Piola Rizzante, Fabio Antonio; Schlögel Cunali, Rafael; Soares Bombonatti, Juliana Fraga; Correr, Gisele Maria; Castiglia Gonzaga, Carla; Yoshio Furuse, Adilson

Indications and restorative techniques for glass ionomer cement

RSBO Revista Sul-Brasileira de Odontologia, vol. 12, núm. 1, enero-marzo, 2015, pp. 79-87

Universidade da Região de Joinville

Joinville, Brasil

Available in: http://www.redalyc.org/articulo.oa?id=153040039010
Literature Review Article

Indications and restorative techniques for glass ionomer cement

Fabio Antonio Piola Rizzante
Rafael Schlögel Cunali
Juliana Fraga Soares Bombonatti
Gisele Maria Correr
Carla Castiglia Gonzaga
Adilson Yoshio Furuse

Corresponding author:
Adilson Yoshio Furuse
Departamento de Dentística, Endodontia e Materiais Odontológicos
Faculdade de Odontologia de Bauru, Universidade de São Paulo
E-mail: furuse@usp.br

Received for publication: October 20, 2014. Accepted for publication: November 24, 2014.

Keywords: glass ionomer cements; biocompatible materials; dental restoration, permanent.

Abstract

Introduction: Due to its chemical, mechanical and biological properties, the glass ionomer cements (GIC) consist in one of the most versatile direct restorative materials, with many potential clinical indications, especially in the context of minimally invasive dentistry. Nevertheless, they have some limitations and require the knowledge of their characteristics and procedures of application in order to achieve their maximum potential. Objective: To demonstrate through literature review the main characteristics, indications, limitations and future perspectives for the use of GIC. Literature review: The database, such as Pubmed and Lilacs were used. Additionally, books were also evaluated and included. Conclusion: The GIC is in constant evolution and is one of the materials that are best suited in the context of preventive and conservative dentistry. It has satisfactory properties and versatility. On the other hand, presents inferior properties when compared to other direct restorative materials, requiring caution during its handling.
Introduction

Glass ionomer cements (GICs), also known as glass polyalkenoic cement, has a fundamental role in current Dentistry. This is not only because of the social and preventive aspect of this material when one considers dental caries and concepts based on scientific evidence and minimally invasive dentistry, but also its excellent physical-chemical-mechanical properties, such as fluoride release, adhesion to tooth structure, biocompatibility and coefficient of thermal expansion similar to that of dentin [40, 45]. Moreover, unlike other aesthetic adhesive materials, such as composite resins, adhesion to dental structures of GIC is less sensitive to technique and its quality increases with time [10].

Despite its good properties, constant changes, and improvements, so that GIC restorations show good clinical success, it is important to know its characteristics and proper technique of use. Thus, this paper aims to demonstrate, through literature review, the main characteristics, indications, limitations, and future aspects for the use of this material.

Literature review and discussion

Development and evolutions

Glass ionomer cements are available since the early 1970s [56] and are derived from silicate and zinc polycarboxylate cements. The polycarboxylate cements were the first materials to provide adhesion to tooth structures, mainly produced by the polycrylic acid to ensure their biocompatibility, because it is a weak and high molecular weight acid, which does not diffuse through the dentinal tubules. Based on this finding, the polycarboxylate cements gained quickly popularity as cementing agents, but could not be used as restorative materials because of the high solubility of unsatisfactory mechanical properties and unacceptable aesthetics caused by residual zinc oxide. Silicate cements, in turn, appeared on the market in the first decade of the twentieth century and were the first esthetic restorative materials, having anticariogenic properties due to the fluoride release and good dimensional stability, but had numerous disadvantages, including high disintegration and porosity in the oral environment, low color stability and the toxic action on the pulp [42] (Parula, 1975 #142). Glass ionomer cements then came from the replacement of the zinc oxide by an ionizable reactive glass. This reactive glass is similar to that existing in the silicate cements. Thus, a more durable, less soluble, and more translucent material was developed [33], with chemical bonding to the dental substrate by the bonding of calcium ions to carboxylic radicals existing in the enamel, dentin and cementum. It is noteworthy that in addition to adhesion to dental structures, GIC also bonds to many metals such as stainless steel, tin or Platinum covered by tin oxide and gold; but it does not adhere to porcelain, pure platinum, or pure gold [33, 36, 45].

