SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK - CIVIL TERM - PART: 32

----------X

MICHELE DIPIETRO, as Temporary Conservator for RONALD DIPIETRO, and MICHELE DIPIETRO, Individually,
Plaintiffs,

- against -

56TH Street, LLC, and PLAZA CONSTRUCTION CORP.,
Defendants.

----------X

Ind. No.: 114038-01

60 Centre Street
New York, New York
June 10, 2003

Before:
HON. CAROL E. HUFF,
Justice, and a jury

A P P E A R A N C E S:

SACKS & SACKS
150 Broadway
New York, New York 10038
BY: HOWARD R. BOROWICK, ESQ.
Attorney for the Plaintiff

WILSON, ELSER, MOSKOWITZ EDELMAN & DICKER
150 East 42nd Street
New York, New York 10017
BY: PAUL BOTTARI, ESQ.
Attorney for the Defendant

Michael Barfield
Official Court Reporter

A F T E R N O O N S E S S I O N

THE COURT: Another one.

Step up, please.

(Whereupon, a bench conference is held.)

THE COURT: Are you ready?

MR. BOROWICK: Yes.

THE COURT: We'll have the jury, please.

COURT OFFICER: Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: You may call your witness.

MR. BOROWICK: Dr. Touliopoulos.

S T E V E N T O U L I O P O U L O S, being duly sworn, testified as follows:

COURT CLERK: State your name and address for the record.

THE WITNESS: Stephen Touliopoulos. My address is 23-18, 31st Street, Astoria New York 11105.

COURT CLERK: Thank you. The witness states his name as Stephen Touliopoulos, living at 23-18 31st Street, Astoria, New York 11105.

THE COURT: You may inquire.

DIRECT EXAMINATION BY MR. BOROWICK:

Q Doctor, I ask you to keep your voice up. The microphone is right there. Mine is on here.

Would you tell the jury was your occupation?

A I am a orthopedic surgeon.

Q And do you have a specialty?

A Yes.

Q What is your specialty?

A Sports medicine; injuries of the shoulder and knee.

Q Have you and I ever met before half hour ago?

A No, we have not.

Q And sir, would you tell the jury are you licensed to practice medicine in the State of New York?

A Yes, I am.

Q What background, education and training have you had that allows you to call yourself Dr. Stephen Touliopoulos?

A I went to medical school at the State University of New York Health Science Center of Brooklyn. I went on to become a resident at the same institution where I was a orthopedic resident. I subsequently went on to do a sports fellowship at Lenox Hill Hospital.

Q And what types of surgeries have you done?

A I do surgeries of the extremities; the upper extremities and lower extremities. The majority of my surgeries involve the shoulder and the knee.

Q And as part of the sports team or the sports medical team at Lenox Hill what experience did you get there?

A We took care of professional athletes, athletes that

play for the Jets, the Rangers, also athletes at the collegiate level at Hofstra University.

Q Would you tell the jury have you published in your field of specialization?

A Yes, I have.

Q Do you teach other doctors about the shoulder and its anatomy and the treatments of the shoulder?

A Yes. I teach residents at three different programs; the Lenox Hill program, the Valhalla-St. Vincent's program and the Downstate program.

Q Sir, are you a member of any professional associations in medicine or your specialty as an orthopedic surgeon?

A Yes. The American Medical Association, the Medical Society of the County of Queens in the State of New York. I am a member of the -- I am board certified.

Q What does that mean?

A To become board certified you have to complete a accredited residency program and then pass a written examination, begin a practice, and then two years later pass an oral examination which is based on your practice.

Q Sir, do you know what I am holding here?

A Yes.

Q Is it a fair and accurate replica of a model of what it purports to depict?

A Yes.

Q And would it be helpful for the jury to understand your testimony about your examinations of Mr. DiPietro for you to use this in your discussion?

A Yes, it would.

MR. BOROWICK: I would offer it in evidence.

MR. BOTTARI: No objection.

THE COURT: In evidence.

(Whereupon, the exhibit was marked.)

Q Dr. Touliopoulos, would you tell me -- you know what? I am going to ask him to come down with that you can leave it there. Thank you.

Are you on the staff of any particular hospital or hospitals in the city of New York?

A Yes, I am.

Q And what hospitals?

A St. Vincent's Hospital, St. Clare's Hospital and Lenox Hill Hospital.

Q And I am going to ask you to assume subject to connection that -- by the way, are you familiar with Mr. DiPietro's history of this accident and the injuries which followed?

A Yes.

Q And I am going to ask you are you familiar with the term tracheostomy?

A Yes.

Q And intubation?

A Yes.

Q And I want you to assume for a moment that after a period of intubation Mr. DiPietro was switched to a tracheostomy. Are you familiar with how that's performed?

A Yes, I am.

Q Based on your review of the records do you have an opinion with a reasonable degree of medical certainty as to why he was weaned off the intubation and put on a tracheostomy?

MR. BOTTARI: Objection.

THE COURT: Foundation, please.

Q Have you reviewed the records of his hospitalization?

A Yes.

Q And are you familiar with the procedures at St. Vincent and generally in the New York State area, New York City metropolitan area, about the performance of a tracheostomy?

A Yes.

Q I am going to show you a document and I am going to ask you if this fairly and accurately depicts the procedure, number 1, of intubation, number 2, of the tracheostomy?

A That is correct.

MR. BOROWICK: I would offer it in evidence.

