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Malpractice Minute

Dentist Misdiagnoses Abscess, Resulting in Loss of Tooth and Malpractice Lawsuit

Mario Catalano, DDS, MAGD

BACKGROUND

Unfortunately, in the practice of dentistry, a cluster of symptoms may indicate more than one disease condition. The dentist has to identify which condition is the source of the problem and treat it appropriately. In this interesting case from the Southwest, the dentist's conclusion was incorrect, resulting in a lost opportunity to treat the problem at the optimal time.

CASE DISCUSSION

The patient, a 16-year-old male who was generally healthy, had recently completed orthodontic treatment by a specialist. His parents brought him to a large dental group for follow-up after the orthodontic treatment, and he was assigned to Dr. J, a general dentist who was new to practice.

At the initial appointment, a complete set of intraoral radiographs was taken to complement the panoramic study previously done by the orthodontist. After a clinical examination and a review of the radiographs, it was determined that the patient had a significant number of carious lesions. Dr. J formulated and discussed a treatment plan with the patient's parents, and subsequently they scheduled a series of appointments with Dr. J.

Dr. J had prioritized the order in which he would restore the problem teeth, and, accordingly, at the first treatment visit he placed deep composite restorations on teeth 9 and 10. The patient missed his next appointment, but about one month later he presented with vague pain in the left maxillary region. Dr. J evaluated the patient's symptoms that included a slight sensitivity to percussion of teeth 9 and 10, but thought the pain probably resulted from a large carious lesion on tooth 15. He treated tooth 15 with a large composite restoration.

About 10 days later, the patient again presented with pain in the left maxillary region from tooth 9 to 15. Dr. J noted that teeth 9 and 10 were slightly mobile, so radiographs were taken, but they were inconclusive for periapical pathology. Dr. J then concluded that clenching and bruxing most likely caused the teeth mobility, especially when it was determined that the patient had not been wearing his retainer regularly as advised (it no longer fit properly after the restorative dentistry). Dr. J then took impressions and fabricated a nocturnal mouthguard to alleviate the current symptoms.

Because of a scheduled vacation and the absence of any further symptomology, the patient's parents rescheduled his next two appointments. However, shortly after returning from vacation (and about a month after the mouth guard was delivered), the patient developed significant swelling under his left eye. Dr. J ordered

radiographs that revealed a sizable area of bone loss around tooth 10, which was now extremely mobile. Dr. J referred the patient to an oral surgeon, who performed an incision and drainage, placed him on an antibiotic, and referred him to an endodontist for further treatment.

Despite the oral surgery and endodontic treatment, intraoral drainage developed. The endodontist ordered two additional antibiotic regimens. Then the endodontist returned the patient to the oral surgeon for a tooth extraction and bone grafting in anticipation of future implant placement. A temporary partial denture was fabricated for cosmetic purposes.

The patient's parents were very upset, and they ultimately brought a dental malpractice lawsuit against Dr. J. The allegations in the lawsuit included lack of expertise in diagnosing the abscess, misdiagnosing the problem as bruxism, and failing to refer the patient to one of the more experienced dentists in the practice, resulting in the loss of tooth 10, future dental care expenses, pain, and suffering.

After negative reviews by two expert witnesses, the doctor consented to settle the case.

Risk Management Considerations

Theodore Passineau, JD, HRM, RPLU, CPHRM, FASHRM

This case illustrates the sort of diagnostic dilemma regularly faced by dentists in their day-to-day practice. A cluster of symptoms, similar to those presented in this case, can lead to a differential diagnosis. From a patient safety standpoint in both dentistry and medicine, the accepted approach is to treat the condition on the differential list that is potentially the most serious until the condition is resolved or can be ruled out by other means. It appears that did not occur here.

Dr. J may have also made a mistake in relying on his second set of radiographs, which were "inconclusive for periapical pathology" (not ruling it out). The importance of clear radiographs cannot be overemphasized. One can speculate that if the radiographs had been repeated, or a cone beam computed tomography had been performed, the dentist may have seen the abscess and avoided a poor outcome.

This case raises an important point that was not an issue here, but is commonly encountered in daily practice − patients' refusal of routine radiographs. Many dental conditions simply cannot be diagnosed by direct visualization, and some of them are very serious. If a patient refuses routine radiographs, the dentist should carefully consider the potential health consequences to the patient, as well as the difficulty in defending a malpractice case in which radiographs were not taken.

The treatment in question was not helped by the timing of the patient's vacation, during which time he was out of contact with Dr. J. However, this lack of communication would not have assisted in the defense of this case unless it could be shown that the patient was in pain during the vacation and failed to contact Dr. J or a local dentist.

Finally, it would have been helpful for Dr. J to consult with one of the senior dentists in the practice when he saw mobility in teeth 9 and 10 and found the radiographs to be essentially inconclusive. At any point in one's career, formal or informal consultation with a trusted colleague is always advantageous.

CONCLUSION

Dentistry is better than it has ever been at diagnosing pathology because of significant improvements in imaging. However, the opportunity to misdiagnose is ever present. Paying careful attention to the total clinical picture, combined with consultative assistance when appropriate, can be valuable to a doctor in minimizing diagnostic error.

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