1999 WL 34833172 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
Bronx County

FLORENCIA FLORES,
v.
PARKCHESTER PRESERVATION COMPANY, L.P., et al.

No. 1999-24500.
1999.

(Transcript of Thomas Kolb, M.D.)

Name of Expert: Thomas M. **Kolb**, M.D.
Area of Expertise: Medical & Surgical >> Radiology
Area of Expertise: Medical & Surgical >> Pediatrics
Representing: Unknown
Jurisdiction: Bronx County, New York

[Note: Pages 1-115 missing in original document]

DR. THOMAS KOLB, having been called as a

witness by and on behalf of the Plaintiff in this case, having been first duly sworn, testified as follows:)

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

THE WITNESS: Thomas Kolb, K-O-L-B, M.D. 222 East 68th Street, New York, 10021.

THE COURT: All right.

MR. GORAYEB: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. GORAYEB:

Q Dr. Kolb, are you a physician licensed to practice medicine in the State of New York?

A Yes.

Q What is your field of specialty?

A Diagnostic radiology.

Q Would you please, briefly, describe to the jury your educational and professional background and qualifications?

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A Went to college here in Queens College, City of New York, graduated in 1979. I then went to medical school in Brooklyn at Downstate Medical Center and graduated in 1983. I then did a pediatric internship and residency here in the Bronx at Albert Einstein College of Medicine, became a pediatrician and finished that program in 1986, became Board certified. I then went back and did a second residency from 1986 through 1990 in radiology at, in Manhattan Columbia Presbyterian Medical Center and became again Board certified in radiology. And from 1990 to the present I've been practicing radiology.

Q And within the practice of radiology do you have a specific specialty?

A Yes, my specialty is in breast cancer diagnosis and in orthopedic imaging. It's my two main focuses.

Q At the request -- and, Dr. Kolb, at the request of our office did you review certain firms concerning Florencia Flores?

A Yes.

Q And did you have a chance to review those same films this morning here in the courtroom?

A Yes.

Q With her Honor's permission, would you please use the films to describe the conditions that are present in Florencia Flores?

THE COURT: Do we have the shadow box?

MR. GORAYEB: Your Honor, with your permission we can use the blowups and the easel.

THE COURT Okay.

Q Dr. Kolb --

THE COURT: Can all the jurors see? Okay.

Q The blowups are premarked, so just refer to which one you're looking at.

A Yes. I'm going to put them in order of the dates. All right.

Q Which blowup is that?

A This is number 2-A. And these are X-rays of this patient, Florencia Flores' elbow, taken 4/19, 1999, April 19, '99. We have two pictures here.

And for what I'm going to talk to you, we're going to limit ourself to the elbow. The elbow is, obviously, a joint that we can move up and down like this, but we can also turn like that, there's movement in the elbow when we turn our arm like that.

MR. GOLDSMITH: Objection. I don't even know there's a question on the floor.

Q Okay, Doctor, would you please describe for us what's depicted in the X-ray?

THE COURT: Sustained.

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Q Would you please describe for us what's depicted in the X-ray and the function of the elbow as what's depicted, what it pertains to it?

A Okay. So what we're seeing here on these particular pictures with the elbow, there are three bones in this picture. And those are the three bones of the elbow. One bone that comes down our arm, that's call the humerus, and then two bones in the forearm, radius and ulna. So three bones that connect up at the elbow. Here's the two bones in the forearm, a radius and the ulna. And this is the bone coming down from the shoulder to the elbow, this is the humerus. Then there's another piece of bone out here that's been broken off. And this is a fracture.

What happened here is that -- on number 2-F, taken April 19, 1999, the same day. You can see here the elbow, this is the bone coming up from the shoulder down to the elbow, the humerus, and these are the two bones of the forearm. And you'll see that in this bone there should be one bone here. That's the bottom bone that you feel here, point of your elbow, there's a big crack right here, this is fractured. And the ligament that attaches to this bone is pulling it away from the other bones, so there's a fracture going through this bone, a fracture of the ulna. And this point of the elbow has a fancy name, called the olecranon. It's still just the ulnar bone, so the fractures of the ulna or the olecranon, and the fracture goes through from the outside of the bone all the way to the inside of the bone.

Q I'm sorry, Dr. Kolb, would you tell us whether, where in that photograph there's a joint shown, and whether the fracture involves the joint?

