

## **Tensile Bond Strength of Resin Composite and Ceramics**

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### **I. Introduction**

Buonocore explained the acidification of the enamel with liquid solution in liquid form in 1955 and the formation of resin tags with the penetration of resin monomers into the resulting microporosities and the formation of a micromechanical bond after polymerization. The enamel bonding technique has become standard and accepted, and problems with dentin bonding have been experienced. However, with the development of various bonding systems, there has been a significant improvement in bonding to dentine (Kugeland Ferrari 2000). Dental adhesives have many classifications in the scientific literature. Functional based classification; It is presented to contain three main groups of adhesives: total-etch, etch and rinse adhesives, self-etch adhesives and glass-ionomer adhesives (Van Meerbeek et al 2003).

After introducing the acid enamel roughening technique to increase adhesion to the enamel, Buonocore has seen an incredible improvement in the bonding of dental adhesives and resins to enamel and dentine in 40 years. While the first dental adhesives were attached only to enamel, they showed little or no connection to the dentine. Subsequent generations, while maintaining a strong enamel connection, also increased the bond strength of dentin to cover the dentin margins. The use of adhesive techniques with resin composites has been used for the restoration of decayed or broken teeth, as well as for filling erosion and abrasion defects in the cervical areas. In addition, modern adhesive techniques allow the correction of non-aesthetic shapes, positions, proportions or colors by adding restorative material to the tooth.

Production processes and capacity of CAD / CAM systems continue to improve. Despite the method of obtaining restoration by abrading the blocks, the method of creating restoration by adding the material continues to progress in this context. As porcelain blocks are prepared before, CAD / CAM systems are expected to be used more widely in the future due to their advantages such as less error in baking of the material and no need for laboratory operations (Çelik 2012).

Our aim in this study is; To compare bond strength of composite and porcelain laminar restorations in *in vitro* conditions.

### **II. Materials and methods**

For the bond strength test, 55 newly extracted upper human incisors were used. Teeth were cleaned with the help of pumice and rubber. In molds prepared with silicone impression material, teeth were embedded in autopolymerizing acrylic (Meliodent; Heraeus Kulzer, Hanau, Germany). Laminar burs were used for laminar preparation (Meisinger, Düsseldorf, Germany). First, the depth of preparation was determined with depth determination burs (834-016, 834-021 Meisinger, Düsseldorf, Germany). Later, a labial preparation was made with burs that cut at a depth of 0.5mm. The incisal overlap was finished with the preparation. The samples, whose preparations were completed, were sent to the laboratory. Laminated veneers were prepared using E.max CAD and Empress CAD porcelain blocks. The compatibility of the laminar veneers with the teeth was checked. The incompatible veneers were adapted and made ready to be glued. Before applying the veneers, 37% phosphoric acid was applied to the tooth surfaces for 15 seconds according to the manufacturer's instructions. Teeth were washed and dried. Panavia F 2.0 (Liquid A, Liquid B, Panavia F 2.0 Kuraray Dental, Japan) and porcelain samples were glued one by one according to the manufacturer's instructions.

For the bond strength test, 50 newly extracted human upper incisors were collected. Teeth were cleaned and kept in saline. Laminar preparation was done as prepared in porcelain samples. Before applying restorative materials, 37% phosphoric acid was applied to the tooth surfaces for 15 seconds according to the manufacturer's instructions. Teeth were washed and dried. In the first group, Clearfil® SE Bond (Kuraray Co, Japan) was applied and polymerized according to the adhesive company's instructions. Restoration is completed with Filtek Ultimate (3M ESPE, St Paul, USA) composite resin. In the second group, All Bond SE (BISCO, Schamburg,

USA)

adhesive resin was applied according to the manufacturer's instructions and the restoration was completed with the All Purpose Body (BISCO, Schamburg, USA) composite resin.

