EXAMINATION OF: GEORGE DIGIACINTO, M.D.; 2000 Depo. Trans. LEXIS 12143

SUPERIOR COURT OF NEW JERSEY, PASSAIC COUNTY, LAW DIVISION

DOCKET NO. L-5878-98

November 20, 2000

Reporter
2000 Depo. Trans. LEXIS 12143 *

ANTONI FILEWICZ and JOZEFA FILEWICZ, Plaintiffs, vs. THE GENERAL HOSPITAL CENTER AT PASSAIC, HAROLD HESS, M.D., HENRY ROSE, M.D., A. BERKMAN, M.D., D. SUNDSTROM, M.D., DAVID BLADY, M.D., et al., Defendants.

Expert Name: Dr. Vincent DiGiacinto, M.D.

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Counsel

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Proceedings

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[12]T R A N S C R I P T of the

[13]stenographic notes of the proceedings in the

[14]above-entitled matter, as taken by and before GLENN

[15]R. FRIIS, a Certified Shorthand Reporter, held at

[16]the office of GEORGE DiGIACINTO, M.D., 425 W. 59th

[17]Street, New York, New York, on Monday, November 20,

[18]2000, commencing at approximately two o'clock in

[19]the morning.

[20]

[21]

[22]

[23]FRIIS ASSOCIATES
Certified Shorthand Reporters

[24]P.O. BOX 84
WOODBRIDGE, NEW JERSEY 07095

[25]800-636-1136
[MISSING PAGE 3]

[4]

[1]G E O R G E D i G I A N C I N T O, M.D., 425 W.

[2]59th Street, New York, New York, having been duly

[3]sworn, testified as follows:

[4]DIRECT EXAMINATION BY MR. PYLE:

[5]Q Good afternoon, Dr. DiGiancinto. My

[6]name is Tom Pyle. I'm an attorney with Post,

[7]Polak, Goodsell & MacNeill and we represent two

[8]defendants in this case; Dr. Hess and Dr.

[9]Sundstrom. We have asked you to spend some time

[10]with us today to take your deposition. Have you

[11]ever been deposed prior to today?

[12]A Yes.

[13]Q On approximately how many occasions?

[14] **[*3]** A Depositions of this type?

[15]Q Depositions in general.

[16]A That's what I meant. Probably six or eight

[17]times, something like that.

[18]Q Would it be fair to say then that

[19]you're somewhat familiar with the rules that are

[20]governing depositions of this type?

[21]A I have given depositions. I don't think I

[22]could quote any of the rules.

[23]Q Before I give you some instructions,

[24]actually I'm going to defer to one of the attorneys

[25]in the room here who I understand represents a

[5]

[1]defendant who recently came into this case and he'd

[2]just like to put a statement on the record. I want

[3]to defer to him for one second and then we will get

[4]back to asking you some questions.

[5]MR. KIPNIS: My name is Adam Kipnis

[6]and I represent Dr. Seid. We recently came into

[7]this case on November 17, 2000. Sam Rosenberg sent

[8]a letter to plaintiff's attorney indicating that we

[9]have yet to receive Interrogatories and a Notice to

[10]Produce, so we're going to reserve the right, in

[11]order to proceed, to redepose you in the future if

[12]we choose to. So I just wanted to make you aware

of that.

MR. KAHN: **[*4]** Just for the record we responded to that letter by taking the position that at this time we couldn't agree to produce Dr. DiGiancinto in the future, but we'll argue that at some point in the future.

Q Thank you, Doctor. Sorry for that brief interruption. A little housekeeping we had to do.

You indicated that you've been deposed approximately six to eight times in the past. Just before I begin I want to give you some brief instructions to hopefully make this process go a

[6]

lot faster.

A deposition is essentially a question and answer session where I get to ask you questions and your obligation is to answer them completely and as truthfully as possible. Do you understand that?

A Yes.

Q If I ask you a question during the course of the deposition that is unclear to you for whatever reason, please tell me it's unclear. Please help me and tell me what you don't understand about the question and I will be more than happy to rephrase it. Do you understand?

A Yes.

Q Your answers must be verbal; meaning you have to speak your answers and use words. **[*5]** Grunts, groans, uh-huhs, shrugs of the shoulder or

[17]nodding your head can't be taken down by the court

[18]reporter so I'd ask that you keep all your answers

[19]verbal. Is that understood?

[20]A Yes.

[21]Q If during the course of the deposition

[22]somebody in this room has an objection, they're

[23]going to say the word objection. I ask at that

[24]point in time if you would hold your answer and

[25]wait until the attorneys reserve the objection and

[7]

[1]then you'll be directed as to what do. Do you

[2]understand that, Doctor?

[3]A Yes.

[4]Q With respect to the depositions that

[5]you've had six to eight times, when you have been

[6]deposed, were any of these six to eight times as an

[7]expert in a medical malpractice case?

[8]A Yes.

[9]Q Approximately how many of those

[10]occasions were you an expert in a medical

[11]malpractice case?

[12]A Of the ones I'm thinking of, I think they

[13]all were as an expert in a medical malpractice

[14]case. And I might, to be as honest as I can, I

[15]might be underestimating by another six or eight.

[16]I'll just have to take mental inventory to try to

[17]remember.

[18]Q With **[*6]** respect to those six to eight

[19]cases that you were a med-mal expert that you've

[20]been deposed in, did any of them involved cauda

[21]equina syndrome?

[22]A Now you're really testing my memory because

[23]there certainly could have, but I can't remember.

[24]I don't think I could list all of the cases I've

[25]been deposed on. It would be hard for me to

[8]

[1]separate those out from other things that I've

[2]reviewed, for example, that would have included

[3]cauda equina, so I don't think I can answer the

[4]question honestly.

[5]Q To go a little broader, have you ever

[6]written a report in a medical malpractice case

[7]where the issue was the diagnosis or failure to

[8]diagnose cauda equina syndrome?

[9]A I don't believe I've ever written a report

[10]like that.

[11]Q Except for the one in this case I'm

[12]assuming?

[13]A Yes, yes, I assumed that we all know about

[14]this one.

[15]Q Sometimes we don't want to assume, we

[16]want to make sure the record is clear. I'd like to

[17]show you what we've premarked as DD-1. It's a May

[18]30, 2000 letter to Mr. Kahn on your letterhead.

[19]It's a four-page document. I'd like you to take **[*7]** a

[20]look at this and tell me whether or not that's a

[21]written report you issued in connection with this

[22]case?

[23]A Yes, it appears to be.

[24]Q Other than the report that you have in

[25]front of you that's marked DD-1, have you authored

[9]

[1]any other written reports in connection with this

[2]lawsuit?

[3]A No, I have not.

[4]Q Doctor, bear with me. Doctor, overall

[5]your report indicates that Mr. Filewicz had cauda

[6]equina syndrome, is that correct?

[7]A Yes.

[8]Q Could you explain to me what cauda

[9]equina syndrome is?

[10]A The cauda equina is the group of nerve roots

[11]that exists at the end of the spinal cord which

[12]ends approximately at the lower thoracic or upper

[13]lumbar spine. It derives its name from the Latin

[14]caudique, which means horse's tail, and it

[15]basically is a group of roots. A cauda equina

[16]syndrome is a group of symptoms which relate to

[17]compression of those nerve roots.

[18]Q With respect to cauda equina syndrome

[19]itself, you indicated that there are some symptoms

[20]that go along with that syndrome. Could you

[21]explain for us what type of symptoms would be

[22]considered **[*8]** to be part of a cauda equina syndrome?

[23]A There's tremendous variety of symptoms that

[24]can be related to cauda equina syndrome including

[25]pain in the lower extremities, numbness in the

[10]

[1]lower extremities, tingling in the lower

[2]extremities, weakness or paralysis in one or both

[3]lower extremities, loss of bowel/bladder function,

[4]complete or partial, change in sphincter tone

[5]relating to bladder function, urinary retention,

[6]which again is a sign of bowel or bladder function

[7]change. Those I think are the major ones. If I

[8]think of any others I'll add them.

[9]Q I appreciate it. Were these symptoms

[10]that you just explained to us would be the typical

[11]symptoms for cauda equina syndrome back in

[12]September of 1996?

[13]A Yes.

[14]Q If I can just ask you for one second,

[15]are there any known causes for cauda equina

[16]syndrome? That may not be an artfully phrased

[17]question. What I'm getting at is obviously you've

[18]explained the syndrome to us. My question to you

[19]is in the medical profession are there any causes,

[20]any known causes for such a syndrome?

[21]A Yes, there are.

[22]Q Could you **[*9]** explain those to me?

[23]A The presentation of the syndrome being, as I

[24]mentioned, include some, almost none or all of the

[25]symptoms that I mentioned above. The classic cauda

[11]

[1]equina syndrome is caused by compression of the

[2]cauda equina, and that can occur through trauma,

[3]infection, osteoporosis causing a collapse of bone,

[4]acute or chronic disk herniation, acute or chronic

[5]spinal stenosis of the degenerative type among

[6]others.

[7]The syndrome can also be mimicked by

[8]compression in the neuraxis and specifically the

[9]spinal cord higher than the cauda equina because

[10]remember a syndrome is a group of symptoms and one

[11]can present with that syndrome and yet have

[12]compression above the level of cauda equina.

[13]Q Are any of the symptoms that you just

[14]described to us, are any of those symptoms more

[15]dispositive than the others with respect to whether

[16]or not cauda equina syndrome exists?

[17]A I'll make you define that legal term

[18]dispositive since I'm not familiar with that.

[19]Q Meaning if there are any symptoms, if

[20]the symptom does present itself among all of these

[21]symptoms you **[*10]** can definitively say this is cauda

[22]equina syndrome as opposed to something else?

[23]A I don't think of any one symptom is so

[24]outstanding that it absolutely defines cauda equina

[25]syndrome because there are several of the symptoms

[12]

[1]which in and of themselves demand that cauda equina

[2]syndrome be ruled in or ruled out. I'll stop

[3]there.

[4]Q Doctor, I'm going to direct your

[5]attention to DD-1, which is your report. If you

[6]have a copy in front of you, you can use that.

[7]A I do.

[8]Q That's fine. Your report indicates in

[9]the first paragraph that you reviewed medical

[10]records referring to Antoni Filewicz's treatment at

[11]the General Hospital Center at Passaic commencing

[12]on 9/06/96. Do you see that, Doctor?

[13]A Yes, I do.

[14]Q Could you tell us exactly what you

[15]reviewed in preparation of this report because I

[16]didn't find a list of it anywhere in the report.

[17]A I reviewed the hospital chart referrable to

[18]that admission. In addition, let me find my way

[19]through this. I had for review a deposition by Dr.

[20]Sundstrom. Dr. Seigh, Dr. Blady, and Dr. Hess;

[21]deposition of Dr. Rose. **[*11]** No, I'm sorry. Yeah, I

[22]did have that. And deposition of Dr. Berkman. [ILLEGIBLE TEXT]

[23]believe those were the main reports that I had [ILLEGIBLE TEXT]

[24]review.

[25]Q Do you have a file for this case,

[13]

[1]Doctor?

[2]A What I found is sitting right in front of

[3]me. What I know I have and I didn't find for today

[4]was a copy of the record, hospital record, which

[5]this is one of your copies. Other than that, I

[6]think this is the majority of what I have.

[7]Q Would you mind if I took a look

[8]through that?

[9]A I also received information later. Should I

[10]give you that as a separate pile or same pile?

[11]Q Whatever way is best for you to keep

[12]everything in order for your file.

[13]A And I have a copy of my report here.

[14]Q Thank you. Doctor, would you please

[15]let me know what documents or other information you

[16]reviewed after you issued your May 30, 2000 report

[17]in this case?

[18]A The documents that I know I reviewed

[19]afterwards, because I have them right in front of

[20]me, include expert witnesses by Dr. Aaron Rabin,

[21]Dr. Bernard Davidoff, Dr. Richard Hodash and Dr.

[22]Robert **[*12]** Dunn.

[23]Q Did any of the information or

[24]documents that you have reviewed after issuing or

[25]rendering your May 30, 2000 report, in any way

[14]

[1]change the opinions contained in that report?

[2]A No.

[3]Q Other than what you've just told us

[4]about, Doctor, did you review anything else in

[5]preparation of the report?

[6]A Not that I recall at this moment.

[7]Q Did you prepare any notes during the

[8]course of your review of this case in preparation

[9]of your report?

[10]A I don't think so, no.

[11]Q That means notes that are either

[12]hand-written, typewritten on a computer, any way,

[13]shape or form. Did you prepare any?

[14]A There're probably some are scribbles or

[15]highlights in the body of the documents, but beyond

[16]that, no.

[17]Q Did you prepare a draft of the report

[18]prior to sending the copy that we now see, the May

[19]30 report?

[20]A My normal technique would be to dictate the

[21]report off the records. It's transcribed by a

[22]transcribing service. I would then edit and

[23]correct any typos or gross mistakes on my report,

[24]and that would be done right on the computer and I

[25] **[*13]** would discard something with typos, et cetera. So

[15]

[1]other than doing that editing, no.

[2]Q Now, Doctor, I'm going to ask you some

[3]detailed questions now about your May 30 report;

[4]specifically, the first full paragraph indicates

[5]that the patient was logged into the emergency room

[6]at 09/06/1996 at 9:17 p.m. The next sentence says

[7]it is noted that the patient had decreased

[8]sensation in the left leg. Do you see that

[9]sentence, Doctor?

[10]A Yes.

[11]Q What's the significance, if any, that

[12]the patient had decreased sensation in the left

[13]leg?

[14]A The significance is that it's indicative of

[15]loss of neurological function and potentially nerve

[16]root compression.

[17]Q You also make a statement that the

[18]impression was herniated disc at this time. Did

[19]you get that information from some part of the

[20]medical record?

[21]A Yes.

[22]Q Any significance to you in writing

[23]your report as to whether or not there was a

[24]herniated disc at the time the patient presented?

[25]A The presentation I think was consistent with

[16]

[1]that of a herniated disc.

[2]Q A little further down **[*14]** it indicates

[3]that there is an X-ray done and the patient

[4]returned from X-ray complaining of numbness in both

[5]legs, left greater than right, able to move right

[6]leg, full range of motion. Do you see that,

[7]Doctor?

[8]A Yes.

[9]Q With respect to those complaints, and

[10]if you want to take them one by one we can do it

[11]that way, but my question to you is what, if any,

[12]significance would you ascribe to those complaints?

[13]A Taking them all together, again, it's

[14]indicative of loss of neurological function; the

[15]etiology of which was yet to be determined. It

[16]also indicated that there was a problem in more

[17]than just the left leg, but the left and the right

[18]leg, though the changes in terms of strength

[19]appeared to be more on the left and not so much on

[20]the right.

