2002 WL 34451760 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
Kings County

Eric MATTHEWS and Diana Matthews,
v.
Clair L. KERRICK, Sr., et al.

No. 2002-42759.
2002.

(Transcript of Thomas Kolb, M.D.)

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

[Note: Pages 1-599 missing in original document]

(Jury entered the courtroom.)

THE COURT: Good morning, jurors.

I trust you have all had a pleasant weekend. Now we are ready to get back to the trial. Counsel, you may call your next witness

MS. MORENO: One moment, your Honor.

Plaintiff calls Dr. Kolb to the stand.

THOMAS KOLB, called as a witness, having been first duly sworn by the Clerk of the Court, was examined and testified as follows:

THE COURT CLERK: Thank you, sir. Please be seated.

In a loud, clear voice, please tell the Court your name.

THE WITNESS: Thomas Kolb, K-O-L-B, M.D.

THE COURT CLERK: Your address, sir?

THE WITNESS: 222 East 68th Street, New York 10021.

THE COURT CLERK: Thank you.

THE COURT: You may inquire, counsel.

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MS. MORENO: Thank you, your Honor.

DIRECT EXAMINATION

BY MS. MORENO:

Q Dr. Kolb, could you please tell the jury a little about your educational background.

A Yes. I went to college here, Queens College, City of New York, graduated 1979, went to medical shool here in Brooklyn at Downstate Medical Center from 1979 through 1983 ahd graduated with a M.D. degree.

And then from 1983 through 1986 I did an internship and residency at Albert Einstein College of Medicine in the Bronx in pediatrics and became a board-certified pediatrician in 1983 -- I am sorry 1986. Then 1986 through 1990, I did a second residence in diagnostic radiology at Columbia Presbyterian Medical Center in Manhattan. In 1990, I became board-certified again, a second time, in diagnostic radiology, From. 1989 to the present, I have been in the practice of diagnostic radioloy.

Q Can you tell the jury what is the practice of radiology?

A Radiology is the use of X-rays, CAT scans, MRIs, ultrasounds, mammography, to look inside the body to see if there is a problem and or if everything is okay.

Q Are you being compensated for your time today, doctor?

A Yes, I am.

Q How much are you being compensated?

A $5,500.

Q Have you ever been qualified as an expert in the State of New York before?

A Yes, I have.

Q Approximately how many times?

A I testified approximately six times, give or take, per year for the last number of years.

Q Have you ever testified on behalf. of me before?

A No, I have not.

Q Have you ever examined Carley Gervais?

A No, I have not.

Q Have you ever examined John Lamacchia?

A No.

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Q Have you ever examined Michael Macivor?

A Not physically.

Q Right.

A Right.

Q Have you reviewed MRI films or X-rays or CT scans on behalf of Carley Gervai?

A. Yes.

Q Have you reviewed MRI, CT scans, or X-rays on behalf of John Lamacchia?

A Yes.

Q. Have you reviewed MRI, CT scans, or X-rays on behalf of Michael Macivor?

A Yes.

Q I am going to start off with John, doctor.

Doctor, I am going to show you what has already been marked in evidence as Plaintiffs' Exhibit 46. Can you tell the iurv what --

MR. HORBATIUK: Your Honor, with your permission, I am going to move.

THE COURT: Yea.

Q Can you tell the jury that they are looking at, doctor?

A Yes. I

Q. You, can stand up, please.

(Witness approached exhibit.)

A Can I use this pen to point?

We are looking at the forearm of the patient. You could see, with the bottom of the hand, this is the wrist. There is the elbow up here. There are two bones, radius, ulna, two bones of the forearm. The bones themselves are intact. In between the two bones there is actually ligament that holds the bones together. Then there is a structure right here, which is abnormal, should not be there. other words, this gray area here should look like the gray area here. There is - this is a foreign body, a piece of some material that is entered inside of the boy.

The finding on this X-ray here, there i a foreign body inside the body that is shown here on the X-ray

Q Doctor, I am going to show you. what has been marked into evidence as Exhibit 51 of Tohn Lamacchia. Can you tell the jury what they are looking at?

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A This is a CAT scan. It is a very specific area of the body we are looking at It is right here. It is the breast bone that you can feel here, which is the sternum. This is this triangular bone here. Then we feel our clavicles coming down here, one on the left and one on the right. They come down to form that bump that we have right here, which is the joint, which is the sterno, the sternoclavicular joint. You have one on the right and one on the left. That is the bump we have here. These two bones coming together, sternum and then the clavicle.

Q Before you tell the jury more, you have said CT scan. They have heard MRI. Can you explain CT scan?

A CAT scan is a fancy Way of taking X-rays that a computer can use to push the X-rays through the body to present these image or to acquire these images in very, very thin sections.

So, for example, when we are looking from this picture through the final picture at the front row, then start on the second row, we are looking at pictures through millimeters thick, instead, as in the X-rays we saw before, we saw the entire hand on one picture.

We are able, with CAT scans, to take very thin sections of the hand, and in this case, the sternum, pull out look at these pictures one after the other after the other. Instead of looking at one picture of the sternoclavicular points that I could see, you look at very this pictures. The advantage of this is you can look at the anatomy in thin sections, and you can look at any problem at all.

CAT scans are very important tests. We here at the sternum, we have one bone. These gray areas are the bones. This is the area we are focused on, one bone coming from this side. That is the right clavicle, the sternoclavicular joints the juncture between the right clavicle on the sternum on this side. Then we have the left clavicle on here. Then we have the left sternoclavicular joints.

We see these two joints looking different. Everything in our body is symmtrical and should okalike. The reason there joints look different, the head of the clavicle is pulled out of this joint. In other words, the ligment that holds in it place has been torn instead of. the clavicle coing into the sternum like that, it is like that. It look asymmetric. The reason it was pulled out we a looking at the tight side youwill see this is the clavicle and this is the clavicle. It supposed to be one bone that is connected like that.

What happened is the clavicle was fractured, which means it is broken. The clavicle is a number of pieces. That's a beautiful CAT scan. You can see piece, piece, piece, piece. This is clavicle here. This is the clavicle. That is fracture point right there and of the pieces of the clavicle that are fractured are projected up above where they are supposed to be In other words, this should be a continuous line going down. So they should be a continuious line here. You see, as we go into the joint, picture, picture, picture. fracture fracture, fracture, fracture,, fracture, fracture here then fracture here. We see the fracture lines in here. The joint, the clavicle that should be part, of this joint is pulled out.

supposed to look normally. You see the clavicle is intact here. There is one piece of bone. This is the normal appearance of this joint. The left sternoclavicular joint pulled out, except there is a little black area on the left side, as well. This black area is air. In other words, the trauma that occurred to the chest hot only fractured this whole right clavicle and pulled it the right clavicle from the joints, it pulled the left side a little bit and introduced some air to the joint.

The major findings of the CAT scan is a fancy word for many fractures, comminuted fractures, and pulling out of the clavicle from the joint space here on the right side.

Q Doctor, I am going to put on the board Exhibit 52 of John Lamacchia. Can you tell the jury what they are looking at?

A Now, this also a CAT scan, but we are not looking at that joint we looked at before. We are actually looking at the patient's side and back. This is the right side of the patient. You will see here again the gray structures are bones. You will see here, I am going to tell you, this black area here is the lung, okay? That is the right lung.

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Now, outside the lung, we all know we can feel a rib. Each one of these are ribs. These structures here are ribs. We can go all way the around the lung. It is cut off here. We are not interested in looking at the other part. This is all ribs. Behind here is the white structure. Here is the shoulder blade behind the ribs We can feel our back shoulder blades and ribs and underneath is lung.

The shoulder blade, just like every other bone in our body, should be one bone and continuous, like we were just talking about. You will see here in the shoulder blade here -- the medical term is the scapula -- comes here and then becomes discontinuous. There is a break right here in the shoulder bone. You can see it perfectly right here where there is a piece of bone here and, here and there is a gap between them. This bone, this line should be a continuous white line It is ot broken. So there is a fracture of the scapula right here in the back of the patient.

By the way, all this gray area around, here are the muscles of the back encasing the scapula. You could see that the fracture isdisplaced. In other words, part of the bone is coming up towards the lung, and part of it goes away from the lungs. There is a gap in between the fracture

Sometimes when you crack a bone, the bone cracks in the middle. It is still the two sides are next to each ther. So we say that the fracture is in.good alignment. In other words, the bone may be broken at least the bones are in good alignment. Here the bones are not aligned correctly. in fact, when it heals, there will always be a contour irregularity or a deformity. Some fractures will heal with deformity, and some will heal without deformity, depending on what the fracture, was that is here. This bone, the scapula.

That is the major finding of the CAT scan of that portion of the body.

Q Doctor, I am putting Plaintiffs' Exhibit 53 on the stand. Could you tell us what the jury is looking at?

A Now, we just looked at a CAT scan of that area of the back, the upper back. We are also looking at the area of the upper back but CAT scans, what we can do with thes X-rays, how we get these pictures as CAT scan, we pan tell the computer we want to look at cutting the patient. Of course, none of these patients actually get cut.

We can look at the patient this way axially and pull a slice out and show it to you, which is what I just did. We can reconstruct the bone looking at the bone straight like this. Here is the scapula we were just talking about. This is the bone right here. you could see again here, there are actually two to three fractures in the scapula. All we are doing is looking straight at the bone instead of looking at it from -- cutting it.here and pulling it up, we are looking straight at it. This way, basically, we are looking at the straight bone. We are taking two different looks. Instead of looking at that, we look at. that. This confirms -- not that we needed it -- this confirms the multiple fracture sites of the scapula here, here, here. You see the bones are discontiuous. They are not aligned correctly.

This, in another way or another fashion, shows you the fracture of the scapula.

Q On the board I am putting Plaintiffs' Exhibit 54 in evidence. Can you tell the jury what they are looking at, doctor?

A If you remember, we started talking about the sternotclavicular joint. Another way of looking at it again, CAT scans, the sternum is here now. Before we looked at it when we were cutting just at different angle. We are looking straight at the patient with the clavicles coming in. Now we are taking those cuts axially, like this, this, this, this, and we pull it out and look at it.

This here is the sternum here, sternum, sternum, sternum, and as we go up we see the two bones coming from the side,, this bone here from the side, this bone here coming from the side. Those are the clavicles. And, again, the right clavicle is fractured. There are multiple fracture, fragments.here. If you look at the sternoclavicular joints, you will see the clavicle is way off from the sternum here. It is dislocated, what we talked about before.

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What we are again seeing on this picture, it is another view. These are findings of multiple fractures of the proximal or part of the clavicle that is near the sternoclavicular joints is dislocated on the right. The same findings, just another way of looking at it.

Q I am going to show you what has been placed into evidence as Plaintiffs' Exhibit 55. And can you tell the jury what they are looking at, doctor?

A Finally, at this CAT scan, we are looking at another view of it. We want to look at the entire clavicle from the beginning to the end of the clavicle. Here it is right here. Here is the whole clavicle. This piece here is completely broken off where it should be. In other words, the clavicle should be just like that. This entire piece what we: have already seen in two different ways, it has been fractured off the sternoclavicular joint, is dislocated.

You also have the other end of the clavicle, which is the part of the clavicle that goes up to your shoulder, is also broken here, and you can see the fractures there as well. So we are seeing fractures of both ends here, the clavicle. This one I showed you before in different ways. Now we are seeing the entire length of the clavicle, an easier way to look at it. So you can see these fractures.

Q Doctor, I am going to show you blowups of films of John Lamacchia's shoulder, also Exhibit 48 in.evidence. Can you tell the jury what they are looking at?

A Now, this is an MRI scan -- this is a whole. different technology -- but we are going to look here on these pictures of the shoulder again. Here we are starting with the front of the shoulder. We are taking picture, picture, picture, picture, picture until we ended back of the shoulder. On the bottom each of these pictures are very thin pictures.

Now, I have to tell you a little bit about the shoulder joint. This round area here is the humerus. This big bone is. the humerus, okay? That is the bone that runs up and down our arm. Now, that bone comes next to another bone here, this triangular area, the glenoid. So if I were' to talk to you about the joint space between this bone when we move our arm and this bone, this would be the glenohumeral joint space.

Now, there are two things you have to know. How do all these structures get held together in the shoulder joint? In other words, what keep the shoulder joint together? Well, there are muscles here but also there are four tendons that make up the rotator cuff -- you may have heard of the rotator cuff -- there are four tendons that hold the bones and the joint in place so that we are able to to have normal movement of our shoulder.

Now, one of the tendons, one of the major tendons of the rotator cuff is supraspinatus tendon. Everything has a fancy medical term. It is the name. It has muscle. Each of the tendons connected to the muscle is connected to the spine or supraspinatus muscle. This here is the supraspinatus muscle.

Then the muscle forms a tendon. And what a tendon means, what it means is a connection between a muscle and bone. The way muscles attach to bones are via tendons. Tendons are very thick fibrous structures. They start at the muscle. They insert on the bone. These tendons have no -- they should have no abnormal signal in them. In other words, what I am saying, they should just be totally black. The muscle is gray. The tendon, since it is not made of material like the muscle -- it is fibrous material: -- it should be black. If it is not black, that means abnormality in the tendon. This little dark area here really extends from the edge of the bone all the way to the bottom of that bone, which we will talk about in a minute. This whole area here should be black, black, black, black, black You will see there is a lot of white area in here, in here. This area in here is a tear.

What happens is, when a tendon gets torn, water gets in. An MRI scan is very, very sensitive for water. We will talk about water in a minute. These white areas here and here are all white because of water. Now, this tendon should have no water in it. It should be completely black. The fact it has water in it tells someone reading it there is a tear in the tendon. This tendon is not completely torn. It is not ripped off of the bone. It is partially torn. This is a partial rotator cuff tear. This is what it looks like in an MRI, a partial rotator cuff tear right here. That is one thing you see on this MR.

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The other thing you see on the MR is a white blob over here. I told you everything watery is white upon this MRI picture. That is the joint between the clavicle and the acromion, acromioclavicular joint, the. bone on top of the shoulder you feel. We talked about the clavicle, how it got down to the end towards the shoulder, was fractured. This is here the water buildup around the fracture site. Tear of the acromioclavicular ligaments, none of this should be here. If you look at the normal shoulder, you will not see any of this. You see gray. You see bone come to bone. Bone, gray here. Bone, gray here. You would not see any of that There is a fracture up here causing swelling around this. joint, the.top of the shoulder joint. There is also a partial tear of the rotator cuff on this picture here.

These are the major findings, so two major findings in the shoulder, as well, so far.

Q Doctor, I am going to show you Plaintiffs' Exhibit 49 in evide .e. Will you tell the jury what they are looking at?

A Now, this is the same shoulder, the right shoulder. Instead of looking at it straight on like we look at the bone coming on straight on, we are going to do our old trick, look at it cut from top to bottom, pull the picture out and look at it. Here are 20 pictures from the top.We talked about the fracture site, the acromioclavicular joint. We are going to come down to the round bone, the humerus. Now, it does not look straight up and down. It is cutting it like a loaf of bread. It is round.

