In The Matter Of:

ERWIN HERRERA & LAUTERIA HERRERA v.
KENT AVE, J.E. LEVINE, J&A CONCRETE, NEW CASSEL

DR. KOLB & DR. GRIMM
October 2, 2024

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Original File 10-2-24 HERRERA v KENT_LEVINE_J&A CONCRETE_NEW CASSEL.txt
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX : CIVIL TERM : STP

ERWIN HERRERA & LAUTERIA HERRERA, : Index: 304215/2013E

Plaintiff(s).:

-against- :

KENT AVENUE PROPERTY III, LLC, J.E. LEVINE BUILDER, INC., and J & A CONCRETE CORP.,

Defendant(s).:

J & A CONCRETE CORP., :

Third-Party Plaintiff(s).:

-against- :

NEW CASSEL CONSTRUCTION CORP.

Third-Party Defendant(s).:

851 Grand Concourse
Bronx, New York 10451
October 2, 2024

B E F O R E:
THE HONORABLE ASHLEE CRAWFORD,
Justice of the Supreme Court & jury

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

THE PLAINTIFF:

GORAYEB & ASSOCIATES, P.C.
100 Williams St. 19th floor
New York, NY 10038
BY: FRANK V. KELLY, ESQ.

THE DEFENDANT:

LAWRENCE, WORDEN, RAINIS, BARD, PC
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Melville, NY 11747
BY: MATTHEW RAINIS, ESQ.

THE DEFENDANT AND THIRD-PARTY PLAINTIFF

CERUSSI & SPRING
One North Broadway, Suite 1000
White Plains, New York, 10601
BY: CHRISTOPHER B. ROBERTA, ESQ.

THE DEFENDANT THIRD-PARTY DEFENDANT

BAXTER & SMITH, P.C.
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Hicksville, NY 11801
BY: ROBERT C. BAXTER, ESQ.

Lorraine L. Ramsey
Senior Court Reporter

THE COURT: On the record. Good morning. The jury is not with us yet, we're going to deal with a preliminary issue national attorneys want to race. So go ahead Mr. ROEBT at that.

MR. ROBERTA: Yes, Judge, we received on September 30th, the fourth narrative report of Doctor Grimm dated September 25th. And the report adds, which is completely absent from the prior three narrative reports, it adds over eight times the opinion that plaintiff would have gotten this treatment, would have gotten that treatment, would have gotten this other treatment, but for the resources available to him. The costs, he couldn't afford it and it's clearly a blatant play for sympathy. Aside from the fact that Doctor Grimm's not his accountant, and on top of that --

THE COURT: Doctor Grimm is not his accountant? You're saying he has no basis to know that?

MR. ROBERTA: Yeah, Your Honor. And on top of that, we're not allowed to mention, because it's a collateral source and has to do with insurance, the fact that plaintiff willingly executed Section 32 with no future medical and took $200,000 plus dollars cash, and didn't put it towards his medical care. So, allowing him to supplement this now and add this basically claim of pauperism and why he can't proceed with treatment it's prejudicial at this

point.

MR. KELLY: So, he's a treating physician, he wrote a recent narrative report that would have given me grief if he had not done a recent narrative report.

THE COURT: Can you hear him, Lorraine?

MR. KELLY: I'm happy to have him cross examine him, the plaintiff, on anything they think is important to cross examine the plaintiff on, including his settlement with workers compensation. Because there's a charge on it that if workers compensation comes into the trial, the Court has to charge the jury with every nickle paid in comp has to go back to comp. I'm very happy. They can raise whatever they want with that.

MR. ROBERTA: None of this treatment was recommended, nor sought to be undertaken while he had people paying for his medical treatment for like seven years, and now all of sudden two days before this witness is about to testify all of sudden he can't afford all this treatment, Your Honor. It goes over and over. And we're not talking about little items like he would have gotten a spinal cord stimulator, but for the fact that he can't afford it. He would have gotten these injections and their cervical stimulator, but the resources are unavailable to him. He would have gotten another EMG, but he's unable to proceed because of the costs and the resources.

And there's plenty of time he had to get this treatment, if it was something that was going to happen. And to the extent I don't see how we can remedy the issue, unless we go in-depth into the workers compensation, and all the insurance and that's prejudicial to us, as well.

MR. KELLY: Well, they can't have it both ways. They either want to do it, and they can't say I want to do it but it's prejudicial to me. And there's absolutely no guarantee from what counsel is saying or from what anybody here's saying that workers comp approved that treatment.

Doctor Grimm drafted an optimal care treatment plan. Workers compensation is an insurance company. They have a habit of denying things. You have to apply for them 5, 6, 7 times. There's no guarantee that any of the optimal care would have been approved by workers comp.

MR. ROBERTA: All that's utter sheer speculation.

MR. KELLY: If they want to call somebody, they can do that at the collateral source hearing, or they can call somebody into the trial.

THE COURT: I'm having a hard time hearing you, and I need you to slow down because it's very echoey.

MR. KELLY: It's completely speculative that they're claiming that workers compensation would approve Doctor Grimm's optimal medical care plan. They may or may not approve a spinal stimulator. If Doctor Grimm wants him

to have a spinal stimulator, he doesn't have the money for that. It's $25,000 for the trial. Workers comp's not going to pay for that. And if they want to cross him on workers comp, they can do that. We can solve it by a charge. The charge says that all the workers come paid has to be paid back to comp. They can go into it, that's fine.

MR. ROBERTA: And it would have been a different story if perhaps he exchanged this prior to trial, Your Honor. This was exchanged during trial. We got it a day and a half before the witness is supposed to take the stand.

MR. RAINIS: I still haven't gotten it.

MR. KELLY: He's a treating physician, he can examine him on the morning on the way in here, and testify about his examination. He's a treating physician, and nothing changes other than that one sentence that they don't like. Everything else in there is exactly the same.

THE COURT: The statements I have it up on my screen, but I haven't -- I have it here, but I haven't had a chance to read it either. So, I mean the fact that he's -- I don't know speculating about the reason for him not getting treatment? What?

MR. KELLY: I didn't intend to ask him anything about whether or not the client -- whether or not Mr. Herrera can afford treatment. I didn't plan on asking him anything about that.

THE COURT: I think that needs to stay out. He can talk about whether or not he recommended treatment, and whether or not treatment happened. But I think to the extent he's, you know, stating that he didn't get it because he couldn't afford it, I think at this point that it's too late for that to come in.

MR. KELLY: Okay. They are similarly bound, right?

THE COURT: Say that again?

MR. KELLY: They are similarly bound by that constraint.

THE COURT: Yeah, obviously, they can't use it as a sword and a shield. So, you know, if then -- they are not going to bring that up.

MR. KELLY: When they get up and say you didn't have treatment you were supposed to have, that's a little disingenuous.

THE COURT: No, you can both say was there treatment that was recommended that you didn't get? Yes or no.

MR. ROBERTA: I'm sorry, there's already been testimony that plaintiff was compliant with the treatment plans. Both those doctors testified yesterday that's not an issue.

MR. RAISIN: Yeah. Exactly, Judge.

MR. KELLY: They were compliant with the surgeon's

treatment plans. Doctor Grimm is not a surgeon. He's a chronic pain management specialist. There's a difference.

THE COURT: Well, it's the same type of testimony. Is he being compliant with the recommended treatment. So, no you're asking are they going to be able to ask about that, and are you going to be able to ask about it? Yes. You already have been asking your experts about that, but we're not going to get into he couldn't afford it because, you know, workers comp this and whatever.

I think it's, you know, bringing it up right now in the middle of, you know, once the trial's already started, we are not going to do that.

MR. KELLY: It's a little unfair then because then they are going to imply that he's noncompliant with treatment, and he is not having the treatment because he can't afford it. They are implying that he's noncompliant and they are going to ask for a charge, I assume, on mitigation and noncompliance, which is absolutely wrong.

THE COURT: You can ask plaintiff about that, you know. I don't see -- do you have a problem with that?

MR. ROBERTA: What was it, Judge, I'm sorry?

THE COURT: He can ask plaintiff about his financial circumstances, and, you know, we heard testimony from doctors so that you didn't adopt all of his recommendations for treatment, why was that? Do you have a

problem with that? I know you might not like it, you're making a face, but is there any legitimate reason why you think he can't ask that?

MR. KELLY: That's an appropriate solution, Judge, I'm fine.

MR. ROBERTA: In that case, I think we should be able to, of course, then bring up the fact that he received the workers compensation from the plaintiff, not from the doctor. But in the event he elicits that testimony from the plaintiff, we should then be able --

THE COURT: I think it's more appropriate, I feel, like it's more appropriate coming from the plaintiff then going down this path from the doctor.

MR. ROBERTA: Definitely.

THE COURT: Where he isn't really.

MR. KELLY: I'm fine with that.

THE COURT: Really isn't. And your doctor's sitting here right now, while we're having a conversation?

MR. KELLY: That's a different doctor. He's the radiologist.

MR. RAINIS: He's the witness this afternoon.

THE COURT: Okay. All right. So, that's what we're going to do. You can talk about these things through plaintiff, but I don't want -- I don't want this coming up with this witness. Okay?

MR. ROBERTA: Thank you, Judge.

MR. RAINIS: Thank you.

THE COURT: All right. Anything else you guys want to talk about, we can bring the jury in?

MR. ROBERTA: Just before tomorrow morning, I believe the engineer's coming, so we'll just need a ruling on those other industrial codes before that witness.

THE COURT: I just printed that out. I didn't see anything from you, Mr. Kelly.

MR. KELLY: With respect to the two things he handed me in court, I have no issue with 9.2K, and what was the other one?

MR. ROBERTA: Those two are already struck, Frank. This is 1.5A, 1.5B, and 1.5C.

THE COURT: Mr. Roberta filed something two days ago. This is Document 747 in NYSCEF this is about 1.5A, 1.5B, C-1 and C-2.

MR. KELLY: Right.

THE COURT: And I scheduled you to put something in if you have any opposition or wanted to be heard on that, that you put it in by yesterday, and I didn't see anything.

MR. KELLY: No, I didn't do anything in writing. I thought we had the full discussion on the record with respect to that.

THE COURT: Do you want -- let's talk about it now

and then I'll look at it. I'll try my best to look at it this afternoon or I'll have to do it tonight but.

MR. KELLY: Sure.

THE COURT: Do you want to look at a copy of what he filed?

MR. KELLY: No, no. I thought we argued yesterday about 1.5, and the argument was that --

THE COURT: It was two days, yeah, on Monday you guys did argue and then Mr. Roberta said -- did me the courtesy of filing it, because I am handling all of these things with no assistance. Because my court attorneys are both handling my regular calendar, and everything else. So, he just reduced his position to writing. And if you don't want to do that, that's perfectly fine.

MR. KELLY: No. Generally trial motions, as far as I understand, are orally argued, and don't require filing because that requires a notice period, so.

THE COURT: I was just giving you an opportunity since I gave him that opportunity.

