Should a Townie refund a patient whose PARL survived root-canal treatment?

Coming and Going

The conversation, taken from one of Dentaltown's

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busiest message boards, begins on the next page.

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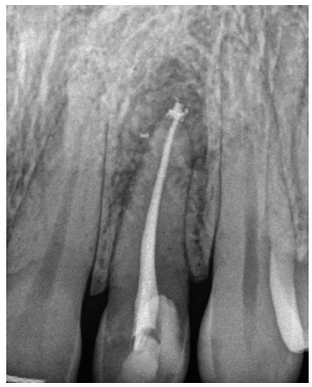
Would You Refund an RCT in a Case Like This?

Persistent PARL and endo referral make the Townie wonder how others would proceed

MetalDoc
Member Since: 05/20/13
Post: 1 of 98

I'll keep it short and sweet: Patient with fistula around 10. PA reveals large radiolucency and decay. RCT recommended. I'm a GP but seemed straightforward enough. RCT completed in one step in early January. Patient comes in in September, saying tissues have not healed, slight pain in area. PA reveals radiolucency still present. My buddy says it's gotten smaller but to me, honestly looks about the same. Advised endo consultation. Patient now wants a refund because endodontist will be redoing treatment. I told patient I'm fine with a refund as long as I can get notes or chat with the endodontist. Recent PA included. ■



10/23/2017

winnfd
Member Since: 02/12/15
Post: 2 of 98

Your RCT looks good. The radiolucency looks somewhat J-shaped. Did you probe around the tooth to look for a crack? ■

10/23/2017

eeznogood
Member Since: 02/23/06
Post: 4 of 98

It is not cracked. The endo does look good, but this on its own is not a good indication of clinical success. This case should have ideally been two-stepped, in order to assess healing of the fistula before sealing the tooth. Laterals are notorious for not healing well. Possibly because they are too fast to treat.

Technically, there is no need for a refund, but in reality, it will be kind of tough to get out of this one. In my office I would refund (and have done it before, unfortunately). You do enough endo, some stuff will fall back on you, and whether you find it fair or not, it's there and you need to make it go away.

For the future:

1. Cases like this one, I two-step or multistep until resolution of symptoms before sealing.
2. Beforehand, I tell the patient that when I see a PARL, there is a possible need for an apico if the area does not heal after endo. I always tell them that. And I always give them the quote for the apico and tell them that 5 percent will need it. So that they know ahead of time and it is not a surprise if it happens.

These two things have now almost eliminated the need to refund and made my endo journey more pleasant. ■

10/23/2017

docdino
Member Since: 11/25/02
Post: 5 of 98

Why would you refund the money? RCT looks like it is done to the standard of care. What is the endodontist's dx of why RCT is failing? Sometimes RCTs don't solve the problem; tooth could be cracked. If the endo RCT doesn't solve problem, does patient get another refund? Could be more significant path. ■

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MetalDoc
Member Since: 05/20/13
Post: 8 of 98

Thank you all for your replies.
Update: I spoke with the other dentist.
1. He's a GP.
2. He never said the RCT was done wrong.
3. He isn't doing it.
4. He recommended an endo consult.

How hard is it to just go to the endo person I work with? ■

10/23/2017

dentist_ne
Member Since: 10/19/14
Post: 9 of 98

What do you fill the tooth with if you do the endo as two-step—calcium hydroxide or something else? How long do you wait for signs of healing? (rads? clinical?)

10/23/2017

eeznogood
Member Since: 02/23/06
Post: 11 of 98

I use Formocresol and close the access with anything that you'd like. I use Tempit. It is a white paste. It is very easy to remove. I wait two weeks usually. If there is a draining tract you can inspect it visually. If not, you open the tooth and smell the insides for a bad rotting smell and/or for fluids. You then rinse it and dry it.

If you can get it dry and the patient's symptoms went away, then you can close it. If the patient's symptoms improve but did not go away, no sealing. Just rerinse it and redress it and again wait two weeks. Same if you cannot get it dry. ■

10/23/2017

BreakingFree
Member Since: 09/03/09
Post: 15 of 98

I will kindly disagree with eeznogood's tx plan of two-stepping with Formo. I think that's really opening up a can of worms. By the way, I really respect eeznogood's advice most of the time!

I would have two-stepped this with CaOH. I think one of the things I would do in the beginning is not instrument enough the first visit before I put CaOH into the canal. Now I fully instrument and then place CaOH into the canal, cotton pellet and temp filling. I bring the patient back in about two weeks and take a PA. If the area is resolving and I can keep the canal dry, I will pack that day. If it isn't dry and I am getting some "weeping" from the apex, I will use NaOCl to irrigate, followed by sterile saline and then dry. Pack CaOH again and bring back. ■

10/23/2017

boringholes
Member Since: 08/09/01
Post: 16 of 98

When you guys say two-step, you are talking about full shaping and disinfection at the first visit, fill with CaOH paste, let sit for some number of weeks, then bring back for obturation visit?

