

SCAN

**SHORT FORM ORDER**

**SUPREME COURT - STATE OF NEW YORK**

**Present:**

**HON. ROY S. MAHON**

**Justice**

**ABDOOL KHAN and BIBI F. KHAN,**

**Plaintiff(s),**

**- against -**

**GERARD T. MALONEY and SHANNON N. MALONEY,**

**Defendant(s).**

**TRIAL/IAS PART 8**

**INDEX NO. 19532/06**

**MOTION SEQUENCE  
NO. 1**

**MOTION SUBMISSION  
DATE: July 14, 2009**

**The following papers read on this motion:**

<b>Notice of Motion</b>	<b>X</b>
<b>Affirmation in Opposition</b>	<b>X</b>
<b>Reply Affirmation</b>	<b>X</b>

Upon the foregoing papers, the motion by defendants for an Order pursuant to CPLR §3212 dismissing plaintiffs' complaint and granting summary judgment that the plaintiffs have not met the "serious injury" requirements of Insurance Law §5102(d) as a matter of law, is determined as hereinafter provided:

This personal injury action arises out of a motor vehicle accident that occurred on May 3, 2006 at approximately 7:12 pm on Southern State Parkway at or near its intersection with Peninsula Boulevard, Hempstead, New York.

The respective plaintiffs set forth in the plaintiff's Verified Bill of Particulars:

"4. Plaintiffs sustained the following severe and serious injuries as a result of the occurrence.

**ABDOOL S. KHAN**

**C4-C5 HERNIATED DISC WITH IMPINGEMENT  
C5-C6 HERNIATED DISC WITH IMPINGEMENT  
L2-L3 DISC HERNIATION WITH IMPINGEMENT  
L3-L4 DISC HERNIATION WITH IMPINGEMENT  
L4-L5 DISC HERNIATION WITH IMPINGEMENT**

L5-S1 DISC HERNIATION WITH IMPINGEMENT  
CERVICAL RADICULITIS  
RESTRICTION OF MOTION OF CERVICAL SPINE  
LUMBAR SPRAIN/STRAIN

BIBI F. KHAN

C3-C4 DISC HERNIATION WITH IMPINGEMENT  
C4-C5 DISC HERNIATION WITH IMPINGEMENT  
C6-C7 DISC HERNIATION WITH IMPINGEMENT  
L3-L4 DISC HERNIATION WITH IMPINGEMENT  
L4-L5 DISC HERNIATION WITH IMPINGEMENT  
L5-S1 DISC HERNIATION WITH IMPINGEMENT  
CERVICAL SPRAIN/STRAIN  
CERVICAL RADICULITIS  
RESTRICTION OF MOTION OF CERVICAL SPINE  
LUMBAR SPRAIN/STRAIN  
LUMBAR RADICULITIS  
RESTRICTION OF MOTION OF LUMBAR SPINE  
LUMBAR RADICULITIS  
RESTRICTION OF MOTION OF LUMBAR SPINE"

The defendants in support of the requested relief, amongst other things, submit an affirmed letter report dated November 18, 2008 of Leon Sultan, MD, an orthopedist of an orthopedic examination of the plaintiff Abdool S. Khan conducted on November 18, 2008; an affirmed letter report dated November 24, 2008 of Paul Lerner, MD, a neurologist of a neurological examination of the plaintiff Abdool S. Khan conducted on November 24, 2008; an affirmed letter report dated August 29, 2008 of Audrey Eisenstadt, MD, a radiologist of a review of an MRI of Abdool Khan's cervical spine performed on June 17, 2008 at All County Open MRI & Diagnostic Radiology; the October 13, 2008 deposition transcript of Abdool S. Khan; an affirmed letter report of Dr. Sultan dated November 18, 2008 of a November 18, 2008 orthopedic examination of the plaintiff Bibi F. Khan; an affirmed letter report of Dr. Lerner dated November 24, 2008 of a November 24, 2008 neurological examination of the plaintiff Bibi F. Khan; an affirmed letter report dated April 29, 2008 of Dr. Eisenstadt of a review of an MRI of the plaintiff Bibi F. Khan's cervical spine performed on June 10, 2008 at All County Open MRI & Diagnostic Radiology.