MR. KELLY: I just would rely on whatever the prior argument was on the record and cite the Court to Sawicki against AGA, 143, AD 3d, 549, First Department 2016. And Toussaint against Port Authority 219 Slip Op. 804302. And Witt against -- I'm sorry, Lopez against City of New York, 220, New York Slip Op. 34923/2020.

THE COURT: Were you doing that from memory or are you looking at a sheet of paper.

MR. KELLY: I'm looking at some notes I scribbled.

THE COURT: I was going to say you have magical skills if you're doing that off the top of your head.

MR. KELLY: I'm good, but not that good.

MR. ROBERTA: Which codes?

MR. KELLY: It 231.5.

MR. ROBERTA: A, B, C 1.

MR. KELLY: Each one talks about a different one, but they are generally A.

THE COURT: All right, I'll look at those.

MR. ROBERTA: I'll reply lie on the case law in my memorandum, Judge.

THE COURT: Fair enough. Okay.

Let's bring the jurors.

(Whereupon, there is a pause in the proceedings.)

THE COURT OFFICER: All rise jury.

(Whereupon, the sworn jurors enter the courtroom and take their respective seat.)

THE COURT OFFICER: All rise, jury entering.

(Whereupon, the sworn jurors enter the courtroom and take their respective seat.)

THE COURT: All right. Good morning. Please have a seat. Welcome back. I hope everyone had a restful

evening. We have a full day ahead of us, so we'll get started. Thank you.

MR. KELLY: Good morning. The plaintiff calls Doctor Thomas Kolb, on the part of the plaintiff.

D O C T O R T H O M A S K O L B, a witness called by and on behalf of the PLAINTIFF, upon being duly sworn, testified as follows:

THE WITNESS: Yes.

THE COURT OFFICER: In a loud clear voice please state your name and address for the record.

THE WITNESS: Doctor Thomas Kolb, KOLB. 257 West 34th Street, New York 10001.

THE COURT: As we get started, doctor, just so you know my court reporter is listening to us through the microphone because the acoustics, as you can hear, are a bit challenging. Just make sure you try to speak right into the microphone.

THE WITNESS: Thank you.

THE COURT: Thank you.

DIRECT EXAMINATION

BY MR. KELLY:

Q Good morning, Doctor Kolb. How are you today?

A Good morning, sir.

Q Can you kindly tell the jury what is your profession?

A I'm a diagnostic radiologist.

Q And describe a little bit about your professional education?

A So, I went to college here at Queens College, City of New York, graduated 1979. I went to medical school in Brooklyn, at Downstate Medical Center, and graduated as M.D., in 1983. I then did a pediatric internship and residency here in the Bronx at Jacobi Medical Center, Montefiore Medical Center, and became board certified as a pediatrician in 1986. I then went back and did another four years of training in Manhattan, in Washington Heights, at Columbia Presbyterian Medical Center from 1986 through 1990, in diagnostic radiology. And I've been practicing radiology since along time ago.

Q Are you licensed to practice medicine, in the State of New York, doctor?

A I am.

Q Are you board certified, doctor?

A I am.

Q Tell the jury what does it mean in your profession to be board certified?

A So, to be board certified you have to finish a number of years of training, and radiology is four years. You then have to take a written examination, and then I had to take an oral examination, and if you pass everything, you become a member or a diplomat of the board of radiology, or board certified.

Q Have you published in your field, doctor?

A I have.

Q Tell the jury a little bit about your publication and research?

A So, my practice is split into two parts. One is breast cancer diagnosis, and I see thousands of woman a year. I specialize in young high-risk woman for breast cancer, and this is for more than 30 years, and I'd done research and publications in that field. I've published papers that won the American Medical Association Scientific Publication of the year. That's the AMA, on finding breast cancer in woman with dense breasts. So, all that data early data came from my publications. So, that's part of what I do, in my practice.

The other part of what I do in my practice are other types of radiology studies, MRI, CAT scans, x-rays on patients that are sent to me by doctors to do those tests.

Q Tell us a little about your current professional affiliations societies?

A Well, I belong to the Radiological Society of North American, I was a Clinical Assistant Professor of radiology for many years at Columbia University. And right now I'm in private practice, as I said, seeing patients for diagnosing breast cancer and also reading MRI's and CAT scans for this past 30 years.

Q If you'd kindly tell the jury a little bit about what

an MRI is? What it does?

A So, an MRI stands for magnetic Resonance Imaging, and it's a big machine and it has a very large tube that many of us know already about. It's a very common test, and it uses magnetic waves.

There's the magnet that you lie in, there's a very powerful computer that pulls magnetic waves into your body, those have interaction with parts of your body, and the computer produces a picture which you will see MRI scans of the body. So that's the test that's very commonly used to look inside the body for abnormalities.

Q And can you tell us a little bit about what a CT scan is?

A So, CT scan is very different. CT scan uses x-rays different energy use x-rays to take pictures of the body. It's very good. The differential between x-rays and MRIs are x-rays are really good to look for things that are hard so. If you want to look at bones, you want to look at fractures, x-rays are really good, CAT scans are each better.

An MRI is a totally different test and that could not only see hard verses soft, it can see everything. It could see ligaments and tendons, and the meniscus, and the rotator cuff, tendons. All things you can see on MRI, but you can't really see very well or at all on x-rays or CAT scans. So, MRI's a very powerful test.

Q And do you perform studies with MRIs and CT scans?

A So, the way it works with MRIs and CAT scans is the technologist that sits at a console puts the patient into the machine. Many of us have had these tests. The technologist would then take those pictures and those pictures will be transmitted and read by a radiologist, like me.

Q All right, is that what you do in your normal private practice?

A Exactly.

Q And with what frequency do you perform those kind of studies?

A Daily.

Q In our case, Mr. Herrera contends he was injured when he was struck by an excavator at a construction site and suffering neck, back shoulder and ankle injuries including soft tissue and boney injuries.

Do you have experience in applying your professional skills to problems of Mr. Herrera's kind?

A Yes, patients are often sent for MRI's or CAT scans because of pain, pain can be from various reasons. Pain can be from trauma. So, yes for over 30 years I've seen testing radiologic imaging, MRIs, CAT scans on patients like this, yes.

Q Have you previously been qualified as an expert in New York State courts?

A I have.

MR. KELLY: Your Honor, I offer Doctor Kolb, as an expert in radiology.

THE COURT: No issues.

MR. ROBERTA: No objection.

THE COURT: Okay, I find him so qualified.

DIRECT EXAMINATION

BY MR. KELLY:

Q Doctor, did there come a time when you were asked to consult on Mr. Herrera's case?

A Yes.

Q And, please, you can feel free to refer to your records to refresh your recollection to testifying. You can look at your records.

Okay, were you asked to provide radiological services and or review studies?

A Both. I was asked to actually do the scanning of this patient at various times, and I was also then given prior x-rays and MRIs and CAT scans to review to understand the whole picture on this patient, yes.

Q So, please, tell the jury what things you looked at in your forming an opinion with respect to Mr. Herrera?

A Well, I looked at a lot of things. So, bear with me for a second. So, in the cervical spine, I looked at a CAT scan from 2013. I have looked at an MRI of 2013. I looked at another MRI of 2018. And I looked at x-rays of different years.

That's just of the neck.

Of the back, which is the lumbar spine, I looked at a CAT scan in 2013, I looked at MRI in 2013, I looked at another MRI in 2014, I looked at another MRI, in 2018; and then I reviewed a number of x-rays that were done at different years.

In the ankle, I looked at a CAT scan of 2013, another CAT scan in 2014, and then multiple x-rays of the left ankle over the course of many years.

In the left foot, I looked at a CAT scan of 2014, and then multiple x-rays that were done during the course of multiple years.

For the right shoulder, I looked at an MRI of 2013, and then multiple x-rays done over the course of many years. And then I looked -- I was sent to look at chest x-rays, other x-rays of the ankle, right shoulder and ribs, in March 2013. Left leg, in 2013, CAT scan of the chest, CAT scan of the thoracic spine, CAT scan of the brain, all from 2013, CAT scan of the abdomen and pelvis, and CAT scan --

MRI of the brain in 2014, MRI of part of the brain called the internal auditory canals in 2014. So, a lot of images.

Q Okay, doctor, during the course of your examination, I'm going to be asking you for certain opinions. All those opinions I ask you for need to be to reasonable degree of medical certainty. I may not say those words all the time, but

all your opinions when I asked about findings so on, need to be to a reasonable degree of medical certainty. Is that okay with you?

A Sure.

Q All right. Doctor, in the course of this litigation, we've developed certain demonstrative aids which you've reviewed, have you not?

A Yes, I have.

Q And did those demonstrative aids reflect the underlying films or studies?

A Yes, they do.

Q And fairly and accurately represent those studies?

A They do.

Q Okay. Doctor, we're going to show the jury, with the Court's permission, some of those studies, and I'm going to kindly ask you to explain them in a little bit. But first I need to get the Court's permission to use the easel and show some of those.

THE COURT: Go ahead.

Q Doctor, would you like a marker or laser pointer?

A Sure I would.

Q Doctor, I think we'll start with the neck, if that's okay with you?

A Sure.

Q I'm going to ask you to kindly take a look at what

we've previously marked as Plaintiff's 20E, and ask you to come down -- sorry, the easel's low?

A Thank you.

Q Now, doctor, we've put up this display board, and I'm trying to ask you to just kindly orient the jury. What is it we're looking at, and what part of the body and so on. Just tell us what we're doing?

A So, this -- we are looking at a single image of the patient's neck, the cervical spine. The patient's brain is up here, the patient's feet are down here, this is the back of the patient. And you can see the patient's mouth here in the front.

Now, in this spine, there's a long gray stripe coming down the middle, and that's the spinal cord. The spinal cord comes from the brain up here, and goes all the way down to our lower back. So, that's what this stripe is.

And the spinal cord there's a thin white stripe in the front and a thin white stripe here that contains spinal fluid, and it's contained in a sack. You don't have to remember the names of anything. You'll just, you'll see what I mean when I show you everything.

So, there's spinal fluid in a thecal sack around the cord. In the neck we know that there are bones, there are seven bones in the neck. Whether you're tall or short or male or female we all have the same anatomy.

These are the seven bones, and I'm just going to label

them for you, so we're all on the same page, okay. So, I put a number on each bone starting with the second bone here is 2, 3, 4, 5, 6, 7. Okay?

So, you'll see that those gray boxes are the bones. In between the bones are these dark structures here. Those are the discs. In between each bone in our neck and our back there's a disc.

Discs is like a shock absorber, so that when you jump up and down, you move around, the bone doesn't touch the bone. So, when you jump up and down, the bones may come together a little bit from jumping, gravity. But then it will spring back to normal because a disc is like a little shock absorber because there's fluid in the discs.

So, what holds the disc in place? Why doesn't the discs just spurt out? It's held in place because there are ligaments running up the back, and the front of these bones and there's a ligament that goes around each disc and they all have fancy names. The only one that we'll talk about is called the annulus. You don't have to remember the names, but they are all held into place.

So, on a normal disc is held in place by the ligament. And when you look at an MRI, let's look down here, you see this disc here, it goes to the very back of the bone and it completely stops. And the reason it stops is a because ligament is holding it in place.

