Effects of the Finishing Protocols and Oral Hygiene Procedures in the Microhardness and Surface Roughness of CAD/CAM Ceramics

Efectos de los Protocolos de Acabado y Procedimientos de Higiene Oral en la Microdureza y Rugosidad Superficial de las Cerámicas CAD/CAM

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ABSTRACT: The objective of this in vitro study was to evaluate the effects of finishing protocols and oral hygiene procedures on the surface and mechanical properties of CAD/CAM ceramics. Specimens (n = 96, (15x10x2mm) of the leucite glass-ceramic (LGC) and feldspathic ceramic (FP) received mechanical polishing or glazing. Surface roughness (Ra) and microhardness (VHN) were obtained with a profilometer and a hardness tester, respectively, before and after each oral hygiene procedure (TB: toothbrushing; PB: prophylaxis with paste and rubber cup; and BJ: prophylaxis with bicarbonate jet). ANOVA, paired t and Tukey’s tests were applied (a=0.05). For both materials, only BJ affected Ra’s values when mechanical polishing was performed. Moreover, no significant variations in VHN were observed only for LGC glazed with TB. Significant Ra and VHN changes in both materials were observed with BJ. Besides, BJ exhibited similar effects to TB on VHN, regardless of the material and finishing protocol used. Changes in mechanical and surface properties varied with the finishing protocol and the oral hygiene method. In general, prophylaxis with bicarbonate jet was the most harmful method for both materials and the type of finishing protocol did not have a protective effect against changes produced by oral hygiene methods.

KEY WORDS: ceramics, CAD/CAM, polishing, oral hygiene, surface treatment.

INTRODUCTION

Technological advances in restorative dentistry, as well as the great demand of patients for aesthetic treatment, has contributed to the improvement in restorative materials (Hu et al., 2020). Present dental ceramics exhibit good aesthetic, biological, mechanical, and functional properties (Pol & Kalk, 2011; Conrad et al., 2007). These characteristics vary depending on the material composition (Bajraktarova-Valjakova et al., 2018). Among the main advantages of ceramics, their chemical inertness ensures that restorations have a chemically stable surface, do not release potentially harmful elements, and minimize the increase in surface roughness (Ra) and the increase in abrasiveness or susceptibility to bacterial adhesion (Belli et al., 2018).

Finishing protocol of ceramics is a strategy employed to reduce the inherent roughness of these materials (Guilardi et al., 2019; Abdullah et al., 2019; Vasconcellos et al., 2006; Preis et al., 2012). Mechanical polishing or glazing can be performed, but which technique is better for each material remains unclear (Kanat-Ertürk, 2020; Maciel et al., 2019; Kurt et al., 2020; Alencar-Silva et al., 2019; Yilmaz & Ozkan, 2010; Alencar et al., 2022). Regardless of the material used in a restoration, it is subject to degradation and wear processes by various factors (Ludovichetti et al., 2018; Joshi et al., 2014; Kusuma Yulianto et al., 2019), such as chewing and daily oral hygiene procedures (Flury et al., 2017; Yuan et al., 2018).
Clinical longevity and aesthetics are dependent on the mechanical properties of restorative materials (Alencar et al., 2022; Goujat et al., 2018; Spitznagel et al., 2018). Previous studies showed that usual oral hygiene methods can degrade the surface of restorative materials and these effects can be dependent on the material composition (Honório et al., 2006; Rosentritt et al., 2015; Galloway & Pashley, 1987; Soares et al., 2010; Samra et al., 2012; Bollen et al., 1997).

In addition, are no scientific basis about what oral hygiene methods are better indicated for each restorative material (Bidra et al., 2016; Barbosa et al., 2012). The effects of these different methods on the mechanical and surface properties of indirect restorative materials should be clarified. Thus, this study aimed to analyze the surface properties of indirect restorative materials should effects of these different methods on the mechanical and material composition (Honório et al., 2015; Galloway & Pashley, 1987; Soares et al., 2010; Samra et al., 2012; Bollen et al., 1997).

