

Colletti v Deutsch

2014 NY Slip Op 30579(U)

March 5, 2014

Supreme Court, Suffolk County

Docket Number: 08/22229

Judge: Denise F. Molia

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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]).

In support of this motion for summary judgment dismissing the complaint as asserted against them, the defendants submitted, inter alia, an attorney’s affirmation; the expert affidavit of Jacob Shani, M.D.; copies of the summons and complaint, plaintiffs’ verified bill of particulars, and the defendants’ answer; copies of the deposition transcripts of Paul Colletti dated September 18, 2009, Diane Coletti dated November 17, 2009, Ezra Deutsch dated March 30, 2010; and certified medical records maintained by defendants and by North Shore Long Island Jewish Health System.

Paul Colletti testified to the extent that he is 66 years of age. In June 1988, he had open heart surgery at St. Vincent’s Hospital, consisting of one bypass of the left anterior descending artery. He followed with Suffolk Heart Group for yearly evaluations and annual stress tests. Dr. Lee advised him after the stress test performed in April 2005 that he had a moderate blockage in a right coronary artery. He then had a nuclear stress test, and Dr. Lee told him that he had moderate damage and moderate blockage. He was experiencing fatigue. At the time he was taking one 325 mg Aspirin daily. Dr. Lee sent him to see Dr. Deutsch, who, on July 21, 2005, performed an angiogram and angioplasty, and placed two stents in his coronary artery at North Shore Hospital on July 21, 2005. The second stent was placed because Dr. Deutsch found an additional blockage. The plaintiff testified that Dr. Deutsch advised him that the blockage was life threatening and that he inserted coated stents. He was thereafter started on Plavix, which he was instructed he would have to take for at least six months, along with Aspirin 325 mg, and Toprol (for cholesterol) for life. He was advised by Dr. Deutsch that the Plavix could cause bruising and bleeding. At the visit with Dr. Deutsch two weeks after surgery, an EKG was taken, his groin was examined as he had complaints of pain and swelling. He was again instructed about his medication. Another stress test was conducted and he had another two or three week post-operative visit with Dr. Deutsch. He still experienced fatigue, and had just gone back to work.

The plaintiff testified that he had a history of diverticulitis since about 1990, diagnosed by Dr. Alcedo. His colon perforated in 1991, for which a sigmoid colon resection surgery was performed on an emergency basis. He stated that Dr. Blumstein, his gastroenterologist, treats him for acid reflux and performs endoscopies and colonoscopies routinely every five years. He continued that in 2007, he told Dr. Deutsch that Dr. Blumstein wanted to do a colonoscopy. He asked how it could be done if he was on Plavix and Aspirin. The plaintiff testified that Dr. Deutsch told him that after his stress test in June 2007, he could have it done. He had his stress test, which was ok, but he was still feeling fatigued. The Plavix was discontinued, but he continued to take Aspirin 325 mg, Protonix, and Xanax. He testified that Dr. Deutsch told him to follow his gastroenterologist’s instructions to prepare for the colonoscopy, and to stop

the aspirin seven to ten days prior to the colonoscopy scheduled for July 25, 2007. He did not have the exam, however, because he had a heart attack on July 21, 2007. He had stopped the Aspirin for three and a half days. His wife took him to Southside Hospital where he was treated by Dr. Caselnova in the cardiac catheterization room and admitted to ICU. He testified that he was told by Dr. Caselnova that a clot formed in his stent. He was hospitalized for four days and was out of work for a total of two and a half weeks.