The rule in motions for summary judgment has been succinctly re-stated by the Appellate Division, Second Dept., in **Stewart Title Insurance Company, Inc. v. Equitable Land Services, Inc., 207 AD2d 880, 616 NYS2d 650, 651 (Second Dept., 1994):**

"It is well established that a party moving for summary judgment must make a prima facie showing of entitlement as a matter of law, offering sufficient evidence to demonstrate the absence of any material issues of fact (*Winegrad v. New York Univ. Med. Center*, 64 N.Y.2d 851, 853, 487 N.Y.S.2d 316, 476 N.E.2d 642; *Zuckerman v. City of New York*, 49 N.Y.2d 557, 562, 427 N.Y.S.2d 595, 404 N.E.2d 718). Of course, summary judgment is a drastic remedy and should not be granted where there is any doubt as to the existence of a triable issue (*State Bank of Albany v. McAuliffe*, 97 A.D.2d 607, 467 N.Y.S.2d 944), but once a prima facie showing has been made, the burden shifts to the party opposing the motion for summary judgment to

produce evidentiary proof in admissible form sufficient to establish material issues of fact which require a trial of the action (*Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324, 508 N.Y.S.2d 923, 501 N.E.2d 572; *Zuckerman v. City of New York*, *supra*, 49 N.Y.2d at 562, 427 N.Y.S.2d 595, 404 N.E.2d 718)."

It is noted that the question of whether the plaintiff has made a prima facie showing of a serious injury should be decided by the Court in the first instance as a matter of law (see *Licaro v. Elliot*, 57 NY2d 230, 455 NYS2d 570, 441 NE2d 1088; *Palmer v. Amaker*, 141 AD2d 622, 529 NYS2d 536, Second Dept., 1988; *Tipping-Cestari v. Kilhenny*, 174 AD2d 663, 571 NS2d 525, Second Dept., 1991).

In making such a determination, summary judgment is an appropriate vehicle for determining whether a plaintiff can establish prima facie a serious injury within the meaning of Insurance Law Section 5102(d) (see, *Zoldas v. Louise Cab Corp.*, 108 AD2d 378, 381, 489 NYS2d 468, First Dept., 1985; *Wright v. Melendez*, 140 AD2d 337, 528 NYS2d 84, Second Dept., 1988).

Serious injury is defined, in Section 5102(d) of the Insurance Law, wherein it is stated as follows:

"(d) 'Serious injury' means a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment."

As to the plaintiff Abdool S. Khan, the report of Dr. Sultan sets forth:

**"PRESENT COMPLAINTS:** His only complaint is that after prolonged standing, his neck or lower back would bother him.

**PHYSICAL EXAMINATION:** He is 66 years of age standing 5'8" in height, his stated weight is 162 pounds and he is right-hand dominant. He has no known allergies and presently takes Diovan for hypertension.

**CERVICAL SPINE EXAMINATION:** In the standing position, his head is normally centered on the shoulders, the shoulders are level. The cervical curvature is maintained, but I note mild forward thrust of his head and neck on the shoulders secondary to underlying cervical spondylosis. I detect no active paracervical muscle spasm. There are no trigger points on palpation over the right and left trapezius musculature. Range of motion testing of the head and neck has been obtained with accurate visual measurements. Head and neck extension is to 20-25° (normal 25-35°), flexion is to 35-40° (normal 40-50°), right and left rotation is to 40-45° (normal 45-60°), right and left lateral tilt is 20° (normal 20-30°). With forward flexion, he complains of mild neck soreness, but I detect no reactionary muscle spasm or resistance to range of motion testing. Biceps and triceps reflexes are symmetrically dull.

