SCAN

SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present:

HON. ROY S. MAHON

Justice

STEPHEN TONG,

Plaintiff(s),

- against -

MTA LONG ISLAND BUS,

Defendant(s).

TRIAL/IAS PART 7

INDEX NO. 10804/08

MOTION SEQUENCE NO. 1

MOTION SUBMISSION DATE: June 1, 2010

The following papers read on this motion:

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

Upon the foregoing papers, the motion by defendant for an Order pursuant to Article 51 of the NYS Insurance Law for summary judgment dismissing plaintiff's Complaint as plaintiff has not sustained a "serious injury", is determined as hereinafter provided:

This personal injury action arises out of an incident that occurred on October 13, 2007 at approximately 11:00 am when the plaintiff was attempting to board the M24 bus owned and operated by the defendant at New Hyde Park Road and Plaza Avenue, Nassau County, New York.

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

> "9. The following injuries were caused and/or created by the negligence, careless and/or reckless conduct of the defendants as follows:
>
> Sprain of the medical collateral ligament, left knee
> Exacerbation of Cervical strain
> Thoracic strain
> Exacerbation of Lumborascral strain
> Exacerbation of Derangement of shoulders bilateral
> Restriction of range of motion of the left knee, lumbar, thoracic, cervical spine and both shoulders
> Restriction of the range of motion to the left knee, thoracic, lumbar, cervical

spine and both shoulders"

In support of the defendant's requested relief, the defendant, amongst other things, submits an undated affirmed letter report of Jacqueline Emmanuel, MD an orthopedist, of a March 16, 2009 orthopedic examination of the plaintiff; an affirmed letter report dated March 16, 2009 of Maria Audrie DeJesus, MD, a neurologist of a March 16, 2009 neurological examination of the plaintiff; an unsworn report of Mrk Stuart Snyder, dated July 27, 2007, a treating chiropractor of the plaintiff relative to a July 24, 2007 examination of the plaintiff relative to an automobile accident involving the plaintiff on July 3, 2007; an unsworn report of Dr. Snyder dated April 18, 2008 of an examination of the plaintiff conducted on April 18, 2008 relative to a motorcycle/automobile accident involving the plaintiff on September 6, 2007 and an unsigned and undated letter report of Mihir Bhatt, MD, a treating physician of the plaintiff relative to the plaintiff's July 3, 2007.

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, 616 NYS2d 650, 651 (Second Dept., 1994):**

> "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 851, 853, 487 N.Y.S.2d 316, 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 718). Of course, summary judgment is a 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, 501 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 718)."

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. Emmanuel sets forth:

"Findings on Physical Examination:
For identification purposed only, the claimant is a 39-year old, right-handed male. He stands 5 feet 6 inches tall and weighs 165 pounds. He has black hair and brown eyes.

Cervical Spine: Examination of the neck reveals no tenderness to palpation of the cervical paraspinal musculature. No muscle spasm was noted. Cervical compression was negative. There was full range of motion of the cervical spine on flexion to 45 degrees (45 degrees normal), extension to 45 degrees (45 degrees normal), lateral bend to 45 degrees (45 degrees normal), right and left rotation to 70 degrees (70 degrees normal).

Neurological examination, there were no motor or sensory deficits in the upper extremities. Deep tendon reflexes in the biceps and triceps were present and equal bilaterally. Muscle strength in each range was 5/5. There is firm grasping power in both hands. There is no radiation of pain or paresthesia.

Bilateral Shoulder: There is no deltiod atrophy. There is no tenderness on palpation of the acromioclavicular joint or over the greater tuberosity. Range of motion of the shoulders reveals anterior flexion to 170 degrees (170 degrees normal), abduction to 180 degrees (180 degrees normal), adduction to 45 degrees (45 degrees normal), internal rotation to 45 degrees (45 degrees normal) and posterior extension to 45 degrees (45 degrees normal). Apley, drop arm, and apprehension tests are all negative. Impingement sign is negative. There is no winging of the scapula. There is no sensory loss to light touch or pinprick.