What is the criteria for needing to do that? Every necrotic case? PARL above a certain diameter? One observation about that: The profit margin falls to approaching zero at PPO fees if you have to do it that way. ■

10/23/2017

eeznogood
Member Since: 02/23/06
Post: 18 of 98

All of the work is done at the first visit except the obturation. I now do this on almost all necrotic and or symptomatic cases, even if vital. ■

10/23/2017

dentist_ne
Member Since: 10/19/14
Post: 32 of 98

Is anyone having good success with single-visit RCTs? The endodontist at my residency almost never did multiple visits unless he couldn't get the canal dry. I don't know what his success rate was though. He did it because according to him the literature does not show a clear benefit of two visits. ■

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HaasEndo
Member Since: 11/28/15
Posts: 35 and 40 of 98

With that apical extrusion, re-treat will very likely *not* help. I wouldn't refund the patient, especially if it's explained to them that the ongoing infection might be due to resistant bacteria outside the root, which a good and routine root canal can't get to. That's why I never quote a patient a 100 percent success. As in medicine, nothing is 100 percent and unfortunately this unlucky patient is one of them. That's how I briefly explain it. Refund in this case means you're guilty of something wrong, as far as many patients see it. And I don't see that with your best efforts and good intentions. Communication with the patient and explaining things clearly and firmly and sincerely can go a long way.

What I don't tell such a patient, for obvious reasons, is that the extrusion reduces success rates and may be a contributing factor. That's why I'd only recommend apicoectomy. Re-treatment will *not* remove that extruded sealer/g percha and may also not be able to deal with any possible resistant apical bacteria. And, who knows what colleague somewhere said the wrong thing to make the patient question your work and good intentions in a case that we've all faced personally.

Good luck.

[10/23/2017]

I really don't know why Formocresol is still discussed, let alone used, in 2017. There is no university undergrad/grad program in the Western Hemisphere, no textbook, no article, no study, no specialist that even speaks of the "F" word when discussing medication.

Those that say it works don't realize that the symptoms may go away because the pulp may have become necrotic or symptoms chronic or the patient learned to stay away from a symptomatic tooth. But "F" does nothing at all for endo. Period.

As for re-treat, I agree that you need to clean the inside of the root and that bacteria may still be there. But this real-world scenario with a potential hot potato means that we need more definitive treatment. In other words, deal with the two issues with only one treatment. The two issues are canal bacteria and extrusion. And this patient and whoever is coaching her behind the scenes doesn't need more perceived proof that something was done wrong the first time around. Re-treat will still require apicoectomy afterwards (very likely.) The success for this apico (if not fx'd, which I don't think it is) will be very high with an apical filling and with the use of a microscope. Very high.

As for extrusions, it is never good to have any foreign body in the periodontium. Even porcelain. Radiographically it may seem to disappear but histologically it's been shown years ago, already, on poor monkeys that were sacrificed, that there is long term apical inflammation that continues even if radiographically there is no more material seen apically. This case definitely needs to have that material removed.

P.S. I wish we could just have this friendly discussion over a beer, or two! ■

10/24/2017

rtcnls
Member Since: 06/24/03
Post: 44 of 98

I medicate with either Vitapex or CaOH (I use the Edge brand currently). Vitapex is usually my first choice except for where I want more flow/easier removal or if there is a very large lesion and I want some extrusion with quicker resorption. The CaOH will flow better and resorb more quickly.

As for obturation, I am looking for closure of any sinus tract, healing of a perio pocket if I suspect endo-perio, and resolution of any symptoms. I usually wait anywhere between one week and two months depending on the case and the decision to give up is highly subjective depending on the tooth, the situation, and the patient. ■

10/24/2017

flyfishdr
Member Since: 02/26/04
Post: 45 of 98

Manor, guys use Formocresol for both vital, necrotic adult teeth and primary pulpotomy.

You're not going to be able to tell guys who use it that it doesn't work. Especially when a lot

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of these guys have been doing it longer than you and can certainly back it up. And many really good endodontists routinely get sealer extrusion. You are not going to be able to suggest to them their cases won't work, either. Suggesting extrusion is one potential cause of a failure means you are going to need to explain why that is rarely actually the case but if a failure occurs, you are able to suggest some slight extrusion is the reason. ■

10/24/2017

Karim, when I said it opens up a can of worms, I am talking about from a legal perspective. In the U.S. I believe we have to pay additional coverage for our malpractice insurance if we use Formo. I think it is a great tool, but I don't have it in my office due to liability. ■

10/24/2017

BreakingFree
Member Since: 09/03/09
Post: 51 of 98

OK, then what is the explanation for lesions resolving post treatment if there is biofilm left? Perhaps the biofilm is entombed/sealed off by our efforts? Again, in the case posted, the residual lesion was fairly substantial. Wouldn't you conclude something has to be feeding this lesion? Bacteria leaking from the biofilm on the inside of the canal? ■

10/25/2017

alanrw
Member Since: 05/16/11
Post: 69 of 98

What do you think?

Search: "Refund RCT"

Have you been in a situation like this before? Would you have given the patient a refund? To read more posts or to share your thoughts, go to **dentaltown.com** and search the message boards for "refund RCT"—this conversation will be one of the top results.

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