IPS e.max CAD and Zenostar: Monolithic brothers

Fabricating individualised monolithic restorations

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Aesthetic and functional rehabilitation of the anterior dental arch and occlusal height can be completed in a single day using IPS e.max CAD (Ivoclar Vivadent) lithium disilicate ceramics in combination with CAD/CAM technology. In this case, the CEREC system (Sirona) was used. The articulation was assessed with the help of T-Scan technology (Tekscan), which provided excellent results.

Until recently, closing lateral gaps in patients who refuse implant treatment posed a problem with timescales for us. For these cases, zirconia bridges proved to be a valuable solution. In order to speed up, or simplify, this treatment modality, we use IPS e.max CAD (Ivoclar Vivadent) silicone material. The bridges were manufactured using a Wieland scan-and-mill system (Wieland). As the next step, we replaced all the existing single restorations with crowns made of IPS e.max CAD milled with the CEREC MC XL CAD/CAM system and IPS e.max CAD LT blocks in shade BL2 (staining technique). The occlusal height was raised on the same day and temporarily stabilised with Telio CAD (Ivoclar Vivadent) bridges.

The anterior mandibular teeth were restored with laminate veneers made of IPS e.max CAD (staining technique). Prior to placing the Telio CAD bridges with Telio CS Link (Ivoclar Vivadent), impressions were taken using Virtual 380 (Ivoclar Vivadent). A bite record of the new vertical dimension was taken with Virtual CADbite (Ivoclar Vivadent) silicone material. The bridges were manufactured using a Wieland scanner and a Zenotec mini-milling unit.

The restorations were designed with 3Shape software (Figs. 6–8). In order to reconstruct the bridge from tooth #23 to 26, the caninier, the first premolar and the second premolar of the first quadrant were milled, whereas the first molar was reconstructed on the basis of data retrieved from the 3Shape library. From the beginning, the contours of the molar were very clear and detailed. Therefore, no additional manual tissue adjustment was necessary. The restorations were milled, sintered in a Programat S1 furnace (Ivoclar Vivadent) and then customised by applying stains from the Zenotec Art Module in the staining technique. Finally, the occlusal contact points were polished (Fig. 9).

On the second day, the temporary Telio CAD bridges were removed and the teeth were cleaned with chlorhexidine-containing Cervitec Liquid (Ivoclar Vivadent) mouthrinse. A try-in was performed without any problems and additional ad-
The restorations were then cleaned with Ivoclean and silanised with Monobond Plus (both Ivoclar Vivadent). The preparations were pre-treated with Multilink Primer A and B and then seated using Multilink Automix luting composite (yellow shade; both Ivoclar Vivadent). After the luting composite had been cured with a Bluephase (Ivoclar Vivadent) curing light and the excess material had been removed, the restorations were permanently cemented in place by activating the Turbo mode of the curing light a number of times. Articulation and occlusal contact points were assessed with a T-Scan device and then the occlusal surfaces were polished (Figs. 10 & 11).

**Conclusion**

A slight difference in brightness between the Zenostar zirconia bridges and the IPS e.max CAD crowns was noticeable. With hindsight, we would adjust the shade of the Zenostar framework with Zenostar Color Zr (Ivoclar Vivadent) colouring solution before conducting the sintering process to adapt the brightness level in such cases. As an alternative, a pre-shaded block could be used instead of adjusting the shade later by means of the staining technique.

For the patient, her new bright smile was simply a wish came true (Figs. 12 & 13). From our point of view, the 5Shape software was very efficient in completing the rehabilitation. Tooth shapes were easy to copy. An initial proposal for the design of the occlusal surface of the posterior teeth was immediately available and could be adjusted quickly and predictably. The restorations showed a smooth surface and clearly contoured fissures both on the screen and after milling in the four-axis milling unit.

As further adjustments were not necessary, we were able to seat the restorations straight-away. Monolithic zirconia restorations have shown similar, if not lower, levels of enamel wear on antagonists to other ceramic restorations in clinical applications. By using monolithic restorations, we are able to complete certain cases in a single day. If we consider a recent investigation that evaluated the enamel wear caused by monolithic zirconia crowns and other ceramic materials and compared these results with the enamel wear caused by natural antagonists, we may conclude that we chose a functional and sensible solution.

**Reference**