

K072995

**Histological Evaluation 810nm Vs 980nm Wavelength Laser Radiation on Pig  
Liver Tissue**

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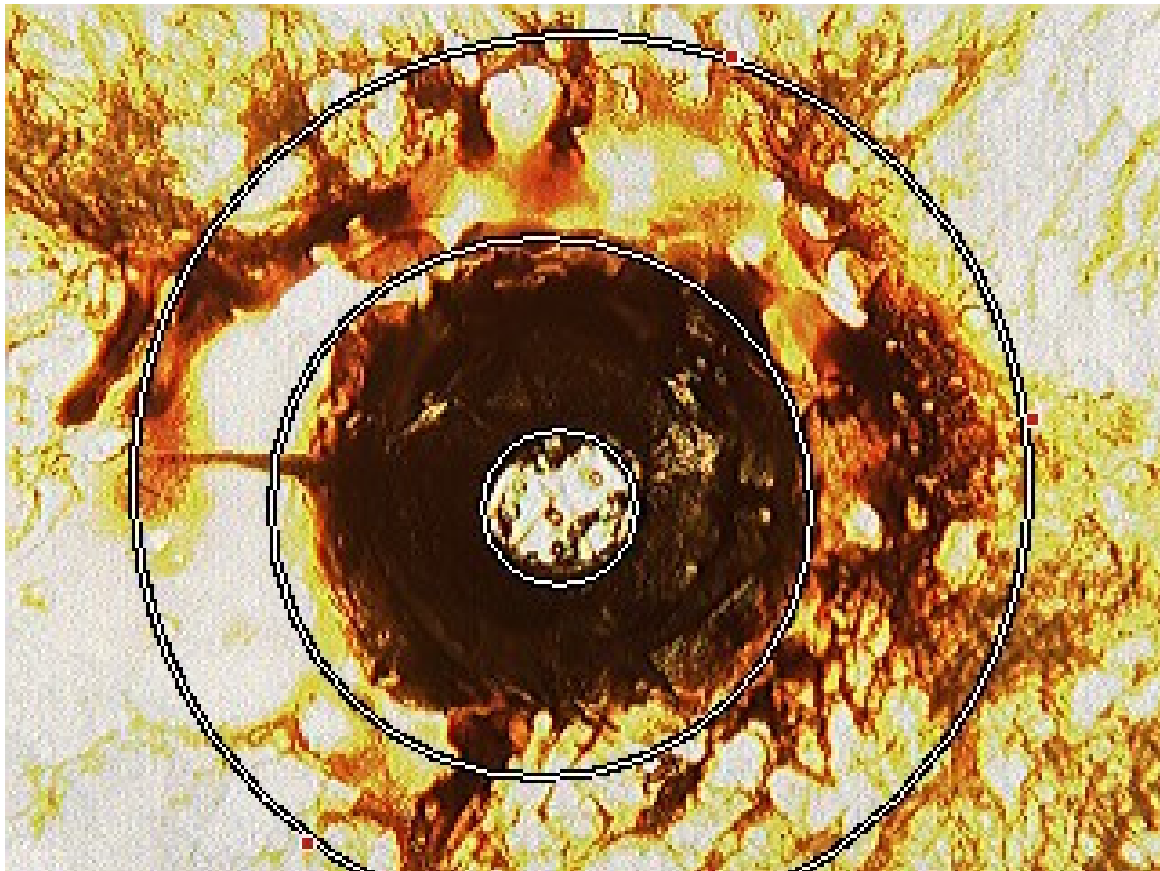
## **Abstract**

