e-ISSN: 3049-2904, Print ISSN: 3107-6262

Oral Sphere Journal of Dental and Health Sciences

www.oralsphere.com

Case Report

A Novel Orthodontic Camouflage Approach to Correct an Adult Class III Malocclusion in Combination with Porcelain Laminate Veneers

Rajesh Kuril[1*], Suchita Daokar[2], Omkar Shete[3], Janhvi Sonavane[1]

[1]Department of Orthodontics and Dentofacial Orthopedics, Dr. G D Pol Dental College and Hospital, Navi Mumbai, Maharashtra, India

[2]Department of Orthodontics and Dentofacial Orthopedics, CSMSS Dental College, Chhatrapati Sambhaji Nagar, Maharashtra, India

[3]Department of Prosthodontics, Dr. G D Pol Dental College and Hospital, Navi Mumbai, Maharashtra, India

Citation: Kuril R, Daokar S, Shete O, Sonavane J. A Novel Orthodontic Camouflage Approach to Correct an Adult Class III Malocclusion in Combination with Porcelain Laminate Veneers. *Oral Sphere J Dent Health Sci.* 2026;2(4):253-262.

For reprints contact:
publisher@fontfusionspublication.com

Received: June 20, 2026;

Revised: July 25, 2026;

Accepted: August 21, 2026;

Published: October 01, 2026

***Corresponding author:** Rajesh Kuril
Email: rajeshlibran3@yahoo.com

DOI: https://doi.org/10.63150/osjdhs.2026.37

©The Author(s). (2026)

Open Access.
Published by Font Fusions Publication

This article is licensed under the Creative Commons Attribution-NonCommercial 4.0 International License (https://creativecommons.org/licenses/by-nc/4.0/) allowing non-commercial sharing, adaptation, and distribution, provided you give appropriate credit to the original author(s), provide a link to the license, and indicate if changes were made.

ABSTRACT

Background: Management of adult Class III malocclusion may involve orthognathic surgery or orthodontic camouflage, depending on the severity of the skeletal discrepancy, dental compensation, facial esthetics, functional considerations, and patient preference.

Case Presentation: A 19-year-old female patient with mild Class III malocclusion, with mandibular prognathism, unilateral crossbite, and ANB angle of −1.4°, Wits line of −2.8 mm, and SN–MP of 18.2°. The patient opted against surgery, extractions or temporary anchorage devices. Fixed prosthetics for camouflage and Class III elastics were performed during about 30 months and then porcelain laminate veneers were placed on the six maxillary anterior teeth. The functional shift was eliminated, crossbites were corrected with acceptable overjet and overbite, dental midlines coincided with facial midline and the facial profile and smile esthetics enhanced.

Conclusion: Selected mild Class III malocclusions can be managed effectively with a combined orthodontic and prosthodontic approach when surgery is not pursued.

Keywords: Camouflage, Class III malocclusion, Porcelain laminate veneers, Class III elastics, Orthodontic-prosthodontic interdisciplinary treatment.

BACKGROUND

Anterior overjet, smile esthetics, lip support, and overall facial harmony are especially affected by the position and line of the maxillary incisors during camouflage therapy [1]. It may be necessary to correct the underlying discrepancy by controlled proclination of the maxillary incisors in order to achieve a positive overjet. Too much proclination, however, can cause issues with the esthetics, periodontal health and long-term stability. Moreover, Class III elastics can result in further anterior incisor proclination and posterior incisor retroclination, which necessitates careful biomechanical control [2]. Thus, a proper dentoalveolar compensation, functional

occlusion, incisor inclination and facial esthetic balance still represents a great clinical challenge in adult camouflage Class III treatment [3].

Class III elastics have been recommended to correct functional Class III malocclusion, especially in cases with mild skeletal discrepancies and significant functional component of malocclusion [4]. When used appropriately, they can help to correct anterior cross bite, help to create a more favorable antero-posterior relationship and help to create a more favorable occlusal relationship [5]. If the dental morphology, tooth proportions, or pre-existing esthetic deficiencies also add to the treatment goals, however, treatment outcomes may be constrained [6]. In these cases, orthodontic correction can sometimes not completely meet the esthetic demands of the patient [7].

Earlier case reports have shown that successful correction of Class III malocclusion can be achieved with the use of Class III elastics; however, this combination of Orthodontic camouflage and laminate veneers as an adjunctive treatment to the esthetic correction is not well documented [8]. Once a tooth has been orthodontically corrected, laminate veneers may be used as an additional tool to correct any esthetic discrepancies that cannot be corrected by tooth movement, especially in the modification of tooth morphology and proportion and in the correction of tooth visual alignment [9]. This interdisciplinary approach may thus enable the functional correction to be achieved while at the same time providing controlled improvements in anterior dentition esthetics, without resorting to surgery [10]. The present case reports the treatment of functional Class III malocclusion with facial asymmetry with application of Class III elastics and laminate veneers. The case demonstrates the importance of using orthodontic biomechanics and minimizing esthetic compromise while correcting the function, maximizing the inclination of the maxillary incisors and achieving harmony of the patient's smile in an adult patient who is not seeking orthognathic surgery.

