The Case History Portfolio Submission Guidelines were updated on the following dates.

August 2013

Page 19 ‘Clinical Procedures’ ‘Anesthetic(s)’ “Name and amount of local anesthetic(s) administered” replaces “Anesthetic(s) administered and amounts in milligrams”

Page 19 under ‘Clinical Procedures’ ‘Technique’ the following sentence was added to the end of this section: “If a rubber dam clamp does not show on working length or cone-fit radiographs, explain your technique of rubber dam application”

The Case History Grading Criteria has the following changes:

In the ‘Excellent’ section, “Informed consent was not obtained” was moved from the ‘Diagnosis and Treatment Plan’ column to the ‘Treatment’ column

In the ‘Deficient’ section the statement “Radiograph and Digital Image dates are not referenced in the narrative (for example, the write-up must state that a radiograph or photograph was made in the appropriate location of the Case History template was added to the ‘Pretreatment’, ‘Diagnosis and Treatment Plan’, ‘Treatment’, and ‘Post-treatment’ columns

In the ‘Unacceptable’ section, “No informed consent” was added to the ‘Diagnosis and Treatment Plan’ column.

Important Notice Regarding the Case History Portfolio Submission Process

Portfolios will no longer be returned to Candidates for correction following the first review
Failed Notebook

If a notebook contains one or more of the following errors, it will be returned to the Candidate and will be recorded as a failed exam.

Required Case Categories
The Portfolio will fail if any of the required cases have not been submitted or are not in the correct order.

Photograph Masking
If this has not been done, the entire portfolio will fail.

Document Masking
If complete masking has not been done, the entire portfolio will fail.

One-Year Recall
If the one-year recall requirement was not met in any of the required cases, the entire notebook will fail

Page Protectors
If all reports, radiographs and images have not been put in page protectors per the instructions, the entire notebook will fail.

Failed Case

If a Case contains one or more of the following errors, the case will receive a zero in each of the three areas that are graded.

<table>
<thead>
<tr>
<th>Clinical Evaluation, Diagnosis, Treatment Plan</th>
<th>Treatment, Post Treatment Evaluation</th>
<th>Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Radiographs, Digital Images
Radiographs and images are not placed in date sequence
Quality of radiographs/images did not meet criteria
Smaller than 2x3 or larger than 5x7

Case Number, Candidate Number, Dates
Not indicated on radiograph mounts and/or printed on digital images

Cone Beam Computed Tomography
Submission was not a screen shot with adequate masking

Non-English Language Documents
English translation not included

May 2013
The requirement of submitting a Medically Compromised has been eliminated.

Current Case Requirements.

Diagnosis
One Case
Diagnostic evaluation of the patient (dental or systemic) was the most significant feature of the case. A one year recall is not required for this case. Adequate documentation that assures a definitive diagnosis was made should be included in the write-up.
Emergency
One Case
Emergency treatment procedures in addition to endodontic procedures were required, e.g. incision for drainage, trephination, or splinting with rationale for their use.

Nonsurgical Root Canal Treatment
Two Cases
Nonsurgical root canal treatment, including cases with calcified canals, curved/long canals, unusual anatomy, etc. These two cases must include one maxillary molar and one mandibular molar.

Nonsurgical Retreatment
Two Cases
These two cases must be molars. Whether they are mandibular, maxillary, or both is at the discretion of the candidate.

Periapical Surgery
One Case
Maxillary or Mandibular Molar Periapical Surgery with Root-end Resection and Root-end Filling.

Other
Three Cases
The three cases presented in this category can be selected by the Candidate from the above case types, from the list below, or any surgical or non-surgical case of sufficient complexity that fits in the Current Scope of Endodontic Practice. (Note that Case Types May Be Repeated)

In addition to the categories previously described, this category may include, but is not limited to management of:

- Traumatic injuries and their sequelae (crown/root fractures, luxations, avulsions, etc.)
- External/internal resorption
- Iatrogenic/resorptive perforations
- Incompletely Developed Apices (Vital Pulp Therapy and Apexogenesis, Apexification, Apical Barriers, Pulp Revitalization or Regeneration)
- Perio-Endo lesions
- Hemisections/Root amputations
- Intentional replantation/transplantation
- Ortho-Endo Cases (such as root extrusion)
- Separated instrument/Post removal
- Developmental Anomalies (dens invaginatus, gemination/fusion, etc.)

Medically Compromised (A one year recall is not required for this case type)
Endodontic management of a medically compromised patient. This requires modification of treatment procedures because of the patient’s medical condition. 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.

Note: When a Diagnosis Case is submitted as an Other case type, a one-year recall is required.

Osseo-integrated implants or endodontic endosseous implants are not acceptable.
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 American Board of Endodontics has two very important announcements to make regarding the Case History Portfolio Exam.

After much discussion and careful consideration the Board has decided to revise the First Reviewer grading process for the Case History Exam. There are now certain criteria, which if not met, will result in an automatic failure of an entire portfolio. In keeping with our policy, if your portfolio fails once, you can submit again during a later cycle provided your eligibility is still current. However, if your portfolio fails twice, you must re-establish eligibility in order to again take the exam and continue to pursue Board Certification.

The Board has also outlined other grading criteria that will not fail a portfolio, but will fail an entire case, which is a great detriment to your overall grade.

Included in the guidelines you will the Candidate Review Document that explains in detail the criteria for “Errors That Result in a Failed Portfolio” and “Errors That Result in a Failed Case”. This is a checklist that you must now go through, sign and submit along with your completed Case History Exam. The Candidate Review Document is designed to help you proof and prepare your portfolio. We urge you to use it wisely, and for each of your cases. If a mentor is reviewing your portfolio, give the document to your mentor so that they can check for errors, too.

