1 SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: CIVIL TERM: IA-6
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FRANKLIN ABREU-DEPENA Index No:
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Plaintiff(s). 305352/2013
4
-against- WITNESSES:
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JAMES P. WEBER, TC HUDSON VALLEY C. MANDELBAUM, MD
6 AMBULANCE CORP. d/b/a TRANSCARE CORP. R. FIJALKOWSKI PhD
TC HUDSON VALLEY AMBULANCE CORP.
7 and TRANSCARE CORPORATION

8 Defendant(s).
---------------------------------------x
9 851 Grand Concourse
Bronx, New York 10451
10 February 15, 2019

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12 B E F O R E: HONORABLE JAMES W. HUBERT,
J U S T I C E
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14 A P P E A R A N C E S:

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23 Rosemary Yancey, RPR, CSR
Senior Court Reporter
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1 COURT OFFICER: Jurors entering.
2 (Whereupon the jury enters the courtroom.)
3 THE COURT: Please be seated. All right. We are
4 going to resume with today's testimony. We are going to
5 continue the presentation of the evidence. Counsel for the
6 plaintiff, you have a witness.
7 MR. PFLUGER: Yes, sir. Thank you.
8 Dr. Mandelbaum, please.
9 COURT OFFICER: Please remain standing. Raise your
10 right.
11 C H A I M M A N D E L B A U M, having been first duly
12 sworn by the court officer, testifies as follows:
13 THE WITNESS: Yes, I do.
14 COURT OFFICER: Please be seated. In a loud, clear
15 voice say and spell your name for record and give your
16 business address.
17 THE WITNESS: Dr. Chaim. C-h-a-i-m. Mandelbaum.
18 M-a-n-d-e-l-b-a-u-m. Business address is 75 Maiden Lane
19 Suite 1206, New York, New York 10038.
20 THE COURT: All right. Doctor, during your
21 testimony you will need to keep your voice up because we
22 don't have any microphones or audio here.
23 THE WITNESS: Okay.
24 THE COURT: Also speak slowly enough so that the
25 reporter seated in front of you can accurately record your

1 testimony. Wait until the question is fully asked before
2 responding so that both question and answer can be recorded
3 properly and the jury can understand it.
4 And finally if you don't understand a question
5 please indicate that, we will have it rephrased.
6 THE WITNESS: Okay.
7 THE COURT: You may inquire.
8 MR. PFLUGER: Thank you, Judge.
9 DIRECT EXAMINATION
10 BY MR. PFLUGER:
11 Q Good morning, sir.
12 A Good morning.
13 Q Are you a doctor licensed to practice medicine in the
14 state of New York?
15 A I am.
16 Q What's your specialty?
17 A I am a board certified anesthesiologist and also board
18 certified in pain medicine.
19 Q Okay. Could you give us your education and background,
20 please?
21 A Yes. I attend State University of Health Science
22 Center of Brooklyn. Otherwise known as Downstate for medical
23 school, four years. Followed by an internship at Staten Island
24 University Hospital, a residency in anesthesiology at Mount
25 Sinai in New York City, followed by a fellowship at Mount Sinai,

1 New York City.
2 Q Okay. What is the name of your practice?
3 A It's Comprehensive Pain Management.
4 Q All right. Have you taught in your experience as a
5 doctor in residents, or...
6 A Yes. Occasionally there are some either medical
7 students or residents, usually medical students that will rotate
8 through our office to learn about pain management, what we do.
9 Q Okay. What are your hospital affiliations?
10 A Yes, I'm affiliated with Mount Sinai Medical Center at
11 Beth Israel, now New York Methodist Hospital in Brooklyn.
12 Q Okay. Have you been published?
13 A No.
14 Q Okay. Did there come a time that you Mr. Depena came
15 to your office?
16 A Yes.
17 Q Okay. And, sir, you have a grouping of documents
18 there, what is that?
19 A This is the copy of the medical records.
20 Q For?
21 A For Mr. Depena.
22 Q Okay. And are the records, are those records made in
23 the ordinary course of business?
24 A Yes, they are.
25 Q Is it the business of Comprehensive Pain to keep and

