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SHORT FORM ORDER

COPY

INDEX No. 10-8214
CAL No. 12-02317MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 39 - SUFFOLK COUNTY

PRESENT:

Hon. DENISE F. MOLIA
Acting Justice of the Supreme Court

MOTION DATE 3-7-13 (#002)
MOTION DATE 4-19-13 (#003)
ADJ. DATE 10-25-13
Mot. Seq. # 002 - MG
003 - MG; CASEDISP

ALLISON PEPP,

Plaintiff,

- against -

ALISON D. SILHANEK, DPM, FACFAS, MARK J. ZUCKERMAN, MD, DPN, TOTAL FOOT CARE, P.C. and TOTAL FOOT CARE GROUP,

Defendants.

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Upon the following papers numbered 1 to 33 read on these motions for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers (002) 1-18; (003) 19-33; Notice of Cross Motion and supporting papers _; Answering Affidavits and supporting papers _; Replying Affidavits and supporting papers _; Other _; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that motion (002) by defendant Mark J. Zuckerman, M.D. pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against him is granted; and it is further

ORDERED that motion (003) by defendants Alison D. Silhanek, DPM, FACFAS, Total Foot Care, P.C. and Total Foot Care Group pursuant to CPLR 3212 for summary judgment dismissing the complaint as asserted against them is granted.

In this medical malpractice action, the plaintiff, Allison Pepp, asserts that the defendants negligently departed from good and accepted standards of medical and podiatric care and treatment, and failed to provide her with proper informed consent. The plaintiff came under the podiatric care and treatment of defendants Alison D. Silhanek, DPM, Total Foot Care, P.C. and Total Foot Care Groups (collectively referred to as Total Foot Care) from on or about December 1, 2007 to on or about October 9, 2008. Dr. Silhanek performed an

Austin bunionectomy with screw fixation on the plaintiff's right foot on December 21, 2007. Post-operatively, the plaintiff developed itching of her right foot, then mild edema, and mild guarding with range of motion of the right great toe, for which she was referred for physical therapy, followed by a referral to Dr. Vaillancourt, a neurologist, with whom the plaintiff did not obtain an appointment. It is alleged that Total Foot Care failed to properly diagnose plaintiff's post-operative condition, failed to properly treat it, and failed to promptly refer her to a specialist. The plaintiff came under the care and treatment of defendant Mark Zuckerman, M.D., a neurologist, on or about February 8, 2008 to on or about November 4, 2008. Due to pain, burning, stiffness, and swelling in her toes, the plaintiff was prescribed Neurontin and Pamelor. It is alleged that defendant Zuckerman failed to treat the plaintiff in a timely manner, failed to order appropriate testing, failed to timely surgically intervene with appropriate lumbar sympathetic blocks, and failed to refer her to a pain management specialist. The plaintiff alleges that as a result of the defendants' negligence, she developed complex regional pain syndrome (CPRS) in the right lower extremity with associated discoloration, burning sensation, chronic pain, difficulty standing and running. She further claims that she is now unable to work, had to undergo lumbar sympathetic blocks and epidural venograms, and take medications.

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 (***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 motion (002), Dr. Zuckerman has submitted, inter alia, an attorney's affirmation; copies of the pleadings and answers, bill of particulars, supplement and second supplement bills of particulars; copies of various uncertified medical records which are not in admissible form; copies of the transcripts of the examinations before trial of Allison Pepp dated November 28, 2011 which is not signed but is certified and not objected to (*see* ***Zalot v Zieba***, 81 AD3d 935, 917 NYS2d 285 [2d Dept 2011]), Alison Silhanek dated April 24, 2012[1], and Mark Zuckerman dated June 21, 2012 which is deemed adopted as accurate by him (*see* ***Ashif v Won Ok Lee,*** 57 AD3d 700, 868 NYS2d 906 [2d Dept 2008]); and the affirmation of the defendants' expert, Joseph S. Jeret, M.D.

Motion (003) by the Total Foot Care defendants is support by, inter alia, an attorney's affirmation; copies of the summons and complaint, defendants' answers, and plaintiff's verified bill of particulars; transcripts of the examinations before trial of Allison Pepp dated November 28, 2011, Alison Silhanek dated April 24, 2012, Mark Zuckerman dated June 21, 2012; photographs; the affidavits of the moving defendants' experts Harvey Strauss, DPM. and Jay M. Coblentz, M.D.; and uncertified medical records.

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[1]While the transcript is not signed, it is noted that Dr. Silhanek has submitted a signed copy with her moving papers.

