

Polanco v New York City Health & Hosps. Corp.

2025 NY Slip Op 33744(U)

October 3, 2025

Supreme Court, Kings County

Docket Number: Index No. 528715/2023

Judge: Consuelo Mallafre Melendez

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At an IAS Term, Part MMESP-7 of the Supreme Court of the State of NY, held in and for the County of Kings, at the Courthouse, at 360 Adams Street, Brooklyn, New York, on the 3rd day of October 2025.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

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EPIFANIO POLANCO,

Plaintiff,

-against-

NEW YORK CITY HEALTH & HOSPITALS
CORPORATION,

Defendant.

-----X

HON. CONSUELO MALLAFRE MELENDEZ, J.S.C.

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

NYSCEF #s: 19 – 21, 22 – 51, 54 – 56, 57 – 58

Defendant New York City Health and Hospitals Corporation (“NYCHHC”) moves (Seq. No. 1) for an Order, pursuant to CPLR 3212, granting summary judgment in their favor and dismissing Plaintiff’s Complaint.

Plaintiff opposes the motion.

Plaintiff commenced this action on October 4, 2023, asserting claims of medical malpractice against NYCHHC in connection to a laparoscopic sigmoidectomy he underwent at Woodhull Hospital on March 27, 2023, and the alleged failure to timely diagnose and repair an anastomotic leak during the surgery or post-operatively through March 29, 2023.

Plaintiff underwent a colonoscopy on March 1, 2023 which revealed a likely malignant mass obstructing his sigmoid colon. Surgery was recommended to resect the sigmoid colon and tumor.

On March 27, 2023, Plaintiff underwent a laparoscopic sigmoidectomy at Woodhull, performed by a staff general surgeon George Ojo, M.D. (“Dr. Ojo”). The procedure also included a loop ileostomy, diverting bowel contents to a port in abdomen. During the procedure, Dr. Ojo recognized an “incomplete donut,” where the bowel did not make a complete circle, and performed an air leak test. He found no leak at the anastomosis (where the colon had been sealed). Plaintiff was transferred to the PACU after the surgery at 2:09 p.m.

Following surgery, his initial bloodwork showed normal white blood cell count, but he had hypotension and worsening cardiac symptoms, including a low ejection fraction of 30% revealed by an echocardiogram. A critical care consult was ordered at 5:12 a.m. and shortly after the patient was diagnosed with septic shock of unknown origin. He was intubated and transferred to the ICU. A differential diagnosis was noted including intrabdominal leak, pneumonia, or urinary tract infection.

At 12:50 a.m. on March 29, Dr. Ojo returned Plaintiff to the operating room for an exploratory laparotomy. The anastomosis was found to be partially necrotic, and a leak was identified. The anastomosis was resected and a temporary wall closure was performed.

Subsequently, Plaintiff showed signs of encephalopathy and was unarousable after being taken off sedation on April 6. He remained intubated and was discharged from Woodhull to a subacute rehabilitation center on June 6, 2023.

Plaintiff alleges that NYCHHC, through its physicians and staff including Dr. Ojo, departed from the standard of care by failing to revise the incomplete donut ring intraoperatively, and by failing to timely diagnose and treat Plaintiff’s anastomotic septic leak. They allege that these departures proximately caused his injuries including the anastomotic leak, intrabdominal

sepsis, septic shock, multiorgan failure, need for multiple surgeries, and prolonged intubation and hospitalization.

In evaluating a summary judgment motion in a medical malpractice action, the Court applies the burden shifting process as summarized by the Second Department: “[A] defendant must make a prima facie showing either that there was no departure from good and accepted medical practice, or that the plaintiff was not injured by any such departure” (*Rosenzweig v Hadpawat*, 229 AD3d 650, 652 [2d Dept 2024]). “In order to sustain this prima facie burden, the defendant must address and rebut any specific allegations of malpractice set forth in the plaintiff’s complaint and bill of particulars” (*Martinez v Orange Regional Med. Ctr.*, 203 AD3d 910, 912 [2d Dept 2022]). “Once a defendant physician has made such a showing, the burden shifts to the plaintiff to demonstrate the existence of a triable issue of fact, but only as to the elements on which the defendant met the prima facie burden. Summary judgment is not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions.” (*Rosenzweig* at 652 [2d Dept 2024] [internal quotation marks and citations omitted].) However, “expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact” (*Barnaman v Bishop Hucles Episcopal Nursing Home*, 213 AD3d 896, 898-899 [2d Dept 2023]).

In support of the motion, Defendant submits an expert affirmation from Dan Seth Reiner, M.D. (“Dr. Reiner”), a licensed physician board certified in general surgery and surgical critical care.

