SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

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G[redacted] L[redacted], an infant, by her Parents and Natural Guardians, FRANK LEVA and FRANCES LEVA, and FRANK LEVA and FRANCIS LEVA, individually

Plaintiffs,

Index No. 156318-2012

-against-

DECISION/ORDER

Motion Sequence 003

ALAN HARAWITZ, M.D., EVAN HARAWITZ, M.D., MONROE PEDIATRIC ASSOCIATES, P.C., MIRNA CHEHADE, M.D., KEITH BREGLIO, M.D. and MOUNT SINAI MEDICAL CENTER,

Defendants.

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HON. GEORGE J. SILVER, J.S.C.

Recitation, as required by CPLR § 2219 [a], of the papers considered in the review of this motion:

Papers	Numbered
Notice of Motion, Attorney's Affirmation & Collective Exhibits Annexed.....	1, 2, 3
Affirmation in Opposition, Physician's Affirmation & Exhibit Annexed.....	4, 5, 6
Reply Affirmation.....	7

In this medical malpractice action defendants Keith Breglio, M.D. (Breglio), Mirna Chehade, M.D. (Chehade) and Mount Sinai Medical Center (Mt. Sinai) (collectively movants) move pursuant to CPLR § 3212 for an order granting them summary judgment dismissing the complaint of plaintiffs G[redacted] L[redacted] (the infant), an infant, by her Parents and Natural Guardians Frank Leva and Francis Leva, and Frank Leva and Francis Leva, individually (collectively plaintiffs). Plaintiffs oppose the motion. The gravamen of plaintiffs' complaint is that Breglio and Chehade negligently failed to diagnose and treat the infant's medulloblastoma and that Mt. Sinai is vicariously liable for their malpractice. The bill of particulars alleges that Breglio committed malpractice on November 3, 2009 by negligently misdiagnosing the infant as having gastroesphageal reflux compounded with an anxiety disorder. The bill of particulars further alleges that Breglio committed malpractice on November 3, 2009 by failing to refer the infant for neurological testing, by failing to consider a cause of the infant's vomiting other than gastroenterological, by ordering that the infant take 1 mg/kg per day of Pepcid for two months,

by waiting an additional two weeks before considering further evaluation with radiological studies, and by prescribing Prevacid 30 mg once daily. Plaintiffs' further allege that Breglio committed malpractice on December 29, 2009 by failing to timely and properly investigate a specific trigger for the infant's emesis. Breglio allegedly committed malpractice on January 8, 2010 by negligently performing an endoscopy and thereafter negligently diagnosing eosinophilic esophagitis. It is also allegedly that Breglio failed to consider cancer as part of a differential diagnosis.

The bill of particulars alleges that Chehade committed malpractice on or about February 5, 2010 by ordering that the infant be placed on a strict elimination diet, by negligently diagnosing the infant with eosinophilic esophagitis, by negligently determining that esophageal biopsies demonstrated significant esophageal eosinophilia despite adequate therapy with proton pump inhibitor, by negligently determining that the biopsies ruled out acid-induced gastroesophageal reflux disease that could histologically mimic eosinophilic esophagitis, by negligently predicting that a strict elimination diet would take months to take effect, by abandoning the infant when the infant's physical condition deteriorated, and by negligently advising agaisnt a neurological exam for the infant. The bill of particulars further alleges that on or about March 17, 2010 Chehade negligently advised that the infant's problems probably resulted from malnutrition, that Chehade negligently prescribed a high energy diet, and that Chehade failed to consider cancer as part of a differential diagnosis.

The bill of particulars alleges that Mt. Sinai is vicariously liable for Breglio and Chehade's negligence and that it failed to use reasonable care in hiring and supervising the medical personnel involved in the infant's care and treatment.

