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SHORT FORM ORDER

INDEX No. 07-10827
CAL. No. 11-00711DM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 9 - SUFFOLK COUNTY

PRESENT:

Hon. DANIEL M. MARTIN
Justice of the Supreme Court

MOTION DATE 8-17-11
ADJ. DATE 8-28-12
Mot. Seq. # 002- MG
003- MD

CAROL A. DRAGO and BRUCE DRAGO, Plaintiffs, - against - JEFFREY M. ETESS, JOAN FRANCIS, RICHARD J. KLEIN, NOW DENTAL OF SUFFOLK, JEFFREY M. ETESS, D.M.D., P.C., and RICHARD J. KLEIN, D.D.S., P.C., Defendants.	CHRISTOPHER S. OLSON, ESQ. Attorney for Plaintiffs 199 East Main Street, Suite 4 Smithtown, New York 11787 KAUFMAN BORGEEST & RYAN LLP Attorney for Defendants Etess 1205 Franklin Avenue, Suite 200 Garden City, New York 11530 CHESNEY & MURPHY, LLP Attorney for Defendants Klein 2305 Grand Avenue Baldwin, New York 11510

Upon the following papers numbered 1 to 115 read on this motion and cross motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers (002) 1 - 18 ; Notice of Cross Motion and supporting papers (003) 19- 30 ; Answering Affidavits and supporting papers 31- 70; 71-104 ; Replying Affidavits and supporting papers 105-106; 107-108 ; Other sur-reply 109- 115; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (002) by the defendants, Jeffrey M. Etess, and Jeffrey M. Etess, D.M.D., P.C., pursuant to CPLR 3211 (a) and (b) and 3212 for summary judgment dismissing the complaint, is denied; and it is further

ORDERED that motion (003) by the defendants, Joan Francis, Richard J. Klein, and Richard J. Klein, D.D.S., P.C., for summary judgment dismissing the complaint and any cross claims and/or counterclaims asserted against them, is denied.

In this dental malpractice action, Carol A. Drago and her spouse, Bruce Drago, seek damages personally and derivatively arising out of the dental care and treatment rendered to Carol A. Drago by the defendants, Jeffrey M. Etess, Jeffrey M. Etess, D.M.D., P.C., Joan Francis, Richard J. Klein, and Richard J. Klein, D.D.S., P.C. from January 1999 through January 2006. It is claimed that the defendants, Jeffrey M. Etess, and Jeffrey M. Etess, D.M.D., P.C., negligently departed from accepted dental practices, in, inter alia, failing to diagnose and treat plaintiff for an infection in her oral cavity and surrounding structures, causing permanent damage to adjacent structures of the face, sinus cavities, skin tissue, nerves, muscles and bones, and failing to provide informed consent for the services provided.

The defendants, Jeffrey M. Etess, and Jeffrey M. Etess, D.M.D., P.C., now seek summary judgment dismissing the complaint as asserted against them on the bases that any claims arising prior to September 1, 2001 are barred by the applicable statute of limitations as set forth in CPLR 214-a, that they did not negligently depart from the applicable standards of care and treatment, that they provided proper informed consent, and that they did not proximately cause the plaintiff's claimed injuries.

The defendants, Joan Francis, Richard J. Klein, and Richard J. Klein, D.D.S., P.C. now seek summary judgment dismissing the complaint on the bases that all claims arising out of the dental treatment rendered prior to October 3, 2004 are barred by the applicable statute of limitations, and that they did not negligently depart from good and accepted standards of dental care in rendering treatment to the plaintiff. It is noted that the Note of Issue and Certificate of Readiness were filed with this court on April 6, 2011. The last date to serve a motion for summary judgment pursuant to CPLR 3212 was on August 4, 2011. The moving defendants did not serve this cross motion for summary judgment until September 26, 2011, well beyond the statutory 120 days. The moving defendants have made no application for leave of court on good cause shown to file this cross motion beyond the statutory one hundred twenty days, and, in fact, have not submitted any reason for the delay in submitting the moving papers (*see, **Davidson v Brisman***, 40 AD3d 574, 833 NYS2d 406 [2d Dept 2007]; ***Brill v City of New York***, 2 NY3d 648, 781 NYS2d 261 [2004]).

Accordingly, motion (003) by defendants Joan Francis, Richard J. Klein and Richard J. Klein, D.D.S., PC, for summary judgment, is denied.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering evidentiary proof in admissible form sufficient to eliminate any material issues of fact from the case (***Alvarez v Prospect Hosp.***, 68 NY2d 320, 508 NYS2d 923 [1986]; ***Friends of Animals v Associated Fur Mfrs.***, 46 NY2d 1065, 416 NYS2d 790 [1979]). The proponent has the initial burden of proving entitlement to summary judgment (***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (*id.*). Once a prima facie showing is made, the burden shifts to the opponent of the motion who, in order to defeat summary judgment, must proffer evidence in admissible form sufficient to require a trial of any issue of fact or demonstrate an acceptable excuse for his failure to do so (***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]; ***Joseph P. Day Realty Corp. v Aeroxon Prods.***, 148 AD2d 499, 538 NYS2d 843 [2d Dept 1989]). The opponent must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleading are real and capable of being established at a trial (***Castro v Liberty Bus Co.***, 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]). Summary judgment shall be granted when the cause of action or defense is established sufficiently to warrant the court as a matter of law in directing judgment in favor of any party (CPLR 3212 [b]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (***Holton v Sprain Brook Manor Nursing Home***, 253 AD2d 852, 678 NYS2d 503 [2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see, **Derdiarian v Felix Contracting Corp.***, 51 NY2d 308, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious***, 221 AD2d 674, 638 NYS2d 700 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see, **Fiore v Galang***, 64 NY2d 999, 489 NYS2d 47 [1985]; ***Lyons v McCauley***, 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

