Bernardes et al concluded that: CBCT provides enhanced and accurate information for the diagnosis of root fractures, thereby constituting an excellent alternative for diagnosis in the dental practice. Hassan et al found CBCT better than periapical radiographs in detecting vertical root fractures. Although one can’t predictably demonstrate incomplete root fractures on CBCT, I have seen some rather dramatic cases.

Fig 5 shows a periapical image of an upper cuspid with a lateral bony lesion mid root. Lateral periodontal cyst, lateral canal, non-healing ends, and fractured root were included in my differential diagnosis. CBCT (Fig 4) clearly shows a fractured root was the cause of the lesion.

Even if you can’t see the fracture on CBCT, you can often see the amount and location of bone loss caused by them. Fig 6 shows a PA that is inconclusive. Fig 6 shows bone loss on the second molar consistent with vertical root fracture. (arrow)

Internal or external resorption
Fortunately, resorption is much rarer that fractures; it can be no less frustrating to demonstrate the location and extent of the defect on conventional two
Fig 20: Endo Tribune United Kingdom Edition - July 19-25, 2010

dimensional periapical x-rays. CBCT makes this a breeze. Car-
los Estrela, et al (6) concluded that: “CBCT seems to be useful in the evaluation of IRR (intra-
rootal resorption) and its diagnostic performance was better than that of periapical radiography.”

Fig 9 shows a PA with suspected external inflammatory root resorption on the mesial of the second molar. Figs 10 and 11 show the location and extent of the defect much more precisely on CBCT. One can even measure how close to the pulp it gets!

Difficult anatomy (upper molars especially), dens-in-
dente, severe curves, etc

Here is another case where the anatomy hid the lesion. The PA was inconclusive (Fig 12). The patient was swollen and all the teeth quite tender. Instead of guessing, I could tell for certain which tooth was the cause of his pain and swelling with CBCT (see Fig 15).

Maxillary sinus involvement

The patient in Figs 12 and 13 is an MD radiologist who was di-
agnosed by a fellow radiologist with a sinusitis. Unfortunately they missed that an infected upper
peir first molar was the source of the sinus infection. Fig 14 shows the lesion on the palatal root had perforated the sinus floor. Fig 14a is a medical CT that shows the sinus infection but not the dental cause.

Gaggers, physically chal-

gened, patients unable to tolerate intraoral x-rays

We all have a few of these. Some patients tolerate treatment just fine, but cannot stand to have film, the sensor, or a phosphor plate in their mouth. Pre and post treatment x-rays taken with CBCT is a breeze for them.

Trauma cases

Are the roots fractured, is the bone fractured? You often can’t tell if the buccal plate is broken and the tooth subluxated in a trauma case. CBCT will usu-
ally show the extent of such in-
juries. Fig 15 illustrates a badly fractured tooth from trauma. It is easy to see the extent of the fracture.

Retreatment etiology (per-

formation, missed canals, inade-
quate root canal filling etc)

I routinely take CBCT on any retreatment case. Knowing that there is a missed canal, a perfor-
ation, inadequate filled canals, or some other etiology invisible on 2D images gives me an ad-
vantage in recommending re-
treatment versus surgery, versus extraction.

Surgery planning (apico-

reimplant, endo/perio, perforations, mental nerve, inferior alveolar nerve, max-
illary sinus)

Knowing the size and extent of the peripical lesion as well as its proximity to the nerve or si-

nus, takes the guess work out of endodontic surgery.

Suspected pathologic lesions

size and location

Again, it is good to know what you are up against.

Calculated canals

Location and existence of calci-

fied canals are easier visualised on 3D CBCT than on 2D periapi-
cal radiographs.

Locate extra canals, calcified canals, MB2 MB5)

Do you need to chase the MB2 ca-

nal until you perforate or does it join the MB1 just a couple of mm bey-

ond where you are search-

ing? Preoperative CBCT tells you that for sure. Here is a case (see (Fig 18,19,30) with three canals in the mesial root of a lower sec-

ond molar. Not common, but you know they are probably there. I found it with a scope and didn’t have a pre treatment CBCT but it looks cool on the report to the referring doctor.

Facial pain cases to rule out odontogenic etiology

This makes you most confident in making the referral to the oral facial pain specialist or neurolo-
gist when you can be sure there isn’t a tooth the pa-
tient thinks is the cause of their neuralgia and you get a normal response to pulp tests.

Endo-perio cases

CBCT is very useful in determin-

ing the extent and location of periodontal bone loss. Fuhr-
mann et al (9) showed that only one out of 14 furcation defects were visible on periapical x-

rays where all 14 were vis-

ible on CBCT. How much bone is lost, does the endo lesion communicate with the perio-
defect? Here is a case of an upper

bicusp (Fig 21) with e-

xtensive periodontal bone loss to the apex. The pulp remained vi-

tal to cold tests.

Implant placement

This is a whole presentation in itself. Hans-Joachim Nickenig et al (6) concluded that CBCT guided implant placement is “significantly more accurate than free-hand insertion”. If you are placing implants, it is much easier to treatment plan and place them with a guide generated by CBCT than to just “eye ball” it. Even basic software allows measurement of bone, tracing the nerve and virtual placement of implants (Fig 22).

Here is a case (Fig 25) from a well-respected oral surgeon who does a lot of implants and proba-

bly wishes he had taken a CBCT to guide him in this case.

Measure canal length

In most cases, my CBCT is more accurate in determining tooth and canal length than an intra-
treatment 2D image or an apex locator. Figure 24 shows case I measured accurately on CBCT without using trial length PA or apex locator.