1 maintain those records?
2 A Yes.
3 Q Are those office visit notes made in and around the
4 time you saw Mr. Depena?
5 A Yes. For each visit that he comes in, there is a note
6 that we generate describing what we have seen and done, physical
7 examinations for Mr. Depena.
8 MR. PFLUGER: I'm offering his chart into evidence.
9 THE COURT: Counsel.
10 MS. WALTERS-HINDS: That's fine. Subject to
11 redaction.
12 THE COURT: What's the number up to?
13 COURT CLERK: Plaintiff 25.
14 THE COURT: Plaintiff's 25, marked in evidence.
15 COURT OFFICER: Plaintiff 25 in evidence so marked.
16 THE WITNESS: Thanks.
17 MR. PFLUGER: Thank you, sir. When is the first
18 time that you saw Mr. Depena?
19 THE WITNESS: So Mr. Depena came to our office in
20 November 5, 2015.
21 THE COURT: What was that?
22 THE WITNESS: 2015.
23 Q What was the last time that your office saw Mr. Depena?
24 A We had just seen him on January 8, 2019.
25 Q Okay. How many visits in total did you see him, did

1 your office see him?
2 A It was 33 times over the time period.
3 Q Okay. We're not going through each visit. Can we do
4 this, how many visits did Mr. Depena come to your office in '15?
5 A From 2015 which he came in November, he was seen four
6 times between November and December.
7 Q Okay. Tell us what, if anything, happened the first
8 time that Mr. Depena came to your office November 5, 2013?
9 A Okay. When he first presented to our office we got a
10 history of what injuries he had occurred. We knew that the date
11 of accident on July 27, 2013, he was a taxi driver.
12 He was hit on the left side of his vehicle by an
13 ambulance, getting thrown in the vehicle, injuring his neck, his
14 back and his left shoulder.
15 He was taken to the hospital and he had x-rays.
16 Eventually was discharged home to follow-up with an orthopedist.
17 Before we had seen him, he was already evaluated by an
18 orthopedist regarding his shoulder, as well as his neck and
19 back.
20 He had undergone a left shoulder surgery anthroposcopy
21 because of a fracture that had occurred there, Hill-Sachs
22 compression or deformity of the left shoulder, as well as some
23 annular tears. And he also had undergone a cervical lumbar
24 fusion already prior to coming to our office.
25 When he came to our office he had complaints of the

1 same body parts, still was having neck pain, neck pain shooting
2 to his upper extremity on the left.
3 He was still having lower back pain. He was still
4 complaining of lower back pain shooting to his low extremity on
5 the left, and he was still complaining of left shoulder pain as
6 well.
7 Q And do you have history of present illness, Dr. Capiola
8 recommended a second surgery to relieve symptoms, but patient is
9 unsure about that, you made a note of that, correct?
10 A Correct.
11 Q What was the level of pain that you did note on that
12 first visit, back pain?
13 A On the first visit he stated, usually we use a scale,
14 what we call a visual analogue scale, from 0 to 10. Zero being
15 no pain at all, 10 being the worst pain you can imagine. He
16 stated that the pain was about an 8 out of 10.
17 Q Okay. You also noted the cervical region, that C3
18 through C7 pain and spasm, what is the significance of that
19 note?
20 A Well, pain and spasm, pain is someone subjective, spasm
21 is less subjective, which is significant, especially this far
22 out from an accident, plus he had surgery. It's significant for
23 some underlying pathology that is causing the muscle to become
24 much more rigid and causing spasm and pain.
25 Q Okay. Just briefly what is a pain management doctor,

