Apical Morphology of the Palatal Roots of Maxillary Molars by Using Micro–Computed Tomography

Lindsey Meder-Cowherd, DDS, Anne E. Williamson, DDS, MS, William T. Johnson, DDS, MS, Dragos Vasilescu, MS, Richard Walton, DMD, MS, and Fang Qian, PhD

Abstract

Introduction: The apical constriction (AC) has been a traditional landmark as an end point of canal preparation and obturation. However, the morphology and incidence of this structure have not been definitively determined. The purpose of this study was to determine these factors by using a noninvasive technology, micro–computed tomography. Methods: Forty extracted maxillary molar palatal roots were separated and mounted. Each root was scanned with micro–computed tomography. Slices from the scan were computer reconstructed by using special software. This rendered each root three-dimensionally “transparent.” Roots were rotated, and the apical canal region was selected. In 2 sessions, trained evaluators identified the AC as to (1) presence (single and tapered) or (2) absence (flaring, parallel, and delta). Evaluator agreement was assessed by Cohen’s kappa. Descriptive frequencies were determined for apical constriction presence and morphology. Results: Interagreement and intra-agreement of evaluators were good. In regard to frequency of occurrence, most (65%) canals did not demonstrate an AC. The morphology, in order of most to least, was parallel 35%, single 19%, flaring 18%, tapering 15%, and delta 12%. Conclusions: From the noninvasive evaluation of our sample it was concluded that an AC was usually not present and that this apical canal region was variable. If this is true with other tooth groups, the AC should not be used as an anatomical marker for preparation and obturation. (J Endod 2011;37:1162–1165)

Key Words

Apical constriction, micro-computed tomography, palatal root

The morphology of the apical third of the root canal system is complex. This is a critical area to appropriately clean, shape, and adequately seal. Although the apical morphology of canals varies, an overall understanding of common anatomies of this area is helpful to better understand the requirements necessary for treatment (1). Different methodologies have been used to study apical canal anatomy. The most used technique has been to expose the apical few millimeters of the canal system by grinding and then examining with a light dissecting microscope (1–4) or with the scanning electron microscope (5). Variations in anatomy were reported within and between these studies.

In 1955 in a frequently quoted classic report, Kutltler (2) examined a large number of apical regions. He apparently introduced the term apical constriction, meaning the point close to the apical foramen at which the canal was of the smallest diameter, reportedly an average of approximately 1 mm from the root apex. This apical constriction has been widely accepted and presumed to be the best location to clean and shape and to obturate (5). The important location for the constriction would be within the apical 3 mm; this is the preferred area to prepare and to obturate the canal (6).

Other investigators (3, 4) had similar findings as Kutltler (2), but with variations. Dummer et al (3) approached their analyses with the assumption that a constriction was present; they characterized and identified different shapes and distances and numbers of constrictions, including some canals with an absence of a most narrow point. Although the above studies presented interesting findings and variations, they have a common problem, lack of three-dimensional (3D) examinations. Grinding and then examining only 1 surface gives perspective of only 2 dimensions of a 3D object. What appears to be the anatomy in one plane will give very different perspectives in other planes. In addition, the action of grinding to expose a tiny canal might alter the structural anatomy, resulting in an inaccurate representation.

The universal presence of a constriction in the apical region is questionable. Studies (2, 3) that described this region in detail approached their analysis from a standpoint that there is always a constriction or “minor diameter.” However, at least in one report (3), some of the descriptions could be interpreted as no constriction, that is, flaring and parallel. The frequency of occurrence of the apical constriction is yet to be clarified.

Very sophisticated technology, micro–computed tomography (micro-CT) scanning, has been applied in endodontic anatomical research (7). This method of examination renders the root “transparent,” allows a 3D interpretation, and also gives a less altered view of the constrictions, because no sectioning is necessary to evaluate apical canal morphology.
**Objectives**

The purpose of this study was to noninvasively apply micro-CT to characterize the apical canal morphology of the palatal roots of maxillary molars. Reconstructed 3D micro-CT demonstrates the nature of the apical canal anatomy and the presence or absence, as well as the shape and location (when present), of these constrictions. Specifically determined were (1) the incidence of the occurrence of an apical constriction and, when present, and (2) the morphology of the constriction.

**Materials and Methods**

**Materials**

Forty recently extracted maxillary first and second molars were used. No demographic information was available relative to these teeth. The teeth were stored in a mixture of water and thymol. The teeth were soaked in 6% sodium hypochlorite for 30 minutes for surface disinfection and soft tissue removal. The palatal root of each was then sectioned approximately 10 mm from the apex with a diamond separating disk.

**Methods**

The roots were prepared for micro-CT scanning. Each was placed on a Styrofoam base with horizontal orientation, 4 to a row. A Styrofoam cover matching the dimensions of the base was taped over the base to sandwich all roots and eliminate risk of dislodgement during each scan. A 4 × 4 cm area was available for each scan, allowing 8 roots per scan. The Micro-CAT II (Siemens Pre-Clinical, Knoxville, TN) micro-CT scanner was used for a total of 5 scans. After all scans were complete, individual slices were cropped by using MatLab (The MathWorks, Inc, Natwick, MA). 3D image processing of the cropped slices was performed by using Analyze (AnalyzeDirect, Inc, Overland Park, KS) and Image J (National Institutes of Health, Bethesda, MD) computer programs. The processing steps included basic thresholding of the images and adjacent 3D surface rendering.

By computer reconstruction, the roots were rendered transparent; therefore, both the root surface and the canal were visible. Each root was rotated. One investigator selected the plane of apical one-third that was most representative in both a mesial/distal and a buccal/lingual dimension.

**Evaluation**

Examinations of the apical constriction morphology were performed by 5 trained endodontists. Each evaluator underwent a calibration session to standardize examining methods. A Microsoft Power Point (Microsoft Corp, Redmond, WA) presentation included buccal/lingual and mesial/distal views of each tooth to be evaluated. Each endodontist viewed the 40 teeth at 2 separate sessions to assess intrarater agreement. Evaluators were asked to choose from 5 different shapes to categorize the constriction morphologies of each buccal/lingual and mesial/distal view: single constriction, tapering, flaring, parallel, or delta (Fig. 1). Horizontal red lines were imposed in the apical region (approximately 1–3 mm) where a constriction might or might not be present. These were the areas analyzed.

To provide data for statistical analysis, evaluators examined and categorized the morphology between the red lines. The data were subdivided into (1) presence (single and tapering) or (2) absence (flaring,

![Figure 1](https://example.com/figure1.png)

Figure 1. (A) Single constriction; (B) tapering; (C) flaring; (D) parallel; (E) delta.
Download English Version:


Download Persian Version:

https://daneshyari.com/article/3148990

Daneshyari.com