Uncertified medical records are not in admissible form pursuant to CPLR 3212 and 4518 (*see* ***Friends of Animals v Associated Fur Mfrs.***, *supra*). Expert testimony is limited to facts in evidence (***Allen v Uh,*** 82 AD3d 1025, 919 NYS2d 179 [2d Dept 2011]; ***Marzuillo v Isom***, 277 AD2d 362, 716 NYS2d 98 [2d Dept 2000]; ***Stringile v Rothman***, 142 AD2d 637, 530 NYS2d 838 [2d Dept 1988]; ***O'Shea v Sarro***, 106 AD2d 435, 482 NYS2d 529 [2d Dept 1984]; ***Hornbrook v Peak Resorts, Inc.*** 194 Misc2d 273, 754 NYS2d 132 [Sup Ct, Tomkins County 2002]).

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[1998], *app denied* 92 NY2d 818, 685 NYS2d 420). 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***, 221 AD2d 674, 638 NYS2d 700 [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 [1998], *app denied* 92 NY2d 814, 681 NYS2d 475; ***Bloom v City of New York***, 202 AD2d 465, 465, 609 NYS2d 45 [1994]).

To rebut a prima facie showing of entitlement to an order granting summary judgment by defendants, 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 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 [2004]; ***Domaradzki v Glen Cove OB/GYN Assocs.,*** 242 AD2d 282, 660 NYS2d 739 [1997]).

"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" (***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 853, 487 NYS2d 316 [1985]; ***Toomey v Adirondack Surgical Assoc.***, 280 AD2d 754, 755, 720 NYS2d 229 [3d Dept 2001][citations omitted]; ***Machac v Anderson***, 261 AD2d 811, 812-813, 690 NYS2d 762 [3d Dept 1999]).

Allison Pepp testified to the extent that sometime in 2004, she saw Dr. LaRocca for complaints of pain in her right bunion which affected her ability to wear any type of footwear and to walk distances. Anti-inflammatories were prescribed. Thereafter, in 2007, she saw Dr. Locastro for a very painful right bunion, pain in her big toe, side of her foot, and the joint "where the big toe moves." There was also a bump on the side of her foot where the bone stuck out by her big toe. Dr. Locastro administered a cortisone injection to her foot. She signed consent for a bunionectomy on November 21, 2007 with Dr. Locastro, but she did not return to him for the surgery.

The plaintiff continued that from August 2006 until December 20, 2007 she worked for InGenious Targeting Labs screening stem cells for a genetic mutation or difference, which required both standing and sitting. She was on her feet a lot, and the right bunion was painful and affected her ability to be on her feet at work. She then presented to Dr. Silhanek for the pain in her right foot. She described the foot as having a normal color with a bump by her right great toe. Dr. Silhanek recommended surgery and explained to her how it would be corrected and what the surgery would entail. The plaintiff explained that an incision would be made

on the top of her foot, the bump on the side would be shaved off, a bone that leads to her big toe would be broken so it could be realigned, and a screw would be inserted. She stated that X-rays were taken. Dr. Silhanek drew a diagram for her demonstrating the cut and screw. She was told she would use crutches for two to three days and be out of work for two weeks. The plaintiff read the consent document presented to her by Dr. Silhanek and signed it. The plaintiff testified that her boyfriend, Jeff Bell, was present with her and discussed the procedure with Dr. Silhanek.

The plaintiff continued that on December 21, 2007, the surgery for the painful bunion on her right foot was performed by Dr. Alison Silhanek at St. Catherine of Siena Hospital. Dr. Silhanek met with her just before surgery, marked the foot, and they engaged in a very brief discussion. After the surgery, she was discharged home. Two days later she spoke with Dr. Silhanek because she felt like she had bugs crawling on her foot. She was instructed to come to the office where she was seen by Dr. Bodamer, who changed the dressing. She stated she was having a lot of pain, and if she did not keep her foot elevated, that it felt as though it would explode. She described that the front of her foot, including her toes, had a "swollen feeling" when she saw Dr. Silhanek after surgery, and she still felt bugs crawling and burning. She had five to ten post-operative visits with Dr. Silhanek, during which time her foot was not getting better. She first observed her foot in January. It had a purplish hue from the toes down, there was a big incision, and it was very swollen. She still had pain, burning, and the feeling that bugs were crawling on her foot. She was referred by Dr. Silhanek for physical therapy as the joint at the big toe was stiff, and stated that the physical therapy, which she had about three times a week for six months, did not help. The plaintiff continued that she obtained a second opinion with Dr. Laieta who x-rayed and examined her foot. Dr. Laieta did not mention the possibility of complex regional pain syndrome to her and did not recommend any treatment except orthotics. Dr. Silhanek referred her to Dr. Zuckerman, a neurologist, about six or seven weeks after surgery, so that she could be evaluated for complex regional pain syndrome.

The plaintiff testified that when she saw Dr. Zuckerman, she had swelling, pain, burning, and a purplish hue in her right foot. She stated that he told her that he believed she had complex regional pain syndrome and prescribed Neurontin and Pamelor to lessen the burning and pain. She could not remember if the Neurontin helped. She saw Dr. Zuckerman about five to ten times. At her second visit with him, Dr. Zuckerman referred her to Dr. Groth for pain management, whom she saw in March 2008, and was treated with lumbar sympathetic nerve blocks and an epidural injection. She was also prescribed Cymbalta and Percocet. She had been taking Nortriptyline and Amitriptyline, but both were discontinued due to side effects. She had an EMG of both feet and both hands. She stopped taking her prescription medications on her own and now takes Tylenol or Advil when needed.

