

digital images

correct labeling

**Revised
March
2008**

important dates

cover sheet



**The
American
Board of
Endodontics**

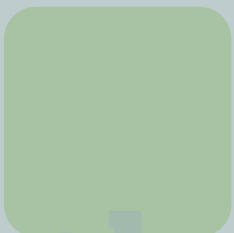
**Case History
Portfolio
Submission
Guidelines**



narrative

case history report form

radiographs



follow instructions

helpful hints

Dear Candidates,

On behalf of the American Board of Endodontics, I am pleased to provide you with the most current version of the *Case History Report Submission Guidelines*.

The Case History Examination portion of your journey toward Diplomate status is a demanding step where attention to detail is crucial. Carefully following all of the instructions, while compiling and proofing your Portfolio, is mandatory in the achievement of a passing grade. This part of the process is completely under your control.

The *Case History Report Submission Guidelines* were created to give you a well-illustrated easy to follow roadmap while you are creating your Portfolio. **We urge you to read it cover to cover before you begin** and then use it as a reference as you treat patients, collect your cases, record your data and check your work.

The Guidelines begin with “Helpful Hints” collected from newly certified Diplomates who share their experience and advice.

Next are the “Pet Peeves” which were written by Directors of the Board to point out common errors to avoid while putting your Portfolio together.

Everything from the preparation of each case to assembling the Portfolio is detailed within this document. There is also an important section on completion of the Case History Report Form. It is essential that all the required information be included in the form and that the form itself (upon completion) has retained the original format.

In order to help you understand the process used in grading Portfolios, we have included a grading chart with an explanation of how the various grades are determined. This is the very criteria the Directors use as they examine your Portfolio case by case.

Finally, we have included a thorough checklist. **Please use this to review each and every one of your cases** to ensure that you have all the required information and that it is properly presented. Also, be sure to give this checklist to whoever will be critically reviewing your notebook.

The *Case History Report Submission Guidelines* were created to assist you in your journey. Again, please read them over carefully, and if you have any questions, please contact our Executive Secretary, Margie Hannen at (312)266-7310 or via e-mail at abe@aae.org.

The entire Board joins me in wishing you success in achieving this meaningful goal in your career.

Yours truly,



Carl W. Newton, D.D.S., M.S.D.
Secretary

Table of Contents

Helpful Hints	1
Pet Peeves	4
Submission Deadlines	7
Portfolio Preparation	7
Required Cases for Submission	7
Narrative	8
Pulpal & Periapical Diagnostic Terminology	8
Radiographs.....	9
Digital Images	11
Patient Photographs	13
Laboratory and Biopsy Reports	13
Recall	13
The Case History Report Form Instructions and Information	15
To Create a Case History Report Form Template	15
To Create a Case History Report Form	15
Navigating the Form.....	15
Case History Report Form Required Information	17
The Case History Report Form & Addendum Page	20-23
Assembling the Portfolio	24
The Case History Evaluation Form Instructions	25
The Case History Evaluation Form	25
How Cases are Graded	26
Case Grading Charts	27-28
Case History Portfolio Submission Checklist	29-31

Submission of the Portfolio	32
Examination Scoring	32
Candidate Notification	32
Appeal Process for an Adverse Decision	32
Certification Process Timeline	33

Helpful Hints

Check those Dates (Hints from the Central Office)

Have a non-dental proofreader do a review in which only the dates are compared within the Case History Report Form and also between the report form and the digital images/radiographs.

	Copy date as shown on first page of the Case History Report Form	List the dates as shown in Section H and Section I as well as the Addendum Page	List the dates as shown on X-rays and Digital Images
Date Case Started			
Date Case Finished			
Date of Last Recall	*		
All Additional Appointments listed in Section H and Section I			

*A post-operative evaluation must be conducted after a minimum of one year (12 months) from the date **definitive endodontics was completed (i.e. if the final date of endodontic treatment was 01/05/06 the soonest the recall examination could be completed is 01/05/07).**

Example

	Copy date as shown on first page of the Case History Report Form	List the dates as shown in Section H and Section I as well as the Addendum Page	List the dates as shown on X-rays and Digital Images
Date Case Started	1/10/2006	1/10/2006	1/10/2006
Date Case Finished	2/7/2006	2/7/2006	2/7/2006
Date of Last Recall (Verify that it is a full year)	2/7/2007	2/7/2007	2/7/2007
All Additional Appointments listed in Section H and Section I		1/13/2006 – 1/26/06 – 4/11/2006	1/13/2006 – 1/26/06 – 4/11/2006

Hints from New Diplomates

Over the past few years, we have asked newly certified Diplomates to pass on some advice to our current Candidates. What follows is a list of the most popular “Helpful Hints” that we have received. These hints are specifically geared toward assisting you in the preparation and proofing of your Case History Portfolio. You will find a wealth of information in their suggestions, please read them over as the guidance they provide is invaluable.

- **FOLLOW DIRECTIONS!**
 - **The key suggestion for this examination was to follow instructions very carefully.**
 - Details, Details, Details – Life and the success of your case submissions is all in the details.
 - Keep an eye on your write-ups; they are as important as the quality of the cases.
 - The instructions are very specific and should be closely followed.
 - Take advantage of the ABE’s detailed information about each case. Follow their instructions.
 - Follow the directions given to a “T”.
 - Follow the guidelines, be brief and do anything you can do make it easier for the Directors to read the cases quickly!
 - Consider every case that you treat in residency and private practice as a potential Board case. It is very important that you follow the Board instructions for case criteria,

radiographs and notes. Make it easy for the Board to follow your notes and radiographs. Have other Diplomates and colleagues critique your cases and notes.

- Treat every case as a Board patient. Know the guidelines and directions. This part is an exercise in following the rules. Make sure to develop a system to organize potential Board patients so that it is easy to gather them when you start the write-up process. Also, stay up with the recalls for the potential Board patients.

- **Search for Potential Cases**

- Amass 25+ cases and then wean.
- Look for cases that are not easy to come by first.
- It is important as you go through your day-to-day practice that you treat each patient as though they could be a part of your Portfolio.
- Start to identify cases in residency and create a “follow-up” log complete with all the necessary contact data for the patient (including the contact information for a relative of the patient who might be able to help you locate your patient at a future time).
- Keep a log on a notebook or computer file of potential Board cases. Anytime you come across a potential Board case, write the patient’s name, tooth number and reason why you feel it is a Board case.
- Try to accumulate about two – three as many cases as needed per category and pick the best for submission.
- Keep track of which categories you already have a sufficient number of cases for submission, so that your energy is spent towards finding those that are more difficult to complete (diagnosis, medically compromised patient and the molar surgery).
- Treat every case as a potential Board case with appropriate documentation and quality radiographs.
- Begin preparing your cases as soon as possible. Keep a list on your desk of the categories that are required, and whenever you come across a case that meets the requirements, make note of it. Tell potential Board case patients at the time of treatment that their case may be a ‘Board case’. This may make it easier to recall them one year later. Also, ask a mentor to review your cases.
- Try to accumulate as many cases as possible for each category with backups in case a patient is lost to recall. Give yourself plenty of time to write up each case and review it thoroughly to make sure it meets the proper guidelines.
- Prepare nice cases during your residency; they may be potential Board cases. Keep copies of records, letters, biopsy reports, etc. Focus on the ‘medically compromised patient’, for me it was the most difficult case to get. Look for 30 good cases and then select 15. The one-year follow-up recall is sometimes problematic, so monitor your patient for the next 12 months.

- **Radiographs**

- Take all the intra-oral radiographs and pictures you can. I don’t know how many successful cases I examined, when preparing for this portion of the Board, only to find that I didn’t have the adequate radiographic representation.
- During a patient treatment, if you ever ask yourself the question, Should I expose an x-ray? -you should! That radiograph will be the one that you need to support your case.
- Take at least two (preferably three) pre-op and post-op films. Take working films even if you don’t routinely do so, it strengthens your cases.
- Always take high quality radiographs from multiple angles; you never know if that case may be needed as part of your Portfolio.

