**Title:** PEDODONTIC/VETERINARY DENTAL CROWN SYSTEM

**Abstract:** A dental crown consisting essentially of stabilized zirconia. The dental crown is particularly suited for pedodontic and veterinary applications. The zirconia crown may be formed by one of several manufacturing processes. The formed crown exterior is polished and fine polished to produce an aesthetic outer surface mimicking a natural tooth. Also disclosed is a method for providing a dental crown to a natural tooth and a kit of prefabricated crowns.

**FIG. 1**
PEDODONTIC/VETERINARY DENTAL CROWN SYSTEM

CROSS REFERENCE TO RELATED APPLICATION


BACKGROUND OF THE INVENTION

The present invention relates to a novel and useful prefabricated crown for pedodontic and veterinary applications.

At present, crowns used to repair adult human teeth are custom fabricated according to a mold of a tooth being repaired which is provided by the dental practitioner. The crowns may be formed of stainless steel or other metal clad with porcelain or a ceramic such as zirconia clad with porcelain. Using the mold as a guide, computer software, through a CAD/CAM technology, directs a milling machine to mill a coping or framework of the crown out of the chosen material, such as metal or ceramic, which is eventually clad with porcelain. Although satisfactory in result, the patient receiving such a crown must make multiple visits to the dental office to achieve this result and the process is time-consuming and expensive. The foregoing procedure is particularly difficult when the tooth being replaced is a child's (baby) tooth which will eventually be lost and replaced by permanent teeth through the natural maturing process. Veterinary crowns are also produced in the same manner and can be just as difficult to produce.

Given the difficulties of dealing with a child in a dentist's chair, dentists have developed prefabricated crowns that do not require molds and multiple visits to the dentist. The use of prefabricated, stainless steel crowns for restoring badly broken-down children's teeth is now the standard of care in pediatric dentistry. Recently, the American Academy of Pediatric Dentists has encouraged crown restorations due to the poor outcomes resulting from the use of fillings in certain high-risk groups, especially children with the inability to cooperate in the dental chair,
thereby necessitating the use of general anesthesia for their dental treatment. Prefabricated crowns are a very efficient and reliable restoration resource and are the restoration of choice in teeth with moderate to severe dental decay.

Stainless steel prefabricated crowns are the most versatile and widely used crowns in pediatric dentistry. However, due to their unaesthetic appearance, many dentists are turning to other manufacturers of preformed pediatric crowns for a more aesthetic option for their patients. In the late 1980s, the idea of creating a stainless steel crown and covering the visible surface with a tooth-colored composite material veneer started to gain favor. Cheng Crowns (1987), Kinder Krowns (1989), and NuSmile Crowns (1991) are some of the most notable manufacturers to gain significant market share with this revolutionary new crown for pediatric dentistry. Although these new crowns were much more aesthetic than the all-stainless-steel crowns, they came with some significant drawbacks.

The main benefit of the pre-veneered crowns was their more aesthetic appearance compared to their stainless steel predecessors. This new product, however, required a new method for preparing the tooth and seating the crowns. Because the plastic material was bonded to the metal substructure, it was recommended that these restorations have a passive fit to the tooth, minimizing the potential to crack the facing. Crimping or altering the metal substructure, which dentists were accustomed to doing before seating a crown, is not recommended in order to avoid weakening the bond between metal and facing. However, due to the increased strength of modern cements, this passive fit method has become accepted and works quite well with most luting agents used on the market today.

However, because of the interface between the metal and the plastic facing, there is also a tendency for the facing material to crack or chip off the metal substructure. The fragile nature of this interface is a major negative. Dentists often crack a facing when seating the crown or are required to re-treat a returning patient because of an unsightly failed restoration caused by the failure of this weakened interface.

Since the plastic facing must be applied to the front of the tooth over the metal substructure, the facing has a very bulky and bulbous appearance. This is particularly noticeable
when the need arises to crown only one anterior tooth. It is very hard to match the contour of the patient's natural teeth when using these bulky crowns, necessitating a significant reduction of the tooth structure in order to ensure a proper fit which can lead to unnecessary involvement of the pulp chamber and the need to perform a pulpotomy on the tooth.

Figure 11 shows a perspective view of one such bulky crown comprising a stainless steel base 80 and polymeric coating 82.

