Class II challenge
Clinical solutions to common problems when placing Class II direct composites

By Robert Lowe, DDS, FAGD, FICD, FADI, FACD

Direct composite restorations that involve posterior proximal surfaces are still a common finding in many dental patients. Unlike dental amalgam, which can be a very forgiving material technically and can be condensed against a matrix band to create a proximal contact, proper placement of composite restorative materials presents a unique set of challenges for the operative dentist.

The adhesion process itself is well understood by most clinicians as far as preparation and execution; however, there are some steps in the placement process that cause difficulty and ultimately lead to a less than desirable end result.

In this article we will look at three specific areas: management of the interproximal region; creation of proximal contour and contact; finishing and polishing of the restoration.

Management of the interproximal gingival tissue

The most common area for the adhesion process to fail is the proximal gingival margin. Compounding this problem is the inability to gain access to the area to effect a repair without removal of the entire restoration.

As stated by Dr. Ron Jackson, bonded restorations are unique in that minor defects (decay or microleakage) at the marginal interface can often be “renewed,” or repaired by removal of the affected tooth structure and repaired with additional composite restorative material.

Because of the bond of the restorative material to enamel and dentin, the recurrence is usually self-limiting. This is not true with metallic restorations that are not bonded to tooth structure. However, if the defective area is at the proximal gingival margin or line angle, access is not possible.

Therefore, precise marginal adaptation of the direct composite restorative material and the seal of this margin in the absence of moisture or sulcular fluid contamination is of paramount importance.

However, whether due to the subgingival level of decay and/or gingival inflammation, it can be difficult to seal the gingival margin with a matrix in the presence of blood.

Proximal contact and contour

Another challenge for the dentist has always been to re-create contact to the adjacent tooth and, at the same time, restore proper interproximal anatomic form given the limitations of conventional matrix systems.

The thickness of the matrix band and the ability to compress the interproximal ligaments of the tooth being restored and the one adjacent to it can sometimes make the restoration of proximal tooth contact arduous at best.

Anatomically, the posterior proximal surface is convex occlusally and concave gingivally. The proximal contact is elliptical in the buccolingual direction and located approximately one millimeter apical to the height of the marginal ridge.

As the surface of the tooth progresses gingivally from the contact point toward the cemento-enamel junction, a concavity exists that houses the interdental papilla.

Conventional matrix systems are made of thin, flat metallic strips that are placed circumferentially around the tooth to be restored and affixed with some sort of retaining device.

While contact with the adjacent tooth can be made with a circumferential matrix band, it is practically impossible to re-create the natural convex/concave anatomy of the posterior proximal surface because of the inherent limitations of these systems.

Attempts to “shape” or “burnish” matrix bands with elliptical instrumentation may help create nonanatomic contact, but only “distorts” or “indent” the band and does not re-create complete natural interproximal contours.

Without the support of tooth contour, the interdental papilla may not completely fill the gingival embrasure, leading to potential food traps and areas for excess plaque accumulation. Direct Class II composite restorations can present even more of a challenge to place for the dentist due to the inability of resin materials to be compressed against a matrix to the same degree as amalgam, making it difficult to create a proximal contact.

Finishing and polishing composite restorations

Direct composite material does not carve like amalgam, although many clinicians wish that it did! Unfortunately, this means that most posterior composites are carved with a bur.

This is not part of the finishing and polishing of the restoration. It must be remembered that cuspal forms are convex and cannot be carved with a convex rotary instrument that imparts a concave surface to the restorative material.

Composite should be incrementally placed and sculpted to proper occlusal form prior to light curing. The finishing and polishing process is done to accomplish precise marginal adaptation and make minor occlusal adjustments.

Rubber abrasives further refine the surface of the composite, and surface sealants are used to gain additional marginal seal beyond the limitations of our instrumentation.

Case report

The patient shown in Figure 1 presented with radiographic decay on the mesial proximal surface of tooth No. 3. The operative area is isolated using an OptiDam (Kerr Hawe). The decay is minimal, so the operative plan is to keep the preparation very conservative.

