

What’s new for the clinician – summaries of recently published papers (April 2026)

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1. FRACTURE RESISTANCE OF ENDOCROWNS PRODUCED BY 3D PRINTING AND – CAD-CAM BLOCKS: A COMPARATIVE ASSESSMENT

Endocrown is a restoration design based on the principle of minimally invasive dentistry for endodontically treated teeth¹. Endocrown restorations are monoblock restorations that achieve macromechanical retention from the pulp chamber and micromechanical retention through adhesive cementation. Endocrowns are particularly recommended for short, curved, calcified, or structurally damaged roots in molar teeth and in cases with significant coronal tissue loss or limited interocclusal space. Advances in CAD/CAM technology have led to the increased preference for endocrowns by enabling the rapid and accurate fabrication of precision restorations. However, the success of endocrowns hinges on material selection, as diverse options—ranging from ceramics to composites and hybrids—exhibit varying mechanical, optical, and biological properties under occlusal loads. Comparing these materials is crucial for optimizing clinical outcomes, especially amid evolving CAD/CAM and 3D-printing technologies that expand fabrication possibilities.

Common Endocrown materials include glass ceramics, lithium disilicate, resin nanoceramics, leucite-reinforced ceramics, and emerging printable resins. Leucite-reinforced glass ceramics (e.g., G-Ceram blocks for LRC-NF group) offer excellent aesthetics and polish ability but demonstrate lower fracture resistance, often failing first in non-ferruled designs due to brittleness under load. Lithium disilicate (e.g., Tessera blocks for LDS-NF) provides superior strength (up to 400 MPa flexural) and retention, with studies showing higher tensile forces post-thermocycling compared to hybrids; however, it risks catastrophic fractures without adequate ferrule. Resin nanoceramics (e.g., CERASMART for RNC-NF) balance elasticity (mimicking dentin) with reparability, yielding restorable failure modes and resistance above chewing

forces (~150-250 N), making them forgiving in high-stress posterior regions.

Hybrid composites and 3D-printable resins (e.g., Crowntec for PRM-NF) further diversify options, with the latter enabling additive manufacturing for precise fit and cost-efficiency. Intact teeth as controls consistently outperform restorations, underscoring the need for materials that approximate natural biomechanics. Recent 2026 in vitro data reveal LRC-NF as weakest, while RNC-NF, LDS-NF, and PRM-NF cluster similarly, all exceeding physiological demands but varying in failure patterns—adhesive for resins, cohesive for ceramics.

Ferrule vs. Non-Ferrule Designs

The ferrule effect—defined as a 1.5-2 mm band of healthy coronal tooth structure encircling the restoration—has long been debated in endocrown design, particularly for non-ferruled (NF) preparations like those in LRC-NF, RNC-NF, LDS-NF, and PRM-NF groups. Recent 2026 in vitro studies reveal that ferrule presence offers minimal enhancement to fracture resistance in adhesively bonded endocrowns, with non-ferrule groups still surpassing physiological chewing forces (~150-250 N) despite lower overall loads compared to controls. Ferruled counterparts (e.g., LRC-F) showed no statistically significant superiority ($P > .05$), attributing this to modern hybrid materials’ elasticity and pulp chamber retention, which distribute stress effectively even without peripheral dentin support.

These challenges traditional post-and-core dogma, favouring conservative NF endocrowns in moderately damaged molars, provided adhesion protocols are optimized. Clinically, NF designs reduce chair time and tooth sacrifice, ideal for South African public health contexts under NHI constraints.

