REVIEW ARTICLE

Therapeutic Approaches in Adult Orthodontic-Restorative Patients with Dental Anomalies: A Narrative Review

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Abstract

This narrative review (2023–2025) summarizes the treatment of adult orthodontic-restorative patients with different dental anomalies, such as hypodontia, microdontia, or enamel anomaly. It is, therefore, extremely important to have an interdisciplinary and digitally guided approach while managing adult dental anomalies. Digital dentistry, supported by cone beam computed tomography, computer-aided design/computer-aided manufacturing, and Digital Smile Design, enables diagnosis, treatment planning, as well as the interdisciplinary approach to be more effectively realized. Research comparing clear aligners and fixed appliances revealed that although the results regarding alignment are similar between the two systems, clear aligners are more comfortable to wear, easier to maintain, and cleaner, as well as esthetically pleasing. Fixed appliances are still critical for mainly severe malocclusions that need to be treated. In restoring teeth using ceramic veneer bonding to crowns on enamel, the survival rate is above 90%, whereas composite bonded crowns fail readily. The existing technique is thereby shifted by present restorative techniques toward the preservation of enamel and minimally invasive techniques using bioactive materials. Orthodontic alignment in combination with restorative excellence offers digital control over the predicted function and esthetics of a case. It is, therefore, extremely important to have an interdisciplinary and digitally guided approach while managing adult dental anomalies.

Key words: Adult, dental anomalies, orthodontic alignment, orthodontics, restorative

INTRODUCTION

The proportion of adult individuals seeking orthodontic treatment has significantly increased, with one in three patients currently being an adult.[1] These patients are more likely to present with some developmental dental anomalies, which include. Still, they are not limited to hypodontia, microdontia, and enamel defects, as well as some acquired conditions and tooth wear. These all affect the function, esthetics, and occlusion of the teeth. Hypodontia (1–5 teeth, commonly permanent laterals) and microdontia conditions, often accompanied by "peg" lateral incisors, are common.

In addition, developmental enamel defects, such as amelogenesis imperfecta or molar-incisor hypomineralization may also be present. These anomalies are often associated with other conditions, such as tooth position anomalies, class II/III relations, or periodontal conditions (e.g., adjacent bone loss).[2] These factors shape the treatment of adult patients with such anomalies to become integrated orthodontic tooth movements with restorative frameworks, considering all other disciplines. This entails shared orthodontic treatment, where leveling/alignment plans are created to idealize tooth positions, followed by restorative or adhesive treatment (veneers, crowns, implants/bridges) to rehabilitate missing, altered, or disproportionate elements. This narrative review assesses the most recent literature (2023–2025) on the interdisciplinary orthodontic–restorative management of general anomalies in adults.

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INTERDISCIPLINARY TREATMENT OF DENTAL ANOMALIES

A dental anomaly that is pretty common is hypodontia (absence of teeth). The reported prevalence of hypodontia is about 6–7% of the population (this figure tends to go up with more sensitive diagnostics).[1] The most commonly absent teeth are lower second premolars and upper lateral incisors. Patients with agenesis (or other anomalies) are more likely to develop secondary problems. Adjacent teeth are liable to tilt and rotate, opposing alveolar ridges may atrophy, and spaces may become conformed and accumulate, creating malocclusion and exacerbating dysfunction.[3,4] It is imperative that the treatment of these cases involves the restoration of both esthetic and functional balance, necessitating the collaboration of a multidisciplinary team. Kumar *et al*.[5] cited a case of missing premolars and lateral incisors, representative of hypodontia, and mention treatment options, such as "adhesive bridges, tooth transplantation, implants," while asserting that "an interdisciplinary approach is the most important requirement for the ideal treatment of hypodontia." Similarly, Alhaqbani *et al*.[4] Noted That Managing hypodontia requires collaborative work among prosthodontists, orthodontists, and other specialists to address spacing, esthetics, and occlusion effectively.