1 what do they do?
2 A Okay. It's always a good question. So what exactly do
3 we do? Typically we will see a patient neurologically for neck
4 and lower back pain for some other nerve related issue.
5 Typically they've been treated elsewhere, for some
6 reason the pain has remained, regardless of conservative
7 treatment by another physician. So they come to our office.
8 Our office we specialize in dealing with these chronic
9 issues. We do a lot of (1) adjust medication that deals
10 specifically with pain, in addition to we do a lot intervention.
11 We do a lot of procedure injections that target pain, pain
12 pathways, certain specific nerves that hopefully will diminish
13 the pain.
14 There are even more interventional modalities that can
15 be used, as far as nerve block, destroying certain nerves that
16 start pain, or continue pain. So there's a whole spectrum of
17 things, modalities that we do to help with chronic pain.
18 Q Okay. And with reference to his neck and back, what
19 notation did you make?
20 A So he was complaining of neck pain. Again, he had
21 already neck fusion. He was having a lot of spasm in his neck.
22 He stated that he was having pain into his upper extremity,
23 especially down the left arm.
24 He describes numbness and tingling and weakness and
25 burning sensation and shooting sensation that went down into his

1 left arm. In addition to that he was complaining of lower back
2 pain. Again, he had a fusion. He still was having spasm in the
3 lower back.
4 He had greatly diminished range of motion, but he was
5 complaining of pain that would shoot down into his lower
6 extremity, mostly on the left. He was complaining of inability
7 to do his regular function, as far as standing, walking and
8 bending and twisting.
9 He was very limited as far as all those normal
10 activities was concerned. He also had left shoulder pain and
11 had pain with movement, range of motion. He had diminished
12 range of motion.
13 Q You did note, pain is located in left shoulder with
14 decreased range of motion exacerbated by overhead activities
15 associated with catching and popping, what does that mean?
16 A He is somebody that had surgery already to the shoulder
17 because of the injuries that occurred during that motor vehicle
18 accident. Normal shoulder motion is exactly complicated.
19 A motion that is typically smooth, but when they are
20 changes, such as surgery, all of a sudden that motion, you know,
21 you have a ball in a socket, type of motion, that should be nice
22 and smooth and you don't feel any cracking or popping or
23 dysfunction. In his case, he was having limitation and he was
24 having pain, and all that cracking and popping and motion is
25 because of the ongoing injury.

1 Things are not lined up as they should have been. And
2 even despite having surgery, there's still, it's not the same as
3 it was if he did not have the surgery, or he did not have any
4 injury.
5 Q So tell us the results, you did do a physical
6 examination?
7 A Yes.
8 Q Okay. You did range of motion for what parts of the
9 body?
10 A Yes. So we zoned in on the neck, the back and the
11 shoulder. We did a physical examination just taking his neck,
12 again, there was spasm along his neck, along these, your
13 cervical muscles, more on the left than the right.
14 And you can actually feel a difference in the muscle,
15 that could be palpated, which is just touching those muscles.
16 He had pain on movement of the neck. So movement such as
17 flexion, which is forward movement at 20 degrees.
18 He already had pain, which is not a lot. So slight
19 bend. Normal should be 40 degrees, so that was greatly
20 diminished. He also had pain extension of the neck at 15
21 degrees. Normal should also be about 40 degrees. Also turning
22 to the right.
23 Q You said 15 not 50?
24 A Fifteen. One, five.
25 Q Okay.

1 A He also had pain on bending his neck right and left.
2 Q Okay.
3 A He was noted to have -- and you can do what they call a
4 sensory exam. You can actually touch certain parts of the arm,
5 and he was having numbness to different sensations.
6 Usually you use a pin, a light pinprick down into,
7 along all the nerves, for instance, in the neck, go to specific
8 areas in the arm. Okay.
9 So, for instance, C7 goes down to the middle finger, C8
10 goes into the little finger, C6 over here. So you can actually,
11 you can touch certain parts and use a little needle or something
12 that's sensation, and you can say there is abnormal sensation
13 along the C7 nerve root.
14 In his case, it was along C6-C7 nerve root. So mostly
15 the sensation that you're feeling going along, again, talking
16 about the thumb, the index finger, middle finger.
17 Q Okay. You did make a note, lateral bending neck, 25,
18 normal bending 45, correct?
19 A Correct.
20 Q Okay. Can you, just so we have it, you did physical
21 exams on all of these visits, correct?
22 A Correct.
23 Q Did you do one in November, I'm just trying,
24 November 5th is the first visit, did you do one November 13,
25 2018, just to compare the two physicals?