A You also have to remember this entire area here, when bones come together it forms a joint, that allows us to move. And a joint has things in it like fluid which allows us to move smoothly, and some cartilage in there and everything from here, from the back of this bone all the way to the front around the entire humerus where the bone gets near the bone here, is the joint. So the joint extends from here all the way around to here. So you can see this fracture line going directly through the ulna through the olecranon, fracture right through into the joint space. So there's a fracture that extends all the way from the outside of the bone to the inside of the bone. So the fracture involves the space itself, and that's called an infra-articular fracture, or fracture that extends into the bone.

Also on these pictures there is fluid in the joint space, called the joint effusion. And that also tells you that the fracture extends into the joint space because there's fluid not just swelling outside in the soft tissue that you feel, but inside the joint space there's also a joint effusion, meaning there's fluid in the joint.

Q Explain to the jury where that is and how you can see it?

A Well, the joint effusion is -- this is also taken 4/19.

Q Which picture is that?

A This is number 2-B. First we looked at 2-A, then 2-F, now 2-B.

And again you can see the fracture being pulled off here, it's a big piece of bone being pulled off, and the fracture line going straight into the joint, and then there's a line coming up here as well, which you can see well on the original films, the front of the joint space here, which is lifted, and that has a fancy name called a sail sign. In any case, that tells you that there's liquid inside the joint that's normal.

So the finding here, the major finding here on the initial films when the patient first had these films done, is that there's a fracture straight through of this bone, the olecranon or the ulna, the bone itself is being pulled away from the other bone and the fracture extends into the joint space, there is a joint effusion fluid in the joint, and also there's a big soft tissue swelling around the joint as you would expect whenever there would be a fracture like this. So those are all the findings on the initial films.

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Q Doctor, would you go to the next film in chronological order and tell us what that depicts?

A Now, this is, the next film is May 12, 1999. May 12, 1999. Again, just to set it up the way, looking at it the way we just did, if you remember, here we have the bone coming in from the humerus from the arm, and this is the two bones coming in the forearm, and here's the shoulder -- I'm sorry, the elbow joint. But, so the shoulder is here, here's the arm, here's the elbow, we talked about the joint space going around here, we talked about the fracture in this bone which is right here, and you can see the fracture, there's still a line going through it, but the surgeon went in and fixed this, meaning they opened up the elbow, did surgery and did two things, inserted two pins through the fracture line, through the fractured bone into the bone that's not fractured, and also into the bone that wasn't even involved, which is the radius. Which is this other bone right here. And they also took wire loop and attached it to the bone and attached it to the ulna here, which is not fractured.

The point of this is they want to grab the piece of fractured bone and bring it together to the bone that's not fractured for it to heal. Because if you don't bring the bones together, it will stay apart, won't heal. That's what was done here.

These are staples in the skin. They went in and opened up the elbow and they put these devices in, wire and the pins, and then they put, closed up the skin with staples.

And if you look at it from the front, straight from the front, from the, a side view, looking from the side, if you look at the elbow from the front, you see here a looping wire, a figure eight wire which is attaching the fracture. When you look at it from the front, the fracture is in the back, So you're going to have all the bones, you're going to have greater difficulty seeing the fracture.

MR. GORAYEB: Doctor, speak a little slowly, there's smoke coming out of her fingers.

A The fracture is here. Because we're looking straight through all the bones, the fracture, the back of the elbow. And we're looking from the front to the back. So here we have that loop wire, and here are the two pins that we talked about going through the fracture, and here are the staples. Bottom line, the patient had internal fixation with surgery. Had a wire put in, had two pins put in, two nails put in, and then was closed up and, hopefully, will heal.

Q Okay. Doctor, let's go to the next films, please.

A The next one is 2-E. That was done on August 19, 1999, which is three months later. And here you see what we talked about before. The nails are still in, the wire is still in, and you see what we had here before. So these are films that are taken of an injury, after a patient gets fixed like this they take films with all the hardware in to see how the patient is progressing. And the fracture is healing, it's getting closer together and the fracture fragments are healing.

The next one is 2-C, which was done in February 2000, which is about six months later. Again, we see about the same picture, but look what's happened here, is ?? this fracture line that was right here is now clos??. So the fracture, bone is forming, between the fractured bone and the non-fractured bone to bring it together. So this is working. The wires that were put in and the pins that are going through, that's working.

