A note on digital dental radiography in forensic odontology

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Introduction

Radiographs are an integral part of dental practice. In clinical dentistry, intraoral and extraoral radiographs are integral part of diagnosis of dental disease and treatment planning.

While in forensic odontology, radiographs are an implicit part of practice used mainly in identification and age estimation. Radiographs allow shapes of restorations and anatomical structures otherwise not visible at clinical examination.\(^{[1,2]}\)

The tenet of identification by dental means is the comparison of antemortem records with postmortem records. Records include dental charts, written records, and dental radiographs. Radiographs are important when comparing consolidated antemortem with postmortem information.\(^{[3-5]}\) Radiographs are nonabstract and observable when antemortem and postmortem data are presented to the end users of forensic odontological reports.\(^{[3]}\) Indeed, “A picture is worth a thousand words”, attributed to French leader Napoleon Bonaparte is an apt allegory here.

However, radiographs are obtained through a multi-step procedure, and as outlined later in the text, operator error can be introduced at different stages.\(^{[6,7]}\) The main errors that will be presented and discussed are those that lead to difficulties or mistakes in orientation of the radiographs and the possible ramifications arising from that.

Focus of this paper is as follows:

- The inversion of the right and left marker orthopantomographs (OPG), causing the image to be laterally inverted
- The reverse placement of phosphor storage plate (PSP) receptor for intraoral dental radiograph resulting in confusion of the right and left.

Both of these errors can result in potential problems in practice as illustrated by the case examples presented here.
Case Report

• An adult male was referred for an extraction of lower left erupted carious third molar under local anesthetic. It was noted that on OPG, when placed in the correct orientation for viewing according to the indicator, the carious tooth to be extracted was the right lower third molar. Consultation before the procedure and confirmation with previously obtained periapical radiographs confirmed that OPG was laterally inversed [Figures 1 and 2]

• As illustrated above, the indicator in the digital intraoral radiograph can help with orientating an X-ray. This is the case provided that the correct side of the receptor has been placed toward the X-ray tube. This is illustrated with an example [Figures 3-5].

Discussion

There are several different types of radiograph of interest to dentistry.

They can be categorized by the purpose and views required. Bitewings or periapical radiographs are used for intraoral views, and OPG are used for extraoral views. They can also be classified by method of acquisition into either digital or analog radiographs.

Regardless of the method of acquisition, radiographs are obtained by exposure of ionizing radiation to a receptor.

The receptors can be analog radiographic films or digital charge-couple devices (CCD) plates and PSPs. The exposed receptor containing the latent image is then processed to produce the final visible image. Analog dental radiographic films require a chemical process to develop the latent image, whereas digital receptors require a computer to process the stored information into a visual image on a computer monitor. All of these receptors, analog and digital, have only one recommended surface of exposure toward the source of radiation. To help with film placement, the analog dental intraoral radiograph has an embossed dot on the film that serves as an indicator for the surface for exposure. As for digital and film OPG, “R” for right or “L” for left is indicated on the receptor and these are transferred to the final radiographic image.
In clinical practice, failure to detect this error can result in initiation of procedures on the wrong tooth or site, especially when this error is not detected in patients with few distinctive characteristics to help orientate the radiograph. For example, in bitewings of fully dentate individuals with the absence of existing restorations. In addition, dental records are legal records; when legal disputes arise, inaccurate records can be confusing and problematic.

Some may argue that in routine practice, if the clinician who takes the X-ray is the end user, the clinician should be able to orientate the X-ray to allow meaningful analysis and correct interpretation. However, if the X-ray is used for a referral, this may cause confusion as to the area of interest and result in a procedure being carried out on the wrong tooth or site.

In forensic dentistry, radiographs are of high diagnostic and analytical value. They give assurance and weight to decisions of identification. Non-radiographic dental records alone have been shown to be a valuable source as the different permutations and combinations of patterns of missing and filled teeth may allow identification to be done with a certain degree of confidence. However, such records have also been shown to contain mischarting, incorrect reports, and even fraud. Therefore, radiographs have always been considered as more reliable. McKenna states that radiograph provides "irrevocable evidence". Forrest and Wu state that radiographs "are a direct representation of a physical item and are an objective method of recording information", whereas clinical notes are less reliable especially when recording may not even be done by the clinician. Wood and Kogon mentioned that few odontologists would be
confident enough to depend solely on non-radiographic records and that X-rays are important component in identification.[5] Radiographs are also useful when few restorations are present, where other anatomical features may be used such as root morphology, canal, trabecular bone pattern, and sinus radiographic outlines.[1-3,13,19]

When dental records are required to be submitted as antemortem records (and this can occur months or years since last visit or treatment), the clinician responsible for submitting the records may have forgotten about the error or may overlook the mistake.

It is important to submit original and full records[19,20] even though some records may seem irrelevant. Full records afford the opportunity and possibility of this error being noted by the dentist who receives the antemortem record for transcription into antemortem chart. Otherwise, errors of this nature can result in exclusion due to visually obvious non-matching of X-rays. Furthermore, partial recovery of remains or inexperienced forensic odontologists may lead to exclusion, particularly in mass fatality incidents where multiple reconciliations are required.

In a disaster victim identification (DVI) situation, this problem can be magnified when the number of victims is large. DVI is a complex process, especially when different nationalities are involved, and where different disciplines are required to work together for the process to work. This usually involves multidisciplinary collaboration and numerous people working within each discipline to collate information under the challenging physical and political backdrop of the inherent chaos that accompanies the event.[21] Within the forensic odontology discipline, there will usually be teams working in each section with rotation of personnel in a large-scaled DVI. Quality management comprising quality assurance and control has been given much attention. The complexity of a large-scale operation with information (antemortem and postmortem data) coming from different sources and often at different points of time throughout the process provides the potential for complications.[21-23] The compilation and management of information becomes a Herculean task.

Often, multiple antemortem dental records from one potential victim can come from different practitioners and may be only made available at different points during the progress of the DVI process. Dental records can be handwritten or computer generated; the task of collating and consolidating records and X-rays for each possible victim is an onerous one. In addition, there can be a large amount of postmortem information by virtue of the sheer number of victims involved. For example, in the Thai tsunami, as many as 200 dental radiographs were obtained in a single day.[24] This, together with many other challenges that are inherent in a large-scale DVI process, e.g., physical and mental fatigue or when records are from international sources with different languages and systems of recording, can further complicate the process.[25]

Sweet (2010) mentions the importance of original records.[19] One of the reasons why original X-rays are important is that original analog X-rays allow unambiguous identification of the correct site.

Digital clinical record keeping is becoming more popular. Digital radiographs do not allow physical verification of the orientation unlike analog dental radiographs. This applies to films that have been scanned or photocopied, and this important information may not be transmitted correctly.[19] With scanned digital radiographs, mistakes have been made where the radiographs have been scanned in a reversed order.[24]

**Conclusion**

Identification by comparison of dental features is a primary scientific method that is “stand alone” identification in DVI Interpol guidelines. In routine practice, a majority of cases are confirmatory, where possible identification has already been made and a dental identification is needed to confirm other evidential or circumstantial finding.[14] The task of matching antemortem and postmortem radiographs is one where judgment is required as differences may be explainable.[13-15] The Australian Society of Forensic Odontology recommends the inclusion of statements about the consistencies and lack of irreconcilable discrepancies in reports of cases of established identification.[23] The occurrence of errors in the interpretation of antemortem and postmortem radiographic or digital images will lead to incorrect identifications. This will have disastrous consequences for the integrity of the entire investigation.

Forensic odontologists do not have complete control of the antemortem evidence submitted; it is not possible to check the whole trail and history of the evidence to ensure that evidence submitted is true and correct. Quality checks can be done, e.g., through direct communication with the dentist who submitted the evidence to confirm records but this can only go so far. In DVI situations, original records may not be submitted[25] and communication with the treating dentist can be difficult especially where the records are from overseas. It is important to include in statements and reports, descriptions of the evidence as they were received.

In other areas of clinical practice, being aware of the possibility of such error can save some difficult and troublesome medicolegal problems at a later stage.

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