Management of pulp canal obliteration: A clinical case report and tips and tricks

Dr Hugo Sousa Dias, Portugal

Introduction

Clinical management of calcified teeth provides an endodontic treatment challenge and makes up a significant portion of current endodontic practice. People are living longer and want to maintain their natural dentition. There are several factors that might influence the development of varying degrees of moderate and severe calcification of the pulp chamber, as well as the root canal system, such as multiple restorations, trauma, vital pulp therapy and chronic irritation arising from deep restorations or cracks.1

Pulp stones in the pulp chamber, sclerotic dentine usually in the pulp chamber, dystrophic calcification in the root canals, and pulp canal obliteration in the pulp chamber and the root canal are some of the clinical situations commonly encountered by endodontists.1 Pulp canal obliteration, also called calcific metamorphosis, is a sequelae of tooth trauma. It has been reported to develop
Calcific metamorphosis is defined by the American Association of Endodontists as “a pulpal response to trauma characterised by rapid deposition of hard tissue within the canal space.” It is generally asymptomatic and patients present clinically with yellow discolouration of the affected tooth crown and apparent loss of the pulp space radiographically. This discolouration is due to a greater thickness of dentine deposition. The incidence of pulp canal obliteration after dental trauma has been reported to be approximately 4–24%. It is generally accepted that the frequency of pulp canal obliteration is dependent on the extent of the luxation injury and the stage of root formation, and generally, obliteration of the pulp canal spaces advances in a coronoapical direction. The exact mechanism of canal obliteration is unknown, but is believed to be related to damage to the neurovascular supply of the pulp at the time of injury.

The critical management decision is whether to treat these teeth endodontically immediately, upon detection of the pulpal obliteration, or to wait until signs and symptoms of pulp or periapical disease occur. Only 1–16% of teeth with pulp canal obliteration will develop pulpal necrosis and only 7–27% of them will develop radiographic signs of periapical disease.

There is a progressive decrease in the response to thermal and electrical pulp testing as pulpal obliteration becomes more pronounced. Furthermore, a significant difference in electric pulp testing between partially obliterated and totally obliterated teeth has been reported. It is generally accepted that an absence of a positive response to the electric pulp test does not automatically imply pulpal necrosis. Teeth undergoing pulpal obliteration are generally asymptomatic. Such teeth are often an incidental finding during clinical or radiographic investigation.

The literature suggests that pulpal necrosis and periapical disease are not common complications of pulp canal obliteration, and if root canal therapy is selected as a routine procedure, most treatments would be unnecessary, as the majority of teeth with pulp canal obliteration will never suffer pulpal necrosis or periapical disease. Smith recommends delaying treatment until there are symptoms or radiographic signs of periapical disease, a view accepted by many.

It is possible to differentiate two types of radiographic pulp canal space obliteration: partial pulp canal obliteration...
tion (limited to the coronal part of the tooth) and total pulp canal obliteration (extended to the coronal and radicular pulp canal spaces), with or without associated periapical pathosis. Complete radiographic obliteration of the pulp space does not necessarily mean the absence of the pulp canal space; in the majority of these cases, a pulp space with pulp tissue is present, but the sensitivity of conventional radiographs is too low to allow visualisation of this.

Taking into account the degree of difficulty of the clinical management of these kinds of cases, the practitioner should be aware of the possible complications that may occur. The complications include root perforation and irretrievable instrument fracture. This article presents a case report with some valuable tips regarding the clinical approach to such cases.

Case report

A 47-year-old male patient was referred to our clinic in order to evaluate a symptomatic tooth (tooth #11). The patient had spontaneous pain in the right maxilla, in the vestibule of the maxillary right central incisor. At the clinical examination, a fistula in the buccal area of the tooth was identified. The tooth was very sensitive to percussion and non-responsive to thermal and electric pulp tests, without mobility, and periodontal probing around it was within physiological limits.

The patient gave a history of trauma in childhood. On examination, tooth #11 was found to have a discoloured crown (Fig. 1) and undergone a previous root canal therapy attempt. Initial radiographs were taken (Fig. 2), and these revealed that the canal could not be traced from the coronal and middle thirds. Cone beam computed tomography (CBCT) scans were requested for the patient (Figs. 3 & 4). Based on the results of the clinical and radiographic examination, a diagnosis of necrotic pulp with chronic apical abscess was made and root canal therapy recommended.

Local anaesthesia was performed, and the tooth was isolated with a rubber dam (Fig. 5). The access cavity was prepared, with an incisal orientation (following the long axis of the tooth), under continuous inspection

Fig. 10a–c: Working length radiographs. Fig. 11: Final radiograph. Fig. 12: Three-month follow-up radiograph.

Fig. 10a
Fig. 10b
Fig. 10c
Fig. 11
Fig. 12
Fig. 13
Fig. 14

Fig. 13: Level of the cementoenamel junction (CEJ). Fig. 14: Incisal access allows straight-line access to locate the pulp chamber.
under the operating microscope. The action of the long shank bur is only in the darker dentine (tertiary dentine), avoiding removal of the lighter dentine (primary dentine; Figs. 6a & b). After finding a ring of calcification (Fig. 7), we use an ultrasonic tip to have a more controlled cutting action and better visual control; in this clinical case, we selected the RedStar RS-2 ultrasonic tip (Kerr Endodontics).

