

## Chapter 1 : Smile enhancement the conservative way: Tooth whitening procedures

*Interest in bleaching teeth has grown dramatically in the last few years as new markets become available and stimulate further development. This guide is written to help the busy restorative dentist who needs to keep up to date with the types of product available, the techniques to use them effectively and safely, and how to use them in combination with restorative dentistry in treating patients.*

This article has been cited by other articles in PMC. Bleaching agents may affect the properties of dental materials. The aim of this study was to evaluate the effect of different polishing techniques on the surface roughness of composite resins submitted to the at-home and in-office bleaching treatment. Finishing step was performed after light curing L1 and polishing after 24 h with two systems L2. Then, specimens were submitted to the home or in-office bleaching procedures, and roughness was re-evaluated L3. The surface roughness Ra readings were measured at L1, L2, and L3 times using a profilometer. The polishing procedures decreased Ra for both composites compared to baseline values L1. The roughness of specimens polished with jiffy did not present significant difference after polishing step L2 and bleaching treatment L3. However, the groups polished with Sof-Lex discs had increase on the Ra values after bleaching. The polishing is an important procedure to reduce the roughness of dental restorations and composite surface polished with jiffy system improved the degradation resistance to the bleaching agents compared to Sof-Lex discs. Dental bleaching is a treatment that improves the appearance of teeth, and it is considered a safe procedure when well indicated and performed. Currently, dental restorations are performed mainly with microhybrid and nanofilled resin-based materials, nanocomposites showed similar mechanical properties of universal hybrids and high esthetic quality. The null hypotheses tested were that: The polishing techniques, The home-use and in-office bleaching agents, and The different composites would not affect the roughness according to the timespan tested. The factors considered were: Material in two levels, Polishing technique in two levels, Bleaching agent in two levels, and Timespan in three levels. Table 1 Open in a separate window Eighty circular specimens 5 mm in diameter and 2 mm in thickness of each material were made using a Teflon Mold. It was filled with one increment of the composite, covered with a mylar strip, and pressed with a g load. The initial surface roughness L1 was measured using a profilometer SurfTest ; Mitutoyo Corp. Then, the arithmetical average of surface roughness Ra parameter was obtained. The average of these three measurements was calculated as roughness value of the specimen. After this period, the polishing procedure was performed at low speed. Then a second surface roughness reading was performed immediately after polishing step L2 , 24 h after L1. Two bleaching sessions were performed with a 7-day interval between them. In each bleaching session, the three applications of 15 min totalizing 45 min of the bleaching agent were performed on the top surface of the specimen. After bleaching procedure, roughness was re-evaluated L3. The normality of the data was previously analyzed by the Kolmogorov-Smirnov test. The four factors in the study were: The roughness was performed on the same specimen in different evaluation times. The polishing procedures decreased surface roughness for both composite resins compared to baseline values L1. The roughness of the specimens polished with jiffy system did not present statistical difference after polishing step L2 and bleaching treatment L3. However, the groups polished with Sof-Lex discs had an increase on the surface roughness after bleaching. This findings are showed in Table 2. Table 2 Open in a separate window DISCUSSION The present investigation evaluated the surface roughness of microhybrid and nanofilled composite resins after different polishing techniques and at-home and in-office bleaching procedures. Restoration polishing is an important clinical procedure to obtain final smoothness surface, reducing plaque retention, and staining susceptibility. One possible explanation for this could be related to the composition of polishing systems. Jiffy polishers and brush are impregnated with SiC particles to provide composite polishing, while Sof-Lex discs are impregnated with Al<sub>2</sub>O<sub>3</sub> particles. In addition, despite both polishing systems produced smoothest surfaces, a jiffy is more advantageous clinically because accesses areas that not readily accessible to discs.

