SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: CIVIL TERM: PART IA-22

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CHARLES SARMIENTO,

Plaintiff,

-against-

Index No.
804481/2021e

HP RIVER CREST HOUSING DEVELOPMENT FUND COMPANY, INC., 1 RIVER TERRACE, LLC, J. EQUITIES II, LLC, MADDD EQUITIES, LLC, JOY CONSTRUCTION CORP.,

Defendants.

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Testimony:
Dr. A. Merola
Dr. S. Touliopolis

851 Grand Concourse
Bronx, New York 10451
October 21, 2025

B E F O R E:

HON. MARISSA SOTO,
Justice of the Supreme Court

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

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ALSO PRESENT:
Majelie Smith-Oritz

Valerie E. Monaco
Senior Court Reporter

*** M O R N I N G S E S S I O N ***

COURT OFFICER: All rise.

THE COURT: Good morning. You may be seated.

I believe that we are still waiting on one juror. Oh, I'm sorry, two jurors. But we did have just some administrative things to go over and I figured we could use this time to do so.

We were alerted last night, after we had wrapped, that juror number three has disclosed that they will not be able to be here on Friday. So that presents a question to us, clearly, as to what we want to do with that information. Do we want to go down on Friday? Do we want to replace juror number three with an alternate? You know, there are benefits and risks on both sides depending on which way we proceed to do it. So I definitely want to give you guys as much notice as possible so that way you can begin to have your conversations.

Counsel Gjelaj?

MR. GJELAJ: I have two witnesses scheduled for trial Dr. Shah, who's a lifecare planner, but he's also a practicing doctor at various hospitals. I have Dr. Macagno, who's a spinal surgeon. I would prefer if we take one of the alternates and slide them in.

MR. WHALEN: I would prefer to keep the juror. I mean, I'll take it under advisement because I understand

the difficulty that counsel is going to have.

THE COURT: Okay. So, yes, and just to be clear, this was the Court's assessment of it was everyone here is aware that November 3rd is the last day that the Court is available until I believe November 14th or 15th which would put us out a week-and-a-half of down time.

I recognize that if we go down on Friday, that could mean that that pushes us past that November 3rd date. In the Court's mind, November 3rd -- the safest position for us to be in is that at most we're looking at deliberation on November 3rd.

And so clearly, if we go down Friday, that presents a risk as to that. But that leaves us with four alternates and, hopefully, those four would provide us with the minimum of six. We would need to continue when I return.

However, if we don't go down Friday, and instead use the alternate, then that could put us potentially in a better situation to totally wrap by the 3rd and not have to worry about the additional but both have uncertainty.

So I understand that those require some deliberation on your part. I'm not looking for any concrete answer but just know that the Court is also aware that there's no really pat right answer to this because

there are risks and benefits on both sides.

So there was that issue, and then the other goes to the closing charges and the verdict sheet.

The Court has received the plaintiff's iteration of the closing charges and verdict sheet. I believe yesterday Counsel Gjelaj mentioned that he was going to supplement the closing charges, I believe, by at least one. However, this Court's normal way of operating is that the parties should exchange their closing charges and verdict sheets, identify what are the points of contention and deliver to the Court unified with the points of contention identified. And then what we would do is based on the number, we would either schedule a charging conference, if necessary, or if there are only a few items that remain, we would fill in gaps when we're waiting on jurors or when we don't have a witness and use that time. But the Court is looking at the combined iteration of exactly what remains outstanding in contention between the parties by the 28th which is Tuesday I believe.

MR. GJELAJ: One more thing, Your Honor, in regards to the first item, the juror that can't be here on Friday. Not only would it affect those two witnesses, and I have no idea when they'll be able to testify again, it's going to affect my Monday testimony because Monday I have the economist coming in who I really can't have before my

lifecare planner. I mean, I could subject to connection but it's not ideal. So if counsel can think about that. I think --

MR. WHALEN: I will. Subject to connection wouldn't be an issue for me. But I have other people that I have to answer to.

THE COURT: Okay. So at this time, the two jurors have still not arrived. I had hoped by the time we had wrapped up with our administrative affairs that they would have shown up. But that is not the case. So I will allow the parties to talk about the issue as to juror number three. Again, I'm not coming back on the bench and expecting an answer. But I would say, hopefully, by this afternoon after lunch we should have a plan as to what we're going to do going forward.

MR. GJELAJ: Thank you, Judge.

THE COURT: Okay. Thank you very much.

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

COURT OFFICER: All rise.

THE COURT: You may be seated.

COURT OFFICER: All rise, jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: You may be seated. Good morning.

THE JURY: Good morning.

THE COURT: I just want to again thank the jurors for being here today. And to again stress that your participation is essential to us being able to continue. And I want you to know it is a weighty responsibility but it's a responsibility that was given to each of you because you have represented in voir dire that you would be an impartial juror in this action, and the parties have that faith in you that you would be able to perform this function. And I just want you to know that it is appreciated when you show up every day in order to do so. The courts and the parties are really relying on you in order to resolve this dispute.

So I just want you to know that while we recognize it is an inconvenience, it is something that is an interruption in your everyday activities. We do not -- I don't want you to think that it is something that we take for granted in that. It is something we are aware of and so when we make every decision, we make that considering you and considering the interruption in your life and the service that you're providing to us in coming every day.

So, again, I just want to thank you for being here today. And again, really stress for you the contribution that you're making in showing up every day and participating in this process. So thank you.

Counsel Gjelaj?

MR. GJELAJ: Plaintiff calls Dr. Merola to the stand. Dr. Andrew Merola.

(Whereupon, the witness enters the courtroom.)

COURT OFFICER: Raise your right hand.

A N D R E W M E R O L A M D, a witness called on behalf of the Plaintiff after having been first duly sworn and having stated his address as 567 First Street, Brooklyn, New York, took the witness stand and testified as follows:

COURT OFFICER: Can you please state your name and business address for the record.

THE WITNESS: Andrew Merola. M-E-R-O-L-A. 567 First Street, Brooklyn, New York.

COURT OFFICER: The witness is sworn, Judge.

THE COURT: Thank you.

You may be seated.

Counsel, you may inquire.

MR. GJELAJ: Thank you.

DIRECT-EXAMINATION

BY MR. GJELAJ:

Q. Good morning. How are you?

A. Good morning.

Q. We're referring to you as Dr. Merola.

Are you a physician duly licensed to practice medicine in the State of New York?

A. Yes, I am.

Q. For how long have you been so licensed?

A. Since 1992.

Q. Can you please briefly tell the jury your educational background, any awards, honors, basically bring them up to date as to who you are today?

A. I graduated from Howard University, College of Medicine in 1990. After I graduated from medical school, I went to State University of New York in Brooklyn where I did an internship in general surgery. I then did an orthopedic residency for four years. I then did an additional year of training in spinal surgery at the University of Colorado in Denver. And then I returned to New York City to practice orthopedic surgery.

Q. What is orthopedic surgery?

A. It's that branch of surgery that deals with your bones and your joints.

Q. Do you have a subspecialty within orthopedic surgery?

A. Yes.

Q. What is that subspecialty, please?

A. My subspecialty is neck and back.

Q. Okay. Are you board certified?

A. Yes, I am.

Q. Please explain to the jury what it means to be board certified?

A. Board certification is a two-step process. After you complete your residency training, you take a written examination in your field. And then after you've been in practice for two years, you do a subsequent oral examination and then when you have passed both of those exams you're board certified.

Q. Is that certification up to date currently?

A. Yes.

Q. Do you teach?

A. Yes.

Q. Tell us about that.

A. So I have an opportunity to teach medical students and residents, orthopedic residents, fellows, and medical students in orthopedic surgery.

Q. Do you have any hospital privileges?

A. Yes, I'm at SUNY Downstate Medical system and also at New York Presbyterian.

Q. Okay. Do you have a practice?

A. Yes.

Q. What's the name of your practice?

A. It's my name.

Q. Andrew Merola?

A. Yes.

Q. And do you operate?

A. Yes.

Q. What body parts do you operate on?

A. Neck and back.
Q. About how many surgeries do you do a year?
A. It can vary but anywhere between 150 to 200 or so.
Q. Okay. Doctor, I'm going to be asking you some questions about Mr. Sarmiento. If I stop you at some point, I'm not being rude, but you're the first medical witness here and I may want you to explain a term to the jury. Okay?
A. Yes.
Q. Now, are you here today pursuant to subpoena?
A. Yes.
Q. You were given a subpoena fee?
A. I don't know.
Q. Are you being compensated at all by my office or anybody else for your time here today?
A. No.
Q. Have you and I spoke before this morning?
A. No.
Q. You spoke to my office about scheduling though; right?
A. Yes.
Q. Okay. Now, did there come a time when Mr. Charles Sarmiento came to your office for the first time?
A. Yes.
Q. Do you have your records in front of you?
A. Yes.
Q. I'm going to give you your records that have been

entered into evidence as Exhibit 3.

(Handed to the witness.)

Q. You use that to refresh your memory at any point. It's in evidence, so you can read from it, Doctor.

Tell us about the first time that you saw Mr. Charles Sarmiento?

A. My first visit was on November 20, 2020.

Q. Okay. And did you take a history from him?

A. Actually, you know what? This is University of Orthopedics.

Q. Oh, did I give you the wrong one?

A. Yes, you did.

Q. I'm sorry. That's the afternoon witness, sorry.

A. And I don't even have my glasses on.

Q. Sorry about that, Doctor.

MR. GJELAJ: What exhibit is that, Officer?

COURT OFFICER: Exhibit 5.

Q. Okay. The officer just handed you up Plaintiff's Exhibit 5 which is your chart.

When was the first date that you saw Mr. Sarmiento?

A. The first time I saw Mr. Sarmiento was March 15, 2021.

Q. Did he give you a history?

A. Yes.

Q. What history did he give you?

A. He had sustained a fall in August of 2020.

Q. And I want you to assume for purposes of your testimony that Mr. Sarmiento testified yesterday that prior to seeing you he underwent physical therapy, chiropractic, and injections. What, if anything, is the significance medically of that testimony?

A. Those are forms of what we would consider conservative or non-surgical care.

Q. And, Doctor, in medicine, especially in your role as a spinal surgeon, does medicine go from most conservative to most invasive?

A. In general that's true; yes.

Q. Can you explain that to the jury?

A. Under normal circumstances where patients have an issue that can hopefully be treated with a non-invasive treatment, that is to say conservative care or non-invasive care, you start that first essentially to give the body an opportunity to recover. Should that fail to relieve symptoms, you get progressively more invasive depending upon the nature of the patient's particular problem.

Q. Okay. Did you perform a physical examination?

A. Yes.

Q. On March 15, 2021 to be specific?

A. Yes.

Q. Can you please tell us about the examination you performed and the findings, if any?

A. Sure. So it was a musculoskeletal and spinal examination to look at the patient overall. And he demonstrated what we call an antalgic and a kyphotic gait pattern which basically means that he had had a limp with a pitched forward low-back posture.

The examination of his neck revealed that he had a test called a Spurlings maneuver which was positive and that reproduced spasm in the neck with radiating pain into the arms and hands. He had some weakness in his right wrist, ability to extend or lift the wrist upwards towards the sky. And he also had some sensory loss in addition to something known as a Hoffmann's sign which is a sign of nerve and spinal cord irritation.

Q. Okay. Are you familiar in a medical sense of the terms objective versus subjective?

A. Yes.

Q. Can you please explain to the jury what that is?

A. Subjective is essentially what a patient tells you. So it is, for example, a complaint or a symptom. Something that is objective is something that is in some way measurable and not under the patient's control.

Q. So if something is objective, can a patient fake that?

A. Typically not, no.

Q. The test that you just told us about that you did involving the neck, were those objective or subjective tests?

A. Objective.
Q. So the spasm, for example, was that objective?
A. Yes.
Q. These tests were of the type that the patient couldn't fake?
A. Yes.
Q. What other tests did you perform?
A. A low-back examination where his extension was restricted to 10 degrees, that's the ability to bend backwards in your low back area. And beyond that what was known as a Positive Spinal Phalen's test was appreciated which is where spasm is reproduced and then pain travels down into the legs. He had a straight-leg raise which is a method for examining the sciatic nerve that goes down your leg to see whether or not there's irritation and that test was also positive.
Q. In regards to the test that you performed on his lumbar spine, were those tests objective, subjective, some combination thereof?
A. Well, everything is, in essence, a combination of subjective and objective but in terms of the response given and during the physical exam, objective.
Q. Okay. I'm trying to move quickly. I don't want to move too quick. We're using some terms that I'd like to define for the jury.
A. Yes.

Q. Cervical is your neck?
A. Correct.
Q. Lumbar is your back?
A. Yes.
Q. When he came to you that first visit, was he wearing any assistive devices?
A. Yes, he did have bilateral knee braces on his knee.
Q. So he had knee braces on both knees?
A. Correct.
Q. Okay. After your exam, what did you do?
A. I reviewed MRI films of both his neck and his back. And then based on the MRIs, and his symptoms, and his physical findings, made some recommendations for treatment.
Q. Before we get to the treatment, you stated that in your notes that the patient manifested severe radiculopathy.

Can you please define for the jury what that means?

A. Radiculopathy is a term that means irritation in a nerve. And when you're talking about nerve irritation with respect to the neck and back, it's irritation in the nerves that are coming from either your neck or your back.
Q. You also mentioned myelopathy, can you define that for us?
A. It typically refers to a condition where there is a weakness and signs of spinal cord irritation such as a Hoffmann's sign or motor loss that is muscle weakness.

Q. Okay. You said that you reviewed the MRIs personally?
A. Yes.
MR. GJELAJ: All right. Can we put it up, please?
How do we do this, Judge? This is the first time we're using it.
THE COURT: It should just be the same as on her computer. You should be able to use the same functions.
MR. GJELAJ: I mean, with the witness? Do you want the witness to go there? I have a laser.
THE COURT: Oh, that's up to you.
Q. Doctor, I have a laser pointer here if you want.
A. Sure.
Q. Okay. What is that that we put up --
MR. GJELAJ: What exhibit is that?
MR. SMALLETS: I don't know what you have up there.
Q. Doctor, what is that? While I look at the exhibit number for the record.
A. This is an MRI image, side view image of a cervical spine.
Q. And what, if anything, were your findings when you reviewed it?
A. So if you look at this image and you're basically -- the laser pointer disappears inside this thing so I can't really

point to it with the laser pointer very well.

Q. I'll point. You tell me where.

A. Sure. So if you look at the squares, those are the vertebral bodies. If you start at the top with the pointy one, that's the second one. Next down is three, four, five and six. If you go between the C5 and the C6 vertebral bodies, there's -- what's in between those areas is disc material in the spinal canal area, one right above your finger. That's it; correct. Yes.

THE COURT: Counsel. The doctor can approach. The only issue would be the court reporter would need some kind of amplification. So is that screen active?

MR. GJELAJ: It is, Your Honor.

THE COURT: So if you flip that screen, he can use that microphone and then the court reporter will be able to pick it up while he is actually much closer to the screen.

So, Dr. Merola, you can approach it if you feel that's necessary. I just ask that you keep that microphone close enough so that your audio can be picked up.

MR. GJELAJ: My microphone?

THE COURT: Yes.

MR. GJELAJ: Okay.

A. Is it possible to scroll one more shot?

MR. GJELAJ: Scroll one more, please.

THE COURT: I'm sorry, Counsel Gjelaj, Counsel Whalen is also trying to see so he's going to be coming around.

MR. GJELAJ: That's fine.

A. So let's -- if we just look in between the bones starting at the top this is number two, three, four. This is five, and six. Five and six are the two squares. Beyond five and six there's an area where there's disc material coming into the area where the nerves and the spinal cord are that travel down into the wrist and hand area. And if you've also noticed in this area the neck should have a typical C shaped curvature to it where it tilts backwards. And this has flattened itself out. And to a certain extent it's also tipping forward a little bit here at C5-C6.

Q. That's what's typically called a herniated disc, Doctor?

A. Herniation refers to disc material that's -- yes, beyond the confines of the vertebral bodies.

Q. Have you ever heard the disc analogized as a jelly doughnut?

A. It can be considered like a jelly doughnut if you want to picture it; yes.

Q. So the jelly doughnut popped and the fluid came out there?

A. The inner jelly-like material and the outer crust area

are protruding; correct.

Q. Is that a condition associated with pain?

A. Yes, it can be.

Q. Okay.

MR. GJELAJ: Put up the lumbar, please, while you're up there.

