2002 WL 34222909 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.

Dennis CIOFFI, et al.,
v.
AMERICAN AIRLINES, INC., et al.

No. 2002-124258.
2002.

(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: Unknown
Jurisdiction: N.Y.Sup.

[Note: Pages 1-496 missing in original document]

sitting here.

MR. BOROWICK: Thank you, Judge.

Dr. Touliopoulos.

Plaintiff calls Dr. Touliopoulos. STEVEN TOULIOPOULOS, M.D., residing at New York County, New York, called as a witness by and on behalf of Plaintiffs herein, having been first duly sworn, was examined and testified as follows:

COURT OFFICER: For the record, please state your full name and county of residence.

THE WITNESS: S-T-E-V-E-N, T-O-U-L-I-O-P-O-U-L-O-S, New York, New York.

MR. BOROWICK: May I proceed?

THE COURT: Please do.

MR. BOROWICK: Thank you.

DIRECT EXAMINATION

BY MR. BOROWICK:

Q What is your occupation, sir?

A I am an orthopedic surgeon.

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Q Will you tell the Jury what an orthopedic surgeon is, or does?

A It's a physician who takes care of musculoskeletal injuries with respect to diagnosis and treatment.

THE COURT: Doctor, I think counsel is about to say the same thing.

The acoustics are horrible.

Nobody can hear you unless you shout it out.

Okay.

Q So, if you can project to the back, it will be great.

Tell us what an orthopedic surgeon does?

A It's a doctor that takes care of muscles and bones.

Q Are you licensed in the State of New York?

A Yes.

Q Will you tell the jury, what is your educational background that allows yourself to call yourself an orthopedic surgeon?

A I went to medical school at the State University of New York Health Science Center of Brooklyn, stayed there to do my orthopedic residency, then a fellowship at Lenox Hill Hospital in sports medicine.

Q Are you a member of any professional associations?

A Yes, I am.

Q What are those?

A The American Academy of orthopedic surgery, New York State Medical Society, the medical society of the counties of Queens and Brooklyn.

Q Will you tell the jury what your specialty is in within the general overview of orthopedic surgery?

A I did fellowship training in sports medicine, and I specialize in injuries of the shoulder and knee.

Q Do you -- in particular, do you do spinal surgery?

A No, I do not.

Q Are you a member of a group?

A Yes, I am.

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Q Does that group include Dr. -- Dr. Merola?

A Yes.

Q When did you first meet Dennis Cioffi?

A I first meet him November 4, 2002.

Q How did he come to be referred to you, do you know?

A I am not quite sure.

It may have been through his union hall, or through the emergency room.

Q Now, what role have you played in his care over the last two years?

A I have been seeing him for his injuries to his left shoulder and left knee.

Q Tell us the first occasion -- by the way, when you see a patient, when you treat a patient who has been involved in an accident, suffered from traumatic injuries, et cetera, have there been occasions you had to go to court, in your practice, to explain to the jury what that patient's injuries are?

A Yes.

Q When you do go to Court, does your office exact a fee, from the law firm who calls you as a witness, for your time?

A Yes.

Q Sir, will you tell the Jury, have I represented, in Court, other patients that you had, that you treated?

A Yes.

Q Over the course of, say, the last five, six years, how many times would you say you have had to come to Court for one of your patients?

A I would say, once or twice a year.

Q Now, let me ask you, on the first occasion of your first visit, which is two days after the accident, what history did you adduce, generally, car accident, or whatever?

A He was a 42-year-old male who was in a work accident.

Q Now, did I see you were looking down?

Do you have your office chart with you?

A Yes.

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Q If you need to refer to anything to refresh your recollection, I want you to feel free to do so, try not reading from a record, if you can avoid it, but please be as thorough as you can in your answers.

Did you review the record from St. Vincent's?

A Yes.

Q By the way, are you an attending physician at any hospitals in the City of New York?

A Yes, I am.

Q What hospitals?

A St. Vincent's Hospital in Manhattan, Lenox Hill Hospital, Manhattan Ear, Nose and Throat Hospital, St. Clare's Hospital, Brookdale Hospital, Long Island College Hospital, and Mount Sinai Hospital of Queens.

Q When he appeared in your office two days after the accident, what part of his body did he make complaints about?

A His neck, back, left shoulder, left knee.

Q Which of those problems have you treated him for over the last two years?

A His left shoulder and left knee.

Q Now, did you, as an orthopedic surgeon, ever operate on Mr. Cioffi?

A No.

Q Are you aware that he actually went through surgery in January and March, I think on his, first knee, and then shoulder?

Are you aware of that?

A Yes.

Q Have you reviewed the hospital record from California, where his surgery took place?

A Yes, yes, I reviewed the operative report.

MR. BOROWICK: Your Honor, I have had -- I premarked, as Plaintiffs' Exhibit 10 for identification, a certified copy of those records.

I would offer them in evidence.

(Handed.)

MR. WHITELEY: Your Honor, this witness is not the operating --

THE COURT: Just tell me if you have an objection.

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MR. WHITELEY: Yes, your Honor.

THE COURT: Your objection is?

MR. WHITELEY: To --

THE COURT: Don't argue, the basis.

MR. WHITELEY: This is not the surgeon.

THE COURT: What?

MR. WHITELEY: Not the surgeon.

THE COURT: These are certified?

MR. WHITELEY: Correct.

THE COURT: What number?

MR. BOROWICK: This is Plaintiffs' 10.

THE COURT: All right.

Ten in evidence.

(Whereupon, Plaintiffs' Exhibit 10 was received and marked in evidence as of this date.)

THE COURT: Did you have any voir dire on that, by the way?

MR. WHITELEY: No, your Honor.

THE COURT: Okay.

Q Sir, you can use your own copies of the report, if you would like, or you can find them in these, I will refer to portions of those, and I'll just ask you to help us with some terms.

In the emergency room record, I think -- I believe it's -- the hospital --

MR. BOROWICK: The hospital record is there.

Do we have the records that are in evidence?

I think counsel offered the hospital record, or deemed it marked, or something.

MR. WHITELEY: Yes, I did, Mary Immaculate Hospital.

There are also blowups of the x-ray.

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MR. BOROWICK: While he is looking for it --

COURT OFFICER: I'm not looking.

I don't know where it is.

He might.

MR. BOROWICK: We will -- he offered it.

I said, okay.

I'll read from the record, and ask the witness --

Q On the physical assessment, “Patient is 42-year-old male. Patient is alert.”

“Patient found lying” -- “laying on back.”

“Patient stated he tripped and fell.”

“Positive pain to left shoulder, left knee, lumbar spine.”

“Patient has negative LOC.”

What is that?

A Shorthand for “loss of consciousness.”

Q “Patient's left shoulder secured with sling -- what is “C” with a dash over it --

A “With.”

Q -- “pain.”

“Patient's left shoulder secured with sling, and” -- another word -- “left knee immobilized with splint.”

Sir, will you tell us -- “Patient placed in C collar,” what is that --

A Cervical collar.

Q -- what is that--

A It's to stabilize the neck.

Q -- “placed on long board.”

What is a long board for?

A It's to protect the back from injury.

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Q Now, the call for the ambulance was received at 8:05 a.m., and he arrived -- they arrived at the scene at 8:09 a.m., arrived at the hospital 8:54 a.m.

Can you tell us, what is the significance, in an accident, where someone falls, and, upon the first presentation to a facility, those things are immobilized, the neck, the knee, and the shoulder?

A They're immobilized in case there is a fracture -- a fracture, to prevent the bone from shifting and causing more injuries to nerves in the neck, or blood vessels in the knee or shoulder.

Q Does there need to be a fracture for there to be serious injury in any of those joints, the neck, shoulder, or the--

A No, you can have serious injury without fracture.

Q Now, I am going to ask you to define terms.

Before I do, I would like to ask you, with the Court's permission, to step down, and --

MR. BOROWICK: Your Honor before I do, I am showing you this morning, Exhibit 11 and 12, these models.

Q Are they fair and accurate models of these joints in the body?

A Yes.

Q In your opinion, would the Jury, you -- would this help the Jury in understanding the testimony, if you are able to demonstrate with these models?

A Yes.

MR. BOROWICK: I offer them in evidence.

MR. WHITELEY: Your Honor, again, this is not the surgeon.

He will testify to surgeries he would do.

We object.

THE COURT: What?

MR. WHITELEY: He is not the surgeon that performed the shoulder or the knee surgery.

THE COURT: He will show us what these represent in relation to the body.

Do you mind stepping down?

MR. WHITELEY: Just general terms, or with --

THE COURT: What?

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MR. WHITELEY: Is he going to testify --

THE COURT: I don't know what he will testify to.

MR. WHITELEY: We would object.

MR. BOROWICK: I am just offering the models asa fair and accurate replication in evidence.

THE COURT: Eleven and 12

(Whereupon, Plaintiffs' Exhibits 11 and 12, models, were received and marked in evidence as of this date.)

Q Let's take the knee first.

Will you give us a general overview of the anatomy of the knee, the structures involved in this case generally?

A This is a plastic model of a right knee (indicating).

THE COURT: Doctor, the reporter is having trouble hearing you.

Sorry.

Q Doctor, why don't you stay here, and angle yourself so the reporter can hear you as well.

Just take it, so everybody can see.

A This is a plastic model of a right knee (indicating).

This is the -- this is patellar tendon (indicating).

This is the kneecap (indicating), which is the patella.

Then inside the knee now --

Q I'm sorry.

Will you move further down so that the Jurors on the end can see and hear?

MR. BOROWICK: If Juror Two can move back a bit --

A I will specifically speak about the areas of injury related to this patient.

This is the anterior cruciate ligament (indicating), called the ACL. It's the main stabilizing ligament of the knee, and it prevents the knee from shifting.

It stretches when I do this (indicating).

This is -- this was a main structure injured, in the patient, of this accident.

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These are the menisci (indicating).

The menisci is the type of cartilage.

It's a cushion that is in the shape of a disk between the two main bones, the shin and thigh bone.

It helps cushion the knee while the patient walks.

The patient also had a tear in the lateral meniscus, which is on the outside part of the knee.

Q What are these bones (indicating), the top and the bottom?

A This is the femur (indicating), the thigh bone.

This is the tibia (indicating), which is the shin bone.

The small bone is called the fibula (indicating).

The kneecap is called the patella (indicating).

Q Now, if you bend this guy back (indicating), and you just take the tendon off or move it around, what is the articulating surface of the bone that comes into contact with the menisci or ligaments?

A This structure at the end of the femur is called the femoral condyle (indicating). It has a shiny covering to it called cartilage.

You probably have seen it when you eat a chicken, you see the white, shiny thing.

That is what we walk on. We don't walk on our bones.

There's a covering to this, to the femur, femoral condyle and the tibial plateau.

The top is called the plateau.

That has a covering of cartilage on top of it.

Q Now, just define, for a moment, from the hospital record, certain terms before I ask you to describe the injury.

What are “loose bodies” when you talk about the knee?

A Something that is floating around in the knee. It could be, usually, a piece of cartilage, or cartilage with bone.

Q What is “reactive synovitis”?

A We all have, within our knees, synovium that makes the lubrication for our joints.

When there is the inflammatory process going on after injury, the synovium gets inflamed, and they can swell.

