food that is significantly larger than most people would eat during a similar period of time and under similar circumstances; and, (2) a sense of lack of control over eating during the episode, such as a feeling that one cannot stop eating.

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or enemas (purging type); or, through fasting or excessive exercise (nonpurging type).

C. These behaviors occur at least twice a week for at least three months.

As a group, patients with eating disorders have a caries rate that is higher than for a similar reference group. More than one-half the subjects in a paper by Ohms et al had erosive tooth wear involving the dentine and about one-third had very low un-stimulated salivary flow rates with very high counts of streptococci mutans and lactobacilli. Erosive tooth wear was significantly related to the number of years of binge eating.[4,5] Dental patients with eating disorders need more aggressive preventive programs created in consultation with the health professionals directly involved with their ongoing supportive care.[6]

All but one of the many eating disorder cases I have been involved in over the last thirty-seven years were female. Tooth erosion varied from mild to extremely severe. This case involved a multidisciplinary approach to therapy.

PROSTHODONTIC TREATMENT APPROACH

The patient presented as a referral in August, 2001, specifically to treat her severely eroded teeth. She was 30-years-old and weighed 110 pounds. In addition to bulimia she suffered from moderate asthma. Ventolin and Flovent twice daily on a regular basis controlled the asthmatic episodes. The rest of her medical-dental history was unremarkable. There was doubt, expressed by her father, a physician, regarding the cessation of bulimic practices.

As is evident in Figures 1-6 there was generalized erosion of the entire dentition. Amalgams in the posterior teeth were 1-2mm above the remaining tooth structure. Clinically these amalgams projected above the enamel and had maintained the vertical dimension of occlusion (VDO).

The dilemma as I saw it was the absence of any usable anterior guidance and the lack of space to create restorations with proper resistance and retention form. Even if the case could be opened up to a new

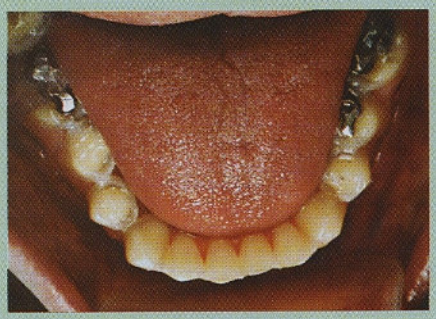

FIGURE 3—Lower occlusal – initial.

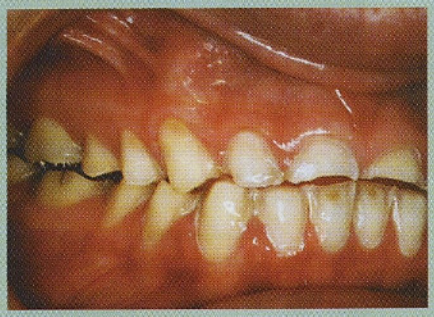

FIGURE 4—Right occlusal – initial.

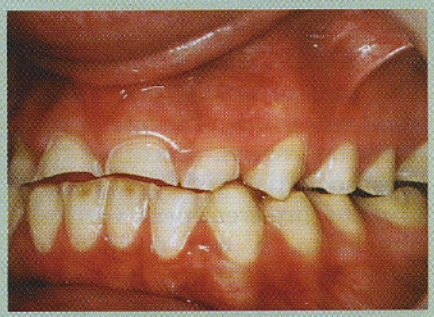

FIGURE 5—Left occlusal – initial.

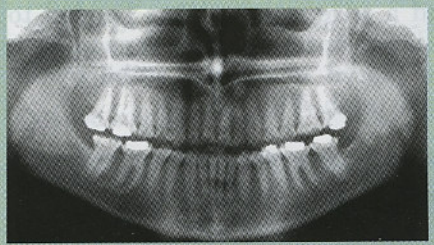

FIGURE 6—Panoramic – initial.

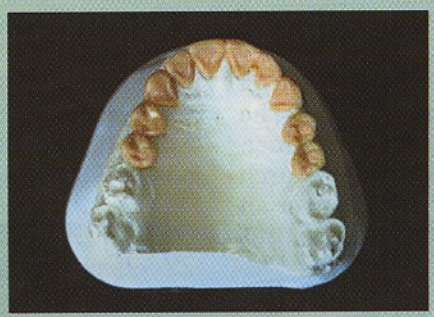

FIGURE 7A—First wax-up.

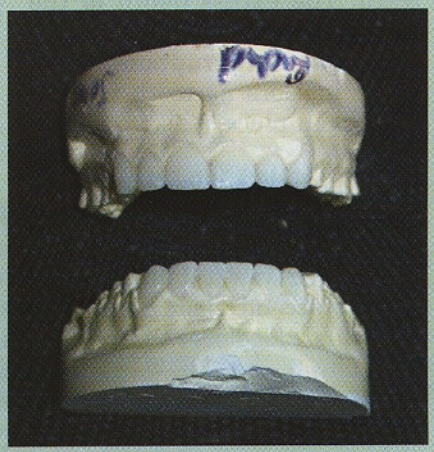

FIGURE 7B—Second wax-up.