

Flobeck v Stony Brook Surgical Assoc.
2008 NY Slip Op 30662(U)
March 5, 2008
Supreme Court, Suffolk County
Docket Number: 0008496/2003
Judge: Emily Pines
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SUPREME COURT - STATE OF NEW YORK
POST-NOTE MOTION PART - SUFFOLK COUNTY

PRESENT:

Hon. EMILY PINES
Justice of the Supreme Court

MOTION DATE 10-31-07
ADJ. DATE 12-5-07
Mot. Seq. # 003 - MG

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DONNA FLOBECK, as Administratrix of the :
Estate of RUSSELL FLOBECK and DONNA :
FLOBECK, individually, :
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: :
Plaintiff, :
: :
: :
- against - :
: :
STONY BROOK SURGICAL ASSOCIATES, :
P.C., ERIC EZRA SMOUHA, M.D., GHASSAN :
JOS SAMARA, M.D., RAFAEL P. DAVIS, M.D., :
And DAVID B. DURAND, M.D., :
: :
: :
Defendants. :
-----X

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Upon the following papers numbered 1 to 23 read on this motion for leave to renew; Notice of Motion/ Order to Show Cause and supporting papers 1 - 9; Notice of Cross Motion and supporting papers ; Answering Affidavits and supporting papers 10 - 21; Replying Affidavits and supporting papers 22 - 23; Other ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that this motion by defendants Eric Ezra Smouha, M.D. and Rafael P. Davis, M.D. for an order granting them leave to renew that portion of their prior motion for summary judgment dismissing plaintiff's first cause of action claims of medical malpractice based on negligence that were not time barred as well as plaintiff's third cause of action for wrongful death to recover funeral expenses, fourth cause of action for wrongful death claiming loss of support, and fifth cause of action for loss of services, which portion was denied by this Court by order dated August 20, 2007, is considered under CPLR 2221 and is granted.

“A motion for leave to renew is addressed to the sound discretion of the court” (*Matheus v Weiss*, 20 AD3d 454, 454-455, 797 NYS2d 774 [2d Dept 2005]). A motion for leave to renew must be based upon “new facts not offered on the prior motion that would change the prior determination” (CPLR 2221 [e][2]) and must contain “reasonable justification for the failure to present such facts on the prior motion” (CPLR 2221 [e][3]). However, the first requirement is a flexible one and the Court, in its discretion, may grant renewal, in the interest of justice, upon facts which were known to the movant where the movant offers a reasonable justification for failing to submit them on the earlier motion (*see, Heaven v McGowan*, 40 AD3d 583, 835 NYS2d 641[2d Dept 2007]; *Gomez v Needham Capital Grp., Inc.*, 7 AD3d 568, 775 NYS2d 903 [2d Dept 2004]). The Court in its prior order dated August 20, 2007 did not consider the unsworn purported affirmations of Michael Setzen, M.D.(Dr. Setzen), an otolaryngologist, and Mihai Dimancescu, M.D.(Dr. Dimancescu), a neurosurgeon, inasmuch as said expert submissions were unsworn and thus, in inadmissible form to support a motion for summary judgment (*see, CPLR 2106; CPLR 3212 [b]; Loadholt v New York City Trans. Auth.*, 12 AD3d 352, 783 NYS2d 660 [2d Dept 2004]). However, defendants Eric Ezra Smouha, M.D. (Dr. Smouha) and Rafael P. Davis, M.D. (Dr. Davis) have now corrected this inadvertent procedural error and have submitted proper affirmations from said experts (*see, Leonardis v Brown*, 15 AD3d 525, 790 NYS2d 686 [2d Dept 2005]). Therefore, under the circumstances of this case, the Court exercises its discretion and grants defendants Drs. Smouha and Davis leave to renew said portion of their prior summary judgment motion through the submission of the now properly affirmed statements of their experts (*see, id.; see also, Simpson v Tommy Hilfiger U.S.A., Inc.*, ___ NYS2d ___, 2008 WL 269504, 2008 NY Slip Op 00953 [NYAD 2 Dept Feb 01, 2008]). Upon granting leave to renew, the Court modifies the prior order solely to the extent indicated herein.

This is an action to recover damages for medical malpractice and the wrongful death of plaintiff’s spouse, Russell Flobeck, allegedly as a result of defendants’ negligent misdiagnosis as and treatment of recurring sphenoid sinus¹ mucocele² and lack of informed consent from May 1997 through March 2002. Plaintiff’s decedent died on April 5, 2002 at the age of 35 years due to complications following a procedure at Sloan Kettering Memorial Hospital to remove a myxoma³ of the sphenoid sinus that was infiltrating the bone and involved both internal carotid arteries and extended up to the dura of the brainstem.

In the summer of 1997, plaintiff’s decedent, who was a landscaper, complained of severe headaches and visual disturbances to his primary care physician, non-party Louis Greenblatt, M.D. (Dr. Greenblatt). Dr. Greenblatt ordered a CT scan of the brain and the resulting report dated August 7, 1997 indicated a possible posterior nasopharyngeal mass. Dr. Greenblatt also ordered an MRI of the brain and the resulting report dated August 12, 1997 indicated that the MRI revealed a large lobulated mass in the

¹Sphenoidal sinus is defined as one of a pair of paranasal sinuses in the body of the sphenoid bone communicating with the upper posterior nasal cavity or sphenothmoidal recess (Stedman’s Medical Dictionary 1645 [27th ed 2000]).

