Failure is NOT Poor Workmanship

This 38-year-old female patient came to my office due to a severe toothache after crown preparation of tooth #19. Diagnosis was a symptomatic irreversible pulpitis with symptomatic apical periodontitis. RCT was rendered. Due to the prior pain associated with the tooth and severe pulpitis, it was very difficult to anesthetize! I eventually got her comfortable and treated the canal system. I noted a large ovoid distal canal with two canals that joined into one. RCT was completed followed by immediate fiber post build up and recementation of the temporary crown. The case was rather routine in my office: lots of pulp calcifications, tough anesthesia, multiple canals and ramifications, restricted access to maintain the integrity of the crown preparation, etc. To me: all in day's work and that is very typical for me!

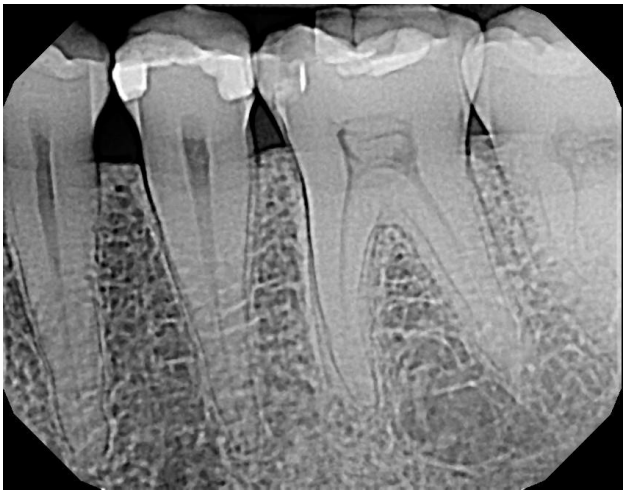
She returned to my office 10 months later complaining of persistent pressure sensitivity. She thought it just needed time to heal and par for the course for a root canal. X-ray was taken by her general dentist who emailed it to me for my opinion. I immediately saw a suspicious lesion at the end of the distal root. We called her to get her in for a CBCT. CBCT confirmed inflammation at the end of the distal root and some inflamed tissue/space in the distal canal towards the lingual! We then got her in to reassess the RCT and retreat the distal canal.

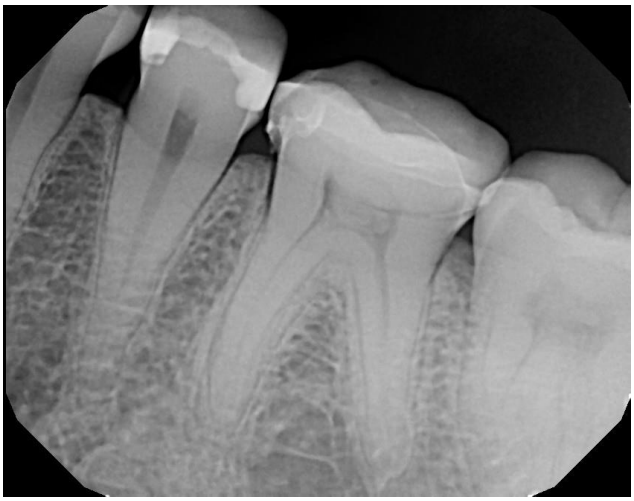
Upon access, it was challenging to carefully drill the fiber post out of the distal canal. After removal of the post and some of the gutta percha, I was able to detect a faint trail of sealer towards the lingual more than halfway down the root! I was able to fit a #8 C file and find the infected canal space. DB and DL canals joined into one canal, but that untreated space was the source! After completion, an angled x-ray was taken to see the missed canal space.

In practice, I am always working to achieve the best possible care I can render. For that reason, I have changed my philosophy of taking a CBCT before all cases. Ultimately, what you don't see is what you don't see and don't treat. When I see my failures return, a sense of disappointment takes over. After this case, I realized that I did do the very best possible care the first time and failure is a part of healing or non-healing. From this case, there would have been no way to track that branch unless there was a failure. I think as an Endodontist, we put too much stress on our work and make it a reflection of ourselves and our integrity. Ultimately, I know that I work with very high expectations and failures are not a reflection of my workmanship. We need to rethink the term failure and retreatment. Perhaps a better term would be refractory healing and revision.

