Endo-Perio Symbiosis

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Abstract

The interrelationship between endodontic and periodontal diseases has been a subject of speculation, confusion and controversy for many years. Pulpal and periodontal problems are responsible for more than 50% of tooth mortality today. An endo-perio lesion can have a varied pathogenesis which ranges from quite simple to relatively complex one. These lesions often present challenges to the clinician as far as diagnosis and prognosis of the involved teeth are concerned. It is very essential to make a correct diagnosis so that the appropriate treatment can be provided. To make a correct diagnosis the clinician should have a thorough understanding and scientific knowledge of these lesions and may need to perform restorative, endodontic or periodontal therapy, either singly or in combination to treat them. Therefore, this paper will highlight the diagnostic, clinical guidelines and decision making in the treatment of these lesions from an endodontists point of view to achieve the best outcome.

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Introduction

As clinicians we come across the term Endo-periodontal lesions. Endo-perio lesions are localized, circumscribed areas of bacterial infection that originates from either dental pulp or periodontal tissues surrounding the involved tooth/teeth or both. Dental pulp and periodontium both the tissues are interrelated from embryonic stage itself, as we know that precursors of both the tissues (dental papilla and dental follicle) have common mesodermal origin. In 1964, Simring and Goldberg (Simring et al., 1964) were the first one to describe the relationship between both the tissues.

Turner and Drew (Turner et al., 1919) in 1919 were the first one to describe the effect of diseases of periodontium on pulpal tissue. They validated that pulpal changes like fibrosis, calcification and cystic degeneration are induced by pyorrhoea (suppurative periodontitis). Reinforcing the opinion, Seltzer et al., (1963) reported that 94% of 85 periodontally involved extracted teeth exhibited pulpal changes such as inflammation, atrophy and even complete necrosis.

Sinnai and Soltanof (1973) along with Sharp (1977) also supported this opinion. Though few others reported that periodontal diseases either minimally or do not affect the pulpal tissue at all. They supported their opinion with a study conducted on white rats (Bergenholtz et al., 1978; Hettler et al., 1977).

Endodontic along with periodontal disease accounts for more than half of the tooth mortality. The various pathways through which microorganisms communicate between pulp and periodontal tissue are enumerated as (Mjör et al., 1996; Zehnder et al., 2002)

Anatomic/Developmental origin: These include apical foramen, auxillary /furcation canals and dentinal tubules.

Apical foramen is believed to be the main route of communication. The microorganisms, infection transmits
from pulp to periodontal tissue and vice-versa through foramen (Rotstein et al., 2004).

The S-shaped microscopic channels extending from outer dentin surface to pulp is known as dentinal tubules. Periodontal disease and various procedures of periodontal therapy, developmental grooves, gap joint at cemento-enamel junction can lead to exposure of dentinal tubules (Simon et al., 2000).

Our teeth have huge number of accessory/auxillary canals which act as potent pathway for spread of infection. De dues conducted a study on 1,140 teeth and reported that 27.4% of the teeth have auxiliary canals (De Deus et al., 1975).

Furcation area also has accessory canals which can range from 2% to 59% (Kirkham, 1975; Shobha et al., 1974).

Pathological origin: These include root fracture following trauma, idiopathic root resorption, loss of cementum due to irritants.

Iatrogenic origin: these include root fractures, root canal perforation.

Post preparation, over instrumentation can lead to root perforation which opens a pathway between pulp and periodontal tissue and can lead to poor prognosis of the tooth (Kerns et al., 2006; Kvinnsland et al., 1989).

Vertical root fracture is characterized by an incomplete or complete fracture line that extends through the long axis of the root toward the apex.

**Etiology**

The cause of endo-perio lesions can be divided into two categories, living and non living pathogens along with various contributing factors concisely tabulated below.
Microbiology of endo-perio lesions includes bacterial species like *Actinobacillus Actinomyces committans*, *Bacteroides forsythus*, *Ekinella corrodens*, *Fusobacterium nucleatum*, *Porphyromonas gingivalis*, *Prevotella intermedia* (Rupf et al., 2000). Also fungal species like *Candida albicans* (Hannula et al., 1997) are predominant in endodontic and periodontal lesions. Recently it has been found that Cytomegalovirus, EB virus, Herpes virus can also be the causative agents (Contreras et al., 2000).

**Classification**

In 1972, Simon et al., were the first one to classify endo-perio lesion based on diagnosis, prognosis and treatment

- Primary endodontic lesion
- Primary periodontal lesion
- Primary endodontic lesions with secondary periodontal involvement
- Primary periodontal lesion with secondary endodontic involvement
- True combined lesion

Guldener and Langeland gave a classification based on pathologic relationship (Guldener, 1982)

- Endodontic – periodontal lesion
- Periodontal – endodontic lesion
- Combined lesions

Endodontic and periodontal lesions commonly present with features like

- Swelling of gingiva
- Pus discharge
- Pocket formation
- Fistulous tract formation
- Tenderness to percussion (horizontal and vertical)
- Tooth mobility
- Bone resorption
- Periapical resorption

However it is difficult to distinguish between both the lesions, still there are few clinical features to help us in reaching a diagnosis as tabulated below:

In 1996, Torabinejad and Trope came with new classification from the treatment point of view

- Endodontic origin
- Periodontal origin
- Combined endo-perio lesions
- Separate endodontic and periodontal lesions
- Lesions with communication
- Lesions with no communication

Grossman's classification based on therapy is:

- Teeth that require only endodontic therapy
- Teeth that require only periodontal therapy
- Teeth that require endodontic as well as periodontal therapy

Rateitschak et al., gave a classification based on endodontic therapy

- Type I- primarily of endodontic origin and pulp is usually dead
- Type II-primarily periodontal disease which may affect pulp, and pulp is normal or sometimes damaged by ascending pulpitis
- Type III-combined case of root canal and periodontal disease and pulp is usually dead.

**Diagnosis**

The correct diagnosis can be made on the basis of patient history, hard and soft tissue examination, pulp vitality test, determining periodontal pocket depth.

The detailed description of diagnostic features for various types of endo-perio lesions is
Primary endodontic lesion

1. There is definite presence of large carious lesion/huge restoration/erosion/crack/poor endotreated tooth.
2. There is chance of presence of sinus tract opening.
3. Patient will experience sharp pain and there will be high mobility.
4. Tooth will be tender to percussion
5. Pulp vitality test will give negative or delayed response
6. Deep narrow solitary pocket
7. X-ray(IOPA) with gutta percha points to apex or furcation area in molars
8. Periapical radiolucency will be evident in radiograph
9. Pain on chewing, especially on release of biting pressure.

Primary periodontal origin

1. Gingival inflammation/recession around multiple tooth, plaque and sub gingival calculus, periodontal abscess.

Primary endodontic and secondary periodontal lesion

2. Pain on palpation
3. Localized to generalized mobility
4. Pulp vitality test is positive
5. Deep and wide multiple pockets
6. Sinus tract at lateral aspect of root
7. Generalized vertical bone loss
Primary periodontal and secondary endodontic lesion

1. Plaque, calculus and gingival inflammation around multiple teeth, localized/generalized recession exudates and pus
2. Tender on percussion
3. Generalized mobility
4. Vitality test may be positive in case of multi rooted tooth
5. Wide deep multiple periodontal pockets
6. Sinus tract at lateral aspect of root
7. Angular bone loss

True combined lesion

1. Plaque, calculus and periodontitis, swelling around single/multiple teeth
2. Dull ache but in acute conditions pain will be severe
3. Tender on percussion
4. Generalized mobility with high mobility of the involved tooth
5. Vitality test will give negative response. except in case of multi rooted tooth
6. At edge of swelling, probe suddenly drops till apex of the tooth. This swelling is characterized as “blown – out”

Results and Discussion

Endo perio lesions pose a challenge in our clinical practice. Dahlen et al., (2008) studied the microbiology of the lesion and they reported that diagnosis depends on vitality of the tooth. Kerekes and Olsen reported similarity in micro biota of root canal and periodontal pocket. Zehnder et al., study also affirmed this report.

Kurihara et al., (1995) analyzed endo- perio lesions microbiologically and immunologically and reported dissimilarity in micro flora of periodontal pocket and root canal. Also it was reported by Drucker et al., (1997) that Prevotella species found in root canal and periodontal pocket have association with pain and Bacteroides, Fusobacterium with pus exudates. Notwithstanding, Lin et al., (2007) demonstrated that combination of group of bacteria have no association with symptoms.

The management of endo-perio lesion requires both endodontic and periodontal treatment but it has to be done sequentially and it has to be taken care that cross infection does not happen. If both the treatment are indicated then endodontic treatment has to be done before periodontal therapy, as toxic material removal from canal will lead to improved soft tissue re-attachment and post periodontal therapy sensitivity and patient discomfort is also reduced.

The ideal interval between the endodontic treatment and periodontal surgery has also been challenged by controversial findings. It was reported that root canal treatment performed 2.5 months before periodontal surgery not to impair periodontal healing. Miranda et al., (2013) suggest that endodontic treatment performed 6 months before the surgical debridement of the furcation of mandibular molars did not impair the clinical parameters of periodontal healing (Perlmutter et al., 1987).

There has been lot of studies, case reports and publications done on endo- perio lesions and this review article was an attempt to give an insight of this topic.

References


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