

**Caceres v Nassau Univ. Med. Ctr.**

2008 NY Slip Op 33073(U)

November 12, 2008

Supreme Court, Nassau County

Docket Number: 4714/06

Judge: Kenneth A. Davis

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SCAN

SHORT FORM ORDER  
SUPREME COURT - STATE OF NEW YORK

Present: HON. KENNETH A. DAVIS,

Justice

TRIAL/IAS, PART 3  
NASSAU COUNTY

NICHOLAS CACERES and MARIE CACERES,

Plaintiff,

SUBMISSION DATE:  
10/20/08  
INDEX No.: 4714/06

-against-

NASSAU UNIVERSITY MEDICAL CENTER,  
NASSAU HEALTH CARE CORPORATION,  
ABLE DENTAL, P.C., DAWER NADI, D.D.S.,  
REBEKAH KANE, D.D.S. and HO LEE, D.D.S.

MOTION SEQ. #  
2, 3, 4, 5

Defendants.

The following papers read on this motion:

Notice of Motion/Cross-Motion.....	XXXX
Answering Papers.....	X
Reply.....	XXX
Briefs: Plaintiff's/Petitioner's.....	
Defendant's/Respondent's.....	

This motion by defendant Ho Lee, D.D.S. and cross-motions by Rebekah Kane, D.D.S.; Nassau University Medical Center and Nassau Health Care Corporation ("NUMC"); and, Able Dental, P.C., for an order pursuant to CPLR 3212 granting them summary judgment dismissing the complaint against them are determined as provided herein.

The plaintiffs in this action seek to recover damages for dental malpractice, lack of informed consent and loss of consortium. The plaintiffs allege that plaintiff Nicholas Caceres ("plaintiff") was treated by the defendants between February 14, 2005 and March 1, 2005 and that in treating him, the defendants failed to diagnose and treat him for rhizopus sinus mycosis infection with extension into the cavernous sinus or, at a minimum, to make the appropriate referrals to enable that diagnosis and ensure his timely treatment. Plaintiffs allege that as a result of the delay in treatment, the plaintiff suffered orbital apex syndrome with complete paralysis of cranial nerves II, III, IV and

VI, permanent blindness in his right eye, infection of his sinus cavity, infection of his brain, neurological injury, ptosis (sagging) of his right eye, headaches, diplopia, facial pain, decreased innervation of cranial nerves II, III, IV and VI, decreased vision in his left eye, facial disfigurement and fear of total blindness.

Defendants Dr. Kane, Dr. Lee, NUMC and Able Dental seek summary judgment dismissing the complaint against them.

"On a motion for summary judgment pursuant to CPLR 3212, the proponent must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact." Sheppard-Mobley v King, 10 AD3d 70, 74 (2d Dept. 2004), aff'd. as mod., 4 NY3d 627 (2005), citing Alvarez v Prospect Hosp., 68 NY2d 320, 324 (1986); Winegrad v New York Univ. Med. Ctr., 64 NY2d 851, 853 (1985). "Failure to make such prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." Sheppard-Mobley v King, supra, at p. 74; Alvarez v Prospect Hosp., supra; Winegrad v New York Univ. Med. Ctr., supra. Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. Alvarez v Prospect Hosp., supra, at p. 324. The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. See, Demishick v Community Housing Management Corp., 34 AD3d 518 (2d Dept. 2006), citing Secof v Greens Condominium, 158 AD2d 591 (2d Dept. 1990).

"To establish a prima facie case of liability in a medical malpractice action, a plaintiff must prove (1) the standard of care in the locality where the treatment occurred, (2) that the defendant breached that standard of care, and (3) that the breach of the standard was the proximate cause of injury." Sampson v Contillo AD2d \_\_\_\_\_, 2008 WL 4491469 (2nd Dept. 2008), citing Nichols v Stamer, 49 AD3d 832 (2nd Dept. 2008), quoting Berger v Becker, 272 AD2d 565, 565 (2nd Dept. 2000). "To establish proximate cause, the plaintiff must present 'sufficient evidence from which a reasonable person might conclude that it was more probable than not that' the defendant's deviation was a substantial factor in causing the injury." Alice v Liguori, 54 AD2d 784 (2nd Dept. 2008), quoting Johnson v Jamaica Hosp. Med. Ctr., 21 AD3d 881, 883 (2nd Dept. 2005); see also, Zak v Brookhaven Memorial Hosp. Medical Center, 54 AD2d 852 (2nd Dept. 2008), citing Lyons v McCauley, 252 AD2d 516 (2nd Dept. 1998). To establish proximate cause where a delay in diagnosis is alleged, a plaintiff must establish "that the delay was the cause of a diminution of a substantial chance of avoiding the devastating result that the injured plaintiff suffered." Fellin v Sahgal, 35 AD3d 800, 802 (2nd Dept. 2006), citing Wong v Tang, 2 AD3d 840 (2nd Dept. 2003); Gagliardo v Jamaica

Hosp., 288 AD2d 179, 180 (2<sup>nd</sup> Dept. 2001); Cavlin v New York Med. Group, 286 AD2d 469, 470 (2<sup>nd</sup> Dept. 2001); Jump v Facelle, 275 AD2d 345, 346 (2<sup>nd</sup> Dept. 2000). " 'The plaintiff's evidence may be deemed legally sufficient even if [his] expert cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased [the] injury as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased his injury.' " Alicea v Liguori, *supra*, at p. 464-465, quoting Flaherty v Fromberg, 46 AD3d 743 (2<sup>nd</sup> Dept. 2007) and citing Barbuto v Winthrop Univ. Hosp., 305 AD2d 623, 624 (2<sup>nd</sup> Dept. 2003); Wong v Tang, *supra*; Jump v Facelle, *supra*.

