SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

- X

JAMES SIMEONE,

Plaintiff,

-against- Index No.
063791/13

ALEXIOS APAZIDIS, M.D. and BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER,

Defendants.

- X

2174 Jackson Avenue
Seaford, New York

June 6, 2016
10:13 a.m.

EXAMINATION BEFORE TRIAL of ALEXIOS APAZIDIS, M.D., the Defendant herein, taken by Plaintiff's attorney, pursuant to a Court Order, held at the above-mentioned office, before Josephine Giordano, a Stenotype Reporter and Notary Public within and for the State of New York.

Job No. NJ2325567

A P P E A R A N C E S:

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BY: STEPHEN E. RACH II, ESQ.

S T I P U L A T I O N S

IT IS HEREBY STIPULATED, by and between attorneys for the respective parties hereto, that: All rights provided by the CPLR, and Part 221 of the Uniform Rules for the Conduct of Depositions, including the right to object to any question, except as to form, or to move to strike any testimony at this examination is reserved; and in addition, the failure to object to any question or to move to strike any testimony at this examination shall not be a bar or waiver to make such motion at, and is reserved to, the trial of this action; this deposition may be sworn to by the witness being examined before a Notary Public other than the Notary Public before whom this examination was begun, but failure to do so or to return the original of this deposition to counsel, shall not be deemed a waiver of the rights provided by Rule 3116 of CPLR, and shall be controlled thereby. The filing of the original of this deposition is waived. IT IS FURTHER STIPULATED, that a copy of this examination shall be furnished to the attorney for the witness being examined without charge.

A L E X I O S A P A Z I D I S, M.D.,

The witness herein, having first been duly sworn by a Notary Public in and for the State of New York, was examined and testified as follows:

BY THE COURT REPORTER:

Q. Please state your name for the record.

A. Alexios Apazidis.

Q. Please state your address for the record.

A. Business address is 2780 Middle Country Road, Suite 140, Lake Grove, New York 11755.

EXAMINATION BY

MR. WARYWODA:

Let's have these marked.

(Whereupon, documents were marked Plaintiff's Exhibits 1, 2A, 2B and 3A for identification, as of this date.)

Q. Good morning, Doctor.

A. Good morning.

Q. My name is Nicholas Warywoda. I am with the law office of Parker Waichman.

A. APAZIDIS, M.D.

I am going to be asking you some questions today.

You've been deposed before; correct?

A. I have.

Q. How many times?

A. Twice, I guess.

Q. Those two times you have been deposed, where you a defendant in a medical malpractice action?

A. Yes.

Q. When was the last time you were deposed?

A. I guess it was a couple of weeks ago.

Q. That action, other than yourself, can you tell me are there any other co-defendants in that action?

A. I don't know.

Q. Okay. Who is the defense attorney that represents you in that action?

A. Stephen.

Q. The same firm that represents you today?

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A. Yes.

Q. It's allegations against you in that action, can you tell me what the allegations are against you?

MR. RACH: Just note my objection, but to the extent you can tell.

A. I don't really understand what the allegation was against me in that case.

Q. All right. Did you perform a surgery on that patient?

A. Yes.

Q. Is the allegation that something was done improperly during the surgery or after the surgery or both, if you know?

A. I don't really understand what the allegation is in that case, to be honest with you.

Q. When you say you don't understand what the allegation is, do you know what the allegation is? I'm not saying if you understand it or not, but do you know what they are alleging.

A. I think initially the allegation

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was there was insufficient pre-surgical treatment.

Q. What kind of surgery was it?

A. It was lumbar fusion.

Q. Do you know what the name of the of the patient is in that case?

A. Yes.

Q. What's the name?

A. Robels (phonetic).

Q. Robels is the last name?

A. Yes.

Q. If you know, where is that case venued?

A. I have no idea.

Q. You don't know what court it's in front of?

A. No.

Q. The other time that you said you were involved in a lawsuit, how long ago was that that you were deposed in that case?

A. I guess, couple of months ago.

Q. Do you know the name of the patient in that case?

A. Pasquale (phonetic).

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Q. The same attorneys represent you in that action?

A. Yes. Well, it was his partner.

Q. Same firm?

A. Yes.

Q. If you can, tell me did that case involve a surgery that you performed?

A. No.

Q. What does that case involve?

A. I believe the allegation was failure to provide a follow-up appointment.

Q. Did that case involve a post-surgical infection?

A. No.

Q. So just for my edification, you know the rules of a deposition since you just had one recently, but I'm going to go over them again.

A. Sure.

Q. First thing is, answers must be verbal. Another thing is, let me finish my question before you begin to answer. I'll give you the same courtesy. If you don't understand my question or hear it, just tell

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me and I will repeat it or rephrase it for you. Okay?

A. Sure.

Q. If you need to take a break, need to make a phone call, just tell me and I'll accommodate you the best I can. All right?

A. Thank you.

Q. We have marked as Plaintiff's Exhibit 1 what I have been told is a copy of your CV; is that correct?

A. Yes.

Q. Is this a complete and up-to-date CV?

A. Can I see?

Q. Sure (handing). What I mean by complete and up-to-date I mean, does it list all your employers, the places you've worked and does it list all your publications and presentations?

A. I guess the only thing it doesn't list -- it doesn't list my current practice. I'm an editor for this journal, but I also have, obviously, my own private practice. I guess, it's not listed here.

A. APAZIDIS, M.D.

Q. The private practice, what is the private practice that you currently have?

A. Alexios Apazidis, M.D, P.C.

Q. What is the address of that?

A. The 2780 Middle Country Road, Suite 140, Lake Grove, New York 11755.

Q. How long have you been working at Alexios Apazidis, M.D., P.C.?

A. I guess about nine months.

Q. Other than the Lake Grove address, are there any other addresses of that office?

A. Yes, I have a satellite office in 21 Washington Avenue, Brentwood, New York and 27 West Columbia Street, Hempstead, New York.

Q. Those two addresses in Brentwood and Hempstead, have those also been open for about nine months?

A. No. Maybe Brentwood has been open, maybe, eight months. I think one month less than Lake Grove. Hempstead, I just opened that office in February. So four months.

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Q. Other than yourself, are there any other physicians that are employed at Alexios Apazidis, M.D.?

A. No.

Q. What field of medicine do you currently practice?

A. Orthopedic surgery.

Q. When did you first become licensed to practice medicine?

A. 2008.

Q. Are you board certified?

A. Yes.

Q. In what?

A. Orthopedic surgery.

Q. When did you become board certified?

A. 2012.

Q. Are you currently licensed to practice medicine in the state of New York?

A. Yes.

Q. Are you licensed to practice medicine in any other states, currently?

A. I did -- I don't know what the official status is, but I did have a license

in New Hampshire. I don't practice there anymore and the license is currently inactive. So I don't know if that exactly means I still have a license there, but it's in an inactive status voluntarily because I don't go to New Hampshire anymore.

Q. Any other states that you currently have a license to practice medicine?

A. No.

Q. Have you been licensed to practice medicine in any other states besides New York and New Hampshire?

A. No, I've never held a license in any other state except those two.

Q. It's my understanding that your license to practice medicine had been suspended or revoked in the past?

A. It was a suspension stayed with probation. So I'm on probation.

Q. What was the date of that suspension?

A. June 18th of 2015.

Q. As a result that suspension, you

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signed an agreement agreeing that you were guilty of certain charges against you?

MR. RACH: Just note my objection, but to the extent you can answer, you can answer.

A. I don't know what the exact legal term is. It was a consent agreement. I signed it at the advice of my attorney. Not Steve.

Q. If you could, who was your attorney in that suspension action?

A. Bill Lewis. William Lewis of the Lewis Johs Agency.

Q. According to the terms of that suspension, the suspension was stayed; is that correct?

A. Yes.

Q. The suspension is thirty-six months?

A. Yes.

Q. The terms of that suspension, it requires you to have a medical monitor, so to speak?

A. It's something called a practice

monitor.

Q. Who is your practice monitor?

A. It's anonymous.

Q. When you say it's anonymous, what do you mean by that? I know what you mean by that. Why is it anonymous?

A. The state requires him to remain anonymous.

Q. As part of your suspension, did the Workers' Compensation board take action against you where you're not allowed to perform Workers' Compensation exams?

A. Yes.

Q. Is that also for thirty-six months, if you know?

A. There's nothing in the letter indicating the timeframe. The way the board works is you are not allowed to ask any questions. So my current health care attorney, his impression is that it's a reaction to the OPMC finding and that it will be suspended for the period of the same thirty-six months.

Q. In your past have you ever

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performed defense medical exams in personal injury lawsuits; meaning, you are retained by an insurance company to perform medical exams of plaintiffs in lawsuits?

A. Yes. Independent Medical Examination, yes.

Q. When did you start performing those type of exams?

A. I guess about 2012. Late 2012, maybe, or early 2013.

Q. Do you still perform them today?

A. No.

Q. Was it once your license was suspended you stopped doing these medical exams?

MR. RACH: Note my objection. His license was not suspended. It is now on probation. He stills practices medicine.

MR. WARYWODA: According to the consent order, his license is suspended, but it's stayed. So it is technically suspended, but the suspension is stayed, so.

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A. That is the -- I mean, technically, my license has been suspended.

Q. Right. Did you stop performing these medical exams on behalf of the insurance companies once your license became suspended?

A. I mostly did Independent Medical Examinations for Workers' Compensation patients. So when I was precluded from doing that, I just stopped doing it. Most of the independent medical exam work that I did was for the Workers' Compensation board. So it didn't make any sense for me to do it, you know, any longer if I wasn't going to have privileges with the Workers' Compensation board.

Q. How about outside the Workers' Compensation board, you have performed independent medical exams on behalf of insurance companies for people who had brought lawsuits; is that correct?

A. I believe so, yes.

Q. Do you know how many in 2012 you were doing; like per week, per month, per

year?

A. Numbers, I couldn't estimate. I mean it was variable. Sometimes you go and there might be twenty scheduled and ten show up. I would have to ask the office for exact numbers.

Q. Are you still currently a member of the Suffolk County Medical Society?

A. Yes.

Q. When did you first become a member there?

A. I guess when I moved to Suffolk County, 2010.

Q. In 2013 were you a delegate for the Suffolk County Medical Society?

A. Yes, I was a delegate to the state convention. I think even before 2013.

Q. I see according to your CV you are a member of the New Jersey Orthopedic Society; is that correct?

A. I lived in New Jersey for six years. I'm not an active member there anymore, obviously.

Q. Were you ever licensed to

practice in New Jersey?

A. No.

Q. For any of the societies that you have listed on your CV, did any of them require you to take any sort of tests in order to become a member of any of those societies?

A. Examination, no. Well, I shouldn't say that. The Institutional Review Board required testing.

Q. What kind of testing?

A. It was done online. It was various testing, you know, for ethical treatment for patients and research, for the Geneva accords for research. It's just the review board members approve or help to navigate their way through approval. So the purpose of the review board the members have to go through certain training for that. Otherwise, some of the societies being board certified is what allows you to participate in a society.

Q. Now, the boards, did you pass the first time when you took your boards?

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MR. RACH: Just note my objection. You can answer.

A. Yes.

Q. Other than orthopedic surgery, have you ever practiced in any other field of medicine?

A. No.

Q. Are you familiar with a company named Long Island Orthopedic & Spine Specialists?

A. Yes.

Q. Were you employed by them at one time?

A. Yes.

Q. When did you first become employed there?

A. August 2nd, 2010.

Q. What is the Long Island Orthopedic & Spine Specialists affiliation, if any, with Brookhaven Hospital?

A. I mean, I don't know what the legal relationship is, but my impression is that it is a hospital owned practice.

Q. When you were employed with Long

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Island Orthopedic & Spine Specialists, were you also employed by Brookhaven or was it Brookhaven you were employed with, had that work out; like your paycheck, who signed your paycheck?

A. I did it electronic depositing. I never really actually got a paycheck. I remember when we first starting working there it was called Total Joint Replacement Services. Then, maybe, some of the checks were something called Brookhaven Surgical Services. These are just the name I kind of remember. After a couple of years, I guess, we settled on this name, Long Island Orthopedic & Spine Specialists.

Q. What was your position at Long Island Orthopedic & Spine Specialists when you left there.

A. Orthopedic surgeon.

Q. Did you hold any position on a board as part of a partnership, anything like that?

A. No, I mean I was -- I volunteered for the medical board of the hospital. I

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served two years on the medical board of the hospital.

Q. I'm talking about with Long Island Orthopedic & Spine Specialists. Did you hold any position other than orthopedic surgeon with that entity, Long Island Orthopedic & Spine Specialists?

A. No.

Q. When were you last employed at Long Island Orthopedic & Spine Specialists?

A. I resigned as of July 1st, 2015.

Q. When was the last time you were employed at Brookhaven Hospital?

A. Same day.

Q. When you left Long Island Orthopedic & Spine Specialists and Brookhaven Hospital on the same day, what is the next place you were employed?

A. I started my own practice, Alexios Apazidis, M.D., P.C.

Q. As part of the terms of your suspension, are you still permitted to perform surgeries?

A. Yes.

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Q. Can you tell me what type of surgeries you have performed?

A. Orthopedic surgery.

Q. When you say orthopedic surgery, sure, like what kind, certain areas of the back; I mean, laminectomies, fusions?

A. I perform all surgeries of the cervical, thoracic and lumbar spine. You know, I tend to stay away from sports procedures, not voluntarily at least, and whatever else I'll need to do if I'm on call, such as fracture work. From surgical respective, I try to specialize on spine surgery, but then if I'm on call, I take care of whatever comes in. That tends to be more fractures.

Q. Are you familiar with a patient named James Simeone?

A. Yes.

Q. As you sit here today, do you have an independent recollection of any of the care and treatment that you performed on James Simeone?

A. I do. I remember the patient.

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Q. What about the patient do you remember? First, we will just say off the top of your head without looking at the chart.

A. I remember that he was in extreme pain. He was in a car accident. That nobody could explain what was going on with him because he had an imaging study that was negative. I got a repeated imaging study, which showed a large disc herniation, an instability. I took care of him. He, subsequently, at surgery developed an infection, and we took care of the infection. That's my recollection in terms of his care.

Q. Now, you said we took care of the infection. Who is we?

A. I took care of the infection, I should say.

Q. You said that he was in a large amount of the pain. Is that before surgery, after surgery, both?

A. Well, before surgery he didn't know what to do with himself. My

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recollection -- I didn't look at the pre-surgical MRI -- but my recollect is that he had an MRI, which was something around six months or so before I had seen him, that was negative. It didn't show anything. He had been to some people and nobody believed him that had a problem, but I believed him. I got a new MRI and it showed the problem, which sometimes happens in traumatic situations where the first MRI is negative and the second -- but over time things occur. So he had a disc herniation there and explained all his symptoms. We did the appropriate surgery, and he had relief of the radiculopathic pain that he had.

Q. In terms of Mr. Simeone, do you remember him as being a patient who was a malingerer or a patient who was trying to better? Do you understand my question?

A. Yes. He had a very real problem.

Q. Do you recall him as being a patient who followed the instructions you gave him or would he not follow your instructions?

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A. No. He followed the instructions, and we were in close contact with the patient at all times.

Q. When you say close contact with the patient at all times, what do you mean by that?

A. There were frequent visits. There was frequent communications with the patient. I was in touch with the nurses that were going to his house for the dressing changes. There was lots of forms and things that I filled out for him for his resources, his insurance and then, maybe, he got a different insurance, I forget. But there was a lot of paperwork to be done for Jimmy and things like that.

Q. Before coming here today, what, if anything, did you review in preparation for your deposition?

A. The hospital records and some of my notes that we had previously, but not the new notes that completed the record.

Q. Let's talk about that. The medical chart that Long Island Orthopedic &

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Spine Specialists had for Jimmy, was there one chart, was there more than one chart; what's your recollection?

A. The way the -- we had an all electronic system. The way it worked was there was one, you know, an electronic chart in the E-clinical medical record system and that's what we used. So everything should be in the E-clinical system under his name.

MR. RACH: Just by counsel, I think one of the issues we have is, explain to him what happened when you hit print.

A. It does whatever it wants.

Q. What do you mean by that?

A. So there is no print record function or button. So when someone asks for medical records, somebody -- and there's no designated person for this. Sometimes it's not even someone in the office of Long Island Orthopedic & Spine. It might be someone in the hospital at the medical records department -- has to go in to E-clinical and print each note or each

telephone encounter. Meaning, if I have a telephone conversation with a patient, I create something called a telephone encounter or telephone note. Someone has to go in and print all these things.

Then there's also a section for anything that gets scanned like the forms, the forms, that Mr. Simeone needed filled out. I would fill them out and they would be scanned in and hopefully, uploaded to the system. So you have to go into a separate section and print each form out. So there's no like print all function on it. So someone has to go in and do it manually.

Q. Okay. Now, the system, the medical record keeping system that was in use at Long Island Orthopedic & Spine Specialists, if you inputted something from the office of Long Island Orthopedic & Spine Specialists, would it be uploaded to a system where someone from Brookhaven Hospital would also be able to access those records?

A. I have no idea.

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Q. Okay. It's my understanding, and correct me if I'm wrong, you had nothing to do with the printing out of medical records that we have marked at our deposition today; is that correct?

A. Correct.

Q. What I'm going to do is we have marked as Plaintiff's Exhibit 2A and 2B. Can you take a look through these and tell me is there anything that you notice is missing from this medical record, both these, 2A and 2B, that you think, well, I know something is missing or there's a document that I believe should be part of this chart that's not here?

MR. RACH: Take your time.

Q. Doctor, you are reviewing the records and you wanted to make a statement about the records.

A. Yes. To the best of my recollection, this appears to be most of the notes and telephone encounters that I can recall. Obviously, it was three, four years ago.

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Q. You used the term most of, which would indicate to me that there is stuff missing.

Is there anything that your review shows that you think there's something missing or should be there that isn't there?

A. There may be -- I do remember filling out forms for him for his insurance or for, you know, benefits from his union, possibly. I remember filling out forms to get him services and things like that. So we did try to scan those in and retain copies of those. That's the only thing off the top of my head that I can recall that I don't see here.

I suppose there may also be notes from the visiting nurses. They frequently sent in reports or prescriptions for, you know, further products, dressing products, things like that. There would be encounters or messages from nurses, visiting nurses.

Q. Would you get copies of blood test results?

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A. Copies, not unless they were done outside the hospital. If they were done in the hospital, then I had access to the hospital lab, the hospital system so I can review those. We wouldn't necessarily input them into our practices, medical records, so to speak.

MR. WARYWODA: At this time, I'm just going to call for a search be done for any encounters or phone messages from Visiting Nurse Service who may have called in, and I will follow up in writing.

MR. RACH: Okay.

Q. So if you can tell me when James Simeone first became a patient of yours?

A. Sure. June 17, 2011.

Q. Were there any other orthopedic surgeons who were working at Long Island Orthopedic & Spine Specialists in June of 2011?

A. Yes.

Q. Do you know how it was Mr. Simeone first met with you as opposed to a

different orthopedic surgeon at the practice?

