Introduction

Periodontitis is a chronic inflammatory disease of the tooth’s supporting tissues. The continuous process of alveolar bone loss leads to the formation of bone defects around the teeth and in the interradicular region. The progression and expansion of periodontal disease into the bi- or trifurcation region of multirooted teeth is called furcation involvement (FI).

FI may be detected during the clinical assessment, while the destruction of periodontal tissue in the region between the roots can be detected as a furcation defect (FD) on radiographs. Clinical assessment is performed by probing using a Nabers probe, which isn’t always easy and accurate due to limited physical access to furcation region, morphological variations and errors in measurement. Radiographic diagnosis relies on two-dimensional (2D) and three-dimensional (3D) imaging modalities. The main limitation and major drawback of currently used conventional intraoral imaging methods for FD is the representation of a 3D structure in a 2D image, which leads to anatomical structures overlap. Precise
Material and methods

The study group was comprised of fifteen patients (11 women, 4 men, average age 44.5 years) with chronic generalized severe periodontitis. Selection was based on the following criteria: at least two intrabony defects with probing depth ≥6mm in both jaws indicated for surgery, no systemic disease, no pregnancy and lactation. Included patients were selected from the pool of patients at the Department of Periodontology, School of Dental Medicine, University of Belgrade. The study was approved by the Ethics Research Committee of the School of Dental Medicine, University of Belgrade, Serbia (ethics approval № 36/2). All study participants were informed of the examination purpose and signed an informed consent.

Clinical assessment of FI

Patients received hygiene instruction, scaling and root planning with ultrasonic device and hand instruments. Six weeks after initial periodontal therapy, when decision making related to the need for periodontal surgery was made, 30 upper molars at three furcation sites (buccal, mesiopalatal and distopalatal) and 36 lower molars at two furcation sites (buccal and oral) were analyzed using curved Nabers probe (PQ2N; PH-Friedy Europe, Rotterdam, Netherlands). A total of 168 furcation sites were analyzed by two independent, previously calibrated, experienced periodontists (k=0.697). The existence of FI was established when periodontal pocket detected by inserting the probe horizontally into the furcation. The clinical findings were recorded by using dichotomous scale: present/absent.

CBCT assessment of FD

CBCT scanning was performed using imaging system SCANORA 3Dx (Soredex, Tussula, Finland) and scanning parameters from the Table 1. CBCT image analysis was performed using recommended software (OnDemand3D, Cybermed, Korea) and 17” monitor (VA2232WA-LED, ViewSonic) with 1.280х1.024 resolution in a darkened room. Two observers with different working experience in the clinical and CBCT assessment were analyzed furcation regions of the upper and lower molars on CBCT images. The first observer was senior year undergraduate student (O1), whilst the second was a PhD student with a three-year experience in working with CBCT (O2). Both observers were briefly trained, and the protocol for the analysis of CBCT images was presented in detail to each of them before the radiographic evaluation. The existence of FD was recorded when the radiolucency observed between the roots of teeth. Each of the observers analyzed the CBCT images on two occasions, separately, with an interval of seven days, and was blinded for the clinical evaluation. FDs were assessed on CBCT images in all three planes (axial, sagittal, coronal) using a dichotomous scale: present/absent.

Table 1. Scanning parameters

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOV (mm)</td>
<td>80x100</td>
</tr>
<tr>
<td>Voxel size (mm)</td>
<td>0,25</td>
</tr>
<tr>
<td>Tube voltage (kV)</td>
<td>90</td>
</tr>
<tr>
<td>Tube current (mA)</td>
<td>10</td>
</tr>
<tr>
<td>Scanning time (s)</td>
<td>2,4</td>
</tr>
</tbody>
</table>

Statistical analysis

Statistical calculations were carried out using IBM SPSS, version 20. Intraobserver agreement for each observer was calculated by using Kappa coefficient (k) according to the following criteria: <0.10 = no agreement; 0.10 to 0.40 = poor agreement; 0.41 to 0.60 = moderate agreement; 0.61 to 0.80 = strong agreement; and 0.81 to
1.00 = excellent agreement\textsuperscript{16}. Interobserver agreement and agreement between CBCT data and clinical findings for both observers were calculated (ANOVA test, percentage).