²Mucocele is a retention cyst of the salivary gland, lacrimal sac, paranasal sinuses, appendix, gallbladder or other site (Stedman’s Medical Dictionary 1136 [27th ed 2000]).

³Myxoma is defined as a benign neoplasm (tumor) derived from connective tissue, consisting chiefly of polyhedral stellate cells that are loosely embedded in a soft mucoid matrix, thereby resembling primitive mesenchymal tissue (Stedman’s Medical Dictionary 1178, 1893 [27th ed 2000]).

sphenoid sinus with extension into the clivus and sella turcica. Said MRI report provided differential diagnoses of “a chordoma invading the sphenoid sinus and the clivus vs. a large invasive pituitary adenoma invading the clivus and sphenoid sinus or a large sphenoid sinus tumor.”

Dr. Greenblatt referred plaintiff’s decedent to Dr. Davis, a board certified neurosurgeon, who ordered a CT scan of plaintiff’s decedent’s orbits⁴ which was performed on August 18, 1997. The impression from said CT scan was a large sphenoid sinus mucocele extending through the floor of the sella and elevating the pituitary gland as well as sinus disease with evidence of acute sinusitis in the left maxillary sinus. Dr. Davis referred plaintiff’s decedent to Dr. Smouha, a board certified otolaryngologist employed by defendant Stony Brook Surgical Associates, P.C. whose office was located at 37 Research Way in East Setauket, New York, for evaluation. Dr. Smouha then sent plaintiff’s decedent for an ophthalmology consultation with another physician who found a normal ocular examination. On August 20, 1997, Dr. Davis discussed his proposed surgical procedure, endoscopic sphenoidectomy, a transnasal drainage of the sphenoid sinus mucocele with plaintiff’s decedent. Plaintiff’s decedent signed a consent form for a transphenoidal excision of mass lesion, fat graft and lumbar drain to diagnose and remove cystic lesion of sphenoid sinus and sella.

On August 26, 1997, Dr. Davis and Dr. Smouha performed the endoscopic sphenoidectomy for excision of mucocele at Stony Brook University Medical Center (Stony Brook University Hospital). Following the procedure, plaintiff’s decedent continued to complain of headaches but no visual problems. When Dr. Davis saw plaintiff’s decedent one and two days after the procedure, and when he was discharged plaintiff’s decedent was still complaining of headaches which were controlled by Demerol and Percocet. Plaintiff’s decedent was discharged on August 28, 1997 with instructions to make follow-up appointments with Dr. Smouha in one to two weeks and with Dr. Davis in three weeks. A pathology report dated August 29, 1997 concerning specimens received from the procedure three days prior indicated that the “sphenoid sinus cyst wall” biopsy had fibrous tissue with marked edematous and myxoid⁵ change and that no cyst wall seen.

Dr. Davis indicated in a note dated October 10, 1997 that plaintiff’s decedent was status post excision of sphenoid mucocele, that plaintiff’s decedent was doing extremely well with almost complete resolution of his headaches, and that Dr. Davis had discharged him from his care. He added that plaintiff’s decedent would see Dr. Smouha for one additional follow-up visit.

Plaintiff’s decedent had post-operative visits with Dr. Smouha on September 5, 1997, September 16, 1997 and on October 28, 1997. In a letter dated October 28, 1997 to Dr. Davis, Dr. Smouha indicated that plaintiff’s decedent’s headaches were gone, his allergic symptoms and nasal mucosal swelling were improved, and that he had requested that plaintiff’s decedent return in three months. Dr. Smouha added that he planned to obtain a CT scan “down the road.”

⁴Orbit is defined as the bony cavity containing the eyeball and its accessory structures and is formed of parts of seven bones: the frontal, maxillary, sphenoid, lacrimal, zygomatic, ethmoid and palatine bones (Stedman’s Medical Dictionary 29,1271 [27th ed 2000]).

⁵Myxoid is defined as resembling mucous (Stedman’s Medical Dictionary 1178 [27th ed 2000]).

