The General Dentist-Endodontist Relationship

by Drs. Kenneth Koch and Dennis Brave

We have had the privilege over the past 10 years to write more than 100 articles on different aspects of endodontics. Topics have ranged from the latest techniques and technology, to debunking some of the myths surrounding endodontics. However, we have never specifically written about the special relationship that exists between the general dentist and the endodontic specialist. Consequently, we believe the time has come to evaluate this relationship and we would like to discuss it from a few different perspectives.

The first perspective, and perhaps the most significant one, is the need for the general dentist to work within a comfort zone. This is a zone that obviously varies from one clinician to another. However, it makes little sense to attempt a root canal in cases that are beyond your skill and experience level. Don't try to be a hero. These cases will ramp up your anxiety level, generally require extended time and energy and often prove to be non-profitable. In the long run the majority of these difficult cases wind up being referred anyway, so be honest with yourself and do what is in the patient's best interest from the outset.

Previously, we have recommended the AAE Case Difficulty Assessment Form (www.aae.org) and it is a good place to start. The Assessment Form ranks the various cases in terms of difficulty and will give you a heads-up for specific cases. Some of the warning signs noted are calcified and ledged canals, severe curvatures and retreatment cases. These are all good cases to refer but there are additional cases (not addressed in the form) that might be troublesome and, in fact, are not related to the specific anatomy of a tooth.

The first of these are elderly patients (or medically compromised individuals) who cannot sit in one position for any significant period of time. These cases require speed in addition to skill, and we believe they are best served through the referral process.

Another group that frequently merits referral is difficult patients. The old bromide that says, "bad things happen to bad patients" is too often true. As endodontists, we frequently see floor perforations that have occurred as the result of a dentist trying to get into the pulp chamber (of an endodontic tooth) on a difficult patient. Furthermore, difficult patients are many times best treated in one appointment, which helps to minimize the experience for both the patient and the doctor.

Another patient group that warrants consideration for referral is anxious or phobic patients, where one can appreciate that the treatment itself might very well be comprised because of the level of anxiety of the patient. Root canal treatment

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Cases You Might Refer

Anatomy Related
- Calcified or ledged canals
- Severe curvatures
- Retreatment cases

Not Specific to Tooth Anatomy
- Elderly or medically compromised patients
- Difficult patients
- Phobic patients
- Difficult to diagnose cases

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can be difficult under the best of circumstances, so to compound the technical challenges with emotional ones makes no sense. Identifying your own comfort zone is equally important in making the decision to refer. The best time to refer a difficult case is before you a start it. This is why it is so important to get an angled X-ray (or image) of the tooth before you begin the case. Take your cone head and move it about 15 degrees to the mesial. Moving the cone head in such a manner will allow you to separate the roots of the tooth in question. Additionally, a good angled X-ray will help identify the periodontal ligaments that surround the multiple roots. It will also help identify bifurcations and apical delta formations. In particular, this is a great way to identify deep furcations in mandibular premolars. A deeply bifurcated premolar is perhaps the most difficult endodontic case and it is one usually best referred to a specialist.

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Another example where a referral to a specialist is indicated but might not be so obvious is the difficult diagnosis case. The most difficult part of endodontics is not a curved canal. It is diagnosis. Furthermore, it is not the typical run-of-the-mill cases. When a patient presents in pain and the diagnosis is not apparent, rather than have the patient return to your office multiple times, refer them to your endodontist. It is very important that you have a working relationship with your specialist that includes his or her willingness to see your emergencies immediately. This does not mean the next day or the next week. We have no tolerance for endodontists who will not see emergencies in a timely manner… and nor should you.

There is a wonderful old axiom in endodontics that states, "When you are lost, stop and take an X-ray." This can be extrapolated to a new axiom that states, "If you cannot reproduce the chief complaint, stop and refer it to a specialist." This will make your life a whole lot easier and your patient will appreciate it.

Another aspect of the general dentist-endodontist relationship and one that receives little attention is the ability to perform appropriate emergency treatment. Once you have proper anesthesia, you can handle emergencies. Seeing emergency patients and treating them in the proper manner can be a huge help in establishing your practice and enhancing your relationship with your specialist. The key is to deliver the appropriate treatment for vital and non-vital teeth. Consequently, the first thing you need to determine with your patient is whether you are dealing with a vital or non-vital tooth. As a general rule, vital teeth can be handled with a pulpotomy while non-vital teeth require a pulpectomy. Let's take a closer look.

