Many patients think a beautiful smile is just about straight, white teeth. But the gingival contours have as significant an influence as do the teeth. Attaining gingival symmetry with the contra-lateral tooth and attaining a flowing gingival form with the adjacent teeth can take a smile from poor to excellent (Figure 1 and Figure 2). Use of an ophthalmic scalpel (Figure 3) and tunneling with a full-thickness intra-sulcular flap (Figure 4) allows for placement of augmentation materials or for crown lengthening. Sometimes combining both gives the optimal results for symmetry, with the added bonus of improvement of tissue health and reduction of root surface sensitivity. Many patients have an aversion to the word surgery, but with careful technique there is often no or little bruising and mild post-operative pain, which can be controlled with NSAIDs like ibuprofen or naproxen.

Here is an example of moving the gingival tissue back coronally 10 years after placement of ceramic crowns: the diastemal gingival margin of #8 had receded and an abfraction had begun to form. The patient complained of slight sensitivity to cold in the last few months (Figure 5). The biotype was thick and hygiene was acceptable. The occlusion was checked and adjusted to remove a heavy, provocative contact. Local anesthesia with 2% Lidocaine 1:100 epinephrine was administered and the abfraction was smoothed to remove any angular edges. An intra-sulcular incision was created with an ophthalmic scalpel, and the connective tissue removed and immediately placed into the prepared recipient site. A small envelope incision was made making it comfortable for the patient (Figure 6). A periosteal elevator with a hole for injection was used to administer through a hole in a periosteal elevator to develop pressure anesthesia while injecting. Donor palatal anesthesia was achieved with approximately 1cc of 2% Lidocaine 1:50,000. Using an instrument like a periosteal elevator with a hole for injection allowed the application of pressure anesthesia before and during the injection, making it comfortable for the patient (Figure 6). A small envelope incision was made on the palate and a piece of subepithelial connective tissue removed and immediately placed into the prepared recipient site. The donor site was then closed with one interrupted 6-0 Prolene polypropylene suture and Peri-Acryl cyanoacrylate tissue adhesive (Figure 7).

The graft and the reflected flap were then stabilized with a single Prolene horizontal suture (Figure 8). The Prolene has almost no discernible tissue inflammation, but is non-resorbable and was removed at two weeks post operatively (Figure 9). By five weeks the tissue had healed very well and solved what is often an overlooked problem for our patients (Figure 10).