

<b>Kuznetsov v Ukrainsky</b>
2022 NY Slip Op 33874(U)
November 16, 2022
Supreme Court, Kings County
Docket Number: Index No. 503570/19
Judge: Genine D. Edwards
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At an IAS Term, Medical Malpractice Early Settlement Part 6 of the Supreme Court of the State of New York, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 16<sup>th</sup> day of November 2022.

P R E S E N T:

HON. GENINE D. EDWARDS,  
Justice.

-----X  
SERGEY KUZNETSOV and MARINA KUZNETSOV,

Plaintiffs,

-against-

GENNADY UKRAINSKY, M.D.,  
Defendant.

-----X<sup>1</sup>

DECISION AND ORDER

Index No. 503570/19

Mot. Seq. No. 4

The following e-filed papers read herein:

NYSCEF Doc. Nos.:

Notice of Motion, Affirmations, and Exhibits Annexed.....	83-106
Affirmations (Affidavits) in Opposition and Exhibits Annexed.....	107, 113, 115, 117-122
Reply Affirmation.....	124

In this action to recover damages for medical malpractice, lack of informed consent, and loss of consortium, Gennady Ukrainsky, M.D. (“defendant”), moves (in Seq. No. 4) for summary judgment dismissing all Sergey Kuznetsov and Marina Kuznetsov’s (collectively, “plaintiffs”) claims.

**Background**

Between August 4, 2016 and November 28, 2016, defendant diagnosed Sergey Kuznetsov (the “patient”) with (and treated him for) chronic sinusitis of his right maxillary

<sup>1</sup> The caption herein reflects the amended caption as set forth in the Court’s order, dated January 13, 2022 (NYSCEF Doc No. 81).

sinus (among other conditions). After a course of medical treatment failed, defendant directed that the patient undergo a screening CT scan (non-contrast-enhanced) of his maxillary sinuses (the “pre-operative CT scan”).<sup>2</sup> Performed on August 22, 2016, the pre-operative CT scan found, in relevant part, that:

“The patient has undergone prior right-sided uncinectomy and antrostomy. There is a right-sided Haller cell that [is] . . . secondarily opacified, with adjacent mild mucosal thickening along the medial aspect of the right uncinectomy bed, *although the postoperative uncinectomy/antrostomy bed otherwise appears well ventilated.*”<sup>3</sup>

As discussed below, the italicized finding in the pre-operative CT scan was sufficiently concerning to plaintiffs’ ENT expert to require a further radiologic investigation. In defendant’s opinion, however, the pre-operative CT scan (read as a whole) confirmed his previous diagnosis that the patient was suffering from chronic sinusitis in the right maxillary sinus (among other areas).

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<sup>2</sup> Defendant confirmed (at page 48, lines 22-24 of his deposition at NYSCEF Doc No. 93) that a CT scan was a *screening* modality, whereas an MRI was a *diagnostic* modality. Defendant’s assertion (in ¶ 19 of his counsel’s reply affirmation at NYSCEF Doc No. 124) that defendant “referred [the patient] for a sinus CT scan, in part as a *diagnostic* study attempting to detect or rule out cancer” (emphasis added), mischaracterized defendant’s deposition testimony.

<sup>3</sup> Kings Highway Imaging Records at 000004 (emphasis added) (NYSCEF Doc No. 98). A “Haller cell” is “a variant of ethmoidal air cell developing into the floor of the orbit adjacent to the natural ostium of the maxillary sinus[; a] diseased Haller cell is capable of obstructing that ostium and producing a maxillary sinusitis.” Stedman’s Medical Dictionary, Entry 156440 “Haller cell” (online edition). “Antrostomy” is the “[f]ormation of a permanent opening into any antrum.” *Id.*, Entry 51770 “antrostomy.” “Uncinectomy” is the total resection of the “uncinate process.” *Id.*, Entry 723600 “uncinate process of ethmoid bone.”