In support of the motion movants submit an affirmation from Dr. Bradley Kessler (Kessler), a physician board certified in pediatrics and pediatric gastroenterology. According to Kessler, the infant first presented to co-defendant Monroe Pediatrics Associates, P.C. (Monroe Pediatrics) on August 25, 2009 with complaints of vomiting food off and on but without diarrhea, fever or upper respiratory infection symptoms. The impression of co-defendant Alan Harawitz, M.D. was vomiting. A flu vaccine was administered on a subsequent visit on September 10, 2009. The infant was seen at Monroe Pediatrics on October 25, 2009 , again for vomiting. The infant also had a cough and discharge from her right eye. The impression was gastroenteritis and conjunctivitis. The infant presented to Breglio on November 3, 2009. A questionnaire completed on the infant's behalf by her mother indicated that the current complaint was vomiting. Breglio documented the infant's history to include vomiting issues since the prior August which began shortly before the infant was to begin kindergarten. Breglio noted that the infant initially vomited in the morning but that over the prior two months the episodes of vomiting had become more sporadic with the infant vomiting a small amount each day and after eating. The vomiting would occur once per day or multiple times per day and no precipitating event was identified. The infant was noted to be anxious. Breglio's physical examination revealed that the infant was well appearing, well nourished, active and cooperative. The infant was alert and active neurologically with no focal findings. Breglio's assessment was that the infant was a healthy girl experiencing almost daily vomiting of various amounts with no abdominal pain or other symptoms. Breglio also noted that the infant appeared to have reflux prior to emesis as noted by straightening of the back and wincing. Breglio felt that the infant's

vomiting was caused by gastroesophageal reflux compounded with an anxiety component. Breglio's treatment plan included getting a basic set of labs and celiac testing. The infant was prescribed Pepcid 1 mg/kg/day for two months and if there was no improvement Breglio would consider further evaluation.

According to Kessler, the infant's mother advised Breglio during a November 4, 2009 telephone call that the infant was taking the Pepcid but that she had vomited while putting on her shoes. The infant's mother further advised Breglio that there were students in the infant's school that had a stomach virus. During another telephone conversation on November 10, 2009, Breglio advised the infant's mother that the infant was unlikely to be celiac. The infant's mother informed Breglio that the infant was having some good days and some bad days. Pepcid was continued and the infant's mother was to follow up in approximately one week. During a November 18, 2009 telephone conversation the infant's mother advised Breglio that the infant was doing very well, which included eating breakfast in the morning and no vomiting. The infant was to continue on Pepcid for two months with a follow up to occur at that time. On November 25, 2009 Breglio was advised that the infant had an episode of vomiting on the prior evening and on the morning of November 25. Breglio was further advised that the infant was having a snack before bed time and was drinking apple and other juices at school. Breglio advised that the infant's juice intake be limited and that she not eat up to two hours before going to bed.

On December 2, 2009 Breglio documented that the infant was overall improved but that she had experienced three days of mild vomiting in the morning. The Pepcid was discontinued and the infant was prescribed Prevacid 30 mg. On December 29, 2009 Breglio scheduled an esophagogastroduodenoscopy (EGD) due to continued vomiting. The EGD was performed on January 8, 2010 at Mt. Sinai. The results of the EGD revealed small white plaques near the GEJ and linear furrowing, more pronounced distally. Multiple biopsies were taken and the esophageal findings were suggestive of allergic esophagitis. The esophagus revealed approximately 80 eosinophils per high powered field in the distal esophagus and 35 eosinophils in the proximal esophagus with basal cell hyperplasia and lamina fibrosis. The findings were most consistent with eosinophilic esophagitis and Breglio referred the infant to Chehade.

The infant presented to Chehade on February 5, 2010. A questionnaire completed by the infant's mother listed the infant's symptoms as including weight loss, vomiting and hiccups. During the initial visit Chehade performed a neurological examination and determined the infant was alert, awake and oriented with a normal mood and affect. The infant's general appearance was normal and her eyes revealed conjunctivae and sclerae to be normal with pupils that were equal, round and reactive to light. Chehade noted that the infant had non-bilious intermittent emesis with occasional epigastric pain and occasional nausea. Chehade's assessment was that the infant was a mildly atopic child with abdominal pain and eosinophilic esophagitis that was confirmed by esophageal biopsies. Chehade further noted that the persistent abdominal pain with antacid therapy was consistent with the diagnosis of eosinphilic esophagitis. The treatment plan included an empiric 7-food elimination trial. In addition, Chehade recommended a gradual wean off of Prevacid and that the infant meet with a dietician and allergist. The infant was to be seen in follow up in two months.

