SHORT FORM ORDER

INDEX No. 02-16320
CAL. No. 06-02581-MM

SUPREME COURT - STATE OF NEW YORK
POST-NOTE MOTION PART - SUFFOLK COUNTY

PRESENT:

Hon. ROBERT W. DOYLE
Justice of the Supreme Court

MOTION DATE 3-20-07
ADJ. DATE 5-10-07
Mot. Seq. # 004 - MD

JEANETTE D'ANDRAIA, as Administratrix of the Estate of ANTHONY D'ANDRAIA deceased, and JEANETTE D'ANDRAIA, individually, Plaintiff, - against - ANTHONY PESCE, M.D., Defendant.	DUFFY, DUFFY & BURDO Attorneys for Plaintiff 1370 Reckson Plaza Uniondale, New York 11556-1370 SILVERSON, PARERES & LOMBARDI, LLP Attorneys for Defendant 300 East 42nd Street New York, New York 10017

Upon the following papers numbered 1 to 24 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1 - 12; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 13 - 24; Replying Affidavits and supporting papers ___; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that this motion (004) by defendant Anthony Pesce, M.D. for an order pursuant to CPLR 3212 granting summary judgment dismissing plaintiff's complaint, opposed by plaintiff, is denied

The complaint of this action sets forth causes of action sounding in medical malpractice and lack of informed consent on behalf of plaintiff's decedent, Anthony D'Andraia, and a cause of action for loss of consortium on behalf of his wife, Jeanette D'Andraia. This action is based upon plaintiffs' claims that defendant Anthony Pesce, M.D. delayed and failed to properly diagnose and treat decedent for cancer of the prostate from June, 1999 through June 20, 2001, which cancer metastasized and caused Anthony D'Andraia to die on February 8, 2004.

Defendant alleges there were no departures from the appropriate medical standards of care and treatment of plaintiff by defendant Pesce, and that nothing he did or did not due caused the injuries claimed by plaintiff.

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[2nd 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 [2nd 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 [2nd Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2nd Dept 1994]).

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 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 (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must present facts sufficient to require a trial of any issue of fact by producing evidentiary proof in admissible form (***Joseph P. Day Realty Corp. v Aeroxon Prods.***, 148 AD2d 499, 538 NYS2d 843 [2nd Dept 1979]) and must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.***, 79 AD2d 1014, 435 NYS2d 340 [2nd Dept 1981]). Summary judgment shall only be granted when there are no issues of material fact and the evidence requires the court to direct a judgment in favor of the movant as a matter of law (***Friends of Animals v Associated Fur Mfrs.***, 46 NY2d 1065, 416 NYS2d 790 [1979]).

In support of motion (004), Anthony Pesce, M.D. has submitted, inter alia, copies of the pleadings and bill of particulars; copy of the office record maintained by defendant Pesce for decedent; and the affirmation of defendant's expert urologist, Noel A. Armenakas, M.D.

Noel A. Armenakas, M.D. affirms he is a physician duly licensed to practice medicine in New York State and is board certified in Urology. He states he reviewed the pleadings, deposition transcripts,[1] and medical records pertaining to the care and treatment rendered by Dr. Pesce to plaintiff Anthony D'Andraia, and based upon the same, states it is his opinion with a reasonable degree of medical certainty that Dr. Pesce's care and treatment of Anthony D'Andraia was proper and within accepted medical

---

[1] The moving defendant has not submitted a copy of the deposition transcripts with the supporting papers.

standards, and that no action or inaction by Dr. Pesce caused the injuries claimed by Mr. D'Andraia.

Dr. Armenakas states that Mr. D'Andraia, had recently moved to New York, and on January 1, 1999, was seen by Dr. Pesce who performed a complete physical examination, took a full medical history, and noted that plaintiff requested prescriptions for his antihypertensive medications. Mr. D'Andraia gave a history of benign prostatic hypertrophy, which states Dr. Armenakas, means he had an enlarged prostate. Defendant's expert sets forth that plaintiff did not have any complaints or symptoms relating to his urinary tract, urination or prostate at this time, and there was no family history of prostate cancer.

Mr. D'Andraia next saw Dr. Pesce on February 15, 1999, March, 18, 1999, April 14, 1999, and May 6, 1999, which Dr. Armenakas states were visits related to plaintiff's heartburn and abdominal bloating after being treated for H. pylori in Florida, anxiety, elevated blood pressure and hypertension. There were no complaints or symptoms related to his urinary tract, urination or prostate on any of these visits. At an office visit on June 7, 1999, Dr. Pesce noted that a dipstick test of plaintiff's urine showed trace proteinuria and the urine was sent to the laboratory for analysis.

