



Long-term evaluation of apical root resorption after orthodontic treatment using periapical radiography and cone beam computed tomography

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Objective: To evaluate the frequency of Apical Root Resorption (ARR) after orthodontic treatment at 52-288 months using periapical radiography (PR) and cone beam computed tomography (CBCT).

Methods: Radiographic images obtained from 58 patients, before (T_1) and after orthodontic treatment (T_2), and following 52-288 months of treatment were analyzed by three members of the Brazilian Board of Orthodontics. Apical structures were evaluated by PR images (T_2 and T_3), using Levander and Malmgren scores. The presence of ARR on CBCT images were detected only at T_3 . The Kolmogorov-Smirnov test was used for statistical analyses, and the level of significance was set at 5%. Kappa statistics determined interobserver agreement.

Results: The more frequent ARR were with scores 1 in T_2 (51.6%) and T_3 (53.1%), when evaluated by PR ($p > 0.05$). When compared the frequencies of ARR in T_3 among PR and CBCT images, the differences were significant for maxillary and mandibular pre-molar groups, and for mandibular molar group ($p > 0.05$). The teeth with highest frequency of ARR presence using CBCT images were maxillary lateral incisors (94.5%) and mandibular central incisors (87.7%), while the premolars showed the lowest frequency. The CBCT images showed that the teeth involved in orthodontic treatment with extraction present higher ARR frequency ($p < 0.05$).

Conclusion: PR showed more frequency of ARR in posterior teeth groups when compared with CBCT images. ARR did not change in long-term post treatment.

Keywords: Tooth resorption. Cone beam computed tomography. Corrective orthodontics.

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INTRODUCTION

Apical root resorption may occur after orthodontic tooth movement. Its etiology is multifactorial and may be associated with individual biological variability, genetic predisposition, effect of mechanical factors, root morphology, and tooth injuries sustained before orthodontic treatment.¹⁻⁶

Root resorption associated with orthodontic tooth movement is classified as inflammatory because it results from inflammation of the apical periodontium and the consequent destruction of tooth structures caused by clastic activity.⁷ Clinical relevance is not often mentioned when the rate of ARR is low. However, in severe ARR, structural tooth changes may result from an unfavorable combination of factors, such as anatomic, physiological and genetic variations.^{8,9,10} The understanding of the pathological mechanisms of radicular resorptions due to orthodontic treatment may help to establish accurate treatment plans.

Clinically, periapical radiographs are often used for diagnosis, treatment planning and follow-up. The revolution of information technology in health investigations started with computed tomography (CT), which has been used for planning, diagnosis, treatment and prognosis of several diseases.^{11,12} Cone beam computed tomography (CBCT) is a recently developed technology^{13,14} with important applications in research, clinical dentistry in general, and orthodontics in particular.¹⁵⁻¹⁸

A longitudinal prospective study¹⁹ of the progression of ARR associated with orthodontic treatment using PR showed that central incisors do not continue to lose root length during the retention phase. Furthermore, no association with gender, age, overbite, overjet, headgear use, or intrusion mechanics was found. ARR was greater in patients that had undergone extractions.

Reukers et al²⁰ used digitally reconstructed images of maxillary incisors and found that ARR prevalence was 63% in the group of incisors. Relevant root shortening was found in only a few cases.^{10,20} In another study, orthodontically induced ARR was evaluated using panoramic radiography and CBCT, and results showed that ARR was found in 69% of the teeth when CBCT scans were used and in 44% when panoramic radiography was the imaging method.²¹

As the application of CBCT in orthodontics seems promising, it may become a useful tool for the long-term follow up of patients that may develop ARR in association with orthodontic tooth movement in different tooth groups. However, few studies have focused on that use of CBCT. This study evaluated ARR at 52 to 288 months after treatment using periapical radiography and cone beam computed tomography. The null hypothesis was that there was no difference in apical root resorption frequencies detected by periapical radiography and cone beam computed tomography.