The samples, whose restorations were completed, were stored at 37 °C in the oven for 24 hours. The teeth, the roots of which were separated 2mm below the cement-enamel joint, were glued to the acrylic blocks with their crowns on top. Rods containing ~1.25-mm

dentin-adhesive interface were obtained so that the teeth were perpendicular to the adhesive surface in the low-speed sectioning device with a diamond separator. The thickness of the rods was measured again with a digital caliper. On average, 4-5 sticks were obtained from each tooth. The resulting rods of cyanoacrylate adhesive (Patex Henkel, Turkey) on the microtensile test apparatus (Micro Tensile Tester is Bisco, USA) placed in a multi-glued to the T apparatus. Tensile strength was applied at a speed of 1mm / min until fracture occurred between the tooth and the composite. The force at which the breakage occurred was recorded in Newton and the breakage area was calculated using a digital caliper. Refraction values in MPa were calculated using the formula below.

After the bonding test, the surfaces of all samples were examined under a stereomicroscope at x40 magnification. Fracture types; It was classified as (1) adhesive break between dentin and bonding, (2) mix break, (3) cohesive break in dentin, (4) cohesive break in composite (Price and Hall 1999, Can-Karabulut 2009). The bond strength test was evaluated by One-way ANOVA and Tukey HSD tests.

### III. Results

The average, standard deviation, maximum and minimum values of the micro-tensile bond strength tests of four materials. In our study, the highest microtensile bond strength was found in Filtek Ultimate ( $26.69 \pm 6.67$  MPa) (Table 1). A statistically significant difference was observed between the groups ( $p = 0,000$ ;  $p < 0.05$ ). In the advanced analysis conducted to see the difference between the groups, Filtek Ultimate and Aelite microtensile bond strength values were found statistically significant compared to other materials ( $p < 0.05$ ), but there was no statistically difference between them ( $p = 0.061$ ;  $p > 0.05$ ) (Table 1). But Filtek Ultimate ( $26.69 \pm 6.67$ ) had higher bond strength than Aelite ( $20.92 \pm 12.09$ ). Empress ( $6.71 \pm 4.14$ ) had higher bond strength than E.max ( $3.64 \pm 2.11$ ) (Table 1), but there was no statistically difference between the two materials ( $p = 0.776$ ;  $p > 0.05$ ). E.max was found to have the lowest bond strength among all materials ( $3,64 \pm 2,11$ ) (Table 1). When we look at the difference between materials as composites and porcelain, it was seen that there was a high degree of difference ( $p = 0,000$ ;  $p < 0.05$ ). As a result, the bond strength of composite materials was found to be higher than the bond strength of porcelain materials (Graphic 1). All fracture types are summarized regardless of the adhesive type, the most observed type of fracture was found to be adhesive type fracture. Fracture before testing was only seen in E.max restorations and these samples were not used. Adhesive fracture type was generally observed in porcelain (Empress: 58%, E.max: 72%) and composites (Filtek Ultimate: 69%, Aelite: 73%). Cohesive fractures were more common in Aelite and Filtek Ultimate than Empress and E.max.

### IV. Discussion

Composites produced in 1970s have been the most preferred material in aesthetic restorations from past to present. They have been widely used for their aesthetic properties, attachment to the tooth structure, and easy and fast application. Today, it is claimed that aesthetic restorations using porcelain material are better in terms of biological compatibility than others (Wendt et al 1992). In addition, it is known that porcelain is preferred for both anterior and posterior restorations due to its advantages such as better abrasion resistance than composite resins, no polymerization shrinkage when using porcelain blocks (Baunan and Heideman 1991, Rykke 1992, Hornbrook and Crispin 1994). However, there are major disadvantages such as the construction of porcelain restorations require precision and long time, they are fragile, they wear the opposite tooth (El-Mowafy 2000).

Laboratory tests contribute to clinical evaluations by allowing the development and initial evaluation of restorative materials. Our hypothesis was accepted that composite laminar restorations will show higher bond strength than porcelain laminar restorations.

