DeTolla v Pourmand
2014 NY Slip Op 30580(U)
February 28, 2014
Supreme Court, Suffolk County
Docket Number: 10-25621
Judge: Joseph Farneti

[* 1]

SHORT FORM ORDER

INDEX No. 10-25621
CAL No. 13-00127MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 37 - SUFFOLK COUNTY

PRESENT:

Hon. JOSEPH FARNETI
Acting Justice Supreme Court

MOTION DATE 6-20-13 (002, 003, 004, 005)
MOTION DATE 6-27-13 (001)
ADJ. DATE 1-9-14
Mot. Seq. # 001 - MD # 004 - MD
002 - MD # 005 - MD
003 - MG

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JADIE SHING DeTOLLA, Individually and as Executrix of the Estate of NEILL DeTOLLA, deceased,

Plaintiffs,

- against -

RAHMAN POURMAND, M.D., ZWANGER & PESIRI RADIOLOGY GROUP, LLP, MEDICAL ARTS RADIOLOGICAL GROUP, P.C., AJAY E. CHITKARA, M.D., DEV R. CHITKARA, P.C., OTOLARYNGOLOGY ASSOCIATES OF LONG ISLAND, P.C., PAUL LERNER, M.D., PAUL LERNER, M.D., P.C., and ROBERT M. GALLER, M.D.,

Defendants.

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Upon the following papers numbered 1 to 88 read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (001) 1 - 12; (002) 13-33; (003) 34-47; (004) 48-85; (005) 86-88 ; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers_; Replying Affidavits and supporting papers __; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (001) by defendants, Ajay Chitkara, M.D. and Otolaryngology Associates of Long Island, P.C., pursuant to CPLR 3212 for summary judgment dismissing the complaint asserted against them is denied; and it is further

ORDERED that motion (002) by amended notice of motion by defendants, Paul Lerner, M.D. and Paul Lerner, M.D., P.C., pursuant to CPLR 3212 for summary judgment dismissing the complaint asserted against them is denied; and it is further

ORDERED that motion (003) by defendant, Medical Arts Radiology Group, P.C., pursuant to CPLR 3212 for summary judgment dismissing the complaint asserted against it is granted; and it is further

ORDERED that motion (004) by defendant, Robert M. Galler, D.O. s/h/a Robert M. Galler, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint asserted against him is denied; and it is further

ORDERED that motion (005) by defendant, Rahman Pourmand, M.D., pursuant to CPLR 3212 for summary judgment dismissing the complaint asserted against him is denied.

In this medical malpractice action, the plaintiff, Jadie Shing DeTolla, as executrix of the estate of Neill DeTolla, asserts causes of action premised upon the negligence of the defendants; wrongful death of the decedent, lack of informed consent, and a derivative claim. It is alleged that the defendants departed from the good and accepted standards of medical care and treatment in failing to timely and properly diagnose and treat the decedent's brain stem cancer, resulting in the death of the decedent on July 26, 2009.

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]).

Medical records are required to be submitted in admissible form which requires that they be certified pursuant to CPLR 3212 and 4518 (***Friends of Animals v Associated Fur Mfrs.***, *supra*). Expert testimony is

limited to facts in evidence (*see also* ***Allen v Uh***, 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Marzuillo v Isom,*** 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]; ***Hornbrook v Peak Resorts, Inc***., 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]), and uncertified medical records are not admissible in evidence. It is noted that neither moving party has submitted medical records in admissible form, as none of the records have been certified.

In support of motion (002), the Lerner defendants have submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, their answers and demands, and plaintiff's verified bill of particulars; one page of the transcript of the examination before trial of J. Shing DeTolla without certification or signature which is not in admissible form (*see* ***Martinez v 123-16 Liberty Ave. Realty Corp.***, 47 AD3d 901, 850 NYS2d 201 [2d Dept 2008]; ***McDonald v Maus***, 38 AD3d 727, 832 NYS2d 291 [2d Dept 2007]; ***Pina v Flik Intl. Corp.***, 25 AD3d 772, 808 NYS2d 752 [2d Dept 2006]); expert disclosure; a copy of medical records certified by an officer manager of an unknown entity which is not identified in the purported certification labeled "Supreme Court of the State of New York County of Queens," an uncertified copy of medical records possibly of Dr. Richard Miller, additional uncertified medical records and MRI reports which are not in admissible form to be considered on a motion for summary judgment (CPLR 3212, 4518; ***Friends of Animals v Associated Fur Mfrs.***, *supra*). These moving defendants have also failed to provide copies of the answers served by their co-defendants as required pursuant to CPLR 3212.

In support of motion (003), defendant Medical Arts Radiological Group, P.C. has submitted, inter alia, an attorney's affirmation; the affirmation of Karen S. Black, M.D.; copies of the summons and complaint, its answer, plaintiff's verified bill of particulars; and copies of uncertified medical records and radiology reports which are not in admissible form (CPLR 3212, 4518; ***Friends of Animals v Associated Fur Mfrs.***, *supra*). These moving defendants have also failed to provide copies of the answers served by their co-defendants as required pursuant to CPLR 3212.

In support of motion (004), defendant Robert M. Galler, D.O. has submitted, inter alia, an attorney's affirmation; the affirmation of Stephen Burstein, M.D.; copies of the summons and complaint, answers and demands served by defendants Galler and Pourmand, plaintiff's verified bills of particulars for defendants Galler and Pourmand, and their bill of particulars relating to their affirmative defenses; the unsigned but certified transcript of the examination before trial of defendant Pourmand dated December 2, 2011 which is considered as adopted as accurate by him (*see* ***Ashif v Won Ok Lee***, 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]); and multiple uncertified and/or unidentified medical records which are not in admissible form (CPLR 3212, 4518; ***Friends of Animals v Associated Fur Mfrs.***, *supra*). These moving defendants have likewise failed to provide copies of the answers served by their co-defendants as required pursuant to CPLR 3212.

In support of motion (005), defendant Rahman Pourmand, M.D. has submitted, inter alia, an attorney's affirmation; affirmation of Jai Grewal, M.D.; copies of the summons and complaints, answers, plaintiffs verified bill of particulars, and various discovery demands; and uncertified medical records.

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]).

"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]).

Jadie Shing DeTolla, D.D.S. testified to the extent that her deceased husband, Neill DeTolla, obtained his law degree in 1982 from St. John's Law School, Brooklyn and was self-employed. His last date of practice was October 31, 2008. He had a heart transplant in 1987 due to cardiomyopathy and was under the care of Dr. Kantrowitz at the University of Utah for yearly visits after the surgery. He took immunosuppressant medication relating to the cardiac transplant, but was weaned off the medications. In New York, he treated with Dr. Beasetty who retired, then with Dr. Consonin. He also treated with Dr. Warm and Dr. Miller, and then Dr. Shulman from about 2003 through 2008, for multiple skin cancers, some basal, some squamous, most notably on his face and hands. Dr. Lebeouf, a gastroenterologist, treated him with chemotherapy for a cancerous rectal papilloma in 1998. He was treated by Dr. Rabony in the 1990s at Memorial Sloan Kettering for a removal of two separate cancerous tumors in his kidney. In 2006, the decedent had a seizure while he was in the office of Dr. Nicolotis, a urologist, who admitted him to Memorial Sloan Kettering for evaluation. A CAT scan did not reveal anything. He had both hips replaced, at different times, in about 2006. He also saw Dr. Sateen who treated him for snoring.