After removal of the decay and completion of the proximal and occlusal cavity form, the operative area is isolated with a rubber dam in preparation for the restorative process. Figure 2 clearly shows that the proximal gingival tissue was abraded during cavity preparation and there is evidence of hemorrhage.

It is not advisable to try and “wash” the hemorrhage away with water and quickly apply the matrix band.

Even if this is successful, it is...
likely that blood will infiltrate into the preparation in the gingival area and make etching and placement of the dentin bonding adhesive without contamination impossible.

An excellent way to manage the proximal tissue hemorrhage quickly and easily is to apply Expa-syl (Kerr) to the area, tap it to place with a dry cotton pellet, and wait one to two minutes (Fig. 5).

Using the water mixture, rinse away the Expa-syl leaving a little bit of the material on top of the tissue, but below the gingival margin of the preparation (Fig. 4A).

The Expa-syl will deflect the tissue away from the preparation margin, maintain control of any hemorrhage and facilitate placement of the proximal matrix without the risk of contamination of the operative field.

Class II preparations that need a matrix band to aid in the anatomic restoration of the chosen is one that will best correspond anatomically to the tooth being restored. The shape, size and thickness of the material on top of the tissue, the height of the proximal surface.

If the matrix band cannot be easily positioned, its placement can be lightened. The contact can be lightened in the anatomic restoration of the maxillary first molar.

The appropriate matrix band chosen is one that will best correspond anatomically to the tooth being restored, and also to the width and height of the proximal surface.

The height of the sectional matrix should be no higher than the adjacent marginal ridge when properly placed. Because of the concave anatomic shape, the proximal contact will be located approximately one millimeter apical to the height of the marginal ridge.

The Composi-Tight Matrix Forcepts are used to place the selected sectional matrix band in the correct orientation in the proximal area.

The positive grip of this instrument will allow for more exact placement than a cotton plier, which could damage or crimp the matrix band.

The sectional matrix band (Garrison Dental Solutions) is positioned and placed using the Composi-Tight Matrix Forcepts to the mesial proximal area of tooth No. 14 (Fig. 4). The orientation of the band and the positive fit make precise placement possible, even in posterior areas with tight access.

Next, the gingival portion of the band is stabilized and sealed against the cavosurface margin of the preparation using the appropriate size.

WedgeWand flexible wedge (Fig. 6)

The size of the WedgeWand® flexible wedge should be wide enough to hold the gingival portion of the matrix band sealed against the cavosurface of the preparation, while the opposite side of the wedge sits firmly against the adjacent tooth surface.

To place the wedge, the Wedge Wand is bent to 90 degrees where the wedge meets the handle. The flexible wedge can now be placed with pressure conveniently, without the use of cotton forceps, that often can be very clumsy. Once the wedge is in the correct orientation, a twist of the wand releases the wedge.

The G-Ring® Forcepts are then used to place the Soft Face™ 3D Ring into position. The two sides of the Soft Face 3D Ring are placed on either side of the flexible wedge and the ring is released from the forceps.

The force of the 3D Ring causes a slight separation of the teeth due to periodontal ligament compression. The unique pads of the Soft Face 3D ring hug the proximal morphology of the buccal and lingual surfaces of the adjacent teeth, while at the same time creating an unbelievably precise adaptation of the sectional matrix to the tooth cavosurface margins (Fig. 7).

Once the sectional matrix is properly wedged and the Soft Face 3D Ring is in place, the restorative process can be started.

A 15-second total-etch technique, 10 seconds on enamel margins and five seconds on dentin surfaces, is performed using a 57 percent phosphoric etch.

The etchant is then rinsed off for a minimum of 15 to 20 seconds to ensure complete removal. The preparation is then air-dried and treated with AcQuaSeal desensitizer (AcQuaMed Technologies) to disinfect the cavity surface, create a moist surface for bonding and begin initial penetration of HEMA into the dentinal tubules.

A fifth generation bonding agent (Optiphase Solo Plus, Kerr) is then placed on all cavity surfaces. The solvent is evaporated by spraying a gentle stream of air across the surface of the preparation. The adhesive is then light cured for 20 seconds.

The first layer of composite is placed using a flowable composite (Premise, Kerr) to a thickness of about 0.5 mm.

