Candulor Denture System

in accordance with the philosophy of Prof. Dr. A. Gerber

"Try everything and keep the best."

(Quotation from Prof. Dr. A. Gysi)
Foreword

One important factor for success with dentures is stability when chewing. We know from what denture wearers tell us that painful pressure points, inadequate stability of the denture and an inability to chew properly are the most frequent complaints. When a new denture is to be made, it can therefore be assumed that all stages of the procedure will be adhered to exactly. In this brochure, rather than discussing that part of the work which falls within the competence of the dentist we will, instead, concentrate on the details of the work done in the dental laboratory. Here it is important never to lose sight of the fact that the hold factor of a denture is the result of a combination of physical, biological and prosthetic forces.
1. Important criteria for the stability of full dentures

1.1 Physical factors affecting the hold
The physical factors that affect the hold are those forces that arise as a result of the interaction between the denture base, the saliva and the mucous membrane, i.e. adhesion, cohesion, surface tension and the flow of saliva in narrow gaps. The fundamental adhesion of a denture depends on the accuracy of its fit and the viscosity of the saliva between the denture and the gum. Maximum retention is achieved when the film of saliva is as thin as possible and a vacuum forms. Fundamentally, the upper and lower dentures are held in place by the same mechanisms, but because of the morphological differences, the physical factors of the hold are more obvious in the upper jaw than in the lower jaw.

1.2 Biological factors affecting the hold
The biological factors that affect the hold include the quality and amount of saliva, the shape of the jaw (which may be more or less retentive) and the muscular forces applied to the denture by the muscles of the cheeks, lips and tongue. As soon as the denture begins to tip, the muscles of the cheeks, lips and tongue have to be used to hold the denture in place. This requires the training of conditional reflexes – i.e. a learning process that again calls for a high level of muscular coordination. The influence of the tongue muscle should not be underestimated. The fact that the tongue often tends to enlarge with age has to be taken into account when planning the future denture.

1.3 Prosthetic factors affecting the hold
The prosthetic factors that affect the hold are the occlusion and the shape of the occlusion. In our set-up system we try to position the posterior teeth so that they are both independently stable when chewing (Gerber 1974) and in the zone of muscular balance between the muscles of the cheeks, lips and tongue. The problems of mounting the posterior teeth lie precisely in fulfilling these two requirements at the same time. The borderline between the stable and unstable zones corresponds to the centre of the ridge. The advantage of positioning the teeth so that they are independently stable when chewing lies in the fact that the occlusal forces that arise during mastication push the denture against the jaw without causing it to tip or slip. In point of fact, this only applies to a limited extent because of the resilience of the mucous membrane, as every denture embeds itself more firmly in the masticatory area than in other places. The more pronounced the resilience, the stronger the effect of this instability of the denture caused by the tegument. Forces outside the stable zone cause a drop in pressure in the cleft area so that it increases in size and the denture begins to tip, and as a result saliva is sucked out of the surrounding area and under the denture. This happens every time the chewing motion is repeated. If there is no longer sufficient saliva to seal the gaps, air gets underneath the denture and it loses its hold.
2. Articulation

In order to achieve an optimum result in complete dentures, one important requirement is the correct three-dimensional alignment of the lower jaw to the skull. The decision on which method to choose always lies with the dentist. However, it is indisputably one of the most difficult tasks and can only be achieved with skill and a great deal of practice.

Checkbite
Determining the central position of the condyles in the glenoid fossa [fossa glenoidalis] by measuring the intra-oral angle of sweep.

If no checkbite is available, the procedure may be carried out as follows:

Instrument adjustment on the Candulor articulator:
• Set the inclination of the condyle pathway to the average of 30°.
• Close the centric fixing.
• Slide the vertical pin in the zero position (millimeter scale) in the incisal pin holder until it reaches the stop position and fix it.
• Centre the incisal plate on the vertical pin. Take the long part of the incisal point indicator through the upper hole and the short part through the lower hole on the incisal pin and slide until it reaches the stop position.
• The notches on the lateral supports and the circular groove on the vertical pin are used to align the occlusal plane.
• Then fit the thin rubber band.
• Align the occlusal plane to the rubber band. Line up the incisal point between the lower central points or on the wax wall onto the corresponding marking.
• Ideally fix and set up the lower jaw model on plasticine or No-Plast. Then plaster in the upper jaw model.
• Apply plaster to the model and base plates and slowly close the articulator.
• Finally plaster in the lower jaw model in the same way.
3. Analysing the model

