DeTolla v Pourmand
2015 NY Slip Op 32321(U)
November 30, 2015
Supreme Court, Suffolk County
Docket Number: 10-25621
Judge: Joseph Farneti
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SHORT FORM ORDER

INDEX No. 10-25621
CAL No. 13-00127MM

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 37 - SUFFOLK COUNTY

PRESENT:

Hon. JOSEPH FARNETI
Acting Justice Supreme Court

MOTION DATE 3-26-15
ADJ. DATE 4-23-15
Mot. Seq. # 007 - MD

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JADIE SHING DeTOLLA, Individually and as Executrix of the Estate of NEILL DeTOLLA, deceased,

Plaintiffs,

- against -

RAHMAN POURMAND, M.D., ZWANGER & PESIRI RADIOLOGY GROUP, LLP, MEDICAL ARTS RADIOLOGICAL GROUP, P.C., AJAY E. CHITKARA, M.D., DEV R. CHITKARA, P.C., OTOLARYNGOLOGY ASSOCIATES OF LONG ISLAND, P.C., PAUL LERNER, M.D., PAUL LERNER, M.D., P.C., and ROBERT M. GALLER, M.D.,

Defendants.

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Upon the following papers numbered 1 to 77 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1 - 69 ; Notice of Cross Motion and supporting papers __; Answering Affidavits and supporting papers 70 - 75 ; Replying Affidavits and supporting papers 76 - 77 ; Other __; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that this motion by defendant Dr. Rahman Pourmand for an Order granting summary judgment dismissing the complaint against him is denied.

Plaintiff Jadie Shing DeTolla, individually and as Executrix of the Estate of Neill DeTolla, commenced this action to recover damages for medical malpractice, wrongful death, and loss of services. The complaint alleges that defendants departed from good and accepted medical care in failing

to timely and properly diagnose and treat decedent's brain stem cancer, resulting in his death on July 26, 2009. According to the Bill of Particulars, defendant Dr. Rahman Pourmand, who treated decedent from October 2007 until November 2008, was negligent in, among other things, failing to properly formulate a differential diagnosis, "in failing to timely and properly identify medical conditions consistent with decedent's condition," and "in negligently and improperly ruling out a potential diagnosis."

Decedent Neill DeTolla has an extensive medical history dating back to 1987. In October 1987, he underwent a cardiac transplant for idiopathic cardiomyopthy, and was placed on life-long immunosuppressive therapy with Cyclosporine to prevent organ rejection. Decedent returned annually to the facility where he underwent the transplant for post-cardiac transplant surveillance. In April 1998, decedent was diagnosed with sqamous cell carcinoma (SCC) of the anus following an excision of persistent perianal warts. In August and September 1998, decedent received chemotherapy and radiation therapy. In September 2002, during a surveillance computerized tomography (CT) scan for perianal cancer, a renal mass was observed, and a subsequent magnetic resonance image (MRI) showed a lesion on decedent's left kidney. A pre-op renal evaluation of decedent performed in October 2002 noted, among other things, SCC on both hands, chronic renal failure for six years due to long-standing use of Cyclosporine, and multiple excisions for basal cell carcinoma and SCC. Beginning in 2003, decedent saw various dermatologists to treat and monitor his actinic keratoses and basal and squamous cells lesions. In February 2006, decedent had a seizure while he was in the office of his urologist, who admitted him to Memorial Sloan Kettering for evaluation; the cause of the seizure was not determined.

In August 2007, decedent presented to Dr. Robert Galler, a neurologist, with complaints that he could not raise his head without support, neck and arm pain for several weeks. Decedent also advised that his symptoms worsened after a boat incident, in which a wave caused his neck to jerk. On October 31, 2007, decedent saw Dr. Rahman Pourmand, a neurologist, on referral from Dr. Galler. Decedent was treated by Dr. Pourmand, as well as by various other physicians, from July 2007 until November 2008, but his symptoms continued. During this time period, he underwent muscle biopsies, MRI examinations and CT scans. Decedent's condition worsened, and in October 2008 he had difficulty speaking and swallowing, his tongue deviated to the left, and he could not pick his head up. In December 2008, decedent saw Dr. Marcel Olarte at New York Presbyterian Hospital. An MRI examination revealed thick secretions versus discrete lesion at the level of the second tracheal ring left. A neck MRI examination performed in January 2009 revealed "an enhancing lesion of the left inferior capitis muscle with extension into left C2 and 3 pedicles, tumor extending into spinal canal C1 and 2 to the left sternomastoid foramen to involve the skull base." It was determined that surgery was not an appropriate option because the tumor was unresectable. In March 2009, decedent started both radiation therapy and chemotherapy, which were completed in May 2009. Decedent passed away on July 26, 2009.