1 A Yes.

2 Q Okay. Can you go there, tell us what that range of
3 motion was like, the results?

4 A So on November 13, 2018, correct?

5 Q Yes, sir.

6 A He was, again, still we had seen him over a couple year
7 period, just to give you the interim we had done certain
8 injections, which we can talk about a little bit later. It was
9 done, different medications that he changed.

10 But on physical examination, again, he was having still
11 significant spasm along the neck area. He was still having
12 diminished range of motion of the cervical spine.

13 Looking at the physical examination he had flexion at
14 30 degrees. He had right lateral bending that was diminished
15 both left and right.

16 He had also numbness still in his arm, C6-C7
17 dermatomes, which I didn't describe before, is that the lower
18 back on physical examination was similar to earlier physical
19 examination low back spasm bilaterally. He had diminished range
20 of motion of his lower back with flexion at 50 degrees when
21 normal should be 90 degrees.

22 So that's bending forwards. He was about 50 degrees.
23 Extension was at 20 degrees. Normal should be 35 to 40 degrees,
24 as well as right and left lateral bending which were diminished
25 as well.

1 He was noted, which is important, is that he on what
2 they call positive straight, he had a positive straight leg
3 raise on the left at about 45 degrees.
4 That is a test where you actually have, you're lifting
5 the patient's left leg up, and trying to reproduce some of the
6 pain shooting into the lower extremity. That can actually be
7 reproduced, and at 45 degrees is significant for some type of
8 trauma or nerve injury with one of the nerves that goes down
9 into the leg from the lower back.
10 He was also noted to have decreased sensation in his
11 leg as well along the certain dermatomes, which is the L4 and
12 L5, as well as S1 on the left side, but it was normal on the
13 right side. So there was discrepancy between left and right
14 side.
15 Q Okay. When was the last time you saw Mr. Depena?
16 A The last time he was seen was in January 8, 2019.
17 Q Okay. Was a physical exam done at that time?
18 A Correct. It was.
19 Q Tell us the findings?
20 A The findings were similar to the prior month. He was
21 still having lower back pain and spasm, the left side still
22 greater than the right side. He did have diminished range of
23 motion with extension and flexion. Extension at 45 degrees
24 flexion at 50 degrees, as well as right and left lateral
25 bending.

1 He still had decreased sensation along certain areas in
2 his leg, that corresponded to a specific nerve at L4 and L5 and
3 S1. He still had neck pain and spasm. He still had diminished
4 range of motion with regard to the neck with extension and
5 flexion, similar to the prior examination with flexion at
6 30 degrees.
7 Right and left lateral bending was diminished, as well
8 as decreased sensation that he had in his left upper extremity
9 along those specific nerve roots at C6-C7.
10 Q Okay. With reference to his neck, the last time you
11 saw him, what was the percentage of loss of range of motion for
12 his neck?
13 A That wasn't exactly calculated, but it's somewhere
14 between about 40 to 50 percent, depending between what is normal
15 and what he actually was able to do.
16 Q Okay. How about his back?
17 A Similar.
18 Q Have you formulated an opinion, within a reasonable
19 degree of medical certainty, whether that 40, 50 percent loss
20 range of motion in his neck and his back is permanent?
21 A Yes. Absolutely.
22 Q Tell the jury why?
23 A Well, he is somebody who had no injury, no pain prior
24 to this accident.
25 MS. WALTERS-HINDS: Objection.