This study addresses the current dental laser surgical industries' arguments that one of the other of two predominate wavelengths in the industry is 'better' than the other; those wavelengths being the 808-810nm and 980nm wavelengths that are produced by the so called solid state "diode lasers" because the laser energy is actually produced by a laser diode. While there is clearly a major difference between earlier dental surgical laser, namely the Argon Ion Laser and the Nd:YAG (also the Carbon Dioxide Laser). The major performance differences in the earlier laser was clearly because of the different tissue elements which reacted/absorbed the wavelengths produced by the lasers. The Argon Ion Laser producing visible blue (457-488nm) and visible green (501-514nm) was rapidly and readily absorbed by the red hemoglobin in blood. This made the Argon Ion Laser a very good coagulation device, but in a relative sense, a poor tissue remover (ablation). The Nd:YAG producing invisible infrared laser energy (1064nm) was not well absorbed by blood relative to the Argon Ion Laser but was very rapidly absorbed by water which made it and excellent tissue removal surgical laser. The recent marketing claims made by the relative manufactures lend the argument to the fact that 810nm is closer to Argon Ion Laser and would be a better coagulator than tissue remover and that the 980nm wavelength is very closer to Nd:YAG and is therefore a better tissue remover. The difference between 514nm (best coagulation wavelength of the Argon Ion Laser) and 1064nm produced by the Nd:YAG is 550nm, a large difference. The difference in between 810nm and 980nm is a relatively small 170nm. This study examines the clinical significance of this difference. The results of this study demonstrate that the 810nm wavelength nearly doubles the coagulation performance of the 980nm wavelength in pig liver. The results of the study further show that the 980 wavelength is produces more than double the ablation performance and involves less tissue overall in pig liver. This study demonstrates that by combining the two wavelengths coagulation and ablation performance can be adjusted and even increased beyond the performance of a single wavelength in pig liver. Conclusion: there is a clinical difference in the performance in pig liver. There may be major clinical advantages in mixing the wavelengths in surgery and oral tissue treatment.

## **Introduction**

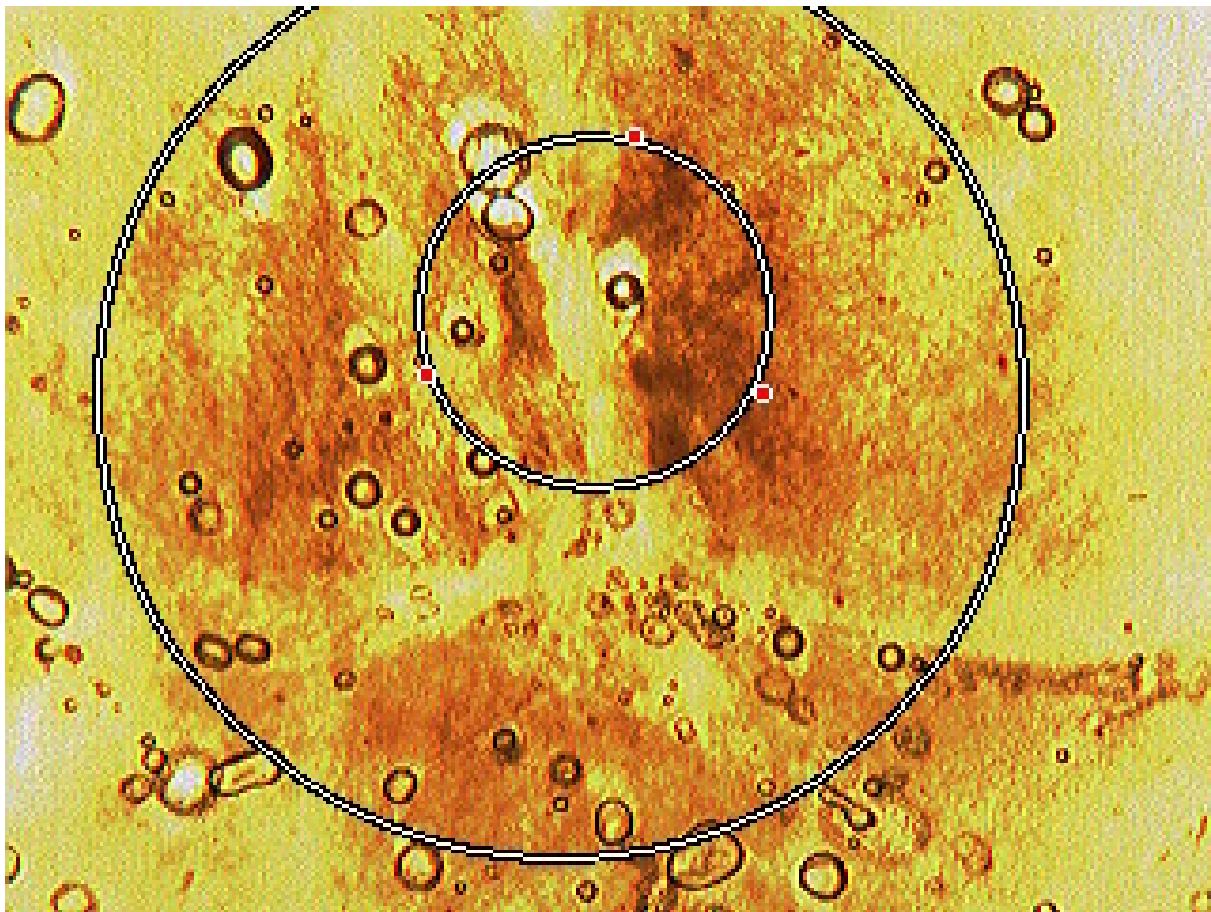
The ablation, necrotic zone and coagulation zone of the 810nm and 980nm laser, individually, are well defined and well understood. However, the TidalWave Dental Diode Laser will supply both wavelengths simultaneously. Furthermore, the TidalWave Dental Laser will mix user defined amounts of each wavelength. Therefore, this study is designed to determine the effects on the ablation zone, necrotic zone, and coagulation zone of pig liver tissue of mixtures of the two wavelengths.

