



International Federation of
Endodontic Associations



**SPRIT
OF IFEA**

**IFEA
NEWSLETTER**

Vol. I 2024 - 2025





IFEA NEWSLETTER

Editorial by Catherine Ricci

Dear colleagues and friends,

When the General Assembly in Glasgow entrusted me with the mission — or rather, the challenge — of reviving a journal for the IFEA, I must admit I was surprised. After so many years of involvement within the Federation, I had assumed that digital tools were enough to keep us all connected. And yet...

Back in 1987, Jean-Marie Laurichesse launched the IFEA NEWSLETTER to give everyone occasional insight into the activities of the different national societies or associations. It was a modest tool, but a valuable one — nurturing that sense of belonging. Since then, communication methods have evolved. Our website now gives every member access to reports and updates from across the member associations. But let's be honest — it takes effort to search, click, and navigate.

That's precisely where SPIRIT OF IFEA finds its purpose: a publication that brings together, in one place, what makes our Federation so vibrant — events, research, educational initiatives, and most importantly, the spirit of community that drives us.



Editorial by Catherine Ricci

In this very first issue, we wanted to highlight that "IFEA spirit." That's why we asked the representatives of the countries present at the 15th World Endodontic Congress in Glasgow to share their impressions and reflections. Not everyone responded, but I want to warmly thank all those who took the time to contribute to this edition.

We also invite you to explore the work of the Research Committee, coordinated by David Jaramillo, and the recent research efforts led by our colleagues and rewarded with the Jean-Marie Laurichesse Research Award. The Education Committee, under the leadership of Mehmet Baybora, shares the flowchart on the management of internal root resorptions and the use of calcium hydroxide — a highly relevant clinical topic.

I would also like to take this opportunity to thank the IFEA Executive for renewing their trust in me for the preparation of this issue: Immediate Past-President Alan Nerwich, Treasurer Patrick Taylor, Secretary Hyeon-Cheol Henry Kim, President and my dear friend Elisabetta Cotti, and of course, President-Elect Gopi Krishna, who stood by my side throughout the development of this edition.

Finally, to all those who were unable to join us in Glasgow: I hope this issue inspires just one wish — to meet again in Sydney, Australia, in 2026 to celebrate together the global festival of Endodontics.

LONG LIVE IFEA !!



Presidential message

by Elisabetta Cotti



Welcome from the President !

Dear colleagues, dear friend endodontists from all over the world,

It is my pleasure to open this first issue of the new IFEA journal. It is also my pleasure to have Dr. Catherine Ricci, Past President, taking care of this project, Her loyalty and determination have been very important.

IFEA is in my heart since the very first World Congress which was held in Mexico City in 1990 when I was a new resident at Loma Linda University.

I was moving my first step towards a future profession and had the chance to understand how small the world becomes when you gather a thousand people and more from many different Countries to promote the field of Endodontics.

Ever since that congress I learned the pleasure of being connected even before the word "being connected" was invented and that consciousness has given my everyday job a twist, motivating the difficulties raising from working hard with the constant confrontation with my peers.

From that point on IFEA has become a big family for me.

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Presidential message

by Elisabetta Cotti

Now that I have the honor of being the president it is time to look forward.

We have navigated through the 2020 crisis and still were able to be together and held two world congresses online, we have instituted the World Endodontic Day, and IFEA is stronger than ever now representing 49 Endodontic Associations throughout the world.

Now it is time to move, and we are planning to continue promoting research for the younger members with the research price and helping developing Countries to implement the field of Endodontics. Next step will be to become more effective in the website creating additional session dedicated to Clinical Endodontics, and possibly a discussion forum to enhance the connection.

I take this opportunity to thank the present Executive Committee for their work and support, and the next WORLD ENDODONTIC CONGRESS TEAM working hard for SYDNEY.

Wait to see you in Australia, Sydney 2026.

Romans used to say: ad majora!



Message from Past-President by Alan Nerwich

IFEA Immediate Past-President report : Dr Alan Nerwich

It has been an honour to serve as IFEA President for the past two years. As my presidency comes to an end, I reflect on my 12-year journey with IFEA, realizing that a presidency is defined by the legacy one leaves throughout their entire tenure.

When I first joined IFEA as the Oceania Regent in 2012, the organization was far from the digital organization it now is. Most business was conducted via post, bank cheques, and other analogue means. The leaders at the time had realized that many governance issues needed review.

During my time as the Oceania Regent on the BOD and as IFEA transitioned to a paperless organization, I was given the task of rewriting the WEC guidelines and updating our By-Laws which finally were passed during my tenure as IFEA secretary on the Executive committee. During my time on the Executive Committee (EC), I realized that there was no legal protection for the Board of Directors (BOD) nor for the EC, and no formal contract arrangements for the World Endodontic Congress (WEC). Thankfully, we now have an insurance policy safeguarding our officers and a legal contract for the WEC which were both finalized during my term as IFEA president.

During my time on the Executive committee, we initiated the use of a secretariat in India to assist with organizational matters and ensure smooth transitions within the BOD and EC. Our website has been updated and continues to improve, and we have established a social media presence on Facebook and YouTube.

The journey, however, was not without challenges. Seven years ago, we lost contact with our treasurer, leading to significant financial difficulties. It took considerable dedication from our Executive Team, notably Drs Catherine Ricci, Elisabetta Cotti, Mark Wotzke and Patrick Taylor to reorganize our accounts, regain access to our funds and implement systems to prevent such issues in the future.

Another major challenge was the COVID-19 pandemic, which occurred during Dr. Cathy Ricci's leadership. The WEC in India was postponed and eventually held as a highly successful online conference, thanks to the tremendous efforts of Dr. Gopi Krishna and the organizing team. This experience not only demonstrated our resilience but also strengthened our global communication and collaboration, enhancing IFEA's relevance and influence worldwide.

During my presidency, we introduced World Endodontic Day, celebrated annually on October 16th, to promote endodontics and the importance of saving teeth. This initiative, conceived by Dr. Gopi Krishna, was a resounding success, with over 68,000 views for the inaugural online symposium. We look forward to continuing this tradition.

Our membership has now grown to over 45 countries confirming our status as the true Global endodontic group with a promising and exciting future.