Sensory testing of both upper extremities is intact. Grip strength is strong on both sides, pinch mechanism is also strong bilaterally.

**THORACOLUMBAR EXAMINATION:** His spinal column is well aligned, the pelvis is not tilted, lordotic curvature is intact. On palpation, I detect no active parathoracic or paralumbar muscle spasm. Sacroiliac joints are non-tender with palpation. He is able to stand on his heels and toes without difficulty and the Trendelenburg test is negative on both sides. Observed ambulating without external support, his walking pattern is steady without any clinical signs of antalgia. Range of motion testing of the thoracolumbar spine has been obtained with accurate visual measurements. Forward flexion at the waist is to 60° normal (normal 60-90°), lumbar extension is to 10° (normal 10-15°), trunk rotation to the right and left is to 45° (normal 45-70°), trunk tilting to the right and left is to 20° (normal 20-25°). With forward flexion, he complains of mild soreness in his lower back, but I detect no reactionary muscle spasm or resistance to range of motion testing. In the supine position, the straight leg raising test is negative bilaterally. Knee jerk and ankle jerk reflexes are symmetrically dull. Plantar reflexes are downgoing. Sensory testing of both lower extremities is fully within normal limits. Big toe extension is strong bilaterally. The Patrick test is negative bilaterally. I note incidental thick skin callouses over both knees secondary to chronic kneeling. I also note an incidental large bunion deformity on the left side.

**DISCUSSION:** Today's orthopedic examination in regard to this gentleman's cervical spine and thoracolumbar spine is unremarkable except for low grade motion restriction as described above in regard to his neck and back secondary to underlying multilevel cervical spine and lumbar spine disc disease. These degenerative changes are clearly described in the cervical spine and lumbar spine x-ray films taken on 5/5/06. In regard to the cervical spine and lumbar spine MRI film readings, those multilevel reported disc changes are not reflected in today's examination. For completion, I would kindly request that films taken in this case be obtained for review and an addendum to this report will be forwarded to your attention."

Dr. Lerner states in said physician's report of examination:

**"EXAMINATION:**

General Physical Exam: The head and neck are normal and atraumatic in appearance. Cervical ROM shows 40 degrees flexion (50 degrees normal), 40 degrees extension (60 degrees normal), 30 degrees L Tilt (45 degrees normal), 30 degrees R Tilt (45 degrees normal), 55 degrees L Rotation (80 degrees normal) and 60 degrees R Rotation (80 degrees normal). Lumbar ROM show 30 degrees flexion (60 degrees normal) and 15 degrees extension (25 degrees normal). Range of motion measured using an inclinometer and arthroidal protractor. Normal values of range of motion are those published by the AMA in "Guides To the Evaluation of permanent Impairment". 5th ed., pg 597. Pulses are strong and regular. Bruits are not heard. Tinel's sign at left wrist and Tinel's sign at right wrist is present. There is no adenopathy or thyromegaly.

The trachea is midline. There is discomfort reported to percussion of the spine and palpation of the paravertebral muscles. Straight leg raising is positive bilaterally.

**Mental Status:** Higher cognitive functions are grossly intact.

**Cranial Nerves:** Olfaction is normal by history. The pupils are equal and reactive, the visual fields are full and funduscopic examination is normal. Extraocular muscle function is normal without nystagmus. Muscles of mastication are strong. Facial sensation is normal and corneal reflexes are present. The face, tongue and palate are symmetric. Hearing is grossly intact. The accessory muscles are strong.

**Motor:** Muscle strength is 5/5 for all groups tested. There are no fasciculations, tremors or dysmetria and muscle tone is normal in the extremities. Spasm is present at the thoracolumbar paraspinal muscles.

**Sensory:** Touch, pin, vibratory and proprioception sensations are normal. There is no abnormality to double simultaneous tactile stimulation and higher sensory function are intact.

