TESTIMONY OF DR ALI GUY; 2000 Trial Trans. LEXIS 685

New York Supreme Court, Nassau County

027769-95

July 6, 2000

Reporter
2000 Trial Trans. LEXIS 685 *

JANET WATERBURY AND JAMES WATERBURY, Plaintiff v. YVES N PASCAL AND MARIE JACQUES, Defendant

Expert Name: Dr. ERAJ GUY, M.D., F.A.A.P.M.R.

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Counsel

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Proceedings

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[2]THE COURT OFFICER: Jury entering.

[3](.Whereupon, the jury entered the jury box.)

[4]THE COURT: Ready to proceed, counsel?

[5]MR. BUTTAFUCCO: Yes.

[6]The plaintiff calls Dr. Ali Guy to the

[7]witness stand.

[8]D R. A L I G U Y, having first been

[9]duly sworn, was examined and testified as follows:

[10]THE CLERK: For the record, **[*2]** state your name

[11]and spell it, please.

[12]THE WITNESS: Dr. Ali, A-L-I, last name Guy,

[13]G-U-. Fifteen Jericho Turnpike, Jericho, New York

[14]11753.

[15]THE COURT: Proceed, counsel.

[16]DIRECT EXAMINATION

[17]BY MR. BUTTAFUCCO:

[18]Q Good morning, Dr. Guy.

[19]A Good morning.

[20]Q Doctor, are you a duly licensed doctor,

[21]licensed to practice medicine and surgery in the State

[22]of New York?

[23]A Yes, sir, I am.

[24]Q When did you receive your license?

[25]A 1985.

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[2]Q Can you briefly go over your educational

[3]background?

[4]A Yes. High school, I went to Bayside High

[5]School. College. was Queens College, Flushing, New

[6]York. Medical school I graduated from University of

[7]Northeast Dominican Republic June of'81.

[8]Thereafter I did three separate

[9]residencies. My first residency was in the field of

[10]internal medicine Mt. Sinai. School of Medicine, Mt.

[11]Sinai Medical Center for a period of eighteen months.

[12]Then I did one year of general surgery at Cabrini

[13]Medical Center. Then I did three years of physical

[14]medicine and rehabilitation at Mt. **[*3]** Sinai School of

[15]Medicine, Mt. Sinai Medical Center.

[16]I'm board certified in the field of physical

[17]medicine and rehabilitation.

[18]I'm the director of, the department of rehab

[19]medicine at Maimonides Medical Center, Brooklyn, New

[20]York where my duties are to be in charge of all the

[21]in-patient, out-patient rehabilitation services,

[22]conducting teaching rounds to the house staff, to the

[23]orthopedic residents, to the internal medicine.

[24]residents, to teach the physical therapy students, the

[25]physician assistant students and also render quality
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]

[2]assurance to other doctors in my department and render

[3]consultation to other specialists in my hospital.

[4]I'm also the director of the neuro-muscular

[5]equipment clinic at Hospital for Joint Diseases _

[6]Orthopedic Institute where I'm also the clinical

[7]instructor'to the residents from NYU that rotate

[8]through that hospital.

[9]Q You mentioned, Doctor, that you are board

[10]certified. Can you explain to the jury what it means

[11]to be board certified?

[12]A To be board certified in my specialty, which

[13]is the highest specialization **[*4]** or degree you can obtain,

[14]you have to fulfill the following prerequisites:

[15]First, you have to have training in a field

[16]other than physical medicine and rehabilitation, namely

[17]and preferably internal medicine and/or general

[18]surgery. That was met.

[19]You have to pass the yearly examinations

[20]given by your department. You have to score at least

[21]seventy per cent or higher, get good evaluations on a

[22]monthly basis from your teachers during your

[23]residency.

[24]You then must take your boards part, which

[25]encompasses an eight hour written examination which
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[2]covers everything you learned from the beginning to

[3]that point.

[4]You then have to prepare for your boards part

[5]two, which is a half day oral examination which

[6]encompasses everything you learned from the beginning,

[7]plus additional clinical experience.

[8]You have to be in private practice for a

[9]period of not less than eighteen months, be sponsored

[10]by two other board certified doctors.

[11]You then fly to the Mayo Clinic in Minnesota

[12]where all the research and textbooks are written. You

[13]get tested by a group of doctors on orthopedics, **[*5]**
[14]principles of neurology, principles of physical

[15]medicine, rehabilitation, interpretations of x-rays,

[16]CAT scans, MRI's, EMG's and you must prove to these

[17]doctors that your knowledge is up to par.

[18]If you do, they pass you, then you are given

[19]the title of Diplomate of the American Board of

[20]Physical Medicine and rehabilitation. That title was

[21]met in May of 1989.

[22]Q Were you ever chief resident in any of your

[23]training programs?

[24]A Yes, sir, I was chief resident in my training

[25]at Mt. Sinai in physical medicine and rehabilitation
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[2]for a period of six months.

[3]Q Are you clinical instructor at any major

.4 teaching facility?

[5]A Yes, Hospital.for Joint Diseases, Orthopedic

[6]Institute and Maimonides.

[7]Q What does it mean to be clinical instructor?

[8]A You have to be board certified, in good

[9]standing, you have to pass the credential committee of

[10]that hospital. You have to possess knowledge to teach

[11]and then you are given the ability to teach.

[12]You are on probation for one year. If your

[13]work and performance is good, you are **[*6]** asked to

[14]continue.

[15]Q Are you a member of any major medical

[16]organization?

[17]A Yes I'm a diplomate and fellow of the

[18]American Board of Physical Medicine Rehabilitation,

[19]member of the Queens County Medical Society and the New

[20]York State Medical Society.

[21]Q Now, you mentioned physical medicine and

[22]rehabilitation. Could you please explain to the jury

[23]what that is?

[24]A It's a medical specialty that was founded

[25]shortly after World War II by Dr. Harold Rusk, hospital
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[2]named after him, the Rusk Institute, at NYU. It's a

[3]fifty-five year old medical specialty. There are

[4]approximately six thousand, seven thousand doctors in

[5]this specialty which are board certified.

[6]It's the most holistic of all the medical

[7]specialties because it deals with so many different

[8]disciplines. It deals with neurology, orthopedics,

[9]kinesiology, which is the study of motion, and internal

[10]medicine, pulmonary rehabilitation, cardiac

[11]rehabilitation. So you really have to know your

[12]internal medicine and your other disciplines to be able

[13]to treat a patient as a whole. It **[*7]** deals with

[14]orthopedic problems, neurological problems. It deals

[15]with disabilities and impairments.

[16]We treat patients from all walks of life,

[17]from birth defects, from multiple injured patients with

[18]cerebral palsy, with polio, to patients with strokes,
19. multiple gun shot wounds, car accidents, sports

[20]injuries, carpal tunnel syndrome. You name it, so on

[21]and so forth.

[22]How we differ from an orthopedic surgeon is

[23]an orthopedic surgeon concentrates on specifically the

[24]bone system of the body and mostly the surgical aspects

[25]and the fractures of the bone.
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[2]A physiatrist deals with the whole body and

[3]we try to prevent surgery if at all possible..

[4]How we differ from a neurologist, a

[5]neurologist concentrates on mostly disorders of the =
.6 central nervous system such as multiple sclerosis,

[7]Parkinson's disease, Lou Gehrig's disease, so on and so

[8]forth.

[9]A physiatrist, which is doctor of physical

[10]medicine and rehabilitation, deals with disorders of

[11]the central nervous system as well as disorders. of the

[12]spine and the peripheral nervous system, such as nerve **[*8]**
[13]root problems, disk herniations, nerve injuries to the

[14]hands or arms.

[15]Of course there is a great deal of overlap

[16]between what we do and the other two specialists do and

[17]we cross refer patients back and forth to each other.

[18]Q Now, as part of your training, did you

[19]receive formal training in neurology, in orthopedics,

[20]internal medicine, general surgery, interpretation of

[21]x-rays, MRI's, CAT scans and EMG's?

[22]A Yes, sir.

[23]Q What training did you receive?

[24]A Training in both. Internal medicine for a

[25]period of eighteen months. I did a formal rotation in
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[2]neurology for a period of two months and every third

[3]night we would admit patients. The patients we

[4]admitted had multiple problems, including neurological

[5]problems and we would have to present these cases to -

[6]our preceptors who would teach us additional

[7]information after each case presentation.

[8]Also, any general surgery, there were

[9]multiple trauma cases that had neurological

[10]complications. I rotated through the neurosurgical

[11]division of.my hospital during my general surgery.

[12]Also **[*9]** in physical medicine rehabilitation,

[13]most of the patients have neurological problems.. We

[14]had combined neurology rehab clinics. We had formal

[15]teachings from the neurology department. So a

[16]combination from the three different trainings that I

[17]have had.

[18]Q I'm going to ask you to slow it down a little

[19]for the reporter's sake, just so we can help her.

[20]THE COURT: Also allows the jury and the

[21]Judge to absorb what the witness is saying.

[22]Q Now, you mentioned - - in my question I

[23]mentioned CAT scans and MRI's. Have you read CAT.

[24]scans and MRI's? [

[25]A Yes.

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[2]Q Have you been trained to read them?

[3]A Yes.

[4]Q How many CAT scans and MRI's have you read?

[5]A Thousands.

[6]Q Where did you receive training for that?

[7]A Again, in my training in internal medicine,

[8]general surgery, physical medicine and rehabilitation.

[9]Q Does your f ield.deal with traumatic injuries,

[10]physical medicine and rehabilitation?

[11]A Yes, sir, it does.

[12]Q Can you explain, please, how it applies?

[13]A My **[*10]** field is called physical medicine and

[14]rehabilitation. Who needs rehabilitation are people

[15]that have been injured or people that have a birth

[16]defect or people that have had some sort of injury to

.17 the body that required rehabilitation.

[18]So most of our patients are either birth

[19]defect injuries or they are accidents, whether it's on

[20]the job, from a car accident or a sports related

[21]injury.

[22]Q As a result, does your field deal with

[23]disability and impairment valuation?

[24]A Yes.

[25]Q Do you perform such evaluations?

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[2]A Yes, sir, I do.

[3]Q How often do you do that?

[4]A At the hospital I work at, almost every day.

[5]In my private practice, periodically.

[6]Q For whom do you perform such evaluations?

[7]A For my patients.

[8]Q Have you ever testified before in court?

[9]A Many times.

[10]Q How many times, approximately?

[11]A In my fifteen year career as a physician,

[12]slightly more than a hundred. Between a hundred to a

[13]hundred and five times. Could be a little more or

[14]slightly less. Averages **[*11]** to be approximately seven to

[15]eight times per year.

[16]Q How come you are in court so much?

[17]A I don't think it's so much. It's the

[18]patients that I treat. It's like asking how come

[19]every cardiology patient has chest pain. It's the

[20]nature of my practice.

[21]Q Do you give lectures to various people?

[22]A Yes, sir, I do.

[23]Q Who do you give lectures to?

[24]A I give lectures to just about every walk of

[25]life. Doctors, nurses, police officers, firemen,

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[2]medical students, rehab nurses, the legal sector,

[3]attorneys. Just about every walk of life.

[4]Q Now, what percentage of your practice is

[5]devoted to treating patients?

[6]A The vast majority, I would say ninety to

[7]ninety-five, per cent of my practice is devoted to

[8]treating patients and teaching.

[9]Q Do you do consultations for other doctors?

[10]A Yes, I do.

[11]Q What type?

[12]A At the hospital, mostly EMG consultations,

[13]rehabilitation consultations, disability and evaluation

[14]consultations. ??

[15]Q Are you being paid to appear in court today? **[*12]**
[16]A I'm being compensated for my time to be here.

[17]Q How much are you being paid?

[18]A My fee is three thousand for half a day and

[19]one thousand for pre-trial preparation. All together,

[20]four thousand.

[21]Q Did you have to cancel office hours to be

[22]here today?

[23]A Yes, sir.

[24]Q Now, are you familiar with a patient known as

[25]Jane Waterbury?
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[2]A Yes, Sir.

[3]Q And how did this patient come to you?

[4]A The neurologist that she works for, Doctor

[5]David Biddle and Blau.

[6]Q Can you please for the jury review the

[7]patient's history, the physical examination findings

[8]and tell us what they mean?

