Anisis v Husain
2009 NY Slip Op 30550(U)
March 3, 2009
Supreme Court, Nassau County
Docket Number: 2837-06
Judge: Randy Sue Marber
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.

[* 1]

SHORT FORM ORDER

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU

Present: **HON. RANDY SUE MARBER**

JUSTICE TRIAL/IAS PART 23

_______________________________________X

JOHN ANISIS and VALERIE ANISIS,

Plaintiffs,

-against-

Index No.: 2837/06
Motion Sequence...01,02,03,04,05,06
Motion Date...02/04/09

MOHAMMAD S. HUSAIN, M.D., JULIUS A. BAZAN, M.D., DAVID D. LOWENKRON, M.D., JOSEPH EICHENBAUM, M.D., MOHAMMED MUNEERUDDIN, M.D., MERCY MEDICAL CENTER, FRANKLIN HOSPITAL MEDICAL CENTER, DR. MOHAMMAD S. HUSAIN, PHYSICIAN, P.C., JOSEPH EICHENBAUM, M.D. & DAVID WEINSTOCK, M.D., P.L.L.C. and MOHAMMED MUNEERUDDIN, M.D., P.C.,

Defendants.

_______________________________________X

Papers Submitted:
Notice of Motion..x
Notice of Cross-motion....................................x
Notice of Cross-motion....................................x
Order to Show Cause..x
Notice of Cross-motion....................................x
Order to Show Cause..x
Affirmations in Opposition..............................x
Reply Affirmations...x

The motion (Sequence No. 1) by Defendants, David D. Lowenkron, M.D.,

Joseph Eichenbaum, M.D., Franklin Hospital Medical Center, Joseph Eichenbaum, M.D. and David Weinstock, M.D., P.L.L.C., seeks an order pursuant to CPLR § 3212, granting them summary judgment dismissing the complaint against them, is determined as provided herein.

The cross-motion (Sequence No. 2) by Defendant, Mohammed Muneeruddin, M.D., for an order pursuant to CPLR § 3212, granting him summary judgment dismissing the complaint against him is **DENIED**.

The cross-motion (Sequence No. 3) by Defendants, Julius A. Bazan, M.D. and Mohammad S. Husain, M.D. and Mohammad S. Husain, Physician, P.C. ("Husain") (Sequence No. 5) for an order pursuant to CPLR § 3212 granting them summary judgment dismissing the complaint against them are adjourned to April 6, 2009 at 9:30 a.m. in Part 23 of this Court.

The motions by Plaintiffs, John Anisis and Valerie Anisis, by Orders to Show Cause for an order pursuant to CPLR § 3212(a) denying Defendants, Bazan (Sequence No. 4) and Husain's (Sequence No. 6) motions for summary judgment and/or staying them are **GRANTED** to the extent that Bazan and Husain's motions for summary judgment are adjourned to April 6, 2009 at 9:30 a.m. in Part 23 of this Court.

The Plaintiffs in this action seek to recover damages for medical malpractice. On February 2, 2005, the Plaintiff, John Anisis ("Plaintiff") was admitted to the Defendant, Mercy Medical Center via the Emergency Room with stroke symptoms including slurred speech, drooling on the left side of his face and weakness in his left hand and arm by the

Defendant neurologist, Mohammad S. Husain, M.D. A CT Scan of the Plaintiff's brain was unremarkable. On February 3, 2005, the Defendant cardiologist, Mohammed Muneeruddin, M.D., examined the Plaintiff at Dr. Husain's request. The Plaintiff was kept on a cardiac monitor which showed no signs of arrhythmias including atrial fibrillation. The Plaintiff was found, via an MRI of his brain, to have a small right temporal lobe infarction in the right temporoparietal region of his brain without thrombus or aneurysm. A transesophageal echocardiogram was done to rule out a cardiac source of the embolism and it revealed that the Plaintiff had a small ventricular septal defect in the upper end of his intraventricular septum adjacent to the aortic root. The Plaintiff was ultimately diagnosed with having suffered a Cerebral Vascular Accident ("CVA") or a Transient Ischemic Attack ("TIA"). Coumadin was not prescribed because there were no indications that the Plaintiff's stroke symptoms had a cardiac source of embolus. The Plaintiff was discharged on February 5, 2005. As a follow up, the Plaintiff was seen by the Defendant neurologist, Julius A. Bazan, M.D., on February 8, 2005 and by the Defendant cardiologist, David D. Lowenkron, M.D., on February 9, 2005. Neither Dr. Bazan or Dr. Lowenkron found a cardiac source of embolism either and so they concurred that Coumadin was not appropriate.