Dr. Alison Silhanek testified to the extent that in December 2007, was licensed to practice podiatry in New York State and was affiliated with St. Catherine of Siena Hospital as an attending physician. She was with Total Foot Care Group, a professional corporation. She testified that the plaintiff first presented to her office on December 1, 2007 with a bunion on her right foot, arch pain, and pain on the top of her foot that had resolved, and pain in her heel. Her symptoms had become progressively worse over two years, even when she was barefoot. Dr. Silhanek testified that she was advised that Dr. Locastro had seen her and recommended accommodative shoes, administered a cortisone shot, and prescribed anti-inflammatories. She discussed her first examination of the plaintiff, and took x-rays to evaluate the bunion deformity. She noted the plaintiff had mild to moderate increased IM (intermetatarsal) and HA (hallus abductus) angles, with no portable destructions. Joint spaces were grossly intact. She testified that she did not remember whether she measured the IM and the HA angles. Because the plaintiff had exhausted conservative measures with Dr. Locastro, she recommended an Austin bunionectomy with full pre-operative evaluation in two weeks if she desired to have the surgery done.

She also advised the plaintiff to purchase firm, over-the-counter arch supports to be worn in supportive shoe gear at all times for her plantar fascia symptoms. If that did not improve her symptoms, casting for custom orthotics would be considered. She continued that the risks of the Austin bunionectomy surgery are pain, swelling, infection, recurrence of the deformity, and failure of the surgery to eliminate pain. She felt this procedure would adequately correct the plaintiff's bunion, so she did not discuss other techniques with the plaintiff.

Dr. Silhanek testified that the plaintiff elected to have the surgery. On December 13, 2007, she provided a full pre-op evaluation, the perioperative and postoperative course of the procedure, the risks, benefits and possible complications to the plaintiff. She reviewed written and pictorial consents, dispensed postoperative anti-inflammatory and pain prescriptions, and a bandage cover for showering. On December 21, 2007, the surgery was performed under intravenous sedation with local anesthesia. When she performed the Austin bunionectomy, she considered K-wires instead of screws, but used the screws to obtain greater compression of the osteomtomy. Because the screws are buried and do not penetrate the skin, they cause less edema and pain following the surgery. The benefit to using a K-wire is that it is removed.

Dr. Silhanek reviewed the surgical procedure performed on the plaintiff's right foot and used an x-ray taken pre-operatively to evaluate the bony anatomy that she might not be able to see intra-operatively. Her goal was to translocate the head of the first metatarsal, such that it would be sitting directly back over the sesamoid bone, which she evaluated visually intra-operatively. She stated that typically, a 60 degree Austin bunionectomy is made, but she made the angle 55 degrees to create a longer dorsal arm, such that it can accommodate the screw fixation. She provided the plaintiff with written post-operative instructions, including minimal weight bearing, elevating the foot above the level of the heart, keeping the bandage dry, not removing the dressing, and while sleeping, to stay in the post-operative surgical shoe dispensed by the hospital. She continued that on December 24, 2007, Dr. Bodamer from her office saw the plaintiff for a rash on her arm. She saw the plaintiff for a visit on January 3, 2008, relating to complaints of itching in her foot. The rash was gone. She noted minimal diffuse edema of the right forefoot, as expected. The incision was completely healed without erythema. The first MPJ was in excellent position and alignment, with good range of motion determined manually. X-rays were taken. The plaintiff was restricted as to everything except limited walking and driving, only as absolutely necessary.

Dr. Silhanek testified that on the visit of January 19, 2008, she noted stiffness with mild guarding with range of motion when she tried to move the plaintiff's toe manually. The plaintiff complained of pain at the area of the surgery on the foot if it was in a dependent position for too long. There was no discoloration of the foot. She told the plaintiff that she could attempt to use a sneaker, however, the plaintiff stated that it was too sensitive for her, so she wrapped the forefoot with a compressive dressing to counteract swelling with use of the surgical shoe, which the plaintiff was to continue using. On January 24, 2009, the plaintiff was wearing slippers when she came into the office. Upon examination, stiffness of the toe was noted at the right MPJ, so the plaintiff was referred to physical therapy as the stiffness made it difficult for her to wear shoes. The plaintiff was reluctant to perform any passive range of motion exercises previously recommended because she had pain. The plaintiff advised her on January 30 and 31, 2008 that she was having difficulty going to work and had not put on a sneaker. She had increased pain when the physical therapist attempted to increase the range of motion, and the day after could barely walk. She recommended that the plaintiff have physical therapy three times a week and continue range of motion exercises at home.

