

Research Article

Comparative Clinical Evaluation of Nanofilled Composite vs. Resin Modified Glass Ionomer Cement in Class V Non-Carious Cervical Lesions: A Split Mouth Technique

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Abstract

Background: Non-carious cervical lesions (NCCLs) pose a restorative challenge due to their multifactorial etiology, absence of enamel margins, and high stress concentration at the cervical region, which predisposes restorations to marginal breakdown and debonding. Nanofilled composites and resin-modified glass ionomer cements (RMGIC) are widely used for restoring NCCLs, offering distinct advantages in esthetics, mechanical strength, and adhesion, respectively. However, their comparative clinical performance remains debated. This split-mouth trial evaluated and compared nanofilled composite and RMGIC in Class V NCCLs using modified United States Public Health Service (USPHS) criteria.

Materials and Methods: Thirty patients with 100 Class V NCCLs were enrolled, and lesions were randomly allocated to nanofilled composite (Filtek Z350 XT, 3M ESPE) or RMGIC (GC Gold Label LC 2), following standard adhesive protocols. Restorations were evaluated at baseline, 3 months, and 6 months for anatomic form, surface roughness, marginal adaptation, marginal discoloration, retention, fracture, secondary caries, and postoperative sensitivity using modified USPHS criteria. Data were analyzed using ANOVA ($p < 0.05$).

Results: All 100 restorations were available at 6 months. Both materials showed clinically acceptable performance across all parameters, with no significant differences in anatomic form ($p=0.337$), surface roughness ($p=0.695$), marginal adaptation, retention, fracture, secondary caries, or postoperative sensitivity ($p=0.954$). A significant difference was noted in marginal discoloration ($p=0.031$), with RMGIC showing progressive color mismatch, while nanofilled composite maintained superior color stability.

Conclusion: Both materials performed satisfactorily in NCCLs over 6 months, but nanofilled composite demonstrated superior esthetic stability, making it preferable in esthetically demanding regions.

Keywords: Non-carious cervical lesions, Nanofilled composite, Resin-modified glass ionomer cement, USPHS criteria, Clinical evaluation, Marginal discoloration

Introduction

Non-carious cervical lesions (NCCLs) involve the irreversible loss of tooth structure at the cervical region, typically around the cemento-enamel junction, in the absence of bacterial involvement, and their prevalence and clinical guidelines for restoration have been comprehensively reviewed in the literature [1]. Abrasion, erosion, and abfraction are considered the principal etiological factors, often acting synergistically to produce progressive cervical dentin exposure, which in turn is frequently associated with dentinal hypersensitivity requiring active clinical management [2]. Given the absence of enamel margins and the high stress concentration at the cervical region, restoration

of NCCLs remains technically demanding, and no single restorative material has been established as clearly superior, with material selection continuing to be guided largely by clinician preference and lesion characteristics [1,3]. Among the restorative options available, glass ionomer cements (GICs) and composite resins remain the most extensively studied and compared. A systematic review and meta-analysis comparing GICs with composite resins in NCCL restorations found comparable clinical performance between the two material classes across parameters such as retention, marginal adaptation, and marginal discoloration, though considerable heterogeneity was noted across the included studies [3]. Resin-modified glass ionomer cement (RMGIC) was subsequently introduced to overcome the mechanical

