2001 WL 36383438 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
Queens County

Spryos STYLIANOU, Plaintiff,
v.
Joseph CALABRESE, Defendant.

No. 026500/98.
January 26, 2001.

**(Transcript of Steven Touliopoulos, M.D.)**

**Name of Expert: Steven** J. **Touliopoulos**, M.D.
**Area of Expertise:** Medical & Surgical >> Surgery -- General
**Area of Expertise:** Medical & Surgical >> Orthopedics
**Representing:** Plaintiff
**Jurisdiction:** Queens County, New York

Appearances.

Queller, Fisher, Dienst, Serrins, Washor & Kool, LLP, Attorneys for the Plaintiff, 233 Broadway - 18th Floor, New York, New York 10279, By: Lambros Y. Lambrou, Esq.

Law Office of Robert Tusa, Attorney for the Defendant, 1225 Franklin Avenue, Garden City, New York 11530, By: C. Frank Sena, Esq.

Before: Honorable Joseph G. Golia, Justice of the Supreme Court.

General Courthouse

88-11 Sutphin Boulevard

Jamaica, New York 11435

(And a jury)

LINDA CALDERON

OFFICIAL COURT REPORTER

[Note: Pages 173-184 missing in original document]

Good morning everyone. Your bosses enjoy seeing you for the two days? I'm sure they did. Thank you for your timeliness in going along with the Court in terms of the recesses we had going along with the case.

You have another witness?

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MR. LAMBROU: Thank you, your Honor.

At this time the plaintiff calls Dr. Steven Touliopoulos to the stand.

THE COURT: Doctor, please.

THE OFFICER: Remain on your feet, raise your right hand and face the clerk, sir.

DR. STEVEN TOULIOPOULOS, called as a witness on behalf of the Plaintiff, having been first duly sworn by the Clerk of the Court, was examined and proceeded to testify as follows:

THE CLERK: Thank you, please be seated.

THE OFFICER: Doctor, please state and spell your name.

THE WITNESS: Last name Touliopoulos, T-O-U-L-I-O-P-O-U-L-O-S, first name Steven, S-T-E-V-E-N.

THE OFFICER: And your business address?

THE WITNESS: 31-09 Newtown Avenue, Astoria 11102.

THE OFFICER: Thank you.

**DIRECT EXAMINATION**

BY MR. LAMBROU:

Q Good morning, Doctor.

A Good morning.

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

A Yes, I am.

Q When were you so licensed?

A 1992.

Q And could you tell the ladies and gentlemen of the jury a little bit about your educational background starting with your undergraduate training.

A Yes, I went to college at Columbia University in Manhattan. I majored in chemical engineering. I stayed on and obtained a masters in bioengineering at Columbia University.

I went on to medical school at Downstate Medical Center in Brooklyn where I spent four years. I stayed on there for my internship in general surgery and then I did four years of training in orthopedic surgery at Downstate Medical Center.

I then did an additional year of fellowship training in shoulder and knee injuries at Lenox Hill Hospital in Manhattan.

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Q During that time, during the time of your fellowship, did you consult with any professional athletic organizations?

A Yes. I was part of the team of physicians taking care of the New York Jets and the New York Rangers, together with injuries at the collegiate level at Hofstra University and Hunter College.

Q And what did you do professionally after completing that fellowship at Lenox Hill?

A I began a solo private practice based in Queens, Manhattan and Brooklyn.

Q And are you still in private practice?

A Yes, I am.

Q And where is your office currently?

A My address in -- my main address is in Astoria, Queens.

Q Are you board certified, Doctor?

A Yes, I am.

Q By what board are you certified?

A The American Board of Orthopedic Surgeons.

Q And in what area are you certified?

A As an orthopedic surgeon.

Q And are all doctors board certified?

A No, they are not.

Q How does a doctor become board certified?

A They have to complete their residency in an accredited program in the United States, at which point they take a written examination which is one day in length. After passing that examination, they take an oral exam two years later which is based on their clinical practice, and after passing both tests they become board certified.

Q And have you authored any articles that were published?

A Yes, I have.

Q How many?

A Three.

Q And have you made any medical presentations?

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A Yes, I have.

Q And have you held any teaching positions in the medical profession?

A Yes, I have academic affiliations with several hospitals.

Q Which hospitals are those?

A Lenox Hill Hospital, Saint Vincent's Hospital in Manhattan, Brookdale Hospital in Brooklyn.

Q And what is your teaching title?

A Adjunct assistant professor.

Q And do you have any attending privileges at any hospitals?

A Yes.

Q Which ones?

A Those three I mentioned. In addition, Mount Sinai Hospital of Queens, and Long Island College Hospital in Brooklyn.

Q What are attending privileges?

A You have the right to admit patients to the hospital, to treat patients during the hospitalization, and to perform surgery on the patients.

Q Have you ever testified in court before?

A Just one time.

Q And have you ever testified for myself or my law firm?

A No, I have not.

Q Have you ever conducted an examination of a patient for the exclusive purpose of testifying at trial?

A No, I have not.

Q Are you being compensated for your time here today?

A Yes, I am.

Q At what rate?

A At $400 an hour.

MR. SENA: Excuse me, Doctor, 400 what?

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THE WITNESS: $400 an hour.

MR. SENA: An hour?

THE WITNESS: Yes.

Q And did you prepare a narrative report at the request of my law firm?

A Yes, I have.

Q And did you charge us for that?

A Yes, I did.

Q What was the charge for that?

A I believe it was $400 or $350, in that ballpark.

Q Now, Doctor, can you tell the ladies and gentlemen of the jury what orthopedic surgery -- what orthopedics is?

A It's the profession that deals with the treatment of bone and muscle injuries of the body.

Q And, Doctor, are you familiar with the mechanics of the human shoulder?

A Yes, I am.

Q I would like for you to explain the mechanics of the shoulder to the ladies and gentlemen of the jury.

MR. LAMBROU: I have a chart here, I would like to have it marked please.

THE COURT: Plaintiff's 9 for ID.

(Whereupon, Plaintiff's Exhibit 9, chart, was received and so marked for identification.)

MR. LAMBROU: Please show it to the witness.

THE OFFICER: (Handing.)

A (Examining Plaintiff's Exhibit 9.)

Q Would that chart be helpful to you in explaining the mechanics of the human shoulder to the ladies and gentlemen of the jury?

A Yes, it would be.

MR. LAMBROU: I offer it into evidence, your Honor.

MR. SENA: No objection, your Honor.

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THE COURT: Mark it in evidence.

(Whereupon, Plaintiff's Exhibit 9, chart, was received and so marked in evidence.)

THE COURT: You want to stand?

THE WITNESS: Sure.

THE COURT: You want to move over?

A The shoulder is a joint. It's a ball and cup. And it's held -- this is the joint, this is the ball. This is called the humerus, the head of the humerus, and this is the cup. That's called the glenoid.

It's held in place by ligaments. And these are the ligaments. They go from the ball to the cup. And these ligaments are the primary restraint of the shoulder, they prevent the shoulder from coming out of the socket in either direction, either forward, backward or down or up.

Q Okay. And are you finished with your answer?

A I can go into a little more detail, actually.

If you look inside the cup, you have a circle of cartilage. This is called the labrum. This also helps to anchor the ball and the cup. The labrum and the surrounding structure which are the ligaments are the structures frequently injured in traumatic accidents of the shoulder.

I could go into more detail about the pathology of the specific case if you want me to?

Q We will get into that in a minute.

Doctor, have you treated people in the past who had shoulder injuries?

A Yes, I have.

Q And have you performed surgery on those people?

A Quite frequently.

Q How frequently?

A I would say one to two a week.

Q And have you performed surgery on those people that have shoulder injuries as a result of car accidents in the past?

A I would say most of the patients I operate on, most of the injuries that I see are from motor vehicle accidents.

Q Okay. Thank you, Doctor, we will get back to the chart in a few minutes.

Did there come a time when you met Spyros Stylianou?

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A Yes.

Q When was that?

A Let me look at my notes.

Q Sure.

A (Examining documents.)

His first visit was on October 14th, 1998.

Q Now, Doctor, that chart you have there in front of you, is that the chart of Spyros Stylianou?

A Yes, it is.

Q And is that chart kept in the ordinary and normal course of business?

A Yes, it is.

MR. LAMBROU: I offer this chart into evidence, your Honor.

MR. SENA: Objection, your Honor.

The doctor's chart being admitted in evidence -- I mean I will look at it.

THE COURT: Look at it.

MR. SENA: He can testify from it.

THE OFFICER: (Handing.)

MR. SENA: (Examining doctor's chart.)

May we approach, your Honor?

THE COURT: Sure.

(Whereupon, an off-the-record bench conference was then held.)

THE COURT: Overruled.

(Whereupon, Plaintiff's Exhibit 10, Dr. Touliopoulos's file, was received and so marked in evidence.)

THE OFFICER: For the witness?

MR. LAMBROU: Yes, please.

THE OFFICER: (Handing.)

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A (Examining Plaintiff's Exhibit 10.)

Q Now, Doctor, the medical records within that chart that were offered by other doctors, did you rely upon them in treating the patient?

A The medical records of other doctors, no, not entirely. I would look at them but I would base my medical opinion on my examination.

Q Well --

THE COURT: Did those reports not assist you in your recommendations?

THE WITNESS: Yes, they did. But I base my -- let me correct myself.

They assist me in my evaluation of the patient but I base my decision of treatment on my findings.

THE COURT: Okay.

Q Now, at the time you met Mr. Stylianou for the first time, how was he referred to you?

A He was referred from the Sports Medicine center from one of the treating physicians.

Q Okay. And at that time, did you obtain that record?

A Yes, I did.

Q Okay. Now, did you elicit a history from Mr. Stylianou the first time you met him?

A Yes, I did.

Q Okay. Can you tell us what that history was?

A He was involved in a motor vehicle accident in which he sustained injuries to his right shoulder, neck, lower back and right rib cage.

He presented to the office complaining of -- referred for specifically the shoulder, although he did have significant pain involving the right side of the neck and the upper extremity.

And his complaints included stiffness of the shoulder, pain with motion, weakness and intermittent numbness of the hand, of the right upper extremity.

Q Okay. And, Doctor, what's the importance of eliciting a history from a patient?

A It's important, you know, we delve into his past history, and the patient did not have any prior history of shoulder symptoms or trauma prior to this accident.

Q And did you conduct a physical examination after eliciting the history and the complaints from the patient?

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A Yes, I did.

Q And what did your physical examination consist of?

A I was unable to move the shoulder to any significant degree because of pain. There was also associated weakness in the shoulder when I tested for more strength.

Of the greater significance, however, were signs of shoulder looseness, and these are called the apprehension and relocation tests.

Q Okay. What are those tests?

A These tests are pathonomic for shoulder looseness. What I mean by pathonomic, they basically make the diagnosis that the shoulder is loose. And what it is, involves bringing the arm back in this position (indicating.)

The best we could, because he was having a lot of pain, and as you do this the ball comes forward out of the cup and produces significant pain. It kind of reproduces his symptoms.

As I push back on the ball with his arm still in this position, that's called the relocation test. And if the pain goes away, it's positive, meaning that I'm pushing the ball back in the cup, and a lot of his symptoms of pain are alleviated, they get better. So those -- both those signs were positive.

Q And what's the medical significance of that?

A It means that the shoulder is loose, and we call, the medical term is instability.

Q Now, with those two tests that you just told us about, are those objective or subjective tests?

A Those are objective tests.

Q And explain to the ladies and gentlemen of the jury the difference between objective and subjective tests.

A An objective test is one which I perform in which the patient has very little input into. He -- something that he can lie about. Subjective findings are those that a patient reports to me, such as pain, loss of motion.

Q Okay. Now, after this physical examination and your findings, did you come to make a medical plan or a plan of treatment for this patient?

A Yes.

Q What was that plan?

A The plan was -- we also had MRI findings that confirmed my diagnosis.

Q Well, I will get to those in a minute.

A Okay.

Q I'm asking you about your plan.

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A We had diagnosed him with shoulder instability, and I knew at that point that he would likely require an operation. Of course surgery is the last resort and I wanted to try everything first. And he had already begun a therapy program. I recommended a continuation of physical therapy, emphasizing range of motion of the shoulder and strengthening hopefully to regain some of his dysfunction.

Q And at some point after you saw him on that date, did you review his MRI films?

A Yes, I did.

Q Okay. And are those -- do you have those films of his shoulder here with you?

A Yes, I do.

Q Okay. And can you please explain the findings of the MRI for the ladies and gentlemen of the jury.

A Sure.

Q Do you need a shadow box?

A It would be helpful.

Q Okay.

A These are MRIs of the patient's shoulder.

THE COURT: What shoulder are we talking about, Doc?

THE WITNESS: This is the patient's right shoulder.

A And this is the ball, the humerus that I showed you a picture of. This is the glenoid or the cup. And on these pictures we see the little indentation here. This is called a Hill-Sachs lesion. Basically there is a dent in the bone. It got punched in. And that occurs in patients with shoulder looseness, whether it be the shoulder coming out completely or coming out halfway, the ball comes out of the cup, okay, and on its way back in, it bangs the wall, and it puts a big dent in the head. And then it can either slip back into the cup, if it goes this way or if it goes that way, it stays dislocated in this patient, it slipped back into the cup.

I'll show you another film.

This is also more films of the patient's right shoulder. And what we are looking at are pictures in this direction of the shoulder.

(Indicating.)

And this is again the cup in a different view and the ball.

Here we see we're looking at the labrum, that structure I pointed to on the diagram that helps hold the shoulder in place. This is the posterior labrum which you see a black dot which is in place. The anterior labrum is completely torn from the -- from the glenoid where it belongs, which also goes along with instability.

So, in other words, as the shoulder comes forward, it rips the labrum off, which helps to hold the shoulder in place. And then as it comes back it dents in. So all these findings are consistent with my physical examination.

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Q And did there come a time when you recommended surgery to this patient?

A Yes.

THE COURT: Are we going to mark those documents?

MR. LAMBROU: Oh, I'm sorry.

THE COURT: I appreciate they were already shown to the jury.

MR. LAMBROU: I'm sorry.

THE COURT: Have it clear for the record.

MR. LAMBROU: Sure, can we please have them.

I offer them into evidence as Plaintiff's 10.

MR. SENA: Before they are marked into evidence, he should read whether there is a name on it and the numbers of those x-rays.

THE COURT: I agree.

MR. SENA: So my doctor will know which ones.

THE COURT: Which ones we are talking about.

Label which ones you talked about because he looked at two films.

MR. LAMBROU: Okay.

THE COURT: Take the two out.

THE WITNESS: The front two.

THE COURT: And the first film you referred to, Doctor.

THE WITNESS: The first film is this and the name is Spyros Stylianou, and --

MR. LAMBROU: Should we mark them individually, your Honor?

THE COURT: One minute.

The name on it is?

THE WITNESS: The name is on the -- is on here. I'm trying to find the number of the image.

THE COURT: Yes.

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THE WITNESS: So it's 000006668-31.

THE COURT: We will mark that as 11A.

(Whereupon, Plaintiff's Exhibit 11A, MRI, was received and so marked in evidence.)

THE COURT: And the second film, also the name Spyros Stylianou, and the number is 000006668-10.

THE COURT: Mark that 11B.

(Whereupon, Plaintiff's Exhibit 11B, MRI, was received and so marked in evidence.)

Q When was that?

A It was a couple of months after my initial evaluation.

Q And what was the reason why you recommended surgery at that time?

A We had spoken, and basically the patient's symptoms had not improved. They were the same as they were from the time I had seen him. So he was not making any progress with conservative treatment.

Q So what kind of surgery did you have planned?

A I had planned an arthroscopy, which is basically -- it's microsurgery. Made three or four small holes in the shoulder and going with a fiberoptic camera where we can look around the shoulder, look at the damage, and through multiple other little holes we can usually do a cleaning and a tightening of the shoulder.

Q And did there come a day when you did in fact perform surgery on Mr. Stylianou?

A Yes, I did.

Q And what day was that?

A That was December 10, 1998.

MR. LAMBROU: Your Honor, if I may approach, I would like to put the Lenox Hill records close to the doctor in case he needs to refer to them in his testimony?

THE COURT: Sure.

MR. LAMBROU: Thank you.

(Handing.)

Q Now, was general anesthesia required for the surgery?

A Yes, it was.

Q What is general anesthesia?

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A It's basically an induced coma, where the patient is heavily sedated, and is sedated to the point where he cannot breathe on his own, and a tube is inserted through the mouth into the --

Q Doctor, if I may, can you speak up louder, I'm having a problem hearing you.

A A tube is inserted into the trachea so the machine can breathe for the patient.

Q And was there an anesthesiologist present during the surgery?

A Yes.

Q Was there a doctor assisting you?

A I had a resident assisting me.

Q Now, how long did this surgery last?

A Three to four hours.

Q Okay. And what did you do -- feel free to look at your operative report -- during the course of the surgery?

A After the patient had the anesthesia, we repositioned the patient into a sitting position. At that point we cleaned the shoulder, we painted it with Betadine to clean the germs.

Q Doctor, speak louder, I'm having problem hearing you.

A We make a small incision in the back of the shoulder where we go in with the camera through the muscles and into the joint, and we begin our diagnostic, meaning that we are taking a look, basically arthroscopy.

When we went in the shoulder I was actually a little shocked because it was much more severely injured than the MRI had revealed, and what struck me initially was that the surfaces of the bone were chipped. In other words, there was -- I will give an example.

On the ends of the chicken bone there is a shiny white thing. That's cartilage. That covers the bone and lubricates the joint.

In Mr. Stylianou he had large areas of this cartilage that was chipped off the bone on both the glenoid, which the cup, and on the humerus, which is the ball, so basically instead of having two nice smooth surfaces rubbing each other he, had bone rubbing on bone which at this early age is not good.

There was fraying in the shoulder. We made another incision in the front in which we went in with a --

Q Doctor, before you get to that, let me just take you a few steps back.

The findings that you just made or you just told the jury about, what's the medical significance of those findings?

A It's an arthritic condition, meaning it's osteoarthritis.

Q Okay. And did you in fact photograph the condition of his shoulder at that point of the surgery?

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A Yes, I did.

Q Okay. Why did you do that?

A I wanted to show the patient how badly damaged his shoulder is so he was aware of the damage.

I also wanted to keep a file because of the pathology present to show the residents and for teaching purposes.

Q Okay. When you say “the pathology present,” can you explain to the jury in layman's terms what that means?

A The amount of injury in the shoulder, it was kind of classical and I wanted to document it to show residents at conference what it really is when you have a torn labrum and what it is when you have a chipped bone in the shoulder.

Q Can you -- with the Court's permission -- stand down and explain to the jury what's in those photographs?

MR. LAMBROU: Your Honor?

THE COURT: Sure.

A This is arthroscopic pictures taken --

Q Doctor, I'm sorry, can you come closer so all the jurors can hear.

A These are called arthroscopic pictures. These are pictures taken with a camera that I had positioned in the shoulder joint.

This structure here is the labrum. This belongs attached to this. This is the cup. So this was yanked off the labrum and it was over here, resulting in his looseness.

These areas here are areas where the cartilage was knocked off the bone, so whereas this area still has some cartilage on it and is whitish, this area is red and is -- we call it denuded, meaning that the cartilage was removed from the bone surface and is present on both.

This is the cup, all this pink is abnormal, and also on the humeral, on the ball.

You see these red areas. Again this white area is fairly normal although it still has abnormalities. This area is completely devoid of any covering.

Q And is there anything -- there are two sets of photographs?

A There is more. Actually there is three sets that -- those basically cover the same thing over and over again. Again the area here, which is almost normal, and this whole area here on the head which no longer has any covering.

So whenever the patient moves his arm now it's basically his bone is rubbing bone and over time it's just going to progress and get worse and worse and worse.

Q Okay. Now, the condition that's depicted in those photographs, is that a long-standing condition?

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A No. These findings are acute, meaning that these are something that happened within the -- within several months of the surgery or within -- it's hard to say, I would say within several months of the operation, and I can tell that they are new because there is still, we call erythema, things are still red, meaning they are still in the posttraumatic period where things are healing or trying to heal.

The edges of the cartilage here, the area where it goes from almost normal to abnormal is kind of sharp, where it kind of falls from that in a sharp, over a sharp small area.

If it was chronic, this would be smoothed out. It would -- there would be different findings.

Q Now, when you say “chronic,” what do you mean?

A If it was years old.

Q Okay. And the condition depicted in those photographs, is that consistent with, you know, diving or swimming over a long period of time?

A It is not at all.

Q Okay. Why not?

A These findings are the result of a traumatic event. The findings you find with swimming are problems that happen in the bone, not findings that happen in the joint.

Q Okay. Now --

THE COURT: I'm sorry, would you sit down, Doctor.

MR. LAMBROU: I was just going to tell him that, thank you.

(Whereupon, the witness then resumed the witness stand.)

THE COURT: Is it clear that the photographs shown to the jury are already in evidence?

MR. LAMBROU: No, it is now, your Honor.

THE COURT: Is it now?

Q Well, Doctor, are those photographs part of the chart that's already in evidence?

A Yes, they are actually stapled in the chart.

Q Now, can you continue with what you did during surgery after the photographs.

A Yes. We made an additional portal, meaning an additional hole to which we were able to go to in with a probe and kind of feel things out, and we examined the labrum and found that it was completely torn. It was torn in the accident; that it was not repairable arthroscopically.

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With a small labrum tear we can tack it with small tacks arthroscopically. This injury was so severe that we needed to open the shoulder to tack it back.

There were other smaller findings in the shoulder. We did some cleaning of the cartilage injury.

Q And how did you do cleaning of the cartilage injury?

A We go in with a motorized shaver, okay, and we kind of trim the areas where the cartilage is loose, which is about to fall off in the shoulder. We trim areas of the labrum that's been frayed, meaning that there is roughened edges.

Q Okay. And was this all done before another bigger incision was made?

A That is correct.

Q Okay. Did you do anything else before that bigger incision was made?

A Arthroscopically?

Q Yes.

A We look throughout the shoulder at the different structures; at the tendons, at the ligaments. We noted that the ligaments were loose as was previously diagnosed on my examination, and there was findings of the Hill-Sachs lesion that we also discussed on the MRI.

At this point we went on and we did the open operation, which involves an incision in the armpit region several inches long, where we go in and we have to -- it's the dissection, is fairly difficult.

We have to go through multiple muscle layers. We have to go through the pectoralis major muscles and the deltoid muscles and actually go to remove some of the rotator cuff muscles that are in the shoulder to get down into the shoulder joint. And when we finally reached the shoulder, again, it was as we found arthroscopically. The labrum was completely off the bone. We had to tack it back in. We used anchors. We drilled holes into the cup, and we put --

Q Doctor, if I can stop you for one second.

What did you use to drill holes into the cup?

A It's like basically like a Black and Decker, like a motorized drill. And then we hammer in these metal tacks that have -- that have sutures attached to them. We use those sutures to kind of last so the labrum, to tie the labrum back to where it came off of.

That helps restore the patient's anatomy and helps control the patient's shoulder and prevent it from wanting to come out.

Q Did you do anything else after that?

A After we tacked the labrum, we had to tighten up the ligaments in the capsule which was part of the problem. Not only is the cartilage torn, the labrum is torn from the bone, the ligaments are stretched out.

We cut the ligaments in this direction (indicating.) And we bring the bottom ligament up to tighten up and the top one down. It's called a capsular shift and it's a standard procedure for this injury.

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Q And did you do anything else while this surgery was going on?

A Well, we -- again we -- when we opened the shoulder we had a much -- kind of a big picture, you know, with a camera. We kind of look at parts but we were able to look at the entirety of the head and cup and were able to engage the extent of the injury again. It was severely -- both the head and the cup were both severely injured.

At that point we start closing. We have to close in layers; put the muscles that we had detached, we had to put back on. We had to close all the splits that we made in the muscles and we finally closed the skin with sutures.

Q Okay. Now, I see in your operative report it says that you rasp the labrum to stimulate blood flow.

Can you explain to the ladies and gentlemen of the jury what that is?

A Yes. We want the labrum to heal back to the bone. The labrum is like a piece of rubber, doesn't have a good blood supply. So to help it heal back to the bone we actually take this -- like a fingernail file and we kind of scratch the bone surface with this to help -- to cause it to bleed, because the bleeding will bring in new blood cells that will help heal the labrum back to the bone.

Q And at that point did you begin to close the patient?

A Yes.

Q Explain how that was done, please.

A Again, we -- during the closure we have to maintain the arm in a certain position, because at that point there are only sutures holding everything in place. So the arm has to be held by the side.

(Indicating.)

And we have to repair back different ways. We fix the labrum, we fix the ligaments and the capsule, we have to sew back to the rotator cuff tendon back to where it was torn -- where it was detached, rather.

Then we had to close the deltoid muscle and the pectoralis muscles. We closed that and finally closed the skin. There are multiple layers involved.

Q And what do you use to close all those layers?

A We use sutures.

Q Are there different sutures for the different layers?

A Yes. We use -- for the deep layers we use sutures that are not absorbable, they will not melt over time because we want them to be there forever to help hold things in place. The closer we come to the skin, the more likely we are likely to use sutures that melt with time, and we did that in this case.

Q Did you also use staples?

A Correct.

Q Okay. And what was the purpose of using staples?

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A The staples close the skin basically and it's a substitute for sutures to close the skin.

Q Now, Doctor, going back to when you were putting sutures into the joint of the shoulder, how many sutures did you have to put in the actual joint?

A Let me just review my records.

I believe there were four suture anchors. We call these anchors because they actually, if you look at them, they look like an anchor. It's a piece of metal that has fins on it. You punch into the bone and the fins prevent it from coming back out. And attached to those anchors are the sutures we use to sew the labrum.

Q And, Doctor, did the patient tolerate the procedure well?

A He tolerated the operation well.

Q Were there any complications after?

A It's a very painful procedure, as you can imagine, and he required analgesic medications.

Q What analgesic medications?

A They are narcotics, and ranging from Demerol to morphine.

Can look through the records to see which ones he received.

(Examining document.)

Q Sure, Doctor, why don't you do that.

A He received morphine injections every one to two hours for pain.

Q And when was that?

A That was following the surgery.

Q How long after the surgery?

A Those injections continued for approximately two days until he was discharged.

Q Okay.

A And he also received the pill form of the narcotic called Percocet. Both are very potent painkillers.

Q Now, after surgery did you see the patient again?

A Yes, I did.

Q And what was the purpose of that visit?

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A Just a routine postoperative follow-up to see how the patient was progressing.

Q Okay. And did you remove the staples or sutures at that time?

A They were removed in the postoperative period in the office.

Q Okay. And did you conduct a physical examination at some point after the surgery?

A Yes, I did.

Q When was that?

A I have notes here from May 10th, 1999.

Q Okay. And what did your examination reveal?

A My examination -- well, first let me say what the patient's complaints were.

He had improved with respect to some of his symptoms compared to his preoperative symptoms as far as his pain from the looseness went, but he still had significant problems with stiffness and discomfort in the shoulder, despite having undergone physical therapy.

When I examined him at that time all the wounds were healed --

MR. SENA: Your Honor, I have to object. There is no question before the doctor as to this area. He is just volunteering a narrative here without any question being asked here.

MR. LAMBROU: Okay.

Q What did your examination reveal?

A My examination revealed healed surgical incisions. There were no signs of infection. There was -- a concern was limitation of motion, and I was only able to turn his arm out about 25 degrees.

Q Doctor, what is normal?

A Well, normal is 60 to 90.

Q Okay.

A He also had limitation of forward flexion in this direction. So he basically was able to go to about 135 where about normal is 180.

Q And did there come a point in time where you recommended he go for physical therapy?

A That is correct.

Q Okay.

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A That is correct.

Q And did you see him again after that May visit?

A Yes, I did.

Q When was that?

A I saw him on June 30th, 1999.

Q Okay. And did he make any complaints to you at that time?

A He basically had the same complaints. His symptoms of instability had resolved, had gone away. But he still had significant limitation in his motion.

Basically he states that he had no progress in his motion since his last visit the month before, and that was about seven months after the surgery.

Q Did you perform an examination at that time?

A Yes, I did.

Q What did that examination reveal?

A It did not reveal any significant improvement at that time in his motion. He had -- he did not have any significant improvement at that time in his motion. He had minor improvements, and he went from 25 degrees to 30 degrees of external rotation, from 125 to 130 degrees of flexion.

Q And what is the medical significance of that?

A The shoulder has stiffened up, and that is --

Q And what is the medical significance of that?

A That it may require future surgery.

Q Okay. Now, did you see him again after that visit?

A Uh-huh.

Q Doctor, let me take you back to the visit you just discussed. Is that the June '99 visit?

A Correct.

Q Did you note his range of motion in his arm at that time?

A Yes, I did.

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Q What was that range of motion?

A For flexion it was to 130 degrees, external rotation was to 30 degrees, and internal rotation, which is basically the act of reaching up your back was to L3, meaning that he could barely get his arm to his back. Normal is we should be able to reach your arm all the way up back to about the mid portion of the back.

Q And did you see him again after that June visit?

A Yes, I did.

Q When was that?

A That was September 22, 1999.

Q Okay. And did he make any complaints to you at that time?

A He did make complaints. He states that his progress was very slow. And he still complained of stiffness and weakness of the shoulder. And he states that the numbness of his hand and upper extremity of the right upper extremity had improved.

Q And did you conduct a physical examination at that time?

A Yes, I did.

Q And what did that reveal?

A It revealed some modest gains in motion. He was now moving his arm to 145 degrees in flexion, 35 degrees in external rotation. Although his internal rotation was still limited, his ability to reach up his back --

Q Did you make any recommendation to him at this time?

A Yes, I did.

Q And what were those recommendations?

A We discussed further surgery involving an arthroscopy, to go back in the shoulder with a camera to shave the scar tissue in the shoulder that was causing him to have this stiffness.

Q Okay. Now, did you see him again after that?

A Yes.

Q When was that?

A I saw him December 13th 2000.

Q And did he make any complaints at that time?

A He still complained of stiffness of the shoulder, especially when -- involving the use of his arm in the overhead lifting.

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(Indicating.)

Q And did you conduct a physical examination at that time?

A I did. And --

Q And what were your findings?

A The findings were limitation of motion, and since -- actually since his previous visit he had actually lost a little bit of external rotation so now it was down to 20 degrees where in the last physical it was 35 degrees. He had also some limitation of flexion but to a less degree.

There are no signs that the shoulder was loose at this point.

Q I'm sorry, I didn't hear you?

A There were no signs that the shoulder was loose, however, there was weakness of the rotator cuff muscles. His ability to push his arm out in this direction and that direction were all limited.

(Indicating.)

Q Can you quantify for us what this loss of motion was in December?

A Yes. I have a notation of 20 degrees of external rotation.

Q Okay. And you said earlier that the normal was 90?

A Was 60 to 90.

Q And how about his other losses of range of motions, can you quantify that?

A I have a notation that he also has limitation of forward flexion of those notes.

Q And, Doctor, have you formed an opinion as to what the future holds for this patient medically?

A Yes, I do.

Q And what is that opinion.

A Over time --

MR. SENA: My objection, your Honor, to this question, it's too broad. And let him be more specific with his question.

THE COURT: Overruled.

You may testify.

A The patient already has arthritis in this joint. He is only in his 30s. Arthritis is a progressive disease, meaning that it doesn't get better, it doesn't stay the same. It can only get worse with time.

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Every time he moves his arm, the bone is -- bone is rubbing bone, and over time this will progress, there is no doubt about it. And it's going to progress to the point where at some time in his life he will be severely affected with pain and stiffness from his arthritis.

At that point the patient would require further surgery, and that operation --

Q Let me ask you this. What kind of future surgery would he require?

A The surgery recommended for advanced arthritis of the shoulder is called a total shoulder replacement. It's much more common for the knee and hip, but it's also done with the shoulder. That involves --

Q Why don't you tell the ladies and gentlemen of the jury what that surgery involves.

A That involves replacing the worn out surfaces with a metal surface, so we shave, we basically cut off the bone with a saw.

Q Doctor, let me interrupt you for one minute.

Would it be easier for you to describe it using the chart?

A It would be.

Q Please use the chart and describe it.

MR. SENA: Your Honor, note my objection and continued objection for future surgeries. It's speculative and no basis for this, and I moved before there is no CV concerning this material.

THE COURT: That's on the record, counselor. What we discussed on the record I never do twice.

MR. SENA: I'm renewing it.

THE COURT: Overruled.

A You see this shiny part, that's the cartilage the patient no longer has, he is missing a large portion of that.

This is the area that will progress with arthritis. We actually take a saw and cut off that -- the head of the humerus, and we also shave the other surface with a burr, with a metal burr.

We put on a metal -- we cement actually a metal cap on the humerus to replace this ball, and we cement in a plastic cup so he basically has a prosthetic joint.

Now the benefit of that is obviously decreased pain and improved motion and strength, but it will not give him a normal shoulder by any means. By any means.

Q And, Doctor, what's the cost associated with that surgery in the medical community here in New York?

A I would say the total cost, including anesthesia, hospitalization, the cost of the implants, which are expensive, is between 15 and $20,000.

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Q And would that surgery require a hospital stay?

A It would require a hospital stay of approximately five days.

Q And would it require physical therapy after surgery?

A It requires approximately a six month course of therapy.

Q And what would that therapy entail?

A It would entail a slow process of regaining his motion, stretching the shoulder, working with weights and elastic bands to help regain the strength.

Q And, Doctor, you said earlier that he has arthritis in his shoulder?

A That's correct.

Q What has caused that arthritis?

A The arthritis is caused from the motor vehicle accident.

Q And, Doctor, do you have an opinion, and every time I ask you for an opinion, I want you to understand I'm asking your opinion to a reasonable degree of medical certainty so I don't have to constantly repeat that.

Do you have an opinion as to whether Mr. Stylianou has suffered a permanent partial disability to his right shoulder as a result of the accident of September 10, 1998?

A Yes, I do.

Q What is that opinion?

A He has.

Q And do you have an opinion as to whether the injuries you have described and the surgery you described were caused by the accident of September 10, 1998?

A Yes, I do.

Q What is that opinion?

A They were caused by the accident.

Q And what is the basis for your opinion?

A My basis is the history, my physical examination, and the -- both the MRI findings and the findings of the operation.

Q Okay. And can you please tell the ladies and gentlemen of the jury the mechanics of an injury such as the one -- actually, let me withdraw that question.

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Can you tell us the mechanics of the injury he sustained in this accident?

A The action is usually caused by what -- we call it an external rotation type of injury. The patient's arm at the time of accident was on the steering column. In the accident his body was jolted, and the force of the accident was transmitted mostly to his right upper extremity. This caused the arm to be jolted and this occurs within a second. It's extremely fast. Something that we may not realize at that time or until days or weeks later that you actually hurt it. The arm is torqued, and in this -- at the time of this accident, the shoulder is forced out of the socket, either completely, which it probably was because of the extent of injury, or part way. And either it comes back in the shoulder by banging off the other bone and goes the other way, in which it stays out.

When it stays out it usually requires a physician to put it back into place in the emergency room.

Q And the loss of range of motion that you noted on the last visit, do you have an opinion as to whether that loss of motion is permanent?

A That loss of motion, it's two years now from the operation --

Q Well, Doctor, do you have an opinion?

A Yes, I do.

Q What is that opinion?

A Yes, it's permanent.

Q And, Doctor, in your October 14th, 1998 visit -- excuse me, the visit that the patient had with you, did you note numbness in his right hand?

A He complained of that as per his visit with me.

Q Do you know what the cause of that numbness was?

A His neck injury.

MR. LAMBROU: I have no further questions.

**CROSS-EXAMINATION**

BY MR. SENA:

Q Good morning, Doctor. Doctor, let me just ask you some questions about the last statement you have made.

You said that this patient has arthritis in his arm?

A Uh-huh.

Q Did you take any subsequent MRIs other than the ones that were taken immediately after the accident?

A No, I did not.

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Q As a matter of fact, Doctor, when you looked into this shoulder there was arthritis there at the time; is that correct?

A There was -- it depends on how you define arthritis.

If you are defining it as loss of cartilage on the bone, then he did have arthritis.

Q Now, what type of arthritis are you talking about that you found when you did this operation?

A He had posttraumatic arthritis.

Q Now, Doctor, arthritis, that can come to a patient within a couple of months, or is arthritis something that develops over a long period of time?

A It depends. Posttraumatic of course can develop within months of an injury.

Q And it's your testimony, Doctor, that within two months of this accident or three months of this accident, this patient developed arthritis from the accident?

A Yes, it is.

Q And it did not exist before the accident?

A No --

Q -- is that correct?

A That's correct.

Q Now, on your last examination, which I believe was March 15th of 2000; is that correct?

A I have one on December 13th.

Q December 15th?

A December 13th of 2000.

Q May I see that, Doctor?

A Yes.

(Handing.)

Q (Examining document.)

Would you not say, Doctor, that the examination and the results of December 13th, 2000, were more or less the same as what you found on March 15th of 2000; would you say that they are practically the same?

MR. LAMBROU: Your Honor, I object to the form exclusively.

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THE COURT: Do you understand the question, Doctor?

THE WITNESS: I have to look at my notes to answer that.

Q Look back at the notes.

A So you want me to compare December 13th to which date?

Q March 15th. March 15th in your narrative, your operative -- your narrative report dated -- let me see if it's dated -- see if it's there.

A (Examining reports.)

The findings are -- they both reveal limitation of motion. The numbers are a little different.

Q I will read this to you, Doctor. The last office visit was on March 15, 2000. That's before that visit there.

And, Doctor, was this last visit with Mr. Stylianou because of this lawsuit or because it was a regular examination concerning the operation?

A As far as I'm concerned, as far as I know, the patient came to see me as follow-up.

Q It would have nothing do with today's --

A Not that I know of.

Q By the way, Doctor, at what point did you learn that this injury was the subject of a lawsuit; could you tell us that?

A I'm not quite sure to tell you the truth. It was recently. It was in the last month or two.

Q Staying with this next to last physical examination, Doctor -- withdrawn.

Doctor, would you say that your operation, all that you explained to the jury was successful?

A It was -- we did all that was medically possible.

Q So that it was successful?

A It was successful in treating his instability.

Q And, Doctor, on March 15th, 2000: “Patient is now approximately 13 months status post right shoulder arthroscopic debridement and open anterior/inferior capsule shift with Bankart repair.”

Now, you described what you did at that point, right?

Now: “The patient complains of intermittent anterior shoulder discomfort. Once again, the patient has noted improvement in his range of motion and strength of the right shoulder. Patient continues to complain of partial limitation secondary to right shoulder stiffness.”

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Now, Doctor, isn't one of the reasons why you are talking about future surgeries is because this patient, Mr. -- the plaintiff in this action, Mr. Stylianou, keeps complaining of limitation of motion; is that correct?

A I'm basing my recommendation based on the extent of damage from the time of surgery and from prior experience as to progression of disease.

Q Well, put aside your other patients, Doctor, we are only talking about this one.

A Correct.

Q You spoke -- you answered counsel, you talked about two types of pain, objective --

A Uh-huh.

Q -- and subjective?

First let's start off with pain. You can't see pain; is that correct?

A That's correct.

Q None of us can see pain.

Now, subjective pain, isn't that when a patient tells you it hurts; is that correct?

A That is correct.

Q He puts his arm up, you are asking him to extend his arms, and he says that's it and then you try to push it and he says oh, it hurts, and that's subjective; is it not, Doctor?

A That is correct.

Q Okay. Was there ever a time that you saw Mr. Stylianou that he did not complain about some restriction in motion?

A I believe that on each of my visits he had complaints.

Q But physically, from a surgeon's point of view, from an orthopedic specialist, you found that shoulder not to be loose when you examined him that the day but it was a stable shoulder; you said the shoulder was stable?

A In follow-up visits the shoulder was stable.

Q The shoulder was stable.

So your operation was a success?

A For the stability.

Q And that the patient's continual complaints is what now makes you anticipate that he needs some surgery in the future; isn't that a fact?

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A It's not just his subjective complaints.

Q Have you taken any MRIs recently?

A There is no purpose for an MRI.

Q Well, as a matter of fact, how old is the MRI that we're testifying about here?

A The MRI is two years old.

Q Okay. And yet, Doctor, you are making a decision and telling this jury all about this future surgery without having an x-ray or an MRI to back up your statements; is that correct, yes or no?

A It is.

Q You don't have them; is that correct?

A That's correct.

Q Doctor, let's start now from the beginning.

You stated that most of your treatment in your association with this sports center -- by the way, let's get that straight, too.

Are you associated with the sports center?

A I was at that time.

Q As a matter of fact, there are five sports centers; is that correct?

A I'm not sure. I went to that one center as an orthopedic consult.

Q I show you a letter here.

THE COURT: You both can't talk at the same time. Do me a favor, let him finish and then do your question.

Q Doctor, when were you associated with the sports center?

A From '97 to '98.

Q Now take a look at that letterhead. How many locations of sports centers are there?

A (Examining document.)

Six.

Q All right. And which one were you affiliated with?

A The one on Astoria Boulevard.

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Q Now, Dr. Kyriakides, he was not associated with your particular center; is that correct? He was on Northern Boulevard?

A No, he was at that center also.

Q Okay. And you stated that this is a Sports Medicine facility, and yet you stated to us that most of your patients are from automobile accidents; is that correct, did you say that?

A My practice is as a general orthopedist with a subspecialty in shoulder and knee injuries.

Q But do they all come from automobile accidents?

A No.

Q Or come from sports in general?

A From all types of trauma.

Q Now, are you referred work by any of these sports facilities today? Are you referred patients?

A I have moved the office and they still refer me orthopedic consultations.

Q And would you say how much of your income is derived from this center referring patients to you?

A It's only a fraction of my three offices.

Q 5 percent? 10 percent? What do you say?

A Under 5 percent.

Q And even when you were associated with the group, was it still 5 percent or was it more than 5 percent?

A It's very hard to quantify.

Q Now, who referred this patient to you?

A It's been a while. I can't -- I'm not sure. It probably was Dr. Kyriakides.

Q And are you familiar with Dr. Finkelstein, do you know him?

A I may have met him once.

Q Dr. Shumko?

A Who? Shumko?

Q Yes?

A Yes.

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Q Dr. Vanderwalle?

A I have met him personally, yes.

Q How about Dr. Buonocore?

A I was never met him. I have spoken to him on the phone.

Q Now, how long, again you said you were affiliated since 1979 with this sports center?

A No --

MR. LAMBROU: Objection?

A 1997.

MR. LAMBROU: It's 1997.

Q 19970 when, how many years were you associated?

A It may have been a year, year and a half.

Q And was it the procedure when a patient came to that facility that he would be treated by many of the doctors in that facility?

A I went there strictly as a consult. I don't know the workings of the office.

Q And that are you familiar with the fact that he would then or any patient would be put on a physical therapy program; is that correct?

A That is correct.

Q This patient was?

A This patient, correct.

Q Doctor, I'm going to show you this report from Dr. Kyriakides of October 7th. I ask you to just --

MR. LAMBROU: Can I see it?

MR. SENA: (Handing.)

MR. LAMBROU: (Examining report.)

THE OFFICER: (Handing.)

A (Examining report.)

Q Concerning this patient --

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MR. LAMBROU: Your Honor, if I may, that report is not in evidence.

MR. SENA: I just want to ask him a question on it.

THE COURT: He can ask him a question. If he needs something to refresh his recollection, he can do it, whatever it is.

Q And in that report dated October 7th '98, look at that first large paragraph, three lines up, which is marked in color there.

Dr. Kyriakides say: X-rays were performed today --

MR. LAMBROU: Your Honor, he is reading from a document not in evidence.

THE COURT: Yes, sustained.

MR. SENA: I'll mark it, put it into evidence as soon as he confirms what I'm saying here.

MR. LAMBROU: Your Honor, can we approach?

THE COURT: Once he confirms we don't need it in evidence.

MR. LAMBROU: Your Honor, may we approach?

THE COURT: Sure.

(Whereupon, an off-the-record bench conference was then held.)

Q Now, Doctor, would you look at your narrative report, please. I assume you have it?

A Yes.

Q Would you look at it. Okay?

A Yes.

Q Doctor, you see where it says, second paragraph: “Patient was initially treated at the North Shore Hospital.” You got it?

A Yes.

Q You see that?

A Yes, I do.

Q Okay. And then it goes on to say: “As per patient history, radiographs of the right shoulder were performed and were reported negative.”

Now, Doctor, I can show you the North Shore Hospital record, unless counsel concede that x-rays were never taken of his right shoulder, so that history is not correct, is that right, or do you want to see the record?

A I believe you. The patient may have been confused between the shoulder and the neck.

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Q It shows only a cervical x-ray, Doctor, so that history given to you that there was an x-ray of the right shoulder is not correct.

Now, Doctor, is a history given to you by a patient something very important before you begin to examine him?

A Yes, it is.

Q And this patient told you he was involved in an automobile accident; is that correct?

A Correct.

Q Did he tell you the force or impact that was involved in this particular accident?

A No, he did not.

Q You have no description in your report of exactly how this accident occurred; is that correct?

A That is correct.

Q Doctor, when you performed your surgery here, you found, amongst other things, a complete detachment of the anterior and inferior glenoid labrum. That's as you explained to the jury, that's -- it's a cartilage --

A Uh-huh.

Q -- that sort of keeps the humerus and the glenoid together --

A Correct.

Q -- all right?

That was completely ripped off, is that correct, the both sides, the anterior and posterior?

A No, not posterior.

Q Just the anterior?

A Just the anterior.

Q Okay. You also found, Doctor, and that's in your operative report, which you should know that the glenoid labrum was fraying, it was fraying along its course. It was fraying, besides being torn, it was frayed.

Now, doesn't fraying, Doctor, doesn't fraying mean to you that that was of long-standing; that that is a deteriorated kind of a condition, the fraying, Doctor?

A No. There are two types of fraying. One is a chronic degenerative type, and the other is -- can be of a more acute nature.

Q So this was the acute type of fraying when you say that?

A Correct.

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Q And now in your operative report, you don't use the word acute, do you, you just say fraying?

A Correct.

Q So it could be of long-standing then, Doctor, is that correct?

A No.

Q No. Doctor, what does the word chondromalacia mean, you found a chondromalacia of the surface?

A Chondromalacia, again, is injury of the cartilage of the surfaces we spoke about. I know you are referring to the two types. There is one that can be chronic and one that can be posttraumatic.