Q. What is that, Doctor?

A. This is a side view of the lower back. Once again, the squares are the vertebral bodies and everything that's in between the vertebral bodies are the discs. And all the way at the bottom where the lower back meets what we call the sacrum or the pelvis, there's an area where there's disc material protruding or herniated so that would be between L5 and S1.

Q. Doctor, have you ever heard of something called the straight-edge method?

A. So if you're looking at the edges of the vertebral bodies, you would want to see disc material lined up behind all of the vertebral bodies.

Q. So is it fair to say, Doctor -- you tell me if I'm doing it right -- there's nothing supposed to be on the right of this paper that I'm holding?

A. Yes; correct.

Q. And is there something there?

A. Yes.

Q. What is that?

A. Disc material.
Q. Is that a herniation?
A. Yes.
Q. Okay. Thank you.
You can go back and sit down.
THE COURT: Oh, I'm sorry. The court officer made it clear that some of the jurors couldn't see what you had just demonstrated.
Q. Sorry, I don't mean to -- Doctor, I'm trying to speed things up.
So, Doctor, for the benefit of the jury, I asked you before if you're familiar --
THE COURT: Oh, it unplugged.
Q. Okay. Dr. Merola, for the benefit of the jury, I asked you before if you were familiar with the straight edge test and you said yes. Then you told the jury what you saw. I then -- how about you do it then, and explain to the jury.
A. So if you take anything that has a straight edge on it, a piece of paper or a ruler or what have you, and you place it up along the boarders of the vertebral body, and if you see anything that goes beyond the boarders of the vertebral bodies, that would be outside the normal area where discs should be and that would be a protrusion of the disc material or herniation.
Q. Is the word "protrusion" and "herniation" interchangeable?

A. Yeah. Protrusion means sticking out herniation means asymmetrically sticking out.

Q. Thank you.

After examining Mr. Sarmiento, taking a history, performing the tests, did you formulate a diagnosis?

A. Yes.

Q. What was that diagnosis?

A. Radiculopathy cervical and lumbar with some myelopathy.

Q. And did you request for approval or a certain type of procedure?

A. Yes.

Q. What type of procedure?

A. What's called a cervical discectomy and spinal fusion, which is basically removing the disc, taking pressure off the nerves, and then fixing the bones so that they don't continue to cause any more nerve compression.

Q. How do you fix the bones?

A. You put a device in between the bones to hold them apart, and then you hold the bones together to clamp them together by putting a small clip with several screws.

Q. So this is hardware in the neck?

A. Yeah, implants, yes.

Q. And is that something that Mr. Sarmiento will require for the rest of his life?

A. Yes.
Q. Did you eventually get approval for that surgery?
A. Yes.
Q. Why did you focus on the neck prior to the back?
A. The neck showed an area of weakness in his arms and hands. So he had symptoms in addition to weakness. So those are neurological deficits and nerves can have a lot of problems getting better if they have deficits to them.
Q. Okay. You saw him again on April 26th?
A. Yes.
Q. Okay. Was the exam similar to the first or anything different?
A. It was essentially the same in April as it had been in March.
Q. And you were still waiting for approval for the cervical fusion?
A. Yes.
Q. Did you eventually get approval for it?
A. Yes.
Q. Did you perform the surgery?
A. Yes.
Q. Tell us about the surgery you performed?
A. Surgery was done on May 11, 2021. And it involved a removal of the disc between C5 and C6 to take pressure off of the spinal cord and the nerve roots with a process called fusion

in order to lock the C5 nerve root -- C5 bone and C6 bone together to prevent any collapse or damage in that area.

Q. Is this a serious surgery?

A. Any type of surgery is quote-unquote "serious" depending upon what your definition of serious is, but it's certainly a surgical procedure.

Q. Is it an open surgery?

A. It is -- it does involve making an incision, yes.

Q. Opening up the neck?

A. Correct.

Q. Visualize it?

A. Yes.

Q. Performing whatever you did as a doctor. I don't know the technical terms.

A. Yes.

Q. Where is this done at?

A. This was done at New York Methodist Hospital.

Q. When did you see him for the first time post surgery?

A. The first postoperative visit was on May 24, 2021, about a week or so after surgery.

Q. Tell us about that.

A. That's a first postoperative visit to make sure that there were no issues regarding the surgery itself and the examination on this day showed that he was healing appropriately after surgery.

Q. Okay. After a cervical fusion, is a patient required to wear a cervical collar for a period of time?

A. I typically don't use a collar. It's only used for what we call PRN basis for comfort.

Q. Let's go to the next visit, Doctor. June 15, 2021?

A. Yes.

Q. Okay. What did you do on that date?

A. So that's a placement of what's called an electronic -- an external. That means on the outside -- electronic bone growth stimulator. That's a device that it's really a battery that sets up like a magnetic current or field around the area of your neck that stimulates the healing process. So it helps to make sure that the healing process proceeds normally.

Q. Okay. And your next visit with him was?

A. So let's see. June 15th and then I saw him on August 2nd of 2021.

Q. Okay. So tell us about that August 2nd visit, please.

A. So that was really the third postoperative visit. And at that time, surgery was helpful in decreasing what we call radiating pain. As his neck got better, I had indicated that his lower back felt worse.

Q. All right. You have used the term "radiating" a few times. I want to make sure that the jury understands.

Is radiating pain pain that goes down an extremity?

A. Yeah. Another term would be traveling. So pain that travels down either your arms and hands or legs and feet.

Q. So if you have a problem with your cervical spine, would the pain radiate or travel down your arms?

A. Yes.

Q. And if you had a problem with your lumbar area, your lower back, would the pain radiate down your legs?

A. Yes.

Q. Did both of those things -- was he complaining about both of those pain going down his leg and down his arms?

A. On his initial visit, yes.

Q. Okay. Continue with this visit, please.

A. So here his lower back was most prominent. And so the examination on this visit showed that he was healing appropriately with respect to his neck and the surgery that had been done in his lower back, his extension went from 10 degrees to 5 degrees with a continued positive spinal Phalen's test.

Q. Is that an objective test?

A. Yes.

Q. And continue, please.

A. And he also continued to have a straight leg raise, which was positive, on his right side. So there was evidence of nerve root irritation in the lower back between L5 and S1.

Q. And on that visit, did you review the lumbar MRI?

A. Yes.

So I reviewed the MRI of the lumbar spine, which showed herniation at L5-S1 and then I further recommended a CT scan of the lumbar spine to get a closer look at the bones.

Q. What is the difference between an MRI and a CT scan?

A. An MRI is a very good way of looking at the softer tissues, for example, nerves and discs and things like that. A CT scan can give you more definition and detail with respect to bone and bony structures.

Q. Okay. Do you know if he had a CAT scan?

A. Yes.

Q. Did you review the CAT scan yourself?

A. Yes.

Q. Before I ask you that, are you qualified to read MRIs and CAT scans?

A. Yes.

Q. How so?

A. It's part of orthopedic training. Because when we see and treat patients, we have to not only see and treat and evaluate the patient, but then we look at diagnostics in order to compare the diagnostics and the patient.

Q. How many MRIs, CAT scans and x-rays do you review on an average week?

A. Typically, for every patient. So if I see 30 patients a week or so, then I look at least 30 MRIs or so, if not more.

Q. Tell us about your review of the CAT scan and the findings, if any.

A. So the CAT scan was basically done to make sure that there wasn't a condition called a lysis, which is basically a defect in the way the bones come together. So it did not show any evidence of lysis or any pathological bony condition which would influence the way you treated the patient. It did show a persistent disc protrusion at L5-S1.

Q. Did you formulate an impression plan after that?

A. Yes.

Q. What was that?

A. One of the things that I thought would have been helpful, just to get a better idea of what the nerves themselves were doing, was to get what's called a nerve test.

Q. Was a nerve test done?

A. Yes.

Q. What were the results?

A. The nerve test did show electrical instability in the muscles of the lower legs that correlated to the disc at L5-S1.

Q. What, if anything, is that indicative of?

A. So a nerve test tests the way the nerves are functioning in the muscles. And so it tells you whether or not there's an abnormality in that nerve as it relates to the muscles of the legs, and it correlated with the patient's symptoms and the disc herniation. So it was further indication

that at this point in time surgical intervention would be offered.

Q. What kind of surgery?

A. Basically, what we call a decompression surgery which is, once again, removing any portions of disc material that are pressing up against the nerve in order to relieve pressure on the nerve to decrease nerve symptoms.

Q. This is an open surgery?

A. Yes.

Q. Is it similar to the fusion?

A. Well, it's different because it does not involve locking any of the bones together. It's a simple procedure to only remove pressure from the nerves to give the nerves an opportunity to heal.

Q. Why did you feel that he needed a laminectomy to his back as opposed to fusion for his cervical spine, which you told us you performed?

A. So they're really two different animals, the neck and the back. In the neck, the discs are extremely important in terms of maintaining the distance between the bones and maintaining normal anatomy. So if you remove a disc in the neck and you don't do a fusion, the bones will collapse and then cause more damage. In the lower back, by only removing portions of the discs that are touching the nerves, the bones themselves can still maintain stability so you don't have to do a fusion.

So the standard surgical philosophy is to do the least amount of surgery for the most potential benefit in order to decrease any potential complications.

Q. Did he agree to undergo the lumbar surgery for the back surgery?

A. Yes.

Q. Did you perform it?

A. Yes.

Q. Tell the jury about it, please.

A. So that was done on June 14th of 2022. And it involved essentially making an opening in the area on the backside of the lower back in the area where the nerve or that portion of the sciatic nerve is that was getting punched up by the disc to basically remove any disc material that was touching that nerve.

Q. Where was that surgery done?

A. That was done at Lower Manhattan Hospital.

Q. Okay. When did you see him for the first time after the surgery?

A. So the first postoperative visit after that operation was on June 27, 2022.

Q. Okay. At that visit, did you write down in your notes your opinion as to whether or not he was disabled?

A. Yes.

Q. And what did you write?

A. That he was disabled from his occupation.

Q. Did you write that he was 100 percent totally disabled?

A. Yes.

Q. You wrote in these notes to within a reasonable degree of medical certainty this patient's spinal injuries are causally related to the accident of record.

What does that mean, Doctor?

A. Yeah, that was -- that's a requirement for those particular follow ups in order to basically indicate that we're treating the patient under a particular peer-reviewed process.

Q. Do you have an opinion, based on your notes, do you have an opinion within a reasonable degree of medical certainty what the competent producing cause of the condition in his neck and his back were?

A. Based on the information available to me and on the information that I had, the neck and back injuries were secondary to the fall.

Q. Okay. At that first postop visit after the back surgery, did you come up with an impression and plan?

A. So after the first postoperative visit subsequent to the lumbar surgery, he was healing appropriately from his low back surgery.

Q. Okay. Did you give him any restrictions post surgery?

A. Avoid repetitive motion and to avoid bending, lifting,

and twisting.

Q. When was the next time you saw him?

A. January 23, 2023.

Q. Okay. Did you perform an exam on him?

A. I did.

Q. Tell us about the exam.

A. So on that visit -- let's see. He still had an antalgic and a kyphotic gait pattern. He had some difficulty with heal-to-toe raising. In his neck, the Sperling's maneuver was negative. The compression distraction maneuver was negative. He did have some residual spasm and he had no progressive neurological deficits.

Q. Oh, I'm sorry.

A. Go ahead. I'm sorry.

Q. That's okay. I thought you were done.

A. I was going to move on to the lower back where extension this time had gone up to 30 degrees, and he was able to flex to 40. Right and left bend to 40, and right and left rotate to 35 and 40 degrees. And his straight leg raise on this examination was negative. He did have some Achilles tendon reflex loss and some residual L5-S1 sensory loss.

Q. Going back to your physical examination, Doctor.

For the cervical spine, your note says that cervical spine upper extremity arms and hands demonstrate chronic permanent residual sixth nerve root deficits with residual

Hoffmann signs.

Can you explain that note to us?

A. Sure.

Basically, it means that he had some wrist extensor weakness and some sensory loss with what's known as a Hoffmann sign. Preoperatively and postoperatively, it remained essentially stable.

Q. Is that permanent based on your notes?

A. Based on the note as of that day, yes.

Q. Okay. Just quickly, because you gave us the range of motions before that you noted.

Can you give the range of motions again as opposed to a normal range of motion each?

A. Sure. So a normal extension is 65. So he was 30.

Q. So that's less than 50 percent?

A. It's about 50 percent, correct.

Q. Okay.

A. Normal flexion is 60. He's at 40.

Q. So he lost a third of that?

A. Normal bending is 45. He's at 40.

Q. Okay.

A. Normal rotation is at 80 and he's one side 35 and one side 40.

Q. Okay. Also in your note you stated that you counseled the gentleman. The gentleman obviously is Mr. Sarmiento,

Doctor?

A. Yes.

Q. But you consulted Mr. Sarmiento regarding his current injuries and that given his young age, it's more likely than not that over the course of time future surgeries would be necessary. Did you tell him that?

A. Yes.

Q. Okay. And in your note, there it says that it's more likely than not; right?

A. Yes.

Q. Okay. And your note says surgeries. Plural; correct?

A. Yes.

Q. Thank you. Next visit?

A. June 5, 2023.

Q. Quickly tell us about the exam and your findings, please.

A. So on that examination, he maintained a negative Spurling's test and a negative compression distraction test. Neurologically, he was stable with respect to his neck.

His lower back did show some spasm with extension on this visit at 15 degrees. Flexion of 30, right bending of 30, left bending to 40, right rotation to 35, and left rotation to 40. Straight leg raise remained negative. Some Achilles tendon reflex loss and some sensory loss in L5 and S1.

Q. Did he remain disabled?

A. Yes.
Q. What percentage?
A. I indicated a hundred percent from his occupation.
Q. And you wrote in your note that prognosis is guarded. What does that mean?
A. That he continued to require treatment.
THE COURT: Counsel Gjelaj, if we could find a breaking point?
MR. GJELAJ: I could do it right now.
THE COURT: Okay. Let's just take a ten-minute break.
COURT OFFICER: All rise; jury exiting.
(Whereupon, the jury exits the courtroom.)
THE COURT: You may be seated.
(Whereupon, there was a recess taken.)
COURT OFFICER: All rise.
THE COURT: You may be seated.
COURT OFFICER: All rise; jury entering.
(Whereupon, the jury enters the courtroom.)
THE COURT: You may be seated.
So just as we are going into the second half of the morning, the Court will break at 12:45 for lunch.
MR. GJELAJ: I am almost done.
Q. Doctor, before we broke, what date were we up to in your records?

A. I believe we were on June 5, 2023.

Q. Before we get to that, I'm going to show you what's been put into evidence.

Please put it up, Ms. Ortiz. Am I'm blocking anyone?

What is this, Doctor?

A. That's an x-ray side view cervical spine.

Q. Was this x-ray taken after the fusion was done?

A. That's correct. That's a postoperative x-ray.

Q. Is there any bone here in that section?

A. Yeah. That's the area where the fusion is. So that's between C5 and C6. And that's the --

Q. Sorry?

A. That's basically the clip that's holding the two bones together at C5 and C6.

Q. Is this a screw?

A. Yes.

Q. Is that a screw?

A. Yes.

Q. All right. June 5th, tell us the exam that you performed and the findings, if any, that you came up with?

A. So on that examination, his neck was essentially stable. Negative Spurling's maneuver. Negative compression distraction maneuver. In the lower back, he had straight leg raising, which remained negative. His extension had decreased to 15 degrees, though.

Q. Okay. And did you come up with an impression and plan?

A. Yes.

Q. What was that?

A. At that time, because of some increase in low back stiffness and loss of motion at that 15 degree mark. I had suggested an updated MRI.

Q. Was he still disabled?

A. Yes.

Q. What percentage?

A. I had indicated a hundred percent from his occupation.

Q. Was his prognosis still guarded?

A. Yes.

Q. Next please. August 7th.

A. Yes.

Q. Okay. Tell us about the exam that you performed and the findings, if any?

A. Same type of examination. Once again, the neck was stable. Negative Spurling's test. Low back extension had improved to 30 degrees. Straight leg raising had remained negative. Some residual L5-S1 sensory loss and some residual Achilles tendon reflex loss.

Q. You had said at the last visit or you wrote at the last visit that you suggested updated MRIs.

Did he, in fact, have those done?

