Understanding sonic-powered irrigation

By Dr Vittorio Franco, Italy

Thoroughly irrigating the entire root canal system—including isthmus and lateral canals—is important for success of endodontic treatment. Research has shown that sonic activation of irrigants offers significant improvement in cleaning efficacy, since it removes considerably more debris and smear layer than needle irrigation. Besides cleaner root canals, it increases the effectiveness of disinfectant solutions to support long-term success. We spoke with leading Italian endodontist Dr Vittorio Franco about his daily irrigation protocol, passion for endodontics and experience with EDDY, a sonic-powered irrigation tip.

What do you like most about endodontics? Nothing is clearly visible in endodontics, so one has to constantly adapt one’s strategy. In the end, one must discover the anatomy, understand the difference between one’s imagination and reality, and find a good treatment solution. Many recent dental studies have confirmed the importance of retaining the natural dentition and thus of endodontics as opposed to implantology. Now is the right time to be an endodontist. We now have more possibilities for preserving natural teeth and that is a wonderful thing.

Why is proper rinsing so important, and how can one see when the canal has been cleaned properly? I think that the cleaning of the canal is the most important aspect of an endodontic procedure. Of the three major steps, shaping and obturation are less important than eliminating bacteria from the root canal. The main purpose of endodontic treatment is to clean the canal. Otherwise, root canals can become a good environment for bacteria to grow in. If the dentist retains vital tissue that will then become necrotic, it will facilitate bacterial growth. The main reason for retreatment is the presence of an infection due to poor cleaning in the first place. There are many published studies on the time required for proper irrigation. We have many variables to consider—contact time, refreshment of the solution, amount of tissue/bacteria, volume, temperature, shear stress and so on—so we cannot standardize this process and final result. There are studies that say one needs 30 minutes to achieve the complete elimination of bacteria, but they did not consider activation possibilities. If you ask me how I decide when irrigation has been sufficient, from my point of view, the only clinical way to determine whether the irrigating solution is working is from seeing bubbles in the solution. That means that the solution is reacting with something inside the root canal system—obviously if there is no communication like a large foramen or perforation.

If bubbles stop being produced, the clinician can stop cleaning the canal.
because the sodium hypochlorite is probably no longer reacting. There may still be something inside the canal, but the solution has achieved its best result. That would be my only suggestion.

What is your irrigation protocol? I start with 5 per cent sodium hypochlorite, which I use for the entire shaping procedure. At the end, I use 17 per cent EITIA, activate it and remove it quickly. Then I use sodium hypochlorite again and activate it up to four times depending on the case. For necrotic cases, I wait until I see the reaction of the irrigant and the substrate. After removal of the sodium hypochlorite, I use 95 per cent ethanol to dry the canal. I do not use citric acid and chlorhexidine, but prefer EITIA to remove the smear layer.

How did you activate the irrigant before you began using EDDY? I tried all activation tools before EDDY, as irrigation activation has been one of my favourite methods ever since I was introduced to it. Before EDDY, I used passive ultrasonic activation and still use it sometimes in my Italian practice. Now, I use EDDY for most of my cases.

How important is it to have a flexible tip? EDDY is quite different from passive ultrasonic tips. With EDDY, one can combine two different things. First, one has an activation protocol that some studies have shown is at least as good as passive ultrasonic tips. With EDDY, one can achieve a very impressive shear stress so that is one of the best ways to activate the solution and clean the canal.

EDDY requires an air scaler. Should this be an obstacle to making the switch to this device? Honestly, buying an air scaler is not a high-cost investment. As a general practitioner, one can use an air scaler for a number of applications, including prophylaxis, endodontics, periodontics and minimally invasive therapy. Personally, I use it for bone surgery. It is not as expensive as a piezoelectric surgery unit or a laser. I think that the cost benefits of EDDY and an air scaler are fantastic.

Thank you very much for the interview.

How does EDDY work, and how long does the activation need? I use EDDY in the same way as passive ultrasonic irrigation, applying three to four cycles of 30 seconds for each canal. I help the EITIA to contact the dental surface with EDDY for 15–20 seconds. After this, I activate every sodium hypochlorite twice for 30 seconds. The number of cycles depends on the kind of canal. If I think that there is some necrotic tissue or a complicated anatomy, I use more than three cycles. If it is an easy case, I still use three cycles of activation.

Would you recommend EDDY? Absolutely. It is a great solution, being inexpensive, easy to use and effective. One can effectively promote the contact of the irrigant with the dental tissue. This is one of the main ways in which the irrigating solution should work. One can achieve a very impressive shear stress so that is one of the best ways to activate the solution and clean the canal.

