‘Class II Challenge’

Robert Lowe discusses various clinical solutions to common problems dental professionals face when placing class II direct composites

D irect composite restorations that involve poste-
rior proximal surfaces are still a common finding in many dental patients. Unlike dental amalgam, which can be a very forgiving material tech-
nically, they can be placement against a matrix band to create a proximal contact, proper place-
ment of composite restorative materials present a unique set of challenges for the operative den-
tist. The adhesion process itself is well understood by most clini-
cians in its isolation and ex-
ecution, however, there are some steps in the placement process that cause difficulty and ulti-
ma
tely lead to a less than desir-
able end result. In this article we will look at three specific areas, 1) Management of the soft tis-
ue in the interproximal region, 2) Creation of proximal contour and contact and 5) Finishing and polishing of the restoration.

Management of the Inter-
proximal Gingival Tissue

The most common area for the adhesion process to fail is the proximal gingival margin. Com-
pounding this problem is the inability to gain access to the area to affect 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 re-
pair with additional composite restorative material. Because of the bond of the restorative mate-
rial to enamel and dentin, the re-
currence is usually self limiting. This is not true with metallic res-
torations 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 mar-
gin in the absence of moisture or sulcular fluid contamination is of paramount importance! How-
ever, whether due to the subgingi-
val level of decay and/or gingi-
val inflammation, it can be hard to seal the gingival margin with a matrix in the presence of blood.

Proximal Contact and Contour

Another challenge for the den-
tist has always been to recreate the interproximal contact and to do so in such a way that the band and the ability to compress the periodon-
lal ligaments of the tooth being restored and the one adjacent to it can sometimes make the resto-
ration 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 approxi-
mately one millimeter apical to the height of the marginal ridge. As the surface of the tooth progresses gingivally from the contact point toward the cemen-
to-enamel junction, a concavity exists that houses the interdental papilla. Conventional matrix sys-
tems are made of thin, flat metal-
lic strips that are placed circum-
ferentially 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 circumfer-
ential matrix band, it is practi-
cally impossible to recreate the natural convex/concave anat-
omy of the posterior proximal surface because of the inherent limitations of these systems. At-
tempts to “shape” or “burnish” matrix bands with elliptical in-
strumentation may help create nonanatomic contact, but only “distorts”, or “indent” the band and does not recreate complete natural interproximal contours. Without the support of tooth con-
tour, 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 chal-
lenge to place for the dentist be-
cause of the inability of resin ma-
terials to be compressed against a matrix to the same degree as amalgam making it difficult to create a proximal contact.

Finishing and Polishing Com-
posite Restorations

Direct composite material does not carve like amalgam, al-
though many clinicians wish that it did! Unfortunately this means that most posterior com-
posites are carved with a bur. This is not part of the finishing and polishing of the restoration. It must be remembered that cus-
pal forms are convex and cannot be carved with a convex rotary instrument that imparts a con-
cave surface to the restorative material. Composite should be incrementally placed and sculpt-
ed to proper occlusal form prior to light curing. The finishing and polishing process is done to ac-
complish precise marginal adap-
tation and make minor occlusal adjustments. Rubber abrasives further refine the surface of the composite, and surface sealants are used to gain additional mar-
ginal 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 number 5. The operative area is isolated using an OptiDam (Kerr Hawe). The decay is minimal, so the opera-
tive plan is to keep the prepara-
tion 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 dur-
ing cavity preparation and there is evidence of hemorrhage. It is not advisable to try and “wash” the hemorrhage away with wa-
ter and quickly apply the matrix

Figures 1–4: After the cavity preparation is completed, bleeding is seen in the proximal area. a) Expa-syl (Kerr Corporation) is placed into the proximal area with the delivery syringe then tapped to place using a dry cotton pellet. b) After removing the majority of the Expa-syl (note that a small amount of Expa-syl remains sub marginal for additional hem-
orrhage control) the proximal tissue is deflected away and bleeding is about allowing for easy placement of the sectional matrix band.

Fig1
true for the interproximal surface. Because of the constraints of clinical access to the proximal area, it is extremely difficult to sculpt and correctly contour this surface of the restoration. Proper reconstitution of this surface is largely due to the shape of the matrix band and the accuracy of its placement. After removal of curvies and old restorative material, the outline form of the cavity preparation is assessed. If any portion of the proximal contact remains, it does not necessarily need to be removed. Conserve as much healthy, unaffected tooth structure as possible. If the matrix band cannot be easily positioned through the remaining contact, the contact can be lightened using a Fine Diamond Strip (D25SF - Kerr USA).