Comparative Performance Metrics

Material Group NF= non-ferruled F= ferruled	Flexural Strength (MPa)	Fracture Load (N) Example	Failure Mode	Key Advantage
LRC-NF (G-Ceram) LRC=Leucite-reinforced glass ceramics	~150-200	Lowest (~800-1000)	Catastrophic	Aesthetics
RNC-NF (CERASMART) RNC= Resin nanoceramics	~200-250	~1500-2000	Restorable	Repairable
LDS-NF (Tessera) LDS= Lithium disilicate	~400	~1800-2200	Cohesive	Retention
PRM-NF (Crowntec) PRM= Hybrid composites and 3D-printable resins	~150-200	~1600-1900	Adhesive	Cost-effective
Control (Intact)	N/A	>2500	N/A	Benchmark

Hekimoğlu et al (2026) ¹ reported on an invitro the study that sought to compare the fracture resistance of LRC, resin nanoceramic (RNC), lithium disilicate ceramic (LDS) blocks, and printable resin used for endocrowns manufacturing on mandibular molars. Two hypotheses were tested in this study: The first null hypothesis states that there is no significant difference in the fracture resistance of endocrown restorations fabricated from different materials; the second null hypothesis suggests that the presence of a ferrule does not have a significant effect on the fracture resistance of these restorations.

Materials and methods

108 mandibular molars that were extracted for periodontal reasons, with homogeneous dimensions and free of fractures, cracks, or caries, were used. Root canals were prepared using the ProTaper Next rotary file system. The mesial canals were sequentially enlarged with files X1 and X2, while the distal canals were prepared using files X1, X2, and X3. Root canal was obturated with gutta-percha points and epoxy resin sealer using the lateral compaction technique. Then canal orifices were sealed with flowable composite resin.

A periodontal ligament simulation was performed for all specimens using a polyether impression material with a thickness of 0.2–0.3 mm. To simulate the bone level, the specimens were embedded in standardized polymethyl methacrylate blocks up to 1 mm below the cemento-enamel junction (CEJ).

For the preparation of the ferrule (F) group teeth, the crowns were sectioned 1 mm above the cemento-enamel junction under water cooling. Subsequently, adhering to the principles of endocrown preparation, a circumferential shoulder-type finish line with a width of 1 mm and a pulp chamber with a depth of 2 mm were prepared (Fig. 1). In the ferrule group, the remaining coronal wall thickness was standardized between 1 and 1.5 mm to ensure uniformity and adequate structural support. For the preparation of the non-ferrule (NF) group teeth, the crowns were removed at the cemento-enamel junction under water cooling, and a pulp chamber with a depth of 2 mm was prepared.

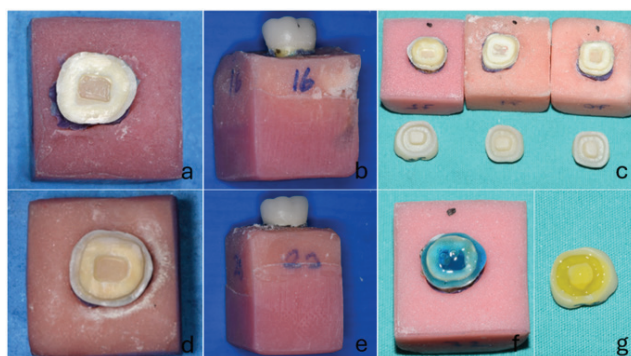


Fig1: a) Preparation of non ferrule specimens, b) Cementation of endocrowns in specimens non ferrule, c) Ferrule group specimens and endocrowns before cementation, d) Preparation of ferrule specimens, e) Cementation of endocrowns in specimens ferrule, f) Etching of the specimens with 37% orthophosphoric acid, g) Etching of the LDS restoration with 5% hydrofluoric acid

The digital impressions of the prepared specimens were obtained using an intraoral scanner (Cerec Primescan, Sirona). The digital data were then exported into the inLab CAD software. The occlusal form and anatomy of the restorations were determined based on the right mandibular first molar model available in the software database. All

restorations were designed such that the distance between the cusp tip and the restoration margin ranged from 5.5 to 6 mm, and the distance between the central fossa and the pulpal floor ranged from 3.5.

Subsequently, to achieve an equal distribution of teeth among the groups, specimens with ferrules and non-ferrules were separately randomized, and 108 teeth were divided into nine groups, with the average surface areas of each group as close as possible.

