All- Ceramic Crown Preparation and the Remained wall Thickness of the Pulp Chamber

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KEY WORDS
All-Ceramic; Crown Preparation; Pulp Chamber; Wall Thickness

ABSTRACT

Statement of Problem: A minimally invasive method of preparation is essential to prevent tooth structure weakening and pulp irritation; especially for mandibular anterior single-tooth all-ceramic crowns. According to many investigations, one of the most important reasons of pulp injury caused by tooth preparation for different restorative procedures is reduced “remained wall thickness” (RWT). In order to protect the pulp from irritation, it is necessary to maintain a 0.5 mm of RWT.

Purpose: The purpose of the present study was to evaluate the effect of all-ceramic crown preparation on pulp chamber RWT of mandibular incisors.

Materials and Method: Mesiodistal and buccolingual initial images of 24 extracted mandibular incisors were provided. The pulp chamber initial wall thicknesses of buccal, lingual and proximal surfaces of cervical, 1 and 2 mm above the cervical areas and also the incisal surfaces of incisal sections were measured using digital radiography and Photoshop software. After all-ceramic crown preparation, images were provided at the same initial positions. The initial and remained pulp chamber wall thicknesses were statistically evaluated and analyzed by ANOVA, paired t-test and a post hoc Tukey test.

Results: Repeated measures ANOVA showed that the mean of pre- or post-preparation wall thicknesses were not significantly different for each surface at the three horizontal levels (p > 0.05). However, there were significant differences between the surfaces for each section. Comparison of pre- and post-preparation wall thicknesses revealed significant differences (p < 0.05). Proximal surfaces of cervical sections had the least RWT (0.42±0.12).

Conclusion: According to the results of the present study, the least amount of initial and remained wall thicknesses of pulp chamber were related to the proximal surfaces, particularly in cervical areas. Therefore a reduction of preparation to 0.7 mm is suggested to prevent future pulp injury for mandibular incisors of 35 to 40-year-old patients and younger who require all-ceramic crown preparations.

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Introduction

A minimally invasive method of preparation is essential to prevent tooth structure from weakening and pulp irritation; especially for mandibular anterior single-tooth all-ceramic crowns [1-6].

According to many investigations, one of the most important reasons of pulp injury caused by tooth preparation in different restorative procedures is reduced RWT [7-10], which can result in the subsequent inflammation and necrosis of the pulp [11-12].
Many studies have evaluated the pulp and periapical status of crowned teeth [4-6, 13-19] but few have considered the interaction between RWT and pulp injury [8-9, 20-24]. When the RWT is less than 0.5 mm, more reactionary dentine will be produced [9]. The maximum amount of reactionary dentine is formed when there is a wall thickness of 0.25-0.5 mm [8]. In order to protect the pulp from irritation, it is necessary to maintain a minimum of 0.5 mm RWT [22]. Less pulpal reactions are observed when RWT is more than 1 mm [23]. Pulp is less irritated with the RWT of 1 mm, compared to an RWT of 0.5 mm [24]. According to Christensen, in an all-ceramic preparation procedure operated on a young vital tooth with large pulp, all aspects are subjected to a 1.5-mm reduction in thickness except for occlusal aspect that is subjected to a reduction of 1.5-2 mm [25]. The number of odontoblasts is one of the parameters involved in the repair of the dentine after restorative treatment, and RWT has a significant influence on the number of underlying odontoblasts [21]. Because of the limited circulation of pulp chamber, biological stimulants, such as decreased RWT, would lead to irreversible pulpitis [26]. The purpose of this study was to evaluate the effect of all-ceramic crown preparation on the pulp chamber wall thickness of extracted mandibular incisors.

**Materials and Method**

In this quasi experimental study a hundred human mandibular incisors, extracted as a result of periodontal disease, were collected from patients with the age range of 35 to 45. The teeth had no caries, attrition, external resorption, cracks and fractures. The teeth were disinfected by 5.25% NaOCl (Golrang co, Tehran, Iran) for 30 minutes and were stored in a normal saline solution till the time when the preparation procedures were carried out. All the teeth were radiographed, using the parallel technique. The samples with internal resorption or without pulp chamber were excluded from the study. Finally, 24 teeth were selected.

Impressions of mesiodistal and buccolingual dimensions of each tooth were taken using immediate acrylic resin. To maintain a constant and reproducible position to the rim of Endoray II (DENTSPLY, Elgin, IL, USA), usually employed in parallel technique, they were randomly numbered. The baseline radiographs (Figure 1) were taken in mesiodistal and buccolingual directions, for each sample, using Digora Optime Cordless phosphor plate digital radiography (Sordex, Tussula, Finland), and an X-ray machine [CSN Industry, Cinisello B. (MI), Italy]. The radiographic cone was 22.9 cm long and 6 cm in diameter. The exposure time was 0.14 seconds. The pre-preparation images of each
Table 1 The means and standard deviations of pulp chamber wall thicknesses for buccal, lingual and proximal surfaces before and after preparation at cervical area, 1 mm and 2 mm above the cervical area in millimetre (N=24)