On October 6, 2016, defendant performed an 18-minute<sup>4</sup> endoscopic surgery on the patient's right maxillary sinus (again, among other areas).<sup>5</sup> During surgery, "the curved microdebrider was utilized to remove polypoid degeneration within the right maxillary sinus."<sup>6</sup> The surgically removed contents from the patient's right maxillary sinus were diagnosed by the examining pathologist as representative of "chronic sinusitis."<sup>7</sup>

Post-operatively, defendant (at his office) saw the patient four times between October 13, 2016 and November 28, 2018. At each office visit, defendant performed (under local anesthesia) endoscopic debridement of the patient's operated-on areas. At the conclusion of defendant's fourth post-operative debridement session on November 28, 2016, the patient's signs and symptoms sufficiently abated to enable him to function normally both at work and at home. The patient, then 54 years old, was a licensed dentist in private practice with his wife and son (both of whom were also dentists), with offices in Manhattan and Brooklyn.

Twelve months passed without any contact between the patient and defendant. On November 9, 2017, the patient underwent (at the recommendation of his primary medical doctor as well as of his oral surgeon) another screening CT scan (likewise non-contrast-

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<sup>4</sup> New York Eye & Ear Infirmary Records ("NYEEI's Records"), Surgical Case Record at 000027 ("[post-anesthesia] Procedure Start: 1400 [hours]"; "[post-anesthesia] Procedure End: 1418 [hours]" (NYSCEF Doc. No. 97).

<sup>5</sup> The medical term for the relevant surgical procedure is "Nasal Endoscopy, Surgical with Maxillary Antrostomy (revision)" (NYEEI's Records at 000018) (abbreviations spelled out). The qualifier "revision" was used because the patient had undergone (some six to ten years prior) a maxillary antrostomy by another ENT surgeon before he started treating with defendant in August 2016.

<sup>6</sup> Defendant's Operative Report at page 3 of 3 (NYEEI's Records at 000023).

<sup>7</sup> Surgical Pathology Report at page 1 of 2 (NYEEI's Records at 000037).

enhanced) of his maxillary sinuses in response to his complaint of the right maxillary pain (the “subsequent CT scan”). The findings on the subsequent CT scan were suspicious for the presence of malignancy in the patient’s right maxillary sinus, as more fully set forth in the margin.<sup>8</sup> An MRI of the patient’s face and neck (with and without contrast), performed on November 13, 2017, confirmed the presence of very advanced local disease in the patient’s right maxillary sinus, as more fully set forth in the margin.<sup>9</sup> On November 16, 2017, a surgical biopsy of the suspicious mass in the patient’s right maxillary sinus revealed an “infiltrating non-keratinizing squamous cell carcinoma” (“maxillary sinus carcinoma” or “MSC”).<sup>10</sup> Under the tumor-node-metastasis classification of oropharyngeal tumors issued by the American Joint Commission on Cancer, the patient’s right-sided MSC was then in Stage IV-B.<sup>11</sup> Thereafter, the patient’s right-sided MSC was treated with multimodal

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<sup>8</sup> Specifically, the subsequent CT scan found:

“[E]rosion of the posterior and medial walls of the right maxillary sinus with soft tissue extending into the right nasal cavity as well as the right masticator space. There is [additional] erosion of the posterior aspect of the right orbital floor with soft tissue abutting the right inferior rectus muscle. Soft tissue is seen extending through and widening the right pterygopalatine fossa with partial erosion of the right pterygoid processes. There is soft tissue which extends into the sphenoid sinus. *Rule out neoplasm. Further evaluation with contrast-enhanced MRI of the brain and sinuses is recommended.*”

Bay Ridge Medical Imaging, P.C., page 2 of 3 (emphasis added) (NYSCEF Doc No. 102).

<sup>9</sup> The MRI showed a “malignant mass [which was] centered along the posterior wall of the right maxillary antrum with extensive invasion of adjacent structures[,] including the central skull base where there [was] evidence of perineural extension along [maxillary nerve] V2 to the cavernous sinus.” Northwell Health, Lenox Hill, Department of Radiology, Final Report, page 2 of 2 (NYSCEF Doc. No. 120). The takeaway from the MRI report was that the patient’s maxillary sinus carcinoma was growing by: (1) invading the adjacent structures, and (2) extending along the maxillary (a cranial) nerve.

