

Issue 4, August 2012

# VOICE OF ADITI

Official Publication of  
Association of Dental Industry & Trade of INDIA



REGD. NO. 5/20884 OF 1990

Digital shade taking with VITA Easyshade Advance

## The Importance of Shade Determination In Direct Fillings

Dr. KNUT MAU

Dental Surgeon, Tuttlingen, Germany

## Simple and Effective Haemostasis in Crown and Bridgework

Michael N. Mandikos

BDS, MS, Cert Pros, FRACDS, FICD

## Post-endodontic restoration of a deeply decayed tooth option and limitation

Michael Bruder

DDS, Hamburg, Germany

## Solving Complexities in Endodontics

Dr. Ajay Bajaj

BDS, MDS

## History of Aditi

## Upcoming Events



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Karan Bir Suri  
Editor

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Mr. Vishal Anand

I write to you with great Elan and Candor as the rejuvenated issue of the **Voice of ADITI** goes to Press. Soon it is going to be amongst you all!! I hope you will look upon it as you would, holding a new born baby in your hands. Free, Frank and Fearless is going to be the new logo of the **Voice of ADITI**. Folks I invite you to come forward and join hands, for together we shall march to greater glory for our new baby, **Voice of ADITI** (VOA). Let people say, here comes an era of comradeship and friendship and together we will bond well and stir up bon homie amongst us all.

In this issue we put our ADITI Spotlight on 4 Senior Members from all Four Zones mentioning about their companies and activities towards ADITI. Then we also have a few case studies to highlight the importance of certain clinical studies which should be useful to all. We have also incorporated a special page in which we would like to highlight the ADITI Activities and upcoming activities in the Dental Trade. One concept which we really wanted to incorporate in our magazine was to start a proposal under the Heading "BUY & SELL" wherein all ADITI Members, Non ADITI Members or Dentists would send their requirements or details of items that they would like to sell and this would be printed in our magazine at a very nominal cost. Imagine a dentist putting up an advert for setting up of a Dental Clinic and the kind of responses he would get through this small advert or maybe a Manufacturer describing his range of products in a few lines and the responses or queries it could generate for his business!! We have also tried to portray to you as to when and how ADITI was formed along with the details of all National Presidents till now.

Also **EXPODENT Mumbai** and the **EXPODENT Bangalore** are round the corner and we, the Team of VOA and ADITI Head Office would like to wish everyone participating at these prestigious events a whole lot of success and Happy Selling. We are sure that under the able leadership of Mr. Bharat Thakkar, President ADITI West Zone and Mr. Uday Raj Shetty, President ADITI South Zone, both of these Expodents' would break all previous records. We wish them and their team of great workers all the very best for these great successful events.

We also understand that this being the latest issue with a completely new team at the helm, there are bound to be some mistakes, which we would request you to kindly ignore, but do inform us quietly and gently, so that we can make amends for the future issues. We do hope that you will write to us with any of your ideas or suggestions which you would like our team to incorporate in the VOA. Your suggestions, ideas and information will find paramount importance and we will certainly try our best to make this forum lively, informative and entertaining and last but not the least, revenue generating !!!

Finally a word of thanks to a few ADITI stalwarts for their complete support at all times, whose names we would not mention here as it would be belittling their selfless dedicated love for our Association and towards this inaugural issue of **Voice of ADITI**. A special thanks to the One Person who has helped the team of VOA at any given time and at all times, Thank You for all your Support and Encouragement!!!

Till we reach you again, all of us at VOA hope that you will enjoy reading this issue as much as we enjoyed making it.

