Why should a dentist be worried about bacterial contamination or even worse biofilms? And by this, I don't just mean plaque. Let us have a look on the definition of “biofilm” by the University of Montana under the chairmanship of Dr. David Costerton.

It says: “Biofilm forms when bacteria adhere to surfaces in aqueous environments and begin to excrete a slimy, glue-like substance that can anchor them to all kinds of material – such as metals, plastics, soil particles, medical implant materials, and tissue. A biofilm can be formed by a single bacterial species, but more often biofilms consist of many species of bacteria, as well as fungi, algae, protozoa, debris and corrosion products. Essentially, biofilm may form on any surface exposed to bacteria and some amount of water. Once anchored to a surface, biofilm microorganisms carry out a variety of detrimental or beneficial reactions (by human standards), depending on the surrounding environmental conditions.” (http://www.erc.montana.edu/CBSessentials-SW/6f-basics-99/basics-01.htm)

A dentist’s concern? Now, why and how should this concern the dental practitioner? A prosthesis, an implant, or any device added to the oral cavity could be surrounded by biofilm once exposed to saliva. Virulence factors of bacteria surviving in biofilm differ heavily from planktonic ones. Infective processes can be induced, leading to as much as rejection of the incorporated device. Researchers at the Max Planck Institute in Mainz, Germany, started to research developing a surface coating to reduce or even prevent biofilm from forming on devices, prosthesis and implants. Dr Renate Förch, the spokesman of the research group, has outlined the future achievements on polymertechnology and the use of plasma technology (http://www.mpi-p-mainz.mpg.de/www/pages/aktuelles/pressemitteilungen/?year=2010&kap,2&). Involved in this project, are research institutes from Spain, the UK, Switzerland and of course Germany, covered by a grant of the European Community. The biological attachment process of bacteria and the formation of biofilm are its main focus.

Daily practice

We deal with monomers and polymers in our daily practice. We use materials such as composites for restorations or veneering and help turn monomers into polymers. Polymers are chains of monomers, which offer new and unique properties. But do you remember what plasma is? Brian Kross, chief engineer at Jefferson Lab explains:

‘Plasma is the fourth state of matter… there are three states of matter: solid, liquid and gas, but there are actually four. The fourth is plasma. To put it very simply, a plasma is an ionized gas, a gas into which sufficient energy is provided to free electrons from atoms or molecules and to allow both species, ions and electrons, to coexist. The funny thing about that is, that as far as we know, plasmas are the most common state of matter in the universe. They are even common here on earth. A plasma is a gas that has been energized to the point that some of the electrons break free from, but travel with, their nucleus. Gases can become plasmas in several ways, but all include pumping the gas with energy. A spark in a gas will create a plasma. A hot gas passing through a big spark will turn the gas stream into a plasma that can be used. Plasma torches like that are used in industry to cut metals. The biggest chunk of plasma you will see is that dear friend to all of us, the sun. The sun’s enormous hot rays electrons off the hydrogen and helium molecules that make up the sun. Essentially, the sun, like most stars, is a great big ball of plasma.’ (http://education.jlab.org/qa/plasma_01.html)

Results are to be expected within the next five years. ‘Many patients will be benefit and have fewer problems after surgery relating to implant infections and healing delays,’ says Professor Katharina Landfester, director at the Max-Planck-Institute for Polymertechnology.

A light at the end of the tunnel?

Professor Liviu Steier asks if there’s a future for bacteria-free dental devices such as implants
The Nobel Active implant

Dr Tidu Mankoo demonstrates the interdisciplinary restoration of six maxillary anterior teeth and a single Nobel Active implant

Abstract
This case illustrates the use of the Nobel Active (Nobel Biocare) implant for restoration of a failed maxillary central incisor, as part of the wider interdisciplinary restoration of the maxillary anterior teeth, in a 35-year-old female patient with a history of extensive treatment including previous crowns, multiple endodontic treatments and post cores.

There are a number of key factors in achieving inconspicuous aesthetic integration of an implant restoration, particularly in the case where a failed maxillary central incisor has led to considerable damage to the alveolar bone and compromised soft tissue volume.

The goal of any implant therapy in the aesthetic zone is to produce a restoration of the tooth (or teeth) that blends inconspicuously into the patient's smile and maintains stable soft-tissue form over time. It is understood that bone and soft tissue remodelling occurs around all dental implant restorations and while this remodelling has been attributed to a number of factors, it is now commonly accepted that it is probably due to the establishment of a "biologic seal", commonly described as a "biologic width" between the free gingival margin to the crest of the peri-implant alveolar bone.

