The American Board of Endodontics

Digital Case History Submission Guidelines

Updated: January 2019

Dear Candidates,

The Digital Case History Submission Guidelines were created to give you a roadmap to follow while you are creating your Portfolio. This latest edition contains the following updates to the January 2018 edition:

- Due to an ever-increasing number of portfolios submitted, the ABE may need to limit the number of submissions accepted for review in any given cycle. Any such limitation on submissions would be dynamic and based exclusively on available examiner resources. Any portfolio that meets the scheduled deadline that cannot be reviewed would be automatically held and reviewed the following cycle, with candidate notification by ABE staff. We recommend not waiting until the deadline to submit your portfolio because the sooner you submit your portfolio, the more likely you are to be included in the cycle for which you are submitting. **(p 31)**
- Pre-operative and Post-treatment intraoral radiographic images are required for each case receiving treatment. CBCT screen shots may be used to supplement imaging. **(pp 8, 17)**
- Vital signs must be recorded during the initial visit and monitored at subsequent appointments when indicated. For standardization, they should be included near the beginning of either the Medical History or Clinical Evaluation sections. Subsequent vital sign entries, as appropriate, should also be placed near the beginning of any treatment or post-treatment narrative. **(p 14)**
- Preferably, diagnostic testing information as well as periodontal assessment, should be included in a single table format. **(pp 4, 15)**
- The designated completion or "finished" date for a surgical case is considered the date of suture removal. **(pp 5, 13)**
- The use of "WNL" or "within normal limits" is highly discouraged throughout the entire case portfolio. **(p 6)**
- Emergency treatment recommendations are only required when urgent care is appropriate and treatment short of definitive care (pulpotomy/pulpectomy/I&D/etc.) could be sufficient to provisionally eliminate or reduce existing symptoms. **(p 15)**

We urge you to read the updated guidelines cover to cover before you begin, and then continue to use it as a reference as you treat patients, record your data and assemble the cases for your portfolio. The instructions need to be followed very closely since you are graded for the accuracy as well as the content of your Portfolio.

Another must read document is the Digital Case History Exam Submission Instructions which will guide you through each step of the process from registering for the exam to the final upload of your portfolio. You can find the Digital Case History Exam Submission Instructions at: www.amboardendo.org/home/instructions.

An additional resource is a series of case history exam tutorial videos that can be found at: https://vimeopro.com/user38730038/the-american-board-of-endodontics-digital-case-history-website-tutorials These videos are designed to show you, step-by-step, how to register, complete a case history form, and upload your portfolio onto the Case History Portfolio website. In addition, there is a video which details how to redact identifying information from a pdf document. If you have any questions regarding the technical aspects of submitting a portfolio, our Chief Administrative Officer, Ivana Bevacqua can be reached via e-mail at ivana@amboardendo.org.

The Directors and Staff of the American Board of Endodontics join me in wishing you success in achieving board certification.

Yours truly,

Timothy C. Kirkpatrick, DDS
Secretary, American Board of Endodontics

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A Must Read for All Candidates

Important Notice Regarding the Case History Portfolio Submission Process
The Candidate Review Document

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

Failed Portfolio
If a Portfolio 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 Post-Treatment Evaluation
If the one-year post-treatment evaluation requirement was not met in any of the required cases, the entire Portfolio will fail.

