

Leigh v Kyle

2014 NY Slip Op 32342(U)

September 3, 2014

Supreme Court, Suffolk County

Docket Number: 06-30268

Judge: Jr., Andrew G. Tarantino

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ORIGINAL
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SHORT FORM ORDER

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INDEX NO. 06-30268
CAL No. 12-01576MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 50 - SUFFOLK COUNTY

PRESENT:

Hon. ANDREW TARANTINO
Acting Justice of the Supreme Court

MOTION DATE 4-11-14 (#007)
ADJ. DATE 5-8-14 (#008)
Mot. Seq. # 007 - MG
008 - MD

MELINDA YOLANDA LEIGH, a/k/a MELINDA
LEIGH and CHRISTOPHER LEIGH,

Plaintiffs,

- against -

ANNMARIE KYLE, MD, ADRIAN POPP, MD,
ANDRES GONZALEZ, MD, WILLIAM
SPENCER, MD, BARRY SCHUVAL, DO,
GEORGE SCHMITZ, MD, BARRY
MORGENSTERN, MD, ROBERT GOODMAN,
MD, JOANNE M. KECHEJIAN, MD, ROBERT
G. COURGI, MD, ALAN MECHANIC, MD,
HUNTINGTON HOSPITAL a/k/a NORTH
SHORE LIJ HUNTINGTON HOSPITAL,
HUNTINGTON MEDICAL GROUP, PC,
NORTH SHORE MEDICAL GROUP a/k/a
NORTH SHORE MEDICAL GROUP OF THE
MOUNT SINAI SCHOOL OF MEDICINE,
LONG ISLAND INFECTIOUS DISEASE
ASSOCIATES, CENTER FOR DIABETES AND
ENDOCRINOLOGY, MEDICAL ARTS
RADIOLOGY a/k/a HUNTINGTON MRI and
LONG ISLAND NEUROSURGICAL
ASSOCIATES, PC,

Defendants.

PEGALIS & ERICKSON, LLC
Attorney for Plaintiffs
One Hollow Lane, Suite 107
Lake Success, New York 11042

SHAUB, AHMUTY, CITRIN & SPRATT, LLP
Attorney for Defendants Kyle, M.D., Schmitz,
M.D., Kechejian, M.D., & North Shore Medical
Group
1983 Marcus Avenue
Lake Success, New York 11042

MULHOLLAND, MINION, DUFFY DAVEY,
MCNIFF & BEYRER
Attorney for Defendant Popp, M.D.
374 Hillside Avenue
Williston Park, New York 11596

SANTANGELO, BENVENUTO & SLATTERY
Attorney for Defendant Spencer, M.D.
1800 Northern Boulevard
Roslyn, New York 11576

KRAL, CLERKIN, REDMOND, RYAN, PERRY
& VAN ETTEN, LLP
Attorney for Defendant Schuval, DO
538 Broadhollow Road, Suite 200
Melville, New York 11747

Upon the following papers numbered 1 to 46 read on these motions to renew and reargue; Notice of Motion/ Order to Show Cause and supporting papers (007)1 - 29; Notice of Cross Motion and supporting papers (008)30-39; Answering Affidavits and supporting papers 40-42; Replying Affidavits and supporting papers 43-44; 45-46; Other ; (~~and after hearing counsel in support and opposed to the motion~~) it is,

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ORDERED that motion (007) by defendants, Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology a/k/a Huntington MRI, pursuant to CPLR 2221(d) for leave to reargue motion (006) for summary judgment dismissing the complaint, which motion was denied as untimely by order dated February 28, 2014, is granted as to reargument, and upon reargument, motion (007) is granted and the complaint as asserted against Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology a/k/a Huntington MRI is dismissed; and it is further

ORDERED that motion (008) by plaintiffs pursuant to CPLR 2221 (d) and (e) for leave to renew and reargue their opposition to motion (004) by defendants Alan Mechanic, M.D. and Long Island Neurosurgical Associates, PC for summary judgment dismissing the complaint as asserted against them, which motion was granted by order dated February 28, 2014, is denied as to renewal and reargument.