CASE REPORT

Patient information

A 19-year-old woman complained of a forward lower jaw. A positive family history suggested a multifactorial etiology with a strong genetic component.

Clinical findings

Extraoral examination revealed a mesofacial pattern, concave profile and prominent chin, with no signs of TMJ dysfunction. Occlusal trauma was indicated by incisal attrition of the anterior teeth in the maxilla. The left molar relationship was Angle Class III with a crossbite on the right. A functional mandibular shift from centric relation to maximum intercuspation was identified clinically (Figures 1 and 2).

Figure 1: Pretreatment facial and intraoral photographs showing a concave profile and Angle Class III molar relationship with anterior crossbite. (A) Frontal view at rest; (B) frontal view smiling; (C) right lateral profile; (D) right buccal intraoral view; (E) frontal intraoral view; (F) left buccal intraoral view

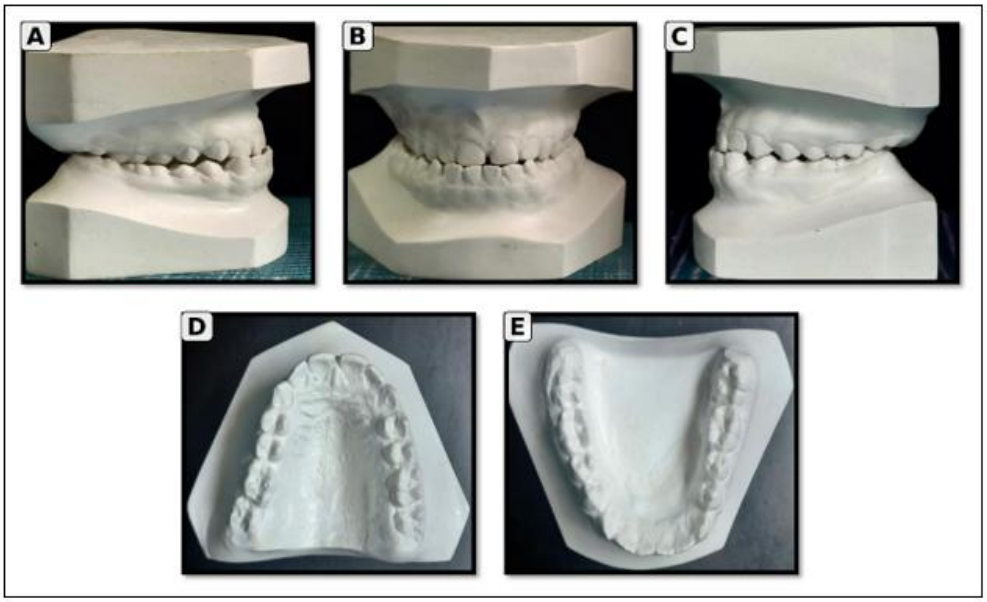

Figure 2: Pretreatment dental casts confirming the Class III molar relationship and posterior crossbite. (A) Right lateral view; (B) frontal view in occlusion; (C) left lateral view; (D) maxillary occlusal view; (E) mandibular occlusal view

Diagnostic assessment

X-rays showed a Class III pattern (ANB −1.4°, Wits −2.8 mm) and a horizontal growth pattern (SN–MP 18.2°). Radiographic abnormalities also included proclined upper incisors (U1–SN 119°) and normally aligned lower incisors (IMPA 96.8°) (Figure 3).

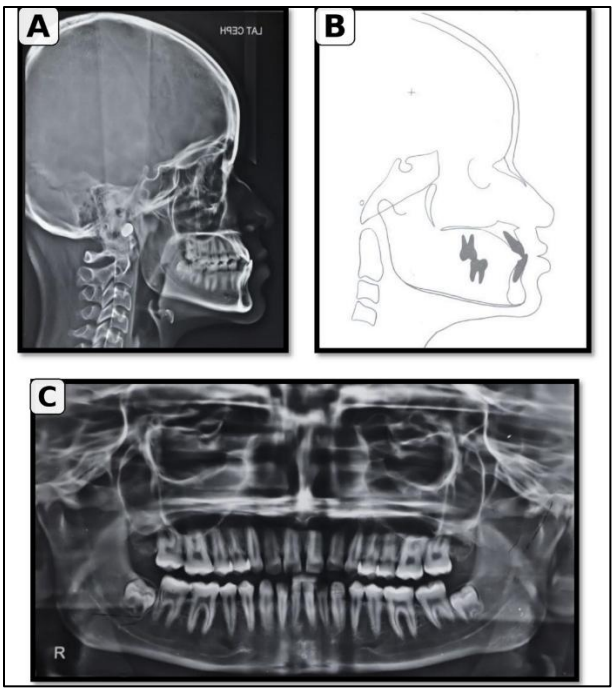

Figure 3: Pretreatment radiographs: lateral cephalogram, cephalometric tracing, and panoramic radiograph showing a skeletal Class III pattern. (A) Lateral cephalogram; (B) cephalometric tracing; (C) panoramic radiograph

Therapeutic intervention

1. Treatment objectives: The treatment objectives were to correct the anterior and posterior crossbites and functional mandibular shift, establish coincident dental midlines, achieve a Class I molar relationship, and obtain a stable functional occlusion.
2. Treatment alternatives: Treatment options included orthognathic surgery with mandibular setback and/or maxillary advancement, but the patient refused surgery. Given the relatively mild skeletal discrepancy and the presence of a significant functional component, a non-surgical orthodontic camouflage approach was considered feasible. Alternatives were considered such as distalizing the lower arch fully using TADs and slow maxillary expansion for the posterior crossbite. Single mandibular incisor extraction was also being evaluated for anterior crossbite correction (extraction-based camouflage). When the patient refused to have either extractions or temporary anchorage devices, the decision was made to proceed with a conventional Class III elastic fixed orthodontics. After orthodontic treatment, a multi-disciplinary consultation took place with a prosthodontist for consideration of veneers.

