Crown preparation techniques utilising the dental operating microscope

Dr Craig Barrington
USA

Successful crown preparations start at the diagnosis. Early detection of the need for a full-cover restoration can minimise many difficulties associated with the preparation of a tooth for a crown, obtaining an accurate impression, and the achievement of a precise fitting, long-lasting, aesthetic restoration. Proper diagnosis is the all-important first step.

The second most important component is vision. The dental operating microscope (OM) has proven to be valuable in endodontics but it is just as valuable – or more valuable – for restorative efforts. High magnification above 4x is necessary to inspect out the rubber dam pieces that are easy to impress and temporise. Magnification of 2 to 24x is available with the OM. Management of gingival health and biological width is important to the overall final look of the crown and the cleanliness for the patient. A poor finish line and a poorly positioned finish line not only result in poor impressions and final restoration fit, but also make for poor-fitting provisional.

If the finish line cannot be found, our cannot properly trim and fit the provisional restoration and remove any temporary cement properly. When patients return, gingival tissues can be irritated, making the placement of the final restoration challenging. If by chance one does achieve a good fit, then, when the soft tissue heals, the junction of the final restoration and the tooth may be visible, ruining the overall aesthetics.

Management of gingival health

Proper reduction of the soft tissue heals, the junction of the final restoration challenge. Working deep subgingivally and irritant tissues exponentially complicates the task of crown preparation. Haemorrhagic areas, or those that are deep subgingivally, can be difficult to visualise and control. Early diagnosis can minimise these tissue complications. Good tissue management protocol is paramount to the success of the final restoration.

Tissue management is the fourth concern and it points back to the number one concern of good finish-line visualisation. Until a tooth is severely decayed or broken down. Working deep subgingivally and irritant tissues exponentially complicates the task of crown preparation. Haemorrhagic areas, or those that are deep subgingivally, can be difficult to visualise and control. Early diagnosis can minimise these tissue complications. Good tissue management protocol is paramount to the success of the final restoration.

Radiosurgery: A useful instrument

Lasers have been used in dentistry for quite some time but their cost and other fundamental limitations make them difficult to acquire and use. However, radiosurgery has been in use for years and is an affordable and useful instrument that can solve many problems regarding finishing, finishing, line exposure and haemorrhage control. In addition, this simple, conservative instrument can make cord placement quick and simple by preserving the gingival architecture.

The Parkell unit with a #118 tip allows the creation of a very conservative trough or trench around a tooth. In combination with good visualisation using the OM and good patient and procedural management with the rubber dam, we can reliably create a finish line, expose it, place a cord if necessary and impress it.

With a radiosurgical unit, inflamed tissue can be removed such that the healthier tissue is exposed to our haemostatic agents. Healthy haemorrhagic tissue responds better to haemostatic agents than inflamed haemorrhagic tissue does. When inflamed tissue is encountered, use of high magnification and the radiosurgical tip to conserve contour or remove this nuisance tissue can provide a predictable result. Reducing tissue thickness but not modifying tissue height can leave the gingival tissue in proper position such that we achieve nice aesthetics in our final result.

Handpiece and bur choices

The final item and of least concern in this protocol are the handpiece and bur choices. There is existing debate between electric versus air-driven handpieces and regarding which bur is best for which task. Specifying a particular handpiece or bur would be similar to directing an artist regarding which paintbrush to use. What works in one’s hands is the most important factor and that changes from individual to individual and situation to clinical situation. If a practitioner follows the diagnosis, magnification, isolation and tissue management protocol, then bur and handpiece choices will fall into place on their own with time and experience. I typically use an air-driven handpiece and an assortment of Axis turbo diamonds.

In a stepwise fashion for an individual crown preparation, the primary concern is achieving nice aesthetics in our final result.
Next step: Occlusal reduction

Once the tooth has been isolated and the patient is confirmed to be comfortable, the next step is the occlusal reduction. This makes the tooth shorter and allows better access and visualization for the axial reduction. There is an existing restoration in the form of an alloy or composite filling, it is removed and the tooth is reduced to the level of the depth of this restoration. Existing restorations usually provide a good guide to achieving nice occlusal clearance without having to verify prior to the next step. Hopefully, I have not diminished the importance of this step, as I know this can make or literally break a final restoration.

Completing the occlusal reduction first allows me to warm up and work out any kinks in terms of patient issues, patient positioning, handpiece water flow or bur choice etc., before moving to the more complicated axial reduction. On the upper arch, the full-crown preparation is done with a mirror and indirect vision. The OM places us in an ergonomic position for doing this and the rubber dam creates a nice situation for a high volume suction to create an air flow that will keep our mirrors cleaner. The water spray from the handpiece. On the lower arch, I conduct three-quarters of the procedure with direct vision and then finish certain corners through indirect vision. Indirect vision on the lower arch is not a common technique but with understanding and desire, it is an easy technique to master.

