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

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SAMUEL MOISE,

Plaintiff,

-against-

Index No: 20028/2016E

BAGNIKIM YAKADJENE and IYESHA NESBITT,

Defendants.

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Bronx Supreme Court
851 Grand Concourse
Bronx, New York 10451
October 8, 2024

B E F O R E:

THE HONORABLE VERONICA HUMMEL,
Justice of the Supreme Court

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

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BRYNN REYNOLDS SEYMOUR
Senior Court Reporter
Amended 10/15/24

COURT OFFICER: All rise. The honorable Veronica G. Hummel presiding over case number 20028/2016E, Moise Samuel versus Iyesha Nesbitt.

MR. LESNEVEC: Good morning, your Honor. Jason Lesnevec from the Law Office of Michael S. Lamonsoff, for the plaintiff Samuel Moise who is present in court.

MR. CORRING: John Corring, counsel for the defendant Bagnikim Yakadjene.

MR. JONES: Timothy Jones for the defendant Iyesha Nesbitt.

THE COURT: Good morning. Be seated. Any issues before we bring the jury in?

No, okay, we're ready then.

COURT OFFICER: All rise. Jury entering.

THE COURT: Good morning, everyone. We're going to start right away. Let's call the witness, unless there's an objection?

MR. LESNEVEC: No.

THE COURT: Let's call the witness up.

(Dr. Touliopoulos approached the stand.)

S T E V E N T O U L I O P O U L O S, called as a witness by and on behalf of the Plaintiff, after having been first duly sworn, was examined and testified as follows:

(Whereupon, Defendant's Exhibit 1 was marked in evidence.)

COURT OFFICER: Please state your name for the record.

THE WITNESS: Steven Touliopoulos.

COURT OFFICER: Please state your address for the record.

THE WITNESS: 23-25, 31st Street, Astoria, New York 11105.

THE COURT: Good morning. Go ahead, Counselor.

MR. JONES: Thank you, Judge.

CROSS EXAMINATION

BY MR. JONES:

Q Good morning, Doctor. Welcome back.

A Good morning.

Q You're here for second day of testimony.

What are you charging for today's testimony?

A There will be an additional charge. Again, it will be determined by my office manager.

Q And will you charge for your review of records before coming to court today?

A No, I will not.

Q And what was the charge for yesterday that you discussed with your office manager?

A I haven't discussed it. It's going to be submitted once I'm done with the testimony.

Q Somewhere around ten thousand dollars?

A The charge for yesterday would be between six and ten thousand dollars.

Q And same for today?

A It may or may not be. It's hard to say depending on how long I'm here.

Q Doctor, when we broke yesterday, we were discussing the MRI of the plaintiff's right knee taken on October 11th of 2015 and interpreted by Dr. David Payne. Diplomate of the American Board of Radiology with added qualifications in neuroradiology.

Those are pretty impressive credentials, right?

A He is qualified. He's not a musculoskeletal radiologist, he doesn't specialize in reading in neuroMRIs, but he is a neuroradiologist, yes.

Q And, again, you have never spoken with Dr. Payne after reading these films.

Correct?

A That is correct.

Q But this film study formed one of your indications for right knee surgery.

Correct?

A His interpretation of the meniscus tear is one of the indications for the surgery, yes.

Q Okay. Doctor, let's talk about congenital conditions you've heard of. You have heard testimony about that.

Correct?

A Yes.
Q Congenital means something by birth.
Correct?
A Yes.
Q And degenerative means over time?
A Yes.
Q And acute means something that happened recently.
Correct?
A That's correct.
Q And an MRI is a diagnostic test that can tell the difference between an acute injury, a degenerative injury, and a congenital injury.
Correct?
A I would say it's not the gold standard. It can give you clues whether or not something is acute or chronic or degenerative or congenital. But it's not always definitive.
Q Well, Doctor, the MRI in terms of diagnostic tests is the gold standard to determine whether or not one has an injury.
Correct?
A No, it's not the gold standard.
Q You said arthroscopy is the gold standard?
A Regarding this patient's knee injury, the important factors are the examination as well as the findings during the surgery.
Q So regardless of what the MRI says, you were going to

do a surgery anyway and find out what was in there.

Correct?

A I wouldn't say disregard the MRI, I have my own interpretation of the MRI, but the examination of the knee pain required surgery in my opinion.

Q Let's talk about the congenital, and I have here a model of the knee. And, looking at it, can you tell us if it's a left knee or a right knee?

A It's a right knee.

Q And show the jury, can you point to the medial side of the knee?

A This side (indicating).

Q And this side, that would then be the lateral side.

Correct?

A That's correct.

Q And menial, meaning middle, the part of your knee that points to the middle of your body.

Correct?

A It's basically the inside, yes.

Q Okay.

Doctor, if you take a look at the MRI report, it refers to a lateral tilt and subluxation of the patella.

Correct?

A Yes.

Q That's a maltracking patella, isn't it?

A Well, it's -- maltracking is -- it's a dynamic problem. This is a static examination with a knee extension, and this is a very common finding, and is not always pathologic, meaning it doesn't always mean something is wrong.

Q Well, Doctor, the patella is also the kneecap.

Is that correct?

A Yes.

Q And when the knee bends, the patella is supposed to move smoothly within these parts of the bone.

Correct?

A Yes.

Q The femur and tibia.

Correct?

A Yes, once the knee bends past a certain degree, the kneecap engages in the groove --

Q I'm going to ask you answer yes or no, Doctor.

This is the femur.

Correct?

A Yes.

Q And the lower bones are the fibula and tibia.

Correct?

A That's correct.

Q Okay. And this is the patella I'm pointing to.

Correct?

A You're pointing out the patella tendon, but below that,

if you turn it around, that's the patella. Yes.

Q That's the patella.

And when the knee bends, the patella is supposed to move smoothly between the upper bones and the lower bones.

Correct?

A That's not correct.

Q Well, Doctor, when the patella maltracks or has subluxation, meaning dislocation, that means it's rubbing on either one side or the other of the leg bones.

Correct?

A I can answer that if you want me to explain further.

Q I'll put it to you this way, Doctor.

He has a maltracking patella which is a degenerative condition.

Correct?

A He doesn't have a maltracking patella.

Q According to this MRI report, he has lateral tilt and subluxation of the patella.

Now, subluxation is also a word meaning slight dislocation.

Correct?

A It's not dislocation, but it's when the joint partially comes out of place.

Q So when someone has a lateral tilt and subluxation of the patella, it can cause damage to the back of the kneecap, the

patella.

Correct?

That's yes or no.

A In general, in a patient that has maltracking, the answer is yes.

Q And when it maltracks and the back of the patella rubs against the bones, it causes cartilage damage, doesn't it?

A It potentially can.

Q Well, you addressed that during the surgery, didn't you?

A I addressed cartilage damages from the accident, yes.

Q You addressed cartilage damage which was caused by this preexisting condition, didn't you, Doctor?

A No, I did not.

Q Doctor, take a look at the MRI report and tell the jury where the word trauma appears in it.

A The word trauma --

Q Just take a look at it, Doctor. See where the word trauma appears.

A I don't think it appears in this report.

Q You don't think it appears or it doesn't appear?

A It does not appear.

Q It does not appear.

So if we can go through the remainder of the MRI report, it states that the anterior and posterior cruciate

ligaments are intact. Medial and co-lateral ligaments are preserved.

Would it be fair to say, Doctor, that the ligaments are the structural stability of the knee?

A They aid in stability of the knee, yes.

Q Keeps these bones from moving around, right?

These little ligaments?

A It keeps the femur and the tibia in position, yes.

Q And according to this MRI report, they were intact.

Correct?

A According to the report, yes.

Q And there is no diagnosed ACL tear in this MRI report.

Correct?

A That is correct.

Q The MRI report also refers to cartilage loss.

Do you see that?

A Yes.

Q That's a degenerative condition, isn't it, Doctor?

A I answered that it can be degenerative.

Q And in this case, with a maltracking patella and a lateral tilt, the constant rubbing over one's lifetime of the back of the kneecap against those bones will cause cartilage loss, won't it?

A He doesn't have patella femoral maltracking.

Q He has a lateral patella.

Correct?

A On a static MRI scan with a knee extension that is reported, yes.

Q And a lateral tilt means the patella, the kneecap is not articulating well between the upper and lower bones of the leg.

Correct?

A That is incorrect.

Q And the impression of Dr. Payne is intact cruciate and collateral ligaments.

Do you see that?

A Yes.

Q And nevertheless, despite this, you see here on the MRI report where it says, again, lateral tilt and subluxation of patella.

That means the patella is out of place, doesn't it?

A It means it's tilting and slightly out of place, yes.

Q And, Doctor, when the patella is tilted and slightly out of place, that can cause cartilage and chondral injury to the knee, can't it?

A If there's a patella instability, it can. But this is not diagnosing that condition.

Q Do you see it right there, Doctor, in plain English?

A It's reported with a knee extension. Patella normally does that with a knee extension. The way you diagnose is when

the knee is bending. We have pictures in the operating room. We have -- the patella is tracking normally when the knee is bent, so it doesn't have patella tracking.

Q Well you've got lateral tilt and subluxation of the patella, do you see it?

A On that report, yes.

Q And, Doctor, that condition known as lateral tilt and subluxation of the patella preexisted from this accident, didn't it?

A I don't know if that MRI predated this accident. He did have injury in that area, and that could be post-traumatic in origin.

Q Do we need to go back to the emergency room records, Doctor, to show that there were no complaints of knee pain in the emergency room after spending 40 minutes with the trauma doctor?

Do we need to see that or are you satisfied?

A I don't believe there was a complaint of knee pain in the ER records.

Q We know there was no complaint of knee pain in the emergency room records. We don't need to go over that again, right?

Yes or no?

A I would need to review those records in more detail to say that for certain.

Q Well, you need to review his records in detail? You're in front of the jury now.

When did you review his records in detail?

A It was a while ago.

Q Let's talk about arthrosis. Doesn't that refer to arthritis?

A It depends on the interpretation. It could be arthritis, or it could be traumatic.

Q You're a board-certified surgeon.

Is that correct?

A Yes.

Q Do you want to go on the record saying arthrosis is not arthritis?

A He's writing arthrosis, which means arthritis.

Q Thank you.

A But arthrosis is loss of cartilage, and loss of cartilage can be traumatic in origin.

Q But, Doctor, this MRI was taken weeks, only weeks after the accident.

You're aware of that?

A Yes.

Q So the arthrosis, by medical definition, predated this accident, didn't it?

A I would say that the cartilage damage I noted at the surgery did not predate the accident.

Q Doctor, the cartilage loss caused by the arthrosis predated this accident, didn't it?

A I think I answered that question.

Q And as you discussed yesterday, you performed a left knee operation on the plaintiff, right?

MR. LESNEVEC: Objection. It was the right knee.

MR. JONES: Right knee. I apologize.

Q A right knee operation.

Correct?

A That's correct.

Q Now, do you recall, with reference to the anterior cruciate ligament, an occult anterior cruciate ligament deficiency?

Do you see that?

A Yes.

Q Occult meaning you can't see it?

A Occult meaning difficult to diagnose, which it was, because it wasn't reported on the initial MRI scan.

Q Occult meaning it didn't present on the MRI that you interpreted for the jury yesterday, right?

A It wasn't recorded on the MRI report.

Q Because it wasn't there on the MRI.

Correct?

A It wasn't there on the MRI report, but it's there on the MRI images.

Q Okay. Doctor, where on your preoperative diagnosis do you say ACL tear?

A ACL deficiency is a term that represents a dysfunctional ACL.

Q That's not what I'm asking you. Listen to my question, and if you don't want to answer it at all, let me know and I'll rephrase it.

Where on your preoperative diagnosis does it say ACL tear?

A It says ACL deficiency.

Q It doesn't say ACL tear does it?

A No, it does not.

Q Okay. You stood in front of this jury yesterday and you, in front of the MRI films of the right knee, said that you identified an ACL tear.

Do you remember that testimony?

A Yes, I said there was a partial tear and deficiency, which includes the terminology I used yesterday, meaning the partial tear and the insufficiency of the ACL.

Q Doctor, you can appreciate the difference between a deficiency and a tear.

Correct?

A Yes.

Q Deficiency could mean stretching.

Correct?

A Tear and stretching falls under deficiency.

Q You're telling the jury that an ACL deficiency is the same thing as a tear?

A The tear falls under deficiency, yes.

Q Well, Doctor, you don't say tear in the report, do you?

A I do not, no.

Q As a matter of fact, you called the operation a right knee diagnostic arthroscopy.

Do you see that?

A Yes.

Q Diagnostic means you don't have a diagnosis before you perform the surgery. You are going to perform the surgery to see what's wrong.

Correct?

A No, it does not mean that.

Q All right.

Take a look at your operative report. And by the way, just for the record, I'm referring to what's Plaintiff's Exhibit 14 in evidence and what I have under the projector is Defendant's Exhibit E, which is a copy of Defendant's Exhibit 14 in evidence. Just for identification purposes.

THE COURT: Any objection?

MR. LESNEVEC: No.

MR. JONES: No.

THE COURT: Okay.

Q All right, Doctor. Let's talk about chondral changes. I've highlighted this portion of your operative report. Grade 1 chondral changes were noted along the lateral tibial plateau, which is in this part the knee (indicating).

Correct?

A Yes, it's on the outside, yes.

Q And chondral changes also refers to chondromalacia.

Correct?

A It means there's chondral change because of the softening of the cartilage in the knee.

Q Softening of the cartilage in the back of the kneecap.

Correct?

A You're referring to the lateral plateau, but there was also findings on the kneecap also, yes.

Q And the softening of the cartilage is caused by the constant rubbing of the patella on the bony structures of the leg.

Correct?

A There are various causes which I can go into.

Q Is that one of them, Doctor?

A Yes, that could be.

Q And a lateral tilt will cause chondral injury.

Correct?

A A patient with a significant abnormal tilt can have chondral changes, yes.

Q And you found that intraoperatively, didn't you?
A I did.
Q And the chondral changes preexisted before this accident, didn't it, Doctor?
A It's my understanding that the chondral changes are the result of the accident.
Q Now, with respect to the patella trochlea, point to the trochlea for the jury.
A The trochlea is the lower part of the femur, it's this groove that's part of the femoral bone.
Q Okay. And you noted Grade 1 and 2 chondral injury to that part of the bone.
Correct?
A That's correct.
Q And that's a bony type of condition.
Correct? Not ligament, not -- let me ask you this: That's a bone injury.
Correct?
A It's a chondral injury, a cartilage injury.
Q And also caused by the rubbing of the patella over the course of years against the bony structures of the legs.
Correct?
A Well, not in this case, but that is one of the causes, yes.
Q That is one of the causes.

And for somebody that's been a basketball player his entire life, a skier, and a snowboarder, would you expect somebody with a congenital condition of a maltractive [sic] patella, would you expect to find chondral injury in someone like that?

A Again, this patient was in his early 30s at the time of the accident, and patients that are very athletic who are early 30s we don't expect to find arthritis in the knee.

Q And again, Doctor, there's no word trauma in the MRI report.

Correct?

A That is correct.

Q Now, let's talk about Grade 4 chondral injury, loose chondral flaps along the trochlear groove that you just pointed to. Grade 4.

A Yes.

Q Four out of four is as bad as it gets, right?

A Yes.

Q And that's a lifetime of the back of this patella rubbing against the back of the bones on the knees.

Correct?

A That's not how it happened, no.

Q Doctor, are you telling us that despite the fact that he doesn't have one complaint of knee pain after his accident, that these conditions you find, and the associated arthritis in

the knee, that the accident caused these things you addressed surgically?

A He had complaints of knee pain, that's why he came to my office, and the findings that I noted at the time of surgery, in my opinion, are traumatic in origin.

Q Let's talk about the component of your report that addresses the anterior cruciate ligament.

Okay?

A Yes.

Q You said yesterday on cross examination when I asked you about the gold standard of diagnostic testing, you said arthroscopy is the gold standard, right?

A To diagnose an ACL injury, I would say yes.

Q Okay. Show the jury where the word tear of the ACL occurs in the operative report.

A I didn't use the word tear. I used injury.

Q So the word "tear" doesn't appear.

Correct?

A That is correct.

Q As a matter of fact, you never used the word tear in your interpretation of the right knee MRI.

Correct?

A I can't remember what I said yesterday. I think I may have said partial tear.

Q You did say partial tear, but you never wrote that down

anywhere.

Did you?

A It's not in this operative report, that is correct.

Q It's not in your interpretation, ever, of the MRI written anywhere, and it's not in your operative report.

Correct?

A It's not in my operative report, and I don't believe it's noted in my other notes.

Q And you consider yourself a detailed surgeon?

A Yes, I do.

Q And you didn't even write the word "tear" down, and you're telling the jury he has a tear?

A I'm detailed, I have a very good picture showing it.

Q Doctor, you knew you were coming to court to testify eventually because there was an attorney that referred you to the case.

Isn't that correct?

A I don't know that for sure.

Q Well, you knew there was a possibility, right?

A I would say there was a very small possibility, yes.