[9]A Yes, I saw the patient for the first time on

[10]consultation was February 28th, 1998. I reviewed

[11]various past medical records from Doctors David Biddle

[12]& Blau, including MRI's of the lumbar spine, which

[13]shows a disk herniation at L-5, S-1. A disk bulge at

[14]L-4, L-5.

[15]I reviewed CAT scan film, being both the

[16]films and report, which shows a C-5, C-6 disk

[17]herniation. C-6, -C-7 disk bulge. C-2, C-3 disk **[*13]**
[18]bulge.

[19]I reviewed the reports of Drs. Biddle & Blau

[20]which showed carpal tunnel syndrome and cervical and

[21]lumbar radiculopathy.

[22]THE COURT: What does that mean.

[23]THE WITNESS: The word cervical means

[24]neck. Lumbar means lower back. The word

[25]radiculopathy- - .
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[2]THE COURT: What does that mean?

[3]THE WITNESS: Radicula comes from the Latin,

[4]meaning nerve root. Radicula, nerve root. Opathy

[5]means pathology related to a nerve root.

[6]If I say cervical radiculopathy, it means

[7]damage to a nerve in the neck. Lumbar

[8]radiculopathy means damage to a nerve root in the

[9]lower back.
"10 And the history I obtained, that the patient

[11]was thirty-seven years of age at the time,

[12]right-handed, no history of any significant prior

[13]medical problems or injuries. That she was well

[14]until July 26th, 1995 when she was driving a car

[15]she became involved in a motor vehicle accident.

[16]She sustained an injury from the rear.

[17]Initially she was not taken to any hospital,

[18]she thought she was fine. Several hours later or

[19]about twelve to eighteen hours later she was seen

[20]by the neurologist **[*14]** where she worked at, Doctor
.21 David Biddle and he examined her, sent her for an

[22]MRI of her lumbar spine, CAT scan of her cervical

[23]spine because she was claustrophobic because of

[24]the MRI and also a scan of her brain to.make sure.

[25]there was no bleeding inside the skull. And the
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[2]results of the CAT scan and brain scan was

[3]normal.

[4]The other studies I mentioned showed the disk

[5]bulge and herniations.

[6]She told me she had neck pain which traveled

[7]down her left arm with numbness and tingling in

[8]the first two fingers of the left hand. She

[9]complained to me of lower back pain with radiation

[10]down both lower extremities, left more than right.

[11]Then I examined her and I found that her neck

[12]was diffusely tender.

[13]The word "diffuse" means the whole entire

[14]area. There was spasm.

[15]Spasm is defined as a prolonged involuntary

[16]contraction of a muscle fiber. Which means the

[17]patient has absolutely no control over that

[18]tightness. Spasm is muscle tightness. When a

[19]muscle gets injured, you get a microscopic

[20]bleeding in the muscle fibers. The fibers

[21]shorten by fibrosis **[*15]** or degeneration or damage.

[22]Once those microscopic bleeding areas heal, you

[23]form what is called trigger points, which are

[24]areas of muscle destruction.

[25]She had numerous trigger points in her neck,
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[2]upper back and lower back. Range of motion of

[3]her neck was one half normal lateral flexion.

[4]Then I examined her back. There was, again,

[5]diffuse tenderness, again diffuse spasm, numerous -

[6]trigger points present. Range of motion was one

[7]half normal extension.

[8]Extension is backwards bending of the lower

[9]back.

[10]Then I did a straight leg raising test which

[11]is done by laying the patient flat on the

[12]examining table. I hold one hand directly

[13]underneath her foot and ankle area. The other

[14]hand goes underneath the hamstring and I try to

[15]bring up to normal. ??

[16]Normal is ninety to one hundred ten degrees p

[17]for a thirty-seven year old female. Anything

[18]less than ninety degrees is abnormal. or

[19]On the left side it went to seventy-five

[20]degrees. On the right side, it went to one??

[21]hundred ten degrees, with complaints of left sided

[22]lower back pain.. This indicates an abnormal **[*16]**
[23]test, which indicates either there is a disk

[24]herniation or nerve root damage in the lower back

[25]or a combination of both.
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[2]So as a physician, you have to take a good

[3]history, a good physical exam to arrive at your

[4]final diagnosis. Seventy per cent of your

[5]diagnosis comes from the history, ten per cent

[6]comes from the physical exam. The remainder,

[7]twenty per cent, comes from other diagnostic

[8]studies which either confirms or disconfirms your

[9]working diagnosis.

[10]Q Let me stop you there. You mentioned

[11]several times this thing called herniated disk?

[12]A Yes.

[13]Q Can you explain to the jury so they can

[14]understand it, what it means to have a herniated disk?

[15]A Yes, I brought with me some charts and some

[16]models which will assist me in explaining better.

[17]MR. BUTTAFUCCO: May I approach the witness,

[18]Judge?

[19]THE COURT: Yes.

[20]While Mr. Buttafucco is approaching, Doctor,

[21]what were the cervical problems that you either

[22]read about or found out about from the MRI or CAT

[23]scan.

[24]THE WITNESS: C-5 C-6 disk herniation, C-6

[25]C-7 disk bulge. C-2 **[*17]** C-3 disk bulge. Cervical
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[2]radiculopathy.

[3]THE COURT: Okay.

[4]BY MR. BUTTAFUCCO:

[5]Q Now, Doctor, using your models and the

[6]chart. - First of all, would your models and your chart

[7]aid you in explaining your testimony to the jury?

[8]A Yes, sir.

[9]Q And would you be able, with the Court's

[10]permission, to do that?

[11]THE COURT: Why don't we put the easel where

[12]the officer is moving it to.

[13]MR. BUTTAFUCCO: Also I brought an
rr ?.

[14]additional model, maybe they will help, too.

[15]THE WITNESS: May I step down, Judge?

[16]THE COURT: Sure.

[17]THE WITNESS: In the human spine. we have

[18]three segments.

[19]THE COURT: The record should indicate the

[20]doctor is using a spinal model which goes from

[21]where to where, Doctor?

[22]THE WITNESS: From the neck all the way down

[23]to the coccyx.

[24]THE COURT: Go ahead.

[25]A In the cervical spine, which is the neck, we
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[2]have seven vertebra. Mid-back, which is known as the

[3]thoracic spine, we have twelve. vertebrae. The lower

[4]back, which is known as the lumbar spine, we have five

[5]vertebrae. The lumbar **[*18]** spine ends with the tail bone, _

[6]known as the coccyx. Each area in the spine has a

[7]specific curvature.

[8]As you can see, the neck and the back have

[9]the same type of a curvature. It's a concavity

[10]depending how you look at it.

[11]The thoracic spine, in contrast, is the

[12]opposite way. It's convex. This is how the body

[13]holds itself in proper alignment, by the weight of

[14]these different curves along with ligaments, muscles

[15]and tendons.

[16]Between each vertebra we have a structure

[17]called a disk. The function of a disk is twofold. To

[18]serve as a protection between the two vertebrae so with

[19]the shocking forces as we fall and as we walk, bone

[20]does not hit bone and break each other.

[21]Also, the disk is a.fluid filled cavity.

[22]Outside is a fibral cartilage material called the

[23]annulus fibrosis. Inside is a gelatinous material

[24]known as water and a gelatinous material. It's called

[25]a nucleus pulposis.

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[2]Picture a disk as a jelly donut. Outside is

[3]fibrous cartilage analagous to the doughy portion of a

[4]jelly donut. Inside is the jelly or the jelly portion

[5]of the jelly donut. **[*19]** Because of this fluid filled

[6]cavity, we get our normal range of motion. We can

[7]bend forward, backward, left, right, left and right

[8]lateral rotation. We can bend forward and backwards

[9]and have extreme flexibility. It's all because of

[10]this fluid filled cavity inside the disk.

[11]Now, right behind the disk, this is the back

[12]portion of the spine, this is the front portion.

[13]Right behind the vertebrae is the spinal canal, well

[14]protected by bone in all directions. The spinal cord

[15]starts right from high up in the brain and it goes all

[16]the way down to the lower back. It ends between the

[17]first and second lumbar vertebrae.

[18]Each vertebrae is numbered according to its

[19]anatomic location. For example, if I say C-1 C-2,

[20]C means cervical, one means the first vertebra. If I

[21]say C-1, C-2, it means the space between the first and

[22]second cervical vertebrae. If I say L-3, L-4, it

[23]means the space between the third and fourth lumbar
.24. vertebrae.

[25]Now, all these nerves in the neck supply
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[2]power and sensation to-the different muscles in the

[3]arms. For example, biceps is supplied by the nerve **[*20]**
[4]root between the fifth and sixth cervical vertebrae or

[5]the C-5 C-6 nerve root. The calf muscle is supplied

[6]by the nerve root between the L-5 and S-1 nerve root.

[7]So whenever a patient complains of radiating pain down

[8]the arms, it means it's origin is in the neck. If a

[9]patient complains of radiating pain down the legs, it

[10]means it's origin is in the lower back. Because all

[11]the nerves that go in the arms originate in the neck

[12]and lower back to the legs, so on and so forth.

[13]We have nerve roots on the right and left

[14]sides. Each nerve root has two branches, motor for

[15]movement, sensory for perception of sensation. If the
16. sensation is diminished to pinprick or touch in the

[17]first two fingers, it could mean the problem could be

[18]either from the nerve in the wrist, the median nerve

[19]called the carpal tunnel syndrome or if the sensation

[20]is lost in the left calf, that's the L-5 S-i, which

[21]means the problem could be here.

[22]If you have loss of backwards extension, it

[23]could mean the problem is from a disk herniation in the

[24]lower back.

[25]Now, we have three abnormal conditions to a

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f.

[2]disk. The first one is a normal disk. As you can

[3]see, it's nice and thick, it's turgid, has a normal

[4]fluid filled cavity.

[5]Q What does turgid mean?

[6]A Water content. It is filled with water and

[7]it's normal.

[8]The first abnormal condition to a disk is a

[9]bulge, which is a partial tear.

[10]THE COURT: Indicating the doctor is showing

[11]a model to the members of the jury?

[12]A And the way you see it on the diagram, there

[13]is two ways to look at a disk, the side view or the

[14]saggital view and the axial view, which is called the

[15]salami.

[16]THE COURT: Salami?

[17]THE WITNESS: Salami, bologna, you slice it.

[18]THE COURT: That's what I thought.

[19]A What I'm looking at is this spinous process,

[20]this is the transverse process which is right here.

[21]What we're looking at is the disk in this fashion. As

[22]you saw from this model, a bulge is a partial tear.

[23]The disk tears, tears here.

[24]Once a disk tears, the pressure inside the

[25]disk normally increases. When you sit, the pressure
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[2]has increased. When you sit and lean forward, the

[3]pressure on **[*22]** the disk is very, very light. When you

[4]sit, lean forward and try to lift anything, the

[5]pressure on the disk is several hundreds times normal

[6]pressure. When you lay flat, the pressure is at its

[7]lowest.

8. When you have a disk partially torn, with

[9]time and pressure and increased exertion on the injured

[10]areas, this will inevitably tear more and more. The

[11]disk will begin to bulge more and more.

[12]So the first abnormal condition to a disk is

[13]a disk bulge, which is a partial tearing.

[14]Second is a disk protrusion. Definition of

[15]a disk protrusion is the disk is completely torn from

[16]the periphery, which is the annulus fibrosis, which is

[17]fibrous cartilage, but it has not yet passed the

[18]boundaries of the disk, where a herniation you have a

[19]complete tear. But the torn material and the

[20]gelatinous term passes this disk margin. So it's one

[21]grade more involved, more abnormal than a disk

[22]protrusion.

[23]Q First there's a bulge, then a protrusion?

[24]A Then there's a herniation.

[25]Q Is that degree of severity with herniation

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[2]being the most severe?

[3]A **[*23]** Yes, to show you a protrusion, this is a

[4]protrusion, this is a herniation.

[5]THE COURT: Indicating on the model.

[6]A This is a protrusion, this is a herniation.

[7]Protrusion - herniation.

[8]THE COURT: May I see?

[9]A' Whenever you have a disk tear of annulus

[10]fibrosis, it iss a permanent, irreversible condition.

[11]Why? Because the outer portion consists of fibral

[12]cartilage material. This material does not have the

[13]ability to repair itself.