We call it “synovitis.”

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Q I will ask you about three different procedures.

What is a meniscectomy?

A “Meniscectomy” is an arthroscopic procedure done through two little holes placed in front of the knee.

A camera is placed into the knee joint in one hole, the other hole, you go with a shaver and trim away the piece of torn meniscus.

Again, you see it's a disk.

Only the piece of one torn is removed. Whatever is healthy is left behind.

Q What is intercondylar notch plasty?

A That is formed as part of the ligamentary construction.

When the ACL is reconstructed, it's placed in the tunnel.

In order to do that, we have to widen the tunnel.

This is a notch (indicating).

The notch has to be widened to do the surgery, and we call that a notch plasty. We make it bigger.

We take a burr, and we remove a centimeter of bone from this side of the femoral condyle (indicating).

Q You say, “a burr.”

Is that carpentry equipment?

A Yes.

Q What is it like?

A It's a high-steel -- it's a high-speed burr, high-speed instrument.

It's a burr that spins at several thousand r.p.m.s per minute to remove the bone.

Q Now, I will go through the hospital record from January 22, '03, Nations Surgery Center in Encino, California, Dr. Sisto.

I ask you to explain as we go.

Pre-op diagnosis was ACL tear of left knee.

Post diagnosis-- why is there a pre and postoperative diagnosis?

A Because the pre-op diagnosis is what you suspect is wrong with the knee based on clinical examination and the MRI.

Postoperative diagnosis is what you find wrong with the knee when you go in and do the arthroscopy.

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Q Okay.

Now, the post-op diagnosis -- I will ask you to discuss the first one.

Postoperative diagnosis was, 1, ACL tear of the left knee -- and, you know, I'll go through it -- and go to the surgery.

2, was torn lateral meniscus, 3, femoral intercondylar notch stenosis, 4, reactive synovitis, 5, loose bodies, 6, grade III chondromalacia.

Sir, upon arthroscopic surgery -- first, describe to the Jury, what is arthroscopic surgery?

A It's a microsurgery performed through mini incisions in the knee, including a camera, shaver, and burrs.

Q Have you done that surgery?

A Yes.

Q Perhaps how many times, in your/career?

A Over a thousand.

Q Okay.

Now, upon -- it's done under general, or local?

A The ACL is usually done under general or spinal.

Q What do you mean?

A General, when the patient goes asleep with gas.

Spinal is when we make the legs numb with Ovocain injected into the spine.

Q Fair to say, during surgery, whichever it was, general or spinal, the patient felt no pain during the surgery?

A That is correct.

Q Now, after incision into the knee is made, the surgeon reports an ACL was absent, while the posterior cruciate ligament was intact.

“There was marked femoral intercondylar notch stenosis,” what does that mean?

A This notch (indicating), this space was narrowed.

Q Is that just a normal, natural variation among people?

A It's a normal variation.

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Q What does it mean, the ACL was missing, was absent?

A It means it was torn.

Q "There were loose bodies and reactive synovitis throughout.

The lateral femoral condyle was normal.

The lateral tibial plateau has grade III chondromalacia" -- "there" -- "grade III chondromalacia, percent."

"There was a tear of the posterior horn of the lateral meniscus, 30 percent."

First, Doctor, what does it mean, "There were loose bodies, and reactive synovitis throughout"?

A Throughout the knee.

If you are on the top, back, side, there was -- synovium was inflamed, and it looks red and thickened.

The loose bodies are what it sounds like, loose pieces of -- chips of cartilage floating around in the knee.

Q Now, based on the sequence, the accident was November 2 of '02, you saw him on November 4 of '02, and this surgery in California was January 22 -- 22 of. 03, so, if my math is correct, ten weeks after the accident, when they went in there, they found loose bodies.

In your opinion, Doctor, was the synovitis -- reactive synovitis and loose bodies, were they caused by the accident, or were they degenerative conditions?

A In my opinion, they were caused by the accident.

Q Now, it goes on to say the "tibial plateau had grade 3 chondromalacia, 30 percent."

What does it mean?

Describe it as traumatic, or degenerative, or -- if you can.

A Unfortunately, I read through the operative report, and all he mentions is "chondromalacia."

It can be -- there are two causes, it can be post-traumatic or degenerative.

It's not well-described as to what he believed the etiology was.

Q What does it mean, though?

What does it mean, there is 30 percent on the tibial plateau and -- and a torn posterior horn of the lateral meniscus?

A The tibial plateau is this structure right here (indicating), and 30 percent of that area had damage to the cartilage.

There are four grades.

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Four is the worst.

Grade 3 is a pretty significant injury.

It's a common -- when people tear their ACL, it's common for -- for them to injure it traumatically.

It's a good chance the injury to the plateau was a result of the accident, because, when an ACL is torn, the bones are shifting on each other, and that incurs damage to the cartilage, as well as the meniscus, which they found a tear.

Q Where was the tear on the meniscus?

A Posterior horn of the meniscus.

This is it right there (indicating).

The back, this area here (indicating) was torn.

Q Add to the mix, if you will -- I want you to assume that Mr. Cioffi was 42 years old, had an active life, he was an ironworker for 17 or 18 years, very heavy duty, he was a -- he played sports with retired professional athletes, baseball, he did surfing, he did things that are active, and would affect all the joints.

Do you -- but, he had no prior treatment for the knee, no prior complaint, symptoms, therapy, surgery, no medication for the knee.

Based upon -- and had no limitation at work, and no limitation in his sports.

Do you have an opinion, based on that additional information, whether or not the chondromalacia was caused as a result of the accident itself, or as a result of the torn meniscus, torn ACL, et cetera?

A With -- with no prior history of injury or symptoms, the injury is likely to result from his work accident.

Q Then it goes on to say, there was -- the diagnostic arthroscopy was carried out, a partial lateral meniscectomy was done, then resecting the meniscus back to a stable rim.

What does that mean?

A There is a tear of the meniscus, so we wants to remove the torn pieces, but not remove anything that is still working.

We want to preserve the meniscal cushion.

Without it, it's a higher chance for the patient to get arthritis later in life.

We remove the portion not functional back to the level that is working.

That is what they refer to, a stable rim.

Q How do you remove it?

A With the biters that you use, then a shaver to smooth the surfaces of the meniscus.

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Q With regard to the loose bodies and the torn piece of meniscus, if those remained in his knee for those ten weeks leading up to surgery, during which time, he tried to walk, he tried rehab, and PT, et cetera, what effect would those injuries cause on the chondral surface of the tibia?

A You can imagine there are loose pieces of cartilage and bone in the knee.

If that piece, one of the pieces, was to get stuck in here (indicating), the patient was to walk, it would grind the cartilage, and cause chondromalacia, a common injury to the plateau.

Q The femoral notch -- that is the burring and expanding of the hole?

A Yes.

Q Chondral plateau, tibial plateau was done, and then a pars synovectomy.

What is a pars synovectomy?

A It's probably --

Q It talks about replacing the AC ligament and screwing it in.

Will you just, as basically as you can, tell us how the reconstruction works?

A This ligament (indicating).

(Continued on the following page.)

A The ACL, which is the anterior cruciate ligament, is torn. You can't repair that injury. You have to make a new ligament.

There are two options, you can get a new ligament from a part of the patient's own body, or you can get it from somebody else's, from a cadaver.

The patient elected to use a piece of his own body, and the doctor chose to use the patellar tendon.

So, this structure is the patellar tendon (indicating). It attaches the kneecap to the tibia. It's usually about 3 centimeters thick.

So, they removed the center of the patellar tendon with a little piece of bone from the kneecap and a little piece of bone from the shin, and they used that as the new ACL.

They -- once it's harvested, they drill a hole here (indicating) in the knee, and they drill another hole here in the femur (indicating), pass the graft into the knee, and they fix it to the femur and the tibia, usually, with screws.

Q Well, by having to drill into the femur and the tibia, through the joint, doesn't that disrupt the condylar surface again?

A No, because we are drilling into the knee in the -- in this notched area between the two condyles (indicating), between the plateaus, so this cartilage here (indicating), cartilage here (indicating), but there's no cartilage in the middle.

That is where the drill comes into the knee joint.

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Q Now, with regard to -- by the way, did he tolerate the procedure well?

A Yes.

Q Was it a successful procedure?

Did it accomplish what it was supposed to?

A Initially, the patient's knee had shown improvement.

Q Now let's talk about the ankle for a second.

Before we leave the knee, let's -- actually, let's finish with the knee.

Do you have an opinion, with a reasonable degree of medical certainty, as to whether or not those diagnoses that I read, the six diagnoses, the torn meniscus, torn ACL, the notch stenosis, the synovitis, the loose bodies and chondromalacia, do you have an opinion, with a reasonable degree of medical certainty in your field, based on your experience, as to whether or not those were caused during or following the fall as a result of the fall?

A It's my opinion that they're -- they were the result of the patient's fall, except for the notch stenosis, which, as we mentioned, is a variation of normal.

Q Were those changes, the tear of the meniscus, tear of the ACL, the grinding away of the meniscectomy, the result of the meniscectomy, and the stuff that you said they had to do, did they affect permanent changes in the natural anatomy of the knee?

A Yes.

Q And, does -- do those permanent changes affect the mechanical function of the knee?

A Yes.

Q And, why?

A The ACL can be reconstructed, and it usually helps improve the patient's symptoms. However, it hardly ever is as good as the one we were born with.

And, in this patient's case, this patient is not working. He needs further surgery.

The injuries and surgeries can result in problems with the knee and the kneecap area -- we call that patellofemoral syndrome -- which can result in ongoing kneecap pain for a very long time, conceivably, for the rest of the patient's life.

The condyle injury is there permanently, once you injure the cartilage on the bone, it can never get better, it can only get worse.

In the face of a meniscal injury in the same compartment, the patient will have progression of the -- in this patient, of the chondral damage for the rest of his life.

Q When the chondromalacia damage takes place over time, is that damage accelerated, or is there any effect upon that damage and the rate of that damage by further exertion or weight bearing?

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A Yes.

The more the patient uses the knee, the quicker the chondromalacia will progress, and, in the face of a ligament that is not working, that increases the abnormal mechanics in the knee, it increases abnormal wear in the area of injury.

Q Does that have any relationship or any effect upon pain levels felt by the patient?

A Yes, it does.

Q And, describe that.

A As the --

Q In other words -- let me just back up a second -- what, about the injuries sustained in this fall, would lead to pain at the present, and in the future?

A At the present, the main cause of the patient's pain is the ligament is not working, his knee is loose, and it's buckling.

The chondromalacia injury is also resulting in symptoms of pain, and swelling, and so forth.

But, one, they kind of feed on each other, the ligament can affect the chondral injury, and vice versa.

Q And, over time, as the chondral surface further deteriorates, why does that cause pain?

A Eventually, the cartilage that is covering the bone will wear out completely, and the patient will ??e walking on bone, and then, when that happens, the other. side of the knee starts to wear out, and, before you know it, this is bone rubbing bone, and that results in progressive arthritis, and that results in pain.

Q Now, when you examined him for the first time -- and, if you need your notes, you can take the model, and go back up and resume your seat -- maybe that's a good idea.

We will get to the shoulder in a second.

Why don't you go back up there so you can have your notes and do it.

