Fool Me Once …

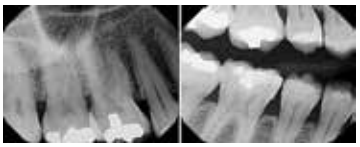
A Townie treatment-plans root canal treatment with most of his cracked-tooth cases.

Overture
Member Since: 04/11/10
Post: 1 of 532

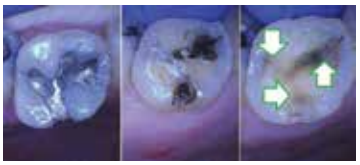
Good thing I treatment planned the RCT with this crown. In fact, I treatment plan an RCT with almost every cracked tooth nowadays. We end up doing the RCT about 60–80 percent of the time.

Ain't nobody got time for crack! Not getting suckered by cracked teeth again. I've been burned one too many times by these little buggers.

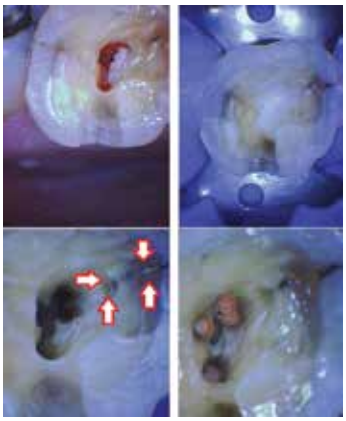
Pre-op



Teardown



Money shot



At this stage in my career, I am much more cautious (and less stressed) about cracked teeth. And I believe my patients are, as a result, much better off and in less post-operative pain. ■

12/1/2016

GoOutside
Member Since: 05/24/11
Post: 2 of 532

Talk me through this. My current plan with dx cracked tooth syndrome:

1. B/U + crown
2. Inform that endo is likely (30 percent of cases within 6 months … forget which lit this was from)

Continued on p. 42

Continued from p. 40

3. Wait.

Sometimes I think I should just offer the endo and crown straight from the beginning if they want a more aggressive approach that is sure to take away their symptoms. ■

12/1/2016

socrdoc
Member Since: 12/06/06
Post: 3 of 532

What kind of symptoms was the patient having? ■

12/1/2016

John Kanca
Member Since: 06/21/03
Post: 4 of 532

In patients over the age of 40, nearly all teeth are cracked. ■

12/1/2016

Overture
Member Since: 04/11/10
Post: 8 of 532

Classic cracked tooth syndrome presentation. ■

12/2/2016

alanrw
Member Since: 05/16/11
Post: 13 of 532

The problem with any crack in a tooth is the propensity for the crack to propagate (and that can occur post endo and crown). Like a crack on a car windshield, they always get bigger. ■

12/2/2016

Tom Mitchell
Member Since: 02/16/04
Post: 21 of 532

I'm dealing with one right now. #4 with old MOD amalgam. Tooth slot sensitive to pressure only in June. Did MOD composite. Has photo of crack under L cusp. Now more sensitive. Very conservative MD. Now have limited time in my schedule so we're going to do provisional crown and see what happens. I'm guessing we'll end up with endo before we take the final impression. WWJKD? ■

12/5/2016

Overture
Member Since: 04/11/10
Post: 23 of 532

This is exactly what you will find most dentists doing. And when you read it a few times, you clearly see how it is:

1. Frustrating to patients
2. A waste of your clinical time
3. Adds many levels of uncertainty to our treatment plans

Which is why I always treatment plan for the RCT upfront, and end up doing it roughly 60–80 percent of the time. Not saying I'm right, just presenting my line of thinking.

The approach outlined above may be more conservative in the short run, but it is not very healthy for running an efficient and predictable practice (from a patient's standpoint).

Discomfort ---> filling ---> pain ---> let's do a temp crown and see ---> more pain ---> more wasted (un-reimbursed) chairside time. ■

12/5/2016

Tom Mitchell
Member Since: 02/16/04
Post: 26 of 532

I understand your point of view. I don't know, and I don't think it's ever been established, what the rate is of symptomatic cracked teeth that when appropriately treated, do not become necrotic. If anyone knows please chime in. I don't believe, as you have indicated, that it's 100 percent, but that may be true. Until I/we know more, I'll keep on with the provisional technique. Btw, as long as you can get an impression when you prep, there's no wasted time. ■

12/5/2016

Packmanfan1
Member Since: 10/12/13
Post: 44 of 532

Great thread. From my experience, there are multiple factors that affect each tooth and individual. A lot of them have been addressed in the above comments. One thing that has not been addressed is how a tooth is prepared for a crown. I have worked with some docs that use very little water and very aggressive drilling when doing a crown prep. Guess what, a lot of those patients end up needing RCT. Heat generated during tooth preparation and amalgam removal has severe detrimental effects on the pulp. ■

12/6/2016

amarengi
Member Since: 05/22/05
Post: 89 of 532

This discussion has been in my head today. I feel like I brought a problem to the surface that otherwise maybe wouldn't have popped up for a while. I'm all about guiding patients to informed decisions on their own but at the end of the day, we make recommendations.