Karan Bir Suri  
Editor

#### Aditi Head Office Bearers



Rajiv Seth  
President, ADITI



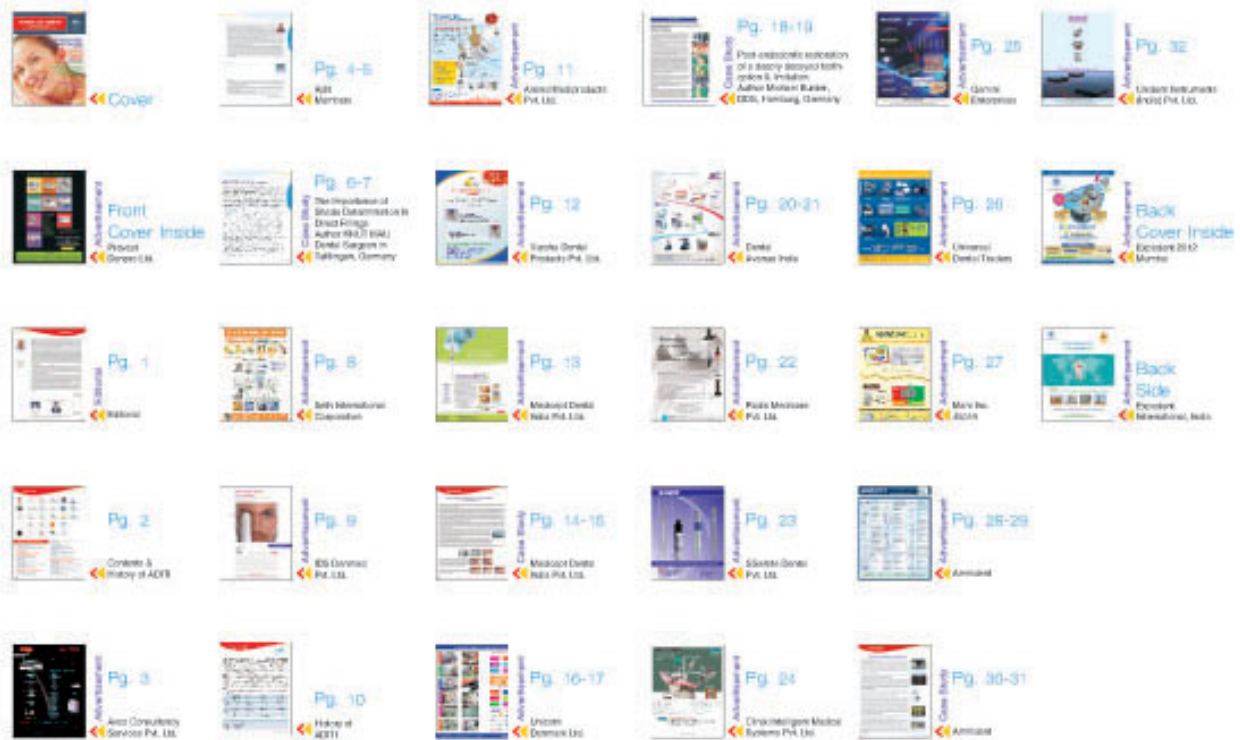
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# Contents



## Upcoming Dental Events

**Aug 29 - Sep 1, 2012**

**100th meeting of the FDI Annual World Dental Congress**  
The Hong Kong Dental Association (HKDA Hong Kong Convention and Exhibition Centre Hong Kong  
[www.fdiworldental.org](http://www.fdiworldental.org)

**Sep 14 - 16, 2012,**  
**Expodent - Mumbai**  
**Bombay Exhibition Center, Goregaon, Mumbai,**  
**E Mail : [dilipvilambe@gmail.com](mailto:dilipvilambe@gmail.com)**

**Sep 14-15, 2012**  
**ITI Congress Helsinki, Finland, [www.iti.org](http://www.iti.org)**

**Sep 17-20, 2012**  
**Dentalexpo, Moscow, [www.dental-expo.com](http://www.dental-expo.com)**

**October 4-6, 2012**  
**BDTA Dental Showcase, London, [www.dentalshowcase.com](http://www.dentalshowcase.com)**

**October 11-13, 2012**  
**Pragodent, Prague, [www.incheba.cz](http://www.incheba.cz)**

**Oct 12 - 14, 2012**  
**Expodent - Bengaluru, ADITI - South Zone**  
**<http://www.expodent-india.com/bangalore/index.html>**

**Oct 12 - 14, 2012**  
**37th ISP National Annual Conference Shimla,**  
**Himachal Pradesh, [www.ispconference.com](http://www.ispconference.com)**

**Oct 20 - 21, 2012**

**Kerala Dental Meet, Lulu Convention Center, Thichur, Kerala**

**October 24-27, 2012**

**Dentech, Shanghai, [www.dentech.com.cn](http://www.dentech.com.cn)**

**November 25-28, 2012**

**Greater New York Dental Meeting, New York, USA**  
**<http://www.gnydm.com/general-information.html>**

**Dec 6-9, 2012**

**27th IACDE & 20th IES, Hotel Atlantis, The Palm, Dubai**  
**<http://www.indianendodonticsociety.org/events.htm>**

**Dec 7-9, 2012**

**40th IPS Conference, Chennai Trade Center, Chennai**  
**<http://www.ipsonline.in/futureconference.asp>**

**Dec 28 - 30, 2012**

**Expodent International India, ADITI, Pragati Maidan, New Delhi**  
**<http://www.expodent-india.com/Delhi/index.html>**