Treatment timeline and progress:

On November 15, 2023, fixed orthodontics started with a pre-adjusted edgewise appliance [MBT (McLaughlin, Bennett, and Trevisi) slot], 0.022 × 0.028-inch slot. The following were applied and bonded to the two arches:

conventional metallic brackets and bite blocks to relieve occlusion. Sequential archwires were used to level and align the teeth in the upper arch from 0.016 NiTi to 0.019 × 0.022 SS and in the lower from 0.016 NiTi to 0.018 round SS, in 12 months. Both the anterior and posterior crossbites were substantially corrected within 6 months using expanded archwires and Class III elastics (3/16 oz, TP Orthodontics). The treatment period was for a total of about thirty months. The case was subsequently referred for a prosthodontic evaluation for laminate veneers of the maxillary anterior teeth.

Prosthodontic rehabilitation

Once orthodontic correction was completed, attention shifted to the esthetic rehabilitation of the maxillary anterior region. Diagnostic impressions and facebow-mounted casts were obtained, followed by dentofacial analysis and shade selection. An orthopantomogram and intraoral periapical radiographs were also evaluated. Because the primary restorative objectives were correction of tooth discoloration and modification of tooth form, porcelain laminate veneers for the six maxillary anterior teeth were selected as a minimally invasive restorative option. The desired tooth morphology was established using a diagnostic wax-up on the mounted casts. Following discussion of the proposed treatment, alternatives, potential risks, and expected outcomes, written informed consent was obtained from the patient. Once orthodontic correction was completed, attention shifted to the esthetic rehabilitation of the maxillary anterior region. Diagnostic impressions and facebow-mounted casts were obtained, followed by dentofacial analysis and shade selection. An orthopantomogram and intraoral periapical radiographs were also evaluated. Because the primary restorative objectives were correction of tooth discoloration and modification of tooth form, porcelain laminate veneers for the six maxillary anterior teeth were selected as a minimally invasive restorative option. The desired tooth morphology was established using a diagnostic wax-up on the mounted casts. Following discussion of the proposed treatment, alternatives, potential risks, and expected outcomes, written informed consent was obtained from the patient.

A silicone index prepared from the horizontally sectioned diagnostic wax-up was used to guide tooth reduction and ensure controlled preparation depth, which is critical for the predictable outcome of porcelain laminate veneers. Dual planes of convergence were made, leaving the natural labial contour, and depth cuts of 0.5 mm were made from the gingival to the incisal margin. The labial wall was chamfered off by a long-tapered chamfer-end diamond bur, and the finish line was created between the teeth margins with a defined line at the gingival margin (which is just inside the embrasures), and with the palatal margin coronal to the contact point so that all visible surfaces would be covered. The full-arch addition silicone impressions (Aquasil, Dentsply Sirona, USA) were sent to the lab alongside an occlusal record, with the shade of the underlying dentition indicated and the desired length, width and position of the anterior teeth recorded. Refractory dies were used for processing lithium disilicate veneers (IPS e.max).

The teeth were isolated using a retraction cord and cleaned with pumice. The enamel surfaces were etched with 37% phosphoric acid for 15 seconds, followed by rinsing for 20 seconds and gentle drying, leaving the surfaces slightly moist. Adper Single Bond (3M ESPE, USA) was applied in two coats and light-cured for 20 seconds using a Demi LED curing light (450 nm; Kerr, USA). The intaglio surfaces of the veneers were etched and silanated according to the manufacturer's instructions. The veneers were then luted with 3M ESPE Veneer Cement and seated under finger pressure. Excess cement was removed after tack curing for 5–8 seconds, followed by final light curing for 20 seconds from the incisal, buccal, and palatal surfaces. Home care and hygiene instructions were provided specific to the veneer, and were reviewed at 1 week, 3 months and 6 months (Figure 4). Once the prosthodontic phase, the remaining bonded teeth were freed of orthodontic braces. Full-time Essix retainers were provided, since the patient wanted to delay bonding retainers as he was going to study abroad.

