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Clinical Advantages and Negative Consequences of Dental Veneers: A Review

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Abstract

Despite the widespread use of dental veneers within contemporary esthetic dentistry as a restorative treatment option capable of masking imperfections of the dental appearance with little tooth structure loss, there has not been an attempt to identify and evaluate dental veneers within the dental literature along the lines of evidence-based benefits and harms with a clear clinical focus. Clinical benefits of veneers consist of superior aesthetic results, superior tp color stability, optimal tooth form and ideal patient acceptance especially if conservative preparation designs are used in conjunction with contemporary ceramic materials. A classic illustration of the strengths of these materials would be lithium disilicate or feldspathic ceramics; they retain excellent optical properties and demonstrate the best long-term survival when bonded appropriately to enamel. However, dental veneers have their complications. Adverse effects may include irreversible loss of enamel, dentine hypersensitivity, marginal staining, fracture of the ceramic, debonding, and inflammatory reaction of the periodontal tissues, especially in case of inadequate case selection or over-preparation. Based on this, biological risks such as pulp irritation or long-term restorative dependence should also be evaluated, especially in young patients with an intact dentition. Introduction Occlusal overload, parafunctional habits, and inadequate bonding protocols are frequently implicated in mechanical and technical failures of fixed partial dentures (FPDs). Conservative treatment planning, an accurate diagnosis, and a patient-centered approach play an important role in achieving favorable clinical outcomes and preventing adverse effects, as summarized in this review. Dentists need to be mindful of both the pros and cons of dental



veneers to ensure reliable esthetic results while still protecting healthy teeth for years to come.

Keywords: Dental veneers, esthetic dentistry, invasive restorations.

Introduction

The dental veneers have embraced one of the most popular conservative esthetic restorative modalities in the field of modern prosthodontics and esthetic dentistry and among people suffering from discolored or fractured teeth. Veneers are individualized thin shells bonded onto the facial surfaces of teeth, aiming to enhance color, shape, and smile design, while keeping as much dental tissues sound, as possible in comparison to full-coverage crowns. The shift towards aesthetic restorative treatment alongside functional rehabilitation has rendered veneers as a popular choice, thus prompting both clinicians and researchers to explore their benefits in conjunction with their potential adverse outcomes. Not only are simple aesthetics taken into account, but the long-term survivability, periodontium, and mechanics are all important for evidence-based practice and patient acceptance (Peumans et al., 2000).

The esthetic benefits of dental veneers, have been well described in literature. Porcelains and lithium disilicate ceramic veneers have been shown to retain color significantly better than composite resin and some natural dentition due to their natural optical properties (e.g., enamel mimetic translucency) (Komine et al., 2024). This provides a significant breadth of anterior dental esthetic options for clinicians, such as intrinsic discoloration, enamel hypoplasia, diastemas, and moderate malalignment, with a conservative approach of dental tissue removal (Asiri et al., 2023). The predictability of bonding veneers has also increased due to advances in adhesive dentistry and luting protocols, leading to improved marginal adaptation and high numbers of patients satisfied with medium- to long-term results (Peumans et al., 2000). Another less invasive option for esthetic rehabilitation is the direct composite veneering where the enamel sacrifice is slightly more limited, and their chairside application can be an advantage in certain cases (Campos et al., 2021).

Besides esthetics, functional improvements in terms of occlusal contacts and phonetics have been reported especially when they are included in a comprehensive rehabilitational plan. Porcelain veneers, which are made from ceramic materials, show clinically satisfactory intrinsic properties to extrinsic staining and wear, which is favorable for long-term restorations (Alqutaibi et al., 2025). In addition to their esthetic function, veneers could also perform therapeutic roles, as shown in case reports in the literature describing effective restorations of endodontically treated teeth with ceramic veneers, allowing adequate restoration

of appearance together with improved patient self-confidence (Galiatsatos & Galiatsatos, 2024).

Though these advantages exist, side effects attributable to veneer remedy are frequently reported and ought to be considered. One of the senior concerns is the nonreversible nature of the incisal planning essential for conventional veneer placement. Although there are no-prep and minimal-prep alternatives, the most common type of veneer treatment involves the irreversible reduction of enamel (Alqutaibi et al. 2025). Success over time of veneers is also related to the amount of enamel preserved; veneers bonded to almost entirely enamel experience the fewest failures and complications, while veneers with wide dentin exposure fail more frequently and need therapy. Debonding, chipping, marginal staining or fracture are among the most disruption (Alhekeir et al., 2014) that can affect the function and esthetics. Moreover, research has been done on the periodontal outcome of prep-up veneer treatments. But systematic reviews have shown that different preparation and/or cementation procedures may affect periodontal indices (a marginal restoration may or may not increase plaque retention and/or gingivitis as another overcontoured restoration). When proper oral hygiene can be achieved, gingival responses are often adequate with veneers, however, incorrect margin placement and unfavourable bonding protocols may jeopardise periodontal stability [17]. 2024).

However, the possible contribution of the patient-related factors to rapid veneer failures and poor results (bruxism, parafunctional habits, and poor maintenance) is more difficult to predict, so not only technical complexities [171, 172]. The price and desire to replace, particularly for porcelain veneers that last typically 10 years 15 at most, weighs heavily in-patient education and treatment planning. Consequently, the advantages should be weighed against the associated risks of veneer therapy, emphasizing the importance of careful case selection, informed consent, and execution of treatment with extreme caution. The recent literature suggests that success and failure with veneers is multifactorial and supports individualized evidenced-based medicine (Sholji et al., 2025).

This review addresses the actual knowledge on the clinical advantages and disadvantages of dental veneers, with the intention to inform clinicians and to set the priorities for subsequent research in prosthetic dentistry.

Clinical Advantages of Dental Veneers

Due to its important clinical relevance, dental veneers have become one of the most requested procedures in modern prosthetic and esthetic dentistry. They are a proven way to improve aesthetics, as well as, functionality, biocompatibility, and preservation of tooth structure. Veneers are thin restorations



that are attached to the facial surfaces of anterior teeth and can serve as a conservative esthetic replacement for full-coverage crowns, which in many cases can be harmful to sound dental tissues. It is in accordance with current principles of minimally invasive dentistry, which are directed towards the long-term preservation of tooth structure and function (Peumans et al., 2000). One of the top benefits of dental veneers is that they simply can look more esthetic. Ceramic veneers—especially those made of feldspathic porcelain or lithium disilicate—mimic the visual properties of natural enamel such as translucency and a gradient of color. These properties allow clinicians to obtain highly esthetic results in intrinsic discoloration, enamel defects, and mild malalignment cases, even when conventional bleaching protocols fail (Aluaş et al., 2025). In addition, veneers are ideal for an esthetic restoration because they have better color stability and stain resistance properties than direct composites ensuring long-term satisfaction for the patient (Asiri et al., 2025). Regardless of esthetics, dental veneers also have additional functional benefits. Indicated in worn dentition or altered morphology, veneers restore the architectural form of anterior teeth and improve incisal edge integrity, anterior guidance, and phonetics. Veneers can distribute occlusal forces appropriately when they are carefully designed and can consequently assist in the improvement of functional balance, without the use of more invasive treatment such as orthodontics or surgery. When suitably polished and glazed, their wear properties can be such that excessive wear is reduced when in contact with opposing natural enamel surfaces (Alqutaibi et al., 2025).

One of the leading advantages of veneers is their conservative preparation design! Although conventional porcelain veneers are usually minimally invasive with little to no loss of enamel (0.3–0.7 mm, they are more tissue-invasive than the new semi-permanent laminate veneer restorations with high aesthetic potential that could provide an alternative to conventional primary therapy by combining aesthetic placement with the benefits of tooth vitality and structural integrity (Peumans et al., 2000). Restorations that are enamel-bonded are able to achieve greater bond strengths and less microleakage than for preparations extending into dentin, resulting in the potential for better marginal integrity and tooth health over the long term. Recently, it has been applied on a more conservative approach in the form of "no-prep" or ultra-thin veneers in some cases, broadening the options for irreversible reduction of natural tooth structure (Carvalho et al, 2012). Veneers not only maintains the structure but has also demonstrated favorable biological compatibility with soft tissues. Well-contoured restorations with margins at or slightly above the gingival crest will minimize plaque build-up and promote acceptable biocompatibility and periodontal health. Prior research has shown that veneers

