Uydess v Manhattan Eye, Ear & Throat Hosp.
2008 NY Slip Op 31494(U)
May 29, 2008
Supreme Court, New York County
Docket Number: 0106302/2006
Judge: Joan Lobis
Republished from New York State Unified Court System's E-Courts Service. Search E-Courts (http://www.nycourts.gov/ecourts) for any additional information on this case.
This opinion is uncorrected and not selected for official publication.

SCANNED ON 6/2/2008

[* 1]

SUPREME COURT OF THE STATE OF NEW YORK - NEW YORK COUNTY

PRESENT: HON. JOAN B. LOBIS
Justice

PART 6

VIRGINIA UYDESS
Plaintiff

- v -

MANHATTAN EYE, EAR & THROAT
Defendant

INDEX NO. 106302/06

MOTION DATE 3/11/08

MOTION SEQ. NO. 001

MOTION CAL. NO.

The following papers, numbered 1 to 29 were read on this motion to/for Summary judgment

	PAPERS NUMBERED
Notice of Motion / Order to Show Cause – Affidavits – Exhibits	1-22
Answering Affidavits – Exhibits	23-29
Replying Affidavits	30-35; 36; 37

Cross-Motion: [ ] Yes [X] No

MOTION DECIDED IN ACCORDANCE WITH ACCOMPANYING DECISION AND ORDER

FILED
JUN 02 2008
NEW YORK
COUNTY CLERK'S OFFICE

Dated: 5/29/08

JOAN B. LOBIS, J.S.C.

Check one: [ ] FINAL DISPOSITION [X] NON-FINAL DISPOSITION

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY: IAS PART 20

---X

VIRGINIA UYDESS and MICHAEL UYDESS,

Plaintiffs,

Index No. 106302/06

-against-

Decision and Order

MANHATTAN EYE, EAR AND THROAT HOSPITAL, LENOX HILL HOSPITAL, SEAN E. McCANCE, M.D., PLLC, SEAN E. McCANCE, M.D., PARK AVENUE RADIOLOGISTS, P.C., ALBERT V. MESSNIA, M.D., MICHAEL MIZHIRITSKY, M.D., and CHRISTOPHER RIEGLER, M.D.,

Defendants.

---X

JOAN B. LOBIS, J.S.C.:

Motion Sequence Numbers 001 and 002 are consolidated for disposition. In Motion Sequence Number 001, defendants Lenox Hill Hospital ("Lenox Hill"), Sean E. McCance, M.D., PLLC and Sean E. McCance, M.D. (together, "Dr. McCance"), move for summary judgment in their favor, pursuant to C.P.L.R. § 3212; in the alternative, they move for an order directing plaintiffs to provide certain specified authorizations for the release of records, pursuant to C.P.L.R § 3124. In Motion Sequence Number 002, defendant Michael Mizhiritsky, M.D., moves for summary judgment in his favor, pursuant to C.P.L.R. § 3212. At oral argument of the motion on March 11, 2008, the parties entered into a so-ordered stipulation which resolved that branch of Motion Sequence Number 001 regarding defendants' request for authorizations. Further, by letter to the court dated March 20, 2008, and copied to all parties, Lenox Hill withdrew its branch of Motion Sequence Number 001 seeking summary judgment on its behalf. The motions for summary judgment on behalf of Drs. McCance and Mizhiritsky will be decided herein.

This is an action for medical malpractice which arises from the treatment of plaintiff, Virginia Uydess. Plaintiff commenced this action against defendants by the filing of a summons and complaint on May 8, 2006. Issue was joined, and plaintiff has served verified bills of particulars. Depositions have been conducted, and plaintiff filed a note of issue and certificate of readiness on November 19, 2007.

On February 5, 2005, Mrs. Uydess experienced a sudden onset of severe pain in her neck and right arm. She was taken via ambulance to Lenox Hill, where she was given an injection of Toradol and a prescription for Valium; she was then released. After Mrs. Uydess' emergency admission to Lenox Hill, her primary care physician, Lawrence Hecker, M.D., referred her to defendant McCance, an orthopedic and spinal surgeon, for a cervical evaluation. Mrs. Uydess first met with Dr. McCance on February 8, 2005. According to Dr. McCance's notes from the first office visit, plaintiff described

> some chronic neck symptoms on and off, but very severe in the last four days with radiation down the right scapula and arm towards the elbow. She developed urinary retention symptoms yesterday. Her balance is somewhat off. She has a general sense of weakness. She thinks this may be caused by some heavy lifting.