[21]Q Two sentences down from that it says

[22]it was also noted that the patient had a great deal

[23]of difficulty turning. Do you see that sentence,

[24]Doctor?

[25]A Yes.

[17]

[1]Q What, if any, significance is that to

[2]you in diagnosing the patient?

[3]A Putting it together with everything else we

[4]have been looking at, **[*15]** it's again consistent with

[5]and part of his admitting diagnosis of probable

[6]disk herniation. I think it just strengthens that

[7]as the probable diagnosis.

[8]Q Now, the next paragraph indicates it

[9]was noted that the patient had difficulty voiding

[10]and was straight cath'd for 600 cc's of urine. The

[11]exact time of this is not clear from the record.

[12]With respect to that statement, Doctor, what

[13]significance, if any, was the fact that the patient

[14]had difficulty in voiding?

[15]A That specific difficulty voiding is a very

[16]important sign in determining what type of deficit

[17]the patient may have. Finding 600 cc's of urine in

[18]the bladder, which was a very large amount of urine

[19]which had to be removed by catheter as opposed to

[20]the patient being able to remove it, clearly is

[21]indicative of an inability to pass urine

[22]spontaneously and I think that is a major factor in

[23]attempting to reach probable diagnosis as to the

[24]etiology of that problem, plus all of those

[25]problems mentioned above.

[18]

[1]Q With respect to the difficulty voiding

[2]and all of the types of symptoms that are explained

[3]in that **[*16]** second full paragraph of your report, I

[4]understand, and correct me if I'm wrong, but it

[5]seems that those symptoms are consistent with a

[6]herniated disc, is that correct?

[7]MR. KAHN: Object to the form of the

[8]question.

[9]Q You can answer, Doctor.

[10]A I'm formulating an answer. I think that if

[11]that's the only thing that they're -- if your

[12]question implies that that's the only thing that

[13]they're consistent with, I have to say no; but if

[14]the question is can they be consistent with disk

[15]herniation, the answer is yes.

[16]Q And, in fact, that's what the doctors

[17]on 9/6/96 initially thought that diagnosed the

[18]patient as having a herniated disk, is that

[19]correct?

[20]A Again, I have to preface my yes by adding

[21]the same warning that I did with my previous

[22]answer, that if you say that's all it's consistent

[23]with and if you say you can stop at that, I

[24]couldn't answer the question yes, but otherwise I

[25]can answer the question yes.

[19]

[1]Q Well, my question is based on your

[2]review of the records. It's your understanding

[3]that the patient was diagnosed as having a

[4]herniated disk **[*17]** when first presenting to the

[5]hospital?

[6]A Yes.

[7]Q And you also indicated that the

[8]symptoms that we had just discussed that are noted

[9]in your report are consistent with a herniated

[10]disk, that's correct?

[11]A I would not be able to say correct and say

[12]that that's a complete diagnosis. That's why I'm

[13]hesitating to answer.

[14]Q I'm just asking whether or not those

[15]symptoms in and of themselves, one of the diagnoses

[16]could be a herniated disc?

[17]A Yes.

[18]Q Later on down in your report, the next

[19]paragraph I think, it looks like it's the fourth

[20]paragraph on Page 1, says a CT scan was performed

[21]and was read as showing lumbar stenosis, L3/4 and

[22]L4/5, and a possible L4/5 -- 4 and 5 laterally as

[23]well as essentially an S-1 through S-5 herniation.

[24]Doctor, could you do me a big favor and

[25]please explain that in layman's terms for the

[20]

[1]neophyte that I am?

[2]A Yes, a CT scan was performed which was read

[3]as showing lumbar stenosis, which is a narrowing of

[4]the spinal canal and the space where the nerve

[5]roots are running. It's reported that this was

[6]present **[*18]** between the third and the fourth lumbar

[7]vertebrae as well as the fourth and the fifth

[8]lumbar vertebra.

[9]In addition to that statement the report

[10]went on to say that there may be evidence of a

[11]herniation of a disk, a so-called herniated nucleus

[12]pulposis or herniated lumbar disk at the L4/5 level

[13]off to one side; although, I did not make note of

[14]which side, as well as herniation of the lumbar

[15]disk between the L-5, S-1 level, which is the

[16]lowest movable segment in the spine. That was

[17]ascribed as more central in location rather than

[18]off to the side.

[19]Q Now, Doctor, when you said off to the

[20]side but you did not note it, does that mean that

[21]it did not appear in the report or it does not

[22]appear in the medical records as to which side it

[23]was?

[24]A I would have to look at the medical record

[25]to tell you that.

[21]

[1]Q Would you please do that?

[2]MR. PYLE: Just for the record I'm

[3]showing the doctor the radiology report which is

[4]two pages dated 9/8/96 but it looks like the date

[5]of the request was actually 9/7/96.

[6]A Actually, I found it. There was a question

[7]as to **[*19]** which side the herniation appeared to be in.

[8]In the body of the report it does say considerable

[9]soft tissue density in the left side of L4/5 where

[10]a lateral herniation is possible. So it was off to

[11]the left side.

[12]Q What, if any, significance is it that

[13]the herniation was off to the side, and

[14]particularly in this case, the left side as opposed

[15]to being central or being to another side?

[16]A The symptomatology that the patient

[17]presented seemed to be predomiately on the left

[18]side, although there was indication that it was

[19]bilateral from several aspects, and the finding of

[20]the disk off to the left side at L4/5 would be more

[21]consistent with symptoms on the left side.

[22]Q And, Doctor, would it be correct that

[23]if the patient had, in fact, had problems

[24]bilaterally on 9/6/97, that you would expect to see

[25]the CT scan that was done show that?

[22]

[1]A The CT scan that was done in this setting?

[2]Q Yes. If, in fact, the patient had

[3]problems bilaterally, would you expect the CT scan

[4]to show that?

[5]A This CT scan which was done from L3/4

[6]through L5/S1 did not show that, and **[*20]** I'm hestitant

[7]to answer your question yes or no because this scan

[8]did not identify the level of the primary

[9]pathology, so I would not expect this scan to show

[10]bilaterally and I hope that is responsive to your

[11]question.

[12]Q So, in other words, there would have

[13]been a scan that would have had to go to a

[14]different level in the lumbar area that would be

[15]able to show if there's anything bilaterally, is

[16]that what you're saying?

[17]A Yes.

[18]Q Doctor, I want to back up for a second

[19]because I understand that we're talking about the

[20]numbness in both legs and able to move the right

[21]leg type of symptoms a little bit earlier, that

[22]your report does indicate that you got that

[23]information from the emergency department nursing

[24]notes.

[25]Where did you get the information that the

[23]

[1]patient had difficulties voiding from?

[2]A I would, again, have to look in the chart.

[3]I believe it was either in the nurse's notes or the

[4]doctor's notes in the chart.

[5]Q That won't be necessary, Doctor. What

[6]is lumbar stenosis?

[7]A Stenosis means narrowing, and I try to

[8]describe it to **[*21]** patients as, for example, rust

[9]inside a pipe which is progressively making the

[10]opening or lumen of the pipe more and more narrow.

[11]The phenomenon of lumbar stenosis is one in which

[12]because of bony ligamentus or disk abnormalities,

[13]and I suppose tumor infection under other

[14]circumstances, the space where the nerve root is

[15]running becomes small and closed down or stenotic.

[16]Q Doctor, your report goes on to quote a

[17]history dictated by a Dr. Henry Rose on 9/7/96.

[18]The last sentence on the first page begins, later

[19]on in the evening, the back stiffened up further

[20]and he was able to feel -- he was unable to feel

[21]anything in the dorsum and lateral aspects of the

[22]left lower extremity. Do you see that, Doctor?

[23]A Yes.

[24]Q Are you aware of any complaints that

[25]Mr. Filewicz had on 9/7 regarding problems with his

[24]

[1]right lower extremity?

[2]A Other than the fact that he mentioned and

[3]it's documented in the notes in the chart that he

[4]had some numbness in his right leg, I don't believe

[5]he came in complaining about that as the major

[6]complaint.

[7]Q And that note was, again, in a nurse's

[8] **[*22]** note from the day before, correct?

[9]A Either 9/6 or 9/7. I don't recall exactly.

[10]Q But other than that you're not aware

[11]of any complaints that the patient had regarding

[12]any problems with his right lower extremity, are

[13]you, on 9/6 or 9/7?

[14]A Again, I would have to look line by line

[15]because my report indicates that he -- he was

[16]complaining of numbness in both legs as reported by

[17]someone and, again, numbness is a subjective

[18]complaint, so no one could have ascertained it

[19]without his saying that.

[20]Q On the first full paragraph of the

[21]second page of your report it says on physical

[22]examination. Are we still talking about Dr. Rose's

[23]physical examination?

[24]A Yes.

[25]Q It is noted that he had no cyanosis or

[25]

[1]clubbing. What, if any, significance is the fact

[2]that the patient had no cyanosis or clubbing?

[3]A In this setting it's of no major importance.

[4]Q Was --

[5]A But the one acute possibility that cyanosis

[6]might relate to would be some sort of vascular

[7]compromise; i.e., lack of circulation to the legs.

[8]Q What do you mean by clubbing, Doctor?

[9] **[*23]** A Clubbing is a chronic change. Clubbing of

[10]the toes is a curling over of the nails, which is

[11]a very chronic change that takes years to acquire,

[12]usually related to pulmonary problems, things of

[13]that nature. Nothing acute.

[14]Q And if a patient had cauda equina

[15]syndrome, would you expect to see some type of

[16]cyanosis or clubbing?

[17]A No.

[18]Q A little further down in that same

[19]second page of your report, Doctor, the next

[20]paragraph, it indicates that a Dr. Berkman,

[21]B-e-r-k-m-a-n, indicated that the patient had

[22]received an injection for medication and that

[23]immediately in response to the injection he felt

[24]severe burning pain radiating down his left lower

[25]extremity. Do you see that, Doctor?

[26]

[1]A Yes.

[2]Q What, if any, significance do you

[3]attach to that in connection with the patient's

[4]cauda equina syndrome?

[5]A In relationship to the patient's cauda

[6]equina syndrome, I don't think it had any

[7]significance. In relationship to possible

[8]explanations for some of his symptoms, it's an

[9]important piece of information to have available.

[10]Q Why is it important, Doctor? **[*24]**

[11]A One is trying to at this point reach some

[12]conclusion about why the patient is having the

[13]problems he's having, and if indeed you knew that

[14]an injection was given directly into a nerve, it

[15]would be a useful piece of information to have to

[16]include with everything else that you have.

[17]Q And what are the symptoms that you --

[18]you referred to some symptoms that were exhibited

[19]by the patient that could be connected with

[20]receiving an injection into the nerve. Could you

[21]tell me what symptoms those are, Doctor?

[22]A I don't think I said or did I mean to imply

[23]that they were directly related to the injection

[24]into a nerve because we don't know if he had an

[25]injection in the nerve. The patient was quoted as

27

[1]saying he felt severe pain radiating down his lower

[2]left extremity. He reported weakness and pain in

[3]his left lower extremity in response to the pain

[4]medication that was given yesterday. Whether the

[5]patient has any evidence to know that that was a

[6]nerve injection or whether there was a coincidental

[7]relationship between the two, I don't know. I

[8]don't know and I don't know if Dr. **[*25]** Berkman knows.

[9]Q And these symptom of the burning pain

[10]radiating down his left lower extremity, that's a

[11]symptom that's new as far as -- it seems like that

[12]doctor, according to your record, Dr. Berkman's

[13]note as dictated on 9/8/96, this is not a symptom

[14]that the patient presented to the hospital with

[15]initially?

[16]MR. KAHN: Object to the form of the

[17]question.

[18]A As far as the chart indicates, this appears

[19]to be a new symptom which was temporally related [ILLEGIBLE TEXT]

[20]the event of the injection, yes.

[21]Q Your report also indicated that you

[22]reported weakness and pain in the left lower

[23]extremity associated with numbness in response to

[24]the pain medication injection that he was given

[25]yesterday.

28

[1]A Yes.

[2]Q With respect to that statement, is

[3]that numbness now something that's inconsistent

[4]with cauda equina syndrome?

[5]A No.

[6]Q So numbness is a symptom of cauda

[7]equina syndrome?

[8]A Yes.

[9]Q It's also a symptom of a herniated

[10]disk, is it not?

[11]A Yes.

[12]Q And it's also a symptom -- is it also

[13]a symptom of one who **[*26]** has received an injection into

[14]the nerve?

[15]A One who receives an injection into a nerve

[16]could have such symptoms, yes.

[17]Q So at this point in time there are at

[18]least three potential differential diagnoses for

[19]pain the patient was having on the left side on or

[20]about 9/7/96, is that correct?

[21]A I think that's reasonable, yes.

[22]Q Doctor, the next paragraph, the last

[23]sentence says at this time the symptoms were all

[24]unilateral. I'm assuming that when you refer to

[25]unilateral, you're referring to all on the left
29

[1]side, would that be accurate?

[2]A I believe that's what Dr. Berkman meant.

[3]Q And this is a direct quote from Dr.

[4]Berkman, is that what you mean?

[5]A I'm not sure if it's a direct quote or close

[6]paraphrasing, but it's based on his report.

[7]Q I see here, Doctor, that in the next

[8]paragraph down it begins with Dr. Berkman

[9]mentions -- the next sentence says the doctor went

[10]on to state no caudal sensory loss. What, if any,

[11]significance is that statement to you in reaching

[12]your opinions in this case?

[13]A It's a finding on physical examination **[*27]** which

[14]was part of the patient's clinical presentation.

[15]Q And when you as a doctor see a

[16]statement that says no caudal sensory loss, what

[17]does that mean to you?

[18]A It means that checking the perianal region

[19]the sensation was, to this doctor at this time,

[20]preserved.

[21]Q I'm sorry?

[22]A At the time that Dr. Berkman in this case is

[23]examining the patient he finds that sensation is

[24]preserved on his exam.

[25]Q Would that indicate that at that point
30

[1]in time, at least as according to this doctor who's

[2]making this statement, that the patient is not, or

[3]one of the diagnoses would not be cauda equina

[4]syndrome?

[5]A No, no, it would not mean that it was not a

[6]cauda equina syndrome. It's an observation which

[7]is part of the total picture.

[8]Q Just to get the record straight,

[9]because I believe I started with double negatives

[10]and continued to go on, would the statement no

[11]caudal sensory loss indicate to you that the

[12]patient did not have cauda equina syndrome?

[13]A No.

[14]Q Why not?