The plaintiff testified that in about July 2007, the decedent was out on his boat fishing with his son when the boat was hit by a wave, causing her husband's neck to jerk. Prior to this incident, he had drooping in his neck, but after the boating incident, it became progressively worse. He began treatment for his neck with Jamie Skurka, a chiropractor, who then referred him to a neurologist who provided pain management treatment for the pain in his neck. He also saw a doctor at the Hospital for Joint Diseases for treatment to his neck. He treated with Dr. Lerner, a neurologist, who could not find anything wrong with the decedent's neck. He saw Dr. Galler in 2007 for complaints of pain in his neck and numbness on the left side of his face and was prescribed physical therapy. Thereafter, from about July 2007 to about November 2008, the decedent

saw Dr. Pourmand, a neuromuscular neurologist, for his neck drop. He had muscle biopsies and MRIs or CAT scans, or both. From the middle of October 2008 through November 2008, the decedent lost fifteen pounds. He couldn't eat, he choked on water, he had difficulty speaking, and his voice became raspy. He had pain in his neck, and left arm weakness with muscle wasting of the left shoulder and left back. The plaintiff accompanied her husband to a November 2008 office visit with Dr. Pourmand. She testified that Dr. Pourmand told her husband that he looked better and sounded better. Dr. Pourmand suggested that the decedent use a straw to take liquids and eat puddings. No further treatment was recommended by Dr. Pourmand, whom, she stated, did not perform a physical examination at that visit.

The plaintiff continued that the decedent had become disabled on October 31, 2008 as he could not eat, talk, or drive, and he was unable to pick his head up. The decedent's internist, Dr. Consonin, referred the decedent to Dr. Chitkara, and it was determined that the decedent had vocal cord paralysis. He saw Dr. Chitkara only once. The decedent was admitted to Stony Brook University Hospital in November 2008 by Dr. Pourmand for placement of a feeding tube and for further evaluation. She stated that it was determined that the decedent had an involvement with the 9th, 10th, and 11th cranial nerves. The plaintiff testified that her husband did not return to Dr. Pourmand because Dr. Pourmand did not know what was wrong with him, and that there was nothing Dr. Pourmand could do. In December 2008, a PET scan was performed. He then went to Columbia University where he was seen by Dr. Olarte on referral from Dr. Kantrowitz.

The plaintiff testified that Dr. Olarte asked for the decedent's symptoms and events, then told the plaintiff that he did not have myasthenia gravis, MS or ALS, but instead, he had a tumor, which might be small, but it could be found. Some diagnostic testing and biopsies were performed and the tumor was located. The biopsy revealed squamous cell carcinoma. The decedent was seen by Dr. Michael Kaiser. Fragments of the tumor had gone into the spinal cord, so surgery was not possible to treat the tumor. Radiation was recommended, for which he was referred by Dr. Kaiser to Dr. DeAngeles at Memorial Sloan Kettering. Dr. DeAngeles told her that the squamous cell carcinoma was in an unusual site as it is normally just in the soft tissue and bone; that it is very responsive to radiation, but, because it was in the spinal cord, she could not tell what the outcome would be. Dr. DeAngeles referred her husband to Dr. Fury for medical care, and Dr. Zalefsky for radiation. Chemotherapy was ordered. When the plaintiff learned of her husband's diagnosis, she called Dr. Pourmand's office to cancel his January appointment. Dr. Pourmand called her back at home, then hung up on her when she told him that her husband had cancer in his neck. A PET scan in January 2008 also revealed hot spots in the neck. The decedent received both chemotherapy and radiation at Stony Brook University Hospital, and had to be hospitalized several times at Sloan Kettering and Mather Memorial Hospital for treatment from the side effects. Upon completion of the treatment, he was to have a PET scan in August 2009 to see if the tumor had shrunk. In July, 2009, the decedent had difficulty breathing, which was thought to be from the tumor pressing on the spinal cord. He was intubated and died on July 26, 2009.

It is noted in motion (002) by the Lerner defendants, and motion (004) by defendant Galler, that the defendants' respective experts have proffered conflicting opinions concerning when the decedent's squamous cell carcinoma of the brain stem was present. Dr. Burstein, the expert for Dr. Galler, opined within a reasonable degree of medical certainty that the decedent did not have a brain stem tumor in 2007, and that his eventual squamous cell brain stem tumor did not present until the decedent was seen at New York Presbyterian Hospital in 2009. It is noted however, that Dr. Phillips, the expert for defendant Dr. Lerner, opined that the pathology of the decedent's squamous cell carcinoma was incredibly rare, that the decedent's neck symptomatology developed some time in 2006, according to his complaints to Dr. Lerner, and due to his

symptoms of radiculitis and a myopathy as far back as 2006, there was considerable neurological involvement by an infiltrative squamous cell malignancy in that area. It is Dr. Phillip's opinion that the disease could not have been resected from its onset, and that the tumor at C2 was not diagnosable by any clinician until the plaintiff began experiencing cranial neuropathies in November 2008. It is further noted in motion (005), that defendant Pourmand's expert, Dr. Grewal stated that the decedent's cranial nerve involvement presented around October 2008, and his downhill course was extremely rapid thereafter. Dr. Grewal opined that had the decedent been symptomatic of this tumor in 2007, his demise would have occurred long before July 2009. Dr. Grewal stated that he reviewed the imaging studies conducted in the area of the plaintiff's head from February 2006 through January 2008, and that those studies were negative for potential cancer or lesions, and that the decedent did not have a brain stem tumor then.

Based upon the foregoing, defendants' experts, Dr. Burstein, Dr. Phillips, and Dr. Grewal have presented conflicting expert opinions which preclude summary judgment. Dr. Burstein opined that the decedent did not have a brain stem tumor in 2007. Dr. Phillips opined that as far back as 2006 there was considerable neurological involvement by an infiltrative squamous cell malignancy in the area of C2. Dr. Grewal opined that the imaging studies conducted in the area of his head from February 2006 through January 2008 were negative for potential cancer or lesions, and the decedent did not have a brain stem tumor at that time. Due to the conflicting expert opinions set forth by defendants Lerner, Pourmand, and Galler's expert physicians, the factual issues preclude summary judgment for being granted on motions (002), (004) and (005). However, their respective motions will be addressed below.

MOTION (001)

Ajay Chitkara, M.D. seeks summary judgment dismissing the complaint on the bases that he saw the decedent Neill DeTolla on one visit on October 28, 2008, that he did not depart from the standard of care, and that he did not proximately cause the injuries or death of the plaintiff's decedent.

Defendant Chitkara submitted the affirmation of Peak Woo, M.D. in support of his motion for summary judgment. Dr. Woo affirms that he is a physician licensed to practice medicine in New York State and is board certified in otolaryngology. He affirmed that his statements are based upon his medical education and training, but has not set forth his education and training. He stated that he has been an attending at Mount Sinai Medical Center since 2008. Dr. Woo set forth the materials and records which he reviewed and opined within a reasonable degree of medical certainty that the treatment rendered by Ajay Chitkara, M.D. was within good and accepted medical practice and did not in any manner proximately cause or contribute to the injuries suffered by the decedent.

Dr. Woo set forth a brief history of the plaintiff's medical/surgical care and treatment, including decedent's neurological complaints, including neck pain with limited range of motion, as well as numbness of the jaw, and eventual inability to lift his head. Although Dr. Woo set forth that these complaints occurred from 2006 to 2008, he does not set forth when the various complaints actually occurred. Dr. Woo noted some of the decedent's treating physicians and indicated that multiple diagnostic studies were undertaken, none of which revealed a mass at the base of the patient's skull. Dr. Woo does not indicate the tests performed, the dates of such testing, and the results of the tests. He stated that on October 31, 2007, the decedent began treatment with co-defendant Rahman Pourmand, M.D. for complaints of worsening head drop. Biopsy of the

biceps and quadriceps showed non-specific changes. Pourmand prescribed Prednisone from January through April 2008 for myopathy of an undetermined etiology. Physical therapy was attempted, but in September 2008, it was noted that weakness was causing neck pain. Physical therapy was to be continued, and the decedent was to return in six months.