**Results**

High intraobserver agreement for both observers was calculated using Kappa coefficient (strong agreement for the O1 k1 = 0.75, excellent agreement for the O2 k2 = 0.94). The number and percentage of FDs detected on CBCT images by both observers are presented in Table 2. Agreement between the observers in detection of FDs on CBCT images was 72.6 % for both jaw (Table 2). Interobserver agreement was slightly higher in the maxilla (73.0%) compared to mandible (71.7%) (Table 2). There was no statistically significant difference between observers in detection of FDs on CBCT images.

<table>
<thead>
<tr>
<th>CBCT O\textsubscript{1} ASSESSMENT</th>
<th>CBCT O\textsubscript{2} ASSESSMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAXILLA</td>
<td>ABSENT</td>
<td>PRESENT</td>
</tr>
<tr>
<td>ABSENT</td>
<td>8 (7.3%)</td>
<td>14 (13.0%)</td>
</tr>
<tr>
<td>PRESENT</td>
<td>15 (13.0%)</td>
<td>71 (65.7%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>108 (100.0%)</td>
<td>60 (100.0%)</td>
</tr>
<tr>
<td>AGREEMENT</td>
<td>73.0%</td>
<td>71.7%</td>
</tr>
</tbody>
</table>

**Table 3. Number (and percentage) of FI detected clinically and FD detected on CBCT images by the first observer (O1) and agreement between the methods, according to the jaw (maxilla / mandible).**

<table>
<thead>
<tr>
<th>CBCT O\textsubscript{1} ASSESSMENT</th>
<th>CLINICAL ASSESSMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAXILLA</td>
<td>ABSENT</td>
<td>PRESENT</td>
</tr>
<tr>
<td>ABSENT</td>
<td>20 (18.5%)</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>PRESENT</td>
<td>50 (46.3%)</td>
<td>36 (33.3%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>108 (100.0%)</td>
<td>60 (100.0%)</td>
</tr>
<tr>
<td>AGREEMENT</td>
<td>51.8%</td>
<td>43.3%</td>
</tr>
</tbody>
</table>

**Table 4. Number (and percentage) of FI detected clinically and FD detected on CBCT images by the second observer (O2) and agreement between the methods, according to the jaw (maxilla / mandible).**

<table>
<thead>
<tr>
<th>CBCT O\textsubscript{2} ASSESSMENT</th>
<th>CLINICAL ASSESSMENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAXILLA</td>
<td>ABSENT</td>
<td>PRESENT</td>
</tr>
<tr>
<td>ABSENT</td>
<td>23 (21.3%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>PRESENT</td>
<td>47 (43.5%)</td>
<td>38 (35.2%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>108 (100.0%)</td>
<td>60 (100.0%)</td>
</tr>
<tr>
<td>AGREEMENT</td>
<td>56.5%</td>
<td>41.7%</td>
</tr>
</tbody>
</table>

**Agreement between clinical findings and CBCT data for the first observer**

Agreement between the clinical and CBCT evaluation of furcation regions for the O1 was 48.8%, where 50% of FDs were detected on CBCT images, but not during the clinical examination (Table 3). Higher agreement between diagnostic methods was detected in maxilla (51.8%) than in the mandible (43.3%) (Table 3). The differences between tested methods was higher in the mesiopalatal sites of maxillary molars (agreement 44%), than in the in the buccal and distopalatal sites (agreement 55%) (Figure 1). The highest disagreement was presented in the examined furcation sites of mandibular molars, where the agreement between testing methods was the same in buccal and oral sites (43%) (Figure 1).
observers received detailed instructions regarding the CBCT image analysis during the training session. Furthermore, the results in the present study showed that there were no statistically significant differences between the observers when compared to clinical findings. These results are in accordance with the results of study Cimbaljevic et al.14, where FDs were more frequently detected on CBCT images than during the clinical examination. Almost half of the FDs were detected on CBCT images by both observers (50% by the O1, 48.8% by the O2), but not during the clinical examination by means of probing. Namely, only 2.1% of FI was detected clinically, but were not seen as FD on CBCT images during the radiographic evaluation by the O1. All the differences between the diagnostic methods was related to detection of FD on CBCT images, but not clinically by the O2. Likewise, stronger agreement between the diagnostic methods was observed in maxilla than in the mandible by both observers (Tables 3 and 4).