Now, two things have happened though during the interim. That is, we're now a number of months, or ten months away from the fracture, two things have happened. If you look at this bone down here and you look at this bone here, you'll see that this bone is darker. The reason why this bone is darker is because it's starting to lose calcium because of not being able to use, which is called disuse of the elbow. Calcium is leaching out of bone, coming out and losing strength. Meaning that it's at further risk of fracturing as well.

Second thing that is happening is that the joint space that we talked about, remember we talked about the fracture going right through the bone into the joint space, is starting to narrow. In other words, the point where the fracture is up here is much

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narrower or thinner than the point here. And that's arthritic. So there are arthritic changes occurring in the elbow about ten months after the fracture. Sc those are two new findings that are occurring as a result of this trauma to the elbow.

THE COURT: What exhibit is that?

THE WITNESS: That was 2-C. Sorry.

Q Go ahead, Doctor, what film is that?

A Next is 2-G.

Q What is the date?

A This one is -- I thought the original films -- the next two have no dates on them.

Q Okay. The original films?

A Well, let me not talk about them. Let's not talk about them. They're not dated.

Again, on 2-J, which is June 2000, four months later we see what we've been talking about all along, the pins are still in, the wires are still in. Again you can see very clearly here the fracture site that we have osteopenia, which means loss of calcium, bone weakening here, and now we see the joint space is even narrower than it was before. So we have two things ongoing, losing calcium from the bone, weakening of the bone, and arthritic changes of the elbow with orthopedic hardware still in the elbow.

And, finally, on 2-D, which is 3/29/04, which is almost four years later, the hardware has been taken out. See, the pins and the wire are all gone, somebody went in and took out the hardware. And what we're left with is areas of arthritis in the joint. The bone is healed, the bone is now together. It was apart when we started five years before, the bone is now together but we have arthritic changes in the elbow, we have the loss of calcium from the bone, which weakens the bone, and we still have swelling in the joint spice that persists. And that can either be from the arthritis, that is ongoing which is likely to be the cause, or a piece of bone that may have a little tiny piece of bone that may have fractured off from the larger fracture in the joint space that's still there causing an irritation which would cause the effusion or water in the joint space as well.

So what we're left with, to sum it up, was fracture of the olecranon, or ulna, which extended into the joint space which was fixed orthopedically with these wires and pins which subsequently caused an arthritic condition to the elbow, which, what we talked with the narrowing of the joint space, a persistent or continued effusion or water in the joint space due to either the arthritis or a small fragment of the fracture still being there in the joint space, and loss of calcium, or osteopenia from the joint which will weaken the joint at risk for further fracture. So those are the major findings of all these films.

Q Doctor, please take the stand.

(Witness resumes the witness stand.)

Q Doctor, I want you to assume that prior to April 19, 1999, Florencia Flores was a healthy twenty-five year old Hispanic woman with no history of injury or trauma to her left elbow; that on that day while walking on a path at Parkchester Apartments she was caused to trip and fall, at which point she sustained the injuries that you've described for us.

Do you have an opinion, Doctor, with a reasonable degree of medical certainty as to whether those fractures were causally related to the fall of April 19, 1999?

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MR. GOLDSMITH: Objection.

THE COURT: What's your objection?

JURORS: Objection is he's a radiologist, he's a diagnostician, he cannot be discussing the causal relationship at all as to how this fracture occurred.

THE COURT: Well, do you want to say something, sir?

MR. GORAYEB: It's exactly his specialty, your Honor. He sees these things, I think he sees these things all the time, and based upon my hypothetical, which has been established by Florencio Flores, and the rest of which I ask to be subject to connection, because I'm going to have other witnesses come in, and we'll finish with Ms. Flores' testimony, and he does have the ??oundation and expertise to --

THE COURT: You want to voir dire?

MR. GOLDSMITH: Sure.

THE COURT: I'll allow that.

VOIR DIRE EXAMINATION

BY MR. GOLDSMITH:

Q You didn't examine Florencia Flores on April 19th of 1999, correct?

A No, I did not physically examine her, that's correct.

Q And you did not physically examine her during 2000 after her open reduction and internal fixation?

A That's correct.

Q And you were not there at Lincoln Hospital w?? she arrived in the emergency room on April 19th of 1999, correct?

A That's correct.

Q You've only examined her films, is that correct?

A Yes.

Q And you've only examined her films of quite recently, isn't that correct?

A Yes, within the past year.

Q And based totally on the films, there's nothing within those films that would indicate to you as to how she received that fracture, isn't that correct?