This here is the humerus, the humeral head, the top of the humerus. We talked about one bone, the topof the humerus. That is the glenoid. That other triangular area that is here, the glenoid. One thing you have to know from this set of pictures is that these bones come very close to each other. All joints, the bones come close to each other. That is what the definition of a joint is. We don't want the bones to touch because if the bones touch that causes pain and limitation of the movement. So the body cushions itself and over joint is cushioned by some cartilage, cartilaginous material in between the bones.

In this case the shoulder those are called labrum -- that is the fancy word for fiber -- that is two labra. We can could see actually more than that, this is in this picture, two labra. This black triangular area, you have labrum here and here. It is putting a piece of rubber here and here so it does not touch each other.

As I told you, the labra are fibrous. The supraspinatus tendons we talked about, there should be no whiteness at all. It should be completely back on these pictures. As you see white coming here the triangle is smaller than it should be. These white areas over there, tear of the glenoid labra. There are tears of both, and the labra have names. This is the one in the front or anterior. Then this is the one in the back called posterior. There is an anterior glenoid labrum and a posterior glenoid labrum. The whiteness is an abnormal amount of fluid a lot of fluid. That mean effusion joints.-- effusion is a lot of fluid -- in the joint space.

The findings of the entire shoulder looking here are tears, anterior and posterior glenoid labra. There tears, which is important to separate the bones, there is a partial rotator cuff tear. There is a joint effusion, as well. There was a fracture up here, up top, at the acromioclavicular joint, as well.

These are the major findings. There are a lot of them in this particular shoulder.

Q Doctor, I am going to show you what has been marked as Plaintiffs' Exhibit 22 in evidence. Can you tell the jury what they are looking at?

A Now, this is an MRI of the cervical spine. This is the spine, the neck, cervical part. This is the brain up here. Okay? So spine goes from the bottom of the brain down, and we divide up the spine into, really, four different segments.

For thin particular picture, we are looking at the cervical spine, the neck. We all have the same number of bones in the different portion of our spine. in the cervical spine there are seven bones. These gray things -- we got used to look at these gray things -- are the bones of the spine.

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They start off, this is the second one, is the first one, goes around this one. Number two,, three, four, five, six, seven. The cervical spine go into this area right here and stops here. We make an artifical end by making only seven bones. Then starts the other parts of the spine is the back, thoracic or the back. We are not interested in that. We are only interested in the cervical spine up here. There are very important structures right behind these bones, which is what comes out from the brain or the spinal cord. The spinal cord comes out from the bottom of the brain, goes all the way down our back. Spinal cord stops in the mid-back over here. In each level where the spinal cord comes out, there are two levels in between the bones, neuroforamen, means a hole. Each one of these holes, right, on the left and right. Nerves comes out the spinal cord, goes out the right hole. Nerves comes out the spinal cord, goes out the left hole. On each level the nerves come out. Some nerves go to the shoulder. Some go to the upper arm, forearm, pinky, down the legs. Every part of our body gets these nerves from the spinal cord.

So what we are looking at here is a side view. You don't see the holes that they come out because we are looking at the mid-part of the spine. This is the spinal cord here. These are the bones. You will see that in between the bones, there are the -- in between the bones, there are these more whitish longish structures here, just like. we said in the shoulder. We don't want the bone touching bone in the cervical spine. We don't want these bones touching each other. In between these bones, again, are shock absorbers. They are called disks.

other parts of the spine, in between the bones are the disks. The disks have to line up with the bones so that they stay in correct position. The way they stay in correct position, just like the shoulder stays in correct position are there are ligaments that hold them in place. Each one of these ligaments have a fancy name. The point is these ligaments hold it in place. These ligaments should hold the disks right to the edge of the bone. It should not go past, beyond the edge of the bones. If we did, it would jump up and down, move around. The disk would go anywhere. Something has to hold it in place.

Now, if something occurs to this ligament, like a tear of the ligament, instead of the disk coming to the edge of the bone and stopping, it will go through that hole if there is a hole in the ligament. The way you know there is a hole in the ligament, at least a partial hole or complete hole going through the ligament, is that these disks will extend the beyond the margin of the bone. If you look at all of these disks here you will see this disk here comes to the edge of the gray and stops. This one comes to the edge of the gray and stops. This one you see there is a piece of black that comes out beyond the opening of the bone. Here is the edge of the bone here. Then we have in the circle right here -- that circle right there - a piece of disk that is one out beyond the bone here. Again, the disk comes just to the edge and comes to the edge and stops. This one piece pushes out more. You can see that piece right there. That piece pushes out because there is a hole in the ligament, and that's a disk herniation. The disk is herniated through the hole and it is now pushing on the covering of the spinal cord, which is called the thecal sac. So there a sac of liquid spinal fluid. If we put a needle in the back, put a spinal tap, and drew fluid out. This disk herniation is pushing on the thecal sac. Right here at that level, the remainder of the scan is normal. This disk otherwise has a normal appearance.

Q Before I take you to other films, what is the significance of the herniated disk sitting upon the thecal sac or pressing upon the thecal sac?

A Well, this is a very small space. That is maybe a big picture, that blowup. We are talking about millimeters.

Anything that pushes on an area that should not be pushed on can cause pressure upon the nerves or cords. It is possible to have symptoms from or feeling pain, limitation of motion, not telling difference between hot and cold, pins and needles sensation.

All these different things can occur to a patient if they have a herniation that causes pressure upon a nerve or upon the spinal cord that contains all the nerves. So there's a possibility that this patient can have symptoms from the herniation.

Q Is herniated disk at C4-C5, will that cause tingling down the arm?

A It can. There are dermatomes. There are charts. Remember I told you nerves goes to different, very specific areas --

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Q Doctor, perhaps this can help you right here.

A There is a chart called a dermatome. This is --

Q Exhibit 24 in evidence.

A Whidc you may have seen or may not. We are talking about nerves C2-C3. The Cnerves from the cervical spine, you see the C nerves go from the neck up the chest and upper back and down the arms. So you have C4 and C5. Both of those nerves can be involved because it is pushing on the spinal cord at that area. You will see the C4 nerves are here in the upper neck. And C5 goes all the way down the forearm here in the front of the patient here and in the back of the patient, yes will see C5. It goes just to the back of the neck. So C5 can come down the front of the patient and cause symptoms down the front of the arm on both sides, right side, left side, or in the back. It is mainly in the back. These are -- we are all the same. We are all mapped out by this one chart.

Q We talk about those symptoms. Can that include numbness?

A Yes.

Q Can it include tingling?

A Yes.

Q Can it include a sharp pain?

A. Yes.

Q Doctor, I want you to assume that John had a previous accident in 1995 in which there was an MRI scan of the cervical spine, and that came out normal.

Does that have any significance upon you? Does that mean. anything to you?

A It tells me that something happened after that accident from 1995 to the date of the MRI scan of September 2002. Something occurred within the interim to cause that herniation.

Q The fact that he had a clean MRI in 1995, what does that tell you about the MRI that was taken of John in 2002?

A It tells me that something -- again, it just tells me that something occurred between ‘95 and 2002 to have caused herniation.

Q I want you to assume on September 9, 2002, John was involved in a car accident, which was a very heavy, very heavy, heavy impact. I want you to assume as a result of that impact, John suffered injuries, for the most part, to his right shoulder and his neck.

Do you have an opinion within a reasonable degree of medical certainty whether the fractures that we discussed -- and let me just list them -- the fracture to the right clavicle, the scapula, the fracture to medial and distal aspects of the clavicle, the partial dislocation of the right sternoclavicular joint, and the incomplete fractures of the medial aspect of the' humeral neck, do you have an opinion within a reasonable.degree of medical certainty whether those.fractures were caused by the accident on September 9, 2002?

A Yes.

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Q And what is your opinion, sir?

A They were caused by that trauma.

Q Do you have an opinion within a reasonable -- oh, doctor those films that we saw, the CT scans of the shoulder that were taken on December 2, 2002, is that evident that almost three months after the accident.the fractures were still showing up?