and esthetic limitations of conventional GIC while retaining its fluoride release and chemical adhesion to tooth structure; a retrospective evaluation of Class V restorations found substantially lower loss rates for RMGIC compared with conventional GIC, supporting its favorable long-term retention [4]. Randomized split-mouth trials directly comparing RMGIC with resin composite restorations in NCCLs have similarly reported acceptable short-term clinical performance for both materials, though postoperative sensitivity and marginal behavior have shown material-dependent differences [5,6]. Combined surgical-restorative approaches using RMGIC and nano-ionomer restorations alongside connective tissue grafting for NCCLs with associated gingival recession have also been explored, reflecting the broader clinical interest in optimizing both esthetic and periodontal outcomes at the cervical margin [7]. Building on this evidence base, the introduction of nanofilled composites, incorporating nanoscale filler particles, has further expanded the restorative options available for NCCLs, offering improved mechanical properties, wear resistance, and surface finish compared with earlier microfilled composite systems. More recent randomized split-mouth trials evaluating newer esthetic restorative systems, including surface pre-reacted glass-ionomer (S-PRG)-containing composites against nanotechnology-based composites, have generally found no statistically significant differences in overall clinical performance between materials over extended follow-up, underscoring that the comparative behaviour of contemporary esthetic and ion-releasing materials in NCCLs remains an active area of investigation [8]. Despite this expanding body of evidence, direct split-mouth comparisons specifically between nanofilled composite and RMGIC using standardized clinical criteria over a defined follow-up period remain relatively limited. Given this continued need for material-specific comparative data, the present study was undertaken to clinically evaluate and compare the performance of nanofilled composite and RMGIC in Class V NCCLs using modified USPHS criteria over a 6-month follow-up period.

Study Design and Participants

This interventional, split-mouth clinical study was conducted in the Department of Conservative Dentistry and Endodontics, Government Dental College and Hospital, Nagpur. Ethical approval for the study protocol was obtained from the Institutional Ethics Committee of the same institution (IEC/GDCHN/29/2024). Written informed consent was obtained from all participants prior to their enrolment in the study. The sample size was calculated based on proportions reported in a previous study [10] for subjects presenting with at least two non-carious cervical lesions (NCCLs), using a significance level of $\alpha = 0.05$ and a statistical power of 80%. With proportions of 0.077 and 0.154 for the two comparison groups, the minimum calculated sample size was 45 teeth per group. To compensate for potential loss to follow-up, the sample size was increased to 50 teeth per group, yielding a total of 100 restorations placed in 30 patients. Participants were selected based on predefined inclusion and exclusion criteria. Patients aged 18–55 years, presenting with at least two NCCLs that responded positively to vitality testing and demonstrated acceptable oral hygiene (Oral Hygiene Index–Simplified [OHI-S] score of 0.0–3.0), were included in the study. Patients were excluded if they presented with poor oral hygiene, active carious lesions, heavy bruxism, tooth fracture

or cracks, or were currently undergoing orthodontic treatment. Additionally, patients who had undergone dental bleaching within the preceding six months or presented with lesions of abfraction origin were excluded from participation. A total of 100 NCCLs were diagnosed in 30 patients, each presenting with a minimum of two qualifying lesions, irrespective of the underlying etiology; lesion width and depth were not considered as selection criteria. The lesions were randomly allocated into two groups of 50 teeth each: Group I, restored with nanofilled composite (Filtek Z350 XT, 3M ESPE), and Group II, restored with resin-modified glass ionomer cement (RMGIC; GC Gold Label LC 2). A split-mouth design was employed, wherein a lesion in one quadrant was restored with nanofilled composite while the corresponding contralateral lesion was restored with RMGIC, thereby minimizing inter-patient variability.