MATERIAL AND METHODS

Patients

Fifty-eight patients, 28 male and 30 female (1,392 teeth) were selected in a database search of a private orthodontic clinic in Goiânia, GO, Brazil. Inclusion criteria were: Complete orthodontic records, radiographs, pictures, plaster models, and orthodontic treatment completed at least 52 months before. Only patients whose radiographs showed high quality were included, and no patient had any history of retreatment. Time since treatment completion was up to 52 months, and patient mean age was 12 years and 4 months (SD = 2.31).

All the patients had been treated using edgewise mechanics by the same orthodontist and were invited to return for a follow-up examination, which included a full mouth set of periapical radiographs and CBCT scanning. The study was approved by the local Ethics in Research Committee (UFG, Prot. #169/2008).

Imaging methods

Periapical radiographs were acquired using a Spectro 70X Dental X-ray unit (Dabi Atlante, Ribeirão Preto, SP, Brazil) at 70 kV, 8 mA, 0.8 mm x 0.8 mm focal spot, using Kodak Insight film (Eastman Kodak Co, Rochester, NY, USA), using bisector technique with position indicating device and exposure time in accordance with the region imaged. All films were processed automatically and developed using standard methods (Peri-Pro II, Air techniques, NY, USA).

CBCT images were acquired with a first generation i-CAT Cone Beam 3D imaging system (Imaging Sciences International, Hatfield, PA, USA). The vol-

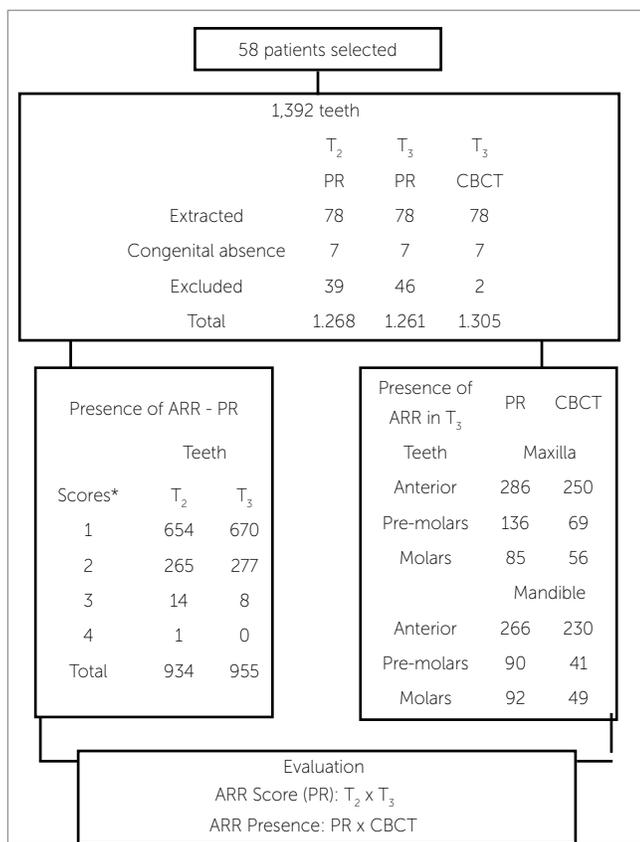


Figure 1 - Distribution of teeth according to presence or absence of ARR. (Source: modified from Levander and Malmgren²).

umes were reconstructed at 0.2 x 0.2 x 0.2 mm voxel size. The tube voltage was 120 kVp, and the current, 3.8 mA. Exposure time was 40 seconds. Images were examined using the scanner proprietary software (Xoran 3.1.62; Xoran Technologies, Ann Arbor, MI, USA) in a PC workstation running Microsoft Windows XP professional SP-2 (Microsoft Corp., Redmond, WA, USA), Intel® Core™ 2 Duo-6300 1.86 GHz (Intel Corporation, Santa Clara, CA, USA), NVIDIA GeForce 6200 turbo cache videocard (NVIDIA Corporation, Santa Clara, CA, USA) and an EIZO - Flexscan S2000 monitor at a resolution of 1600 x 1200 pixels (Eizo Nanao Corporation Hakusan, Ishikawa, Japan). The program tools permitted the evaluation of each tooth in three dimensions.