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This fact could be explained by the de-bonding of fillers from resin matrix by water uptake and stress corrosion cracking due to the action of free radicals generated during bleaching can have an adverse effect on the resinous matrix–filler interface. The active bleach agent HP is very unstable, its high oxidative capacity may cause adverse consequences for both organic and inorganic structures of resin-based composites. When the peroxide contacts with organic components of the composite it impairs the polymer linkages that form the network structure, besides causing alterations in the inorganic phase, reducing the long-term material performance. The surface roughness comparing nanofilled and microhybrid composites resins were similar; therefore the third null hypothesis was accepted. Previous studies have been observed that nanocomposites showed excellent surface quality, such as high polish and polish retention, similar to microfill, maintaining physical properties and wear resistance equivalent to the traditional composites. Several studies have shown that the performance of different composite resins is strongly influenced by the monomer composition. Therefore, it can be speculated that probably the damage was more evident on the resin matrix, filler content, and the interface between the organic matrix and filler due to the higher surface change caused by Sof-Lex polishing. Usually, anterior restorations are replaced after dental bleaching to improve shade matching. In situations such as deep cavities arising from noncarious lesions that warrant restoration and defective restorations that need to be repaired or replaced prior to bleaching procedures, the clinician can opt for lighter shades so that the restorations match better. This also applies to posterior restorations in which color match is not critical. Therefore, others properties should be investigated for better decision if replacement or repolishing of dental composite restorations is really necessary after bleaching procedures. Conflicts of interest There are no conflicts of interest. Carbamide peroxide bleaching agents: Effects on surface roughness of enamel, composite and porcelain. Abd Elhamid M, Mosallam R. Effect of bleaching versus repolishing on colour and surface topography of stained resin composite. Effect of bleaching gels on surface roughness of nanofilled composite resins. Mineral loss and color change of enamel after bleaching and staining solutions combination. Effect of curing lights and bleaching agents on physical properties of a hybrid composite resin. J Esthet Restor Dent. Peroxide bleaching agent effects on enamel surface microhardness, roughness and morphology. Discoloration of restorative materials after bleaching application. Effects of home bleaching on surface hardness and surface roughness of an experimental nanocomposite. Effect of bleaching on restorative materials and restorations – A systematic review. An application of nanotechnology in advanced dental materials. J Am Dent Assoc. Characterization of nanofilled compared to universal and microfilled composites. The effect of home bleaching agents on the surface roughness of tooth-colored restoratives with time. The effect of different bleaching agents on the surface texture of restorative materials. Surface roughness of packable composite resins polished with various systems. Rai R, Gupta R. In vitro evaluation of the effect of two finishing and polishing systems on four esthetic restorative materials. Surface finish produced on three resin composites by new polishing systems. Surface finish produced on resin composites by new polishing systems. Effect of finishing and polishing procedures on the surface roughness of packable composites. Gurgan S, Yalcin F. The effect of 2 different bleaching regimens on the surface roughness and hardness of tooth-colored restorative materials. Effect of two different bleaching regimens on the gloss of tooth colored restorative materials.

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## Chapter 2 : Advanced Restorative Dentistry | Pocket Dentistry

*Interest in bleaching teeth has grown dramatically in the last few years as new markets become available and stimulate further development. This guide is written to help the busy restorative dentist who needs to keep up to date with the types of product available the techniques to use them.*

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## Chapter 3 : Bleaching Techniques in Restorative Dentistry: An Illustrated Guide - Google Books

*Download Bleaching Technique in Restorative Dentistry. Interest in bleaching teeth has grown dramatically in the last few years as new markets become available and stimulate further development.*