"In a medical malpractice action, the party moving for summary judgment must make a *prima facie* showing of entitlement to judgment as a matter of law by showing the absence of a triable issue of fact as to whether the defendant physician [and/or hospital] were negligent." Taylor v Nyack Hospital, 18 AD3d 537 (2d Dept. 2005) citing Alvarez v Prospect Hosp., *supra*. Thus, a moving defendant doctor or hospital has "the initial burden of establishing the absence of any departure from good and accepted medical malpractice or that the plaintiff was injured thereby." Chance v Felder, 33 AD3d 645 (2<sup>nd</sup> Dept. 2006) quoting Williams v Sahay, 12 AD3d 366, 368 (2d Dept. 2004), citing Alvarez v Prospect Hosp., *supra*; Johnson v Queens-Long Island Medical Group, P.C., 23 AD3d 525, 526 (2<sup>nd</sup> Dept. 2005); Taylor v Nyack Hospital, *supra*; *see also*, Thompson v Orner, *supra*. A moving party must address the specific factual allegations set forth in the complaint and the Bill of Particulars (Terranova v Finklea, 45 AD3d 572 [2<sup>nd</sup> Dept. 2007]; Hutchinson v Berenstein, 22 AD3d 527 [2<sup>nd</sup> Dept. 2005]; citing Seefeldt v Johnson, 13 AD3d 1203 [4<sup>th</sup> Dept. 2004]; Vinvini v Insel, 1 AD3d 351 [2<sup>nd</sup> Dept. 2003]; Muscattello v City of New York, 215 AD2d 463 [2<sup>nd</sup> Dept. 1995]; Ritt v Lenox Hill Hosp., 182 AD2d 560 [1<sup>st</sup> Dept. 1992]). And, an expert may not make conclusions which are directly contradicted by the evidence or are based on facts not in evidence. *See*, Holbrook v United Hospital Medical Center, *supra*; *see also*, Kaplan v Hamilton Medical Associates, P.C., 262 AD2d 609, 610 (2<sup>nd</sup> Dept. 1999). In fact, a qualified expert's opinion that "a plaintiff's injuries were caused by a deviation from relevant industry standards has no probative force when the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation." *See*, Wong v Goldbaum, 23 AD3d 277, 279 (1<sup>st</sup> Dept. 2005) citing Diaz v New York Downtown Hosp., 99 NY2d 542, 544 (2002).

If the moving party meets his burden, "in opposition, 'a plaintiff must submit a physician's affidavit of merit attesting to a departure from accepted practice and containing the attesting doctor's opinion that the defendant's omissions or departures were a competent producing cause of the injury.' " Domaradzki v Glen Cove Ob/Gyn Assocs., 242 AD2d 282 (2d Dept. 1997); *see also*,

Mosezhnik v Berenstein, 33 AD3d 895 (2d Dept. 2006). The plaintiff's expert must not only differentiate between the specific acts of each defendant but must also address the operative facts relied on by the defendants' experts. See, Kaplan v Hamilton Medical Associates, P.C., supra, at p. 610; see also, Rebozo v Williams, 41 AD3d 457, 459 (2<sup>nd</sup> Dept. 2007); Slone v Salzer, 7 AD3d 609 (2d Dept. 2004); Ventura v Beth Israel Medical Center, 297 AD2d 801, 803 (2d Dept. 2002), lv den., 99 NY2d 510 (2003); Fhima v Maimonides Medical Center, 269 AD2d 559, 560 (2d Dept. 2000).

The pertinent facts are as follows:

The plaintiff was a patient of co-defendant, Able Dental, P.C. since April 22, 2003. At his initial presentation, a full mouth assessment was performed. He was missing all of his teeth on the upper left, had teeth #4, #5 and #6 present only in the upper right and was missing teeth #17, #19, #29, #30 and #31 on the lower arch. The plaintiff denied any significant medical history except being allergic to a local anesthetic. Prior to the treatment at issue, the plaintiff underwent surgical extraction of teeth #18 and #32; had a partial upper and partial lower denture placed; cavities filled; and, routine scaling and prophylactic treatment.

The plaintiff presented to Able Dental on February 14, 2005 for an emergency appointment and was seen by Dr. Nadi. Periapical films of teeth #4, #5 and #6 were taken. Dr. Nadi diagnosed a slight infection between teeth #4 and #5 and prescribed an antibiotic, Keflex. The plaintiff was instructed to return if the pain persisted and was told that he may need a root canal or extraction. Dr. Nadi noted that the infection might be due to a deep mesial occlusal cavity on tooth #5. The plaintiff returned to Able Dental two days later on February 16, 2005 and was seen by defendant Dr. Kane. The plaintiff complained that the pain was "radiating to his head." Dr. Kane noted that tooth #5 had severe recession and bone loss and might have to be extracted. He prescribed Tylenol #3 and referred the plaintiff to an oral surgeon.

Five days later, on February 21, 2005 the plaintiff was seen at Able Dental by Dr. Lee, an oral surgeon and medical doctor. After reviewing the periapical films and examining the plaintiff, Dr. Lee concluded that the plaintiff had severe periodontitis on tooth #5 as well as a history of an abscess there. Because the tooth was non-restorable, he extracted it and provided the plaintiff with postoperative instructions.

The plaintiff was again seen by Dr. Lee on February 28, 2005 for follow-up. The plaintiff had pulled tooth #4 himself three days earlier and continued to complain of pain. Upon examination, Dr. Lee concluded that the sockets were healing well. No facial swelling was noted. Dr. Lee instructed the plaintiff to follow up as needed, i.e., to return if he experienced swelling or bleeding. Later that day, the plaintiff returned to Able Dental and was seen

on an emergency basis by Dr. Kane. The plaintiff complained that he felt a piece of tooth still under his gum and that tooth #6 hurt, too. A peripheral x-ray was normal. Dr. Kane explained to the plaintiff that a bone fragment might be present and that he needed to allow two weeks for healing. The plaintiff also complained of pain at tooth #6. Dr. Kane placed a composite filling in the outer occlusal of that tooth and advised the plaintiff that it might need to be pulled and to follow up. This was the plaintiff's last visit at Able Dental.

