RICHMOND
ENDODONTIC CENTRE

GP REMOVAL ≠ ReTx

MAR 2014

The case in this newsletter demonstrates the oft overlooked complexities of retreatment. This 26 was initially treated > 10 years ago and presented with a chronic abscess. The dentist initiated the retreatment but decided to refer it to me when the MB1 or DB orifices could not be located. The referral slip stated that an untreated MB2 canal may have been located.

I found an 8mm narrow probing defect on the furcal aspect of the MB root and advised a root fracture or strip perforation may be present (see Pre-Op PA). Upon access, it was not an MB2 orifice but indeed a perforation on the chamber floor just palatal to an uncovered MB2 (see photo with Diapex in MB 1 & 2). MB2 unites with the MB1 at the mid-root level. Care was taken to not extrude chamber material into the perforation; irrigation was necessary to cleanse the site without further irritating the hard and soft furcal tissue. Early during the first appointment, ProRoot MTA was carefully placed to seal the perforation.

Using a combination of various ultra-sonic tips, high and slow speed burs, and specialty instruments/devices it took > 20 minutes before the separated rotary file was removed from the DB canal (look again at the Pre-Op PA and the 2nd photo). The severe mid-root curve on the DB canal was renegotiated and patency gained. The remaining GP was removed and patency achieved on all four canals while avoiding ledge formation or apical transportation. The canals were re-instrumented, irrigated actively, and then medicated. At the second appointment, both the probing defect and swelling were not present. The set of the MTA was confirmed; the length and size of the canals re-checked, and the intra-canal medication removed. The canals were then actively irrigated and obturated. The second radiograph is from the one-year recall. Since the completion of treatment this 26 has remained asymptomatic and functional with no probing defects, sinus tracts, or swelling.

As this case demonstrates retreatment is more than just removing the old GP and looking for the odd untreated canal. One has to be prepared to address a number of possible surprises including but not limited to perforation(s), separated files, and blocked or transported canals. The signs and symptoms will not resolve if legitimate patency cannot be achieved on all canals, the canals are transported or inadequately prepared, soft tissue or old GP remain on walls or in isthmuses, smear layer blocks significant portions canal walls, and the list goes on.

Endodontic microsurgery has great success rates, especially if the canals were previously retreated by an endodontist. Getting the GP out is often the easiest part of retreating canals while the more challenging aspects require unique treatment techniques incorporating a microscope with specialised equipment and materials.

Regards,

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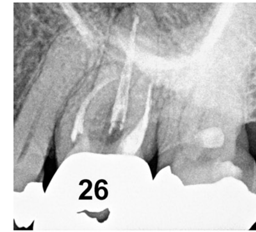
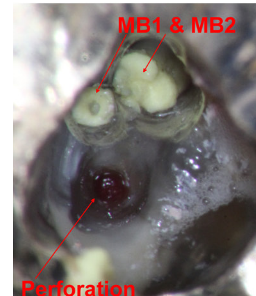
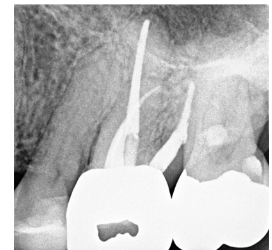


PRE-OP PA



PERFORATION

SEPARATION



1 YEAR RECALL

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The Richmond Endodontic Centre Boardroom is open; it is available for meetings, lectures, and study clubs. Please come by and have a look at our new presentation centre!

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