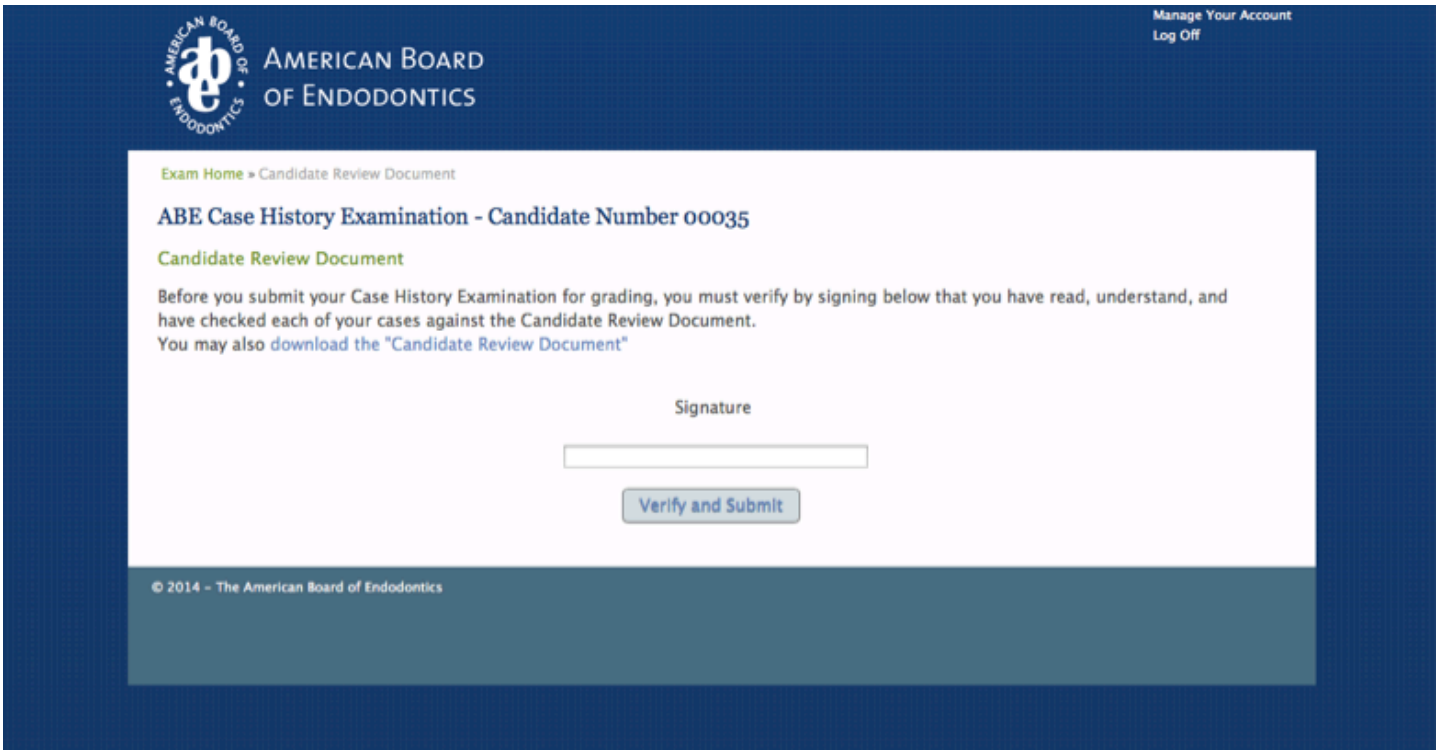
Common Errors
Please review your Portfolio closely for these common errors. These errors can adversely affect your overall grade.

Radiographs, Digital Images
Radiographs and images are not placed in date sequence.
Quality of radiographs/images did not meet criteria for high quality/high resolution.

Dates & Descriptions
Not indicated clearly for each image.

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** as they prepare their cases.



As you can see from the screenshot above, you will be asked to verify that you checked your portfolio against the Candidate Review Document prior to submitting your completed exam. Typing your name in the “Signature” field will serve as your official signature.

Please remember: 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 *Digital 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.

Below are common errors and also suggestions from the ABE examiners. Please be sure to read these carefully as you compile your cases.

Incomplete Document Masking

This 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, Social Security Number, Medicare and Medicaid numbers, etc.**

Radiographs/Images

Please use high quality radiographs and images.

Unacceptable features include radiographs/images that are too dark, too light, not clear, or too small.

Recommended image size:

Minimum image size: 200 KB AND 540 x 360 pixels. For better image resolution, image size: 300 KB and higher AND 800 x 600 pixels and higher. Image files should not exceed 4 MB.

Only JPEG, JPG, GIF and PNG radiographs/image files are acceptable.

Prior to uploading the images onto the case history website, it is up to the Candidate to determine that the images are clear, of high quality, do not blur or pixelate (even if zoomed in) and clearly illustrate what needs to be communicated diagnostically, during the course of treatment and for the post- treatment evaluation.

After uploading your cases, please review all images for quality and resolution as well as the proper sequence prior to hitting the “submit” button.

ALL Radiographs and Images MUST be referenced in the write-up.

Anesthetics

Types of local anesthetics and amount in mg 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!
The presence of errors that are clearly described in the *Submission Guidelines* as deficient or unacceptable.
Not making a recommendation about elevated blood pressure or not checking the blood pressure at subsequent appointments.
Textbook descriptions of techniques in the introduction.
Not making appropriate recommendations to referring dentist for restoration.

Suggestions for Improvement

"Review of the patient's medical history revealed no significant findings" in place of writing "WNL" in the Medical History section.

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 length, post-op, and post-treatment evaluations).

"Copious irrigation." What does that mean? What is the volume?

Limit abbreviations to one (1) page and use all that are listed or do not include. The use of uncommon abbreviations can be distracting. If abbreviations are not used frequently within the portfolio, then writing the entire word makes the document easier to read.

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.

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

Inadequate dental history.

Confirm original symptoms are no longer present on post-treatment evaluation visit. Example: Patient is percussion sensitive at original visit and doctor never performs this test on post-treatment evaluation.

Put clinical testing results in table format.

Preferably, diagnostic testing information as well as periodontal assessment, should be included in a single table format.

Case Submission Dates

Portfolios are accepted for review twice a year – **May 1 and September 1**. Portfolios must be uploaded and submitted online on or before the submission date. Late portfolios will be included in the next cycle, providing eligibility is still current. While you have until midnight on May 1 and September 1 to submit, **we urge you to not wait until the last few days to begin uploading your portfolio**. Give yourself plenty of time, and be sure you understand the digital process and upload instructions.