Based on these initial studies, it was launched in the European market in the mid-1970s, the first GIC, produced by Dentsply, called ASPA (aluminum silicate and polyacrylate), with unsatisfactory properties such as reduced working time and longer setting time [40, 41].

The GICs are composed of powder and liquid and consist of polymeric matrices with ionic crosslinking around reinforcing glass particles [45]. The powder is composed of three basic components: silica (SiO2), alumina (Al2O3) and calcium fluoride (CaF2). The liquid is an aqueous solution of polyalkenoic acids with the addition of setting accelerators [39]. The setting reaction is acid-base type and starts from the mixture of powder and liquid to form a hydrogel salt, which acts as a binding matrix and unreacted glass particles acting as filler particles [31].

Since its development, the GICs have been constantly improved. During the 1970s, several studies have analyzed and modified the original formula, resulting in improvements in the material, which is now indicated as an excellent alternative for various procedures in practice, since the first formulations presented problems as short clinical time, unsatisfactory aesthetic, reduced working time, sensitivity to moisture variations (syneresis and imbibition), low mechanical strength and longer setting time. To enhance the slow setting reaction of ASPA, in 1976, low molecular weight chelating (tartaric acid) was added to the liquid, which accelerated the setting reaction and facilitated the incorporation of glass powder ions, resulting in ASPA II [9].

Another problem is the initial rapid gelation of liquid because of the formation of internal chains between the hydrogen ions, so the itaconic acid was incorporated into the liquid 1977 with ASPA IV [39].

The first major change in its composition happened during the 1980s, when metal dust particles were incorporated, seeking better mechanical properties and radiopacity (so-called Cermet GIC) [35, 50].
Another important development of the GIC occurred in the late 1980s, when the resin-modified glass ionomer cements appeared (RMGIC) [3]. This development has brought many advantages, such as control of working time, ease of handling, fast setting time, less sensitive to syneresis and imbibition and the opportunity immediately finishing procedure [40]. RMGICs have shown stable adhesion to dentin over the months. It is believed that this stability is related to both the chemical bonding mechanism to hydroxyapatite regard to micromechanical retention [52]. Franco et al. [17] and Fagundes et al. [13], in clinical trials with follow-up of 5 and 7 years, respectively, observed that the evaluated RMGIC presented a clinical performance higher than that of the composite resin. RMGICs tend to be employed because of the longest working time, improved physical properties and aesthetic qualities, and because they are more resistant to dehydration and cracks during setting than the conventional versions, chemically activated.

More recently, with the advent of ART (atraumatic restorative technique), there was the need to improve the physical properties of these materials, leading then to high viscosity GICs, with chemical activation. These materials have a greater number of particles with smaller sizes.

Susceptibility to syneresis and imbibition

Because of GIC and RMGIC setting reaction, sometimes they are more susceptible to syneresis and imbibition [59]. The syneresis is the loss of water due to evaporation of the liquid and can cause gaps and cracks in the cement surface. Moreover, contamination with water (imbibition) can cause the dissolution of the matrix formed by cations and anions in the surrounding areas [4]. These characteristics justify the need to protect the material after its insertion into the cavity with insulating materials such as: Vaseline, varnishes, fluid resins [6], or colorless nail polish [54].

GIC mechanical properties

Compared to resin composites, GICs have lower compressive strength and diametral tensile strength [40], lower resistance to wear [15, 18] and acid erosion [10, 44], and greater friability [38], making unfeasible their use in areas of high concentration of masticatory forces and aesthetic areas.

Another GIC feature is the low modulus of elasticity of the order of 7.3 GPa, half of the modulus of a micro-hybrid composite (15 to 20 GPa) [4], thereby giving it a unique elastic characteristic that will define some of its clinical indications, e.g., restoration of cervical lesions, because of the bending stress exerted in the area requiring the use of a material with better elastic properties [28].

The low modulus of elasticity also allows its use as a liner material, since the association of GIC with the resins assists in relieving of the forces resulting from the polymerization shrinkage. In this context, it is reported that the use of a glass ionomer as liner material caused a significant reduction in the cusp deflection compared with composite resin restorations without liner [2]. Sampaio et al. [46] observed that the use of RMGIC as liner resulted in lower crack formation on dentin/adhesive interface after laboratorial aging.