The infant was next seen on February 12, 2010 by the pediatric allergy nutritionist, non-

party Marion Groetch (Groetch), for assessment and planning with respect to the 7-food elimination diet. Following the assessment milk, egg, wheat, soy, peanut/tree nut, fish/shell fish and beef/lamb were eliminated from the infant's diet. The addition of hypoallergenic calcium and vitamin D supplements were suggested.

During a telephone conversation between the infant's mother and non-party Katie Atkinson, NP (Atkinson) on March 1, 2010 the infant's mother advised that she was concerned because the infant was continuing to vomit. The infant had been on the elimination diet for three weeks at the time of this telephone conversation. According to the records, the infant vomited approximately once per day, usually in the morning, but did not vomit for three consecutive days the prior week. The infant's mother reported this to be an improvement from before the initiation of the elimination diet. The infant's mother further advised Atkinson that the infant might be allergic to chocolate as she vomited when she ate a chocolate bar. The infant's mother was advised to continue the elimination diet, to keep the follow up appointment and to call if the infant developed severe vomiting or other GI symptoms, if the infant's symptoms did not improve or if the infant's mother had any further questions.

On March 3, 2010 the infant's mother spoke with Chehade and advised that the infant continued to vomit intermittently but that the infant was overall 25 percent better. The infant's bowel movements had also improved while on the elimination diet. On March 17, 2010 the infant was seen by Chehade secondary to eosinophilic esophagitis. The infant was on the fifth week of the elimination diet but continued to vomit up to five times per week. During this visit it was reported to Chehade that the infant had been having headaches and weakness over the past week and that her parents noticed the infant had been arching her back and breathing deeply during her sleep. Chehade was also advised that the infant had been seen by her pediatricians for the nocturnal symptoms, that dehydration was suspected and that the infant's fluid intake had therefore been increased. Chehade's assessment on March 17, 2010 was that the infant had not yet experienced much improvement on the elimination diet, but that it was still early, and that the infant may have concomitant gastroesophageal reflux considering that Prevacid had been stopped. A treatment plan which included restarting Prevacid, starting amino acid-based formula supplements and continuing the elimination diet was initiated. If the infant's symptoms did not subside within two weeks Chehade would also consider implementing Flovent to swallow instead of dietary therapy for the eosinophilic esophagitis.

In a March 19, 2010 e-mail from the infant's mother to Groetch the infant's mother indicated that the infant was drinking her supplements and eating. On March 23, 2010 Chehade received a telephone call from the infant's pediatrician indicating that the infant had been lethargic at school. The infant also exhibited muscular rigidity and shallow breathing. The infant had appeared very lethargic in the pediatrician's office and exhibited vertical and horizontal nystagmus. The pediatrician's impression was questionable seizure versus dehydration versus question tumor. The pediatrician and Chehade agreed that the infant should be sent to the emergency department at Mt. Sinai for evaluation. Chehade further documented that she spoke with the infant's other on March 23, 2010 and was told that the infant was on the way to the emergency department. The infant's mother advised that the infant was vomiting less frequently and was eating and drinking better. Chehade advised the infant's mother to allow the emergency department physicians to do a full assessment of the infant.

The infant presented to the Mt. Sinai emergency department on March 23, 2010 with complaints of lethargy and headaches. The infant was awake, alert, verbally responsive, able to state her name and smiling. Following evaluations and consultations, the infant was scheduled for a head CT which revealed a large posterior fossa mass measuring approximately 3.8 x 4.6 x 3.6 cm. The infant was transferred to New York Presbyterian Hospital-Columbia University Medical Center where she underwent a resection of the mass on March 26, 2010. On July 10, 2012 the infant was documented as continuing to experience vomiting episodes. An EGD was performed to assess the condition of the esophagus on February 27, 2013 and the findings were consistent with eosinophilic esophagitis.

