INTRODUCTION

Anomalies of maxillary lateral incisors including shape, size or even agenesis are quite common, with a prevalence varies from 1.6% to 4.9% with higher prevalence in women than men.1,8 They can be either unilateral or bilateral touching the left or the right side with a higher incidence on the left-side dental arch.7 Peg-shaped anomaly of lateral incisors is one of the most common form of localized micродontia that affects the shape of permanent maxillary lateral incisors (peg lateral). It is characterized by the reduction of the incisal mesiodistal width compared with the cervical region.6 This shape anomaly leads to anterior diastemas, which causes functional and esthetic major concerns for the affected patients.4,5 Many treatment options of peg-shaped lateral incisors are available including...
one or many of these clinical procedures: no treatment, orthodontic treatment first, direct or indirect composite restorations, bonded ceramic crowns or veneers, and finally, extractions and implant placement. The multiple management possibilities make it difficult in some clinical situations to take the right therapeutic decisions by general dentists especially with growing esthetic demands of patients.

Many affected patients with peg-shaped lateral incisors present maxillary skeletal deformities and maxillomandibular teeth discrepancies (Bolton index is greater than 77.2% +/- 0.22). In these conditions, orthodontic treatment must be considered at the first line before prosthodontic rehabilitation of deformed lateral incisors. The final therapeutic options will depend on orthodontic objectives and methods. Several alternative therapeutic solutions must be considered like extractions or closing the interdental diastemas with possible consequences on the dental disharmony or morphological rehabilitation of these teeth to ensure the establishment of ideal occlusion.

When orthodontic treatment is considered before rehabilitation: definitive mesiodistal diameter and final vertical positioning of affected teeth must be determined before starting the orthodontic phase. To facilitate active orthodontic treatment, peg-shaped lateral incisors may be provisionally reconstructed according to the esthetic and functional decided criteria (shape, mesiodistal width, and color according to the adjacent teeth) prior to the placement of any orthodontic appliance. This procedure cannot be achieved when maxilla arch exhibits other dental discrepancies (crowding, teeth rotation, and palatally tipped teeth), which require orthodontic treatment to be started for teeth aligning and leveling before proceeding to the temporary restoration.

The lack of established clinical recommendation in the literature encouraged us to establish such protocol to facilitate the therapeutic decisions by the general practitioner, the orthodontist, and the patient, and ultimately to guarantee the most suitable therapeutic solution according to the individual clinical situations. The patient is often referred to the general practitioner once the orthodontic treatment has been completed. This lack of coordination between specialties represents a real loss of chance for patients. In this article, we aimed to clearly define the different considerations to be evaluated and the steps to follow, before and after orthodontic treatment. Our ultimate objective was to ensure the most appropriate multidisciplinary rehabilitation of affected teeth (Figure 1).

**FIGURE 1** Interdisciplinary coordination for the management of peg-shaped maxillary lateral incisors
2 | DEFINING THE TREATMENT OBJECTIVES

Before any therapeutic decision, three main biological, aesthetic, and functional objectives (bio-esthetic-functional triad) must be defined between practitioners and then be validated with the patient to establish the adequate individual treatment plan (Table 1). Healthy periodontal tissues will assure the esthetic results of the prosthodontic reconstitution.10,11

The clinical analysis of the patient consists of extraoral examination, intraoral environment examination, and then the analysis of the affected teeth.

The extraoral analysis that is very important in our bio-esthetic-functional triad. Practitioners should evaluate: 1) the proportion and the equality of three parts of the face and their symmetry including the vertical esthetic and occlusal dimensions, 2) maxillary labial protrusion as well as the nasolabial angle in order to determine the amount of labial and dental support, 3) the orientation of the horizontal lines of the face, and 4) the position of the chin. At the same time, practitioners should evaluate the different orofacial functions including 5) phonation and speech and finally evaluate 6) the patient’s smile in three different situations: without the appearance of teeth, social, and spontaneous smiles.13,14

3 | STUDY AND ANALYSIS OF THE CLINICAL SITUATION

3.1 | Extraoral environment: The smile

The smile represents a real importance in everyone’s social life. It influences physical, social, and intellectual attraction.15 Several smile variables must be evaluated before reconstructing a maxillary anterior tooth (Table 2). The study of smile can be carried out either dynamically (video) or statically (images).16