Intra-operative to find canals

It is easy to demonstrate with Fig 21 that you are placing implants, it

“significantly more accurate

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Conclusions

Can we practice endodontics without CBCT? Yes, we did do for years, but then some of us used to work without microscopes, digital x-rays, and apex locators. Why not have the best informa-
tion available to make your di-

agnosis and treatment plan? The more you know about the patient’s anatomy and the shape

and number of roots and canals in those roots, the better you will be to diagnose and treat their dental disease. We live and treat patients in a 3D world. Why don’t use 3D CBCT to better visualise anatomy and pathology?

About the author

Dr Jones has been in private practice limited to endodontics in the greater Kansas City area for 51 years. He re-

ceived Masters of Scien-

tce in Denistry in endodontics from the University of Nebraska, Lincoln in 1978. He practiced general dentistry in Lawrence, Kansas for over 2 years af-

er graduating in 1973 with distinction with a DDS from University of Missous-

ita, Kansas City. Prior to dental school, he attended the University of Kansas School Of Pharmacy. He was one of the first Endodontists in his area to utilise computers in the office (late 1980s), digital radiography (early 1990s) and Cone Beam CT (2009). He has lectured on Endodontic Diagnosis, Maximizing the Use of Technology in Your Personal and Professional Life, Dental Implants from an Endodontist Perspective, and Three Dimensional Cone Beam Com-

puters in Endodontics. He is a member of Omicron Kappa Upsilon and Phi Kappa Phi honorary societies. He is a member of the American Asso-

iation of Endodontists, the American Dental Association, the Kansas Dental Association, the Fifth District Dental Society, the Chicago Dental Society, the Kansas City Dental Implant Study Club, the Dental Abstract Study Club, and the American Academy of Oral and Maxillofacial Radiology. He is an asso-

ciate professor in Endodontics at the University ofMissouri/Kansas City School Of Dentistry.

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The fight against bacteria
Dr Michael Sultan discusses the importance of cleanliness in the field of Endodontics

Dentistry often involves a battle against bacteria – the invisible invaders that wreak havoc with our oral health, infiltrating into gums and teeth causing tenderness, pain and sensitivity. The basic premise of endodontic procedures is to remove inflamed and infected tissue from the tooth, to clean the root canal system and to seal the tooth back up again. In short, endodontics is all about infection control; one of the fundamental elements of good dentistry.

The rubber dam
It goes without saying that maintaining cleanliness throughout the endodontic procedure should be key to a successful outcome. Nevertheless, teeth are incredibly complex structures and it is impossible to get the tooth sufficiently clean for it to be considered completely sterile.

The endodontist needs to carry out everything within their powers to facilitate infection control to reduce the risk of failure. For this reason, placing a rubber dam during treatment is mandatory.

This thin square of latex rubber serves to isolate the tooth from its environment, in particular from bacteria in the oral cavity, permitting a clean, dry operative field and enabling the treatment of the appropriate tooth without contamination from blood or saliva. I actually find that most patients prefer to have a rubber dam in place as a protective barrier. Medico-legally, one of the first questions to be asked following a mishap is whether a rubber dam was used during the procedure, so this device not only protects the tooth and the patient but also the practitioner.

Single-use instruments
The roots of teeth contain very fine, narrow and tortuous channels, some of which can be easily missed or undetected. Despite continuing advances in dental technology, the equipment at the dentist’s disposal is hopelessly inadequate for the job it has been designed to do. Relying on a small, stainless steel file or even super flexible nickel titanium files to successfully clean, shape and decontaminate the nooks and crannies within the tooth is really quite unrealistic.

Nevertheless, they are vital for opening up the canals so that they are accessible to our chemicals for disinfection.

Surprisingly, despite the recommendations that files should be for single-use only, the sales of such instruments for endodontics have actually fallen over the years, suggesting that some practitioners are reusing the same instrument on more than one patient. Aside from the obvious risks this poses to patients’ health and cross infection control, this also contravenes Department of Health legislation which states: “Dentists should ensure that Endodontic reamers and files are treated as single use in order to reduce the risk of prion transmission in dentistry”.

If we are to protect the health of our patients and their teeth, reusing single use items is simply not an option.

Chemical options
Most endodontists use chemicals...
However, some forms of bacteria such as enterococcus faecalis are resistant to bleach. This microorganism is commonly detected in teeth with asymptomatic, persistent endodontic infections and its prevalence in such infections ranges from 24 per cent to 77 per cent. Enterococci faecalis are hardy bacteria able to compete with other microorganisms, invade dentinal tubules, and resist nutritional deprivation. Currently the most effective methods used to combat these bacteria within the root canal systems of teeth include the use of good aseptic technique, and soaking the tooth in iodine for ten minutes during treatment.

After the root has been successfully treated and bacteria eliminated, the next challenge that must be overcome is how to keep bacteria out. Although the endodontist often will place a temporary seal after treatment, the duty of fitting a permanent restoration with a good coronal seal usually falls to the GDP. This will prevent coronal leakage, which will inevitably compromise the long-term prognosis of a root canal treated tooth.

This should be done as soon as possible to protect the tooth and reduce the chance of fracture. Similarly, if the tooth lacks sufficient structure to hold the restoration and a post has to be placed, the post hole should be left empty for the minimum time possible and ideally dressed with calcium hydroxide.

Indeed, no matter how well the root is treated, if the coronal seal is poor, the root treated canal may well fail and the patient will have to return for further treatment.

Can it be cleaned?

In short, the clinician needs to ask themselves two fundamental questions when considering Endodontic treatment: Can the root be cleaned and can we keep it that way? If the answer to both questions is yes, then endodontic treatment is a very effective option to reduce infection and relieve oral discomfort. With the help of a well-trained and efficient nurse who also appreciates the fundamental importance of cleanliness in Endodontics, the patient can enjoy a very high success rate and make use of their natural teeth for many more years to come.