In support of motion (002), the Etess defendants have submitted, inter alia, an attorney's affidavit, copies of the summons and complaint, the answers submitted by the moving defendants; the plaintiff's verified bills of particulars; uncertified copy of the plaintiff's dental records; the expert affirmations of Charles Solomon, D.D.S. and Kenneth Schneider, M.D.; the signed transcripts of the examinations before trial of Carol Dragos dated September 4, 2008, Joan Francis dated March 18, 2010, and the unsigned transcripts of the examinations before trial of Jeffrey Etess dated December 20, 2009. The unsigned transcript of the moving defendant, Jeffrey Etess, is considered pursuant to ***Ashif v Won Ok Lee,*** 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]) as testimony adopted by him. The uncertified copies of the plaintiff's medical/dental records are not in admissible form pursuant to CPLR 3212, but have not been objected to by the plaintiffs.

CAROL DRAGO

Ms. Drago testified that in November 2003, Dr. Etess performed a root canal to her left upper molar. After the root canal was done, a crown was later placed on the tooth by Dr. Francis. Although she no longer had sensitivity to sweets after the crown was in place, she still had the same complaints about the tooth as she did prior to the tooth being treated, so Dr. Francis adjusted the crown. Throughout 2004, the tooth hurt when she chewed, and she had a more intense sensitivity to cold than previously. She then had a crown placed on the tooth in back of the tooth on which root canal was done. In 2005, she had increased sensitivity to cold and developed tenderness while brushing her teeth on the left side of her mouth. She saw Dr. Francis in March 2005, and was advised that her gum was red and swollen. She was referred to Dr. Etess, who advised antibiotics for gingivitis. She experienced relief of the tenderness but still had sensitivity to cold. From about October 2005, she had a foul taste in her mouth, and the sensitivity, soreness, and tenderness were increasing. In November 2005, Dr. Francis recommended that she see Dr. Etess who believed she might have a retained root for which an apicoectomy was performed on December 16, 2006. Ms. Drago stated that while Dr. Etess was performing the procedure, he advised her that he invaded the sinus cavity and irrigated it with an antibiotic. She testified that afterwards she was placed on antibiotics, her nose was dripping, and her throat and eyes were burning and sore for several days.

Ms. Drago continued that Dr. Etess examined her on December 19, 2005 and removed the sutures on December 23rd. On December 26, 2005, she was rinsing her mouth and noticed water coming out of her left nostril. She could not remember if it occurred again after that, but she believed it did. On December 27th, she saw Dr. Etess who stitched an open area in her mouth. When she saw Dr. Etess on January 3, 2006, she told him she had numbness in her lip, pain in her left upper jaw, difficulty chewing, and that her face was still a little bit swollen. She could not recall his response, but she stated that he advised her it would get better. He also removed the sutures, but later that day, she drank water and it started pouring out of her nose. She started drinking with a straw and had no further instances until she saw Dr. Etess again on January 6, 2006, at which time the area was resutured. Sutures were removed on January 13, 2006. The pain in her left upper jaw decreased thereafter, but she still had some numbness in her lip. She began experiencing some dizziness, with pressure in her left eye and forehead.

Ms. Drago stated that she had a CT scan performed, then saw an ear, nose and throat physician, Dr. Grosso, who told her there was a communication to the sinus where she had the dental surgery, and that there was an infection. She then testified that Dr. Grosso told her the infection was in her tooth and that she needed to see an oral surgeon. She went to Plainview Oral Maxillo-Facial Associates and saw Dr. Bass who advised her that the tooth was infected and that she needed to have it removed to clear up the infection. It was extracted on February 17, 2006 by a Dr. Morris of Dr. Bass' office. She did not recall if he indicated to her that the tooth was infected. When she returned to him a week later, she told him that she still had a lot of pain and numbness,

she could not eat on that side, she felt very congested, and also felt pressure in her eye. Dr. Morris advised her that the area was healing well and to give it some time. She followed up with Dr. Grosso and had sinus surgery on March 23, 2006. After the ENT surgery, the numbness in her lip was worse, she had numbness in her gum and the left cheek, the pain and sensitivity in her teeth was worse, and she still had soreness to the left side of her face. She stated that Dr. Grosso told her the numbness would resolve in about a year, but it only improved. Thereafter, she developed clicking and pain in her left upper jaw and saw Dr. Tracey Rosenberg who prescribed muscle relaxants for TMJ. She did not recall if Dr. Rosenberg told her that this was attributable to clenching her teeth, however, Dr. Rosenberg prescribed a night guard to place in her mouth, but she did not have the prescription filled because her insurance did not cover it.

