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December 5, 1988

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1501 Euclid Avenue
Playhouse Square
Cleveland, Ohio 44115

Attention: Mr. Gary Singletary

Re: Kathleen A. Rowan v. David Kermode
Your File No. 900-88557

Dear Mr. Singletary:

Please be advised that I have had adequate opportunity for oral, regional, radiographic, and historical examination on the above-named patient, Ms. Kathleen Rowan, a 22-year-old female bookkeeper. The examination took place in my office on December 2, 1988. The examination was in regard to alleged injuries suffered by Ms. Rowan to her temporomandibular joints and to her upper front tooth as the result of a moving vehicle collision. Please be further advised of the following information which I believe to be germane to these alleged injuries.

I. History as presented by the patient.

Ms. Rowan presented herself to my office for examination together with her attorney, David Mast, Esq., an attorney with the firm of Spangenberg. Mr. Mast tape recorded our conversation. Ms. Rowan states that she was in apparent good health until June 1, 1986, on which date she was involved in a moving vehicle collision which took place on Ford Road in Madison, Ohio. Ms. Rowan states that she was the front seat passenger, and she was not wearing a seat belt. In regard to direct injuries to her person at the time of the MVA, Ms. Rowan states that "I struck the side of my left face with the dashboard." She denies having suffered any lacerations to her jaws or to her teeth. She alleges rather that she had a corneal laceration. She states further that she was conveyed by ambulance to the Emergency Room at the Northeast Ohio Hospital. In the Emergency Room of that facility, she had multiple X-rays taken. I asked Ms. Rowan specifically which X-rays were taken, and she stated, "Practically my whole body." She was discharged thereafter to her home.

Upon arriving at her home, Ms. Rowan realized that she chipped her left upper central incisor tooth. The chip is on the incisal angle, and it is not very extensive. Ms. Rowan alleges that she had jaw complaints at the time of her presentation to the Emergency Room, and that she informed the Emergency Room doctor about it. She also alleges that jaw X-rays were taken (she thinks) at the time of her presentation to the Emergency Room. For the record, let me point out that the Emergency Room report for the Northeast Ohio General Hospital does not bear out these allegations. Rather, that document states only that Ms. Rowan complained of pain in the shoulders, neck, face, right eye, and right side of the forehead. The Emergency Room physician made a final diagnosis of corneal abrasion, and multiple contusions. There is no recorded evidence of any complaints vis-a-vis temporomandibular joint pain nor jaw pain. The radiologist's report from that same hospital on the same day indicates that, indeed, multiple X-rays were taken which included bilateral ribs, skull, cervical spine, clavicles, and knee. However, the radiology request states that the patient's clinical history "complains of pain in the shoulders, neck, eye, and knee." Again, there is no evidence of complaints vis-a-vis TMJ problems, nor was any X-ray taken of the jaws nor were there any X-rays taken of the temporomandibular joints.

Ms. Rowan continues in her history, stating that it was suggested by the Emergency Room doctor that she see her dentist, and that she put eye cream in her left eye. The following Monday, according to Ms. Rowan, she went to her dentist, Dr. William Koenig, D.D.S. Ms. Rowan alleges that Dr. Koenig filed down the sharp edges of the chipped front tooth but did not place a filling in it. She gives as his reason the fact that she did not have up front money to pay for it. Apparently, Ms. Rowan made no complaints to Dr. Koenig in regard to her temporomandibular joint problem.

Next, Ms. Rowan states that she saw her family physician, Dr. Smith, M.D. She states that she saw him only for her neck and for her back. She quotes him as telling her that "the neck could hurt for a year." However, he did not treat her. Ms. Rowan continues in her history, stating that she eventually went to see another dentist, Dr. Kenneth Kosovich, D.D.S. She states that she saw Dr. Kosovich in February of 1987. She states quite specifically that the reason she saw Dr. Kosovich in February of 1987 was "because