- **Get an Early Start**

- Start early, it’s easier on the family relationships.
- Be systematic. It takes time to organize all the information.
- When you have cases that qualify, start writing them up because they take more time than you think to write and edit them.
- Start case selection early. Every patient is a possible Board case.
- Keep a folder on your PC desktop that keeps reminding you everyday to enter interesting cases to follow-up on!
- This portion of the Certification process takes a lot of time, maybe more than you can imagine. Set aside time to write up your cases, scan your images, etc.

- Prepare early with foresight! Understand what is required ahead of time – do your recalls early.
- Start looking for cases at the start of your residency. I had 12 cases completed with the one year follow-up when my residency was finished. The other three I just needed the follow-up at one year.
- **Contact Patients**
 - I found the majority of my patients could be found for follow-up and were quite receptive.
 - Keep track of potential Board cases in each category and recall as soon as possible.
 - Make certain your office staff realizes the importance of the Boards and works hard with you in getting patients back into the office for necessary recalls.
 - I found that if I explained to my patients what I was trying to achieve and made them a part of the process, they were more than happy to help me by following through with permanent restorations and coming back for recall appointments.
- **Get a Second Opinion**
 - Have colleagues and a mentor help review your cases.
 - Have a mentor review your cases for complexity and content.
 - Having other review my Portfolio was an extremely valuable experience. Their suggestions and advice were priceless.
 - Utilize mentors early as you write up your cases to build momentum, identify areas for improvement and reduce redundant deficiencies.
 - Absolutely essential that a Diplomate review this prior to your submission. Cases need to fit the criteria outlined so read carefully the criteria. It is all spelled out. Have back-ups available if your mentor throws out a case that may not be strong enough.
 - The more critical they are - the better.
- **Be Careful**
 - The ABE template does not have grammar and spell check, so you must type and do all editing in Word, correct, then past into the ABE template. I learned this the hard way!
 - The worst is a beautiful case with insufficient documentation.
 - Make certain that all radiographs are of excellent quality and can be archived.
 - When preparing your cases, it's important to be obsessive about checking dates; spelling, and your write-up for organization. Your goal is for the cases to be black and white. Don't leave any question marks.
- **Proof Read**
 - Have dental, but also non-dental proofreaders.
 - Evaluate and grade each case yourself by following the scoring criteria used by the Directors.
 - Proofread your cases. Have your mentor proofread your cases. Proofread your cases again.

Pet Peeves

Submitting a successful Portfolio does not require any additional time in the preparation, it simply requires understanding and following the instructions contained in the guidelines. The Directors spend considerable time evaluating each Portfolio. Candidates put in a great deal of time putting them together. Rushing to meet a deadline will often lead to technical errors, such as failure to date radiographs or using the incorrect tooth number for a case. These technical errors reduce the score of the Portfolio and are easily avoidable by simply using the check list that is supplied. The entire Board was surveyed to find out what their "Pet Peeves" are when grading Case History Portfolios. A pet peeve is defined as; to be put into ill humor. That is what happens when Directors grade Portfolios that have easily correctable or recognizable deficiencies. We, as a group, really hate to mark down any Portfolio. Each Director submitted opinions about the Case History Portfolio deficiencies. MRA Inc., the firm that evaluates all aspects of the examination process, the Written, the Case History Portfolios and the Orals, confirm that the evaluations are fair and without bias. Each Portfolio is examined by three Directors. Each case has three areas that are graded. That means that each Portfolio receives a total of 135 grades (45 per examiner). This makes it highly unlikely that any one single case that is deficient or unacceptable could fail the entire Portfolio. Each Director was asked to list three of his/her most egregious peeves. It is one thing to list all the "do's" on constructing an excellent Portfolio, but what about the little things that could be done better and can add up to taint the notebook? Hence, the Pet Peeves. Anyone of these does not necessarily result in an unacceptable score (except as indicated in the scoring criteria) but if there are enough of them, the reviewing Director will have a tendency to grade the case lower.

Now that the road to Board Certification can be completed in a faster timeframe, there may be a tendency to rush the Portfolio submissions. Cases that might make up the majority of your Portfolio may come from cases done during your residency. There is nothing wrong with that, but keep in mind that cases that are deemed too difficult for dental students and are referred to postgraduate endodontics are not necessarily too difficult for general dentists. The submission guidelines clearly state that cases must "demonstrate a broad spectrum of diagnostic, treatment and evaluative procedures, and the ability to manage complex clinical problems at a specialist's level. The diversity and complexity of the cases must thoroughly document exceptional knowledge, skill and expertise in the specialty of endodontics."

The Board wants you to pass! We truly hope that with all of the material and suggestions that are available to you, you will successfully complete the Board examination process. On behalf of the entire Board, Good Luck!

Avoiding Pitfalls

Utilize the checklist in the Portfolio guidelines.

1. Use this document as a second check list.
2. Get the assistance of a mentor (the more critical the review the better) who can not only check your completed Portfolio but who can offer suggestions while assembling your Portfolio. Be certain that your mentor has a copy of the current guidelines and uses the checklist and grading criteria during the review.
3. Don't wait until the last possible moment to submit your Portfolio.

Mentors

The College of Diplomates of the American Board of Endodontics can supply you with a mentor (www.collegeofdiplomates.org). The Board Certified professors in your program would be another source. Make sure your mentor is up to date with all of the requirements and has successfully mentored other Candidates.

Anesthetics

- Amounts, types of local anesthetics used at each appointment were not included.
- Make it clear when local anesthetic was not used and why.
- Inappropriate dosages of anesthetics.

Case Complexity

- Submission of cases that could be done by a general practitioner. This was listed by almost every Director as being the number one egregious error.

Diagnostic Procedures

- Where appropriate, you must include diagnostic data on all teeth in the affected quadrant or side. **Pulp testing only the tooth to be treated is not acceptable.** The same is true of radiographic evaluation. When describing the radiograph, include what is seen in the entire radiograph, not just the tooth in question. And don't forget to mention the extra-oral exam.

Medical History

- The medical history is a must, along with vital signs. Vital signs should include blood pressure, pulse and temperature if swelling is present. A review of systems should be included. The medical history must be thorough. Make sure medications are listed, their dosages, and why the patient is taking them.

Narrative

Diagnosis

- Pulpal and periapical diagnosis that does not match the subjective history and the clinical finding, e.g. draining sinus track and a diagnosis of asymptomatic apical periodontitis instead of chronic apical abscess.

Errors

- Spelling errors! Please use the spell check in Word before cutting and pasting the text into the Case History Portfolio forms!
- The presence of errors that are clearly described in the submission guidelines as deficient or unacceptable.

Information

Inconsistent

- Dates and narrative that do not match, e.g. radiograph has one date and the narrative for that radiograph has a different date.

Missing

- Failing to include in the narrative that a follow-up was done that night or the next day on your emergency patient or the patient that had pain on their initial visit.
- Prescribing antibiotics when there is no indication for administration.
- No cover page (explaining abbreviations, techniques, irrigants, anything above and beyond the usual and customary, etc.)
- Inadequate explanations where needed, e.g. if you chose to use or not use a splint in a trauma case, you should explain your decision. This can be in the narrative or the cover page.
- No biopsy submitted during surgery and no explanation of why one was not submitted.

Necessary

- Not enough necessary information; biopsy reports, how calcium hydroxide (if used) is prepared, just to name a few.

Unnecessary

- Too much unnecessary information. The Board is not interested in what clamp you used to retain the rubber dam (just that a dam was used) or what bur was used to open an access, files used to clean and shape, etc.
- Pages and pages of introductory material. Keep the introduction short. Keep technique descriptions short. List important abbreviations. Do not write War and Peace!

- Writing an extensive pulp testing and diagnostic narrative when a simple chart would do.

Radiographs

- Radiographs that are not described or dated in the narrative.

Recall Appointments

- Recall appointment that fell on a Sunday or Holiday. Check those dates! If the appointment was held on a Sunday or Holiday indicate that in the narrative.

“Other” Cases

Several complaints about the case category called “OTHER”

1. Make sure the cases in this category are of *specialist* caliber,
2. Make sure all three are different, and
3. Explain what the “other” is, i.e. “OTHER-APEXGENESIS”, or “OTHER-PERF REPAIR”. Reviewers don’t like to guess what the case is all about. (Please contact Margie at 312/266-7310 or abe@aae.org) for the updated Case History Report form that includes the section **OTHER subcategory** _____ within the form.

