

Malpractice Minute

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Complications From Implant Lead to Paresthesia and Malpractice Suit Against Dentist

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Background: This edition of *Malpractice Minute* discusses a case involving an implant placed by a dentist who had limited experience with implantology, which resulted in injury to the inferior alveolar nerve and paresthesia.

Case Discussion: The patient was a 28-year-old female who presented to Dr. E with a chief complaint of pain associated with tooth number 30. After a visual and radiographic examination, the doctor determined that the patient had a deep carious lesion on the tooth. The lesion had penetrated through the floor of the pulp chamber, necessitating removal of the tooth.

A treatment plan was developed and discussed, and it was decided that the tooth would be removed and an immediate implant would be placed. Although Dr. E was only in her third year of private practice, she had been trained to place implants and bone grafts in her residency program. The patient accepted the plan, and she was then placed on antibiotics and pain medication and scheduled for the procedure.

On the day of the appointment, Dr. E verbally discussed the expected benefits and known risks of the procedure, and she responded to the patient's concerns. Lidocaine anesthetic was administered, the tooth was extracted, and the implant was placed. A graft was also accomplished, and the patient was sent home.

On the second postoperative day, the patient called the office to inquire about the fact that she still had some numbness in her lip. She was scheduled for an exam that day, and the area of paresthesia was confirmed. Suspecting an inflammatory cause, Dr. E prescribed a steroidal solution and an antibiotic to assist with the healing process. The patient was then scheduled for a follow-up appointment.

The patient was followed closely, but the paresthesia persisted. A radiograph taken after the surgery indicated at least 2 millimeters between the apex of the implant and the superior border of the inferior alveolar nerve (IAN) canal, so the doctor did not suspect traumatic nerve damage. She followed the patient for 6 months, with no improvement. At that point, she referred the patient to an oral and maxillofacial surgeon for evaluation.

The oral surgeon charted the area of altered sensation and concluded that the IAN had been injured. A cone beam computed tomography (CBCT) scan of the area was obtained, which confirmed that the implant was not in the IAN canal. However, the scan indicated a small perforation of the cortical bone superior to the canal, and it showed that the IAN had been transected. Unfortunately, due to the time that had elapsed, it was too late to attempt a nerve repair.

Although the patient had been verbally informed of the risk of this complication, she insisted that she was unaware of the potential problem — and, unfortunately, Dr. E failed to enter the actual information that was explained to the patient into her record. The patient was also quite displeased to discover that a potential remediating treatment might have been possible with a timely referral.

The patient sued Dr. E for lack of informed consent and failure to timely refer to an appropriate specialist. With the doctor's consent, the case was settled in the midrange.

Risk Management Considerations:

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This is an interesting case from a medico-legal standpoint. Typically, when malpractice cases are brought against providers, the allegations are related to technical failures that result in patient injuries. However, that was not the case here.

In this case, all of the imaging indicated that the apex of the implant never came into contact with the IAN. However, a careful analysis of the CBCT, which the oral surgeon ordered, indicated that there may have been a breach of the superior aspect of the IAN canal. How could this happen?

Most likely, as Dr. E was shaping the site for placement of the implant, she went too deep with the drill, breaching the canal and transecting the nerve. For whatever reason, the plaintiff's complaint did not raise this allegation, so the defense did not have to address it.

The first allegation that *was* made was that Dr. E's informed consent process was inadequate. Although Dr. E did engage the patient in an informed consent process (yes, it is a process), it appears that her process only consisted of a verbal discussion of the procedure, the expected results, and, very importantly, the known risks.

Although dental professionals are familiar with this information, patients are often hearing it for the first time during this brief conversation. Given that the informed consent process can involve a fairly large amount of technical information, it is likely that patients might not fully comprehend everything they hear. Consent forms can help address this issue.

Although comprehensive, well-written consent forms have many advantages, two stand out in particular. First, the receipt of a copy of the consent form allows the patient to review the information and seek clarification of anything they do not understand. Many

studies support the notion that people retain greater amounts of information when they have the opportunity to review it. (Imagine trying to study dentistry if you did not have textbooks to support what you hear in lecture.)

The second advantage is that the consent form provides a permanent record of which risks were disclosed to the patient. This is much more efficient than recording each informed consent discussion in the patient record (something Dr. E did not do in this case). The use of a written consent form is integral to the informed consent process. The dentist should note in the patient's dental record that he or she provided the patient with an informed consent form, and a copy of the signed form should be included in the patient's record.

The second allegation that was raised was that Dr. E did not make a timely referral of the patient to an oral surgeon or other appropriate specialist. Although the right time to refer is a matter of clinical judgment, defending the decision to refer to a specialist after the "window of opportunity" for corrective treatment has already closed is difficult.

Some dentists consider a referral as an indication that they have failed or are inadequate to "get the job done." On the contrary, specialists and subspecialists exist for a reason. In some cases, things just don't go as planned. It is far more likely that a specialist has seen a similar scenario before, and she or he is in a much better position to develop an appropriate plan of action. Thus, making a referral sooner rather than later is often a wise decision.

In the end, it is impossible to say whether more prompt treatment of the patient's paresthesia by a specialist would have been successful; however, as noted previously, the delay was difficult to defend.

Conclusion: Despite our best efforts, occasionally patients will be injured in the process of receiving dental care. When this happens, prompt and aggressive follow-up will provide the best opportunity for full recovery. Further, it will serve dentists well to fully inform patients of the inherent risks of proposed treatments, so that they can make informed decisions about whether to proceed with treatment.

Question: What indicators or "cues" can the general dentist use to help him or her recognize the need for prompt referral?

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