(The witness resumes the witness stand.)

Q What were the complaints about the knee, and what did your examination -- strike that.

What is the difference between subjective complaints and objective findings, generally?

A Subjective complaints are complaints that the patient tells you, while objective findings are things noted on examinations while the doctor examines the patient.

Q Have you ever had patients which come to your office and lie, or fake, or exaggerate, in other words, where you can't reconcile what you find and what they say?

A It happens on rare occasions.

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Q And, are you trained to reconcile or not reconcile complaints with objective findings?

A Yes, I am trained.

Q In your opinion, over the last 12 years, since you saw him for the -- by the way, when was the last time you saw him as his treating orthopedic surgeon?

A October 19th, 2004.

Q So, over those two years less two weeks, could you tell the jury, did you ever sense from him that he was exaggerating or ??lingering?

A No.

Q Tell the jury what his complaints were, and what was causing it, based on your exam, and limit yourself -- forget the back and the neck, with regard to the knee itself.

A He complained of significant left knee pain with episodes of buckling, meaning the knee is giving out. He said that his knee gives out two or three times a day.

With respect to his shoulder --

Q No, no.

Let's keep it one at a time. Keep it separate and distinct.

When you examined his knee, what did you find?

A When I examined the knee, there was a moderate degree of swelling, meaning there was water inside the knee joint.

Q When the body reacts with swelling, what is the body doing?

A The body is making water because the knee is irritated.

It's like when somebody gets poked in the eye, the eye waters.

The same thing goes on with the knee, the knee is injured, there is an inflammatory process, and it's creating water.

Q What is the body doing mechanically to the joint that's been injured?

A Well, the knee is giving out, and what the body does is, it thinks, by filling the knee with water, it's going to make the knee more stable and stiff so it won't give out, so the water is coming from the synovium that was noted, at the time of arthroscopy, as being inflammatory.

Q What other findings did you do -- what other tests did you do?

What other findings did you make?

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A There was tenderness on the joint lines. In other words, when I pushed on the meniscus, it created pain. The meniscal signs were positive.

"Meniscal signs" are signs to test for meniscal tears. Those were also positive.

The pivot shift test is a test for the ACL, and that test produced pain and apprehension, which goes along with injury of the ACL.

The Lachman, L-A-C-H-M-A-N, examination also was positive, it revealed -- it's a test where, basically, in the office, we test for looseness of the ligament.

We, basically, lie the patient down, bend his knee 20 degrees, and pull on the knee, and we compare it to the other knee, which is the normal knee, and we kind of measure how much motion there is, and it was noted that the left knee was loose, so at that time, based on positive examination and the patient's symptoms and complaints, I diagnosed him with a deficient ACL, meaning that the anterior cruciate ligament was not working, whether it was torn or stretched out.

Q On a physical examination, and purely a clinical exam in your office, can you definitively say, or could you, at that time, definitively say there was a meniscal tear, loose bodies, or any of the other things?

I mean, what were you able to determine?

A I could definitively say that the ACL was not working.

The other things, the loose bodies and the torn meniscus, that is hard to say definitively without further tests such as an MRI, which may also miss these.

The most definitive is an arthroscopy, which was performed later.

Q Did you review films through your review of the records after you examined him?

Did you become aware that MRIs had been done of, amongst other parts of his body, of his knee?

A Yes.

Q And, did you -- what did those find?

A The -- I have the MRI results of the repeat MRIs that were done after surgery of his shoulder and knee.

My understanding -- I don't have the result of the preoperative MRI -- my understanding, there was a tear at his ACL, and there was an abnormal signal of the menisci.

Q How often would you see Mr. Cioffi, even though you didn't do the surgery?

A I saw him initially in November of 2002, and then I started seeing him regularly in March of 2004.

Q Before, or after -- that would be after the surgery?

A That is correct.

Q Now, why did he have the surgery done in California instead of in your office?

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A My understanding is that for personal reasons, they -- the patient's wife was in California, and that he had no support system here in New York to take care of him after the surgeries.

Q So, let's just try to wrap up the knee here.

The injuries which you attribute to the accident, and which you've found on initial examination, in the films, and through the operative report, are those injuries permanent in his case?

A Yes.

Q And, do you have an opinion as to whether or not they have, or, over the last two years, disabled him from any form of construction work?

A Yes, they have.

Q And, what about at the present time, is he disabled from construction work?

A Yes, he is.

Q In your opinion, will he ever be able to return to construction work, even that amount of work on construction sites where the ground level is uneven, or he has to climb stairs, or anything like that, on a 40-hour-week basis?

A He will not be able to return as a construction worker.

Q Are you suggesting that he will never be able to work in anything again?

A No.

I'm referring to the left knee at present.

Q With regard to sedentary work, sitting at a desk, doing some filing, lifting files out of a cabinet, something sedentary, has he been able -- just with regard to his knee, has he been able to do that kind of work over the past two years?

A No.

Q Is he able right now, given his knee problems -- let me do the gestalt, the whole patient.

Have you followed his medical treatment for your partner, Dr. Merola, with the spinal surgery?

A Yes.

Q Do you have an opinion, with a reasonable degree of medical certainty in your field --

MR. WHITELEY: Objection, Judge as to Dr. Merola's finding, who has already testified.

THE COURT: He hasn't finished the question.

Q I will rephrase it.

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I want you to assume that Dr. Merola indicated that this gentleman had problems in his low back which were the subject of MRIs, which he operated on in a fusion.

I want you to further assume that Dr. Merola has testified that based on the back injury, he is unable, at the present time, to sit for any great length of time without being medicated or otherwise.

Do you have an opinion, with a reasonable degree of certainty in your field, as to, right now, having seen him as recently as last month, whether or not he could do a sedentary job 40 hours a week, you know, 50 weeks a year?

A At present, he cannot do that.

Q Now, would you tell the jury, with regard to his shoulder -- before you get into the exact dynamics of your treatment of him for the shoulder, can you give -- again, come down, and, with as loud a voice as you can, as succinctly as you can, give us a little bit of anatomical background about the shoulder joint?

(The witness leaves the witness stand.)

A This is a plastic model of a right shoulder (indicating).

There are three main bones in the shoulder, there is the humerus (indicating) or the arm, the clavicle (indicating) or the collarbone, and the scapula (indicating).

The shoulder is made up of several muscles called the rotator cuff muscles. There are four muscles all together, and they surround the shoulder, and they allow the shoulder to move.

There's also a biceps tendon that helps move the elbow. The tendon actually enters the joint, and attaches into the bone here (indicating).

The shoulder is a ball-and-socket joint, the ball is called the humeral head, the socket is called the glenoid, and the shoulder is held together with multiple ligaments.

Similarly, there's a joint between the collarbone and the scapula. This is called the AC joint.

Q Excuse me one second, Doctor.

J. want you to look at these two diagrams -- come behind it, please -- before we offer them.

Have I showed you these documents before?

A This morning.

Q And, are they fair and accurate depictions of both the injury, and the reconstruction of the shoulder?

A Yes.

Q And, would it be helpful for the jury if, during your explanation, they were able to observe the diagrams with all the labels, et cetera?

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A Yes, it would.

MR. BOROWICK: I offer them in evidence.

MR. WHITELEY: No objection, your Honor.

MR. BOROWICK: Could we deem them marked 13 and 14, just to save time?

THE COURT: Yes.

(The aforementioned diagrams were deemed Plaintiffs' Exhibits 13 and 14, in evidence, as of this date.)

Q With regard to 13, I'm going to place this up here (indicating), and again, with a loud and clear voice, adjusting the model and diagram, if you need to, describe the anatomy as it relates and is relevant to this case.

A The plaintiff sustained injuries to his AC joint.

That, the "AC," is short for "acromioclavicular."

These ligaments, the acromioclavicular ligament (indicating) and coracoclavicular ligament (indicating), were torn.

When these ligaments tear, it causes an AC separation, that is when the collarbone pops up.

So, the patient was diagnosed with an AC separation on my initial examination.

In addition, I believe the plaintiff had instability of the shoulder. Just as he had ligament looseness in the knee, I thought he had ligament looseness in the shoulder.

These are the ligaments inside the shoulder (indicating), this view (indicating) is a view like this (indicating), and these ligaments wrap around the ball to help hold it in place.

When those ligaments are loose, it causes the shoulder to shift, and again, it causes abnormal mechanics, with the cartilage rubbing each other abnormally, and that could cause synovitis, which is inflammation, and loose bodies in the joint, which the patient had.

Q Doctor, while you are doing this, would you incorporate -- presurgically, you saw him on the 2nd -- on the 4th of November.

Could you tell the jury, when you saw him, what tests, objective tests, you did upon his complaints, and what you found?

A When I saw him initially, on November 4th, I performed tests to test his strength, motion, and stability.

It was obvious that he had swelling and pain in the AC joint.

Q Would you show us, in the three-dimensional model, what those tests consisted of?

A Basically, it's observation, you look at -- you look at this area (indicating), and you can see it's swollen, palpation which produces pain in this area, and then, of course, we asked the patient to move his shoulder, and we test motion and strength.

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We also test for stability, and there is two tests I like to perform to determine whether or not the shoulder is loose, that is, the first test is called the apprehension test, where we have the patient lie on his back, and we bring the arm backward.

And, in patients with loose shoulders, the ball wants to kind of slide out, and that causes pain, so, therefore, the patient would have a positive apprehension test.

Q Did he?

A Yes.

Q Did he have swelling or tenderness to the top, as you've described it?

A Yes.

Then we do the relocation test, which is we push the shoulder back into the socket, and that usually alleviates this pain because the shoulder is no longer out of the socket.

And, that was also positive.

Q Okay.

Have you completed your discussion of the anatomy?

A Yes.

Q Now I'm going to ask you to look at, I believe it's 14, and tell the jury what was done to repair the damage.

And, I believe it was March of '03, some.15 or 16 weeks after the accident.

A The patient had a two-phase operation, one was an arthroscopy to look inside the shoulder, and the other was an open procedure to fix the AC separation, so, basically, the patient had the. mini surgery that we spoke about in the knee with the small incision, and the camera was inserted into the shoulder -- that is the camera (indicating), and that is the shaver (indicating), and patient had removal of the inflammatory synovitis, and the loose bodies with the shaver.

The patient; then went on to have an open operation through an incision performed on top of the shoulder.

Q What is -- excuse me.

I'm sorry -- what's a Mumford, M-U-M-F-O-R-D, procedure?

A It's a procedure for AC separation, and this is, basically, it right here (indicating), the end of the collarbone is removed, okay -- this is the clavicle that's sticking up (indicating), so this part of the -- the very end, the very distal one centimeter or so is removed from the collarbone (indicating).

Q Can you show us on this model?

A Yes.

So it's, basically, here (indicating), the cut is made in the bone, and this is what it looks like after it's been removed (indicating).

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Now, the idea is to put the collarbone back down where it belongs, and, you know, you can push it down, but it won't stay there, you have to stabilize it by kind of reconstructing the ligament.

So, these ligaments are torn (indicating), so, what is used are these healthy tissues (indicating).

You see that all these ligaments are torn except for this one (indicating). Those are called it the coracoacromial ligaments.