In this medical malpractice action, causes of action for negligence and lack of informed consent have been pleaded by plaintiff, Melinda Yolanda Leigh, a then 40 year old female. A derivative cause of action has been asserted on behalf of Christopher Leigh, plaintiff's spouse. Melinda Yolanda Leigh had surgery at Mount Sinai Medical Center by Dr. Kalmon Post, on January 6, 2003, for transphenoidal drainage and excision of a Rathke's Cleft cyst. On July 17, 2003, the plaintiff returned for surgery at Mount Sinai Medical Center where Dr. Kalmon Post performed transnasal-transphenoidal drainage of a recurrent Rathke's Cleft cyst. Cultures were taken. Thereafter, the plaintiff came under the care of Dr. Edward Laws at the University of Virginia Medical Center, and on May 10, 2004, underwent a gross total resection of the Rathke's Cyst, also with a transphenoidal approach. She received a fat graft wherein fat was packed into her sinuses. On June 3, 2004, she presented to Huntington Hospital with headaches, fatigue, and weakness, and was admitted by defendant Dr. Annmarie Kyle and released on June 11, 2004, only to be readmitted on June 24, 2004 for a thrombotic stroke. She was then flown to the University of Virginia on June 26, 2004, where she was admitted until July 13, 2004. The plaintiff alleges that the defendants negligently departed from good and accepted standards of medical care and treatment in failing to timely diagnose and treat her for a cavernous sinus thrombosis, left internal carotid thrombosis, left middle cerebral artery thrombosis, and in failing to prevent a stroke, failing to diagnose and treat diabetes insipidus, failing to obtain fat graft cultures, failing to diagnose infection and fungal infection in a differential diagnosis, failing to take proper testing and studies, and failing to call proper consults, inter alia, and in misdiagnosing her medical condition. The plaintiff alleges that due to the defendants' negligent departures from the standard of care, she was left with multiple deficits, including impaired speech, mental, and physical functioning, and right hemiparesis.

CPLR 2221 (d) (2) provides that a motion for leave to reargue shall be based upon matters of fact or law allegedly overlooked or misapprehended by the court in determining the prior motion but shall not include any matters of fact not offered on the prior motion (*see Bolos v Staten Island Hosp.*, 217 AD2d 643, 629 NYS2d 809 [2d Dept 1995]). A motion to reargue is not to be used as a means by which an unsuccessful party is permitted to argue again the same issues previously decided (*Pahl Equipment Corp. v Kassis*, 182 AD2d 22, 588 NYS2d 8 [1st Dept 1984]). Nor does it provide an unsuccessful party with a second opportunity to present new or different arguments from those originally asserted (*Giovanniello v Carolona Wholesale Office Machine Co., Inc.*, 29 AD3d 737, 815 NYS2d 248 [2d Dept 2006]).

Pursuant to CPLR 2221(e)(2), a motion for leave to renew shall be based upon new facts not offered on the prior motion that would have changed the prior determination or shall demonstrate that there has been a change in the law that would change the prior determination. Pursuant to CPLR 2221 (e) (3), a motion for leave to renew shall contain reasonable justification for the failure to present such facts on the prior motion. "A motion for renewal is properly made to the motion court...to draw its attention to material facts which, although extant at the time of the original motion, were not then known to the party seeking renewal and, consequently, were not placed before the court. Renewal is granted sparingly, and only in cases where there exists a valid excuse for failing to submit the additional facts on the original application; it is not a second chance freely given to parties who have not exercised due diligence in making their first factual presentation," (*Beiny v Trustees of the Trust Created by Elizabeth N.F. Weinberg, as Grantor*, 132 AD2d 190, 522 NYS2d 511 [1st Dept 1987]).

In motion (008), plaintiffs seek to renew and reargue motion (004) by defendants Alan Mechanic, M.D. and Long Island Neurosurgical Associates, PC, wherein summary judgment was granted to defendants Alan Mechanic, M.D. and Long Island Neurosurgical Associates, PC. However, plaintiffs have not demonstrated a basis for renewal or reargument. The redacted expert affirmations submitted by the plaintiffs, without submitting unredacted copies to the court, were nonetheless considered by this court in reaching its decision.¹ No facts or law misapprehended by this court have been demonstrated. There was no change in the law or new facts previously unavailable for this court to now consider. The plaintiffs have demonstrated no basis for this court to grant either renewal or reargument of motion (004).

Accordingly, motion (008) by plaintiffs for leave to renew or reargue their opposition to motion (004), wherein summary judgment was granted to defendants Alan Mechanic, M.D. and Long Island Neurosurgical Associates, PC., is denied.

In motion (007), defendants Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology a/k/a Huntington MRI seek to reargue their prior motion (006) which was denied as untimely. Here, the moving defendants demonstrated that a stipulation dated May 30, 2013 extended the time in which Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology were permitted to serve a motion for summary judgment, and said motion was therefore timely submitted.

Accordingly, motion (007) for reargument of motion (006) is granted and the motion for summary judgment as to Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology is now considered.

