Pulpal Diagnoses: Feedback Response Document

Summarised Feedback Categories	Committee Response
'Dynamic nature of pulpitis' not reflected in classification	We will add preamble on dynamic nature of both pulp and apical conditions in the larger classification document. At present diagnostic tests cannot decipher whether lesions are quiescent or active.
Including 'intraoperative diagnosis' information could assist in pulp diagnosis	General tenet that diagnosis should be preoperative, however, intraoperative information to be added into one of the columns. Not sure we can add to diagnostic term however in the current framework. This should mainly be covered in a document preamble.
Mixed diagnosis in one pulp (e.g., coronal irreversible pulpitis and apical normal)	This is indeed true but hard to ascertain the extent of the pulpitis both preoperatively and intraoperatively. A description has already been added in the third column 'progressive level of pulpal inflammation and possibly infection of the coronal pulp portion.'. If we add two diagnoses to one tooth the complexity will increase.
The spectrum of pulpal inflammation should reflect a 'range' or 'staging' rather than binary categories (mild and moderate).	This may not be possible due to the limitations of current diagnostic aids. This comment was linked to 'intraoperative diagnoses.
Could simplify to two categories 'hypersensitive pulp' and pulpitis'	Need some discussion on 'hypersensitive' clearly some like while others don't. the plan is too 'road test' this term in scenarios, to gauge its clinical usefulness.
Reduce emphasis on clinical sensibility tests as definitive indicators of pulpal status, emphasizing the need to recognize their diagnostic limitations.	Although this is true, they presently represent at present one of the very few diagnostic tools that all dentists have in their practices. We can mention their limitations in table.

Consider placing trauma-related pulp necrosis under existing categories rather than as a separate diagnostic term	Discuss again consider the benefit of 'trauma-related' pulp necrosis.
Terminology revisions to harmonize with ICD-11	ICD-11 (DA09) has 'Pulpitis, necrosis of pulp, pulp abscess, pulp degeneration, abnormal hard tissue formation in pulp'. We already have some of these terms.
A number of participants suggested that diagnostic findings should be clearly separated from management considerations (both tables)	We have a 'management recommendations to preserve the tooth' column in the table. We can remove, leave as is or say 'management suggestions'
Include 'Cracked Tooth Syndrome' in pulpal table	The symptoms of cracked tooth syndrome are linked to pulpitis, not sure there is benefit in an additional category
Avoid redundancy by removing the 'previous regenerative endodontics category'	Some have suggested removal, others have suggested adding VPT to this category. VPT at present is within normal pulp. VPT (pulp cap/ pulpotomy) could also be added to this category, which may be the best option.
The classification of symptoms into mild, moderate, and severe is unclear and confusing. It should be clarified.	This is something we should address, we have mild or moderate pulpits with mild, moderate or severe symptoms. Could we describe the pain in another way; e.g., asymptomatic, stimulated pain, spontaneous pain.
'Transitional pulp' rather than 'hypersensitive pulp'	Better with hypersensitive. However, term hypersensitive to be considered as indicated above.
Severe pulpitis add information; 1st column: +/- Secondary to: Dental anomaly which communicates with the pulp space e.g., dens invaginatus. 2nd column: Definition and clinical presentation including symptoms: lingering pain if pain is provoked by a thermal change. Commonly associated with severe symptoms but can be associated with no symptom or mild symptoms	Can add 1st column here and elsewhere.

Hypersensitive pulp and mild pulpitis could be merged	As above discuss benefit of these two categories, is there a benefit in keeping separate?
Inconclusive and necrotic may result in confusion	We need to ensure inconclusive not a waste bin. Text at present fairly clear.
Remove ‘clinically’ from ‘clinically normal pulp’	If added here, clinically should be added everywhere. The pulp may not be normal, but it is normal clinically.
‘Healthy’ rather than normal pulp	Ambivalent, but ‘normal’ used elsewhere.
Mild, severe pulpitis, may be better to add location terms such as partial, localised, initial	This is linked to two diagnoses in the one tooth.

Periapical Diagnoses: Feedback Response Document

Summarised Feedback Categories	Committee Response
The development of a distinct neurosensory or neuropathic diagnostic category falls outside the scope of a periapical tissue–based classification and would be more appropriately addressed within pain-medicine or orofacial pain taxonomies rather than endodontic diagnostic terminology	The terminology is intentionally limited to conditions of pulpal origin and their effects on the apical and peri-radicular tissues. Neuropathic pain conditions are explicitly recognized in the classification as non-odontogenic causes, and such presentations are appropriately captured under Apical hypersensitivity (secondary to non-odontogenic causes)
Apical periodontitis with systemic involvement: I am not in agreement with this term unless augmented with an additional term to indicate localized (vestibular)swelling without systemic signs (separate from localized symptomatic apical periodontitis).	Apical periodontitis with systemic involvement is reserved for cases in which there are clear systemic signs of infection (e.g., fever, lymphadenopathy, diffuse facial swelling, malaise) which may require additional treatment measures (eg., antibiotics prescription) Localized vestibular swelling or fluctuant intraoral swelling without systemic signs is already encompassed within localized symptomatic apical periodontitis
Add/clarify surgical intervention as part of therapy to establish drainage.	Regarding management considerations, the terminology intentionally limits recommendations to whether endodontic intervention is indicated or urgent, rather than detailing specific therapeutic steps.
add "Biopsy or referral for pathology consultation may be considered."	While biopsy or referral for pathology consultation may be clinically appropriate in selected cases, these decisions depend on factors beyond periapical diagnosis alone (e.g., lesion size, growth pattern, medical history). As such, they were not incorporated into the standard management guidance to preserve the diagnostic focus of the classification.

Use “dentin” consistently to align with North American usage.	The diagnostic terminology was developed jointly by international organizations and therefore it follows internationally accepted spelling.
Elevate root canal treatment (RCT) above pulpotomy/partial RCT in the treatment hierarchy. Rationale: RCT is a predictable and widely accepted procedure with extensive outcome data, whereas pulpotomies and partial RCT are more situational alternatives with less long-term evidence.	The document is not intended to rank procedures by predictability or outcome data, but rather to indicate whether endodontic intervention is indicated, not indicated, and possible treatment options. Specific procedural selection (e.g., RCT versus pulpotomy) depends on clinical context, patient factors, and evolving evidence.
Introduce a distinct diagnosis: “Postoperative endodontic flare-up (acute exacerbation of apical periodontitis/infection).” Flare-ups are clinically significant events requiring treatment.	Postoperative flare-ups are recognized as clinical events or complications, rather than primary diagnostic entities.
Remove “localized.” Apical periodontitis is by definition a localized disease, so the qualifier adds redundancy.	While apical periodontitis is anatomically localized by definition, the qualifier “localized” is used to distinguish it from entities with systemic involvement, where disease behaviour and management urgency differ.
"healing periapical tissues" appears to be compatible only with cases in which the periapical lesion is not fully resolved, and this can compromise diagnosis and clinical practice. There is no indication to use the term "Clinically normal apical tissues" paired with the pulpal and pulp spaces diagnosis of "Previously obturated root canal," which may be misleading to clinicians. We suggest specifying if the diagnosis is compatible with previous endodontic and vital pulp therapies in which complete repair of the periapical space has been achieved.	Healing apical tissue is intentionally reserved for previously treated teeth in which there is evidence of ongoing resolution of apical disease, either clinically, radiographically, or both. As outlined in the terminology, this includes cases where a peri-radicular radiolucency may still be present but demonstrates reduction in size. The diagnosis is therefore not intended to be used once complete resolution has been achieved. When complete repair of the periapical tissues has occurred, with absence of symptoms and radiographic findings within normal limits, the appropriate apical diagnosis is clinically normal apical tissues. Disease resolution in progress → Healing apical tissue Disease resolution completed → Clinically normal apical tissues
Symptoms must be experienced by the patient in their everyday life and recognized as different in intensity, frequency, or significance compared to	Symptoms is intentionally used in a pragmatic clinical context to encompass patient-reported experiences that may arise either

their normal bodily sensations to be considered clinically relevant symptoms.	spontaneously or in response to functional activities (e.g., biting or chewing) and are often clarified or reproduced during clinical testing. Mechanical provocation during examination is not intended to redefine a sign as a symptom, but rather to correlate patient-reported experiences with clinical findings and improve diagnostic reliability.
The diagnostic terms should also distinguish entities with different prognoses, such as symptomatic apical periodontitis related to a vital pulp from an acute or chronic apical abscess.	Prognosis was not considered as part of the tables. The tables focus primarily on diagnosis and potential treatment options.
The current definition does not address the possibility of sinus tract formation with direct purulent drainage through periodontal tissues. Given that periodontal condition can significantly influence the prognosis of endodontically compromised teeth, its inclusion in future revisions is warranted. From an endodontic perspective, incorporating either a separate diagnostic term for E-P lesions or mandatory assessment of periodontal status in such compromised teeth would be a reasonable approach.	The current periapical diagnostic terminology was intentionally designed to characterize the biologic status of the apical and peri-radicular tissues of pulpal origin, rather than to serve as a comprehensive classification of combined endodontic–periodontal conditions. Sinus tract formation is explicitly recognized within the category localized apical periodontitis with sinus tract, which captures drainage pathways originating from apical disease, regardless of whether the tract exits through mucosa or the periodontal tissues.
Evidence from studies on systemic biomarkers indicates that even asymptomatic cases of apical periodontitis can induce a transient increase in systemic inflammatory markers. This suggests that all cases of AP may exert a systemic effect.	The diagnostic terminology, the term “systemic involvement” is used in a strict clinical sense to denote the presence of overt systemic signs and symptoms of infection (e.g., fever, malaise, lymphadenopathy, diffuse facial swelling) that have direct implications for diagnosis, urgency, and management. The use of “systemic involvement” is therefore not intended to imply that other forms of apical periodontitis lack systemic biologic effects, nor to comment on subclinical inflammatory responses detectable at the biomarker level.
During "healing" the DX could be inconclusive. If, after a period of time, pulpal necrosis is confirmed then that DX should be adequate. Adding causes of a DX would open up Pandora's Box to even more diagnoses.	The terminology intentionally distinguishes between diagnostic uncertainty, healing, and established disease states. The category inconclusive apical condition is specifically intended for situations in which

	clinical findings are absent and radiographic presentation is uncertain, including periods during which healing or disease status cannot yet be definitively determined. This allows for appropriate monitoring without premature diagnostic labelling.