Endodontic retreatment and adhesive restoration of structurally compromised second premolar

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In a light of the scientific literature concerning the outcome of the endodontic treatment, it doesn’t sound inappropriate that the restoration of the endodontal treatment can be completed by the endodontist.1 In this context the following report provides an account of the rehabilitation of a second premolar, including retreatment and definitive restoration.

Teeth that need retreatment are mostly long term fully decayed due to caries, fracture or/and previous restoration. The endodontic retreatment in such cases is a challenge concerning the isolation, overcoming different obstructions, perforation management (if they exist) and final restoration. The success rate for teeth that exhibit one or more technical problems, such as transportation, striping, perforation or internal resorption, is reported to be 47 per cent.2 Perforations have the most negative incidence.3

One of the factors that influence the outcome following non-surgical retreatment is the final restoration. Though some authors question the importance of the coronal restoration for the longevity of endodontically treated teeth,4 it is well accepted that the final restoration is as important for the outcome of the endodontic treatment as the quality of the treatment itself.5 Still, restoration of endodontically treated teeth remains a controversial issue. In the context of the increasing relevance of biomimetics,6 adhesively inserted indirect partial tooth-colored restorations are gaining more and more attention. The restoration or mimicking of the biomechanical, structural and aesthetic integrity of the tooth in a conservative manner is an advantage that must be used and preferred whenever possible. Still, these types of restorations are considered to be less esthetically idealized restorations, particularly endodontically treated teeth with a demineralization crown.7 This may be because clinicians and dental technicians are more inexperienced with crown restorations, the results of which are predictable, and inescapable about the adhesive protocol for bonded partial restorations.

Once the decision for tooth-colored partial restoration is made, the operator must choose between two materials—composites or ceramics. The benefits of the former (less abrasiveness and brittleness, lower costs, easy to polis h and repair, user friendly) encounter the strength, inerti ness and biocompatibility of the latter. While some studies indicate that ceramic and composite inlays provide similar fracture resistance on endodontically treated premolars,8 other suggest that when cuspal coverage is required composite resin may be more beneficial in endodontically treated posterior teeth compared to ceramics pertaining to its greater survival rate, fatigue resistance and more favorable failures.9 This can be explained with the more friendly stress distribution of composite resin onlays, confined above the cemento-enamel junction.10

The present report describes the microscopic retreatment and the definitive restoration of a grossly decayed perforated maxillary premolar. The reasons for the applied treatment are discussed.

Case report
A 34-year-old male patient reported to the department of Operative Dentistry and Endodontics, complaining of symptoms from another tooth. The radiographic examination revealed inadequate endodontic treatment and perforation with radiolucent area at the apex of tooth 15. The tooth was endodontically treated four years ago.

Medical history was non-contributory. Probing was within normal limits. Local anesthesia with Lidocaine 2.5% was administered. After the removal of the old restoration (Fig. 2) and cleaning up the decay, a pre-endodontic buildup was accomplished.

Unerupted were not removed but were undercut with the composite resin. The operati on field was isolated with rubber dam (Fig. 3). Then in AIC3 and Matrix band (Fig. 5). While keeping the band tautly with the help of gutta-percha points and Cavit, a total etch technique was performed. Enamel and dentin were covered with adhesive (Prime Bond NT, DENTSPLY) and polymerized for 10 seconds. Bulk-fill flowable composite was applied (SDF, DENTSPLY) and polymerized for 40 seconds in order to create a reservoir for the irrigants during endodontic retreatment (Fig. 4). After the removal of gutta-percha points and Cavit, the real canal (blue arrows) and the perforation (red arrow) were easily accessible (Fig. 5).

Since the artificial canal was previously obturated with a paste, cleaning, with a combina tion of hand files, ultrasonic (Pro Ultra 5 and 6) and irrigation with citric acid was used. To confirm the effectiveness of the cleaning procedure, an intra-operative X-ray was done (Fig. 6). Because of the different angulation of the beam, it seems as if the perforation is on the level of the crestal bone, which is not the real case.

For cleaning and shaping of the real root canal, the following protocol was used:

1. Glide path was established using SS K-files 8, 10, and Path Files 015, 016, 016 (DENTSPLY Maillefer).
2. The upper two-thirds was prepared using S1 and S2 files from Pro Taper system (DENTSPLY Maillefer).
3. The apical third—20 (04) GTX file (DENTSPLY Maillefer) was used.

Throughout the whole procedure, irrigation with Citric acid (40%, Cerkamed, Poland) and NaOCl (2%, Cerkamed, Poland) was used.

We preferred S1 and S2 files because of their ability to brush against the canal wall, which is very useful in cases with oval cross sections, where it is of paramount importance to clean all aspects of the root canal spaces. For the apical one-third we choose landed GTX file, because the canal was narrow and we had the possibility to transport the apical foramen. Both artificial and natural roots were obturated using warm vertical compac tion of gutta-percha and MTA (FILApex, America, Israel). On the post-op radiograph, the preparation and obturation seem short, but this was the reading we repeatedly got with our apex locator (BayPex5, VDW, Germany) (Fig. 7).

After the completion of the endodontic retreatment, the pre-endodontic buildup was left at place and the endodontic access was restored again with SDR, creating a core, on which an onlay preparation with diamond burs (Mani Inc.) was performed (Figs. 8 & 9). The enamel margins were exposed and unsup ported enamel prisms were removed using fine-grit diamond points. The remaining tooth structure was prepared to receive a built-in joint with the restoration margins. Internal line angles were rounded and the walls provided 5- to 15-degree path of divergence. The proximal box preparations extended to the existing composite, since they were located in the dentin.