The Case History Exam fee of $435 is required when submitting your portfolio. Payment can be made by check (place check in an envelope and put inside your notebook) or can be paid through PayPal. The link for PayPal is on our website http://www.aae.org/casehistoryexam/. Please submit a copy of your receipt from PayPal with your portfolio.

The Case History Report Submission Guidelines were created to give you a well-illustrated and 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.

Again, please read the guidelines 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,

Karl Keiser, D.D.S., M.S.
Secretary
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Important Notice Regarding the Case History Portfolio Submission Process

Candidate Review Document
The first examiner uses the Candidate Review Document on page 32 during the initial evaluation.

Portfolios will no longer be returned to Candidates for correction following the review of the portfolio by the first examiner.

Failed Notebook
If a notebook contains one or more of the following errors, it will be returned to the Candidate and will be recorded as a failed exam.

Required Case Categories
The Portfolio will fail if any of the required cases have not been submitted or are not in the correct order.

Photograph Masking
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Document Masking
If complete masking has not been done, the entire portfolio will fail.

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Page Protectors
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If a Case contains one or more of the following errors, the case will receive a zero in each of the three areas that are graded.

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Radiographs and images are not placed in date sequence
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Case Number, Candidate Number, Dates
Not indicated on radiograph mounts and/or printed on digital images

Cone Beam Computed Tomography
Submission was not a screen shot with adequate masking

Non-English Language Documents
English translation not included
It is extremely important that each Candidate carefully review the revised policy and carefully follow the Candidate Review Document on page 32 as they prepare their cases. This document must be signed by the Candidate and submitted with their portfolio.

Careful attention to detail during portfolio preparation will ensure that each Candidate’s portfolio is accepted and graded in a timely fashion.
Starting your Portfolio

The Case History Report Submission Guidelines were created to give you a well-illustrated and 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.

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.

Below are common errors and also suggestions from the ABE examiners.

Incomplete Document Masking
This error occurs in approximately 25% of the portfolios submitted each circulation and will result in an automatic failure.

All identifying information must be thoroughly masked. This includes but is not limited to all names (Candidate, facility, patient, physician, referring dentist), addresses (the entire address must be masked), phone and fax numbers, and signatures, SSN, Medicare and Medicaid numbers, etc.
After you have completed the masking, please be sure that you read the documentation and the Case History Report Form from top of the page to the bottom to ensure you have masked all identifying text.
Before inserting into a page protector, make a copy of the report and submit the copy. This will prevent information being visible through the pen or marker used to mask the information

Radiographs/Images
Poor quality radiographs/images that are too dark, too light, not clear, or too small are just a few examples.
Images/radiographs must be high quality and supportive of the narrative.
Must be referenced to in the narrative (for example, the write-up must state that a radiograph or photograph was made in the appropriate location of the Case History template), and dates must match back to the dates in the Case History Form. This is a very common error.
Do not submit photographs unless they truly help illustrate your case.
Lack of sufficient radiographs (no angled views, working length, cone fits etc.).
Radiographs that do not reveal: 1) the entire periradicular lesion if present, 2) what is described in the narrative, or 3) all of the canals and their apical terminations.
Lack of bitewing radiographs when restorability is questionable

Anesthetics
Amounts and/or 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 Examiner as being the number one egregious error.

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.
Not making recommendation about HBP or checking HBP at subsequent appointments
Textbook descriptions of techniques in the introduction
Not making appropriate recommendations to referring dentist for restoration

Suggestions for Improvement
Justify the use of analgesics and antibiotics
Root Canal Anatomy: if you find unusual anatomy or additional canals, make sure that your images show it (working films, finals and recalls).

“Copious irrigation.” What does that mean? What is the volume?

Limit abbreviations to one (1) page and use the ones that are listed.

Cases with very little to no diagnostic/treatment information in the write-up; conversely if every case needs an addendum sheet then your write-ups are too verbose and can be condensed. Give me enough information that I know what’s going on but don’t write a novel.

Absence of comments regarding restorative recommendations for the treated tooth

Cases where the final radiographic outcome looks ambiguous or somewhat suspect to me and the write-up assures me that all turned out great. The radiographs should substantiate the information in the write-up.

Inadequate dental history

Not confirming original symptoms are no longer present on recall visit. Example: Patient is percussion sensitive at original visit and doctor never performs this test on recall.

Not putting clinical testing results in table format
Case Submission Dates

Portfolios are accepted for review twice a year – **May 1 and September 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 ten specific cases (as explained below) that they have selected from their specialty practice of endodontics and that demonstrate a broad spectrum of diagnostic, treatment, and evaluative procedures, **with 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.

**Case 1**
**Diagnosis**
Diagnostic evaluation of the patient (dental or systemic) was the most significant feature of the case. **A one year recall is not required for this case. Adequate documentation that assures a definitive diagnosis was made should be included in the write-up.**

**Case 2**
**Emergency**
Emergency treatment procedures in addition to endodontic procedures were required, *e.g.* incision for drainage, trephination, or splinting with rationale for their use.

**Cases 3**
**Nonsurgical Root Canal Treatment**
Nonsurgical root canal treatment, including cases with calcified canals, curved/long canals, unusual anatomy, etc. **This case must be maxillary molar**

**Case 4**
**Nonsurgical Root Canal Treatment**
Nonsurgical root canal treatment, including cases with calcified canals, curved/long canals, unusual anatomy, etc. **This case must be a mandibular molar.**

**Cases 5**
**Nonsurgical Retreatment (Maxillary or Mandibular Molar)**

**Cases 6**
**Nonsurgical Retreatment (Maxillary or Mandibular Molar).**

**Case 7**
**Periapical Surgery**
Maxillary or Mandibular Molar Periapical Surgery with Root-end Resection and Root-end Filling.