**MATERIAL AND METHOD**

This *in vitro* study evaluated two CAD/CAM ceramic materials: Leucite glass-ceramic [IPS Empress CAD (Ivoclar Vivadent AG)] and Feldspatic Ceramic [CEREC Blocs (Dentsply Sirona)]. The sample size (n = 8/group) was defined using the G* Power 3.1.9 software (Faul et al., 2007) considering a minimum effect size of 45% - (roughness or microhardness) for the outcomes (Maciel et al., 2019), 80% statistical power, and 5% significance level. Specimens (15mm x 10mm x 2mm) were obtained from CAD/CAM ceramics blocks by using a cutting machine (Isomet 4000, Buehler, Lake Bluff, IL, USA) with Buehler diamond discs under refrigeration. In sequence, the specimens were randomized to receive mechanical polishing or glazing. Surface finishing and polishing were carried out with an automatic polishing machine (Metaserv 2000, Buehler, Lake Bluff, IL, USA) following a sequence of grift silicon carbide papers (3M ESPE, St. Paul, MN, USA) #360, #400, #600, #800, and #1200 (30 s per grift). The samples were washed in an ultrasound (Boekel Analog Model 139400, PA, USA) with distilled water for 15 min and then dried at room temperature. Glazing was performed by applying a thin layer to the samples, which were heated in a specific oven according to the manufacturer’s instructions.

The specimens were randomly divided into three groups (n = 8/material) based on the oral hygiene procedures:

1. **TB** - toothbrushing: Toothbrushing was carried out on a brushing simulation machine (Odeme Dental Research, Brazil) programmed to perform 80,000 cycles, simulating 5 years. The brushing system, which involved a machine that had an internal ambient temperature of 370 °C, was operated at a frequency of 2 Hz. Middle toothbrushes were used (Regular Regular TEK, Johnson & Johnson Ind.Com.Ltda., SJdos Campos, São Paulo, Brazil). A solution was prepared with a dentifrice (Colgate Total 12 Clean Mint, Colgate-Palmolive Company, Sao Paulo, SP, Brazil) and distilled water to immerse the specimens during brushing.

2. **PR** - prophylaxis with prophylaxis paste and rubber cup: Prophylaxis with a rubber cup and oil-free prophylactic paste (Shine, Maquira; Maringá, Brazil) coupled to a low-speed micromotor (Dabi Atlante, Ribeirão Preto, Brazil) was performed for 20 s.

3. **BJ** - prophylaxis with bicarbonate jet: Specimens were subjected to prophylaxis carried out with a Profi Neo appliance (Dabi Atlante, Ribeirão Preto, Brazil) and Polident sodium bicarbonate powder (Polidental). The tip of the apparatus was positioned at an angle of 90° and 5.0 mm away from the specimen surface for 20 s.

After oral hygiene methods were performed, all specimens were again washed in an ultrasonic bath with distilled water for 15 min and dried at room temperature based on previous property measurements.

Three readings of Ra were performed using a digital profilometer (Mytutoyo Corporation, Tokyo, Japan; Model SJ 400), and the means were determined as the Ra (m) value. The reading accuracy of the profilometer was 0.01 m, the reading length was 2.4 mm, the active tip velocity was 0.5 mm/s, and the radius of the active tip was 5 m.

The surface microhardness was assessed using a hardness tester equipped with a Vickers diamond indenter. Five indentations were made in each specimen under 20 N load and a 20 s dwell time. Vickers hardness number (VHN) was calculated with the following equation: $H = \frac{P}{2d^2}$, where $P$ is the load in Newton, and $d$ is the average of diagonal values. The Ra and VHN were measured before and after the oral hygiene methods.
Data from all response variables were evaluated for the presence of outliers (Tukey’s method), the assumption of normality (Shapiro–Wilk test), and homoscedasticity (Levene test). Ra and microhardness data were submitted to two-way ANOVA. Normality was confirmed in all cases \((p \geq 0.061)\). The Tukey’s test was performed when significant differences were detected by ANOVA. Paired t-test was applied to show differences in the evaluated parameters with each oral hygiene method. A \(p\)-value less than .05 was determined to indicate statistical significance. SPSS version 22.0 (IBM) was used for data analysis.

**RESULTS**

The results of 2-way ANOVA (Table I) demonstrated that finishing protocol influenced the variations in Ra \((p = .002 - FP; p<.001 - LGC)\) and microhardness \((p<.001\) for both materials). The influence of oral hygiene methods on Ra was observed only for LGC \((p=0.043)\), and oral hygiene methods did not influence the microhardness for any material. Furthermore, the interaction among the tested factors was not significant only for Ra in the LGC group \((p=.447)\). A comparison of the effect after different oral hygiene methods for both glazed and polished groups is presented in the Table II.