Analysing the model involves assessing the shape of the jaw and appraising the transverse and sagittal interalveolar relationships. We have to ask ourselves in which areas the load can be transmitted safely to the base of the denture. In the upper jaw there is a stable denture base everywhere within the innermost and deepest points in the duplicature. In the lower jaw the inner limit is the mylohyoid line [linea mylohyoidea] and in the outer area the linea opliqua. When analysing the model you should assess whether a denture will tend to tip or slip under load and which shape of occlusion must be selected. This determines whether a normal bite, cross bite or lingualised occlusion is indicated. The aim is to obtain the maximum amount of information with as few orientation lines as possible.

N.B.: Model analyses are basically carried out on articulated models only.

The model analysis used up to now with the static lines across the reference points of the first premolar and the retromolar pad often shows a significant narrowing of the tongue space. Our objective is to transmit the forces as far as possible to the centre of the alveolar ridge. This is easily done thanks to the lingualised occlusion of the Condyloform® II posteriors. In the case of large lateral deviations of the alveolar ridges, set-up in cross-bite occlusion is indicated. This objective applies equally for the lower and upper dentures.
1. We start off by dividing the mandibular model in half in the sagittal plane. We do this by dividing the line between the centres of the two retromolar tubercles in half and joining it with the symphysis (front seam). This gives us the anatomical centre of the model which does not necessarily correspond with the centre of the patient’s face.

2. Holding the pencil horizontally, we then mark the highest point on the alveolar ridge, in both the lower and upper jaws.

3. The lowest point on the contour of the alveolar ridge viewed in the sagittal plane is marked to define the position of the largest masticatory unit in the lower jaw.
4. The profile compass is used to trace the sagittal contour of the alveolar ridge on the model base from the lowest point. When doing this, make sure that the curved end and the pencil are always vertical and exactly at right angles to the contour of the alveolar ridge and maintain contact with it.

5. The tangent is then marked, a parallel line to the Camper’s line (occlusal plane) which intersects with the lowest point in the sagittal contour of the alveolar ridge.

6. The functional zone (blue) of the lowest point of the alveolar ridge is now marked between the anterior and posterior confines. It is the bandwidth above which the centric contact points must be located.

7. The posterior confine is located behind the lowest point, at the position where the contour of the alveolar ridge rises. This posterior confine of the functional zone is also the stop line (red). No tooth with antagonist contact should be positioned behind the stop line. The anterior confine is located at the position where the contour of the alveolar ridge rises.

Note:
Ultimately, the posterior confine for the set-up of the teeth can only be determined from checks carried out by the dentist in the patient’s mouth. Only the finger pressure of the experienced practitioner shows whether a tooth is still stable for chewing or is causing the denture to slide forwards.

To be on the safe side, the analysis lines that have already been drawn on in pencil can be inscribed and marked using a colour code.
Useful facts ...

Angle’s classification method is well-known in the field of orthodontics. This was set up by the American orthodontist Edward H. Angle to describe the relationship between the maxillary first molar and its antagonist after the eruption. Its relevance to full denture prosthetics is that this relationship allows conclusions to be drawn regarding the position of the anteriors and the patient’s profile.

Angle Class I

In this relationship which is referred to as normal bite, the maxillary canine lies half the width of the premolar behind the mandibular canine between the tip of the canine and cusp tip of the first mandibular premolar. With this molar relationship, the patient’s profile shows a harmonious transition from the nose tip to the point of the chin.

Angle Class II

Angle Class II is severe deep overbite, where the lower jaw is more distal in relation to the upper jaw. Observation of the patient’s profile shows that the point of the chin is further back than the nose tip. Angle Class II also has further subdivisions:

- Angle Class II/1 with a labial inclination of the axis of the upper teeth and usually with a tapered front. Angle Class II/1 malocclusions can also have occurred through other causes, e.g.:
  - underdevelopment of the lower jaw (microgenia)
  - overdevelopment of the upper jaw (macrognathia)
  - and/or through mandibular prognathism

- Angle Class II/2 with a retrusive inclination of the axis of the upper teeth.