1 THE COURT: Well, this is based on what was told to
2 you, correct?
3 THE WITNESS: Correct.
4 THE COURT: Okay. You can answer the question.
5 THE WITNESS: He did have an accident subsequent to
6 surgery which was a fusion which is essentially hardware
7 that's in the spine, and it's going to limit your range of
8 motion, because you have now metal on both the neck and the
9 lower back, so inevitably your range of motion is not going
10 to be the same. So, within a reasonable degree of medical
11 certainty, this diminished range of motion is permanent and
12 significant.
13 Q Okay. So after the first time you saw -- what types of
14 treatment was rendered to him over the years, I'm trying to give
15 it a broad so we can move through?
16 A So he had a number of modalities. One, we always look
17 at the, what the symptom are. So we try different medications.
18 He was on specific medications geared for spasm, and he was on
19 a medications called baclofen which is used a lot for spasm.
20 He was also on an antiinflammatory medication,
21 Diclofenac, which was otherwise known as Voltaren. There was
22 also a gel and a cream that he was given so that he can use on
23 his shoulder which is a Voltaren gel. He was still taking a
24 mild narcotic medication, Norco, subsequent that he's currently
25 not on.

1 But at that time he was having significant amount of
2 pain, and that was continued. Our approach at this point was
3 (1) when he first came to us, his neck was the worst pain. So
4 we did a specific type of injection to see if we can eliminate
5 some of the pain called a facet joint injection.
6 This is almost a diagnostic injection used to numb
7 medication and gets to the joint in the neck area, one bone sits
8 on top of the other bone, there is a movable joint. That's why
9 you're able to move your head and neck, up and down, back and
10 forth.
11 And that joint after an accident is an injury, you may
12 call it a whiplash or accident injury, everything gets jolted
13 around. That joint can cause a lot of pain. He already had
14 surgery, so there's definitely strain on all the joint. So you
15 do a diagnostic block which is localized and you can see if that
16 eliminates the pain.
17 If it doesn't eliminate the pain, then you can actually
18 do a procedure called a radiofrequency procedure, which is a
19 rather painful procedure, but you can actually put a needle
20 close to the little nerves that goes to those joints and
21 essentially ablate or destroy that nerve to help with the pain.
22 Q What that done to Mr. Depena?
23 A Yes.
24 Q When was that done?
25 A That was done on February 24, 2016.

1 Q Have you brought instruments to show the jury?
2 A Yes. I can show you what it may look like. I can show
3 you, radiofrequency is, this is a --
4 MS. WALTERS-HINDS: Objection, Judge. I don't know
5 what he is doing.
6 THE COURT: He is showing something that was
7 utilized in this procedure on February 24, 2016. Is that
8 what you're doing?
9 THE WITNESS: Yes.
10 THE COURT: What's the nature of your objection? I
11 think this is a demonstrative exhibit.
12 MS. WALTERS-HINDS: I don't think he is the one
13 that did it on 2/24/2016.
14 THE COURT: Well, do you do these surgeries at
15 various times?
16 THE WITNESS: Yes. All the time.
17 THE COURT: So it's not like you don't know how to
18 do it, just maybe you didn't do this particular one on this
19 particular date?
20 THE WITNESS: Correct.
21 THE COURT: Okay. Do you understand from studying
22 the charts of that procedure that day, what was done?
23 THE WITNESS: Yes.
24 THE COURT: Okay. You can proceed.
25 THE WITNESS: All right. So the idea is, and you