A number of factors have been proposed as playing a role in this process and in recent years, new implant designs have been suggested as being potentially helpful to reduce the impact of the remodelling process on the marginal bone; therefore creating enhanced stability of the marginal soft peri-implant soft tissues. While it is clear that the components alone are not the whole story, nevertheless most of the new designs serve to enhance the thickness of the soft tissue cuff around the implant-abutment complex.

The Clinical Case
In this example, a 35-year-old female patient with a history of extensive dental treatment required revision of her previously restored maxillary anterior teeth (canine to canine), as well as additional treatment in the posterior regions, which are not relevant to the article. The teeth had been previously crowned in a piece-
meal approach over some years, and the most of the teeth in question were root treated and restored with post crowns.

The overall aesthetic situation was compromised by the appearance of short clinical crowns, giving the teeth (particularly the central incisors) a rather ‘short and broad’ appearance (Fig 1). In addition, there were pre-existing endodontic treatments and post crowns in a number of the teeth and residual apical radiolucencies evident on some of the teeth (Fig 2).

These were asymptomatic (except for the failing left central incisor), the right lateral incisor and canine had been apexected and retrograde root filled a couple of years prior, the right central incisor had been previously root treated and contained a fibre post and composite core although the root filling was difficult to assess radiographically. However, as the tooth was stable and symptom free it was decided to accept the situation as re-treatment would be difficult, and lastly the radiolucency on the left lateral incisor had been symptomless and stable for a number of years and may have been a scar.

Nevertheless, it was clear that the prognosis of some of these teeth was uncertain and that further surgical endodontic treatment may be required in the future for the left lateral and possibly the right central incisor. The patient was made aware of this and the risk of possible future root fractures, particularly in the left lateral incisor where there was a large metallic post.

An additional point to note is that the presence of metallic post and cores and dark root substrate makes ideal colour of the gingival margin tissue difficult to achieve and has to be managed carefully when being restored with all-ceramic restorations to avoid affecting the value of the crowns.

The maxillary left central incisor needed surgical endodontic treatment, but had to be removed shortly after due to root fracture (Fig 4), and it was not possible to place an implant immediately due to the infection and damage to the labial bone.

Soft-tissue healing
A provisional metal-acrylic fixed-partial denture was fabricated and fitted at the time of tooth extraction and soft-tissue healing allowed to occur (Fig 4, 5). After approximately six weeks surgical treatment was performed to place the implant and augment the bone and soft tissues in the implant site. A wide mucoperiosteal flap was raised across the anterior maxilla using sulcular incisions with no vertical releasing incisions necessary. At the same time, crown lengthening of the maxillary anterior teeth was carried out, by recontouring both the gingival margins and labial alveolar bone around the anterior teeth. Figure 6 shows the damage to the labial bone plate in the area of the tooth extraction and loss of labial contours in that area.

Positioning the implant
The correct three-dimensional

The maxillary left central incisor using sulcular steal flap was raised across the implant site. A wide mucoperiosteal flap was raised across the anterior maxilla using sulcular incisions with no vertical releasing incisions necessary. At the same time, crown lengthening of the maxillary anterior teeth was carried out, by recontouring both the gingival margins and labial alveolar bone around the anterior teeth. Figure 6 shows the damage to the labial bone plate in the area of the tooth extraction and loss of labial contours in that area.

Positioning the implant
The correct three-dimensional

For more information, contact BioHorizons Customer Care: +44 (0)1344 752560 Email: infouk@biohorizons.com visit us online at www.biohorizons.com
Fig 2. Verification of biologic width during osseous recontouring and crown lengthening. Fig 3. Ideal positioning of the temporary implant. Note apical and 2mm palatal to the desired final crown margin.

Fig 4. Augmentation bone marsupialization as an add-on procedure. Note the bone graft is in place. Note good labial bone contours.

Fig 5. Good primary closure achieved and maintenance of the flap using 4-0 mono-filament polypoxydalone suture. Note the reconstructed gingival margin. Fig 6. Provisional crowns and bridge after healing and maintenance of soft tissue and bone, and tooth preparation and relining.

Fig 7. Radiograph of the implant with provisional bridge in place. Fig 8. The case just before final impressions and cast alignment of the cast in situ. Fig 9. Occlusal view with the healing abutment removed to show the thick labial bone contours.