The study intent is to evaluate the effects of a varying mixtures of 810nm and 980nm laser radiation on pig liver. The parameters of interest are the area of ablation, the fringe of necrotic tissue surrounding the area of ablation, and the area of coagulation surrounding the necrotic fringe (refer to photograph below):



The photograph is of a thin section of pig liver that has been exposed to laser radiation. It is presented here to illustrate the regions, zones, fringes, discussed above. For the sake of this study the following definitions of those regions, zones, fringes, areas, etc. apply. The center circle is the ablation zone. This is the area where the tissue has been ablated (or vaporized), the tissue is all but gone. The area between the center circle

and the middle circle represents the zone, fringe, or region that is comprised of charred, dead, or necrotic tissue that was not ablated or vaporized by the laser. The area between the middle circle and the outer circle represents that area in which the tissue is not necrotic but the blood in the tissue has coagulated, this is considered the coagulation region, zone, fringe, area, etc. How each of these regions, zones, fringes, areas, etc. change as the mixture of wavelengths change is the object of this study. Because the depth of cut of laser energy delivered through a cleaved fiber (no clear focal point as with lens focused lasers) varies not only in power applied but also hugely varies in the distance the fiber is held from the tissue and the angle the fiber is held to the tissue, objective, statistically significant data is all but impossible to obtain. By way of example, the section above was positioned .5mm from the fiber delivery tip.



Identical sections (refer photograph above) exposed to the same radiation for the same amount of time at a position 1.5mm from the fiber show only minor to moderate coagulation; no ablation and no necrotic tissue. The center circle shows moderate coagulation zone while the area between the center circle and the outer circle represents minor coagulation. As one can clearly see the removal of oral soft tissue by a dentist with a cleaved fiber delivery system is very technique sensitive. The purpose

of this study is to not to evaluate various techniques or fiber distances for depth of cut but is to study the three tissue effects of different mixtures of the two wavelengths as discussed above.

### **Design**

The object of the study is to evaluate the effect that different mixtures of 980nm and 810 nm wavelength energy have on three surgical characteristics of treated tissue, namely: ablation, necrosis, and coagulation. The study is therefore designed to eliminate all other variables.

All tissue comes from the same pig liver.

The thickness of the tissue sections are maintained +/- 15%

The distance between the end of the fiber and the surface of the tissue is held constant.

The total output power is held constant

The exposure time is held constant

4 sections of pig liver are exposed to the same wavelength mixture and the average values of the three diameters from the 4 sections is used for the data point.