I wanted my tooth fixed." However, instead of fixing her tooth, Dr. Kosovich told her, in his view, she had temporomandibular joint problems. At this juncture, I asked Ms. Rowan specifically if, indeed, she had gone to see Dr. Kosovich in regard to any temporomandibular joint complaints. She answered, "No . . . I didn't think I had temporomandibular joint problems." She adds that he only discovered this malady by doing an examination. Inasmuch as it has been my experience over many years to note the fact that patients usually discover temporomandibular joint pain and discomfiture well before they go to a dentist to tell about it, I was, of course, baffled by Dr. Kosovich's unusual discovery of TMJ symptoms in a patient who did not complain of any TMJ symptoms. I, therefore, asked Ms. Rowan what it was that Dr. Kosovich discovered. She stated, "I had a popping noise . . . I told him about the popping . . . he did something with my neck . . . he could tell where it was hurting." She adds that her neck was still hurting and her shoulders were still hurting at that time (February of 1987). Ms. Rowan adds that Dr. Kosovich then made her a bite splint or bite guard. He also referred her to an osteopathic physician, Dr. Thomas, D.O. Dr. Thomas, according to Ms. Rowan, "put electrodes and wires and hot packs on my back and shoulders." Again I asked Ms. Rowan if she had told Dr. Koenig about the clicking of her jaw, at the time of her appointment with him. She answered, "No, that was only two days after the accident."

Ms. Rowan continued in her history, alleging that "Dr. Kosovich made the splint for me because I was chewing more on one side than the other, and it would switch back and forth." This observation appears to me to be incorrect. On her first visit to Dr. Kosovich, February 28, 1987, in answer to an interrogatory which Ms. Rowan filled out herself, she answered the question, "Do you chew on only one side of your mouth?" by indicating "No." Apparently, however, at her first visit to Dr. Kosovich, Ms. Rowan was not having TMJ pain symptoms. She adds, "It was screwing up my ears . . . it popped my ears shut." However, when I asked Ms. Rowan when the popping began "to pop her ears shut," she stated, "I'd have to say after the splint had been made and put in my mouth." Nevertheless, even though it apparently caused popping, Ms. Rowan alleges that she wore the bite splint twenty-four hours a day. She states that she chewed through three of them. She adds, "I chewed right through them." Inasmuch as this indicates some degree

of clenching, a parafunctional habit which is very common, and frequently a causative factor in temporomandibular joint dysfunction, I asked Ms. Rowan if she, indeed, was a clencher. She denied doing so. She adds that sometime thereafter, when the popping and clicking were continuing, she was referred by Dr. Kosovich to an oral surgeon, Dr. Karl Schneider, D.D.S. This was not until March of 1988, however. The time lag was explained by Ms. Rowan, "I had a kid in between." Ms. Rowan adds that Dr. Schneider also made a hard plastic bite splint for her, and then another one after that, the reason being "I chewed right through it."

In regard to current symptoms, Ms. Rowan states only that she has headaches, jaw aches (only on the left), her ears pop, but she is able to eat a normal diet. She adds, "certain foods give me a problem . . . when you're wearing a splint, you can't chew gum and you can't eat a steak."

II. Review of the Charts and Records.

1. The Emergency Room report from Northeast Ohio General Hospital dated 6/1/86 indicates, indeed, that Ms. Rowan did visit that facility on that date. Her chief complaint, however, as previously noted, was that of "pain shoulders, neck, face, and right eye." There is no mention of temporomandibular joint nor jaw discomfort. There is a note that she had a redness of the right side of the forehead, and an abrasion of the upper right eyelid. She also had tenderness of the muscle on the right neck, and tenderness over the shoulders and the clavicle. Her final diagnosis was that of corneal abrasion and multiple contusions. Again, the X-ray report indicates that her chief complaints to the radiologist were those of pain in the shoulders, neck, right eye, and right knee. No X-rays were taken of the jaw or of the temporomandibular joint, nor is there any mention made of temporomandibular joint or jaw distress.

2. Letters and Chart from Dr. William Koenig, D.D.S. Dr. Koenig's chart indicates that his office only saw Ms. Rowan on two occasions in 1983, and not at all in 1984 and 1985. Two days after her MVA, on 6/3/86, Dr. Koenig notes on his chart that Tooth #9 (the upper left central incisor) had an incisal angle fracture. Dr. Koenig

suggested bonding the tooth in order to repair it. He did not do the bonding procedure, which he quotes as between $65 and $75, because, as Ms. Rowan had suggested in her history, she did not have the money up front. However, the chart makes no mention of any injury to the jaws or the temporomandibular joints.