**Feb 21 - 24, 2013**

**66th IDC, Kolkatta**  
**<http://idc2013.org.in/Textpages/NewTextpages/IDAhomessage.aspx#>**

**Mar 12 - 16, 2013**

**35th IDS, Cologne, Germany**  
**<http://english.ids-cologne.de/en/ids/home/index.php>**

**May 7 - 12, 2013**

**Asia Pacific Dental Conference, Kuala Lumpur Convention Center,**  
**Kuala Lumpur, Malaysia**  
**<http://www.mda.org.my/35th-apdc.html>**

# Hu-Friedy



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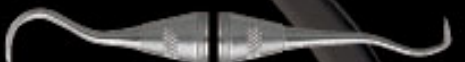
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S31

S18



1/2

SG18



3/4

SG24



5/6

SG36



7/8

SG48



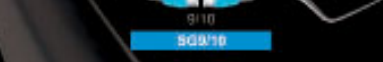
9/10

SG78



11/12

SG9/10



13/14

SG11/12



15/16

SG13/14



17/18

SG15/169



17/18

SG17/189



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# Aditi Members

## West Zone



Dr. J.C. Godiwala

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J.C. Godiwala's Associated Dental & Medical Supply Co even today believes in the same principles of straight forwardness and honesty set by their founding fathers.

## South Zone



Mr. I.V. Ramana Rao

I have established my company in the year 1953 along with my uncle Shri I. V. L. Naidu with the help of M/s Associated Dental Medical Supply Co., till 1976 and there after continued with the help of my brothers Mr. I Shambu and Mr I. Nageswara Rao. When I started my career in 1953 in Dental field there were only 4 Dental depots in south zone i.e 2 at Chennai and 2 at Bangalore , for my developing the business many dealers of Delhi, Mumbai etc were responsible. I could still continue my business at the age of 79 with my two sons Mr I. Murali Krishna and I. Seshu Babu and earned a decent name in this field in the country.

Thanking you



# Case Study

## Discussion

Experience has shown that due to the characteristic gradation of shade, cervical caries presents a particular challenge for a practitioner. The choice of intensive opaque nuances within the color spectrum of a composite is quite limited. During layering, it is difficult to progress towards the appropriate shading and to correct it. This is particularly true as the tooth affected becomes dehydrated under the rubber dam during the procedure and lightens. When placing the increments, the filling cannot be compared with the shade of the surrounding dentition. Attempting to set a composite point does not achieve results that are always reliable. Reliable determination of the shade in advance is required so that layering can be planned appropriately. When the patient is recalled a few days after rehabilitation and dehydration has diminished, the result must be convincing. If the shade is taken under defined measurement light that excludes ambient lighting, this eliminates uncertainties and minimizes the risk of shade correction.

## About the author

Knut Mau studied dental surgery in Freiburg, Germany, and passed the state exam in 1997. Following three years of residency, he opened his own practice in Tuttlingen, Germany. His practice has recently celebrated its tenth anniversary.

Knut Mau offers a comprehensive range of services, concentrating on preventive dentistry and focusing in particular on highly esthetic restorations.

**Knut Mau**, dental surgeon  
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Fax: (0 74 61) 96 87 88  
Email: info@zahnarzt-mau.de  
Website: www.zahnarzt-mau.de



KNUT MAU  
Dental Surgeon in  
Tuttlingen, Germany

## LIST OF FIGURES:



Fig. 1: The wireless digital shade-taking device VITA Easyshade Advance with its characteristically narrow measurement probe



Fig. 2: Initial diagnosis: cervical caries (tooth 12)



Fig. 3: Step 2: rapid tooth shade determination



Fig. 4: Verification indicated a filling that matches in terms of shade



Fig. 5: Measurement is easy: place the probe tip flush to the surface, press the control button



Fig. 6: Drape using the anti-infection cover



Fig. 7: Measurement is performed under defined lighting conditions, the impact of light from the exterior cannot distort the result.



Fig. 8: Device base with VITA classical A1-D4 and VITA SYSTEM 3D-MASTER values



Discussing digital shade taking in the practice run by Knut Mau, dental surgeon. From right to left: Arndt Lommerzhelm, Head of VITA Public relations; Dr. Gisela Peters, journalist specializing in dentistry; Knut Mau, dental surgeon.