Fig 10. An example of a caution, narrow abutment as was used in this case showing the current design with a scalloped margin to facilitate cementation of the crown. The implant abutment connection lends itself to creation of a natural perimplant mucosal cuff, which enhances the tissue thickness in this critical area. Fig 11. Final radiograph at two month follow-up.

Note improved crown proportions and good restoration of labial contours around the implant restoration.

Fig 12. Frontal radiograph. Fig 13. Close-up view of the final result.
positioning of the implant is of critical importance in helping to achieve a lasting aesthetic result and here it is important to place the implant correctly, ie, three mm apical and two mm palatal to the final gingival margin desired on the implant restoration. In this case the teeth were to be crown lengthened, so it was necessary to recontour the alveolar process to achieve the correct biological width on the teeth (Figs 7, 9) prior to positioning the implant so that the final gingival margins will harmonise.

In effect, this meant that the implant was placed deeper than would have been in a case where no crown lengthening was required and facilitated a good housing of bone for the implant. Despite this, it was still necessary to augment the labial osseous and soft tissue contours for the purposes of achieving the correct soft tissue aesthetics.

A Nobel Active 4.5 x 13mm implant was placed after preparation of the osteotomy, achieving excellent primary stability, and bone augmentation was carried out using the principles described in the previous publications by the author 25 using an organic bone mineral (Nu-Oss, Ace Surgical Co, Brockton, USA) and covered with resorbable collagen membrane (Bio-Gide, Geistlich AG) (Figs 9, 10).

A narrow healing abutment was placed, the bone augmentation carried out and the tissue on the crest of the ridge was deepithelialized and rolled under itself to the labial to create an increase of the soft tissue volume on the labial of the implant healing abutment and the flap sutured using 6-0 mono filament polypropylene sutures (Fig 11). This could be further enhanced with a connective tissue graft if necessary, but in this case, the roll flap created sufficient thickness. The bridge was re-cemented after adjustment of the pontic to fit passively against the augmented ridge and healing abutment, and to allow for a slight tissue excess in the area of the implant.

The healing process begins

After three months of healing, the remaining crowns and provisional bridges were removed and the teeth re-prepared to the new gingival margins. The bridge retainers were re-lined and provisional crowns made and cemented provisionally to allow for tissue maturation to occur (Figs 12, 15).

After six months, final refinement of the tooth preparations (Fig 14) and the achievement of good soft-tissue contours can be seen particularly on the labial aspect of the implant, where a thick collar of labial tissue is evident (Figs 15, 16). The final impressions of the preparations and a transfer impression of the implant were made and subsequent steps to try-in the abutment and bisque bake of crowns were carried out. After all necessary adjustments were made the final Procera alumina crowns were finished and final cementation performed with a glass ionomer cement (Fuji 1, GC) over a period of a few weeks. It is essential that retraction cord is used when cementing the crown (whether provisional or final) on the implant abutment to ensure that no cement excess travels into the sub-mucosal area as this can lead to peri-implantitis and therefore compromise the result.

A Procera Zirconia abutment was fabricated and Fig 17 shows an example of this, demonstrating the ideal contours of the abutment with the scalloped margins resembling a tooth preparation.

This enables crown margins to be ideally placed for cementation. The design of the Nobel Active implant components lend themselves naturally to the creation of the transmucosal under-contour that facilitates a thicker transmucosal tissue cuff and therefore greater stability.

Figs 18, 20 show the final crowns at two-month follow up. It is interesting to note the difficulty in achieving ideal soft-tissue col-
## Screw versus cement-retained, implant-supported prosthetic restorations

Professor Liviu Steier discusses passive-fit, cement hydraulics/overhangs and retrievability of implant-supported prosthetics.

It was the year 1999 when Kim et al. stated that: ‘The use of cement-retained implant prosthesis is increasing because of improved occlusal anatomy, esthetics, and simplified laboratory procedures. Little is known about the biomechanics of cement retained implant prosthesis compared with that of screw retained implant prosthesis.’

While comparing, cement retained versus screw retained implant restoration, Michalakis et al. reviewed the literature in 2005. His research emphasised the following factors:

1. Ease of fabrication and cost
2. Passivity of the framework
3. Retention
4. Occlusion
5. Esthetics
6. Delivery
7. Retrievability

Weber et al. (2007) could not find enough evidence to prove any significant difference among restoration design and treatment outcome and Chee et al. (British Dental Journal 2006; 201; 501-507) summarised the differences they have identified:

- Screw-retained restorations are more easily retrieved and maintained
- Cemented restorations can accommodate more implant positions
- Screw-retained restorations are easier to manage when immediately loading implants.

