Grullon v Levine
2012 NY Slip Op 31615(U)
June 11, 2012
Sup Ct, Suffolk County
Docket Number: 07-19484
Judge: Joseph C. Pastoressa
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SHORT FORM ORDER

INDEX No. 07-19484
CAL. No. 11-01416MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 34 - SUFFOLK COUNTY

COPY

PRESENT:

Hon. JOSEPH C. PASTORESSA
Justice of the Supreme Court

MOTION DATE 11-23-11 (#002)
MOTION DATE 12-5-11 (#003)
ADJ. DATE 3-28-12
Mot. Seq. # 002 - MD
003 - MD

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YUDELKA GRULLON, as Mother and Natural Guardian of YERAZDY ALVARADO, an Infant,

Plaintiffs,

- against -

HEIDI JILL LEVINE, D.O, IVY ANNE ENGEL, M.D., LONG ISLAND RADIOLOGY, P.C., WILLIAM EDWARD MCCORMICK, M.D., WILLIAM E. MCCORMICK, M.D., P.C., SOUTHSIDE HOSPITAL, CATHERINE GENITI CARONIA, M.D., JOHN WALL FRANCFORT, M.D., JOHN W. FRANCFORT, M.D., P.C., BAYSHORE NON-INVASIVE VASCULAR P.C., and GOOD SAMARITAN HOSPITAL MEDICAL CENTER,

Defendants.

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Upon the following papers numbered 1 to 35 read on this motion and cross motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers (002) 1 - 9 ; Notice of Cross Motion and supporting papers (003) 10-24 ; Answering Affidavits and supporting papers 25-27 ; Replying Affidavits and supporting papers 28-29; 30-33 ; Other 34-35 ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

CA

ORDERED that motion (002) by the defendant, Catherine Geniti Caronia, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against her, is denied; and it is further

ORDERED that motion (003) by the defendant, Good Samaritan Hospital Medical Center, pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against it, is denied.

This is an action premised upon the alleged medical malpractice and negligence of the defendants arising out of their care and treatment of the infant plaintiff, Yerazdy Alvarado. It is alleged that the defendants improperly interpreted a CT scan of the infant's brain, failed to detect a density or infarct in the middle cerebral artery of the brain, failed to suspect an infarct, and failed to administer other medications to dissolve the clot and prevent further stroke in the infant plaintiff. It is alleged that the infant plaintiff, following a motor vehicle accident at about 8:35 p.m. on November 28, 2005, presented to the emergency department at Southside Hospital with right arm weakness and paresis, increasing combativeness, and unresponsiveness to verbal command. The infant was thereafter transferred to Good Samaritan Hospital at approximately 2:00 a.m. on November 29, 2005, and later transferred to NY Presbyterian, where she was treated for left middle cerebral aneurysm stroke, and carotid dissection. It is alleged that due to the negligence of the defendants, the infant plaintiff suffered severe, permanent brain damage, and serious neurological deficits.

In motion (002), Catherine Geniti Caronia, M.D. seeks summary judgment dismissing the complaint on the basis that she was not involved in the care and treatment of the infant plaintiff, Yerazdy Alvarado.

In motion (003), Good Samaritan Hospital Medical Center seeks summary judgment dismissing the complaint on the bases that its employees acted within the good and appropriate standard of care and practice during their care and treatment of the infant plaintiff in the pediatric intensive care unit on November 29, 2005; that if thrombolytic treatment were indicated, the window of opportunity for such treatment passed by the time the infant plaintiff was admitted to Good Samaritan Hospital Medical Center; that the infant being under the age of 18 was under an exclusion criteria for thrombolysis in 2005; that the infant's status as a trauma patient contraindicated the use of Plavix and Aspirin; that Good Samaritan Hospital is not vicariously liable for the treatment rendered to the infant plaintiff by her attending physicians, Dr. McCormick and Dr. Francfort, who were not employees of the hospital; that the infant's condition remained stable during her stay at Good Samaritan Hospital; and that none of the care and treatment rendered by the staff and employees at Good Samaritan Hospital was the proximate cause of the infant plaintiff's injuries.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (Friends of Animals v Associated Fur Mfrs., 46 NY2d 1065 [1979]; Sillman v Twentieth Century-Fox Film Corporation, 3 NY2d 395 [1957]). The movant has the initial burden of proving entitlement to summary judgment (Winegrad v N.Y.U. Medical Center, 64 NY2d 851 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the

opposing papers (Winegrad v N.Y.U. Medical Center, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; Zuckerman v City of New York, 49 NY2d 557 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (Castro v Liberty Bus Co., 79 AD2d 1014 [2d Dept 1981]).

