

Aesthetic improvement of white spot lesions with resin and fluorine paint in orthodontic treatment

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Abstract

White spot lesions (WSL) are common during orthodontic treatment with multibracket appliances and may raise aesthetic concerns. Although fluoride varnish is widely employed, resin infiltration has emerged as a more effective alternative for improving aesthetics and preventing additional enamel demineralization. This study aimed to compare the effectiveness of resin infiltration (Icon®) and fluoride varnish (Flairèsse®) in enhancing the visual appearance of White spot lesions. A randomized controlled trial was conducted involving 38 patients under the age of 17 who exhibited at least one White spot lesion. Color variations (ΔE) were measured at baseline and after six months, with secondary parameters including ICDAS scores and periodontal health indices. The group treated with resin infiltration demonstrated a significant and sustained reduction in ΔE (from 8.81 to 5.19), whereas the fluoride varnish group showed no notable changes (ΔE at six months: 8.46). Furthermore, resin infiltration resulted in lower ICDAS scores,



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indicating improved lesion stability. These findings suggest that resin infiltration offers superior and enduring aesthetic improvements compared to fluoride varnish, with early intervention during orthodontic therapy producing optimal outcomes. Additional research with long-term follow-up is recommended to confirm these results.

Keywords: White Spot Lesions, Resin Infiltration (Icon®), Fluoride Varnish (Flaioresse®)

Introduction

The multibracket appliance (MBA) is widely employed and effective in the correction of malocclusions; however, it also presents certain adverse effects, including the formation of plaque retention sites caused by the appliance itself (1–29). These sites facilitate the accumulation of pathogenic biofilm, which can lead to plaque-induced gingivitis and the initiation of carious lesions, commonly known as white spot lesions (WSL) (23,30–38). The prevalence of WSL among orthodontic patients is notably high: up to 40% within the first six months of treatment, with some studies reporting incidences as high as 79.3% in academic settings (39–49). Given the frequency and the aesthetic and functional implications of WSL, their prevention and management have become paramount concerns within the field of orthodontics 50–60.

WSL manifests as whitish opacities visible on the enamel (EN) surface, resulting from a loss of minerals and an increase in water content within the pores of demineralized enamel (26,61–73). This structural alteration modifies the optical properties of the dental tissue, leading to enhanced light scattering and a consequent reduction in transparency (74–91). Mineral particles within the lesions are encapsulated by water rather than mineralized material, thereby creating greater differences in the refractive index and rendering

WSL visually distinguishable from the adjacent healthy enamel (24,92–107).

Traditionally, fluoride-containing products have been employed to prevent and treat white spot lesions (WSL) (108–120). These include dentifrices, mouthwashes, gels, and fluoride varnish (FV), which facilitate enamel (EN) remineralization (121–136). Nevertheless, their aesthetic effectiveness is frequently limited, particularly in cases where the lesion is already apparent (137–145). In recent years, an alternative technique has emerged: infiltration with low-viscosity resin (25,146–161). This approach not only enhances the aesthetic appearance of WSL by diminishing their visibility, but also halts the initial progression of caries by infiltrating the micropores of the demineralized enamel and sealing the lesion see Figure 1 (162–175).

Mechanism of action of resin infiltration

Resin infiltration treatment operates by introducing a flowable resin into the porosity and microspaces of the EN (176–178). Owing to its low viscosity, the infiltrating resin penetrates the tubules of the EN and fills the microscopic cavities caused by mineral loss (179–182). This process facilitates the 'masking' of the lesion, thereby restoring a more uniform and natural appearance to the tooth surface without the removal of adjacent healthy tissue (183–188).

Once cured, the resin diminishes the opaque white appearance characteristic of white spot lesions (WSL), thereby notably enhancing the aesthetics of the tooth (189–194). In contrast to conventional treatment approaches, such as fluoridation or sealing, resin infiltration offers the benefit of a more durable effect and does not necessitate significantly invasive procedures (195–200). Furthermore, the resin not only conceals the lesion but also, through its adhesive properties, can assist in halting the demineralization process and preventing subsequent damage to the tooth structure see Figure 2 (201–206).