The flowable composite will “flow” into all the irregular areas of the preparation and create an oxygen-inhibited layer to bond sub-surface layers of microhybrid material.

After light curing for 20 seconds, the next step is to layer in the microhybrid material.

First, using a unidose delivery, the first increment of microhybrid composite (Premise, Kerr) is placed into the proximal box of the preparation.

A smooth-ended confined finishing bur (H134UF-014) was used in the adjusted areas for precise finish (Fig. 10). Komet Diamond Composite polishing points (green, polishing; and gray, high shine) were then used to polish and refine the restorative surface (Fig. 11).

Finishing and polishing were accomplished using Q-Finisher Cartridge Finishing Burs (Komet USA).

An excellent surface quality on composite and natural tooth is achieved due to the cross-cut design of the finishing instrument.

The small, pointed (H1540-014) Q-Finisher was used to make minor occlusal adjustments on the restorative surface as needed and to smooth and refine the marginal areas of the restorative material where accessible (Fig. 9).

The fine, white stripe ultra-fine finishing bur (H134UFP-014) was used in the adjusted areas for precise finish (Fig. 10). Komet Diamond Composite polishing points (green, polishing; and gray, high shine) were then used to polish and refine the restorative surface (Fig. 11).

Once polishing is complete, the final step is to place a surface sealant (Seal and Shine, Pulpectra) to seal and protect any microscopic imperfections at the restorative marginal interface that may be left as a result of our inability to access these areas on the micron level.

Fig. 8: The composite restoration immediately after matrix removal.

Fig. 9: The pointed Q-Finisher carbide finishing bur is used to make minor occlusal adjustments and refine the restorative margins.

Fig. 10: The ultra-fine pointed composite finishing bur is used to further refine and finish the restoration’s adjusted areas.

Fig. 11: A fine-pointed diamond composite polisher smooths adjusted areas during polishing.

Fig. 12: An occlusal view of the direct MR composite restoration after application of Seal-n-Shine sealant.
Three essential lessons for every new dentist

By Sally McKenzie, CEO

After years of schooling, thousands of dollars in tuition, hours upon hours of clinics and exams, and tests and on and on, finally you entered the working world as a dentist. Just you and the patients. Wouldn’t it be great if it could really be that simple?

It’s likely that it didn’t take you long to realize that once your tour in dental school was over, use the Q-Finisher, two-burr composite finishing system (Komet USA) to finish then polish with diamond composite abrasives (Komet USA), refining marginal integrity without destroying occlusal anatomy.

The interproximal surface has been re-created with natural anatomy and has a predictable, elliptical contact with the adjacent tooth.

With proper occlusal and proximal form, this “invisible” direct composite restoration will service the patient for many years to come.

How can professionals enroll?

They can either sign up for a one-year (10 exercises) or a three-year (30 exercises) subscription for the magazine for one year ($65) or pay ($20) per article. After submission of the answers, (name and membership number must be included for processing) they will receive the certificate with unique ID Number within 48 to 72 hours.

Articles and Questionnaires will be available in the website after the publication.

www.cappmea.com

Three essential lessons for every new dentist

By Sally McKenzie, CEO

After years of schooling, thousands of dollars in tuition, hours upon hours of clinics and exams, and tests and on and on, finally you entered the working world as a dentist. Just you and the patients. Wouldn’t it be great if it could really be that simple?

It’s likely that it didn’t take you long to realize that once your tour in dental school was over, use the Q-Finisher, two-burr composite finishing system (Komet USA) to finish then polish with diamond composite abrasives (Komet USA), refining marginal integrity without destroying occlusal anatomy.

The interproximal surface has been re-created with natural anatomy and has a predictable, elliptical contact with the adjacent tooth.

With proper occlusal and proximal form, this “invisible” direct composite restoration will service the patient for many years to come.

How can professionals enroll?

They can either sign up for a one-year (10 exercises) or a three-year (30 exercises) subscription for the magazine for one year ($65) or pay ($20) per article. After submission of the answers, (name and membership number must be included for processing) they will receive the certificate with unique ID Number within 48 to 72 hours.

Articles and Questionnaires will be available in the website after the publication.

www.cappmea.com