A No, I'd have to be told how she fell down, or was injured, the hypothetical.

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Q Baser on the hypothetical, you would still need multiple information to give an accurate, accurate description of the impact of the blow upo?? the individual bones, isn't that correct?

A No, I was just being asked whether if she was asymptomatic, fell down, and we had these films, whether the falling down caused those fractures, that's all I was asked, and the answer was yes, that's what I do, I look at films, including trauma films.

Q But to that extent you could only discuss the fact that an initial -- the incident in and of itself caused the fracture and nothing else about the incident, isn't that correct?

A From what I was told, yes.

MR. GOLDSMITH; Nothing further.

THE COURT: You still have an objection, sir?

MR. GOLDSMITH: To the extent that he could limit his testimony based on that, I have no objection.

THE COURT: Okay. H?? testimony should be so limited to those facts.

DIRECT EXAMINATION CONTINUED

BY MR. GORAYEB:

Q Assume the same hypothetical and testimony you just gave us, that this condition has been present now for over five years; do you have an opinion with a reasonable degree of medical certainty as a radiologist as to whether the conditions that you've just described to the jury are permanent in nature?

A They, the arthritic cond??cion that I described are definitely permanent. Absolutely.

Q And, Dr. Kolb, have you had occasion to view films for our office before?

A Yes.

Q And have you had occasion to come to court and testify before?

A Yes.

Q And you're being compensated for taking time out of your office?

A Yes.

Q And did you have to reschedule your office?

A Yes.

Q What are you being compensated for your time?

A Fifty-five hundred dollars.

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Q Thank you, Dr. Kolb.

MR. GORAYEB: Thank you your Honor. Nothing further.

THE COURT: Okay, sir.

CROSS-EXAMINATION

BY MR. GOLDSMITH:

Q Dr. Kolb, you are, you have referred to, what you call this, some degeneration in the joint. Based upon what you know, would it be likely a tiny piece of bone could be causing irritation?

A It's possible.

Q It's possible that within the timeframe of the actual event and seeking medical attention, that had the plaintiff moved her arm around, she could have displaced some of that fracture causing a chip to move, isn't that correct?

A Anything is possible, can make anything up to that extent.

Q And it's also possible some of this further irritation from that bone chip could be causing or contributing to the arthritis which you've referred to as progressive, isn't that correct?

A It's possible.

Q And the calcium loss which you've referred to, is, would it be fair to say that it would be, or would it be fair to characterize that as a side effect of the surgery?

A No, side effect of disuse. In other words, the patient is not using her elbow normally and, therefore, the bones that aren't being used normally are losing the calcium.

Q So it's possible that someone who had this surgery, who had the use of the wires and the pins, could be using their elbow in a similar, normal fashion, isn't that correct?

A I'm sure it's possible.

Q And it's possible that if they were using their elbow in a normal fashion, that they would not have experienced such a loss in calcium density, isn't that correct?

A Yes.

Q Doctor, you co-founded a mammography screening program, isn't that correct?

A Many years ago.

Q And you have your post doctoral training in mammography at Columbia Presbyterian?

A Post doctoral training in radiology which includes mammography, yes.

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Q Doctor, you work about five days a week?

A Five days a week.

Q And your hours are 8:00 to 5:00, give or take?

A Well, often later than 5, maybe till 6 or 7 sometimes.

Q And you perform, you and your partner perform about three hundred mammographies a week?

A No. I would say two hundred or, give or take between one fifty and two hundred.

Q And in terms of some of the publications that you've contributed to, those include the utility of the breast ultrasound clinically asymptomatic in mammographically normal patients?

A That's not a title of my paper but I wrote papers about that, correct.

Q Including an ultrasound differentiation between benign and malignant breast cancer?

A Yes.

Q You're also member of the New York Metropolitan Breast Group?

A Yes.

Q You've also dealt with occult cancer in women with dense breasts?

A It's correct.

Q Effect of breast density, age and hormonal status upon b??ast cancer detection?

A That's correct.

Q Ultrasound differentiation for fine needle aspiration and open biopsies in breast cancer detection?

A Yes.

Q And you'd also agree with me that the anatomy of the female breast is far different from that of an elbow?

A I would agree with you.

Q And when you're using your mammographies, you use ultrasounds and sonograms, isn't that correct?

A When you use mammography you use X-rays. Ultrasound is separate tests, sound waves.

Q Okay. And there's not any dense bone matter within the female breast that you're looking at?

