Alzona v Kaplan
2012 NY Slip Op 32815(U)
November 20, 2012
Supreme Court, Suffolk County
Docket Number: 10-45291
Judge: Ralph T. Gazzillo
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SHORT FORM ORDER

INDEX No. 10-45291
CAL. No. 12-00622MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 6 - SUFFOLK COUNTY

PRESENT:

Hon. RALPH T. GAZZILLO
Acting Justice of the Supreme Court

MOTION DATE 6-29-12
ADJ. DATE 10-4-12
Mot. Seq. # 001 - MotD

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JESSICA ALZONA, an infant by her father and natural guardian, ROMEO ALZONA,

Plaintiffs,

- against -

CARL PHILIP KAPLAN, M.D.,

Defendant.

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Upon the following papers numbered 1 to 20 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1 - 14; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers 18-20; Replying Affidavits and supporting papers 15-17; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (001) by the defendant, Carl Philip Kaplan, M.D., for summary judgment dismissing the complaint is denied, or in the alternative, precluding the defendant from presenting testimony on the issue of possible future infertility and/or bowel obstruction and/or future damages, and/or striking the plaintiff's bill of particulars with regard to those issues, is granted

In this action for medical malpractice, the plaintiff, Romeo Alzona, on behalf his infant daughter, Jessica Alzona, asserts that defendant Carl Philip Kaplan, M.D. negligently departed from good and accepted standards of medical care and practice in failing to timely diagnose the infant for appendicitis, and caused a delay in her care and treatment. A cause of action for lack of informed consent has also been pleaded, in addition to a derivative claim. As a result of the alleged malpractice, it is claimed that the infant developed a perforated appendix, intra-abdominal abscess requiring drainage and treatment and prolonged hospitalization and that the infant plaintiff has been placed at an increased risk for bowel obstruction, fertility problems, and persistent abdominal complaints.

Carl Philip Kaplan, M.D. seeks summary judgment dismissing the complaint on the bases that he did not depart from good and accepted standards of medical care and treatment, and that there were no acts or omissions by him which proximately caused the alleged injuries claimed by the plaintiff, as the diagnosis of appendicitis was not indicated by the medical evidence and circumstances present on June 10, 2009; an appendectomy would have had to be performed in any case; and any increased damages were caused by the appendicitis and are unsupported by admissible evidence.

The proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case. To grant summary judgment it must clearly appear that no material and triable issue of fact is presented (***Friends of Animals v Associated Fur Mfrs.,*** 46 NY2d 1065, 416 NYS2d 790 [1979]; ***Sillman v Twentieth Century-Fox Film Corporation***, 3 NY2d 395, 165 NYS2d 498 [1957]). The movant has the initial burden of proving entitlement to summary judgment (***Winegrad v N.Y.U. Medical Center***, 64 NY2d 851, 487 NYS2d 316 [1985]). Failure to make such a showing requires denial of the motion, regardless of the sufficiency of the opposing papers (***Winegrad v N.Y.U. Medical Center***, *supra*). Once such proof has been offered, the burden then shifts to the opposing party, who, in order to defeat the motion for summary judgment, must proffer evidence in admissible form...and must "show facts sufficient to require a trial of any issue of fact" (CPLR 3212[b]; ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]). The opposing party must assemble, lay bare and reveal his proof in order to establish that the matters set forth in his pleadings are real and capable of being established (***Castro v Liberty Bus Co.,*** 79 AD2d 1014, 435 NYS2d 340 [2d Dept 1981]).

In support of this application, the moving defendant has submitted, inter alia, an attorney's affirmation; copies of the summons and complaint, defendant's answer, plaintiffs' verified bill of particulars; copies of the examinations before trial of Jessica Alzona, Beatrice Alzona, and Romeo Alzona, each dated September 30, 2011; Carl Philip Kaplan, M.D. dated November 14, 2011; the infant's pediatric records maintained by Dr. Kaplan, and hospital records from Stony Brook University Hospital; and the affidavit of defendant's expert physician, Nikhil B. Shah, M.D.

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]).

Nikhil B. Shah, M.D. averred that he is a physician licensed to practice medicine in New York and is board certified in pediatrics and pediatric emergency medicine. He set forth his education and training and experience in pediatrics, and the records and materials reviewed in basing his opinions. Dr. Shah opined with a reasonable degree of medical certainty that defendant Dr. Kaplan did not depart from good and accepted standards of medical or pediatric practice, and that no treatment by Dr. Kaplan caused or contributed to any claimed injuries or damages that the infant plaintiff may have suffered.

