SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

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LAURA M. BURDICK-SHERMAN and
MARK SHERMAN,

Plaintiffs,

Index No. 805062/13
Motion Seq. No.002

-against-

KAREN L. HIOTIS, M.D., FARBOD DARVISHIAN, M.D., SARA D. SHAYLOR, M.D., AMY D. TIERSTEN, M.D., NYU BREAST AND SURGICAL ONCOLOGY ASSOCIATES, NYU CANCER INSTITUTE, NYU CLINICAL CANCER CENTER, NYU IMAGING, INC., NYU LANGONE MEDICAL CENTER, TISCH HOSPITAL, NYU HOSPITALS CENTER and NYU MEDICAL CENTER,

Defendants.

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SCHLESINGER, J.:

In this action, which sounds in medical malpractice, the plaintiff Laura M. Burdick-Sherman is claiming that the various named defendants were negligent in failing to timely diagnose the cancerous mass in her right breast. The action is scheduled to proceed to trial on September 8, 2015. The motion now before the Court is brought by one of the defendants. The motion is for summary judgment.

The material facts which comprise the claim against the main defendant, Dr. Karen Hiotis, as well as the moving defendant, Dr. Sara D. Shaylor, begin in May 2011. Specifically on May 5, 2011, Ms. Burdick-Sherman was referred by her primary care physician, Dr. Jeremy Stopker to Dr. Hiotis, a Surgeon because of pain in her right breast. Dr. Hiotis specialized in breast surgeries and in fact, testified that 40-50 percent of her patients had been diagnosed with cancer.

At the first visit between the plaintiff and Dr. Hiotis, Ms. Burdick-Sherman reported pain in her right nipple for about a week. She also stated that she had fallen two days before. Additionally, but significantly, she told the doctor that she had a bloody discharge from the right nipple. In fact, during Dr. Hiotis' physical examination that day, the doctor was able to reproduce the bloody discharge. Finally, the plaintiff told Dr. Hiotis that she had a mammogram at Westside Radiology on February 1, 2011, which was negative.

Dr. Hiotis, as stated above, conducted a physical examination. She located the bloody discharge at an 8:00 position near the duct. She also noted thickening at the 9:00 position. But she felt no masses or lumps. Nor was there evidence of retraction. Her plan was to do an ultrasound in order to rule out any discreet masses.

To proceed with the ultrasound, Dr. Hiotis referred Ms. Burdick-Sherman to the moving defendant, Dr. Shaylor, a board certified Radiologist. There does not appear to have been, nor has one been preserved, any actual written prescription for the ultrasound but both Dr. Hiotis and Dr. Shaylor testified that they spoke about the patient and how Dr. Hiotis believed the right breast should be imaged. In Dr. Hiotis' EBT, she made clear that she wanted Dr. Shaylor to do an ultrasound of the retroaveolar area of plaintiff's right breast. Dr. Hiotis also testified that requesting this kind of imaging was "the standard protocol for bloody discharge... and they did what was appropriate for the diagnosis".

Dr. Shaylor proceeded to image the plaintiff's breast on May 11, 2011. She followed the directions orally given to her by Dr. Hiotis. This means that she imaged the retroaveolar area of plaintiff's right breast. This imaging resulted in a finding by Dr. Shaylor that there was no sonographic evidence of malignancy. The two doctors then discussed the results after Dr. Hiotis had viewed the image herself. She indicated that she was

satisfied that an adequate area of the breast had been imaged.

After this imaging, Dr. Hiotis had the plaintiff come in so that Dr. Hiotis could perform a ductal excision of the right breast. This was done on May 20, 2011. Dr. Hiotis then sent the excised tissue to a pathologist, Dr. Darvishian, who returned a finding that the tissue was benign.

Ms. Burdick-Sherman then saw Dr. Hiotis again on June 1. On that date, since no discernable disease had yet been found, Dr. Hiotis attributed the symptoms to trauma, arguably from the fall she had reported to the doctor at the first visit. Dr. Hiotis then asked the plaintiff to return to see her in 6 months.

However on September 21, 2011, Ms. Burdick-Sherman returned to Dr. Hiotis complaining of swelling and tenderness in the right breast. Dr. Hiotis again did a physical examination. Her impression was of a seroma of the right breast which she related to the ductal excision that she had performed in May. However, she found no masses, nipple discharge or skin retraction.

