The Genesis and Development of CBCT for Dentistry

A Peer-Reviewed Publication
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Educational Objectives
The overall goal of this article is to provide dental professionals with information on the introduction of radiographic imaging to dentistry and the more recent evolution of dental imaging towards 3-dimensional imaging with cone-beam CT. Upon completion of this course, the participant will be able to do the following:
1. List the principles of cone beam computerized tomography (CBCT)
2. State the dosage considerations and the comparative doses with traditional radiographs and computerized tomography (CT)
3. List the indications for which CBCT offers enhanced imaging and aids in the identification of anatomical structures and oral-maxillofacial conditions
4. List the considerations in deciding whether to purchase a CBCT device or refer patients to imaging centers

Abstract
Cone beam computerized technology (CBCT) offers 3-dimensional visualization and more complex and more accurate imaging compared to analog and digital radiographs. It is an accurate tool for many clinical oral-maxillofacial indications, with lower radiation doses than computerized tomography. The clinician must determine the risk:benefit of imaging for each patient. Clinicians are rapidly realizing the significant advantages of CBCT imaging. Factors to consider in determining whether to purchase a CBCT device or to refer patients to imaging centers include cost, training, time required to generate images and reports, data transmission and storage, and responsibility for interpretation and pathology review.

Introduction
“I have discovered something interesting, but I do not know whether my observations are correct,” stated Wilhelm Conrad Roentgen (Figure 1) in 1895 after he saw the bones of his hand clearly displayed in an outline of flesh when he held it between a cathode ray tube and a barium-coated screen. In December 1895 he reported this to the Wurzburg Physical-Medical Society with a radiograph of his wife’s hand (Figure 2), and within weeks of Roentgen’s report, newspapers and professional journals exploded with descriptions of his finding. By February 1896, most cities and small towns in the United States had seen demonstrations of the “new light.”

Table 1. Use of X-rays in dentistry

<table>
<thead>
<tr>
<th>Number of radiographs</th>
<th>1999</th>
<th>1990</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bitewing</td>
<td>112,836,100</td>
<td>95,618,400</td>
</tr>
<tr>
<td>Periapical</td>
<td>80,259,100</td>
<td>NA</td>
</tr>
<tr>
<td>Complete series</td>
<td>17,024,800</td>
<td>14,510,400</td>
</tr>
<tr>
<td>Panoramic films</td>
<td>20,845,900</td>
<td>15,389,500</td>
</tr>
</tbody>
</table>


Although the basic technology of dental radiography has remained unchanged for conventional imaging, a significant development was the introduction of faster films, which reduced radiation doses to patients. This development was furthered by the introduction of digital radiography. With digital radiography, radiation doses generally are lower than with conventional dental radiographs. They offer quicker image taking and accuracy, the ability to store the images indefinitely in computer archives without deterioration, and the ability to send them to other clinicians as a digital file when required.

Cone Beam Computerized Tomography
From the early days of dental radiographs, the concepts did not change significantly until 3-dimensional imaging was introduced. Computed tomography was available for 3-dimensional dental imaging in the 1980s, but due to the high cost, limited access, and radiation exposure, utilization was limited to management of craniofacial anomalies, complex surgeries, and other unique dental situations. In 1988, cone beam computerized tomography (CBCT) was introduced to dentistry. This technology offered 3-dimensional visualization and more complex and more accurate imaging compared to analog and digital radiographs. CBCT is not a new concept and was originally devised as a cost-effective and efficient
method for obtaining cross-sectional 3-dimensional images for radiotherapy, and later for angiography. Conventional medical computerized tomography (CT) devices image patients in a series of axial plane slices that are captured as individual stacked slices or from a continuous spiral motion over the axial plane. Conversely, CBCT presently uses one or two rotation sweeps of the patient similar to that for panoramic radiography. Image data can be collected for a complete dental/maxillofacial volume or limited regional area of interest. Scan times for these vary from approximately 5 to 90 seconds. The X-ray energy of CBCT is similar to that of panoramic radiography with a typical operating range of 1-15 mA at 90-120 kVp, while that of medical CT is significantly higher at 120-150 mA, at 220 kVp. These operational differences are some of the most significant differences between the two technologies, although there is often confusion since both provide 3-dimensional visualization and include “computed tomography” in their description.

