Bitewing radiograph showing failing first and second molars. Teeth 31 were removed simply. Teeth greater palatine. Teeth 1, 30 and 1:100,000 was administered via cent lido with epinepherine after this. Then 72mg two per hour. The patient returned later that extraction appointment) and taken PO 60 minutes prior to the amalgam was prescribed (to be replace tooth 30 (and possibly 2 and 32 were sectioned and the roots were delivered. Finally, 3-0 chromic gut sutures were placed.

Transporting the teeth
The teeth were transported in a 10 per cent buffered forma-lin solution. Upon arrival, they were immediately transferred to a hydrochloric acid solution and soaked for 24 hours. From there they were moved to a 95 per cent alcohol solution. They were again soaked for 24 hours, and after that they were placed in methyl salicylate for one hour.

For the photography, the teeth were placed in a glass dappen dish and totally submerged in methy salicylate. They were then back lit with a xenon fibre-optic light source and photographed with a Canon A 650 IS camera mounted on a high power dental operating microscope.

A valuable process
Clearing teeth is a valuable process to allow us to evaluate endodontic failures as teeth are left in virtually their true anatomic form yet we can see through them to see what was accomplished or not accomplished in a treatment protocols.

Direct view of the distal root of the lower first molar in the x-ray. Note again the incomplete treatment of the canal system.

Side view of the distal root with the mesial root(s) in the back ground.

Here is another direct view of the distal root. The picture was mostly taken to try to capture the “white lines” coming off the post. The source of the white lines are unknown but are demonstrated as they were as this tooth was held at specific angles to allow the light to reflect off of them. It was a feature never witnessed before by this photographer of cleared teeth that seemed interesting.

On examination, teeth 2, 30, and 50 were painful to palpation and percussion. Panoramic and full mouth radiographs revealed large periradicular radiolucencies associated with the lower right first and second molars. These teeth were deemed unrestorable and the patient elected to have them extracted. Additionally, tooth 2 had gross distal caries and needed extraction. Fixed partial dentures utilising the third molars were discussed as a potential, though far from ideal, treatment option. The patient elected to extract the third molars as well and move toward dental implants to replace tooth 50 (and possibly 2 and 51).

For anxiolysis, 0.25mg Tria-nolam was prescribed (to be taken PO 60 minutes prior to the extraction appointment) and the patient returned later that afternoon. Then 2mg two per cent lido with epinepherine 1:100,000 was administered via IANB, PSA, long buccal, and greater palatine. Teeth 1, 30 and 31 were removed simply. Teeth 2 and 32 were sectioned and the roots were delivered. Finally, 3-0 chromic gut sutures were placed.

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Dr Hank Willis is a 2005 graduate of the University of Washington School of Dentistry in Seattle. He practices general dentistry at his own practice in Bonners Ferry in Idaho and has a particular interest in microscope-enhanced dentistry. He is also a member of the Academy of Gen- eral Dentistry and the American Dental Association and you can contact him by calling 001 208 267 6454 or emailing hank.willis- dds@gmail.com.
The patient presented for endodontic treatment of a maxillary molar. The tooth had developed mild to moderate unprovoked pain, and the referring dentist had prescribed penicillin five days prior to the treatment visit. The pre-operative diagnosis was necrotic pulp with periapical periodontitis of endodontic origin.

A lesion was visible radiographically at the apical area of the mesiobuccal root. (See Figure 1).

Upon entry, the chamber presented as a curved groove from the mesio-buccal to the palatal. Figure 2 shows debris accumulated in the mesiobuccal orifice (bottom of image), the distobuccal orifice (middle of image), and the palatal orifice is not shown (top of image).

Mesiobuccal roots of maxillary molars are characterized by an isthmus extending palatally from the mesiobuccal orifice. These isthmus areas present with a variety of configurations, and can harbor significant amounts of bacteria and debris. It is imperative to debride these areas thoroughly as possible, because the isthmus may be in communication with the attachment apparatus, and may be a source of persisting disease after treatment.

Vital cases with inadequately treated mesiobuccal root canal systems may present with vague symptoms of discomfort, and non-vital cases may show lesions which do not resolve or worsen, following therapy.