Screw loosening is among the biggest post-loading problems. Cavazos et al. (1996) summarise reasons for screw loosening: ‘Screw stretch, less than ideal implant position, inappropriate occlusal scheme or crown anatomy, variations in hex dimension coupled with equal variations in the abutment counterparts, slight differences in fit and accuracy, tension on abutment and cylinder from ill-fitting restorations.’

Several approaches have been researched and suggested to avoid screw loosening, from silicon to resin sealing, from screw material innovation to coating techniques.

### Fit variation

As early as 1961, Kurosu and Ide demonstrated that marginal fit of cemented restorations varies between 20 and 90 microns. Wilson et al. proved in 1990 the deformation of restorations with the cementation procedure. Kim et al. (1999) measured the deformation of restorations with marginal fit variation.

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<td>BA720W</td>
<td>Cement-retained prosthesis</td>
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### Screw connection

- **Destra**: Connection (Midwest 4-hole)
- **Superior**: Connection (Borden 2-hole)

### Perio tips (pack of 3)

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<td>BAC163</td>
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<tr>
<td>BAC164</td>
<td>Scaling tip to remove all supragingival calculus</td>
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</tr>
</tbody>
</table>

### BA Ultimate Hygiene Range

- **New**: Scaling tip to remove supragingival calculus £229
- **New**: Scaling tip to remove all supragingival calculus £89
- **New**: Scaling tip to remove supragingival & interdental calculus £89
- **New**: Scaling tip to remove maxil calculus £89

### BA Ultimate Air Scalers

- **New**: Compact, ergonomic, and very quiet £89
- **New**: 3 new innovations: vibration frequency 17Khz £89
- **New**: Auto-clavable up to 135°C £89
- **New**: Includes 3 tips and an autoclavable tip changer £89

### BA720 Ultimate Air Polisher

- **New**: Ergonomic design, very well balanced £489
- **New**: Colour: ivory white £489
- **New**: Excellent visibility £489
- **New**: Great grip, comfortable head for difficult access £489
- **New**: Available with your choice of connection: W&H, W&H, Sirona or Air Air £489
- **New**: Very light, only 14.7g £489
- **New**: Low-pinion, compact £489
- **New**: Fully autoclavable £489
implant crown when a vertical force was applied.

Researching the literature, only one paper by Scherwelm et al. (2005) has been identified addressing the cementation problem in implant-supported crowns. He suggested a lateral crown venting to allow elimination of cement excess and reduce deflection/deformation of the prosthetic part as well nocive forces to the implant. 

A clinical case study

Missing tooth 46 was replaced by an implant: Internal Implant RFT, Laser-Lok 4.0 x 12mm, 4.5 Platform (Biohorizons UK, 17 Wellington Business Park, Dukes Ride, Crowthorne, Berkshire RG45 8LS). After adequate osseointegration time (three months after insertion), the second-stage surgery has been performed and the gum sculpted with a provisional.

The laboratory delivered the prepped abutment mounted into the transfer key. The PFM crown (high precious metal) guarantees a coronal access to the screw.

The abutment will be tightened according to the indications of the manufacturer using a torque control device. The impression as well as to be used as definitive abutment. The preparation of the abutment is performed by the technician. It is important to make sure that a nice prep margin is defined. This will ease the removal of the cement at the crown margins.

The author prefers a technique of cementation with coronal venting. The presented crown design addresses the following technology shortcomings:

- Cementation will easier pardon crown discrepancies.
- Coronal access will facilitate and allow screw retightening at any needed time.
- Coronal access will facilitate excess cement evacuation and clearly facilitate a better fitting.

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Untying the Gordian Knot; Part I

Kenneth Serota discusses the Endodontic Implant Algorithm, which provides highlights in the assessment and identification of determinant factors leading to endodontic failures, in order to help in the decision-making process whether or not it is adequate to implement a new endodontic approach vs. extraction and replacement with dental implants.

Over the years, endodontics has diminished the variables in the equation of optimal oral health. Interventional or interceptive endodontics, restorative endodontics, the re-engineering of failing therapy, transitional endodontics and surgical endodontics encompass a vast scope of therapeutic considerations prior to any decision/tipping point to replace a natural tooth. Everything we do as dentists is “transitional”, with the exception of extractions. No result is everlasting; none are permanent; thus our treatment plans must reflect this reality. Artifice versus a natural state is not a panacea for success; treatment outcomes (Figs 2a, 2b, 2c, 2d).

