Class II challenge

Clinical solutions to common problems when placing Class II direct composites

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Direct composite restorations that involve posterior proximal surfaces are still a common finding in many dental patients.

Unlike dental amalgam, which can be a very forgiving material technically and can be condensed against a matrix band to create a proximal contact, proper placement of composite restorative materials presents a unique set of challenges for the operative dentist.

The adhesion process itself is well understood by most clinicians as far as preparation and execution, however, there are some steps in the placement process that cause difficulty and ultimately lead to a less than desirable end result.

In this article we will look at three specific areas management of the soft tissue in the interproximal region; creation of proximal contour and contact; finishing and polishing of the restoration.

Management of the interproximal gingival tissue

The most common area for the adhesion process to fail is the proximal gingival margin. Compounding this problem is the inability to gain access to the area to effect 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 repaired with additional composite restorative material.

Because of the bond of the restorative material to enamel and dentin, the recurrence 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 submersal fluid contamination is of paramount importance.

However, whether due to the subgingival level of decay and/or gingival inflammation, it can be difficult 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 re-create contact to the adjacent tooth and, at the same time, restore proper interproximal anatomical form given the limitations of conventional matrix systems.

The thickness of the matrix band and the ability to compress the periodontal ligaments of the tooth being restored and the one adjacent to it can sometimes make the restoration 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 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 cemento-enamel 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 re-create 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 re-create 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 of the restoration. It must be remembered that cuspal forms are convex and cannot be carved with a convex rotary instrument that imparts a concave surface to the restorative material.

Composite should be incrementally placed and sculpted to proper occlusal form prior to light curing. The finishing and polishing process is done to accomplish precise marginal adaptation and make minor occlusal adjustments.

Rubber abrasives further refine the surface of the composite, and surface sealants are used to gain additional marginal 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 No. 5. The operative area is isolated using an OptiDam (Kerr Hawe). The decay is minimal, so the operative plan is to keep the preparation 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 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 easily is to apply Expa-syl (Kerr) to the area, tip it to place with a dry cotton pellet, and wait one to two minutes (Fig. 5).

Using a tapering 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 (Fig. 7a).

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 restoration 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 essential to select a flexible 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 caries 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 (DS25F, Komet USA). The Composi-Tight Matrix System was chosen to aid in the anatomic restoration of this maxillary first molar.

The appropriate matrix band chosen is one that 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 For-ecps are 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 plier, which could damage or crimp the matrix band.

The sectional matrix band (Gar-rison Dental Solutions) is positioned and placed using the Composi-Tight Matrix Forceps to the mesial proximal area of tooth No. 14 (Fig. 4).

The orientation of the band and the positive fit make 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 prepa-ration using the appropriate size.

WedgeWand flexible wedge (Fig. 6)

The size of the WedgeWand® flexi-ble 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 forcepts, that often can be very clumsy. Once the wedge is in the correct orientation, a twist of the wand releases the wedge.

The G-Ring® forcepts are then used to place the Soft Face™ 3D Ring in 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 forcepts.

The force of the 3D Ring causes a slight separation of the teeth due to peridontal ligament compression. 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 mar-gins (Fig. 7).

Once the sectional matrix is prop-erly wedged and the Soft Face 3D Ring is in place, the restorative pro-cess can be started.

A 15-second total-etch technique, 10 seconds on enamel margins and five seconds on dentin surfaces, is performed using a 57 percent phos-phoric acid.

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 treated with AcQuaSeal desensitizer (AcQuaMed Technologies) to dis-infect 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) is then placed on all cavity surfaces. The solvent is evaporated by spraying a gentle stream of air across the sur-face of the preparation. The adhe-sive is then light cured for 20 sec-onds.

The first layer of composite is placed using a flowable composite (Premise, Kerr) to a thickness of about 0.5 mm.

The flowable composite will “flow” into all the irregular areas of the preparation and create an oxygen-inhibited layer to bond sub-sequent layers of microhybrid mate-rial.

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 com-posite (Premise, Kerr) is placed into the proximal box of the preparation.

A smooth-ended condensing instrument is then used to adapt the restorative material to the inside of the sectional matrix and prepara-tion.

This first increment should be no more than 2 mm thick. After light curing the first increment, the next increment should extend to the apical portion of the interproximal contact and extend across the pulpal floor.

Facial and lingual increments are placed and sculpted using a Gold-stein Flexiblith Mini 4 (Hu-Friedy).

A #2 Keystone brush (Pat-terson Dental) is lightly dipped in resin and used to feather the material toward the incisal edge, ensuring the smooth surface of the composite.

Figure 8 shows the restoration after completion of the enamel layer prior to matrix band removal.

The Composi-Tight Matrix For-ecps were used to remove the sec-tional 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 were accom-plished using Q-Finisher Cartridge Finishing Burs (Komet USA).

Typically, three grits and, correspondingly, three different burrs are used to finish composite mate-rials. With the Q-Finisher system, the blue-yellow striped bur with its unique blade configuration does the work and seals.

An excellent surface quality on composite and natural tooth is achieved due to the cross-cut design of the working instrument.

The small, pointed (H1540-014) Q-Finisher was used to make minor occlusal adjustments on the restorative surface as needed and to smooth and refine the margin-al areas of the restorative material where accessible (Fig. 9).