Dr. McCance's physical examination revealed that Mrs. Uydess had good balance but had difficultly with tandem gait and had a markedly decreased cervical range of motion. Dr. McCance noted that Mrs. Uydess had signs and symptoms of severe neck pain, but also had symptoms suggesting a herniated disc. Dr. McCance referred Mrs. Uydess to Park Avenue Radiology for an x-ray and an MRI of the cervical spine, and noted that the patient would follow up after the radiologic studies were complete.

On February 10, 2005, plaintiff had an x-ray and MRI without contrast at Park Avenue Radiology, performed by defendant, Albert Messina, M.D., a radiologist. Dr. Messina's MRI report found straightening of the normal cervical lordosis, small central nuclear herniation at C3-4, chronic endplate changes at the C5-6 level, and a "right lateral nuclear herniation causing considerable neuronal impingement within the right neural foramen at C5-6." The impression in the MRI report was that Mrs. Uydess had multilevel nuclear hernatitions, most severely at level C5-6 on the right side. Degenerative changes and findings related to muscle spasm were also noted.

Dr. McCance's records reflect that on the same day as the MRI, Mrs. Uydess left a message with Dr. McCance's office with the complaint that she was having trouble urinating, and wanted to know if it was a side effect of the hydrocodone or Vicodin she was taking. Although he did not recall having a conversation with Mrs. Uydess, Dr. McCance's handwriting on the phone message note reads "It can be. If it persists, discuss with primary MD. Did she do MRI? C spine."

Mrs. Uydess went to Dr. McCance for a follow-up visit on February 14, 2005. Her current symptoms were pain in the lower back of her head, right shoulder and right arm; skin breakout; constipation; and, difficulty in urination. Dr. McCance noted that Mrs. Uydess was having pain in her right neck and trapezius of the right arm. He reviewed the MRI with her and noted that she was positive for herniation of the C4-5 and C5-6; he recommended a Medrol dose pack and a follow-up in four weeks. That day, Dr. McCance referred Mrs. Uydess to Dr. Mizhiritsky, a specialist in physical medicine and rehabilitation, who first saw plaintiff on February 15, 2005. In a letter to Dr. Hecker, Dr. Mizhiritsky gave an account of plaintiff's medical history from the day

[* 5]

before her admission to Lenox Hill until February 15, and noted:

> [Mrs. Uydess] had x-rays and an MRI of the cervical spine. MRI report was obtained and was read as multilevel nuclear herniations, most severe at C5-6 on the right side. The patient was told by Dr. McCance that her condition is not surgical; therefore, she is referred to me for further management.
>
> The neck and upper back pain is more right-sided and is associated with radiation down the right upper extremity. She denies any bowel or bladder incontinence. She was initially on hydrocodone but she thinks it may have caused rash. She stopped taking that medication and was switched to Percocet by Dr. McCance. She was also prescribed Medrol dose pack and the first dosage was taken earlier today.

Upon examination, Dr. Mizhiritsky noted that there was "diffuse tenderness to palpation over the cervical and upper thoracic paraspinal muscles." Mrs. Uydess' range of motion was decreased, sensation was intact, and her strength was decreased in her right shoulder abduction and elbow flexion. Dr. Mizhiritsky's impression was that plaintiff had neck and upper back pain secondary to myofascial pain syndrome, and a documented disc herniation. He recommended that she be ruled out for cervical radiculopathy. Dr. Mizhiritsky gave her a prescription for physical therapy and advised her to discontinue the Percocet but to continue the Medrol dose pack until finished. Dr. Mizhiritsky also noted that he would schedule an "EMG/NCV" (electromyography and nerve conduction velocity) study in two weeks to rule out radiculopathy if Mrs. Uydess' symptoms persisted, and would consider trigger point injections for pain relief.