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 (*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

¹Plaintiffs' counsel is referred to *Marano v Mercy Hospital*, 241 AD2d 48, 670 NYS2d 570 [2nd Dept 1998].

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 motion (007), defendants Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology a/k/a Huntington MRI have submitted copies of the prior motion papers, including opposition papers and replies. In their opposing papers, plaintiffs do not oppose the submission of uncertified medical records and unsigned deposition transcripts and make reference to the same.

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 Derdiarian 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 defendants, 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 defendants’ 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]).

Robert Goodman, M.D. testified to the extent that he is licensed to practice medicine in New York State and is board certified in diagnostic radiology. He was a member of Medical Arts Radiology,

a professional radiology group, and in 2004, he was also a staff radiologist at Huntington Hospital. He interpreted the imaging studies and issued a report for the contrast enhanced brain MRI, MRV of the intercranial veins, and an MRA of the intracranial circulation studies, ordered by Dr. Andres Gonzalez and performed on the plaintiff on June 8, 2004. Dr. Goodman testified that he found no pathology on the MRA study. He recommended clinical correlation of his findings with the clinical history because he had concerns about the pituitary, and because the study did not demonstrate the typical appearance of an empty sella turcia (bony region that contains the soft tissue of the pituitary gland within it-also known as the pituitary fossa). He testified that it was not his role as a radiologist to come up with a differential diagnosis or the cause of the inflammation within the sphenoid sinus.

In support of the motion for summary judgment submitted on behalf of Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology a/k/a Huntington MRI, the supporting affirmation of Scott J. Sherman, M.D., has been submitted. Dr. Sherman affirms that he is a physician licensed to practice medicine in New York State and is board certified in radiology and nuclear medicine. He set forth his education and training and work experience. He opined within a reasonable degree of medical certainty that the care and treatment provided by defendants Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology was in keeping with good and accepted radiology practice standards, that sound radiology judgment was rendered, and nothing they did or failed to do was the proximate cause of any injuries alleged by the plaintiffs.

Dr. Sherman stated that radiology imaging modality is limited by its underlying technology. Tissue that has been altered by disease or trauma responds abnormally to the imaging and sends back an abnormal signal, however, an abnormal condition can only be detected when it is large enough or has progressed enough to be detected. In the case of a brain abscess, this abnormality cannot be detected until the tissue changes caused by inflammation have reached a critical mass to alter the structure of the infected brain tissue. It is then that imaging can detect edema, low intensity signals on axial T1-weighted MRI images, abscess, or clots in the blood vessels in the brain.

Dr. Sherman continued that the plaintiff had her pituitary gland removed and was ultimately diagnosed with presumptive meningitis, as all cultures were negative to identify the causative organisms of either bacteria or viruses. This set up the condition for the formation of blood clots. Due to decreased blood supply to the brain tissue fed by the affected artery, ischemia progresses to the death of brain tissue known as infarction. The end result is a stroke. Dr. Sherman stated that findings associated with meningitis, including edema and mass formation, are non-specific and can be associated with many other conditions. Therefore, the diagnosis of acute meningitis is not made on the basis of imaging studies, but by patient history, physical examination, and laboratory results. Lumbar puncture is the most important diagnostic study.

Dr. Sherman stated that imaging studies may demonstrate normal findings even in acute meningitis, and therefore imaging studies do not exclude or prove the presence of acute meningitis. Dr. Sherman set forth the considerations in interpreting imaging studies, and stated that the standard of care requires that any given radiologist's interpretations should be evaluated in light of how the reasonable radiologist would have interpreted the films, and not through the hindsight of knowledge. Dr. Sherman stated that although CT imaging is not used to primarily evaluate for sinus disease, it can detect

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thickening of the sinus tissue or presence of fluid in the sinus cavities. Non-enhanced (without contrast) CT scans of patients with acute meningitis may be unremarkable and appear negative, but do not exclude the presence of meningitis. With regard to MRI imaging, Dr. Sherman stated it is useful in the diagnosis of stroke, neurological disorders such as multiple sclerosis, and the connectivity of the white matter axons in the central nervous system. There can be a normal study which does not rule out meningitis. He continued that magnetic resonance angiography (MRA) can suggest the presence of thrombus/embolus or vascular disease. If spasm and/or occlusion are not present at the time an MRA is performed, these conditions will not be detected. However, a normal MRA does not rule out meningitis.

