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Management of tooth Resorption

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Tooth resorption is perplexing problem for all dental practitioners. The etiology factors and diagnosis are vague, chosen treatment dose not prevent the rapid disappearance of the calcified dental tissues. Since the etiologic factors, diagnosis, treatment and prognosis differ for these various types of resorptive defects, it is important to diagnose resorption radiographically or clinically and distinguish internal from external resorption.

Following these cases are internal root resorption, external root resorption of serious complication subsequent to avulsion and traumatic injury.

Case 1

A 29-year-old female patient was referred for pus discharge of gingiva on maxillary right incisors. About 2 years ago, maxillary right central incisor had been avulsed and replanted in the department of Oral Maxillofacial Surgery.

During examination, fistula was shown in the area of labial gingiva of right maxillary incisors. There was also periapical lesion and external root resorption of maxillary right central incisor, which didn't respond to EPT test. It was considered to be ankylosed due to its high metallic sound to percussion and no mobility.

Calcium hydroxide, vitapex dressing was planned after cleaning and shaping. Vitapex was replaced every two or three months for nine months. Fistula was disappeared within 3 weeks after cleaning and shaping and then first vitapex dressing was placed.

Canal was obturated by vertical compaction with thermoplasticized injectable gutta percha using Obtura II.

Maxillary left central incisor didn't respond to vitality test and endodontic treatment was performed.

She was referred to the department of Prosthodontics for crown fabrication of these teeth.

At three year recall visit, patient was symptom-free.

Case 2

A 41-year-old male patient presented with a complaint of gingival swelling in the area on Maxillary left central incisor for five months. He had traumatic injury on maxillary left central incisor 20 years ago.

Taking his medical history, there was recognized that Caldwell-Luc operation as to Maxillary sinusitis had been performed 10 years ago.

Clinical examination was revealed discoloration of maxillary left central incisor. Fistula was present over labial

gingiva around maxillary left central incisor, which was negative to percussion, cold and hot test.

Endodontic treatment and calcium hydroxide, vitapex dressing were planned. At the first visit, during working length determination, palatal perforation was identified. After cleaning and shaping, vitapex was filled. For six months, vitapex was replaced every three months.

Palatal perforation site was repaired with MTA. Six months later, fistula recurred on labial gingiva over maxillary left central incisor. Radiographic view showed external root resorption and then intentional replantation was planned. During operation, external root resorption was seen on labial, mesial root surface, granulation tissue was removed. Root resection and retrograde filling with MTA were performed. Resorptive defects were also repaired with MTA. At six month recall check, fistula was completely disappeared and patient had no symptom. As there was no mobility, high metallic sound to percussion, I could realize it was ankylosed.

Walking bleaching of maxillary left central incisor was performed using sodium perborate as patient complained of tooth discoloration.

Recently, six year recall check was done.

Case 3

A 19 year-old-male patient presented with a complaint of both facial swelling for 2 weeks. During clinical examination, inflammation around both mandibular third molar was shown. At the department of Oral Maxillofacial Surgery, these teeth were extracted surgically. Radiographic view showed internal resorption of maxillary right premolar and then he was referred to the department of Conservative Dentistry. Determining of working length, internal-external communication was identified after cleaning and shaping and calcium hydroxide, vitapex dressing was placed. As maxillary left premolar was also nonvital, endodontic treatment was performed.

Three months later, vitapex was removed using Ultrasonics, canal was filled with GP cone by lateral condensation method and perforation site was repaired with MTA.

At the next visit, coronal third of canal was obturated with Obtura II and core was filled with Ketac-Silver.

He was referred to the department of Prothodontics for crown fabrication.

At eight month recall visit, patient was asymptomatic and radiograph didn't show any specific change.