**Cases 8, 9 & 10**
**Other**
**Three Cases**
The three cases presented in this category can be selected by the Candidate from the above case types, from the list below, or any surgical or non-surgical case of sufficient complexity that fits in the **Current Scope of Endodontic Practice.** *(Note that Case Types May Be Repeated)*
In addition to the categories previously described, this category may include, but is not limited to management of:

- Traumatic injuries and their sequelae (crown/root fractures, luxations, avulsions, etc.)
- External/internal resorption
Iatrogenic/resorptive perforations

Incompletely Developed Apices (Vital Pulp Therapy and Apexogenesis, Apexification, Apical Barriers, Pulp Revitalization or Regeneration)

Perio-Endo lesions

Hemisections/Root amputations

Intentional replantation/transplantation

Ortho-Endo Cases (such as root extrusion)

Separated instrument/Post removal

Developmental Anomalies (dens invaginatus, gemination/fusion, etc.)

Medically Compromised (A one year recall is not required for this case type)
Endodontic management of a medically compromised patient. This requires modification of treatment procedures because of the patient’s medical condition. 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.

Note: When a Diagnosis Case is submitted as an Other case type, a one-year recall is required.

Osseo-integrated implants or endodontic endosseous implants are not acceptable.
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.

Pulpal & Periapical Diagnostic Terminology
In February 2010 the ABE unanimously voted to support the adoption of the diagnostic terminology proposed by the Consensus Conference on Diagnostic Terminology and published in the December, 2009 special issue of the *Journal of Endodontics*. We applaud the efforts of the American Association of Endodontists to arrive at terminology supported by best evidence.

This terminology is 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 and 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 you 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 pulp testing.

Reversible Pulpitis
A clinical diagnosis based upon subjective and objective findings indicating that the inflammation should resolve and the pulp return to normal.

Symptomatic Irreversible Pulpitis
A clinical diagnosis based on subjective and objective findings indicating that the vital inflamed pulp is incapable of healing. Additional descriptors: Lingering thermal pain, spontaneous pain, referred pain.

Asymptomatic Irreversible Pulpitis
A clinical diagnosis based on subjective and objective findings indicating that the vital inflamed pulp is incapable of healing. Additional descriptors: No clinical symptoms but inflammation produced by caries, caries excavation, trauma.

Pulp necrosis
A clinical diagnostic category indicating death of the dental pulp. The pulp is usually non-responsive to pulp 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:

Normal Apical Tissues

Teeth with normal periradicular tissues that are not 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 a painful response to biting and/or percussion or palpation. 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 track.

Condensing Osteitis

Diffuse radiopaque lesion representing a localized bony reaction to a low-grade inflammatory stimulus, usually seen at apex of tooth.

Radiographs & Images

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.

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.

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.

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.

Size

The individual size of a digital image/radiograph must be no smaller than 2”x3” and no larger than 5”x7”.
A sufficient number of diagnostic radiographs is essential so that the reviewing examiner can understand and verify the information presented by the Candidate.

**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.

**Periradicular Lesion**
It is important that radiograph/images show the entire periradicular lesion, what is described in the narrative and all of the canals, and their apical terminations.

Either working length or point fit radiographic images should be included with each case. Both may be included if desired.

**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.

**Postoperative**
All treated canals must be visible on at least one postoperative radiograph.
Each treated canal must be visible on at least one postoperative radiographic image.

**Kodachromes**
Kodachromes are not acceptable.

Computed Tomography
Only printed digital images with masking permitted. The CD-ROM must not be submitted with the portfolio.

**Description & Reference**
When describing the radiograph, include what is seen in the entire radiograph, not just the tooth in question.

All radiographs and digital images (including all photographs) must be referenced to in the narrative (for example, the write up must state that a radiograph or photograph was made in the appropriate location of the case history template), and dates must match back to the dates in the Case History Form.

All radiographs and digital images need to be placed in chronological order.

**Slide Mounts**
Identification
The case number, Candidate number and all radiograph dates need to be indicated on the mounted radiographic images (patient names cannot be listed).

Labeling
It is recommended that a white label be used for date and radiograph 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 Pre-op, 8/15/00 WL, 8/15/00 Ca OH, 9/25/00 WL.

Placement
Radiographs must be placed in the order of sequence they were taken (left to right from the top of the mount).
**Page Protector**  
Slide mounts must be placed in a page protector.

### Original Radiographs
Copies of radiographs are not permitted. Scanned conventional films are acceptable in the Case History Portfolio. Digital radiographic guidelines, as they pertain to printing and media, should be followed in assembling the portfolio. The minimal resolution for scanned images should be 300 dpi.

### Presentation
Images can be printed on 8 ½” 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.

### Identification
The case number and Candidate number should be listed on each page. Patient names cannot be listed.

### Page Protector
All materials must be inserted in the provided plastic page protectors.

### Labeling
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.

(fig.3. Example of correctly labeled digital images placed in chronological order.)

(fig2. Close-up example of radiographs correctly labeled and placed in the radiographic mount.)
Photographs

Patient Photographs All photographs of patients must have their eyes masked to prevent identification.

![Example of correctly masked patient photograph.](image)

Laboratory and Biopsy Reports

Masking A common error in the submission of portfolios is incomplete masking within the additional document(s) submitted. All identifying information must be thoroughly masked. This includes but is not limited to all names (Candidate, facility, patient, physician, referring dentist), addresses (the entire address must be masked), phone and fax numbers, and signatures, SSN, Medicare and Medicaid numbers, etc.

After you have completed the masking, please be sure that you read the documentation from top of the page to the bottom to ensure you have masked all identifying text.

