Abrasiveness – How Low Can You Go?

By Beverly Hills Formula

The variety of toothpastes available means that many patients choose a brand based on how effective it is at targeting some of the most common dental problems: staining, bad breath, sensitivity and gum disease. However, results from Missouri Analytical Laboratories confirm that dental professionals and patients should be concerned with the abrasiveness and level of abrasives in toothpaste and the degree to which they should choose a toothpaste that is more gentle to the patient’s teeth and overall oral health.

As a dental professional, your advice and professional recommendation carries considerable weight and it’s important that your patients understand what is inside their toothpaste before committing to a particular brand.

High vs. Low

All toothpastes contain abrasives; they provide the cleaning power needed to keep teeth clean and help prevent gum disease by removing plaque, stains and debris. However, in the search for the right toothpaste, it’s important to find one that does “all of the above” but is not so harsh that the abrasives attack the enamel.

The development of toothpaste and its abrasive qualities date back as far as the Egyptians in 4th Century AD and the Romans, when the most effective recipes included crushed flowers, bones and oyster shells. Today, abrasives in toothpaste may include particles of aluminum hydroxide (Al(OH)3), calcium carbonate (CaCO3), various calcium hydrogen phosphates, silicones and zeolites, and hydroxyapatite (Ca5(PO4)3OH), and can account for up to 80% of some brands of toothpaste.

Patients should steer clear of highly abrasive toothpastes as they can damage the teeth and gums. As tooth enamel is worn away, the dentin beneath is more visible and teeth become stained, bad breath, sensitivity and in the most severe of cases can result in infection and even tooth loss.

Abrasion Testing

The abrasiveness of toothpaste is measured according to the RDA (relative dentin abrasivity) value, and any value over 100 is considered to be “abrasive”. Unfortunately the RDA Value is often not included in the marketing or promotional information supplied with toothpaste products, making what is a common problem.

In a study recently performed by Missouri Analytical Laboratories (July 2011), a range of whitening toothpastes were tested to compare and evaluate their levels of abrasion. The results confirmed that Beverly Hills Formula toothpaste is proven to be less abrasive than some other leading whitening and regular toothpaste brands.

Beverly Hills Formula whitening toothpastes are low in abrasion, safe for everyday use!

Contact Information

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About the Author

Eric Peterson is founder of the whitening toothpaste Beverly Hills Formula.
Size matters when recommending daily cleaning with an interdental brush

By Jordan

In a recent survey¹ we asked dentists and hygienists what the most important criteria was when recommending an interdental brush to their patients. The right size, a good grip and effective bristles that do not break loped the list.

So why should you or your patients start using them? Studies tell us that most of us (up to 90%) will experience some form of mild gum disease (gingivitis). Early symptoms of gum disease (gingivitis) can be detected by inflamed gum tissue. This is caused by the bacteria in dental plaque. If the bacteria is not brushed away, it may form tartar and can eventually result in a cavity. As many as 50% of cavities are between our teeth².

The good news is that gingivitis is reversible and preventable with daily brushing and cleaning between your teeth. A tooth has five surfaces that you need to clean thoroughly in order to get the best cleaning results.

An international study³ showed that brushing with an interdental brush removes more plaque than brushing with a toothbrush alone. The study showed a positive significant difference using an interdental brush with respect to plaque scores, bleeding scores and probing pocket depth. The majority of the studies also showed a positive significant difference in the plaque index scores when using an interdental brush compared to using dental floss.

Size is important when using an interdental brush¹. Interdental brushes are a good alternative for many of your patients. Statistics show that the population is aging and growing, and many of these people are also keeping their own teeth. This is also a contributing factor to the increase in bridges, crowns and implants. Interdental brushes are easier to use than many other products, including traditional floss. Our advice is to look for an interdental brush that has a sturdy but compact handle so that the users get a good and comfortable grip. Shorter handles give the user more control as the position of thumbs/fingers grip is closer to the point of contact.

A non-slip grip also helps controlled movement. It is important that the user is able to navigate easily in the mouth, reaching the back molars.

The highest usage of interden-
tal brushes was found among consumers between the ages of 40-49³. 6 out of 10 of these use the interdental brushes on average 3-5 times a week. But not all your recommendations should be to older patients. As many as 1/5 of children in Norway have orthodontic treatment⁴. Among these, there are a number that do not necessarily need it, but for cosmetic and confidence reasons choose to have corrective treatment. The most common age to start using braces is between 12-14 years but we are also seeing a trend in an increasing number of older consumers wearing braces, says Renate De- maas, dental Hygienist, Norway.

Two of the most common diseases within the U.S., diabetes and cardiovascular disease, have growing evidence of a relationship with plaque within the mouth⁵. To keep your teeth free of plaque you need to do more than just brush your teeth twice a day. Help your patients keep their teeth healthy by recommending the best option for them to clean properly between their teeth as well as motivate them to use daily.

References
1. Questback, Nordental, Norway, 2014
2. www.ada.org
4. www.ada.org
5. Questback, Nordental, Norway, 2015

Clinical Case: Restoration of Anterior Sectors

By Prof. Angelo Putignano, Italy

The case refers to a young patient who suffered a fracture while swimming.

The fracture, as we can observe in the initial shots, concerns the entire incisal edge even with a cerebral flute-beak fracture (Fig.1).

After physical and electrical vitality tests were performed (pulp testers), two impressions were taken for diagnostic wax-up’s to reconstruct the patient’s teeth, both functionally and aesthetically, (Fig.2, 5 and 4).

We examined the patient two days later, checked pulp vitality and used fluoride free Cleanic® prophylactic paste on the surface of the preparations, together with water spray to avoid dehydration that would interfere with shade selection. We then conducted a morphological and colorimetric study of the dentin requiring reconstruction. On completion of the study, the case did not appear too difficult, except for a hint of orange in the central area, and several white spots on the incisal edge. We selected Herviculite® XR UltraTM A2 Enamel, A2 and A5 Dentin & Universal Incisal, and Ochre and White kolor + Plus® to be applied in a pictorial technique.

The Palatal wall is constructed with A2 Enamel, followed by the application of a small amount of A5 Dentin on the most coronal part of the preparation. A layer of A2 Dentine

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² Perceptor, Sweden, 2014, tested on 104 consumers, Age 40+
¹ Tested against TePe, Market leader in Sweden
⁴ Perceptor, Sweden, 2014, tested on 104 consumers, Age 40+
⁵ Love your teeth
was then applied to cover the previous layer and then the mamelons were sculpted. (Fig. 5-9)

The incisal composite is placed, both around and between the mamelons, to create a translucent effect, and to highlight the dentine anatomy. (Fig.10)

The most coronal aspect is slightly pigmented with ochre, while whitish areas are replicated with White Kolor + Plus®. (Fig.11)

At this point we coated it all with a very fine layer of A2 Enamel, also considering the enamel mass’ limited translucency. (Fig.12)

A 40 micron diamond was used to finish the anatomy, while the initial polishing was achieved using silicon polishers with decreasing abrasive grades. (Fig.13)

After checking the occlusion, the patient’s treatment was completed; the final polishing and shade confirmation was postponed for 10 days. At the next appointment the structure surface was replicated and the restoration was polished using Occlustrush® which is impregnated with silicon carbide and aluminium oxide paste applied with felt pads. (Fig.14)

The patient was pleased with the final result, but we reminded him that, considering the extent of the injury, he should attend periodic pulp vitality checks, and that the need for endodontic treatment should not be ruled out.

Herculite® XRV UltraTM performed a significant mimetic feature and, with the addition of Kerr Kolor + Plus® for the incisal characterizations, a highly aesthetic value end result.