socioeconomic status of parents with high caries rates and high frequency of sugar consumption.3 Preventive measures should be initiated along with restoration to ensure the success of the restoration. The clinician should remember that the cure for caries lies in changing life styles and topical treatments, restorations per se do not offer these and hence do not provide the cure they are often believed to produce. The caries susceptible fissures should be sealed with pit and fissure sealant.

Restoring a previously restored tooth decreased the life span of the second restoration in all ages. Many dentists are quick to replace restorations that they judge to be imperfect in some way, even though they are frequently unable to state the cause of the defect.4 Thus it is not unusual that the original error is repeated in the same restoration while the cavity increases in size. At each replacement, the tooth becomes weaker and restoration cycle more complex and costly- resulting in repeat restoration cycle. The clinician should take his time in deciding whether a secondary caries is present or not by thorough investigations and how the replacement of restorations should be done.

Behavioral considerations:
Children may not cooperate during restorative procedures. In such cases, a material which permits ease of handling and placement in less amount of time, yet durable and less sensitive to moisture is desirable. The age of the patient at the time of restoration placement is a determinant in restoration longevity of primary molars. Clinical studies indicate that if the child is less than 4 years, the likely survival rate of restoration is one year.5 If the permanent restoration is delayed to a later time, the older patient will have increased longevity of restorations. Replacement rate of restorations done by general practitioners was higher as compared to those done by specialists. The major cause for replacement was operator error. This suggests that familiarity with the behavior management techniques increase the success rate in young children. Also, lack of experience in placing SSC among general dentists results in placement of amalgam restorations when it is not ideal to place the same.6,7 Picking the right restorative option involves understanding the advantages and limitations of restorative materials as well.

GLASS IONOMER CEMENTS
Conventional glass ionomer
The greatest advantage of glass ionomer is its ability to bond to tooth structure. By bonding a restorative material to tooth structure, the cavity is theoretically sealed, protecting the pulp, eliminating secondary caries and preventing leakage at the margins. This allows cavity forms to be more conservative and to some extent reinforces the remaining tooth by integrating the restorative material with tooth structure which is of great significance in primary molars as the size is much smaller than permanent teeth. Other particular advantages as restorative materials in the primary dentition are their ability to release fluoride which can be recharged by topical fluoride application and hence acts a fluoride reservoir. The fluoride released is taken up by the underlying dentin making it more caries resistant. It also promotes remineralization of adjacent tooth enamel. Hence it is used as a treatment restorative material for caries control in high caries risk children. Though invitro studies have shown the material to be cariostatic, they do not significantly affect the recurrent caries rates.8 They require only a short time to fill the cavity which is an additional advantage in treating children. Coefficient of thermal expansion is close to that of dental hard tissues. Hence the chance of