A significant difference in Ra variation was observed between the polished and glazed groups in both materials when BJ was performed. For the LGC groups, Ra variations also differed with TB. For the FP group, the finishing protocols significantly influenced microhardness variations. In the groups with mechanical polishing, TB was the procedure that promoted a high reduction, similar to BJ. PR promoted decreased microhardness when glazing was performed, whereas the other procedures promoted increased microhardness.

In the LGC group with mechanical polishing, nonsignificant effects of oral hygiene methods were observed in the variations in microhardness. However, when glazing was performed, PR decreased microhardness, similar to the effects of TB. In addition, increases in VHN were observed in BJ.

**Table I. Two-way ANOVA results for comparison of surface roughness and microhardness.**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Feldspatic Ceramic</th>
<th>Leucite Glass Ceramic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surface Roughness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral hygiene procedures (OHP)</td>
<td>0.047</td>
<td>3.394</td>
</tr>
<tr>
<td>Finishing protocol (FP)</td>
<td>10.532</td>
<td>60.068</td>
</tr>
<tr>
<td>OHP X FP</td>
<td>7.532</td>
<td>0.820</td>
</tr>
<tr>
<td><strong>Microhardness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral hygiene procedures (OHP)</td>
<td>2.298</td>
<td>1.569</td>
</tr>
<tr>
<td>Finishing protocol (FP)</td>
<td>154.265</td>
<td>67.267</td>
</tr>
<tr>
<td>OHP X FP</td>
<td>13.732</td>
<td>7.303</td>
</tr>
</tbody>
</table>

\*F - multifactorial; \(\dagger\) 2-way ANOVA; a significant statistically \((a=0.05)\).

**Table II. Mean results \(\pm\) standard deviation and post hoc comparisons for variation in surface roughness (Ra) and microhardness (VHN).**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Polishing</th>
<th>Glaze</th>
<th>Polishing</th>
<th>Glaze</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ra</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB</td>
<td>-0.02 (\pm) 0.02(^{Aa})</td>
<td>-0.01 (\pm) 0.04(^{Aa})</td>
<td>-0.01 (\pm) 0.02(^{Ba})</td>
<td>-0.11 (\pm) 0.06(^{Aa})</td>
</tr>
<tr>
<td>PR(\dagger)</td>
<td>0.01 (\pm) 0.19(^{Aa})</td>
<td>-0.02 (\pm) 0.08(^{Aa})</td>
<td>0.01 (\pm) 0.02(^{Ba})</td>
<td>-0.07 (\pm) 0.01(^{Aa})</td>
</tr>
<tr>
<td>BJ(\dagger)</td>
<td>0.05 (\pm) 0.01(^{Ba})</td>
<td>-0.07 (\pm) 0.06(^{Aa})</td>
<td>0.03 (\pm) 0.01(^{Ba})</td>
<td>-0.08 (\pm) 0.04(^{Aa})</td>
</tr>
<tr>
<td>VHN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB</td>
<td>-122.31 (\pm) 35.88(^{Aa})</td>
<td>26.16 (\pm) 24.45(^{Bb})</td>
<td>-63.82 (\pm) 44.19(^{Aa})</td>
<td>-8.14 (\pm) 24.51(^{Bab})</td>
</tr>
<tr>
<td>PR(\dagger)</td>
<td>-65.03 (\pm) 38.97(^{Ab})</td>
<td>-17.37 (\pm) 14.70(^{Ba})</td>
<td>-52.33 (\pm) 34.33(^{Aa})</td>
<td>-22.43 (\pm) 14.38(^{Aa})</td>
</tr>
<tr>
<td>BJ(\dagger)</td>
<td>-84.24 (\pm) 35.33(^{Aa})</td>
<td>29.76 (\pm) 12.39(^{Bb})</td>
<td>-72.37 (\pm) 9.39(^{Aa})</td>
<td>27.18 (\pm) 6.93(^{Bb})</td>
</tr>
</tbody>
</table>

\(*_{TB}:\text{toothbrushing; }\dagger_{PR}:\text{prophylaxis with propy paste and rubber cup; }\dagger_{BJ}:\text{prophylaxis with bicarbonate jet. In the same parameter and material, different uppercase letters (horizontally) and different lowercase letters (vertically) denote mean significantly different (p-value <.05).})*
Table III shows the mean results for Ra and VHN after different oral hygiene methods. For both materials, when mechanical polishing was performed, only BJ affected Ra. BJ also was the only procedure that affected the FP glazed group. However, for the LGC glazed group, all oral hygiene methods decreased Ra. When TB was performed, no significant variations were found in the VHN values only for the LGC glazed group.