On November 16, 2011, the plaintiff once more presented herself to Dr. Hiotis. This time she showed Dr. Hiotis a large subaveolar mass in her right breast. Dr. Hiotis then did a fine needle aspiration. This mass was located approximately 3cm from her nipple at the 8:00 position. The aspiration demonstrated a malignancy. On November 18, Ms. Burdick-Sherman had an MRI of the right breast. This showed an 8cm irregular mass in the right breast extending from the nipple to the 8:00-9:00 axis posteriorly. Finally, as pointed out in the moving papers by counsel, the May 11 sonogram by Dr. Shaylor had included the area of the malignancy as it viewed the entire retroaveolar area of the breast at the 8:00-9:00 position.

Supporting the motion is an affirmation from Dr. Jane Tuvia. She is board certified in Radiology and Nuclear Medicine. She completed a residency in Diagnostic Radiology in 1993. She has been an attending Radiologist at various hospitals since 1994 and has been in her own private radiology practice "Madison Avenue Women's Imaging" since 2001.

Dr. Tuvia has reviewed all the records, depositions of the parties and expert disclosures. She states in the beginning of her affirmation that her opinions, with a reasonable degree of medical certainty, are that Dr. Shaylor treated Ms. Burdick-Sherman in all ways in accordance with accepted medical practice. She further adds that the imaging conducted by Dr. Shaylor was in no way a proximate cause of the injuries being alleged. It should be stated here that the injury being alleged is the diagnosis of metastatic Stage 4 breast cancer in November 2011, as compared to Stage 2 or 3 which would have been the case if a diagnosis had been made in May.

Dr. Tuvia urges that the claims against Dr. Shaylor are without merit "because they are beyond the scope of Dr. Shaylor's role and duty as a consulting Radiologist." Put another way, Dr. Shaylor had a limited role pursuant to the referral that Dr. Hiotis made to her.

As to the performance of the ultrasound, Dr. Tuvia says that Dr. Shaylor imaged the entire retroaveolar area which included the 8:00 position where the bloody discharge was. Dr Shaylor's findings included a few minimally prominent ducts. But she identified no masses. Finally, Dr. Shaylor found no abnormalities in the retroaveolar area. This defendant doctor concluded her impressions by stating that further investigations of the ducts could be pursued if such was clinically appropriate.

In reviewing these findings, Dr. Tuvia emphasizes that what Dr. Shaylor did, pursuant to the symptoms that had been related to her, was limited to the entire retroaveolar area of the right breast. Further, imaging only that part of the breast was in accordance with accepted standards of practice. In other words, there was no reason for Dr. Shaylor to perform any other ultrasound. Dr. Tuvia also concurs with Dr. Shaylor's interpretation of the ultrasound as benign. Therefore she opines that Dr. Shaylor's impressions were in accord with accepted radiological standards.

Finally, Dr. Tuvia points out that 9 days after the ultrasound, Dr. Hiotis did the ductal excision. She states that this was the "gold standard" for attempting to determine the cause of the bloody discharge. Therefore, Dr. Tuvia states, if pathology were present in the area imaged on May 11, it would have been discovered with the incision and tissue analysis. But it was not. The interpretation was benign cells. Thus, according to Dr. Tuvia, this result confirmed Dr. Shaylor's impressions of May 11.

Dr. Tuvia's affirmation succeeds in making out a prima facie case in favor of Dr. Shaylor. The question then becomes, is the plaintiff able to show that, despite the Tuvia affirmation, there are factual issues discernable, as to whether Dr. Shaylor committed malpractice in how she conducted the May 11 ultrasound.

The plaintiff attempts to do this, and in this Court's belief, succeeds in this endeavor, by offering two affirmations. The first is from Dr. Douglas Boxer, who is board certified in Diagnostic Radiology. He states that he has performed and interpreted thousands of ultrasound studies. The second is from Dr. Bert Petersen, a board certified surgeon who has completed a Fellowship in Surgical Oncology. Dr. Boxer discusses issues involving liability, while Dr. Peterson talks about causation and the effects of the alleged delay in

diagnosis.