We would appreciate a sample copy of any reprints.

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# History of ADITI



REGD. NO. 5120884 OF 1998

During the year 1975 – 1976, Delhi Sales Tax Laws were changing. ST 1 Forms were being introduced. Delhi Dental Dealers were given an option of charging about 15% - 16% as Sales Tax or instead sell goods against ST-1 Forms. To counter such problems a Delhi Dental Dealers Association was formed with Mr. Mushtaq Ahmed of M/s National Dental being the President, Mr. Phool Chand Mathur of M/s K.S. Mathur & Company as Vice President, Mr. S.D. Mathur of M/s Prem Behari & Company as Hony Secretary and Mr. Tilak Raj Seth of M/s Seth International as the Treasurer. Business followed normally with not much problems being faced by any one. About 7 – 8 years later, a Bombay Dental Dealers Association was also formed with Mr. Nitin Patel, Mr. Vinod Bawal, Mr. Abdul Sattar and Mr. Jehangir forming this association. Meanwhile, many representations were sent by the Delhi Dental Dealers Associations to the Local Government to come with a better sales tax scheme for the dealers. Soon the Sales Tax was revised to 8%. There were not much activities in the Delhi Dental Association or by the Bombay Dental Dealers Associations but just normal social activities like making a list of holidays to be observed by the Association and small social gatherings.

During the APDC in 1987, Elections were held for the National Level when Dr. J.L. Sethi was declared as the Chairman, Mr. S.D. Mathur as the Hony Secretary while Mr. R.D. Mathur and other senior members helped with the process. At the same venue, Dr. Vidya Sagar was declared the Zonal President and Mr. Rajinder Mathur the North Zone Secretary. In January 1989 IDA organized an Expo in Pune. Members decided at this venue to merge the Bombay Dental Traders Association with ADITI and make it a complete National Level Association. This is where the Constitution of our Association was also formed. Elections were held during this IDA Conference with Mr. R.D. Mathur and Mr. Vadhera fighting elections for the National President and Mr. Viraf Doctor & Dr. B.S. Shetty fighting it out for the post of National Secretary. After the elections result was declared with Mr. R.D. Mathur becoming the first President of ADITI National and Mr. Viraf Doctor becoming the first National Secretary of ADITI. Mr. S.D. Aggarwal becoming the first Treasurer at the National Level.

That is how our Association of Dental Industry & Trade came along and over the years we have had some great Presidents at the helm with able support from their Hony Secretaries and Team. We have put together the complete list of Presidents and their Secretaries with their tenure for your ready reference.

	Year 1989-1990 (ADHOC)	Year 1990-1991	Year 1991-1994	Year 1994-1997
<b>President</b>	Mr. R. D. Mathur	Mr. Vadhera D.	Dr. Shetty B. S.	Dr. Shetty B. S.
<b>Secretary</b>	Mr. Viraf Doctor	Mr. Viraf Doctor	Mr. Nitin Patel	Mr. Raju Mathur
<b>Treasurer</b>	Mr. S. D. Agarwal	Mr. Rammana Rao	Mr. Rammana Rao	Mr. Rajiv Seth
	Year 1997-2000	Year 2000-2003	Year 2003-2006	Year 2006-2009
<b>President</b>	Mr. Vadhera D.	Mr. N. K. Patel	Dr. Subhashchandra Shetty	Mr. Vinod Bawal
<b>Secretary</b>	Mr. Raju Mathur	Mr. Vinod Bawal	Mr. Praveen Malhotra	Mr. Firoz Merchant
<b>Treasurer</b>	Mr. Vinod Bawal	Mr. Naresh Kumar Puri	Mr. Prakash Bagadiya	Mr. Praveen Malhotra
	Year 2010-2012			
<b>President</b>	Mr. Rajinder Kumar Mathur			
<b>Secretary</b>	Mr. Shammi Gumbhir			
<b>Treasurer</b>	Mr. Prakash Bagadiya			

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# Case Study

## Simple and Effective Haemostasis in Crown and Bridgework

Michael N. Mandikos  
BDS, MS, Cert Pros, FRACDS, FICD

Preparing crown margins that are defined, continuous and of the proper depth and position is a significant daily challenge in fixed Prosthodontics. However, once these margins have been formed, capturing the margins with high fidelity in an elastomeric impression can be just as challenging.

