

Management Of Tooth With Deep Furcal Defect By Endo- Perio Management – An Interdisciplinary Case Report

Case Report

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Abstract

Multi disciplinary approach was followed in treatment of endo perio lesion in a mandibular molar with furcal involvement and apical lesion. The patient presented with pain and mobility in the right mandibular first molar. There was grade I mobility and periapical lesion along with furcal involvement in relation to 46. A probing depth of 7mm was elicited in relation to buccal aspect of 46. The endodontic management of 46 was done using sonic activation of irrigant along with calcium hydroxide intracanal medicament. Periodontal flap surgery along with placement of bone graft and Platelet rich fibrin was done to facilitate healing kinetics of periapical healing as well as periodontal regeneration. The patient was recalled after 1,3,6 months and at one year follow up, complete healing of the furcal defect was seen in 46.

Keywords: Bone Graft; Calcium Hydroxide; Endo-Perio Lesion; Platelet Rich Fibrin (PRF); Sonic Irrigant Activation.

Introduction

The pulp and periodontium are interconnected embryologically, anatomically and functionally. Endo-perio lesion is a clinical manifestation of pathologic/ inflammatory intercommunication between pulp and periodontal tissues via open structures such as apical foramina, dentinal tubules and lateral accessory canals [1].

The relationship between pulp and periodontium was first discovered by Simring and Goldberg in 1964 [2]. Endodontic- periodontal problems are responsible for more than 50% of tooth mortality and the prognosis depends on identifying and eliminating the etiological factors for the disease process [3, 4]. The pathways of communication responsible for endo perio lesions include lateral and accessory canals, dentinal tubules and apical foramen [5]. Simon et al has classified endo perio lesions based on the primary origin of the disease process and the extent of involvement in the pulpal and periodontal tissues [6].

Accessory canals in the furcal area of molars paves a direct pathway of communication between the pulp and periodontium [7, 8].

The incidence of these canals may vary from 23% to 76% [9-11]. These accessory canals communicate with pulp and periodontium by means of connective tissue and blood vessels. Accessory canals are concentrated at the apical delta region and lateral canals in the furcal region [12]. Seltzer et al, has reported that inflammation of pulp may cause inflammatory reactions in the interradicular periodontal tissues [13, 14]. The treatment of endo perio lesion presents a challenge to the clinician and the prognosis of a tooth with endo perio lesion depends on identifying the cause and establishing the appropriate diagnosis [15].

Disinfection of teeth with pulp necrosis and apical periodontitis is augmented with efficient irrigant activation [16] for dislodgement of biofilms and debris and placement of intracanal medication facilitates increased contact time to eliminate the microbes [17]. Platelet concentrates are rich in growth factors and aid in effectively initiating the bone repair and healing by proliferation, chemotaxis and differentiation of locally derived progenitor cells [18].

Bone replacement grafts serve as a framework for blood clot for-

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mation and maturation and support the formation of bone in osseous defects [19, 20].

Previously our team has a rich experience in working on various research projects across multiple disciplines [21-35] Now the growing trend in this area motivated us to pursue this project.

Case Report

A 24 year old male patient reported to our dental outpatient department with the chief complaint of pain and mobility in the right lower back tooth for the past 3 months that pain aggravated while chewing food. Patient revealed a history of restoration in the right lower back tooth region before 5 years. The medical history was non contributory. On clinical examination, there was dislodged restoration in relation to 46 (Figure 1A). There was grade I mobility in relation to 46 [36]. The probing depth was 7mm in the furcal region in relation to the buccal aspect of 46. Pulp sensibility tests such as electric pulp test (Gentle Pulse™ Pulp Vitality Tester, Parkell, USA) and cold test (Coltene/Whaledent, Switzerland) showed no response and confirmed that the tooth was non vital. Tenderness on percussion was present in relation to 46. Radiographic examination using Intra Oral Periapical Radiograph revealed, radiolucency in the coronal aspect involving pulp and periapical radiolucency involving the mesial root of 46 and furcal bone loss suggestive of dislodged restoration and secondary caries with periodontal involvement (Figure 1B). Thus the diagnosis was made as pulp necrosis with symptomatic apical periodontitis in relation to 46 [37] suggestive of primary endodontic lesion with secondary periodontal involvement [38].

Therapeutic intervention

Endodontic treatment was taken up first and then periodontal regenerative surgery was planned for treatment of the defect with alloplastic bone substitute and platelet rich fibrin (PRF).