[15]A You can't take one finding and rule out

[16]something like cauda equina **[*28]** syndrome simply on the

[17]basis of that.

[18]Q But does the statement no caudal

[19]sensory loss indicate to you that doctors were

[20]looking at this patient to determine whether or not

[21]cauda equina syndrome existed?

[22]A Yes.

[23]Q And when did Dr. Berkman make that

[24]note again?

[25]A Some time on the 8th. I don't have a time

[31]

[1]on it.

[2]Q Prior to that time, based on your

[3]review of the records, did you see anything in the

[4]records that indicated that there was -- that the

[5]patient had cauda equina syndrome?

[6]A I don't recall if anyone specifically

[7]mentioned that in the differential diagnosis. I

[8]think Dr. Berkman did entertain some problem, if

[9]I'm not mistaken, of that nature, but I don't

[10]recall anyone else mentioning it.

[11]Q Since I represent Dr. Hess in this

[12]case, we're getting to an area that interested me

[13]more than the other areas, although they all

[14]interest me.

[15]Based on your review of the records, do you

[16]have an understanding as to when Dr. Hess became

[17]involved in the care and treatment of Mr. Filewicz?

[18]MR. KAHN: Object to the form of the

[19]question. **[*29]**

[20]A My recollection is that he became involved

[21]with Mr. Filewicz after Dr. Berkman had seen the

[22]patient some time on 9/8, and I want to generally

[23]say in the evening, but I don't recall exactly what

[24]time.

[25]Q Based upon your review of the records,

[32]

[1]do you know what complaints, symptoms, the patient

[2]had when Dr. Hess saw the patient?

[3]A I have to --

[4]Q First saw the patient.

[5]A I'd have to refer to my report.

[6]Q Please do.

[7]A I mention that Dr. Hess wrote a consultation

[8]on the 8th reviewing the history and noting -- and

[9]I don't beyond that mention it. Let me go through

[10]those two paragraphs and I think I'll answer some

[11]of your questions, unless you want to break it down

[12]more.

[13]Q No.

[14]A He noted on examination one to two strength

[15]of the left quads, normal strength on the right,

[16]one to two strength on the left iliopsoas and zero

[17]strength through the rest of the leg. He noticed

[18]right side two out of the five strength of the

[19]extensor hallucis longus, normal strength

[20]otherwise. Positive straight leg raising at 45

[21]degrees bilaterally, absent **[*30]** ankle jerks, and a

[22]decreased knee jerk on the left.. That was really

[23]his exam. He also restated the history of left

[24]buttocks injection causing burning and pain and

[25]that was the other piece of history that I had

33

[1]concluded earlier.

[2]Q Doctor, could you explain for me a

[3]little bit about what an examination of one to two

[4]strength of the left quads means?

[5]A We call five out of five strength, which I
[6]think was adopted by everyone in this chart as
[7]normal, so two out of five strength is no movement.
[8]Four out of five strength is almost normal. Three
[9]out of the five strength is again minimal
[10]resistance. Two out of five strength is against
[11]gravity with no resistance. One out of the five
[12]strength is with gravity eliminated. So, for
[13]example, instead of lifting the arm away from the
[14]ground, you put the arm in a position that it could
[15]be parallel to the ground and if it could move
[16]parallel real and not away, that would be graded
[17]one out of five because that's not against gravity.
[18]Two out of five against gravity. Three, minimal
[19]resistance. Four, almost normal resistance. Five,
[20]full **[*31]** strength.
[21]Q You indicate in your report that Dr.
[22]Hess noted that there was, quote, normal strength
[23]on the right, close quote.
[24]A I'm sorry. I noted right side two out of
[25]five strength of the extensor hallucis longus.
[34]
[1]Normal strength otherwise.
[2]Q I apologize. I'm reading from another
[3]part of the report. I apologize. At this point in
[4]time when Dr. Hess sees the patient, are we still
[5]talking about problems that are unilateral?
[6]A I think that he's noted problems there that
[7]are bilateral at this point.
[8]Q Specifically what are those problems

that you think he noted that indicate there's a
bilateral or that there are problems bilaterally
with the patient's lower extremities.
A He noted two out of five strength in the
extensor hallucis longus on the right side. That
was the major finding that I at least made note of.
Q What does that mean to you with
respect to what's happening with this case?
A I'm not sure how to answer that question.
Ask it again. I'll try again.
Q Dr. Hess makes certain notes regarding
the strength of various parts **[*32]** of the patient's
right side. What, if any, significance does it
have with respect to diagnosing what the patient
has?
A I think it continues to present a problem,
specifically talking about the right-sided strength
35
now. I'm not talking about the left-sided
weakness, is that correct?
Q Yes.
A That he has to be a little bit concerned
that although it's a very focal limited weakness,
it's a very significant weakness on the side away
from that which has most of the weakness and I
think your question was, if I'm correct, what is
the significance of that?
Q Yes.
A It certainly pushes one away from being able
to use a potential injury on the sciatic nerve by

[13]an injection as explaining weakness to the other

[14]leg.

[15]It brings into question what significance that

[16]injection has, if any.

[17]Q Which was my next question. You

[18]indicate that Dr. Hess suggested a possible

[19]sciatic nerve injury and then says lumbar

[20]stenosis. I think you already explained why the

[21]possible sciatic nerve injury in your mind should

[22]be ruled out at that time based upon the bilateral

[23] **[*33]** findings, is that correct?

[24]MR. KAHN: Object to the form of the

[25]question.

36

[1]A I don't think that's a complete answer to my

[2]thoughts about this, but it's part of my thoughts

[3]about it.

[4]Q When you say it's part of your

[5]thoughts about it, do you think that a diagnosis of

[6]a possible sciatic nerve injury was incorrect?

[7]A I think it could be entertained as

[8]explaining part of the patient's problems, but

[9]based upon examination, based on history, based on

[10]diffuse findings in terms of strength, I think it

[11]would be very difficult for anyone to explain all

[12]of his neurological findings on a sciatic nerve

[13]even if it was cut right in half.

[14]Q Specifically what symptoms or history

[15]would you point to that would indicate that you

[16]couldn't explain it all as a possible sciatic nerve

injury?

A The three that come to mind quickly are the weakness on the right side that we discussed, the fact that he had weakness by Dr. Hess's examination in the quads and the iliopsoas, which is higher than any muscle served by the sciatic nerve, and in addition the question the urinary **[*34]** retention which could not be caused by a sciatic nerve injury.

Q With respect to these three items that

37

you just indicated, are any or all of those consistent with a finding of lumbar stenosis or a diagnosis of lumbar stenosis?

A Yes.

Q What, if anything, is the difference or the interplay between lumbar stenosis and cauda equina syndrome, if any? Could you explain that to me if you understand my question?

A Cauda equina syndrome is a syndrome that involves loss of function of some, most or all of the nerves of the cauda equina. Lumbar stenosis is a possible explanation for the cause of the cauda equina syndrome. Stenosis is a physical finding. Lumbar rust in the pipe, that's not a syndrome, that's a physical findings. Cauda equina syndrome is a group of symptoms which can be the result of something pressing on the nerves, including lumbar stenosis among other things.

Q So a finding of lumbar stenosis would be consistent with the presence of cauda equina

[21]syndrome, is that correct?

[22]A Yes.

[23]Q Up until this point in time, the time

[24]Dr. Hess **[*35]** first saw the patient, only a CT scan had

[25]been done. At that point in time there hadn't been
38

[1]anything like an MRI or myelogram, am I correct?

[2]A Yes.

[3]MR. KAHN: Object to the form of the

[4]question.

[5]A That's my understanding, yes.

[6]Q And correct me if I'm wrong, but as I

[7]see in your report here Dr. Hess suggested a lumbar

[8]myelogram, is that correct?

[9]A Yes.

[10]Q What exactly is a myelogram?

[11]A He suggested a myelogram, a post myelogram

[12]CT. A myelogram is a study that's done by doing a

[13]lumbar puncture and injecting into the spinal fluid

[14]or subarachnoid space an iodine-based compound

[15]which we call a contras material. Its

[16]characteristics that makes it useful in this

[17]setting is that it shows up on X-ray, on a plain

[18]X-ray. The procedure involves doing a spinal tap,

[19]running the dye or contrast material into the

[20]subarachnoid space and then taking a series of

[21]X-rays both plain, radiographic X-rays while

[22]tilting the patient in various positions and then

[23]following that up with an X-ray, specifically a CT

[24]scan running through the area of the lumbar spine

[25] **[*36]** in this case.
39

[1]Q Is a lumbar myelogram more definitive

[2]than a CT scan for cauda equina syndrome?

[3]A A lumbar myelogram alone is in many ways

[4]more definitive because it can show things that the

[5]CT won't show. The myelogram in this day and age

[6]is usually combined with a CT scan after the

[7]myelogram is done.

[8]Q Would you agree, Doctor, that prior to

[9]operating on a patient for cauda equina syndrome it

[10]would be necessary to have a myelogram done?

[11]A Exclusively as the only test? I'm not sure.

[12]Q Well, prior to operating on a patient,

[13]if you believe the patient had a cauda equina

[14]syndrome and based upon the symptoms that presented

[15]and any other tests that were done, prior to

[16]operating on a patient is it warranted to have a

[17]myelogram before doing the surgical procedure?

[18]A It is a test which would be useful among

[19]others. I'm hesitant to say yes because I don't

[20]want to exclude other possibilities.

[21]Q For instance, if you had a CT scan

[22]alone, based upon a CT scan would you operate on a

[23]patient for a cauda equina syndrome?

[24]A If the CT scan clearly demonstrated

[25] **[*37]** pathology, one could, yes.
40

[1]Q In this case did the CT scan clearly

[2]indicate pathology?

[3]A The CT scan done up to the L3/4 level, but

[4]not above, failed to demonstrate pathology which

[5]explained the cauda equina syndrome. It would have

[6]been inappropriate on the basis of that CT scan to

[7]operate.

[8]Q Page 3, first full paragraph, there's

[9]a statement that says upon my examination, and once

[10]again you're referring --

[11]A Help me. Sorry.

[12]Q Sure. About midway through the first

[13]full paragraph of Page 3. The next sentence says

[14]upon my examination, and I'm assuming there you're

[15]referring to Dr. Hess stating upon my examination,

[16]is that correct?

[17]A Yes.

[18]Q He had good strength throughout all

[19]muscle groups in the right leg except for

[20]extensor -- please help me.

[21]A Hallucis.

[22]Q Longus be 2/5.

[23]A Correct.

[24]Q What, if any, significance to you is

[25]the fact that the patient had good strength

[41]

[1]throughout all muscle groups on the right except

[2]for that particular muscle?

[3]A I think the significance is that on

[4]examination he had **[*38]** weakness in a muscle group on

[5]the right side but only one muscle group, but it

[6]implies that there was some problem on the right

[7]side. It indicates, not implies. It indicates

[8]there was a problem on the right side.

[9]Q And with respect to that problem on

[10]the right side, what does the finding that he had

[11]problems with that particular muscle extensor --

[12]A Hallucis.

[13]Q Longus. What relationship, if any,

[14]does that have to cauda equina syndrome, on the

[15]diagnosis of that?

[16]A That is most commonly innervated on the

[17]right side by the right L-5 nerve root which is one

[18]of the nerve roots of the cauda equina.

[19]Q According to your understanding of

[20]this case, when did Dr. Hess first become aware

[21]that the patient had complained he wasn't able to

[22]move his right leg?

[23]A The morning of the 9th.

[24]Q September 9?

[25]A Yes.

[42]

[1]Q According to your understanding of

[2]this case, when did the patient first complain that

[3]he couldn't move his right leg?

[4]A Some time overnight. Some time two or three

[5]in the morning catches in my mind, but I can't be

[6]sure.

[7] **[*39]** Q Was that after Dr. Hess first examined

[8]him?

[9]A Yes.

[10]Q Do you recall exactly what the

[11]patient's complaints were as far as not being able

[12]to move his right leg; meaning what clinically was

[13]happening with his leg that he couldn't move? Let

[14]me withdraw that. I butchered the heck out of that

[15]one.

[16]With respect to the patient's complaints

[17]some time in the early morning of September 9, 1996

[18]that he couldn't move his right leg, Doctor, do you

[19]know exactly what the nature of those complaints

[20]were?

[21]A I don't recall exactly, no.

[22]Q Do you have a general recollection as

[23]to what was happening with the patient's right leg

[24]on the early morning of September 9, 1996?

[25]A Other than the general recollection that he
43

[1]or the nurses noted weakness in the leg, no, I

[2]don't recall the absolute specifics.

[3]Q Do you understand that to be a change

[4]in the condition of his right leg from the time

[5]that Dr. Hess first examined him?

[6]A Yes.

[7]Q Could you expand upon the nature of

[8]that change at all?

[9]A We have made note of the fact that Dr.

[10]Hess's examination **[*40]** revealed weakness in the

[11]extensor hallucis longus. My understanding is that

[12]the next morning the patient had significant

[13]difficulty moving the leg at all; i.e., he covered

[14]many more muscle groups. Therefore, he had

[15]significantly diminished strength in the leg

[16]compared to the strength before.

[17]Q And as I understand it, correct me if

[18]I'm wrong and if your understanding differs, Dr.

[19]Hess finds out about this right around the time

[20]that the myelogram was being performed, is that

[21]correct?

[22]MR. KAHN: Object to the form of the

[23]question.

[24]A Yes, around that time.

[25]Q And immediately upon finding or

44

[1]getting the result of the myelogram Dr. Hess

[2]decided that surgery was necessary, is that

[3]correct?

[4]A Yes.

[5]Q I'd like to ask you a few general

[6]questions about the significance of the patient

[7]having complaints bilaterally in his lower

[8]extremities as opposed to unilateral. What, if

[9]anything, is the relationship of unilateral versus

[10]bilateral pain in the diagnosis of cauda equina

[11]syndrome?

[12]A The diagnosis of cauda equina syndrome, or

[13]more specifically **[*41]** the presence of cauda equina

[14]compression can exist with either unilateral or

[15]bilateral pain, unilateral or bilateral weakness,

[16]unilateral or bilateral numbness. The bilateral

[17]doesn't rule in or rule out cauda equina

[18]compression; nor does unilateral. Does that answer

[19]your question?

[20]Q Yes, it does. Doctor, what does rule

[21]in or rule out cauda equina in your opinion?

[22]A The combination of patient complaints,

[23]physical examination and radiographic studies are

[24]the way that one makes the diagnosis, and I think

[25]you asked me earlier on the symptoms which can or

[45]

[1]are related to cauda equina compression, so the

[2]presence of some or all of those plus the

[3]radiographic appearance of significant compression

[4]of the nerve roots of the cauda equina would

[5]comprise the appropriate syndrome/diagnosis.