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Thank you very much for the interview.
Single Visit Endodontic Treatment for Calcified Lower Centrals

By Dr Mostafa Anwar, Egypt

Single visit root canal treatment (RCT) is becoming more popular and achievable among patients nowadays. Lots of reasons lie behind, such as new advances in tools and devices used for RCT, advanced techniques in activation of irrigation for proper disinfection, decreasing incidence of post-operative pain, lack of time due to work responsibilities by patients who can't come several times, or an economically efficient solution for both dentist and patient, among others. This leads to a high demand for single visit treatment which is becoming a trend among patients, especially professionals. This case report shows how single visit treatment can be done easily, even in complex cases, as long as the proper tools, devices and equipment are available.

First Contact with the Patient

A 37 years old female came to our dental clinic seeking for a smile makeover due to protruded upper and anterior teeth. The patient was advised to opt for orthodontic treatment at first, but refused due to special reasons. The patient decided to go for aesthetic treatment, which will be crowning the upper and lower anterior teeth. After performing a smile analysis and reviewing the required radiographs, the prosthodontist referred the case to my clinic for doing RCT of the lower anterior teeth. An IOPA radiograph (Fig. 1) was taken using CD Elite by FONA for the lower anterior region, but focusing on the lower centrals which seems to be the challenging case here, not to mention that the patient had a shallow floor of the mouth. Note that there is a Type III root canal morphology, according to Vertucci’s classification (1 canal coronally then 2 canals cranial and no canal negotiation could be done; as illustrated in Figures 2 and 3 with the help of a clear radiograph).

Endodontic Treatment

Before starting this treatment, it was planned that the Lower Lateral and Canines will be done first, then continue the treatment, leaving the lower two centrals for the last stage. This decision was confirmed during the access cavity step, where the two centrals showed calcification at the coronal third and no canal negotiation could be done; as illustrated in Figures 2 and 3 with the help of a clear radiograph. Using Unitek Loupes of Magnification x5, it was again confirmed that these two teeth will need more steps for RCT, so now the case was confirmed radiographically and clinically under magnification. The decision was taken and RCT was done for the lower laterals and canines on both sides using iStat files by MicroMega for mechanical preparation and using a standard rinse protocol of 5.25% NaOCl, 17% EDTA and 2% CHX, with irrigation using passive ultrasonic irrigation.

Once the RCT of the above-mentioned teeth was done, negotiating the canals of the lower centrals started. Newton ultrasonic device by Acteon and EDTA tip were used to locate the calcified canals and explore the floor of the pulp chamber but there was still no sign of the canal, although the tip was nearly 5 mm below the cervical line. So, I decided to go for canal negotiation guided by radiograph, where I take OPTA X-ray with a differently-sized sharp explorers placed in 2 different directions (labial and lingual) to decide where the ultrasonic tip will be directed. As the rubber dam was already in place, it was challenging to know if the proposed direction of the ultrasonic tip is in the right path or not, due to the superimposition of the clamp on the tip of the explorer. I found that I have to trough in the middle, between the tips of the two sharp explorers. More troughing was done and the canals were negotiated and prepared, using iShape rotary system till TS2 (for obturation, referring the mechanical preparation of the canals, the type III canals of each mandibular central joined and became a single canal. Then a master cone X-ray was taken before the obturation step and the clamp was put back in place, as shown in Figure 4.

In the next step, the teeth were ready for obturation, which was done using TotalFill buccal sealer by FKG and gutta-percha cones of size .25/0.06. After obturation, a post-operative radiograph was taken to confirm the quality of the RCT, as shown in Figures 5-8.

Result

The patient had RCT of the lower anterior teeth completed in a single visit. Analgesics were prescribed for the patient in case of post-operative flare up. Then, she was referred to the prosthodontist who will further complete the treatment plan. She was satisfied with the RCT and was happy that all teeth were done in such a short time.

Conclusion

This clinical case shows that if we have enough knowledge of the latest dental trends and advanced equipment, we can provide our patients the required treatment in one visit, even in the complex cases that would otherwise require multiple appointments.

CD Elite helped diagnose the case correctly first, allowing to go through the next steps of the RCT quickly and smoothly. Moreover, the tools provided in the FONA imaging software aided in getting more enhanced images with minimal radiation dose, especially in this case where many radiographs were taken for diagnosis and treatment.