A survey conducted by Gordon Christensen which was published in the Journal of the American Dental Association<sup>1</sup> reported that the most frequently reported problem encountered by Laboratory Technicians doing fixed Prosthodontics was the poor quality of the impressions. Subsequent studies have reported that the prevalence of poor quality impressions for fixed Prosthodontic procedures is widespread and of significant concern.<sup>2, 3</sup> There are many factors that contribute to inaccurate impressions; however, the most observable problem would appear to relate to accuracy of capture of the margin finish line.<sup>4</sup>

The margins of a crown preparation can be difficult to capture in an impression due to inadequate soft tissue retraction or due to moisture or poor control of bleeding. Traditionally, retraction cords have been the preferred means of achieving both tissue retraction and haemostasis. A survey of over 1200 members of the American College of Prosthodontists (all specialist Prosthodontists) revealed that 98% used retraction cord. Of those using cord, 81% soaked it first in a haemostatic solution, and of those who soaked their cord, 55% used Aluminium Chloride.<sup>5</sup>

Placing a retraction cord is a deliberate procedure with the aim being to place it at the level of the preparation and within the confines of the gingival sulcus. Finer, braided cords are easier to place, and, similarly, fine placement instruments are required. The cord should horizontally retract the tissue, not displace it vertically. Practice is needed to allow the clinician to rotate and roll the cord as it goes into the sulcus and the cord must remain in the sulcus for in excess of 10 minutes to achieve effective retraction and haemostatic control.

This complicated and time-consuming process has allowed the introduction and adoption of alternative, cord-less retraction techniques. Expanding polyvinyl siloxane and Kaolin-based paste materials have been introduced to the market with claim of faster, easier and more effective retraction. A recent study has hinted that these materials may be even more efficient to use, as they were much less likely to stimulate bleeding in the gingival sulcus either during placement or immediately after removal, when compared to retraction cord.<sup>6</sup>

The following case report describes the use of a new material, "Traxodent®", from Premier®. Traxodent is a clay-based paste which contains 15% Aluminium Chloride. The paste is delivered to the sulcus directly from its syringe as an alternative to use of a separate haemostatic solution and retraction cord. It can be used alone for haemostasis or in combination with Premier's "Retraction Caps" if greater retraction is desired. It is recommended to leave the paste in place for two minutes prior to rinsing it away.



Traxodent's ergonomic disposable syringe and bendable syringe tip provide excellent reach.

The patient presented with symptoms associated with gross caries in the distal of the lower right second premolar (#45). The patient was referred to an Endodontic colleague and the #45 was subsequently root canal treated (Figures 1 to 3).



Figure 1



Figure 2



Figure 3

After root-canal treatment, the tooth was restored with a direct post and core, then prepared for a Lava zirconia crown. The extent of the caries meant that the distal margin was located very deep and in a subgingival position. This resulted in significant bleeding as "gingival curettage" was performed by the preparation bur (Figures 4 and 5).



Figure 4



Figure 5

Significant haemostasis was needed, so Traxodent was syringed directly into the gingival sulcus and left in place for two minutes (Figures 6 to 8).



Figure 6



Figure 7



Figure 8



## Case Study

The Traxodent then was rinsed away, and the bleeding was observed to have stopped (Figures 9 and 10). Retraction cord then was placed and the impression made.

Approximately four weeks later, the patient returned for insertion of the definitive crown. At this appointment, the soft tissues were observed to have healed very nicely, with no residual inflammation and no recession. The crown was adjusted and seated, and the procedure was performed in a healthy gingival environment (Figures 11 and 12.).

The author has found this material to be invaluable in situations where there is excessive gingival bleeding. In particular, when necessity has meant margins are placed very subgingivally or electrosurgery has been performed, I have observed Traxodent to work very quickly and effectively in controlling the bleeding in these instances.

The six images below demonstrate an upper-right first premolar (#14) that lost its palatal cusp through fracture, nearly 3mm subgingivally. A combination of electrosurgery and tooth preparation created a significant amount of bleeding, which then was arrested by the application of Traxodent for two minutes. After rinsing the Traxodent away, the clean, dry tissue surface then facilitated an accurate impression for the fabrication of a gold post and core. The final crown subsequently was made and cemented to place.



Figure 9



Figure 10



Figure 11



Figure 12



### Acknowledgement:

I would like to thank the Teams at Prestige Milling Services and Slater Dental Studio for their excellent technical skills to allow successful restoration of these two challenging cases.