**CBCT Indications and Accuracy**

A basic principle of diagnostic imaging is that a specific clinical indication calls for selected diagnostic imaging to better plan treatments. CBCT is an accurate and useful tool for many clinical oral-maxillofacial indications, including the identification of anatomical structures and locations prior to implant placement and other oral surgery procedures, prior to and during endodontic procedures and when planning treatment for orthodontics. Recently, CBCT scans have also been studied for their ability to noninvasively measure the thickness of palatal mucosa in different locations, and have been found to be accurate.

CBCT also plays a role in the identification, diagnosis, and determination of the severity of diseases. A retrospective assessment in Germany found that 90% of referrals for CBCT scanning were largely for identification and examination of structures prior to oral and maxillofacial surgery or implant placement, and to enable treatment planning and preparation. Reasons for referrals were mainly related to wisdom tooth anatomy, cystic lesions, and the positioning of mediodents and impacted canines and premolars. The majority of CBCT users in dentistry in the United States are clinicians placing dental implants.

**Dental Implants**

Information about bone height, regional width, bone ridge thickness and morphology, and inferior alveolar nerve canal location (if applicable) is essential for selection of the correct dental implant size and length. Implant planning using a surgical guide stent and CBCT will provide information that results in a safe clinical procedure that avoids inferior alveolar nerve trauma, maxillary sinus penetration, and other iatrogenic sequelae of dental implant placement. CBCT provides the clinician with more precise and accurate imaging, providing better preoperative information and thereby helping avoid problems associated with any surgery in sites close to these structures or where compromising factors are present (Table 3). The importance of such accuracy should not be underestimated. Researchers have found that CBCT accurately detects differences in the loop length and diameter of mandibular canals in the interferomental region, and that large variations in these structures occur between individuals. Investigators concluded that CBCT scans offer important preoperative

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**Radiation Doses for X-ray Technologies**

CBCT technology allows scan times to vary, typically from 5.7 to 40 seconds, with an exposure dose typically in the range of 40 to 135 µSv, a fraction of the radiation dose of an equivalent CT scan. The effective absorbed radiation dose for a complete cone beam volume tomographic image of the maxillofacial area is within the range of a full-mouth dental periapical survey. For the purposes of comparison, the effective absorbed radiation doses for dental images are listed in Table 2. One must bear in mind that one cone beam volumetric imaging session can provide all of the other dental images with the exception of the full-mouth series, although this capability seems to be in the near future. CBCT offers accurate 3-dimensional scanning with radiation doses that are lower than those of computerized tomography and enable its use in a normal clinical dental setting. As a result, CBCT scanning for accurate diagnosis and planning can be performed in-office or referred out. Since the systems and software are specifically developed for dental applications, the images are superior to those of medical CT for dental uses.

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**Table 2. Effective doses from dental imaging**

<table>
<thead>
<tr>
<th>Imaging Type</th>
<th>Effective Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panoramic film</td>
<td>3-11 µS</td>
</tr>
<tr>
<td>Lateral cephalograph</td>
<td>5-7 µS</td>
</tr>
<tr>
<td>PA cephalograph</td>
<td>5-7 µS</td>
</tr>
<tr>
<td>Occlusal film</td>
<td>5 µS</td>
</tr>
<tr>
<td>Full mouth series</td>
<td>30-80 µS</td>
</tr>
<tr>
<td>TMJ series</td>
<td>20-30 µS</td>
</tr>
<tr>
<td>CBCT</td>
<td>18-135 µS</td>
</tr>
</tbody>
</table>

Ranges above are for traditional and digital imaging combined.
information for patients receiving implants in the interfo-
ramenal region (Figure 4). In addition, CBCT scans can
detect accessory mental foramina.11

Figure 4. CBCT views for implant treatment planning

Table 3. Implant planning and anatomical considerations

<table>
<thead>
<tr>
<th>Planning of exact implant position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinus lift</td>
</tr>
<tr>
<td>Intra-alveolar distraction osteogenesis</td>
</tr>
<tr>
<td>Reduced vertical bone height</td>
</tr>
<tr>
<td>Reduced horizontal bone width</td>
</tr>
<tr>
<td>Anatomical variations of the alveolar nerve</td>
</tr>
<tr>
<td>Preparation of templates</td>
</tr>
</tbody>
</table>