Thoracic Spine: The shoulder blades are symmetrical and no discomfort is noted. There is no tenderness over the trapezuis proximal to the superior angle of the scapula, along the medial border down to the interior angle or over the spinous process from T1 through T12. The thoracic curvature is normal. There is no sensory loss.

Lumbosacral Spine: Claimant has a normal gait. The claimant has a normal toe/heel walk. The lordotic curve is normal There is no spasm or tenderness noted over the paraspinal musculature on palpation. Sitting lasegue testing is negative to 80 degrees. Straight leg raising is negative to 75 degrees in both the seated and supine positions. Range of motion of the lumbar spine reveals flexion: 90 degrees (90 degrees normal), extension: 30 degrees (30 degrees normal); right and left lateral flexion: 45 degrees (45 degrees normal), rotation: 45 degrees (45 degrees normal).

Neurological examination reveals patellar and Achilles deep tendon reflexes to be 2+ (2+ normal). There is no sensory deficit. Muscle strength of the lower extremities is grated at 5/5 (5/5 normal). There is no atrophy noted in the muscles of the lower extremities. There is no radiation of pain, numbness or tingling.

Left Knee: Examination of th left knee reveals no redness, swelling or increased temperature. Range of motion is 0-130 degrees without crepitus (0-130 degrees normal). There is no tenderness above the joint line or bony structures, medial or lateral joint lines. McMurray Test is negative. There is no ligamentous instability. There is no evidence of atrophy. Muscle tone and bulk are normal.

Diagnosis:
1. Resolved sprain/strain of cervical, thoracic and lumbar spine
2. Resolved sprain/strain of bilateral shoulders
3. Resolved sprain/contusion of left knee.

Impression:
Based on my examination, there is no medical necessity for further treatment including physical therapy from an orthopedic standpoint. There is no evidence of permanency in the claimant's condition. There is no need for future testing.

In my opinion, I find the claimant has no disability. The claimant is currently not working. He may return to work and conduct his activities of daily living without restrictions."

Dr. DeJesus' report of neurological examination provides:

"Physical Examination:
The claimant is a 39 year old right handed male who stands 5'6" tall and weighs 165 pounds. He has black hair and brown eyes. Photo ID was presented at the time of the examination.

Mental Status:
The claimant is alert and oriented to person, place and date and appears to have normal intellectual functions. Comprehension, memory and recall are normal. His speech is fluent and clear without expressive or receptive aphasia. The information provided is appropriate and relevant. There are no depressive symptoms, no impairment or mood or affect and his through processes appear to be intact without delusion or hallucination. Cognitive functions show no deficit. He understands the nature of the examination and is cooperative with all aspects of the examination.

Cranial Nerves:
The pupils are equal and reactive to light. Extraocular movements are full and visual fields are grossly intact. There is no nystagmus. The face shows symmetry and facial sensation is intact. Funduscopic examination revealed no papilledema. Hearing is normal. There is no weakness of the tongue,

uvula, sternocleidomastoid or trapezuis muscles.

Motor Examination:
Normal muscle tone is observed in both the upper and lower extremities. There is no atrophy or deformity. Strength is normal in the proximal and distal muscles of the upper extremities including the biceps, triceps, brachial radialis and extensor group of the forearms. Intrinsic hand muscles are intact with no atrophy. The claimant shows a normal handgrip bilaterally and cold oppose the thumbs without difficulty. Rapid alternating movements are fully preserved. The muscles in the hands show normal appearance. The strength in the legs is intact including the pelvic girdle, quadriceps, hamstrings, extensor and flexor groups of the ankles and toes. The claimant has good weight bearing.

Reflexes:
The deep tendon reflexes in the biceps, triceps, supinator, patellar and Achilles are symmetrical. There is no spasticity or clonus.

Sensory:
The claimant evidences normal sensation to all modalities. Stereognosis and graphesthesia senses are intact. There is decreased pinprick in the left upper and left lower extremities.

Gait and Coordination:
The claimant's gait is normal and without limp or ataxia. The claimant is able to walk on heels and toes as well as in tandem. Romberg test is negative. Grasp and coordination are normal in both hands. Finger to nose testing is normal.