Dr. Pourmand now moves for summary judgment dismissing the complaint against him arguing that his treatment of decedent was in accordance with accepted medical practice, and that such treatment was not a proximate cause of his death. In support of his motion, Dr. Pourmand submits, among other things, copies of the pleadings, an expert affirmation of Dr. Jai Grewal, a transcript of his own deposition testimony, and various medical records and reports regarding decedent's extensive medical treatment. Plaintiff opposes the motion on the ground that there are triable issues of fact as to whether

Dr. Pourmand deviated from the acceptable standards of medical practice while rendering treatment to decedent. In opposition, plaintiff submits a redacted expert's affirmation, expert affirmations of Dr. Stephen Burstein and Dr. Reed Phillips, and a transcript of Dr. Pourmand's deposition testimony.

On a motion for summary judgment the movant bears the initial burden and must tender evidence sufficient to eliminate all material issues of fact (***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 487 NYS2d 316 [1985]). Once the movant meets this burden, the burden then shifts to the opposing party to demonstrate that there are material issues of fact; mere conclusions and unsubstantiated allegations are insufficient to raise any triable issues of fact (*see* ***Zuckerman v City of New York***, 49 NY2d 557, 427 NYS2d 595 [1980]; ***Perez v Grace Episcopal Church***, 6 AD3d 596, 774 NYS2d 785 [2004]). As the court's function on such a motion is to determine whether issues of fact exist, not to resolve issues of fact or to determine matters of credibility; the facts alleged by the opposing party and all inferences that may be drawn are to be accepted as true (*see* ***Roth v Barreto***, 289 AD2d 557, 735 NYS2d 197 [2d Dept 2001]; ***O'Neill v Fishkill***, 134 AD2d 487, 521 NYS2d 272 [2d Dept 1987]).

The requisite elements of proof in an action to recover damages for medical malpractice are a deviation or departure from accepted practice, and evidence that such departure was a proximate cause of plaintiff's injury or damage (*see* ***Ahmed v Pannone***, 116 AD3d 802, 984 NYS2d 104 [2d Dept 2014]; ***Feinberg v Feit***, 23 AD3d 517, 806 NYS2d 661 [2d Dept 2005]; ***Lyons v McCauley***, 252 AD2d 516, 675 NYS2d 375 [2d Dept], *lv denied* 92 NY2d 814 [1998]). On a motion for summary judgment dismissing the complaint, a defendant hospital or physician has the burden of establishing through medical records and competent expert affidavits the absence of any departure from good and accepted practice, or, if there was a departure, that the plaintiff was not injured thereby (*see* ***Carioscia v Welischar***, 124 AD3d 816, 2 NYS3d 550 [2d Dept 2015]; ***Stukas v Streiter***, 83 AD3d 18, 918 NYS2d 176 [2d Dept 2011]; ***Luu v Paskowski***, 57 AD3d 856, 871 NYS2d 227 [2d Dept 2008]). In opposition, "a plaintiff must submit evidentiary facts or materials to rebut the defendant's *prima facie* showing, so as to demonstrate the existence of a triable issue of fact" (***Deutsch v Chaglassian***, 71 AD3d 718, 719, 896 NYS2d 431 [2d Dept 2010]). Further, the plaintiff "need only raise a triable issue of fact with respect to the element of the cause of action or theory of nonliability that is the subject of the moving party's *prima facie* showing" (***Stukas v Streiter***, 83 AD3d 18, 24, 918 NYS2d 176 [2d Dept 2011]).

Dr. Jai Grewal, a physician licensed to practice medicine in the State of New York and board certified in neurology and neurological oncology, opines that Dr. Pourmand acted appropriately and did not depart from the accepted standards of medical practice in his care and treatment of decedent. Dr. Grewal opines that Dr. Pourmand timely and appropriately evaluated and diagnosed decedent for an isolated myopathy of the neck extensor muscles when decedent presented to his office on October 31, 2007. He further states that Dr. Pourmand timely and appropriately formulated a differential diagnosis based on decedent's complaints, past medical history, imaging studies, and clinical findings, ruling out multiple peripheral and neurological disorders while decedent was under his care. He states that Dr. Pourmand appropriately performed a detailed and comprehensive neurological examination of decedent, which revealed no neurological findings indicating that decedent was suffering from a central neurological disorder.

