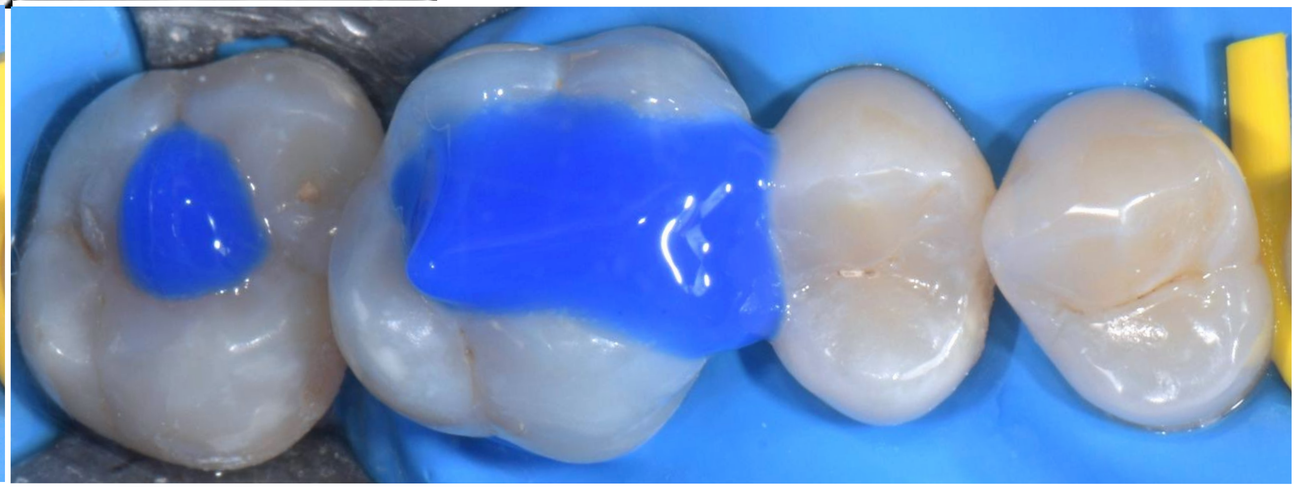
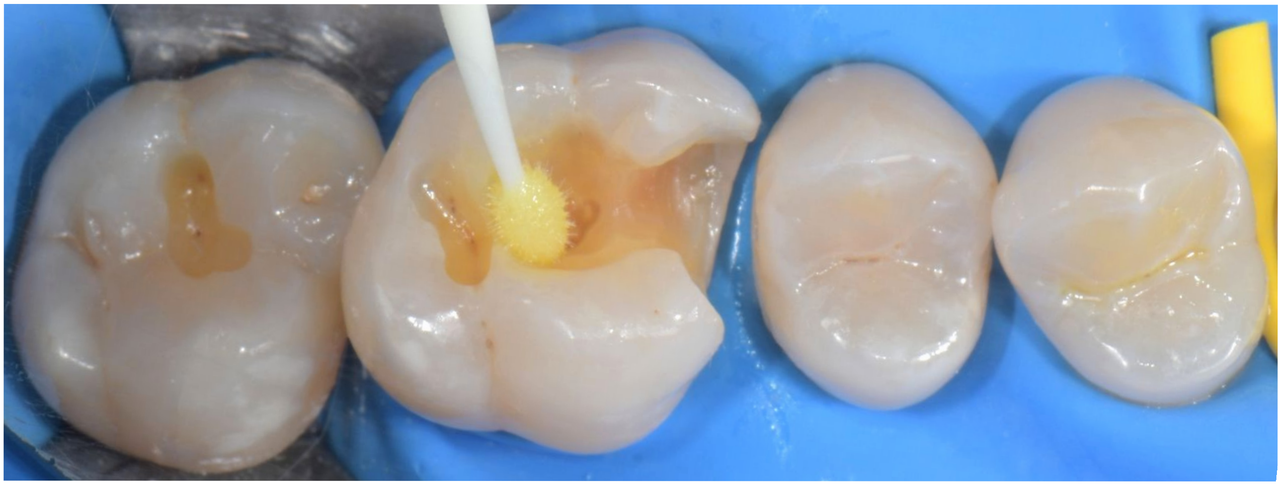
1

Direct Restoration





Diagnostic

In this case, from the clinical aspect we can see the infiltrated composite filling on 26 with a secondary carious lesion, but corroborated with the radiograph we can visualise the extent of a mesial approximal D2 (Martaler & Lutz classification) carious lesion.

Clinical approach:

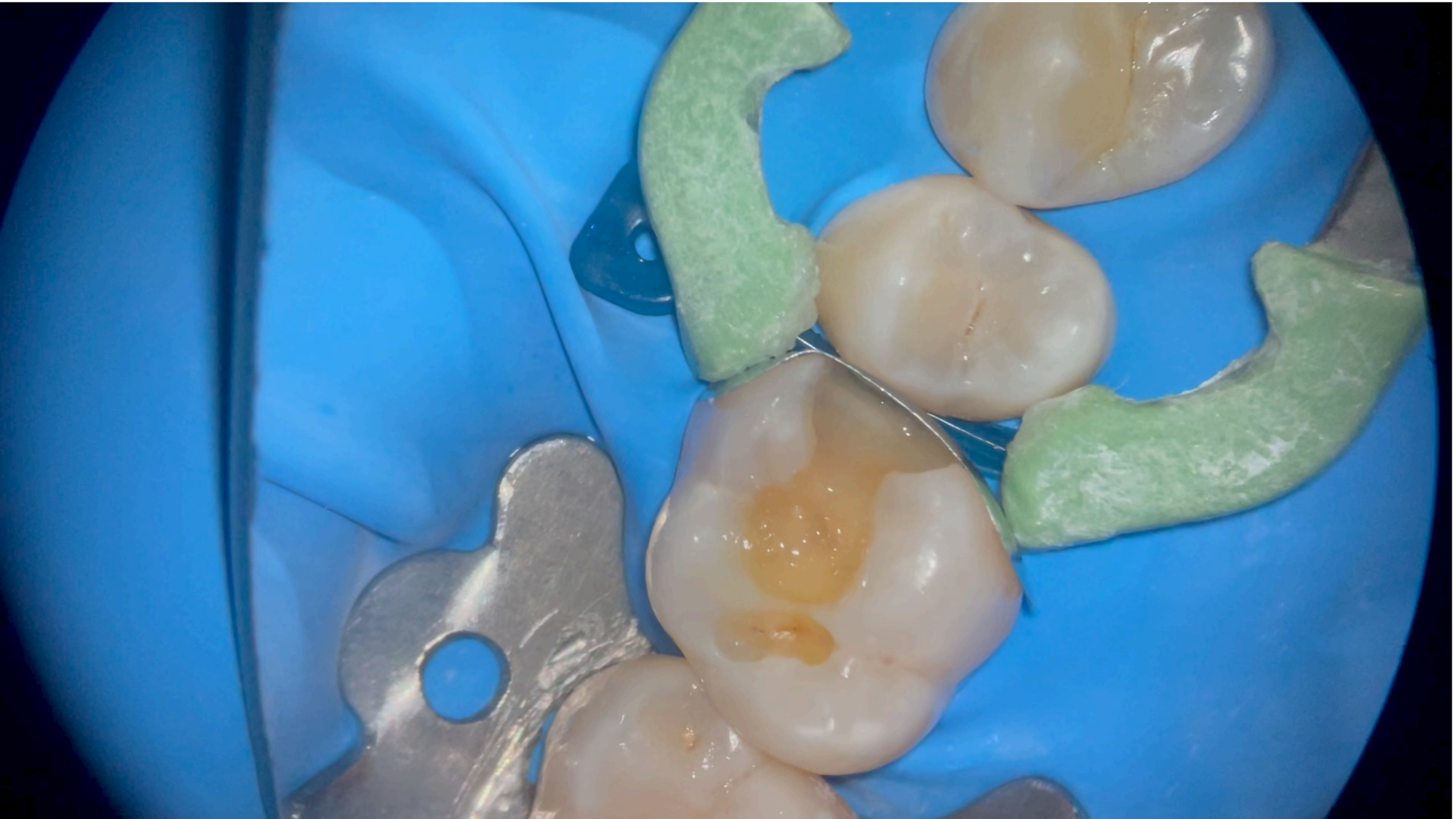
In this situation, from a defect size point of view a direct restoration would normally be expected as a treatment option.However, if we look at the general perspective the tooth is extruded we have no antagonist depending on the treatment plan, it may be the final option or just an intermediary option within the general context

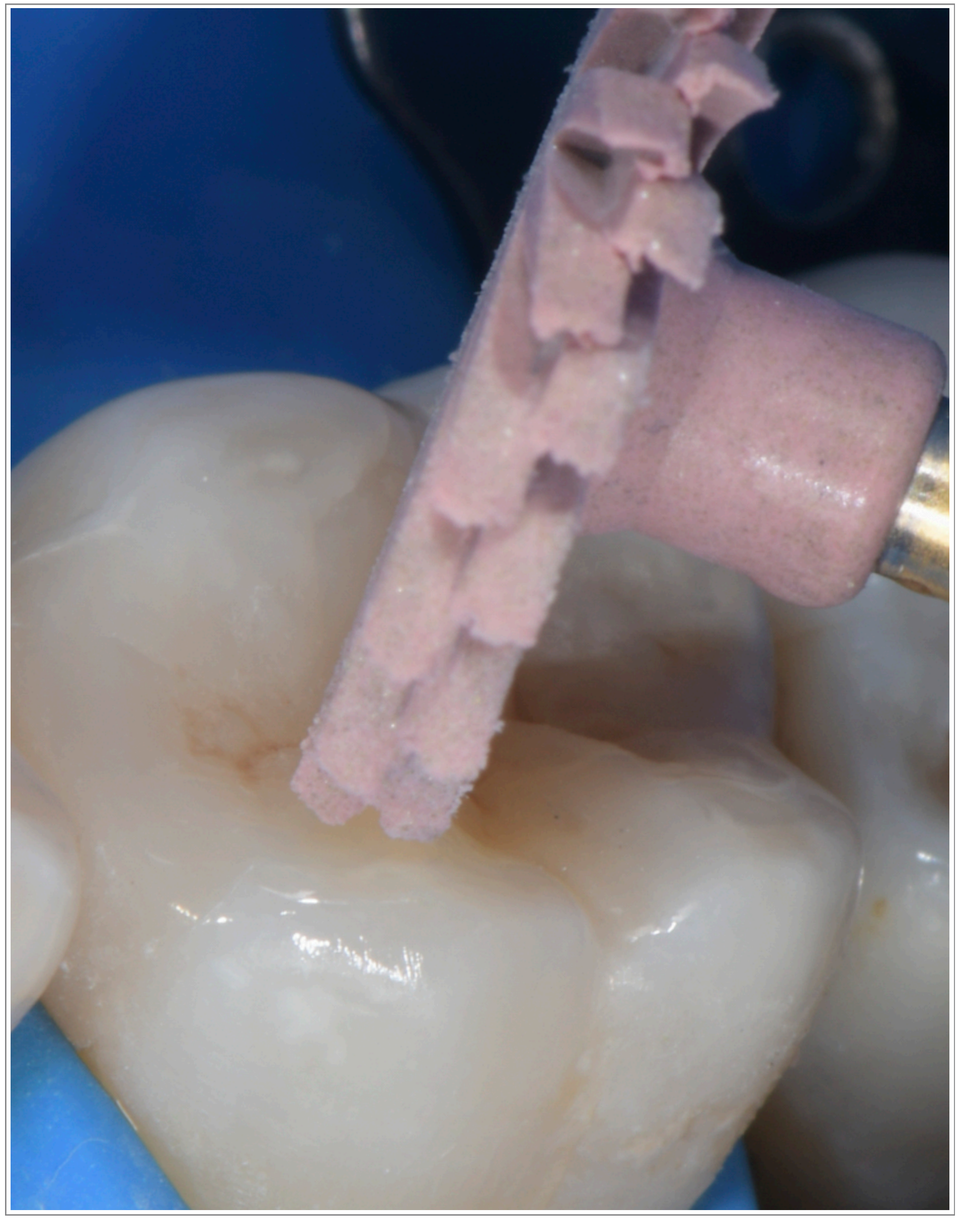
C e n t r i p e t a l

B u

When we face a large restoration and we choose a direct technique, two of the main challenges are the structu
point of view and reconstructing the occlusal table
Regarding the first aspect, I use a flowable glass-reinforced flowable composite, and there are several studie
regarding the use of this type of composites in large reconstructions when combined with a hard composite on
All the new materials and adhesive systems give us great advantages in terms of resitance and the ability to b
more conservative
When it comes to morphology and reconstruction of occlusal table,
the first thing, when pe have a Class 2 or an MOD, is to reduce it to a Class 1 by using the centripetal build-u
But we still have a orientation problem, especially when we work in indirect view and use a cusp-by-cusp layer
technique.The cusp-by-cusp technique has the disadvantage that you may end with too much space or too little
the last cusp
So the first thing I do is reconstruct the non-functional cusps first and then insert the functional cusps between
non-functional ones.In this way we can get the orientation we need.The secondary morphology will be much ea
to build afterward.

Materials :
Ultra etch , G Premio Bond , Injectable composite A3 base layer, Ever X flow and Achord composite GC





P o l i s h