Ezra Deutsch, M.D. testified to the extent that the plaintiff was a moderately obese middle-aged male with coronary disease and high cholesterol. He had first cared for the plaintiff in 1999, but did not see him again until June 21, 2005 due to a very abnormal nuclear stress test. He performed a cardiac catheterization on the plaintiff at North Shore University Hospital on June 21, 2005, including a left heart catheterization, coronary angiography, bypass graft angiography, left ventriculography, peripheral arteriogram, balloon angioplasty and drug-eluting coronary stent therapy of the right coronary artery. The plaintiff had a 90 % stenosis (occlusion) of his left anterior descending coronary for which he had undergone bypass surgery in 1988, however, the bypass itself was patent with normal flow to the artery beyond it. He also had a very small branch at the tip of his LAD that was severely stenosed, and which had been noted in 1998 as well, and which was the indication for the 1988 bypass surgery. The artery beyond that stenosis was supplied by the bypass graft that was normal. His left circumflex artery had mild irregularities, and he had an eccentric, hazy 90 % stenosis in the distal right coronary artery with diminished flow. He also performed a ventriculogram to ascertain heart function, which revealed that the inferior wall was not moving normally (moderate and severe hypokinesis) and which was supplied by the right coronary artery.

Dr. Deutsch described that the left ventricular and diastolic pressure, is measured at the end of the diastolic filling period in the left ventricle, the main pumping chamber for the heart. He stated that the plaintiffs' end diastolic pressure was minimally elevated in the setting of significant hypertension, but was mildly elevated initially in the setting of systemic hypertension that can be explained by his hypertension. It was also explained, he stated, by the fact that the plaintiffs' heart was ischemic with a severe narrowing in the right coronary artery, a reflection of the severity of the ischemia due to the stenosis in his right coronary artery. It can also be seen in hypertensive patients, and the plaintiff was hypertensive. Dr. Deutsch continued that the hypokinesis in the inferobasal segment of the plaintiffs' heart was due to limitation in blood flow to it from a severe narrowing in the right coronary artery, and may be a reflection of ischemic, of possible injury, or myocardial stunning due to insufficient blood supply. The plaintiffs' ejection fraction was in a normal range at 60 %.

Dr. Deutsch testified that he inserted a Taxus drug-eluting stent to treat the severe stenosis in the plaintiff's right coronary artery. He used this particular stent because the plaintiff already had prior bypass surgery, this drug-eluting stent has a lower rate of renarrowing or restenosis than bare metal stents, and he wanted to give the plaintiff the best chance of long-term success for treatment of his condition. The stent provided normal distal flow and no residual stenosis. He thereafter ordered the plaintiff to take Plavix 75 mg daily for a minimum of six months, Aspirin 325 mg indefinitely, and Lipitor (later changed to Zocor), to maintain patency of the stents and for permanent prevention and secondary prevention of his coronary artery disease. The plaintiff had an echocardiogram on July 5, 2005, which indicated his inferior wall was moving normally, demonstrating revascularization of the right coronary artery. It also showed that the plaintiff had trace mitral regurgitation, reversal of EA waves of the mitral inflow pattern consistent with reduced compliance of the left ventricle, which he stated was a common finding in patients with

hypertension. His ejection fraction was 65%. The plaintiff's EKG was normal on July 6, 2005 at his office visit.

Dr. Deutsch testified that he next saw the plaintiff on September 7, 2005, at which time the plaintiff complained of dizziness with changes in position, and bruising. He reviewed the Myoview stress test with him, which was normal with recovery of the inferior wall of the heart with normal perfusion, a small abnormality at the tip of the heart due to a very small branch narrowing in the LAD, and an ejection fraction of 72 %. His EKG was normal. He next saw the plaintiff on January 4, 2006, and reviewed the carotid ultrasound ordered to investigate the complaints of dizziness. The carotid ultrasound showed evidence for atherosclerotic changes and thickening in his carotid systems, but no evidence of significant stenosis. EKG was normal. On June 21, 2006, at the office visit, the plaintiff complained of bruising. He had completed twelve months of Plavix therapy, and he was allowed to discontinue the Plavix as he had a normal stress test. He was to remain on the Ecotrin 325 mg daily. The Myoview stress test was normal with an ejection fraction of 71 %. EKG was unchanged, still showing sinus rhythm of 54, QS complex in V-1, and T wave inversion in V-1 and V-2.

