CASE REPORT
Gina M. Savani
SURGICAL RCT TOOTH #8

10/04/2012
28 year old Caucasian female presented for evaluation and treatment of tooth #8.

SUBJECTIVE

Chief Complaint: “I was referred from a dental clinic across town for evaluation of swelling above my front tooth.”

Medical History: The patient has no known drug allergies, reports no systemic illnesses and is not taking any medications. ASA: I

Dental History: Original RCT done 15 yrs ago and crowns placed shortly thereafter. Pt had a history of trauma. Pt feels pressure in her upper front tooth and more congestion on the right side. The swelling in front started about 1 year ago. There has been no change in symptoms over the last year and no change in the size of the swelling. Pt has seen an ENT and had a CT scan. ENT noticed a "cyst" close to end of root. ENT recommended getting it removed if it gets bigger but the patient reports that he did not seem too concerned. Pt has not taken antibiotics for the swelling. Pt has not tried decongestants or pain medications either. Pt does not want to monitor this swelling any longer.

OBJECTIVE

Vital Signs: BP 112/76 P 56

Extra-oral Exam:
Slight fullness to right upper lip. No signs of drainage. No lymphadenopathy. TMJ evaluation WNL.

Intra-oral Exam:
Intraorally yellowish 3x3 mm swelling next to the frenum mesial to #8 with a more diffuse swelling surrounding it but extending distally and apically toward #8. Tooth #8 and #9 have all ceramic restorations with intact margins. The lingual margin of #8 is mid-crown. #7 and #10 are intact with no restorations or signs of caries.
# Diagnostic Findings

<table>
<thead>
<tr>
<th>Tooth</th>
<th>Percussion</th>
<th>Palpation</th>
<th>Probing</th>
<th>Mobility</th>
<th>Cold</th>
<th>Radiographic Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>WNL</td>
<td>WNL</td>
<td>WNL</td>
<td>WNL</td>
<td>WNL</td>
<td>PDL intact</td>
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<tr>
<td>8</td>
<td>WNL</td>
<td>+ (over the swelling)</td>
<td>WNL</td>
<td>WNL</td>
<td>NR</td>
<td>Radiolucency Mid-root on Mesial</td>
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<tr>
<td>9</td>
<td>WNL</td>
<td>WNL</td>
<td>WNL</td>
<td>WNL</td>
<td>WNL</td>
<td>PDL intact</td>
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<tr>
<td>10</td>
<td>WNL</td>
<td>WNL</td>
<td>WNL</td>
<td>WNL</td>
<td>WNL</td>
<td>PDL intact (where visible)</td>
</tr>
</tbody>
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# Radiographic Findings

Normal horizontal bone levels. Restorations #8 and #9 consistent with all ceramic crowns. Radiolucency associated with M lateral root surface of #8 about mid-root. Two small radiolucent areas on the root surface adjacent to the radiolucency. No caries noted. Root fill #8 is of adequate length, density and taper. #7 and 9 are caries free with intact PDL and lamina dura.
**Assessment**

#8 Previously treated with acute apical abscess

**Plan**

Root-end resection, ultra-sonic root-end preparation, and root-end filling with MTA

**Treatment:**

10/22/12:

BP 117/77  P 60  pARQ'd the pt for #8. Obtained consent for surgical treatment of #8. Administered 600 mg ibu. Pt rinsed with Peridex for 60 secs. Pre-op photos. Reviewed CT and lesion appears to be associated with root of #8. 108 mg lidocaine with 54ug of epi and 72mg articaine with 18ug of epi during procedure. Reconfirmed periodontal probings after local anesthesia administered to ensure submarginal flap design was appropriate. #7 and #8 2mm probings across facial and #9 3mm probings across facial. Submarginal scalloped incision made from distal of # 7 to distal of #9 with 2 vertical releasing incisions. Reflected mucoperiosteal flap. Fenestration noted in the bone on the mesial of the root of #8. SOM used during procedure after flap reflected. Enlarged the osteotomy with round bur. Currettage of tissue. Specimen submitted for biopsy. Lateral defect or accessory canal noted on mesial of #8. Resected 3mm from root end of #8. Root-end preparation of apical and lateral canals. Stained with methylene blue and evaluated with SOM. No cracks noted. Rinsed then dried with Stropko. Placed MTA root-end fills in mesial and apical preps. PA to check root-end fills. Sharp dissected the yellowish soft tissue mass that was visible clinically and submitted for biopsy. 3 mins of pressure. 6.0 vicryl interrupted sutures. 5 mins of pressure. POI oral and written. Pt given bottle of Peridex and prescription for 600 mg ibuprofen. Pt instructed to take 600mg ibuprofen every 6 hours for the next 3 days. 5mg hydrocodone with 500mg acetaminophen also prescribed as a rescue medication to be taken if needed. Attempted post-op photo but strain was causing oozing of blood. NV suture removal.

10/23/12: Called pt to check on her. Left a message for pt to call back with any problems and reiterated to follow post-op instructions.
10/25/12:
BP 114/75 P 62 Pt reports slight swelling of upper lip. Pt managed pain with ibuprofen alone. Last dose taken this morning. Pt reports no problems or complications. Pt reports #8 feels numb. No numbness to the tissues, just the tooth. Extraorally, no apparent facial swelling. Possible fullness above upper lip but very slight.
Intraorally, no swelling. Sutures intact. Slight ecchymosis inside of upper lip. Some redness to the tissues coronal to the incision on #8.
Application of 20% benzocaine as topical anesthetic. Suture removal. Post-op photos. Reviewed post-op instructions. Informed pt that the feeling of "numbness" in #8 is probably due to the surgical wound. With healing the feeling should subside. NV 3 month recall. Pt advised to call if any problems in the interim.

1/28/13:
Pt presents for 3 month recall #8. Pt reports no problems.BP 112/74 P 64. Extraorally and intraorally no signs of swelling or drainage. Thin scar in attached gingiva at site of original incision. Percussion, palpation, probing, mobility WNL for #7,8,9. The feeling of numbness in #8 has resolved. Radiograph reveals bone fill apically and increased trabeculation in area of the lateral lesion. Diagnosis #8: previously treated, healing periapex. NV 6 month recall
4/25/13:
Pt presents for 6 month post-op evaluation. Pt reports no problems with tooth and no changes to medical history. BP 109/73 P 69. Extraorally and intraorally no signs of swelling or drainage. Percussion, palpation, probing, and mobility WNL for #7,8,9,10. Cold response WNL for #7,9,10. Restorations #8 and #9 are intact. Radiographically, the PDL is intact on #8 and there has been increased bone fill on the mesial of #8 but bone density has still not returned to normal. Diagnosis #8 is previously treated with healing periapex. NV 1 year recall
Prognosis:
Favorable