A structured protocol is described by these authors as follows: Assess tooth loss, carry out orthodontic space redistribution, and integrate the final restoration (implant, bridge, denture) with the consideration of bone and periodontal structures. Typically, guiding elements (severity of anomaly, occlusion, patient age, and desires) streamline the plan, and combined ortho-restorative planning is deemed the optimal route; however, there is still general agreement.[4]

ORTHODONTIC APPLIANCE MODALITIES: FIXED VERSUS REMOVABLE

Orthodontists can focus on two broader categories: Fixed braces (metal or ceramic) attached to the teeth, and removable aligners, which can be transparent plastic trays. Much of the literature suggests that both can achieve the same overall alignment results in a significant number of cases. A systematic review performed by Bhagwan *et al*. on clear aligners vis-à-vis traditional braces summarized that clear aligners have "comparable effectiveness to traditional orthodontic methods in terms of treatment outcomes, patient satisfaction, and adverse effects."[6] In day-to-day practice, however, fixed appliances are recognized for their more precise control over specific complex movements (root torque, space closure, and vertical control). At the same time, clear aligner systems have advanced to the point where marginal to moderate malocclusions can be treated predictably.[7]

There are variations in hygiene practices and how patients perceive treatment. With aligners, patients can brush and floss without restriction because the aligners can be removed. Numerous studies have demonstrated highly favorable periodontal outcomes in patients treated with aligners. In a controlled study by Giannini *et al*., patients wore fixed braces on the lower arch and aligners on the upper arch. The results showed that the fixed appliances accrued significantly more plaque and caused more gingival inflammation.[8]

In contrast, the aligners were able to maintain a healthy plaque level and periodontal health. Giannini *et al*. concluded that, "aligners appear to be more favorable in protecting periodontal tissues, improving plaque control, and reducing gingival inflammation."[8] Experts also agree with this, emphasizing that fixed brackets increase the likelihood of food impaction and the formation of caries, while aligners lessen the hygiene problems. Aligners are also associated with significantly higher treatment satisfaction, as previously shown in the literature. In fact, a study conducted in the adult population, focusing on aligners and braces, showed that patients in the aligner group had significantly higher satisfaction ratings in terms of comfort and the estimated treatment outcome. Those in the aligner group had an average satisfaction score of 8.7 out of 10 in terms of esthetics, and 5.4 out of 10 for the brace group, nearly a twofold difference. Both groups achieved comparable alignment results, which were deemed acceptable in the study.

For adults, the removable aligners are usually the most appealing option due to their discretion and ease of maintenance.[4] However, aligners are simply not feasible for all cases. Clinicians appreciate that for cases involving severe crowding, significant vertical corrections, or particular root movements, even mini-implants require additional fixed braces for accurate control. Therefore, most modern practices tend to match the complexity of the case with the type of appliance: Aligners are used for cases with low complexity or for patients with esthetic preferences. In contrast, fixed braces are used for complex corrections.[4]

RESTORATIVE MATERIALS AND PROSTHETIC

Restorative work addresses teeth that are either malformed or missing, and it is performed after the teeth have been adequately aligned with orthodontics. The option of prosthetic materials and the type of prosthesis depend on the type of defect, patient values, and biological considerations. For example, in cases of hypodontia, various options have been used, including adhesive composite bridges, conventional porcelain bridges, removable partial dentures, and implants. If the patient is an adult and there is adequate alveolar bone, implants are usually the best option. If bone is limited, bridges or dentures can be used as intermediates or when bone is limited. According to Alhaqbani *et al*., prosthetic options primarily depend on occlusal relationships and bone volume, as well as essential patient considerations, including costs and maintenance.[4]

FOR PEG LATERALS OR MICRODONTIA

Recent literature suggests that with certain principles in place, long-term survival of ceramic veneers can be excellent. A 2024 narrative review stated that veneer restorations have survival rates exceeding 90% and can last for over 10 years, provided the bonding is maintained within the enamel. It is also stated that a greater amount of enamel should be preserved, as veneers bonded to intact enamel perform the best, while dentin exposure almost guarantees poor veneer longevity.[9] When higher strength is necessary (e.g., diastema closure and tilted teeth), glass-ceramics (lithium disilicate, feldspathic, and zirconia) should be used instead of feldspathic porcelain. In fact, restoratives of greater strength may be required in thicker veneers in complex cases, as suggested by the literature, to utilize high-flexural-strength ceramics or zirconia with veneering to prevent fracturing. In addition, it is worth noting that the survival rate of composite resin veneers is significantly lower than that of ceramic veneers. One comparison stated that composite veneers failed four times as often as the ceramic veneers. Therefore, if the situation and budget allow, it is preferable to have indirect ceramic restorations due to their excellent and long-lasting results.[9]