Dr. Reiner opines that Dr. Ojo and other NYCHHC staff complied with the standard of care at all times in their treatment of Plaintiff. He opines in detail as to the performance and operative techniques used in the laparoscopic sigmoidectomy on March 27. In relevant part, Dr.

Reiner states that Dr. Ojo identified and documented an incomplete proximal “donut,” i.e., a normally ring-shaped circle of tissue which forms when the stapler is removed, which in this case did not form a complete circle. He opines that in light of the incomplete proximal donut, Dr. Ojo “adjusted the procedure accordingly” by performing an underwater air leak test. Dr. Reiner opines that an incomplete donut does not constitute a departure from the standard of care and was appropriately “recognized and addressed.”

Through the air leak test, the expert opines that Dr. Ojo confirmed “the anastomosis during surgery was intact with no leak.” He also opines that Dr. Ojo performed a loop ileostomy to further ensure the patient’s safety and divert stool away from the anastomosis, “out of an abundance of caution.”

Following the surgery, Dr. Reiner notes that Plaintiff’s white blood cell count remained within normal limits. However, he began to exhibit hypotension and cardiac symptoms, and a cardiac consultation was timely ordered and performed at 4:20 p.m. Dr. Reiner opines that when the patient began to exhibit signs of septic shock at approximately 5:12 a.m., an intrabdominal leak was appropriately noted as part of his differential diagnosis, but “it was appropriate for the staff to rule out the cardiology cause of the patient’s symptoms” first, as this was the more likely cause given his echocardiogram results and normal white blood cell count. The expert also opines that his low blood pressure was appropriately controlled with Metropolol and Levophed.

The expert opines that in light of the patient’s cardiac condition, surgical intervention carried a high risk of mortality and was a “last resort” after other attempts to stabilize him were unsuccessful. He opines that despite this risk, Dr. Ojo and his team “timely identified the need to bring him back to the OR” in the early morning of March 29, 2023, and identified and repaired the leak, though this required a temporary abdominal wall closure and further surgeries.

Dr. Reiner opines that no departures from the standard of care were a proximate cause of Plaintiff's anastomotic leak, septic shock, or resultant injuries. He opines that an anastomotic leak is a known complication of this type of surgery which can occur in the absence of any surgical error. He also opines, based on the air leak test, that the anastomosis was intact when the surgery was completed, and the leak developed post-operatively. He further opines that it was most likely the patient's low blood pressure, decrease in blood supply to the organs, and the necessary use of vasopressors which caused the anastomosis breakdown and leak to occur.

Based on these submissions, the movant has established prima facie entitlement to summary judgment on behalf of NYCHHC. The movant's expert set forth detailed and well-grounded opinions as to the performance of Plaintiff's surgery and post-operative care. Further, the expert opined that the anastomotic leak and other complications were not proximately caused by any negligent acts or omissions of Dr. Ojo or other NYCHHC staff. The burden therefore shifts to Plaintiff to raise a triable issue of fact.

In opposition, Plaintiff submits an expert affirmation from a licensed physician [name of expert redacted], board certified in general surgery. The Court was presented with a signed, unredacted copy of the affirmation for *in camera* inspection.

Plaintiff's expert opines that Dr. Ojo departed from the standard of care during the March 27, 2023 surgery by failing to revise Plaintiff's anastomosis during surgery. The expert explains that during the procedure, "an end-to-end anastomosis endorectal stapling instrument was used to anastomose or connect the proximal colon to the distal rectal stump," with a row of staples connecting the two ends of the bowel. The expert opines that a surgeon should examine the two rings or "donuts" of excess tissue from each side of the anastomosis, which "indicates a trustworthy, well-formed anastomosis" if the donuts are complete.

The expert opines that an incomplete donut indicates a flawed anastomosis “which is virtually guaranteed to leak stool into the patient’s abdomen if not corrected during the initial surgery.” Thus, in the face of an incomplete donut, the expert opines that Dr. Ojo was required by the standard of care to redo the anastomosis by removing the prior anastomosis and using a new end-to-end stapler to reconnect the bowel ends.

The expert opines that performing an air-leak test was insufficient and should only have been performed *after* the anastomosis and donuts were redone. They opine that an air leak test can appear negative despite a defective anastomosis, because of the temporary compression sealing. In this case, the expert opines that compression sealing caused a false negative result, but the flawed anastomosis inevitably broke and began to leak after the procedure.

The expert also opines that Dr. Ojo should have examined the anastomosis for gaps or holes in the staple line with a flexible sigmoidoscopy. They opine that Dr. Ojo departed from the standard of care by terminating the surgery after relying only on an air-leak test, despite the incomplete proximal donut which indicated the anastomosis was “dangerously flawed.” The sigmoidoscopy test, in the expert’s opinion, would have been more reliable to identify defects and redo the staple line intraoperatively.

The expert opines that the loop ileostomy performed by Dr. Ojo was only an “ineffective Band-Aid” to divert fecal matter and did not mitigate the failure to create a stable anastomosis.

With respect to post-operative care, Plaintiff’s expert opines that Dr. Ojo and the NYCHHC staff failed to recognize the signs and symptoms of an anastomotic leak and perform a CT scan and timely surgery. The patient went into septic shock at approximately 5:12 a.m. on March 28. An anastomotic leak was noted in Dr. Ojo’s differential diagnosis at 2:33 p.m., but a

CT scan was not performed, and he was not returned to the operating room until the early morning of March 29 at 12:50 a.m.

Plaintiff's expert disagrees with the movant's expert Dr. Reiner that it was appropriate to rule out a cardiac cause of his symptoms due to his normal white blood cell count. Plaintiff's expert states that his cardiac symptoms were "simply manifestations of progressive multiorgan failure from the worsening leak and intraabdominal sepsis," and that severe sepsis cannot be ruled out by a suppressed/non-elevated white blood cell count. Plaintiff also opines that even if a cardiac cause was suspected, a CT scan to rule out a leak should have been ordered concurrently with his other tests. The expert opines that an abdominal and pelvic CT scan is the gold standard and go-to test to identify an anastomotic leak, and the failure to order one was a departure from the standard of care.

The expert further opines that a patient exhibiting clear clinical signs of a leak, or a leak confirmed by a CT scan, should proceed directly to the operating room for "stat emergency surgery." The expert rebuts the opinion of the expert that surgical intervention was delayed due to the "risk of death," opining that a delay in treating an anastomotic leak itself "causes exponential increases in the morbidity of leaks and risk of death from sepsis."

On the issue of proximate causation, the expert opines that the mechanically flawed anastomosis resulted in "colonic contents and pathogenic bacteria" leaking into the abdomen, as demonstrated by the cultures of E. coli, E. Fragilis, and Bacteroides Fragilis which were identified in the patient on March 28, 29, and 31. The expert counters the opinion of Dr. Reiner that the anastomosis broke down after surgery due to the patient's hypotension and use of vasopressors. Plaintiff's expert instead opines that because of the flawed stapler line, "the leak was ongoing and immediate, clinically manifesting in the early morning hours of March 28."

The expert also opines that early diagnosis and reoperation could have prevented the sequelae of sepsis and multiorgan failure. They opine that an urgent CT scan or exploratory laparotomy would have identified the leak, but instead surgery was delayed until the early morning of March 29, several hours after his signs and symptoms of septic shock began to manifest and worsen.

Thus, the expert opines that both the failure to revise the donut intraoperatively and timely diagnose and treat Plaintiff post-operatively led to his worsened condition and development of “peritonitis, intrabdominal sepsis, septic shock, cardiovascular collapse, multiorgan failure, [and] multiple extensive abdominal surgeries.”

Based on the parties’ submissions, Plaintiff’s expert has raised clear issues of fact as to whether Dr. Ojo departed from the standard of care, including his alleged failure to intraoperatively revise and redo the anastomosis in the face of an “incomplete donut” and relying on an air-leak test rather than a flexible sigmoidoscopy. Plaintiff’s expert also raised issues of fact on his post-operative care, specifically the delay in performing an abdominal/pelvic CT scan or surgical intervention before he was taken back to the operating room on March 29.

Plaintiff’s expert also countered the movant’s expert as to the proximate cause of Plaintiff’s anastomotic leak, opining that its breakdown was directly caused by flaws in the staple line which should have been corrected intraoperatively, rather than post-operative complications from the patient’s low blood pressure or vasopressors.

“When experts offer conflicting opinions, a credibility question is presented requiring a jury’s resolution” (*Stewart v. North Shore University Hospital at Syosset*, 204 AD3d 858, 860 [2d Dept. 2022], citing *Russell v. Garafalo*, 189 A.D.3d 1100, 1102 [2d Dept. 2020]). As there are

clear issues of fact and credibility raised by the experts, which must be resolved by a jury, NYCHHC's motion for summary judgment on the medical malpractice claims is denied.

Plaintiff does not oppose the part of the motion seeking summary judgment on the issue of informed consent. Accordingly, the motion is granted to the extent of dismissing any claims against NYCHHC for lack of informed consent, and the motion is otherwise denied.

It is hereby:

ORDERED that NYCHHC's motion (Seq. No. 1) for summary judgment is **granted to the extent** of dismissing Plaintiff's claims against them for lack of informed consent, and the motion is otherwise **denied**; and it is further

ORDERED counsel for both parties shall appear for a Settlement Conference on December 4, 2025, virtually over Microsoft Teams. A link will be provided.

This constitutes the decision and order of this Court.

ENTER.



**Hon. Consuelo Mallafre Melendez
J.S.C.**