

1 SUPREME COURT OF THE STATE OF NEW YORK
2 COUNTY OF SUFFOLK

3 - - - - - X

4 JAMES SIMEONE,

5 Plaintiff,

6 -against-

Index No.
063791/13

7 ALEXIOS APAZIDIS, M.D. and BROOKHAVEN
8 MEMORIAL HOSPITAL MEDICAL CENTER,
9 Defendants.

10 - - - - - X

11 2174 Jackson Avenue
12 Seaford, New York

13 June 6, 2016
14 10:13 a.m.

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

22
23
24
25 Job No. NJ2325567

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

PARKER WAICHMAN, LLP

Attorneys for the Plaintiff

6 Harbor Park Drive

Port Washington, New York 11050

BY: NICHOLAS E. WARYWODA, ESQ.

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Attorneys for the Defendants

2174 Jackson Avenue

Seaford, New York 11783

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.

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

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

6 BY THE COURT REPORTER:

7 Q. Please state your name for the
8 record.

9 A. Alexios Apazidis.

10 Q. Please state your address for the
11 record.

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

15 EXAMINATION BY

16 MR. WARYWODA:

17 Let's have these marked.

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

22 Q. Good morning, Doctor.

23 A. Good morning.

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

1 A. APAZIDIS, M.D.

2 I am going to be asking you some questions
3 today.

4 You've been deposed before;
5 correct?

6 A. I have.

7 Q. How many times?

8 A. Twice, I guess.

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

12 A. Yes.

13 Q. When was the last time you were
14 deposed?

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

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

20 A. I don't know.

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

23 A. Stephen.

24 Q. The same firm that represents you
25 today?

1 A. APAZIDIS, M.D.

2 A. Yes.

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

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

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

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

13 A. Yes.

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

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

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

25 A. I think initially the allegation

1 A. APAZIDIS, M.D.

2 was there was insufficient pre-surgical
3 treatment.

4 Q. What kind of surgery was it?

5 A. It was lumbar fusion.

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

8 A. Yes.

9 Q. What's the name?

10 A. Robels (phonetic).

11 Q. Robels is the last name?

12 A. Yes.

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

15 A. I have no idea.

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

18 A. No.

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

22 A. I guess, couple of months ago.

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

25 A. Pasquale (phonetic).

1 A. APAZIDIS, M.D.

2 Q. The same attorneys represent you
3 in that action?

4 A. Yes. Well, it was his partner.

5 Q. Same firm?

6 A. Yes.

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

9 A. No.

10 Q. What does that case involve?

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

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

15 A. No.

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

20 A. Sure.

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

1 A. APAZIDIS, M.D.

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

4 A. Sure.

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

8 A. Thank you.

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

12 A. Yes.

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

15 A. Can I see?

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

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

1 A. APAZIDIS, M.D.

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

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

5 Q. What is the address of that?

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

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

10 A. I guess about nine months.

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

14 A. Yes, I have a satellite office in
15 21 Washington Avenue, Brentwood, New York
16 and 27 West Columbia Street, Hempstead, New
17 York.

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

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

1 A. APAZIDIS, M.D.

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

5 A. No.

6 Q. What field of medicine do you
7 currently practice?

8 A. Orthopedic surgery.

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

11 A. 2008.

12 Q. Are you board certified?

13 A. Yes.

14 Q. In what?

15 A. Orthopedic surgery.

16 Q. When did you become board
17 certified?

18 A. 2012.

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

21 A. Yes.

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

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

1 A. APAZIDIS, M.D.

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

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

11 A. No.

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

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

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

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

22 Q. What was the date of that
23 suspension?

24 A. June 18th of 2015.

25 Q. As a result that suspension, you

1 A. APAZIDIS, M.D.

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

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

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

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

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

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

18 A. Yes.

19 Q. The suspension is thirty-six
20 months?

21 A. Yes.

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

25 A. It's something called a practice

1 A. APAZIDIS, M.D.

2 monitor.

3 Q. Who is your practice monitor?

4 A. It's anonymous.

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

8 A. The state requires him to remain
9 anonymous.

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

14 A. Yes.

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

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

25 Q. In your past have you ever

1 A. APAZIDIS, M.D.

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

6 A. Yes. Independent Medical
7 Examination, yes.

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

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

12 Q. Do you still perform them today?

13 A. No.

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

17 MR. RACH: Note my objection.

18 His license was not suspended. It is
19 now on probation. He stills practices
20 medicine.

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

1 A. APAZIDIS, M.D.

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

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

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

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

23 A. I believe so, yes.

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

1 A. APAZIDIS, M.D.

2 year?

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

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

10 A. Yes.

11 Q. When did you first become a
12 member there?

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

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

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

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

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

25 Q. Were you ever licensed to

1 A. APAZIDIS, M.D.

2 practice in New Jersey?

3 A. No.

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

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

12 Q. What kind of testing?

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

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

1 A. APAZIDIS, M.D.

2 MR. RACH: Just note my

3 objection. You can answer.

4 A. Yes.

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

8 A. No.

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

12 A. Yes.

13 Q. Were you employed by them at one
14 time?

15 A. Yes.

16 Q. When did you first become
17 employed there?

18 A. August 2nd, 2010.

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

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

25 Q. When you were employed with Long

1 A. APAZIDIS, M.D.

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

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

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

20 A. Orthopedic surgeon.

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

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

1 A. APAZIDIS, M.D.

2 served two years on the medical board of the
3 hospital.

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

9 A. No.

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

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

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

15 A. Same day.

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

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

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

25 A. Yes.

1 A. APAZIDIS, M.D.

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

4 A. Orthopedic surgery.

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

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

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

20 A. Yes.

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

25 A. I do. I remember the patient.

1 A. APAZIDIS, M.D.

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

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

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

21 A. Yes. He had a very real problem.

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

1 A. APAZIDIS, M.D.

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

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

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

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

15 A. It does whatever it wants.

16 Q. What do you mean by that?

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

1 A. APAZIDIS, M.D.

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

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

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

25 A. I have no idea.

1 A. APAZIDIS, M.D.

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

7 A. Correct.

8 Q. What I'm going to do is we have
9 marked as Plaintiff's Exhibit 2A and 2B. Can
10 you take a look through these and tell me is
11 there anything that you notice is missing
12 from this medical record, both these, 2A and
13 2B, that you think, well, I know something
14 is missing or there's a document that I
15 believe should be part of this chart that's
16 not here?

17 MR. RACH: Take your time.

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

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

1 A. APAZIDIS, M.D.

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

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

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

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

24 Q. Would you get copies of blood
25 test results?

1 A. APAZIDIS, M.D.

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

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

15 MR. RACH: Okay.

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

18 A. Sure. June 17, 2011.

19 Q. Were there any other orthopedic
20 surgeons who were working at Long Island
21 Orthopedic & Spine Specialists in June of
22 2011?

23 A. Yes.

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

1 A. APAZIDIS, M.D.

2 different orthopedic surgeon at the
3 practice?

4 A. I was the spine specialist at the
5 practice.

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

9 A. Correct.

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

12 A. Yes.

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

18 A. I would do both.

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

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

1 A. APAZIDIS, M.D.

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

7 I don't recall when I did more
8 dictating because it had some problems
9 initially. It wasn't working that well. So
10 I did do a lot of typing, initially. I
11 don't remember when, if it was a by June of
12 2011 or not, that I was doing more dictation
13 or more typing. There might be even entire
14 notes that I simply typed because it leant
15 itself more to typing, but I don't recall
16 specifically for this patient.

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

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

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

24 A. Yes.

25 Q. He told you that he had a

1 A. APAZIDIS, M.D.

2 previous surgery, a discectomy previously?

3 A. Yes.

4 Q. Do you read MRI films?

5 A. Yes.

6 Q. On that first visit in June 17th,
7 2011, did you perform an examination of him?

8 A. Yes.

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

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

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

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

1 A. APAZIDIS, M.D.

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

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

10 A. Yes.

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

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

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

20 A. Yes.

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

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

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

5 A. Yes.

6 Q. That was your interpretation; is
7 that correct?

8 A. Yes.

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

12 A. Yes.

13 Q. What do you mean by that?

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

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

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

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

25 A. Maybe, they follow a predictable

1 A. APAZIDIS, M.D.

2 course.

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

7 A. Yes.

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

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

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

1 A. APAZIDIS, M.D.

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

5 Q. Did you form a differential
6 diagnosis?

7 A. Yes.

8 Q. What was your differential?

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

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

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

1 A. APAZIDIS, M.D.

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

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

10 A. Yes.

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

14 A. Yes.

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

18 A. Yes.

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

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

1 A. APAZIDIS, M.D.

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

5 Q. Yes.

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

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

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

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

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

1 A. APAZIDIS, M.D.

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

10 Q. Now, the next time that
11 Mr. Simeone say you, was that on July 27,
12 2011?

13 A. Yes.

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

16 A. Yes.

17 Q. That's a phone message on July
18 14, 2011; is that correct?

19 A. Yes.

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

22 A. Yes.

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

1 A. APAZIDIS, M.D.

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

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

7 A. Yes.

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

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

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

22 Q. Do you remember, did you have a
23 conversation with Dr. O'Leary before July
24 27, 2011 about Mr. Simeone?

25 A. I don't remember having one with

1 A. APAZIDIS, M.D.

2 him.

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

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

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

11 A. I don't know.

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

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

7 A. Yes.

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

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

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

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

25 A. Yes.

1 A. APAZIDIS, M.D.

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

4 A. Yes.

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

8 A. Nothing that I recall, no.

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

11 A. Yes.

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

16 A. Yes.

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

19 A. Yes.

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

22 A. Yes.

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

25 A. Yes, and also, flexion of

1 A. APAZIDIS, M.D.

2 forty-five.

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

5 A. Yes.

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

8 A. Yes.

9 Q. What was your plan?

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

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

16 A. Yes.

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

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

1 A. APAZIDIS, M.D.

2 A. Because he seems to be getting
3 worse.

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

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

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

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

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

1 A. APAZIDIS, M.D.

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

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

14 A. Yes.

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

17 A. Yes.

18 Q. He had had the MRI by that point?

19 A. Yes.

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

22 A. Yes.

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

1 A. APAZIDIS, M.D.

2 Do you say that?

3 A. Yes.

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

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

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

12 A. Yes.

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

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

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

24 A. Yes.

25 Q. So at this point did you consider

1 A. APAZIDIS, M.D.

2 Mr. Simeone to be a surgical candidate?

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

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

11 A. Yes.

12 Q. Where he was asking about the
13 MRI?

14 A. Yes.

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

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

1 A. APAZIDIS, M.D.

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

4 A. September 23rd.

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

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

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

15 A. I did examine the patient, yes.

16 Q. What were your findings on your
17 physical exam?

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

25 Q. At this point, at this visit,

1 A. APAZIDIS, M.D.

2 what was your diagnoses; your differential
3 diagnoses of him?

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

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

9 A. Yes.

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

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

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

19 A. Yes.

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

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

1 A. APAZIDIS, M.D.

2 Q. You continued Ultracet; is that
3 correct?

4 A. Yes.

5 Q. What is Ultracet?

6 A. It's a pain medication.

7 Q. And Percocet?

8 A. It's also a pain medication.

9 Q. And Valium?

10 A. It's a muscle relaxer.

11 Q. What's Flexeril?

12 A. It's also a muscle relaxer.

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

16 A. Yes.

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

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

1 A. APAZIDIS, M.D.

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

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

8 A. No.

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

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

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

1 A. APAZIDIS, M.D.

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

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

15 A. I don't remember the specific
16 conversation.

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

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

1 A. APAZIDIS, M.D.

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

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

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

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

1 A. APAZIDIS, M.D.

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

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

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

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

25 A. We can never say one hundred

1 A. APAZIDIS, M.D.

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

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

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

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

24 A. Yes.

25 Q. There is a phone message from

1 A. APAZIDIS, M.D.

2 September 27th, 2011. Do you see that?

3 A. Yes.

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

8 A. Yes.

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

11 A. I spoke to him.

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

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

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

1 A. APAZIDIS, M.D.

2 procedure?

