Aesthetic analysis of natural anterior teeth and their restoration with resin composites

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CHAPTER 9

A combined chemo-mechanical approach for aesthetic management of superficial enamel defects

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A combined chemo-mechanical approach for aesthetic management of superficial enamel defects.
Abstract

Objective: The aim of this article is to describe an easy technique for managing small superficial defects in light to medium fluorosis.

Material and methods: The proposed technique is based on a selective abrasion of the superficial enamel and a re-creation of the superficial macro and micro morphology. The aesthetic appearance can be enhanced by a power or a home bleaching.

Results: The presented technique can manage enamel defects which are confined in the most external enamel surface with satisfying aesthetic results.

Conclusion: This conservative approach may be considered an interesting alternative to more invasive prosthetic techniques based on composite reconstructions or ceramic veneers, minimising invasivity, chair side time and costs for patients.
Introduction

In recent decades, due to fluoridation of drinking water and the addiction of fluoride into milk and salt, fluorosis has increased in western countries [1-3]. This kind of pathology leads to a whitish, opaque, unpleasant appearance of enamel which is often visible at speaking distance. The proposed treatments, depending on fluorosis severity [4], range from expensive ceramic veneers to free hand bonding restorations and abrasive chemical treatments.

Although, aesthetic demands for pleasing, brighter smiles are steadily increasing, economic problems are also concerning more of the population. Dentists therefore have the dilemma of being obliged to create highly aesthetic results even if patient’s means are rather limited. More conservative approaches based on cheaper and less chair time consuming treatments such as bleaching, micro-abrasive treatments and resin composite restorations are widely used where, in the past, conventional prosthetic approaches were employed. Even if micro-abrasion is less expensive than a prosthetic approach, it can still be expensive due to its high chair time, especially in cases of medium to severe fluorosis where the treatment has to be repeated several times.

The aim of this article is to describe an easy technique for managing small superficial enamel defects such as the ones present in medium to medium-severe fluorosis.

Clinical Procedure

The proposed technique is based on a combined chemo-mechanical approach which allows the management of enamel fluorosis affecting the most superficial part of the enamel. This approach is based on a combination of mega-abrasion [5], microabrasion [6], and power bleaching or home bleaching [7, 8].

Once a light to moderate EF (enamel fluorosis) is diagnosed (Figures 1a, 1b, 2a-2c) by anamnesis and clinical examination, the patient is informed of this minimal invasive treatment option and the decision of finishing the treatment by in office bleaching or home bleaching is evaluated. Then a mechanical removal of the superficially affected enamel is carried out using a 60-80 μm diamond bur (D8GS bur Intensive SA CH-6916 Grancia, Switzerland) used with a light pressure (Figures 1c, 2d). Once the superficial 200-400 enamel μm are removed, depending on the severity of the fluorosis [4], a superficial enamel reshaping is performed aiming to recreate the macro-morphology and the micro-morphology of a sound tooth. For this aim medium to fine abrasive discs (Sof-lex 3M, St. Paul, USA, MN 55144-1000) or silicon points (Diatech Silicone Polishers, Coltène/Whaledent AG, Altstätten, Switzerland) can be...
used (Figures 1d, 2e). Then after the preparation of a photopolymerisable rubber dam (Diva Smiles Kit, Marcs Group, Aarau, Switzerland) a micro-abrasion is performed. For this an abrasive paste containing silicon carbamide micro-particles in water soluble paste and 6.6% hydrochloric acid (Opalustre®, Ultradent, South Jordan, Utah, USA) is employed. A layer of 2-3 mm is applied on the affected teeth (Figure 1e) and a specific rubber cup is used (Oralcups™, Opalustre®, Ultradent, South Jordan, Utah, USA) attached to a gear reduction contra angle (Figure 1e). The tooth surface is microabraded with slight pressure for about 60 to 120 s. Whenever necessary, a small water drop can be added [9] and the abrasion can be repeated. In such a case, after each application an optical evaluation must be done after water rinse, before proceeding to the next application. Then, to achieve more uniform tooth colour [10] if the patient has chosen a complete in office approach, power bleaching is performed (Figures 1f-1g) according to the manufacturer’s instructions for 10-15 minutes (Diva Smiles Kit, Marcs Group, Aarau, Switzerland). After bleaching agent suction a second application can be performed if necessary followed by a thorough water rinsing and removal of the photopolymerisable rubber dam. Consequently, the desensitising agent (Diva Smiles Kit, Marcs Group, Bahnhofstrasse 43 I 5000 Aarau, Switzerland) is applied (Figure 1h), left undisturbed for ten minutes and then suctioned.

