

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*

*Lorraine Ramsey
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Min-U-Script® with Word Index

1 SUPREME COURT OF THE STATE OF NEW YORK
2 COUNTY OF BRONX : CIVIL TERM : STP

3 -----x
4 ERWIN HERRERA & LAUTERIA HERRERA, : Index:
5 : 304215/2013E
6 Plaintiff(s)::

7 -against- :
8 KENT AVENUE PROPERTY III, LLC, J.E. LEVINE
9 BUILDER, INC., and J & A CONCRETE CORP.,
10 Defendant(s)::

11 -----x
12 J & A CONCRETE CORP., :
13 Third-Party Plaintiff(s)::

14 -against- :
15 NEW CASSEL CONSTRUCTION CORP.
16 Third-Party Defendant(s)::

17 -----x
18 851 Grand Concourse
19 Bronx, New York 10451
20 October 2, 2024

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

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

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

THE DEFENDANT:
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175 Pinelawn Road
Melville, NY 11747
BY: MATTHEW RAINIS, ESQ.

1 THE DEFENDANT AND THIRD-PARTY PLAINTIFF

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BY: CHRISTOPHER B. ROBERTA, ESQ.
4

5 THE DEFENDANT THIRD-PARTY DEFENDANT

6 BAXTER & SMITH, P.C.
99 North Broadway
7 Hicksville, NY 11801
BY: ROBERT C. BAXTER, ESQ.
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Lorraine L. Ramsey
Senior Court Reporter

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

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

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

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

1 point.

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

5 THE COURT: Can you hear him, Lorraine?

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

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

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

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

11 Doctor Grimm drafted an optimal care treatment
12 plan. Workers compensation is an insurance company. They
13 have a habit of denying things. You have to apply for them
14 5, 6, 7 times. There's no guarantee that any of the optimal
15 care would have been approved by workers comp.

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

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

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

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

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

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

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

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

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

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

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

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

8 THE COURT: Say that again?

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

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

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

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

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

24 MR. RAISIN: Yeah. Exactly, Judge.

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

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

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

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

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

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

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

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

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

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

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

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

14 MR. ROBERTA: Definitely.

15 THE COURT: Where he isn't really.

16 MR. KELLY: I'm fine with that.

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

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

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

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

1 MR. ROBERTA: Thank you, Judge.

2 MR. RAINIS: Thank you.

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

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

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

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

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

15 THE COURT: Mr. Roberta filed something two days
16 ago. This is Document 747 in NYSCEF this is about 1.5A,
17 1.5B, C-1 and C-2.

18 MR. KELLY: Right.

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

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

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

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

3 MR. KELLY: Sure.

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

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

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

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

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

20 MR. KELLY: I just would rely on whatever the prior
21 argument was on the record and cite the Court to Sawicki
22 against AGA, 143, AD 3d, 549, First Department 2016. And
23 Toussaint against Port Authority 219 Slip Op. 804302. And
24 Witt against -- I'm sorry, Lopez against City of New York,
25 220, New York Slip Op. 34923/2020.

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

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

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

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

7 MR. ROBERTA: Which codes?

8 MR. KELLY: It 231.5.

9 MR. ROBERTA: A, B, C 1.

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

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

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

15 THE COURT: Fair enough. Okay.

16 Let's bring the jurors.

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

18 THE COURT OFFICER: All rise jury.

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

21 THE COURT OFFICER: All rise, jury entering.

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

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

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

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

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

8 THE WITNESS: Yes.

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

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

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

18 THE WITNESS: Thank you.

19 THE COURT: Thank you.

20 DIRECT EXAMINATION

21 BY MR. KELLY:

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

23 A Good morning, sir.

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

25 A I'm a diagnostic radiologist.

1 Q And describe a little bit about your professional
2 education?

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

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

15 A I am.

16 Q Are you board certified, doctor?

17 A I am.

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

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

1 Q Have you published in your field, doctor?

2 A I have.

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

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

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

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

19 A Well, I belong to the Radiological Society of North
20 American, I was a Clinical Assistant Professor of radiology for
21 many years at Columbia University. And right now I'm in private
22 practice, as I said, seeing patients for diagnosing breast
23 cancer and also reading MRI's and CAT scans for this past
24 30 years.

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

1 an MRI is? What it does?