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

5 MR. RACH: Off the record.

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

8 MR. WARYWODA: Back on the
9 record.

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

13 A. Yes.

14 Q. That was for the surgical
15 procedure?

16 A. Yes.

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

19 A. Is there something in the
20 hospital record there?

21 MR. RACH: Off the record.

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

24 MR. WARYWODA: Back on the
25 record.

1 A. APAZIDIS, M.D.

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

4 Q. You performed a surgery during
5 this admission?

6 A. Yes.

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

10 A. He had a discectomy and fusion
11 operation.

12 Q. Was it both anterior and
13 posterior?

14 A. Yes.

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

19 A. Yes.

20 Q. Why was that?

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

25 Q. Prior to Mr. Simeone getting on

1 A. APAZIDIS, M.D.

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

5 A. Yes.

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

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

18 Q. Was it Dr. Chen?

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

1 A. APAZIDIS, M.D.

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

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

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

17 Q. Mr. Simeone, he underwent
18 presurgical testing?

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

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

24 A. Not that I know of right now.

25 Q. So pre-surgery his blood work all

1 A. APAZIDIS, M.D.

2 came back fine; correct?

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

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

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

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

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

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

22 A. Again, it would depend on the
23 infection.

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

1 A. APAZIDIS, M.D.

2 would perform surgery?

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

12 Q. What is an antibiotic?

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

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

18 A. Yes.

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

22 A. Yes.

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

25 A. Yes.

1 A. APAZIDIS, M.D.

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

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

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

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

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

15 A. Here it appears we used the
16 Stryker System.

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

22 A. Not by me.

23 Q. By anyone?

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

1 A. APAZIDIS, M.D.

2 don't have any recollection of it.

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

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

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

14 A. It would be Ancef.

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

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

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

1 A. APAZIDIS, M.D.

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

4 A. Yes.

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

9 A. During the anterior portion?

10 Q. During any portion of the
11 surgery.

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

14 THE WITNESS: Yes.

15 A. I did call for Dr. Candito
16 Fuentes.

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

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

1 A. APAZIDIS, M.D.

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

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

7 A. Yes.

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

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

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

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

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

1 A. APAZIDIS, M.D.

2 and ten percent; is that correct?

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

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

16 MR. RACH: Objection. You can
17 answer.

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

1 A. APAZIDIS, M.D.

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

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

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

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

18 A. No.

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

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

24 Q. Any others?

25 A. I have an online subscription to

1 A. APAZIDIS, M.D.

2 The Orthopedic Trauma Association, The
3 Journal of the Orthopedic Trauma Association
4 and The Spine Journal.

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

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

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

15 A. Yes.

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

18 A. Dr. Fuentes.

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

21 A. No.

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

1 A. APAZIDIS, M.D.

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

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

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

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

16 A. Correct.

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

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

1 A. APAZIDIS, M.D.

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

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

9 A. It was based on height and
10 weight.

11 Q. How long did the operation take?

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

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

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

1 A. APAZIDIS, M.D.

2 after surgery.

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

7 A. Ancef.

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

10 A. That is a nationwide surgical
11 protocol.

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

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

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

23 A. Posterior.

24 Q. Who performed the anterior?

25 A. Dr. Martin.

1 A. APAZIDIS, M.D.

2 Q. Who was Dr. Martin?

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

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

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

10 Q. What is an incisional vacuum
11 dressing?

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

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

25 A. It was something that we do

1 A. APAZIDIS, M.D.

2 rather routinely.

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

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

2 placed?

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

5 Q. On every patient?

6 A. Yes.

7 MR. RACH: Every?

8 Q. Every obese patient?

9 A. Yes.

10 MR. RACH: With a posterior
11 fusion?

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

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

23 A. Yes.

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

1 A. APAZIDIS, M.D.

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

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

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

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

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

16 Q. Is that for all posterior
17 fusions?

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

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

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

1 A. APAZIDIS, M.D.

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

5 A. Not that I recall or that are
6 documented.

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

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

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

15 A. Yes.

16 Q. It says "ortho surge"?

17 A. Ortho spine.

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

20 MR. RACH: Slowly.

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

1 A. APAZIDIS, M.D.

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

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

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

1 A. APAZIDIS, M.D.

2 22nd.

3 MR. WARYWODA: Let's mark this.

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

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

9 A. Yes.

10 Q. What was abnormal?

11 A. So his potassium was slightly
12 elevated at 5.5 with 5.1 being normal.
13 Glucose or sugar was slightly elevated at
14 140 with 110 being normal. The BUN was
15 slightly elevated at 24 with 18 being normal
16 and the creatinine was elevated at 1.7 with
17 1.3 being normal. The calcium was slightly
18 decreased at 8.0 with 8.5 being normal.

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

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

1 A. APAZIDIS, M.D.

2 are pretty much the reasons for increased
3 glucose.

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

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

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

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

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

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

25 Q. Could infection be a cause of a

1 A. APAZIDIS, M.D.

2 high BFN and creatinine?

3 A. It could.

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

2 concerned there may be an infection present?

3 A. In terms of routine blood
4 testing?

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

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

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

17 A. So something called an ESR and a
18 CRP.

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

22 A. For both, they would both be
23 elevated.

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

1 A. APAZIDIS, M.D.

2 A. Yes.

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

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

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

11 MR. RACH: Off the record.

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

14 MR. WARYWODA: Back on the
15 record.

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

19 A. Yes.

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

22 A. Yes.

23 Q. That was given by you?

24 A. Yes.

25 Q. From reviewing the record that

1 A. APAZIDIS, M.D.

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

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

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

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

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

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

14 A. Yes.

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

17 A. The 28th.

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

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

23 MR. WARYWODA: Let's mark this.

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

1 A. APAZIDIS, M.D.

2 identification, as of this date.)

3 Q. So we have marked as Exhibit 3C.

4 This is a note of Dr. Trehan?

5 A. Yes.

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

9 A. October 27th.

10 MR. WARYWODA: Just mark this,
11 please.

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

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

19 A. The top note.

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

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

1 A. APAZIDIS, M.D.

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

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

12 Pain control: Decrease narcotics
13 in face of ileus.

14 Electrolyte imbalance:
15 Hypokalemia impending. Potassium after
16 resolve the hypokalemia.

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

20 Q. Is that it?

21 A. That's it.

22 Q. Who is Dr. Kota?

23 A. He is a general surgeon.

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

1 A. APAZIDIS, M.D.

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

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

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

16 A. It's a cardiac enzyme.

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

19 A. No.

20 Q. When was the vac removed?

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

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

1 A. APAZIDIS, M.D.

2 A. It was removed on the 24th.

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

7 A. The wound was --

8 Q. What's the date of the note?

9 A. 10/24/2011.

10 Q. And time?

11 A. The time is noon, 12:00.

12 Q. Can you read that note for the
13 record?

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

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

19 A. There were.

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

22 A. October 23rd, 2011.

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

25 A. Yes.

1 A. APAZIDIS, M.D.

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

4 A. Yes.

5 Q. Is that high?

6 A. Yes.

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

10 A. Yes.

11 Q. What was it?

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

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

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

1 A. APAZIDIS, M.D.

2 was improving.

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

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

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

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

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

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

19 MR. WARYWODA: Sure.

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

1 A. APAZIDIS, M.D.

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

5 A. No, they were treating the ileus.

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

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

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

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

25 Q. With that information, you would

1 A. APAZIDIS, M.D.

2 determine a treatment plan; correct?

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

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

11 A. I treated his ileus.

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

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

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

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

1 A. APAZIDIS, M.D.

2 MR. WARYWODA: I understand.

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

8 A. Yes.

9 Q. What was your opinion?

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

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

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

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

23 A. No.

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

1 A. APAZIDIS, M.D.

2 correct?

3 A. Yes.

4 Q. The white blood cell count is 17;

5 correct?

6 A. Yes.

7 Q. That's high; correct?

8 A. Yes.

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

11 A. Marginally, yes.

12 Q. So it's gone up?

13 A. Yes.

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

16 A. Yes.

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

19 A. Yes.

20 Q. HCT, that's hematocrit?

21 A. Hematocrit, yes.

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

23 A. Yes.

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

1 A. APAZIDIS, M.D.

2 A. I check them on the computer.

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

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

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

16 A. No.

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

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

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

1 A. APAZIDIS, M.D.

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

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

10 A. Eighteen, in that range.

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

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

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

1 A. APAZIDIS, M.D.

2 post-surgical infection?

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

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

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

13 Q. Anything else?

14 A. That's what comes to mind.

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

18 A. Any of these things.

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

23 A. I'm always concerned about
24 infection.

25 Q. Why is that?

1 A. APAZIDIS, M.D.

2 A. Because we're surgeons.

3 Q. Why are you always concerned
4 about infection?

5 A. Because we take care of patients.

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

8 A. Well, we could harm the patient.

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

14 MR. RACH: Note my objection.

15 If you can answer, you can answer.

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

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

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

1 A. APAZIDIS, M.D.

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

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

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

1 A. APAZIDIS, M.D.

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

2 specific description.

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

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

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

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

21 A. Yes.

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

1 A. APAZIDIS, M.D.

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

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

6 Q. How is a CT guided aspiration
7 performed?

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

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

12 A. No, I order it.

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

16 A. Yes.

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

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

1 A. APAZIDIS, M.D.

2 500 cc's of blood loss would be expected in
3 a surgery like this. Again, we typically
4 would see a small decrease in the hemoglobin
5 numbers. As long as the patient doesn't
6 have cardiac risk factors or diabetes, and
7 most importantly, is not symptomatic. You
8 know, lightheaded, dizzy, things like. Then
9 we don't have to do anything about that.
10 Again, we expect to see a decrease in the
11 hematocrit or hemoglobin or red blood cell
12 count. Again, they are all markers for the
13 same thing.

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

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

1 A. APAZIDIS, M.D.

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

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

7 A. Yes.

8 Q. White blood cell count again,
9 15.1, still high; correct?

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

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

15 A. Still anemic; yes.

16 Q. Red blood cell count still low;
17 correct?

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

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

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

1 A. APAZIDIS, M.D.

2 ways to measure the same thing, which is
3 anemia.

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

10 A. Yes.

11 Q. What was it?

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

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

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

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

21 A. On the 28th.

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

1 A. APAZIDIS, M.D.

2 cell, hemoglobin and hematocrit?

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

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

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

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

1 A. APAZIDIS, M.D.

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

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

10 A. They were removed on the 27th,
11 27th or 28th. We, typically, remove them
12 when the output is low. In the presence of
13 infection, the output would be high.

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

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

18 Q. What notes are you referring to?

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

1 A. APAZIDIS, M.D.

2 without surgery.

3 Q. You wrote a note on October 28
4 2011 at 1700 hours; is that correct?

5 A. Yes.

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

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

16 Q. AP is assessment?

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

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

1 A. APAZIDIS, M.D.

2 Dr. Kota and Dr. Trehan."

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

6 A. Yes.

7 Q. Can you just read that now?

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

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

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

1 A. APAZIDIS, M.D.

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

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

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

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

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

25 Q. Now, there's a blood test result

1 A. APAZIDIS, M.D.

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

4 A. Yes.

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

8 A. Yes.

9 Q. White blood cell count is 13.2;
10 true?

11 A. Yes.

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

15 A. Yes.

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

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

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

25 A. Again, from my notes from these

1 A. APAZIDIS, M.D.

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

5 Q. Now, what, if anything, did you
6 do to rule out that it was a surgical
7 infection that was causing the elevated
8 white blood cell count on October 29th,
9 2011?

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

13 Q. That was on the 28th?

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

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

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

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

25 A. Dr. Trehan ordered for urine

1 A. APAZIDIS, M.D.

2 testing.

3 Q. What else did he order?

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

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

8 A. Yes. P.m.

9 Q. There's one and two there?

10 A. Yes, one and two.

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

13 MR. RACH: Impression.

14 Q. Impression?

15 A. Impressions. IMP.

16 Q. Same thing as diagnosis?

17 A. Uh-huh.

18 Q. Yes?

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

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

23 A. No.

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

1 A. APAZIDIS, M.D.

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

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

8 A. "Lumbar spine surgery."

9 Q. What does number two say?

10 A. Something "Leukocytosis".

11 Q. And what is the R0?

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

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

17 A. No.

18 Q. How about FN?

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

22 MR. RACH: Okay, don't guess.

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

25 Q. So it's a guess?

1 A. APAZIDIS, M.D.

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

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

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

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

12 A. Fourth line.

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

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

19 Q. Okay. What else can you read?

20 A. I think the third line says,
21 "blood cultures if temperature greater than
22 102", which is a typical recommendation.

