Reyes v MTA Long Is. Bus

2010 NY Slip Op 31615(U)

June 23, 2010

Supreme Court, Nassau County

Docket Number: 3462/08

Judge: Roy S. Mahon

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SCAN

SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present:

HON. ROY S. MAHON
Justice

ADALINDA REYES, Plaintiff(s), - against - MTA LONG ISLAND BUS and "JOHN DOE", Defendant(s).	TRIAL/IAS PART 7 INDEX NO. 3462/08 MOTION SEQUENCE NO. 1 MOTION SUBMISSION DATE: April 14, 2010

The following papers read on this motion:

Amended Notice of Motion	X
Affirmation in Opposition	X
Reply Affirmation	X

Upon the foregoing papers, the motion by the defendants for an Order pursuant to CPLR §3211 and 3212 granting summary judgment on behalf of the defendants, is determined as hereinafter provided:

This personal injury action arises out of an incident that occurred on August 31, 2007 at approximately 12:30 pm on Old Northern Boulevard and Main Street, Nassau County, New York. At that time, the plaintiff was a passenger on a bus operated by the defendants. The plaintiff in substance contends that as she was getting off the bus, the bus moved causing her to fall.

The plaintiff in the plaintiff's Verified Bill of Particulars sets forth:

> "17. The following injuries were caused and/or created by the negligence, careless and/or reckless conduct of the defendants as follows:
>
> Subligamentous posterior disc herniation at L2-3 and L4--5 impinging on the anterior aspect of the spinal canal and on the nerve roots bilaterally at L4-5, greater on the left
>
> Subligamentous posterior disc herniation at C4-5 impinging on the anterior aspect of the spinal canal
>
> Posterior disc bulges at T8-9 and at T9-10 impinging on the anterior aspect

> of the spinal canal
>
> Decreased range of motion of the cervical and lumbar spines
> Cervicalgia
> Thoracic spine pain
> Thoracic segment dysfunction
> Lumbar spine pain
> Muscle spasm
> Myofascitis
>
> The above injuries are accompanied by severe pain, tenderness, swelling, stiffness, discomfort, distress, weakness, stress, restriction of motion, degeneration of the underlying soft tissue, blood vessels, bones, nerves, tendons, ligaments and musculature and all of the natural consequences flowing therefrom.
>
> Plaintiff has further suffered and continues to suffer severe pain and difficulty with prolonged sitting, standing, walking, bending, climbing stairs, lifting or carry in heavy objects, performing strenuous activities and finding a comfortable position sleeping.
>
> Plaintiff has and will continue to experience impairment, disruption and difficulty with daily activities, way of life and enjoyment of life including significant impairment of numerous daily activities that plaintiff had previously taken for granted.
>
> Any and all of the above injuries will result in traumatic arthritis and/or onset of arthritis, osteoarthritic involvement, osteoporosis and/or necrosis at an earlier age, at an accelerated rate and with greater severity than would have otherwise occurred.
>
> All of the above injuries are permanent in nature."

The defendants in support of the requested relief, amongst other things, submit the plaintiff's deposition transcript; an affirmed letter report dated June 4, 2009 of Stanley Ross, MD, an orthopedist of an orthopedic examination of the plaintiff conducted on June 4, 2009; and an affirmed letter report dated June 4, 2020 of Charles Bagley, MD, a neurologist of a neurological examination of the plaintiff conducted on June 4, 2009.

The rule in motions for summary judgment has been succinctly re-stated by the Appellate Division, Second Dept., in **Stewart Title Insurance Company, Inc. v. Equitable Land Services, Inc., 207 AD2d 880, 6l6 NYS2d 650, 65l (Second Dept., l994):**

> "It is well established that a party moving for summary judgment must make a prima facie showing of entitlement as a matter of law, offering sufficient evidence to demonstrate the absence of any material issues of fact (*Winegrad v. New York Univ. Med. Center*, 64 N.Y.2d 85l, 853, 487 N.Y.S.2d 3l6, 476 N.E.2d 642; *Zuckerman v. City of New York*, 49 N.Y.2d 557, 562, 427 N.Y.S.2d 595, 404 N.E.2d 7l8). Of course, summary judgment is a

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drastic remedy and should not be granted where there is any doubt as to the existence of a triable issue (*State Bank of Albany v. McAuliffe*, 97 A.D.2d 607, 467 N.Y.S.2d 944), but once a prima facie showing has been made, the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish material issues of fact which require a trial of the action (*Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324, 508 N.Y.S.2d 923, 50l N.E.2d 572; *Zuckerman v. City of New York, supra*, 49 N.Y.2d at 562, 427 N.Y.S.2d 595, 404 N.E.2d 7l8)."