Linda Greenwall Clinical The dangers of chlorine dioxide tooth bleaching Linda Greenwall clarifies the situation and dispels the myths on teeth bleaching techniques Introduction contain no more than 0. This limit is statu- bleaching products which a dentist supplies. This has come about due to Products Safety Regulations This is UK and ways of seeking a means to bypass the Scientific Committee for Consumer Products causing worry to these dentists so they are legislation and offer alternative to whitening. Many In the 18 months that followed, the debate beauty therapists and other non dental prac- UK dentists are now seeing patients who have continued to rage as more manufacturers and titioners, such as health spas and beauty spas experienced the damaging effects of chlorine importers sold equipment to dentists and, in- on cruise liners. Many of these companies dioxide tooth bleaching. There are not many creasingly, to beauty therapists. Was it legal to supplying these Chlorine dioxide agents are established protocols in how to deal with the supply products containing more than 0. Most of the products that beauty products will thus be under maritime age. It is the aim of this article to discuss the have proven effectiveness and safety studies legislation as the treatments are not officially dangers of this material as a bleaching treat- Haywood and Heymann contain a conducted in the UK soil. These products are thus subject to the ing the damage will be also discussed. The committee has product should cause harm to the consumer. The House of Lords counter products being sold direct to consum- ty and effectiveness of chlorine dioxide as a Judgement in June confirmed that tooth ers. They recommend that these products are whitening treatment on the pubmed website whitening agents are covered by European only prescribed and administered by dentists. The time scale on this is not clear. Truman is often credited with intro- and runs a multi disci- products illegally to their patients. As such drochlorite and acetic acid Haywood of Aesthetic Dentistry they will prosecute any non dentist for un- chlorine was also inserted into non-vital teeth Today magazine and has written a book called dertaking such whitening treatment no mat- in attempts to lighten them in the late s. Linda lectures all over the world on all aspects of Council GDC which they are at present deal- at the time advised that it was not worth the combining Bleaching with Aesthetic and ing with. At this present stage this means that effort to whiten these teeth. The most effec- Restorative Dentistry. She is also the President the Department of Trading Standards can send tive technique for bleaching nonvital teeth, of the British Bleaching Society. Intraoral view of teeth following whitening Figure 1a and b: Lateral views of the teeth - the arrows shows the difference between the teeth were not whit- ened were shiny and had not lost their lustre cium hydrochlorite and acetic acid Fasanara out of any lease agreements on the hardware. If eating is undertaken then Chlorine dioxide is a green-yellow gas The current chlorine dioxide Problems arising which oxidise rapidly. Chlorine dioxide has whitening treatments Many of the chlorine dioxide gels are acidic. As a result of the duction of oral malodour for breathe neutrali- a chairside procedure in the beauty spa. The acid effect directly on the teeth, the resultant sation. It is often used in the paper and pulp material consists of two products which are effect is that of etching the tooth permanently. One is a sodium chlorite and At the end if the treatment the teeth appear In relatively low concentrations of chlo- the other one portion contains a chlorine di- white and this may be due to the dehydration rine dioxide, when contained in or released oxide precursor CDP , such as sodium chlo- effects as with other power whitening chair- by tooth whitening compositions it may be rite, and another portion contains an acidulant side techniques. The tooth loses its tooth effective and useful in whitening teeth. The ACD containing 2. This loss of tooth lustre also makes the tooth whitening compositions, when placed of the two portions may be placed in contact tooth feel rougher. Many of the clients have in contact with the tooth surface, is observed with a stained tooth surface to effect whiten- reported that the teeth seem to pick up further to rapidly oxidise tooth stains, rendering the ing. The resulting dis- contact Montgomery This material is colouration is yellow to

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brown. Many patients then left in place for a period of about twenty report increased tooth sensitivity which is difficult to manage and not easy to desensitise. Usually three applications are applied to the teeth. It appears that the majority of non-dental practitioners who are using these treatments patient is then given a take home kit which contains further chlorine dioxide gels used as safe for teeth. These chlorine dioxide treatments are advertised as safe for teeth. The UK Beauty therapists either use either chlorine dioxide gels used as safe for teeth. Intraoral view showing etched appearance Figure 4: Close up detail of the central incisor Figure 5: Results of whitening with chlorine dioxide from another patient. Dealing with the discolouration: This is misleading information as the grapefruit juice has a very be difficult. This seminar will bring Surgeons. Am J Dent Sci 1: Quintessence Int and the recent changes that have been made, which Linda will also be hosting a full-day Kirk EC: For further information and to book your Tom S.

## Chapter 4 : Bleaching Techniques in Restorative Dentistry : Linda Greenwall :

*In book: Bleaching Techniques in Restorative Dentistry, Chapter: 7 Power Bleaching and In-office Techniques, Publisher: Martin Dunitz, London, United Kingdom, Editors: Dr Linda Greenwall, pp*