In 1992, funding from the Cochrane Collaboration was obtained for a UK Cochrane Centre based in Oxford to facilitate the preparation of systematic reviews of randomised trials of healthcare. The Cochrane Systematic Review is a process that involves locating, appraising, and synthesising evidence from scientific studies in order to provide informative empirical answers to scientific research questions. In 1952, the engineering son of an inventor named Ron Popeil created infomercials using 30 to 120 second television spots to sell his Singer slicer. The singular goal of an infomercial was to get the viewer on the phone immediately and have them place their order. No waiting weeks, months or even years for the lofty marketing goals of branding to pay off. Somewhere along the way, dentistry morphed into a phone immediately and have them place their order. No waiting weeks, months or even years for the lofty marketing goals of branding to pay off. Somewhere along the way, dentistry morphed into the algorithm by which sacrifice replaces artifice. Nowhere is this more apparent than in the debate on the endodontic implant algorithm.

New treatment modalities Scientific doctrine is the cornerstone of Endodontic therapeutics. However, of late, anecdotal testimony has become the default setting, the presentation of systematic reviews of randomised trials of healthcare. The Cochrane Systematic Review is a process that involves locating, appraising, and synthesising evidence from scientific studies in order to provide informative empirical answers to scientific research questions. In 1952, the engineering son of an inventor named Ron Popeil created infomercials using 30 to 120 second television spots to sell his Singer slicer. The singular goal of an infomercial was to get the viewer on the phone immediately and have them place their order. No waiting weeks, months or even years for the lofty marketing goals of branding to pay off. Somewhere along the way, dentistry morphed into the algorithm by which sacrifice replaces artifice. Nowhere is this more apparent than in the debate on the endodontic implant algorithm.

In December 2004, Salehrabi and Rotstein [3] published an epidemiologic study on endodontic treatment outcomes in a large patient population. The outcomes of initial endodontic treatment done by general practitioners and endodontists participating in the Delta Dental Insurance plan on 1,462,936 teeth of 1,126,288 patients from 50 states across the USA were assessed in an eight year timeline. Ninety seven per cent of teeth were retained in the oral cavity subsequent to nonsurgical endodontic treatment over this period. The combined incidence of untoward events such as extractions, apical surgeries, and extractions was three per cent and occurred primarily within three years of the completion of treatment. Analysis of the extracted teeth revealed that 85 per cent had no full coronal coverage. A statistically significant difference was found between covered and uncovered teeth for all tooth groups tested which is consistent with the findings from numerous investigations.

The purpose of this publication is to evaluate current trends and perceptions pertaining to the standard of care in endodontics and provide an evidence-based consensus on their relevance and application. Part II will address the algorithm which by sacrifice replaces artifice. New orthopedic replacements can be validated and the engineering principles and designs that best mimic clinical dictates.

Evolutionary paradigm shifts Three surveys have been conducted with the membership of the American Association of Endo...
Dentists since the late 1970s. The first reflected what is now an anachronistic view of emergency procedures and the standard of care defining non-surgical therapy during that period \(^7\); the second, done prior to the technologic advances of the last decade of the 20th century, was hallmark by a dramatic decrease in leaving pulpless teeth open in emergency situations and a significant decline in the use of cultured prior to obturation \(^8\). The report indicated that the concept of "debridement and disinfection" versus "cleaning and shaping" was now the focus of the biologic therapeutic imperative and the need for expansive microbial strategies was recognised as being of paramount importance (Fig 5). The primary patho-physiologic vectors of pulpal disease and the myriad complexity of the root canal system had always been understood; as the century closed, clinicians were provided with new tools and technology to expand the boundaries and limitations of endodontic treatment procedures (Fig 4a, 4b).

Root canal infections are polymicrobial, characterised predominantly by both facultative and obligate anaerobic bacteria \(^9\). The necrotic pulp becomes a reservoir of pathogens, toxic consequences and their resultant infection is isolated from the patient's immune response. Eventually, the microflora and their by-products will produce a periradicular inflammatory response. With microbial invasion of the periradicular tissues, an abscess and cellulitis may develop. The resultant inflammatory response will initiate either a protective and/or immun-
opathogenic effect; additionally, it may destroy surrounding tissue resulting in the five classic signs and symptoms of inflammation; calor, dolor, rubor, tumor and pain. Patient evaluation and the appropriate diagnosis/treatment of the source of an infection are of utmost importance.