The Composi-Tight 3D™ Matrix System has been chosen to aid in the anatomic restoration of the mesial proximal tooth morphology of this maxillary first molar. The appropriate matrix band is chosen which 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 Forces is 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 pick, which could damage, or crimp the matrix band. The sectional matrix band (Garrison Dental Solutions) is positioned and placed using the Composi-Tight Forces to the mesial proximal area of tooth number 14 (Figure 5). The orientation of the band and the positive fit in the makes precise placement possible, even in posterior areas with tight access. Next, the gingival portion of the band is stabilized and sealed against the cavitous surface margin of the preparation using the appropriate size. The WedgeWand® flexible wedge (Figure 6). The size of the WedgeWand flexible wedge should be wide enough to hold the gingival portion of the matrix band sealed against the cavitous surface of the preparation, while the opposite side of the wedge sits firmly against the adjacent tooth surface. To place the wedge, the WedgeBand 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 times can be very clumsy. Once the wedge is in the correct orientation, a twist of the wedge releases the wedge. The G-Ring® forceps is then used to place the Soft Face™ 3D-Ring in position. The foot 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 3DRing causes a slight separation of the teeth due to periodontal ligament compression and 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 un believably precise adaptation of the sectional matrix to the tooth cavitous margins (Figure 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 37 per cent 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 rewet with AcQuaSeal desensitizer (AcQuaMed Technologies) to disinflect the cavity surface, create a moist surface for bonding, and begin initial penetration of HEMA into the dentinal tubules. A fifth generation bonding agent (Optibond Solo Plus: Kerr Corporation) 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 10 seconds. The first layer of composite is placed using a flowable composite.

(Revolution 2: Kerr Corporation) to a thickness of about .5 millimetres. The flowable composite will “flow” into all the irregular areas of the preparation and create an oxygeninhibited layer to bond subsequent 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 Corporation) is placed into the proximal box of the preparation. A smooth ended condensing instrument is used to adapt the restorative material to the inside of the sectional matrix and preparation. This first increment should be no more than two millimetres thick. After light curing the first increment, the next increment should extend to the apical portion of the interproximal contact and across the pulpal floor. Facial and lingual increments are placed and sculpted using a Goldstein Flexithin Mini 4 (Hu Friedy). A #2 Keystone brush (Patterson Dental) is lightly dipped in resin and used to feather the material toward the margins and smooth the surface of the composite. Figure 8 shows the restoration after completion of the enamel layer prior to matrix band removal. The Composi-Tight Matrix Forceps is used to remove the sectional matrix after removal of the flexible wedge and Soft Face 3D-Ring. The Composi-Tight™ 3D-Ring reduces flash to a minimum. Finishing and polishing will be accomplished using Q-Finisher Carbide Finishing Burs (Komet USA). Typically, three grits and corresponding, three different burs are used to finish composite materials. With the Q-Finisher system, the bluish-yellow-stripped bur with its unique blade configuration does the work of two burs with one. An excellent surface quality on composite and natural tooth is achieved due to the cross cut design of the cutting instrument.

The small, pointed (H154Q - 014) Q-Finisher is used to make minor occlusal adjustment on the restorative surface as needed and to smooth and refine the marginal areas of the restorative material where accessible (Figure 9). The fine, wide stripe (H154UF - 014) ultra fine finishing bur is used in the adjusted areas for precise final finishing (Figure 10). Komet Diamond Composite polishing points (Green - Polishing and Gray – High Shine) then are used to polish and refine the restorative surface (Figure 11). Once polishing is complete, the final step is to polish with various sized carbide composite abrasives (Komet USA) at a masticating level. Remember, an explorer can “seep” a 5-micron marginal gap at best. Bacteria are 1 micron in diameter. The purpose of the Seal and Shine is to fill these areas. Figure 12 shows an optical view of the completed Class II composite restoration. Conclusion A technique has been described

1) to control proximal tissue bleeding prior to matrix placement with Expan-sil (Kerr Corporation), 2) utilise a sectional matrix system (Composi-Tight 3D™, WedgeWand®: Garrison Dental Solutions) and a nanofil mi crohybrid composite (Premise: Kerr Corporation) to create an anatomically precise proximal area surface, and 3) Use the Q Finisher, two bur composite finishing system (Komet USA) to finish polish with diamond composite abrasives (Komet USA) refining marginal integrity without destroying occlusal anatomic form. The interproximal surface has been treated with natural anatomic contour 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.