

Ordower v Kassapidis

2023 NY Slip Op 31426(U)

April 25, 2023

Supreme Court, New York County

Docket Number: Index No. 805270/2019

Judge: John J. Kelley

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**SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY**

PRESENT: HON. JOHN J. KELLEY PART 56M

Justice

-----X

ILENE ORDOWER and HENRY ORDOWER

Plaintiffs,

- v -

ELIAS KASSAPIDIS, M.D., and RIVERSIDE
ORTHOPAEDIC AND SPORTS MEDICINE ASSOCIATES,
P.C.,

Defendants.

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INDEX NO. 805270/2019

MOTION DATE 02/02/2023

MOTION SEQ. NO. 002

**DECISION + ORDER ON
MOTION**

The following e-filed documents, listed by NYSCEF document number (Motion 002) 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52

were read on this motion to/for JUDGMENT - SUMMARY.

I. INTRODUCTION

In this action to recover damages for medical malpractice based on alleged departures from good and accepted medical practice and loss of spousal consortium, the defendants move pursuant to CPLR 3212 for summary judgment dismissing the complaint on the ground that the action was time-barred. The plaintiffs oppose the motion. The motion is granted only to the extent that summary judgment is awarded to the defendants dismissing, as time-barred, the cause of action alleging loss of spousal consortium, and the motion is otherwise denied.

II. FACTUAL BACKGROUND

The crux of the plaintiffs' claims is that, on December 4, 2015, the defendant orthopedic surgeon Elias Kassapidis, M.D., while working for the defendant Riverside Orthopaedic and Sports Medicine Associates, P.C. (Riverside), committed malpractice by improperly performing a left knee replacement surgery on the plaintiff Ilene Ordower (the patient). Specifically, the plaintiffs alleged that Kassapidis placed the implant in an improper position and failed to align the device in an appropriate or anatomically correct position, causing a derangement of the

knee and the need for additional surgeries to remove scarring and relieve both pain, limitation of motion, and issues with the patient's balance on her left side. The plaintiffs further averred that the patient may need to undergo additional surgery to remove and replace the implant at some time in the future..

The patient first presented to Kassapidis on July 28, 2010, complaining of pain to both of her knees after falling, with the pain to her right knee greater than that in her left knee. She was diagnosed with localized osteoarthritis in her lower legs, and chondromalacia of her patella. After several visits with Kassapidis in 2010, the patient also saw Kassapidis on October 21, 2015, and November 24, 2015, complaining of problems with her left knee.

On December 4, 2015, Kassapidis performed a total left knee replacement procedure upon the patient at Lenox Hill Hospital, utilizing a Zimmer artificial knee, which was implanted on the patient's left side, with patellar resurfacing of the left knee. Both the pre-operative and post-operative diagnoses were identified as "left knee degenerative joint disease." In his operative report, Kassapidis explained that the patient's knee was first exsanguinated, and a previously placed tourniquet was thereupon inflated. Kassapidis thereupon reported as follows:

"A standard midline incision of the knee was performed. The incision was extended down to the extensor mechanism. A standard medial parapatellar arthrotomy was performed. A standard medial release was performed. The fat pad was removed. The ACL was cut, and the tibia was subluxed forward. The PCL was removed. The medial meniscus was removed. The lateral meniscus was removed, and the lateral genicular artery was coagulated. With the tibia fully subluxed forward, the tibia was cut according to preoperative plan. The tibial cut was checked for appropriate slope in varus and valgus alignment and deemed to be appropriate.

"Attention was then turned to the femur. The femur was entered using intramedullary drill. Standard distal femoral cut of 5 degrees valgus and 10 mm was performed. The knee was locked into extension, and extension gap was checked and deemed to be appropriate with size 12.5 mm block with varus and valgus stress.

"Attention was then turned to the femur. The femur was sized to be a size 2 femur. Using the 4-in-1 cutting block, the anterior and posterior cuts were performed, and the flexion gap was checked. Flexion gap was deemed to be appropriate. The notch cut was then performed followed by the two chamfer cuts.