Now, I want you to look at a normal level here, okay. At the very bottom of the cervical spine, and let's start working our way up. Let's look at this level right here which is the worst level. Between the fourth bone and the fifth bone, is the C, for cervical, C4-5 disc. And you can see very clearly that this disc does not look like that disc. You'll see that this disc is pushing into the thecal sack, and it's actually -- well, it's just pushing into the thecal sack here. That is the largest disc. And what has happened here is that ligament that was supposed to hold it in place has torn, and that's a disc herniation. When there's a torn ligament.

Now, you may have heard about disc bulges and discs herniations in your neck and your back. A bulge is a partial tear of the ligament. The ligament this is the disc and this is the ligament holding it in place. Normal means it goes to the margin of the bone and stops. Just like here. But if the ligament starts to tearing partially, and the disc pushes out, that's a disc bulge. If the ligament tears completely, then the disc pushes through, and that's a disc herniation.

Why do we care about bulges and herniations? Because this is a very very tight space. There's very little room between the discs, the spinal cord, and all the nerves that come off the spinal cord in the case of the neck that go down our neck, down our shoulder, and all the way down to our fingers.

So, a disc bulge or herniation, can cause symptoms to a

patient, and that's why we care about discs bulges or herniations. Now, that's all I really need to know about anatomy.

And in this particular case right here, you'll see that there are four discs that are out of place. Some larger, and some smaller. But between 3 and 4, between 4 and 5, between 5 and 6, and between 6 and 7, all of these discs are pushing into an abnormal space. These are discs herniations. Compared to the next discs underneath, this is what normal should look like and what these should look like.

So, the bottom line is that this particular MRI of the cervical spine shows discs herniations at C3-4 at this Level, C4-5; C5-6, and C6-7. And as I said disc herniation here you can see a small indentation of the spinal cord. It actually touches the spinal cord. That's the main findings on this MRI, that was done April 30, 2013.

Q Doctor, let me ask you, when disc herniation touches the spinal cord or thecal sack, what happens? Tell the jury what happened?

A Anytime there's a discs herniation, there's a -- the disc is in a place that it shouldn't be. For example, let me give you an analogy.

If you had a balloon filled with air, and in the middle of the balloon there was an object, a marble, a nerve into the middle of the balloon and you took your first and you pushed on

the outside of the balloon, there would be increased pressure from your fist pushing in on that object in the middle. Not only could it be touching it, but it's increasing pressure. That increased pressure or direct impingement, direct pushing, on the cord or its nerves can cause pain. That's why it's important to know whether there's a herniation there or not. And the referring doctor who examined the patient will correlate whether this herniation is related to the patient's pain or not.

Q Doctor, are these images, are they objective? That is to say, can a patient manipulate the findings?

A No the pictures are what the pictures are.

Q Doctor, can we move to the next demonstrative aid?

A The next one is Plaintiff's 20M, if I'm reading it correctly. It's a CAT scan of the patient's, Erwin here, done April 30, 2013.

So, this is a different test. This was done before that MRI. And I just showed you the MRI because it's pretty clear to see those herniations. As I said to you, MRI is very clear with these things.

CAT scans shows you very abnormal C4-5. This is the disc, this is the herniation. You can see there's asymmetric, because a herniation is pushing down, and the gray circle is the spinal cord. It looks like a circle because we're cutting -- no one's really getting cut. It's just in the machine. We are looking at the patient in different ways. For example, to make

things very clear. You could have along love of French bread or Italian bread and you can make one long cut and make a hero sandwich, that hero sandwich will contain two long slices of bread, and that's what I showed you in the picture before. You saw the whole spine, you saw all seven bones. But you don't have to cut the bread like that. You can cut the bread and I can make many slices. And you can make ten slices in that same loaf, and then when you pull a slice out it's not long it's round or square and that's what we've done here. Instead of looking for the -- looking at the patient from top to bottom, from the brain to the feet, we've cut the patient. No one's being cut.

We've looked at the patient from top to bottom, we pull a slice out, and put it up to look at and now what was a long spinal cord now looks round.

In any case, this is what the CAT scan picture of the patient on April 30th, 2013, look like showing the herniation at C4-5.

Q What is the significance for the patient of this kind of finding?

A Well, the patient could feel pain. The patient could have symptoms. The patient could have numbness, tingling, wherever the nerve is going to the patient could lose reflexes, the patient could have problems with the nerve.

Q And similarly this CT scan is this objective finding?

A Yes.

Q Can the patient fake what the findings on CT or exaggerate them in any way?

A No. The pictures are what the pictures are. They are not manipulated by anybody.

Q I'm sorry, what level is this again?

A C4-5.

Q Doctor, you need to see anything more from this?

A Well -- so, we're looking at Plaintiff's 21F. This is a regular x-ray. And on x-ray you see what's hard, and you can't see what's soft. So, what's hard? Hard are the bones, okay. And we talked about these bones. This is 2, 3, 4, 5, 6. But we see something else here and that's this white plate and there are screws here. This patient had surgery and the surgeon fused the C4-5, and C5-6 levels, and that's what you're seeing on this x-ray of the patient. This is what the patient looks like after surgery.

Q And when was this film taken?

A August 14, 2014.

Q Are there any significant finds on this film?

A No.

Q All right, doctor, is the condition shown there permanent?

A Yes. Once the patient has a fusion like this, it's almost always left in place, and the patient lives the rest of

their lives just like this.

Q And the prior to demonstrative aids, we saw results in this surgery, is that correct?

A Sorry.

Q Prior to the demonstrative aids, we saw the condition shown on the prior two demonstrative aids result in this surgery, is that correct?

A Right. The CAT scan, and the MRI is what I think you meant that we just showed were before the surgery, and then the surgeon went in and fused those two levels.

Q I'm sorry, what levels is that again?

A C4-5 and C5-6.

Q And would the conditions shown to Mr. Herrera's cervical spine presurgically would they heal on their own?

A No, once the ligament is torn and the disc is screwed and herniated, it doesn't come back to normal. Those are permanent.

Q Could you just identify what demonstrative aid we are looking at?

A 20D.

Q Thank you, doctor.

A So, this is an MRI of the lumbar spine. The reproduction here is very dark, but there are -- the anatomy's the same at cervical spine. Instead of there being seven bones there are five bones in our back. And each bone is called L,

for lumbar. The neck is up here, and the lower back is down here, and they are called L-1 through L-5. And between each bone there's a disc.

So, if you want to talk about the disc between the 4th bone and the 5th bone, it's L4-5, is the disc. Everything that I told you is the same. Nothing else to learn. The discs are held in place by ligaments, a normal disc goes to the edge of the bone and stops. An abnormal discs punches out through the ligament, if it's herniated, and pushes on abnormal structures.

This gray structure's the spinal cord coming down. This picture is very dark, but there are five bones in here. And here you can see two levels. This was done April 30th, 2013. There are two levels here where the discs are bulging. So, they are not herniated. They are not pushed through completely. So in this case it's a little darker. I'm going to show you that other view in a second.

There are discs bulges which means partial tears of the ligaments at two levels in the lumbar spine. L4-5, and L5-S1.

If we look at that cross section picture here, which is number 20H, we see here a round disc. Again, going like slices. This here are the nerves coming down. Patient's head is on the back of this board. The patient's feet are coming out towards you. So the patient's here, pulling the picture out, putting it on the board here. This is the sack, the thecal sack, and you can see that the disc is pushing on it here. And there's some

thickening of the ligaments and facets joint which are other bones in the back.

The bottom line is on that MRI, this MRI of 2013, there are discs bulges at L4-5 and L5-S1. There's also one other finding which is important. There's slippage of two bones, so the bones, as you saw, have to be lined up like this. What holds them in place are again ligaments, like everything else in the neck and the back.

Sometimes our bones slip, and if one bone slips in front of the other bone, that's called the anterolisthesis. And the reason it slips usually is because ligaments are torn. And in this patient which you can see on the first picture, though a little dark, is there's a gray one anterolisthesis of the fourth bone upon the fifth bone.

Those are all the findings, including facet hypertrophy. Those are all the findings on the lumbar MRI. There's two bulges at L4-5, and L5-S1, and there's grade one slippage anterior of L4 upon L5.

Q Doctor, may I ask you. You mentioned the thecal sack couple of times. I'm not so sure all know what that is. Could you tell us what that is, what it does?

A So, thecal sack is like a long balloon. It goes up from our brain, down all the way to the lower back, and it contains spinal fluid. And that is the white stripe that goes around the spinal cord. It provides nutrients to the spinal

cord, and it also is like a shock absorber. So, when you move the spinal cord doesn't touch the bone. So those are its functions. The sack is like the actual balloon that holds the spinal fluid in it.

Q All right, and if there's imposition or pushing on the thecal sack, what can happen?

A That transmit pressure to nerve roots, and it can cause pain.

Q And is that the situation we are looking at here in the lumbar spine?

A We're looking at discs bulges that are pushing on the anterior epidural fat at L5-S1. And upon the thecal sack at L4-5, and also the lower parts of the neuroforamina. We haven't talked about the neuroforamina, that's the last part of the anatomy. These nerves have to get out somehow to our legs, to our shoulders. So, they get out through hole on sides of spine. Those holes are called neuroforamina, which means holes with nerves. And they have to come out here. This is actually a nerve root coming out here to the left of the patient at L/4. This is the right sided L/4 nerve root. This little gray line here is actually the nerve root. And as the bulge in this case pushes down, it can exert pressure on the sack and the neuroforamen which can cause the patient to have symptoms.

Q When you say symptoms, what kind of symptoms can we expect?

A If the patient has symptoms most often pain. There's other symptoms related to nerve roots, but most often pain.

Q And that's the same with the neck impingement, as well, right?

A Same.

Q Okay. All right. Doctor, similarly with the lumbar, this is an objective finding, is it not?

A Yes.

Q All right, and can the patient manipulate this kind of finding or fake or exaggerate it?

A No, the patient cannot manipulate these pictures.

Q And the condition shown in this study, would that heal without medical intervention?

A No once the ligament is torn, it stays torn.

Q Do we need to see anything more from this?

A That's it.

Q All right.

A So, next just very similarly two x-rays. There's an x-ray of the back.

Q That's plaintiff's?

A This is number 21J. These are the bones of the back. This is 5, 4, 3, 2, 1. So, again, this is what you should look like. These squares are the bones in the back and there are five bones that are labeled. But what the patient now has is this surgical hardware. A plate with screws that go into the

patient, and you'll see it also on number 21I. And this is when you're looking straight at the patient like this. You'll see the plate and the screws. And this is when you're looking at from the side of the patient 21J looking from the side of the patient. There are screws coming in from the back. There's a screw coming in from the front. And there's a disc stabilizer put in by the surgeon.

Everything you see here is all put in by the surgeon. Again, the surgeon has fused these two levels in the lumbar spine L4-5, and L5-S1.

Q Is the condition shown in study permanent?

A Yes.

Q And, of course, this study, again, is the x-rays objective?

A Yes.