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### About the Author

Dr. Mandikos is a registered specialist in Prosthodontics. He received his Bachelor of Dental Science Degree with honours from the University of Queensland and completed a three-year residency program at the State University of New York at Buffalo (USA) graduating with a Certificate in Prosthodontics and Masters Degree in Biomaterials. His research was in composite resin materials and he published several papers in Australian and international journals on clinical and dental material topics.

Dr. Mandikos is a Fellow of The Royal Australasian College of Dental Surgeons and a Visiting Prosthodontist to the University of Queensland Dental School and the Royal Australian Air Force. He is a Reviewer for the Australian Dental Journal, Quintessence International and Clinica as well as a product evaluator for several dental companies.

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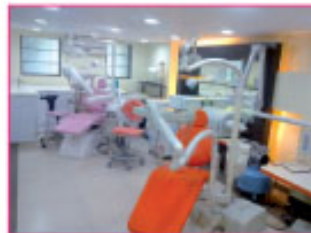
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## User Report

### Post-endodontic restoration of a deeply decayed tooth – options and limitation

Michael Bruder, DDS, Hamburg, Germany

In some cases root canal treated teeth with extensive loss of coronal hard tissue require a post as additional supporting element for the build-up and definitive restoration. For quite some time now glass fiber enforced composite posts have become an established alternative to metal and ceramic posts [1]. Frequently, various different composites are required for setting the posts and for restoring the lost hard tissue portions. A complete system with matching components would be most welcome. Such a system will be presented in the following article.

The long-term prognosis for a root canal treated tooth depends on the endodontic treatment as well as on the post-endodontic restoration [2]. The objectives for the restorative measures after filling the root canal are to restore the function, create a bacteria-proof closure, and contain the fracture risk.

The question whether or not the loss of pulp including the blood vessel system would cause a tooth to dry out and thus increase the risk of fracture was discussed for a long time. However, numerous studies showed no change of the hard tissue's physical properties after a vital extirpation and subsequent endodontic treatment. The fracture risk of an endodontically treated tooth is mainly due to the trepanation-based loss of the pulp cavity roof. The root canal and post bed preparations also contribute, though on a minor scale, to the reduction of the hard tissue and thus to weakening the tooth.

The indication for the restoration of endodontically treated teeth with posts has undergone a significant change in recent years [3]. While a restoration including a post build-up used to be considered a stringent indication in the past, today many dental professionals agree that rather the amount of remaining hard tissue is the decisive factor for a root post application [2]. More simply phrased, for front teeth and premolars an intraradicular cementation of the restoration is required if only two coronal dentine walls remain. If the remaining two dentine walls on molars are less than 3mm high and only a flat pulp cavity exists with insufficient retention surface for an adhesive restoration a root post is indicated as well [4]. As far as a bacteria-proof closure is concerned a post-endodontic restoration should be performed without delay. This requirement also takes into account the procedure for a planned post insertion. For one, temporary luting cements cannot sufficiently prevent a re-infection of the endodont through saliva, and secondly, temporarily cemented posts increase the risk of a longitudinal fracture. Glass fiber enforced composites make it possible to begin reconstruction immediately following the root canal filling, thus fulfilling the above-mentioned requirement.

#### Material

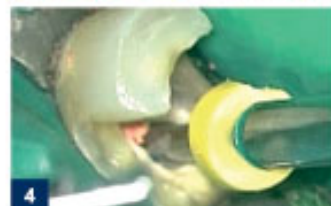
Three post sizes with diameters of 1.25 mm, 1.375 mm, and 1.5 mm in tapered form are available. For each size a corresponding post drill is included in the set. Due to their cutting performance pre-drilling is not necessary. The posts are silanized with a two-component system consisting of an adhesive silane and activator to create a chemical bond between the glass fibers and the composite's resin matrix.

LuxaBond-Total Etch is a fourth generation adhesive system consisting of a prebond, an adhesive to be mixed, and corresponding endo brushes specifically designed for root canal applications. For the post cementation and filling of the coronal cavity LuxaCore Z-Dual, a dual-curing, fluid, and highly pressure resistant composite is used.

#### Case report

The following case report is a step-by-step description of a post-endodontic restoration of a deeply decayed upper jaw premolar with an adhesively cemented glass fiber post and core build-up.

