

Provided by Dentistry for Children

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THE PEDIATRIC DENTAL REPORT

Your source for pediatric dentistry news



Primary tooth pulp involvement: Extraction is the last choice.

There is a large pool of approaches for addressing a distressed pulp in a primary tooth. A provider's training, clinical experience and scientific literature help mold one's treatment choices when considering options for pulp therapy.

There are still many who feel a fistula associated with a primary tooth, whether trauma or caries-related, means extraction. I posed the question to a group of pediatric dental residents one time on the best course of action for a primary tooth with a fistula. The universal response was "extraction." My next question was "Do you extract a permanent tooth with a fistula?" What difference does it make if it is a permanent or primary tooth with a compromised pulp associated with a fistula?

Primary teeth respond very well to pulp therapy even when associated with a large soft tissue swelling. The key to a

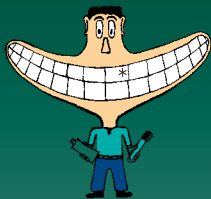
good outcome is whether or not root resorption is present. Even moderate root resorption is not a barrier to pulp therapy. The prognosis with a fully intact root for a successful procedure is approximately 95%. With root resorption, the success goes down. A provider can estimate, with enough clinical experience, a chance for success (80%, 50%, etc.) with varying degrees of root resorption present. This allows parents and pro-viders a framework in which to help, weighing the pros and cons of saving or extracting a particular tooth.

There is also a benefit to "buying time" with a low prognosis candidate if necessary. One scenario is if a second primary molar with a necrotic pulp and significant root resorption could help guide a 6 year molar into place. If the primary tooth can be stabilized with pulp therapy long enough, then a fully erupted 6 year molar is a candidate for a

lower lingual holding arch on full eruption. The alternative is to extract the second primary molar, construct and place a distal shoe, and then later convert to a second space maintainer (LLHA). Distal shoes are notoriously more complicated and sometimes hard to place in a pre-cooperative child.

We lean heavily in favor of pulp-ectomies for primary teeth needing pulp therapy. Pulpotomies generally have a higher failure rate for a variety of reasons. A pulpotomy is indicated for a tooth with inflammation just in the pulp chamber but not beyond. That can be very difficult to determine. In addition, the days of formocreasol are over. Several replacement techniques/material have been attempted over the years: Ferric sulfate, gluteraldehyde, calcium hydroxide, electro-cautery, etc. We prefer pulp

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extripation, irrigation with hydrogen peroxide, and filling with zinc oxide and eugenol. We frown upon the use of sodium hypochlorite for an intra-canal irrigant. There was a recent report of a very young child who had sodium hypochlorite used to intra-coronally flush necrotic tissue from maxillary incisors. The large pulp chamber and immature apices allowed for the irrigant to be forced through the teeth and into the fascial spaces resulting in rapid necrosis and hemorrhage of soft tissue beyond

the dentition. The child was transported to the hospital and was in the ICU for several days.

Providing pulp therapy as indicated in primary teeth can simplify treatment planning, maintain an intact dentition and limit a child's fear of "pulling teeth." An intact root is key to prognosis regardless of a history of pain, swelling of fistula.

As always, we are happy to provide guidance to any provider who has a question on options for care with their patients, either by phone or a direct referral. 



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