Dr. Deutsch testified that he next saw the plaintiff on December 6, 2006. His EKG was the same. His lipids were in superb control. He noted that the plaintiff had a history of diverticular disease and was due for a colonoscopy. He was cleared for colonoscopy from a cardiac standpoint. His note indicated that his letter to Dr. Mandarano stated that he may come off Aspirin for a few days in advance of this procedure, and that it was the practice of most gastroenterologists to withhold Aspirin in patients who need biopsies. He stated that he did not instruct the plaintiff to stop his Aspirin. His plan was for a Myoview stress test in six months. When questioned, Dr. Deutsch stated that he was aware that there is a small but significant incidence of late stent thrombosis with any stent whether or not Aspirin is stopped. In 2006, he was not aware that patients who were two years out from stent therapy were at increased risk of stent thrombosis coming off Aspirin.

Dr. Deutsch continued that on June 8, 2007, the plaintiff had another stress test, but he did not return for his follow-up visit in June. The stress test, however, indicated no evidence of ischemic or infarction, and his ejection fraction was 72 %. Thereafter, his office received the catheterization report and echocardiogram report from Southside Hospital on July 30, 2007. He saw the plaintiff in his office on August 1, 2007, and indicated that the plaintiff did not have current chest pain, shortness of breath, dizziness, light-headedness, complication or loss of consciousness. His femoral puncture sites in his groin were ecchymotic but healing nicely. The EKG showed he had sinus bradycardia of 50, with minor ST segment abnormalities, unchanged from the prior tracings. In his signed and typed, but not proof-read letter to Dr. Mandarano, he indicated "we" stopped his Aspirin, and thought it was a typo, because in his October 3, 2007 letter, he stated that "he stopped his Aspirin." He felt the plaintiff fell into that .08 % of patients with late stent thrombosis due to antiplatelet therapy cessation, even though it was two years after his event and particularly in that his Myoview stress study three weeks prior was entirely normal. He testified that the entire interventional cardiology community became aware in 2007 that there were concerns with respect to antiplatelet therapy and stent thrombosis, and late stent thrombosis. He testified that his office note reflects that he felt that the stent thrombosis occurred in the setting of an elective hold of the Aspirin. On his October 3, 2007 visit, the plaintiff complained of some generalized fatigue and leg fatigue. They discussed his stress test of September 19, 2007. His scans were normal, however, there were EKG changes which were not noted in the EKG findings of his previous stress test in June. He was concerned with

respect to the right coronary artery and coronary stents. His September 19, 2007 stress test was a positive exercise stress test with ECG evidence of ischemia, however, the nuclear portion was normal. He offered the possibility of a repeat angiogram to determine that the stents were okay and to redefine the plaintiff's coronary stents and coronary anatomy due to the ECG changes, however, the plaintiff declined the repeat angiogram. He did not see the plaintiff thereafter.

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 [1999]). 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 Derdarian v Felix Contracting Corp.*, 51 NY2d 308, 434 NYS2d 166 [1980]; *Prete v Rafla-Demetrious*, 224 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], *app denied* 92 NY2d 814, 681 NYS2d 475 [1998]; *Bloom v City of New York*, 202 AD2d 465, 465, 609 NYS2d 45 [2d Dept 1994]).

"The affidavit of a defendant physician may be sufficient to establish a prima facie entitlement to summary judgment where the affidavit is detailed, specific and factual in nature and does not assert in simple conclusory form that the physician acted within the accepted standards of medical care" (*Toomey v Adirondack Surgical Assoc.*, 280 AD2d 754, 755, 720 NYS2d 229 [3d Dept 2001][citations omitted]; *Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853, 487 NYS2d 316 [1985]; *Machac v Anderson*, 261 AD2d 811, 812-813, 690 NYS2d 762 [3d Dept 1999]).

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]).

Defendants' expert, Jacob Shani, M.D., averred that he is licensed to practice medicine in New York State and is board certified in cardiovascular disease and interventional cardiology. He set forth his education and training and work experience, as well as the records and materials which he reviewed and which have been provided to this court. Dr. Shani testified that it is his opinion within a reasonable degree of medical certainty that the care and treatment rendered by defendants Ezra Deutsch, M.D. and Suffolk Heart Group to Paul Colletti was at all times within the standard of care and did not proximately cause any of the injuries alleged by the plaintiffs.

