Endo/BU/Crown Sequence

A future dental school graduate wonders how his fellow Townies schedule patients who need endo work, a buildup and a crown. His peers share their preferred techniques for efficient appointments and treatment

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I'm a soon-to-be new grad, and was wondering what your endo/buildup/crown sequence looks like. In dental school, we do it in multiple (!) appointments. I've heard philosophies on doing the crown prep first and then endo access, caries removal first and then endo access, etc.

I'm wondering what a good efficient system would look like for a typical procedure, and I'm aware that it also would look different if it is an emergency patient that you are fitting into the schedule.

Most of my endos in school were due to interproximal decay that went into the pulp. So, after caries excavation, I was left with no mesial and/or distal walls, so I was told to build up the walls (using a matrix) with composite before doing the endo. Is this what is typically done? This is my sequence I have in my head:

- Topical.
- Anesthetize.
- Take impression for temp crown and get shade while waiting to get numb.
- Endo ice on tooth to make sure it is numb (more anesthetic if necessary.)
- Rubber dam.
- Occlusal reduction.
- Caries removal.
- Rebuild M and/or D walls with resin.
- Do the endo.
- Buildup.
- Crown prep.
- Stump shade.
- Impression.
- Temp crown.
- Cement temp.

If there are any corrections or suggestions, or if I missed anything, I would love to hear them. ■

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I do this constantly at a clinic that takes Medicare patients. Get good at this and you can have a job anywhere, because most doctors do not like doing molar endo and it is needed.

Here is what I do:

- Ensure you have an X-ray that shows all the roots to the apex. Better yet, get a limited view CBCT.
- Topical first. Numb them good.
- Take the temp impression as the anesthetic is soaking in. The only time I do not do this is when there is a hunk of tooth missing. In that case you can get it after the BU. Alternatively you can put some old composite and shape it quickly and take the impression.
- Rubber dam. Please don't skip this step like so many do.
- Flatten cusps with occlusal reduction bur. Easier to access pulp chamber.
- Access pulp chamber. Be conservative but also get straight line access. If there is a lot of decay I will remove any decay, but I am not super concerned with getting all of it out right now.
- Find your canals. I use a #8 25mm file. I will then go straight to the Dentsply Pathfinder files attached to the endo motor with the apex locator attached. I progress from the #10

to the #15 to the #20. I do not force it; 90% of the time they drop right to the apex. If I cannot get it there then I use bent hand files and gently get to the apex. I will put a curve in them and rotate as I try to get to the apex. If that does not work I will straighten it and put a 1mm or less 15–30 degree bend and do it again, rotating gently to try and find the apex. If you get stuck on one canal, move on to the next. *Do not force it*. This is where you can pull the ripcord and send them to an endodontist if you cannot get to the apex. Do not be afraid to just charge out a pulpotomy and refer. Nobody will think less of you.

- Be sure to inspect each file as you use it. If you see *any* bend or unraveling … toss it.
- I then use a Dentsply Vortex orifice opener, gently. Again, don't force it, you are just getting easy access. Rinse with endo solution.
- I will use SS hand files to gauge which WaveOne file to use. If the #10 has resistance, I will use a small. If the #15 or #20 has resistance I will use primary. If the #25 or #30 has resistance I will use medium. If greater than #30 but less than #40, I will use a large. If larger, then it will be done with large SS hand files and the step back protocol.
- I use a single-swipe-and-clean SSC method with the reciprocating endo motor with the apex locator attached. This means I take my file gently until resistance then remove it completely and have my assistant swipe the file with a Brasseler Endo swipe sponge on a stick soaked in alcohol. I then wipe it in RC prep or whatever lube you use and go again. This prevents any buildup tooth shaving in the flutes.
- I will go about 5 SSC then rinse and put a #10 file to length. Rinse and recapitulate. I usually get to the apex rather quickly with this method.
- Examine the WaveOne file each time it comes out. Don't use a knockoff file.
- When all canals are cleaned to the apex with the apex locator, I take the matching SS file (small=20, primary=25, med=35, large=40) and with the Apex locator I get my final length.
- I rinse with endo solution and use the endo activator with the matching attachment to ultrasonically activate the endo solution for about 30 seconds a canal. Rinse, repeat once.
- I dry all the canals. At this point you can take an X-ray for final length if you want; I do not. If my cones go all the way to the measured apex then I place the BC Sealer and a single cone, melt it off and take off the rubber dam for an X-ray.
- Remove all the decay and old restoration and place my BU and prep the crown.
- If one looks too short, then I put the rubber dam back on and use a Hedstrom file to pull the GP cone and re-instrument to get it right. This does not happen often.

I am sure that someone will disagree with what I posted. Everyone has their own way of doing things and you can fight about endo all day long. I can get a molar RCT/BU/crown done in about an hour. With Medicare and state aid you have to be quick or you will never make any money. My private practice patients also enjoy getting root canals done quickly.

My suggestion is to:

1. Case select carefully.
2. Use new files. I like WaveOne because they are one use only.
3. Don't force anything.
4. Know when to bail out.
5. Do the same thing every time. Have a SYSTEM (save yourself time energy and money.) ■

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