Radiographs

- Even though the requirements do not absolutely require more than a pre-, post- and recall radiograph, some working radiographs would really strengthen the case, especially in multiple canals in a single root .Taking multiple views for preoperative films is text book stuff. If you took them, include them. Post obturation and recall radiographs must clearly show the apical termination of each canal.
- Poor quality radiographs. Films that are too dark, too light, not clear, digitals that are too small are just a few examples.
- Lack of enough radiographs (no angled views, working length, cone fits etc.).
- Radiographs that don’t show: 1) the entire periradicular lesion if present, 2) what is described in the narrative, or 3) all of the canals and their apical terminations.
- Dates on the radiographic mounts that are illegible or hard to see on the mounts.
- Entries written with a pencil are not legible; therefore please use a white label. Use a label maker or print out the information on a label (and then trim to fit the space) to make the radiographic presentation legible.
- Radiographs in the wrong slots in the radiographic mounts (radiographs must be placed in the order of sequence they were taken and placed left to right in the slide mount).
- Radiographs that are not described or dated in the narrative.

Terminology

- Wrong or inappropriate terminology gives the impression that the Candidate may have misdiagnosed the case. Make sure your diagnosis fits the facts of the case!
- The ABE approved terminology should be used. Candidates are allowed to submit cases utilizing diagnostic terminology of their own choosing. However, it is essential that they provide an introductory letter preceding the cases describing the terminology used in the Case History Form.

Case Submission Dates

Portfolios are accepted for review twice a year – **May 1 and October 1**. Portfolios must be received in the Central Office on or before the submission date. If the submission date falls on a weekend notebooks must be sent via overnight delivery no later than the next business day. Late Portfolios will be included in the next cycle, providing eligibility is still current.

Portfolio Preparation

Required Cases for Submission

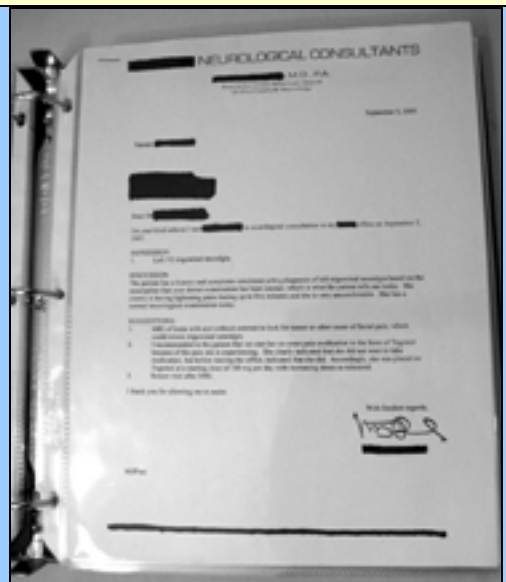
Candidates are required to submit documentation of fifteen specific cases (as specified below) from their specialty practice of endodontics that demonstrate a broad spectrum of diagnostic, treatment, and evaluative procedures, and the ability to manage **complex** clinical problems at a specialist's level. The diversity and complexity of the cases must thoroughly demonstrate exceptional knowledge, skill, and expertise in the specialty of endodontics. Each case should contribute added dimension to the Portfolio. The Portfolio should also demonstrate that the Candidate is practicing the full scope of the specialty of endodontics. Remember, only cases treated since the start of your endodontic program may be included.

Diagnosis	One Case	Diagnostic evaluation of the patient (dental or systemic) was the most significant feature of the case. One-year evaluation required with radiograph/image.
Emergency	One Case	Emergency treatment procedures in addition to endodontic procedures were required, e.g. incision for drainage, trephination, prescription of medications, and splinting with rationale for their use.
Medically Compromised	One Case	Endodontic management of a medically compromised patient. This requires modification of treatment procedures. Recognition and/or documentation of a medical problem does not meet this criteria. Prescribing prophylactic antibiotic coverage or treating patients with common medical conditions does not satisfy the criteria for this category.
Nonsurgical Root Canal Treatment	Five Case	Nonsurgical root canal treatment, including cases with calcified canals, curved/long canals, unusual anatomy, etc. These five cases must include at least one maxillary molar and one mandibular molar.
Retreatment	Two Cases	Nonsurgical retreatment of endodontic cases. One of the two cases must be a molar.
Surgical Root Canal Treatment	Two Cases	Surgical root canal treatment. One of the two cases must be a posterior (molar) surgery with root-end resection, root-end preparation and root-end fillings.
Other	Three Cases	The cases presented in this category are cases that do not qualify for the previous 12 cases. The three <i>Other</i> cases must be different from each other and may include, but are not limited to the following: trauma (management of traumatic injuries and their sequelae, such as crown/root fractures, luxations, avulsions, open apices, resorptions, etc.); perforations, hemisections, root amputations, endodontic endosseous implants, replants, transplants, endo-perio, endo-pedo, endo-ortho, removal of separated instrument, decompression and vital pulp therapy (including apexogenesis). Osseointegrated implants are not acceptable. No more than one case from each category is permissible.

Narrative

Quality of Presentation	It is essential that the narrative include proper and consistent diagnostic terms, acceptable grammar, and correct spelling.
Follow Instructions	The narrative reports must be complete and prepared according to instructions. Failure to follow instructions is a frequent reason for failure.
Cover Sheet	A cover sheet describing routine policies and procedures and defining abbreviations (the use of abbreviations is acceptable but should be limited) is permitted.

(fig.1. Example of supplemental material with correctly masked information that might otherwise reveal Candidate, institution, geographic location and patient's name.)



Pulpal & Periapical Diagnostic Terminology

At the April 22, 2007 Board Meeting, the ABE Directors considered and approved a simplified pulpal and periradicular diagnostic terminology list to be used by Candidates to document their cases for the Case History Portfolio and while sitting for the Oral Examination. The Case History Form has the accepted terminology included in a drop-down box. It is essential that you make sure your diagnosis fits the facts of the case. A wrong diagnosis will result in an unacceptable score in the Clinical Evaluation, Diagnosis, Treatment Plan section of the Case History Evaluation Form. Candidates are allowed to submit cases utilizing diagnostic terminology of their own choosing. However, it is essential that they provide an introductory letter preceding the cases describing the terminology used in the Case History Form. Again, make sure your diagnosis fits the facts of the case.

Pulpal

Normal Pulp	A clinical diagnostic category in which the pulp is symptom free and normally responsive to vitality testing.
Reversible Pulpitis	A clinical diagnosis based upon subjective and objective findings indicating that the inflammation should resolve and the pulp return to normal.
Irreversible Pulpitis - Symptomatic	A clinical diagnosis based on subjective and objective findings indicating that the vital inflamed pulp is incapable of healing. <i>Additional description:</i> - Lingering thermal pain, spontaneous pain, referred pain.

Irreversible Pulpitis - Asymptomatic	A clinical diagnosis based on subjective and objective findings indicating that the vital inflamed pulp is incapable of healing. <i>Additional description</i> - No clinical symptoms but inflammation produced by caries, caries excavation, trauma, etc.
Pulp necrosis	A clinical diagnostic category indicating death of the dental pulp. The pulp is non-responsive to vitality testing.
Previously Treated	A clinical diagnostic category indicating that the tooth has been endodontically treated and the canals are obturated with various filling materials, other than intracanal medicaments.
Previously Initiated Therapy	A clinical diagnostic category indicating that the tooth has been previously treated by partial endodontic therapy (e.g. pulpotomy, pulpectomy).