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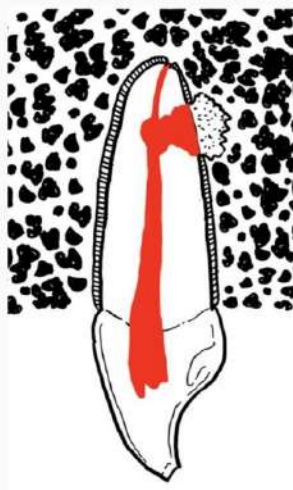
**SPIRIT
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IFEA EDUCATION COMMITTEE

POSITION STATEMENT

Management Of Internal Root Resorption: Suggested Clinical Protocol



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Introduction

Internal root resorption (IRR) results due to loss or damage of the predentin layer around the pulp chamber/root canal in association with a chronic inflammatory process, which activates odontoclasts leading to the progressive destruction of adjacent radicular dentin (1, 2). Based on the tissue present, IRR can be classified as inflammatory IRR (granulation tissue) or replacement IRR (granulation + bone-like tissue) (3). The data on the prevalence of IRR is uncertain and ranges from being as low as 0.01% to 28% (4, 5). A six-year long-term follow-up of 33 autotransplanted teeth demonstrated a incidence of 55% of IRR (6). This variation could be related to the etiology of IRR as well as methods used to assess prevalence. Numerous risk factors, such as traumatic injury, orthodontic tooth movement, excessive heat during restorative procedures, bleaching, and pulp capping procedures, have been proposed to be responsible for the development of IRR (2, 7). Damage to the unmineralized predentin layer with subsequent exposure of mineralized dentin is a crucial step for clastic cell adherence and initiation of IRR (8). The pathogenesis of IRR could be transient (self-limiting) or progressive based on the absence or presence of inflammatory triggers/pulp canal infection (9). The progression of IRR involves a complex process that includes continued noxious stimuli from the necrotic pulp tissue as well as sustained nutrients from the viable apical pulp in the resorptive lacunae (1).

Clinically, the IRR may be predominantly asymptomatic and often detected as an incidental finding in its early stages (4). In later stages, patients may present with acute or chronic pulpitis and/or apical periodontitis, which can manifest as pain, swelling, or discoloration (4). Based on location along the root canal, it can be categorized as coronal, middle, or apical IRR (3). Coronal IRR may present as a “pink spot” in the tooth due to the replacement of dental hard tissue with granulomatous tissue (2). Radiographically, inflammatory IRR is characterized as a round/oval-shaped radiolucent lesion along the root canal, which causes ballooning of the root canal (10). However, replacement IRR demonstrates mottled appearance radiographically (2). The progression of IRR may lead to complications, such as perforations into the periodontal space that cause periodontitis (3, 11). Complete removal of the pulp or necrosis of the pulp tissue can arrest the progression of IRR (1, 2). Gabor *et al.* (12) has shown that 50% of teeth with pulpitis exhibited IRR defects along the root canal, whereas nearly 77% of teeth with pulp necrosis demonstrated IRR. The resorptive lesions



occurred frequently in the middle and apical third in comparison to that of the coronal third of the root.

The irregularities within the root canal system, combined with the ballooning of the resorptive defect, often complicate the biomechanical preparation and root canal obturation procedures in IRR (2, 4). Therefore, managing IRR may be challenging if not diagnosed and appropriately treated, which could result in loss of the affected teeth.

Three-dimensional imaging techniques, in particular cone-beam computed tomography, is proven to be a valuable tool for the accurate diagnosis and treatment planning of IRR (13). This clinical protocol document aims to share some key strategies for effective management of perforated and non-perforated internal root resorption.

Clinical Protocol for Internal Root Resorption Management:

Long-term clinical outcome studies on treatment outcomes of internal root resorption are lacking in endodontic literature, probably due to the rarity of its occurrence and varied clinical characteristics. Currently, cumulative evidence such as systematic reviews on management and outcome of IRR is limited (14, 15, 16). A systematic review by Prialgauskė (14) has assessed the outcomes of IRR management; however, the inclusion was limited to only 38 teeth. The other two systematic reviews have restricted the inclusion criteria to regenerative endodontics as a therapeutic strategy for IRR (15, 16). Thus, the following protocol for preoperative assessment and arrival of a diagnosis followed by therapeutic management is proposed based on systematic search of evidences published in endodontic literature.

Preoperative Assessment

Transient IRR is associated mostly with intra-alveolar root fractures and can be presented as internal surface or tunneling resorption and is self-limiting (13). Progressive IRR, such as inflammatory and replacement types, shows similar clinical presentation and is predominantly asymptomatic, which may be an incidental finding during routine radiographic examination (3). The clinical symptoms depend on the pulpal status and usually respond positively to pulpal sensibility tests. Based on the degree of inflammation of the pulp, IRR can be presented as pulpitis with apical periodontitis



(3, 4). Coronal IRR has to be differentiated from external cervical root resorption by assessing the delineation of the outline of the root canal through the resorptive defect on an intraoral periodical radiograph (4). However, the European Society of Endodontics recommends the use of cone beam computed tomography in distinguishing IRR from external cervical resorption (ECR) as well as assessing the degree and extension of perforation to the external root surface (4, 13, 17, 18).

Preoperative assessment involves

- 1) Careful documentation of the patient's history to assess the potential causes of the resorption
 - i) Etiology such as traumatic injury or orthodontic treatment,
 - ii) Medical status of the patient
 - iii) Previous dental treatment (root canal treatment, dental fillings, and periodontal scaling)
- 2) Clinical examination should include assessing vitality, discoloration, pain, swelling, sinus tract presence, and any existing cracks or fractures.
- 3) Radiographic examinations/imaging

Following the routine radiograph examination, Cone Beam Computed Tomography (CBCT), having a high resolution with reduced field of view (FOV) and voxel size evaluation, should be carried out for:

- i) A differential diagnosis between IRR and EICR
- ii) The size of the resorptive defect
- iii) The exact localization of the resorptive defect
- iv) Communication to the periodontium, indicating perforation.
- v) The size of the perforation site in the external root surface
- vi) Size of apical lesion (if needed)



Once internal root resorption has been diagnosed, the clinician should evaluate the prognosis and categorise into favourable or questionable. Smaller resorptive defects are generally associated with favorable prognosis may in comparison to larger defects, as the remaining dentinal thickness is adequate and provides structural support reducing the risk of tooth fracture.

Monitoring and extraction as therapeutic strategies:

Monitoring IRR is suggested for transient lesions and is followed up annually for assessment of the progression of resorptive lesions (2). IRR lesions in the coronal third of the root canal that are large with the ballooning of the canal expanding to the outer thirds of root dentin and/or perforating the outer surface with extensive circumferential spread could be considered for extraction (4).