On April 17, 2006, when she saw Dr. Grosso, she told him that she had more pressure, numbness and congestion, but the gum sensitivity and swelling went down, and on August 9, 2006, told him that the numbness to her lip and upper mouth had not improved, the pain in her teeth and gum increased, and she was having a difficult time chewing on that side due to pain. She then saw Dr. Ruggiero, a dentist/medical doctor, who examined her and referred her to a pain specialist and an endodontist for nerve pain. She followed with Dr. Stamatos in July 2007, and was referred to Dr. Ford, a facial pain specialist, and to Dr. Levine, a neurosurgeon. Dr. Ford referred her back to Dr. Stamatos for a nerve block, which only improved her symptoms for a short period of time. Dr. Levine performed a rhizotomy wherein the nerve causing pain in her face was identified and zapped to stop the pain, under general anesthesia. Thereafter, she experienced excruciating pain, and still experiences pain on the side of her head and face, extreme sensitivity to her upper front teeth, and muscle spasms, however, she had less pain to the left upper tooth area. She also began to experience a tapping sound in her ear, which interferes with hearing while she is eating. Dr. Levine told her he felt it was caused by fifth motor root nerve damage. She then saw Dr. Kayden, an endodontist, who told her the roots of the teeth were causing her pain, but she could not remember which teeth. She has also had acupuncture from Dr. Chen for spasms, pain in her eye, numbness to her left upper lip and tooth, and muscle spasms down her neck and back on the left side. She also had all her wisdom teeth extracted in order make more space to have a bridge fitted.

JEFFREY ETESS, DDS

Dr. Etess testified that he is licensed to practice dentistry in New York. He became an independent contractor for Now Dental in September 2003 pursuant to an oral agreement with Dr. Richard Klein, and is self-employed as Jeffrey M. Etess, D.M.D., P.C. since 2000 or 2001. He had no independent recollection of Carol Drago but could recall some instances that he spoke with her. He testified that the first time he saw Ms. Drago as a patient was on October 7, 2003. He testified as to his care and treatment of tooth #14 (upper left), which had been previously cut down for either a dental crown or a large dental restoration. He stated that tooth #14 had a very thin pulpal floor, that its viability was questionable, and that he treated it with a root canal. He referred Ms. Drago back to Dr. Francis, her treating dentist from whom she was receiving active treatment. When she returned to Dr. Etess on March 18, 2005, to see the dental hygienist, he noted that she had a perio abscess of tooth #14 for which he prescribed an antibiotic and Peridex mouth rinse. Ms. Drago was again referred to him for an endontic consult on December 1, 2005 concerning tooth #14. He determined the tooth had a draining fistula to the mesial buccal root, as determined by gutta percha application. He stated that the mesial buccal root sits within the maxillary sinus. In this instance, it was the legendary fourth canal which he felt was treatable. He testified that it was not a normal pathophysiology for a periodontal abscess to progress into a fistula, and that the abscess and the fistula were two separate conditions. He performed a curettage and root resection apicoectomy on December 16, 2005 for an obvious cyst-like lesion over the apex of the mesial root of tooth #14. There was no periodontal abscess present and he did not determine that there was a maxillary

sinus infection. He stated that he would have told Ms. Drago that sinus exposure is a risk or complication of the procedure which involves delayed healing and possible secondary infections.

Dr. Etess stated that, thereafter, over the weekend, Ms. Drago had swelling and Dr. Francis changed her antibiotic. He saw her on December 23, 2005 for suture removal. He noted no swelling of her face, and she offered him no complaints of pain or pressure or tearing in her left eye, and showed no signs of infection. On December 27, 2005, Ms. Drago called and advised that the suture site opened up. He wrote in his note that she developed an oral angular fistula which he stated was a communication, not a fistula, as the infection had been removed, so he resutured the area and prescribed another antibiotic for any secondary infection while the area was healing or granulating. Those sutures had to be removed on January 3, 2006, at which time, no signs of infection were noted and she offered no complaints. Thereafter, she called him repeatedly, and returned to see him on January 6, 2006, at which time he placed another suture into the area and found a sensitivity at tooth #30. Dr. Etess testified that final suture removal was performed on January 13, 2006, after which time she abandoned further treatment with him.

CHARLES SOLOMON, M.D.

Charles Solomon, D.D.S. has set forth in his expert affirmation that he is a dentist duly licensed to practice dentistry in New York and an endodontist with over forty years of clinical experience in the treatment of teeth and is fully familiar with the standards of endodontic care, including root canals and apicoectomies. He has set forth the materials, including dental records, x-rays, the records of subsequent medical providers, and the plaintiff's bill of particulars, which he reviewed to form his opinions, and set forth his opinions with a reasonable degree of dental/endodontic certainty that the care and treatment rendered by Dr. Etess was reasonable at all times and well within the endodontic standard of care. It is Dr. Solomon's additional opinion that Dr. Etess, did not proximately cause any of the injuries claimed by the plaintiff in her bill of particulars.