Dr. Silhanek continued that she had spoken with the plaintiff on February 4, 2008, and her note indicated that there was no bony block on any attempt of range of motion. There was minimal edema and no evidence of

tingling, numbness, or burning symptoms. She felt that any chance for any type of CRPS (Complex Regional Pain Syndrome a/k/a RDS) Type I was of minimal suspicion. CRPS is characterized by an inciting trauma with pain out of proportion, swelling and often vasomotor changes. She saw the plaintiff on February 6, 2008 as she continued to have pain with physical therapy. She noted very mild, very diffuse edema of the right foot as compared to the left. The incision was completely healed. There was significant stiffness of range of motion of the right first MPJ. The plaintiff complained of worsening pain. No discoloration of the foot was noted. Upon x-ray examination of the operative site, no problem with the osteotomy site was noted to account for the plaintiff's pain. Because the plaintiff's complaints of pain were out of proportion and increased with physical therapy and home exercises, and due to the lack of improvement in the stiffness of the MPJ, she advised the plaintiff that she would like her to be seen by a neurologist, Dr. Vaillancourt, to rule out CRPS. The plaintiff was further instructed to stay in the surgical shoe and restrict her activity, but continue physical therapy. The plaintiff called her on February 7, 2008, advising that Dr. Vaillancourt could not see her until March 7, 2008. Dr. Silhanek then contacted Dr. Mark Zuckerman by phone on that date, discussed the plaintiff's procedural history, and her suspicion of CRPS as a possible diagnosis.

Dr. Silhanek stated that the plaintiff contacted her on February 9, 2008, advising that she had seen Dr. Zuckerman who started her on pain medication, advised her to continue physical therapy, and told her that her course was suspicious for CRPS. When she saw the plaintiff on February 16, 2008, there was minimal edema present which was improved since her last visit. The plaintiff demonstrated a significant restriction of first MPJ range of motion, however, the range of motion was more supple and flexible than on previous visits. The plaintiff was not complaining of pain upon gentle range of motion. Dr. Silhanek recommended continued follow up with Dr. Zuckerman and continued physical therapy, and discussed shoe gear with her. Since the plaintiff was going on vacation, she recommended that the plaintiff restrict walking as tolerated, stay in a support sneaker, and if a sandal is worn, to make sure it is as stable as possible. On March 15, 2008, the plaintiff, upon examination, was noted to have greater range of motion of the first MPJ than on the last visit, there was no pain with range of motion, and edema was minimal. Dr. Silhanek testified that on March 15, 2008, she was not managing the care of the CRPS in any way, and that the plaintiff was being follow by a neurologist and pain management. At the April 19, 2008 office visit, there was increased range of motion of the first MPJ. It was supple without crepitus and there was soft-end range of motion, with 30 degrees dorsiflexion and 10 degrees plantar flexion from a neutral position. Dr. Silhanek stated that normal dorsiflexion is 60 degrees and normal plantar flexion is 20 degrees. Physical therapy was continued. Dr. Zuckerman had prescribed Neurontin and Pamelor. On June 5, 2008, the plaintiff demonstrated greater, and non-painful, range of motion. Limited range of motion was still present, but improved. On October 9, 2008, there was no edema noted. There was excellent and nonpainful range of motion of the right first MPJ. Dr. Silhanek stated that she did not see the plaintiff again after that visit. She stated that she never formed an opinion that the plaintiff developed CRPS and that there was not anything that the plaintiff did nor did not do which contributed to CRPS.

Mark Zuckerman, M.D. testified to the extent that he is licensed to practice medicine in New York and Florida, and is board certified in neurology with added qualifications in clinical neurophysiology. Dr. Zuckerman testified that, in February 2008, the plaintiff had some elements of CRPS, as she had claims of color changes and sensitivity to the top of her foot, which elements are indicative of reflex sympathetic dystrophy (RSD). Dr. Zuckerman stated that if there was nerve damage, it was referred to as causalgia in the past. If there was no direct nerve injury, it was referred to as reflex sympathetic dystrophy in the past.

Dr. Zuckerman continued that the plaintiff had some elements of reflex sympathetic dystrophy or complex regional pain syndrome. Dr. Zuckerman stated that signs and symptoms of complex regional pain syndrome Type I are pain, color changes, swelling, hypersensitivity, atrophy of the tissue, atrophy of the skin,

and possible bone deterioration. He continued that, hypothetically, when a patient has severe nerve damage and severe swelling and atrophy of the tissues, it is better to start treatment early. If the patient is responding to simple measures and has mild symptomatology, then one could or would wait to see how, and if, there is an evolution. He was not aware of any specific literature that suggests early treatment of a mild case can change the outcome.