3.2 | Analysis of the intraoral environment of the tooth

3.2.1 | Periodontium

As mentioned previously, the periodontium has all its importance in esthetics17 but also in the biofunctional integration of the reconstitution.10,11 The position of the gingival edges of the maxillary anterior teeth can be modified by gingival or osteogingival plasties,18,19 for esthetic reasons.20

3.2.2 | Adjacent teeth

Determining the color shade of affected lateral incisors can be complex due to the high saturation of the adjacent canine and the less saturated central incisor. Besides, teeth may have dyschromic anomalies like white stains of fluorosis or brown stains of molar-incisor hypomineralisation (MIH).21 Patient’s desire to reproduce or not these anomalies in the final prosthetic rehabilitation should be also verified.

3.2.3 | Tooth size

Several studies agree that the golden ratio (width/height) of maxillary lateral incisor are of 62%, but this ratio is not the reference for patients as they seem to prefer a ratio ranged from 67% to 72%.22–24 German et al. have concluded that the ideal mesiodistal width of a maxillary lateral incisor is to be 2 mm narrower than one of the maxillary central incisors.25

3.2.4 | Teeth position on the dental arch

A smile is considered esthetic if the maxillary central incisal edge is at the same level as the maxillary canine edge26 and if the maxillary lateral incisal edge is between 0.5 and 1.5 mm coronally to this of central incisor.2,7,27

3.2.5 | Occlusion (static and dynamic)

The evaluation of the anterior guidance as well as the occlusal plane are necessary to select the most appropriate restoration materials and shape.28

3.2.6 | Position of the tooth in the mouth

Affected teeth should be analyzed according to its position in the oral cavity. This includes its relations to the adjacent central incisors and canines and to its inclination (vestibular and palatal). This step is very important to achieve our bio-esthetic-functional triad. The amounts of dental tissues of the affected laterals are then evaluated (the quantity of remaining enamel, dentinal exposure, and pulpal vitality). The chromic color shade plays a crucial role in determining the final prosthetic options (for example, making a crown instead of a veneer). Once this global analysis is done, a virtual project can be elaborated to make a wax-up of the future rehabilitation.
This step must be done during the orthodontic finishing phase. Using DSD, we can determine the ideal dimensions of the future restoration (height and width), its morphology and gingival margin. The DSD also allows us to determine whether modifications of the other anterior teeth are necessary.

When the DSD is validated by the practitioner and the patient, it will be communicated to the orthodontist to guide the positions of the anterior teeth. To facilitate the movement of the peg-shaped affected teeth, DSD can be transformed into a wax-up and then a mock-up when it is possible. In our clinical case, DSD was not performed because it would not have provided any additional information (Figure 3).

### 4.1 Determining the final position of anterior teeth

This step plays a key role in our protocol. Determining the ideal position of the tooth and its placement will allow us to maximize the preservation of dental tissues and guarantee an optimal durability of the restoration. One of the main goals when defining the final position of teeth is to provide a sufficient space for a veneer, crown, or direct...
composite resin restoration. It is interesting to cite that temporary rehabilitation of peg-shaped teeth with the mock-ups will stabilize the final position of the anterior tooth during and after orthodontic treatment.

a. **Mesiodistal position**: sufficient space must be maintained for the final restoration (0.5 mm for veneers and 1.5 to 2 mm for the direct technique or crowns). The mesial and distal spaces must be evenly distributed to better reproduce anatomical form of the tooth with the same proportion of enamel/dentin of natural maxillary lateral incisor. In case of dental disharmony with persistent anterior space, we recommend either a diastema distal to the lateral (studies show that this is the least unesthetic location in a smile) or a diastema distal to the canine. The decision should be discussed with the patient especially when this diastema is considered unesthetic by the general population.

b. **Vertical position**: within the framework of a rehabilitation with a laminate veneer, a palatal covering cap can be performed depending on the patient’s occlusion. This is recommended when anterior overlap ranges between 0 and 2 mm to avoid excessive preparation of the incisal edge of the peg-shaped tooth. In addition, when the affected tooth is taller, width/height proportion will be lower, which gives a more esthetic appearance. This notion is to be considered if the space of the peg-shaped tooth is too large and therefore requires an increase in its mesiodistal width. According to the clinical situation, to avoid any periodontal surgery, we recommend taking advantage of the orthodontic treatment to harmoniously position the gingival edges.

c. **Vestibulo-palatal position**: since an additional thickness will be added to the vestibular face of the peg-shaped tooth, we recommend placing the tooth in a more palatal position, which avoids an alignment of the incisal edge with the other teeth to limit dental preparations.

