Cleaning is key

By Aws Alani, UK

Completely disinfecting the canal system is challenging when all factors are considered. If we are looking at the nano level there are approximately 76,000 dentinal tubules per square millimetre of dentine. Each of which can harbour a colony of bacteria. Then there may be inaccessible anatomy such as lateral canals, apical deltas or fins.

It seems that irrigation and instrumentation are both highly inter-related in canal disinfection. Take washing your car for instance, purely covering it with soap and rinsing won’t remove the motorway bugs and bird produced projectile. A good scrubbing with a sponge is needed, or if you are really serious about cleaning, a pressure washer! This begs a further question—how would your patients feel if they knew that, more or less, the same or very similar liquid they use to clean bathroom suites is the same that we use to clean the inside of their teeth? On recent evidence of a dentist to the “stars” appearance on national TV not much—he advocated using charcoal to whiten teeth, which you may be able to buy from your local petrol station.

Dressing the canal with calcium hydroxide may continue the treatment. Dressing the canal with calcium hydroxide during obturation but after completion of preparation and instrumentation is sensible. A penultimate rinse with EDTA then a final rinse with hypochlorite prior to drying has been advocated heavily in the literature.

Bacteria and the biofilms

Unlike what we once thought, bacteria do not tend to just sit alone and remote from each other. If only they were this antisocial and could be picked off one by one! Bacteria join forces and create symbiotic groups, share resources and protect each other from external influences. This is commonly known as a “biofilm”, which has a thin but robust layer of mucilage that adheres to a solid surface. The smear layer protects bacteria residing in the dentinal tubules from being exposed to the irrigant as well as reducing the contact between the dentine and sealant during obturation. Hence, utilising EDTA to remove the smear layer prior to obturation but after completion of preparation and instrumentation is crucial for endodontic success.

The smear layer consists of organic material (protein, pulp remnants, saliva, microorganisms) with an inorganic component consisting of minerals and protect each other from external influences. This is commonly known as a “biofilm”, which has a thin but robust layer of mucilage that adheres to a solid surface.
process of eradication of the residual microorganisms over a 2-week period. The choice between the two schemes sometimes boils down to the presenting factors of the case. Where a tooth is difficult to instrument, has a large lesion or is quite obviously chronically infected with a history of pain, then a single visit treatment could be utilised.

The goal of obturation is to seal the canal system to prevent any reinfection and entomb any bacteria not eradicated by chemomechanical debridement. If the obturation is through the apex, this can have significant implications. GP through the apex can carry bacteria outwith of the canal and exacerbate symptoms. A foreign body reaction could also develop.

We also have to remember that a beautiful obturation of a canal achieved without rubber dam and utilising saline or local anaesthetic irrigation is sub-standard treatment. It can be difficult to assess the “quality” of treatment when a radiograph of a “failed” tooth is examined in this context. Indeed, an obturation that is short of the radiographic apex having been treated under rubber dam and with copious amounts of irrigation is more likely to be successful than the previous scenario. Attributing too much significance to the radiographic appearance of the obtura- tion is short-sighted. Indeed, Katezadeh and colleagues in the late ‘90s witnessed healing in the absence of obturation where teeth were instrumented and irrigated optimally under isolation. Sealants are also antibacterial and aide filling the voids between the GP and the canal system. One further option would be to provide a sub-seal to each of the canal orifices. This can be achieved by removal of 1 mm of GP and packing a good thick mix of IRM packed with a plugger.

Covering the cusps

The provision of a coronal restoration (if provided optimally) can improve the coronal seal while also structurally protecting the underlying tooth tissue. Due to endodontic treatment, resulting in reduction of tissue bulk and stiffness, the risk of fracture increases. Where both mesial and distal margins have not been breached and the access cavity is confined to the occlusal surface, a crown restoration may not be required. Once a margin is breached the tooth is more likely to flex and result in cracks or fractures. A commonly asked question, “When should the crown be provided?” Soon after the root canal treatment or when the treatment has proven to be successful?

The success of endodontic treatment is significantly in doubt then this should be communi- cated to the patient and a well compacted direct restoration may be the best option, otherwise an onlay or if tooth tissue is significantly reduced, a crown should be provided soon after completion.

Conclusion

Bacteria are public enemy number one in dentistry. Disinfecting the root canal system by irrigating in combination with mechanical instrumentation is key to success in root canal therapy. Preventing further re-infection or persistence of residual bacteria after the formal stages of treatment through dressing initially and a quality coronal seal subsequently is as important as the root canal therapy.

Editorial note: Aws Alani is leading a two-year postgraduate diploma in operative dentistry at King’s Col- lege London Dental Institute www.restorative.dentistry.org. More information is available online at www.kcl.ac.uk/study/ postgraduate/sought-courses/operative-dentistry-pgdip.aspx.