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 post-treatment evaluation is not required for this case. If endodontic therapy is not required, then ancillary documentation that assures a definitive diagnosis was made should be included in the write-up and supporting letters / reports from other specialists / providers should be masked and uploaded under Reports.**

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.

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

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

Case 5
Nonsurgical Retreatment - Maxillary or Mandibular Molar
This requires removal of previous obturating materials from the canal(s) of the tooth.

Case 6
Nonsurgical Retreatment - Maxillary or Mandibular Molar
This requires removal of previous obturating materials from the canal(s) of the tooth.

Case 7
Periradicular Surgery - Maxillary or Mandibular Molar
Maxillary or Mandibular Molar Periapical Surgery with Root-end Resection and Root-end Filling is required. A biopsy report is required. If no tissue was available for biopsy, this should be stated in the Clinical Procedures section. Please note that the designated completion or "finished" date for a surgical case is considered the date of suture removal.

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).* Osseo-integrated implants, endodontic endosseous implants, and extractions are not acceptable.

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, dens evaginatus, gemination/fusion, etc.)

Medically Compromised (**A one year post-treatment evaluation 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 post-treatment evaluation is required.

Narrative

Quality of Presentation	It is essential that the narrative include proper and consistent diagnostic terms, acceptable grammar, and correct spelling. Also, use of the term "WNL" or "within normal limits" is highly discouraged throughout the entire case report.
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. The cover sheet must be saved as a PDF in order to upload it onto the site.

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*.

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.

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

Quality	**Please use high quality radiographs and images.** **Unacceptable features include radiographs/images that are too dark, too light, not clear, or too small. Radiographs and images should be presented in their entirety and should NOT be cropped.**
Size and File Types	Recommended image size: Minimum image size: 200 KB AND 540 x 360 pixels. For better image resolution, image size: 300 KB and higher AND 800 x 600 pixels and higher. Only JPEG, JPG, GIF and PNG radiographs/image files are acceptable. Image files should not exceed 4 MB. Prior to uploading the images on to the case history website, it is up to the Candidate to determine that the images are clear, of high quality, do not blur or pixelate (even if zoomed in) and clearly illustrate what needs to be communicated diagnostically, during the course of treatment and for the post-treatment evaluation. After uploading your cases, please review all images for quality and resolution as well as the proper sequence prior to hitting the “submit” button. **ALL Radiographs and Images MUST be referenced in the write-up.**
Quantity	A sufficient number of diagnostic radiographs is essential so that the reviewing examiner can understand and verify the information presented by the Candidate. **Pre-operative intraoral radiographic images are required for all cases.** CBCT screen shots can be utilized as supplemental imaging as appropriate. Due to the complexity of the cases required, in most instances, a single pre-operative radiograph will not be acceptable.
Type	**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 cone fit radiographic images should be included with each case.** Both may be included if desired. **EAL (Electronic Apex Locater)** EAL are an acceptable substitute for file measurement radiographs although the anatomy **must** then be demonstrated with a cone fit image before obturation. **Post-treatment** All treated canals must be visible on at least one post-treatment radiograph. Post-treatment clinical examinations and radiographs / digital images can be completed by another provider but the interpretation of radiographs / digital images should be done by the candidate.
Computed Tomography	Only screen shot images are acceptable. Images **must** be masked.

Description & Reference	When describing the radiograph, include what is seen in the entire radiograph, not just the tooth in question. **All images 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.
Image Dates and Descriptions	**Dates and Descriptions** Dates and image descriptions need to be entered as you upload each image. For example, you will enter a date: **8-15-2000** and as your Description, you can enter: **Pre-op, WL, or whatever best describes the images you are uploading. There is a limit of 50 characters for the image description. The interpretation of the radiograph is included in the clinical evaluation section.** **Placement** You must place images in chronological sequence on your screen, from left to right. If you accidentally upload your images out of sequential order, you may use the "drag and drop" feature to place your images in the correct order. Please be certain that your date and description for each image is still accurate. You can learn more about this process in the *Digital Case History Exam Submission Instructions*.

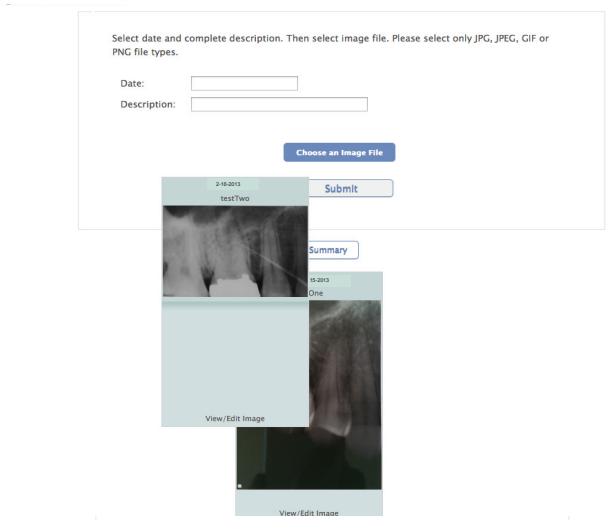


Illustration of "Drag and Drop" functionality to organize images in chronological sequence.