The requisite elements of proof in a medical malpractice action are (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of injury or damage (Holton v Sprain Brook Manor Nursing Home, 253 AD2d 852 [2d Dept 1998], *app denied* 92 NY2d 818). To prove a prima facie case of medical malpractice, a plaintiff must establish that defendant's negligence was a substantial factor in producing the alleged injury (*see* Derdiarian v Felix Contracting Corp., 51 NY2d 308 [1980]; Prete v Rafla-Demetrious, 221 AD2d 674 [2d Dept 1996]). Except as to matters within the ordinary experience and knowledge of laymen, expert medical opinion is necessary to prove a deviation or departure from accepted standards of medical care and that such departure was a proximate cause of the plaintiff's injury (*see* Fiore v Galang, 64 NY2d 999 [1985]; Lyons v McCauley, 252 AD2d 516 [2d Dept 1998], *app denied* 92 NY2d 814; Bloom v City of New York, 202 AD2d 465 [2d Dept 1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (see Lifshitz v Beth Israel Med. Ctr-Kings Highway Div., 7 AD3d 759 [2d Dept 2004]; Domaradzki v Glen Cove OB/GYN Assocs., 242 AD2d 282 [2d Dept 1997]). "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" (Bengston v Wang, 41 AD3d 625 [2d Dept 2007]).

In support of motion (002), defendant Catherine Geniti Caronia, M.D. has submitted, inter alia, an attorney's affidavit; her supporting affirmation; copies of the summons and complaint, the answer submitted on behalf of Drs. McCormick, Caronia, Francfort, and Bayshore Noninvasive Vascular, and the plaintiff's verified bill of particulars.

It is noted that Dr. Caronia, as a defendant in this action, has submitted an affirmation instead of an affidavit as required pursuant to CPLR 2106. The affirmation is treated herein as a technical defect in form, considering the plaintiff has not objected to the use thereof (see Sam v Town of Rotterdam, 248 AD2d 850; Uscudera v Mahbubur, 299 AD2d 535 [2d Dept 2002]).

Upon a review of all the evidentiary submissions it is concluded that there are factual issues which preclude summary judgment as to motions (002) and (003). Good Samaritan's expert and the plaintiff's expert have differing opinions concerning the physical condition of the infant upon admission to Southside Hospital and Good Samaritan Hospital, and whether or not the dissection of the internal carotid artery and the MCA should have been diagnosed more timely and treated with medications to help prevent and reduce brain damage in the infant plaintiff. There are also factual issues concerning whether Catherine Geniti Caronia, M.D. was involved in the admission, treatment, and/or consultation regarding the infant plaintiff.

Catherine Geniti Caronia, M.D. (Dr. Caronia) has set forth in her supporting affirmation that she is licensed to practice medicine in New York State and is board certified in pediatric critical care. She continues that in November 2005, she was the Director of Pediatric Critical Care at Good Samaritan Hospital Medical Center, and thus her name is listed as the admitting and attending physician for any patient brought into the pediatric intensive care unit. She affirms, however, that she did not see or treat the infant plaintiff, Yerazdy Alvarado, while she was admitted to the pediatric intensive care unit at Good Samaritan Hospital, nor did she author any notes concerning her care. Dr. Caronia continues that on November 29, 2005, she was not on call, and consequently, would not have been contacted or consulted with regard to the infant's care. Although the discharge summary has her crossed-out name typewritten on it, she states that her name was on the discharge summary solely as the director of the pediatric intensive care unit in November 2005, and not because she was involved in the infant's care and treatment.