Patients demonstrating signs and symptoms associated with severe endodontic infection (Table I) should have the root canal system filled with calcium hydroxide and the access sealed. In the event of copious drainage, the access can be left open for no longer than 24 hours, the tooth then isolated with rubber dam, the canals irrigated and dried and calcium hydroxide inserted into the root canal space and the access sealed (10). The antibiotic of choice for periradicular abscess remains Penicillin VK; however, recent studies have reported that amoxicillin in combination with clavulinate (1gm loading dose with 500mg q8h for seven days) was a more effective therapeutic regimen (11).

Systemic antibiotic administration should be considered if there is a spreading infection that signals failure of local host responses in abating the dispersion of bacterial irritants, or if the patient’s medical history indicates conditions or diseases known to reduce the host defense mechanisms or expose the patient to higher systemic risks. Antibiotic treatment is generally not recommended for healthy patients with irreversible pulpitis or localised endodontic infections (Table II).

Numerous studies with well-defined diagnosis and inclusion criteria failed to demonstrate enhanced pain resolution beyond the placebo effect (12, 13).

The sophistication of endodontic equipment, materials and techniques has been steadily iterated and innovated since the second survey. The microscope first introduced to otolaryngology around 1950, then to neurosurgery in the 1960s, is now standard of care for the voyage into the microcosmic world of the root canal space. Recursions in the micro-processing technologies of electronic foramenal locators have surpassed accuracy lev-
els, improved digital radiographic sensors and software enhanced diagnostic acumen, and ultrasonic units with a variety of tips designed specifically for use when performing both non-surgical and surgical endodontic procedures minimised damage to coronal and radicular tooth structure in the effort to locate the pathways of the pulp. The treatment outcome of non-surgical root canal therapy at this point in time is far more predictable than at any other period in our history.

Diagnosis

Of all the technologic innovations embraced by endodontics, digital radiography should have generated the greatest impact; however, its value remains limited in diagnosis, treatment planning, intraoperative control and outcome assessment. Flat field sensors still require three to four parallax images of the area of interest to establish better perception of depth and spatial orientation of osseous or dental pathology. These three-dimensional information deficits, geometric distortion and the masking of areas of interest by overlying anatomy or anatomic noise are of strategic relevance to treatment planning in general and in endodontics specifically (14) (Fig 5a, 5b).

Cone beam computed tomography (cbCT) produces up to 580 individual projection images with isotropic submillimeter spatial resolution enhanced by advanced image receptor sensors; it is ideally suited for dedicated dento-maxillofacial CT scanning. When combined with application-specific software tools, cone beam computed tomography can provide a complete solution for performing specific diagnostic and surgical tasks. The images can be resliced at any angle, producing a new set of reconstructed orthogonal images and studies have shown that the scans accurately reflect the volume of anatomic defects. The limited volume cbCT scanners best suited for endodontics require an effective radiation dose comparable to two or three conventional periapical radiographs and as such are set to revolutionise endodontics (15, 16) (Fig 6).

Three dimensional pre-surgical assessment of the approximation of root apices to the inferior dental canal, mental foramen and maxillary sinus are essential to treatment planning. The ability of cbCT to diagnose and manage dento-alveolar trauma using multiplanar views, the determination of the root canal anatomy and the number of canals, the detection of the true nature and exact location of resorptive lesions and the discovery of the existence of vertical and horizontal fractures outweigh concerns about the degree of ionising radiation and the risks posed (17). Provided cbCT is used in situations where the information from conventional imaging systems is inadequate, the benefits are essential for optimisation of the standard of care.

Patel reported that periapical disease can be detected sooner and more accurately using cbCT compared with traditional periapical views and that the true size, extent, nature and position of periapical and resorptive lesions can be accurately assessed (18). Using a new periapical index based on cone beam computed tomography for identification of apical periodontitis, periapical lesions were identified in 50.5 percent by radiography and 60.9 percent of cases by cbCT respectively ($P < .01$). Simon et al compared the differential diagnosis of large periapical lesions with traditional biopsy. The results suggested that cbCT might provide a faster method to differentially diagnose a solid from a fluid-filled lesion or cavity, without invasive surgery (19). In spite of the presence of artifacts, the learning curve related to image manipulation and the cost, cone beam tomography will invariably be the accepted standard of diagnostic care and treatment planning in endodontics in the very near future.