It's actually resected from this end hire (indicating), on the acromion, and it's moved over here (indicating) -- so here (indicating), they show the cut-- and they actually stick it at the end of the cut bone, and it's demonstrated here (indicating).

So, this is what -- reconstruction of these ligaments which were torn, and not working.

Q Now, in the surgical report of the diagnostic arthroscopy, he indicates -- this is Domenick Sisto -- “loose bodies were grasped, and suctioned out of harm's way.”

“A Mumford procedure was then done to resect the lateral clavicle.”

Then he goes on to say, “Dissection was then carried out to” -- I'm sorry -- “free up the acromioclavicular joint and the acromioclavicular ligament, and the coracoacromial ligament was harvested”?

A Right.

Q What does that mean?

A Exactly what they are showing here (indicating), that they harvested this ligament (indicating) to reconstruct these ligaments which are torn.

Again, you may ask, why don't they just sew these ligaments up?

By the time they do the surgery, the ligaments are atrophied, there's not much there, they've kind of like disintegrated.

You can't sew up the ones that were torn. You have to use a fresh ligament.

We are fortunate to have one right next to the ones that were injured.

Q “A number 5 fiber-wire was then placed under the coracoid and brought through drill holes into the clavicle.”

Using the model or diagram, give us a description of what is done.

A Basically, this part of the operation takes two, three months to heal.

Before it heals, it can rip, these stitches can rip out, and the suture can fail.

In order to protect the ligament while it heals, a strong suture is looped around the coracoid, which is this bone here (indicating), into a drill hole here (indicating), and tied.

They use fiber-wire, which is -- it's made of Kevlar, which is the stuff used in bulletproof vests, it's extremely strong, and the idea, this won't break until these heal.

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Q Okay.

And, did he tolerate the procedure well?

A Yes, he did.

Q What was -- was it successful?

In other words, did it accomplish what it was intended to accomplish from an orthopedic surgical point of view?

A Yes, the surgery addressed the patient's AC joint separation, which, at the present time, is not an issue.

However, there was no surgery to address the patient's instability, which is an ongoing issue.

Q How do you address that?

A With additional surgery.

Q Is additional surgery for his shoulder anticipated?

A Yes.

Q Sir, would you tell us, what is a Stryker pain -- S-T-R-Y-K-E-R, pain pump?

A Stryker is a company that makes the pump, but it's a pump that slowly infuses Novocain into the shoulder over a day, two, three days, and before the surgery is finished, a catheter is placed into the shoulder joint, and that's attached to a pump filled with a few hundred cc.s of Novocain that's slowly leaked into the shoulder so the patient's post-op pain is minimized.

Q Have you done arthroscopic shoulder surgery?

A Yes.

Q About how many times?

A About maybe 500.

Q Have you done AC joint reconstruction?

A Yes.

Q About how many times?

A One to two dozen.

Q We talked about the weight-bearing knee.

Is the shoulder, to any degree, weight-bearing?

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A We don't walk on our shoulders, obviously, but, when we use our arms and we carry things, that does cause the two bones to rub each other, and there is friction between the bones.

Q Would these injuries that he sustained in his shoulder as a result of this accident affect the mechanical function -- well, withdrawn.

Are those injuries permanent?

A Yes.

Q Are the permanent injuries, do they change, permanently, the mechanics and the anatomy of the joint?

A Yes.

Q And, does that change in the anatomy and mechanics of the joint affect the rate of wear and tear that one would normally go through if one didn't have the injury?

A Yes, especially the diagnosis of shoulder instability, because, basically, what is going on is that the shoulder is kind of -- is sliding around, and -- instead of normal shoulder rolls.

But, the patient's shoulder is sliding, and that sliding is causing abnormal friction between the surfaces in the shoulder.

(Continued on the following page.)

DIRECT EXAMINATION (Continued)

BY MR. BOROWITZ:

Q I want you to assume he was 42 years old.

As I asked you before, I will ask you again, it relates now to the-- to the shoulders.

Assume he is 42 years old, worked as an ironworker, 17, 18 years, lifting heavy tools, devices, materials, that he was an accomplished athlete, throwing, batting, and all the other things that he was doing.

Do you have -- and he never had a shoulder problem, shoulder complaint, shoulder pain, took medicine -- never took medication or treatment for the shoulder, no surgery or therapy, and has stated he never had any problem with his shoulder before the accident, but in November of '02, after he tripped, slipped and tripped and fell, he fell down onto his shoulder.

Do you have an opinion with a reasonable degree of medical certainty, given the medical history, given the past medical or history, or no medical history in the past, do you have an opinion as to what the cause of the shoulder problems and conditions were?

A Yes.

Q What is your opinion?

A My opinion is that all the patient's shoulder injuries are the result of that fall that occurred November 1st, 2002.

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Q Does interaction or the -- does the coincidence, the occurring of, at the same time of the knee problem you described and shoulder problem that you described on the same side of the body, does that bring about any additional problems to the patient?

A Yes.

The patient now, we consider it multitrauma.

Instead of one area of injuries, he has multiple areas which increases his overall level of disability.

Q Add to that a back -- do you treat patients with knee injuries, should injury and back injuries all in. the same body?

A Yes.

Q From your point of view as an orthopedic surgeon, knee and shoulder specialist, of what significance is the coincidence of the multitraumas?

A Significance meaning -- of his prognosis you mean?

Q Not necessarily the prognosis.

How does a back injury, does that affect his knee?

A Yes.

If you have a bad knee that is going to throw off your gait, the way you walk.

That is going to affect your back, vice versa.

Having a bad back will affect the way you walk on your knee, and in effect you can rehab your knee after injury.

Similarly, with a bad knee, you are limited as far as using your shoulder to help you get up out of a chair, you have to use a cane in the arm because you have a bad shoulder.

They feed off each other, you know, exponentially increase the level of disability for the patient.

Q He uses a cane.

Would a crutch be better?

A Depending on the daily level of pain in the back and the knee, if he was able to use crutches-- there are certain crutches which would be preferable to a cane.

Q Have you prescribed medication for him or therapy for him?

A Yes, therapy and medication such as antiinflammatory medication.

Q What does antiinflammatory medication do?

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A It's what it is meant to say, inflammation-- the patient was known to have inflammation of the shoulder and the knee and the medication is ?? at, in decreasing the water and swelling in the synovium.

Q Will the changes in his shoulder anatomy affect the degree or rate at which the aging process deteriorates the joint?

A Yes.

As we touched upon in the knee, the mechanics are different in the shoulder.

The bones are grinding each other. They are not rolling each other; that over time increase chondromalacia which progresses into arthritis.

Q Whereas the shoulder injury will-- assume this, doctor, for a moment, if you will:

He'd been able to use a hell dog which is a machine or tool which is seventy-five or hundred pounds over his head-- would he even lift it at all?

A No.

Q With regard to a sedentary job, if he was able to get stabilized with his back and knee, would his shoulder affect his ability to work on a computer or a screen or anything like that?

A Yes.

Any sort of repetitive activity, any lifting, any sort of activity, it requires a patient to use his arm cane, would result in increased shoulder symptoms of discomfort and pain.

Q If his back was stabilized after the surgery had or future surgery, if his shoulder was stabilized after additional surgery or if, and his knee was stabilized after additional surgery, do you have an opinion with a reasonable degree of medical certainty after all of that, would he be a candidate for retraining vocationally?

A Well, you know, it is worth a try.

It depends on the outcome of surgery.

This is a gentleman who already had one surgery to the shoulder and one to the knee and requires more surgery.

Anyone that requires a second surgery automatically does not have as good a prognosis that only. needed one surgery.

So, the use of his arm and use of extremity will be significantly limited in the future.

Hopefully with further surgery, we can increase the function to certain degree.

Q Right now is he, or he has been, over the last two years, both questions, has he been over the last two years a reasonable candidate for retraining, vocationally?

A No, because he needed surgery initially and now he needs more surgery.

Q Would he, so that was my second question, currently for the near future, would he be a. candidate for vocational refraining?

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A Not in the near future, no.

MR. BOROWICK: You can resume your seat.

Q Si??, with regard to pain, have you with physical therapy, on these multitraumas that you mentioned in the surgical site, does therapy cure a person with these injuries?

A No.

There is a focus for therapy.

Therapy can help increase range of motion, and strength, but, if you have a loose shoulder it will not get better with surgery.

If you have chondromalacia of the knee, it will not get better with surgery.

Q The injuries you say which are permanent from the accident, is medication going to cure him?

A No.

Q Why not?

A Again, the medication helps pain.

The underlying problem is still there.

The cause of the pain is not being addressed by medication.

Q I thought you said there is some medication to prevent or retard the inflammation process.

If you take enough of that, won't inflammation just stop?

A It helps control it.

It is still there.

You are not controlling the cause of inflammation.

There's a problem of the knee, and inflammation causing pain.

So, I mean, the medication helps somewhat, but not always the inflammation part of the problem.

The problem may be inflammation is still there. Until that is addressed, the patient will have ongoing problems.

Q What is the prognosis for the future as a general proposition, having treatment two days since the accident up until last month.

Having reviewed all the records, having examined him on a number of occasions over that course and monitoring his progress, what is your-opinion as to his prognosis with regard to his function, his pain level, et cetera?

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A Prognosis is poor.

Because of the chronicity of the symptoms, it's ongoing for two years, severity, despite surgical intervention, physical therapy, and treatment with medication. The fact-- and the fact he needs further surgery.

Q Assume for the moment, Doctor, that he has three surgeries that we know about, the shoulders, knee and the back function.

He has had injection therapy from Dr. Lefkowitz.

He has radiofrequency therapy.

He has had physical therapy.

He has had medication therapies, doctors visits, hospitalizaiton for surgeries, initial hospitalization.

Sir, do you have an opinion with a reasonable degree of medical certainty as to the approximate cost of all of those things that have, medical costs of all of those items which have taken place already?

MR. WHITELEY: Your Honor, I don't know if this witness has any knowledge of that.

MR. BOROWICK: I'm asking him.

THE COURT: I cannot hear you.

MR. BOROWICK: I'm asking him.

Q Assume all the things that were done.

THE COURT: You said you did not ask that.

THE COURT: Re-ask your question.

Q Given all of the procedures he has had, all of the visits and procedures that were done in hospitals, all of the theapies,, post op, nurses, doctors, the assistance, the materials used, given all of that, given the therapies, the medications, are you familiar with, given all of that, the reasonable and necessary costs associated with all of those things?

THE COURT: Within his speciality?

MR. BOROWICK: Yes.

MR. WHITELEY: Note my objection.

THE COURT: Within his specialty, if he knows.

Do you know, sir?

THE WITNESS: Yes.

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Q As an orthopedic surgeon, sir, what would the reasonable cost without being exact, what is perhaps the reasonable cost of all the medical services that he needed for his orthopedic problems?

A I would estimate around hundred thousand dollars.

Q Sir, would you describe for a moment on your last, on the last visit, this will be my last area of questioning.

On your last visit, tell us about his shoulder and his knee as of a month ago?

A He complained of signficiant left shoulder pain; episode of popping, coming from the left shoulder.

He had feeling of looseness in the shoulder.

The pain was disabling and debilitating.

He was unable to lie on his left side.

The shoulder pain actually radiated to his arm and had weakness and numbness of the left hand which is attributable to his shoulder injury.