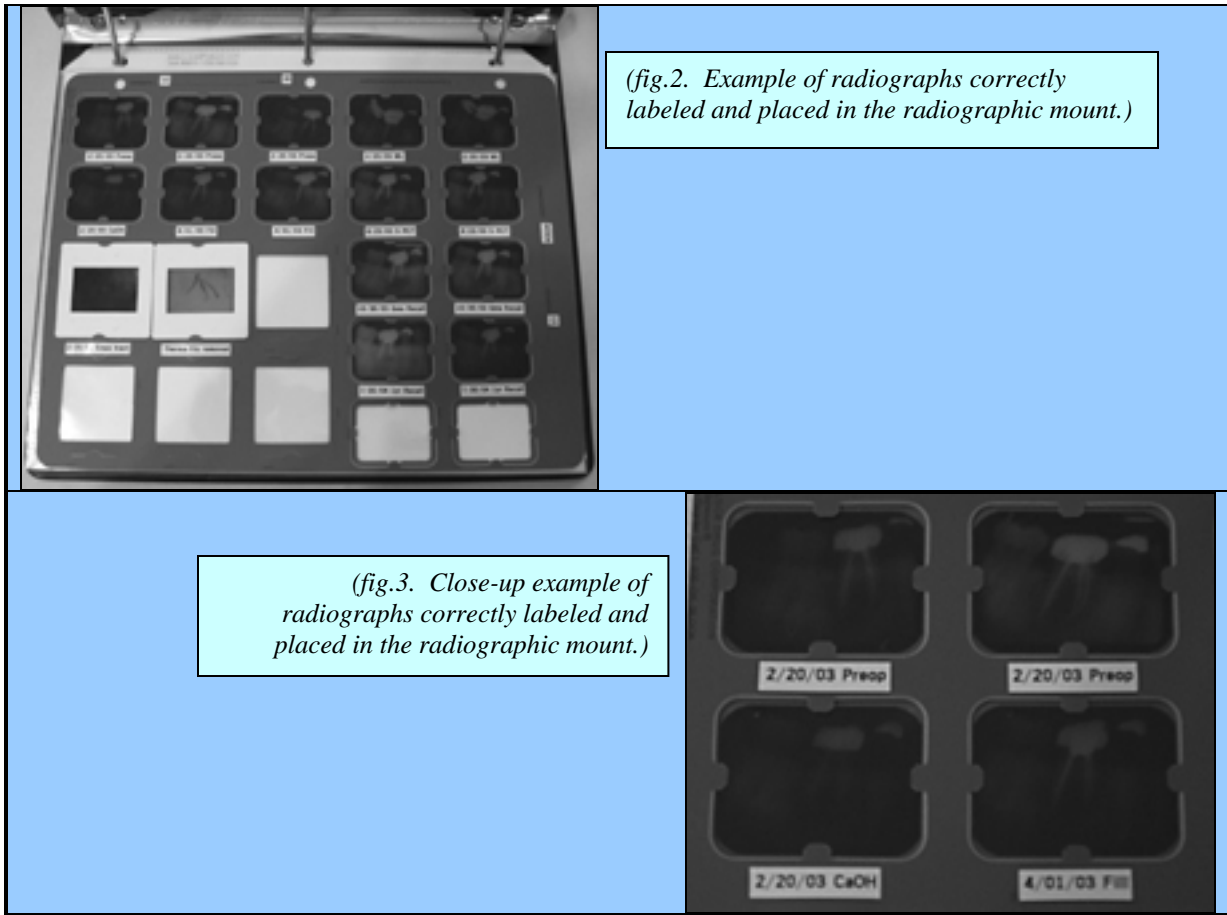
Apical (Periapical):

Normal apical tissues	Teeth with normal periradicular tissues that will not be abnormally sensitive to percussion or palpation testing. The lamina dura surrounding the root is intact and the periodontal ligament space is uniform.
Symptomatic apical periodontitis	Inflammation, usually of the apical periodontium, producing clinical symptoms including painful response to biting and percussion. It may or may not be associated with an apical radiolucent area.
Asymptomatic apical periodontitis	Inflammation and destruction of apical periodontium that is of pulpal origin, appears as an apical radiolucent area and does not produce clinical symptoms.
Acute apical abscess	An inflammatory reaction to pulpal infection and necrosis characterized by rapid onset, spontaneous pain, tenderness of the tooth to pressure, pus formation and swelling of associated tissues.
Chronic apical abscess	An inflammatory reaction to pulpal infection and necrosis characterized by gradual onset, little or no discomfort and the intermittent discharge of pus through an associated sinus tract.

Radiographs

Quality	The quality of the radiographs/images must be excellent. Poor quality radiographs that are too dark, too light or not clear and digital images that are too small are not acceptable.
Quantity	It is strongly suggested that a sufficient number of diagnostic quality radiographs be presented for each case. Interim treatment radiographs are suggested but not required.

<p>Type</p>	<p>Variety of Views Proper film/sensor placement, use of altered angulations to permit visualization of superimposed structures such as canals or roots, working length measurements, cone fits, etc and adequate processing are essential.</p> <p>Periradicular Lesion It is important that radiographs show the entire periradicular lesion, what is described in the narrative and all of the canals, and their apical terminations.</p> <p>EAL (Electronic Apex Locator) EAL are an acceptable substitute for file measurement radiographs although the anatomy must then be demonstrated with a cone fit image before obturation.</p> <p>Postoperative All treated canals must be visible on at least one postoperative radiograph.</p> <p>Kodachromes Kodachromes are not acceptable.</p>
<p>Computed Tomography</p>	<p>Cone beam computed tomography is acceptable but the viewer must accompany the submitted CD-ROM and the inclusion into your notebook can not considered a substitute for detailed radiographs or digital images.</p>
<p>Description & Reference</p>	<p>When describing the radiograph, include what is seen in the entire radiograph, not just the tooth in question.</p> <p>All X-rays and digital images must be referenced to in the narrative and dates must match back to the dates in the Case History Form.</p>
<p>Slide Mounts</p>	<p>Identification The case number, Candidate number and all X-ray dates need to be indicated on the X-ray mount form (patient names cannot be listed).</p> <p>Labeling It is recommended that a white label be used for date and X-ray identification on the radiograph mounts. Use a label maker or print the information on a label and trim to fit. For example, labels should read; 8/15/00 Preop, 8/15/00 WL, 8/15/00 Ca OH, 9/25/00 WL.</p> <p>Placement Radiographs must be placed in the order of sequence they were taken (left to right from the top of the mount).</p> <p>Page Protector Slide mounts must be placed in a page protector.</p>
<p>Original Radiographs</p>	<p>Copies of radiographs are not permitted.</p>



(fig.2. Example of radiographs correctly labeled and placed in the radiographic mount.)

(fig.3. Close-up example of radiographs correctly labeled and placed in the radiographic mount.)

Digital Images


<p>Quality</p>	<p>Requirements for Quality Images Quality and image clarity of digital images are dependent upon three primary factors: quality and type of paper, quality and type of printer, and overall resolution.</p> <p>Paper A high-grade paper such as document quality paper or photo-quality paper (glossy) provides exceptional resolution and is required. Thermal paper, thermal printers, and normal copy paper are not acceptable.</p> <p>Printer High quality ink jet printers in conjunction with document or photo quality paper have proven to be excellent choices for digital images. Inkjet printers appear to print superior images over those printed by laser printers.</p>
<p>Quantity</p>	<p>It is strongly suggested that a sufficient number of diagnostic images be presented for each case. Interim treatment radiographs are suggested but not required.</p>

Type	<p>Variety of Views Proper film/sensor placement, use of altered angulations to permit visualization of superimposed structures such as canals or roots, working length measurements, cone fits, etc and adequate processing are essential.</p> <p>Periradicular Lesion It is important that images show the entire periradicular lesion, what is described in the narrative and all of the canals and their apical terminations.</p> <p>Postoperative All treated canals must be visible on at least one postoperative digital image.</p>
Size	<p>The individual size of a digital image should be minimally equivalent to a 2x3 size film but no larger than 5x7.</p>
Presentation	<p>Images can be printed on 8 1/2 x 11 photo quality paper or individually mounted on standard copy paper so long as the mounting medium does not interfere with the respective image.</p>
Identification	<p>The case number and Candidate number should be listed on each page. Patient names cannot be listed.</p>
Labeling	<p>Each digital image should be identified with the date and description. For example 8/15/00 Pre-op, 8/15/00 WL, 8/15/00 CaOH, 9/25/00 WL, 9/25/00 Fill, 11/01/01 Recall.</p>
Page Protector	<p>All images must be inserted in the provided plastic page protectors.</p>



(fig.4. Example of correctly labeled radiographs placed in chronological order.)