A Yes. There isn't as much healing at all going on between thepe fractures. We talked about healing bones coming together. When the bone heals,whether it is deformed or not, the whiteness should he joined together. It should be no breaks in it. This bone did not show any appreciative healing all together over the course of the many months you pointed out. That is another important finding on the CAT scan. We don't look at the position of the fracture. We look at the time going from the date of the trauma on how the patient has responded byhealing And so there's not much evidence of healing going on in any of these fracture sites.

Q I want you to further assume that prior to September 9, 2002, he had no clinical symptoms like numbness, tingling, or radiating pain down his right arm. I want you to assume that the MRI of the cervical spine showed that he had a heriated disk at C4-CS.

Do you have an opinion within a reasonable degree of medical certainty whether the herniated disk at C4-C5 was caused, by the accident of September 9, 2002?

A Yes.

Q What is it, doctor?

A It is. It is everything we have discussed here. It is due to the accident.

Q Doctor, how much do MRIs cost?

A Approximately 800 to a thousand dollars.

Q How much do CT scans cost?

A Somewhere in the order of $400.

Q Doctor, I am now turning your attention to Michael Macivor I am going to show you what has been marked into evidence as Plaintiffs' Exhibit 11. Can you tell the jury what they are looking at?

A You're looking at very similar picture to what we were just looking at. Now we are all experts at this. You're looking at the shoulder on this other patient. Here i is our humerus here coming down. Here is the glenoid, the triangular spine. Here is your supraspinatus muscles. I told you the tendon, just like the labrum, had to be completely black here. Again, you see the tendon begins right here, which is where the muscle ends. This whole area here is muscle.

Then it forms the tendon, which attaches to the bone right here. But you see again there is a lot of white area here in the tendon, and that again is a partial tear. It is not completely torn. The tendon is still attached, but there a partial tear of the supraspinatus tendon. Again, as we just discussed, that is a partial rotator cuff tear.

Q It is considered an intrasubstance tear?

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A The tendon is this entire area from the surface of the bone up to the white line above the bones, which is fat into and in between the two muscles here. So the signal that in the tendon is in the middle of the tendon. Most of it is here in the middle. Intrasubstance means in the. middle of the substance of the tendon. And the answer is yes.

Q Doctor, I am going to show you what has already been previously marked into evidence as Plaintiffs' Exhibit 15 of Michael Macivor. Can you please tell the jury what they are looking at?

A Again, we are familiar with this. This is the cervical spine, the upper neck. We are all together on this now. Here are the bone, C2, two, three, four, five, six, and seven. And, again, you can see that as we go down here, the disk, which is in between the bone, we see very obvious pushing out here between four and five right there. There there is a herniation there, the rest of the disks. You see that the whiteness, the part of the disk, that watery part of the disk, comes right to the edge. Then is the edge of the disk pushing out. There a little more pushing out at the bott?? as well. This is herniation here between four and five, which is higher. There may be pushing out up, down, lower between six and seven. You see five and six is normal. Seven and one is normal. Three and four is normal, at least. There is a disk herniation at C4 and 5 again, which we are familiar with.

Q Doctor, I am going to show you what has already been marked into.evidence as Plaintiffs' Exhibit 8, which is Michael Macivor's lumbar spine -- Plaintiffs' Exhibit 9 -- pardon me.

Can you tell the jury what they are looking at?

A Now, this is an MRI of the lower back of the lumbar spine, and I told you -- I didn't tell you yet -- there are five bones in the lumbar sapine. I am going to label them. You can. see them, five, four, three, two, one. So the lumbar spine starts in here and goes down to the bottom here.

This piece of - bone here is called the sacrum, which is the last part of the spine. That is called the sacrum. And instead of saying L for lumbar for each one of these levels, if I wanted to look at the disk between three and four, I would say L3 and 4. For this disk here, it would be L5 and S1 for sacrum.

I am going to put a S1 down here. These are all L's. We talked about the disks that are held in place by ligaments. As long as they come to the edge of the bone, they stop here. You see a beautiful representation of what normal is between one and two, between two and three, three, and four, four and five. They come to the edge of bone and stop.

What happens here between five and one, there is actually a very large piece right here, very large piece of gray that is coming out from the disk here. And this is a larger herniation. It has broken through or torn the ligament that holds it in place and broken through here and pushes out into the thecal sac where the nerve roots are.

Again, in this picture the nerve roots run up and down the spine. The spinal cord ended here, sending nerve roots down. The way the nerve roots come out we will talk about in second, through those holes in the spine.

Looking here, this is a large herniation between L5 and Si.

That is a major finding of this particular portion of the MRI.

Q When disk material is pressed upon a nerve root, what does that mean?

A When it pushes on a nerve root is exactly what we talked about before. It can cause problems to what the nerve's function is. The nerve's function is to tell the difference between hot and cold. When you lose that other things. There's motion, okay? Motion nerve allows you to move. You can feel numbness, pain, tingling, problems in moving the muscle that the nerve is supposed to be moving. All of those things can happen when there's pressure on a nerve root.

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In the one -- these are two pictures now -- this, is number. In number 8, we are now taking pictures more to the sides again. We See -- I will label it. When we go out to the side, we will see, and if we actually, if you put up number you will see a little bit better, let's put up number 10. I told you about the holes on the side of the spine where the nerve roots come down, then come out. Well, this is what they look at.

Actually, let's look at this one right here. I am going to label the bone so we know what we are talking about, L5,L4, L3, L2. this is S1. This here, this white area here is that round -- is the nerve, neuroforamen is the hole where the nerve root comes but. This gray dot that you see up here, this gray dot that you see here, this gray dot that you see there are actually the nerve roots that have come out -- remember we were looking in the middle on --

Q Plaintiffs' Exhibit 8?

A Let's go one more back.

Q All right.

A If you remember here, number 9, we are looking dead center in the patient. So if you were to tale a picture of me, the very middle of me and pull it out, it would look like this. But, remember, these pictures are now taken going from side to side. The holes are on the side of the patient, not dead center. We would not see them on this picture.

When we go over to the side on number 10, it looks a little bit the same We see the square bones. We see here -- what don't we see on the picture? We don't see. the nerves roots coming down the thecal sac here. This gray stripe is now gone, that gray stripe where the spinal cord comes down in our center of the body. When you go out in the center of our body, that is only when the nerve roots come out in the side.

Actually, if we look at this for one second, you will see what I am talking about. This is number 17. This is a model of the entire spine here. You could see when you look at it from the side, you all see. You will see the bones here, and in between the bones are the disks. The spinal cord comes frown the brain. The brain is on top here, comes down the middle. Each level there is a hole.

These roots come out. One root comes out to the right side at the same level. One root comes to the left side. They go where they are supposed to go. This is the anatomy when we look at the picture from the middle here and what we are doing in this central picture here, where you see the: sac coming down the middle where the spinal cord is in for most of the way, we have taken a picture very much on the inside of the middle here.

Now, when we go out to the sides is when we are going to see these holes. That is what we are seeing here on picture number 10, Exhibit 10. These are the holes here. Look what happens. Here you see white. This is the hole. This whiteness is occupying the hole. It shows you where the hole is. This looks like this, like this, looks like this, but what happens between five and one, it is gone. The reason it is gone is because all of this disk material, the disk that is herniated out at 5-1 not only goes back to the center but also goes out to the right and the left and is occupying the hole where the nerve is which should have the nerve root up again. The other line going there.

So what happened here is there's a herniation at 5-1 pushing directly back on the sac. It is also pushing out on the holes that contain the nerve roots.

That is the major finding of the lumbar spine MRI.

Q Doctor, I am going to show you what has been marked as Plaintiff' Exhibit 5 in evidence and Plaintiffs' Exhibit 6 in evidence.

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Can you talk to the jury about these two exhibits, please?

A I can talk. There, here is number five. This round gray area is -- we are now taking these pictures, we are now taking these pictures straight down. So instead of seeing the whole spine up and down, we are cutting the spine like a a long structure, like a loaf of bread here.

And so when we see a picture like that, just like in the shoulder, instead of seeing the long humerus coming down, we saw a round object, the circle, which is the humerus, the same thing here. This is the vertebral body. The bone, this here are the nerve roots, the gray structures. These are the foramen here. That are what the foramen look like. They are white. We are taking a picture like this. The first picture I told you went down the middle. The next one went over to the side. Here you see normal opening of the foramen, of the opening, normal coming out of the right side, normal coming out of the left side.

I told you that the disk material gets held in place. It never goes beyond the contour of the bone. Now, if you put that in your mind and look down at L5-1 where there is a disk herniation, which is on number 6 here, look at the difference between these two pictures.

Q Let me help you, doctor.

A You can see the difference between these two pictures. There a big glob of black here that is extending beyond the margin of the bone, push on the sac here directly back and extending out to the right side and the left side. All this material here was disk herniation. I showed you on that straight up and down picture that I put a circle around. That is what it looks like when we cut the patient a different way. It just confirms what we have here seen and told you it is another way radiologists look at things to make sure they are what they are. Over here look at it, you see it is supposed to look like this, this whole area in here this is normal healthy level. And now at L5-S1 where the herniation is, it looks like that.

So the finding is a heriation pushing on the sac and pushing on the foramen, that of the holes.

Q Doctor, very quickly, I would like to show you thoracic films of Michael Mccivor. In evidence, I am going to show you Plaintiffs' Exhibit 18B.

Here, doctor, I will let you do what you do best.

Can you just tell the jury what they are looking at?

A Now, those are pictures of the mid-back or thoracic spine. The thoracic spine, you see the cervical spine seven bones. the lumbar spine has five bones. The mid-back, thoracic bones, have twelve bones. We don't need to count all of them. The numbers are here already. The concepts are all the same. In between the bones are whitish objects. Here are the disks. The whiteness behind the bones here. Right here is the sac with the fluid around the spinal cord. And this gray line going down the middle is the spinal cord.

Again, here, you will see between 9 and 10, between there is a line here. There's a mark between 9 and 10. You will see there a gray area coming down to the side here. This is and 9. The point being that there is a pushing out of the disk at two levels and thoracic spine between 8 and 9 and between 9 and 10. These are again disk herniations, which means that the ligament has torn. The disk, instead of being held by the ligament, is pushed through like that and causes pressure on the sac and on the spinal cord, which is running down right behind it.

So those are the major findings here of the thoracic spine.

Q Thank you, doctor.

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Before we go to the next patient, have a couple of questions to ask you.

I want you to assume that on September 9, 2002, that Michael Macivor was involved in a very bad motor vehicle accident, which there was lots of damage to the vehicle. It turned over several tines. I want you to assume he was taken to the hospital where he made complaints of back, neck, right shoulder.

I want you to assume that he went to see Dr. Maranga, who is a chiropractor who has been treating him consistently up to then for neck and back and shoulder injury. I want you to assume that Michael Macivor had shoulder surgery on his right shoulder for impingement syndrome.

Do you have an opinion within a reasonable degree of medical certainty, first, doctor, whether the terniated disk that he sustained at L5-S1 was caused by the September 9, 2002, accident?

And before you answer that question, I want you to further assume that Michael did not have a prior injury to his neck or to his entire back, and he did not have a prior injury to his right shoulder.

Do you have an opinion?.

A If he had no prior injury, and he had no complaints or was seeing doctors or being treated for the back, the entire back or neck, suffered a trauma, and then developed symptoms that required treatment and/or surgery, then all the findings that we have discussed here on the MRIs would be causally related within a reasonable degree of medical certainty to the trauma itself.

Q So, specifically, the herniation at L5-S1, do you have an opinion within .a reasonable degree of medical certainty, is causally related to the accident of September 9, 2002, and is a substantial factor of that injury?

A Given what we have said, it would be a causal relationship to the accident.

Q Would the partial tear of the supraspinatus tendon, would that have been caused by the September 9, 2002, accident, within a reasonable degree of medical certainty?

A Given everything we have said about it, yes, it would be causally related.

Q The herniaton at T8-T9, would that have been caused by the September 9, 2002, accident?

A Given everything we said, with symptoms relating to that site, it would be.

Q Would the herniation at C4-C5, would that be caused by the September 9, 2002, accident?

A Again, given everything we have said before and after, yes, it would be related.

Q Okay, doctor. I am now going to turn you to Carley Gervais I am going to show you what has been marked previously as Plaintiffs' Exhibit 44 in evidence.

Can you tell the jury what they are looking at?

A Okay. Now I am going to another, body part. We are going to the knee But in the knee it is also a joint, so there's two bone that come together. The bones are called femur in our thigh. Then we have two bones in the leg. But the bone that really comes

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up to the knee is called the tibia. We have the femur and the tibia. They form a joint. It is more of a hinged joint different joint than the shoulder, right? But we also need to have cartilage or shock absorbers between the two bones of the knee, in the knee.

Instead of being called the disk like it.is in the spine, or labra like it is called in the shoulder, in the knee it is the miniscus. The menisci are in the knee. This white structure coming down here is the very bottom of the femur. The femur bone, this underneath it here is the tibia.

Each one of these is a separate picture. So we have one, two. The way it works on these, you look at the first picture on the top left. Underneath it, the second picture. Then nuter three and four, five and six, seven, eight, nine, 10, 11, 12. That is just the way things are set up to fit everything on one sheet.

So we are starting off here in the inner part of the knee, which is medial part of the knee the inner part of the knee. We are taking pictures from the inner part of the knee going out to the outer part of the knee, from inner to outer, lateral part of the knee in is all the medial part of the knee in is all the lateral part of the knee.

Hang on one second.

They, when they photographed it, you see this little triangle here. It is hard to.ae on the bottom. That is the fibula. That is the second bone is the leg. That tells you this is the lateral part of the knee. The way they photographed it, they started from the lateral and came to the inner part. In any case, we are going across the knee.

Now, this is the lateral part of the knee and this is the medial part of the knee her. These.triangle here, which we are familiar with the labra, the way we looked at it in the shoulder, are the menisci. Now, the meniso meniscus, medial meniscus, the inner part of the knee, the lateral meniscus, the outer part of the knee. Each meniscus has three parts, front or anterior, or front horn. The back part called the posterior or back horn. Then connecting up the anterior to the posterior in the body, this anterir horn, a body and posterior horn. It is all one curve is a curve of cartilage meniscus that goes to the medial part in the knee between the two bones. Same thing laterally.

So what we are seeing here is the front part. This is the front of the knee here. You could see a piece i over here of the kneecap, the front of the knee. This is the anterior horn. This is the posterior horn. Lateral meniscus. Here is the anterior horn and posterior horn, medial meniscus. If you look, these are very whited out pictures, just like in the labra, and just like in the supraspinatus tendon of the shoulder, the rotator cuff.

Anything that is white in the meniscus, anything abnormal signal will look white in the meniscus. That is due, the abnormality here of the posterior horn of the knee of the meniscus here is area of white here. Also, the posterior horn of the lateral meniscus, if you come up and see a little bit closer, you will see a white line going through it there. Those are tears of the menisci. Both the medial and lateral menisci are torn.

That is what -- that is the major finding of these films right here.

Q What is the function of the meniscus or menisci?

A Menisci are shock absorber cartilage, just cushy material that keeps bone against bone. If there is a tear in the meniscus, the meniscus be torn and degenerate, become abnormal. The bones could become closer to each other and cause pain and limitation in motion:

Those are the major findings that can occur from the meniscal tear, pain and limitation of motion. You could also get swelling from the knee, from joint effusion or water on the knee. Those are things that could happen.

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Q Doctor, I am going to show you on what has been marked as Plaintiffs' Exhibit 43 E in evidence. They are of the MRI of the shoulder.

Can you please tell the jury what they are looking at?

A Well, we have a head start on the shoulder here. We looked at a few. Number 43 A is our picture -- 43 A is our shoulder. Again, the humerus bone, again the supraspinatus muscle coming to the tendon. Again, you see here an abnormal signal in the tendon itself here, indicating here in this tendon as well.

Now this tear is a little thicker than the other teare in this sheet here, a little darker than the other sheets. This tear may extend actually from the bone to the edge of. the bone underneath it or it may not. At the very least, this is a partial thickness tear, a partial rotator cuff tear of the shoulder of the supraspinatus tendon. That is what you aee on this particular picture here.

Okay. We also looked at the shoulder.a different way. And then it was cutting it straight down from the top to the bottom. We were looking at glenoid labra last time here. Again, you have to make out here you see there a little bit of fluid between those two bones. You make out - here there is a little bit of liquid surrounding anterior one. There is not much white fluid, fluid in the posterior here. There are more grainy images of the shoulder, not as pristine as the one we saw before. You could see here instead of being a triangle in the anterior one where there a big round glob here where the posterior one, there is a big glob down here. But the anterior one is a problem, which is here that has a white line around it here, whereas the posterior one does not. It looks like the anterior one, you see. this thin white line is liquid, meaning the labrum is being pulled away from the bone. There is at least a tear near the anterior abrum. I don't see the white line here on posterior labrum. It shows at least the anterior labrum is pulled away from the bone.

Q Now, let me give you -- I am going to show you what has been marked as Plaintiffs' Exhibit 31 in evidence, which is the lower lumbar spine of Carley Gervais.

A Well, again, we are back to what we saw in other patients. And, again, see here, let's look at picture like we are used to. Actually, let's look at number 29. We could look at number 29 first. You could leave that up -- this is a picture where we are used to looking at on the other patient.

This here is the spine cord. That is endings, the nerve roots coming down. It is a beautiful picture. We get to see it.nicely. The nerve roots coming down here. Here are the disks. I mean, the vertebral bodies, name them, five, four, three, two, one. That is S1. You will see here again. That, nicely, the disk comes to the edge of the bone. You could see it actually being held in place by the ligament. It comes and kind of.pushes and stops. It comes and stops. This pushes out a little more between four and five. Four and five is pushing out more than any of the others. Look what happens between 5.and 1. It is almost like an instant replay. There is a piece of the disk that comes straight out here a way beyond the bone. You can see the contoured deformity pushing directly on the thecal sac. You could see these individuals gray nerve roots actually pushing on the nerve roots there. Again, we talked about the foramen, that the white structures here being the hole. You will see 4 and 5 pinched off. At 5-1 it is gone. You see normal, normal, normal Pinched off at 4-5 where there's at least the bulge. Then at 5-1, completely gone, obliterated on 5-1, both on one side of the patient and on the other side of the patient as well, the right and left side.

Q What does that mean to Carley that's totally pinched off?

A This means there is some pressure, abnormal pressure being applied to the nerve roots. And we can look at dermatome charts and look at where the nerve roots go that I could cause pain and numbness, tingling, inability to move a muscle, a loss of reflexes at a joint. Those are all the things that the nerves control. And so that there's abnormal pressure on the nerve. Any of those things could be felt by the patient.

Q Let' go to a bigger blowup. I want to ask you --

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A This is just number 31 she first put up is another way of looking at it. You can see actually see the piece being pushed out here. Normal, normal, pushed out at more than normal 4-5. At 5-1 you could see the whole piece actually coming out. There is a hole in the ligaments that goes from here to here. That hole allows this piece to come out.

Q Do you see any degenerative changes on the MR?

A Now I would have to go back to the one that was just up.

Q The other one?

A Now the answer is yes. Degenerative change is just another why of saying arthritis, arthritic condition. If you looked at all the disks, you can do two things to the disk. You can measure how tall they are, how think they are. You can see what color they are. All those disks are white. White, white, white white. Then look at this disk here. It is not that white anymore. The reason it is. not white because in this particular way that we did the MR, anything that has water or fluid in it, this is white. Anything that loses water or loses fluid becomes dark. These disks, I told: you, like cushions or shock-absorbers. They are very watery. They are supposed to be watery. They are acting as the shock absorber. Like this disk has lost water. You will see this disk is herniated.

5-1 is not as white as other disks. We can see two things about that disk. We lost water and the fancy word is desiccated. We can say it has not lost height yet. If you measure the height, it is same from here to here. You don'nt have to be a doctor You can use a ruler to measure that out.

There are some early changes of arthritis of this disk. It lost water. It lost its ability to cushion. But it has not yet become so brittle that it is lost its height. Because what happens, the progression of this is that first a disk will lose its water, become brittle, then will become narrower and lose it height. What happens then, the two bones get closer to each other. Then you have real problems of. bone touching bone We know there are early arthritic changes of that disk, is herniated.

Q By the way, what is the function of a disk in terms of lumbar spine? Does it allow you to bend? And can you just tell the jury what is its function?:

A The function of the disk is to protect one-bone away from the other bone. And also since there are many, many disks, it allows flexibility of the spine. It is not like one bone like clavicle or humerus. You were able to flex, extend your back, for example, your back and move from side to side. The normalcy of the joint allows us to move. It is a disk that protects that ability to move.

Q The meniscus protects the ability of the joint in the knee to bend, correct?

A Yes.

Q And to apply pressure, correct?

A Yes.

Q Does it also absorb shock like jumping up and down?

A Well, yes. When we go about our daily movements of moving around including jumping, walking, running, we don't want those bones to touch each other. There are these protector mechanisms at each joint labra, disk, menisci.

All of those protects the bones.

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The answer to the question is yes.

Q What happens to. the disk when someone is jumping or running?

A Well, anything may happen to the disk. The normal function is to remain shock absorber. That is what its function is. That is what should happen.

Q Can you show the jury, tell them what they are looking at in Plaintiffs' Exhibit 28 and 27 in evidence.

A Very similar to what you have seen. 28 is between L2 and L3.

Q Sorry, doctor. Let. me help you.

A Between L2 and 3, which is normal, we saw this before, beautiful white thecal sac. You can see the actual each individual's nerve roots. When you go to the level of the herniation between 5 and 1, you will see, you can now point to the disk herniation here. This is all abnormal. You can see the nerve root coming out here and here. You can actually see the herniation touching the nerve root on the left and the right side here. It is going to exit eventually from the sides. You can see the herniation very well both ways .

Q Doctor, I want you to assume that Carley is a performer, and then when he's on stage, he is jumping up and down. He could be bending over. Is that inconsistent with having a herniated disk at the level that Carley has?

A I don't understand. Could you rephrase that?

Q I am sorry.

I want you to. assume that Carley, when he performs on stage, he is a singer, and he is jumping up and down. His knees come off -- are coming up, you know, off the ground.

A Right.

Q He can -- you know, he is singing. He is leaning towards the audience Is that inconsistent with someone who has a herniated disk at L5-S1?

A You mean whether he can do that?

Q Right, with a herniated disk, yes.

A It is possible, sure.

Q Doctor, I want you to assume that on September 9, 2002, that there was a car accident. And if you pardon me one moment, I am going to show you what has been marked as. Plaintiffs' Exhibit 2 in evidence.