A. I was the spine specialist at the practice.

Q. You generated a report of your visit with Mr. Simeone of June 17th, 2011; is that correct?

A. Correct.

Q. It's a typed note; is that correct?

A. Yes.

Q. What was your custom and practice back in June 2011; would you dictate into a machine documenting your visit, would you write notes and then have them transcribed; what was your practice?

A. I would do both.

Q. Do you remember with Mr. Simeone in June 17th, 2001 what you did; did you dictate, did you take written notes?

A. I don't remember how did his particular notes. But, in general, I would tape things because we did have computers on the walls in the examination rooms. So

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sometimes as I'm talking to the patient I might type, perhaps, as he is speaking. I did also at my office desk did have a dictation system where I could dictate directly into the computer.

I don't recall when I did more dictating because it had some problems initially. It wasn't working that well. So I did do a lot of typing, initially. I don't remember when, if it was a by June of 2011 or not, that I was doing more dictation or more typing. There might be even entire notes that I simply typed because it leant itself more to typing, but I don't recall specifically for this patient.

Q. What was it that brought Mr. Simeone to your office on June 17th; what were his complaints --

A. He had numbness, tingling and pain going down his left leg.

Q. He told you that he was involved in a car accident a month before?

A. Yes.

Q. He told you that he had a

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previous surgery, a discectomy previously?

A. Yes.

Q. Do you read MRI films?

A. Yes.

Q. On that first visit in June 17th, 2011, did you perform an examination of him?

A. Yes.

Q. Can you tell me what your examination entailed and what the results were?

A. Sure. So I examined his lumber spine. I did not note much back tenderness or spasm. He did have a positive straight leg raise sign on the left. He did have intact motor and sensory findings were intact. Reflexes were normal. He did have a normal range of motion of the lumbar spine, and some other provocative maneuvers were negative.

Q. Now, you said Gaenslen maneuver. What is the Gaenslen maneuver?

A. So these are taken in combination. The Gaenslen's, the lateral compression, the Yeoman's test and Patrick's

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test, these are manipulations of the leg meant to exacerbate symptoms of sacroiliac or hip pain. We use them to differentiate if the pain is coming from the sacroiliac joint, the piriformis fossa or from the lumbar spine.

Q. At that point all those tests were negative; is that correct?

A. Yes.

Q. According to your note, the patient had the MRI studies with him?

A. Yes. I must have seen the actual pictures based on what I have written here.

Q. According to the assessment part of your note, it says, "The L4, 5 segment is severely affected with disc bulges, ligamentous hypertrophy and facet inflammation; is that correct?

A. Yes.

Q. That's what you saw or is that like just copying what the MRI report said?

A. Might be a combination of both. Based on what I've written here, it appears that I did see the actual pictures.

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Q. It says, the fifth sentence, "At no level is there any sign of direct nerve root impingement." Do you see that?

A. Yes.

Q. That was your interpretation; is that correct?

A. Yes.

Q. Two sentences later it says, "I fail to identify any surgical targets on his MRI."

A. Yes.

Q. What do you mean by that?

A. I did not see an area that would be amenable to surgery to benefit him.

Q. Now, four lines from the bottom in the assessment paragraph it says. "As with all nerve root contusion the following guidable course." Is that what this sentence is supposed to say?

A. No, it doesn't make any sense to me.

Q. Do you know what you meant to write there?

A. Maybe, they follow a predictable

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course.

Q. Then you wrote, "it may take several months for the symptoms to completely resolve and they may never resolve"; is that correct?

A. Yes.

Q. It says, "I've explained these issues to the patient." What did you explain to Mr. Simeone?

A. Based on my description here and having encountered this situation before, we do see after car accidents, there may not be a compressive lesion or something that is actually putting a lot of pressure on the nerve root. So that would be a surgical target. Although we don't always necessarily do surgery on those either.

But this would be a situation where I felt that it was the trauma of the accident, whiplash-type affect or stretching of the nerve roots, and that just as if you received a punch to the arm and there was a stinger aspect to it that over time it would resolve. The time course of that is

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variable. And, of course, there is always a possibility that it doesn't improve. We've seen that as well.

Q. Did you form a differential diagnosis?

A. Yes.

Q. What was your differential?

A. The patient had radicular radiculopathy of the left lower extremity. I referred the patient to a pain management doctor, Dr. O'Leary. Since this was not a surgical situation at this time, I did refer him for, you know, medications and possibly, more injections.

Q. Under follow-up it says "PRN". Is that as required?

A. Yeah, as required because I work closely with Dr. O'Leary. He was just on the other side of the hospital. So, typically, it wasn't a point to make a follow-up appointment with me at this time since he was going to see Dr. O'Leary. If at any point Dr. O'Leary feels like a patient needs to see me again, he just sends

them right over. So there was no point to make an actual appointment at this time.

Q. Was that the custom and practice, if you would refer a patient to Dr. O'Leary, Dr. O'Leary would, generally -- if a patient wasn't getting better or the symptoms were getting worse, he would send them back to have an appointment with you?

A. Yes.

Q. Now, if you can go back and just explain to me -- there is a signature on this; correct?

A. Yes.

Q. It says, "Electronically signed by Alexios Apazidis, MD on 5/31/2016." Do you see that?

A. Yes.

Q. In terms of signing off on these office notes, what was the procedure on how you would sign off on them?

A. So I would complete my notes, typically, within either the same day or within days of seeing the patient. However, on this medical record system, at any time

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that you go in to print out a note, it always puts the date of the printout -- do you see the date that it was printed?

Q. Yes.

A. Assigns it there. It has been mentioned on several occasions to the bosses, and there's probably a ticket out with the EMR consultants. It's does this. You may even have an another copy of it and it will have a different date.

Q. So my question, though, is, did you ever review this note after it was transcribed just to make sure that everything inside the note was accurate, if you remember?

A. I don't remember doing that, no.

Q. Did you have a custom and practice in terms of what you would do once you transcribed a note and it was put into the chart; would you have a custom and practice of reviewing the note, not reviewing it?

A. Once I finished my note, you know, once I finished -- in other words,

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once I got to the section of plan and wrote this part, there is a button. I don't remember what the button said. But there was a button that I would click to kind of indicate that I'm done with this note. That would allow the people who did billing to know that the note was done and they can then bill for the visit.

Q. Now, the next time that Mr. Simeone say you, was that on July 27, 2011?

A. Yes.

Q. Is there a phone message in between those two visits?

A. Yes.

Q. That's a phone message on July 14, 2011; is that correct?

A. Yes.

Q. That is about a rash that Mr. Simeone had; is that correct?

A. Yes.

Q. Did you speak to Mr. Simeone on the phone as a result of this phone call or did someone from the office?

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A. I don't think that I spoke -- I don't recall, but I don't think that I spoke to Mr. Simeone at this time.

Q. Then we have a July 27, 2011 visit with you; is that correct?

A. Yes.

Q. What complaints did he make to you on that day?

A. You know, same complaints. Radiation of the pain now down to the toes. Odd sensations we call paresthesias, aching, burning, shooting pain, severe, which, again, a similar history had been going on a month or so after his car accident.

He had started the medication prescribed by Dr. O'Leary. He had a reaction to it, so he stopped it. Dr. O'Leary had informed that he did not think he was any longer a candidate for epidural injections.

Q. Do you remember, did you have a conversation with Dr. O'Leary before July 27, 2011 about Mr. Simeone?

A. I don't remember having one with

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him.

Q. Dr. O'Leary, you said he was an employee in the hospital; is that correct?

A. No, no, no. He had an office on the other side of -- my office was on Hospital Road and his office was on the other side of the hospital on Sills Road.

Q. What was the name of his practice, do you know?

A. I don't know.

Q. As part of the HPI, it says that Mr. Simeone was asking you for other treatment modalities?

A. Yes, he came in asking about what do you do next, basically.

Q. You did an examination of him on this date; is that correct?

A. Yes. It's a similar exam that I had the previous month.

Q. It says assessment. Is that your diagnoses or your differential?

A. Yes. I mean, there wasn't much of a differential. The patient clearly had radiculopathy of the lower extremity.

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Q. The last sentence says, "I believe that an appropriate course of anti-inflammatory medications, muscle relaxants and adequate time will allow him to fully recover in time." Do you see that?

A. Yes.

Q. What do you mean by that, that it will allow him to fully recover in time?

A. Well, in the absence of an impinging lesion, the absence of something that's actually putting a lot or pressure in the nerve, we expect that the nerve will recover from this stinger or stretch or contusion-type affect that must have been caused during the car accident.

So that's the expectation that with time the nerve will come back, unless there's something actually putting pressure on it, at which point the nerve may get worse. We don't know.

Q. You tried starting him on certain medications, Valparin (phonetic) and Ultracet; is that correct?

A. Yes.

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Q. Follow-up says "Two months check effective medications." Do you see that?

A. Yes.

Q. Is there anything you remember about this visit that's not documented in this report?

A. Nothing that I recall, no.

Q. Next visit was August 11, 2011; is that correct?

A. Yes.

Q. At that visit Mr. Simeone told you, patient, he was complaining of persistent pain rating down left leg that is worsening; is that correct?

A. Yes.

Q. He now had an episode of loss of bladder control; is that correct?

A. Yes.

Q. You did an examination of him; is that correct?

A. Yes.

Q. You found that he had extension of zero; is that correct?

A. Yes, and also, flexion of

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forty-five.

Q. You, again, assessed him, a radicular syndrome of lower limbs; correct?

A. Yes.

Q. You formed a plan of treatment for him at the visit?

A. Yes.

Q. What was your plan?

A. To get new imaging studies because of the new symptoms.

Q. Now, on page 2 of 2 of this visit, under "Plan", it says, "I have recommended that he go to the ED"; is that the emergency department?

A. Yes.

Q. "But he has to go home for his daughter. I have asked the patient to come as soon as possible do get emergency MRI and possibly be admitted to the hospital. I'll get to the other part of the sentence for now.

But why is it that you recommended that he go immediately to the emergency department?

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A. Because he seems to be getting worse.

Q. So why was it you told him I want you to immediately go as opposed to going the next day or a day after?

A. Because he had said that he lost control of his urine, one episode. But in traumatic situations, you know, car accidents, I have seen things progress quickly. So I had concern.

Q. You told him to follow up with you in two weeks or when the MRI is complete; is that correct?

A. Yes. I mean it sounds like he had no intention of going to hospital. So I did the next best thing that I could, which is order an outpatient MRI since he wasn't going to get it through the ER. Typically, you know, we have to get authorized for the insurance, scheduled. By the time it all gets done, it's usually at least a week.

Q. He told you the reason why he couldn't go because he had to get home to his daughter and his wife?

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A. The wife, yeah. Describe here -- his wife would be returning form a business trip the next day and then he would be more available. So he's already, basically -- it seems that he has told me at this point that he is not going to be able to take care of this for the next couple of days. So we, probably, initiated an authorization to be done as an outpatient to another facility.

Q. The next time he came to your office was August 25th, 2011; is that correct?

A. Yes.

Q. It's says under "CC or chief complaint MRI review"; is that correct?

A. Yes.

Q. He had had the MRI by that point?

A. Yes.

Q. Under assessment it says that you reviewed the MRI; is that correct?

A. Yes.

Q. It mentions "there are some interval worsening of the L4/5 and L5 F1 disc collapse with a bulging of the discs."

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Do you say that?

A. Yes.

Q. Was that your findings, was that the radiologist's findings, combination?

A. This sounds like my description of the pictures that I saw.

Q. You also say, "there was some worsening of the left L4/5 foraminal stenosis from the previous MRI, which would explain his symptoms." Do you see that?

A. Yes.

Q. So what was it about the MRI findings that explained the symptoms that he had?

A. The disc herniation had gotten worse. It had progressed.

Q. At that point it says, "Based on the most recent imaging, I feel that he would benefit from a repeat that the L 4/5 foraminal epidural injection N/4 an L5 S1 epidural injection interlaminar"; is that correct?

A. Yes.

Q. So at this point did you consider

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Mr. Simeone to be a surgical candidate?

A. It, certainly, was something that could be occurring in his future. But, obviously, you know, you don't jump into surgery. You try to exhaust all nonsurgical measures, which is why I sent him back of another epidural injection.

Q. After that visit is there a phone message of September 1st, 2011?

A. Yes.

Q. Where he was asking about the MRI?

A. Yes.

Q. Your response was that you are going to see him on September 7th. So you will discuss the imaging at that time; is that correct?

A. Yes. Apparently, he had someone else -- a friend of his look at the MRI and they thought they saw some darkening, but, obviously, I had seen the MRI. I had reviewed it with him at the August visit, and I didn't feel it was necessary to discuss it again.

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Q. When was the next visit that he came to your office?

A. September 23rd.

Q. At this time he came to make complaints of what to you?

A. He had the same complaints, and he had gone through more epidural injections, two, I believe, which only gave him a few hours of relief after each injection.

Q. At this point did you do a range of motion testing or physical examination on him at this visit?

A. I did examine the patient, yes.

Q. What were your findings on your physical exam?

A. Similar findings. Although he did have more muscle spasm and tenderness. He, again, had a positive straight leg raise on the left side. However, he was starting now to develop decrease sensation of numbness and some decreased strength on the left side.

Q. At this point, at this visit,

what was your diagnoses; your differential diagnoses of him?

A. That he had lumbar radiculopathy particularly of the left leg. He has a disc herniation and he has back pain.

Q. At this point you considered him a candidate for surgery; is that correct?

A. Yes.

Q. What surgery was it that you believed he was a candidate for?

A. For a decompression procedure, which is when we take the pressure off of the nerve roots and also for a fusion or stabilizing procedure.

Q. You formed a plan, is that correct, it says plan on your report; is that correct?

A. Yes.

Q. You continued the prescribing of medication to him; is that correct?

A. Yes. Some medications were continued. Voltaren was stopped because it's an anti-inflammatory, which you cannot take with during surgery.

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Q. You continued Ultracet; is that correct?

A. Yes.

Q. What is Ultracet?

A. It's a pain medication.

Q. And Percocet?

A. It's also a pain medication.

Q. And Valium?

A. It's a muscle relaxer.

Q. What's Flexeril?

A. It's also a muscle relaxer.

Q. Under the third paragraph of the plan where it says, "lumbar and sacral arthritis." Do you see that?

A. Yes.

Q. It says, "I have explained the risks and benefits of surgery to the patient, including bleeding, infection, paralysis, death, nerve damage, failure to cure his pain, continued weakness and dural tear."

Do you remember, actually, having the conversation with him about the risks and benefits of the surgery?

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A. I don't remember the specific conversation, no.

Q. In terms of infection, sitting here today, do you remember what you told Mr. Simeone, specifically, about the risks of infection?

A. No.

Q. What was your custom and practice in terms of when you would discuss with a surgical candidate, patient, what would you tell them about the risk of infection in the surgery?

A. I would tell them that spine surgery carries a risk of bleeding, infection, nerve damage and dural tears. The risks are between one and ten percent depending on what the specific type. I don't know what else I would kind of more go into, but that's, basically, the conversation.

A lot of times it's more answering their specific questions. You know, most patients don't really go into the percentages. So I don't really have

extended conversations about that. More patients are more concerned with what's going to be the end result. So we end up spending a lot more time discussing what the chances I'm going to better, what's the chances I'm going to be worse. So we discuss that more.

Q. That was my next question. Do you remember having a conversation with Mr. Simeone on this visit about what your prognosis was for him, whether or not you thought the surgery would be effective on him or not?

A. I don't remember the specific conversation.

Q. Do you recall going into the surgery of Mr. Simeone what you believed how effective the surgery would be for Mr. Simeone?

A. Well, I don't recall specifically, but from reviewing the records at least, you know, I have a patient who has been suffering for at this point three or four months is having a worsening course,

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deterioration now with worsening back pain, which he did not have significantly three months earlier, now with weakness and numbness as well as a bladder accident.

So I think that I would have discussed with him that -- again, surgery is never necessary. However, he appears to be having a worsening neurologic deterioration and that we should be able to stop at least the worsening.

I do all -- you know, in terms of custom and practice, I do always I tell all patients that nerve damage can be permanent. So even at this point, the weakness and numbness that he had experienced at this point may now be permanent. Even if I do the surgery and take the pressure off the nerve, it may not come back. Now, it does frequently come back, but I always tell patients even what you have now might not get better.

Q. Now, in terms of what you reviewed with Mr. Simeone with the MRI findings, do you have an opinion with these

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findings as to how effective a surgery would be on Mr. Simeone?

MR. RACH: Just note my objection, but if you understand the question, you can answer.

A. I think I would have thought that the surgery would be effective for him because the recent MRI showed an acute worsening of the disc herniation and we were getting to it in a reasonable time course. In other words, this wasn't something that has been going on for a year and it's like, well, I don't know what kind of improvement I'm going to get in this nerve root. This is clearly something that has worsened over the last three months and we are addressing it in a timely fashion. So I would have expected some improvement in his condition.

Q. So when you say some improvement with these findings that we have for Mr. Simeone, would you have expected a total improvement back to no radicular symptoms, no numbness?

A. We can never say one hundred

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percent, but what I, usually, tell patients is that the things like pain tend to get better when you take the pressure off the nerve root. Things like numbness and sensation changes paresthesias are a little harder to get back. But if they are addressed in a timely fashion, due tend to do get better.

The weakness is the worst prognosis. So when he started to get weak, that's what lent a little urgency to the surgery, because weakness is the last to come and the last -- like the last symptom to come on from a compression, and it tends to be the hardest one to resolve.

Again, the fact that we were addressing it in a timely fashion, if I would have said that I would hope that this was going to improve, but we can never say promise one hundred percent.

Q. Sure. The next time Mr. Simeone saw you was that in the hospital?

A. Yes.

Q. There is a phone message from

September 27th, 2011. Do you see that?

A. Yes.

Q. Under action taken it says, "I spoke to the patient and reassured him that everything is fine for the surgery for October 21." Do you see that?

A. Yes.

Q. Is that that you spoke to him or the nurse spoke to him?

A. I spoke to him.

Q. Do you remember when it was he called you; what was his concern about the surgery?

A. I don't remember exactly, but it, probably, had to do with insurance authorization and scheduling and/or scheduling issues. You know, whether -- again, I don't remember specifically, but from the -- Denise Nugent is the surgical coordinator. So she handles scheduling or at the time. She's not there anymore.

Q. It probably dealt with the actual scheduling and getting the authorization for the surgery and not I'm scared of having the

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procedure?

A. Not that I recall, no. He was very enthusiastic.

MR. RACH: Off the record.

(Whereupon, a discussion was held off the record.)

MR. WARYWODA: Back on the record.

Q. The next time Mr. Simeone saw you was at Brookhaven Memorial Hospital; is that correct?

A. Yes.

Q. That was for the surgical procedure?

A. Yes.

Q. What was the date of admission of Mr. Simeone at Brookhaven Hospital?

A. Is there something in the hospital record there?

MR. RACH: Off the record.

(Whereupon, a discussion was held off the record.)

MR. WARYWODA: Back on the record.

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A. He was admitted on October 21st of 2011.