THE USE OF BIOACTIVE AND LESS INVASIVE MATERIALS

Authors acknowledge that present approaches to managing anomalies aim to preserve dental tissues employing no-prep veneers, minimal additive composites, and the use of adhesives and ceramics that maintain the health of the tooth.[3] Digital wax-ups and mock-ups help to streamline these steps; for instance, the systematic review by McGarty *et al*. on anomalies of the maxillary incisors endorses the use of Digital Smile Design (DSD) simulations for the best smile preview. They state that "pre-visualization using DSD, a treatment plan centered on minimally invasive restorations, and a multidisciplinary approach" yield optimal esthetic results.[3] This illustrates that an orthodontist and a dentist devise a digital strategy (standard tools include 3D models or software) to be followed for teeth alignment and refinement of the final tooth forms, which will then be executed using specific veneers, crowns, or implants.

RESTORATIVE MATERIALS AND PROSTHETIC

Restorative work focuses on teeth that are malformed or missing after they have been appropriately positioned using orthodontics. Various prosthetic options and types of prosthesis are determined by the nature of the defect and biological, economic, and patient preference factors. For instance, options, such as adhesive composite bridges, conventional porcelain bridges, removable partial dentures, and implants have been used to address hypodontia. Implants are the preferred option for adults who have sufficient alveolar bone. If bone is insufficient, bridges or dentures can serve as temporary solutions or endpoints. As stated by Alhaqbani *et al*., occlusal relationships and bone volume are key factors, along with patient factors, such as cost and maintenance.[4]

Recent studies have shown that, with certain principles in place, ceramic veneers can enjoy exceptional longevity. As stated in a 2024 narrative review, veneers have a survival rate of over 90% and can last for more than a decade, provided that retention is within the enamel and bonding remains intact over time. It is also stated that more enamel should be preserved, as veneers bonded to uncut enamel tend to stay intact and perform best. At the same time, dentin exposure virtually guarantees poor longevity for veneers.[9] In situations that require more strength, that is, diastema closures and tilted teeth, use glass-ceramics (lithium disilicate, feldspathic, and zirconia) instead of feldspathic porcelain. For thicker veneers in complex cases, restoratives of greater strength may be needed, as the literature suggests, to prevent fracturing. In addition, the survival rate of composite resin veneers is lower than that of ceramic veneers. One comparison stated that composite veneers failed four times more often than ceramic veneers. Thus, if the case and financial situation allow it, it is advisable to opt for indirect ceramic restorations due to their impressive and enduring results.[9]

Recent restorative techniques utilize bioactive and innovative minimally invasive materials. Compared to the management of dental anomalies, restorations are less aggressive. No-prep veneers, minimal additive composites, adhesives, and ceramics that preserve the tooth's tissue are used to maintain dental health. Digital wax-ups and mock-ups streamline these steps. For example, McGarty *et al*. (2025) review on anomalies of the maxillary incisors describes the use of DSD simulations as the best smile preview. They state "pre-visualization using DSD, a treatment plans centered on minimally invasive restorations, and a multidisciplinary approach" yields optimal esthetic results. This demonstrates that an orthodontist and a dentist collaborate to create a digital plan (utilizing 3D models or other software as a standard tool) to determine the sequence for tooth alignment and the refinement of tooth shapes to be applied as veneers, crowns, or implants, which is then digitized for execution.

USE OF TECHNOLOGY AND PLANNING

When planning complex ortho-restorative procedures, dentists utilize technologies, such as intraoral scanning, cone beam computed tomography imaging, and computer-aided design/computer-aided manufacturing (CAD/CAM) to visualize the expected outcome. As noted by Andrews, the application of digital techniques right from the beginning of diagnosis and planning improves communication with

patients as well as other professionals, allowing for more profound analyses.[10] In the setup, the team can collaborate to work out space requirements. For example, a virtual orthodontic "ClinCheck" aligner plan may be used together with planned veneer contours to check on spacing and occlusion as well as general harmony. This helps to ensure the treatment will satisfy the intended goals.

Numerous authors highlight the benefits of "comprehensive digital workflows." Of all the case authors, McGarty *et al*. claim DSD directly supports the most significant number of multidisciplinary cases. Other case reports (2024–2025) describe the integration of guided orthodontics and surgical stents from digital models designed in one cohesive plan to position the implants and contour the gingival tissue. The Alhaqbani *et al*. review, along with others, emphasizes computer-aided design and 3D imaging as "imperative in advanced diagnostic accuracy, treatment planning, and prosthetics construction" to hypodontia cases.[8] Overall, the literature suggests that digital planning minimizes surprises during treatment. For example, orthodontists can evaluate cases digitally to determine if any orthodontic movement will create sufficient restorative space. At the same time, restorers can prepare guides and mock-ups according to the provisions of any passed case. The outcome is an improved esthetic result, reduced treatment time, or a combination of both.