On June 17, 1999, Mr. D'Andraia returned to Dr. Pesce for an acute visit, with complaints of a coin-sized blood stain in his underwear after having intercourse with his wife. Dr. Armenakas states this is the first time plaintiff made a complaint to Dr. Pesce about any urinary symptoms. He states Dr. Pesce examined plaintiff and noted there was no discharge, open wounds or bleeding from his uncircumcised phallus, the prostate was nontender, without any significant nodules or enlargement appreciated, and there was no rectal mass. A Prostate-Specific Antigen (PSA) test was taken on that date with a result of 3.1 which Dr. Armenakas states was within the normal range of 0-4.

Thereafter, Mr. D'Andraia returned to Dr. Pesce on July 8, 1999 for follow-up regarding hypertension. On August 4, 1999, he requested Ativan for symptoms of panic attacks for which Dr. Pesce treated him. On the visit of October 26, 1999, plaintiff complained of gastroenterolgy symptoms and requested Prilosec, which Dr. Pesce prescribed along with instructions about diet and food to avoid. Plaintiff returned to Dr. Pesce on November 2, 1999 at the request of Dr. Pesce to discuss abnormal liver function tests and plaintiff's use of 20 different herbs and vitamins, which after examination, Dr. Pesce recommended Mr. D'Andraia discontinue except for a multivitamin and Vitamin E. On November 18, 1999, Mr. D'Andraia returned with complaints of nasal and respiratory symptoms.

At the office visit with Dr. Pesce on March 3, 2000, Mr. D'Andraia complained of worsening sexual function, which Dr. Armenakas opined was not necessarily related to prostate problems and that blood pressure medications such as the one which plaintiff was taking, can cause sexual dysfunction.[2]

By telephone on March 16, 2000, Dr. Pesce recommended to plaintiff that he discontinue all of his herb supplements due to elevated blood levels.[3] Plaintiff was again seen on April 3, 2000 with no prostate complaints, and on April 28, 2000, Dr. Pesce noted plaintiff was "totally asymptomatic" and did not have

---

[2]Dr. Armenakas did not set forth the name of the blood pressure medication Mr. D'Andraia was taking at the time.

[3]Dr. Armenakas did not state which blood levels were elevated or which herbs plaintiff was taking.

any complaints or symptoms relating to his urinary tract, urination, blood in the semen or prostate.

However, Mr. D'Andraia was seen on May 17, 2000 by Dr. Pesce who noted that Mr. D'Andraia noted a drop of blood on his underwear two days ago and that he "minimizes the dysuria he had for one week which he stated was quite mild as though there was a small irritation on the head of his penis. He denied any systematic discharge. Physical and rectal examinations revealed a nontender prostate and no mass on rectal examination, urine dipstick test was negative for blood, urinalysis and culture and sensitivity were ordered and later found to be negative without any abnormal findings. He was directed to call if there was any recurrence of blood. Dr. Armenakas opined that even though plaintiff complained of a drop of blood on his underwear, it was unclear whether the blood had come from patient's penis and it was appropriate for Dr. Pesce to believe that plaintiff may have had a prostate infection for which Dr. Pesce appropriately ordered a urinalysis and culture and sensitivity, all of which were negative.

On July 19, 2000 and August 21, 2000, Dr. Pesce saw plaintiff for complaints unrelated to his urinary tract, urination, blood in the semen or prostate.

However, on September 12, 2000, plaintiff returned with a complaint of a lump in the axilla and an inability to maintain an erection for the prior two to three months. Physical examination revealed a right axilla without lymphadenopathy. Blood tests were ordered and Viagra was prescribed. On December 21, 20000, plaintiff presented "acutely complaining of some penile urethral burning after intercourse" but denied blood in the ejaculate. Physical and rectal examinations by Dr. Pesce revealed no lesions of the genitalia and no mass, his prostate was slightly tender, symmetric and without nodules. Dr. Pesce's assessment was probable non-gonococcal urethritis. A PSA test was taken and the level was 4.4. There was a SED rate of 1. Defendant's expert opines that it was within accepted standards of medical care for Dr. Pesce not to suspect cancer on December 21, 2000, that Dr. Pesce appropriately performed a rectal examination which it was determined the prostate was symmetrical and without nodules. Defendant's expert further opined that every elevated PSA is not indicative of cancer as most minimal PSA elevations are due to benign disease processes (e.g. prostatic hyperplasia and infection); older men have larger prostates and therefore their PSA levels tend to be higher than younger men.