Before inserting into a page protector, make a copy of the report and submit the copy. This will prevent information being visible through the pen or marker used to mask the information.

Photocopies Photocopies of supporting or supplemental materials e.g. laboratory, medical consults and biopsy reports should be included in the portfolio. 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 chronological order. They must be placed back to back in a page protector.
**Recall**

### 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 for all cases. Dates for the recall visit in the 12<sup>th</sup> month after completion of treatment will be considered acceptable.

#### Exceptions to the One Year Recall Requirement

- **Case 1 Diagnosis** – See Below
- **Medically Compromised Case** - See Below

### 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

Adequate documentation that assures a definitive diagnosis was made should be included in the write-up. A follow-up recall of one year minimum is not required in this category but may be provided if the Candidate wishes to do so. If a diagnostic case is included in the “Other” category a one year recall IS required.

### OTHER Case Subcategory

A follow-up recall of one year minimum from the date treatment was completed is not required in this category.

### 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.
The Case History Report Form

Word 1997 – 2003 –

Instructions for the Case History Report Form and Addendum Page for Word 1997 - 2003

To Create the Case History Report Template

Step 1. Open the Case History Report Form Template.
Step 2. Click on File then click on Save As.
Step 3. Save in Desktop – leaving the filename as is – click Save.
Step 4. Click File then Close – then close out of Word.
Step 5. On your desktop screen you will have an Icon for the Case History Report Template. This Template is now ready to be used to create your 10 Case History Report Forms.

To Create the Case History Report Forms

Step 1. Double-click on the Case History Template Icon.
Step 2. Click yes to open as read only.
Step 3. Click File – click on Save As (If you receive the Before you Save prompt, click on Don’t Save As Suggested Format).
   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 10).
   3b. Save as a Word Document.
   3c. Use this procedure to create your 10 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 View – then Toolbars – then Forms.

Tab Button
Use the tab button to navigate from one section to another.

Select Buttons
In the Patient Sex, Procedure Category, Pre-Treatment Diagnosis: Pulpal and Periradicular and Prognosis fields - click on the select pull-down menu box – then click on the appropriate response. A text box is located next to the select pull-down menu box for the Pulpal and Periradicular Diagnosis 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.
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allowed Space</strong></td>
<td>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. <strong>The Case History Report Form must always be locked.</strong></td>
</tr>
<tr>
<td><strong>Changes</strong></td>
<td>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 <strong>no</strong> when it asks if you want to open as <strong>Read Only</strong> and then enter your changes and save when closing the document. Again, do not unlock the form while making any changes in text.</td>
</tr>
<tr>
<td><strong>Inserting Charts</strong></td>
<td>In order to insert a chart into the Case History Report Form, the form must be unlocked. This is accomplished by clicking on the padlock that is visible on the Forms toolbar – if the toolbar is not visible, click on (1) View, (2) Toolbars and (3) Forms. The form is unlocked when the padlock is clicked. Paste the chart into the appropriate section, then immediately relock the padlock by clicking on the padlock. The form must be relocked as soon as you have finished inserting the chart or the form will not keep its required format. When the form is locked the sections of the toolbar are gray, this is how the toolbar must be set while you are entering information with the exception of when it is unlocked for insertion of a chart.</td>
</tr>
<tr>
<td><strong>Addendum Page</strong></td>
<td>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 &quot;See Addendum Page&quot; at the end of that particular section. Scroll down to the Addendum Page; indicate the area you are continuing, i.e. &quot;C. Medical History continued:&quot; 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.</td>
</tr>
<tr>
<td><strong>Backup Copies</strong></td>
<td>As an additional safeguard, make backup copies of this file and of any reports you write.</td>
</tr>
<tr>
<td><strong>Printing</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
The Case History Report Form

Word 2007 – 2010 –

Instructions for the Case History Report Form and Addendum Page for Word 2007 - 2010

Step 1. Download the 2010 version of the Case History Form onto your desktop.
Step 2. Click on File then click on Save As.
Step 3. Save in Desktop – leaving the filename as is – click Save.
Step 4. Click File then Close – then close out of Word.
Step 5. On your desktop screen you will have an Icon for the Case History Report Template. This Template is now ready to be used to create your 10 Case History Report Forms.

To Create the Case History Report Forms

Step 1. Be sure the Developer Tab is Open.
Step 2. If your “Developer” Tab is not open on your Toolbar, please go to:

File>Options>Customize Ribbon

On the right side of your screen, under the “Customize Ribbons” pane, select “Main Tabs” from the Dropdown

Click on the selection box next to “Developer” (make sure there is a check mark next to it) and click “Okay”.

Step 3. Working on the Form

The form comments and dropdowns will work with the default form settings

Inserting Charts

If you need to insert a table, you must do the following:

1. Be sure your Developer tab is selected in your Toolbar
2. Click “Protect Document”
3. On the Developer tab, click “Restrict Editing”
4. A pane to the right side of your screen should open. On this pane, click on “Stop Protection.”
5. Proceed to insert your table. When you are done with the table, you need to lock the form again so that the rest of the form will function properly and so you do not tamper with the layout of the form.
6. To re-lock the form, please go back to the pane on the right side of your screen and click under the first choice, Formatting Restrictions, check the box “Limit formatting to a selection of styles.”
7. Under the second selection: Editing restrictions, check the box “Allow only this type of editing in the document:”. From the dropdown, select: Filling in forms
8. Under the third selection, Start Enforcement, click on the box that says, “Yes, Start Enforcing Protection”
9. You will then be prompted by a box to enter a password. PLEASE DO NOT ENTER A PASSWORD. Simply select “OK”. Do not select “Cancel”