Q. You performed a surgery during this admission?

A. Yes.

Q. What was the surgery that was performed on Mr. Simeone during this admission?

A. He had a discectomy and fusion operation.

Q. Was it both anterior and posterior?

A. Yes.

Q. Prior to Mr. Simeone coming to the hospital, was it your intention of performing an anterior and posterior portions of the surgery?

A. Yes.

Q. Why was that?

A. That's how the surgery is performed. You can do it from a posterior approach, but my preference was for a combined approach.

Q. Prior to Mr. Simeone getting on

the operating table, was it your intention of having certain physician or physicians assist you in the procedure?

A. Yes.

Q. What physicians, prior to the surgery beginning, did you intend to have assist you in the procedure?

A. Dr. Martin. He's a vascular access surgeon. So he would be necessary to do the anterior part of the surgery. I, usually, try to get another spine surgeon. So once Dr. Martin has performed the access portion and has shown us the way to the spine, I then do the discectomy infusion part with another spine surgeon. I don't even remember who it was in that case.

Q. Was it Dr. Chen?

A. Yeah, Dr. Morgan Chen. That's somebody who frequently assisted me. Then we would then do the anterior portion of the surgery. I frequently would have a plastic surgeon to ensure the wound would handle especially in a case like this where he is a big guy, obesity, and there's going to be

some change in the height of the spine because he's collapsed and we going to resort that height. And, you know, sometimes the skin has changed during the surgery. It would involve plastic surgery, if they're available. Sometimes they're not available.

Q. So prior to this surgery taking place, did you anticipate that you would have to have a plastic surgeon assist you in the wound closure?

A. I try to get plastic surgery involved in these cases. They are not always available. If someone is available from plastic surgery, I would, yes.

Q. Mr. Simeone, he underwent presurgical testing?

A. Yes. That is, typically, the hospital policy, yes.

Q. Was there any issues with any of his presurgical testing; any abnormal finding during his presurgical testing?

A. Not that I know of right now.

Q. So pre-surgery his blood work all

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came back fine; correct?

A. Again, I haven't reviewed it. But if there was an abnormality, we would have addressed it or held up the surgery.

Q. If you want to just take a look, is there anything pre-surgery testing showed that caused Mr. Simeone not to be a surgical candidate?

A. I do not have records of the presurgical testing.

Q. But we can agree that if there was something abnormal with Mr. Simeone's presurgical testing, you would not have performed the surgery; correct?

A. Well, it would depend on what the nature of the abnormality was.

Q. If Mr. Simeone had an infection prior to the surgery, you would have cancelled the surgery until he didn't have the infection; correct?

A. Again, it would depend on the infection.

Q. Okay. What type of an infection could a patient be suffering from where you

would perform surgery?

A. I mean a urinary tract infection, for instance. That comes up. Infectious decease literature and our own infectious disease doctor in the hospital at the time, he would agree that -- we've had it come up before. Where if somebody had a urinary tract infection, you can give him a dose of antibiotic that day and you can proceed with the surgery.

Q. What is an antibiotic?

A. It's a medication used to treat infections.

Q. There are different types of antibiotics that treat different types of infections; correct?

A. Yes.

Q. Okay. So on October 21st, 2011, you performed a surgical procedure on Mr. Simeone; is that correct?

A. Yes.

Q. You authored or wrote a report of that operation; is that correct?

A. Yes.

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MR. WARYWODA: Can we just mark this as 3A?

(Whereupon, a report was marked Plaintiff's Exhibit No. 3A for identification, as of this date.)

Q. Can you just tell me what part of the surgical procedure did you perform?

A. The discectomy and the fusion as well as placement of the biomechanical device, which is a metal and plastic device with screws.

Q. Which device did you use; which device did you implant, what brand?

A. Here it appears we used the Stryker System.

Q. Prior to the surgery, from admission to the hospital until when first incision was made, was Mr. Simeone prescribed any antibiotics? Please review the chart.

A. Not by me.

Q. By anyone?

A. I don't have any records here from my last visit until October 21st. So I

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don't have any recollection of it.

Q. No, I'm saying from when he first was admitted to the hospital on October 21st until the time an incision was first made during the surgery, were any antibiotics administered to Mr. Simeone?

A. Based on the records I see here, other than the normal pre-surgical antibiotic that we give, I don't see that he received any other antibiotics.

Q. What was the normal pre-surgical antibiotic given to Mr. Simeone?

A. It would be Ancef.

Q. In what in Mr. Simeone's case was the Ancef used for; was that prophylactic?

A. Yes, it's an antibiotic that we give as part of the surgical protocol of, basically, every hospital in the country. We give a dose of Ancef within one hour of surgical incision. Then it's redosed, typically, four hours into a surgery. It's redosed.

Q. Now, according to the operative note, your operative note that we have

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marked, your assistant was Dr. Morgan Chen; correct?

A. Yes.

Q. During your portions of the surgery, did you encounter any issues or problems that required you to call in another physician to assist you?

A. During the anterior portion?

Q. During any portion of the surgery.

MR. RACH: You know there's two operative reports.

THE WITNESS: Yes.

A. I did call for Dr. Candito Fuentes.

Q. Why was it that you called for Dr. Fuentes?

A. Because the patient was obese. He was a big person. There was a change from the reconstruction where there was a collapse in disc spaces. Disc spaces were now back out to the appropriate heights and there was placement of hardware. So, again, if available, it's good to have a plastic

surgeon provide for a tension-free closure in cases like this.

Q. When you say tension-free closure, you called Dr. Fuentes for closure of the wound; is that correct?

A. Yes.

Q. Why was it that you wanted a plastic surgeon like Dr. Fuentes to perform the wound closure as opposed to yourself?

A. Well, I trained at Hospital For Joint Diseases and the training there, and there has been literature to back this up, is that using plastic surgeon to close lumbar wounds tends to result in better outcomes.

Q. When you say better outcomes, better outcomes how?

A. Decreased infection rates. Basically, decreased infection rates.

Q. You mentioned before on a previous question about the risks of infection of a procedure like this, and you mentioned that the risk of infection in the medical literature is somewhere between one

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and ten percent; is that correct?

A. No, the risks of all of those things. You know, things like dural tears or bleeding problem is between one and ten percent. Infection rates in spine surgery, actually, are closer to ten percent. Some literature even has it at greater than ten percent. Fourteen, seventeen percent. It depends on the literature that you use. For surgeries like this, infection rates do tend to run around ten percent.

Q. What is it that you as a doctor can do to, hopefully, prevent an infection from occurring post surgery?

MR. RACH: Objection. You can answer.

A. That's a fantastic question. There's an area active research. What we can do to decrease infection rates? Nobody can answer that question a hundred percent, but things that we believe help is irrigating the wound copiously with Saline antibiotics infused Saline. Things like a Betadine rinse. There is some papers to

support doing that, which I typically do, and I did do in this case and using plastic surgery.

Q. How about the prescription of antibiotics post-surgery; is that a way to help prevent infection?

A. No. There is a surgical protocol for two doses of Ancef following surgery, but there is no data to support more long term use of antibiotics.

Q. Have you ever read any articles in the medical literature, any case studies or published articles that state that the prescription of antibiotics post-surgery are effective in preventing post-surgical infections?

A. No.

Q. What, if any, medical journals do you subscribe to?

A. Journal Bone & Joint Surgery and the Journal of the American Academy of Orthopedic Surgery, JAAOS.

Q. Any others?

A. I have an online subscription to

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The Orthopedic Trauma Association, The Journal of the Orthopedic Trauma Association and The Spine Journal.

Q. Do you read those two, Orthopedic Trauma and the Spine Journal on a regular basis?

A. I don't tend to read the OTA Journal regularly. The Spine Journal, yes. Yellow journal or the JAAOS journal, yes. The JBJS journal selectively.

Q. Now, you took part in both of the anterior and the posterior portion of the surgery; is that correct?

A. Yes.

Q. The wound closure, who was the wound closure performed by?

A. Dr. Fuentes.

Q. Did you first attempt to perform wound closure on Mr. Simeone?

A. No.

Q. At what point did you realize that it would be most prudent for you to have Dr. Fuentes do the wound closure as opposed to you or Dr. Chen?

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A. Well, I don't know. I don't remember at which point that would be. Largely, it would depend on the availability of plastic surgeon. They are not all readily available.

Q. Now, when you say Mr. Simeone was obese, your definition of obesity, what is your definition of obesity?

A. Well, it's not my definition of obesity. The definition of obesity is, unfortunately, is a BMI greater than thirty. His BMI is thirty-five.

Q. No, insult to you, but Mr. Simeone is a muscular man; correct?

A. Correct.

Q. So his obesity was due in large part to his muscular build as opposed to his fat; is that correct?

A. So the BMI calculation and the Center for Disease Control and the FDA do not take into account fat percentage versus muscular percentage. They have provided us with a definition of obesity, which is a BMI, which only takes into account height

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and weight. It does not take into account fat percentage. So in theory, yes, a very muscular person could have a diagnoses of obesity simply based on the BMI calculation.

Q. With Mr. Simeone, his BMI calculation was based on his musculature as opposed to his fat; correct?

A. It was based on height and weight.

Q. How long did the operation take?

A. From start to finish, approximately, six hours.

Q. What, if anything, during the procedure did you do with a specific purpose of preventing infection, post-surgical infection, in Mr. Simeone?

A. Well, I insured that he did receive the pre-surgical dose of antibiotic. That it was redosed four hours into the surgery. I performed irrigation of the wound as well as a Betadine soak. We placed Vancomycin powder into the wound prior to closure. Also, ensured that he receive the standard twenty-four hours of antibiotics

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after surgery.

Q. When you say the standard twenty-four hours of antibiotics, what antibiotic was prescribed for Mr. Simeone post-surgery?

A. Ancef.

Q. You said standard, is that for all patients?

A. That is a nationwide surgical protocol.

Q. The wound closure performed by Dr. Fuentes, were you present in the operating room during the wound closure?

A. I don't remember. I would, certainly, be there for parts of it or most of it. I don't remember if I was there for the entire closure. Yes, I assisted him for the closure.

Q. The closure, are we talking about the anterior or posterior closure; which one did Dr. Fuentes perform?

A. Posterior.

Q. Who performed the anterior?

A. Dr. Martin.

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Q. Who was Dr. Martin?

A. He's the vascular surgeon who, basically, performs a portion of the surgery that gets us to the lumbar spine.

Q. Dr. Fuentes, he placed a wound vac to the lower back; is that correct?

A. Yes, he did what is called an incisional vacuum dressing.

Q. What is an incisional vacuum dressing?

A. So vacuum dressing is a negative pressure dressing. Sometimes when there is an open wounds, you put them in the open wound or you can also use them after you were able to close the wound, you can put it on top of a closed wound using a different pressure setting, usually, less. Seventy-five or less or opposed to seventy-five or more of millimeters of, mercury, MMHG. It's a dressing that's used to help healing and decrease edema.

Q. What was the reason why Mr. Simeone needed a wound vac to be placed?

A. It was something that we do

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rather routinely.

Q. When you say rather routinely, on what type of patients?

A. You know, posterior lumbar wounds in obese patient. It's a dressing that helps with edema and helps wounds heal. Again, there's lots of plastic surgery literature discussing incisional vacuum dressings for this purpose.

Q. Is the purpose of placing the wound vac have anything to do with infection?

A. I do believe the plastic surgery literature does discuss that it promotes healing. So by definition, there are decreased infection rates when you use this dressing.

Q. So upon the closure of Mr. Simeone's wound, were you concerned that Mr. Simeone may develop an infection?

A. I'm concerned that every patient may develop an infection.

Q. Were you concerned and that's one of the reasons why you had the wound vac

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placed?

A. No, again, using the wound vac is something we did routinely.

Q. On every patient?

A. Yes.

MR. RACH: Every?

Q. Every obese patient?

A. Yes.

MR. RACH: With a posterior fusion?

A. With a posterior lumbar wounds. Risk factors, such as obesity, diabetes, heart conditions are all risks of delayed wound healing and is a situation where we would use what is called a incisional vacuum dressing, like we did here. There wasn't anything specific that I recall in this case. But again, this is something that we do routinely.

Q. If you can take a look at the report of operation of Dr. Morgan Chen.

A. Yes.

Q. I want to draw your attention to the last paragraph, first line. It says,

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"At this point a plastic surgeon was called in to assist Dr. Apazidis in closure of this complex wound." Do you know why Dr. Chen was referring to this as a complex wound?

MR. RACH: Just note my objection. You can answer.

A. Yes, a complex wound refers to multiple layers.

Q. When you say multiple layers, what do you mean by that?

A. It's not just a one layer or skin wound. It involves skin, fascia, muscle. It's complex in terms of it's not a one layer wound.

Q. Is that for all posterior fusions?

A. Yes, all posterior surgeries, wounds are, again, by definition complex.

Q. Prior to the surgery, did you have an anticipation as to how long Mr. Simeone was to remain in the hospital for?

A. I, usually, tell patients in surgery like this to expect, you know, a three to four day hospital stay.

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Q. Were there any complications that occurred during the surgery that we haven't discussed?

A. Not that I recall or that are documented.

Q. When is the first time that you saw Mr. Simeone post-surgery in the hospital?

A. So other than seeing him in the recovery area after the surgery, I saw him the next morning at 8:00.

Q. That is a note dated 10/22/2011 at 08:00?

A. Yes.

Q. It says "ortho surge"?

A. Ortho spine.

Q. Spine. If you could, could you just read your note?

MR. RACH: Slowly.

A. "Ortho spine, status post or SP, L4 to S1 A/P. Which stands for anterior and posterior fusion. Pain moderately well controlled. Physical exam, he is positive or he has active motion at the TA, tibialis

anterior. EHL, extensor hallucis longus, FHL, flexor hallucis longus and GS, gastroc soleus. Positive sensation." And then it says, "Vac patent", which stands for the vacuum dressing was working. It's dependent on a dressing to seal it. Sometimes you get leaks. So at this time the vacuum was patent. My plan was to get pain management or "pain management was involved. The patient had a patient controlled anesthesia unit." "Pulmonary consult." I always get a pulmonary consult after surgery because of their intubation because sometimes they have coughing and things like that. "X-ray, XR this morning." Routinely get X-rays after the patients have surgery. And "PT, weight bearing is tolerated." So physical therapy was to get the patient up and he was weight bearing as tolerated. "WBAT."

Q. Can you tell me when the first time post-surgery a blood test was taken of Mr. Simeone?

A. It appears that the first labs are at, approximately, 9:00 a.m. on October

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22nd.

MR. WARYWODA: Let's mark this.

(Whereupon, a lab report was marked Plaintiff's Exhibit No. 3B for identification, as of this date.)

Q. According to these labs, were there abnormal findings?

A. Yes.

Q. What was abnormal?

A. So his potasium was slightly elevated at 5.5 with 5.1 being normal. Glucose or sugar was slightly elevated at 140 with 110 being normal. The BUN was slightly elevated at 24 with 18 being normal and the creatinine was elevated at 1.7 with 1.3 being normal. The calcium was slightly decreased at 8.0 with 8.5 being normal.

Q. Glucose of 140, what are the causes or possible causes of high glucose?

A. It could be from IV fluids have glucose in them. It can be that you just ate something. So after you eat your glucose goes up. You could have diabetes, but you would have a history of that. Those

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are pretty much the reasons for increased glucose.

Q. Infection could be a good cause of high glucose?

A. It's not a very specific marker, but, yeah, I do recall there is something about high glucose for infection.

Q. When you say it's not a specific marker, what do you mean by that?

A. It's not even the top ten of the things that you would associate with infection. It's something that you -- you know, I don't recall. But I don't, specifically, recall from medical school, but there is something about glucose associated with infection, but it's not anything that, you know, we look at for infection.

Q. Creatinine, what are the possible causes of high creatinine?

A. Sure. The BUN and creatinine are slightly elevated. That's a sign of dehydration.

Q. Could infection be a cause of a

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high BFN and creatinine?

A. It could.

Q. Now, you said we normally don't look at glucose to determine if there is an infection.

What is it that you personally would look at on a blood test and where infection would be part your differential diagnosis?

A. So, I guess, are you asking if I think this an infection, what do I order in terms of labs or if there is a lab value that makes me concerned about infection?

Q. The second one. Is there a lab value where you would be looking at a lab report and look at a lab value and say this number concerns that there may be an infection present?

A. Sure. Usually, there would be an elevated, what's called, white blood cell count, WBC.

Q. Anything else besides the elevated white blood cell count that you would look at a finding and say I am

concerned there may be an infection present?

A. In terms of routine blood testing?

Q. Does it matter; is there a difference in routine and non routine?

A. Yes. So in routine blood testing, which would be a CBC and a chemical panel, that's pretty much it. But there are, certainly, other tests that are done not routinely, but only when you have a suspicion of infection.

Q. So what other tests are done doctor where you would think there may be an infection present and you would order a test?

A. So something called an ESR and a CRP.

Q. What would the findings of an ESR test be where you would think infection may be present?

A. For both, they would both be elevated.

Q. Post-surgery, you said that Ancef was given to Mr. Simeone; is that correct?

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A. Yes.

Q. How long was that given to Mr. Simeone post-surgery; meaning right after surgery and when was it last administered?

A. Well, it's ordered for two doses, you know, past the conclusion of the surgery within a twenty-four hour period.

Q. With Mr. Simeone, can you tell me when he received the Ancef?

MR. RACH: Off the record.

(Whereupon, a discussion was held off the record.)

MR. WARYWODA: Back on the record.

Q. Doctor, you have reviewed the Brookhaven Admission Chart for this admission; correct?

A. Yes.

Q. There was an order for Ancef to be given post surgery?

A. Yes.

Q. That was given by you?

A. Yes.

Q. From reviewing the record that

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you have before you, is there any indication that the Ancef was given post-surgery?

A. I have no reason to think it was not given.

Q. That wasn't my question. You're answering a little different question.

My question was, is there any indication in the hospital chart that the post-surgical Ancef was given to Mr. Simeone?

A. I do not see the pharmacy records included here. So I cannot answer your question.

Q. So when you say you do not see any pharmacy records, do you see any records indicating other medications that were given to Mr. Simeone?

A. Only the Patient Controlled Anesthesia Pharmacy Records are here, which is just showing that the patient had this PCA machine.

Q. Other than what you say is the Ancef was prescribed post-surgery for twenty-four hours, while Mr. Simeone was in

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the hospital during this admission were any antibiotics administered to Mr. Simeone while he was in the hospital?

A. To the best of my ability, I do not see that any antibiotics were ordered. Since I do not have pharmacy records, since they were not ordered, I do not believe that any were given.

Q. Did you order infectious disease consult during this admission? When I say this admission, it's the October 21st through October 29th admission.

A. Yes.

Q. When for the first time did you order an infectious disease consult?

A. The 28th.

Q. Right now you are looking at a record of Dr. Martin; is that correct?

A. No, these are the progress notes. I see a progress note from Dr. Trehan dated October 28th.

MR. WARYWODA: Let's mark this.

(Whereupon, a progress note was marked Plaintiff's Exhibit No. 3C for

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identification, as of this date.)