1 can imagine this is a spinal cord. So this is the lower
2 back. You can imagine the neck is sort of similar. You
3 take out the lower part of this. There are joints where one
4 part of the spine sits on top of other part of the spine.
5 You actually -- this is the outside. This is his
6 back, there are muscles on the outside here. So you've got
7 to go through the skin, through the muscles and get into
8 where these, close to where the joints are, where this nerve
9 is, and you do it with a patient somewhat awake because you
10 want to get feedback off of it, so you get a little bit
11 sedation, it can be uncomfortable.
12 When we get into the right spot, we can actually,
13 there is another probe that fits through this needle and it
14 heats up the tip of the needle so that's 80 degrees Celsius,
15 extremely hot, and you're burning that nerve. You are
16 causing adhesion on that specific nerve that goes to those
17 joints.
18 You've got to do it on a few levels on the side of
19 the pain, in his case it was the left side, to catch all the
20 nerves that go to those areas of pain. That's basically the
21 radiofrequency procedure.
22 It can be done similarly to the lower back, as well
23 as the neck and other areas if that is the positive means --
24 the facet joints are the positive factors in causing the
25 pain.

1 Q You mentioned it burns the nerve?
2 A Yes.
3 Q Okay. And how long does that procedure, is it a
4 permanent fix, or something else?
5 A Unfortunately it's not a permanent fix. It does --
6 nerves do regrow, but it can last for six months or a year.
7 Sometimes even longer by just burning that nerve. Does it come
8 back at times? Yes. It can come back.
9 But since you get some longstanding relief and then
10 with other modalities, physical therapy, helping with the muscle
11 spasm, it doesn't necessarily have to be repeated right away.
12 We expect at least, we tell patients hopefully six months out of
13 it.
14 Q Okay. You mentioned it was uncomfortable?
15 A Yes. So these needles, especially the radiofrequency
16 can be rather uncomfortable. You are heating up the tip of the
17 needle, using local anesthetic to numb it up. It heats up 80
18 degrees celsius. Pretty hot actually.
19 Q How many of those procedures were done on Mr. Depena?
20 A He had it done once.
21 Q Okay. And what other modalities did you use to treat
22 his pain over the course of years?
23 A All right. So initially we had done also some shoulder
24 injections with a lubrication called Orthovisc, that happens to
25 be a lubricant that can be injected in the joint.

1 it's well documented in the literature.
2 THE COURT: Was he diagnosed with that?
3 THE WITNESS: That is part of his diagnosis, yes.
4 Q All right. Continue.
5 A So, to say that the surgery is causing his pain, maybe
6 a failed surgery. Now, when they put hardware in the neck and
7 the lower back, as the judge said, it puts strain on other parts
8 of the spine that can further deteriorate and cause strain in
9 other discs and areas and that may mean that he may need surgery
10 down the line.
11 Unfortunately surgeries, I'm not a surgeon so I don't
12 want to ridicule surgeons, it doesn't always work. I mean
13 they're stabilizing the spine. It doesn't always -- there is no
14 guarantees.
15 And if a surgeon says that there's a guarantee that
16 you'll be 100 percent better, don't believe them. You know, we
17 see, unfortunately, like I guess my mind is spewed cause we see
18 a lot of patients who's had surgery that still have ongoing
19 pain, and despite having what looks or appears on a radiological
20 study that it's a decent fusion, yet they still have pain.
21 THE COURT: All right. My question to you had to
22 do with the causative source of the pain.
23 THE WITNESS: So, all that, what it comes down to
24 is the causative cause of the pain was the accident that
25 caused the initial injury, that led to surgery and he had

1 particular procedure was done in the lower back similar to what
2 I described in the neck. These are the facet joints. Where one
3 bone is sitting on the next bone and these are movable joints.
4 So these are called facets. So these are facet joints.
5 You can you actually take a needle, put it close or
6 within that joint and inject local anesthetics, inject a little
7 bit of steroids and hopefully help with that localized pain.
8 Usually the facet pain is localized in a specific area, for
9 instance, for him it was the lower back.
10 Facet mediated pain doesn't -- usually it's localized
11 back pain. Pain that's shooting in the leg is usually because
12 something's hitting against a nerve. And that is a different
13 cause for source of the pain.
14 If it's going down into his leg, which it is, and
15 causing numbness and tingling in his leg, it's usually the big
16 nerve. And usually we give a different type of injection for
17 that, which he actually had undergone.
18 Q How many injections did he go through over the years?
19 A He had, I'm looking quickly, probably about 11, looking
20 quickly.
21 Q I'm sorry?
22 A About 11 or 12.
23 Q Okay. What does palliative therapy mean?
24 A Palliative therapy is a term used to say that the
25 patient is going to get some relief from his pain, especially