Restorative Procedure and Clinical Evaluation

Prior to restoration, all selected teeth were cleaned using a slurry of pumice and water. A 1-mm bevel was placed along the enamel margins using a high-speed diamond bur under continuous water coolant. Teeth were isolated using cotton rolls and gingival retraction cord to ensure adequate moisture control and prevent contamination. Following bevel preparation, the enamel and dentin surfaces were dried using oil-free air from the dental unit's triple syringe. For lesions assigned to the nanofilled composite group, a universal bonding agent (Single Bond Universal, 3M ESPE) was applied according to the manufacturer's instructions, involving active application with agitation for 20 seconds, followed by gentle air-thinning to achieve a uniform, even layer, and light-cured for 20 seconds using an LED curing unit (Bluephase). The nanofilled composite was then placed incrementally and light-cured. For lesions assigned to the RMGIC group, only bevel preparation was performed prior to material placement, in accordance with the manufacturer's self-adhesive application protocol, without the use of a separate bonding agent. Following restoration, gross finishing was performed using yellow-coded flame- and football-shaped diamond finishing burs, followed by Shofu polishing discs. Final polishing was achieved using Shofu silicone polishers, including rubber cup, flame, and wheel-shaped tips, to obtain a smooth, high-luster surface finish. All restorations were clinically evaluated at 7 days (baseline), 3 months, and 6 months by two calibrated, blinded examiners using the modified United States Public Health Service (USPHS) criteria (Table 1). The parameters assessed included anatomic form, surface roughness, marginal adaptation, marginal discoloration, retention, fracture, secondary caries, and postoperative sensitivity. Data obtained at each follow-up interval were statistically analyzed using one-way analysis of variance (ANOVA), with a significance level set at $p < 0.05$.

Statistical Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS, version XX; IBM Corp., Armonk, NY, USA). Descriptive statistics (mean $\pm$ standard deviation) were calculated for each clinical parameter at 7 days, 3 months, and 6 months. Between-material comparisons (Nanofilled Composite vs. RMGIC) were performed using one-way analysis of variance (ANOVA). A significance level of $p < 0.05$ was considered statistically significant.

Table 1: Categories and score descriptions for the clinical evaluation of restorations according to the modified USPHS criteria.

Category	Score	Criteria
Anatomic Form	0	Restoration is continuous with tooth anatomy.
	1	Slightly under- or over-contoured restoration.
	2	Restoration is under-contoured, dentin or base exposed.
	3	Restoration is missing or partially fractured; restoration causes pain in tooth/adjacent tissue.
Surface Roughness	0	Smooth surface.
	1	Slightly rough or pitted, can be polished.
	2	Rough, cannot be polished.
	3	Surface deeply pitted with irregular grooves.
Marginal Adaptation	0	Restoration is contiguous with tooth anatomy, explorer does not catch.
	1	Explorer catches, but no visible crevice into which explorer will penetrate.
	2	Crevice at margin, enamel exposed.
	3	Obvious crevice at margin, dentin or base exposed.
Marginal Discoloration	0	No discoloration evident.
	1	Slight staining, can be polished away.
	2	Obvious staining, cannot be polished away.
	3	Gross staining.
Retention	0	No loss of restorative material.
	1	Partial loss of restorative material.
	2	Missing restoration.
Secondary Caries	0	No evidence of caries contiguous with restoration margin.
	1	Caries evident contiguous with restoration margin.
Fracture	0	Absent.
	1	Small fracture, clinically acceptable.
	2	Clinically unacceptable fracture.

Result

All 100 restorations (100%) were available for evaluation at baseline, 3 months, and 6 months, with no loss to follow-up. Both restorative materials demonstrated clinically acceptable performance over the 6-month follow-up period, as evaluated by USPHS criteria. No statistically significant differences were observed between Nanofilled Composite and RMGIC with respect to anatomic form ($p = 0.337$), surface roughness ($p = 0.695$), and post-operative sensitivity ($p = 0.954$). Neither material exhibited failures related to retention, fracture, marginal adaptation, or secondary caries during the study duration. A statistically significant difference was observed for marginal discoloration ($p = 0.031$), with RMGIC restorations exhibiting progressive colour mismatch, while Nanofilled Composite maintained superior colour stability throughout the evaluation period. Taken together, these findings suggest that although both materials performed satisfactorily, Nanofilled Composite demonstrated enhanced aesthetic stability compared to RMGIC (Table 2).

