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Simba Taylor-Austin: Evaluation of medical records for oral treatment and follow-up starting December 16, 2008

I am providing the following evaluation of the medical records for Simba, a 13yr old, spayed female, Domestic Shorthair cat, owned by Lisa Taylor-Austin. Simba had extensive oral surgery/extractions done at Silver Sands Veterinary Center and had a difficult recovery period with lack of appetite (anorexia) the first few days she was home. Simba was readmitted to SilverSands Veterinary Center for further treatment and developed a respiratory infection while at the hospital being treated for her anorexia. The client was not allowed visitation during this time. After 10-11 days in the hospital Simba had improved and was sent home. She continued to have a decreased appetite and rocky recovery. Simba was re-evaluated 7 days later at the Silver Sands Veterinary Center and an esophageal feeding tube was placed and she was referred to VCA Veterinary Referral and Emergency Center where she was evaluated and diagnosed with early kidney failure. I have been asked to review the records as an expert, in veterinary dentistry, for appropriateness of the dental treatment and management of the case (post operatively). I am a board certified veterinary dentist as a Diplomate of the American Veterinary Dental College. I have been focused in veterinary dentistry for 30 years and a specialist since 1989. I am a co-author of a veterinary dental textbook and currently present several seminars a year on dental topics for veterinarians and technicians in Portland, Oregon, Washington state and California. I also continue to treat small animal dental patients at several veterinary hospitals in Vancouver, Washington, Portland, Oregon metro area and Fresno, California.

Simba, was presented to Dr. Donald DeForge at Silver Sands Veterinary Center, 17 Seemans Lane, Milford, Connecticut for evaluation of her mouth on 12-15-2008. Her owner sought out Dr. DeForge specifically since he advertised as a dental specialist.

Dr. DeForge is not a board certified dental specialist. He is a Fellow of the Academy of Veterinary Dentistry, showing he only has a special interest in dentistry. (A Fellow of the

Academy of Veterinary Dentistry is a veterinarian who has had additional training in veterinary dentistry and has passed a credentialing process and examination to achieve Fellow status.)[1]

Dr. DeForge's initial assessment of Simba in his records indicates he was suspicious of odontoclastic resorptive lesions, which can be common in aging cats. Dr. DeForge recommended a preanesthetic work up, general anesthesia and a full oral evaluation with recommendations for treatment based on these findings. A full physical exam was not noted if one was done. "CAUTION" was noted on the record and ket/val sedation (ketamine/valium) was noted in order to obtain blood for the preanesthetic screen. No indication of dose or route of administration for this sedation is present in the records. (Ket/Val) sedation is not uncommon to use in order to safely obtain a blood sample in an anxious cat. Dosages should be noted in the record. In an older cat, staying in the hospital giving fluid support with subcutaneous fluids or placing an intravenous (IV) catheter and maintaining supportive IV therapy overnight would be my approach to treating a 13yr old cat prior to an extensive dental procedure.

A full blood screen was done which would be normal protocol for a 13yr old cat. He also ran additional viral and toxoplasmosis screening. These tests are less valuable in an aged cat that has been indoors and does not present with oral inflammation or other illness concerns, in my opinion. The blood work results were normal except a moderate elevation of amylase at 1625U/L (normal 100-1200U/L) and Cholesterol at 290mg/dl (normal is 75-200mg/dl). Amylase is non specific in cats and with normal clinical signs and other blood parameters would not be a reason not to proceed with treatment. A urinalysis was not done which could have given additional baseline information about her kidney function in a 13yr old cat.

According to the anesthetic sheet in Simba's record she had only received 11ml of fluid by the first hour of her procedure. Standard fluid therapy is recommended to be 10ml/kg for the first hour and then 5ml/kg for additional hours if the blood pressure is adequate[2]. For Simba at 10.6lbs/4.8kgs that would mean her fluid rate should have been 48ml/hr.

The anesthetic record documented Buprinex (an analgesic) at the beginning and completion of surgery and no additional narcotic pain medication. No local/regional blocks were documented in the record. (Use of regional/local blocks among veterinary dentists is variable and a personal preference. Simba was sent home the same day after her oral surgery on oral gabapentin to be given in food for 15 days. In my opinion, this is inadequate pain management for even a few extractions. Options could have been oral buprinex which is easily administered or a fentanyl patch which can provide 4-5 days of pain relief to a cat without the need for oral dosing. I have used both of these options for my patients with good results and comfortable patients. I also use regional blocks for any extractions in each quadrant for additional intraoperative and post operative pain management. For older cats it is often preferable to support their kidney function around a long dental procedure with post operative IV fluid treatment for several

[1] AVDonline.org homepage
[2] DiBartola, SP. Fluid therapy in Small Animal Practice. Philadelphia, Saunders:2000.

hours or overnight. If the patient is not tolerating the catheter, a good bolus dose of subcutaneous fluids can be given, if the cat is to be sent home.

The dental record portion of the record has incomplete information of what was going on in Simba's mouth. Many notations are more radiographic findings versus clinical appearance of the teeth and gingiva, making it unclear what the indication was for the extraction procedures done. The mandibular incisors and left caudal maxillary teeth and canine are marked as being extracted with an X over the teeth on the dental chart. For these teeth, there is no indication on the chart of mobility, resorptive lesions, probing depth measurements, or gingivitis noted, just the radiographic findings. When I chart a cat's mouth I note amount of calculus, gingival inflammation present, mobility present, furcation exposure and degree, if present, presence and stage of tooth resorptive lesions, probing depths over 1mm, crown damage or discoloration, mucosal inflammation, oral masses, gingival enlargement or boney enlargement. In cats I also note whether the canine teeth appear to be extruded or super erupted, which is a common finding in older cats. Separately, I note and summarize the radiographic findings. All of these findings along with radiographic evaluation are used to determine which treatment option is most appropriate. Determination of whether a tooth is to be extracted or not is often based more on the clinical findings of early stage tooth resorption or gingival recession and excessive inflammation of the soft tissues. In my opinion, the dental record is below the standard of care for indicating the need for extractions.

Full mouth digital radiographs were done. The radiographic interpretation was noted on the chart of root resorption, apical osteolysis and horizontal bone loss. Two views were foreshortened masking full interpretation of the left maxillary quadrant and rostral maxillary view of the canine teeth. There are some more lucent areas of the crowns on the maxillary R caudal view of tooth 108, 107 (3rd and 4th premolar) and tooth 407, 408 (right mandibular third and fourth premolar) that could be consistent with early stage tooth resorption if there was a clinical finding of a lesion with loss of tooth substance. Sometimes these radiographic changes are present without clinical lesions and can be related to the high contrast and slight overexposure as seen with these images. The dental chart notes resorptive lesions, horizontal bone loss and odontoplasty for the mandibular right caudal teeth (407, 408, 409). Odontoplasty is removal of sharp edges, points or incisal tip of the crown and can expose the dentin as the enamel is very thin in cats. To protect dentin that becomes exposed it is preferable to apply a dentin sealant. Odontoplasty of the sharp points of the mandibular molar and premolar can be done to minimize contact and trauma to the maxilla when maxillary teeth are removed. Aggressive odontoplasty can inadvertently lead to exposure of the pulp tissue with pain and infection the outcome for the patient. A notation of a dentin sealant is not present and in post operative photos of Simba's mouth taken in May of 2009, the caudal mandibular teeth are not present.

The 80% attachment loss noted with the mandibular incisors should have correlated to mobility and irregular spacing of the teeth which is not seen on the radiographs or noted on the chart. The apparent loss of attachment noted can also be related to the dark contrast and quality of the image burning out what little bone is present around these small teeth. All the caudal teeth

noted with root resorption have visible periodontal ligaments and normal root density consistent with a Type 1 resorption pattern if clinical crown/neck lesions were present. The roots of 207 (left 3rd maxillary premolar) are not clearly visible on the images available. If clinical, early enamel and dentin lesions associated with feline tooth resorption or significant gingival recession for these caudal maxillary teeth were present then extraction would be indicated. These were not noted on the dental chart. By just by the radiographic images, I do not see sufficient reason to extract 309, 308, 407, 408, 409, 207, 208, 209. The maxillary canine teeth 104-204 do show some apical (root end) resorptive changes with decreasing density and streaking and an abnormal outline of the root. The image is foreshortened (a shorter appearing root) and the oblique view of the left canine (204) is also foreshortened. There is no periodontal pocketing, alveolar osteitis or super eruption noted on the dental chart just; a fractured crown of 204. There is a mild tip fracture of 104 visible on the radiograph. The oblique views of 204 appear to have a normal tip. Without clinical findings these apical resorptive changes are being found commonly in aging cats and don't necessarily indicate a need for extraction. There is no radiographic evidence of osteomyelitis in my opinion, as noted on the treatment summary page.

It is not uncommon to find various dental problems such as bone loss and resorptive lesions in a 13yr old cat. If lesions were present they were at a very early stage as there is little evidence of the tooth destruction that will be visible with advanced lesions on the dental radiographs. Once lesions are noted and involve the dentin of the tooth and can be detected on visual and/or tactile exam with an explorer, extraction is recommended. Resorptive lesions are progressive in their destruction of tooth structure over time and can lead to more discomfort and difficulty eating in the future.

For the record material provided, the documentation of the oral status of Simba's mouth on 12/16/08 is inadequately recorded to show the need for extraction of all the teeth except the mandibular canines and maxillary incisors. The records do not even clearly state that all of these teeth were extracted yet post operative photos taken in May of 2009 show only the mandibular canine teeth and maxillary incisors as being present. Bone augmentation was noted in the summary discharge sheet and bill but was not noted in the dental record or what product might have been used. Bone augmentation is the placement of material in the alveolar sockets post extraction to support bone healing. Several different products and materials are available for this step and the one used should be clearly documented in the record.