Precede filling out the form and saving it as you would any other document. If you need to insert something else, or go back to edit your table, you will need to unlock the form and repeat the process again.
| **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**

<table>
<thead>
<tr>
<th><strong>Case Report Number</strong></th>
<th>This number must be consistent with the number on the Case History Evaluation Form.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Age</strong></td>
<td>This must indicate the patient's age when treatment was started.</td>
</tr>
<tr>
<td><strong>Patient Sex</strong></td>
<td>Select male or female from the drop-down box.</td>
</tr>
<tr>
<td><strong>Candidate Number</strong></td>
<td>Use the number assigned to you by the Board. Names must never be used.</td>
</tr>
<tr>
<td><strong>Date Started</strong></td>
<td>This date indicates the first appointment with the patient.</td>
</tr>
<tr>
<td><strong>Date Finished</strong></td>
<td>This date indicates the last appointment where active treatment was provided.</td>
</tr>
<tr>
<td><strong>Date of Last Recall</strong></td>
<td>This date indicates date of last recall.</td>
</tr>
</tbody>
</table>

**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. It is required that the type of case being presented is listed in the OTHER subcategory for the three OTHER cases.

B. **Procedure Category:** OTHER

OTHER subcategory _____

**Chief Complaint**

As stated in the patient's own words.

**Medical History**

**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.

**Medications**

All medications must be documented (include dosages, frequency of dosing and the condition for which the drug is being given).
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. **Omission of the vital signs is considered unacceptable in grading the diagnosis category of a case.**

Dental History
A thorough synopsis of the patient’s dental history, including symptoms pertinent to the endodontic treatment should be provided with each case.

If you have included a radiograph image from the referring dentist indicate that in this section.

Clinical Evaluation (Diagnostic Procedures)

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm the patient’s chief complaint and symptoms.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report all diagnostic tests performed on adjacent and involved teeth and the findings as well as clinical signs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radiographic Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>List significant radiographic findings (interpretations) from the recent pre-treatment radiograph(s)/image(s).</td>
</tr>
</tbody>
</table>

Pretreatment Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>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. A text box is located next to the select pull-down menu box for the Pulpal and Periradicular Diagnosis to accommodate entering a diagnosis that is not included in the pull-down box.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approved Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Pages 5-6 for approved terminology. Use all terms consistently throughout the documentation.</td>
</tr>
</tbody>
</table>

Treatment Plan

<table>
<thead>
<tr>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prognosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate your prognosis as <strong>FAVORABLE</strong>, <strong>QUESTIONABLE</strong>, or <strong>UNFAVORABLE</strong> from the drop-down box.</td>
</tr>
</tbody>
</table>

Clinical Procedures

<table>
<thead>
<tr>
<th>Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>List in chronological order all dates the patient was seen.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Informed Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate that informed consent was obtained.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe and justify (where necessary) clinical procedures performed. Describe emergency care rendered (if any), complications encountered (if any and how managed).</td>
</tr>
</tbody>
</table>
Clinical Procedures
Indicate if treatment was modified in accordance with the medical and dental history. Application of biologic principles should be demonstrated. Include in the narrative if a follow-up was done that night or the next day.

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. If a rubber dam clamp does not show on working length or cone-fit radiographs, explain your technique of rubber dam application.

Anesthetic(s)
Name and amount of local anesthetic(s) administered.

Medications
Medications prescribed (including dosages, time intervals, method of administration, and rationale).

Table
Record the canal working length, master apical file, filling core, sealer, and obturation technique in the table provided.

Postoperative Diagnosis
Record the postoperative diagnosis only if it differs from the preoperative diagnosis.

Postoperative Evaluation
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 with the exception of the Diagnosis and Medically Compromised cases.

When a Diagnosis Case is submitted as an Other case, a one-year recall is required (see page 12 for Recall requirements). A Medically Compromised Case does not require a one year recall.

Summary of Treatment
Provide a summary of the pertinent 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.

Radiograph/Image
Provide a recall radiograph/image and interpretation.
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 remain locked, except when inserting a chart.
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
CHIEF COMPLAINT: _____

OTHER subcategory _____

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
DIAGNOSIS (If different post-treatment) Pulpal: _____
HISTOPATHOLOGIC DIAGNOSIS (If biopsy) Periradicular: _____

<table>
<thead>
<tr>
<th>CANAL (M,D,B,L, etc)</th>
<th>WORKING LENGTH</th>
<th>APICAL SIZE*</th>
<th>OBTURATION MATERIALS AND TECHNIQUES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Size of the largest instrument used at the apex

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

Date: _____

Date: _____

Date: _____
Assembling the Portfolio

Your completed portfolio must be submitted in a three ring binder and all documentation must be placed in page protectors.

Cases are placed in numerical order (1-10). Please place the components of each case in the following order:

<table>
<thead>
<tr>
<th>Case Number</th>
<th>Component</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pledge Form</td>
<td>Sign and place the form in the pocket of the notebook.</td>
</tr>
<tr>
<td>2</td>
<td>Candidate Review Form</td>
<td>Sign and place the Candidate Review Form in the pocket of the notebook</td>
</tr>
<tr>
<td>3</td>
<td>Payment</td>
<td>Place the Case History Exam fee payment in an envelope and place in the pocket of the notebook. An exam fee of $435 is due with the submission of the notebook unless you have already paid the $750 Final Application fee. You can also pay the fee through PayPal – go to <a href="http://www.aae.org/casehistoryexam/">http://www.aae.org/casehistoryexam/</a></td>
</tr>
<tr>
<td>4</td>
<td>Case History Evaluation Form</td>
<td>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.</td>
</tr>
<tr>
<td>5</td>
<td>Introduction*</td>
<td>A cover sheet describing routine policies and procedures. Keep the introduction and technique descriptions brief.</td>
</tr>
<tr>
<td>6</td>
<td>Abbreviation Explanation*</td>
<td>A document defining abbreviations (the use of abbreviations is acceptable but should be limited).</td>
</tr>
<tr>
<td>7</td>
<td>Terminology Explanation*</td>
<td>If you use terminology other than the ABE approved terminology place a document defining the terminology in a page protector, however, ABE approved terminology is preferred.</td>
</tr>
<tr>
<td>8</td>
<td>Case History Report Form*</td>
<td>Place in a page protector per instructions below.</td>
</tr>
<tr>
<td>9</td>
<td>Addendum Page*</td>
<td>If an Addendum Page was required, place it in a separate page protector.</td>
</tr>
<tr>
<td>10</td>
<td>Medical consults, laboratory and biopsy reports*</td>
<td>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.</td>
</tr>
<tr>
<td>11</td>
<td>Radiograph Mounts*</td>
<td>Place the radiograph mount in a page protector. Radiographs must be placed in chronological order. The case number, Candidate number and all radiograph dates need to be indicated on the radiograph mount form. Patient names cannot be listed. Refer to Page 8 for labeling requirements.</td>
</tr>
<tr>
<td>12</td>
<td>Digital Images*</td>
<td>Place the digital images in a page protector – two pages can be submitted per page protector – see instructions below - images must be placed in chronological order. See Page 8 for labeling requirements.</td>
</tr>
</tbody>
</table>
All documents included in the Portfolio should be placed in a page protector.

The Case History Report form must be placed 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. In any case where the Addendum Page has been used, place it in a new page protector.

Medical consultations, laboratory and biopsy reports are placed in chronological order in page protectors.

Each slide mount must be placed in a separate page protector.

Digital images should be placed in page protectors and placed in the notebook in chronological order.
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 #: ___________ Date Received: ______ 
Examiner: _______________ Date Mailed: ________

CANDIDATE USE ONLY: 
EXAMINER’S USE ONLY:

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

Enter your Candidate Number above

Type the Tooth Number opposite the Required Procedure in column three

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Required Procedures</th>
<th>Tooth Number</th>
<th>Clinical Evaluation Diagnosis Treatment Plan</th>
<th>Treatment, Post Treatment Evaluation</th>
<th>Complexity</th>
<th>Place an X in this column if the case failed the First Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>DIAG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>EMERG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>NS RCT Maxillary Molar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>NS RCT Mandibular Molar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>NS RETX Maxillary or Mandibular Molar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>NS RETX Maxillary or Mandibular Molar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Maxillary or Mandibular Molar Periapical Surgery with Root-end Resection and Root-end Filling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 third category is the overall complexity of the case.

Each category is evaluated according to the following scale:

Excellent 3  
Acceptable 2  
Deficient 1  
Unacceptable 0

Measurement Incorporated, the firm that evaluates all aspects of the examination process, the Written, the Case History Portfolios and the Orals, confirms that the evaluations are fair and without bias. Each Portfolio is examined by two Examiners. Each case has three areas that are graded. That means that each Portfolio receives a total of 60 grades (30 per examiner).

The following chart 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.

It 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.
<table>
<thead>
<tr>
<th>Pretreatment</th>
<th>Diagnosis and Treatment Plan</th>
<th>Treatment</th>
<th>Post-treatment</th>
<th>Documentation</th>
<th>Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thorough medical and dental history was obtained.</td>
<td>Complete and thorough clinical findings were recorded.</td>
<td>Clinical procedures were performed at the highest level of skill.</td>
<td>Appropriate recall intervals were prescribed.</td>
<td>The narrative was complete, thorough, and readable with correct spelling and proper grammar.</td>
<td>Cases required the highest level of knowledge and technical skill.</td>
</tr>
<tr>
<td>There was an appropriate review of systems.</td>
<td>Appropriate diagnostic tests were performed and the results recorded.</td>
<td>All essential procedures were performed and in an appropriate sequence.</td>
<td>The clinical examination at follow-up was complete and appropriate tests performed.</td>
<td>The First Reviewer Checklist was followed with no deviations.</td>
<td>Cases required the highest level of patient management.</td>
</tr>
<tr>
<td>Appropriate medical consultations were obtained and documented.</td>
<td>Appropriate radiographs/images and interpretation.</td>
<td>Pharmacological management was appropriate and justified.</td>
<td>Radiographs/images were appropriate and diagnostic.</td>
<td>The terminology used was consistent with ABE terminology. If different terminology was used, an explanation was provided.</td>
<td>If treatment consultations were required, they were clearly addressed and documented.</td>
</tr>
<tr>
<td>Appropriate vital signs were recorded.</td>
<td>The pulpal and periapical (periradicular) diagnosis was correct.</td>
<td>Treatment was modified in accordance with the medical and dental history.</td>
<td>The tooth was adequately restored. If final restoration is not present, recommendations for final restoration are clearly noted.</td>
<td>Abbreviations were clearly explained.</td>
<td>If the treatment sequence was a critical component, the treatment sequence followed was clearly explained and documented.</td>
</tr>
<tr>
<td>Medications were documented (including rationale for prescribing, dosages, and frequency of dosing.</td>
<td>The treatment plan was appropriate.</td>
<td>Application of biologic principles was demonstrated.</td>
<td>Issues with the treated tooth or adjacent teeth visible on the post-treatment radiographic images were clearly noted and patient informed.</td>
<td>The radiographic documentation was complete and of the highest quality. Procedures were justified and explained.</td>
<td></td>
</tr>
<tr>
<td>Pretreatment</td>
<td>Diagnosis and Treatment Plan</td>
<td>Treatment</td>
<td>Post-treatment</td>
<td>Documentation</td>
<td>Complexity</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Minor information was omitted that does not significantly affect the treatment and prognosis.</td>
<td>The pulpal and periapical (periradicular) diagnosis was correct despite the fact limited diagnostic tests were performed.</td>
<td>Procedures were performed at a satisfactory level.</td>
<td>The clinical examination and data provided was adequate but lacked enough detail to grade as excellent</td>
<td>Minor errors are evident but do not affect the interpretation or understanding of the case.</td>
<td>High technical skill required. Adequate patient management. Treatment sequence important but was not critical.</td>
</tr>
<tr>
<td></td>
<td>The radiographic examination was minimally adequate.</td>
<td>The treatment sequence was not appropriate but this did not affect the treatment outcome.</td>
<td>Results reported were consistent with the data provided.</td>
<td>The tooth was inadequately restored but noted in the narrative.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is missing diagnostic information that does not affect the diagnosis, treatment plan, or prognosis.</td>
<td>Minor procedural deficiencies were evident that do not compromise the outcome.</td>
<td>The tooth was inadequately restored but noted in the narrative.</td>
<td>The tooth was inadequately restored but noted in the narrative.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The alternative treatment plans were incomplete.</td>
<td>Procedures were documented or demonstrated in an acceptable manner but lacked enough detail to grade as excellent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretreatment</td>
<td>Diagnosis and Treatment Plan</td>
<td>Treatment</td>
<td>Post-treatment</td>
<td>Documentation</td>
<td>Complexity</td>
</tr>
<tr>
<td>--------------</td>
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</tr>
<tr>
<td>Incomplete medical and dental history.</td>
<td>The clinical examination was incomplete.</td>
<td>Procedural errors were evident that may have affected the outcome.</td>
<td>Misinterpretation of radiographs/images.</td>
<td>Frequent narrative errors.</td>
<td>Routine diagnostic and technical difficulty requiring average skills.</td>
</tr>
<tr>
<td>Insufficient information that influences the prognosis.</td>
<td>Appropriate diagnostic tests were not performed.</td>
<td>Treatment performed was not consistent with the diagnosis and treatment plan as outlined.</td>
<td>Poor quality of radiographs/images.</td>
<td>Poor grammar and spelling errors.</td>
<td></td>
</tr>
<tr>
<td>Insufficient information that influences and/or affects the diagnosis, treatment, or prognosis.</td>
<td>Interpretation of the data/radiographs (images) was incorrect.</td>
<td>Radiographs/images lack detail and proper interpretation.</td>
<td>Incomplete clinical examination.</td>
<td>Poor radiographs/images.</td>
<td></td>
</tr>
<tr>
<td>Appropriate vital signs were not repeated at subsequent visits when indicated.</td>
<td>Alternative treatment plans were not appropriate or were missing.</td>
<td>Treatment sequence adversely affects outcome.</td>
<td>Failure to recognize the lack of an adequate permanent restoration.</td>
<td>Processing errors.</td>
<td></td>
</tr>
<tr>
<td>Radiograph and Digital Image dates are not referenced in the narrative (for example, the write-up must state that a radiograph or photograph was made in the appropriate location of the Case History template.)</td>
<td>The prognosis was inaccurate.</td>
<td>Treatment was not supported by the best available evidence.</td>
<td>Outcome shows underfill, overfill or poor quality condensation.</td>
<td>Lack of medical consultation reports when indicated.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radiograph and Digital Image dates are not referenced in the narrative (for example, the write-up must state that a radiograph or photograph was made in the appropriate location of the Case History template)</td>
<td>Radiographs or images lack adequate detail.</td>
<td>Radiograph and Digital Image dates are not referenced in the narrative (for example, the write-up must state that a radiograph or photograph was made in the appropriate location of the Case History template)</td>
<td>The lack of biopsy reports when indicated.</td>
<td></td>
</tr>
</tbody>
</table>
### Pretreatment

- The medical and dental history was not provided.
- Incorrect information was provided.
- Appropriate consultations were not obtained.
- Appropriate vital signs were not recorded.

### Diagnosis and Treatment Plan

- No data to justify the pulpal and (periradicular) diagnosis.
- The pulpal and/or (periradicular) diagnosis was incorrect.
- Radiographs/images were improper or of poor quality.
- The treatment plan was inappropriate.
- No informed consent.

### Treatment

- Major procedural errors.
- Inappropriate treatment.
- Inappropriate pharmacological management.
- Sequence of treatment adversely affects the prognosis.
- Radiographs/images are improper or of poor quality.
- Inappropriate application of biologic principles.

### Post-treatment

- An appropriate clinical examination was not performed.
- Radiographs/images were inadequate.
- The radiographic interpretation was not correct.
- Appropriate treatment/recall recommendations were not provided.

### Documentation

- Incomplete information.
- Information was presented that could not be interpreted.
- The radiographic documentation were not representative of the case.
- Digital Images are not the correct size.

### Complexity

- The knowledge and technical skills required were within the scope of the general dentist.

### Errors that Result in a Failed Notebook

- Required Case Categories
  The Portfolio did not contain all of the required cases or the cases were not presented in the correct order.

- Photograph Masking
  Complete masking was not done.

- Document Masking
  Complete masking was not done.

- One-Year Recall
  The one-year recall requirement was not met in any of the required cases.

- Page Protectors
  All reports, radiographs and images were not put in page protectors per the instructions.

### Errors that Result in a Failed Case

- Radiographs, Digital Images
  Radiographs and images are not placed in date sequence. Quality of radiographs/images did not meet criteria
  Smaller than 2x3 or larger than 5x7

- Case Number, Candidate Number, Dates
  Not indicated on radiograph mounts and/or printed on digital images.