Dr. Woo stated that on October 7, 2008, when the decedent returned to Pourmand with complaints of slurring words and occasional difficulty swallowing, he was referred by Pourmand to defendant Ajay Chitkara who saw the decedent on October 28, 2008 for complaints of hoarseness, increasing dysphagia (difficulty swallowing) for about one month, and a one year history of facial numbness. Examination by Chitkara revealed the decedent's nasal septum and tongue deviated to the left, and that there was kyphosis secondary to myelopathy; and that his voice was breathy and wet. Following flexible laryngoscopy, Chitkara diagnosed left vocal fold weakness, left lingual weakness, dysphagia and hoarseness, for which Chitkara recommended a neck and brain MRI and FEESST (flexible endoscopic evaluation of swallowing with sensory testing). Dr. Woo stated that the MRI of the orbit/face/neck of November 3, 2008 revealed a mass that could not be excluded. The radiologist from Zwanger-Pesiri recommended non-contrast CT. The brain MRI revealed age related involutional changes, and clinical assessment was suggested. Copies of the reports were sent to Drs. Chitkara, Pourmand, and Konczynin (sic- Consonin). Dr. Woo stated that the FEESST was performed on November 4, 2008 at St. Charles Hospital, although he does not indicate who performed the procedure. Medical follow up was recommended due to the examiner's conclusion that the decedent could not take oral nutrition and needed alternate means of nutrition and hydration.

Dr. Woo continued that Chitkara noted both MRI reports on November 6, 2008 and relayed the findings to defendant Pourmand of lingual paresis, increased dysphagia, and aspiration. Dr. Woo stated that the plaintiff continued his care with Pourmand, who opined that the left tongue deviation was related to a hypoglossal nerve problem. The decedent was admitted to Stony Brook University Hospital from November 9 through 15, 2008 where he was diagnosed with palsies of cranial nerves 9-12. Dr. Woo stated that Dr. Chitkara was consulted for the primary purpose of determining the cause of the decedent's hoarseness which was attributed to vocal cord paralysis, contemplated to be secondary to an underlying neurological issue. Dr. Woo continued that Chitkara properly relied upon defendant Pourmand, as the decedent's treating neurologist, to continue the neurological evaluation that was already in progress. Based upon the information available to Chitkara, the only consultation indicated was neurology. Dr. Woo stated that Dr. Pourmand, as the patient's treating neurologist, was to follow through with further neurological workup, and a non-contrast CT recommended by the radiologist, if Pourmand deemed it warranted.

Dr. Woo continued that a spinal lesion was diagnosed by MRI on December 22, 2008, and had it been diagnosed during the November 3, 2008 MRI seven weeks earlier, or on December 5, 2008, less than three weeks earlier, the decedent's treatment options and prognosis would have remained the same. However, he does not set forth a basis for such opinion. Although Dr. Woo opined that Dr. Chitkara was a fully qualified physician to care for the decedent, such hearsay is unsupported by the record as neither Chitkara's resume nor his deposition transcript have been submitted in support of this application. It is additionally noted that Chitkara's office records have not been provided with the moving papers. Dr. Woo bases his opinions upon documents which have not been provided to this court and are not in evidence. It is further noted that Dr. Woo has not rendered an opinion with regard to the cause of action for lack of informed consent.

Based upon the foregoing, defendant Dev R. Chitkara has not demonstrated prima facie entitlement to summary judgment dismissing the complaint.

Accordingly, motion (001) is denied.

MOTION (002)

In motion (002), Paul Lerner, M.D. and Paul Lerner, M.D. P.C. seek summary judgment dismissing the complaint on the bases they did not depart from the standard of care and did not proximately cause the decedent's injuries. The affirmation of Joseph. S. Jeret, M.D. has been submitted in support. Dr. Jeret affirmed that he has been licensed to practice medicine in New York State since 1989, and is board certified in psychiatry and neurology. Dr. Jeret does not set forth his work experience to qualify as an expert, except to state he is currently in private practice with privileges at Mercy Medical Center. He set forth that he reviewed certain medical records which he identified, as well the plaintiff's bill of particulars. Dr. Jeret opined within a reasonable degree of medical certainty that the care and treatment rendered by Dr. Lerner to the plaintiff was within the standards of good and accepted medical practice, and did not proximately cause the injuries claimed to have been suffered by the decedent.

Dr. Jeret set forth that defendant Lerner first saw the decedent on February 2, 2007 on referral from Dr. Skurka, a chiropractor. The decedent presented with a history of neck pain, numbness of the left chin and shoulder as well as occasional burning of the shoulder. Upon examination, Dr. Lerner found a mild cervical paraspinal spasm with decreased neck range of motion, left cheek wounds from prior skin cancer treatments and reduced ankle jerks. He ordered an MRI of the cervical spine and a prolonged EEG, and referred the decedent to physical therapy. Dr. Jeret continued that the MRI indicated there was no evidence of an intradural lesion and no paravertebral soft tissue abnormalities identified; posterior disc bulges from C2-3 through C4-5 which impinged on the thecal sac; and ventral marginal osteophyes and diffuse disc bulging in the C5-6 level causing a moderate ventral impression on the thecal sac, and narrowing of C5-6 neural foramina bilaterally secondary to uncinate hypertrophy. Physical therapy was provided from February 27 2007 through April 10, 2007 with reduction of myospasms on the left, improved cervical range of motion by 15 degrees with rotation and side-bending, and improved posture awareness. However, when Dr. Lerner saw the decedent on May 8, 2007, he complained of constant neck pain, worse with movement and radiating from the neck into the left shoulder and left scapula. Dr. Jeret stated that defendant Lerner noted no new focal deficits or significant changes, and his assessment was that of cervical radiculopathy and radiculitis. The decedent was referred to All Island Pain Consultants, with his first visit on July 5, 2007 with Dr. Steven Litman.

Dr. Jeret stated that Dr. Litman noted that the decedent suffered from neck pain and stiffness and started him on a trial of Lyrica. When the decedent was seen at Skurka Chiropractic on July 19, 2007, he was referred for x-rays and chiropractic care. On July 20, 2007, the decedent had his upper thoracic spine and cervical spine x-rayed at Zwanger-Pesiri Radiology, which revealed degenerative disc disease in both the thoracic and cervical spine with kyphosus and torticollis. Defendant Lerner thereafter found a new-onset neck extensor weakness upon examination of July 23, 2007; assessed the decedent as having cervical radiculopathy/exacerbated radiculitis; obtained MRI clearance; and referred the decedent for spine surgery consultation and pain management. Dr. Jeret stated that Dr. Goodman of Medical Arts Radiology interpreted

the MRI as showing disc disease at C3-4, C4-5, and C5-6, with questionable mild wedging and compression along the superior endplate at C5. On August 1, 2007, Dr. Lerner examined the plaintiff, reviewed the MRI report, assessed the plaintiff with cervical radiculopathy/exacerbated radiculitis, administered two trigger point injections to the cervical paraspinals, and referred the decedent for spine surgery consultation and pain management.

Dr. Jeret continued that the decedent continued to be examined by various neurologists, neuromuscular specialists, pain specialists, and neurosurgeons, and was diagnosed with isolated cervical extension myopathy as per EMG/NCV studies on December 13, 2007 at Stony Brook Hospital, explaining Dr. Lerner's finding of neck weakness on July 23, 2007. No tests were positive for cancer until December 2008. The PET/CT on December 5, 2008 from the skull base to the mid-thigh revealed no evidence of malignancy. However, Dr. Marcelo Olarte diagnosed the decedent with a lytic lesion which was determined to be squamous cell carcinoma as evidenced by the MRI dated January 27, 2009.