When closing interdental spacing becomes an indispensable procedure for practitioners, this may result in wide lateral incisors (square form). This happens especially when dental disharmony is presented at the dental arch. If the mesiodistal space is too large, either the diameter of the adjacent teeth can be increased or the anterior portion (incisors and canines) can be retrieved. If these solutions are unesthetic or nonfunctional, the orthodontic mesial advancement of canines (about 1 mm or more depending on clinical situation) may be a good alternative solution. However, this solution should not interfere or disturb the anterior guidance.

5 | **Mock-up**

When a mock-up is realized during orthodontic treatment, a temporary removal of the bracket of the concerned tooth will allow for the placement of the mock-up. Mock-ups allow to validate the final position of the tooth as well as the prosthetic project. A mock-up is normally placed with the mean of a silicon tray. Once the project is validated, the bracket can be rebonded and orthodontic appliance can be restored. Meantime, the temporary restoration can be modified as needed to facilitate orthodontic movements according to the final objectives (Figure 4).

6 | **Removal of the Orthodontic Appliance and Retention**

If the coronary reconstruction appointment with the general practitioner does not take place on the day of the removal of the orthodontic appliance, then we recommend the installation of a transformed thermoformed resin tray to avoid parasitic movements between appointments.

7 | **Reconstruction of the Concerned Tooth**

Depending on the results of clinical analysis, the reconstruction of the peg-shaped teeth can then begin. The mock-up previously placed can either be used as a reduction guide (if the practitioner and the patient opt for a veneer), or the mock-up can be used to make a palatal key for the direct composite resin restoration. The various steps of our protocol are summarized in Figure 1 and illustrated in our clinical case (Figures 2–7).

8 | **Discussion**

Management of peg-shaped maxillary lateral incisors must be achieved with a multidisciplinary approach. This allows to re-establish esthetic and functional treatment goals with minimally invasive clinical procedures. Being the most conservative one, orthodontic treatment plays a very important role in the management of peg-shaped lateral incisors and allows in certain cases to avoid useless periodontal surgeries. Orthodontic treatment achieves better position of lateral incisor and redistributes the interproximal diastemas to facilitate their direct or indirect restorations.

It is important to understand that the term “beautiful smile” remains a subjective issue. Miyoshi et al. have
shown that the appreciation of a smile varies according to the age of the evaluator. Elderly patients seem to be less concerned about interdental black triangles or gummy smile than younger patients.20 Even though there are no intersex differences in smile appreciation, it has been reported that women seem to be more concerned about the size of their maxillary lateral incisors than men,37 while other studies show that there are no intersex differences, especially concerning the appreciation of the mesiodistal diameter of the maxillary lateral incisors.38
Orthodontists seem to have a more critical point of view toward smile than a general practitioner, and people in the general population seem less critical than general practitioners. However, it has been shown that smile arc analysis seems to be evaluated identically between orthodontists, general practitioners, and the general population. For this, from an esthetic point of view, it is important to focus more on the patient’s appreciation than on our own professional appreciation as practitioners and to consider the individual differences of each patient (sex, age, origin, and profile).

The most conservative approach to re-establish lateral incisor shape is the direct resin composite bonding because it can be achieved without removal of any dental tissues. Recent esthetic composite resin materials have similar physical and mechanical properties to those of natural teeth. They offer a wide range of color shades and varying opacities designed specifically for the layering technique. In addition, direct resin composite bonding treatment is less expensive compared with ceramic veneers. In our case, we decided to set up a veneer on the left lateral incisor because of its shape and the high interproximal space to fill. We decided to establish a direct resin composite on the right lateral because of the low interproximal space. If a veneer was set up, it would have led to unnecessary deterioration of the enamel.

Adhesive ceramic veneers constitute a minimally invasive therapeutic approach and can replace defective natural enamel with a ceramic laminate veneer. This conservative technique is very suitable to treat many clinical situations where preserving the vitality of the tooth is essential. However, the indication must be well defined, and the protocol must be strictly followed.

