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

PRESENT: ALICE SCHLESINGER PART ~~1A~~ PART 16

Justice

Index Number : 108708/2007

ELEISH, MARY CATHERINE

VS.

SAINT VINCENTS CATHOLIC

SEQUENCE NUMBER : 001

SUMMARY JUDGMENT

INDEX NO. _____

MOTION DATE _____

MOTION SEQ. NO. _____

MOTION CAL. NO. _____

this motion to/for _____

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	
Answering Affidavits — Exhibits	
Replying Affidavits	

Cross-Motion: ☐ Yes ☒ No

Upon the foregoing papers, It is ordered that this motion by the defendants for summary judgment is granted to the extent provided in the accompanying memorandum decision and is otherwise denied.

FILED

JAN 10 2012

NEW YORK
COUNTY CLERK'S OFFICE

Dated: JAN 06 2012

ALICE SCHLESINGER J.S.C.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Check one: ☐ FINAL DISPOSITION ☒ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

☐ SUBMIT ORDER/ JUDG. ☐ SETTLE ORDER/ JUDG.

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

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MARY CATHERINE ELEISH and
M. GAMAL E.M. ELEISH

Plaintiffs,

-against-

SAINT VINCENT'S CATHOLIC MEDICAL CENTERS OF NEW YORK d/b/a SAINT VINCENT CATHOLIC MEDICAL CENTERS a/k/a ST. VINCENT'S MANHATTAN, JOHN PL. KOULOS, M.D., and GENNADIY GRIGORYAN, M.D.,

Defendants.

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Index No. 108708/07
Motion Seq. No. 001

SCHLESINGER, J.:

Before the Court in this medical malpractice action is a motion for summary judgment by all the defendants. The plaintiff Mary Catherine Eleish is claiming that her gynecologist Dr. John Koulos was negligent in the manner in which he performed a necessary surgical procedure, a total abdominal hysterectomy and bilateral salpingo-oophorectomy on January 25, 2005. Specifically, she says that he departed from accepted standards of surgery in the way in which he closed the vertical abdominal incision. She is also claiming that St. Vincent's Manhattan and its attending surgeon Dr. Gennadiy Grigoryan were negligent in her post-surgical care. Counsel for Ms. Eleish argues that these departures resulted in the development of a post-surgical wound dehiscence and Methicillin-sensitive Staphylococcus aureus (MSSA), as well as an intra-abdominal and vertebral infection.

The defendants support their motion with affirmations from Dr. James Howard, a board certified OB/GYN for forty-five years, and Dr. Jeffrey Bruce Greene, a physician board certified in Infectious Disease. Dr. Howard speaks to departures and opines that

there were none, while Dr. Greene speaks to causation, opining that Ms. Eleish did not suffer from a post-surgical infection and that the later infection diagnosed in December 2005 had no relation to the earlier surgeries and their aftermath. Dr. Howard also states that the treatment given to the plaintiff was not a substantial factor in causing her injury.

Dr. Howard, who has performed hundreds of gynecologic surgeries, first talks about the necessary nature of the surgery. Dr. Koulos, plaintiff's private gynecologist, had seen Ms. Eleish on December 3, 2004, where she complained of heavy vaginal bleeding. Following up on this complaint, Dr. Koulos performed a biopsy that revealed the presence of a Grade 1 uterine adenocarcinoma. He recommended a hysterectomy, to which Ms. Eleish consented. No one involved with this action takes any issue with the absolute need for this surgery. Rather, it is the way in which the surgery was conducted that is at issue.

Dr. Howard, who read all the hospital and medical records, the court papers and the depositions of the parties, first describes Ms. Eleish's past medical history. This included a diagnosis of Hodgkin's lymphoma, a splenectomy, and that the patient was morbidly obese. Further, he points out that the patient had received chemotherapy and radiation to treat her Hodgkin's lymphoma. He then comments significantly that chemotherapy and radiation and extreme obesity are factors that could adversely affect a patient's wound healing. Also, he adds that patients who have undergone splenectomies have a significantly increased risk of certain bacterial infections affecting the blood stream (¶6). Despite this risk, plaintiff's blood work values were within the accepted range for people without a spleen. Dr. Howard then explains that informed consent was properly obtained here, pointing out that the consent form included infection as a known risk of any surgical procedure.

With regard to the manner in which the incision was closed after a surgery without complications, Dr. Howard says that, "the incision was closed in layers with a number 1 looped polydioxanone suture (PDS) which was used for fascial layer closure. Staples were used on the dermis layer." (¶7). The doctor opines that PDS sutures are one of the accepted methods of suturing used to close an abdominal incision and "at this time there was no indication or need for retention sutures." (¶7).