MR. BOTTARI: May we approach, your Honor.

THE COURT: Yes.

(Whereupon, a bench conference is held.)

THE COURT: Overruled.

Q Sir, would you -- you know, if you can hold this up next to you.

THE COURT: Are you offering it?

MR. BOROWICK: I am.

MR. BOTTARI: Objection.

THE COURT: Overruled.

(Whereupon, the exhibit was marked.)

THE COURT: Subject to connection.

MR. BOROWICK: Yes.

COURT OFFICER: Plaintiff's 13 in evidence being shown to the witness.

THE COURT: Use the easel, please, because some jurors can and cannot see.

MR. BOROWICK: You know what? With the Court's permission would you step down to the easel?

COURT OFFICER: Let me get it first.

Q Would you describe for the jury what it entails to intubate a patient while he is in a coma?

A Any patient that --

THE COURT: A little louder.

A Any patient that can't breathe on their own requires respiratory assistance. Initially it is done via an

endotracheal tube which is this structure here placed through the mouth and into the trachea. That's connected to a machine called a respirator which breathes for the patient.

Q Is that the same as a ventilator?

A Yes. Because of the pressure that this balloon places on the trachea it is not advised to leave it in for a prolonged period of time. Any patient that requires prolonged assistance in breathing undergoes a tracheostomy. That's performed by making, usually, a transverse incision over the level of the trachea which is right here, and then dissecting through the subcutaneous tissues, locating the veins on either side of the thyroid and then incising the thyroid which exposes the trachea. This is then incised and this tube is placed into the trachea.

Q While you are down here would you, using the model of the shoulder, would you explain to the jury the anatomy of the shoulder?

A We have here a model of a right shoulder.

Q You can take it off the stand if you would like.

A And the shoulder is a ball and socket joint. It is unusual in that it has a very shallow socket whereas the hip has a very large socket. So if I remove the ball, which is called a humerus, you can look into the shoulder here and see this structure here is called the glenoid. It is a very thin, very shallow structure. Because the shoulder does not have any

inherent bony stability the ligaments are extremely crucial in holding the ball and the socket, and actually are our main stabilizers to the shoulder. Whereas in the hip the bones are what keep the ball in the socket.

The ligaments are below this structure, which is the muscle, and run from this bone to that bone. Overlying the ligaments are the rotator cuff structures. And the rotator cuff muscles surround the ball and help move the shoulder. They arise from the scapula, which is this large triangular bone.

Q Would you tell the jury, scapula, that large bone that you are holding with your left hand, of what significance is it that Mr. DiPietro's sustained a fractured scapula? What does that tell you?

A To fracture a scapula requires a significant amount of force. It just doesn't happen from a fall. We usually see it in either a high speed motor vehicle accident or a fall from a significant height. Associated with the scapula fractures are other usually life-threatening injuries such as rib fractures and in a pneumothorax which is air in the chest, or hemothorax which is blood in the chest.

Q Did Mr. DiPietro have all of those?

A Yes, he did.

Q And would you tell the jury, the cuff, what's the function of the rotator cuff?

A The rotator cuff, again, is made up of four muscles which surround the shoulder and help to raise the arm up, sideways, forward and help to rotate the shoulder in addition.

Q Are there diagnostic tests which are considered very reliable for determining whether or not there has been a rip or tear in the rotator cuff?

A Yes. The MRI is fairly accurate in finding a tear in the tendon of the rotator cuff, although it does have a false negative and false positive rate.

Q And what about in determining whether or not the ligaments or the cartilage -- let's take the cartilage. What is cartilage as it relates to bone and joints, particularly the shoulder joint?

A Around the glenoid, that bone that I exposed earlier, is a rim of cartilage. We call that the labrum. And the ligaments from the ball attach to the cartilage, which is the labrum, and that attaches to the glenoid.

Q And is the MRI a useful tool in diagnosing whether or not there has been a rip or an alteration in the cartilage?

A It is usually fairly accurate in diagnosing a tear in the cartilage.

Q What about -- is the MRI the gold standard in determining or diagnosing every anomaly with the shoulder?

A By all means no.

Q In what ways is the MRI limited? In what kind of

anomalies with the shoulder?

A The MRI is very good at seeing things that are ripped or broken. So if there was a fracture in the ball or socket the MRI would be very, very good at finding it. Or if there was a complete tear of the tendon the MRI is very good at seeing that. However, it is very poor at seeing subjects that are stretched out. So if there is a ligament in the shoulder, or any other part of the body, actually, that is stretched out the MRI almost never sees that on the films.

Q Now, what types of injuries have you explored as an orthopedic surgeon for the Rangers and whatever other losing team that you --

MR. BOTTARI: Objection.

THE COURT: Sustained.

Rephrase it, please.

Q In your experience what types of injuries or traumatic injuries have you examined or treated that are not picked up by MRI?

A A vast number of my patients that I see for shoulder problems have something called instability, meaning that the shoulder is loose. It is loose to the point that it bothers them. Rarely is there a test that can find that. The diagnosis is made in the office by physical examination.

Q And how is it confirmed if not by MRI or x-ray or CAT scan? In what ways can you ever confirm an instability in

the shoulder?

A Again, the diagnosis is made in the office and can be confirmed by further examination of the shoulder under anesthesia. And also by looking into the shoulder with a camera. We call that procedure an arthroscopy.

