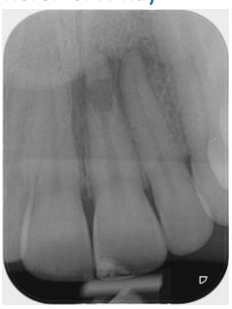
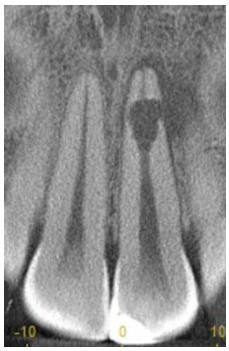
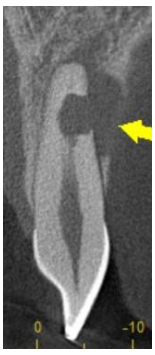
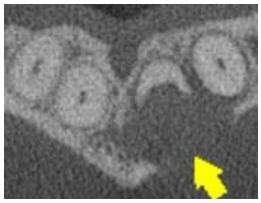
21st July 2023

To Dr XXXX – Via Email

Would you please arrange for Dr Irene Soriano to see XXXX for diagnosis and treatment of the UL1 which is non-vital and has root resorption. He gets married in 6 week and needs this tooth treated before then.

Re: Mr XXXXX– DOB: 1991.

Thank you for asking us to see Mr XXXX. Your patient was seen for a consultation and the observations are listed below.

Tooth	UL1
Presenting Issue/s	XXXX gave a history of two trauma accidents related to his UL1. The first one was at the age of 18 when he fell onto the floor. As a consequence of this accident the UL1 chipped, and it was restored with a composite filling. The second trauma happened approximately one year ago, with a similar pattern. He fell onto the floor and the UL1 was chipped again on the same area. XXX has had no pain or symptoms related to this tooth until recently he noticed an abscess on the gum related to this tooth. Referrer X-Ray 
Examination/ Tests	Clinically, the composite filling on the mesial incisal edge of the UL1 was confirmed. This tooth was slightly dark yellow discoloured. The UR2, UR1 and UL2 were unrestored. Pre-op Clinical Pic  Specific tooth examination of the UR2, UR1, UL1 and UL2 revealed that they were not tender to finger pressure, percussion, or palpation of the adjacent soft tissues. There was a soft erythematous swelling on the buccal alveolar mucosa adjacent to the UL1. There were no obvious periodontal probing defects noted. Sensitivity tests revealed the UL1 was the only tested tooth unresponsive to Endo-Ice and electric pulp testing (EPT).
CBCT Report Radiography	Scan Slices  UR1-UL1  UL1  UR2-UL2 axial view UR2, UR1 and UL2. The UL1 had an irregular oval radiolucency continuous with the root canal space on the apical root third. It had perforated the buccal aspect of the root at that level and there was an associated buccal and lateral radiolucency that had perforated the buccal cortical plate. This image was consistent with internal root resorption. There was no obvious pulpal or periapical pathosis related to the
Diagnosis	Pulp necrosis and internal root resorption UL1. The clastic cell action was most likely related to one of the traumas XXXj had had in the past. Once the tooth became necrotic the resorptive process ceased.

Suggested Tx Plan	Treatment options were discussed. Conventional root canal treatment won't be able to efficiently clean the resorption defect and seal the perforated buccal aspect of the root. I discussed the case with Richard, and he proposed a 'through and through' apical surgery for the UL1. It was explained to XXX that this is a small surgical procedure that we usually carry out under local anaesthesia. It is not usually more bothersome than the original root canal treatment although we do place a couple of stitches at the end which require removal 7 days later, and there is a greater likelihood of some swelling and puffiness around the area for a few days. The discomfort will usually be well controlled by routine painkillers. Prognosis for the surgical procedure is considered fair/good. XXX's other option would be to simply extract the tooth and consider an implant replacement (which might require a bone graft), dental bridge or removable partial denture.
Next Stage	XXX understood his options and he agreed to go ahead with the apical surgery on the UL1. He would contact us shortly after his wedding and honeymoon to organise the appointment for this procedure.

Many thanks again for this kind referral and I will keep you updated of the patient's progress.

Kind regards,

Irene

Irene Soriano MSc
Masters Graduate in Endodontics
Academy of Advanced Endodontics

Scan Link -