**Reflexes:** Deep tendon reflexes are normal and symmetric. Pathological reflexes are absent.

**Locomotor:** The gait and station are normal and steady without parkinsonian features, ataxia and circumduction. Romberg's sign is absent.

...

**Impression:** The neurologic examination reveals objective findings supporting a diagnosis of lumbar strain in the form of paravertebral muscle spasm. The remainder of the examination is devoid of any objective abnormalities supporting subjective complaints. Nevertheless, subjective complaints and subjective findings on examination suggest carpal tunnel syndrome and cervical strain. The medical record supports these diagnosis. While maximum benefits from PT has likely been achieved, future treatments such as injection therapy or surgical intervention is reasonable.

Based upon the history and records, I cannot conclude that any causal relationship definitely exists between the above conditions and the MVA of 5/3/06. There was prior injury to the neck and back. It is impossible at this time to determine if any permanent exacerbation has resulted from the 5/3/06 MVA. To this end, a radiology review of imaging, both prior and after the 5/3/06 accident, may be of some value. Also a review of treatment and diagnostic records from prior trauma may be of value. In the absence of bilateral wrist trauma, there is no evidence of any causal relationship between carpal tunnel syndrome and the MVA of 5/3/06."

In the report of the review of the MRI of Abdool S. Khan's cervical spine and MRI of Abdool S. Khan's lumbar spine, Dr. Eisenstadt provides:

"At your request, a cervical spine MRI examination performed on Abdool Khan was reviewed. The examination was performed at All County Open MRI & Diagnostic Radiology on 06/17/06. This is one and a half months following the accident of 05/03/06.

#### CERVICAL SPINE -MRI

A cervical spine MRI was submitted for review. Sagittal and axial images were provided. Multiple pulse sequences were obtained.

There is normal cervical alignment noted. Mild osteophyte formation is seen at the C4-5 and C5-6 intervertebral disc levels. The morphology is otherwise normal. The marrow signal is maintained. No marrow edema is seen. No compression fractures are identified.

The intervertebral discs reveal degeneration at the C5-6 and C6-7 levels. Discogenic ridging and bulging is seen at the C4-5, C5-6 and C6-7 intervertebral disc levels. A superimposed left paracentral C5-6 disc herniation is seen. No other intervertebral disc abnormality is noted. No annular tears are seen.

The spinal canal is adequate in size. No Arnold-Chiari deformity is seen.

**IMPRESSION: OSTEOPHYTE FORMATION C4-5 AND C5-6 LEVELS. DISCOGENIC RIDGING AND BULGING C4-5, C5-6 AND C6-7 LEVELS. DISC DEGENERATION C5-6 AND C6-7 LEVELS. SUPERIMPOSED LEFT PARACENTRAL C5-6 DISC HERNIATION SEEN.**

**CONCLUSION: Review of the cervical spine MRI examination performed one and a half months following the accident reveals degenerative changes involving the osseous, ligamentous, and intervertebral disc structures. Osteophyte formation and discogenic ridging is seen from the C4 through C7 vertebral levels. These bony productive changes could not have occurred in less than six months time and clearly predate the 05/03/06 accident. Disc degeneration is seen at the C5-6 and C6-7 levels. This involves drying out and loss of disc substance which is also greater than six months in origin. It has not traumatic basis or casual relationship to the accident. Desiccation is seen at the C4-5 level. This drying out of disc material is greater than three months in origin and also pre-existing. Bulging is seen at the C4-5, C5-6 and C6-7 levels. Disc bulging is not a traumatic process. It is degenerative in origin, related to ligamentous laxity. These findings suggest that the single C5-6 disc herniation is degenerative as well. Degenerative disc disease is a common etiology for disc herniations and the C5-6 intervertebral disc level is the most common level in the population for degenerative disc disease to occur. The bony and intevertebral changes at this level are clear indication of long standing pre-existing degenerative disc disease."**

#### "LUMBAR SPINE - MRI

A lumbar spine MRI was submitted for review. Sagittal and axial images were

provided. Multiple pulse sequences were obtained.