Dr. Shah set forth that the infant plaintiff was born on October 31, 1997. On June 9, 2009, she felt ill and was picked up from school by her father. The following day, June 10, 2009, she still felt ill and was taken by her parents to Stony Brook Hospital emergency room, where she was seen by the defendant Dr. Kaplan. She testified that she told Dr. Kaplan that her lower abdomen, especially on the right, hurt when he pressed on it and when he stopped pressing, and that she had nausea, but no vomiting, ear pain, or throat pain. She was having problems with urinary burning. Dr. Kaplan's note indicated that she had a one day history of abdominal pain, dysuria (pain with urination), headache, no nausea, but that she vomited the day prior. A strep test was

performed as she had pharyngeal erythema (redness at the back of the throat). He also found that there was abdominal tenderness in both right and left lower quadrants, with no rebound tenderness, and the Psoas, Obturator and Rovsings's signs were negative, which, if positive, indicate that appendicitis may be present. Dr. Shah stated that Dr. Kaplan testified that although these signs were negative, it did not rule out the possibility of appendicitis. He continued that the lack of a significant number of white blood cells and nitrites in the urinalysis is indicative that urinary tract infection is unlikely. Dr. Kaplan's discharge diagnosis on June 10, 2009 at 11:15 a.m. was abdominal pain and strep pharyngitis. Amoxicillin, effective against strep and urinary tract infections, was ordered. Ibuprofen for abdominal and headache pain was suggested. She was instructed to seek other medical help or to return to the emergency room if she felt worse.

Dr. Shah continued that no further care and treatment was sought on June 10, 2009 after the infant plaintiff was discharged from the emergency room. The infant's pain increased slowly and steadily in the same area of her abdomen throughout the day, evening, and night, accompanied with urinary burning, nausea, and vomiting, as well as difficulty walking. That afternoon, Beatrice Alzona, the infant plaintiff's mother, took her to her see Dr. Rubin, her pediatrician, who then referred her back to the emergency room at Stony Brook. An abdominal ultrasound was conducted, followed by a CT scan, after which she was advised that she had a ruptured appendix. The infant plaintiff was then seen by Dr. Thomas Lee, the attending pediatric surgeon, and by the pediatric surgery resident, who both agreed that the infant had a ruptured appendix. The treatment planned by Dr. Lee was for intravenous antibiotic administration, and laparoscopic appendectomy the following day on June 12, 2009. Dr. Shah indicated that Dr. Lee's note documented that the risks and benefits of the proposed surgery were described to the child's parents, who testified that they were not apprised of the same, but then stated they were apprised of a possible blockage and that she might not be able to have children. Dr. Shah further set forth that the medical record does not set forth the risks and benefits with specificity, nor is there a mention of possible complications from surgery, such as the specific risks of infertility or bowel obstruction.

Dr. Shah continued that postoperatively, the infant plaintiff had a delayed return to bowel function and was treated with nasogastric suction for several days. A CT of the abdomen, taken on June 21, 2009, showed abdominal abscesses which were treated by a CT guided interventional radiology drainage of the abdominal fluid through a small (½ inch) abdominal incision on June 22, 2009, resolving the abscesses. At the time of her deposition, the infant plaintiff testified that she was in the ninth grade, and participated in a marching band, soccer, and gym with no pain or restrictions. No medical care has been sought for the infant plaintiff to determine any condition associated with infertility or bowel obstruction.

Dr. Shah opined that Dr. Kaplan conformed to the appropriate standard of care for the specialty of pediatric emergency medicine and the clinical situation presented by the infant plaintiff. He continued that Dr. Kaplan obtained an adequate history, conducted an examination of her throat and abdomen, conducted appropriate testing, and recorded his findings, which confirmed a positive rapid strep throat culture, negative urinalysis, and little or no support for a finding of appendicitis on June 10, 2009, despite examination for specific signs of appendicitis. Differential diagnoses were set forth as strep pharyngitis with non-specific abdominal pain. Dr. Shah set forth the bases for the opinions rendered and stated that both clinical and laboratory evidence present in the emergency room on June 10, 2009 indicated that Dr. Kaplan exercised reasonable judgment in placing appendicitis as a very unlikely diagnosis on his list of differential diagnoses, making his treating diagnosis as most likely correct. Based upon the circumstances, given the clinical and lab findings confirming strep pharyngitis, making appendicitis unlikely, the use of ionizing radiation imaging techniques was not indicated on June 10, 2009, as it would have exposed the child to a significant dose of radiation, especially in a preadolescent female, for whom radiation could be particularly harmful and should not

be used without strong clinical indications for its use. Such indication did not exist on June 10, 2009, opined Dr. Shah. However, on June 11, 2009, when there were positive signs consistent with appendicitis, including significant fever, rebound tenderness, and positive Rovsing's sign, a basis supporting the use of CT scan imaging was indicated, which use outweighed the risks.