Regarding the all examined furcation sites, results showed that the highest differences between the observers was in the distopalatal region of maxillary molars (55% of FDs were detected by the O1, and 69% were detected by the O2). Also, the differences between the observers were detected in the buccal and oral region of the mandibular molars. Although these differences were not statistically significant, detection of FDs requires caution because of the possibility of “over-diagnosis”, while the underestimation may lead to inadequate treatment plan14.

The accuracy of the CBCT method in the analysis of FDs was assessed in several in vivo studies, and showed that surgical findings were in accordance with CBCT data in more than 80% of cases, which indicated that this method could have the potential in treatment decision making3, 10, 11. In the studies of Walter et al.10, 11. CBCT image analysis were conducted by two periodontist, whilst two trained radiologists, analyzed the furcation regions in the study of Qiao et al.3. Although CBCT image analysis were carried out by several researchers in the mentioned studies, the influence of clinical experience and experience in working with CBCT in analyzing FDs was not investigated.

Results of the present study are in accordance with the existing results in the literature17, 20, 21. In the study of Guo et al.17 four postgraduate students with different CBCT experience (three majoring in dental and maxillofacial radiology and one in periodontology) analyzed the level of alveolar bone on CBCT images17. Although all the researchers were post-graduates at different grades, intraobserver and interobserver variability was not found17. In another study, the dimensions of combined alveolar bone defects were measured on CBCT images and PA radiographs by three trained observers (the radiologist with two years of professional experience, and two master students in oral radiology)20. Agreement between the observers regarding
the identification of the pattern of alveolar bone loss and combined defect detection was about 100%20. In another study periodontal ligament space was assessed on CBCT images and PA by previously calibrated and trained dentists, dental assistants and dental students21. The significant difference between the observers was not found21. The authors pointed out that the observers’ calibration and training in CBCT image analysis play a more significant role in CBCT image interpretation than the observers’ clinical experience17.

Experimental studies (in vitro and ex vivo) which considered the impact of experience in working with CBCT showed high accuracy in FD detection on CBCT images12, 22-24. Three observers with different level of education (PhD student, two radiology faculty members) were assessing the alveolar bone level, craters and FD on CBCT images and PA22. No intra or interobserver variability was found in measurements or classification when the imaging methods were compared22. In the study of Umetsubo et al.12 initial FDs were detected by two observers with extensive experience in interpreting CBCT scans, who passed CBCT training. Moderate inter and intraobserver agreement could be explained by the fact that in the study a dry mandible was used and trabeculations were wide, only contrasting with air25. Likewise, in another in vitro study the impact of different voxel sizes on FD assessment in rat model were evaluated by two dentomaxillofacial radiology specialists and two periodontology specialists and showed strong and excellent intraobserver agreement (0.600 to 0.999) and moderate interobserver agreement (0.366 to 0.589)23.

The results of Fleiner et al.24 suggested an accurate assessment of bone craters and FD by means of CBCT. In this study, three trained and calibrated observers with different levels of CBCT proficiency (observers with 1, 3 and 6 years of working experience with CBCT devices) and several years of clinical experience assessed circumferential periodontal bone loss, intrabony craters and FD in the human dry cadaver skull and CBCT images24. They concluded that the effect of individual observers’ activity on measurement error was not statistically significant24. All clinically detected FI in the examined teeth could be radiologically detected and confirmed by all observers24.

The results of these experimental studies must be interpreted cautiously. The factors that may affect the clarity and accuracy of CBCT images, such as motion artefacts and artefacts due to the presence of metal structures (“scatter”, “streaking artifacts”, “beam hardening”) were avoided in these studies26-28. Further, it is also important to note that the artificially created defects were more regular in shape, with clearer edges and positioned on the expected sites than those that are formed in the course of periodontitis, which may facilitate their detection on CBCT images2.

Since no effort was made to calibrate the observers, the results of these study suggest that the detection of FD is not observer dependent. However, only the presence or absence of FD were assessed on the CBCT images with no attempt to classify the FD. Further studies are indicated to elucidate whether the CBCT proficiency and clinical experience would have an impact on FD classification on CBCT images.

Conclusions

According to the obtained results, it can be assumed that clinical experience and CBCT proficiency do not have an impact on FD detection on CBCT images, if an appropriate training was previously performed.

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References


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