Aws Alani
is a Consultant in Restorative Dentistry at King’s College Hospital in London, UK. He can be contacted at awsalani@hotmail.com.

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The patient reported on in this article is a student in dentistry and his parents are both dentists. They referred their son to a good endodontist, who then referred the case to me. As always, peers are more than welcome in either of my practices, in Rome and London, so when I treated this case, I had three dentists watching me, a future dentist on the chair, placing a great deal of pressure on me.

The 22-year-old male patient had a history of trauma to his maxillary incisors and arrived at my practice with symptoms related to tooth #21. The tooth, opened in an emergency by the patient’s mother, was tender when prodded, with a moderate level of sensitivity on the respective buccal gingiva. Sensitivity tests were negative for the other central incisor (tooth #12 was positive), and a periapical radiograph showed radiolucency in the periapical areas of both of the central incisors. The apices of these teeth were quite wide and the length of teeth appeared to exceed 25 mm.

My treatment plan was as follows: root canal therapy with two apical plugs with a calcium silicate-based bioactive cement. The patient provided his consent for the treatment of the affected tooth and asked to have the other treated in a subsequent visit.

After isolating with a rubber dam, I removed the temporary filling, and then the entire pulp chamber roof with a low-speed round drill. The working length was immediately evaluated using an electronic apex locator and a 31 mm K-type file. The working length was determined to be 28 mm.

As can be seen in the photographs, the canal was actually quite wide, so I decided to only use an irrigating solution and not a shaping instrument. Root canals are usually shaped so that there will be enough space for proper irrigation and a proper shape for obturation. This usually means giving these canals a tapered shape to ensure good control when obturating. With open apices, a conical shape is not needed, and often there is enough space for placing the irrigating solution deep and close to the apex.

I decided to use only some syringes containing 5 per cent sodium hypochlorite and EDDY, a sonic tip produced by VDW, for delivery of the cleaning solution and to promote turbulence in the endodontic space and shear stress on the canal walls in order to remove the necrotic tissue faster and more effectively. After a rinse with sodium hypochlorite, the sonic tip was moved to and from the working length of the canal for 30 seconds. This procedure was repeated until the sodium hypochlorite seemed to become ineffective, was clear and had no bubbles. I did not use EDTA, as no debris or smear layer was produced.

I suctioned the sodium hypochlorite, checked the working length with a paper point and then obturated the canal with a 3 mm in thickness plug of bioactive cement. I then took a radiograph before obturating the rest of the canal with warm gutta-percha. I used a compomer as a temporary filling material.

The symptoms resolved, so I conducted the second treatment only after some months, when the tooth #11 became tender. Tooth #21 had healed. I performed the same procedure and obtained the same outcome (the four-month follow-up radiograph showed healing).

Irrigating the root canal: A case report

By Dr Vittorio Franco, UK and Italy

Dr Vittorio Franco is an endodontist who runs an endodontic referral practice in Rome and a practice in London. An active member of the European Society of Endodontology, Franco is also the President-elect of the Italian Society of Endodontics.
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With his high-definition photography of complex root canal systems, Dr Craig Barrington, who practices dentistry in Waxahachie, Texas, is developing quite a name for himself. Just check out his presence on Facebook, at craiggbarringtondds.com. In an interview with DrT America, Barrington talks about how he captures these high-definition endodontic images and how he uses them to increase his knowledge and help improve the level of care he provides to his patients.

Please tell our readers a little bit about yourself and your dental practice.

I graduated Summa Cum Laude from the University of Texas Health Science Center in San Antonio in 1996. I am a general dentist in Waxahachie, Texas, and have been in my current location for 20 years.

What do you like best about practicing dentistry?

I most enjoy the science, the biology and having a front-row seat in and around the ability to interact with, affect and watch the human body function and heal. I appreciate the ability to solve problems and the ability to work on problems that are yet to be solved. I like being a part of a “past, present and future” continuum that is the overall profession of dentistry. I enjoy having the ability to affect an individual person, from patient to fellow practitioner to dental student, all the way up to having the ability to have a positive effect on dentistry, all the way up to having the ability to have a positive effect on the overall profession of dentistry. I like being a part of a “past, present and future” continuum that is the overall profession of dentistry. I like being a part of a “past, present and future” continuum that is the overall profession of dentistry.

Who influenced you most in your career?

First, I would thank Dr Joel B. Alexander. He was an endodontic professor when I was in dental school who encouraged and taught the value of recalling your cases in order to assess your treatment outcomes.