Dr. Armenakas further stated that the prostate is a gland through which the urethra runs, and as men get older, the prostate enlarges and squeezes down on the urethra, causing poor urinary stream and other benign conditions such as benign prostatic hypertrophy, and that the growth of the prostate is a normal and natural process of aging. Dr. Armenakas further opined that knowledge and implementation of PSA subcategories, including PSA velocity, PSA density and age-specific PSA is not the jurisdiction of an internist, but rather of a urologist, as in 1999-2000 the role of theses tests was still evolving.

On January 4, 2001, plaintiff returned to Dr. Pesce with the complaint of "some burning with ejaculation." Dr. Armenakas states Dr. Pesce noted that plaintiff stated he had a history of prostatitis dating back to when he was a young man and had been on antibiotics for quite some period of time with some resolution of symptoms. A presumptive diagnosis of acute prostatitis was made and plaintiff was prescribed a four weeks course of antibiotic therapy. It is Dr. Armenakas' opinion that Dr. Pesce correctly prescribed antibiotics for the diagnosis of acute prostatitis based upon his clinical impression concerning the PSA elevation, variable symptoms of urethral burning after intercourse and with ejaculation and prior history of prostatitis. Dr. Armenakas further opines that Dr. Pesce appropriately told Mr. D'Andraia to

return in six weeks wherein he would perform a rectal exam and repeat the PSA, and if it remained over 4, he would refer plaintiff to a urologist for consideration of a biopsy, and that this was an appropriate plan.

Mr. D'Andraia returned ten weeks later on March 21, 2001 complaining of purulent seminal discharge, for which a repeat PSA was ordered which revealed a level of 5.3, and for which plaintiff was referred to a urologist. It is Dr. Armenakas's opinion that it was within accepted standards of care for Dr. Pesce to refer the patient to the appropriate specialist for the subsequent urological evaluation, including a prostate biopsy.

Dr. Kahn, the urologist, performed a rectal examination and noted a nodule on the prostate during the examination. A biopsy was done which report suggested a Gleason 6 adenocarcinoma, which was upgraded to a Gleason 8 adenocarcinoma by a pathologist at Memorial Sloan Kettering. It is Dr. Armenakas's opinion within a reasonable degree of medical certainty that Mr. D'Andraia had an aggressive cancer with a poor prognosis, and that he had a greater than 77% chance of having cancer outside the prostate. Dr. Armenakas states that within less than four months, Mr. D'Andraia was confirmed by biopsy to have bone metastasis. During that period however, his PSA remained stable, despite the aggressive nature of the prostatic cancer. He further stated some very aggressive prostate cancers fail to produce significant PSA elevations, as may have been the case in this situation.

Based upon the foregoing opinions set forth in the affirmation of defendant's expert, Dr. Armenakas, defendant Anthony Pesce has demonstrated prima facie entitlement to an order granting summary judgment.

Plaintiff has opposed this motion for summary judgment. To rebut a prima facie showing of entitlement to an order granting summary judgment by defendants, 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 defendants' 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 [2nd Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.,*** 242 AD2d 282, 660 NYS2d 739 [2nd Dept 1997]).

In support of plaintiff's opposition, plaintiff has submitted, inter alia, a copy of the medical record of Mr. D'Andraia maintained by defendant; copies of the transcripts of the examination before trial of plaintiff Anthony D'Dandraia, Dr. Pesce, and Evan Roy Berger, M.D.; death certificate of plaintiff's decedent; medical records from Memorial Sloan Kettering; and the affirmation of an expert witness with the name redacted. A copy of the affirmation with the expert's name and signature has been provided to this court under separate cover.[4]

Plaintiff's expert, who is licensed to practice medicine in the State of New York and who is board certified in Internal Medicine, states familiarity with the evaluation, diagnosis and treatment of a male patient's prostate condition, including the required testing for possible cases of prostate cancer, the

---

[4]The Court has conducted an in-camera inspection of the original unredacted affirmation and finds it to be identical in every way to the redacted affirmation in plaintiff's opposition papers with the exception of the redacted expert's name. In addition, the Court has returned the unredacted affirmation to plaintiff's attorney.

progression of prostate cancer and a patient's prognosis. Plaintiff's expert also states familiarity with the standards of good and accepted medical care which prevailed from 1999-2001, applicable to an internist with respect to prostate evaluation and care. Plaintiff's expert reviewed the medical records of Anthony Pesce, M.D.. Matthrew Lief, M.D., Memorial Sloan Kettering Cancer Center, A. Ali Kahn, M.D., Patrick J. Boland, M.D., Roy Berger, M.D., and Farhang Rabbani, M.D., the parties' depositions, the deposition of non-party Dr. Berger, and the pleadings and bills of particulars.