FIXED VERSUS REMOVABLE ORTHODONTIC OUTCOMES

In terms of alignment outcomes, both traditional braces and clear aligners are comparable in effectiveness. More recently, braces are no longer a necessity for adult aligners, as these aligners can achieve the same alignment goals as braces.[7] One study found that after one year, the aligner treatment achieved an 80% reduction in the malocclusion index compared to 75% by braces—a clinically insignificant difference.[6] Where aligners shine is in the patient-centered consideration of treatment goals. Aligners prioritize patient comfort and deliver excellent oral hygiene results. Giannini *et al*. proved that fixed braces increased bacterial plaque and gum inflammation more than aligners did, compared to baseline periodontal health. Patients are satisfied when they are comfortable because aligners are more comfortable and esthetically pleasing.[8] Aligners address soft-tissue outcomes and patient preference more effectively, while fixed appliances might provide a greater advantage in complex movement control.

RESTORATIVE MATERIAL OUTCOMES

Ceramic restorations result in excellent esthetics and durability. When bonded to enamel, ceramic veneers/crowns present a survival rate >90% over a period extending from 5 to 10 years. Strong ceramics (glass-ceramic or zirconia) produce fewer fractures than weaker feldspathic porcelain, but compare this to the poor stability of direct composite solutions. Composite laminate veneers have a much higher failure rate compared with porcelain. Implants placed into orthodontically created spaces report high functional outcomes according to the chewing function recovery described in these reports. Tooth structure preservation was explained in all the cases by comparison; therefore, it is assumed that ultrathin veneers and minimal prep techniques yield long-term success that is better than full crowns.

DIGITAL PLANNING IMPACT

Digital Smiling Design and virtual mock-ups ensured that orthodontic space changes would be ideal for the final restoration, and esthetics would be even better than what is achieved with traditional analog methods. It was noted by McGarty *et al*. in their review of maxillary anterior tooth anomalies that the teams who used DSD and CAD/CAM guides received the "best possible esthetic result." In tandem, simple digital diagnostic tools most certainly increase the predictability of achieving "esthetic, biological, and functional interdisciplinary outcome," according to Andrews (2024). There will be fewer midtreatment changes and better patient satisfaction with smile appearance. For instance, one study found that 3D surgical guides, together with digital wax-ups, made therapy integration seamless minimized unexpected outcomes at final delivery.[10]

ESTHETIC AND FUNCTIONAL OUTCOMES

It is ultimately from the patient's perspective that outcomes take precedence. Orthodontic alignment, restorative contours, and periodontal health work together to balance and harmonize the smile, meeting the patient's esthetic desires while improving and ensuring functional bite relation. High-quality materials further increase function—they include ceramics, modern composites, and zirconia. This multidiscipline makes life much better between teeth for many authors who have cited it. For example, an orthodontic space closure with bridges or implants increased eating function in a hypodontia patient and occlusal drift was prevented by function.[5] A similar approach gave beautiful esthetics that were maintained for a long period: Orthodontic alignment followed by porcelain veneers for peg lateral incisors.[9]

This review highlights that an interdisciplinary approach to treating adult patients with dental anomalies requires dedicated planning and a combination of orthodontic and restorative methods tailored to each individual. Recent literature (2023–2025) reiterates the classic sequence of steps: Begin with orthodontic alignment to achieve optimal tooth positioning, followed by restorative work to achieve form and function with a conservative approach. Digital

dentistry technologies (3D imaging, CAD/CAM, and aligner simulation) have significantly streamlined this process by enabling precise pre-visualization and execution.[11,12]

There is a distinct trend toward the increased use of clear aligners in the treatment process.