Oral Surgery

CBCT imaging offers improved intra- and inter-observer
reliability for the identification of some facial anatomical
features. Safe and optimal removal or transplantation of
impacted wisdom teeth and localization of impacted canines
are enhanced with the use of CBCT. In oral surgery, CBCT is
superior in generating images to locate root position and prox-
imity of impacted third molars to the inferior alveolar nerve,
compared to 2-dimensional cephalographs (Figure 5) as well
as other structures such as the infra-orbital artery (Figure 6).14

Figure 5. Mandibular CBCT views of impacted third molar

Bone quality is one of the factors responsible for primary
implant stability and can be difficult to assess using tradi-
tional techniques. Song et al. found that bone thickness as
determined by CBCT scans in 61 patients was accurate
and predictive for primary implant stability.12 These col-
lective advantages of CBCT led the authors to conclude,
“This imaging technology provides 3-D and cross-sec-
tional views of the jaws. It is obvious that this hardware is
not in the same class as CT machines in cost, size, weight,
complexity, and radiation dose. It is thus considered to be
the examination of choice when making a risk-benefit as-
sessment.”13
Figure 6. Maxillary CBCT views with infra-orbital artery

Note the ability to measure available bone to plan the surgery to avoid the infra-orbital artery

As an illustration of the accuracy of CBCT, bifid (bifurcated) mandibular canals are one of many considerations when planning mandibular surgery, and have been reported to be present in less than 1% of the population based on studies using panoramic radiographs. However, a recent study of more than 100 patients found bifid canals in 65% of patients when CBCT scanning was used. In a study correlating intra-operative surgical findings of impacted third molars and their relationship to the inferior alveolar dental canal, use of conventional imaging had 66% sensitivity as far as its ability to determine if the impacted third molar was in contact with the IDC, and 74% specificity to eliminate this possibility. This study underscores the limitations of conventional imaging approaches to evaluation of relatively common dental situations.

Orthodontics

For orthodontics, one single CBCT scan can effectively generate all the images needed for orthodontic diagnosis including the lateral cephalograph, the panoramic radiograph, the antero-posterior cephalogram, temporo-mandibular joint tomograms, and many other oblique/cross-sectional slices previously unavailable in flat planar films, at a relatively equivalent radiation dose for a set of orthodontic X-ray initial records. In addition, leading technological developments are allowing for the production of virtual orthodontic study models from the same data set (Figure 7).

Figure 7. Rapid prototyped anatomodels from CBCT

Many published articles have validated the use of CBCT images in orthodontics, including measurement accuracy, comparisons between 2-D and 3-D images for diagnosis and treatment planning, and the clinical use of native 3-D information from the DICOM data set. As Dr. B. Holly Broadbent’s standardization of 2-D lateral cephalometric parameters has led to numerous orthodontic analyses, many research groups are in the process of developing new 3-D norms using anatomic landmarks previously unavailable on 2-D images. 3-D imaging allows for accurate and reliable assessment of the positions of impacted canines and supernumeraries as well as of the adjacent teeth for resorption and surrounding soft and hard tissues. Serial CBCT scans can also measure and quantify volumetric changes of craniofacial structures using superimposition techniques.

Figure 8. 3-D view of a supernumerary
Advancements in software also allow analysis of skeletal structures, dental structures, and soft tissue structures in the same instance. Moving forth into the 4th and 5th dimension, many groups are also using these 3-D structures to study movement, e.g., TMJ function, occlusion (Figure 9a,b), and to develop finite element models (muscle attachment, bone biology with tooth movement). Furthermore, novel computer algorithms have been created to allow for voxel-based superimposition of 3-D data sets (Figure 10a,b). A voxel is a volume element or “volume cell”, representing a value on a grid in 3-dimensional space. It is analogous to a pixel or “picture cell” which represents 2D image data in a bitmap.

This approach utilizes information from thousands of voxels in two-image sets to obtain the best possible superimposition. In contrast, conventional methods using landmark and/or anatomic structure identification, subsequent labeling, and matching create a significant chain of events that contain margins of error within each step.