Since the experiments related to dental materials are time consuming, difficult and in some cases impossible to perform directly in vivo conditions, these problems were tried to be eliminated by creating experimental mechanisms that mimic the oral environment. For this purpose, aging methods such as thermal cycle, water soaking and load application are used (Arcoria et al 1990). Thermal cycle is the process of restoration and imitation of temperature changes in which the teeth are exposed in the mouth (Arcoria et al 1990, Atta et al 1990, Wendt et al 1992). In thermal cycle process, water temperatures vary between 4 °C-5 °C and 50 °C-60 °C. The samples are kept alternately in these water baths for 20-60 seconds and this process is repeated between 500-20.000 cycles (Arcoria et al 1990). In our study, thermal cycle test was applied to the samples in order to ensure compatibility with the oral environment.

Thermal cycles were applied to all samples 500 times at  $5 \pm 1$  ° C and  $55 \pm 1$  ° C. Teeth were kept at each temperature for 1 minute.

Shear test is one of the most frequently used methods in the literature to evaluate the bond strength of restorative materials (Özcan et al 2007). However, some researchers prefer modified tensile tests to prevent the formation of irregular interface forces (El Zohairy et al 2003). In the tensile tests, however, the form and geometry of the samples affect the results. Tensile testing and shear testing methods may not give real information about the bond strength of materials alone due to their irregular force distribution during force loading (Azer et al 2000). In addition, it was reported in these tests that the breakage model may cause cohesive breaks and may cause erroneous results. In microtensile tests, it is said that the force distribution is more homogeneous, therefore the types of fracture are more adhesive (Amaral et al 2006). For this reason, we preferred the microtensile test method in our study. In this study, All Bond SE, one of the adhesives used with Aelite composite, is a single-stage self-etch adhesive from the same company. One study found that All Bond SE has higher bond strength than Clearfil S 3 (Hass et al 2011). In another study, it was reported that All Bond SE provides good attachment to the near-root dentine (Onay et al. 2010). In another study, it was stated that the other adhesive Clearfil SE Bond we use with Filtek Ultimate has high bond strength especially when roughened to the enamel (Llie et al 2006). In many studies, Clearfil SE Bond has been reported to bind not only to enamel but also superficial and deep dentine (O'Keefe and Powers 2001, Perdigao et al 2001, Kaaden et al 2002, Nikaido et al 2002). Many researchers even accept Clearfil SE Bond as the gold standard because of its high connection in dentine (De Munck et al 2009, Mine et al 2009, Sarr et al 2010, Van Meerbeek et al 2010). We can say that composite laminar restorations have good bond strength and adhesives are used. DüNDAR et al (2007) found that the porcelain binding values obtained by shear test method are higher than the binding values obtained by microtensile test method. However, they said that more homogeneous results were obtained with the microtensile test method. The obtained microtensile binding strengths are between 9-15 Mpa. These results are similar to our study. The porcelain bond strengths obtained in our study (IPS Empress;  $6 \pm 4$  Mpa and IPS E.max;  $3 \pm 2$  Mpa) are as low binding values. According to the results obtained, the bond strength of IPS Empress was found higher than IPS E.max. In addition, the results obtained with the microtensile test method were higher for IPS Empress than IPS E.max, whereas the shear test method had the opposite bond strength for the opposite IPS E.max. Therefore, although it is said that more homogeneous results are obtained with the microtensile test method, shear test may be a more suitable method to measure the bond strength of IPS E.max.

The bond strength results we obtained in composite samples (20-26 MPa) are higher than porcelain samples (3-6 MPa). In a study related to Panavia F and other resin cements (Variolink 2, Rely X Unicem, Rely X ARC), it has been reported that, although resin cements have similar chemical properties, their physical properties differ and polymerization methods can create differences (Kumbuloglu et al 2005). Mak et al (2002) found in their study that Clearfil SE Bond has a higher bond strength in dentine than Panavia F and stated that the reason for this may be that Panavia F contains more fillers. In another study with Panavia F, the lowest bond strength compared to other resin cements (Choice, Rely X) was observed in Panavia F (16.1 MPa) (Mak et al 2002). As a reason, it was concluded that the concentration of acidic monomers of the ED primer in it was due to excessive concentration. It has

been stated that most acidic monomers may have low bond strength due to their non-polymerization. In this study, the resin cement used may be the factor causing the bond strength of porcelain laminar restorations compared to composite laminar restorations.