### **Experimental**

Two fresh pig livers are obtained from Tooele Valley Meats, Grantsville, Utah. Tooele Valley Meats were given the instruction to slice the livers as thin as possible. Tooele Valley Meat then partially froze the liver, sliced both livers, individually, wrapped the livers individually and hard froze both livers. Upon receipt and evaluation of the livers the liver were sectioned too thick for practical histological work. One of the livers was chosen and sectioned into approximately 3cm X 3cm X 10cm block running with Tooele Valley Meat slices cross sectioned on the 3cm X 3cm face, The liver was section into the block while hard frozen on a 12" band saw manufactured by Rigid. A medium coarse wood band saw blade was used for the sectioning of the blocks. The blocks were then wrapped and returned immediately to the freezer and were kept in a hard frozen state.

Immediately prior to laser exposure a hard frozen liver block was removed from the freezer, four standard 25mm X 75mm X 1.15mm thick microscope slides were placed on the counter next to the cutting board containing the hard frozen live block. Four thin sections of hard frozen pig liver were taken from the frozen block using a manual

dermatome. The sections were less than .5mm thick and approximately 1cm square. The freshly taken, still frozen sections were then placed on the microscope slide using tweezers. The section was then immediately covered with a brand new standard 18mm X 18mm \$ .17mm thick microscope slide cover glass. The freshly prepared set of four slides were then moved to the laser testing area and allowed to stand for 5 minutes directly on a counter top to attain room temperature.

The freshly warmed slide was then placed in a custom made fixture to which the laser delivery fiber was permanently mounted. The fixture was designed to take the slide with the cover glass toward the laser delivery fiber. The fixture is made to maintain a distance of 0.5mm between the end of the laser delivery fiber and the inside surface of the microscope slide cover glass. The fixture was also designed to apply even amounts of pressure squeezing the microscope slide and microscope slide cover glass together. With this adjustable even pressure we were able to maintain a tissue thickness between the microscope slide and microscope slide cover glass of 0.25mm +/- 10%.

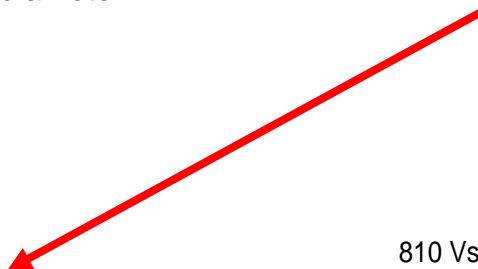
All measurements were made using a Model 799 Digital Veneer Caliper manufactured by Starrett and purchased, freshly calibrated, in June 2007.

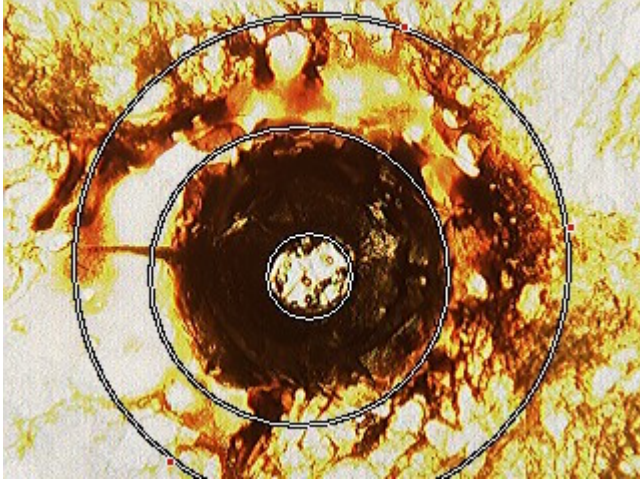
The slide is then exposed to the laser radiation for 15 seconds and removed from the fixture. Once all 4 freshly prepared slides have been exposed to the laser radiation the slides are moved as a labeled set to the biological microscope workstation.