- Cone Beam Computed Tomography
  Submission was not a screen shot with adequate masking.

- Non-English Language Documents
  English translation not included.
# Candidate Review Document

<table>
<thead>
<tr>
<th>Errors That Result in a Failed Portfolio</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required Case Categories</strong></td>
</tr>
<tr>
<td>The portfolio will fail if any of the cases below have not been submitted or are not in the correct order</td>
</tr>
<tr>
<td>Case 1 Diagnosis</td>
</tr>
<tr>
<td>Case 2 Emergency</td>
</tr>
<tr>
<td>Case 3 NS RCT - Maxillary Molar</td>
</tr>
<tr>
<td>Case 4 NS RCT - Mandibular Molar</td>
</tr>
<tr>
<td>Case 5 NS RETX - Maxillary or Mandibular Molar</td>
</tr>
<tr>
<td>Case 6 NS RETX - Maxillary or Mandibular Molar Periapical</td>
</tr>
<tr>
<td>Case 7 Maxillary or Mandibular Molar Periapical Surgery with Root-end Resection &amp; Root-end Filling</td>
</tr>
<tr>
<td>Case 8 OTHER</td>
</tr>
<tr>
<td>Case 9 OTHER</td>
</tr>
<tr>
<td>Case 10 OTHER</td>
</tr>
<tr>
<td><strong>Photograph Masking</strong></td>
</tr>
<tr>
<td>All patient photographs must have their eyes masked.</td>
</tr>
<tr>
<td><em>If this has not been done, the entire portfolio will fail</em></td>
</tr>
<tr>
<td><strong>Document Masking</strong></td>
</tr>
<tr>
<td>The Case History Report and all supplemental reports must be completely masked. This includes but is not limited to all names (facility, patient, physician, referring dentist, Candidate name) addresses (the entire address, number, street, city, state, country, zip must be masked), phone and fax numbers. There should be no language that suggests geographic locations.</td>
</tr>
<tr>
<td><em>If this has not been done, the entire portfolio will fail</em></td>
</tr>
<tr>
<td><strong>One-Year Recall</strong></td>
</tr>
<tr>
<td>Clinical evaluations and recall radiographs (one year from the date treatment is completed) are required for all cases (including all 'Other' cases) with the exception of the Case 1 'Diagnosis' and a 'Medically Compromised' submitted in the 'Other' category. Dates for the recall visit in the 12th month after completion of treatment will be considered acceptable.</td>
</tr>
<tr>
<td><em>If this has not been done, the entire portfolio will fail</em></td>
</tr>
<tr>
<td><strong>Page Protectors</strong></td>
</tr>
<tr>
<td>Case History Report Forms and supplemental reports must be placed in a page protector in the proper format. All images must be also inserted in page protectors.</td>
</tr>
<tr>
<td><em>If this has not been done, the entire portfolio will fail</em></td>
</tr>
<tr>
<td>Case Number</td>
</tr>
<tr>
<td>-------------</td>
</tr>
</tbody>
</table>

**Radiographs, Digital Images**

Dates must match back to the dates in the Case History Form.

*Any case where this is not followed will fail.*

Radiographs must be placed in date order (left to right from the top of the slide mount). Images need to be printed & placed in date order.

*Any case where this is not followed will fail.*

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.

*Any case where this is not followed will fail.*

**Radiograph/Image Size**

The individual size of a digital image must be minimally equivalent to a 2x3 size film but no larger than 5x7.

*Any case where this is not followed will fail.*

**Case Number, Candidate Number and Radiograph/Image Dates**

Must be indicated on the Radiograph mount and printed on image pages (patient names cannot be listed).

*Any case where this is not followed will fail.*

**Cone Beam Computed Tomography**

Only printed screen shots with adequate masking are permitted.

*Any case where this is not followed will fail.*

**Non-English Language Documents**

If any included documents are submitted in a language other than English, a translation in English notarized as a true-copy, must accompany each report.

*Any case where this is not followed will fail.*

Please carefully read the Case History Submission requirements above and indicate your understanding and agreement by signing below:

Candidate Number ________________________________

Signature ______________________________________


Submission of the Portfolio
Policy requires that the Case History Portfolio is sent to the Headquarters Office of the ABE via FedEx, UPS, or other similar services that provide tracking information. **Sending through the U.S. Post Office is not recommended, if you use this method and encounter issues, the Central Office will not contact the Post Office to attempt to track it.**

Please send your notebook to:
**American Board of Endodontics**
211 E. Chicago Avenue - Suite 1100
Chicago, IL 60611

Candidates are strongly advised to duplicate and retain a copy of their Case History Portfolio before submitting. 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 Fee
The Case History Exam fee of $435 is required when submitting your portfolio. Payment can be made by check (place check in an envelope and put inside your notebook) or can be paid through PayPal. The link for PayPal is on our website [http://www.aae.org/casehistoryexam/](http://www.aae.org/casehistoryexam/). Please submit a copy of your receipt from PayPal with your portfolio.

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 ten cases. During the Portfolio evaluation by two examiners, the Candidate’s identity is always strictly protected. Evaluation of the ten 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 feedback in general terms.

Appeal Policy
*The Appeal Process for Adverse Decisions Affecting Certification or Diplomate Status* document is available upon written request to the Central Office of the ABE.

To be valid, the request for reconsideration must be received by the Secretary of the Board within 30 calendar days after receipt by the Candidate/Diplomate of notice of the adverse decision. The request must contain a statement of why the Candidate/Diplomate 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.

- Please note that upon receipt of an appeal the Review Committee will conduct a review to assure that all grades were accurately reported – the portfolio will not be re-examined.

American Board of Endodontics
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Chicago, IL 60611
abe@aae.org
312/266-7310
800/872-3636