Kessler contends that the infant received appropriate treatment and care from Breglio, Chehade and Mt. Sinai and that the injuries sustained by the infant were not proximately caused by any act or omission by the movants. With respect to Breglio, Kessler contends the gastrointestinal focus of Breglio's examinations and evaluations was appropriate because the infant presented to Breglio for evaluation and assessment for complaints of vomiting. According to Kessler, Breglio performed a complete and thorough physical examination of the infant including the infant's overall condition pertaining to neurologic, constitutional, abdominal and head. Kessler also claims that Breglio elicited a full and complete history from the infant's family. Kessler argues that based upon the infant's presenting symptomology, her history and Breglio's evaluation and assessment, Breglio's diagnosis of gastroesophageal reflux was reasonable and within the standard of care. Kessler further opines that the infant's straightening of the back and wincing as a precursor to vomiting was consistent with gastroesophageal reflux because the mechanism of reflux may cause an uncomfortable feeling that triggers straightening of the back and wincing. Kessler also contends that Pepcid is an acceptable form of treatment for gastroesophageal reflux and that its implementation was within the standard of care. According to Kessler, no further work-up or referral were warranted at the infant's initial office visit because her presenting symptomology did not require it.

Kessler contends that Breglio appropriately inquired as to changes in the infant's behavior and daily routine following the November 3, 2009 visit and, upon learning of such changes, including the infant's juice intake and eating before bedtime, appropriately advised the infant's family to limit such intake. Breglio's altering of the infant's treatment plan to include Prevacid instead of Pepcid was also appropriate, in Kessler's opinion. The implementation of Prevacid, a proton pump inhibitor, was appropriate in light of the fact that the infant's episodes of vomiting had not subsided. According to Kessler, Prevacid is a stronger medication than Pepcid and because it is a proton pump inhibitor, it provides more persistent acid suppression throughout the day compared to an H2 blocker like Pepcid. Since the infant had not developed any symptoms beyond vomiting, treatment with Prevacid was within the standard of care. Kessler contends that because the infant's vomiting became intermittent after the implementation of Prevacid, it was within the standard of care for Breglio to continue to monitor the infant on Prevacid.

Kessler next opines that it was within the standard of care for Breglio to schedule an EGD upon determining that the infant's episodes of vomiting had not subsided. According to Kessler, the EGD produced results consistent with eosinophilic esophagitis and the diagnosis of eosinophilic esophagitis was within the standard of care given the results of the EGD and the infant's symptoms. Kessler also opines that it was appropriate to refer the infant to Chehade for

the purpose of treating the infant's eosinophilic esophagitis. Finally, Kessler contends that because the infant did not develop new symptomatology during the course of her treatment with Breglio, the actions of or inactions of Breglio did not cause or contribute to the infant's injuries.

Kessler opines that Chehade properly evaluated, assessed and developed a treatment plan for the infant based upon the presenting symptoms, which included vomiting, hiccups and weight loss, the history provided and the her evaluation of the infant. Chehade, according to Kessler, appropriately determined, based upon the presenting symptomatology and the EGD with biopsy findings, that eosinophilic esophagitis was the source of the infant's vomiting. Kessler also contends that there were no other presenting factors to suggest any other source of the vomiting episodes experienced by the infant. Kessler contends that 7-food elimination diet was an appropriate treatment for the infant's eosinophilic esophagitis, that such a diet normally takes two months of continuous utilization in order to determine the effectiveness of the treatment, and that Chehade met the standard of care by implementing the diet with the help of a registered dietician.