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

25 A. If you get a temperature greater

1 A. APAZIDIS, M.D.

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

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

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

19 Q. What is your definition of an
20 infection?

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

23 Q. How about blood infection?

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

1 A. APAZIDIS, M.D.

2 Q. How about a surgical site
3 infection?

4 A. What about it?

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

7 A. An infection at the site of
8 surgery.

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

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

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

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

20 Q. Does it say "rule out CD"?

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

1 A. APAZIDIS, M.D.

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

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

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

11 A. Normal post-operative course.

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

15 MR. RACH: During this
16 admission?

17 MR. WARYWODA: During this
18 admission, yes.

19 A. There was just the discharge
20 instruction.

21 MR. WARYWODA: Let's mark this.

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

1 A. APAZIDIS, M.D.

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

5 A. Yes.

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

8 A. Yes.

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

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

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

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

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

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

23 Q. How about the Valium?

24 A. Valium is a muscle relaxer.

25 Q. And Colace?

1 A. APAZIDIS, M.D.

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

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

7 A. None was indicated.

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

12 A. I did not.

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

16 A. Yes.

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

22 A. Nothing.

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

1 A. APAZIDIS, M.D.

2 A. Yes.

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

6 A. Yes.

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

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

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

19 A. Nothing in these records, no.

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

25 A. Not necessarily.

1 A. APAZIDIS, M.D.

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

4 A. No.

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

7 A. Yes.

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

11 A. I have not.

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

17 A. Not that I'm aware of.

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

20 (Whereupon, a short recess was
21 taken.)

22 MR. WARYWODA: Back on the
23 record.

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

1 A. APAZIDIS, M.D.

2 8, 2011; is that correct?

3 A. Yes.

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

7 A. No, I did not.

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

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

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

16 A. Yes.

17 Q. Who was Dr. Artale?

18 A. He is an emergency room
19 physician.

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

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

25 Q. Is that on the page that on top

1 A. APAZIDIS, M.D.

2 it says page 6?

3 A. Yes.

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

9 A. No.

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

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

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

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

24 A. Yes.

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

1 A. APAZIDIS, M.D.

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

5 A. I'm sure there was.

6 Q. Are you seeing a record showing
7 the temperature?

8 A. Yes.

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

11 A. Yes.

12 Q. Is that a temperature?

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

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

21 A. Yes.

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

1 A. APAZIDIS, M.D.

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

4 A. Yes.

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

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

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

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

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

25 A. Give me the numbers.

1 A. APAZIDIS, M.D.

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

6 A. Infection of what?

7 Q. Post-surgical infection.

8 A. Yes.

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

11 A. Yes.

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

15 A. Yes.

16 Q. That would be a normal finding to
17 you?

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

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

24 A. Yes.

25 Q. A history is important so you

1 A. APAZIDIS, M.D.

2 know what complaints the person's making;
3 correct?

4 A. History is always important.

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

12 A. Well, I always tell patients if
13 they have any concerns to get in touch with
14 me, if they're concerned about anything.
15 There a some kind of standard hospital
16 discharge instructions. You know, some of
17 them, you know, if you have a fever above
18 101 or 101.5. I don't know exactly the
19 number that they typically tell patients.
20 Again, there are some standard discharge
21 instructions that all patients get.
22 Certainly, all post-surgical patients.

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

1 A. APAZIDIS, M.D.

2 their patients?

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

10 Q. Okay. Erythema, what is
11 erythema?

12 A. Redness.

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

16 A. Yes.

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

20 A. Yes.

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

23 A. Yes.

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

1 A. APAZIDIS, M.D.

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

4 A. Yes.

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

7 A. Yes.

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

11 A. Yes.

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

16 A. When the staples are removed.

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

19 A. As long as they have to.

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

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

1 A. APAZIDIS, M.D.

2 weeks.

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

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

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

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

1 A. APAZIDIS, M.D.

2 scan in this setting.

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

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

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

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

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

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

25 Q. Do you recall whether you formed

1 A. APAZIDIS, M.D.

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

6 A. Differential diagnosis of what?

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

9 Q. Did you form one?

10 A. Of what?

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

13 A. Differential diagnosis of what,
14 his presentation?

15 Q. What is a differential diagnosis?

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

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

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

1 A. APAZIDIS, M.D.

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

4 A. Yes.

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

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

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

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

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

17 A. Correct.

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

22 A. Yes.

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

1 A. APAZIDIS, M.D.

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

4 A. Yes.

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

8 A. Yes.

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

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

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

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

23 Q. That wasn't my question.

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

1 A. APAZIDIS, M.D.

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

7 Q. And redness around the surgical
8 site; correct?

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

11 Q. Where does it say that?

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

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

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

1 A. APAZIDIS, M.D.

2 further work-up.

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

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

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

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

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

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

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

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

1 A. APAZIDIS, M.D.

2 MR. RACH: Note my objection.

3 There's no way he could answer that
4 question.

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

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

10 A. Yes.

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

17 A. No, I didn't say that.

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

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

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

1 A. APAZIDIS, M.D.

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

5 A. Yes.

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

8 A. Examination of the patient.

9 Q. What kind of examination of the
10 patient?

11 A. Physical examination of the
12 patient.

13 Q. Consisting of what?

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

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

19 A. Yes.

20 Q. Fever; correct?

21 A. Yes.

22 Q. High white blood cell count;
23 correct?

24 A. Yes.

25 Q. Wound drainage; correct?

1 A. APAZIDIS, M.D.

2 A. Yes.

3 Q. Worsening pain; correct?

4 A. Yes.

5 Q. Anything else?

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

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

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

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

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

1 A. APAZIDIS, M.D.

2 A. Yes.

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

6 A. I would examine the patient.

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

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

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

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

1 A. APAZIDIS, M.D.

2 want you to read it.

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

8 A. Yes.

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

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

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

23 A. Okay.

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

1 A. APAZIDIS, M.D.

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

11 A. Yes.

12 Q. What else would be on your
13 differential diagnosis besides post-surgical
14 infection?

15 A. Other things that would be on the
16 diagnosis would be normal post-surgical
17 course.

18 Q. What else?

19 A. Resolving ileus. Other sources
20 of infection, such as lung, pneumonia,
21 atelectasis or urine, less likely in this
22 setting, but always possible, urine
23 infection.

24 Q. Anything else that would be part
25 of your differential diagnosis?

1 A. APAZIDIS, M.D.

2 A. That would be the top four or
3 five.

4 Q. So what would you do to rule out
5 -- let's start with resolving ileus. What
6 would you do to rule out that it's not
7 resolving ileus?

8 A. Well, is the patient having bowel
9 movements. Is the patient passing flatus
10 (phonetic). There's no definitive test. We
11 know that he had an ileus when he was in the
12 hospital, approximately, a week before this
13 presentation in the ER. Ileus do not --
14 it's not a light switch. Ileus is on, ileus
15 is off. We know he is having a resolving
16 ileus, although he was passing flatus,
17 having bowel movements and tolerating
18 intake. There's, you know --

19 Q. Which would be that the ileus has
20 resolved; correct?

21 A. Resolving, but again, it's not an
22 on and off switch. It certainly is
23 improving and we certainly had no reason to
24 keep him in the hospital at that status.

25 Q. Well, according to the doctor's

1 A. APAZIDIS, M.D.

2 note of prior to discharge, I believe it
3 said resolved with regards to ileus;
4 correct?

5 A. Yes. Dr. Kota's note said that
6 the ileus was resolved.

7 Q. That was as of October 29th?

8 A. Yes.

9 Q. Okay. Again, back to this
10 presentation, what would you do to rule out
11 post-surgical infection?

12 A. Check blood levels.

13 Q. So you go to the blood test?

14 A. Yes.

15 Q. What else, if anything?

16 A. Again, vital signs and an
17 examination of the patient.

18 Q. Are you saying a further
19 examination of the patient?

20 A. No, I mean the physical
21 examination of the patient, basic labs,
22 vital signs.

23 Q. What would you be looking for on
24 the blood test where it would lead you to
25 believe that this presentation and the

1 A. APAZIDIS, M.D.

2 complaints is being made because of a
3 post-surgical infection?

4 A. So when he was in the hospital,
5 the white blood cell count had been
6 decreasing down to, I think, a level of 13.
7 I think it was, approximately, 13. Now,
8 it's a week later. If the white count had
9 gone back up, that would be a sign of going
10 in the wrong direction.

11 Q. Anything else on the blood test
12 that you would look at to determine whether
13 or not it's post-surgical infection?

14 A. Nothing else on blood testing,
15 you know, on regular labs no.

16 Q. Low red blood cell count,
17 hemoglobin and hematocrit, could that be
18 caused by infection?

19 A. Chronic infection over, you know,
20 months or people who have these chronic
21 osteomyelitis, they do have anemia. It's
22 a condition called anemia of chronic
23 infection. Acute infections, no.

24 Q. Okay. How about high glucose.
25 Isn't high glucose a sign of a surgical site

1 A. APAZIDIS, M.D.

2 infection?

3 A. I mean high glucose can be a sign
4 of inflammation or it's an acute response,
5 but is far from specific for infection.

6 Q. Have you ever read any articles
7 in the medical literature that state that a
8 high glucose is a good indicator of whether
9 or not someone is suffering from a
10 post-surgical site infection?

11 A. I'm not familiar with any such
12 articles, no.

13 Q. So the only thing you would be
14 looking at on a blood test is white blood
15 cells to rule in or rule out post-surgical
16 site infection?

17 A. White blood cell count, yes.

18 Q. Anything else?

19 A. On basic labs?

20 Q. Sure.

21 A. No. Nothing else is really
22 specific, no.

23 Q. Now, according to this record of
24 November 8th, 2011, it says that the "ED
25 record was faxed to you." Do you see that?

1 A. APAZIDIS, M.D.

2 A. Yes. "ED record faxed to Dr.
3 Apazidis."

4 Q. That indicates it was on November
5 10, 2011; is that correct?

6 A. Yes.

7 Q. Sitting here today, do you ever
8 remember reviewing a copy of this ED record
9 prior to your review of the records for your
10 deposition?

11 A. Do I remember -- say it again?

12 MR. WARYWODA: Read it back,
13 please.

14 (Whereupon, the requested
15 question was read back by the
16 reporter.)

17 Q. Did you ever review a copy of the
18 these ED records prior to your review of the
19 records for your deposition?

20 MR. RATH: In other words, we
21 reviewed the records. Did you review
22 them before that?

23 A. I mean, no, other than at the
24 time.

25 Q. I'm asking, do you remember

1 A. APAZIDIS, M.D.

2 reviewing these records at the time?

3 A. Oh, at the time. I don't
4 remember, no. However, in my note of the
5 next day, I did document that I'm aware he
6 went to the emergency room.

7 MR. WARYWODA: Okay, I don't
8 have a note of the next day. Do you
9 have a note of the next day?

10 THE WITNESS: The 11/09 note.

11 MR. WARYWODA: Can you make a
12 copy of this?

13 MR. RATH: Off the record.

14 (Whereupon, a short recess was
15 taken.)

16 MR. WARYWODA: Back on the
17 record.

18 A. It says here that they were
19 created on 11/10. So I don't know if that
20 means it was faxed to me on 11/10, which
21 would be the day after I saw him in the
22 office. I don't know if that helps at all.

23 Q. My question was, after reading
24 that now does it refresh your recollection
25 of you actually reviewing the Brookhaven

1 A. APAZIDIS, M.D.

2 emergency record of November 8th, 2011 prior
3 to your review with your attorney?

4 A. I don't remember. I don't
5 remember having reviewed these records at
6 the time.

7 Q. So November 9th, 2011 Mr. Simeone
8 presented to your office; correct?

9 A. Yes.

10 Q. Did he make certain complaints to
11 you on that visit?

12 A. He reported that he went to the
13 emergency room because of temperatures of a
14 101.

15 Q. Was this visit of November 9th,
16 2011, was this scheduled prior to Mr.
17 Simeone presenting to the emergency room on
18 November 8th, 2011?