The plaintiff was brought to Nassau University Medical Center Emergency Room on March 1, 2005 by his stepson Jaime Hernandez complaining of pain in the upper right quadrant of his mouth. He stated that after two weeks, he still felt a piece of tooth remained in his gum. He was referred to the Dental Clinic where he was seen by Dr. DiBernardo. Using his son as a translator, the plaintiff complained of pain on the right side of his face and Dr. DiBernardo ordered a panoramic and periapical radiograph. The films revealed clean extraction sockets at teeth #4 and #5 with no piece of tooth. Dr. DiBernardo also examined the plaintiff physically, including his head and neck, to determine whether there was any swelling, pain upon palpation, facial asymmetry or anything else abnormal. All exams were within normal limits. Dr. DiBernardo testified at his examination-before-trial that he did not observe any swelling around the plaintiff's right eye. His oral exam of plaintiff's mouth revealed poor dental hygiene with accumulated debris in his mouth. He diagnosed plaintiff with alveolitis, a dry socket in the area where a tooth had been extracted, which had become inflamed and painful. He administered Artucaine anesthetic and curetted the sockets. Eugenol paste was placed in sockets #4 and #5 and the sockets were sutured closed. Dr. DiBernardo prescribed penicillin and Tylenol #3 and advised the plaintiff to follow up with his dentist.

The plaintiff went to Long Island Jewish Medical Center the following day, March 2, 2005, complaining of right eye pain and swelling for three weeks, as well as vomiting, weight loss and double vision. Later that day, the plaintiff developed ptosis (a sagging eyelid) and decreased vision and range of motion in his right eye. The doctors were suspicious of cavernous sinus thrombosis and an MRI was taken. An endoscopic sinus drainage of an abscess on the right side was done the next day. A few days later on March 6, 2005, the plaintiff was diagnosed with rhizopus sinus infection and mucorsinusitis (a fungal infection) and placed on antibiotics. A CT Scan performed on March 19, 2005 revealed that the disease of the right orbital apex and right cavernous sinus had progressed. Plaintiff was kept on antibiotics, anti-fungals and Heparin followed by Coumadin. The plaintiff was discharged on April 14, 2005. As a result of this infection, the plaintiff lost sight of his right eye.

At his examination-before-trial, the plaintiff testified that he went to Able Dental on February 14, 2005 with pain in his upper right jaw. After examining him, the dentist prescribed an antibiotic. He further testified that when he returned to Able Dental on February 16, 2005, the pain started in his gum, advanced up his cheek under his eye, up the right side of his head to his forehead and that he had some slight swelling on his right cheekbone under his eye. When he returned on February 21, 2005 with the same symptoms, he again saw Dr. Kane but was referred to another doctor after x-rays were taken. The plaintiff testified that when he first saw Dr. Lee, the outside of his face was slightly swollen and his skin under his eye to his right jaw line was a little red. The plaintiff testified that his tooth cracked into pieces when Dr. Lee pulled it. He also testified that the tooth next to the tooth that was pulled became loose so he pulled it himself. He testified that that whole tooth came out as well as pieces of the one Dr. Lee had pulled. He further testified that his pain increased after his tooth was pulled. The pain pulsed up the right side of his face up his cheek to his eye and temple. He also testified that when he returned on February 28, 2005, he saw Dr. Kane and Dr. Lee. He complained that the pain in his gum remained and that his right eye vision was blurry and fuzzy and that his eye was "falling" or "closing up" affecting his upper lid. The plaintiff testified that his son brought him to NUMC on March 1, 2005 because of the terrible pain in his head and because of his eye closing. He recalled the doctor removing stitches from his gum, cleaning it and restitching it. He acknowledged that he was instructed to go to a doctor. The next day he went to Long Island Jewish Medical Center where he was hospitalized for a total of four months on two occasions.

Jamie Hernandez, the plaintiff's stepson, testified at his examination-before-trial that on February 21, 2005, the right side of his father's face was swollen and red on the cheek and around the eye. He testified that he took the plaintiff to Able Dental on February 28, 2005. That day, his father was complaining of blurry vision and a partial swollen eye. He also testified that he took the plaintiff to NUMC on March 1, 2005 because he had pain in his mouth and his right eye was swollen shut. His father complained that his eye was puffy, that he had blurry vision and that the right side of his face was swollen. Jamie testified that his dad's face had been swollen for possible a week and a half. Jamie testified that he told the doctor that his father's vision was blurry and that he was seeing black dots and spots and that his face was swollen and painful. Jamie testified that the doctor told him that the site was dirty with debris present; that the tooth had not been properly extracted; and, that whatever had been done at Able Dental was not done properly. Jamie also testified that his father's eye looked more swollen when they left NUMC than it did

when they got there.

The plaintiff's wife Maria Caceres testified similarly at her examination-before-trial. She confirmed that the plaintiff's eye was swollen on February 28, 2005 and that he had difficulty opening it. She testified that later that night, she noticed the swelling in his eye and he complained of blurry vision and that he was seeing double. Maria Caceres also testified that by the morning of March 2, 2005, her husband could not open his eye at all and he continued to complain of blurry vision.