Dr. Zuckerman testified that when the plaintiff first presented to his office on February 8, 2008, she complained of pain in her right toe after having undergone a bunionectomy of the right foot on December 21, 2007. She stated that all her toes were stiff as far as the ankle, and that it was almost burning. She told him that she was experiencing variable color change from a dusky, to blotchy, to purple. She told him that she had some swelling on the top of her foot which improved when she elevated it. It bothered her when she touched the top of her foot and toes. He described his examination and findings of sensitivity to touch at the top of her foot. She claimed she could not feel vibration on her toes upon examination. Pinprick was a little more sensitive in the right foot, but sensation was essentially normal. Pedal pulses were normal. There was very mild swelling and a very slightly dusk color to the foot. Both feet were symmetrically cool to touch. There was a Tinel's at the top of her foot when he tapped over the superficial peroneal nerves at the ankle, as she felt a little bit of tingling, which was a suggestion that there was nerve irritation. However, he stated, there were no other signs of nerve irritation. Some signs and symptoms were consistent with CRPS. She did not have a full-blown syndrome of tissue injury or significant swelling as her swelling was minimal and mild. Dr. Zuckerman continued that CRPS is a syndrome that has various elements, and if all the elements are present, a full diagnosis of CRPS can be made, but not every case has all the elements. His differential diagnosis was that the plaintiff had mostly post-operative pain at the joint. He recommended medication to modulate the pain, Neurontin and Pamelor (nortiyptyline), and a Lidocaine patch.

On February 15, 2008, Dr. Zuckerman spoke with the plaintiff and increased the Neurontin to 200 mg three times a day, and Pamelor to 20 mg at night. Because she told him the Lidocaine patch did not work, he changed her medication to an anesthetic cream, EMLA. He did not refer her to a pain management specialist as he did not feel she needed immediate nerve blocks for the mild signs and symptoms she had. He felt it would be more appropriate not to do an invasive procedure before pain modulation was tried. He stated that the plaintiff's pain reduced for about one week after her medications were increased, but then her pain and sensitivity increased, and she experienced some burning in the shower, and some blotchiness and swelling. Thereafter, there was improvement of the blotchiness and swelling. When he saw her on March 6, 2008, he observed that the color of her feet was symmetric and that there was no blotchiness. Of significance was that she was able to flex her toes much better, and the movement in the first toe was not as painful. She felt she could flex the toe but could not extend it yet. Sensitivity was improved and she felt a pinprick. He stated that there was no loss of sensation, with slight sensitivity noted in tapping the top of the foot. She could feel vibration well and the swelling was reduced quite a bit. Pedal pulses were normal. He felt she was improving in just one month, and suggested Dr. Groth for pain management to see if any other medication, or anything else should be done. He also increased the Neurontin for the residual symptoms. He did not advise her about returning to work, however, she asked him to fill out some disability forms.

Dr. Zuckerman saw the plaintiff on April 3, 2008, at which time she advised him that she saw Dr. Groth who administered one nerve block which provided her with improvement for one hour and a half. Her foot was still bothering her. Her ankle hurt when she drove her car, but otherwise, she had no ankle pain. She said she had a little sensitivity in the top of the foot, and that the medial foot bothered her from the great toe to the ankle, sometimes at night. She had sensitivity over the surgical scar. There was no allodynia (pain out of proportion to the stimulus). He increased Pamelor to 50 mg at night since she still had some symptoms. He felt she was

improving. Dr. Zuckerman stated that due to the elements he cited earlier, his diagnosis was more consistent with a mild case of post-operative complex regional pain syndrome. He tried increasing the Neurontin further. She was receiving physical therapy. She was to continue with Dr. Groth.

Dr. Zuckerman saw the plaintiff on May 21, 2008. She complained of her fingers feeling numb and she was having trouble sleeping. Her right great toe was still bothering her. She was feeling forgetful and misplacing things. Upon examination, both her feet were warm. He examined her upper extremities with findings suggesting some carpal tunnel syndrome. She was to return for nerve conduction studies of the feet and hand. He decreased the nortriptyline and prepared to switch her to Cymbalta. On June 13, 2008, nerve conduction studies were performed which showed no clear evidence of median neuropathy in the right hand or carpal tunnel, or any nerve problem in the right foot. On July 9, 2008 the plaintiff complained that she had some hand swelling; difficulty driving due to pain in her foot while it was on the pedal. She couldn't walk more than a half hour, and could not return to her job because she has to walk all day, and the pressure on the foot and the shoes hurt. He had no opinion as to what was causing the hand swelling. Upon examination, her feet were warm. There was no weakness or sensory loss. She was sensitive in the right great toe. He felt her condition was improving. He increased the Cymbalta, continued the Neurontin, and discontinued the nortriptyline (Pamelor). He filled out disability forms for her.

