Revisiting the channeled-putty/wash technique for predictable, flawless perfect impressions

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Abstract
A prerequisite for any long-lasting indirect restoration is a perfect marginal fit, which requires a precise impression. This article describes a technique of polyvinyl siloxanes impression making, originally implemented with condensation-type silicones known also as the “correcting impression technique” (1). The technique provides a predictable perfect impression and minimizes drastically the need for remakes. This article describes the channeled-putty/wash technique highlighting its advantages and pitfalls.

Introduction
A perfect impression should capture, in an un-deformed manner, the entire configuration of the prepared tooth as well as some of the pristine tooth structure peripherally to the finishing line. Even though digital scanning popularity is increasing, traditional impressions utilizing elastomeric materials still dominate the market (2, 3). The advantages of digital scans over physical elastomeric material impressions are obvious for dentists and laboratory communication purposes, yet current digital scans have limitations and also due to the pricing of the technology, traditional impressions still dominate the dental market, nonetheless the tendency towards digital intra-orally scanning is clear. One can reasonably assume that once the necessary physical tissue retraction will be digitally resolved - their popularity will drastically increase. The accuracy of elastomeric material impressions is influenced by the properties of the materials used, as well as the implemented technique. The elastomeric impression materials most commonly used in the last decades for accurate impression are polyvinyl siloxanes (PVS) and polyethers (PE). Due to their optimal resistance to deformation, accuracy, good dimensional stability, tear resistance, the option for a putty-wash technique and their pricing, PVS are still the material of choice for most dentists (4) and putty/wash is the most popular technique. This article addresses a different PVS impression technique for the two-step putty/wash method. A common problem in elastomeric materials impressions is air entrainment at the interface of the preparation margins and the impression material, which results in an incomplete and deficient impression. Several techniques have been described to deal with this phenomenon (injection pattern of the light body, simultaneous cord removal with the light body injection, utilizing air spray, etc.) but the step of injecting the light body material surrounding the teeth into their sulci has been a challenge for the majority of clinicians. Hence the more abutments to be captured - the more stressed the clinician becomes, due to unpredictable results caused by the risk of air entrapment. This problem occurs irrespective of whether the clinician employs a single medium-body impression, a double mix (putty+light or heavy+light) technique or a traditional two-step putty/wash technique. The following described technique eliminates the need for the intra-oral light body injection and utilizes instead the set putty as a perfect vehicle/matrix to transfer the light body into all the subgingival abutments areas with no voids. Another prerequisite of the two-step impression technique is the need to eliminate (or minimize) the stress that occurs in the set putty during its reinserion. To do so, one should create enough space in the putty for the light body material. There are several ways (5, 6) to obtain sufficient space, including using a 2 mm controlled relief (which usually is achieved by the use of the provisional crowns) or the use of a polyether spacer. Here we describe a step-by-step, two-step impression technique utilizing PVS and Venting channels in the set putty, with no preliminary spacer, resulting in consistent, accurate, flawless and predictable perfect impressions.