A. Yes.

Q. And did you review the films?

A. Yes.

Q. And in order to just speed things along, did you personally review them?

A. Yes.

Q. To speed things along, can you tell the jury what your findings were?

A. Sure.

So that MRI that was done postoperatively showed that there was some collapse in the area of the disc space between L5 and S1. So a little like, you know, if you could picture like a bed of a flat tire, how a tire would kind of flatten out a little bit. So that's what the L5-S1 segment looked like.

Q. Okay. And he still remained a hundred percent disabled?

A. Yes.

Q. And the prognosis was still guarded?

A. Yes.

Q. Can you read the portion of your notes right below "prognosis is guarded" beginning with "patient understands"?

A. "Patient understands, given his young age, more likely than not over the course of time future surgeries to both the neck and back regions would be indicated and warranted and we will continue to follow him from a surgical perspective

accordingly."

Q. Doctor, have you ever seen any medical record involving any back or neck pain or complaints or treatments from prior to this accident involving Mr. Sarmiento?

A. I have not, no.

Q. Did you ask him if he ever had any prior accidents?

A. On the initial visit in his surgery, the only surgeries and surgical or medical history that he had given was right knee surgery but nothing else.

Q. Okay. Next note November 6, 2023.

A. Yes.

Q. Okay. Did you do the same tests that you told us about?

A. Yes.

Q. Did you have relatively the same findings that you had on prior exams?

A. Yes.

Q. Did you come up with a plan or a prognosis at that time?

A. Yes.

Q. What was that?

A. Guarded.

Q. Okay. Now, in your findings in page two of your note for November 6th, the last sentence, first paragraph, can you read that to us?

A. Last sentence, first paragraph?
Q. You may.
A. Oh, yes, yes, yes, I see it.
He has chronic permanent residual, neurological deficits as a consequence of an injury sustained and he has evidence of mechanical and axial low back dysfunction.
Q. What does that mean?
A. Low back pain.
Q. What does the chronic part mean?
A. Longstanding.
Q. And permanent?
A. Yes.
Q. Means he's going to have that forever?
A. At least as of this note, correct.
Q. Okay. Now, you are aware at some point, and we'll get to your last note, that he transferred his care to Dr. Macagno?
A. Yes.
Q. Dr. Macagno will be testifying Friday here.
Do you know Dr. Macagno?
A. Yes.
Q. Is he a good doctor?
A. Yes.
Q. Let's go to your last office note, okay?
A. Yes.
Q. March 25, 2024.

A. Yes.

Q. Tell us the tests you performed and the findings, if any, on that date?

A. So on that day, his cervical spine showed a negative compression distraction maneuver and a negative Spurling's maneuver. He had cervical extension of 35 and normal to 60. Flexion of 40. Normal to 60. Right lateral bending 40. Normal 45. Left lateral bending 40. Normal 45. Right lateral rotation 45. Normal 80. Left lateral rotation 40. Normal 80. He had some left-sided and right-sided upper extremity wrist extensor weakness, but non-progressive. Some 1.25 centimeter atrophy on his left side.

Q. What is atrophy, Doctor? That's the first time you're using the word.

A. Shrinkage of the muscle.

Q. What is that due to?

A. It can be due to several things. And in this case, typically, just neurological issue.

Q. Okay. Continue, please.

A. And a residual Hoffmann's sign.

Q. The test that you mentioned before, were those objective or subjective?

A. Objective.

Q. Could he fake those?

A. No.

Q. You mentioned the word "spasm." And I apologize I didn't have it defined earlier.

Can you please explain to the jury what spasm is?

A. Spasm in a muscle is an abnormal contraction of the muscle. So it's like a Charlie horse.

Q. Did you come to an opinion as to his functional capabilities?

A. Yes.

Q. On that date, obviously?

A. Yes.

Q. What was that opinion?

A. Well, he was able to lift and carry up to an occasional 10 pounds. Push and pull up to an occasional 10 pounds. Sitting and standing and walking, could all be on an occasional basis. Sustained climbing or kneeling, bending, stooping or squatting on another basis. Using arms and hands to grasp, manipulate all on an occasional basis. Reaching overhead or below shoulder level on an occasional basis. Driving on an occasional basis. Operating machine to be avoided as well as temperature extremes and environmental hazards, which should be avoided.

Q. Higher up on your office note there's a question there that says "Has the patient reached maximum medical improvement?"

What is maximum medical improvement?

A. So typically about a year or so subsequent to surgery,

you can come to a conclusion about what the maximum benefit of that surgical procedure was.

Q. Okay. And you answered this question yes?

A. Yes.

Q. What did you mean by that?

A. That he was, in my opinion at that time, had achieved his maximum benefit.

Q. So the range of motion restriction that you told us about in the neck and in the back, given the passage of four years plus from the time of the accident, would it be fair to say that those restrictions were permanent?

A. As of that date, yes.

Q. Okay. So they can't get better; right?

A. Well, we're making an assessment based on that period of time at that particular date, yes.

Q. Okay. Doctor, thank you.

A. Thank you.

THE COURT: Counsel, I just ask since we're breaking at 12:45, do you want the court to notify you or will you monitor your own time?

MR. WHALEN: I appreciate it if you monitored me, Judge.

THE COURT: Okay.

CROSS-EXAMINATION

BY MR. WHALEN:

Q. Good morning, Dr. Merola.
A. Good morning.
Q. We have met before today?
A. Yes.
Q. Correct?
A. Yes.
Q. And I think our last time we were doing this was in Kings I believe?
A. Yes.
Q. You testify frequently, Doctor?
A. About six times or so per year.
Q. You also told the jury earlier you do somewhere between 150 to 200 surgery a year -- is that correct? -- or thereabouts?
A. Yes.
Q. You didn't have Mr. Sarmiento as a patient before this accident; correct?
A. Correct.
Q. And the first time you saw him obviously was after the accident; correct?
A. Yes.
Q. And in seeing Mr. Sarmiento, you had some history as to how the accident happened; is that fair to say?
A. Yes.
Q. And for that, you were relying on Mr. Sarmiento;

correct?

A. Yes.

Q. You had no other source of information but Mr. Sarmiento; correct?

A. Yes.

Q. And Mr. Sarmiento, in sum and substance, told you that he was at a construction site and fell from a ladder; correct?

A. Yes.

Q. Okay. And you took him at his word; correct?

A. Yes.

Q. Okay. And you had no idea if he fell one foot or 10 feet. Is that fair to say?

A. Yes.

Q. Okay. And you had no idea about whether or not he slid down the ladder or fell backwards off the ladder from a distance; correct?

A. Yes.

Q. Okay. And that's true with all your patients. You have to rely on their truthfulness; correct?

A. Yes.

Q. In treating Mr. Sarmiento, you reviewed these MRIs; correct?

A. Yes.

Q. Okay. And I'd like to bring back up the lumbar spine and cervical spine MRIs and talk to you a little bit about them

with you. Okay?

A. Yes.

Q. So this is the cervical spine as we know; correct?

A. Yes.

Q. And this is a sagittal view; correct?

A. Yes.

Q. And for the purpose of jury, that's from the side; correct?

A. Yes.

Q. Okay. And it shows the various discs and what is disc desiccation, Dr. Merola?

A. So disc desiccation refers to the disc, which is the cartilage in between the bones, and desiccation is a term that refers to a loss of water content. An MRI looks at the water content of your tissues of what you're made out of. And so radiologists use the term "desiccation" to indicate a loss of signal or loss of color on the MRI to indicate some drying of that area.

Q. And drying would be indicated by darkness?

A. Correct. So things that are full of water are brighter or lighter, more white. Things that are absent water are darker or more gray.

Q. And that would be a sign of what?

A. That's a sign of loss of water in those tissues. Some tissues normally should have no water in them. For example, the

trachea is that large black void. So there shouldn't be any water in there. Otherwise, you're drowning. So that's normal for the trachea.

The tissues that your body is made out of contain water and so a loss of water typically happens over time and that's a process called "degeneration."

Q. And Mr. Sarmiento is a young man here, but there's significant degeneration there already. Is that fair to say?

A. So I believe he's -- this is 2020. I think he was born in 1990, if I'm not mistaken. So he's about 30 years old here.

Q. And there's significant disc desiccation. Is that fair to say?

A. There is disc desiccation, yes.

Q. Another word for disc desiccation, besides part of that aging process, is arthritis part of that process?

A. Arthritis, typically, refers to the inflammation that can occur in joints.

Q. You did that flat edge test here. This is this, and if I'm pointing to it wrong, please correct me, Doctor, this is the spinal cord right here; is that correct?

A. Correct.

Q. That gray area on the film?

A. Yes.

Q. I'll move over a little.

And these are disc -- these are the vertebrae, the bones; correct?

A. Yes.

Q. Okay. And this is the disc we were talking about; correct?

A. Yes.

Q. And these discs down here seem a lot lighter than the discs up here and that's because the aging process has been affecting them. Is that fair to say?

A. Yes.

Q. Okay. Would it also be fair to say that right here throughout the cervical spine there doesn't appear to be any compression on the nerve root. Is that fair to say?

A. Well, this is the -- so this sagittal view is looking at the mid portion of the cervical spine in the area of the cord. So we're actually missing the roots on this particular cut.

Q. Okay. With a reasonable degree of medical certainty the condition of this spine is aging above and advanced for his various age. Would that be fair to say?

MR. GJELAJ: Objection, Your Honor.

MR. WHALEN: What part of the spine is he referring to?

MR. GJELAJ: Cervical spine.

THE COURT: I'm sorry. Okay. There's an

objection as to form. The court is sustaining that objection as to form.

Counsel, please rephrase.

Q. Regarding the cervical spine and the various discs in the cervical spine, is the desiccation an indication of the aging process?

A. Dessication is an indication of the aging process.

Q. And what are the affects of this disc desiccation on his nerves?

A. It depends. So desiccation can have varying affect on the nerves.

Q. Let me get to the surgery you did here and -- C2; is that correct?

A. Go up to the one that's really pointy. That's C2.

Q. C3?

A. Correct.

Q. C4?

A. Yes.

Q. C5?

A. Yes.

Q. C6?

A. Yes.

Q. So between five and six was the fusion; correct?

A. Yes.

Q. Okay. And this disc material here was taken out;

correct?

A. Yes.

Q. Okay. And this disc material between five and six is blackish and showing desiccation; right?

A. Yes.

Q. Part of the aging process on this young man?

A. Yes.

Q. More advanced than an individual you see at this age?

A. Thirty-year olds is when you start to see it. So he's right around that age.

Q. Do you see on this film any indication of traumatic injury?

A. So there were no fractures or dislocations or bleeding appreciated on that MRI.

Q. So that would mean no?

A. Correct.

Q. Okay. If we can go to the lumbar spine.

By the way, we were going to that, Doctor.

Both of the surgeries that you performed was on an outpatient basis, correct?

A. Yes.

Q. Okay. That means Mr. Sarmiento came in some time during the day you performed -- he got prepared for the operation, you did the operation, and then he went home that same day; correct?

A. Yes.

Q. By the way, do you know what pain medication Mr. Sarmiento is on now, if any, for his spine?

A. I do not know.

Q. You haven't prescribed at your last visit any pain medication; is that correct, though?

A. Correct.

Q. And you didn't suggest any further treatment to either his neck or spine; correct?

A. Yes, correct.

Q. The lumbar spine?

A. Yes.

Q. Correct. Okay. I need your help again, Doctor, but I'm going to go from the bottom S1-L5?

A. Actually, you know that's -- he's got an interesting anatomical variant called the transactional junction, which means there's actually a disc down there. So if you look at that last square -- go up one -- that's the sacrum right there. That's S1. So that's -- and that's L5.

Q. Okay. This would be a defect here, Schmorl's node?

A. Yeah. Schmorl's node refers to disc beyond the area of what's called the vertebral endplate on the inside of the vertebral body and he does have a tiny small node there, correct.

Q. That's a genetic defect?

A. It's, you know, you could -- it's a developmental condition. So it's something that you're born with.

Q. Nothing to do with trauma in this instance, though; correct?

A. Correct.

Q. Okay. And that Schmorl's node has caused a -- it looks like an adjustment or a defect into the vertebral bone; is that; correct?

A. Yeah. So there's an abnormality in what's called the endplate of the vertebral body, right. So, you know, it's that bottom portion of the vertebral body is a bit invaginated. So there's a disc in that zone inside the vertebral body.

Q. And this is the spinal canal here also?

A. That's correct.

Q. And you performed your surgery at L4 and L5; is that correct?

A. L5 and S1.

Q. L5 and S1?

A. Correct. That's L5 and then below S1, yes.

Q. Was this something you had to deal with in your surgical procedure, this Schmorl's node?

A. No.

Q. In fact, the disc remains there; is that correct?

A. Yes.

Q. Okay. And what you did was -- well, tell us what you

did.

A. Sure.

So if you go to the right side of the MRI, go a little bit further, yeah, keep going, right.

So that's the area of the spinal lamina, the covering of the spinal canal. That's the area that's underneath the skin and muscles of your back. And that's the zone and the region where the nerves are exiting their normal exit holes. So you access the disc area and the nerve area from the backside in the lower back area in order to basically make room for the nerves. So you enlarge the area of nerve exit by basically shaving away some bone and then removing any disc material that's impinging on the nerve.

Q. Did you find any disc material back here in the bone when you were doing the laminectomy?

A. Not inside the bone, but if I just -- if I go to the op report -- hang on.

There's some disc material that was removed at the L5-S1 segment. And that's typically down in the area where the nerve is so it's closer to the canal. So that area is open that you're pointing to, but you access the canal by removing the roots out of the way, and then the disc material's down in that zone next to where the nerve roots are.

Q. So I'm going to try and simplify this surgery.

So this was to give the canals or the tunnels that the

nerves are going through a little more room?

A. Yes.

Q. Because would it be fair to say that either disc material or bony material had developed that was pressing and was continuing to develop and pressing on these nerves?

A. Correct. Basically, pressure on the nerves and the procedures decompression or a procedure to remove pressure, that's right.

Q. Not from trauma?

A. Well, you know that's based on the patient's history.

Q. What the patient told you; right?

A. Yes, correct.

Q. Told you about his fall off the ladder and everything like that?

A. Yes.

Q. Okay. You haven't seen him since -- when was your last appointment? I think 2024?

A. Yeah, my last visit was --

Q. I believe it was December '24?

A. Yeah, I'm almost there. March 25, 2024.

Q. And at that time, you weren't prescribing him any medication; is that correct?

A. Correct.

Q. You weren't prescribing any physical therapy, correct?

A. That's correct.

Q. You weren't prescribing any future visits; correct?
A. Yes, correct.
Q. And no future MRIs; correct?
A. Right.
Q. No x-rays; correct?
A. Yes.
Q. Or CAT scans; correct?
A. Yes.
Q. People recover from cervical fusions, don't they?
A. Yes.
Q. And people go on to have a normal life after having cervical fusion; is that correct?
A. They can, yes.
Q. Okay. And I'm not talking about everybody. Everybody's different? Is that a hesitation?
A. Certainly, we are all different, yes.
Q. Professional athletes, after having a cervical fusion, can return to their sport. Is that fair to say?
A. In certain instances, yes.
Q. With Peyton Manning won a Super Bowl after having a fusion. Are you familiar with that?
A. Yes.
Q. Tiger Woods became -- yeah, had some more difficulty but --
A. Everyone's had some more difficulties.

Q. Won a big tournament after a lumbar fusion; correct?
A. Yes.
Q. And, in your last report, Mr. Sarmiento can work; right?
A. Yes.
Q. You know what kind of work he did in construction?
A. No. I don't know the specific job title but I know he was involved in heavy construction.
Q. And that's because that's what he told you?
A. Yes.
Q. Okay. How would you define or could you define heavy construction?
A. Heavy construction is typically anything that involves lifting, carrying, pushing or pulling greater than 50 to 75 pounds with repetitive motion to the neck and back, with the requirement to be able to get into different positions in order to perform those activities.
Q. But he would work I believe you said in your last report sedentary work?
A. Yes.
Q. And he's completely capable of doing that; correct?
A. Yes.
MR. WHALEN: Thank you very much.
THE WITNESS: Thank you.
MR. GJELAJ: May I, Your Honor?

THE COURT: Yes, you may proceed.

REDIRECT-EXAMINATION

BY MR. GJELAJ:

Q. Doctor, just a few questions.

A. Yes.

Q. Have you ever seen any records whatsoever indicating that Mr. Sarmiento was injured in any other way besides falling from a ladder on the date of his accident?