Dr. Shah also opined that despite the infant's parents acknowledging an understanding of the discharge instructions given by Dr. Kaplan, to follow up with her doctor or return to the emergency room, the parents did not seek medical attention for their daughter for more than twenty-four hours, despite her increasing pain. Had she been returned to the emergency room prior to the rupture of her appendicitis, she would have had a faster recovery, less pain, and a shorter hospital stay. An appendectomy would have been needed in any event. Dr. Shah further opined that it was Dr. Lee's choice of surgery which was a significant factor in causing the complications claimed by the infant plaintiff, as Dr. Lee's surgical choices were made independent of the time the diagnosis of appendicitis was made, and independent of whether the appendix had ruptured. Additionally, Dr. Shah opined that there is no reasonable degree of medical certainty, and the plaintiff cannot prove with the available evidence, when the child's appendix ruptured. He continued that the evidence of the location of the retrocecal abscess, as noted in Dr. Lee's operative report, effectively masked any reasonable possibility of its diagnosis on June 10, 2009. Thus, plaintiffs' claim that the child suffered increased or extraordinary damages as a result of her appendix rupturing after she was seen by Dr. Kaplan on June 10, 2009, remains unsupported by admissible evidence. Moreover, the plaintiff's claims of damages proximately caused by the rupture of the appendix after the child was seen by Dr. Kaplan is unsupported. As related to claims of potential infertility and bowel obstruction, Dr. Lee's operative report is silent on the description of the child's pelvic organs during surgery, and there has been no subsequent testing, imaging study, or direct visualization to determine the status of her pelvic organs. Dr. Shah continued that there is no evidence to demonstrate such damages which are only speculative, frivolous, and unproven. Additionally, opined Dr. Shah, studies indicate that potential infertility in a female patient with a ruptured appendix is not more common than in those patients who had never had a ruptured appendix.

Based upon a review of the evidentiary submissions and the expert opinions expressed by Dr. Shah, it is determined that defendant Kaplan has demonstrated prima facie entitlement to summary judgment dismissing the complaint.

To rebut a prima facie showing of entitlement to an order granting summary judgment by the defendant, the plaintiff must demonstrate the existence of a triable issue of fact by submitting an expert's affidavit of merit attesting to a deviation or departure from accepted practice, and containing an opinion that the defendant's acts or omissions were a competent-producing cause of the injuries of the plaintiff (*see* ***Lifshitz v Beth Israel Med. Ctr-Kings Highway Div.***, 7 AD3d 759, 776 NYS2d 907 [2d Dept 2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.***, 242 AD2d 282, 660 NYS2d 739 [2d Dept 1997]). Here, the plaintiffs have opposed this motion by submitting an affirmation by their expert physician.[1] Although the defendant opposes this affirmation on a CPLR 3101 (d) discovery basis, this court considers the plaintiffs' expert's affirmation.

The plaintiffs' expert, a physician licensed to practice medicine in New York and board certified in pediatrics, set forth his experience and the records and materials reviewed in rendering his opinion, which he set

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[1]The Court has conducted an in-camera inspection of the original unredacted affirmation and finds it to be identical in every way to the redacted affirmation in plaintiffs' opposition papers with the exception of the redacted expert's name. In addition, the Court has returned the unredacted affirmation to the plaintiff's attorney.

forth with a reasonable degree of medical certainty. He set forth a description of the appendix and defined appendicitis as a swelling or inflammation of the appendix wherein, when blocked, traps bacteria and irritates the appendix. He set forth the symptoms of appendicitis, which he stated can vary, but generally include localized right sided/lower quadrant abdominal pain, nausea, loss of appetite, vomiting, elevated white blood count, and low fever. There may be atypical localization of pain due to the anatomic position of the appendix. Usually, if there is no complication such as perforation, the appendix can be removed by a surgeon soon after it is diagnosed. If appendicitis continues without treatment, it can rupture or perforate, spilling bacteria-laden intestinal contents into the abdominal cavity, causing peritonitis or a pus-filled pocket of infection (abscess) to form.

The plaintiffs' expert stated that appendicitis should be considered as a differential diagnosis in every patient with abdominal pain, nausea and vomiting, especially in children who may have an atypical presentation. The plaintiffs' expert continued that a primary responsibility of the emergency room physician in this respect is to keep appendicitis in the differential until it is ruled out. Rebound tenderness and guarding are to be considered upon examination of the abdomen, as well as evaluating the Psoas sign upon flexion of the hip, the Obturator sign upon rotating the hip, or Rovsing's sign wherein there is pain on the right side when pressing on the left side of the abdomen. He continued that these are valuable indicators of inflammation, but not all patients have these signs. Therefore, they have a low predictive value, and their absence does not rule out appendicitis. He stated that laboratory tests, a high white blood cell count, blood chemistries, and urinalysis should be considered and evaluated. Anorexia is often found early in the evolution of an appendicitis. He continued that a normal temperature and white blood cell count do not rule out appendicitis, and a positive pharyngeal strep test may be coincidental, but is not found with appendicitis.