Dr. Kane acknowledge at her examination-before-trial that when she saw the plaintiff on February 16, 2005, he told her that the pain was radiating from his tooth to his head which he said had been going on for a few days and that his x-ray showed severe bone loss. She attributed the pain radiating to the plaintiff's temple to the severe recession of tooth #5, as gum recession leaves the sensitive parts of the tooth open which can cause headaches. Dr. Kane testified that she did an intra-oral exam and did not recall examining any other parts of his body, i.e., his face or head, as there was no reason to. As for the plaintiff's February 28, 2005 appointment, Dr. Kane again did not recall examining his anatomy. She testified that the plaintiff's face was not swollen and she did not recall being told about any visual problems. She admitted that blurry vision is not commonly found in connection with dental problems.

Dr. Lee testified at his examination-before-trial that given its condition, the plaintiff's pain radiating to his head was referable to his tooth. Dr. Lee also testified that when he saw the plaintiff on February 28, 2005, he thought that the socket was healing well. The plaintiff did have alveolitis, or dry socket, which Dr. Lee testified happens a few days after an extraction. He did not notice any facial swelling.

Dr. Lee admitted that he was taught about cavernous sinus thrombosis in dental school and that he knew that surface gum infections could lead to an infection of the cavernous sinus. While he never treated anyone for this condition, he knew the symptoms a little bit: He testified "the late complications are things like periorbital edema, ptosis, which is the protrusion of the globe of the eye, lid lag, if it's severe, you know, they could have fever, periorbital retrobulbar pain." He then added that one might have double vision; that it could also cause blurred vision; and that it could cause facial edema, which not only would involve the eye, but the cheek." Dr. Lee stated that retrobulbar pain would include ". . . patient's complaint of facial pain or headache, and this type of pain will be, you know, a headache or a pain in the head that's, you know, very deep. I would say. You know, it's like behind the eye, so that's called retrobulbar." However, Dr. Lee testified that in his experience, it was common for patients that have a toothache to complain the pain radiates up and into their head. While Dr. Lee

would not concede that a patient complaining of a toothache radiating into the head should open the physician to a diagnosis of cavernous sinus, he conceded that if a patient complained of a headache extending into the temple area and blurry vision, that would "trigger a whole cascade of, you know, other questioning and so forth". He admitted that at that point the differential diagnosis would include "obviously a toothache is a possibility, and everything in between that and a cavernous sinus thrombosis." Dr. Lee testified that if presented with complaints such as those, a dentist should refer the patient to an ophthalmologist, and if the condition was severe enough, they should be sent to an emergency room. He testified that "after the extraction, if that tooth needed treatment, such as extraction of whatever that tooth needed, if the tooth was symptomatic, a patient suffering from complaints of a toothache with pain radiating to the temple area, along with blurry vision, should be sent to a medical doctor." When asked what if facial edema was also present, Dr. Lee testified that the patient would either go to an ophthalmologist, an ENT physician or the emergency room, depending on the severity.

Dr. DiBernardo of NUMC recalled the plaintiff telling him in words and actions that he was experiencing pain in his jaw and cheek and that he felt that a piece of tooth was still in his gum. He had no recollection of being told that the plaintiff was experiencing vision problems, which, he admitted, would have been significant because that indicates medical problems. X-rays did not show any tooth fragments left behind but it did show horizontal bone loss. Dr. DiBernardo diagnosed the plaintiff with alveolitis, i.e., dry sockets and stitched them closed. He prescribed penicillin because he thought that the plaintiff had a lingering localized infection and Tylenol #3 for the pain. He instructed him to go back to Able Dental as soon as possible. He also testified that he learned about cavernous sinus thrombosis in dental school but that is a medical emergency, not a dental one. Symptoms of that disease are diffuse pain to the head and tingling sensations in the lower portions of the face. Dr. DiBernardo acknowledged that cavernous sinus thrombosis can result from a dental infection.

Long Island Jewish Medical Center's records reflect the plaintiff giving a history of three weeks eye pain with double vision and four days swelling and decreased vision of his right eye. The plaintiff was diagnosed with diabetes mellitus for the first time upon his admission.

In support of his motion, defendant Dr. Lee has submitted the Affirmation of Allan Kucine, D.D.S., a Board Certified Oral and Maxillofacial Surgeon, and Alan Pollock, M.D., a Board Certified Internist and Infectious Disease doctor.

After reviewing the pleadings, bills of particulars, the plaintiff's dental records and the examination-before-trial testimony of the plaintiff, Drs. Lee, Kane and DiBernardo, Dr.

Kucine affirms to a reasonable degree of dental certainty that Dr. Lee acted within the applicable medical standards of care in his treatment of the plaintiff. More specifically, Dr. Kucine opines that after examining the plaintiff's records and the plaintiff personally on February 21, 2005, Dr. Lee properly concluded that tooth #5 was non-restorable and had to be pulled. Dr. Kucine also opines that Dr. Lee properly performed an intra-oral and extra-oral examination of the plaintiff on February 28, 2005 and found that despite the plaintiff's continued pain, the two sockets were healing. Thus, Dr. Kucine avers that Dr. Lee correctly told the plaintiff to return if swelling or bleeding occurred or the pain worsened and to otherwise follow up as needed. Dr. Kucine concluded that at no time did the plaintiff display any signs or symptoms that required Dr. Lee to refer him to a specialist, which, he notes, is further confirmed by Drs. Kane and DiBernardo's subsequent treatment of the plaintiff. As for the plaintiff's ultimate diagnosis of a fungal sphenoid sinus infection that resulted in cavernous sinus thrombosis, it is Dr. Kucine's opinion to a reasonable degree of dental certainty that that infection was not related to the extraction of tooth #5 and in fact, was not dental in origin.