Vital teeth: In these cases a pulpotomy will work, although in molars we also recommend removing the inflamed tissue from the largest canal (such as the palatal or distal) in conjunction with the pulpotomy. Do not put files down into each of the canals, unless you plan on removing all the tissue. If you put a file into an inflamed canal you have just committed yourself to a pulpectomy.

Non-vital teeth: If the tooth is necrotic, you really need to do a pulpectomy. A great benefit of rotary instrumentation is that a pulpectomy can be accomplished quickly and efficiently. You need to remove as much of this necrotic material as possible at this initial visit. However, even a partial pulpectomy accomplished with one or two rotary instruments will often suffice. Following the pulpectomy, we recommend filling the canal with calcium hydroxide, a cotton pellet and an appropriate temporary dressing. Also, do not forget to adjust the tooth.

The final perspective is communication with your endodontist. This is important for both parties. The specialty of endodontics is referral-based and the endodontist should be willing to reach out to his or her referring doctors. The doctor should be approachable and willing to share his or her experience. Your

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endodontic specialist should be an education resource to you, his or her referring doctor. While it might seem obvious, the lack of communication between general dentist and specialist can often have unforeseen consequences.

For the general practitioner, part of creating a good relationship with the specialist is not to just send them cases when something goes wrong, such as perforations or broken instruments. It really does help to refer these difficult cases before you start definitive treatment. It is also wise to be honest. As we like to say, "Don't deceive your attorney and don't try to deceive your specialist." If you break an instrument or think you might have ledged a canal, inform them in advance. It makes it easier for endodontists if they know what's going on when they initiate treatment and they are going to discover the truth during the course of treatment anyway. Being up front and honest accomplishes a better relationship between both parties based on trust. The establishment of trust is the foundation on which all referrals are based.

The relationship between the general practitioner and the endodontist is indeed special and to summarize this, we asked Dr. Jerry Cymerman, an endodontist with more than 25 years of experience, to comment:

The general practitioner and the endodontist must realize that they are on the same team. The endodontist really must be seen as an educational resource, not just as a clinician, and it can be very constructive if the specialist can help the general dentist do the straight-forward cases in the best manner possible. I also believe that the endodontist needs to be on the same frequency as his referring doctor, when it comes to restorative needs. In fact, I have a referring doctor who wants me to do all the necessary things required, so that when the case is returned to him, it is (in his words) 'ready to go.' I cannot recommend strongly enough that the general dentist needs to communicate their restorative needs to the specialist, before the root canal is initiated.

As has been previously stated, endodontic diagnosis can be a real challenge for even the most experienced dentists. I also recommend the AAE Case Difficulty Assessment Form as a guide in case selection for the general dentist. This form, as well as other information on endodontics, is available on the American Association of Endodontists Web site (www.aae.org). When the case is beyond the scope of general practitioners, the endodontist has the experience and technology to provide exceptional treatment. We use cone beam computer tomography in our office to aid in diagnosis and treatment. This technology is extremely useful in the diagnosis of lesions not apparent on two-dimensional radiographs, in evaluating traumatic injuries, root resorption, root fractures, previously treated cases and patients scheduled for periapical surgery. Our goal is to preserve the natural dentition and to assist the general dentist in treatment planning.

The general dentist-endodontist relationship is a relationship based completely on trust and the knowledge that the ultimate goal is the same for each party – superb treatment of the patient. ■

Author Bios

Dr. Dennis Brave is a diplomate of the American Board of Endodontics, and a member of the College of Diplomates. Dr. Brave received his DDS degree from the Baltimore College of Dental Surgery, University of Maryland and his certificate in endodontics from the University of Pennsylvania. He is an Omicron Kappa Upsilon Scholastic Award Winner and a Gorgas Odontologic Honor Society Member. In endodontic practice for more than 25 years, he has lectured extensively throughout the world and holds multiple patents, including the VisiFrame. Formerly an associate clinical professor at the University of Pennsylvania, Dr. Brave currently holds a staff position at The Johns Hopkins Hospital. Along with having authored numerous articles on endodontics, Dr. Brave is a co-founder of Real World Endo.

Dr. Kenneth Koch received both his DMD and certificate in endodontics from the University of Pennsylvania School of Dental Medicine. He is the founder and past director of the new program in postdoctoral endodontics at the Harvard School of Dental Medicine. Prior to his endodontic career, Dr. Koch spent 10 years in the Air Force and held, among various positions, that of Chief of Prosthodontics at Osan AFB and Chief of Prosthodontics at McGuire AFB. In addition to having maintained a private practice, limited to endodontics, Dr. Koch has lectured extensively in both the United States and abroad. He is also the author of numerous articles on endodontics. Dr. Koch is a co-founder of Real World Endo.