Table III. Mean ± standard deviation for surface roughness (Ra) and microhardness (VHN) before and after oral hygiene methods.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Feldspatic Ceramic</th>
<th>Leucite Glass Ceramic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>After</td>
</tr>
<tr>
<td>Ra Polishing TB</td>
<td>0.15 ± 0.02</td>
<td>0.13 ± 0.01</td>
</tr>
<tr>
<td>PR</td>
<td>0.14 ± 0.02</td>
<td>0.15 ± 0.02</td>
</tr>
<tr>
<td>BJ</td>
<td>0.12 ± 0.03</td>
<td>0.17 ± 0.03</td>
</tr>
<tr>
<td>Glaze TB</td>
<td>0.49 ± 0.11</td>
<td>0.48 ± 0.07</td>
</tr>
<tr>
<td>PR</td>
<td>0.49 ± 0.11</td>
<td>0.46 ± 0.08</td>
</tr>
<tr>
<td>BJ</td>
<td>0.49 ± 0.08</td>
<td>0.42 ± 0.05</td>
</tr>
<tr>
<td>VHN Polishing TB</td>
<td>461.94 ± 35.87</td>
<td>339.62 ± 13.84</td>
</tr>
<tr>
<td>PR</td>
<td>457.55 ± 46.62</td>
<td>397.45 ± 23.09</td>
</tr>
<tr>
<td>BJ</td>
<td>423.18 ± 22.21</td>
<td>338.94 ± 26.09</td>
</tr>
<tr>
<td>Glaze TB</td>
<td>292.80 ± 13.96</td>
<td>318.96 ± 10.99</td>
</tr>
<tr>
<td>PR</td>
<td>300.62 ± 16.24</td>
<td>283.25 ± 16.95</td>
</tr>
<tr>
<td>BJ</td>
<td>297.17 ± 9.87</td>
<td>326.93 ± 6.63</td>
</tr>
</tbody>
</table>

*TB: toothbrushing; PR: prophylaxis with prophy paste and rubber cup; BJ: prophylaxis with bicarbonate; Paired t test.

DISCUSSION

Finishing protocols are essential for finalizing restorative procedures with ceramics. The literature remains inconclusive on the superiority of mechanical polishing or glazing on the surface and mechanical properties of ceramics (Alencar et al., 2022). Besides, the possible clinical implications of oral hygiene methods depending on the surface treatment performed remain unclear. In this study, the effects of finishing protocols on the surface and micromechanical properties exposed to different oral hygiene methods were analyzed. Our results demonstrated that some oral hygiene methods promoted more changes than others. Furthermore, these changes were dependent on the material and finishing protocol. Thus, the null hypotheses were rejected.

Mechanical polishing and glazing are two external surface procedures used in ceramic restorations (Preis et al., 2012; Kurt et al., 2020; Alencar-Silva et al., 2019). Polishing removes traces of milling and scratches on the surface to reduce roughness (Bollen et al., 1997). Thus, polishing is considered a reduction process. By contrast, glazing consists of applying a thin fluid layer to the surface, making it an addition process (Vasconcellos et al., 2006). The superiority of one of the finishing protocols in obtaining enhanced surface smoothness or mechanical properties is unclear (Kanat-Ertürk, 2020; Maciel et al., 2019; Kurt et al., 2020; Alencar-Silva et al., 2019; Yilmaz & Ozkan, 2010; Alencar et al., 2022).

