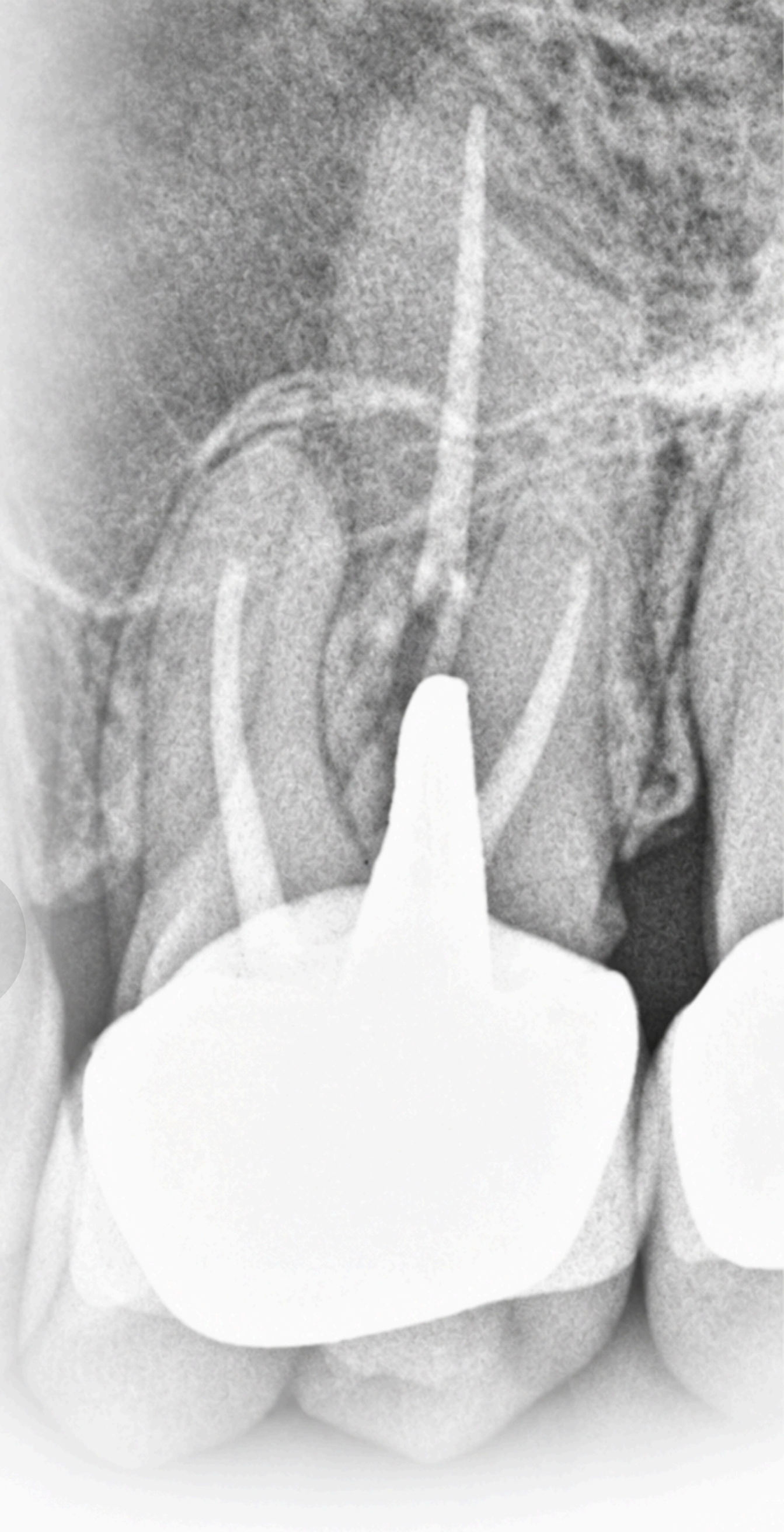
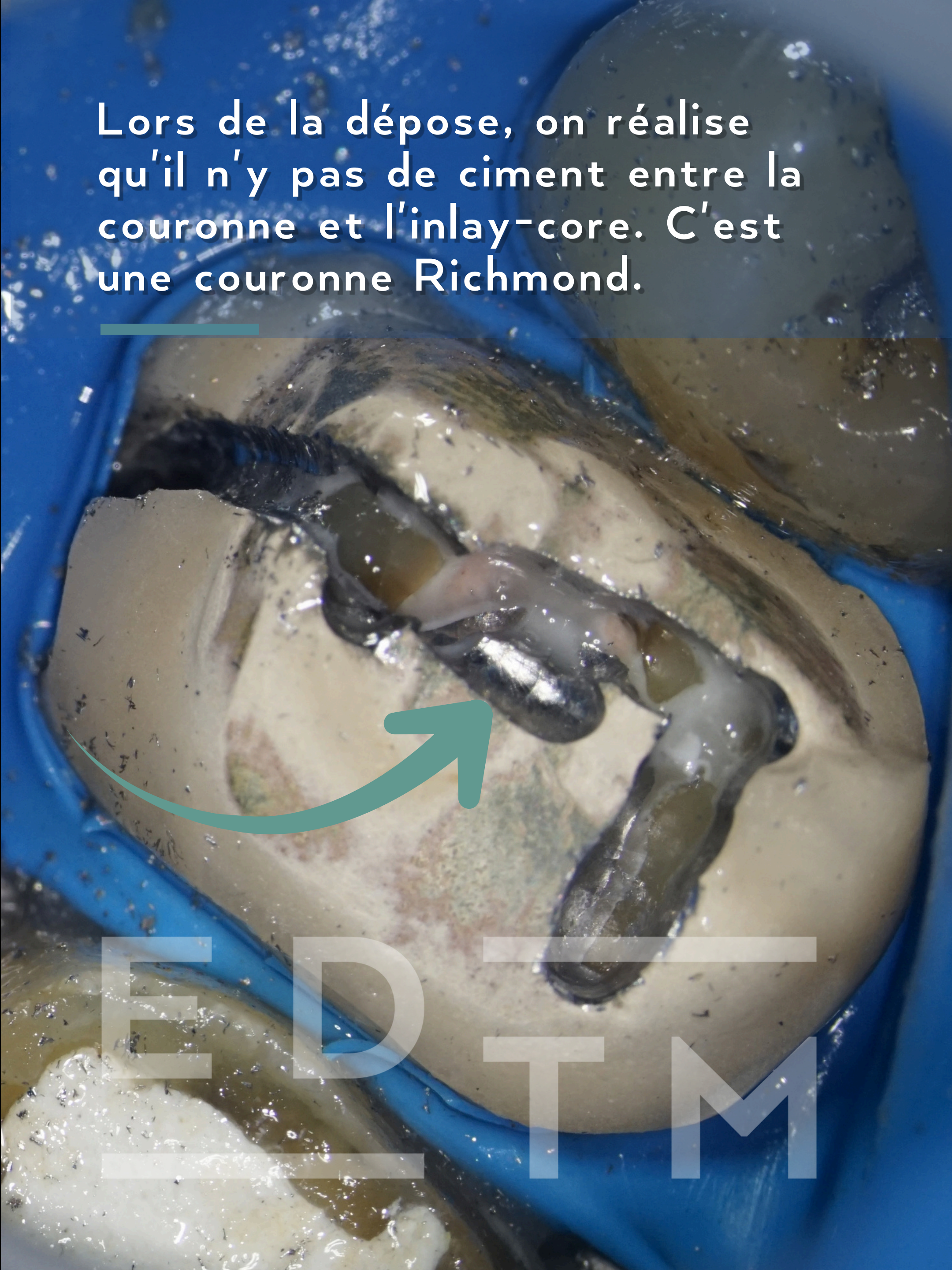
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EDTM

Lors de la dépose, on réalise qu'il n'y pas de ciment entre la couronne et l'inlay-core. C'est une couronne Richmond.



La tranchée vestibulaire est alors prolongée afin de réduire la couronne monobloc en un simple inlay-core



La situation clinique est ainsi plus classique



Après élimination des éléments anti-rotationnels du tenon, il est vibré avec un US à forte puissance



La couronne Richmond a été inventée par le Dr Cassius Richmond, un dentiste américain en 1880.

This is the second of a three-part series. Part 3 of this Historical Perspective will appear in next month's Journal.

A historic review of endodontics, 1689-1963, part 2

William P. Cruse, DDS, and R. Bellizzi, DDS

Dr. G. O. Rogers suggested in an article published in *Dental Cosmos* in 1878 that pathogenic organisms might be the most common causes of diseases of the pulp. He concluded that successful treatment required the total destruction of these organisms.

This conclusion based on the recognition of the pathogenicity of bacteria, led to the eventual demise of the theory of vitalism and consequently opened the door to the new septic theory.[1]

One of the most interesting articles on diseases and treatment of the pulp during the transition from belief in the vitalistic theory to belief in the septic theory, was written by Charles S. Tomes in 1879. In his work, Tomes attempted to incorporate the recent discoveries in pulpal bacterial pathology with the older theory that the etiologic factor of pulp sequelae was a lack of vitality in the tooth.

According to Tomes, the rejection of a pulpless tooth was not accounted for by a septic process that originated in the apical foramen but rather was the result of contamination of one tissue by another. In this case, dentin, the least vital tissue, lost its vitality under septic or arsenical influence and affected cementum, a more vital tissue, which also became infected and involved the periodontal membrane.[1]

The old "dead tooth" theory was supplanted by the septic theory.

In 1882, Arthur Underwood offered a more satisfactory alternative to the dead tooth theory by further developing the septic theory. He proposed that suppuration of the pulp, with its resultant alveolar abscess, depends on the toxic effects of the pathogens. Underwood theorized that, if the pathogens were successfully excluded with the use of powerful and penetrating antiseptic agents, the disease could be prevented.

Underwood believed that whether the pulp was vital made no difference as long as the contents of the pulp chamber and canal were sterilized with antiseptics.

This concept provided clinicians with a new justification for pulp therapy and obturation and clinicians began using caustic germicides to eliminate bacteria. These agents would be widely accepted for more than 30 years' (Neaverth, E.J., unpublished material).

Dr. G. A. Mills, Brooklyn, in 1883, described in *Dental Cosmos* a procedure in which dental pulps were extirpated by driving a hickory or orangewood stick into the root canal. The wooden stick first was tapered to allow it to reach the apex; then it was dipped in creosote or in carbolic acid. A quick blow with a mallet drove the tapered wedge to the apex, where it was left for a few seconds before being withdrawn with the pulp firmly attached.[2-3] Others reported performing this procedure as early as 1863.[3]

The obvious brutality of Mills' procedure did not deter acceptance of it by dentists of his time. Curson,[1] for example, gave Mills credit for attempting to do without arsenic in pulpal extirpation. (By that time, arsenic was known to seep beyond the pulp chamber and to damage the vital supporting structures of the periodontium). By 1895, wooden points for "knocking out the pulps" were available commercially.[2]

The same year, Dr. Bowman, Missouri, introduced a solution of chloroform and gutta-percha, aptly termed, chloropercha. This solution was used with gutta-percha cones to obturate root canals. Dentists quickly accepted use of this material; its greatest advocate was Dr. M. L. Rhein, New York, who further developed and described the technique ten years later.[2]

In 1884, Dr. Cassius M. Richmond, originator of the Richmond crown, taught a method of filling root canals based on the following:

—The root canal (and apical area when infected) were sterilized as much as possible with Phenol and iodine.

—The foramen was sealed with a sterile, solid material that did not protrude from the apex.

—The remaining canal and chamber were filled with an antiseptic cement.

Richmond also was the first to use carbolized orangewood as a root canal filling material, and was an advocate and early practitioner of

Cette technique est heureusement marginale de nos jours car la dépose peut s'avérer complexe.

ENDODONTIC HISTORICAL PERSPECTIVE

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