Capacity of fluoride release and storage

Among all the properties of GIC, one of the most important is its ability to release and store fluoride [51], which can be extended for 8 years [16]. It is known that fluorides are extremely important in the prevention and treatment of dental caries, having the main function of adsorption on the surface of the tooth in the form of CaF₂, protecting the tooth and favoring the remineralization process [32]. Given this ability to release and store fluoride, the GIC becomes an excellent choice of restorative material for the treatment of patients at high risk for caries.

This release occurs mainly in the first 24-48 hours, but decreases and stabilizes over time, although it can occur throughout the life of the clinical restoration, with the possible reintroduction of F⁻ ions [11, 41].

Adhesion to tooth structure

GICs present chemical adhesion to tooth structure by means of ion exchange. The carboxylic groups replace the phosphate ions of the substrate to establish ionic bonds with calcium ions derived from partially dissolved apatite crystals [11, 41]. This adhesion mechanism was shown by X-ray electron spectroscopy (XPS) in the study of Yoshida et al. [58].

This reaction is also observed for RMGICs [30], although RMGICs generally require that primers containing HEMA and polyacrylic acid are applied on the surface prior to its insertion. These primers infiltrate and polymerize on dentin forming micromechanical retention, similar to what occurs in the hybrid layer in the composites, and should be light cured [26].
It is noteworthy that the quality and intensity of GIC adhesion to tooth structure can be affected by factors such as physical strength of the material, the substrate nature, surface contamination and type of treatment and/or cleaning performed on the surface in which the restoration is inserted. Adhesion is severely hampered by the presence of smear layer, as this reduces the free energy of the dentin surface and therefore their reactivity, and is still able to harbor bacteria. Thus, treatment of the tooth surface with polyacrylic acid is essential [23].

It should be noted that, compared with the resins, ionomer cements have a lower bond strength to the dental tissue [10, 34, 45]. However, it is believed that this adhesion is reliable and resistant to disintegration [10]; Furthermore, the results obtained in microtensile tests should be evaluated with caution, because often cohesive failures caused by the material properties do not represent bond strength of the material, but the low cohesive strength of the restorative material, since GIC cohesive fractures were observed in transmission electron and scanning microscopy [57].

Biocompatibility

Ionomer cements have low pulp response compared to that produced by the zinc oxide and eugenol cements [53], similar to the response generated by zinc polycarboxylate cements [43].

This biocompatibility occurs because the polyacrylic acid is weak, with macromolecules of high molecular weight, prone to join the calcium of the tooth, making it difficult to move inside the dentinal tubules. Generally, they are less irritating to the pulp tissues when compared to resinous adhesives. However, in deep and very deep cavities, it is recommended the use of a liner with calcium hydroxide cement to ensure that the acid portion of the ionomer (although having low penetrability and being quickly quenched) can not cause any harm [8].

GIC biocompatibility occur not only for pulp tissues, but also for periodontal tissues because GIC is capable of reducing subgingival biofilm compared with resin composite restorations, not irritating the tissues if the biological principles are followed [47-49].

Coefficient of linear thermal expansion

GIC present a linear thermal expansion coefficient very close to that of the dental structures and it is suitable as support for undermined enamel (artificial dentin), without compromising the final bond strength of the restoration. This feature, combined with the chemical bonding capacity with the dental structures, clinically results in a reduced chance of marginal leakage. Note that this property is reduced in RMGIC, with values closer to those presented by the amalgam and composite resins [11, 40].

Classification, indications, limitations, and contraindications

Given GIC properties and characteristics, these materials can be classified according to their clinical indication and composition [39].

Concerning to clinical indication

Type I: Ionomers indicated for the cementation of inlays, crowns, fixed partial dentures, orthodontic appliances, and endodontic filling. They are fluid materials, also identified as Type I, CEM, C or Luting.

Type II: Ionomers indicated for restorations, presenting particles larger than those of Type I, also identified as R or FIL.

Type III: Ionomers indicated for lining, sealing of pits and fissures, also known as Bond and Lining or F.

Concerning to composition

Conventional GIC: Ionomers with conventional acid-base reaction, displayed as powder and liquid inside different flasks or encapsulated. The glass components and the fluoride are inside the powder and the acids components inside the liquid.