In this study, the effects of the performed finishing protocols on changes in the properties observed varied among the materials and oral hygiene methods. In terms of hardness, the effect of finishing protocol was not significant only for LGC submitted to PR. However, for roughness, finishing protocol altered the effects of BJ for all materials and the performance of TB on LGC. Performance differences for BJ with different finishing protocols may be justified by the protective effect of glazing on air abrasion (Kanat-Ertürk, 2020; Maciel et al., 2019; Kurt et al., 2020; Alencar-Silva et al., 2019). The effects of this procedure on the properties of restorative materials remain unclear, and further studies are needed.
The effects of different hygiene procedures on the surface properties of direct restorative materials and the enamel are reported in the literature (Honório et al., 2006; Rosentritt et al., 2015; Galloway & Pashley, 1987; Soares et al., 2010; Samra et al., 2012). In the direct restorative materials, BJ appears to be effective in removing pigments, increasing the longevity of restorative procedures. However, BJ has no deleterious effect on surface properties (Honório et al., 2006; Galloway & Pashley, 1987). However, our results demonstrated that BJ had deleterious effects on the mechanical and surface properties of the evaluated ceramics. Similar roughness variations were found for each material when the same finishing protocol was performed, regardless of the oral hygiene methods conducted. However, hardness variations were affected by oral hygiene methods.

Variations in mechanical and surface properties of ceramics with BJ were dependent on the finishing protocol. In polished materials, BJ caused abrasion and increased roughness. In the groups that received glazing, the opposite effect was observed, resulting in high smoothness. There are no reports in the literature to support these results. However, sodium bicarbonate particles are believed to cause an abrasion on the ceramic surface. Thus, the abrasion may reverse mechanical polishing, justifying an increase in Ra in the groups that received this finishing protocol.

At the best level of knowledge of the authors, this study is the first to report the effects of the oral hygiene procedures commonly observed in clinical practice on the surface and mechanical properties of ceramics that received different finishing protocols. Our results suggested that hygiene procedures should consider the properties of the restorative material used and the finishing protocol performed to ensure the longevity of restorative procedures.

There are limitations to this in vitro study. The oral hygiene methods with parameters applied to simulate in vivo conditions could not reproduce the dynamic oral environment, such as changes in pH, masticatory forces, and the presence of bacteria and saliva. Furthermore, the uniform flat surface of the specimen may lead to behavior that differs from the curved contours of crowns. However, no standardized protocol has been established to correspond with the physiological oral environment. Therefore, future studies that include additional parameters are needed for in vivo simulations, and their impact on the clinical longevity of restorative materials should be clarified.

The main findings of this study show that different finishing protocols promoted different roughness and microhardness variations to different oral hygiene methods. The longevity of ceramic restorations seems to be dependent on the finishing protocol and oral hygiene methods. Knowing the deleterious effects arising from the association of finishing protocol with oral hygiene methods are fundamental for clinical decision making.

**CONCLUSION**

Within its limitations, it can be concluded that CAD/CAM ceramics that receive different finishing protocols present different variations to different hygiene methods. Bicarbonate jet prophylaxis seems to be the hygiene method most deleterious to the properties of the tested ceramics, regardless of whether they receive mechanical polishing or glaze. Besides, greater variations in microhardness, regardless of the hygiene method, were observed for ceramics that received mechanical polishing. Therefore, the success of ceramics restorations can vary depending on the finishing protocol and oral hygiene method. The most suitable oral hygiene method should be determined by the clinician according to the finishing protocol and CAD / CAM ceramic used.

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prueba de Tukey (a=0.05). Para ambos materiales, solo BJ afectó los valores de Ra cuando se realizó el pulido mecánico. Además, no se observaron variaciones significativas en VHN solo para LGC vidriado con TB. Se observaron cambios significativos de Ra y VHN en ambos materiales con BJ. Además, BJ exhibió efectos similares a TB en VHN, independientemente del material y protocolo de acabado utilizado. Los cambios en las propiedades mecánicas y superficiales varían con el protocolo de acabado y el método de higiene oral. En general, la profilaxis con chorro de bicarbonato fue el método más perjudicial, tanto los materiales como los protocolos de acabado dependieron del material y protocolo de acabado utilizado y la situación de la superficie. Además, no se observaron variaciones significativas en afector los valores de Ra cuando se realizó el pulido mecánico.

PALABRAS CLAVE: cerámica, CAD/CAM, pulido, higiene oral, tratamiento de superficies.

REFERENCES


