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SHORT FORM ORDER

COPY

INDEX No. 10-6651
CAL No. 11-02325MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 39 - SUFFOLK COUNTY

PRESENT:

Hon. DENISE F. MOLIA
Justice of the Supreme Court

MOTION DATE 4-16-12
ADJ. DATE 8-17-12
Mot. Seq. # 001 - MG; CASEDISP

MARY GUINN,

Plaintiff,

- against -

ANNE ELBIAADI, M.D. and NORTH SHORE MEDICAL GROUP,

Defendants.

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Upon the following papers numbered 1 to 18 read on this motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers (001) 1-13 ; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 14-16 ; Replying Affidavits and supporting papers 17-18 ; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (001) by the defendants, Anne Elbiaadi and North Shore Medical Group, pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is granted and the complaint is dismissed with prejudice.

In this action, the plaintiff interposes separate causes of action against Anne Elbiaadi, M.D. and North Shore Medical Group for medical malpractice, and a third cause of action against both defendants for lack of informed consent. It is alleged that Mary Guinn came under the care of the defendants on or about September 8, 2008 through about February 6, 2009 for opthamology treatment, that the defendants negligently departed from good and accepted standards of opthamology care and treatment, and failed to provide her with informed consent. The plaintiff further alleges that the defendants misdiagnosed her with cataracts, failed to properly review the Ocular Coherence Tomography (OCT), failed to order a Fluorescein angiography, and further failed to refer her to a retinal specialist for wet macular degeneration of her right eye, causing her to have decreased visual acuity in that eye and to require multiple Lucentis injections to her right eye, and to develop macular degeneration of her left eye, among other things.

The defendants seek summary judgment dismissing the complaint on the bases they did not depart from the good and accepted standards of opthamological care and treatment and did not proximately cause the injuries complained of by the plaintiff.

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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, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [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, 427 NYS2d 595 [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, 435 NYS2d 340 [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, 678 NYS2d 503 [2d Dept 1998], *app denied* 92 NY2d 818, 685 NYS2d 420). 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, 434 NYS2d 166 [1980]; ***Prete v Rafla-Demetrious,*** 221 AD2d 674, 638 NYS2d 700 [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, 489 NYS2d 47 [1985]; ***Lyons v McCauley,*** 252 AD2d 516, 517, 675 NYS2d 375 [2d Dept 1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York,*** 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

In support of this motion (001), the moving defendants have submitted, inter alia, an attorney's affirmation; the affidavit of their expert physician Barry Belgorod, M.D.; copies of the summons and complaint; defendants' answer; various discovery demands; plaintiff's verified bill of particulars; copies of the plaintiff's medical records maintained by the defendants; and the signed and certified transcripts of the examinations before trial of Mary Guinn and Anne Elbiaadi.

Mary Guinn testified to the effect that she has been wearing eye glasses for astigmatism, near sightedness, and far sightedness, since she was eighteen. She set forth her medical history and treatment, including Graves Disease and chemotherapy relating to a bowel resection. She worked as a registered nurse and a nurse practitioner. She now experiences difficulty reading and cannot read except in large print or with electronic readers. Her hand-eye coordination is off, and her driving is affected. She did not recall what her visual acuity was in September 2010. Between 2000 and 2008, she did not have an opthamologist and went to Dr. Tannenbaum at Northport Optical. She began to develop photosensitivity in 2008 and blind spots in the center of her vision in August 2008. She also developed wavy lines and distortion in her right eye with blurry areas. She went to Dr. Elbiaadi on September 8, 2008, who, after examining her eyes, told her that she had age related changes to her right eye and a cataract, and that her left eye was good. She was given a prescription for new glasses, but did not go to have the prescription filled until January 2009.

At that September 8, 2008 visit, it was recommended that she return for an OCT exam, which she did on September 24, 2008. She testified that Dr. Elbiaadi instructed her to use the Amsler dot grid to determine any changes in her vision. She did not remember Dr. Elbiaadi using the term macular degeneration. She was to return in one year unless things got worse.

