Stainless steel crowns

* Restoration of choice for the primary molar with caries affecting more than one surface
* SSCs are available for:1- anterior and posterior teeth but mostly posterior teeth.

2- for permanent molars badly destructed 6

3-child with MIH

**Advantages:**

Extremely durable and superior to multi-surface fillings

Relatively inexpensive

Minimal Technique Sensitivity during placement

Offers advantage of full tooth coverage

**Indications:**

Primary molars with extensive carious lesions

Following pulpotomy and pulpectomy procedures

Fractured primary molars

Developmental problems such as; amelogenesis imperfecta, enamel hypoplasia, and dentinogenesis imperfecta

In patients with high caries susceptibility

An abutment for certain appliances such as space maintainers

Patients where routine oral hygiene measures are impaired (patients with special needs

In patients undergoing restorative care under GA

Infra-occluded primary molar

**Contraindications:**

1. If the primary molar is close to exfoliation with more than half of the roots are resorbed.
2. Patients with a known nickel allergy or sensitivity

* SSCs are flexible and elastic.

Flexible: they are capable of bending easily without breaking.

Elastic: they are capable of resuming the normal shape spontaneously after distortion

* why we don’t prepare the buccal or lingual surface of primary teeth.?

To save the buccal bulge on primary molar that provide retention

* The snap sound means good size and fit

**Preparation:**

The preparation is very simple; occlusal and interproximal reduction.

We use Fine tapered fissure bur or needle bur*.*

The gingival finish line should be 1mm below the gingival margin.why?

To give retention and good cemntal seal

**Crown Selection:**

The kit that we use is 3M (Upper and lower D’s and E’s, from sizes 2 to 7)

it’s written on the buccal side of the crown whether it’s an upper or lower crown; that’s how we can differentiate between both sides)

well-fitting crown --🡪marginal gingiva will blanch

# cementation

1. Resin bonded cement is the best (highest tensile bond strength, retention and least microleakage)
2. The next best luting agent is resin modified glass ionomer +the bonding agent
3. Conventional glass ionomer cement
4. The least effective cement is zinc polycarboxylate

# Occlusion

The primary dentition has the ability to adjust to a slightly opened bite of 1 mm or so over a few weeks with no adverse effect.

The occlusion returns to pretreatment level after 15-30 days

**Gingival Condition:**

No any increase in supra-gingival plaque accumulation associated with SSCs except in defective margins or where excess cement has been retained.

**The Hall Technique:**

* It’s a method for managing carious primary molars were decay is seen under preformed metal crowns without local anesthesia, tooth preparation or any caries removal
* GI cement is used for cementation
* Crowns were not placed on any teeth with clinical signs and symptoms of pulpal involvement
* Contraindication:

1. -irreversible pulpal involvement
2. -insufficient sound tooth left to retain the crown
3. -patient cooperation where the clinician can’t be confident
4. -parent or child unhappy with esthetics

* Indication:

1. for an active, early to moderate proximal lesion involving the dentine in primary molars with no signs or symptoms of pulpal involvement
2. for moderately advanced occlusal lesions where the extend of the cavity would make it difficult to obtain a good seal with an adhesive restorative material

* the good predictor of success when a hall crown is placed:

A visible band of normal appearing dentine between the carious lesion and the dental pulp on a bitewing radiograph

* Two main methods of seating the crown:  
  1)finger pressure (by the clinician)  
  2)occlusal force (by the child)
* Child should bite fairly on the crown for 2-3 minute
* If we have a tight contact and can’t put the crown; use a separator for a week