DAILY DENTAL JOURNAL · PATIENT CHECK

Veneers? First classify substance, alternatives and risk.

This page is not a treatment recommendation or a substitute for diagnostics. It helps to sort an offer, a consultation or a smile makeover promise so that the crucial questions are not overlooked.

> DDJ separates requests, advice, study situation and provider navigation. The site remains a decision check: no guarantees, no hidden recommendation for a specific treatment and no shortcut around a personal diagnosis.

What veneers are really about

A good consultation doesn't just answer what a smile should look like. It clarifies what the initial situation is, what alternatives have been seriously examined and what follow-up care is realistically planned.

DESIRED IMAGE

What exactly should change?

Color, shape, length, gaps, edges, old fillings or a combination of these lead to different paths. A blanket smile package is not yet a plan.

SUBSTANCE

What happens to healthy tooth structure?

Before making any decision, it should be clear whether and where preparation needs to be made, which teeth are affected and what would need to be repaired or replaced later.

ALTERNATIVES

What less invasive option has been explored?

Bleaching, composite bonding, correction of small edges, aligners, periodontal pretreatment or even waiting can be part of the classification depending on the initial situation.

Questions for the consultation

Don't take these points as mistrust, but as structure. A good practice can calmly answer most of these or explain why it prioritizes differently in a specific case.

01 **Initial situation and diagnosis**

- Which findings speak in favor of veneers and which ones against them?
- Have tooth decay, old fillings, cracks, abrasion, gums or bites been cleared up beforehand?
- Which photos, scans, x-rays or models are used for planning?
- Which teeth are really part of the plan and which remain untouched?

02 **Alternatives and order**

- Has bleaching been considered as the first step if the color is the main concern?
- Can small shape or edge problems be solved with composite bonding?
- Is there orthodontic or periodontal pretreatment that makes the result more predictable?
- What happens if I test a smaller, reversible option first?

03 Substance, material and provisional

- Where exactly does tooth structure need to be reduced and why?
- How is it explained whether the bonding surface remains predominantly in the enamel or becomes critical?
- What material is planned and what restrictions does it have for my situation?
- What does the provisional phase look like and what shouldn't I expect during this time?

04 Function, repair and aftercare

- How are bite, grinding, clenching or anterior guidance assessed before treatment?
- What would be a realistic repair path for a chip, edge problem or solution?
- What checks are planned and how can I recognize a problem early?
- What care and protection measures are included in the plan without making it a guarantee promise?

05 Cost, schedule and consent

- Is the estimate separated into diagnostics, wax-up/mock-up, laboratory, treatment and controls?
- Which round of changes is included and when do additional costs arise?
- What risks are there in written information, not just in conversation?
- Do I get enough time between plan, mock-up, costs and decision?

What a good answer boils down to

The question is not whether a practice uses a certain magic word. What is crucial is whether it can explain the biological and technical chain. These criteria are the points that DDJ also expects from practices as study-based patient communication.

What studies show about lifespan

- In systematic reviews, ceramic veneers often achieve high values over 5 to 10 years. One review reported a 10-year survival rate of 95.5%.
- Material-separated reviews show approximately 92.4 to 95.7% for 5 years. For 10 years, the range is wider: around 64 to 95%, depending on the material, study and failure definition.
- That's why the right question is not "How long are veneers guaranteed to last?", but rather: Is my case closer to the favorable enamel case or to a technically more difficult dentin, composite, functional or light case?

SUBSTANCE

Enamel is the most important adhesive base

A strong answer explains whether the veneer edges and the main bonding surface remain predominantly in the enamel. Enamel is the cheaper substrate for veneers. If there is a lot of dentin or old composite fillings involved, the practice should not downplay this but rather discuss it as a risk issue in its own right.

> **Lifespan:** Studies have shown that when ceramic veneers are bonded to enamel, survival and success were around 99% over the evaluated periods. With strong dentin exposure, the values were lower, around 91% survival and 74% success. With existing composite fillings, approximately 94% survival but only approximately 70% success has been reported.

Good question: Does the bonding surface remain predominantly in the enamel, or does dentin or old filling become part of the bonding?

DENTIN

If dentin is exposed, it needs its own protocol

Dentin is not just “also a tooth”. If it cannot be avoided, the practice must explain how it will protect the area, seal it and prepare it again later. The specialist literature describes, among other things, immediate dentin sealing. This is not a guaranteed trick, but it is an indication that dentin should not be treated like enamel.

> **Lifespan:** Studies have shown that in an 11-year cohort with more than 50% exposed dentin, the survival rate with immediate dentin sealing was 96.4% and without this sealing was 81.8%. That doesn't mean that IDS solves everything, but it clearly makes dentin cases easier to plan for.

Good question: What happens to exposed dentin between preparation, temporary and final placement?

BONDING

More steps are often not a luxury, but rather control

When it comes to veneers, it is the interface between tooth, cement and ceramic that counts. A practice should be able to explain whether it only uses a universal product or whether etching, primer, bonding and silane are deliberately separated. A multi-bottle system is not automatically better, but it shows that the individual surfaces are not treated equally across the board.

> **Lifespan:** Studies have shown that the big differences in lifespan are not caused by a single magic bottle, but by the substrate. Enamel cases were around 99%, severe dentin or composite cases were significantly lower. That's why a clearly explained bonding system is, above all, a protection against treating different surfaces incorrectly in the same way.

Good inquiry: What steps do you have for enamel, dentin and ceramic separately?

CERAMICS

Glass ceramic needs a suitable surface treatment

For glass-based ceramics, material-appropriate acid etching technology and silanization are part of the bonding logic. It is not important that patients learn chemistry by heart. It is important that the practice can explain how the ceramic is prepared before insertion and how it is protected from contamination.

> **Lifespan:** Studies have not provided a simple ten-year percentage just for “silane yes or no”. But they show: With glass-based ceramics, the appropriate surface treatment is part of the bonding logic. For example, study protocols describe 5% hydrofluoric acid for 20 seconds plus silane for 1 minute, always depending on the material and manufacturer.

Good question: How is the inside of the veneer prepared before it is glued in?

CEMENT

The luting cement is not irrelevant

A conventional, light-curing resin cement is often discussed as an obvious strategy for thin, translucent ceramic veneers. Self-adhesive systems are not automatically the simpler, equivalent solution. Dual-cure also does not automatically mean safer because the ceramic thickness, color, light transmission and cement chemistry have to match.

> **Lifespan:** Studies have shown: Light-curing resin cements fit primarily into a window made of thin, non-opaque glass ceramics; For veneers, reviews often mention less than 1.5 mm. In a laboratory study, self-adhesive systems demonstrated more edge leakage than an etch-wash protocol. This is not a brand recommendation, but a warning sign against abbreviations.

Good question: Why exactly does this cement match my material, my veneer thickness and my tooth color?

MATERIAL

Veneer material changes the risk

Feldspar ceramics, leucite-reinforced ceramics, lithium disilicate and composite laminates are not the same product with a different name. They differ in terms of surface, repairability, aging, fracture behavior and reintervention. Good advice clearly separates ceramic veneers and composite solutions instead of lumping everything together as “veneers”.

> **Lifespan:** Studies have shown that 5-year values for ceramic veneers are approximately 92.4 to 95.7%. Over 10 years, the range is wider, approximately 64 to 95%, depending on the material and failure definition. Therefore, a practice should not just say “ceramic,” but explain the material, thickness, risk of breakage, and repair path.

Good question: What material is planned and what speaks against it in my case?

LIGHT

Curing depends on thickness, color and lamp

The cement must harden sufficiently under the ceramic. General seconds are not enough for this. Ceramic thickness, translucency, cement type, lamp power, clean light guide and stable light guidance belong together. For thicker, opaque or darker veneers, the exposure strategy must be actively considered.

> **Lifespan:** Studies have shown that with 0.5 to 1.0 mm ceramic, laboratory values for a light-curing veneer cement were close to control; at more than 1.5 mm it became more critical depending on the material. In other tests, a dual-cure cement remained significantly weaker at 1.2 mm. For patients this means: Thickness and light are not details.

Good demand: Is light curing customized according to material, thickness and cement?

DESIGN

Preparation design is not just a question of style

No-prep, window, butt-joint or incisal setting are not a ranking. The decision depends on the remaining enamel, cutting edge, desired change in length, risk of fracture, bite and planned material thickness. If a cutting edge is grasped, the practice should explain why this is necessary in this particular case.

> **Lifespan:** Studies have shown that in one evaluation, veneers without an incisal setting had an estimated survival rate of around 91%, with an incisal setting around 88%. This is not a “never grip” rule, but a note: Each additional socket needs a justification about the cutting edge, length, load or material.

Good question: Why do you choose this preparation design and not the more substance-friendly alternative?

SEQUENCE

Veneer durability arises as a process chain

The result does not depend on a single product. Indication, mock-up, preparation that protects the substance, dry isolation, try-in, ceramic and tooth surfaces, choice of cement, controlled insertion, removal of excess, light, bite control and recall form a chain. Weak points in this chain should be identified.

> **Lifespan:** Studies have shown: The high 5 to 10 year values do not apply to “just any” veneer, but to cases with appropriate indications, choice of material, bonding and follow-up checks. If several links in the chain are unfavorable, the practice should set the expectation more narrowly.

Good question: Which steps are the critical points for me and how do you control them?

FUNCTION

Grinding, bite and aftercare are part of the decision

Fracture, debonding, marginal problems and repairs are different events. Anyone who grinds, clenches heavily or has an unfavorable front tooth alignment needs different risk information than someone with quiet function. A splint, closer monitoring or another treatment route can be part of the planning.

> **Lifespan:** Studies have shown that when failures are considered separately, isolated 10-year values for fracture, detachment, secondary caries and endodontic problems in a review range from 96.3 to 99.3%. Nevertheless, fracture and separation are clinically important because they are often noticed early and depend heavily on load, bite and adhesion.

Good question: How does biting, grinding or clenching change my plan and aftercare?

If you only have a minute

Green signal for a second conversation

The practice explains the initial situation, alternatives, question of substance, bonding protocol, function, repair and costs separately. You don't feel pressured.

Pause instead of a quick commitment

The goal is clear, but diagnosis, preparation, materials, light, aftercare or costs remain unclear. Then it's worth asking a calm question.

Get a second opinion

There's guarantee language, strong urgency, little diagnostics, no alternative, or a package deal that sounds more like sales than planning.

Warning signs in advice

- Before and after pictures replace diagnostics.
- Durability is guaranteed without discussing your own initial situation.
- There is only one option and hardly any room for alternatives.
- The plan starts with the price or discount, not with the findings.
- Temporary solutions, repairs and aftercare are only mentioned upon request.
- Bonding, cement, ceramic surfaces and light curing are dismissed as “standard” without explaining their own material.

What DDJ makes visible

- Veneers are not considered in isolation from bleaching, bonding, aligners, function and aftercare.
- An aesthetic target image is important, but is not a substitute for findings, substance and repair issues.
- Provider information remains commercially separate from study and article decisions.

- You should decide before you understand the plan.