Ms. Guinn continued that she used the Amsler grid no less than every two weeks. Her vision got slightly worse, but she did not feel it was consistently worse and did not contact Dr. Elbiaadi. In January 2009, she thought her cataract was getting worse and that she needed different glasses, so she saw Dr. Tannenbaum who advised to see a retina specialist. She returned to Dr. Elbiaadi on February 6, 2009. Upon examination and an OCT test, Dr. Elbiaadi gave her a different prescription for eyeglasses, and advised that the changes in her retina and the macular area had worsened in her right eye. She advised her that she had macular degeneration and referred her to a retina specialist for further testing. Ms. Guinn then made an appointment with Dr. Carnevale, a retina specialist, and never returned to Dr. Elbiaadi for any type of care or treatment. She then described her care and treatment with Dr. Carnevale and stated that after treating with him, her vision was better than when she first started treating with him, and that it responded to the injections he administered. Dr. Carnevale advised her at her last visit that he believed she had a small cataract.

The defendant's expert, Barry Belgorod, M.D. affirms that he is a physician licensed in New York State and is board certified in opthamology. He set forth his education and training, and the materials which he reviewed in rendering his opinion, which he sets forth within a reasonable degree of medical certainty. It is Dr. Belgorod's opinion that the defendants rendered care and treatment to Ms. Guinn in accord with the appropriate standards of care and did not cause or contribute to her AMD and subsequent vision problems.

Dr. Belgorod stated that when the 61 year old plaintiff presented to Dr. Elbiaadi's office at the North Shore Medical Group on September 8, 2008, she complained of decreased visual acuity in her right eye, floaters in both eyes, ocular migraines, and metamorphopsia (visual distortion) in the right eye, which had already resolved. Upon examination, her corrected vision was 20/30 in both eyes. When her eyes were dilated, the optic nerves and peripheral retinas and blood vessels were noted to be normal. When Dr. Elbiaadi examined the maculae (central retinas) the right macula was flat (dry) and had some RPE mottling (color changes), but no subretinal fluid or hemorrhage. The plaintiff's left macula was also noted to be flat with some RPE mottling. The impression was that of metamorphopsia with macula RPE changes, left greater than right, consistent with early dry AMD (age related macular degeneration) bilaterally. Therefore, OCT (ocular coherence tomography which creates a laser scanned image of the maculae), AREDS (Age Related Eye Disease Study) compliant eye vitamins to attempt to slow the progression of ADM, and self-monitoring using an Amsler grid (chart to determine the presence, or lack of visual distortion, or "metamorphopsia") were ordered.

The OCT of the plaintiff's right eye, taken September 24, 2008, revealed foveal (very center of the macula) thickness to be within normal limits, with no sub-retinal fluid accumulation and a minimally greater foveal thickness in the right eye, but both within normal range. The left eye was unremarkable. The study confirmed Dr. Elbiaadi's suspicion that the plaintiff had the dry form of AMD in both eyes, and she instructed her to follow regularly with the Amsler grid, and to call ASAP if there were any changes. In that there was resolution of the metamorphopsia, and her symmetrical corrected visual acuity was 20/30

bilaterally, there was no indication for invasive medical therapy. She did not refer the plaintiff to a retina specialist for Lucentis (anti-VEGF) injections, as such injections were not FDA approved for the treatment of dry AMD. A repeat OCT and possible Fluorescein angiography were to be done in six months.

Dr. Belgorod continued that the plaintiff presented to Dr. Tannenbaum, an optometrist, on February 6, 2009, due to changes in her vision, and she was advised that she needed a retinal evaluation. When she presented to Dr. Elbiaadi's office on February 6, 2009, she complained of "decreased/missing vision in the right eye." An OCT revealed significantly increased thickness of the plaintiff's fovea of her right eye to 299 microns, up from 230 microns on September 24, 2008, with loss of foveal contour, and trace sub-retinal fluid/sub-retinal hemorrhage. Dr. Elbiaadi formed an impression of sub-retinal fluid in the right eye, possibly due to CNV (choroidal neovascularization), consistent with wet AMD. She recommended fluorescein angiography and a stat evaluation with Dr. Small, a retina specialist at the North Shore Medical Group, however, the plaintiff presented to Dr. Ken Carnevale on February 9, 2009, with complaints of loss of central vision, distortion, difficulty reading, and increased sensitivity to sunlight over the right eye.