Take preoperative periapical radiographs and perform vitality tests. Replace any leaking restorations. Clean the teeth with pumice and water to remove extrinsic staining. Apply topical anaesthetic to gingival margins. Isolate each tooth to be bleached using individual ligatures. The end teeth should be clamped usually from second premolar to second premolar. Cover the metal rubber dam clamps with damp strips of gauze to prevent them from getting hot under the influence of the heat source. Etch the labial and a third of the palatal surfaces of the teeth with phosphoric acid for 60 seconds, wash, and dry. Thoroughly soak a strip of gauze in the hydrogen peroxide and cover the teeth to be bleached. Set the rheostat to a mid-temperature range and increase it until the patient can just feel the warmth in their teeth; then reduce it slightly until no sensation is felt. Keep the gauze damp by reapplying the hydrogen peroxide every 3-5 minutes using a cotton bud. Make sure that the bottle is closed between applications as the hydrogen peroxide deactivates on exposure to air. Apply the fluoride drops for 2-3 minutes. Note that postoperative sensitivity may occur and should be relieved with paracetamol. Assess the change—it may be necessary to repeat the process three to ten times per arch. Treat one arch at a time. Keep the patient under review as rebleaching may be required after a year or more. Take postoperative photographs with the original Vita shade tooth included. This technique is very time-consuming and re-treatment may be necessary, so the patient must be highly motivated. The technique can be used in the treatment of discolouration caused by pulp chamber sclerosis Fig. These cases require isolation of the single tooth. As the name suggests, it is carried out by the patient at home and is initially done on a daily basis. Take an alginate impression of the arch to be treated and cast a working model in stone. Relieve the labial surfaces of the teeth by about 0. The splint should be no more than 2mm thick and should not cover the gingivae. It is only a vehicle for the bleaching gel and is not intended to protect the gingivae. Instruct the patient on how to floss their teeth thoroughly. Perform a full-mouth prophylaxis and instruct them how to apply the gel into the mouthguard Fig. Note that the length of time the guard should be worn depends on the product used. Both urea and hydrogen peroxide have low molecular weights, allowing them to diffuse rapidly through enamel and dentine. This explains the transient pulpal sensitivity occasionally experienced with home bleaching systems. Although most carbamide peroxide materials contain trace amounts of phosphoric and citric acids as stabilizers and preservatives, no indication of etching or a significant change in the surface morphology of enamel has been demonstrated by scanning electron microscopy analysis. However, no evidence of this process has been noted to date in any clinical trials or laboratory tests, possibly because the urea and subsequently the ammonia and carbon dioxide released on degradation of the carbamide peroxide elevate the pH. There is an initial decrease in bond strengths of enamel to composite resins immediately after home bleaching, but this returns to normal within 7 days. This effect has been attributed to the residual oxygen in the bleached tooth surface which inhibits polymerization of the composite resin. The home-bleaching systems do not affect the colour of restorative materials. Any perceived effect is probably due to superficial cleansing. Minor ulceration or irritation may occur during the initial treatment. It is important to check that the mouthguard does not extend onto the gingivae and that the edges of the guard are smooth. If ulceration persists, a decreased exposure time may be necessary. If there is still a problem, allergy is a possibility. There are no biological concerns regarding the short-term use of carbamide peroxide. It has a similar cytotoxicity on mouse fibroblasts to zinc phosphate cement and Crest toothpaste, and has been used for a number of years in the USA to reduce plaque and promote wound healing. However, there are no long-term studies of its safety. Laboratory studies have shown that carbamide peroxide has a mutagenic potential on vascular endothelium and there may be harmful effects on the periodontium, together with delayed wound healing. Although this would appear to take home bleaching out of the remit of paediatric dentistry, it may still have a part to play in

cases of mild fluorosis. Irrespective of the clinical application, evidence suggests that annual retreatment may be necessary to maintain any effective lightening. This further highlights the importance of more research into the long-term effects of this treatment on the teeth, mucosa, and periodontium. The exact mechanism of bleaching in any of the methods described is unknown. Theories of oxidation, photo-oxidation, and ion exchange have been suggested. Conversely, the cause of re-discolouration is also unknown. This may be a combination of chemical reduction of the oxidation products previously formed, marginal leakage of restorations, allowing ingress of bacterial and chemical by-products, and salivary or tissue fluid contamination via permeable tooth structure. There is currently, and has been for some years, continued confusion relating to the legal position of dentists using tooth-whitening techniques which involve the use of bleach. The situation at the time of publication is that it is illegal in the UK to supply a product for the purpose of tooth-whitening if that product contains or releases more than 0. When considering such products for clinical use it is advisable to seek medico-legal advice. Known as the inside-outside bleaching technique, it is essentially a combination of the walking and vital bleaching techniques. Tooth preparation is the same as described for the walking bleach technique Section A custom-made tray see Fig. However, rather than creating space labially as in the vital bleaching technique, a small reservoir is created palatal to the affected tooth only. The tray is then worn full time for up to 4 days, with the gel being replaced every 2-4 hours. Once an aesthetically acceptable result is achieved, the access cavity is refilled appropriately. Long-term results for this approach are not yet available, but relapse is as likely as for any of the other bleaching techniques. This restorative technique uses recent advances in dental materials science to replace defective enamel with a restoration that bonds to and blends with enamel. Take preoperative photographs and select the shade Fig. Apply rubber dam and contoured matrix strips if required. Remove full extent of demarcated lesion with a round diamond bur down to the amelodentinal junction ADJ. Chamfer the enamel margins with a diamond fissure bur to increase the surface area available for retention if required. Etch the resultant cavity margins. Apply the chosen shade of composite, use a brush lubricated with the bonding agent to smooth and shape, and light-cure for the recommended time. Polish with graded Soflex discs 3M, finishing burs, and interproximal strips if required. Add characterization to the surface of the composite. Take postoperative photographs Fig. The localized restoration is quick and easy to complete. Despite the removal of defective enamel down to the ADJ, there is often no significant sensitivity and therefore no need for local anaesthesia. If the hypo-plastic enamel has become carious and this extends into dentine, administration of local anaesthesia will be necessary. Advances in bonding and resin technology make these restorations simple and obviate the need for a full labial veneer. Disadvantages are marginal staining, accurate colour match, and suboptimal aesthetics if the full extent of the demarcated lesion is not removed to the ADJ. Composite veneers may be direct placed at the initial appointment or indirect placed at a subsequent appointment having been fabricated in the laboratory. Conservative veneering methods may offer not just a temporary solution, but a satisfactory long-term alternative to the PJC. Before proceeding with any veneering technique, the decision must be made as to whether to reduce the thickness of labial enamel before placing the veneer. Certain factors should be considered. Log In or Register to continue Share this:

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## Chapter 5 : Bleaching Techniques in Restorative Dentistry PDF - Am-Medicine

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Tooth whitening is a cosmetic dentistry procedure that lightens teeth and helps to remove stains and discoloration. It is the most popular treatment by both men and women alike and the treatments available range from one-hour one-time dental visits to take-home do-it-yourself kits. Tooth whitening is popular because it can significantly improve the appearance of your teeth at much less cost and inconvenience than other techniques. Yellow or stained teeth are a common problem most Americans will develop at some point in their lives but can remedy with proper treatment. Our teeth contain enamel, a porcelain-like surface that started out sparkling white. Tooth enamel is designed to protect the teeth from the effects of chewing, gnashing, trauma and acid attacks caused by sugar. As more stains and debris accumulate because of normal wear and tear and eating habits, the teeth develop a dull, lackluster appearance. Tooth whitening exists to remove the stains and debris associated with diet and aging. Types of Tooth Stains There are two types of staining as related to teeth: Extrinsic Staining and Intrinsic Staining Extrinsic Stainingâ€” Extrinsic stains are caused by external factors such as coffee, red wine, tea, other dark-colored foods and drinks, tobacco and routine wear and tear. Essentially they are a natural part of life but they are unsightly and can be removed. Superficial extrinsic stains can be removed with good hygiene techniques such as regular brushing and dental check-ups with cleanings. More stubborn stains can be removed with more involved efforts like teeth bleaching or whitening. Intrinsic Stainingâ€” Intrinsic stains occur much deeper in the tooth than extrinsic stains, forming in the interior of teeth. The terms are generally mistakenly used interchangeably even though they have different meanings. Whitening sounds less harsh than bleaching and therefore is used even when products contain bleach. It really is a marketing technique more than anything else although there are some distinctions that should be made between over-the-counter OTC whitening and dentist bleaching, including: Mouthpiece Trays- Mouthpiece trays from the dentists as opposed to OTC trays are custom molded to fit the exact impression of your teeth. This allows for maximum contact between the whitening gel, which is applied to the mouthpiece tray, and the teeth. Additional Protective Measuresâ€” In an office setting, the irritation and concerns associated with the gums from gel contact are protected by your dentist as an extra preventive measure. Unsupervised Processâ€” A dentist-supervised at-home or in-office treatment may be safer because it allows the dentist to view your medical history and determine which course of whitening treatment is most appropriate for you. With OTC treatments, you are left on your own. Over-the-counter bleaching products are not endorsed by the ADA because the organization believes that professional consultation is important to ensuring safe and effective use. Just because a product does not meet the ADA standard does not mean it is not safe or ineffective. It is wise to consult with your dentist if you are concerned about a product you are interested in trying. Causes of Tooth Staining Food and diet are the most common culprits of teeth discoloration, but there are a number of causes that can incite discolored teeth. Below is a list of the top causes of teeth stains and discoloration according to a representative of the American Dental Association: Medicineâ€” Some over-the-counter medications and antibiotics can dull your teeth. Minocycline, a derivative of Tetracycline a bacteria-fighting antibiotic has been shown to turn teeth yellow in small children and can cause a permanent bluish-gray stain in adults. There are certain antihistamines that can also discolor teeth. Your dentist will be able to tell you if your medications are impacting the color of your teeth and if there may be alternatives to their use. Excessive Fluorideâ€” Fluoride in large concentrations can cause chalky white spots to appear on your teeth. Fluoride is generally good for teeth however people can get too much fluoride from drinking water with high concentrations of fluoride, or from excessive use of fluoride-containing toothpaste. A good suggestion would be to use a sensible pea-sized amount of toothpaste each time you brush. Genetics and Agingâ€” As you age the enamel of your teeth wears thin and the natural yellow or brown color of the