<table>
<thead>
<tr>
<th>Panoramic views</th>
<th>Lateral cephalographs</th>
<th>Impacted canines</th>
<th>Planning of orthodontic anchorage implants/pins</th>
<th>Supernumerary teeth</th>
<th>Periodontal bone support</th>
</tr>
</thead>
</table>

**Endodontics**

CBCT scans offer increased accuracy for the identification of root canals, and their location, prior to endodontic therapy. When compared with 2-dimensional digital radiographs, CBCT enables clinicians to identify more canals in multi-canal teeth that can then be instrumented and obturated, thereby increasing the likelihood of a successful outcome. CBCT scans were found in an in vitro study to be more accurate in showing apical periodontitis than were periapical radiographs. The CBCT scans detected these 84% of the time compared to 71% for apical radiographs, while apical periodontitis was found histologically 93% of the time. Periapical radiographs were concluded to be more likely to miss apical periodontitis and to be less accurate than CBCT scans. One study found that artificially created voids larger than 300 μm in root canal sealers were detected using CBCT, standard radiographs (analog), and digital radiographs, while for smaller voids digital radiograph techniques were best. CBCT scans have also been found to increase accuracy in identifying horizontal

Figure 9a. Assessment of the TMJ and occlusion

Note: Occlusal pattern and condylar positions

Figure 9b. Close up of condylar positions

Note: Condyles are unseated revealing an anterior mandibular shift

Figure 10a. Frontal superimposition to highlight orthodontic outcomes following functional appliance therapy

Figure 10b. Lateral superimposition to highlight orthodontic outcomes following functional appliance therapy
and vertical root fractures, which can be difficult to definitively diagnose using traditional methods (Figure 11). Hassan et al. found that CBCT offered greater sensitivity (80% versus 37%) compared to periapical radiographs for detecting vertical root fractures, with a specificity that was only slightly lower (92% versus 95%). It was also found that the presence of root canal fillings reduced accuracy. Overall, the accuracy of CBCT was 86% compared to 66% for periapical radiographs.\(^25\)

In one study in which radiographs led to the conclusion that the periapical tissues were healthy, CBCT scans detected apical periodontitis in a high percentage of cases. Furthermore, while the investigators found periapical healing with radiographs, the CBCT scans showed evidence of enlarged radiolucencies, indicating disease. They concluded that evaluation of long-term longitudinal studies using CBCT, and stricter criteria, were required to determine endodontic outcomes and success rates.\(^26\) CBCT can also be used to help rule out endodontic pathology in cases of referred pain due to sinus infection.

Table 5. Endodontics and CBCT uses

<table>
<thead>
<tr>
<th>Root morphology—shape, number of canals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathways of infection</td>
</tr>
<tr>
<td>Quality of root canal filling</td>
</tr>
<tr>
<td>Rule out referred pain (sinus)</td>
</tr>
</tbody>
</table>

Other Oral Pathological Conditions

CBCT scans are useful in cases where orofacial pain exists, and for the detection and/or diagnosis of osteoarthrosis, osteoarthritis, hypoplasia, hyperplasia, aplasia, loose bodies, and neoplasia of the temporomandibular joints. Figure 12 shows the phenomenon of enostosis of the TMJ. CBCT scanning has also been used to assess the severity of TMJ osteoarthritis,\(^27\) as well as to detect various oral pathological conditions such as apical cysts, fibrous dysplasia, and cemotomas. Other dental applications include visualization of cleft palate cases in craniofacial anomalies, assessment of pharyngeal airway patency or obstruction, and sinus evaluation.\(^28,29\)