Simply click on the image that you want to move. While holding down your mouse, drag it to the correct sequential order, and drop it by releasing mouse.

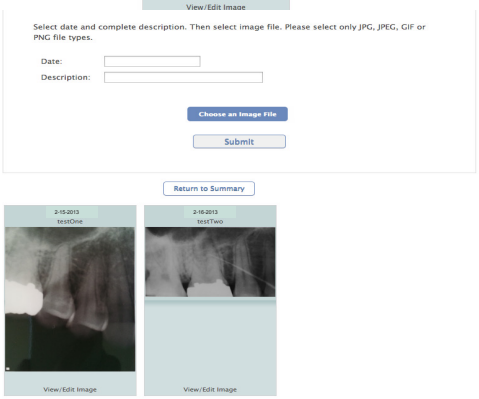
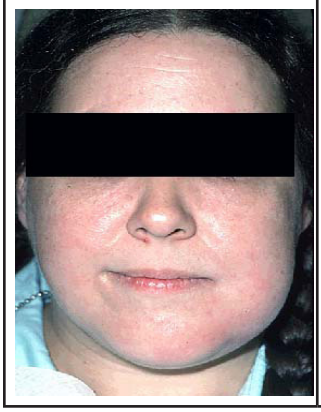


Illustration of images placed in correct date order.

Photographs

Patient Photographs	**All photographs of patients must have their eyes masked to prevent identification**.
	*Example of correctly masked patient photograph.*

Laboratory and Biopsy Reports

Biopsy	**A biopsy report is required for periradicular surgery cases. If no tissue was available for biopsy, this should be stated in the Clinical Procedures section.**
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, institution(s), patient, physician, referring dentist), addresses (the entire address must be masked), geographic locations, phone and fax numbers, signatures, Social Security Numbers, Medicare and Medicaid numbers, etc.** **After you have completed the masking, please be sure that you read the documentation from the top of the page to the bottom to ensure you have masked all identifying text. Be certain that your masking still provides enough coverage after you have scanned your document and saved it as a PDF file for upload.**
Photocopies	Supporting or supplemental materials (e.g. laboratory, medical consults and biopsy reports) should be included in the portfolio. All supplemental reports must be masked. This includes but is not limited to all names (Candidate, facility, institution(s), patient, physician, referring dentist), addresses (the entire address must be masked), geographic location, phone and fax numbers, signatures, Social Security Numbers, Medicare and Medicaid numbers, etc. These documents should be saved as PDF files for the case under Reports.

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. These documents must be saved as PDF files and uploaded under Reports.

Post-treatment evaluation

One-year Requirement **One-year Requirement**	A post-treatment 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 post-treatment evaluation visit in the 12th month after completion of treatment will be considered acceptable. **Exceptions to the One Year Post-treatment Evaluation Requirement** **Case 1 Diagnosis** – See Below **Medically Compromised Case** - See Below
Calcium Hydroxide Therapy	Cases requiring calcium hydroxide therapy require a one-year post-treatment evaluation 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 post-treatment evaluation 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 post-treatment evaluation **IS** required.
OTHER Case Subcategory Medically Compromised	A one year post-treatment evaluation is not required in this category.
Evaluation Write-up	The post-treatment 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

Downloading the Form

PLEASE NOTE: You must use Adobe Acrobat Reader to open up and fill out your case history form. Using an alternate PDF Reader with the digital case history form will corrupt the file, and it will not function properly for you, nor will it render properly for examiners when uploaded onto the site for final submission. If you do not have a Adobe Acrobat Reader, you can download a free version for either a Mac or PC via the case history website at: http://www.amboardendo.org.

To download a Digital Case History Report form, go to: http://www.amboardendo.org.

The Case History Forms in the digital upload process are PDF forms that you download onto your computer. You will save this form onto your computer, name your forms (ie, case1, case2), and fill it out. Only when you have completed the form will you upload it to the Digital Case History server. **All ten completed case history forms should be saved on your computer, as well as all of your images and supporting documentation**. Again, you should upload each form when it is your final, completed form that is ready for grading. The file must remain in a PDF format for upload. Please do not save the form as any other file type.

You do not need to register for the Case History Exam to download the Digital Case History PDF form, however, you DO need to be registered for the exam to upload your forms/Portfolio.

For in depth instructions on the form, how to save your files, registering for the exam and uploading your Portfolio, please go to http://www.amboardendo.org and download the *Digital Case History Exam Submission Instructions.*

Navigating and Filling Out the Case History Report Form

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 Apical* 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 Apical 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 while "spell check" is a useful tool, it is the responsibility of the Candidate to present an error free report. Please proofread your report for content and then reproof your report strictly for spelling errors.
Allowed Space	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, you can click on the "MORE" button at the beginning of each field and you will automatically be taken to the Addendum page where you can type in the rest of your answer for a specific section. You will have one addendum page and cannot exceed this one page for all of your answers.