<table>
<thead>
<tr>
<th>Section surface</th>
<th>Cervical</th>
<th>1 mm above the cervical</th>
<th>2 mm above the cervical</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buccal</td>
<td>1.8±0.24</td>
<td>1.99±0.2</td>
<td>1.85±0.44</td>
<td>0.26</td>
</tr>
<tr>
<td>Lingual</td>
<td>2.02±0.3</td>
<td>2.14±0.27</td>
<td>2±0.52</td>
<td>0.25</td>
</tr>
<tr>
<td>Proximal</td>
<td>1.25±0.14</td>
<td>1.31±0.12</td>
<td>1.37±0.31</td>
<td>0.13</td>
</tr>
<tr>
<td>P Value</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 The mean and standard deviation of the pulp chamber wall thicknesses before and after preparation of incisal surface in millimetre (N=24)

<table>
<thead>
<tr>
<th>Section</th>
<th>Incisal</th>
<th>P value</th>
<th>Incisal</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buccolingual</td>
<td>3.7±0.8</td>
<td>0.78</td>
<td>3.7±0.85</td>
<td>1.57±1.15</td>
</tr>
<tr>
<td>Mesiodistal</td>
<td>2.28±0.085</td>
<td></td>
<td>1.57±1.15</td>
<td></td>
</tr>
</tbody>
</table>

Results

Regarding the primary wall thickness, Kolmogorov-Smirnov test showed that distribution of the samples followed the normal distribution curve (p>0.05).

Repeated measures ANOVA showed that the mean of pre- or post-preparation wall thicknesses of each surface were not significantly different at the three horizontal levels (p>0.05). Comparison of the initial and remained wall thicknesses in different sections and surfaces exhibited significant differences and the least amount of the RWT was observed in the proximal surfaces of cervical level (0.42±0.12 mm). Table 1 and 2 shows the mean of initial and remained wall thicknesses of the pulp chamber.

Discussion

Due to the widespread use of prostheses nowadays, particularly all-ceramic crowns, evaluation of the effect of these preparations on pulp vitality is necessary [1].
The results of this study highlight the effect of all-ceramic crown preparations on the RWT of the pulp chamber in mandibular incisors for following reasons: a) small dimension of enamel and dentine thickness, b) the importance of these teeth in aesthetic considerations, and c) in case of failure, removal of all-ceramic crowns without damaging the tooth is almost impossible.

To assess the effect of all-ceramic preparations on the wall thickness of pulp chamber, the pre- and post-preparation radiographs were provided using cordless phosphor-plate digital radiographs taken with the parallel technique and the initial and remained wall thicknesses were measured using Adobe Photoshop CS3 software. In studies of Murray et al. [8-9] and Zollner et al. [10] the measurements were carried out using an electron microscope. In this study, the initial and remained pulp chamber wall thicknesses of mandibular incisors were evaluated within a limited age range. Only a few studies [8-9, 20-24] have considered this issue. This study assessed the pulp chamber wall thicknesses in various surfaces in four sections.

To determine the magnification of digital radiography with the parallel technique, we compared the measurement of real calibre of a ball bearing with a digital one. The measurements were the same so the phosphor-plate digital radiography did not show any magnification. To provide an identical position in pre- and post-preparation X-rays, immediate acrylic resins were used to reduce minimum dimensional changes.

In this study RWT was not evaluated in the same conditions as in Murray's study and the results may be more accurate because of the all-ceramic shoulder crown preparation and evaluation of all the surfaces.

The pulp chamber wall thicknesses were measured at three horizontal levels (cervical, 1 mm and 2 mm above the cervical area) for buccal, lingual and proximal surfaces and also vertical section for evaluation of the incisal wall. The minimum wall thicknesses of pre- and post-preparation sections were observed at cervical level of proximal surfaces (1.25 mm and 0.42 mm, respectively). Murray et al. [22] showed that a RWT of 0.5 mm protects the pulp from injury. They also reported that maximum reactionary wall deposition occurred in a RWT of 0.25 to 0.5 mm [8] and that a RWT of 0.5 mm had a small effect on vitality of odontoblasts [9]. Zollner et al. [10] showed that RWT had a more profound effect on pulp injury than the type of tooth preparation, and maximum pulp reactions were reported in marginal pulp chamber area in RWT values of less than 2 mm. Pameijer et al. [24] reported that a RWT of 1 mm and Stanley et al. [23] showed that a RWT of 2 mm are essential for protecting the pulp. Our study showed that minimal RWT in proximal surfaces was less than 0.5 mm. Therefore, the possibility of pulp injury in mandibular incisors following all-ceramic crown preparations may be high. Valderhaug et al. [18] reported a low incidence of pulp injury in crowned teeth with vital pulps. Jackson et al. [16] reported that 5.7% of crowned vital teeth showed symptoms of irreversible pulpitis.

Some attentions including using plentiful water spray, non continuous preparation and less tapering wall are other important factors in preventing pulp injury. Jalalian and Aletaha [29] suggested more conservative preparation (0.7 mm) for zirconia crowns.

Conclusion
According to the results of the present study, the least amount of initial and remained wall thicknesses of pulp chamber were related to proximal surfaces, particularly in cervical areas. Therefore a reduction of preparation to 0.7 mm is suggested to prevent future pulp injury for mandibular incisors in 35 to 40-year-old patients and younger who require all-ceramic crown preparations.

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