[6]Q Doctor, I'm going to direct you to the

[7]impression part of your report which is page 4, the

[8]first full paragraph, and you indicate that it is

[9]clear that this patient presented to the hospital

[10]on the evening of 09/06/96 with significant loss of

[11]neurological function and urinary retention.

[12] **[*42]** Doctor, I'd like to ask you what is your

[13]basis for stating that the patient presented with

[14]significant loss of neurological function?

[15]A He complained of loss of sensation and had

[16]weakness sometime around 9/6 or early 9/7, as his

[17]major neurological finding. In addition, the

[18]presence of urinary retention represents a major

[19]loss of neurological function.

[20]Q When you say complained of weakness,

[21]can you be any more specific?

[22]A Without being able to tell you exactly when

[23]he said his foot was weak, some time between the

[24]6th and the 7th it was noted that he had weakness

[25]as well as numbness and pain. That all had to be

46

[1]part of the picture. Whether it was on the 6th or

[2]7th, I don't recall.

[3]Q And in your opinion that would

[4]constitute a significant loss of neurological

[5]function?

[6]A Urinary retention is probably the most

[7]neurological function, but the other combined with

[8]it adds up to a significant loss of neurological

[9]function.

[10]Q Based upon your review of the records,

[11]did you have any indication as to how long the

[12]patient had been experiencing the urinary **[*43]** retention

[13]that he presented to the hospital which was on 9/6?

[14]A Based on the fact that he had 600 cc's of

[15]urine, it wasn't for a very long time but probably

[16]on the order of 6 to 12 hours, something of that

[17]magnitude.

[18]That's a guesstimate depending on whether or not

[19]he had had fluid run in, whether or not he had a

[20]lot to drink or factors such as that.

[21]Q I believe you may have explained this

[22]earlier, but what part, if any part, does the fact

[23]that the patient had urinary retention play in the

[24]diagnosis of cauda equina syndrome? Is that one

[25]symptom of it?

47

[1]A I think that's a very important symptom of

[2]it, yes.

[3]Q Is it a symptom of anything else?

[4]A I suppose it could be a symptom of a lot of

[5]other things.

[6]Q Is it a symptom of some sort of disk

[7]injury?

[8]A It can be if the disk is causing cauda

[9]equina compression.

[10]Q Could it be also a symptom of some

[11]sort of nerve injury, nerve damage?

[12]A Yes, but that's what cauda equina

[13]compression is.

[14]Q Anything else relevant to this

[15]patient, the fact that he had urinary retention

[16] **[*44]** could have indicated a diagnosis of?

[17]A Well, in any patient it could be relative to

[18]prostatitis, acute prostate infection. Beside

[19]prostatic hypertrophy, some kind of trauma other

[20]than to the spine. The differential is probably

[21]pretty large. But relative to this patient, no, I

[22]don't think so.

[23]Q You also make a statement in the next

[24]sentence in your report that says that examination

[25]should have immediately brought up the question of
48

[1]a cauda equina syndrome with compression at any

[2]level in the lumbar spine. Do you see that

[3]statement, Doctor?

[4]A Yes.

[5]Q What's your basis for that statement?

[6]A As soon as the patient presents with loss of

[7]neurological function, pain in the leg, weakness in

[8]the leg or any combination, plus urinary retention,

[9]one has to be concerned about possible cauda equina

[10]compression. That cauda equina compression can

[11]occur at L-4, S-1, L4/5, L3/4, L1/2 and maybe even

[12]T-1, L-1. So any level in the lumbar spine has to

[13]be considered as a possible etiology for that

[14]compression.

[15]Q Just to jump back for a second,

[16]Doctor, with respect **[*45]** to your statement about the

[17]significant loss of neurological function, you seem

[18]to indicate that the complaints of weakness

[19]constitue a significant loss of neurological

[20]function. Would that be an accurate statement?

[21]A That's one of them, yes.

[22]Q With respect to this patient, when you

[23]say significant loss of neurological function, what

[24]particular weakness are you referring to? You

[25]generally told me weakness in the legs, but is
49

[1]there a specific, either weakness in an area of the

[2]leg or a particular deficit in the leg? You

[3]explained to me earlier zero through five is the

[4]scale. Is there any particular area of the leg

[5]that you look to for a finding on a scale of zero

[6]to five to indicate a significant loss or weakness.

[7]A I think that, again, combining the loss of

[8]neurological function to include urinary retention,

[9]the development of numbness, paresthesias and any

[10]weakness of any degree with the more severe, the

more important, any of these things combined with the urinary retention certainly constitute a neurosurgical emergency.

Q When you say a neurosurgical emergency, **[*46]** what exactly do you mean by this?

A A situation wherein which a diagnosis has to be made as expeditiously as possible. And if a clear etiology which is correctable is found, it should be corrected as soon as possible.

Q When you say as expeditiously as possible, can you give me, in your opinion, a time frame?

A If I see a patient with urinary retention and weakness in the leg that's involved with a foot drop, I drag that patient across the street either

50

to an MRI scan or a myelogram or at least a CT and operate on him immediately if a lesion is found; within hours.

Q And this patient had a foot drop?

A At some point along the way he did, yes.

Q Do you know specifically when he had a foot drop?

A It was well documented by the time that Dr. Berkowitz saw him on the 8th.

Q Do you know at what point in time prior to the 8th that the foot drop was first noted?

A I'd have to go back in the chart. I can't recall exactly when it was first noted.

[15]Q The next statement the doctor says, I

[16]feel that given that set of circumstances **[*47]** this

[17]patient should be considered an absolute emergency

[18]in the sense that one had to either rule in or rule

[19]out cauda equina compression expeditiously. Do you

[20]see that?

[21]A Yes.

[22]Q I understand you explained a little

[23]bit about what you would do if this patient

[24]presented and that it was in the explanation of an

[25]emergency. When you say that set of circumstances,

[51]

[1]are you referring to the significant loss of

[2]neurological function and the urinary retention

[3]that we talked about before?

[4]A The evolving set of circumstances that we're

[5]looking at at many points along the way demanded

[6]that it be treated as an emergency.

[7]Q I'm just focusing right now on

[8]September 6, 1996. What set of circumstances

[9]existed on September 6, 1996 that indicate that

[10]this patient had an absolute emergency or was an

[11]absolute emergency?

[12]A The major indication at that point was

[13]urinary retention plus loss of neurological

[14]function in a patient whose primary diagnosis was a

[15]disk herniation as it was in this patient.

[16]Q And as a result of those symptoms that

[17]you just told us about, **[*48]** what should have been done?

[18]A A study to image the entire lumbar spine

[19]should have been orchestrated as soon as possible.

[20]Q To what level would you go to look at

[21]the lumbar spine?

[22]A The entire lumbar spine.

[23]Q And in this case I believe you stated

[24]that the CT scan went to L3/4?

[25]A Correct.

[52]

[1]Q Anything else that would have

[2]indicated to you that it is among the circumstances

[3]that indicate it's an absolute emergency other than

[4]what you've just told us?

[5]MR. KAHN: What period of time?

[6]MR. PYLE: On 9/6.

[7]A I think once he becomes an absolute

[8]emergency, it's a absolute emergency. It could be

[9]a double, triple absolute emergency, but I think

[10]once he reaches the threshold for being

[11]expeditiously worked up it should be done

[12]expeditiously.

[13]Q With respect to the test that you just

[14]told me, that you told me about, a CT scan of the

[15]lumbar spine, what, if anything, else would you do

[16]to, in your words, rule in or rule out cauda equina

[17]compression expeditiously?

[18]MR. KAHN: Object to the form of the

[19]question.

[20]A The lumbar spine **[*49]** had to be imaged. The

[21]choices then would include MRI scan, CT scan, myelo

[22]CT scan. If one or the other couldn't be done,

[23]something had to be done to image and either, as I

[24]said, rule in or rule out cauda equina compression.

[25]Q And this is on September 6?

53

[1]A Yes.

[2]Q With respect to September 6, what in

[3]your opinion were the deviations from accepted

[4]standards of medical care which existed on

[5]September 6?

[6]MR. KAHN: Object to the form of the

[7]question.

[8]A I'm going to have to be careful because as I

[9]remember he came in fairly late on the 6th, so if

[10]this rolled over to the 7th --

[11]Q Doctor, if it's easier for you to

[12]answer sixth and seventh together, feel free to

[13]answer it that way.

[14]A I feel more comfortable with that.

[15]Q Fine. With respect to this patient

[16]and the issues in this case, could you tell for me

[17]what you feel in your opinion were the deviations

[18]from accepted standards of medical care in

[19]connection with this patient's care and treatment

[20]on November 6 and/or November 7 -- I'm sorry

[21]September 6 or 7.

[22]MR. KAHN: Object to the **[*50]** form.

[23]A I feel that the deviations of standards

[24]existed in failure to adequately demonstrate the

[25]entire lumbar spine to visualize compression of the

54

[1]nerve roots of the cauda equina; that there was

[2]sufficient indication that this potentially existed

[3]to make this something that had to be done in an

[4]expedited fashion.

[5]Q Anything else?

[6]A I think all of the treatment of the patient

[7]stemmed from the failure to make an effort to

[8]recognize and diagnose cauda equina compression, so

[9]that treatment, for example steroid medication, or

[10]surgery if so indicated, was withheld as a result

[11]of the failure to make the appropriate diagnosis.

[12]Q Do you have a specific opinion as to

[13]what doctor/physician deviated by not doing what

[14]you said should have been done on September 6 and

[15]September 7?

[16]A My understanding from the chart is by the

[17]time the 6th became the 7th, the patient had been

[18]in the emergency room and was admitted under the

[19]care of Dr. Henry Rose. During that period of time

[20]he would be the physician primarily responsible for

[21]making that diagnosis and expediting it, **[*51]** its

[22]diagnosis.

[23]Q Do you know who ordered the CT scan?

[24]A I don't recall.

[25]Q Doctor, you have a statement here that
55

[1]says, in addition I feel it is inappropriate that a

[2]myelogram was not done until 9/9/1996. It's a

[3]little more than halfway down the impressions.

[4]A Yes.

[5]Q Do you see that statement?

[6]A Yes.

[7]Q What's the basis for that opinion?

[8]A It's a reiteration of everything that I've

[9]said up to that point and the needs or the

[10]indication or the clarity of indication become

[11]progressively more obvious as the patient's

[12]clinical picture become more obvious to more people

[13]and as it apparently evolved in terms of

[14]progressive weakness, et cetera. So that I think

[15]from the very beginning the clinical diagnosis of

[16]cauda equina compression was entertained and

[17]certainly by the 8th it was entertained and

[18]actually mentioned and yet no specific effort was

[19]made to rule it out. A myelogram done at the

[20]appropriate time would have made that diagnosis.

[21]Q And what do you feel was the

[22]appropriate time to do the myelogram in connection

[23]with Mr. Filewicz's **[*52]** care and treatment?

[24]A I think there was indication to make this

[25]diagnosis on 6/7, which was one, and more of an

[56]

[1]indication, even if you needed more of an

[2]indication, by the 8th to do that study.

[3]Q What in your mind makes it more of an

[4]indication to do that myelogram study on the 8th?

[5]A We have our best documentation of the

[6]patient's neuro exam when Dr. Berkman saw him,

[7]appreciating the degree of weakness that he had and

[8]combining that with the knowledge that he had

[9]urinary retention, that screams cauda equina

[10]compression. And certainly at this time, and more

[11]than likely at some time before that moment, there

[12]was sufficient indication that this was an

[13]emergency procedure.

[14]Q As soon as Dr. Hess saw the patient on

[15]the evening -- I believe you said you recall it

[16]being the evening of 9/8/96 -- Dr. Hess did order

[17]that a myelogram be done, did he not?

[18]A Yes.

[19]Q What, if any, deviations from accepted

[20]standards of medical care occurred on September 8,

[21]1996, after you indicated that we now have, I

[22]believe your words were, we now have the best

[23]understanding **[*53]** of the patient's condition?

[24]A I feel that the deviations from standards of

[25]care occurred when Dr. Berkman failed to on an

57

[1]emergency basis make a diagnosis of cauda equina

[2]compression or rule it out. I feel a deviation

[3]from standards of care existed when Dr. Hess failed

[4]on the 8th of September 1996, to make a diagnosis

[5]or rule out a diagnosis of cauda equina

[6]compression, and in both cases that failure to make

[7]that diagnosis delayed treatment.

[8]Q On what do you base that opinion that

[9]Dr. Hess deviated from accepted standards of care

[10]on September 8, 1996 in failing to diagnose it?

[11]A Dr. Hess had available for himself the

[12]history that we have all discussed, including the

[13]urinary retention that was noted; he had the

[14]history of the injection, but he also had an

[15]examination that showed profound weakness in the

[16]left leg which by his own examination was zero to

[17]one out of two in the entire leg. Given just those

[18]two circumstances alone I feel that it's imperative

[19]that an emergency study be done to determine

[20]whether there's cauda equina compression and

[21]failure to do that by Dr. **[*54]** Hess constituted a

[22]departure from standard of care.

[23]Q Any other deviations from accepted

[24]standards of care committed by Dr. Hess in

[25]connection with this patient's care and treatment?

58

[1]A I think that's the major area.

[2]Q I realize it's the major area, but I

[3]just want to know if there are any others, any

[4]other opinions that you have regarding any other

[5]deviations of accepted standards of medical care by

[6]Dr. Hess?

[7]A Relating to the failure to diagnose cauda

[8]equina syndrome, it would have been possible to

[9]institute treatment, specifically the institution

[10]of steroid medication to the patient. That also

[11]represents a departure.

[12]Q What would the purpose have been to

[13]institute steroid treatment to the patient at or

[14]about when Dr. Hess first saw him on September 8?

[15]A The goal of institution of steroid

[16]medication is to try to reverse injury to nerve

[17]roots by relieving inflammation of the nerves and

[18]of the structures potentially compressing the

[19]nerves to potentially preserve neurological

[20]function.

[21]Q Would that not have been true based

[22]upon what I **[*55]** understand of your opinion as far as

[23]the deviation in this case, would that not also be

[24]true back on September 6, 1996; meaning that

[25]steroid medication should have been instituted?

59

[1]A Yes.

[2]Q So it's your opinion, that steroid

[3]medication could have or in your opinion should

[4]have been -- more precisely should have been

[5]instituted on September 6, September 7?

[6]A Yes.

[7]Q When you make the statement in your

[8]report that Dr. Hess, the neurosurgeon, and Dr.