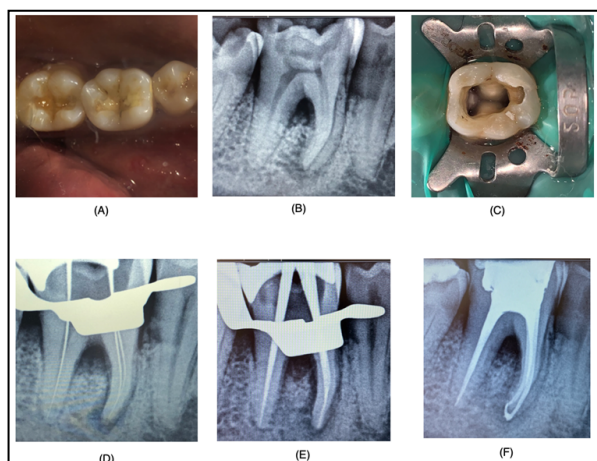
First visit: Patient was detailed about the treatment protocol, the number of visits, the merits and demerits of this procedure and alternate treatment options were explained in case the treatment failed. A written consent was taken from the patient before starting the procedure. No premedication was given. During the first visit, the patient was administered local anesthetic with vasoconstrictor (2% lidocaine with 1:100000 epinephrine). Rub-

ber dam isolation was done and access cavity preparation done in 46 (Figure 1C). Working length determination was done using apex locator (J Morita) and confirmed radiographically (Figure 1D). Routine chemomechanical preparation was done in 46 using Protaper Gold Rotary files (Dentsply). Apical preparation was done upto F2 size for mesial canals and upto F3 for distal canal. 3% sodium hypochlorite, 17% EDTA and saline were used as irrigants and irrigant activation was performed using Sonic irrigant activation (Endoactivator), placing the tip, 2mm short of the working length. The canals were then dried using sterile paper points and calcium hydroxide (RC Cal, Prime dental products, India) was placed as intracanal medicament. Closed dressing was given using Intermediate restorative material and the patient was recalled after two weeks for obturation.

Second visit: During the second visit, the intracanal medicament was removed from the root canals and cleaning and shaping and irrigation protocol was repeated using 3% sodium hypochlorite and 17% EDTA final rinse for smear layer removal. The canals were then dried using sterile paper points and obturation was done using 6% gutta percha cones and AH plus sealer (Figure 1E,F). There was sealer extrusion seen in relation to mesial root of 46 (Figure 1F). The patient was administered pain analgesics (Zerodol P) twice a day for two days. Patient was recalled after 2 weeks for surgical management of furcal defect.

Third visit: When the patient reported after 2 weeks, the patient was completely asymptomatic but the probing depth was persistent (Figure 2A). The area selected for flap surgery was anesthetized using lignocaine with adrenaline 1: 1,50,000. A full thickness mucoperiosteal flap was elevated at the buccal aspect following intracrevicular incision in relation to 46 and the furcal defect was assessed (Figure 2B). The necrotic tissue was completely debrided using Gracey curettes #1-2 and 3-4, until the bleeding stopped. There were greenish calculus deposits found in the roots. Ultrasonic scaler tips (Satelac, Acteon) were used to remove the calculus and root planning was done. Meanwhile, 10ml of patient's blood was collected and centrifuged for PRF [18, 39]. The PRF was made into a membrane. Bovine derived xenograft (Bio-Oss) was used [40]. The bone graft mixed with blood from PRF (Figure 2C) and was packed well into the furcal bony defect area and the PRF membrane was placed over it (Figure 2D,E). The flap was then approximated with non resorbable black silk (3-0) suture using interrupted suturing technique and periodontal dressing was

Figure 1. Endodontic intervention - (A) Preoperative clinical picture, (B) Preoperative IOPAR, (C) Access cavity picture, (D) Working length IOPAR, (E) Master cone IOPAR, (F) Obturation IOPAR.



placed (Figure 2F). The patient was advised antibiotics for 5 days and was recalled after a week for suture removal. Permanent full coverage restoration was planned after 3 to 6 months after the uneventful repair of the endo perio lesion (Figure 3A).

Follow up and outcome

The follow up schedule was given to the patient at 1,3,6 and 12 months according to Merin's classification [41, 42]. The outcomes to be assessed include absence of mobility, reduction in probing depth, radiographic resolution of periapical and furcal radiolucency due to bone fill. Both clinical and radiological outcomes were successful at one year follow up. The probing depth was reduced to 2mm, there was good healing of the surgical site. Radiographically, substantial bone fill was seen in the periapical lesion of mesial root of 46 as well as the furcal defect (Figure 3B). The sealer extrusion in relation to mesial roots have also resolved [43].

Discussion

The diagnosis of the key etiological factor is of prime importance in establishing the diagnosis of endo-perio lesions. The primary causative factor of the disease is microbial invasion and the rapidity of disease progression depends on the microbes present and its virulence.

The persistent nature of the endodontic pathogens is mainly due to biofilm formation which makes them firmly adherent to the root canal walls and this organised structure also makes them resistant to intracanal medicaments. Hence in our case, we have activated the irrigant sonically in order to facilitate biofilm removal as well as for the irrigant to reach all the inaccessible areas of the complex root canal system [44]. In many cases of endo perio cases with primary endodontic involvement, the periodontal regen-

eration occurs once the root canal treatment is performed. But in cases of furcation involvement, the rate of healing is hindered by the microbes still hiding in the inaccessible furcation areas [45].

In order to facilitate healing of the furcal bony defect, bone graft(xenograft) was placed which is osteoconductive in nature [46]. It serves as a matrix for bone growth. Platelet rich fibrin is an autologous platelet concentrate, which is rich in growth factors and highly biocompatible avoiding the possibility of immune rejection. PRF is a second generation platelet concentrate and is capable of progressive and sustained release of cytokines, TGF-β, PDGF in high concentrations during remodeling of fibrin matrix. It may also be used as a membrane to stabilize the bone graft [39, 47]. Bone grafts may be autografts, allografts or xenografts that are osteoinductive or osteoconductive [20].

Thus the treatment of endo perio lesion requires both endodontic treatment as well as periodontal regenerative procedures to achieve long term good prognosis of the treated tooth. The treatment strategy primarily should focus on disinfection of the root canal system followed by an observational period. The goal of periodontal flap surgery is to debride all the necrotic tissues from the surgical site and facilitate the regeneration of hard and soft tissues along with the formation of new connective tissue apparatus [48].

Our institution is passionate about high quality evidence based research and has excelled in various fields [25, 49-58]. This has us to apply the concepts of autologous platelet concentrates in improving healing outcomes of endo perio lesions.

Acknowledgement & Declaration

I would like to acknowledge my mentors and guide for helping me

Figure 2. Periodontal surgery as intervention- (A) Preoperative probing depths, (B) Flap elevation and curettage of the furcal defect, (C) Bone graft with PRF, (D) Bone graft placement at the site of defect, (E) Placement of membrane, (F) Suturing.

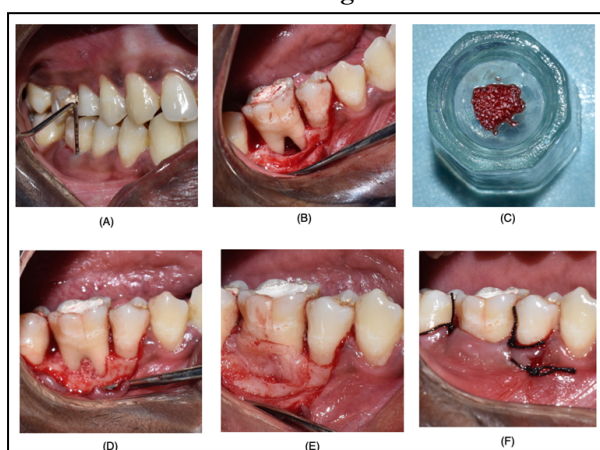
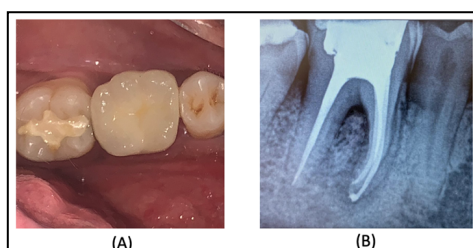


Figure 3. Follow up at 1 year (A) Clinical picture, (B) IOPAR.



in case selection and treatment planning and the lab facilities for PRF preparation.

Conclusion

Multivisit endodontic therapy along with autologous platelet-rich derivatives and alloplastic bone substitute resulted in successful, clinical and radiological outcomes at one year follow up. There was gain in clinical attachment, reduction in probing depth, and radiographic bone fill and good healing of the surgical site.

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