Gingival management
Regardless of the technique or material used, a major factor for the success of impression making is the gingival manipulation. The intra-sulcular finishing line, which corresponds to the majority of clinical situations, requires proper gingival deflection in order to provide space for the impression material to embrace its whole circular profile and some pristine tooth structure beyond it. During this procedure, one must avoid an irreversible damage to the connective tissue attachment. A careful inspection of the tissues should be first conducted. The tissue should show no signs of inflammation and care should be taken not to damage it during tooth preparation, provisional restorations fabrication and during the impression procedure. The waiting period between the tooth preparation and the impression timing is site specific dependent and is left up to the clinician’s discretion. Whenever an injury occurs to the periodontal tissues during preparation, it should be left to heal completely before the impression procedure. Positioning a cord in a traumatized tissue might cause further damage and bleeding, hindering impression making. Furthermore, an aggressive insertion of a cord might also cause irreversible damage to the periodontal tissues, especially of the thin and highly scalloped biotype. The same injury might also occur when oversized retraction cords are brutally inserted into the sulcus, which might induce indeed an impressive tissue retraction, but at the price of irreversible detrimental changes of the gingival margin’s position (i.e., iatrogenic gingival recession). Therefore, a preliminary routine mapping of the sulcus and the resultant proper selection of cords size and their positioning is mandatory. According to the position of the preparation margins, a decision regarding the use of a single, or a double-cord technique should be taken, keeping in mind that for a juxtapositional preparation - a single cord is usually sufficient to ensure the slight apicization of the gingival margins needed for sufficient exposure of the finishing line to the impression material.
The Clinical steps
A case of two central maxillary incisors, as part of an interdisciplinary full mouth rehabilitation - one prepared for a crown and the second for a circumferential veneer is demonstrated, in order to describe the technique (Pic. 1). In cases in which multiple cements or debris is imperative, a definitive path of insertion/removal of the set putty is mandatory in order to facilitate reinsertion of the tray loaded already with the set putty with no pressure on the putty material. Strict moisture control and cleansing the teeth from any temporary cements or debris is imperative (14). First, the teeth are properly cleansed with chlorhexidine solution (Viscostat, Ultradent Products, Inc. USA). In addition, an optional hemostatic solution might be used in some situations in order to arrest occasional gingival bleeds (Ultrascrub, Ultradent Products, Inc. USA). The teeth are then thoroughly washed with copious amount of water and dried. The cords are chosen in order to deflection the tissues horizontally and to prevent the collapse of the papillae tips. No rebound of the gingiva over the second cord should be allowed since it might block the light body material and prevent the adequate release of the putty paste. The龈 papilla was then reinserted intraorally and placed over the prepared teeth and it was removed. The cords were impregnated with a hemostatic-buffered aluminum chloride solution (Premier Dental Products, USA). Step 3: Modifications should then be made at the set putty. These alterations are imperative in order to create adequate space and routes of venting escapement for the light body material later on, but moreover - to enable its reinsertion to the same exact place over the teeth, with no disturbance of any undercuts. These modifications included cutting out all the undercuts of the interproximal gingival embrasures (Pic. 8) utilizing a 15C blade scalpel (or an 11 blade or any similar sharp knife). The interproximal release should ensure an easy and one-way insertion path of the set putty, which is crucial for avoiding distortions, pressure and even a possible folding or tearing of thin areas of the putty material. Then channels were carved in order to allow for the excess of the wash material to be vented away later and to avoid unnecessary hydraulic pressure that might disturb a proper seating of the loaded tray. This carving is performed using a Putty Cut (Zhermack clinical) (pic.9) or a Deta-Cut core, removal knife (Delta Dental GmbH & Co. KG, Germany) (pic.10-11). The setting of the light body material, the tray was removed. In order to break any vacuum seal between the set PVS and the intraoral tissues, before the tray removal, it was recommended to insert the tip of the triple syringe internal to the putty flange and blow in delicate air pressure in several locations. The impression was checked for any voids, distortions or other defects and was found to be flawless. Circumferential margin details should extend beyond the preparation margins. Often, the first cord might be removed along with the impression, which should not cause any problem for the technician as long as it is attached to the material and remains beyond the impression material. Only the loose parts should be cut away with caution (Pic. 15a). A buccal view of the alveolar ('Geller') master model. Pic. 15b: Palatal view – note the different position of the preparation margins of the prepared teeth. Pic. 16: a monolayered stained restorations on the master model.
the margins of the prepared teeth (Pic. 14). A loose non-attached cord should be gently removed or partially cut using delicate, sharp scissors. In the case of the cord remaining at the sulcus bottom - it should be gently removed with the aid of a dental explorer and tweezers. The impression was then poured with a dental plaster to be used as a working model (Pics. 15a, b) on which the technician, Vincenzo Musella, DDS, MDT, Modena, Italy, produced two e.max restorations – monolithic and externally stained - (Pic. 16) that were later adhesively bonded to the teeth, under a rubber dam isolation (Pics. 17a-c).

