RICHMOND
ENDODONTIC CENTRE

Discomfit DX

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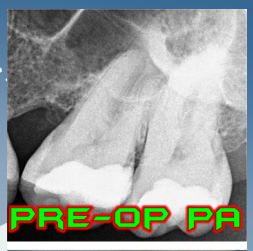
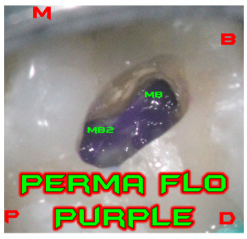
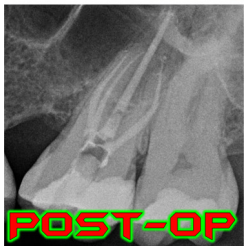
DEC 2020







A diagnosis of symptomatic irreversible pulpitis with symptomatic apical periodontitis is rather common. Seldom does the condition of the pulp deteriorate, overnight, into an indomitable nightmare of constant wrenching pain that puts an end to any hope of contentful torpidity. To the chagrin of the emergency room physician and big pharma, no pain relief was had via a tablet, regardless of its size or colour. The dishevelled haggard shell of a lady required an emergency appointment within twenty-four hours of our examination. A discomfiting facet of this deleterious escapade is that there was not a single discernable warning sign to treat this case with more urgency. The symptoms were typical for entry-level symptomatic irreversible pulpitis, sensitivity to cold that lingered for just over five seconds, the occasional bout of spontaneous pain and the symptoms had been present for about a fortnight with no obvious degradation. There was no precipitous trauma either. It remains a mystery why the pulpitis symptoms idiopathically degraded from bothersome to debilitatingly-ruinous in a matter of hours.

Patient management was not problematic as the lady was in such abject pain that a more motivated person for endodontic treatment I have not seen in donkey's years. However, attaining adequate pulpal anaesthesia for such a symptomatic tooth is a formidable endeavour. Hyperalgesia is afoot with a deluge of problematic physiological changes in the pulp. Buccal infiltration, in itself, will not suffice. An enhanced local anaesthetic regimen was provided:

- Copious topical anaesthetic placed, for two minutes, in a relatively dry buccal vestibule
- A 'fluffed' cotton swab is sprayed with Endo Ice and firmly pressed against the tissue just distal to the prospective injection site
- Three carpules of different types of local anaesthetics were used for buccal infiltration
- A quarter of a carpule of local anaesthetic was placed proximal to the greater palatine foramen and the remainder was infiltrated palatal to the 26

Five minutes afterwards the tooth was not responsive to cold but there was slight tenderness to percussion. It was decided to provide PDL injections at the four corners of this tooth (MB, ML, DB, DL line angles). This is a high-pressure injection, taking both time and effort to dispense even a small amount of anaesthetic. Fortunately, that was sufficient to achieve adequate pulpal anaesthesia and no further injections were required.

To accommodate for the mesial inclination, the access preparation was shifted 2mm more distal of the mesial marginal ridge than normal. Munce burs were used to remove pulp tissue from the chamber as there was a tsunami of haeme upon initial access. Hand files were gingerly reamed in the coronal portion of the canals to scotch the percolation of blood from the orifices. Each canal was sufficiently challenging to warrant individualised treatment from start, gaining patency and attaining glide path, to finish, confirming the fit of the GP cone. One carpule of Bupivacaine was provided at the end of the appointment to compliment the post-op regimen of medications.

Despite my best efforts, I am at a loss as to why this case of symptomatic irreversible pulpitis cascaded out of control so spectacularly. As my pathology professor used to like to say, rare things occur rarely. However, as the spectre of a second lockdown looms the most discomfiting aspect of this case is the care this lady would receive if no dental office was open.

Regards,

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Office Hours
8am to 5pm - Monday to Friday
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