Figures 7 and 8 show the result of careful development of the "mb2" orifice. In this case, the resulting canal was confluent apically with the primary mesiobuccal canal. This is frequently not the case, and furthermore, this author has retreated cases with persisting disease on the MB root with untreated MB2 canals, despite the canals being confluent after instrumentatıon. An excellent source for information about the morphology of maxillary molars can be found in an article by Dr John Stropko, Journal of Endodontics, June 1999, “Canal morphology of maxillary molars: Clinical observations of canal configurations.”
In a study of more than 1,700 teeth (1,096 first molars), the operator discovered the MB2 in 93 percent of maxillary first molars, with 54.9 percent of those being separate canals. This emphasises the importance of uncovering and negotiating this mesiobuccal root isthmus to maximise debridement.

Obturation of the canals to orifice level is accomplished prior to placement of an orifice barrier (not shown). Final radiographs, as well as radiographs from other cases, demonstrating a variety of presentations of mesiobuccal root anatomy.

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Fig. 4: The dark circle is created by the bur, revealing the darker coloration of the furcal dentin. Within this area, a small dot is forming. – Fig. 5: Further troughing shows the dot becoming more of a line. – Fig. 6: A file pointing to MB2, for demonstration only, not yet ready for negotiation. – Fig. 7: MB1 and MB2. – Fig. 8: MB1 and MB2. – Fig. 9: MB1 and MB2 obturated. – Fig. 10: A completed case.

Fig. 11: First molar with separate MB1 and MB2. Second molar with MB2 existing only as a fin off of the MB1.

Fig. 12: First molar with separate MB1 and MB2. Second molar with MB2 existing only as a fin off of the MB1.

Fig. 13: A similar case pre-op.

Fig. 14: A completed case.

Fig. 15: The completed case, angled view.
Choosing wisely
Deciding which materials and products to use in your practice can be a difficult task, but one that has been made easier by Dr Michael Miller, founder of Reality Esthetics. Prof. Dr. Liviu Steier explains.

You’ve just come across a new technology (maybe a new material) that you really like. You’re unsure of what to do next - should you buy it? There are lots of questions:

- Could it help/compliment my daily work?
- Who is the manufacturer?
- What are the strengths and weaknesses?
- Where could I get some additional user information and/or tips?
- How does this perform with my colleagues? Rating?

A colleague told you some time ago about product evaluators… are they worth looking at? What was the name again…? Yes, indeed that is exactly what could help now… Does this scenario sound familiar? It is 20 years since someone made this dream come true: Dr Michael Miller. He founded Reality Esthetics (www.realityesthetics.com) and not so long ago RealityEndo.

How does it work?
Dr Miller gathered a group of about 20 renowned clinicians. He then spoke to product manufacturers and offered them the chance to have their products tested by the clinicians.

Himm, you may think now: “This sounds awkward! Why would the manufacturers want to have clinicians test, evaluate and rank their products?”

The answer is simple: The feedback received is extremely useful in that it can be implemented in further developments; for example, the evaluation received can be useful for advertising.

What you might be thinking now is that the people carrying out the product evaluations are working for the dental manufacturers. Well, they’re not and this is what makes this group so special.

To be accepted as an evaluator, Dr Miller set up a very strict list of criteria. To maintain objectivity, the Reality Esthetics group does not accept any advertisements nor support by third parties or manufacturers. The publication is created by professionals like yourself to benefit professionals like yourself.

Now it is time to have a closer look into the way the evaluations are done.

Carrying out evaluations
Each product evaluation starts with a ranking out of five. Details are then given of the manufacturer and its website. Next, a product’s benefits and disadvantages are mentioned – perhaps it’s of Gold standard, a new design or a new piece of software. Or maybe it’s cumbersome or complex to maintain.

Most of us don’t take much care or notice of the information we are given when we purchase a new product, so it’s good to know there is a place we can find this. On this website, you can find out what to do if your product, for example, needs a repair.

A detailed product description follows, and because it is created by professional colleagues, all their good and bad experiences, their helpful suggestions and advice are implemented in the specially created section called Use. It is highly accessible and easy to read, interesting, extremely relevant for the daily routine. It isn’t called the ‘bible of Esthetic Dentistry’ by many colleagues for no reason!

Because one day you may need to know about maintenance, Reality Esthetics stores this information for you. Almost everyone prefers first to learn about the essence of a product before reading the details – well here you go!

If you’re curious? Just have a look by logging on to www.realityesthetics.com.