Specimens with 1-mm shoulder-type ferrules were divided into four groups according to the restorative material used for endocrown fabrication;

- **Group LRC -F:** Endocrowns manufactured from LRC blocks (G Ceram)
- **Group RNC-F:** Endocrowns manufactured from RNC blocks (Cerasmart)
- **Group LDS-F:** Endocrowns manufactured from LDS blocks (Tessera)
- **Group PRM-F:** Endocrowns were manufactured using a 3D printer with PRM (Crowntec)

Specimens with non-ferrule were divided into four groups according to the restorative material used for endocrown fabrication;

- **Group LRC-NF:** Endocrowns manufactured from LRC blocks (G Ceram)
- **Group RNC-NF:** Endocrowns manufactured from RNC blocks (Cerasmart)
- **Group LDS-NF:** Endocrowns manufactured from LDS blocks (Tessera)
- **Group PRM-NF:** Endocrowns were manufactured using a 3D printer with PRM (Crowntec)
- **Group Control:** Intact teeth

Restorations were fabricated using a CEREC MCX milling unit (Dentsply Sirona) for the LRC, LDS, and RNC blocks. After milling, LDS and LRC restorations were glazed using a calibrated furnace (Speedfire, Dentsply Sirona). 5% hydrofluoric acid was applied to the bonding surfaces of LDS and LRC restorations for 60 s to achieve surface conditioning according to the manufacturer's instructions. Following the etching procedure, a silane agent was applied to the treated surfaces and allowed to dwell for 60 s.

After milling, RNC restorations were glazed with a resin composite glaze. After the glazing process, the cementation surface of the RNC restorations was roughened with 30 µm silica-modified aluminum oxide particles (Rocatec Soft, 3 M Oral Care; St Paul, MN, USA) perpendicular to the surface from a distance 10 mm during 10 s with 30 psi pressure according to the manufacturer's instructions.

PRM restoration was fabricated using an Asiga Max 3D printer (Asiga). The fabrication parameters were set as follows: 50 µm layer thickness, 0.017 s minimum exposure time, 0.01/10.66 mW/cm² minimum/maximum light intensity. After completion of the additive manufacturing process, residual resin on the Crowntec restorations was cleaned using an applicator with alcohol, and post-curing procedures were performed according to the manufacturer's instructions. After the post-cure process, the cementation surface of the PRM restorations was roughened by using 110 µm aluminum oxide particles. During the cementation protocol, the enamel and dentin surfaces of each specimen were conditioned with 37% phosphoric acid for 30 s. The surfaces were then

rinsed with an air-water spray for 20 s and dried. A universal adhesive resin (All-Bond Universal) was applied for 20 s and gently air-thinned for 5 s. The manufactured restorations were cemented using a dual-cure resin cement following the manufacturer's instructions.

After cementation, fracture resistance testing was performed on the specimens using a universal testing machine (Instron). The maximum load at fracture was recorded in Newtons (N). The failure mode of the specimens was classified as follows: Type I, restoration fracture; Type II, restorable fracture involving both the tooth and the restoration; or Type III, non-restorable fracture of the remaining tooth structure.

Results

A statistically significant difference was observed in the mean fracture resistance values among the materials in the groups ($P < .05$). Independent of the presence of a ferrule, the Control group exhibited the highest fracture resistance, whereas the LRC group demonstrated the lowest. In the comparison of the ferrule groups, a statistically significant difference was observed ($P < .05$). The differences between the Control, PRM-F, RNC-F, and LDS-F groups and the LRC-F group were found to be statistically significant ($P < .05$), whereas no significant difference was detected among the Control, PRM-F, RNC-F, and LDS-F groups. Nonetheless, the fracture resistance values of all endocrown groups were determined to exceed the maximum masticatory forces reported in the literature.

In the comparison of the non-ferrule groups, a statistically significant difference was observed ($P < .05$). The differences between the Control, PRM-NF, and RNC-NF groups and the LRC-NF group, as well as between the Control and PRM-NF groups and the LDS-NF group, were found to be statistically significant. Among the ferrule groups, statistically significant differences were also observed between the Control, PRM-F, RNC-F, and LDS-F groups and the LRC-F group.

