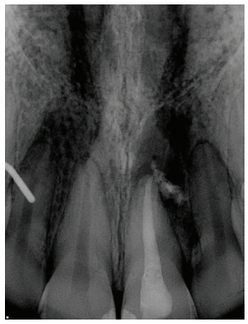
Swelling #9

After a patient returns with swelling after an RCT, this doc asks Townies where the treatment went wrong

Kelster08
Member Since: 08/28/17
Post: 1 of 89

I started an RCT on #9 for a 23-year-old patient yesterday. She came to the office early this morning after being in the emergency room since 3 a.m. She was given antibiotics and pain meds there. When she arrived, her upper lip was very swollen. When I accessed the tooth, purulent drainage came flowing from the canal. I cleaned and filed and filled with calcium hydroxide. Covered the access opening with EdgeTemp. Her lip was immediately less swollen. This morning she called and said that she is more swollen again. What did I do wrong? Should I leave it open? There is no distinct abscess to open and allow to drain. Thanks in advance! ■



11/17/2017

hendoc4ct
Member Since: 04/12/11
Post: 2 of 89

If she is not in pain, leave it and monitor it day by day. If she is in pain, open the tooth and leave it open. Maybe put a loose cotton pellet in the access so food doesn't contaminate it. ■

11/17/2017

Kelster08
Member Since: 08/28/17
Post: 3 of 89

The only pain she has is from the tissue swelling, not the tooth. She is taking Augmentin. Just took her third dose while she was sitting in the chair because she was afraid the swelling was an allergic reaction. ■

11/17/2017

gclive
Member Since: 03/19/14
Post: 5 of 89

Don't use Formocresol in permanent teeth. Don't leave teeth open. This case calls for incision and drainage, antibiotics and analgesics. ■

11/18/2017

rtcnls
Member Since: 06/24/03
Post: 6 of 89

Why not leave teeth open? ■

11/18/2017

gclive
Member Since: 03/19/14
Post: 7 of 89

The same reason you use a rubber dam: bacteria. Between bone and the open environment, a seal is needed. That's why we have a periodontal attachment seal. The research on this question is all old, because the question has been sufficiently answered. That's why most endodontists will never leave teeth open. Also, preventing pulse granuloma. ■

11/18/2017

Fondcombe
Member Since: 09/24/11
Post: 8 of 89

I would prescribe Clindamycin 300mg QID for 8–10 days. ■

11/18/2017

jjj
Member Since: 04/23/05
Post: 9 of 89

Nothing wrong with leaving a tooth open in this situation for a day or two. Why have her suffer? It can be closed later. No cotton pellets in the chamber if you're leaving it open. It will swell up and cork it closed. Use an endo sponge. No need to automatically go to Clindamycin. Penn-based antibiotics are your first line. Clinda is not stronger, it just has a mechanism of action that is different than penn-based antibiotics.

If the gingiva is swollen and the tooth is not painful you can close it and do an incision and drainage. ■

11/18/2017

rtcnls
Member Since: 06/24/03
Post: 13 of 89

I think that the articles you linked need to be put in perspective based on when they were published. At that time, there were many questions that were sufficiently answered until they weren't. Many or most dentists wouldn't dare complete endodontic treatment—even vital cases—in a single visit and maybe not without a negative culture from the canal. Overfills caused failures. Mechanical instrumentation of the PDL caused cyst formation.

IMO, is it sensible to say that a vital tooth that is left open was not as infected as it will be after being open for a few days? Conversely, how about an already necrotic infected tooth like the OP's case? Is it going to get more infected than it already is?

I have found that not leaving teeth open in appropriate situations can lead to unnecessary patient misery. I'm curious if your comment on most endodontists not leaving teeth open is based on fact or opinion. Honestly don't know what the general feeling is among the majority endodontists in the U.S. or anywhere, other than I'm sure most were taught not to leave teeth open in their residencies by older instructors. ■

11/18/2017

dalmacija
Member Since: 04/14/15
Post: 29 of 89

Just had a case about a month ago ... large abscess, tooth was depressible, opened up the tooth irrigated, tooth was draining like a volcano. Put him on antibiotics, left the tooth open, he came back in three days and swelling was gone, finished RCT. Saw him a week ago, everything has healed well. ■

11/19/2017

LoveThisJob
Member Since: 05/16/13
Post: 31 of 89

The canal is already full of bacteria with the pus present. Leaving it open a few days to drain is not going to harm the success of the endo. You're actually allowing oxygen into the canal, which IMO would help destroy the anaerobic bacteria we are battling with.

Your profile says dental student; have you ever seen a patient with swelling and lots of pus? Try closing that tooth off early and not leaving it open for a few days and I guarantee your patient will be back the next day in pain. I'm speaking of the serious abscesses when patients are in severe pain, necrotic tooth and the pus is a fountain. Not the pulpitis types.

While I&Ds may be necessary at times, opening a tooth and leaving it open is not nearly as traumatic and much easier to heal accompanied with antibiotics. ■

11/19/2017

flyfishdr
Member Since: 02/26/04
Post: 42 of 89

I would have done exactly as the OP did here. It's kind of a tough spot. This works a high percentage of time for me. You get a case where the swelling does not immediately go down and guys start critiquing the treatment in a perfect hindsight scenario. If the case just proceeds as expected everyone says yes,

that sounds right. It does not, then it wasn't right? Seems the only way to do things right is to decide after if it was right. Hardly helpful clinically.