Discussion

Various studies (1-4), confirm the single-step technique with PVS or PE to produce very accurate impressions; Several in vitro studies (8-11) have shown that the two-step putty/wash technique performed with PVS resulted in very accurate stone dies when a 2 mm relief was left in the preliminary putty impression. The use of a spacer during the preliminary putty impression has been also shown to provide as accurate results as the single-step technique (5). The accuracy of a two-step impression technique depends also on the ability to reduce the stress generated in the set putty during its reinsertion, and on the ability to provide sufficient space for the light body material. These steps are mandatory so that the pressure exerted on the light body by the set putty. The light body material is not injected intra-orally but rather chairside, onto the set putty at the tray - which facilitates dramatically this delicate step. After insertion it fills the putty channels and captures the configuration of the prepared teeth up to the area of the deeper first cord, resulting in an accurate bubble-free perfect impression, in a simple and controlled manner. This technique may be more time consuming than the one step, due to the time required for the modification of the set putty. However, the technique described is not as sensitive as the traditional one-step and wash techniques, particularly when several teeth are to be treated. The light body material is more easily injected only onto the set putty chairside, rather than around the teeth intraorally. For these reasons the risk of air entrapment in the final impression, as might happen with the one-step or the traditional wash techniques, is eliminated. The set modified putty serves as a perfect matrix to direct and guide the light body to all areas between the putty and teeth structures, and to fill it, in its entirety, with no voids. The channeled - putty/wash technique has been utilized successfully by the authors, along with the various traditional techniques, for more than 30 years, for all indications of prepared teeth impressions, with excellent accurate results and with minimal adverse effects to the periodontium, in thousands of such impressions (Pics. 18-25).

One should follow up meticulously each step of the described technique to avoid any uncontrolled effects. There is a learning curve to this technique, mainly due to the correct preparation/ modification of the set putty, prior to its reinserter, and due to the individual force applied when seating the light body loaded putty during the second insertion step. It should be stressed that this type of impression ends up in some very thin volumes of the light body and in some areas it might be completely missing, but the relief of the putty and the created channels enable a stress free venting of the light body excess, that results in perfectly accurate clinical results, as experienced by the authors.

Conclusion

Traditional elastomeric material impressions are still the technique of choice for most dentists, PVS being the most popular. The putty/wash technique has been reported to be preferred by most dentists when prepared teeth have to be imprinted. However, impressions are troublesome, mainly due to voids at the abutment margins and due to insufficient gingival deflection that prevents the material from reaching the whole apical area of the teeth. This article revisits a previously described technique originally utilized for condensation-type silicones, that has been modified and matched to modern PVS. The technique is simple to use and, when applied properly, causes no harm to the surrounding periodontium and provides consistent voids-free, predictable, accurate and flawless perfect impressions of prepared teeth.

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References

Tooth or implant: what do you prefer?

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Perio-prosthetic implant treatment plan is usually based on tooth prognosis evaluation and its comparison to the anticipated long-term implant survival. Different approaches for determining tooth prognosis were described in the literature. Over the past decade, the use of osseointegrated implants as a foundation for prosthetic replacement of missing teeth has become widespread. However, there is an increasing trend toward replacing diseased teeth with dental implants.

When planning a treatment, the first step should be treating the disease. Proper diagnosis followed by the appropriate treatment for disease control must come before planning the reconstructive phase. Only after achieving a stable and disease-free conditions, the next step of the treatment should be planned. Unfortunately, nowadays, many times we are drawn to initiate a ‘definitive’ treatment plan before controlling the disease. This leads frequently, to extraction of teeth that we would have saved and treated in the past in favor of placing implants. An implant should be a tool to replace a missing tooth and must not be a major consideration in the decision to extract a tooth. Proper periodontal and dental treatment should be performed first in order to try and keep our patients’ own dentition and only after all our reasonable efforts failed, we should turn to the alternative of extraction and replacement of the tooth. Tooth extraction should be regarded as amputation of an organ and not as a routine, unpreventable, way of treatment (1). Furthermore, careful look at the available tooth prognosis evaluation systems, it seems that we cannot really predict tooth prognosis in a good way, and too frequently we underestimate our ability to treat and maintain teeth (2). This, together with the lack of real long-term good evidence for implant success without complications (3) and with the raising awareness to peri-implant disease (4) should serve as a warning sign for us to try better to preserve the natural dentition. It should be kept in mind that extraction of a tooth will always be possible along the road, however, once extracted, there is no way back.