Q In your experience have you sent patients out for MRIs of the shoulder on complaints of pain and discomfort or laxity or looseness and those MRIs come back negative?

A That's correct. It is actually quite frequent.

Q Ultimately if you ever do surgery on patients with negative MRIs have you in your experience -- is it common to find that there are positive findings on their scope that is negative for MRI?

MR. BOTTARI: Objection.

THE COURT: Rephrase it, please.

Q You mentioned before that there is a range of false negatives in MRIs of the shoulder. What do you mean?

A That the MRI will say that -- the report will say that the MRI is negative. In reality there is something that's there that the MRI misses.

Q Was an MRI done on Mr. DiPietro?

A Yes.

Q And did it -- was there a diagnosis as to whether or not there was a cuff tear?

A The MRI was limited due to the patient's weight, but

it did not report a cuff tear.

Q By its own terms was that MRI compromised because of the patient's weight?

MR. BOTTARI: Objection.

THE COURT: Form, please.

Q Would you tell the jury -- have you analyzed the MRI, the report of the MRI? Have you had him examined -- withdrawn.

When did you first meet Mr. DiPietro?

A Can we go back?

Q You can resume your seat. Take the model with you, if you want.

Again, my question was when did you first meet Mr. DiPietro?

A On November 4, 2002.

Q And that would be about 7 months ago? Have you seen him since?

A Yes, I have seen him once again on June 2, 2003.

Q That would be last week.

Do you have any scheduled visits, whether or not you know the date of the next visit, are you scheduled to meet with him again?

A He was advised to follow up in 6 to 8 weeks.

Q When you met with him on the first occasion was he able to communicate a history of his accident and his medical

treatment with any great detail?

A No, he wasn't.

Q Were you able to get it from either a review of the record -- by the way, how did he come to be evaluated by you? Do you know how he came? A referral?

A I am not quite sure. It may be from a fellow patient.

Q Do you know when he came to see you and you took a history did you come to be in possession of his hospital records and the reports of MRI films?

A Yes, I did.

Q Would you tell the jury when he came in what were his presenting complaints?

A He presented to my office primarily for evaluation of his shoulder injuries. When he presented the first time on November 4, 2002 his chief complaint was his right shoulder which was worse than his left.

Q Is that the shoulder that had sustained the fracture?

A That is correct.

Q And beginning -- well, let me ask you this. Did you review anything or receive anything from any source that there was any past medical history related to either shoulder? In other words, past medical history he had a shoulder problem, complaint, treatment, surgery or otherwise before this

accident?

A From my records there is no prior history of shoulder symptoms prior to the accident.

Q So assuming that the fall and the fractured shoulder and all the other assorted injuries, ribs, et cetera, were the onset of the shoulder problems, is it unusual for there to be a hiatus given the multitude of injuries that he had, brain injuries, spinal injuries, for it to take over a year to seek treatment for a shoulder?

MR. BOTTARI: Objection.

MR. BOROWICK: Withdrawn.

Q Sir, is it unusual for you in a case with someone who had a brain injury and four spinal surgeries to show up in your office a year and-a-half after an accident?

MR. BOTTARI: Objection.

THE COURT: I will allow it.

A It is not unusual.

Q When you did see him and he made his complaints of discomfort what did you exam -- did you examine?

A Yes, I did.

Q What was your examination and what were your findings on examination?

A On examination of the right shoulder I noted that there was swelling along the trapezius muscle which is the muscle that is right here. I also noted swelling on the area

of the right deltoid, which is this area here.

His motion was limited, both actively and passively. So whether I asked the patient to move his arm or if I attempted to move it on my own the motion was limited. Forward flexion was measured to be approximately 120 degrees, which is approximately this high.

Q Let the record reflect that the witness has raised his arm to eye height. Eye level.

Go on.

A His rotator cuff strength which we mentioned earlier was diminished on both shoulders with the right shoulder effected more than the left.

The impingement signs were positive.

Q Because does -- what does that mean?

A That's the test performed -- if I can show you on the model?

Q Please?

A By raising the shoulder forward and then raising it and turning it in trying to determine whether or not there is pain. If it does the test is considered positive.

Q What is it impingement of?

A The rotator cuff actually -- this is the rotator cuff. It impinges between the acromion, which is this structure here, and the humerus, which is this structure here. So as you raise the arm up the tendon gets pinched. In a

patient of his age that is very consistent with shoulder instability.

Q Is shoulder instability a diagnosis that is recognized in the field of orthopedic surgery with a subspecialty of shoulders?

A Yes.

Q And is shoulder instability productive of pain if you just relax your shoulders and don't move them?

A There are different grades of instability. Some patients are only effected when they are doing certain activities. Other patients have trouble raising their arms to a certain level. Other patients have pain even at rest when they are sitting still.

Q When you examined Mr. DiPietro what did you find about his instability?

A It was more symptomatic with motion of the shoulder.

Q Did he have any atrophy?

A Yes, he did.

Q What is atrophy?

A Atrophy is when your muscle basically shrivels up. It can be from disuse, which is likely the cause in this patient.

Q Were you able to discern whether or not he had any translation?

First, what is translation in the context of a

shoulder injury?

A Again, if I could show you on the model?

Q Sure?

A The patient is positioned on his back on a table and one hand is placed on the scapula. The other hand is placed on the bone of the humerus. We move it back and forth. We can kind of measure the amount of motion there is. So this anterior translation would be motion forward. Posterior translation would be motion backward.