The New Swiss Endo Academy Training Centre

FKG Dentaire is proud to announce the opening of its new Training Centre in Dubai in 2014 (Swiss Endo Academy), based at the company’s headquarters, FKG Dentaire is proud to announce a new Continuing Education Centre, located at its representative office, FKG Dentaire DMCC (Dubai, UAE).

This Centre exhibits the latest generation of high-end equipment (operating microscopes, phantom heads, ) and offers a real simulation laboratory, allowing general dentists and specialists, to enhance their clinical experience while exposed to the latest endodontics Ni-Ti systems, more particularly to 3D Ni-Ti treatments range: the XP-Endo® sequence.

The centre of the Swiss Endo Academy in Dubai has been inaugurated on February’s 5th 2014 before the AEDIC congress, in the presence of the top management of the mother company and the entire SHUA team of FKG Dentaire.

By FKG Dentaire

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By Dr Mostafa Anwar

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Lecture room with high definition projector
Training table and center view
Training set up with FKG Root Rooter (Endo Motor), S-Apex (Apex Locator), Training Kit and obturation devices
Training table with 24 stools, monitors, FKG training kits, Endo motor and Apex Locator, Licolored Microscopes, Phantoms Heads, Surgery LED lights, Dental Shaver

Fig. 2: Calcified Lower Central incises with Dentin island in tooth 41
Fig. 3: The sharp explorer couldn't locate the orifice
Fig. 4: The clamp is superimposing the two explorers
Fig. 5: Removal of the clamp for better radiograph interpretation
Fig. 6: Master Cone X-ray of the lower central incisors
Fig. 7: Post-operative radiographs

Fig. 1: Calcified Lower Central incises with Dentin island in tooth 41
Fig. 2: The bar showed no drop at the calcified pulp chamber
Fig. 3: The sharp explorer couldn’t locate the orifice
Fig. 4: The clamp is superimposing the two explorers
Fig. 5: Removal of the clamp for better radiograph interpretation
Fig. 6: Master Cone X-ray of the lower central incisors

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Rotary vs Reciprocation: “How Do I Choose?”

By Dr. John West, USA

As a practicing endodontist and a clinical endodontic educator for more than 30 years, the most frequent question I am asked about technique is: “Is it predictable?” While every dentist wants his or her endodontic treatment to be easier, more efficient, simpler, and profitable, in the end, it is predictability that trumps all considerations.

When I am asked the question “Rotary vs Reciprocation: How Do I Choose?” my answer is “Rotary and Reciprocation,” because the predictability of both methods is similar; they are just different in sequence, purpose, and motion. This article should help to explain these critical distinctions of Rotary vs Reciprocation so that the clinician is aware of these differences, understands his or her options, and makes the best choice for his or her particular practice and patient needs. It is an invitation to be self-educated about your best way to produce endodontic preparations that can be easily obturated.

The Greatest Variable

In all of dentistry, the greatest variable is always the clinician. While product and operatory infrastructure play a significant role, the answer to Rotary vs Reciprocation depends mostly on technique, and technique depends on the clinician’s skill, care, and judgment.

Q: How Do I Choose?
A: Take the Challenge

Here is a simple and revealing test for each clinician to determine his or her preferred “Rotary vs Reciprocation” choice. Speak to your local Dentsply Sirona sales representative and explain to them that you want to do this “challenge” test: Purchase enough Rotary files (ProTaper Next® or ProTaper Gold™) and enough Reciprocation files (WaveOne® Gold) to treat 10 endodontic patients with Rotary and 10 endodontic patients with Reciprocation. You could treat every other patient alternately with Rotary and Reciprocation, or you could treat 10 patients in a row with Rotary and then 10 with Reciprocation. Reverse the order if you prefer. You can use this same telltale test for comparison with your current preferred system. Take good notes about what worked and did not work. Your answer for Rotary vs Reciprocation will be right in front of you!

Closing Comments

Using predictability as your critical benchmark distinction, your own testing will reveal your best choice of “Rotary vs Reciprocation.” The result: clinical confidence, consistency, and control. The marketplace has actually already answered the question of Rotary vs Reciprocation. The market’s answer: “Rotary and Reciprocation.” Those clinicians who have done their own in-house, controlled homework and testing will be happy with their answers. Now it’s your turn!

Dr. West is a co-inventor of the ProTaper® and WaveOne® Gold endodontic shaping systems.

References

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Dentsply Sirona Endodontics

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Founder and Director of the Center for Endodontics, Dr. John West, is recognized as one of world’s premier educators in clinical & interdisciplinary endodontics.