Different Clinical Applications of Bondable Reinforcement Ribbond in Pediatric Dentistry

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ABSTRACT
Ribbond is a bondable, biocompatible, esthetic, translucent and easy-to-use reinforced ribbon. By virtue of its wide spectrum of intended properties, it enjoys various applications in clinical dentistry. This case report demonstrates usage of Ribbond as a space maintainer, a fixed partial denture with a natural tooth pontic, an endodontic post and cores and a splint material in children. Ribbond can be used as an alternative to conventional treatment in pediatric dentistry. (Eur J Dent 2009;3:329-334)

Key words: Ribbond; Fixed partial denture; Endodontic post; Trauma splint; Space maintainer.

INTRODUCTION
The development of fiber-reinforced composite (FRC) technology has brought a new material into the realm of metal-free, adhesive esthetic dentistry.¹ Not only has the combination of composite resin and FRC been shown to have significant benefits in terms of mechanical properties,² the possibility of direct chairside application and the ability to bond to tooth structure make FRC an attractive choice for a variety of dental applications.³⁵

Different fiber types such as glass fibers, carbon fibers, kevlar fibers, vectran fibers, polyethylene fibers have been added to composite materials.⁶ Glass fibers consisting of glass interlaced filaments, improve the impact strength of composite materials. They have excellent esthetic properties, but do not easily stick to resinous matrix.⁷ Carbon fibers prevent fatigue fracture and strengthen composite materials, but they have a dark color, which is undesirable esthetically.⁶,⁸,⁹ Kevlar fibers made of an aromatic polyamide, are the evolution of nylon polyamide.⁴ They increase the impact strength of composite materials. However, they are also unesthetic, and hence, their use is limited.¹⁰ Vectran fibers are synthetic fibers of a new generation, made of aromatic polyesters. They show a good resistance to abrasion and im-
Pact strength, but they are expensive and not easily wielded. Polyethylene fibers improve the impact strength, modulus elasticity, and flexural strength of composite materials. Unlike carbon and Kevlar fibers, polyethylene fibers are almost invisible in a resinous matrix and for these reasons, seem to be the most appropriate and esthetic strengtheners of composite materials.

Ribbond is a spectrum of 215 fibers with a very high molecular weight. First introduced to the market in 1992, Ribbond consists of bondable, reinforced ultra-high-strength polyethylene fibers with a high elasticity coefficient (117 GPa) that makes them highly resistant to stretch and distortion and a high resistance to traction (3 GPa) that allows them to easily adapt to tooth morphology and dental-arch contours. Ribbond fibers easily absorb water because of the “gas-plasma” treatment to which they are exposed. This treatment reduces the fibers’ superficial tension, ensuring a good chemical bond to composite materials. Ribbond is bio-compatible, esthetic, translucent, practically colorless and disappears within the composite or acrylic without show-through. Ribbond fibers are also characterized by an impact strength five times higher than that of iron.

Ribbond can be used in stabilizing traumatized teeth, restoring fractured teeth and creating a fixed partial denture and for direct-bonded endodontic posts and cores, orthodontic fixed lingual retainers and space maintainers. Despite this versatility, there are few reports on the use of Ribbond in pediatric dentistry. Therefore, this case report aimed to present four different applications of Ribbond as an alternative procedure in pediatric dentistry.

CASE REPORTS

Case 1: Fixed space maintainer

A 7-year-old girl was referred to the pediatric dental clinic with an extracted primary maxillary right second molar. According to the patient’s parents, the molar had been extracted one month earlier (Figure 1a). Following clinical and radiographic examinations, the decision was made to create a fixed-space maintainer using Ribbond (Ribbond Inc., Seattle, WA, USA). The length of the dental arch between the neighboring teeth (54-16) was measured (21 mm), and the required length of 2-mm-wide Ribbond was cut with the special scissors supplied by the manufacturer to prevent unraveling. The Ribbond was wetted with Single Bond (3M/ESPE, St. Paul, MN, USA) and protected from exposure to light until ready for use. The palatal surfaces of the abutment teeth were cleaned with a non-fluoridated pumice paste, etched with 37% phosphoric acid (Etch-37 with BAC, Bisco, USA), rinsed and dried. Single Bond and a flowable composite resin (Aelite Flo, Bisco, Inc., Schaumburg, USA) were applied to the enamel surfaces, the Ribbond was placed, and slight pressure was applied using a rounded instrument to create close contact during the curing process. The Ribbond was coated with flowable composite, the excess composite was removed, and the composite was cured for 20 s using an LED curing unit (Elipar Free Light II, 3M/ESPE, St. Paul, MN, USA; light intensity: 1000 mW/cm²). The embrasures were shaped to facilitate good oral hygiene, and the composite was polished using a polishing disc (Figure 1b).

