

Forging Effective Alliances for Quality Patient Care

How Endodontists and General Dentists Can Build Successful Partnerships

Complementary Skills

Properly cultivated partnerships between endodontists and general practitioners can lead to powerful, mutually beneficial relationships that strengthen both practices. More importantly, these collaborations ensure that patients receive the best possible care.

According to a recent American Association of Endodontists (AAE) study, in the United States endodontists perform more than a quarter of all root canal treatments each year.

While general practitioners perform the majority of root canal treatments, they often rely on the expertise of endodontists for procedures that exceed their training or comfort level. This practice allows general dentists more time for other procedures and enhances their relationship with patients by improving patient satisfaction.

"When I used to do endodontic treatments, I did a really good job, but I was slow as molasses," says Jeff Chamberlain, D.D.S., of Santa Rosa, Calif. "I'm always impressed with my endodontist because he can do the procedures two to three times faster. He's helpful because my patients don't think of root canals as a big deal. They're in his chair for an hour or so and they leave happy. Referring my endodontic cases frees up my time to do things I'm more effective at."

On average, endodontists perform nearly 25 root canal treatments a week, while general practitioners perform less than two. This familiarity with the procedure, combined with endodontists' advanced training in endodontics, expertise in achieving anesthesia, and adoption of technologies, such as digital imaging and operating microscopes, makes them more adept at handling difficult endodontic cases.

"A great deal of the success of my practice is due to endodontists with whom I've cultivated relationships," says Stephen D. Davis, D.D.S., of Santa Rosa, Calif. "I've never been comfortable with endodontics and don't perform the procedures. It's so different from general dentistry, where vision and access are key. To me, endodontics is like working in a closet with the lights turned off."

Availability Is Essential

For the sake of patients, it's best for general practitioners to initiate and build relationships with endodontists prior to the need for referrals, so delays in treatment are kept to a minimum. "If a patient is in pain, I'll want him or her seen right away," says Robert Huot, D.D.S., of Framingham, Mass. "I would prefer that if it isn't an emergency case, the office would see the patient within a few days, depending on the patient's schedule."

Fortunately, most endodontists offer tremendous flexibility in accommodating emergency cases, because they realize its importance to their continued success. "We respond to our top referrers immediately, no matter the time of day," says endodontist Shepard Goldstein, D.M.D., of Framingham, Mass. "The awkwardness occurs when we hear from a dentist only a few times a year, always at a strange hour, and every case is an emergency." A strong relationship between an endodontist and general practitioner can prevent these situations and best meet the needs of patients in pain.

To Refer or Not to Refer?

The decision that has the greatest impact on the quality of patient care during endodontic treatment is the decision whether or not to refer. To prevent treatment errors that cause patients unnecessary complications, the AAE has developed a Case Difficulty Assessment Form, available on the AAE Web site at www.aae.org, that helps general dentists catalogue and characterize cases prior to treatment.

"The dentists who consistently refer patients to a specialist don't find themselves in emergency situations – it just doesn't happen," says endodontist James Abbott, D.D.S., M.S., of Santa Rosa, Calif. "The Case Difficulty Assessment Form is a valuable tool to help dentists decide whether a referral should be made."

When the practitioner determines that a referral is in the patient's best interest, it should be made as quickly as possible to minimize the likelihood of complications such as pain or swelling associated with untreated endodontic pathosis.





Guidelines for Using the AAE Endodontic Case Difficulty Assessment Form

The AAE designed the Endodontic Case Difficulty Assessment Form for use in endodontic curricula. The Assessment Form makes case selection more efficient, more consistent and easier to document. Dentists may also choose to use the Assessment Form to help with referral decision making and record keeping.

Conditions listed in this form should be considered potential risk factors that may complicate treatment and adversely affect the outcome. Levels of difficulty are sets of conditions that may not be controllable by the dentist. Risk factors can influence the ability to provide care at a consistently predictable level and impact the appropriate provision of care and quality assurance.

The Assessment Form enables a practitioner to assign a level of difficulty to a particular case.