Restorative strategies for IRR:

Clinical Scenario 1: If the internal root resorption does not perforate the root, an orthograde approach may be suggested;

Clinical Procedure

- 1.1. Administer local anesthesia for the innervation of the tooth with resorption.
- 1.2. Remove existing crowns if present.
- 1.3. Under rubber dam isolation, remove restorations or caries if present.
- 1.4. Prepare an appropriate access cavity to provide direct access to the root canal or canals of the tooth that has internal resorption.
- 1.5. Determine the working length for each canal, including the one with resorption.
- 1.6. The creation of a glide path using hand instruments may be preferred because of the possibility of irregularities creating discontinuities in the resorbed root.
- 1.7. Following the creation of the glide path, the root canals are biomechanically prepared using appropriate instruments. If the case is a multirooted tooth, root canals not affected by internal root resorption (IRR) can be in-



strumented using rotary systems. The root canal, including the resorptive defect, has to be properly shaped to aid irrigation of this irregular space.

1.8 Remove granulation tissue from the resorptive defect, using 2.5 – 5.25% sodium hypochlorite (NaOCl). Irrigation is a crucial step in the management of internal root resorption. Tissue-dissolving ability as well as antimicrobial activity of NaOCl makes it an ideal irrigant for management of IRR(19).

1.9. Activate the NaOCl using sonics, ultrasonics, laser-agitated approaches, or finishing files. This activation increases the dissolving capacity and antibacterial effect of the NaOCl (20, 21, 22). It has been suggested that the use of anatomic finishing files was the most effective method to remove the granulation tissue both physically and by activating the irrigation solutions (22). These files can adapt the irregular areas three-dimensionally and provide effective removal of granulation tissue inside the resorptive defect.

1.10. Fill the entire root canals, including the resorptive defect, with calcium hydroxide (23). Do not skip the calcium hydroxide dressing and complete the treatment of root resorption in one session. Calcium hydroxide with an ideal pH of 12 not only provides a satisfactory disinfection of the root canal system, but it also inhibits the clastic activation that is crucial to arrest root resorption (24, 25).

1.11. After 2-4 weeks, the calcium hydroxide can be removed from the root canals in non-perforated cases. Although the resorption area is not large and perforating, the use of multiple calcium hydroxide dressings is suggested to increase the efficacy of biomechanical debridement of the internal root resorption defect (3). Use 2.5%-5.25% NaOCl in combination with any appropriate chelating agent (17% ethylenediaminetetraacetic acid (EDTA)/ 2% peracetic acid (PAA)/9% etidronic acid), which may be activated using ultrasonic energy or a diode laser (26).

1.12. The root canal affected by internal resorption can be obturated using thermoplastic gutta-percha techniques. These techniques were suggested to provide a better adaptation of the obturation material to the irregular areas, like resorptive defects, compared to the cold lateral condensation (27). However, the risk of periodontal tissue damage due to the rise in temperature of the external root surface when using thermoplastic gutta-percha techniques should be weighed against their benefits, as the resorption cavity has thin dentinal walls (28).



1.13. Calcium silicate-based cements can be used with the hybrid technique described by Hsien *et al.* (29). Use of tricalcium silicate-based cements increases the fracture resistance of roots with internal root resorptions and thin dentinal walls obturated using hybrid techniques (30).

1.14 .Restore the access cavity using resin composites

Clinical Scenario 2. If the internal root resorption defect perforates the root, an orthograde approach combined with surgical intervention or an orthograde approach alone may be suggested.

If the resorption results in a perforation, endodontic-periodontal communication is created. Before deciding on the appropriate treatment approach, the following items should be evaluated:

- a) Location of the perforation site,
- b) Dimensions of the perforation site,
- c) Location of the tooth in the dental arch,
- d) Marginal bone level,
- e) Presence or absence of bone in the perforating area,
- f) Patient cooperation.

An orthograde approach may be suggested when:

- 1. The dimension of the perforation site is not so large.
- 2. The perforation site is not accessible within surgical procedures (e.g., perforations localized at the apical third of the root).
- 3. The cortical bone thickness around the tooth is not appropriate for surgical intervention. e.g., mandibular molar teeth may not be convenient to be operated on surgically, as this region has a thick cortical plate and there is sufficient marginal bone level.



4. The tooth with internal resorption is located in the regions of the dental arch that are difficult to reach for surgical procedures.
5. The patient does not consent for the surgical intervention.

Clinical procedure

- 2.1. Administer local anesthesia for the innervation of teeth with resorption.
- 2.2. Remove existing crowns if present.
- 2.3. Rubber dam isolation is to be performed.
- 2.4. Remove restorations or caries if present.
- 2.5. Prepare an appropriate access cavity to provide direct access to the root canal or canals of the tooth that has internal resorption.
- 2.6. Determine the working length for each canal, including the one with resorption.
- 2.7. The creation of a glide path using hand instruments may be preferred because of the possibility of irregularities creating discontinuities in the resorbed root.
- 2.8. Following the creation of the glide path, the root canals are chemo-mechanically prepared using appropriate instruments. If the case is a multirrooted tooth, root canals not affected by internal root resorption (IRR) can be instrumented using rotary systems. The root canal, including the resorptive defect, has to be properly shaped to aid irrigation of this irregular space.
- 2.9. Remove all granulation tissue from the involved canal, rinsing with copious sodium hypochlorite (NaOCl). Irrigation is a crucial step in the management of internal root resorption. Due to the tissue-dissolving ability of granulation tissue inside the resorptive defect and the root canal system, 2.5%-5.25% NaOCl is recommended as an irrigant (22). NaOCl also has antibacterial activity that plays an important role in the treatment of root resorption cases (19). However, the irrigation can be limited to the coronal region of IRR due to its inadvertent effect in case of extrusion through the perforation site (2, 17).



2.10. Activate the NaOCl using sonics, ultrasonics, laser-agitated approaches, or finishing files. This activation increases the dissolving capacity and antibacterial effect of NaOCl (20, 21, 22). It has been suggested that the use of anatomic finishing files was the most effective method to remove the granulation tissue both physically and by activating the irrigation solutions (22). These files can adapt the irregular areas three-dimensionally and provide effective removal of granulation tissue inside the resorptive defect.

2.11. Fill the entire root canals, including the resorptive defect, with calcium hydroxide to ensure antibacterial ability and prevent elastic activity (24, 25).

2.12. After 1 week, remove the calcium hydroxide from the root canals. Use of 5.25% NaOCl combined with any appropriate chelating agent, 17% ethylenediamine tetraacetic acid (EDTA), 2% peracetic acid (PAA), or 9% etidronic acid, which is activated using ultrasonic energy, laser, or anatomic finishing files. However, consider that some chelating agents could deteriorate the structure of dentine and result in erosion and hardness reduction in dentine (31). These changes may be harmful to the fragile roots with thin dentinal walls in the resorption site.