Changes	Prior to uploading the case, you can change your form and save it to your computer as often as you like. However, if you have uploaded a case, and then make a change, you will need to re-upload the updated case file. You can do this as many times as you like PRIOR to submitting your entire exam. Once you submit your exam, you can no longer access your portfolio to make changes to your cases, images, documentation, etc., even if it is prior to the submission date.
Inserting Tables	In the "Clinical Evaluations – Tests" section, you will notice that you can add a table into this response. Simply define the number of rows and columns you require, click on "Insert Table" and a table will appear. If your table requires more than 6 columns or 6 rows, you can insert it into the Addendum by defining your rows and columns, checking the box next to "Check to insert table into addendum" and then click "More". You will then be taken to the Addendum page. Navigate back to the "Tests" section on Page 1 and click on "Insert Table". You can then navigate to the Addendum page and your table will be there ready to fill out.
Addendum Page	You will have one addendum page on which to type any and all of your responses that do not otherwise fit in the given response space.

Case History Report Form - Required Information

Case Report Number	The number you enter on your form must be consistent with the number you will enter when you upload your form and log it onto your Portfolio Submission Main Screen. (See the *Digital Case History Exam Submission Instructions.*)
Patient Age	This must indicate the patient's age when treatment was started.
Patient Sex	Select male or female from the drop-down box.
Candidate Number	Use the number assigned to you by the Board. Names must never be used.
Date Started	This date indicates the first appointment with the patient. Please enter date in this format: m-d-yyyy (Example 4-28-1999).
Date Finished	This date indicates the last appointment where active treatment was provided. For a surgical case, completion date is considered the date of suture removal. Please enter date in this format: m-d-yyyy (Example 4-28-1999).
Date of Last Post-Treatment Evaluation	This date indicates date of last post-treatment evaluation. Please enter date in this format: m-d-yyyy (Example 4-28-1999).

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. The tooth number you enter on your form must be consistent with the number you will enter when logging it onto your Portfolio Submission Main Screen. (See the *Digital Case History Exam Submission Instructions.*)
Procedures	Select the correct procedure from the drop-down box. This entry must be consistent with the list of 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. For the three cases in the procedure category OTHER, the subcategory is also required to be listed. **B. Procedure Category:** **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. For standardization, they should be included near the beginning of either the Medical History or Clinical Evaluation sections. Subsequent vital sign entries, as appropriate, should also be placed near the beginning of any treatment or post-treatment narrative. 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 and History of Present Condition	**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)	**Patient Information** Confirm the patient's chief complaint and symptoms. **Diagnostic Tests** Report all diagnostic tests performed on adjacent and involved teeth and the findings as well as clinical signs. Preferably, diagnostic testing information as well as periodontal assessment, should be included in a single table format. **Diagnostic Data** You must include diagnostic data on multiple 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. **Radiographic Findings** List the radiographic findings (interpretations) from the pre-treatment radiograph(s)/ image(s).
Pretreatment Diagnosis	**Diagnosis** Select a preoperative pulpal and apical 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 Apical Diagnosis* to accommodate entering a diagnosis that is not included in the pull-down box. **Approved Terminology** Use all terms consistently throughout the documentation.
Treatment Plan	**Treatment** Record a recommended plan of treatment based on the clinical diagnosis. Emergency treatment recommendations are only required when urgent care is appropriate and treatment short of definitive care (pulpotomy/pulpectomy/I&D/etc.) could be sufficient to provisionally eliminate or reduce existing symptoms. Indicate an alternative treatment plan when appropriate. Make recommendation(s) for treatment following endodontic procedures when appropriate. **Prognosis** Indicate your prognosis as **FAVORABLE, QUESTIONABLE,** or **UNFAVORABLE** from the drop-down box.

Clinical Procedures	**Appointments** **List in chronological order all dates the patient was seen**. **Informed Consent** Indicate that informed consent was obtained. **Procedures** Describe and justify (where necessary) clinical procedures performed. Describe emergency care rendered (if any), complications encountered (if any and how managed). 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 in mg 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, size and taper, filling core, sealer, and obturation technique in the table provided. **Postoperative Diagnosis** Record the postoperative diagnosis ***only if it differs*** from the preoperative diagnosis**.** **Care Calls, Post Surgery Checks and Suture Removals** Should be entered under CLINICAL PROCEDURES and NOT under Post-treatment Evaluations.

Post-Treatment Evaluation	**Minimum of One Year** A post-treatment 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 post-treatment evaluation <u>is required</u>. A Medically Compromised Case does not require a one year post-treatment evaluation.** **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 post-treatment evaluation and document the periodontal probing depths and restorative status. The criteria for success should be described. **Radiograph(s)/Image(s)** Provide post-treatment evaluation intraoral radiograph(s)/images and interpretation demonstrating all treated canals. CBCT screen shots can be utilized as supplemental imaging.