The axial surface reduced first depends on which tooth is being treated. I start with the distal contact of the tooth, mostly removing tissue thickness and/or reducing certain corners through indirect vision. This is a very conservative and precise technique but with understanding and desire, it is not a difficult area to visualise, so this is the part that is refined using indirect vision.

Tissue management and cord placement

Once all occlusal and axial reductions have been accomplished, the next step is tissue management and cord placement. I initially reduce the buccal and lingual surfaces to break contact from the buccal to palatal direction. The difficult area to prepare in an upper left first molar is the disto-buccal (DB) line angle. Therefore, I prepare the tooth as far as I can through the distal contact and around the DB line angle. I then complete the buccal reduction and connect the buccal finish line at the DB line angle.

Mirror position is critical in achieving a solid finish line on the entire tooth including the DB line angle. These steps, for me, remain true for most upper right teeth, with difficulties being increased as we move more posteriorly and considering patient limitations such as anatomy, patient attitude, tooth anatomy and existing restorations or decay.

Axial reduction

The steps for axial reduction on the upper right arch mirror themselves on the upper left arch. On the upper left arch, I initially reduce the buccal and lingual contact towards the buccal side. This is the easier of the two surfaces to break. First, it is further forward in the mouth and therefore easier to reach; and, second, it is a shorter contact as it is against a premolar. Following the mesial contact break, I continue around the tooth through the mesio-buccal line angle onto the buccal surface. I then break the distal contact, also moving from the palatal side to buccal direction. The most challenging area to prepare on an upper right first molar is the disto-buccal (DB) line angle. Therefore, I prepare the tooth as far as I can through the distal contact and around the DB line angle. I then complete the buccal reduction and connect the buccal finish line at the DB line angle.

This is a very conservative step under the OM. The OM allows precise and accurate tissue removal, and increases tactile sense and the steadiness of our hands.

A size 00 cord is placed in a haemostatic agent to soak at the start of the procedure. Literature supports that a cord soaked for 15 to 20 minutes in a haemostatic agent works better than any other alternative cord/haemostatic agent combination or method.1 Personal clinical experience and observations find this to be true. With the radiosurgical gingival trough in place, the cord placement is a simple, pressureless technique. The radiosurgical gingival trough in place, the cord placement is a simple, pressureless technique. In the time that it takes to place the cord and rinse most haemorrhage will be controlled, if any.

Now the sharpness and position of the finish line can be re-evaluated and refined. An ultrasonic unit is used, with the irrigation on, to clean the crown preparation around the contactus and/or other debris. Occasionally, a BUC-1 endodontic tip (Ultracut) may be used about the same size and shape as a 1DT diamond bur, can be used in the ultrasonic unit to refine the crown preparation finish lines. This is done with the irrigation feature turned off on the ultrasonic unit. To sharpen, slightly
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refine, or minimally move a finish line, I occasionally run the handpiece at a very low speed without water.

Rinsing and drying

Once all refinements have been accomplished, the preparation is rinsed and dried and for the first time, the entire preparation is evaluated in one view. The uniformity of the axial reduction and the position of the gums in relation to the cord, and the cord in relation to the finish line are all evaluated. The axial reduction should have uniform thickness throughout the different positions, as different areas need more reduction, while others need less, based on material and aesthetic demands. There should be no areas where the gingiva is over the cord. If this does occur, that area is refined with the radiosurgical unit to ensure a full view of the cord 360° around the tooth of tooth-tissue-cord.

One of the main reasons we use polyvinyl-siloxane impression materials is because they are repourable. If adequate strength and thickness of this material are not obtained through the proper radiosurgical troughing technique, then the impression may tear upon separation of the model. Having an impression tear after the first pour limits the ability to fabricate a well-fitting restoration.

When a clear tooth-tissue-cord and a visible, sharp finish line are present, the rubber dam is removed and the preparation is evaluated in all dimensions with the naked eye. At times the OM can create a ‘cannot-see-the-forest-for-the-trees’ type of situation, so it is always valuable to take another look from a different perspective without the OM. This can allow one to identify sharp angles or irregularities in the preparation.

Full-arch impressions

A full-arch impression is taken with a single tray for the arch that contains the prepared tooth. For the opposing arch, a full-arch alginate impression is taken. With full-arch impressions, a bite registration is usually not required. Most often, one chairside assistant is utilized for the entire procedure, but for difficult and challenging impressions, a second assistant may be utilized for saliva or tongue control.

Once all the impressions have been taken, a provisional is fabricated, refined, polished and cemented. Shades are taken and the patient is released with post-operative instructions.

Reference


Dr Craig M. Barrington practices general dentistry in Waxahachie, USA, with his wife, and has a particular interest in endodonic and microscope dentistry. He can be contacted at cbdds002@prodigy.net