Dr. Jeret opined that the care provided by Dr. Lerner was appropriate and within the standard of care, and that defendant Lerner appropriately recognized the significance of the plaintiff's medical history, examined the plaintiff at each visit, and listed the plaintiff's complaints in his office record; referred the decedent for appropriate testing and consultations; and prescribed physical therapy, pain management, and two MRIs. Dr. Jeret continued that Dr. Lerner, as a neurologist, was entitled to rely upon the negative findings of the MRIs and appropriately deferred interpretation of the MRIs to the radiologists, and made an appropriate diagnosis of radiculopathy and radiculitis based upon the decedent's complaints, which were not indicative of squamous cell carcinoma of C2, or a more sinister process based upon radiological testing.

It is noted, however, that Dr. Jeret had not set forth the neurological standard of care and how the care and treatment provided by defendant Lerner to the decedent complied with such standard. Dr. Jeret does not comment upon whether or not any differential diagnoses could or should have been considered and ruled in or ruled out. He does not opine as to whether or not the decedent was properly provided with informed consent by defendant Lerner. Dr. Lerner's transcript of his examination before trial has not been provided. It is further noted that on August 1, 2007, Dr. Lerner's note indicates that an MRI of the cervical spine was recommended, but Dr. Jeret does not indicate whether the same was ordered by Dr. Lerner and if the results were obtained.

Dr. Lerner has also submitted the affirmation of Dr. Reed Phillips in support of his application. Dr. Phillips stated that he is board certified in internal medicine with subspecialties in medical oncology, hospice, and palliative medicine. He does not indicate whether he is licensed to practice medicine in New York or any other state, and does not set forth any of his past or current work experience to qualify as an expert. He set forth the materials and records which he reviewed and opined within a reasonable degree of medical certainty that the care and treatment rendered by Dr. Lerner was not the cause of the decedent's alleged injuries and death.

Dr. Phillips set forth the decedent's history of squamous cell carcinoma of the skin, cancer of the anal canal in 1998, and renal carcinoma in 2002 and 2003. While Dr. Phillips stated that Dr. Lerner appropriately examined the plaintiff on February 2, 2007, he does not describe the examination or the standard of care for a neurological examination. He continued that Dr. Lerner's impression was cervical radiculopathy with a history of seizure, and that he appropriately ordered an MRI of the cervical spine and prolonged EEG, as well

as physical therapy. Dr. Phillips also set forth the results of the cervical MRI and physical therapy, as indicated by Dr. Jeret as well. Dr. Phillips noted Dr. Lerner's visits with the decedent, set forth the care and treatment provided, orders, and findings on May 8, 2007, July 23, 2007 and August 1, 2007. While Dr. Phillips stated that Dr. Lerner did not see the decedent for further visits after August 1, 2007, he stated that Dr. Lerner prescribed Lyrica on September 25, 2007 for the decedent. Dr. Phillips continued that the PET/CT scan from the skull base to the mid-thigh on December 5, 2008 revealed no evidence of malignancy, however, on January 27, 2009, Dr. Marcelo Olarte diagnosed the decedent with a lyric lesion centered on the left inferior oblique capitis muscle with extension into the left C2 and C3 pedicle, and the enhancement involved the left C1 lamina superiorly. The tumor extended into the spinal canal along the neural foramen at C1 and and C2 with consequent enlargement of the dorsal and ventral C1 and C2 nerve roots. Intramedullary extension of the tumor was noted at that level, as well as abnormal enhancement of the cord at the left C1-C2, and C3 levels, with associated extension of the tumor through the left stylomastoid foramen to involve the skull base in the region of the jugular foramen.

Dr. Phillips stated that when the decedent was evaluated by Dr. Michael Kaiser at the Neurological Institute, he believed the tumor was unresectable. A CT scan guided biopsy of the tumor was done on February 10, 2009, revealing invasive moderately to poorly differentiated squamous cell carcinoma involving fibromuscular tissue, for which he was treated with radiation and Cetuximab therapy at Memorial Sloan Kettering. Dr. Phillips opined that the pathology of the decedent's squamous cell carcinoma was incredibly rare, and was "likely an infiltrative process throughout the muscular planes infiltrating the nerves that produced the plaintiff's symptoms." He stated that the decedent's neck symptomatology developed some time in 2006, according to his complaints to Dr. Lerner. Due to his symptoms of radiculitis and a myopathy as far back as 2006, there was considerable neurological involvement by an infiltrative squamous cell malignancy in that area. It is Dr. Phillip's opinion that the disease could not have been resected from its onset, and that the tumor at C2 was not diagnosable by any clinician until the plaintiff began experiencing cranial neuropathies in November 2008. However, he stated, the plaintiff had a negative MRI in 2008 and any delay in diagnosis at that point was also unavoidable. He continued that the decedent's lesion would not have shown up on the MRI of July 24, 2007, even if it were performed under general anesthesia, and a subsequent MRI one year later failed to reveal any evidence of the disease process. Dr. Phillips continued that as a neurologist, Dr. Lerner would not be expected to review the MRIs himself as this was not his specialty.

Dr. Phillips concluded that Dr. Lerner's treatment of the decedent had no influence on the decedent's clinical course and the outcome of the decedent's disease as the tumor was terminal by the time Dr. Lerner saw the decedent; that if the C2 tumor was diagnosed earlier and the tumor was resectable, the decedent was unlikely to be able to undergo any procedure to remove the tumor due to his extensive co-morbidities of prolonged immunosupression, impaired cardiac function, and impaired renal function. However, Dr. Phillips does not set forth the bases for these conclusory and unsupported statements and opinions.

Based upon the foregoing, it is determined that Lerner defendants have failed to establish prima facie entitlement to summary judgment dismissing complaint as asserted against them.

Accordingly, motion (002) is denied.

MOTION (003)

In motion (003), defendant Medical Arts Radiology Group P.C. seeks summary judgment dismissing the complaint asserted against it on the bases that its only treatment of the decedent was Dr. Goodman's interpretation of an MRI of the decedent's cervical spine on July 24, 2007 which revealed degenerative disc disease of the cervical spine and no suspicious masses, and that the technique used by Medical Arts for the MRI was consistent with good and accepted medical practice.

It is noted that the cervical MRI report dated July 24, 2007 set forth that due to the patient's severe claustrophobia and difficulty breathing, he was placed in the decubitus position which caused significant degradation in image detail. He was administered Ativan 2 mg, intravenously. The cervical MRI report dated August 21, 2007, taken at Comprehensive MRI of New York, P.C., indicated at the extension positional imaging, there was increasing posterior disc herniation and development of acquired central stenosis at C3-4, C4-5 and C5-6.

The affirmation of Karen S. Black, M.D. has been submitted in support of motion (003). Dr. Black affirmed that she is a physician licensed to practice medicine in New York State and is board certified in radiology with added qualifications in neuroradiology. She set forth her current employment and prior position. While she stated she reviewed the relevant medical records, she does not identify which records were reviewed and upon which she bases her opinion. She set forth that she reviewed the cervical spine x-ray of July 20, 2007 which revealed no evidence of metastic squamous cell carcinoma or suspicious masses or abnormalities except for those of degenerative changes.