“The trial femur was impacted. The tibia was subluxed forward, and the trial tibia was prepared with size 2 tibia. The knee was reduced using a trial polyethylene and checked for stability with extension and flexion deemed to be appropriate. The patella was cut according to preoperative plan and was sized to be a size 35-mm patella. Patellar tracking was checked and deemed to be appropriate. After real components were brought into the field, the trial components were removed. The tourniquet was deflated. Hemostasis was achieved. The knee was exsanguinated, and the tourniquet was re-inflated. The knee was copiously irrigated with joint solution.

“The femur was cemented first followed by the tibia. The real polyethylene was inserted, and the patella was cemented. The wound was copiously irrigated with Betadine solution, joint solution, injected with standard analgesic cocktail. The knee was checked for stability in varus and valgus and flexion and extension were deemed to be appropriate.”

“The knee was then sprayed with the hemostasis fibrin clot product. The arthrotomy was closed with #2 Quilt, the subcutaneous tissue with 0 Quilt. Skin was closed with 3-0 Monoderm. Sterile dressing was applied. X-ray was taken confirming anatomic alignment of the components

The patient was discharged on December 6, 2015.

The patient saw Kassapidis for post-operative visits on December 14, 2015, January 4, 2016, and March 10, 2016. She again saw Kassapidis on June 6, 2016 and June 15, 2016, complaining of left knee pain and feeling a “crunch” upon her extension of the knee.

On June 24, 2016, in light of the patient’s continued post-operative complaints, Kassapidis performed a left knee arthroscopy and debridement. In his operative report, Kassapidis indicated that both the pre-operative and post-operative diagnoses were “patellar clunk syndrome, left knee, status post left knee arthroscopy.” In his description of the indications for the procedure, Kassapidis wrote that

“[t]he patient is an otherwise relatively healthy 70-year-old female who had undergone left knee uncomplicated replacement a few months earlier. The patient developed an anterior clunk with extension, especially going up and down stairs and it had become painful. The patient was told that the underlying condition is known as patellar crunch/clunk syndrome effecting scar formation on the underside of the distal aspect of the quadriceps tendon, she decided to undergo elective left knee arthroscopy for debridement of the scar, which in mind has been highly effective in removing this issue. The patient decided to undergo elective left knee arthroscopy.”

He further described the how the procedure was performed, noting that he

“utilized superior, medial, and lateral portal sites and were able to clearly visualize the offending scar tissue, which was excised thoroughly. At the end of the surgery, the wound was thoroughly irrigated. We closed the wounds with standard nylon sutures and placed the patient in a knee immobilizer to prevent flexion and therefore possibility of suture rupture for the next 48 hours. The patient would follow up with me in 10 days in the office.”

The patient saw Kassapidis again for post-operative visits on June 27, 2016, July 6, 2016, and July 12, 2016, at which she complained of continuing pain in her left knee.

On May 8, 2017, the patient presented to orthopedic surgeon William Schell, M.D., at Lenox Hill Hospital, complaining of right knee pain. Dr. Schell, like Kassapidis, worked for Riverside. Dr. Schell ordered a magnetic resonance imaging scan of the patient’s lower right leg. On May 25, 2017, she presented to orthopedic surgeon Jeffrey Dermksian, M.D., at Lenox Hill Hospital, complaining of left foot pain and problems with balance on her left side. He, too, was employed by Riverside.

The patient next saw Kassapidis on October 23, 2018, and again on November 30, 2018. At the November 30, 2018 visit, Kassapidis performed surgery on the patient at Lenox Hill Hospital, assisted by resident Marcel Bas, M.D., and fellow Shazaan Hushmendi, M.D. Kassapidis’s operative report for this procedure indicated that both the pre-operative and post-operative diagnosis were of left knee synovitis with patellar clunk syndrome. The particular procedure that he performed was described as a “left knee arthroscopic suprapatellar synovectomy.” As Kassapidis himself described the procedure,

“a lateral suprapatellar portal was then utilized visualizing the prior site of her prior synovectomy and those were utilized. Starting with the lateral portal, a sharp incision was made through the skin onto the capsule and through the capsule. At this point in time, the scope was inserted in order to be in the knee joint with visible total knee components and attention was then paid to the suprapatellar pouch.