1 It adds a little bit more cushion to the joint. It
2 makes it a little bit more smoother. So he had three of those
3 initially. We did do the radiofrequency to the neck area. He
4 had a specific different type of injection called, it's an
5 epidural injection which, this is in the neck area, which we
6 actually take a needle, and it's a different needle, it goes
7 into the epidural space.
8 So you actually take a needle through the spine. You
9 are going midline, very close to where the spinal cord is, when
10 it pops into that space, the medication, such as a steroid,
11 which is usually used, it is injected but spreads within that
12 space and gets to the areas of inflammation.
13 That targets a different aspect of where pain comes
14 from. You can't think of a pain, especially for him, neck pain,
15 it's coming from different sources.
16 There are the joints, there are the nerves, there are
17 the discs, and each space, each area can actually cause its own
18 source of pain. So by doing these other injections, we are
19 targeting different sources of pain.
20 Q Okay. Well, what other modalities, because I see on
21 April 19, 2016, it was a facet block?
22 A Correct.
23 Q Okay. What is that?
24 A So the facet block is similar to the radiofrequency,
25 like a diagnostic block. These facets, these joints, and that

1 for exacerbation of pain, but that pain is not going to go away.
2 It's only getting him by and helping with symptomatic relief.
3 Usually temporarily to get him by exacerbations of pain, and
4 that pain is going to remain.
5 Q Okay. Is that the type of treatment that was rendered
6 to Mr. Depena by Comprehensive Pain?
7 A Yes, it was a palliative, a lot of what we do is
8 palliative, and just helping with the pain.
9 Q Okay. The last time you saw him, 2019 and 2018, what
10 complaints of pain was he making, if any?
11 A He still was having pain, as I stated before, mostly
12 the neck and the lower back. He describes pain and spasm in the
13 neck area, shooting into his arm. He describes lower back,
14 shooting into his left leg, and that has remained.
15 There are times where we've done some injections and
16 his pain improves, especially when the pain gets bad. We all
17 had pain where you take a misstep, or you wake up and you cough
18 or sneeze, and all of a sudden your back goes out, and there are
19 times when the pain gets bad, sometimes these injections subside
20 that type of pain.
21 Long-term which was mentioned in the notes is the idea
22 of implant that can go into the back. That's something we had
23 discussed with him, something called spinal cord stimulator
24 which is an implant that can actually go into the neck and the
25 lower back that can help with some of that chronic longstanding

1 pain, and I wouldn't call it curative, but it's definitely a
2 more advanced modality that can help with someone in his
3 situation.
4 Q When was that discussed?
5 A That was discussed on our office visit April 11, 2018.
6 Q Can you go to that notes, sir?
7 A Sure. Yes.
8 Q Okay. As far as pain management, which step is the
9 spinal cord stimulator in the overall toolbox of pain
10 management, Doctor?
11 A It's not something that we advise early on. It's
12 usually an end stage. The last resort, because it's a major
13 procedure. It is an implant that stays in permanently in
14 somebody. And it's not the first treatment that we do.
15 It's somewhere down the line. In his situation, he's
16 almost an ideal candidate for it. It's something that should be
17 considered. I do feel that he will likely benefit significantly
18 from a spinal cord stimulator.
19 Q Okay. Do you have an exemplar of that?
20 A Yes. I'm going to show you kind of what the stimulator
21 entails.
22 Q The stimulator has a couple of components. It's done
23 in two stages. Usually we do a test first, what we call a
24 trial. The trial consists of two wires that go into the spinal
25 column.