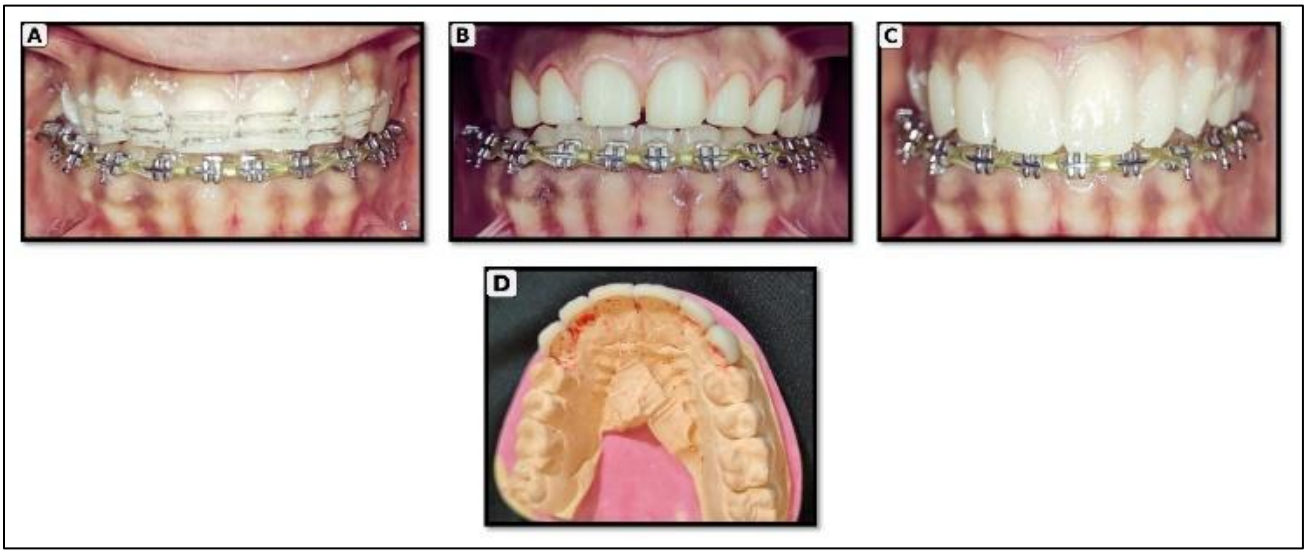

Figure 4: Prosthodontic phase: tooth preparation, try-in, and cementation of porcelain laminate veneers on the maxillary anterior teeth. (A, B, C) Frontal intraoral views showing the anterior prosthetic replacement in situ; (D) occlusal view of the maxillary cast with the interim prosthesis

FOLLOW-UP AND OUTCOMES

Treatment outcome

The treatment goals were met in post treatment documentation. The functional mandibular shift was removed and the facial profile was improved and concavity reduced. Dental and facial midline matched and smile esthetics were significantly enhanced. The crossbites were corrected, which led to satisfactory overjet and overbite. Proper incisal guidance and good intercuspation was achieved (Figures 5 and 6). The post-orthodontics panoramic radiography showed good root parallelism (Figure 7). Lateral cephalometric analysis showed limited skeletal changes, with an increase in the SN–MP angle from 18.2° to 19.9° and a decrease in the SNB angle from 90.7° to 88.5°, suggesting a slight downward and backward rotational change in mandibular position rather than true sagittal skeletal advancement. These changes may be associated with the vertical and sagittal effects of Class III elastic mechanics. The E-line soft-tissue analysis demonstrated a better facial profile with less concavity due to a relatively more advanced upper lip, and the decreased prominence of the lower lip (Figure 8; Table 1). A counterclockwise rotation of the occlusal plane in combination with dental compensation was achieved to correct the discrepancies.

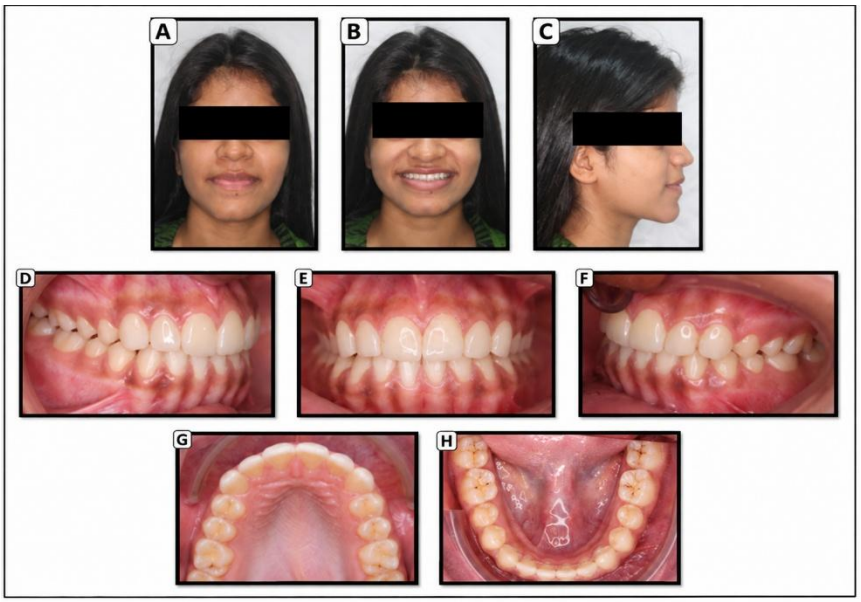

Figure 5: Posttreatment facial and intraoral photographs showing a corrected crossbite, coincident midlines, and improved smile esthetics. (A) Frontal view at rest; (B) frontal view smiling; (C) right lateral profile; (D) right buccal intraoral view; (E) frontal intraoral view; (F) left buccal intraoral view; (G) maxillary occlusal view; (H) mandibular occlusal view

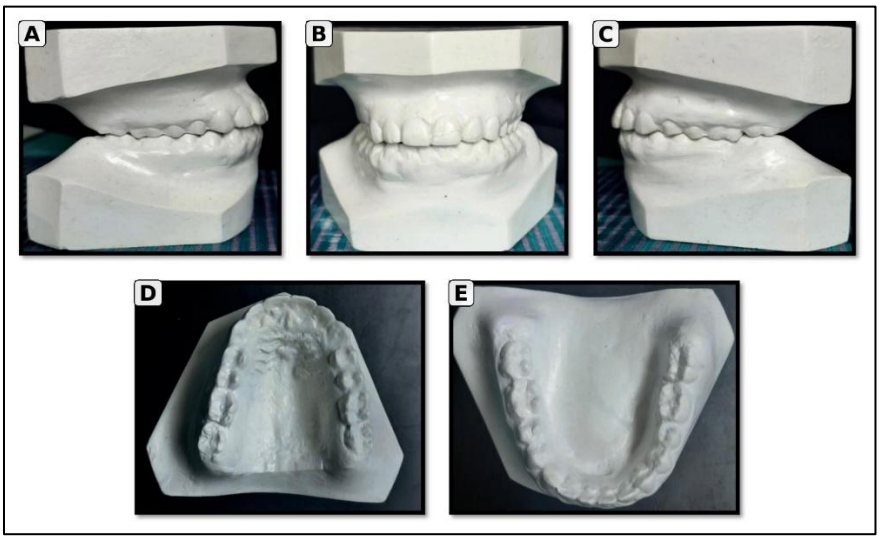

Figure 6: Posttreatment dental casts showing a Class I molar relationship and corrected crossbite. (A) Right lateral view; (B) frontal view in occlusion; (C) left lateral view; (D) maxillary occlusal view; (E) mandibular occlusal view

Table 1: Cephalometric measurements: norms, pretreatment, and posttreatment values

Measurement	Norm	Pretreatment	Posttreatment
SNA	82°	88.5°	89.3°
SNB	80°	90.7°	88.5°
ANB	2°	−1.4°	0°
Wits appraisal (mm)	F=0mm, M=−1mm	−2.8 mm	−0.7 mm
SN–MP	32°	18.2°	19.9°
FH–MP	25°	9.5°	13.1°
LFH (ANS–Me/N–Me) (%)	65%	72.3%	73.7%
U1–SN	104°	119°	119.7°
U1–NA (mm)	4 mm	4.2 mm	4.9 mm
IMPA	90°	96.8°	94.6°

L1–NB (mm)	4 mm	4.6 mm	4 mm
U1/L1	130°	116.9°	119.5°
Lower lip to E-plane (mm)	0 mm	−2.1 mm	−4.6 mm

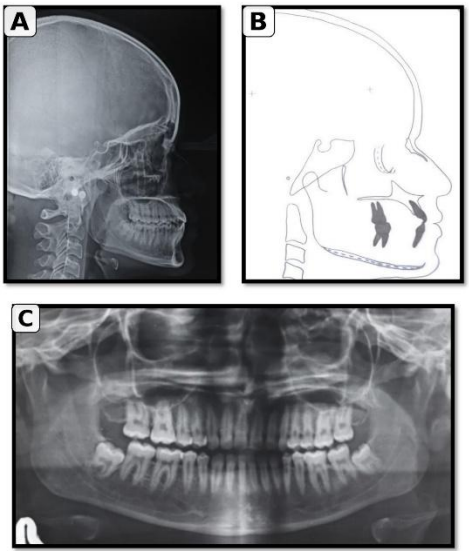

Figure 7: Posttreatment radiographs: lateral cephalogram, cephalometric tracing, and panoramic radiograph showing adequate root parallelism. (A) Lateral cephalogram; (B) cephalometric tracing; (C) panoramic radiograph

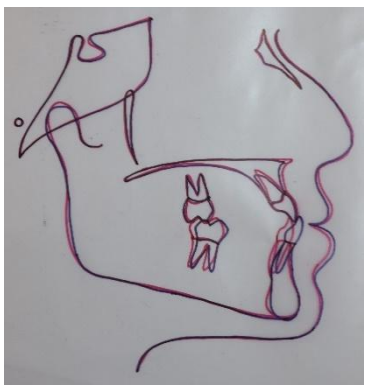

Figure 8: Pretreatment and posttreatment cephalometric superimposition illustrating counterclockwise occlusal plane rotation and elimination of the functional mandibular shift

Cephalometric interpretation

The observed skeletal changes did not represent true sagittal skeletal correction, as the SNB angle decreased by 2.2° with an increase in the mandibular plane angle (SN–MP, 18.2° to 19.9°), suggesting slight downward and backward mandibular rotation. The improvement in ANB from −1.4° to 0° therefore appears to have resulted primarily from rotational changes rather than true sagittal skeletal correction. The dental compensation was not completely resolved, and the inclination of the upper incisors was maintained (U1–SN 119° to 119.7°), with a slight decrease in the inclination of the lower incisors (IMPA, 96.8° to 94.6°), indicating mild mandibular incisor retroclination, and the posttreatment interincisor angle was 119.5°, which remained 10.5° below the reference norm of 130°. The improvement in the Wits appraisal from −2.8 mm to −0.7 mm should be interpreted cautiously because Wits appraisal is influenced by the inclination of the occlusal plane. In the present case, elimination of the functional mandibular shift and associated occlusal changes may have contributed to the observed improvement. Therefore, the change in Wits appraisal should not be interpreted as evidence of substantial true skeletal sagittal correction.