Dr. Solomon stated that Carol Drago became a patient of Now Dental on January 6, 1999 when she presented for a routine dental examination. He set forth her care and treatment with Dr. Francis, including a visit on July 23, 2003, when Ms. Drago returned to Dr. Francis with complaints of discomfort with sweets involving tooth #14. At the time, tooth #14 had an old crown, which Dr. Francis advised her needed to be replaced. On October 3, 2003, she was still having symptoms with tooth #14 for almost a year, so Dr. Francis questioned periapical pathology on the distal buccal root and referred Ms. Drago to Dr. Etess for an endodontic evaluation. She was fitted with a temporary crown. There was barely any solid tooth structure revealed on x-ray.

Dr. Solomon continued that Dr. Etess first saw Ms. Drago on October 7, 2003 when she presented with the chief complaint of chronic pain in the left maxilla for six months. Upon examination, Dr. Etess documented the questionable vitality of tooth #14, and further noted probable periapical pathology, that there was an extremely thin pulpal floor, and her tooth was sensitive to percussion. She was to undergo root canal therapy to remove the pulp tissue of tooth #14 on the next visit on November 24, 2003. Ms. Drago had been advised of the risk of the root canal, including infection, root perforation, and susceptibility to fracture. The root canal therapy to tooth #14 was performed without any apparent problems. Dr. Solomon set forth the procedure used by Dr. Etess, including measuring the lengths of the three canals, biomechanically preparing the canals, and filling them with gutta percha and a sealer. On November 24, 2003, Ms. Drago also saw Dr. Francis for crown prep placement of a temporary restoration of tooth #14, and had no complaints of swelling, soreness or tenderness. When she returned to Dr. Francis on December 8, 2003 for placement of a crown with temporary cement, she reported sensitivity to tooth #15. Bitewing and periapical x-rays were taken and a temporary filling material was placed in tooth #15. On March 30, 2004, Dr. Francis placed a permanent filling in tooth #15 and

permanently cemented the crown on tooth #14. It was noted that tooth #15 required a crown due to a buccal crack. On April 6, 2004, Ms. Drago presented to Now Dental complaining that tooth #14 was painful, that she could not bite down, and that the crown on that tooth felt loose. Dr. Francis found no abnormalities upon examination of the whole mouth on April 7, 2004, except for tooth #15, which was prepared for a crown on April 26, 2004. On May 13, 2004, Dr. Francis attempted placement of the crown on tooth #15, however, this was unsuccessful in that it did not seat properly and a new impression was taken. On July 14, 2004, a temporary crown was placed on tooth #15 by Dr. Francis, and on September 8, 2004, the crown was permanently cemented.

Dr. Solomon stated that on March 8, 2005, Ms. Drago presented to Dr. Francis with discomfort of her upper left mouth and slight swelling on the buccal gingiva of tooth #14, with soreness of the gingiva. Scaling and irrigation with Perioguard was done, and Clindimycin was prescribed for a periodontal infection. X-ray examination of the tooth revealed no abnormalities. When Ms. Drago presented to Dr. Francis on March 18, 2005 for a cleaning, Dr. Francis asked Dr. Etess to see Ms. Drago concerning a periodontal abscess to tooth #14 for which Dr. Etess prescribed an antibiotic after examining Ms. Drago and reviewing x-rays taken ten days prior. He further instructed her to brush and floss around the crown. There were no complaints about tooth #14 until November 29, 2005, when Dr. Francis noted a fistula[1] upon x-ray exam, and traced it with gutta percha, however, the plaintiff offered no complaints of tenderness, swelling or soreness. Thereafter, Ms. Drago presented to Dr. Etess for an endodontic consult for tooth #14.

Dr. Solomon further indicated that Dr. Etess traced the fistula to the mesial-buccal root and suspected a fourth canal was present which was not observable during the prior root canal in 2003. She did not have increased pain, soreness, tenderness or swelling, and there was no build up of pressure from the infection. She was advised of the risk that there was no guarantee that the procedure would be successful, and that her treatment options were apicoectomy or extraction of tooth #14. At the next visit on December 16, 2005, Ms. Drago returned to Dr. Etess for an apicoectomy to remove the root tip and surrounding infected tissue on tooth #14. Dr. Etess observed an obvious cyst like lesion over the apex of the mesial buccal root. Curettage and apical root resection were performed, retrofill seats in the mesial and distal root apices were bonded, the sinus was exposed to the adjacent mesial buccal root and a collagen membrane was placed over the sinus exposure area to give the membrane the opportunity to heal. The site was irrigated with Peridex and saline, and sutures were placed. Pain medication, Prednisone, Peridex, Motrin, and an antibiotic were prescribed. A note of December 19, 2005 reveals that the antibiotic was changed by Dr. Francis over the weekend due to swelling. Dr. Francis advised Dr. Etess that the periodontal dressing placed on tip of the gum tissue and sutures had fallen out the previous day. Dr. Etess called Ms. Drago two times at home over the weekend and once on her cell phone. Sutures were removed by Dr. Etess on December 23, 2005. Healing was noted to be within normal limits and there were no complaints by the plaintiff of sinus congestion, pain, swelling or heat sensation.