Plaintiff's decedent returned to see Dr. Smouha on January 14, 2000 at which time he complained of recurrent left-sided headaches for several months and loss of vision. During said visit, Dr. Smouha noted an MRI showing a large mass in the right sphenoid sinus crossing over to the left side and his impression following the examination was chronic sinusitis, acute exacerbation as well as possible recurrence of sphenoid sinus mucocele. Dr. Smouha testified that he ordered a CT scan of the sinuses which was performed on January 24, 2000 and that the results showed a mucocele of the sphenoid sinus as well as mucocele disease in the ethmoid sinus. On February 10, 2000 plaintiff's decedent was hospitalized for a second surgery performed by Dr. Smouha, bilateral endoscopic sphenoidectomies with excision of tissue and mucocele and a left endoscopic ethmoidectomy. The pathology report following this procedure indicated respiratory mucosa with mild and severe chronic inflammation. Plaintiff's decedent was discharged on February 11, 2000. He then returned for a follow up visit on February 18, 2000 with Dr. Smouha still complaining of chronic headaches. According to Dr. Smouha, plaintiff's decedent was doing well and the treatment plan was to resume Flonase, complete antibiotics, saline lavage twice a day, and to return in two weeks. Plaintiff's decedent had follow-up visits with Dr. Smouha on March 3, 2000 at which time plaintiff's decedent reported doing well; on March 17, 2000 when he complained of headaches and pain killer withdrawal; and April 7, 2000 when plaintiff's decedent reported that he had not felt this well in 15 years and that his headaches were infrequent. Dr. Smouha advised plaintiff's decedent to return in two months. Plaintiff's decedent returned to see Dr. Smouha on October 4, 2000 complaining of headaches, Dr. Smouha diagnosed occasional nasal congestion and headaches and his plan was to continue Flonase and Motrin and to see plaintiff's decedent in six months. Dr. Smouha did not see plaintiff's decedent again until 2002.

Plaintiff filled out a Neurology Adult Outpatient Questionnaire dated February 4, 2001 on behalf of plaintiff's decedent indicating that her husband was still complaining of headaches, dizziness, light sensitivity and pressure.

Then, on January 15, 2002, plaintiff's decedent had seizures and lost consciousness and was taken to the emergency room of Stony Brook University Hospital and was seen by Ghassan Samara, M.D. (Dr. Samara), an otolaryngologist, and then admitted to the Hospital. The report of a CT scan performed on January 16, 2002 indicated a soft tissue density occupying the sphenoid sinus and that sinus disease was noted on the left. On January 18, 2002 plaintiff's decedent was discharged with a diagnosis of new onset seizure, sphenoid sinusitis, maxillary sinusitis and deviated nasal septum.

On January 21, 2002 Dr. Samara performed surgical procedures that included nasal septoplasty, transeptal sphenoidotomy with removal of tissue from the sphenoid sinus, and bilateral nasal sinus endoscopy. Dr. Samara post-operatively diagnosed sphenoid mucocele with erosion of the superior, posterior and lateral walls and chronic pansinusitis bilaterally. The pathology report of said date indicated that the left sphenoid sinus contained myxomatous neoplasm. Said diagnosis was confirmed by the Armed Forces Institute of Pathology.

Dr. Davis saw plaintiff's decedent on February 14, 2002 for a follow-up visit and wrote to Dr. Samara that he had spoken briefly to Dr. Smouha about surgical intervention and understood that plaintiff's decedent again underwent "resection of what was thought to be sphenoid mucocele," that the pathology report was "consistent with myxoma" and that he "must admit I have very little clinical expertise with this clinical diagnosis." In said letter dated February 14, 2002, Dr. Davis indicated that

plaintiff's decedent was concerned and that based on the pathology report there was a concern about recurrence and that "[t]his has been the case over the last five years." He added that plaintiff's decedent was going to see a head and neck surgeon at Sloan-Kettering Memorial Hospital and that plaintiff's decedent "continues to have intractable headaches which quite frankly I do not have a good answer for in terms of treatment." Dr. Davis stated that since plaintiff's decedent had been seen by another physician from a neurologic standpoint, (non-party Philippe Vaillancourt, M.D. also of Stony Brook University Hospital's neurology department), he had asked that plaintiff's decedent be re-evaluated by that physician. A CT scan of face sinuses was performed on February 18, 2002 at the request of Dr. Davis, who wrote a prescription for the CT scan on February 14, 2002, which scan was interpreted by radiology in comparison with a prior study of January 16, 2002 and the report indicated that the left maxillary sinus was now, after the sphenoidotomy of January 21, 2002, essentially free of disease. Then, on February 26, 2002, plaintiff's decedent was seen again by Dr. Samara and diagnosed with chronic sinusitis and instructed to follow up with Dr. Samara in one week.

By her complaint, plaintiff alleges a first cause of action for medical malpractice based on negligence; a second cause of action for medical malpractice based on lack of informed consent; a third cause of action for wrongful death to recover funeral expenses; and a fourth cause of action for wrongful death claiming loss of support; and a fifth cause of action for loss of services. Defendants Dr. Smouha and Dr. Davis assert affirmative defenses in their answers that plaintiff failed to commence the action within the applicable Statute of Limitations. The summons and complaint were filed with the Suffolk County Clerk on March 28, 2003. The Court's computer records indicate that the note of issue in this action was filed on November 6, 2006.

By her bill of particulars, plaintiff alleges that defendants were negligent in, among other things, failing to understand the nature of plaintiff's decedent's complaints and failing to refer him to appropriate specialists; failing to conduct a complete and adequate examination of plaintiff's decedent; failing to seek consultation from appropriate knowledgeable experts; failing to order and perform appropriate film tests and studies; failing to recognize plaintiff's decedent's recurring and continuing symptoms despite the various surgeries performed on him by the defendants; and failing to arrive at a correct diagnoses of plaintiff's decedent's brain tumor.