19 A. I don't know, but it is standard
20 for me to see the patient about two weeks
21 after surgery and this is within that
22 timeframe.

23 Q. Under ROS or review of symptoms,
24 it says "fever, yes" and it says "low
25 grade". Do you see that?

1 A. APAZIDIS, M.D.

2 A. Yes.

3 Q. What is considered a low grade
4 fever to you?

5 A. 101 and below.

6 Q. Now, it says, "weight loss" and
7 it says "yes", and it says "unintentional".
8 Do you see that?

9 A. Yes.

10 Q. It says "loss appetite, yes,
11 associated with weight loss". Do you see
12 that?

13 A. Yes.

14 Q. Is it expected by you for a
15 post-surgical patient to have weight loss?

16 A. Expected? No, I wouldn't say
17 it's expected.

18 Q. When Mr. Simeone told you that he
19 had weight loss unintentional, was that
20 concerning to you?

21 A. Well, of course it's concerning.

22 Q. Why is it concerning?

23 A. Well, we never want a patient to
24 have unintentional weight loss. But he did
25 have an ileus and he didn't eat for almost a

1 A. APAZIDIS, M.D.

2 week when he was in the hospital. He's,
3 probably, not eating much since he's been
4 home, again, with the resolving ileus.

5 Q. So do you remember, did you form
6 an opinion as to what the cause of the
7 unintentional weight loss was of Mr.
8 Simeone?

9 A. Again, I don't have a specific
10 memory of it. But looking at the evidence
11 here, I would have, you know, concluded that
12 the fact that he didn't eat for several days
13 in the hospital and that his resolving ileus
14 would lead to a decreased appetite. As well
15 as the necessary pain medication decreases
16 your appetite, narcotics, our appetite
17 suppresses. We have an explanation as to
18 his weight loss. When he says
19 unintentional, he's not dieting or
20 exercising to lose weight.

21 Q. You formed an assessment or it
22 says "assessment"; correct?

23 A. Yes.

24 Q. What was your assessment of him?

25 A. I thought he was doing well three

1 A. APAZIDIS, M.D.

2 weeks after the surgery in terms of the
3 spine issues. His pre-operative
4 radiculopathy had resolved. I said here,
5 obviously, the fevers are concerning. He
6 did have significant constipation and ileus
7 while in surgery and he was now having some
8 diarrhea, which I thought some of his weight
9 loss. Also, his intermittent fevers may
10 contribute to diarrhea or vise versa.
11 Diarrhea can contribute to fevers.

12 It says, "I do not see any signs
13 of a superficial or deep infection. We will
14 keep track of his fever profile." Some of
15 the words are mixed up. It says, "His labs
16 show a slight elevation in liver enzymes
17 likely related to the use of Percocet, which
18 has Tylenol in it."

19 Q. Now, just on that you said,
20 obviously, the fevers are concerning?

21 A. Yes.

22 Q. Did you form a differential
23 diagnosis on this November 9th, 2011 as to
24 what the possible causes of Mr. Simeone's
25 fever was?

1 A. APAZIDIS, M.D.

2 A. Yes.

3 Q. What was your differential?

4 A. Surgical site infection.

5 Diarrhea, ileus. That would be it.

6 Q. What, if anything, did you do in
7 terms of what did you order to rule out
8 whether or not the fevers were being caused
9 by a surgical site infection?

10 A. We were going to monitor the
11 patient closely.

12 Q. Monitor how; monitor what?

13 A. Ask him to keep track of the
14 fevers and bring him -- have him follow up
15 as scheduled.

16 Q. Follow up with you?

17 A. Yes.

18 Q. Now, Diarrhea, could diarrhea be
19 caused by a surgical sight infection?

20 A. I'm not familiar with surgical
21 site infection causing diarrhea,
22 specifically.

23 Q. Now, it says, you said "I do not
24 see any signs of a superficial or deep
25 infection." Do you see that?

1 A. APAZIDIS, M.D.

2 A. Yes.

3 Q. What signs were you looking for
4 where you would see signs; if you saw these
5 things, you would say I see signs of a
6 superficial or deep infection?

7 A. Sure. Swelling, Erythema,
8 tenderness, edema of the skin, worsening
9 back pain, worsening radiculopathy. That
10 would be it.

11 Q. Did you prescribe any medications
12 on this visit?

13 A. No.

14 Q. On this visit Mr. Simeone, prior
15 to coming to you, was not taking an
16 antibiotic; correct?

17 A. Correct.

18 Q. You didn't prescribe an
19 antibiotic; correct?

20 A. Yes.

21 Q. Why didn't you prescribe an
22 antibiotic on this visit?

23 A. I had no reason to.

24 Q. When you say you have no reason
25 to, what, if anything, were you doing to

1 A. APAZIDIS, M.D.

2 treat or try to lower his fever?

3 A. Well, the Percocet has Tylenol in
4 it, which is a fever reducer.

5 Q. On this visit did you ask him how
6 many days he was having a fever for?

7 A. I don't see that I documented
8 that.

9 Q. Now, you said, "We will keep
10 track of his fever profile." What is that;
11 is that something Mr. Simeone does, what is
12 that?

13 A. He would report to me if he was
14 continuing having fevers. Also, there's a
15 Visiting Nurse Service and they go to see
16 the patient typically they draw vital signs.

17 Q. Do you remember getting those
18 Visiting Nurse Service records for Mr.
19 Simeone between October 29th, 2011 and
20 November 9th, 2011?

21 A. I don't remember.

22 Q. Now, under plan, the procedure
23 codes, it says, "Electrical bone
24 stimulation." Do you see that?

25 A. Yes.

1 A. APAZIDIS, M.D.

2 Q. What is that?

3 A. So it's an external device. It's
4 an electrical bone stimulator. My protocol
5 for multilevel fusions is to employ this.
6 It's something that aids fusion.

7 Q. Does that mean you were
8 prescribing it on that day, the electric
9 bone stimulator?

10 A. I applied it that day. I gave it
11 to the patient, put it on him and showed him
12 how to use it. We would have applied for
13 this even before surgery. It takes some
14 time to obtain.

15 Q. For follow-up it says, "four
16 weeks". Do you see that?

17 A. Yes.

18 Q. Is that when you told him to come
19 back to your office in four weeks?

20 A. Yes. Typically, we made these
21 appointments two week, six week, twelve week
22 standard follow-ups after surgery.

23 Q. Did you give him any instructions
24 as to when to return if his fevers continued
25 for a certain amount of days?

1 A. APAZIDIS, M.D.

2 A. I don't remember specifically.

3 Q. Custom and practice; what would
4 your custom and practice be?

5 A. Call me if you have any concerns
6 or problems.

7 Q. When say if you have any concern
8 or problems, do you explain to them what
9 concerns or problems that should contact you
10 with?

11 A. I mean every case is different.
12 But I suppose for him, I would certainly say
13 if your fevers are persistent, come back and
14 see me sooner.

15 Q. Sitting here today, do you have
16 any recollection of having that conversation
17 with him?

18 A. No.

19 Q. If you did tell a patient return
20 to me if your fevers are persistent, would
21 you explain to them what persistent means or
22 what the duration of time it would have to
23 be for them to contact you?

24 A. I don't think so that I would go
25 into great detail about that. But lots of

1 A. APAZIDIS, M.D.

2 times patients ask the question, you know,
3 what do you mean, so I answer.

4 Q. What if they don't ask the
5 question or what if they do ask the
6 question, would you give them a date or
7 would you leave it up to them to determine
8 what a persistent fever is?

9 A. I mean, one thing we always -- if
10 the conversation is taking place, I would
11 say, you know, do you have fevers like
12 spiking at night. Those are more
13 concerning. That might be something that we
14 would have gone into about.

15 Q. Would you give them a definition
16 of what persistent means in terms of the
17 days of a fever in order for them to contact
18 you?

19 A. I don't think I would.

20 Q. Other than installing or applying
21 the electrical bone stimulator, did you
22 order anything else for Mr. Simeone after
23 this November 9th, 2011 visit?

24 A. Not that I'm aware of.

25 Q. Did you order a blood test?

1 A. APAZIDIS, M.D.

2 A. I doubt it, since he had one the
3 day before.

4 Q. Just so it's clear to me, why was
5 it that you didn't order a blood test on
6 this visit?

7 A. I had no reason to.

8 Q. Why is that?

9 A. I had lab values from the
10 previous day.

11 Q. Now, lab values from the previous
12 day, do you remember when you first received
13 them?

14 A. No, but I do have access to the
15 computer. I can see them at any time.

16 Q. Do you remember reviewing the lab
17 values on the previous day, on November 9th,
18 2011?

19 A. No. I don't have a specific
20 memory of that, no.

21 Q. If you had reviewed them, would
22 you have documented them in your report?

23 A. Not necessarily, but I might
24 have. I think if they were concerning, I
25 probably, would have documented. But if

1 A. APAZIDIS, M.D.

2 they were essentially normal, I'm not sure I
3 would necessarily have documented.

4 Q. Let's look at the November 8th,
5 2011 labs from Brookhaven. White blood cell
6 count is normal?

7 A. It's within the normal range,
8 yes.

9 Q. Red blood cell count, hemoglobin,
10 hematocrit are still low; correct?

11 A. Yes.

12 Q. Did you form an opinion as to why
13 Mr. Simeone's red blood cell, hemoglobin and
14 hematocrit were still low about eighteen
15 days post-op?

16 A. Yes.

17 Q. What was it?

18 A. Normal post-operative course.

19 Q. How about PLT, that's platelets?

20 A. Yes.

21 Q. It says "561". That's high;
22 right?

23 A. Yes.

24 Q. What are the possible causes of a
25 high platelet count?

1 A. APAZIDIS, M.D.

2 A. Surgery.

3 Q. When you say surgery, just the
4 surgery itself?

5 A. Post-operative course. You know,
6 hemoglobin goes down, platelets go up.

7 Q. How about infection; could
8 infection be a cause of high platelet count?

9 A. Yes.

10 Q. NE number sign, what is that?

11 A. Neutrophils.

12 Q. A high neutrophil, what are the
13 possible causes of a high neutrophil?

14 A. Neutrophils are a form of white
15 blood cells. You know, different types of
16 white blood cells.

17 Q. Could high neutrophils be caused
18 by post surgical infection?

19 A. Yes.

20 Q. How about M0 number sign; what
21 does that stand for?

22 A. Monocyte.

23 Q. That's 1.5; is that correct?

24 A. Yes.

25 Q. That's high?

1 A. APAZIDIS, M.D.

2 A. It's elevated, yes.

3 Q. What are the possible causes of a
4 high monocyte?

5 A. Infection.

6 Q. There's LY and a percentage sign,
7 10.3. What is that?

8 A. Lymphocytes.

9 Q. Low lymphocytes, what are the
10 possible causes of low lymphocytes?

11 A. You know, this a really getting
12 more into hematology. So I --

13 Q. Just what you know. I have
14 doctors tell me before they don't know what
15 the thing is. So you're not quite sure.
16 That's more for a hematologist; those are
17 the values that a hematologist would look at
18 and you as an orthopedic really wouldn't?

19 A. First of all, in the setting of a
20 normal white blood cell count, the
21 differential becomes less significant. But
22 if the white bloods cell count was elevated,
23 then we would look at shifts. But in a
24 setting of a normal white cell count, I am
25 not sure these would be that significant.

1 A. APAZIDIS, M.D.

2 But I think that a hematologist would be
3 better qualified to answer that question.

4 Q. But if someone has a normal white
5 blood cell count and a high platelet count,
6 that high platelet count could be caused by
7 a post-surgical infection; correct?

8 A. Among other things, yes.

9 Q. Among what other things?

10 A. Normal post-surgical course.

11 Platelets are what's called acute phase
12 reactants. So trauma, fracture, surgery is
13 going to elevate platelet count.

14 Q. So what's your expectation in
15 terms of when the platelet count will return
16 back to a normal range post-surgery?