Access

An improperly designed access cavity will hamper facilitation of optimal root canal therapy. If the orientation, extension, angulations and depth are inaccurate, retention of the native anatomy of the root canal space becomes precarious. The requirements of access cavity design can be achieved by conceptual and technical regression of the existing configuration to that which one would logically expect to have seen prior to the insults of restoration, function and aging.

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If tertiary dentin were perceived of as “irritational dentin” or dystrophic calcification considered “decay”, the chamber outline could be used to blueprint an inlay configuration for the access design that literally replicates the “virgin” tooth (Fig 7).

Removal of the existing restoration in its entirety and/or preliminary preparation of the coronal tooth structure for the subsequent full coverage restoration will identify decay, fractures, unsupported tooth structure and expose the anatomy of the underlying root tubuli which assists in discovery of the spatial orientation and morphology of the roots. The pulp chamber ceiling and pulp stones can be peeled away with a football diamond bur to grossly identify the primary orifices. Micro-etching (Danville Materials, San Ramon CA) the floor of the chamber, perhaps the most underused of all access tools, is invaluable in the exposure of fusion lines and grooves in order to identify accessory orifices.

Dissection with ultrasonic tips of any design is used solely to trace fusion lines, not effect gross removal. The use of ultrasonics to “jackhammer” pulp stones is simply too risky as one approaches the floor of the chamber, particularly if there are no water ports on the tips. Orifice lengthening and widening enables straight line glide path to the apical third. The strategic objective is not to impede the file, stainless steel or nickel-titanium rotary along the axial walls with minimal dentin removal (Fig 8a, 8b).

It is equally as important to produce a high quality coronal restoration at the time of sealing the root canal system (9, 10).

Fig 8a – Dissective calcification outlines even the most experienced clinicians. The key to identification of the orifices is to regress the inner space using the continuum, exap bottle, canal orifice. In lieu of an ultrasonic tip which tends to strip the stone and wattier debris, gross removal is best done with a diamond bur in a high speed handpiece. The fine removal of residual can be done with a multifluted carbide bur to trace the fusion lines.

Fig 8b – Keeping the chamber wet with alcohol improves optics and highlights colour differentiation. The most important tool for orifice identification in addition to direct is a micro-etcher. The satin finish produced highlights the disparity between the natural tooth structure of the floor and the secondary and tertiary dentin of the calcified orifice.

Irrigation

The complex anatomy of the root canal space presents a daunting challenge to the clinician who must debri de and disinfect the corridors of sepsis with absolute accuracy to achieve a successful treatment outcome. (see Fig 10). In addition, the absence of a cell-mediated defense (phagocytosis, a functional host response) in necrotic teeth means the micro-organisms residual in tubuli, cul de sacs and arborisations are mainly affected by the redox potential (reduction potential) which reflects the oxidation-reduction state of the environment – anaerobes micro flora may only be active at a positive Eh, whereas strict anaerobes can only be active at negative Eh values) and availability of nutrients in the various parts of the root canal (24). While our knowledge of persistent bacteria, disinfecting agents and the chemical milieu of the necrotic root canal has greatly increased, there is no doubt that more innovative basic and clinical research is needed to optimise the use of existing methods and materials and develop new ones in order to prevent and/or treat apical periodontitis.

Varying degrees of sterility of the root canal space are achieved by mechanistic removal, the chemical reactivity and fluid dynamics of irrigants and their introduction to the canal space;
however, the protocols used today cannot predictably provide sterile canals. As none of the elements of endodontic therapy (host defense system, systemic antibiotic therapy, instrumentation and irrigation, inter-appointment medicaments, permanent root filling, and coronal restoration) can alone guarantee complete disinfection, it is of utmost importance to aim at the highest possible quality at every phase of the treatment. In the classic study by Sjogren et al, 55 single-rooted teeth with apical periodontitis were instrumented and irrigated with sodium hypochlorite and antibiotics, which effectively disinfects the root canal anatomy. Siqueira et al showed that regular exchange and the use of large amounts of irrigant should maintain the antibacterial effectiveness of the NaOCl solution, compensating for the effects of concentration. Numerous devices have appeared in the endodontic armamentarium to address this situation; EndoVac (Discus Dental) – a negative pressure differential device designed to deliver high volumes of irrigation solution while using apical negative pressure through the office high vacuum evacuation system, Negative Pressure Safety Irrigator (Vista Dental, Racine WI) – device is similar to EndoVac, Rinsendo (Air Techniques, Concora CA) uses pressure suction technology; 65% of irrigant are automatically drawn from the attached syringe and aspirated into the canal (pressure created is lower than manual irrigation), Viberinge (Bisco Canada, Richmond BC) – sonic flow technology facilitates enhanced irrigation through the myriad complexities of the root canal system (Fig 11).

