Castillo v Mount Sinai Hosp.
2015 NY Slip Op 30360(U)
March 6, 2015
Supreme Court, Bronx County
Docket Number: 309886/10
Judge: Stanley B. Green
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: IA-6

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PEDRO CASTILLO, As Administrator of the Estate of JESSENIA CASTILLO, deceased,

Plaintiff(s),

INDEX №.: 309886/10

-against-

THE MOUNT SINAI HOSPITAL, ARIK OLSON, M.D., DOMINICK HOLLMAN, M.D. and ELLEN BLANK, M.D.,

Defendant(s). DECISION

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HON. STANLEY GREEN:

The motion by plaintiff for an order pursuant to CPLR §3025(b) granting permission to serve a Second Amended Bill of Particulars as to Mount Sinai Hospital is granted, and upon granting the motion, the cross-motion by Dr. Olson and The Mount Sinai Hospital for summary judgment dismissing the complaint is granted. (Plaintiff previously stipulated to discontinue this action against Dr. Hollman and Dr. Blank).

Plaintiff claims that decedent, age 21, died on October 4, 2009, while confined at Mount Sinai Hospital, as a result of defendants' failure to timely and properly diagnose and treat her for a blood disorder she developed after giving birth to her daughter on March 21, 2009.

On August 12, 2009, decedent presented to the Emergency Department of Mount Sinai with a generalized macular rash and right upper quadrant pain. She had a history of gallstones and childbirth on March 21, 2009 at Mount Sinai. She was diagnosed with contact dermatitis, given Benadryl and told to follow up in the Dermatology clinic. Decedent was seen in the dermatology clinic on August 18 and September 1, 2009. On September 2, 2009, decedent went

to the Mount Sinai Emergency Department with complaints of itchy rash, myalgia and fever. Blood was drawn and she was instructed to follow in the clinic for results of the lab work and further referral to Rheumatology. On September 4th, decedent returned to the Dermatology clinic. Based on the results of the blood work, the diagnosis was myalgia and the differential diagnoses were lupus and dermatomyositis. Decedent was instructed to follow up with Dermatology on September 14th and with Rheumatology on September 16, 2009. However, on September 13, 2009, plaintiff presented to the Emergency Department at Mount Sinai with complaints of fever, progressive rash, myalgias, nausea and shortness of breath. She was admitted to the service of Dr. Olson, an attending physician specializing in Internal Medicine.

Decedent's initial evaluation was complicated by a large number of abnormalities, including substantial and sustained eosinophilia (a higher than normal level of eosinophils - a type of disease-fighting white blood cell), an elevated LDH, an elevated ferritin (an intracellular protein that stores iron and releases it in a controlled fashion) and possible allergic reactions to Doxepin and, previously, to NSAIDS. She was seen by multiple consultants, including rheumatologists, nephrologists, and dermatologists, but no solid diagnosis was made. Drug allergy, the DRESS Syndrome (Drug Reaction (or Rash) with Eosinophilia and Systemic Symptoms) and diffuse vasculitis were all considered. On the assumption that there was some allergic or vasculitic process underway, decedent was started on Prednisone and Levaquin for possible pneumonia.

On September 16th, decedent's platelet count, which had been normal on admission at 315, fell to 100. A repeat count two hours later was reported as 274. No platelet count was ordered on September 17, but on September 18, decedent's platelet count was normal. On

September 19, no platelet count was ordered. On September 20, decedent's platelet count was low, at 26, with a duplicate test of 33. At that point, a hematology consult was conducted and a peripheral blood smear was also obtained. The hematologist made a provisional diagnosis of Thrombotic Thrombocytopenic Purpura/Hemolitic Uremic Syndrome (TTP/HUS), disorders that are characterized by thrombocytopenia (a deficiency of platelets in the blood) which causes bleeding into the tissues, bruising, slow blood clotting after injury, and microangiopathic hemolytic anemia. Plasmapheresis therapy (therapeutic plasma exchange) was initiated, but decedent did not respond to the therapy.