Digital smile design and mock-up play a crucial role in our protocol. Not only they facilitate the orthodontic finishing process (determination of the final desired position of the teeth, provision of a better bonding surface for orthodontic brackets), but also they help with the preparation of the tooth. In the reported clinical case, the mesiodistal diameter of the laterals was within the normal compared with the mesiodistal diameters of the central incisors; therefore, the DSD provided little additional information. However, mock-up is of high interest in the case of severe dental anomalies where restoraion results in excessively high mesiodistal diameters of the lateral incisors. In such a case, interdental diastemas are some kinds unavoidable.

Furthermore, no study has discussed the esthetic aspect of the diastema between the canine and the maxillary first premolar in comparison with the one between the maxillary lateral incisor and the canine. Despite the efforts made to limit diastema, it is sometimes unavoidable, which may alter a patient’s smile esthetics. Several indexes have been developed to estimate the ideal mesiodistal diameters of the 6 maxillary anterior teeth, such as the Mavroskousfis or Lee indexes. Mavroskousfis index states that the sum of the mesiodistal diameters of the 6 maxillary anterior teeth is equal to the interalar distance +7mm. The Lee index states that the mesiodistal diameter of the maxillary central incisor is equal to one quarter of the interalar distance. In our reported case, the interalar distance is 46 mm, and the sum of the maxillary intercanal mesiodistal diameters is 44.6 mm. If we applied the Mavroskousfis index, this would result in an excessively palatal position of the maxillary sector and consequently a subnasal profile in retroposition. The Lee index was not applicable in our clinical case because the diameter of the central incisor was 8.2 mm, and the quarter of the interalar distance was 11.2 mm. For these reasons, we therefore applied the rule of German et al. cited above.

9 CONCLUSION

The prevalence of peg-shaped maxillary lateral incisors is relatively high in the general population. We aimed to precise the role of general dentistry and orthodontics with the proposition of a reproducible and easy to follow multidisciplinary approach for the management of peg-shaped teeth to guarantee an optimal result for the patient.

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CONFLICTS OF INTEREST
The authors declare no conflict of interests.

AUTHOR CONTRIBUTION
NO involved in the study conception and design, material preparation, prosthodontics treatment of patient, and wrote most of the manuscript; AN involved in the English proof-reading and the scientific reviewing of the article. SF involved in orthodontic treatment of patient; BV involved in criticizing the content of the manuscript; JB contributed to writing a part of the manuscript and did the final review.

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Raw versions of all presented data are available upon simple request of the corresponding author.