Based upon the foregoing, Dr. Caronia has established prima facie entitlement to summary judgment dismissing the complaint as asserted against her. In opposing this motion, the plaintiff has submitted the affirmation of her expert physician who opines, inter alia, that Dr. Caronia departed from good and accepted standards of care with regard to the treatment of Yerazdy Alvarado during her admission to Good Samaritan Hospital on November 29, 2005. Co-defendant Dr. Heidi Levine, D.O. testified that she was working in the emergency department at Southside Hospital and rendered care and treatment to the infant plaintiff. The infant plaintiff was being transferred from Southside Hospital to Good Samaritan Hospital, Pediatric Intensive Care Unit. Dr. Levine testified that she personally spoke with Dr. Caronia about the infant. The Southside Hospital Request/Refusal/Consent to Transfer sheet signed by the emergency room physician, Heidi Levine, at 00:18 hours on November 29, 2005, indicates that the receiving facility, "Good Samaritan Hospital, has agreed to accept transfer and to provide appropriate medical treatment as acknowledged by ... Dr. Caronias (sic)." Thus, there are factual issues concerning the conversation that Dr. Levine stated she had with Dr. Caronia on the transfer sheet note, and any contact Dr. Caronia may have had with Dr. Kamath, D.O. concerning her admission orders dated November 29, 2005 at 1:00 a.m. upon the infant plaintiffs admission to "Peds ICU-Dr. Caronia." Such factual issues preclude summary judgment.

Accordingly, motion (002) by Catherine Geniti Caronia, M.D. for summary judgment dismissing the complaint as asserted against her is denied.

Turning to motion (003), Good Samaritan Hospital Medical Center (Good Samaritan) has submitted, inter alia, an attorney's affirmation; the undated affirmation of its expert physician, Regina R. DeCarlo, M.D.; the summons and complaint, its answer and plaintiff's verified bill of particulars; the unsigned but certified transcript of the examination before trial of Heidi Jill Levine, D.O. dated June 29, 2010; the signed and certified transcript of the examination before trial of William Edward McCormick dated October 4, 201; certified copy of the infant plaintiff's Good Samaritan Hospital record; a copy of a subpoena requiring non-party Columbia Presbyterian Hospital to produce a certified copy of the infant plaintiff's admission record; affirmation of Fred Landon dated November 3, 2011; plaintiff's expert witness response; and the affirmation of Catherine Geniti Caronia, M.D.

The affirmation of Fred Landon does not comport with CPLR 2106 which does not authorize an affirmation on behalf of someone who is not a physician, dentist, attorney, or osteopath. Even if the

affirmation were in admissible form, it raises a factual issue as Landon does not define what is meant by "Dr. John W. Francfort held the position of 'voluntary physician' with admitting privileges to Good Samaritan Hospital," leaving this court to speculate as to the meaning of "voluntary physician."

Heidi Jill Levine, D.O. testified to the extent that in November 2005, she was licensed to practice medicine in New York, was board certified in emergency medicine, and was an employee of Southside Hospital working in the emergency department. She was involved in the care and treatment of the infant plaintiff on the evening of November 28, 2005, and indicated that while the infant was being transferred from the triage area into the main emergency room, she became verbally unresponsive. Dr. Levine did not review CT images and did not have the expertise to interpret CTs of the brain or spine. She learned of the CT results through Teller Radiology System. From the website, she pulled up the report concerning the interpretation of those CTs of the brain images taken of the infant, which showed no hemorrhage, mass, or shift. She did not call the interpreting radiologist to discuss the reading of the CT scan. She stated that she called for consults with William McCormick, M.D., a neurosurgeon, and John Francfort, M.D., a trauma surgeon, who both saw the infant plaintiff in the emergency department on the evening of November 28, 2005 at Southside Hospital. However, she did not request a neurology consult for the infant plaintiff.