Matching tooth color is another big challenge when using current aesthetic pediatric crowns. The nature of the plastic overlaying the metal substructure gives them their nickname of "Chiclets." This is a word that is used frequently by both dental professionals and parents when describing the appearance of the current crowns available on the market.

In the course of sizing the crowns on the teeth to ensure proper fit, it is often necessary to sterilize and restock the unused crowns. The use of heat sterilizing techniques weakens the facing and the overall integrity of the crown. Therefore, it is necessary to use a 24-hour cold sterilizing technique on these crowns because of their plastic facing/metal interface. However, the use of the cold sterilizing technique tends to alter the shade of the facing from its original color. Due to this fact, many offices must maintain a separate storage container for crowns that have been sterilized. As the sterilized crowns will often not match those that have never been tried in the mouth, dental offices must stock a larger inventory of crowns which is a major unnecessary disadvantage for the dentist.

Even with all the potential negatives to these aesthetic crowns, until now they have been the best alternatives for dentists and parents who want a more natural smile for their children.

Various ceramics have been used in dentistry. Alumina, for example, has been used for implant abutments and crown and bridge frameworks and copings. Alumina has more translucency and better matches the translucency of natural teeth, but it lacks in strength and is more prone to failure.

Zirconia formulations have been used in adult dentistry for several years as a replacement for metal for the manufacturing of crown coping or frameworks. The copings are typically layered with porcelain to build up the entire structure of the tooth restoration and to develop the
aesthetic surface characteristics. Zirconia has also been used for implant abutments and as endosseous implant cylinders. Zirconia is white in color, and extremely strong. Zirconia has been replacing alumina as the framework material of choice due to its strength. The downside of zirconia is that it is very bright white and by itself, does not match the human dentition well.

Dental crowns and impression systems of various sorts have been proposed in the past.

For example, United States Patent 6,769,913 describes a device for taking dental impressions. The device includes impression cap having an injection port configured to receive material in an inner cavity.

United States Patent 4,492,579 shows a dental crown substrate formed of a noble-based metal formed over a thin metal foil substrate. A veneering material such as porcelain is then coated over the substrate.

United States Patents 4,992,049, 5,314,335, and 5,538,429 teach dental crowns utilizing a base of metallic mesh or stranded material covered by a veneer of porcelain.

United States Patents 3,058,216, 3,375,582, 4,392,829, 4,846,718, 5,624,261, 6,106,295 and 7,008,229 describe dental crowns utilizing metal or plastic as a coping which is veneered by porcelain or plastic material.

United States Patent 6,663,390 illustrates a ceramic prosthesis in which a metallic core is provided for attachment to an implant in the patient's mouth. A ceramic crown of porcelain zirconia, or polymeric material then covers the extending metallic core.

United States Patent 1,609,549 shows a telescopic tooth crown in which the interior of the crown includes a number of indents to aid in the adhesion of the inner and outer shells of the crown.

United States Patent 4,766,704 discloses machining a crown from a ceramic blank.

United States Patent Publication US2006/0 154211 describes a pediatric crown which may be prefabricated in various sizes and shapes for primary dentition. Porcelain has been employed as a outer crown material due to aesthetic appeal.

United States Patent 6,638,069 shows a shaping cap using a matrix material including
fillers such as zirconia mixed with silica and titanium dioxide.

United States Patent 5,775,913 shows an acrylic material filled with quartz or silicon dioxide, called Artglass.

United States Patent 6,592,373 shows a crown formed from an injection molded acetal homopolymer.


WO 2007/046693 describes a method for increasing the bond strength of stabilized zirconia to another substance.

The disclosures of each of the above references are incorporated by reference herein.

A pre-fabricated strong crown for pedodontic and veterinary applications and process for making the same would be a notable advance in the dental field.

**BRIEF SUMMARY OF THE INVENTION**

In accordance with the present invention, a novel and useful crown for pedodontic and veterinary applications is herein provided.

The present invention provides a dental crown composed of substantially pure zirconia (ZrO2) to create a strong crown. The zirconia is stabilized with stabilizers including, but not limited to, magnesium oxide (MgO), calcium oxide (CaO), yttrium oxide (Y2O3), cerium oxide (CeO2), aluminum oxide (Al2O3), scandium oxide (Sc2O3), ytterbium oxide (Yb2O3) and hafnium oxide (HfO2). Preferably, the zirconia crown is formed by designing in CAD (Computer Aided Design) followed by milling of sintered stabilized zirconia. Other methods of manufacturing the zirconia crown include electrophoretic deposition, ceramic injection molding or slip casting.