Six months later, on August 10, 2005, the Plaintiff was admitted to the Defendant, Franklin Hospital Medical Center, via the Emergency Room, with stroke symptoms, by the Defendant cardiologist on-call that day, Joseph Eichenbaum, M.D. Despite another battery of tests, again, a cardiac source of embolus was not found, but the Plaintiff

was put on Heparin and treated with the anticoagulant Coumadin as a preventive measure. Coumadin was prescribed at the Plaintiff's discharge on August 16, 2005, along with the antiplatelet medication Plavix.

Concerned about his recurrent strokes, the Plaintiff was examined at the Mayo Clinic in Minnesota from October 17, 2005 through October 21, 2005 to determine their etiology. Again, a cardiac source was not definitively identified, nor was it definitively ruled out.

In this action, the Plaintiff alleges that the Defendants failed to properly diagnose him; negligently ruled out an embolic source for his stroke; failed to determine the etiology of his stroke; failed to make proper referrals; failed to prescribe proper medications; failed to perform indicated tests; failed to recognize his increased risk of strokes; and, failed to recognize the importance of his history, in particular, of Tetrology of Fallot. The Plaintiffs predominantly fault the Defendants for failing to prescribe Coumadin after his first stroke in February.

The Defendants seek summary judgment dismissing the complaint against them. Defendants, Lowenkron and Muneeruddin's motions are timely brought under CPLR § 3212(a), but the Defendants, Bazan and Husain's motions are not.

Nevertheless," 'an untimely motion or cross-motion for summary judgment may be considered by the court where, as here, a timely motion for summary judgment was made on nearly identical grounds' " because " 'the nearly identical nature of the

grounds.......... provide[s] the requisite good cause (*see* CPLR § 3212[a]) to review the untimely motion or cross motion on the merits.' " Ellman v Village of Rhinebeck, 41 AD3d 635, 643 (2nd Dept. 2007), lv den., 9 NY3d 812 (2007), quoting Grande v Peteroy, 39 AD3d 590, 591-592 (2nd Dept. 2007), citing Bressingham v Jamaica Hosp. Med. Ctr., 17 AD3d 496, 497 (2nd Dept. 2005); Boehme v A.P.P.L.E., 298 AD2d 540 (2nd Dept. 2002); Miranda v Devlin, 260 AD2d 451 (2nd Dept. 1999). " 'Notably, the court, in the course of deciding the timely motion, is, in any event, empowered to search the record and award summary judgment to a nonmoving party (*see* CPLR § 3212[b]).' " Ellman v Village of Rhinebeck, supra, at p. 643, quoting Grande v Peteroy, supra, at p. 592. In medical malpractice actions, otherwise untimely cross-motions are considered timely when they evolve from the same underlying factual scenario and are made on nearly identical grounds as the timely motion. See, Joyner-Pack v Sykes, 54 AD3d 727 (2nd Dept. 2008), citing Grande v Peteroy, supra; Boehme v A.P.P.L.E., A Program Planned for Life Enrichment, supra.

