Diagnosis and management of a rare case of a maxillary second molar with two palatal roots - Supported by conventional radiography and CBCT

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Besides adequate knowledge of root canal morphology in general, it is of utmost importance to evaluate each individual case for aberrant anatomy and to identify any morphological variation before performing and during an endodontic procedure on such teeth. In clinical practice, conventional radiography with the assistance of an operating microscope is the most common method for evaluating root canal anatomy. However, it has been shown that their use does not reveal all anatomical details. Recently introduced and developed cone beam computed tomography (CBCT) for dental use has proved to be more accurate in detecting root canal morphology, especially in maxillary posterior teeth. One of the most unusual and rare aberrations of tooth anatomy is a maxillary second molar with two separated palatal roots. This article presents the case of such a patient, who presented ten years after another such patient had been recorded.

Case report
A 26-year-old male patient sought treatment at the Department of Restorative Odontology and Endodontics at the University of Belgrade with the following chief symptoms, which had persisted for several weeks already:

- spontaneous dull, mild and intermittent pain in the region of the left maxillary molar;
- moderate sensation of pain when biting hard food.

Additional information was acquired from further anamnesis:

- There were no other symptoms, and no irradiation of existing pain.
- The patient recalled that a root canal therapy had been performed on the same tooth several years before.
- He also recalled that two teeth on the same side of the upper jaw had been extracted at least ten years before.

Furthermore, clinical examination confirmed the following:

- only the second molar, #27, with an extensive amalgam restoration, was present in the left maxilla;
- moderate sensitivity on vertical percussion of the buccal cusps, and painful response to percussion of the mesiopalatal cusp;
- no sensitivity on digital palpation on the vestibular or palatal side;
- both hot–cold and electric vitality tests were negative;
- no pathological mobility of the tooth.

The diagnostic periapical radiograph (bisecting angle technique) showed:

- partly obturated palatal and mesiobuccal (MB) root canals and an unfilled distobuccal (DB) root canal;
- slight radiolucency around the palatal root apex; no distinctive border towards the surrounding maxillary bone structure.

The necessity of an endodontic retreatment of the tooth was explained in detail to the patient, who accepted the suggested therapeutic procedure and the general schedule for further appointments.

Treatment procedure
The old amalgam restoration and the phosphate cement base were completely removed, and the cavity walls were additionally prepared to enable clear visibility and straight-line access to all root canal orifices. The orifices of the palatal and MB root canals had been blocked with obturation material, presumably iodine phosphate cement and a gutta-percha cone. Approximately 5 mm distal from the orifice of the obturated palatal root canal, another oval, crack-like orifice could be seen, with the appearance of a perforation. Further assessment of the pulp chamber floor was performed with 4.5 x magnifying loupes and the Endodontic Probe Orifice Opener (DENTSPLY Maillefer). Using the probe and a #10 k-file to negotiate the flat oval orifice, the presence of a second palatal (distopalatal, DP) root canal was detected. The orifice of the DB root canal was hidden under brownish deposits of tertiary dentine, located about 2 mm distal from the obturated MB canal orifice and approximately 2 mm buccal from the DP canal orifice. The DB canal orifice was negotiated and...
A combined surgical and nonsurgical approach to repair an external root resorption utilizing a nano-particulate bioceramic root repair material

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Introduction

The applications of bioceramic compounds in endodontic therapy range all the way from their nonsurgical use as a root canal sealer, a pulp capping agent, and a perforation dressing agent, to their surgical applications for root repair and apicoectomy procedures. The first bioceramic compound introduced, MTA (Tulsa Dentsply, Tulsa, OK), was derived from Portland cement and has proven to be a valuable root repair material for surgical applications.1 More recently, medically pure nanoparticulate bioceramic formulations (that have been engineered from the ground up) have improved on some notable shortcomings of MTA by addressing the clinical handling challenges associated with this first generation material2,3. In addition, the removal of heavy metals, that can cause tooth staining in MTA repaired cases, has also been addressed with these newer 2nd generation formulations.

This new family of compounds known as EndoSequence BC Sealer, Root Repair Material (BUSA/Brasseler USA, Savannah GA) has shown significant clinical handling advantages over MTA for both nonsurgical and surgical applications. Due to their nanosized particle size and viscosity, these materials can now be used as a sealer and/or filler for root canal obturation, as well as for the surgical repair of root defects and apicectomies. This clinical case report demonstrates the use of EndoSequence BC, which is the only root repair material that both the nonsurgical root canal treatment and the surgical repair of an external root resorption defect in a single central incisor.

Case Report

A 28 year old female presented with a chief complaint of the comfort and swelling around her front tooth (Figure 1). She explained that she was seeking a third opinion after being told twice that tooth #9 was not salvageable and had to be extracted. Clinical and radiographic examination revealed a chronically infected lesion on the buccal aspect of tooth #9 with deep probing (4+ mm with BOP on the buccal and normal probing on the lingual). Testing also revealed that all anterior teeth were within normal limits to thermal and percussion test except for tooth #9, which was positive to percussion with severe and lingering response to cold. A post radiographic examination, tooth #9 was diagnosed with extensive external root resorption. A history of protracted orthodontic therapy ten years ago was noted in the patient’s dental history. A pulpal diagnosis of symptomatic irreversible pulpitis was made and the prognosis, given the large extent of the resorptive defect was deemed guarded to questionable at best. Extraction was deemed the most predictable option. The patient, however, was very motivated and wanted to attempt to save her tooth despite the guarded prognosis.

The non-surgical endodontic therapy was completed in a single visit using a combination of EndoSequence BC Root Repair Material (BUSA/Brasseler USA, Savannah GA) in a barier technique and EndoSequence BioCeramic Root Repair Material (BUSA/Brasseler USA, Savannah GA) in a syringeable form in the following manner:

Following cleaning and shaping to a size 70/04 EndoSequence Fiele (BUSA/Brasseler USA, Savannah GA) the tooth was further disinfected with full strength (7%) Sodium Hypochlorite. This was accomplished by using a negative irrigation system (Endo- Vac/Medical Solutions, Houston, TX) with a size 20 U-blade insert (BUSA/Brasseler USA, Savannah GA). Thereafter, a size 70/04 EndoSequence BC Gutta Percha Cone (BUSA/Brasseler USA, Savannah GA) was fitted to the apex with tug back. The cone was then trimmed with a scalpel blade so that it would fit 4mm short of the apex. A 4mm plug of EndoSequence BC Puffy was then condensed to the apex using the fitted cone so that a 4mm plug of puffy filled the apex, creating a barrier (Figure 2). The apical barrier technique has been described previously4,5. The cone was then removed and the entire remaining canal was filled with Syringeable BC (BUSA/Brasseler USA, Savannah GA) after backfilling the root canal with Fuji IX (Figure 3). The patient was rescheduled for surgical repair of the external defect 2 weeks later. The surgical appointment was not scheduled concurrently in order to allow time for the intra-radicular cement to set and to evaluate patient response.

The patient returned for the surgical root repair visit and a sinus tract was noted on the buccal aspect of the tooth pre surgically (Figure 4.) A large external resorption defect was noted on the buccal aspect of the root after a full thickness intra-sulcular flap was raised (Figure 5.) Using a high speed round bur and copious amounts of water, the defect was prepared and all visible resorptive soft tissue in the area were excised (Figure 6.) The root canal was reached, exposing the set EndoSequence Bioceramic Material inside the root canal (Figure 7.) Once all the soft tissue was removed, the remaining preparation and the exposed root surfaces were conditioned with citric acid. The remaining root defect was then repaired with an equivalent amount of bioceramic patty trying to keep the material below the level of the root (Figure 7) and the flap was sutured closed.

The immediate post operative radiographs show the extent of the root repair with the Puffy in this tooth (Figure 8.) Following normal post operative healing the patient was evaluated at 6 months and two years, where the gingival tissue was observed to be fully healed and probing was found to be within normal limits (Figure 9). At this point, the surgical repair procedure was deemed successful. The post operative esthetics were completely acceptable to the patient and no tooth staining was noted as a result of the material used to repair this tooth interproximally.