On February 21, 2005, Mrs. Uydess made an unscheduled visit to Dr. Mizhiritsky's office because her neck pain had worsened, to the point where during the previous night she took three Percocet tablets over a period of four and a half hours. She had finished the Medrol dose pack

by this point and had been taking Flexeril and Naproxen. Dr. Mizhiritsky performed trigger point injections at the left upper trapezius, right upper trapezius, and right levator scapula muscles. She was advised to ice and stretch the muscles over the next 24-48 hours; to continue with physical therapy; to continue with the Flexeril and Naproxen; and, to follow up in one week with an EMG to rule out radiculopathy. The follow-up EMG took place on February 28, 2005. The study revealed "mild cervical radiculopathy affecting the C6 region on the right side. Only posterior rami denervation was noted." Plaintiff was advised to continue with physical therapy and medications, and to consider further trigger point injections and acupuncture. Mrs. Uydess saw Dr. Mizhiritsky on March 10, her pain and strength having improved, but now had decreased sensation in the C-6 dermatome. Plaintiff again saw Dr. Mizhiritsky on March 14, her pain having worsened over the previous twelve hours, without having had any recent trauma, accidents, or significant repetitive work. Mrs. Uydess was advised to ice and stretch the area over the next 24-48 hours and to continue with physical therapy; she was also given a prescription for Vicodin, although it was noted that she may have had a reaction to generic hydrocodone, and she was instructed to stop taking the Vicodin if she had a similar reaction.

On March 22, 2005, Mrs. Uydess saw Dr. McCance for a follow-up visit. Her current symptoms were pain in her shoulder, arm, and neck, and difficulty with lifting her neck when getting up after lying down. She stated that she felt "40% better" and that she had a relapse and then improved. She was experiencing pain in her right trapezius toward the elbow, with numbness into the right hand. She was noted to have weakness of the right wrist extensor and biceps, with a decreased cervical range of motion. The office note states:

> The patient would like to do two more weeks of physical therapy and then consider an epidural steroid injection. She does not want to consider surgery at this time, as it is 'too drastic.'
>
> We will work with her and recommend the epidural when she is ready. I will see her again in six weeks' time for reevaluation. She was advised that she does have significant nerve compression that may lead to chronic neurological problems.

Mrs. Uydess had been going to physical therapy approximately three times per week since February 18. However, on March 29, 2005, Dr. McCance referred Mrs. Uydess for a cervical epidural steroid injection on C5-6, after Mrs. Uydess called him and said that she wanted the steroid injection and that the physical therapy did not work.

The cervical epidural steroid injection was performed on March 31, 2005, by defendant, Christopher Riegler, M.D., in his office. After the injection, Mrs. Uydess was moved from the table and she became alarmed that she had no feeling in her torso. Dr. Riegler called Dr. McCance to inform Dr. McCance that during the epidural injection, Mrs. Uydess had developed pain and could not move her arms or legs. It was determined that Mrs. Uydess had developed acute onset paraplegia, also known as Brown-Sequard syndrome, and she was immediately transferred to Lenox Hill for an MRI scan to determine why she had become paralyzed. The MRI with contrast revealed an acute large C5-6 disc space infection with abscess and spinal cord compression. Mrs. Uydess was sent to the operating room for cervical decompression and stabilization. Dr. McCance performed the surgery, which was an anterior cervical debridement of the disc space with fusion and decompression of the spinal canal, plating, and bone graft with titanium cage. The surgery revealed findings of a C5-6 disc space infection with excessive granulation tissue and necrotic disc space,

vertebral end plate erosions and vertebral defect, spinal cord compression. It was noted that post-operatively, Mrs. Uydess had "some improvement of her right-sided strength in the arm and leg, with persistent paraparesis in the left leg and some residual weakness of the left arm and hand." On April 1, 2005, Dr. McCance's hospital note described plaintiff as having "markedly improved mobility of her left leg, arm and hand. The right leg still remains paralyzed. She can move the right arm a little bit better, but the hand is quite weak."

Following the surgery, Mrs. Uydess spent approximately eight days in intensive care at Lenox Hill. On April 8, 2005, she was transferred to inpatient treatment at Mt. Sinai Hospital for rehabilitation, where she stayed through June 7, 2005. Mrs. Uydess continued to receive outpatient therapy at Mt. Sinai, and at the time of her examination before trial on March 16, 2007, plaintiff was still going to Mt. Sinai for rehabilitation two times a week. Although her condition had improved since the onset of paraplegia on March 31, 2005, as of her deposition, plaintiff was still experiencing pain and the sensation of pins and needles; continuing to have trouble walking because she has trouble lifting her toes and knees; walking with a Lofstran crutch; experiencing both hypersensitivity and loss of motor on her right side (Brown-Sequard syndrome); and relying on Access-A-Ride to go long distances. She was also wearing a leg brace and orthopedic shoes, and she had received Botox injections in order to improve the condition of the muscles in her leg.