The microscope is a standard trinocular biological microscope manufactured in China, manufacturer is not listed on the microscope, Model # XSZ-105E, S/N 046865. The objective lens used is an Olympus brand MPlan 5X. The eyepieces are Olympus brand 10X wide field, the left eye piece contains a pointer the right eye piece contains a 100 division reticle which is scale calibrated with this set of optics at .025mm per division. The third eye piece is fitted with a Moticam 1000, 1.3 megapixel live resolution digital microscope camera manufactured by Motic company. Images are captured on a Satellite model laptop computer manufactured by Toshiba, with a Windows XP operating system. Software used to capture the images is produced by the camera manufacture Motic and is Motic Images PLUS, Version 2.0.

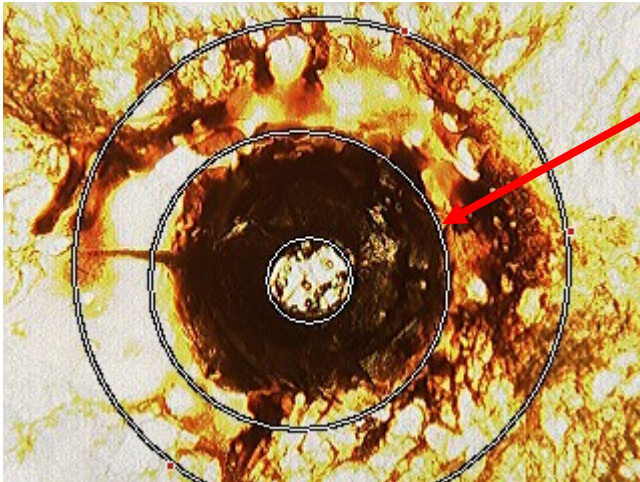
Technicians then take and record three diameter measurements on each of the four freshly prepared and exposed slides:

First the Ablation Zone diameter:

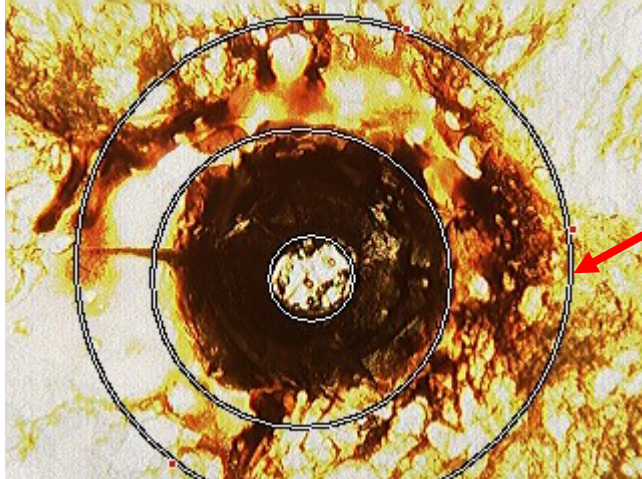




Second the Necrotic Zone diameter:



Third the Coagulation Zone diameter:



The slides were then immediately submerged in 90% denatured ethanol and allowed to soak for 48 hours before they were discarded. On 6 occasions technicians noted grossly aberrant specimens. In all 6 cases the aberrations were diagnosed as being caused by fixture issues. In these cases all four slides for that exposure were discarded and four more slides were prepared at that exposure level after the fixture issue was identified and corrected.

The four measurements were for each category were then averaged and the results entered into the raw data spreadsheet.

Initial pre-study experimentation with the same pig liver and same equipment determined the ideal thickness of the section to be 0.25mm. The ideal distance of the section from the end of the fiber optic delivery system to be 0.5mm. The ideal power level was determined to be 3.0 watts. The ideal exposure time was determined to be 15 seconds.