Conclusion

External extensive root resorption and other aggressive forms of cervical root resorption are challenging when they cause significant root damage. These lesions can sometimes be monitored requiring no intervention at all. However, when endodontic involvement results in pulpal and later infection of the resorption defect, extraction of the tooth or surgical repair of the root are the only viable options. In cases where direct surgical access with good visualization of the defect can be achieved, the use of modern bioceramic formulations (which are easily to apply to the site and have demonstrated excellent biocompatiblity, bonding, and hydrophilic qualities) may help optimize the clinical outcome. In this clinical case, the use of nano-particulate bioceramic formulations, both EndoSequence Syringeable BC Root Repair Material (BUSA) & Puffy (BUSA/Brasseler USA, Savannah GA) were demonstrated. Long term follow up of the healing of the gingival tissues and acceptable esthetics were achieved in a tooth that was otherwise deemed unsalvageable. The ease of clinical handling during surgery and a lack of dentin staining were noted. Further studies in this area are warranted in order to explore the true potential of this family of compounds in root repair applications, as well as all other aspects of endodontic therapy, where direct contact between biological tissues and biocompatible repair material is essential to success.

References

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Figure 7. After removal of the resorptive cells in the defect, the cavity was restored with the EndoSequence RRM Putty material. The material was manipulated gently to the shape of the original root structure.

Figure 8. The immediate surgery placement and post operative radiograph shows the extent of defect after it was filled with the BioCeramic RRM Putty.

Figure 9. 6 months and two year recall visit shows excellent esthetics and bony healing in the area with reattachment and no dentinal staining.
slightly widened with the Orifice Opener, ensuring that it could be easily detected in a further procedure. The second MB root canal could not be found with meticulous searching under loupes and the application of a decalcifying solution (17% EDTA). After consultation and receiving the approval of the patient, it was decided to conduct the entire procedure in at least two sessions. First, the root filling material in the MB and mesiopalatal (MP) root canals was removed using rotating NiTi files, ProTaper D1, D2 and D3 files (DENTSPLY Maillefer), and manual H-files (DENTSPLY Maillefer). Further instrumentation of those canals was performed using WaveOne drills (DENTSPLY Maillefer) with reciprocating motion; the MP canal with black (#40) and the MB canal with red (#25). The working length was determined and checked throughout the entire procedure using an electronic apex locator (RomiApex A-15, Romidan). The DP root canal was then negotiated and a glide path was created approximately 1.1-1.5 mm shy of the apical foramen using #10 and 15 k-files. The coronal portion was flared successively with #5 and 2 Gates-Glidden drills. The same procedure was performed at the DB root canal. Clear visibility and straightline access were established for all four canals (Fig. 1). Two intra-oral radiographs were captured from two different horizontal angles with an inserted k-file in each root canal, but only one revealed all four root canals (Fig. 2), showing vague contours of the apical portion of the roots. A calcium hydroxide dressing was applied at the MP root canal and a paper point, soaked with a 2% solution of chlorhexidine (B4, Septodont), was left in the MB root canal. A cotton pellet with chlorhexidine was left in the pulp chamber and the cavity was then sealed with a temporary filling material.

In the second session, two weeks later, the DP and DB root canals were carefully prepared, applying the same WaveOne technique as used for the MP and MB root canals; the DP canal with WaveOne black (#40) and the DB canal with WaveOne red (#25). The working length was determined and checked using the same electronic apex locator.

Throughout the entire endodontic procedure, 2.2% sodium hypochlorite and 10% citric acid solutions were used as irrigants, successively, in all four root canals. Each of the four canals was finally irrigated with 40 ml of a 2.2% NaOCl solution, dried and obturated using Acroseal (Septodont) and a single gutta-percha cone with an adequate taper (DENTSPLY Maillefer; Fig. 5).

The intra-oral, retro-alveolar radiograph captured post-treatment was of relatively poor quality owing to superimposition and interference of the infraanatomic arch and adjacent bone structures, and failed to show the most important apical portions of the roots with the correct root canal fillings (Figs. 5, 9, arrows).

Conclusion and key learning points
A careful assessment of the internal anatomy of the pulp chamber is essential for detecting all root canals. A maxillary second molar with two separate palatal roots is a rare anatomical variation and, according to our records, is detected only once in a decade.

CBCT images provide more accurate and reliable information regarding roots and the root canal morphology than conventional radiographs are able to provide. Furthermore, concerning the treatment outcome, CBCT images enable a much more predictable and successful endodontic treatment procedure.

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