17 A. Everyone is different, but a few
18 weeks.

19 Q. When you say a few weeks, what
20 are we talking?

21 A. Three to six weeks.

22 Q. MO percentage of 13.7; what is
23 MO?

24 A. I believe it stands for
25 monocytes.

1 A. APAZIDIS, M.D.

2 Q. Do you know what a high monocyte
3 can be caused by?

4 A. I don't really feel comfortable
5 evaluating the percentages of the white
6 blood cells in the setting of a normal white
7 blood cell count.

8 Q. That's fine. Urine analysis of
9 clarity it says "cloudy". That's abnormal;
10 correct?

11 A. Yes.

12 Q. Do you know what the possible
13 causes of cloudy urine could be?

14 A. Urinary tract infection.

15 Q. How about a surgical site
16 infection?

17 A. I'm not familiar with cloudy
18 urine being associated with a surgical site
19 infection.

20 Q. There was a trace of protein
21 found in his urine; is that correct?

22 A. Yes.

23 Q. If you saw a trace of protein on
24 someone's urinalysis, would you consider a
25 post-surgical site infection being a cause

1 A. APAZIDIS, M.D.

2 of it?

3 A. In isolation? No.

4 Q. What else would you have to see
5 along with a trace of protein in the urine
6 for you to include post-surgical site
7 infection on your differential?

8 A. Elevated white blood cell count
9 and physical exam findings consistent with
10 infection?

11 Q. Again, what physical exam
12 findings?

13 A. Swelling, edema, erythema,
14 tenderness, worsening pain.

15 Q. The same as your answer was
16 before. It doesn't have to be one of them
17 or two of them, it doesn't have to be all
18 inclusive; correct?

19 A. Of course, yes.

20 Q. Now, Mr. Simeone's glucose, we
21 started talking about this before. It says
22 "123 high". Do you see that?

23 A. Yes.

24 Q. Did you ever form an opinion as
25 to what the cause of Mr. Simeone's high

1 A. APAZIDIS, M.D.

2 glucose was on November 8th, 2011 test?

3 A. No.

4 Q. On this November 9th, 2011 after
5 this visit, between November 9th and
6 November 18th, 2011, did you ever advise or
7 prescribe Mr. Simeone to see an infectious
8 disease doctor?

9 A. Between November 9th and November
10 18th?

11 Q. Correct.

12 A. I don't have any notes to that
13 effect.

14 Q. Between November 9th and November
15 18th, did you ever advise him to follow-up
16 with any of the other physicians who had
17 seen him in the hospital during that October
18 21st admission?

19 A. I don't have any notes to that
20 effect, but it was the typical practice of
21 the plastic surgeon to make his own
22 follow-up appointments with the patients
23 that he operated on. I don't know if Dr.
24 Kota would have made his own follow-up
25 appointments with the patient, again,

1 A. APAZIDIS, M.D.

2 through their independent offices.

3 Q. But there's no indication that yo
4 told him go see Dr. Kota or go and see any
5 of the other doctors that he saw during that
6 October 21st, 2011 admission; correct?

7 A. No.

8 Q. Mr. Simeone presented to
9 Brookhaven Hospital on November 18th, 2011;
10 is that correct?

11 A. Yes.

12 Q. Were there any visits with you at
13 your office between November 9th and
14 November 18th, 2011?

15 A. I don't have any record of
16 visits.

17 Q. Were there any telephone calls
18 made by Mr. Simeone or anyone else on his
19 behalf between November 9th, 2011 and
20 November 18th, 2011?

21 A. We don't have any records of
22 that.

23 Q. Did your office follow up with
24 Mr. Simeone between November 9th, 2011 and
25 November 18th, 2011 to determine how he was

1 A. APAZIDIS, M.D.

2 doing during that time period?

3 A. I don't have any records about
4 that.

5 Q. If your office had made a phone
6 call, is that something that would be
7 inputted into the computer?

8 A. Typically, yes.

9 Q. When you say typically, that was
10 the policy and procedure?

11 A. Yes.

12 MR. WARYWODA: Off the record.

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

15 MR. WARYWODA: Back on the
16 record.

17 Q. Now, November 18th, 2011 Mr.
18 Simeone presented to Brookhaven Hospital for
19 an abdominal pelvic CT with contrast; true?

20 A. Yes.

21 Q. According to the report of dated
22 November 18, 2011 at 1331, time, it says
23 that it was "ordered by Alexios Apazidis".
24 That's you; correct?

25 A. Yes.

1 A. APAZIDIS, M.D.

2 Q. Do you remember when you ordered
3 that CT scan?

4 A. No, I don't have a note to go
5 along with that order.

6 Q. Sitting here today, do you recall
7 any contact by Mr. Simeone to you where you
8 ordered a CT scan around this time period of
9 November 18th, 2011?

10 A. I mean, I don't have any records
11 of it. I do recall him being in my office
12 and me sending him to the hospital, but I
13 don't know if that was after.

14 MR. RATH: That's after.

15 THE WITNESS: That's after.

16 A. So I don't recall how this
17 occurred.

18 Q. You said you recall him being in
19 your office and you sending him to the
20 hospital. What about that do you recall?

21 A. That was, I think, the subsequent
22 visit.

23 Q. Was that on the 21st of November?

24 A. Yes. Yes. Three days, yeah.

25 Q. That's when he was admitted to

1 A. APAZIDIS, M.D.

2 the hospital and some surgeries were
3 performed; correct?

4 A. Yes.

5 Q. All right. Your office at Long
6 Island --

7 A. Orthopedic & Spine Specialists.

8 Q. Yes. Did you have access in your
9 office to CT films if they were taken at
10 Brookhaven Hospital?

11 A. Yes.

12 Q. So as you sit here today, do you,
13 personally, remember reviewing the CT scan
14 of November 18th, 2011?

15 A. I don't remember personally
16 reviewing this test.

17 Q. Sitting here today, do you recall
18 why it was you referred Mr. Simeone for an
19 abdominal pelvic CT with contract?

20 A. Well, apparently, the history
21 given by the radiologist who performed the
22 test is that to rule out unspecified
23 intestinal obstruction.

24 Q. Do you know what complaints it
25 was that Mr. Simeone made to you in order

1 A. APAZIDIS, M.D.

2 for you to refer him for a CT scan on

3 November 18th, 2011?

4 A. Unfortunately, I don't have a
5 record of it. I don't remember why.

6 Q. Are there any abnormal findings
7 on this CT scan?

8 A. There are patchy infiltrates of
9 both lower lobes, which it says were present
10 on the chest CT scan of 10/28/2011. It does
11 say some partial clearing of his infiltrates
12 have occurred since the prior study.

13 There's a hepatic cyst. There is
14 a calcified gallstone. There i s
15 diverticulosis of the descending and sigmoid
16 colon. There is a small left inguinal
17 hernia. The surgical findings of "status
18 post-discectomy at L4/5 and at L5 S1 and
19 laminectomy at L5 with associated posterior
20 spinal fusion bilaterally of L4 to S1 with
21 metallic bars and screws in place in the
22 posterior lumbar spine region."

23 Surgical clips were noted. There
24 were post-surgical changes in the
25 intramuscular and in the subcutaneous fatty

1 A. APAZIDIS, M.D.

2 tissues. Those are the only abnormalities
3 noted.

4 Q. Okay. This CT scan with contrast
5 of the abdomen and pelvis, is that a test
6 that you would prescribe if you were
7 concerned of a post-surgical site infection?

8 A. Yes.

9 Q. What is it you would be looking
10 for or what is it you would see on a CT scan
11 of the abdomen and pelvis with contrast
12 where you would say this patient is
13 suffering from a post-surgical site
14 infection?

15 A. You would see a collection of
16 fluid that is enhancing with the IV
17 contrast.

18 Q. When you reviewed the CT scan, do
19 you recall whether or not you saw a
20 collection of fluid?

21 A. I don't recall the exact event of
22 me looking at this. So I can't tell you
23 what I saw and what I didn't see.

24 Q. Is there any indication here that
25 the radiologist was looking for a post

1 A. APAZIDIS, M.D.

2 surgical site infection here?

3 A. Well, he mentions in detail the
4 structures of the spine and the surgical
5 site. So he looked in the area.

6 Q. Isn't it common for the
7 radiologist if they were looking for an
8 infection, whether an abscess or collection
9 of fluid, they would write in their report
10 no collection of fluid seen or words to that
11 effect?

12 MR. RACH: Note my objection.

13 If you can answer, you can answer.

14 A. That is definitely verbiage that
15 is used commonly.

16 Q. Is that verbiage anywhere within
17 this CT scan report?

18 A. No, I don't see them using those
19 exact words.

20 Q. Okay. Sitting here today, and
21 just so we have it clear for the record, is
22 there anything that you recall about any
23 contact that Mr. Simeone made to you that
24 caused you to order this CT scan on November
25 18th, 2011?

1 A. APAZIDIS, M.D.

2 A. I don't remember.

3 Q. Do you remember having a
4 conversation with him between November 9th,
5 2011 and November 18th, 2011 with regards to
6 whether or not he was continuing to have
7 fevers?

8 A. I don't remember.

9 Q. Now, your November 9th, 2011
10 note, it says, "We will keep track of his
11 fever profile"; right?

12 A. Yes.

13 Q. When you had a patient that you
14 were going to keep track of his fever
15 profile, would you tell your nurses or
16 someone to contact the patient within a
17 certain amount of days just so you could
18 keep track of his fever profile?

19 A. It would depend on the patient.
20 Some patients are more reliable than others.
21 If a patient seemed very reliable, you know,
22 able to take care of themselves, I would
23 rely on the patient to document the
24 temperatures and let me know if they are
25 having a temperature. If a patient didn't

1 A. APAZIDIS, M.D.

2 really appear capable of doing that, then we
3 might employ a Visiting Nursing Service.

4 Q. When you said not capable of
5 doing that, what do you mean by that?

6 A. If they don't have a thermometer
7 at home. If they are illiterate and can't
8 write. Sometimes they can't keep it
9 together enough to keep a notebook to
10 document fevers or things like that. If it
11 appeared to be something above their ability
12 to do and there was a concern, then we would
13 try to get a visiting nurse to visit the
14 patient and take vital signs, if the
15 resources were there to do it.

16 Q. Now, you mentioned that Mr.
17 Simeone had a Visiting Nurse Service after
18 the surgery; correct?

19 A. Standard practice is that all my
20 patients have a visiting nurse come to see
21 them. It depends on how many times they see
22 them. That is definitely a variable. But
23 again, if the insurance will provide for it,
24 I always like to have a nurse visit the
25 patient within a couple of days of being

1 A. APAZIDIS, M.D.

2 discharged at home.

3 Q. That's my question. Do you
4 recall, sitting here today, are there any
5 notes that you have reviewed in preparation
6 for your deposition to indicate whether or
7 not Mr. Simeone had Visiting Nurse Service
8 at his house?

9 A. After the first surgery?

10 Q. Correct.

11 A. I do not have any notes here
12 specific for that. I don't see that I have
13 the discharge planner's notes. They work in
14 the hospital. My standard practice was that
15 all my patients had a Visiting Nurse Service
16 assigned to them.

17 Q. When you say you don't see the
18 discharge planner's notes, are you saying
19 that there's a copy of something in the
20 medical records that should be there but
21 isn't? Now, I'm just trying to ask you in
22 terms of whether we have the entire chart?

23 A. There are people called discharge
24 planner's, and they are the ones who arrange
25 for the Visiting Nurse Service.

1 A. APAZIDIS, M.D.

2 I don't see any notes from them
3 here. I don't know if that's a part of the
4 chart or it's part of the hospital records
5 or what that's a part of, but I don't have
6 it.

7 Q. Now, if there was no Visiting
8 Nurse Service ordered would there not be a
9 discharge planner's note in the record?

10 A. No, there's always a discharge
11 planner there.

12 Q. You just don't see that note?

13 A. I don't have anything from the
14 discharge planning department.

15 Q. Do you recall whether you formed
16 a differential diagnosis after the getting
17 the abdominal CT with contrast test of
18 November 18th, 2011?

19 A. I don't recall what my assessment
20 of the CT scan was at the time.

21 Q. Now, Mr. Simeone presented to the
22 hospital on November 21st, 2011; is that
23 correct?

24 A. Yes.

25 Q. Prior to him be going to the

1 A. APAZIDIS, M.D.

2 hospital, did he go to your office?