Dr. Levine stated that upon the infant's return from the CT scans, she was not moving her right upper extremity as well as the left, and had urinary incontinence, and tremor vs. seizures. Dr. Levine stated that her differential diagnoses were infarct and carotid artery dissection, which are included in the differentials of intracranial hemorrhage and extracranial hemorrhage, epidural bleed, subdural bleed, subarachnoid hemorrhage, and intracerebral contusion. The differential diagnosis also included internal hemorrhage to other parts of the body. Dr. Levine stated that she did not write down the differential diagnoses as she kept them in her head. She continued that carotid artery dissection could cause an infarct to the brain. Dr. Levine testified that tPA is used to break up a blood clot or infarct in the brain or coronary artery, and restore circulation, but that it had to be used within three hours of the clot or symptomology. She believed Southside Hospital had tPA availability in November 2005. She ordered tPA in the past, usually in conjunction with neurology, in the absence of bleeding in the brain, as determined by CT scan of the brain, and in the absence of internal bleeding, as determined by CT of the chest, abdomen, and pelvis. Dr. Levine stated that the absence of bleeding in the CT scan of the chest, abdomen and pelvis, taken two hours after the accident, did not rule out that the infant had bleeding, only that she did not have significant bleeding. Dr. Levine continued that it was unlikely that the infant had major or severe bleeding internally, and that bleeding can be delayed. The fact that none of the CT scans indicated any bleeding would be considered significant in determining whether tPA would be used, but its use would not be based on that factor alone. Its use would be made in consultation with neurology and trauma physicians.

Dr. Levine testified that a brain infarct is essentially damage that occurs to the brain due to lack of oxygenation, which could be due to the blockage of a blood vessel. In November 2005, treatment with tPA for brain infarcts was a method of treatment if there was no bleeding or contraindication, and its use could restore brain function. She did not discuss the use of tPA with Dr. McCormick or Dr. Francfort. Dr. Levine stated that she determined that the infant plaintiff was to be transferred to Good Samaritan Hospital at about 11:30 p.m. on November 28, 2005, and that Dr. Caronia, a pediatrician, was the accepting physician at Good Samaritan Hospital. The infant plaintiff was transferred at 1:20 a.m. on November 29, 2005. She continued that she personally spoke with Dr. Caronia.

Dr. William McCormick testified to the extent that he has been licensed to practice medicine in New York since 2003 and is certified in neurosurgery. He examined the infant plaintiff at Southside Hospital emergency department on November 28, 2005, just prior to midnight. He observed that her eyes opened in response to pain, her pupils responded to light, cranial nerves were intact as evidenced by symmetry in her facial musculature, gag reflex was present, no clonus was noted, and the infant had greater movement of the right upper extremity than the left. He testified that this disparity could be caused by injury to that area of the arm or leg, it could be related to seizure activity in the brain, or closed head injury (such as subarachnoid hemorrhage, contusion, epidural hematoma, subdural hematoma, skull fracture). He also stated it could be caused by a stroke, however, he did not consider stroke in his differential diagnosis. He did not call for a neurological consult because neurologists are not typically consulted for trauma patients. As a neurosurgeon he did not typically examine a trauma patient to evaluate the carotids, but he knew trauma patients can get carotid dissection, which can put a patient at increased risk for stroke

Dr. McCormick continued that he reviewed the CT scan in the emergency room but did not remember looking at the carotids, or seeing carotid dissection. Based on his custom and practice, he would have focused on looking at the spine. His examination at Southside Hospital emergency room did not rule out injury to the blood vessels within the neck. He learned on November 29, 2005 that the infant had been diagnosed with left internal carotid dissection based upon the MRA which was conducted at Good Samaritan Hospital, and that the CT scan of the head showed evidence of an infarct in the brain. He was unaware if in 2005, either Southside Hospital or Good Samaritan Hospital had tPA protocols. He did not know if there were protocols for Heparin administration for carotid artery dissection. He defers decisions concerning the use of Heparin or tPA to neurology, whom he did not call in on consult. He did not know what the window of opportunity was for tPA. As a neurosurgeon, he stated, he does not treat carotid dissection, and that either a vascular surgeon or interventional radiologist would more typically treat the condition. He felt the infant should be transferred from Southside Hospital to Good Samaritan Hospital ICU because she was in a major trauma with suspicion of closed head injury, and an examination which was poor. He ordered hourly neuro checks but did not know what the nursing assessment for such checks consisted of. He thought that the checks might include motor response, verbal response, and level of consciousness. When he examined the infant again at Good Samaritan the following morning, he felt she was less combative and had decreased proximal right upper extremity movement compared to the left. His differential diagnosis was closed head injury, a sedated patient, possible seizure, and possible soft tissue injury, but did not include stroke. His opinion was that it was likely that the stroke was caused by thrombi from the carotid dissection caused by the trauma. After the morning of November 29, 2005, he did not see the infant again.