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

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

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

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

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

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

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

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

9 A Exactly.

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

12 A Daily.

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

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

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

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

25 A I have.

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

3 THE COURT: No issues.

4 MR. ROBERTA: No objection.

5 THE COURT: Okay, I find him so qualified.

6 DIRECT EXAMINATION

7 BY MR. KELLY:

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

10 A Yes.

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

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

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

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

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

1 That's just of the neck.

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

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

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

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

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

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

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

4 A Sure.

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

8 A Yes, I have.

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

11 A Yes, they do.

12 Q And fairly and accurately represent those studies?

13 A They do.

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

19 THE COURT: Go ahead.

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

21 A Sure I would.

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

24 A Sure.

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

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

3 A Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 A No the pictures are what the pictures are.

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

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

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

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

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

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

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

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

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

25 Q And similarly this CT scan is this objective finding?

1 A Yes.

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

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

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

7 A C4-5.

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

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

18 Q And when was this film taken?

19 A August 14, 2014.

20 Q Are there any significant finds on this film?

21 A No.

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

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

1 their lives just like this.

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

4 A Sorry.

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

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

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

12 A C4-5 and C5-6.

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

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

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

20 A 20D.

21 Q Thank you, doctor.

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

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

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

10 This gray structure's the spinal cord coming down.
11 This picture is very dark, but there are five bones in here.
12 And here you can see two levels. This was done April 30th,
13 2013. There are two levels here where the discs are bulging.
14 So, they are not herniated. They are not pushed through
15 completely. So in this case it's a little darker. I'm going to
16 show you that other view in a second.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 A Same.

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

8 A Yes.

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

11 A No, the patient cannot manipulate these pictures.

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

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

15 Q Do we need to see anything more from this?

16 A That's it.

17 Q All right.

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

20 Q That's plaintiff's?

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

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

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

11 Q Is the condition shown in study permanent?

12 A Yes.

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

15 A Yes.

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

18 A No.

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

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

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

25 A Yes.

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

4 A Yes.

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

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

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

23 A Grade three separation is often very painful.

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

1 A Right shoulder.

2 Q And what is the date of the study?

3 A March 7, 2013.

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

5 A Yes.

6 Q Can it be manipulate or exaggerated in any way?

7 A No.

8 Q Would it spontaneously heal without surgical
9 intervention, doctor?

10 A No, definitely not.

11 Q Okay. Let's move onto the next.

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

13 THE WITNESS: This is 21G.

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

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

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

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

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

1 A So, not white matter signal.

2 Q Oh, sorry, sorry.

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

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

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

11 Q And these objective findings, as well, doctor?

12 A They are.

13 Q They can't be faked or exaggerated?

14 A The pictures are what the pictures are.

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

16 A We are done.

17 Q I think there's another shoulder.

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

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

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

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

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

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

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

9 Q Plaintiff's exhibit?

10 A This is 20A.

11 Q Thank you, doctor.

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

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

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

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

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

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

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

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

25 So those are the findings, the main findings on this

1 ankle, and there are degenerative changes, as well.

2 Q Is that all we need from those?

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

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

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

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

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

1 surgery.

2 Q Doctor, is that all for the demonstrative evidence?

3 A I think that's a lot.

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

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

8 A Definitely.

9 Q And that limits -- I'm sorry?

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

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

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

23 A Yes.

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

1 in your practice?

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

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

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

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

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

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

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

4 Q Okay. Disc degeneration happens to everybody?

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

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

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

12 Q Okay.

13 A Right.

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

16 A I would be in my office.

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

19 A Both.

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

22 A It is.

23 Q Can you tell us what that so?

24 A \$12,000.

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

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

2 A They did.

3 Q Okay. Do you recall what that is?

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

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

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

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

11 CROSS EXAMINATION

12 BY MR. RAINIS:

13 Q Good morning, doctor.

14 A Good morning, sir.

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

19 A Yes, sir.

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

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

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

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

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

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

13 A Yes.

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

16 A Correct.

17 Q Okay, and how often do you do that?

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

23 Q You don't know?

24 A No.

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

1 A No.

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

3 A Yes.

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

6 A Degeneration of the spine, yes.

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

9 A Correct.

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

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

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

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

19 Q So, looking at the ankle images that you put up there,
20 I think you were looking at a CT scan of the ankle dated May 7,
21 2013?