According to Kessler, it was not until March 17, 2010 that Chehade was informed of additional symptoms beyond vomiting. Kessler contends that because Chehade had been advised that the infant's new symptoms of headaches, weakness, arching of the back and deep breathing during sleep had already been communicated to the infant's other treating physicians and that a treatment plan for the new symptoms had been instituted it was within the standard of care for Chehade, as a specialist for the treatment of eosinophilic esophagitis, to continue the infant on the elimination diet. Kessler also contends that the presentation of horizontal and vertical nystagmus, communicated to Chehade by the infant's pediatrician on March 23, 2010, were new symptoms not previously indicated to Chehade. Kessler further opines that Chehade did not cause or contribute to the injuries sustained by the infant because the first new, non-gastroinstestinal symptoms presented to Chehade did not occur until March 17, 2010, just six days prior to the ultimate diagnosis of the brain mass.

Kessler contends that the staff at the Mt. Sinai emergency department acted within the standard of care in its assessment and treatment of the infant.

In opposition, plaintiffs submit a redacted affirmation from a physician board certified in pediatrics and pediatric hematology/oncology. Plaintiff's expert opines that medulloblastoma is a pediatric malignant primary brain tumor the signs and symptoms of which are vomiting and a morning headache. According to plaintiff's expert, Breglio and Chehade's inordinate delay in diagnosing the tumor resulted in, among other things, the inability of the infant's pediatric surgeon to remove the large tumor in its entirety. The expert also contends that the delay in diagnosis caused the infant to endure multiple, more complicated surgeries, chemotherapy and radiation and a much longer stay in the hospital. The expert further claims that Breglio and Chehade's malpractice caused the infant to suffer permanent bilateral hearing loss, left facial weakness, ocular motor dysfunction, left sided coordination difficulties, left hemi neglect, ataxia, difficulties with mobility and gait and major academic delays.

With respect to the alleged malpractice, plaintiffs' expert contends that Breglio and Chehade had an obligation to recognize and appreciate the signs and symptoms that were being displayed by the infant, that a neurological problem was forming and present, to perform standard examinations including clinical neurological examinations, and to include the

possibility of a neurological problem within their differential diagnosis. The expert contends that the movants departed from good and accepted standards of medical practice in negligently failing to recognize the signs and symptoms of the infant's neurological disorder. Specifically, plaintiff's expert contends that the infant's brain tumor was causing increased intracranial pressure and that this pressure triggered the infant's vomiting. According to plaintiff's expert, even if there are no other neurological signs present, persistent uncontrollable vomiting is one of the most obvious signs of a brain tumor. Uncontrollable positioning of the spine is also a notable neurological symptom, according to plaintiffs' expert. According to plaintiffs' expert a child experiences abnormal posturing of the spine due to damage to the child's spinal cord or brain which reduces or even prevents the muscles from contracting in certain muscle groups. Plaintiff's expert contends that since the infant presented to both Breglio and Chehade with vomiting and straightening/arching of the back and the vomiting did not subside after months of aggressive gastrointestinal treatment, Breglio and Chehade should have recognized the symptoms of a neurological disorder and completed a full work-up and thorough examination. Plaintiffs' expert opines that a simple and proper neurological exam would have disclosed signs caused by the tumor and led to an earlier diagnosis of the medulloblastoma with considerably less damage and resulting disability to the infant.

