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Trevor Burke

A new look at the diagnosis of pulpitis

The diagnosis of pulpitis has remained static for what seems like centuries, namely, that a diagnosis of irreversible pulpitis leads to treatment by extraction or by root canal filling, with the latter allowing the tooth to be retained, but with the requirement of a (potentially expensive) cusp coverage restoration. It was fortuitous that my attention was drawn to a recent paper[1] shortly after I saw a lower molar tooth which, to all intents and purposes appeared non-vital, but which had one vital root canal. In this paper, a group of pre-eminent endodontists propose a new classification which, somewhat perversely, will reduce the number of root canals that they will need to fill but questioning whether the term 'irreversible' should continue to be used. Given that only a small proportion of readers of *Dental Update* will have access to the journal in which this was published (*International Dental Journal*), I will precis the findings from the paper for readers.

The paper provides evidence from new research on vital pulp therapy, facilitating a new biologically driven treatment protocol. Results of a histological study, by Ricucci and co-workers,[2] indicated good correlation between clinical symptoms of pulpitis and the histological state of the pulp. This study suggested that the radicular pulp could be retained when a pulpotomy procedure was carried out, with the result being a less invasive endodontic procedure which has been termed 'Endolight', or Indirect Pulp Treatment (IPT), *aka*, coronal pulpotomy. This is obviously less invasive than a conventional root filling, with the cost and inconvenience to the patient being reduced as a result.

The authors propose a new classification, namely, mild pulpitis (treated using IPT), moderate pulpitis (treatment – coronal pulpotomy), and severe pulpitis (treatment – coronal pulpotomy). The latter group is the most difficult: the authors suggest that the pulp stumps are covered with MTA in mature teeth but, if bleeding continues, it is suggested that more inflamed pulp tissue is removed, up to 3 to 4 mm from the radiographic apex. If bleeding ceases, then the root canal(s) are filled with gutta percha and sealer to this working length, but if bleeding persists, then a full pulpectomy is indicated.

This new approach is minimally invasive and maintains the viability of as much pulp tissue as possible. It saves tooth structure and may therefore improve survival of affected teeth, as they will be less weakened structurally and, at the same time, saving time and cost for the patient and/or third party insurers and also reducing the time and discomfort for the patient.

My questions? Is the only person who could carry out the treatment above successfully a specialist endodontist with an operating microscope? I am advised that this is not the case. In other words, has this admirable new concept been developed to a stage where general dentists (worldwide) will be able to revise their treatment strategies on an everyday basis? I am advised that this will shortly be the case.

Fortunately, I have just received confirmation that the authors of the paper proposing this change in classification have agreed to explore this concept further in a future issue of *Dental Update*, so that I and the readership will be aware of this new look in the diagnosis of pulpitis and how to treat it.

References

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