After reviewing, *inter alia*, plaintiff's Able Dental's records as well as the pleadings, Bills of Particulars, and the examination-before-trial testimony of Drs. Lee, Kane and DiBernardo, Dr. Pollock also opines that Dr. Lee did not commit medical malpractice in treating the plaintiff nor was his treatment a proximate cause of the plaintiff's injuries. Dr. Pollock notes that when Dr. Lee saw the plaintiff on February 28, 2005, he had already been on an antibiotic, Keflex, since February 21, 2005. Dr. Pollock further notes that Dr. Lee performed an intra-oral and extra-oral exam and the periapical x-ray was normal. There were no signs of an infection. Dr. Pollock similarly notes that when the plaintiff was seen by Dr. DiBernardo at Nassau University Medical Center on March 1, 2005, he still did not display swelling around his right eye and the panoramic and periapical radiographs revealed clean extraction sockets.

Most importantly, Dr. Pollock opines that the fungal infection in the sphenoid sinus that the plaintiff was ultimately diagnosed with "could not have originated as a dental infection." He opines to a reasonable degree of medical certainty that the plaintiff had pre-existing chronic sinusitis. He explains that:

The rhizopus sinus mycosis infection from which the plaintiff suffered could not have happened overnight and was present for some time. The severe abnormalities which were present in all the sinuses took weeks to develop. The plaintiff testified at his deposition that he had light headaches and

occasional purulent discharge for weeks prior to his treatment by [Lee], and which he attributed to his toothache. The type of infection the plaintiff had affected sphenoid sinuses. If the infection had spread from the teeth it would have affected the maxillary sinus which is in anatomic proximity to the gum. There is no direct path from the mouth to the sphenoid sinus without including the maxillary sinus. The plaintiff developed cavernous sinus thrombosis which was secondary to an infection in the sphenoid sinus but not an infection in the mouth.

Defendant Dr. Lee has established his entitlement to summary judgment thereby shifting the burden to plaintiff to establish the existence of a material issue of fact.

In support of her motion for summary judgment, defendant Dr. Kane has submitted the affidavits of Dr. David S. Rosenthal, a Board Certified Internist and Endocrinologist and Lindsey P. Wolfer, D.D.S.

After reviewing the complaint, Bills of Particulars, all of the plaintiff's dental and medical records as well as the examination-before-trial testimony, Dr. Wolfer attests that Dr. Kane acted at all times in accordance with good and accepted standards of dental practice and that his care and treatment of the plaintiff did not cause any of his injuries. More specifically, Dr. Wolfer attests that Dr. Kane properly referred the plaintiff to an oral surgeon on

February 16, 2005, as that is customary when a dentist is presented with a patient with complaints of pain radiating to the head with severe recession and bone loss in the upper right arch. He attests that there was no evidence of a large abscess or excessive swelling on the x-rays suggestive of cavernous sinus thrombosis. And, he explains: "Tooth number 5 is located in the right upper arch near the infraorbital nerve, which travels from the cranium and enervates the area around the eye and just below the eye. The severe recession and bone loss in this area demonstrated on the x-rays was consistent with the plaintiff's complaints of pain radiating to the head." He opines that there was no indication for a CT scan or an MRI or any other diagnostic testing, nor was there cause for a referral to an ophthalmologist, neurologist, infectious disease doctor or an internist as there was no emergent condition and the plaintiff was already taking antibiotics.

As for Dr. Kane's treatment of the plaintiff on February 28, 2005, Dr. Wolfer opines that a periapical x-ray was properly performed which showed that there was no tooth structure remaining. And, Dr. Wolfer notes pain following tooth extractions is common

and that it takes two to three weeks for the extraction site to heal. Dr. Wolfer also concludes that Dr. Kane's treatment of tooth #6 was appropriate and that there was no indication for a CT scan, an MRI or referral to an expert on February 28, 2005, either.

Dr. Wolfer states that it is his opinion to a reasonable degree of medical certainty "that the plaintiff did not present with signs or symptoms of cavernous sinus thrombosis, the fungal disease or mucormycosis (an infection of the cavernous sinus which is located at the base of the brain) on February 16<sup>th</sup> and 28<sup>th</sup>, 2005." He explains that "the common symptoms include high fever, severe pain, paralysis of eye movement and bulging eyeballs," and that "[t]he plaintiff only had complaints of pain . . . [which] were easily explained by the recent extraction of tooth numbers 4 and 5, as well as the severe recession and bone loss in the area." It is also his opinion, to a reasonable degree of dental certainty, "that it is not within the purview of a general dentist to diagnose mucormycosis and/or cavernous sinus thrombosis." He explains that "[t]hese medical conditions are extremely rare and are not related to dental treatment. Most dentists will never come across these conditions in their lifetime of practice and it would be virtually impossible for a general dentist to diagnose." Dr. Wolfer further opines that there was no evidence of an emerging condition or infectious process which would have called for referral to a medical expert. He explains that pain radiating to the head was consistent with the plaintiff's dental condition because teeth #4 and #5 are located in the upper arch near the infraorbital nerve which travels from the cranium and enervates the area around the eye and so to cause pain radiating to the head.

It is also Dr. Wolfer's opinion to a reasonable degree of medical certainty that Dr. Kane's care and treatment of the plaintiff did not cause the plaintiff's injuries. In fact, he opines that "[it] is not possible that Dr. Kane's treatment caused the claimed cavernous sinus thrombosis and/or mucormycosis." He explains that "the claimed injuries in this case are attributable to the plaintiff's previously undiagnosed diabetes and are not related to his dental treatment. As mucormycosis and cavernous sinus thrombosis are not within the purview of a general dentist's diagnosis, it is not possible for Dr. Kane to have diagnosed the plaintiff with mucormycosis or cavernous sinus thrombosis." Dr. Wolfer concludes that Dr. Kane properly referred the plaintiff to an oral surgeon who is also a medical doctor on February 16, 2005 and that there was no reason to refer him to another specialist on February 28, 2005 as he had already seen a medical doctor and surgeon, Dr. Lee, that very day and his complaints were consistent with his dental history. Dr. Wolfer ultimately opines "[e]ven assuming for the sake of argument only, that any of the plaintiff's symptoms were related to these rare medical conditions, it is not reasonable to have expected a general dentist to make that

diagnosis or refer to other specialists, as the symptoms were explained and supported by radiographic evidence as being related to a dental condition (i.e., recent extractions, decayed teeth and bone loss)."

In further support of Dr. Kane's motion, based upon a review of the pleadings, the Bills of Particulars, the plaintiff's dental, medical and hospital records as well as the examination-before-trial testimony, Dr. Rosenthal opines to a reasonable degree of medical certainty that the care and treatment provided by Dr. Kane was in accordance with good and accepted medical standards and he in any event opines that Dr. Kane's care and treatment of the plaintiff was not a contributing factor to the plaintiff's injuries and that it is unreasonable to have expected Dr. Kane, a dentist, to diagnose and suspect that the plaintiff was suffering from mucormycosis and/or cavernous sinus thrombosis. Dr. Rosenthal notes that the first time Dr. Kane saw the plaintiff was on February 16, 2005. The plaintiff was taking antibiotics which Dr. Nadi had prescribed two days earlier and was complaining of pain radiating to his head. Periapical x-rays were taken. Dr. Kane noted that tooth #5 had severe recession and bone loss and might need to be extracted. He prescribed Tylenol #3 and referred plaintiff to an oral surgeon, Dr. Lee, who is also a medical doctor. The plaintiff saw Dr. Lee on February 21, 2005 and had tooth #5 extracted and on February 28, 2005, at which time he reported pulling tooth #4 himself three days earlier. Dr. Rosenthal notes that Dr. Kane saw the plaintiff on an emergency basis on February 28, 2005 at which time the plaintiff complained that it felt like a piece of a tooth remained in his gum. Periapical x-rays were normal. Dr. Kane advised the plaintiff that a bone fragment may be present and that the extraction sites needed two weeks to heal. Dr. Kane also treated the plaintiff for pain at tooth #6, putting in a composite filling, adjusting the occlusion and warning the plaintiff that tooth #6 might also need to be extracted.

Dr. Rosenthal notes that the plaintiff went to Nassau University Medical Center on March 1, 2005, again complaining that he felt like a tooth remnant remained in his gum which was causing him pain. X-rays did not reveal any tooth fragment. The plaintiff was diagnosed with alveolitis and Artucaine anesthetic was administered and the sockets were curetted. Eugenol paste was placed in the sockets of teeth #4 and #5 and they were sutured closed. The plaintiff was given prescriptions for Tylenol and penicillin and instructed to follow up with his dentist.

Dr. Rosenthal also notes that the plaintiff went to Long Island Jewish Hospital's Emergency Room on March 2, 2005. The plaintiff then reported ptosis (a drooping eyelid), decreased vision and decreased range of motion in his right eye, as well as a headache on his right side for two weeks. As for plaintiff's treatment at Long Island Jewish, Dr. Rosenthal notes that the

plaintiff exhibited no light perception in the right eye and neurological deficits at the cranial nerves II, III, IV and VI. Blood tests revealed an elevated glucose level of 650. The plaintiff was diagnosed with type II diabetes and was administered insulin. An MRI of the head revealed extensive opacification of the sphenoid sinus that was suspicious for cavernous sinus thrombosis. The head CT scan revealed bony destruction of the posterior lateral wall of the right sphenoid sinus. The plaintiff underwent emergent endoscopic sinus surgery on March 3, 2005, to drain the sinus and culture the fluid. When Tolosa Hunt Syndrome was ruled out, the ophthalmologist recommended discontinuing the steroids immediately and to start the plaintiff on intravenous anti-fungals. On March 4, 2005, an ENT consult was ordered and a culture was negative for bacterial infection. An Ophthalmologist consult noted that the plaintiff's visual prognosis was poor and unlikely to recover. Ultimately, on March 6, 2005, a culture was positive for fungus and an Infectious Disease consult was ordered. The plaintiff was administered Ceftriaxone, Flagyl, Vancomycin and Ambisome (anti-fungal) and a PIC line was placed intravenously. On March 9, 2005, the fungus was identified as Rhizopus. Surgical debridement was considered, a CT scan ordered and Heparin administered. The March 9, 2005 CAT scan of the head revealed that the sinus opacification had substantially progressed. Heparin was discontinued due to the plaintiff's nosebleeds. On March 11, 2005, the plaintiff underwent a debridement of the cavernous sinus without complication. The plaintiff was continued on IV antibiotics and anti-fungals and close management of diabetes. On March 24, 2005, the plaintiff developed gastrointestinal symptoms of vomiting and nausea likely due to the Ambisome. The plaintiff refused the anti-fungal medication for approximately two days and then resumed its administration. The plaintiff remained on the same medication regimen through the remainder of his admission and discussions were commenced regarding discharge planning. Arrangements were made for home care to administer all of his intravenous medications including the anti-fungal and he was discharged to home care on April 14, 2005.

Dr. Rosenthal notes that the plaintiff returned to the Emergency Room at LIJ on May 8, 2005 with complaints of dizziness, nausea and vomiting with an increased blood pressure. He had been sent to the Emergency Room by the home care nurse. He was diagnosed with Acute Cavernous Sinus Syndrome, mucormycosis (an infection of the cavernous sinus which is located within the skull at the base of the brain) with elevated liver function studies, nausea and vomiting. Physical examination revealed that his right eye remained closed without any vision. He was readmitted to the hospital.

Dr. Rosenthal opines to a reasonable degree of medical certainty that there was no connection between Dr. Kane's care and treatment of the plaintiff and his diagnosis of mucormycosis and

cavernous sinus thrombosis. Dr. Rosenthal explains that the fungus that caused the plaintiff's infection was Rhizopus which is a common fungus which most people frequently commonly come in contact with. It usually enters through the nasal passages and is eradicated when confronted by a normal immune system. The fungus however can be deadly when someone who is immuno-compromised like a person who is a diabetic or HIV positive contracts it. Thus, Dr. Rosenthal notes that the plaintiff was an undiagnosed diabetic for a long period in view of the findings made at Long Island Jewish and that that caused the plaintiff to develop mucormycosis and cavernous sinus thrombosis. Dr. Rosenthal also opines that there was no reason to order an MRI or a CT scan or to refer the plaintiff to another physician when Dr. Kane saw him: His complaints of pain radiating to his head was explained by his dental condition. Dr. Kane properly referred the plaintiff to an oral surgeon/physician/dentist. Dr. Rosenthal further opines to a reasonable degree of medical certainty that it was "virtually impossible" for Dr. Kane to diagnose mycormycosis or cavernous sinus thrombosis because plaintiff did not exhibit the signs and symptoms associated with those conditions. A patient with those conditions develops orbital cellulitis, pallatal lesions and cavernous sinus thrombosis which plaintiff did not exhibit unrelated to his dental problems. It is also Dr. Rosenthal's opinion to a reasonable degree of medical certainty that a diagnosis of mucormycosis is not within the purview of a dentist. That disease is not considered unless the patient is immuno-compromised and Dr. Kane could not have known that the plaintiff was. Dr. Rosenthal also opines that even assuming for the sake of argument only that the plaintiff's complaints were related to mucormycosis, it is not reasonable to have expected Dr. Kane, a dentist, to have made that diagnosis, especially since his symptoms were consistent with his dental condition and supported by the dental x-rays.

Defendant Dr. Kane has also established his entitlement to summary judgment thereby shifting the burden to the plaintiff to establish the existence of a material issue of fact.

In support of their motion, Nassau University Medical Center and Nassau Health Care Corporation have submitted the affirmation of Mark Henry, a Board Certified Emergency Medicine physician. After reviewing the pleadings, Bills of Particulars, the plaintiff's medical records and the testimony at the examination-before-trial, it is Dr. Henry's opinion to a reasonable degree of medical certainty that the care and treatment afforded the plaintiff at NUMC was at all times within good and accepted standards of medical practice. He opines that the plaintiff was appropriately triaged and referred to oral surgery. Dr. DiBernardo testified that the plaintiff did not have pain in his temple and neither the plaintiff nor his son complained about the plaintiff's

vision. The x-rays did not reveal that a piece of tooth remained. Dr. Henry notes that Dr. DiBernardo properly performed a physical extra-oral examination of the plaintiff's head and neck, looking for swelling, pain to palpation and facial asymmetry and everything was normal. As for plaintiff's mouth, Dr. Henry notes that Dr. DiBernardo properly concluded that the plaintiff had alveolitis as well as a lingering local infection that was resolving. Dr. Henry opines that Dr. DiBernardo appropriately anesthetized the patient and cleaned out the extraction sockets; then placed eugenol paste to calm down the inflamed area; and, closed the area with a stitch. He also appropriately provided the plaintiff with penicillin based upon the plaintiff's poor hygiene and lack of generalized healing in the area. He prescribed Tylenol No. 3 for pain and told him to follow up with his dentist as soon as he could. Dr. Henry opines that all of the plaintiff's symptoms and complaints were addressed at NUMC and that based upon the plaintiff's complaints and Dr. DiBernardo's examination of him, there was no need for any additional tests or any referrals to a specialist.

It is Dr. Henry's opinion to a reasonable degree of medical certainty that the care and treatment rendered by the staff at NUMC was appropriate in all respects and within standards of acceptable medical care and treatment. Dr. Henry explains that emergency medical care's aim is to stabilize the patient, which was done here, and the plaintiff was told to follow up with his own dentist as soon as possible.

NUMC has also established its entitlement to summary judgment thereby shifting the burden to the plaintiff to establish the existence of a material issue of fact.

The defendant Able Dental seeks dismissal of the complaint on the grounds that its liability, if any, is vicarious based upon the acts or omissions of Drs. Nadi, Kane and Lee. Thus, Able Dental accordingly asks that if the complaint is dismissed as against those defendants, it should be dismissed against it, too. Dr. Nadi has not moved for summary judgment. Able Dental's motion is accordingly denied.

In opposition to the defendants' motions, the plaintiffs have submitted the Affirmation of a doctor board certified in Internal Medicine and Infectious Diseases and a dentist who is a Diplomate of the American Board of Oral and Maxillofacial Surgeons. Having reviewed the plaintiff's medical records as well as the examination-before-trial testimony of the parties as well as the witnesses, both doctors have concluded that each of the movants committed an act of dental and/or medical malpractice which proximately caused the plaintiff's injuries.