[9]Berkman, the orthopedic surgeon, both had

[10]sufficient information available to indicate that

[11]this should be done emergently without any delay

[12]whatsoever, you're referring to what you just told

[13]us about, correct?

[14]A Yes.

[15]Q Patient's history and the patient's

[16]current condition or the condition of the patient

[17]on September 8?

[18]A Yes.

[19]Q The last paragraph, Doctor, you

[20]indicate that in summary I do feel that there are

[21]departures in standards of care and this should

[22]have been diagnosed and operated on immediately for

[23]probable cauda equina syndrome some time on 9/6 or

[24]9/7. Do you have, with respect **[*56]** to that statement,

[25]do you have a definitive time in your mind based
60

[1]upon, what you've seen in this case as to when that

[2]diagnosis should have been made?

[3]A I think the diagnosis should have been

[4]entertained and ruled in or ruled out in that

[5]initial 9/6, 9/7 time period. I think sufficient

[6]information existed at this time to warrant rapid

[7]workup.

[8]Q And essentially what you would have

[9]done in your opinion to rule in or rule out the

[10]diagnosis of cauda equina syndrome would have been

[11]to do a more complete CT scan of the lumbar spine,

[12]is that correct,

[13]and/or a myelogram?

[14]A And/or an MRI scan, yes. So I would have

[15]either ordered -- a preference -- done an MRI scan

[16]or a myelo CT or a CT. A CT alone, I think I would

[17]be worried as being adequate unless it clearly

[18]showed the pathology.

[19]Q Other than the opinions that are

[20]expressed in your report and the ones that you've

[21]told us about here at your deposition here today,

[22]do you have any other opinions regarding the care

[23]and treatment of Mr. Filewicz that you have not

[24]told us about that you expect to offer at the time

[25] **[*57]** of trial?

[61]

[1]MR. KAHN: Object to the form of the

[2]question.

[3]A The only other one that I might consider

[4]offering is that if it was felt that this patient

[5]had to have an MRI scan or if it was felt by any of

[6]the treating physicians that he couldn't be worked

[7]up expeditiously, he should have been transferred

[8]to an institution where this could have been done.

[9]Other than that, I don't think there are any major

[10]areas which we haven't touched on.

[11]Q Just so I understand it, you're

[12]talking about the ability to perform an MRI or

[13]other diagnostic test expeditiously?

[14]A Yes, if it was felt for any reason by any of

[15]the treating physicians that this patient had to

[16]have something done and yet it couldn't be done at

[17]this facility, it's reasonable in this day and age

[18]to say he has to go someplace where it can be done.

[19]Q Is there any information or statements

[20]in the record that you reviewed in preparation of

[21]your report or for today's deposition that indicate

[22]that this was the case?

[23]A The only indication I have of a difficulty

[24]in working up the patient is that it would **[*58]** have

[25]taken, I believe, several days to do an MRI scan.

62

[1]I don't believe that there was any issue about

[2]being or not being able to do a myelo CT to my

[3]recollection.

[4]Q You indicated earlier that you don't

[5]recall writing any reports as an expert in medical

[6]malpractice cases that dealt with cauda equina or

[7]cauda equina syndrome?

[8]A Yes.

[9]Q My question for you then is have you

[10]within say the last five years treated any patients

[11]with cauda equina syndrome or cauda equina

[12]injuries, so to speak?

[13]A Have I personally?

[14]Q Yes.

[15]A Yes.

[16]Q Approximately how many in the last

[17]five years?

[18]A Probably two or three times a year.

[19]Q And did you treat patients with cauda

[20]equina syndrome or cauda equina injuries in 1996?

[21]A Yes.

[22]Q Doctor, I'm going to show you what we

[23]have marked as DD-2, which hopefully you will

[24]recognize as your curriculum vitae.

[25]A Yes.

63

[1]Q I'd like you to take a look at this

[2]and just tell me whether this is current.

[3]A Should I offer changes that would make it

[4]more current?

[5]Q Yes. **[*59]**

[6]A It's listed associate attending neurological

[7]surgery Harlem Hospital 1978 to present. I retired

[8]from Harlem Hospital in 1998. The only other

[9]change is that it's noted 1992 to present acting

[10]director division of neurosurgery St. Luke's

[11]Roosevelt Hospital Center from 1996. I was

[12]director of the division rather than acting

[13]director. And in terms of publications, there are

[14]I believe two other publications which don't appear

[15]on this CV; one referable to lipomatosis of the

[16]lumbar canal and one related to the simultaneous

[17]performance of open heart surgery and aneurysm

[18]clipping in a patient.

[19]Q With respect to the publications --

[20]I've reviewed the publications, and correct me if

[21]I'm wrong but it doesn't seem that any of them

[22]directly dealt with cauda equina syndrome or cauda

[23]equina injuries, is that correct, Doctor?

[24]A I believe that's correct.

[25]Q You also indicate that you're board
64

[1]certified in neurological surgery, is that correct?

[2]A Yes.

[3]Q Do you have any other board

[4]certifications?

[5]A No.

[6]Q I'm assuming that you have a New York

[7] **[*60]** license?

[8]A Yes.

[9]Q It didn't state it in your CV -- at

[10]least I couldn't find it, unless you want to point

[11]it out to me.

[12]A I'll add it if it doesn't. Sorry.

[13]Q I just assumed that that was probably

[14]true.

[15]A Yes, I've had a New York State license since

[16]1974.

[17]Q Do you presently hold any licenses in

[18]any other states?

[19]A No.

[20]Q At any point in time did you hold any

[21]licenses in any other states?

[22]A Yes, I did.

[23]Q Massachusetts?

[24]A No.

[25]Q Where at?
65

[1]A South Carolina.

[2]Q How long did you hold that license?

[3]A 1972 to '74 or '75 while I was in the Navy.

[4]Q And am I to understand that you

[5]voluntarily relinquished that license once you left

[6]South Carolina?

[7]A That's correct.

[8]MR. PYLE: That's all for me, Doctor,

[9]but some of the attorneys will have question for

[10]you.

[11]CROSS EXAMINATION BY MR. ESPOSITO:

[12]Q Good afternoon, Doctor. My name is

[13]Dan Esposito. I represent Dr. Berkman in this

[14]case. I just have some follow-up questions. Just

[15]to focus my questioning, I take it, as I **[*61]** understood

[16]your testimony today, would I be correct that

[17]saying that all of your opinions as to deviation

[18]from standard of care by Dr. Berkman deal with his

[19]actions on September 8 when he saw the patient?

[20]A That's correct.

[21]Q Just in terms of your background,

[22]you're board certified in neurosurgery?

[23]A Correct.

[24]Q Does that require certification in the

[25]field of neurology?

66

[1]A No.

[2]Q Do you practice neurology at all?

[3]A Only indirectly as part of practicing

[4]neurosurgery. It is impossible to examine a

[5]patient and say you're not practicing neurology.

[6]Q Have you ever practiced in the field

[7]of orthopedics?

[8]A No.

[9]Q Sol assume you don't consider

[10]yourself an expert in the field of orthopedics?

[11]A I would disagree only in that I could render

[12]expert opinions in terms of orthopedic spine

[13]surgery, which is essentially the same as

[14]neurological spine surgery. So in reference to the

[15]spine, I think any orthopedic procedure would come

[16]under my area of expertise. Anything beyond that,

[17]I don't think would.

[18]Q Okay. Doctor, I think **[*62]** you testified

[19]that you see in your own practice cauda equina

[20]syndrome approximately two to three times a year?

[21]A That's a very rough estimate, yes.

[22]Q Would you agree with me that the

[23]syndrome, cauda equina syndrome, would be something

[24]that could be considered rare in practice?

[25]A You'd have to really define rare for me.

[67]

[1]It's something that is seen often enough so that it

[2]doesn't get written up in a journal article because

[3]it's so unusual, but it's not something that you'll

[4]see 15 or 20 times a year. So rare -- your

[5]interpretation of rare is subject to your view and

[6]mine. I don't think it's rare. I think it's

[7]something that occurs.

[8]Q Well then maybe I'll try to define it

[9]a little better. Out of in general, what

[10]percentage of patients who have say a ruptured or

[11]ruptured lumbar disk or herniated disk would go on

[12]to have a cauda equina syndrome?

[13]MR. KAHN: Object to the form of the

[14]question.

[15]A I think a very small fraction of a percent

[16]really. So by that definition I guess relative to

[17]all patients, it's pretty unusual.

[18]Q What about patients who **[*63]** have spinal

[19]stenosis, the same percentage or any different?

[20]A I think it would be essentially that same

[21]group that I was discussing.

[22]Q Fraction of a percentage point?

[23]A Yes.

[24]Q You mentioned that you have reviewed

[25]cases as an expert witness before. Could you cell
68

[1]me on a percentage basis the times that you've

[2]reviewed cases -- today you're here for a

[3]plaintiff -- plaintiff versus defendant?

[4]MR. KAHN: Object to the form of the

[5]question.

[6]A Very roughly 75 percent defendant and 25

[7]percent plaintiff.

[8]Q Have you ever testified in court?

[9]A Yes.

[10]Q About how many times?

[11]A About 40 times.

[12]Q 40?

[13]A Something on that order, yes.

[14]Q Have you ever testified in the State

[15]of New Jersey?

[16]A Yes.

[17]Q When was the last time that did you

[18]that?

[19]A It must have been four or five years ago.

[20]Q Do you remember who the attorney was

[21]who retained you?

[22]A Lee Goldsmith.

[23]Q Do you remember the issue in this

[24]case?

[25]A Ulnar nerve injury during the administration
69

[1]of general anesthesia. **[*64]**

[2]Q Out of the 40 or so times you

[3]testified in court, had any of those cases involved

[4]cauda equina syndrome?

[5]A Not to my recollection, but my recollection

[6]is so subject to sudden jogging that I would be

[7]glad to think about that and I promise if it's okay

[8]I'll notify you. I'm not trying to be obscure, I

[9]just can't remember.

[10]Q I understand.

[11]A But I will, if it's okay with Counsel, let

[12]you know if I find one or don't find one.

[13]MR. KAHN: Let me know.

[14]Q Have you ever testified on behalf of a

[15]defendant in a court in New Jersey?

[16]A Defendant in court in New Jersey? I don't

[17]think so, no.

[18]Q About how many times have you

[19]testified in New Jersey?

[20]A I think just that one time.

[21]Q All the other times, have they been in

[22]New York?

[23]A I've actually given testimony only in New

[24]York, that's correct. Not to be misleading, I've

[25]testified in New York on cases brought in Vermont,
70

[1]Kansas, California, and maybe Connecticut.

[2]Q I assume you mean in depositions?

[3]A Yes. I think there's an extra state in

[4]there, but again, I don't **[*65]** want to be misleading in

[5]saying only New York. There have been other states

[6]that I've been retained in, but I've not gone to

[7]California or Kansas and testified.

[8]Q Doctor, are you aware of any

[9]significant history that this patient had before he

[10]was admitted to the hospital in September of 1996

[11]related to either the back or neurological history?

[12]A I hate to give a vague recollection becaue I

[13]might be thinking of the wrong case, but I thought

[14]there was some injury as far back as '91, but

[15]you're making me speculate now which I don't want

[16]to do. So with certainty, no.

[17]Q Did you review any records of this

[18]patient at all from prior to his 1996 admission?

[19]A My recollection was that the first records I

[20]saw time-wise began with the 1996 hospital

[21]admission.

[22]Q Are you aware of him; that is, the

[23]plaintiff, having any surgery involving his spine

[24]prior to September of 1996?

[25]A I don't recall.

[71]

[1]Q Would that be at all potentially

[2]significant related to his condition in September

[3]of 1996?

[4]A I do recall that there was no surgery on the

[5]lumbar spine **[*66]** and that would be the area of major

[6]relevance, I don't recall if there's any cervical

[7]surgery.

[8]Q Doctor, did you receive any summaries

[9]of the facts of this case provided by plaintiff's

[10]counsel?

[11]A Not to my recollection.

[12]Q What is your fee for testifying?

[13]A Herein depositions, $ 350 an hour. For

[14]court testimony, depending on where it is, on an

[15]average of 4 to $ 5,000 a day.

[16]Q That's a flat fee?

[17]A Yeah, unless there's a lot of traveling or

[18]excess time in which case it would be more.

[19]Q And for your initial review and

[20]preparation of your report, is that the $ 350 an

[21]hour?

[22]A I think I have charged $ 600 for that.

[23]Whether that is a blanket fee or not, I don't

[24]recall. I believe that's the charge I rendered.

[25]Q With regard to cauda equina syndrome,
72

[1]would you agree with me that it is more typical

[2]that you would have a bilateral weakness or

[3]numbness in the extremities than a unilateral

[4]weakness or numbness in the extremities?

[5]A It can happen either way. I think taking

[6]all comers it's likely that there will be symptoms

[7]in both **[*67]** extremities.

[8]Q So that would be more likely?

[9]A Yes.

[10]Q Would it be more likely that if the

[11]patient has cauda equina syndrome that they would

[12]have either perianal or peroneal numbness?

[13]A That may or may not be present.

[14]Q Would it be more likely that it would

[15]be?

[16]A My own experience and the literature shows

[17]that it may or may not be present.

[18]Q And what about what would be called

[19]saddle numbness or anesthesia, do you know what I

[20]mean by that?

[21]A Yes, basically the same answer.

[22]Q Is it more likely that you would find

[23]a patient, with regard to bowel or bladder

[24]dysfunction, is it more likely that a patient with

[25]cauda equina syndrome would have bowel incontinence
73

[1]or bowel or bladder retention?

[2]A The more common bowel and bladder finding in

[3]cauda equina syndrome would be urinary or bladder

[4]retention.

[5]Q That would be more common in your view

[6]than incontinence?

[7]A The two aren't mutually exclusive. You can

[8]have bladder incontinence with retention.

[9]Q I think of them as sort of opposite.

[10]A You're wrong. **[*68]**

[11]Q You can have someone who has retention

[12]and incontinence at the same time?

[13]A There is -- one of the types of incontinence

[14]is called overflow incontinence. The patient has

[15]urinary retention where it will distend their

[16]bladder until the point where the urine pressure

[17]builds up and overcome the sphincter, so the

[18]bladder in distinction can have urinary

[19]incontinence.

[20]Q Was there any indication of that in

[21]this case?

[22]A No.

[23]Q There was no indication of either

[24]bowel or urinary incontinence at least up until

[25]September 8, is that correct?

74

[1]A That is correct, as far as I recall.

[2]Q And, again, up until that time, other

[3]than the finding that you mentioned by Dr. Hess of

[4]the right leg on September 8, was there any finding

[5]of bilateral numbness or weakness?

[6]A Not to my recollection, although there

[7]were -- I'm sorry, your question said finding of.