3 A. Yes.

4 Q. Is there an office record for
5 November 21st, 2011?

6 A. There is not.

7 Q. Do you know why there isn't one
8 if he presented to your office?

9 A. Because I was going to see him in
10 the hospital. So I didn't make a note. I
11 didn't bother making the note in my office
12 because I was going to see him across the
13 street in the hospital where I did dictate
14 the admission somewhere.

15 Q. When you said you were going to
16 see him in the hospital across the street,
17 he came to your office and you thought that
18 his complaints were severe enough for him to
19 go to the hospital; correct?

20 A. Yes.

21 Q. You were going to follow him
22 there and see him there?

23 A. Yes.

24 Q. Doctor, you generated you said an
25 admission note for this admission; is that

1 A. APAZIDIS, M.D.

2 correct?

3 A. Yes.

4 MR. WARYWODA: Can you mark
5 this?

6 (Whereupon, an admission note
7 for 11/21/11 was marked Plaintiff's
8 Exhibit No. 3F for identification, as
9 of this date.)

10 Q. Doctor, you dictated an admission
11 note; correct?

12 A. Yes.

13 Q. That's what we marked as
14 Plaintiff's Exhibit 3F; correct?

15 A. Yes.

16 Q. The history of present illness,
17 that is Mr. Simeone's complaints to you; is
18 that correct?

19 A. Yes.

20 Q. It says, the first line of
21 history of present illness, it says, "The
22 patient approximately one month status post
23 interior, posterior lumbar procedure for
24 fusion and for the last week or two he has
25 been having some spiking temperatures, which

1 A. APAZIDIS, M.D.

2 self-resolve or go away with Tylenol." Do
3 you see that?

4 A. Yes.

5 Q. Do you remember where you got
6 that information from where he told you that
7 he had spiking temperatures, which
8 self-resolve or go away with Tylenol; did he
9 tell you that?

10 A. I think that that has -- I don't
11 remember the specific conversation we had,
12 but that seems to be the history that we've
13 uncovered here.

14 Q. How does that seem to be the
15 history that you have uncovered here?

16 A. Well, it said in the ER record
17 that he had reported some temperatures.
18 When I saw him on November 9th, well, I
19 think he said he went to the emergency room
20 with a low grade fever.

21 Q. Well, let me go back to November
22 9th, 2011 note, did you take his temperature
23 on that day?

24 A. I did not.

25 Q. Why not?

1 A. APAZIDIS, M.D.

2 A. I don't know. The thermometer
3 that we had --

4 MR. RACH: Don't guess. Only
5 if you know.

6 THE WITNESS: Okay.

7 A. I don't know why or why not.

8 Q. Was there anything wrong with the
9 electrical thermometer at your office in
10 November of 2011?

11 A. I don't know.

12 Q. Well, I believe you started to
13 indicate that there was evidence in certain
14 records that prior to November 21st, 2011,
15 that the temperature would self-resolve or
16 go away with Tylenol.

17 What evidence in the records,
18 prior to November 21st, 2011, indicates that
19 these spiking temperatures would
20 self-resolve or go away with Tylenol?

21 A. He must have told me that.

22 Q. So just because you made, I'll
23 call it, a comment before you started
24 looking through the records. Is there any
25 evidence in the medical records that he had

1 A. APAZIDIS, M.D.

2 spiking temperatures over the, approximate,
3 one month that would self-resolve or go away
4 with Tylenol?

5 MR. RACH: Other than that
6 statement in the admission note?

7 MR. WARYWODA: Yes.

8 A. Well, when he first went to the
9 emergency room on November 8th, he had told
10 them that he had a temperature. However, in
11 the ER, he didn't have a temperature. So it
12 resolved.

13 Q. Well, he had a rectal temperature
14 on that day of 101.9; is that correct?

15 A. That's correct. Again, I don't
16 know what the normal range of rectal
17 temperatures are. They are higher than oral
18 temperatures. However, the oral
19 temperatures around the same time period
20 were normal. I don't know what caused him
21 to get a temperature.

22 Q. It says, "However, he presented
23 on the day of admission with swelling and
24 fluctuance in the area of the lumbar wound."
25 Do you see that?

1 A. APAZIDIS, M.D.

2 A. Yes.

3 Q. Sitting here today, do you recall
4 what it looked like; what the surgical wound
5 looked like?

6 A. I do.

7 Q. What do you recall?

8 A. I remember that Jimmy took his
9 shirt off and the area of the surgery was
10 raised and red and warm.

11 Q. Now, it says, "Previously he had
12 CT scan, which ruled out any collections
13 either in the lumber or the abdomen areas.
14 However, did show consolidation of the lower
15 lobes of the lungs diagnosing him with
16 pneumonia and was placed on Levaquin for
17 pneumonia." Who placed him on Levaquin?

18 A. I don't know. I don't know who
19 placed him on Levaquin.

20 Q. On this November 8th, 2011, the
21 documents that we have before us, is there
22 any indication that he was given Levaquin by
23 the hospital on November 18th, 2011?

24 A. No.

25 Q. Is there any indication in your

1 A. APAZIDIS, M.D.

2 records from your office that he was
3 prescribed Levaquin between November 18th,
4 2011 and November 21st, 2011?

5 A. I do not have that.

6 Q. Do you know where you got that
7 information from based on Levaquin for
8 pneumonia?

9 A. I don't know where I got that
10 information from.

11 Q. Levaquin is for pneumonia; is
12 that correct?

13 A. Yes.

14 Q. Levaquin is used to treat what
15 type of condition or infections?

16 A. All types.

17 Q. You've heard the term
18 gram-positive and gram-negative infections?

19 A. Yes.

20 Q. Levaquin, is that a gram-positive
21 or a gram-negative?

22 A. I'm not a infectious disease
23 specialist --

24 MR. RACH: Note my objection.

25 You can answer it.

1 A. APAZIDIS, M.D.

2 Q. To you knowledge. What you know.

3 A. It is effective against
4 gram-positive. I believe it has some
5 effectiveness against gram-negative as well.
6 It's not my area.

7 Q. Is Levaquin prescribed to treat
8 post-surgical site infections?

9 A. Not typically.

10 Q. When you saw not typically, is it
11 ever prescribed for that?

12 A. I suppose it might be.

13 Q. Have you ever prescribed Levaquin
14 for a post-surgical site infection?

15 A. Not to my recollection, no.

16 MR. WARYWODA: Off the record.

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

19 MR. WARYWODA: Back on the
20 record.

21 Q. At this presentation on November
22 21st Mr. Simeone had 102 fever?

23 A. Yes.

24 Q. It says, "His white count was
25 27"; correct?

1 A. APAZIDIS, M.D.

2 A. Yes.

3 Q. Is that extremely high?

4 A. Yes.

5 Q. You said that "four days after
6 the CT scan he presented with increase
7 swelling in the area of the lumbar wound and
8 area of fluctuance." Do you see that?

9 A. Yes.

10 Q. What is fluctuance?

11 A. That's a feeling of fluid under
12 the skin.

13 Q. And under assessment, why don't
14 you read that? Under assessment what did
15 you write?

16 A. "This is a patient with a likely
17 hematogenous spread of infection from his
18 pneumonia to the area of the surgical wound
19 and hardware who needs irrigation and
20 debridement and likely muscle flap
21 mobilization."

22 Q. What is a hematogenous spread of
23 infection?

24 A. That's when the infection spreads
25 from one part of the body to another by

1 A. APAZIDIS, M.D.

2 bloodstream.

3 Q. How is it you came to the opinion
4 that it's likely hematogenous spread of
5 infection from his pneumonia to the area of
6 the surgical wound?

7 A. Because the CT scan three or four
8 days prior showed no evidence of any fluid
9 or collection or signs of infection. But it
10 did show signs of an pneumonia. So the
11 supposition was that since he had had no
12 infection four days before but now had an
13 infection, where did it come from and the
14 only site that we have here is this
15 consolidation in the lungs or an pneumonia
16 in the lungs.

17 Q. That was your assessment on the
18 date of admission?

19 A. Yes.

20 Q. At that time you booked him to go
21 in the operating room?

22 A. Yes.

23 Q. When did Mr. Simeone undergo his
24 first operation during this admission?

25 A. 11/22.

1 A. APAZIDIS, M.D.

2 Q. Who was the surgeon?

3 A. Dr. Candito Fuentes.

4 Q. Were you present during that
5 surgery?

6 A. I am sure I was.

7 Q. I'm only asking because you --

8 A. Yes. If you look on the -- well,
9 a says page 1 of 1. But I'm listed there as
10 assistant for the 11/22. But for some
11 reason on the other side for assistant slot
12 is blank.

13 Q. That's why I'm asking. So
14 there's a report of operation, which is a
15 one short paragraph, and you're listed as
16 the assistant. Do you see that?

17 A. Yes.

18 Q. So was that a report of the
19 operation an addendum, so to speak, of the
20 report of operation of 11/22/2011 where the
21 surgeon is listed as Candito Fuentes Felix?

22 A. Is what, the one where I'm listed
23 as assistant?

24 Q. Correct.

25 A. I don't think it's an addendum.

1 A. APAZIDIS, M.D.

2 What it appears to be is, perhaps, he
3 started to dictate, you know, listed me as
4 the assistant and it looks like it was cut
5 off. So, maybe, the phone line or the
6 dictation machine might have clicked or cut
7 off. Then it looks like he then restarted
8 to dictate, but maybe neglected to mention
9 that I was the assistant thinking that he
10 mentioned it earlier. I can only speculate
11 on that.

12 Q. Right.

13 A. That's what it appears like what
14 happened.

15 Q. Okay. Sitting here today, do you
16 recall being present for the November 22nd,
17 2011 surgery?

18 A. Yes.

19 Q. Okay. Did you ever dictate your
20 own operative report or report of what
21 occurred during that operation?

22 A. As the assistant, I do not have
23 to dictate a second operative report.

24 Q. So you didn't; correct?

25 A. I don't think I did, no.

1 A. APAZIDIS, M.D.

2 Q. During this surgery an abscess
3 was found; correct?

4 A. Yes.

5 Q. Where was the abscess found?

6 A. It was a full thickness down to
7 the level of the hardware and down to the
8 level of the bone and spine.

9 Q. Did you do anything during this
10 surgical procedure?

11 A. Well, as the assistant, I would
12 assist him in evacuating the purulent
13 material. I would take away any areas that
14 -- assist him in taking away any areas that
15 I thought were or we thought were necrotic
16 or, you know, dead muscle or dead tissue.

17 We did do an ostectomy of the
18 spinous processes that would help us to
19 bring the muscle back together again.
20 Anything you can take out at that point
21 that's not actually necessary would be
22 helpful. That would be something I would
23 probably assist him with. Then we placed
24 drains and a vacuum dressing.

25 Q. After this surgery of November

1 A. APAZIDIS, M.D.

2 22nd, 2011, did you form an opinion, to a
3 reasonable degree of medical certainty, as
4 to what the cause of the abscess that was
5 found during the surgery was?

6 A. As I said in my admission note,
7 it seems that it was a hematogenous spread
8 from his pneumonia.

9 Q. Was your opinion the same after
10 the November 22nd, 2011 surgery as it was in
11 your admission note?

12 A. Yes. There wouldn't -- I mean
13 the surgery itself wouldn't -- I don't think
14 would show me anything to the contrary of
15 that. You can see that there's an
16 infection, but you can't see where it came
17 from. The history and the radiographic date
18 of the CT scan on the 18th would seem to
19 lend itself to that story.

20 Q. Now, on the November 18th, 2011
21 CT scan report, it documents that this study
22 was compared to the prior CT scan of the
23 chest on October 28th, 2011; correct?

24 A. Yes.

25 Q. It indicates that "there was some

1 A. APAZIDIS, M.D.

2 partial clearing of the infiltrates have
3 occurred since prior study"; is that
4 correct?