When a home bleaching option is preferred, only a 5 minutes topical fluoride application [10] is performed and then the patient is dismissed after a 2 arch impression in order to provide bleaching trays and products at the following appointment.

All aesthetic evaluations can be carried out only after a complete teeth rehydration (Figures 1e-1k, 2f-2i) and, if the result is not satisfactory, the complete treatment can be performed again.
Figures 1a-j (from left to right, in descending order) Initial view of a patient affected by fluorosis. Mega abrasion performed with a 60μm diamond bar. Surface finishing with Sof-Lex™ discs. Light curing rubber dam application and micro-abrasion with Opalustre™. Application of a power bleaching agent (35%H₂O₂, Diva Smiles™). Specific view of the bleaching agent action. Application of the desensitizing agent (Diva Smiles™). Final view of the clinical case 3 months after the end of the treatment. Recall at 12 months.
Figures 2a-i (from left to right, in descending order) Initial view of a patient affected by fluorosis and rests of luting composite after brackets debonding. Mega abrasion performed with a 60μm diamond bar. Surface finishing with a silicon point. Final view of the clinical case 3 months after the end of the treatment. Recall at 18 months.
Discussion

Due to the recent increase in dental fluorosis [2, 3], extensive research has been performed to understand the aetiology and the pathogenesis of this systemic disease. The aetiology seems to be, currently, well established [1] and strictly based on an excessive assumption of fluoride during specific critical ages. This critical period, according to Browne, is 21-30 months of age for females and 15-24 months of age for males [1]. Regarding the mechanisms which are responsible for the development of the EF several theories have been proposed which can be summarized into a unique comprehensive concept.

The characteristic opacity of fluorotic enamel results from incomplete apatite crystal growth. Matrix proteins, which are associated with the mineral phase, to permit a correct crystal growth, normally degrade and disappear during the enamel maturation phase. In fluorotic enamel, they are not eliminated resulting in their retention in the enamel tissue. Fluoride and magnesium concentrations increase while the carbonate level is reduced. Crystal surface morphology is slightly altered. Such changes in crystal chemistry and morphology, involving stronger ionic and hydrogen bonds, also lead to greater binding of modulating matrix proteins and proteolytic enzymes. This results in reduced degradation and enhanced retention of protein components in mature tissue. This is most likely responsible for porous fluorotic tissue, since complete matrix protein removal is necessary for a “healthy” crystal growth [11]. In other words fluorosed enamel is characterised by a retention of amelogenins in the early maturation stage of development and consequent formation of a more porous enamel with a subsurface hypomineralisation [12]. This can result in a whitish, brownish enamel aspect till the loss of enamel prisms, depending on EF severity.

In our technique we suggest starting with a mega-abrasion by a 60-80 μm diamond bur in order to reduce the unaesthetic whitish enamel minimising the clinical chair time. This approach is, in fact, less time consuming than the more conventional micro-abrasion and, consequently more advantageous for patients. Furthermore the unaesthetic loss of the macro and micro morphology typical of the deep micro- abrasive paste driven procedures [9] can be avoided by simple enamel re-contouring by using the same diamond bur.

After completion of the micro-abrasion, a chair side (power) bleaching or a home bleaching technique can be indicated to hide residual whitish enamel and to better harmonize tooth colour.

Finally, the application of a desensitising paste based on fluoride and/or CPP-ACP (casein-phosphopeptide and amorphous calcium phosphate) during 5 to 15 minutes is recommended [9]. This approach is justified for two reasons. First it
reduces the risk of post treatment sensitivity and second it protects teeth from possible external demineralization. In Segura’s experience [10], in fact, teeth treated with micro-abrasion followed by a 4-minute application of 1% neutral topical sodium fluoride exhibited significantly less enamel demineralization when subjected to an artificial caries challenge than did teeth that underwent micro-abrasion alone, topical fluoride treatment alone, or no treatment at all.

Conclusions

This combined chemo-mechanical approach may be considered an interesting alternative to more invasive prosthetic techniques based on composite reconstructions or ceramic veneers and even chair-aside time if compared to the classical micro-abrasion. Furthermore, this new minimal invasive approach allows good aesthetic results and a possible cost reduction for patients.

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References