On the next three pages, you will find a printed version of the Digital Case History Report Form. Of course, you will not be submitting the printed form and this serves only as an example, but please take a moment to see all of the required information on the form.

To download the PDF form that you will use for your Digital Exam Submission, please go to https://www.amboardendo.org.

AMERICAN BOARD OF ENDODONTICS

CASE HISTORY REPORT

Case Report Number: _____ **Candidate Number**: _____
Patient Age: _____ **Date Case Started**: _____
Patient Sex: _ **Date Case Finished**: _____
Date of Last Post-Treatment Evaluation: _____

A. Tooth # (1 - 32): _____ **B. Procedure Category:**
OTHER subcategory _____

CHIEF COMPLAINT: _____

C. MEDICAL HISTORY: _____

D. DENTAL HISTORY AND HISTORY OF PRESENT CONDITION:

SAMPLE ONLY

E. CLINICAL EVALUATION: (Diagnostic Procedures)

Exam: SAMPLE ONLY

Tests: _____

Radiographic Interpretation: _____

F. PRE-TREATMENT

Pulpal: Select _____
Apical: Select _____

G. TREATMENT PLAN:
Recommended: **Emergency**: _____
Definitive: _____
Alternative: _____
Restorative: _____

PROGNOSIS: Select
_

H. CLINICAL PROCEDURES: Treatment Record
Date: _____ **Operations**:_____
_____

SAMPLE ONLY

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

CANAL (M,D,B,L, etc)	WORKING LENGTH	APICAL SIZE/TAPER*	OBTURATION MATERIALS AND TECHNIQUES

*Size of the largest instrument used at the apex

I. POST-TREATMENT EVALUATIONS: (Last post-treatment evaluation recorded must be must be 1 year minimum with the exception of the Diagnosis & Medically Compromised Cases)
Date: _____

Date: _____

Date: _____

ADDENDUM

SAMPLE ONLY

The Components of Your Digital Case History Portfolio

As you walk through the process of registering for and submitting your Case History Portfolio online, these are the main components and steps each exam should contain. Please read the *Digital Case History Exam Submission Instructions* for an in depth explanation of the online registration and upload process.

1.	**Candidate Pledge**	When you register for your exam, you will be prompted to sign the Candidate Pledge which states that all of the cases in your portfolio were for patients you treated during your practice.
2.	**Candidate Review Document**	Just before submitting your completed Portfolio, you will be asked if you have checked that your Portfolio follows all the criteria listed in the Candidate Review Document. Please be certain to review this form AS YOU BEGIN YOUR CASE HISTORY EXAM process. Refer to this document throughout the process as it outlines the errors that result in a failed portfolio, as well as common errors that you should avoid.
3.	**Payment**	To register for the exam, you will need to pay the case history fee via PayPal or using a major credit card. You will not be able to register or upload your portfolio if you do not pay the exam fee.
4.	**Cover Page (Optional)**	It is suggested to include a document explaining routine policies and procedures. Keep the introduction and technique descriptions brief. This document must be saved as a PDF for upload onto the site.
5.	**Abbreviation Explanation (Optional)**	It is suggested to include a document defining abbreviations (the use of abbreviations is acceptable but should be limited). This document must be saved as a PDF for upload onto the site.
6.	**Terminology Explanation**	If you use terminology other than the ABE approved terminology please upload a PDF document defining the terminology. Please note that ABE approved terminology is preferred.
7.	**Case History Report Form**	You will upload 10 separate case history PDFs to the site.
8.	**Medical consults, laboratory and biopsy reports**	All supportive or supplemental materials must be masked. This includes but is not limited to all names (Candidate, facility, institution(s), patient, physician, referring dentist), addresses (the entire address must be masked), geographic location, phone and fax numbers, signatures, Social Security Numbers, Medicare and Medicaid numbers, etc., and if required contain a translation in English notarized as a true copy. You must save any supplemental material as a PDF document for upload to the site.

9.	Digital Images	**Please use high quality radiographs and images. Unacceptable features include radiographs/images that are too dark, too light, not clear, or too small.** Place the digital images in chronological order on your screen from left to right. Please be certain to enter the correct date and description when prompted. Recommended image size: **Minimum image size: 200 KB AND 540 x 360 pixels.** **For better image resolution, image size: 300 KB and higher AND 800 x 600 pixels and higher.** Image files should not exceed 4 MB. Only JPEG, JPG, GIF and PNG radiographs/image files are acceptable. Prior to uploading the images on to the case history website, it is up to the Candidate to determine that the images are clear, of high quality, do not blur or pixelate (even if zoomed in) and clearly illustrate what needs to be communicated diagnostically, during the course of treatment and for the post- treatment evaluation. After uploading your cases, please review all images for quality and resolution as well as the proper sequence prior to hitting the "submit" button. Do not first save images into another application such as Word, PowerPoint, etc. **ALL Radiographs and Images MUST be referenced in the write-up.**

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 and History of Present Condition**
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-Treatment 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 charts 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 guideline 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).