A letter from Dr. Koenig dated February 6, 1987 restructures his statements on the chart, and negates the notion of putting a crown on the tooth. Dr. Koenig also believes that permanent nerve damage to the tooth is highly unlikely because of the small amount of external damage to the tooth. Again, Dr. Koenig makes no mention of any temporomandibular joint injury, nor any temporomandibular joint discomfiture, two days after her MVA. Instead, he talks only about the tooth. I presume this is because Ms. Rowan talked only about the tooth. However, Dr. Koenig suggested to Ms. Rowan that she was informed to return to his office if she suffered any more discomfort, which she did not do.

3. Charts and Letter from Dr. E. David Thomas, D.O., dated November 9, 1987. Herein, Dr. Thomas indicates in his chart that he did not see Ms. Rowan for the first time until March 7, 1987. That is more than nine months after her MVA. Dr. Thomas treated Ms. Rowan with various physical therapies. In his letter, Dr. Thomas states that Ms. Rowan's chief complaints consisted in neck and back pain throughout the entire spine, headaches, and pain when chewing her food, with the center of her pain being in the neck region. Dr. Thomas notes that Ms. Rowan had headaches after the accident, but he also notes that she had headaches prior to the accident. Dr. Thomas' treatments were on an interim basis, and they extended for approximately fifteen months.

4. Charts and Letters of Dr. Kenneth Kosovich, D.D.S. The charts indicate that Dr. Kosovich did not see Ms. Rowan until February 28, 1987. Again, that is nine months after her MVA. In her interrogatories, which she filled out herself, she states that she was having pain in and around the ears. She does not agree that she had popping or clicking or snapping noises in her jaws. In answer to the question about discomfort about the time of the examination, Ms. Rowan stated that it was only "occasionally."

Hereafter, Dr. Kosovich's charts turn into a murky cryptogram. It is, in my opinion, an attempt to dissemble. To begin with, Dr. Kosovich states in the same paragraph that the patient is "four months pregnant" and at the same time, and on the same day, he took a full series of dental X-rays. It is my understanding that taking a full set of dental X-rays, subjecting the patient to a great deal of radiation exposure when the patient is four months pregnant, is considered by most of us to be unacceptable practice. It is my belief that a full set of dental X-rays on a patient who is four months pregnant is a dental oxymoron. Furthermore, Dr. Kosovich presents the same chart twice. The original chart is legible enough to be understood. Nevertheless, he has transcribed the second chart, in which he has added a great deal of after-the-fact information. It is my belief that that process is called "doctoring up a chart" and I believe it is not acceptable in any way. What he has done is add some perjorative and advocational comments to a chart which has already been finished. The comments were put in on March 8, 1988, and they refer to a charting which has already been completed on March 17, 1987. I simply reject that misuse of a patient's chart, not because I believe it to be inappropriate, but rather because I believe it to be unlawful. One cannot doctor up a chart after the fact. You can't erase from it, you can't scratch things out, and you can't add on to it. I should, therefore, like to approach the original chart as it stands.

In the original chart as it stands, Dr. Kosovich notes that he saw the patient for the first time on February 28, 1987. He did a number of silver fillings and temporary fillings on Ms. Rowan between February 28, 1987 and October 8, 1987. He notes that the patient was having pain, presumably in a tooth because he did a pulp capping on the tooth (Tooth #14), and then he noted that the patient had a possible sinus infection. He did not note that the patient had any tempormandibular joint complaints, nor does he make any observations in regard to jaw or TMJ discomfiture or injury. In fact, he does not mention TMJ in his chart until October 8, 1987. At this time he notes that there is TMJ, left symptoms. But the reader should be mindful of the fact that in all the eight months that Dr. Kosovich treated Ms.

Rowan, he had her mouth open on a great number of occasions very widely in order to fill the teeth. She did not complain of TMJ symptoms at that time. She only complained of sinusitis. It was not until October 1987, sixteen months after her MVA, that he notes any TMJ symptoms. On 3/8/88, in his addendum, Dr. Kosovich states that he now believes that the pain that the patient suffered was due to a malocclusion from the TMJ. I mean, give me a break! Charts are charts, and we will take them as they are written.

