An 11-year-old female reported to department of Pediatric and Preventive Dentistry with the chief complaint of spacing in between the upper anterior teeth. Intraoral examination revealed maxillary arch 1 molar relation with generalized spacing in the maxillary arch was evident. The child was born to non-consanguineous parents. The pregnancy and delivery were uneventful. There was no history of any severe systemic diseases, trauma or infections to the anterior region. Family history revealed no similar finding in any other members of the family. Panoramic examination revealed congenital absence of permanent mandibular central incisors and maxillary right lateral incisor. (Figure: 2)

Permanent maxillary right lateral incisors were missing clinically and presence of peg shaped left lateral incisors was seen. (Figure: 1) Class 1 molar relation with generalized spacing in the maxillary arch was evident. The child was born to non-consanguineous parents. The pregnancy and delivery were uneventful. There was no history of any severe systemic diseases, trauma or infections to the anterior region. Family history revealed no similar finding in any other members of the family. Panoramic examination revealed congenital absence of permanent mandibular central incisors and maxillary right lateral incisor. (Figure: 2)

After assessing the present case, acrylic crowns were planned to be placed on the lower retained mandibular primary central incisors. Crown preparation was done, impression was made with elastomeric material and cast was poured and retrieved. Wax pattern was fabricated on the cast and using the typical lost wax technique, heat cure acrylic crowns were fabricated with appropriate shade match. Good quality of surface finishing and polishing was done and the acrylic crowns were cemented on 71 and 81.

Bonding of brackets to the permanent incisors and banding of maxillary first permanent molars was performed at the next stage. 0.012-inch Niti was used for initial alignment and closure of midline diastema. (Figure: 3)
Fabrication of fixed functional space maintainer, i.e., lingual arch with anterior acrylic prosthesis (Hollywood appliance) was planned. Appropriate preformed orthodontic bands (0.005-inch thickness and 0.180-inch width) were adapted on 16 and 26. The appropriate shade selection for the teeth was performed under natural light. On the upper cast, a stainless-steel wire (0.9 mm) framework was made, spanning from one band to the other. The free ends of the wire were then soldered to the corresponding molar bands. In the anterior region of the upper cast, a trial wax up was done with trimmed acrylic teeth (A2 shade). After cold-mold seal application and cold cure acrylic resin application, the appliance was then removed from the cast. After trimming, finishing, and polishing, the appliance was cemented on 16 and 26 with luting glass ionomer cement (Fuji I) and occlusion was checked for any premature contact. The patient and her parents were educated about the care of the appliance. This included vigorous rinsing after every meal and that the food be chewed only on the molars. Cutting/incising was to be avoided as this appliance had only the cemented molar bands for resistance and stability. (Figure 3)

Direct composite restoration was done with maxillary left permanent peg lateral to enhance the esthetic appearance. The maxillary left permanent peg lateral was prepared, isolated with cotton rolls, etched with 37% phosphoric acid for 15 seconds and bonding agent (Single Bond Adhesive System, 3M ESPE Adper Dental Products, St. Paul, Minn, USA) was applied to the tooth surface. The curing of the composite was done with halogen light. Before restoration, any sharp margins on the prepared tooth surface were rounded to ensure that there was enough surface area for bonding. Also, a retention groove was prepared to increase the retention of the composite restoration (Z-350,2M ESPE Dental Products, St. Paul, Minn, USA). Occlusal adjustments were done to prevent any premature contacts, and excess material was removed. After finishing and polishing with diamond burs and Soflex discs (3M ESPE Dental Products, St. Paul, MN, USA), the final esthetic appearance was well accepted by both the patient and the parents.

DISCUSSION
The ideal multidisciplinary team for management of hypodontia includes specialists from orthodontics, pediatric dentistry, prosthodontics, and implantology. The need to await complete eruption and root formation of permanent abutment teeth with huge pulp chambers has contraindicated the provision of fixed prosthetic reconstructions in children with hypodontia. As the age of the child is 11, we considered giving composite restorations and acrylic crowns over retained primary incisors that could serve as interim restorations rather than going for bulky removable partial dentures that could be esthetically unacceptable by young patients.

The use of cure acrylic crowns as long term provisional restoration is well accepted in permanent teeth, however restoring primary teeth with them can be challenging. Important parameters for successful restoration include at least 1–1.5 mm healthy tooth structure to be available above gingiva, sufficient clearance with respect to overjet and bite should be present, radiographically at least two-third of root length with no periapical pathology or internal resorption should be present. All the above mentioned criteria were present in relation to 71 in the present case whereas 81 shows slight signs of root resorption.

A tapered diamond point was used to widen the mesial, distal, and labial axial surfaces at a 15° to 20° taper. This provides room for an adequate bulk of crown material for the strength of the restoration, a desirable margin and optimal esthetic appearance. In the present case, thin chamfer type of finish line was placed. SO-20 and TR. 13 EF diamond points were used in the present case for tooth preparation and finishing.

In the present case, brackets were bonded to permanent incisors and banding of permanent molars were done. 0.012 inch NiTi wires were used for initial alignment and closure of midline diastema. Lateral incisors were not bonded as it was missing in the first quadrant and 22 appeared to be a peg lateral. Hence the modification of 2*4 appliance was used in this case. Rotation, diastemas and incorrect tooth angulations can be easily corrected using this versatile technique.

The esthetic rehabilitation of primary anterior teeth has a vital psychological impact on recovery of patient's self-esteem (slack and johns). But in the present case, permanent lateral incisors were missing from the first quadrant. Hence our treatment objectives included preservation of the space, maintenance of the alveolar integrity and the prosthetic replacement of the missing tooth to enhance the function and esthetics. A functional space maintainer was given to the patient and the patient will be followed up until the growth ceases for future permanent prosthesis.

A peg shaped lateral is defined as “an undersized, tapered, maxillary lateral incisor” (glossary of prosthodontic terms (1990) that may be associated with other dental anomalies, such as canine transposition and over retained deciduous teeth. Individuals with malformed lateral incisors often display a diastema in the midline region caused by the distal movement of the central incisor. In the present case midline diastema was closed using 2*4 appliance so that further build up on the peg lateral using direct composite became much easier.

Patient was reviewed after one week following treatment. Repolishing of rough edges was done and functional occlusion was checked. Patient was instructed to follow proper oral hygiene measures to maintain excellent integrity of the composite tooth margin.

CONCLUSION
Bringing back the esthetics and function are the primary priority in the treatment plan for children with congenitally missing anterior teeth. Multidisciplinary treatment approach is done in the management of oligodontia. Pedodontist plays a vital role in diagnosing such cases during the transitional period and providing proper interim restorations.

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Figure: 4 (post-operative)