Various sizes of pedodontic and veterinary crowns may be pre-fabricated for children and animals.

In addition, the interior surface of the crown preferably includes at least one retention feature which assists in a lasting bond of the crown to the stub of the natural tooth.
Zirconia possesses a fairly, although not perfect, natural white color. The zirconia crown prepared as described above may be further amplified aesthetically to closely match dental teeth by creating a pearlescent outer surface. Such a result is achieved by pre-polishing the external surface of the cast zirconia crown with a diamond impregnated silicon wheel. A final polish is then accomplished by a brush wheel with the application of a diamond paste prior to placement in a patient. In addition, color modifiers may be added to the zirconia before sintering to modify the color of the zirconium.

After the crown has been created, crowns of various sizes may be placed in a kit for use by the dental practitioner. In this regard, the practitioner follows standard preparation guidelines for primary dentition for placement of a pre-fabricated crown. Thus, a pedodontic crown may be installed or placed on a natural tooth in a single visit simply by preparing the tooth stub, and selecting a proper size of a pre-fabricated zirconia crown by its mesiodistal width. The selected crown is then evaluated for fit and possible tissue impingement. Any extension of gingival margin is then trimmed where necessary with a fine diamond at relatively slow speed and with copious water spray. The crown is then filled with glass ionomer or self curing composite resin cement. The crown is then seated in the mouth completely. It should be noted that the at least one retention feature in the zirconia crown greatly aids in the fixing of the same to the stub of the natural tooth. Following such seating, the orientation of the crown is checked and, if necessary the occlusion is adjusted using a fine diamond. The emplaced crown is as hereinabove described mimics a natural tooth in appearance.

It should be realized that a new and useful dental crown system has been hereinabove described.

It is therefore an object of the present invention to provide a pedodontic and veterinary crown which is simple to use and easy to manufacture.

Another object of the present invention is to provide a pedodontic and veterinary crown in which the crown is essentially formed of stabilized zirconia or similar material and greatly mimics the natural tooth appearance of a patient.

Another object of the present invention is to provide a pedodontic and veterinary crown
in which a zirconia crown is employed that possesses great strength and durability.

Yet another object of the present invention is to provide a zirconia dental crown which is suitable for use with front and rear natural teeth.

Another object of the present invention is to provide a dental crown composed solely of stabilized zirconia whose outer surface has been altered to closely resemble the appearance of a natural tooth.

A further objective of the present invention is to provide a pedodontic and veterinary dental crown which overcomes the problems of durability, non-uniformity, and the like of prior pedodontic dental crowns.

The invention possesses other objects and advantages especially as concerns particular characteristic and features thereof which will become more apparent in the following description of the invention considered in conjunction with the accompanying drawings.

**BRIEF DESCRIPTION OF THE SEVERAL VIEWS OF THE DRAWING**

Figure 1 is a side elevational view of the dental crown of the present invention with a directional arrow indicating its installment on a tooth stub.

Figure 2 is a top plan view of the dental crown of the present invention.

Figure 3 is a sectional view of another embodiment of the dental crown of the present invention.

Figure 4 is a block diagram depicting the general process for creating a zirconium crown.

Figure 5 is a top plan view of a kit having pedodontic crowns of various sizes which may be employed through a process selection.

Figures 6 and 7 are sectional views of another embodiment of the dental crown showing retention features.

Figure 8A is a side view of a dental crown according to the present invention while Figure 8B is a side view of a dental crown according to the prior art.

Figure 9 is a frontal view of natural teeth demonstrating the interproximal line angle.

Figures 1OA, 1OB and 1OC are plan views showing the crowding that can occur with
tooth decay and resulting mesiodistal dimension decrease.

Figure 11 is a perspective view of a prior crown made of stainless steel with a polymeric coating.

For a better understanding of the invention reference is made to the following detailed description of the preferred embodiments of the invention which should be taken in conjunction with the above described drawings.

DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENTS OF THE INVENTION

Various aspects of the present invention will evolve from the following detailed description of the preferred embodiments thereof which should be referenced to the prior described drawings.