Risk-Benefit

An important aspect of the diagnostic imaging using radiation is risk-benefit determination. This relies on less tangible information such as estimation of risk of populations and other generic information. In addition, each patient has a specific risk-benefit depending on the nature of his or her problems, history, and treatment plan. For X-rays, the principle of ALARA (As Low As Reasonably Achievable) applies; however, it can often be very difficult to specifically define this for a given patient, particularly if the patient’s problem is atypical. For this reason, the American Dental Association has published general guidelines on the use of X-ray imaging in dentistry. There is very little if any information available to address the risks to patients if the imaging views are insufficient. The National Radiological Protection Board (NRPB) estimates risk of X-ray imaging as the additional risk of cancer due to exposure. On average, humans have a one in three chance of getting some type of cancer. Dental X-ray imaging is typically in the range of 10 to 100 \(\mu\)Sv. At 10 \(\mu\)Sv, the NRPB estimates the additional risk of cancer is negligible and is equivalent to a day or two of natural background radiation with some variation due to geographic location. On average, the daily exposure from naturally occurring sources such as the sun and earth is 8 \(\mu\)Sv. At 100 \(\mu\)Sv, the NRPB estimates that the additional risk, above the baseline of one in three, is minimal (1:100,000 to
Sensor type and size:
Many of the newer CBCT devices marketed toward the dental implant sector need only a limited field of view, and are installed with smaller sensors. Therefore, in order to capture all of the anatomical structures that are needed for orthodontic diagnosis (sella to nasion to pogonion to basion as a rough perimeter outline), it is necessary to increase the field of view. This can be done via two methods: (1) a larger sensor, which will increase purchase cost; or (2) a greater scan time with two scan passes that are subsequently “stitched together” for the 3-D image; this method increases operational costs.

Primary/secondary reconstruction:
There is considerable variation in the time required to process the raw image captures and reconstruct this data into a format that can be visualized and manipulated on screen, depending on the specific CBCT device. During the active capture phase in which the X-ray generator rotates or moves around the patient’s head in approximately 10, 20 or 40 seconds, the device is capturing hundreds of raw X-ray images (e.g., the Hitachi MercuRay captures 288 raw images in a 9.8-sec pass and the Suni captures 280 raw images in 8.3 seconds). Using computer mathematical algorithms, these images are then pieced together and reconstructed into a 3-D volume. This process can take anywhere from 5 or 6 minutes to 30 minutes, depending on the device and amount of image data generated during the scan. Some systems allow the operator to perform a quick reconstruction for previewing the data and return later to perform a much higher resolution reconstruction taking a significantly longer time. This “downtime” is especially important if there is a high patient volume scan throughput, because during this reconstruction phase the scanner/computer is busy and cannot be used for other purposes. Recent developments allow for batching of patient scans so that they may be reconstructed at a later time when the computer is not occupied with image acquisition.

Image formatting/reports:
After the secondary reconstruction in which the 3-D volume is exported as a series of small Digital Imaging and Communications in Medicine (DICOM) files, similar to those of conventional medical CT slices, the 3-D volume is available for analysis. All CBCT devices come with imaging software for capturing and analyzing the information. Some are simple and user friendly for easy visualization of the 3-D object, while others are more complex but more powerful in the ability to measure distances, angles, and object segmentation. This is a consideration for the clinician, as staff training is required for extraction of useful information from the DICOM data. Generating a standard report with volumetric images, dentition views, panoramic radiograph, lateral cephalogram, and cephalometric analysis, in addition to any cross-sectional views necessary to view anomalous conditions, such as impacted canines or root resorption, becomes the crux of CBCT implementation in an orthodontic practice. Just as important is the amount of time needed to generate this report, because streamlining of the CBCT process from image capture to report output will dictate its success in the clinical private practice. Recently, service bureaus have emerged that offer to perform the reformating for dental offices, thus providing high-level reformatted images while saving the office valuable clinical time.
Cost Sharing

The acquisition and operational costs of a CBCT device often exceed the budget for an individual clinician. Cost sharing is a feasible alternative when there is a group of clinicians who can provide the internal referrals required to support the use of a CBCT device. Many dental groups include providers for oral surgery, periodontics, pedodontics, endodontics, and orthodontics. While the demand for CBCT imaging is increasing, each specialty has certain specific needs from its CBCT images. A ready example is the difference between a dental implant clinician and an orthodontist or an endodontist. For placing dental implants, the usual region of interest is limited to a single arch or quadrant, and the resolution should be high enough to trace the inferior alveolar canal. However, for orthodontic purposes, a larger field of view is necessary to capture all the necessary sites of growth and development. Since orthodontists are looking at larger skeletal structures, resolution in the range of 300-400 µm is very acceptable, while an implantologist may prefer resolution in the range of 200-300 µm, and further, an endodontist may call for resolution in the range of <100-200 µm. Therefore, the selection of the CBCT device to store and transmit data must be considered in this shared ownership model. Newer CBCT softwares operate on a partial download platform, server-based software system, or a data compression system to expedite the DICOM information transfer. Recurring costs of technician salary and generation of report outputs are still applicable in this ownership model.