Q Is there a norm within the field of orthopedic surgery and your subspecialty of shoulders, is there a norm with a range for the allowance of such movement, translation forward and back?

A Yes, there is.

Q And was his range within the norm or was it abnormal?

A It was abnormal.

Q What is the significance of that to you?

A That is found with patients that have instability of the shoulder.

Q And was it on his right shoulder or alone or was it both?

A It was in both shoulders.

Q Do you have an opinion, sir, with a reasonable degree of medical certainty in the field given that if it is

correct that there was no past medical history, given the fact that -- and I want you to assume that up until the time of the accident he was working 50 to 60 hours a week, very heavy labor, demanding career as an iron worker, without complaints or restrictions, without being treated by doctors with medication therapy or otherwise. Do you have an opinion as to whether or not the instability in both shoulders was caused by his accident of May 7th?

MR. BOTTARI: Objection.

THE COURT: Overruled.

Q What is your opinion?

A That it was caused by his work accident.

Q And the fractured scapula, do you have an opinion as to whether or not this was caused by the accident?

A Yes, I do.

Q What is your opinion?

A That it was caused by the accident.

Q Now, when you diagnose a bilateral shoulder instability like Mr. DiPietro's is there in your opinion a way to cure him non-surgically?

A There is no cure -- there is no non-surgical cure for -- for a shoulder instability. Basically the problem is the ligament is loose. And there is no medicine, there is no injections, there is no therapy that is going to tighten up that ligament. The only way to actually tighten it is with an

operation. There are other forms of treatment that can help to some degree, help the patient's symptoms, such as physical therapy.

Q Will that tighten up the ligament or will that cause a compensatory reaction by some other part of his body?

A It will not tighten up the ligament. And frequently in patients with instability sometimes you can even aggravate the shoulder.

Q Let me ask you this. Add to the instability a four-time operated on multi-level, 8 level fusion surgery in his back. Does that impact on the type of physical therapy that might be beneficial to a patient with bilateral instability?

MR. BOTTARI: Objection.

THE COURT: Overruled.

A Yes, it would.

Physical therapy on the shoulder requires a level of flexibility to be able to lie and turn and pull on pulleys and lift weights. And that would be adversely effected by the nature of his back injury.

Q And if he couldn't go through the kind of physical therapy regimen that would be required in a non-back injured candidate what is the surgery involved that you are suggesting to this jury with a reasonable degree of medical certainty he needs on those shoulders?

MR. BOTTARI: Objection.

THE COURT: Foundation, please.

Q Is it your opinion, sir, with a reasonable degree of medical certainty in your field having examined him on how many occasions?

A Two.

Q Two occasions some six months apart that he needs shoulder surgery on both shoulders if the instability is going to be corrected. Do you have an opinion?

A Yes, I do.

Q What is your opinion?

A That he would.

Q Is he a candidate right now, being a year or so post his last surgery for removal of hardware from his spine and being in cognitive therapy, physical therapy, all sorts of therapy, is he a candidate right now to have that kind of surgery?

A No, he is not.

Q Have you discussed with him the need -- withdrawn.

When you last saw him last week and you examined him what did that examination include or entail, if it was at all different from your original exam? If it was just a repeat exam going through all the same motions and analysis just tell me?

A It was basically the same exam. What we didn't

mention previously is the apprehension test and the relocation test which are both tests for shoulder instability.

Q What were your findings?

A The tests were positive in both shoulders on both occasions.

Q Based on that would you tell the jury what the surgeries that you would use to correct his instability, what they involve?

A It would involve bringing the patient into the operating room and administering anesthesia. And actually the first thing we do is re-examine the shoulder under anesthesia when the muscles are relaxed to reconfirm our diagnosis of instability. Patient is then repositioned to a sitting position at which point we perform an arthroscopy where we enter the shoulder with a camera and look around at the bones, the ligaments, the tendons and the cartilage and assess the stability of the shoulder.

Q Now, the anesthesia that you talk about, is this a local or is he under general anesthesia?

A Almost always under general.

Q And is this an out-patient procedure in an office or is he admitted to a hospital?

A The surgery is done in a hospital. Some patients usually stay overnight.

Q And with Mr. DiPietro's medical picture would this

-- does this surgery ever extend to open surgery beyond the scope?

MR. BOTTARI: Objection.

THE COURT: Overruled.

A Yes. At the time of surgery if everything is consistent with instability we go ahead and perform a procedure called a capsulorraphy.

THE COURT: A what.

A Capsulorraphy. Which is basically tightening of the capsule of the shoulder. The capsule is made up of the ligaments.

Q Is that done through the scope?

A It can be done through the scope, but the vast majority of the times it is done via an open incision.

Q And when it is an open incision we heard from a doctor this morning about the different layers to get through the back musculature and fascia. Without going into the details of it is it the same kind of thing where you have to go down to the joint?

A Yes. It is performed through a incision in the front of the shoulder. And the shoulder is actually fairly deep. It is below a lot of muscles. And we either have to split certain muscles or actually dissect the muscles off the bone to be able to reach the ligaments.

Q And how is that tightening of the ligament

accomplished once you are down through the fascia, through the skin, through the musculature. How do you actually tighten the capsule?

A What we do is the -- I guess the best way is to show you with my fingers. Say this is a ligament. We cut the ligament in half. We bring it over itself. We called that imprecation. So we shorten the ligament and sew it up so the effective length of the ligament is shortened.

