BAY ENDODONTICS
Root Canal Specialists

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INFORMED CONSENT FOR ENDODONTIC SURGERY - APICOECTOMY

Patient Name_____Date of Birth_____

Diagnosis_____Treatment_____

Facts for Consideration

Apicoectomy (root end surgery) is the most common endodontic surgery. It is recommended when inflammation or infection persists in the bony area around the root after endodontic therapy. There are several reasons for persistent infection, such as twisted, curved, accessory or blocked canals which may impede complete canal debridement during endodontic treatment. Since leaving any pulp/nerve in the root canal may cause symptoms to continue or worsen, apicoectomy may be necessary. During surgery, an opening is made in the gum tissue and surrounding bone to remove inflamed/infected tissue and root tip. A small filling is then placed to seal the end of the resected root. The root(s) will be checked for possible fractures. If fractured, the affected root or the entire root may have to be removed (**root amputation**). Significant loss of supporting bone may require guided tissue regeneration (GTR), which is bone graft with barrier membrane.

Root amputation is recommended when severe gum disease or crack in the root is observed in a tooth with more than one root that has had previous endodontic therapy. During the surgery, an opening is made into the gum tissue and surrounding bone and the entire affected root is removed.

Benefits of Apicoectomy (not limited to the following)**:**

1. Apicoectomy helps you keep your teeth in the mouth.
2. It allows you to maintain your natural bite.
3. It allows you to maintain the healthy functioning of the jaw.
4. It removes infection or inflammation, allowing you to maintain healthy oral tissues.

I **understand** that an **Apicoectomy** includes possible inherent risks, but not limited to the following, including the understanding that no promises or guarantees of results have been made nor are expected:

Patient's initials
Required

_____ **Pain and swelling** of the area following the treatment: Often the tooth may become mobile, but usually tightens after several weeks. There may be prolonged and heavy **bleeding, bruising** (temporary tissue discoloration) and delayed healing.

_____ **Infection.** No matter how careful surgical sterility is maintained, it is possible infection may occur postoperatively, due to existing nonsterile or infected oral environment. Infection severity varies. Attention should be sought as soon as possible if swelling is severe, especially with presence of fever or malaise.

_____ **Bacterial endocarditis.** Because bacteria live in the normal oral flora, they may travel (via blood vessels, fascial planes, etc.) to the heart to cause an infection(bacterial endocarditis). Pre-existing heart conditions causing valvular dysfunction are the most likely cause of this complication. It is the patient's responsibility to inform the dentist of any heart problems known or suspected

_____ **Injury to the nerves**. This would include injuries causing numbness of the lips, tongue, tissues of the mouth and/or cheeks or face. This numbness may be temporary, lasting days/weeks/months, or permanent as a result of the surgical procedures or anesthetic administration.

_____ **Sinus or Mandibular canal involvement.** In some cases, the roots of the teeth undergoing surgical treatment lie closer to anatomic structures than they appear on radiographs, such as maxillary sinus, mandibular canal and mental foramen. Although a rare occurrence, these structures may be perforated or the nerves emanating from the foramen may be traumatized during surgery.

_____ **Injury to the adjacent teeth or roots.** An adjacent tooth or root may get injured during surgery. If an adjacent tooth or roots are inadvertently nicked or damaged then conventional endodontic treatment, an alternate endodontic surgery, or extraction may be required.

_____ **Failure.** Even when the apicoectomy is properly performed, the surgery may fail due to the tooth/tissues not responding as expected, necessitating extraction. Retrofills placed in the resected root may also leak which can contribute to failure.

_____ **Unusual reaction to medications given or prescribed.** Reactions, either mild or severe, may occur from anesthetics or medications administered or prescribed. All prescription drugs must be taken according to instructions. Women using oral contraceptives must be aware that antibiotics that may be necessary to control infection can reduce the effectiveness of contraceptives.

_____ **Retrofill induced discoloration.** Some materials used to seal the apicoectomy site at the end of the root may cause temporary or permanent discoloration of the surrounding gingival tissues.

_____ It is the patient's responsibility to seek attention should any undue circumstances occur postoperatively and the patient shall diligently follow any preoperative and postoperative instructions given.

Treatment alternatives:

1. No treatment at all. My present condition will probably worsen with time and the risks to my health may include, but not limited to, pain, swelling, cyst formation, hospitalization, loss of supporting bone around my teeth and/or premature loss of teeth.
2. Extraction with no restoration to fill the space. This may result in teeth shifting, change in occlusion (bite), or periodontal disease.
3. Extraction followed by a bridge, partial denture or implant restoration to fill the space.
4. Endodontic retreatment of previous unsuccessful endodontic therapy.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of root canal retreatment and have received answers to my satisfaction. I have been given the opportunity to seek alternate treatment. I do voluntarily assume any and all possible risks including, but not limited to, those listed above. No promises or guarantees have been made to me concerning the results. The fee(s) for service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr. Quang and her associates to render any treatment necessary and/or advisable to my dental conditions, including prescribing and administering anesthetics and/or medications.

☐ **I consent to the root canal retreatment as described by *Dr. Phuong N. Quang* and/or her associates.**

☐ **I refuse to give my consent for the proposed treatment as described above.**

☐ **I have been informed of and accept the consequences if no treatments are rendered.**

_____ _____

Patient's Signature (or Legal Guardian) Date

I attest that I have discussed the risks, benefits, consequences, and alternatives to root canal retreatment with _____, who has had the opportunity to ask questions.

_____ _____

Dentist's Signature Date

_____ _____

Witness' Signature Date