DISCUSSION

The treatment dilemma in adult skeletal Class III malocclusion is complex, as the decision for a camouflage treatment or orthognathic surgery includes several factors, including the degree of skeletal involvement, dentoalveolar compensation, facial esthetics, periodontal limitations, functional requirements, and patient preference. Eslami S et al. [11] indicated that patients with mild to moderate skeletal discrepancies with good facial esthetics might benefit from orthodontic compensation, while those with larger discrepancies and poor facial esthetic profiles would better be treated with surgery. In the present case, surgery was deemed best for definitive correction of the skeleton, but the patient was not interested in surgery and therefore the best choice was to use a camouflage approach. The patient demonstrated a mildly negative ANB angle (−1.4°) and Wits appraisal (−2.8 mm), suggesting a relatively mild sagittal skeletal discrepancy that may be amenable to orthodontic camouflage. The Wits value observed in the present patient was, therefore, consistent with a possible favorable camouflage prognosis.

Evidence also suggests that the decision on whether to select a camouflage or surgery treatment should not be made solely on one cephalometric measurement. A systematic review by Alhammadi et al. [12] showed that orthodontic camouflage is a good alternative to orthognathic surgical treatment in improving occlusion and facial appearance; however, orthognathic surgery offers more skeletal change than orthodontic camouflage, which is mainly based on dentoalveolar compensation. Likewise, Meuli et al. [13] showed that surgical treatment resulted in higher changes in sagittal skeletal parameters

(Wits appraisal and mandibular position), while controlled incisor positioning and dental changes were more strongly associated with camouflage. These results corroborate the treatment approach taken in the present patient in which treatment goal was not total skeletal correction, but functional correction and enhancement of dental esthetics within the limits of orthodontic camouflage.

Another factor of importance in treatment planning was the vertical skeletal pattern. In the present patient, SN–MP angle was low (18.2°), which is a very hypodivergent skeletal pattern. This is desirable in the presence of Class III elastics as the extrusive effects of intermaxillary elastics may be more tolerable in low-angle than in hyperdivergent patients. Chávez Sevillano et al. [14] showed that intermaxillary elastic mechanics with vertical dimension management can be used to achieve nonsurgical correction of Class III malocclusion in adult patients and that it is thus a viable treatment option in well-selected patients. In this instance, hypodivergent pattern was more forgiving with regard to the vertical actions of Class III elastics and minimized the risks associated with an undesirable increase in lower anterior facial height.

The dentoalveolar response noted in the present case is similar to the previously described mechanism of Class III camouflage. Class III elastics usually cause proclination of the maxillary incisors and retroclination of the mandibular incisors and help correct the anterior crossbite and the sagittal interarch relationship. Nyakale MD [15] showed that the dentoalveolar changes seen in the adult patients treated with orthodontic camouflage were significant, affecting the maxillary and mandibular incisors, while the skeletal changes in patients treated with orthognathic surgery were much greater. In the present patient, the supporting alveolar bone of the retracted mandible incisor was not clinically compromised, indicating good anatomical space in the initial mandibular symphysis. However, one drawback of camouflage treatment is that the excessive movement of the incisors outside of the alveolar housing.

When planning mandibular incisor retraction the morphology of the mandibular symphysis and the relationship between the mandibular incisor roots and the surrounding cortical bone are of particular interest Priya P et al. [16] showed that it is necessary to carefully monitor movement of the mandibular incisors during Class III camouflage treatment because of the limited alveolar envelope available which might limit the amount of safe dental compensation and that more movement could place a greater risk of periodontal problems. In this clinical case, no clinically evident adverse periodontal or osseous changes were observed following mandibular incisor retraction. This discovery is significant for the fact that the initial relationship between the incisors is of critical importance before embarking on any significant dentoalveolar compensation in an adult Class III patient.

Control of the inclination of the maxillary incisors was especially critical as the use of Class III elastics can create unwanted proclination of the maxillary incisors. In the present case, minimization of this effect was achieved by ensuring that the nickel-titanium wires were rectangular, as well as using extra torque control during finishing. As a result, the U1-SN angle was only adjusted from 119° to 119.7°, which is a difference of only 0.7°. This relatively small change indicates that relatively little uncontrolled proclination of the maxillary incisors occurred during correction of the anterior crossbite. Orthodontic camouflage has been shown to yield facial profiles that are clinically acceptable when compared to simulated surgical correction, but may result in more superior correction in some patients. The low inclination of the maxillary incisors in the present case may therefore have helped to maintain facial and smile esthetics in the face of Class III elastic mechanics.