Dr. Shani set forth that the plaintiff had a medical history of hypertension, obesity, and elevated cholesterol. In June 1988, he underwent coronary artery bypass graft surgery with an arterial graft placement to the left anterior descending artery at St. Vincent's Catholic Medical Center. On June 8, 2005, he had an abnormal EKG and the exercise stress test demonstrated ischemia, wall motion abnormality, and

a global ejection fraction of 55%. On June 21, 2005, Dr. Deutsch performed a cardiac catheterization and placed two drug-eluting stents for the 90% occlusion of the plaintiff's right coronary artery at Long Island Jewish Medical Center. Thereafter, Dr. Deutsch continued to follow the plaintiff's condition. A Myoview stress test in June 2006 demonstrated preserved left ventricular function with an ejection fraction of 71%. On December 6, 2006, the plaintiff advised Dr. Deutsch that he was overdue for a colonoscopy wherein Dr. Deutsch, by letter to plaintiff's primary care physician, Dr. Mandarino, and to plaintiff's gastroenterologist, Dr. Blumstein, advised that the plaintiff could come off Aspirin for a few days in advance of his procedure. The plaintiff did not see Dr. Deutsch again until August 1, 2007. Dr. Shani continued that the plaintiff scheduled his colonoscopy for July 25, 2007 and stopped taking Aspirin. However, on July 21, 2007, the plaintiff presented with chest pain to Southside Hospital and underwent revascularization in the catheterization laboratory. He was discharged on July 24, 2007 after his echocardiogram indicated normal ventricular function. Periodic testing thereafter indicated good heart function and no significant heart damage. He stated that the intervention at Southside Hospital was timely and appropriate.

Dr. Shani stated that Dr. Deutsch used Tazus stents in June 2005 during the angioplasty as these drug-eluting stents are preferable as they have less risk of restenosis, about 10% chance, and that less than 1% of patients will develop late stent thrombosis. Dr. Shani continued that in December 2006, Dr. Deutsch appropriately advised the plaintiff that he could cease Aspirin intake for a few days prior to his upcoming procedure, and that such advice was within the standard of care. However, the medical clearance for the colonoscopy was good for only thirty days because a patient's medical condition is not guaranteed to remain the same. He stated that there was no way Dr. Deutsch could anticipate that the plaintiff would wait nearly seven months to schedule the colonoscopy in July 2007. Dr. Shani also stated that there is no indication that the plaintiff was told by Dr. Deutsch that he could stop taking Aspirin for seven days. The plaintiff did not represent to Dr. Deutsch for medical clearance prior to his colonoscopy after not having been seen since by him since December 6, 2006.

Dr. Shani concluded that the plaintiff did not suffer significant damage to his heart as the testing performed subsequent to plaintiff's myocardial infarction indicated good heart function. He added that Dr. Deutsch's recommendation in December 6, 2006 that the plaintiff could cease Aspirin intake a few days prior to the planned colonoscopy was within the standard of care and that the care and treatment by Dr. Deutsch was not the proximate cause of any of the injuries alleged by the plaintiff.

Based upon the foregoing, it is determined that the defendants established prima facie entitlement to summary judgment dismissing the complaint on the bases that they did not depart from the good and accepted standards of care and treatment; that Dr. Deutsch cleared the plaintiff for colonoscopy within thirty days, advising that he could cease Aspirin intake for a few days prior to the procedure; that the plaintiff did not obtain medical clearance from the defendants before the colonoscopy which the plaintiff did not schedule for nearly seven months later; and that the defendants did not proximately cause any of the injuries alleged by the plaintiff.

The plaintiffs oppose this motion by submitting, inter alia, an attorney's affirmation; plaintiff's various records from his treating physicians; various unauthenticated publications; deposition transcripts of Dr. Deutsch and the plaintiff; and a redacted expert affirmation.