5 A. Yes.

6 Q. Is infiltrate another way of
7 saying pneumonia?

8 A. Yes. Not exactly, but yes.

9 Q. So what on this November 18th,
10 2011 CT scan indicates to you that pneumonia
11 was present?

12 A. The infiltrates.

13 Q. Now, there is an indication that
14 after this CT scan Levaquin was given;
15 correct?

16 A. Yes, that's what I documented in
17 my admission note.

18 Q. Was any medication given after
19 the October 28th, 2011 CT scan to treat the
20 infiltrates that were present then?

21 A. Looking at Dr. Trehan's notes who
22 would be the person that I would consult on
23 the treatment of the October 28th CT scan of
24 the lungs, I don't see that he indicated
25 that he was interested in prescribing

1 A. APAZIDIS, M.D.

2 antibiotics at that time.

3 Q. Sitting here today, do you know
4 why he didn't?

5 MR. RACH: Just note my
6 objection to that question.

7 Q. What you know.

8 A. Sure. I mean, so after surgery,
9 especially prolonged surgery, we do
10 sometimes see congestion in the lungs. It
11 doesn't always mean pneumonia. Certainly,
12 not in the first few days. So I don't think
13 that he would be diagnosed with pneumonia at
14 that time to necessitate treating with
15 antibiotics. Particularly since we kind of
16 had a sense that his problem was really more
17 related to the ileus in terms of his white
18 count and things like that.

19 But certainly on November 18th,
20 which is almost a month later, persistent
21 infiltrates in the lungs at that point would
22 be more consistent with a diagnosis of
23 pneumonia at that point, if that make sense.

24 Q. An infiltrate in the lungs other
25 than pneumonia. What else would be causing

1 A. APAZIDIS, M.D.

2 an infiltrate in the lungs?

3 MR. RACH: Just note my
4 objection to the extent that you can
5 answer and it's not out of your field,
6 you can answer.

7 A. In my experience with
8 post-surgical patients, we do sometimes see
9 patchy infiltrates in the lungs that can be
10 related to atelectasis or mucous congestion.
11 Unless there is further clinical suspicion
12 or further evidence that this represents
13 anything significant, it's not typically
14 treated.

15 Q. Mucous congestion is different
16 than pneumonia?

17 A. Yes, and is something that we see
18 after surgery after intubation.

19 Q. When you say you, typically, see
20 it after surgery, how long after surgery do
21 you, typically, see these infiltrates before
22 you would consider them to be pneumonia?

23 A. Well --

24 MR. RACH: Objection to form,
25 but to the extent can answer, you can

1 A. APAZIDIS, M.D.

2 answer.

3 A. Let me say, I don't typically get
4 CT scans of chests. After most of my
5 surgical patients we don't need to. When it
6 becomes necessary, we see it. I can tell
7 you that it's certainly not always treated
8 or diagnosed as pneumonia. That's why I
9 have a pulmonologist, as well as an
10 infectious disease doctor. My pulmonologist
11 sees all my patients. He helps me
12 differentiate whether it is something to be
13 treated or something not to be treated.

14 Q. I appreciate that. But my
15 question was a little more specific. You
16 used the term we generally see infiltrates
17 post-surgery or something to that affect.
18 I'm trying to -- for you to explain that
19 comment to me as to how many days after
20 surgery would you normally see infiltrates
21 in a patient?

22 MR. RACH: Note my objection to
23 the extent that he said he normally
24 doesn't get CT scans. But the
25 patients that you do get CT scans, is

1 A. APAZIDIS, M.D.

2 there a normal --

3 Q. We'll adopt your attorney's
4 question.

5 A. Or the patients that my
6 pulmonologist may get chest X-rays on, three
7 or four days after surgery is not uncommon
8 to have some type of infiltrate or
9 congestion, you know, after being intubated.
10 It is not typically treated with antibiotics
11 that I have seen.

12 Q. Now, I'm going to start at the
13 end. You authored a discharge plan and
14 instructions after at the end of this
15 November 21st, 2011 admission; is that
16 correct?

17 A. My discharge summary?

18 Q. Yes.

19 MR. WARYWODA: Can we mark
20 this?

21 (Whereupon, a discharge summary
22 was marked Plaintiff's Exhibit No. 3G
23 for identification, as of this date.)

24 Q. Now, we have marked as
25 Plaintiff's Exhibit 3G. Is that your

1 A. APAZIDIS, M.D.

2 discharge summary?

3 A. Yes.

4 Q. That indicates that you dictated
5 it on December 6, 2011; is that correct?

6 A. Yes.

7 Q. During this hospital admission,
8 was a wound vac placed on Mr. Simeone?

9 A. Yes.

10 Q. How many procedures did he
11 undergo while he was in the hospital during
12 for this admission?

13 A. Five.

14 Q. Were you present during all five
15 procedures?

16 A. I don't believe I was.

17 Q. These five procedures, were they
18 all related to the infection that brought
19 him into the hospital on November 21st,
20 2011?

21 A. Yes.

22 Q. During the hospitalization, fluid
23 was aspirated during that initial procedure
24 on Mr. Simeone; correct?

25 A. Yes.

1 A. APAZIDIS, M.D.

2 Q. The culture came back as
3 methicillin-resistant staphylococcus aureus?

4 A. I have a speako, not a typo, but
5 a speako here. It's actually
6 methicillin-sensitive staph aureus because
7 the patient was treated with Nafcillin. If
8 it were methicillin-resistant, he would have
9 been treated with Vancomycin.

10 I believe what I had seen in the
11 microbiology records was that it was indeed
12 sensitive to multiple drugs. Dr. Rehang,
13 again, who is the expert, recommended
14 Nafcillin for long term treatment.

15 Q. So, initially, they thought it
16 MRSA?

17 A. I don't think at any point it was
18 believed to be MRSA. The initial reading
19 was gram-positive cocci, which means
20 typically, staph aureus, and then we wait,
21 for the sensitivities.

22 I think, you know, I speak this
23 and I, probably, said methicillin-sensitive
24 staph aureus and the transcriber, everything
25 to them is MRSA. So she transcribed MRSA.

1 A. APAZIDIS, M.D.

2 When I reviewed this for the final signing,
3 it slipped my attention to correct it.

4 Q. Upon discharge Mr. Simeone was
5 given the vac therapy to continue at home;
6 correct?

7 A. Yes.

8 Q. Was a PICC line inserted during
9 that hospitalization?

10 A. Yes.

11 Q. Did Mr. Simeone go home with a
12 PICC line still in?

13 A. Yes.

14 Q. You prescribed certain
15 medications for Mr. Simeone upon his
16 discharge from the hospital; is that
17 correct?

18 A. Yes.

19 MR. WARYWODA: Can you mark
20 that?

21 (Whereupon, document was marked
22 Plaintiff's Exhibit No. 3H for
23 identification, as of this date.)

24 Q. What medications did you
25 prescribe? Please tell me what medication

1 A. APAZIDIS, M.D.

2 and what it's prescribed for.

3 A. Effexor.

4 Q. What is that used for?

5 A. Actually, I have to double check.
6 I'm not sure if I prescribe this. This may
7 be a medication he was taking. So we list
8 it here as a medication that he was normally
9 taking and he can continue to take. I'm not
10 immediately familiar with Effexor. I
11 believe it is an anti-anxiety medication.
12 He did have a history of anxiety. I think
13 he was on it before and it was just
14 continued.

15 Q. Dilaudid?

16 A. Sure. Next medication is
17 Dilaudid, which is 2 milligrams, which is
18 for pain. It's a short acting pain
19 medication. Valium, which is a muscle
20 relaxer. Nystatin powder. This is to be
21 used on the skin because the long term
22 antibiotics can sometimes cause candidiasis
23 or fungal. He was a big guy, you know,
24 full. So we, typically, prescribe that.
25 And Nafcillin, which is the antibiotic Dr.

1 A. APAZIDIS, M.D.

2 Trehan recommended for long term treatment.

3 Q. You told him to follow up with
4 you on December 12th, 2011; is that correct?

5 A. Yes.

6 Q. And Dr. Fuentes in one week, as
7 well; correct?

8 A. Yes.

9 Q. Did you ever have a conversation
10 with Dr. Fuentes as to what he believed the
11 cause of the abscess was that was found on
12 November 22nd, 2011?

13 A. I'm sure we must have discussed
14 it, but I don't remember a specific
15 conversation.

16 Q. This is the November 22nd, 2011
17 note authored by you?

18 A. Yes. I saw the patient on
19 November 22nd, 2011.

20 Q. What's the time of that note?

21 A. 0200 hours.

22 Q. Can you slowly for the record
23 read that?

24 A. Sure. "Hospital day 2, with
25 increased white blood cell and swelling at

1 A. APAZIDIS, M.D.

2 lumbar wound. Physical examination,
3 neurovascularly intact distally. Assessment
4 and plan, to OR today for incision and
5 drainage with Dr. Fuentes. Pain control, ID
6 consult with Dr. Trehan, pneumonia
7 Vancomycin."

8 Q. After discharge from the hospital
9 on December 6th, 2011, Mr. Simeone followed
10 up in your office?

11 A. Yes.

12 Q. That was December 12th, 2011;
13 correct?

14 A. Yes.

15 Q. At that point he still had the
16 wound vac on?

17 A. Yes.

18 Q. "History per patient" it says,
19 "There have been several issues with the
20 pump machine and it has been replace three
21 times." Do you see that?

22 A. Yes.

23 Q. Do you remember what problems, if
24 any, he was having with the pump machine?

25 A. I don't specifically remember. I

1 A. APAZIDIS, M.D.

2 can speculate.

3 Q. I don't want you to speculate.

4 Can you tell me when the last time Mr.

5 Simeone say you was?

6 A. Looks like June 11th of 2012.

7 Q. On that day under history

8 presentation it says, "47 year old male

9 presents with complaints of pain"; correct?

10 A. Yes.

11 Q. It says, "Complaint of radiation

12 of pain to both buttocks. Left side is

13 worse to the leg on the left side." Do you

14 see that?

15 A. Yes.

16 Q. It says, "Patient continues to

17 have episodes of low back pain. He also had

18 persistent numbness and tingling around his

19 wound, buttock area and groin"; correct?

20 A. Yes.

21 Q. Did you ever form an opinion as

22 to what the cause of the persistent numbness

23 and tingling around his wound and buttock

24 area and around his groin was on his June

25 11, 2012 visit?

1 A. APAZIDIS, M.D.

2 A. Yes.

3 Q. What was your opinion?

4 A. That he had, secondary to the
5 infection and manner of healing for the
6 infection, that there was some persistent
7 nerve irritation likely from scar tissue
8 formation.

9 Q. From the infection?

10 A. Yes, I mean from the healing of
11 the infection. When you heal from an
12 infection, you lay down scar tissue and that
13 can certainly irritate nerve roots. I
14 should say also, around the wound itself --
15 we expect numbness around the wound. So
16 that is secondary just to the fact that the
17 skin was cut and you're going to have
18 numbness around there.

19 Q. Did you perform range of motion
20 testing on him at that visit?

21 A. I did.

22 Q. What was his range of motion?

23 A. Approximately, forty-five degrees
24 of flexion and no extension.

25 Q. Did you form an opinion, to a

1 A. APAZIDIS, M.D.

2 reasonable degree of medical certainty, as
3 to what the cause of forty-five degree
4 limitation of flexion and extension was?

5 A. Again, he did have lumbar fusion
6 on two levels. The bottom two levels would
7 be primarily responsible for a lot of
8 forward function movement as opposed to the
9 upper three.

10 Also, the fact that he did have
11 an area of infection that had filled in with
12 scar tissue, as was our intention, and that
13 would cause some limitations to excursion of
14 the musculature in the back.

15 Q. Now, under assessment you say
16 "Patient is healed from his infection". He
17 wasn't using the wound vac at that point; is
18 that correct?

19 A. He was not.

20 Q. So when you say he is healed from
21 his infection, what do you mean by that?

22 A. That he has filled in his wound
23 with noninfected and stable healthy tissue,
24 that he no longer needs antibiotics and that
25 there's no longer any active infection in

1 A. APAZIDIS, M.D.

2 place.

3 Q. It says, "His back pain situation
4 is slowly improving, but I believe that he
5 may be at maximal medical improvement." Do
6 you see that?