X-Ray Imaging Labs

The third option is to outsource this 3-D imaging, and it is rapidly becoming popular. Many 3-D X-ray imaging labs are opening as CBCT technology gains popularity and momentum. The cost of the scan is usually paid for by the patient in the form of an X-ray records fee, and most imaging centers are willing to work with the referring doctor to develop a customized report template to be delivered directly to the doctor’s office. Advantages of this include no initial overhead, no operational costs, no investment for staff training, and no data communication/storage issues. However, this option is only available if there is a physical 3-D imaging center in the vicinity of the office. There is also the turnaround time between giving the patient the referral form, the patient actually getting the scan at the 3-D imaging center, and then the report being mailed back to the doctor’s office. Most of the lag time in this situation is the patient actually making an appointment at the 3-D X-ray lab, possibly due to the associated inconvenience. As we become more aware of patient information privacy, The Health Insurance Portability and Accountability Act (HIPAA) becomes more of a concern in this emerging medical information field. There is usually a consent form signed by the patient giving permission to release information to the 3-D imaging centers. With outsourcing, the obvious limitation is the availability of these services. In many urban communities, X-ray imaging labs have started to provide these 3-D imaging services, and almost all academic dental institutions in the United States have acquired a CBCT device.

Summary

The benefits of 3-D imaging apply to every dental discipline, and there is a corresponding trend toward integrating it into dental offices. Whether a clinician decides to buy a CBCT device, share the purchase with other colleagues, or refer the patient to an imaging center, this powerful technology will shape the future of dental diagnosis and treatment planning. Of particular note, malpractice litigation cases are already starting to cite the availability of this technology to provide additional and more accurate information obtained from CBCT scans compared to traditional 2-D planar radiography. Therefore, risk-management issues present the question of whether it is a liability if a clinician does not use this technology in diagnosis and treatment planning. However, it is also very important to emphasize that the use of 3-D imaging in itself does not preclude litigation issues. The 3-D data needs to be adequately interpreted. There are advantages and disadvantages of having a static printed report generated by a technician versus active manipulation of the 3-D data set by the trained clinician. Interpretative radiology reports provided by board-certified oral and maxillofacial radiologists can become important in the identification of other incidental or pathological findings within the 3-D data set.

There are numerous factors and issues involved with the use of CBCT. It is important for the private practice clinician not to shy away but rather to embrace this new concept of craniofacial diagnosis. Searching out as much information as possible about this technology is the first step toward successfully implementing it into private practices.

References

7. Barriviera M, Duarte WR, Januario AL, Faber J, Bezerra AC. A new method to assess and measure palatal masticatory

www.ineedce.com
Questions

1. The first radiographs by Wilhelm Roentgen used a _______.
   a. diode ray tube and a barium-coated screen
   b. cathode ray tube and a barium-coated screen
   c. cathode ray tube and a barium-coated screen
   d. none of the above

2. The number of radiographs taken by private practitioners, excluding those taken in hospital and academic settings, has _______.
   a. steadily decreased
   b. steadily increased
   c. remained the same
   d. none of the above

3. Radiation doses with digital radiography generally are _______ with conventional dental radiographs, and they offer _______.
   a. lower than; slower image taking
   b. the same as; quicker image taking
   c. lower than; quicker image taking
   d. none of the above

4. Cone beam computerized tomography was introduced to dentistry in _______:
   a. 1978
   b. 1988
   c. 1998
   d. 2008

5. Using CBCT, image data can be collected for a _______ of interest.
   a. complete dental volume
   b. complete maxillofacial volume
   c. limited regional area
   d. all of the above

6. The X-ray energy of CBCT is similar to that of panoramic radiography with a typical operating range of _______.
   a. 1-10 mA at 60-90 kVp
   b. 1-15 mA at 90-120 kVp
   c. 1-20 mA at 120-150 kVp
   d. none of the above

