Today more and more often we see the performing of techniques of coronal relocation of cervical margin (Deep Margin Elevation) in clinical situations in which you would need to do resective bone surgery, with lengthening of the clinical crown. We emphasize that the Deep Margin Elevation procedure recently introduced by Prof. Pascal Magne, Dr. Didier Dietschi and Dr. Roberto Spreafico is not an optional procedure to surgery, but it is applied in borderline clinical situations in which the isolation with a rubber dam is difficult but still possible, anywhere there is the need to facilitate the impression maneuvers and subsequent isolation for bonding, but in those clinical situations in which the periodontal biological width is still present. The concept of biological width postulated by Gargiulo et al in 1961 is a major requirement in restorative and prosthetic. The biological width must be respected, both in restorative procedures than in prosthetic ones otherwise we'd create iatrogenic periodontal pockets. The scientific article wants to clarify illustrating a very simple and repeatable procedure in which the ideal steps are first the cleaning of caries with the preparation of a cervical margin, which then must no longer be moved apically, then the surgery to put the bone crest to three mm from the cervical margin already prepared and finally the restorative maneuvers. It is a huge mistake to perform the surgery procedures before preparing the cervical margin, thus often it results in the need to also perform a Deep Margin Elevation too, which is a contradiction in terms.
Fig. 1  
Img. 1 – Pre-operative bitewing. It shows a huge decay on the distal, cervical wall of 1.6
Fig. 2  Img. 2 – Pre-operative picture
Fig. 3  - After the 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
Fig. 5 - Tip: It’s mandatory to put the bone crest at 3 mm of distance from the cervical step, already prepared and cleaned.
Fig. 6

Img. 6 – The stitches in place
Fig. 7 - In the same session the rubber dam it's put in place, back and the mesial decay is cleaned too. Note the good isolation obtained due to the surgical procedures.
Fig. 8 – Details after the cleaning, the disto-palatal cusp's removed because too thin. In fact we reduce all the cusps that are less than 2 mm of thickness. Tip: for composite onlay we need to reduce two mm in height, for lithium disilicate one mm is sufficient.
Fig. 9 - A build up is performed, with the sealing of the dentinal tubules, and the preparation of an onlay is done. Tip: Clean the dentin with glycine powder and disinfect it with clorexidine at 2% then etch the enamel for 20 seconds, and apply an Universal adhesive on the dentin and on the enamel, in a self etch mode. It works and performs very well and it allows you not to have post operative sensitivity.
Fig. 10 – Only at this point we can clean the decays on 1.5 and 1.7 and do the direct fillings on them. Tip: don’t do them before so 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.
Fig. 12 – The direct restorations on 1.5 and 1.7 are done only with one body mass (A2 in this case) and brown stains to increase the perception of depth, and it’s finished and polished under the dam. Tip 1: use again an Universal adhesive in self etch mode, with the selective etching technique to have the best performance without any post operative sensitivity. Tip 2: finish and polish the restorations under the dam so to have the perfect control without blood and saliva and tissues to move away.
Fig. 13 – Before impressions taking we check the occlusion. No corrections are needed. Tip: remember to check the occlusion and to do corrections if needed before the impressions so not to give wrong informations to the dental technician.
Fig. 14 – Details of the impressions taken with the stitches in place. Tip: take one time impression with two different viscosities so to have the best performance of the impression materials with the less distortions
Fig. 15 – The composite onlay, on the plaster model
Fig. 16 - After fortyeight hours from the start the indirect restoration is tried, with the stitches still in place. Tip: this will reduce the time of the provisionals and the disconfort of the patient.
Fig. 17 – We proceed with the occlusal check
Fig. 18 – The rubber dam’s put in place again and the onlay’s tried with the rubber dam too, before the bonding procedures. Tip: check it back with the rubber dam in place because the rubber dam sometimes gives orthodontic movements.
Fig. 19 – Finishing and polishing under the dam
Fig. 20 – The occlusal check at the end of the bonding procedure shows no need to corrections
Fig. 21 – Final check of the three restorations
Fig. 22 – Two weeks post operative, there’s a good integration of the restorations of 1.5 1.6 1.7
Fig. 23 – Details of the morphology and anatomy of 1.5 1.6 1.7
Fig. 24 – Details of the restorations. The tissues after two weeks are healing but they’ll mature in six months.
To restore means to give back function and esthetics to our patients’ teeth. This must be done with precision and must last in time. We have to follow simple rules and protocols to obtain these goals, without any flight of fancy.

As much as these steps can be feasible, predictable and applicable as much we’d reach the results required.

Eventually the Universal Adhesives nowadays work and perform really nice, 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 any fear or doubt.

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