Dr. Belgorod continued, that upon examination, the plaintiff's corrected vision was 20/150 and 20/30 in her right and left eyes, respectively. Dr. Carnevale, pursuant to the plaintiff's written consent, administered intra-vitreal Lucentis injection into her right eye approximately every four weeks. On March 4, 2009, Dr. Carnevale found the plaintiff's corrected vision to be 20/60 and 20/30 in her right and left eyes, respectively. On March 18, 2009, the plaintiff's visual acuity in her right and left eyes was 20/50 and 20/25, respectively. By May 27, 2009, the plaintiff had received three injections of Lucentis into her right eye. On June 2, 2009, the plaintiff described distortion and micropsia (objects appearing smaller than they are) in her left eye. Dr. Carneval administered an off-label (not FDA approved) intravitreal injection of Avastin on July 1, 2009. The plaintiff was seen by Dr. Carneval from July 15, 2009 to June 2, 2010 on eighteen occasions, during which time, Lucentis injections were made to both her left and right eyes, with the aid of visual acuity testing, clinical retinal examination and OCT testing, mostly without flourescein angiolgraphy. On April 28, 2010, her corrected visual acuity was 20/40+1 and 20/30-2 in the right and left eyes, respectively, and 20/40 bilaterally on June 2, 2010.

It is Dr. Belgorod's opinion that when the plaintiff presented to Dr. Elbiaadi on September 8, 2008, that she did not have signs and symptoms requiring referral to a retinal specialist or Lucentis injections. Fluorescein angiography was not indicated as the plaintiff's OCT did not reveal any evidence of sub-retinal fluid in either eye. Dr. Elbiaadi documented and performed a thorough work-up and utilized an approach which was both appropriate and reasonable with appropriate clinical judgment. The OCT on September 24, 2008 revealed no significantly increased or significant inter-ocular difference in foveal thickness. The right eye OCT did reveal irregularities consistent with dry AMD, and she was appropriately instructed to continue self-screen Amsler grid and call ASAP if any changes were noted.

Dr. Belgorod opined that given that Lucentis injection is not indicated, nor FDA approved for the treatment of dry AMD, the plaintiff did not qualify for invasive therapy at that time. In 2008, there was no other efficacious prophylatic treatment for dry AMD, other than the AREDS-compliant nutritional supplements, which Dr. Elbiaadi prescribed for the plaintiff. When clinical examination and diagnostic OCT do not reveal any evidence of sub-retinal fluid or hemorrhage, the 2008 standard of care did not mandate fluorescein angiograpy. Dr. Belgorod opined that Dr. Elbiaadi appropriately diagnosed and treated the plaintiff. When she returned to Dr. Elbiaadi on February 6, 2009 and the OCT revealed

significantly increased thickness of the right fovea with loss of foveal contour, and new, trace sub-retinal fluid/hemorrhage, Dr. Elbiaadi appropriately formed the impression of CNV (choroidal neovascularization consistent with wet AMD) and appropriately referred the plaintiff to a retinal specialist. Thus, opines the defendants' expert, the OCT examinations were ordered and interpreted in a timely fashion; fluorescein angiography was not indicated without sub-retinal fluid and/or sub-retinal hemorrhage on clinical and OCT examination on September 8, and September 24, 2009. He continued that fluorescein angiography can result in anaphylatic shock, thrombophlebitis, and death, and should not be performed casually. OCT testing has reduced the necessity for fluorescein angiography, from a screening test to a test performed most often when the OCT reveals the sub-retinal fluid, which the plaintiff did not have upon presentation to Dr. Elbiaadi. When the plaintiff's clinical examination and OCT were diagnostic of the change in status from dry to wet AMD by Dr. Elbiaadi on February 6, 2009, Dr. Elbiaadi appropriately referred the plaintiff to a retina specialist for definitive treatment for her changed condition.