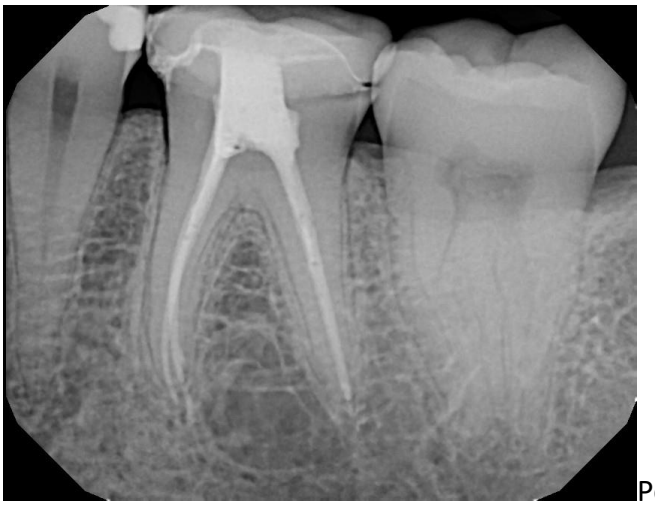
One Tooth at a Time,

Dr. Lauren Phan

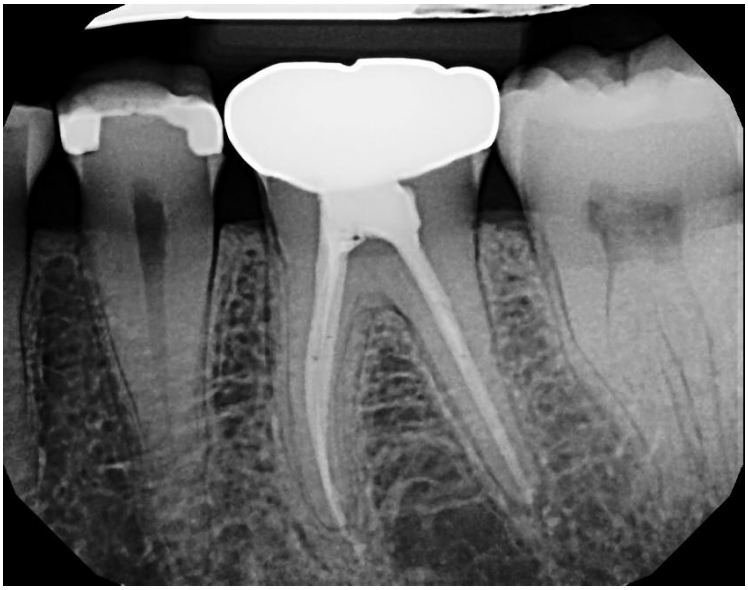




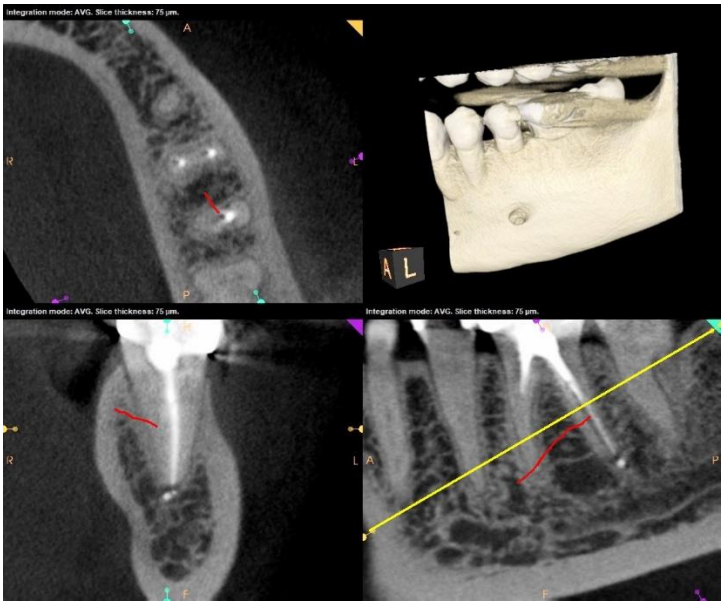
Pre Treatment X-rays



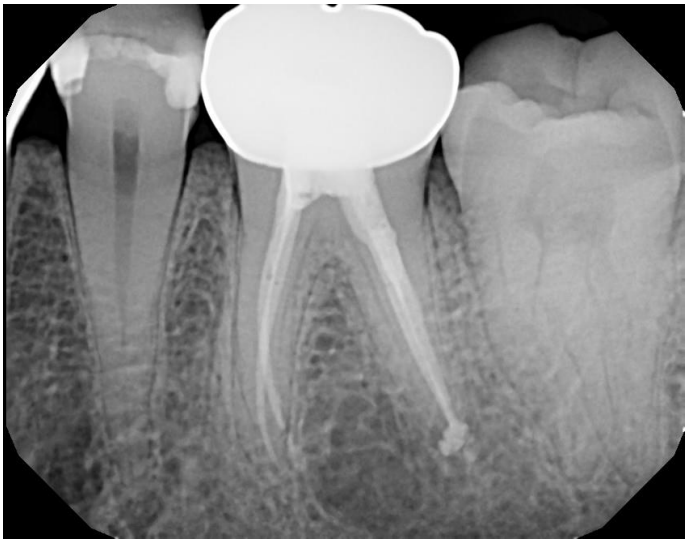
Post RCT X-ray



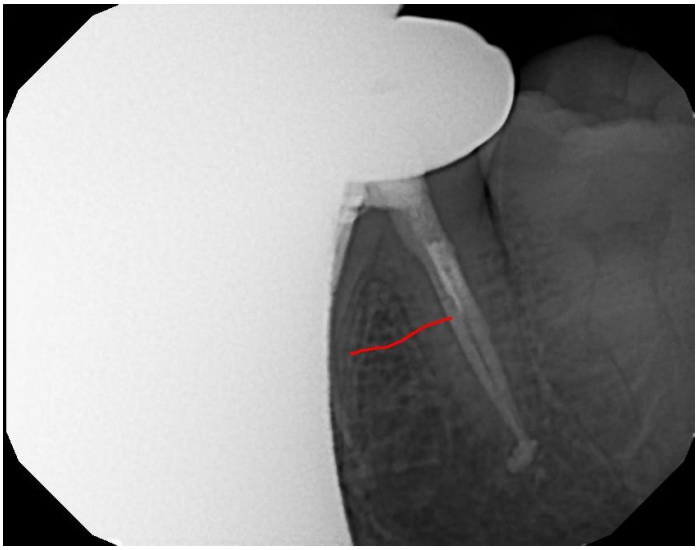
10 month X-ray taken from GP



CBCT showing the additional untreated space (red) at the level of the yellow lin.



Post RCT revision of the Distal Canal.



A distal angled x-ray showing the DL branch.