22 A Yes.

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

25 A Yes.

1 Q Okay, and you showed the jury those?

2 A Yes.

3 Q And that's from an older injury, correct?

4 A I agree I wrote in my report that they look chronic.

5 So, I can't tell you exactly when they occurred, but the

6 difference between chronic means awhile ago.

7 Q Okay. So, we don't know when, but we can agree --

8 A Right.

9 Q That by May of 2013, those weren't caused by the
10 March 2013 accident, correct?

11 MR. KELLY: Objection.

12 THE COURT: Repeat the question.

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

15 THE COURT: Overruled. Answer the question.

16 A So, two months before, so they look chronic meaning
17 longer or older. I can't tell you exactly when they occurred.
18 It's two months already since. It's not the same day. It's
19 they didn't have -- I don't have the picture from the same day
20 of the accident to give you a more definitive statement than
21 that.

22 Q And I just want to clarify. So, you're saying it looks
23 like those fragments in the ankle are older than two months old?

24 A They can be.

25 Q And you mentioned that those fragments were in the

1 joint spaces?

2 A Yes.

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

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

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

12 A It can.

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

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

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

21 A Yes.

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

23 A Yes. In my report, yes.

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

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

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

5 A Articular.

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

8 A Correct.

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

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

15 Q I got a copy.

16 A Yes.

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

19 A Yes.

20 Q And that included the osteochondral lesion you
21 described?

22 A Yes, I believe so.

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

1 A Okay.

2 Q And that was the day of his accident, correct?

3 A Yes.

4 Q And this was a film, I believe, taken in the emergency
5 room, at Bellevue? Or in the radiology department at Bellevue?

6 A Sounds reasonable, yes.

7 Q And it described the things you showed us on other
8 studies disc bulges at L4/5 and L5/S- 1. Impinging on the
9 epidural sack and thecal sack, right?

10 A Yes.

11 Q And those are the same things you showed us before,
12 right?

13 A Yes.

14 Q And then you said, you went on to say that this CT scan
15 taken on the day of the accident reviewed hypotrophic changes
16 with facet and ligamentous hypertrophy resulting in bilateral
17 foraminal narrowing at L3/4, L4/5, and L5/S1, right?

18 A Correct.

19 Q And there was grade one anterolisthesis on L4 and L5,
20 correct?

21 A Correct.

22 Q And then again you concluded that all those changes
23 were degenerative, correct?

24 A All the ones you just mentioned.

25 Q Okay. Talking about -- returning to that CT report,

1 hypotrophic changes those are degenerative findings?

2 A Yes.

3 Q They are consistent with degenerative disease, right?

4 A Yes.

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

8 Ossification is consistent radiologically with an old
9 process, correct?

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

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

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

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

22 A Correct.

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

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

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

6 A That is correct.

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

9 A Yes posteriorly, yes.

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

12 A Yes.

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

15 Don't know?

16 A No opinion as to that.

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

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

20 CROSS EXAMINATION

21 BY MR. ROBERTA:

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

25 A Yes.

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

4 A That's correct.

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

8 A Yes, within reason that's true.

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

11 A That is true. It's possible.

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

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

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

23 A That is possible.

24 MR. ROBERTA: No further questions. Thank you.

25 THE WITNESS: Sure.

1 MR. BAXTER: No questions.

2 THE COURT: I'm shocked.

3 MR. KELLY: Redirect.

4 REDIRECT EXAMINATION

5 BY MR. KELLY:

6 Q Doctor you were asked about CT scans taken on March 5,
7 2013. Now, the CT scan would show boniness, is that correct?

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

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

11 A Yes.

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

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

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

18 A Often MRI is better, often.

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

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

1 A Yes.

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

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

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

13 A He can.

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

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

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

21 A He can.

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

24 A He can.

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

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

2 A That would be important.

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

4 MR. RAINIS: I have nothing.

5 THE COURT: Okay.

6 MR. ROBERTA: Nothing further, Judge.

7 MR. BAXTER: Nothing.

8 THE COURT: Thank you, doctor.

9 THE WITNESS: Thank you.

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

16 THE COURT OFFICER: All rise jury exiting.

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

20 (Whereupon, the sworn jurors exit the courtroom.)