In this study, the types of fracture were shown as adhesive, cohesive or mixed. Fracture before testing was only seen in E.max restorations. Adhesive fracture type was generally observed in porcelain (Empress: 58%, E.max: 72%) and composites (Filtek Ultimate: 69%, Aelite: 73%). Cohesive fractures were more common in Aelite and Filtek Ultimate than Empress and E.max. Generally, cohesive fractures are seen at higher bond strengths (Sarr et al 2010). In this study, we can say that the bond strength of composite restorations is better than fracture types. The low rate of cohesive fractures of porcelain restorations and especially the pre-test fracture in E.max restorations may be due to the force applied during the preparation of test samples. It causes the samples to break before and during the test as a result of defects that occur while preparing samples at the dentine-adhesive-porcelain interface (Tanumiharja et al 2000). The force exerted during the acquisition of samples may have caused premature disruption of the binding of more fragile porcelain.

### **Conclusion**

In general, it was found that composite laminar restorations were bonded higher than porcelain laminar restorations. The bond strength of the materials was Filtek Ultimate, Aelite, IPS Empress, IPS E.max, from highest to lowest respectively.

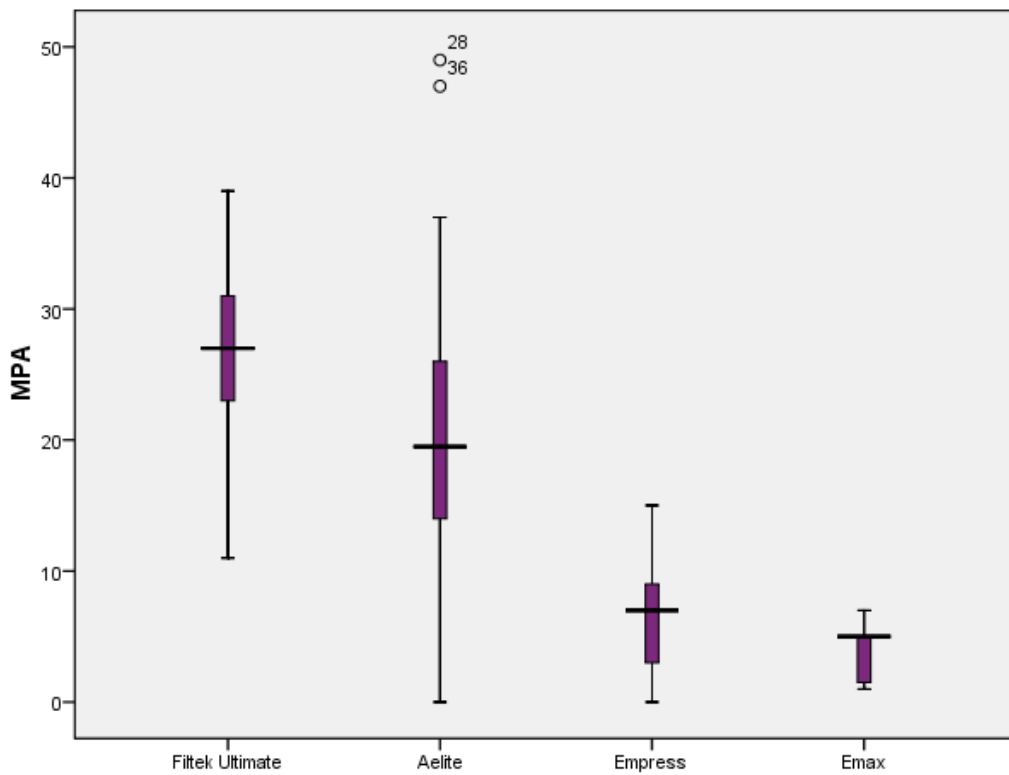
References

1. Kugel G, and Ferrari M. Thescience of bonding: fromfirsttosixthgeneration. J AmDentAssoc. 2000;1:20-25.
2. Van Meerbeek B, Munck JD, Yoshida Y, Inoue S, Vargas MA, Vijay P, Landuyt KV, Lambrechts P, Vanherle G. Adhesiotoenamelanddentin: Currentstatusandfuturechallenges. OperDent. 2003; 28:215-35.
3. Çelik G, Sarı T, Üşümez A. Bilgisayar destekli diş hekimliği ve güncel CAD/CAM sistemleri. CU Dişhek Fak Derg. 2012;16.1:74-82.
4. Can-Karabulut DC, OzFT, Karabulut B, Batmaz I, İlk O. Adhesiotoprimaryandpermanentdentinand asimple model approach. EurJDent. 2009;1:32.
5. Price RB, Hall GC. Invitrocomparison of 10-minute versus 24-hour shearbondstrengths of sixdentinbondingsystems. QuintessenceInt. 1999;30:122-34.
6. Wendt SL, McInnesPM, Dickinson GL. Theeffect of thermocycling in microleakageanalysis. Dent. Mater. 1992;8.3:181-84.
7. Baunann MA, Heidemann D. Biocompatibility of dentalinlayceramics, "Proceedings of theinternational symposium on computer 103 restorations: State of the art of thecererecmethod" Berlin QuintessenceVerlag, 1991; 373-76.