While the plaintiffs have provided a copy of a redacted affirmation of their expert physician, they have not provided an unredacted copy of the affirmation to this court as required (*Marano v Mercy Hospital*, 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]). A redacted version of an expert affidavit lacks evidentiary value (*Marano v Mercy Hospital*, 241 AD2d 48, 670 NYS2d 570 [2d Dept 1998]). “A party may successfully oppose a summary judgment motion without disclosing the names of the party’s expert witnesses. In opposition to such a motion the party defending against a summary judgment motion may serve the movant with a redacted copy of its expert’s affirmation as long as an unredacted original is provided to the court for its in camera inspection” (*Marano v Mercy Hospital, supra*). This procedure preserves the confidentiality of the name of plaintiff’s medical expert while also preserving plaintiffs’ obligation in opposing defendant’s motion, in that by submitting a redacted affirmation and by offering the original to the court for in camera inspection, plaintiff has opposed the motion by evidence in admissible form (*Rubenstein v Columbia Presbyterian Medical Center*, 139 Misc.2d 349, 527 NYS2d 680 [NY County 1988]). A copy of the affidavit with the expert’s name and signature have not been provided to this court under separate cover. Accordingly, plaintiffs’ expert affidavit is not in admissible form and is insufficient to raise a triable issues of fact as to the defendant’s alleged malpractice (*Rose v Horton Medical Center*, 29 AD3d 977, 816 NYS2d 174 [2d Dept 2006]). Even if plaintiffs’ expert affidavit were considered, it is determined that the plaintiffs have failed to raise a factual issue to establish that any act or omission by the moving defendants proximately caused plaintiff’s claimed injuries.

The plaintiffs’ expert opined that Dr. Deutsch departed from the standard of care in advising the plaintiff that he could stop the Aspirin prior to the colonoscopy, which he stated is a low risk procedure. He cited to the Chest, October 29, 2003, a publication concerning coronary syndromes following aspirin withdrawal, and quoted “[A]lthough our results do not quantify the problem, they nevertheless support the hypothesis that aspirin withdrawal in coronary patients may represent a real risk for the occurrence of a new coronary event....” In citing two other publications, he indicated the rates of myocardial infarct for recent withdrawers of Aspirin was reported as 2.7%. The plaintiffs’ expert opined that even without any cardiac stent, the plaintiff’s documented cardiac history and cardiac disease placed him at an increased risk of myocardial infarct should he stop taking Aspirin for a low risk colonoscopy procedure, and that the plaintiff should not have been instructed to stop taking Aspirin prior to his colonoscopy. He continued that the risk of bleeding from a low risk procedure on Aspirin outweighs the risk of sustaining a myocardial infarct. He further stated that in July 2007, when the plaintiff was scheduled to undergo an elective routine colonoscopy, his risk for formation of stent thrombosis was significantly increased with the cessation of Aspirin.

In his detailed affidavit, plaintiffs’ expert stated that stents were vulnerable to restenosis, and to address this problem, drug-eluting stents that deliver medication directly to limit the growth of neointimal scar tissue to reduce the likelihood of stent restenosis were developed and limit formation of a new endothelial layer over the new drug-eluting stent to inhibit clot formation. He continued that for drug-eluting stents, the incidence of clot formation within the stent may persist for a longer period of time, even after several years. He also indicated that thrombus may occur around the stent. He stated that cessation of Aspirin even one year after drug-eluting stenting markedly increases the risk of stent thrombosis and myocardial infarction. He described several case studies involving Aspirin cessation just under one year after stenting, one year and several weeks after stenting, and one year and almost three months after stenting, in individuals who subsequently suffered myocardial infarction due to stent occlusion or thrombosis due to delayed vascular healing that rendered the surface of the stent prothrombotic. He cited to other studies wherein life-long Aspirin treatment is recommended for late stent thrombosis.

The plaintiffs' expert stated that the plaintiff was not at risk for bleeding with the colonoscopy procedure with low dose Aspirin as he had no history of a bleeding disorder. He continued that in 2002, the American Society for Gastrointestinal Endoscopy published its guidelines for endoscopic procedures and set forth that routine colonoscopy with or without biopsy, was designated a "low-risk" procedure, and absent a bleeding disorder, the cardiac patient could have the procedure without stopping their Aspirin. The plaintiffs' expert stated that the abrupt withdrawal of Aspirin could, and did, result in rebound platelet activation and aggregation causing an occluding stent thrombus within a few days of the plaintiff stopping Aspirin. He considered a few days to be more than a couple of days and less than a week.