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

25 MR. KELLY: Sure.

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

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

3 THE COURT: And here's Terra, my fantastic clerk.

4 Back on the record.

5 MR. KELLY: So plaintiff moves in Doctor Kolb's
6 records Plaintiffs Exhibit 19, for identification, with the
7 rational that Doctor Kolb's reports are contained on the CD,
8 in addition to the actual radiologist studies and the
9 demonstrative aids that are developed from the radiology
10 studies from Doctor Kolb's office, in addition to
11 Plaintiff's Exhibit 20, for identification, which plaintiff
12 also moves into evidence. Lenox Hill radiology, Lenox Hill
13 radiology performed the bulk of radiologic service here, MRI,
14 CT etcetera demonstrative evidence were developed from Lenox
15 Hill radiology original records which are in court in
16 response to subpoena.

17 THE COURT: Any issues?

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

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

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

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

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

12 MR. KELLY: They're not.

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

16 MR. KELLY: Right, so.

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

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

24 THE COURT: Okay 19 in?

25 MR. RAINIS: Yeah, with that --

1 THE COURT: With that caveat if.

2 MR. RAINIS: We will deal at that point.

3 THE COURT: 20, no issue.

4 MR. RAINIS: 20's in.

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

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

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

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

15 MR. RAINIS: How did you pick those numbers.

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

PROCEEDING

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1 MR. RAINIS: Understood.

2 MR. KELLY: Okay.

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

5 MR. KELLY: No issues.

6 MR. RAINIS: Correct.

7 THE COURT: Okay.

8 MR. KELLY: Subsequently plaintiff also moves in.

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

12 Mr. Kelly?

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

17 THE COURT: No issue?

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

20 THE COURT: Plaintiffs 21 is in. Anything else?

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

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

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

25 THE COURT OFFICER: All rise, jury entering.

DR. GRIMM -PLAINTIFF - DIRECT

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

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

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

9 THE COURT OFFICER: Raise your right hand.

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

13 THE WITNESS: Yes.

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

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

18 DIRECT EXAMINATION

19 BY MR. KELLY:

20 Q Good afternoon Doctor Grimm.

21 A Hello.

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

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

25 Q Tell the jury a bit about your educational background,

LLR

1 please?

2 A Uh, I went to undergrad at Penn State University,
3 graduating in electrical engineering. I went to medical school
4 Jefferson Medical College, in Philadelphia, I graduating in
5 2005, and I did a residency in physician medicine and
6 rehabilitation at the University California Irvine and William
7 Beaumont Hospital outside of Detroit Michigan. I graduated in
8 2009. I then did a fellowship in interventional pain
9 management, in Marietta, Georgia, graduating 2010 and then I
10 started 2011 at New York Ortho Sports Medicine and Trauma, here
11 in New York.

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

14 A Yes, since 2011.

15 Q Are you board certified?

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

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

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

25 Q Doctor, tell the jury about any medical societies or

1 affiliations you may have?

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

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

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

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

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

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

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

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

14 Q In your practice, do you regular see patients?

15 A Yes, I see patient everyday.

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

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

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

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

3 A Yes.

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

6 THE COURT: Any issues?

7 MR. ROBERTA: No, Judge.

8 THE COURT: Okay, I find him so qualified.

9 MR. KELLY: Thank you.

10 DIRECT EXAMINATION

11 BY MR. KELLY:

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

16 A Sure.

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

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

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

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

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

3 A Yes.

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

5 A He just reported a work-related accident, on March 5,
6 2013, which he was struck by an excavator, with a loss of
7 consciousness, sustaining injury, crush injuries to his legs.
8 Head injury, neck injury, right shoulder injury, a left ankle
9 injury, and lower back injury.

10 Q Was a physician examination performed?

11 A Yes.

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

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

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

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

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

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

9 Q Goniometer that's an instrument you use?

10 A Instrument where it just test degrees.

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

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

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

18 A No.

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

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

1 probably moderate to mild weakness.

2 Q And how do you measure reduced sensation?

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

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

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

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

1 with respect to Mr. Herrera?

2 A I did review some records.

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

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

6 Q I'm sorry?

7 A Diagnoses or?

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

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

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

15 A Cervicalgia is fancy name for mechanical neck pain.

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

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

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

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

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

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

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

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

23 Q Back brace?

24 A Yes.

25 Q And did was Mr. Herrera compliant with your treatment

1 plan?

2 A Yes.

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

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

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

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

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

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

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

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