Q All right, and it can't be faked or otherwise manipulated or exaggerated?

A No.

Q Thank you. Can we move onto the next one.

A It's the same. We're done with the lumbar. That's the story of the patient's back.

Q So, you were asked to do a review of certain studies and perform studies with respect to Mr. Herrera's right shoulder, correct?

A Yes.

Q And those demonstrative aids that are in the courtroom reflect your records with respect to the records with respect to the right shoulder, correct?

A Yes.

Q Doctor, can you kind of identify the demonstrative aid we are utilizing are now on the easel, and so just tell us what we're looking at and orient us to anatomy and function?

A So, the first thing we're looking at is just an x-ray. This is an x-ray of the patient's acromial clavicular joint. This is the clavicle this bone that you feel here, and it attaches to the bone in the shoulder called the acromion and this joint, this bone here, which is your clavicle should be together, should attach right here. But as you can see it doesn't. It is all the way up in the air here, that's because the ligament that attached here the acromioclavicular ligament is torn, and the clavicle, since it's not being held in place, has jumped up to an abnormal place. This is called grade three separation of the acromioclavicular joint, that's what this picture is showing.

Q Can we expect the patient to be making any complaints as with respect to the condition shown in these demonstrative aids?

A Grade three separation is often very painful.

Q And this is to Mr. Herrera's right shoulder, is that correct?

A Right shoulder.

Q And what is the date of the study?

A March 7, 2013.

Q And what's shown in this x-ray is an objective finding?

A Yes.

Q Can it be manipulate or exaggerated in any way?

A No.

Q Would it spontaneously heal without surgical intervention, doctor?

A No, definitely not.

Q Okay. Let's move onto the next.

MR. RAINIS: What's the number of the last one?

THE WITNESS: This is 21G.

A Now, the next one is 20L, and that was -- this is an MRI of the right shoulder, June 7, 2013. Switching gears to the shoulder for one second. The shoulder is a joint that we obviously can do a lot with move around. That's because this bone, which is your humerus is shaped like a circle or a ball up here, and that's what you're see here. This round shape here is the humerus. The humerus, is attached to the rest of the body, to this other bone called the glenoid. Again, you don't have to remember any medical terms. So this is the humerus, this is the glenoid.

Now still we always need ligaments and tendons to hold everything in place or else it will just fall apart. In the

shoulder, there are four tendons that makeup the rotator cuff. Those tendons, the ones that we're going to talk about here, are called supraspinatus and infraspinatus. These tendons should be in this MRI completely black here. There should be nothing in them. There is obviously a very abnormal large area of white signal right there in the supraspinatus and infraspinatus tendons. This is called a full thickness tear, because it extends from the bottom of the tendon, the articular side to the top of the tendon the bursa side. And there's a complete tear of the tendon here with a small area of retraction. In other words it's pulled off the bone. These tendons come in off the muscle, goes into the bone, and here it's being pulled off the bone. This is a very obvious finding.

Again, you don't see the clavicle as well as the x-ray. But there's grade two on the MRI, because that was the x-rays were weightbearing. In other words, not so important, but the reason why there's grade three separation of the AC joint, on the x-ray is because the patient was holding weights. Because we want to see if that AC joint how bad the injury is. On an MRI the patient a not holding weights and there's a grade two separation. It just mean how far the clavicle is away from the acromion. Bottom line is the ligament is torn, it doesn't make a difference.

Q Doctor, you mentioned something called white matter signal? Can you tell us what that means?

A So, not white matter signal.

Q Oh, sorry, sorry.

A But an area of abnormal white signal here. That means that the tendon that should be completely black inserting on this bone has been disruptive or torn. That's what it means.

Q And what kind of complaints can be expected from a patient exhibiting these findings?

A The most common complaint is going to be pain, but also a limitation in motion. Those are the two most common complaints with something like this.

Q And these objective findings, as well, doctor?

A They are.

Q They can't be faked or exaggerated?

A The pictures are what the pictures are.

Q Okay. Go to the next. Are we done with that?

A We are done.

Q I think there's another shoulder.

A It was done on the same day. No -- yes. So, it was the same day. The MRI I showed you was June 7, 2013. This is the same day. It just shows you -- we don't just take one picture. We take many, many, many pictures. I have chosen the pictures to show you with the most obvious abnormality.

All this on 20K, is abnormal. It's exactly what I told you before it's a rotator cuff tear. All this liquid is abnormal, here is the clavicle, here is the acromion, here is

the fluid in between the joint which shouldn't be there because of the tear of the ligament. Same thing I told you before.

Q And do these conditions shown with respect to the right shoulder shown these demonstrative aids, do they heal without surgical intervention?

A They evolve over time, but the tear will remain.

Q Okay. Let's move onto the next body part.

A So, next we're looking at the ankle.

Q Plaintiff's exhibit?

A This is 20A.

Q Thank you, doctor.

A So we're now switching gears and looking at the ankle. And we are looking at the ankle directly from the front. There are three major bones that we're going to talk about in the ankle. More than that, but just for the moment.

This long bone is coming down from the top of the patient all the way down, that's called the tibia. This thin bone you can feel that, that's your shin. This bone on the side of it is a thin little bone on the outside of the leg, and going down to the ankle and that's called the fibular. And then there's a bone here that's in the ankle called the talus.

You see the tibia and the talus and the fibular all share the joint space. The space here is actually filled with cartilage, and CAT-scan you just see what's hard, you don't see the cartilage. So, this is space. But what you do see on this

picture is there's a piece of bone that shouldn't be there. This is a fracture coming off the piece of the tibia here. That's called the medial malleolus and this fracture is well corticated.

On another picture, there's a fracture there. There's also a piece of bone which is also well corticated here between the fibular and the talus on a different picture.

So, these in my reports look chronic, meaning difference between -- there's two things that fractures can be. They can be acute, which means it happened right there and then or soon after. Or chronic, which means it happened at sometime later. As fractures sit there, as the bone just sit there, their margins change from being raged. So, as time goes by, the fractures become -- they go from acute to chronic over time. And they look a bit different.

These fractures that I described have a chronic appearance. They are sitting in the joint spaces which can cause the patient to have problems. That's the major findings of this scan. This CT scan in addition there's what's called an osteochondral defect means there's a little hole in the bone and the cartilage, that's also seen here.

On 20A this round low grey area here is an osteochondral defect in the medial talus bone. Lot a words, but a lot of abnormalities here.

So those are the findings, the main findings on this

ankle, and there are degenerative changes, as well.

Q Is that all we need from those?

A Yeah. So, in an attempt to make the patient feel better, the patient's doctor on 21A put a screw which fixed or fused the talus with the calcaneous. These two bones. The doctor also put here a plate with screws transfixing here the talus and the bones beyond it.

If you look at 21B, here is the ankle. You see the screw going through. You see there's a fusion here and midfoot near the patient's toes. In the middle of the foot there's a screw. In the back of the foot and the heal there's a screw. And then in the midfoot right next to it there's another orthopedic fusion device. That was done on -- this is an x-ray of August 14, 2014.

And then, again, on 21D, March 3, 2016, now a second screw. Here, look at the difference between the picture on the bottom where there's one screw here, that's called a subtalar fusion.

Now, there are two screws, right? Now, there are two screws here. The patient went in and had a surgical revision, and was fused a second time.

This screw here in the middle of the foot is taken out. It's not there anymore. So, there's an extra screw between the talus and calcaneous. And the screw here was taken out. Those are all the pictures, and that's what happened to the patient at

surgery.

Q Doctor, is that all for the demonstrative evidence?

A I think that's a lot.

Q I think it's a lot too. You can retake your seat.

Doctor, just so we're clear, the condition shown post surgically to Mr. Herrera's left ankle, that's a permanent condition, is it not?

A Definitely.

Q And that limits -- I'm sorry?

A It's permanent, but a screw was taken out. In other words, surgeons can do things to change, but the patient is fused and the attempt to -- the whole reason the ankle had those screws in it was to fuse the bones together. Because with the patient walking without it being fused, the bones were touching the bones, and it was a lot of pain. The purpose of that surgery is to limit the patient's pain and give the patient back more function by fusing the bones together.

So, this patient was fused and then revised. So, the answer to your question is it's permanent until the surgeon does something else or not.

Q Okay. Doctor, can you have degeneration in your bones and joints without pain? Without symptoms?

A Yes.

Q Tell the jury, if you would, we've heard a little bit about degeneration. Tell the jury what it is, and what it means

in your practice?

A So, unfortunately, as we get older, we all degenerate. And when we talk about degeneration, we're talking about joints. Whether it's in the spine, or in the shoulder, or in the ankle.

In the spine, those discs first thing that happening is they get dark because on certain sequences because they lose water, they dry out. Once the discs dry out, they become less springy, so they become brittle, and as the bones come together, they don't spring apart so much. And so second thing that happens is that the bones get closer together, and don't go back to where they were when we were younger, they stay narrow. The discs narrows. And the third thing that happens is that the bones will actually know that this is happening, and they will try to fix it by forming spurs or osteophytes. Bone spurs. Bone spurs are an attempt by your body, specifically your bones, to try to fix the condition that is causing the problem. That's the body's way of fixing it.

So, in the spine, there are three stages of degeneration. These discs lose water, they become narrow and they form bone spurs.

In the shoulder, similarly, the bones can form extra bones that can cause more problems by these spurs pushing into parts of your shoulder that continue to make it hurt.

In the ankle, it's all the same. There are pieces of cartilage, there are -- there's cartilage in each of the joints

spaces of the ankle, that if they are narrowed can cause pain.

So, all of these are a process of degeneration or arthritis that occurs with time.

Q Okay. Disc degeneration happens to everybody?

A Invariably. In other words, some older people can look great. Some younger people could look not so great. But in general overtime people become arthritic.

Q All right, and you can have degeneration with no limitation of your function and no limitation of your lifework, right?

A Right. You never know it's even there.

Q Okay.

A Right.

Q Doctor, if you're not testifying with us today, what would you be doing?

A I would be in my office.

Q And would that be seeing patients or performing studies, things like that?

A Both.

Q And is your office charging a fee for your time away from work today?

A It is.

Q Can you tell us what that so?

A $12,000.

Q And you've developed a number of reports in the case.

Did your office charge a fee for that, as well?

A They did.

Q Okay. Do you recall what that is?

A Can't give you total amount. I can tell you that the x-rays are $450, reading MRI, CT $950.

Q And, doctor, you have testified with me three times in the last ten years, something like that?

A I don't remember exactly, but a small number.

Q And doctor I appreciate your time. I have nothing further from you. Thank you so much.

CROSS EXAMINATION

BY MR. RAINIS:

Q Good morning, doctor.

A Good morning, sir.

Q I'm going to ask you some questions. I'm going to try to elicit yes or no answers. If you can't answer a question yes or no, let me know, and I'll move on or ask a different question, okay?

A Yes, sir.

Q Aside from testifying approximately three times for Mr. Kelly, how many times have you testified for the firm he works for the Gorayeb firm?

A I don't work for them. In other words, I have testified in court from studies exact like this case, and the answer is I don't know the exact number of times, but I come to

court in general 5 to 6 times per year for many years. So, I at least 20 years.

Q So, how many times -- so 5, 6 time per year for the Goryeb firm?

A No, it could be for other firms or whoever calls me. I mean, these are pictures I took in 2018, and somebody contacted me a couple months ago five years later, six years later, so. I don't have an answer for how often this happens, but I do know I come to court that many times per year.

Q And in addition to coming to court, you do these radiology image reviews for law firms where you write your reports?

A Yes.

Q And as you said, it's $450 to interpret an x-ray, and I think you said $950 for CT or MRI scan?

A Correct.

Q Okay, and how often do you do that?

A Uhm, usually, they are sent to me and for the purposes of coming to court or testifying. So, the majority of times, as I said, I come to court 5 to 6 times per year. It's possible someone will send me x-rays to interpret that doesn't come -- doesn't go to court, but I won't know how frequently that is.

Q You don't know?

A No.

Q Do you do this type of review on a weekly basis?

A No.

Q Now, you have your reports in front of you?

A Yes.

Q Okay. Let's -- we talked about you mentioned degeneration of the vertebrate, for example, correct?

A Degeneration of the spine, yes.

Q Okay. And that's something that, as you said, happens to all of us to some to more or less a degree overtime, correct?

A Correct.

Q And someone engaged in heavy labor activities has a greater likelihood of developing degenerative changes, correct?

A As I say, it's variable. I mean you could do heavy labor and have a normal looking spine. You could be sitting at a disc and have a disc herniation. So, I can't give you a better answer than that.

Q So, you can't say that performing heavy labor increases the risk of degenerative changes?

A Right. I personally don't have any data for that, so.

Q So, looking at the ankle images that you put up there, I think you were looking at a CT scan of the ankle dated May 7, 2013?

A Yes.

Q Now, you talked about those fracture pieces that were visual floating in the joint. Remember that?

A Yes.

Q Okay, and you showed the jury those?
A Yes.
Q And that's from an older injury, correct?
A I agree I wrote in my report that they look chronic. So, I can't tell you exactly when they occurred, but the difference between chronic means awhile ago.
Q Okay. So, we don't know when, but we can agree --
A Right.
Q That by May of 2013, those weren't caused by the March 2013 accident, correct?
MR. KELLY: Objection.
THE COURT: Repeat the question.
(Whereupon, the requested testimony was read back by the Court Reporter.)
THE COURT: Overruled. Answer the question.
A So, two months before, so they look chronic meaning longer or older. I can't tell you exactly when they occurred. It's two months already since. It's not the same day. It's they didn't have -- I don't have the picture from the same day of the accident to give you a more definitive statement than that.
Q And I just want to clarify. So, you're saying it looks like those fragments in the ankle are older than two months old?
A They can be.
Q And you mentioned that those fragments were in the

joint spaces?

A Yes.

Q And when you have a fragment of bone in the joint space, and the joints move, that fragment disrupts the articular surface of the joint, correct?

A If there's a fracture by definition the articular surface would be disrupted that's correct.

Q But when there's a fragment like we saw in those ankle x-rays, in the joint spaces, and the foot is moving, that fragment in the middle of the joint space will irritate and damage the articular surfaces of the joint, correct?

A It can.

Q And that would be a type of degenerative change that would be occurring, correct?

A Yeah, that would be a posttraumatic degenerative change, yes.

Q Okay. And, so when you looked at the x-ray -- I'm sorry, the CT-scan of the left ankle in May 7, 2013, you talked about the fracture fragments, and the osteochondral defect, okay, which was in the talar dome?

A Yes.

Q Okay, and the narrowing of the subtalar joint, correct?

A Yes. In my report, yes.

Q And that would be subsequent with having that osteochondral defect there, correct?

A No. The narrowing of the subtalar joint is very different than the osteochondral defect, two different areas.

Q Okay. And the narrowing of the talar talonavicular articulation correct?

A Articular.

Q That's the joint space between the talus and navicular bone of the foot?

A Correct.

Q And as you said in your report, all of those things are degenerative in nature, correct?

A Just one second. I described it as narrowing, yes. And at the end I say degenerative changes. These are all the narrowing of the joint spaces that you talked are degenerative, yes.

Q I got a copy.

A Yes.

Q So, for whatever reason by May of 2013, Mr. Herrera had significant degenerative changes of the ankle, correct?

A Yes.

Q And that included the osteochondral lesion you described?

A Yes, I believe so.

Q Now, talking about the -- let's go back -- one of the other films you reviewed, but you didn't have a picture of it here, was a CT scan of the lumbar spine dated March 5, 2013?

A Okay.
Q And that was the day of his accident, correct?
A Yes.
Q And this was a film, I believe, taken in the emergency room, at Bellevue? Or in the radiology department at Bellevue?
A Sounds reasonable, yes.
Q And it described the things you showed us on other studies disc bulges at L4/5 and L5/S- 1. Impinging on the epidural sack and thecal sack, right?
A Yes.
Q And those are the same things you showed us before, right?
A Yes.
Q And then you said, you went on to say that this CT scan taken on the day of the accident reviewed hypotrophic changes with facet and ligamentous hypertrophy resulting in bilateral foraminal narrowing at L3/4, L4/5, and L5/S1, right?
A Correct.
Q And there was grade one anterolisthesis on L4 and L5, correct?
A Correct.
Q And then again you concluded that all those changes were degenerative, correct?
A All the ones you just mentioned.
Q Okay. Talking about -- returning to that CT report,

hypotrophic changes those are degenerative findings?

A Yes.

Q They are consistent with degenerative disease, right?

A Yes.

Q And as for ossification would be another -- something consistent with an old -- I'm not saying it's present in that x-ray. This is just a general question now.

Ossification is consistent radiologically with an old process, correct?

A Ossification, means there's bone where there wasn't before. So, it could be from trauma, could be from living life. It's a general term, yes.

Q For example, if you talked about the natural progression in general of degenerative spine disease. At one point you said the spine actually tries to grow additional bone, and that would be the process of ossification, correct?

A I wouldn't use that word for it, but it is the process of degeneration growing bone spurs those are osteophytes. Ossification those are osteophytes.

Q So, then osteophytes in the presence of osteophytes is consistent with a degenerative process, correct?

A Correct.

Q And going back to the CT scan taken on the day of the accident, March 5, 2013, that also showed hypertrophy at both the sacroiliac joints, correct?

A I believe you're right, if that's what I read. But yes, I said that correct. If that's what's in my report, then I agree with you.

Q Okay. And then on that CT scan there was osteophytes formation at each of the lumbar verbal levels, correct?

A That is correct.

Q And you noted that there was loss of height of the L/4-5, and L5/S1 discs, correct?

A Yes posteriorly, yes.

Q And that's part of the degenerative process you described where the discs actually compressed down over time?

A Yes.

Q And that's why sometimes people actually get shorter as they get older because -- that's what they say, right?

Don't know?

A No opinion as to that.

Q Okay. Not everybody? I think I'm getting shorter.

MR. RAINIS: Thanks. That's all I have. Thank you.

CROSS EXAMINATION

BY MR. ROBERTA:

Q Doctor, you had testified earlier that the images are objective findings? They can't be manipulated they show what they show; is that correct?

A Yes.

Q The images, though, when they just show what they show, they don't show what caused what's there? They just show what's there, correct?

A That's correct.

Q Now, when it comes to the findings that are on there, isn't it also correct that different radiologists can interpret the images differently?

A Yes, within reason that's true.

Q So, you might find a herniation, somebody else might find a bulge?

A That is true. It's possible.

Q So, to the extent that they can be interpreted differently, they don't necessarily show the same thing, correct? Because one person could look at it and see a bulge, one person can look at it and see a herniation, correct?

A I didn't think that was the question asked of me. I thought the question asked was can they be manipulated and changed. The answer to that is no. The answer to your question is radiologists can disagree within reason, yes.

Q So, one radiologist could look at an image and say it shows a bulge, another one can look at it and say it shows a herniation, correct?

A That is possible.

MR. ROBERTA: No further questions. Thank you.

THE WITNESS: Sure.

MR. BAXTER: No questions.

THE COURT: I'm shocked.

MR. KELLY: Redirect.

REDIRECT EXAMINATION

BY MR. KELLY:

Q Doctor you were asked about CT scans taken on March 5, 2013. Now, the CT scan would show boniness, is that correct?

A We're talking about the CT of the cervical spine?

Q The lumbar spine -- you were asked about CT of lumbar spine March 5, 2013?

A Yes.

Q And the CT scan just generally the CT shows boney injuries, is that correct? The boney structures?

A It does, but you can see the discs as well on a CT, not as well as an MRI. But you can see the discs, yes.

Q So, for a definitive reading, you would need an MRI; right?

A Often MRI is better, often.

Q And you were asked some questions about the left ankle, and all about degeneration and so on.

To determine whether or not the left ankle -- and I didn't ask you about causation on direct, but they ask it on cross. But, in termination of pain to Mr. Herrera, in the presentation of the left ankle, you would need a clinical correlation would you not?

A Yes.

Q Describe to the jury what does that mean clinical correlation?

A Well, clinical correlation means the person who's examining the patient has to have some input here, as to what's going on. You just can't look at the MRI pictures and say definitively what's going on that day you have to actually examine the patient.

Q Okay, and with respect to the questions about ossification, hypertrophy, osteophytes, all of that. Mr. Herrera can have all of those things, without any pain; is that correct?

A He can.

Q And upon intervention of a trauma, those things can now be painful; is that correct?

A Well, he could have new things in addition to that, that can be painful.

Q And can he have all of these hypertrophy changes, bilateral foraminal narrowing and things like that without any limitations to his work life?

A He can.

Q And upon introduction of a trauma, he can be convert to being painful and being limited, is that correct?

A He can.

Q And you would need to talk to a clinician about that,

somebody who's treating Mr. Herrera; is that correct?

A That would be important.

MR. KELLY: Nothing further for you. Thank you.

MR. RAINIS: I have nothing.

THE COURT: Okay.

MR. ROBERTA: Nothing further, Judge.

MR. BAXTER: Nothing.

THE COURT: Thank you, doctor.

THE WITNESS: Thank you.

THE COURT: Okay folks, we are going to break, you'll have an extra long lunch. We'll have another witness starting at 2 o'clock. We are going faster than anticipated. So, you have a little extra time. So, I'll have everyone back here 2 o'clock, and we'll get started. The jury can exit.

THE COURT OFFICER: All rise jury exiting.

THE COURT: I remind you, you can't discuss the case with each other or anyone else. All of those other admonitions that I talked to you about before.

(Whereupon, the sworn jurors exit the courtroom.)

THE COURT: All right, so let's deal with some of the evidence. Because I think there are a lot of those all of those demonstrative, and I think also Doctor Kolb's records that weren't moved in, right?

MR. KELLY: Sure.

THE COURT: I lost track. There was a lot there.

MR. KELLY: No worries, I'll take care of that now.

THE COURT: And here's Terra, my fantastic clerk. Back on the record.

MR. KELLY: So plaintiff moves in Doctor Kolb's records Plaintiffs Exhibit 19, for identification, with the rational that Doctor Kolb's reports are contained or the CD, in addition to the actual radiologist studies and the demonstrative aids that are developed from the radiology studies from Doctor Kolb's office, in addition to Plaintiff's Exhibit 20, for identification, which plaintiff also moves into evidence. Lenox Hill radiology, Lenox Hill radiology performed the bulk of radiologic service her, MRI, CT etcetera demonstrative evidence were developed from Lenox Hill radiology original records with are in court in response to subpoena.

THE COURT: Any issues?

MR. RAINIS: I shall I have with respect to Doctor Kolb to the extent he interpreted films as treating physician, and I can't remember whether there's 1 or 2 that he was -- I have no objection to those interpretations being marked into evidence. But to the extent he did reviews as an expert not a treater, I have an objection to those reports going into evidence. The expert reports, as oppose to the treatment reports.

MR. KELLY: I stipulated reports that counsel aren't considered in evidence, they don't go into evidence.

THE COURT: So I, haven't seen any of these things. I don't know what exactly you're looking at. So you're saying number 19 are his records as treating physician?

MR. KELLY: 19 contains his reports and the radiologic studies on a disc. So, we can't pars them out at this juncture. They'd have to be printed.

MR. RAINIS: I think the likelihood that the jurors are going to take the CD and try to look at image is so remote.

MR. KELLY: They're not.

MR. RAINIS: So remote, I'm not going to worry about that. Or about the reports because I don't think that's going to be the case.

MR. KELLY: Right, so.

MR. RAINIS: What I would suggest, Judge, is we'll deal with it if, in fact, they, for example, they ask for something off this disc, then we'll' have to deal with what could be shown to them.

MR. KELLY: I will bring a disc reader in everyday, and if the jury requests whatever they request, I can at least convert the reader into visual, perhaps print some.

THE COURT: Okay 19 in?

MR. RAINIS: Yeah, with that --

THE COURT: With that caveat if.

MR. RAINIS: We will deal at that point.

THE COURT: 20, no issue.

MR. RAINIS: 20's in.

THE COURT: And then demonstrative were all numbered. Tell me what the numbers were. Tell me Tara.

THE CLERK: He had a whole bunch. He had the doctor 20A, 21A, 21B, 21C, 21D, 21F and then because he did it backwards.

THE COURT: Tara was saying Doctor Kolb showed the jury 20A, D, as in David. 21A, B, C, D and you said F and what else?

MR. ROBERTA: 20D, 20E, 20L, 21G, 21I, 21J and 20M like in Marie.

MR. RAINIS: How did you pick those numbers.

MR. KELLY: I premarked all the evidence that came in, as it came in. Demonstrative aid were tied to the evidence in court. The marks for the demonstrative aids are all as a result of the subpoenaed evidence in court subject to certification. Those items were premarked by me and agreed by counsel to be premarked and identified. When the demonstrative aids were brought into court, they were affixed to the already identified subpoenaed records here in court, so plaintiff's demonstrative aids have a number followed by a letter tying it to the subpoenaed records.

MR. RAINIS: Understood.

MR. KELLY: Okay.

THE COURT: All of those that Tara just listed then are coming in, no issues?

MR. KELLY: No issues.

MR. RAINIS: Correct.

THE COURT: Okay.

MR. KELLY: Subsequently plaintiff also moves in.

THE COURT: Hold on, Lorraine is making a face, and so that means that she doesn't have what she needs. Are you okay? She's nodding yes.

Mr. Kelly?

MR. KELLY: Plaintiffs moves in Plaintiff's Exhibit 21, for identification, New York Ortho Sport, Doctor Kaplan's radiology records from which the demonstrative aids were extracted.

THE COURT: No issue?

MR. RAINIS: New York Ortho film, basically, no issue.

THE COURT: Plaintiffs 21 is in. Anything else?

MR. KELLY: At this time, I'm good.

THE COURT: Have a long lunch, and I'll see you guys 2 o'clock.

A F T E R N O O N S E S S I O N

THE COURT OFFICER: All rise, jury entering.

(Whereupon, the sworn jurors enter the courtroom and take their respective seat.)

THE COURT: All right, everyone have a seat. I hope everyone had a good lunch, stretched your legs, got all the calcium, whatever you needed to do. And let's get started.

MR. KELLY: Thank you, Judge. Plaintiff calls Doctor Matthew Grimm.

THE COURT OFFICER: Raise your right hand.

D O C T O R M A T T H E W G R I M M, a witness called by and on behalf of the PLAINTIFF, upon being duly sworn, testified as follows:

THE WITNESS: Yes.

THE COURT OFFICER: In a loud clear voice, state your name and address.

THE WITNESS: Matthew Grimm. 160 East 56th Street, New York, New York 10022.

DIRECT EXAMINATION

BY MR. KELLY:

Q Good afternoon Doctor Grimm.

A Hello.

Q Tell the jury, please, what is your profession?

A I'm a physician in the field of physician medicine and rehabilitation and pain management.

Q Tell the jury a bit about your educational background,

please?

A Uh, I went to undergrad at Penn State University, graduating in electrical engineering. I went to medical school Jefferson Medical College, in Philadelphia, I graduating in 2005, and I did a residency in physician medicine and rehabilitation at the University California Irvine and William Beaumont Hospital outside of Detroit Michigan. I graduated in 2009. I then did a fellowship in interventional pain management, in Marietta, Georgia, graduating 2010 and then I started 2011 at New York Ortho Sports Medicine and Trauma, here in New York.

Q Are you licensed to practice medicine in the State of New York?

A Yes, since 2011.

Q Are you board certified?

A Yes, I am board certificated in physician medicine and rehabilitation.

Q Describe for the jury what being board certified means in your particular speciality?

A Board certification is the series of tests, both oral and written, actually on the computer that they we took after finishing our residency. It's just to check to make sure that following complexion of residency we're competent in our field and just so we got people who know what they are doing.

Q Doctor, tell the jury about any medical societies or

affiliations you may have?

A I'm a member of the American Board Physician Medicine and Rehabilitation. I'm a member of the New York County Medical Society, I am the director of pain management at Fifth Avenue Surgical Center on the eastside.

Q And do you engage in the private practice of medicine?

A Yes. I am an employee of New York Ortho Sports Medicine and Trauma.

Q Tell the jury a little bit about your discipline in pain management? What does that mean to you?

A Pain management sort of encompasses initially it's sort of a nonsurgical treatment of patients who can have injuries. I specialize primarily in the neck and back, but it can be also joint injuries, as well. Or patients initially will come in, they will be treated nonsurgically, assessed initially too make sure it's an option. Physician therapy, medications. If those don't help we sometimes progress to interventional injections, after trying to help diagnosis as well as treat. Injections into the spine or joints. If treatment doesn't improve or pain doesn't improve, they often times will get surgery. If they have surgery, and have continued pain, and they will revert back to pain management and they will be treated in more of a chronic manner, in that sense. Both again with topical periodic injections, medications, direction on physician therapy or therapeutic exercise that can help and also recommendation for

modalities. Sometimes with heat, message, Tens unit, which is just electrical stimulation of the muscles to try and treat it just sort of multiple disciplinary approach in a nonsurgical manner treatment of pain.

Q Let me ask you, doctor, is your discipline something that cures pain or manages pain for people?

A Uhm, it can, like I said earlier, initially I do have patients that we can help treat the pain, and they hopefully don't need to proceed with more invasive issues. Or often times it does become a chronic issue, and we're just sort of managing the pain and the chronic manner palliatively. So, treating it symptomatically. When there's flare ups, we're trying to put the fire out.

Q In your practice, do you regular see patients?

A Yes, I see patient everyday.

Q And, doctor, in our case, Mr. Herrera was in the state of good health working without restriction and had no complaints of neck, back, right shoulder or left ankle pain until such time as he was struck by an excavator at work.

Do you have experience in applying your professional skills to problems of Mr. Herrera's kind?

A Yes. Especially, in New York. I see patients a few different ways, and I see a lot of construction patients and I also see a lot of Broadway performers. Varied dichotomy of patients involved.

Q Have you previously been qualified as an expert witness in New York State courts?

A Yes.

MR. KELLY: Your Honor, I move Doctor Grimm as an expert in pain management.

THE COURT: Any issues?

MR. ROBERTA: No, Judge.

THE COURT: Okay, I find him so qualified.

MR. KELLY: Thank you.

DIRECT EXAMINATION

BY MR. KELLY:

Q Doctor Grimm, during the balance of this testimony, you can refer to your records that you brought into court, and if you use the spine just, please, identify it for the record what it is and what you're doing with it?

A Sure.

Q All right. So, did there come a time when you encountered Mr. Herrera?

A Yes, he was referred to me by another physician whom I practice Doctor Kolb, on April 23rd, 2013.

Q And did Mr. Herrera see you for treatment or something else?

A He was referred to me for diagnosis and treatment of his neck and his low back injuries and for pain management, in general.

Q When you first encountered Mr. Herrera, did you obtain a history?

A Yes.

Q Tell the jury, please, what that history was?

A He just reported a work-related accident, on March 5, 2013, which he was struck by an excavator, with a loss of consciousness, sustaining injury, crush injuries to his legs. Head injury, neck injury, right shoulder injury, a left ankle injury, and lower back injury.

Q Was a physician examination performed?

A Yes.

Q Tell us about the physician examination, what it is you do, why you do it, and what your findings were?

A Do a physician examination just to try and figure out exactly what area's injured, what the injury is and to help assist with diagnosis and treatment.

And on his initial visit, he had, I'd say, decrease ranging of his neck and his lower back calling them moderate to severe range. He also was displaying some decreased strength in his right shoulder musculature. He also showing some depressed sensation to the left -- sorry. Left lower extremity, and he was showing some weakness in his distal, so the far part of his left leg. He also had an ankle brace in place on his left ankle. And those are the pertinent positives.

Q Okay. So, let's talk a little about the reduced range

of motion. What kind of things do you do to test for range of motion?

A I generally, I mean, I'm testing to see how far they can range before pain sort of limits it. So, I usually try to test them in an active manner asking them to show as far as they can go left, right, up down. Just their neck and their lower back. And when it gets too far where it hurts, we measure that with a goniometer and take a measurement.

Q Goniometer that's an instrument you use?

A Instrument where it just test degrees.

Q Okay, and that's an objective measure in some respects?

A It's subjective and objective. I'm relying on the patient to give their best effort. If they don't give a best effort, I generally will notate that, but it's driven by their pain tolerance.

Q Okay, did you make any notations in your early records that Mr. Herrera was not giving his best efforts?

A No.

Q You noticed that there was a reduced strength in the right shoulder. How do you test that?

A I generally would just use, if a patient can break my strength. If it they can't lift it against gravity, then that's severe. If it's just like generally you're not able to sort of break the patient's strength, and so that's generally full strength. If you're able to sort of break it down, then it's

probably moderate to mild weakness.

Q And how do you measure reduced sensation?

A Generally we use a filament that's in the back of my reflection hammer, and I just test different areas of dermatome, dermatome will distribution is where just an area where nerves supposed to be innovating. Just test different areas and again relying on the patient's response and compare one side to the other, and ask them if they feel it, it feels normal, if it feels less.

Q Okay, and you said something called dermatomal distribution, I believe. Can you explain a little bit more what that means. Tell us what that means?

A Just for sensation, every nerve in your body will follow a specific pattern, and if like C-4, 5, 6 is usually in the shoulder area. C6-7 pass on the lateral part of the arm, and it just gives us a better idea of sort of following and putting some of the puzzle pieces together, depending on what we see on MRIs. What's the patient's tolerance in pain, and sort of correlating their pain. So, if a patient has issues, MRI say C5-6, but they are telling me that the pain is down in their hand, that wouldn't correlate. If they are saying C5-6, and in the shoulder area somewhat into the area to this part of the arm, that is correlating. So, it sort of agrees along with the picture.

Q Okay, and did you have an opportunity to review records

with respect to Mr. Herrera?

A I did review some records.

Q Okay. And can you tell us were there any significant findings made from your first encounter?

A Uh, I mean, I don't quite understand. Diagnoses or?

Q I'm sorry?

A Diagnoses or?

Q We'll get, okay, sure, all right. Did you make an initial diagnosis?

A I mean I was diagnosing him with regards to the neck and the back with the cervicalgia, questionable cervical radiculopathy, lumbar radiculopathy, lumbar radiculopathy.

Q Let's talk about the first thing you said cervicalgia, can you tell the jury what that means?

A Cervicalgia is fancy name for mechanical neck pain.

Q Okay, and I'm sorry the second thing you said?

A Lumbar radiculopathy he was showing signs of that cervical radiculopathy.

Q All right, let's talk about that. What is cervical radiculopathy mean?

A So, radiculopathy is pain that is radiating or shooting into the arms and legs. If it's in the cervical or the neck, it's when I'll just use my model here. If the nerves where they are escaping the neck or the lower back, they'll go through these holes called the foramen. Generally the foramen are open

and allow enough room for the nerve to go through. And the signal can get out.

If there's something either that has blocked the nerve or inflamed the nerve at some point, the nerve can become inflamed and then the signal isn't flowing to the muscles or the arm or the leg and the manner it should, and then patients will develop pain. It will start in the neck and back, and it will radiate or flow to the arm and leg in a specific pattern, depending on which nerves are involved, and that's diagnosed as radiculopathy.

Q And can you tell us did you form a treatment plan for Mr. Herrera?

A At his initial visit, I did recommend an MRI, due to his neck and back. He was prescribed a steroid pack to help treat the radiculopathies and the pain, and he was also given a opiate medication Tramadol for his severe pain and muscle relaxer Flexeril for spasms, and I gave him something called musculo trigger point injection, which are injection into sort of muscular type bands that form secondary to pain or stress in the neck or back muscles often, and he was given that at the office, and he was also fit for an lumbosacral lordosis, back brace.

Q Back brace?

A Yes.

Q And did was Mr. Herrera compliant with your treatment

plan?

A Yes.

Q Did Mr. Herrera follow with you for any future care?

A Yes, I have seen him over the years initially, which is common you see a patients that are much more often, much more frequent manner, and then as they become more chronic pain patients. Those tail off a lot, and you don't see them quite as often because you're just sort of monitoring things.

Q Did you have an opportunity to review the MRIs for which you sent Mr. Herrera?

A I did review them, yes, back years ago.

Q Okay. No problem. All right, did your diagnosis with respect to Mr. Herrera develop over the course of your treatment?

A Yeah, I mean he continued. He had findings subsequent with the radiculopathy, these as well as the mechanical sort of injuries to his neck and back and muscular injuries, and he received treatment for those.

Q Was Mr. Herrera treating with other physicians at this time?

A Yes, over the timeframe he did treat with Doctor Jeffrey Kaplan, I believe for his ankle injuries. He treated with Doctor Brisson for his neck and his back who performed his surgeries on those areas, he also was seeing a psychiatrist Doctor Kuhn, and he treated with Doctor Kuhn who's an orthopedic

surgeon in our office. I believe he saw neurologists for times, as well.

Q Is that common that a patient will treat with a number of physicians?

A Yes, everybody specializes in their own area. So, it's very common.

Q Is that something called the continuum of care something like that?

A Yeah. It's sort of everybody -- I wouldn't treat someone for a head injury, and someone with a head injury I wouldn't treat for their neck and back.

Q Okay. I'd like you to assume, doctor, that Mr. Herrera had no prior neck and back injuries, no prior right shoulder injuries, and no complaints at the time of the happening of the accident to his left ankle.

Do you have an opinion, to a reasonable degree of medical certainty, whether the complaints and pain which Mr. Herrera was exhibiting when he came to see you was the result of the accident of March 5, 2013?

A Yes, I would say based on what I know, with a reasonable degree of medical certainty, his injury was the competent producing cause of his pain.

Q And do you have an opinion to a reasonable degree of medical certainty, whether or not the treatment rendered by you was the result of the accident to Mr. Herrera?

A Yes, I would find it with reasonable, a reasonable degree of medical certainty, as a result of accident.

Q Tell us a little bit about Mr. Herrera's course over the years as he treated with you. There seems to be a large number of records there. I assume he was seen that many times, I don't want you to go through every visit, but?

A Initially, we did do something called epidural injections, which will help diagnosis and treat nerve and disc issues and radiculopathy, but it can also help with diagnosis.

He received -- which we using a needle go into the epidural space, and inject antiinflammatory medication, as well as anesthetic, something to just sort of mask the pain and also treat the inflammation. And then based on their response, some patient's proceed with additional injection. If the response is only temporary and quickly, then they sometimes go into surgery. That is what happened with Mr. Herrera. He ended up proceeding to a cervical lumbar fusion surgery with Doctor Brisson.

Q Let me backup a little bit, I know you're familiar with it but. So, tell us about these epidural injection. This isn't like the vaccination you get, something like that is it?

A No, no. So, it's something that I perform, do it every week on different patients. But we use a fluoroscope which is a machine that can take live x-rays. I have a peddle I will a hit it, it takes an x-ray where I'm guiding a needle down into the epidural space, and the epidural space is the space sort of

outside the spinal cord, and that's where the discs or the nerves are being inflamed, and it allows me to put medication around the nerves.

So, I'm taking live shots, and it can be swiveled so I can get a 3-D sort of picture to check the depth and the top and bottom view of the needle. Once the needle is in place, a die is placed into the epidural space to make sure that the medication is going to go around the nerve roots, and not in soft tissue, and also not in the spine. And then after that, the medication is injected, and then usually it takes effect somewhere between 12 to 72 hours.

Q And is the patient awake during this procedure or something else?

A Depends on the patient. It is a -- some patients, it is a painful procedure, and somewhat traumatic for some patients to have three and a half inch needle injected down into their spine. So, I would say about 70 percent of patients probably get some form of sedation. Some patients have a very high pain tolerance would just get the area numbed and we'll drive it down.

Q How many times did Mr. Herrera undergo these epidural treatments?

A He had -- let's see. It was one for the lower back in July of 2014, he had one to the neck in August of 2013, July 2013. And then we also he had some other procedures done

to his lower back, because again with these injuries, with traumatic injuries to the spine often time it's not just one issue causing their pain. It can be pain in the joints. So, he did have some injections called facet joint injection, where we put some medication around the facet joints to see if that is producing some or causing some of his pain. That would not be pain going to the legs, that would just be pain sort of in the back. And he did have I believe three injections there, as well. It's the same type of procedure using the x-ray machine to guide the medication down. And again it's about three and a half inch needle that's guided down that to that area.

Q Tell us, if you would, doctor, please, what other kinds of treatments did you perform on Mr. Herrera, during the course of time that he was your patient?

A So I have performed --

THE COURT: Please mute all of your devices, so we don't have to do this multiple times. Thank you. Just turn your phone off.

Was there a question outstanding?

A So, I think you asked --

Q I asked tell us about the other treatments you rendered to Mr. Herrera, during the course of your treatment with Mr. Herrera?

A So, I had given him what I discussed earlier trigger point injections. The trigger point injections are going into

the muscular type veins muscle performed on many patients when they have pain. It's not always just with injuries. I mean I used to get them when my children were younger and I get them in my shoulder here. I actually give myself trigger point injection. It's just needles in the muscle to try to get it to sort of relax and release and they will reform sort of something that is performed periodically on patient. I have one patient who comes in weekly for them. I also gave him something called occipital nerve locks which is for head aches. Again, when patients have head injuries where the muscle spasm will form and they have the neck muscles pulling down in the neck, you have what are called occipital nerves which go up the back of your neck here back of your skull and when they become irritated and inflamed they get headaches that start in the back and then they will sort of go around forward to your eye. Often times patient will describe blurry vision and pain and so what I would do is inject medication around the occipital nerve in the back of the neck here. Utilizing ultrasound guidance to visualize nerves and injection medication around it and that generally would help treat the headache pain. He's also been given sacroiliac joint injections in the office.

Q Telling us where that is?

A The sacroiliac is the joint between your coccyx and your pelvis. Often times in patients who have had lumbar fusions, the body generally when it's moving, any force on it is

distributed amongst all of the joints in the body. If you fuse some joints in the body, then often times when you're moving that can put an increased force in the joints either both above or below.

And so patients often times will develop what we call sacroiliitis which is inflamed sacroiliac joint because of the increased force that is placed following the fusion. And then they'll have pain sitting, they'll have difficulty with sitting for long periods of time, and then often will have to shift and stand or stand to offset at the time the pain (sic).

The injection is just using the x-ray machine, again, and guiding the needle down into putting a die to visualize it on the joint and then injection the medication.

Q Did you do what's known as radio frequency ablation for Mr. Herrera?

A I did that to his the facet joints. So, as I stated earlier, when we injected medication into his facet joints, he did receive some temporary relief and the nerves that are there pain generating nerves from those joints are called medial branch nerves, and you can go in and you can burn those to try and decrease your pain in those areas. He did receive some relief in his axial pain but he still had significant pain going to the legs, so that was sort of one of the contributing factors that lead to his surgery of the lumbar spine that he did not receive a tremendous response to the ablation.

Q Tell us, you said you burn the nerves. Tell the jury what that means?

A Uh, again, we use -- I use a larger needle that again about three and a half inches long or so, that we guide down to the medial branch nerve which is generally right here beside the facet joint. And it gets heated up to eighty degrees celsius for 90 seconds and that denatures the nerve, so it's not conducting the pain signal. It does grow back generally between 6 to -- 6 months to a year and a half. And some patients receive periodically radial frequency ablations. Other patients it does grow back, but the irritation isn't there and they do fine.

Q Now during these epidural treatments trigger point treatments, radio ablations, sacroiliac joint injections, is that what we call noninvasive or conservative treatment?

A It's certainly less invasive than surgery, but more invasive than just oral medication. So, I would still consider it conservative, in terms of surgery.

Q Did Mr. Herrera receive oral medications, as a result of his complaints?

A He did receive multiple oral medications. He had both for awhile he was treating him with, I believe, neuropathic medication called Gabapentin which just masks radiating pain in generally. He was also treated with some opiate pain medications. I believe Tramadol, and I think for a time he was

on some morphine when his pain was severe. But again we don't like to keep patients on those types of medications, so it's just used initially when pain is severe and we were able to tapper him off both --

THE COURT: Turn phones off all. Just pause everyone turn their phone off.

(Whereupon there is a pause in the proceeding.)

THE COURT: Thank you. Put it into airplane mode, whatever you need to do. I just don't want any interruptions. Okay? Thank you.

DIRECT EXAMINATION

BY MR. KELLY:

Q Okay. So, did Mr. Herrera receive any topical medications?

A Yes, he was given some topical antiinflammatory jells that's an diclofenac cream which he just sort of rubbed it where it hurts.

Q And all of these treatments are they permanent solutions to pain? Do they provide temporary relief, something else?

A They would be a temporary relief.

Q All right, and eventually Mr. Herrera was sent for surgery, is that correct?

A Yes, he was. I referred him to Doctor Paul Brisson

who, I believe, did a cervical fusion and lumbar fusion.

Q And did Mr. Herrera return to you after his neck and back surgery?

A Yes.

Q Tell us about his return to you and his complaints?

A I mean he's returned to me and been treating throughout the years. He's had continued complaints of neck and lower back pain. Pain radiating to his arm still pain radiating to his legs. Over time he's sort of learned to deal with it.

Q Okay. Is that an unusual result or is that something that happens or are people's pains diminished instead of going away?

A It's not an unusual result. I'd say most patients after having a fusion surgery, although they say it may help some, they still have some realm of pain.

Q And did you continue to treat him after his surgeries?

A Yes.

Q And can you tell us, doctor, I don't want to go through each individual date, but when you saw Mr. Herrera in August of 2024, could you tell us your observations and so on?

A Yes. He just, again, we discussed his pain. Like I said earlier, I hadn't been seeing him quite as often over the past couple years. But he said that his pain would wax and wain. He reported it never completely goes away due to resource available to him. He'd only been utilizing over the counter

medication primarily. He's just trying to live with the pain, trying to stay as active as he can tolerate, still notes numbness and pain to his both legs, increasing when he walks. And noting an increase in pain towards the end of the day feeling heavy legs. He did report that he's modified his activities so that he's able to be more independent with dressing and showering as previous visits. He reported that his wife had to help him primarily with his activities of daily living. He did reported that he can only drive short distances, increase in lower back pain when he would have to sit for too long in the car. He utilized a cane in the winter because of instability, but in the summer warmer weather he was a bit more stable, so he would not use the cane. I generally advocate trying to avoid use of the cane as much at possible. Using cane puts uneven pressure on the spine, and can increase the other issues. He's doing home exercises mornings stretches due to resources available to him.

Q Doctor --

A Sorry.

Q Doctor, just your treatment, if you don't mind --

A Okay.

Q Not editorials, please. Thank you.

A So, again, for his neck, he was reporting continued cracking when he would move his neck. And, generally, I generally, advice patients that's very common following these

injuries. It's just like every your knuckles crack the joints in your neck are going to crack as your muscles stiffen up and you're not using it and moving it as much. He did report pain radiating to his shoulder region, muscles tension, and just again he's dealing with his pain in his neck, as well.

Q Did you perform a physician examination that's your last visit with Mr. Herrera?

A Yes, yes.

Q Tell the jury if you would your findings with your physician examination August of 2024?

A Okay. With regards to his neck, again, he did have moderate decrease ranking with extension at 45 degrees, with a normal 60. Flexion at 40 degrees, normal 50 to 80. Left and right lateral flexion 35 degrees, normal is around 45 degrees. Rotational pain at 60 degrees, normal is around 80 degrees.

Mild shoulder area weakness on the right compared to the left with resistance testing. And he did show positive Spurling sign. Spurling sign is a tension compression test for the neck to see if there's any irritation of the nerves. The way we do that is you put down pressure with rotational movement to the affected side, and extension. And what we're trying to do is narrow where the nerves are coming out. If there's infected irritated nerve, then it should reproduced some pain in the manner of like I talked about earlier. If it's nerve that's irritated, we should see a pattern of pain in that area. And he

did show a more severe pain than testing to the right and the left.

He did show muscle spasm in his paraspinous muscles, as well as his shoulder girdle muscles, trapezius and rhomboid muscles which are just muscles in the shoulder areas.

The lumbar of the low back, he was walking with an antalgic gait, altered painful walking partner, and he does have an ankle foot orthosis in his left ankle, that's to give him strength because he does have severe weakness with bringing his ankle up. Without it, it would catch on and cause him to trip.

Q Is that due to the surgery?

A I think I believe he did have in record review of other doctors he had some type of preexisting issue, but it's something that got much mores on his accident, the foot drop, from what I understand.

He has the weakness in the left, and again with regard to his ranging of his lower back probably put it moderate deficit with pain at extension to 15 degrees flexion at approximately 55 degrees left and right lateral flexion at 15 degrees, and I think his initial visits he had pretty much he shown some improvement over time, which is good following his surgery and treatments. And he has a positive straight leg raise which that's another tension provocative test that you would do to see if there's nerves still irritated in his lower back, low back, which is fairly common after surgeries.

Patients have these injuries their nerves get sort of fried over time. The structural elements maybe healed, but the nerves can still be irritated and inflamed. And if you do provocative test, you can reproduce some pain. And then he showed some depression of sensation on his left side in the L-5/S-1 nerve roots and he was showing some trigger points present on examination.

Q Did you test his reflections?

A He showed a depressed patella and ankle jerk reflex and that's just that test to see if there's any still nerve issues related to the L2/L4 nerves for the knee reflex. And the S1 nerve for the ankle reflex.

Q All right, were they depressed or normal?

A Depressed on the left side.

Q Okay, and what does that mean if they are depressed?

A That there's still some sort of issue going on with the nerves in that area.

Q Did you make any further findings at your August 2024, examination?

A He did have a great deal of atrophy. So the muscle loss involving his left lower extremity.

Q Did you make any diagnoses at your August 2024 examination?

A Again, he had diagnosis of cervicalgia and lumbago which is a fancy terms for mechanical neck and back pain. Felt

back syndrome which is terminology for patients who had surgery and have continued radiating pain related to the nerves, back and or the neck. Sacroiliitis which is what I described earlier. He does display the irritation of the SI nerves and he did show positive response to pain office SI injections on prior office visits which helps diagnosis and treat.

He was diagnosed with cervical radiculopathy, and then trigger points which he had received injection for in the past, and then foot drop and depression. I'm not treating him for those.

Q Okay. Doctor, based upon Mr. Herrera's complaints to you in August of 2024, years after the surgeries, do you have an opinion to a reasonable degree of medical certainty, whether or not Mr. Herrera's condition on his presentation to you August 2024 is permanent?

A Yes, he has permanent deficits on examination.

Q Do you have an opinion, to a reasonable degree of medical certainty, whether the condition he presented to you in August of 2024, was the result of the accident on March 5, 2013?

A Yes, with a reasonable degree medical certainty related to the accident.

Q All right, and all of Mr. Herrera's treatments up to that time, do you have an opinion, as to whether or not they're caused by the accident of March 5, 2013?

A Yes, I think the treatments are related to the

accident.

Q And, doctor, did you make a plan for Mr. Herrera's lifetime medical care?

A Yes, I was asked to come up with treatment plan for future care for some of his injuries.

Q We'll get into that in just a second, but do you have a prognosis, and tell the jury or remind the jury, again, what prognosis means, and do you have a prognosis for Mr. Herrera?

A Prognosis is just how his future outcome is likely. For him, with all his injuries and generally it's a progressive issue over time with chronic pain I would classify it as poor.

Q Poor? Okay. Well, does the condition worsen over time?

A Again, as I stated earlier, with these fusion surgeries, you're disrupting the body's natural mechanics, so you are changing what the stressors would normally be placed on the spine. So, it's something that generally does progress over time and then everything stems from that with the pain from those issues the muscles become involved, and so yes it's something that I feel will progress.

Q And do you anticipate that Mr. Herrera will continue with some level of pain for the balance of his lifetime?

A Yes. Some level. Like I said he's shown that he does have a pretty good tolerance to pain. He's trying to deal with it, but as it progresses, he may require or he may be hoping to

doing more things.

Q Is Mr. Herrera disabled from his chosen profession, as a construction worker and heavy laborer?

A Absolutely.

Q And is that permanent?

A Yes.

Q Doctor, I want to talk briefly about the medical costs and plan you projected over Mr. Herrera's life time. Did you project medications, including anti-inflammatories, muscles relaxants, neuropathic pain medications, topical medications and Tens Unit supplies for Mr. Herrera?

A Yes, I've -- and in an ideal world, I came up with what I think would help and benefit a patient with his complaints and injuries.

Q Okay, and do those medication costs -- the medications have a cost?

A Yeah. I put it an approximate roughly $400 a month.

Q And is that to occur over the balance of Mr. Herrera's life time?

A Yes.

Q And this approximation of $400 a month, is that based upon your experience and your profession prescribing such medications?

A Yes, based on the medications I would prescribe. Again, if resource were available to patients with his

complaints that I feel would help.

Q Did you include in your treatment plan pain management office visits?

A Yes.

Q And is there a cost affiliated with those visits?

A The out of pocket costs would be approximately $250, for the visit.

Q And what is the frequency of those visits over Mr. Herrera's life time?

A For chronic pain patients, I generally will have them schedule visits every 3 to 4 months, but I was -- I always tell them -- I mean, that's variable. If they are doing well they may stretch those out. If something immediate happens, they come in sooner but that's what I usually recommend.

Q Did you design a treatment plan for which included orthopedic surgeon office visits for Mr. Herrera?

A Yes. My boss Doctor Kaplan is and orthopedic surgeon and I've asked him generally in patients who he performed surgery on how often he likes follow-up.

Q And what is the frequency per year of those visits?

MR. RAINIS: I'm going to object, Your Honor. It's hearsay.

MR. KELLY: It's not.

THE COURT: I'm sorry, I just got the Order to Show Cause.

Last one that you -- very last one answer to the one before, can you just read me the answer.

(Whereupon, the requested testimony was read back by the Court Reporter.)

THE COURT: Overruled.

Q You may answer, doctor.

A Yes. So he's generally, like approximately, 2 to 4 time a year is what he advises to me.

Q Is there a cost affiliated with them?

A Out of pocket costs for his visit is approximately $300.

Q And that for the right shoulder?

A Yes.

THE COURT: Your testimony that you just gave was that based on your own opinion or was that from a conversation you had with Doctor Kaplan?

THE WITNESS: So, in making these plans, I have I generally do research to try and discuss with surgeons what their -- because I'm not an orthopedic surgeon, to ask them what their frequency follow-up is, recommendations are, and then I use that base to put in my plan.

THE COURT: And you're adopting that.

THE WITNESS: Pardon?

THE COURT: And you're adopting that?

THE WITNESS: Right.