Defendant Drs. Smouha and Davis now move for summary judgment dismissing plaintiff's remaining first cause of action claims alleging medical malpractice based on negligence that were not time barred, as well as her third, fourth and fifth causes of action on the grounds that both physicians' treatment of plaintiff was at all times in accordance with good and accepted medical standards. Through their experts' submissions, defendant Drs. Smouha and Davis point out that myxoma of the sphenoid sinus is an extremely rare condition, particularly for someone of plaintiff's decedent's age, and can only be diagnosed histologically. Their experts indicate that the proper diagnostic tests performed prior to the 1997 and 2000 surgeries and the pathology results of biopsies from said surgeries, which were properly relied on by both physicians, revealed findings consistent with a more common condition, mucocele, without any evidence of myxoma.

In support of their motion, defendants submit, among other things, the now properly affirmed statements of their experts Michael Setzen, M.D., an otolaryngologist, and Mihai Dimancescu, M.D., a neurosurgeon, as well as the summons and complaint; the answers of Dr. Smouha and Dr. Davis;

plaintiff's bills of particulars with respect to Drs. Smouha and Davis; plaintiff's decedent's medical records from the offices of Dr. Smouha and Dr. Davis and from Stony Brook University Hospital; and the deposition transcripts of Dr. Smouha, Dr. Davis and plaintiff.

With respect to plaintiff's medical malpractice claims based on negligence that remain, the requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted standards of medical practice, and (2) evidence that such a departure was a proximate cause of the plaintiff's injury (*see, Bloom v City of New York*, 202 AD2d 465, 609 NYS2d 45 [2d Dept 1994]). "On a motion for summary judgment, a defendant doctor has the initial burden of establishing the absence of any departure from good and accepted medical practice or that the plaintiff was not injured thereby" (*Williams v Sahay*, 12 AD3d 366, 368, 783 NYS2d 664 [2d Dept 2004]). In order to make a prima facie showing of entitlement to judgment as a matter of law in an action to recover damages for medical malpractice, a defendant hospital or physician must establish through medical records and competent expert affidavits that the defendant did not deviate or depart from accepted medical practice in the defendant's treatment of the patient (*see, Mendez v City of New York*, 295 AD2d 487, 744 NYS2d 847 [2d Dept 2002]). In opposition to the motion, a plaintiff must submit a physician's affidavit of merit attesting to a departure from accepted practice and containing the attesting doctor's opinion that the defendant's omissions or departures were a competent producing cause of the injury and subsequent death of the patient (*see, Thompson v Orner*, 36 AD3d 791, 792, 828 NYS2d 509 [2d Dept 2007]; *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]). General allegations that are conclusory and unsupported are insufficient to defeat summary judgment (*see, Alvarez v Prospect Hosp.*, 68 NY2d 320, 324, 508 NYS2d 923 [1986]).

During his deposition, Dr. Smouha testified that he did not recall reviewing either the MRI film of plaintiff's decedent's brain or its resulting report dated August 12, 1997. In addition, he testified that after the August 26, 1997 surgery he ruled out a tumor of the sinuses because the surgical appearance was characteristic of a mucocele, that is, it had a lining and was filled with mucous, and based on the pathology report from non-party pathologist, David Weissman, M.D. Dr. Smouha admitted that he did become aware that no cyst wall was seen by pathology and testified that to him, this meant that a piece of the sinus contents rather than the actual lining, which may be very thin, was removed. Dr. Smouha also testified that he performed most of the August 26, 1997 surgery.

A discharge summary denoted "Doctor's Copy" concerning the August 26, 1997 procedure and unsigned by Dr. Davis indicates "Laboratory: Lab data from preadmission testing was within normal limits. MRI showed sphenoid sinus tumor"; and provisional diagnosis and final diagnosis as sphenoid sinus mucocele. Dr. Davis testified during his deposition that said discharge summary was dictated by his nurse practitioner, non-party Marilyn Higgins, and was likely reviewed by him and that it was signed by him electronically. Dr. Davis further testified that he did not know where the aforementioned information concerning an MRI came from.

Defendants' expert otolaryngologist, Michael Setzen, M.D. (Dr. Setzen) opines in his affirmation with a reasonable degree of medical certainty that Dr. Smouha treated plaintiff's decedent in accordance with good and accepted medical practice and that no action or inaction on Dr. Smouha's part proximately caused plaintiff's decedent's injury or death. In addition, he opines that based on plaintiff's decedent's

presentation, signs and symptoms, and the pre-operative diagnostic studies, including the August 18, 1997 CT scan of the orbits which revealed a sphenoid sinus mucocele, it was reasonable and in accordance with good and accepted medical practice for Dr. Smouha to diagnose a mucocele. He explains that plaintiff's decedent's debilitating headaches and visual disturbances were consistent with mucocele inasmuch as symptomatic mucoceles can lead to substantial complications including significant erosion of bones and pain and points out that a slow-growing tumor, particularly an extremely rare one like myxoma of the sphenoid sinus, is uncommon in a young, thirty-five year old patient such as plaintiff's decedent. Dr. Setzen further explains that mucoceles and other non-tumorous diseases of the sinuses are much more common, adding that close to 40 million Americans suffer from sinus disease.