Discussion

Non-caries cervical lesions (NCCLs) are frequently encountered in clinical practice and pose considerable challenges in restoration [9]. Research evaluating Class V restorations placed in cervical (root) caries lesions has reported substantially higher failure rates. In university clinical settings, cumulative failure rates after two years have been shown to vary widely, ranging from approximately 27% to as high as 96% [11]. Aesthetic materials commonly used for Class V restorations can be broadly classified as resin composites, conventional glass ionomer cements (GICs), resin-modified glass ionomer cements (RMGICs), and compomers. Among these options, RMGICs have demonstrated consistent clinical performance due to their ability to chemically adhere to tooth structure and their relatively low elastic modulus, which allows them to better withstand tensile stresses in the cervical area during function or occlusal discrepancies. Additionally, their coefficient of thermal expansion closely approximates that of natural tooth structure, contributing to improved durability of

Table 2: Comparative evaluation of clinical performance of Nanofilled Composite and Resin-Modified Glass Ionomer Cement (RMGIC) at 7 days, 3 months, and 6 months based on USPHS criteria. Data are presented as mean $\pm$ standard deviation (SD). ANOVA * means significant. d- Days; m-Months.

Criteria	Nanofilled Composite (Mean $\pm$ SD)	RMGIC (Mean $\pm$ SD)	Between-Material p-value
Anatomic Form	7d: 0.06 $\pm$ 0.23 3m: 0.06 $\pm$ 0.23 6m: 0.06 $\pm$ 0.23	7d: 0.08 $\pm$ 0.24 3m: 0.07 $\pm$ 0.25 6m: 0.09 $\pm$ 0.26	0.337
Surface Roughness	7d: 0.07 $\pm$ 0.25 3m: 0.07 $\pm$ 0.25 6m: 0.07 $\pm$ 0.25	7d: 0.06 $\pm$ 0.22 3m: 0.07 $\pm$ 0.23 6m: 0.08 $\pm$ 0.27	0.695
Marginal Discolouration	7d: 0.12 $\pm$ 0.38 3m: 0.12 $\pm$ 0.38 6m: 0.12 $\pm$ 0.38	7d: 0.10 $\pm$ 0.35 3m: 0.14 $\pm$ 0.39 6m: 0.18 $\pm$ 0.42	0.031 *
Retention & Fracture	7d: 0.00 $\pm$ 0.00 3m: 0.00 $\pm$ 0.00 6m: 0.00 $\pm$ 0.00	7d: 0.00 $\pm$ 0.00 3m: 0.00 $\pm$ 0.00 6m: 0.00 $\pm$ 0.00	–
Marginal Adaptation & Secondary Caries	7d: 0.00 $\pm$ 0.00 3m: 0.00 $\pm$ 0.00 6m: 0.00 $\pm$ 0.00	7d: 0.00 $\pm$ 0.00 3m: 0.00 $\pm$ 0.00 6m: 0.00 $\pm$ 0.00	–
Post-operative Sensitivity	7d: 0.08 $\pm$ 0.27 3m: 0.08 $\pm$ 0.27 6m: 0.00 $\pm$ 0.00	7d: 0.07 $\pm$ 0.25 3m: 0.05 $\pm$ 0.22 6m: 0.02 $\pm$ 0.15	0.954

restorations, especially at enamel margins frequently involved in NCCL [12]. Long-term clinical evaluations of conventional composite restorations, whether placed directly or indirectly in high-stress regions, indicate that fracture of the restoration is among the most common failure modes. While their survival exceeds 10 years, this longevity is comparatively lower than that of GIC restorations, prompting continuous improvements in composites—progressing from microfilled formulations to the development of nanofilled composites [13]. Microfilled composites used in non-carious cervical lesions provide satisfactory esthetics and a smooth surface finish; however, long-term evaluations have shown reduced retention and increased marginal degradation when compared with microhybrid or nanofilled composites. Although initial research proposed that their greater flexibility could be advantageous in stress-prone cervical areas, clinical findings suggest that lower stiffness does not markedly enhance retention, and microfilled composites generally exhibit inferior durability over time [14]. Hence the present study aimed to compare clinical evaluation of nanofilled composite vs. resin modified glass ionomer cement in class v non-carious cervical lesions a split mouth technique. The split-mouth design minimizes inter-individual variability by allowing direct intra-patient comparison of restorative materials. This strengthens the validity of treatment effect estimates, making it well-suited for clinical evaluation in NCCLs [15]. The clinical evaluation over the 6-month follow-up period confirmed that while both the Nanofilled Composite and Resin-Modified Glass Ionomer Cement (RMGIC) provided a clinically acceptable performance, the Nanofilled Composite demonstrated a statistically superior aesthetic outcome by maintaining better color stability across the seven criteria analyzed. This was evidenced by the RMGIC's progressive marginal discolouration, thus indicating the composite as the preferred material when aesthetics are paramount. The RMGIC showed progressive marginal discolouration, a finding that was statistically significant. Consequently, the composite is the preferred choice when aesthetics are paramount. The findings of the present study are in accordance with Kaur et al.(2015) [16], who reported that nanofilled composites exhibited superior resistance to erosive and abrasive challenges compared to microfilled composites and RMGIC. This supports the present observation that nanofilled composites demonstrate better surface stability and esthetic durability than RMGIC in cervical restorations.

In the oral environment, restorative materials face cyclic cervical stresses during occlusal loading, leading to fatigue cracks and potential abfraction-related wear. They are further subjected to abrasion and erosion, contributing to surface degradation. In addition to wear and surface degradation, another clinical concern with NCCL restorations is postoperative sensitivity, which is often distressing for patients [17,18]. The introduction of self-etch adhesives and selective etching techniques has improved outcomes by dissolving the smear layer and incorporating it into the hybrid layer, thereby minimizing sensitivity. Over time, this discomfort tends to resolve naturally through tertiary dentin formation, further enhancing the long-term success of restorations. Advances such as modifying GIC into RMGIC, developing new composites, and reducing filler particle size have enhanced both wear resistance and surface texture and reduce post operative sensitivity [19]. The recent systematic review

and meta-analysis by Arbildo-Vega et al.(2025) [19] compared the clinical performance of GIC and composite resin in NCCL restorations. Analyzing 18 RCTs, the study found no statistically significant differences between the two materials across evaluated clinical parameters. This reinforces the notion that both restorative approaches are reliable, and material choice may ultimately depend on clinical situation, handling preference, and aesthetic requirements. Adhesion in NCCLs is challenged by limited enamel, shrinkage stress, and oral stresses, causing marginal gaps and discoloration. Newer adhesive systems with enhanced sealing ability, along with advanced polishing techniques, minimize these issues, while good oral hygiene helps prevent secondary caries and maintain periodontal health [20]. A 36-month split-mouth randomized clinical trial by Vural et al. [21] compared micro-hybrid resin composites with resin-modified glass ionomer in cervical caries lesions. Both materials demonstrated high retention and acceptable marginal adaptation, with no significant difference in clinical performance, though RMGIC showed more discoloration over time. These results are in accordance with the present study, reinforcing the comparable success of both restorative options in NCCLs. The present study was limited by a relatively short follow-up period of six months, which restricts assessment of the long-term clinical performance of the restorative materials. The sample size, though adequate for preliminary evaluation, may not fully capture variations across a broader population. Additionally, the study did not stratify results based on lesion size, depth, or occlusal loading patterns, which may influence restoration performance. Being a single-center study, the findings may have limited generalizability to different clinical settings. Finally, patient-related factors such as dietary habits, parafunctional activity, and oral hygiene practices were not extensively controlled, which could have affected restoration outcomes.

Conclusion

Within the limitations of the study, both nanofilled composite and RMGIC showed clinically acceptable performance in NCCL restorations over 6 months. While no significant differences were observed in most criteria, nanofilled composite maintained superior color stability, making it preferable when aesthetics are prioritized.

Conflict of Interest

The authors declare no conflict of interest.

Institutional Review Board Statement

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Author Contributions

Declared

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