A. No, I haven't.

Q. Okay. Now, you got to know Mr. Sarmiento treating him for all those years. Is that fair?

A. I had treated him for a number of years, yes.

Q. Have you ever had any reason to disbelieve him when he told you things?

A. I did not, no.

Q. You were shown the film here. We'll get to that in a second.

Have you ever heard the following phrase in a medical sense "medicine is like putting the pieces of the puzzle together"?

A. Yeah. Treatment is like putting puzzle pieces together, yes.

Q. One of the pieces is a history; right?

A. Yes.

Q. A clinical exam?

A. Yes.
Q. That's what you told us earlier about the different tests that you did that were objective; right?
A. Yes.
Q. That's part of it?
A. Correct.
Q. Films?
A. Yes.
Q. Anything else?
A. Those are the essential parts of a history and a physical and a determination for what a diagnosis is.
Q. Would you ever treat a patient or operate on a patient solely based on a film?
A. No.
Q. Okay. This film right here --
MR. GJELAJ: Withdrawn.
Q. You mentioned before the word age-appropriate changes.
A. Yes.
Q. Remember that?
A. Yes, I think we talked about --
Q. So as we get older, our bones, in this case the spine, it loses water; right?
A. Yes.
Q. That's for everybody; correct?
A. Yes.

Q. Somebody, such as myself and Mr. Whalen, we have lost probably a lot; right?

A. Yes. That's a fair guess.

Q. Okay. Does that mean that we need surgery?

A. No.

Q. Does that mean that we're in pain?

A. No.

Q. Does that mean we need MRIs?

A. No.

Q. Does that mean that we need physical therapy?

A. No.

Q. Somebody like Ms. Ortiz, for example, given her youth age, probably has no age-appropriate change; correct?

A. May not, correct.

Q. Okay. So we all go through this; is that correct?

A. Yes.

Q. Is there anything in that lumbar MRI there to indicate just based on that that he needed surgery?

A. Just based on the prognosis? No.

Q. Correct. All right.

Was it important for you to elicit the --

MR. GJELAJ: Withdrawn.

Q. Was it important to you to correlate that film by the tests that you performed on Mr. Sarmiento in your office?

A. Yes.

Q. Okay. And you told us about all those tests; correct?
A. Yes.
Q. And those are all objective tests that you could not fake; correct?
A. Yes.
Q. You noted spasm on every single visit. Is that fair?
A. Yes.
Q. Spasm is an involuntary reflex. Is that fair?
A. Yes.
Q. You can't fake that; right?
A. Yes.
Q. It's the body's reaction to pain?
A. Yes.
Q. Okay. Did the Schmorl's node -- what is it? How is it pronounced?
A. Schmorl's node.
Q. Schmorl's node. Does that have anything to do with the surgery that you performed?
A. No.
Q. Did it have anything to do with the pain that he was experiencing?
A. No.
Q. Did it have anything to do at all with the treatment that he required?
A. No.

MR. GJELAJ: Put up the cervical, please. I mean the other one.

Q. You were asked questions about the cervical spine, Doctor.

Was there anything here to indicate that solely based on the film that that man needed surgery?

A. No.

Q. You were asked about the levels of desiccation; right?

A. Yes.

MR. WHALEN: I'm only doing this so the jury can see, Judge. I'm sorry. I'm trying to speed this up.

Q. This is C1?

A. C2, C3.

Q. C2, C3?

A. Yes.

Q. Those are a little blacker. Is that fair?

A. Yes.

Q. There is some age-appropriate changes there?

A. Sure.

Q. Which level did you operate on?

A. Right there.

Q. Okay. That's not as black, is it?

MR. GJELAJ: Withdrawn. I will ask it a different way.

Q. The disc that I'm pointing at, the level where you

formed the fusion, that's pretty hydrated; isn't it?

A. It's got some shades of gray within it, yes.

Q. But it's not like the ones above it that are pretty dark?

A. It is different from the other one, yes.

Q. You didn't operate on these, did you?

A. Correct, I did not there.

Q. These dark ones?

A. No, I didn't.

Q. You operated on this one; correct?

A. The one above that.

Q. The one above that right there?

A. Yes, correct.

Q. Okay. You were asked if there was any sign of trauma there.

If there had been fractures in his spine, that would have been picked up at the hospital; isn't that fair?

A. Typically, yes.

Q. If he had a fracture in his spine, that's a major, major event; isn't that?

A. Depending upon the type of fracture.

Q. It could lead to paralyze; right?

A. Depending upon the type of fracture.

Q. And there was no bleeding you said, too; right?

A. Yes.

Q. If there was bleeding there, would that have been picked up at the hospital?

A. Depends on what kind of bleeding he would have suffered.

Q. So if he had fractured something in his spine or was bleeding from the spine, that would be a catastrophic injury; correct?

MR. WHALEN: Objection, Your Honor. Improper redirect.

THE COURT: Beyond the scope. I'm sorry. What's --

MR. WHALEN: Improper redirect.

THE COURT: Based on?

MR. WHALEN: I didn't discuss that.

THE COURT: Beyond the scope.

MR. GJELAJ: Well, he discussed, Your Honor, the non traumatic finding there.

THE COURT: Madam Court Reporter, can you read back the question.

MR. GJELAJ: I'll withdraw the question, Your Honor, just to move things along.

Q. Did you need a catastrophic event in the spine in order to require a fusion?

A. Not necessarily, no.

Q. Okay. Somebody falling with their feet 9 to 10 feet

above the ground who stands 5-foot-7 -- are you with me?

A. Yes.

Q. -- and falls from a height, is that the type of mechanism that could lead to a herniated disc in the neck and in the back?

A. It can, yes.

Q. Have you treated patients that have fallen from those heights before?

A. Sure.

Q. Many times?

A. I'm sure over the course of my career, yes.

Q. Okay. And those are the types of falls that can lead to those kind of injuries, right, a herniated disc in the neck and in the back; correct?

A. Yes, they can.

Q. You testified on your direct that within a reasonable degree of medical certainty that the competent producing cause of the condition in his neck and his back was the accident, the fall from the ladder. Have any of Mr. Whalen's questions caused you to change that opinion?

A. No.

Q. Do you still believe that the competent producing cause of the herniated disc in his neck and the herniated disc in his back, which led to two surgeries, was the accident of November 18th -- excuse me -- August 18th, 2020?

A. Yes.
Q. Okay. You're a medical doctor; right?
A. Yes.
Q. So medically from a spine surgeon's perspective Mr. Sarmiento can do some sedentary work; correct?
A. Yes.
Q. You're not a vocational rehabilitation specialist; right?
A. No.
Q. You don't know, for example, his education level, how well he can write, how well he can add things like that; right?
A. Yes.
Q. So you're saying from a purely physical standpoint, you as a spinal surgeon, you feel that he could perform sedentary work; right?
A. Yes.
Q. Now, you treated his neck and his back; fair?
A. Yes.
Q. Are you aware that he had three other surgeries?
A. I know that he was being treated by orthopedics for other injuries, yes.
Q. By Dr. Touliopolis?
A. Yes.
Q. And Dr. Touliopolis performed three surgeries on him.
I want you to assume that there was testimony

yesterday by Mr. Sarmiento that Dr. Touliopolis performed three surgeries on him.

Your opinion doesn't even take into account those surgeries; right?

A. Yes.

Q. Just the two surgeries that you performed?

A. Yes.

Q. Correct?

A. Yes.

Q. Now, you were asked about future treatment -- oh, excuse me --

MR. GJELAJ: Withdrawn.

Q. When you operated on his back, did you remove a specimen?

A. Yes.

Q. What does that mean?

A. In the op report, I indicated that I removed disc specimen and sent it to pathology.

Q. Why did you do that for?

A. You know, typically, depending upon the institution, some institutions have varying rules and regulations regarding pathology reports, but we typically remove stuff that we find.

Q. And were you told by the lab what the results were?

A. There should be a lab report for that, yes.

Q. And were you told that it was a herniated disc?

A. I don't have the report with me.

(Handed to the witness).

THE COURT: Counsel, is this an exhibit?

MR. GJELAJ: It's already in evidence, but I'm trying to speed things up.

THE COURT: Okay.

A. Yes. This is my operative report, but this is not the pathology report.

Q. Well, it says there that you were advised that that specimen was a herniated disc at L5-S1?

A. I dictated that I removed the pathological specimen, herniated disc from L5-S1, yes.

Q. You did do the same thing for the cervical surgery?

A. I did.

Q. What was the result of that?

A. Specimen was sent to pathology.

MR. GJELAJ: One more thing. Sorry.

Q. Doctor, at some point in your notes, did you recommend that he treat with physical medicine with a physiatrist?

A. Yes.

Q. Did you recommend that he treat with any other specialties?

A. Physical therapy following up with orthopedics as best I can recall. I'd have to look at my notes for anything more specific.

Q. That's fine. Dr. Macagno will come in Friday and fill in the blanks.

Thank you very much, Doctor.

A. Thank you.

THE COURT: Counsel Whalen.

MR. WHALEN: A couple of things.

RECROSS-EXAMINATION

BY MR. WHALEN:

Q. Mr. Gjelaj asked you about objectivity and subjectivity of some of your tests just again now. Do you recall that?

A. Yes.

Q. When you ask Mr. Sarmiento in this case to rotate their neck or elevate their arm or bend their back or neck, you're relying on the truthfulness of the patient in this case Mr. Sarmiento when they say it hurts or they can't move it; correct?

A. Yes.

Q. Okay. And that would make it subjective?

A. Part of that component, yes.

Q. The pathology reports, the pathology reports regarding the cervical and the lumbar operations are not contained in those notes; correct?

A. Yes, correct.

Q. So I don't know if the pathology report says

desiccation or something else; correct?

A. I'd have to refer to the report, yes.

MR. WHALEN: Thank you, Doctor. That's all.

THE WITNESS: Thank you.

THE COURT: Okay. So it's 12:22, slightly earlier than we had thought, but I think this is a good breaking point before lunch. So we will break and resume again at 2:00 p.m. Thank you.

THE WITNESS: Thank you.

COURT OFFICER: All rise; jury exiting.

(Whereupon the jury exits the courtroom.)

THE COURT: You may be seated. Okay.

I'm sorry. Before we break, however, I would like juror number three to come down so we can ask about Friday's schedule and get as clear an answer as possible.

(Whereupon, juror number three enters the courtroom.)

THE COURT: Okay. Juror number three, first, I just want to say that I don't want you to be nervous that we called you. This is just so that we can get some information from you so that we can figure out the trial schedule going forward.

We understand that you have a life and you have commitments and that some of those commitments you may not have anticipated during the voir dire. And so right now --

so again I'm just saying this to you because I don't want you to feel like we're putting you on the spot or feel as though you're in trouble.

We were informed that you weren't going to be able to make it on Friday. And so what we're trying to figure out now is whether or not and, again, I say this to say it's absolutely fine if you have a commitment that prevents you from coming here. We're just trying to figure out is it that level where it's a commitment that you have that you really can't move around without experiencing a real detriment to your life or is it something that you could move. Because one of the things we're considering is if you can't make it on Friday, what we might do is have one of the alternates take your spot that way we can continue on Friday.

Again, we understand that you have commitments and you things in your life so this is not meant to put pressure on you one way or another. It's just meant to give us the most information so that way as we proceed we're proceeding in the best light possible. So given that, do you think that you can make it Friday or is it somebody that's not possible?

JUROR NUMBER THREE: I could try to reschedule it. I'm just getting my real ID renewed because I'm traveling for my birthday November the 15th. So I'm just trying to

get it renewed now so by that time it's renewed and I can leave like that. I can see if I can make it earlier in. It's at ten or see if I can reschedule. It's nothing. If you guys -- if I need to be here I could be here. Basically, this can be rescheduled.

THE COURT: Okay. So how about this? How about you see if you can reschedule it today and then we'll talk tomorrow to see if you can -- because if you can't get an appointment before your November 15th travel date, then clearly it doesn't make sense for you to reschedule because then that will be putting your trip in jeopardy. I'm assuming you're scheduling online with DMV.

JUROR NUMBER THREE: Triple A.

THE COURT: Okay. Can you see if that -- can you do that online some time today?

JUROR NUMBER THREE: Yes, I can.

THE COURT: Okay. So then if you can let Court Officer Garcia know and he can communicate to us or if you think it makes sense for you to speak with us in more detail about it, you can also let him know that. But, again, I just want you to know it is 100 percent just for purposes of keeping the trial moving. We don't want to put any undue pressure on you or make you feel as though we're trying to move you one way or the other. We just do want to understand.

JUROR NUMBER THREE: Okay, no problem.

THE COURT: If you can find that out.

JUROR NUMBER THREE: One question. Do you have the schedule for next week? So if I need to, I can move it to a day next week.

THE COURT: So we do know that this Thursday is a down day.

JUROR NUMBER THREE: Okay.

THE COURT: So on Thursday none of the jurors will be here. In terms of next week?

MR. GJELAJ: I don't know.

MR. WHALEN: Neither do I, Judge.

THE COURT: We don't know yet. But, Counsel Whalen, do you think you would have some idea by the end of the today or --

MR. WHALEN: Yes.

THE COURT: -- something. Okay.

So we'll also try to get more clarity, but if you can figure out what the availability is because, again, if you look and you see there's no dates available between now and the 15th, then that answers the question even if he don't know exactly what the schedule is next week. So if you could just endeavor to do that, we would be very appreciative.

JUROR NUMBER THREE: Okay. No problem.

THE COURT: Thank you so much.

I also understand your employer is causing some confusion and some stress for you.

JUROR NUMBER THREE: They keep emailing me and emailing me all the time like where am I? They want more proof. Like they just -- I tried to give them your number multiple times. I have proof in the email. They never call, but they're still emailing all the time. I think because of the switch last week, because it was supposed to be the 15th. I went to work the 15th, I got proof that I went to back the 15th, then it changed to yesterday which I was here and they're not trying to hear it, but I did give them your number. I emailed them.

THE COURT: So we do a letter sometimes for jurors to basically say that we are on trial. So we'll do another one and that will also include the chambers, my chamber's number, as well as the courtroom number. So then your employer will have two methods of reaching the court.

PROSPECTIVE JUROR: Okay. But they did provide the letter and I did send it to them as well.

THE CLERK: She received two letters. All right.

THE COURT: All right. So it's not that. Okay. So please keep the court officer appraised if it continues. And we will try to assist you if that is the source of your stress.

JUROR NUMBER THREE: They're just short staffed. So I'm the only one in the building right now so that's why they're doing that.

THE COURT: Okay. All right. Thank you. Have a good lunch.

JUROR NUMBER THREE: Thank you. Thank you Your Honor.

THE COURT: Thank you. Okay. Thank you. So we're breaking for lunch now.

(Whereupon, a luncheon recess was taken at 12:30 p.m.)

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

(Whereupon, the proceedings resumed at 2:11 p.m.)

COURT OFFICER: All rise.

THE COURT: You may be seated.

So we have all the jurors. They're in the process of coming down. I did want to provide an update as to juror number three. She said that it is possible that she may be able to reschedule.

So Counsel Whalen, once you have the update as to what the schedule will be next week, we can provide that to her so that she can then verify that --

MR. WHALEN: I was justing looking for my paralegal but that's why I turned around.

Oh, there she is. I will talk to her and then

I'll provide it to you, Judge. I don't want to hold anything up.

THE COURT: Okay, perfect. So where it stands right now is that she will be able to continue with us on Friday and she is endeavoring to reschedule the DMV appointment or whatever agency she's going through in order to get her Real ID by her travel date.

So I'm assuming Dr. Touliopolis is here?

MR. GJELAJ: Yes, Your Honor.

THE COURT: Okay. Perfect.

(Whereupon, CD's of x-rays were marked as Plaintiff's Exhibits 18 and 19 in evidence.)

COURT OFFICER: All rise, jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: You may be seated.

So Counsel Gjelaj, before you call your next witness, I believe that the parties have agreed to admit additional exhibits into evidence?

MR. GJELAJ: Yes, we have, Your Honor.

We have admitted Plaintiff's 18 and 19 both of which are CD discs of x-rays taken by Dr. Touliopolis.

THE COURT: Okay. And Counsel Whalen, you consented?

MR. WHALEN: Yes.

THE COURT: Thank you.

Counsel Gjelaj, you can call your next witness.

MR. GJELAJ: Plaintiff calls Dr. Touliopolis to the stand.