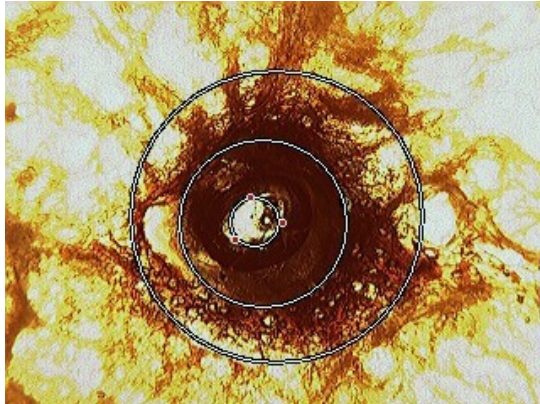
A TwinWave Diode Dental Laser S/N TWPT0003 was adjusted and calibrated by Electrical Engineer to perform the study in 50 individual settings where slide set 1 was 100% (3 watts) 980nm and slide set 50 was 100% (3 watts) 810nm. Each setting from 1 to 50 adjusted the 980nm down .06 watts (2%) and adjusted the 810nm energy up .06 watts (2%). In total 4 freshly prepared slides were made and exposed to each of the 50 individual settings totaling 200 slides and exposures (refer to Attachment A for tabular representation of the settings and average raw results).

The TwinWave Diode Dental Laser power output was monitored before every series of four slides to insure proper energy was supplied. The power output was measured with an Orion/TH digital laser power meter manufactured by Ophir, S/N 500594, Calibrated in Feb. 2007 and a L30A-SH-V1 head manufactured by Ophir, S/N 501265, Calibrated

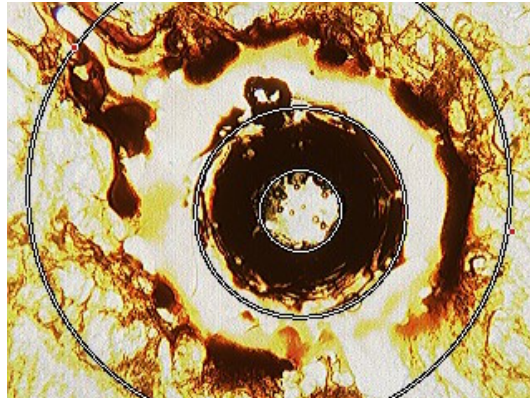
in Feb. 07. Both the head and laser meter are not scheduled for recalibration until 8/2008.

**Results**

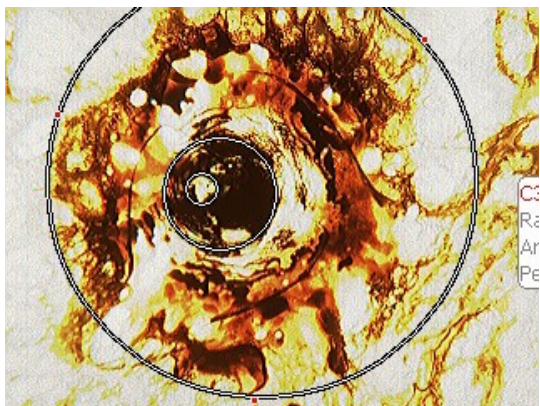
Refer to the two photographs below:



**Specimen 0C**



**Specimen 25B**



**Specimen 50D**

The photographs above were captured in the course of the experiment. The photograph on the top left was labeled Specimen 0C was exposed to 100% (3 watts) of 980nm for 15 seconds. The photograph on the top right labeled Specimen 25B is of a section of pig liver that was exposed to 50% (1.5 Watts) of 980nm and 50% (1.5Watts) of 810nm laser energy for 15 seconds. The photograph on the bottom is a section of pig liver that was labeled Specimen 50D and was exposed to 100% (3 watts) of 810nm for 15 seconds. The recorded diameter values for the three specimens on each of the three zones are:

<b>Measured Parameter</b>	<b>0C, 100% 980nm</b>	<b>25B, 50%-50%</b>	<b>50D, 100% 810nm</b>
Ablation Diameter	0.425mm	0.488mm	0.200mm

Necrotic Diameter	0.800mm	1.375mm	0.600mm
Coagulation Diameter	1.250mm	2.488mm	2.200mm

Please refer to Attachment A for full results.

**Discussion**

The marketing wing of the laser dental business has recently engaged in debates and positioning that one of either of the two predominate surgical wavelengths available in dentistry is 'better' for removal/treatment of oral soft tissue. One company (Biolase Technology Inc.) has released a laser that introduces yet a third wavelength into the argument with the claim that its 940nm wavelength was the perfect merging of the two predominate wavelengths. Even more recently, however, the same model laser has been released by the same company in 810nm wavelength with the paraphrased claims that it is available for the more traditional dentist. Of course, in many instances, marketing claims which may even attain statistical significance has little to no clinical relevance.

