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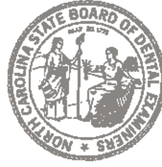

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June 11, 2019

CERTIFIED/RETURN RECEIPT MAIL

Dr. Christopher T. Durusky
16 Rolling Meadows Lane South
Chapel Hill, North Carolina 27517

Dear Dr. Durusky:

The Investigative Panel ("IP") of the North Carolina State Board of Dental Examiners ("Board") has completed its review of all materials and documentation presented at the Pre-Hearing Conference of Monday, February 11, 2019 regarding (i) a malpractice report submitted to the National Practitioner Data Bank (NPDB) following the settlement of a claim against you on July 27, 2017; and (ii) an evaluation of additional patient charts as a result of the IP's investigation.

The investigation establishes that the standard of care was not met when providing endodontic treatment to the following patients:

- Patient KB: On April 22, 2014, you diagnosed KB with carious exposure on tooth #15 and recommended endodontic treatment. The clinical chart notes indicate that four canals were located but only three were instrumented. On April 30, 2014, KB returned to your office for root canal therapy. Obturation of only three canals was performed with ProTaper thermoplastic obturators, resulting in significant radiographic voids in all three canals.

- Patient SC: On March 22, 2014, SC presented for endodontic treatment of tooth #15. You diagnosed her with irreversible pulpitis with symptomatic apical periodontitis, but there were no chart notes or clinical diagnosis to justify the diagnosis. Three canals were located, but the working length radiograph only indicated two canals. On June 17, 2014, SC returned to your office for obturation

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of tooth #15. You used ProTaper thermoplastic obturators. The final radiograph indicates inadequate obturation with voids and the palatal canal was short by approximately 3 millimeters.

- Patient OS: OS presented to your office for endodontic treatment of tooth #10 on June 24, 2014. Your clinical notes for this patient do not reflect that you performed any pulpal testing or clinical evaluation for your diagnosis of irreversible pulpitis with symptomatic apical periodontitis. On July 1, 2014, OS returned for the obturation of tooth #10. You used ProTaper thermoplastic obturators. The final radiograph indicated significant overfill, and no explanation was provided in the patient's chart.

- Patient LW:
    - Patient LW presented to your office initially on October 30, 2013 for evaluation of a periapical radiolucency at tooth #7. At this time, tooth #7 responded normally to Endo Ice with no other significant findings. LW returned to your office on May 7, 2014 with discomfort upon pressure of tooth #7. You recommended endodontic treatment of the tooth, but there was no additional testing or pulpal reevaluation noted in the chart. On May 23, 2014, LW returned to your office to initiate endodontic treatment of the tooth with no additional clinical testing or pulpal reevaluation. You diagnosed her with irreversible pulpitis with symptomatic apical periodontitis. The clinical chart notes indicated you located four canals when tooth #7 only has one canal. You completed the obturation of tooth #7 on May 31, 2014 using ProTaper thermoplastic obturators with significant overextension of sealer and obturator and no clinical notes notifying the patient of the situation.

    - Patient LW returned to your office on December 3, 2014 with discomfort upon pressure of tooth #8. You made no notations regarding pulp testing or clinical evaluation, but you diagnosed tooth #8 with necrotic pulp with symptomatic apical periodontitis. On December 19, 2014, LW returned for instrumentation of tooth #8 and there was still no mention of clinical evaluation or testing. Patient LW returned for obturation of tooth #8 on

January 6, 2015 using ProTaper thermoplastic obturators. There was significant overextension of sealer and obturator due to loss of minor constriction as a result of external apical resorption. No clinical notes indicated LW was informed of the situation. On May 13, 2015, LW returned with complaints of tenderness to tooth #8 with biting pressure. No clinical testing or pulpal evaluation was noted.

- On March 2, 2017, patient LW returned with a history of retreatment and apicoectomy of teeth #7 and #8 completed in the past. LW decided upon extractions and implants at teeth #7 and #8. The clinical notes were acceptable, but there were significant charting errors including: number of canals, clinical testing, pulpal evaluation, recommendations to the patient with overextension, and a discussion of implants following retreatment and apicoectomy.

- In July 2017, your insurer agreed to a settlement with LW concerning your treatment. The settlement was reported to the NPDB. As a result of the settlement, you proactively elected to take continuing education courses to rectify the situation.

Based on the information available, the Board concluded that your endodontic treatment and recordkeeping prior to 2017 for the patients listed above violated the standard of care and N.C. Gen. Stat. § 90-41(a)(12). For this reason, the Board proposes to officially reprimand you. An official reprimand would include a copy of this letter being placed in your permanent file, notification of the reprimand being sent to the NPDB, and a copy of the reprimand placed on the Board's web page for approximately 3 months. A copy of the reprimand would also be available to the public, upon request, at any time.

If you do not wish to accept this reprimand, you may request a formal hearing. The request must be in writing, made within 30 days of your receipt of this letter. If you desire to accept the reprimand, please do so by signing below and returning the original letter to the Board office. You should keep a copy for your own records.

If you have any questions or need additional information, please do not hesitate to contact the Board office. Thank you for your cooperation with the Board during its investigation of this matter.

Very truly yours,

Betty A. Sines

Betty A. Sines
Investigations Coordinator

ACCEPTED:

Christopher T. Durusky, D.D.S.

6/14/2019
DATE

July 26, 2019
DATE EXECUTED

cc: Case Officer
Crystal S. Carlisle, Esq. - Board Counsel