Posterior Composites in General Practice

Trevor Bigg gives an overview of restorative composites

For the majority of dentists, general practice has changed beyond recognition over the past decade. Minimal Invasive Dentistry, digital imaging and the computerisation of records, amongst many other changes, have altered the way dentists practise in their surgeries throughout the country.

But, although this is hardly ever mentioned, the greatest change that has occurred in the day-to-day running of a general practice has been the increasing use of composite filling materials in the restoration of posterior teeth.

Amalgam or Composite?
Dental amalgam has been the material of choice for restoring posterior teeth during the past 160 years. Despite repeated attempts to prove the dangers to the patient of using this material no significant link has been shown and, on July 28, 2009 the US Food and Drug Administration stated that unless the patient is allergic to mercury “the levels (of mercury) released by dental amalgam and batteries, as next to chlor-alkali production for batteries (to be phased out by 2020), dental amalgam will be the largest mercury use in the EU.”

In June this year, a joint DoH and DEFRA meeting isued a statement that the UK should support the EU strategy to reduce the environmental impact of mercury, and should, subject to certain exemptions, support a ban on the use of dental amalgam from 2016.

The exemptions, which would be reviewed after five years to identify if they were still required, would allow amalgam to be used under the following conditions:

1. Poor moisture control
2. Difficult cavity accessibility
3. Large cavities
4. Large interdental spaces to be bridged.

It is at this point that some readers may be thinking that the banning of amalgam is long overdue, but it must not be forgotten that amalgam, for all its faults, is a very forgiving material and even the EU is aware that there are situations where amalgam restorations as a routine procedure. In the long term our patients may be better served by the placement of posterior composites as:

- The placement of posterior composites in Class II cavities is successful and predictable. Using composite and not amalgam increases the lifespan of the tooth.
- Composite is the ‘material of choice’ for initial posterior cavities. Amalgam should only be used in already heavily restored dentitions in older patients.
- Why is composite resin better than amalgam at increasing the lifespan of a tooth?
- It increases fracture resistance of the remaining tooth
- It can be used to repair or refurbish restorations without total replacement.

And not forgetting:
- It has an aesthetic tooth colour

However, composite is not ‘tooth-coloured amalgam’ and must be handled and placed differently.

Who will teach how to place composite restorations?
Older dentists had little teaching in the use of composite resin for posterior teeth at Dental School. Only 13 years after dam’s study published in 2007 showed that survival rates for...
composite fillings at 5 and 10 years was greater than that for amalgam. 6

But although there has been a substantial increase in composite teaching at our Dental Schools over the past 10 years, recent research showed that erroneous techniques were still being taught. These included beveled enamel margins; causing a thin ‘flash’ which fractures later and the use of transparent matrix bands and wedges; based on the old idea that composite contracts towards the light. 7

So can lectures and ‘hands-on’ courses help teach dentists good practical techniques?

The majority of dentists attending a course on posterior

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composites are working for the NHS either fully or part-time. Unfortunately, too many courses are aimed at private practice, and a form of private practice that even a full-time UK private practitioner would not recognise. Experts from Europe describe how to place the perfect posterior restoration over a two-hour appointment and others spend a morning describing, in great detail, occlusal anatomy and mandibular movement.

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Some Practical Tips
Imagine the scenario, one that occurs many times during the week: a patient attends with a fractured tooth and is booked in to a half-hour appointment. (Fig. 5)

How can we fill that tooth with composite resin cheaply, quickly and effectively?

Moisture control:
Moisture control is essential, but a rubber dam is not mandatory!
Rubber dam is mandatory for root canal treatment and strongly advised in areas of difficult access and for certain procedures, such as the placement of posterior Resin Bonded Bridges. However, the financial cost of rubber dam precludes its use for routine restorative work in most NHS practices.

Does this affect the longevity of the subsequent restoration?
One study has shown that rubber dam incorrectly applied affected the proximal contact strengths of posterior composites leading to food impaction and periodontal problems. 8

So rubber dam is no sub-

Fig 4. 45 post-treatment Shade A2 Ceram-X
be shaped so that the correct contact area is produced on the proximate tooth to reduce the risk of food packing and drifting. A sectional matrix, such as Falodent (Dentsply) is excellent at producing a good contact, but care should be taken in older patients as the wide contact area produced by wear over time is not reproduced by most sectional systems.

Bulk fillers: Returning to the original scenario, already 5-10 minutes of the half-hour appointment has been used. To enable the rapid placement of a composite restoration a new generation of flowable composites has been developed to use as a liner or bulk filler, such as SDR (Dentsply), Venus Bulk Fill (Helios) and Tetric Evoceram Bulk Fill (Ivoclar Vivadent). These generally overcome the problem of light-activated composites shrinking while curing, by means of a polymerisation modulator that reduces shrinkage stress and force at the tooth-restoration interface. This shrinkage stress is one of the causes of post-operative sensitivity almost immediately after placement of a composite restoration. This shrinkage stress and force at the tooth-restoration interface micro-cracks (Fig. 8)

1. Place a 0.5 mm liner at first, as the base of a thicker layer may be further than the maximum depth of 4 mm when a matrix band has been fitted or a deep cavity is present. The initial thin layer is self-leveling as it flows into the irregularities of the cavity floor and may increase marginal adaptation in the gingival margin area. It also acts to stabilize the matrix band, preventing slippage if little tooth is left supra- gingivally. (Fig. 7)

2. Place a further layer of liner, or bulk fill if the cavity is deep, allowing a minimum of 2 mm of conventional composite to be used to improve wear resistance and appearance. Adaptation of the second layer of flowable or conventional composite is enhanced by the smooth surface left by the initial lining.

Finishing techniques: Good finishing techniques reduce the failure rate caused by secondary caries in composite restorations:

- Trim using a copious quantity of water as coolant, as over-heating the composite encourages rapid shrinkage causing failing margins in time
- Try not to use ‘coarse’ diamonds, as they can cause deep surface scratches and loss of filler particles
- Direct the bur from the tooth to the filling to reduce iatrogenic damage
- Remove ‘high-spots’ and contacts on the tooth-restoration junction
- Do not ‘over-carve’ the surface, as deep fissures can be cleaned more difficult in some cases and could predispose towards fracture
- Etch and wash the finished restoration and use the remaining bonding agent to re-seal the margins and repair surface micro-cracks (Fig. 8)

Conclusion
Posterior composite restorations are ‘technique sensitive’ and do require training and experience if a good restoration is to be placed in the limited time available in general practice.

Materials research is slowly improving the outcome of these restorations and part of a dentist’s Continuing Professional Development should be in engaging in these advances so that a long lasting, functional and aesthetically pleasing restoration can be provided in a realistic time-scale, to the benefit of the dental health of our patients and the financial health of our practices.

References: