Which all-ceramic system is optimal for anterior esthetics?

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Dentistry has undergone a revolution in the last 30 years, not only with regard to the introduction of new materials and techniques, but also with regard to the scientific evidence supporting their clinical applications. Land introduced all-ceramic crowns in 1903, but the material was weak, the fabrication technique complicated and the choice of luting agents limited.

EVOLUTION OF ALL-CERAMIC MATERIALS

McLean introduced alumina-reinforced porcelain jacket crowns in the mid-1960s. About 10 years later, research began to be published documenting the success—or lack thereof—of all-ceramic crowns. By the mid-1980s, the literature showed that anterior porcelain jacket crowns had a 25 percent chance of failing in vivo by 11 years; the failure rate was even higher in the posterior regions. Fortunately, significant advances in materials and techniques have occurred in the last 30 years that justify the routine use of all-ceramic

ABSTRACT

Background. As ceramic materials for dentistry evolve and patients’ demand for esthetic restorations increases, practitioners must keep up with the science as well as the demand. The authors offer guidance to the practitioner in selecting the appropriate all-ceramic systems for crowns when faced with different esthetic demands.

Conclusions. Clinicians should reserve dental ceramics with high translucency for clinical applications in which high-level esthetics are required and the restoration can be bonded to tooth structure. Ceramics with high strength tend to be more opaque and pose a challenge when trying to match natural tooth color, but they can mask discoloration when present.

Practice Implications. Knowledge of the optical properties of available ceramic systems enable the clinician to make appropriate choices when faced with various esthetic challenges.

Key Words. All-ceramics; esthetics; crowns; veneers; restorative materials.

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restorations in dentistry today.

One of the most significant of these changes occurred in 1983 when Horn\textsuperscript{5} and Simonsen and Calamia\textsuperscript{6,7} independently introduced acid-etched ceramics to create the bonded porcelain veneer, one of the most successful restorations when bonded primarily to enamel. With the advent of dentin adhesives in the early 1990s, porcelain restorations with significantly higher bond strengths than those that had been available previously became possible.\textsuperscript{8,9} This prompted many practitioners to forego metal-ceramics and use bonded ceramics in clinical situations in which they had never before been used—sometimes successfully and sometimes unsuccessfully. A challenge still exists in that the dentin/adhesive bond is not as durable or predictable as the enamel/adhesive bond.\textsuperscript{10}

Major strides in technology permitting routine use of all-ceramic restorations are the improvement and scientific innovations in the ceramic materials themselves. High-strength core materials containing alumina, zirconia, zirconia-toughened alumina, magnesium aluminate spinel and lithium disilicate have been introduced and clinically tested. Laboratory technicians (ceramists) then apply esthetic veneering ceramics over these core materials to create a final, esthetic restoration.

The other change that has occurred in the use of all-ceramic restorations has been societal attitudes concerning esthetics. Before the early 1980s, people in the entertainment industry were primarily the only patients who requested elective esthetic dental procedures. With the only treatment option being full-mouth rehabilitation involving the use of complete-coverage crown preparations with sub-gingival margins, these patients were faced with the potential risks of recession, exposure of the margin, discolored gingivae and pulpal involvement. These classic metal-ceramic restorations required not only extensive tooth reduction, but a highly skilled master technician to achieve excellent esthetics.

MATERIALS OPTIONS

Modern all-ceramic systems can be categorized broadly into two groups: those that are translucent and those that consist of an opaque, high-strength core onto which esthetic layering ceramic must be applied to achieve a natural appearance (Figure 1). Examples of translucent materials are conventional sintered feldspathic porcelain fabricated on refractory dies or platinum foil, pressable ceramics (for example, IPS Empress Esthetic, Ivoclar Vivadent, Amherst, N.Y.) and some of the in-office machinable ceramics made via computer-aided design/computer-aided manufacturing (for example, Vitablocs Mark II, Vita Zahnfabrik, Bad Säckingen, Germany). Examples of opaque layered materials are nonmetallic restorations made with alumina, zirconia or lithium disilicate used as high-strength core materials (for example, IPS e.max, Ivoclar Vivadent; Procera, Nobel Biocare, Göteborg, Sweden; In-Ceram, Vita Zahnfabrik; Lava, 3M ESPE, St. Paul, Minn.; and Cercon, Dentsply Ceramco, York, Pa.).

Properties. As a general rule, the two groups of all-ceramic systems have distinctly different properties in several areas. With regard to tooth reduction, clinicians can use the translucent materials with more conservative tooth preparations compared with the opaque, layered systems. Optically, the translucent materials usually are more esthetic than the layered materials. Most translucent restorations must be bonded to improve their predictability, while layered restorations do not have this sensitivity to choice of luting agent.\textsuperscript{11}

Because of these differences, dentists can use most opaque layered materials for traditional
crown or bridge restorations, while they can use
translucent materials for full-coverage or more
conservative partial-coverage bonded restorations.
We can best summarize these differences as
esthetic but weaker versus stronger but more
opaque, a dichotomy that drives the process of
selecting all-ceramic materials.12

Restorative needs. Dentists should base
their choice of material on the requirements of
the tooth being restored. For purposes of sim-
plicity, we can group restorations into four major
categories: porcelain laminate veneer restorations
that replace primarily enamel, partial-coverage
restorations that replace enamel and dentin, con-
ventional complete crowns that cover acceptably
colored dentin, and complete crowns that cover
dischored dentin or metal posts that must be
masked.

PARTIAL ENAMEL REPLACEMENT
The most conservative of all indirect restorations
essentially replace enamel with minimal, if any,
preparation into dentin. These restorations are
useful when the overall tooth color is pleasing
and the restorative goal is to place a new, more
pleasing external surface on the tooth without
changing the tooth color significantly.13,14 Because
the enamel thickness of a natural tooth varies
from 0.4 millimeters on the facial aspect in the
cervical one-third to 0.8 to 1.0 mm on the facial
aspect in the incisal one-third, true enamel
replacement restorations typically are 0.3 to
0.5 mm thick and require minimal preparation.15
In general, some tooth preparation is desirable to
allow for ideal cervical emergence contours.16,17
Because of the ceramic thickness needed for
enamel replacement restorations, dentists should
use only translucent unlayered materials.

In addition to the low possibility of pulpal irri-
tation, margin placement is another advantage of
enamel replacement restorations. The ultrathin,
highly translucent ceramic that makes changing
color difficult with these restorations also allows
them to have invisible supragingival margins.15,16
This allows conservative margin preparation
short of the proximal contact or incisal edge and
helps maintain gingival health.

DENTIN AND ENAMEL REPLACEMENT
As desirable as the conservative nature of enamel
replacement restorations may be, many teeth
simply cannot be treated minimally. Situations
involving large interproximal restorations, tooth
malposition, tooth discoloration, wear or fractures
may require a restoration that involves the
removal of more tooth structure but does not
necessitate a conventional complete-coverage
crown. When the clinician must replace both
dentin and enamel but will not alter the occlusion
or color, translucent ceramics still are the
materials of choice, because of their excellent
enamellike appearance and ability to be bonded to
natural tooth structure.

COMPLETE CROWN AND ACCEPTABLY
COLORED DENTIN
In general, the reasons to use an all-ceramic,
complete-coverage crown for an anterior tooth
include replacement of an existing crown; the
tooth structurally requires that the lingual sur-
face be prepared; the occlusion requires a signifi-
cant change so that lingual coverage is needed;
and large proximal areas of decay are present or
the patient has pre-existing restorations. This is
the one restoration for which clinicians may find
it difficult to decide whether to use translucent
materials or opaque, layered materials, because
both may work equally well. In general, the deci-
sion will be based on the need for high strength
owing to the lack of anterior guidance or the pres-
ence of parafunctional habits, the amount of tooth
reduction required, the laboratory’s preference
and whether the clinician wishes to cement or adhesively bond the restoration.

For teeth with normally colored preparations, translucent materials enable clinicians to reduce less tooth structure (typically 1.0 mm), create esthetic margins when they are supragingival or equigingival, and achieve a predictable bond to the restoration itself, because sintered feldspathic ceramics and pressable ceramics are etched easily. This can be a particular advantage when an anterior tooth is fractured, because a tooth with a traditional cemented restoration might not have adequate resistance and retention form to retain the restoration. By choosing an adhesively bonded, translucent ceramic, the dentist might be able to use as little as 2 mm of vertical preparation height without the need for additional foundation restorations.\textsuperscript{19,20} (Figure 2).

A highly discolored anterior tooth presents an esthetic challenge. In such cases, the dentist will need to use a restorative technique capable of re-creating the natural color of dentin and then overlay the tooth preparation with a more translucent material to achieve an esthetic final appearance.

To achieve this, authors have advocated several approaches.\textsuperscript{21-24} One method\textsuperscript{21} advocates that clinicians use relatively translucent ceramics, which have the greatest potential to be affected adversely by the color of the dark preparation, but also use an opaque cement to mask the discoloration. This technique can be successful, but often it is the least predictable solution, because there is no way for the dentist to see the final color until the restoration is luted. This becomes difficult for the technician, who must estimate the impact that the tooth preparation color and cement will have on the final restoration color (Figure 3).

A far more predictable approach is to use a crown with a more opaque core that is less affected by the preparation color.\textsuperscript{25,26} The layered ceramic systems with more opaque cores are well-suited for the treatment of discolored teeth. The
The technician can see the final restoration color during fabrication, because preparation color has little impact on the seated restoration. When using these restorations for discolored teeth, the clinician must ensure a reduction of 1.2 to 1.4 mm on the facial aspect, and he or she should use subgingival margins to avoid an unesthetic cervical appearance. Clinicians also should use these materials when the need arises to cover a metal post and core that cannot be removed27 (Figure 4).

**CONCLUSION**

We have described the possible types of anterior restorations and the ceramic materials of choice for them. It is clear that the requirements for optical properties, tooth reduction, margin placement, strength and method of placement (bonded versus cemented) vary for different clinical situations. Is there a single material that can be used in all situations? The closest are the translucent ceramics, owing to their ability to be bonded to tooth structure, as well as to their translucency. How do dentists choose the material to use, particularly in the anterior region? First, we recommend that they take into consideration the laboratory’s experience and expertise. Second, we advise them to refer to the table to best address the clinical situations encountered. 

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**TABLE**

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>PARTIAL COVERAGE ENAMEL REPLACEMENT ONLY</th>
<th>PARTIAL COVERAGE ENAMEL AND DENTIN REPLACEMENT</th>
<th>COMPLETE CROWN COVERING ACCEPTABLY COLOR DENTIN</th>
<th>COMPLETE CROWN COVERING DISCOLOR DENTIN OR METALLIC POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of Tooth Reduction</td>
<td>Minimal (0.3-0.5 mm*) in enamel only</td>
<td>As needed; does not involve lingual surface</td>
<td>Circumferential, 1.0-mm chamfer</td>
<td>Circumferential, 1.2- to 1.4-mm chamfer</td>
</tr>
<tr>
<td>Margin Placement</td>
<td>Supragingival</td>
<td>Supragingival or equigingival</td>
<td>Supragingival or equigingival</td>
<td>Subgingival</td>
</tr>
<tr>
<td>Strength Requirements</td>
<td>None, no occlusal forces encountered</td>
<td>Low, few occlusal forces encountered</td>
<td>Depends on presence of anterior guidance, parafunctional habits</td>
<td>Depends on presence of anterior guidance, parafunctional habits</td>
</tr>
<tr>
<td>All-Ceramic Material of Choice</td>
<td>Requires translucent ceramic</td>
<td>Requires translucent ceramic</td>
<td>Translucent or opaque ceramic if greater strength needed</td>
<td>Requires opaque ceramic</td>
</tr>
<tr>
<td>Cementation</td>
<td>Adhesive resin necessary</td>
<td>Adhesive resin necessary</td>
<td>Adhesive resin or conventional luting agent</td>
<td>Adhesive resin or conventional luting agent</td>
</tr>
</tbody>
</table>

* mm: Millimeters.

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