Q Isn't that a form of arthritis, chondromalacia?

A Chondromalacia can result from arthritis too.

Q And you found that also?

A Correct.

Q Now, Doctor, just talking about the first two where there was a complete tearing of this labrum, plus you found a Hill-Sachs lesion -- did you find a Hill-Sachs lesion?

A There was a dent in the --

Q Was that not on the MRI report, a Hill-Sachs lesion?

A Yes.

Q And isn't a Hill-Sachs lesion, Doctor -- and you can stop me if I'm incorrect -- but a Hill-Sachs lesion is an indentation made to the head of the humeral bone, which is softer than the glenoid bone which comes up on it?

A Yes.

Q Is that correct, like it's almost like a fracture, almost; is that --

A Well, it is a type of fracture, because the bone, the surface of the bone was cracked.

Q Now, Doctor, when that happened, you have a Hill-Sachs lesion, you also have a Bankart lesion, which is that -- that's in the glenoid process there; am I correct?

A Uh-huh.

Q Would this type of injury cause some kind of pain?

A Yes, it would.

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Q Wouldn't it be excruciating pain, Doctor?

A Not at all. It depends.

Q Not at all?

A Just some --

Q What degree of pain?

MR. LAMBROU: Your Honor, can the witness finish his answer, please?

Q I'm sorry, Doctor, I went too fast.

THE COURT: He said it depends.

Your next question.

Q Okay. It would be a painful thing; would it not?

A It depends on several factors.

Q Doctor, in order to have this type of injury, isn't it a medical fact that there has to be a dislocation of that shoulder?

A Usually there is a -- there is a complete dislocation, although sometimes the bone -- we call it a subluxation, the bone comes out partially and can still be injured.

Q Can go in and out, called a subluxation, but in order to have a Hill-Sachs lesion, Doctor, do you not have to have an anterior dislocation of that shoulder, meaning front to back?

A The bone has to actually come out in order to come back and hit the thing, hit the glenoid.

Q And do you not in your practice, Doctor, have many patients who have this type of condition where the arm subluxes sometimes for years and the patients even know how to feel them back into position; is that a fact?

A That's a different type of instability.

Some patients are born with a loose shoulder, and those patients can put their shoulders in and out. Those patients usually do not have a labrum tear or a Hill-Sachs lesion. Those are the results of a traumatic dislocation or subluxation.

Q Getting back to basics, Doctor, to have a Hill-Sachs lesion you must have a dislocation?

A Depends on the terminology. The shoulder, the bone has to pop out of the shoulder.

Q Okay.

A So that is correct.

Q And to have a Bankart lesion and to do a Bankart repair, that would be the result of a dislocated shoulder; is that correct?

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A Dislocation or subluxation.

Q And it would be painful, would it not, Doctor?

A To have a Bankart lesion?

Q Right.

A Like I said, it depends. It depends on the severity of the injury, how loose the shoulder is.

Patients can have -- two patients can have a Bankart lesion, one patient can be very loose and another patient not that loose. One patient can have a lot of pain and some would have moderate pain --

Q Doctor --

MR. LAMBROU: Your Honor, if you could, can you please instruct Mr. Sena to allow the witness to answer the questions.

THE COURT; He's got to finish his answer.

Q Are you finished, Doctor?

THE COURT: Finish your answer.

A Patient, however, would be symptomatic, meaning that he would know that something is wrong with his shoulder.

Q Okay.

A He would not walk around with these injuries and think he has a normal shoulder.

Q Correct. He wouldn't know that something happened to that shoulder, would he, to have this type of injury; would he, Doctor?

A That's correct.

Q Did you look at the North Shore Hospital record before you came here to testify?

A No, I didn't.

Q Well, if you look at the record, Doctor, I can show it to you.

Tell me this, Doctor, was there any complaint of pain to the shoulder or any dislocation remarks in that entire record?

THE OFFICER: (Handing.)

A (Examining record.)

Well, you know, they do diagnose a trapezius strain.

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Q The trapezius underneath the occipital comes into the neck, he was complaining of neck pain, and the trapezius is up into the neck; isn't it, Doctor?

A Also considered part of the shoulder musculature.

Q It eventually filters down there. But is there any word about the shoulder, right shoulder being injured or pain from the shoulder?

A (Examining record.)

I don't see the word shoulder mentioned, per se.

Q Look at the x-rays, Doctor, x-rays were taken of what part of the body?

A Of the cervical spine.

Q Okay.

A Which is the neck.

Q Doctor, assuming a person had this type of injury that we have been discussing here for the last hour, would this hospital have taken at least an x-ray of the shoulder if there were these complaints?

MR. LAMBROU: Objection, your Honor.

THE COURT: Sustained.

MR. SENA: He is an expert witness, Judge.

MR. LAMBROU: Objection as to the form of the question.

THE COURT: Yes, you have to rephrase that a little differently.

MR. SENA: Fine.

Q Doctor, if a patient or if this patient had gone to the North Shore Hospital and complained of the injuries as described by you that he has, would there have been some recording of that in that record?

MR. LAMBROU: Objection to form.

Q Just yes or no?

THE COURT: I will allow him.

Q Doctor, you understand my question?

THE COURT: It's for me to say.

MR. SENA: All right, I'm sorry, Judge.

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THE COURT: You may answer the question.

A It's my opinion that the patient complained of pain. The neck and the shoulder are intermittently related, they are right next door to each other. Neck pain would give a shoulder pain, shoulder pain would give a neck pain.

A patient -- and they did diagnose him with a trapezius strain, and the trapezius is a muscle in the shoulder, so I think the job of the emergency room is to make sure that nothing severely bad has happened to the neck, and I think they did that. I don't think they had any suspicion of a dislocation so they didn't x-ray the shoulder.

It's also possible that if a patient does not speak English well they may not have understood him --

Q Doctor, Doctor, please.

MR. LAMBROU: Are you finished with your answer?

THE WITNESS: No, I'm not.

MR. SENA: Now he is going into the language business, that they didn't understand. That's absolutely improper.

Q I'm asking whether or not they would record any type of injury complained of in that record; yes or no, Doctor?

A If -- I would say that the pain depends on how much of the pain the patient was -- thought was coming from the shoulder and whether or not he thought it was coming from the neck, but it was obvious he was having pain in that region of the body.

Q Now, the neck, Doctor, with due respect to you, the neck is the neck and the shoulder is the shoulder; is that right?

A No, it's not that simple.

Q All connected?

A It is all connected.

Q Doctor, let's talk about the glenohumeral ligament complex.

Now, isn't that a ligament that also supports the cup and the head of the humerus?

A That is correct.

Q That prevents, that cartilage is there, that ligament is there to help prevent the dislocation; is that right?

A That is correct.

Q And in your operative report, you found that glenohumeral ligament complex, you used the word lax, l-a-x?

A Uh-huh.

Q Means loose --

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A Right.

Q S am I correct?

And did you repair it?

A Yes, I did.

Q You tightened it up, right?

A Yes.

Q Doctor, could you tell us how long that ligament was loose?

A From the time of the accident.

Q Oh, you mean you knew that from looking at that ligament, you looked at that ligament, you said this happened on the date of the accident?

A No. I put all the facts together and I can say that.

Q Doctor, could not the looseness come from a shoulder that was subluxing way before this accident; could that happen?

A Not with his history.

Q Doctor, you asked the patient when you got involved with his shoulder, you asked him what he did and he told you he was a student; is that correct?

A That's what I recall.

Q Did you ever ask him about his occupation?

A The fact that he was a fisherman, no.

Q Or any past occupation that might be involved with this shoulder; did you ask him that?

A I did -- I asked him what he did at that time. I didn't ask him about past.

Q And what did he say?

A That he was a student.

Q A student.

Did he tell you that he was a commercial deep sea diver; did he tell you that --

A No.

Q -- for years?

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Did he tell you that he did underwater demolition; did you know that?

A No.

Q Did you know that he worked with hyperbaric chambers under water?

A No.

