Pusey v Parithivel
2014 NY Slip Op 33418(U)
December 16, 2014
Supreme Court, County of Bronx
Docket Number: 303214/11
Judge: Stanley B. Green
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: IA-6M
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EDIE PUSEY,

INDEX No. 303214/11

Plaintiff(s),

- against-

VELLORE PARITHIVEL, M.D. and BRONX-LEBANON HOSPITAL CENTER,

Defendant(s)

DECISION

---X

HON. STANLEY GREEN:

The motion by Vellore Parithivel, M.D. and Bronx-Lebanon Hospital Center (BLHC) for an order pursuant to CPLR §3212 granting summary judgment dismissing the complaint is denied.

Plaintiff was referred to Dr. Parithivel on June 25, 2010 for evaluation to undergo a screening colonoscopy. Dr. Parithivel examined plaintiff and noted no significant bowel complaints or rectal bleeding. A colonoscopy was scheduled for September 14, 2010. On September 14, 2010, plaintiff was admitted to BLHC for ambulatory surgery. Prior to the procedure, she signed consent forms. During the procedure, Dr. Parithivel encountered an obstruction at the recto-sigmoid junction and could not see any more open lumen (the pathway within the intestine). He decided to abort the procedure and withdrew the colonoscope. After the procedure, plaintiff was admitted to BLHC for observation due to complaints of pain. She was given pain medication and improved.

The following day, plaintiff was discharged as she had no complaints, was afebrile and

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her white blood cell count was normal. She was instructed to return to the ED if she had difficulty moving her bowels, any bleeding, or fever over 101F.

On September 17, 2010, plaintiff returned to Dr. Parithivel's office for a follow up visit. She was afebrile and her vital signs were normal, but she complained of upper abdominal pain and pain in the neck. She stated that she had moved her bowels that morning and reported, for the first time, that she had experienced a two week bout of mucoid diarrhea in Antigua, which had ended approximately two weeks prior to the follow up visit. Plaintiff's abdomen was soft with no distension, but there was vague, diffuse tenderness, so she was admitted to the hospital.

Plaintiff's admitting diagnosis on September 17, 2010 was perforated colon with free air observed by chest x-ray. The plan was to rule out perforation and rule out diverticulitis. An abdominal CT was performed and revealed a collection in the pelvis. Plaintiff underwent an exploratory laparotomy, which revealed extensive adhesions between the rectum and small bowel, with an "abscess with thick yellow pus around the recto-sigmoid and distal sigmoid colon." A colostomy and Hartmann Procedure (which involves a resection of the recto-sigmoid colon with creation of a colostomy) were performed by Dr. Parithivel. The pathology repot dated September 23, 2010, indicates the principal pathology finding was "perforated acute and chronic diverticulitis." On September 23, 2010, plaintiff was discharged home with a colostomy in place. The colostomy was successfully reversed on April 6, 2011 at another hospital.

Plaintiff claims that Dr. Parithivel and Bronx Lebanon deviated from accepted standards of medical practice by failing to timely diagnose and treat a perforation of her colon and that as a result of the delay in diagnosis, she had to undergo a Hartmann's procedure and endure the discomfort and embarrassment of having a colostomy for seven months.

Dr. Parithivel and BLHC seek dismissal of the complaint on the grounds that the care and treatment rendered to plaintiff was at all times within the standard of care and their actions were not the proximate cause of the claimed injuries.

In support of the motion, Dr. Parithivel and BLHC submit the expert affirmation of Dr. Frank, who opines that plaintiff's colon was not perforated by the scope during Dr. Parithivel's performance of the colonoscopy and that her abdominal pain and the need to undergo a surgical resection of the diseased and abscessed portion of her colon and the placement of a temporary colostomy were "directly and solely caused by her chronic diverticulitis" and not as a result of negligence on the part of Dr. Parithivel and/or Bronx-Lebanon.

Dr. Frank explains that "diverticulitis" means that there is a diseased section of intestine with micro-perforations and often a gross perforation in the intestinal wall and that the perforations occur spontaneously, as part of the disease process, because the bowel wall degrades from the disease until it finally forms actual holes through which fecal matter and air can pass. He opines that Dr. Parithivel and BLHC staff properly observed plaintiff for twenty-three hours after the colonoscopy due to her initial complaints of pain and that in light of abscesses, thick yellow pus, and diverticula at the recto-sigmoid that were found upon surgical exploration on September 17th and the large length of resected edematous colon, with multiple shallow and deep pouches including one diverticulum with a 1.5 cm perforation, plaintiff's treatment options, the extent of reparative surgery and the need for a colostomy would have been the same, regardless of whether the condition had been discovered on the day of the colonoscopy, the following morning before she was discharged from the hospital, or at any moment in between her post-colonoscopy discharge and her re-admission to BLHC on September 17, 2010.

