Here is this week’s cases that I completed. Some are interesting, some routine. None were easy!

Case 1: This looked like a slam-dunk mandibular molar. Nope. Two-and-a-half hours and five canals later, we’ve got the final result. Would have liked a denser apical fill on the mesial, but oh well.

Case 2: Previous treatment done by an endodontist. The MB2 was huge. This is totally unacceptable that it was missed, especially by an endodontist. It had a completely separate POE [portal of entry]. The patient was so impressed with his initial 30-minute endo; not so impressed when I saw him a month ago, swollen like a pumpkin. He’s much better now.

Case 3: This was again supposed to be a routine lower molar. Nope. A third distal canal was located on the second visit. This is getting old... no?
Tough week, but hey, that's life! Take care everyone. ■ John E. Levin, DDS, MS

[Editor's note: Due to size constraints, some cases were omitted and can be viewed online at www.dentaltown.com]

John, fantastic cases as usual, from a “real deal” endodontist. Thanks for sharing them and inspiring us. Now, who was saying endo is easy? ■

Rod W. Tataryn, DDS, MS

Levinje, what type of digital radiographs do you use? Those are the clearest films I think I have ever seen. ■

Thanks for the compliments. Suffix 76, I use Kodak RVG 6000. Here’s the last case of the day. I just packed it. The initial treatment had several problems with it and the patient’s percussion pain never went away. Note on the pre-op how large the palatal canal is and how small the cone is. This was basically a single-cone obtura-
tion technique that resulted in poor adaptation of the gutta percha to the canal wall. I re-sealed it entirely with MTA [mineral trioxide aggregate]. The MB root had a single, long ovoid orifice with a deep apical bifurcating system. This one was around the curve and not visible in the scope. I had to feel it. There were restorative problems too. The crown was placed six months ago. Hmmm, that’s a lot of decay on the palatal under the resin to form in only six months. Restored the access with dual-cured white blockout core paste underneath Heliomolar A1 after etch/silanation of the porcelain. Take care everyone and thanks again!

John, clap, clap, clap… raising the bar is what it’s all about. I want to thank you for taking the time to post those cases, both the initial treatment and the retreatment. The accompanying prose gives us all insight into what you found and why it was significant. Even the restorative work is beautiful and I assume done under the scope. Clean accesses, extra anatomy discovered, deep bifurcations, removal of all decay and cleaned up orifices, all a sign of attention to detail. That is what molar endo requires to be successful and with the current rise in popularity of implants as the be-all and end-all, those who have an interest in preserving the dentition we came into this world with should read and reread your post. That’s what it takes to be a success with molar endo. So much of what you have posted answers so many questions. Most of it is in the lines; some between it. Thanks again for sharing, that is what makes DT [Dentaltown] the success that it is.

Wow, the Kodak sensors really are the best. How about that!

John, are you going to divulge your theory on the MB/ML isthmus you nailed? Suffice it to say that after seeing several other clinicians’ cases using this device, I made the decision to place an order for the device myself after seeing this beautiful case of yours.
John, that’s great stuff. I have a question on your bonded post in the bicuspid. I’ve seen you do this before, always bicuspid, if memory serves (it doesn’t always). The question is why? This is not meant in a disrespectful manner. Really an honest query. I just see no advantage to that here and possibly some disadvantage. Just my view. ■ Peter

Peter, it’s a good question. Here’s my thinking on this:

1. I don’t remove much more root structure to prepare the tooth for the post, so it’s not very invasive.

2. And more importantly; I don’t know, but assume the tooth will be covered with an all-ceramic restoration; or at least a porcelain-fused-to-alumina core. This is a young, very attractive girl with maximum demand on aesthetics. Both of these preparations will result in pretty heavy axial/occlusal reduction to get clearance and adequate emergence profile and contour of the crown. The bicuspid here was pretty small, and not much tooth would likely be left axially after crown preparation. My hope is that the bonded fiber posts will help resist long-term snap-off of the crown over the years by distributing lateral forces throughout the root, while minimizing internal enlargement of the root w/ post preparation. But, time will tell. ■ John E. Levin, DDS, MS