The fine, white ultrafine finishing bur (H1544-F-014) was used in the adjusted areas for precise finishing (Fig. 10). Komet Diamond Composite polishing points (green, polishing; and gray, high shine) were then used to polish and refine the restorative surface (Fig. 11).

Once polishing is complete, the final step is to place a surface seal-ant (Seal and Shine, Pulpdent) 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 Exa-syi (Kerr) and a sectional matrix system (Compose-Tight 3-D, Wedge-Wand, Garrison Dental Solutions) and a nanofilmed microhybrid composite (Premise, Kerr) to create an anatomically precise proximal surface, and
2) to use the Q-Finisher, a two-box composite finishing system (Komet USA) to finish then polish with diamond composite abrasives (Komet USA), refining marginal integrity without destroying occlusal anatomical form.

The interproximal surface has been re-created with natural anatomy and has a predictable, predictable form, this “invisible” direct composite contour and has a predictable, predictable form, been re-created with natural anatomy.

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With proper occlusal and proximal form, this “invisible” direct composite restoration will service the patient for many years to come.

Three essential lessons for every new dentist

By Sally Mckenzie, CEO

After years of schooling, thousands of dollars in tuition, hours upon hours of clinics and exams, and tests and on and on, finally you entered the working world as a dentist. Just you and the patients. Wouldn’t it be great if it could really be that simple?

It’s likely that it didn’t take you long to realize that once your tour in dental school was over, you probably barely touched upon in the dental school curriculum.

Lesson No. 1: How to deal with people

I’m not talking about the patients. You’ve been trained to manage them. I’m talking about the people you see every day, the ones you work with, the people who depend on you to represent you, to make sure you have enough money to pay your bills, to keep your schedule on track, etc.

Obviously, I’m talking about your team. Your success as a dentist is directly dependent upon your employees’ success. Unfortunately, one bad hiring decision can cost you a small fortune — estimates range between 1.5 to 5 times annual compensation — it can also damage patient relations, staff morale and overall effectiveness of the practice.

Given what’s at stake, pay close attention to Lesson No. 1: Do your best to hire the best and never hire under pressure. Follow these steps and take a clear and measured approach to ensure that every employee you hire is the best fit for your growing practice.

Assess the systems before you bring in a new employee. If you’re hiring an office manager, look at business operations first. Are the business systems, scheduling, collections, recall, etc., working efficiently? If not, this is your chance to fix them, to integrate new protocols and establish up front how you want these handled in your practice.

Take 15 minutes. Set aside 15 minutes to think about what you want the person in this position to do. Make a list. Consider what you are looking for in this individual.

Write a job description. If you’ve given some thought to the position, update or write a job description for the job tailored to attract the employee you need. Include the job title, job summary and specific duties. This clarifies what skills the applicant must possess and explains what duties she/he would perform.

Cast a wide net. Develop an ad and place it on multiple websites in different publications. Promote those aspects of the job you think you will have the greatest appeal, including money. Sell the position.

Keep the copy simple but answer the reader’s questions — job title, job scope, duties, responsibilities, benefits, application procedures, financial incentives and location. Direct prospects to your website to learn more about your practice and the position.

Read the resumes; don’t just scan them. Highlight those qualities that match the position’s requirements. Look for longevity in employment. Be careful of those applicants that only note years, such as 2008–2009. Chances are this person was hired in December of ‘08 and fired in January of 2009.

Watch for sloppy cover letters. The applicant may have poor attention to detail. Flag resumes with “yes,” “no,” “maybe.” The “yes” candidates are the first to be considered.

Find out who your applicants are on the phone. Address your most pressing concerns up front. If there are gaps in employment history, now is the time to find out why. Ask the applicant what salary range she/he is expecting. Listen for tone, attitude and grammar on the phone, particularly if the position requires handling patient calls. Based on the applicant’s phone demeanor, would this person represent your practice well?

Prepare for the interviews. Conduct interviews using a written set of standard questions for each applicant so you are able to compare responses to the same questions.

Avoid asking any personal questions. Ask follow-up questions based on the applicant’s responses. Jot down personal details to keep track of who’s who. The candidate is likely to be on her/his best behavior in the interview. If the applicant doesn’t impress you now, she/he will not get better after she/he is hired.

Test for the best. Take advantage of Internet testing tools that are available to dentists. Such testing has been used in the business sector for years to help companies identify the better candidates for specific positions.

Check ‘em out. Once the interview and testing process has enabled you to narrow the selection down to a couple of candidates, check their references and work histories. This step can yield tremendously helpful information and will save you from multiple hiring horrors.

Budget for training. Give your new employee the tools and the knowledge to achieve her/his best, and you’ll both benefit significantly.

Above all else, when it comes to staff hiring, make your decisions based on real data, not a candidate’s sunny disposition or your “gut feelings.”

Lesson No. 2: Lead your team to excellence

If you’re frustrated by what you perceive as average or below average team performance, determine if you’ve given them the foundation to achieve the standards you expect.

First, avoid the most common pitfall in leading employees: Assuming that your staff knows what you want. Don’t assume.

Spell out your expectations and the employees’ responsibilities in black and white, and do so for every member of your team.