[14]When bone breaks, it has a tremendous ability

[15]to repair itself. When a bone breaks, it heals with

[16]bone cement known as callus, c-a-1-1-u-s. In fact, it

[17]becomes the strongest part of the body. If you break

[18]your tibia in one spot, two years later you break the

[19]leg again, the site that was broken before will not

[20]break again. The Evil Kneivel x-rays confirm this.

[21]So when you have a tear or damage to the

[22]outer portion of a disk, which is the annulus fibrosis,

[23]once it tears, it cannot repair itself. You cannot

[24]suture it.back together. You cannot surgically glue

[25]it back together. It's permanent, irreversible
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[2]damage.

[3]What happens **[*24]** to a disk once it's

[4]herniated. The water content inside the disk comes

[5]out. As soon as the disk is torn or herniates, the

[6]water content comes out.

[7]what happens is the disk space begins to

[8]shrivel up or become degenerated. It goes from a

[9]thick, juicy disk to a shriveled up disk.
10. Compare the normal space between the two

[11]disks. One is a lot thicker than the other one.

[12]Furthermore, once.a disk herniates, the body

[13]tries to stabilize the injured area by forming

[14]osteophytes. Osteophytes are bone spurs which we form

[15]around vertebrae and when a nerve root exits, which is

[16]called a neuroforamen. As time goes on, the disk

[17]begins to shrivel up and degenerates more and more.

[18]It's like having a worn out shock absorber

[1]
[19]You will start to lose your flexibility and range of

[20]motion and stiffness.starts to set in.

[21]Once these ostephytes begin to form, they

[22]continue to grow like the nail on your fingernails.

[23]You, once this happens, you lose flexibility, you get

[24]stiffness and once they go into the neuroforamen they

[25]causee compression on a nerve root that's already
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[2]damaged **[*25]** by a disk herniation, adding insult to

[3]injury. This becomes a progressive, worsening

[4]condition over time.

[5]Finally, over many, many years, the disk will =

[6]go from a normal disk to-a shriveled up disk like this

[7]and now the disk has lost it's normal function. It

[8]has lost it's normal flexibility, normal range of

[9]motion. Now tremendous stiffness will set in and

[10]osteophytes will begin to form and you have tremendous

[11]loss of range of motion and the disks wear out.

[12]Q Can I stop you there, Doctor?

[13]A Yes.

[14]Q Let's talk about the MRI's in this particular

[15]patient, Janet Waterbury.

[16]Can you pull out the MRI's and explain how

[17]these actual disks are diagnosed?

[18]A If I may have one more minute. I just want
.19 to explain the last part of a disk, what happens to a

[20]disk once it herniates.

[21]When a disk herniates, the outer one third of

[22]a disk has nerve fibers called nociceptors which come

[23]off the actual nerve root, so the stretching mechanism

[24]or the tear will cause pain around the area where these

[25]nerve roots are. Once a disk completely tears and

145 **[*26]**

[2]degenerates, the nerve root is right behind it. You

[3]either compress the nerve root or the spinal cord right

[4]behind it and you release these chemicals which

[5]irritate the surrounding structure, causes pain and

[6]spasm. They are nitric oxide, prostaglandins,
7. phospholipase, so on and so forth.

[8]You don't have to have direct compression of

[9]a nerve root to cause this radiculopathy or nerve root

[10]damage. it can be caused by these chemicals

[11]released.

[12]Q Let's look at the MRI's, if you would. I

[13]believe we have a shadow box here supplied by the

[14]court.
i5 THE COURT: Mr. Buttafucco, when the two of

[16]you marked in the exhibits you both partcipated

[17]in, did you in any way differentiate 1-A from

[18]1-E?

[19]MR. BUTTAFUCCO: Yes, ' we marked separate

[20]films.

[21]THE COURT: But what they are?
22. MR. BUTTAFUCCO: No, because we are not

[23]really able to tell.

[24]THE COURT: So we aren't labeled for our

[25]purposes.
i.
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[2]MR. BUTTAFUCCO: Me may in fact be, but it's

[3]beyond my comprehension, Judge.

[4]THE WITNESS: This is MRI of the patient's

[5]lumbar spine, taken on 7/28/95. As **[*27]** you can see,

[6]this is the tail bone, known as the sacrum. This

[7]is the L-5. This is the S-1. So this is L-5,

[8]L-4, L-3, L-2, L-1.

[9]Between each vertebrae this white space, are
r

[10]the disks. Right between the L-5, S-1, you see

[11]the disk herniating, sticking out, hitting the

[12]nerve root which"is.right behind it. You can see

[13]it here and here and here.

[14]Right above is the L-4, L-5 also sticking out

[15]of its place. It's compressing the nerve root

[16]which is existing both here and here.

[17]Q What is the significance? Is L-5- - ?

[18]A L-4 herniation. This L-4, L-5 disk bulge

[19]compresses on nerve structures which cause pain and

[20]radiates down to the legs. Once a disk tears or

[21]ruptures, it's a permanent, irreversible injury. It

[22]doesn't heal.

[23]As you can see, the L-5, S-1 disk is

[24]shriveled up compared to this one. Look at the

[25]thickness of these disks compared to the L-5, S-1.
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[2]That is because the water content has leaked out once

[3]the desk herniated, along with all. the chemicals. Once

[4]a disk is herniated it causes pain and inflammation to

[5]the local structures. **[*28]**
[6]Q Is there any way to tell from the MRI whether

[7]or not it's on the left side or on the right side or

[8]both?

[9]A From this view, it's difficult to say.

[10]Q Is there a different view that would help us?
1.1 A The axial views.

[12]Q Is that what you call the salami view?

[13]A The salami view, that's correct.

[14]I'll get the other views.

[15]The disk herniation is central, right in the

[16]middle.. It goes straight in the back.

[17]Q Can you explain the various types of disk

[18]herniations you are familiar with?

[19]A Yes, the most common type is postural

[20]lateral. Goes backwards and sideways.

[21]Next is lateral, to the sides. Next is

[22]central right, back. Then parasaggital, right along

[23]the spinal cord or nerve roots. Then there's

[24]anterior, goes forward as opposed to backwards.

[25]As you can see from the salami view, this is
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[2]the disk, this is the nerve root. This is labeled as

[3]left side, right side. Here is the disk again. This

[4]is the nerve root. It's right smack in the middle.

[5]If it was going to the left, it would be more this

[6]way. If it was **[*29]** going towards the right, it would be

[7]more this way. It's right smack in the middle.

[8]This is the-disk, this is the nerve root.

[9]You should be able to see the normal boundaries between

[10]the two nerve roots. Here you will have the elipse,

[11]which means the disk is herniated, it's locking or

[12]hitting or covering this nerve root.

[13]Sometimes one side can get the leakage more

[14]than the other, the left more than the right and so on

[15]and so forth.

[16]Q Doctor, are these films read on a regular

[17]basis by radiologists?

[18]A Yes, sir.

[19]Q And you have stated you are a physiatrist,

[20]not a radiologist?

[21]A That's correct.

[22]Q But you do have training in reading MRI's?,

[23]A Yes.

[24]Q Did you ever have a chance to see the

[25]radiologist records in connection with this MRI?
149

[2]A Yes, sir.

[3]Q Indeed, does it form part of your records?

[4]A It does.

[5]Q Did you utilize it in the care and treatment

[6]of this patient?

[7]A Yes.

[8]Q Is that radiologist's report in evidence'

[9]anything different than what **[*30]** you said?

[10]A Exactly. Left posterior disk herniation. L-5,

[11]S-1. Left posterior disk herniation with borderline

[12]left S-1 nerve root effacement. And a central disk

[13]bulge at L-4, L-5 with a tiny, midline protrusion, also

[14]present at L-4, L-5.

[15]THE COURT: Go ahead, Doctor.

[16]Do you want him to refer to anything else.

[17]Q Doctor, are you done with the shadow box?

[18]A I'm done.

[19]Q Now, Dr. Guy, you mentioned in your prior

[20]testimony the term osteophytes?

[21]A Yes, sir.

[22]Q Osteophytes would indicate a long standing

[23]condition?

[24]A That's correct.

[25]Q Are there any osteophytes present in MRI's?
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[2]A None.

[3]Q What does that indicate to you???

[4]A If there were osteophytes present, it means 9

[5]that this condition would have to be long and c

[6]pre-existing of at least two years or greater. So that

[7]none were found, it means this is a recent injury.

[8]Q When was this MRI done in connection with the

[9]date of this accident?

[10]A I believe one to two days after. Let's

[11]see. Two days after.

[12]Q **[*31]** Now, you used the term degeneration earlier?

[13]A Yes.
L

[14]Q Is there any degeneration shown?

[15]A Yes, at L-4, L-5 as affected.

[16]Q Why?

[17]A Because once it tears or herniates, the water

[18]content leaks out, the disk becomes shriveled up or

[19]degenerated.

[20]THE COURT: How long does that take?

[21]THE WITNESS: It can happen almost

[22]immediately, can happen one to two days, one to

[23]two weeks or longer.

[24]In all the medical literature there is not

[25]one study that has been able to prove or show
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[2]exactly how long it takes. So the concensus is

[3]it can happen immediately, can happen within a few

[4]days or a-couple of weeks. Every case is

[5]different.

[6]Q In addition to the degeneration of a

[7]particular disk, as we age, do we have a normal amount

[8]of degeneration as part of the aging process?
9- A Absolutely.

[10]Q Can you explain how that works?

[11]A As we age, the. water content in the disk

[12]becomes less and less and the disk space becomes

[13]narrowed and we have some wear and tear around the

[14]vertebral bodies. And once we go over fifty **[*32]** years or

[15]older, we begin to have some tiny osteophytes which

[16]begin to form.

[17]Q Is that different, what you just described,

[18]the normal degeneration, from a bulge or protrusion or

[19]herniation?

[20]A Yes, it is different.

[21]Q What causes a bulge or protrusion or

[22]herniation?

[23]A The most common cause of protrusion or

[24]herniation in a young, healthy adult is trauma. In the

[25]elderly, fifty or sixty, years old, a bulge can be part
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[2]of a normal aging process.
3. THE COURT: Excuse. me, elderly, fifty or

[4]sixty?

[5]A Excuse me, sixty or better. Fifty is

[6]middle- aged.

[7]THE COURT: Thank you.

[8]Q Do you have an opinion, Doctor, to a

[9]reasonable degree of medical certainty as to the cause

[10]of all these conditions that you have described in this

[11]particular patient?

[12]A Yes.

[13]MR. PESCE: Your Honor, I object to the

[14]question.

[15]May I approach?

[16]THE COURT: Yes.

[17]May I have the question read back.

[18](Whereupon, the reporter read back, as

[19]requested.)

[20]THE COURT: I will sustain the objection.

[21]Do you want a conference? **[*33]**
[22]MR. BUTTAFUCCO: Yes, please.'

[23](Side bar discussion held off the record.)

[24]THE COURT: Objection on the last question

[25]sustained. Rephrase your question.
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[2]Q Doctor, the MRI revealed herniation at one

[3]level?

[4]A L-5, S-1.

[5]Q With respect to that particular injury, does

[6]that correlate with respect to any of the pain that the

[7]patient reported to you?

[8]A Yes.

[9]Q Can you explain to the jury how there is a

[10]clinical part of an exam, a diagnostic part of an exam

[11]and how the two pieces fit together in forming a

[12]diagnosis?

[13]A Yes., as I mentioned earlier, seventy per cent

[14]of a doctor's working diagnosis comes from the

[15]history. In some cases you can diagnose a condition

[16]without even examining the patient or doing a single

[17]test.

[18]For example, in a patient over forty years of

[19]age telling the doctor I have been having substernal

[20]chest pain below the sternum, until proven otherwise,

[21]that's a. heart attack.

[22]If a young. patient tells a doctor I have

[23]right sided lower quadrant abdominal pain, until proven

[24]otherwise, **[*34]** that's appendicitis.

[25]So whatever you think, the first thing you

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[2]have to think of is appendicitis. You admit the

[3]patient to the hospital. You will prove whether it is.

[4]or it's not appendicitis. You cannot afford to be

[5]wrong because the patient can die. _

[6]If a patient complains to a doctor, I have

[7]radiating pain down the lower back with numbness and

[8]tingling in the calf, that calf, its origin is the L-5,

[9]S-1 nerve root.