LEVELS OF DIFFICULTY

MINIMAL DIFFICULTY	Preoperative condition indicates routine complexity (uncomplicated). These types of cases would exhibit only those factors listed in the MINIMAL DIFFICULTY category. Achieving a predictable treatment outcome should be attainable by a competent practitioner with limited experience.
MODERATE DIFFICULTY	Preoperative condition is complicated, exhibiting one or more patient or treatment factors listed in the MODERATE DIFFICULTY category. Achieving a predictable treatment outcome will be challenging for a competent, experienced practitioner.
HIGH DIFFICULTY	Preoperative condition is exceptionally complicated, exhibiting several factors listed in the MODERATE DIFFICULTY category or at least one in the HIGH DIFFICULTY category. Achieving a predictable treatment outcome will be challenging for even the most experienced practitioner with an extensive history of favorable outcomes.

Review your assessment of each case to determine the level of difficulty. If the level of difficulty exceeds your experience and comfort, you might consider referral to an endodontist.

The AAE Endodontic Case Difficulty Assessment Form is designed to aid the practitioner in determining appropriate case disposition. The American Association of Endodontists neither expressly nor implicitly warrants any positive results associated with the use of this form. This form may be reproduced but may not be amended or altered in any way.

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AAE Endodontic Case Difficulty Assessment Form

CRITERIA AND SUBCRITERIA	MINIMAL DIFFICULTY	MODERATE DIFFICULTY	HIGH DIFFICULTY
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A. PATIENT CONSIDERATIONS

MEDICAL HISTORY	<input type="checkbox"/> No medical problem (ASA Class 1*)	<input type="checkbox"/> One or more medical problems (ASA Class 2*)	<input type="checkbox"/> Complex medical history/serious illness/disability (ASA Classes 3-5*)
ANESTHESIA	<input type="checkbox"/> No history of anesthesia problems	<input type="checkbox"/> Vasoconstrictor intolerance	<input type="checkbox"/> Difficulty achieving anesthesia
PATIENT DISPOSITION	<input type="checkbox"/> Cooperative and compliant	<input type="checkbox"/> Anxious but cooperative	<input type="checkbox"/> Uncooperative
ABILITY TO OPEN MOUTH	<input type="checkbox"/> No limitation	<input type="checkbox"/> Slight limitation in opening	<input type="checkbox"/> Significant limitation in opening
GAG REFLEX	<input type="checkbox"/> None	<input type="checkbox"/> Gags occasionally with radiographs/treatment	<input type="checkbox"/> Extreme gag reflex which has compromised past dental care
EMERGENCY CONDITION	<input type="checkbox"/> Minimum pain or swelling	<input type="checkbox"/> Moderate pain or swelling	<input type="checkbox"/> Severe pain or swelling