Dr. Setzen opines with a reasonable degree of medical certainty that in the absence of any shred of radiological and pathological evidence of an aggressive tumor such as myxoma, it was appropriate for Dr. Smouha to diagnose mucocele and sinusitis and that at no time while plaintiff's decedent was under the care of Dr. Smouha could a diagnosis of myxoma of the sphenoid sinus have been made or included in the differential diagnosis. According to Dr. Setzen, a definitive diagnosis can only be arrived at by way of pathology. He notes that the pathology report of August 26, 1997 from a specimen obtained during the trans-nasal endoscopic drainage of mucocele reflected a benign condition of rhinitis and did not contain any evidence or indication that should have raised Dr. Smouha's index of suspicion for any other condition other than his original diagnosis of mucocele. Dr. Setzen opines that Dr. Smouha properly relied on the pre-operative diagnostic studies, and most importantly, on the pathology report in arriving at his diagnosis of mucocele.

Dr. Setzen also opines with a reasonable degree of medical certainty that the procedure performed by Drs. Smouha and Davis on August 26, 1997 was indicated and properly performed. Dr. Setzen points to plaintiff's decedent's subsequent visits in the Fall of 1997 to Drs. Smouha and Davis during which he reported feeling better and the fact that plaintiff's decedent did not return to see Dr. Smouha or contact Dr. Smouha until January 2000 as a basis for Dr. Smouha to believe that the 1997 surgery was a success in accomplishing the objective of relieving plaintiff's decedent's symptoms. Dr. Setzen adds that Dr. Smouha cannot be faulted for plaintiff's decedent's failure to return for his follow-up, as directed.

Dr. Setzen opines that when plaintiff's decedent returned in January 2000, Dr. Smouha properly ordered diagnostic studies to investigate the cause of his recurrent complaints of headaches and other symptoms and that Dr. Smouha properly arrived at a diagnosis of recurrence of mucocele inasmuch as a mucocele can recur if not completely resected during an operation, even with the best of surgical hands. He adds in support that the operative pathology report from the 2000 surgery revealed respiratory mucosa with mild chronic inflammation, which he states is hardly evident of an aggressive, invasive, and slow-growing tumor. According to Dr. Setzen, Dr. Smouha properly treated plaintiff's decedent after the February 10, 2000 operation and based on plaintiff's decedent's positive responses concerning how he felt in April 2000, it was reasonable and in accordance with good and accepted medical practice for Dr. Smouha to believe that the 2000 surgery and post-operative treatments were successful.

Dr. Setzen further opines that Dr. Smouha properly treated plaintiff's decedent when he returned in January 2002 and referred plaintiff's decedent to the appropriate consultations, with Dr. Samara who was a specialist in the area of sinuses, as well as diagnostic studies. He emphasizes that it was not until the pathology from Dr. Samara's procedure of January 21, 2002 was analyzed that the diagnosis of

myxoma was made and later confirmed by the Armed Forces Institute of Pathology. In conclusion, Dr. Setzen opines with a reasonable degree of medical certainty that Dr. Smouha did not depart from good and accepted standards of medical care in plaintiff's decedent's treatment and that plaintiff's decedent's alleged injuries and death were not proximately caused by any action or inaction on the part of Dr. Smouha.

Defendants' expert in neurosurgery, Mihai Dimancescu, M.D. (Dr. Dimancescu), opines in his affirmation with a reasonable degree of medical certainty that Dr. Davis did not depart from good and accepted medical practice in his treatment of plaintiff's decedent and that no action or inaction on the part of Dr. Davis proximately caused plaintiff's decedent's alleged injuries and death. In addition, Dr. Dimancescu opines with a reasonable degree of medical certainty that the procedure performed by Dr. Smouha and Dr. Davis on August 26, 1997 was indicated, appropriate and properly performed. He notes that a symptomatic mucocele, as was present in plaintiff's decedent, requires surgical intervention because if left untreated, a symptomatic mucocele can cause significant complications, including substantial bone erosion and pain and if large enough, a mucocele can put pressure on the pituitary gland and ultimately cause visual disturbances. Dr. Dimancescu opines that the CAT scan of the orbits and sinuses is the optimal diagnostic test for sinus disorders and that the diagnosis of mucocele for plaintiff's decedent was based on a CAT scan, and plaintiff's decedent's clinical presentation of headaches and visual changes. Dr. Dimancescu also opines with a reasonable degree of medical certainty that at no time while plaintiff's decedent was under the care of Dr. Davis could a diagnosis of myxoma of the sphenoid sinus be made or should have been included in the differential diagnosis inasmuch as myxoma of the sphenoid sinus is one of the rarest tumors, the CAT scan of the orbits and sinuses were diagnostic of a large mucocele and the surgical pathology report was not indicative of myxoma. He emphasizes that the entirety of data available to Dr. Davis at the time pointed to mucocele. Dr. Dimancescu further opines that it is not uncommon for patients such as plaintiff's decedent to experience post-operative headaches for several weeks after such a surgery and plaintiff's decedent's complaints of headaches should not have caused Drs. Davis and Smouha to suspect that the surgery was unsuccessful or change their diagnosis.

Dr. Dimancescu explains that although Dr. Smouha sent Dr. Davis two letters in 2000 concerning plaintiff's decedent's condition, said actions were performed as a professional courtesy so as to provide Dr. Davis with a status update on plaintiff's decedent's condition and in no way sought Dr. Davis' intervention, treatment or medical advice. He adds that Dr. Smouha never directly contacted Dr. Davis concerning plaintiff's decedent in 2000; plaintiff's decedent never contacted Dr. Davis after October 10, 1997; and Dr. Davis did not send plaintiff's decedent for any diagnostic studies or review any reports or studies relating to plaintiff's decedent between October 1997 and February 2002. On said basis, Dr. Dimancescu opines that after October 10, 1997 there was no continuity of care between Dr. Davis and plaintiff's decedent. Dr. Dimancescu further notes that after a gap of almost four and a half years, Dr. Davis saw plaintiff when called in for a neurosurgical consultation in the emergency room when plaintiff's decedent was hospitalized for seizures and briefly examined plaintiff's decedent, ordered tests and referred plaintiff's decedent to the appropriate specialists, including Dr. Smouha. He points out that Dr. Davis last saw plaintiff's decedent in his office in February 2002 by which time the diagnosis of myxoma had been made and plaintiff's decedent was to be seen at Sloan Kettering Memorial Hospital for a second opinion. Lastly, Dr. Dimancescu opines that proper informed consent was obtained by plaintiff's decedent inasmuch as the record reflected that the procedures were explained to plaintiff's decedent as well as the risks, benefits and alternatives and plaintiff's decedent signed a consent form.

Here, defendant Drs. Smouha and Davis established their prima facie entitlement to judgment as a matter of law by submitting the affirmations of medical experts in otolaryngology and neurosurgery who opined, to a reasonable degree of medical certainty, that the treatment of plaintiff's decedent by Drs. Smouha and Davis from 1997 through 2000 based on a diagnosis of mucocele of the sphenoid sinus did not depart from accepted standards of medical practice and that there were no indications to perform any other tests or procedures which would have led to a diagnosis of the extremely rare condition of myxoma (see, *Shahid v New York City Health & Hospitals Corp.*, ___ NYS2d ___, 2008 WL 191796, 2008 NY Slip Op 00484 [NYAD 2 Dept Jan 22, 2008]; *DiGiario v Agrawal*, 41 AD3d 764, 839 NYS2d 212 [2d Dept 2007]; *Rebozo v Wilen*, 41 AD3d 457, 838 NYS2d 121[2d Dept 2007]).

The burden then shifted to plaintiff to demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a departure from accepted practice and containing an opinion that the defendants' acts or omissions were a competent-producing cause of plaintiff's decedent's injuries and death (see, *Dellacona v Dorf*, 5 AD3d 625, 774 NYS2d 776 [2d Dept 2004]).

In opposition to the motion for summary judgment, plaintiff contends that defendant Drs. Smouha and Davis departed from accepted medical practice in their care and treatment of plaintiff's decedent in failing to correctly diagnose the sphenoid sinus tumor and failing to immediately completely remove the tumor and that said departures resulting in the growth of the tumor to such an extent that its removal became extremely risky and said departures were a substantial factor in bringing about plaintiff's decedent death. Specifically, plaintiff contends that defendant Drs. Smouha and Davis negligently misinterpreted the initial, pre-operative, 1997 CT scan as showing mucocele and made such a diagnosis when the images showed tumor characteristics and a prior CT scan and MRI performed before plaintiff's decedent's contact with the Hospital were interpreted as indicating a sphenoid sinus tumor. Plaintiff further contends that as a result of the incorrect diagnosis, said defendants incorrectly treated plaintiff's decedent by draining mucocele rather than totally excising the tumor by intra-operatively obtaining frozen sections of the tumor.

Plaintiff points to inconsistencies in Dr. Smouha's testimony that during the surgery he believed he was dealing with a mucocele due to the appearance of a very thick cyst wall whereas pathology found no evidence of a cyst wall when analyzing the specimen. Plaintiff criticizes Dr. Smouha for failing to order a post-operative CT scan or MRI by the time of plaintiff's decedent's office visit two months after the surgery to make sure that the mass had been completely resected or had recurred rather than, as indicated in his records, planning to do so "down the road." According to plaintiff, by the time another CT scan was performed in January 2000, it was too late and in any event, Dr. Smouha departed from accepted medical practice when he failed to provide the pathologist with a clinical history after the February 2000 surgery so as to alert the pathologist to review the pathology slides from the 1997 surgery. Plaintiff argues that Dr. Smouha's departures continued in the months following the February 2000 surgery when plaintiff had constant and intense pain and a March 2000 CT scan revealed a mass still occupying the entire sphenoid sinus. In conclusion, plaintiff emphasizes that plaintiff's decedent died from a benign tumor. In support of her opposition, plaintiff submits, among other things, the redacted⁶

⁶Plaintiff may submit an unidentified expert's affirmation or affidavit provided that the Court may require submission of an unredacted copy for in camera inspection (see, *Marano v Mercy Hosp.*, 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]; *McCarty v Community Hosp.*, 203 AD2d 432, 610 NYS2d 588 [2d Dept 1994]).

affirmation of a physician licensed to practice medicine in New York and board certified in diagnostic radiology with a CAQ in neuroradiology; the redacted affirmation of a physician licensed to practice medicine in New York and board certified in neurological surgery; the affidavit of a physician licensed to practice medicine in Connecticut and board certified in otolaryngology⁷; and a portion of the deposition transcript of defendant David B. Durand, M.D.