[8]I believe there were complaints of bilateral

[9]numbness early in the course that we have testified

[10]to earlier.

[11]Q Was that something that was a

[12]subjective complaint by the patient?

[13]A Sensory **[*69]** complaints are always subjective.

[14]Q Do you know if after that complaint

[15]there was any indication in your review that there

[16]was returned sensation and function in the right

[17]leg?

[18]A I don't recall that it was so specifically

[19]addressed. Specifically I don't recall if the

[20]patient was asked on an ongoing basis whether he

[21]still had numbness in both legs or not.

[22]Q Was that recorded by a nurse, that

finding that you mentioned?

A My recollection, again, was that that was

initially noted in the emergency room; numbness in

75

both legs, left greater than right.

Q Prior to September 9, was there any

finding upon examination by a physician of

bilateral numbness or dysfunction in the

extremities?

A Numbness is subjective. It's not a finding.

I don't recall anyone documenting bilateral sensory

loss.

Q Am I correct from your testimony that

an MRI would be a definitive study in order to rule

in or rule out cauda equina syndrome?

A It would be one, yes.

Q And that would be something you would

consider to be an appropriate test to order for one

[*70] who is considering this syndrome?

A Yes.

Q Doctor, the consultation with Dr.

Berkman, do you have that?

A I'm sure it's in there.

Q You reviewed this prior to preparing

your report, correct?

A I'm sure I did.

Q And Dr. Berkman at this time documents

several of the findings that would be considered

significant neurologically for this patient at this

76

time?

[2]A Yes.

[3]Q Dr. Berkman indicates at several

[4]points in this report that he was -- it was

[5]conveyed to him from the patient that he thought

[6]his symptoms had improved from the prior day. Did

[7]you see that?

[8]A Yes, I do recall that.

[9]Q Would that finding or that statement

[10]from a patient that it was improving, would that be

[11]significant in terms of the putting together a

[12]diagnosis?

[13]A It's another piece of information that would

[14]be important.

[15]Q Would that be consistent with a

[16]patient who was having an ongoing cauda equina

[17]syndrome if they said he thought his symptoms were

[18]improving from the prior day?

[19]A Yes.

[20]Q It would be?

[21]A Yes.

[22] **[*71]** Q Would that be indicative of a patient

[23]who is progressing or not?

[24]A The improvement in symptoms speaks mainly,

[25]as I understand the chart, to the pain, and the
77

[1]patient was on pain medication, so I think that's

[2]maybe a false benefit. Progression of weakness,

[3]urinary retention can exist in the face of less

[4]pain. You may feel less pain because the nerve

[5]fibers can't feel the pulses of pain, so there's a

[6]way to explain anatomically why the patient may say

[7]I feel better, so the quote unquote improved

[8]symptoms don't rule out cauda equina syndrome.

[9]Q All of Dr. Berkman's findings were

[10]unilateral, is that correct?

[11]A It looks like he mentions only unilateral

[12]symptoms and I believe they were all on the left

[13]side, yes.

[14]Q Dr. Berkman performed what he says --

[15]he documents perianal sensation was intact to light

[16]moving scratch. Is that light moving scratch an

[17]appropriate way to determine whether or not there

[18]was a loss of sensation with these nerves that are

[19]involved?

[20]A I think that's a reasonable test, yes.

[21]Q And if those two findings are intact,

[22]understanding **[*72]** it would not rule something out, but:

[23]would that lead one away from a diagnosis of cauda

[24]equina syndrome as opposed to pointing them towards

[25]it?

[78]

[1]A It's another piece of information that has

[2]to be grouped together with everything else. It

[3]doesn't strongly point toward, but I don't think

[4]it's sufficient to rule it out or lead you away

[5]from it.

[6]Q But you would, wouldn't you, expect

[7]someone who has cauda equina syndrome to have a

[8]loss of sensation in the nerves that are in the

[9]caudal area?

[10]A I wouldn't expect that because I've seen

[11]preservation of that sensation in the presence of a

[12]clear cauda equina syndrome which I've proven

[13]surgically. So I can answer the question

[14]absolutely that you can have intact sensation and

[15]still have very severe cauda equina compression.

[16]Q Is the more typical or more classic

[17]presentation of cauda equina syndrome to have a

[18]loss of sensation in the perianal area and caudal

[19]area?

[20]A It's more typical, yes.

[21]Q Dr. Berkman specifically documents a

[22]consideration of cauda equina syndrome, is that

[23]correct?

[24]A Yes.

[25] **[*73]** Q And he's the first physician on the
79

[1]chart to document that consideration, is that

[2]correct?

[3]A That is my recollection, yes.

[4]Q And would you agree with me that that

[5]was appropriate for him to consider that at that

[6]time?

[7]A Yes.

[8]Q And would you agree with me that it's

[9]clearly documented that he considered it and went

[10]through a process of indicating symptoms of whether

[11]they were -- whether that condition was occurring

[12]or not?

[13]A He did such, yes.

[14]Q Dr. Berkman also states that this

[15]represents a most extremely complicated case,

[16]possibly multi-factoral, with evidence for

[17]longstanding chronic disease and superimposed acute

[18]findings; do you agree with that statement?

[19]A Yes.

[20]Q Would you agree with me that it was

[21]appropriate due to the complexity of the case for

[22]him to involve and defer to a neurosurgery

[23]specialist?

[24]MR. KAHN: Object to the form.

[25]A There are two questions there.

80

[1]Q Okay. I'll split them apart then.

[2]Would you agree with me that it was appropriate for

[3]him to involve, due to the complexity of the **[*74]** case,

[4]a neurosurgical specialist?

[5]A Yes.

[6]Q And would you agree with me that it

[7]would be appropriate for him to defer to the

[8]neurosurgical specialist at this time?

[9]A I don't think I could answer that question

[10]without knowing Dr. Berkman's interest, knowledge,

[11]or involvement in the spine. If he's considered an

[12]appropriate person to do a consultation, he should

[13]be able to render an opinion without deferring to

[14]the neurosurgeon. So defer is the word that I'm

[15]not sure how to respond to. He's certainly

[16]appropriately qualified to obtain neurosurgical

[17]consultations', but whether we should run aside and

[18]say whatever he says goes and whatever I say

[19]doesn't go, that's what I'm not sure about.

[20]Q Would that depend in part on what Dr.

[21]Berkman's, I guess, subspecialty in the field of

[22]orthopedics is?

[23]A No, I think it depends on Dr. Berkman and

[24]his ability to diagnose cauda equina syndrome.

[25]Q What about with regard to the

[81]

[1]treatment of cauda equina syndrome, assuming it is

[2]a condition that is occurring at this time, would

[3]it be appropriate for him to be treated **[*75]** by the

[4]neurosurgeon?

[5]A As opposed to the orthopedic surgeon?

[6]Q Yes.

[7]A What's the question?

[8]Q Is it appropriate for this patient to

[9]be treated, if he needed to have particular surgery

[10]that is required to decompress the area, would he

[11]be more appropriately treated by the neurosurgeon

[12]than the orthopedist?

[13]MR. KAHN: Object to the form of the

[14]question. That would depend on whether Dr. Berkman

[15]performs spine surgery or not.

[16]Q If he does not, is it more

[17]appropriate?

[18]A Yes.

[19]Q And particularly Dr. Hess is a spine

[20]specialist, is that correct?

[21]A That's my understanding, yes.

[22]Q Dr. Berkman also ordered the MRI, is

[23]that correct?

[24]A I would trust your representation as such,

[25]yes.

82

[1]Q And that was an order that you would

[2]consider appropriate within standards of care for a

[3]patient that you're considering may have cauda

[4]equina syndrome?

[5]MR. KAHN: Object to the form of the

[6]question.

[7]A Yes.

[8]Q And would you require the information

[9]from an MRI or another more complete scan such as a

[10]CT **[*76]** myelogram before the patient could be treated

[11]surgically?

[12]A Yes.

[13]Q Doctor, are there any texts or

[14]journals which you consider to be reliable that you

[15]rely upon in your practice?

[16]A I read any number of texts and journals, but

[17]I'm not sure what the test of reliability is.

[18]Q Do you read the journal called

[19]Neurosurgery?

[20]A Yes, I do.

[21]Q Do you consider that journal to be a

[22]generally reliable one?

[23]MR. KAHN: Object to the form of the

[24]question.

[25]A I think that the information presented

83

[1]offers opinions by those who write it who are

[2]represented as reputable neurosurgeons or people

[3]involved in the area.

[4]Q So what does that mean, do you

[5]consider it reliable or not?

[6]MR. KAHN: Object to the form of the

[7]question.

[8]A I answered the question as best I can.

[9]Q In other words, it says what it says?

[10]A Right. And I put it into my data bank along

[11]with everything else.

[12]Q Is it something that you read

[13]regularly?

[14]A Yes.

[15]Q Doctor, do you have an opinion within

[16]a reasonable medical probability as to **[*77]** when the

[17]onset of cauda equina syndrome occurred in this

[18]case?

[19]A Sometime around the 6th of September 1996.

[20]Q And that opinion, is that based on the

[21]findings on the presentation to the emergency room?

[22]A Based on the information offered in the

[23]chart with the history offered by the patient.

[24]Q And can you specify what that history

[25]exactly is?

84

[1]A The most useful piece of information in

[2]terms of the cauda equina compression is the

[3]presence of the urinary retention some time on the

[4]night of the 6th or early morning of the 7th. I

[5]don't remember when it was exactly.

[6]Q That's the most important finding that

[7]you're referring to?

[8]A I think that that's the one that gives us

[9]the first clear indication that there was cauda

[10]equina compression.

[11]Q Doctor, can urinary retention be

[12]caused by the use of analgesia?

[13]A Yes.

[14]Q Did the patient receive analgesia when

[15]he was admitted to the hospital?

[16]A Yes.

[17]Q Would it be reasonable for the

[18]physicians treating this patient to consider that

[19]the urinary retention was related to the **[*78]** use of

[20]analgesia?

[21]A No.

[22]Q Why not?

[23]A Because if you reach that conclusion you're

[24]eliminating the possibility that it relates to

[25]cauda equina compression, something that you have
85

[1]to be sure it doesn't relate to. If you say it

[2]relates to the analgesia, you can only do that

[3]after ruling out the dangerous and emergent causes

[4]of urinary retention.

[5]Q Doctor, are you aware of any studies

[6]with regard to the effectiveness of treatment and

[7]timing from the start of cauda equina syndrome to

[8]when it's treated?

[9]A I believe there have been a number of

[10]studies in the literature looking at cauda equina

[11]syndrome and its treatment in terms of timing, yes.

[12]Q And are you aware of any definition in

[13]terms of time frame, whether you're talking about

[14]24 hours, 48 hours, or otherwise that is defined in

[15]terms of effectiveness within that time frame of

[16]treatment?

[17]MR. KAHN: Object to the form.

[18]A There are all types of numbers which are

[19]thrown about and which again in the accumulation of

[20]review of the literature provide information

[21]without providing absolutes. **[*79]**

[22]Q Are you aware of whether there is any

[23]statistical difference between 24 and 48 hours in

[24]terms of onset to treatment?

[25]MR. KAHN: Object to the form of the
86

[1]question.

[2]A My general awareness is that the more

[3]expeditiously it's treated the better the potential

[4]for a good outcome.

[5]Q Would you expect to find a loss of

[6]anal sphincter tone in a patient who has cauda

[7]equina syndrome?

[8]A You may, yes.

[9]Q And how would that manifest itself?

[10]A You do a rectal examination on the patient

[11]and feel what's called the patulous analous. It

[12]would feel as though there's no tone. Normally

[13]when you do a rectal, whether asked to or not, the

[14]patient will react by contracting down. It will

[15]feel as though there's a loosening instead of a

[16]tightening, and if you ask the patient to contract

[17]down they may not be able to do at all or may be

[18]able to do so only weakly.

[19]Q If a patient has an intact perianal

[20]exam, would that be a patient who has a generally

[21]normal anal sphincter tone?

[22]A Perianalis around the anus, so I'm being

[23]careful with your question. When **[*80]** you're talking

[24]about a perianal exam, you're talking about an anal

[25]exam when you're doing a rectal, so that would be a

87

[1]rectal, normal rectal exam.

[2]Q Are there any levels of the lumbar

[3]spine when they have a problem with the disk either

[4]ruptured or bulging that are more likely to lead to

[5]cauda equina syndrome than others?

[6]A The only way I can answer that is by saying

[7]that statistically discs are more clean at L4/5, so

[8]there would are no cauda equinas directly related

[9]to disc herniations with regard do that, but in

[10]terms of the capabilities of a disc causing a cauda

[11]equina syndrome, factoring in the frequency of

[12]higher number, lower down, no, any given level disc

[13]can be cause a cauda equina syndrome.

[14]Q And where was it in this patient,

[15]again with regard to the disc, the disc problem?

[16]A L-2, L-3.

[17]Q And do those levels of the lumbar

[18]spine correspond to any particular areas of the

[19]cauda equina nerves or is that something that's

[20]generally distributed?

[21]A That's a very bad question.

[22]Q What I want to know is would there be

[23]any particular findings **[*81]** associated with a disc

[24]herniation at those levels that are particular to

[25]L-2, L-3?

88

[1]A At each level L-1, 2, 3, 4, all of them, the

[2]nerve roots are exiting. A disc herniation above

[3]the level of a nerve root exiting can cause

[4]compression. Nerve roots that exit above the disc,

[5]again, cannot become compressed by a disc. So at

[6]L-2, 3, the root exiting between the first and

[7]second wouldn't be compressed; whereas anything

[8]below that would be compressed.

[9]MR. ESPOSITO: Thank you, Doctor.

[10]CROSS EXAMINATION BY MR. CONLON:

[11]Q Good afternoon, Doctor. I introduced

[12]myself before. My name is Tom Conlon and I

[13]represent Dr. Rose.

[14]A Which doctor?

[15]Q Dr. Rose. Same rules apply. If you

[16]don't understand one of my questions, let me know.

[17]Doctor, you are not an internist, correct?

[18]A Correct.

[19]Q And do you know Dr. Rose to be an

[20]internist?

[21]A I believe he is, yes.

[22]Q And, in fact, you haven't seen

[23]patients in the capacity as an internist since

[24]probably your early residency days, correct?

[25]A I don't think I ever saw patients in that

[89]

[1]capacity. **[*82]**

[2]Q Most of the time you're the person who

[3]comes in on request for a consultation as a

[4]neurosurgeon?

[5]A That's a generalization I would agree with,

[6]yes.

[7]Q And, Doctor, are you at the time of

[8]trial intending to offer expert testimony as to the

[9]standard of care for an internist in 1986?