A transitional S1 vertebra is seen. There is a mild spondylolisthesis of L5 on the transitional S1 vertebra. Osteophyte formation is seen at the L2-3, L3-4 and L4-5 intervertebral disc level. The morphology is otherwise normal. The marrow signal is maintained. No marrow edema is noted. No compression fractures are seen.

Degeneration at the L2-3, L3-4 and L4-5 intervertebral disc levels is noted. Desiccation at the L5 - transitional S1 intervertebral disc level is seen. Bulging of disc material is seen at the L2-3, L3-4 and L4-5 intervertebral disc levels. There are no focal disc herniations noted. No annular tears are seen.

**IMPRESSION: TRANSITIONAL S1 VERTEBRA, GRADE 1 SPONDYLOLISTHESIS OF L5 ON S1. DISCOGENIC RIDGING AND OSTEOPHYTE FORMATION L2-3, L3-4 AND L4-5 LEVELS WITH ENDPLATE SIGNAL CHANGE SEEN AT THE L4-5 LEVEL. DISC DEGENERATION L2-3, L3-4 AND L4-5 LEVELS. DESICCATION L5-S1 LEVEL. BULGING L2-3, L3-4 AND L4-5 LEVELS. FACET JOINT DISEASE L4-5 LEVEL ASSOCIATED WITH SPINAL STENOSIS.**

**Conclusion: Review of the lumbar spine MRI examination performed less than one and half months following the accident reveals no evidence of acute or post-traumatic injury. There is a transitional vertebra at the S1 level. The transitional vertebra is a congenital variant, a condition the patient was born with. It predisposes to abnormal movement and premature degenerative disc disease. There is evidence of ligamentous laxity and degenerative disc disease in the lumbar spine. The spondylolisthesis or slippage of the L5 vertebra on the transitional S1 vertebra is related to ligamentous laxity and has traumatic basis or bony etiology. Bony overgrowth or osteophyte formation is seen at the L2-3, L3-4 and L4-5 levels. Endplate signal change is also seen at these levels. These bony productive changes are greater than six months in origin, and due to their extent, they are more likely years in development. They are arthritic in origin. Disc degeneration is also seen at these levels, a drying out and loss of disc substance, another process greater than six months in development. Bulging of these intervertebral discs is seen. Bulging has no traumatic basis. It is degenerative in origin as well and related to ligamentous laxity. There is spinal stenosis seen at the L4-5 level. This is a narrowing of the spinal canal, in this case related to the bony productive changes of the facet joints, and bulging of the L4-5 intervertebral disc, all of which could not have occurred in the short interval between examination and injury and has no traumatic basis. The degenerative disc disease seen in the lower lumbar spine is typical in appearance for arthritis and likely associated with the congenital transitional vertebra. No traumatic abnormalities are seen. No recent osseous ligamentous or intervertebral disc changes are seen attributable to the 05/03/06 accident."**

Dr. Sultan states in his report of orthopedic examination of the plaintiff Bib F. Khan:

"PHYSICAL EXAMINATION: She is 62 years of age, standing 5'3" in height,

her stated weight is 126 pounds and she is right hand dominant. She has no known allergies and presently takes thyroid medication.

**CERVICAL SPINE EXAMINATION:** The head is normally centered on the shoulders, the shoulders are level. The cervical curvature is well preserved. I detect no active paracervical muscle spasm. There are no trigger points on palpation over the right and left trapezius musculature. Range of motion testing of the cervical spine has been obtained with accurate visual measurements. Head and neck extension is to 25° (Normal 25-35°), flexion is to 40° (normal 40-50°), right and left rotation is to 45° (normal 45-60°), right and left lateral tilt is to 20° (normal 20-30°). Sensory testing of both upper extremities is intact. Grip strength is strong on both sides, pinch mechanism is firm bilaterally. Biceps and triceps reflexes are symmetrically dull. Radial reflexes are symmetrically dull.