Cerebellar Examination:
There is no finger/nose or heel/shin dysmetria. There is no nystagmus, ataxia or dysdiadochokinesia.

Range of Motion:
There is full range of motion at the neck with flexion and extension to 45 degrees (45 degrees normal) and bilateral rotation to 50 degrees (50 degrees normal) with minimal pain and no spasm. No tenderness or muscle spasm is noted over the thoracic spine on range of motion. There is full range of motion of the lumbar spine with flexion to 90 degrees (90 degrees normal), extension to 10 degrees (10 degrees normal) and bilateral lateral bending to 25 degrees (25 degrees normal) with complaints of minimal pain. There is no spasm palpated. Bilateral straight leg raise is normal at 90 degrees. Phalen's and Tinel's tests are negative. Patrick's and Kering's tests are negative.

Diagnosis and Assessment:
Status post cervical, thoracic and lumbar sprain

Disability:
There is no objective evidence of any disability. The claimant is capable of performing all activities of daily living and occupational duties without any

limitation or restriction.

Treatment:
From a neurologic standpoint, there is no need for the claimant to continue with further treatment. There is no permanency. There is no need future testing."

The respective reports of Dr. Snyder, a treating chiropractor of the plaintiff are properly considered herein (see, **Pagano v Kingsbury**, 182 AD2d 268, 587 NYS2d 692 (Second Dept., 1992). Said reports related to the plaintiff's prior accidents set forth:

"Stephen Tong has been under our care for this condition since July 24, 2007. According to the patient, the injury occurred in an automobile accident on July 3, 2007.

The patient was examined in our office on July 24, 2007, for a determination of his present status. The following is a report of his subjective complaints and our objective findings and current recommendations...

HISTORY & COMPLAINTS
Severe neck pain
Severe lower back pain
Bilateral leg weakness/numbness
Arms/hands weak/numb

EXAMINATION
Positive cervical compression test.
Pain in lumbar spine when asked to cough
Pain in lumbar spine on sitting root test of right/left leg
Pain in lumbar spine on sitting root test of right leg
Pinwheel sensitivity is decreased on all extremities
Cervical flexion causes severe pain
Cervical extension causes severe pain
Cervical lateral flexion causes severe pain
Cervical rotation causes moderate pain
Lumbar pain on rising from sitting position
Lumbar pain on oblique forward bending
Lumbar pain on oblique backward bending
Lumbar flexion causes severe pain
Lumbar extension causes severe pain
Lumbar lateral flexion causes severe pain
Lumbar rotation causes moderate pain
Positive Soto Hall test
Patient unable to actively raise both legs due to pain
Passive raising of right leg causes pain at 55 degrees
Grip strength on dynamometer-Right hand weak, left hand weak

DIAGNOSIS
722.0 Cervical disc syndrome

722.10 Lumbar IVD displacement with myelopathy

TREATMENT
Chiropractic manipulation, ultrasound and home ice therapy

PROGNOSIS
Poor"

""Stephen Tong has been under our care for this condition since November 27, 2007. According to the patient, the injury occurred in a motorcycle/automobile accident on September 6, 2007.

The patient was examined in our office on April 18, 2008, for a determination of his present status. The following is a report of his subjective complaints and our objective findings and current recommendations.

HISTORY & COMPLAINTS
Headaches
Neck pain
Lower back pain
Sitting/standing increases lower back pain
Sleeping affected due to the pain
Anxious since the accident

EXAMINATION
Positive cervical compression test.
Pain in lumbar spine when asked to cough
Pain in lumbar spine on sitting root test of right leg
Pinwheel sensitivity is decreased on the lower extremities
Cervical flexion causes severe pain
Cervical extension causes severe pain
Cervical lateral flexion causes severe pain
Cervical rotation causes moderate pain
Lumbar pain on rising from sitting position
Lumbar pain on oblique forward bending
Lumbar pain on oblique backward bending
Lumbar flexion causes severe pain
Lumbar extension causes severe pain
Lumbar lateral flexion causes severe pain
Lumbar rotation causes moderate pain
Patient unable to actively raise both legs due to pain
Positive Soto Hall test
Passive raising of right leg causes pain at 60 degrees
Passive raising of the left leg causes pain at 50 degrees

DIAGNOSIS
722.71 Cervical intervertebral disc disorder with myelopa
724.9 Cervical nerve root compression
722.73 Lumbar IVD disorder with myelopathy
724.9 Lumbar nerve root compression

TREATMENT
Chiropractic manipulation, ultrasound, electric muscle stim and home stretching

PROGNOSIS
Poor. Mr. Tong is treating on a regular weekly basis The injuries are directly related to the accident stated above and will affect him for the rest of his life. The injuries are permanent in nature."

As to the July 3, 2007 accident Dr. Bhatt, a treating physician of the plaintiff states:

"PHYSICAL EXAMINATION:

General Appearance:
Patient is alert, oriented to person, and place and time, memory is intact. Speech is fluent and coherent. Patient appears in distress from headache, all body pain and discomfort.

Head
Normocephalic. There is pain and tenderness in low occipital area on palpation.

Cervical Spine:
Active and passive range of motion severely restricted in flexion, extension, lateral bending and rotation due to pain and discomfort. Pain and tenderness in paraspinal muscles is radiating to the shoulders and upper extremities, bilaterally, worse on the right side. Movement aggravate pain. Foraminal compression test is positive. Spurling's maneuver is positive on right and left. Severely painful spasm of the Para vertebral musculature in the cervical area is striking. Pain is strong at palpation of some trigger points in posterior neck.

Chest:
No tenderness at palpation, no gross deformity.

Flank Area:
No tenderness/pain at deep palpation.

Thoracic Spine:
No pain at palpation.

Lumbosacral Spine:
Active and passive range of motion severely restricted in flexion, extension, lateral bending, and rotation due to pain and stiffness. Pain and tenderness in lumbosacral paraspinal muscles radiating to the buttocks and legs bilaterally, worse on the right side. Pain aggravated by movement. Lassegue's test is positive on right. Kemp's test is positive. Severely painful spasm of the paravertebral musculature in lumbosacral spine and patient has pain at palpation of some trigger pints in lumbosacral area.

Extremities:
Toe and heel walking tests were positive. He is limping on right leg with right leg/knee pain. Right shoulder has full range of motion but with pain. Right

knee has painful range of motion.

Cranial Nerves:
Cranial Nerves II-XII observed grossly intact.
Romberg's test negative.

Motor System
Motor muscle tests were +5/5 with the exception of right shoulder and right knee, which was graded +4/5. Deep tendon reflexes are bilaterally equal and symmetric, except right triceps and right ankle, which were decreased to +1. No muscle trophy noted.

Sensory System:
Sensory examination of upper and lower extremities revealed normal sensitivity with the exception fo right forearm and right thigh along dermatome C6-7 and L3-4 respectively, which were mildly hypoesthetic and paraesthetic, respectively. There is also numbness noted on left thumb in dermatome C6.

MUSCULOSKETETAL EXAMINATION:

C-Spine:
Decreased active range of motion with decreased lordotic curvature of C-spine and decreased passive range of motion due to guarding by patient due to pain.

Flexion:	30 degrees	
Extension:	20 degrees	
Lateral bending:	20 degrees on left	20 degrees on right
Lateral rotation:	30 degrees on left	30 degrees on right

Spurling's sign is positive on left and right. Presence of paracervical spasm with multiple tender spots on left and right was noted. Interspinous tenderness is present from C4 to C7.

Shoulder:
Shoulder examination was remarkable on left and right shoulder with pain in end range of motion with positive impingement signs. Drop arm test is negative.

Elbow:
Elbow examination was unremarkable.

Hand:
Hand examination was unremarkable.

L-S Spine:
Paraspinal spasms are present on left/right along L-S spine. Interspinous tenderness is present at L4 to L5 and S1.

Flexion:	30 degrees

Extension: 10 degrees
Lateral Bending: 10 degrees

SLR test is positive on right side with shooting pan in calf at 30 to 45 degrees.

Hip:
Normal. Unremarkable examination. Patrick's test is not positive on left or right.

Knee:
Both knees have remarkable examination for painful and full range of motion on right and left knee, and right knee showed medial plateau tenderness and positive Apley's test.

Ankle:
Normal, unremarkable examination in both ankle and feet is noted.

DIAGNOSTIC IMPRESSION:
Status post motor vehicle accident on 7-3-07, amounting to:

1. Acute traumatic strain/sprain of the cervical, dorsal and lumboactral paraspinal muscles and ligaments.
2. Myofascitis and possible post concussion syndrome.
3. R/O cervical and lumbosacral radiculopathy vs. neuropathy
4. Right shoulder and knee contusion and sprain

DIAGNOSTIC PLAN:
For complete evaluation of the patient's condition, the following tests cold be indicated:

1. Nerve conduction study (NCV) and electromyography (EMG) of both, upper extremities to detect or R/O peripheral neuropathy andradiculopathy if symptoms persist.
2. Somatosensory evoked potential (SSEP) of both upper/lower extremities to R/O sensory nerve damage and/or probable spinal cord involvement as a result of spinal trauma.
3. MRI of right shoulder to rule out internal injury.

TREATMENT PLAN:

Medications: Oral analgesics and muscle relaxants to alleviate pain and muscle spasms. Relafen 750-mg. twice daily is recommended and prescription given.

Physical Therapy to alleviate pain and muscle spasm, prevent stiffness, improve blood circulation, promote healing and restore normal spine and joint mobility in the affected areas, consisting of:

- Hot pack (10-20 min./area)
- Interferential current stimulation 80-120 Hz intensity, for 10-30 min., 3 times/week.

- Micro current stimulation (Pads) 10 Hz., Biphasic square wave polarity Intensity 50 micro Amps, 15-20 min., 3 times/week.
- Ultrasound therapy
- Therapeutic exercises.

Assistive devices:
To support office treatments, additional therapeutic equipment has been prescribed for patient's home use: Moist heating pad and right knee support Patient will be periodically evaluated during the course of treatment and the treatment plan will be modified according to the patient's individual needs.

PROGNOSIS:
Prognosis is reserved (guarded). Patient sustained significant limitations in using the right shoulder, knee as well as cervical, dorsal and lumbosacral spine as well as both knees. The above-mentioned limitations interfere with the patient's working ability, and in his activity of daily living.

Overall prognosis for full complete recovery is difficult to determine at the time. Additional diagnostic test will be performed to determine the full extent of the injury, and consultations, of specialists will be obtained necessary. We will observe the patient's response to provided treatment and conduct additional examinations, which will lead us to the final decisions regarding this patient's prognosis."

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, amongst other things, submits an affirmation of Richard J. Rizzutti, MD, a radiologist as to an April 15,2008 MRI of the plaintiff's lumbosacral spine; an affidavit of Mark Snyder, DC; the plaintiff's treating chiropractor and an affidavit of the plaintiff Stephen Tong.

The Court initially observes that the affirmation of Dr. Rizzutti does not causally relate said physician's findings to the accident in issue (see, **Ukonu v Velazquez**, 213 AD2d 628, 624 NYS2d 195 (Second Dept., 1995).

Of significance to the plaintiff's accident of October 13, 2007, Dr. Synder states:

"5. On October 13, 2007, the patient while still treating for the July 3, 2007 accident, as well as s subsequent accident on September 5, 2007, the patient exacerbated his injuries to his cervical and lumbar spine. The patient suffered additional injuries to his lumbar spine. On April of 2008, an MRI was taken of the patient's lumbar spine.

6. Based upon the physical examination of the patient, MRI and other tests,

my diagnosis at the time was: posterior disc herniations at L4-5 and L5-S1 impinging on the anterior aspect of the spinal canal, on the neural foramina bilaterally at L4-5 and on the nerve roots bilaterally at L5-S1; Mild spinal stenosis at L4-L5 and at L5-S1; bilateral S1 radiculopathy and right C5-C6 radiculopathy.

5. It was my expert chiropractic opinion that the injuries sustained by the patient were causally related to the accident of October 13, 2007 and said finding were consistent with the clinical presentation in my office. It was further my expert chiropractic opinion that the limitation of motion of the cervical and lumbar spine were significant and permanent in nature. It was further my expert chiropractic opinion that the injuries as diagnosed would inhibit the patient's ability to carry out normal activities of daily living such as sitting, standing, bending, lifting and other strenuous activities.

6. Thereafter, the patient was placed on a course of chiropractic therapy consisting of chiropractic manipulations, ultrasound, electric muscle stimulation and home ice packs at r ate of five times per week. The patient continued to utilize the services of my office from October of 2007 through the present.

7. I also referred the patient for an MRI of the lumbar spine with results as follows: posterior disc herniations at L4-5 and L5-S1 impinging on the anterior aspects of the spinal canal, on the neural foramina bilaterally at L4-5 and on the nerve roots bilaterally at L4-5 and on the nerve roots bilaterally at L5-S1.

8. It was my expert chiropractic opinion that the injuries sustained by the patient were causally related to the motor vehicle accident of October 13, 2007 and said finding were consistent with the clinical presentation in my office. It was my expert chiropractic opinion that the disc pathology diagnosed via MRI were causally related to the subject accident as the findings of the MRI were consistent with the clinical presentation in my office and further that said injuries are of a permanent nature and not subject to resolution without surgical intervention. It was further my expert chiropractic opinion that the injuries as diagnosed would inhibit the patient's ability to carry out normal activities of daily living such as sitting, standing, bending, lifting and other strenuous activities.

9. Mr Tong returned to my office for an evaluation on March 15, 2010 and presented with the following complaints: neck pain, accompanied by intermittent numbness; lower back pain which is continuous, accompanied by tingling sensations and difficulty sleeping."

In examining a similar submission, the Court in **Houston v Gajdos**, 11 AD3d 514, 782 NYS2d 839 (Second Dept., 2004) stated:

"The affirmation of the plaintiff's doctor and the affidavit of the plaintiff's chiropractor submitted in opposition to the defendant's motion failed to raise

> a triable issue of fact as to whether the plaintiff sustained a serious injury. The plaintiff's doctor based his opinion upon his examination of the plaintiff two days after the accident. The plaintiff's chiropractor failed to adequately account for the almost five-year gap between the end of the plaintiff's medical treatment with the chiropractor and the chiropractor's most recent examination of the plaintiff (*see Jimenez v Kambli, 272 AD2d 581, 582 [2000]; Smith v Askew, 264 AD2d 834 [1999],* and failed to account for the serious neck, shoulder, and back injuries sustained by the plaintiff in one or more of his three prior motor vehicle accidents (*see Poince v Magliulo, 10 AD3d 644 [2004]; Mahoney v Zerillo, 6 AD3d 403 [2004]; Dimensheyn v Caruso, 262 AD2d 348 [1999]).*"
>
> **Houston v Gajdos, supra at 839**

A review of Dr. Snyder's submissions sets forth that Dr. Snyder initially has not offered an explanation for the plaintiff's 2½ gap in treatment (see, **Pommells v Perez**, 4 NY3d 566, 797 NYS2d 380; also see, **Nemchyonok v Peng Lui Ying**, 2 AD3d 421; 767 NYS2d 811 (Second Dept., 2003). In addition, Dr. Snyder fails to distinguish in his affidavit the injuries alleged to be caused by the plaintiff's accident of October 13, 2007 from the plaintiff's prior two accidents of July 3, 2007 and September 6, 2007 (supra).

Based upon the foregoing, the defendant's application for an Order pursuant to Article 51 of the NYS Insurance Law for summary judgment dismissing plaintiff's Complaint as plaintiff has not sustained a "serious injury", is **granted**.

SO ORDERED.

DATED: 8/17/2010

Roy S. Mahon
J.S.C.

ENTERED

AUG 19 2010

NASSAU COUNTY
COUNTY CLERK'S OFFICE