Dr. Black stated that she reviewed the Medical Arts Radiology cervical MRI of July 24, 2007 which revealed no evidence of metastic squamous cell carcinoma, abnormalities except for degenerative changes, or suspicious masses in particular in the C2-3 region. She noted that decedent had claustrophobia and breathing difficulties which required that he be placed in the decubitus position which limited the study but still provided diagnostic information. She stated that a supine position is ideal with close proximity to the coils, however, a patient can not be forced into a particular position if he or she is uncomfortable or has difficulty breathing. She stated that the use of contrast for an MRI is contraindicated for a patient suffering from chronic kidney disease, which the decedent had. Dr. Black continued that without orders from the referring physician, it was appropriate to conduct the study in the decubitus position. She stated that it is incumbent upon the clinician to follow up if a study is limited. Sedation is not customary when first attempting to perform an MRI, and it is preferred to avoid the use of anesthesia, unless there is a failed attempt at an MRI. She continued that a patient cannot just be placed under sedation once an effort to conduct the MRI fails as the patient must be cleared medically. Medical Arts Radiology only performed one study on the decedent, and was therefore not in a position to employ different techniques at a later date.

Dr. Black reviewed the cervical spine Comprehensive MRI of August 16 and 17, 2007, performed in a neutral/sitting technique, and stated that there was no evidence of metastatic squamous cell carcinoma abnormalities except for degenerative changes or suspicious masses of the cervical spine, in particular at the C2-3 location. In reviewing the July 24, 2007, and the August 2007 MRIs in tandem, there is no evidence of metastatic squamous cell carcinoma.

Dr. Black concluded within a reasonable degree of medical certainty that Medical Arts Radiology did not deviate from the standard of care and medical practice and employed appropriate techniques, protocols, methods, diagnosis, and care and treatment. She stated that Dr. Goodman's impression of the July 24, 2007 MRI of the cervical spine was accurate in that there was no evidence of metastatic squamous cell carcinoma. Because to the decedent's history, an MRI with contrast was contraindicated, and an MRI without contrast was consistent with good and accepted medical practice. When reviewing the July 2007 and the August 2007 MRIs of decedent's cervical spine, a complete view of the decedent's cervical spine at the C2-3 level can be viewed, with no evidence demonstrating metastatic squamous cell carcinoma, abnormalities except degenerative changes, or suspicious masses in decedent's cervical spine, in particular at C2-3.

Based upon the foregoing, defendant Medical Arts Radiology P.C. has demonstrated prima facie entitlement to summary judgment dismissing the complaint asserted against it. The plaintiff has submitted not opposition to this motion.

Accordingly, motion (003) is granted and the complaint and any cross claims asserted against Medical Arts Radiology P.C. are dismissed with prejudice.

MOTION (004)

In motion (004), defendant Robert M. Galler, D.O. seeks summary judgment dismissing the complaint as asserted against him on the bases that he did not depart from good and accepted standards of medical care and treatment of the decedent and that he did not proximately cause the injuries and death of decedent as alleged.

The affirmation of Stephen Burstein, M.D. has been submitted in support of Dr. Galler's application. Dr. Burstein affirms that he is licensed to practice medicine in New York and is board certified in neurological surgery. However, he has not set forth his education and training or his work experience upon which he bases his opinions to qualify as an expert, and has not provided a copy of his curriculum vitae. It is Dr. Burstein's opinion within a reasonable degree of medical certainty that Dr. Galler acted appropriately and did not depart from the standard of care and treatment of the decedent, and did not proximately cause injury or death of the decedent.

Dr. Burstein set forth a summary of the decedent's medical care and treatment. He noted that Dr. Albom, a surgeon who removed several superficial invasive posterior scalp squamous cell carcinomas and performed MOHS procedures on the decedent, contacted decedent's dermatologist, Dr. Miller, and advised and emphasized the risk of metastatic squamous cell carcinoma developing in the decedent because he was status post organ transplant. Dr. Burstein noted that the decedent had been admitted to Memorial Sloan Kettering from February 9 through 14, 2006 for neurology consult. He had a seizure with a history of aura for one year suggesting a long-standing process. A head CT scan without contrast indicated no evidence of a suspicious lytic or blastic lesion within the skull base. In February 2007, the decedent was seen by defendant Paul Lerner, M.D., a neurologist. Dr. Burstein set forth Dr. Lerner's care and treatment and the results of various diagnostic tests, as well as the decedent's changing condition.

Dr. Burstein continued that the decedent saw defendant Robert M. Galler, M.D., a neurosurgeon, on August 13, 2007, on referral from decedent's internist. He stated that Dr. Galler reviewed the cervical spine x-ray of July 20, 2007 and cervical MRI of July 24, 2007. He noted that Dr. Galler's notes indicated that the decedent presented for evaluation based on the cervical MRI, and because he could not raise his head, and that he had neck and arm pain for several weeks, worsening after a boating injury. Dr. Galler found decreased range of motion of the cervical spine flexion/extension. His assessment/plan was cervical spondylosis and kyphosis; continue prior medications; physical therapy; consider pain injections; surgery-anterior cervical decompression and fusion at C4-7 with failed conservative management; risks and benefits of surgery and conservative action discussed; J-collar provided; and MRI and CT of the cervical spine was ordered. Dr. Burstein noted Dr. Galler's findings on August 20, 2007, including no change in the decedent's neurological status. On September 17, 2007, Dr. Galler noted that the decedent could not maintain his head in a neutral position. An EMG revealed denervation of the cervical paraspinal muscle. Dr. Galler noted that it was not clear whether the cervical spondylosis and torticollis was due to denervation or myopathy, so he referred the decedent to the neuromuscular clinic at New York Presbyterian-Columbia, to Dr. McCormick and Dr. Kaiser, neurosurgeons.

Dr. Burstein stated that the decedent saw Dr. John Bendo, an orthopedic surgeon at NYU Hospital for Joint Diseases on September 21, 2007, on referral by Dr. Skurka. Dr. Bendo noted that while he could move the decedent's head to neutral, the decedent could not keep his neck there. Dr. Bendo's assessment/plan was cervical kyphosis/chin on chest deformity (a/k/a dropped head), of which he was unsure of the etiology. He considered prolonged steroid use as a possible cause. Dr. Bendo recommended physical therapy and discouraged surgery due to increased wound infection secondary to the use of steroids.

Dr. Burstein stated that on October 10, 2007, the decedent saw defendant neurologist Rahman Pourmand, M.D., on referral by Dr. Galler. Dr. Burstein stated that Dr. Pourmand noted that the decedent had extensor muscle weakness manifesting as head drop. His differential diagnoses were motor neuron disease, polymyositis, and myasthenia gravis. On December 6, 2007, Dr. Pourmand performed a skeletal muscle biopsy which revealed non-specific changes. On December 17, 2007, Dr. Pourmand noted that the etiology of the head drop could be isolated extensor neck myopathy and that the head drop could be due to Cyclosporin which the decedent had been taking for many years. Dr. Burstein continued that Dr. Pourmand started the decedent on Prednisone on January 21, 2008 for isolated extensor neck myopathy, and Baclofen for muscle spasm. On February 25, 2008, Dr. Pourmand's noted the neuro exam to be unremarkable except for the extensor neck myopathy of unknown cause. He also noted that the decedent had been admitted to Stony Brook University Hospital for a cardiac abnormality and neurological workup. Dr. Burstein set forth Dr. Pourmand's care and treatment and findings for April 4, 2008 and September 9, 2008. On September 10, 2008, Dr. Pourmand noted the decedent had slurring of his speech and difficulty swallowing. He was going to test for MuSK antibodies and discuss immunoglobin therapy upon decedent's return from China.

