

Endodontic management of maxillary second molar with 2 palatal roots and root canals: A rare case report

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ABSTRACT

This case report presents the endodontic management of a maxillary second molar with 2 palatal roots, which have canals with separate orifices and apical foramen. The diagnosis was confirmed by the clinical and radiographic examination of the tooth. Root-canal treatment was performed using rotary instrumentation with Protaper files and obturated with corresponding protaper gutta percha cones and AH Plus sealer.

Key words

Maxillary second molar, root canal anatomy, 2 palatal roots

INTRODUCTION

The goal of root canal treatment is to clean the root canal system as thoroughly as possible and to fill it 3 dimensionally.^[1] In-depth knowledge of the root canal anatomy of each tooth is crucial in order to reach this goal.

The maxillary first molar most commonly has 3 or 4 canals, with 1 canal in both the palatal and distobuccal roots and 1 or 2 in the mesiobuccal root. The incidence of a mesiolingual canal has been reported between 18%^[2] and 96.1%^[3] (Hartwell and Bellizzi 1982, Kulild and Peters 1990). Cecic *et al.* (1982),^[4] Jacobsen and Nii (1994),^[5] and Stone and Stroner (1981)^[6] found cases of maxillary first molars, in which the palatal canal contained one orifice, a bifurcated canal, and 2 separate foramina. Beatty (1984)^[7] presented a case of a maxillary first molar with 5 canals, 3 of which were located in the mesiobuccal root. Bond *et al.* (1988)^[8] reported a case of a maxillary first molar with 6 canals: Two canals with separate foramina in the mesiobuccal root, 2 canals with separate foramina in the distobuccal root, and 2 canals joining in

the apical third of the palatal root. Hulsmann (1997)^[9] presented a maxillary first molar with 2 distinct canals in the distobuccal root. Slowey (1979)^[10] showed a case of a maxillary molar with 2 palatal canals and separate foramina. Martinez-Berna and Ruiz-Badanelli (1983)^[11] reported 3 cases of maxillary first molars with 6 canals: Three canals in the mesiobuccal root, 2 in the distobuccal root, and 1 in the palatal root and finally, Wong (1991)^[12] reported a case, in which the palatal root had a single canal orifice, a trifurcation in the apical third, and 3 separate foramina.

The frequency of 2 palatal roots is low; however, a few cases have been reported in the literature [Table 1]. Stone and Stroner (1981)^[6] reported variations of the palatal root of maxillary molars, such as a single root

Table 1: Reported canal configuration of maxillary first molar

Year	Author	Palatal root	Mesio-buccal root	Disto-buccal root
1979	Slowey	2	1	1
1979	Thews	2	1	1
1982	Cecic	2	2	1
1983	Martinez-Berna	1	3	2
1984	Beatty	1	3	1
1988	Bond	2	2	2
1991	Wong	3	1	1
1994	Jacobsen	2	1	1
1997	Hulsmann	1	1	2

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with 2 separate orifices, 2 separate canals and 2 separate foramina; 2 separate roots, each with 1 orifice, 1 canal and 1 foramen; single root with 1 orifice, a bifurcated canal and 2 separate foramina. Benenati (1985)^[13] reported a maxillary second molar with 2 palatal roots and a groove located in this side of the tooth. According to the author, this groove was the result of the formation of 2 palatal roots. Christie *et al.* (1991)^[14] analyzed endodontic treatment in 16 maxillary molars and of 6 extracted teeth with 2 palatal roots and classified these 22 molars into 3 types (I-III), according to the root separation level and their divergences. According to this same classification, Di Fiore (1999a,b)^[15,16] classified as type II : A case of a maxillary first molar with 4 independent roots. Anatomical variations can occur in maxillary permanent molars. Although not very common, Christie *et al.* (1991)^[14] speculated that maxillary molars with 2 palatal roots may be encountered once every 3 years in a busy endodontic practice. Peikoff *et al.* (1996)^[17] observed that 1.4% of maxillary molars might have second palatal roots.