Angle Class III

Angle Class III denotes mesiocclusion or progenia. This means that the bottom row of teeth are too far mesially in relation to the uppers. In terms of facial harmony, this means that when viewed in profile, the patient’s chin protrudes beyond the nose tip, depending on the severity of the progenia.
4. Setting up the front teeth

Frequently a great deal of bony substance is lost in both the horizontal and transverse sagittal planes as a result of atrophy of the jawbone. Positioning the front teeth on the rim of the upper and/or lower jaw and thus facilitating biting for the denture wearer is therefore not supportable in practice. Front teeth that are set up on the jaw rim ignore two important functional areas: phonetics and physiognomy. To this must be added the fact that aesthetics are very important in the area of the front teeth.

One photo or study model too many is better than no information at all. Basically, however, it is the case that cosmetics and phonetics can only be finally checked and corrected on the patient.

Exactly matched synthetic bases should always be used for the setting up of full dentures. We also recommend the use of wax that is as hard as possible, so that a check can be made of the impact on each individual tooth during the wax fitting without altering the shape.

The first challenge is to select suitable front and side teeth. A useful aid to finding suitable front teeth is the Alameter, which helps us to assess the shape of the patient’s teeth. Here the width of the nose is measured and the alameter calculates the approximate shape of the Candulor teeth.

On the following pages we show three different methods of setting up the front teeth on an individual basis.

- 4.1 CPC (canine-papilla-canine) orientation
- 4.2 Using a silicon key
- 4.3 Individual set-up on the patient
4.1 CPC (canine-papilla-canine) orientation

We can also find important pointers to the set-up of the front teeth in the anatomy and morphology of the patient’s mouth. Various authors have pointed out the correlation of the position of the front teeth to that of the papilla incisiva and the folds of the palate. Thus the average distance from the middle of the incisive papilla to the labial surface of the central incisors is 8 mm. The distance from the labial surface of the canine tooth to the end of the first large fold of the palate is 10 mm. The points of the canine lie on a line leading through the middle of the papilla incisiva (CPC line). As the positions of the papilla incisiva and the folds of the palate do not change during the resorption of the alveolar process, what we have here is the only fixed point of reference for the positioning of artificial teeth.

4.2 Using a silicon key

Another possibility is to use a physiognomic checking template that has been customised by the dentist to fit the patient. This is a minimum requirement for full dentures.

Using a silicon key, the information from the physiognomic checking template is saved for the later stages of the work.
It includes essential information on
1. the sagittal contours of the teeth
2. the occlusal plane
3. the closure line of the lips
4. the smile line
5. the midline (center of the face)
6. the points of the canines
7. the buccal corridor (cheek contact)
8. the vertical dimension.

The cutting edges of the two central front teeth are simply aligned with the lowest forward and outermost points of the silicon impression.
When the two central incisors have been set correctly, we can now bring into position the two canines, again orienting ourselves to the marks on the silicon impression. The approximate axis of the upper canines is slightly inverted, i.e. the cutting edge points inwards and the neck of the tooth outwards.

The labial axes of the upper canines stand slightly towards the mesial with their cutting edges touching the impression. Here it can be seen clearly that the distal-incisal alignment of the canines points towards the midline of the jaw rim.

In the lateral view of the lower canines it can be seen clearly that the canines are positioned one above the other. The distal incisal edge of the lower canines points towards the midline of the jaw rim.
4.3 Setting the teeth individually on the patient
Ideally the dental technician will be present when the front teeth are tried out. The technician can now begin to position the teeth one at a time, starting with the two upper central teeth. At the same time he has the opportunity to continually check his set-up for aesthetics, phonetics and function.

Completing the set-up of the front teeth
The overbite and sagittal step depend on a number of factors. It is a mistake always to assume the same rule of thumb “1 mm overbite equals 1 mm sagittal step” in different patients. The information regarding the overbite and sagittal step can only be determined by the dentist during an examination of the patient.
5. Configuring the occlusions in full dentures

The aim is to set up the Condyloform® II teeth so that they are not only autonomously stable for mastication but also within the zone of muscular balance between the muscles of the cheeks, lips and tongue. There are certain problems in fulfilling all these requirements at the same time.

A tooth is autonomously stable for mastication when the forces arising in close functional contact centre the denture on the jaw – i.e. when hardly any forces arise that would cause it to tip or slip. It is thus eminently important that the inclination and size of the slanting planes of the masticatory surface are selected so that they press the denture onto the jaw.

With each individual masticatory unit the question must be asked as to whether the occlusal forces are acting as stabilisers or destabilisers. Here, the technician working on the denture will find Condyloform® II teeth, constructed according to the mortar pestle principle, to be ideal.

When setting up the denture in the articulator it is only possible to guess whether the chosen design of the occlusion is stable for mastication.

The static laser has proved itself to be an indispensable checking aid. A further criteria is that the body of the denture should be shaped so that the muscles hold it the very first time it is tried out.

During the wax trial, each tooth must be strictly isolated and checked for positional stability.

On the following pages we show and describe a few cases in which different designs of occlusion were chosen.

The diagram shows the centric contact points in normal cases. Here one should note the inverted mortar pestle principle in the case of the first premolars and the relief of the buccal load in the case of the second premolars and first and second molars.

Looking ahead to the functional grinding in, one should make sure that the appropriate balancing contacts are possible in the case of excursive movements when setting up the teeth (min. 3 – working side 2, non-working side 1).
Occlusion principle for the first premolars

Setting up the upper first premolar
After the upper front teeth have been positioned correctly, the next to be set up temporarily are the upper first premolars. The inclination of the axis of the upper first premolar is somewhat steeper than that of the adjacent canine. The tip of the buccal cusp is approximately the same height as the adjacent mesial tooth. Both the palatal and buccal cusps must be parallel to the occlusal plane. Viewed from the occlusal, the central masticatory groove is set up parallel above the highest point of the line of the jaw rim. In the case of an Angle Class II dentition, there is a palatal displacement of the fossa, which means that the fossa is moved slightly towards the palatal cusp by grinding it in slightly. At the same time, the axis has to be displaced towards the buccal.

Setting up the lower first premolar
The very pronounced buccal cusp of the lower first premolar with its distinct distal masticatory ridge is brought into contact with the mesial fossa of the opposing tooth (reversed mortar pestle principle). At the same time, the palatal cusp of the upper premolar may be in slight contact with the fossa of the lower premolar. The masticatory ridge of the lower 4th is set on the midline of the jaw rim, running parallel to this. Afterwards, if necessary, final corrections are made to the positioning of the upper first premolar.
Occlusion principle for the second premolars

**Setting up the lower second premolar**
The lower second premolar is attached to the lower first premolar so that it is slightly lower than the adjacent mesial tooth. The buccal and lingual cusps lie parallel to the occlusal plane.

**Setting up the upper second premolar**
The upper second premolar is attached to the upper first premolar and its palatal cusp centred on the fossa of the lower second premolar.
Occlusion principle for the molars

Setting up the lower first molar
In principle the lower first molar stands beneath the lowest point of the line of the jaw rim. In order to achieve a corresponding Curve of Spee, the tooth is attached mesially to the second premolar and distally stands slightly high. The buccal and lingual cusps lie parallel to the occlusal plane.

Setting up the upper first molar
The upper first molar is attached to the upper second premolar. At the same time the tooth is positioned so that the mesio-palatal cusp is centred on the central fossa of the lower molar.

Setting up the second molars
Here the same occlusion principle applies as for the first molars. Only if the dorsal portion of the lower jaw does not begin to rise immediately after the lowest point can the positioning of the lower second molar be taken into consideration. A tooth which is positioned dorsally to the stop line may promote a slippage.
5.1 Step-by-step procedure

Positioning the posterior teeth in “normal cases”

Before we begin setting up the premolars and molars we should take another look at the crucial point of the condylar theory according to Gerber. Here the important statement is that the movements in the jaw joint have to be transferred to the masticatory cavities of the molars and premolars in a type of mortar pestle principle. For this he developed a special masticatory surface relief which corresponds to the shape of the jaw joint (condylar theory). This principle has been adopted in the new Condyloform® II tooth.

The initial provisional positioning of the upper first premolar. We orientate ourselves by the length and position of the canine.

Now the lower first premolar is positioned so that the buccal cusp is placed into the mesial masticatory cavity of the opposing tooth. Moreover, care must be taken to ensure that the masticatory forces act upon the jaw rim. We check this continually with our static laser. Care must also be taken to ensure that the buccal axis is straight. In conclusion – if necessary – final changes can also be made in the positioning of the upper first premolars.

The lower first molar, set up in the centre of the masticatory area and checked with the static laser.
Setting up the lower second premolar and checking the static with the static laser. If the marginal ridges are correctly positioned in relation to one another, the result is a Curve of Spee. The buccal and lingual cusps should be set up on a single plane.

Completed set-up of the posterior teeth on the lower jaw and final check with the static laser.

The control points are exactly on the line of the jaw rim and/or in the masticatory centre.
Buccal view of the second upper premolar.

In the lingual view we can see how the palatal cusp of the second premolar engages with the masticatory cavity of the opposing tooth.

Set-up of the first molar in the upper jaw from the buccal viewpoint

Intra-oral view of the toothwork

Again it should be noted that the buccal cusp of the lower first premolar engages with the central masticatory cavity of the upper first premolar.
Setting up a cross bite

If a particular case requires it, it may be that it will be necessary to set up the teeth in a cross bite. The first premolars are positioned as described for the “normal case”. Now the second upper premolar becomes the transition into the cross bite and is positioned in the occlusion bite. In the first molar the buccal cusps then engage with the central fossa of the opposing tooth. Frequently, the palatal cusps prevent lateral movement. In this case, the position of the axis is somewhat inclined. In cases of progenic occlusion, the canines are usually already in the cross bite position. The static of the lower denture improve if first premolars are set up instead of canines.

If a cross bite situation results, we begin with a transitional tooth – in this case the second upper premolar. We very slightly round off the buccal cusps of the upper second premolar. Afterwards we grind a fossa in the buccal and lingual cusps of the lower second premolar so that the result is an occlusion.
In cross bite situations in the molar region, care must be taken that the mesiobuccal cusp of the upper first molar takes over the function of the mesiopalatal cusp, i.e. the mesiobuccal cusp must engage with the central masticatory groove of the lower first molar. To do this, again the mesiobuccal cusp must be ground down in such a way that it can take over a grinding function. It is sufficient to slightly round off the point of the cusp.

If we should now reach the point where there is no correlation between the cusp and fossa, we grind down the mesial contact surface of the lower first molar until we have an ideal correlation between the cusp and fossa. As an alternative, instead of the lower first molar, the lower second molar can also be set against it.

The lingualised set-up
An inter-alveolar contact in a transverse direction that does not explicitly indicate a cross bite sometimes allows us to change to a lingualized set-up. Here, as a result of the grinding, the fossae of the second premolar and first molar are positioned lingually so that the palatal cusps of the first premolar and the molar make contact in the fossa.
6. Contouring the denture base so that the muscles can grip

The outer surfaces of the denture base are designed so that the muscles can grip it. This means that in the frontal area so-called lip shields are built up for the orbicularis oris muscle. In the area of the posterior teeth, buccinator support plates are created and the muscular traction on the cheek ligaments is incorporated.

The distribution of the muscular traction starting from the node of the cheek muscles (marked “Wk” in the diagram) indicates the necessity of shaping the base so that the muscles can grip it:

- The muscular traction of the orbicularis oris (a+b) grips the lip shields
- The levitor anguli oris and depressor anguli oris (c+d) pull in the direction of the cheek ligaments
- The zygomatic muscle (e) pulls with parts of the buccinator (g) towards the zygomatic ridge
- The risorius (f) also runs backwards with parts of the buccinator (g) towards the diagonal
- The masseter muscle (m) overlaps the cheek eminence towards the back of the mouth
Fully set up and modelled denture ready to be tried in. Trial dentures made of wax should always be prepared in such a way that their volume matches that of the final acrylic denture base.

**Self-monitoring**

Before the wax trial denture is handed over, the following checks should be carried out once more using the silicon key:

- Frontal positioning
- Occlusion level
- Centering
7. Completing the dentures

There are many possible methods of flasking and polymerising the final denture. At Candulor we advocate the use of the open flask technique in the following manner.

**Embedding**

For embedding we use only Class 4 plasters in order to transfer the pressure to the models without loss. It is important to position the models in such a way that the approximal axes are positioned at a right angle to the plane of the vessel. In this way, during the pressing there is no surface where the pressure can engage so that it could possibly damage the front teeth. In the JST flask shown here, we align the front teeth dead centre to one of the three centring studs. As a result we later have the option of closing the flask by screwing it together asymmetrically in a wedge shape. This becomes necessary if we decide to give an individual character to the gum section. In order to make it easier to remove them, in the initial phase we cover the teeth only thinly with plaster and allow this to harden. Only at the second stage do we then fill the flask to the top.