Here, the overriding allegations of negligence against all of the defendants are identical, i.e., the failure to prescribe Coumadin, as are the defendants' defenses, i.e., that it was contraindicated by the Plaintiff's medical condition at the time. In light of the fact that Defendants Bazan and Husain's motions for summary judgment are predicated upon the identical facts and theories as the timely motions, they will be considered. See, Joyner-Pack v Sykes, supra. The Plaintiffs' motions for an order pursuant to CPLR § 3212(a) denying Defendants Bazan and Husain's motions as untimely are **DENIED**. Those motions are

adjourned to April 6, 2009 at 9:30 a.m. in Part 23 of this Court.

"On a motion for summary judgment pursuant to CPLR § 3212, the proponent must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact." Sheppard-Mobley v King, 10 AD3d 70, 74 (2d Dept. 2004), aff'd. as mod., 4 NY3d 627 (2005), citing Alvarez v Prospect Hosp., 68 NY2d 320, 324 (1986); Winegrad v New York Univ. Med. Ctr., 64 NY2d 851, 853 (1985). "Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers." Sheppard-Mobley v King, supra, at p. 74; Alvarez v Prospect Hosp., supra; Winegrad v New York Univ. Med. Ctr., supra. Once the movant's burden is met, the burden shifts to the opposing party to establish the existence of a material issue of fact. Alvarez v Prospect Hosp., supra, at p. 324. The evidence presented by the opponents of summary judgment must be accepted as true and they must be given the benefit of every reasonable inference. See, Demishick v Community Housing Management Corp., 34 AD3d 518, 521 (2d Dept. 2006), citing Secof v Greens Condominium, 158 AD2d 591 (2d Dept. 1990).

"In a medical malpractice action, a plaintiff must prove that there was a deviation or a departure from good and accepted practice and that such departure or deviation was a proximate cause of injury or damage." Luu v Paskowski, 57 AD3d 856 (2nd Dept. 2008), citing Myers v Ferrara, 56 AD3d 78 (2nd Dept. 2008). "On a motion for summary judgment dismissing the complaint, a defendant physician has the burden of establishing the

absence of any departure from good and accepted practice, or, if there was a departure, that the plaintiff was not injured thereby." LUU v Paskowski, supra, citing Rebozo v Willen, 41 AD3d 457, 458 (2nd Dept. 2007); Thompson v Orner, 36 AD3d 791, 791-792 (2nd Dept. 2007); Taylor Nyack Hosp., 18 AD3d 537, 538 (2nd Dept. 2005); Alvarez v Prospect Hosp., 68 NY2d 320, 324 (1986). "To establish proximate cause, the plaintiff must present 'sufficient evidence from which a reasonable person might conclude that it was more probable than not that' the defendant's deviation was a substantial factor in causing the injury." Alicea v Liguori, 54 AD3d 784, 785 (2nd Dept. 2008), quoting Johnson v Jamaica Hosp. Med. Ctr., 21 AD3d 881, 883 (2nd Dept. 2005); citing Holton v Sprain Brook Manor Nursing Home, 253 AD2d 852 (2nd Dept. 1998), lv to app den. 92 NY2d 818 (1999). " 'The plaintiff's evidence may be deemed legally sufficient even if his expert cannot quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased [the] injury, as long as evidence is presented from which the jury may infer that the defendant's conduct diminished the plaintiff's chance of a better outcome or increased [the] injury.' " Alicea v Liguori, supra, at p. 786, quoting Flaherty v Fromberg, 46 AD3d 743, 743 (2nd Dept. 2007); citing Barbuto v Winthrop University Hosp., 305 AD2d 623, 624 (2nd Dept. 2003); Wong v Tang, 2 AD3d 840, 841 (2nd Dept. 2003); Jump v Facelle, 275 AD2d 345, 346 (2nd Dept. 2000), lv dism., 95 NY2d 931 (2000), lv den., 98 NY2d 612 (2002).