Post operatively Simba was confined to a small bathroom and then a dog crate, per Dr. DeForge's recommendation, with an Elizabethan collar and was not eating. Since she was to be given her pain medication in her food this meant that for the first 2 days post operatively she was not getting adequate pain management and may not have been taking in much water either. She was taken to Silver Sands Veterinary Center to be rechecked and was admitted for intravenous treatment and medication either late 12/18/08 or 12/19/08. At this visit there is no record of physical exam or oral evaluation 3 days post op. It is unclear if intravenous fluids were given as a type and rate are not listed on the order sheet. Simba was given one dose of Lasix according to the daily hospitalization record. IV Buprinex pain medication,

Dexamethasone (a corticosteroid) and Cefazolin (an antibiotic) and intravenous valium for appetite stimulation were given and she was noted to be eating 3 days later on 12/22/08. It appears that she was improving until she developed a suspect upper respiratory infection with congestion and sneezing. She was started on treatment and moved to the isolation ward. She was apparently improving and discharged on 12/29/08. No mention on the condition of her mouth is noted anywhere in the chart. In my experience most cats with extractions are eating well within the first few days of the procedure with adequate pain management and can often return to a dry kibble diet if they choose by 10 days post operative. I have had some patients eat kibble prior to that. Intravenous fluid therapy would have been crucial in supporting her hydration and kidney function while she was anorexic during her post operative recovery.

Simba was not current on her vaccinations, being an indoor only cat, and with several days of hospitalization after her oral surgery she was suspectible to a respiratory infection. Since she was placed in the isolation ward it seems that this was the concern versus a sinusitis which is mentioned later in the record when Simba was being taken to the VCA clinic. These consequences may have been avoidable if Simba had received adequate post operative pain management and fluid treatment in the first place. With older cats I prefer to have intravenous fluids prior to the procedure, during the procedure at an adequate rate and after to maintain hydration and maintain blood pressure during the anesthetic and after the procedure to maintain kidney function, even with normal preanesthetic values. If overnight hospitalization is not feasible then a loading dose of subcutaneous fluids should be given to provide fluid support until the cat is drinking on their own. In my experience multiple tooth extractions in a cat can be handled quite comfortably. I have not found the need to send home cats with an Elizabethan head collar post operatively. This can be a deterrent to eating and drinking for many cats. When a cat is reluctant to eat within the first few days I reevaluate pain management and antibiotic treatment. Baytril (an antibiotic) was dispensed post operatively to be placed in the food. This is not the preferred antibiotic for oral infections. It is most easy to give a liquid Clavamox antibiotic which is well accepted by most cats or a liquid Clindamycin antibiotic if more deep seated infection is present.

There are several notations in the record showing concern for the owner to be giving Simba medications etc if the cat was uncooperative where she might be scratched. In the record the owner was noted to be on Coumadin. As I have noted previously, if this were a valid concern there are several options for pain management with a fentanyl patch and easily dosed liquid antibiotics and/or Buprinex that could have been used for Simba in the post operative period. The client was not able to visit Simba during her long hospitalization. There are no record notations concerning visitation, just progress updates. Veterinary hospitals I have worked in generally allow visitation by clients of their pets, even when in isolation, if proper precautions are taken.

The subsequent lack of appetite and poor recovery after returning home from her hospital stay with eventual diagnosis of renal failure by the VCA clinic were symptoms of her changing kidney function status. Whether these changes were brought on by the oral surgery, post operative

dehydration, post operative upper respiratory infection or a combination of all three, Simba is fortunate that she came through the whole episode and is still hanging in there.

Summary of problems:

1. Dr. DeForge's appearance/advertising as a dental care specialist when he isn't.
2. Below the standard of care for recording of physical examination/s and oral/dental findings on dental chart and record and other medical treatments.
3. Inconsistent radiographic interpretation of dental disease.
4. Misrepresentation of seriousness of Simba's dental disease to owner.
5. Inadequate information provided in dental chart to document need for extractions.
6. Incomplete recording of dental treatment provided.
7. Poor post operative pain management for the extent of oral surgery done.
8. Inadequate patient support with fluid therapy (pre, intra and post-operatively.)

Respectfully,

Patricia Frost Fitch

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Jordan J Brown

JORDAN J. BROWN
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
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Disclaimer:

“Lisa Taylor-Austin believes there was merit to her claims that Dr. Deforge negligently cared for her cat, Simba, and that he misrepresented whether he was a Board-certified dental specialist. Dr. Deforge denies these claims and asserts that the Department of Public Health’s veterinary board cleared him of any wrong doing. However, Dr Deforge agreed to pay $7,500.00 to compensate Ms. Taylor-Austin because he believed the risks inherent in any lawsuit and the cost of missing two weeks from his practice made it imprudent to go to trial.”

Note: My guardian’s costs for my medical care and all legal avenues exceeded $20,000.