Dr. Sherman stated that on June 4, 2002, the plaintiff was seen at Huntington Hospital for a five day history of headaches, fatigue and weakness, and was admitted by Dr. Kyle. A noncontrast head CT was ordered by the emergency room physician, Dr. Moskowitz, and was performed on June 4, 2004 and interpreted by Dr. Barry Morganstein. Dr. Sherman stated that Dr. Morganstein reviewed the plaintiff's history and compared the CT study to a previous CT study done on September 12, 2003. Clinical correlation was then suggested. Thereafter, Dr. Gonzalez performed a lumbar puncture.

On June 5, 2004, Dr. Mechanic recommended MRI, MRA and MRV studies which were done on June 8, 2004, and interpreted by Dr. Robert Goodman. On the June 8, 2004 MRI, Dr. Goodman noted inflammatory changes were identified within the sphenoid air cells, bilaterally, ventricles were not enlarged or displaced, and there was no evidence of acute infarct or cytotoxic edema. Normal appearing pituitary tissue was not identified and Dr. Goodman questioned whether the patient had a transsphenoid hypophysectomy. Clinical correlation was recommended. The MRI angiography interpreted by Dr. Goodman noted a normal anatomic variant, and a prominent posterior inferior cerebral artery with no obvious AVM. Dr. Goodman interpreted the MRV as a normal venogram.

Dr. Sherman stated that when the plaintiff presented to the hospital again on June 24, 2004, the admitting CT scan of the head indicted abnormalities including an area of swelling in the left temporal lobe that was new since June 4, 2004. On June 24, 2004, an MRI/MRA were performed and interpreted by Dr. Laucella. Dr. Sherman set forth Dr. Laucella's findings, and stated that the MRA read by Dr. Laucella was compatible with occlusion of the left middle cerebral artery, decreased blood flow in the left internal carotid artery with marked narrowing of the lumen due to inflammatory changes. There was significant enhancement in the region of the left cavernous sinus distal left internal carotid and left middle cerebral artery, most compatible with meningitis which resulted in the occlusion and vascular changes.

Dr. Sherman continued that the plaintiff was airlifted to the UVA Hospital facility on June 26, 2004 where her pituitary gland had been removed in May 2004. Her surgeon, Dr. Laws, concluded that she had basal meningitis which produced vasospasm, representing an unusual and very disappointing complication of surgery for what ordinarily is a relatively simple process. He continued, that upon reviewing plaintiff's imaging studies, he initially conducted a "cold read" solely of the imaging studies of the head CT scan of June 4, 2004, and the brain MRI/MRA/MRV of June 8, 2004, and thus he had no prior knowledge about the plaintiff's ultimate clinical outcome or her subsequent radiology findings. Upon his review, he did not observe or otherwise detect any of the radiology findings which can be associated with meningitis, including inflamed meninges, narrowed arteries, arterial spasm, edema,

infarcted brain tissue, stroke, abscess, or venous or arterial thrombosis. Dr. Sherman continued that none of the abnormalities reported or demonstrated on subsequent brain imaging studies 17 to 20 days later were present on the June 4, 2004 and June 8, 2004 imaging studies. Dr. Sherman set forth, in detail, the bases for his opinions that these imaging studies were of good quality, that they were accurately read and interpreted, and the findings and impression, with which he agreed, were properly set forth in the radiology reports by Dr. Morgenstern, who properly suggested clinical correlation of the findings which were not entirely normal. Thus, the attending physician was properly advised by Dr. Morgenstern to consider the findings in light of the patient's entire clinical picture, including history, physical, objective and subjective findings, and other diagnostic test results.

Dr. Sherman opined within a reasonable degree of medical certainty that Dr. Morgenstern's impressions were correct and accurately reflected his findings of postoperative changes, fat replacement in the pituitary fossa, and soft tissue changes in the sphenoid sinus and posterior ethmoid air cells bilaterally, and the possibility of co-existing sinusitis that should be considered clinically. No further imaging studies were indicated at that time and Dr. Morgenstern appropriately did not recommend further imaging studies. There were no radiology findings consistent with meningitis or its sequellae, including abscess formation, edema, or stroke. Dr. Sherman continued that Dr. Morgenstern did not fail to diagnose a cavernous sinus thrombosis, left internal carotid thrombosis, left middle cerebral artery thrombosis, anticipate a stroke, or fail to define the sinus process responsible for the plaintiff's symptoms.

Dr. Sherman also opined that the CT scan was not the imaging modality of choice for the evaluation of cerebral blood vessels, including cavernous sinus, internal carotid artery, or middle cerebral artery, and is not capable of generating imaging findings diagnostic of an "anticipated" stroke. CT imaging does not have the capability to define the sinus process responsible for the presenting symptoms and cannot distinguish mucous from pus. Dr. Sherman continued that the CT scan did not demonstrate intracranial infection. There was no swelling of the left medial temporal lobe, and no questionable increased attenuation in the left and mid cerebral artery.