(Whereupon, the witness takes the witness stand.)

COURT OFFICER: Can you raise your right hand?

S T E V E N T O U L I O P O L I S, M. D, a witness called on behalf of the Plaintiff after having been first duly sworn and having stated his address as 23-25 31st Street, Astoria, New York 11105, took the witness stand and testified as follows:

COURT OFFICER: Please state your name and business address for the record.

THE WITNESS: My name is Steven John Touliopolis. My address is 23-25 31st Street, Astoria, New York 11105.

COURT OFFICER: The witness is sworn, Judge.

THE COURT: Thank you.

You may be seated.

Counsel, you may inquire.

DIRECT-EXAMINATION

BY MR. GJELAJ:

Q. How are you, sir?

A. I'm well. How are you?

Q. I'm good. Thank you.

Are you a physician duly licensed to practice medicine in the State of New York?

A. Yes, I am.

Q. For how long have you been duly licensed for?

A. I became licensed in 1993.

Q. Okay. Can you please tell the jury briefly about your educational background, any kind of honors, fellowships, basically bring them up to date so they know who you are?

A. Sure. I attended college at Columbia University. I majored in chemical engineering. I stayed on at Columbia University and received a Masters in Bioengineering before entering medical school at SUNY Downstate in Brooklyn.

After completing my residency, I did an additional year of training called a fellowship in sports medicine at Lennox Hill Hospital and finished that in 1997. And after that point I started my private practice. I'm board certified both in orthopedic surgery as well as orthopedic sports medicine.

Q. Now, this morning Dr. Merola testified and he told us that he was board certified in orthopedic surgery also.

Is there a subspecialty in which you're board certified vis-a-vis orthopedics?

A. Yes, and that's a separate examination.

Q. What's your specialty?

A. I practice both orthopedic as well as orthopedic sports medicine.

Q. Are you familiar with the term extremities?

A. Yes.

Q. Appendages?

A. Yes.

Q. What are they?

A. It's basically your arms and legs. So my practice is focused on treatment of extremity injuries. So basically from the shoulder to the wrist, from the hip to the ankle. These are areas that I treat and manage. I ordinarily do not treat disorders of the spine.

Q. And do you maintain a practice?

A. Yes.

Q. What's the name of your practice?

A. University Orthopedics of New York.

Q. Are you an active surgeon?

A. Yes, I am.

Q. About how many -- in a typical year about how many surgeries do you perform?

A. I would say on average -- I haven't counted recently since COVID, but it used to be in the range of five to 600 a year.

Q. And those are shoulders?

A. Again, it could range from shoulder, elbow, wrist, hip, knee and ankle. But the majority would be shoulder, hip knee and ankle.

MR. GJELAJ: Okay. Can I have these marked for identification only, please?

THE COURT: Yes.

(Whereupon, a model of the knee was marked as Plaintiff's Exhibit 20 for identification.)

(Whereupon, a model of the ankle was marked as Plaintiff's Exhibit 21 for identification.)

Q. Doctor, is it fair to say that you treated Mr. Sarmiento with regards to his knee and his ankle?

A. Yes.

Q. Let's begin with the knee, please.

Can you please explain to the jury the anatomy of the knee? And you if need to use the model, please do so.

A. Sure. This is a model of the right knee. And the knee is made up of three bones. So it's the kneecap, which is here. The lower part of your shinbone, which is the femur. And the upper part of your shinbone which is the tibia. And when we walk, we walk on articular cartilage. So the covering of the bone is -- it's not actually below, it's this white shiny substance. If you're not a vegetarian, if you're eating a chicken leg, the end of the chicken leg you can see a white covering, that's the cartilage that you walk on.

And in addition, you have -- in the knee you have a meniscus which is a disc of cartilage that makes like a C and helps cushion the knee. It helps make the contacting surface more symmetrical to the other side. And to hold the knee together you have ligaments.

You have four main ligaments. The collateral ligaments, which are on the side of the knee. And the cruciate ligaments which are in the center of the knee, they're called cruciate because they make a cross which are the anterior and posterior cruciate ligaments. That helps the knee in place. Without the ligaments, the knee can be unstable.

Q. Doctor, the cushion that you were referring to just now, Dr. Merola told us this morning about the disc and how it acts as a cushion. Is that similar to the disc?

A. It -- it is --

Q. The way it functions.

A. The idea is similar, yes.

Q. Okay. So did there come a time when you first saw Mr. Charles Sarmiento?

A. Yes.

Q. And if you could reference the notes if you need to, this is marked as Exhibit 3 in evidence also.

What was the date of that first visit?

A. Let me just pull up my records. I believe the first time that I saw the patient -- he was initially seen by another physician in my practice. But the first time I saw the patient was January 5, 2021.

Q. Okay. You said that he was seen by another physician in your practice. Is that something that's customary in your practice?

A. Yes, usually there's more than one physician in the practice.

Q. Who saw -- which physician?

A. Dr. Charles DeMarco.

Q. He is an employee of your company?

A. Yes, he is.

Q. Is he board certified?

A. Yes, he is.

Q. In what?

A. In orthopedic surgery and orthopedic sports medicine.

Q. And what was done at that first visit?

A. The first visit with myself or with Dr. DeMarco?

Q. The first visit that he came with Dr. DeMarco. The first time he came to your practice on November -- oh, wait a minute. That's not the date.

A. November 20, 2020.

Q. Correct.

A. Dr. DeMarco obtained a history through a translator and -- for injuries of his knees sustained in an accident. He had complaints of clicking, popping and buckling of his knees, difficulty with prolonged walking and standing and heavy lifting as well as going up and down steps. He reported the pain as being persistent and debilitating. He also reported injury of a right ankle for which he was seeing another doctor. And the pain was both on the front as well as the inside of both knees.

He denied any prior history of injuries to the knees prior to this accident. The accident occurred while working as a construction worker.

Q. When he came into the office that first time and Dr. DeMarco saw him, was he using any kind of assistive devices?

A. I'm reviewing Dr. DeMarco's note. Dr. DeMarco did recommend the use of a cane.

Q. If you look down under assessment and plan towards the bottom, does it say there the patient ambulates with the use of a cane?

A. Yes.

Q. Okay. It also says that he had an unsteady gait. Can you describe to the jury -- excuse me. Can you explain to the jury what unsteady gait means?

A. Basically when he walks, it maybe be a little wobbly and in this patient it would be the result of his knees not being stable.

Q. Was there a physical examination done by Dr. DeMarco?

A. Yes.

Q. What did he do? And what, if anything, did he find?

A. He noted range of motion of the knees. The extension was 0 degrees which is normal. The flexion was limited to 100 degrees. So normal is about 135 to 140. There was tenderness along the patella which is the kneecap, as well as medial and lateral joint-line tenderness and pain with the

anterior drawer test.

Q. What is that test, Doctor?

A. It's a test performed by the examiner to assess of the anterior cruciate ligament. It's -- it's -- again, it's one of the four ligaments I noted earlier and it's one of the main stabilizing ligaments to the knee.

Q. Were there any x-rays done that day?

A. Yes.

Q. What did the x-rays reveal?

A. That there's good alignment, good medialization, no fractures, no dislocations.

Q. Okay. Did you bring a copy of the x-ray with you today?

A. Yes.

Q. Okay. This morning, Dr. Touliopolis, Dr. Merola came here and demonstrated to the jury whatever he wanted. Is that something you'd want to do or are you okay from the stand?

A. I could point something out quickly.

Q. Hold on. I could give you a laser pointer. Is that okay?

A. Yes.

Q. Oh, will the laser pointer catch on here? He couldn't do it on the MRI.

A. We can try. I can try.

Q. Oh, okay. You did it.

Doctor, first of all, to lay the foundation, what are we looking at here?

A. So this is an x-ray of both knees. It's an AP x-ray, anterior/posterior, so in other words, the x-ray is taken in this direction from the front to the back of the knee. And, again, you could see this bone which is the lower end of the thighbone. This bone is the upper end of the shinbone. And this is the joint. And it's a fairly clean joint. There's no signs of any arthritis. The spaces between the bones are maintained, there are no bone spurs noted. So these x-rays initially are fairly normal.

Q. Okay. The height there, is it maintained in between the two bones?

A. Yes, the height is maintained and it's fairly symmetrical between both sides.

Q. If someone hypothetically had degeneration in their knee, what would this x-ray show?

A. It could show osteophytes which are bone spurs. We call those productive changes, as well as Sclar changes where the bone becomes thicker. You can get cysts in the bone under the joint line, and you can get narrowing of the joint spaces, so the space between the bones where the cartilage is.

So this space between these blue areas is cartilage which it does not show up on the x-ray. But when the cartilage is damaged, you can tell that on the x-ray because the space is

more narrowed. And initially these x-rays had no evidence of any joint space narrowing.

Q. Is this x-ray, and your interpretation of it, consistent with a 29-year-old knee?

A. Yes.

Q. Okay. Were there any MRIs done?

A. Yes.

Q. Tell us about that.

A. The -- I'm just pull up the date of the MRI scan. With reference to the right knee there was an MRI scan that was performed on October 28, 2020.

Q. What did it reveal?

A. It revealed a tear of the medial meniscus on the report. And also when I reviewed the images, it also revealed partial tearing of the anterior cruciate ligament.

Q. Using the knee model, can you explain to the jury where the tear was that you visualized?

A. Yes, so the medial meniscus tear, medial means inside. So it will be this disc that was torn but more in the back of the knee. And once torn, the patient loses that area of cushioning and, again, this is an area that later does develop arthritis on the inside of the knee. And this is the ligament, the cruciate ligament that was partly injured.

Q. Now, Mr. Sarmiento testified yesterday that prior to seeing you he had undergone various conservative methods for the

ankle. As of this date, had he begun physical therapy for the knee yet?

A. Therapy was prescribed by Dr. DeMarco when he was first seen on this date. I believe he had already been receiving it though.

Q. So when a patient comes to you at first and he's exhausted --

MR. GJELAJ: Withdrawn.

Q. Is that something that's considered a conservative measure?

A. Physical therapy, yes.

Q. So a patient comes to you having exhausted conservative methods, you do an x-ray, shows good alignment, you look at an MRI that shows a torn meniscus, do you automatically recommend a surgery for that patient?

A. Yeah, so it varies patient to patient. So the patient had -- you individualize your treatment for the patient. So if the patient has therapy, still had pain, had a large tear of his meniscus, that is something that would likely need surgery and would be discussed earlier than later.

But, again, when he saw Dr. DeMarco he did recommend some additional therapy.

Q. Did he continue to treat with you?

A. Yes.

Q. With your facility? When I say you, I'm referring to

your facility.

A. That's correct.

Q. When did your facility see him next?

A. I saw the patient on January 5, 2021.

Q. And that on that date you saw him yourself; right?

A. Yes.

Q. Okay. Can you tell us about that examination?

A. Yes, he had complaints of knee pain. The right knee was worse than the left with episodes of his knee buckling and giving out, difficulty kneeling, squatting and bending, going up and down steps, difficulty turning and pivoting. And he did not respond to physical therapy as well as the use of the cane. Examination of the knee revealed a limited flexion to 105 degrees actively and 120 passively on the right knee with a positive Lachman's test, a positive anterior drawer test and a positive pivot shift test.

Q. What, if anything, is the significance of that?

A. So those are the three main exams for testing the anterior cruciate ligament. The knee instability is really it's a clinical diagnosis made more in the office then by MRI. And when a patient complains of buckling of the knee or giving out of the knee, there is obviously suspicion that there's injury to a ligament. These are tests that are performed by the examiner for their basically objective tests where the examiner pulls on the knee and assesses how much motion there is. And if the knee

is unstable, there is more translation, more motion to the knee.

The pivot shift test is a test performed by first bending the knee and rotating it and then slowly extending the knee. And basically what happens is the knee goes from a position where it's actually not completely in place because of the knee injury and pops into place. And when that test is positive, it basically makes the diagnosis that the anterior cruciate ligament is not working properly.

Q. And you said that this was an objective test. Dr. Merola testified this morning about the difference between objective and subjective.

These tests that were objective, they can't be faked by the patient; is that fair?

A. Yes, an objective test cannot be faked by the patient. Sometimes an objective test can be limited by pain. So you may be limited. So you may end up getting a false negative because of pain. But when it's positive, there's really no patient input for that.

Q. Okay. And did you formulate an impression after that visit?

A. Yes.

Q. What was your impression?

A. That of bilateral knee anterior cruciate ligament which I will call ACL insufficiency, rule out meniscal tearing and further internal derangement.

Q. And did you formulate a plan?

A. Yes.

Q. What was your plan?

A. I did recommend right knee surgery based on his ongoing symptoms despite his treatment and the review of the MRI images. And the surgery would be that of an arthroscopy where we go in the knee with a camera, we assess the knee. The surgery with the arthroscopy where you go in with a camera and a lens and you watch it on T.V. is really the gold standard to figure out what's really going on inside the knee. The MRIs can have false positives and false negatives. But with the arthroscopy, I should look at things with your own eyes and actually probing them with a probe.

So the first thing that is done is a diagnostic arthroscopy which was recommended. And either depending on what was found, either a repair of the meniscus tear or a debridement of the meniscus tear which is called a meniscectomy as well as a possible ligament reconstruction of the ACL injury.

Q. Did he eventually have this surgery?

A. Yes.

Q. Can you please tell -- and you performed the surgery, Doctor?

A. Yes, I did.

Q. Can you please tell us what you did during that surgery?

A. Yes, the surgery was performed on January 18, 2021 and it involved the arthroscopy, the reconstruction of the ligament of the anterior cruciate lig -- with a graft that was taken from part of his own knee, as well as a meniscectomy. So the meniscus tear was fairly large and complex and was not something that could be repaired and was treated with the removal of the torn fragments of the meniscus.

Q. What did you do to repair it?

A. To repair the ACL it's really called a reconstruction. So we took a piece of -- to use the model again -- the patient's own disc tendons, it's called the patella tendon. It attaches the kneecap to the shinbone. So basically we take the third middle of the tendon with a piece of bone from the kneecap and a piece of bone from the shin, and we use that to make a new ligament, a new ACL ligament. And we drill holes in the bone. We pass that ligament through the holes, and then we secure it with a two metal screws.

Q. Was the surgery a success?

A. The surgery went well without complication and I would call it successful initially; yes.

Q. And did he come back to see you after the surgery?

A. Yes.

Q. And tell us about the -- when was that?

A. So the surgery was January 18th.

Q. Direct your attention to your January 22, 2021 note,

Doctor.

A. Okay. That was done by Dr. DeMarco.

Q. What's that?

A. I have Dr. DeMarco's notes separate. If you can just let me know --

Q. You know -- you can look at that.

A. Okay. Sure.

Q. That's actually in order.

A. Okay. I will do that.

Q. That's the same order I'm looking at too.

So I direct your attention to January 22, 2021.

MR. GJELAJ: What exhibit was that, Officer?

COURT OFFICER: Three.

MR. GJELAJ: So when I mentioned -- just so the record is clear, when I said to the witness he could look at that, I was referring to Plaintiff's Exhibit 3 in evidence.

A. Yes, I have the note.

Q. Okay. Please tell us about that visit, that first postop visit.

A. So this was just a few days after the surgery. He presented with his wife with his brace following the surgery. He was put into a fairly large brace that he's to walk on. And he was complaint with use of the brace. He had some swelling as well as ecchymosis which is bruising which are normal findings

following surgery. And he reported that his pain was tolerable.

On examination his motion was obviously very limited. He just had a knee reconstruction. He had extension of 0 degrees and flexion of only 20 degrees. There was a moderate effusion in the knee which is a moderate degree of water inside the knee, as well as some bruising around the knee but no signs of infection.

Q. You mentioned extension and what was the other one?

A. Is flexion.

Q. Okay. I have been wondering what that is and I'm sure the jury has, too. What is flexion?

A. So flexion is bending your knee back.

Q. Like this? (indicating)

A. Yes.

And extension is straightening the knee.

Q. The way I am right now? (indicating)

A. Right. So normal extension is about 0 degrees. Some people can hyperextend but usually normal is 0. Flexion is usually back to about 135 to 140 degrees.

Q. Thank you, Doctor.

When is the next time that he was seen in your practice?