Dr. Solomon continued that on December 27, 2005, the plaintiff was seen by Dr. Etess who documented that the plaintiff had a tear at the suture site over the weekend. Dr. Etess diagnosed an oral-antral fistula, or communication without infection, which was sutured after irrigation of the area. On January 3, 2006, the oral-antral fistula was still present, but smaller, with no signs of infection. Sutures were removed. On January 6, 2006, Dr. Francis saw the plaintiff who offered complaints of extreme sensitivity in the lingual/gingival area of tooth #31 to which Gluma, a desensitizer, was applied and for which Prevident was given. There was much

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[1]Dr. Francis indicates that a fistula is a communication between the outside of the mouth and the inside bone where there is an infection.

occlusal wear/recession and Dr. Francis advised her that the tooth might require an endodontist. Ms. Drago also saw Dr. Etess on January 6, 2006. Tooth #30 was checked for sensitivity and no infection was found. He advised her, in response to her complaint that the suture site at #14 was not closing, that the granulation takes six to eight weeks. A cross-stitch suture was placed on tooth #14 and was removed on January 13, 2006. She was to be re-evaluated in two weeks, but did not return.

Dr. Solomon stated that Ms. Drago underwent a CT of the sinuses on January 18, 2006 at North Shore University Hospital-Plainview, which CT revealed mucoperiosteal thickening in the bilateral maxillary sinuses and thickening in the ethmoid sinuses, with complete opacification of the left frontal sinus, as well as mucoperiosteal thickening in the right frontal sinus. The findings were strongly suggestive of sinusitis. Dr. Solomon stated that Dr. Grosso, an ENT physician, saw the plaintiff on February 10, 2006 and noted that the fistula was closed and there was no evidence of an inflamed gingiva. On February 13, 2006, the plaintiff presented to the Plainview Oral & Maxillofacial Associates with complaints of sinus pain. She had an apicoectomy on December 17, 2005, followed by an opening of the incision with nasal return and sinusitis. It was noted that the plaintiff needed an extraction of tooth #14, which was done on February 17, 2006. On February 23, 2006, the plaintiff returned to Plainview Oral & Maxillofacial Associates, complaining of sinus pain. She was advised that if the fistula did not close within a certain time that a procedure would be needed to close it. However, by March 14, 2006, it was noted that there was no opening and the tissue was healthy. On March 23, 2006, the plaintiff underwent a Caldwell-Luc procedure by Dr. Grosso. Dr. Solomon indicated that according to the hospital record, that the plaintiff gave a history of a recurrent and chronic sinus infection, mostly left sided; and that she had a history of an associated dental infection which was resolved with antibiotics. During the Caldwell-Luc procedure, Dr. Grosso noted a large amount of polyps in the left maxillary area. Surgical pathology identified paranasal sinus with chronic inflammation and moderate eosinophilia, with a large amount of polyp disease, hypertrophic mucosa, as well as polyps in the left maxillary antrum without any indiction of infection.

Dr. Solomon continued that on April 28, 2006, the plaintiff returned to Plainview Oral & Maxillofacial Associates and stated that she felt as if her jaw was locked. She was seen by Dr. Tracey Rosenberg who diagnosed her with severe bruxism or teeth grinding, accompanied by clenching of the jaw. Dr. Rosenberg noted there was no sequellae to the Caldwell -Luc procedure, and radiographic examination revealed the TMJ bony structures to be within normal limits. She recommended moist heat, soft diet, a night guard, and a non-steroidal anti-inflammatory for pain. One year later, on April 26, 2007, the plaintiff presented to Dr. Sal Ruggiero, an oral surgeon, for evaluation of left facial pain. Dr. Ruggiero noted that the symptoms of regional pain were not present prior to the sinus surgery, and that there was some injury to the peripheral branches of the alveolar nerve supplying that area. Because the pain localized to the tooth that had apical surgery and was then extracted, the treatment associated with that tooth #14 could not account for the anterior extension of the pain. He recommended that she have the left maxillary teeth evaluated by an endodontist.

Dr. Solomon set forth his opinion that the treatment rendered by Dr. Etess was reasonable at all times, and that it did not proximately cause the plaintiff's alleged injuries. He set forth the dates of treatment and his opinions that the proper procedure and treatments were employed. He continued that the root canal was properly indicated and performed. He stated that there was a question of viability of tooth #14 because the plaintiff had pain in that tooth for six months prior. He also stated that the records and films establish that a fourth canal on the affected tooth #14 was not detectable. Because Dr. Etess did not see the plaintiff for nearly sixteen months after the procedure, and because she had no complaints during that time, that it was not possible for a sinus infection to lie dormant and asymptomatic for sixteen months. On March 18, 2005, when Dr. Etess diagnosed a peridontal abscess on tooth #14, antibiotics were the proper treatment. Instructions to brush and

floss around the crown, as well as prescribing Peridex rinse were appropriate. Dr. Solomon continued that the plaintiff's allegations with regard to the time period from March 22, 2005 through November 29, 2005 are without merit, as the plaintiff was not seen by Dr. Etess nor was there any contact between them. Dr. Etess did not treat the plaintiff on November 29, 2005, as she was seen by Dr. Francis, thus, any claim of malpractice by Dr. Etess on that date is without merit, and there were no signs of infection on that date. Dr. Solomon opined that on December 1, 2005, when Dr. Etess decided to perform an apicoectomy, that the development of the fistula was not related to the periodontal abscess that was previously treated by him, as it is not the normal pathophysiology of a periodontal abscess to turn into a fistula, and that it was separate and apart from the previous periodontal abscess. Additionally, opined Dr. Solomon, fistulas represent localized chronic draining infections that dry up and disappear after endodontic therapy.

