RICHMOND
ENDODONTIC CENTRE

PARA NORMAL

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Paramolars are supernumerary teeth that are either buccal or lingual to molars. They are most often small (i.e. tubercle) and rudimentary (i.e. dysmorphic). This case is particularly rare in that it is between the first and second molars and fused. The young gentleman, of Filipino heritage, admitted finances were a barrier to addressing this anomaly in the past, but a promotion at work and pronounced pain had obliged a recent rethink.

The 27 and accompanying paramolar both have necrotic pulps due to an extensive carious defect with an accompanying deficiency on the distal of the 26. The patient confirmed his general dentist will address the caries on the distal of 26 in the not too distant future. The paramolar/27 site is a hygiene challenge with significant plaque retention, localised gingival swelling, and a periodontal defect. The 27 is bodily malpositioned towards the palate with a pronounced rotation positioning the MB root palatal to the interproximal contact with the 26.

The paramolar was slightly mobile and its retention was inimical to stable oral hygiene and function. It was decided to extract the paramolar. Preoperatively, I was trepidatious about the possibility the paramolar and 27 canal systems were united at the mid-root level. If so, surgical repair would be ineludible. The extraction revealed a strong mid-root fusion and I started to plan for a surgical repair.

Isolation and haeme control was not a piece of cake as the carious defect extended apically onto the MB root surface. A combination of glass ionomer and composite, after a fashion, did provide a sound coronal seal. Attaining a reliable working length with the apex locator was not possible in the MB1 and DB canals. This increased my suspicion of a mid-root communication between a canal and the PDL. The canals were medicated with Diapex and the patient advised of the challenges we faced and the benefits a CBCT would provide. The patient declined a CBCT, at this time, but would reconsider if the response to treatment was unfavourable.

Thirty days later the fellow returned reporting almost immediate post-operative pain relief. The extraction site was healing well. However, the mal position of the 27 in conjunction with the bone defect, secondary to the previous presence of the paramolar, will require further attention likely involving a combination of restorative/prosthodontic, orthodontic, and periodontal considerations.

Attaining reliable working lengths was no longer problematic and no evidence of a mid-root fenestration in the walls of either of the buccal roots was apparent. With this in mind as well as the favourable response to treatment, the diagnostic endodontic microsurgery was cancelled.

Paramolars are rare and this one proved to be particularly abnormal and challenging. Despite my best efforts, this gentleman may not fully comprehend how unique his situation was. Nevertheless he is pain-free and espouses a desire for a comprehensive dental plan to stabilise his oral condition and maximise function.

Regards,

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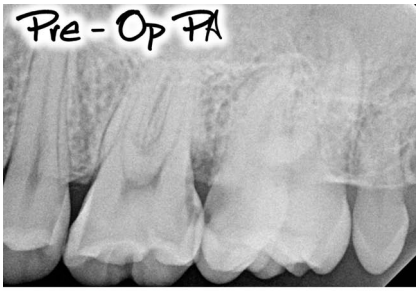

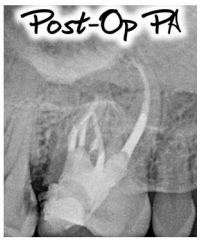

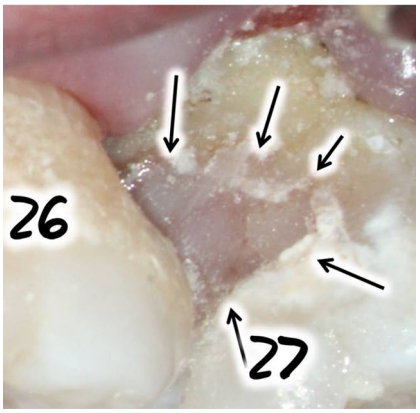

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