

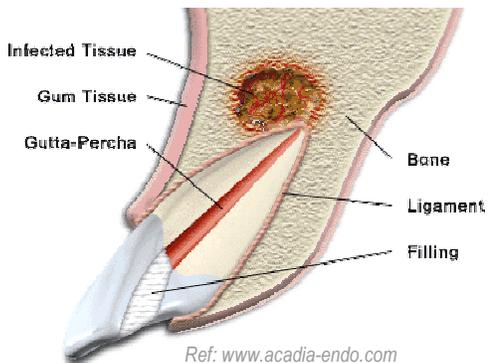
# Wendel Family Dental Centre

## Apicoectomy Procedure

### Why the procedure is needed:

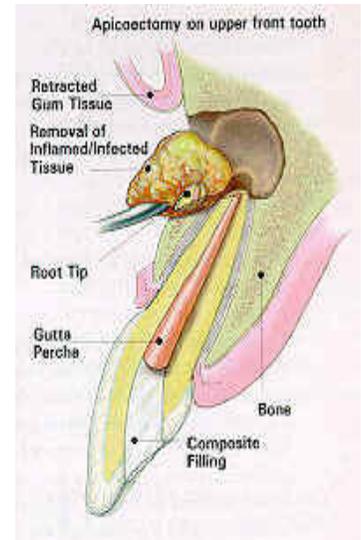
In general, 10% - 30% of root canal treatments are unsuccessful, creating a need for retreatment or a surgical procedure called an apicoectomy. An apicoectomy is performed when the area around the end of the tooth root becomes infected or the root fractures. Your dentist can perform an apicoectomy to try and fix this problem in hope of avoiding the need to extract the tooth. An apicoectomy is generally performed after a tooth has had an unsuccessful root-canal treatment.

### How the procedure works:



The dentist will open and lift the gum away from the tooth so the root is easily accessible. The infected tissue, called granulation tissue, will be removed along with a small part of the root tip. A dye will be used that highlights cracks and fractures in the tooth. If the tooth is cracked or fractured it may have to be extracted, and the apicoectomy will not continue, or more of the root tip may be taken off. After shaving off the tip of the

root, the end of the tooth is resealed (called a retrograde filling). This is one of the most common surgical procedures that can be performed to save a tooth.



### What to expect after Surgery:

With an apicoectomy procedure, you can expect slight bleeding for the first 24 hours. Swelling could be excessive and reach into the tissue near the eye, and discomfort may be experienced for which you will receive appropriate medication. If surgery was performed in the lower jaw, a tingling of the lower lip is possible due to stretching of the nerve supply in this area. This is a rare occurrence and should subside within a few days. In some cases, facial discoloration (bruising) may be present for up to 10 days following surgery. This is a normal part of the healing process and will gradually disappear. There is a slight possibility for gums to recede after an apicoectomy, making your teeth appear longer after surgery. Even though gum tissue heals, the surgical site may be sensitive to touch for several months as new bone forms at the end of the tooth. Patient's receiving an apicoectomy may also experience numbness which is generally temporary and rarely permanent.

### Post-Operative Instructions:

- Rest as much as possible and avoid strenuous activity over the next 48 hours.
- Do not skip meals, drink plenty of fluids, and avoid hot liquids and foods.
- Eat soft bland foods for the next 48 hours. Avoid hard or chewy foods for one week.
- Avoid chewing around the surgical site until the sutures are removed.
- Ice the area 10 minutes on and 20 minutes off for (2) two days following surgery.
- Do not lift your lip to examine the surgical area, the stitches may tear.
- Brush your teeth as normal, but avoid the surgical site for 2 days.
- Rinse with 8 ounces warm water and 1 tsp. salt 2-3 times a day for 7 days.
- If you have been provided a mouthwash, moisten a Q-tip with the mouthwash and gently wipe the teeth surrounding the site. Otherwise, moisten the Q-tip with water.

**Wendel Family Dental Centre**  
**Consent for Endodontic Surgery (Apicoectomy)**

I, \_\_\_\_\_, hereby authorize Dr. \_\_\_\_\_ and staff to perform upon me the following treatment and procedures:

***Removal of the end of the root(s) (apicoectomy) and/or placement of a filling in the end(s) of the root (retrograde filling) on tooth number(s): \_\_\_\_\_***

I understand that my doctor may discover conditions requiring different or additional procedures from that which were planned, including but not limited to involvement of other roots, extensive bone loss requiring more extensive procedures than originally planned for the repair, sinus and nerve involvement or root fracture. I give my permission for those additional procedures that are advisable in the exercise of professional judgment, which would include extraction of the tooth, if the prognosis was very poor.

Certain risks and complications are associated with Endodontic surgery including, but not limited to:

1. Adverse healing which may take months or years to develop and would require additional treatment. These conditions include but are not limited to root fracture, infection, cyst formation, lack of new bone formation at the root end or perforation of the root into the gum at the root end.
2. Leaving a small piece of root in the jaw if its removal would require extensive surgery.
3. Post-operative bleeding, swelling, and discomfort that may require at-home recuperation for a few days.
4. Bruising of mouth tissues or skin of face or lips in areas sometimes distant from the surgery site.
5. Injury to adjacent teeth or soft tissues.
6. Numbness of the lip, chin, gums, cheek or tongue (including possible loss of taste sensation), usually temporary but sometimes permanent.
7. Fractures of the jaw or thin bony plates of the jaw that may require additional treatment.
8. Perforations into the sinus (a chamber in the upper jaw) that may require additional treatment.
9. Swallowing or inhaling of instruments or fillings.
10. Restricted mouth opening for several days sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).
11. Cut oral tissues, including lip or tongue.

Dental anesthetics used for these procedures, although considered safe, have certain associated risks and side effects that include, but are not limited to: adverse drug responses or allergic reactions, heart irregularities, dizziness and nausea. The use of other drugs and medicines such as sedatives and antibiotics may also cause adverse or unexpected responses.

I have given a complete and accurate medical history, including all medicines and drug use. I also agree to fully comply with instructions given to me during the course of my treatment.

No guarantees concerning the result of the planned treatment have been given me, and I have been given the opportunity to have all questions answered to my satisfaction. I understand that the need for additional treatment to save my tooth might result in additional cost.

I hereby authorize Wendel Family Dental Centre to perform the treatment indicated above.

\_\_\_\_\_  
Patient's (or Legal Guardian's) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
Date