Q And let's talk about what your findings were with regard to the ACL.

It talks about posterior fibers, fibers of the ACL, they were found to be with abnormal laxity and an abnormal orientation. Diagnosis of anterior cruciate ligament

deficiency. That's stretching it, isn't it?

Yes or no?

A It's laxity of the posterior fibers.

Q You used the word yesterday "taut," T-A-U-T meaning tight.

Yes?

A Yes.

Q And for a knee to be structurally sound, it has to be taut.

Correct?

A Depending on the ligament, yes.

Q That refers to the ACL.

Correct?

A Yes.

Q And when it has ligament laxity, it means it's a little loose.

Correct?

A It could be a little or moderately or very loose.

Q And you find stretching and anterior cruciate ligament deficiency, not a tear.

Correct?

A Again, the tear is not noted on that report, but the images do show a partial tear of the anterior cruciate ligament.

Q Go into your chart that you have in that big white binder and tell the jury where you used the word tear anywhere

to refer to the ACL.

A I may not have used the word tear, but the word injury and deficiency include injuries of the ACL, including tears and laxity.

Q Doctor, we can agree it's not in there, right?

A No, but there's a picture showing it.

Q There's a picture showing it but you never wrote it down, right?

A I may not have, no.

Q Let's talk about the left knee. Okay?

He's got a lateral tilt and subluxation of the left knee as well.

Correct?

A On the MRI report, yes.

Q Okay.

Well, did you interpret that as well?

A I don't think I interpreted the left knee MRI.

Q You didn't bother reading it?

A I don't recall reading it.

It did improve, that may be one of the reasons why I never interpreted it.

Q Well, that can cause degenerative, that meaning lateral tilt and subluxation of the patella, can cause degeneration and subluxation of the knee.

Correct?

A Depending, yes.

Q Left knee does not have arthritis but the right knee does?

A Arthritis in the right knee, yes.

Q Doctor, if you want to come to court and testify to the jury about the issue of causation, do you think it would have been prudent for you to look at the MRI of the left knee as well as the right knee?

That's a yes or no question.

A I would say no.

Q We see he's got the identical condition on the left knee that he's got on the right knee.

Correct?

A It's not identical. Both knees were injured in the accident, but again, the left knee improved.

Q I want to talk to you about the shoulder, Doctor.

The plaintiff underwent an MRI of his right shoulder on October 7th, 2015.

Do you see that?

A Yes.

Q And again, this was also interpreted by Dr. David Payne.

Do you see his name at the bottom?

A Yes.

Q How did Dr. David Payne interpret this film study of

the right shoulder with regard to the rotator cuff?

A He interprets it as being intact.

Q Intact.

Now, let's go over the anatomy of the rotator cuff. It consists of four tendons?

Correct?

A Yes.

Q Have you heard of the acronym SITS, S-I-T-S?

A I don't use that, but are you referring to the four muscles of the rotator cuff?

Q The supraspinatus, infraspinatus, teres minor and the subscapularis. Correct?

A That's correct.

Q And the four tendons of the rotator cuff operate below the acromion which is a bony structure, correct?

A The supraspinatus and infraspinatus operate below the acromion. The other two either in front or in back.

Q All right.

So the acromion, the position of the acromion and the room between the acromion and those tendons can have an effect on the operation of the rotator cuff tendons.

Correct?

A It can, yes.

Q And his congenital condition that the plaintiff has with regard to the acromion, can you just tell the jury what

that is?

A It's a curvature of the acromion, which is actually the majority of us have this curvature in our shoulder, and in the absence of trauma, usually it never bothers us.

Q You like to use the word trauma, but let's talk about the acromion. There are three types of acromions identified in the record medical literature.

Correct?

A That is correct.

Q Type I, Type II, and a Type III.

Right?

A Yes.

Q Type I means there's plenty of room between those tendons and the acromion.

Am I right? It's not downward sloping?

A Well, it's not downward sloping, there's other factors that affect the room, but it's not downward sloping.

Q Type II acromion is a little sloped down.

Correct?

A Type II is a slight curvature.

Q And Type III is more curvature.

Correct?

A Yes.

Q And the plaintiff here has a downward sloping acromion.

Correct?

A The interpretation is -- I'm sorry, I'm having trouble reading this. Oh, I can see. Yes it.

Q And he has acromioclavicular joint hypertrophy; you didn't mention that yesterday on plaintiff's, did you?

A No, I did not.

Q Let's go into it a little bit.

Hypertrophy means excess bone growth, doesn't it?

A It's enlarged bone growth, yes, you could consider that.

Q And hypertrophy or excess bone growth occurs over a period of time, months or years, doesn't it, Doctor?

A It does happen over a period of time, usually months to years, if not decades.

Q Now, the date of this MRI was 10/7/15.

Do you see that?

A Yes.

Q And our accident date is 9/27 of 15.

Correct?

A Yes.

Q So this hypertrophy and downward sloping acromion, that's been there for years.

Correct?

A Yes, the downward sloping acromion I believe he was born with, the acromion is something happened after birth.

Q After birth?

The hypertrophy takes years to develop, doesn't it?

A I would say months to years.

Q So it predated this accident.

Is that right?

A Yes.

Q And when the hypertrophy grows enough, it causes a spur in the acromion, doesn't it?

A It can cause spurring of the acromioclavicular joint.

Q And when that spur grows large enough, it can impact those tendons of the rotator cuff, doesn't it?

A The spurs from the acromioclavicular joint are usually more medial, are more on the inside, and they don't usually impinge on the rotator cuff, but they can cause pain.

Q Where does the word trauma appear in this MRI report?

A It doesn't.

Q This MRI report finds no tears in the rotator cuff.

Correct?

A That is correct.

Q As a matter of fact, the report by Dr. Payne states evaluation of the rotator cuff musculature reveals no loss of integrity, supraspinatus, infraspinatus, teres minor, and subscapularis muscles are preserved. And that's the acronym I referred to, SITS.

Correct?

A Yes.

Q And they're all in good shape according to this MRI report, right?
A Yes.
Q No injury at all.
Correct?
A According to the report, yes.
Q No traumatic injury at all.
Correct?
A No injury, no traumatic injury, yes.
Q But it does note the degenerative condition we discussed of joint hypertrophy.
Do you see that?
A Yes, but that's not in the shoulder joint.
Q Yes or no: Is it joint hypertrophy?
A Yes, of the AC joint.
Q Of the AC joint?
A Correct.
Q And you addressed that during the surgery, didn't you?
A It did not need any surgery. No.
Q Did you take a Burr and Burr down for decompression purposes the under surface of the acromion during the surgery?
A Yes, but I did not touch the acromioclavicular joint.
Q But what you did address is the spur that was under the acromioclavicular joint.
Correct?

A No, it was the patient's natural anatomy that I addressed.

Q Natural anatomy, which was impinging upon the rotator cuff. Is that correct?

A It was done to make more space for the rotator cuff to help it in the healing process.

Q Because you identified impingement syndrome, didn't you, Doctor?

A Yes.

Q Impingement syndrome, which was caused by that preexisting joint hypertrophy.

Correct, Doctor?

A Actually, the impingement syndrome was primarily caused by the labral shear instability of the shoulder, when the shoulder is unstable, it wants to slip out and that causes the impingement. So the patient had a spur his entire life that never caused this until the accident, and we addressed that with the shaving of the bone prominence.

Q Doctor, I'm going to ask you to answer yes or no to my questions. Okay?

A Will do.

Q Where is the anesthesia record for this surgery, the right shoulder surgery?

A The anesthesia record would be in the hospital records.

Q And you didn't bring that with you.

Correct?

A No, I only brought the records that I generated in my office.

Q Now, you knew you were coming to testify here today.

Correct?

A Yes.

Q And you asked your office manager to prepare your chart to come testify?

A Yes.

Q Is your office manager a physician?

A No.

Q Does your office manager know what an anesthesia record is?

A The --

Q Yes or no?

A I would say she does, yes.

Q Did you ask her to get the anesthesia record?

Yes or no?

A No, I didn't ask for the hospital records, no.

Q Did you consult with plaintiff's attorney about what or what not to bring to trial before you tested?

A No, I did not.

Q The anesthesia record would tell us how long the surgery was, right?

A Yes.

Q And the anesthesia record would tell us what time the operation started and what time it ended.

Correct?

A Yes.

Q It would tell us when anesthesia was administered and when it was stopped.

Correct?

A Yes, it would.

Q And the actual arthroscopy for the shoulder would take anywhere from 10 to 20 minutes?

A The arthroscopy of the shoulder?

Q Yes.

A Which part of that?

Q Doctor, the entire operation, beginning to end, takes about 20 minutes?

A I don't recall the length of this surgery. I would say it would be longer than 20 minutes, though.

Q You don't know because you didn't bring the record, right?

A I don't know the exact duration.

Q Okay. Let's talk about what you found intraoperatively with regard to the acromion.

Subacromial space means below the acromion, doesn't it?

A That's correct.

Q Revealed evidence of both bony and soft tissue

impingement.

Do you see that?

A Yes.

Q You dictated this, right?

A Yes.

Q With hypertrophic and hyperemic subacromial and subdeltoid bursitis, now, Doctor, the word hypertrophy appears, referring to bone growth excess.

Correct?

A No, it's referring to the synovial tissue that's inflamed.

Q Do you see "subacromial bony prominence" in your report?

A Yes.

Q And a subacromial bony prominence is put under the undersurface of the acromion.

Correct?

A Yes.

Q So before, what you told the jury was that you didn't address the acromion?

A I said I didn't operate on the acromioclavicular joint.

Q Well, your operation did address subacromial bony prominence, right?

A Yes.

Q And that bony prominence causes impingement on the

rotator cuff.

Correct?

A It can cause impingement.

Q And it did in this case, didn't it?

A Yes, but secondary to the other injuries.

Q Did you address it surgically?

A Yes.

Q And that was in existence well before this accident.

Correct?

A The bony prominence was there since birth, yes.

Q Birth?

A It's something you're born with, yes.

Q But the bony prominence is a hypertrophy that occurs over years?

A No, the bony prominence occurs to the curvature of the acromion.

Q And you addressed that surgically, didn't you?

A Yes, I did.

Q You took a burr and shaved down the bone?

A Yes.

Q And in shaving down the bone, you're addressing the bony structures of the shoulder, right?

A I'm addressing the bony structures of the shoulder, yes.

Q Because you want to make sure there's no more

impingement on the rotator cuff.

Correct?

A I want to reduce the possibility of any tear to the rotator cuff, yes.

Q You didn't repair the tendons of the rotator cuff, did you?

A Yes, I did.

Q And you put an anchor, correct?

A Yes.

Q Now, how long did it take you to do the burring under the acromion?

A I don't know the exact duration it took me to burr the acromion on this patient.

Q Well, we can agree, Doctor, that the burring you did was on a condition that preexisted this accident by years.

Correct?

A Well, the condition was asymptomatic, until this accident, and after the accident it required treatment, yes.

Q That's what the plaintiff says, Doctor, but we both know that impingement is a painful condition.

Correct?

A A post-traumatic impingement is a painful condition, can be, yes.

Q What about degenerative impingement, is that painful too?

