Revascularisation of the necrotic open apex

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Two years ago, I was struggling to learn how to perform a good apical MTA plug. I used all the existing MTA carriers and absorbable barriers that I could find on the Greek dental market. It took me a while, but I finally ended up performing some proper apical MTA plugs and with practice, I am now able to perform apical MTA plugs even without using absorbable barriers (Figs. 1a–c).

It was back then, that I started gathering information on revascularisation procedures of the necrotic open apex. A case report by Iwaya et al. published in a 2001 issue of Dental Traumatology was reproduced by Banchs and Trope in 2004, giving the work of Nygaard-Ostby et al. and Skoglund et al. from the seventies a whole new meaning. According to Dr Martin Trope, “If the canal is effectively disinfected, a scaffold into which new tissue can grow is provided, and the coronal access is effectively sealed, revascularisation should occur as in an avulsed immature tooth.” I believe this is an excellent description of the philosophy behind the revascularisation procedure. Dr Trope’s words gave me all the information that I needed for making the attempt myself.

Case report

On a rainy morning, the phone in my private practice rang. The referring doctor was very anxious to obtain an early appointment, as it concerned a trauma case of an eight-year-old child. I saw the little girl the same afternoon. Two days earlier, little Marlene had been hit by a car. Her right maxillary central incisor had suffered an enamel-dentine frac-
ture while her left maxillary central incisor had been displaced into the alveolar bone ( intrusion; Figs. 2a & b). Thermal and electrical pulp testing was positive for the right maxillary central incisor. However, it was impossible to perform vitality tests on the intruded incisor.

The treatment plan aimed mainly at protecting the vital pulp tissue of the immature fractured tooth with bonded resin, while the intruded tooth was left for spontaneous repositioning. Instructions for a week long, soft food diet was given and an appointment was scheduled for the following month. Unfortunately, the little girl did not return to my practice until one year later. At that time, there were two sinus tracts associated with the traumatised central incisors, and both thermal and electrical vitality tests were negative for both incisors. Probing depths were within normal limits (Figs. 3a–c). The spontaneous repositioning of the left central maxillary incisor had succeeded, but the pulp tissue had become necrotic.

I then decided to attempt revascularisation of the necrotic immature apices. The treatment plan aimed mainly at the effective disinfection of the wide canals, followed by blood clot induction and MTA placement. Effective disinfection is one of the main issues in endodontics. Articles by Sato et al. and Hoshino et al. describe an effective disinfection procedure using a triple antibiotic paste. The effectiveness of a metronidazole, ciprofloxacin and minocycline mixture for the disinfection of the immature necrotic open apex was demonstrated by Windley et al. However, the minocycline component of the mixture stained the dentine excessively. Therefore, many researchers suggest either a bi-antibiotic paste regimen (without minocycline) or with cefaclor as a substitute.

Back then, I thought it was not safe to place antibiotics inside the wide-open canal of an nine-year-old child. Therefore, I sought to achieve effective disinfection by using only syringe irrigation of a 2% chlorhexidine digluconate solution. After administering infiltration anaesthesia, the incisors were isolated with Hygenic Wędjets (Coltène/Whaledent) and access was achieved. The wide canal was completely necrotic in the right central incisor. In the left central incisor, however, there appeared to be vital pulp tissue in the middle part of the wide-open canal. Both canals were irrigated with a 2% chlorhexidine digluconate solution. The thin dentinal walls were lightly brushed using a #110 Hedström file. The final rinse was accomplished using sterile water, and the canals were dried using sterile paper points.

A sterile #60 K-file was used for bleeding induction. Only in the left central maxillary incisor was a
Revascularisation research has introduced me to a whole new area of great interest. I have learnt that it is important to distinguish between revascularisation and pulp regeneration.

“When looking for the ‘bag of gold coins from the Emperor’ we must separate the treatment of immature teeth from stem cell research. Both topics are valid topics for research but with very different objectives and pathways.” These are the exact words of Prof Larz Spångberg in his editorial titled The emperor’s new cloth, which was published in Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology and Endodontology 5/2009. Prof Spångberg goes on to say that “there is much indirect evidence that revascularization of necrotic pulp space content will result in fibrous connective tissue with cellular/acellular apposition on the root canal walls.”

A couple of months later, a study on dogs by Wang et al. provided direct evidence on the importance of the blood clot as a scaffold for the stimulation of the revascularisation process. Their histological findings found bone ingrowth in the lumen of infected immature dog teeth and cementum on the inner root wall, which was the reason for the thickening of the root.

Further studies are probably underway to find new and more predictable scaffolds for tissue ingrowth. Until a definite predictable revascularisation protocol is proposed, the procedure described in this paper could be safely attempted in most cases. An apical MTA plug can always be performed, if no signs of regeneration are present after three months.

Editorial note: A list of references is available from the author.