The party moving for summary judgment in a medical malpractice action must make a prima facie showing of entitlement to judgment as a matter of law by showing the absence of a triable issue of fact as to whether the defendant physician was negligent. Alvarez v. Prospect Hosp.,

68 N.Y.2d 320, 324 (1986). Once the movant satisfies this burden, the burden shifts to the party opposing the motion "to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action." Id. (citation omitted). Specifically, this requires, in a medical malpractice action, that a plaintiff opposing a physician's summary judgment motion

> must submit evidentiary facts or materials to rebut the prima facie showing by the defendant physician that he was not negligent in treating plaintiff so as to demonstrate the existence of a triable issue of fact. . . . General allegations of medical malpractice, merely conclusory and unsupported by competent evidence tending to establish the essential elements of medical malpractice, are insufficient to defeat defendant physician's summary judgment motion.

Id. at 324-25 (citations omitted).

In support of his motion, Dr. McCance submitted an affirmation by James Tait Goodrich, M.D., a board-certified neurosurgeon. Dr. McCance's expert opines that when Dr. McCance first examined Mrs. Uydess on February 8, 2005, he took an appropriate history and determined that cervical spine studies were needed to evaluate the source of Mrs. Uydess' neck pain. Dr. Goodrich sets forth that Mrs. Uydess did not exhibit any signs of a condition that would have required a contrast evaluation, such as an ongoing infection, prior surgery, or scar tissue; thus, he opines that Dr. McCance appropriately ordered an MRI without contrast on February 8, 2005. Further, Dr. Goodrich notes that Dr. McCance reviewed the MRI studies himself, but deferred to the radiologist's report, which did not indicate any infection. As there were no indications for infection (such as fluid collection, exuberant tissue abscess, destruction of bone, or destruction of disc), Dr.

Goodrich asserts that Dr. McCance did not fail to recognize a bacterial epidural abscess or an acute discitis on the films, nor did he fail to recognize an abnormal signal intensity and enhancement within plaintiff's spinal cord.

Dr. Goodrich further notes that when Dr. McCance examined Mrs. Uydess on March 22, 2005, Dr. McCance felt that Mrs. Uydess was a surgical candidate, but he deferred to his patient's request to try less "drastic" measures first, and instead prescribed pain medication and directed plaintiff to go to physical therapy. Upon plaintiff's request for an epidural injection, Dr. McCance gave her the prescription because, although it was not Dr. McCance's first choice, an epidural injection for pain management was an appropriate non-surgical alternative for Mrs. Uydess, as she did not have symptoms that would have rendered the procedure inappropriate. Dr. Goodrich states that Dr. McCance "clearly could not 'force' her [Mrs. Uydess] to have surgery," and that on March 22, Dr. McCance explained to her the problems that could occur as a result of compression, namely chronic neurological problems such as permanent pain, permanent numbness, permanent weakness, progressive neurological disorder, or paralysis. Having heard the problems, Mrs. Uydess opted not to have the surgery at that time and instead pursued a course of physical therapy and an epidural spinal injection. Dr. Goodrich opines that the emergency spinal surgery performed by Dr. McCance was successful in that Dr. McCance debrided the abscess and successfully performed effusion and decompression in a "now complicated" case.

Dr. Goodrich states that, contrary to plaintiff's claims that an MRI should have been performed before the March 31, 2005 surgery, there was no clinical manifestation of any symptoms

that would have led Dr. McCance to suspect an ongoing infection at either the February 14 or March 22 office visits; as such, there was no indication to perform a pre-surgical MRI. Dr. Goodrich states that it is not the standard of care to perform another MRI six weeks after a previous MRI when there are no new manifestations and the findings from the first MRI correspond to the patient's symptoms; furthermore, he opines that there is no standard of care to obtain blood tests prior to an epidural injection for a patient presenting with pain in her neck radiating down one side.

Defendant McCance has met his burden as the proponent of summary judgment. He submitted an expert affidavit in which the expert concluded, after reviewing all relevant documents, medical records and the transcripts of the parties' examinations before trial, that to a reasonable degree of medical certainty, the care and treatment rendered to Mrs. Uydess on and after February 8, 2005 was at all times in accordance with good and accepted medical practice. Having established a prima facie showing of entitlement to summary judgment, the burden shifts to plaintiff to rebut the prima facie showing by demonstrating the existence of a triable issue of fact.