Q. So we have marked as Exhibit 3C. This is a note of Dr. Trehan?

A. Yes.

Q. Can you tell me when your last examination of Mr. Simeone was prior to this October 28th Dr. Trehan note?

A. October 27th.

MR. WARYWODA: Just mark this, please.

(Whereupon, a note of Dr. Trehan was marked Plaintiff's Exhibit No. 3D for identification, as of this date.)

Q. If you could, slowly for the record, your note on Exhibit 3D, is that the top note or the bottom note?

A. The top note.

Q. Okay, if you could slowly for the record, please read that in?

A. Sure. It's says, "Post-operative base number 6, status post L4 to S1, AP fusion. Ambulating 80 feet. Pain well controlled.

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Physical exam: Neurovascular intact distally. Drained. Put out 15cc over 12 hours over two shifts. Wound is non-erythematous and non-tender. The belly is soft, decreased distension with positive bowel sounds.

Assessment and plan: Keep nothing per mouth. Keep IV fluids until hiccups resolve. Appreciate Dr. Kota consult.

Pain control: Decrease narcotics in face of ileus.

Electrolyte imbalance: Hypokalemia impleading. Potassium after resolve the hypokalemia.

CPK decreasing. Ileus KUB confirmed resolving with NPO status. Likely DC home two to three days."

Q. Is that it?

A. That's it.

Q. Who is Dr. Kota?

A. He is a general surgeon.

Q. Why is it that there was a consult with Dr. Kota?

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A. Because the patient had what's called an ileus or a slow down of his stomach, which sometimes happens after the surgeries and also with the use of narcotic medication.

So again, I usually if it's happening, I usually involve the general surgeon early so that he can follow it. It rarely becomes necessary to do anything, but I like to have the person who will end up doing something involved earlier rather than later.

Q. When you say CPK decreasing, what is that; what is CPK?

A. It's a cardiac enzyme.

Q. At this point he still had the wound vac?

A. No.

Q. When was the vac removed?

A. Our protocol is to remove it post-operative day two, and then convert to a dry dressing.

Q. When you say protocol, with Mr. Simeone, when was the vac removed?

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A. It was removed on the 24th.

Q. When the vac was removed, could you tell me is there a note in the chart documenting what the wound looked like once the vac was removed?

A. The wound was --

Q. What's the date of the note?

A. 10/24/2011.

Q. And time?

A. The time is noon, 12:00.

Q. Can you read that note for the record?

A. Sure. "The wound is described as non-erythematous and non-edematous.

Q. During the hospitalization, were there orders for routine blood testing to be done of Mr. Simeone?

A. There were.

Q. Now, there's a test that's dated October 23rd, 2011; do you see that?

A. October 23rd, 2011.

Q. I am talking about the hematology test that has the white blood cell count.

A. Yes.

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Q. It's says "white blood cell count", it says,"18"; correct?

A. Yes.

Q. Is that high?

A. Yes.

Q. Did you ever form an opinion as to what the cause of his high white blood cell count was on October 23rd, 2011?

A. Yes.

Q. What was it?

A. So -- and I talked about it in my notes. We, typically, after surgery do see elevations in the white count. They are routinely seen. Also, the patient was having an ileus. So when the intestines slow down, that also creates inflammation and we do see increases in the white cell count.

Q. What, if anything, was being done on October 23rd, 2011 to determine what the cause of his elevated white blood cell count was?

A. Well, we had our reason. He had reasons to have a white cell count and it

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was improving.

Q. What treatment was being done to Mr. Simeone on October 23rd, 2011 to treat the elevated white blood cell count?

A. We don't treat labs. We treat patients.

Q. Well, you treat patients based on the findings on labs; correct?

A. Labs are something that contribute to our information about a patient. We don't treat lab values.

Q. Are you sitting here telling me that if there's an elevated white blood cell count, you wouldn't do anything to try and reduce that white blood cell count?

MR. RACH: In the face of this patient at this time?

MR. WARYWODA: Sure.

A. In this patient we have the reason for the white blood cell count. Number one, it's routine after surgery. Number two, he had an ileus. So the patient was made NPO, was given IV fluids and we were monitoring him.

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Q. So was it the NPO and the IV fluids that were being used to try and lower the white blood cell count to normal?

A. No, they were treating the ileus.

Q. So what, if anything, was being done to try and reduce Mr. Simeone's white blood cell count?

A. These values tend to come down as you come out from surgery, and also, by treating the ileus, you treat the inflammation and the stoppage in the bowel. Usually, these values come down a with that as they did here.

Q. Is that what was being done to try and reduce the white blood cell count, the treatment of the ileus?

A. Again, you don't treat lab values. You treat patients. I don't treat a lab value. I treat the patient's condition of ileus and just being post-surgical. So again, we don't treat lab values. Lab values gives us information about what's going on with the patient.

Q. With that information, you would

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determine a treatment plan; correct?

A. It would contribute to my diagnosis and what I would do for the patient.

Q. So I'm just trying to find out, when you have this elevated white blood cell count of 18, did you do anything in terms of forming a treatment plan to try and reduce the white blood cell count?

A. I treated his ileus.

Q. Okay. Other than treating his ileus, is there anything else that you did to try and reduce his white blood cell count?

A. You are asking a question that is not medically clear of appropriate. You cannot reduce a white cell count. You can treat what's going on with the patient.

Q. With the intentions of reducing the white blood cell count; correct?

MR. RACH: My objection is, he'll treat the ileus that will in turn lower the lab. He cannot reduce a white blood cell count.

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MR. WARYWODA: I understand.

Q. So did you ever form an opinion to a reasonably degree of medical certainty as to what the cause of Mr. Simeone's high elevated white blood cell count was for this test?

A. Yes.

Q. What was your opinion?

A. It's normal elevations after surgery in addition to post-operative ileus.

Q. What, if anything, was being done to treat Mr. Simeone's post -- the ileus?

A. He was made NPO and he was given IV fluids. I should say, also, I did have Dr. Kota see the patient, who is a general surgeon and specializes in the bowel, and he did obtain an X-ray, what's called a KUB X-ray.

Q. Did you prescribe any antibiotics to treat any causes of the elevated white blood cell count on that day?

A. No.

Q. On October 27th, 2011 there was blood drawn and tests from that day;

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correct?

A. Yes.

Q. The white blood cell count is 17; correct?

A. Yes.

Q. That's high; correct?

A. Yes.

Q. It has actually gone up from last time; correct?

A. Marginally, yes.

Q. So it's gone up?

A. Yes.

Q. The red blood cell count is 3.29, which is low; correct?

A. Yes.

Q. Hemoglobin is 10.7, which is low; correct?

A. Yes.

Q. HCT, that's hematocrit?

A. Hematocrit, yes.

Q. Is 30, and that's low; correct?

A. Yes.

Q. You would receive a copy of these blood test results?

A. I check them on the computer.

Q. Did you ever form an opinion to a reasonably degree of medical certainty as to what the cause of the elevated white blood cell count of 17 on October 27, 2011 was in Mr. Simeone?

A. Again, it's part of a normal post-operative course as well as the patient having an ileus.

Q. Now, if a patient during, what you would say, a normal post-op course has an elevated white blood cell count, do you do anything to treat to and reduce that white blood cell count?

A. No.

Q. So what is it you do; just hope for it to go down or?

A. So I expect for there to be an elevation in the white count after any surgery. Unless the patient is showing any other signs of infection, then there's nothing to do.

Also, I should say, that in the first two to three, four, five days after

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surgery, that is not, typically, when you would see an infection. So in that time course, these are normal post-operative events for every patient.

Q. Is there a certain number on the white blood cell count that you would anticipate or expect the elevation to be up to?

A. Eighteen, in that range.

Q. You said it wouldn't be normal for an infection to be three, four or five days after operation; did I get that correctly?

A. We don't, typically, see that time course in terms of infection causing, you know, elevated white counts from a surgical wound. You, certainly, could see that from a urinary tract infection, pneumonia, things like that. Those types of infections, sure, that can certainly bump up the white count.

Q. When would you, using your term, typically expect to see a white blood cell count elevation being caused by a

post-surgical infection?

A. It's something that you would see over the course of a week or two following the surgery, if it was a surgical origin.

Q. What signs or symptoms would you be looking for to where, as part are your differential diagnosis, you would include post surgical infection?

A. Fever. Persistent fever. Spiking fevers. Wound drainage. Persistent wound drainage. Worsening pain.

Q. Anything else?

A. That's what comes to mind.

Q. Would it be you would be looking for all of these things or would it be a combination of on or two of these things?

A. Any of these things.

Q. So if you would see any of these things a week or two after the surgery, part of your differential diagnoses would include infection caused by surgery?

A. I'm always concerned about infection.

Q. Why is that?

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A. Because we're surgeons.

Q. Why are you always concerned about infection?

A. Because we take care of patients.

Q. What is it about infection that makes you concerned about it?

A. Well, we could harm the patient.

Q. Now, if you do determine that a patient does have an infection caused by the surgery, what is the treatment or different treatments that you would prescribe the patient?

MR. RACH: Note my objection.

If you can answer, you can answer.

A. Well, first you have to get the diagnoses of infection.

Q. Yes. Once you diagnose the patient with an infection caused -- a post-surgical infection caused by the surgery itself, what is the treatment or treatment options that you would recommend?

A. Well, there is no, like, kind of one infection. So it depends. Once you have diagnosed infection, in theory you have

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diagnosed it with some imaging, CAT scan or MRI, showing fluid collections. We try to get an aspiration, a CT guided aspiration, done by radiology to get some fluid and test it for infection to make sure. Because having fluid is normal after surgery. So that can just be called sterile fluid collection. It's not an infection at all.

So we try to get some of that fluid to test is. You know, is it puss. Is there bacteria in that fluid. Is it infection. Once we have that diagnosis, it depends on where the fluid is. Is the fluid deep close to the spine or is it more superficial or above the muscle and fascia. We try and have radiology drain it, and they can actually put in a drain. Again, depends on where the fluid is, how much.

Once you have drained it, you can in theory treat it with antibiotics, IV, typically, antibiotics, and follow to see if you are winning. If it's not an amendable to or cannot be drained, then typically surgery has to be employed to incise and

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drain the infection, as well as clean up the infected material.

Q. Now, a deep infection, if someone is suffering from a deep infection, would there be erythema present?

A. There could be. It doesn't necessarily have to be. The absence of erythema -- like I said, any one thing or -- it's not necessary for all things to be present. But the absence of erythema, would not necessarily rule out an infection if there were other things to concern you.

Q. Well, is there something like erythema, is it more likely to be present in a superficial infection as opposed to a deep infection or vise versa?

A. Not necessarily. It also depends on the timing. So, certainly, wounds after surgery have a redness to them. That can be present for a week or two, even three weeks depending on how well they are healing.

So it's difficult to answer that question, because there is no really, like, one erythema. It would have to be a more

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specific description.

Q. Okay. Now, something that you said in your last answer. I believe you said earlier that you would, typically, see an infection caused by surgery to begin about a week or two after the surgery?

A. No. I shouldn't say begin. That's when it would more blossom or that's when it would make itself more evident.

So in other words, right after the surgery, it's not enough -- the next day after surgery you don't have a blossoming infection. You know, even if you had a gross contamination, you wouldn't really see that. It takes a few days to, you know, a week or two for the infection to build up to the point where you would notice it.

Q. You mentioned about the CT guided aspiration; is that correct?

A. Yes.

Q. In a lumbar fusion surgery, a patient who just had a lumbar fusion, do you have to do the aspiration CT guided or can you just do the aspiration to get fluid to

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have it sent off to see if there's an organism present?

A. I don't, typically, like to stick needles in places I can't see.

Q. How is a CT guided aspiration performed?

A. You would have to ask the radiologist who performs them.

Q. Okay. So that's something that you don't perform?

A. No, I order it.

Q. Back to the October 27, 2011 blood test. He had a low red blood cell count. Do you see that?

A. Yes.

Q. What are the possible causes of a low red blood cell count?

A. So the red blood count, hemoglobin and hematocrit are all different ways of describing the same thing, which is anemia. His red blood cell count is down. During the surgery, there is some blood loss. I would have to look at the records for the exact amount, but, typically, 300 to

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500 cc's of blood loss would be expected in a surgery like this. Again, we typically would see a small decrease in the hemoglobin numbers. As long as the patient doesn't have cardiac risk factors or diabetes, and most importantly, is not symptomatic. You know, lightheaded, dizzy, things like. Then we don't have to do anything about that. Again, we expect to see a decrease in the hematocrit or hemoglobin or red blood cell count. Again, they are all markers for the same thing.

Q. So in Mr. Simeone's case, was it your opinion, to a reasonably degree of medical certainty, that the low red blood cell, hemoglobin and hematocrit was due to the normal loss of blood during surgery?

A. Yeah, surgical blood loss, as well as receiving IV fluids. So the IV fluids, obviously, don't have blood in them, but they do serve to dilute your blood. Thus artificially decreasing -- because these numbers are also volume based. So if you put in a solution that doesn't have

blood in it, the concentration of the blood will be decreased.

Q. The 28th there's another blood test result. It's timed at 08:01; is that correct?

A. Yes.

Q. White blood cell count again, 15.1, still high; correct?

A. Yes, but down from the day before. You can see here that the hemoglobin has now come up to 11.

Q. Come to 11, but still low; correct?

A. Still anemic; yes.

Q. Red blood cell count still low; correct?

A. Again, these are all going to be proportional.

Q. When you say they are going to be proportional, meaning the red blood cell count, hemoglobin, hematocrit are going to be low?

A. You're always going to see them the same, because they're just different

ways to measure the same thing, which is anemia.

Q. On this day of October 28, 2011, did you ever form an opinion, to a reasonably degree of medical certainty, as to what the cause of the high white blood cell count and the low red blood cell, hemoglobin and hematocrit was?

A. Yes.

Q. What was it?

A. Normal post-operative course, as well as post-operative ileus.

Q. What, if anything, at that time did you do to rule out any other causes of these findings on the blood test?

A. I did have an infectious disease consultant see the patient.

Q. When was that that the ID guy saw Mr. Simeone?

A. On the 28th.

Q. So at that point when you asked for an ID consult, were you concerned that infection may be the cause of the elevated white blood cell count and low red blood

cell, hemoglobin and hematocrit?

A. Not surgical infection. But, certainly, bacteremia from the ileus, from the stoppage of the intestines, can certainly cause, you know, persistent problem, and there is always the normal things; lungs and urine. So, also, to make sure we're doing everything possible for the patient. Get another specialist in infection to make sure that we're not missing anything.

Q. Why was it at that point when you called for the IV consult, you weren't concerned that it was surgical infection?

A. Again, because it's only, you know, five, six days out of the surgery. I mean, I shouldn't say I wasn't concerned about surgical infection. We are always concerned about surgical infection. It's just there was nothing else pointing towards that.

Q. When you say nothing else pointing towards that, what do you mean by that?

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A. The wound looked good. The wound was described as non-erythematous, non-edematous. There were drains placed. You know, drains placed there and the drain outlet was low. It may, actually, have been removed at this point.

Q. Yes, there were drains in place, but when were they removed?

A. They were removed on the 27th, 27th or 28th. We, typically, remove them when the output is low. In the presence of infection, the output would be high.

Q. In Mr. Simeone's case, was the output low when the drains were removed?

A. Yes, the last note that I had on it was that --

Q. What notes are you referring to?

A. My progress note from the 27th. My progress note from the 27th was that the drain put out 15 cc's over twelve hours times two shifts. So we would be monitoring. The drain out -- and 15 cc's is three teaspoons. If I put a drain in you, it would put out 15 cc's every twelve hours

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without surgery.

Q. You wrote a note on October 28 2011 at 1700 hours; is that correct?

A. Yes.

Q. Can you just read that for the record slowly?

A. "Post-operative day 7. Status post L4 to S1 AP fusion. Tolerated PO intake today. PO by mouth intake today. No nausea, vomiting, diarrhea, fevers or chills. Afebrile with vital signs stable. Wound no erythema, non-tender. No edema. Dressing is clean, dry and intact. Neurovascular in tact distally."

Q. AP is assessment?

A. "AP, assessment and plan: Ileus resolving. Positive bowel sounds. Positive flatus. Leukocytosis, likely post surgical and due to ileus. Getting studies per ID consult." So he must have ordered some studies.

"Hypokalemia resolved. Pain well controlled. Urinary retention resolved. Will DC home in the morning if cleared by

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Dr. Kota and Dr. Trehan."

Q. Then there's a note right under that you have. It's dated 10/29 at 9:30; is that right?

A. Yes.

Q. Can you just read that now?

A. Sure. "Post-operative day number eight. Status post, L4 to S1 AP fusion. Again, tolerating PO intake. No nausea, vomiting, diarrhea, fevers or chills. Afebrile vital signs stable. Wound no erythema, no edema. Dressings clean and dry, intact. Neurovascular intact distally. Assessment and plan: Ileus resolved. Leukocytosis post-surgical CT results pending. Electrolyte abnormalities resolved. DC home when cleared by Dr. Kota and Dr. Trehan."

Q. Now, why would -- you said discharge home when cleared by Dr. Kota and Dr. Trehan?

A. I wanted there to be agreement by the specialists for the ileus. And also, the infection disease specialist that there

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was nothing further to do and that the patient was fine to go home.

Q. With regards to Mr. Simeone, did you ever speak to Dr. Kota and Dr. Trehan after October 29th, 2011 at 9:30 and before Mr. Simeone was discharged; did you ever speak to them?

A. I don't remember specific conversations, but they were consulting on my patient. So there must have been some conversation.

Q. When you say must, that must have been an oral conversation between you and them?

A. There might have been a phone message. We have each other's cell phones. I don't recall, specifically, speaking to them, but we, typically, would get in touch with either calling each other on cell phones, leaving messages on cell phones, speaking to the PAs who would convey messages. That would be the typical form of conversation.

Q. Now, there's a blood test result

of October 29, 2011 at 11:01. Do you see that one?

A. Yes.

Q. That is the last blood test result prior to Mr. Simeone's discharge; correct?

A. Yes.

Q. White blood cell count is 13.2; true?

A. Yes.

Q. Red blood cell is 3.24, hemoglobin, 10.5 and hematocrit, 29.7; correct?

A. Yes.

Q. Did you see these blood tests results before Mr. Simeone was discharged?

A. I don't remember specifically looking at them, but we, typically, review lab results when we round.

Q. Did you ever form an opinion, to a reasonably degree of medical certainty, as to what the cause of the high white blood cell count was on this 10/29/11 blood test?

A. Again, from my notes from these

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days, my opinion at the time was that it was due to normal post-operative course as well as post operative ileus.

Q. Now, what, if anything, did you do to rule out that it was a surgical infection that was causing the elevated white blood cell count on October 29th, 2011?

A. I did have the infectious disease consultant see the patient and offer his opinion.

Q. That was on the 28th?

A. Yes, I saw him on the 28th.

Q. How about on the 29th, anything that you did to rule out whether or not the elevated white blood cell count was caused by a post-surgical infection?