In an action premised upon medical malpractice, a defendant doctor or hospital establishes *prima facie* entitlement to summary judgment when he/she establishes that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged (*Thurston v Interfaith Med. Ctr.*, 66 AD3d 999, 1001 [2d 2009]; *Myers v Ferrara*, 56 AD3d 78, 83 [2d 2008]; *Germaine v Yu*, 49 AD3d 685 [2d Dept 2008]; *Rebozo v Wilen*, 41 AD3d 457, 458 [2d Dept 2007]; *Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004]). With respect to opinion evidence, it is well settled that expert testimony must be based on facts in the record or personally known to the witness, and that an expert cannot reach a conclusion by assuming material facts not supported by record evidence (*Cassano v Hagstrom*, 5 NY2d 643, 646, 159 NE2d 348, 187 NYS2d 1 [1959]; *Gomez v New York City Hous. Auth.*, 217 AD2d 110, 117 [1st Dept 1995]; *Matter of Aetna Cas. & Sur. Co. v Barile*, 86 AD2d 362, 364-365 [1st Dept 1982]). Thus, a defendant in a medical malpractice action who, in support of a motion for summary judgment, submits conclusory medical affidavits or affirmations, fails to establish *prima facie* entitlement to summary judgment (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853, 476 NE2d 642, 487 NYS2d 316 [1985]; *Cregan v Sachs*, 65 AD3d 101, 108 [1st Dept 2009]; *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Further, medical expert affidavits or affirmations, submitted by a defendant, which fail to address the essential factual allegations in the plaintiff's complaint or bill of particulars fail to establish prima facie entitlement to summary judgment as a matter of law (*Cregan*, 65 AD3d at 108; *Wasserman* 307 AD2d at 226).

Once the defendant meets its burden of establishing prima facie entitlement to summary judgment, it is incumbent on the plaintiff, if summary judgment is to be averted, to rebut the defendant's prima facie showing (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324, 501 NE2d 572, 508 NYS2d 923 [1986]). The plaintiff must rebut defendant's prima facie showing without "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence" (*id.* at 325). Specifically, to avert summary judgment, the plaintiff must demonstrate

that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries (*Coronel v New York City Health and Hosp. Corp.*, 47 AD3d 456 [1st Dept 2008]; (*Koeppel v Park*, 228 AD2d 288, 289 [1st Dept 1996]). In order to meet the required burden, the plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged (*Thurston* 66 AD3d at 1001; *Myers* 56 AD3d at 84; *Rebozo* 41 AD3d at 458).

Movants' submission of deposition transcripts, medical records and an expert affirmation based upon the same established a prima facie defense entitling them the summary judgment (*Balzola v Giese*, 107 AD3d 587 [1st Dept 2013]). The foregoing submission established, inter alia, that movants' treatment of the infant did not depart from accepted medical practices or proximately cause the infant's injuries.

In opposition, plaintiffs fail to raise a triable issue of fact. As an initial matter, plaintiffs' expert, who is board certified in pediatrics and pediatric hematology/oncology, does not profess to possess the knowledge necessary to render an opinion concerning the gastroenterological treatment administered to the infant by Breglio and Chehade (*see Atkins v Beth Israel Health Servs.*, 2015 NY Slip Op 08346 [1st Dept]; *Mustello v Berg*, 44 AD3d 1018 [2d Dept 2007]). While it is true that a medical expert need not be a specialist in a particular field in order to testify regarding accepted practice in that field (*Lopez v Gramuglia*, 2015 NY Slip Op 08068 [1st Dept]) where a physician opines outside his or her area of specialization, a foundation must first be laid wherein the expert professes to have the requisite knowledge necessary to make a determination on the issues presented (*Limmer v Rosenfeld*, 92 AD3d 609 [1st Dept 2012]). Once such a foundation is laid the issue of the expert's qualifications to render such an opinion is a question of weight for a jury resolve. While it cannot be disputed that plaintiff's expert is an expert in the field of pediatric cancer, there is nothing in the expert's affirmation indicating how expert became familiar with the applicable standards of care in the particularized field of pediatric gastroenterology (*see Nguyen v Dorce*, 125 AD3d 571 [1st Dept 2015] [plaintiff's expert, a pathologist, failed to profess personal knowledge of the standard of care in the field of emergency medicine]). This is evidenced by the fact that plaintiff's expert offers no opinion regarding the diagnosis and treatment by Breglio or Chehade of the infant's gastroenterological conditions, despite the fact that the bill of particulars sets forth numerous allegations of malpractice with respect to the gastroenterelogical treatment rendered by Breglio and Chehade. Plaintiff's expert's affirmation, therefore, is of no probative value (*see generally Velez v New York Presbyt. Hosp.*, 2015 NY Slip Op 32122[U] [Sup Ct, New York County]).