appropriately designed and correctly placed do not cause significant gingival inflammation when the restorations are cemented with careful margin design and cementation protocols (Al-Shorman et al.2024). When it comes to how predictable and how long dental veneers can keep the patients smiling, long-term data are well documented. Clinical studies over long periods of time have also demonstrated that the survival of ceramic veneers bonded mainly to enamel has a survival of more than 90% in 10 years (Peumans et al. 2000; Sholji et al. 2025). A frequent issue, such as veneer chipping or discolouration at the marginal areas is rather seen very rarely and it can be treated without replacing the restoration altogether. If any failures do occur, the minimally invasive design of the veneer provides options for retreatment with minimal intervention and with the preservation of the tooth for potential further restorations (Sholji et al., 2025).

Psychological Benefits of Dental Veneers and Quality of Life Benefits Background Increased self-esteem, social confidence and overall satisfaction has been directly linked to esthetic enhancement of the anterior dentition. Smile esthetics have psychosocial correlations as esthetics of maxillary anterior teeth has great impacts on facial expression and affect social perception among people. Not only do patients report high satisfaction with the aesthetic results, but veneers feel natural and are comfortable (Aluaş et al., 2025).

Not only do these give the practitioner an alternative to ceramics, but direct and indirect composite veneers have unique clinical indications advantages in specific cases. The development of composite veneers permits chairside restorations in a single visit, thereby lowering the cost and time of treatment, likewise proving favorable for younger patients or those in need of interim restorations or systemically where reversibility is desired. While ceramics possess better esthetic and mechanical performance than composite materials, some nanohybrid composite materials have provided an improvement in terms of color stability and wear resistance as compared to traditional composites. Incorporating composite veneers are excellent for long-term maintenance because repairs can be made intraorally (Patel et al., 2025).

Advances in technology have expanded the clinical scope of dental veneers. Digital smile design and fabrication tools such as CAD/CAM systems improve diagnostic ability, communication with patients, and the quality of restorations. The utilization of digital workflows aids the clinician to visualize esthetic goals to obtain more chairside time and confidence with treatment planning and execution. These innovations lead to more reproducible outcomes and allow the clinician to manage patient expectations accordingly. Similarly, veneers are congruent with modern fine-grain philosophies of conservative and restorative dentistry, in which functional and esthetic improvements do not



cost increasingly more delicate tooth structure. The successful execution of veneer therapy can only be achieved by appropriate case selection, thorough occlusal analysis, precise preparations, solid bonding protocols, and patient education. Thus, veneers offer a sweet spot between patient esthetic demands and biological integrity (Alqutaibi et al., 2025).

Negative consequences of dental veneers

Dental veneers have negative downsides and limited duration, while being highly popular and satisfying patients. However, inappropriate veneer selection or technique can jeopardize tooth structure, periodontal health, occlusal stability, or long-term restoration success. Awareness of such shortcomings is necessary for appropriate case selection, valid informed consent, and overall long-term quantitative and qualitative success in esthetic dentistry (Peumans et al., 2000).

The most painful drawback of dental veneers is that you are losing a lot of tooth structure in an irreversible way. Although conservative veneer preparations involve minimal removal of enamel, there is still a need to remove enamel, usually on the facial aspect and incisal edge. However, removal of enamel is irreversible, resulting in altered tooth structure and limiting future restorative treatments, with a higher reliance on adhesive bonding for restorative longevity (Magne & Belser, 2003). Owing to the presence of the bonding agent on defected dentin, over-prepared areas where dentin is exposed reduce bond strength and increase microleakage, postoperative sensitivity and restoration failure especially in young patients with wider pulp chambers (Peumans et al., 2000).

Preservation of pulpal vitality is another major issue of importance. While veneers are less invasive than full crowns, over-reduction, heavy preparation, or high-speed bur overheating may result in pulpitis or death. Management of veneers Sensitivity after veneer placement has been reported, particularly if dentin is exposed or excessive interocclusal adjustment occurs. With pulp complications in some instances needed endodontic therapy, this can lie counter to the intent of providing a more conservative veneer therapy (Fradeani et al., 2005).