A. February 26, 2021.

Q. Please tell us about the exam, assessment and plan?

A. Again, he's being followed up after his surgery. He

was compliant with home exercises. He was compliant with the use of his postoperative brace. The knee exam revealed healed incisions. His extension was still 0 degrees. His flexion had already improved to 100 degrees. And there were no signs of instability which is a good finding considering that he had a reconstruction of his ligament.

Q. So he was doing pretty well postoperatively; is that fair?

A. He had some initial -- yes, he did respond quickly following the surgery.

Q. When did you see him again?

A. April 6, 2021.

Q. What did you -- tell us about your exam, your assessment and your plan?

A. Again, he was complaint with the use of his brace and his exercises. He had started physical therapy. His motion was again from 0 degrees to 100 degrees. The Lachman anterior drawer test was stable. The meniscal signs was diminished. He did have some atrophy on the right thigh. And the plan at this point was continued physical therapy, home exercises and antiinflammatory medication. He had also had complaints to his right ankle and left knee.

Q. And in your note you said that in the next visit once he's feeling better that you were going to focus on those two?

A. For him to be evaluated.

Q. Did you comment on his level of disability at that exam?

A. So his level of disability at this point would still be total following his surgery.

Q. Okay. When did you see him again?

A. On July 20, 2021.

Q. Okay. Tell us about the physical exam that was done?

Before you answer, Doctor, every office visit that you -- that Mr. Sarmiento came to your office for, did you perform the same physical exams?

A. The body parts could vary from visit to visit depending what the focus of the visit was.

Q. Well, how about for the knee, were those exams the same each time?

A. The exams were -- were -- were -- there may be some variation but fairly consistent, yes.

Q. So then tell us about the exam that you performed, any positive findings, assessment, plan?

A. Yeah, so his knee exam his flexion improved to 110 degrees. The knee -- there were no signs of knee instability. The meniscal signs were diminished. Overall, again, all positive findings. There was atrophy of the right thigh of approximately two to 3 centimeters compared to the left.

Q. Is that significant?

A. It is a moderate to significant degree of atrophy; yes.

Q. Okay. Continue, please.

A. And left knee exam revealed motion from 0 to 110 degrees with positive meniscal signs, a positive anterior drawer test, the Lachman test. And right ankle exam revealed tenderness along the anterior lateral joint line. A positive anterior drawer test and a positive Talar tilt test.

Q. Doctor, this is the first time that we're talking about the ankle today and in this trial. Can you please, using the model that's in front of you, show the jury what you mean?

A. Yes. So this is a model of the ankle. And -- of the ankle is made up basically three bones. The small bone, which is the fibula. The big bone is the tibia. This is a -- this bone actually goes all the way up to the knee. So the upper part of this bone makes up the low part of the knee. And the low part of this bone makes up the upper part of the ankle and the talus, which is this bone in here. And basically the talus is held in place by the ankle mortise which is made up by the bones. So the fibula and the tibia bones as well as the ligaments around the ankle that help hold the ankle in place, make the ankle stable. And a fallen-ankle injury involving the ligaments the ankle can become unstable. And some of the symptoms can include rolling where you slip on a crack and the ankle kind of rolls on you. Again, that's something that's

initially treated with physical therapy. But if it doesn't respond, it may require surgery.

And on examination to test for the ligaments there are tests that we do that are similar to the knee where we actually hold the bones and pull on the ankle. One is the anterior drawer test where we kind of pull the ankle forward. And if that reveals no motion in the ankle, that usually signifies that the ATFL, which is the Anterior Talo-Fibular Ligament, has been injured. And the other is called the Talar Tilt test where the ankle is rolled this way. And if that reproduces the pain and produces a laxity, it signifies injury of the CFL which is the calcaneofibular ligament, the ligament that goes from the calcaneus to the fibula. So on examination both those ligaments were found to be loose.

Q. Did you come up with an assessment at this visit?

A. I'm sorry, I lost my page.

Okay. Yes, the assessment was that -- well, on the injuries requiring right knee surgery, as well as right ankle lateral ligament tearing, rule out chondral injury.

Q. What is a chondral injury?

A. Again, it's that shiny white structure that covers the ends of the bones that we walk on.

Q. Okay. And did you formulate a plan?

A. Yes.

Q. What was your plan?

A. At this point we recommended continued physical therapy for his right knee, especially because of the atrophy that he had, as well as physical therapy for the left knee and the right ankle, to follow up with his spine specialist. And that further intervention may be required in the form of surgery if his ankle did not get better.

Q. Did you provide him with a home exercise program?

A. Yes.

Q. And tell the jury about that?

A. It's basically instructions on what to do at home. Physical therapy is important but it's something the patient can only do two, three times a week. We do recommend daily home exercises when possible. And obviously you're limited at home with machinery but there are certain exercises that we instruct the patient that is safe to do at home without equipment.

Q. Is that good and accepted practice within the field of orthopedics?

A. I would say yes.

Q. Let's go to your note of September 21st.

A. Yes.

Q. We're not going to go over every visit.

Did you perform an examination?

A. Yes.

Q. Tell us about the exam, any findings, your assessment, and your plan, please?

A. Yes, the patient came in on September 21st. He did report that his right knee was improving. His chief complaint at this visit was his right ankle. He had right ankle pain along the anterior and lateral aspects of his ankle which is the front and outside of his ankle, as well as clicking and popping and buckling of the left knee.

On examination his right knee exam was fairly consistent to the previous visit. Again, there was atrophy noted of his thigh. He was able to do a straight leg raise which is you ask the patient to lift his leg off the table. He previously had difficulty doing this. So this was a positive sign.

His left knee exam revealed limited flexion as well as positive Lachman and anterior test findings. And on right ankle examination his ankle motion was limited. His dorsiflexion, which is your ability to bring your ankle up, which is normally 20 degrees, and in this case it was 10 degrees. And plantar flexion is pointing your toes downward with your ankle. Normal is 40 degrees and that was limited to 10 degrees.

He also had tenderness along the ligaments that I noted earlier, the ATFL ligament and the CFL.

Q. Did you review any MRIs at that visit?

A. The September 21st visit was by Dr. DeMarco. I -- and he did refer the patient to me and I did eventually review the MRI, yes.

Q. Of what?

A. Of the ankle.

Q. Did you formulate an impression and a plan?

A. Yes.

Q. Tell us about that?

A. My impression was that of a lateral ligament injury. There are three ligaments on the lateral side which is the outside of the ankle. I believe that two of them were injured and not working properly, and at this point did require surgery.

Q. And did you put in a request for that surgery?

A. Yes.

Q. Was the request approved?

A. Yes.

Q. Did you perform the surgery?

A. Yes.

Q. Tell us briefly the surgery using the model if you need to.

A. Yes. So surgery was performed on November 29, 2021. And, again, once the patient received anesthesia, the first thing we did is examine the ankle. The benefit of the examination under anesthesia is that the patient has no pain, so that is no longer a limiting factor to your examination. So we performed the same examinations I did in the office. And, again, they were found to be positive.

The first part of the surgery was an arthroscopy where

we go into the ankle with a camera and we looked around at the cartilage. We did find an area where there was some damage to the cartilage on the talus that we debrided.

Q. What does that mean debrided?

A. Basically there -- there are loose flaps of cartilage tissue that covers the bone and we smooth it out with a shaver to make it more congruent and less likely to bother the patient. And then we performed the open surgery.

So the surgery had two parts. One was with the camera, and the other is open where we make an incision on the outside of the ankle here, and we go down to the ligaments of the ankle. We found them to be injured. And unlike the knee where we have to actually make a whole new ligament in the ankle, we're able to use the patient's own ligament. The difference is in the knee the ligament's inside the joint and it's bathed in fluid, whereas, in the ankle it's outside the joint and it's something that can be repaired, and usually the repairs are successful. If they don't work, then the patient may need further surgery with a graft.

But in this particular case we're able to repair the torn ligaments, we use sutures to tighten up the ligaments as well as anchors to the bone to sew the ligament tears back to the bone.

Q. Doctor, what is an intraoperative photo?

A. The intraoperative photos are pictures that we take

with a camera. So when we're performing an arthroscopy, again as I mentioned earlier, we're using a camera and we're watching it on T.V. But during the surgery we're able to take pictures. And I do have pictures of all three surgeries that I brought with me.

Q. We're a little short for time.

But did the intraoperative photos show the tears that you mentioned?

A. Yeah, the intraoperative photos for the knee show the tears. For the ankle, again, the ligaments are outside the joint so you can't see the majority of the ligament with a camera. But it did show it on the knees.

Q. When you did the knee surgery -- when you performed the knee surgery on January 18, 2021, the one that you testified to already, did you also take intraoperative photos?

A. Yes.

Q. Did those show tears?

A. Yes.

Q. Was the ankle surgery a success, Doctor?

A. Yes, I would -- if you define success as are you better than before? Then I would say it is successful. He does have some residual limitation of motion. But overall his pain level is better and the ankle is more stable.

Q. Was the first knee surgery successful? The first right knee surgery successful?

A. It was initially successful, however, eventually the graft failed and he required additional surgery.

Q. We'll get to that now.

In terms of the ankle, did you continue to treat him for the ankle?

A. Yes.

Q. Has he had any more surgeries to the ankle other than that one?

A. No, he has not.

Q. Has he had physical therapy?

A. He had after surgery.

Q. Let's go back to the right knee then.

At some point was there a change in the level of pain he was experiencing in the right knee post first surgery?

A. Yes.

Q. Okay. Tell us about that.

A. Yes, so he developed recurrent symptoms to his knee. It was not immediate. Let me just see it if I can pinpoint. Yeah, he did report on February 22, 2022 residual pain, clicking, popping and buckling of the knee. I believe these may have been some early findings consistent with his recurrent ligament problem.

Q. Is that something that's typical or common or associated with these types of conditions in the knee?

A. Yeah, so I always explain to the patient that with a

reconstruction of the ACL, there is -- there's a 10 percent failure rate where the ligament graft may not incorporate, it may get loose again and may need additional surgery. So it's not -- I wouldn't say it's common but 10 percent is a real number and it does happen.

Q. So it's not rare but it's not common; is that fair?

A. I think that's a fair statement.

Q. Okay. What did you -- tell us about the examination, the -- well, tell us about the examination and any findings. February 22, '22.

A. Yeah, so on the ankle, the ankle it was stable now. It was no longer any signs that it was loose. There was some improvement to his motion, 10 degrees of dorsiflexion and 20 degrees of plantar flexion.

And with the right knee, his flexion at this point was less than previous. It was only 95 degrees. There was tenderness along the joint lines. There was pain with the Lachman test which limited that examination. So there was increased findings on this date for the right knee.

Q. Did you have any -- did you perform any x-rays on him on that date?

A. The x-rays were performed, yes.

Q. Take a look -- do you still have the laser pointer?

A. Yes.

Q. Please take a look at Exhibit 18. Is this the x-ray

that was taken on that date?

A. I can't see the date.

Q. It says 2022/02/22.

A. Yes.

Q. Okay.

A. So again, these are the two screws that were used for his ligament reconstruction. They're in place, they're inside the bone, and those are inside the bone, they usually don't bother the patient. Sometimes they need to be removed later if they become symptomatic. But now, if you look in the inside of the knee now, um, it's a little more narrowed then it is on the outside of the knee. This is the outside and this is the inside. So he is developing some wear of the cartilage on the inside of the knee.

And when we performed the surgery initially, we did find an area of grade two to grade three of cartilage damage on the inside of the knee. And basically -- so a grade 0 is normal cartilage. A grade one is softening of the cartilage. Grade four is basically a bare bone, you have no cartilage there. So he had like grade two to grade three which is moderate degree of cartilage damage on the -- exactly where the x-ray is showing some narrowing on the x-ray.

Q. And in medical terms, how did it get narrower? I mean we just saw an x-ray showing good joint space. How could something like this occur?

A. So basically when you tear your meniscus, especially he had a large tear, you lose the cushioning effect of the meniscus on the inside of the knee. And you also can damage the cartilage that covers the bone at the time of the accident which he also had. So I think these two factors contributed to the development of the arthritis which is really just on the inside of the knee at this point in time.

Q. Okay. That's in '22?

A. Yes.

Q. Okay. And did you formulate a plan, Doctor?

A. I'm sorry, what was the date of that visit?

Q. February 22nd of '22.

A. Okay. It was for home exercises, continued physical therapy. We did discuss possible further intervention for his left knee when his right knee was feeling better and repeat x-rays and a repeat MRI scan of right knee were prescribed.

Q. Did there come a time when you recommended a further surgery to the right knee?

A. Yes.

Q. Did you request authorization for that?

A. Yes.

Q. Was it granted?

A. Yes.

Q. Did you perform the surgery?

A. Yes.

Q. Tell us about that surgery, please?

A. The surgery was performed on September 19, 2022. And again included the arthroscopy and a revision of the ACL reconstruction. So this time, because we already used his own tendon, we used the tendon from a cadaver.

Q. What is a cadaver?

A. It's basically a dead person. Okay. So this section of the tendon of the bone from another person was used to reconstruct the ligament. The old screws were removed and new screws are put in during the surgery.

Q. Was the surgery a success?

A. Yes. Following the surgery in the operating room we found that the knee was very stable and that the ligament was functioning.

Q. Now, I've been asking about the surgeries for both body parts if they've been successes. Did they cure the conditions in his knee and his ankle?

A. So in the ankle the tear was repaired. So he has a good result. I don't believe the ankle rolls any more. It is stiff. So it is a success because it is better than before. But it's by no means a normal ankle. Right. So he does have some residual limitation and stiffness of his ankle.

And the knee you can stabilize the ligament and you can clean the meniscus tear. But once there's cartilage damage, it is something that is -- um, it's progressive. So we did

split out the cartilage damage initially but it's still there and it's something that will progress over time. So -- and the arthroscopy is not a surgery that can address that problem.

Q. Did you continue treating him?

A. Yes.

Q. Did he continue coming to your office?

A. Yes.

Q. Okay. Did he continue physical therapy?

A. Yes.

Q. All right. I direct your attention to the last time you saw him. September 19, 2025. Is that in there?

A. It's not in here but I have it in my notes. Yes, I have it.

Q. Okay. The last visit was September 19, 2025, Doctor?

A. Yes.

Q. All right. Tell us about that visit, please?

A. So, again, he presented for a follow-up evaluation. It's basically his right ankle and his left knee conditions were fairly stable. He presented primarily for his right knee. Even though he did report some stability, I mean I have that it no longer gave out on him or buckled, like he had at least to the same degree as it had prior.

He did have residual symptoms of soreness, stiffness with prolonged ambulation. He was using a knee sleeve. He did report clicking of his knee. At this point in time he was not

receiving therapy but was compliant with home exercises, and I reported that he was not working.

Q. Okay. Did you perform a physical exam?

A. Yes.

Q. Tell us about the exam and findings, if any?

A. On examination of the knee, at this point he was walking without a brace, without a cane. His knee extension was 0 degrees. His flexion was limited to 100 degrees. There was crepitus with knee motion.

Q. What is crepitus?

A. Crepitus is basically cracking and popping noises when a joint is moved. And the Lachman test at this point, in my opinion, was -- was -- was negative. So when I examined the knee, and I did the three tests, the Lachman test, the anterior drawer test and the pivot shift test, there were no signs that the knee was loose again. It didn't -- there wasn't translation like there was prior to the last surgery. But there was tenderness along the femoral condyles which is bones around the knee as well as the kneecap, and along the medial joint line which is the inside of where he was developing the arthritis.

Q. And you also noticed some atrophy?

A. Yes.

Q. What, if anything, is the significance of that?

A. Atrophy is basically when, um, your muscle size gets smaller. So -- um, and we usually compare it to the other side.

In this case he does have two bad knees. So a comparison can be a little difficult. But even with the other side being injured, the right thigh was smaller than the left thigh, meaning that the muscles were smaller. And that signifies that the muscles are not being used normally. And, therefore, since they're not being used normally when walking and going up and down stairs, they can get smaller than the other side.

Q. Did you perform x-rays that day?

A. Yes.

MR. GJELAJ: Put them up. It's up? Oh, thank you. Sorry.

Q. Doctor, I'm going to show you Exhibit 18. Patient ID 82245; Sarmiento, Charles; study date 2025/09/19. Is this the x-ray that you took that day?

A. Yes.

Q. Please tell us what, if anything, you see there?

A. So, again, you see the -- oops. I almost blinded myself. You can see the screws where we used for the second ligament surgery. These screws I believe are slightly wider. And then on the far inside of the knee right there you can see how narrow that space is compared to that area on the other side of his knee.