Dr. Solomon further opined that just because a root canal is unsuccessful, it is not indicative of malpractice, and that 10% of root canals fail. He also stated that the record reveals that there was no evidence of an infection of the maxillary sinus. The plaintiff did not complain of sinus congestion, dull, achy, constant pain on the left side of her face, pain or pressure in her left eye, facial swelling, or redness and heat sensation on the left side of her face. He continued that there were no signs of infection through December 27, 2005, or on January 6, 2006 when Dr. Etess placed the cross-stick suture at tooth #14. On January 13, 2006, when Dr. Etess saw the plaintiff, she was noted to be doing well. It is Dr. Solomon's further opinion that the plaintiff's complaints of temporomandibular joint disorder and the accompanying complaints were not proximately caused by Dr. Etess' treatment of the plaintiff, but rather the plaintiff's TMJ condition. He continued that the resulting complaints were attributable to bruxism (teeth grinding), clenching of the teeth, lack of use of a night guard to prevent teeth grinding and clenching, despite the same having been recommended.

Dr. Solomon concluded that Dr. Etess obtained the plaintiff's informed consent for both the initial root canal and the apicoectomy in December 2005 as the procedures were fully explained to the plaintiff, including the treatment options and potential risks, and that the plaintiff consented, as would a reasonable person in an attempt to reduce pain, salvage the tooth, and clear up the infection of the tooth.

KENNETH SNEIDER, M.D.

Dr. Kenneth Sneider is a physician licensed to practice medicine in the State of New York and is board certified in otolaryngology. It is Dr. Sneider's opinion that the plaintiff's claim of a causal connection between the oral-antral fistula, or communication, and infection to the area around tooth #14 and her need for sinus surgery on March 23, 2006 is without merit. Dr. Sneider set forth the records and materials he reviewed, and the plaintiff's presentations during her care and treatment by the defendants, and also her visits with Dr. Grosso and the Plainview Oral & Maxillofacial Associates. Dr. Sneider stated that according to the plaintiff's admission history, she had a "chronic headache secondary to chronic sinusitis, mostly left sided. When the Caldwell Luc procedure was performed, Dr. Grosso noted a large amount of polyps in the left maxillary area, and surgical pathology revealed no infection, but instead, paranasal sinus with chronic inflammation and moderate eosinophilia, with a large amount of polypoid disease, hypertrophic mucosa, and polyps in the left maxillary antrum without infection.

Dr. Sneider continued that when Dr. Rosenberg examined the plaintiff for her pain in the bilateral masseter region due to clenching, he determined that the myofacial pain disorder was due to bruxism. Dr. Rosenberg also documented that there was no sequellae to the Caldwell Luc procedure on March 23, 2006. When Dr. Ruggiero, an oral surgeon, examined the plaintiff on April 27, 2007 for evaluation of left facial pain, Dr. Ruggiero noted that the episode of oral antral communication was dealt with by the treating oral surgeon,

and the CT scan taken prior to the sinus surgery revealed thickened mucosa in and around the floor of the sinus and around the pre-molar and molar area. There did not appear to be any changes within the bone itself, which would indicate an infection. The CT scan was significant only for some minor thickening of the floor of the left sinus. A Panorex revealed that the bone in the area of the posterior and anterior maxilla was normal. She was given Lidocaine and Epinephrine which removed all of her tooth pain and gum pain, but she still had tingling sensation of the left upper lip. Dr. Sneider stated that Dr. Rosenberg noted that although the plaintiff had pain localized to the tooth that had apical surgery, which was then extracted, the treatment associated with that tooth #14 could not account for the anterior extension of the pain. He further noted the possibility, that the teeth could be non-viable and thus encouraged her to have the left maxillary teeth evaluated by the endodontist.