The rarity of literature on this anatomical variation has led us to report this case of maxillary second molar with 2 palatal roots.

CASE REPORT

A 28-year-old Indian male patient presented with pain, both spontaneous and temperature related, on the right side of the face for several days. The patient's medical history was non-contributory. Clinically, the right maxillary second molar had a deep carious lesion. Electric pulp testing (Vitality Scanner; Analytic Technology, Glendora, CA) was indicative of irreversible pulp damage. The clinical diagnosis was irreversible pulpitis. A pre-treatment radiograph was taken, [Figure 1] and conventional coronal access was performed. The patient received local anesthesia of 2% lidocaine with 1:100,000 epinephrine. After removing pulpal tissues located in the pulp chamber, clinical evaluation of the internal anatomy revealed 3 principal root canal systems: MB, distobuccal (DB), and

palatal. After probing with a Hu-Friedy (Chicago, IL) DG 16 endodontic explorer, a small hemorrhagic point was noted near the orifice of the main palatal canal. A small amount of dentin that was occluding the orifice of the second palatal canal was removed with the help of Endo Access bur no. A0164 (Dentsply Maillefer, Ballaigues, Switzerland). The conventional triangular access was modified to a trapezoidal shape with the help of slow-speed diamond KGS3203 (Dentsply Maillefer) to improve access to the additional canal. The pulp was extirpated, and the appointment was then concluded. At the next visit, the working lengths of each canal were estimated by means of an electronic apex locator (Root ZX; Morita, Tokyo, Japan) and then confirmed by a radiograph [Figure 2]. The canals were initially instrumented with #15 nickel-titanium files (Dentsply Maillefer). Biomechanical preparation was done using the crown-down technique with rotary Protaper files (Dentsply/Maillefer, Ballaigues, Switzerland) attached to Xsmart endomotor (Dentsply/Maillefer, Ballaigues, Switzerland). Apical preparation was performed till F2. Canal preparation was accompanied with irrigation using 2.5% NaOCl and EDTA. Obturation was performed with the aid of corresponding Protaper gutta-percha cones (Dentsply/Maillefer, Ballaigues, Switzerland) and AH Plus sealer (Dentsply/Maillefer, Ballaigues, Switzerland). Final radiograph was taken to establish the quality of the obturation [Figure 3]. After completion of root canal treatment, the tooth was restored with a posterior composite filling (P60; 3M Dental Products, St Paul, MN).

Radiographs taken during treatment [Figure 2] showed 2 independent palatal roots, which were relatively broad, presenting 2 distinct foramina. This indicates a type II tooth, according to the classification of Christie *et al.* (1991).

DISCUSSION

Anatomical variations can occur in maxillary permanent molars. The tooth described in this case report had totally separated palatal roots, each with a distinct root



Figure 1: Pre-operative radiograph

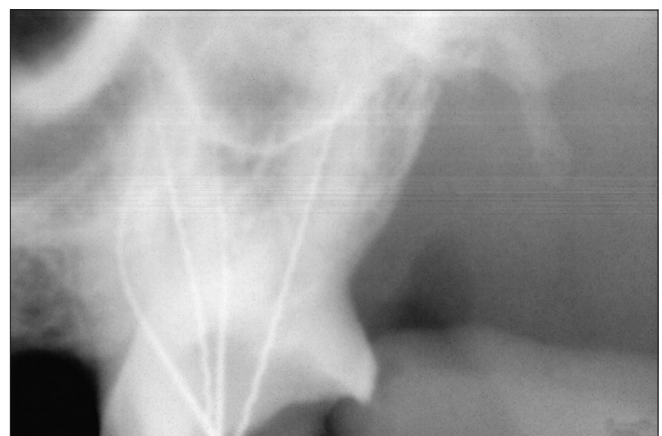


Figure 2: Working length radiograph

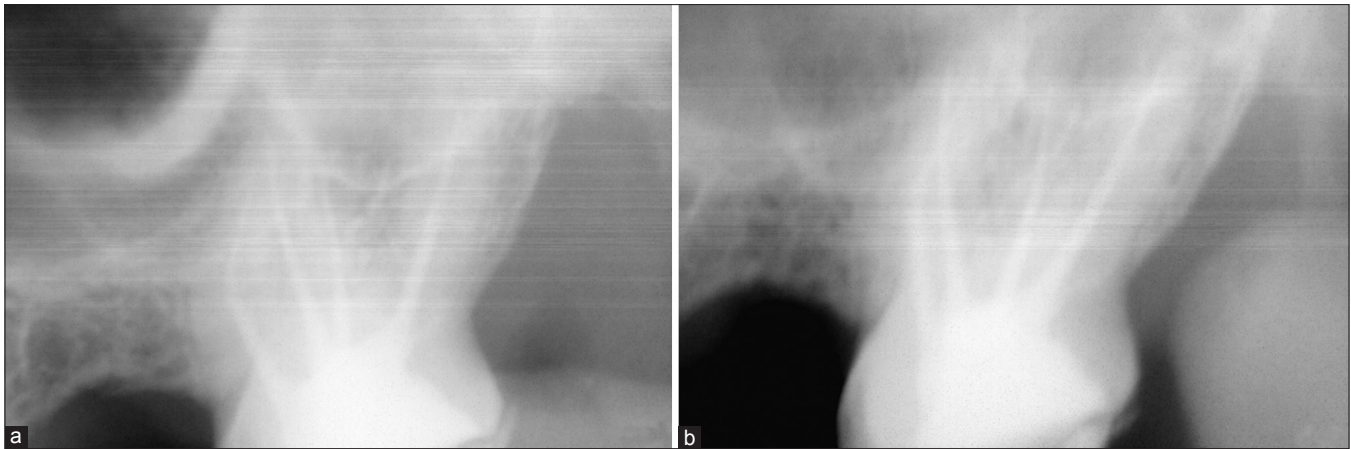


Figure 3: Post-operative radiographs (a) immediately after treatment, (b) after two months

canal. The majority of endodontic literature describes the maxillary molars as having 3 roots with 3 or 4 root canals.^[12] The prevalence of maxillary second molars with 2 palatal canals is rare. Also, literature is scarce regarding presence of 2 separate palatal roots, which have canals with separate orifices and separate foramen.

When indistinct images of palatal roots are presented in pre-operative X-ray images, the clinician must consider the possibility of 2 palatal roots. Dissociation of images must be performed and, if this anomaly is confirmed, a broad coronal access will allow the correct localization of root canals.^[18] Shape of pulp cavity is variable, making every treatment unique. Properly designed and prepared access cavities help the clinician to diagnose and negotiate the root canal morphology.^[19] In the presented case, a large access was required to locate the 2 palatal canals. The access cavity on maxillary molars exhibiting 2 palatal canals should be wider than usual on the palatal aspect. The access outline will be trapezoidal rather than triangular. In the current case, the 2 palatal orifices were also found to be well-developed and large. Treatment sequence and prognosis for molars with 2 palatal canals should be considered to be the same as those for any maxillary molar.^[20] A clinician should open his/her mind to the various possible canal morphologies and should not stick only to a limited and standard number of canal patterns. In certain conditions, the root canals might be left untreated during the endodontic therapy if the practitioner is unable to detect their presence. These undetected extra roots or root canals are a major reason for the failure of endodontic treatment.^[20] Hence, the ability to locate all the canals in the root canal system is an important factor in determining the eventual success of a case.

CONCLUSION

Anatomic variations can occur in any tooth, and maxillary second molar is no exception. Careful examination of radiographs and internal anatomy of teeth is essential. Although such cases occur infrequently, the clinician

should be aware of them when considering endodontic treatment of a maxillary first molar.

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