Photographs

Patient Photographs	All photographs of patients must have their eyes masked to prevent identification.
	<div data-bbox="526 380 1049 474" style="border: 1px solid black; padding: 5px; background-color: #e0f7fa;"> <p><i>(fig.5. Example of correctly masked patient photograph.)</i></p> </div>

Laboratory and Biopsy Reports

Photocopies	Photocopies of supporting or supplemental materials e.g. laboratory, medical consults and biopsy reports are acceptable. All supplemental reports must be masked to prevent identification of the Candidate, institution(s), geographic location, and patient's name.
English Translation	If the included documents are written in any language other than English, a translation in English notarized as a true copy, must accompany each report.
Page Protectors	Place in page protectors in sequential order. They can be placed back to back in a page protector.

Recall

Requirement	Clinical evaluations and recall radiographs (one year minimum from the date treatment is completed) are required for <i>each</i> case.
One-year Requirement	A post-operative evaluation must be conducted after a minimum of one year (12 months) from the date definitive endodontics was completed (i.e. if the final date of endodontic treatment was 01/05/06 the soonest the recall examination could be completed is 01/05/07).
Calcium Hydroxide Therapy	Cases requiring calcium hydroxide therapy require a one-year radiograph recall examination following completion (final obturation) of root canal treatment.
Diagnostic Category	Cases in the diagnostic category must have a one-year follow-up evaluation regardless of whether endodontic treatment was instituted.

Evaluation Write-up	The recall evaluation must include a comprehensive narrative including comments on any change in the original condition. The criteria used for success should be clearly stated.
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The Case History Report Form

Instructions for the Case History Report Form and Addendum Page

To Create the Case History Report Template

Step 1.	Open the Case History Report Form Template.
Step 2.	Click on <i>File</i> then click on <i>Save As</i> .
Step 3.	Save in <i>Desktop</i> – leaving the filename as is – click <i>Save</i> .
Step 4.	Click <i>File</i> then <i>Close</i> – then close out of <i>Word</i> .
Step 5.	On your desktop screen you will have an Icon for the <i>Case History Report Template</i> . This Template is now ready to be used to create your fifteen Case History Report Forms.

To Create the Case History Report Forms

Step 1.	Double-click on the <i>Case History Template Icon</i> .
Step 2.	Click <i>yes</i> to open as <i>read only</i> .
Step 3.	Click <i>File</i> – click on <i>Save As</i> (If you receive the <i>Before you Save</i> prompt, click on <i>Don't Save As Suggested Format</i>). 3a. Change the file name appropriate to the case report you are making (you will use this template to create each Case History Report Form – Case 1 through Case 15). 3b. Save as a <i>Word Document</i> . 3c. Use this procedure to create your 15 Case History Report Forms.

Navigating the Form

Tool Bar	Be sure the Form Toolbar is locked. When the Form Toolbar is locked the other symbols (abl – the check box – etc, are grayed out). The form will not work properly if the Form Toolbar is not locked. If the Form Tool Bar is not visible – click on <i>View</i> – then <i>Toolbars</i> – then <i>Forms</i> .
Tab Button	Use the tab button to navigate from one section to another.
Select Buttons	In the <i>Patient Sex</i> , <i>Procedure Category</i> , <i>Pre-Treatment Diagnosis: Pulpal and Periradicular</i> and <i>Prognosis</i> fields - click on the <u>select</u> pull-down menu box – then click on the appropriate response. A text box is located next to the <u>select</u> pull-down menu box for the <i>Pulpal and Periradicular Diagnosis</i> to accommodate entering a diagnosis that is not included in the pull-down box. In addition, the OTHER category has a text box below the Select pull-down box to describe the type of OTHER treatment (i.e., Root Amputation, Intentional Replantation, Perforation, or Hemisections).
Spell Check	The Case History Evaluation Form does not provide the functionality of “spell check”. A work-a-round solution is to type your report in a word document and then copy the text and paste into the appropriate section in the Case History Report Form. Please remember that “spell check” is a great tool, but it is the responsibility of the writer to present an error free report. Please proofread your report for content and then reproof your report strictly for spelling errors.

Allowed Space	While typing a report on this form, you will be restricted to the allowed space for each section of the form. If you exceed the limits of the space, what you type will not appear on the form. The form has been created to allow you to enter information up to the end of each section, however, due to capital letters, lower case letters and spaces being different sizes, you may find that you are stopped before reaching the end of the last line. Do not try to change this or the font to squeeze the typing into the form. The lines will not accommodate any font other than Arial, regular, size 10. Continue your report on the Addendum Page. The Case History Report Form must always be locked.
Changes	Creating each Case History Report from the template will allow you to make changes and additions to the form as needed. When you need to make a change to your created Case Form - open the form and click no when it asks if you if you want to open as <i>Read Only</i> and then enter your changes and save when closing the document. Again, do not unlock the form while making any changes in text.
Addendum Page	The two pages of the form should accommodate most case reports. However, for those cases where additional space is needed continue the text on the Addendum page. When you have exceeded the limits of the current section you are working on, you will no longer be able to enter information. Use the backspace to allow enough room to enter "See Addendum Page" at the end of that particular section. Scroll down to the Addendum Page; indicate the area you are continuing, i.e. "C. Medical History continued:" then continue with your narrative of that area. All areas continued for a case can be on the same Addendum Page. Using an Addendum Page for each case or using more than two Addendum Pages for one case probably indicates a need to edit your narrative to make it thorough but brief and concise.
Backup Copies	As an additional safeguard, make backup copies of this file and of any reports you write.
Printing	The margins have been made wide enough on this form to accommodate any inkjet or laser printer. Reports must be printed on white high quality paper.

Case History Report Form

Required Information

Case Report Number	This number must be consistent with the number on the Case History Evaluation Form.
Patient Age	This must indicate the patient's age when treatment was started.
Patient Sex	Select male or female from the drop-down box.
Candidate Number	Use the number assigned to you by the Board. Names must never be used.
Date Started	This date indicates the first appointment with the patient.
Date Finished	This date indicates the last appointment where active treatment was provided.
Date of Last Recall	This date indicates date of last recall.
Tooth Number	Use the numbering system one to thirty-two to designate the teeth. Tooth number (1) is the maxillary right third molar, tooth number sixteen (16) is the maxillary left third molar, tooth number seventeen (17) is the mandibular left third molar, and tooth number thirty-two (32) is the mandibular right third molar.
Procedures	Select the correct procedure from the drop-down box. This entry must be consistent with the Case History Evaluation Form that lists the required procedures and order of placement in the Portfolio. While more than one procedure code may apply to the case, only one procedure can be entered in this section.
Chief Complaint	As stated in the patient's own words.
Medical History	<p>Thorough Synopsis Each case must provide a thorough synopsis of the patient's medical history. Include any allergies, previous and present medical conditions, diseases, and if appropriate, document that medical consultations were obtained. Alterations in your normal treatment regimen should be explained and justified. Medical consultations and biopsy reports of surgically excised tissue must be included.</p> <p>Medications All medications must be documented (include dosages, frequency of dosing and the condition for which the drug is being given).</p> <p>Vital Signs Vital signs must be recorded during the initial visit and monitored at subsequent appointments when indicated. Vital signs should include blood pressure, pulse, and temperature if swelling is present. This omission results in an unacceptable score.</p>