Regina R. DeCarlo, M.D., Good Samaritan Hospital's expert physician, affirms that she is licensed to practice medicine in New York State and is board certified in psychiatry and neurology, with special competence in child neurology and sub certification in neurodevelopmental disabilities. She sets forth the medical records which she reviewed from Southside Hospital, Good Samaritan Hospital, and New York Presbyterian Hospital, the deposition transcripts of Yudelka Grullo, Heidi Jill Levine, Anne Engel, M.D., and the plaintiff's expert witness response. Dr. DeCarlo sets forth that the infant plaintiff, Yerazdy Alvarado, then fourteen years of age, was triaged at Southside Hospital at 9:35 p.m. following a traumatic motor vehicle accident on November 28, 2005.

Dr. DeCarlo sets forth the infant's care and treatment at Southside Hospital and noted that at

10:15 p.m., the infant was combative and not following commands, so she was medicated with Ativan by order of the emergency room physician, Dr. Levine, who also ordered neurosurgical and trauma surgical consults. A CT scan of the chest revealed questionable left sided rib fracture. The CT scan of the abdomen showed left adnexal cyst and pelvic free fluid, but no definite solid visceral lacerations or hematomas. Follow-up ultrasound was recommended. Dr. Francfort, the trauma surgeon, performed a consult at about 11:00 p.m. and found that the CT scan films revealed no fractures or bleeding. He recommended transfer to Good Samaritan Hospital pediatric intensive care unit, with a repeat head CT scan, chest x-ray, and labs to be performed in the morning. Dr. DeCarlo states that Dr. McCormick, the neurosurgeon, saw the infant on consult at about 11:54 p.m., and noted asymmetry in movement, with the left upper extremity moving better than the right. His plan was to transfer the infant to Good Samaritan Hospital for observation, hourly neurological checks, and a CT scan of the head in the morning of November 29, 2005.

Thereafter, the infant plaintiff was admitted to Good Samaritan Hospital at approximately 2:00 a.m. on November 29, 2005, where she was followed by Dr. McCormick, Dr. Francfort. and Dr. Duchatelier, a pediatric neurologist. The repeat CT scan of the head conducted about 8:34 a.m. was suggestive of middle cerebral thrombosis. An MRI thereafter showed left middle cerebral artery hypodensity. MRA of the neck revealed findings consistent with thrombus formation within an area of dissection of the left cervical internal carotid artery. Dr. DeCarlo states that Dr. Duchatelier determined that the infant was not in the window of opportunity for thrombolytic therapy for the thrombus, as the risk of bleeding from Heparin administration was too great. Instead, he recommended that the infant be transferred to a neurological intensive care unit. Dr. Nimkoff, a pediatric critical care physician, also determined that thrombolytic agents were contraindicated and that stenting could not be done without anticoagulation with Plavix and Aspirin, which were contraindicated as these treatments can convert an ischemic stroke to a hemorrhagic stroke, with risk of further damage, and even herniation (of the brain).

It is Dr. DeCarlo's opinion with a reasonable degree of medical certainty that if the infant plaintiff were a candidate for thrombolytic treatment, that the window of opportunity for thrombolytic treatment passed by the time the infant-plaintiff was admitted to Good Samaritan Hospital; that the risk of bleeding outweighed any potential benefit from the use of Aspirin, thrombolytics, tPA (tissue plasminogen activators) and Heparin; the infant's hemoglobin and hematocrit dropped from 12.0 and 36 to 10.0 and 31.2 in less than ten hours, and thus, internal bleeding needed to be ruled out before thrombolytic treatment could be administered. Dr. DeCarlo continues that while there were no solid visceral lacerations or hematomas (internal bleeding) noted on the CT scan of the abdomen and pelvis taken on November 28, 2005 at about 10:30 p.m., there were questionable rib fractures. A repeat CT scan, taken about 11:51 a.m. on November 29, 2005 at Good Samaritan, showed a small amount of higher density fluid anterior to the ascending aorta and main pulmonary. Thus, further evaluation for possible vessel injury was required. Dr. DeCarlo opines that anticoagulation and thrombolytics were contraindicated in this child due to the risk of bleeding from other injuries.