Plaintiff's expert sets forth in the affirmation that prostate cancer is the second leading cause of cancer death in men, and the second most common form of cancer in men after skin cancer. In some patients, the cancer progresses slowly, causing mildly differentiated tumors that remain in the prostate gland, and in other patients, the cancer spreads beyond the prostate. If the cancer remains localized, it can be readily cured by a variety of highly effective treatments including hormonal therapy, cryosurgery, radiation seed implantation, or if necessary, through more aggressive methods such as chemotherapy, radiation treatments, prostatectomy, or a combination of these treatments. When prostate cancer breaches the capsule of the prostate and metastasizes, however, the patient's chances for survival are significantly reduced. Thus, diagnostic strategies for prostate cancer are geared toward early detection and treatment before the cancer spreads beyond the prostate gland.

Plaintiff's expert further sets forth that the American Cancer Society recommends a yearly prostate-specific antigen (PSA) blood test and digital rectal examination ("DRE") for all men 50 years of age and over who have at least a 10 year life expectancy to aid in the early detection of prostate cancer. Thus, the accepted standards of care during the 1999-2001 period required such annual testings, and when a patient had a prior history, including an abnormal finding on biopsy, as well as an enlarged prostate, and experienced signs, symptoms and complaints suggestive of an abnormal prostate condition, such as hematospermia (the presence of blood in the semen), urinary pain, or erectile or ejaculatory difficulties, more frequent PSA testing was required under accepted practice.

Plaintiff's expert further states that PSA is a tumor marker used to aid in the early detection of prostate cancer. PSA is a protein produced by cells in the prostate gland and is concentrated within the prostate, meaning that in healthy patients, serum PSA levels are relatively low since PSA does not enter the circulatory system. But, when prostatic tissue becomes "leaky" due to the presence of cancer, greater amounts of PSA tend to enter the circulatory system and thus become detectable by a blood test. The serum PSA is a useful tool to aid the practitioner in determining a patient's probability of prostate adenocarcinoma. A PSA level above 4.0 ng/mL is considered abnormally elevated. In addition to serum PSA levels, the amount in which serum PSA levels rise over time, referred to as "PSA velocity" is also an important indicator of probability of prostate cancer. An increase in PSA of .75 ng/mL or greater over a period of one year is a cause for concern, as this frequently indicates the presence of prostate cancer and requires further investigation.

Accepted standards of care during the 1999-2001 period required a physician observing an abnormal PSA velocity to consider the possibility of prostate cancer, particularly so where the patient was also experiencing other signs and symptoms and complaints suggestive of prostate cancer with a past medical history of prostate problems. Plaintiff's expert opines that accepted practice requires that prostate cancer be included in the physician's "differential diagnosis" and as part of that "ruling out" process, it is incumbent on the physician to obtain additional informtion via appropriate testing (e.g., ultrasound or

biopsy) and/or consultation with a urologist or other specialist. Good and accepted practice in evaluating any patient during the 1999-2001 period, required a physician to attempt to establish the cause and nature of the patient's complaints or illness by eliciting a full, accurate and complete history, the performance of a thorough physical exam and the ordering of various laboratory and diagnostic studies when indicated, then formulating a differential diagnosis where the physician considers the entire constellation of a patient's signs, symptoms and complaints, and to consider any and all disease processes or conditions which may be causing the same. After doing so, the physician must then rule out each possible condition via clinical examination, appropriate laboratory testing, or by referral to an appropriate specialist. The process required ruling-out the most life-threatening potential conditions first and then ruling-out other, or coexisting, causes for the patient's symptoms and complaints. Prostate cancer is a potentially life-threatening condition that must be ruled out initially and promptly when considered in a properly formulated differential diagnosis, states plaintiff's expert.

Plaintiff's expert stated that accepted standards of care in 1999 required a physician seeing a patient for the first time to elicit and record a complete medical history and to obtain the patient's pertinent medical records.

