made with a semilunar incision. The option for this type of incision was determined by the absence of a large, radiographically visible bone defect (Figure 2) and for aesthetic reasons. This type of incision does not carry the risk of post-operative gingival recession.

After raising the surgical flap, it was possible to note the integrity of the cortical bone. The osteotomy was performed with surgical piezoelectric ultrasound and CVDentus® W1-0 insert for more precise control of the cut, followed by apicectomy, also performed with ultrasound.

The benefits of ultrasound
There are technical and biological advantages to osteotomy performed with ultrasound when compared with the use of high or low speed burs. Ultrasound has highly selective tissue cutting ability. Its action occurs only on mineralized tissues such as bone and teeth, preserving soft tissues such as nerves, vessels and mucosa. During osteotomy, the amplitude of the micro-movements generated by the ultrasonic insert permitted cutting between 60 and 210 micrometers making the hard tissue cut extremely precise. This is associated with the formation of acoustic microstreams and cavitation in extremely precise. This is associated with hard tissue cut exeters making the ultrasonic insert between 60 and 210 micrometers making the hard tissue cut extremely precise. This is associated with the formation of acoustic microstreams and cavitation in the osteotomy field, which promote a clean field, as observed in Figures 8a, 8b and 8c. The biological benefits of piezoelectric surgery particularly involve the maintenance of cellular viability in the operated region, so that the first post-operative stages of the bone repair process are better. It induces a faster increase in morphogenetic bone proteins and modulates the inflammatory reaction, in addition to stimulating healing.

The fractured instrument was removed together with the apical root third in the apicectomy (Figure 8d). The apical root cut was performed at an angle of 90° to the long axis of the root, to expose the smallest quantity of dentinal tubules and preserve the most root extension, favoring microbiological control and function of the dental remainder.

The quality of the root remainder filling was evaluated by introducing a micromirror into the apical bone recess and reviewing the root remainder filling, considered satisfactory if it unilaterally filled the root canal (Figure 8c). This was the criterion used for not performing retroreparation and retrofilling of the root canal, since this region of the canal had been adequately cleaned, shaped and filled.

The sutures were made with the aid of the operating microscope. Two simple stitches with Vicryl 9-0 thread were made to stabilize the flap, and another continuous stitch with Vicryl 9-0 thread to coat the edges (Figure 9).

Clinical control was performed after seven, 30 and 90 days. There was remission of all the clinical signs and symptoms of endodontic infection.

References
12. Leandro AP Pereira is a specialist in Endodontics, Professor of the specialist Course in Endodontics at the School of Dentistry, São Leopoldo Mandic, Campus São Paulo, Brazil; Professor of the specialty Endodontics course, EAP “Associação dos Cirurgiões Dentistas de Campinas”, Campinas, São Paulo, Brazil. He is also studying for a Masters in Stem Cell Research, Angiogenesis, and Therapeutics at the Pratech Dental School, University of Campinas Brazil and runs his own private clinic, also in Campinas, São Paulo Brazil. To contact him, email leandroapp@sedcare.com.br.
13. About the author

Clinical control was performed after seven, 30 and 90 days. There was remission of all the clinical signs and symptoms of endodontic infection.
Managing maxillary molars - case study

How meticulous root-canal therapy lays the foundation for successful long-term retention and restorative care - Dr Mark Dreyer

Maxillary first molars are fundamental to the complex root canal system morphology. The mesio-buccal roots are characterised by an irregular ovoid morphology, resulting in an isthmus or fin of pulpal tissue extending in the palatal direction off of the princi-pal mesio-buccal canal. This case report presents steps taken to address this anatomy to maximise the disinfection and debridement of the root canal system. Failure to address this anatomic complexity may lead to persistence or recurrence of endodontic disease.

Endodontic evaluation

A 58-year-old female patient presented for endodontic evaluation and therapy in the upper left quadrant. Mild pain was reported by the patient for several days prior to the appointment. Medical history was non-con-trIBUTORY and dental history was remarkable for multiple existing large amalgam restorations (Figures 1, 2, 3). Clinical exami-nation and diagnostic evaluation were performed for all posterior teeth on the right side, including cold testing, percussion, pulpa-tion, periodontal probing and bite challenge. Findings led to a pre-operative diagnosis of irreversible pulpitis/maxillary right first molar with normal peri-radicular.

After anesthesia, and isolation with the rubber dam, entry was made into a calcified pulp chamber. Use of the dental op-erating microscope greatly enhances lighting and visibility allowing for careful and deliberate clearing of reparative dentin, pulp stones, and other potential impediments to canal orifices. It is important to stress resisting the urge to take files into the canals prior to developing proper access form. In such cases, ledging and blockages can easily occur, needlessly compromising and complicating treatment. The pulpal pulpal tissue was calcified and extirpated in toto, as seen in Figure 4.

Ultrasonic tips

In this case, ultrasonic tips were used to plane the pulpal floor and increase visibility. These instruments are available from many manufacturers in a va-riety of sizes and shapes designed to address specific case needs. In this case, the orifice of the MB2 canal was located toward the palatal orifice in an unusual presentation (Figures 5, 6). This stresses the impor-tance of continuing to examine the pulpal floor with the micro-scope throughout the procedure, as irrigants and instrumen-tation constantly alter the pres-entation of subtle cues and clues to orifice location.

Once orifice location is completed, canal negotiation and instrumentation is carried to completion. Warm vertical compaction of gutta percha and ZOE sealer is used in this case, demonstrating the treated canal morphology (Figures 7, 8, 9). The MB2 canal was addressed as a completely separate canal. One study examined more than 1,700 teeth, which included more than 1,000 first molars. The presence of the MB2 canal was demon-strated in 93 per cent of these teeth (Stropko, JOE June 1999).

These findings are not surpris-ing given the morphology of the mesio-buccal root in maxil-lary molars. To better acquaint oneself with this anatomy, examine extracted teeth or see Brown and Herbranson’s Tooth Atlas, a rich source of 3D imagery. The final radiographs demonstrate placement of an orifice barrier, subsequent to temporisation and referral back to the restorative dentist. Image (not included) shows the easily identifiable bonded high contrast composite used for this purpose.

A complex system

This case presented an opportu-nity to demonstrate the complex canal system anatomy present in maxillary molars. Use of the dental-operating microscope throughout a carefully execut-ed coronal and radicular ac-ces procedure maximises the ability to disinfect and debride these teeth.

Ultrasonic instrumentation allows for the judicious removal of dentin required to prevent iatrogenic mishaps and unnec-essary weakening of the tooth. When patients present with en-dodontic disease, meticulous root-canal therapy lays the foun-dation for successful long-term retention and restorative care.

Desensitise Clean Rebuild Enamel

... in one easy step!

For more information please check out our website www.osspray.com

UK Distributor – J&S Davis
Atlantic House, Gates Way, Stevenage, Hertfordshire SG1 3HG

Tel: 0044 (0) 1438 758408
Fax: 0044 (0) 1438 758409