Dr. Zuckerman continued that he saw the plaintiff on September 3, 2008 and stated she had pain and a burning sensation in the medial foot. She was having some sweating in the evening. She reported no edema or color change in her foot. The pain in her foot could shoot up if she tried too much activity. The Pamelor helped her sleep better. She had seen Dr. Cohen at the Rusk Institute, who referred her to Dr. Wu for acupuncture. Dr. Zuckerman thought that the burning sensation in her medial foot was possibly from injections associated with the acupuncture and other treatment. He noted that when she walked, she walked with her foot flexed to avoid pressure on the ball of the foot, for which he recommended warm soaks and gel cushion for her shoe to cushion the metatarsal. On November 4, 2008, her pain was localized in the great toe and the metatarsal area with weight-bearing, which was at the operative site. He noted limitation in movement of the great toe at the operative joint. She felt there was decreased pinprick at the top of the great toe, but sensation was good otherwise. There was very little color difference, if any, and no temperature difference. His impression was that she still had some residual post-operative complaints of pain in her right foot. He recommended multivitamins to improve any numbness or tingling. She went on a trip to Costa Rica at some point which he thought could have contributed to her pain, as it is difficult to travel abroad without some sort of standing, or walking, or carrying suitcases. Sometimes she missed doses of her medications. She did not follow up with acupuncture treatment or with Dr. Cohen. He did not see her after the November 4, 2008 visit.

In support of motion (002), Dr. Zuckerman submitted the affirmation of his expert, Joseph S. Jeret, M.D. who affirmed that he is a physician licensed to practice medicine in New York State and is certified in psychiatry and neurology, and maintains a private practice specializing in neurology. He set forth the materials and records he reviewed and opined within a reasonable degree of medical certainty that Dr. Zuckerman appropriately evaluated the plaintiff for her complaints relating to her right foot and leg; reached an appropriate diagnosis relating to those complaints; provided appropriate and reasonable treatment for the diagnosis of CRPS; reached that diagnosis in a timely fashion; properly monitored her care; appropriately referred her for more specialized treatment of the CRPS; appropriately and reasonably prescribed and adjusted the dosages of pain modulating medications; and properly treated her with physical therapy and pain management care. Dr. Jeret stated that the plaintiff received more invasive procedures with the pain management specialists pursuant to Dr. Zuckerman's referral. He concluded that Dr. Zuckerman did not depart from the standard of care in

treating the plaintiff, and that his care and treatment did not cause or contribute to the injuries claimed by the plaintiff.

Dr. Jeret set forth the dates and the care and treatment provided by Dr. Zuckerman to the plaintiff, as well as his findings and treatment. He stated that on February 8, 2009, when the plaintiff presented at her first visit with Dr. Zuckerman, that Dr. Zuckerman timely diagnosed CRPS, and that he did not delay in making the diagnosis. He stated that Dr. Zuckerman could not have made such diagnosis any earlier than he did on the first visit. Dr. Zuckerman did not refer the plaintiff to a pain specialist at the first visit and appropriately waited until the second office visit. In so doing, he was able to assess any change in the plaintiff's condition or complaints which might result from the treatment modalities he instituted at the first visit. It is Dr. Jeret's opinion that the plaintiff would have developed the same symptoms and complaints, and physical problems, and would have required the same treatment that she ultimately underwent, even if she had seen a pain management specialist earlier.

Dr. Jeret continued that it is appropriate and reasonable medical practice to treat CRPS initially with pain modulating medication and to defer invasive treatments, such as lumbar sympathetic blocks and lumbar epidural steroid injections, until the patient's response, or lack of response to the pain modulating medications can be assessed. Therefore it was appropriate and reasonable for Dr. Zuckerman to wait until the second visit to refer the plaintiff to Dr. Groth for pain management, and such referral was timely. As a neurologist, Dr. Zuckerman does not perform surgery and does not perform lumbar sympathetic blocks, which procedures are typically and customarily performed by pain management specialists, and are out of the realm of a neurologist. Dr. Zuckerman carried out his duties as a neurologist in referring the plaintiff for pain management.

Dr. Jeret noted that during his care and treatment of the plaintiff, Dr. Zuckerman administered or prescribed several pain modulating medications, adjusted the dosages based upon her response, and at times discontinued medications or replaced medications with other medications. He performed physical examinations at each visit and documented his examinations, his findings, his treatment, and testing, including nerve conduction testing. He was aware that the plaintiff was receiving physical therapy. He concluded that Dr. Zuckerman did not depart from the accepted standards of care and did not cause the injuries complained of by the plaintiff.

Based upon the foregoing, it is determined that Dr. Zuckerman has demonstrated prima facie entitlement to summary judgment dismissing the complaint.

In support of motion (002), Dr. Silhanek and the Total Foot Care defendants have submitted the affidavits of Harvey Strauss, DPM, and Jay Coblentz, M.D.