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REFERENCES
1. Thongudomporn U, Freer TJ. Prevalence of dental anomalies in orthodontic patients. Aust Dent J. 1998;43(6):395-398.
2. Bello A, Jarvis RH. A review of esthetic alternatives for the restoration of anterior teeth. J Prosthodont. 1997;7(5):437-440.
3. Kokich VO, Kiyak HA, Shapiro PA. Comparing the perception of dentists and lay people to altered dental esthetics. J Esthet Dent. 1999;11(6):311-324.
4. Noureddine A, Fron Chabouis H, Parenton S, Lasserre J-F. Laypersons’ esthetic perception of various computer-generated diastemas: a pilot study. J Prosthodont. 2014;112(4):914-920.
5. Machado AW, Moon W, Gandini LG. Influence of maxillary incisor edge asymmetries on the perception of smile esthetics among orthodontists and laypersons. Am J Orthod Dentofacial Orthop. 2013;143(5):658-664.
6. Vastardis H. The genetics of human tooth agenesis: new discoveries for understanding dental anomalies. Am J Orthod Dentofacial Orthop. 2000;117(6):650-656.
7. Bozkaya E, Canigur Bubek N, Ulusan B. New perspective for evaluation of tooth widths in patients with missing or peg-shaped maxillary lateral incisors: quadrant analysis. Am J Orthod Dentofacial Orthop. 2018;154(6):820-828.
8. Ittipuriphat I, Leevaiijol C. Anterior space management: interdisciplinary concepts. J Esthet Restor Dent. 2013;25(1):16-30.
9. Disharmony BWA. Tooth size and its relation to the analysis and treatment of malocclusion*. Angle Orthod. 1958;28(3):113-130.
10. Belser UC, Grütter L, Vailati F, Bornstein MM, Weber H-P, Buser D. Outcome evaluation of early placed maxillary anterior single-tooth implants using objective esthetic criteria: a cross-sectional, retrospective study in 45 patients with a 2- to 4-year follow-up using pink and white esthetic scores. J Periodontol. 2009;80(1):140-151.
11. Pencl BM, Keagle JG. Presiding factors in the etiology of chronic inflammatory periodontal disease. J Periodontol. 1977;48(9):517-532.
12. Nakamura M, Nozaki K, Nagamune K, Takimoto H, Fujigaki M, Wada S. Experimental analysis for the contribution of tooth vibration to production of sibilant measurement of sound and vibration. Conf Proc IEEE Eng Med Biol Soc. 2010;2010:1320-1323.
13. Dindaroğlu F, Ertan Erdenç AM, Doğan S. Perception of smile esthetics by orthodontists and laypersons: full face and a localized view of the social and spontaneous smiles. Turk J Orthod. 2016;29(3):59-68.
14. Dindaroğlu F, Doğan S, Erdenç AME. Smile esthetics: age related changes, and objective differences between social and spontaneous smiles. J Clin Pediatr Dent. 2011;36(1):99-106.
15. Papio MA, Fields HW, Beck FM, Firestone AR, Rosenstiel SF. The effect of dental and background facial attractiveness on facial attractiveness and perceived integrity and social and intellectual qualities. Am J Orthod Dental Facial Orthop. 2019;156(4):464-474.e1.
16. Coachman C, Calamita MA, Sesma N. Dynamic documentation of the smile and the 2D/3D digital smile design process. Int J Periodontics Restorative Dent. 2017;37(2):183-193.
17. Singh VP, Uppoor AS, Nayak DG, Shah D. Black triangle dilemma and its management in esthetic dentistry. Dent Res J (Isfahan). 2013;10(3):296-301.
18. Dym H, Pierre R. Diagnosis and treatment approaches to a «gummy smile». Dent Clin North Am. 2020;64(2):341-349.
19. Shenoy BS, Punj A, Ramesh A, Talwar A. Salvaging the lost pink triangle: a case series of papilla reconstruction. Case Rep Dent. 2020;2020:9735074.
20. Miyoshi CS, Rached RN, Meira TM, Allahham A, Saga AY, Tanaka OM. The eye-tracking study of the impact of the gingival margin height of maxillary lateral incisors. Int J Periodontics Restorative Dent. 2020;40(2):261-270.
21. Ghanim A, Silva MJ, Elfrink MEC, et al. Molar incisor hypomineralisation (MIH) training manual for clinical field surveys and practice. Eur Arch Paediatr Dent. 2017;18(4):225-242.
22. Levin EI. Dental esthetics and the golden proportion. J Prosthodont. 1978;40(3):244-252.
23. Buhkry SMN, Gill DS, Tredwin CJ, Moles DR. The influence of varying maxillary lateral incisor dimensions on perceived smile aesthetics. Br Dent J. 2007;203(12):687-693.
24. Al Taki A, Hamdan AM, Mustafa Z, Hassan M, Abu-Alhuda S. Smile esthetics: impact of variations in the vertical and horizontal dimensions of the maxillary lateral incisors. Eur J Dent. 2017;11(4):514-520.
25. German DS, Chu SJ, Furlong ML, Patel A. Simplifying optimal tooth-size calculations and communications between practitioners. Am J Orthod Dentofacial Orthop. 2016;150(6):1051-1055.
26. Machado AW. 10 commandments of smile esthetics. Dental Press J Orthod. 2014;19(4):136-157.
27. Haak R, Siegner J, Ziebolz D, et al. OCT evaluation of the internal adaptation of ceramic veneers depending on preparation design and ceramic thickness. Dent Mater. 2021;37(3):423-431.
28. Vanlooglu BA, Kulak-Özkan Y. Minimally invasive veneers: current state of the art. Clin Cosmet Investig Dent. 2014;6:101-107.
29. Simon H, Magne P. Clinically based diagnostic wax-up for optimal esthetics: the diagnostic mock-up. J Calif Dent Assoc. 2008;36(5):355-362.
30. Garcia PP, da Costa RG, Calgaro M, et al. Digital smile design and mock-up technique for esthetic treatment planning with porcelain laminate veneers. J Conserv Dent. 2018;21(4):455-458.
31. Machado AW, Moon W, Campos E, Gandini LG. Influence of spacing in the upper lateral incisor area on the perception of smile esthetics among orthodontists and laypersons. J World Fed Orthodontis. 2013;2(4):e169-e174.
32. Albanesi RB, Pigozzo MN, Sesma N, Laganá DC, Morimoto S. Incisal coverage or not in ceramic laminate veneers: a systematic review and meta-analysis. J Dent. 2016;52:1-7.
33. Chai SY, Bennani V, Aarts JM, Lyons K. Incisal preparation design for ceramic veneers: a critical review. J Am Dent Assoc. 2018;149(1):25-37.
34. Witt M, Flores-Mir C. Laypeople’s preferences regarding frontal dentofacial esthetics: tooth-related factors. *J Am Dent Assoc*. 2011;142(6):635-645.