[10]If on physical exam the back shows spasm,

[11]reduction of range of motion, reduction in normal

[12]straight leg raising and a sensory deficit in the left

[13]calf, it all confirms an L-5, S-1 lesion. When the

[14]EMG. confirmed it - - A

[15]Q Let me stop you, Doctor. What's an EMG?

[16]A An EMG stands for electromyography. It is

[17]analogous to EKG to the heart. EMG is for muscle and

[18]nerve damage. A physician performs this test to see

[19]if there's any muscle or nerve damage by way of placing

[20]electrodes over these different muscles and nerves in

[21]the lower extremities and inserting a sterile three

[22]and-a-half inch long needle into various muscles in the

[23] **[*35]** legs and back. If there is electrical abdominality

[24]indicative of nerve root damage, the physician confirms

[25]his diagnosis. There was electrophysiological
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[2]evidence of nerve damage.

[3]Q Was an EMG done here?

[4]A Yes.

[5]Q Who did the EMG?

[6]A Dr. Biddle.

[7]Q Are you, trained in reviewing EMG's?.

[8]A Yes.

[9]Q Do you in fact perform EMG's?

[10]A I take it.

[11]Q Can you tell us if you reviewed Dr. Biddle's

[12]EMG's as part of your review of this patient?

[13]A Yes, sir.

[14]Q Were they positive, the results?

[15]A Yes, sir.

[16]Q What were they positive for?

[17]- A For cervical and lumbar radiculopathy, as

[18]well as carpal tunnel syndrome.

[19]Q Does that fit into the picture with the disks

[20]and the clinical complaints and your physical

[21]examination?

[22]A The radiculopathy, yes, it does.

[23]Q Putting all of these puzzles together, do you

[24]have an opinion as to a reasonable degree of medical

[25]certainty as to what his diagnosis was?

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[2]A Yes.

[3]Q **[*36]** What was her damage?

[4]A C-5, C-6 disk herniation, C-6, C-7 disk

[5]bulge, C-2, C-3 disk bulge. L-5, S-1 disk =

[6]herniation. L-4, L-5 disk bulge with a protrusion.

[7]Cervical and lumbar radiculopathy and bilateral carpal

[8]tunnel syndrome, left worse than right and

[9]trisplanchnic myelofascial pain syndrome.

[10]Q Is that consistent with what a radiologist

[11]found when he reviewed the CAT scan and MRI?

[12]A That's correct.

[13]THE COURT: I'm sorry to interrupt,

[14]counsel. The facial numbness, what would that be

[15]linked to.

[16]THE WITNESS: That could be microfascial

[17]pain syndrome. That's when you have damage to

[18]the soft tissues, the muscles. Whenever you have

[19]a flexion extension injury, the same force that

[20]breaks the disks and causes the herniation and

[21]causes the muscle spasm, you get a microscopic

[22]bleed in the muscle fibers. Trigger points form

[23]at the base of the muscle sac. From the pain up

[24]here in-the upper trapezius, you get referred pain

[25]to the face, jaw, down to the arms and sometimes

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[2]to the chest.

[3]Sometimes people think they are having a

[4]chest **[*37]** pain from a heart attack and the doctors are

[5]fooled, they do an EKG, when in fact it's referred

[6]pain. Upper trapezius is C-4, C-5 and some C-6

[7]nerve root fibers. The pain distribution area is

[8]the upper arm and the chest area. It's referred

[9]pain and so is the face. It goes to the face, as

[10]well-

[11]Q I, wasn't as fast as our esteemed court

[12]reporter. C-5, C-6 was bulge or herniation?

[13]A C-5, herniation.
' 14 Q C-5, C-6 was a herniation?

[15]A Yes.

[16]Q Let me break it down. Do you have an

[17]opinion to a reasonable degree of medical certainty as

[18]to the cause of the C-5, C-6 herniation in this

[19]patient?

[20]A Yes, the accident of July 26, '95.

[21]Q Do you have an opinion to a reasonable degree

[22]of medical certainty as to the bulge in this patient at

[23]C-6, C-7?

[24]A Again, the traumatic events of 7/26/95.

[25]Q Do you have an opinion to a reasonable degree.
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[2]of medical certain as to the bulge of C-2, C-3 in this

[3]patient?

[4]A Again, same accident.

[5]Q And do you have an opinion to a reasonable

[6]degree of medical certainty **[*38]** as to the herniated disk at

[7]L-5, S-1?

[8]A As of 7/26/95.

[9]Q Do you have an opinion to a reasonable degree

[10]of medical certainty as to the bulge with protrusion at

[11]L-5, S-1 in this patient?

[12]A L-4, L-5?

[13]Q I'm sorry, L-4, L-5?

[14]A Yes, same accident.

[15]Q Now, can you explain to the jury how it is

[16]that that car accident- -

[17]Let me ask you a hypothetical question. I
18, want you to assume that on July 26th, 1995, the patient

[19]was struck from the rear by another vehicle and that as

[20]a result, the frame was bent to her car, the bumper was

[21]pushed in, there was damage to the car behind her and

[22]the speed is anywhere from five miles per hour to forty

[23]miles per hour.

[24]Are you with me so far?]'

[25]A Yes.
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[2]Q Do you have an opinion to a reasonable degree

[3]of medical certainty as to the cause of these injuries

[4]you just reiterated?

[5]MR. PESCE: Note my objection. _

[6]THE COURT: Overruled.

[7]A Yes, I do have.an opinion and the cause of

[8]these injuries is the accident of 7/26/95, for very

[9]good reason.

[10]Q **[*39]** Explain, please.

[11]A Number one, the history of the patient had no

[12]prior medical problems or injuries to the lower neck or

[13]back, nor hands or wrist.
?s -

[14]Number two, the MRI's did not reveal any

[15]osteophytes. If they revealed any osteophytes, we

[16]cpuld confirm or conclude this may have been

[17]pre-existing. None were detected.

[18]Number three. Patients with pre-existing

[19]problems do not have nerve damage. They don't have

[20]radiculopathy. They don't have carpal tunnel syndrome

[21]and not know about it and not seek medical treatment

[22]for it.

[23]So normal patients don't have loss of range

[24]of motion in their necks., their backs, with sensory

[25]deficits in their legs and/or their hands. When you
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[2]put the whole picture together it's only then you can

[3]arrive at your final conclusion.

[4]If you take one part of the crossword puzzle

[5]and say is this possible or is that possible, yes, sir,

[6]anything is possible and nothing is impossible. But

[7]when you put the whole picture together is when you can

[8]arrive at this final conclusion and assessment that it

[9]was caused by this accident.

[10]Q **[*40]** Doctor, can you tell the jury what a

[11]prognosis is??

[12]A Prognosis means future outcome, what the

[13]future holds for a particular patient.

[14]Q Before we get to the prognosis, you mentioned

[15]I believe your opinion that in general, herniated disks

[16]were permanent. I want to ask you specifically with

[17]respect to this patient. Do you have an opinion to a

[18]reasonable degree of medical certainty as to whether or

[19]not the herniation at C-5, C-6 is a permanent

[20]condition?

[21]A I just want to make a correction for the

[22]record. I didn't say in general. Herniations are

[23]permanent. Not in general. They are permanent

[24]because the annulus fibrosis is a materialk that once

[25]torn does not have the ability to repair and regenerate
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[2]itself once it's torn. It's permanent or

[3]irreversible. The same is true for cartilage in your

[4]knees, meniscus, once it's torn, it doesn't have the

[5]ability to repair itself. It's a permanent,

[6]irreversible injury.

[7]Q I have to go do down the list. Do you have

[8]an opinion to a reasonable degree of certainty as to

[9]whether C-5, C-6 herniation **[*41]** is permanent?

[10]A Yes, sir, it's permanent.

[11]Q Same question with respect to C-6, C-7 bulge?

[12]A It's permanent because you have a partial

[13]tear.

[14]Q Same question with respect to C-2, C-3?

[15]A Same answer, same reason.

[16]Q And with respect to the L-5, S-i herniated

[17]disk, is that a permanent condition?

[18]A Yes, it is a permanent condition.

[19]Q And the L-4, L-5 bulge with the protrusion?

[20]A Yes, that's a permanent condition.

[21]Q Can you explain to the jury what the term

[22]prognosis means. I think you said that it's future

[23]outcome?

[2]4 A Yes. E'

[25]Q Tell us what your opinion is to a reasonable
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[2]degree of medical certainty with respect to the

[3]prognosis of this patient?

[4]A She is left with a.permanent injury. As

[5]time goes on, the condition gets progressively worse. _

[6]The best way to explain it is the models in

[7]front of you. It shows the progression of a normal

[8]disk to an injured disk and shows you the end stage of

[9]a disk. It's clearly evident from the progression of

[10]a disk disease. **[*42]** As time goes on, the disks shrivel

[11]up, they lose their water content, osteophytes begin,

[12]joint space narrows significantly. That causes

[13]stiffness and, pain and reduction of range of motion.

[14]As these osteophytes continue to form, they

[15]eventually compress on the surrounding structures,

[16]which is the nerve roots.

[17]Q Now, is this patient under your care?

[18]A Yes, sir.

[19]Q And for how long has she been under your

[20]care?

[21]A From February 28th, 1998 to the present.

[22]And I just recently re-examined her on May 9,

[23]2000. -

[24]Q And is she still under medical treatment?

[25]A Yes.
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[2]Q Do you have an opinion as to a reasonable

[3]degree of medical certainty as to what required future

[4]medical treatment she will need?

[5]A Yes, I do have an opinion. She will need,

[6]since this is a permanent injury and since traumatic

[7]arthritis will set in and since there's no cure for

[8]this condition, there is treatment. There's no cure
9. for arthritis, there is treatment.

[10]She will need physical therapy on an as-

[11]needed basis for the rest of her **[*43]** life. I estimate

[12]this to be approximately two to three times per week

[13]until she reaches maximum medical improvement,

[14]approximately thirty sessions per year, a very, very

[15]low ball conservative number.

[16]She will require medications for pain, spasm

[17]in the form of whatever she has been taking, Napercin,

[18]Valium. The approximate cost for that on a yearly

[19]basis is anywhere from a thousand to two thousand.

[20]Q You mentioned thirty sessions of physical

[21]therapy per year?

[22]A Yes.

[23]Q What is the price per session?

[24]A Approximately a hundred dollars'.per session.

[25]Q What kinds of physical therapy should be done
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[2]to this patient?

[3]A Hot packs, electrical stipulation, manual

[4]massage, microfascia release techniques and special

[5]therapeutic exercises.

[6]I also recommended trigger point injections.

[7]Q The therapeutic exercises, can she do that at

[8]home?

[9]A Yes.

[10]Q Will that reduce the cost of therapy?

[11]A Yes.

[12]Q What would it knock it down to?

[13]A Still a hundred dollars per session.

[14]Q **[*44]** How would it reduce the costs, then?

[15]A Because physical therapy is the same fee

[16]whether you do one modality, two, five modalities, a

[17]hundred modalities, you get the same effect. Half

[18]hour blocks. For a half hour block, a hundred

[19]dollars. For a one hour block, it's more.

[20]Q Is that the standard billing practice in this

[21]locale?

[22]A Yes, sir.

[23]MR. PESCE: Note my objection.

[24]THE COURT: Sustained. Strike that.

[25]Q Do you have an opinion to a reasonable degree
E
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[2]of medical certainty as to whether that is standard

[3]billing practice in New York?

[4]MR. PESCE: Note my objection..

[5]THE COURT: Sustained.

[6]Q Now, you mentioned trigger point injection?

[7]A Yes.

[8]Q Did you suggest trigger point injection in

[9]this patient?

[10]A Yes.

[11]Q What is a trigger point injection?

[12]A First, a trigger point is an area of muscle

[13]degeneration, muscle scarring. The muscles become

[14]damaged and scarred on a permanent basis. The muscles

[15]become fibrosed. With trigger point injection you

[16].numb the area and with a needle **[*45]** you break up these

[17]adhesions or scar tissue. Then.the surrounding

[18]muscles begin sprouting new muscle fibers and you get

[19]rid of the area of pinpoint tenderness with an

[20]excruciating area of inflammation.

[21]Q It helps the patients?

[22]A Helps the patients.

