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it should be noted that any endodontic therapy is more likely to be successful if the length of the root canal is known. there are reports in the literature where the length of root canals was estimated with the help of radiographs and then a working length was determined by using radiographic apex locators. according to leuckfeld and seibert, "overcorrection is the most common cause of treatment failure in endodontics and, thus, it should be avoided" [23]. if the length of the root canal is not estimated before treatment, it increases the risk of over treatment. if the working length of the root canal is not known, the procedure may be attempted with the available instrumentation. if the working length of the root canal cannot be determined radiographically, the final length of the root canal must be determined by using electrical resistance [24]. the quality of the coronal filling is an important factor in the outcome of endodontic treatment. most clinicians strive to achieve a tight and homogenous filling in the coronal third of the root canal. however, leakage is the most common complication associated with root canal filling and the most likely cause of endodontic failure. the leakage may be caused by microleakage or by macroleakage. the associations between demographic and anatomic characteristics and the presence of isthmi in the apical third are presented in table 3. among these factors, age, mbml isthmus (cervical third), the mbml orifice distance, and weines classification were found to be associated with the presence of isthmi in the apical third (p60years was 59.4% (38/64), 44.2% (196/443), 36.1% (91/252), and 23.4% (15/64), respectively, meaning the presence of isthmi in the apical third decreased with age. among mfms with isthmi in the apical third, 169 (49.7%) presented isthmi in the cervical third. in mfms without isthmus in the apical third, 188 (38.9%) had isthmi in the cervical third (p

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The success of endodontic treatment may be affected by a number of variables including tooth type, canal location and morphology, presence of a previous restoration and caries [5, 48]. Recently, several studies have shown that canal morphology influences the quality and success of root canal treatment, and it has been reported that the presence of ICCs may be as high as 52% [49]. Our review of the literature revealed only one case of tooth with two or more canals, where subgingival root resorption was observed in the furcation area of the maxillary left canine [49]. Recently, Kamburoğlu et al. [51] reported a case of a maxillary first permanent molar with two canals at the mesial root, where inflammation and migration of apical granulation tissue into the furcation area were observed on the left. The surgical treatment was performed, resulting in complete resolution and elimination of inflammation; the tooth was then endodontically treated 3 years after treatment. This case report provides strong evidence to support the possible benefits of surgical intervention as a treatment option for teeth with ICCs. It has been reported that some types of ICCs do not respond to endodontic therapy, and this has implications for treatment of the canal system [52]. There are a number of reasons that may be responsible for this. In some teeth, the root canal system is entirely open and or calcified and in such cases, the endodontic therapy that is available to the clinician is likely to be limited. This may also be the case for teeth with open or calcified root canals that are radiographically difficult to identify [45]. Notably, the presence of an ICC increases the chances of encountering canal perforations during access and preparation of the canal system [52]. Canal perforations increase the risk of microbial leakage and persistence of periapical infection in the treated tooth. This is not conducive to successful root canal treatment [53, 54]. 5ec8ef588b

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