35. Brandão RCB, Brandão LBC. Finishing procedures in orthodontics: dental dimensions and proportions (microesthetics). *Dental Press J Orthod*. 2013;18(5):147-174.

36. Saeidi Pour R, Engler MLPD, Edelhoff D, Prandtner O, Frei S, Liebermann A. A patient-calibrated individual wax-up as an essential tool for planning and creating a patient-oriented treatment concept for pathological tooth wear. *Int J Esthet Dent*. 2018;13(4):476-492.

37. Bolas-Collee B, Tarazona B, Paredes-Gallardo V, Luxan SA-D. Relationship between perception of smile esthetics and orthodontic treatment in Spanish patients. *PLoS One*. 2018;13(8):e0201102.

38. Tan D, Playle R, Harris A, Tredwin C, Addy L. Does the gender of the subject affect perceived smile aesthetics when varying the dimensions of maxillary lateral incisors? *Br Dent J*. 2018;225(3):235-240.

39. Kokich VO, Kokich VG, Kiyak HA. Perceptions of dental professionals and laypersons to altered dental esthetics: asymmetric and symmetric situations. *Am J Orthod Dentofacial Orthop*. 2006;130(2):141-151.

40. Geevarghese A, Baskaradoss JK, Alsalem M, et al. Perception of general dentists and laypersons towards altered smile aesthetics. *J Orthod Sci*. 2019;8:14.

41. Passia N, Blatz M, Strub JR. Is the smile line a valid parameter for esthetic evaluation? A systematic literature review. *Eur J Esthet Dent*. 2011;6(3):314-327.

42. Antov H, Jablonski RY, Keeling A, Nixon P. CAD/CAM techniques for the conservative and efficient management of tooth wear. *Br Dent J*. 2019;227(9):791-796.

43. Murrell GA. Phonetics, function, and anterior occlusion. *J Prosthet Dent*. 1974;32(1):23-31.

44. Özk AA, Akdeniz BS, Canlı E, Çelik S. Smile attractiveness: differences among the perceptions of dental professionals and laypersons. *Turk J Orthod*. 2017;30(2):50-55.

45. Oshagh M, Zarif NH, Bahramnia F. Evaluation of the effect of buccal corridor size on smile attractiveness. *Eur J Esthet Dent*. 2010;5(4):370-380.

46. Silva BP, Jiménez-Castellanos E, Martinez-de-Fuentes R, Fernandez AAV, Chu S. Perception of maxillary dental midline shift in asymmetric faces. *Int J Esthet Dent*. 2015;10(4):588-596.

47. Silva BP, Jiménez-Castellanos E, Stanley K, Mahn E, Coachman C, Finkel S. Layperson’s perception of axial midline angulation in asymmetric faces. *J Esthet Restor Dent*. 2018;30(2):119-125.

48. Sriphadungporn C, Chamannidadha N. Perception of smile esthetics by laypeople of different ages. *Prog Orthod*. 2017;18(1):8.

49. Simões D, Meyge de Brito G, Teixeira Cangussu MC, Machado AW. Does the vertical position of maxillary central incisors in men influence smile esthetics perception? *Am J Orthod Dentofacial Orthop*. 2019;156(4):485-492.

50. Tjan AH, Miller GD, The JG. Some esthetic factors in a smile. *J Prosthet Dent*. 1984;51(1):24-28.

51. Machado AW, McComb RW, Moon W, Gandini LG. Influence of the vertical position of maxillary central incisors on the perception of smile esthetics among orthodontists and laypersons. *J Esthet Restor Dent*. 2013;25(6):392-401.

52. Menezes EBC, Bittencourt MAV, Machado AW. Do different vertical positions of maxillary central incisors influence smile esthetics perception? *Dental Press J Orthod*. 2017;22(2):95-105.

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