Dr. Sneider addressed all of the plaintiff's claims set forth in her bill of particulars, and stated his opinion with a reasonable degree of medical certainty, that there is no causal connection between the oral-antral fistula or communication and infection to the area around tooth #14 and the need for the sinus surgery on March 23, 2008. Dr. Sneider opined that the plaintiff's findings on the CT scan of January 18, 2006 of bilateral mucoperiosteal thickening in the maxillary sinus (adjacent to the oral cavity), ethmoid sinuses, complete opacification of the left frontal sinus and mucoperiosteal thickening in the right frontal sinus, are consistent with chronic sinusitis, also known as rhinosinusitis. Dr. Sneider continued that sinusitis refers to inflammation of the sinuses, and is not necessarily infection of the sinuses. It is Dr. Sneider' opinion that the plaintiff suffered from chronic sinusitis which manifested inflamed sinuses, not infected sinuses. Dr. Sneider opined that there is absolutely no evidence from the operative report and pathology report from the March 2006 surgery that an infection had spread, or was even present in the sinuses. He stated that inflamed polypoid tissue, and hypertrophic mucosa, is typical inflammation observed with patients with sinusitis. The revelation in the pathology report was that of eosinophilia, which is a white blood cell indicative of allergic and other types of reactions. He continued that had there been an infection present in the sinuses, that neutrophils would have been present, as they are the white blood cells which create pus and ingest and kill bacteria. The absence of the neutrophils is indicative that there was no infection of the sinus. Additionally, if plaintiff's sinusitis involved a dental infection that spread to the maxillary sinus, the area of infection would have been seen only on the left side, however, the CT and the record revealed inflamation on both sides. Dr. Sneider concluded that it is an impossibility for an infection to have spread from the left side sinus to the right side of the face as there is no anatomical connection between the sinuses on the left and the right. Dr. Sneider concludes that Dr. Etess' treatment of the plaintiff did not proximately cause the plaintiff's claimed injuries.

Based upon the foregoing, it has been established prima facie that the moving Etess defendants did not depart from good and accepted standards of dental care and treatment, that they provided proper informed consent to the plaintiff, and they did not proximately cause the injuries claimed by the plaintiff.

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see*, ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]). "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions. Such credibility issues can only be resolved by a jury" (***Bengston v Wang,*** 41 AD3d 625, 839 NYS2d 159 [2d Dept 2007]).

In opposing this application, The plaintiff has submitted, inter alia, the affirmations of Thomas W. Manders, D.D.S.; Richard Lechtenberg, M.D.; Michael S. Morris, M.D.; the affidavits of Carol Drago; as well as numerous uncertified medical records and literature.

Based upon a review of the plaintiff's submissions, it is determined that the plaintiff's experts offer opinions with regard to the many alleged departures from the standards of care by Dr. Etess and proximate cause of the alleged injuries to plaintiffs. Thus, triable issues of fact are presented which warrant denial of defendants' motion for summary judgment.

THOMAS W. MANDERS, D.D.S.

The plaintiff's expert, Thomas W. Manders, D.D.S. affirms that he is licensed to practice dentistry in New York and Connecticut, and that he specializes in Endodontics. Dr. Manders set forth the records and materials which he reviewed and stated his opinions within a reasonable degree of medical certainty. Dr. Manders set forth the dates that Dr. Etess allegedly departed from the dental standard of care from November 24, 2003 through January 6, 2006. Dr. Manders opined that Dr. Etess departed from the standard of care as he missed a root canal at tooth #14; failed to incise and drain a periapical abscess, failed to consider the source of infection involving tooth #14, and prescribed an ineffective antibiotic on March 18, 2005; between March 2005 and October 2005, Dr. Etess inappropriately treated the periapical abscess at tooth #14 permitting it to spread, resulting in erosion into the palate of the mouth, causing a fistula and thin bone of the maxillary sinus and infection into the maxillary sinus; failed to trace the fistula to the apex of the tooth and drain it, failed to perform scaling, or irrigating of the fistula; failed to timely perform an apicoectomy on December 1, 2005; inappropriately prescribed a high dose of steroid medication; failed to consider or rule out that the infection traveled to the maxillary sinus; failed to timely refer Ms. Drago to an ENT specialist on December 17, 2005; and failed to remove tooth # 14 permitting the migration of infection into the sinus and oral cavity on December 27, 2005, January 3, 2006 and January 6, 2006.

Dr. Manders continued that on March 22, 2005, Dr. Francis noted redness and swelling in the area of tooth #14 and prescribed an antibiotic. Months later in November 2005, Ms. Drago experienced a foul taste in her mouth, which he stated, is consistent with a chronic abscess. Dr. Manders then opined that on December 1, 2005, Dr. Etess noted a draining fistula (at tooth # 14) but failed to trace the fistula to the source of the infection, which was the apex of the root canal. He continued that Dr. Etess then failed to do scaling and root planing, or irrigation of the apex of the root and the fistula after he removed the infection via incision and drainage. Then, he stated, on December 16, 2005, Dr. Etess failed to administer an appropriate antibiotic before he performed the apicoectomy.

Dr. Manders continued that the fourth root of the tooth, the mesial buccal root, sits within the maxillary, and was allowed to proliferate and spread into the maxillary cavity. Because Ms. Drago felt burning in her eyes and nose, it is established that there was a communication between the root and the maxillary sinus. He then continued that she should have been treated with Clindamycin instead of Biaxin, which are both antibiotics, but does not opine that the Biaxin was not effective and that the alleged organism which was being treated was not sensitive to Biaxin. She was seen again by Dr. Etess on December 19, 2005 and on December 23, 2005, at which time she complained of pain and numbness on the side of her face. Dr. Manders opined that the pain and numbness should have cleared by the third or fourth post operative day. Ms. Drago's last visit with Dr. Etess was on January 13, 2006. Dr. Manders opined that because Dr. Etess did not refer Ms. Drago to an ENT specialist, it was a deviation from the standard of care. Dr. Manders continued that on January 18, 2006, Dr.