The plaintiffs' expert continued that the plaintiff had a stress test in June 2007, prior to his colonoscopy. He stated that Dr. Deutsch sent a letter to Dr. Mandrano advising that the Myoview stress test of June 8, 2007 was normal and unchanged from the prior stress test. The plaintiffs' expert opined that there were no medical or cardiac contraindications in July 2007 to the plaintiff undergoing a routine colonoscopy and endoscopy. He stated that the only question needing an answer is whether the thrombus that caused the plaintiff's heart attack formed in proximity to the stents involving the right coronary artery, or formed in another artery of the heart. He opined that, based upon the catheterization findings at Southside Hospital on July 21, 2007, the mid vessel stent in the right coronary artery had 100% occlusion with evidence of thrombosis, consistent with thrombosis. It is his opinion that the cessation of the Aspirin approximately three days before was the proximate cause of the stent occlusion and resultant myocardial infarct and damages. While he indicated that the plaintiff has ischemia of the inferior wall, he also noted that he has a normal ejection fraction. He stated that the plaintiff has shortness of breath and fatigue, but it is also noted that he continued to have fatigue and shortness of breath after his coronary occlusion and stent placement in June 2005. On July 5, 2005, the echocardiogram showed trace mitral regurgitation and a reversal of EA waves of the mitral inflow pattern consistent with reduced compliance of the left ventricle. The plaintiffs' expert did not believe that this was due to the plaintiff's hypertension, although he acknowledge that it could be. Two years later, the myocardial blood flow returned to normal after the angioplasty, he stated.

It is determined that the plaintiffs' expert has not differentiated between true and pseudo normal EA ratio in that there has been no measurement of the pulmonary venous flow pattern, and he makes a conclusory opinion that the plaintiff's diastolic dysfunction was worsened to moderate in July 2007, as compared to it being mild in July 2005, and does not relate plaintiff's history of hypertension. Prior to the 2007 stent occlusion, the plaintiff already experienced decreased ejection fraction, diastolic dysfunction, and myocardial ischemia. Additionally, the plaintiffs' expert has not set forth that any further testing was done to determine whether or not the plaintiff has any degree of occlusion in the coronary vessels which may be the cause of his continuing fatigue and shortness of breath and myocardial ischemia, leaving this court to speculate. It is noted that the possibility of future coronary artery occlusion is recognized by the plaintiffs' expert, even continuing antiplatelet therapy. The plaintiffs' expert stated that if the plaintiff experiences significant occlusion/stenosis in his right coronary artery again, he will be required to undergo another coronary artery bypass surgery. Thus, the plaintiffs' expert has demonstrated that such occlusion may occur even in the absence of negligence, irrespective of whether or not antiplatelet therapy is discontinued. It is further noted that the plaintiffs' expert, in citing to the 2002 publication of the guidelines for endoscopic procedures by the American Society for Gastrointestinal Endoscopy, that in routine colonoscopy, with or without biopsy, and absent a bleeding disorder, the cardiac patient could have the procedure without stopping their Aspirin. Based upon the foregoing, the guideline indicated that the cardiac patient could have the procedure without stopping Aspirin, but did not preclude stopping the Aspirin. The plaintiffs' expert does not indicate a protocol which should be followed should the cessation

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of Aspirin be ordered, and has not demonstrated a departure relative thereto. Thus, it has not been established that the defendants departed from the standard of care by stopping the Aspirin for a few days prior to the colonoscopy, and more than two years after the stent placement.

It is determined that even if the plaintiffs' expert's affirmation were in admissible form, the plaintiffs' expert has not demonstrated that any action by the defendants was the proximate cause of the plaintiff's cardiac condition and the injuries alleged by the plaintiff, including future cardiac damage. Nor has plaintiffs' expert raised factual issues to preclude summary judgment.

Dated: 3-5-14

Hon. Denise F. Molia

A.J.S.C.

X FINAL DISPOSITION _____ NON-FINAL DISPOSITION