Plaintiff's expert sets forth that Mr. D'Andraia moved from Florida to New York and presented to Dr. Pesce on or about January 22, 1999 for a "complete physical." Mr. D'Andraia was fifty eight years old. Dr. Pesce noted in his record of this visit that Mr. D'Andraia had a past medical history "significant for BPH (benign prostatic hypertrophy)." Plaintiff's expert states that what is more significant is what Dr. Pesce did not record from this first visit, that is, the fact that Mr. D'Andraia underwent a prostate biopsy in April 1993 in Florida, and that this biopsy revealed an abnormal prostate condition, reflected by the presence of microscopic areas of glandular abnormalities and atypical cellular appearance. The urologist, Dr. Lief, had told plaintiff at that time that he had the possibility of having cancerous cells. Plaintiff's expert states that Dr. Pesce either failed to elicit or neglected to recognize the significance of the facet of Mr. D'Andraia's prior medical history, contrary to accepted practice in 1999.

Despite a past biopsy showing an abnormal prostate and BPH, and even though Mr. D'Andraia was 58 years old, contrary to accepted practice, Dr. Pesce did not order a PSA test, nor do his records note that he performed a DRE during the initial "complete physical." Thereafter, on February 5, 1999, March 18, 1999, April 14, 1999, May 6, 1999, and June 7, 1999, when Mr. D'Andraia was seen by Dr. Pesce, PSA testing was still not ordered even though Dr. Pesce had blood work done for other purposes at those visits.

On June 17, 1999, when Mr. D'Andraia next presented to Dr. Pesce with complaints of a coin-sized blood stain in his underwear after sexual relations with his wife, Dr. Pesce performed a DRE and concluded Mr. D'Andraia's prostate was "nontender without any significant nodules or enlargement appreciated," then for the first time ordered a PSA which revealed a level of 3.1. Plaintiff's expert states Dr. Pesce's records do not reflect a plan to follow-up this PSA testing or to monitor Mr. D'Andraia's prostate condition. During the eight subsequent visits between July 8, 1999 and April 28, 2000, Dr. Pesce did not address Mr. D'Andraia's PSA level or prostate condition.

On May 18, 2000 when Mr. D'Andraia presented to Dr. Pesce with the complaint that he had noticed a drop of blood in his underwear from an overnight discharge, and dysuria for a week, Dr. Pesce

did not order repeat PSA testing despite a past abnormal biopsy and prior history of enlarged prostate and was approaching the anniversary of his sole prior PSA test. He did perform a rectal exam which revealed "no mass with a nontender prostate." When Mr. D'Andraia presented again on July 7, 2000, July 19, 2000, and August 21, 2000, Dr. Pesce did not order a PSA or perform a DRE.

When Mr. D'Andraia presented on September 12, 2000 and reported that "over the past 2-3 months, he has had difficulty attaining an erection" and was "unable to penetrate during intercourse," there was no indication a DRE was performed nor an order for PSA testing. Dr. Pesce concluded Mr. D'Andraia was suffering erectile dysfunction and prescribed Viagara. On the September 25, 2000 visit, neither a follow-up PSA or DRE were performed.

On December 21, 2000, Mr. D'Andraia presented to Dr. Pesce "acutely complaining of some penile uretheral burning after intercourse." Dr. Pesce did perform a DRE and found no mass but a "slightly tender prostate which is symmetric and without nodules." Dr. Pesce then ordered a PSA test which revealed the PSA level had risen to 4.4 ng/mL, which was a abnormal level and also reflected an abnormal PSA velocity as the PSA had risen more than .75 ng/mL from the prior reading.

Dr. Pesce concluded Mr. D'Andraia was suffering from "probable acute prostatitis" when he presented for follow-up on January 4, 2001 and reported some burning with ejaculation. Dr. Pesce's plan was to reevaluate Mr. D'Andraia in six weeks with a DRE and PSA test. If, at that time his level was still above 4 ng/mL, Dr, Pesce's plan was to then refer Mr. D'Andraia to a urologist for consideration of a biopsy. When Mr. D'Andraia presented on March 21, 2001 with complaints of 'purulent discharge with his semen" and ongoing problems with urinary frequency, and a PSA level which dramatically rose from its prior reading to 5.3 ng/mL, Dr. Pesce first referred Mr. D'Andraia to a urologist. This, states plaintiff's expert, was close to two years after Dr. Pesce first observed signs and symptoms and complaints suggestive of an abnormal prostate condition (*i.e.,* that as of the June 17, 1999 visit, Mr. D'Andraia, who had a prior history of prostate abnormalities, had a PSA level of 3.1 ng/mL, which was at the high end of normal range, and a bloody penile discharge).