A Degenerative impingement can be painful, yes.
Q And we have degenerative impingement here, don't we?
A No, we don't.
Q Referring to how you addressed that preexisting condition, it's an acromioplasty performed on the acromion with the arthroscopic burr.
Do you see that?
A Yes.
Q So you did address the acromion during surgery, right?
A That is correct.
Q And you burred that bone until there was no longer any evidence of subacromial impingement following the subacromial decompression.
Do you see that?
A Yes.
Q How much burring did you do?
A Enough to open the space. Usually we convert the Type II acromion to a Type I acromion.
Q Again, addressing the congenital condition, right?
A No, that's -- the acromion prominence is not a degenerative condition.
Q Doctor, Type II acromion is a congenital condition, right?
A I'm sorry, the Type II acromion is congenital, it's not degenerative. I take that back, yes.

Q So it's congenital and it's Type II meaning it had curvature?

A Yes.

Q And 2 out of 3, 3 being the worst, right?

A Correct.

Q And you took this congenital condition with all the burring you did and you made it Type I, correct?

A We tried to push it to Type I, we tried to flatten out the acromion, yes.

Q Did I hear you correctly that you made a Type II a Type I?

A Yes, we made it like a Type I. We tried to flatten the acromion like a Type I.

Q So the majority of this operation, Doctor, is addressing a preexisting condition.

Correct?

A No, that was a small part of the surgery and probably the least important part of the surgery.

Q Doctor, the impingement we're talking about, the bony structure, that can impinge upon the tendons of the rotator cuff, can't it?

A It can, but the important part of the surgery were the tears that the patient had.

Q What did you charge for the shoulder operation?

A I think I went into that yesterday. I believe it was

around five thousand dollars.

Q And for the knee operation it was how much?

MR. LESNEVEC: Objection, Judge. These were all asked yesterday, and he's just trying to delay this now.

THE COURT: Overruled.

A I believe I said six thousand dollars.

Q So eleven thousand for the surgeries, somewhere in the twenty thousand range to come testify for two days.

Correct?

A I don't know what the cost of the testimony will be.

Q And on how many occasions did you speak with Mr. Lamonsoff's office about this plaintiff?

A I don't recall ever speaking to him about this patient.

Q Thank you, Doctor.

MR. JONES: Nothing further.

THE COURT: Counsel?

MR. LESNEVEC: Yes, your Honor.

RE-DIRECT EXAMINATION

BY MR. LESNEVEC:

Q Doctor, when was the first time that you and I met?

A It was yesterday morning that we met in person.

Q And you've never met me at any time before that.

Is that correct?

A That is correct.

Q Did you know that our office has been in business for

27 years?

A I did not know the duration, no.

Q But does it surprise you that we've been in business for 27 years?

A No.

Q You testified yesterday that you've come to court before on behalf of the defense.

Did I hear that correctly?

A I have, I believe on one occasion, yes.

Q So it's not the situation where you've come in here every single time on behalf of a plaintiff, correct?

A That is correct.

Q Can you just tell us more about the setup of your office? Do you have a billing department, do you have an office manager? Just kind of tell us about the various roles that work there.

A So I have two office locations, one in the city, in Manhattan, one in Queens. But the office it really based in Queens, and that's where we have a billing department. That's where my office manager operates and we have secretarial staff. I have a physician assistant, I also work with a colleague, Dr. DeMarco that I mentioned I believe yesterday. It's a fairly small practice. And I would say that total employees may be about 8 or 10.

Q And what do you do, Doctor, when you're not in court?

A When I'm not in court, you mean my hobbies?

Q Let me ask it this way.

Did you have anything scheduled or did you have to cancel any appointments or anything this morning?

A So yesterday afternoon I canceled surgeries. I did some in the morning, and then I rushed here. And then I canceled the afternoon to be here, and today I had office hours in Queens that I canceled. The morning. I haven't canceled the afternoon yet, but hopefully I won't have to.

Q And how is it that you get your patients? Is it solely only from attorneys or is it something else?

A No, it's not solely from attorneys. I have been in practice since 1997, so a lot of patients come to me by referrals from other patients or family members. We do have attorney referrals, we have referrals from the internet, from the hospital, so we have kind of a mixture of referral sources.

Q And what percentage of your patients do you have to come into court and testify at a trial like this? Is it the majority of your patients or something else?

A It's a very, very small percentage. I may see hundreds or even a thousand patients in a year, and like I said, I may testify three or four times. So this is a really, very, very small part of my practice. And I would rather not even be here, I would rather be in the operating room, but I do this, again, because I'm asked to do this.

Q And does your office ever send records, maybe not you personally, but anyone in your office send records to attorney's offices if they have a patient that's injured and they represent them?

A Yes, the records are shared with who the patient requires them to be shared with.

Q And would the patient put the name of their attorney in the intake sheet so that you know who to send the records to?

A Yes.

Q There was some testimony about which records you have from the hospital.

The surgeries that were performed, where were those performed at?

A New York Presbyterian Lower Manhattan Hospital. The old Beekman Hospital.

Q Since you were the one that performed surgery, is that the reason why those records of that hospital are a part of your records?

A Yeah, they're not ordinarily a part my private office records.

Q Does the absence of the mention of the right knee in the emergency room records, does that change your opinion in any way?

A No, it doesn't.

Q Why not?

A It's not uncommon where an emergency room setting, whether it's the patient that reported all the injuries because of the traumatic event that just occurred, or the emergency room staff, their concern really is life-threatening injuries. There may not always be notations or complaints in the emergency room records, and a lot of times when there's an acute injury but there's other areas of the body that hurt more, the brain can only take in so much pain. So the knee may not have been something on his mind at the time of the accident, and the inflammatory process may not kick in for days after the accident such as, I'll give you an example.

You may sprain your ankle today, you may walk around on it, and then tomorrow you wake up and your ankle is swollen like a balloon because the inflammation had time to develop over the night.

Q You were asked questions yesterday about inflammation and you said something about you can't assess the severity of the impact.

Why is that?

A Well, that's a very mechanical question. You have to look at the frame damage, and that's not something I can assess by talking to the patient.