7 A. Yes.

8 Q. What is it you mean by that?

9 A. I mean at this point he's about
10 six months out of the surgery. He is a few
11 months of no longer needing a wound vac. He
12 over his infection. I don't know how much
13 further improvement he is going to get in
14 terms of -- you know, for a maximal medical
15 improvement, we look at things like range of
16 motion, function and so forth.

17 It may be that I was being asked
18 by an insurance company to document maximal
19 medical improvement. Maybe that's why I put
20 it in my notes. Sometimes I know insurance
21 companies want to know in, typically, six
22 months after surgery is a time point when
23 they want your opinion as to if he's going
24 to get better or worse or whatever they do
25 with that.

1 A. APAZIDIS, M.D.

2 Q. Someone's condition six months
3 out after surgery, is that an indicator to
4 you as a physician as to what the prognosis
5 holds for that patient after surgery?

6 MR. RACH: Just note my
7 objection. You can answer the
8 question.

9 A. Yes, six months would be a
10 reasonable time point. Certainly, we can
11 see improvement past that. Again, for the
12 purposes, typically, for the insurance
13 companies and disability companies and so
14 forth, six months is the point that they
15 have references when they want MMI opinions.

16 Q. I'm also talking about, isn't the
17 reason why the insurance companies want this
18 six months out what the condition is then is
19 because as a doctor that's considered how
20 the patient is six months out is a good
21 indication as to how the patient is going to
22 be continuing thereafter?

23 MR. RACH: Just note my
24 objection, but you can answer.

25 A. It's certainly a very fair time

1 A. APAZIDIS, M.D.

2 point to make that opinion.

3 Q. Now, the last sentence of the
4 assessment says, "The energy of the injury
5 was significant enough to cause complete
6 degeneration of his disc." When you say the
7 energy of the injury, what are you talking
8 about?

9 A. The car accident that initially
10 caused him to this have this condition.

11 Q. Now, as your assessment you said,
12 "lumbar radiculopathy". So on that day Mr.
13 Simeone, he was still suffering from lumbar
14 radiculopathy; is that correct?

15 A. Well, let's see.

16 Q. Well, it says, "He has persistent
17 numbness and tingling around his wound,
18 buttock area and groin"; is that correct?

19 A. Yes. That's not exactly --
20 radiculopathy would more refer to the long
21 nerve findings. I mean, he still had some
22 decreased strength on both the right and
23 left. I think I was basing the diagnosis of
24 radiculopathy that based on the fact that he
25 still had some decreased strength in the

1 A. APAZIDIS, M.D.

2 lower extremities.

3 Q. Do you have an opinion, to a
4 reasonable degree of medical certainty, as
5 to what the cause of the decrease in
6 strength was on June 11th, 2012?

7 A. In this setting of a patient who
8 had a infection and significant wound
9 treatment afterwards, when you have them
10 stand on their toes, it may hurt. They may
11 not be able to do it very well. Not because
12 they're weak, but because it hurts their
13 back when they do it. So if you have them
14 walk on their heels, it hurts their back
15 when they do it.

16 So I don't think that it was
17 actual nerve damage that was causing the
18 weakness. I say that because he had a
19 negative straight leg raise test and he also
20 had intact sensation. So the motor weakness
21 was more likely related to back pain rather
22 than nerve damage.

23 I think keeping the lumbar
24 radiculopathy diagnosis in the assessment
25 section, perhaps, might have been more

1 A. APAZIDIS, M.D.

2 historical than what was actually going on
3 at the time there.

4 Q. Well, the back pain that you
5 documented on June 11th, 2012, did you form
6 an opinion, to a reasonable degree of
7 medical certainty, as to that being caused
8 by the infection?

9 A. Well, certainly, after healing an
10 infection and the necessary muscle
11 mobilization, it's possible that you can
12 have chronic back pain from that.

13 MR. RACH: He's not asking you
14 in general. He's asking about this
15 patient.

16 A. Right, for this patient. It's
17 difficult for me to pinpoint the exact
18 source of his back pain. He did have
19 significant injury to his lumbar spine. He
20 had to undergo fusion. So he's been in the
21 absence of infection. Sometimes patients
22 have back pain after these surgeries.
23 That's a well documented phenomenon.

24 He had the addition of an
25 infection that was healed. So it's

1 A. APAZIDIS, M.D.

2 difficult to say which one thing was causing
3 his back pain. He had reasons to have back
4 pain to start off with.

5 Q. Your findings on June 11th, 2012,
6 the back pain that Mr. Simeone was
7 complaining to you, did you ever form an
8 opinion, to a reasonable degree of medical
9 certainty, as to whether that back pain was
10 being caused by infection, surgery, the
11 surgery itself, the fusion itself, both or
12 you don't have an opinion one way or the
13 other?

14 A. I mean, I have an opinion. As I
15 was kind of just saying, he no longer had an
16 infection at this point. So infection
17 itself would be a source of back pain. But
18 healing an infection, which does lead to
19 scar tissue formation, which is what we
20 want, that could certainly be a source of
21 back pain.

22 What I just meant to say was
23 that, even in the absence of an infection
24 and healing that infection. You could have
25 back pain. Unfortunately, it's something

1 A. APAZIDIS, M.D.

2 that we live with. We do, you know, spine
3 surgery and some of our patients go on to
4 have back pain.

5 Q. I understand that. Did you ever
6 form an opinion, to reasonable medical
7 certainty, as to what the cause of Mr.
8 Simeone's back pain was on June 11th, 2012?

9 A. Yes.

10 Q. What was your opinion?

11 A. Scar tissue formation from
12 healing his infection and from a phenomenon
13 called pain after spinal surgery. Some
14 people call it failed back syndrome. We
15 like to call it pain after spinal surgery
16 because his back didn't fail. He did fuse.
17 However, he just continues to have back
18 pain.

19 Q. Now, failed back surgery
20 syndrome, isn't that a condition where
21 someone has a back surgery and they continue
22 to have the same complaints they had prior
23 to the surgery?

24 A. I don't know that it's ever been
25 definitively defined. We tend to use this

1 A. APAZIDIS, M.D.

2 term of failed back surgery to refer to
3 people who have pain after surgery.

4 But we are trying to be more
5 specific. So if there is someone who say
6 had failed to fused and has back pain, well,
7 he has pseudarthrosis. He doesn't have
8 failed back surgery.

9 But in someone who has fused, but
10 continues to have back pain, we call that
11 pain after spinal surgery. The surgery
12 didn't fail, he fused. The purpose was to
13 fuse him and he did. But the pain is the
14 component that we don't have a good grasp
15 on.

16 Q. During the spinal fusion on
17 October 21st, 2011, were you able to perform
18 all procedures that you intended to when you
19 went in that day?

20 A. Yes.

21 Q. Were there any conditions present
22 on October 21st, 2011 that were there prior
23 to the surgery that you are unable to
24 correct during the surgery of October 21st,
25 2011?

1 A. APAZIDIS, M.D.

2 A. No.

3 Q. When Mr. Simeone was discharged
4 from the hospital, from that November 21st,
5 2011 admission, you said that Nafcillin was
6 prescribed; correct?

7 A. Yes.

8 Q. Was that continued; was he
9 receiving Nafcillin within the hospital and
10 it was just continued after?

11 A. Yes.

12 Q. Do you know who it was that
13 prescribed that Nafcillin?

14 A. Dr. Trehan.

15 Q. From October 21st, 2011 until
16 June 11th, 2012, which we have said that
17 that was the last time you saw Mr. Simeone
18 was June 11, 2012; is that correct?

19 A. According to my records, yes.

20 Q. Do you remember any visits after
21 June 11th, 2012?

22 A. I don't remember any. I don't
23 have any records of any.

24 Q. Do you remember any conversations
25 you ever had with Mr. Simeone after June

1 A. APAZIDIS, M.D.

2 11th, 2012?

3 A. I do not.

4 Q. Between October 21st, 2011 and
5 June 11th, 2012, did you ever prescribe any
6 antibiotics for Mr. Simeone?

7 A. The Nafcillin prescription, I may
8 have renewed that in conjunction with
9 working with Dr. Trehan, because he was
10 seeing me in the office and most of the
11 visiting nurse and infusion services contact
12 point would be to me.

13 So I believe Dr. Trehan didn't
14 have an out of the hospital office or a
15 contact point. So my habit in these types
16 of cases would be to deal with him by phone
17 and tell him what's going on with the
18 patient. Should we continue it, stop it,
19 change it and I would renew Nafcillin with
20 the infusion service.

21 MR. RACH: Just to be clear, do
22 you mean separate and apart from the
23 prophylactic antibiotics given
24 intraoperatively?

25 MR. WARYWODA: Correct.

1 A. APAZIDIS, M.D.

2 Q. So other than the Nafcillin and
3 the Ancef that you say was administered
4 intraoperatively on October 21st --

5 A. 21st and 22nd.

6 Q. Well, there is no indication in
7 the record that the Ancef was given
8 post-surgery; correct?

9 A. It's ordered. I don't have the
10 pharmacy records.

11 Q. There is no indication that it
12 was administered; correct?

13 A. I don't have any evidence before
14 me that it was or it was not.

15 Q. Okay. But there is evidence that
16 it was administered during the surgery?

17 A. Yes.

18 Q. Other than the Ancef being
19 administered during the surgery and the
20 Nafcillin that was prescribed on discharge
21 from the November 21st, 2011 hospitalization
22 and the renewals of the Nafcillin, did you
23 prescribe any other antibiotics for Mr.
24 Simeone?

25 A. No, I did not.

1 A. APAZIDIS, M.D.

2 Q. At some point you received a copy
3 of this lawsuit; correct?

4 A. Yes.

5 Q. After you received this lawsuit,
6 from that time until today, have you spoken
7 to any doctors about the care and treatment
8 provided to Mr. Simeone?

9 A. No.

10 Q. Have you ever spoken to Dr.
11 Trehan from the time you received this
12 Summons and Complaint until today about
13 James Simeone?

14 A. No.

15 Q. How a Dr. Kota, between receiving
16 the lawsuit and today, have you ever spoken
17 to Dr. Kota about Mr. Simeone?

18 A. I have not.

19 Q. The physician who is doing the
20 monitoring pursuant to the terms of your
21 suspension, did you ever have him review a
22 copy of any of the treatment records of Mr.
23 Simeone?

24 A. No.

25 Q. Did you ever have a conversation

1 A. APAZIDIS, M.D.

2 with Dr. Fuentes between the time you
3 received the lawsuit and today about Mr.
4 Simeone?

5 A. No.

6 Q. Did you ever have a conversation
7 with Dr. Fuentes about whether or not he
8 believed the abscess found during the
9 November 21st, 2011 surgery, what the cause
10 of that abscess was?

11 A. I don't remember having a
12 conversation with him about the origin.

13 Q. Did you ever have a conversation
14 with any infectious disease physician as to
15 what they believe the cause of the abscess
16 was that was found during the November 21st,
17 2011 admission?

18 A. I don't remember, but it
19 certainly is possible that I discussed with
20 Dr. Trehan.

21 Q. Do you recall what the
22 conversation was?

23 A. No, I don't have a specific
24 recollection of it. But it's a conversation
25 I might have had with him because he is the

1 A. APAZIDIS, M.D.

2 specialist.

3 Q. But sitting here today, you don't
4 remember one way or the other what Dr. --
5 you said Trehan --

6 A. Trehan.

7 Q. -- what Dr. Trehan's opinion was
8 with regards to what the cause of the
9 abscess was?

10 A. No, I don't remember any such
11 conversation.

12 MR. RACH: If you don't
13 remember, just say you don't remember.

14 A. I don't remember.

15 MR. WARYWODA: Doctor, I have
16 no further questions. Thank you.

17 (Continued on the following
18 page to include the signature and
19 jurat.)
20
21
22
23
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25

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 30
phone messages from Visiting Nurse
Service who may have called in

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C E R T I F I C A T I O N

STATE OF NEW YORK)

: S.S.:

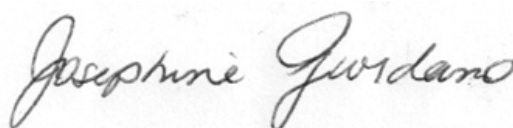
COUNTY OF)

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

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New York Code
Civil Practice Law and Rules
Article 31 Disclosure, Section 3116

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