[23]Q Does it have long term benefits?

[24]A It does have long term benefits, yes.*

[25]Q This patient, did she have these trigger
166

[2]point injections?

[3]A No, she was afraid of needles and injection.

[4]Q How would you describe this patient, in

[5]general, from your experience with her?.

[6]MR. PESCE: Objection to the form of the

[7]question. Describe in general?

[8]THE COURT: As to form, sustained.

[9]Q How would you describe her response to your

[10]therapy in general, her response to your suggested

[11]therapy?

[12]THE WITNESS: May I answer, Judge?

[13]THE COURT: Yes.
r.

[14]A Very stoic, trying to solve the problems on

[15]her own with home exercise. She has a portable TENS

[16]unit.

[17]A TENS unit is a portable electrical

[18]stimulator. It looks like a beeper. It has two

[19]electrodes, **[*46]** outlets on the right side and two on the

[20]left side with electrodes coming out and the patients

[21]can place these electrodes on her own neck and muscles

[22]and give herself electrical stimulation which

[23]diminishes pain and spasm. She was doing that, pain

[24]medications and home exercise and she had i?wo or three

[25]kids to take care, plus a full-time job and the house.
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[2]She felt it was difficult to do all these things

[3]together and to come for the trigger point injections

[4]and therapy. She would only come when she found she

[5]absolutely had to.

[6]Q Is that your recommendation? Is she

[7]following your recommendation?

[8]A In the beginning she didn't because this was

[9]advised to her from the first visit. She waited until

[10]the condition got worse, then she came in. Now she is

[11]getting better, she is slacking off on the therapy

[12]because she is feeling somewhat improved.

[13]Q Do you have an opinion with respect to
f 14 whether the medical conditions you described can be

[15]subject to remissions and exacerbation, meaning the

[16]patient can have good days and bad days, ..

[17]A **[*47]** That's exactly how this condition relapses.

[18]Law of physics, in the cold weather everything becomes

[19]cold and contracted and stiff. In the warm weather,

[20]heat expands, breaks up spasm. Humidity,, rain,

[21]stiffens up the patient. Depending what the patient

[22]does, stressful conditions tighten up the muscles.

[23]Relaxed conditions improve the muscles. Housework

[24]increasingly aggravates the condition. A lot of work

[25]at the office aggravates the condition, so forth and so
168

r.
[, . 2 On.

[3]Q When she is having good days, when the laws

[4]of physics are in her favor, does that mean she is- - ?

[5]A Temporarily better. Her condition is

[6]permanent, subject to good and bad days.

[7]Q what is the overall progress?

[8]A The models show the progress.

[9]Q Whether or not she has good days or bad days,

[10]will that affect that?

[11]A The condition itself is progressive. Good

[12]and bad days depends what she does or doesn't do.

[13]Q Now, you mentioned physical therapy?

[14]A Yes.

[15]Q And you mentioned the trigger point

[16]injections?

[17]A **[*48]** Yes.

[18]Q What other treatment would she need in the

[19]future, in your opinion, to a reasonable degree of

[20]medical certainty?

[21]A Last resort she'll need neurosurgical

[22]intervention for neck pain.

[23]Q Which is?
.24 A Neck is anterior cervical diskectomy. And

[25]lumbar laminectomy.
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[2]And the approximate cost is about twenty

[3]thousand dollars for each area of surgery.

[4]MR. PESCE: Objection to the cost.

[5]THE COURT: Objection sustained. Not

[6]responsive to the question.

[7]Q Let's go slow, Doctor, please. Let's start

[8]with the anterior cervical diskectomy. Can you
9. explain.

[10]A Anterior means the front approach. The

[11]surgeon cuts from the front so the surgeon has a better

[12]approach to the disk as opposed to the lower back where

[13]the approach is from the posterior or backward side.

[14]Q Why would that be needed, in your opinion?
.15 A Once you have disk herniation, the condition

[16]is progressive. Once you've exhausted all conservative

[17]forms, the next step is remove the fragments sticking

[18]out causing compression on the spinal cord and on the

[19] **[*49]** nerve root., If there's osteophytes, to saw them away

[20]so it frees up the nerve root.

[21]Q And do you have an opinion to a reasonable

[22]degree of medical certainty as to the cost of that

[23]treatment?

[24]MR. PESCE: Objection.

[25]THE COURT: Overruled.
170

[2]Do you do the surgery?

[3]THE WITNESS: I have assisted on these

[4]procedures.

[5]THE COURT: Are you familiar with-the cost of

[6]such surgery?

[7]THE WITNESS: Yes, sir, I am.

[8]-THE COURT: I'll overrule the objection.

[9]Q Would you please answer the question?

[10]A The cost is approximately twenty thousand

[11]dollars or $ 25, 000., including the associated expenses

[12]from the anesthesia, the hospital admission care, et

[13]cetera.

[14]Q That includes the whole package?

[15]A Yes, excluding the post operative

[16]rehabilitation phase.

[17]Q In other words, it excludes the out patient

[18]treatments?

[19]A That's correct.

[20]Q Do you have an opinion to a reasonable degree

[21]of medical certainty as to whether or not she'll
2'2 require the lumbar 'laminectomy?

[23]A The answer is yes for the same **[*50]** reason stated.

[24]Q Explain that procedure? k.

[25]A Lumbar laminectomy, the incision is made in
171
4,.

[2]the lower back, the backwards section. The surgeon

[3]cuts the area of the laminectomy, means you cut

[4]portions of the lamina, the part of the spine right

[5]around the disk. You cut that part to have better

[6]access to the disk and you surgically remove the

[7]herniated portion to try to free the compression on the

[8]nerve root and the local structures. And if there is

[9]any osteophytes, again, you will shave it away.

[10]Q Doctor, can you give us your best estimate to

[11]a reasonable degree of medical certainty as to when she f
ko
'

[12]will require the surgery, Doctor, with the cervical

[13]diskectomy? ??

[14]A If I gave you, I would be guessi g. With a

[15]reasonable degree of medical certainty, as time

[16]progresses, this happens anywhere from five to ten

[17]years after a traumatic event.

[18]Q Is that true of the lumbar, as well?

[19]A Yes.

[20]Q Have you in fact referred her out to surgical

[21]consultation?

[22]A Yes.

[23]Q Who?

[24]A **[*51]** Doctor Jeffrey Klein. k.

[25]Q Who is Jeffrey Klein?

s

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[2]A He is a spinal surgeon at the same hospital I

[3]work. We refer patients back to one another.

[4]Q He is an orthopedic surgeon?

[5]A Orthopedic surgeon with fellowship in spinal =

[6]surgery.

[7]Q Is that what he does?

[8]A That's what he does.

[9]Q Where does he do these surgeries?

[10]A Maimonides, Hospital for Joint Diseases.

[11]Q Do you know whether she had that

[12]consultation?

[13]THE COURT: Do you know.if she did have that

[14]consultation?

[15]A She did.

[16]Q When did she have it?

[17]A Sometime in April of this year.

[18]Q Did you get any reports yet from Dr. Klein

[19]with respect to that consultation?

[20]A Not yet.

[21]I always have this argument with him. He is

[22]always two or three months - -

[23]MR. PESCE: Objection.

[24]THE COURT: Don't tell us. [

[25]MR. BUTTAFUCCO: I think that's it, Judge.
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[2]I'il just check my notes.

[3]Q Doctor, I want you to assume that Mrs.

[4]Waterbury testified that the episodes of radiating **[*52]** pain

[5]to her arm and the episodes of radiating pain to her

[6]leg, they happen approximately at the same time, which

[7]is two times a month from the beginning but they occur,

[8]they are lasting longer. In other words, the pain
.9 stays around for more days than it did previously.

[10]Assuming that to be true, do you have an

[11]opinion to a reasonable degree of medical certainty as

[12]to what is going on in her body?

[13]A Yes.

[14]MR. PESCE: Your Honor, I object to the form

[15]of the question. I.believe it's been asked and

[16]answered with respect to the causality and the

[17]explanation as to the pain.

[18]THE COURT: I don't think so. But it's the

[19]information I have a problem with. Sustained.

[20]MR. BUTTAFUCCO: I'll rephrase it.

[21]Q Assuming that Mrs. Waterbury testified that

[22]the episodes of pain last longer when the pain radiates

[23]to her leg and when it radiates to her arm and to the

[24]first two fingers, do you have an opinion to a

[25]reasonable degree of medical certainty as to why that
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[2]has changed from the beginning?

[3]A Yes. Traumatic arthritis is setting in

[4]clinically. The joint **[*53]** space is becoming more and more

[5]narrowed and obviously there is a nerve root irritation

[6]in progress simply increasing in intensity. That's

[7]the best way I can describe it.

[8]Q is that an unusual scenario?

[9]A This is a normal sequence of events.

[10]Q Now, do you have an opinion, Doctor, to a

[11]reasonable degree of medical certainty as to how her

[12]injuries and the treatment she is going to have will

[13]impact her ability to perform her job as time goes
r.

[14]on?

[15]MR. PESCE: Your Honor, I object to this
.16 line of questioning. May I approach?

[17]THE COURT: I don't believe we have

[18]foundation for this question of this witness.

[19]Sustained.

[20]Q Doctor, as part of your treatment of patients

[21]and even this patient, in particular, do you do

[22]evaluations of what they call functional capacity

[23]evaluations?

[24]A Yes, sir.

[25]Q Can you tell the jury, please, what a
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[2]functional capacity evaluation is?

[3]A Functional capacity evaluation is you will

[4]test the patient to see what they can or cannot do

[5]within the limits of their injuries and on **[*54]** the

[6]diagnosis.

[7]For example, if a patient has a herniated

[8]disk in the lumbar area, they cannot sit as long as an

[9]average person that doesn't have a disk herniation,

[10]because as you sit, after a certain amount of time,

[11]whether it's a half hour or an hour, the pressure on

[12]the disk exponentially increases. So you would want

[13]to test the patient to see how long they can sit on a
i _ .

[14]continuous basis without having difficulty. How long

[15]they can spend time on a computer if they have a neck

[16]injury, without going into spasm.

[17]And also, as times goes on, the arthritic

[18]process.

[19]MR. PESCE: Your Honor, if I may, only with.

[20]respect to future disability as being speculative

[21]and remote. Testimony with respect to

[22]disabilities now with respect to the condition is

[23]proper. To go beyond that is remote and pure

[24]speculation. 4

[25]MR. BUTTAFUCCO: May I comment on that now,
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[2]Judge.

[3]THE COURT: Yes.

[4]MR. BUTTAFUCCO: How else can you possibly

[5]ever prove a future disability if not by expert

[6]opinion. We don't have a crystal ball and the

[7]future didn't happen yet. We have to do **[*55]** it this

[8]way or otherwise you would never be able to do it.

[9]THE COURT: I believe the witness can testify

[10]to this. I'm not sure all the little spaces in

[11]between the point he is at and the point he

[12]started from have been reached.

[13]MR. BUTTAFUCCO: In other words, you want me

[14]to continue to lay. the foundation?.

[15]THE COURT: I would suggest that.

[16]MR. BUTTAFUCCO: Fair enough.

[17]Q With respect to this particular patient,

[18]Janet Waterbury, have you performed an analysis as you

[19]treated her of her residual function and capacity?

[20]A Yes.

[21]Q Can you explain to us how her injuries affect

[22]her motor function, her coordination, ability to

[23]tolerate a workday, et cetera?

[24]A I saw her the first time February 1999'and

[25]saw her back this year May 9th. She still has
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[2]reduction of range of motion one half. Still

[3]reduction of range of motion per leg one half

[4]extension.

[5]Anything in medicine that lasts more than

[6]twelve months is considered permanent by all

[7]criteria. She still has the spasm, still has the

[8]trigger point. It is now approximately five **[*56]** years

[9]after this accident, these have not gone away and they

[10]are considered permanent at this point.

[11]As time goes on, this condition does not

[12]improve. It gets progressively worse because of the

[13]osteophytes, because of the joint space narrowing,

[14]because of the disk degeneration. When you put the

[15]whole thing together, it adds to a progressive

[16]condition.

[17]Eventually she'll have difficulty even

[18]sitting, standing and working on a computer, a

[19]keyboard, a typewriter, et cetera. This will

[20]lead to reduction in her work capacity.