Plaintiff contends that the motion must be denied because the affirmation of her expert shows that Dr. Parithivel departed from the prevailing standard of care by failing to order a flat and upright abdominal x-ray and/or a CT scan of the abdomen immediately following the aborted colonoscopy. He states that it was a breach of the standard of care for Dr. Parithivel to have encountered an obstruction after advancing the scope 30 cm and not to have investigated the cause of his inability to further advance the scope. Plaintiff's expert opines that it was not enough to simply admit plaintiff for monitoring following the procedure and that the failure to perform a timely x-ray and/or CT scan of the abdomen deprived plaintiff of the chance to be placed on bowel rest and antibiotics to address the diverticulitis if, in fact, a perforation had not yet developed, which would have likely improved plaintiff's chance of avoiding any surgical intervention. In the event that the imaging would have revealed a perforation on September 14, 2010, then plaintiff would have been a candidate that day for primary closure with no need for a colostomy. The expert opines that the failure to order the required imaging resulted in a delay of 48 hours during which no treatment of plaintiff's developing and progressive diverticulitis was given. He opines that this delay allowed the condition to progress to the point where plaintiff developed multiple adhesions and ultimately required lysis of adhesions, a peritoneal washout, an emergency Hartmann's procedure and a colostomy for seven months.

Plaintiff's expert also opines that BLHC staff departed from the standard of care by failing to contact Dr. Parithivel at or about 8 p.m. on the night of September 14, when plaintiff complained of "unbearable abdominal pain", accompanied by sweating. He opines that pain that is so bad that it required pain medication (Demerol) should have precipitated the ordering of a flat and upright x-ray of the abdomen and/or a CT scan of the abdomen. He opines that the

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omissions of Dr. Parithivel and BLHC staff were the proximate cause of plaintiff's need for surgery and a colostomy.

In reply, Dr. Parithivel and BLHC contend that plaintiff's expert's opinion is conclusory and not supported by reference to the medical records. They submit a further affirmation by Dr. Frank, who opines that plaintiff's expert's opinion is contradictory in that he opines, at the outset, that the colonoscopy caused the perforation but then goes on to posit that plaintiff likely would have been fully treatable with rest and antibiotics if a film had been taken after the colonoscopy and the "true situation" discovered. Dr. Frank states that, while he agrees that a gross perforation must be addressed by classical surgery or endoscopically, plaintiff's expert's opinions are irreconcilable and fail to address plaintiff's bowel symptoms of several weeks earlier. He also opines that the abscess that had formed in plaintiff develops slowly when the disease is already established and does not develop in 48 hours. Thus, he opines that plaintiff would have required a colostomy and the use of a Hartmann's procedure even if her condition had been diagnosed earlier.

On a motion for summary judgment, it is the burden of the summary judgment proponent to demonstrate, prima facie, that he is entitled to judgment as a matter of law with evidence sufficient to eliminate any material issue of fact; failure to do so requires denial of the motion regardless of the sufficiency of the opposing papers (Alvarez v. Prospect Hosp., 68 NY2d 320; Winegrad v. New York Univ. Med. Ctr., 64 NY2d 851). The burden then shifts to the party opposing the motion to demonstrate by evidentiary proof in admissible form that a triable issue of fact exists (Zuckerman v. City of New York, 49 NY2d 557). A court's task is issue finding rather than issue determination (Sillman v. Twentieth Century-Fox Film Corp., 3 NY2d 395) and

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the court must view the evidence in the light most favorable to the party opposing the motion, giving that party the benefit of every reasonable inference and ascertaining whether there exists any triable issue of fact (Boyce v. Vazquez, 249 AD2d 724).

While Dr. Parithivel and BLHC have presented competent evidence sufficient to establish, prima facie, that they did not depart from the accepted standards of care in their treatment of plaintiff, the opinion of plaintiff's expert, that: (1) Dr. Parithivel departed from good and accepted standards of gastroenterological practice by failing to perform x-ray or a CT scan of plaintiff's abdomen immediately following the colonoscopy to investigate and evaluate for a mass or perforation; (2) BLHC staff departed from the standard of care by failing to contact Dr. Parithivel on the night of September 14, 2010 regarding plaintiff's complaint of "unbearable abdominal pain" accompanied by sweating; and (3) that the delay in diagnosis of plaintiff's condition deprived her of the opportunity to be treated with either bowel rest and antibiotics if there was no perforation or by primary closure of a perforation, if one existed, with no need for a colostomy, raises material issues of fact which preclude a grant of summary judgment.

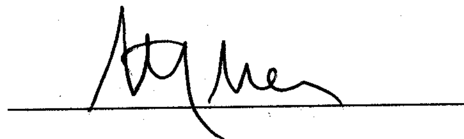
Although Dr. Frank opines that plaintiff's expert's opinion is contradictory because he opines that the colonoscopy "did most likely cause or contribute to the perforation," in fact, his opinion is not contradictory because he then opines that if the tests revealed that plaintiff's "true situation" was that no perforation had developed, then she would have had a chance to be placed on bowel rest and antibiotics to address the diverticulitis and if she had already developed a perforation, then she would have been a candidate on that day for primary closure with no need for a colostomy.

While Dr. Frank opines that a colostomy would have been necessary regardless of

whether the tests were performed two days earlier because the abscess could not have formed in 48 hours, this contention is not properly considered because it was raised for the first time in reply papers. In any event, plaintiff medical records, which show that she did not report any abdominal pain prior to the colonoscopy and the conflicting expert opinions raise triable issues of fact and credibility, which preclude a grant of summary judgment (Frye v. Montefiore Med. Ctr., 70 AD3d 15). Accordingly, this motion for summary judgment is denied.

This constitutes the decision and order of the court.

Dated: December 16, 2014



STANLEY GREEN, J.S.C.