The scientific argument between the two wavelengths (980nm and 810nm) is that the difference lies in the tissue elements which absorb or react to the specific wavelengths of the well documented early laser surgical devices, namely the Argon Ion Laser and the Carbon Dioxide Lasers (considered Predicate Devices by FDA, i.e. all dental surgical laser ultimately claim substantial equivalency to these two wavelengths), and more recently the Nd:YAG lasers. B The Argon Ion Laser produces visible blue (457-588nm) and visible green (501-514nm) laser radiation. These wavelengths, particularly the visible green and 514nm preferentially, are well and rapidly absorbed by hemoglobin in blood because of its red color. This absorption causes the blood to heat up and coagulate, heated further it vaporizes (ablates) the surround tissue. This makes the Argon Ion Laser a very good coagulator but a relatively poor tissue remover. The Nd:YAG and Carbon Dioxide Laser produce invisible infrared energy at 1064nm and 10,600nm respectively. These wavelengths are readily and rapidly absorbed by water and translated into rotational and vibrational energy. This translation of energy causes the liquid water in tissue to immediately change to steam. This change literally blows the cells apart causing the tissue removal (ablation). Because of the efficiency of this translation and the concentration prevalence's of water in tissue, the Nd:YAG and Carbon Dioxide Lasers are very good ablaters but relatively poor at coagulation. A brief discussion on the performances difference between the Nd:YAG and Carbon Dioxide Lasers is warranted. The Carbon Dioxide wavelength is/was less expensive to produce than the Nd:YAG and its performance as an ablator is superior to that of the Nd:YAG. The Carbon Dioxide laser, is in fact the best ablator of all laser discussed in this study, however, the 10,600 nm wavelength will not transmit through a glass fiber, it is therefore difficult to get the energy from the laser tube to the tissue. With the introduction of the

very inexpensive diode laser that can ablate and be transmitted through a glass fiber both the Carbon Dioxide laser (and Nd:YAG because of its relative expense) have fallen out of favor in the dental community.

The difference in wavelengths between the best coagulation wavelength of the Argon Ion Laser, which is 514nm and the ablation wavelength of the Nd:YAG (1064nm) is a large 550 nanometers, while the difference between 810nm and 980 nanometers is a relatively small 170nm. This study address the clinical significance of that small difference and the any benefits of mixing the wavelengths.

Astonishingly this study demonstrates a substantial difference in performance despite such a small difference in wavelengths. The results demonstrate a large difference in coagulation affects, ablation affects, and tissue involvement affects between the two wavelengths. As theorized in the industry the 810nm wave is a better wavelength for coagulation. This study demonstrates that the 810nm wavelength was near twice as effective at coagulation in pig liver. This study also demonstrates a substantial difference in ablation performance with the 980nm wavelength being more than twice as effective at ablation of pig liver. The 980nm performance also involves about half of the tissue as well. In short, 810nm involves a larger area of tissue providing more coagulation and less outright destruction, 980nm involves far less tissue but the tissue that is involved is mostly ablated with less surrounding coagulation. The results of this study provide additional verification of the theorized clinical performance difference in these two wavelengths.

Most astonishingly the study demonstrates that by combining the two wavelengths in different percentages the user can actually control or dial in the amount of ablation Vs coagulation and adjust the tissue involvement as well. The greatest ablation, coagulation, and tissue involvement mixture is a 50%-50%. The further the user goes to 100% 810nm from that 50-50 point the less ablation and a little less coagulation produced. The closer the user goes to 100% 980nm from the 50-50 point, less ablation is witness but far less coagulation and tissue involvement is apparent, in pig liver. Please refer to Attachment B for graphic representation of this data and discussion.

### **Conclusions**

810nm wavelength energy provides better coagulation and would be preferred in larger area surgeries involving more vascularized tissue.

