Get your Endo right first time
Richard Kahan discusses why you should be getting your endo right, first time

In about the middle of 2013 and in a fit of post-CQC inspection guilt that I had cast aside mundane management issues for more interesting pastimes, I decided to carry out an audit on my treatment profile. I wanted to find out whether the type of cases I was treating had changed over time.

I was not really expecting to improve anything within the practice, as some audits do, but I was seeking clarification as to whether the nature of the treatments I was carrying out were becoming more complex requiring greater time and effort as I had thought, or whether I was just becoming more knackered and complaining with age!

Treatment sessions were categorised and I analysed four random months of appointments three years apart.

The result of the null hypothesis was, I have to admit, inconclusive, but as a pilot study it gave me some food for thought and what I would like to share with you was a finding that might shock (or not, depending on how much of a sceptic you are).

Above some of the more complex stratified layers of categories was, Primary Treatment, Retreatment unrelated to Primary Treatment, and Retreatment due to unsatisfactory Primary Treatment.

A staggering 45.4 per cent of my treatment time in a random period of four months, was spent treating the consequences of other dentists’ substandard work. Whether due to underfilling, under extension, missed canals, poor coronal seals, ledges, transportation, or perforation, I was spending almost half of my time sorting out the legacy of poor primary root canal treatment.

Being fair, not all retreatment work was done due to poor treatment and 21.8 per cent of my time was spent diagnosing and retreating issues probably unrelated to the quality of the root treatment, such as fracture, complex anatomy, lateral canals, and extra radicular infection.

Returning to the eye watering 43.4 per cent, this will not come as a great surprise to the hospital endodontists who are sitting on a huge mountain of never-to-be-managed ‘GP Retreat’ referrals, as they were categorised at the Eastman Dental Institute.

For those of a more cynical outlook this could be considered good news for specialist endodontists such as myself,
and certainly the implantologists. The rather alarmist decline of the dentition through iatrogenesis, starting with overenthusiastic ‘drill and fill’ in the younger and immature tooth, the placement of cosmetic leaking restorations, pulpal damage during crown preparation, and then poor ‘quick-fix’ endodontics. This is a pattern I am seeing all too often in my middle aged patients.

There are a number of consequences to this category of retreatment.

1. Patient management. With an increasingly litigious population, being informed that failure of treatment is due to inadequate or substandard work, is likely to trigger off a complaint or two. Could this be the next big legal bonanza after injuries at work? Text messages reading ‘Contact us if you have had root canal treatment’? It is of course how you tell it, and most patients are very reasonable (many times too reasonable!), but the process leaves a poor impression. A patient loses confidence in the general practitioner they have had faith in for many years, and with the dental profession as a whole.

2. Treatment management. Retreatment is more complex and time-consuming than primary treatment. This makes the process more expensive and what with deconstruction, retreatment and then a new restoration if successful, the expense will not be that far away from an extraction and implant placement.

3. Treatment prognosis. The more complex treatment is, the higher the failure rate. By-passing materials, ledges and blockages created by a previous visitor, is not always possible, bringing in the possible need for surgery to accomplish treatment objectives. Even if a technical masterpiece is achieved, our success/failure research clearly shows retreatment success lagging 10-15 per cent behind primary treatment. The reason for this is that the contaminating bacteria are no longer primarily anaerobic as in primary treatment, but more hardy and resistant facultative anaerobes.

The solution to this ever-growing mountain of iatrogenic endodontic disease and patient dissatisfaction, is education. It may be a simplistic approach but I believe that if general dental practitioners were taught how to carry out effective endodontic treatment first time around, much future grief could be avoided.

Indeed, there are political issues at the heart of this, but if dedicated practitioners truly understood the issues at hand, maybe they would not let themselves be pushed around by government agencies only interested in saving money.

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