Q. What, if anything, is the significance of that?

A. Again, it's gotten progressively more narrowed over time. So with this I'm diagnosing the patient with progressive

posttraumatic medial compartment degenerative joint degrees.

Q. Arthritis in his knee?

A. Yes.

Q. And you've shown the jury three sets of x-rays over the course of about four years; is that fair?

A. Yes.

Q. Do you see the progression in all three of those?

A. Yes.

Q. Tell us about that?

A. The space on the inside of the knee has narrowed over time, over the period of those four years in those three x-rays.

Q. What is the remedy for that?

A. So because the arthritis is on the inside of the knee, and it doesn't involve the entire knee, eventually the patient, in my opinion, would be a candidate for a partial knee replacement.

So for a partial knee replacement, you have to have arthritis as predominantly on the one side of the knee, and in this case it's the inside. You have to have a knee that's fairly stable, which he has on this -- at least on this examination where his ACL felt like it was working. And you have to have fairly descent knee motion which, you know, he does have some limitation of flexion, but he does have full extension. So it's something that's in his future. Obviously he's only 34-years of age. I don't recommend it now. But it's

something that would be required as he gets older.

Q. Why don't you suggest it now?

A. Because, again, he's very young. And sometimes you have no option and you still have to operate and do a knee replacement on a young person. But at this stage I do recommend active modification, antiinflammatory medication as necessary, periodic injections to the knee. And when he gets older, and his pain gets worse, he will be a better candidate for a knee replacement.

Q. That opinion that he will need a knee replacement, is that within a reasonable degree of medical certainty within your field?

A. Yes.

Q. Can you show the jury, using that knee model, how the knee replacement is performed?

A. Yes, so basically it's an open surgery. It's not with a camera and the incision is from here to here, and the kneecap is kind of moved out of the way. And we actually -- as of recent we're actually using a robot to assist us with the surgery and pins are put in both bones and an array is set up and the information is fed into a computer. And basically with a robot and a saw, we cut off the ends of the bones on this side of the knee, the inside of the knee, actually on the knee it's this high, on the inside of the knee. And then we cement on metal caps on both sides and then put in a plastic liner. So

when a patient walks, he's walking on plastic. He's not walking on metal.

Q. Once that knee replacement is done, what, if anything, happens to the mobility in the knee?

A. Um, it's variable. So you could have a -- you could have someone that has really bad motioning and gets better motion with a knee replacement. And you can have patients that have decent motion before the surgery but because of scar tissue that develops after surgery during the healing process, you may end up losing motion and have less motion then you had before the surgery.

Q. And when someone has a procedure such as the one you just said, is there physical therapy required afterwards?

A. Yes.

Q. Is there life-long care required afterwards?

A. I'm sorry?

Q. Life-long care, sorry?

A. So after knee replacement, there is a period of physical therapy and he would need periodic evaluations.

Q. Fair enough.

Is there a shelf life on the knee replacement?

A. There is with all -- with all replacements. Um, um, I gave the mechanical that they don't last forever. And over time it can wear out. Um, the plastic can wear out and may need to be changed. The metal that's cemented to the bone can get loose

and may need to be changed. Um, and, um -- you know, it can last a certain amount of time but eventually there's a chance that it would need to be revised.

Q. What's the shelf life these days for a knee, for a total knee?

A. Well, this will be a partial knee replacement and I would say it would be in the ballpark of 12 to 15 years.

Q. In other words, once he has this and you've already told us he needs it, it's going to have to be redone every 12 to 15 years; is that fair?

MR. WHALEN: Objection, it's not what he testified to, Judge.

THE COURT: I'm sorry. Wait. Counsel, I didn't rule on the objection. So are you withdrawing that question and rephrasing?

MR. GJELAJ: I thought you --

THE COURT: No, I did not. So I'm going to answer an objection, it's going to be verbal. It's going to be on the record one way or the other.

So, Counsel Whalen, what was your objection?

MR. WHALEN: Objection as to what he just said, Judge. He testified already what the life of the knee was and he was just asked again. So it was asked and answered.

THE COURT: Okay. So sustained.

Q. Once the shelf life of the knee replacement expires --

is that the right word, Doctor?

A. Once the -- I would say once the knee replacement fails.

Q. Once the knee replacement fails, do you need to go in and redo it?

A. Ordinarily yes.

Q. Okay. Now, do you have an opinion within a reasonable degree of medical certainty within your field, as to what the competent producing cause of the condition in both his left and right knee were?

A. Yes.

Q. What is that opinion, Doctor?

A. As a result of his work accident --

Q. Okay.

A. -- of August 18, 2020.

Q. Do you have an opinion as to what the competent producing cause of the condition in Mr. Sarmiento's ankle was?

A. Yes.

Q. What is that opinion?

A. The same result of the work accident of August 18, 2020.

Q. Do you have an opinion within a reasonable degree of medical certainty as to whether or not the deficits in his right knee are permanent?

A. Yes.

Q. What is that opinion?

A. That the deficits are permanent. And even with additional surgery, there would be residual and permanent deficits to his knee.

Q. Same question regarding the right ankle.

A. With respect to the right ankle, it's my opinion that he's reached maximum medical improvement, that his ankle condition would not improve any further from where it is now.

Q. Do you have an opinion within a reasonable degree of medical certainty as to whether or not Mr. Sarmiento is disabled from employment?

A. Yes.

Q. What is that opinion, Doctor?

A. That he's disabled from his previous employment as a construction worker. I do believe he is capable of doing sedentary work where he's able to sit most of the day. I believe that would not stress his knee unnecessarily. As far as his ability to sit for prolonged periods of time, I would defer to the spine surgeon. But I do believe he's capable of sedentary work.

Q. Physically?

A. Yes.

MR. GJELAJ: Okay. Thank you, Doctor. Nothing further.

THE COURT: Let's take a 15-minute break.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: You may be seated.

(Whereupon, there was a recess taken.)

COURT OFFICER: All rise.

THE COURT: You may be seated.

Counsel Whalen, do we have any update on next week?

MR. WHALEN: Do you want me to approach or just tell you? I have a schedule.

THE COURT: It's up to you. If you want to share.

MR. WHALEN: I shared it with Nick already.

MR. GJELAJ: Yes. And Ms. Ortiz is actually plugging it into the calendar that I gave you at the beginning of the trial.

THE COURT: Perfect. Thank you. That was very helpful.

MR. WHALEN: Okay. Then you'll have it then. But we have witnesses for Monday, Tuesday, Wednesday, Thursday.

THE COURT: So Monday, Tuesday, Wednesday, Thursday?

MR. WHALEN: Yes. I know there's going to be some time constraints because Mr. Gjelaj has witnesses on a

couple of those days.

MR. GJELAJ: Well, I have Monday only.

MR. WHALEN: Yes.

MR. GJELAJ: Monday I have Dr. Dwyer and the wife I could finish that in the morning.

MR. WHALEN: Yeah, and I have my guy coming in at 2:00.

MR. GJELAJ: Who?

MR. WHALEN: Stewart the investigator for the surveillance.

MR. GJELAJ: Okay.

THE COURT: Okay. So we expecting -- I'm assuming then that we're expecting full days Tuesday, Wednesday, Thursday?

MR. GJELAJ: Yes.

MR. WHALEN: Yeah.

THE COURT: Okay. So then we will be able to tell the juror Friday. But, again, that would be a day that we would likely be doing closing arguments and, hopefully, they begin deliberation.

MR. GJELAJ: Right.

MR. WHALEN: Right. It could move back a day, Judge, but we will know better tomorrow. I mean, maybe tomorrow. We'll see who we have scheduled for Thursday.

MR. GJELAJ: Uh-huh.

MR. WHALEN: And, Judge, one of my witnesses Wednesday afternoon, needs a zoom link. I have to do him by zoom.

THE COURT: By zoom? So generally --

MR. WHALEN: I don't know why yet, Judge. I'm just looking at his schedule. But I've heard that's what he's been doing in the past.

THE COURT: So we don't use zoom. The courts use Teams. And generally in terms of whether or not we allow witnesses to testify via remotely instead of in person is a question that's raised to the Court rather than a declaration made to the Court.

MR. WHALEN: And I'm raising -- I apologize. I'm raising that question. I meant it phrased as a question anyway, Judge.

THE COURT: Is there any objection, Counsel?

MR. GJELAJ: No. No objection.

THE COURT: Okay. So then we would need that. I'm sorry, you said Thursday?

MR. WHALEN: Wednesday.

THE COURT: Okay. And he's in the afternoon?

MR. WHALEN: Yes.

THE COURT: Okay. So we can set up a Teams link for this trial on Wednesday afternoon, the 29th.

So when Karen sets it up, counsel will be copied

on it and so then you can forward it as necessary to your witness so that everyone can join the link. And it will just be here -- just separate and apart, we should just do a trial run because we have had some issues with Teams and the sound. So just to make sure, we should just do a trial run ahead of time. And we'll figure that out based on when we have, like, free time when the jurors aren't here just to run that test run. I just want to make sure that the court reporter will be able to pick up everything and it won't be delayed because of that.

Are we ready?

COURT OFFICER: All rise, jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: You may be seated.

Counsel, you may inquire.

MR. WHALEN: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. WHALEN:

Q. Good afternoon, Dr. Touliopolis.

A. Good afternoon.

Q. We have met before; correct?

A. Yes.

Q. Okay. It was this same situation it was last May I believe.

A. I don't remember where and when but I'll take your

word for it.

Q. So in 2025, this would be your third time testifying in the Bronx; is that correct?

A. I testified -- I don't recall, um, to be honest with you. It could be three times.

Q. Okay. You testified for the plaintiff back in April or May when you and I met; do you remember that?

A. Again, I don't remember the month.

Q. Okay. And two weeks before that you testified for another patient here in the Bronx also; you don't remember that either?

A. I'm very bad with dates. But, yeah, I'll take your word for it.

Q. Okay. As you were going through your direct testimony you relied on the notes of some of the other members of your team; is that fair to say?

A. Yes.

Q. That Mr. Sarmiento was seen by other persons, doctors, and otherwise in your office; is that correct?

A. That is correct.

Q. And that's part of the records of your facility regarding your treatment to Mr. Sarmiento; right?

A. That's correct, yes.

Q. Is Dr. DeMarco still with your practice?

A. He is, um, no longer with us full time. Um, um, he's

moved on to a different job opportunity.

Q. Okay. And Andrew Cruz is he still with your --

A. Yes, he is.

Q. And Mr. Cruz who saw Mr. Sarmiento many -- a few of the times, is not a doctor; correct?

A. He is a physician assistant.

Q. Now, you first -- and please refer to your notes as I go through this if necessary.

Your initial orthopedic exam was on November 20, 2020; correct?

A. Yes.

Q. And you kept detailed notes and records regarding Mr. Sarmiento; correct?

A. We do have notes for the visits. He was seen.

Q. And at the time of the initial orthopedic evaluation you provided him with a Spanish -- you put translator/interpreter here; correct?

A. That's correct.

Q. And you were going to make evaluations as to the injuries Mr. Sarmiento was claiming to his knees and his ankle; correct? That's what he was coming to you for treatment; right?

A. Yes, initially he came to us for his knees. I believe he was under the care of another physician for his ankle injury but later came under our care also for his ankle injury.

Q. Okay. And to assess Mr. Sarmiento's injury, you have

to determine what the mechanism of injury is to hold the defendant accountable; correct?

MR. GJELAJ: Objection.

THE COURT: Basis?

MR. GJELAJ: Holding defendant accountable?

THE COURT: So to form?

MR. GJELAJ: Form, yeah.

THE COURT: Sustained.

Please rephrase, counsel.

Q. Doctor, is it necessary in forming your opinions regarding the injuries that Mr. Sarmiento sustained in accordance with your records to understand the injury mechanism or how the accident happened?

A. Well, again, we do have that he slipped and fell down stairs while at work and that he denied any prior history of injuries to his knees prior to this accident. And based on this history, I determined that the knees are the result of this accident.

Q. Fair enough. And that's what I was getting to.

So Mr. Sarmiento told you he had no previous injuries to the knee or the ankle; correct?

A. That is correct.

Q. And he told you, as it is reflected in your records, that he slipped and fell down stairs; correct?

A. Yes.

Q. And on that date, do you know how many stairs he fell down?

A. No.

Q. Do you know if it was a steep set of stairs or --

MR. WHALEN: Withdrawn.

Q. Do you know if it was a lot of stairs or a few stairs or something else?

A. I do not know.

Q. But falling down stairs, okay, as he told you, you relied on his truthfulness; correct?

A. Yes, I do rely on an accurate history.

Q. And an accurate history is very important for you determining whether or not the mechanism of injury was present, okay, to cause these injuries; correct?

A. Well, I do rely on an accurate history. If it's inaccurate, it may alter my opinion.

Q. Well, the history allows you to assess whether or not the history could cause these injuries; correct?

A. Yes, I'm relying on the fact that he never had problems with his knees or ankles before the accident, that he had this particular accident and the onset of symptoms happened following the accident.

Q. And this accident was a fall down some stairs in accordance with what he told you?

A. That is correct.

Q. During your initial -- your -- and when I say this, your office's initial contact with Mr. Sarmiento, you asked him to fill out a patient information Workman's Compensation accident form; is that correct?

A. He filled out an intake sheet; yes.

Q. An intake sheet; right?

A. Yes.

Q. And Mr. Sarmiento filled that out by himself or with the assistance of the translator?

A. Well, again, he doesn't, um, speak English at least at that point in time. That would have been with the assistance, I'm assuming, with a translator.

Q. And one of the important things that you need to know, okay, is how the accident happened; correct?

A. Yes.

Q. And Mr. Sarmiento in filling out that accident report or the intake sheet, with somebody from your office, said how did the accident happen? That's the question your form has. He trips -- tripped on stairs and fell one floor.

A. That's correct.

Q. And that was important for you to have that in assessing the forces that were present in causing these injuries; correct?

A. Well, the category of the injury is important to know.

Q. Right. So on your first visit is January -- hold on.

I'm sorry. Your first visit is on November 20, 2020, okay, where he gave you that history.

A. Yes.

Q. And the course of treatment was, at that point in time, physical therapy and use of a cane; correct?

A. Yes, initially. That's correct.

Q. You next saw him on January 5, 2021?

A. Yes.

Q. And, Doctor, also correct me if I miss a page, I'm trying to go in order though.

And at that point in time there were MRIs taken; correct?

A. Yes.

Q. And at that point in time on January 5th on his second visit you felt it necessary where you say in the follow-up visit the patient fell down stairs and sustained an injury to both knees. Okay. And at that point in time you were suggesting surgical intervention; correct?

A. That is correct.

MR. WHALEN: Just bear with me for a second.

Q. By the way, did your office notes or records reflect that you got the ER records, the emergency room records?

A. No, I do not have the ER records.

Q. Have you ever seen the ER records?

A. No, I have not.

Q. Okay. Would the ER records, the records that are kept the day of the accident, be important to you in assessing Mr. Sarmiento's injuries and what he claimed to injure and how he injured it?

A. Well, again, I'm relying primarily on the patient's history to me. The ER records may or may not be of assistance.

Q. But you don't know because you've never seen them?

A. I don't know what they say. That's correct.

Q. Okay. You diagnosed Mr. Sarmiento with a torn meniscus; correct?

A. Yes.

Q. Is that painful?

A. A torn meniscus can be painful. The symptoms can be variable depending upon the type of tear, the level of activity, but can vary from day to day.

Q. Well, let's talk about this one. You told us it was a significant tear to the medial meniscus; is that correct?

A. Yes.

Q. And a significant tear would produce pain; would that be fair to say?

A. It can produce pain, um, the timing -- it may not produce pain right away. And usually meniscus tears are not associated with a lot of swelling of the knee, um, unlike other types of injuries. So you may not have initial swelling and stiffness and, again, pain may be a factor of how ambulatory he

is after the accident.

Q. What's the mechanism of injury for a meniscus tear? Is it a planting and twisting, something else?

A. There are various types of injuries. It could be a hyperextension, a hyperflexion, axial force, twisting injury.

Q. And a fall down the stairs could cause a meniscal tear?

A. Yes.

Q. And you also diagnosed -- did he sustain an anterior cruciate ligament tear, an ACL tear; correct?

A. A partial tear; yes.

Q. A partial tear.

And a partial tear of the ACL would be painful; correct?