8. Rykke M. Dentalmaterialsforposteriorrestorations. EndodDentTraumatol. 1992;8.4:139-48.
9. Hornbrook DS, Crispin BJ. Indirectanddirectcompositerestorations, "ContemporaryEstheticDentistry: Practice Fundamentals".Tokyo: Quintessence Publishing Co Ltd. 1994. p.137-54.
10. El-Mowafy O. Management of extensivecariouslesions in permanentmolars of a childwithnonmetallicbondedrestorations-a casereport. J Can DentAssoc. 2000;6:302-7.
11. Arcoria CJ, Vitasek BA, Ferracane, JL, Microleakage of compositeresinrestorationsfollowingthermocyclingandinstrumentation. Gen Dent. 1990;2:129-31.
12. Özcan M, Barbosa SH, Melo RM, Galhano GÁP, BottinoMA. Effect of surfaceconditioningmethods on themicrotensilebondstrength of resincompositetocompositeafteragingconditions. Dent Mater. 2007;23.10:1276-82.
13. Atta MO, Smith BG, Brown D. Bond strengths of threechemicaladhesivecementsadheredto a nickel-chromiumalloyfordirectbondedretainers. JProsthetDent. 1990;2:137-43.
14. Wendt SL, McInnesPM, Dickinson GL. Theeffect of thermocycling in microleakageanalysis. Dent. Mater. 1992;8.3:181-84.
15. Özcan M, Barbosa SH, Melo RM, Galhano GÁP, BottinoMA. Effect of surfaceconditioningmethods on themicrotensilebondstrength of resincompositetocompositeafteragingconditions. Dent Mater. 2007;23.10:1276-82.
16. El Zohairy AA, De Gee AJ, Mohsen MM, Feilzer AJ. Microtensilebondstrengthtesting of lutingcementstoprefabricated CAD/CAM ceramicandcompositeblocks. Dent Mater. 2003;7:575-83.
17. Azer SS, Drummond JL, Campbell SD. Cyclicloading of OPC all-ceramiccrowns. AmAssocDentRes. 2000;79:343-43.
18. Amaral R, Özcan M, Bottino MA, Valandro LF. Microtensilebondstrength of a resinacementtoglassinfiltratedzirconia-reinforcedceramic: theeffect of surfaceconditioning. Dent Mater. 2006;22.3:283-90.
19. Hass V, Folkuenig MS, Reis A, Dourado LA. Influence of adhesiveproperties on resin-dentinbondstrength of one-step self-etchingadhesives. JAdhesDent. 2011;5:417.
20. Onay EO, Korkmaz Y, KıremiçA. Effect of adhesivesystemtypeandrootregion on thepush-outbondstrength of glass-fibrepoststoradiculardentine. IntEndod J. 2010;43:259-68.
21. Ilie N, Kunzelmann KH, Hickel R. Evaluation of micro-tensile bondstrengths of compositematerials in comparisontotheirpolymerizationshrinkage. Dent Mater. 2006;7:593-601.
22. O'Keefe KL, Powers JM. Adhesion of resincompositetocorematerialstodentin. Int J Prosthodont. 2001;14:451-56.