Aligners can be especially useful for adult patients who require discretion for esthetic reasons or have compromised periodontium.[13] There has been an increase in the use of "pre-restorative" aligners in shorter phases, such as 3–6-month periods of using Invisalign to space/open/close for veneers. For the most complex corrections, however, fixed braces are still indispensable. Clinicians need to consider the marginal difference in long-term stability. There are studies suggesting that aligners have slightly more relapse than braces, although both methods are highly effective.[11] Clear aligner protocols occasionally utilize attachments. These bonded composite "buttons" attachments need bonding and technical care, especially when challenged by abnormal enamel. Hence, in cases of severe enamel defects and restorations, some clinicians favor braces over aligners due to concerns about broken deboning issues.[12,14]

On the restorative side, invasiveness of the procedure and longevity of the intended outcome are primary considerations when choosing the material. The available literature suggests that composite resins are suitable for interim corrections or minor esthetic enhancements. At the same time, veneers and ceramic crowns are more appropriate for achieving long-lasting and durable esthetic outcomes.[15] The esthetic outcome, however, depends on the harmony of all varying disciplines and parts. For instance, even the most perfect functional veneer is likely to fail esthetically if the orthodontic alignment is poor (e.g., unbalanced occlusion). The veneer study, discussed above, illustrates how patient satisfaction depends on function and hygiene, as well as the esthetic outcome.

For this reason, clear instructions about care and maintenance should be provided, including how to wear and clean aligners and veneers, as well as how to prevent relapse through lifelong retainer use.[16]

SPECIFIC ANOMALIES

Treatment divergence from standard protocols due to alveolar under development and skeletal discrepancies in hypodontia. Pace-Balzan *et al*. noted that orthodontic approaches would suffice to address mild hypodontia, while more severe cases would be treated prosthodontically from the outset.[1] In our review, we observe that recent guidance emphasizes flexibility, recommending that clinicians begin with less invasive steps (such as ortho leveling and removable dentures) and advance to fixed implants or bridges when feasible. This patient-specific staging ensures that even patients with few teeth can achieve acceptable esthetics and function without extensive, overly invasive procedures applied too early.

LIMITATIONS

We observe that retrospective case series and expert reviews are the most common types of published reports, and that this area has limited high-level evidence (i.e., randomized trials) available. Take, for instance, the scoping review of aligner use, which reported only case literature and very few controlled studies. Similarly, Paschoal *et al*. report that laboratory studies and case reports most commonly support the treatment of enamel defects. We need more prospective clinical studies that compare different interdisciplinary approaches, as well as more standardized outcome measures (i.e., patient-reported esthetic satisfaction, occlusal stability).

For practitioners, this synthesis highlights the importance of understanding the underlying principles of an integrated, evidence-based approach to interdisciplinary treatment planning. Initially, digital-enabled multidisciplinary collaboration discusses, within the context of the overarching treatment plan, the most appropriate provisional esthetic and functional objectives to be achieved over the treatment plan timeline. As a guide to the complexity of the case, the choice of orthodontic appliances is also a determining factor. For some instances, aligners may be an appropriate choice. In contrast, in other cases, fixed braces may be necessary to gain control of complex movements and ultimately achieve improved patient compliance and hygiene. Determining the restorative materials to be used is also essential within the context of the planned orthodontic outcomes. Direct composite restorations should be used when the teeth require shaping and an adequate volume of enamel is present. Otherwise, if the restoration needs to be more durable and thinner, porcelain should be used. In cases of advanced enamel hypoplasia or other bonding substrate compromises, modified etching and other pretreatment techniques should be used to more restoratively intervene, e.g., stabilizing function and esthetics with provisional veneers. Finally, there should be no questioning of the long-term retention and maintenance of clear aligners, as well as restorative extensive maintenance, both of which require monitoring for early signs of relapse, wear, and tissue or material degradation, to ensure the treatment goals remain achieved.

CONCLUSION

Coordinated, digitally driven care is vital for adult orthodontic and restorative treatment. Mild to moderate cases can be treated effectively and esthetically with clear aligners, and for complex cases, braces are still required. During the restorative phase, digitally driven tools, such as DSD and CAD/CAM strengthen planning, provide communication tools for specialists and patients, and enable patients to visualize the proposed outcome, which is exceptional. The

harmony between orthodontics and restorative dentistry enhances the functional esthetics that patients retain, and it also assures patient satisfaction. Directly linked to this is the still scarce high-quality clinical research, with the need for validated and standardized evaluation criteria to attest to the long-standing outcomes. The precise, digitally tailored, individualized, and minimally invasive approaches are the contemporary benchmark for treating dental dysfunction in adult patients, and they also delight the patients.

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