In such a clinical situation, it is important to follow a basic sequence of irrigate and scrub with sodium hypochlorite/EDTA, dry, observe and cut until one can find the root canal. Radiographic control during this procedure is fundamental in order to avoid any mishap.

When the root canal entrance was identified (Fig. 8), a short (21 mm in length) and more rigid hand file was selected to allow more tactile control and a more effective cutting action. The root canal was instrumented with size 8, 10, 12 and 15 D Finders (Mani Inc.) to obtain a manual glide path using the M4 Safety Handpiece (Kerr Endodontics; Fig. 9).

Working length radiographs were captured (Figs. 10a–c). Cleaning and shaping were performed using TF Adaptive (Kerr Endodontics) up to size 25.06 with the Elements Motor (Kerr Endodontics) in Adaptive Motion. Irrigation was performed during the entire treatment with 5.25% sodium hypochlorite. A final irrigation protocol was done with 17% EDTA and 5.25% sodium hypochlorite, and irrigant was activated with the manual dynamic activation technique. The canals were thoroughly dried and obturation performed using Autofit 4% gutta-percha cones (Kerr) and AH Plus (DENTSPLY Maillefer), employing the continuous wave of condensation technique with the Elements Obturation Unit (Kerr Endodontics). The pulp chamber was sealed with Ionoseal (VOCO) and a temporary restoration was performed (Fig. 11). The patient was referred to his dentist for the permanent coronal restoration. At a follow-up visit after three months, the tooth was asymptomatic (Fig. 12).

Tips for clinical management of pulp canal obliteration

1. It is essential to remember that the pulp chamber is always located in the center of the tooth at the level of the cementoenamel junction (CEJ; Fig. 13).5
2. The calcified pulp chamber is darker than and appears a different colour to the axial wall root dentine.5
3. A much better solution is to prepare the access cavity close to or through the incisal edge. This approach facilitates straight-line access and is a more predictable approach to locating the pulp chamber while avoiding unnecessary damage (Fig. 14).5
4. The use of the dental operating microscope is recommended to identify colour changes (Fig. 15).5
5. Using long shank burs in a slow handpiece or preferably ultrasonic tips to penetrate deeply into the canal system is recommended.6
6. Sodium hypochlorite can also be used to aid in the identification of a calcified canal by visualising the occurrence of bubbling (called a bubble or champagne test).5
7. Take radiographs at multiple angles to maintain alignment and direction during the procedure.
8. A CBCT scan is quite useful in the planning and progression of treatment.1
9. Alternate between size 8 and 10 K-files with a gentle watch-winding motion with minimal vertical pressure with regular replacement of the instruments before fatigue occurs.5
10. Frequently irrigate and scrub with chelating agents/sodium hypochlorite. After that, dry and observe.
11. A crown-down approach has been recommended to improve tactile sensation and better apical penetration.5
12. In single-rooted teeth, never forget the root canal centricity in the root, look for the colour changes (sometimes, it is useful to use the fisheye view: deliver irrigant to the pulp chamber) and search the root canal lingually in maxillary incisors. In multirooted teeth, look for white lines and white spots.
13. The calcification process as seen in pulpal obliteration occurs in a coronoapical direction, so once the initial canal has been located an instrument tends to progress more easily as it advances toward the canal terminus.5
14. In premolars and molars, taking into consideration the following anatomical landmarks may be useful.

**Important anatomical landmarks (Figs. 16 & 17)**

- D ≈ 7 mm (distance from midpoint of a line connecting the two cusp tips to the pulp chamber ceiling)
- C ≈ 11 mm (distance from midpoint of a line connecting the two cusp tips and closest point to the furcation)
- E ≈ 2.5 mm (height of the pulp chamber)
- C ≈ 11 mm (distance from the buccal cusp tip to the closest point to the furcation)
- E ≈ 6 mm (distance from the buccal cusp to the pulp chamber ceiling)
- F ≈ 2 mm (height of the pulp chamber)

The measurements were similar for both maxillary and mandibular molars.

15. The decision flowchart (Fig. 18) outlines the various treatment options that can be considered depending on the presenting signs and symptoms.

**Conclusion**

In this article, I have provided several tips for approaching the endodontic challenge of pulp canal obliteration. However, in an era devoted to conservative dentistry, other tools are emerging that may allow a more conservative, faster and more predictable approach in a large number of clinical situations where root anatomy is favourable: microguided endodontics.

**Editorial note:** This article was first published in Clinical Masters, Issue 1/2018. A list of references is available from the publisher.

**About**

Dr Hugo Sousa Dias graduated with a DDS from University Fernando Pessoa, Porto, and completed the postgraduate programme in endodontics at the University of Lisbon. Besides running a practice limited to endodontics in Porto, he is Director of the Master in Endodontics clinical residency programme at Foramen Dental Education. Dr Dias is the founder of the Portuguese Group for Endodontic Study (study club). He is a member of the European Society of Endodontology and the Sociedade Portuguesa de Endodontologia [Portuguese endodontic society]. He has given more than 20 lectures around the world and is co-author of a chapter in the book *The Root Canal Anatomy in Permanent Dentition* (Springer, 2018).