That is it for the shoulder.

Q Okay.

What about the knee?

A He developed recurrent episodes of instability, looseness, buckling and giving way of the knee.

And that he also had swelling of the left knee with activity.

I believe of then minutes of walking, he developed swelling in the knee.

Q If he had any preexisting condition in either his knee or his shoulder, would he have been able to play baseball with retired professionals, I don't mean 90 year old guys or whatever, would he be able to play that pain free on a regular basis?

A No.

Q I will show you a photograph, two photographs of Mr. Cioffi taken two weeks ago.

Assume for moment, subject to connection, that they were taken two to-- two weeks after his-- two weeks before his accident during his honeymoon.

I ask you, first of all, I ask it be marked for identification subject to connection.

(Plaintiff's Exhibit 15 marked for identification.)

MR. BOROWICK: Your Honor, subject to connection, I would like to offer it in evidence with respect to my client when he testifies this afternoon who will identify this as him two weeks before the accident.

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MR. WHITELEY: No objection.

(Whereupon, the aforementioned document was received and marked Plaintiff's Exhibit 15, in evidence, as of this date.)

Q Sir, I will ask you to look at these photographs; and will you describe for the jury whether whether or not someone who had a preexisting shoulder injury or preexisting left knee injury could have performed this kind of activity on a regular basis without pain?

A No.

Q If you observed him use these motions amongst other motions, performing as he did without pain, in your opinion, is there any way he had a preexisting grade three chondromalacia and did this without pain?

A No.

MR. BOROWICK: I have nothing further of the witness.

THE COURT: All right.

MR. WHITELEY: Break or do you want me to continue?

THE COURT: Well, if you are ready, we can proceed.

Perhaps we will take a few minutes for everybody's comfort.

Please do not discuss the case.

(Jury excused.)

(Court recess.)

COURT OFFICER: Jury entering.

(Whereupon, the jurors entered the courtroom and took their respective seats in the jury box.)

THE COURT: Have a seat.

THE COURT: Ready to proceed?

MR. WHITELEY: Yes, your Honor, I am trying to find two exhibits.

(Pause.)

CROSS EXAMINATION

BY MR. WHITELEY:

Q Good morning, Doctor.

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How are you, sir?

A Thank you.

Q Dr. Touliopoulos, on your direct examination, you indicated that you had been treating Mr. Cioffi for perhaps two years, is that correct?

A Yes.

Q You first saw Mr. Cioffi on November 4, 2002, perhaps three days after the accident, is that correct?

A That is correct.

Q That was the first and only time you really saw Mr. Cioffi before he went out to California, isn't that correct?

A Yes.

Q You saw him on one occasion in November of 2002.

Q As of the time that you treated Mr. Cioffi in November, I think November 4, 2002, what objective findings or objective tests had you done?

A There were X-rays done of the left shoulder and left knee.

Q You did not do those, they were done at Mary Immaculate Hospital?

A I don't have a notation where they were done.

MR. WHITELEY: These are in evidence, they're not, the other two were.

Counsel, these are the X-rays.

MR. BOROWICK: No objection.

MR. WHITELEY: Defendant I,J.

(Defendant Exhibit, I and J, for identification, as of this date.)

(Handed;)

Q Doctor, I ask you to look at Defendant I, J for identification and ask if that helps refresh your recollection as to who took those X-rays?

A These x-rays of the left shoulder and left knee done at Mary Immaculate Hospital on November 1st, 2001.

Q Could you read to jury what the findings of those x-rays were beginning with the knee?

THE COURT: This will not work.

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The Reporter cannot really hear the doctor.

Correct?

A That is correct.

Q The next time you saw Mr. Cioffi, was in March of 2004 or April of 2004, almost a year and a half, two years later?

A It was March 29, 2004.

Q So, for that entire time, year and a half, you did not see Mr. Cioffi at all, you did not have any role in his medical treatment, is that accurate?

A That is correct.

Q All of the things you were discussing here today were things that happened during that time, all of the surgeries to the shoulder, surgery to the knee, those type of things?

A I also discussed my recent examination of the patient, too.

Q We will get to those.

But, the surgeries, you had nothing to do with the surgery.

Correct?

A That is correct.

Q Did Dr. Sisto, the surgeon in California ever consult you in any way with regard to your opinion about the shoulder, or the knee?

A No.

A The impression is: Negative study for the left knee.

Q Tell the Jury what that means, negative study of the left knee?

A The X-ray is a test for the bones.

And they're saying basically there are no fractures, no dislocation, and no arthritis.

Q Can you now read the X-ray with regard to the left shoulder.

A Also report a normal study.

Q That would also refer to disclocations, to fractures.

What was next?

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A Arthritis.

Q Doctor, the X-rays don't always show what the soft tissue injuries are.

Is that fair?

A Yes.

Q The best test out there is the MRI tests.

Is that an accurate statement?

A The best is the MRI, but a better test is a pure clinical examination overall.

Q With regard to the MRI, did you, in fact, order an MRI be taken of Mr. Cioffi when you saw him in November of 2002?

A That is correct.

Q Were those MRIs ever taken in New York before Mr. Cioffi left and went out to California?

A They were done.

I'm not sure if they were done in New York or California.

Q You brought your file with you today.

Correct?

A Yes, that is correct.

Q If the MRI were done in New York, could you find those for us?

A I don't have the MRI in my chart.

Q So we are clear, in that one visit you had of Mr. Cioffi, before he left for California, there were no MRI films provided to you, is that accurate?

A That is correct.

Q You might have ordered them, you never saw them, they were never taken in the New York City area, is that also correct?

A I don't know where they were done.

They may have been done in New York.

Q Sorry.

A They may have been done in New York.

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Q Do you have any record to suggest any MRIs were done in New York?

A I have no records.

Q Now, do you have MRI records that were done in California in your file?

A I have MRIs done of patient's left knee and left shoulder.

Q What were the dates of those MRIs that were done and where were they taken?

A The MRI of left knee was done on March 25, 2004 at University Imaging Center.

Q March 25, 2004, is that the first MRI of the left knee?

A No, that was the postoperative MRI of the left Knee.

Q Do you have the preoperative MRI in your file-- do you not?

A No, I do not.

Q Were you ever shown the preoperative MRI films?

A I remember reviewing the results.

Q What happened to them?

Why are they not in your file?

A They were never sent to me.

Q You reviewed them and then taken away?

THE COURT: You mean the actual MRI or the report?

Q Let's talk about the report or the films.

A I never saw the films.

I believe the report, I did review it. I'm not sure if it was in the office with the patient.

Q The first MRIs done, Doctor, were done by Dr.

Udkoff U-D-K-O-F-F, in December of 2002.

I'll show them to.

Are you sure you do not have that?

(Pause.)

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A I'm looking again.

Q Let me --

MR. WHITELEY: Let me make sure I have an extra set. If I do.

(Pause.)

MR. WHITELEY: Can we mark this K?

MR. BOROWICK: No objection.

You can mark them both.

MR. WHITELEY: K and L.

(Whereupon, Defendant's Exhibits K and L marked for identification.)

MR. BOROWICK: No objection.

(Whereupon, the aforementioned films received and marked Defendant's Exhibits K and L, in evidence, as of this date.)

Q Doctor, first, I ask you to take a look at Defendant's K.

With regard to the knee, Doctor, I ask you if you could, to find where it says that there's an ACL or anterior cruciate ligament tear anywhere in the MRI report that was taken in December of '02.

(Pause.)

A Reports sprain of ACL.

Q What is the difference between a sprain and tear of the ACL?

A Clinically speaking there is very little difference.

Either the ACL is working, or it's not working.

If it's not working, it's either torn completely or stretched out like elastic.

The way I would treat it is the exactly same way.

His ACL was not working.

Q Does the MRI report say possible sprain of the ACL as the finding?

A Yes.

Q So, if I have a possible sprain of the ACL, that, in your medical opinion, is the name thing as a torn ACL that is cut in half?

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A The possible sprain on MRI and positive tests on findings make the diagnosis of ACL insufficient, and the intraoperative finding by the surgeon that his ACL was torn confirms it.

Q With respect to the chondromalacia that you talked about that is what becomes permanent, correct?

A Yes.

Q That is the softer tissue around the bone, the chondromalacia?

A It's the wearing of the cartilage that covers the bone.

Q Is there any indication here, sir, of any chondromalacia damage to the knee, the left knee, sir?

A No, they do not mention it.

Q Isn't that an important thing that MRI tests for?

A Best test to --

Q Doctor, isn't that an important thing that MRI tests for?

A No.

The MRI is limited as far as diagnosing the chondromalacia.

Only when the chondromalacia is advanced does the MRI become more accurate in diagnosing the degree of injury.

Q Forgive me, I thought you said this was grade three we are dealing with-- that is advanced?

A Yes. It is advanced clinically speaking.

There is still a way of cartilage covering the bone, therefore, the MRI may not pick up the injury.

Q Doctor, you have a postoperative MRI report of the left knee from University Imaging Center dated --

A Yes, yes, I do.

Q -- March 25, '04?

A Yes, yes, I do.

Q Can you read what it says, Doctor, in the middle about the chondromalacia?

A “There is no significant medial or lateral compartment chondromalacia or marrow edema.”

Q If you are telling the jury on direct examination this is a grade three chondromalacia, that this would be kind serious?

A No, grade four is.

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Q It's worse than one?

A That is correct.

Q This finding which is a postoperative finding shows there is no significant medial or lateral compartment chondromalacia or marrow edema.

How does that work?

A I am not describing the MRI result.

I'm saying the best test to gauge extendable degree of chondromalacia is arthroscopy because MRI can miss Grade three chondromalacia.

Q Doctor, wouldn't it be fair to say you never looked inside that knee personally, you have no personal knowledge of what is inside that man's knee today?

A My personal knowledge comes from those reports which document the patient's injuries.

Q It has nothing to do with your personal observation, correct?

A Correct.

Q You also rely on the objective MRI findings in forming your opinion, your own opinion and prognosis, isn't that correct?

A I look at all the facts and weigh arthroscopic findings most heavily.

Q No chondromalacia in the X-ray, is there?

A X-rays cannot diagnose chondromalacia.

Q No chondromalacia in the preoperative report, and there is no chondromalacia in the postoperative report. You never had anything to do with the surgery.

Isn't that correct, sir?

A That is correct.

Q Now, so I am clear on this, when you first examined Mr. Cioffi in November of '02, November 4, '02, did you say:

Mr. Cioffi, we can start you on a long course of treatment, start you on this or that.

Maybe you can get it some other I way.

Sustained.

(Whereupon, James Allocca relieved Robert Chodos as the official court reporter.)

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(Continued on next page.)

Q Did you discuss with the patient, Mr. Cioffi, the option of having his wife come to New York to help with his care?

A I don't recall having such a conversation.

Q Was it your impression that he would stay in New York, and have treatment with you and come back, or did he leave --

THE COURT: Would you please speak a little louder?

MR. WHITELEY: Yes, your Honor.

Q Was it your impression that he was going to stay in New York when he left your office on November 4th, '02, and continue treatment there, and come back to see you?

Is that your impression?

A I don't have any recollection.

I think, the way we left it, was that he was supposed to come back.

Whether or not he called the office later to tell us that he was going to have it done in California, I'm not sure.

