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Evaluation of White Spot Lesions on Teeth with Orthodontic Brackets

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Abstract

Accurate evaluation of demineralised white spot lesions during orthodontic treatment is important to both clinicians, so they might implement early prevention and/or treatment, and researchers who wish to study the effectiveness of those methods. Assessment will depend upon accurate detection and measurement of a lesion, using procedures that demonstrate good validity and reproducibility. A range of evaluative techniques are outlined and the advantages and disadvantages of each are discussed. Some methods can be applied by the busy clinician, whereas others are more suitable for the researcher undertaking a clinical trial. Regardless of who is using the technique, it should be relatively straightforward to apply in the clinical situation and whatever technique is undertaken, researchers and the clinicians must appreciate the need for proper research designs to produce reliable information regarding the effectiveness of any intervention.

Introduction

The evaluation of demineralised white spot lesions during orthodontic treatment is important for both clinicians and researchers. Clinicians must discover enamel lesions early so that they can advise their patients regarding changes in oral hygiene and diet, as well as implement suitable preventive measures. Accurate evaluation of demineralisation is essential for research workers to assess new products or interventions, which might help prevent the appearance of demineralised lesions during orthodontic treatment. Evaluation will depend upon accurate detection and measurement of a lesion.

If a form of assessment is to be relied upon to produce accurate detection and measurement then it must fulfil several criteria:

Validity

The method of assessment should determine that the white spot is caused by mineral loss from enamel by acid demineralisation during orthodontic treatment, rather than an opacity that may have been present before the appliance was placed, the causes of which are numerous(1). A trained and experienced observer will usually be able to distinguish between the two (Figure 1).

Reproducibility

Any form of assessment needs to be reproducible so that a reading taken by a single assessor on one occasion is very similar to a reading taken by the same assessor on an unchanged lesion at another time. Also there should be very little difference between readings of an identical lesion carried out by different assessors. Both clinicians and researchers need to distinguish between those lesions that were present before the appliance was placed and those developing during treatment. To ensure this the assessments need to be reproducible over a long period of time as they should be carried out at the start and at the end of treatment, which might be several years later, particularly if improvement in the lesion over time after removal of the appliance is to be followed up.

Ease of Use

Clinicians require a technique, which can be easily applied to their clinical practice and is relatively inexpensive. An instrument that produces an accurate reading of demineralisation, but requires half an hour to set up, will not be used. Research workers might allow more time and use more sophisticated instruments to obtain precise assessments; however they are still restrained by issues of practicality and flexibility if they are going to assess outcomes in a sufficient number of patients and a wide range of settings in order to get meaningful results.

Any evaluation requires two outcomes to be assessed. The first outcome is to decide if demineralisation is present or not. The second outcome is to measure the severity of the lesion.

Severity might be expressed macroscopically in terms of the area and the relative difference in the whiteness of the lesion compared with the surrounding sound enamel or microscopically by the amount of mineral loss or lesion depth. It is essential to assess both outcomes if a realistic assessment of an intervention is to be obtained, because a product may not completely prevent demineralisation, but may reduce the area of the tooth surface affected or amount of mineral loss and lesion depth.

There are macroscopic and microscopic methods used in the detection and measurement of demineralised white lesions.

Macroscopic Methods

Macroscopic methods rely mainly upon the change in optical properties of enamel with demineralisation. The reason that a demineralised lesion in enamel is white is due to an increase in the backscatter of light. Sound enamel is a low light scattering material. When a light photon enters sound enamel, it travels an average distance of 0.1mm before being scattered (2). A large portion of light penetrates the enamel, which is about 1mm thick and is backscattered by dentine, which is why the colour of dentine is often more clinically apparent than the colour of enamel. When mineral is lost from enamel it becomes more porous. The mineral is partly replaced by water, leading to an increased difference in refractive index between sound and demineralised enamel. A light photon travels a much shorter distance in carious enamel before being backscattered. Most photons are scattered within the lesion, rather than penetrating to dentine and the backscatter is greater, resulting in the clinical appearance of a white spot. When the lesion is dried the water is replaced by air and the average refractive index declines even more, leading to an even whiter lesion.