The Infectious Disease doctor affirms that Rhizopus is the most common form of Mucormycosis and that it can be found in the nasal passages, the throat, stool and the oral cavities. He also

explains that cavernous sinus thrombosis is an infection of the central face or paranasal sinuses and that it may be related to bacteria, trauma or infections of the ear or maxillary teeth. He explains that headaches are the most common symptoms and derive from the ophthalmic and maxillary branches of the fifth facial nerve, or the trigeminal nerve, which provides sensation to the face. The portion of the trigeminal nerve known as the ophthalmic nerve is responsible for sensory information from the scalp and forehead, the upper eyelid, the conjunctiva and cornea of the eye, the nose (including the tip of the nose), the nasal mucosa, the frontal sinuses, and parts of the meninges (the dura and blood vessels). The portion of the trigeminal nerve known as the maxillary nerve is responsible for sensory information from the lower eyelid and cheek, the nares and upper lip, the upper teeth and gums, the nasal mucosa, the palate and roof of the pharynx, the maxillary, ethmoid and sphenoid sinuses, and parts of the meninges. Thus, the condition can be related to dental treatment. LIJ's Infectious Disease doctor noted that the CT scan of March 10, 2005 indicated infection of both the right maxillary sinus and the ethmoid sinus, indicating a possible dental origin of the infection. The Infectious Disease doctor notes that the swelling of plaintiff's eye and face as well as his visual disturbances began on February 21, 2005 and only grew worse by February 28, 2005 when he was seen by Drs. Kane and Lee and March 1, 2005 when he went to NUMC. He opines that had treatment been started by any one of those dates, blindness in the plaintiff's right eye may have been avoided. He explains that earlier hospitalization would have led to an earlier diagnosis of the plaintiff's previously unknown diabetes and his blood sugar brought under control, which would have helped him fight the infectious process. He explains that it is well known that diabetes can slow down a patient's ability to fight infection. High blood glucose leads to high levels of sugar in the body's tissues. When this happens, bacteria grow and infections can develop more quickly in people with diabetes. As such, the sooner the blood sugar is brought under control, the more likely that the body will be able to fend off an infection with proper treatment. With the treatment of the diabetes in place, taken together with the antibiotic regimen instituted upon admission, the advancement of the infectious process could have been delayed and the diagnosis of the fungal infection made and immediate treatment of the condition with antifungal medication started sooner. While the Infectious Disease doctor does not fault the moving defendants for their failure to make a specific diagnosis, once the plaintiff began complaining of pain radiating to his head in combination with swelling of his cheek, medical conditions had to be ruled out. And, taking into consideration his eye swelling and visual disturbances, it became clear that his problem was not entirely dental: A medical referral was mandated

and it is the Infectious Disease doctor's opinion that had a referral been made on or before March 1, 2005, immediate and appropriate treatment could have began and the advancement of the infectious process slowed so as to avoid permanent injuries. He further opines that the delay certainly deprived the plaintiff of any chance for a cure and the avoidance of the disabling injuries he suffered.

The plaintiff's expert dentist agrees that the most common forms of mucormycosis is Rhizopus which can be found in the nasal passages, throat, stool and oral cavity. He also notes that cavernous sinus thrombosis is taught in dental school and opines that a dentist should be able to recognize its signs and symptoms and while it is a medical condition outside of their field, referrals to medical practitioners are necessary. He notes that plaintiff's visual disturbances and face and eye swelling began after Dr. Lee pulled tooth #5. He notes that the plaintiff testified that he told Dr. Kane on February 16, 2005 that "the pain was all the way up here, up to my head. . . ." that the right side of his face was swollen and red from his right eye down to his jaw line when he saw Dr. Lee on February 21, 2005; and, that his eye was visibly drooping and that he told Dr. Kane that his eye hurt, was closing up and that his vision was blurry on February 28, 2005. Nevertheless, Dr. Kane did not examine his eye nor did Dr. Lee. He also notes that his stepson testified that the right side of the plaintiff's face was swollen and reddish on the cheek and around the eye on February 21, 2005. He also notes that the plaintiff's wife testified that his eye was swollen when he saw the doctor on February 28, 2005, and that he had told her he had trouble opening it. And the plaintiff's stepson testified that he complained to the doctor of blurry vision and a partially swollen eye. The dental expert further notes that the plaintiff's stepson also testified that his father's eye was swollen on the right side and had been for possibly a week and a half when he took him to NUMC on March 1, 2005. In fact, he testified that he told the doctor that his father's vision was blurry and that he was seeing black dots and spots and could not see well and that his father's face was swollen and in pain. In fact, the plaintiff's stepson testified that his eye looked even worse when they left NUMC.

The dental expert opines to a reasonable degree of dental certainty that as of February 21, 2005 in addition to his continuing pain, the plaintiff had swelling and redness of the cheek and right eye and that the standard of care dictated that antibiotic coverage be continued and even altered due to the ineffectiveness of Keflex. He further opines to a reasonable degree of dental certainty that in view of the pain and visual disturbances evident on February 28, 2005, a referral by Dr. Kane and/or Dr. Lee to a medical or infectious disease doctor was required. A cause not associated with a dental condition should

have been considered and the failure to do that deviated from good and accepted standards of dental practice.

The plaintiff's dental expert similarly opines that NUMC also deviated from good and accepted standards of dental practice when it too failed to consider a non-dental cause of the plaintiff's condition or to refer him to a medical doctor or at least an attending oral surgeon when with his history, he presented there on March 1, 2005, complaining of facial pain and swelling as well as visual disturbances.

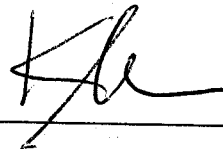
Like the Infectious Disease doctor, the dental expert did not hold the movants responsible based upon a failure to diagnose but rather based upon their failure to recognize that the plaintiff was suffering from more than a dental infection of the gum and poor dentition and to make appropriate referrals. He opines that cavernous sinus thrombosis has clear signs and symptoms regardless of the underlying cause and that it is not the failure to make a complicated diagnosis but a failure to recognize that the patient was suffering from more than a dental condition and advise the patient that he needed to be evaluated by a medical doctor.

The plaintiffs' experts clearly detail based upon facts in the record how the movant defendants deviated could have been a proximate cause of plaintiff's injuries.

Issues of fact clearly preclude an award of summary judgment.

This decision constitutes the order of the court.

Dated: NOV 12 2008



KENNETH A. DAVIS

J.S.C.

**ENTERED**

NOV 17 2008

**NASSAU COUNTY  
COUNTY CLERK'S OFFICE**