Dr. Strauss averred that he is a podiatrist licensed to practice in New York State and is board certified in podiatric surgery, quality assurance and utilization review, and is a fellow of the American College of Foot and Ankle Surgeons and Podiatric Sports Medicine. He set forth the materials and records which he reviewed. He opined within a reasonable degree of medical certainty that the procedure performed by Dr. Silhanek was indicated, properly performed, and that timely and appropriate post-operative care was provided by the defendants. He continued that Dr. Silhanek timely recognized the possibility of CRPS and made a timely and proper referral to the appropriate specialist, Dr. Zuckerman, for neurology cae and treatment. He continued that Dr. Silhanek met the podiatric medical standard of care in the selection and performance of the bunionectomy procedure performed on the plaintiff; as did the post-operative care provided by her and Total Foot Care Group.

Dr. Strauss set forth that CRPS is a rare condition that may develop from various causes, including but not limited to, trauma, crush injury, surgery, or even illness. The possibility of its development is so remote that a pre-operative discussion of the risk of development of this unlikely and remote condition was not required by the podiatric medicine standard of care. In a typical presentation of CRPS, the symptoms do not wax and wane. Dr. Strauss continued that the plaintiff demonstrated inconsistent presentation of complaints and symptoms typically seen in the immediate post-operative period in patient who do develop CRPS. Dr. Strauss stated that the plaintiff did not meet the criteria for a definitive diagnosis of CRPS, and the fact that she was referred to Dr. Zuckerman within less than seven weeks of the bunionectomy was a testament to Dr. Silhanek's diligence, and was well within the podiatric medicine standard of care.

Dr. Strauss noted the plaintiff's history of complaints of right foot bunion for approximately two years. Dr. Silhanek noted the plaintiff had mild pain in the right heel after prolonged weight bearing, and that her symptoms were not alleviated by change to more accommodative shoes, oral anti-inflammatories, and limitation of activities. Dr. Silhanek's impression was hallux valgus with bunion on the right foot as well as right plantar fasciatus. Surgical management via Austin bunionectomy was discussed with the risks, benefits, and possible complications, including pain, swelling, infection of soft tissue, failure of surgery to eliminate all pain, and recurrence of the deformity. Dr. Strauss addressed the plaintiff's post-operative visits on December 24, 2007, January 3, 2008, January 19, 2008, and January 24, 2008. There was no erythema, minimal edema diffusely on the right foot, and the first metatarsophalangeal joint demonstrated excellent position and alignment on x-rays. Stiffness with range of motion with mild guarding was noted on January 19. The plaintiff was encouraged to wear a sneaker. On January 24, 2008, when the plaintiff presented wearing a slipper, a stiff soled sneaker or surgical shoe was recommended. Due to the stiffness to the right first metatarsalphalangeal joint, Dr. Silhanek referred the plaintiff to physical therapy. When the plaintiff called on January 31, 2008, she had not used a sneaker and was having difficulty going to work. She provided the plaintiff with paperwork to permit her to stay home from work, which was the plaintiff's intention at the time. Dr. Silhanek did not believe the plaintiff had CRPS at this time. On February 6, 2008, less than seven weeks post-operatively, the plaintiff was referred to Dr. Zuckerman, a neurologist.

Dr. Strauss stated that the plaintiff's development of what Dr. Zuckerman described as mild CRPS symptomology is not due to any departures from the standard of care by Dr. Silhanek. He continued that the plaintiff's post-operative presentation prior to referral to Dr. Zuckerman was less than consistent with the very remote possibility of CRPS. He stated that persons with typical cases of CRPS experience such severe levels of pain and sensitivity that the slightest touch will cause extreme pain. These patients would not polish their toenails as the plaintiff did, as depicted in photographs produced by the plaintiff. The extreme pain levels would also make vacationing, such as plaintiff did, unlikely to be undertaken. He stated that the plaintiff did not have the hallmark discoloration, swelling and hyperhidrosis that is observed in patients with CRPS. The plaintiff exhibited no temperature change, cyanosis, or discoloration on the January 19 and February 6, 2008 visits. Dr. Strauss continued that pain, post-operative swelling, and decreased range of motion are normal post-operative findings and are not necessarily indicative of the remote condition of CRPS. Post-operative swelling can continue for more than one year.

Dr. Strauss stated that Dr. Silhanek spoke to plaintiff's physical therapist on about January 31, 2008, who reported that the plaintiff was making progress. On January 24, 2008, Dr. Silhanek observed no edema in the plaintiff's foot. There was no evidence of osteopenia or motor change such that CRPS should have been considered earlier, or to warrant the patient being referred earlier to a neurologist. Dr. Silhanek obtained the neurology appointment immediately with Dr. Zuckerman when the plaintiff could not obtain a consult with Dr. Vaillancourt for several weeks. In fact, stated Dr. Strauss, Dr. Zuckerman himself indicated that plaintiff's

condition presented as one of mild CRPS symptomology. Dr. Silhanek followed the plaintiff's care and treatment with Dr. Zuckerman at the February 16, 2008 and March 15, 2008 visits. On April 19, 2008, Dr. Silhanek learned that the plaintiff was seeing Dr. Groth for pain management, and noted that the plaintiff had much improved range of motion to the first metatarsaphalangeal joint. On June 5, 2008, the plaintiff reported her pain had improved. The plaintiff's last visit with Dr. Silhanek was on October 9, 2008, at which time the plaintiff complained of pain, that the nerve blocks did not help, and that an epidural was recommended by Dr. Groth. Dr. Silhanek noted that there was no edema and that the plaintiff had excellent non-painful motion of the right first metatarsalphalangeal joint. Pain was associated with prolonged weight bearing. Dr. Strauss concluded that Dr. Silhanek and Total Foot Care comported with the accepted standard of podiatric medical care, and that the treatment provided by them did not cause any of the injuries claimed by the plaintiff.