4. A letter from Dr. Kosovich dated January 22, 1988 tells us among other things, that Dr. Kosovich does "Gentle Family Dentistry." This is in apparent contra-distinction to the rest of us, who either do "Brutal Family Dentistry" or perhaps do "Gentle Orphans, Widows, Illegitimate Children Dentistry." The rest of the letter is made up of, in my belief, mostly hyperbole. Dr. Kosovich states that it is not feasible to determine a definitive diagnosis at this time . . . "due to the complexity of the damage." He states that he cannot even determine the type of TMJ damage until he restores all the teeth. Yes, that's what it says. He has to restore the teeth in order to tell what kind of TMJ damage the patient has. Then he will "use additional techniques to hone in on a specific diagnosis." As a tangential comment, it is my belief that Dr. Kosovich also ought to "hone in" on what's wrong with taking a full set of dental X-rays on a patient who is four months pregnant, and what's wrong with doctoring up one's charts after the facts.

III. Oral, Regional, and Radiographic Examination.

As was previously mentioned, this examination took place in my office on December 2, 1988. I believe the following physical findings are germane to Ms. Rowan's current oral and temporomandibular joint status.

1. Ms. Rowan's panorex X-rays exhibit a normal jaw with normal dentition. She has seven dental restorations, which appear to be well done. Her temporomandibular joints appear to be normal in every way, at least on this panorex X-ray. There is no evidence of mottling of the bone in either the ball or the socket, and there is no evidence of arthritic changes or bone spurs.

2. Ms. Rowan's upper left central incisor still has the incisal edge shirred off. In 2-1/2 years, after a long series of dental treatments, she has still not had the incisive bonding placed on the tooth. The chip fracture of the upper left central incisor is, of course, accident related.

3. Ms. Rowan, who, incidentally, presented herself as most cooperative and pleasant throughout our examination, is able to open her mouth to an interincisive aperture of 40 millimeters. This is considered to be within the normal limits of incisive aperture. Further, she does so with no pain whatsoever. However, she adds that "it bothers my jaw when I have to open it for a long time."

4. She is able to move her jaws into lateral excursion from side to side to a width of approximately 10 millimeters, with no difficulty and with no pain.

5. On my first examination with a stethoscope, I could hear no click on either the right or the left temporomandibular joints. However, when I listened again, I could hear a click on the closing phase on the left side.

6. Ms. Rowan has a remarkable dental malocclusion. While I realize that she has completed three years of orthodontic treatment, the treatment has apparently produced a certain degree of failure. She has what is called a Class II bite, with an overjet of 3 millimeters. She has, in addition to that, an anterior overbite.

7. These dental malocclusions, or dental occlusal disharmonies, are frequent producers of temporomandibular joint dysfunction.

8. At the time of my examination at least, and with the exception of sometime clicking on the opening phase on the left side, Ms. Rowan presents no acute signs or symptoms of temporomandibular joint disease whatever. I believe that she has had it in the past but, right now, she is relatively symptom free.

IV. Discussion.

1. Temporomandibular joint disease, more recently termed temporomandibular disorder or TMD, othertimes referred to by a subset of acronyms such MPD (myofacial pain dysfunction), or PDS (pain dysfunction syndrome) is a remarkably common disease. It affects approximately 30% of all Americans, according to some reports, but according to a new report issued by the ADA Workshop on TM Disorders, November 1, 1988 recently published, it occurs in up to 84% of all adult Americans. It affects females to the ratio of 9 to 1 over males, and it affects young females to a ratio of 5 to 1 over older females. While there is still some controversy over the exact etiology and causative factors involved in TMD, there is a general consensus among authors and lecturers on the subject that the primary causes are dental disharmonies and dental malocclusions, and the parafunctional habit of biting. Cathy Rowan fits the perfect silhouette of the chronic TMD sufferer. She has a remarkable dental malocclusion, consisting in an anterior Class II relationship, overjet, and overbite. She is in the right age group, the right sex group, and of course, while Ms. Rowan denies clenching, Dr. Kosovich's records refer not only to her malocclusion on his entry for 3/8/88, but on 2/19/88 he notes (his words) "Cathy had chewed and ground through the soft splint." So I must presume that, indeed, she does clench and grind her teeth. She stated in her history that she chewed through Dr. Carl Schneider's splint as well. It is my sincere dental opinion that if, indeed, Ms. Rowan has TMJ disease, it arises from these two factors.

2. While it is occasionally possible to suffer an injury to the temporomandibular joint as the result of a moving vehicle collision or other external trauma, it has been my experience over the past thirty-three years of treating patients with TMD, that it is a rare instance. However, when it does happen, it has also been my experience to observe the fact that when a patient injures him/herself via external traumatic injury, the patient suffers pain and discomfort immediately. He or she sits on the bench in the Emergency Room, and is in exquisite pain. This observation of mine is reinforced by an excellent author, Dr. Harold Gelb, D.M.D., in his

textbook Clinical Management of Head, Neck, and TMJ Pain and Dysfunction (1985), page 376. Dr. Gelb states in regard to acute trauma to the TMJ, the following, "These conditions (TMJ injuries) may be diagnosed clinically by noting severe tenderness or exquisite pain in the area of the joint with minimal pressure on chin, and severe to complete limitation in mandibular opening." Of course, after all, TMJ injury is very much like any other joint injury, perhaps the elbow or the ankle. That is, if you injure it, it hurts very badly and it hurts right away. We have all seen the scenario on our television screens where a football player injures one of his joints, perhaps the elbow, or the knee, or the ankle (Bernie Kosar is a good example several months ago when he injured his elbow.) Such a player does not report the injury nine months later. No, rather, he lies down on the turf in a great deal of pain, and he rolls about, and the viewing audience, and the coaches, and the trainer all know that this man has hurt one of his joints. This is true of TMJ injuries as well. If you hurt it, it hurts right away and it hurts very badly.

Now then, consider that Ms. Rowan did not report to the Emergency Room of any TMJ injury or any TMJ pain. What's more, when she had plenty of time to consider it, she reported to Dr. Koenig's office in 48 hours. She reported to him only the injury to her tooth. She did not make any complaints vis-a-vis TMJ injury.

In an article in the Journal of Oral and Maxillofacial Surgery, which is frequently quoted, cervical extension-flexion injury (whiplash) and internal derangement of the temporomandibular joint, Weinberg, et al., page 653, February 1987, the authors state that it is possible to have a whiplash type of injury to the muscles of the temporomandibular joint. However, they state rather definitively that when they discovered this whiplash type of injury, "the onset of symptoms occurred immediately after the accident, on the day of the accident, or within one or two days. . . ." To me, nine months later is simply out of the question.

More significantly, to me, is the fact that, indeed, when Ms. Rowan went to Dr. Kosovich February 28, 1987, she did not go because of any TMJ complaints. Rather, she went to talk about her fractured tooth. In the previously cited recent text TMJ Update, A Special Report, the ADA Workshop on TM Disorders, November 1, 1988, the authors state that a definition of TMD ought to exclude specifically certain types of TMJ disorders. Specifically excluded according to Dr. Mohl in this paper is "single signs such as joint clicking, which have not been identified by the patient as a symptom." That exclusion, it is my belief, includes Kathleen Rowan. After all, she did not discover the TMJ, Dr. Kosovich discovered it for her.

3. I am not convinced that TMJ disease or TMJ disorder includes popping and clicking alone. It is my understanding that that is all Ms. Rowan presented when she went to see Dr. Kosovich. In fact, in her history, Ms. Rowan states specifically that "the popping of her ears shut" began sometime after the bite splint treatment by Dr. Kosovich. Surely then, that symptom cannot be attributed to the MVA.

4. In regard to Ms. Rowan's fractured anterior tooth, it remains fractured. It is not going to turn dark or discolor or die, but it needs to be repaired. The cost of such is approximately $75.00. I believe this is accident related.

5. In regard to Ms. Rowan's current and future status, it is my belief that, at least on the day of my examination, she did not present any remarkable TMJ symptoms. I feel sorry for Ms. Rowan inasmuch as her orthodontic treatment has, indeed, relapsed, and it would be nice if she had new orthodontic bands placed. This, of course, is not going to happen, but I believe that if she could wear the bite splint on occasion, she will have normal TMJ function.