Dr. DeCarlo continues that internal carotid artery dissection is a rare event following blunt trauma injury to the head or neck. In 2005, the optimal diagnostic treatment of pediatric carotid dissection was controversial, and if the patient was less than 18 years of age, there was an exclusion criterion for thrombolysis. The use of intra-arterial thrombolysis with tPA, or urokinase, and intracranial angioplasty, was only reported in the medical literature on a case by case basis, and it was not the accepted standard of care in pediatrics in 2005. She states that the antiplatelet effect of Aspirin in

children was not proven to be clinically effective, and the use of Heparin hinged on the likelihood of either extension of an infarction, or whether a second infarction from an embolus might be prevented, along with weighing the risk of inducing hemorrhage because of the anticoagulation. She notes the unacceptable rate of bleeding if the thrombolytics were given more than four to six hours after the onset of stroke, and that intravenous thrombolysis must be started within three hours of symptom onset. She continues that the American Heart Association suggested the window of opportunity for tPA may be extended from 3 to 4.5 hours in non-diabetic, adult ischemic patients, and that the standard is not applicable to pediatric patients.

Dr. DeCarlo states that the care and treatment provided by the PICU staff at Good Samaritan Hospital was within accepted standards of care, that the nursing staff promptly followed all orders and appropriately monitored the infant. She continues that the physicians at Good Samaritan reasonably relied upon the CT scan of the brain conducted at Southside Hospital; that the physicians promptly and timely diagnosed middle cerebral artery infarct (stroke) and dissection of the left internal carotid artery; promptly and timely consulted with specialists, both within the hospital and outside the hospital, regarding treatment and management of the infant; and that they promptly made efforts to transfer the infant plaintiff to a hospital with a pediatric neurological intensive care unit. Dr. DeCarlo further opines that the infant's medical and neurological condition remained stable throughout the admission to Good Samaritan Hospital until her transfer to NY Presbyterian Hospital, and that there was no evidence of neurological deterioration. Upon transfer to NY Presbyterian Hospital at 4:23 a.m. on November 30, 2005, a prophylactic hemicraniotomy was performed as the infant was at high risk for edema due to her young age and the distribution of the stroke. Dr. DeCarlo concludes that none of the claimed injuries were caused by any acts or omissions by any staff of Good Samaritan Hospital.

It is noted that while Dr. DeCarlo opines that the physicians at Good Samaritan Hospital reasonably relied upon the CT scan of the brain conducted at Southside Hospital, and that the physicians promptly and timely diagnosed middle cerebral artery infarct (stroke) and dissection of the internal left carotid artery, Dr. Nimkoff set forth in her critical care note of November 29, 2005 in the Good Samaritan Hospital record, that "[h]aving spoken with neurology, neurosurgery, interventional neuroradiolist elsewhere, neuroradiologist here-there was a misreading of last night's CT scan at Southside. Our repeat and that one show an MCA thrombotic vessel with subsequent infarct. We did an MRI/MRA/carotid study which showed the MCA infarct as well as a left internal carotid artery dissection." Dr. DeCarlo does not opine as to whether or not the CT films from Southside Hospital were sent to Good Samaritan Hospital, and whether or not the residents and staff physicians at Good Samaritan Hospital had an obligation to review these films, and if so, whether or not there were any departures from the standard of care. It is further noted that on November 30, 2005, after the infant was transferred to NY Presbyterian Hospital, she was started on Aspirin for antiplatelet effect, however, anticoagulation was held off as she had the craniotomy. Dr. DeCarlo opines that Aspirin and other anticoagulants and antiplatelets were contraindicated and not given at Good Samaritan Hospital.

In opposing this application, the plaintiffs have submitted the affirmation of their expert[1] who is

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[1]The Court has conducted an in-camera inspection of the original unredacted affirmation and finds it to be identical in every way to the redacted affirmation in plaintiff's opposition papers with the exception of the redacted expert's name. In addition, the Court has returned the unredacted affirmation to plaintiff's attorney.