**THORACOLUMBAR EXAMINATION:** In the standing position, the spinal column is normally aligned, the pelvis is not tilted, lordotic curvature is maintained. I detect no active parathoracic or paralumbar muscle spasm. Sacroiliac joints are non-tender to palpation. Heel and toe standing is unimpaired and the Trendelenburg test is negative on both sides. Observed ambulating without external support, gait pattern is steady without any clinical signs of antalgia. Range of motion testing of the thoracolumbar spine has been obtained with accurate visual measurements. Forward flexion is to 65-75° (normal 60-90°), extension is to 10-15° (normal 10-15°), trunk rotation to the right and left is to 45-50° (normal 45-70°), trunk tilting to the right and left is to 20° (normal 20-25°). In the supine position, the straight leg raising test is negative bilaterally. Sensory testing of both lower extremities is intact. Big toe extension is strong bilaterally. The Patrick test is negative bilaterally. Knee jerk and ankle reflexes are symmetrically dull. Plantar reflexes are downgoing. I also note an incidental pigmented birthmark just to the right of midline involving the lumbar spine.

**DISCUSSION:** From an orthopedic point of view, today's examination in regard to this woman's cervical spine and thoracolumbar spine reveals that she is orthopedically stable and neurologically intact. Today's examination does not confirm any ongoing causally related orthopedic or neurological impairment in regard to the occurrence of 5/3/06. From a clinical point of view, there is no correlation between today's spinal examination and the above-described spinal MRI and electrodiagnostic readings. I would kindly request that MRI films taken in this case be obtained for review, in addition to those taken after the occurrence of 1/12/06 and an addendum to this report will be forwarded to your attention."

Dr. Lerner sets forth as th his neurological examination of Bibi F. Khan:

"EXAMINATION:

General Physical Exam: The head and neck are normal and atraumatic in appearance. Cervical ROM shows 40 degrees flexion (50 degrees normal), 40 degrees extension (60 degrees normal), 40 degrees L Tilt (45 degrees



normal), 65 degrees L Rotation (80 degrees normal) and 70 degrees R Rotation (80 degrees normal). Lumbar ROM shows 45 degrees flexion (60 degrees normal) and 20 degrees extension (25 degrees normal). Range of motion measured using an inclinometer and arthroidal protractor. Normal values of range of motion are those published by the AMA in "Guides To The Evaluation of Permanent Impairment", 5th ed., pg. 597. Pulses are strong and regular. Bruits are not heard. There is discomfort reported to percussion of the spine and palpation of the paravertebral muscles. Straight leg raising is negative bilaterally.

**Mental Status:** Higher cognitive functions are grossly intact.

**Cranial Nerves:** Olfaction is normal by history. The pupils are equal and reactive, the visual fields are full and funduscopic examination is normal. Extraocular muscle function is normal without nystagmus. Muscles of mastication are strong. Facial sensation is normal and corneal reflexes are present. The face, tongue and palate are symmetric. Hearing is grossly intact. The accessory muscles are strong.

**Motor:** Muscle strength is 5/5 for all groups tested. There are no fasciculations, tremors or dysmetria and muscle tone is normal in the extremities. Paraspinal muscle tone is normal.

**Sensory:** Touch, pin, vibratory and proprioception sensations are normal. There is no abnormality to double simultaneous tactile stimulation and higher sensory function are intact.

**Reflexes:** Deep tendon reflexes are normal and symmetric. Pathological reflexes are absent.

**Locomotor:** The gait and station are normal and steady without parkinsonian features, ataxia and circumduction. Romberg's sign is absent.

...

**Impression:** The neurologic examination is objectively within normal limits. From a neurologic point of view, the examination does not reveal any evidence of impairment or need for treatment. Subjective symptoms are allegedly associated with disc herniations. An independent radiology review of films, both before and after the 5/3/06 accident, is recommended."