Q At my request, Dr. Touliopoulos, did you assess what treatments, including the surgeries or physical therapy or rehab, did you assess what would be required for each of these surgeries and provide that information to a life-care planner named Barbara Scheffel at my request?

A Yes.

Q Now, the rehab from this type of surgery, would you do them at the same time or would you stagger them?

A No, it is -- the recovery is probably the worst part of the whole procedure. It is a very lengthy recovery and it requires a period of four to six months. The first six weeks a patient is usually immobilized in a sling and has very little use of his arm. After that point he begins a therapy program to help regain his motion and his strength. Because it is such a disabling procedure for one arm to do both at the same time it would severely limit the patient's ability to take care of himself. I would recommend when they are performed that they

are performed over a period of six months to a year.

Q Can you tell us approximately what the charge for one of these surgeries is, including your fee, an anesthesiologist, the hospital fees and the rehab. In other words, soup to nuts how much would it cost to do one side?

A I know we calculated the numbers in the office and I don't remember the figures we came up with.

Q Is it on the order of a thousand dollars or $10,000 or $20,000? $50,000?

A I would have to say in the order of for both shoulders probably 50,000, if not more.

Q Would you give us your opinion, if you have one, about -- given Mr. DiPietro's medical circumstance at the present time do you have an opinion when in the future, if not now, when he would be a suitable candidate for the first of the two surgeries?

A That's fairly indeterminate. It depends on a lot of factors, including his back and his head injuries. And I would have to say he would have to be fairly free of significant back pain and he would have to be of sufficient mental abilities to undergo a surgery and the post-operative treatment required.

Q Would he have to have significant mental capacity to go through surgery?

A Any type of surgery is very traumatic. The patient has been through quite a number of surgeries within a short

period of time. He may not be in the mind frame of having any more surgery in the near future.

Q If he doesn't have surgery do you have an opinion with a reasonable degree of medical certainty in your field as to his prognosis with regard to level of pain? In other words, if he doesn't have surgery is the pain level going to get worse, stay the same or get better?

A In the near future his pain will be the same. Over time it will more than likely slowly progress.

Q And what type of -- what does this develop into, this laxity or this instability of the shoulder? What does that lead to in the shoulder joint itself?

MR. BOTTARI: Objection.

THE COURT: Rephrase it, please.

Q What is arthritis?

A Arthritis is wear of a joint. It can occur with aging or it can occur after a traumatic injury. It can occur, also, as a sequela of somebody with shoulder instability.

Q Can you tell us when you said that in the short term the pain would remain the same but in the long term it would be get worse, what is that pain from?

A Remember the bones are moving abnormally in the shoulder. That's causing abnormal friction. Also, the rotator cuff tendons have to be working extra hard to keep the ball in the socket. So the patients can develop problems with the

rotator cuff tendon and even tears over a prolonged period of time. And also eventually arthritis of the ball and socket, of the shoulder joint.

Q Absent surgery do you have an opinion with a reasonable degree of medical certainty in your field as to his prognosis with regard to function? Separate and apart from the pain? What about function? Is his level of function with his shoulders going to get better, going to get worse or is it going to remain the same in his future?

A Over time his level of function will deteriorate.

Q Is he limited in any way functionally now as a result of this bilateral shoulder instability? In other words, what kinds of activities can't he do without pain?

A Lifting any object of any significant weight, pushing or pulling objects of any significant weight, performing repetitive activity, requiring him to raise his arm, even below the level of his shoulder. Performing any activity above the level of the shoulder is at this point extremely difficult.

MR. BOROWICK: I have nothing further.

Thank you, your Honor.

THE COURT: You may inquire.

CROSS-EXAMINATION BY MR. BOTTARI:

Q Good afternoon, doctor?

A Good afternoon.

Q You indicated that this gentleman had MRIs of the shoulders; am I right?

A That is correct.

Q The MRIs were negative for tears; am I correct?

A That is correct.

Q And by the way, do you have copies of the MRI reports with you?

A Yes, I do.

Q May I see them, please?

(Handing.)

MR. BOTTARI: May we have these marked, your Honor?

MR. BOROWICK: No objection.

THE COURT: You are offering them in evidence or identification?

MR. BOTTARI: Identification.

THE COURT: Identification only, please.

(Whereupon, the exhibit was marked.)

MR. BOTTARI: May I approach the witness, your Honor.

THE COURT: You may.

Q Now doctor, with reference to defendant's B for identification, can you tell us what that is?

A This is a report of the MRI scan of the patient's right shoulder. The test was performed on December 26, 2002.

Q Now, the test that we are referring to is an MRI of the shoulder; am I right?

A That's correct.

Q Can you tell by looking at that report, can you tell us what type of MRI procedures were used? Can you explain that to the jury?

MR. BOROWICK: Excuse me, Judge. If he is reading off the document I think it should be in evidence.

MR. BOTTARI: I will gladly offer this in evidence, your Honor.

MR. BOROWICK: No objection.

THE COURT: In evidence.

(Whereupon, the exhibit was marked.)

(Handing.)

Q Can you tell us if certain types of views were taken with the MRI machine?

A Yes.

Q What do they list as those views on that first report, defendant's B? And what does that mean in English?

A It states that the MRI of the right shoulder was performed in oblique, coronal and axial images, which basically means that they used two planes of image. Axial means the MRI machine looked at images through cuts, through the shoulder this way. And the coronal, it means images taken through cuts this way.