A You're correct.

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Q There's certainly no joints in the female breast?

A There are no joints in the female breast.

Q And are you able to tell with any degree of certainty from these films how there would be a difference in the actual machinations of a joint?

A You can tell that there, where the fracture is, you can tell the ligament that attaches to the fracture where the patient should be having pain and limitation of motion. After the patient is fixed with the pins and wires you can also predict where the patient would have limitation of motion as well.

Q Well, but you can't tell exactly what their range of motion might be, based solely on these films?

A No, you would test the patient.

Q And you haven't tested Florencia Flores?

A I've not done a physical examination on this patient, no, that is correct.

Q Doctor, as a radiologist you don't do any long term therapy at all, correct?

A I don't do therapy at all, period, I don't treat, I only diagnose.

Q And you wouldn't be able to discuss the ramifications of any different kind of treatment on a particular plaintiff?

A I can discuss the, all I can discuss is over time how things look and predict how things will be, but I can't say the ramifications of a particular treatment.

Q And you can only discuss with a degree of certainty the treatment that the plaintiff has undergone from 1999 up until the last film, I believe March 29th of 2004, correct?

A Yes.

Q So, Doctor, would you be able to give any kind of a conclusion whatsoever about how well the joint may be --

MR. GOLDSMITH: Withdrawn.

Q You wouldn't be able to give any kind of conclusion whatsoever about the quality of the surgery as performed on Florencia Flores?

A No. Well, to the degree that the pins look like they're in good position, and post the pins being taken out and the hardware being taken out, that the bone, the fractured bone has fused with the non-fractured portion of the bone, to that degree I can.

Q But aside from the actual fusion of the fracture, that's visible, and the rest of the bone, you cannot speak to the quality of the care?

A The quality, no.

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Q In your experience, Doctor, with your own patients, have you seen any expectations of one hundred percent recovery with this kind of a fracture?

A You'd have to ask a clinician for a hundred percent. There are abnormalities that persist on those films after the surgery, after the surgical hardware has been removed. To answer your question, as to whether there's been complete recovery after surgery like this, I think it's on an individual basis, and every patient would have to be, you know, determined that way, I don't think I can give a blanket answer to that.

Q Doctor, I didn't see any photographs taken recently that are fully extended. Did you happen to notice any there?

A I'd have to go up and look.

Q Please feel free.

A Yes, you have a fully extended one on 2000, June 2000, number 2-J. This one here is extended.

Q That's fully extended with the hardware in it, correct?

A With the hardware. Well, I can't say fully extended, looks like there's some bend in it here because the bones are not completely -- it's not completely, I can't see for sure it's fully extended or there's limitation of extension, based on this picture, but it is, an attempt was to take one of an extended elbow.

Q Would y u be able to tell with any degree of certainty as to what the degrees of extension may be on that photograph?

A No.

Q On that X-ray?

A No, it can't be measured on that picture.

Q I'm sorry, which date was that again?

A June 2000.

Q June 2000?

A Yes.

Q Okay.

(Witness resumes the witness stand.)

Q Doctor, were there any other X-rays -- I'm sorry that you walked back -- are there any other X-rays of a fully extended arm or an attempt to fully extend the arm?

A Whenever we take the elbow we always want to extend it as much as possible.

Q Can you just take a look? I want to know if there's any other fully extended or attempt to --

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A Yes, there's an attempt on number 2-C, February, 2000. I mean in every one of them there will be an attempt to extend as much as possible. And then there's 2-E, which is August '99. And even when they put the pins and wires in, which was 2-I, and that is May 1999, all the way back, even at the time of the fracture they attempted to fully extend it. So every time we take pictures of the elbow, we always want to take one from the side and one from the front as much extended as possible. So the answer is there are many.

Q And once again, on each and every one of those there's no degree of certainty that you can tell to measure the degree of extension?

A Right.

Q Nothing further.

REDIRECT EXAMINATION

BY MR. GORAYEB:

Q Dr. Kolb, would you tell the jury how frequently over the course of a week you read film?? concerning orthopedic injuries?

A Very frequently, extremely frequently.

Q And approximately how many would you say?

A Plain films and MRIs, in a week, I would say easily over a hundred.

MR. GORAYEB: Thank you, your Honor. Nothing further.

THE COURT: Anything, sir?

MR. GOLDSMITH: No.

THE COURT: Thank you very much, Doctor.

(Witness steps down.)

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