[21]Q We haven't talked about pain too much. With

[22]respect to the conditions that you have enumerated and

[23]I don't want to list all of them, but the various neck

[24]bulges and herniations, in your opinion to'a reasonable'

[25]degree of medical certainty, is that the competent
178
4. '

[2]producing cause of the pain as described and reported

[3]by this patient?

[4]A Yes, sir, it is.

[5]Q Is that likely to change, stay the same, can

[6]you tell us?

[7]A It's subject to remissions and exacerbation,

[8]good and bad days. Eventually the condition **[*57]** is

[9]progressive. Eventually her pain will get

[10]progressively worse and as she gets older, traumatic

[11]arthritis will set in on, top of normal, natural

[12]arthritis and the condition will exponentially. worsen

[13]over time.

[14]Q Do you have an opinion as to what affect her

[15]injuries will have upon her ability to earn a living?

[16]A As she grows older, because of the

[17]combination of all these factors, she will be less and

[18]less able to work on a full time basis. Eventually her

[19]work capacity will be diminished and cyclically reduced

[20]as she gets older.

[21]Q Is there any way that can be quantified?

[22]A No, it's usually based on medical experience

[23]and what a doctor has seen with these types of

[24]patients. It's usually, based on my experience, there

[25]is usually a five to ten year reduction once they reach
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[2]their late fifties.

[3]MR. BUTTAFUCCO: No further questions.

[4]Thank you very much.

[5]THE COURT: Would you.explain what you meant,

[6]there's a five to ten year reduction once they

[7]reach their fifties.

[8]THE WITNESS: Average retirement age is

[9]approximately sixty-seven. **[*58]** Once a patient

[10]reaches fifty-five or older, the traumatic

[11]arthritis is very much pronounced on top of a

[12]normal, natural arthritic process. If a person
.13 without these injuries works normally to

[14]sixty-seven, now they have these injuries, they

[15]would have five to ten year reduction in their

[16]work capacity that would be they could work

[17]approximately to age fifty-eight to sixty-two.

[18]Q That's obviously an estimate?

[19]A That's correct.

[20]Q Every patient is different?

[21]A That is correct.

[22]MR. BUTTAFUCCO: Thank you very much.

[23]THE COURT: Why don't we take ten minutes for

[24]the jury, and then we will resume.

[25]Jury is excused for the moment and is
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[2]directed not to talk about this case among

[3]themselves or form any opinion about this case.
4. Take the jury out, please.

[5](Whereupon, the jury exited the courtroom.) _

[6]THE COURT OFFICER: Jury entering.

[7](Whereupon, the jury entered the jury box.)

[8]THE COURT: Cross, counsel.

[9]MR. PESCE: Thank you, Judge.

[10]CROSS EXAMINATION

[11]BY MR. PESCE:

[12]Q Dr. Guy.

[13]A Good morning.

[14]Q **[*59]** Dr. Guy, you said you testified approximately

[15]seven to eight times a year?

[16]A Average, average. I testified approximately

[17]about one hundred five times, give or take a couple of

[18]times.

[19]Q On all those occasions that's been for

[20]plaintiffs in lawsuits claiming injury?

[21]A Mostly for my patient, except for one case,

[22]yes.

[23]Q In fact, you have testified before with

[24]respect to cases involving patients represented by Mr.

[25]Buttafucco?
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[2]A I have, yes.

[3]Q Approximately how many times before?

[4]A Approximately three to four times.

[5]Q And on each of these occasions, do you in

[6]fact get paid for giving your testimony, for your time?

[7]A Yes. I don't work for free, if that's what

[8]you are asking.

[9]THE COURT: I think that is the essence of

[10]his question, yes.

[11]Q Absolutely.

[12]On February 28, 1995 was the first time you
13. saw Mrs. Waterbury?

[14]A Yes, sir.

[15]Q When you first saw Mrs. Waterbury, did you

[16]have an opportunity beforehand to review her medical

[17]records and her diagnostic tests? **[*60]**
[18]A When this report was rendered, yes.

[19]Q ..Did you review those before actually seeing

[20]her or afterwards?

[21]A I believe the first time I saw her I took the

[22]history, I did the physical exam. I obtained the

[23]records one or two days later when I dictated it

[24]because I have my handwritten notes. [

[25]Q When you examined her, did you ask her where
i
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[2]she was experiencing pain?

[3]A Yes.

[4]Q And she told you?

[5]A Yes.

[6]Q Now, Doctor, what is the difference between

[7]subjective findings and objective findings from a

[8]medical perspective?.

[9]A Subjective is what a patient complains of.
i

[10]Objective is what a physical examination or a doctor

[11]finds on his examination by way of a clinical

[12]assessment or by way of diagnostic study.

[13]Q Would you say objective findings are those

[14]which you as a physician can touch, hear, see?

[15]A That is one way of putting it, which means

[16]the patient has no control over it.

[17]Q Subjective complaints, however, are what the

[18]patient tells you; correct?

[19]A **[*61]** Correct.

[20]Q Now, isn't it true that Mrs. Waterbury gave

[21]you subjective complaints of pain?

[22]A Yes, sir.

[23]Q Is it true the only diagnostic tests you had

[24]to look at were those that were taken two 'days after

[25]the accident and the EMG taken in October of '95?
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[2]A That's enough, yes.

[3]Q There were no other diagnostic tests taken

[4]after that?

[5]A None were needed.

[6]Q You did not have any performed after that?

[7]A That's correct.

[8]Q When you reviewed the MRI films and reports-
9.

[10]Let me digress. Let me clear up something

[11]from the outset so we don't-forget.

[12]With respect to the carpal tunnel syndrome,

[13]isn't it true when you examined Mrs. Waterbury again in

[14]March of 2000 that that complaint appeared to have

[15]resolved itself?

[16]A Yes, sir.

[17]Q And with respect to the CAT scan of the

[18]brain, that was normal, there was no problem?

[19]A Yes, sir.

[20]Q With respect to an initial complaint of pain

[21]after the accident that Mrs. Waterbury had, is it safe

[22]to say when you examined **[*62]** her she did not have facial

[23]pain?

[24]A That's correct. Recently the facial pain is

[25]gone.

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[2]Q Those three things are gone. No carpal

[3]tunnel syndrome?

[4]AThat's correct.

[5]Q Now, with respect to the MRI reports. I

[6]would like you to take a look at what was marked as

[7]Defendant's Exhibit 3, which is the July 27, 1995

[8]report?

[9]THE COURT: What. was the exhibit number.

[10]MR. PESCE: That's Exhibit 2.

[11]THE WITNESS: It says 3, Judge.

[12]MR. PESCE: Three? I'm sorry.

[13]THE COURT: It's a 3 on the final report.

[14]Report drain. D-r-a-i-n.

[15]MR. BUTTAFUCCO: I think it's brain.

[16]THE COURT: I didn't write this.

[17]There's another report from July 27 of '95

[18]from the cervical spine. Do we have two separate

[19]reports?

[20]MR. PESCE; This is Exhibit 3, the July 27,

[21]1995 report of the cervical MRI.

[22]A Cervical CAT scan.

[23]Q I want to draw your attention to where it

[24]refers to disk bulges at C-6, C-7? '

[25]THE COURT: Before we do that, I want to see
185

[2]2 and 3.

[3]MR. BUTTAFUCCO: Yes, mine are all mixed up,

[4]too. I think that's the brain **[*63]** one. No. This

[5]is the brain.

[6]THE COURT: What is the brain one.

[7]MR. BUTTAFUCCO: This is wrong.

[8]MR. PESCE: The CAT scan of the brain dated

[9]July 27th is marked as Plaintiff's 4.

[10]THE COURT: Plaintiff's 4 is supposed to be

[11]the lumbar spine.

[12]Let's do some changing. Let's change the
13. list, rather than change the exhibits.
" 14 Exhibit 3 is the cervical spine. Exhibit 2

[15]is now what?

[16]MR. BUTTAFUCCO: Lumbar and that's the MRI.
17. THE COURT: Exhibit, 4 is, 'counsel?

[18]MR. PESCE: The CAT scan of the brain.

[19]THE COURT: Fine.

[20]MR. BUTTAFUCCO: And the doctor has in front

[21]of him Exhibit 1.

[22]THE COURT: He has Exhibit 3.

[23]MR. BUTTAFUCCO: What happened to I?

[24]THE COURT: One are all the MRI's, A through

[25]M.
186

[2]Now we'll proceed with the right number.

[3]You had the right report. We just didn't have it

[4]numbered correctly.

[5]BY MR. PESCE:

[6]Q With respect to the disk bulges known as

[7]C-6, 7 and C-2, 3?

[8]A Yes.

[9]Q In your experience, disk bulge doesn't

[10]necessarily encroach upon nerves; is that correct?

[11]A That's correct.

[12]Q In **[*64]** fact, it's possible to have a disk bulge

[13]without any painful symptomology?

[14]A It's possible.

[15]Q Have you seen in your practice a number of

[16]patients who have disk bulges who don't complain of

[17]pain?

[18]A Usually when I see them is when they have

[19]pain. But there have been times when they don't have

[20]pain, yes.

[21]Q And you have seen patients, other than Mrs.

[22]Waterbury, who sometimes have a combination of bulges

[23]and herniations?

[24]A Yes.

[25]Q And in some of those situations the bulge is
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" 2 not creating pain, correct?

[3]A Yes.

[4]Q Now, with respect to Exhibit 3, the cervical

[5]MRI. There is no notation of any nerve root

[6]involvement with the disk bulges at C-6, 7 and C-2, 3?

[7]A That's correct.

[8]Q Therefore, Mrs. Waterbury was not

[9]experiencing pain as a result of the bulges at C-6, 7

[10]and C-2, 3?

[11]A That's incorrect.

[12]Q Doctor, there i.s no nerve root involvement?

[13]A Just because you don't have nerve root

[14]involvement doesn't mean you don't have pain. When I

[15]was showing the **[*65]** diagrams - -

[16]THE COURT: Is she experiencing pain as a

[17]result of C-6, 7?

[18]A I cannot tell you exactly where she is

[19]experiencing the pain from, whether it is C-5, 6 only,

[20]or a combination of all those three areas. It's

[21]physically impossible for any physician to tell you

[22]exactly where all of her pain is coming from.

[23]Q But you will agree that the MRI report where
24. it refers to the disk bulges, cervical disk bulges does

[25]not make any mention of nerve root encroachment,
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[2]effacement, compression?

[3]A That's correct, yes, sir.

[4]Q With respect to the disk herniation at C-5,

[5]C-6, there is also no mention of any nerve root

[6]involvement; correct?

[7]A Nerve root, that is correct. But there is

[8]cord compression.

[9]Q There is cord compression?

[10]A Yes, it says there is indentation, but

[11]without gross cord compression. Indentations and

[12]compression are not synonymous, it's just a matter of

[13]the'severity.
t

[14]THE COURT: How can it be synonomous. it

[15]says they are- - ?

[16]A No, if you have something indenting, it means

[17] **[*66]** touching it, but not compressing." Compression is a

[18]further tension. Indentation is a mild pressure on

[19]it.

[20]Q But this report does state and you did note

[21]without gross cord compression?

[22]A That's correct.

[23]Q In fact, that was consistent with your

[24]reading of the MRI when you read it in February'of

[25]1995?

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[2]A That's correct.

[3]Q Now, I would like to refer you to Exhibit 2

[4]which is the lumbar MRI report.

[5](Document handed.)

[6]Q And also there's reference to a disk bulge at
. 7 L-4, 5?

[8]A Yes.

[9]Q There is no mention of any nerve root

[10]involvement, correct?

[11]A Not in those exact words. It says mild sac
.12 effacement.

[13]Q Based on your review of the MRI film as well

[14]as this report, at L-4, 5 there was no nerve root

[15]compression?

[16]A Compression, no. Effacement, yes.

[17]Q Tell us what effacement is again?

[18]A Compression. is a severe amount of pressure.

[19]Effacement is just barely touching it.

[20]Q If you look at the reference to the disk

[21]herniation at L-5, S-1, **[*67]** it refers to it as a small.

[22]herniation, correct?

[23]A Yes, sir.

[24]Q And you agreed with the findings when you

[25]reviewed the MRI film that it was a small herniation,
190

[2]correct?

[3]A Yes, sir.