Thereafter, Mr. D'Andraia consulted with Dr. Khan on April 14, 2001 whose DRE revealed a slightly enlarged prostate. A biopsy was then performed by Dr. Khan on May 1, 2001 which revealed a prostatic adenocarcinoma, Gleason's score 6 (grades 3 +3). A bone scan performed on May 23, 2001 revealed an area of questionable uptake in Mr. D'Andraia's left femur, indicating that the cancer had metastasized. A later biopsy of the bone performed on August 14, 2001 confirmed a "metastatic adenocarcinoma involving bone...entirely conistent with prostatic origin."

Mr. D'Andraia subsequently underwent various radiation, chemotherapy and hormonal therapies over the following two and a half years. Mr. D'Andraia died on February 8, 2004, with his death certificate setting forth the cause of death as a consequence of "metastatic carcinoma of the prostate."

Plaintiff's expert opines with a reasonable degree of medical certainty that Dr. Pesce departed from accepted standards of medical care in 1999 by failing to perform PSA and DRE testing when Mr. D'Andraia presented to him during visits between January 22, 1999 and June 7, 1999. Given Mr. D'Andraia's age, his past finding of an abnormal prostate condition and his past history of an enlarged prostate, Dr. Pesce's initial assessment and "complete physical" of Mr. D'Andraia should have included

an assessment of his prostate condition through these tests. Moreover, he states, given that an abnormal PSA velocity would indicate the presence of cancer at a later time, it was incumbent on Dr. Pesce to obtain an initial baseline PSA for future comparison, but he failed to do so. It was also a departure from accepted practice in 1999 for Dr. Pesce to have failed to elicit and record that Mr. D'Andraia had a past finding of an abnormal prostate condition via biopsy.

It is also plaintiff's expert's opinion, stated with a reasonable degree of medical certainty, that Dr. Pesce departed from accepted standards of medical care in 1999 and 2000 by failing to order PSA testing and to perform regular DREs during the multiple office visits between July 9, 1999 and September 25, 2000. This period of time was after Mr. D'Andraia registered a PSA with a level of 3.1 ng/mL, which was at the high end of normal, Mr. D'Andraia reported at various times that he had discharged blood, experienced dysuria and had difficulty maintaining an erection. Given Mr. D'Andraia's age, these symptoms and complaints, along with past history of BPH and PSA approaching the abnormal range, and finding of an abnormal prostate, Mr. D'Andraia's PSA level should have been regularly monitored during this time frame. Mr. D'Andraia had 14 separate visits with Dr. Pesce without a single PSA test being ordered. Had Dr. Pesce regularly monitored the PSA levels, he would have become aware that it was rising. Armed with that knowledge, Dr, Pesce would have been able to timely order additional diagnostic tests and consultations which would have led to Mr. D'Andraia's cancer being diagnosed at a much earlier time.

Mr. D'Andraia's expert also opined with a reasonable degree of medical certainty that Dr. Pesce departed from accepted standards of medical care during the period of 1999-2001 by failing to properly formulate and perform a differential diagnosis which included prostate cancer, to consider and rule out the most lethal conditions suggested by the constellation of the patient's history, signs and symptoms and complaints. Mr. D'Andraia's constellation suggested the possibility of prostate cancer, yet Dr. Pesce did not seek any additional study or consultation to rule out prostate cancer, thus departing from accepted standards of care.

Plaintiff's expert also opined with a reasonable degree of medical certainty that Dr. Pesce departed from accepted standards of medical care during the period 1999-2001 over an 18 month period by continuing to fail to consider and rule out prostate cancer in response to Mr. D'Andraia's subsequent complaints of dysuria and erectile difficulty; and continuing to fail to formulate and carry out a plan to monitor Mr. D'Andraia's prostate condition during the period from June 1999 through December 2000; and continuing to fail to perform a repeat PSA test for 18 months even though the June 17, 1999 PSA test was at the high end of normal range.

By Dr. Pesce failing to act upon the finding of a PSA level of 4.4 ng/mL in connection with Mr. D'Andraia's December 21, 2000 visit was a departure from accepted standards of care as this level was abnormal; the PSA velocity was abnormal as it had increased 1.3 ng/mL from when it had last been tested in June 1999: Mr. D'Andraia, on the heels of his prior complaints of urinary pain, erectile difficulty and abnormal, bloody penile discharge, was then acutely complaining of some penile uretheral burning after intercourse; had a prior medical history, a biopsy showing an abnormal prostate condition, and a finding of a slightly tender prostate. The standard of care in 2000 required Dr. Pesce to consider prostate cancer as part of his differential diagnosis, and thus to seek appropriate diagnostic testing such as ultrasound, and/or biopsy, and a consultation with a urologist or other specialist.