If the defendant meets his burden, "a plaintiff must submit the affidavit of a

physician attesting to a departure from good and accepted practice, and stating the physician's opinion that the alleged departure was a competent producing cause of the plaintiff's injuries." Luu v Paskowski, supra, citing Rebozo v Wilen, supra, at p. 458; Thompson v Orner, supra, at p. 792; Taylor v Nyack Hosp., supra, at p. 538; Domaradzki v Glen Cove Ob/Gyn Assoc., 242 AD2d 282 (2nd Dept. 1997). "[A]n expert's affidavit containing general allegations of medical malpractice which are conclusory in nature and unsupported by competent evidence tending to establish the elements of medical malpractice" does not suffice. Luu v Paskowski, supra, citing Alvarez v Prospect Hosp., supra, at p. 324-325; Rebozo v Wilen, supra, at p. 458-459; Thompson v Orner, supra, at p. 792; Furey v Kraft, 27 AD3d 416, 418 (2nd Dept. 2006), lv den., 7 NY3d 703 (2006); Taylor v Nyack Hosp., supra, at p. 538. "Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions . . . . Such credibility issues can only be resolved by a jury." Feinberg v Feit, 23 AD3d 517, 519 (2nd Dept. 2005), citing Shields v Baktidy, 11 AD3d 671 (2nd Dept. 2004); Barbuto v Winthrop University Hosp., supra; Halkias v Otolaryngology-Facial Plastic Surgery Assoc., 282 AD2d 650 (2nd Dept. 2001); see also, Roca v Perel, 51 AD3d 757, 759 (2nd Dept. 2008); Graham v Mitchell, 37 AD3d 408 (2nd Dept. 2007).

In support of their motion, Defendants, Eichenbaum, Eichenbaum &Weinstock, Franklin Hospital and Dr. Lowenkron have submitted the Affirmation of a Board Certified Internist and Cardiologist, Mark A. Goodman, M.D. He states that he is fully familiar with

the standard of care in 2005 with respect to the issues presented in this case, including the standard for determining the propriety of prescribing Coumadin. Dr. Goodman states that he has reviewed the claims advanced by the Plaintiffs in their Bills of Particulars as well as the Plaintiff's medical records and the testimony given at the examinations-before-trial, and has concluded to a reasonable degree of medical certainty that neither Dr. Eichenbaum, Eichenbaum & Weinstock, Franklin Hospital nor Dr. Lowenkron deviated from accepted medical standards in the care and treatment they provided the Plaintiff nor did any of them cause or substantially contribute to the Plaintiff's alleged injuries sustained by the Plaintiff.

Dr. Goodman reviewed the results of the MRI done at Mercy Medical Center on February 3, 2005 and noted that there was a focal acute infarction in the right temporoparietal region, a localized cerebral infarct, but no evidence of multiple areas of cerebral infarction as might be seen in a case of cerebral embolization from a cardiac source. He notes that the transesophageal echocardiogram performed at Mercy Medical Center on February 4, 2005 indicated a small ventricular septal defect at the upper end of the Plaintiff's intra-ventricular septum adjacent to the aortic root with normal left and right ventricles. He notes that there was good ventricular systolic function. The right and left atria were normal with intact interatrial septum and no evidence of spontaneous contrast nor patent foramen ovale. The left atrial size was described as being normal. There was no evidence of any clot in the left atrium nor in the left atrial appendage. He states that the results of the echocardiogram indicate that the left atrial and left ventricular size and function were normal.

He therefore concludes that the results from the transesophageal echocardiogram make it less likely that the Plaintiff was at risk for atrial fibrillation or for cerebral embolization from a cardiac source. Dr. Goodman further notes that the Plaintiff was on a cardiac monitor while at Mercy Medical Center and that there was no evidence of arrhythmias or atrial fibrillation. He concludes that since the transesophageal echocardiogram did not show any evidence of left atrial enlargement or left ventricular dysfunction, the echocardiogram did not suggest that the Plaintiff was at risk to develop cerebral emboli from a cardiac source, and the cardiac monitor did not show any evidence of cardiac arrhythmias, it was reasonable to conclude that the Plaintiff had sustained a CVA secondary to cerebral thrombosis and there accordingly was no indication to prescribe Coumadin.