A. I followed the infectious disease consultant's recommendation and evaluation.

Q. When you say you followed that, which recommendation and consultation are you referring to with the infectious disease doctor?

A. Dr. Trehan ordered for urine

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testing.

Q. What else did he order?

A. I can't make out everything that he wrote here.

Q. So on this 10/28/2011 note, it's timed at 3:35?

A. Yes. P.m.

Q. There's one and two there?

A. Yes, one and two.

Q. What does it say before the one; is that diagnosis?

MR. RACH: Impression.

Q. Impression?

A. Impressions. IMP.

Q. Same thing as diagnosis?

A. Uh-huh.

Q. Yes?

A. It's not my notes. I don't know. It's his impression.

Q. When you use the word impression, is it the same as diagnosis or different?

A. No.

Q. What's the difference between impression and diagnosis?

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A. My impression is what's going on with the patient. Diagnosis is that I'm actually providing a diagnosis. It has a specificity to it.

Q. After one can you read his handwriting what that says?

A. "Lumbar spine surgery."

Q. What does number two say?

A. Something "Leukocytosis".

Q. And what is the RO?

A. "Rule out." I don't know. "Rule out TN or PN or FN", but I don't know what rule out.

Q. If it was PN, would that mean indicated to you?

A. No.

Q. How about FN?

A. No. I mean it's something called a functional neutrophilia, but I don't think that's what he would be referring to.

MR. RACH: Okay, don't guess.

A. Okay. It says, "rule out" something and "rule out", maybe it says UTI.

Q. So it's a guess?

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A. It's a guess. Also, based on the fact that he also ordered a urine culture sensitivity.

Q. Under plan, I know you didn't write the note, but would you able to read the his handwriting under plan?

A. It says, "UAC and S today". So he's testing the urine.

Q. That's the fourth line of the plan?

A. Fourth line.

Q. Anything above that you can't read or you don't know what it says?

A. The second one, "non-contrast -- I think the second line says, "non-contract CT scan" because I do also refer to a CT scan in my follow-up note.

Q. Okay. What else can you read?

A. I think the third line says, "blood cultures if temperature greater than 102", which is a typical recommendation.

Q. When you say it's a typical recommendation, what do you mean by that?

A. If you get a temperature greater

than 102, it implies that there may be bacteria in your bloodstream. So if you check blood cultures, you may capture that bacteria. So then you can know what's going on.

Q. When you say bacteria in the bloodstream, infection?

A. Not necessarily. You can have bacteria in your bloodstream after you get your teeth cleaned. Again, everything is taken in the setting of what's going on. So if you are concerned about something or if there's something that's drawing your attention and the patient spikes a temperature, and you can capture blood and get a microbe out of it, that may provide a clue as to what's going on.

Q. What is your definition of an infection?

A. It depends what of. Lung infection, urine infection?

Q. How about blood infection?

A. So bacteremia or septicemia is when you have bacteria in the bloodstream.

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Q. How about a surgical site infection?

A. What about it?

Q. What would your definition of surgical site infection be?

A. An infection at the site of surgery.

Q. An infection, what type of infection; are we talking bacteria, some other organism?

A. No. Typically, it would be a bacterial infection at the site of surgery.

Q. Anything else under that? I think does the last one say "stool for C-diff"?

A. I think it does. There was a negative stool sample in the labs, as I recall.

Q. Does it say "rule out CD"?

A. I think under impression -- oh, that's probably what it says. Looks like. I think number two under "impression" it says, "rule out C-diff and send stool for C-diff".

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Q. C-diff is a type of infection; correct?

A. Yes, it's an infection of the bowel.

Q. Back to the blood test result of October 29th, did you ever form an opinion, to a reasonable degree of medical certainty, as to what the cause of the low red blood cell, hemoglobin and hematocrit was?

A. Normal post-operative course.

Q. After this October 29, 2011 note at 9:30, did you draft any other notes with regards to Mr. Simeone?

MR. RACH: During this admission?

MR. WARYWODA: During this admission, yes.

A. There was just the discharge instruction.

MR. WARYWODA: Let's mark this.

(Whereupon, a discharge plan of instructions was marked Plaintiff's Exhibit No. 3E for identification, as of this date.)

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Q. We have mark as Plaintiff's Exhibit 3E of today's date. It's a Discharge Plan Instructions; correct?

A. Yes.

Q. Is that your handwriting that's located on the upper portion of the note?

A. Yes.

Q. In terms of medications, if you could just for the record, could you read what medications you prescribed upon discharge for Mr. Simeone?

A. I prescribed him "Percocet, OxyContin, Valium, Colace and Senekot."

Q. The Percocet, why did you prescribe Percocet for Mr. Simeone?

A. The Percocet is an acute short acting narcotic for pain control.

Q. How about the OxyContin; why did you prescribe that?

A. So OxyContin is a long acting narcotic for pain control.

Q. How about the Valium?

A. Valium is a muscle relaxer.

Q. And Colace?

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A. Colace is a stool softener, as is Senokot?

Q. So did you not prescribe an antibiotic for Mr. Simeone for discharge; correct?

A. None was indicated.

Q. That wasn't my question. The question was, you did not prescribe an antibiotic for Mr. Simeone upon discharge; correct?

A. I did not.

Q. Now, upon discharge you agree with me that Mr. Simeone's white blood cell count was still high; correct?

A. Yes.

Q. Okay. Upon discharge, what, if anything, did you prescribe, whether it be a plan of treatment or medication, to reduce or attempt to reduce the elevated white blood cell count?

A. Nothing.

Q. It says, "follow-up appointment with Dr. Apazidis", and it says "two weeks"; is that correct?

A. Yes.

Q. So that indicates when the next time you wanted Mr. Simeone to come to your office is; correct?

A. Yes.

Q. Did any other physicians besides yourself request a follow-up visit with Mr. Simeone after his discharge from the hospital?

A. The plastic surgeon may have. I don't know how his office handles follow-ups.

Q. Anything in the medical record of Brookhaven Hospital that indicates that a plastic surgeon or any other doctors requested Mr. Simeone to come to their office post-discharge?

A. Nothing in these records, no.

Q. If the plastic surgeon had requested a follow-up visit with Mr. Simeone after discharge, is that something that would be put in the Brookhaven Hospital chart?

A. Not necessarily.

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Q. Why is that; was he an employee of Brookhaven Hospital?

A. No.

Q. So the plastic surgeon, is that Dr. Fuentes?

A. Yes.

Q. Have you ever seen any office notes of his outside the medical chart of Brookhaven Hospital?

A. I have not.

Q. I know I asked if you did. Did any physician, according to your review of the record, prescribe an antibiotic for Mr. Simeone to be used by him post-discharge?

A. Not that I'm aware of.

MR. WARYWODA: Let's take a short break. Off the record.

(Whereupon, a short recess was taken.)

MR. WARYWODA: Back on the record.

Q. You are aware that Mr. Simeone presented to Brookhaven Hospital on November

8, 2011; is that correct?

A. Yes.

Q. Between October 29, 2011 and November 8th, 2011, did you have any contact with Mr. Simeone?

A. No, I did not.

Q. When Mr. Simeone presented to Brookhaven Hospital on November 8th, 2011, were you present at the hospital that day while he was there?

A. I do not believe that I saw him in the hospital that day.

Q. Do you know a doctor by the name of Joseph Artale?

A. Yes.

Q. Who was Dr. Artale?

A. He is an emergency room physician.

Q. Do you recall having any conversation with Dr. Artale about Mr. Simeone?

A. I don't recall, but it's documented here in his notes.

Q. Is that on the page that on top

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it says page 6?

A. Yes.

Q. Under Artale, Joseph, D.O. created 11/08/2011 19:46. It says last entry 19:50, it says MD note. It says, "spoke so Dr. Apazidis". Do you remember a conversation that you had with Dr. Artale?

A. No.

Q. It says, "We'll see in office tomorrow and general surgery in a few days due to GI issues."

Did you recall giving any instructions to Dr. Artale as to Mr. Simeone's following up with you or anyone else?

A. I don't recall, but it seems that he's documented that I was due to see him in the office tomorrow.

Q. It says, "As per Dr. Apazidis, no need for CT since he is post-op two weeks and it is unlikely to develop an abscess now." Do you see that?

A. Yes.

Q. Let's go to -- does this record

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-- you're looking at the Brookhaven chart -- was a temperature taken of Mr. Simeone when he arrived at the hospital?

A. I'm sure there was.

Q. Are you seeing a record showing the temperature?

A. Yes.

Q. It says "101.9 for rectal." Do you see that?

A. Yes.

Q. Is that a temperature?

A. My familiarity with vital sign testing is that rectal temperatures do tend to run higher than oral temperatures. I'm not immediately familiar with the exact parameters for rectal verses oral temperatures.

Q. On page 3 in the bottom it say HPR. That's history presentation; correct?

A. Yes.

Q. It says "Had surgery 10/21/11 and discharged 10/29/11. Had double fusion procedure done. Now running fevers the last four days. Staples remaining intact with

surrounding area reddened. No drainage noted." Do you see that?

A. Yes.

Q. If a patient like Mr. Simeone presented to your office with having had a double fusion procedure done on 10/21, so we are now post-op day 18?

A. Yes. It's looks like in that range.

Q. "Post-op date 18 with running fevers the last four days. Staples remain intact with surrounding area reddened and no drainage noted." Would infection be part of your differential diagnosis?

A. It doesn't appear that these fevers are not documented.

Q. What do you mean by they are not documented?

A. This is a patient report of fevers. During this time the patient also had visiting nurses. So during this time period, if there was documented fevers on post-operative day 18, then that would be -- and there were, obviously, other things

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going on in terms of, you know, wound issues, primarily come to mind. Then, yes, that would be a cause for the work-up.

Q. So if a patient just came to you and said like this presentation it says, "I'm running fevers for the last four days", if it wasn't documented by a visiting nurse service or a doctor, would you not include infection on your differential diagnosis?

A. The question would be are these subjective temperatures or fevers or did he actually take a number. Typically, again, typically -- this is not my note or not my assessment -- but, typically, when a patient says to me I have been running temperatures. I say did you measure them. If they measured them and say yes, I put the oral thermometer and it's 102, that's different. If they say I feel like I'm having temperatures, that's also different.

Q. So if someone says that I have measured my temperature and I've had fevers the last four days?

A. Give me the numbers.

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Q. Okay. If they did have fevers the last four days with this presentation, would you include infection in your differential diagnosis?

A. Infection of what?

Q. Post-surgical infection.

A. Yes.

Q. Now, it says, "Surrounding area reddened." Do you see that?

A. Yes.

Q. Would you expect to see the surrounding area of the surgical site reddened on post-op day 18?

A. Yes.

Q. That would be a normal finding to you?

A. Yes. That is also the patient's report. That's the history -- the patient is reporting to Dr. Artale. That's not Dr. Artale's assessment.

Q. Now, when a patient sees you, you take a history from them; correct?

A. Yes.

Q. A history is important so you

know what complaints the person's making; correct?

A. History is always important.

Q. When Mr. Simeone was discharged from Brookhaven on the 29th of October, did you give him any instructions as to if he had certain complaints, like to contact you or go to an emergency room or a hospital sooner than the two weeks you recommended that he go to your office?

A. Well, I always tell patients if they have any concerns to get in touch with me, if they're concerned about anything. There a some kind of standard hospital discharge instructions. You know, some of them, you know, if you have a fever above 101 or 101.5. I don't know exactly the number that they typically tell patients. Again, there are some standard discharge instructions that all patients get. Certainly, all post-surgical patients.

Q. Other than the fever of over 101 or 101.5, any other standard instructions that you know that Brookhaven Hospital gives

their patients?

A. I'm not immediately familiar with them. I know I always tell patients if anything is bothering you and you are concerned, call me or call my office. I usually give patients my cell phone. That's kind of my -- I'd rather hear about things sooner rather than later.

Q. Okay. Erythema, what is erythema?

A. Redness.

Q. In this record on page five, it says on the bottom half, it says "Physician HNP." Do you see that?

A. Yes.

Q. According to this record, it indicates that Dr. Artale did a physical examination; correct?

A. Yes.

Q. On the last line where it says "abdomen", do you see that?

A. Yes.

Q. Last sentence of that it says, "ABD incision has slight erythema around

staples, but no DC, and non-tender." Do you see that?

A. Yes.

Q. Was an abdominal incision made on Mr. Simeone?

A. Yes.

Q. Would you, as a physician, anticipate seeing slight erythema around the staples 18 day post-op?

A. Yes.

Q. When would you, as a physician, expect the erythema around the staples of a patient who just had this type of surgery to go away?

A. When the staples are removed.

Q. How long do staples remain in place on a patient like this?

A. As long as they have to.

Q. When Mr. Simeone was discharged from the hospital, was there anticipation as to how long you expected the staples to remain in place?

A. I mean, averages could be a week or two, but some need to stay in for three

weeks.

Q. It says according to the doctor's note on page 6, it says, "As per Dr. Apazidis, no need for CT since he is post-op for two weeks and unlikely he developed abscess now." Do you remember telling the doctor that?

A. I don't, specifically, remember the conversation, no.

Q. From the review of your record, is that what your opinion would be if he presented to you on that 18th day with these complaints and this physical exam?

A. Yes. I mean, first, I have no reason to doubt Dr. Artale's record. But based on his examination of non-tenderness, no discharge of the examination of the back, being no tenderness. Healing well. No signs of infection. His examination of saying some swelling, but no tenderness, which he would have related to me during our conversation. Based on the results of his examination and his reported to me, I, probably, would not have recommended a CT

scan in this setting.

Q. Why is it that you wouldn't have recommended a CT scan?

A. So a CT scan is a large dose of radiation. I would not want surgical wounds and fusion to be exposed to needless radiation unless I had a reason to get that test.

Q. Why is that, what is it about the radiation for a CT scan; how could it affect a surgical wound?

A. It would -- it's radiation. It would weaken healing and possibly, inhibit fusion. Now, of course, if we needed to get it, we would, of course, get it, if the benefits outweigh the risks. But in this setting, certainly, the benefits do not outweigh the risks.

Q. Why is that; why do you say the benefits -- in this instance the benefits don't outweigh the risks?

A. There's no clear benefit of getting a CT scan.

Q. Do you recall whether you formed

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a differential diagnosis after being told, given the information by Dr. Artale, whether or not you formed a differential diagnosis with regards to Mr. Simeone on this date?

A. Differential diagnosis of what?

MR. RACH: No, he is asking if you formed one.

Q. Did you form one?

A. Of what?

Q. What do you mean of what? Do you know what a differential diagnosis is?

A. Differential diagnosis of what, his presentation?

Q. What is a differential diagnosis?

A. A list of diagnoses to explain a patient's symptoms.

Q. Okay. So did you form a differential diagnoses with regards to Mr. Simeone with regards to the information that was relayed to you about the complaints about the examination; did you form a differential diagnosis?

A. Well, I didn't examine the patient.

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Q. But you were given information by Dr. Artale; correct?

A. Yes.

Q. You told him don't do a CT scan; correct?

A. I told him that I did not think a CT scan would benefit the patient.

Q. Okay. Before you said don't do a CT scan, did you form a differential diagnosis?

A. I guess I need you to be a little more specific with the question. Of what? Of just the patient in general? There is no -- of just his back pain? I'm not clear. What am I forming a differential diagnosis of?

Q. Well, you told the doctor don't do a CT scan; correct?

A. First of all, one doctor cannot tell another doctor what to do. I would -- it appears that he would have inquired here, do I think a CT scan is necessary. And based on what he's noted here and what I assume he would have related to me, I would

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have said, no, I don't think a CT scan is necessary, do you. We would have had a conversation about it.

Q. In order for you say -- recommend whether or not Mr. Simeone should have a CT scan or not, you would have had to have formed a differential diagnosis; correct?

A. No. I would have needed a reason to get a CT scan, which may or may not help me to form a differential diagnosis.

Q. Wait a minute. Isn't a differential diagnosis the possible causes of what your examination and the complaints are of a patient that presenting to you; correct?

A. Correct.

Q. Okay. So you would form a differential diagnosis and then you would list the possible causes of every complaint that the patient is making; correct?

A. Yes.

Q. Then once you formed your differential diagnoses, you would then make a list of how do I rule out number one, how

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do I rule out number two, how do I rule out number three; correct?

A. Yes.

Q. Then you will order tests or treatments to try and rule out what your possible differential diagnosis is; correct?

A. Yes.

Q. So in this case we have a record that says you do not recommend a CT scan; correct?

A. I said I did not think one was necessary.

Q. Okay. So could we assume or not assume, I don't want to put words in your mouth, I just want to know, did you form a differential diagnosis as to the possible causes of the presenting complaints and the findings on physical examination for you to say a CT scan was not necessary?

A. Well, again, I did not examine the patient.

Q. That wasn't my question.

A. So I cannot -- I'm given over the phone information by a doctor who was

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telling me that a patient is coming in because he felt he had fevers, I don't remember if they were documented or not, of a patient who was has a complaint of, basically, just fever.

Q. And redness around the surgical site; correct?

A. And redness, which the examining physician did not feel was remarkable.

Q. Where does it say that?

A. Well, he says here, "Back, no back tenderness, back incision healing well with no signs of infection." He says, "Some swelling palpated, but no tenderness. Abdomen, normal bowel sounds. Soft. No abdominal tenderness. No guarding. No rebound. No masses. Abdominal incision has slight erythema around staples. No discharge and non-tender."

Q. So what part of that line are you saying that the doctor found that it's not to be significant?

A. He's not reporting anything here that is remarkable to warrant pursuing

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further work-up.

Q. Were you given that information over the phone about the doctor's physical examination and his findings?

A. I'm sure that would have transpired during our conversation.

Q. Were you also given the history of what the patient said and the four days worth of fever?

MR. RACH: Just note my objection. He said he doesn't remember, but he believes that would be the conversation.

A. I don't remember the conversation, but I'm sure in our course of the conversation that that would have been related.

Q. Again, I'm going back to, did you form a differential diagnosis after speaking to Dr. Artale as to what the possible causes of Mr. Simeone's complaints and physical examination findings were?

A. Again, not having examined the patient, but in discussion over the phone

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with Dr. Artale, I suppose I would have considered that the patient is two weeks post-operative and that this is a normal post-operative course.

Q. Now, do you remember forming a differential diagnosis? That's my first question. Do you remember forming a differential diagnosis on November 8, 2011?

A. I do not remember this conversation or my thoughts on that date.

Q. Sitting here today, are you saying that if a doctor had called you who was seeing one of your patients with these findings on physical exam and these presenting complaints, your differential diagnosis would be normal post-op?

A. There is nothing that he documented here that I assume he would have related to me to make me or apparently, even him, overly concerned that there was a post operative wound infection occurring here.

Q. Well, from this note, does it indicate that Dr. Artale was considering sending Mr. Simeone for a CT scan?

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MR. RACH: Note my objection. There's no way he could answer that question.

A. I don't know if he was considering it or not. Obviously, we seemed to have discussed it.

Q. You recommended that there's no CT scan be done; correct?

A. Yes.

Q. So you have a patient who presented two weeks post-op who is telling you he has a history of four days of fever and he has redness around the surgical site. You're saying infection was not or would not be part of your differential diagnosis?