One of the most important factors in the smile esthetic consideration is its influence on the treatment when it's chosen in an adult patient camouflage. The sagittal relationship can be corrected orthodontically, which may result in an improvement of overjet and occlusion, but may also affect the appearance of the incisors, the inclination of the occlusal plane and the smile. Both orthodontic camouflage and orthognathic surgery were shown to increase the attractiveness of smiles in Class III patients, but orthognathic surgery may yield a better overall esthetic outcome according to Psomiadis et al. [17] They demonstrated that orthodontic camouflage can produce measurable changes in facial appearance, although the esthetic improvement may be less pronounced than that achieved with combined orthodontic–orthognathic treatment. In the present patient, superimposition demonstrated a tendency toward counterclockwise mandibular rotation associated with the dentoalveolar changes; however, this did not adversely affect the smile, suggesting that the vertical and sagittal effects of the applied elastics remained within clinically acceptable esthetic limits.

Facial asymmetry will be further complicated as orthodontic camouflage can correct dental compensation but not directly counteract the underlying skeletal asymmetry. Sha HN et al. [18] have presented their experiences in treating skeletal Class III malocclusion

with facial asymmetry that was nonsurgically managed, and they highlighted the need for proper dentoalveolar compensation throughout the treatment. In the current case, treatment was still oriented towards correcting the function relationship of the anterior teeth and improving dental esthetics, albeit with the understanding of the constraints of the underlying skeletal asymmetry. The lack of clinically significant changes in facial balance and smile appearance also suggests that the camouflage mechanics chosen were suitable for this patient's skeletal and dental anatomy.

Lastly, Skeletal anchorage is an alternative approach to gain better biomechanical control in adult Class III camouflage. Temporary anchorage devices can be used to effect controlled distal movement of the lower dentition, and can minimize some of the unwanted reciprocal effects from conventional intermaxillary elastics. Ramadayanti et al. [19] showed that the sagittal correction, control of unwanted dental and vertical effects, is possible by using skeletal-anchorage assisted camouflage. However, in the current case, the patient refused to have skeletal anchorage in addition to orthognathic surgery. Conventional Class III elastics was thus considered as a suitable alternative as there was a favorable hypodivergent pattern, a relatively mild sagittal discrepancy, good symphyseal support and good dental anchorage. Careful attention to the maxillary incisor torque, the vertical position of the molars, the inclination of the mandibular incisors and the occlusal relationship were critical to avoid undesirable treatment effects. In summary, the present case demonstrates that adult Class III camouflage is a treatment option which should be thought of not only as an alternative to surgery, but as a carefully considered, individualized treatment plan. The mildly negative ANB and Wits value, marked hypo divergence, favorable alveolar support of the mandible, controlled inclination of the maxilla and the refusal of surgery and skeletal anchorage were all favorable for and in support of conventional Class III elastic therapy. The laminate veneers added to the anterior dentition did not necessitate a high degree of orthodontic compensation for improved anterior dental esthetics. The present clinical results are in agreement with recent literature reporting on the possibility of obtaining a satisfactory functional and esthetic result in carefully selected adult Class III patients, allowing the use of a combination of controlled orthodontic camouflage and minimally invasive restorative therapy, respecting the dentoalveolar compensation biological limits.

LIMITATIONS

This report is based on a single case, thus presenting only a low level of clinical evidence and not applicable for generalization to other Class III adults. Sagittal relapse was reported in the literature following camouflage in adults, and non-extraction camouflage is more prone to relapse than extraction-based camouflage.

PATIENTS' PERSPECTIVE

The patient was satisfied with the decision to avoid orthognathic surgery, extractions, and temporary anchorage devices.
She underwent orthodontic camouflage with Class III elastics to improve her bite and jaw relationship. The treatment corrected the crossbite and functional mandibular shift and improved her facial profile. Porcelain laminate veneers further enhanced the shape, color, and overall appearance of her anterior teeth. The combined treatment resulted in satisfactory functional and esthetic outcomes from the patient's perspective.

CONCLUSION

In carefully selected adult patients with mild skeletal Class III malocclusion and a functional shift, orthodontic camouflage using Class III elastics may provide clinically acceptable correction when the skeletal discrepancy is within the limits of dentoalveolar compensation. In the present case, correction was primarily associated with elimination of the functional shift and controlled dentoalveolar changes, while porcelain laminate veneers provided additional esthetic correction of tooth form and discoloration. Longer-term follow-up is required to assess the stability of the orthodontic and prosthodontic outcomes.