“Once the overgrowth of synovial tissue at the level of the suprapatellar space, an 18-gauge needle was then utilized to enter some of the medial aspect through the prior incision site. At this point in time, a sharp incision was then made through that same area where the 18-gauge needle was placed and a chamber was then inserted. A thorough synovectomy was then completed at the suprapatellar pouch removing all those overgrown soft tissue growth was then completed successfully without debriding any of the quad tendon itself. The

scope was then moved around to visualize the entirety of the quad tendon as well as for any excess growth and the area was deemed to be free of any adhesions or excessive synovitis. The excess fluid was then removed from the knee and local anesthesia was then applied at the portal site and into the knee joint. At this point in time, nylon 2-0 sutures were then utilized medially and laterally. Xeroform was then utilized as well with a padding with 4x8 followed by Webril followed by Ace bandaging. The patient's extremity was then placed in the knee immobilizer."

The patient saw Kassapidis for several follow-up visits between December 2018 and March 2019.

The plaintiffs commenced this action on August 21, 2019.

III. THE PLAINTIFFS' CONTENTIONS

In their complaint, the plaintiffs alleged that Kassapidis departed from good and accepted medical practice on December 4, 2015 in the course of providing care and treatment to the patient. In their bill of particulars, they alleged that the defendants were negligent "in that during the performance of the knee replacement surgery on or about the 4th of December 2015, utilizing a Zimmer artificial knee, said device was implanted on plaintiff's left side with patellar resurfacing of the left knee with a[n] arthroscopic suprapatellar synovectomy." They asserted that "[t]he implant was placed in an incorrect position," and that Kassapidis "failed to appropriately align said device in the anatomically correct position resulting in a femoral component rotation of 3.2 degrees of internal rotation and the tibial component axis at a 24.8 degree of internal rotation relative to the tibial tubercal. When measured at the tibial component axis it demonstrated 42 degrees of internal rotation relative to the tibial turbanet." The plaintiffs further alleged that the patient

"complained of pain on ambulation in the left knee post operatively continuously through March 2019 and was seen many times from the date of surgery to March 2019. She was arthroscopically scoped but there was a failure to perform a CT scan post operatively while she continued to complain of pain and balance issues."

In addition, the plaintiffs alleged that, as a proximate result of the defendants' negligence, the patient experienced painful popping of her left knee, left foot pain, and dizziness, as well as the

derangement of the left knee, pain on ambulation, imbalance, patellar issues, including component rotation of the left knee, left knee pain upon extended flexion, arthritis of the left knee, chondromalacia of the left patella, arthralgia of the left side of the ankle and foot, and lateral epicondylitis. The averred that the rotation of the femoral and tibial components were improper, and that the problems caused by the December 4, 2015 surgery necessitated a total left knee arthroplasty with component rotation by Kassapidis on June 24, 2016, a left-knee synovectomy on November 30, 2018, which also was performed by Kassapidis, and the potential for the future surgical removal and replacement of the implants, which the patient has already discussed with other orthopedic surgeons.

IV. THE SUMMARY JUDGMENT MOTION

In support of their motion, the defendants submitted the pleadings, the bill of particulars, the transcripts of the parties' depositions, relevant medical and hospital records, an attorney's affirmation, a statement of undisputed material facts, and a memorandum of law. They did not submit an expert affirmation from a physician addressing the issue of whether there was any connection, or lack thereof, between the December 4, 2015 left-knee replacement surgery, and the November 30, 2018 left-knee synovectomy and post-operative visits that the plaintiff had with Kassapidis through March 2019. In opposition, the plaintiffs relied upon the same documentation, and also submitted an attorney's affirmation and a counter statement of material facts. In reply, the defendants submitted an attorney's affirmation and a memorandum of law.

V. SUMMARY JUDGMENT STANDARDS

It is well settled that the movant on 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" (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853 [1985] [citations omitted]). The motion must be supported by evidence in admissible form (*see Zuckerman v City of New York*, 49 NY2d 557, 562 [1980]), as well as the pleadings and other proof such as affidavits, depositions, and written admissions (*see CPLR*

3212). The facts must be viewed in the light most favorable to the non-moving party (see *Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012]). In other words, “[i]n determining whether summary judgment is appropriate, the motion court should draw all reasonable inferences in favor of the nonmoving party and should not pass on issues of credibility” (*Garcia v J.C. Duggan, Inc.*, 180 AD2d 579, 580 [1st Dept 1992]). Once the movant meets his or her burden, it is incumbent upon the non-moving party to establish the existence of material issues of fact (see *Vega v Restani Constr. Corp.*, 18 NY3d at 503). A movant's failure to make a prima facie showing requires denial of the motion, regardless of the sufficiency of the opposing papers (see *id.*; *Medina v Fischer Mills Condo Assn.*, 181 AD3d 448, 449 [1st Dept 2020]).