Dr. Belgorod stated that the decrease in visual acuity from 20/100 in the right eye on February 6, 2009, as diagnosed by Dr. Elbiaadi, to 20/150+, as diagnosed by Dr. Carnevale on February 9, 2009, suggested an acute process in evolution which signified that the process was being treated promptly and timely, and thus, Dr. Elbiaadi took appropriate and timely steps in diagnosing the plaintiff and referring her to a retina specialist on February 6, 2009. The distortion which occurred in the plaintiff's left eye occurred while the plaintiff was under Dr. Carnevale's care and treatment and presented the same clinical course that the plaintiff experienced under Dr. Elbiaadi's care in the right eye. The eventual outcome was the same, despite Dr. Carnevale waiting three months between the plaintiff's onset of the unresolved symptoms to initiate treatment to the plaintiff's left eye. Dr. Belgorod concluded that both of plaintiff's eyes underwent an unpredictable conversion from dry to wet AMD, which is the nature of the disease. He concluded that the development of wet AMD in plaintiff's both eyes was not the result of any departures on the part of either Dr. Elbiaadi or Dr. Carnevale.

Based upon the foregoing, it is determined that the defendants have established prima facie entitlement to summary judgment dismissing the complaint.

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, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [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, 839 NYS2d 159 [2d Dept 2007]).

The plaintiff has submitted the affirmation of her expert in opposition to the defendant's motion. However, the plaintiff has failed to raise a factual issue to preclude summary judgment from being granted to the defendant. Plaintiff's expert opined that the OCT performed on September 24, 2008 revealed fluid in the right macula. However, Dr. Belgorod stated that the OCT of the plaintiff's right eye, taken September 24, 2008, revealed foveal (very center of the macula) thickness to be within normal limits, with no sub-retinal fluid accumulation and a minimally greater foveal thickness in the right eye, but both within normal

range. The left eye was unremarkable. He continued that because there was resolution of the metamorphopsia, and her symmetrical corrected visual acuity was 20/30 bilaterally, there was no indication for invasive medical therapy, and the plaintiff was not referred to a retina specialist for Lucentis (anti-VEGF) injections, as such injections were not FDA approved for the treatment of dry AMD. While the experts disagree as to whether or not there was a wet macula as of September 24, 2008, plaintiff's expert opined that given the suspicion of wet macula degeneration, Mrs. Guinn should have immediately been sent for fluorescein angiography to further evaluate the macula due to the degenerative nature of this disease, and the failure to do so was a departure from good and accepted medical practice.

The plaintiff's expert continued that after the February 6, 2009 visit, the plaintiff was sent to a retinologist where she was diagnosed with wet macular degeneration in her right eye. The plaintiff's expert opined that when the wet macular degeneration is diagnosed and treated earlier, more likely than not the visual prognosis would be better. However, this statement is conclusory and unsupported. The plaintiff's expert does not set forth what the plaintiff's visual acuity or prognosis was before and after treatment of the wet macular degeneration, and does not opine with specificity as to the prognosis in this particular patient, given her history, presentation, and clinical findings. The plaintiff's expert does not set forth that this alleged failure to refer the plaintiff for a fluoroscein angiography in September 2008 was the proximate cause of the plaintiff's claimed injuries. The plaintiff's expert does not set forth the standard of care in 2008 for treatment of wet macular degeneration. He does not opine as to whether or not this was an acute process and whether the outcome would have been any different had she been referred to a retina specialist in February 2008. Thus, the plaintiff has failed to raise a factual issue to preclude summary judgment from being granted on the issues of damages and proximate cause.

Accordingly, motion (001) by defendants for summary judgment dismissing the complaint is granted and the complaint is dismissed with prejudice.

Dated: 9/17/2012

Hon. Denise F. Molia

J.S.C.

__X__ FINAL DISPOSITION ____ NON-FINAL DISPOSITION