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Periodontal Associates, Inc.

BENTON E. COLE, D.D.S.
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April 14, 1989

Doc 111

Mr. Richard Lillie
Attorney at Law
1504 Hanna Building
Cleveland OH 44115

Dear Mr. Lillie:

After having reviewed the information which you sent to me, consisting of the dental records of Mrs. Susanne Josepho, x-rays, the dental records of Dr. Stosak, Dr. Gallagher and Dr. Williams, and the reports of Drs. Williams and Dr. Gallagher. Before I discuss the specifics of Mrs. Josepho's case , I would make some general comments regarding periodontal disease. Periodontal disease is a disease which affects the supporting structure of the teeth, namely the soft tissues and bone, as well as the outer root surface. Periodontal disease is caused by bacteria and its byproducts, along with deposits that accumulate at and below the soft tissue level. As a result of this inflammation ultimately the loss of bone occurs and one develops not only mobility or losseness of teeth, but also pocket depth. Pocket depth is an area that one can measure with a measuring device, a periodontal probe, as it is placed below the gingival margin along the root of the tooth. As a general rule, bone resorption or bone loss occurs slowly over a long period of time, that is many years. So that when we see a patient who has more than a normal measurable depth of 3mm's, it is a problem that has been there for some period of time. In most cases the more loss of bone that has occurred, the longer the problem has been present. When pocket depth reaches approximately 10mm's, it is usually beyond our ability to manage it. However, mobility is also an important factor and when teeth get rather loose, which would be at least 2 degrees or more of mobility, this also affects the prognosis.

Mrs. Josepho, when seen by Dr. Williams, presented herself with a number of teeth that had at least 2 degrees of mobility. These were numbers 2, 10, 13, with 1 to 1½ degrees on many other teeth. In addition, when Dr. Williams probed the patient, he found measurable pocket depth of at least 5 or 6 mm's on almost every tooth, with the exception of a few teeth and many areas of 7 mm's, with 8 mm's on the lower right second molar, upper right second molar, and 9 mm's on the first and third molars in the upper right. These measurements indicate a rather advanced periodontitis, which undoubtedly took a number of years before it could reach this stage.

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According to Dr. Stosak's records, she had been seeing him since 1976. When I reviewed the records, it was quite obvious that throughout the period from 1976 through 1986, approximately 10 years, that Dr. Stosak carried out intermittent exams, prophylaxis and only bitewing x-rays. There is no record of any full mouth set of x-rays taken during this period of time. There were approximately 9 visits for prophylaxis and bitewing x-rays over a period of 10 years. This would average about one each year. This is certainly not adequate. An occasional periapical x-ray was also taken. The radiographs that I have which have been duplicated from 1977 bite-wings do not show any significant bone loss at that time. In 1979 there was also some difficulty in seeing any significant bone loss. In 1980, however, one can see some bone loss starting to occur in the molar areas. Unfortunately bitewing x-rays do not always reveal bone loss because you cannot see all the areas that are important for diagnosis. Secondly, bone loss is often masked by one of the plates of bone on the buccal or lingual surface and therefore you cannot always see the loss. That is why it is necessary to probe the patient carefully each time one sees a patient for a periodic exam. Certainly on the x-rays from 1984 one can see some significant bone loss occuring. It certainly would have been helpful to have additional x-rays other than bitewings taken periodically. More importantly, probings should have been done. The other obvious fact that is missing in Dr. Stosak's records is that no mention is made until January 1986, of any pocket depth; then suddenly, a note appears about an 8 mm pocket. There is no mention of the condition of the soft tissue, nor any dicussion about the patient's hygiene. It is also of concern to me that only prophylaxis were done, rather than any significant scalings sub-gingivally to remove those deposits that accumulate over a period of time.

Dr. Williams carried out periodontal therapy which consisted of initial preparation and extensive periodontal surgery throughout the mouth. After completion of this treatment in addition to three teeth that he anticipated having to extract, two additional teeth were also extracted. However, two of these teeth were third molars. Therefore, it is obvious from the examination of Dr. Williams and the report that he subsequently provided, as well as that of Dr. Gallagher, that Mrs. Josepho had a very involved periodontal problem.

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The standard of care in dentistry today is to provide for patients a through examination and diagnosis, not only of cavities and other dental pathology, but for periodontal disease as well. In order to accurately diagnose periodontal disease, in addition to a full series of x-rays which show all the apicies of the teeth, periodontal probing is of critical importance moreover, all of this is in addition to other information from the visual exam. This is a standard to which all general dentists should and must adhere to. Because Dr. Stosak failed to take adequate x-rays and provide adequate probings, he was unable to recognize or diagnose that Mrs. Josepho has and was continuing to have an advanced periodontal problem which was destroying the bone support around her teeth. This lack of care on Dr. Stosaks part resulted in Mrs. Josepho having to lose some teeth, and to experience a rather extensive and involved surgical procedure in order to eliminate all the areas of periodontal infection. Even with the completion of this treatment, I am sure there are still a number that remain questionable because of the significant mobility and bone loss that has already occurred. Over a period of many years, Dr. Stosak didn't recognize and either treat or refer Mrs. Josepho to someone who could treat her. He failed to meet the standard of care applicable to general dentists and to use reasonable care and diligence in exercising that knowledge and skill possessed by other practitioners in similar circumstances. Thus, as a proximate result of Dr. Stosaks failure to meet this standard, Mrs.Josepho has developed this advanced periodontal problem.

It is obviously very difficult to ascertain whether or not any given patient would develop periodontal problems even under proper diagnosis and treatment by the dentist. There are undoubtedly some people who do develop periodontal disease even under the best circumstances, but most individuals who receive the appropriate care, instruction and management are able to sustain their dentition without significant mobility and without significant bone loss, and certainly without having to go through extensive restorative dentistry.

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In determining Mrs. Josepho's restorative needs, there is no question that a bruxing habit and mal-occlusion contribute to periodontal disease in terms of accelerated bone loss and/or mobility. But in and of themselves, they are not a cause of pocket depth and gingival inflammation. The lack of missing teeth, particularly in the lower right first molar area is also a contributing factor and appropriate fixed bridge work should be done. The upper arch, because of the missing teeth on the left side and the mobility that is present in the remaining teeth, an upper fixed unit would be advantageous. This upper fixed splint would in my opinion, not have been necessary had Mrs. Josepho been properly diagnosed and treated long before she reached this stage in 1986, The three unit fixed bridge in the lower right would certainly have had to be done regardless of her other problems because of the missing tooth. This is true of the full crown on the lower left second molar. A nightguard appliance would also be appropriate if, in fact, she is continuing to clench and grind her teeth (bruxing). It is, therefore, my opinion that had Dr. Stosak made the correct diagnosis, Mrs. Josepho would not have had need for an upper fixed splint.

It is my professional opinion that more likely than not as a result of Dr. Stosak's failure to recognize and diagnose Mrs. Jospeho's periodontal problems at an early stage and having allowed it to continue for a number of years until it reached this very advanced stage, that his lack of care and diligence in recognizing her problem resulted in Mrs. Josepho having to lose some teeth, to have gone through extensive periodontal therapy and to have had extensive restorative dentistry,particularly in the upper arch. It is the responsibility of every general dentist, and even any specialist, to examine patients both visually and be probings and to take appropriate x-rays so that they can recognize periodontal disease at a stage where successful treatment can be done without significant bone loss or extensive restorative work needed. If I can be of any further help, please don't hesitate to call.

Sincerely,

Dr. Benton E. Cole

Benton E. Cole D.D.S., J.D.