Dental History	<p>For each case submitted provide a thorough synopsis of the patient's dental history, including symptoms pertinent to the endodontic treatment.</p> <p>If you have included an X-ray from the referring dentist indicate that in this section.</p>
Clinical Evaluation (Diagnostic Procedures)	<p>Patient Information Confirm the patient's chief complaint and symptoms.</p> <p>Diagnostic Tests Report all diagnostic tests performed on adjacent and involved teeth and the findings as well as clinical signs.</p> <p>Radiographic Findings List significant radiographic findings (interpretations) from the recent pre-treatment radiograph(s)/image(s).</p> <p>Diagnostic Data You must include diagnostic data on all teeth in the affected quadrant or side, where appropriate. Pulp testing only the tooth to be treated is not acceptable. And don't forget to mention the extra-oral exam.</p>
Pretreatment Diagnosis	<p>Diagnosis Select a preoperative pulpal and periradicular diagnosis for each case from the drop-down box showing consistency with reported symptoms and examination findings, using all appropriate clinical tests.</p> <p>Approved Terminology See Pages 7-8 for approved terminology. If you use other terminology, list those terms on a cover sheet and give definitions. Use all terms consistently throughout the documentation.</p>
Treatment Plan	<p>Treatment Record a recommended plan of treatment based on the clinical diagnosis. Indicate an alternative treatment plan when appropriate. Make recommendation(s) for treatment following endodontic procedures when appropriate.</p> <p>Prognosis Indicate your prognosis as FAVORABLE, QUESTIONABLE, or UNFAVORABLE from the drop-down box.</p>
Clinical Procedures	<p>Appointments List in sequential order all dates the patient was seen.</p> <p>Informed Consent Indicate that informed consent was obtained.</p> <p>Procedures Describe and justify (where necessary) clinical procedures performed. Describe emergency care rendered (if any), complications encountered (if any and how managed). Indicate if treatment was modified in accordance with the medical and dental history. Application of biologic principles should be demonstrated. Include in the narrative that a follow-up was done that night or the next day on your emergency patient or the patient that had pain on their initial visit.</p>

<p>Clinical Procedures (Continued)</p>	<p>Techniques Instrumentation techniques, irrigants and medicaments, microbiologic findings (if any), obturating materials (including sealers) and techniques used, reports of biopsy findings and immediate post-treatment history should provide a summary of signs, symptoms, and radiographic findings.</p> <p>Anesthetic(s) Anesthetic(s) administered and amounts in milligrams. Make it clear when local anesthetic was not used and why.</p> <p>Medications Medications prescribed (including dosages, time intervals, method of administration, and rationale).</p> <p>Table Record the canal working length, master apical file, filling core, sealer, and obturation technique in the table provided.</p> <p>Postoperative Diagnosis Record the postoperative diagnosis <i>only if it differs</i> from the preoperative evaluation.</p>
<p>Postoperative Evaluation</p>	<p>Minimum of One Year A post-operative evaluation must be conducted after a minimum of one year (12 months) from the date treatment is completed. For example if the final date of endodontic treatment was 01/05/06, the soonest the recall examination could be completed is 01/05/07.</p> <p>Summary of Treatment Provide a summary of the treatment and/or restorative procedures that followed endodontic treatment. Record the clinical signs and symptoms associated with the case at recall, indicate the periodontal and restorative status with probing depths. Criteria for success should be described.</p> <p>Radiograph/Image Provide a recall radiograph/image and interpretation</p>

On the next three pages you will find the Case History Report Form and the Addendum Page. Please take a moment to note the actual format of the form. After you have completed the form with all the required information, the layout of this form should not change. You are only typing your information within the space provided, and if necessary, on the Addendum Page. For example, the section "Prognosis" under the subheading "G. Treatment Plan" should never move to the second page. It should remain at the bottom of the first page as it is in the original format. Please remember that the form must never be unlocked.

AMERICAN BOARD OF ENDODONTICS
CASE HISTORY REPORT

Case Report Number: _____

Candidate Number: _____

Patient Age: _____

Date Case Started: _____

Patient Sex: Select

Date Case Finished: _____

Date of Last Recall: _____

A. Tooth # (1 - 32): _____

B. Procedure Category: Select

OTHER subcategory _____

CHIEF COMPLAINT: _____

C. MEDICAL HISTORY: _____

D. DENTAL HISTORY: _____

E. CLINICAL EVALUATION: (Diagnostic Procedures)

Exam: _____

Tests: _____

Radiographic Interpretation: _____

F. PRE-TREATMENT DIAGNOSIS:

Pulpal: Select _____

Periradicular: Select _____

G. TREATMENT PLAN:

Recommended: _____ Emergency: _____

Definitive: _____

Alternative: _____

Restorative: _____

PROGNOSIS: Select

H. CLINICAL PROCEDURES: Treatment Record

Date: _____ **Operations:** _____

DIAGNOSIS (If different post-treatment)
HISTOPATHOLOGIC DIAGNOSIS (If biopsy)

Pulpal: _____
Periradicular: _____

CANAL (M,D,B,L, etc)	WORKING LENGTH	APICAL SIZE*	OBTURATION MATERIALS AND TECHNIQUES

*Size of the largest instrument used at the apex

I. POST-OPERATIVE EVALUATIONS: (Last recall recorded must be 1 year minimum)

Date: _____

Date: _____

Date: _____

ADDENDUM

Assembling the Portfolio

Cases are placed in numerical order (1-15). Please place the components of each case in the following order:

- 1. Pledge Form** Sign and place the form in the pocket of the notebook.
- 2. Case History Evaluation Form** Indicate the tooth number(s) for each case (you can write this information in by hand). Place in the pocket of the notebook along with the signed pledge.
- 3. Introduction*** A cover sheet describing routine policies and procedures. Keep the introduction and technique descriptions brief.
- 4. Abbreviation Explanation*** A document defining abbreviations (the use of abbreviations is acceptable but should be limited).
- 5. Terminology Explanation*** You should use the ABE approved terminology. Candidates are allowed to submit cases utilizing diagnostic terminology of their own choosing. However, it is essential that an introductory letter is provided preceding the cases that describes the terminology used in the Case History Form.
- 6. Case History Report Form*** Place in a page protector per instructions below.
- 7. Addendum Page*** If an Addendum Page was required, place it in a separate page protector.
- 8. Medical consults, laboratory and biopsy reports*** Place in page protectors (they can be placed back to back in sequential order). All supportive or supplemental materials must be masked to prevent identification of the Candidate, institution(s), geographic location, patient's name (e.g., pathology reports, medical lab reports and photos) and if required contain a translation in English notarized as a true copy.
- 9. X-Ray Mounts*** Place the X-ray mount in a page protector. Radiographs must be placed in the order of sequence they were taken. The case number, Candidate number and all X-ray dates need to be indicated on the X-ray mount form. Patient names cannot be listed. Refer to Page 9 for labeling requirements.
- 10. Digital Images*** Place the digital images in a page protector – two pages can be submitted per page protector – see instructions below - images must be placed in the order of sequence that they were taken. See Page 11 for labeling requirements.

***Page Protectors**

All documents included in the Portfolio should be placed in a page protector with the exception of the signed pledge and Case History Evaluation Form which are placed in the pocket of the notebook. Place the Case History Report form in the page protector with the back of page one (unprinted side) and the back of page two (unprinted side) together – after insertion it should read in the same way that a book does – upon turning page one of the report form, page 2 is now viewable in the same page protector. The Addendum Page is placed in a new page protector. Medical consultations, laboratory and biopsy reports are placed in chronological order in page protectors in the same manner as the Case History Report form (two to a page protector if applicable). X-Ray mounts are placed one to a page protector. Digital images should be placed in the notebook in chronological order two to a page protector as was completed for the Case History Report Form and supplemental materials.

Case History Evaluation Form Instructions

The Case History Evaluation Form indicates the required cases and the order of their placement in the Portfolio. Complete the Case History Evaluation Form by indicating the tooth number opposite the required procedure. Use the numbering system one to thirty-two to designate the teeth. Tooth number one (1) is the maxillary right third molar, tooth number sixteen (16) is the maxillary left third molar, tooth number seventeen (17) is the mandibular left third molar and tooth number thirty-two (32) is the mandibular right third molar.

**AMERICAN BOARD OF ENDODONTICS
CASE HISTORY EVALUATION FORM**

Candidate Number: _____ Prefix #: _____
Examiner: _____

Date Received: _____
Date Mailed: _____

CANDIDATE USE ONLY:

TYPE the Following:

Enter your Candidate Number above

Type the Tooth Number opposite the Required Procedure in column three

EXAMINER'S USE ONLY:

Enter evaluation scores as indicated for each of the three categories.