Excellent - 3					
Pretreatment	**Diagnosis and Treatment Plan**	**Treatment**	**Post-treatment**	**Documentation**	**Complexity**
Thorough medical and dental history was obtained. There was an appropriate review of systems. Appropriate medical consultations were obtained and documented. Appropriate vital signs were recorded. Medications were documented (including rationale for prescribing, dosages, and frequency of dosing.	Complete and thorough clinical findings were recorded. Appropriate diagnostic tests were performed and the results recorded. Appropriate radiographs/images and interpretation. The pulpal and periapical (periradicular) diagnosis was correct. The treatment plan was appropriate. Alternative treatment plans were appropriate. Possible complications were considered. .	Clinical procedures were performed at the highest level of skill. All essential procedures were performed and in an appropriate sequence. Pharmacological management was appropriate and justified. Treatment was modified in accordance with the medical and dental history. Application of biologic principles was demonstrated. Informed consent was obtained.	Appropriate post-treatment evaluations intervals were prescribed. The clinical examination at follow-up was complete and appropriate tests performed. Radiographs/images were appropriate and diagnostic. The tooth was adequately restored. If final restoration is not present, recommendations for final restoration are clearly noted. Issues with the treated tooth or adjacent teeth visible on the post-treatment radiographic images were clearly noted and patient informed.	The narrative was complete, thorough, and readable with correct spelling and proper grammar. The terminology used was consistent with ABE terminology If different terminology was used, an explanation was provided. Abbreviations were clearly explained. The documentation with radiographs/ images was complete and of the highest quality. Procedures were justified and explained. Any clinical photographs were of high quality and appropriate and necessary for proper documentation. The dates and treatment sequencing were accurate. Radiograph and Digital Image dates are referenced in the narrative (for example, the write-up must state in the appropriate area that a radiograph or photograph was made), and dates match the dates in the Case History Form.	Cases required the highest level of knowledge and technical skill. Cases required the highest level of patient management. If treatment consultations were required, they were clearly addressed and documented. If the treatment sequence was a critical component, the treatment sequence followed was clearly explained and documented.

Acceptable - 2					
Pretreatment	**Diagnosis and Treatment Plan**	**Treatment**	**Post-treatment**	**Documentation**	**Complexity**
Minor information was omitted that does not significantly affect the treatment and prognosis.	The pulpal and periapical (periradicular) diagnosis was correct despite the fact limited diagnostic tests were performed. The radiographic examination was minimally adequate. There is missing diagnostic information that does not affect the diagnosis, treatment plan, or prognosis. The alternative treatment plans were incomplete.	Procedures were performed at a satisfactory level. The treatment sequence was not appropriate but this did not affect the treatment outcome. Minor procedural deficiencies were evident that do not compromise the outcome. Procedures were documented or demonstrated in an acceptable manner but lacked enough detail to grade as excellent.	The clinical examination and data provided was adequate but lacked enough detail to grade as excellent. Results reported were consistent with the data provided. The tooth was inadequately restored but noted in the narrative.	Minor errors are evident but do not affect the interpretation or understanding of the case. Minimal and infrequent spelling and grammatical errors.	High technical skill required. Adequate patient management. Treatment sequence important but was not critical.

Deficient - 1					
Pretreatment	**Diagnosis and Treatment Plan**	**Treatment**	**Post-treatment**	**Documentation**	**Complexity**
Incomplete medical and dental history. Insufficient information that influences the prognosis. Insufficient information that influences and/or affects the diagnosis, treatment, or prognosis. Insufficient number of pretreatment radiographs. Appropriate vital signs were not repeated at subsequent visits when indicated. 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.	The clinical examination was incomplete. Appropriate diagnostic tests were not performed. Interpretation of the data/radiographs (images) was incorrect. Alternative treatment plans were not appropriate or were missing. The prognosis was inaccurate. 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.	Procedural errors were evident that may have affected the outcome. Treatment performed was not consistent with the diagnosis and treatment plan as outlined. Radiographs/images lack detail and proper interpretation. Treatment sequence adversely affects outcome. Treatment was not supported by the best available evidence. Radiographs or images lack adequate detail. Poor interpretation of radiographs or images. More explanation of procedures was needed. Unsafe or ineffective use of antibiotics.	Misinterpretation of radiographs/images. Poor quality of radiographs/images. Incomplete clinical examination. Failure to recognize the lack of an adequate permanent restoration. Outcome shows underfill, overfill or poor quality condensation. 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.	Frequent narrative errors. Poor grammar and spelling errors. Poor radiographs/ images. Processing errors. Lack of medical consultation reports when indicated. The lack of biopsy reports when indicated.	Routine diagnostic and technical difficulty requiring average skills.