Dr. Goodman notes that Dr. Lowenkron examined the Plaintiff only once, on February 9, 2005. He notes that Dr. Lowenkron appropriately took the Plaintiff's history which included Tetralogy of Fallot which had necessitated two heart surgeries and that the Plaintiff had had normal echocardiograms every two years ever since, as well as a normal recent nuclear stress test. Dr. Goodman notes that Dr. Lowenkron examined the Plaintiff and performed an EKG which revealed a sinus rhythm and a left axis deviation, possibly left ventricular hypertrophy and a right bundle branch block. Dr. Goodman opines that while Dr. Lowenkron found the EKG to be abnormal, he rightfully believed that the findings were possibly consistent with the Plaintiff's history of Tetralogy of Fallot. Dr. Goodman notes that Dr. Lowenkron proceeded to evaluate the Plaintiff's records at Mercy Hospital and

properly concluded that a cardiac source of embolus as a cause of the Plaintiff's stroke had been properly ruled out. Dr. Goodman notes that Dr. Lowenkron considered that the Plaintiff did not have cardiomyopathy, did not have specific blocking in the aorta or the aortic arch, did not have thrombus in the left atrial appendage and did not have signs of an interatrial right-to-left communication. Thus, Dr. Goodman concludes that Dr. Lowenkron appropriately told the Plaintiff that there was evidence of a very small ventricular septal defect which appeared to be in the classic location for a person with Tetralogy of Fallot and properly advised him that it appeared to be hemodynamically insignificant and simply warranted monitoring via serial echocardiograms. Given all this, Dr. Goodman concluded that Dr. Lowenkron properly concluded and advised the Plaintiff that there was no cardiac source of embolus and that he should not be placed on Coumadin at that time.

Dr. Goodman also affirms that he reviewed the records of Franklin Hospital and found no evidence of atrial fibrillation. The multiple electrocardiographic strips from August 10, 2005 through August 16, 2005 show normal sinus rhythm.

Dr. Goodman also notes that the Plaintiff was evaluated at the Mayo Clinic from October 17, 2005 to October 21, 2005 and that there were still no findings which conclusively suggest an intracardiac source for an embolic event nor was any cause in fact found for the Plaintiff's recurrent strokes. The doctors there advised the Plaintiff to remain on his present medicines including Plavix and Coumadin.

On the basis of the information that he reviewed, including the doctors' records

and the medical records of Mercy Hospital, Franklin Hospital, the Mayo Clinic and the deposition testimony of Drs. Lowenkron and Eichenbaum, Dr. Goodman found that there was no indication that the Plaintiff should have been placed on Coumadin by Dr. Lowenkron in February 2005. He did not have any evidence of atrial fibrillation in the hospital. There was no evidence of multiple cerebral emboli on the MRI. There was no evidence on the cardiogram that raised the suspicion that the Plaintiff might be at risk for cerebral embolization. Thus, it is Dr. Goodman's opinion to a reasonable degree of medical certainty that there was no deviation from good and accepted medical practice by Dr. David Lowenkron.

With respect to Dr. Joseph Eichenbaum, Joseph Eichenbaum, M.D. & David Weinstock, M.D., P.L.L.C. and Franklin Hospital, it is Dr. Goodman's opinion, to a reasonable degree of medical certainty, that there was no deviation from good and accepted medical practice by any of them nor did the care provided by them cause or substantially contribute to any of the various claimed injuries and damages that have been alleged in this lawsuit.

In support of his motion for summary judgment, Dr. Muneeruddin has submitted the affidavit of a Board Certified Internist with a subspecialty in Cardiovascular Disease and Critical Care Medicine, Philip M. Gelber, M.D. He also attests to having reviewed the Plaintiff's medical records as well as the examination-before-trial testimony in this case and has concluded, to a reasonable degree of medical certainty, that Dr.