In reply, defendant Drs. Smouha and Davis contend that plaintiff's opposition papers fail to raise an issue of fact inasmuch as plaintiff's experts fail to specifically identify any departures from accepted standards by Dr. Davis, much less any that occurred after 1997, and instead allege malpractice against both physicians in a conclusory fashion. In addition, defendant Drs. Smouha and Davis note that plaintiff does not dispute that they did not ignore the radiological findings prior to the 1997 surgery and took the proper steps of performing a biopsy and that plaintiff's clinical presentation of headaches and visual changes was consistent with a mucocele especially when combined with a CT scan of the orbits specifically diagnostic of said condition. They also contend that the deposition testimony of co-defendant Dr. Durand that a non-party pathologist misread the 1997 slides does not alter their demonstration that defendant Drs. Smouha and Davis were entitled to rely on said pathologist's interpretation. Defendant Drs. Smouha and Davis further contend that plaintiff's experts fail to address their experts' opinions that myxoma is extremely rare; that plaintiff's failure to follow up as instructed with Dr. Smouha in 1997 prevented any further diagnostic testing or examination; and that mucoceles can recur. Defendant Drs. Smouha and Davis argue that plaintiff's expert's pronouncement that plaintiff's decedent's mass was not behaving like a typical mucocele fails to account for the explanation by the experts of Drs. Smouha and Davis that mucoceles can recur and present with symptoms substantially similar to those of plaintiff's decedent's symptoms and that plaintiff's expert's characterization that there was overwhelming evidence after the February 2000 surgery pointing to a tumor fails to take account of the fact that plaintiff reported to Dr. Smouha in April 2000 that he had not felt this well in 15 years.

Plaintiff's radiology expert opines, by affirmation, to a reasonable degree of medical certainty that Dr. Smouha improperly interpreted the August 18, 1997 CT scan of plaintiff's decedent's orbit and sinuses inasmuch as the margins of the mass were highly irregular and fuzzy and thus more consistent with a tumor rather than a mucocele whose margins tend to be smooth and sharp. Plaintiff's radiology expert opines in conclusion to a reasonable degree of medical certainty that it would be a departure from accepted medical practice to render a diagnosis of mucocele based upon all three radiological studies from August 1997.

By affidavit, plaintiff's expert in otolaryngology opines based on his review of the materials as well as his training, knowledge and experience, to reasonable degree of medical probability that Dr. Smouha's care and treatment of plaintiff's decedent constituted a departure from accepted medical practice which was a substantial factor in bringing about his death. Plaintiff's expert in otolaryngology points out that there was radiological evidence from 1997 that plaintiff's decedent had a tumor and not mucocele and that the pathology report from the 1997 surgery failed to identify a cyst wall and did not diagnose a mucocele. Plaintiff's expert adds that the 2000 MRI findings of a right sided mass extending

⁷ Plaintiff's expert sufficiently established his or her qualifications as an expert and the fact that plaintiff's expert does not practice in New York does not render his or her testimony inadmissible; rather, it affects the weight of that testimony (see, *Kenny v Lesser*, 281 AD2d 853, 722 NYS2d 302 [3d Dept 2001]).

to the left side were not consistent with the intra-operative findings of a small left sided mucocele but rather inflamed polypoid tissue and Dr. Smouha had an obligation to inform the pathology department of the clinical history concerning the specimen. Based on the testimony of the radiologist who interpreted the 2000 slides that had the clinical history suggested some abnormality, the radiologist would have retrieved the previous pathology specimens for comparison, plaintiff's expert opines that had Dr. Smouha provided a proper clinical history, a proper diagnosis may have resulted. According to plaintiff's expert, the mass was not behaving like a typical mucocele; in February and March 2000 plaintiff's decedent was complaining of constant pain and then decreased vision and was taking up to 25 Percocets a day to alleviate the pain; and a CT scan indicated that the mass had again filled the sphenoid sinus. Plaintiff's expert in otolaryngology states that once a mucocele is drained, the symptoms should be alleviated and that the return of the mass within a month after the surgery, with increased pain, should have alerted defendant physicians that they were not dealing with a mucocele. Plaintiff's expert in otolaryngology further states that repeat radiological studies and a biopsy of the recurrent mass should have been performed rather than merely advising plaintiff's decedent to quit his job as a landscaper due to its negative effect on his condition.