Dr. Sherman opined that Dr. Goodman's interpretation and findings on the June 8, 2004 brain MRI were accurate, and accurately set forth in the report. He set forth the detailed bases for his opinions, including that the images were of good quality, inflammatory changes in the sphenoid air cells, and that the MRI imaging modality is not capable of detecting a bacterial or fungal infection, per se, but is capable of detecting inflammation. He continued that any number of etiologies can cause sinus inflammation, including allergy, bacteria, or virus. The MRI cannot diagnose pus. Due to the limitations of MRI technology, Dr. Goodman was unable to diagnose any more information about the abnormal finding of the inflammatory changes noted, and recommended clinical correlation. As a consulting radiologist, it was not up to Dr. Goodman to determine the clinical significance of the inflammatory changes identified in the sphenoid sinuses. There was no evidence of ventricular size abnormalities to suggest meningitis. The diffusion images failed to demonstrate evidence of acute infarct, stroke, or edema, which is highly relevant to the issue of whether the plaintiff had radiological evidence of meningitis on June 8, 2004.

When Dr. Sherman reviewed the transaxial MRI images, both middle cerebral arteries were well

demonstrated and symmetric. The middle cerebral artery was perfectly normal, which is significant because the internal carotid arteries, right and left, are adjacent to the sphenoid sinus. This was true also after contrast was used. There was symmetry of the right and left carotid arteries, and the right and left cavernous sinuses. Thus, opined Dr. Sherman, Dr. Goodman did not fail to diagnose focal narrowing of the left internal carotid artery and left middle cerebral artery as they were symmetric and there was no increase in arterial signal and no reduced signals evident either in the MRI study. No enhancing lesions were noted and there were normal parenchyma signals, highly relevant on the issue of whether the plaintiff had radiologic evidence of meningitis on June 8, 2004. Dr. Sherman continued that Dr. Goodman's interpretations were correct, including the finding that the empty sella did not have a normal appearance. He correctly recommended clinical correlation by the plaintiff's treating physicians. There was no radiologic evidence of meningitis or the plaintiff being at risk for a stroke, or new conditions found later on the MRI of June 24, 2004. The report accurately reflected and reported the findings.

Dr. Sherman continued that the MRI of June 24, 2004, demonstrated significant changes when compared to the June 8, 2004 brain MRI. He set forth the reasons why, as well as the findings which he stated were most compatible with inflammatory change. There was occlusion of the left middle cerebral artery resulting in infarction along its distribution. Dr. Sherman also reviewed the MRA of June 8, 2004, interpreted by Dr. Goodman, and found the findings and impressions were accurate and accurately set forth in his report, and set forth the bases for his opinion. There was no failure to detect a focal narrowing of the internal carotid artery as the left and right carotid arteries were symmetric in appearance and patent, with no signal abnormality. Dr. Sherman also addressed the MRV images of the brain of June 8, 2004, and opined that they were appropriately interpreted and reported, and he provided the bases for his opinion.

Dr. Sherman concluded that both Dr. Morgenstern and Dr. Goodman each exercised his best judgment in the course of their radiologic treatment of the plaintiff. He also added that the plaintiff has not set forth in the bill of particulars any identifying information concerning which images were allegedly misinterpreted. Dr. Sherman concluded that there was no treatment or alleged omission by these moving defendants which was the proximate cause of, or significant contributing factor to any of the injuries alleged by the plaintiff, and he set forth the bases for these opinions.

Based upon the foregoing, it is determined that Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology a/k/a Huntington MRI have demonstrated prima facie entitlement to summary judgment dismissing the complaint.

In opposing motion (007) the plaintiff provided this court with unredacted copies of the redacted expert affirmations² previously submitted to this court and previously considered by this court, as acknowledged by counsel for the plaintiff.

Plaintiffs submitted the unredacted affidavit of a physician licensed to practice medicine in Pennsylvania who is board certified in neurological surgery. Plaintiffs' neurosurgical expert set forth his work experience and the basis upon which to render expert testimony in this matter. He indicated that a

²These unredacted expert affidavits/affirmations have been returned to counsel for plaintiffs.

review of the plaintiff's imaging studies of her June 4, 2004 admission to Huntington Hospital suggests sinusitis, specifically an inflammation of the sphenoid sinuses. Plaintiff's neurosurgical expert set forth that plaintiff was admitted to Huntington Hospital for a thrombotic stroke on June 24, 2004. At that admission, he stated that Dr. Anne Sacks-Berg, an infectious disease specialist, dictated a consultation report in which she noted that a "CT scan of the brain without contrast compared to 6/4/04 reveals swelling and edema of the medial left temporal lobe, which is new; and a questionable area of high attenuation within the left middle cerebral artery-question spasm, question clot within the vessel." Plaintiff's neurosurgical expert continued that the plaintiff underwent an MRI study of the brain, with and without contrast, and an MRA of the brain. He stated that in the official report of the MRI, the following impression was noted, "Extensive inflammatory appearing changes involving the base of the brain about the left internal carotid artery and left middle cerebral artery. There is narrowing of the left internal artery and occlusion of the left middle cerebral artery. Findings have resulted in infarction in the left lenticular striate and middle cerebral distribution. There are probable inflammatory changes/cerebritis involving the medial aspect of the temporal lobe and the contrast enhancing changes are compatible with the clinical history of meningitis."

The plaintiff's neurosurgical expert stated that the June 24, 2004 admission record included the official MRA, which confirmed the occlusion of the left middle cerebral artery and narrowing of the left internal carotid artery. He continued that the radiologist further commented that "...on the MRI of the brain with contrast, there was significant enhancement in the region of the left cavernous sinus, distal left internal carotid artery and left middle cerebral artery most compatible with meningitis which has resulted in occlusion and vascular changes." The plaintiff's neurosurgical expert continued that Dr. Andres Gonzalez, a neurologist who had seen the plaintiff during the June 4, 2004 admission, testified that the plaintiff had a stroke secondary to the occlusion of her left middle cerebral artery, caused by infection, however, Dr. Gonzalez did not know if the infection was present during the first hospitalization of June 4, 2004.

The plaintiff's neurosurgical expert continued that upon admission to University of Virginia Medical Center (UVA), that Dr. Oskouian assisted Dr. Gregory Helms in performing a transsphenoidal re-exploration with gross total removal of the sphenoid sinus contents which were consistent with infection. Dr. Oskouian dictated the operative note dated June 26, 2004, stating that the plaintiff was taken to Long Island Memorial Jewish Hospital three days ago, and that the MRI performed showed thrombosis of her left internal carotid artery as well as the left middle cerebral artery with a left MCA distribution stroke on diffusion-weighted imaging. Her MRA showed complete occlusion of her left ICA as well as her MCA. Her diffusion weighted imaging studies were consistent with a left lenticular striate artery stroke. The plaintiff's neurosurgical expert stated that the discharge summary from UVA noted that the plaintiff sustained an episode of post-surgical vasospasm which prompted repeat imaging with radiographic evidence of progression of the infarct.

It was the plaintiff's neurosurgical expert's opinion on the overwhelming evidence from the imaging studies showing left sided vascular occlusion and left sided sphenoid sinus inflammation and infection, the laboratory reports, and the operative finding of an infected sphenoid sinuses, and consistent with the opinion of the treating physicians, the cause of the stroke was vascular occlusion, secondary to inflammation, secondary to the untreated infection in the sphenoid sinuses. He stated that

such infection was present during the June 4, 2004 hospitalization. In his opinion, whatever the infectious organism was, the real issue was the abscess formation within the sinus, and the major departure from the standard of care at Huntington Hospital during the June 4, 2004 admission was in the failure to look at and evaluate the sphenoid sinus. Plaintiff's neurosurgical expert does not raise factual issues with regard to the moving defendants' treatment and radiological interpretations, however.

In addition, plaintiff submitted the unredacted affidavit of a physician licensed to practice medicine in Connecticut who is board certified in internal medicine, with a sub-specialty in infectious disease. Plaintiff's expert stated that his affidavit is submitted in opposition to the motion of Dr. Annmarie Kyle and the North Shore Medical Group of the Mount Sinai School of Medicine. The plaintiffs' internal medicine/infectious disease expert stated that relating to the June 4, 2004 admission, Dr. Kyle discharged the plaintiff on June 11, 2004 with the diagnosis of sinusitis and viral meningitis. He continued that during the admission of June 24, 2004, the plaintiff was seen by Dr. Gonzales who opined that the plaintiff had a stroke incited by an infectious process, however, he could not say that the infection was present during the plaintiff's previous hospitalization. The plaintiff's internal medicine expert continued that the plaintiff should not have been discharged after the June 4, 2004 admission without a clear diagnosis. However, the plaintiff's internal medicine/infectious disease expert then opined that Dr. Kyle, the attending physician, was responsible for ensuring the plaintiff's hospital evaluation and work-up was complete and appropriate, and addressed all the plaintiff's needs.