Dr. Grewal opines that Dr. Pourmand's initial impression appropriately indicated that decedent appeared to have an isolated extensor muscle weakness/isolated extensor neck myopathy; that he appropriately included the differential diagnoses of motor neuron disease, polymyositis, inclusion body myositis, myasthenia gravis or chronic inflammatory demyelinating polyneuropathy; and that he appropriately set forth a plan to repeat an electromyelogram (EMG) and obtain a muscle biopsy. The muscle biopsy was obtained during the admission to Stony Brook University Hospital on December 6, 2007, which revealed non-specific changes. On December 17, 2007, an EMG nerve conduction study was performed to rule out motor neuron disease, myopathy, and neuropathy. The EMG report indicated an abnormal study due to the presence of a diffuse axonal neuropathy and isolated cervical myopathy with no evidence of neuromuscular junction disorder. According to Dr. Grewal, Dr. Pourman noted that the neurological examination was significant for weakness of the extensor neck muscles with a plan for biopsy of those muscles and administration of prednisone.

Dr. Grewal states that based on his review of the records, decedent returned to see Dr. Pourman on January 21, 2008, at which time prednisone was started and an examination revealed weakness of the extensor muscles of the back. He states that decedent was admitted to Stony Brook University Hospital from January 25 through January 31 for episodes of losing time over the prior two to three days, loss of concentration for two to three hours at a time, and falling asleep for seconds at a time. It was determined that decedent had atrial fibrillation. According to Dr. Grewal's affidavit, a CT scan without contrast of decedent's head was done on January 25, 2008, which revealed no acute intracranial pathology. Dr. Grewal states that on February 25, 2008, decedent saw Dr. Pourmand, but a determination as to the cause of decedent's condition could not be made, and decedent continued to follow-up with Dr. Pourmand every few months for isolated extensor neck myopathy.

Dr. Grewal states that In October 7, 2008, decedent was referred by his internist to Dr. Chitkara, an otolaryngologist, for slurred speech and difficulty swallowing. He states that an MRI of decedent's neck and brain were ordered and reviewed by Dr. Chitkara, who called Dr. Pourmand on November 6, 2008 to discuss the findings of acute lingual paresis and increased dysphagia. He states that decedent was seen by Dr. Pourmand on that day, who noted that decedent's condition had worsened and that his tongue was deviating to the left side, indicating hypoglossal nerve problems and multiple cranial neuropathies. Dr. Grewal opines that this new complaint was the first indication of a central neurological problem, and that Dr. Pourmand appropriately formulated a differential diagnosis of possible carcinomatous meningitis, sarcoidosis, or Guillain-Barre Syndrome, and timely admitted decedent to Stony Brook University Hospital for further work-up to rule out infectious etiology and paraneoplastic process. Dr. Grewal states that when decedent was discharged from the hospital, the diagnosis was possible paraneoplastic process and he was told to follow-up with Dr. Pourmand for a PET scan to rule out occult malignancy. Dr. Grewal states that a CT scan of plaintiff's neck showed degenerative changes but no mass was noted. Dr. Grewal opines that on November 26, 2008, Dr. Pourmand appropriately indicated a progressive neurological problem which could be paraneoplastic, and appropriately ordered a PET scan, which revealed no evidence of malignancy. Decedent did not return to see Dr. Pourmand after this visit.

Dr. Grewal opines that decedent's head drop was not related to his squamous cell brain stem tumor, as he did not present to Dr. Pourmand with complaints or symptoms consistent with cranial nerve involvement. He states that it was not until about one year later, in October 2008, when decedent presented with slurred speed and tongue deviation, at which time Dr. Pourmand appropriately started a work-up for central neurological disorder including admission to Stony Brook University Hospital and ordered a PET scan. Dr. Grewal opines that the tumor affected only the left side of decedent's spinal column, and that his head drop was not caused by the cancer. Significantly, Dr. Grewal states that the findings of the MRI exam done at New York Presbyterian Hospital on January 27, 2009, were consistent with his recent history of ninth, tenth, and eleventh cranial nerve palsy.

Dr. Grewal further states that decedent did not present with cranial nerve involvement until October 2008, and that once cranial nerves are involved, a patient's downhill course would be extremely rapid. He opines that if decedent was symptomatic of this tumor in 2007, his demise would have occurred long before July 2009. Dr. Grewal states that he reviewed the imaging studies conducted in the area of decedent's head from February 2006 through January 2008, and that those studies were negative for potential cancer or lesions, and concludes that decedent did not have a brain stem tumor during that period of time. He states that the CT scan on August 16, 2007 was of good quality, and if a tumor was present at that time, it would have been picked up on that imaging. He further states that the tumor showed significant growth after it was revealed on January 27, 2009 neck MRI exam, and that the CT-guided needle core biopsy done on February 10, 2009 revealed invasive squamous cell carcinoma. He opines that Dr. Pourmand did not deviate from the accepted standard of care, because decedent did not present with any symptoms or complaints consistent with cranial nerve involvement until October 2008, and therefore no additional imaging during the period prior to that was necessary.