In anhydrous cements, the liquid acid component was freeze-dried (dehydrated) and incorporated into the powder. The liquid is usually distilled water or in an aqueous solution of tartaric acid, which accelerate the setting reaction. These cements have emerged in an attempt to better control the proportioning of powder and liquid and solve the problem of instability of polyacrylic acid, which is very volatile.

Metal reinforced GICs: The liquid is similar to that of the conventional ionomers, while the powder consists of a mixture of conventional powder with amalgam alloy particles or silver particles sintered with the glass. These cements have arisen with the expectation of improving GIC mechanical properties, and although the mechanical properties have been reported to be superior to conventional cements, these do not seem to be different when compared to
modern cements. The inclusion of metallic particles brought damage to materials in relation to fluoride release, adhesion to tooth structure, as well as the aesthetic damage arising from the darkening of the edges of the cavities. Cermet type GIC has been employed in invasive sealing of posterior teeth and some cases of crown reconstruction.

Resin modified GICs (RMGIC): Incorporation of resin components, primarily HEMA and initiators of polymerization, replacing part of the polyalkenoic acid liquid. These materials were introduced to overcome the problems of sensitivity to moisture, and poor initial mechanical properties associated with the conventional cements. In these materials, the original acid-base reaction is supplemented by a secondary polymerization process initiated by exposure to light. Regardless of the type and amount of resinous material present, so that these new materials could be classified as GIC, they must present adequate acid-base reaction to promote hardening, even in the absence of light.

High-viscosity GICs: Those employed in Atraumatic Restorative Treatment (ART) with high powder-liquid ratio and fast setting reaction.

Based on the classification presented, it can be inferred that the GICs are very versatile materials, indicated for preventive procedures (oral environment adequacy and pits and fissures sealing), restoration of areas of lower masticatory load (class I, class II vertical and horizontal slot, class III and class V restorations) [1, 55]; cavity lining; sandwich restoration (open and close); primary tooth restorations; cementation of post and cores, prostheses; and dentin replacement. Moreover, GICs have a fundamental role in ART [19, 20, 27].

GIC contraindications are: class II restoration involving the marginal ridge; class IV restoration and teeth with great loss of the labial/buccal enamel; cusp areas; and areas submitted to great masticatory load.

Another GIC limitation is related to aesthetics. As a restorative material, conventional GICs are not as aesthetic as composite resins, and therefore are not generally recommended for use in areas of significant cosmetic concern. The RMGIC, on the other hand, can be used in some aesthetically demanding areas, since they have better aesthetic qualities [45]. Notwithstanding, according to Navarro et al. [40], GIC optical properties greatly improved, allowing it to be suitably used in restorations, such as Class III. The authors also claim that conventional GICs have greater color stability when compared with those modified by resin.

A fast surface wear loss may occur in some cases, however, since the technique is less demanding, the GICs may function in many aspects, more successfully than the composites. Thus, as the surface properties are apparently lower than those of composite resins, ionomer cements have been widely reported as substitutes for sandwich type restorations [10]. An interesting finding is the inhibition of demineralization areas in restorations of dentin margins with GIC lining, in which the open sandwich technique was employed [52].

Whereas the GICs have unsatisfactory properties of resistance to erosion and abrasion, its application in high-risk patients can be compromised if educational measures regarding hygiene and control of sugar intake are not adopted.

Despite the aforementioned limitations, there are reports of significant percentages of success in clinical evaluations of extensive classes I and II cavities in molars restored with ART technique, comparable to the results obtained with the use amalgam [21, 25, 39], but GIC properties still need to be improved s [7].

Restoration techniques

Preliminary considerations

During the restorative technique, care must be taken to prevent early failure of the material. Among them, we can cite [39]:
1. Clean and dry the prepared cavity. The dental structure (dentin and enamel), before receiving the glass ionomer cement should be treated with weak acid solutions, such as polyacrylic acid (10 to 25%), in order to improve the adhesive characteristics of the cement by increasing the surface energy and wetting ability of the surface to be restored;
2. Proper powder-liquid ratio;
3. The vial of powder must be shaken before use (especially the anhydrous cement, in order to prevent excessive amounts of glass particles or lyophilized acid be mixed with the liquid);
4. The liquid bottle should be positioned vertically and at a distance from the glass plate to allow a free drop output;
5. Mixing time should follow the manufacturer's instructions;
6. The material to be inserted should present a wet brightness;
7. Caution should be taken during the material insertion to avoid bubbles inside the restoration. This can be prevented by using Centrix syringe;
8. Prevent the wet contamination;
9. Press the material with a matrix for 1 min
(chemically activated) or during light-curing (photo activated);