Q At least when these tests were done does this report indicate -- does this report indicate anything about the humeral head and the glenohumeral joint?

A Yes, it does.

Q What does it say?

A That they appear normal.

Q Does it indicate -- first, what is joint effusion?

A A joint effusion means that there is water within the joint.

Q And did this MRI find any joint effusion?

A No, it did not.

Q Can joint effusion, could that translate into swelling? If you had joint effusion, water in the joint, would your shoulder swell?

A You would not be able to see swelling by looking at a patient's shoulder.

Let me rephrase that. If there was water inside the shoulder joint you can't tell that by just looking at the patient. Unlike the knee which is much more superficial. You can obviously tell by looking at the knee whether or not there is water in the knee.

Q Now, the subacromial bursa, did they find any abnormality in that part of the shoulder?

A No, they did not.

Q Did they find any abnormality in the periarticular

soft tissues?

A No, they did not.

Q And did they find any rotator cuff tear?

A No, they did not.

Q And is there a section called impression with regard to this MRI?

A Yes, there is.

Q And what was the impression of the radiologist who did the MRI?

A As I said earlier, it reported as negative.

Q That means they didn't find anything?

A That is correct.

Q If I was to ask you about the MRI that was performed on the left shoulder would your answers be exactly the same to all those questions?

A That is correct.

Q Now, if Mr. DiPietro needs an arthroscopic surgery --

A Yes?

Q -- how much would that cost, approximately?

A The cost of an arthroscopic capsulorraphy versus an open capsulorraphy would not be significantly different.

Q An arthroscopic procedure on his right shoulder would cost approximately how much?

Let me ask you this. You do arthroscopic

procedures, right?

A That is correct.

Q How much of them have you done in the last month?

A The last month I would have to say 15 to 20.

Q Do you have any idea how much your office charges for an arthroscopic procedure of the shoulder?

MR. BOROWICK: Your Honor, can we limit it to the type of procedure he is recommending for Mr. DiPietro as opposed to --

THE COURT: Yes, sustained.

A I'm sorry?

Q The type of procedure that you are recommending for Mr. DiPietro, if you were to perform that by arthroscopy, right, approximately -- first of all, how long would that take, that procedure?

A It takes approximately two hours. It can take as long as two and-a-half hours and as little as an hour and-a-half.

Q And approximately how much would your office charge for that procedure?

A That I can give you. What I can't give you is the cost of the hospital and anesthesiologist.

Q I am not asking you that question, doctor. I am asking you how much your office would charge for that procedure?

A I would say anywhere between 5 and $10,000.

Q And if Mr. DiPietro needed an arthroscopic procedure -- his left shoulder isn't as bad as his right. Would you agree with me? At least from the examination you did?

A His pain is not as great as his right. His motion is slightly better than his right.

Q Well, if he were to have an arthroscopic procedure on his left shoulder approximately how much would your office charge him?

A It would be very similar since the pathology is identical.

Q Now, you indicated that if you had an open type surgery the normal recovery period is four to six months; is that correct?

A That is correct.

Q If you had an arthroscopic procedure what is the normal recovery time for that?

A I have to differentiate between a simple arthroscopy and an arthroscopic capsulorraphy. Meaning that if we tighten the ligaments through the camera the recovery is very similar in length. If it is just a simple arthroscopy the recovery is usually, probably three months.

Q So it could be as little as three. It could be as much as six, correct?

A The patient would like to undergo a capsulorraphy so

I have to say it is likely to be 6.

Q You wouldn't recommend that he have them both done at the same time for the reasons you gave, right?

A That is correct, sir.

Q In your testimony earlier this afternoon you indicated that Mr. DiPietro could raise his right arm to 120 degrees. Is that about what you said?

A That is correct.

Q So 90 degrees is straight out; am I right?

A Yes.

Q So another 30 degrees would be where? Most likely above his head?

A Probably slightly at the level of his forehead.

Q Okay. And it is at that point that he has pain. Is that what he was indicating to you?

A Yes.

Q So from anywhere from at a resting position to 45 degrees, 75, 90, 100, 110, 115 he doesn't have pain; am I right?

A At 120 degrees he has so much pain I can't move him anymore. It doesn't mean he doesn't have pain in the other ranges of motion.

Q Well, when you examined him you didn't find any numbness, did you, in his upper extremities?

Let me make this a little quicker. Do you remember

writing a report to somebody in November of 2002, November 4?

A I have a report on November 4, 2002. In my examination I state that he is grossly neurovascularly intact.

Q I am referring you to the last line of your first full paragraph. Can you just look at that for me, doctor?

A Yes.

Q The patient didn't have any numbness in his upper extremities, right?

MR. BOROWICK: Objection, Judge. If he is going to read from the report it should be in evidence.

THE COURT: Sustained.

Q Do you recall examining this patient?

A Yes.

Q Did you take notes when you examined him or do you dictate?

A I dictate.

Q Did you bring those notes with you today?

A Yes, I did.

Q Can you look at the notes that you have? I ask whether or not you recall whether this patient had any numbness in his upper extremities that he told you about when you examined him?

A Your first question was whether or not I found any numbness. That's why I looked in my examination.

As far as if the patient stated he had any numbness,

in the last sentence of the first paragraph I state that he denies any numbness of his upper extremities.