A 22 year old patient visited our practice in search of treatment. The patient's general medical health history was normal. The dental anamnesis showed a fracture of the clinical crown of the endodontically treated tooth no. 15 (initial x-ray, fig. 1). An emergency medical service had previously treated the premolar with a temporary restorative filling (initial situation, fig. 2). The inspection of the tooth's hard tissue after removal of the filling showed a remaining palatal dentine wall so that a post insertion could be indicated.



## User Report

A rubber dam was applied in order to prevent further contamination of the endodont and to not impede the adhesive reconstruction of the crown through saliva penetration (fig.3). Based on the buccal defect situation the respective canal for the insertion of the post was chosen (LuxaPost, DMG). The canal's cross-section determined the selection of the 1.5 mm post diameter. A drill with length marker matching the post diameter was used to prepare the post canal (fig. 4). The preparation depth depended on the working length of the root canal treatment. The objective was to leave 4 mm of the apical root canal filling as a sealed closure. An x-ray with post drill was used a) to control the targeted canal depth, and b) to monitor the correct preparation direction (fig. 5).

The post bed was first rinsed with a 17% EDTA solution to remove the smear layer and then disinfected with a 5.25% NaOCl solution. After drying the well, the post was sealed and checked using a marker and foil pen (fig. 6). With artery forceps the post was fixated at the top, cleaned with alcohol, and dried with air (fig. 7). The silanization concluded the preparation of the post for insertion (fig. 8). In the next step the post bed and the coronal cavity were conditioned with 37% phosphoric acid. After etching the enamel for 20-60 seconds and the dentine for 15 seconds, both areas were rinsed for the same amount of time (fig. 9). After careful drying with moisture-free compressed air (fig. 10), the prebond was applied to all dentine areas for 15 seconds using an endo brush (fig. 11) and gently blown off.

Subsequently, the components A and B of the bonding system were mixed in a 1:1 ratio for approx. 5 seconds, worked into all dentine areas for 20 seconds, and also gently blown off. Following both steps, the post well was additionally dried with paper syringes. Light-curing is not necessary for this chemically curing adhesive system.

For the post cementation the canal was completely filled with LuxaCore Z-Dual, and with gentle rotating motions the post was moved to the targeted position. This procedure prevents bubble formation to a great extent and promotes an optimal bond of the components involved: post, composite, and canal wall dentine. A 40 second light polymerization accelerates the curing process. For the reconstruction of the coronal portion LuxaCore Z-Dual was used as well and light-cured as described above (fig. 12). After the so-called ferrule preparation was completed (fig. 13) a provisional was made and cemented in using a temporary adhesive.

### Summary

In cases where the clinical crown is extensively destroyed the retention of an adhesive restoration is limited and a root post may be necessary in order to improve this retention. Glass fiber enforced composite posts are especially well-suited due to their prompt and direct application, their dentine-like material properties, and their optical advantages. With regard to their biomechanical characteristics core build-up materials are primarily designed to replace lost coronal dentine. As to its mechanical and polishing properties LuxaCore Z-Dual is very dentine-like [5]. However, long-term clinical studies need to show whether or not the material properties of the posts or the bond between the dentine, composite, and post may have adverse effects under permanent load.

Besides the composite root post, the advantage of this DMG system is to have all the materials necessary for a post-endodontic treatment available from one source. Therefore, this system can be rated as practical and reliable.

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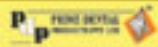
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# Case Study

## Solving complexities in Endodontics

Treating poorly obturated root canal treated teeth with ledges and broken instruments can be night mare for any dentist.

A patient aged 25 years was referred to our clinic with pain under the bridge. Upon examination, we found that a 4 unit bridge has been given on 35 and 38. 38 showed pain on percussion. The bridge was removed and IOPA radiograph was taken for 38. X ray examination revealed poorly obturated root canal treated tooth. (Fig. 1) Upon closer examination, one could see some radio opaque material also inside the canals. Fractured instruments are expected inside.

The tooth was badly mutilated. As it was difficult to apply rubber dam, mesial wall was built up with composite resin before doing access cavity preparation.

Access cavity preparation was done and rubber dam applied. The orifices are located. As you can see some GP points in the canal, they need to be removed with the special systems like R Endo (Micro-Mega- BDS) (Fig.2) , H files, GP solvents like Canal Solve (Ammdent) (Fig. 3) . I prefer to use Canal Solve like organic solvents over GP softener oils. Organic solvents penetrate around the GP points better and faster. Use RM file first and make some space for next file to enter inside. Then R1, R2, R3 files of R Endo system can be used to remove softened GP points.