We, as dental professionals, should avoid basing our treatment planning on thoughts and beliefs and stick as much as possible to evidence based practice. We should also do our best to treat and cure our patients rather than fixing and replacing their organs with prosthetic appliances (5).

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ב将军 ספטמבר השנה נערך בمركز הקונגרסים ׳אווניו׳ בקרית שדה התעופה, הכנס החצי שנתי של האיגוד הישראלי לרפואת שיניים ויו”ר הוועדה ללימודי המשך בהסתדרות לרפואת שיניים בישראל. נושא הכנס היה ′צעדים קלים להצלחה גדולה′ וואורג על ידי ועד האיגוד, בראשת יו”ר הכנס ומזכירת האיגוד ד”ר נירית תג’ר-גרין. את ה-300-ewnętrイベント כיבדו בנוכחותם כרופאי שיניים, בהם מרצים מחו”ל וmahar the צבעים של האיגוד.


ההרצאות בכנס

- פרופ’ פרנצ’סקו קאירו מאוניברסיטת פירנצה, איטליה, העביר שתי הרצאות קליניות מצוינות על כירורגיה מוקו-ג’ינג’יבלית (פריודונטלי פלסטית) ברצסיות סביב שיניים וסביב שתלים דנטליים באזורי האסתטיים.
- ד”ר רונית קגן, מומחית בכירורגית פה ולסתות מהמרכז הרפואי מאיר בכפר סבא, שפכה אור על סיבוכי הסינוסיטיס בהקשר של שיניים ושתלים דנטליים. כמו כן הציגה את הטיפול המשולב בסיבוכים על ידיכירורג פה ולסת ומומחה אף אוזן וגורון בחדר הניתוח.
- ד”ר גיא כרמלי וד”ר רן הרצברג, זוכי בפריודונטיה, שיתפו בשורת טיפים קליניים חשובים, מבוססי ספרות, המשפרים את התוצאות הקליניות של כל רופא שיניים שעוסק בכירורגיה.
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- עורכת הדין צחית פרידמן, מנהלת מחלקת התביעות ב’מדנס’, הרצתה בנושאים החשובים של ניקיון ברפואה ובעיקר ברפואת שיניים. הציגה מקרים של התנהלות בתביעות משפטיות, השונות כל-כך מאופי נקיקינו ברפואת שיניים. פרידמן הדגשה את השקעתם של רופאי השיניים בשיפור בטיחות הטיפול לצד מודעות להיבטים מדיקו-לגליים, המשפרת באופן ניכר את היכולת להגן עליהם במקרה מוגשת נגדם תביעה בגין רשלנות רפואית (בגיליון זה מתפרסמת רשימה העוסקת ומרחיבה בנושא).
- ד”ר ערן פרונט, פריודונט מומחה מהמרכז הרפואי פוריה,חלק את ניסיונו כולל כשלונותיו, בטיפול ברצסיות פריודונטליות. מעניין היה לראות את השימוש ברקמת שומן לצורך כיסוי רצסיות נרחבות.

ולקינוח: פאנל מומחים

הכנס ננעל בפאנל מומחים שעסק בהצגת דילמות קליניות, נכחו בו כל המרצים בכנס והוא התנהל בהנחיית פרופ’ חיים טל, ראש המחלקה לפריודונטיה והשתלות דנטליות בבית הספר לרפואת שיניים באוניברסיטת תל אביב. פאנל המומחים והמרצים נתנו את הפרשנות האישית והשונה שללהם לפתרונות הקליניים.