“The drastic remedy of summary judgment, which deprives a party of his [or her] day in court, should not be granted where there is any doubt as to the existence of triable issues or the issue is even ‘arguable’” (*De Paris v Women's Natl. Republican Club, Inc.*, 148 AD3d 401, 403-404 [1st Dept 2017]; see *Bronx-Lebanon Hosp. Ctr. v Mount Eden Ctr.*, 161 AD2d 480, 480 [1st Dept 1990]). Thus, a moving defendant does not meet his or her burden of affirmatively establishing entitlement to judgment as a matter of law merely by pointing to gaps in the plaintiff's case. He or she must affirmatively demonstrate the merit of his or her defense (see *Koulermos v A.O. Smith Water Prods.*, 137 AD3d 575, 576 [1st Dept 2016]; *Katz v United Synagogue of Conservative Judaism*, 135 AD3d 458, 462 [1st Dept 2016]).

In connection with a motion for summary judgment dismissing a complaint as time-barred, “a defendant must establish, prima facie, that the time within which to sue has expired. Once that showing has been made,” the burden shifts to the plaintiff to raise a triable issue of fact as to “whether the statute of limitations has been tolled, an exception to the limitations period is applicable, or the plaintiff actually commenced the action within the applicable limitations period” (*Flintlock Constr. Servs., LLC v Rubin, Fiorella & Friedman, LLP*, 188 AD3d 530, 531 [1st Dept 2020], quoting *Quinn v McCabe, Collins, McGeough & Fowler, LLP*, 138 AD3d 1085, 1085-1086 [2d Dept 2016]; see *MLB Sub I, LLC v Clark*, 201 AD3d 925, 927 [2d

Dept 2022]; *Murray v Charap*, 150 AD3d 752 [2d Dept 2017]; *Precision Window Sys., Inc. v EMB Contr. Corp.*, 149 AD3d 883, 884 [2d Dept 2017]; *Guzy v New York City*, 129 AD3d 614, 615 [1st Dept 2015]; *Williams v New York City Health & Hosps. Corp.*, 84 AD3d 1358 [2d Dept 2011]; *Rakusin v Miano*, 84 AD3d 1051 [2d Dept 2011]).

The statute of limitations applicable to actions to recover for medical malpractice against a private health-care provider is two years and six months, measured from “the act, omission or failure complained of or last treatment where there is a continuous treatment for the same illness, injury or condition which gave rise to the said act omission or failure” (CPLR 214-a). The “continuous treatment” provision of that statute posits that the limitations period “does not begin to run until the end of the course of treatment when the course of treatment which includes the wrongful acts or omissions has run continuously and is *related to the same original condition or complaint*” (*Nykorchuck v Henriques*, 78 NY2d 255, 258 [1991] [internal quotation marks omitted] [emphasis added]; see *Massie v Crawford*, 78 NY2d 516, 519 [1991]; *McDermott v Torre*, 56 NY2d 399, 405 [1982]; *Borgia v City of New York*, 12 NY2d 151, 155 [1962]; *Jajoute v New York City Health & Hosps. Corp.*, 242 AD2d 674, 676 [1st Dept 1997]).

The Appellate Division, First Department, has not adopted the bright-line rule articulated by the Appellate Division, Second Department, in decisions such as *Sherry v Queens Kidney Ctr.* (117 AD2d 663, 664 [2d Dept 1986]), which holds “that treatment is not considered continuous when the interval between treatments exceeds the period of limitation.” Rather, the First Department has articulated a more nuanced rule that takes account of a “plaintiff’s belief” that he or she “was under the active treatment of defendant at all times, so long as” the treatments did not “result in an appreciable improvement” in the patient’s condition (*Devadas v Niksarli*, 120 AD3d at 1006). Even where a “plaintiff pursued no treatment for over 30 months after” the initial, allegedly negligent surgical treatment (*id.* at 1005),

“[i]n determining whether continuous treatment exists, the focus is on whether the patient believed that further treatment was necessary, and whether he [or she] sought such treatment (see *Rizk v Cohen*, 73 NY2d 98, 104 [1989]). Further, this

Court has suggested that a key to a finding of continuous treatment is whether there is ‘an ongoing relationship of trust and confidence between’ the patient and physician (*Ramirez v Friedman*, 287 AD2d 376, 377 [1st Dept 2001]).