7. CBCT technology allows scan times to vary, typically from _______ seconds, with an exposure dose typically in the range of _______ μSV.
   a. 3.7 to 20; 20 to 115
   b. 4.7 to 30; 30 to 125
   c. 5.7 to 40; 40 to 135
   d. 6.7 to 50; 50 to 145

8. The _______ for a complete cone beam volumetric image of the maxillofacial area is within the range of a full-mouth dental periapical survey.
   a. actual absorbed radiation dose
   b. actual absorbed radiation dose
   c. effective absorbed radiation dose
   d. effective absorbed radiation dose

9. The majority of CBCT users in dentistry in the United States are _______.
   a. clinicians removing lower wisdom teeth
   b. clinicians placing stents
   c. clinicians placing dental implants
   d. clinicians removing tori

10. Researchers have found that CBCT accurately detects differences in the _______ in the interforamenal region.
    a. loop length and length of mandibular canals
    b. loop length and diameter of mandibular canals
    c. static height and length of mandibular canals
    d. loop length and diameter of mandibular canals

11. Bone thickness determined from CT scans was found in one study to be _______ for primary implant stability.
    a. accurate but predictive
    b. inaccurate but predictive
    c. accurate and predictive
    d. none of the above

12. Safe and optimal removal or transplantation of impacted wisdom teeth and localization of impacted canines are enhanced with the use of _______.
    a. radiographs
    b. direct vision
    c. CBCT
    d. none of the above

13. 3-D imaging allows for accurate and reliable assessment of the positions of _______.
    a. impacted canines
    b. trephines
    c. supernumeraries
    d. a and c

14. A single CBCT scan can effectively generate _______ the images needed for orthodontic diagnosis.
    a. some of
    b. most of
    c. all
    d. none of

15. Serial CBCT scans can measure and quantify volumetric changes of craniofacial structures using _______.
    a. bilateral
    b. superimposition
    c. trigonal
    d. none of the above

16. _______ can be created from CBCT scans.
    a. Virtual demography
    b. Virtual orthodontic study models
    c. Virtual orthodontic study models
    d. a and c

17. In one in vitro study, CBCT scans detected apical periodontitis _______ of the time compared to _______ of the time using apical radiographs.
    a. 65%; 51%
    b. 73%; 56%
    c. 78%; 67%
    d. 84%; 71%

18. CBCT scans increase accuracy in identifying _______ root fractures.
    a. horizontal
    b. vertical
    c. translucent
    d. a and b

19. Hassan et al. found that CBCT offered greater sensitivity _______ compared to periapical radiographs for detecting vertical root fractures.
    a. 70% versus 37%
    b. 80% versus 37%
    c. 90% versus 47%
    d. none of the above

20. Dental applications of CBCT scans include _______.
    a. detection of various oral pathological conditions such as apical cysts
    b. visualization of cleft palate cases
    c. sinus evaluation
    d. all of the above

21. Recent developments allow for _______ of patient scans so that they may be reconstructed at a later time.
    a. caching
    b. catching
    c. batching
    d. batchng

22. Piecing together raw X-ray images and reconstructing these into a 3-D volume can take anywhere from _______ to _______ minutes, depending on the manufacturer.
    a. 4 or 5; 20
    b. 5 or 6; 20
    c. 4 or 5; 30
    d. 5 or 6; 30

23. The _______ must arrive at a risk:benefit determination for every diagnostic imaging session.
    a. patient
    b. assistant
    c. clinician
    d. a and b

24. _______ CBCT devices come with imaging software for capturing and analyzing the information.
    a. Benefit deflection
    b. Cost deflection
    c. Benefit deflection
    d. None of the above

25. _______ is a feasible option when there is a group of clinicians who can provide the internal referrals required to support the use of a CBCT device.
    a. Benefit sharing
    b. Cost sharing
    c. Benefit deflection
    d. None of the above

26. Annual maintenance agreements for CBCT machines have fees ranging from _______ annually.
    a. $4,000 to $10,000
    b. $8,000 to $20,000
    c. $12,000 to $30,000
    d. none of the above

27. Since orthodontists are looking at larger skeletal structures, resolution in the range of _______ is very acceptable.
    a. 100-200 μm
    b. 200-300 μm
    c. 300-400 μm
    d. none of the above