B. DIAGNOSTIC AND TREATMENT CONSIDERATIONS

DIAGNOSIS	<input type="checkbox"/> Signs and symptoms consistent with recognized pulpal and periapical conditions	<input type="checkbox"/> Extensive differential diagnosis of usual signs and symptoms required	<input type="checkbox"/> Confusing and complex signs and symptoms: difficult diagnosis <input type="checkbox"/> History of chronic oral/facial pain
RADIOGRAPHIC DIFFICULTIES	<input type="checkbox"/> Minimal difficulty obtaining/interpreting radiographs	<input type="checkbox"/> Moderate difficulty obtaining/interpreting radiographs (e.g., high floor of mouth, narrow or low palatal vault, presence of ton)	<input type="checkbox"/> Extreme difficulty obtaining/interpreting radiographs (e.g., superimposed anatomical structures)
POSITION IN THE ARCH	<input type="checkbox"/> Anterior/premolar <input type="checkbox"/> Slight inclination (<10°) <input type="checkbox"/> Slight rotation (<10°)	<input type="checkbox"/> 1st molar <input type="checkbox"/> Moderate inclination (10-30°) <input type="checkbox"/> Moderate rotation (10-30°)	<input type="checkbox"/> 2nd or 3rd molar <input type="checkbox"/> Extreme inclination (>30°) <input type="checkbox"/> Extreme rotation (>30°)
TOOTH ISOLATION	<input type="checkbox"/> Routine rubber dam placement	<input type="checkbox"/> Simple pretreatment modification required for rubber dam isolation	<input type="checkbox"/> Extensive pretreatment modification required for rubber dam isolation
MORPHOLOGIC ABERRATIONS OF CROWN	<input type="checkbox"/> Normal original crown morphology	<input type="checkbox"/> Full coverage restoration <input type="checkbox"/> Porcelain restoration <input type="checkbox"/> Bridge abutment <input type="checkbox"/> Moderate deviation from normal tooth/root form (e.g., taurodontism, microdens) <input type="checkbox"/> Teeth with extensive coronal destruction	<input type="checkbox"/> Restoration does not reflect original anatomy/alignment <input type="checkbox"/> Significant deviation from normal tooth/root form (e.g., fusion, dens in dente)
CANAL AND ROOT MORPHOLOGY	<input type="checkbox"/> Slight or no curvature (<10°) <input type="checkbox"/> Closed apex <1 mm diameter	<input type="checkbox"/> Moderate curvature (10-30°) <input type="checkbox"/> Crown axis differs moderately from root axis. Apical opening 1-1.5 mm in diameter	<input type="checkbox"/> Extreme curvature (>30°) or S-shaped curve <input type="checkbox"/> Mandibular premolar or anterior with 2 roots <input type="checkbox"/> Maxillary premolar with 3 roots <input type="checkbox"/> Canal divides in the middle or apical third <input type="checkbox"/> Very long tooth (>25 mm) <input type="checkbox"/> Open apex (>1.5 mm in diameter)
RADIOGRAPHIC APPEARANCE OF CANAL(S)	<input type="checkbox"/> Canal(s) visible and not reduced in size	<input type="checkbox"/> Canal(s) and chamber visible but reduced in size <input type="checkbox"/> Pulp stones	<input type="checkbox"/> Indistinct canal path <input type="checkbox"/> Canal(s) not visible
RESORPTION	<input type="checkbox"/> No resorption evident	<input type="checkbox"/> Minimal apical resorption	<input type="checkbox"/> Extensive apical resorption <input type="checkbox"/> Internal resorption <input type="checkbox"/> External resorption

C. ADDITIONAL CONSIDERATIONS

TRAUMA HISTORY	<input type="checkbox"/> Uncomplicated crown fracture of mature or immature teeth	<input type="checkbox"/> Complicated crown fracture of mature teeth <input type="checkbox"/> Subluxation	<input type="checkbox"/> Complicated crown fracture of immature teeth <input type="checkbox"/> Horizontal root fracture <input type="checkbox"/> Alveolar fracture <input type="checkbox"/> Intrusive, extrusive or lateral luxation <input type="checkbox"/> Avulsion
ENDODONTIC TREATMENT HISTORY	<input type="checkbox"/> No previous treatment	<input type="checkbox"/> Previous access without complications	<input type="checkbox"/> Previous access with complications (e.g., perforation, non-negotiated canal, ledge, separated instrument) <input type="checkbox"/> Previous surgical or nonsurgical endodontic treatment completed
PERIODONTAL-ENDODONTIC CONDITION	<input type="checkbox"/> None or mild periodontal disease	<input type="checkbox"/> Concurrent moderate periodontal disease	<input type="checkbox"/> Concurrent severe periodontal disease <input type="checkbox"/> Cracked teeth with periodontal complications <input type="checkbox"/> Combined endodontic/periodontic lesion <input type="checkbox"/> Root amputation prior to endodontic treatment

*American Society of Anesthesiologists (ASA) Classification System

Class 1: No systemic illness. Patient healthy.
 Class 2: Patient with mild degree of systemic illness, but without functional restrictions, e.g., well-controlled hypertension.
 Class 3: Patient with severe degree of systemic illness which limits activities, but does not immobilize the patient.

Class 4: Patient with severe systemic illness that immobilizes and is sometimes life threatening.
 Class 5: Patient will not survive more than 24 hours whether or not surgical intervention takes place.

www.asahq.org/clinical/physicalstatus.htm



Reading List

ENDODONTICS: COLLEAGUES FOR EXCELLENCE, SPRING/SUMMER 2005

Endodontic Case Difficulty Assessment and Referral

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