980nm wavelength energy provides better ablation and narrower tissue area involvement and would be preferred in areas were the tissue is less vascularized and/or in areas where narrower tissue involvement is indicated.

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Mixing the two wavelengths provide definite advantages and general recommendations can be advanced on the preferred mixture of the two wavelengths based on tissue types. Please refer to Attachment C for the recommendations.

ATTACHMENT A  
HISTOLOGIC PIG LIVER STUDY RAW DATA

% 810nm	% 980nm	810nm/ Watt	980nm/ Watt	4 Sample Average		
				Ablation Dia./mm	Necrotic Dia./mm	Coagulation Dia./mm
0	100	0.000	3.000	0.431	0.796	1.295
2	98	0.060	2.940	0.443	1.031	1.322
4	96	0.120	2.880	0.422	0.790	1.421
6	94	0.180	2.820	0.444	0.795	1.419
8	92	0.240	2.760	0.438	0.791	1.520
10	90	0.300	2.700	0.439	0.808	1.523
12	88	0.360	2.640	0.442	0.851	1.734
14	86	0.420	2.580	0.437	0.903	1.695
16	84	0.480	2.520	0.458	0.961	1.741
18	82	0.540	2.460	0.466	0.912	1.752
20	80	0.600	2.400	0.469	0.950	1.775
22	78	0.660	2.340	0.471	0.951	1.823
24	76	0.720	2.280	0.470	0.948	1.826
26	74	0.780	2.220	0.465	0.962	1.950
28	72	0.840	2.160	0.475	0.995	1.899
30	70	0.900	2.100	0.472	1.010	1.875
32	68	0.960	2.040	0.479	1.002	2.133
34	66	1.020	1.980	0.485	1.041	2.142
36	64	1.080	1.920	0.488	1.045	2.101
38	62	1.140	1.860	0.480	0.105	2.134
40	60	1.200	1.800	0.481	1.063	2.069
42	58	1.260	1.740	0.482	1.101	2.226
44	56	1.320	1.680	0.485	1.100	2.154
46	54	1.380	1.620	0.480	1.268	2.316
48	52	1.440	1.560	0.483	1.300	2.398
50	50	1.500	1.500	0.490	1.291	2.422
52	48	1.560	1.440	0.458	1.156	2.301
54	46	1.620	1.380	0.418	0.961	1.986
56	44	1.680	1.320	0.362	0.812	2.041
58	42	1.740	1.260	0.333	0.655	1.985
60	40	1.800	1.200	0.293	0.756	1.756
62	38	1.860	1.140	0.286	0.853	1.988
64	36	1.920	1.080	0.251	0.862	1.860
66	34	1.980	1.020	0.254	0.875	1.985
68	32	2.040	0.960	0.243	0.888	2.103
70	30	2.100	0.900	0.238	0.929	2.165
72	28	2.160	0.840	0.234	0.921	2.152
74	26	2.220	0.780	0.229	0.909	1.958
76	24	2.280	0.720	0.222	0.925	2.133
78	22	2.340	0.660	0.226	0.924	2.115

ATTACHMENT A  
HISTOLOGIC PIG LIVER STUDY RAW DATA

% 810nm	% 980nm	810nm/ Watt	980nm/ Watt	4 Sample Average		
				Ablation Dia./mm	Necrotic Dia./mm	Coagulation Dia./mm
80	20	2.400	0.600	0.219	0.919	2.311
82	18	2.460	0.540	0.225	0.931	2.222
84	16	2.520	0.480	0.224	0.925	2.156
86	14	2.580	0.420	0.215	0.875	2.212
88	12	2.640	0.360	0.214	0.865	2.136
90	10	2.700	0.300	0.195	0.752	2.142
92	8	2.760	0.240	0.180	0.850	2.012
94	6	2.820	0.180	0.234	0.755	2.203
96	4	2.880	0.120	0.251	0.658	2.155
98	2	2.940	0.060	0.233	0.602	2.101
100	0	3.000	0.000	0.220	0.552	2.155

### Attachment B Graphic Results of Study