In opposition to Dr. McCance's motion, plaintiff submitted an affirmation by a board-certified neurosurgeon (name redacted) who reviewed the original February 10, 2005 MRI films, together with Dr. Messina's report, and the records of defendant, Dr. McCance. He states that Dr. McCance departed from accepted standards of medical practice by failing to recognize the signs of infection, epidural abscess, discitis, and osteomyelitis from his review of the February 10, 2005 MRI films. Plaintiff's expert states that Dr. McCance had a duty to, and did, review plaintiff's MRI studies, and that he improperly interpreted those studies, which he states show

> an obvious infection in plaintiff's cervical spine at the level of C5-C6. The infection is evident for many reasons. First, the MRI films show that plaintiff Virginia Uydess had degenerative disc disease at multiple levels of her cervical spine. These degenerative changes show on plaintiff's MRI films as hypointense T2 signal in the discs. To the contrary, at the C5-C6 disc, plaintiff's MRI films reveal hyperintense T2 signal in this disc. In light of plaintiff's multilevel degenerative disc disease, the hyperintesity/brightness at C5-C6 is an unusual finding, and is a sign of an infectious process at that level.

The expert further states that the MRI films show edema in the vertebral bodies at C5-6; destruction of the superior aspect of the vertebral body endplate at C6; and, an anterior epidural mass at the C5-6 level, compatible with an abscess when associated with the MRI signs of an adjacent discitis. The indicia of infection that plaintiff's expert cites are the same indicia that defendant and his expert cite, but plaintiff's expert concludes that these indicia are present and visible on the February 10, 2005 MRI, while Dr. McCance and his expert state that they are not.

Plaintiff's expert also asserts that Dr. McCance's "failure to recognize the clinical significance of plaintiff's repeated complaints of urinary retention . . . , as well as his neurological findings that her balance was off and she had difficulty with tandem gait, was a departure from accepted medical practice and a substantial factor in bringing about plaintiff's injuries." Plaintiff complained of difficulty in urination at least twice to Dr. McCance. Plaintiff's expert states that urinary retention is not a known reaction to hydrocodone or Vicodin, and notes that any patient who has neck or back pain and urinary abnormalities should be considered to have spinal cord compression until proved otherwise. Plaintiff's expert concludes that plaintiff's injuries could have been prevented if Dr. McCance had recognized the signs of an infection or abscess, and that it was a departure from accepted medical practice for him not to have done so.

Summary judgment must be denied as to Dr. McCance. Plaintiff has submitted sufficient evidence to rebut defendant's prima facie showing that there was no clinical manifestation of any symptoms that would have led Dr. McCance to suspect an ongoing infection at either the February 14 or March 22 office visits. The conflicting expert affidavits raise triable issues of fact as to whether defendant Dr. McCance departed from the prevailing standard of care by failing to properly read plaintiff's diagnostic films and failing to recognize the signs and symptoms of an existing infection.

In support of his motion, Dr. Mizhiritsky submitted the affirmation of Michael D. Liebowitz, M.D., a physician board-certified in physical medicine and rehabilitation. Dr. Liebowitz opines that during the time that Mrs. Uydess was under Dr. Mizhiritsky's care, the clinical presentation was not compatible at any time with a pyogenic, or pus producing, infection of the cervical spine. Dr. Mizhiritsky's expert states that common indicators of a pyogenic infection of the cervical spine are very rapid onset, fevers, focal neurological deficits, and nuchal rigidity. In contrast, Mrs. Uydess was afebrile during the initial consultation by Dr. Mizhiritsky, and did not present with significant focal neurological deficits or nuchal rigidity.

Dr. Liebowitz also states that Dr. Mizhiritsky was not required by standards of medical practice to review the actual radiologic image studies from the February 10, 2005 MRI, since he relied on the expertise of the radiologist (Dr. Riegler) and the radiologist's report. Further, as set forth in Dr. Riegler's x-ray radiology report, the plain x-rays taken of Mrs. Uydess' cervical spine on February 10, 2005 did not reveal indicia of a pyogenic infection of the spine (irregular erosions on the endplates of adjacent vertebral bodies with a narrowing of the disc space).

