An Unusual Dilacerated Root of a Second Maxillary Molar

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ABSTRACT

An unusual case of a second maxillary molar with a dilacerated root visible clinically is described. Apicectomy followed by retrograde amalgam filling was performed whereby gingival coverage and gingival seal was achieved.

INTRODUCTION

Dilaceration is an angulation, or sharp bend or curve in the root or crown of a formed tooth[1]. It can be seen in the maxillary central incisors when there is a disruption of the follicle of the developing teeth secondary to traumatic injury of the deciduous incisors[2]. The direction and degree of force appear to determine the extent of the dilaceration. The dilaceration may be present anywhere along the length of the tooth.

Some cases, however, cannot be related to traumatic injury and appear to be an idiopathic developmental disturbance[1]. A dilacerated tooth may not erupt properly because of its angulation[1,3]. A case is presented in which a dilacerated mesiobuccal root of a maxillary second molar was exposed clinically.

CASE REPORT

A 28-year-old Caucasian lady was referred to the Maxillofacial Unit with a complaint of intermittent pain and swelling associated with bony-like spicule on the gingiva buccal to her left maxillary second molar (27). There was no previous history of extraction at the site of complaint.

On intraoral examination, an immobile white hard mass was palpable on the gingiva buccal to 27. No associated swelling or discharge was detected and the surrounding gingiva was healthy. Electric vitality test of 27 was positive.

Figure 1: Pre-operative radiograph of 27 showing a shortened

An orthopantomogram and a periapical radiograph of 27 revealed a shortened mesial root of 27 but there was no abnormal opacity (Figure 1). A provisional diagnosis of a fenestrated root was made.

The area was explored under local anaesthesia. A mucoperiosteal flap was raised. The white mass was found to be the "U-shaped" dilacerated mesiobuccal root of 27 (Figure 2). Some granulation tissue surrounding the dilacerated root was removed. Apicectomy of the root was performed in order to ensure it being placed subgingivally after the closure of the flap. The open apex was sealed with a retrograde amalgam filling.

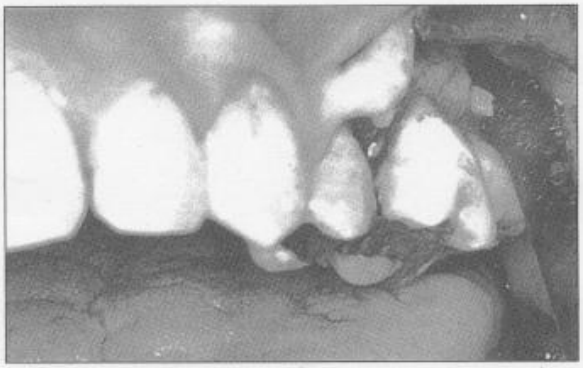

Figure 2: Intra-operative pnotograph showing the dilacerated root of 27.

Figure 3: Post-operative radiograph of 27 showing the retrograde amalgam filled root.

When reviewed two weeks later, the site had healed with complete mucosal coverage of the root. A post operative periapical radiograph showed a well placed retrograde amalgam filling (Figure 3). The tooth remained asymptomatic and the vitality test remained positive.

DISCUSSION

Dilaceration can occur in any tooth in the permanent dentition[1]. It is well recognised that dilaceration of central