28. An implantologist may prefer resolution in the range of _______, while an endodontist may call for resolution in the range of _______.
    a. 300-400 μm; <200-300 μm
    b. 200-300 μm; <200-300 μm
    c. 200-300 μm; <25-50 μm
    d. none of the above

29. X-ray imaging labs are only an option if there is a _______ imaging center in the vicinity of the office.
    a. physical
    b. virtual
    c. labial
    d. a or b

30. The benefits of 3-D imaging apply to _______.
    a. only dental disciplines
    b. some dental disciplines
    c. every dental discipline
    d. none of the above
**Educational Objectives**

1. List the principles of cone beam computerized tomography (CBCT)

2. State the dosage considerations and the comparative doses with traditional radiographs and computerized tomography

3. List the indications for which CBCT offers enhanced imaging and aids in the identification of anatomical structures and oral maxillofacial conditions

4. List the considerations in deciding whether to purchase a CBCT device or refer patients to imaging centers

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### Course Evaluation

Please evaluate this course by responding to the following statements, using a scale of Excellent = 5 to Poor = 0.

<table>
<thead>
<tr>
<th>Objective</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were the individual course objectives met?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Objective #1:</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Objective #2:</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Objective #3:</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Objective #4:</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 2. To what extent were the course objectives accomplished overall? | 5 | 4 | 3 | 2 | 1 | 0 |
| 3. Please rate your personal mastery of the course objectives. | 5 | 4 | 3 | 2 | 1 | 0 |
| 4. How would you rate the objectives and educational methods? | 5 | 4 | 3 | 2 | 1 | 0 |
| 5. How do you rate the author’s grasp of the topic? | 5 | 4 | 3 | 2 | 1 | 0 |
| 6. Please rate the instructor’s effectiveness. | 5 | 4 | 3 | 2 | 1 | 0 |
| 7. Was the overall administration of the course effective? | 5 | 4 | 3 | 2 | 1 | 0 |
| 8. Do you feel that the references were adequate? | Yes | No |
| 9. Would you participate in a similar program on a different topic? | Yes | No |
| 10. If any of the continuing education questions were unclear or ambiguous, please list them. | |
| 11. Was there any subject matter you found confusing? Please describe. | |
| 12. What additional continuing dental education topics would you like to see? | |

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# Requirements for successful completion of the course and to obtain dental continuing education credits:

1. Read the entire course.
2. Complete all information above.
3. Complete answer sheets in either pen or pencil.
4. Mark only one answer for each question.
5. A score of 70% on this test will earn you 2 CE credits.
6. Complete the Course Evaluation below.
7. Make check payable to PennWell Corp.

**For Questions call 216.398.7822**

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**Educational Disclaimer**

The author of this course has no commercial ties with the sponsors or the providers of the medical imaging company. No manufacturer or third party has had any input into the development of course content. All content has been derived from references listed, and the opinions of clinicians. Please direct all questions pertaining to PennWell to PennWell Continuing Education, 3425 S. Sheridan Road, Tulsa, OK 74112 or macheleg@pennwell.com.

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**Course Credits/Cost**

- 1.  | 2.  | 3.  | 4.  | 5.  | 6.  | 7.  |
| 23. | 24. | 25. | 26. | 27. | 28. | 29. |
| 30. | 31. | 32. | 33. | 34. | 35. | 36. |

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**AGD Code 731**

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**PLEASE PHOTOCOPY ANSWER SHEET FOR ADDITIONAL PARTICIPANTS.**

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**INSTRUCTIONS**

All participants should have only one answer. Grading of this examination is done manually. Participants will receive an immediate score report. The exam will be scored within two weeks after test-taking. Exam results will be mailed within two weeks after test-taking. If you earn a score of 70% or higher, you will be awarded 2 continuing education credits.

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**Requirements for Successful Completion of the Course and to Obtain Dental Continuing Education Credits:**

1. Read the course in its entirety.
2. Complete the course evaluation.
3. Complete the answer sheet in either pen or pencil.
4. Mark only one answer for each question.
5. A score of 70% on this test will earn you 2 CE credits.
6. Make the check payable to PennWell.

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**For Questions call 216.398.7822**