I want you to assume that in the car accide Carley Gervais was a passenger. As a result of that he sustained injuries at the time to his right shoulder, his right knee, and to his back.

Doctor, do you have an opinion, with the degenerative changes that you were discussing about could this accident have caused those degenerative changes?

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A The time interval between the accident and theMRI is how long?

Q The time interval -- the MRI was taken on November 19, 2002 -- so a little over two months.

A In general, arthritic changes or degenerative changes take longer time than shorter time to occur. You can get arthritic changes just by living life. You can get arthritic change by damage to a disk, like by an accident which would accelerate the degeneration or arthrits to that disk now that the ligament is torn. This is a relatively short interval between the accident and the I. You can see one of two things. There's only one of two things you can say. One thing you can say is that there was no arthritic change at the time of the accident. He had a trauma. He had a herniation due to the trauma, now has accelerated arthriti, accelerated arthritic condition due to that trauma and the herniated disk. So you could or you can say there could have been some arthritis prior to the accident, which was not painful to him, which allowed him to do what he wanted to do. He suffered a trauma, which now herniated the disk through the ligament, which now caused him whatever symptoms he is having that caused him to come to medical attention, which again would accelerate degenerative change.

There is no way of knowing exactly what happened. But given that history or if I was told that he was not having a problem, had an accident and then started having problems, one of those two scenarios has happened here. But both have the accident asbeingan important part of that change in his back.

Q. Doctor, I want you to assumee that on September 9, 2002, that Carley was involved in a car accident, that a result of that car accident, he sustained injuries to his right should to his right knee, and to his back.

Do you have an opinion -- well, he has no prio history of a prior neck or prior back injuries. He has no prior history of a prior right shoulder or prior right knee. I want you to assume that since the day of the accident, he has been under the care of a doctor who focuses on physical rehab.

Do you have an opinion, within a reasonable degree of medical certainty -- I am sorr want you to assume that as a result of this accident, he has surgery to his right shoulder, he has surgery to his right knee.

Do you have an opinion within a reasonable degree of medical certainty whether the injury to his right shoulder, specifically the rotator cuff tears that we spoke about and the supraspinatus tear, is that a result of the September 9, 2002, accident?

A Yes. If he had no history of any symptoms, pain or whatever to the body part had an accident and now has symptoms, then the findings on the MR would be causally related to the accident.

Q What about the right knee? Do you have an opinion within a reasonable degree of medical certainty whether the menisci that were torn as a result of the accident was a result of the September 9, 2002, accident?

A For the same reasons, yes.

Q That is, this accident, September 9, 2002, is a substantial factor of his right knee injury, correct?

A For the same reasons, yes.

Q And, now, doctor, I want you to -- I want to ask you if the herniated desk that he has at L5-S5, and the bulge that he has at L4-L5, is that a result of the accident on September 9, 2002?

A Within a degree of medical certainty, for the same reasons that we said before, yes.

MS. MORENO: Thank you, doctor. I have no further questions.

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THE COURT: Okay. Resume your seat, doctor.

(Witness resumed the witness stand)

THE COURT: With that, counsel, you may cross-examine.

CROSS-EXAMINATION

BY MR. HORBATIUK:

Q Let me know when you're ready, doctor.

A I am ready. Thank you.

Q Good morning, Dr. Kolb. My name is Kevin Horbatiuk. I have a.few question for you.

First of all did you bring with you to court today a file regarding anything?

A Yes.

Q And what is your file?

A My readings, certain MRn, my partners' readings of certain MRs and CT scans, as well as previous readings of MRs and CT scans or MRs as well as operative report for these three patients.

MR. HORBATIUK: Your Honor, may I have the opportunity to see what he has brought?

THE COURT: Yes. You.may pass them to him.

MR. HORBATIUK: May we approach?

THE COURT: Yes.

Q Thank you doctor.

(Pause in the proceedings.)

MR. HORBATIUK: May I approach, your Honor?

THE COURT: Yes.

(Witness handed documents.)

A Thank you.

Q Thank you, doctor.

The documents you just handed to me, they are. all loose documents is that correct?

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A Yes.

Q Were these documents maintained in separate files for each separate patient?

A The answer to the examinations that our office performed, the answer is yes. And then I was faxed over documents that pertained to the other patients, as well as the operative reports.

Q Who faxed over to you the additional documentation?

A The counsel, the lawyer

Q And do you actually have the file folders for the specific patients?

A No. This is all that I have in our office. When we dictate, it just is a single page of dictation. Unless it is very long, it would be two pages, everything, from my office and that was sent to me about, these three patients.

Q. Okay. When were these documents sent to you, sir?

A I asked them to be sent to me in one fax so that I could coherently go through them over this. past weekend.

Q Sometime this last week you got these documents?

A Over these three days the documents from my office are studies I have read. I have had them as long as we have read them, 2002. The other documents we.have asked to refax them to me so I could have them.

Q And the studies which your office conducted, all of all the patients, all the plaintiffs, these occurred in. 2002, isn't that correct?

A Yea.

Q And what would be the earliest they occurred in 2002?

A September 2002 would be the earliest for Mr. Macivor, and then he had studies done in October 2002, two more studies in October 2002. And Mr. Lamacchia had studies also in September of 2002 of the right shoulder and the cervical spine and then came back and had more studies I done in September -- December of 2002.

Q Let's focus initially on Lamacchia's studies, okay, sir?

A Yes.

Q You have those reports in front of you, sir?

A Yes.

Q Now, the studies of Mr. Lamacchia's shoulder were taken in September of 2002, isn't that correct?

A Yes.

Q And you have never seen or reviewed any further studies of Mr. Lamacchia's shoulder, isn't that correct?

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A Mr. Lamacchia's shoulder, no, except for a CAT scan which showed the shoulder in December of 2002. There was a MRI of September 2002 and a CAT scan of December 2002

Q After the CAT scan was taken in December of 2002, you're unaware of any further studies?

A Righ.

Q Of his shoulder?

A That's correct.

Q What study was taken in September 2002 by your office of Mr. Lamacchia?

A A CAT scan of the right shoulder, right ribs, right aternoclavicular joints, and CAT scan of the chest

Q Okay. You testified that the CAT scan that was taken on December 2002 showed a fracture of the right clayicle and the right capula, isn't that correct?

A Yes.

Q And at this point the only thing, Bn't it true doctor, the only thing you can testify to that on that date i diagnostic studies showed that that fracture existed on that date?

A Yes.

Q You have no idea as far as what happened subsequent to that date regarding that fracture?

A Subsequent to that date, no. I have not seen any other studies.

Q Now, you have also reviewed an MRI of Mr. Lamacchia's cervical spine?

A Yes.

Q And, again, that date was September 25, 2002, isn't that correct?

A Yes

Q And you indicated that the herniaton touched the thecal sac?

A Yes, I believe it did.

Q Okay. And you indicated that the nerve cord is surrounded by fluid which then is held in place by the thecal sac?

A Yes.

Q And you also testified that it is possible to have pain when a disk touches the thecal sac?

A Yes.

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Q Now, as a radiologist, you have no idea, though, whether the patient has pain as a result of this finding, isn't that correct?

A Unless I am told, that's correct.

Q So, again, as you sit here today, with regard to the cervical MRI taken on September 25, 2002, you know what it shows, and that it shows the herniation touching the thecal sac, but you have no idea whether that is a cause of pain for Mr. Lamacchia at that point in time? .

.A That is right. I cannot tel you that.

Q. As a matter of fact, you have no idea what happened with regard to that disk finding subsequent to the MRI being taken?

A That's correct.

Q And one of three things can happen to a disk, isn't it correct, doctor, if there is a finding on an MRI about the disk: It can either shrink, it can even remain the same, or it can get larger?

A. Yes.

Q You have no idea what happened to the disk at that level subsequent to the MRI that was taken on September 25, 2002?