2.13. Place a freshly prepared calcium hydroxide dressing inside the root canal to decrease the size of the perforation area and provide an unmineralized matrix around the perforation site, which can act as a barrier to prevent the extrusion of tricalcium silicate-based cement. Depending on the size of perforation, calcium hydroxide dressing is retained for 4 to 12 weeks. Furthermore, long term application of calcium hydroxide allows to observe the healing signs of the periapical bone defects. However, to reduce the treatment duration, an internal matrix, such as collagen, can be placed at the perforation site to prevent the extrusion of the tricalcium silicate-based cements and to ease the packing procedures of the filling material (23, 32).

2.14. Remove the calcium hydroxide from the root canal using NaOCl and a chelating agent.

2.15. Obturate the root canal with internal root resorption using the hybrid technique (29). Fill the root canal below the root resorption defect with gutta-percha, and use tricalcium silicate-based cement such as MTA or Biodentine (29) to fill the resorptive defect and the perforation



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3.5. Fill the perforation site using tricalcium silicate cement such as MTA, Biodentine, or tricalcium silicate cements, adapting the external anatomical shape of the root. Scientific evidence suggests that the use of MTA or other bioactive materials in the perforation area within the root facilitates new periodontal attachment (34). On the other hand, discoloration of MTA should be considered before repairing resorptions in the anterior teeth.

3.6. Replace and suture the mucoperiosteal flap.

3.7. Prescribe the patient analgesics. Recall the patient for suture removal after one week.

3.8. In the presence of mobility, a semi-rigid splint can be used for 1–2 weeks.

Postoperative follow-up

The patient should be recalled for clinical and radiographic follow up initially once every month and every 3 months the first year. Annual follow-ups for five years for assessment of survival and clinical success is suggested as appropriate. The tooth is considered to have a good survival prognosis if the patient is asymptomatic clinically and no progression of existing resorption.

Formation of new resorptive sites, tooth fracture or development /increase in size of periapical lesion are the unfavorable outcomes.

In conclusion, treatment of IRR can be challenging due to the varied and complex clinical characteristics. Conventional therapeutic strategy usually comprises of removal of the inflamed pulp, thereby arresting the clastic activity and restoring the root canal and defect with non-surgical root canal techniques. The introduction of tricalcium silicate cements have revolutionised the treatment options. Long term clinical outcome studies are needed with this therapeutic option as well as use of bioceramic sealers for IRR



Acknowledgements:

We gratefully acknowledge Dr. Balaram Alagappan for his valuable contribution by creating the graphical representation of the therapeutic strategies of IRR, which enriched the content of this document, and Dr. Vasfiye Isik for her considerable effort in the preparation of the decision tree.

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Management of Internal Root Resorption

Clinical & Radiographical- CBCT evaluation

Root resorption perforating the root with communication to the periodontal space

No

1.1 Biomechanical preparation with appropriate instruments and 2.5%-5.25% NaOCl activation with Ultrasonics or Sonics

1.2. *Ca(OH)₂ Intracanal medicament (for 2-4 weeks).

1.3. Removal of Ca(OH)₂ with 2.5%-5.25% NaOCl activation in combination with 17% EDTA, 2% PAA or 9% Etidronic acid and finally with saline

1.4 Obturation with thermoplastic gutta-percha technique with sealer or Tricalcium silicates (Complete canal)

1.5. Follow-up

*For long-term application, Ca(OH)₂ can be mixed with glycerine or propylene glycol
NaOCl- Sodium hypochlorite, Ca(OH)₂ - Calcium Hydroxide, EDTA- Ethylene diamine tetra acetic acid, PAA- Peracetic acid, MTA- Mineral Trioxide Aggregate

No

2.1. Biomechanical preparation with appropriate instruments and 2.5%-5.25% NaOCl activation with Ultrasonics or Sonics

2.2. *Ca(OH)₂ intracanal medicament (for 1 week)

2.3. Removal of *Ca(OH)₂ with 2.5%-5.25% NaOCl activation in combination with 17% EDTA, 2% PAA or 9% Etidronic acid and finally with saline / distilled water.

2.4. Reapplication of Ca(OH)₂ for 4-12 weeks and / or placement of collagen matrix

2.5. Obturation performed with Hybrid technique- Filling of the apical third of canal upto the resorptive defect with gutta percha and sealer. The resorptive defect and perforation site using tri calcium-silicate cements(MTA/Biodentine) (or)
Complete Obturation of the canal, resorptive defect and perforation with tricalcium silicate cement

2.6. Follow-up

Yes

Large perforation size, proximal bony defect, Accessible perforation area, patient consenting to surgical approach

Yes

Follow the steps 2.1 to 2.3

3.1. Obturation performed with:

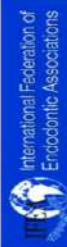
Hybrid technique- Filling of the apical third of canal upto the resorptive defect with gutta percha and sealer. The resorptive defect and perforation site using tri calcium-silicate cements(MTA/Biodentine) (or)
Complete obturation of the canal, resorptive defect and perforation with tri calcium silicate cement

3.2. Surgical Access to perforation site

3.3.- Sealing the perforation externally using tricalcium silicate cements. Surgical Flap repositioning and suture placement.

3.4 Stabilization of the tooth with semi rigid splint for 1-2 weeks in case of mobility .

3.5. Follow- Up



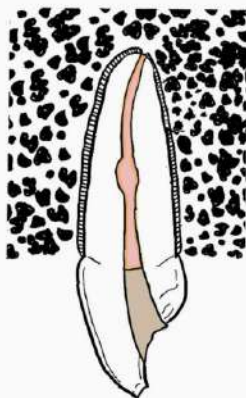
International Federation of
Endodontic Associations

Atasey Ulusoy OI, Cotti E, Suresh N, Gopikrishna V,

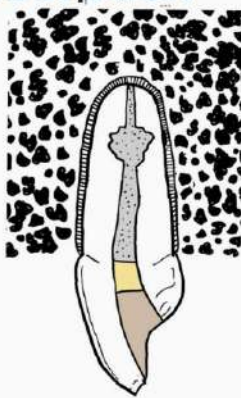
Kavahan MIB



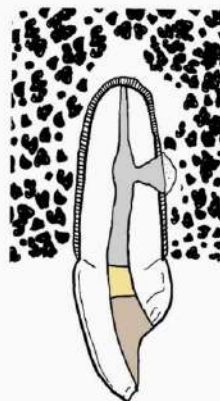
Treatment strategies for internal root resorption



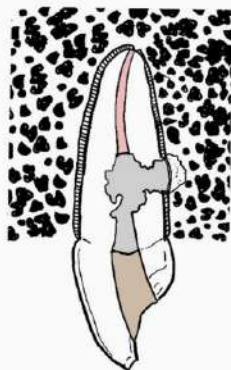
A- IRR without perforation treated with complete obturation of the canal with thermoplastic gutta percha



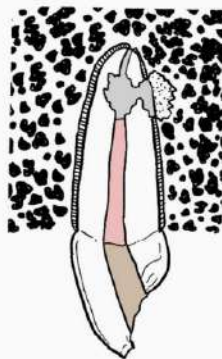
B- IRR without perforation treated with complete obturation of the canal with Tricalcium silicates



C- Mid or coronal third IRR with short roots associated with perforation treated with complete obturation of the canal with the Tricalcium silicate cement



D- Mid third IRR with perforation treated with hybrid obturation with apical gutta-percha and resorptive defect filled with tricalcium silicate cement. Can be performed with orthograde or surgical approach depending on the perforation location



E- Apical IRR with perforation treated with reverse hybrid obturation with apical resorptive defect filled with tricalcium silicate cement and backfilled with thermoplastic gutta-percha.