As to the MRI's of Bib Khan's lumbar and cervical spine, Dr. Eisenstadt states:

**"LUMBAR SPINE - MRI**

A lumbar spine MRI was submitted for review. Sagittal and axial images were provided. Multiple pulse sequences were obtained.

There is normal lumbar alignment noted. The morphology is normal. The marrow signal is maintained. No marrow edema is noted. No compression

fractures are seen.

The intervertebral discs reveal degeneration at the L3-4 and L4-5 intervertebral disc levels. Desiccation is seen at the L5-S1 level. Bulging of the L3-4, L4-5 and L5-S1 intervertebral discs is identified. A superimposed left paracentral L4-5 disc herniation is seen. No other intervertebral disc abnormality is identified.

The spinal canal is adequate in size. No conal abnormality is seen.

**IMPRESSION: DEGENERATION L3-4 AND L4-5 INTERVERTEBRAL DISC LEVELS. DESICCATION L5-S1 INTERVERTEBRAL DISC LEVEL. BULGING L3-4, L4-5 AND L5-S1 LEVELS WITH A SUPERIMPOSED LEFT PARACENTRAL L4-5 DISC HERNIATION.**

**CONCLUSION: Review of the lumbar spine MRI examination performed five weeks following the accident reveals evidence of long standing pre-existing degenerative disc disease in the lower lumbar spine. There are intervertebral disc changes seen which could not have occurred in less than six months time and clearly predates the 05/03/06 accident. Degeneration is seen at the L3-4 and L4-5 levels. This involves a drying out and loss of disc substance, a process greater than six months in development and associated with disc bulging. Bulging has no traumatic basis. It is degeneratively induced related to ligamentous laxity. It strongly suggests that the left paracentral L4-5 disc herniation is degenerative as well. Degenerative disc disease is a common etiology for disc herniations and the L4-5 level is the most common level for degenerative changes to occur. Desiccation is seen at the L5-S1 level. This drying out of disc material is greater than three months in origin and also predates the 05/03/06 accident. Bulging has no traumatic basis, as noted above. The changes seen in the lower lumbar spine are indicative of longstanding, degenerative disc disease and suggest that the herniation, left paracentral in location is degenerative as well."**

#### **CERVICAL SPINE - MRI**

A cervical spine MRI was submitted for review. Sagittal and axial images were provided. Multiple pulse sequences were obtained.

Cervical straightening is noted. Osteophyte formation is seen at the C4-5, C5-6 intervertebral disc levels. The morphology is otherwise normal. The marrow signal is maintained. No marrow edema is noted. No compression fractures are seen.

Degeneration with loss of height and signal intensity is seen at the C4-5 and C5-6 intervertebral disc levels. Desiccation is seen at the C3-4 and C6-7 intervertebral disc levels. Discogenic ridging and bulging is seen at the C3-4, C4-5, C5-6 and C6-7 levels. A superimposed C3-4 disc herniation is noted. A superimposed C6-7 disc herniation is seen. No thecal or neural displacement is noted associated with the discogenic ridging, bulging or herniation seen.

The spinal canal is adequate in size. No Arnold-Chiari deformity is seen.

**IMPRESSION: CERVICAL STRAIGHTENING. DISCOGENIC RIDGING, OSTEOPHYTE FORMATION, DISC DEGENERATION AND BULGING C4-5 AND C5-6 LEVELS. DESICCATION C3-4 AND C6-7 LEVELS. OSTEOPHYTE FORMATION C6-7 LEVEL. BULGING C3-4 AND C6-7 LEVELS. SUPERIMPOSED DISC HERNIATION C-3-4 AND C-6-7 INTERVERTEBRAL DISC LEVELS. NO THECAL IMPINGEMENT SEEN.**