Dr. Boxer states that Dr. Shaylor departed from good and accepted practice by failing to ultrasound the plaintiff's entire right breast. Dr. Boxer acknowledges that the bloody nipple discharge was in a particular area in the retroaveolar part of the breast. But he emphatically opines that on ultrasounds there are no clear, easily definable anatomic borders delineating the extent of the ductal system, or in fact the entire retroaveolar region. Therefore, by engaging in a limited or targeted ultrasound of the retroaveolar area, there is a risk of missing an abnormal finding due to the subjective definition of the retroaveolar region's boundaries. But, if one images the entire breast, the doctor would not run into the problem of defining precisely where the area begins and ends.

Dr. Boxer also opines with a reasonable degree of medical certainty that a bloody discharge from the nipple is suspicious for breast cancer. Finally in this regard, he points out that since the ultrasound does not utilize any kind of harmful radiation, there is no increased risk to the patient by imaging the entire breast.

He concludes his affirmation by stating that he is familiar with patterns of tumor growth. Then he opines on the issue of the size of the mass. He states that the median doubling time for an invasive breast cancer is approximately 130 days. Therefore, a tumor that measured 8cm in diameter on November 11, 2011, when Ms. Burdick-Sherman's mass was first diagnosed, would, according to Dr. Boxer, have been approximately 5cm in May of that year. Therefore, he states that the mass would have been

> "more than large enough to be seen on an ultrasound in May 2011 (and he continues) I believe the tumor was present and observable in May 2011 and it was Dr. Shaylor's obligation to thoroughly investigate the cause of the

> suspicious nipple discharge by evaluating the entire breast." (Opposition, Exhibit 10, ¶6)

Thus there clearly was, in Dr. Boxer's opinion a delay in diagnosis. It should be noted here that plaintiff's counsel points out that Dr. Shaylor, in her deposition, agreed that there were no clear anatomical boundaries in the retroaveolar breast area.

The second affirmation from Dr. Peterson opines as to the way in which Ms. Burdick-Sherman's prognosis has been affected by the diagnosis having been made in November as opposed to May of 2011. He precedes these numbers with a statement that he is fully familiar with tumor growth, cancer staging and cancer prognosis. Also, he states his opinions are all being given with a reasonable degree of medical certainty. Dr. Peterson first states that the duct incision which resulted in a benign pathological finding probably did not reveal pathology because it was the result of a sampling error, which he says is not uncommon.

He then concludes, a critical conclusion here, that in May 2011 Ms. Burdick-Sherman's cancer had not yet metastasized. He says that he knows this from the signs and symptoms that the plaintiff displayed at that time, as well as the fact that a mammogram performed three months earlier in February 2011 failed to reveal enlarged lymph nodes. Therefore, he urges in February 2011, there was no tumor and no signs of metastatics. He also points out that in the physical examination in May 2011 by Dr. Hiotis, no palpable mass was found. Therefore, his opinion is that Ms. Burdick-Sherman was likely suffering from Stage 2 breast cancer in May 2011. For Stage 2, the long term survival rate is 93%. Stage 3 breast cancer has a survival rate of 72%. Finally, and significantly, Dr. Peterson tells us that where there is a diagnosis of metastatic Stage 4

cancer, the diagnosis that was made in November 2011, the longtime survival rate is only 22%. Thus, there was a 70% diminishment of Ms. Burdick-Sherman's chances for survival. I might add here that currently Ms. Burdick-Sherman is quite ill and very weak but wants her day in court.

The motion by Dr. Shaylor is denied. Dr. Boxer is a well credentialed Diagnostic Radiologist whose opinions, as to the lack of clear anatomical boundaries in the breast, particularly in the retroaveolar area, mandated an imaging of the entire breast, makes sense and is certainly sufficient to create an issue of fact, despite Dr. Tuvia' s opinion that targeted imaging was appropriate. I might add that the fact that the mass, first diagnosed in November 2011, was found in the area where Dr. Hiotis directed imaging, a direction Dr. Shaylor followed, does not necessarily support movant's position. This position would be that the mass was not there at that time, May 2011. However, another conclusion can be reached from this fact, one urged by the plaintiff, that an approximate 5cm mass was in fact there in May but was missed by the limited ultrasound when with a complete, thorough imaging of the entire breast, it would not have been.

In any event, since there are clearly issues here as to the facts, summary judgment would not be proper. So once more, that is denied and Dr. Shaylor will continue as a named defendant.

This decision constitutes the order of the Court.

Dated: July 20, 2015

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J.S.C.

ALICE SCHLESINGER