**Boiling out**

Particular attention should be paid to the next two operations, boiling out and isolating. Before actually boiling out the flask, we heat it in a 90 °C water bath for 3 to 4 minutes. The flask is then allowed to cool in the air for 3–4 minutes and the wax is removed in a plastic state. Any wax which liquefies during the boiling out process will penetrate into the plaster and contaminate the surface. The same applies if washing-up liquid and organic solvents such as benzene, alcohol or acetone are used to clean the plaster surface. In this case, alginate-based isolating liquids can no longer bond with the plaster surface. The result can be surface discolouration and porosity in the acrylic.

**Isolating**

Before isolating the models, they must be placed in a (60 °C) hot water bath for approximately 15 minutes to ensure that the models are well soaked in water. Inadequate soaking will cause air to escape from the plaster model and bubbles will form in the acrylic. In the next operation we apply the Candulor Iso-K isolating liquid to the surface of the plaster using a clean brush. Allow the isolated models to dry for at least 10 minutes. If the isolating liquid is not dry it will bind with the acrylic, resulting in white discolouration.
Surface conditioning of the teeth
In order to achieve optimal bonding between the denture base material and the teeth, the surface of the teeth must be roughened or provided with retention grooves (no holes). Then moisten with monomer and leave it to work in for 3–4 minutes.

Packing, pressing and polymerisation
If you decide to colour the acrylic, then proceed as follows: mix the coloured acrylics 53/55/57 from the Candulor Aesthetic Color Set Easy and then apply around the vestibular area with a brush. Place the proven “dough” in the flask and press it onto the characterised denture base material. In order to avoid compressing the characterisation, we tighten the screw lying closest to the front teeth more firmly each time. The resulting wedge-shaped closure movement from mesial to distal deliberately directs the excess towards the dorsal and the characterisation is not compressed. The flask is then placed in the press and pressurised to (80 bar), screwed down completely and then polymerised.
8. Re-occlusion, grinding

Since the excursion movements of the lower jaw were only considered during the positioning of the posterior teeth insofar as the teeth were correctly positioned for the appropriate movement, it is essential to replace the models exactly in the articulator for the final stages of the work. Once this has been done, any final grinding in of the centric occlusion can begin. Here it is important to maintain uniform contact. This happens when the supports of the articulator are secured.

**Translational lateral movement**

In this phase both supports of the articulator must be unfastened. As the lateral excursion is carried out, the supporting pin must rest on the supporting pin plate and be pushed back transversally so far that the buccal cusps or incisal edges of the canines lie above one another. Here it is important that there is no manipulation of the canine and that the pressure on the buccal cusps is released. With green floss inserted, the lateral excursion on the lingual slopes of the cusps of the lower posterior teeth is carefully ground in. If we are carrying out a medial excursion, the guide lines on the buccal cusps of the lower posterior teeth become apparent. The exceptions are the first premolars, because of their inverted mortar pestle principle.

**Protrusion**

The protrusive movements of the lower jaw also have to be carried out whilst the joints are unsecured. We use blue film to check whether there are any possible disruptive contacts in the area of the front teeth. If the angle of the protrusion facetes in the area of the posterior teeth is too steep, this must also be corrected.

**Retrusion**

To do this, the fixing screw on the articulator designed for this purpose is opened, allowing us to move the lower jaw towards the dorsal as desired and thus simulate this short movement, which occurs during swallowing.

Goal: in the case of excursive movements, we should achieve at least three balancing contacts – at least 2 on the working side and at least one on the non-working side.
9. Final details and polish

After the denture has been carefully loosened from the cast, it is finished off with a moulding cutter, sandpaper strips, rubber polisher etc.

It is very important that the plastic does not become heated as a result of the rotating instruments. The consequence would be deformations caused by heat which could lead to imprecise fitting.

For the preliminary polish we recommend a solution of water and pumice, so that the denture surfaces become smooth and free of scratches. This applies in particular to the inter-dental spaces, which are best polished with goats’ hair brushes and KMG. The high gloss finish is achieved using Candulor KMG polish and a leather buffer.

Conclusion

Candulor places great value on meeting patients’ aesthetic and physiological needs. The secret of the success of this concept lies in the symbiosis between retaining what is tried and tested and developing new, high-quality products.

With the instruments described in this document, tried-and-tested processes, well-founded theoretical and prosthetic knowledge and good collaboration with the dental surgeon, we are in a position to produce excellent pieces of work.