The dimensions of the preparation provided at least 2mm of interocclusal clearance, which could be verified on the impression. A condensable silic on cone impression was taken (Fig. 10). A custom made provisional restoration was created using direct technique and temporarily cemented with a non-eugenol luting agent (Temp-Bond NE) (Fig. 11). The fitting aspect of the restoration was sandblasted by the dental technician.

At the second appointment after assessment of the prepared restoration, removal of the provisional and cleaning

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of the preparation the fit and aesthetics of the overlay were evaluated. Rubber dam was placed and the preparation was cleansed with acetone, etched with 57 percent phosphoric acid for 15 seconds, rinsed and dried. The fitting aspect of the restoration was also cleaned with acetone prior to cementation. A dual-cure self-adhesive luting resin (SmartCem2, DENTSPLY) was applied to the walls of the preparation and the restoration was placed with firm pressure until fully seated. The excess cement was removed with an explorer, a 5/8 scalpel blade and dental floss in the interproximal area over five-second polymerization that brought the cement to a “rubbery” stage (Figs. 12 & 15). The restoration was covered with gauze and finally cured for 60 seconds from each side (Figs. 14 & 15). The minimal occlusal adjustments were done with fine diamond burs under water coolant. Finishing and polishing were accomplished with the Enhance system (DENTSPLY) (Fig. 16).

Once finishing and polishing was done, a 57 percent phosphoric acid gel was applied for 15 seconds to clean the surface of the restoration and to acid etch the marginal ename l. After washing and drying, the nanofilled adhesive (Prime&BondNT, DENTSPLY) was applied and permitted to rest for 10 seconds to perme- able the surface and marginal fissures created by the finishing process. The adhesive was then thinned with 20 percent polymerized for 40 seconds (Fig. 17). At the six-month recall, the tooth was asymptomatic and the patient was completely satisfied (Figs. 16,19).

Discussion

This case report demonstrates endodontic retreatment and composite overlay as definitive restoration for a compromised tooth with minimal coronal tooth structure.

The two most important fac- tors in terms of prognosis of treatment of perforations are the age of the lesion and de- gree of bacterial contamination.4,5 In our case, the previ- ous endodontic treatment was done four years ago. The long period of time is not fa- vorable for the prognosis, but since the perforation is in the apical third the likelihood of bacterial contamination is low. After the patient has been informed, he chooses orthodox endodontic retreatment as a treatment modality.

The material of choice for perforation repair is MTA (mineral trioxide aggregate). Because of the small size and apical position of the lesion, we decided to treat it like a second canal and to obturate with gutta-percha and MTA based sealer. The absence of worsening of the peripical conditions in the six months post-op X-ray (Fig. 19) sup- ports this approach, and the patient is still under observa- tion.

Although still debatable, re- cent comprehensive meta-analysis by Gillen et al.6 demonstrates that a well-fitting, bacteria-proof final restora- tion has the same importance for the long-term prognosis of the endodontically treated tooth as does the well-per- formed endodontic therapy. Besides the prevention of coronal microleakage, a key factor for the long-term sur- vival of an endodontically treated tooth appears to be the amount of remaining tooth substance,4,5 which is deter- mined by the dimensions of the final restoration. So an ideal treatment option for an endodontically retreated tooth seems to be adhesively bonded restorations that preserves as much of the tooth structure as possible.

An endodontically treated posterior tooth presenting with extensive decay is most frequently restored with a post and a crown. That is in- telligible, because crowns are a well-established and known, clinically proven restorative modality, and still a consid- erable amount of research is being performed in 3D di- rection.6,7 On the other hand, partial toothcoloured restora- tions are recognized as valu- able alternatives to full cover- age crowns, and questions are raised if intraoral posts are necessary at all for an endo-dontically treated tooth.

Since their introduction in 1984,8 indirect laboratory processed composites are be- ing continuously improved in their physical and mechanical properties. Now this restora- tive option offers adhesive, biomimetic approach far less aggressive than crowns and far less technique sensitive than ceramics.

Achieving a perfect marginal quality with composite overlays, when gingival margin are lo- cated in the dentin, continues to be critical even when new adhesive techniques and sys- tems are used.9 The applica- tion of a composite base un- derneath indirect composite restorations represents a fea- sible non-invasive alternative to surgical crown lengthening or to relocate cavity margins from an intra-cervical to a supra-gingival position. This also permits the placement of rubber dams for absolute isola- tion. Surgical crown lengthen- ing may also compromise the periodontal tissue support of neighbouring teeth.9 We did not relocate simultaneously with the pre-endodontic build up with SJDR. This material has the metastatic property of a low viscosity resin composite and in the same time polymeriza- tion shrinkage stress similar to regular viscosity composite.

To simplify the procedures for bonding indirect resto- rations, resin cements have been introduced recently that are promoted as self-adhe- sive—i.e., do not require a separate adhesive application step. Manufacturers claim that these cements are hy- drophilic when mixed (acidic phase) but become hydropho- bic (neutral pH) upon reaction with the tooth structure. The bond strengths to the tooth structure are questioned. In our case we decided to ad- ditinally etch the enamel margins of the preparation, although not recommended by the manufacturer, because the procedure is simple and, as Duarte et al.9 and de An- drade et al.10 demonstrated, improves the bond strength of the restoration.

We preferred condensation- type silicone impression ma- terial for its better ability to reproduce the surface charac- teristics of low viscosity resin reported by Takano et al.11

The surface and margins of the restoration were sealed with filled adhesive. This treatment improves the mar- ginal adaptation,12 and it could be demonstrated that adhe- sives are superior to specially designed resin coating ma- terials.

Editorial note: A complete list of references is available from the publisher.

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