I don't have a pre-op picture but there was a dark cracked mesial ridge (distal ridge to a lesser extent) and so we scheduled yesterday for an MOD. No symptoms. This picture is after the amalgam was out. We both agreed that converting to cuspal coverage seemed smart so I did a core and sent her on her way until next week. Apparently, she called this morning in pain.

There's not much doubt that the procedure "caused" the pain. Should I have left it alone? When's the right/best/appropriate/reasonable time to intervene? Did I use too much of my own bias in recommending bur-to-tooth? No good answers from me, only questions. ■

12/9/2016

Tom Mitchell
Member Since: 02/16/04
Post: 90 of 532

Really this is so similar to the case I'm showing above. I always give the asymptomatic ones a chance to continue to be asymptomatic is a conservative restoration, and when they become painful then, if symptoms are reversible I do a provisional to allow time before proceeding to either endo and final crown, or if that solves the pain go to final crown. Research shows 20 percent need endo. ■

12/9/2016

kidesperanto
Member Since: 08/03/09
Post: 146 of 532

Speaking of learning, I'd actually like to know more about your methodology here, John. When you first see these distal marginal ridge cracks and signs of parafunction, your first move isn't to crown but to equilibrate locally? Is that what you are saying? I'd like very much to not jump to a crown if this consistently works. ■

12/13/2016

Tom Mitchell
Member Since: 02/16/04
Posts: 147 & 151 of 532

When I see that flat worn DMR on lower second molars with or without the craze line/crack, I round that ridge over to take that force off it.

I see lots of these, especially when there's an occlusal amalgam involved, which inevitably I'm removing/replacing with composite. Once the amals out there is always a crack under a cusp, usually DL, so I complete the composite restoration, and rarely is there any post-op problems. I disagree with John that amalgams do not crack teeth. I don't see cracks like these when I'm replacing old composites in lower second molars. Anecdotal for sure, just observational. ■

12/13/2016

jamie888
Member Since: 07/26/11
Post: 155 of 532

The idea of rounding DMR of lower second molars prior to considering crowning is a great idea Tom, thank you very much for that. It will be in my arsenal from now on. Think first, drill second. That's what both you and JK are saying, eh? ■

12/13/2016

Tom Mitchell
Member Since: 02/16/04
Post: 168 of 532

When we see so much as a wear facet on lower first or second molar DMR we round it over, creating either a pinpoint contact or no contact at all. We keep a high-speed handpiece up in each hygiene room with a 7406 in it and a plastic cover over it so that when we see that it's beyond simple to round that ridge over. Takes both seconds to do and saves the tooth.

Ask my dentist Jim Rosenwald about where his #18 is. We're constantly reshaping wear facets anywhere we see one. Even placing a groove across on will significantly reduce the forces on that section of the tooth. That's one of the basic tenants of occlusal equilibration, which in reality is a very simple concept. Hope this helps. ■

12/14/2016

John Kanca
Member Since: 06/21/03
Post: 171 of 532

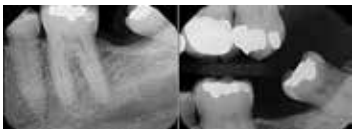
I will also reduce the opposing and offending cusp in parafunctional movements. How many times do you look in the back of the mouth and see a plunger MB cusp on seconds? I see them often. The lower second molars often appear to be hollowed out and as Tom mentioned, the MR's become sharpened. ■

12/14/2016

Overture
Member Since: 04/11/10
Post: 190 of 532

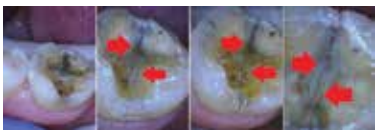
Recall exam reveals an asymptomatic coronal crack on #19, leaking filling and recurrent decay. This tooth is 100 percent asymptomatic, according to the patient. Just like #18 was asymptomatic, up until the day he bit into a chip and split it in half. Anyone want to do anything here? Maybe a "watch"?

#19

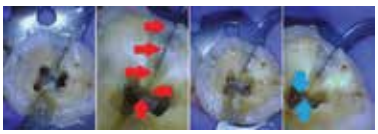


#19 Intraoral

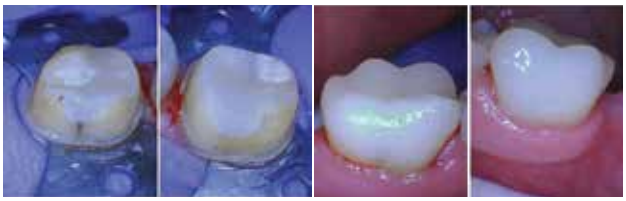
#19 Tear down, reveals two connecting major fault lines straight down the middle of the tooth. If you look back at the PAx more closely, you will see it.



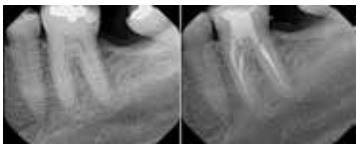
Lingual chamber shots. The coronal crack extends straight into the pulp chamber, right into the ML root.



Lingual Buccal



Final



12/19/2016

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