Typically, margins of dental veneers can negatively influence periodontal health if poorly designed, or if they are placed subgingivally without a clinical rationale. Excessively contoured restorations, poor emergence profiles, and rough or overhanging margins can encourage plaque accumulation and gingival inflammation. Evidence from clinical studies support that subgingival margins of veneers placed deep into the sulcus may lead to higher rates of gingival bleeding, recession, and loss of attachment, especially in the presence of poor oral hygiene habits. Esthetic and long-term tooth prognosis may be affected as a

consequence of these biological complications (Al-Shorman et al., 2024).

Mechanical Reasons- Mechanical complications are another major drawback to veneer restorations. While strength characteristics of ceramic veneers are excellent, they can chip, crack and fracture in some cases, especially in patients with parafunctional habits like bruxism. Additionally, incisal edge veneers and those positioned over heavily restored or endodontically treated teeth have higher failure risks. While small breaks can possibly be repaired, disasters usually demand complete replacement that increases both costs and treatment challenges (Alqutaibi et al., 2025). Introduction Debonding is a clinically relevant complication, especially in cases with low enamel bonding, contamination during cementation, or occlusal overload. Most likely, veneers that are bonded only to dentin or to old restorations have a lower retention than those in virgin enamel. Frequent debonding is not only frustrating for the patient, but it can also lead to damage of the tooth surface and loss of bonding potential (Peumans et al. 2000).

Also, with composite veneers, mismatch of color and esthetic degradation over the years can also be a concern. Although the color stability of ceramic veneers is good, there is a possibility of marginal discoloration due to degradation of the resin cement, microleakage or staining, at the tooth–restoration interface. The surface instability of varnish-based (composite) composites makes this tool more susceptible to surface staining, wear, and loss of gloss, requiring repeated polishing and/or replacement, resulting in reduced long-term aesthetic predictability (Asiri et al., 2023).

Another illustrative outcome is the practical and occlusal danger of a case in which a poor preparation is performed. Failure at loading because of the thick maxillary anterior porcelain veneer–established interference on anterior guidance due to insufficient occlusal analysis before placement of the veneer. On the other hand, for malocclusion, deep overbite, or parafunctional activity, veneers will contribute to occlusal instability rather than stability. Pain for the patient, recurrent, and occlusal discrepancies which lead to the fracture that were not remedied will result in temporomandibular joint signs (Magne & Belser, 2003).

Apart from being high maintenance and pressurizing, dental veneers also have financial implications. Unfortunately, the therapy with veneers can be very pricey. Veneers, on the other hand, require the same maintenance as natural teeth, which provides excellent oral hygiene, professional polishing every six months, and sometimes, when they fail or are abrasive, they need to be replaced. Veneers are not natural enamel, as they do not regrow and every time it is replaced, some enamel is lost, leading to tooth weakening over time (Alothman & Bamasoud, 2018). Moreover, there are psychological and ethical issues concerning



the indiscriminate application of veneers for esthetic reasons, in particular in young patients with intact, healthy dentition. The influence of social media can create unrealistic esthetic expectations, resulting in overtreatment or biological sacrifice due to aggressive cosmetic treatment. Clinicians must then balance what patients may want with patients' best long-term oral health and opt for less invasive treatments when it is appropriate to do so (Aluaş et al., 2025).

Also, the reparability restrictions are determined by the type of veneer material. Composite veneers, on the other hand, are easily repaired intra-orally while when ceramic veneers become damaged, repair often is not an option. Consequently, this variation affects cost per unit cost, chairside time, and patient convenience. This replacement need also adds to the cumulative biological cost over time (Alqutaibi et al 2025).

Conclusion

For the second focus group presentation, one such consideration for the next generation of dental restorations is that the dental veneer is a proven and effective esthetic treatment modality with well-documented clinical benefits, yet the potential downside needs to be weighed carefully against the need for a dental veneer. These irreversible enamel removals, biological complications, mechanical failures and even periodontal issues imply that a conservative treatment planning concept is necessary. Given the proper case selection, clinical execution, and choice of material, the long-term success of direct composites is a guarantee. Ethics is imperative to minimize overtreatment, especially in adolescents whose dentition is otherwise sound. Proper patient education and informed consent can help set realistic expectations as well as inform them on maintenance.

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