



# AAE AND AAOMR JOINT POSITION STATEMENT

*The following statement was prepared by the Special Committee to Revise the Joint American Association of Endodontists/American Academy of Oral and Maxillofacial Radiology Position on Cone Beam-Computed Tomography, and approved by the AAE Board of Directors and AAOMR Executive Council in May 2015. AAE members may photocopy this position statement for distribution to patients or referring dentists.*

## USE OF CONE BEAM-COMPUTED TOMOGRAPHY IN ENDODONTICS 2015 UPDATE

### INTRODUCTION

This updated joint position statement of the American Association of Endodontists and the American Academy of Oral and Maxillofacial Radiology is intended to provide scientifically based guidance to clinicians regarding the use of cone beam-computed tomography in endodontic treatment and reflects new developments since the 2010 statement (1). The guidance in this statement is not intended to substitute for a clinician's independent judgment in light of the conditions and needs of a specific patient.

Endodontic disease adversely affects quality of life and can produce significant morbidity in afflicted patients. Radiography is essential for the successful diagnosis of odontogenic and nonodontogenic pathoses, treatment of the root canal systems of a compromised tooth, biomechanical instrumentation, evaluation of final canal obturation and assessment of healing.

Until recently, radiographic assessments in endodontic treatment were limited to intraoral and panoramic radiography. These radiographic technologies provide two-dimensional representations of three-dimensional anatomic structures. If any element of the geometric configuration is compromised, the image may demonstrate errors (2). In more complex cases, radiographic projections with different beam angulations can allow parallax localization. However, complex anatomy and surrounding structures can render interpretation of planar images difficult.

The advent of CBCT has made it possible to visualize the dentition, the maxillofacial skeleton, and the relationship of anatomic structures in three dimensions (3). CBCT, as with any technology, has known limitations, including a possible higher radiation dose to the patient. Other limitations include potential for artifact generation, high levels of scatter and noise and variations in dose distribution within a volume of interest (4).

CBCT should be used only when the patient's history and a clinical examination demonstrate that the benefits to the patient outweigh the potential risks. CBCT should not be used routinely for endodontic diagnosis or for screening purposes in the absence of clinical signs and symptoms. Clinicians should use CBCT only when the need for imaging cannot be met by lower-dose two-dimensional radiography.

### Volume Size(s)/Field of View

There are numerous CBCT equipment manufacturers, and several models are available. In general, CBCT is categorized into large, medium and limited-volume units based on the size of their "field of view." The size of the FOV describes the scan volume of CBCT machines. That volume determines the extent of anatomy included. It is dependent on the detector size and shape, beam projection geometry and the ability to collimate the beam. To the extent practical, FOV should only slightly exceed the dimensions of the anatomy of interest.

Generally, the smaller the FOV, the lower the dose associated with the study. Beam collimation limits the radiation exposure to the region of interest and helps ensure that an optimal FOV can be selected based on disease presentation.

Smaller scan volumes generally produce higher-resolution images. Because endodontics relies on detecting small alterations such as disruptions in the periodontal ligament space, optimal resolution should be sought (5).

The principal limitations of large FOV CBCT imaging are the size of the field irradiated and the reduced resolution compared to intraoral radiographs and limited-volume CBCT units with inherent small voxel sizes (5). The smaller the voxel size, the higher the spatial resolution. Moreover, the overall scatter generated is reduced due to the limited size of the FOV. Optimization of the exposure protocols keeps doses to a minimum without compromising image quality. If a low-dose protocol can be used for a diagnostic task that requires lower resolution, it should be employed, absent strong indications to the contrary.

In endodontics, the area of interest is limited and determined prior to imaging. For most endodontic applications, limited FOV CBCT is preferred to medium or large FOV CBCT because there is less radiation dose to the patient, higher spatial resolution and shorter volumes to be interpreted.

### **Dose Considerations**

Selection of the most appropriate imaging protocol for the diagnostic task must be consistent with the ALARA principles that every effort should be made to reduce the effective radiation dose to the patient “as low as reasonably achievable.” Because radiation dose for a CBCT study is higher than that for an intraoral radiograph, clinicians must consider overall radiation dose over time. For example, will acquiring a CBCT study now eliminate the need for additional imaging procedures in the future? It is recommended to use the smallest possible FOV, the smallest voxel size, the lowest mA setting (depending on the patient’s size) and the shortest exposure time in conjunction with a pulsed exposure-mode of acquisition.

If extension of pathoses beyond the area surrounding the tooth apices or a multifocal lesion with possible systemic etiology is suspected, and/or a nonendodontic cause for devitalization of the tooth is established clinically, appropriate larger field of view protocols may be employed on a case-by-case basis.

There is a special concern with overexposure of children (up to and including 18 years of age) to radiation, especially with the increased use of CT scans in medicine. The AAE and the AAOMR support the Image Gently Campaign led by the Alliance for Radiation Safety in Pediatric Imaging. The goal of the campaign is “to change practice; to raise awareness of the opportunities to lower radiation dose in the imaging of children.” Information on use of CT is available at [www.imagegently.org/Procedures/ComputedTomography.aspx](http://www.imagegently.org/Procedures/ComputedTomography.aspx).

### **Interpretation**

If a clinician has a question regarding image interpretation, it should be referred to an oral and maxillofacial radiologist (6).

## **RECOMMENDATIONS**

The following recommendations are for limited FOV CBCT scans.

### **Diagnosis**

Endodontic diagnosis is dependent upon thorough evaluation of the patient’s chief complaint, history and clinical and radiographic examination. Preoperative radiographs are an essential part of the diagnostic phase of endodontic therapy. Accurate diagnostic imaging supports the clinical diagnosis.

**Recommendation 1: Intraoral radiographs should be considered the imaging modality of choice in the evaluation of the endodontic patient.**

**Recommendation 2: Limited FOV CBCT should be considered the imaging modality of choice for diagnosis in patients who present with contradictory or nonspecific clinical signs and symptoms associated with untreated or previously endodontically treated teeth.**

### Rationale:

- In some cases, the clinical and planar radiographic examinations are inconclusive. Inability to confidently determine the etiology of endodontic pathosis may be attributed to limitations in both clinical vitality testing and intraoral radiographs to detect odontogenic pathoses. CBCT imaging has the ability to detect periapical pathosis before it is apparent on 2-D radiographs (7).
- Preoperative factors such as the presence and true size of a periapical lesion play an important role in endodontic treatment outcome. Success, when measured by radiographic criteria, is higher when teeth are endodontically treated before radiographic signs of periapical disease are detected (8).
- Previous findings have been validated in clinical studies in which primary endodontic disease detected with intraoral radiographs and CBCT was 20% and 48%, respectively. Several clinical studies had similar findings, although with slightly different percentages (9,10). *Ex vivo* experiments in which simulated periapical lesions were created yielded similar results (11,12). Results of *in vivo* animal studies, using histologic assessments as the gold standard, also showed similar results observed in human clinical and *ex vivo* studies (13).
- Persistent intraoral pain following root canal therapy often presents a diagnostic challenge. An example is persistent dentoalveolar pain also known as atypical odontalgia (14). The diagnostic yield of conventional intraoral radiographs and CBCT scans was evaluated in the differentiation between patients presenting with suspected atypical odontalgia versus symptomatic apical periodontitis, without radiographic evidence of periapical bone destruction (15). CBCT imaging detected 17% more teeth with periapical bone loss than conventional radiography.

### **Initial Treatment**

#### Preoperative

**Recommendation 3: Limited FOV CBCT should be considered the imaging modality of choice for initial treatment of teeth with the potential for extra canals and suspected complex morphology, such as mandibular anterior teeth, and maxillary and mandibular premolars and molars, and dental anomalies.**

#### Intraoperative

**Recommendation 4: If a preoperative CBCT has not been taken, limited FOV CBCT should be considered as the imaging modality of choice for intra-appointment identification and localization of calcified canals.**

#### Postoperative

**Recommendation 5: Intraoral radiographs should be considered the imaging modality of choice for immediate postoperative imaging.**

### Rationale:

- Anatomical variations exist among different types of teeth. The success of nonsurgical root canal therapy depends on identification of canals, cleaning, shaping and obturation of root canal systems, as well as quality of the final restoration.
- 2-D imaging does not consistently reveal the actual number of roots and canals. In studies, data acquired by CBCT showed a very strong correlation between sectioning and histologic examination (16,17).
- In a 2013 study, CBCT showed higher mean values of specificity and sensitivity when compared to intraoral radiographic assessments in the detection of the MB2 canal (18).

### **Nonsurgical Retreatment**

**Recommendation 6: Limited FOV CBCT should be considered the imaging modality of choice if clinical examination and 2-D intraoral radiography are inconclusive in the detection of vertical root fracture.**

#### Rationale:

- In nonsurgical retreatment, the presence of a vertical root fracture significantly decreases prognosis. In the majority of cases, the indication of a vertical root fracture is more often due to the specific pattern of bone loss and periodontal ligament space enlargement than direct visualization of the fracture. CBCT may be recommended for the diagnosis of vertical root fracture in unrestored teeth when clinical signs and symptoms exist.
- Higher sensitivity and specificity were observed in a clinical study where the definitive diagnosis of vertical root fracture was confirmed at the time of surgery to validate CBCT findings, with sensitivity being 88% and specificity 75% (19). Several case series studies have concluded that CBCT is a useful tool for the diagnosis of vertical root fractures. *In vivo* and laboratory studies (20, 21) evaluating CBCT in the detection of vertical root fractures agreed that sensitivity, specificity, and accuracy of CBCT were generally higher and reproducible. The detection of fractures was significantly higher for all CBCT systems when compared to intraoral radiographs. However, these results should be interpreted with caution because detection of vertical root fracture is dependent on the size of the fracture, presence of artifacts caused by obturation materials and posts and the spatial resolution of the CBCT.

**Recommendation 7: Limited FOV CBCT should be the imaging modality of choice when evaluating the nonhealing of previous endodontic treatment to help determine the need for further treatment, such as nonsurgical, surgical or extraction.**

**Recommendation 8: Limited FOV CBCT should be the imaging modality of choice for nonsurgical retreatment to assess endodontic treatment complications, such as overextended root canal obturation material, separated endodontic instruments, and localization of perforations.**

#### Rationale:

- It is important to evaluate the factors that impact the outcome of root canal treatment. The outcome predictors identified with periapical radiographs and CBCT were evaluated by Liang et al. (22) The results showed that periapical radiographs detected periapical lesions in 18 roots (12%) as compared to 37 on CBCT scans (25%). Eighty percent of apparently short root fillings based on intraoral radiographs images appeared flush on CBCT. Treatment outcome, length and density of root fillings and outcome predictors determined by CBCT showed different values when compared with intraoral radiographs.
- Accurate treatment planning is an essential part of endodontic retreatment. Incorrect, delayed or inadequate endodontic diagnosis and treatment planning places the patient at risk and may result in unnecessary treatment. Treatment planning decisions using CBCT versus intraoral radiographs were compared to the gold standard diagnosis (23). An accurate diagnosis was reached in 36%-40% of the cases with intraoral radiographs compared to 76%-83% with CBCT. A high level of misdiagnosis was noted in invasive cervical resorption and vertical root fracture. In this study, the examiners altered their treatment plan after reviewing the CBCT in 56%-62.2% of the cases, thus indicating the significant influence of CBCT.

### **Surgical Retreatment**

**Recommendation 9: Limited FOV CBCT should be considered as the imaging modality of choice for presurgical treatment planning to localize root apex/apices and to evaluate the proximity to adjacent anatomical structures.**

#### Rationale:

The use of CBCT has been recommended for treatment planning of endodontic surgery (24, 25). CBCT visualization of the true extent of periapical lesions and their proximity to important vital structures and anatomical landmarks is superior to that of periapical radiographs.

### **Special Conditions**

#### Implant placement

**Recommendation 10: Limited FOV CBCT should be considered as the imaging modality of choice for surgical placement of implants (26).**

Traumatic injuries

**Recommendation 11: Limited FOV CBCT should be considered the imaging modality of choice for diagnosis and management of limited dento-alveolar trauma, root fractures, luxation, and/or displacement of teeth and localized alveolar fractures, in the absence of other maxillofacial or soft tissue injury that may require other advanced imaging modalities (27).**

Resorptive defects

**Recommendation 12: Limited FOV CBCT is the imaging modality of choice in the localization and differentiation of external and internal resorptive defects and the determination of appropriate treatment and prognosis (28, 29).**

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***Thank you to the Special Committee to Revise the Joint AAE/AAOMR Position Statement on Cone Beam-Computed Tomography:***

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