Dr. Pesce, opines plaintiff's expert, departed from accepted standards of medical care during the 1999-2001 period by failing to diagnose Mr. D'Andraia's prostate cancer. This delay in making a diagnosis of almost two years allowed Mr. D'Andraia's cancer to metastasize, which substantially reduced Mr. D'Andraia's chances for survival and ultimately caused his death. Plaintiff's expert further opines with a reasonable degree of medical certainty that had Dr. Pesce closely monitored Mr. D'Andraia's prostate condition instead of failing to consider the possibility of prostate cancer during the course of his care, as Dr. Pesce was required to do, an earlier, timely biopsy would have been performed and Mr. D'Andraia's prostate cancer would have been diagnosed and treatment commenced before the cancer metastisized. During the nearly two year delay in diagnosing and treating Mr. D'Andraia's prostate cancer, the cancer grew to a Gleason's score 6 tumor and metastasized. This growth of the tumor to this size and its metastasis reflects that the cancer was initially present substantially prior to being ultimately diagnosed. Due to the departures and delay in diagnosing and treating Mr. D'Andraia, his opportunity for successful treatment and his chances for survival were significantly reduced.

In further support of the opposition to this motion, plaintiff has also submitted the transcript of the examination of Evan Roy Berger, M.D., nonparty witness who, since 1975, practiced privately as a general oncologist, and specialized in prostatic cancer since 1985. He is certified in internal medicine, hematology and medical oncology. He had an independent recollection of seeing Mr. D'Andraia who first came to him July 17, 2001 with metastatic prostate cancer and a fair amount of pain in his leg which were treated with different therapies until he died.

Dr. Berger testified Mr. D'Andraia was not referred to him, but came to him on his own because he has a reputation of treating patients with cancer of the prostate. He examined Mr. D'Andraia on July 17, 2001 and found the entire left lobe of his prostate was involved with a firm tumor mass, which felt to him to be extracapsular, especially in the lower lobe. The right side had a large nodule with a firmness and ropiness of the right seminal vesicle. These findings meant that he was a least a stage 3C, meaning seminal vesicle involvement and both sides of the prostatic gland were involved. He had advanced local disease with metastatic disease as he had a sclerotic lesion in the femur which was positive for cancer on biopsy.

Thereafter, a biopsy of the hip on August 14, 2001, taken at MSKCC, was positive for metastatic adenocarcinoma consistent with prostate cancer. On July 17, 2001, Dr. Berger testified that Mr. D'Andraia's prognosis was extremely guarded depending upon whether or not it was in the bone. If he was a C3C, his prognosis was not good; and if in fact, the sclerotic disease that is described in his note that were seen on plain film radiographs were positive, then his prognosis was worse. Then he had hormone sensitive metastatic prostate cancer stage D2 disease, wherein, in that he had not been treated with hormones before, his cancer would be hormone sensitive and would work for a while. The average survival would be 12 to 18 months once you become hormone refractory, or no longer responding to hormones, until death.

Mr. D'Andraia had a Gleason score of 6 adenocarcinoma, which meant it was that sort of a garden variety run-of-the mill prostatic cancer that is not a very aggressive lesion nor a benign cancer, as cancers

go. Whether it lends itself to treatment depends upon variables, the age of the patient, comorbid conditions, stage of the disease, how many cords were positive, and whether or not he had metastatic disease. However, that reading was originally done at Stony Brook and was reclassified by MSKCC on June 17, 2001 wherein the Gleason score was actually read as an 8. Dr. Berger testified that high Gleason score patients generally secrete less PSA and have a worse prognosis as their growth fraction is higher, meaning it spreads faster and grows faster than lower Gleason scores. They secrete less PSA because the less differentiated the cancer, meaning the lower the Gleason score, sometimes, but not in all cases, less PSA is made. With a Gleason score of 8 or 10, less PSA is sometimes secreted.

Dr. Berger testified that at first Dr. Kahn and Dr. Waltzer, both urologists, recommended Mr. D'Andraia have a radical prostatecomy wherein the prostate and a sampling of lymph nodes would be removed, but this was not done when the extent of his disease workup was performed and they found that he had metastatic disease. Then there was no need to do a radical prostaectomy as there was no benefit to doing it because the cancer already traveled elsewhere.