A. No, I didn't say that.

Q. Well, would infection be part of your differential diagnosis?

A. Infection in a post-operative patient is always part of the diagnosis, differential diagnosis.

Q. So in this case if you were given this information with what Dr. Artale, what his physical exam was, and what Mr.

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Simeone's complaints were, would you include post surgical infection on your differential?

A. Yes.

Q. What, if anything, would you do to rule out post-surgical infection?

A. Examination of the patient.

Q. What kind of examination of the patient?

A. Physical examination of the patient.

Q. Consisting of what?

A. Looking at the wounds. Looking for tenderness. For signs of infection.

Q. I thought you said that signs of infection were redness around the surgical site; correct?

A. Yes.

Q. Fever; correct?

A. Yes.

Q. High white blood cell count; correct?

A. Yes.

Q. Wound drainage; correct?

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A. Yes.

Q. Worsening pain; correct?

A. Yes.

Q. Anything else?

A. No, those are the top four or five.

Q. So if your examination found what Dr. Artale's examination found on this November 8th, 2011 visit, would you include post-surgical infection on your differential?

A. I don't mean to be obtuse, but of what, of just the fever?

Q. No. My question was specific. My question was, all of the findings of Dr. Artale's examination, his physical exam, the complaints of the patient. Okay. It's a very clear question.

I'm asking you, if you found these on your examination, patient comes in two weeks post-op or eighteen days post-op and he tells you he had four days of fever, would you include post-surgical infection on your differential?

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A. Yes.

Q. What would you do to rule out whether or not it was a post-surgical infection.

A. I would examine the patient.

Q. You have already examined the patient. I'm saying with these findings, you've already examined the patient, and now you formed a differential that said post-surgical infection. What would you do to rule out that post-surgical infection?

A. We're getting into a circular argument here. There's nothing on the examination that points me towards surgical infection.

Q. I just asked you that. I asked you with this examination. If you were Dr. Artale and you were doing this examination, would you include post-surgical infection on your differential?

Read the note. Take the time and read this note. I want you to read page 1 of 6. Read all of them, one, two, three, four, five, six of Dr. Artale's exam. I

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want you to read it.

If you were Dr. Artale and these were your findings with the history, with the complaints with Dr. Artale's findings, would you include post surgical findings on your differential?

A. Yes.

Q. If that's true, what would you do to try and rule out or rule in infection?

A. Maybe that's the key. Rule out or rule in. Everything starts with a physical examination. On this physical examination there is nothing that is ruling in surgical site infection. Based on the absence of the primary mode of determining what a patient has, you don't do a CT scan.

Q. Doctor, you are not answering my question and I don't know why. It's a very simple question. I would like you to answer it. I'm not going to stop asking the question until you answer it.

A. Okay.

Q. I am asking you, if you were Dr. Artale and you did this examination and you

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found on Mr. Simeone eighteen days post-op and he comes into you complaining of four days worth of fever and you find that the abdominal incision has slight erythema around the staple, but no discharge and non-tender and everything else that was on this examination and these complaints, would you include post-surgical infection on your differential diagnosis, yes or no?

A. Yes.

Q. What else would be on your differential diagnosis besides post-surgical infection?

A. Other things that would be on the diagnosis would be normal post-surgical course.

Q. What else?

A. Resolving ileus. Other sources of infection, such as lung, pneumonia, atelectasis or urine, less likely in this setting, but always possible, urine infection.

Q. Anything else that would be part of your differential diagnosis?

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A. That would be the top four or five.

Q. So what would you do to rule out -- let's start with resolving ileus. What would you do to rule out that it's not resolving ileus?

A. Well, is the patient having bowel movements. Is the patient passing flatus (phonetic). There's no definitive test. We know that he had an ileus when he was in the hospital, approximately, a week before this presentation in the ER. Ileus do not -- it's not a light switch. Ileus is on, ileus is off. We know he is having a resolving ileus, although he was passing flatus, having bowel movements and tolerating intake. There's, you know --

Q. Which would be that the ileus has resolved; correct?

A. Resolving, but again, it's not an on and off switch. It certainly is improving and we certainly had no reason to keep him in the hospital at that status.

Q. Well, according to the doctor's

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note of prior to discharge, I believe it said resolved with regards to ileus; correct?

A. Yes. Dr. Kota's note said that the ileus was resolved.

Q. That was as of October 29th?

A. Yes.

Q. Okay. Again, back to this presentation, what would you do to rule out post-surgical infection?

A. Check blood levels.

Q. So you go to the blood test?

A. Yes.

Q. What else, if anything?

A. Again, vital signs and an examination of the patient.

Q. Are you saying a further examination of the patient?

A. No, I mean the physical examination of the patient, basic labs, vital signs.

Q. What would you be looking for on the blood test where it would lead you to believe that this presentation and the

complaints is being made because of a post-surgical infection?

A. So when he was in the hospital, the white blood cell count had been decreasing down to, I think, a level of 13. I think it was, approximately, 13. Now, it's a week later. If the white count had gone back up, that would be a sign of going in the wrong direction.

Q. Anything else on the blood test that you would look at to determine whether or not it's post-surgical infection?

A. Nothing else on blood testing, you know, on regular labs no.

Q. Low red blood cell count, hemoglobin and hematocrit, could that be caused by infection?

A. Chronic infection over, you know, months or people who have these chronic osteomyelitises, they do have anemia. It's a condition called anemia of chronic infection. Acute infections, no.

Q. Okay. How about high glucose. Isn't high glucose a sign of a surgical site

infection?

A. I mean high glucose can be a sign of inflammation or it's an acute response, but is far from specific for infection.

Q. Have you ever read any articles in the medical literature that state that a high glucose is a good indicator of whether or not someone is suffering from a post-surgical site infection?

A. I'm not familiar with any such articles, no.

Q. So the only thing you would be looking at on a blood test is white blood cells to rule in or rule out post-surgical site infection?

A. White blood cell count, yes.

Q. Anything else?

A. On basic labs?

Q. Sure.

A. No. Nothing else is really specific, no.

Q. Now, according to this record of November 8th, 2011, it says that the "ED record was faxed to you." Do you see that?

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A. Yes. "ED record faxed to Dr. Apazidis."

Q. That indicates it was on November 10, 2011; is that correct?

A. Yes.

Q. Sitting here today, do you ever remember reviewing a copy of this ED record prior to your review of the records for your deposition?

A. Do I remember -- say it again?

MR. WARYWODA: Read it back, please.

(Whereupon, the requested question was read back by the reporter.)

Q. Did you ever review a copy of the these ED records prior to your review of the records for your deposition?

MR. RATH: In other words, we reviewed the records. Did you review them before that?

A. I mean, no, other than at the time.

Q. I'm asking, do you remember

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reviewing these records at the time?

A. Oh, at the time. I don't remember, no. However, in my note of the next day, I did document that I'm aware he went to the emergency room.

MR. WARYWODA: Okay, I don't have a note of the next day. Do you have a note of the next day?

THE WITNESS: The 11/09 note.

MR. WARYWODA: Can you make a copy of this?

MR. RATH: Off the record.

(Whereupon, a short recess was taken.)

MR. WARYWODA: Back on the record.

A. It says here that they were created on 11/10. So I don't know if that means it was faxed to me on 11/10, which would be the day after I saw him in the office. I don't know if that helps at all.

Q. My question was, after reading that now does it refresh your recollection of you actually reviewing the Brookhaven

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emergency record of November 8th, 2011 prior to your review with your attorney?

A. I don't remember. I don't remember having reviewed these records at the time.

Q. So November 9th, 2011 Mr. Simeone presented to your office; correct?

A. Yes.

Q. Did he make certain complaints to you on that visit?

A. He reported that he went to the emergency room because of temperatures of a 101.

Q. Was this visit of November 9th, 2011, was this scheduled prior to Mr. Simeone presenting to the emergency room on November 8th, 2011?

A. I don't know, but it is standard for me to see the patient about two weeks after surgery and this is within that timeframe.

Q. Under ROS or review of symptoms, it says "fever, yes" and it says "low grade". Do you see that?

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A. Yes.

Q. What is considered a low grade fever to you?

A. 101 and below.

Q. Now, it says, "weight loss" and it says "yes", and it says "unintentional". Do you see that?

A. Yes.

Q. It says "loss appetite, yes, associated with weight loss". Do you see that?

A. Yes.

Q. Is it expected by you for a post-surgical patient to have weight loss?

A. Expected? No, I wouldn't say it's expected.

Q. When Mr. Simeone told you that he had weight loss unintentional, was that concerning to you?

A. Well, of course it's concerning.

Q. Why is it concerning?

A. Well, we never want a patient to have unintentional weight loss. But he did have an ileus and he didn't eat for almost a

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week when he was in the hospital. He's, probably, not eating much since he's been home, again, with the resolving ileus.

Q. So do you remember, did you form an opinion as to what the cause of the unintentional weight loss was of Mr. Simeone?

A. Again, I don't have a specific memory of it. But looking at the evidence here, I would have, you know, concluded that the fact that he didn't eat for several days in the hospital and that his resolving ileus would lead to a decreased appetite. As well as the necessary pain medication decreases your appetite, narcotics, our appetite suppresses. We have an explanation as to his weight loss. When he says unintentional, he's not dieting or exercising to lose weight.

Q. You formed an assessment or it says "assessment"; correct?

A. Yes.

Q. What was your assessment of him?

A. I thought he was doing well three

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weeks after the surgery in terms of the spine issues. His pre-operative radiculopathy had resolved. I said here, obviously, the fevers are concerning. He did have significant constipation and ileus while in surgery and he was now having some diarrhea, which I thought some of his weight loss. Also, his intermittent fevers may contribute to diarrhea or vise versa. Diarrhea can contribute to fevers.

It says, "I do not see any signs of a superficial or deep infection. We will keep track of his fever profile." Some of the words are mixed up. It says, "His labs show a slight elevation in liver enzymes likely related to the use of Percocet, which has Tylenol in it."

Q. Now, just on that you said, obviously, the fevers are concerning?

A. Yes.

Q. Did you form a differential diagnosis on this November 9th, 2011 as to what the possible causes of Mr. Simeone's fever was?

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A. Yes.

Q. What was your differential?

A. Surgical site infection. Diarrhea, ileus. That would be it.

Q. What, if anything, did you do in terms of what did you order to rule out whether or not the fevers were being caused by a surgical site infection?

A. We were going to monitor the patient closely.

Q. Monitor how; monitor what?

A. Ask him to keep track of the fevers and bring him -- have him follow up as scheduled.

Q. Follow up with you?

A. Yes.

Q. Now, Diarrhea, could diarrhea be caused by a surgical sight infection?

A. I'm not familiar with surgical site infection causing diarrhea, specifically.

Q. Now, it says, you said "I do not see any signs of a superficial or deep infection." Do you see that?

A. Yes.

Q. What signs were you looking for where you would see signs; if you saw these things, you would say I see signs of a superficial or deep infection?

A. Sure. Swelling, Erythema, tenderness, edema of the skin, worsening back pain, worsening radiculopathy. That would be it.

Q. Did you prescribe any medications on this visit?

A. No.

Q. On this visit Mr. Simeone, prior to coming to you, was not taking an antibiotic; correct?

A. Correct.

Q. You didn't prescribe an antibiotic; correct?

A. Yes.

Q. Why didn't you prescribe an antibiotic on this visit?

A. I had no reason to.

Q. When you say you have no reason to, what, if anything, were you doing to

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treat or try to lower his fever?

A. Well, the Percocet has Tylenol in it, which is a fever reducer.

Q. On this visit did you ask him how many days he was having a fever for?

A. I don't see that I documented that.

Q. Now, you said, "We will keep track of his fever profile." What is that; is that something Mr. Simeone does, what is that?

A. He would report to me if he was continuing having fevers. Also, there's a Visiting Nurse Service and they go to see the patient typically they draw vital signs.

Q. Do you remember getting those Visiting Nurse Service records for Mr. Simeone between October 29th, 2011 and November 9th, 2011?

A. I don't remember.

Q. Now, under plan, the procedure codes, it says, "Electrical bone stimulation." Do you see that?

A. Yes.

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Q. What is that?

A. So it's an external device. It's an electrical bone stimulator. My protocol for multilevel fusions is to employ this. It's something that aids fusion.

Q. Does that mean you were prescribing it on that day, the electric bone stimulator?

A. I applied it that day. I gave it to the patient, put it on him and showed him how to use it. We would have applied for this even before surgery. It takes some time to obtain.

Q. For follow-up it says, "four weeks". Do you see that?

A. Yes.

Q. Is that when you told him to come back to your office in four weeks?

A. Yes. Typically, we made these appointments two week, six week, twelve week standard follow-ups after surgery.

Q. Did you give him any instructions as to when to return if his fevers continued for a certain amount of days?

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A. I don't remember specifically.

Q. Custom and practice; what would your custom and practice be?

A. Call me if you have any concerns or problems.

Q. When say if you have any concern or problems, do you explain to them what concerns or problems that should contact you with?

A. I mean every case is different. But I suppose for him, I would certainly say if your fevers are persistent, come back and see me sooner.

Q. Sitting here today, do you have any recollection of having that conversation with him?

A. No.

Q. If you did tell a patient return to me if your fevers are persistent, would you explain to them what persistent means or what the duration of time it would have to be for them to contact you?

A. I don't think so that I would go into great detail about that. But lots of

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times patients ask the question, you know, what do you mean, so I answer.

Q. What if they don't ask the question or what if they do ask the question, would you give them a date or would you leave it up to them to determine what a persistent fever is?

A. I mean, one thing we always -- if the conversation is taking place, I would say, you know, do you have fevers like spiking at night. Those are more concerning. That might be something that we would have gone into about.

Q. Would you give them a definition of what persistent means in terms of the days of a fever in order for them to contact you?

A. I don't think I would.

Q. Other than installing or applying the electrical bone stimulator, did you order anything else for Mr. Simeone after this November 9th, 2011 visit?

A. Not that I'm aware of.

Q. Did you order a blood test?

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A. I doubt it, since he had one the day before.

Q. Just so it's clear to me, why was it that you didn't order a blood test on this visit?

A. I had no reason to.

Q. Why is that?

A. I had lab values from the previous day.

Q. Now, lab values from the previous day, do you remember when you first received them?

A. No, but I do have access to the computer. I can see them at any time.

Q. Do you remember reviewing the lab values on the previous day, on November 9th, 2011?

A. No. I don't have a specific memory of that, no.

Q. If you had reviewed them, would you have documented them in your report?

A. Not necessarily, but I might have. I think if they were concerning, I probably, would have documented. But if

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they were essentially normal, I'm not sure I would necessarily have documented.

Q. Let's look at the November 8th, 2011 labs from Brookhaven. White blood cell count is normal?

A. It's within the normal range, yes.

Q. Red blood cell count, hemoglobin, hematocrit are still low; correct?

A. Yes.

Q. Did you form an opinion as to why Mr. Simeone's red blood cell, hemoglobin and hematocrit were still low about eighteen days post-op?

A. Yes.

Q. What was it?

A. Normal post-operative course.

Q. How about PLT, that's platelets?

A. Yes.

Q. It says "561". That's high; right?

A. Yes.

Q. What are the possible causes of a high platelet count?

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A. Surgery.

Q. When you say surgery, just the surgery itself?

A. Post-operative course. You know, hemoglobin goes down, platelets go up.

Q. How about infection; could infection be a cause of high platelet count?

A. Yes.

Q. NE number sign, what is that?

A. Neutrophils.

Q. A high neutrophil, what are the possible causes of a high neutrophil?

A. Neutrophils are a form of white blood cells. You know, different types of white blood cells.

Q. Could high neutrophils be caused by post surgical infection?

A. Yes.

Q. How about MO number sign; what does that stand for?

A. Monocyte.

Q. That's 1.5; is that correct?

A. Yes.

Q. That's high?

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A. It's elevated, yes.

Q. What are the possible causes of a high monocyte?

A. Infection.

Q. There's LY and a percentage sign, 10.3. What is that?

A. Lymphocytes.

Q. Low lymphocytes, what are the possible causes of low lymphocytes?

A. You know, this a really getting more into hematology. So I --

Q. Just what you know. I have doctors tell me before they don't know what the thing is. So you're not quite sure. That's more for a hematologist; those are the values that a hematologist would look at and you as an orthopedic really wouldn't?

A. First of all, in the setting of a normal white blood cell count, the differential becomes less significant. But if the white bloods cell count was elevated, then we would look at shifts. But in a setting of a normal white cell count, I am not sure these would be that significant.

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But I think that a hematologist would be better qualified to answer that question.

Q. But if someone has a normal white blood cell count and a high platelet count, that high platelet count could be caused by a post-surgical infection; correct?

A. Among other things, yes.

Q. Among what other things?

A. Normal post-surgical course. Platelets are what's called acute phase reactants. So trauma, fracture, surgery is going to elevate platelet count.

Q. So what's your expectation in terms of when the platelet count will return back to a normal range post-surgery?

A. Everyone is different, but a few weeks.

Q. When you say a few weeks, what are we talking?

A. Three to six weeks.

Q. MO percentage of 13.7; what is MO?

A. I believe it stands for monocytes.

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Q. Do you know what a high monocyte can be caused by?

A. I don't really feel comfortable evaluating the percentages of the white blood cells in the setting of a normal white blood cell count.

Q. That's fine. Urine analysis of clarity it says "cloudy". That's abnormal; correct?

A. Yes.

Q. Do you know what the possible causes of cloudy urine could be?

A. Urinary tract infection.

Q. How about a surgical site infection?

A. I'm not familiar with cloudy urine being associated with a surgical site infection.

Q. There was a trace of protein found in his urine; is that correct?

A. Yes.

Q. If you saw a trace of protein on someone's urinalysis, would you consider a post-surgical site infection being a cause

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of it?

A. In isolation? No.

Q. What else would you have to see along with a trace of protein in the urine for you to include post-surgical site infection on your differential?

A. Elevated white blood cell count and physical exam findings consistent with infection?

Q. Again, what physical exam findings?

A. Swelling, edema, erythema, tenderness, worsening pain.

Q. The same as your answer was before. It doesn't have to be one of them or two of them, it doesn't have to be all inclusive; correct?

A. Of course, yes.

Q. Now, Mr. Simeone's glucose, we started talking about this before. It says "123 high". Do you see that?

A. Yes.

Q. Did you ever form an opinion as to what the cause of Mr. Simeone's high

glucose was on November 8th, 2011 test?

A. No.

Q. On this November 9th, 2011 after this visit, between November 9th and November 18th, 2011, did you ever advise or prescribe Mr. Simeone to see an infectious disease doctor?

A. Between November 9th and November 18th?

Q. Correct.

A. I don't have any notes to that effect.

Q. Between November 9th and November 18th, did you ever advise him to follow-up with any of the other physicians who had seen him in the hospital during that October 21st admission?

A. I don't have any notes to that effect, but it was the typical practice of the plastic surgeon to make his own follow-up appointments with the patients that he operated on. I don't know if Dr. Kota would have made his own follow-up appointments with the patient, again,

through their independent offices.

Q. But there's no indication that yo told him go see Dr. Kota or go and see any of the other doctors that he saw during that October 21st, 2011 admission; correct?

A. No.

Q. Mr. Simeone presented to Brookhaven Hospital on November 18th, 2011; is that correct?

A. Yes.

Q. Were there any visits with you at your office between November 9th and November 18th, 2011?

A. I don't have any record of visits.

Q. Were there any telephone calls made by Mr. Simeone or anyone else on his behalf between November 9th, 2011 and November 18th, 2011?

A. We don't have any records of that.

Q. Did your office follow up with Mr. Simeone between November 9th, 2011 and November 18th, 2011 to determine how he was

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doing during that time period?

A. I don't have any records about that.

Q. If your office had made a phone call, is that something that would be inputted into the computer?

A. Typically, yes.

Q. When you say typically, that was the policy and procedure?

A. Yes.

MR. WARYWODA: Off the record.

(Whereupon, a discussion was held off the record.)

MR. WARYWODA: Back on the record.

Q. Now, November 18th, 2011 Mr. Simeone presented to Brookhaven Hospital for an abdominal pelvic CT with contrast; true?

A. Yes.

Q. According to the report of dated November 18, 2011 at 1331, time, it says that it was "ordered by Alexios Apazidis". That's you; correct?

A. Yes.

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Q. Do you remember when you ordered that CT scan?

A. No, I don't have a note to go along with that order.

Q. Sitting here today, do you recall any contact by Mr. Simeone to you where you ordered a CT scan around this time period of November 18th, 2011?

A. I mean, I don't have any records of it. I do recall him being in my office and me sending him to the hospital, but I don't know if that was after.

MR. RATH: That's after.

THE WITNESS: That's after.

A. So I don't recall how this occurred.

Q. You said you recall him being in your office and you sending him to the hospital. What about that do you recall?

A. That was, I think, the subsequent visit.

Q. Was that on the 21st of November?

A. Yes. Yes. Three days, yeah.

Q. That's when he was admitted to

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the hospital and some surgeries were performed; correct?

A. Yes.

Q. All right. Your office at Long Island --

A. Orthopedic & Spine Specialists.

Q. Yes. Did you have access in your office to CT films if they were taken at Brookhaven Hospital?

A. Yes.

Q. So as you sit here today, do you, personally, remember reviewing the CT scan of November 18th, 2011?

A. I don't remember personally reviewing this test.

Q. Sitting here today, do you recall why it was you referred Mr. Simeone for an abdominal pelvic CT with contract?

A. Well, apparently, the history given by the radiologist who performed the test is that to rule out unspecified intestinal obstruction.

Q. Do you know what complaints it was that Mr. Simeone made to you in order

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for you to refer him for a CT scan on November 18th, 2011?

A. Unfortunately, I don't have a record of it. I don't remember why.

Q. Are there any abnormal findings on this CT scan?

A. There are patchy infiltrates of both lower lobes, which it says were present on the chest CT scan of 10/28/2011. It does say some partial clearing of his infiltrates have occurred since the prior study.

There's a hepatic cyst. There is a calcified gallstone. There i s diverticulosis of the descending and sigmoid colon. There is a small left inguinal hernia. The surgical findings of "status post-discectomy at L4/5 and at L5 S1 and laminectomy at L5 with associated posterior spinal fusion bilaterally of L4 to S1 with metallic bars and screws in place in the posterior lumbar spine region."

Surgical clips were noted. There were post-surgical changes in the intramuscular and in the subcutaneous fatty

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tissues. Those are the only abnormalities noted.

Q. Okay. This CT scan with contrast of the abdomen and pelvis, is that a test that you would prescribe if you were concerned of a post-surgical site infection?

A. Yes.

Q. What is it you would be looking for or what is it you would see on a CT scan of the abdomen and pelvis with contrast where you would say this patient is suffering from a post-surgical site infection?

A. You would see a collection of fluid that is enhancing with the IV contrast.

Q. When you reviewed the CT scan, do you recall whether or not you saw a collection of fluid?

A. I don't recall the exact event of me looking at this. So I can't tell you what I saw and what I didn't see.

Q. Is there any indication here that the radiologist was looking for a post

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surgical site infection here?

A. Well, he mentions in detail the structures of the spine and the surgical site. So he looked in the area.

Q. Isn't it common for the radiologist if they were looking for an infection, whether an abscess or collection of fluid, they would write in their report no collection of fluid seen or words to that effect?

MR. RACH: Note my objection.

If you can answer, you can answer.

A. That is definitely verbiage that is used commonly.

Q. Is that verbiage anywhere within this CT scan report?

A. No, I don't see them using those exact words.

Q. Okay. Sitting here today, and just so we have it clear for the record, is there anything that you recall about any contact that Mr. Simeone made to you that caused you to order this CT scan on November 18th, 2011?

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A. I don't remember.

Q. Do you remember having a conversation with him between November 9th, 2011 and November 18th, 2011 with regards to whether or not he was continuing to have fevers?

A. I don't remember.

Q. Now, your November 9th, 2011 note, it says, "We will keep track of his fever profile"; right?

A. Yes.

Q. When you had a patient that you were going to keep track of his fever profile, would you tell your nurses or someone to contact the patient within a certain amount of days just so you could keep track of his fever profile?

A. It would depend on the patient. Some patients are more reliable than others. If a patient seemed very reliable, you know, able to take care of themselves, I would rely on the patient to document the temperatures and let me know if they are having a temperature. If a patient didn't

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really appear capable of doing that, then we might employ a Visiting Nursing Service.

Q. When you said not capable of doing that, what do you mean by that?

A. If they don't have a thermometer at home. If they are illiterate and can't write. Sometimes they can't keep it together enough to keep a notebook to document fevers or things like that. If it appeared to be something above their ability to do and there was a concern, then we would try to get a visiting nurse to visit the patient and take vital signs, if the resources were there to do it.

Q. Now, you mentioned that Mr. Simeone had a Visiting Nurse Service after the surgery; correct?

A. Standard practice is that all my patients have a visiting nurse come to see them. It depends on how many times they see them. That is definitely a variable. But again, if the insurance will provide for it, I always like to have a nurse visit the patient within a couple of days of being

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discharged at home.

Q. That's my question. Do you recall, sitting here today, are there any notes that you have reviewed in preparation for your deposition to indicate whether or not Mr. Simeone had Visiting Nurse Service at his house?

A. After the first surgery?

Q. Correct.

A. I do not have any notes here specific for that. I don't see that I have the discharge planner's notes. They work in the hospital. My standard practice was that all my patients had a Visiting Nurse Service assigned to them.

Q. When you say you don't see the discharge planner's notes, are you saying that there's a copy of something in the medical records that should be there but isn't? Now, I'm just trying to ask you in terms of whether we have the entire chart?

A. There are people called discharge planner's, and they are the ones who arrange for the Visiting Nurse Service.

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I don't see any notes from them here. I don't know if that's a part of the chart or it's part of the hospital records or what that's a part of, but I don't have it.

Q. Now, if there was no Visiting Nurse Service ordered would there not be a discharge planner's note in the record?

A. No, there's always a discharge planner there.

Q. You just don't see that note?

A. I don't have anything from the discharge planning department.

Q. Do you recall whether you formed a differential diagnosis after the getting the abdominal CT with contrast test of November 18th, 2011?

A. I don't recall what my assessment of the CT scan was at the time.

Q. Now, Mr. Simeone presented to the hospital on November 21st, 2011; is that correct?

A. Yes.

Q. Prior to him be going to the

hospital, did he go to your office?

A. Yes.

Q. Is there an office record for November 21st, 2011?

A. There is not.

Q. Do you know why there isn't one if he presented to your office?

A. Because I was going to see him in the hospital. So I didn't make a note. I didn't bother making the note in my office because I was going to see him across the street in the hospital where I did dictate the admission somewhere.

Q. When you said you were going to see him in the hospital across the street, he came to your office and you thought that his complaints were severe enough for him to go to the hospital; correct?

A. Yes.

Q. You were going to follow him there and see him there?

A. Yes.

Q. Doctor, you generated you said an admission note for this admission; is that

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correct?

A. Yes.

MR. WARYWODA: Can you mark this?

(Whereupon, an admission note for 11/21/11 was marked Plaintiff's Exhibit No. 3F for identification, as of this date.)

Q. Doctor, you dictated an admission note; correct?

A. Yes.

Q. That's what we marked as Plaintiff's Exhibit 3F; correct?

A. Yes.

Q. The history of present illness, that is Mr. Simeone's complaints to you; is that correct?

A. Yes.

Q. It says, the first line of history of present illness, it says, "The patient approximately one month status post interior, posterior lumbar procedure for fusion and for the last week or two he has been having some spiking temperatures, which

self-resolve or go away with Tylenol." Do you see that?

A. Yes.

Q. Do you remember where you got that information from where he told you that he had spiking temperatures, which self-resolve or go away with Tylenol; did he tell you that?

A. I think that that has -- I don't remember the specific conversation we had, but that seems to be the history that we've uncovered here.

Q. How does that seem to be the history that you have uncovered here?

A. Well, it said in the ER record that he had reported some temperatures. When I saw him on November 9th, well, I think he said he went to the emergency room with a low grade fever.

Q. Well, let me go back to November 9th, 2011 note, did you take his temperature on that day?

A. I did not.

Q. Why not?

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A. I don't know. The thermometer that we had --

MR. RACH: Don't guess. Only if you know.

THE WITNESS: Okay.

A. I don't know why or why not.

Q. Was there anything wrong with the electrical thermometer at your office in November of 2011?

A. I don't know.

Q. Well, I believe you started to indicate that there was evidence in certain records that prior to November 21st, 2011, that the temperature would self-resolve or go away with Tylenol.

What evidence in the records, prior to November 21st, 2011, indicates that these spiking temperatures would self-resolve or go away with Tylenol?

A. He must have told me that.

Q. So just because you made, I'll call it, a comment before you started looking through the records. Is there any evidence in the medical records that he had

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spiking temperatures over the, approximate, one month that would self-resolve or go away with Tylenol?

MR. RACH: Other than that statement in the admission note?

MR. WARYWODA: Yes.

A. Well, when he first went to the emergency room on November 8th, he had told them that he had a temperature. However, in the ER, he didn't have a temperature. So it resolved.

Q. Well, he had a rectal temperature on that day of 101.9; is that correct?

A. That's correct. Again, I don't know what the normal range of rectal temperatures are. They are higher than oral temperatures. However, the oral temperatures around the same time period were normal. I don't know what caused him to get a temperature.

Q. It says, "However, he presented on the day of admission with swelling and fluctuance in the area of the lumbar wound." Do you see that?

A. APAZIDIS, M.D.

A. Yes.

Q. Sitting here today, do you recall what it looked like; what the surgical wound looked like?

A. I do.

Q. What do you recall?

A. I remember that Jimmy took his shirt off and the area of the surgery was raised and red and warm.

Q. Now, it says, "Previously he had CT scan, which ruled out any collections either in the lumber or the abdomen areas. However, did show consolidation of the lower lobes of the lungs diagnosing him with pneumonia and was placed on Levaquin for pneumonia." Who placed him on Levaquin?

A. I don't know. I don't know who placed him on Levaquin.

Q. On this November 8th, 2011, the documents that we have before us, is there any indication that he was given Levaquin by the hospital on November 18th, 2011?

A. No.

Q. Is there any indication in your

A. APAZIDIS, M.D.

records from your office that he was prescribed Levaquin between November 18th, 2011 and November 21st, 2011?

A. I do not have that.

Q. Do you know where you got that information from based on Levaquin for pneumonia?

A. I don't know where I got that information from.

Q. Levaquin is for pneumonia; is that correct?

A. Yes.

Q. Levaquin is used to treat what type of condition or infections?

A. All types.

Q. You've heard the term gram-positive and gram-negative infections?

A. Yes.

Q. Levaquin, is that a gram-positive or a gram-negative?

A. I'm not a infectious disease specialist --

MR. RACH: Note my objection.

You can answer it.

A. APAZIDIS, M.D.

Q. To you knowledge. What you know.

A. It is effective against gram-positive. I believe it has some effectiveness against gram-negative as well. It's not my area.

Q. Is Levaquin prescribed to treat post-surgical site infections?

A. Not typically.

Q. When you saw not typically, is it ever prescribed for that?

A. I suppose it might be.

Q. Have you ever prescribed Levaquin for a post-surgical site infection?

A. Not to my recollection, no.

MR. WARYWODA: Off the record.

(Whereupon, a discussion was held off the record.)

MR. WARYWODA: Back on the record.

Q. At this presentation on November 21st Mr. Simeone had 102 fever?

A. Yes.

Q. It says, "His white count was 27"; correct?

A. APAZIDIS, M.D.

A. Yes.

Q. Is that extremely high?

A. Yes.

Q. You said that "four days after the CT scan he presented with increase swelling in the area of the lumbar wound and area of fluctuance." Do you see that?

A. Yes.

Q. What is fluctuance?

A. That's a feeling of fluid under the skin.

Q. And under assessment, why don't you read that? Under assessment what did you write?

A. "This is a patient with a likely hematogenous spread of infection from his pneumonia to the area of the surgical wound and hardware who needs irrigation and debridement and likely muscle flap mobilization."

Q. What is a hematogenous spread of infection?

A. That's when the infection spreads from one part of the body to another by

bloodstream.

Q. How is it you came to the opinion that it's likely hematogenous spread of infection from his pneumonia to the area of the surgical wound?

A. Because the CT scan three or four days prior showed no evidence of any fluid or collection or signs of infection. But it did show signs of an pneumonia. So the supposition was that since he had had no infection four days before but now had an infection, where did it come from and the only site that we have here is this consolidation in the lungs or an pneumonia in the lungs.

Q. That was your assessment on the date of admission?

A. Yes.

Q. At that time you booked him to go in the operating room?

A. Yes.

Q. When did Mr. Simeone undergo his first operation during this admission?

A. 11/22.

A. APAZIDIS, M.D.

Q. Who was the surgeon?

A. Dr. Candito Fuentes.

Q. Were you present during that surgery?

A. I am sure I was.

Q. I'm only asking because you --

A. Yes. If you look on the -- well, a says page 1 of 1. But I'm listed there as assistant for the 11/22. But for some reason on the other side for assistant slot is blank.

Q. That's why I'm asking. So there's a report of operation, which is a one short paragraph, and you're listed as the assistant. Do you see that?

A. Yes.

Q. So was that a report of the operation an addendum, so to speak, of the report of operation of 11/22/2011 where the surgeon is listed as Candito Fuentes Felix?

A. Is what, the one where I'm listed as assistant?

Q. Correct.

A. I don't think it's an addendum.

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What it appears to be is, perhaps, he started to dictate, you know, listed me as the assistant and it looks like it was cut off. So, maybe, the phone line or the dictation machine might have clicked or cut off. Then it looks like he then restarted to dictate, but maybe neglected to mention that I was the assistant thinking that he mentioned it earlier. I can only speculate on that.

Q. Right.

A. That's what it appears like what happened.

Q. Okay. Sitting here today, do you recall being present for the November 22nd, 2011 surgery?

A. Yes.

Q. Okay. Did you ever dictate your own operative report or report of what occurred during that operation?

A. As the assistant, I do not have to dictate a second operative report.

Q. So you didn't; correct?

A. I don't think I did, no.

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Q. During this surgery an abscess was found; correct?

A. Yes.

Q. Where was the abscess found?

A. It was a full thickness down to the level of the hardware and down to the level of the bone and spine.

Q. Did you do anything during this surgical procedure?

A. Well, as the assistant, I would assist him in evacuating the purulent material. I would take away any areas that -- assist him in taking away any areas that I thought were or we thought were necrotic or, you know, dead muscle or dead tissue.

We did do an ostectomy of the spinous processes that would help us to bring the muscle back together again. Anything you can take out at that point that's not actually necessary would be helpful. That would be something I would probably assist him with. Then we placed drains and a vacuum dressing.

Q. After this surgery of November

22nd, 2011, did you form an opinion, to a reasonable degree of medical certainty, as to what the cause of the abscess that was found during the surgery was?

A. As I said in my admission note, it seems that it was a hematogenous spread from his pneumonia.

Q. Was your opinion the same after the November 22nd, 2011 surgery as it was in your admission note?

A. Yes. There wouldn't -- I mean the surgery itself wouldn't -- I don't think would show me anything to the contrary of that. You can see that there's an infection, but you can't see where it came from. The history and the radiographic date of the CT scan on the 18th would seem to lend itself to that story.

Q. Now, on the November 18th, 2011 CT scan report, it documents that this study was compared to the prior CT scan of the chest on October 28th, 2011; correct?

A. Yes.

Q. It indicates that "there was some

partial clearing of the infiltrates have occurred since prior study"; is that correct?

A. Yes.

Q. Is infiltrate another way of saying pneumonia?

A. Yes. Not exactly, but yes.

Q. So what on this November 18th, 2011 CT scan indicates to you that pneumonia was present?

A. The infiltrates.

Q. Now, there is an indication that after this CT scan Levaquin was given; correct?

A. Yes, that's what I documented in my admission note.

Q. Was any medication given after the October 28th, 2011 CT scan to treat the infiltrates that were present then?

A. Looking at Dr. Trehan's notes who would be the person that I would consult on the treatment of the October 28th CT scan of the lungs, I don't see that he indicated that he was interested in prescribing

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antibiotics at that time.

Q. Sitting here today, do you know why he didn't?

MR. RACH: Just note my objection to that question.

Q. What you know.

A. Sure. I mean, so after surgery, especially prolonged surgery, we do sometimes see congestion in the lungs. It doesn't always mean pneumonia. Certainly, not in the first few days. So I don't think that he would be diagnosed with pneumonia at that time to necessitate treating with antibiotics. Particularly since we kind of had a sense that his problem was really more related to the ileus in terms of his white count and things like that.

But certainly on November 18th, which is almost a month later, persistent infiltrates in the lungs at that point would be more consistent with a diagnosis of pneumonia at that point, if that make sense.

Q. An infiltrate in the lungs other than pneumonia. What else would be causing

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an infiltrate in the lungs?

MR. RACH: Just note my objection to the extent that you can answer and it's not out of your field, you can answer.

A. In my experience with post-surgical patients, we do sometimes see patchy infiltrates in the lungs that can be related to atelectasis or mucous congestion. Unless there is further clinical suspicion or further evidence that this represents anything significant, it's not typically treated.

Q. Mucous congestion is different than pneumonia?

A. Yes, and is something that we see after surgery after intubation.

Q. When you say you, typically, see it after surgery, how long after surgery do you, typically, see these infiltrates before you would consider them to be pneumonia?

A. Well --

MR. RACH: Objection to form, but to the extent can answer, you can

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answer.

A. Let me say, I don't typically get CT scans of chests. After most of my surgical patients we don't need to. When it becomes necessary, we see it. I can tell you that it's certainly not always treated or diagnosed as pneumonia. That's why I have a pulmonologist, as well as an infectious disease doctor. My pulmonologist sees all my patients. He helps me differentiate whether it is something to be treated or something not to be treated.

Q. I appreciate that. But my question was a little more specific. You used the term we generally see infiltrates post-surgery or something to that affect. I'm trying to -- for you to explain that comment to me as to how many days after surgery would you normally see infiltrates in a patient?

MR. RACH: Note my objection to the extent that he said he normally doesn't get CT scans. But the patients that you do get CT scans, is

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there a normal --

Q. We'll adopt your attorney's question.

A. Or the patients that my pulmonologist may get chest X-rays on, three or four days after surgery is not uncommon to have some type of infiltrate or congestion, you know, after being intubated. It is not typically treated with antibiotics that I have seen.

Q. Now, I'm going to start at the end. You authored a discharge plan and instructions after at the end of this November 21st, 2011 admission; is that correct?

A. My discharge summary?

Q. Yes.

MR. WARYWODA: Can we mark this?

(Whereupon, a discharge summary was marked Plaintiff's Exhibit No. 3G for identification, as of this date.)

Q. Now, we have marked as Plaintiff's Exhibit 3G. Is that your

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discharge summary?

A. Yes.

Q. That indicates that you dictated it on December 6, 2011; is that correct?

A. Yes.

Q. During this hospital admission, was a wound vac placed on Mr. Simeone?

A. Yes.

Q. How many procedures did he undergo while he was in the hospital during for this admission?

A. Five.

Q. Were you present during all five procedures?

A. I don't believe I was.

Q. These five procedures, were they all related to the infection that brought him into the hospital on November 21st, 2011?

A. Yes.

Q. During the hospitalization, fluid was aspirated during that initial procedure on Mr. Simeone; correct?

A. Yes.

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Q. The culture came back as methicillin-resistant staphylococcus aureus?

A. I have a speako, not a typo, but a speako here. It's actually methicillin-sensitive staph aureus because the patient was treated with Nafcillin. If it were methicillin-resistant, he would have been treated with Vancomycin.

I believe what I had seen in the microbiology records was that it was indeed sensitive to multiple drugs. Dr. Rehang, again, who is the expert, recommended Nafcillin for long term treatment.

Q. So, initially, they thought it MRSA?

A. I don't think at any point it was believed to be MRSA. The initial reading was gram-positive cocci, which means typically, staph aureus, and then we wait, for the sensitivities.

I think, you know, I speak this and I, probably, said methicillin-sensitive staph aureus and the transcriber, everything to them is MRSA. So she transcribed MRSA.

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When I reviewed this for the final signing, it slipped my attention to correct it.

Q. Upon discharge Mr. Simeone was given the vac therapy to continue at home; correct?

A. Yes.

Q. Was a PICC line inserted during that hospitalization?

A. Yes.

Q. Did Mr. Simeone go home with a PICC line still in?

A. Yes.

Q. You prescribed certain medications for Mr. Simeone upon his discharge from the hospital; is that correct?

A. Yes.

MR. WARYWODA: Can you mark that?

(Whereupon, document was marked Plaintiff's Exhibit No. 3H for identification, as of this date.)

Q. What medications did you prescribe? Please tell me what medication

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and what it's prescribed for.

A. Effexor.

Q. What is that used for?

A. Actually, I have to double check. I'm not sure if I prescribe this. This may be a medication he was taking. So we list it here as a medication that he was normally taking and he can continue to take. I'm not immediately familiar with Effexor. I believe it is an anti-anxiety medication. He did have a history of anxiety. I think he was on it before and it was just continued.

Q. Dilaudid?

A. Sure. Next medication is Dilaudid, which is 2 milligrams, which is for pain. It's a short acting pain medication. Valium, which is a muscle relaxer. Nystatin powder. This is to be used on the skin because the long term antibiotics can sometimes cause candidiasis or fungal. He was a big guy, you know, full. So we, typically, prescribe that. And Nafcillin, which is the antibiotic Dr.

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Trehan recommended for long term treatment.

Q. You told him to follow up with you on December 12th, 2011; is that correct?

A. Yes.

Q. And Dr. Fuentes in one week, as well; correct?

A. Yes.

Q. Did you ever have a conversation with Dr. Fuentes as to what he believed the cause of the abscess was that was found on November 22nd, 2011?

A. I'm sure we must have discussed it, but I don't remember a specific conversation.

Q. This is the November 22nd, 2011 note authored by you?

A. Yes. I saw the patient on November 22nd, 2011.

Q. What's the time of that note?

A. 0200 hours.

Q. Can you slowly for the record read that?

A. Sure. "Hospital day 2, with increased white blood cell and swelling at

lumbar wound. Physical examination, neurovascularly intact distally. Assessment and plan, to OR today for incision and drainage with Dr. Fuentes. Pain control, ID consult with Dr. Trehan, pneumonia Vancomycin."

Q. After discharge from the hospital on December 6th, 2011, Mr. Simeone followed up in your office?

A. Yes.

Q. That was December 12th, 2011; correct?

A. Yes.

Q. At that point he still had the wound vac on?

A. Yes.

Q. "History per patient" it says, "There have been several issues with the pump machine and it has been replace three times." Do you see that?

A. Yes.

Q. Do you remember what problems, if any, he was having with the pump machine?

A. I don't specifically remember. I

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can speculate.

Q. I don't want you to speculate. Can you tell me when the last time Mr. Simeone say you was?

A. Looks like June 11th of 2012.

Q. On that day under history presentation it says, "47 year old male presents with complaints of pain"; correct?

A. Yes.

Q. It says, "Complaint of radiation of pain to both buttocks. Left side is worse to the leg on the left side." Do you see that?

A. Yes.

Q. It says, "Patient continues to have episodes of low back pain. He also had persistent numbness and tingling around his wound, buttock area and groin"; correct?

A. Yes.

Q. Did you ever form an opinion as to what the cause of the persistent numbness and tingling around his wound and buttock area and around his groin was on his June 11, 2012 visit?

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A. Yes.

Q. What was your opinion?

A. That he had, secondary to the infection and manner of healing for the infection, that there was some persistent nerve irritation likely from scar tissue formation.

Q. From the infection?

A. Yes, I mean from the healing of the infection. When you heal from an infection, you lay down scar tissue and that can certainly irritate nerve roots. I should say also, around the wound itself -- we expect numbness around the wound. So that is secondary just to the fact that the skin was cut and you're going do have numbness around there.

Q. Did you perform range of motion testing on him at that visit?

A. I did.

Q. What was his range of motion?

A. Approximately, forty-five degrees of flexion and no extension.

Q. Did you form an opinion, to a

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reasonable degree of medical certainty, as to what the cause of forty-five degree limitation of flexion and extension was?

A. Again, he did have lumbar fusion on two levels. The bottom two levels would be primarily responsible for a lot of forward function movement as opposed to the upper three.

Also, the fact that he did have an area of infection that had filled in with scar tissue, as was our intention, and that would cause some limitations to excursion of the musculature in the back.

Q. Now, under assessment you say "Patient is healed from his infection". He wasn't using the wound vac at that point; is that correct?

A. He was not.

Q. So when you say he is healed from his infection, what do you mean by that?

A. That he has filled in his wound with noninfected and stable healthy tissue, that he no longer needs antibiotics and that there's no longer any active infection in

place.

Q. It says, "His back pain situation is slowly improving, but I believe that he may be at maximal medical improvement." Do you see that?

A. Yes.

Q. What is it you mean by that?

A. I mean at this point he's about six months out of the surgery. He is a few months of no longer needing a wound vac. He over his infection. I don't know how much further improvement he is going do get in terms of -- you know, for a maximal medical improvement, we look at things like range of motion, function and so forth.

It may be that I was being asked by an insurance company to document maximal medical improvement. Maybe that's why I put it in my notes. Sometimes I know insurance companies want to know in, typically, six months after surgery is a time point when they want your opinion as to if he's going to get better or worse or whatever they do with that.

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Q. Someone's condition six months out after surgery, is that an indicator to you as a physician as to what the prognosis holds for that patient after surgery?

MR. RACH: Just note my objection. You can answer the question.

A. Yes, six months would be a reasonable time point. Certainly, we can see improvement past that. Again, for the purposes, typically, for the insurance companies and disability companies and so forth, six months is the point that they have references when they want MMI opinions.

Q. I'm also talking about, isn't the reason why the insurance companies want this six months out what the condition is then is because as a doctor that's considered how the patient is six months out is a good indication as to how the patient is going to be continuing thereafter?

MR. RACH: Just note my objection, but you can answer.

A. It's certainly a very fair time

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point to make that opinion.

Q. Now, the last sentence of the assessment says, "The energy of the injury was significant enough to cause complete degeneration of his disc." When you say the energy of the injury, what are you talking about?

A. The car accident that initially caused him to this have this condition.

Q. Now, as your assessment you said, "lumbar radiculopathy". So on that day Mr. Simeone, he was still suffering from lumbar radiculopathy; is that correct?

A. Well, let's see.

Q. Well, it says, "He has persistent numbness and tingling around his wound, buttock area and groin"; is that correct?

A. Yes. That's not exactly -- radiculopathy would more refer to the long nerve findings. I mean, he still had some decreased strength on both the right and left. I think I was basing the diagnosis of radiculopathy that based on the fact that he still had some decreased strength in the

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lower extremities.

Q. Do you have an opinion, to a reasonable degree of medical certainty, as to what the cause of the decrease in strength was on June 11th, 2012?

A. In this setting of a patient who had a infection and significant wound treatment afterwards, when you have them stand on their toes, it may hurt. They may not be able to do it very well. Not because they're week, but because it hurts their back when they do it. So if you have them walk on their heals, it hurts their back when they do it.

So I don't think that it was actual nerve damage that was causing the weakness. I say that because he had a negative straight leg raise test and he also had intact sensation. So the motor weakness was more likely related to back pain rather than nerve damage.

I think keeping the lumbar radiculopathy diagnosis in the assessment section, perhaps, might have been more

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historical than what was actually going on at the time there.

Q. Well, the back pain that you documented on June 11th, 2012, did you form an opinion, to a reasonable degree of medical certainty, as to that being caused by the infection?

A. Well, certainly, after healing an infection and the necessary muscle mobilization, it's possible that you can have chronic back pain from that.

MR. RACH: He's not asking you in general. He's asking about this patient.

A. Right, for this patient. It's difficult for me to pinpoint the exact source of his back pain. He did have significant injury to his lumbar spine. He had to undergo fusion. So he's been in the absence of infection. Sometimes patients have back pain after these surgeries. That's a well documented phenomenon.

He had the addition of an infection that was healed. So it's

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difficult to say which one thing was causing his back pain. He had reasons to have back pain to start off with.

Q. Your findings on June 11th, 2012, the back pain that Mr. Simeone was complaining to you, did you ever form an opinion, to a reasonable degree of medical certainty, as to whether that back pain was being caused by infection, surgery, the surgery itself, the fusion itself, both or you don't have an opinion one way or the other?

A. I mean, I have an opinion. As I was kind of just saying, he no longer had an infection at this point. So infection itself would be a source of back pain. But healing an infection, which does lead to scar tissue formation, which is what we want, that could certainly be a source of back pain.

What I just meant to say was that, even in the absence of an infection and healing that infection. You could have back pain. Unfortunately, it's something

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that we live with. We do, you know, spine surgery and some of our patients go on to have back pain.

Q. I understand that. Did you ever form an opinion, to reasonable medical certainty, as to what the cause of Mr. Simeone's back pain was on June 11th, 2012?

A. Yes.

Q. What was your opinion?

A. Scar tissue formation from healing his infection and from a phenomenon called pain after spinal surgery. Some people call it failed back syndrome. We like to call it pain after spinal surgery because his back didn't fail. He did fuse. However, he just continues to have back pain.

Q. Now, failed back surgery syndrome, isn't that a condition where someone has a back surgery and they continue to have the same complaints they had prior to the surgery?

A. I don't know that it's ever been definitively defined. We tend to use this

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term of failed back surgery to refer to people who have pain after surgery.

But we are trying to be more specific. So if there is someone who say had failed to fused and has back pain, well, he has pseudarthrosis. He doesn't have failed back surgery.

But in someone who has fused, but continues to have back pain, we call that pain after spinal surgery. The surgery didn't fail, he fused. The purpose was to fuse him and he did. But the pain is the component that we don't have a good grasp on.

Q. During the spinal fusion on October 21st, 2011, were you able to perform all procedures that you intended to when you went in that day?

A. Yes.

Q. Were there any conditions present on October 21st, 2011 that were there prior to the surgery that you are unable to correct during the surgery of October 21st, 2011?

A. No.

Q. When Mr. Simeone was discharged from the hospital, from that November 21st, 2011 admission, you said that Nafcillin was prescribed; correct?

A. Yes.

Q. Was that continued; was he receiving Nafcillin within the hospital and it was just continued after?

A. Yes.

Q. Do you know who it was that prescribed that Nafcillin?

A. Dr. Trehan.

Q. From October 21st, 2011 until June 11th, 2012, which we have said that that was the last time you saw Mr. Simeone was June 11, 2012; is that correct?

A. According to my records, yes.

Q. Do you remember any visits after June 11th, 2012?

A. I don't remember any. I don't have any records of any.

Q. Do you remember any conversations you ever had with Mr. Simeone after June

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11th, 2012?

A. I do not.

Q. Between October 21st, 2011 and June 11th, 2012, did you ever prescribe any antibiotics for Mr. Simeone?

A. The Nafcillin prescription, I may have renewed that in conjunction with working with Dr. Trehan, because he was seeing me in the office and most of the visiting nurse and infusion services contact point would be to me.

So I believe Dr. Trehan didn't have an out of the hospital office or a contact point. So my habit in these types of cases would be to deal with him by phone and tell him what's going on with the patient. Should we continue it, stop it, change it and I would renew Nafcillin with the infusion service.

MR. RACH: Just to be clear, do you mean separate and apart from the prophylactic antibiotics given intraoperatively?

MR. WARYWODA: Correct.

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Q. So other than the Nafcillin and the Ancef that you say was administered intraoperatively on October 21st --

A. 21st and 22nd.

Q. Well, there is no indication in the record that the Ancef was given post-surgery; correct?

A. It's ordered. I don't have the pharmacy records.

Q. There is no indication that it was administered; correct?

A. I don't have any evidence before me that it was or it was not.

Q. Okay. But there is evidence that it was administered during the surgery?

A. Yes.

Q. Other than the Ancef being administered during the surgery and the Nafcillin that was prescribed on discharge from the November 21st, 2011 hospitalization and the renewals of the Nafcillin, did you prescribe any other antibiotics for Mr. Simeone?

A. No, I did not.

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Q. At some point you received a copy of this lawsuit; correct?

A. Yes.

Q. After you received this lawsuit, from that time until today, have you spoken to any doctors about the care and treatment provided to Mr. Simeone?

A. No.

Q. Have you ever spoken to Dr. Trehan from the time you received this Summons and Complaint until today about James Simeone?

A. No.

Q. How a Dr. Kota, between receiving the lawsuit and today, have you ever spoken to Dr. Kota about Mr. Simeone?

A. I have not.

Q. The physician who is doing the monitoring pursuant to the terms of your suspension, did you ever have him review a copy of any of the treatment records of Mr. Simeone?

A. No.

Q. Did you ever have a conversation

with Dr. Fuentes between the time you received the lawsuit and today about Mr. Simeone?

A. No.

Q. Did you ever have a conversation with Dr. Fuentes about whether or not he believed the abscess found during the November 21st, 2011 surgery, what the cause of that abscess was?

A. I don't remember having a conversation with him about the origin.

Q. Did you ever have a conversation with any infectious disease physician as to what they believe the cause of the abscess was that was found during the November 21st, 2011 admission?

A. I don't remember, but it certainly is possible that I discussed with Dr. Trehan.

Q. Do you recall what the conversation was?

A. No, I don't have a specific recollection of it. But it's a conversation I might have had with him because he is the

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specialist.

Q. But sitting here today, you don't remember one way or the other what Dr. -- you said Trehan --

A. Trehan.

Q. -- what Dr. Trehan's opinion was with regards to what the cause of the abscess was?

A. No, I don't remember any such conversation.

MR. RACH: If you don't remember, just say you don't remember.

A. I don't remember.

MR. WARYWODA: Doctor, I have no further questions. Thank you.

(Continued on the following page to include the signature and jurat.)

A. APAZIDIS, M.D.

(Whereupon, the examination of this witness was concluded at 4:13 p.m.)

* * * *

STATE OF NEW YORK)
)ss:
COUNTY OF SUFFOLK)

I have read the foregoing record of my testimony taken at the time and place noted in the heading hereof and I do hereby acknowledge it to be a true and correct transcript of same.

ALEXIOS APAZIDIS, M.D.

Subscribed and sworn to
before me this day
of , 2016.

Notary Public

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INFORMATION TO BE SUPPLIED

Search be done for any encounters or phone messages from Visiting Nurse Service who may have called in 30

C E R T I F I C A T I O N

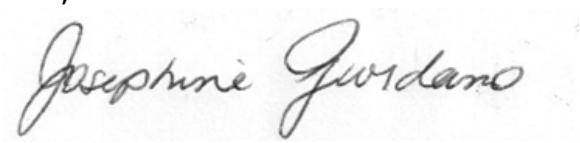
STATE OF NEW YORK)
: S.S.:
COUNTY OF)

I, JOSEPHINE GIORDANO, a Notary Public for and within the State of New York, do hereby certify:

That the testimony in the within proceeding was held before me at the aforesaid time and place. That said witness was duly sworn before the commencement of the testimony, and that the testimony was taken stenographically by me, then transcribed under my supervision, and that the within transcript is a true record of the testimony of said witness.

I further certify that I am not related to any of the parties to this action by blood or by marriage, that I am not interested directly or indirectly in the matter in controversy, nor am I in the employ of any of the counsel.

IN THE WITNESS WHEREOF, I have hereunto set my hand this of , 2016.



JOSEPHINE GIORDANO

ERRATA SHEET
VERITEXT LEGAL SOLUTIONS
800-227-8440
ASSIGNMENT NO. NJ2325567
CASE NAME: Simeone, James v. Apazidis MD, Alexios
DATE OF DEPOSITION: 6/6/2016
WITNESS' NAME: Alexios Apazidis

PAGE/LINE(S)/ CHANGE REASON
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____
Alexios Apazidis
(Notary not required in California)
SUBSCRIBED AND SWORN TO
BEFORE ME THIS______DAY
OF_______________, 2016.

____
NOTARY PUBLIC
MY COMMISSION EXPIRES__________________

n

o

p

New York Code

Civil Practice Law and Rules

Article 31 Disclosure, Section 3116

(a) Signing. The deposition shall be submitted to the witness for examination and shall be read to or by him or her, and any changes in form or substance which the witness desires to make shall be entered at the end of the deposition with a statement of the reasons given by the witness for making them. The deposition shall then be signed by the witness before any officer authorized to administer an oath. If the witness fails to sign and return the deposition within sixty days, it may be used as fully as though signed. No changes to the transcript may be made by the witness more than sixty days after submission to the witness for examination.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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