Secondly, I would thank Dr Terry Pannukk. After much awareness, pursuit and concentration on the topic of mentorship, I certainly believe he is the best doctor alive today. He has done much for our profession from a philosophically significant standpoint to the actualities of clinical healthcare. He sees the value in this tooth clearing and diaphonization project I am involved in and consistently has provided more support and encouragement than anyone else. He has kept me motivated even if it is just by simply saying “wow, that result is amazing.” I can’t say enough about what he has done for me personally or in my career as my friend and mentor. I continue to learn from him daily and I hope that somewhere along the way, I reciprocate some of the support he has given me over the years.

You have become known for your high-definition photography of the root canal anatomy. How did you become interested in this area?

That too goes back to Dr Alexander and Dr Pannukk. Both of these doctors influenced me to recall my work in endodontics and truly take a scientific approach to the question of whether endodontics actually works and whether it actually works in my hands. After recalling many of my own cases, I started to see failures and problems that I was not satisfied with. I started to postoperatively evaluate the area and found that there were clinical aspects I could change to improve my outcomes. It was via the internet that I met Dr Arnoldo Castelluccii. After the interactions we had, I saw the cover of his textbook.

The tooth on the cover put me in awe. This was the first “cleared tooth” I had ever seen. It is from there that my interest in clearing teeth originated. I just had to figure out what was going on and how and why it worked. Fifteen years later, I am still manipulating processes in the diaphonization of human teeth in search of the “answers.” I have a patent pending in the clearing process, and the knowledge it has provided has become one of the most valuable tools in pre-operative and post-operative evaluation of the internal anatomy of human teeth.

Can you tell our readers a little bit about how you go about capturing these images? It must take some technical skill.

The photography is actually not difficult. It is oil immersion oblique illumination light microscopy, which has been done in histology labs for years. It is, however, a new realisation in this area for dentistry. In dentistry, we are familiar with the study of microscopic histologic sections. Teeth, on the other hand, are gross histologic specimens that can understandably be seen via the naked eye; however, viewing of the internal anatomic structures is greatly enhanced with microscopic evaluation. Any photographs of the teeth I work with are simply obtained through my “artist’s” eye.

I am respectfully honored by the immense variability of human tooth anatomy.

With his high-definition photography of complex root canal systems, Dr Craig Barrington, who practices dentistry in Waxahachie, Texas, is developing quite a name for himself. Just check out his presence on Facebook, at craiggbarringtondds.com. In an interview with DrT America, Barrington talks about how he captures these high-definition endodontic images and how he uses them to increase his knowledge and help improve the level of care he provides to his patients.

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Today, I see characteristics of the internal anatomy of human teeth that I never thought possible or knew existed. Visualising the immense variability of human tooth anatomy has changed my clinical practices and improved my clinical results, which benefits the patients I treat.

Do you perform endodontic therapy yourself or do you typically refer cases out?

I do all of my own endodontic treatments in my office. It has taken me years to identify the area of dentistry that I love. Perhaps one day I will take the necessary steps to specialise, but life is currently focused on my family and my children.

Is there anything you would like to add?

I am respectfully honored by the immense variability of human tooth anatomy.
ROOTS SUMMIT: Registration open for 2018 edition

By DTI

BERLIN, Germany: Seats for the next ROOTS SUMMIT, the premier global discussion forum dedicated to endodontic dentistry, are still available. The event, featuring lectures and workshops, will be held at the European School of Management and Technology (ESMT) in Berlin from 28 June to 1 July 2018. Approximately 500 visitors are expected at the international meeting, which is again being organised in collaboration with Dental Tribune International.

Although the 2018 ROOTS SUMMIT will mainly feature presentations on the latest techniques and technologies in endodontics, the organisers are inviting dental professionals in all fields, as well as manufacturers in the industry, suppliers of endodontic products and anyone involved in the practice of endodontic treatment, to attend.

It has been announced that foremost opinion leaders, including Drs Steve Buchanan, Frederic Barnett, Gergely Benyécs and Elisabetta Cotti, will be speaking at the conference next year. There will also be the opportunity to participate in hands-on workshops, speak to industry professionals on-site and engage with new equipment, procedures and protocols in endodontic dentistry. A number of dental companies specialising in endodontics, including META BIOMED and FKG Dentaire, have already confirmed their participation.

The ROOTS SUMMIT, which started as a mailing list of a large group of endodontic enthusiasts in the 1990s, has grown significantly over the last few years. With currently more than 24,000 members from over 100 countries, it has evolved into one of the most prominent global learning forums in the dental industry.

Previous conferences have been held in Canada, the US, Mexico, Spain, the Netherlands, Brazil and India. The 2016 ROOTS SUMMIT took place in the UAE and was one of the most significant events in endodontics that year, drawing over 300 dental professionals to Dubai. These meetings have been known for their strong scientific programmes. An early bird discount of 20 per cent is being offered and dental students too will be granted a 20 per cent discount. Additional information and online registration can be found at www.roots-summit.com.

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