Q And did you know, Doctor, what a hyperbaric chamber is?

A Yes.

Q You know what they use it for?

A Yes.

Q To prevent the bends?

A Yes.

Q Did you know that he did moving of equipment under water with all his physical ability; did you know that?

A No.

Q Again, Doctor, you saw this patient approximately three months after this accident?

A (Examining document.)

I saw him in October and the accident was in September.

Q Did you see him in October, you saw him approximately, yes, one month after the accident; is that correct, Doctor?

A Correct.

Q Before he came to your office, you don't know what transpired as far as his shoulder was concerned; is that correct?

A Prior to his visit with me or prior to the accident?

Q No. Between the automobile accident and you, you don't know the history in between?

A Just that he had been receiving physical therapy.

MR. SENA: Okay.

MR. LAMBROU: Thank you, your Honor.

**REDIRECT EXAMINATION**

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BY MR. LAMBROU:

Q Now, when Mr. Sena was talking about the history of the patient, the work history, Doctor, did you in fact ask him if he had ever injured that shoulder at any time before?

A Yes, I did.

Q And what was his response?

A He said no.

Q And does it make a difference that he did any of that diving from a medical standpoint?

A No, it does not.

Q Why not?

A The injury, the instability that he had, is a result of accident, it's not the result of deep sea diving or working. People who deep sea dive do develop problems with their joints.

Q And what kind of problems are those?

A It's called avascular necrosis. And that is basically due to the pressure changes in the body, the blood supply to the bones are affected and it can cause the bone to die inside.

There is no evidence of that on the MRI. He has no signs of any injury or symptoms from his previous occupation.

Q Now, Doctor, in that hospital record that Mr. Sena showed you, can you please turn to the emergency call report. I think it to be the last or second to last page in the record.

A (Examining document.)

Q It's the prehospital care report.

A Okay.

Q Is there a section there where it discusses complaints?

A Yes.

Q What does it say there as far as his language barrier is concerned?

A Due to language barrier, cannot get all possible information.

Q Okay. Now, pain in the neck, Doctor, is that consistent with a shoulder injury?

A I'm sorry?

Q Is that consistent with a shoulder injury?

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A Is what consistent?

Q Neck pain.

A Yes, it is.

Q And how so? Please explain to the jury.

A When a shoulder is loosened and wants to come out of the socket, all the muscles in the shoulder girdle and the neck have to work extra hard to hold the arm up, and it was not unusual for patients coming to me complaining of generalized neck pain and have a shoulder problem. It's all interconnected.

Q And the trapezius finding in the medical record?

A Uh-huh.

Q What is the medical significance of that it went to the shoulder?

A It tells me it's a shoulder injury.

Q I'm sorry, I didn't hear you?

A It tells me it's a shoulder injury.

Q Okay. Can you please once again go through the mechanics of how this injury occurred during the accident?

MR. SENA: Your Honor, this has been done. It's been asked and it's been done before and it's repetitive and I object.

MR. LAMBROU: Your Honor, he brought it up on cross, and by the very nature of his questions I think it was clear he didn't understand what the doctor said so I would like for the doctor to explain it once again to the ladies and gentlemen of the jury.

THE COURT: Overruled -- sustained.

MR. LAMBROU: The objection is sustained?

THE COURT: Sustained.

Q Okay. Doctor, do you have an opinion as to whether this shoulder dislocated or subluxed during the accident?

A Yes, I do.

Q What is it?

A The patient's right shoulder dislocated or subluxed during that motor vehicle accident.

Q Okay. And is that what caused the lesions that you saw on the MRI?

A Yes.

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Q Now, as far as the subsequent MRI after surgery, is that necessary now?

A Not at all. It's a waste of money.

Q Why?

A Because I saw the insides of the shoulder, I have pictures of the insides of the shoulder. Pictures are ten times more accurate than the MRI.

Q Why is that?

A Because it gives you the actual view of what's going on. It gives you more of a kind of a three-dimensional picture, whereas the MRI gives you a two-dimensional picture.

Also, the MRI will not pick up the findings that we find -- that we found during the operation, the injury of the cartilage.

If anything, the patient would likely benefit from a follow-up x-ray in a year or two. A further MRI is not necessary. And the x-ray would help evaluate the progression of the arthritis.

Q Okay. Now, as far as the successfulness of this surgery, was it successful at all?

A It was.

Q And what aspect of it was successful?

A The patient's symptoms have improved. He -- his pain has decreased, his motion has improved, he is able to use the arm in a more functional manner. And in that respect it was a success.

Q Okay. In what respects was it not a success?

A With respect -- there is no -- further injuries of the bone cartilage that the patient has. There is no medical answer for that at this time. That is something that I have no control over. And that I believe is responsible for a lot of the patient's current symptoms of discomfort.

Q And, Doctor, the ligament and cartilage that you picture there, that is pictured there that you took during surgery, has that cartilage or ligament grown back?

A The ligament was repaired back to the bone. That seems to be --

Q How about the cartilage?

A The cartilage, no. The cartilage -- the bone does not heal with new cartilage. It kind of makes like -- like a little Band-Aid on the bone, but that cartilage is gone for good.

Q As a result of that cartilage being gone for good, what happens with the bone structure in the shoulder?

MR. SENA: Your Honor, note my objection, respectfully. This is not proper redirect here.

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THE COURT: I don't recall him going over that particular issue.

MR. LAMBROU: He went over the success of the surgery and so on and so forth.

THE COURT: I sustain that.

MR. LAMBROU: Okay.

Q Now, as far as the arthritis that Mr. Sena had discussed with you, are there different kinds of arthritis?

A There are.

MR. SENA: Objection, asked and answered.

He explained the two different types of arthritis and he asked him which one.

THE COURT: I know you went over it and he has a right to go back over it because you went over it. Go ahead.

Q What are the different types of arthritis?

A The two main ones are rheumatoid arthritis and osteoarthritis.

Q Which one does the patient, Spyros Stylianou, have?

A This patient has osteoarthritis.

Now, there are ways that someone can get osteoarthritis and that can be something that happens over years or it can happen after an accident. And the one that this patient has is called posttraumatic, meaning it's after the accident.

Q Are there any indications from what you observed during surgery that this patient had arthritis of the nature which pre-existed September 10th, 1998?

A It did not preexist.

MR. LAMBROU: Thank you very much.

**RECROSS-EXAMINATION**

BY MR. SENA:

Q Doctor, you have in your hand the prehospital care report, please, where you read that: Due to -- due to language barrier could not get all possible information. That part.

A (Examining document.)

That is correct.

Q Could you go down, Doctor, where it says: Chief complaint. You see it in quotation marks, Doctor?

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A Yes.

Q My neck and back hurt; does it say that, Doctor?

A Yes, it does.

THE COURT: Anything else, gentlemen?

MR. LAMBROU: That is it, your Honor.

THE COURT: You may step down, Doctor, thank you.

MR. SENA: Judge, can I ask him one more question?

THE COURT: Sure.

BY MR. SENA:

Q Doctor, before you took the stand, did you discuss this case with the attorney for the plaintiff?

MR. LAMBROU: Your Honor, this is beyond my --

THE COURT: Yes, sustained.

MR. LAMBROU: -- redirect.

THE COURT: Yes, sustained.

You may step down, Doctor.

(Whereupon, the witness, Dr. Steven Touliopoulos, was then excused from the witness stand.)

THE COURT: Ladies and gentlemen of the jury, take a brief five minute recess. Please don't discuss the case among yourselves or anyone else during the course of these proceedings.

Form no opinions or conclusions.

You will be back as soon as you can.

(Whereupon, the jury then left the courtroom.)

(Whereupon, a recess was then taken.)

THE COURT: Are you putting your motions on, and are you now resting?

MR. LAMBROU: The plaintiff rests.

MR. SENA: You are resting?

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MR. LAMBROU: Yes.

THE COURT: You have your motions or reserve?

Reserve with your motions and start with your case directly.

**End of Document**

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