Jay M. Coblentz, M.D. averred that he is a physician licensed to practice medicine in New York State and is board certified in neurology. He set forth his education and training, but has not indicated his work experience. He set forth the records and materials reviewed, and opined within a reasonable degree of medical certainty that Alison Silhanek and the Total Foot Care defendants did not depart from the appropriate standard of care in treating the plaintiff, and that no alleged negligent act or omission by them caused or contributed to the injuries alleged by the plaintiff.

Dr. Coblentz stated that post-operatively, the plaintiff's complaints were limited to those typically expected after surgery, but not in excess thereof, including pain, swelling, burning, and limited range of motion. When these complaints persisted seven weeks after surgery, the plaintiff was referred to Dr. Mark Zuckerman for neurological evaluation. Dr. Coblentz set forth the care and treatment rendered to the plaintiff by Dr. Silhanek and Total Foot Group defendants. He continued that on February 6, 2008, there was excellent positioning of the metatarsalphalangeal joint and the x-rays revealed complete healing of the osteotomy. There was mild edema and significant stiffness of the first metatarsalphalangeal joint. The plaintiff reported at this time that she had pain even when the bed sheet touched her foot. In light of these claims of disproportionate pain, Dr. Silhanek referred the plaintiff to a neurologist for consultation, and made arrangements for her to see Dr. Zuckerman when the plaintiff could not get an immediate consult with another neurologist.

Dr. Coblentz stated that the plaintiff was properly evaluated and timely referred to an appropriate specialist, a neurologist, for consultation. Dr. Coblentz continued to set forth the plaintiff's ongoing care and treatment, and stated that generally, recovery from a bunionectomy can take three to four months, and with the utilization of screw fixation, can take six months or more. Here, Dr. Silhanek made the referral less than seven weeks post-operatively. Typically, he stated, pain lasting more than eight weeks warrants referral to a specialist such as a neurologist for consult, and the plaintiff's condition did not warrant a referral sooner. The initial complaint by the plaintiff of the bug-crawling sensation is not specific and does occur post-operatively in patients who do not have CRPS. Subjective complaints of pain, burning sensation, and swelling are typical in the early post-operative period and do not necessarily indicate CRPS. When the complaints continued, Dr. Silhanek then timely and appropriately referred the plaintiff for neurology consult, recognizing the possibility of CRPS.

Dr. Coblentz stated that in the early stages of CRPS, the sympathetic nerves are switched on. A patient will develop additional hair growth. The nails become thicker and may crack. The texture of the skin changes and becomes grainy, robust and thicker. There is no atrophy at this point. Treatment at this stage can include medications or sympathetic nerve blocks. In the immediate post-operative period, the plaintiff's presenting symptoms did not raise a red flag sufficient to require a referral to a specialist such as a neurologist. She did not present as a typical CRPS patient who would try anything to feel pain relief. The plaintiff's symptoms of pain,

swelling, numbness, burning, and redness did not diverge significantly from what could be considered typical post-operative complaints, were not necessarily indicative of CRPS, did not warrant differing treatment, and no earlier referral to a neurologist was indicated. When the plaintiff saw Dr. Zuckerman, her condition was characterized as mild CRPS. Dr. Coblentz continued that the plaintiff's condition did improve with the combination of medications she was taking. She received relief from pain until the medications were discontinued, and she did not return to those medications. This improvement with the medications prescribed by Dr. Zuckerman negates any claims that earlier referral would have affected plaintiff's changes of improving. She next received injections without benefit. Dr. Coblentz concluded that Dr. Silhanek and Total Foot Group defendants did not depart from the standard of care and did not cause the injuries claimed by the plaintiff.

Based upon the foregoing, it is determined that Dr. Silhanek and the Total Foot Care defendants have demonstrated prima facie entitlement to summary judgment dismissing the complaint as asserted against them.

The plaintiff has not opposed these motions and has failed to raise factual issues to preclude summary judgment from being granted to the moving defendants.

Accordingly, motions (002) and (003) are granted and the complaint is dismissed.

Dated: 12-4-13

Hon. Denise F. Molia
A.J.S.C.

__X__ FINAL DISPOSITION _____ NON-FINAL DISPOSITION

RST