Q Wasn't there a discussion in which he said that he was considering moving to California from New York right there at that first visit?

A I don't have any mention of California in my first visit.

Q I will ask you to assume that the plaintiff has testified, in his transcript, that he had a conversation with you in New York at that one treatment, and there was a discussion, essentially, about whether he should have treatment in New York, or treatment in California.

Does that refresh your recollection as to the options that were discussed involving Mr. Cioffi at that one and only visit that you had with him in November of '02?

A It may have been discussed.

I just don't have any recollection without it being in my notes.

Q And, if that discussion took place, as Mr. Cioffi testified to, and I will ask you to assume that he did, it was a discussion that was had before there were any MRI films, correct?

A That is correct.

Q Because those weren't taken until December in California, correct?

A That is correct.

Q So, the only objective thing that it was based upon was the x-ray, which was negative as to the left knee, correct?

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A And, the physical findings are also objective.

Q Which you wiggled his knee, and you feel the different points, and there was pain?

A I wouldn't describe it as “wiggling.”

Q Moved his knee?

A It was a knee and shoulder examination.

Q And, based upon that, and without any MRI evidence, or any MRI films, there was a discussion as to long-term care on one coast or another coast, correct?

MR. BOROWICK: Objection, Judge.

This witness says he doesn't remember.

Counselor is just asking him to assume it.

THE COURT: Is it your purpose to refresh his recollection?

MR. WHITELEY: Yes, your Honor.

THE COURT: Did that refresh your recollection?

THE WITNESS: Yes.

THE COURT: Next question.

Q Do you recall if there were any other influences or factors that were discussed with regard to the plan of treatment?

A My custom and practice for these injuries is to treat the patient with antiinflammatory medication, give the patient some time to get better, and based on the physical findings, if the patient does not improve, then to perform surgery.

Q But, in this case, he never came back until --

A Until later.

Q Until much later?

A Yes.

Q Now, let's go back to your original report and discussion of how the accident occurred, how it was relayed to you.

Your report states “The patient was carrying a plank up a flight of stairs on his right shoulder. While going along a landing, the patient tripped over a pipe.”

Is that a fair and accurate accounting of what Mr. Cioffi said to you in that initial visit?

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A Yes.

Q So, he wasn't carrying it down here (indicating), below his waist, he was carrying it on his right shoulder?

A Correct.

Q And, he also stated that the plank was the mechanism that injured his neck, right, the plank?

A That the plank injured his neck, correct.

Q So, it would have happened to have been over his shoulder, not under his arm?

A Correct.

Q And, you also recount that Mr. Cioffi was treated at Mary Immaculate Hospital, and released that very same day, correct?

A Correct.

Q And, that is based, you were aware, or we refreshed your recollection as to the fact that the x-rays were taken, and they were all negative, correct?

A Correct.

Q And, your report reflects that the radiographs, i.e. the x-rays, were reported to the plaintiff as negative by Mary Immaculate Hospital, that is in your report, is it not, right in the middle paragraph?

A That is correct.

Q So, he was aware that the x-rays showed there was nothing wrong?

MR. BOROWICK: Objection, Judge.

X-rays were negative doesn't mean there's nothing wrong.

THE COURT: Well, sustained, at least as to the form.

What is the question?

MR. WHITELEY: There is none, Judge.

I will withdraw it.

Can we mark, though, the postoperative MRI dated March 25, '04?

MR. BOROWICK: No objection.

MR. WHITELEY: We will offer it.

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THE COURT: Mark it in evidence. Mark it Defendants' Exhibit M in evidence.

(The aforementioned MRI was received and marked Defendants' Exhibit M, in evidence, as of this date.)

Q Doctor, I show you what's been marked as Defendants' M for identification, and ask if you can identify that for the jury.

THE COURT: Are there a lot of exhibits now?

I would appreciate exhibits being premarked.

MR. WHITELEY: There aren't a lot, no.

THE COURT: Okay.

A This is an MRI of the left knee. The study was done on 3/25/2004.

Q Doctor, just so I'm clear, that's about the time that Mr. Cioffi did come back to New York, and you saw him again for the first time since November of 2002?

A That is correct, just a few days before.

Q Did you request that MRI, is that one you asked for, or someone else?

A No, it was requested by Dr. Sisto.

Q But, you had access to that report when Mr. Cioffi came back to see you?

A Yes.

Q What was the first date that he came back to see you?

A March 29th, 2004.

Q And, did he bring that with him?

A I have the results.

I don't know if they were forwarded from Dr. Sisto's office, or the patient brought them along with him.

Q But, you were aware there was a finding of no chondromalacia according to that MRI report?

MR. BOROWICK: Objection, asked and answered.

THE COURT: Are we talking about the same one?

MR. WHITELEY: Yes.

I'm trying to equate it with the time of his first visit with Mr. Cioffi, which was about the same period of time, March of '04.

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THE COURT: I thought it was asked and answered.

But, what is the answer?

THE WITNESS: It says, “without significant chondromalacia,” doesn't say, without chondromalacia.

Q Grade III is significant chondromalacia?

A This is significant chondromalacia, yes.

Q Did you authorize any more MRI films, or any x-rays, or any other intrusive tests of Mr. Cioffi's knee during the period of time you treated him?

A Of the knee, no.

Q So, that MRI report there, we marked as M, is the last radiographic examination of Mr. Cioffi's knee up until the present time, as far as you know?

A That is correct.

Q Now, what does that report say with regard to the ACL, that MRI report?

A It says, “Status post ACL repair. Graft appears intact.”

Q Would that mean that the operation that was done to the ACL is intact?

A No.

Q Well, the graft would be intact, correct?

A The MRI reading is that of an intact ACL graft.

However, the MRI does not diagnose how well the ACL is working.

Q Would you say that an MRI film of an ACL is a better diagnostic tool than any external manipulation or external test that you can perform?

A No.

I say the opposite.

Q You think an external test is a better diagnostic tool than an MRI film that looks inside at soft tissue?

A It's a well-documented fact, large portions of my patients that I perform ACL on does not show on MRI injury

Q You do surgery on patients without doing an MRI film?

A I usually do an MRI.

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I wouldn't say “usually,” but, quite frequ??ly, does not show injury to the ACL.

Q If there is no injury shown on an MRI film, that is not going to stop you from doing surgery if you feel something's wrong; is that correct?

A That's correct.

In the right clinical picture, a patient has the right symptoms, and I feel, on examination, the patient's knee is loose, and the patient does not respond to conservative treatment, I recommend surgery.

Q That is not in the case, you weren't doing any of the conservative-type treatment, is that correct, he was in California all that time?

A He was in California until I saw him in March.

Q And, why did you have an MRI film ordered of Mr. Cioffi when you first saw him?

Wouldn't that be to assist you in your diagnosis of the ACL, and any other part of the knee?

A Which MRI?

Q The first one that you recommended, but he never did in New York.

A Why did I recommend an MRI?

Q Correct.

A The MRI is a useful test.

Based on examination, I knew his ligament was loose.

What I didn't know, was there a torn meniscus, was there a microfracture that the x-ray is missing, did the patient have a tumor that was sitting around.

These things are important to know before surgery, and these are things I can't tell on examination, but I don't need an MRI to tell me if the ACL is working or not.

Q Isn't a lot of what you did, Doctor, based upon what Mr. Cioffi tells you in terms of your evaluation of the patient?

A What I do is based on several factors.

Q I'm sorry?

A -- based on several factors, one is patient history, what the patient tells me, and also, what I find on examination, and lastly, by radiographic studies.

Q Would you say that is the proper chronology of how you look at things, first, what the patient's history is, second, what the patient tells you, third, what your physical examination shows, and fourth and last, what the radiographic films show, or is there any particular order?

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A They are all important.

Q And, so, at least a fourth of what you are learning about Mr. Cioffi's knee is coming from Mr. Cioffi's mouth, what he tells you he's feeling, he's sensing, that kind of thing?

A That is an important part of the entire history and physical.

Q Is there a specific test, an instrument that measures pain?

A No.

Q So, everything with respect to whether there's pain or not is coming from Mr. Cioffi, there is no other source of information about that, is there?

A That is correct.

Q And, Doctor, in your experience, have there been instances in which a person has injured their ACL, and they have surgical repair, and they have gone on to lead productive lives?

MR. BOROWICK: Objection as to, productive life.

Does he mean return to function, or just had a good life?

THE COURT: Clarify the question.

Q Have you experienced -- you've done a number of ACL surgeries; is that correct?

A Yes.

Q Have you ever done any other any sp??s ??gures?

THE COURT: Any sports figures?

Q Sports figures, athletes?

A Yes, I have.

Q Have those athletes, on occasion, been able to return to perform sports, baseball, soccer, what have you?

A It's not a simple question.

Yes, some can go back and play sports again, some cannot.

The ones that do are not always without problems.

You may see them on TV playing, however, what you don't see, their knee is swelling up after the -- after the game.

So, the surgery can improve function, but the knee is almost never as it was before the injury.

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Q And, an athlete such as a soccer player or baseball player would experience a great deal of stress on the knee joint, more so than someone, for instance, walking to work, walking from the subway to his job, sitting down in his chair, reading blueprints on a drafting table, and an athlete would suffer tremendous physical pressure on that knee joint as opposed to someone doing a more sedentary job, correct?

A An athlete playing soccer would be putting more stress on the knee than somebody walking.

Q And, someone performing a sedentary job such as blueprint reading, or walking about and sitting, that kind of thing?

A Walking and standing, yes.

Q Let's turn to the shoulder, Doctor.

Could you tell the jury what -- how big is a centimeter, if you'd just hold up your finger?

A It's about half an inch.

Q Could you just show them?

A (Indicating).

Q What is a millimeter?

A It's a tenth of a centimeter.

Q And, the finding, on the MRI, with regard to the shoulder -- it's the left shoulder, right, that we're talking about here, not the right shoulder, that you had the model of?

A Right.

Q Mr. Cioffi, he's a right-hander, correct?

A That's correct.

Q That picture you have shown throwing the baseball, that's a right-handed throw?

A Yes.

Q We're dealing here with the left shoulder or non-dominant shoulder, correct?

A That's correct.

Q There's nothing wrong with his right shoulder?

A Not that I'm aware of.

Q And, that would be the shoulder, by the way, he would hold a tool, or hammer, or pencil when he writes, that would be the hand he does the most things with, correct?

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MR. BOROWICK: Excuse me, your Honor.

Holding a pencil or holding a tool, I don't think you can lump those --

THE COURT: That is his question.

MR. BOROWICK: I object to the form as combining things.

THE COURT: First of all, do you know if he's right-handed or left-handed?

THE WITNESS: He's right handed.

THE COURT: The primary hand he would use to hold something -- in this case, you are asking about a pencil --

THE WITNESS: To hold a pencil to write, he would use his right hand, but there are instruments that are in construction that are heavy that require the use of two arms.

Q I'm not talking about heavy construction, I'm talking about doing office work, holding a pencil, that kind of thing, right hand?

A He would write with his right hand, correct.

Q Now, the same history is accurate as to your observation of Mr. Cioffi with regard to his shoulder, right, you saw him one time, November 4th, and that was it, right, then he came back two years later, and you saw him a couple of more times, correct?

A That is correct.

Q And, when he came to you, the only diagnostic tool you had, in terms of a film, was that x-ray which we have shown you, which is Defendants' K or L, whatever it was?

A Initially, yes.

Q There wasn ?? any other MRI, or ??-ray, or anything else other than that, right?

A Correct.

Q And, you said you did some testing, pulled, and pushed, and twisted, and that kind of thing?

A I examined the shoulder, correct.

Q And, based upon that, you ordered an MRI again, just like with the knee?

A Yes, I did.

Q But, you didn't get it, and he didn't have it done in New York, he went off to California instead?

A That's correct.

Q When was the first MRI, to your knowledge, ever done of Mr. Cioffi's left shoulder?

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A Similarly, as with the knee, the results were not sent to me.

Q So, you never had those -- in all your direct testimony, you never had access to the initial MRI, the films in this case, or the initial MRI reports, these are the first time they are being shown to you?

A As with the knee, I recall reviewing the MRI of the shoulder, but I don't have the results.

And, when was it that that first MRI was taken of Mr. Cioffi's left shoulder?

A The exact date, I don't know.

Q I think it's on the document there.

A I think you just gave me the knee.

Did you give me the shoulder, too?

COURT OFFICER: (Handing).

A Okay.

It was December 3, 2002.

Q December of 2002.

And, what is a rotator cuff tear, Doctor?

A It's a tear --

MR. BOROWICK: Objection.

No claim for rotator cuff tear.

THE COURT: Do you agree with that?

MR. WHITELEY: I do.

THE COURT: What is the relevance?

MR. WHITELEY: It's in the report. He had it examined, it was negative.

THE COURT: I don't have that in front of me.

MR. BOROWICK: That confirms it, Judge, there is no claim.

THE COURT: It's not part of the case.

Q Doctor, there was no indication, from any of the MRI films, there was any tear of the rotator cuff in the shoulder. Correct?

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A That is correct.

Q And, with respect to the gleno -- G-L-E-N-O-H-U-M-E-R-A-L joint, there was found to be a small joint effusion.

Can you tell the jury what that is?

A “Effusion” is the medical term for water in the joint.

Q “And the glenoid labra are normal to the extent demonstrated, although a tear may not be visualized without distention of the joint.”

Do you see where it says that?

A Yes.

Q So, there was no glenoid tear, according to the MRI films, correct?

A That is correct.

Q And, with respect to the AC joint separation, what is a separation, a pulling apart to a certain extent?

Correct?

A Correct.

Q It was found that there was “a seven-millimeter,” seven-tenths of a centimeter “separation with a low-lying clavicle moderately indenting the supraspinatus muscle, and, lateral down sloping of the acromion,” was that the finding of the MRI, essentially?

A Yes.

Q There was a separation, pulling of seven-tenths of a centimeter?

A That's correct.

Q When someone does a test like that, do they pull the shoulder, do they push the shoulder in its socket?

A During the MRI scan, you can't really do that, but sometimes, when we want to kind of gauge the extant of the separation, regular x-rays are ordered with the patient holding weights to see how much the bone would pop up.

Q If someone pulled their shoulder down like this (indicating) or pushed it up (indicating), that would affect what the MRI showing would be if you had a weight in your hand or you didn't?

A It could.

Q Would that affect the separation reading we're talking about, the seven-millimeter --

A It probably would increase.

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Q -- if someone were to pull down, or the person is pushing up on it?

A Correct.

Q And, what is normal range in the shoulder joint. if someone just pulls your arm, or lets go of your arm, pushes and pulls your arm?

What is that range?

How much does that shoulder move in a person that's a hundred percent healthy?

A It's minimal. We're talking about maybe a millimeter.

Q So, if I were to pull on my arm as hard as I wanted to, you're telling me I would only move one millimeter?

A The AC joint, your shoulder joint, would move more.

There's two joints, there's the collarbone joint, and then there's the ball-and-socket joint, there's two areas where there could be motion.

Q And, if you pull on that shoulder or you push on that shoulder, you are saying, virtually, you wouldn't be able to tell the difference on film, one millimeter?

A If there is no injury, there should be no discernible distance.

Q Was there any injury to the clavicle with respect to Mr. Cioffi?

A Well, it's --

Q The clavicle itself?

A The bone?

Q Correct.

A There is no fracture.

Q No injury to the clavicle itself, correct?

A Well, the ligaments that attach to the clavicle were torn, so the clavicle is not without injury.

Q And, the surgery that was performed to Mr. Cioffi's left, non-dominant shoulder, that was successful, according to the report of Dr. Sisto?

A On review of the OR report, the surgery itself seemed to be successful. Touliopoulos - By Plaintiffs - Cross/Whiteley

Q And, which tendon was it, or which part of the shoulder that was specifically repaired?

What was the specific tendon that was repaired in that surgery?

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A They used the coracoacromial ligament to replace the torn acromioclavicular ligament.

Q Doctor, you said you've done those kinds of surgery, not here, but in other situations?

A Yes.

Q Have you done them to people who are athletes?

A On recollection, yes, I believe so.

Q Tennis players, golfers, have you done them on those types of people?

A I can't remember the exact sport.

Q Is it common, or is it possible that if someone has a surgery like this type of surgery to their left shoulder, non-dominant shoulder, they could return to play sports such as tennis, golf, such as soccer, such as other things?

MR. BOROWICK: Objection.

THE COURT: Sustained.

Q Have you personally, sir, ever seen a situation in which you've done a surgery, this type of surgery, to someone's left, non-dominant shoulder, and that person has been able to return and play the sport?

MR. BOROWICK: Objection.

THE COURT: Asked and answered.

MR. BOROWICK: It was variable.

THE COURT: That's about the knee.

It wasn't asked --

MR. BOROWICK: Objection.

THE COURT: What is the objection?

MR. BOROWICK: Too many variables.

Who are you talking about, what age, what intensity?

THE COURT: That's all right.

The question is, has this doctor seen that in any other patient.

All right.

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Have you?

THE WITNESS: With this patient, -he has other injuries.

Q Not this patient, Doctor, any patient.

THE COURT: I think he's asking you if you've had another patient with the exact same injury.

MR. BOROWICK: Injuries.

MR. WHITELEY: That's not what I'm asking.

THE COURT: What?

MR. BOROWICK: What he just said, this patient had other injuries.

THE COURT: I understand that.

Are you able to answer that as to another person with the exact same injuries?

MR. WHITELEY: Injury.

I'm talking about the left shoulder only here.

MR. BOROWICK: Objection.

He's not just got a left shoulder --

THE COURT: Is it a question you can answer with a “yes” or “no” --

A No.

THE COURT: What is next?

MR. WHITELEY: Your Honor, I'm simply trying to get from this doctor -- we have broken down --

THE COURT: Just ask a question.

MR. WHITELEY; I have virtually the same question.

THE COURT: You can't ask the same question.

MR. BOROWICK: I withdraw the objection.

THE COURT: Okay.

Q With respect to a left shoulder that you've treated, Doctor, for this type of an injury, has such a person that you've treated gone back to play sports, golf, tennis, volleyball, surfing, anything?

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A If the patient has an isolated separation, and does not have instability, as in this case, and the patient has surgery, the patient may be able to do some sort of light recreational activities.

Q In a baseball player that is right-handed, are there surgeries that you have to do commonly in athletes that have shoulder injuries, pitchers, for instance?

A Pitchers occasionally require surgery, yes.

Q What kind of surgery to their shoulders do pitchers usually have?

A They usually get impingement.

Q Do they also have surgery for separations of shoulders, pitchers, from the throwing motion and arm extension?

A Separation is usually the result of direct trauma.

Q Would it be through the result of repetitive trauma, throwing, as hard as you can, a ball a hundred miles an hour?

A They get other problems, but not usually separation of the shoulder.

Q Are there any -- are there surgeries that -- performed to shoulders of pitchers, to allow them to go back to pitching and throwing?

Are there surgeries performed to the shoulders of pitchers that allow the pitchers, once the shoulder has been operated, return to pitching?

A There's a wide variety of injuries that pitchers could have on the shoulder, and there's a wide variety of surgeries.

In general --

THE COURT: Excuse me.

Does someone have a telephone ringing?

MR. WHITELEY: I apologize, Judge.

THE COURT: I have asked all concerned to shut off their telephones.

A In general, when a professional pitcher has a shoulder injury that requires surgery, he has a poor prognosis for returning to sports.

I'm not saying there haven't been instances where they have returned to sports, but usually, it significantly affects their function.

(Continued on the following page.)

CROSS EXAMINATION CONTINUED)

BY MR. WHITELEY:

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Q Doctor, and in this case Mr. Cioffi's throwing arm was his right shoulder, and not the left shoulder that he had surgery on.

Correct?

A His throwing arm is this right shoulder, correct.

Q Do you have, Doctor, in your file the postoperative MRI report of the shoulder surgery?

A Yes, I do.

Q Let me get back to that.

In your report, Doctor, of September 14, '04, just -- sorry, July 27, '04, about four months ago, three, four months.

Do you have that, sir?

A Yes.

Q Can you read to us what it was that the findings were of the MRI of the left shoulder, this is post surgery-- bottom of the page?

A Right.

MRI scan of left shoulder reveals left AC ligament spurring, and degenerative changes.

There is minimal supraspinatus at insertion, no rotator cuff--

Q There is minimal, supraspinatus tendo-nuropathy.

What is that?

A That is one of the four muscles in the shoulder. It's the one that is usually affected by a loose shoulder.

So, if I can refer to the model for a second.

People with a loose shoulder get tendonitis.

There are four muscles, supraspinatus is around here (indicating).

Then the shoulder is loose, it wants to do this (indication).

??ery time it does this (indicating), this muscle gets pulled down a little bit.

Over time, the tendon gets irritated and we get tendonitis of the shoulder.

So, the report of tendonitis is consistent with my diagnosis of a loose shoulder.

Q In this case, there was minimal tendonitis.

Correct?

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A That is correct.

Q The degenerative changes, what are degenerative changes?

Does that take place over a long period of time?

A Well, it's hard to say.

This is the area where the patient had surgery. So, the fact that they see spurring, that can be postoperative changes that the MRI is picking up.

This is the area that the hone was actually removed. And they're saying degenerative changes are there.

So, it's hard for me to fathom what the radiologist was meaning, but my impression is these, the findings of AC ligament spurring and degenerative changes are actual postoperative findings that the radiologist has seen on the films.

Q Doctor, there is no indication anywhere in your report of what the MRI found to suggest separation or seven milliliter separation, is there?

A It has been repaired, that is correct.

Q It has been repaired.

Separation is no longer there.

Correct?

A That is correct.

Q In fact, the MRI report of July 19, 2004, you reviewed that?

A Yes, I did.

Q There is no indication in that MRI of any separation, any seven millimeter separation or anything else with regard to any separation issue, is that fair?

A That is correct.

Q The subclaviculars tendon appears intact in the left shoulder.

Correct?

A That is correct.

Q Bicep tendon is unremarkable.

Correct?

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A That is correct.

Q Infraspinatus and kerrias minor tendon appear to be intact?

A Yes.

Q All tendons in the left shoulder, correct, tendons and muscles in the left shoulder.

Correct?

A Together with the supraspinatus,--

Q Glenoid labrum, unremarkable; that is another muscle in the left shoulder?

A Labrum is a cartilage-- is like the meniscus of the knee.

It is a comparable structure in the shoulder.

Q That is normal?

A That is correct.

Q No evidence of fracture or joint effusion, correct, in left shoulder?

A Correct.

Q Left axial, what is the left axial, you can use the model?

A That is the armpit basically.

Q Unremarkable.

Correct?

A Correct.

Q No atrophy to musculature.

Correct?

A That is correct.

Q What is atrophy?

A It means the muscles have kind of shrunk in size.

Q None of that here?

A That is correct.

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Q Signal with visualized bone appears unremarkable.

Tell us what that means.

A That they don't see any abnormal findings inside the bone whether it's the bone marrow or any other abnormalities.

Q Doctor, is there any further MRI that has been taken of Mr. Cioffi, to your knowledge, since July of 2004, any more recent finding than this?

A Not to my knowledge

Q This is it.

This is the current state in terms of what the last time a diagnostic test was done of that shoulder, this is it, July 19, 2004?

A Yes.

Q That we just read from?

A Yes.

MR. WHITELEY: I ask to mark this as well.

MR. BOROWICK: No objection.

Q One last thing, Doctor.

Artifact-- what is magnetic susceptibility artifact, what is that?

A When we do surgery we use the burr.

You know, we are cutting away the bone. Fragments of metal can remain.

There is nothing we can see on x-rays.

They are microscopic. But it's enough for the MRI to pick that up.

Sometime it can affect the reading.

Q So, there is no specific finding there was any microscopic metal fragments, just a possibility it appeared on the MRI films?

A It says there is magnetic artifact suggesting metal-like density.

Q That suggests further correlation?

A No.

This is common finding after/ surgery.

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Q Is it associated with any pain or symptomatology?

A No.

Q Are you aware of any further tests done with respect to that specific issue from the MRI?

A No.

Q Was it a concern of yours?

A No.

MR. BOROWICK: No objection.

(Whereupon, the aforementioned document was received and marked Defendant's Exhibit N, in evidence, as of this date.)

Q To your knowledge, Doctor, has Mr. Cioffi been engaged in physical therapy for the last couple of years, with the shoulders and knees and so forth?

A Yes.

Q Tell us the kind of exercises people do when they go through physical therapy for their shoulders.

We know Mr. Cioffi left's shoulder.

A The idea of therapy, again, is to help maintain motion and strength of their shoulder.

The shoulder is in pain. We do not want the shoulder to get stiff or weak.

So, the therapist applies either heat, cold modalities-- stretches the shoulder.

They also use machines or elastic bands to straighten the rotator cuff.

Remember, the problem of loose ligament is still there.

Q Show us, if you could, demonstrate the type of exercises that one goes through when they are doing physical therapy for their shoulder?

A Usually, I like the patient to straighten the. rotator cuff, that can sometimes help patients function to a certain degree.

They use dumbbells or weights or elastic bands to strengthen their subscapular tendon and then exercises to straighten the other rotator cuff done as well as shoulder shrugs for the deltoid.

I don't want overhead lifting because that aggravates the joints.

Q Are there flexion or extension exercises that you recommend to increase the range of motion for the Plaintiff?

A There is some stretching.

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As far as strengthening, we don't want anything done above the shoulder.

Q This is under the supervision of a therapist.

What are the stretching exercises that a therapist would permit Mr. Cioffi to do to try to increase the range of motion of the shoulder?

A You want to increase the main range of motion of flexion.

Flexion is this (indicating).

Abduction which in sideways elevation.

External rotation is bringing the arm outward, then inward.

Extension which is bringing the arm backward.

Q Doctor, in your last visit, was there another one after September 13th?

A October 19, 2004.

Q Take September 13th.

The patient was on an off the table easily.

You made that finding, is that correct?

A I said he has difficulty arising from a sitting position.

Q You do say he is on and off the table easily.

What does that mean?

A Where do I say that?

Q In the second full paragraph of page 2 of your -- page one of your report.

A Physical examination?

Q Yes.

A Maybe you can point it out to me.

Q I'm sorry.

A Can you point that out to me?

Q Yes.

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(Pause.)

A I don't --

Q Is that here (indicating)?

A Is that Dr. Merola's report?

Q I'm sorry.

You are in the same office.

A That is probably Dr. Merola.

Q That is Dr. Merola?

A Yes.

Q Did you see him also on September -- did you see him on the 14th?

A I saw him September 14th and October 19th.

Q Dr. Merola, your partner, said that he was on and off the table easily?

A Yes.

Q In his report?

A Yes.

Q Is there anyone else presently treating Mr. Cioffi for his left shoulder other than you?

A To my knowledge, I believe I am the only surgeon taking care of his shoulder.

Q Only one?

A I'm not sure if he does see Dr. Sisto.

I don't believe he has seen Dr. Sisto recently.

Q In how many months or years?

A I cannot comment on that.

Q You are his treating doctor?

A I believe right now, I am his primary doctor for the shoulder, yes.

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Q Mr. Cioffi lives in California and your practice is in New York, right?

A I don't know where his primary residency is right now.

Q I ask you to assume he lives in California with his wife in a house out there and he sold his house in New York.

Based on that, you are his treating doctor in New York. He lives in California.

Is that an accurate statement?

A Yes, it would be, yes.

Q Thank you very much, Doctor.

THE COURT: Any redirect?

MR. BOROWICK: Just a few.

REDIRECT EXAMINATION

BY MR. BOROWICK:

Q Doctor, when you play baseball do you know -- you are from Boston?

A Yes.

Q Red Sox fan. We don't need to know that.

When you play baseball, anything in baseball that you know of as a designated fielder, where somebody, only thing they do on the field, they're designated batters-- they get up to bat.

Are there any designated fielders where all they do is throw the ball from the outfield?

A I don't think the Red Sox has that position.

Q Even throwing a ball as far as the first picture is concerned, it seems to me unless my right and left is wrong, he is putting his weight on his left leg, right?

A Right.

Throwing and batting, there is a lot of turning and pivoting.

Those are the two things that are most effected by a bat, ACL.

You need your ACL specifically for quick turns and pivots.

Q What about if you have, in addition to the ACL problems, you have a knee problem, and you start putting that together with a low back fusion.

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Is this somebody you are going to send back to play baseball?

A There are too many risks for injuries.

Q What about surfing and soccer.

Will you send a person back, as good a doctor you may be, are you going to send him back to do any of those things?

A No, I would advise against anything to result in contact.

Q Counsel is asking you about lifting a tool, a pencil.

As a teacher in ironworker apprentice school, beside holding a pencil, he has to stand.

I want you to assume he has to stand and sometime demonstrate to the ironworker apprentices.

Is that something based on the entirety of his injury picture, is that something he can do?

A No.

Q Counsel asked you about, he suggested that the term minimal changes, that they do not exist, minimal means they do not exist.

You said you can't say that.

Would it be fair to say that if surgery corrects a separation, but leads to tendonitis, that surgery is not a cure for this man's shoulder problems?

A The surgery that was contemplated?

Q No, surgery that was done.

Counsel read the separation was lessened or removed but now you have the onset of tendonitis?

A Right.

Q What does -- withdrawn.

Does surgery sometimes alleviate some problems and lead to others?

A It can.

Also, the patient had the underlying instability of the shoulder from the accident that was not addressed at the first surgery.

The first surgeon took care of the separation issue.

And I believe he did an adequate job.

However, there is still a problem with the loose ligaments in the shoulder that was the result of the accident.

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Q If you operate on an ACL and do reconstruction and shave the meniscus as best you can to remove the ligaments, and get rid of the loose bodies, does that mean the changes in geometry and mechanics of the joint are now cured?

A No.

Q Now, counsel asked you if the fact that an X-ray is negative, he said, well, the X-ray is negative so there is nothing wrong. I think he was talking about the shoulder.

Does an X-ray being negative mean there is nothing wrong?

A No.

Q Does an X-ray of the knee that is negative mean there is nothing wrong?

A No.

Q The fact that the MRI does not pick up a level or degree of chondromalacia, does that mean it is not there?

A No.

Q When you say you do surgeries, knee surgeries on people who have negative MRIs meaning negative, no pathology seen in MRI, you say you find it on clinical exam and based on correlation between symptoms and clinical exam, you will do surgery even with negative MRI, right?

A That is correct.

Q Is there any adequate substitute to determine the degree of chondromalacia or degree of separation that matches arthroscopic visualization?

A No.

MR. BOROWICK: Nothing further.

RECROSS EXAMINATION

BY MR. WHITELEY:

Q Doctor, if you choose to do a surgery despite a negative MRI, the factors you are relying on your physical inspection of the knee and what Mr. Cioffi in this case would be telling you, what is going on when you do the manipulation?

A No.

The manipulation are objective findings.

Q There are also subjective findings.

Part of the physical examination, correct, when you turn someone's knee and say, what do you feel, and the patient says, that feels fine or that hurts, those are subjective, correct?

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A There are subjective parts of the objective exam.

But, with the test we do for ACL, those are purely objective.

Q As is the MRI test is purely objective?

A Yes.

Q And there is a subjective component to a physical examination, it can be colored by complaint or no complaint about pain, that is the only thing you can test about pain is the patient himself.

Correct?

A That is correct.

Q So, if someone moves the knee up and says that hurts, that does not hurt, that part of the test is a subjective part then you are relying on if the patient said it hurts or not.

Correct?

A Yes.

Q If you twist one way or the other and ask if that hurts and the answer is yes or no, you rely on what he tells you.

Correct?

A As far as pain, yes.

Q Correct.

On those type of things, you could go in and do surgery based on what the patient is telling you even though the MRI films say there is nothing wrong?

A No.

The vast majority of the time that I perform surgery on a patient with negative MRI, there are objective findings that I am very comfortable with and not just patients who complain of pain.

However, even if I don't see much on examination, and the MRI is also negative and the patient has chronic pain, nothing help, sometimes a diagnostic arthroscopy is good.

That is sometimes the only way to see what goes on inside the knee.

Q Diagnostic arthroscopy is when you send a camera into a hole?

A Correct.

Q You did not do the surgery here, we already established that.

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MR. BOROWICK: We established it.

Objection.

THE COURT: Is this something new that flows from redirect?

MR. WHITELEY: Yes.

He was talking about objective testing of MRI versus what he would do without MRI.

MR. BOROWICK: He did that.

THE COURT: That was not raised on redirect.

MR. WHITELEY: I will withdrew it.

I have another question.

THE COURT: All right.

Q It was not your decision here to go in and do a surgery.

You had nothing to do with that decision, correct.

MR. BOROWICK: Objection. Asked and answered.

I did not go into it at all.

THE COURT: Sustained.

MR. WHITELEY: That is the whole --

MR. BOROWICK: Objection. Asked, answered.

THE COURT: Sustained.

MR. WHITELEY: Thank you very much, Doctor.

MR. BOROWICK: Nothing further.

May I call my next witness, Judge?

THE COURT: I think there is one chair.

This witness ought to leave before the next witness.

Okay.

MR. BOROWICK: I'm trying, Judge.

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THE WITNESS: Thank you, Judge.

(Witness excused.)

[Note: Pages 611-?? missing in original document]

End of Document

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