However, even assuming that plaintiffs' expert was qualified to render an opinion with respect to Breglio's and Chehade's treatment of the infant, plaintiff's expert's affirmation is insufficient to raise a triable issue of fact because it is speculative, conclusory and unsupported by the record. Plaintiffs' experts' overarching conclusory assertion is that had Breglio or Chehade performed a simple and proper neurological examination of the infant, the exam would have disclosed signs caused by the tumor and led to an earlier diagnosis of the medulloblastoma thereby resulting in considerably less damage and disability to the infant. It is well settled, however, that liability is not supported by an expert offering only conclusory assertions and mere speculation that a condition could have been discovered and successfully treated had the doctors

not deviated from the accepted standard of medical practice (*see Rodriguez v Montefiore Med. Ctr.*, 28 AD3d 357, 814 NYS2d 59 [1st Dept 2006] [plaintiff's expert offered only conclusory assertions and mere speculation that plaintiff's cancer would have been discovered earlier and would not have spread if defendants had more aggressively pursued plaintiff and tracked her follow-up visits more closely]; *Bullard v St. Barnabas Hosp.*, 27 AD3d 206, 810 NYS2d 78 [1st Dept 2006] [plaintiff's expert offered only conclusory assertions that an earlier diagnosis and treatment of plaintiff's heel decubitus would have avoided the eventual bilateral amputation]).

Moreover, plaintiffs' expert affirmation is inconsistent with regard to symptomatology of medulloblastoma. First, plaintiffs' expert opines that vomiting and morning headaches are the symptoms of medulloblastoma . While it is undisputed that the infant presented to both Breglio and Chehade with complaints of persistent episodes of vomiting, there is no evidence in the record that Breglio was ever advised that the infant was experiencing morning headaches and Chehade was only made aware of headaches as a symptom on March 17, 2010, a mere six days before the infant's medulloblastoma was diagnosed. Plaintiff's expert offers no opinion as to whether the infant's injuries and disabilities would have been lessened if Chehade had performed a neurological exam on March 17, 2010.

Plaintiffs' expert next opines that even in the absence of other neurological symptoms, such as morning headaches, persistent vomiting in and of it self is an obvious sign of a brain tumor and uncontrollable positioning of the spine is indicative of some unspecified neurological condition. However, as Kessler opines, the infant's persistent vomiting is explained by the infant's eosinophilic esophagitis and the infant's arching of her back is consistent with gastroesophageal reflux because the mechanism of reflux may cause an uncomfortable feeling that triggers straightening of the back and wincing. Plaintiffs have not submitted any competent medical evidence disputing either of these gastroenterological diagnoses and Breglio and Chedhade's alleged failure to investigate conditions that would have led to an incidental discovery of an unindicated condition does not constitute malpractice (*see Curry v Dr. Elena Vezza Physician, P.C.*, 106 AD3d 413 [1st Dept 2013]; *Rivera v Greenstein*, 79 AD3d 564, 568 [1st Dept 2010]).

Finally, while plaintiffs' expert contends that Breglio and Chehade should have performed a full neurological work-up when the infant's gastroenterological condition failed to subside after months of aggressive treatment, the record establishes that the infant's vomiting had actually improved somewhat over the course of her treatment, as reflected in e-mails from the infant's mother and in other medical records. Plaintiffs' expert has also not offered an opinion with respect to Mt. Sinai's alleged negligent hiring and supervision. Since plaintiffs' opposition fails to raise a triable issue of fact, it is hereby

ORDERED that defendants Keith Breglio, M.D., Mirna Chehade, M.D. and Mount Sinai Medical Center's motion for summary judgment is granted and the complaint against them is dismissed; and it is further

ORDERED that the Clerk is directed to enter judgment accordingly; and it is further

ORDERED that the movants are to serve a copy of this order with notice of entry upon plaintiffs within 20 days of entry.

George J. Silver, J.S.C.

GEORGE J. SILVER
J.S.C.

Dated: January 15, 2016
New York County