

Endodontic Stabilizers

Endoimplants may be good solutions in some dental traumatic cases. However, like every implant, they have many difficulties. Epithelial down-growth and ultimately loosening is the primary defect of implants. However, many alternative therapy methods provide better options.

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For example, when constructing a prosthetic bridge it is wise to prevent a risky operation with a guarded prognosis. In some circumstances, due to patients' demands, we must try to find a therapy that we know only has a limited amount of success. This is the point where endoimplants are useful.

A child with a fractured maxillary central incisor at mid root due to a car accident is faced with one of the most serious treatment plans in the endodontic field. Losing this important tooth may cause the child psychological, aesthetic and phonetic problems in the future. Indeed, constructing a permanent prosthetic is not indicated and using a removable partial denture may be more difficult. Many endoimplant failures cannot be blamed on the therapy chosen, but rather because the implants were overused and misused in cases where their applicability and indications were largely ignored.

The endodontic stabilizer used to solve periodontal problems has proved to be a solution with a low percentage of success, and thus its use is now virtually obsolete.

According to Weine, among the fifty or more implants that he placed 15–22 years ago for periodontal reasons, only one still remains functional. This fact alone stresses one of the most important steps in endoimplant procedures—case selection. It requires that critical information be gathered and evaluated for each case in order to determine whether endoimplants are the best solution.

Case Presentation

A 12-year-old boy presented with a crown fracture in both his maxillary central incisors and some degree of tooth mobility which were the result of a past accident.

On a periapical radiograph, a horizontal root fracture at mid root in his left maxillary central incisor and also root resorption in the apical portion of his right maxillary central incisor were observed (Fig. 1).

Rigid fixation with arch bar and wires were applied for more than two months. Endodontic therapies were used for the maxillary central incisors. After removal of fixation, the right maxillary central had grade II mobility, and a wide radiolucent band between the root pieces was seen. The coronal segment of the right maxillary central incisor was obturated with lateral condensed gutta-percha.

Periapical surgery for removal of the apical segment of the right maxillary central was planned because of its necrotic pulpal contents and persistence of periapical infection.

Because of great mobility in the coronal segment, some type of endoimplant was mentioned, and a chrome-cobalt pin was selected. During one appointment, the canal of the right maxillary incisor was prepared in such a way to allow direct access to the apical tissue. The access was placed labially as far as possible for this direct line of access.

The apical portion of the coronal segment, which was the place where the chrome-cobalt pin exited from the root, was prepared with reamers in order to produce a round preparation that is more suitable in such cases. The length of the chrome-cobalt pin was designed so that 7–12 mm of its length would be placed in osseous tissue and 5–7 mm in the root canal. Such an endoimplant must be nonelectrolytic, inert, and have excellent tissue tolerance. After preparation under local anaesthesia, the surgical procedure began. A sulcular full thickness flap was designed. A window in the osseous tissue was opened in or-