[10]MR. KAHN: Object to the form of the

[11]question. How can he know what he's going to

[12]offer? He's going to answer questions. He's not

[13]going to offer anything.

[14]Q Doctor, are you going to testify as an

[15]expert in internal medicine at the trial?

[16]MR. KAHN: Again, I object to the form

[17]of the question.

[18]A I don't intend to testify. You meant '96,

[19]not '86.

[20]Q I apologize.

[21]A I don't intend to testify as to the

[22]standards of care of an internist, no.

[23]Q And, in fact, a neurosurgeon

[24]approaches a case differently than an internist

[25]would, isn't that a fair general statement?
90

[1]A It's too general a statement for me to

[2]really agree with.

[3]Q Well, Doctor, would you agree that the

[4]knowledge possessed by someone who's an orthopedist

[5]or neurosurgeon **[*83]** as someone who deals in spines is

[6]greater as concerns cauda equina syndrome than an

[7]internist?

[8]A That's again too general a statement for me

[9]to be able to agree with out of hand. I couldn't

[10]tell you.

[11]Q Well, Doctor, would you agree that a

[12]neurosurgeon or orthopedist would be in a better --

[13]have a better knowledge base to diagnose a cauda

[14]equina syndrome than an internist?

[15]A I think an internist in my experience is

[16]very capable of calling me and saying Dr.

[17]DiGiancinto, I have a patient with a cauda equina

[18]syndrome so I believe an internist is capable of

[19]making that diagnosis.

[20]Q Doctor, it's true when an internist

[21]has a belief that a patient has a cauda equina

[22]syndrome or a disc problem that the standard of

[23]care is for them to call a neurosurgeon or an

[24]orthopedist in for a consultation?

[25]A I think that's a reasonable course of

[91]

[1]action, yes.

[2]Q Doctor, do you recall or can you look

[3]at the records to tell me when Dr. Rose first

[4]learned of this patient?

[5]A I believe he first saw the patient on

[6]9/7/96. I don't know if he was called the night

[7] **[*84]** before or not.

[8]Q Doctor, I'll represent to you that the

[9]records reveal that Dr. Rose was notified late in

[10]the evening of 9/6 of the patient and at that time

[11]he phoned in some orders; one of those being the

[12]consultation by an orthopedist, and my question is

[13]in a patient who has the presentation as this

[14]patient did, was that the appropriate thing for him

[15]to do?

[16]A I think it was reasonable for him to consult

[17]an orthpedic surgeon, yes.

[18]Q The idea is to get an orthopedic on

[19]board as soon as possible for the workup of the

[20]patient?

[21]A Yes.

[22]Q And then once the specialist evaluates

[23]the patient or sees the patient, they would

[24]determine what types of studies would be necessary

[25]for the appropriate workup, correct?

[92]

[1]A I think it's reasonable not to exclude Dr.

[2]Rose from that discussion, but certainly the

[3]orthopedic surgeon would make suggestions as to

[4]the appropriate evaluation.

[5]Q Well, Doctor, in your report you state

[6]broadly in my view that it was inappropriate for a

[7]myelogram not to be done until 9/9/96. My question

[8]is to you, is it your opinion **[*85]** that Dr. Rose should

[9]have ordered a myelogram on either when he first

[10]learned of the patient late on the 6th or on the

[11]7th?

[12]MR. KAHN: Object to the form of the

[13]question.

[14]A It would certainly be a reasonable thing for

[15]him to have done.

[16]Q Do internists generally order

[17]myelograms?

[18]A There's no general in that answer. They can

[19]and do.

[20]Q And in your practice you've come upon

[21]a patient who has already had a myelogram ordered

[22]by his internist?

[23]A I would rather answer the question by saying

[24]the study ordered by his internist, yes.

[25]Q Well, specifically a myelogram because

93

[1]that's what you talk about in your reports?

[2]A If that's what's available, yes.

[3]Q Now, Doctor, isn't it true that the

[4]individual who's going to be working up a patient

[5]for the spine pathology, the orthopedist or the

[6]neurosurgeon would be in the best position to

[7]determine what types of studies they would need to

[8]do whatever it is they were going to do for the

[9]patient?

[10]A I think to answer yes to that question would

[11]exclude the possibility that the internist **[*86]** might be

[12]able to make such a suggestion as well and I

[13]wouldn't exclude that possibility.

[14]Q And, Doctor, would you agree that an

[15]internist has the right to rely on the findings of

[16]a specialist?

[17]MR. KAHN: Object to the form of the

[18]question.

[19]Q General question.

[20]A I think an internist will listen to what the

[21]specialist says and plug it into what he's

[22]thinking, yes.

[23]Q And the internist would not be the one

[24]to decide to do surgery, correct?

[25]A The internist might say I really think

94

[1]surgery is necessary. He obviously wouldn't

[2]perform the surgery.

[3]Q In a situation as we have here with a

[4]spinal surgery, it wouldn't be the internist's

[5]decision whether to do surgery, correct?

[6]A The internist, again, could reach a

[7]conclusion that surgery was necessary. He couldn't

[8]say I'm going to take the patient to the operating

[9]room and do it, but he could certainly work up the

[10]patient, work the patient up to the point of it's

[11]clear from the studies that this patient needs

[12]surgery and hand it off at that point.

[13]Q Dr. Rose saw the patient on September

[14] **[*87]**

[15]what time was it?

[16]MR. KIPNIS: I think it was 6.

[17]THE WITNESS: 7.

[18]MR. CONLON: I withdraw the question.

[19]Q Doctor, the CT scan was ordered on the

[20]7th at 4:15 by I believe Dr. Berkman. Are you

[21]aware of that?

[22]A I would trust your representation as such.

[23]Q And it was a CT scan of the lumbar

[24]spine, correct?

[25]A He ordered that, yes.
95

[1]Q And the study that was done was only

[2]from I think L-4, L3/4, to L5/S1?

[3]A Yes.

[4]Q And it's the radiologist or

[5]technologist or whatever phrase they use who put

[6]the patient on the table and actually performs the

[7]study, correct?

[8]A Yes.

[9]Q So you don't know until there's either

[10]a wet read or the official report comes back that a

[11]full lumbar study has been done?

[12]A Correct. You meaning Dr. Berkman in this

[13]case?

[14]Q Or anybody.

[15]A Or Dr. Rose. Yes, I'm sorry.

[16]Q The issue of urinary retention, and

[17]correct me if I'm wrong, but is this the main

[18]component of the your opinion that the patient had

[19]cauda equina syndrome as **[*88]** of some time 9/6 forward?

[20]A Yes.

[21]Q And I believe in response to

[22]co-counsel's questions you stated that he had

[23]difficulty urinating.

[24]MR. CONLON: Withdrawn.

[25]Q Difficulty urinating can be caused by
96

[1]many factors?

[2]A Yes.

[3]Q And it can be caused by a herniated

[4]disc?

[5]A If it's sufficiently large to cause

[6]compression, yes.

[7]Q And it can also be caused by

[8]medications that a patient is taking?

[9]A Yes.

[10]Q And the amount of urinary retention on

[11]9/7 was how much?

[12]A I believe it was recorded that 600 cc's of

[13]urine were put out in the catheter.

[14]Q What is urinary retention?

[15]A Inability to pass urine.

[16]Q Is that different from residual?

[17]A Residual measures how much is in the bladder

[18]after a patient has voided, so you may call it post

[19]void residual retention of urine. On the other

[20]hand inability to void and putting a catheter in

[21]not post voidal residual, it's a residual but you

[22]would be mixing terms to try to make the two

[23]equivalent.

[24]Q So is the 600 cc's of urine that was

[25]the urinary retention **[*89]** or the hundred cc's of
97

[1]residual that was taken out around 2 p.m. that day

[2]by catheter?

[3]A It was the 600 cc's of retention.

[4]Q And had the patient been receiving IV

[5]fluids up to that time of the 600 cc's?

[6]A I don't know.

[7]Q Do you know if he received intravenous

[8]fluids at any time?

[9]A I would only speculate that he did have an

[10]IV and I would have to review the chart to see if

[11]he was.

[12]Q In Dr. Berkman's consultation, you had

[13]responded to the question concerning a statement

[14]that there was no caudal sensory loss, and in

[15]response to a question, and this was just for my

[16]clarification, you spoke of the perianal sensation.

[17]Is that the only finding which you believe Dr.

[18]Berkman used to come to the conclusion that there

[19]was no caudal sensory loss?

[20]A I don't know what he did specifically to

[21]come to that conclusion.

[22]Q But it wouldn't just be looking at the

[23]perianal sensation to see if it was intact to come

[24]to the conclusion that there was no caudal sensory

[25]loss?
98

[1]A It's in response to the patient's reacting

[2]to stimuli in the area **[*90]** of the lower sacrum and

[3]generally in the perianal region, so I think it's

[4]part of the reason that he concluded that.

[5]Q You used the phrase neurosurgical

[6]emergency. When did this patient become a

[7]neurosurgical emergency?

[8]A I think he was evolving into a neurosurgical

[9]emergency from the time that he arrived at the

[10]emergency room and became a neurosurgical let's

[11]work this up quickly -- and I might also say

[12]orthopedic spine surgical to not be exclusive --

[13]again, I'm not being facetious because, again,

[14]treatment of spine problems comes under the purview

[15]of orthopedics and neurosurgeons, too, in many,

[16]many cases to an absolute equivalent degree.

[17]Q And the first time that there's a

[18]notation of a foot drop isn't until Dr. Berkman saw

[19]the patient, is that correct?

[20]A I believe that is correct.

[21]Q And this was a neurological change

[22]that wasn't present when Dr. Rose saw the patient?

[23]A Assuming that Dr. Rose's examination was

[24]adequate, that would be true.

[25]Q In your review of the records do you
99

[1]have an opinion whether or not at any time Dr.

[2]Rose's evaluation **[*91]** is insufficient?

[3]A Well, I noticed in my report --

[4]MR. KAHN: Let me just object to the

[5]form of the question.

[6]A I noted in my report that he made no mention

[7]of motor testing, so I don't know if he did or

[8]didn't do it.

[9]Q Doctor, is it true as a general

[10]medical theory that the sooner that you treated,

[11]the better chance that you have for a positive

[12]outcome?

[13]A Yes.

[14]Q Now, if this patient had a cauda

[15]equina syndrome as you posit it is on the 6th, and

[16]if surgery was done at the time, isn't it medically

[17]probable that the outcome may very well be the same

[18]day?

[19]MR. KAHN: Object to the form of the

[20]question.

[21]A Within a reasonable degree of medical

[22]probability, no.

[23]Q Why?

[24]A On the 6th he had a shorter period of

[25]probable cauda equina compression and many
100

[1]neurological findings. On the 9th he had markedly

[2]in both legs and had been in urinary retention to

[3]some degree for at least three days.

[4]Q Now, you said on the 6th he had many

[5]more neurological findings. Is it true that it

[6]wasn't until the late afternoon, early **[*92]** evening of

[7]the 8th that there were more neurological findings?

[8]A No, it's true that they weren't made note of

[9]until the early afternoon or evening of the 8th. I

[10]don't think we can really tell from the chart when

[11]they evolved. They wouldn't just start the instant

[12]that the orthopedic surgeon walked in, for example.

[13]Q So you don't have any documentation or

[14]any basis within the record for that position that

[15]there was a neurological deterioration from the 6th

[16]through the 8th?

[17]MR. KAHN: Object to the form of the

[18]question.

[19]A It was worse on the 8th than the 6th. It

[20]happened somewhere in there.

[21]Q Isn't it possible that there was an

[22]acute event?

[23]MR. KAHN: Object to the form of the

[24]question.

[25]A It's possible.

101

[1]Q Medically probable?

[2]MR. KAHN: Object to the form of the

[3]question.

[4]A I have no way of knowing. I couldn't state

[5]with certainty.

[6]MR. CONLON: Thank you, Doctor.

[7]CROSS EXAMINATION BY MR. KIPNIS:

[8]Q My name is Adam Kipnis and I represent

[9]Dr. Seid, who was the original emergency room

[10]physician who first **[*93]** saw the plaintiff in this

[11]matter. In your impression section on page 4 of

[12]your letter you indicate at the end, indeed the

[13]information available to the emergency room

[14]doctors. Are you referring to Dr. Seid?

[15]A I think I'm referring to the physicians who

[16]were involved with the patient early on in his

[17]care.

[18]Q Including Dr. Seid?

[19]A He would be one of the doctors included,

[20]yes.

[21]Q And what information do you believe

[22]they had available according to your statement?

[23]would request that you limit your opinions just to

[24]Dr. Seid.

[25]A Again, I'm inadequate in having broken down
102

[1]precisely whether Dr. Seid knew about the urinary

[2]retention, for example. That would be an important

[3]factor in his involvement. I just can't recall

[4]from my review of the chart. My recollection was

[5]that the Foley catheter was put in while he was in

[6]the emergency room and notes written by the nurse

[7]in terms of bilateral numbness and the finding of

[8]600 cc's were generated in the emergency room, but

[9]what I don't know, for example, is what time Dr.

[10]Seid went off duty.

[11]Q I can represent **[*94]** to you that the

[12]bilateral numbness was not noted when Dr. Seid

[13]first saw him. Do you intend to offer an opinion

[14]as to whether or not Dr. Seid, as an emergency room

[15]physician, deviated from any accepted medical

[16]standards?

[17]MR. KAHN: Objection. He's going to

[18]answer questions at the time of trial. He's not

[19]here intending to do one thing or another.

[20]MR. KIPNIS: Well, he indicates in his

[21]report that the information available to the

[22]emergency room doctor should have inspired the same

[23]response, so I assume he would be offering an

[24]opinion.

[25]MR. KAHN: Depends if he's asked.

103

[1]MR. KIPNIS: I'm asking him.

[2]MR. KAHN: You're asking the doctor

[3]if he's going to offer an opinion. My objection is

[4]that he's going to respond to questions, so he

[5]can't sitting here know what he's going to offer or

[6]not offer.

[7]MR. KIPNIS: Well, that's my question.

[8]Q Right now can you offer an opinion as

[9]to whether or not Dr. Seid as an emergency room

[10]physician deviated from any accepted medical

[11]standards?

[12]MR. KAHN: Object to the form of the

[13]question.

[14]A No.

[15] **[*95]** Q Have you ever rendered any opinions

[16]both for or against an emergency room -- as an

[17]expert for the standards of care with respect to an

[18]emergency room physician?

[19]A I would have to say I'm sure I have, but I

[20]would be very hard-pressed to give you case and

[21]situation.

[22]Q Do you know what the responsibilities

[23]are of an ER doctor?

