The advantages of using a rubber dam are well-known when performing operative and endodontic procedures. These benefits include:

- isolation of the operating field to keep it dry and clean;
- improved access and visibility;
- potentially improved properties of dental materials;
- protection of the patient and dentist;
- improved operating efficiency.

Preparing teeth for indirect restorations always is challenging. Small mouths, large tongues, excessive salivation and overactive lips and cheeks are some of the many factors that can increase the difficulty of the procedure. Liebenberg\(^2\) suggested the need for a rubber dam during the preparatory, impression and cementation phases of indirect restorative procedures. He demonstrated how this can be done using alternative rubber-dam procedures.\(^2\) Although these procedures can be beneficial, they also can be time-consuming and difficult. Simplified rubber-dam techniques,\(^3,4\) though not new, do not seem to be used widely to help reduce the problems associated with preparing teeth for indirect restorations. The purpose of this article is to describe the slit–rubber-dam technique used to simplify the preparatory phase of indirect restorative procedures.

**PROCEDURE**

The dentist evaluates the patient’s occlusion to determine the appropriate occlusal reduction for the tooth that is to receive an indirect restoration. He or she places a floss-secured retainer at least one tooth distal to the tooth to be prepared after adequate anesthesia has been achieved. The dentist punches two holes in the rubber dam approximately 1 to 1½ centimeters apart and then cuts a slit in the dam with a scissors to connect the holes. The rubber dam is placed easily over the retainer. The anterior boundary of the rubber dam can be secured with floss, wooden wedges, a rolled rubber dam or a dental dam stabilizing cord (Wedjets, Coltène/Whaledent, Cuyahoga Falls, Ohio). The tooth or teeth now can be prepared in the usual manner, with enhanced visibility and retraction of the soft tissues. The clinician can place a retraction cord easily with the rubber dam in place because of its slit design (Figure).

The clinician removes the dam, checks the patient’s occlusion and refines the preparation as needed. The preparation now is complete, and the clinician can take an impression using his or her preferred technique.

**DISCUSSION**

The slit–rubber-dam technique enables the dentist to achieve optimal soft-tissue retraction with complete interproximal access. I have found that it provides more complete and reliable
tissue management and fluid control than does the use of syedopters, cotton rolls and other isolation techniques. The slit design can cause irrigation fluid and saliva to accumulate, but this problem is controlled easily with a high-speed vacuum and saliva ejector. Some clinicians might argue that this technique is time-consuming. However, the slit dam is prepared easily and placed during the time needed to attain anesthesia. In my experience, treatment can be provided more expeditiously because of the enhanced visibility and ability to achieve optimal soft-tissue retraction.

CONCLUSION

The slit–rubber-dam technique involves the use of a common dental armamentarium to simplify the preparatory phase of indirect restorative procedures. The slit dam enhances visibility, enables the practitioner to retract and protect the soft tissues, helps prevent the patient from swallowing or aspirating the tooth or restorative materials, controls oral fluids and promotes operating efficiency. I have found that this simple technique considerably reduces the stress for the dentist, dental assistant and patient.

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