80) \\
Mean age & Procedure problems & — & 30 years (30) \\
Yes & — & B & 50 (50) \\
No & — & R & 61 (61) \\
Failures & Repairable & R & 7 (7) \\
Totally & R & R2 & 15 (15) \\
\hline
\end{tabular}
\end{table}

Variable: E, experimental; B, baseline; P, patient dependent; R1/R2, recall; R, restoration dependent.

Subjects for this study were 112 patients taking part in the clinical trial on VRs. These patients were treated with one or more restorations with a maximum of six. However, to avoid unwanted dependencies, a maximum of two VRs per patient were evaluated in the study. In cases where more than two VRs were made, two VRs made on the same tooth type were included in the trial (first preference) and/or two VRs were randomly selected (second preference). The other VRs were excluded for analyses.

In nine cases a protocol deviation occurred. In these cases the teeth were restored with another type of VR than assigned because during the treatment it appeared impossible to obtain a good colour match of the VRs. In all these cases the operator decided to make a direct
composite VR instead of an IC- or P-VR. During the treatment phase one tooth fractured. A non-vital lateral incisor, which was intended to be restored with an indirect composite VR, fractured during the removal of the temporary restoration and was subsequently excluded for further evaluation.

At the one-year recall, 107 patients were evaluated. Three patients were lost to follow-up and one VR failed. At the two-year recall only 100 patients were seen. The VRs of five patients failed and six patients were lost to follow-up. One patient who was absent at the one-year recall was present at the two-year recall.

In this study the treatment demand was 100%. Since all treatments were carried out, the treatment need was also 100%. The type of disorder in aesthetic appearance might have an influence on the level of satisfaction of the patient. However, the dentist judgement (objective need) and the patient demand (subjective need) might vary and thus influence the results. Therefore the patient demands were compared with the dentist's opinion.

Table III shows a comparison of the reason for treatment as judged by the dentists and patients.

Statistical tests for factors at the same time point were done by means of the Chi-square test. A paired t-test was done for each level of a factor to test differences between two time points. All statistical tests were performed at a significance level α=0.05.

RESULTS

The comparison of the reason for treatment as judged by the dentists and patients is given in Table III. Although, the indications (discoloration, deviation of shape or deviation of position) for treatment varied, in 71–84% of the cases there was an agreement between the dentist and patient. In further analyses the judgement of the dentists has been used.

Table III. Agreement between dentists' and patients' diagnoses of treated teeth (colour, shape or position) in per cent

<table>
<thead>
<tr>
<th>Dentist</th>
<th>No reason</th>
<th>Reason</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reason</td>
<td>55</td>
<td>45</td>
<td>44</td>
</tr>
<tr>
<td>Reason</td>
<td>2</td>
<td>98</td>
<td>56</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>75</td>
<td>100</td>
</tr>
<tr>
<td>Shape</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reason</td>
<td>88</td>
<td>12</td>
<td>88</td>
</tr>
<tr>
<td>Reason</td>
<td>21</td>
<td>79</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>21</td>
<td>100</td>
</tr>
<tr>
<td>Position</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reason</td>
<td>90</td>
<td>10</td>
<td>69</td>
</tr>
<tr>
<td>Reason</td>
<td>49</td>
<td>51</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>23</td>
<td>100</td>
</tr>
</tbody>
</table>

Table IV. Percentages of satisfied persons according to the variables 'type of VR' and 'number of VRs' at different measurement points

<table>
<thead>
<tr>
<th>Type of VR</th>
<th>Baseline</th>
<th>Recall 1</th>
<th>Recall 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall satisfaction</td>
<td>76 ← *** → 93 ← ** → 78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with colour</td>
<td>92 ← ** → 97 ← 93*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with shape</td>
<td>90 ← ** → 97 ← 93*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type</td>
<td>DC</td>
<td>74 ← ** → 95 ← ** → 67*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P</td>
<td>72 ← ** → 97 ← 93*</td>
<td></td>
</tr>
<tr>
<td>IC</td>
<td>79 ← 99 ← 82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>1 VR</td>
<td>86 ← * → 100 ← ** → 81</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 VR</td>
<td>67 ← ** → 93 ← 73</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;2 VR</td>
<td>70 ← * → 88 ← 61</td>
<td></td>
</tr>
</tbody>
</table>

A ← * → B, indicate a level of significant differences between groups A and B.

The percentage of satisfied persons according to the variables 'type of VR' and 'number of VRs' at different times of measurement is given in Table IV. Most of the satisfaction percentages at the first recall were significantly higher than at baseline for all variables, while at recall 2 the 'overall satisfaction', 'type of DC' and 'number is 1 VR' percentages were significantly lower than at recall 1. The differences between groups at baseline and recall 2 were not significantly different. 'Type of VR' and 'number of VR' had no significant influence on satisfaction except 'type of VR' at recall 2. One month after placing the VR the overall satisfaction about the restoration was 76%. Only one patient was dissatisfied with the VR, while the remaining (23%) group was not clear about their judgement.

The other factors mentioned in Table II, operator, tooth type, reason of treatment, time of existing, gender, age, procedure problems and failures, had no significant influence on the satisfaction of the patients.

DISCUSSION

Evaluation of the aesthetics of teeth or the dentition is a complex process. Because of the dental treatment, patients may become more aware of the aesthetics of their teeth. The restored tooth will always be judged in relation to the whole dentition. This might explain the change in satisfaction during the period of evaluation. Every change in the dentition will require habituation. Especially when there is a change in position or shape it will take some time before the patient does not feel the restoration any more and will look at their dentition in total. Once the patients are getting used to the restoration, they will see that the aesthetics of the tooth is improved. The result may be a more satisfied patients' population at the one-year recall. Then, after a certain
adaptation period, the aesthetic judgement may change again as the patients may become aware of the aesthetics of the adjacent teeth as well. When the patient is no longer satisfied with the aesthetics of the dentition as a whole, the aesthetic satisfaction of the restored teeth will decrease as well. This period will vary from person to person and depends on the adaptation ability of the patient. At the two-year evaluation the restored tooth will be compared with the adjacent teeth. Our results support this theory since, with an increasing number of VRs the difference between the satisfaction at one and two years recall was not so pronounced as in the case of one tooth being restored.

The significant decrease in the satisfaction with direct veneers between one and two years is difficult to explain. Several reports mentioned colour changes of light-cured composite resins influenced by time of light exposure and time after curing, while another study showed no significant difference between some composite resins after five years. It is not very likely that a change in the colour of the restoration material will be noticeable after two years. Other problems with composite resin veneering which were described were roughening of the surfaces, chipping, fracture and staining. However, in this population the occurrence of chipping or fracture had no influence on the satisfaction of the patient. Surface roughening and staining was not investigated in this study.

Several studies report a discrepancy between treatment need of the dentist and treatment demand of the patient. The agreement between dentist and patient in case of cosmetic dental treatment was 72% in the Dutch National Dental Survey. If there was a disagreement, the objective need of cosmetic treatment as judged by the dentist was higher (44%) than the treatment demand of the patient (14%). Several other articles have also reported a higher treatment need than treatment demand. In this study, the reasons for treatment by the dentist and the patient were compared.

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References


CONCLUSIONS

From the results of this study it is concluded that differences in clinical procedures for VRs had no effect on satisfaction. Also the number of VRs had not influenced the level of satisfaction. After two years a significant difference was observed for the variable ‘type of VR’. The best results were found for porcelain VRs. With longer follow-up it is expected that the influence of ‘type of VR’ will become more apparent when the property of the materials will influence the process of ageing, discoloration or strength.