<sup>10</sup> Northwell Health, Surgical Pathology Report at page 1 of 2 (NYSCEF Doc No. 103).

<sup>11</sup> Northwell Health Physician Partners, Visit Date January 24, 2018, Disease Management (NYSCEF Doc No. 122):

(footnote continued)

approaches: first by induction chemotherapy, followed by chemo-radiotherapy, and ultimately by surgery.

On February 18, 2019, the patient (and his wife suing derivatively) commenced this action against defendant (among others). The patient's principal claim is that defendant missed his cancer by failing to differentiate his then-present right-sided (*i.e.*, unilateral) MSC from his chronic bilateral maxillary sinusitis during his three-month course of treatment with defendant in 2016.<sup>12</sup> Defendant interposed his answer.<sup>13</sup> Discovery was completed and a note of issue ("NOI") was filed on November 17, 2021. On March 11, 2022, defendant served the instant motion. On August 12, 2022, the instant motion was fully submitted, with the Court reserving decision.

### Discussion

#### ***Threshold Matters***

Defendant served his motion within 120 days counting from the NOI filing date which was generally allotted by CPLR 3212 (a) to summary judgment motions, but outside the 60-day period that is specifically allotted by ¶ 6 of Part C of the Kings County Supreme Court Uniform Civil Term Rules. Contrary to plaintiffs' objection, defense counsel's reliance on the Part Clerk's broadly worded email response to him that summary judgment motions could

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"TNM Stage: c T 4b N 0 M 0  
" AJCC Stage (8th Ed): IVB"

In the first line, "TNM" stood for tumor-node-metastasis classification; "c," for "clinical"; "TBHC," for tumor; "4b," for the stage; "N 0," for zero (or no) regional lymph node involvement; and "M 0," for zero (or no) distant metastasis. In the second line, "AJCC" stood for the tumor-node-metastasis classification in the 8<sup>th</sup> edition of the American Joint Commission on Cancer, while "IVB" stood for "stage IV b."

<sup>12</sup> Verified Bill of Particulars as to defendant, dated May 9, 2019, ¶ 3 (part of NYSCEF Doc. No. 89).

<sup>13</sup> Defendant's Verified Answer, dated March 4, 2019 (NYSCEF Doc. No. 87).

be served within 120 days after the NOI filing date in accordance with CPLR 3212 (a),<sup>14</sup> constituted, under the circumstances, good cause to excuse his delay and, as significantly, caused no prejudice to plaintiffs.<sup>15</sup> See *Braun v Star Community Pub. Group, LLC*, 125 A.D.3d 913, 5 N.Y.S.3d 151 (2d Dept., 2015); *Nisimova v. Starbucks Corp.*, 108 A.D.3d 513, 967 N.Y.S.2d 838 (2d Dept., 2013).

Plaintiffs, in their opposition papers, did not object to the dismissal of the patient's informed consent claim as against defendant. Accordingly, the patient's informed consent claim was deemed abandoned. See *Clarke v. New York City Health & Hosps.*, \_\_\_ A.D.3d \_\_\_, 2022 NY Slip Op 06106 (2d Dept., 2022).

### ***Substantive Matters***

“[T]o establish the liability of a physician for medical malpractice, a plaintiff must prove that the physician deviated or departed from accepted community standards of practice, and that such departure was a proximate cause of the plaintiff's injuries.” *Templeton v. Papatomas*, 208 A.D.3d 1268, 175 N.Y.S.3d 544 (2d Dept., 2022). “In moving for summary judgment dismissing a complaint alleging medical malpractice, a defendant must establish, prima facie, either that there was no departure or that any departure was not a proximate cause of the plaintiff's injuries.” *Lesniak v. Stockholm Obstetrics & Gynecological Servs., P.C.*, 132 A.D.3d 959, 18 N.Y.S.3d 689 (2d Dept., 2015). “Once a defendant has

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<sup>14</sup> The Park Clerk's response email to defense counsel (with a copy to plaintiffs' counsel), while referencing CPLR 3212 (a), omitted the reference to the Kings County Supreme Court Uniform Civil Term Rules (NYSCEF Doc No. 105).