On July 17, 2001 Dr. Berger thought Mr. D'Andraia was a D2 classification as he thought he was locally advanced, but when the femoral lesion was cancerous , it essentially made it an incurable cancer. He treated Mr. D'Andraia with hormonal therapy in the form of triple androgen blockade to get rid of testosterone, until he became refractory with that regiment. He also received radiation to his femur because he was having pain there, as well as to prevent a pathologic fracture prior of his femur. After September 4, 2001, Dr. Berger stated Mr. D'Andraia was also treated with pain medication and a drug called Aredia, which is a phosphomate which was felt at that time to decrease skeletal-related events, pain and pathologic fracture by helping bone strength and decreasing cancer related events.

Dr. Berger last saw Mr. D'Andraia in his office on January 13, 2003, at which time he had diffuse aches in his arms and legs; had been taking Percocet in the morning and night; had not been to pain management, but took Roxanol the night before he saw him. He was depressed and had been started on Zoloft. Dr. Berger also testified he was not in the position one way or another to comment on the care and treatment rendered by Dr. Pesce. He did testify however that if the patient's prostate cancer had been diagnosed prior to it becoming extracapsular, his prognosis could have possibly been different than it was when he arrived to him in July, 2001, depending upon the Gleason score at the time it was biopsied and whether or not the PSA was really an indicator of how aggressive his cancer was, and whether or not the digital rectal examination was, in fact, accurate. Pathologically, if he had a radical prostatectomy and it was all within the organ, his prognosis would certainly have been better than if it were extracapsular or if it had involved lymph nodes or the seminal vesicle. He stated there have been patients who have either metastasized with clinincally and pathologically organ confined disease, however.

Dr. Berger also stated that he does not believe urologists would be uniform in their testimony as to whether or not a patient should or should not be biopsied. There are other things such as PSA density, age adjust PSA levels, free to total PSA levels, to help decide whether or not someone should or should not be biopsied. Symptoms are also considered. The decision of whether or not someone should have a biopsy of the prostate is best made by a urologist or a medical oncologist cancer

specialist who has a subspecialty interest and knowledge of prostate cancer and its behavior. Dr. Berger also stated that it is difficult oftentimes to distinguish between BPH and prostate cancer. Screening is with a digital rectal exam and PSA testing. If the PSA or the DRE were omitted or done incorrectly in the screening process, that can lead to a delay in the diagnosis of prostate cancer. When there is a PSA velocity of more than .75 per year, it is felt to be suspicious or worrisome for a patient with prostate cancer compared to BPH because the growth rate is much slower with BPH and should not create an increase in the PSA of more than .75. He said an ultrasound is not a very useful screening tool in his opinion.

Based upon the foregoing, it is determined that plaintiff has demonstrated the existence of triable issues of fact attesting to departures from accepted practice by defendant Anthony Pesce, M.D. and that these departures were a competent producing cause of injuries to the plaintiff. Plaintiff has demonstrated factual issues, including, but not limited to, whether defendant Pesce conducted a thorough, appropriate and proper history and physical when decedent first presented for care and treatment; whether Dr. Pesce departed from good and accepted standards of medical care and practice by not obtaining Mr. D'Andraia's medical records concerning his care and treatment for previous problems with his prostate or other conditions; whether Dr. Pesce properly considered Mr. D'Andraia's prior history of prostate problems when making his diagnoses of BPH; whether or not PSA blood tests and digital rectal examinations were performed at appropriate times and frequencies; whether the results of the PSA testing should have alerted Dr. Pesce as to the possibility that Mr. D'Andraia had cancer of the prostate; whether Dr. Pesce properly made cancer of the prostate a differential diagnosis and whether he properly ruled in or ruled out the disease; whether Dr. Pesce delayed in sending Mr. D'Andraia to a urologist or other specialist to aid in diagnosing plaintiff's condition; and if so, whether those delays contributed to the delay in diagnosing his condition, contributed to the metastasis of the disease and caused a delay in the appropriate care and treatment of Mr. D'Andraia for cancer of the prostate, ultimately leading to his death. Summary judgment may not be awarded in a medical malpractice action where the parties adduce conflicting opinions of medical experts. Where, as here, medical experts offer conflicting opinions, a credibility question is presented requiring a jury's resolution (***Feinberg v Feti,*** 23 AD3d 517, 806 NYS2d 661 [2nd Dept 2005]; ***Dandrea v Hertz,*** 23 AD2d 332, 804 NYS2d 106 [2nd Dept 2005]; ***Shields v Baktidy,*** 11 AD3d 671, 783 NYS2d 652 [2nd Dept 2004]).

Accordingly, motion (004) by defendant Pesce for an order granting summary judgment is denied.

Dated: JUL 16 2007

J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**