Figure 1. White spot lesion

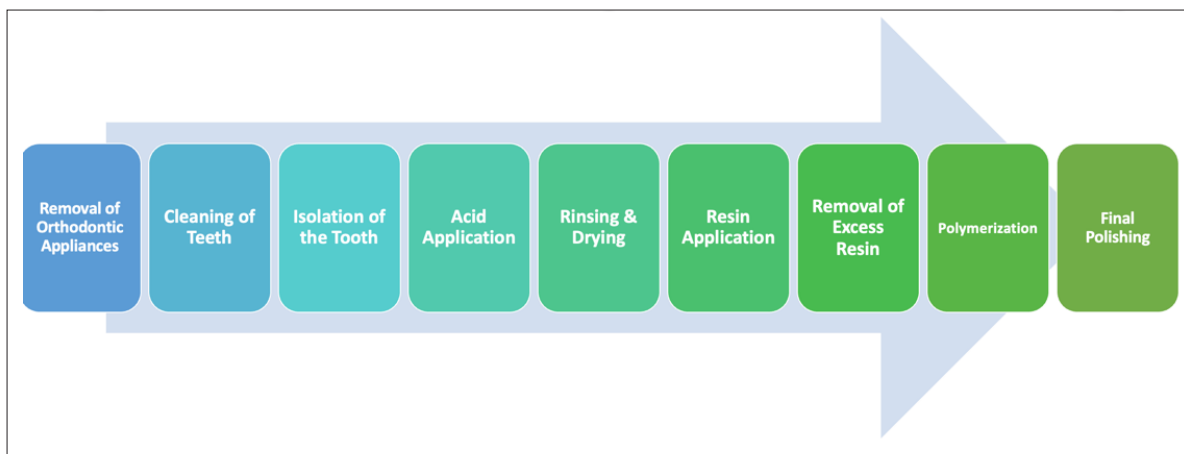


Figure 2. Resin Infiltration Treatment Process.

Aesthetic and functional advantages

One of the main advantages of resin infiltration is its lasting aesthetic improvement (207–211 212–218). WSL, if left untreated, can remain visible for the duration of orthodontic treatment, compromising the smile's aesthetics (219–224). Infiltration solves this problem, restoring the tooth's natural appearance (225–227). Unlike topical fluorination techniques, which may provide a temporary aesthetic improvement, resin infiltration creates a more stable and durable solution (228–231). Indeed, the resin not only aesthetically covers the stain but also helps strengthen the tooth structure, improving its resistance to future demineralization (232–235). In addition, resin infiltration does not damage surrounding healthy teeth, as can happen with other techniques that could lead to further wear of the tooth tissue during removal or application of the treatment (236–242). The approach's micro-invasiveness allows only compromised areas to be treated, avoiding more aggressive treatments that could compromise overall dental health (243–250).

Treatment stability over time

One of the main concerns when it comes to aesthetic dental treatments is the durability of the effect over time (251–256). Several studies have documented that resin infiltration maintains good long-term color stability, with improvements persisting even months or years after treatment (257–264). Once hardened, the infiltrating resin is resistant to abrasion and can adapt to the color changes during normal chewing and oral hygiene (265–270 271–276). This makes it particularly advantageous compared to other temporary solutions, such as the simple application of FV, which cannot offer as lasting an aesthetic improvement (277–283). The resin infiltrant has a refractive index similar to healthy EN, allowing optical camouflage of the lesion (284–289). Clinical studies have shown that resin-treated WSLs show a smaller color difference (ΔE) than the adjacent healthy EN, compared to fluoride-treated lesions (290–292). In addition, the aesthetic improvement obtained with infiltration is stable over time, remaining up to 24 months after treatment

(293–298). Evidence also shows that early treatment, immediately after brace removal, offers the best aesthetic results (299–301). However, it has been hypothesized that even earlier treatment - i.e., during orthodontic treatment - may further improve aesthetic outcomes, although this approach has not yet been studied in depth (302–308).

Material and methods

The study that is the subject of this abstract addressed this gap by proposing a randomized controlled clinical trial to compare the aesthetic efficacy of resin infiltration (Icon®) versus FV (Flairesse®) applied during orthodontic treatment with MBA. The main objective was to assess the color changes (ΔE) of WSL compared to healthy EN six months after surgery. The null hypothesis was that the two treatments had no significant differences.

The study was conducted according to strict methodological standards, including registration with the German clinical registry and ethics committee approval. The design randomly assigned 38 patients (age <17 years) to two parallel groups: one treated with resin infiltration, the other with FV. Patients had to present at least a grade 1 or 2 WSL (according to ICDAS classification) on fully erupted and unrestored permanent canines or incisors.

Infiltration was performed according to the manufacturer's instructions, with up to three applications of 15% hydrochloric acid, followed by drying with ethanol and applying the infiltrant for 180 seconds. After the excess was removed, the material was light-cured. A second infiltrant application was performed for 60 seconds, followed by further light-curing. The control group received a 5% FV, applied every fortnight.

Efficacy was assessed through standardized polarised dental photographs, analyzed with image processing software and calculated color change (ΔE) according to the CIEDE2000 formula. Measurements were taken at six time points: at baseline (T0), after 1 day (T1), 1 week (T2), 1 month (T3), 3 months (T4), and 6 months (T5). The ICDAS score, bleeding index (SBI),

visible plaque index (VPI), and periodontal screening index (PSI) at the start and after six months were also recorded.

Results

The results showed that, already after one day, the resin-treated group showed a significant reduction in ΔE (from 8.81 ± 2.17 to 5.01 ± 1.45), which remained stable until the sixth month (ΔE : 5.19 ± 1.60). In contrast, no significant changes in ΔE were observed in the fluoride group immediately after treatment or during the entire follow-up (ΔE at T5: 8.46 ± 3.52). The difference between the two groups at six months was highly significant ($p < 0.001$), confirming a greater and more lasting aesthetic improvement in the Icon® group. The ICDAS score was also lower in the group with infiltration (mean: 0.40 vs. 1.61; $p < 0.001$), indicating greater lesion stability over time. There were no significant differences between the two groups in oral hygiene indices.

In conclusion, this study demonstrated that resin infiltration during orthodontic treatment with MBA is significantly more effective than FV application alone in improving the aesthetics of WSLs and preventing their progression. The results support the early use of infiltration, even before appliance removal, as a viable therapeutic strategy for managing white lesions in orthodontics.

Discussion

This randomised clinical trial investigated the efficacy of resin infiltration in treating WSL during MBA braces, comparing it with the traditional approach of topical fluoridation using FV (309–316). The main objective was to assess short-term (six months) color stability after treatment. The analysis included 116 permanent teeth with WSL in 36 patients (317–333 334–341).

The results showed that, in the group treated with infiltration, the color difference (ΔE) between the lesion and the sound adjacent EN (SAE) was significantly reduced immediately after treatment and remained stable at six months, demonstrating excellent short-term color stability (342–355). In contrast, the group treated with FV did not show comparable aesthetic improvements (356–361). Consequently, the null hypothesis of no significant difference between the two treatments was rejected (362–371).

Interestingly, the infiltration did not lead to clinically relevant color changes in the surrounding healthy EN, even though it was partially infiltrated, confirming the selectivity and safety of the treatment (372–377). This aligns with previous scientific evidence supporting infiltrating resin's efficacy and aesthetic stability in masking WSL (378–392).

Although its demonstrated efficacy, the infiltration of WSL during orthodontic treatment has not yet been widely adopted in routine clinical practice 393–398. However, administering treatment for WSL at an early stage—specifically during their diagnosis within orthodontic treatment rather than awaiting the post-debonding phase—can offer significant clinical benefits (399–401). In fact, this approach allows for

the cessation of lesion progression, improves their aesthetic appearance, and prevents the need to forcibly cease orthodontic therapy, thereby preserving the integrity of the final outcome (402,403).

Nevertheless, the prevention of WSL remains a pivotal concern. Biofilm accumulation around orthodontic brackets, inadequate oral hygiene, a diet high in sugars, and frequent consumption of fermentable carbohydrates constitute some of the principal causative factors (404). Consequently, the efficacy of any treatment should invariably be complemented by primary prevention strategies, including oral hygiene education, nutritional counseling, and consistent professional monitoring throughout orthodontic therapy (405,406).

Although certain WSL may spontaneously regress following the removal of braces, they continue to pose a persistent aesthetic concern (407). The most frequently employed treatment, topical fluoridation, fails to resolve the blemish, exposes demineralized regions to an increased risk of mechanical abrasion during daily oral hygiene, and does not substantially enhance aesthetic restoration (408).

From a methodological perspective, the assessment of color alterations in lesions was conducted utilizing standardized digital imaging (409). Although alternative instruments, such as colorimeters, spectrophotometers, or fluorescence lasers (DIAGNOdent), are employed within existing literature, they entail several limitations (410). Specifically, the deployment of DIAGNOdent was avoided in this study owing to its limited reliability in the presence of infiltrating materials, which may interfere with readings and produce misleading data (411). Additionally, the device is incapable of detecting all clinically visible lesions (412). Calibrated photographic systems, including multispectral or RGB cameras, facilitate more detailed evaluations; however, they necessitate rigorous protocols and equipment that are not invariably accessible or are no longer commercially available (413,414–420).

The limitations of this study include the selection of the reference area for chromatic evaluation, located in the incisal region, which inherently exhibits a different shade from that near the brackets (421,422). Moreover, for ethical considerations, it was not feasible to incorporate an untreated control group, and the study was designed as a parallel-group rather than a split-mouth study to prevent bias in aesthetic evaluation (423–426). An additional limitation pertains to the initial post-treatment assessment T1, which was conducted the day following treatment to mitigate artifacts caused by temporary dehydration of the dental tissues (396–399, 431). Lastly, follow-up after debonding has not yet been conducted; however, such assessments are planned to facilitate the analysis of long-term outcomes (432–452).

Conclusion

The results of this study affirm that resin infiltration constitutes an efficacious microinvasive intervention for addressing white spot lesions (WSL) during orthodontic multibracket appliance (MBA) therapy. In

comparison to topical fluoridation, infiltration provides superior aesthetic enhancement, which remains stable over time and is devoid of significant adverse effects. Early intervention, conducted prior to the removal of orthodontic brackets, is notably advantageous in halting lesion progression and achieving improved aesthetic outcomes without hindering the continuation of orthodontic treatment. Nonetheless, additional research with long-term follow-up is required to ascertain the durability of efficacy and to evaluate the implementation of this methodology within standardized clinical protocols for WSL management.

Institutional review board statement

Not applicable.

Informed consent statement

Not applicable.

Data availability statement

Data are contained within the article.

Conflict of interest

The authors declare that they have no conflict of interest.

List of Abbreviations

Abbreviation	Meaning
MBA	Multibracket appliance
WLS	White spot lesions
SAE	Sound adjacent EN
EN	Enamel
FV	Fluoride varnish

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