Plaintiff's neurological surgery expert opines by affirmation that it was a departure from accepted medical practice of defendants not to take into account the two radiological studies performed earlier in the month of August 1997 which clearly demonstrated that a tumor was present. Plaintiff's neurological surgery expert points out that an MRI is superior to a CT scan for diagnosing soft tissue masses. In addition, plaintiff's expert opines that the proper procedure in August 1997 should have been a total excision of the mass; intra-operatively defendants should have attempted to identify the margins of the tumor; and frozen sections of the tumor should have been sent to pathology for immediate feedback. Plaintiff's expert also opines that it was essential that an imaging study be performed shortly after surgery to determine if the mass had been removed or had reoccurred and repeat neurological studies should have been performed on a yearly basis thereafter.

Here, the Court initially notes that plaintiff's expert radiologist and expert otolaryngologist make no reference at all to Dr. Davis in their sworn statements (*see, Kaplan v. Hamilton Medical Associates, P.C.*, 262 AD2d 609, 692 NYS2d 674 [2d Dept 1999]). In addition, plaintiff's expert neurosurgeon makes no specific reference to any deviation or departure from accepted standards of medical practice by Dr. Davis and merely generalizes in conclusion that defendants failed to perform proper follow-ups consistent with plaintiff's decedent's signs and symptoms; failed to perform yearly follow-up radiologic studies to track the pathology and failed to timely diagnose myxoma. Such failure to differentiate between the acts of the two defendant physicians and generalized allegations of collective departures by defendants renders plaintiff's expert neurosurgeon's opinions conclusory and insufficient to raise a triable issue of fact with respect to Dr. Davis (*see, Rebozo v Wilen*, 41 AD3d 457, 838 NYS2d 121 [2d Dept 2007]; *Mosezhnik v Berenstein*, 33 AD3d 895, 823 NYS2d 459 [2d Dept 2006]; *Jonassen v Staten Is. Univ. Hosp.*, 22 AD3d 805, 803 NYS2d 700 [2d Dept 2005]; *Dellacona v Dorf, supra*). Therefore, plaintiff has not raised any triable issue of fact concerning Dr. Davis and that portion of the motion for summary judgment dismissing the complaint in its entirety as against Dr. Davis is granted (*see, Suib v Keller*, 6 AD3d 805, 774 NYS2d 608 [3d Dept 2004]).

However, the sworn statements of plaintiff's radiology expert and otolaryngology expert were sufficient to raise a triable issue of fact as to whether Dr. Smouha failed to timely take steps that would

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have led to an earlier diagnosis of myxoma and complete excision of the tumor (*see, Feinberg v Feit*, 23 AD3d 517, 806 NYS2d 661 [2d Dept 2005]). The record is unclear as to whether Dr. Smouha had the August 11, 1997 MRI report available to review at or prior to the time that he reviewed the August 18, 1997 CT scan such that he had the differential diagnosis of sphenoid sinus tumor available for consideration. In his affirmation, defendant's expert otolaryngologist, Dr. Setzen, seems to allude to the availability of other pre-operative diagnostic studies besides the August 18, 1997 CT scan for Dr. Smouha's review but opines that at no time while plaintiff's decedent was under the care of Dr. Smouha could a diagnosis of myxoma of the sphenoid sinus have been made or included in the differential diagnosis. Whereas defendant's expert neurosurgeon opines that a CT scan of the orbits and sinuses is the optimal diagnostic test for sinus disorders, plaintiff's expert neurosurgeon opines that an MRI is superior to a CT scan for diagnosing soft tissue masses. Thus, plaintiff raised issues of fact as to whether the MRI films of August 11, 1997 and the resulting report containing the differential diagnosis of sphenoid sinus tumor were available to Dr. Smouha at the time that he reviewed the August 18, 1997 CT scan, and if so, whether it was a departure from accepted medical standards for him not to consider the possibility of a tumor, to rely mainly on his own review of the August 18, 1997 CT scan, and to fail to investigate further when the pathology report from the 1997 surgery failed to indicate mucocele. In addition, plaintiff's expert in otolaryngology opines, contrary to that of defendant's expert otolaryngologist, that in 2000, plaintiff's decedent's post-surgery symptoms indicated that the mass was not characteristic of a mucocele and that Dr. Smouha's failure to immediately perform repeat radiological studies and a biopsy was a departure from accepted medical standards was a proximate cause of plaintiff's decedent's injuries and subsequent death. Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions (*see, Shields v Baktidy*, 11 AD3d 671, 783 NYS2d 652 [2d Dept 2004]; *Barbuto v Winthrop Univ. Hosp.*, 305 AD2d 623, 624, 760 NYS2d 199 [2d Dept 2003]). Such credibility issues can only be resolved by a jury (*see, Shields v Baktidy, supra; Halkias v Otolaryngology-Facial Plastic Surgery Assoc.*, 282 AD2d 650, 724 NYS2d 432 [2d Dept 2001]). Therefore, the portion of the motion seeking summary judgment on behalf of Dr. Smouha is denied.

Accordingly, the motion for summary judgment is granted solely with respect to Dr. Davis and the complaint is dismissed as against him in its entirety. The motion for summary judgment on behalf of Dr. Smouha is denied. The action is severed and continued as against the remaining defendants.

Dated: 3/5/08

Emily Pines
J.S.C.

 FINAL DISPOSITION X NON-FINAL DISPOSITION