Unacceptable - 0					
Pretreatment	**Diagnosis and Treatment Plan**	**Treatment**	**Post-treatment**	**Documentation**	**Complexity**
The medical and dental history was not provided. Incorrect information was provided. Appropriate consultations were not obtained. Appropriate vital signs were not recorded.	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.	Major procedural errors. Inappropriate treatment. Inappropriate pharmacological management. Sequence of treatment adversely affects the prognosis. Radiographs/images are of poor quality or do not demonstrate adequate treatment. Inappropriate application of biologic principles.	An appropriate clinical examination was not performed. Radiographs/images were inadequate. The radiographic interpretation was not correct. Appropriate treatment/ post-treatment evaluations recommendations were not provided.	Incomplete information. Information was presented that could not be interpreted. The narrative and/ or radiographic documentation were not representative of the case. Digital Images are not the correct size.	The knowledge and technical skills required were within the scope of the general dentist.

Errors That Result in a Failed Portfolio	**Common Errors That Should Be Avoided**
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 Post-treatment Evaluations** The one-year post-treatment evaluations requirement was not met in all of the required cases.	**Radiographs, Digital Images** Poor/Inadequate image quality. Image size should not exceed 4MB per image. **Cone Beam Computed Tomography** Submission was not an image with adequate masking. **Non-English Language Documents** English translation not included.

Candidate Review Document										
Case Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Errors That Result in a Failed Portfolio										
Required Case Categories										
The portfolio will fail if any of the cases below have not been submitted or are not in the correct order										
Case 1 Diagnosis										
Case 2 Emergency										
Case 3 NS RCT - Maxillary Molar										
Case 4 NS RCT - Mandibular Molar										
Case 5 NS RETX - Maxillary or Mandibular Molar										
Case 6 NS RETX - Maxillary or Mandibular Molar										
Case 7 Maxillary or Mandibular Molar Periapical Surgery with Root-end Resection & Root-end Filling										
Case 8 OTHER										
Case 9 OTHER										
Case 10 OTHER										
Photograph Masking										
All patient photographs must have their eyes masked.										
If this has not been done, the entire portfolio will fail										
Document Masking										
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.										
If this has not been done, the entire portfolio will fail										
One-Year Post-Treatment Evaluation										
Clinical evaluations and post-treatment evaluation 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 post-treatment evaluation visit in the 12th month after completion of treatment will be considered acceptable.										
If this has not been done, the entire portfolio will fail										

Common Errors - Please Note: Committing the following errors once will NOT automatically fail your portfolio, but you should check your portfolio thoroughly for these errors, and avoid making them.

Common Errors - Please Note: Committing the following errors once will NOT automatically fail your portfolio, but you should check your portfolio thoroughly for these errors, and avoid making them.										
Case Number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Radiographs, Digital Images										
Dates must match back to the dates in the Case History Form.										
Radiographs must be presented in date order										
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.										
Radiograph/Image Size										
Please begin with high quality images. Image files should not exceed 4 MB. For best results, we recommend images be no smaller than 300 KB in file size and no less than 800 x 600 pixels. Only JPEG, JPG, GIF and PNG image files will be accepted. Even though the ABE provides guidelines for size and quality of images, ultimately it is up to the Candidate to determine, prior to uploading the images on to the case history website, that the images are clear, of high quality, do not blur or pixelate (even if zoomed in), and clearly illustrate what needs to be communicated diagnostically.										
Cone Beam Computed Tomography										
Only screen shots with adequate masking are permitted.										
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. This must be submitted as a Supplemental Document in a PDF format.										
Please carefully read the Case History Submission requirements above and indicate your understanding and agreement by typing your name when prompted onscreen. This prompt will appear after you have uploaded your entire Portfolio.										

Submission of the Portfolio
Uploaded Portfolios must be received online at http://www.amboardendo.org on or before the submission dates of May 1st and September 1st. We urge you to not wait until the last minute to register and upload your Portfolio. Although we have tried to make the process simple and straightforward, there are many steps to be followed and technical difficulties can always occur, especially if you are using outdated web browsers. Please give yourself adequate time for this task. Also, please be certain that you retain on your computer the final version of your completed Portfolio.

PLEASE NOTE: Due to an ever-increasing number of portfolios submitted, **the ABE may need to limit the number of submissions accepted for review in any given cycle.** Any such limitation on submissions would be dynamic and based exclusively on available examiner resources. **Any portfolio that meets the scheduled deadline that cannot be reviewed would be automatically held and reviewed the following cycle, with candidate notification by ABE staff.** We recommend not waiting until the deadline to submit your portfolio because the sooner you submit your portfolio, the more likely you are to be included in the cycle for which you are submitting

Examination Fee
The Case History Exam fee is required when you register for the Exam. When you register, you will be prompted to pay for the exam either by PayPal or with a major credit card. You will not be able to upload your Exam if you have not paid the exam fee.

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 (post-treatment evaluation 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. 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 $300 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.

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