Patients' satisfaction with different types of veneer restorations

A. C. Meijering*, F. J. M. Roeters†, J. Mulder‡ and N. H. J. Creugers*

*Department of Oral Function and Prosthetic Dentistry, TRIKON: Institute for Dental Clinical Research, University of Nijmegen, Nijmegen, The Netherlands
†Department of Cariology and Endodontology, TRIKON: Institute for Dental Clinical Research, University of Nijmegen, Nijmegen, The Netherlands
‡Department of Medical Statistics, TRIKON: Institute for Dental Clinical Research, University of Nijmegen, Nijmegen, The Netherlands

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

J. Dent. 1997; 25: 493–497 (Received 4 January 1996; accepted 29 July 1996)

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). Nordb\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.

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

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 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 dentists opinion.

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

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>Reason</th>
<th>Patient</th>
<th>Dentist</th>
<th>No reason</th>
<th>Reason</th>
<th>Total</th>
</tr>
</thead>
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<td>45</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reason</td>
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<td>56</td>
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<tr>
<td></td>
<td></td>
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<td>75</td>
<td>100</td>
</tr>
<tr>
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<td>12</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reason</td>
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<td>79</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
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<td>21</td>
<td>100</td>
</tr>
<tr>
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<td>Colour</td>
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<td>10</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reason</td>
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<tr>
<td></td>
<td></td>
<td>Total</td>
<td>77</td>
<td>23</td>
<td>100</td>
</tr>
</tbody>
</table>

A ← * → B, indicate a level of significant differences between groups A and B.
* 0.05 > P > 0.01.
** 0.01 > P > 0.001.
*** 0.001 > P.

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
adoption 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. The agreements varied from 84 to 71%. Comparison of the reasons for treatment revealed that the reason ‘shape’ and ‘position’ were more important for the dentist than for the patient, while the reason ‘colour’ was more important for the patient. The overall satisfaction can not be completely explained by the satisfaction of colour and shape. It seems that other factors play a role in this matter. Goldstein suggested that the conservative approach and relative low costs of these restorations are appreciated by the patients and this may influence the satisfaction. The use of a questionnaire to evaluate the treatment with VR at baseline, one and two years after the completion of treatment, is a procedure that may introduce some kind of bias. For example, selection on a population level: the population of the trial with a higher or university education is 44% and the male and female ratio is also not representative for the Dutch population.

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.

Acknowledgements

The authors want to express their gratitude to the companies who financed parts of the study: 3M Co., Heraeus Kulzer GmbH and Elephant Ceramics. This study was part of the Research Programme ‘Restorations and Biomaterials’.

References