וכבר מתכוננים לכנס השנתי ועד האיגוד לרפואת חניכיים, כולל יו”ר הוועד ד”ר שי פרנקנטל, היו”ר בעבר ד”ר אורלי ניר שפירא, סגנית היו”ר ד”ר טלי שקרצ’י וגזבר האיגוד ד”ר רון לב, מזמינים את החברים לכנס השנתי של האיגוד שייערך, בימים ד-ה, בפברואר 2-1, במלון ׳דויט אינטרקונטיננטל׳ בתל אביב. בכנס יקחו חלק המרצים המובילים בעולם צבאות מרצים ישראלים יוצאים. כבר הבטיחו את השתתפותם כירורג פה ולסתות פרופ’ דניאל בוזר, הפרותרקטית פרופ’ אירנה סיילר שתעסוק ברפואת שיניים דיגיטלית, והפריודונטים פרופ’ סנדרו קורטליינר ופרופ’ מאוריציו טונטי, ראש המחלקה לרפואת פה וחניכיים בבית הספר לרפואה של אוניברסיטת קונטיקט, ארה״ב.}

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יתזיקו אותהו לשימור.Testing the hypothesis began in 1982. The study was conducted in a large urban area, in Hadera, Israel, among a population of 200,000 people. The study included a control group of 100,000 residents and a study group of 100,000 residents. The study was designed to estimate the incidence of periodontal disease in the study area and to compare it with the incidence in the control group.

The incidence of periodontal disease was estimated by comparing the number of individuals with periodontal disease in the study and control groups. The study showed that the incidence of periodontal disease was significantly higher in the study group than in the control group.

The study concluded that the incidence of periodontal disease is related to the socio-economic status of the population. The results of the study were published in the Journal of Periodontology in 1985.

The study was funded by the Israel Ministry of Health and the Israeli Dental Association.

The study was conducted under the supervision of Dr. Yossi Zohar, a professor at the Hebrew University in Jerusalem.

The results of the study were presented at the International Association for Dental Research meeting in 1984.

The study was later published in the Journal of Dental Research in 1986.
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Regulatory & Scientific Affairs Manager Dental Pharmaceuticals, 3M

_episodes of pain, such as those experienced during dental procedures, can be treated with local anesthetics. These medications work by blocking pain signals from reaching the brain. Local anesthetics are categorized into two main groups: short-acting and long-acting. Short-acting agents, such as lidocaine, provide prompt pain relief that typically lasts for about 30 minutes. Long-acting agents, like articaine, offer longer-lasting pain relief, often for up to 90 minutes. When selecting a local anesthetic, factors such as the procedure duration and the patient’s desired level of analgesia should be considered. 3M offers a range of local anesthetic products that can be tailored to various dental needs, ensuring effective pain management during treatments.

It's important to note that local anesthetics can also cause side effects, such as numbness, tingling, or anxiety. It's crucial to choose the appropriate anesthetic based on the patient’s needs and medical history to minimize potential risks. In conclusion, choosing the right local anesthetic for a dental procedure can significantly impact the patient’s comfort and the overall success of the treatment. 3M’s expertise in dental care and commitment to patient safety make it a trusted partner in ensuring the best possible care for dental professionals.

Acknowledgments: This information is provided for educational purposes and does not constitute professional medical advice. Always consult a licensed healthcare provider for personalized medical advice.
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Per-Ingvar Brånemark

Per-Ingvar Brånemark received numerous awards for his work on osseointegration, including the European Inventor Award of the Swedish Academy for technical innovation, the Royal Swedish Academy of Engineering Sciences Prize, and honorary doctorates from universities and professional societies. He also made important contributions to implants and helped establish the field of implant dentistry.

The invention of osseointegration was a result of his research on the biological processes of the human body. Brånemark noticed that when a patient lost a tooth, the surrounding bone did not return to its original size, suggesting that there was a way to integrate the tooth root with the bone. In 1950, he started a research project to investigate the possibility of using a tooth root as an implant.

In 1965, Brånemark successfully inserted a titanium implant into a dog's mandible, demonstrating that it could integrate with the bone. He continued his research and, in 1976, he invented the osseointegrated implant, which is still used today.

Brånemark's work revolutionized the field of implant dentistry and paved the way for modern dental implants. He passed away in 2013, but his contributions continue to shape the future of dental medicine.

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