Case 2: Fixed partial denture with a natural tooth pontic

A 12-year-old girl was referred to the pediatric dental clinic with the chief complaint of having lost a permanent maxillary right lateral incisor. According to the parents, the tooth was jarred...
from its socket as the result of a sports accident six days earlier. Immediately following the injury, the tooth was wrapped in a paper towel. Following clinical and radiographic examinations, the decision was made to create a fixed partial denture reinforced with Ribbond using the natural tooth as a pontic (Figure 2a). The root of the tooth was removed below the cemento-enamel junction, and the coronal pulp chamber was cleaned and filled with a light-cured composite resin (Z250, 3M/ESPE, St. Paul, MN, USA). The lingual surface of the crown was trimmed and polished. Following completion of etching and bonding procedures, a thin layer of flowable composite resin was applied (without curing) to the lingual and interproximal surfaces of the abutment teeth, a length of 2-mm-wide Ribbond was placed on the lingual surface of the teeth, and slight pressure was applied with a hand instrument to create close contact at the interproximal area. The excess resin composite was removed, and the Ribbond was light-cured for 20 s. The lingual surface of the pontic was then prepared for bonding. A thin layer of flowable composite was applied to the natural tooth pontic, which was placed in the desired position on the Ribbond and cured for 20 s (Figure 2b). The patient’s occlusion was checked for premature contacts, and the resin composite was polished using a polishing disc (Figure 2c).

Case 3: Endodontic post and core
A 10-year-old girl was referred to the pediatric dental clinic with a complaint of dental caries. Intraoral and radiographic examination revealed hypoplasia of the mandibular left second premolar (Figure 3a,b). Treatment plan was developed that aimed to avoid any future malocclusion by maintaining the mandibular left second premolar for as long as possible, after which time an implant replacement would be inserted. Due to extensive damage to the tooth structure, the decision was made to restore the mandibular left second premolar tooth using an endodontic post. The endodontic procedure was performed, and the root canal was obturated using gutta-percha (Spident, SPI Dental Mfg. Inc, Korea) and Seal Apex sealer (Kerr, Italia). The post hole was shaped using Gates Glidden drills (Roydent, West Palm Beach, FL), cleaned with 5% sodium hypochlorite and dried. The depth of the post space was measured using a periodontal probe, and two lengths of 3-mm-wide Ribbond were cut, each measuring twice the depth of the post space and 3-4 times the height of the core build-up. The root canal wall was etched for 15 s, washed for 30 s and then gently air-dried. Excess water was removed from the post space using paper points (Spident, SPI Dental Mfg. Inc, Korea). The adhesive system (Ed Primer II A&B) was applied using a microbrush in 2 consecutive coats and gently air-dried to evaporate the solvent. The Ribbond was wetted using a bonding agent, folded in a V-shape and coated with dual-curing resin cement (Panavia, Kuraray Medical Inc., Japan). The first piece of ribbon was then placed in the post space in a facial-lingual direction, and a second length of ribbon was placed inside the first piece at a right angle (Figure 3c). Excess resin cement was removed, and the Ribbond was light-cured for 20 s. The lingual surface of the pontic was then prepared for bonding. A thin layer of flowable composite was applied to the natural tooth pontic, which was placed in the desired position on the Ribbond and cured for 20 s (Figure 2b). The patient’s occlusion was checked for premature contacts, and the resin composite was polished using a polishing disc (Figure 2c).
was removed, and the cement was cured for 20 s. The restorative procedure was completed by building up the tooth using Z250 composite resin (Figure 3d,e).