Q Do the airbags in a vehicle have to deploy in a vehicle for there to be an injury?

MR. JONES: Objection. Outside the scope.

THE COURT: Overruled.

Q Do the airbags have to deploy for someone to get injured in an accident, Doctor?

A No, they do not have to be deployed.

Q Do glass windows have to break in a car accident for someone to be injured?

A No, they do not have to break for there to be significant injury.

Q You were asked about whether or not you would expect to see joints swelling immediately after an accident. You said you couldn't answer that with a yes or no.

Why is that?

A I think I kind of went into it a little bit with the ankle because sometimes it's not there right after. You may have a knee injury and you may have immediate bleeding and there may be swelling in the emergency room. Or you may have swelling in the injury that never really swells up. You have a tear, but it's not an injury that causes swelling, or you might have swelling that develops hours or days later. So the absence of swelling immediately after an injury does not preclude there being an injury.

Q There was also a lot of questions about the hospital records in terms of the pulse and different measurements. The fact that his pulse may or may not have been normal, does that change your opinion in any way?

A No, that's not a direct measure of pain.

Q There were also questions about what vitals you may or may not have taken at your office, questions about blood pressure, why you didn't take the blood pressure.

What's the reason behind not needing to take the blood pressure of a patient in your practice?

A Well, I'm an orthopedic surgeon, I'm not an internal medicine doctor, and I don't treat high blood pressure. And they're coming to see me for the bone problems or the joint problems. I would recommend they see the regular doctor regularly for their other medical issues. If any.

Q Yesterday you talked a little bit about atrophy. Do you recall that?

A Yes.

Q What is atrophy?

A Atrophy is thinning of the muscle, the muscles get smaller, and that may be because of a nerve injury where the muscle is not working, or it can be from disuse from not using the muscle, such as if you have a shoulder injury, you're not really using your arm as much, and that arm may be thinner than the other arm.

Q Did you note any signs of atrophy?

A Yes.

Q And what, if anything, did that signify to you or Mr. Moise?

A That it's consistent with there being residual dysfunction in the shoulder and the knee, that the arm and the thigh are thinner on the right side than the left side.

Q Today and yesterday, the report of a Doctor David Payne was shown to you with regards to radiology of the right shoulder and the right knee.

Do you remember looking at that?

A Yes.

Q And did you notice that what wasn't highlighted was that there was a tear of the medial meniscus?

A Yes.

Q Wasn't gone over with you by the defense attorney, do you recall that?

A Yes, I brought it up, though, yes.

Q Can you tell us just more about what that meant to you in terms of a medical sense, when you saw medial meniscal tear in that record?

A Meniscal tear can cause pain. They don't always, because, you know, he has a meniscal tear in his other knee that is not bothering him, but in his right knee it was a source of pain, and together with the cartilage damage and the ACL, in my opinion, required surgery.

Q And did you need to speak to Dr. Schwartz or this radiologist Dr. Payne or anyone before you came to your own conclusions?

A No, I'm an orthopedic surgeon. They're not orthopedic surgeons. And there was no need for me to speak to them.

Q Does it happen at all in your practice where you do come across, I think you testified about a false positive or false negative where the radiologist reports something and you don't see it, or they don't report it but you do see it.

How often does that happen?

A It happens quite frequently. That's why I mentioned today the diagnostic arthroscopy. So what that is, is that before we actually do anything, we look inside the knee with a camera, and we look at everything we can see inside the knee because the MRIs can be wrong. And it happens. And it happened in both the knee and the shoulder.

In the shoulder, he had obvious tears of the rotator cuff and the superior labrum that were not reported on the MRI. So the purpose of the diagnostic arthroscopy is to directly look at the structures that the MRI is trying to look at, and evaluate them directly on the camera, to see what the damage is.

Q There was questions yesterday about why you recommended the right knee surgery and they went through two out of the three dates before surgery.

Do you recall being asked about October 7th, October 14th, but not about October 28th?

A Yes.

Q And can you just tell us, there was a mention of his

range of motion going on October 7th from 60 degrees to the right knee, to then 100 degrees on the 14th. Can you tell us what happened on the 28th?

A So on October 28th, his motion went back down to 80 degrees. And I know this was discussed yesterday, really his motion or lack of motion was not the reason we did the surgery. The reason we did the surgery is his ongoing pain and instability of the knee. And in my opinion, additional therapy would not have changed the condition. He still needed surgery. And I would rather him do the therapy after the surgery.

Q Now, today there was questions about a maltracking patella. And you said that there was no maltracking patella.

Do I have that correct?

A Yes.

Q What does that signify to you, if anything?

A So maltracking is basically the kneecap shifting to the side. And some people have a real problem with that. They actually -- the kneecaps kind of dislocate and pop out of the knee. The kneecap actually does not engage into the trochlea bone until the knee is bent, you know, usually past 30 degrees. So when the knee is straight as it is when the MRI is done, the kneecap is not going to be -- it could be in the center, the outside, the inside. The true gauge of patella maltracking is done when you bend the knee, and that's what we did during the surgery. We bent the knee. Then we took a picture showing that

the patella was dead centered in the trochlea.

So there was no evidence of what we call a dynamic patella from instability. So, you know, it's not common if you do an MRI with the knee in extension that the patella is tracking laterally; that's just a one-time picture. What we're concerned about is the dynamic stability of the patella while it's moving.

Q You talked about lateral tilt and subluxation, I think, of the patella.

Is that correct?

A I'm sorry, can you repeat the question?

Q Just earlier, you were asked about lateral tilt and subluxation of the patella.

Is that correct?

A Yes.

Q What is that?

A So lateral patella tilt is the patella tilts this way, and subluxation of the patella moves that way. And again, you don't diagnose that with a knee straight. You have to bend the knee. If it actually comes out of place when the knee is bending, that's abnormal, we call that pathologic, and the patient doesn't have that. So he doesn't have a patella tracking problem in the knee.