A. Again, at the time -- I don't know exactly what the ER records said but when you have a knee injury, you have to look at the big picture and what else was injured. This knee injury may not have been reported initially. It may or may not have depending upon how much pain he had initially.

But like a lot of injuries sometimes the inflammation doesn't kick in until the day after, the day after that, and you may not have pain and swelling until you go home or you wake up the next morning. So the -- he may not have a lot of initial pain in his knee at the time of the accident. Some patients do, some patients don't. But these injuries are the result of the

accident.

Q. Well, your understanding is that the accident happened when he went down a bunch of stairs; right?

A. Yes.

Q. So a torn partial tear of the ACL, a torn meniscus and you say not all the time would it present with pain; is that a fair statement of what you just testified to?

A. No, I said you have to look at the patient in his entirety. So there are other areas of injury which are more painful. His brain at the time may not have been drawn to the knee injury. So if it was an isolated knee injury, I do believe it probably would have been presented in the ER as a knee injury. But when there's multiple traumas, it's something that may have been missed by the patient as well as the ER staff.

Q. When you say "multiple traumas," you're talking about multiple traumas he would have reported to the ER people?

A. I do know he injured his spine in this accident. So there are other areas of injury.

Q. But that wasn't my question.

You're testifying that whatever he reported to the ER personnel is what his complaints of pain were; is that right?

MR. GJELAJ: Objection, that's not what he said. Judge, objection.

MR. WHALEN: Then he can say it then.

THE COURT: Overruled.

You can answer the question, Doctor.

THE WITNESS: I'm sorry, can you repeat it again?

THE COURT: Would you like it read back, counsel?

MR. WHALEN: Yes.

THE COURT: Madam court reporter, can you please read it back?

(Whereupon, the requested portion of the record was read by the reporter.)

A. I -- I -- again, I -- I -- I was not treating him as an ER doctor but I have worked in the emergency room and it is routine that you do to ask a patient what hurts when they come into the ER. And you evaluate the areas where he has the most complaints, um, or where the physician thinks that are the most urgent to be evaluated.

Q. So we can agree that Mr. Sarmiento not reporting pain at the ER is significant?

A. Well, I would say it's -- it's -- it's not significant. Um, I have seen many a time where patients do have an injury to various body parts. They don't present with pain in the ER and have pain days or even weeks later.

Q. You said you believed that the ER record reflects a report of pain to the spine. Is that what you said?

A. I don't know what the records show. I do know that he injured other areas and that he was evaluated in the emergency room.

Q. Would the ER records have been helpful to you in forming your opinions?

A. I would say I'm relying on a patient's history. If something is in the ER records that is significantly different from that, then I would want to review them.

Q. In your first surgery on -- hold on, I believe it was September 19th. No, that's not right.

A. January 18, '21?

Q. Right.

You were looking -- the complaints suggested that the plaintiff, Mr. Sarmiento, was suffering from an anterior cruciate insufficiency and a medial meniscal tear and that was the premise under which he went to surgical intervention; correct?

A. That is correct.

Q. While you were in the knee with your camera and your art -- by the way, this surgery, and all these surgeries, were outpatient surgeries; is that correct?

A. Yes, they're all ambulatory. In other words, the patient did go home the same day.

Q. Okay. And the arthroscopic surgery that you performed showed that there was a medial meniscectomy necessary to be performed; correct?

A. Yes.

Q. And that you did that with a meniscal biter, that's

like a nail clipper that takes away the frayed meniscal?

A. The end of it -- that is a good way of thinking of it actually. I never thought of it that way. But it's like a -- it's a very long instrument that can reach into the back of the knee. But the end of it does look like the end of a nail biter where we use that to bite the loose pieces of meniscus.

Q. And that was a successful surgery? You brought the medial meniscus back to -- with some integrity; correct?

A. So it was a debridement. So we removed the torn segments of the meniscus. And we did leave a rim of meniscus that was not torn in the medial compartment.

Q. So there was still meniscal present to act as a buffer between the thighbone and the tibia, the shinbone?

A. There was still some but a lot of it was removed.

Q. Okay. Doesn't say how much here, does it in your --

A. It was a large tear meaning that it involved a lot of the posterior horn in the body of the meniscus.

Q. Was the meniscus material that you removed sent out to a lab for examination as to where it came from?

A. I usually do not send meniscal tissue for a lab examination.

Q. So without the lab examination you don't know if it was degenerative or spontaneous or something else; would that be fair to say?

A. Well, an observance of the meniscus tear, there was no

evidence of degeneration. Again, the patient was only 30-years old so we don't expect degeneration. It appeared to be an acute traumatic tear of the meniscus.

Q. Okay. But you can't tell how long it's been there or not; is that fair to stay?

A. That is fair to say. I cannot date the time of the tear by looking at it. In other words, I don't know if it's been there a week or a month or six months. But, obviously, if it's been there several years, that would be something that I would be able to tell.

Q. And you discussed this a little on your direct, you noticed that there was some grade one and grade two chondral changes; is that correct?

A. Yes.

Q. And what exactly is that again, the chondral changes?

A. Grade one is softening and grade two is fibrillation of the cartilage. Grade three is partial loss of the cartilage and grade four is complete loss of the cartilage.

Q. And is it possible to assess when you're in there doing this operation and observing this chondral damage how long it's been there?

A. As with a meniscus, you can't put an exact date on -- on -- on the cartilage damage. Again, you rely on the history and the operative findings to help with that.

Q. Regarding the ACL, you found in the course of your

operation that day that you probed the ACL and you found it to be lax, some laxity?

A. Yes.

Q. Okay. So it was stretched -- what's the mechanism of injury for an ACL? Would laxity indicate tear?

A. Um, so the mechanism of injury of an ACL is similar to meniscus injuries where you can have twisting injury, a pivoting injury, hyperextension injuries. And this particular patient he did not have a complete tear. He had a partial tear. So part of the ligament was torn. And the part that was not torn was stretched. So in other words, he didn't really have any part of the ACL that was actually working properly. It was either loose or torn.

Q. Going back to your records. Go to December 14, 2023.

A. Yes, I have that.

Q. Doctor, at the end of all these reports it reflects that they were electronically signed. And in this particular report it's signed by you and your physician's assistant Mr. Cruz; correct?

A. Yes.

Q. So is it Mr. Cruz who actually sees the patient and then he reports to you or do you both see the patient; how does that work?

A. So if it's just my name at the bottom of the report, then I'm the only person seeing the patient.

Q. Of course.

A. If it also has Mr. Cruz's name, he was participating in the treatment of the patient for that visit under my supervision. So the examination could have been done by him or it could have been done by myself. But if it is done by him, it's under my supervision.

Q. But under your supervision meaning you review the report and review his findings, you're not in the same room together doing it?

A. I'm usually in the same room but I'm definitely in the office.

Q. In this December 14, 2023 report you reflect Mr. Sarmiento was overall improved; correct?

A. That's correct.

Q. So he gets occasional soreness, stiffness and discomfort; correct?

A. Yes.

Q. Okay. No medication was prescribed?

A. I do not see anything that was prescribed but antiinflammatory medications were recommended.

Q. Right. I was going to get to that. So Advil?

A. Yes, something over-the-counter such as Advil, Motrin or Aleve.

Q. You saw him for the last time in preparation for this trial. He was sent to your office on September 19, 2025.

MR. GJELAJ: Objection, Judge. He was sent to your office?

THE COURT: So as to form?

MR. GJELAJ: Yes, as to form.

THE COURT: Counsel, please rephrase.

MR. WHALEN: I'll withdraw that.

Q. Did you call or send any messages to Mr. Sarmiento to ask him to come back into your office in September of 2025?

A. I did not personally call him to come in. When he was seen in April, he was advised to follow up with us again.

Q. April of?

A. In April of 2025 he was advised to follow up in nine to 12 months time or PRN, meaning as necessary.

Q. In his visit he told you he does not take any prescription medications for his knee; correct?

A. Let me just pull that report up, I'm sorry.

That is correct.

Q. And at this point in time we're just talking about the right knee; is that correct?

A. That is correct.

Q. Okay. There aren't any complaints here in your report on September 19, 2025 regarding the left knee; correct?

A. That is correct.

Q. And there's not any complaints also regarding the right ankle and foot; correct?

A. That is correct.
Q. He told you his right knee no longer buckles and gives out; correct?
A. That's correct.
Q. He's not receiving physical therapy but he is compliant with a home exercise program?
A. That is correct.
Q. Okay. He ambulates without a brace and without a cane?
A. Yes.
Q. You're impression, again, patient is overall improved; correct?
A. Yes.
Q. The plan was over-the-counter, it says OTC, over-the-counter though, antiinflammatory medications; correct?
A. Yes.
Q. No further MRIs were prescribed; correct?
A. That is correct. Actually it was taken but no MRIs were prescribed.
Q. No x-rays were taken?
A. X-rays were taken -- x-rays were taken that day on this visit but no MRIs were prescribed.
Q. And no prescriptions were written; correct?
A. That is correct.
Q. No scheduled future appointments with him; correct?

A. Um, I did not give a timeframe but I did advise him to follow up as necessary depending on his decondition.

MR. WHALEN: Thank you, Doctor.

THE COURT: Maybe let's take a five, ten-minute break?

MR. GJELAJ: I don't have that much time. I'll finish up.

THE COURT: I understand, counsel. But I want to make sure everybody is engaged for the remainder. So we'll just take a quick five minute just a leg stretch break.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: You may be seated.

(Whereupon, there was a recess taken).

COURT OFFICER: All rise.

THE COURT: You may be seated.

COURT OFFICER: All rise, jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: You may be seated.

Counsel?

MR. GJELAJ: Thank you, Your Honor.

REDIRECT-EXAMINATION

BY MR. GJELAJ:

Q. Dr. Touliopolis, I'll be brief.

You were asked about the time that you've testified in

the last month or so; do you recall that?

A. Yes.

Q. Have you ever testified in court for a case where I was the trial attorney?

A. I don't believe so. No.

Q. Have you ever testified for my firm? It's called Gjelaj Law?

A. I don't believe so.

Q. Are you being paid today?

A. No, I'm not.

Q. You're here pursuant to a subpoena?

A. Yes.

Q. You were asked about the mechanism of injury; do you recall that?

A. Yes.

Q. There was an interpreter that was speaking to Mr. Sarmiento; correct?

A. That is correct.

Q. You don't speak English; right?

A. I speak English but I --

Q. I'm sorry, you don't speak Spanish. Forgive me. I'm trying to go quick. It's late in the day.

A. My Spanish is extremely bad.

Q. So you used the services of an interpreter; right?

A. Yes.

Q. He told you that he fell down the stairs?

A. That's what I have in my notes, yes.

Q. Are you aware that the word in Spanish for stairs is the same exact word as the word for ladder; are you aware of that?

MR. WHALEN: Objection, Your Honor.

THE COURT: Basis?

MR. WHALEN: Knowledge. He's making a statement as to what is what.

MR. GJELAJ: I'm asking if he's aware.

THE COURT: Overruled.

A. I was not aware of that, no.

Q. Do you know that yesterday we had an interpreter here who got confused as to whether (Spanish word) meant stairs or ladder?

MR. WHALEN: Objection, Your Honor.

THE COURT: Sustained.

Q. Okay. Mr. Sarmiento testified yesterday under oath and every single medical record, other than the one that you were questioned about, states that he fell approximately 10 feet from a ladder. Is that the type of mechanism that can cause the injuries to the knees and to the ankle that you testified to?

MR. WHALEN: Objection, Your Honor.

THE COURT: To form?

MR. WHALEN: Every single record.

MR. GJELAJ: Other than the one you were cross-examined on, that was my question.

THE COURT: Sustained. Please rephrase.

Q. Mr. Sarmiento testified that he fell nine to 10 feet, his feet were nine to 10 feet above the ground when he fell down to the ground below. Is that the type of fall that could cause the injuries in the knees and in the ankle that you told us about?

A. Yes.

Q. You were asked before about Mr. Cruz. Who did the surgeries?

A. I did.

Q. All three?

A. Yes.

Q. Did Mr. Cruz have anything to do with those surgeries?

A. He probably assisted me, but I'm the primary surgeon.

Q. You own the practice; correct?

A. That's correct.

Q. Do most orthopedic surgeons use a physician's assistant?

A. Depending the type of surgery, they usually have an assistant. It can be a physician assistant or a resident.

Q. What about the office visits, do most orthopedic surgeons use physician assistants in office visits?

A. A lot of them do.

Q. Okay. Has your opinion changed, at all, due to Mr. Whalen's questions during his cross examination?

A. No, it hasn't.

Q. Do you still have an opinion within reasonable degree of medical certainty as to what the competent producing cause of the condition in both knees and the angle are?

A. Yes.

Q. What is that opinion?

A. The result of this work accident.

Q. Okay. You were asked about that last visit on September 19, 2025. Do you recall that?

A. Yes.

Q. Subject to connection, are you aware that Mr. Sarmiento does, in fact, have a follow-up appointment scheduled with you?

A. I just thought -- I don't have access to my computer system. So he may or may not. I just don't know.

Q. You don't do the scheduling, do you?

A. I don't.

Q. You have somebody that's employed by you that does that?

A. Yes.

Q. Now, in that last visit, Mr. Whalen read to you a portion, again patient is overall improved; do you recall that?

A. Yes.

Q. But there's a continuation to that sentence; isn't there?

A. Yes.

Q. Can you please read that for the jury?

A. I have that --

Q. Under impression.

A. Okay. Um, again, the patient is overall improved but does have residual symptomatology attributed to his chondral injuries and degree of progressive posttraumatic right knee degenerative joint disease which appears to be involving predominantly his medial compartment.

Q. And that's what you told us about and told the jury about when you looked at the x-ray there; correct?

A. At the inside of the knee. Yes.

Q. So he's overall improved but he's got this permanent condition; is that fair?

A. Yes.

Q. And that condition it's going to require a knee replacement; isn't it?

A. Yes, partial knee replacement. Yes.

Q. Is that within a reasonable degree of medical certainty?

A. Yes, it is.

MR. GJELAJ: Thank you, sir.

MR. WHALEN: Just one more.

RECROSS-EXAMINATION

BY MR. WHALEN:

Q. The partial knee replacement, Doctor, that's a possibility?

A. No, I believe it -- it -- it will be required. I just can't tell you for sure when. But based on the progression of the x-rays over the last few years, I do believe that he will require it in his lifetime.

Q. In his lifetime?

A. Yes. But I would say it's hard to date it but, um, I don't think it will be in the distant future.

MR. WHALEN: Nothing further.

THE COURT: Thank you.

Okay. So Dr. Touliopolis, you can step down. Thank you.

(Whereupon, the witness exits the courtroom.)

THE COURT: Okay. So at this time we're going to break for today. We will be up, meaning that there will be -- the trial will continue tomorrow, Wednesday. We will be down on Thursday, meaning that no one has to come in on Thursday and then we'll resume on Friday.

We've discussed the schedule for next week. And it's our understanding that we should be going every day next week with the expectation that we are going to -- and with the expectation and goal, I say that because it is not

always 100 percent, things don't always go according to the schedule, you know, sometimes things might take longer than what was anticipated and that kind of thing can lead to delays. But it is anticipated that if we continue at the pace that we are, that everything should be wrapped up by Friday. And that means that the closing arguments should be presented and your deliberations should begin ideally at the time. Again, this is just so that as you guys are thinking about how to structure your lives in these coming weeks, you will have that kind of -- and so the goal is for us to be done completely by the November 3rd day which is the Monday after next week. So, again, that's the goal.

So with that being said, and with us having that ambitious goal, we're going to begin starting at 9:30 instead of the 10:00 a.m. start time. Again, just to try to ensure that we are moving along and we are able to wrap this up as soon as possible.

So with that, I hope you guys have a good night tonight and I'll see you tomorrow morning at 9:30.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: You may be seated.

Okay. So I expect that we should hear back from juror number three definitively one way or the other tomorrow morning and we can take that issue again with the

additional information after she's had time to process the schedule update.

Otherwise, I don't believe there are any other issues that we need to cover. So, again, we discussed it at the sidebar, but just to confirm, I said the start time 9:30 but we plan on beginning calling witnesses at 10:00 a.m.

(Time noted: 4:23 p.m.)

(Whereupon, Court is recessed and the case adjourned to Wednesday, October 22, 2022.)

* * * *

I, Valerie E. Monaco, certify that the within proceedings are a true and accurate transcript of the original stenographic record.

_____
Valerie E. Monaco
Senior Court Reporter

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