**CONCLUSION: Review of the cervical spine MRI examination performed five weeks following the accident reveals evidence of degenerative changes involving the osseous, ligamentous, and intervertebral disc structures, which could not have occurred in less than six months time and are clearly indicative of pre-existing, degenerative disease. Osteophyte formation and discogenic ridging are bony productive changes greater than six months in origin. They re centered t the most common location in the population for arthritis to occur, the C5-6 level. Disc degeneration is seen at the C4-5 and C5-6 levels. This drying out and loss of disc substance is another process greater than six months in origin. Bulging is seen at these two levels. Bulging has no traumatic basis. It is degeneratively induced, related to ligamentous laxity. Desiccation is seen at the C3-4 and C6-7 levels. This drying out of disc material is greater than three months in origin and also indicative of degenerative disc disease. The bulging seen at these levels is also related to ligamentous laxity. It strongly suggests that the disc herniations at these same two levels are degenerative as well. Degenerative disc disease is common etiology for disc herniations. Discogenic ridging is also seen at these levels a bony productive change greater than six months in development a clearly pre dating the accident of 05/03/06. The straightening seen is nonspecific in appearance, frequently related to patient position and comfort for the examination."**

The Court finds that the defendants have submitted evidence in admissible form to make a "prima facie showing of entitlement to judgment as a matter of law" (**Winegrad v. New York University Medical Center, 64 NY2d 851, 853; Pagano v. Kingsbury, supra at 694**) and is sufficient to establish that the plaintiff did not sustain a serious injury. Accordingly, the burden has shifted to the plaintiff to establish such an injury and a triable issue of fact (**see Gaddy v. Eyler, 79 NY2d 955, 582 NYS2d 990, 591 NE2d 1176; Jean-Meku v. Berbec, 215 AD2d 440, 626 NYS2d 274, Second Dept., 1995; Horan v. Mirando, 221 AD2d 506, 633 NYS2d 402, Second Dept., 1995**).

In opposition to the requested relief, the plaintiff submit two affirmations of Joseph Gregorace, DO as to the care and treatment rendered to the respective plaintiffs; affirmations of Richard J. Ruzzuti, MD, a radiologist as to a review of the respective MRIs of each plaintiff's cervical spine and lumbar spine; multiple affirmed reports of Sports Medicine & Spine Rehabilitation PC by Joseph Gregorace, DO, a treating physician of the plaintiff Abdool S. Khan and the plaintiff Bibi Khan together with said physician's office notes and affidavits of the respective plaintiffs individually.

The defendants have established in support of the defendants' requested relief that the plaintiff Abdool Khan had been involved in numerous car accidents involving claims of bodily injury prior to the accident in issue. Notwithstanding this contention, the Court notes that the affirmed report of Dr. Gregorace

dated February 12, 2007 states that "The patient did not report any past medical history of significance" in said physician's report designated under "Past Medical History". Dr. Gregorace does not address the issue of Abdool Khan's prior accidents in relation to the physical conditions noted as to said plaintiff (see, **Cervino v W. Gladysz-Steliga**, 36 AD3d 744, 829 NYS2d 169 (Second Dept., 2007) nor does the plaintiff Abdool Khan's radiologist causally related the conditions found on the respective MRIs to the accident of May 3, 2006 (see **Ukonu v Velazquez**, 213 AD2d, 628 624 NYS2d 195 (Second Dept., 1995). As such to the extend that the defendants seeks summary judgment as to the plaintiff Abdool S. Khan on the ground that said plaintiff did not suffer a serious injury pursuant to §5102 of the Insurance Law, said application is **granted**.

As to the plaintiff Bibi F. Khan, Dr. Gregorace has distinguished that said plaintiff had been involved in prior accidents and has causally related the injuries claimed to the accident in issue. Accordingly, that branch of the defendants' application which seeks an Order pursuant to CPLR §3212 dismissing the plaintiff Bibi F. Khan's action on the ground that she did not suffer a serious injury, is **denied**.

SO ORDERED.

DATED:

9/4/2009

  
..... J.S.C.

**ENTERED**  
SEP 16 2009  
NASSAU COUNTY  
COUNTY CLERK'S OFFICE