IFEA JEAN-MARIE LAURICHESSE RESEARCH AWARDS

As Chair of the IFEA Jean-Marie LAURICHESSE Research Award, I'm pleased to report that we have received 14 applications this year. Consistent with previous years, the applicant pool is strong, with projects demonstrating significant potential.

The applications cover a diverse range of topics, including:

- Two on sealers
- One educational project
- Three in regenerative endodontics
- Two in microbiology
- One addressing stress and endodontics
- Three focused on pulpotomy and newer materials
- One on root resorption
- One concerning post-root canal treatment restorability.

AWARDEE # 1

Principal Investigator – Dr. Claudia Isabel Brizuela Cordero Santiago, Chile

Topic – "Assessing the Efficacy of Biomarkers in Dentinal Fluid for Pulp Diagnosis and Prognosis of Vital Pulp Therapy Outcomes"

Research Grant awarded – 4000 USD

AWARDEE # 2

Principal Investigator – Dr. Annie Shrestha, University of Toronto, Canada

Topic – "Engineering a Biomimetic Microenvironment for the Maintenance of Dental Pulp Stem Cells"

Research Grant awarded – 2000 USD



GLOBAL ENDODONTIC SYMPOSIUM

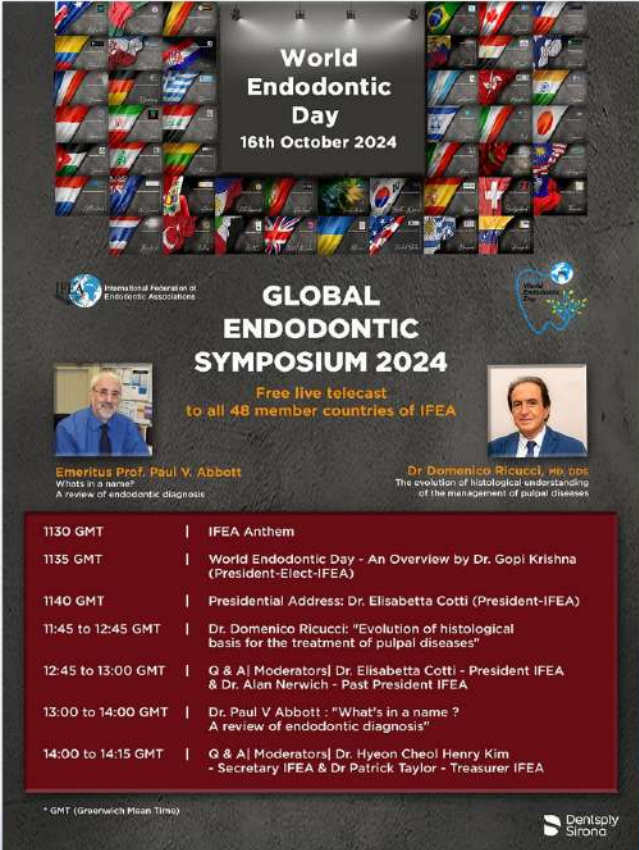
World Endodontic symposium was celebrated on October 16, 2024 worldwide. IFEA organized a *Global Endodontic Symposium* for the benefit of all dentists globally.

This event was organized on our own exclusive online portal wherein any interested dentist can login and register for the symposium.

Dr Domenico Ricucci and Prof Paul Abbott shared their insights with two webinars that was telecasted on Oct 16th 2024.

The symposium was free for all dentists globally.

-The live stream occurred on October 16th, 2024 (1200 GMT onwards) to commemorate the World Endodontic Day.



The poster for the World Endodontic Day 16th October 2024 features a grid of various national flags at the top. Below the title, it mentions the International Federation of Endodontic Associations (IFEA) and the Global Endodontic Symposium 2024. It highlights a free live telecast to all 48 member countries of IFEA. Two speakers are featured: Emeritus Prof. Paul V. Abbott, who will discuss 'What's in a name? A review of endodontic diagnosis', and Dr. Domenico Ricucci, who will discuss 'The evolution of histological understanding of the management of pulpal diseases'. A detailed schedule of events is provided at the bottom, starting from 11:30 GMT with the IFEA Anthem and ending at 14:15 GMT with a Q & A session. The poster also includes the IFEA logo and the Dentsply Sirona logo.

World Endodontic Day
16th October 2024

International Federation of Endodontic Associations

GLOBAL ENDODONTIC SYMPOSIUM 2024

Free live telecast to all 48 member countries of IFEA

Emeritus Prof. Paul V. Abbott
What's in a name?
A review of endodontic diagnosis

Dr Domenico Ricucci, PhD, DDS
The evolution of histological understanding of the management of pulpal diseases

11:30 GMT	IFEA Anthem
11:35 GMT	World Endodontic Day - An Overview by Dr. Gopi Krishna (President-Elect-IFEA)
11:40 GMT	Presidential Address: Dr. Elisabetta Cotti (President-IFEA)
11:45 to 12:45 GMT	Dr. Domenico Ricucci: "Evolution of histological basis for the treatment of pulpal diseases"
12:45 to 13:00 GMT	Q & A Moderators Dr. Elisabetta Cotti - President IFEA & Dr. Alan Nerwich - Past President IFEA
13:00 to 14:00 GMT	Dr. Paul V Abbott : "What's in a name ? A review of endodontic diagnosis"
14:00 to 14:15 GMT	Q & A Moderators Dr. Hyeon Cheol Henry Kim - Secretary IFEA & Dr Patrick Taylor - Treasurer IFEA

* GMT (Greenwich Mean Time)