[4]Q And not all herniations will degenerate

[5]beyond a small herniation. It can remain a small

[6]herniation?

[7]A That's correct.

[8]Q No further MRI was performed after this one,

[9]as far as you know, is that correct?

[10]A That is correct.

[11]Q Now, this report also refers to the nerve

[12]root involvement at L-5, S-i, is that correct?

[13]A That is correct.

[14]Q And the word that is used is abuts?

[15]A That's correct.

[16]Q Not compression, not effacement?

[17]A That is correct.

[18]Q Abuts?

[19]A That's correct.

[20]Q Now, did you also have an opportunity to

[21]review the EMG findings that were done by Dr. Biddle?

[22]A Yes.

[23]Q Those were done in October of 1995?

[24]A Yes. is

[25]Q Now, as you testified you kept referring to
191

[2]different levels of the **[*68]** lumbar and cervical spine?

[3]A Yes, sir.

[4]Q Those are called levels, right?

[5]A Yes, sir.

[6]Q And the disks are referred to by their level,

[7]L-5, S-.1, meaning between L-5 and S-1?

[8]A Level of the nerves.

[9]Q You said there were two sets of nerves

[10]associated with it?

[11]A Right and left side.

[12]A Correct.

[13]Q In your practice when have you tests

[14]conducted, don't you refer to root involvement

[15]according to it's level?

[16]A Me personally, I do. Some doctors do not.

[17]They say lumbar radiculopathies or cervical

[18]radiculopathy.

[19]Q Which is what Doctor Biddle said?

[20]A That's correct.

[21]Q No reference to the level?

[22]'A Correct.

[23]Q Based on your review of the.report only, you

[24]could not determine at which level nerve root

[25]involvement was involved; correct?
192

[2]A Based on the report alone, that is correct.

[3]Q Based on your review of the MRI, did you

[4]agree that the herniation abutted the nerves at level

[5]L-5, S-i?

[6]A Yes.

[7]Q That **[*69]** was Dr. Biddle's?

[8]A Yes.

[9]Q And it was not a compression?

[10]A That is correct.

[11]Q Now, Doctor, with respect to degeneration,

[12]isn't it a fact naturally, as a person ages, there's

[13]natural degeneration of the spine?

[14]A Yes, but it's at all the levels, not just

[15]only one.

[16]Q It's at all levels?

[17]A If there is disk degeneration, it is

[18]uniform. It is not singularly.

[19]Q Are you telling us that all of the disks will

[20]degenerate with the same amount of degeneration?

[21]A The disk will go under degeneration

[22]uniformly. They might get one or two that might go

[23]under degeneration slightly more than the other., All
"

[24]the disks undergo degeneration, not just tkhe one that's

[25]been traumatized.
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[2]Q Isn't it a fact if degeneration shows up in

[3]an MRI a.day or two days after the accident, that's an

[4]indication of a prior condition that existed prior to

[5]the trauma?

[6]A No, that's not correct at all. My

[7]explanation explained to you that that is not the

[8]case. Once a disk herniates, the water content leaks **[*70]**
[9]out and as a result the disk starts to degenerate

[10]because the.moisture content is no longer completely

[11]present inside.

[12]Q Doctor, with reference to the cervical disk,

[13]cervical herniation, there was no evideice of

[14]degeneration there, correct?

[15]A That is correct.

[16]Q And with respect to the natural degeneration,

[17]one would expect that Mrs. Waterbury, as she ages,

[18]would have a natural degeneration, regardless of any

[19]accident or trauma?

[20]A Yes, sir, that's correct.

[21]Q Natural degeneration of the spine wouldn't

[22]necessarily affect one's ability,, disability and

[23]ability to work?
k;.

[24]A That's correct.

[25]Q So that would occur whether or not she had
194

[22]involvement in this accident?

[3]A In other words, it would not alter her normal

[4]ability to work. She would have a normal ability to

[5]work, as, according to all the other normal people,

[6]providing they didn't have disk herniations.

[7]Q Now, is it your testimony that whenever a

[8]person has a herniated disk, that they will require

[9]surgery?

[10]A Every case **[*71]** is different.

[11]Q Every case is different?

[12]A Every case is different. Depends on the

[13]clinical picture, not just on the MRI.

[14]Q Doctor, you examined Mrs. Waterbury

[15]approximately how many times?

[16]A Approximately five times.

[17]Q. When you saw her last in March of 2000, isn't

[18]it true you found her condition essentially the same as

[19]you did in February of 1995?

[20]A First of all, I examined her last May of

[21]2000, not March of 2000 and essentially there was some

[22]improvement since February 20, 1998.

[23]For example, her straight leg raising was now

[24]ninety degrees bilateral. Low back, left side deficit

[25]had improved. Range of motion of her neck and back
195

[2]was essentially the same.

[3]Q So you did find improvement?

[4]A Yes, she got therapy.

[5]Q With reference to March of 2000?

[6]A Yes, sir.

[7]Q Isn't it true that you basically found her at

[8]that point, essentially the same as she had been in

[9]February of '95?

[10]A Except for worsening of the right side

[11]straight leg raises, where before it was one **[*72]** hundred

[12]ten, here it was seventy-five degrees.

[13]Q Is your plan remaining essentially the, same?

[14]A Yes.

[15]Q Plan was to continue therapy. In your

[16]opinion, in March of 2000 was her condition the same

[17]as February of '98?

[18]A Yes, sir.

[19]Q In the two year period her condition, except

[20]for the straight leg raises, was essentially the same?

[21]A Waxing and waning, which is the normal course

[22]of this condition.

[23]Q You did not refer her for surgery in February

[24]of '98, though?

[25]A In February, no.
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[2]Q In fact, she saw no surgeon in consultation

[3]between February of 1998 and April of 2000?

[4]A I believe Dr. Ellman (phonetic) was a

[5]surgeon, was an orthopedic surgeon.

[6]Q In consultation with you?

[7]A with me, no.

[8]Q Isn't it a fact, Doctor, that if Mrs.

[9]Waterbury's therapy continues as it has and she shows

[10]improvement as you said she showed in May of 2000, she

[11]might not need surgery in the future?

[12]A Anything is possible, but not likely in this

[13]case because when she gets **[*73]** physical therapy, she gets

[14]temporary relief.

[15]Same way when you have arthritis you take

[16]pain medication or anti-inflammatory, you get temporary

[17]relief. It does not stop the progress of the disease,

[18]nor does the therapy stop or delay the progression of

[19]the disease. It gives her temporary relief.

[20]Q You told us a few minutes ago every case is

[21]different and not every one with a herniated disk

[22]requires surgery?

[23]A That's correct.

[24]Q Regardless, you said each person with a

[25]herniated disk is going to have natural degeneration,
197
E:.

[2]going to continue throughout the remainder of their

[3]life?

[4]-A That's absolutely correct.

[5]Q So the fact is not everyone needs surgery and

[6]Mrs. Waterbury may not need surgery in the future?

[7]A If you are asking me if it's possible she may

[8]not need surgery, anything is possible. Nothing is

[9]impossible.

[10]If you asked me based on her history and

[11]based on the test results--.

[12]Q That's not my question. My question is, is

[13]it possible?

[14]MR. BUTTAFUCCO: I object to just any.

[15]It's just **[*74]** such a vague question.

[16]THE COURT: That may be, but it's his

[17]question.

[18]Q With respect to Exhibit 2, is it also true

[19]that the herniation, that the S-1 root effacement was

[20]considered borderline when you looked at the impression

[21]on your report?

[22]THE COURT: Referring to Exhibit 2?

[23]A I'm looking to see where it says the word

[24]"borderline". It says the disk projects posteriorly

[25]and abuts the proximate S-1 nerve root.

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[2]Q Under impression at the bottom?

[3]A Yes. Under the impression it says that,.

[4]yes, that's correct.

[5]Q And upon your review of the MRI, you agree

[6]with that assessment, correct?

[7]A Yes.

[8]Q Now it's your understanding that Mrs.

[9]Waterbury has continued to work since the accident,

[10]except for a couple of weeks off in the beginning?

[11]A Yes, sir, that's correct.

[12]Q And you are also aware that since the

[13]accident, she had had a couple of children?
?Y…

[14]A That's correct, yes.

[15]Q Would it be possible in your opinion

[16]something such as childbirth could produce trauma that

[17] **[*75]** could create a back condition or herniation?

[18]A It can.

[19]Q Did you take that into account when you saw

[20]her in February of 1998, which was two and a half years

[21]after her accident, but after she had a child?

[22]A I took everything into consideration

[23]including the initial MRI's, initial doctors reports,

[24]my assessment and my assessment of her current

[25]condition when she is currently not pregnant.
j
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[2]Q Did you review any records with respect to

[3]her childbirth in February of 1995?

[4]A No, sir, I did not.

[5]Q I see. So you took that into account, you

[6]agree that a background such as bulge or herniation

[7]being caused by the trauma of childbirth, but didn't

[8]bother to review- - ?

[9]A Because her condition did not dramatically

[10]worsen compared to before.

[11]Q But yet you are giving testimony today as of

[12]causation?

[13]A The causation--.

[14]Q Yes or no. Your answer is yes or no?

[15]A Yes.

[16]Q And in the past two and-a-half years, have

[17]you at any time sent Mrs. Waterbury for any additional

[18]diagnostic **[*76]** tests?

[19]A I have suggested repeat EMG's to her.

[20]Q Have they been performed?

[21]A No, .I can't force a patient to have it.

[22]MR. PESCE: I have no other questions at

[23]this time.

[24]THE COURT: Redirect, counsel.

[25]MR. BUTTAFUCCO: Yes, your Honor..
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[2]REDIRECT EXAMINATION

[3]BY MR. BUTTAFUCCO:

[4]Q Doctor, what would be the point of a repeat

[5]EMG in this patient?

[6]A To see if the condition has worsened.

[7]Q And did she have EMG's in this particular

[8]case previous?

[9]A She did.

[10]Q When were they taken?

[11]A October of '95.

[12]Q Why would an EMG be significant five years

[13]later. Why would it be?

[14]A To see if there's worsening to the same level

[15]as involved before or if there's any other new levels.

[16]Q In your opinion, is a repeat EMG medically

[17]indicated?

[18]A In my opinion, it is indicated, yes;

[19]Q And how often would she need these?

[20]A Every two to three years.

[21]Q This came up on cross examination as to

[22]whether or not you order the repeat studies, MRI study

[23] **[*77]** and CAT scans. Are repeat MRI's indicated?

[24]A No, sir, they are not. "

[25]Q Why not?
201

[2]A First, it would not change the clinical

[3]picture.

[4]Number two, once you have a disk herniation-
S and you do .a repeat MRI, the 'disk will start.to

[6]degenerate and it will no longer be showing the

[7]extrusion amount that was present before because of the

[8]degeneration. So it would give the treating physician

[9]a misleading diagnosis. that the patient is now.cured,

[10]which in fact is not the case.

[11]Now, if the surgeon is contemplating doing

[12]surgery, the surgeon may do a myelogram. That is

[13]indicated right before surgery.

[14]Q So there is no need for a repeat MRI?

[15]A No, sir.

[16]Q Now, did childbirth cause her condition,

[17]Doctor?

[18]A No, sir.

[19]Q Can you tell the jury why that is the case?

[20]A In this case the chicken came before the

[21]egg. She had the herniation before her pregnancy.

[22]Q How do you know that?

[23]A I have the records. She wasn't pregnant

[24]then. She became pregnant after the accdent.-

[25]Q **[*78]** You did say on cross childbirth can cause an
202

[2]exacerbation after the actual pregnancy is over?

[3]A Yes, it can.

[4]Q Can you explain how that works?

[5]A When you reach the last trimester, the

[6]abdomen is distended, muscles become weak both in the

[7]front and back. It puts more pressure on the disks,

[8]increases weight carrying, increases force on the

[9]abdomen and spine. Typically during the last.

[10]trimester, the patient feels worse.

[11]Q Can we then blame the herniation on the

[12]pregnancy?

[13]A No, sir.

[14]Q Now, you indicated that at various times you

[15]had seen her. You indicated you saw her five times.

[16]That's the times you examined her?

[17]A That's correct.

[18]Q She was seen in your office how many times?

[19]A She has approximately fifteen therapy

[20]sessions.