<sup>15</sup> Plaintiffs' counsel received from defense counsel two consecutive extensions of time in which to substantively oppose the instant motion. See Stipulations Adjourning Motion, dated April 26, 2022 and June 21, 2022 (NYSCEF Doc No. 110 and 111, respectively).

made such a showing, the burden shifts to the plaintiff to submit evidentiary facts or materials to rebut the defendant's prima facie showing." *Pezulich v. Grecco*, 206 A.D.3d 827, 169 N.Y.S.3d 680 (2d Dept., 2022).

Here, defendant shouldered his prima facie burden based upon the expert affirmation of board-certified otolaryngologist Eric Cohen, M.D. ("Dr. Cohen"), who denied that defendant had "commit[ted] any deviations from accepted practice which were a substantial factor in causing any of [the patient's] claimed damages."<sup>16</sup> In Dr. Cohen's opinion (in ¶ 12 of his affirmation), "[t]he records and radiology reflect that [defendant] did not in any way fail to timely diagnose the [patient's right-sided MSC] . . . because at the time [defendant] was treating [the patient], the cancer was not detectable" for the following reasons: First, the patient's signs or symptoms on presentation to (and during his treatment with) defendant in 2016 were not those which were "typically associated with squamous cell carcinoma of the sinus," whereas the patient's signs and symptoms one year later in 2017 when his right-sided MSC was detected were "different, distinct and new" (Dr. Cohen's affirmation, ¶¶ 28, 30-31) (emphasis added). Second, the radiologic findings on the patient's pre-operative CT scan were negative for cancer. In that context, Dr. Cohen noted that the validity of the negative radiologic findings was defended by the deposition testimony of the since-dismissed defendant, radiologist Daniel Meltzer, M.D. (*Id.*, ¶¶ 15-16). Third, the surgical pathology finding of "chronic sinusitis" was that of a benign (rather than of a malignant) process. In that regard, Dr. Cohen further noted that the validity of the benign pathology finding was likewise defended by the deposition testimony of the since-dismissed defendant, pathologist

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<sup>16</sup> Dr. Cohen's Expert Affirmation, dated March 9, 2022, ¶ 12 (NYSCEF Doc No. 85).

Adrienne C. Jordan, M.D. (*Id.*, ¶¶ 20-21). Fourth, defendant (in Dr. Cohen's opinion) removed an adequate amount of tissue from the patient's right maxillary sinus intraoperatively, and the amount so removed (as was defended by the interpreting pathologist in her deposition testimony) was adequate for pathology analysis (*Id.*, ¶¶ 20 and 22). Fifth and finally, the patient (in Dr. Cohen's opinion) achieved a "complete recovery from the sinus surgery and resolution of his symptoms" at the end of his fourth and final post-operative debridement with defendant (*Id.*, ¶ 26).

In opposition, plaintiffs, by way of the expert affidavit of a board-certified otolaryngologist and head/neck surgery specialist ("plaintiffs' ENT expert"), as well as by way of the expert affirmation of a board-certified internist with sub-certification in hematology and oncology ("plaintiffs' oncology expert"), raised triable issues of fact as to whether defendant failed to take steps that would have led to an earlier diagnosis and treatment of the patient's right-sided MSC which, in the opinion of those experts, had already been present (albeit in an early stage) at the time of his treatment of the patient.<sup>17</sup>

According to plaintiffs' ENT expert (in ¶ 46 of his/her affidavit), defendant should have been alerted to a malignancy potential by the pre-operative CT scan's finding that the patient's "uncinectomy/antrostomy bed appeared well ventilated" because such finding was

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<sup>17</sup> Plaintiffs' Medical Expert Affidavit, dated July 5, 2022 (NYSCEF Doc No. 118); Plaintiffs' Medical Expert Affirmation, dated July 7, 2022 (NYSCEF Doc No. 119), respectively.

inconsistent with his presenting complaint of inability to breathe through his right nostril.<sup>18</sup>

Further, plaintiffs' ENT expert opined (in ¶¶ 47-48, 50 of his/her affidavit) that:

"In the course of the patient's surgery, defendant should have "strip[ped] the [right maxillary] sinus lining and submit[ted] same for tissue analysis to evaluate for any signs of malignancy.

Not only did [defendant] fail to strip the lining, which constituted a departure from accepted standard of care, but the tissue that he did obtain [intraoperatively] was 30 mL of bloody fluid with suspended mucosal tissue from the right [maxillary] sinus contents. This was a woefully inadequate tissue specimen to sufficiently evaluate the maxillary sinus for any malignancy as the standard of care required. . . .

In view of the extent of the disease found one year later, there is no question that [the patient] suffered from early stage [right-sided] maxillary sinus cancer while under the care of [defendant]. . . . [T]hat the cancer was in its early stages is evidenced by the fact that there was no bony destruction seen on the [pre-operative] CT Scan[,] . . . which [bony destruction] is seen in later stages and was found on the [subsequent] CT Scan. . . ."

In addition, plaintiffs' oncology expert opined that in light of the advanced stage of the patient's right-sided MSC at the time of its diagnosis in 2017, it was both detectable and diagnosable when he treated with defendant in 2016. As plaintiffs' oncology expert explained (in ¶¶ 33-34 of his/her affirmation):

"It is . . . my opinion that while under the care of [defendant] from August through November 2016, the maxillary cancer was confined to the maxillary sinus based upon the fact that there was no evidence of bony erosion seen on the [pre-operative] CT-Scan performed on August 22, 2016. The maxillary sinus carcinoma was then, in it[s] earliest stage (Stage I).

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<sup>18</sup> Contrary to defendant's contention (in ¶ 19 of his counsel's reply affirmation), the radiologist who interpreted the pre-operative scan did not "specifically rule[ ] out cancer." The interpreting radiologist's finding of the "[m]ucosal disease affecting the . . . maxillary sinuses" was not inconsistent with the presence of concurrent malignancy. Likewise, contrary to defendant's contention (in ¶ 20 of his counsel's reply affirmation), the interpreting pathologist "did not rule out cancer in the submitted specimens."

Had the cancer been diagnosed, as it should have been, in late summer/fall 2016, [the patient] would have undergone resection as a curative form of treatment.”

Plaintiffs thereby raised a triable issue of fact as to whether the patient’s right-sided maxillary sinus cancer could (and should) have been detected sooner, and whether that omission contributed to his damages. *See Stewart v. North Shore University Hospital at Syosset*, 204 A.D.3d 858, 166 N.Y.S.3d 676 (2d Dept., 2022); *Russell v. Garafalo*, 189 A.D.3d 1100, 136 N.Y.S.3d 317 (2d Dept., 2020) (when the parties adduced conflicting medical expert opinions based on documentary, non-speculative evidence, summary judgment was inappropriate).

Any arguments not specifically addressed herein were considered and were rejected as without merit.

**Conclusion**

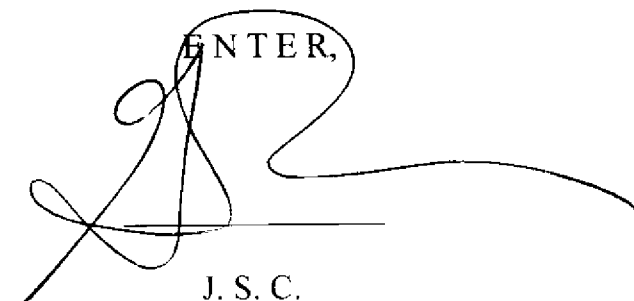
Accordingly, it is

**ORDERED** that in Seq. No. 4, defendant's motion for summary judgment is *granted to the extent* that the patient's informed consent claim as against him is dismissed; and *the remainder of his motion is denied*; and it is further

**ORDERED** that plaintiffs' counsel is directed to electronically serve a copy of this decision and order with notice of entry on defense counsel and to electronically file an affidavit of service thereof with the Kings County Clerk; and it is further

**ORDERED** that the parties are reminded of their next ADR appearance in the Medical Malpractice Early Settlement Part 6 on December 7, 2022 at 12:30 p.m.

This constitutes the decision and order of the Court.

ENTER,  
  
J. S. C.  
**HON. GENINE D. EDWARDS**