Dr. Liebowitz concludes that there is no evidence, from Dr. Mizhiritsky's initial consultation on February 15, 2005, until the last time Mrs. Uydess saw him on March 14, 2005, that Mrs. Uydess had clinical evidence of a pyogenic infection of the cervical spine: "There was no departure from the standard of care by Dr. Mizhiritsky relative to diagnosing a pyogenic infection as there was no clinical or radiographic evidence of same while the patient was under his care." Further, he concludes that there is no evidence that any act or omission by Dr. Mizhiritsky resulted in Mrs. Uydess' spinal epidural abscess, nor that the physical therapy prescribed by Dr. Mizhiritsky was the proximate cause of the abscess. Dr. Liebowitz states that there is no relationship between the complaints for which Dr. Mizhiritsky saw Mrs. Uydess and the onset of the partial Brown-Sequard syndrome that occurred on March 31, 2005. Dr. Mizhiritsky's expert asserts that the treatment was proper and within accepted standards of medical practice for the diagnosis of myofascial pain syndrome, a C5-6 herniated disc, and a right C-6 radiculopathy; and, the diagnosis was correct for the symptoms presented, the clinical findings, and the radiographic findings as reported by the radiologist.

Defendant Dr. Mizhiritsky has met his burden as the proponent of summary judgment. He submitted an expert affidavit in which the expert concluded, after reviewing all relevant documents, medical records and the transcripts of the parties' examinations before trial, that to a reasonable degree of medical certainty, the care and treatment rendered to Mrs. Uydess by Dr. Mizhiritsky was at all times in accordance with good and accepted medical practice, and that Dr. Mizhiritsky's acts or omissions in no way proximately caused any of the injuries plaintiff alleges in her bill of particulars.

In opposition to Dr. Mizhiritsky's motion, plaintiff submits the affidavit of a physician (name redacted) board certified in physical medicine and rehabilitation with a sub-specialty in spinal cord injury medicine. As defendant's reply affirmation correctly asserts, plaintiff's expert's opinion is in complete disagreement with defendant's expert opinion. While Dr. Liebowitz asserts that there was no clinical evidence of an infection while the patient was under Dr. Mizhiritsky's care, plaintiff's expert asserts that clinical indicia of an infection were present, but that Dr. Mizhiritsky failed suspect the possibility of an infection. Plaintiff's expert asserts that the fact that plaintiff was tender to palpation over her cervical and upper thoracic paraspinal muscles at her initial consultation and follow-up consultations was an indication of the possibility of infection. Plaintiff's expert also states that plaintiff's abnormal neurological symptoms, such as decreased sensation and paresthesis (pins and needles), indicated the possibility of a spinal cord compression. Further, while Dr. Mizhiritsky's expert states that commonly, patients with pyogenic infection have a very rapid onset and fevers, plaintiff's expert states that the duration (six weeks) of plaintiff's pain warranted further investigation with respect to conditions such as malignancy or infection, and that it is well known that fever is frequently not present in patients with spinal epidural abscess, so plaintiff's lack of fever was insufficient to rule out infection as the cause of her pain. Plaintiff's expert concludes that it was a departure from accepted medical practice for Dr. Mizhiritsky to have not recognized the signs of infection, and that had he recognized the signs, plaintiff's spinal epidural abscess could have been surgically decompressed and drained under non-emergent conditions.

Summary judgment must be denied as to Dr. Mizhiritsky. Plaintiff has submitted sufficient evidence to rebut defendant's prima facie showing Dr. Mizhiritsky's diagnosis and

treatment was at all times in accordance with accepted standards of medical practice. In view of the experts' conflicting opinions, summary judgment must be denied. See Cruz v. St. Barnabus Hosp., 2008 N.Y. Slip Op. 3115 (1st Dep't April 10, 2008). It cannot be concluded as a matter of law that defendant did not depart from the prevailing standard of care by failing to consider whether plaintiff's symptoms indicated infection as opposed to herniation. Defendant's expert concluded that Dr. Mizhiritsky's treatment was proper in conjunction with Dr. Mizhiritsky's diagnosis, but there are conflicting expert opinions as to whether plaintiff's symptoms and clinical findings were properly diagnosed by Dr. Mizhiritsky. These are issues of fact for a jury to decide.

The motions for summary judgment are denied. The parties are directed to appear for a pre-trial conference on July 15, 2008, at 9:30 a.m. This constitutes the decision and order of the court.

Dated: May 29, 2008

JOAN B. LOBIS, J.S.C.

FILED
JUN 02 2008
YORK
CLERK'S OFFICE