Q There were questions about cartilage, the cartilage of his right knee.

Do you recall those questions?

A I do.

Q What was the cause of any cartilage damage that you observed in the knee?

A It's my opinion that it was caused by the accident.

Q Why do you believe it was caused by the accident?

A Because he had -- when you have arthritis, when you have degenerative arthritis, usually it's not, like, one spot on the knee. Right, it's, like, it involves other areas. He had a ding, like, a trochlea, it was very focal. It was, like, a traumatic injury. So that's why my opinion, I believe that it is traumatic because it had the appearance of being traumatic. When I did the scope, it was very focal, meaning that it was only injured in a specific area, and it did not involve the other areas of the knee.

Q There was questions also about a patella tilt.

Do you believe that caused any of the injuries that you saw when you operated?

A No, because the cartilage damage in the trochlea was kind of in the center of the trochlea. If the tilting caused the cartilage damage, the cartilage damage would be on the lateral side of the trochlea. So it's not actually where the damage would be if he had a patella maltracking problem. In other words, if the patella was rubbing against the outside of the knee, the outside of the knee would be worn down. But

that's not where the damage was. It was actually in the center, it was more in the center of the knee.

Q There was also a question about a Grade 1 chondral change, or chondral changes.

Do you remember that?

A Yes.

Q And do you believe those are as a result of the accident?

A Yes.

Q Why is that your belief?

A Again, when there's a traumatic injury, it can cause damage to the cartilage of the knee together with the meniscus tearing, and the ligament injuries combined can cause the chondral findings that we noted.

Q There's questions about the left knee, the knee that you did not operate on, and whether or not you reviewed the MRI.

Do you recall that?

A Yes.

Q Was his left knee initially injured in the accident?

A I have it as being initially injured in the accident.

Q As time progressed, as you treated him, did he continue to complain of the left knee, the right knee, one or both?

A I believe it was something that was noted by my colleague, Dr. DeMarco, initially, but when I started to see him, really, his complaints were only to the right knee, and my

attention was really on the right knee and the right shoulder.

Q You testified about the acromion in the shoulder. Having an acromion in the shoulder is common in most of us.

Is that correct?

A Yes, a Type II acromion is something that the majority of people have.

Q Did his acromion in any way cause the injuries you saw in the MRIs?

A No, because -- I believe I mentioned this yesterday -- when you do have an acromion problem big enough to damage the rotator cuff, the damage is going to be on that side (indicating). So -- I wish I had a model. So there's two sides of the rotator cuff tendon. The side inside the shoulder and the side under -- in the acromion. The damage to the rotator cuff we found was inside the shoulder. It's not where the acromion was rubbing. The actual area where the acromion would rub looked normal, so the acromion had nothing to do with his rotator cuff tear.

Q There was also testimony this morning about hypertrophy. Is that right?

A Yes.

Q Did hypertrophy have anything to do with the injuries you saw inside his shoulder?

A The right shoulder -- the hypertrophy I do believe was there before the accident, but it had nothing to do with the

injuries, it did not result in any pain, it did not require any surgery, and it does not require any treatment.

Q And you answered a lot of questions about burring. What was the purpose of performing any burring during the operation of the right shoulder?

A So, again, the impingement syndrome is when the acromion kind of, you know, rubs the rotator cuff. Now, he never had impingement syndrome before the accident. And you can develop impingement syndrome after an accident, so you can take a condition that was not bothering you, and it can become a problem.

And also, when you change the mechanics of the shoulder, when the shoulder becomes unstable, as you do when you have anterior labral tear. When you have an anterior labral tear, the shoulder wants to slip out. And as it slips out, it rubs your acromion.

So the entire syndrome was because of the accident and the labral tear. And because we did the repair, we also wanted to increase the space under the acromion to help it with the rotator cuff repair and healing.

Q Doctor, the longer you're kept here with any of our questions, the higher the bill becomes for my client.

Is that true?

MR. JONES: I'm sorry. Can I hear that question again?

(Whereupon, the referred-to portion of the testimony was read back by the reporter.)

MR. JONES: Objection.

THE COURT: Overruled.

Q Is that possible, that the longer you're kept here by anyone, the higher your bill may become for my client?

A Yes.

MR. LESNEVEC: I have no further questions.

THE COURT: Counsel?

MR. CORRING: Two questions.

RE-CROSS EXAMINATION

BY MR. CORRING:

Q How about vital signs, Doctor? Are you telling the jury that when you have a surgical candidate, that you don't take his vital signs?

Is that what you're telling us?

A I do vital signs, but not usually blood pressure.

Q Doctor, if you're going to put somebody under general anesthesia, do you want to know if he or she has high blood pressure?

Yes or no question.

A Well, if they have a history of high blood pressure, I do have them get a medical clearance with a regular doctor, yes.

Q But you don't even check that in your office, is that what you're telling us?

A We may check the blood pressure if there's a clinical indication to check it.

Q Now, back to the emergency room records, how many complaints of left knee pain did you see in the emergency room records if you remember?

A I don't believe there were any.

Q No left knee and no right knee complaints in the emergency room records.

Correct?

A As far as I can tell, yes.

Q Thank you.

MR. CORRING: Nothing further.

THE COURT: Counsels?

MR. JONES: Nothing.

MR. LESNEVEC: Nothing.

THE COURT: Okay. Thank you, Doctor. We're going to take a five-minute break. Actually, let's make it 11:10. Back at 11:10.

(PROCEEDING CONCLUDED.)

* * * * * *

Court Reporter's Certification

I hereby certify that the foregoing transcript is a true and accurate record of the stenographic proceedings in the above matter of Moise v. Yakadjene/Nesbitt.

Brynn C. R. Seymour

Brynn C. R. Seymour
Senior Court Reporter
Bronx County
BCRS

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