It is noted that the question of whether the plaintiff has made a prima facie showing of a serious injury should be decided by the Court in the first instance as a matter of law **(see Licaro v. Elliot, 57 NY2d 230, 455 NYS2d 570, 441 NE2d 1088; Palmer v. Amaker, 141 AD2d 622, 529 NYS2d 536, Second Dept., 1988; Tipping-Cestari v. Kilhenny, 174 AD2d 663, 571 NS2d 525, Second Dept., 1991)**.

In making such a determination, summary judgment is an appropriate vehicle for determining whether a plaintiff can establish prima facie a serious injury within the meaning of Insurance Law Section 5102(d) **(see, Zoldas v. Louise Cab Corp., 108 AD2d 378, 381, 489 NYS2d 468, First Dept., 1985; Wright v. Melendez, 140 AD2d 337, 528 NYS2d 84, Second Dept., 1988)**.

Serious injury is defined, in Section 5102(d) of the Insurance Law, wherein it is stated as follows:

"(d) 'Serious injury' means a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, ember, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment."

The report of Dr. Ross sets forth:

"PHYSICAL EXAMINATION

Examination reveals a 55-year old female who ambulates with a normal gait. She weighs 190 pounds and she has brown hair and brown eyes. She is in no acute distress and is able to understand and cooperate during the examination.

RANGE OF MOTION MEASUREMENTS:

All ranges of motion are based on AMA guidelines. An objective device, a goniometer, was used to measure all ranges of motion.

ORTHOPEDIC EXAMINATION:

Cervical Spine: There is no muscle spasm noted at the paracervical muscles

or at the trapezius bilaterally. There is no tenderness noted on palpation of the paracervical muscles bilaterally. Range of motion is noted to be in flexion at 50 degrees (50 degrees normal), extension at 60 degrees (60 degrees normal), right lateral flexion at 45 degrees (45 degrees normal) and left lateral flexion at 45 degrees (45 degrees normal), and right rotation at 80 degrees (80 degrees normal) and left rotation at 80 degrees (80 degrees normal).

Neurological examination of the bilateral upper extremities shows as follows: Atrophy is noted to be absent bilaterally. Muscle strength in each range is noted to be at 5/5 bilaterally. Deep tendon reflexes, biceps and triceps are noted to be at 2+ bilaterally.

Thoracic Spine: There is no paraspinal spasm bilaterally. There is n tenderness noted on palpation bilaterally.

Lumbar Spine: There is no muscle spasm noted on palpation at the paralumbar muscles bilaterally. There is no tenderness noted on palpation at the paralumbar muscles bilaterally. Range of motion is noted to be in flexion at 60 degrees (60 degrees normal), extension at 25 degrees (25 degrees normal), and right lateral bending at 25 degrees (25 degrees normal) and left lateral bending at 25 degrees (25 degrees normal). Straight leg raise is negative bilaterally.

Neurological examination of the bilateral lower extremities shows as follows: Atrophy is noted to be absent in the muscles of the right and left thigh or right and left calf. Muscle strength in each range is noted to be at 5/5 bilaterally. Deep tendon reflexes are noted to be in the right knee at 2+, left knee at 2+, right ankle at 2+ and left ankle at 2+.

Right Shoulder: Range of motion is noted to be in forward flexion at 180 degrees (180 degrees normal), extension at 50 degrees (50 degrees normal), abduction at 180 degrees (180 degrees normal), adduction at 50 degrees (50 degrees normal), internal rotation at 90 degrees (90 degrees normal), and external rotation at 90 degrees (90 degrees normal).

Left Shoulder: There is no heat, swelling, effusion, erythema, or crepitus appreciated. Impingement sign is negative. There is no tenderness noted on palpation in the acromioclavicular or supraspinatus. Range of motion is noted to be in forward flexion at 180 degrees (180 degrees normal), extension at 50 degrees (50 degrees normal), abduction at 180 degrees (180 degrees normal), adduction at 50 degrees (50 degrees normal), internal rotation at 90 degrees (90 degrees normal), and external rotation at 90 degrees (90 degrees normal).