licensed to practice medicine in New York State and is certified in neurology, and who set forth familiarity with the standards of care in 2005 for a fourteen year old patient, including the use of, implications for, and the efficacy of thrombolytic agents, anti-thrombotics, and treatment of dissection and other related disorders. The plaintiff's expert defines stroke as the sudden occlusion or rupture of cerebral arteries or veins resulting in focal cerebral damage and clinical neurological deficits. The risk factors for arterial ischemic stroke in children differ from those in adults, in whom arteriosclerosis is the leading cause of stroke. History and physical examination can suggest less obvious etiologies, and a recent head or neck injury suggests dissection. The expert continues that the main arteries which bring blood to the brain are the carotid and vertebral arteries. Arterial dissection refers to the abnormal, and usually abrupt, formation of a tear along the inside wall of an artery, which can be damaged by neck injuries or forceful neck movements. Dissection of the carotid or vertebral arteries occurs in 8-20% of children with arterial ischemic stroke. As the tear becomes larger, it forms a small pouch, or a false lumen, in which blood that accumulates can lead to a stroke by pooling and impeding blood flow, clotting and slowly extending into the area where the blood normally flows, limiting or completely interrupting blood flow to the brain, or breaking away small pieces which become trapped in smaller arteries. When a cerebral artery becomes blocked, and inadequate perfusion continues, the area of damage enlarges, which can result in permanent brain damage.

When a stroke is suspected, immediate radiological study is required to rule out brain bleeding, which would exclude the life saving therapies such as tPA. A normal CT of the brain within the hours following an acute stroke does not rule out a stroke. CT findings of arterial stroke in children are similar to an adult's findings. MRI is more sensitive to detecting early, small and multiple infarcts, especially in the first 24 hours after arterial ischemic stroke, suggesting that an MRI should be done initially when an acute arterial ischemic stroke is suspected. MRA can be performed at the same time and adds information regarding the status of the cerebral arteries by visualizing the blood flow in the vessels. The plaintiff's expert continues that the failure to properly assess and treat both carotid artery dissection and acute ischemic stroke would be a departure from accepted standards of care for a fourteen year old patient in 2005. The plaintiff's expert continues that the effects of a stroke can be devastating, and therefore, rapid recognition and proper evaluation and treatment of a stroke and carotid dissection was required by acceptable standards of care in 2005.

The plaintiff's expert continues that the treatment for carotid artery dissection in 2005 for a fourteen year old included the options of stenting, and anticoagulation with Heparin, a medication that prevents the extension of the blood clot in the area of the dissection. The expert continues that tPA is the clot buster which reduces or completely dissolves an obstructing thrombus (clot), thus restoring blood flow and perfusion to the brain. The 1995 study of the National Institute of Neurological Disorders and Stroke showed the benefit of tPA administration, and indicated that it can be administered intravenously within three hours of symptom onset. Prior to 2005, it extended the time frame to 4.5 hours from onset. In 2005, opines the plaintiff's expert, accepted standards of care required that tPA be administered to acute ischemic stroke patients who met the criteria, including administration of such therapy to fourteen year olds.

The plaintiff's expert opines that based upon the EMS findings at the scene of the accident at approximately 8:41 p.m., on November 28, 2005, there were no injuries reported which would contraindicate the use of any thrombolytic agents, antithrombotics, or antiplatelets. Once at Southside Hospital, the infant was noted at 10:15 p.m. to be "behaving unusual," was not following commands,

was fighting, did not answer to her name, was not verbal, and was confused. A doctor's note at 12:14 a.m. indicated that the infant has paresthesia of the left upper extremity, neck pain, her grips were equal, and she was moving all extremities, but then became unresponsive. She opened her eyes but did not follow commands. She was sedated and taken to diagnostic radiology. Upon return from radiology, she was not moving her right or left upper extremity, and became incontinent. It was noted that she was experiencing questionable tremors prior to the CT scan. At this time, opines the plaintiff's expert, ischemic stroke and carotid dissection were required considerations in the differential diagnosis pursuant to accepted standards of care in 2005, based on the signs and symptoms the infant presented. The plaintiff's expert further opines that in the event that there was a legitimate concern that the patient was suffering from an (internal) bleed which would preclude the administration of treatment, such as tPA, heparin or other medication or treatment, arrangements for immediate evaluation of the same must be made and such work up carried out. However, an evaluation for internal hemorrhaging or bleeding was not done at that time as required. The plaintiff's expert continues that thereafter, the infant plaintiff was seen by Dr. McCormick and Dr. Francfort. The plaintiff's expert opines that an immediate work up was required for the potentially serious neurological implications, and the failure to do so was a departure from the standard of care in 2005. He continues that Good Samaritan Hospital departed from the standard of care requiring that appropriate personnel be available to evaluate the patient for ischemic stroke and dissection immediately upon arrival. The note in the Southside Hospital record at 12:14 a.m. indicated that arrangements were made to transfer the child to Good Samaritan Pediatric ICU, and that the patient was discussed with Dr. Caronia, as evidenced by "Discussed case with Dr. Caronias/Frankfort, the on call physician."