Excellent	3
Acceptable	2
Deficient	1
Unacceptable	0

Case No.	Required Procedures	Tooth No.	Clinical Evaluation, Diagnosis, Treatment Plan	Treatment, Post Treatment Evaluation	Complexity
1.	DIAG				
2.	EMERG				
3.	MED COMP				
4.	NS RCT				
5.	NS RCT				
6.	NS RCT				
7.	NS RCT				
8.	NS RCT				
9.	RETX				
10.	RETX				
11.	S RCT				
12.	S RCT				
13.	OTHER				
14.	OTHER				
15.	OTHER				

How Cases are Graded

Category Evaluation

Three Categories are evaluated for each case presented. The first score is for clinical evaluation, diagnosis and treatment plan. This covers the following sections of the Case History Report Form:

Section C	Medical History
Section D	Dental History
Section E	Clinical Evaluation
Section F	Pre-Treatment Diagnosis
Section G	Treatment Plan

The second category includes treatment procedures and post treatment evaluation. This covers the following sections of the Case History Report Form:

Section H	Clinical Procedures
Section I	Post-Operative Evaluations

The overall complexity of the case is the third category.

Each category is evaluated according to the following scale:

Excellent	3
Acceptable	2
Deficient	1
Unacceptable	0

The following chart and checklist will guide you through the scoring criteria used by the Directors and demonstrate how it applies to each section of the Case History Report Form.

The chart on the following page is the same chart that the Board uses as a guidelines in determining how to grade each Case History Portfolio. Please read it over carefully to understand what constitutes a grade of Excellent, Acceptable, Deficient and Unacceptable. Be sure to look at the "Deficient" and "Unacceptable" categories (not just the "Excellent" and "Acceptable" categories). Often times, we can learn more by knowing what not to do.

Following the chart is the Case History Portfolio Submission Checklist. Please use this checklist to your advantage. It is a vital step in the completion of your Portfolio.

Excellent

Pretreatment	Diagnosis and Treatment Plan	Treatment	Post-treatment	Documentation	Complexity
<p>Thorough medical and dental history was obtained.</p> <p>There was an appropriate review of systems.</p> <p>Appropriate medical consultations were obtained and documented.</p> <p>Vital signs were recorded.</p> <p>Medications were documented (including rationale for prescribing, dosages, and frequency of dosing).</p>	<p>Complete and thorough clinical findings were recorded.</p> <p>Appropriate diagnostic tests were performed and the results recorded.</p> <p>Appropriate radiographs/images and interpretation.</p> <p>The pulpal and periapical (periradicular) diagnosis was correct.</p> <p>The treatment plan was appropriate.</p> <p>Alternative treatment plans were appropriate.</p> <p>Possible complications were considered.</p> <p>Informed consent was obtained.</p>	<p>Clinical procedures were performed at the highest level of skill.</p> <p>All essential procedures were performed and in the appropriate sequence.</p> <p>Pharmacological management was appropriate and justified.</p> <p>Treatment was modified in accordance with the medical and dental history.</p> <p>Radiographs/images were adequate and demonstrate quality treatment.</p> <p>Application of biologic principles was demonstrated.</p>	<p>Appropriate recall intervals were prescribed.</p> <p>The clinical examination was complete and appropriate tests performed.</p> <p>Results were consistent with the treatment.</p> <p>Radiographs/images were appropriate and diagnostic.</p> <p>The tooth was adequately restored.</p>	<p>The narrative was complete, thorough, and readable with correct spelling and proper grammar.</p> <p>The terminology used was consistent with the ABE Terms.</p> <p>If different terminology was used, an explanation was provided.</p> <p>Abbreviations were adequately explained.</p> <p>The radiographic documentation was complete and of the highest quality.</p> <p>Procedures were justified and explained.</p> <p>Clinical photographs were of high quality and appropriate.</p> <p>The dates and treatment sequencing were accurate.</p>	<p>Required the highest level of knowledge and technical skill.</p> <p>Required the highest level of patient management.</p> <p>Treatment consultations were required.</p> <p>The treatment sequence was a critical component.</p>

Acceptable

Pretreatment	Diagnosis and Treatment Plan	Treatment	Post-treatment	Documentation	Complexity
<p>Lacking details.</p> <p>Minor information omitted that does not significantly affect the treatment and prognosis.</p>	<p>The pulpal and periapical (periradicular) diagnosis was correct despite the fact limited diagnostic tests were performed.</p> <p>The radiographic examination was inadequate.</p> <p>There is missing diagnostic information that does not affect the diagnosis, treatment plan, or prognosis.</p> <p>The alternative treatment plans were incomplete.</p>	<p>Procedures were performed at a satisfactory level.</p> <p>The treatment sequence was not appropriate but this did not affect the treatment outcome.</p> <p>Minor procedural deficiencies were evident that do not compromise the outcome.</p> <p>Procedures were not sufficiently documented or demonstrated.</p>	<p>The clinical examination and data provided was adequate but not sufficiently complete.</p> <p>Results reported were consistent with the data provided.</p> <p>The tooth was inadequately restored but noted in the narrative.</p>	<p>Minor errors are evident but do not affect the interpretation or understanding of the case.</p>	<p>High technical skill required.</p> <p>Adequate patient management.</p> <p>Treatment sequence important but was not critical.</p>

Deficient

Pretreatment	Diagnosis and Treatment Plan	Treatment	Post-treatment	Documentation	Complexity
<p>Incomplete medical and dental history.</p> <p>Insufficient information that influences the prognosis.</p> <p>Insufficient information that influences and/or affects the diagnosis, treatment, or prognosis.</p>	<p>The clinical examination was incomplete.</p> <p>Appropriate diagnostic tests were not performed.</p> <p>Interpretation of the data/radiographs (images) was incorrect.</p> <p>Alternative treatment plans were not appropriate or were missing.</p> <p>The prognosis was inaccurate.</p>	<p>Procedural errors were evident that may have affected the outcome.</p> <p>Treatment performed was not consistent with the diagnosis and treatment plan as outlined.</p> <p>Radiographs/images lack detail and proper interpretation.</p>	<p>Misinterpretation of radiographs/images.</p> <p>Poor quality of radiographs/images.</p> <p>Incomplete clinical examination.</p> <p>Failure to recognize the lack of a permanent restoration.</p>	<p>Frequent narrative errors.</p> <p>Poor grammar and spelling errors.</p> <p>Poor radiographs/images.</p> <p>Processing errors.</p> <p>Lack of medical consultation reports when indicated.</p> <p>The lack of biopsy reports when indicated.</p>	<p>Routine diagnostic and technical difficulty requiring average skills.</p>

Unacceptable

Pretreatment	Diagnosis and Treatment Plan	Treatment	Post-treatment	Documentation	Complexity
<p>The medical and dental history was not provided.</p> <p>Incorrect information was provided.</p> <p>Appropriate consultations were not obtained.</p> <p>Vital signs were not recorded.</p>	<p>No data to justify the pulpal and (periradicular) diagnosis.</p> <p>The pulpal and/or (periradicular) diagnosis was incorrect.</p> <p>Radiographs/images were improper or of poor quality.</p> <p>The treatment plan was incorrect.</p>	<p>Major procedural errors.</p> <p>Inappropriate treatment.</p> <p>Inappropriate pharmacological management.</p> <p>Sequence of treatment adversely affects the prognosis.</p> <p>Radiographs/images are of poor quality or do not demonstrate adequate treatment.</p> <p>Inappropriate application of biologic principles.</p>	<p>An appropriate clinical examination was not performed.</p> <p>Radiographs/images were inadequate.</p> <p>The radiographic interpretation was not correct.</p> <p>Appropriate treatment/recall recommendations were not provided.</p> <p>There was no recall of at least one year following completion of treatment.</p>	<p>Incomplete information.</p> <p>Information was presented that could not be interpreted.</p> <p>The narrative and/or radiographic documentation were not representative of the case.</p>	<p>The knowledge and technical skills required were within the scope of the general dentist.</p>

Case History Portfolio Submission Checklist

As you know, Candidates put in a great deal of time and effort into creating a Case History Portfolio. Due to the vast amount of required information and the very specific instructions that have to be followed in assembling the notebook, it is imperative that you review each one of your cases against the following checklist. It cannot be stressed strongly enough to use this document to review your entire notebook as it provides you with a comprehensive listing of the required information for each case. Submitting a notebook that does not include all of the required information could result in a failing grade. Simply put, a thorough review of each case has to be considered **the vital step** in the completion of your Portfolio.