Dr. Burstein continued that the decedent presented to his internist on October 1, 2008 for a hematoma on his chest wall, and was referred to a neurologist at Stony Brook to rule out a worsening myositis. On October 28, 2008, the decedent was seen by defendant Ajay Chitkara, M.D., an otolaryngolgist, on referral by his internist. Dr. Chitkara ordered an MRI of the decedent's neck and brain which revealed no apparent mass at the base of the skull, and no apparent acute intracranial abnormality. The MRI of the orbit, face, and neck, performed without contrast due to decedent's renal insufficiency, revealed left vocal fold immobility and left tongue weakness. On November 6, 2008, Dr. Pourmand saw the decedent, noting the new findings, and on

November 9, 2008, admitted him to Stony Brook University Hospital with a working diagnosis of carcinomatous sarcoidosis and Guillain-Barre Syndrome, due to syncope, loss of consciousness for 20 seconds, and dysphagia. A feeding tube was placed, an autoimmune work-up was done, and he was discharged with a diagnosis of cervical myopathy, rule out brain stem encephalitis. Dr. Pourmand's note of November 26, 2008 indicated no conclusive diagnosis. On December 5, 2008, the decedent had a PET/CT scan of the skull base to mid-thigh at Zwanger-Pesiri Radiology, which showed no evidence of malignancy.

Dr. Burstein stated that the decedent, upon referral from his internist, presented to neurologist Dr. Marcel Olarte at New York Presbyterian Hospital. The open MRI of December 22, 2008, ordered by Dr. Olarte, revealed thick secretions versus discrete lesion at the level of the second tracheal ring left, for which direct inspection was recommended. The neck MRI of January 27, 2009, ordered by Dr. Olarte, revealed an enhancing lesion of the left inferior capitis muscle with extension into left C2 and 3 pedicles, tumor extending into spinal canal C1 and 2 to the left sternomastoid foramen to involve the skull base. Dr. Kaiser at New York Presbyterian Hospital, on January 31, 2009, saw the decedent, and indicated the decedent presented with metastatic cervical spine disease. Dr. Kaiser advised the decedent that the tumor was unresectable and that surgery was not an appropriate option. The February 10, 2009 CT-guided needle core biopsy performed by Dr. Orlate revealed invasive squamous cell carcinoma involving the fibromuscular tissue.

Dr. Burstein continued that Dr. Lisa DeAngelis, a neuro-oncologist at Memorial Sloan Kettering, upon referral from Dr. Orlate, saw the decedent and indicated that the decedent presented with a new skull-based squamous cell carcinoma which may be related to his multiple cutaneous squamous cell carcinomas, and that the lesion visible on the MRI accounted for his cranial neuropathies, but did not account for the prominent proximal arm weakness and wasting. Concerned that the decedent had neurocarcinomatosis with infiltration that tracked along the brachial plexus, explaining his profound weakness, she referred the decedent to head and neck medical oncologist, Dr. Matthew Fury, who saw the decedent on February 25, 2009 at Memorial Sloan Kettering. Dr. Fury could not exclude the possibility of a metastatic dermal squamous cell carcinoma and discussed non-surgical and radiation therapy with the decedent. Both therapies were completed by May 2009. However, Mr. DeTolla died on July 26, 2009.

Dr. Burstein opined that defendant Robert Galler, M.D. timely and appropriately diagnosed the decedent with torticollis, kyphosis, and cervical spondylosis upon presentation in August and September 2007; appropriately noted his prior history; appropriately performed physical examinations on the decedent; and appropriately recommended a three-tiered approach to the decedent's treatment plan-physical therapy, interventional pain management, and surgery if conservative management failed; appropriately discussed conservative treatment with the decedent as well as the risks and benefits of both conservative treatment and surgical treatment; appropriately ordered the J-collar, open MRI; reviewed the findings of the MRI and CT of the cervical spine; and he appropriately and timely referred the decedent to the neuromuscular and neurosurgical specialists at New York Presbyterian Hospital, provided him with contact information for the physicians; and indicated that the decedent keep in touch during the work-up.

Dr. Burstein continued that it is his opinion that the decedent's neck deformity was not related to his eventual squamous cell brain stem carcinoma as the decedent presented with the flexion deformity after a jerking injury to his neck. He continued that the decedent did not present with any symptoms or complaints consistent with cranial nerve involvement while under Dr. Galler's care. He stated that there was nothing in the decedent's history or medical records that indicated a brain stem abnormality until the decedent developed

difficulty swallowing and hoarseness in November 2008. Dr. Burstein also stated that the decedent was under the care of multiple physicians whose physical examinations, progress notes, and imaging interpretations revealed cervical spondylosis, torticollis, and kyphosis, for which Dr. Galler appropriately and timely referred the decedent to neurologist, Dr. Pourmand, at Stony Brook University Hospital. Dr. Burstein opined that the decedent did not have a brain stem tumor in 2007 and that the eventual squamous cell brain stem tumor did not present until the decedent was seen at New York Presbyterian Hospital in 2009. Dr. Burstein stated that he reviewed the decedent's imaging studies conducted in the area of the decedent's head and neck in February 2006 through January 2008, and he did not see any obvious lesion at the decedent's brain stem, nor did any of the radiologists see a lesion. Dr. Burstein opined that the decedent did not present with any cranial nerve involvement until around November 2008. He continued that the use of any contrast material was contraindicated because of the decedent's decreased perfusion and function at 50% at both kidneys. Dr. Burstein stated that the decedent had been followed for many years by several physicians at Memorial Sloan Kettering Cancer Center for rectal and renal cancer, and several dermatologists for treatment of basal and squamous cell carcinomas, who were concerned about metastasis of the squamous cell carcinoma. Dr. Burstein concluded that the care and treatment provided by Dr. Galler did not proximately cause the decedent's injuries or death.

As set forth above, summary judgment is precluded by the conflicting medical expert opinions concerning when the plaintiff's decedent developed the brain stem tumor, as defendants' experts, Dr. Burstein, Dr. Phillips, and Dr. Grewal, have presented conflicting expert opinions which preclude summary judgment. Dr. Burstein opined that the decedent did not have a brain stem tumor in 2007. Dr. Phillips opined that as far back as 2006 there was considerable neurological involvement by an infiltrative squamous cell malignancy in the area of C2. Dr. Grewal opined that the imaging studies conducted in the area of his head from February 2006 through January 2008 were negative for potential cancer or lesions, and the decedent did not have a brain stem tumor at that time. Due to the conflicting expert opinions set forth by defendants Lerner, Pourmand, and Galler's expert physicians, the factual issues preclude summary judgment for being granted on motions (002), (004) and (005).

Based upon the foregoing, defendant Robert Galler, M.D. has not established prima facie entitlement to summary judgment dismissing the complaint as asserted against him.

Accordingly, motion (004) is denied.

MOTION (005)

In motion (005), defendant Rahman Pourmand, M.D. seeks summary judgment dismissing the complaint as asserted against him on the bases that he did not depart from good and accepted medical practice and that he did not proximately cause the injuries and death of the decedent. Dr. Pourmand has submitted the affirmation of his expert, Jai Grewal, M.D.

Defendant Pourmand submitted the unsigned and uncertified transcript of his examination before trial, which is considered (***Ashif v Won Ok Lee,*** 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]), wherein he set forth his education and training, and testified that he was a neurologist at Stony Brook University Hospital as a faculty practice member. Dr. Pourmand testified that Neill DeTolla came under his care on October 31,

2007 on referral from Dr. Galler, who advised him the decedent had neck issues and that "he no can do anything neurosurgery." Galler provided him with a copy of the MRI of the decedent's cervical spine. He stated that the decedent presented to him with head drop. He was aware that the decedent had electrodiagnostic studies consisting of an EMG and NCV performed by Dr. Kessler in August 2007, which showed evidence of nerve impingement at C5 on the left. He stated that it ruled out neuropathy and nerve diseases, but added that some neuropathy can cause head drop presentation. He stated that bilateral ongoing denervation in cervical paraspinal muscles can be consistent with disc impingement, or isolated extensor neck myopathy, or ALS. Pourmand testified that Dr. Kessler's testing ruled out Lou Gehrig's disease or ALS, myasthenia gravis, neuropathy, and muscular dystrophy. His own impression was that of isolated extensor neck myopathy which is idiopathic in origin, or can be caused by autoimmune disease. His differential diagnoses were polymyositis, inclusion body myositis, myasthenia gravis, and CIDP (chronic inflammatory demyelinating polyneuropathy). He included myasthenia gravis in the differential diagnosis as there is a form called MuSK antibody that can cause neck muscle issues, and it needed to be ruled out. He considered no other diagnoses.