The expert states that while the CT scan is exquisitely sensitive to bleeding, none of the radiological studies ruled out stroke or acute ischemic infarct, or ruled out dissection of the carotid artery leading to stroke. Despite this, no arrangements were made to have further evaluations performed which would allow for appropriate care and treatment when the infant was admitted to Good Samaritan Hospital PICU. Only bed rest, minimal stimulation, vital and neuro checks hourly, monitoring, seizure precautions, TED stockings, Dilantin and Dilantin level check, respiratory and cardiovascular monitoring, IV fluids and Zantac were ordered at Good Samaritan upon her admission. On November 29, 2005 at 2:00 a.m., it is documented that the infant was still experiencing significant and serious neurological abnormalities. Other than the nurses' recording, no one saw the infant from the time of her arrival at Good Samaritan PICU, until sometime between 7:00 and 8:00 a.m. on November 29, 2005. Instead of providing appropriate treatment and reporting observations, opines the plaintiff's expert, the staff at Good Samaritan Hospital simply watched the patient suffer a stroke during the hours in which effective thrombolytic therapy could have been instituted. Finally, on the morning of November 29, 2005, an MRA of the neck was performed which revealed findings consistent with thrombus formation within an area of dissection of the left internal carotid artery. A CT scan also revealed a left middle cerebral artery sign consistent with an ischemic stroke, leaving the infant with severe neurological deficits and permanent brain damage.

The plaintiff's expert further opines that there was a departure from the standard of care in 2005 because, at 12:14 a.m. on November 29, 2005, the acute ischemic stroke and carotid dissection should have been diagnosed and tPA immediately administered as the infant was an absolute candidate for such administration, and that it should have been administered immediately to bust the clot. The plaintiff's expert continues that even if the staff at Good Samaritan Hospital relied upon the CT reading from Southside Hospital, based upon the infant's clinical presentation, ischemic stroke and carotid dissection

should have been worked up and ruled in or out, as the incorrect reading at Southside Hospital did not permit that absolutely nothing be done to evaluate the child. There was further departure in the delay of not conducting the MRI and MRA prior to 8:00 a.m on November 29, 2005.

The plaintiff's expert disagrees with Dr. DeCarlo's opinion that the patient was not a candidate for tPA as the three hour window from the onset of symptoms in which to administer the drug passed by the time the infant was admitted to Good Samaritan Hospital. The plaintiff's expert states that the three hour window would only be applicable to the intravenous administration of tPA, and that the tPA could have been administered intra-arterially to more quickly dissolve the clot at Good Samaritan Hospital. He continues that in 2005, treatment with intra-arterial administration of tPA at the site of blockage, from six to twelve hours after the onset of symptoms, was successful. In 2005, children were absolutely receiving treatment with tPA for ischemic strokes, and that Dr. DeCarlo's statement that the use of intra-arterial thrombolysis with tPA and urokinase and intra-cranial angioplasty was not the accepted standard of care in pediatrics in 2005, is overly broad, overly simplistic, and not correct. Additionally, notes the plaintiff's expert, the physicians at Good Samaritan Hospital did consider administration of tPA, but due to concerns with bleeding, did not administer tPA, Heparin, Aspirin, or provide any other medical or surgical interventions, despite there not being a proven bleed or internal hemorrhage. The plaintiff's expert concludes that the standard of care does not exclude the use of tPA, Heparin, or Aspirin, but requires an appropriate work up be performed to establish whether or not the suspected bleed was a reality, that the failure to do so was a departure from the standard of care, and that there was no evidence of bleeding upon which to exclude their use.

Accordingly, motion (003) by Good Samaritan Hospital for summary judgment dismissing the complaint as asserted against it is denied.

Dated: June 11, 2012

HON. JOSEPH C. PASTORESSA, J.S.C.

_____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION