Photo essay: Anterior BruxZir Solid Zirconia Crown

By Michael C. DiTolla, DDS, FAGD

BruxZir® Solid Zirconia crowns and bridges were originally designed by Glidewell Laboratories as an esthetic alternative to posterior cast gold or metal occlusals. As dentists began placing BruxZir restorations and were satisfied with the results, they started to prescribe BruxZir for bicuspidis. The lab realized that it needed to increase the translucency of the material if dentists wanted to prescribe BruxZir in the anterior.

When Glidewell R&D was ready to test the material, I gave them an esthetic challenge we all face: the single-unit central incisor crown adjacent to a natural tooth. This article highlights the clinical steps for placing an anterior BruxZir restoration. For a crown that is 100 percent zirconia with no ceramic facing, I think the lab pretty much nailed it.

Figure 1
Tooth #8 is going to be prepped for a BruxZir crown. I chose this case because tooth #8 is a natural tooth, tooth #7 is an all-ceramic crown and teeth #10 and #11 are a PFM cantilever bridge. It will be a good test of how this light interacts with the BruxZir crown versus the natural tooth and two restorations.

After anesthetizing the patient with the STA System, I break the proximal contacts just enough to place the first of two retraction cords into the sulcus (Ultrapak Cord #00). Then I use the 801-021 bur to give the prep a mirror-like finish.

Figure 2
My depth cuts are now finished, which allows me to fly through the rest of the prep because the gingival is essentially done. The incisal edge takes about 15 seconds, and the facial reduction is marked with a depth cut. I turn my handpiece speed to 5,000 RPM and shut the water off to dial in and smooth the margins.

Figure 3
At this point, the prep is essentially done. After I place the top cord (Ultrapak #2E), I have a final opportunity to get a great look at the prep. Typically, I spend about 45 seconds polishing the prep, especially the gingival margin. Once again, I turn the handpiece down to 5,000 RPM and the water off, using a red-striped fine grit 850-025 bur to give the prep a mirror-like finish.

Figure 4
I place on the prep a ROEKO Comprecap anatomic, which helps keep the retraction cord in place. Slightly wetting the inside before placing it keeps the tooth moist. I ask the patient to bite down for 8–10 minutes. The result is a sulcus that cannot be missed with an intraoral tip. (When your assistant pulls the top cord, look down from the incisal with a mirror to see what I mean.) The impression material flows into the sulcus. This level of detail enables the dental technician to build a proper emergence profile into the restoration.

Figure 5
I try in the BruxZir crown and find the fit to be acceptable. I decide to cement the restoration rather than bond it into place because I have sufficient prep length and it is not over-tapered. I use RelyX Luting Plus Cement because of its natural bond to dentin and simple cleanup. The inside of the crown is coated with Z-Prime Plus from Bisco to enhance the bond of the cement to the zirconia crown. A pinewood stick provides pressure while the cement sets.

Figure 6
This is the final BruxZir Solid Zirconia crown (tooth #9) on the day of cementation. It probably won’t be mistaken for a natural tooth, but it blends well with the adjacent natural tooth (tooth #8).

When I compare it to the existing crowns in the anterior segment, I think the BruxZir crown looks better.

While I don’t recommend that you jump into prescribing BruxZir for single-unit central incisors, this clinical anterior BruxZir Solid Zirconia crown cases demonstrates that this material is one step closer to being as well-suited for anterior restorations as it is for posterior restorations.

Fight oral cancer!

Prove to your patients just how committed you are to fighting this disease by signing up to be listed at www.oralcancerselfexam.com. This website was developed for consumers in order to show them how to do self-examinations for oral cancer.

Self-examination can help your patients to detect abnormalities or incipient oral cancer lesions early. Early detection in the fight against cancer is crucial and a primary benefit in encouraging your patients to engage in self-examinations. Secondly, as dental patients become more familiar with their oral cavity, it will stimulate them to receive treatment much faster.

Conducting your own inspection of patients’ oral cavities provides the perfect opportunity to mention that this is something they can easily do themselves as well.

If dental professionals do not take the lead in the fight against oral cancer, who will? And in the eyes of our patients, they likely would not expect anyone else to do so — would you?