Dr. Grewal further opines that no imaging with contrast was warranted prior to December 2009, when decedent began to exhibit neurological signs and symptoms of a brain stem disorder, as decedent had a history of significant kidney disease and the contrast would cause kidney failure and death. He states that Dr. Pourmand timely and appropriately suspected a cancerous process when decedent presented with new complaints of slurred speech, difficulty swallowing and vocal cord paralysis in October 2008. He also states that it was reasonable for Dr. Pourmand not to order a lumbar puncture prior to November 2008, as such test is not indicated until it is fairly obvious that the patient has a central neurological problem, which was not the case at the time. He explains that a lumbar puncture would not necessarily be able to diagnose cancer, especially in its early stages, as squamous cell carcinoma cells can travel along the nerve. Furthermore, Dr. Grewal states that decedent's eventual tumor was metastatic and likely originated from a squamous cell carcinoma lesion on his head or neck, and that once it metastasized, it was stage IV cancer which carries a very poor prognosis. He states that decedent developed a rare, but deadly complication of immunosuppressant therapy, and that organ transplant recipients are at an increased risk for cutaneous squamous cell carcinoma.

Dr. Pourmand has failed to establish his *prima facie* entitlement to summary judgment as a matter of law. Significantly, the expert affirmation Dr. Grewal was conclusory, as he failed to set forth the applicable standard of care, and merely recounted the treatment rendered, and opined, in a conclusory manner, that such treatment did not represent a departure from good and accepted medical practice (*see*

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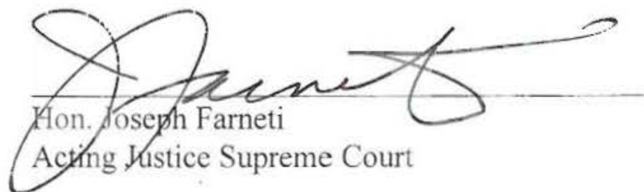
Tomeo v Beccia, 127 AD3d 1071, 7 NYS3d 472 [2d Dept 2015]; ***Barlev v Bethpage Physical Therapy Assoc., P.C.***, 122 AD3d 784, 995 NYS2d 514 [2d Dept 2014]). Furthermore, while Dr. Grewal states that Dr. Pourmand "appropriately formulated a differential diagnosis based on decedent's complaints, past medical history, imaging studies, and clinical findings to rule in and rule out multiple peripheral and neurological disorders," he failed to explain whether Dr. Pourmand departed from the accepted standard of care by not ruling out the possibility of a focal lesion in the neck or skull base based on decedent's medical history. In addition, one of the factors in Dr. Grewal conclusion that the decedent's head drop was not caused by the cancer was because the tumor only affected the left side of his spinal column, and that prior to treating with Dr. Pourmand decedent saw multiple physicians whose physical examinations and progress notes indicated diffuse weakness, not left sided weakness. However, Dr. Grewal does not identify which physicians made such notations or when decedent was seen. Moreover, Dr. Pourmand testified at a deposition that decedent presented with weakness in his left arm, which he attributed to radiculopathy at level C5-6, and had a history of occasional numbness of the left side of his face and shoulder, but that he determined it was not a significant finding because it was occasional and not demonstrated during the examination. This deposition testimony conflicts with Dr. Grewal's statement that physical examinations of decedent indicated diffuse weakness, not left sided weakness. And while Dr. Grewal opines that decedent's complaints of occasional left sided facial and shoulder numbness were not symptoms of his brain stem tumor, it does not sufficiently explain his conclusion. Finally, Dr. Grewal states in his affirmation that the report concerning the December 2007 EMG/nerve conduction study indicated an "abnormal study due to the presence of a diffuse axonal neuropathy and isolated cervical myopathy," but fails to explain the significance of such an abnormal study and the appropriate standard of care in light of such a result. Accordingly, defendant Dr. Pourmand's motion for summary judgment is denied.

Dated: November 30, 2015



Hon. Joseph Farneti
Acting Justice Supreme Court

_____ FINAL DISPOSITION __X__ NON-FINAL DISPOSITION