With regard to infection and its prevention, Dr. Howard comments favorably here on the prophylactic use of the antibiotic Ancef during the surgery of January 25. This drug is used for various bacteria including MSSA.

As to the days after surgery, January 26-28, Dr. Howard observes that there were no signs of infection except for an elevated white blood count and a slight fever, under 100 degrees F, which he says was normal under the circumstances. Based on this presentation, Dr. Howard opines it was appropriate to discharge the patient on the 28th and to do no further testing for infection.

On February 3, Ms. Eleish was seen by Dr. Koulos for a post-operative visit and despite a "slight wound separation," it was acceptable for the surgeon to remove the staples from the dermis after performing a thorough examination that revealed no signs of infection. However, the following night, February 4 at 9:00 p.m., Ms. Eleish appeared at St. Vincent's Emergency Room with a wound dehiscence that had occurred three hours earlier. Beside the wound separation, part of her bowel was protruding. But as Dr. Howard points out, the patient denied nausea or diarrhea and her abdomen was noted to be soft and non-distended with bowel sounds present. Based on this presentation and the fact that the defendant Dr. Grigoryan saw and examined the plaintiff within forty-five minutes

of her admission, Dr. Howard states that the wound dehiscence was diagnosed and treated in a timely manner.

With regard to the second hospitalization, while Ms. Eleish did have an elevated white blood count, there were no other signs of infection. But, according to Dr. Howard as a precaution she was given three intravenous antibiotics, Gentamycin, Clindamycin, and Ampicillin, all of which treat aerobic and anaerobic organisms. This expert states that these antibiotics "would have treated an infection if it had been present." (¶14).

As to the repair surgery that occurred at 2:30 a.m. on February 5, again she was given Ancef. Dr. Grigoryan then performed an exploratory laparotomy and lysis of adhesions from the abdominal wall. This time, retention sutures were used in addition to the PDS sutures and staples which Dr. Koulos had used. Dr. Howard opines that this was all done properly.

Dr. Koulos managed the post-surgical care and Dr. Howard says that there were "no problems". (¶17). The patient was discharged on February 12, 2005. She was seen by Dr. Koulos for post-surgical visits. On February 28, 2005, Dr. Koulos removed the retention sutures, which Dr. Howard says was within the standard of care.

However, on March 8, 2005, a different surgeon, Dr. Sean Deurr, diagnosed "drainage from the surgical wound" and performed an incision and drainage and gave the patient the antibiotic Keflex. Dr. Howard opines that this oral medication treated the infection. Therefore, on December 23 of that year, when Ms. Eleish was diagnosed with MSSA in her disc space, Dr. Howard says in his "opinion with a reasonable degree of medical certainty that there is no correlation between the March 2005 and December 2005 infections as the plaintiff has presented no evidence that the infections were the same organism." (¶20).

In summary, Dr. Howard states that no defendant here committed any malpractice, either by acts or omission, and that the March 2005 infection was not caused by either the January 25 or February 4, 2005 surgeries or any events connected with them.

Dr. Greene, the Infectious Disease expert, then opines in his own affirmation that none of the treatment rendered by the defendants was a proximate cause or substantial factor in causing the plaintiff's injuries. He also gives a history of the conditions leading up to the surgeries and the surgeries themself. In this regard, he also opines, similar to Dr. Howard, that receipt of chemotherapy and radiation as well as morbid obesity (all conditions relevant to Ms. Eleish) may adversely affect a patient's wound healing and that patients, (again like Ms. Eleish) "who have undergone splenectomies also have a significantly increased risk of certain bacterial infections involving the blood stream." (¶5).

Dr. Greene then opines that the plaintiff did not develop a post-operative infection from the first surgery, and he gives the basis for this opinion. That observation, which continues as to the post-hospital visit of February 3, is completely consistent with Dr. Howard's. The same consistency applies to Dr. Grigoryan's surgery and the antibiotics used.

After the surgery, Dr. Greene believes Ms. Eleish had no infection, despite her elevated white blood count which he attributes to the trauma of surgery and the lack of a spleen. He gives the basis for this belief. As to the plaintiff's February visits with Dr. Koulos and the incision and drainage by Dr. Deurr, a surgeon, thirty-one days after the repair in February, on March 8, Dr. Greene points out that since no cultures were taken, there is no confirmation that an infection existed at the surgical site. He believes that even if there were an infection then, it was not present during the February 4, 2005 admission to St.

Vincent's. If an infection had existed, the symptoms would have presented themselves much earlier.

Finally as to the December MSSA finding in the disc space in plaintiff's back, Dr. Greene states that it was not related to either the March 8, 2005 infection or the two preceding surgeries. An MSSA infection can spontaneously occur, he says, for a number of reasons, and patients without spleens have a harder time cleansing their blood streams of certain bacteria. But he asserts that "an MSSA infection would have been prevented by the prophylactic antibiotics prudently employed by Drs. Koulos and Grigoryan in January and February 2005." (¶18). Dr. Greene's concluding paragraphs summarize his earlier opinion that the December 2005 infection was unrelated to events in the early months of the year.

However, these opinions and conclusions are challenged by the plaintiff, who submits two affirmations in opposition. Like the defendants' experts, they are experts in the fields of Gynecology and Infectious Disease. Both, I find, via a long history of practice in their specialties, have the requisite experience to opine on the issues in this case. Both have read all the applicable medical and hospital records, the depositions of the defendants, and the affirmations of Drs. Howard and Greene.

The first departure discussed, the gynecological one, relates to Dr. Koulos' failure to close the vertical incision of January 25, 2005 with the use of mass or bulk closure by suturing layers of tissue including the fascia. Dr. Koulos in his deposition is somewhat ambiguous as to the suturing, but as pointed out here, both the operative report and a handwritten post-op note signed by Dr. Koulos indicate that PDS alone was used for fascial layer closure.

This was a departure in light of Ms. Eleish's history, which included chemotherapy and radiation and removal of her spleen, as well as her body habitus of morbid obesity. These factors all made her more vulnerable to wound disruption, as both defendants' experts and Dr. Koulos agree. That is precisely what happened. Therefore, the gynecological expert opines that the failure to use the stronger bulk sutures was clearly a substantial factor in causing wound dehiscence and then an infection. In other words, according to the plaintiff, this breakdown did not just happen as a risk of the procedure. It was something that could and should have been anticipated and then dealt with because of the history and body presentation of the plaintiff.

The expert then points to various notations made by the hospital staff on January 27 and 28 regarding a serosanguinous fluid coming from the incision site, a surgical wound with a bloody scabbed area, and an abnormality in the midportion of the wound. The expert opines that because these issues were not properly evaluated by a physician, it was a departure to discharge Ms. Eleish on January 28, 2005, particularly since she had not had a bowel movement. This doctor believes that had the patient been kept longer with proper monitoring, which he urges should have occurred, she "would have presumably been in a better position to have the dehiscence and bowel evisceration managed properly." (¶24).

This expert concludes his statement with a brief description of Ms. Eleish's presentation on February 4, referring to the portion of the chart reading: "part of bowels protruding through abdominal wall. Suture site draining purulent drainage. Redness of suture site noted." He adds that during the repair surgery "Dr. Grigoryan noted that the fascial layer of the laparotomy incision was found to be open with loops of small bowel extending through the skin." (¶¶25 & 26). He ends with a conclusory opinion (not stated

to be within a reasonable degree of medical certainty) that the cited departures "were a substantial factor in causing the wound dehiscence to progress to evisceration with exteriorized bowel in unsterile conditions, resulting in significant infection." (¶29).

The second affirmation from an Infectious Disease expert first summarily reviews the January 25 surgery and then quickly gets to his first claimed departure, the failure to work up the purulent drainage. This alleged deviation from accepted medical practice could be characterized as the heart of this case. From this, according to the plaintiff, the infection which this expert believed existed on February 5, contrary to the opinions of Drs. Howard and Greene, was allowed to persist and worsen.

This expert points out that Dr. Greene's opinion regarding the absence of an infection is without any degree of medical certainty and adds that this is understandable because an opinion as to the presence of an infection is not reliable unless cultures are done. This expert states that the fact that the incision dehisced is a strong indication of the presence of an infectious process. Therefore, the expert accuses Dr. Grigoryan of having committed "a gross departure from acceptable medical treatment" (¶16) in light of Ms. Eleish's history of having her wound open and dehisce and the bowel eviscerate one day after her staples were removed.

This expert, as noted above, deals with the central questions in the case. Did Ms. Eleish have an infection in early February 2005 at the time of the repair surgery, and if she did, was it the same MSSA infection that resurfaced in her spine in December of that year? The defendants answer "no" to each question.

But the plaintiff challenges those answers and via the affirmation of this Infectious Disease expert, I believe it is a successful challenge. I make such a finding even though,

in the first instance such an opinion must rely on circumstantial evidence. However, this is not necessarily less persuasive than direct evidence. But here the lack of direct evidence is solely the responsibility or one may say fault of the defendants' never having done a culture during the February admission.[1]

Second, this expert does opine, with a reasonable degree of medical certainty in light of the following enumerated circumstances, that Ms. Eleish was infected at the February 5 admission: 1) the wound dehiscence, the bowel evisceration and the purulent drainage require a presumptive diagnosis of infection unless and until it is ruled out by cultures (¶17); 2) Dr. Deurr, in performing an incision and drainage on March 8, referred to it as a central wound infection where a large knotted suture was felt deep in the wound (¶18); 3) the bowel for a number of hours was outside the abdomen and was contaminated (¶20); and 4) on May 6, a sinus tract from outside was being treated with silver nitrate, which in an abdominal wound "overwhelmingly indicates infection" (¶19).

From that opinion, clearly opposite to the defendants', this expert then sets down a time line beginning with February 5, but more probably from January 25, 2005, indicating "with a reasonable degree of medical certainty, that it is more probable than not that the Staphylococcus infection of the spine was as a result of the incompletely treated post operative wound infection from the initial operation of January 25, 2005." (¶22). This time line notes that pursuant to Dr. Koulos' testimony, Ms. Eleish continued to drain from her incision for two months after her February 12 discharge. This takes us to April. Then

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[1]Nor did Dr. Deurr, the surgeon who saw Ms. Eleish in March 2005 and performed an incision and drainage and gave her antibiotics, take a culture. Interestingly, defendants' experts note this disapprovingly but fail to comment on a similar failure by Dr. Grigoryan and the hospital.

comes the March drainage with Dr. Deurr and the May treatment with silver nitrate. What is then noted is an Infectious Disease consult at Bridgeport Hospital in December 2005, which reported the history including the six months of treatment by Dr. Deurr and the impression that there "may well be a link with the prolonged wound infection as the source of the Staphylococcus aureus disseminated to the vertebral body." (¶25).

Which may be the case, or not. At a trial, it will be plaintiff's burden to prove that this is what happened and further to prove that it was caused by the negligence of the various defendants. But that is not the burden here. In a summary judgment motion, as this one is, it is the burden of the moving defendants who want the action dismissed to prove that there was no negligence and that even if there was, it did not cause the complained of injuries. Here, I find that the burden has not been met in the first instance by the defendants as to departures concerning how the wound was closed and also in the diagnosis of whether an infection was present and the treatment of the plaintiff during the February 5 admission. Beyond that, even if defendants had met their burden, I find that the expert affirmations submitted by plaintiff, particularly as to the departure during the January surgery by the gynecological expert and as to the February departures described by the Infectious Disease expert as well as causation linking these departures to the later surfaced infection in December, sufficiently create issues of fact that require resolution by trial.

However, I do not believe that the plaintiff has put in issue the cause of action sounding in lack of informed consent. Therefore, that claim is dismissed. I also believe that the plaintiff has not sufficiently connected the alleged premature discharge on January 28, 2005 to any subsequent injury. In other words, counsel is convincing in his

Reply when he argues that plaintiff has failed to show how a later discharge would have changed anything. It is also clear that Dr. Grigoryan bears no responsibility for events before he entered the picture on February 5. Obviously, he had nothing to do with the earlier surgery. Therefore, those claims are dismissed as well.

Finally, the defendants have failed to meet their burden regarding causation. As discussed earlier, the failure to do any cultures is alleged by the plaintiff's expert to be a departure. This departure then, at least according to the Infectious Disease expert in opposition, prevented a definitive diagnosis regarding infection to be made. Therefore, the use of powerful antibiotics by the defendants may suggest that a possible infection was successfully dealt with, but it is certainly not conclusive on this most important issue. Further, the time line does create a factual issue, as discussed earlier, on causation.

Accordingly, it is hereby

ORDERED that the motion for summary judgment by the various defendants is granted to the extent of severing and dismissing plaintiff's claims relating to a lack of informed consent and the alleged premature discharge on January 28, 2005; and it is further

ORDERED that the motion for summary judgment is granted to the extent of severing and dismissing plaintiff's claims against defendant Gennadiy Grigoryan, M.D., to the extent that they relate to events before February 5, 2005; and it is further

ORDERED the motion is otherwise denied, and counsel are directed to appear in Room 222 on February 8, 2012 at 9:30 a.m. prepared to select a trial date.

FILED
JAN 10 2012
NEW YORK
COUNTY CLERK'S OFFICE

Dated: January 6, 2012

JAN 06 2012

J.S.C.

ALICE SCHLESINGER