Ben-Moha ordered a CT scan of the sinus due to an episode of dizziness and due to pain in her mouth. Dr. Manders stated that the CT scan was consistent with sinusitis.

MICHAEL S. MORRIS, M.D.

Plaintiff's expert, Michael S. Morris, M.D., avers that he is licensed to practice medicine in Maryland, District of Columbia, and Delaware, and specializes in otolaryngology medicine. Dr. Morris set forth the materials and records which he reviewed and opined with a reasonable degree of medical certainty that Carol Drago suffered an odontogenic infection originating from an abscess located in the maxillary first molar tooth which then involved the left maxillary sinus, while under the care of Dr. Etess. He opined that the Caldwell-Luc procedure performed by Dr. Grosso was done to remove the diseased tissue in the left paranasal sinuses which became diseased as a result of the odontogenic infection. He stated that an odontogenic infection in the maxillofacial region is one whose primary cause is dental in origin, such as periodontal and peri-apical infections.

Dr. Morris set forth the dates and events which he opined were departures from the standard of care by Dr. Etess. He stated that Ms. Drago had a chronic abscess and draining fistula which was diagnosed by Dr. Francis in November 2005, which was directly related to, and a continuation of an untreated "peri abscess" that Dr. Etess diagnosed on March 18, 2005. Significantly, stated Dr. Morris, on December 1, 2005, Dr. Etess again missed the opportunity to provide timely and appropriate treatment by performing an apicoectomy to remove the source of infection, and then waited fifteen days to perform the apicoectomy, allowing the infection to spread, although he was aware that the infected mesial root was sitting within the maxillary sinus. Thereafter, Dr. Morris stated that the infection involving the root of the left first maxillary molar had already invaded and infected the left maxillary sinus by December 1, 2005, and possibly sooner. It is also Dr. Morris' opinion that on December 1, 2005, up to and including the last encounter with Dr. Etess on January 13, 2006, that the acute sinusitis had become chronic because Dr. Etess' treatment was inadequate and required concurrent consultation with a maxillofacial or otolaryngeal specialist.

Dr. Morris asserted his disagreement with the statement of Dr. Etess's expert, Dr. Schnieder, that the operative report and the pathology report did not show evidence of an infection, or that infection was present. Rather, Morris asserts that Ms. Drago had been treated with antibiotics prior to the surgery. He continued that Ms. Drago's medical records do not indicate that she had any allergies and that the presence of eosinophils in the report of the Caldwell-Luc surgery, indicative of allergies, could be triggered by asthma which Ms. Drago stated she had, and that it does not necessarily mean that she had allergies.

RICHARD LECHTENBERG, M.D.

Richard Lechtenberg, M.D. has submitted a notarized affirmation wherein he set forth that he is licensed to practice medicine in New York, New Jersey, and Maryland and specializes in neurology. He set forth the records and materials which he reviewed and opined with a reasonable degree of medical certainty that as a result of the negligent care and treatment by the defendants Etess and Francis, that Ms. Drago sustained a form of trigeminal neuralgia involving several branches of the nerve, manifested by left-sided facial nerve pain, left sided upper jaw tooth pain and sensitivity, left-sided facial muscle weakness, and muscle tics/spasms. He continued that the trigeminal rhizotomy performed by Dr. Mitchell E. Levine was performed in an attempt to alleviate some of the left-sided facial and oral symptoms Ms. Drago experienced after conservative treatment did not help.

Dr. Lechtenberg stated that the nerve can become damaged or injured as a result of an infected tooth, sinus infections, shingles, post herpetic neuralgia, multiple sclerosis, tumors, or an abnormal vein or artery that compresses the nerve. Inflammation and infection of the sinuses or tooth, if invasive and persistent, will cause a deterioration of the protective sheath of the nerve and send abnormal messages along that nerve, and cause pain. Dr. Lechtenberg stated that based upon his review of the records and the affirmations of Dr. Manders and Dr. Morris, that Ms. Drago suffered from a sinus and tooth infection involving the left side for a significant period of time. Dr. Lechtenberg continued that the plaintiff's complaints of left-sided cheek, eye, and tooth pain, and left lip numbness and pain, became pronounced in December 2005.

Based upon the foregoing, plaintiff's experts have demonstrated the existence of a triable issue of fact by submitting expert evidence attesting to a deviation or departure from accepted practice, and containing an opinion that the defendants' acts or omissions were a competent-producing cause of the injuries of the plaintiff.

That part of the defendants' application with regard to CPLR 214-a has been rendered moot by plaintiffs' Bill of Particulars, confirmed in their Affirmation in Opposition, that they do not allege that the defendants Jeffrey M. Etess and Jeffrey M. Etess, D.M.D., P.C., performed any negligent dental care and treatment prior to March 8, 2005, well within the statutory two years and six months limitation of time applicable here.

Accordingly, motion (002) by Jeffrey M. Etess, and Jeffrey M. Etess, D.M.D., P.C., for summary judgment dismissing the complaint as asserted against them is denied.

Dated: DECEMBER 28, 2012.

J.S.C.

____ FINAL DISPOSITION ___X___ NON-FINAL DISPOSITION