Direct resin restoration using the new V4-Ring matrix and the new Micerium Enamel Plus HRi Function composite

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Introduction

In restorative dentistry, as in all dentistry fields, in order to obtain a correct diagnosis it is essential to perform a proper clinical analysis, to take at least bite wings X-rays or preferably full mouth X-rays and to use a magnification system. Once a correct diagnosis has been obtained, the first treatment phase is to eliminate gingival inflammation by teaching the patient proper oral hygiene methods, followed by simple scaling, or complete non-surgical periodontal therapy. It is then possible to proceed with the removal of the carious lesion.

This paper describes the most important steps in performing a correct class II restoration using the new V4-Ring matrix and the new Enamel Plus HRi Function composite (Micerium).
**Case study**

After careful clinical and X-ray examination of the tooth decay on the second upper left premolar (Figs. 1 & 2), we carried out a local anaesthesia with articaine 1:100,000. Before proceeding with the removal of the carious lesion, the adjacent tooth must be protected with a matrix and a wedge (Fig. 3). The access to the cavity is then provided and a rubber dam is placed. Once the operative field has been isolated, the decay is removed first by using a medium-grained diamond bur mounted on a red ring hand piece (Fig. 4) and then a round (rosette) bur on a blue ring hand piece (Fig. 5). The preparation of the cavity is finished with a fine-grained diamond bur on a red ring hand piece (Fig. 6) and with a red rubber on a blue ring hand piece (Fig. 7). In order to optimise the preparation of the cavity at the marginal level metal strips are first used (Fig. 8) followed by paper strips (Fig. 9).

Once the preparation is finished the matrix V-Ring 4 is placed (Figs. 10 & 11) using the pin.
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After checking proper assembly, the wedge and the transparent tines of the V4-Ring are inserted (Figs. 12–15). This allows light to pass through for 360° polymerisation.

After the matrix has been positioned, ENAetch is applied for 30 seconds evenly with a brush to distribute the etching agent (Figs. 16 & 17), and the area is washed with water for 30 seconds and with 0.2 % chlorhexidine digluconate (Fig. 18). Ena Bond is then applied for 60 seconds (Fig. 19). It must be polymerised for 40 seconds (Fig. 20) and at the end ENAseal is brushed on for 30 seconds (Figs. 21–22). Finally the cavity is polymerised again for 40 seconds (Fig. 23).

Every step has to be done properly, from carious lesion removal to cavity surface finishing. Any approximation may compromise long-term outcome and restoration aesthetics. With adhesive techniques it is mandatory to respect all protocols in order to prevent secondary tooth decay and ensure a long lasting restoration.
Once the adhesive step is finished, the interproximal wall is built up with Enamel Function 2 (Fig. 24) and finally, due to the new V4-Ring matrix special design, it is possible to polymerise the buccal, palatal and occlusal aspect of the composite reconstruction.

Once the restoration has been completed with Enamel Plus Dentine UD3 and Enamel Plus HR Function EF2, the fissures are characterised with Stain brown 2 and the marginal ridge with Intensive White. After modelling, the restoration is finished on the interproximal level with paper strips. An occlusal check (Fig. 25), X-ray control (Fig. 26), and careful polishing are mandatory. A well-polished restoration is less likely to attract plaque adhesion, and is more respectful of periodontal tissues, while also maintaining better aesthetics over time (Fig. 27).

References
1. Ricci G. Chapter 1 Diagnosis from the book “Periodontal Diagnosis and Therapy” Quintessence 2012.
2. Ricci G. Chapter 2 Non Surgical Periodontal Therapy from the book “Periodontal Diagnosis and Therapy” Quintessence 2012.
industry report  

direct resin restorations


Fig. 20 Polymerisation for 40 seconds.
Fig. 21 ENAseal for 30 seconds.
Fig. 22 ENAbond and ENAseal. Micerium.
Fig. 23 Polymerisation for 40 seconds.
Fig. 24 Enamel Plus HRi Function 2 Micereum.
Fig. 25 An occlusional check.
Fig. 26 An X-ray check, note the maximum integration of restoration.
Fig. 27 Occlusal view of restoration.

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