A That's correct.

Q Now, you also testified that with regard to the fracture sites in the shoulder area, that there was not much healing evident when you saw the films, isn't that correct?

A Yes.

Q And what was the date of those studies?

A December 2002.

Q And, again, based upon that study you have no idea about what healing occurred to the fractures evident in that study subsequent to that being taken?

A That's correct.

Q You have never, as you said on direct, you have never conducted a physical examination of Mr. Lamacchia?

A That's correct.

Q Now, let's turn to Mr. Hacivor.

Please let me know when you have his reports in front of you, sir.

A Yes. Go ahead.

Q Okay. And, again, what period of time did you conduct studies of Mr. Macivor?

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A September and October 2002.

Q And were you faxed any other reports of studies regarding Mr. Macivor?

A Yes. I Was faxed, I think it was, an operative report. Yes, an operative report. of the right shoulder.

Q But no other MR. studies?

A No.

Q Or no CAT scans?

A No, no other imaging studies.

Q And the study you reviewed dated October 25, 2002, showed what you call a very large piece of disk pushing against the thecal sac at L5-S1, isn't that correct?

A Yes.

Q And, again, the thecal sac is involved, it is possible it could be causing pain, but you really don't know whether that is causing pain?

A That's correct.

Q And also that piece of disk that's pushing against the thecal sac, it can, over time; either shrink, remain the same, or get larger?

A It is possible.

Q And, again, you have no idea of what happened to that disk subsequent to that study being taken on October 25 2002?

A That's correct.

Q Now, the 9/29/02 films for Mr. Macivor, that was the thoracic spine?

A Yes, and the right shoulder, both done the same day.

Q Oh, okay. Let's start with the thoracic spine, sir.

A. Yes.

Q Again, you have testified there were herniations at the T8 and T9, andT9 and T which presed on the thecal sac?

A Yes.

Q And, again, sir, as you sit here today, you have no idea whether the fact that the disks were pressing onto the thecal sac were, in fact, causing pain to Mr. Macivor?

A That'B correct.

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Q And, again, as you sit here today, you have no idea what happened to those disks over time subsequent to September 29, 2002?

A That'.s correct.

Q Now, let's move on to Mr. Gervais, please. Let me know when you have his reports.

A I am ready.

Q Okay. Now, over what period of time did you review imaging studies of Mr. Gervais?

A October 2002, November 2002, September 2002. So September, October, and November 2002.

Q Are these studies that your office conducted or these reports that were forwarded to you?

A They were forwarded to me.

Q Your office did not conduct any of these studies?

A That's correct.

Q When the reports were forwarded to you, were you also handed the films?

A Yes.

Q So you got the films and you were able to review the films before coming here today?

A Absolutely.

Q Okay. And the study on November 19, 2002 of the lumbar spine showed findings a L4-L5, and L5-S1, in't that correct, sir?

A Yes.

Q And you have also noted that there were degenerative changes on the MR?

A Yes.

Q Now, the degenerative changes you noted, were they just at that disk level or were they anywhere else on the lumbar spine?

A it was just L5-S1, If I remember correctly.

Q And -- excuse me -- degenerative changes, basically, can be arthritis?

A Yes, another way of saying arthritis.

(Whereupon, Donna Manning was relieved by Robin Ashby as the Official Court Reporter.)

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Q Doctor Kolb, you were questioned about whether such arthritic findings causes such arthritic findings given the fact the accident happened in September and the MRI study was about two months later. And you indicated that in general it takes longer than two months for such a finding to develop?

A No, I didn't say that. I said in general it takes longer rather than shorter for it to develop.

Q So you're absolutely correct. I didn't read entirely down the line.

And you also indicated there are two possible ways of viewing this. One is that there were no arthritic changes before the accident; the trauma occurred and as a result of the trauma the arthritic process was accelerated.

A Yes.

Q And, therefore, you would see it two months later on MRI studies.

You also testified that there's another way this can play out and there could have been some arthritis beforehand, and as you sit here today and in reviewing Mr. Gervais' films of November 19, 2002 you have no way of knowing which way?

A I have an educated idea of which way it is based on the fact I was told he had no symptoms prior to this accident and then had symptoms, so it's more likely since he wasn't having any problems with his back it's more likely there wasn't nothing wrong with his back or, if it.was, it certainly.wasn't bothering him.

Q Is it an educated idea?

A Yes.

MR. O'TOOLE: I object to this.

Q Are you guessing or can you make statements? If you can make it within a reasonable degree of medical certainty if you're that level of certain then say it. If you're sort of guessing tell us that also.

A A reasonable degree of medical certainty that it' a more likely to have been accelerated degeneration but can't absolutely be certain.

THE COURT: Then objection overruled, I'll allow him to say it.

Q You were also questioned about what happens when someone jumps up and down and up and down and how does that impact on the body. And you testified that with normal disks you should have no affect, that's what the disks are there for, to cushion the spine when the body goes through such motion, even if it's very traumatic jumping?

A Yes. Everyone is individual.

Q However, if someone has a compromised back or some sort of MRI films from September of 2002 and they are running and jumping quite dramatically in 2004, that could have a impact, isn't that correct?

A If they had a finding on MRI in 2002 and they're running and jumping in 2004 without pain, -- has an impact what?

Q On the structure of the spine.

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A It can. The answer.is that it can have an impact. Once you're herniated you're predisposed to having degeneration or arthritic conditions, and further herniatipn of that herniation that occurred in 2002, so the patient is predisposed to having more damage to that site.

Q Based upon running and jumping?

A Based upon any activity individual to any patient. In one patient it could be just leaning forward, and another patient it could be running and jumping; There's a predisposition to having further damage done to that site. From whatever activity.it is I can't tell you because everyone is an individual and one thing may affect one person that may not affect another person.

MR. HQRBATIUK: Thank you very much, Doctor.

CROSS EXAMINATION

BY MS. MORENO:

Q Doctor, you don't examine patients, correct?

A I do not examine patients that have MR scans.

Q Doctors like neurologists refer patients to you to have an MRI or CT scan, correct?

A Yes.

Q And you then review the film. You. make a report and you return it back to the doctor who referred that patient to you for the film, correct?

A Yes.

Q And then is the neurologist or whatever doctor that is a re-hab doctor to correlate your findings with the clinical exam and the patient's complaint, correct?

A Yes.

Q Now, if a person continues to show symptoms like pain shoot from the lower back into their heel or symptoms from their neck going on outside of their arms to their forearms, would that be consistent with a herniated disk at certain levels?

A It can be, yes.

Q If a person has shooting pain down the right arm on the outside going to the forearm, would that be consistent with a herniated disk at C4, C5?

A Yes.

Q And if a person had and is still showing symptoms over two and a half years later of pain from the lower back shooting down the leg into the heel, would that be consistent with a herniated disk at L5 Si?

A Yes.

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Q And a person can, by the way, have arthritic changes in their spine and not have a herniated disk, correct?

A Correct.

Q And a person who does have a herniated disk impinging on a nerve root who does do daily living like walking, sitting down, writing a bicycle, jogging, they can-- they do those things with pain, correct?

A Some can do those things with pain.

THE COURT: Thank you very much, Doctor.

You may step down.

(Whereupon, the witness was hereby excused.)

Jurors, we are going to take a brief break now.

(Whereupon, a brief recess was taken.)

MS. MORENO: I am going to move Plaintiff's Exhibit 5.into evidence on consent.

THE COURT: On consent, okay.

COURT OFFICER: Jury entering.

(Whereupon, John Lamacchia retakes the witness stand.)

THE COURT: The witness is reminded you're still under oath.

Counsel, you may cross-examine.

CROSS-EXAMINATION

BY MR. HORBATIUK:

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