There are various different macroscopic techniques for assessing enamel demineralisation.

Clinical Examination

Clinicians are trained to use a clinical examination to assess the presence of demineralisation. Several clinical orthodontic studies have employed a visual examination to assess demineralisation before, during or after orthodontic treatment (3-12). There are advantages and disadvantages to relying on this:

Advantages

- Simple and inexpensive - no expensive or complex equipment is required.
- Clinically valid - what the examiner sees and measures is likely to be the patient's perceived problem.

Disadvantages

- Validity - it is often difficult to clinically distinguish white spots caused by demineralisation and those that are due to other causes, such as developmental hypoplasia or fluorosis.

In a clinical trial, using adequate methods to reduce the risk of bias, such as masking of examiners can be more demanding. In addition, reducing inter-examiner error by adequate calibration before and during a trial may be time consuming and inaccurate. Assessment of intra-examiner error will involve recalling individuals for re-measuring that may be inconvenient to the patient and may lead to the establishment of a convenience sample for error assessment.

Clinical studies have used many different indices to assess demineralisation. Some of the studies have been less than rigorous when describing aspects of the investigation such as calibration and blinding of examiners, as well as methods of error assessment including both systematic and random error.

Photographic Examination

Photographic techniques have been extensively used to study the prevalence of enamel opacities (13-23) and early investigations into the mechanisms of enamel demineralisation (24, 25). Several clinical orthodontic studies have also used photographs as a means of assessing demineralisation before, during or after orthodontic treatment (26-34).

Advantages

- Many orthodontists now routinely take photographs as part of a patients' clinical record. Clinicians are therefore familiar with the technique and can carry it out quickly and efficiently in most settings. The method used can be standardised so that clinical variability of diagnostic conditions may be minimised.
- They provide a permanent record and can therefore be examined during one assessment session and re-examined at a different time to determine reproducibility.
- It is easy to mask the patient details so they can be examined in a random order to reduce the potential for bias.
- Photographs taken by several examiners may be scored by one independent expert to remove the effects of intra-examiner variability.
- Photographs are more versatile than a visual examination. They might be used to assess the presence or absence of demineralisation by several trained judges to obtain a consensus. They can also be digitised and a computer used to measure the severity of the lesion in terms of area or change in whiteness or grey levels(35, 36).

Disadvantages

The camera might record details differently to the naked eye. Photographs tend to over estimate the incidence of opacities, partly due to the reflection of the flash from the tooth surface (Figure 2 Figure 2). The problems of extraneous light can be reduced by slanting the camera slightly or (37) or by filtering out the flash using cross-polarising filters(38) (Figure 3

- Figure 3).
- Standardisation of the procedures may be difficult, particularly with respect to the wetness of the tooth, but also lighting conditions might differ. Film types and processing methods will vary for conventional photography, although the quality of digital photography and the cost of equipment are now at a level to use routinely in the clinic and for research (39).

Optical Non-Fluorescent Methods

Light Scattering

As explained earlier, demineralisation leads to more scattering of the light entering enamel. The scattering results in a sideward displacement of the light, which can be measured using the Optical Caries Monitor (OCM) first described by ten Bosch *et al* (40, 41). They used a 100 watt white light as a light source and measured backscatter with a densitometer. They showed a good correlation between the OCM readings and other more direct, but destructive methods of measuring mineral loss (42). This method has been used in one clinical study (43).

The advantages of the Optical Caries Monitor are; that it enables a convenient and non-destructive quantification of enamel demineralisation. It can be applied in the clinical environment and has been correlated with established methods of studying mineral loss. The disadvantage is that it is particularly technique sensitive and results can vary with the degree of wetness or drying of the tooth.

Optical Fluorescent Methods

The property of fluorescence is a function of light absorption (2). A material which absorbs light will be more fluorescent, than a material which reflects light. As previously explained demineralisation leads to more backscatter of light, hence less absorption and a lower intensity

of fluorescence. Carious enamel will therefore show up as a dark area with fluorescent techniques.

There are a number of different techniques for producing fluorescence in enamel.

i) Fluorescent dye uptake

Various dyes fluorescent and non-fluorescent have been used to highlight carious enamel (44). Once the fluorescent dye has been applied the specimen is examined under a suitable light source. The disadvantage of these dyes is that slight procedural variations can result in widely different degrees of dye uptake. They are mainly used for the detection and removal of carious dentine(45).

ii) Ultraviolet

Early studies(46) used an ultraviolet (UV) light for the early detection of carious lesions on the smooth surfaces. Special precautions are required to protect the patient and operator because UV radiation, which has a wavelength shorter than visible light (<400nm) is harmful to the eyes and skin. Safer methods using light sources with a longer wavelength have been developed.

iii) Laser

Bjelkhagen *et al* (47) used an argon laser to show differences in luminescence from intact and carious enamel in the laboratory. De Josselin de Jong *et al* (48) developed the technique of quantitative laser fluorescence for use in the mouth. They used an argon-ion laser producing light in the blue-green range of the electromagnetic spectrum (440 - 570nm). A yellow high-pass filter was used on the detection equipment to cut off light with a wavelength less than 520nm (the blue and lower green range). This ensured that tooth scattered blue laser light did not reach the detection apparatus, but allowed fluorescence in the yellow region (wavelength 565-590nm) to be measured. As with all fluorescence techniques the demineralised lesions appear as dark areas (decreased fluorescence or absorption). The equipment was calibrated to calculate the

difference in fluorescence between the demineralised area and the surrounding sound enamel and thereby quantify mineral loss and lesion size.

Quantitative laser fluorescence was used to study the change in fluorescence with time of teeth exhibiting white spot lesions following orthodontic treatment(49). Their results showed that radiance levels increased and the area of almost all white spot lesions decreased over time suggesting mineral gain. Remineralisation of the lesions showed an exponential pattern with most mineral gain occurring early, then the rate slowing down.

Another method using laser fluorescence is an instrument called DIAGNODent (KaVo, Germany). It is a portable system, which emits light of wavelength 655nm or the red end of the electromagnetic spectrum. DIAGNODent does not produce a picture of the tooth, but produces a reading, which is thought to be an indication of bacterial activity, rather than mineral loss. It has been shown to produce reproducible readings in 13 orthodontic patients who had recently been debonded(50). It has also been used to evaluate two ways of managing individuals with demineralised white spots following orthodontic treatment(51). Twelve individuals were randomly allocated to two groups and followed up every three months for one year. The control group received oral hygiene instruction and the experimental group received oral hygiene instruction and professional tooth cleaning. They found that the mean DIAGNODent readings were lower at 12 months than at debond suggesting that the lesions improved, but that there was no difference between the two groups.

iv) Light (Quantitative Light-induced Fluorescence or QLF)

A major problem with the laser system was the size of the light source equipment, which limited the practical use of this technique. A smaller portable system for intraoral use has been developed with a new light source and filter system (52) (Figure 4Figure 4

Figure 4). This is the basis of the most promising fluorescent method of measuring demineralisation in use today. It employs an arc lamp with a liquid light guide. The light is passed through a blue filter in front of the lamp, with a peak intensity of 370nm. The yellow high pass filter (<540nm) is maintained in front of the detecting camera to exclude scattered blue light and the combination is optimised so there are no reflections. The images are stored, processed, and analysed with custom software. The software is even designed to ensure that reproducible images of the tooth are taken over a period of time.

QLF has been shown in the laboratory to be a useful technique that may be applied to orthodontic patients (35, 36, 53, 54). It has recently been used in 55 subjects to evaluate the change in the fluorescence of 406 surfaces with demineralised lesions following orthodontic treatment. They found that the majority of lesions (61%) did not change during the six month observation period after removal of the fixed appliance. Approximately one third (29%) of lesions improved, but a significant minority (10%) actually got worse and they note that these were mainly early lesions.

The potential of QLF has yet to be fully exploited. It is an exciting technique which not only enables early detection of demineralised lesions, but also changes in the mineral loss and size over time and will undoubtedly prove useful to both clinicians and researcher workers in the future.

Microscopic Methods

Caries Models

For many years cariologists have used models to study both demineralisation and remineralisation in the mouth. Orthodontic caries models have usually involved placing a band

(55-60) or a bracket (61) on a tooth that is destined for extraction. Following a period in the mouth the tooth is extracted, then examined using one of the destructive methods of measuring mineral loss and lesion depth, such as microhardness testing, polarised light microscopy or microradiography. These techniques have been used in a number of interventional clinical trials (62-69).

These *in vivo* banding techniques allow direct measurement of mineral loss or lesion depth in enamel, but have a number of disadvantages (70). These include the lack of availability of teeth and only patients requiring extractions can participate. There is less control over lesion reproducibility and restrictions regarding lesion location. The patient cannot commence their orthodontic treatment until the tooth is extracted. Consequently, the length of the experiment is limited; otherwise the patient's treatment will be unduly prolonged. The experiment is confined to the initial stages of treatment, usually the first month, whereas orthodontics can take up to two years. This technique is therefore unable to monitor changes in the enamel throughout the duration of the treatment. There may also be a longer time for treatment effects. The advantages of the technique include the fact that the teeth are in their most natural state with original surface pellicle and under natural occlusion and position and function.

The *in situ* Caries Model

A more sophisticated technique for investigating the processes of demineralisation and remineralisation is called the *in situ* caries model. This involves using a section of enamel, rather than a whole tooth. The enamel is placed in a removable appliance worn by a volunteer, bonded to the tooth of a volunteer or placed in a specially designed holder attached to the orthodontic archwire(71)(Figure 5). After a suitable intervention or time period the specimen is removed and examined. This technique has a number of advantages over the extracted tooth model(72):

- The model reproduces the natural caries process without causing irreversible damage to the volunteer.
- A specimen of the same tooth may be kept as a control, allowing a more accurate determination of the changes which occur.
- It is possible to induce an artificial subsurface lesion in the specimen, so that remineralisation as well as further demineralisation can be studied
- The enamel specimen may be examined using well tested methods of measuring mineral loss and lesion depth, such as microradiography (Figure 6).
- They allow more flexibility of the experimental design, such as crossover studies.
- It will not affect the orthodontic treatment.
- It can be used throughout a course of orthodontic treatment.

The main disadvantage of the *in situ* model is that it is very time consuming, particularly in laboratory and analysis time, therefore the number of subjects in these trials is limited to between five and 40. This raises the question of whether such a small number is representative of the population.

The *in situ* model has been used in one longitudinal, prospective, randomized, crossover clinical trial examining the benefit of fluoride-releasing elastomeric ligatures (73) in 14 individuals with fixed orthodontic appliances. No difference was found in the mineral loss and lesion depth between the three enamel specimens that had been present in the mouth with the fluoridated elastomeric ligatures, the non-fluoridated ligatures and the control.

Research Methods

Finally, as a researcher in the field my main purpose in establishing accurate methods of evaluation is to develop the means by which potential preventive agents can be assessed. It is

essential that investigators use properly controlled trials to reduce bias from selection, allocation and assessment. In particular clinical studies should be prospective, with clear inclusion and exclusion criteria, random allocation to treatment and control groups, masking of outcome assessment and withdrawals and drop-outs accounted for. The reporting and statistical methods should be sound, including a sample size calculation to ensure the study has sufficient numbers of participants to find a clinical difference if one exists and the use of appropriate statistical test which take into account that teeth within individuals are not independent of each other.

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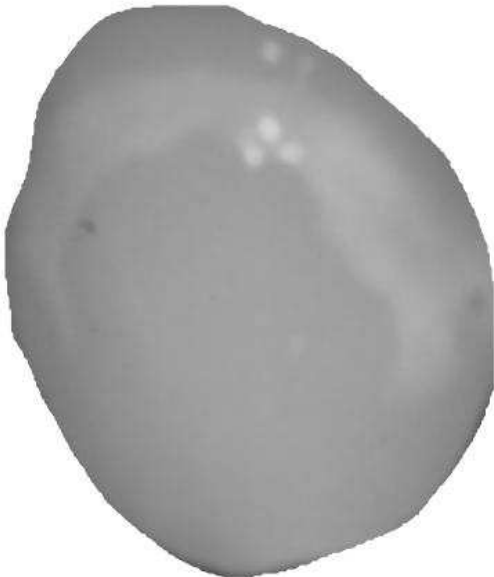
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Figure 1

Examples of post-orthodontic white spot demineralisation (a) and a developmental opacity (b).



a



b

Figure 2

An apparent white lesion caused by reflection from the camera flash.



Figure 3

A digital camera with cross-polarising filters placed to reduce reflection from the flash. The white marks show the direction in which the filter polarises the light. Note that those placed on the lens and those placed on the flash lights are at right angles to each other to maximise their effect. The effectiveness can be seen on the images of the incisors taken without (b) and with (c) cross-polarising filters (courtesy of Professor DR Willmot).



a



b



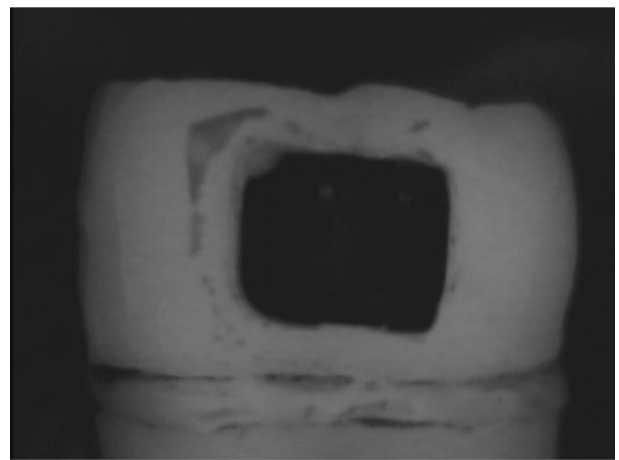
c

Figure 4

Quantitative light-induced fluorescence light source and capture equipment (a) and image (b) of an extracted tooth showing areas of reduced absorption, such as the bracket and artificially demineralised area as dark (reproduced with permission by Inspektor Research Systems BV, Amsterdam, The Netherlands)



a



b

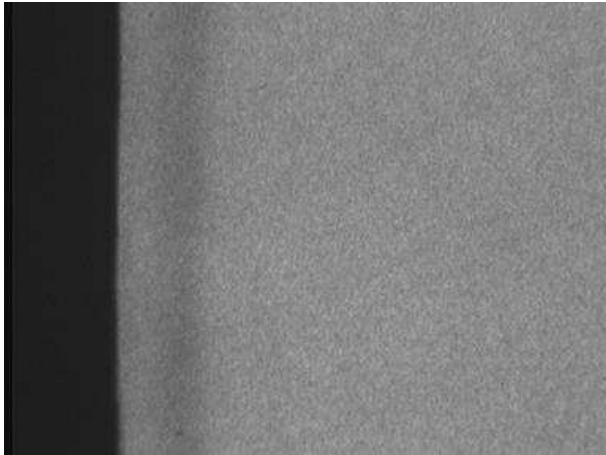
Figure 5

In situ enamel sample in a custom-made holder placed on the archwire mesial to the lower molar band (From Doherty *et al.* Fluoride-releasing elastomeric ligatures assessed with the in situ caries model. European Journal of Orthodontics 2002; 24 (4): 371-8 reproduced by permission Oxford University Press).

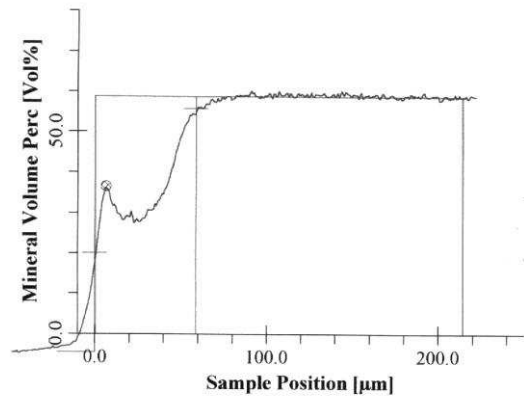


Figure 6

Microradiograph of enamel used as an *in situ* sample showing a sub-surface lesion (a) and computerised analysis of the lesion with calculation of mineral loss and lesion depth (b).



a



b