23. Perdigão J, Eiriksson S, Rosa BT, LopesMG. GomesEffect of calciumremoval on dentinbondstrengths. QuintessenceInt. 2001;32:142-46.
24. Kaaden C, Powers JM, Friedl KH, Schmalz G. Bond strength of self-etchingadhesivestodental hard tissues. Clin Oral Invest. 2002;6:155-60.
25. Nikaido T, KunzelmannKH, OgataM, Harada N, YamaguchiS, CoxCF, Tagami J. The in vitrodentinbondstrengths of twoadhesivesystems in class I cavities of humanmolars. J AdhesDent. 2002;4:31-9.
26. De Munck J, Van den Steen PE, Mine A, Van Landuyt KL, Poitevin A, Opdenakker G, Van Meerbeek B. Inhibition of enzymaticdegradation of adhesive-dentininterfaces. J DentRes. 2009;12:1101-106.
27. Mine A, De Munck J, Cardoso MV, Van Landuyt KL, Poitevin A, Kuboki T, Van Meerbeek B Bondingeffectiveness of twocontemporary self-etchadhesivestoenamelanddentin. J Dent. 2009;37.11:872-83.
28. Sarr M, Kane AW, Vreven J, Mine A, Van Landuyt KL, Peumans M, Lambrechts P, Van Meerbeek B, De Munck J. Microtensilebondstrengthandinterfacialcharacterizationof 11 contemporaryadhesivesbondedto bur-cutdentin. OperDent. 2010;35-1:94-104.
29. Van MeerbeekB, Peumans M, Poitevin A, Mine A, Van Ende A, Neves A, De Munck J. Relationshipbetweenbond-strengthtestsandclinicaloutcomes. Dent Mater. 2010;26.2:100-21.
30. Dündar M, Özcan M, Gökçe B, Çömlekoğlu E, Leite F, Valandro LF. Comparison of twobondstrengthtestingmethodologiesforbilayeredall-ceramics. Dent Mater. 2007;5:630-36.
31. Kumbuloglu O, Lassila LVJ, User A, Toksavul S, VallittuPK. Shearbondstrength of compositeresincementstolithiumdisilicateceramics. J Oral Rehabil. 2005;2:128-33.
32. Mak YF, Lai SC, Cheung GS, Chan AW, Tay FR, Pashley DH. Micro-tensile bondtesting of resincementstodentinand an indirectresincomposite. Dent Mater. 2002;8:609-21.
33. Sarr M, Kane AW, Vreven J, Mine A, Van Landuyt KL, Peumans M, Lambrechts P, Van Meerbeek B, De Munck J. Microtensilebondstrengthandinterfacialcharacterizationof 11 contemporaryadhesivesbondedto bur-cutdentin. OperDent. 2010;35-1:94-104.
34. Tanumiharja M, Burrow MF, Tyas MJ. Microtensilebondstrengths of seven dentinadhesivesystems. Dent Mater. 2000;16:180-7.

**Table 1. Materials bond strength (Mpa).**

Material	N	Mean±SD	Minimum	Maximum
<b>Filtek</b>	26	26,69±6,67	11	39
<b>Ultimate</b>				
<b>Aelite</b>	26	20,92±12,09	0	49
<b>Empress</b>	17	6,71±4,14	0	15
<b>E.max</b>	11	3,64±2,11	1	7

Graphic 1. Bonding strength of restorative materials.



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