[21]Q Did she also speak to a physician's assistant

[22]when she went to your office?

[23]A_ Yes, sir.

[24]Q Do you review those records?

[25]A Yes.
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[2]Q Do you review the therapy records?

[3]A Yes.

[4]Q **[*79]** Is that part of your overall. picture?

[5]A Yes, sir.

[6]Q You indicated in your cross that at various

[7]times she would show some improvement. At least one

[8]time, as I recall, is that right?

[9]A Yes.

[10]Q In fact, there was a time when the straight

[11]leg raising went to one hundred ten degrees?

[12]A Initially the right side it was one hundred

[13]ten, the left side was seventy-five.

[14]Q Then that changed?

[15]A That changed as of March 2000 they were both
16. seventy-five and as of May, they were both ninety

[17]degrees.

[18]Q What do you attribute that change to?

[19]A She was getting physical therapy, she was

[20]improving and when she wasn't getting physical therapy,

[21]she was showing exacerbation.

[22]Q How does physical therapy affect something

[23]like straight leg raises?

[24]A when you get electrical stim and massage and

[25]exercise, you improve flexibility, you improve range of
204
rc;

[2]motion and diminish pain.

[3]Q That doesn't make the disk go back in?

[4]A No, it does not.

[5]Q That doesn't change **[*80]** the overall prognosis?

[6]A It does not.

[7]Q Now, is it true that the neurologist, Dr.

[8]Biddle, also diagnosed a radiculopathy?

[9]A Yes.

[10]Q I believe that came out on cross?

[11]A Yes.

[12]Q Was his diagnosis in a more general sense

[13]than yours?

[14]A Yes.

[15]Q Explain why?

[16]MR. PESCE: Objection to whether Dr.

[17]Biddle's diagnosis was in a general sense.

[18]THE COURT: Sustained.

[19]Q Explain how it differed?

[20]MR. PESCE: Same objection, your Honor.

[21]THE COURT: If he had two reports and sees a

[22]report of one doctor and sees his own report, he

[23]can explain how they differ. Not why they

[24]differ. But one report says A, one'--report says

[25]B. He can tell us how those reports differ.
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[2]A The report of Dr. Biddle, he diagnosed

[3]cervical radiculopathy. He was not able to pinpoint

[4]the exact level. As you could see, there were three

[5]disks involved. He could not determine.

[6]THE COURT: How do you know he could not

[7]determine.

[8]THE WITNESS: He did not mention C-5, C-6.

[9]THE COURT: It's not that he didn't mention.

[10] **[*81]** It's not that he couldn't determine. All we know

[11]is he didn't mention it.

[12]THE WITNESS: That's correct.
.13 Q Was there something that occurred later on.
i

[14]that allowed it to be more accurateIYP nPointed?

[15]A The patient's symptomatology became more

[16]focused and the patient's clinical picture became more

[17]focused and it made itself more evident.

[18]Q How about the EMG, was that able to pinpoint

[19]it somewhat?

[20]A I have the EMG's right here.

[21]It was only able to pinpoint with reference

[22]to the bilateral carpal tunnel syndrome and mentioned

[23]cervical and lumbar radiculopathies, not to the exact

[24]levels. x.

[25]Q You don't have the actual report for the
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[2]EMG. Do you have the actual numerical values?

[3]A With reference to the motor and sensory, I

[4]do. With reference to the actual EMG, I just have the

[5]work sheet. I don't have all the tracings so I can't

[6]really tell you exact level myself, either.

[7]Q And for purposes of this case, does it makes

[8]a difference if it's level A, B or C?

[9]A No, just means there is nerve root damage. **[*82]**
[10]Q Now, you went through the various MRI's and

[11]CAT scan reports with Mr. Pesce on cross examination,

[12]do you remember that?
_ 13 A Yes, sir.

[14]Q Can you explain to the
jury how a patient is

[15]positioned when these diagnostic studies are done and

[16]how that may possibly affect the reading?

[17]MR. PESCE: I object. This goes beyond

[18]cross examination.

[19]THE COURT: Well, it does go beyond the exact

[20]language of cross examination. I think it's a

[21]fair follow up. But I think we are now

[22]speculating.

[23]Unless he can tell me that this patient,

[24]which he can't, was positioned in a Particular

[25]fashion. Unless he can say all patients who are
207

[2]given such a test are positioned in a particular

[3]fashion.

[4]MR. BUTTAFUCCO: I'm not a hundred per cent

[5]sure myself.

[6]THE COURT: Why don't we ask.

[7]Q Can you tell us how a patient is positioned

[8]for, let's start with a cervical CAT scan?

[9]A For CAT scan or MRI the patient is positioned

[10]flat down, facing up.

[11]Q Is there a medical term for that?

[12]A Yes, it's called the upright position, prone **[*83]**
[13]position. Supine is facing down. Prone is facing up.

[14]Q Is that universal?

[15]A Yes, unless they are doing a motion, CINE,

[16]motion, when the patient is flat, moving the neck

[17]forward and back and the record will reflect it's a

[18]CINE MRI.

[19]Q This is not the case?

[20]A Not the case.

[21]Q This is a standard MRI, standard CAT scan?

[22]A That's correct.

[23]Q How does the position of the patient in that

[24]normal position, how does that affect the reading in

[25]terms of what the MRI shows?

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[2]A When a patient is laying in that normal

[3]position, they are not stretching the disks to their

[4]full stretch level as you would with full forward

[5]flexion or full backward extension. When you do.fall

[6]forward, you are stressing the disk and if herniated,

[7]the amount of leakage would be at its maximum level.
.8 That's when they do these CINE studies.

[9]Q This type of fluid we're talking about is not

[10]water?

[11]A No, it's gelatinous material. Water filled

[12]with proteoglycans. Gelatinous material, semi-solid,

[13]like jello.

[14]Q **[*84]** Would you explain the consistency of this

[15]material?

[16]A It's like jello.

[17]Q Because a particular reading on an MRI report

[18]which you, by the way, agreed with, it says abuts the

[19]nerve root. Does that mean it's impossible or does

[20]not cause pain?

[21]A Absolutely not. As I explained earlier, .you

[22]don't even have to have compression on the spinal cord

[23]or nerve root. You can have pain by release of the

[24]chemicals, you can have pain by the stretching of the

[25]outer one third perimeter where you have the nerve
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[2]fibers, the nociceptors.

[3]Q Are there in fact some findings on these

[4]MRI's or CAT scans, I forget which, which-show actual

[5]compression or indentation?

[6]A They are both. The CAT scan of the cervical

[7]spine shows, it says there is sac indentation, but--

[8]THE COURT: What was the word?

[9]THE WITNESS: There is sac. That's the

[10]nerve root. The nerve root has a sac.

[11]Q The sac .is?

[12]A S-A-C.

[13]Q Explain to the jury what that means?

[14]A Here's a picture of a nerve root. As you

[15]can see, right where where the nerve **[*85]** root exits the

[16]spinal cord, it has a sac. It's called a thecal

[17]sac. It's the protective membrane that covers this

[18]nerve root to protect it from vulnerability.

[19]Indentation of the sac means it's the level of

[20]severity. It's a mild case of compression as opposed

[21]to full compression, which is far more severe.

[22]Q If there was full compression, what would

[23]that mean?

[24]A That would mean there would be motor

[25]weakness. Loss of a reflex and transmission of the
210

[2]signals from the arms to the brain would be

[3]significantly interrupted.

[4]Q It's a question of we're talking about it's a

[5]question of degree?

[6]A That's exactly what it is. It's a question

[7]of degree.

[8]MR. BUTTAFUCCO: No further questions.

[9]MR. PESCE: Just a couple of questions on

[10]recross.

[11]RECROSS EXAMINATION

[12]BY MR. PESCE:

[13]Q Doctor, you just made reference to the fact

[14]that after an initial MRI is performed, there is

[15]subsequently no need for a follow-up because you will

[16]base your findings on the patient's symptomatology?

[17]A Called the clinical picture.

[18]Q **[*86]** The patient's symptomatology is based on the

[19]subjectivity of the patient's complaints?

[20]A No, subjective and objective.

[21]Q Saying objective with respect to clinical

[22]observations?

[23]A That's correct.

[24]Q In other words, when you touch tr-he patient or,

[25]move part of the patient's body, she says it hurts?
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[2]A No, that's incorrect. That's part of the

[3]clinical observation. Clinical observatoin is a

[4]whole battery of observation, physical findings, spasm,

[5]trigger point, reduction of range of motion, the loss

[6]of sensation, loss of motor power, loss of range of

[7]motion.

[8]Q Which is all based on an examination and a

[9]discussion with the plaintiff as to what hurts and what

[10]doesn't and how they can move and how far they can't

[11]move?

[12]A No, the examination is irrespective of the

[13]first part, of the history. First you take the

[14]history, then the patient says nothing, you examine the

[15]patient. You tell the patient what to do, not the

[16]patient tells you what hurts or what is bothering her,

[17]that's the first point.

[18]Q The patient **[*87]** says they can only move their

[19]neck so far, they can only move their neck so far.

[20]Don't you follow up with an MRI to see if there's any

[21]objective finding to relate to the subjective

[22]complaints?

[23]A I don't know what medical school you went

[24]to. In the medical practice we don't do!-it that way.

[25]THE COURT: We assume he didn't go to medical
212

[2]school. There are lawyers who are also medical

[3]practioners. But for our purposes now, why don't

[4]we answer his questions.

[5]A No, there was no need for repeat MRI.

[6]Q That was going to be my next question.

[7]in this particular case, based upon the

[8]symptomatology you found in your examination of

[9]February of 1998, two and-a-half years after the

[10]accident, you found no need to do any repeat diagnostic

[11]studies?

[12]A I did.

[13]Q Objective studies such as MRI or EMG?

[14]A I said she needs a repeat EMG.

[15]Q You didn't do it in February of 1998?

[16]A Because the patient refused. It's too

[17]painful.

[18]Q So plain and simple, there was no objective

[19]diagnostic test performed, to back **[*88]** up what her

[20]subjective complaints were and what your clinical

[21]findings were; correct?

[22]A With reference to the way you phrased that

[23]question, it can't be answered yes or no. There was

[24]objective findings, already confirmed by her

[25]symptoms. There was follow up to show worsening or
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[2]pinpoint the exact level of injury.

[3]MR. PESCE: Thank you.

[4]THE WITNESS: You are welcome.

[5]THE COURT: All right, Doctor, thank you very
.6 much. Take your stuff. Don't take our stuff.

[7]I believe you were only referring to. Exhibits

[8]2 and 3.

[9]MR. PESCE: That's correct

[10](Whereupon, the witness was excused.)

[11]THE COURT: Counsel, do you have any other

[12]witnesses this morning?

[13]MR. BUTTAFUCCO: No.

[14]THE COURT: The jury then is excused at this

[15]time. They are, of course directed once again

[16]not to form any opinion about this case, even in

[17]your own minds, forget about talking with others

[18]and do not discuss this case with your fellow

[19]jurors or-with anyone else.

[20]2:00 p.m., please.

[21].(Whereupon, there was a luncheon recess in

[22]the proceedings.)

[23]
[24]
[25]
214 **[*89]**
[2]A F T E R N O O N S E S S 1 O N:

[3]THE COURT: Yes, gentlemen. The clerk tells
I

[4]me your alignment of experts is slightly

[5]different.

[6]MR. PESCE:- Originally I had Dr. Diamond

[7]coming in tomorrow afternoon.

[8]THE COURT: No, tomorrow morning, I thought.

[9]MR. PESCE: No, no, originally tomorrow

[10]afternoon. But when Mr. Buttafucco stated he had

[11]a problem with his economist, he could only bring

[12]him in Friday afternoon, I tried to make some

[13]arrangement to bring the doctor in Monday. He

[14]wouldn't be available again until Wednesday

[15]morning. None of us wants to prolong the

[16]trial. We discussed tomorrow morning I can bring

[17]in the insured for like five questions, then put

[18]on Doctor Pfeffer, who I don't think will take

[19]long. Mr. Buttafucco would then put on the

[20]economist.

[21]THE COURT: In the morning?

[22]MR. BUTTAFUCCO: Yes.

[23]THE COURT.-' I thought you only had him in the

[24]afternoon.

[25]MR. PESCE: First we have to finish up after
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