The checklist follows the format of the Case History Report – please follow the list section by section, for each of the 15 cases.

Tooth Identification:

- Are the teeth properly identified?

Procedure(s):

- Is the procedure properly recorded?
- Is the subcategory completed for the three “Other” cases?

Chief Complaint:

- Is the patient’s chief complaint noted prior to treatment?

Medical History:

- Is the medical history adequate?
- Was the patient’s history or medication record considered?
- Is it documented that appropriate medical consultations were obtained?
- Were dental procedures appropriately modified to meet medical problems?
- Are all medications documented (include dosages, frequency of dosing and the condition for which the drug is being given)?
- Are vital signs, blood pressure, pulse, respirations (and temperature if infection is present) recorded?

Dental History:

- Is the dental history comprehensive – does it provide a thorough synopsis of the patient’s dental history, including symptoms pertinent to the endodontic treatment?

Clinical Evaluation (Diagnostic Procedures):

- Were the patient’s chief complaint, clinical signs and symptoms, and general dental condition recorded?
- Were reasonable and proper diagnostic tests and examinations performed?
- Were pre-treatment radiographs adequate?
- Were radiographic interpretations consistent with films presented?
- Are working radiographs included?

Pre-treatment:

- Were pulpal and periapical diagnoses consistent with medical, dental histories and results of diagnostic tests?
- Were all essential diagnostic procedures properly interpreted?
- Has the ABE Pulpal & Periapical Diagnostic Terminology approved April, 2007 been used?
- If other terminology was used, is it listed on a cover sheet and were the definitions given?
- Have all terms been used consistently throughout the documentation?

Treatment Plan:

- Was appropriate emergency and definitive treatment recommended? Was it performed?
- Were alternative treatment plans acceptable?
- Were appropriate recommendations for post endodontic treatment made?
- Was the prognosis consistent with the plan?
- Have the following terms been used for the prognosis – **Favorable, Questionable, or Unfavorable?**

Clinical Procedures:

- Was sequencing of appointments and timing of operations reasonable?
- Has it been recorded that informed consent was obtained?
- Are dates listed in sequential order?
- Were clinical procedures performed at the highest level of skill?
- Were all essential procedures performed in the appropriate sequence?
- Was emergency care (if any) appropriate?
- Has the emergency care rendered (if any) been described?
- Have the clinical procedures performed been described and justified (where necessary)?
- Does the report indicate if treatment was modified in accordance with the medical and dental history?
- Have complications encountered (if any and how managed) been described?
- Are the radiographs/images adequate and do they demonstrate quality treatment?
- Does the report contain quality radiographs/images? Films that are too dark, too light, not clear, digitals that are too small should not be used.
- Are there sufficient radiographs? Included should be angled views, working length measurements, cone fits, etc.
- Does the notebook include radiographs that show the entire periradicular lesion, what is described in the narrative and all of the canals and their apical terminations?
- Have anesthetic(s) been administered and amounts in milligrams been recorded?
- If anesthetic was not used, is it clear why?
- Was the pharmacological management appropriate and justified?
- Was treatment modified in accordance with the medical and dental history?
- Have the medications prescribed (including dosages, time intervals, method of administration, and rationale) been included?
- Does the report include the following?
 - Instrumentation techniques,
 - Length and size of intra-canal instrumentation at each visit,
 - Intra-canal irrigants and medicaments,
 - Microbiologic findings (if any),
 - Obturing materials (including sealers) and techniques used.
- Do the reports of biopsy findings and immediate post-treatment history provide a summary of signs, symptoms and radiographic findings?
- Is the application of biologic principles demonstrated?
- Have the canal, working length, master apical file, filling core, sealer, and obturation technique been recorded in the table provided?
- Was overall case management and treatment adequate and justifiable?

Post-Operative Evaluation(s):

- Are recalls completed one or more years following completion of treatment?
- Are reported results consistent with recall data provided?
- Is long-term prognosis consistent with data provided?
- Is the criteria for healing clear?
- Was biopsy obtained when tissue was removed?
- Do the post-obturation and recall radiographs clearly show the apical termination of each canal?

Case Criteria

- Are all your images dated and do they correspond with the narrative?
- Have you included at least one maxillary molar and one mandibular molar in the *Nonsurgical Root Canal Treatment* cases?
- Do have one molar case in the *Retreatment* category?
- In the Surgical Root Canal Treatment category is one of the cases a posterior (molar) surgery with root-end resection, root-end preparation and root-end fillings?
- In the *Other* category have you selected three dissimilar cases from the approved list?

General Documentation:

- Is written documentation clear and precise?
- Is data arranged in a neat, orderly fashion using correct spelling and proper grammar?
- Have you recorded dates consistently and accurately (e.g. do your dates match in the Case History Report Form, front and back and also match the date listed on the digital images/radiographs)?
- Does your completed Case History Report form exactly duplicate the copy of the form included in this document?
- Are the Case History Report forms inserted back to back in page protectors?
- If an Addendum Page was used is it inserted into a separate page protector?
- Are the radiographs mounted left to right in sequential order (and identified with a label maker or white label) and inserted into a page protector?
- Are all patient, doctor names and identifying locations completely masked at the top, bottom and in the body of the report?
- Have all patient photographs been masked to prevent identification?
- Is the diagnostic quality of the radiographs/images sufficient to derive the information reported?

Complexity

- Did this case require the highest level of technical skill?
- Did this case require the highest level of patient management?
- Did this case require the highest level of expertise in endodontic treatment?

Submission of the Portfolio

Policy requires that the Case History Portfolio is sent to the Headquarters Office of the ABE via certified mail with a return receipt, FedEx, UPS, or other similar services that provide tracking information. Candidates are strongly advised to duplicate and retain a copy of their Case History Portfolio before mailing. While Portfolios are circulated by FedEx to Directors of the Board for evaluation, we cannot be responsible for Case History Portfolios lost in transit.

Examination Scoring

The Board has modified the evaluation method for the Case History Portfolios to give equal weight to the components that make up the presentation of a case. Three categories are evaluated for each case presented. The Candidate's clinical evaluation, diagnosis and treatment plan make up the first score. Treatment procedures and post treatment evaluation (recall of at least twelve months) form the basis for the second score. The overall complexity of the case is the third score. This process is completed on each of the fifteen cases. During the Portfolio evaluation by three Board Directors, the Candidate's identity is always strictly protected. Evaluation of the fifteen prescribed cases gives the Directors knowledge and insight into the level of the Candidate's diagnostic and clinical skills. The ABE uses a multi-faceted analysis performed by an independent testing service. The impact of all facets of the examination is accounted for, including rater severity, case difficulty, and skill difficulty. This provides examination results that are valid and reliable.

Candidate Notification

The Secretary of the Board will notify the Candidate by letter whether the Case History Portfolio is acceptable or unacceptable. The Case History Portfolio will be returned to the Candidate after evaluation. Actual scores will not be released, although the Board Secretary may be able to provide feed back in general terms.

Appeal Process for an Adverse Decision

A Candidate who has received an adverse decision on the Case History Examination has the right to seek reconsideration of the adverse decision by filing a timely written request for reconsideration with the Secretary of the Board.

To be valid, the Secretary of the Board must receive the request for reconsideration within 30 calendar days after receipt by the Candidate of notice of the adverse decision. The request must contain a statement of why the Candidate believes that the adverse decision was improper and must include any supporting documentation that the Candidate wishes to have considered as part of the reconsideration. The request must be accompanied by a check or money order made payable to the American Board of Endodontics in the amount of \$100 to cover administrative costs associated with the appeal process. This fee shall not be refunded, regardless of the outcome of the appeal.

The Certification Process Timeline

Track I

Part I	Written Examination
Part II	Case History Portfolio Examination
Part III	Oral Examination

Track II

Part I	Case History Portfolio Examination
Part II	Written Examination
Part III	Oral Examination

Preliminary Application Submitted Before 2006	
Step	Maximum Time
Part I	3 years
Final Application	1 year
Part II	3 years
Part III	2 years

Preliminary Application Submitted 2006 or After	
Step	Maximum Time
Part I	3 years
Part II	6 years
Final Application	1 year
Part III	2 years

Completion Range	3-10 years
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Completion Range	1-10 years
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