Use of sodium hypochlorite (Fig. 4) (Ammdent) for irrigation after every instrument is strongly recommended. Sodium hypochlorite is a strong antibacterial, lubricant and dissolves organic tissue in the canal and has excellent washing effect.

As one started seeing the fractured instrument in the canal, Masserann kit (Micro-Mega-BDS) (Fig.5) is used to cut the dentin around the instrument. Masserann KIT is broken instrument removal system which can be effectively used to remove instruments from coronal and middle third. (FIG. 6) It has a trepan bur which makes space around the instrument and then instrument can be removed with some vibration with ultrasonic endo tips. Upon removal of the first instrument (FIG. 7), we took IOPA X ray and discovered 2 more instrument below that! (FIG. 8) It was a herculean task to remove all the instruments. All 3 instrument fragments were extracted. Remaining preparation of the canals is finished with Revo S files (Micro-mega- BDS) (Fig.9) . Use ample amount of EDTA gel- Prep canal (Fig. 10) to facilitate instrumentation by chelating action and also helps softening the dentin thereby negotiating calcified canals better.

Calcium hydroxide- CalExcel- closed dressing was given for 10 days for disinfection of the canals and periapical area and facilitation of new bone formation. (Fig. 11)

The canals were well irrigated with liquid EDTA- Canalarge (Fig. 12) to remove all the smear layer. It is advised to use 2% Chlorhexidine – DentoChlor (Fig. 13)- as last irrigant in such failed root canal cases to tackle the tougher bacterias like Enterococcus fecalis.

It took us 3 visits and almost 4 hours to finish this case. (FIG. 14) It is advised to change instruments regularly and take experts help in case of very difficult cases. Always use new files whenever there is a difficult case. This reduces chances of instrument fracture in the canal drastically. Also new single file disposable systems like One Shape almost eliminate risk of fracture.

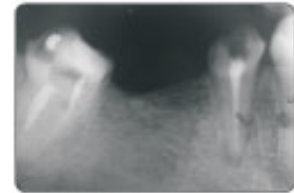


FIG 1 PRE OP IOPA X RAY: Poorly obturated molar with fractured instrument fragments

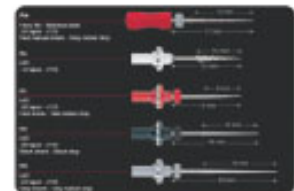


Fig. 2 : R Endo Retreatment Niti File System



Fig. 3 CanalSolve: G.P. Solvent



Fig. 4 : Sodium Hypochlorite For Irrigation



Fig. 5: Masserann Micro kit for broken instrument removal



# Case Study

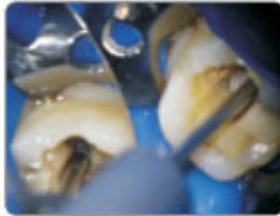


Fig. 6 : Trepan Bur In The Canal



Fig. 7: 1. Broken Instrument Seen In The Canal

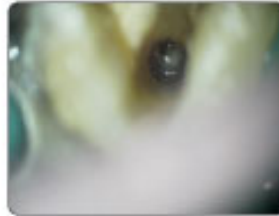


Fig. 8: Upon Removal of 1st Instrument, 2 More Instruments Are Seen!

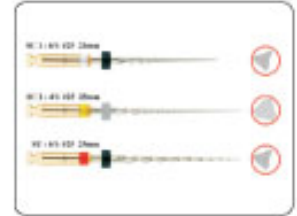


Fig. 9: Revo-s System



Fig. 10 :  
Prepcanal-Chelating Agent



Fig. 11: Calexcel – Water Based



Fig. 12: Canalarge - Liquid Edta



Fig. 13: Dentochlor

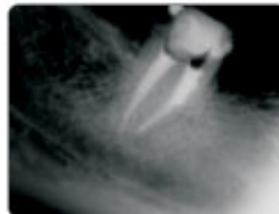


Fig. 14: Post Op Iopa  
Xray of MOLAR



## About the Author

**D**r. Ajay Bajaj has done his BDS from G. D.C. Mumbai and his MDS from Nair H.D.C. Mumbai. He is a Conservative Dentist and Micro-endodontist. He has more than 50 articles and 162 lectures/ workshops in his credit in last 10 years. Teaching Endodontics is his passion and his courses are extremely popular in India and abroad. He has his private practice in Juhu, Mumbai.

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