The plaintiff's internal medicine expert continued that, at Huntington Hospital emergency department on June 24, 2004, the plaintiff was seen by Dr. Anne Sacks-Berg, an infectious disease specialist, who noted that the CAT scan of the brain without contrast compared to June 4, 2004 revealed swelling and edema of the left temporal lobe, which is new. A questionable area of high attenuation within the left middle cerebral artery-question spasm or clot within the vessel was also noted. Dr. Sacks-Berg was concerned about infection, even abscess. Plaintiffs' internal medicine expert also acknowledged that the plaintiff was seen by Dr. Andres Gonzales, a neurologist, who stated that the plaintiff had a stroke secondary to the occlusion of her left middle cerebral artery caused by an infectious process which occurred sometime after her surgery, but he did not know if it was present during the hospitalization of June 4, 2004.

Plaintiff's internal medicine expert opined in a conclusory statement that the sinus infection was present during the June 4, 2004 hospitalization. However, he has not set forth the basis for such opinion. He stated that Dr. Popp, the infectious disease physician, did not have cultures from the sinuses at the June 4, 2004 hospitalization. He also indicated that Dr. Spencer, the otolaryngologist, stated that it was within the scope of his practice, and possible to visualize the sinuses endoscopically, and to obtain cultures from the sinuses with a swab. Plaintiffs' expert stated that Dr. Spencer did not do so, nor did any other physicians, including Doctors Popp, Mechanic, Kyle, Schmitz, and Gonzalez, and no one requested such culture. Plaintiffs' expert continued that the left sided vascular occlusion and left sided sphenoid sinus inflammation and infection, the laboratory reports, and the operative finding of an infected sphenoid sinus, were consistent with the opinions of the treating physicians that the cause of the stroke was vascular occlusion, secondary to inflammation, secondary to the untreated infection in the sphenoid sinuses. He does not comment upon any departures from the standard of care by the moving radiology defendants, however.

Plaintiffs' radiology expert is a physician licenced to practice medicine in New York State who is board certified in diagnostic radiology. Plaintiff's expert has not set forth his education and training to qualify as an expert in this matter, but states his/her familiarity with the standards of care applicable to performing and interpreting CT scans, MRI studies, MRA studies, and other imaging studies of the head and brain, based up his years of academic training as a radiologist and practice. The plaintiff's expert stated that he reviewed CT scan and MRI studies concerning the hospitalization of Melinda Leigh at Huntington Hospital commencing June 4, 2004, including the June 8, 2004 MRI study and the official report concerning that study. He opined within a reasonable degree of medical certainty that the MRI study of June 8, 2004 revealed evidence of a focal narrowing which may have been due to spasm and/or focal stenosis of the internal carotid artery, which finding was not stated in the official report signed by Dr. Robert Goodman. He further stated that he is not aware of any evidence that the radiologists made this information known to any of the providers, and that it was a deviation from good and accepted practice for the radiologist to fail to report this finding.

Based upon the foregoing, it is determined that the plaintiffs have failed to raise a factual issue to preclude summary judgment in favor of Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology a/k/a Huntington MRI. Plaintiff's radiology expert's opinion is broad, vague, non-specific as to the location and level of his purported findings, and conclusory in nature. While he opined that the MRI study of June 8, 2004 revealed evidence of a focal narrowing which may have been due to spasm and/or focal stenosis of the internal carotid artery, which finding was not stated in the official report signed by Dr. Robert Goodman, he does not support his conclusory opinion by describing the evidence he found, how he made such determination, or whether there was any objective method employed by him to make such finding. He does not indicate whether his findings are in the right or left internal carotid, and he does not identify the slices or imaging studies in which he identified evidence of focal narrowing. While plaintiff's radiology expert offered his opinion based upon some part of the June 8, 2004 MRI, he fails to state whether or not he reviewed the MRA which was ordered to rule out stenosis in the arteries, and whether or not that specific study showed focal narrowing or stenosis, or other pathology of the artery on June 8, 2004, or whether the findings were normal. No expert opinion was offered by plaintiff's radiology expert concerning Dr. Morgenstern's interpretation of the June 4, 2004 MRI study of plaintiff's brain.

It is further noted that plaintiff's neurosurgical and internal medicine physicians do not identify any indication of focal narrowing in the internal carotid artery in their reviews relative to the June 4, 2004 and June 8, 2004 studies. In fact, the plaintiff's internal medicine expert stated the plaintiff was seen by Dr. Anne Sacks-Berg, an infectious disease specialist, who noted that the CAT scan of the brain without contrast compared to June 4, 2004 revealed swelling and edema of the left temporal lobe, which is new, and a questionable area of high attenuation within the left middle cerebral artery-question spasm or clot within the vessel. Thus, in comparing the films of June 8, 2004 to the studies of June 24, 2004, Dr. Sacks-Berg recognized new findings not previously found on the prior MRI studies and did not find any narrowing of blood vessels. These same findings were set forth by plaintiff's internal medicine expert as well, and who stated that the plaintiff was seen by Dr. Andres Gonzales, a neurologist, who stated that the plaintiff had a stroke secondary to the occlusion of her left middle cerebral artery caused by an infectious process which occurred sometime after her surgery, but he did not know if it was

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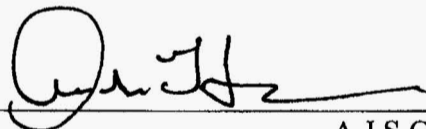
present during the hospitalization of June 4, 2004.

Plaintiffs' neurosurgical expert set forth that a review of the plaintiff's imaging studies during the June 4, 2004 admission to Huntington Hospital suggests sinusitis, specifically an inflammation of the sphenoid sinuses. Plaintiff's neurosurgical expert continued that the plaintiff underwent an MRI study of the brain with and without contrast, and MRA of the brain during the June 24, 2004 admission record. He stated that in the official report of this MRI, the following impression was noted, "Extensive inflammatory appearing changes involving the base of the brain about the left internal carotid artery and left middle cerebral artery. There is narrowing of the left internal artery and occlusion of the left middle cerebral artery. Findings have resulted in infarction in the left lenticular striate and middle cerebral distribution. There are probable inflammatory changes/cerebritis involving the medial aspect of the temporal lobe and the contrast enhancing changes are compatible with the clinical history of meningitis." However, plaintiff's neurosurgical expert does not opine that these findings were present on earlier imaging studies obtained on June 4, 2004 or June 8, 2004.

The plaintiffs' neurosurgical expert stated that he was advised that there was evidence on the June 8, 2004 MRI of the brain of narrowing of the internal carotid artery, and that this was not reported by the radiologist, Dr. Goodman. He reviewed plaintiff's radiology expert's report, and stated that "if the narrowing of the artery was not correctly reported, this was another factor which contributed to the diagnostic failure." However, plaintiff's neurosurgical expert does not indicate that he reviewed actual images, and his opinion can therefore only be speculative. He reviewed only the reports associated with those studies, and the report of plaintiff's expert radiologist, and therefore, he has not provided a basis for his conclusory opinion which is based upon plaintiff's expert radiologist's conclusory opinion. Therefore, plaintiffs have failed to raise a factual issue as to proximate cause between any alleged departures by these moving defendants and plaintiff's claimed injuries, to preclude summary judgment from being granted to Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology a/k/a Huntington MRI.

Accordingly, upon reargument, the motion by Barry Morgenstern, M.D., Robert Goodman, M.D., and Medical Arts Radiology a/k/a Huntington MRI is granted, and the complaint as asserted against them is dismissed.

Dated: SEP 03 2014



 A.J.S.C.

 FINAL DISPOSITION X NON-FINAL DISPOSITION

TO: GEISLER, HENNINGER & FITZMAURICE, LLP
 Attorney for Defendants Gonzalez, M.D. and Huntington Medical Group, P.C.
 170 Old Country Road, Suite 303
 Mineola, New York 11501

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MCHENRY, HORAN & LAPPING, P.C.
Attorney for Defendant Huntington Hospital
6800 Jericho Turnpike, Suite 202E
Syosset, New York 11791

ANTHONY P. VARDARO, P.C.
Attorney for Defendant Long Island Infectious Disease Associates
732 Smithtown Bypass, Suite 203
Smithtown, New York 11787

CHESNEY & NICHOLAS, LLP
Attorney for Defendants Mechanic, M.D. and Long Island Neurosurgical
2305 Grand Avenue
Baldwin, New York 11510

PATRICK F. ADAMS, PLLC
Attorney for Defendants Courgi, M.D. and Center for Diabetes and Endocrinology
30 Vesey Street, Suite 1200
New York, New York 10007

CALLAN, KOSTER, BRADY & BRENNAN, LLP
Attorney for Defendants Morgenstern, M.D., Goodman, M.D., and Medical Arts Radiology
1140 Franklin Avenue, Suite 200
Garden City, New York 11530