Q Okay. Now, you took a social history, did you not?

A Yes, I did.

Q Do you know if the patient is a smoker?

A I fear that he is a social smoker, yes.

Q Did you measure forward flexion on this patient?

A Yes, I did.

Q When you measured forward flexion what did you find?

A At 120 degrees.

Q Can you show the jury once again what you are talking about?

A That is roughly to this point.

Q And when you say you tested the patient actively and passively can you explain what you mean by that?

A Yes. Again, actively means that the patient moves his shoulder on his own accord. He uses his own muscles. Passively is when I tell a patient to relax and I pick up his arm and raise it.

Q Did you test the patient for adhesive capsulitis?

A I state that there are no signs of adhesive capsulitis.

Q Can you tell us what that means?

A Adhesive capsulitis is abnormal scarring of the ligaments and capsule of the shoulder which results in loss of

motion.

Q Now, when you tested his left shoulder you found it to go how far in terms of forward flexion?

A On November 4, 2002 I measured 140 degrees.

Q So he had slightly more range of motion with his left shoulder?

A That is correct.

Q Now, you noted that he had impingement and apprehension signs, right?

A That is correct.

Q But that they were less than in the right shoulder?

A That is correct.

Q Now, when you -- can you describe for me what you mean by bilateral hands were grossly neurovascularly intact?

A Basically it is quick examination of the nerves and the arteries of the hands. So we check for a pulse and we check to see if he can feel your touch. It is not a in-depth examination. We don't test for pain. We don't test for pain or different levels of sensation. We also check to see if he can open and close his fingers. We don't check for motion of the fingers or strength of the hands.

Q Did you do any specific tests regarding strength for his hands? Any Jaymar dynamometer test?

A Not for his hands, no.

Q Did you prescribe any medication for him?

A I recommended anti-inflammatory medication.

Q Do you know if he was on any medication when he saw you?

A In my history he was already on anti-inflammatory medications.

Q Do you know when he came to visit you if he was using any aids to walk with?

A That I don't recall.

Q Well, doctor, isn't that something you would normally note in your report if the patient showed up with a cane or wheelchair?

A Not when they are coming in for examination of the shoulders.

Q Now, you maintain that because of Mr. DiPietro's shoulders he can't lift heavy objects; am I right?

A That is correct.

Q Can he lift objects like a pen?

A Yes, he can.

Q How long did your examination take?

A The initial examination?

Q Right?

A I don't recall. Because of the extensive history it took -- I remember it took quite a white.

Q Do you know what a mental status exam is, doctor?

A Yes, I do.

Q Did you make any notations in your notes as to whether he was alert and oriented?

A No, I don't.

Q Well, did you talk to Mr. DiPietro when he came in for his examination in November of 2002?

A Yes, I did.

Q Was anybody else with him at the examination?

A Not that I recall.

Q So the information that you received was basically from him?

A The information as far as his injury and subsequent treatments were obtained primarily from hospital records.

Q But you in fact didn't have any problem talking to him when he was in your office, correct?

A The few questions I was able to ask him about his shoulders he was able to answer.

MR. BOTTARI: I have nothing further.

REDIRECT EXAMINATION BY MR. BOROWICK:

Q Dr. Touliopoulos, do you know anybody who is going to hire him to hold a pen?

MR. BOTTARI: Objection.

THE COURT: Sustained.

Q Based on his --

MR. BOROWICK: Judge, I offer his report. Counsel read any number of things from it. I am offering

it.

MR. BOTTARI: Objection.

THE COURT: Objection is sustained.

Q Doctor, with positive diminished cuff strength bilateral and positive impingement signs and swelling about the deltoid and significant swelling about the trapezial musculature, would you say that he would be a good candidate to be a messenger of packages around the City of New York?

MR. BOTTARI: Objection.

THE COURT: Overruled.

A In my professional opinion? No he would not.

Q How about working in retail sales? Maybe in a clothing store where he would be hanging up clothing or reaching at The Gap to some shelf with clothing or a supermarket stocking shelves. Could he do that in your opinion?

A No, he can't.

Q Counsel asked you about the MRI which I had suggested that we put in evidence and we have it in evidence. Is there anything about a negative MRI, negative for cuff tear or labrum tear, does that tell you as an orthopedic surgeon specializing in shoulders that he doesn't have an instability disorder that requires that capsulorraphy?

MR. BOTTARI: Objection.

MR. BOROWICK: I was being corrected by the --

what was the word?

THE WITNESS: Can you repeat the question?

MR. BOROWICK: Oh, okay. It's that time of day.

Q The fact that it was negative for tear of the cuff and negative for tear of the labrum, does that MRI rule out that he has got the instability that you found on two occasions?

MR. BOTTARI: Objection.

A No, it does not.

THE COURT: Overruled.

Q Does that rule out the impingement that you found on both occasions?

A No, it does not. In fact, I never saw an MRI report that said that there is no instability. Because an MRI --

MR. BOTTARI: Objection. Move to strike.

THE COURT: Sustained. Just answer the question.

Q And how does MRI measure up to the standards in your field as to evaluating impingement and instability?

MR. BOTTARI: Objection.

THE COURT: Yes, sustained.

A Poorly.

THE COURT: No, the objection was sustained.

THE WITNESS: Sorry.

Q You mentioned something about -- may I have the MRI

report? You know what? I don't need it.

You said there was some compromise of the MRI process itself. What is that about?