Leaving this open may have been the "more correct call" but it's not possible to outline when this should always be done and how we are able to always make the correct call. If this case left open, then the patient swells. Then we get the "... well you should never leave a case open, more bugs get in there," blah, blah. I think this case is "stuff happens" and after the fact, we are all smart. ■

11/22/2017

dalmacija
Member Since: 04/14/15
Post: 43 of 89

Not to be critical, but when you have active purulent drainage and swelling, establishing a drain is important. By sealing off the tooth, the drain is gone. ■

11/22/2017

flyfishdr
Member Since: 02/26/04
Post: 47 of 89

What I do when there is lots of drainage is let it drain. Often accompanied by some I&D. Then put a needle in the canal, attached to high volume. Suck again. I put a paper point in and it's wet. Again wet. Again, etc. I squirt calcium hydroxide in, close access. Next time it's dry and I obturate. If this did not predictably work for me, I suggest, I would not be repetitively doing it.

Then there is your point—which is a good one—how do I know it won't drain more, and I plugged the drain? The answer is I don't. I can't remember the last time (it has happened many times though) where there was so much coming out no matter what I did, I knew closing it was going to be an error. That happens and I guess I am making a clinical judgments on whether it will drain more, for a specific case.

A canal that is just really oozing steady, and will not stop oozing steady, is the only time I would leave it open. (I also have no idea how I quantify "really oozing steady," by the way.) I have found most times, for me, that is not the case, though. So I place calcium hydroxide, close access and easily obturate a dry canal next time. ■

11/22/2017

dalmacija
Member Since: 04/14/15
Post: 50 of 89

Anything can get worse; you need to remove the origin of the infection eventually. If you simply I&D and do nothing else, they will get worse eventually. Just like you see when patients get palliative care, like a extirpation: feels good for a month, then comes roaring back. ■

11/22/2017

Kelster08
Member Since: 08/28/17
Post: 56 of 89

Treatment update: When I saw the patient 24 hours after the RCT was initiated I prescribed Flagyl in addition to the Augmentin. This was on advice given to me from the endodontist we refer to. I think it helped. In the future, on a case that is a gusher like this one was, I think I will leave it open for a short period. It was too scary when the swelling was moving up her cheek toward her eye.

Today patient came in for the final fill. No more swelling, and minimal pain on the tissue surrounding the tooth. Most likely due to the severe stretch of the tissue while swollen. When I opened the tooth, it was clear that the infection was gone and the canal was super easy to clean and dry. ■

11/22/2017

HaasEndo
Member Since: 11/28/15
Post: 69 of 89

I never ever, ever leave a tooth open. No matter how many thousands of endos I've done and how many swollen patients I've had. Never. No matter how swollen. If there's a lot of drainage then I don't let them go home. It's almost never, ever an issue because I place a microsuction tip in the instrumented canal to length, or even a bit past the blown apex, and help Mother Nature with drainage. Then cal hydroxide and close it up.

Leaving it open will only let more bacteria into the tooth with all that are present in the oral

cavity. It's no excuse that many bacteria are in the canal already. Those should be eliminated as much as possible during the endo, so leaving it open to let even more in versus trying to reduce the bacterial count is counterproductive.

For me it's very simple: Open the tooth, if it drains, then instrument fully and help drainage with a microsuction tip, good intracanal meds used during the endo with RDI, cal hydroxide at least one week and then obturate 9 out of 10 cases, at that point in time.

Oh, yes—and I almost never even give an antibiotic in these cases—unless it's a very compromised patient, then maybe, or if there's a clear space infection. ■

12/4/2017

dalmacija
Member Since: 04/14/15
Post: 73 of 89

I disagree with many of your points. The mouth is full of bacteria, leaving a tooth open, leaving a drain in an I&D, leaving the I&D open, extraction site is open ... the point is to allow the tooth to sufficiently drain which results in a huge relief in symptoms, then you complete the RCT. I think we all understand the etiology of the infection needs to be corrected, but we also understand that there are things we can do to improve the symptoms that patient is having and then treat the etiology once we have a nice environment to work in.

Leaving the tooth open is the same exact reasoning behind doing an I&D. Just another route for the infection to drain. ■

12/4/2017

HaasEndo
Member Since: 11/28/15
Post: 75 of 89

Let the train keep rolling. Come on ... do you really think that I don't care about the patient's immediate relief? Really?

Of course, I do, but I also don't lose sight of the ultimate goal in endo and the elimination of the etiology for long term patient comfort and endo success. When I say I don't need to leave a tooth open it's also because I absolutely get excellent immediate relief of symptoms.

I haven't heard of anyone trying the micro-suction into the canal. It seems that most just leave it open, as many have for many years and take it from there. I'd love to see what you folks think after speeding up the process of getting rid of purulence or gases or whatever you're trying to remove in acute swellings, with the micro suction on the high-volume suction. For those acute cases, with such drainage I don't even find the need for an I&D immediately afterwards.

Also, we can't compare leaving extraction sites open to the oral bacteria while healing, with endo. If we thought that was OK, then why not just lubricate the canal with saliva? But of course, we know and mean better. Or maybe I've just been lucky all these years. ■

12/4/2017

Where did this root canal treatment go sideways?

Search: "Swelling #9"

A patient returns after a RCT with significant swelling ... twice. Townies weigh in on where the doc may have gone wrong and discuss best practices for abscesses and drainage. Go to **dentaltown.com** and search the message boards for "Swelling #9." This conversation will be one of the top results.