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underlying dentin layer shows through. Also, genetics play a role as some people just have naturally brighter or thicker enamel than others. Dental Damage- Trauma such as injury or falls can produce sizable cracks in the teeth, which collect large amounts of stains and debris. Drinking through a straw to protect your front teeth or swigging some water around after drinking dark fluids can offset their staining power. Colorful Foods” The habitual consumption of deep colored heavily pigmented foods such as cherries, blueberries, cranberries and soy sauce can quickly stain teeth. To avoid this brush your teeth soon after eating these types of foods. Bad Oral Hygiene” An obvious reason for dull or lackluster teeth, poor oral hygiene means that stain-producing substances are not routinely removed from your teeth and will allow bacteria to build up. The more you brush and floss properly the better chance you have at fighting off yellow and green stains that can result from bad habits. Teeth Whitening at Home and at the Dentist There are generally considered to be three teeth whitening options available today. The options rely heavily on your specific conditions and your preferences of treatments. Your dentist can help you make the best determination and discuss which options will fit your goals and budget. The choices include over-the-counter, in-office whitening, and take-home kits. Over-the-Counter” Over-the-counter whitening kits are the cheapest and most convenient of the teeth whitening options. These include whitening toothpaste, gels, rinses, strips, and trays. This type of whitening is recommended for people who have no fillings and healthy teeth. These types of products are typically considered to be the least effective, brightening teeth just a few shades. In-Office Whitening” In-office whitening offers the benefits of a significant color change in the shortest period of time. This process involves the use of a high-concentration peroxide gel, applied to the teeth by your dentist who ensures that the gums and mouth are protected from the application. The gel remains on the teeth for several 15 to minute intervals that add up to about an hour. Take-Home Kits” Take-home kits offer the convenience of at your leisure teeth whitening and provide professional results. The kits incorporate lower-concentrate peroxide gels that are applied in custom-made trays and worn in the mouth overnight or for a select time period during the day. These can only be provided by your dentist. Zoom Whitening Zoom Whitening is an in-office bleaching process that is widely known for its ability to quickly brighten teeth because of effects of discoloration. The complete procedure takes about one hour, but a preliminary evaluation and teeth cleaning is recommended prior to the treatment. Just as in a more common in-office whitening procedure, the lips and gums are safely covered. Then the dentist will apply the patented Zoom hydrogen peroxide whitening gel. The difference with Zoom is that its technique incorporates a special light that penetrates the teeth to break up stains and discoloration. During the process, the patient is free to relax, watch TV, or listen to music.

### Chapter 6 : The dangers of chlorine dioxide tooth bleaching | Linda Greenwall - calendrierdelascience.com

*This guide is written to help the busy restorative dentist who needs to keep up to date with the types of product available, the techniques to use them effectively and safely, and how to use them in combination with restorative dentistry in treating patients.*

### Chapter 7 : 6: Bleaching Techniques | Pocket Dentistry

*Vital bleaching can be further divided into at-home bleaching (with self-application of the bleaching agent by the patient as instructed by the dentist) and in-office bleaching (in which the dental team performs the bleaching procedure at the dental chair).*

### Chapter 8 : Direct Restorations: Internal Bleaching : Verifiable CPD Online - Dentistry

*restorative dentistry Abstract: The use of a variety of bleaching techniques has attracted much interest from the profession, as they are non-invasive and relatively simple to carry out.*

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## Chapter 9 : Bleaching Videos, Restorative, Dental Education Online

*After reviewing the historical development of bleaching techniques, the author found that in-office vital bleaching technique was introduced to manage the inter-arch color variation of teeth (i.e., the discoloration does).*