IMPRESSION:

1. Cervical spine sprain/strain with evidence of disc herniations as per MRI-resolved.
2. Thoracic spine sprain/strain - resolved
3. Lumbar spine sprain/strain with evidence of disc herniations as per MRI-

resolved.
4. Left shoulder strain/strain/contusion - resolved.

DISABILITY

There is no evidence of a disability. The claimant is capable of working and performing her activities of daily living without restrictions or limitations.

There is no need for household help, special transportation, durable medical equipment, or diagnostic testing.

It is my opinion, with a reasonable degree of medical certainty, that despite Ms. Reyes' subjective complaints, there were no objective findings to support them."

Dr. Bagley states in said physician's report of neurological examination:

"PHYSICAL EXAMINATION:

Examination reveals an obese 55 year-old female. She weighs 190 pounds, and she was brown hair and brown eyes. She is in no acute distress and is able to understand and cooperate during the examination.

Range of motion testing was done by manual palpation and visual inspection and goniometry.

HEAD AND NECK EXAMINATION:

The claimant is complaining of left temporfrontal headaches, which is a migraine type, with a reported frequency of two times per week.

Musculoskeletal Exam:
Cervical Spine: Range of motion: Flexion 45 degrees (45 degrees normal); extension 60 degrees (60 degrees normal); lateral flexion right 45 degrees (45 degrees normal) and left 45 degrees (45 degrees normal); right rotation 80 degrees (80 degrees normal) and left rotation 80 degrees (80 degrees normal).
Lumbar Spine: Range of Motion: Flexion 90 degrees (90 degrees normal); extension 30 degrees (30 degrees normal); lateral flexion right 30 degrees (30 degrees normal) and left 30 degrees (30 degrees normal); rotation right 30 degrees (30 degrees normal) and left 30 degrees (30 degrees normal).

- Distraction test - negative.
- Compression test - negative.
- Straight leg raising test is negative

Neurological Examination:

Mental Status: Alert, oriented x 3, affect appropriate; names, repeats, follows commands well serial 7s intact; memory: the claimant gives a consistent and

coherent history indicating normal memory and language function.

Cranial Nerves: I Smell not tested, II visual fields full to finger counting, III, IV, VI extraocular movements are full in all directions, there is no ptosis, PERLA. V corneal reflexes: normal, facial sensation normal to pin and touch over the V1, V2 and V3 divisions, VII forehead wrinkling, eye closure strength are normal, lip pursing and grimacing are normal, VIII Hearing intact to finger rub, IX gag not tested, uvula midline X no hoarseness noted, VI Sternocleidomastoid strength normal, VII Tongue midline with normal lateral movements and strength, no atrophy or fasciculations.

Motor Examination:
Tone is normal in the extremities, no abnormal movements, posturing, tremor, muscle atrophy or fasciculations are noted.

Deep tendon reflexes are all present and symmetric in the upper and lower extremities including the finger flexors, brachioradialis, biceps, triceps, knee and ankle jerks.

Strength testing is normal in the upper and lower extremities including the hand intrinsics, finger flexion-extension, wrist flexion extension, elbow flexion-extension, shoulder abduction internal and external rotation, hip flexion-extension, knee flexion-extension, ankle dorsiflexion eversion inversion and plantar flexion.

- Babinski signs - negative

Gait and Coordination: Finger-to-nose and heel-to-shin standing are intact, rapid alternating movements in the upper and lower extremities are intact; heel and toe walking, hopping and tandem gait are normal. Romberg is negative.

Sensory Examination: Normal to pin, touch, and vibration.

DIAGNOSIS/IMPRESSION:

1. Normal neurological examination.

I defer all non-neurological complaints to the appropriate specialty.

DEGREE OF DISABILITY:

Today's physical evaluation did not reveal any objective evidence of a residual neurological disability. Current prognosis is good.

The claimant is able to work and carry out her activities of daily living without restrictions or limitations."

In reply to the plaintiff's opposition, the defendants contend that the plaintiff never provided authorizations for certain MRIs of the plaintiff's Cervical Spine; Thoracic Spine and Lumbar Spine. The

defendants contend that upon further demand and in accordance with the Preliminary Conference Order, the foregoing MRI studies were acquired and reviewed by A. Robert Tantleff, MD, a radiologist. The respective affirmed letter reports of Dr. Tantleff, all dated March 10, 2010 set forth:

> "As per your request, I performed an independent radiology review of MRI of the Cervical Spine. My findings are as follows:
>
> MEDICAL RECORDS SUBMITTED: Radiology report not available.
>
> REVIEW OF FILMS: Three sheets of images are submitted from All County Open MRI. The image quality and image detail is fair.
>
> The examination reveals degeneration and desiccation of the visualized intervertebral discs variably throughout the upper thoracic and cervical region.
>
> There is discovertebral endplate spurring of the opposing discovertebral endplates variably throughout the upper thoracic and cervical region consistent with spondylosis and longstanding chronic degenerative discogenic disc disease.
>
> There is a mild levoconvex scoliosis.
>
> There is regional facet arthropathy identified. The neural foramina are open, patent and adequate.
>
> There is no MRI evidence of asymmetry of the paraspinal musculature. There is no evidence of spasm or contusion. There is no evidence of edema, and specifically, there is no evidence of swelling or enlargement of the prevertebral soft tissue space. There is no evidence of abnormal or asymmetric contractions. Therefore, there is no evidence of muscle spasm of the deep muscles adjacent to the cervical spine.
>
> At C3/4, there is a focal degenerative disc protrusion. At C4/5, there is a focal degenerative disc herniation. At C5/6, there is a minimal focal degenerative disc protrusion. The findings do not contact, compress, deviate or displace the cervical cord, compromise the lateral recess or obtrude the exit zone of the neural foramina. The lordosis is maintained as are the regional soft tissues. The posterior cerebral spinal fluid (CSF) space is maintained at all levels. Additionally, in association with the findings is disc degeneration, desiccation, and discovertebral endplate spurring, which further confirms the chronicity of the findings.
>
> There is no evidence of recent trauma or annular endema of any of the outermost annuli noted to suggest a recent herniation or recent acute exacerbatory change. Nor is there evidence of posterior endplate fractures of the opposing discovertebral endplates to suggest whiplash/trauma. Additionally, there is no evidence of bone marrow edema or contusion to suggest traumatic changes to the regional osseous structures, specifically, of the opposing vertebral bodies, which is another indication of the lack of recent trauma to this area.

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There is an increased body habitus/obesity which is comorbidity for the development of degenerative disc disease. Associated with the foregoing is red marrow proliferation/regenerative change, which is a secondary finding, associated with the following: Obesity, idiopathic, smoking, anorexia, irregular menses in young females resulting in iron deficiency-anemia, or anemia, in general, marathoners and chronic obstructive pulmonary disease.

There is no significant narrowing of either the transverse or sagittal diameter of the canal to indicate a spinal stenosis condition. No lytic or blastic lesions, fractures or subluxations are noted. There is no significant compromise of the neural foramina. The nerve roots in the thecal sac as well as existing nerve roots are normally distributed. Prevertebral soft tissues and posterior spinal muscles outline normally. There is no intrinsic abnormality of the cervical spinal cord.

. . .

IMPRESSION: MRI examination of the Cervical Spine reveals longstanding chronic degenerative discogenic disc disease and cervicothoracic spondylosis. There is regional facet arthropathy identified. The neural foramina are open, patent and adequate. There is no evidence of muscle spasm of the deep muscles adjacent to the cervical spine. At C3/4, there is a focal degenerative disc protrusion. At C4/5, there is a focal degenerative disc herniation. At C5/6 there is a minimal focal degenerative disc protrusion. The findings do not contact, compress, deviate or displace the cervical cord, compromise the lateral recess or obtrude the exit zone of the natural foramina. The lordosis is maintained as are the regional soft tissues. The posterior cerebral spinal fluid (CSF) space is maintained at all levels. Additionally, in association with the findings is disc degeneration, desiccation, and discovertebral endplate spurring, which further confirms the chronicity of the findings. Subligamentous disc protrusions are similar to subligamentous disc herniations and disc bulges in that it is a finding that is under the ligament and extra-canalicular and not within the canal, per se; and therefore, does not directly compress, deviate or displace the regional neural elements and is of no definitive clinical significance. The C5/6, and to a lesser extent, the C4/5 and C6/7 levels are areas must subjected to increased physiological stress prone to degenerative change. There is no evidence of recent trauma or anular edema of any of the outermost annuli noted to suggest a recent herniation or recent acute exacerbatory change. Nor is there evidence of posterior endplate fractures of the opposing discovertebral endplates to suggest whiplash/trauma. The findings are consistent with the individuals's age and are not causally related to the date of incident of 8/31/07, approximately two months prior to the performance of the MRI examination as the findings are chronic longstanding processes requiring years to develop as presented and are consistent with wear-and-tear of the normal aging process. Furthermore, please note the associated comorbidities for degenerative disc disease as detailed. The following are potential non-disc related causes of pain identified on this examination unrelated to the date of incident:" Degenerative disc disease."

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"As per your request, I performed an independent radiology review of MRI of the Lumbar Spine. My findings are as follows:

MEDICAL RECORDS SUBMITTED: Radiology report not available.

REVIEW OF FILMS: Four sheets of images are submitted from All County Open MRI. The image quality and image detail is variable.

The examination reveals degeneration and desiccation of the visualized intervertebral discs variably throughout the lower thoracic and lumbar region with variable loss of height from L2/3 through L4/5.

There is discovertebral endplate spurring of the opposing discovertebral endplates variably throughout the lower thoracic and lumbar region with variable loss of height from L2/3 through L4/5.

There is discovertebral endplate spurring of the opposing discovertebral endplates variably throughout the lower thoracic and lumbar region most pronounced at L2/3, L3/4 and L4/5 consistent with spondylosis and longstanding chronic degenerative discogenic disc disease.

There is a mild levoconvex scoliosis.

There is regional facet arthropathy and regional Ligamentum Flavum hypertrophy most pronounced at L4/5 resulting in varying degrees of central canal, lateral recess and neural foraminal compromise as presented. Neural foraminal stenosis/encroachments may be associated with spinal pain and symptoms.

There is no MRI evidence of asymmetry of the paraspinal musculature. There is no evidence of spasm or contusion. There is no evidence of edema. There is no evidence of abnormal or asymmetric contractions. Therefore, there is no evidence of muscle spasm of the deep muscles adjacent to the lumbar spine.

At L2/3, L3/4 and L44/5, there are degenerative traction bulges with anterior vectors of expansion without significant posterior prominence. The lordosis is maintained as are the regional soft tissues. There is no evidence of prevertebral, perivertebral or posterior soft tissue swelling. Additionally, in association with the findings is disc degeneration, desiccation, loss of height and discovertebral endplate spurring, which further confirms the chronicity of the findings.

There is no evidence of recent trauma or annular edema of any of the outermost annuli noted to suggest a recent herniation or recent acute exacerbatory change. Nor is there evidence of posterior endplate fractures of the opposing discovertebral endplates to suggest whiplash/trauma. Additionally, there is no evidence of bone marrow endema or contusion to suggest traumatic changes to the regional osseous structures, specifically, of the opposing vertebral bodies, which is another indication of the lack of recent

trauma to this area.

There is an increased body habitus/obesity which is comorbidity for the development of degenerative disc disease. Associated with the foregoing is red marrow proliferation/regenerative change, which is a secondary finding, associated with the following: obesity, idiopathic, smoking, anorexia, irregular menses in young females resulting in iron deficiency-anemia, or anemia, in general, marathoners and chronic obstructive pulmonary disease.

No lytic or blastic lesions, fractures or subluxations are noted. No abnormal signal changes are present within the canal indicative of disc herniation or mass. There is no evidence of spondylolysis or spondylolisthesis. Psoas and posterior spinal muscles outline normally.

. . .

IMPRESSION: MRI examination of the Lumbar Spine reveals longstanding chronic degenerative discogenic disc disease and thoracolumbar spondylosis. There is regional facet arthropathy and regional Ligamentum Flavum hypertrophy most pronounced at L4/5 resulting in varying degrees of central canal, lateral recess and neural foraminal compromise as presented. Plase note that Ligamentum Flavum hypertrophy is a secondary finding of chronic, longstanding degenerative disc disease. There is no evidence of muscle spasm of the deep muscles adjacent to the lumbar spine. At L2/3, L3/4 and L4/5 there are degenerative traction bulges with anterior vectors of expansion without significant posterior prominence. The lordosis is maintained as are the regional soft tissues. There is no evidence of prevertebral, perivertebral or posterior soft tissue swelling. Additionally, in association with the findings is disc degeneration, desication, loss of height and discovertebral endplate spurring, which further confirms the chronicity of the findings. There is no evidence of trauma or annular edema of any of the outermost annuli noted to suggest a recent herniation or recent acute exacebatory change. Nor is there evidence of posterior endplate fractures of the opposing discovertebral endplates to suggest whiplash/trauma. The L4/5 and L5/S1 levels are the commonest levels for discal degeneration in the lumbar spine and in conjunction with the L3/4 level accounts for approximately 92-95% of all degenerative changes in the lumbar spine. The findings are consistent with the individual's age and not causally related to the date of incident of 8/31/07, approximately two and one third months prior to the performance of the MRI examination as the findings are chronic longstanding processes requiring years to develop as presented and are consistent with wear-and-tear of the normal aging process. Furthermore, please note the associated comorbidities for degenerative disc disease as detailed above. The following are potential non-disc related causes of pain identified on this examination unrelated to the date of incident: Degenerative disc disease; Degenerative neural foraminal stenosis."

"As per your request, I performed an independent radiology review of MRI of the Thoracic Spine. My findings are as follows:

MEDICAL RECORDS SUBMITTED: Radiology report not available.

REVIEW OF FILMS: Three sheets of images are submitted from All County Open MRI. The image quality and image detail is variable.

The examination reveals degeneration and desiccation of the visualized intervertebral discs variably throughout the lower cervical and thoracic region.

There is discovertebral endplate spurring of the opposing discovertebral endplates variably throughout the lower cervical and thoracic region consistent with spondylosis and longstanding chronic degenerative discogenic disc disease.

There is regional facet and costovertebral junction arthropathy identified. The neural foramina are open, patent and adequate.

There is no MRI evidence of asymmetry of the paraspinal musculature. There is no evidence of spasm or contusion. There is no evidence of edema, and specifically, there is no evidence of swelling or enlargement of the prevertebral soft tissue space. There is no evidence of abnormal or asymmetric contractions. Therefore, there is no evidence of muscle spasm of the deep muscles adjacent to the thoracic spine.

There is degradation of the axial images submitted; based on the axial and sagittal series submitted, the thoracic cord, exiting nerves and nerve roots reveal no evidence of compression, deviation, or displacement as a result of discal abnormality nor is there evidence of disc bulge, protrusion or herniation. There is no evidence of central canal, lateral recess or neural foraminal stenosis at any level. Therefore, there is no evidence of muscle spasm of the deep muscles adjacent to the thoracic spine.

There is degradation of the axial images submitted; based on the axial and sagittal series submitted, the thoracic cord, exiting nerves and nerve roots reveal no evidence of compression, deviation, or displacement as a result of discal abnormality nor is there evidence of disc bulge, protrusion or herniation. There is no evidence of central canal, lateral recess or neural foraminal stenosis at any level. Nor is there evidence of mass effect on the thoracic cord or exiting nerve roots.

The thoracic alignment is maintained as are the soft tissues. There is no evidence of prevertebral or perivertebral soft tissue swelling.

There is no evidence of recent trauma or annular endema of any of the outermost annuli noted to suggest a recent herniation or recent acute exacerbatory change. Nor is there evidence of posterior endplate fractures of the opposing discovertebral endplates to suggest whiplash/trauma. Additionally, there is no evidence of bone marrow edema or contusion to suggest traumatic changes to the regional osseous structures, specifically, of

the opposing vertebral bodies, which is another indication of the lack of recent trauma to this area.

There is an increased subcutaneous adipose tissue noted consistent with an enlarged body habitus. Associated with the foregoing is red marrow proliferation/regenerative change, which is a secondary finding, associated with the following: Obesity, idiopathic, smoking, anorexia, irregular menses in young females resulting in iron deficiency-anemia, or anemia, in general, marathoners and chronic obstructive pulmonary disease.

There is in significant narrowing of either the transverse or sagittal diameter of the canal to indicate a spinal stenosis condition. No abnormal signal changes are present within the canal indicative of disc herniation or mass. The thoracic spinal cord is intrinsically normal. There is no paraspinal mass demonstrated. No fracture or subluxation is present. There is no evidence of thecal sac, cord or exiting nerve root impingement. The nerve roots in the thecal sac as well as existing nerve roots are normally distributed.

. . .

IMPRESSION: MRI examination of the Thoracic Spine reveals chronic degenerative discogenic disc disease and cervicothoracic spondylosis. There is no evidence of thecal sac, cord, exiting nerve or nerve root compression, displacement or deviation. Nor is there evidence of disc bulge, protrusion or herniation. There is no evidence of mass effect on the thoracic cord or exiting nerve rots. Thee is no evidence of central canal, lateral recess or neural foraminal stenosis at any level. Nor is there evidence of mass effect on the thoracic cord or existing nerve roots. There is no evidence of recent trauma or annular edema of any of the outermost annuli noted to suggest a recent herniation or recent acute exacebatory change. Nor is thee evidence of posterior endplate fractures of the opposing discovertebral endplates to suggest whiplash/trauma. Furthermore, please note the associated comorbidities for degenerative disc disease as detailed above. The following are potential non-disc related causes of pain identified on this examination unrelated to the date of incident: Degenerative disc disease."

The Court finds that the defendants have submitted evidence in admissible form to make a "prima facie showing of entitlement to judgment as a matter of law" **(Winegrad v. New York University Medical Center, 64 NY2d 851, 853; Pagano v. Kingsbury, supra at 694)** and is sufficient to establish that the plaintiff did not sustain a serious injury. Accordingly, the burden has shifted to the plaintiff to establish such an injury and a triable issue of fact **(see Gaddy v. Eyler, 79 NY2d 955, 582 NYS2d 990, 591 NE2d 1176; Jean-Meku v. Berbec, 215 AD2d 440, 626 NYS2d 274, Second Dept., 1995; Horan v. Mirando, 221 AD2d 506, 633 NYS2d 402, Second Dept., 1995).**

In opposition to the requested relief, the plaintiff submits an affidavit of the plaintiff herself; an affirmation of the plaintiff's treating physician George L. Colvin, D.O. and three affirmations of Richard J. Rizzuti, MD, a radiologist as to respectively a review of an MRI of the plaintiff's lumbar spine; an MRI of the plaintiff's cervical spine and am MRI of the plaintiff's thoracic spine.

The affirmation report of Dr. Colvin sets forth, amongst other things:

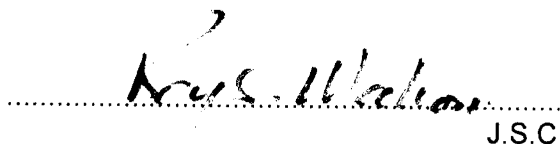
> 5. Based on the history given, in-office examination, diagnostic testing, my initial diagnosis was: posterior disc herniation at C4-5, impinging on the anterior aspect of the spinal canal; posterior disc bulges at T8-9 and at T9-10, impinging on the anterior aspect of the spinal canal; posterior disc herniations at L2-3 and at L4-5, impinging on the anterior aspect of the spinal canal and on the nerve roots bilaterally at L4-5, greater on the left; cervicalgia; cervical segment dysfunction; cervical brachial syndrome; thoracic spine pain; thoracic segment dysfunction; low back pain; lumbar segment dysfunction; and sacroiliac joint disorder.
>
> 6. It was my expert medical opinion that the injuries, as diagnosed, were causally related to the bus accident on August 31, 2007. It was further my expert medical opinion that the disc pathologies were causally related to the bus accident of August 31, 2007. It was my expert medical opinion that the injuries as diagnosed were permanent in nature and had rendered the patient permanently disabled, with regard to the functioning of her cervical, thoracic, and lumbar spine. It was my expert medical opinion that the injuries, as diagnosed, would inhibit her ability to carry out her normal activities of daily living, which involved prolonged sitting, standing, bending, walking, lifting or extreme physical exertion."

The Court notes that the respective affirmation of Dr. Rizzuti set forth impressions of disc herniation.

Based upon all of the foregoing there is an issue of fact as to whether the plaintiff suffered a serious injury pursuant to CPLR §5102 of the Insurance Law in the accident in issue of August 31, 2007. As such, the defendants' application for an Order pursuant to CPLR §3211 and 3212 granting summary judgment on behalf of the defendants, is **denied**.

SO ORDERED.

DATED: 6/23/2010



J.S.C

ENTERED
JUN 28 2010
NASSAU COUNTY
COUNTY CLERK'S OFFICE