On September 22, 2009, decedent underwent a bone marrow biopsy and on September 24, 2009, she underwent a renal biopsy. Her condition did not improve on plasmapheresis and she expired on October 4, 2009. Based on the ante-mortem biopsies and two autopsies, the essential finding was thrombotic microangiopathy (a pathology that results in the formation of thrombi in the arterioles and capillaries) involving several organs, including the brain, skin and kidneys.

Plaintiff's Verified Bill of Particulars alleges that defendants deviated from accepted standards of care by failing to properly and timely investigate, diagnose and treat the cause of her symptomatology and by failing to institute timely and appropriate therapy. Plaintiff's first Amended Verified Bill of Particulars amplified the original Bill of Particulars to include allegations that defendants deviated from the standard of care by failing to include thrombocytopenia in the differential diagnosis, failing to obtain indicated hematological studies, and failing to timely refer decedent for a hematologic work-up.

The Note of Issue and Certificate of Readiness were filed on May 31, 2013. On January

14, 2014, plaintiff served a Second Amended Verified Bill of Particulars, pursuant to a so-Ordered Stipulation dated December 3, 2013, which includes allegations that defendants departed from good and accepted standards of practice by failing to timely institute appropriate therapy, including plasmaphoresis and/or anti-complement therapy, failing to treat decedent with anti-complement therapy and by failing to include atypical hemolytic uremic (aHUS) syndrome or other disease entities which were amenable to treatment with anti-complement therapy in the differential diagnosis, causing and allowing decedent's condition to become fatal.

At a pretrial conference on February 19, 2014, plaintiff's counsel was directed to file a motion for leave to serve the Second Amended Verified Bill of Particulars. Defense counsel was granted permission to file a cross-motion for summary judgment based upon the new theory alleged by plaintiff in the Second Amended Verified Bill of Particulars.

Plaintiff seeks permission to serve the Second Amended Verified Bill of Particulars on the grounds that it amplifies the previous pleadings and expands the prior allegations of negligence with more particularity and with the evidentiary benefit of the expert opinion. He contends that there is no surprise or prejudice to defendants because defense counsel was previously apprised of plaintiff's contention that the diagnosis initially made by the defendants was delayed and in error, and defendant's expert disclosure takes issue with and refutes the allegations made in all of the Bills of Particulars that were served, including the Second Amended Bill of Particulars.

In support of the motion, plaintiff submits the affirmation of Dr. Shohet, who is Board Certified in Internal Medicine and Hematology. Dr. Shohet opines that Dr. Olson and Mount Sinai deviated from good and accepted standards of practice by: (1) failing to order a timely

formal hematology consult; (2) failing to make a prompt initial diagnosis; (3) failing to suspect or consider an alternate diagnosis to TTP when plasmaphoresis therapy failed, including atypical hemolytic uremic syndrome (aHUS); and (4) by failing to timely initiate treatment for aHUS with anti-complement therapy. Dr. Shohet opines that these deviations alone, and in concert, were proximate causes of decedent's death.

Dr. Shohet acknowledges that decedent's presentation was complex and many consultants were involved, but opines that a hematologic consultation should have been obtained earlier than seven days after decedent's admission to Mount Sinai as there were abnormal laboratory findings of grossly elevated ferritin levels, elevated LDH and marked instability and abnormality in the platelet count three days after admission. He opines that these findings were not adequately investigated or followed up, thereby delaying the initial diagnoses of TTP to September 20, 2009,when "profound thrombocytopenia, schizocytes on smear, and progressive neurologic changes demanded hematologic attention."

Dr. Shohet also opines that after the renal biopsy, the assumption that Ms. Castillo had typical TTY/HUS was not adequately tested. He explains that when plasmapheresis had no effect in reversing or slowing the disease, alternative diagnoses should have been considered by urgently obtaining the level of ADAMTS-13 in her blood. He explains that ADAMTS-13 is a normal proteolytic enzyme in blood which is usually markedly reduced or absent in classic TTP and typical HUS and opines that if this assay had been obtained, a normal level would have "strongly suggested" that the provisional diagnosis of TTP/HUS was incorrect and that the atypical Hemolytic Uremic Syndrome should have been considered. He explains that this is important because the atypical variant of the HUS is known to be mediated by abnormal

activation of the complement system which can be determined by measuring the level of the complement protein, C-3, in the blood and, at the time of decedent's illness, a therapeutic antibody (Eculizumab) had been developed which was well known to be effective in reversing abnormal complement activation. Dr. Shohet references articles from the New England Journal of Medicine which show that by September 2009, Eculizumab therapy had been utilized in treating patients with Atypical Hemolytic Uremic Syndrome. Thus, he opines that "it might well have been used to treat Ms. Castillo."

Dr. Olson and Mount Sinai contend that plaintiff's motion should be denied because the proposed Second Amended Bill of Particulars contains a new theory of liability. They cross-move for summary judgment dismissing the complaint on the ground that there are no genuine material issues of fact. In support of the cross-motion, Dr. Olson and Mount Sinai submit the affirmation of Dr. Soff, who opines that the care and treatment rendered by defendants to decedent was at all times in accordance with accepted standards of practice and was not a proximate cause of injury to, or the death of, plaintiff's decedent.

Dr. Soff opines that prior to September 20, 2009, there was no basis on which to diagnose TTP, as decedent's dermatological symptom (macular rash) was not consistent with TTP and decedent did not develop hematologic abnormalities that are associated with TTP until September 20, 2009, at which time the diagnosis of TTP was made and the appropriate treatment initiated. Dr. Soff opines that plaintiff's contention that the lack of response to plasmapheresis in decedent should have led to consideration of other disease entities, such as aHUS, is medically invalid, because the theory implicitly concedes that TTP was not the correct diagnosis. He opines that it is disingenuous and illogical for plaintiff to argue that defendants departed from

accepted standards of practice by not timely diagnosing and treating an incorrect diagnosis. He also opines that the failure of TTP to respond to plasmapheresis is not a basis on which to consider aHUS. Dr. Soff also opines that it was not a standard of care to treat aHUS with Eculizumab in 2009 because it was not FDA approved for treatment of this disorder until September 23, 2011 and there was no medical literature which established the efficacy of Eculizumab in treatment of aHUS during the period of decedent's treatment at Mount Sinai. He also cites a 2008 article by Loriat which notes that plasma therapy was the most widely used modality for treatment of aHUS.

With respect to plaintiff's motion, leave to serve an amended bill of particulars is freely granted in the absence of prejudice or surprise (Alvarado v. Beth Israel Medical Center, 78 AD3d 873) and when the parties already have notice of the gist of the proposed amendment, through discovery or where the amendment merely expounds on prior allegations, such amendment should be freely granted (Martino v. Bendo, 93 AD3d 500). Here, the Second Amended Bill of Particulars (which is addressed only to Mount Sinai) does not allege new facts or occurrences, but includes additional allegations that amplify those in the earlier bills of particulars and defendants' expert disclosure addresses and refutes these allegations. Accordingly, plaintiff's motion for leave to serve the Second Amended Bill of Particulars is granted.

As to the cross-motion, on a summary judgment motion, a defendant establishes prima facie entitlement to summary judgment when he establishes that in treating the plaintiff, there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged (Roques v. Noble, 73 AD3d 204). Once the defendant has met his prima facie burden, the burden shifts to the plaintiff to present competent evidence

sufficient to show that the defendant departed from accepted standards of practice and that such departure was a proximate cause of the plaintiff's injuries (Kafka v. New York Hospital, 228 AD2d 332). In order to sustain this burden, the plaintiff must present expert testimony that the defendant's conduct constituted a deviation from the requisite standard of care (Berger v. Becker, 272 AD2d 565). The standard of care for a physician is one established by the profession itself (Spensieri v. Lasky, 94 NY2d 231; Toth v. Community Hosp., 22 NY2d 255) and the fact that a drug or medication was not FDA approved for a particular condition does not establish that it was not the standard of care for a physician to administer it to a patient in an "off-label" manner (Sita v. Long Island Jewish-Hillside Medical Center, 22 AD3d 743). The mere offering of an expert opinion on proximate cause is not sufficient, in the absence of a showing of the requisite nexus between the malpractice allegedly committed and plaintiff's injuries (Koeppel v. Park, 228 Ad2d 288). If a plaintiff's expert cannot state with a reasonable degree of medical certainty that defendants' departures were a proximate cause of the plaintiff's injuries, the plaintiff's malpractice claim does not lie (Rivera v. Bebbington, 94 AD3d 408, aff'd 20 NY3d 945).

Here, the affirmation of Dr. Soff establishes, prima facie, that the care and treatment rendered to decedent by defendants conformed with accepted standards of medical practice and was not a proximate cause of injury to, or the death of plaintiff's decedent. Thus, the burden shifted to plaintiff to present competent evidence sufficient to raise a material issue of fact to defeat defendants' motion.

While Dr. Shohet's opinion that defendants' delay in obtaining a hematology consult caused a delay in the diagnosis of TTP and consideration of another microangiopathic condition (which was eventually found in Ms. Castillo), and that, after decedent failed to respond to

plasmapheresis, defendant's failure to test the provisional diagnosis and include alternative diagnoses (including atypical Hemolytic Uremic Syndrome) in the differential diagnosis were departures that deprived decedent of the opportunity to receive Eculizumab, a therapeutic antibody that had been developed and was well known to be effective in reversing abnormal complement activation, had been used in patients with Atypical Hemolytic Uremic Syndrome, and "could have been used to treat Mrs. Castillo," nowhere in his affidavit does he state, with a reasonable degree of medical certainty, that Eculizumab would have been successful in treating plaintiff's condition and preventing her demise. He opines that after treatment for TTP/HUS was unsuccessful, aHUS should have been considered and Eculizumab should have been given to decedent because it was known to have been utilized successfully in the treatment of other complement-mediated hematologic disorders and was reported to "hold promise" for treating aHUS as of September 2009, but he does not opine that that administration of Eculizumab was generally accepted in the medical community as a viable treatment for or cure of aHUS. In the absence of an opinion that there was a "substantial possibility" that the alleged departures were a "competent producing cause" of decedent's claimed injuries and death, his affirmation is insufficient to demonstrate that the alleged departures proximately caused the claimed injuries and death (Candia v. Estepan, 289 AD2d 38). Accordingly, defendants' are entitled to summary judgment dismissing the complaint.

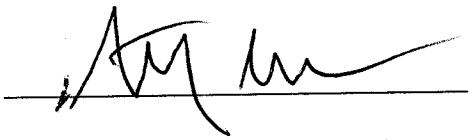
It is noted that on February 19, 2014, this court granted defense counsel permission to move for summary judgment related to the claims set forth in the Second Amended Bill of Particulars. However, that pleading is addressed only to Mount Sinai. Therefore, Dr. Olson's motion, filed more than 120 days after the filing of the Note of Issue, is untimely. However, the

court may search the record on a motion for summary judgment and, upon doing so, Dr. Olson is entitled to dismissal of the complaint for the same reason that it is dismissed as against Mount Sinai.

Movants shall serve a copy of this order with notice of entry on the Clerk of the Court who shall enter judgment dismissing the complaint.

This constitutes the decision and order of the court.

Dated: February 6, 2015



STANLEY GREEN, J.S.C.