Pourmand testified that at the first visit, the decedent also complained of numbness on the left side of his face and left shoulder, but he had no problems swallowing, chewing, and he had no diplopia, ptosis, or generalized weakness. He did, however, report weakness of his left arm. Decedent's history of cancer had no significance to him. Upon examination, Pourmand found isolated weakness to the extensor neck muscles, and indicated that left arm weakness could be consistent with isolated neck extensor myopathy, however, he felt that the left arm weakness was explained by Dr. Kessler's EMG which revealed C5 radiculopathy as the C5-6 nerve innervates the shoulder and the radial nerve distribution. He testified that because the decedent complained of occasional numbness to the left side of the face and shoulder, but showed no sensory and neural deficits, this did not have any significance, but it would have been significant if it were persistent. He did find some atrophy of the decedent's left shoulder, deltoid, and biceps muscles. He did not recall if the decedent informed him that this left sided facial and shoulder weakness persisted since 2006. He did not know how long the decedent experienced these complaints and did not make a notation in his record. He remembered the decedent as "the nicest gentleman I've ever seen." At that October 31, 2007 visit, he wanted a repeat EMG and a muscle biopsy.

Pourmand continued that the muscle biopsies from his left upper and lower extremities, by report dated December 14, 2007, ruled out inclusive body myositis, polymyositis like ALS, muscular dystrophy, and motor neuron disease, so his impression was that there was an idiopathic form of isolated extensor neck myopathy. An addendum for the immunopathology was negative for autoimmune disease or polymyositis. The repeat EMG and NCV testing on December 13, 2007, was consistent with isolated cervical myopathy and idiopathic isolated extensor neck myopathy. Pourmand saw the decedent again on December 17, 2007, and noted that the decedent had been treated with Cyclosporin for many years. He testified that there was an isolated study or report which indicated that Cyclosporin could cause head drop. His examination of the decedent revealed no changes. While he considered doing an extensor muscle biopsy, he stated it could be complicated and cause pain, and the EMG report convinced him that this is what he was dealing with. Prednisone, he stated, would be the treatment with or without the biopsy. If the patient doesn't respond to the Prednisone, it is stopped.

Prednisone was started on January 21, 2008, Pourmand testified. There was no change in the decedent upon neurological examination, he stated, however, he ordered Baclofen for muscle spasms, although he had

no recollection where the muscle spasms were. He had no plan for the decedent on that date. Physical therapy was prescribed. Sometime between January 21 and February 25, 2008, he referred the decedent to Stony Brook Hospital due to dizziness or lightheadedness. He saw the decedent on February 25, 2008 and noted he had cardiac complaints. He did not know what kind of neurological work up was done during the admission to Stony Brook, but believed it was not for the isolated neck extensor myopathy. He stated that the decedent had improvement in the isolated neck extensor myopathy as he could lift his head up further. On April 28, 2008, his note indicated that the decedent's Prednisone had been tapered to 5 mg. as the decedent had not responded dramatically and there were side effects. On that date, he had no expectation of the decedent's isolated neck extensor myopathy ever improving. He considered no other causes for the condition. While the decedent had a history of being placed on Cyclosporin, an immunosuppressive drug, he considered that it could cause less inflammation of the cells, but he ruled out the other diseases in his differential with the testing, and did not see a progression. Pourmand testified that the decedent's condition was stable from October 2007 through September 2008.

Defendant Pourmand saw the decedent again on September 10, 2008, and noted no change. On October 7, 2008, the decedent complained that he had slurring of his speech and difficulty swallowing, which Pourmand considered to be neurological changes. Upon examination, however, he saw no significant changes, but, he did note slurring of the decedent's speech and saw that he had difficulty swallowing, which made him consider the MuSK variant of myasthenia gravis again, and administration of IVIG (immunoglobulin) intravenously. The blood tests for MuSK antibody came back negative. He referred the decedent to an ENT due to the difficulty he was experiencing with swallowing, but recalled no conversation with the ENT consultant. He was provided with copies of the MRI of the brain without contrast which was performed on November 3, 2008, and noted no abnormalities. He had no recollection of speaking with Dr. Chitkara on November 6, 2008. On November 6, 2008, he wanted to admit the decedent to the hospital due to vocal cord paralysis, but the decedent deferred for three days and was hospitalized from November 9 through 15, 2008 at Stony Brook. He noted a new finding, deviation of the decedent's tongue to the left side, indicative of a hypoglossal nerve problem involving cranial nerve 12. He considered carcinomatous meningitis, sarcoidosis, and Guillain-Barre Syndrome in his differential. Although he was the admitting doctor, he was not the attending doctor during this admission. He stated that the decedent underwent spinal fluid examination which was negative for cancer cells. Blood work for MuSK antibodies and neoplastic profile was drawn, and a PET scan was ordered when he saw the decedent on November 26, 2008. Those tests were all negative. He did not see or treat the plaintiff's decedent after November 26, 2008.

Jai Grewal. M.D. affirmed that he/she is licensed to practice medicine in New York State and is board certified in neurology and neurological oncology. Dr. Grewal does not set forth his education and training, or the past or current work experience to qualify as a witness in this matter. He set forth the materials and records reviewed in support of his opinions. It is Dr. Grewal's opinion within a reasonable degree of medical certainty, that defendant Dr. Pourmand acted appropriately and did not depart from the accepted standards of medical practice in his care and treatment of the decedent and that his care and treatment did not proximately cause the decedent's injuries or death.

Dr. Grewal set forth the decedent's history which is identical through paragraph 65 to the affirmation of Dr. Burstein, so Dr. Grewal's statements relating to the decedent's history, diagnostic testing, findings, and treatment will not be set forth again. At paragraph 66, Dr. Grewal opined that Dr. Pourmand timely and appropirately formulated a differential diagnosis of isolated myopathy of the neck extensor muscles on

October 31, 2007 based upon the decedent's complaints, past medical history, imaging studies, clinical findings, and appropriately ruled in and ruled out multiple peripheral and neurological disorders while the decedent was under his care. Dr. Grewal opined that on October 31, 2007, the defendant appropriately performed a very detailed, comprehensive neurological examination that correctly noted no neurological findings to indicate that the decedent was suffering from a central neurological disorder. However, he noted that the decedent's history of occasional numbness of the left side of his face and shoulder was not a significant finding because it was occasional and was not demonstrated during the course of his physical examination. Dr. Grewal did not opine whether or not this history was insignificant.

Dr. Grewal opined that in reviewing the decedent's past medical history, Pourmand's impression on October 31, 2007 appropriately indicated that the decedent appeared to have an isolated extensor muscle weakness/isolated extensor neck myopathy, and appropriately included in his differential diagnosis: motor neuron disease, polymyosotis, inclusion body myositis, myasthenia gravis, or CIDP (chronic inflammatory demyelinating polyneuropathy, then appropriately set forth an appropriate plan to repeat an EMG, obtain a muscle biopsy, and follow up. The muscle biopsy was obtained during the December 6, 2007 admission to Stony Brook University Hospital and revealed non-specific changes. The EMG nerve conduction study, on December 13, 2007, to rule out motor neuron disease, myopathy, and neuropathy, indicated an abnormal study due to the presence of a diffuse axonal neuropathy and isolated cervical myopathy with no evidence of neuromuscular junction disorder. Dr. Grewal did not address the significance of this abnormal study and whether or not the standard of care provided for follow-up testing or studies. On December 17, 2007, Dr. Pourmand noted that the neurological examination was significant for weakness of the extensor neck muscles, with a plan for biopsy of those muscles, and administration of Prednisone.