The plaintiffs' expert continued that due to the ionizing radiation exposure with CT scan, abdominal ultrasound is the first imaging study of choice in children, and is 75% to 90% sensitive for the diagnosis of appendicitis. Surgical consultation is required if appendicitis is not ruled out by clinical examination. The plaintiffs' expert continued that when the surgeon diagnoses appendicitis, surgery is to be performed as soon as possible in an attempt to remove the appendix before it ruptures to prevent a much more severe illness, prolonged antibiotic treatment, and prolonged recovery. If the appendix has already ruptured, surgery can be delayed for a number of hours to allow for the administration of antibiotics and intravenous fluids.

The plaintiffs' expert opined that when Dr. Kaplan obtained the results of the urinalysis, he determined that a urinary tract infection was unlikely, but should he should have then looked elsewhere for the origin of the child's abdominal complaints. He continued that the large amount of ketones in the urine required further investigation; that strep throat does not cause diffuse abdominal tenderness on palpation, as had been noted during the child's examination by Dr. Kaplan; and that Dr. Kaplan did not order complete blood count, imaging tests, or a surgical consult prior to discharging her from the emergency room, and did not obtain a complete history as he did not note that the child had anorexia. The plaintiffs' expert opined that these aforementioned failures were departures from good and accepted standards of medical care and treatment by Dr. Kaplan. He continued that these departures from the standard of care delayed the timely diagnosis of appendicitis prior to the appendix rupturing, the development of an abscess, the need for CT guided drainage of fluid collection, and the need for a prolonged hospitalization that the child suffered, as well as an increased likelihood of infertility due to resultant scar tissue formation. The plaintiffs' expert further opined that it was departure from the standard of care by Dr. Kaplan not to rule out appendicitis prior to the discharge of the child after he evaluated her, thus preventing a timely diagnosis of the child's condition.

The plaintiff's expert continued that when the child was seen the following day by Dr. Rubin, she had diffuse abdominal tenderness and severe guarding, indicative of a rupture occurring between her emergency room visit with Dr. Kaplan and her visit with Dr. Rubin. She was sent by Dr. Rubin to the emergency room at Stony Brook due to increasingly severe pain, diarrhea and vomiting, and dysuria. Her temperature increased from 100 the day before, to 103.7, which the plaintiffs' expert stated is further indicative that the appendix ruptured between the emergency room visit with Dr. Kaplan and the visit with Dr. Rubin. Upon arrival at Stony Brook, the abdominal ultrasound did not identify a definitive distended appendix, but did show an "unusual tubular right lower quadrant structure." A CT scan was then performed with findings consistent with acute appendicitis and the child was admitted by Dr. Lee with a possible perforated appendix. Dr. Lee then performed a laparoscopic appendectomy the following day. The plaintiffs' expert stated that Dr. Lee found purulent fluid in the pelvis which was drained, and the appendix was noted to be retrocecal and was removed. He continued that the pathology report indicated a perforated acute appendicitis and periappendicitis with transmural necrosis. Several days later, she underwent a CT guided drainage of the collection of fluid, resolving her pain which continued postoperatively.

Based upon the foregoing, there are conflicting opinions presented by the plaintiffs' and defendant's experts concerning whether or not Dr. Kaplan departed from good and accepted standards of care in treating the child on June 10, 2009; when the appendix actually ruptured; whether the alleged injuries were proximately caused by the alleged delay by Dr. Kaplan in diagnosing appendicitis, or in its timely removal; and whether there was delay by the treating surgeon Dr. Lee who did not remove the appendix until June 12, 2009, after having diagnosed appendicitis on June 11, 2009. Thus, summary judgment is denied with respect to that part of application (001). With respect to that part of the defendant's application relative to the plaintiffs' allegations of damages on the issue of possible future infertility and/or bowel obstruction and/or future damages, it is determined that the plaintiffs' expert, except for his conclusory and unsupported opinion that the child suffered an increased likelihood of infertility due to resultant scar tissue formation, has not offered any evidentiary proof or bases for such opinion. Thus, partial summary judgment striking the plaintiff's bill of particulars with regard to those issues of possible future infertility and/or bowel obstruction and/or future damages is granted, and are struck from the plaintiffs' bill of particulars.

Dated: 11/20/12

A.J.S.C.

____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION