RICHMOND
ENDODONTIC CENTRE

RED HERRING

SEP
2018

What to do for a 59 year-old gentleman who wants to save his 26? The original RCT was done only a few months ago with the tenderness to bite and palpation not resolving despite a plethora of antibiotics and bite adjustments. I did not detect any narrow probing defects or mobility during the examination but was suspicious of a vertical root fracture of the MB root. Other concerns for this case include the separated instrument in the apical portion of the palatal canal and possible active apical periodontitis for the DB root. A mendacious review of the treatment options would not include root amputation as a viable option.

A pre-operative CBCT was declined as the guy wanted to minimise his exposure to radiation as well as avoid the added expense. The palatal root was to be tackled only if there was direct visual evidence of apical periodontitis discovered during the surgery. The gent was comfortable with this approach even considering the file fragment in the apical portion of the canal.

Endodontic microsurgery was the least expensive treatment option short of extraction and an edentulous 26 site. Orthograde retreatment is not known to be a successful option for a fractured root and perhaps would prove inadequate to address the apical periodontitis and extruded sealer proximal to the DB root. In addition, the plastic carriers used for obturation can, on occasion, prevent one from attaining patency during retreatment. Factors making root amputation a plausible option for this case are:

- Crestal bone levels are remarkably high and healthy for a man his age
- A healthy 27 exists to share the occlusal load
- No mobility
- Full coverage restoration present
- This bloke was motivated to save the 26 and non-litigious towards the previous practitioner

It was humbling to reveal such a substantial fenestration of the buccal cortical plate despite my inability to detect a narrow probing defect. As expected the MB root was amputated and the retro-preparation in the access to the pulp chamber was sealed with bonded PermaFlo Purple. Access of the DB root revealed extruded sealer, purulent exudate, and an abundance of soft tissue. The retro-prep was sealed with MTA. Histopathological diagnosis was chronic apical periodontitis for both surgical crypts.

The fellow recovered well from the surgery and the four year recall reveals the 26 is asymptomatic, aesthetic, and functional. The patient is happy as Larry that our procedure allowed him to save the tooth and several thousand dollars to boot.

In hindsight I could have resected more of the MB root in order to completely eliminate its contact with the crestal bone. Over the long term, the resected portion may be aesthetically pleasing but that may not outweigh its high hygiene demands.

Not all cases go as well as we hope and that happens to all of us. When we come across such cases please resist the urge to bury the perceived malfeasance by opting for extraction. This is an interesting case, not least for the fact that the one canal with the separated instrument did not require any further treatment over the last four years. In this case, the broken file was merely a radiographic red herring.

Regards,

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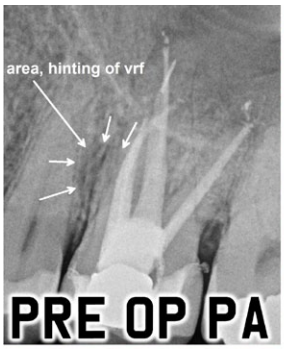

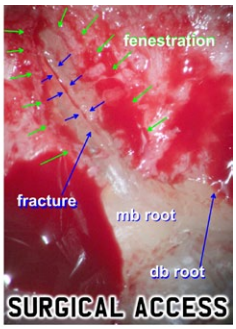

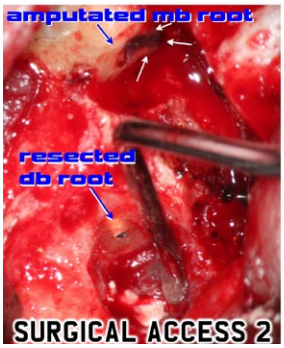

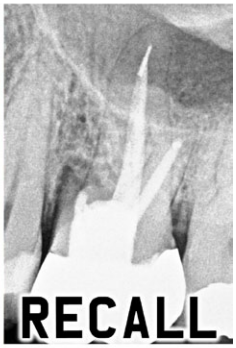

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Extended hours are also available

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