Muneeruddin did not depart from accepted standards of medical care in his treatment of the Plaintiff nor did any act or omission on his part cause of contribute to the injuries the Plaintiff allegedly sustained.

Dr. Gelber notes that Dr. Muneeruddin examined the Plaintiff at Mercy Hospital on February 3, 2005 at Dr. Husain's request. He observes that Dr. Muneeruddin accurately procured the Plaintiff's medical history, including his history of Tetralogy of Fallot, migraines and depression and anxiety. He notes that the Plaintiff's EKG revealed normal sinus rhythm, left anterior hemiblock, anterior T-wave changes and intraventricular conduction delay and that Dr. Muneeruddin believed that the Plaintiff had a TIA and so he wanted to rule out a cardiac source of embolism of a CVA and so he ordered a transesophageal echocardiogram and a carotid duplex scan. The carotid artery scan revealed no evidence of plaque or stenosis in the carotid arteries. The Plaintiff's echocardiography showed mild left ventricular hypertrophy, satisfactory systolic function, normal left and right atria, a likely small ventricular septal defect and unremarkable aortic and mitral valves and normal pulmonary pressures. The transesophageal echocardiogram confirmed the presence of small ventricular septal defect in the upper end of the intraventricular septum adjacent to the aortic roof with normal left and right ventricles and good left ventricular systolic function. The left and right atria were both normal with a normal intact intra-atrial septum and no evidence of patent foramen ovale. Dr. Gelber notes that a hematological work-up was done at Dr. Husain's direction which was normal and that an MRI revealed a focal acute

infarction in the right temporoparietal area. He notes that Dr. Muneeruddin concluded that the Plaintiff suffered a CVA but found no cardiac source for the embolus.

Dr. Gelber notes that the transesophageal echocardiogram ruled out a cardiac source of embolism and while it did reveal a small ventricular septal defect, that was insignificant because that is common in patients who had undergone repair for Tetralogy of Fallot. He notes that the cardiac monitoring had ruled out atrial fibrillation and that the Plaintiff's lipid levels were normal, too.

Dr. Gelber opines that there is no indication in the medical records or charts that there was anything more that Dr. Muneeruddin could have done during the Mercy Medical Center admission in February 2005 that could have prevented the Plaintiff from having a recurrent second stroke. He explains that the work-up for a hypercoagulable state at the time of this admission was negative and there was no indication that Coumadin was indicated at that time. The aspirin and Plavix were appropriate which Dr. Gelber confirmed by subsequent work-ups that were done and resulted in findings of no abnormalities. Dr. Gelber notes that Dr. Muneeruddin appropriately performed two different types of echocardiographic studies during the Mercy Medical Center admissions to check for atrial thrombi, septal defects as well as carotid Doppler studies of the legs to check for venous thromboses and Doppler studies of the carotid arteries to look for arteriosclerotic plaque formation as a source of cardiac emboli. In addition, Dr. Gelber notes that Dr. Muneeruddin looked for arrhythmias and found no significant evidence of atrial fibrillation that warranted

the use of Coumadin. From a cardiac standpoint and based upon the test result studies at the time, Dr. Gelber opines that there was no reason for the Plaintiff to be placed on Coumadin.

Dr. Gelber opines that Dr. Muneeruddin was not negligent in failing to rule out a cardiac source of embolism because there was no medical evidence indicating that there was one. Nor was he negligent in failing to administer anticoagulants such as Coumadin, Warfarin, Heparin and Lovenox as these drugs were not indicated at the time based upon the results of the studies including the sophisticated battery of hematological tests performed to determine if a hypercoagulable state existed which yielded normal findings, as did the repeats of these studies performed by subsequent treating physicians. Dr. Gelber opines that the Plaintiff was placed on aspirin and on Plavix, both of which were sufficient in light of the lack of any findings establishing the existence of a hypercoagulable state. Dr. Gelber further opines that it is highly improbable that the etiology of the strokes was secondary to the ventricular septal defect associated with the surgically repaired Tetralogy of Fallot because the repair of the Tetralogy of Fallot made it unlikely that an emboli would go uphill against a pressure gradient from the right sided circulation to the left arterial circulation to the brain. And, there was no evidence of atrioseptal defect or patent foramen ovale which Dr. Gelber states significantly reduces the possibility or likelihood that the Tetralogy of Fallot had anything to do with the cerebral emboli. Dr. Gelber concludes that Dr. Muneeruddin's care and treatment of the Plaintiff was proper in all respects at the time, given his presenting symptoms, in light of the yielded test results and findings and as supported by the multiple

subsequent treating physicians at a number of institutions whose findings concurred with Dr. Muneeruddin's treatment of the Plaintiff.

Dr. Eichenbaum, Eichenbaum & Weinstock, Franklin Hospital, Dr. Lowenkron and Dr. Muneeruddin have all established their entitlement to summary judgment dismissing the complaint against them.

The burden now shifts to the Plaintiff to establish the existence of a material issue of fact. Dr. Eichenbaum, Eichenbaum & Weinstock and Franklin Hospital's motions for summary judgment are not opposed. As such, they are **GRANTED**.

In opposition to Dr. Lowenkron and Dr. Muneeruddin's motion, the Plaintiff has submitted the affirmation of a Board Certified Internist with a subcertification in the field of cardiovascular disease. He, too, affirms that he has reviewed the Plaintiff's medical records as well as the testimony given at the examinations-before-trial.

The Plaintiff's expert explains that Tetralogy of Fallot is a congenital heart disease and that it is characterized by four defects in the heart: a ventricular septal defect, pulmonary stenosis, right ventricular hypertrophy, and an overriding aorta. He explains that as a result of these four defects, not enough blood is able to reach the lungs to become oxygenated, and poorly oxygenated blood flows out to the body and that the presence of these defects increases the risks of serious health complications, such as infective endocarditis, an inflammation of the inner lining of the heart caused by a bacterial infection, or stroke, caused by a blood clot in the brain. Therefore, open-heart surgery is necessary to correct these

defects. He opines that patients with an uncorrected ventricular septal defect are at risk of a stroke due to a blood clot passing through the hole in the heart and going to the brain and that this risk is present even with small ventricular defects, such as the one found on the Plaintiff's February 4, 2005 transesophageal echocardiogram. He also notes that even the Plaintiff's neurologist, Dr. Bazan, knew that he was at higher risk for strokes because of his history of migraines.

Plaintiff's expert opines, to a reasonable degree of medical certainty, that the failure of Dr. Muneeruddin to prescribe Coumadin to the Plaintiff, upon his discharge from Mercy Medical Center in February 2005, was a departure from good and accepted practice. He explains that good and accepted practice dictates that in a patient such as the Plaintiff, a cardiac source of the stroke must be ruled out. He explains that the Plaintiff, who had previously underwent open heart surgery for Tetralogy of Fallot as a child, had a ventricular septal defect which was confirmed on the transesophageal echocardiogram performed at Mercy Medical Center and that it was more likely than not that this defect in his heart was the cause of his stroke. Therefore, Coumadin should have been prescribed to prevent future clots from traveling from the heart to the brain. The Plaintiff opines that the failure to prescribe Coumadin was a departure from good and accepted medical practice and was a substantial factor in causing the Plaintiff to suffer a second stroke.

The Plaintiff's expert notes that Dr. Muneeruddin testified at his deposition that the cardiac causes of TIA are as follows: a blood clot coming from the heart chambers, atrial

fibrillation, or patent foramen ovals. He also testified that the transesophageal echocardiogram and heart monitoring the Plaintiff had ruled out a cardiac source of the stroke. It was his opinion that the ventricular septal defect was not significant and that the stroke was not cardiac in nature. The Plaintiff's expert notes that the defense experts have stated in support of the requested relief that the ventricular septal defect was of no significance and did not contribute to the Plaintiff's strokes and that it has been further stated by the defense experts that the Plaintiff did not have any signs of interatrial right to left communication. However, it is his opinion that such statements are incorrect. He explains that in general, the pressure in the left ventricle of the heart is higher than the pressure in the right ventricle of the heart, which usually prevents right to left communication of the heart (or "shunting"). This pressure also prevents a clot from passing from the right side of the heart to the left. However, the presence of the ventricular septal defect in the heart alters the pressures and this customary pattern as with all such defects, there is as bi-directional flow. He explains that most clots, or emboli, form in the right side of the heart and are filtered out through the lungs. This occurs because customarily the greater pressure in the left side of the heart prevents clots from entering, and they are filtered through the lungs. However, if a defect is present in the heart, it may allow a paradoxical embolism to travel into the left side of the heart and then to the brain. The abnormal communication between the sides of the heart is called "shunting." Paradoxical embolization occurs when a small blood clot jumps from the right side of the heart to the left, and then to the brain. The embolism arises in the

systemic venous system, right side of the heart, and travels to the systemic arterial embolus. The paradoxical embolism can cause many different problems, including stroke or TIA. The intracardiac communication between the venous and arterial circulations can lead to paradoxical embolization, and can occur because of various conditions, including a ventricular septal defect.

The Plaintiff's expert explains that the Plaintiff's ventricular septal defect was significant because it alters the pressures and customary patterns in the heart and such a defect may allow a paradoxical embolism to travel into the left side of the heart and to the brain which can cause a stroke or TIA. The Plaintiff's expert opines that neurological deficits in patients with cardiovascular history such as that of the Plaintiff should be regarded with a high level of clinical suspicion for paradoxical embolization. Thus, he opines that the vascular septal defect and the Plaintiff's history placed him at a higher risk and that the cause of his stroke was cardiac and so it was a departure from good and accepted medical practice by Mercy, Dr. Muneeruddin and Dr. Lowenkron to not prescribe Coumadin. He acknowledges that even though Coumadin increases a patient's risk of bleeding, in his opinion, in the Plaintiff's case, the benefits outweighed such risk. He explains that a patient on Coumadin is monitored closely with blood tests to ensure that the proper dosage is prescribed and dosage adjustments are routinely made. He opines that the benefits of stroke prevention outweighed the risk of bleeding for the Plaintiff. He believes that the Mayo Clinic's inability to definitively determine the etiology of the Plaintiff's strokes does not

change any of this. Indeed, the Mayo Clinic's findings do not rule out the episode he envisions.

The Plaintiff's expert concludes that it is his opinion, with a reasonable degree of medical certainty, that given his residual ventricular septal defect, the stroke suffered by the Plaintiff in February 2005 was caused by a paradoxical embolism. As a result of this paradoxical embolism, the Plaintiff required anti-coagulation therapy to prevent further strokes. Thus, it is the Plaintiff's expert's opinion that it was a departure from good and accepted medical practice to fail to prescribe Coumadin for the Plaintiff upon discharge from Mercy and for Dr. Lowenkron to fail to prescribe it as well. He opines that that failure, more likely than not, resulted in the Plaintiff's suffering a second stroke in August of 2005. It is also the Plaintiff's expert's opinion, to a reasonable degree of medical certainty, that had the Plaintiff been prescribed the proper anti-coagulant, more likely than not, his second stroke, which has caused him serious and permanent damage, including motor difficulties as well as serious and permanent cognitive problems, would have been prevented.

Through the affirmation of his expert, whose opinions are found in the Plaintiff's medical records, the Plaintiff has established the existence of a material issue of fact regarding the Defendants' Dr. Lowenkron and Dr. Muneeruddin's care and treatment of him. Their motions are **DENIED**.

This constitutes the decision and order of the Court.

DATED: Mineola, New York
March 3, 2009

Hon. Randy Sue Marber, J.S.C.

ENTERED
MAR 05 2009
NASSAU COUNTY
COUNTY CLERK'S OFFICE