(*id.* at 1006). Where such a situation obtains,

“[c]ases such as *Clayton v Memorial Hosp. for Cancer & Allied Diseases* (58 AD3d 548 [1st Dept 2009]) are inapplicable . . . , to the extent they reiterate that ‘continuous treatment exists “when further treatment is explicitly anticipated by both physician and patient as manifested in the form of a regularly scheduled appointment for the near future, agreed upon during that last visit, in conformance with the periodic appointments which characterized the treatment in the immediate past” (58 AD3d at 549, quoting *Richardson v Orentreich*, 64 NY2d at 898-899)”

(*id.* at 1007).

Applying the First Department’s articulation of the law, as this court must (see *D’Alessandro v Carro*, 123 AD3d 1, 6 [1st Dept 2014]), the court concludes that, although the defendants made the necessary prima facie showing that the patient’s last visit with Kassapidis was more than two years and six months after the allegedly negligent December 4, 2015 surgery, the plaintiffs raised triable issues of fact as to whether the continuous treatment doctrine tolled the limitations period so that their commencement of the action on August 21, 2019 was timely. In this regard, the plaintiffs raised triable issues of fact as to whether (a) the patient continued to make complaints about her left knee to Kassapidis throughout 2016 and to a Riverside employee about her left foot during 2017, (b) the patient sought and received treatment from Kassapidis on June 24, 2016 to address problems arising from the December 4, 2015 left-knee replacement surgery, (c) the patient again sought and received treatment from Kassapidis on November 30, 2018 to address problems arising from the December 4, 2015 left-knee replacement surgery, (d) the patient believed the treatment to be necessary, (e) the treatment rendered by Kassapidis between December 4, 2015 and November 30, 2018 did not result in any appreciable improvement in the patient’s condition, and (f) the patient maintained an ongoing relationship of trust and confidence with Kassapidis by retaining him to perform the left-knee synovectomy on November 30, 2018, and for post-operative consultations up to and

including March 2019, rather than solely to obtain the benefit of the continuous treatment doctrine.

The plaintiffs correctly note that, in the defendants' moving and reply papers, they do not submit the affirmation of an expert opining that the November 30, 2018 synovectomy was unrelated to the complaints of left-knee pain and limitation of motion that were made by the patient shortly after the December 4, 2015 surgery, and continued throughout 2016 and 2017. Since the defendants did not make such a showing with medical evidence, the plaintiffs were not obligated to oppose the motion with medical evidence of their own.

The continuous treatment toll, however, is personal to the patient, and does not apply to toll a spouse's derivative cause of action to recover for loss of consortium (see *Devadas v Niksarli*, 120 AD3d 1000, 1008 [1st Dept 2014]; *Wojnarowski v Cherry*, 184 AD2d 353, 354-355, [1st Dept 1992]). Hence the loss of consortium claim here is time-barred.

V. CONCLUSION

In light of the foregoing, it is

ORDERED that the defendants' motion is granted only to the extent that they are awarded summary judgment dismissing the cause of action to recover for loss of spousal consortium, that cause of action is dismissed, and the motion is otherwise denied; and it is further,

ORDERED that the parties shall appear for a pretrial conference on June 13, 2023, at 9:00 a.m.

This constitutes the Decision and Order of the court.



JOHN J. KELLEY, J.S.C.

4/25/2023
DATE

CHECK ONE:	<input type="checkbox"/> CASE DISPOSED	<input checked="" type="checkbox"/> NON-FINAL DISPOSITION
	<input type="checkbox"/> GRANTED	<input checked="" type="checkbox"/> GRANTED IN PART
	<input type="checkbox"/> DENIED	<input type="checkbox"/> OTHER
APPLICATION:	<input type="checkbox"/> SETTLE ORDER	<input type="checkbox"/> SUBMIT ORDER
CHECK IF APPROPRIATE:	<input type="checkbox"/> INCLUDES TRANSFER/REASSIGN	<input type="checkbox"/> FIDUCIARY APPOINTMENT
		<input type="checkbox"/> REFERENCE