Dentsply Sirona

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WORLD ENDODONTIC DAY

Social Media creatives in various World languages



WORLD ENDODONTIC DAY

Social Media creatives in various World languages



WORLD ENDODONTIC DAY

Social Media creatives in various World languages



WORLD ENDODONTIC DAY

Social Media creatives in various World languages



WORLD ENDODONTIC DAY

Social Media creatives in various World languages



WORLD ENDODONTIC DAY

Social Media creatives in various World languages



RADIO CAMPAIGN BY INDIAN ENDODONTIC SOCIETY TO PROMOTE WORLD ENDODONTIC DAY

"Endodontists are dental specialists in saving natural teeth"

ALL INDIA FM RADIO CAMPAIGN

OCTOBER 16

City	Media Name	Language	Frequency	Time Band
Coimbatore	Radio City	Tamil	91.1	0700-1100 & 1700-2300
Madurai	Radio City	Tamil	91.9	0700-1100 & 1700-2300
Pondicherry	Radio Indigo	English	91.9	0700-1100 & 1700-2300
Pondicherry	Radio Mirchi	Tamil	104	0700-1100 & 1700-2300

One message : 12 languages : 22 cities in India

"Endodontists are dental specialists in saving natural teeth"

ALL INDIA FM RADIO CAMPAIGN

OCTOBER 16

City	Media Name	Language	Frequency	Time Band
Pune	Radio City	Hindi / Marathi	91.1	0700-1100 & 1700-2300
Bhubaneswar	Big FM	Odia + Hindi	92.7	0700-1100 & 1700-2300
Guwahati	Big FM	Assamese + Hindi	92.7	0700-1100 & 1700-2300
Ahmedabad	Radio Mirchi	Gujarati + Hindi	98.3	0700-1100 & 1700-2300

One message : 12 languages : 22 cities in India

"Endodontists are dental specialists in saving natural teeth"

ALL INDIA FM RADIO CAMPAIGN

OCTOBER 16

City	Media Name	Language	Frequency	Time Band
Ludhiana	Radio City	Punjabi	91.1	0700-1100 & 1700-2300
Patiala	Radio City	Punjabi	91.1	0700-1100 & 1700-2300
Jalandhar	Radio City	Hindi	98.3	0700-1100 & 1700-2300
Chandigarh	Radio Mirchi	Hindi	98.3	0700-1100 & 1700-2300
Bhopal	Radio Mirchi	Hindi	98.3	0700-1100 & 1700-2300

One message : 12 languages : 22 cities in India

"Endodontists are dental specialists in saving natural teeth"

ALL INDIA FM RADIO CAMPAIGN

OCTOBER 16

City	Media Name	Language	Frequency	Time Band
Cuttack	Radio Mirchi	Odia	98.3	0700-1100 & 1700-2300
Hyderabad	Radio City	Hindi / Telugu / Ma	91.1	0700-1100 & 1700-2300
Bangalore	Radio City	Kannada	91.1	0700-1100 & 1700-2300
Chennai	Radio City	Tamil	91.1	0700-1100 & 1700-2300

One message : 12 languages : 22 cities in India

"Endodontists are dental specialists in saving natural teeth"

ALL INDIA FM RADIO CAMPAIGN

OCTOBER 16

City	Media Name	Language	Frequency	Time Band
Delhi	Radio City	Hindi	91.1	0700-1100 & 1700-2300
Mumbai	Radio City	Hindi	91.1	0700-1200 & 1700-2300
Chennai	Radio City	Tamil	91.1	0700-1100 & 1700-2300
Kolkata	Radio Mirchi	Hindi-Bengali	98.3	0700-1200 & 1700-2300

One message : 12 languages : 22 cities in India

WORLD ENDODONTIC DAY

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IFEA WORLD ENDODONTIC CONGRESS 2024 GLASGOW



A Vibrant International Congress in Glasgow

Over 1,200 participants, 75 countries represented, and an unforgettable scientific and social program: a look back at a landmark event.

From September 11 to 14, 2024, Glasgow (Scotland) hosted the IFEA World Endodontic Congress, bringing together more than 1,200 participants from 75 countries. A unique gathering that combined knowledge, exchange, and camaraderie.

The General Assembly, one of the highlights of the event, welcomed representatives from 40 member countries, while the scientific program, rich and diverse, unfolded across multiple simultaneous sessions. (GOPI, If you have any informations about the numbers of rooms, how many scientific sessions, country Reps or whatever, tell me or complete this text)

But it wasn't just about science—the social program was equally remarkable. The Welcome Reception, held at the Glasgow Science Centre, surprised attendees with the inauguration of an interactive endodontics exhibit titled "At the Root of It", designed to be both educational and engaging—even for young children.

The following day, the Opening Ceremony electrified the audience with a high-energy concert by the Red Hot Chilli Pipers, followed in the evening by a traditional Scottish Ceilidh in the heart of the city at Merchant Square. The festivities concluded on Friday evening with a spectacular Gala Dinner at the iconic Kelvingrove Art Gallery and Museum, where guests enjoyed the stunning setting, impressive collections, and a traditional Scottish menu featuring the famous haggis.

After four days of fruitful discussions and unforgettable moments, it was time to say goodbye. Everyone left with fantastic memories and one thought in mind: meeting again in 2026 in Sydney for another edition.



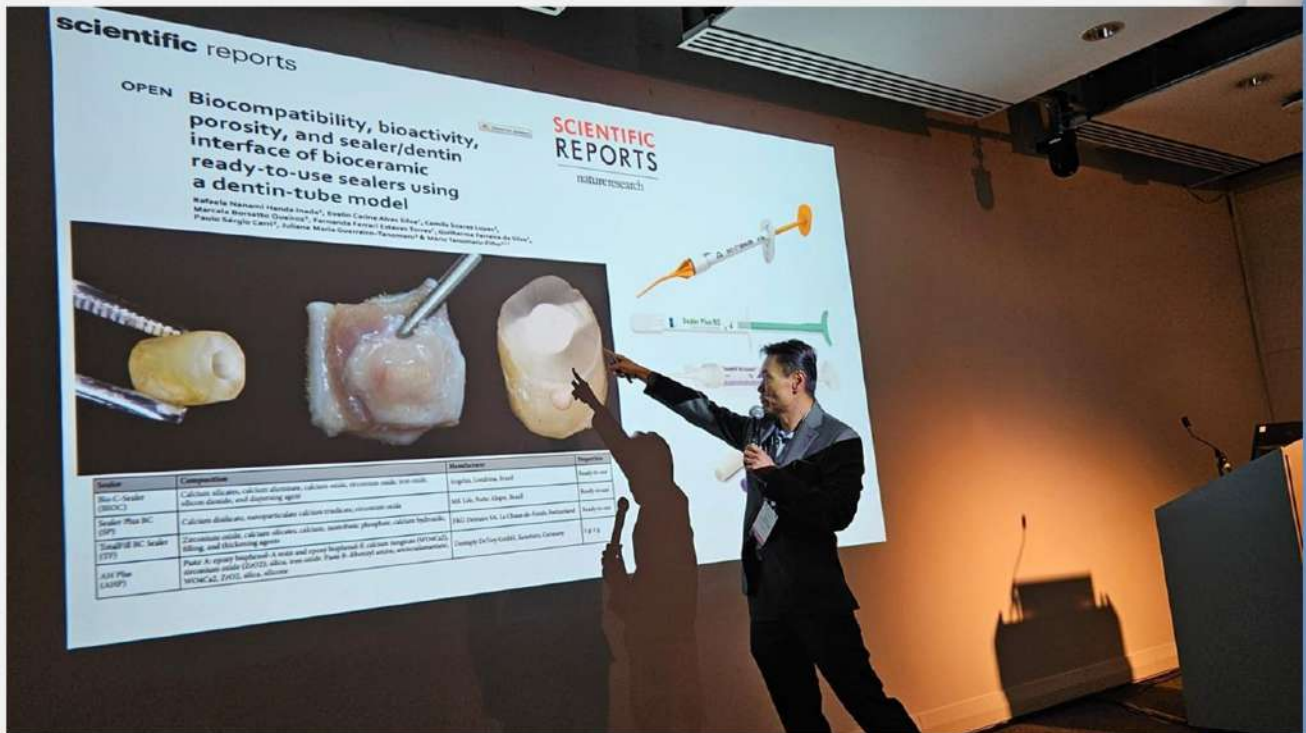
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**SPRIT
OF IFEA**