NaOCl is the most widely used irrigating solution. It is a potent antimicrobial agent and lubricant, which effectively dissolves pulpal remnants and organic components of dentin thus preventing packing infected hard and soft tissue into the apical con- fines. Hypochlorous acid (HClO) is the active moiety responsible for bacterial inactivation. NaOCl is used in concentrations varying from 0.5 to 5.25 per cent; the in vitro and in vivo studies differ significantly in terms of the effectiveness of the range of concentrations as the in vitro experiments provide direct access to microbes, higher volumes are used and the chemical milieu complexity of the natural canal space are absent than in the in vivo experimentation. A study by Siqueira et al showed no difference (in vitro) between one per cent, 2.5 per cent and give per cent NaOCl solutions in reducing the number of bacteria during instrumentation. What has been shown is that the tissue dissolving effects are directly related to the concentration used.

Perhaps the most misunderstood aspect of NaOCl irrigation is the need for the quantities of irrigation required due to the morphologic and anatomic variations in the volumetric size of the root canal anatomy. Siqueira showed that regular exchange and the use of large amounts of irrigant should maintain the antibacterial effectiveness of the NaOCl solution, compensating for the effects of concentration. Numerous devices have appeared in the endodontic armamentarium to address this situation; EndoVac (Discus Dental) – a negative pressure differential device designed to deliver high volumes of irrigation solution while using apical negative pressure through the office high vacuum evacuation system, Negative Pressure Safety Irrigator (Vista Dental, Racine WI) – device is similar to EndoVac, Rinsendo (Air Techniques, Concora CA) uses pressure suction technology; 65% of irrigant are automatically drawn from the attached syringe and aspirated into the canal (pressure created is lower than manual irrigation), Viberinge (Bisco Canada, Richmond BC) – sonic flow technology facilitates enhanced irrigation through the myriad complexities of the root canal system (Fig 11).

NaOCl cannot dissolve inorganic dental particles and thus prevent smear layer formation during instrumentation. Chelators such as EDTA and citric acid are recommended as adjuvants in root canal therapy. It is probable that biofilms are detached with the use of chelators; however, they have little if any antibacterial activity. Several studies have shown that citric acid in concentrations ranging as high as 50 per cent was more effective at solubilizing inorganic smear layer components and powdered dentin than EDTA. In addition, citric acid has demonstrated antibacte- rial effectiveness.

Technology and innovation will not negate the need for optimal preparation (debridement and disinfection) to eliminate microbial content and its impact on a necrotic root canal system. We as a discipline need to be better; however, by the same token, endodontics has shown its commitment to endless reinvention. In time, that will restructure the role of natural teeth in foundational dentistry, currently diminished by the market forces of implant driven dentistry. Orthodontic replacement is not a panacea as random clinical trials increasingly show; the severity of peri-implantitis lesions demonstrates significant vari- ability and as such no treatment modality has shown superiority. The pendulum will continue to swing as the endodontic implant algorithm becomes increasingly multidisciplinary.

Part 2 in next issue, including references

Table I and II – derived from Antibiotics and the Treatment of Endodontic Infections – Summer 2008 – American Association of Endodontists – Colloquium for Excellence

About the author
Kenneth S. Serota, DDS, MMSc: graduated from the University of Toronto, Faculty of Dentistry in 1973 and was awarded the George W. Cochrane Award for excellence in Prosthodontics. He received his Certificate in Endodontics and Master of Medical Sciences Degree from the Harvard-Forsyth Dental Center in Boston, MA. A recipient of the recipient of the American Association of Endodontics Memorial Research Board for his work in nuclear medicine screening procedures related to dental pathology, his passion is education and most recently e-learning and rich media. He was selected for Fellow- ship in the Pierre Fauchard Academy and is a Fellow of the Academy of Dental Implantologists. In addition to more than sixty publications, he has lectured on Endodontics international- ly. He is on the editorial board of En- dogentic Practice, Endodontic Tribune and Implant Tribune. The founder of several online educational forums for dentists from around the world who wish to learn cutting edge endo- dentics therapy, he recently launched IMPLANTS www.rximplants.com and www.idealonline.org in order to bridge the gap between the endodontic/implant algorithm in foundational dentistry. As well, he lectures on the empowerment digital technolo- gies provide to the sophistication of the dental team and the propagation of comprehensive care.