A Due to the patient's size the radiologist reports that the study was compromised.

Q And the fact that it was compromised and the fact that it is not the standard in your field for evaluating instability, does the fact that it was negative for a labrum or cuff tear change your opinion at all or dissuade you from surgery at all for the instability which you found?

MR. BOTTARI: Objection.

THE COURT: Sustained. Rephrase it, please.

Q Would a compromised MRI --

THE COURT: This one?

MR. BOROWICK: Yes.

Q Would this compromised MRI in the face of your examinations where you put hand to tissue and hand to joint and put him through the motions, would that MRI dissuade you from a diagnosis of instability in both shoulders?

MR. BOTTARI: Objection.

THE COURT: I will allow it.

Do you understand this?

THE WITNESS: Yes.

THE COURT: You maintain your diagnosis in the face of this MRI?

THE WITNESS: Absolutely.

THE COURT: All right.

MR. BOROWICK: Nothing further.

One thing further.

Q When you put him through his ranges of motion counsel said that at 120, up until 120, he is pain free. And you corrected him. Would you tell the jury how was he through the ranges of motion as he got up through 70, 75, 80, 5, 90 up through 120?

A It was slow and guarded. I mean that the patient was uncomfortable.

MR. BOROWICK: Thank you.

Nothing further.

THE COURT: Anything else?

RECROSS-EXAMINATION BY MR. BOTTARI:

Q You are not a vocational rehabilitationist, are you?

A No, I am not.

Q Many people who have had horrific shoulder injuries have gone back to work?

MR. BOROWICK: Objection, Judge. We are not talking about -- objection, Judge. Too limited in scope for the question.

THE COURT: Overruled. You may answer.

Q You may answer.

A Repeat the question.

THE COURT: Lost it.

MR. BOTTARI: Can you read that pack.

(Whereupon, the requested portion was read back.)

MR. BOROWICK: Objection, Judge.

THE COURT: Objection is overruled.

A Are you asking for my personal experience?

Q Yes. Why else would you do surgery if not to help the patient, right?

A We do surgery to improve quality of life. Whether they go back to work is a different issue.

Q Okay. Well, let's assume you do this surgery, right?

A Correct.

Q What's the success rate of this surgery in New York City? Or more importantly what's the success rate of your surgical patients?

MR. BOROWICK: Objection.

THE COURT: Yes, sustained.

A My success rate --

THE COURT: No, no, no. Next question, please.

Q Let's assume this patient comes to you and says do the surgery on my right shoulder and you do it. Let's assume it is a success?

THE COURT: Assume it's --

Q A success. Let's assume six months or a year later he comes back and says let's do the left shoulder. And it is a success. Okay? Do you think two years from now after successful surgery and rehabilitation that Mr. DiPietro could do some form of gainful employment?

MR. BOROWICK: Objection.

THE COURT: Overruled.

MR. BOROWICK: May we approach, Judge?

THE COURT: No, stay where you are.

Q Just regarding his shoulders, okay? Because that's what you are here for.

MR. BOROWICK: Excuse me, Judge. He is more than --

THE COURT: No, no, no. Take your seat. Take your seat.

A What's your definition of gainful employment?

Q Well, someone pays me for doing something?

MR. BOROWICK: Excuse me, Judge. He has just established he is not a vocational rehabilitationist.

THE COURT: Please stop talking. You can't make speeches in front of the jury.

A I would say that question is hard to answer. I can say that if we perform surgery and the surgery was a success I imagine that the patient will have decreased pain and some improvement and strength in motion. However, he will never be

able to perform activities such as heavy lifting or activities requiring a lot of overhead lifting.

MR. BOTTARI: Thank you.

I have nothing further.

REDIRECT EXAMINATION BY MR. BOROWICK:

Q Counsel just asked you if surgery was successful and rehab was successful and if he had no other problems other than the shoulder, just based on -- he said just his shoulder. This man had four surgeries on his back. The first one was supposed to be successful. Was it successful?

MR. BOTTARI: Objection.

THE COURT: We are talking about his shoulder, yes?

Q Was the second back surgery --

THE COURT: We are not talking about back surgery, please. The objection is sustained.

Q When you evaluate your patients with a view towards sending them back to work do you consider the patient as a human being with a spine, arms, legs and a head or do you just consider his shoulder?

MR. BOTTARI: Objection.

THE COURT: Overruled.

A We look at the big picture.

MR. BOROWICK: Nothing further.

MR. BOTTARI: Nothing further, Judge.

THE COURT: Thank you very much. You may step down. You are finished.

Step up.

(Whereupon, a bench conference is held.)

THE COURT: We will take a few minutes. You may step out. Don't talk about the case, please.

(Whereupon, the jury exited the courtroom.)

(Whereupon, a recess is taken.)

THE COURT: We will have the jury, please.

COURT OFFICER: Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Be seated, please.

You may call your witness.

MR. BOROWICK: Ron DiPietro, Sr..

R O N A L D D I P I E T R O SR., being duly sworn, testified as follows:

COURT CLERK: State your name and address for the record.

THE WITNESS: Ronald DiPietro. 27 Falcon Drive, Hauppauge, New York.

COURT CLERK: Thank you. The witness states his name as Ronald DiPietro, 25 Falcon Drive, Hauppauge, New York. The witness has been sworn.

THE COURT: You may inquire.

MR. BOROWICK: Thank you.