BRAZIL :



Mario Tanomaru Filho,

Speaker representing the Brazilian Endodontic Society

The World Endodontic Congress - Glasgow represented the excellence of endodontics worldwide



CANADA :



Dr Brian D. Jafine,

Canadian Academy of Endodontics representative.

The IFEA World Endodontic Congress held in Glasgow was a resounding success. The combination of first-class endodontic speakers, exhibits and social events created an atmosphere which will likely not be duplicated. A good time was had by all who attended. Looking forward to the next World Endodontic Congress.

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COLOMBIA



- A Remarkable Experience
at the IFEA World Endodontic Congress

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**SPIRIT
OF IFEA**



COLOMBIA



- A Remarkable Experience at the IFEA World Endodontic Congress

Representing Colombia at the IFEA World Endodontic Congress in Glasgow was an unforgettable experience. The event was a hub of innovation, where top experts shared insights shaping the future of endodontics. I had the honor of presenting my work on tissue engineering applied to regenerative endodontics, which led to fascinating discussions on biomaterials and new clinical approaches. Beyond the scientific exchange, Glasgow itself was a highlight—walking through its historic streets, visiting its incredible art museums, and enjoying its vibrant culinary scene made the experience even more enriching. The congress not only strengthened professional connections but also allowed me to absorb the magic and charm of this wonderful city. Grateful to IFEA for this inspiring opportunity and excited for the future of global endodontics.

Best Regards Camilo Andrés Alfonso.

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FRANCE :



Alexis Gaudin,

President of the French Endodontic Society during his presentation

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FRANCE :



MATHIEU DURAND, President-elect with ADAM AZIZ

We had a truly wonderful time at the IFEA Congress in Glasgow!

The IFEA Board was incredibly welcoming, and it was a pleasure to meet all the leaders of the other national associations.

The congress was a great success, with high-level lectures and very friendly, enjoyable evenings. An enriching and memorable experience!



INDIA



The IFEA World Endodontic Congress 2024 in Glasgow saw one of the strongest representations of India on the global stage, with more than 25 delegates from premier institutions across the country showcasing the nation's scientific strength in Endodontics. One of the highlights was a keynote lecture by **Dr. V. Gopi Krishna**, Secretary General of Indian Endodontic Society, titled "Pulp Preservation Protocols: Position Statement from Indian Endodontic Society." This presentation brought India's latest clinical guidelines to the world stage. The lecture was based on an official IES position statement on vital pulp therapy protocols, co-authored by leading Indian endodontists (including Dr. Ruchika Roongta, Dr. Ajay Logani, Dr. Pankaj Sangwan, Dr. Vasudev Ballal and Dr Gopikrishna) published in the Endodontology journal.

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Dr. Pragya Pandey (King George's Medical University, India) won the Third Prize in the IFEA Research Award 2024 competition for her original study "Effect of Low-Level Laser Therapy during Regenerative Endodontic Procedure in Necrotic Young Immature Permanent Teeth – Clinical and Molecular Perspective." The work offered significant clinical and molecular insights into the use of low-level laser therapy in regenerative procedures and received strong commendation from international peers.

The Glasgow congress saw one of the largest Indian delegations in recent memory, with professors, clinicians, and researchers from across the country actively participating. Notable Indian delegates included: Dr. Ajay Logani (AIIMS, New Delhi), Dr. Ajay Chabra (AIIMS Kalyani), Dr. Jigyasa Grover (PGIMS, Rohtak), Dr. Harpreet Singh (SIRO, Ludhiana), Dr. Rakesh Yadav (KGMU, Lucknow), Dr. Ramesh Bharti (KGMU, Lucknow), Dr. Aarti Bohra (SMBT, Nashik), Dr. Krishna Biswas (AIIMS Kalyani), Dr. Krishna Vyas and many others leading practitioners. These representatives from leading academic and clinical institutions showcased a range of scientific papers, posters, and lectures on the world stage.





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SCHOOL OF
DENTISTRY

P.L.M. Tomson BDS, PhD, MFDS RCSEd, RCSEd,
FDS (Rest Dent) RCSEd
Head of Endodontics
Tel: +44 (0)121 466 5173
Fax: +44 (0)121 625 8815
Email: p.l.tomson@bham.ac.uk

19th September 2024

Dr Pragya Pandey,
Additional Professor,
Department of Conservative Dentistry and Endodontics,
Faculty of Dental Sciences
King Georges Medical University, Lucknow.

Dear Pragya,

Re: IFEA Research Prize 2024

Thank you for your submission and your presentation at the IFEA World Endodontic Congress in Glasgow last week for the IFEA Research Prize 2024. The Scientific Committee were delighted to shortlist your work amongst the many submissions that were received, and the judging panel were very happy to award you 3rd place following your excellent presentation. Your original research was very interesting and a of a very high standard. Congratulations on this work. I encourage you to continue to pursue the high standards you demonstrated and you will inevitably make a valuable contribution to our discipline as your career continues to progress, very well done!

Good luck with your future academic endeavours.