**Case 4: Splint traumatized teeth**

An 11-year-old girl was referred to the pediatric dental clinic two hours after a traumatic injury resulting from a sports accident. Clinical examination revealed subluxation and moderate mobility of the permanent maxillary central incisors. The decision was made to splint the primary canine and canine teeth for patient comfort using a 2-mm-wide strip of Ribbond. The labial surfaces of the teeth were etched, rinsed and dried, and Single Bond was applied. To insure semi-rigidity, the interproximal region was not etched or bonded. After applying a flowable composite to the enamel surfaces, the Ribbond was pressed through the composite against the teeth and cured. The Ribbond was then coated with additional flowable composite and cured again for 20 s (Figure 4a). Two weeks later, the Ribbond splint at the interproximals was cut with a diamond bur. Then, the splint was removed from the abutment by sliding a scalpel blade between the Ribbond and the teeth on the most distal end. The remaining adhesive was removed with a tungsten carbide bur (Komet H284; Brasseler Co., Lemgo, Germany) in a low-speed handpiece under coolant water and surfaces were polished with disks (Figure 4b).

**DISCUSSION**

Not only do polyethylene fibers improve the impact and flexural strength and the modulus of elasticity of composite materials, they are barely visible within the resin matrix. For these reasons, polyethylene fibers appear to be the most appropriate and esthetic strengtheners of composite materials. This article presents 4 different applications of the polyethylene fiber Ribbond in pediatric dentistry.

**Space maintainer**

Various types of space maintainers can be used to avoid malocclusion as a result of premature loss of primary teeth. Removable appliances may be broken or lost, and they provide inadequate treatment results if not worn as prescribed. Properly designed, fixed appliances are not only less of a nuisance to the child patient than removable appliances, they are also less damaging to oral tissue. Polyethylene fiber-reinforced composite used as a fixed space maintainer offers many advantages.
FRC has an esthetic appearance, is easily manipulated, can be quickly inserted in a single-visit procedure that requires no laboratory services, poses no risk of damage to abutment teeth and is easy to clean.\(^{16,17}\)

**Fixed partial denture**

The loss of maxillary incisors in childhood has always been problematic, requiring immediate attention to restore both aesthetics and function.\(^{18}\) An FRC prosthesis can be used for fixed-tooth replacement following traumatic tooth loss in pediatric and adolescent patients. It is a more conservative treatment option than conventional fixed partial dentures and can be more cost-effective than other types of metal-free tooth replacements.\(^{19,20}\) A preliminary retrospective clinical study by Piovesan et al\(^{25}\) suggested that polyethylene FRC fixed partial dentures (FPDs) could be a functional and aesthetic alternative to replace a lost tooth. Unlu and Belli\(^{26}\) concluded that polyethylene FRC FPDs functioned adequately during a mean clinical follow-up time of 3 years. In another report, a functional survival rate of 95% after a follow-up period of 4.3 years was described.\(^{27}\) Also, for the child patients, this treatment could be considered as an interim treatment that can provide acceptable function and esthetics by replacing missing teeth and tissues until a definitive restoration can be performed.

The patient’s natural tooth, an acrylic tooth, or composite resin can be used as a pontic. In the case reported here, good esthetics, availability, short working time and the possibility of direct chairside application dictated the use of the patient’s natural tooth as the pontic.

**Endodontic post and core**

Developmental tooth hypoplasia represents a challenge to the dentist due to the difficulties involved in tooth restoration. Due to insufficient tooth structure, an endodontic post and core may be necessary to provide support to the restoration. Various types of FRC posts have recently come into widespread use as an alternative to cast or prefabricated metal posts in the restoration of endodontically treated teeth.\(^{21}\) Grandini et al\(^{28}\) suggested that restoration of endodontically treated teeth with fiber post and direct resin composites is a treatment option, that in the short term conserves remaining tooth structure and results in good patient compliance. In the case reported here, Ribbond was chosen for its esthetic properties and because its application required no additional tooth preparation.

**Splint**

Dental splinting is frequently needed following traumatic injury to stabilize subluxated, luxated, avulsed, or root-fractured teeth.\(^{22}\) Many different types of splinting techniques have been described in the literature.\(^{29,30}\) Ribbond can be used in the treatment of multiple displaced teeth. A Ribbond splint is esthetic, thin, smooth and non-irritating to the lip. This material is expensive and this is Ribbond’s disadvantage.

**CONCLUSIONS**

Ribbond can be used as an alternative to conventional treatment in pediatric dentistry. However, long-term clinical studies are needed to evaluate the effects of prolonged use of Ribbond in pediatric dentistry.

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**REFERENCES**