10. During the initial removal of the excesses, use the scalpel blade from the restoration towards the tooth structure;

11. The finishing procedure should be performed at the next appointment;

12. Apply the superficial protection immediately after the restoration. GICs are highly sensitive to water gain and loss. Aiming to protect these cements, one can use varnishes provided with the materials, fluid resins, or colorless nail polish;

13. Finishing and polishing procedures should be executed with lubricated instruments to avoid overheating of the restoration, maintaining the moisture of the restorative material.

In addition to these aspects, other care should be emphasized to obtain satisfactory results.

- Caution with the powder and liquid

  The flasks must be tightly closed to avoid the gain or loss of water, since the glass ionomer cements are essentially water. The liquid must not be stored in the refrigerator because it loses its original properties. The powder and mixing pad or plate can be kept in a refrigerator in order to increase the working time [39].

- Caution with the encapsulated cements

  Using the capsule as fast as possible after the breaking of the sheath that protects the environment. Press the clip that lines the fluid reservoir for at least 2 seconds, which will ensure the passage of all the liquid into the capsule. Use mixer device supplied by the manufacturer or a device that enables 4,000 rpm [39].

**Conclusion**

On this basis of this review, it is noted that the CIV are highly versatile materials and with great clinical potential. Based on the idea of improving the properties of these materials, making them even more effective, or enabling its use as biomaterials [24], some authors have proposed changes in its composition whether such changes can be further perspectives of the material. Among the proposed changes can be highlighted: the modifications by incorporating medications (e.g. chlorhexidine), aiming at the improvement in antimicrobial properties and prevention of secondary caries [12]; association with bioactive glass, aiming at improving the properties of remineralization and antimicrobial activity, making them even better for restorations in high-risk patients [29]; and insertion of polymers and nanoparticles in GIC matrix [14, 22] to improve the mechanical properties.

Thus, GICs are not only bioactive, but have characteristics of an intelligent material [10]. These materials are considered bioactive because they release fluoride and, as mentioned, are subject to changes in their formulations. They are considered intelligent, because that fluoride release to the oral environment is proportional to the acidity of the medium [10]. It is known that the fluoride release by ionomers occurs in greater quantities during the first 24 hours after its insertion into the cavity and, after this initial period, the release occurs in small amounts. It is interesting to note that even modified ionomer resin, have a clearance behavior when exposed to fluoride [37].

The biocompatibility of traditional glass ionomer cements has been a clinical concern. Upon initial mixing, there is a potential for causing sensitivity and produce pulp irritation. As the setting reaction proceeds, the pH increases from about 1 in early times to a range of 4 to 5. As the setting reaction nears completion, the final pH reaches 6.7 to 7. Once the acid groups are bound to polymer molecules that have limited diffusivity, any potential effects to the pulp from initial pH are limited to areas immediately adjacent to the material. If the amount of residual dentin at the nearest wall of the pulp chamber is less than 0.5 mm, it may be necessary to protect the dentin surfaces of the direct contact with GIC using a calcium hydroxide liner [45].

Although GICs present a less sensitive technique than that of resin composites, good results can only be obtained if GIC and the RMGIC are employed in accordance with appropriate clinical protocols, respecting the manufacturer's instructions and always carefully considering the indications, limitations and contraindications of the materials.

Since the principles advocated by Black [5], in 1908, the development of dental materials that can assist in the conservation of tooth structure has aroused. Thus, it is possible to start preventive and conservative dentistry. GIC is one of the materials that best fit the context of preventive and conservative dentistry and, as discussed in this review, has satisfactory properties and great versatility. On the other hand, it has some inferior properties, requiring some caution during handling and restoration. It is noteworthy that, despite their excellent properties, GIC is not the material of choice for all procedures and dental professionals should know their composition and properties,
to make a correct diagnosis of oral and systemic conditions of the patient, taking into account their needs and anxieties in order to ensure proper application, thereby reaching the clinical success of the restoration procedure.

References


5. Black GV. A work on operative dentistry: the technical procedures in filling teeth. Chicago: Medico-Dental; 1908.