Very best wishes,

Your sincerely

Dr P. L. Tomson
Chair of the Scientific Committee for the
14th IFEA World Endodontic Congress



**SPIRIT
OF IFEA**



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IRAQ



It was an outstanding event to be a participant in the Glasgow World Endodontic Congress. I have seen many scientific events and I can say that this event is a highly organized scientific congress. The Iraqi Endodontic Society participated by Hussain Al-Huwaizi (myself and my wife), Adel Alani and Linz Shalan.

Regards
Hussain Al-Huwaizi

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ITALY :



FILIPPO CARDINALI

Country representative of the Italian Endodontic Society

IFEA Congress in Glasgow was a blast !! It has been my first participation as speaker on site after the 2 online during pandemic; honored to represent the Italian Society of Endodontics during a lecture that captured the interest of many participants.

Perfect organization starting from the amazing opening ceremony followed by a very interesting high quality scientific program. And as usual a lot of fun meeting friends from all around the world during the congress and the social activities. Looking forward to the next IFEA Congress in Sydney!!!!



FILIPPO CARDINALI,
With Elisabetta Cotti
during the Dinner Gala

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LEBANON



At the entrance of Kelvingrove Art Gallery, before the Dinner Gala

The Lebanese Society of Endodontology was happy to attend IFEA 2024 in Glasgow! It was truly a memorable journey. The congress brought together a passionate global community of endodontists, and it was both exciting and inspiring to be part of such a rich exchange of knowledge and innovation. The atmosphere was vibrant, the scientific content outstanding, and the interactions—whether in lecture halls or over a cup of coffee—sparked fresh ideas and lasting connections.

Glasgow itself added a special charm to the experience, with its blend of history, warmth, and unmistakable Scottish spirit. Attending IFEA's 2024 edition left us with not only academic insights but also heartfelt memories and a renewed sense of pride in being part of this dynamic field. LSE is already looking forward to IFEA Sydney!

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LEBANON



Carla Zogheib

The Lebanese representatives with Hyeon-Cheol Henry Kim (IFEA Secretary), Mehmet Bayboran (Education Committee Chairman) and Sam Dorn (IFEA Past President)

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At the Dinner Gala, with the Executives



MEXICO



Gisella Cañaveras Zambrano

Representative of Mexico Endodontic Association
at the IFEA General Assembly

The 2024 IFEA World Endodontic Congress was an exceptional event, bringing together over 80 international speakers and offering a diverse range of endodontic topics. This gathering not only advanced our academic knowledge but also fostered professional exchange across borders, strengthening global connections.

Representing Mexico and Mexican Endodontic Association, Dr. Alberto Díaz Tueme had a presentation on "Selective Endodontic Retreatment.", which was warmly received by attendees. Additionally, during the IFEA 2024 General Assembly, I attended on behalf of our president, Dr. Jaime Barahona Baduy.

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MEXICO



With William Mc Lean during the Gala Dinner

The extraordinary IFEA World Congress reaffirms our unwavering commitment to global collaboration and the continuous advancement of our specialty.

The social program enriched the academic experience, providing an opportunity to explore Scotland's rich culture and strengthen connections with colleagues from around the world.

An extraordinary congress that reaffirmed the importance of global collaboration in endodontics and the commitment to advancing our specialty.

Truly, this event was an enriching experience.

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TAIWAN



Wan-Chuen Liao

Country representative speaker of
Taiwan Academy of Endodontology

IFEA 2024 in Glasgow was an incredible networking opportunity—not only to stay updated on the latest research and clinical advancements but also to connect with endodontic experts and friends from around the world. It was truly a joyful and unforgettable experience for me

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UKRAINE



Yuriy Riznyk
Speaker and Country representative

When I learned I would have the opportunity to represent Ukraine at IFEA 2024, two lifelong dreams came true: my childhood dream of visiting Scotland and my professional ambition to present at this prestigious congress. Since eighth grade, I had always wanted to travel to Scotland, and ever since beginning my endodontic practice, presenting a report at IFEA had felt nearly impossible.

While attending this incredible event, I was captivated by Scotland's beauty and the friendliness of the people, who showed kindness at every stage of my journey through Britain. At the congress, I was especially impressed by the number of world-renowned experts in endodontics—authors whose research and publications I have studied over the past 15 years.



UNITED STATES OF AMERICA



Natasha Flake, President of the AAE during her lecture

I attend several Endodontic meetings annually and my observation of the meeting in Glasow was very positive. I thought the plenary sessions; exhibit hall and social events were very well done. The meetings of the IFEA Board and the AGM were well run too.

I thought Glasgow was a great host city, and the venue accessibility was good, especially if you stayed at the hotel next to the event center.

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The AAE Board visiting Glasgow



Promoting the 16th WEC in 2028
at New York City

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URUGUAY



With Gopi Krishna (President-elect)



During the Welcome Reception with
Nicolas Ferraro (Chile) and
Jose Aranguren (Spain)

Iliana Modyeievsky,

Country representative speaker of the Uruguay
Endodontic Society

The IFEA congress in Glasgow 2024 was an excellent meeting . The president and his team were seeing all the details in the organization..

The convention centre was very nice and the scientific level was excellent. It was for me to see a lot of endo friends from all over the world and also meet other colleagues. The social activities were wonderful and very funny.

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At the Ceilidh reception
at Merchant Square with
William Mc Lean
(President of the WEC)

The gala dinner was spectacular!!!

It was the 2nd time that I'm a lecturer at the IFEA congress representing my country Uruguay and also my first lecture in english.

I hope to repeat this experience in Sydney.



With all the
South American
representatives
at the end of the
presentation

REFLECTIONS FROM THE SOUTH AMERICA REGENT – LILIANA ARTAZA



The World Endodontic Congress in Glasgow marked the conclusion of a very meaningful chapter for me as IFEA Regent for South America, a role I had the honor of holding since my appointment in Seoul in 2018.

Over these six years, our region experienced remarkable growth within IFEA—expanding from five to eight member countries and building a more connected and dynamic community. It has been a privilege to accompany this process and witness the commitment and excellence of endodontic professionals across South America.

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At the Welcome reception
with Gopi Krishna and Catherine Ricci



During the Gala Dinner with
South American
representatives



The Glasgow Congress was a true celebration of knowledge, global collaboration, and our shared dedication to advancing the specialty. I cherish this experience deeply and step down from the role with gratitude and excitement for the future of South America within IFEA.

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REFLECTIONS FROM THE NORTH AMERICAN REGENT - BETTINA BASRANI



During the Welcome reception

The IFEA Meeting in Glasgow was truly outstanding! A fantastic lineup of speakers, engaging discussions, and a wonderful opportunity to connect with colleagues from around the world. The organization was impeccable, and the warm Scottish hospitality made it even more special. Looking forward to the next one in Australia 2026

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At the Gala Dinner



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