REFERENCES

1. Yongwongsoontorn P et al. Korean J Orthod. 2025 Jan 25;55(1):48-57. [PMID: 39849966]
2. Sahm C et al. Head Face Med. 2025 May 26;21(1):41. [PMID: 40420154]
3. Araujo MTS et al. Dental Press J Orthod. 2021 Sep 10;26(4):e21bbo4. [PMID: 34524381]
4. Ramadayanti SL et al. J Orthod Sci. 2025 Sep 29;14:46. [PMID: 41159150]
5. Goel A et al. IP Int J Med Paediatr Oncol. 2023;9(2):77-82. [DOI: 10.18231/j.ijmpo.2023.016]
6. Joshi NV et al. Cureus. 2025 Dec 12;17(12):e99077. [PMID: 41531572]
7. da Silva Júnior JP et al. Gen Dent. 2025 Jan-Feb;73(1):51-55. [PMID: 40079882]
8. Panpitakkul P et al. Turk J Orthod. 2025 Jul 2;38(2):116-127. [PMID: 40619975]
9. Miyajima K et al. J Can Dent Assoc. 1993 Feb;59(2):167-170. [PMID: 8453519]

10. Spear FM et al. J Am Dent Assoc. 2006 Feb;137(2):160-169. [PMID: 16521381]
11. Eslami S et al. Prog Orthod. 2018 Aug 2;19(1):28. [PMID: 30069814]
12. Alhammadi MS et al. Clin Oral Investig. 2022 Nov;26(11):6443-6455. [PMID: 36098813]
13. Meuli S et al. J Craniofac Surg. 2026 May 12. [PMID: 42117625]
14. Sevillano MGC et al. Case Rep Dent. 2020 Aug 11;2020:8854588. [PMID: 32850154]
15. Nyakale MD. Case Rep Dent. 2025 Jan 4;2025:9839448. [PMID: 39802354]
16. Priya P et al. J Orthod Sci. 2024 Feb 16;13:9. [PMID: 38516113]
17. Psomiadis S et al. J Clin Med. 2023 Dec 23;13(1):91. [PMID: 38202096]
18. Sha HN et al. Angle Orthod. 2020 Jul 1;90(4):607-618. [PMID: 33378502]
19. Ramadayanti SL et al. J Orthod Sci. 2025 Sep 29;14:46. [PMID: 41159150]

Ethical Approval: Not applicable.

Declaration of Patient Consent: Written informed consent was obtained from the patient prior to initiation of treatment. The patient was informed about the nature of the orthodontic and prosthodontic treatment, including the potential benefits, limitations, risks, and expected outcomes of orthodontic camouflage with Class III elastics and porcelain laminate veneers. Written consent was also obtained for publication of the case report and the use of anonymized clinical photographs and relevant patient information for scientific and educational purposes.

Financial Support and Sponsorship: Nil.

Conflicts of Interest: The authors declare that they have no conflicts of interest.

Use of Artificial Intelligence (AI) - Assisted Technology for Manuscript Preparation: The authors confirm that no artificial intelligence (AI)- assisted technology was used to assist in the writing or editing of the manuscript, and no images were manipulated using AI tools.

AUTHOR CONTRIBUTIONS

Rajesh Kuril: Conceptualization, study design, clinical investigation, orthodontic treatment, data interpretation, manuscript drafting, and final approval of the manuscript.

Suchita Daokar: Conceptualization, orthodontic treatment planning, clinical investigation, data interpretation, literature review, critical revision of the manuscript, and final approval of the manuscript.

Omkar Shete: Prosthodontic treatment planning, clinical investigation, porcelain laminate veneer rehabilitation, data interpretation, critical revision of the manuscript, and final approval of the manuscript.

Janhvi Sonavane: Literature review, data collection, manuscript drafting, critical revision of the manuscript, and final approval of the manuscript.

ABBREVIATIONS USED IN THE STUDY

a) ANB: Point A–Nasion–Point B angle
b) TADs: Temporary Anchorage Devices
c) TMJ: Temporomandibular Joint
d) SN–MP: Sella–Nasion to Mandibular Plane angle
e) U1–SN: Upper Incisor to Sella–Nasion angle
f) IMPA: Incisor Mandibular Plane Angle
g) NiTi: Nickel–Titanium
h) SS: Stainless Steel
i) MBT: McLaughlin, Bennett, and Trevisi
j) E-line: Esthetic line
k) LED: Light-Emitting Diode

DECLARATION ON PUBLICATION ETHICS

The authors declare that they adhere to the COPE guidelines on publishing ethics, as described elsewhere at https://publicationethics.org/. The authors also undertake that they are not associated with any other third party (governmental or non-governmental agencies) linking with any form of unethical issues related to this publication. The authors also declare that they are not withholding any information that is misleading to the publisher regarding this article.

DECLARATION ON OFFICIAL E-MAIL

The corresponding author declares that a lifetime official e-mail from their institution is not available for all authors.

COMMENTS FROM READERS

Articles published in the ORAL SPHERE JOURNAL OF DENTAL AND HEALTH SCIENCES are open for relevant post-publication comments and criticisms, which will be published immediately, linking to the original article without open access charges. Comments should be concise, coherent, and critical in fewer than 1000 words.

DISCLAIMER

The Oral Sphere Journal of Dental and Health Sciences provides a platform for the scholarly communication of data and information to create knowledge in the dental and medical domains after adequate peer/editorial reviews and editing, with entertaining revisions where required. The views and opinions expressed are those of the author(s) and do not reflect the views or opinions of Oral Sphere Journal of Dental and Health Sciences (and/or) its publisher, Font

Fusions Publication Pvt. Ltd. Font Fusions Publication remains neutral and allows authors to specify their address and affiliation details, including territory where required.