Comparisons of ferrule and non-ferrule groups fabricated from the same material revealed no statistically significant differences ($P > .05$ for all paired comparisons). No statistically significant difference was detected in the distribution of fracture types among either the non-ferrule groups ($P > .05$) or the ferrule groups ($P > .05$). Although no statistically significant differences were identified among the materials concerning fracture types, the results indicated that LRC restorations, which exhibited the lowest fracture resistance, were associated with the highest incidence of type I fractures. Restorations fabricated from RNC and PRM materials predominantly demonstrated restorable fractures, namely type I and type II. By contrast, the LDS group exhibited the highest incidence of catastrophic fractures.

Conclusions

Within the limitations of this in-vitro study, the materials evaluated demonstrated different fracture resistance behaviours depending on their microstructural characteristics and manufacturing techniques. The resin matrix-based RNC and PRM groups, as well as the LDS group, exhibited higher fracture resistance compared to the LRC group. LRC, which showed lower fracture resistance, generally resulted in restorable fractures. LDS restorations tended to show catastrophic failures. However, PRM and RNC groups exhibited higher fracture strength and predominantly restorable failure modes.

Implications for practice

Endocrowns used Leucite Reinforced Ceramic showed the lowest fracture resistance. In contrast, the fracture resistance values of all materials used are greater than the physiological chewing force value. The presence of a ferrule did not affect the fracture resistance values.

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2. IS SINGLE-SHOT ANTIBIOTIC PROPHYLAXIS REALLY ENOUGH FOR STANDARD ORAL MAXILLOFACIAL (OMF) SURGERIES?

Antibiotic prophylaxis is standard in oral and maxillofacial surgery (OMS) due to the high bacterial load in the oral cavity, which elevates surgical site infection (SSI) risk in clean-contaminated procedures like fracture repair, orthognathic surgery, and third molar extractions. Evidence increasingly supports single or short-course (≤ 24 hours) regimens over multiple doses or prolonged courses (≥ 48 –72 hours) to minimize resistance and adverse effects while maintaining efficacy.

Evidence on Single vs. Multiple Doses: A 2019 systematic review and meta-analysis of 21 prospective trials (1,974 patients) found no significant difference in surgical site infection (SSI) rates between short-course (≤ 24 hours) and extended-course (≥ 72 hours) prophylaxis in OMS and ear, nose and throat (ENT) procedures (RR 0.88; 95% CI 0.63–1.21). Similarly, a 2026 retrospective-prospective study of 856 OMS patients across six procedures (e.g., fractures, orthognathics) showed single-shot prophylaxis yielded comparable postoperative infection rates (9.40% vs. 7.93%) to >48 -hour regimens after risk adjustment (adjusted OR 1.13; 95% CI 0.70–1.84). Contrasting evidence from orthognathic-specific meta-analyses suggests single-day prophylaxis may outperform single preoperative doses (RR 0.28; 95% CI 0.09–0.82), though long-term (2–7

days) regimens reduced SSI vs. single-day in moderate-bias RCTs.

Clinical Outcomes: Surgical site infection (SSI) rates remain low (1.5–4.5%) with prophylaxis, and short regimens show equivalent efficacy to prolonged ones in most OMS contexts, including mandibular fractures and flap reconstructions. No added benefit from extended courses was seen in preventing dehiscence, abscesses, or revisions, even in contaminated sites. Microbial aetiologies (e.g., *S. aureus*, *Pseudomonas*) did not differ by regimen duration.

Hospital Stay Impact: Single/short prophylaxis shortens stays without compromising safety. In the 2026 study, it reduced overall length of stay from 5.83 to 4.32 days ($p < 0.001$), with similar drops in fractures (6.39 to 4.94 days) and plate removals. One ENT/OMS trial noted extended regimens increased stays by ~ 0.7 days. Fewer antibiotic days also cut consumption (63.8 to 47.0 DDD/100 patient-days).

Adverse Effects: Prolonged prophylaxis doubles adverse event risk (RR 2.40; 95% CI 1.20–3.54), mainly gastrointestinal (diarrhoea 18%), nausea (14%), and rash. Each extra 10 antibiotic days raises adverse drug event

odds by 3%, including renal/hematologic issues. Short courses mitigate resistance and costs.

Evidence Strength: High-quality synthesis from meta-analyses of RCTs supports short/single-dose equivalence for standard OMS (low heterogeneity, $I^2 < 12\%$). However, evidence is moderate overall due to bias risks (e.g., incomplete blinding), retrospective elements, and subgroup limitations (e.g., high-risk orthognathics). Guidelines weakly approve perioperative single/short courses (grade IIb), urging tailoring for contamination or host factors; more placebo-controlled RCTs needed for high-risk cases

Schorn et al (2026)¹ reported on a trial that sought to evaluate postoperative complications in patients undergoing six standard oral maxillofacial surgical (OMFS) procedures at an Oral and Maxillofacial Surgery department while being treated with either only single-shot antibiotic prophylaxis or a prolonged scheme of postoperative prophylactic antibiotic use of 48 h. In addition, the duration of the inpatient stay and the total antibiotic consumption of the OMFS ward were examined. It was hypothesized that single-shot antibiotic prophylaxis would provide similar clinical outcomes compared to a prolonged regimen of postoperative prophylactic antibiotics.

Methodology

Fig 1 provides information on the study flow of 982 patients who were considered for inclusion. For inclusion, adult patients had to be undergoing of one of six standard OMF-Surgeries (open reduction and internal fixation with osteosynthesis plate of OMF-Fractures, removal of at least one osteosynthesis plate, orthognathic surgery – only bimaxillary procedures, intraoral ablative tumour surgery (exclusively intraoral tumours without further surgical steps such as plastic reconstruction or neck dissection), exclusively

neck dissection and intraoral bone augmentation). Patients were excluded if they presented with concomitant infections that required antibiotic therapy.

Evaluated data included: type of operation, gender, age, BMI, allergies, general illnesses (divided into subcategories: neurological, pulmonary, cardiovascular, infections, nephrological, endocrinological, cancerous, psychological and other), medication, type of antibiotic prophylaxis (single-shot vs. 48h), type of agent used, form of administration (oral or intravenous), clinical signs of infection (calor, rubor, dolor, tumour, pus), wound dehiscence (mechanical=separation of the wound edges in the absence of infection, caused by physical or technical factors that compromise wound closure, and infectious=separation of the wound edges secondary to an infectious process in the surgical site), surgery duration, surgical approach, laboratory results of parameters indicating infection (C-reactive protein, white blood cell count (WBC)), inpatient length of stay, postoperative complications (wound dehiscence, abscess, infection) and possible revision surgery.

Surgeries and standard of care

All orthognathic procedures were performed following proper orthodontic preparation. Maxillary movements were performed using a Le Fort I osteotomy in all included patients. In the mandible, bilateral sagittal split osteotomy (BSSO) was performed. Throughout the study period, the responsible surgical team remained unchanged. No relevant changes occurred with regard to surgical technique, suture material, or planning protocols. Average operating times were comparable across the study period. The interval between trauma and surgical treatment varied by fracture type: mandibular fractures were generally treated within 0–2 days, whereas midfacial fractures were managed after 4–9 days. In cases of open mandibular fractures, preoperative antibiotics were administered (e.g. Aminopenicillins with β -lactamase inhibitors

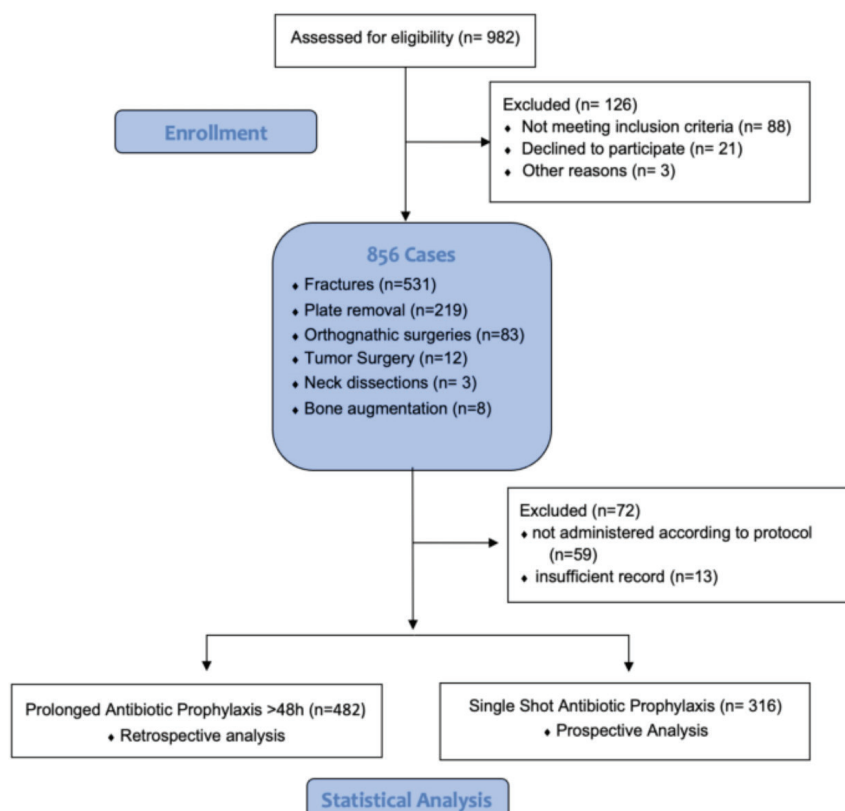


Fig 1 provides information on the study flow of 982 patients who were considered for inclusion.

1-1-1 until surgery). In all cases, trauma or orthognathic, internal fixation was achieved using titanium miniplates. In fractures the method of osteosynthesis was consistently open reduction and internal fixation (ORIF) using titanium plates. For surgeries longer than 3 h, a second dose of antibiotics was administered. Trauma patients typically remained hospitalized for 2–4 days postoperatively. Patients with mandibular fractures are admitted immediately after trauma and operated on without delay, whereas patients with midfacial fractures are admitted depending on severity. At the time of the study, patients undergoing plate removal were routinely hospitalized for 2 days. Orthognathic surgery patients routinely remained hospitalized for 5–6 days postoperatively. Postoperative radiographic controls were routinely performed and reviewed to confirm adequate reduction. There was no standardized scientific follow-up protocol; instead, patients received regular postoperative surgical follow-up based on clinical necessity.

Intravenous antibiotic consumption was calculated as defined daily doses (DDD) per 100 patient days, in accordance with the WHO ATC/DDD methodology. Data collection was limited to systemic antibiotics administered intravenously. Patient-day denominators were obtained from institutional administrative records.

RESULTS:

During the complete study period, 856 patients met the inclusion criteria. Of these 856 cases, the following surgical procedures were performed: A total of 531 fractures were included in the analysis. Midfacial fractures comprised Le Fort I ($n=10$, 1.9%), Le Fort II ($n=20$, 3.8%), Le Fort III ($n=7$, 1.3%), orbital floor fractures ($n=87$, 16.4%), zygomatic bone fractures ($n=148$, 27.9%), alveolar buttress fractures ($n=1$, 0.2%), anterior wall of the maxillary sinus ($n=2$, 0.4%), and isolated zygomatic arch fractures ($n=82$, 15.4%). Mandibular fractures accounted for 174 cases (32.8%), 219 osteosynthesis plate removals, 83 orthognathic surgeries, 12 ablative tumour surgeries, 3 neck dissections and 8 intraoral bone augmentation cases and were included in this study. 482 (56.6%) patients received prolonged antibiotic prophylaxis of 48 h. 316 (37.1%) patients received only a single dose of antibiotic prophylaxis. In 72 (8.28%) cases, antibiotic prophylaxis was either not administered according to protocol or not recorded, resulting in exclusion from the study.

Sociodemographic data revealed an average age of 41.9 years, including 29.7% ($n=259$) women and 70.2% ($n=611$) men. The mean body mass index (BMI) was 24.3. Underlying diseases included nephrological (1.7%), neurological (4.1%), cardio-vascular (17.4%), pulmonary (9.2%), infectious (4.8%), endocrinological (9.8%), oncological (7.8%), psychiatric (5.8%), and other diseases (4.3%), as well as previous or current infection with Methicillin-resistant *Staphylococcus aureus* (MRSA) or multi-resistant gram-negative bacteria (3/4-MRGN) (1.5%).

Postoperative infection rates were 6.36% versus 8.16% for fractures ($p=0.48$), 12.96% versus 7.27% for plate removal ($p=0.18$), and 7.89% versus 20.00% for orthognathic surgery ($p=0.21$) when comparing prophylaxis >48 h with single-shot prophylaxis. Overall infection rates were 7.93% versus 9.40%, respectively ($p=0.46$). For Fractures in the multivariable logistic regression analysis, single-shot antibiotic prophylaxis was not independently associated with the occurrence of postoperative infection compared with prophylaxis administered for more than 48 h (adjusted OR 1.45, 95% CI 0.72–2.94; $p=0.298$). Age, sex, body

mass index, comorbidity burden, and fracture type were not significantly associated with postoperative infection in the adjusted model. Stratified multivariable analyses were conducted for different fracture types with sufficient numbers of postoperative infections (Mandibular fractures, zygomatic bone fractures, Orbital fractures and Le-Fort fractures). In patients with mandibular fractures, the antibiotic prophylaxis regimen was not independently associated with postoperative infection after adjustment for age, sex, body mass index, comorbidity burden, and fracture characteristics (adjusted OR 1.90, 95% CI 0.72–4.98; $p=0.192$). In patients with zygomatic-orbital fractures, no significant association between antibiotic regimen and postoperative infection was observed (adjusted OR 0.66, 95% CI 0.07–6.40; $p=0.717$).

There was no significant difference in laboratory parameters indicative of infection (CRP and white blood cell count) for orthognathic surgeries while there was a significant difference in CRP values for removal of osteosynthesis plates (>48 h antibiotic prophylaxis: 1.74 2.50 mg/dl versus single-shot 2.69 3.14 mg/dl, $p=0.046$). Overall surgeries, in multivariable linear regression models adjusting for age, sex, BMI, and comorbidity burden, and surgical procedure, single-shot prophylaxis was not associated with higher postoperative CRP compared with prophylaxis >48 h.

Length of stay: A significant difference depending on the length of antibiotic prophylaxis could also be demonstrated for the overall in-patient length of stay. In a multivariable linear regression model adjusted for age, sex, BMI, comorbidity burden and procedure category, single-shot prophylaxis was associated with a shorter length of hospital stay compared with prophylaxis >48 hours (>48h antibiotic prophylaxis: 5.83 ± 7.92 days versus single-shot 4.32 ± 4.88 days, 95% CI –2.45 to –0.74; $p < 0.001$). Significant differences in the duration of hospital stay for the surgery subgroups of fracture osteosyntheses (>48h antibiotic prophylaxis: 6.39 ± 5.74 days versus single-shot 4.94 ± 2.89 days, $p=0.001$) and plate removal (>48h antibiotic prophylaxis: 2.48 ± 2.60 days versus single-shot 1.81 ± 2.08 days, $p=0.019$).

Antibiotic consumption: Annual inpatient antibiotic consumption data from the OMFS clinic showed a decrease from 63.8 defined daily doses (DDD)/100 patient days in 2018 to 47.0 DDD/100 patient days in 2020.

Conclusion

The findings of this retrospective study suggest that single-shot antibiotic prophylaxis may be a feasible approach in selected bone-related maxillofacial procedures such as orthognathic surgery, trauma, and augmentation and may reduce patient length of stay and total antibiotic consumption. However, special surgical techniques and hospital-specific aftercare may require adaptation of strict single-shot regimens.

Implications for practice

These results support a reduction of prolonged prophylaxis but maxillofacial departments in different settings may have different pathogen spectra and local circumstances that will require a cautious approach to unilaterally changing guidelines based on studies from other parts of the world.

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