Evaluation methods

Periapical radiographs were analyzed at three time points: T₁ – before fixed orthodontic treatment; T₂ – after fixed orthodontic treatment; T₃ – at 52 to 288 months after treatment. Three members of the Brazilian Board of Orthodontics individually evaluated all images of PR in all teeth (except second and third molars) to detect ARR. The teeth with periapical lesions, traumatism history, and impossibility of diagnosis due to image overlapping and incomplete rhizogenes were excluded. The high number of teeth with incomplete apices hindered the evaluation of apical structures in T₁. To evaluate interexaminer reliability, 10% of the sample was examined.

Levander and Malmgren² modified scoring system was used to evaluate ARR. Root apices were classified into 5 levels of root resorption: 0= no root resorption; 1= irregular root outline; 2= apical root resorption, less than 2 mm; 3= apical root resorption, from 2 mm to one third of the original root length; 4= apical root resorption exceeding one third of original root length. The radiographs were mounted on slit sheets of cardboard and examined in a darkened room using a light box (Medalight LP-300, Universal Electronics Ind., NY, USA) at 3X magnification.

The CBCT images obtained in T₃ were evaluated by a radiology specialist with 5 years of training. CBCT was used only at T₃ because this imaging diagnostic tool was not available at the other time points.

The analysis of apical region was performed in a dynamic way into different plans (axial and cross-sectional). The thickness slices varied between 1 and 1.5 mm.

ARR presence or absence in PR and CBCT images were evaluated in all dental groups. In teeth with more than one root, the most resorbed root was selected to determine the score for that tooth.

The expected initial number of teeth was 1,392; extracted and congenitally absent teeth and teeth whose images had superposed structures (Fig 1) were excluded. The number of teeth involved or not with ARR was recorded.

The Kolmogov-Smirnov test was used to evaluate the data. The level of significance was set at 5%. Kappa statistics was used to determine interobserver agreement according to the study methods.

RESULTS

From all 58 patients, 40 had been classified, at the beginning of orthodontic treatment as Class I; 14 patients classified as Class II, division 1; 2 patients classified as Class II, division 2; 2 patients classified as Class III. Forty-nine patients used some type of intermaxillary elastics. The mean duration of treatment was 22.9 months (SD = 6.72).

The distribution of teeth in sample, showing the presence or absence of ARR, is presented in Figure 1. The radiographic images of 1,268 teeth were analyzed in T₂, 1,261 in T₃, and 1,305 CBCT images in T₃.

The frequency of ARR by PR after orthodontic treatment (T₂) and 52–288 months (T₃) is shown in Table 1. ARR more frequent score was 1, presenting 51.6% in T₂, and 53.1% in T₃. There was no significant statistical difference between T₂ and T₃, when evaluated by PR, in none of the scores.

Kappa value used to determine interobserver agreement according to modified Levander and Malmgren² study methods varied from 0.86 to 0.96 for PR images.

Table 2 summarizes the results of frequency (%) of teeth group most affected with ARR using PR and CBCT scans. The difference was statistically significant to pre-molar maxillary and mandibular group and to molar mandibular group, when compared the frequencies of ARR in T₃, between PR and CBCT images. The highest presence of ARR by PR was detected in these groups. So, the null hypothesis was rejected. Table 3 shows frequency (%) of teeth group most affected with ARR using CBCT scans. The maxillary lateral incisors were the teeth most affected by ARR. The second group of teeth most affected by ARR was the mandibular central incisors. The teeth group presenting less ARR was the premolars. Table 4 shows frequency (%) of ARR according to CBCT scans (T₃) and effect of extractions. The frequency of teeth with ARR was higher in the group with teeth involved in orthodontic treatments with extractions (66.7%) than in the group without extractions (45.2%). The difference was statistically significant.

Figure 2 shows periapical radiographs of the maxillary lateral incisor suggesting that apical root resorption do not change after finishing the orthodontic tooth movement in long term. Figure 3 shows presence or absence of ARR in central incisor, by PR and CBCT, while Figure 4 shows the same in upper premolar.

Table 1 - Frequency (%) of ARR after orthodontic treatment (T₂) and past 52 to 288 months follow-up according to PR.

Score	T ₂ - PR	T ₃ - PR	p
0	334 (26.3%)	306 (24.2%)	p > 0.05
1	654 (51.6%)	670 (53.1%)	p > 0.05
2	265 (20.9%)	277 (21.9%)	p > 0.05
3	14 (1.1%)	8 (0.6%)	p > 0.05
4	1 (0.1%)	0	p > 0.05
Total	1,268 (100%)	1,261 (100%)	p > 0.05

Table 2 - Frequency (%) of teeth group most affected with ARR using PR and CBCT scans.

Teeth	PR n (%)	CBCT n (%)	p
Maxilla			
Anterior	286 (22.7%)	250 (19.2%)	p > 0.05
Premolars	136 (10.8%)	69 (5.3%)	p < 0.05
Molars	85 (6.7%)	56 (4.3%)	p > 0.05
Mandible			
Anterior	266 (21.1%)	230 (17.6%)	p > 0.05
Premolars	90 (7.1%)	41 (3.1%)	p < 0.05
Molars	92 (7.3%)	49 (3.8%)	p < 0.05

Table 3 - Distribution of teeth most affected with ARR using CBCT scans

Teeth	Absence of ARR	Presence of ARR	Classification
Maxilla			
11/21	23 (19.8%)	93 (80.1%)	3 rd
12/22	6 (5.4%)	104 (94.5%)	1 st
13/23	63 (54.3)	53 (45.6%)	
14/24	45 (59.2%)	31 (40.7%)	
15/25	77 (66.9%)	38 (33.0%)	
16/26	60 (51.7%)	56 (48.2%)	5 th
Mandible			
31/41	14 (12.2%)	100 (87.7%)	2 nd
32/42	26 (22.4%)	90 (77.5%)	4 th
33/43	76 (65.5%)	40 (34.4%)	
34/44	66 (82.5%)	14 (17.5%)	
35/45	87 (76.3%)	27 (23.6%)	
36/46	67 (57.7%)	49 (42.2%)	

Table 4 - Frequency (%) of ARR considering tooth involved in orthodontic treatment with or without extraction, analyzed by CBCT (T₃).

Enrolled teeth	Absence of ARR	Presence of ARR
Orthodontic treatment without extractions (n = 815)	446 (54.7%)	370 (45.2%)
Orthodontic treatment with extractions (n = 490)	163 (33.2%)	327 (66.7%)
p	p < 0.05	p < 0.05

p = significance of percentage differences.

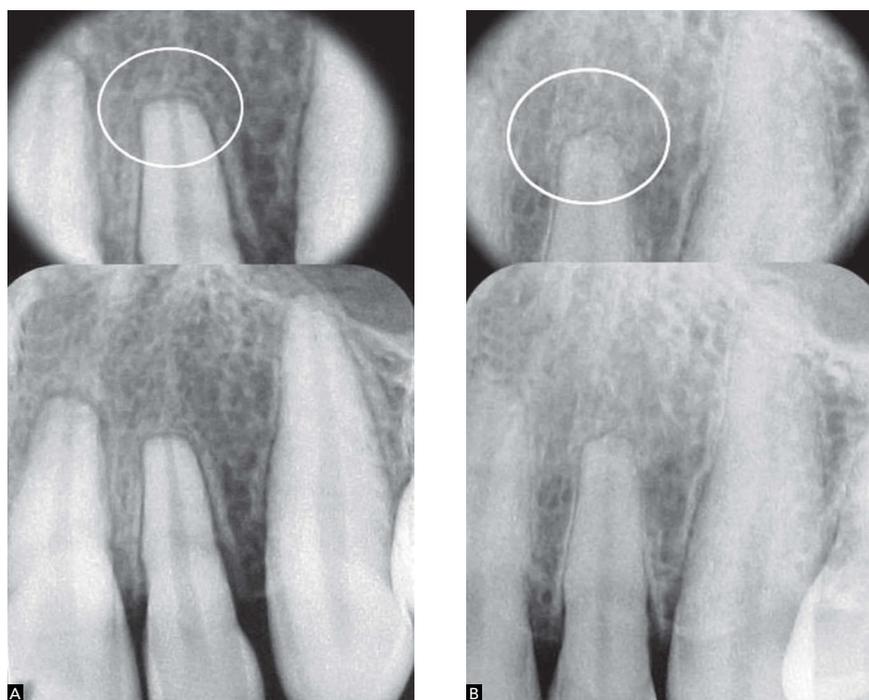


Figure 2 - Periapical radiographs of an upper left lateral incisor presenting the same ARR score after orthodontic treatment (A) and 288 months after treatment (B).



Figure 3 - CBCT scan of a maxillary left central incisor (A) (transverse view) shows more details of apical root resorption than periapical radiography (B).

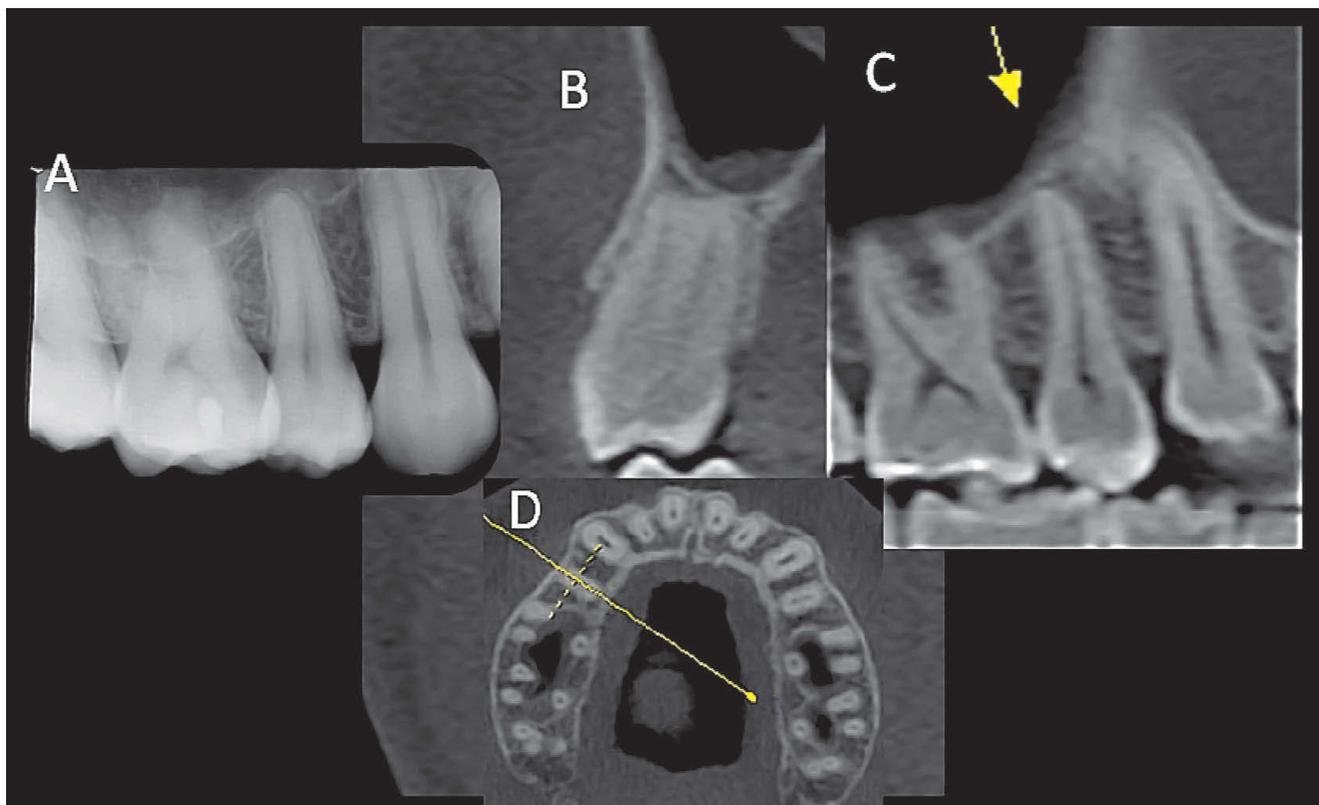


Figure 4 - Periapical radiograph of a maxillary right second premolar shows score 2 according to Levander and Malmgren system (A). The same tooth on CBCT scan presenting absence of ARR (B-D).

DISCUSSION

The advent of computed tomography brought a true revolution in medical sciences.¹⁵⁻¹⁸ Particularly in dental specialties, the possibility of acquiring information from three-dimensional images of the maxillofacial region minimized the chances of underestimating lesions, such as ARR,^{21,24} in dental structures.^{15-18,21-25}

ARR characterize the loss of tooth structure and occurs due to several factors such as individual biological variability, genetic predisposition, mechanical factors, root morphology, and apical lesions prior to orthodontic treatment.¹⁻⁶ The extent of this resorption after orthodontic treatment influences the prognosis. Harmful consequences for the tooth may occur when severe resorption is present, even if observed in a small percentage and forward to well-planned and conducted orthodontic treatment.

Current knowledge does not allow the orthodontists to identify which patients are vulnerable to serious ARR. In a recent systematic review about ARR

associated with orthodontic treatment, Weltman et al¹ found only 11 suitable studies and the protocols were too variable to undertake a quantitative analysis. This revision reflects the timing of the published research about ARR. No study allowed consistent evidence about the longevity of teeth with severe resorption.²⁸

The frequency of ARR, after completion of orthodontic treatment (T_2) and after 52 to 288 months (T_3), was determined by PR images (Table 1). The most frequent ARR score were 1, which did not show significant difference between T_2 (51.6%) and T_3 (53.1%). This study is in agreement with previous findings.^{9,10} Copland and Green⁹ (using lateral cephalometric radiograms) examined 45 individuals to investigate whether ARR in maxillary central incisors associated with orthodontic treatment continues after the end of the active treatment. Mean time between treatment end and final cephalometric radiogram was 2 years 4 months (28 months). When active treatment stopped, further ARR practically stopped, too.

Remington et al¹⁰ conducted a retrospective study (using periapical radiography) to evaluate ARR in 100 patients at a mean 14.1 years (169 months) after orthodontic treatment. They found no apparent changes after appliance removal, except remodeling of rough and sharp edges (Fig 2).

Despite method differences between several studies^{9,10} and our investigation, some important aspects should be analyzed: The mean duration of treatment was 22.9 months; the variation of follow-up time was 52 to 288 months, mean time between treatment end and the final cephalometric radiogram was 1.1 months, range was 0 to 7 months, the evaluation was made according to teeth groups; the scoring system of ARR detected by PR was the one described by Levander and Malmgren,² while the presence or absence of ARR was detected by CBCT images.

The results of CBCT and PR images at T₃, (52-288 months after treatment) revealed differences between the two imaging methods (Table 2). When comparing the frequencies of ARR in T₃, the difference was significant for the group of upper and lower premolars, and for the group of mandibular molars. In these dental groups a greater presence of ARR by PR images was detected. The results suggest that PR, due to limitations, tends to overestimate the ARR into posterior teeth groups (Figs 3 and 4). These findings might be assigned to the fact that analyses were made according to teeth groups. In different teeth group, the apical morphological variations, surrounding bone density (thick or thin bone cortex), x-ray angulations, radiographic contrast and overlapping of anatomic structures may affect radiographic interpretations.²⁶

Advanced technologies that may potentially aid in establishing diagnoses, such as CBCT, bring up challenges that might only be overcome when its properties and limitations are fully understood. Developing new software may greatly improve the acquisition and reconstruction of CBCT scans. In this study, a map-reading approach was used to examine all planes of the root apex, as suggested in a recent study²⁷ which showed that it promotes the perfect management of CBCT images and might reveal abnormalities not detected in conventional PR. For both imaging methods, extra care was taken to ensure an optimal interpretation environment.

Dudic et al²¹ compared ARR in 275 teeth of 22 orthodontic patients using panoramic radiography and CBCT and the scoring system developed by Levander and Malmgren.² They found significant differences between the two methods and for all degrees of ARR. Panoramic radiography underestimated ARR after orthodontic treatment. CBCT imaging should be used to help to monitor patients at risk for developing severe root resorption during orthodontic movement. Our results were similar, but we evaluated ARR after a long-term follow-up of orthodontic treatment using PR and CBCT images.

Maxillary lateral incisors (94.5%) and mandibular central incisors (87.7%) were the most affected teeth (Table 3). ARR analysis, using CBCT, forward to the most affected teeth has not been compared with other literature data by a lack of studies. Newman⁵ investigated possible etiological factors of external root resorption and found that maxillary incisors, maxillary premolars, and mandibular second premolars had the greatest incidence of apical resorption. This sequence differed from that found in other studies about root resorption.^{29,30} In the present study, premolar were the least affected teeth by ARR when evaluated through CBCT image. Hemley²⁹ through PR showed that the teeth more susceptible to ARR were central incisors (9.1%). The lower central incisors were more likely to be affected than upper ones. Sharpe et al³⁰ found a higher frequency of ARR using PR in the central upper central incisors (52.7%) followed by lower ones (45.7%).

In this study, it was found that the most affected teeth are the anterior teeth, as demonstrated in other studies.^{5,9,10,28} It might be suggested that a radiographic control of this dental group during and after orthodontic treatment is benefic for detecting of ARR.⁹

Tooth extraction was shown to be a risk factor for ARR during orthodontic tooth movement (Table 4). The frequency of teeth with ARR was higher in the tooth involved in orthodontic treatment with extractions (66.7%) than the group without extractions (45.2%) analyzed by CBCT ($p < 0.05$). One explanation for these results may be the fact that, in orthodontic treatment with extractions, extensive movements are needed. Our results are in agreement with those reported by Marques et al,²⁸ who found that the main factors directly involved in severe resorption

were extraction of premolars, triangle-shaped roots and root resorption before treatment. Those authors also found a high prevalence of severe root resorptions in Brazilian patients treated with the edgewise method; differently from our findings.

CBCT is not commonly available in most dental offices. The analysis of the cost-effectiveness of 3D imaging in clinical routine should include the caution with radiation dose, variability of radiation between scanners and the lack of a standard recommended dose in some countries.

Silva et al²² compared the radiation doses of conventional panoramic and cephalometric imaging with the doses of 2 different CBCT units and a multi-slice computed tomography (CT) unit in orthodontic practice. They concluded that conventional imaging still emits the lowest dose of radiation, and when three-dimensional imaging is required in orthodontic practice, CBCT scans should be preferred over CT imaging.

It is presumed that a new technology with potential to assist in diagnosis, such as CBCT, set new challenges until there is a complete understanding of their properties and limitations. New machines with low radiation doses and new software to reduce metal artifacts in CBCT image reconstruction should be developed. Further longitudinal studies should determine the behavior of severe ARR due to orthodontic movement.

CONCLUSION

PR showed more frequency of ARR in posterior teeth groups when compared with CBCT images. ARR did not change in long-term post treatment.

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