[24]A In general, yes.

[25]Q Can you tell me what they are?

104

[1]A In general it would be to take an adequate

[2]history, to do an adequate neurological

[3]examination, to order appropriate medical studies,

[4]to make sure those studies are looked at and

[5]interpreted properly and when indicated to make an

[6]appropriate referral to a specialty, for a

[7]specialty consultation if such was indicated.

[8]Q Is one of their responsibilities to

[9]note their impressions or findings?

[10]A Yes.

[11]Q Is one of their responsibilities to

[12]diagnose either an injury or in this case a

[13]neurological problem?

[14]A If the information is available to them,

[15]yes, it would be.

[16]Q Do you believe that the emergency room

[17]physician has the ability to diagnose a

[18] **[*96]** neurological problem?

[19]A Yes.

[20]Q You indicate, and I'm referring to the

[21]same line, that the emergency room doctors and

[22]initial treating physician should have inspired the

[23]same response. The response that you are referring

[24]to, is that everything that you listed above it?

[25]A Yes.

105

[1]Q So can you tell me specifically how

[2]Dr. Seid as an emergency room physician deviated

[3]from any accepted standards of medical care?

[4]A I can't at this instant tell you that;

[5]again, because I would have to be asked if Dr. Seid

[6]had this piece of information or this piece of

[7]information and I'm not adequately prepared at this

[8]moment to say I remember that Dr. Seid knew about

[9]the urinary retention, for example. That would

[10]have a big effect on my opinion.

[11]Q You read over his deposition as part

[12]of your report?

[13]A I did, but I don't recall it, so I can't

[14]answer the question.

[15]Q You indicated before that bilateral

[16]pain would be more indicative of this cauda equina

[17]syndrome, correct?

[18]A I don't remember my exact words.

[19]Q Would you agree that bilateral pain as

[20] **[*97]** opposed to unilateral pain or numbness would be

[21]indicative of cauda equina syndrome?

[22]MR. KAHN: Object to the form of the

[23]question.

[24]A I believe that either could be indicative of

[25]cauda equina syndrome.

106

[1]Q Would you believe that bilateral would

[2]be more indicative as opposed to unilateral?

[3]A I don't think unilateral pain would rule it

[4]out.

[5]Q You indicated in your impression

[6]section that the patient presented to the hospital

[7]on the evening of September 6, 1996 with

[8]significant loss of neurological function and

[9]urinary retention. Can you tell me where

[10]specifically in the medical record you got that

[11]information?

[12]A I can't tell you specifically without going

[13]through the whole thing but I'd be glad to if you'd

[14]like.

[15]Q I would.

[16]A Okay. Dig it out. Anyone who wants to help

[17]me find the sheet is welcome.

[18]Q Why don't we just limit it to the

[19]emergency room, triage room. Do you see any

[20]indication in the triage form as to whether or not

[21]there was a significant loss of neurological

[22]function and/or urinary retention?

[23]A No.

[24] **[*98]** Q So the fact that either neurological

[25]function and/or urinary retention was not in the
107

[1]triage form would not be indicative of cauda

[2]equina syndrome?

[3]A Correct.

[4]Q You also indicate that the patient

[5]should be considered an absolute emergency in the

[6]sense that one had to either rule in or rule out

[7]cauda equina compression expeditiously. When do

[8]you believe cauda equina syndrome should have been

[9]diagnosed? Do you believe that it should have been

[10]when he was first admitted into Passaic General?

[11]MR. KAHN: Object to the form of the

[12]question.

[13]A I think it was reasonable with the

[14]information available on the 7th to feel that it

[15]had to be ruled out as a possibility.

[16]Q So not when Dr. Seid first saw the

[17]plaintiff?

[18]A Again --

[19]Q Dr. Seid first saw the plaintiff on

[20]the night of September 6?

[21]A I have to keep answering the question the

[22]same way, I just don't recall what doctor -- how

[23]far the patient's evaluation had evolved and

[24]specifically whether he had been noted to be in

[25]urinary retention when Dr. Seid was still involved
108

[1]with the **[*99]** patient. I can't answer that question. I

[2]can't make it up.

[3]Q Urinary retention was not noted by Dr.

[4]Seid?

[5]A I think that would be a very significant

[6]factor of my evaluation of his care.

[7]Q So the fact that urinary retention was

[8]not noted and the fact that bilateral numbness

[9]and/or pain was not noted would be indicative that

[10]the cauda equina syndrome had not developed when

[11]Dr. Seid first saw the plaintiff?

[12]A I think without that information available

[13]it would be difficult to make such a diagnosis.

[14]Q Do you believe that Mr. Filewicz was

[15]an absolute emergency when he first presented to

[16]Passaic General?

[17]MR. KAHN: Object to the form of the

[18]question.

[19]A The minute he walked in the door.

[20]Q The minute he walked in the door?

[21]A He was; although I don't think it could be

[22]recognized at the instant he hit the door.

[23]Q And why do you not think that it could

[24]be recognized?

[25]A It's going to take a little time to gather
109

[1]information and find out what's going on with the

[2]patient.

[3]Q Can you assess or come to some type of

[4] **[*100]** reasonable time frame to which to consider him an

[5]absolute emergency?

[6]A I think that once it was realized that he

[7]had 600 cc's of urine in his bladder and was unable

[8]to void, a huge red flag started to wave in the

[9]sky.

[10]Q Does that also include bilateral

[11]numbness or the urinary retention and the bilateral

[12]numbness to be the red flag?

[13]MR. KAHN: Object to the form of the

[14]question?

[15]A The combination of those things certainly is

[16]going to raise that flag pretty high.

[17]Q And if Mr. Filewicz did not complain

[18]of bilateral numbness and if Mr. Filewicz did not

[19]have any urinary retention problems, would you

[20]agree that he did not present with cauda equina

[21]syndrome?

[22]A He certainly didn't present with the

[23]syndrome.

[24]Q Well, cauda equina?

[25]A Yes.

110

[1]Q Would you believe that Dr. Seid should

[2]have performed a myelogram when he first saw Mr.

[3]Filewicz?

[4]A No.

[5]Q Only until the bilateral numbness and

[6]the urinary retention presented themselves?

[7]MR. KAHN: Object to the form of the

[8]question.

[9]A Give me a whole question. **[*101]**

[10]Q It was only when Mr. Filewicz had a

[11]urinary-retention problem and bilateral numbness

[12]that a myelogram should have been performed?

[13]A That's the point at which one should have

[14]started to look very hard at what was going on with

[15]reference to the cauda equina.

[16]MR. KIPNIS: That's all I have.

[17]MR. PYLE: I have a few follow-up

[18]questions, Doctor, as daylight fades to night.

[19]REDIRECT EXAMINATION BY MR. PYLE:

[20]Q What in your opinion, Doctor, was the

[21]cause of the cauda equina experienced by Mr.

[22]Filewicz in September 1996?

[23]A Herniation of the lumbar disc at L-2/3

[24]causing compression of the nerve roots of the cauda

[25]equina.

111

[1]Q September 9, 1996, the surgery was

[2]performed by Dr. Hess, is that correct?

[3]A Yes.

[4]Q With respect to the surgery performed

[5]by Dr. Hess, was that the appropriate surgery to

[6]perform at this point in time?

[7]A I think that the most important component of

[8]the surgery was the decompression at L-2, L-3. I'm

[9]not sure that further decompression lower down had

[10]any major contribution, but I think given the

[11]degree of stenosis **[*102]** that was seen it was probably

[12]appropriate to go all the way down.

[13]Q With respect to that surgery, is there

[14]anything in connection with that surgery that you

[15]felt was a deviation from accepted standards of

[16]medical care, meaning the actual performance of the

[17]surgery?

[18]A No.

[19]MR. PYLE: Nothing further, Doctor.

[20]MR. ESPOSITO: No questions.

[21]MR. CONLON: Just a couple follow up.

[22]RECROSS EXAMINATION BY MR. CONLON:

[23]Q Doctor, in your report you don't

[24]mention Dr. Rose by name. Is there a reason for

[25]that?
112

[1]A I thought I did.

[2]Q In your impression paragraph I mean.

[3]A I think he's included under indeed the

[4]information about emergency room doctors and

[5]initial treating physicians, who was in parens Dr.

[6]Rose.

[7]Q Is there a difference between the

[8]inability to void and the failure to void?

[9]A I don't know.

[10]Q If you had urinary retention, does

[11]that patient have the urge to void?

[12]A He may or he may not.

[13]Q Is that a significant finding

[14]that he has the urge to void?

[15]MR. KAHN: Object to the form of the

[16]question. **[*103]**

[17]MR. CONLON: I'll rephrase it.

[18]A I can answer the question. I'm just

[19]thinking.

[20]Q Is it a significant finding vis-a-vis

[21]cauda equina syndrome?

[22]A A patient with cauda equina syndrome may

[23]have the urge to void and not be able to void or

[24]may neither have the urge to void and be able to

[25]void depending on how many sensory impulses were
113

[1]lost.

[2]Q Is it significant that if a patient

[3]has sensation in his penis?

[4]A It's a finding, yes.

[5]Q Is it a significant finding in a

[6]patient where they're trying to rule out cauda

[7]equina syndrome?

[8]A It's another finding that we throw in with

[9]everything else. It's not one that makes or breaks

[10]the potential diagnosis.

[11]Q Does it point you away from cauda

[12]equina or towards cauda equina?

[13]A Again, as a single -- if that is the only

[14]piece of information you had, it would point you

[15]away from cauda equina, but that alone doesn't have

[16]enough impact to rule in or out cauda equina

[17]syndrome.

[18]Q If you have sensation in the penis and

[19]an urge to void, taken together do those push you

[20]away from **[*104]** cauda equina?

[21]A No.

[22]Q Does it push you towards cauda equina?

[23]A An urge to void without the ability to void

[24]would push me toward cauda equina.

[25]Q And I'll represent to you in the
114

[1]records it states that the patient had a failure to

[2]void, and you don't know what that would mean?

[3]A It means he couldn't void. I don't think

[4]there's a difference between failure to void and

[5]inability to void, but I didn't write it. It's not

[6]a term that I would formally use in the medical

[7]jargon.

[8]Q Is it a term that nurses use?

[9]A I guess that one did.

[10]Q Doctor, if a complete CT scan of the

[11]lumbar spine had been done from L-1 all way down,

[12]as was ordered, then is it your opinion that the

[13]cauda equina syndrome would have been diagnosed

[14]earlier?

[15]MR. KAHN: Object to the form of the

[16]question.

[17]A I couldn't answer that question unless I saw

[18]a CT scan through the L-2, L-3 level and had a

[19]chance to look at it. It's possible that the

[20]resolution wouldn't have been enough to make the

[21]diagnosis.

[22]Q Would a CT scan normally show

[23]herniation of a **[*105]** disc?

[24]A Again, depending on the resolution of the CT

[25]scan, it may or made not show a clear enough
115

[1]picture to be certain of the diagnosis, but it may,

[2]yes.

[3]Q Doctor, did you review any of the

[4]films in this case?

[5]A I don't recall with certainty whether I did

[6]or not.

[7]Q If you had reviewed the films, would

[8]it have been contained in your report?

[9]A I presume it would have been.

[10]Q Doctor, the CT scan which was done

[11]here showed some disc pathology at some of the

[12]levels which were visualized, correct?

[13]A Yes.

[14]Q Would that lead you to believe that

[15]the resolution was enough that it would have shown

[16]pathology at 2/3?

[17]A I'm not sure it would have shown pathology

[18]at 2/3. I'm not sure if it would have been enough

[19]to make an absolute certain diagnosis.

[20]Q That's the pathology that you then

[21]take your next step from, correct?

[22]A Yes.

[23]Q Doctor, did this patient ever reach a

[24]point where regardless of what surgery procedure

[25]was done that he was not going to regain function?

116

[1]A I think that you can never presume that **[*106]** a

[2]patient has no ability to regain function at any

[3]point along the way, so I'd have to, in general,

[4]answer the question no.

[5]Q Is that because you always try on the

[6]off chance something may occur?

[7]A I think it's a question of degree of

[8]functional return.

[9]MR. CONLON: I don't have any further

[10]questions.

[11]MR. KIPNIS: Just one final question.

[12]RECROSS EXAMINATION BY MR. KIPNIS:

[13]Q Are you aware as to whether or not Mr.

[14]Filewicz presented with pain radiating down his

[15]left leg when he first presented to Dr. Seid?

[16]A I'd have to look at the record to be sure.

[17]I don't recall specifically.

[18]Q Take a look at this.

[19]A It appears that the record says pain in

[20]back, but then there's also something left. I

[21]really can't read it. I'm sorry.

[22]Q If I represent to you that he

[23]indicated that there was pain radiating down his

[24]left leg and there was no notation, nor was there

[25]any indication as to whether or not Mr. Filewicz
117

[1]had urinary retention, would you agree that when he

[2]first presented to Dr. Seid he did not have cauda

[3]equina?

[4]MR. **[*107]** KAHN: Object to the form of the

[5]question.

[6]A No, I don't think that I could agree that he

[7]didn't have cauda equina. I think there wasn't

[8]enough evidence at that point for Dr. Seid to reach

[9]that conclusion. You're asking me two different

[10]things; did he have it and was there enough

[11]information available for the doctor to make the

[12]diagnosis.

[13]Q Do you believe that he had the

[14]information available in order to make the

[15]diagnosis?

[16]A At the point that he presented to Dr. Seid,

[17]no;

[18]At least based on the representations today.

[19]REDIRECT EXAMINATION BY MR. PYLE:

[20]Q Doctor, do you have any opinion in

[21]this case as to whether Dr. Seid deviated from any

[22]accepted standards of medical care?

[23]A I do.

[24]Q And what is that opinion?

[25]A That he did not.

118

[1]MR. PYLE: Thank you.

[2](Depositionconcluded at 5:05 p.m.)

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119

[1]

[2]C E R T I F I C A T E

[3]

[4]

[5]

[6]

[7]I, GLENN R. FRIIS, a Certified Shorthand

[8]Reporter, do hereby certify that the foregoing **[*108]** is a

[9]true and accurate transcript of the testimony as

[10]taken stenographically by me and before me at the

[11]time, place and on the date hereinbefore set forth.

[12]

[13]I do further certify that I am neither a

[14]relative, employee, nor attorney, nor counsel of

[15]any of the parties to this action, and that I am

[16]neither a relative nor employee of such attorney or

[17]counsel, and that I am not financially interested

[18]in the outcome of this action.

[19]

[20]
/s/ Glenn R. Friis

[21]GLENN R. FRIIS, C.S.R.,
Certified Shorthand Reporter

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