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‘Class II Challenge’

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Direct composite restorations that involve posterior proximal surfaces are still commonly found in many dental patients. Unlike dental amalgam, which can be a very forgiving material technically, composite can present a unique set of challenges for the operative dentist. The adhesion process itself is well understood by most clinicians in terms of preparation and execution, however, there are some steps in the placement process that cause difficulty and ultimately lead to less than desirable end result. In this article we will look at three specific areas, 1) Management of the soft tissue in the interproximal region, 2) Creation of proximal contour and contact and 3) Finishing and polishing of the restoration.

Management of the Interproximal Gingival Tissue

The most common area for the adhesion process to fail is anatomically the posterior proximal gingival margin. Compounding 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 repair with additional composite restorative material. Because of the bond of the restorative material to enamel and dentin, the repair 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 pulpal fluid contamination is of paramount importance! However, whether due to the subgingival level of decay and/or gingival 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 dentist has always been to recreate the contact and adjacent tooth and simultaneously restore proper interproximal contour. 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 cemen- toenamel 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 recreate 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 “indents” the band and does not recreate 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 because of 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 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 completely is to apply Expa-syl (Kerr Corporation) to the area, tap it to place with a dry cotton pellet, and wait one-two minutes (Figure 5). Using air-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 (Figure 4). 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 for restorations will require rebuilding of the marginal ridge, proximal contact, and often a large portion of the interproximal surface. The goal of composite placement is to do so in such a way that the amount of rotary instrumentation for contouring and finishing is limited. This is especially
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 curies 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 (D252F - Komet 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 (Garrison Dental Solutions) is positioned and placed using the Composi-Tight Forceps 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 cavosurface margin of the preparation using the appropriate size.

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 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 times can be very clumsy. Once the wedge is in the correct orientation, a twist of the wand releases the wedge. The G-Ring® forceps is then used to place the Soft Face 3D Ring into position. The feet 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 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 unbelievably precise adaptation of the sectional matrix to the tooth cavosurface 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 17 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 AQuaSeal desensitiser (AQuaMed 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 (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 20 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 GoldenSite Flexihint 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 O-Finisher Carville Finishing Burs (Komet USA). Typically, three grits and correspondingly, three different burs are used to finish composite materials. With the O-Finisher system, the blue-yellow-striped 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 (H1540 - 014) O Finisher is 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 (Figure 9). The fine, white stripe (H154UF - 014) ultra fine finishing bur is used in the adjusted area to ensure precise fine finishing (Figure 10). Komet Diamond Composite polishing points (Green – Polishing and Gray – High Shine) are then used to polish and refine the restorative surface (Figure 11). Once polishing is complete, the final step is to place a surface sealant (Seal and Shine-Pulpdent Corporation) 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. Remember, an explorer can “feel” a 50-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 occlusal 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 Espa-x1 (Kerr Corporation), 2) utilise a sectional matrix system (Composi-Tight 3D™), WedgeWand®; Garrison Dental Solutions and a nanofilled microhybrid composite (Premise: Kerr Corporation) to create an anatomically precise proximal composite, and 3) Use the O Finisher, two bur composite finishing system (Komet USA) to finish and polish with diamond composite abrasives (Komet USA) refining marginal integrity without destroying occlusal anatomical form. The interproximal surface has been recreated with natural anatomical contour and has a predictable, elliptical contact with the adjacent tooth. With proper occlusal and proximal form, this “invisible” direct composite restoration will serve the patient for many years to come.