Dr. Grewal noted that the decedent returned to see Dr. Pourmand on January 21, 2008, and Prednisone was started. Exam revealed weakness of the extensor muscles of the neck. Dr. Pourmand admitted the decedent to Stony Brook University Hospital on January 25 through 31, 2008 for episodes of losing time over the prior 2 to 3 days, loss of concentration for 2 to 3 hours at a time, and falling asleep for seconds at a time. He was found to have atrial fibrillation. Cranial nerves were intact. Neurology was consulted for amnesia. CT scan of the head without contrast on January 25, 2008 revealed no acute intracranial pathology. The decedent's amnesia resolved by discharge date. On February 25, 2008, Dr. Pourmand saw the decedent, but still did not know the etiology of the decedent's condition, as weakness of the extensor neck muscles persisted. He was kept on Prednisone, and physical therapy was prescribed. Dr. Grewal stated that the decedent continued to follow up with Dr. Pourmand every few months for isolated extensor neck myopathy without significant improvement, even with Prednisone, which was then discontinued. Physical therapy was to be continued and the decedent was instructed to follow up with Dr. Pourmand in six months.

Dr. Grewal noted the decedent's referral by his internist to Dr. Chitkara, an otolaryngologist, for slurred speech and difficulty swallowing whom he saw on October 7 and 28, 2008. MRIs of the neck and brain were ordered and reviewed by Dr. Chitkara, who called Dr. Pourmand on November 6, 2008, to discuss the findings of acute lingual paresis, and increased dysphagia, as the decedent was to see defendant Pourmand the following day. Dr. Pourmand's notes indicated the decedent was seen for worsening of his condition. There was a new finding that his tongue was deviating to the left side, indicating a hypoglossal nerve problems and multiple cranial neuropathies. Dr. Grewel stated that this new complaint was the first indication of a central neurological problem. Dr. Grewel opined that Dr. Pourmand appropriately formulated a differential diagnosis of possible carcinomatous meningitis, sarcoidosis, or Gullain-Barre Syndrome, and

timely and appropriately admitted the decedent to Stony Brook University Hospital for further workup to rule out infectious etiology and paraneoplastic process. After testing was performed and a PEG feeding tube was inserted, the decedent was discharged with a diagnosis of possible paraneoplastic process, follow up, and PET scan to rule out occult malignancy. Although the CT scan of the neck showed degenerative changes, no mass was noted. The final diagnosis was cervical myopathy, rule out brain stem encephalitis. Dr. Grewal opined that on November 26, 2008, Dr. Pourmand appropriately indicated a progressive neurological problem which could be paraneoplastic, for which he appropriately ordered the PET, which revealed no evidence of malignancy. Dr. Grewal indicated that the decedent thereafter treated with various health care providers in New York City.

Dr. Grewal opined that the decedent's head drop was not related to his squamous cell brain stem tumor as he did not present to Dr. Pourmand with complaints or symptoms consistent with cranial nerve involvement until about one year later in October 2008 when he presented with slurred speech, followed with physical findings of tongue deviation, at which time Dr. Pourmand appropriately started a workup for central neurological disorder including admission to Stony Brook and ordered a PET Scan. Dr. Grewal opined that the tumor affected only the left side of the decedent's spinal column, and that the decedent's head drop, profound in 2007,was not caused by this cancer. The MRI findings at New York Presbyterian on January 27, 2009 were consistent with his recent history of cranial nerve 9, 10, and 11 palsy. Dr. Grewal further stated that prior to seeing Dr. Pourmand, the decedent treated with multiple physicians whose physical examinations and progress notes indicated diffuse weakness, not left sided weakness, although Dr. Grewal does not identify those physicians or when the decedent was seen. It is noted, however, that Dr. Pourmand testified that the decedent presented with weakness in his left arm, which Dr. Pourmand attributed to radiculopathy at the C5-6 level, raising factual issues concerning Dr. Grewal's opinion.

Dr. Grewal continued that when the decedent's cranial nerve involvement presented around October 2008, his downhill course was extremely rapid. Dr. Grewal opined that had the decedent been symptomatic of this tumor in 2007, his demise would have occurred long before July 2009. Dr. Grewal stated that he reviewed the imaging studies conducted in the area of the decedent's head from February 2006 through January 2008, and those studies were negative for potential cancer or lesions, and that the decedent did not have a brain stem tumor. He further opined that the CT scan on August 16, 2007 was of good quality, and if a tumor had been present at that time, it would have been picked up on that imaging. Dr. Grewal continued that the tumor showed significant growth after it first presented on the January 27, 2009 neck MRI done at New York Presbyterian Hospital as a lyric lesion. The CT guided needle core biopsy, done on February 10, 2009, revealed invasive squamous cell carcinoma involving fibromuscular tissue at C2. Dr. Grewal opined that Dr. Pourmand did not deviate from the standard of care because the decedent did not present with any symptoms or complaints consistent with cranial nerve involvement until October 2008, and therefore no additional imaging during the period prior to that was necessary while under Dr. Pourmand's care.

Dr. Grewal further opined that no imaging with contrast was warranted prior to December 2009, when the decedent began to present with neurological signs and symptoms of a brain stem disorder at New York Presbyterian Hospital, in light of the fact that decedent's history of significant kidney disease, as the contrast could cause kidney failure and death. He continued that it was entirely reasonable for Dr. Pourmand not to order a lumbar puncture prior to November 2008 as it is not indicated until it is fairly obvious that the patient had a central neurological problem, which was not presenting prior to November 2008. A lumbar puncture, he stated, would not necessarily have been diagnostic for cancer, especially in its early stages, as squamous

cell carcinoma cells can travel along the nerve. The nerve can then shed tumor cells into the spinal fluid, but there must be a significant number of these cells in the spinal fluid to be diagnostic, and this would occur as a late finding. Once tumor cells are in the spinal fluid, the patient's condition would be terminal and incurable. Tumor markers would not have been diagnostic in a tumor like the decedent had. Because the decedent's imaging studies were negative, tumor marker studies would not have been indicated.

Dr. Grewal opined that the patient's eventual tumor was metastatic and likely originated from a squamous cell carcinoma lesion at the patient's head or neck. Once the squamous cell carcinoma metastasized to the area of the patient's neck, it was stage IV cancer that would carry a very poor prognosis under any circumstances. He further opined that the decedent developed a rare, but deadly complication of immunosuppressant therapy. Organ transplant recipients are at an increased risk for cutaneous squamous cell carcinoma, a risk that is potentiated by the use of immunosuppressive medications to prevent organ rejection. The decedent had been monitored for many years by his treating dermatologist. The decedent's immunosuppressant therapy with Cyclosporin was being managed by his cardiac transplant physicians.

As set forth above, summary judgment is precluded by the conflicting medical expert opinions concerning when the plaintiff's decedent developed the brain stem tumor, as defendants' experts, Dr. Burstein, Dr. Phillips, and Dr. Grewal, have presented conflicting expert opinions which preclude summary judgment. Due to the conflicting expert opinions set forth by defendants Lerner, Pourmand, and Galler's expert physicians, the factual issues preclude summary judgment from being granted on motions (002), (004) and (005). Based upon the foregoing, defendant Rahman Pourmand, M.D. has not established prima facie entitlement to summary judgment dismissing the complaint as asserted against him.

Accordingly, motion (005) is denied.

Dated: February 28, 2014

Hon. Joseph Farneti
Acting Justice Supreme Court

_____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**