The present invention is directed to pedodontic and veterinary crowns and to a method of providing pedodontic and veterinary crowns for a natural tooth. Pedodontic and veterinary crowns shall be collectively referred to hereafter in the following description as just crowns.

The ideal crown should have the following characteristics:

- It would be strong and durable;
- It would be made of one material to eliminate the problems associated with the fracturing of the aesthetic facing;
- It would be thin, like a stainless steel crown, to insure the best emergence profile and overall natural appearance of the tooth. This thinness would also facilitate more conservative preparation of the stump tooth, and therefore reducing chances for nerve damage and increasing retention of the restoration;
- It would meet aesthetic scrutiny by having a natural color and surface shine that would mimic adjacent natural teeth;
- These crowns would be able to be sterilized with the auto clave for fast turnaround time without the fear of color alteration or compromise of structural integrity;
• The method for use would be the same as that used for crowns currently on the market, avoiding the need for dramatic changes in clinical technique; and
• The ideal crown would be available in a variety of sizes and at a cost that was competitive in today’s market.

The crowns according to the present invention meet the above characteristics.

Referring to the Figures in more detail, and particularly referring to Figures 1 and 2, the invention as a whole is shown in the drawings by reference character 10. The crown 10 is intended to fit over the stub 12 of a natural tooth and is placed in that position according to directional arrow 14. Dental crown 10 includes an inner surface 16, of Figure 2, and an outer surface 18. Crown 10 is a monolithic structure essentially composed of stabilized zirconia which has been treated to closely follow the color and appearance of a natural tooth. By monolithic, it is meant that crown 10 is only composed of the stabilized zirconia composition and there are no exterior layers of porcelain or plastic. When the crown 10 is placed on the patient's natural tooth, the patient only sees the surface of the stabilized zirconia crown as layering of a plastic or porcelain veneer as shown in the prior art (Figure 11) does not occur with the present invention.

The stabilized zirconia may consist of 85 to 95 weight percent of zirconia and 5 to 15 weight percent of stabilizer which may include, but not be limited to, magnesium oxide (MgO), calcium oxide (CaO), yttrium oxide (Y₂O₃), cerium oxide (CeO₂), aluminum oxide (Al₂O₃), scandium oxide (Sc₂O₃), ytterbium oxide (Yb₂O₃) and hafnium oxide (HfO₂). The presence of the stabilizer is believed to increase the strength of pure zirconia by presenting formation of a monoclinic crystal structure. Included within the foregoing 5 to 15 weight percent may be small elements of other compounds such as iron oxide (Fe₂O₃) or titanium oxide (TiO₂) for coloration purposes. It is important that the amount of zirconia not fall below about 85 weight percent as this could deleteriously weaken the crown.

Inner surface 16, takes the form of a hollowed out area which is intended to fit the stub 12 of the natural tooth. In addition, the interior surface 16 of crown 10 includes at least one retention feature which assists in holding the crown 10 to the tooth 12. Such a retention feature is important for the following reason. Once sintered, zirconia has a smooth surface finish. This
smooth surface finish is satisfactory for the outer aspect of the restoration which will be polished, however, the inside of the restoration is better if it is not smooth.

Metal and ceramic restorations are typically microblasted with abrasive particles and air, and ceramic restorations are then additionally hydrofluoric acid etched to further roughen the internal aspect. Roughening the surface allows better mechanical retention of the cement layer. However, sintered zirconia, unlike traditional dental ceramics and porcelains, is too hard to be air abraded and does not etch with hydrofluoric acid. Furthermore, if the zirconia is drilled on by the dentist to add grooves, the heat generated can weaken and fracture the zirconia molecular structure. All manufacturers of zirconia restorations do not recommend drilling on the zirconia for that reason, unless it can be put back into the sintering furnace to heal any fractures. This is impossible in a clinical situation since sintering takes many hours and requires a special furnace of over 1000 degrees centigrade.

The present inventors have proposed a preferred novel step over milling process which creates macroscopic apertures on the inside of the restoration to aid in retention by locking in the cement layer. The step over milling process can create spirals, grooves, random cuts, indentations or other designs to help improve retention of the cement layer to the restoration. Shown in Figure 6 is a cross section of a crown in which grooves 40 are cut into the interior surface 16 while Figure 7 is a cross section of a crown in which ledges or short segments 42 are cut into the interior surface 16. The grooves 40 and short segments 42 should have a width 92 of about .05-.7 mm and a depth of about 0.05-0.4 mm. In addition, the groves 40 and short segments 42 should be spaced apart 94 from each other by about 0.05-0.7 mm. Alternative retention features may include a plurality of holes or pits 20 in the interior surface 16 of the crown 10 which create interstices to accept cementitious material when the crown 10 is eventually placed over tooth stub 12 and allowed to set. Such retention features help to retain the crown 10 on the tooth 12.

Since the crowns according to the present invention are not made by a layering process wherein plastic is layered over a metal crown, the crowns according to the present invention can be kept thin at the incisal edge. Referring to Figures 8A and 8B, a conventional crown is on the
right (Figure 8B) and the inventive crown is on the left (Figure 8A). It can be seen that the incisal edge 88 which is determined by measuring the last 1.5 mm. of the biting edge buccolingually (lip side to tongue side of the tooth) is about 2.5-3.5 mm for the prior art crown and is about 0.4-2.0 mm for the crown of the present invention. This indicates that the prior art crown has a more rounded and undefined incisal edge 88 which reduces the cutting efficiency of the tooth. Also important to note is that the crowns of the present invention have a bevel 90 on the lingual side of the tooth which give the crowns of the present invention more of a cutting edge like a natural tooth. The angle β of the bevel should be about 28 to 70 degrees measured from the vertical as shown in Figure 8A.

The crowns according to the present invention have been designed so that they have a normal emergence from the root structure. Referring to Figure 9, the inventive crowns have an interproximal line angle, α, of 5 to 12 degrees to allow for a healthy interproximal papilla. The prior art crowns do not allow for such an angle, thereby causing problems for the patient later on.

The crowns according to the present invention have a facial profile similar to that of normal teeth. Referring back to Figure 8, it can be seen that both teeth have a convex facial profile 60 but the inventive crown is much less convex and more in line with a normal curvature of a natural tooth.

The crowns according to the present invention use zirconia that has been specially formulated so that it is strong, aesthetic and, most importantly, thin. These properties enable the best of both worlds - room on the inside for passive fit, and contours on the outside of the crown that blend in with the natural tooth shape. Since the inventive crown is thinner than the current aesthetic crowns, the restoring dentist will not have to prepare the tooth as much, allowing for more retention and decreased chance of damage to the nerve. Referring back to Figure 6, the approximate thickness of the crown axially as indicated 64 is about 0.1 to 0.4mm while the approximate thickness of the crown from the axial-occlusal line angle to the occlusal surface as indicated at 66 is about 0.4 to 0.8 mm. These should be compared to the prior art aesthetic crown whose thickness of the crown axially on the buccal side is about 0.5-2.0 mm (64 in Figure 6 for the inventive crown) and of the crown from the axial-occlusal line...
angle to the occlusal surface (66 in Figure 6 for the inventive crown) on the buccal side is about 0.8-2.5 mm. The thick crown wall of the prior art aesthetic crown creates a dilemma for the dentist. The tooth has to be aggressively prepared so that the thick walled prefabricated pediatric crown will fit passively on the tooth stump. In the situation for baby teeth, the tooth is small already, and grinding them more to allow for the thickness of the crown increases the chance that the crown will fall off after it is cemented, or cause permanent damage to the nerve of the tooth.

The crowns according to the present invention have a thin margin, again indicated by 64 in Figure 6, of about 0.1-0.4 mm around the circumference of the opening of the crown 10. Referring to Figure 8A, the margin 64 is about 0.1-0.4mm on both the buccal side 64A and the lingual side 64B. The advantage of a thin margin is that the margin can fit under the gum 68 as shown in Figure 8. With the prior art crown, shown in the right half of Figure 8, the margin may not fit under the gum 68, since the prior art crown has a margin thickness of about 0.5-1.5 mm on the buccal side 64A even though the margin 64B on the lingual side may be 0.2-0.4mm, thereby causing the margin 64A to impinge on the gum tissue 68, potentially creating inflammation and swelling.

Referring back to Figure 6, the crowns according to the present invention have a thickness of the occlusal surface 84 of about 0.5-0.9 mm while the prior art crowns have a thickness of the occlusal surface of about 0.8-2.5 mm.

A further advantage of the present invention is that crowns can be prefabricated with a normal mesiodistal dimension as well as a reduced mesiodistal dimension as might be needed because of space loss due to decay. When teeth decay and loose tooth structure, the space that is created from the loss of tooth structure allows the adjacent teeth to drift and fill in the space. Referring to Figure 10A, three normal child's teeth are shown. The mesiodistal dimension is indicated by 70 while the buccolingual dimension is indicated by 72. In Figure 10B, the middle tooth 74 has some tooth decay 76. Over time, the adjacent teeth can crowd tooth 74 so that the mesiodistal dimension 70 could be reduced as shown in Figure 10C while the buccolingual dimension stays the same. Current preformed pediatric crowns do not fit
properly in this situation as they are too wide mesiodistally for the appropriate buccolingual
dimension. The dentist has to squeeze the preformed crown mesiodistally to make it fit and it
ends up bulging out buccolingually. The inventive crown is offered in alternative sizes
wherein the standard size has been modified to be narrower mesiodistally while keeping the
normal size buccolingually. This allows a better fit in space loss secondary to caries and
tooth migration situations.

With respect to Figure 3, another embodiment 1OA of the present invention is depicted. 1OA
includes a crown 22 formed similarly to crown 10 of Figures 1 and 2, namely being
composed substantially of pure zirconia. Crown 22 includes an outer surface 24 and an inner
surface 26. In addition, embodiment 1OA is formed with an inner band or sleeve 28 which is
flexible. The edge portion 30 of sleeve 28 may be cut and/or crimped to fit cervical margins
during preparation of the natural tooth. Sleeve 28 may be formed of any suitable material such
as metal, plastic, and the like. For example, stainless steel may be employed in this regard.
Sleeve 28 is bonded to inner surface 26 of crown 22 via an adhesive layer 32. Adhesive layer 32
may consist of Panavia F or other suitable bonding agents. Embodiment 1OA of the present
invention can be employed on the rear teeth of a patient, while the embodiment 10, depicted in
Figures 1 and 2, can be used on the front or rear teeth of a patient.

It should be realized that crowns 10 or 1OA of the present invention may be formed by
various methods, including CAD/CAM machining, electrophoretic deposition, ceramic injection
molding or slip casting. The most preferred method is by CAD/CAM machining. According to
this process, as shown in Figure 4, a presintered block of stabilized zirconia is obtained, step 44,
and then precisely machined using CAD/CAM machining to form the crown and any desired
retention features, step 46. The crown is then conventionally sintered to harden the stabilized
zirconia, step 48. The outer surface of the crown is then polished with a polishing material such
as a diamond paste to result in a pearlescent appearance, step 50.

The process continues by storing the crown in a kit of various sizes, step 52. Thereafter,
the crown may be retrieved from the kit for placement on a tooth, step 54. The crown is tried on
the patient's tooth for fit and adjusted as necessary. If this crown has an unsatisfactory fit, the
process continues by selecting another crown. When the fit of the crown is satisfactory, the crown is cemented into place, step 56

Turning now to Figure 5, there is represented a kit 36 in which a plurality of zirconia crowns 34, fabricated according to the present invention, and of various sizes are displayed on tray 38. The dental practitioner may select a particular crown 10, 1OA for a particular use and insert the same over the stub 12, Figure 1, of the natural tooth quickly and easily without taking a mold of each and every pre-existing tooth to be crowned and milling a new tooth through a CAD/CAM process, or the like. It should be realized that the system of the present invention saves time and is more economical than the prior methods found in the pedodontic and veterinarian fields.

While the present invention has particular application to pediatric and veterinary dentistry because of the lack of a suitable dental crown for these applications on the market today, the present invention nevertheless is also suitable for prefabricated crowns for adults.

The following Examples are intended to illustrate the invention of the present application but are not deemed to limit the scope of the invention in any manner.

EXAMPLE I

The shape of a natural tooth was designed in CAD. From such design, a hardened zirconia block was milled to produce a crown which mimicked a natural tooth. The zirconia block consisted of pure zirconia stabilized by yttria sold under the designation "ZS-blank" by Kabo Dental Corporation, Lake Zurich, ILL. Following such production of the crown, it was pre-polished by applying a diamond impregnated silicon wheel (CERAGLAZE 1, NTI Axis Dental) to remove all surface irregularities. A final polish was achieved with a Robinson brush/wheel and a 40 millimicron diamond paste. (Frontier Dental Laboratories, El Dorado Hills, CA)

EXAMPLE II

A crown prepared according to Example I was placed in the mouth of a child patient. A dental practitioner prepared the natural tooth using standard guidelines for primary dentition to
allow the patient to receive the pre-fabricated crown of Example I. That is to say, a stub similar to stub 12 of Figure 1 was created. The prepared zirconia crown was of the proper size having an acceptable mesiodistal width. The fit of the crown was evaluated and possible tissue impingement was determined. Extension of gingival margin was trimmed with a fine diamond wheel on slow speed with a copious water spray. The crown was filled with glass ionomer to cement the same to the natural stub of the tooth. It should be realized that self-cure composite resin cement may have also been used in this regard. The crown was then seated in the mouth completely. Practitioner then checked and adjusted occlusion. Finally, the final polish was applied to the crown using a diamond impregnated silicon wheel.

EXAMPLE III

To attain a natural appearance of the crown of Examples I and II, a pre-polish was applied to all external surfaces to remove surface irregularities. A diamond impregnated silicon wheel (CERAGLAZE I, NTI Axis Dental) was employed. After such pre-polish, a final polish was accomplished by using a Robinson brush wheel with 40ml diamond paste (Frontier Dental Laboratories of Eldorado Hills of California). The finished dental crown appeared to very closely resemble, on an aesthetic basis, the natural tooth of a human.

While in the foregoing, embodiments of the present invention have been set forth in considerable detail for the purposes of making a complete disclosure of the invention, it may be apparent to those of skill in the art that numerous changes may be made in such detail without departing from the spirit and principles of the invention.
We claim:

1. A dental crown for a natural tooth that is especially useful in pedodontic and veterinary applications, comprising a dental crown for pedodontic and veterinary applications consisting essentially of stabilized zirconia (ZrO$_2$).

2. The dental crown of claim 1 in which said crown includes an outer surface and an open chamber, said open chamber including an inner surface and including at least one retention feature formed on said inner surface.

3. The dental crown of claim 2 wherein said at least one retention feature comprises apertures formed on said inner surface.

4. The dental crown of claim 3 wherein said apertures are formed in a continuous line around said inner surface.

5. The dental crown of claim 3 wherein said apertures are formed as segments around said inner surface.

6. The dental crown of claim 2 wherein said retention features have a width of 0.05 to 0.7 mm and a depth of 0.05-0.4 mm.

7. The dental crown of claim 1 further comprising a sleeve, and an adhesive for holding said sleeve to said crown.

8. The dental crown of claim 1 in which said crown includes an outer surface, said outer surface including a pearlescent polished finish.

9. The dental crown of claim 1 in which said stabilized zirconia comprises zirconia and a stabilizer selected from the group consisting of magnesium oxide (MgO), calcium oxide (CaO), yttrium oxide (Y2O3), cerium oxide (CeO$_2$), aluminum oxide (Al2O3), scandium oxide (Sc?OV), ytterbium oxide (Yb$_2$Os) and hafnium oxide (HfO$_2$).
10. The dental crown of claim 1 in which said stabilized zirconia comprises 85 to 95 weight percent zirconia and 5 to 15 weight percent of a stabilizer selected from the group consisting of magnesium oxide (MgO), calcium oxide (CaO), yttrium oxide (Y2O3), cerium oxide (CeO2), aluminum oxide (Al2O3), scandium oxide (Sc2O3), ytterbium oxide (Yb2O3) and hafnium oxide (HfO2).

11. The dental crown of claim 1 in which the crown has an incisal edge, measured 1.5 millimeters from the end of the tooth, of 0.4 to 2.0 mm buccolingually.

12. The dental crown of claim 1 having an emergence angle of 5 to 12 degrees.

13. The dental crown of claim 1 having a thickness on the side of the crown of 0.1 to 0.8 mm.

14. The dental crown of claim 1 having a thickness at the margin of 0.1 to 0.4 mm around a circumference of an opening of the crown.

15. The dental crown of claim 1 having a beveled surface on a lingual side of the crown.

16. A method for providing a dental crown for a natural tooth, the method comprising the steps of:

preparing a tooth for receiving a dental crown;

selecting a dental crown from a kit of prefabricated crowns comprising a plurality of prefabricated dental crowns of various sizes wherein the dental crowns are dental crowns consisting essentially of stabilized zirconia (ZrO2);

applying a cement to the dental crown; and

seating the dental crown on the tooth.

17. The method of claim 16 in which the selected dental crown includes an outer surface and an open chamber, the open chamber including an inner surface and including retention features formed on the inner surface, the retention features cooperating with the cement to fix the dental crown to the tooth.

18. The method of claim 16 in which the prefabricated crowns comprise a sleeve and an
adhesive for holding said sleeve to said crown.

19. The method of claim 16 wherein the prefabricated crowns have a pearlescent finish.

20. The method of claim 16 in which said stabilized zirconia comprises zirconia and a stabilizer selected from the group consisting of magnesium oxide (MgO), calcium oxide (CaO), yttrium oxide (Y2O3), cerium oxide (CeO2), aluminum oxide (Al2O3), scandium oxide (Sc2O3), ytterbium oxide (Yb2O3) and hafnium oxide (HfO2).

21. The method of claim 16 in which said stabilized zirconia comprises 85 to 95 weight percent zirconia and 5 to 15 weight percent of a stabilizer selected from the group consisting of magnesium oxide (MgO), calcium oxide (CaO), yttrium oxide (Y2O3), cerium oxide (CeO2), aluminum oxide (Al2O3), scandium oxide (Sc2O3), ytterbium oxide (Yb2O3) and hafnium oxide (HfO2).

22. The method of claim 16 wherein the tooth is a child's tooth.

23. The method of claim 16 wherein the tooth is a veterinary tooth.

24. The method of claim 16 wherein the tooth is an adult tooth.

25. The method of claim 16 in which the various sizes include at least one set of crowns having first mesiodistal and buccolingual dimensions and at least one set of crowns having second mesiodistal and buccolingual dimensions wherein the first mesiodistal dimension is larger than the second mesiodistal dimension and the first and second buccolingual dimensions are the same.

26. A method for forming a kit of crowns, the method comprising the step of:

forming a plurality of dental crowns of various sizes of, substantially, stabilized zirconia (ZrO2).

27. The method of claim 26 further comprising forming a pearlescent finish on an outer surface of the plurality of dental crowns comprising:

pre-polishing an outer surface with a diamond impregnated silicon wheel; and

final polishing the outer surface with a diamond paste.
28. The method of claim 26 in which said stabilized zirconia comprises zirconia and a stabilizer selected from the group consisting of magnesium oxide (MgO), calcium oxide (CaO), yttrium oxide (Y2O3), cerium oxide (CeO2), aluminum oxide (Al2O3), scandium oxide (SC2O3), ytterbium oxide (Yb2Os) and hafnium oxide (HfO2).

29. The method of claim 26 in which said stabilized zirconia comprises 85 to 95 weight percent zirconia and 5 to 15 weight percent of a stabilizer selected from the group consisting of magnesium oxide (MgO), calcium oxide (CaO), yttrium oxide (Y2O3), cerium oxide (CeO2), aluminum oxide (Al2O3), scandium oxide (SC2O3), ytterbium oxide (Yb2O3) and hafnium oxide (HfO2).

30. The method of claim 26 in which the various sizes include at least one set of crowns having first mesiodistal and buccolingual dimensions and at least one set of crowns having second mesiodistal and buccolingual dimensions wherein the first mesiodistal dimension is larger than the second mesiodistal dimension and the first and second buccolingual dimensions are the same.
INTERNATIONAL SEARCH REPORT

A CLASSIFICATION OF SUBJECT MATTER
IPC(8) - A61C 5/08 (2009.01)
USPC - 433/183
According to International Patent Classification (IPC) or to both national classification and IPC

B FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)
IPC(8) - A61C 5/08, 13/225 (2009 01)
USPC - 433/1, 9, 168 1, 183, 204, 218, 226

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practical, search terms used)
PatBase

C DOCUMENTS CONSIDERED TO BE RELEVANT

<table>
<thead>
<tr>
<th>Category*</th>
<th>Citation of document, with indication, where appropriate, of the relevant passages</th>
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<td>US 2004/0152049 A1 (CORNELISSEN) 05 August 2004 (05 08 2004) entire document</td>
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Further documents are listed in the continuation of Box C

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