SUPREME COURT OF THE STATE OF NEW YORK

COUNTY OF KINGS : CIVIL TERM : PART 43

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MIKOLAJ JAKOCIUK : INDEX NO.: 47005/07

PLAINTIFF :

- against - :

G BUILDERS IV and MADISON PARK OWNERS CORP. :

DEFENDANT : TRIAL

- - - - - - - - - - - - - - - - - - - -X

360 ADAMS STREET
BROOKLYN, NEW YORK 11201
APRIL 3, 2012

BEFORE: HONORABLE MARK I. PARTNOW,
JUSTICE, AND A JURY

APPEARANCES:

THE PERECMAN FIRM, P.L.L.C.
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JEANMARIE EPISCOPIA
SENIOR COURT REPORTER

(The following is the requested portion of the day's proceedings.)

THE COURT: Let's bring the jury in, please.

COURT OFFICER: All rise. Jury entering.

(Whereupon the jury enters the Courtroom, and is seated in the jury box.)

COURT CLERK: All jurors present. You may be seated.

THE COURT: Good afternoon, ladies and gentlemen of the jury.

I want to first apologize to you for the delay, but I had to decide legal issues before we were able to bring you into the room. Hopefully the argument will be shorter next time.

In any event, Counsel, call your next witness, please.

MR. PERECMAN: At this time I would call Dr. Jeffrey Kaplan to the stand.

D. R. J E F F R E Y K A P L A N, having been called as a witness by and on behalf of the Plaintiff, having first been duly sworn, was examined and testified as follows:

COURT CLERK: Please give us your name and your office address?

THE WITNESS: Yes, Jeffrey Kaplan K A P L A N.

Office address is 160 East 56th Street, Manhattan 10022.

COURT CLERK: Please be seated. Thank you.

THE COURT: Counsel, you can proceed.

DIRECT EXAMINATION

BY MR. PERECMAN:

Q. Dr. Kaplan, good afternoon.

A. Hi.

Q. Dr. Kaplan, would you be kind enough to tell the jury about your educational background, your practice and start with college and take us to today?

A. Education, I went to college at Yale University. When I graduated from college I went to medical school here in the city, Columbia University. When I finished medical school I did a training program in orthopedic surgery. I did that in a place called the Campbell Clinic in Memphis, Tennessee. The Campbell Clinic was the first orthopedic training program in the United States.

Following that I practiced in Tennessee and Mississippi for a short period of time then I moved back to New York in 1994, where I did an internship and have been in private practice ever since.

Q. What is the practice you engage in, sir?

A. I am an orthopedic surgeon. Orthopedics is sort of the study of bones and joints and the supporting structures of bones and joints, things like muscles, tendons,

ligaments, discs.

It has to do with injuries and abnormalities for these structures in the treatment of those injuries or abnormalities either with conservative treatment, meaning medications or injections or physical therapy or if those things don't work, then surgery to those things.

Q. In addition to what you just told us about, your education and your practice, is there anything of note that we should know about? Today is not the day to be humble, honors, awards, writings, certifications, anything?

A. I do surgery in several hospitals around the City. I am on staff the St. Lukes Roosevelt Hospital. Lenox Hill Hospital. I am a professor of orthopedics at Columbia University.

I am a member of state and county medical society. I am a ring physician for the New York City Boxing Commission.

Q. Is that it?

A. What else do you need?

Q. Now, Doctor, did there come a time that you had the -- let me ask you something before we get to that, do you have staff in your office?

A. Yes.

Q. How many staff members do you have, other than physicians?

A. Yes, there are about 19 people that work in my office.

Q. Are any of them Polish speaking?

A. Three of them are Polish speaking.

Q. Do you know their names?

A. Ivana, Ania and Babush (phonetic).

Q. Why do you have Polish speaking people working in your office?

A. I have Polish speaking people working in my office because a number of my patients are Polish.

About 15 years ago I treated a gentleman who was a construction worker that liven in Greenpoint. He was one of those guys who sort of like was the mayor of that area of town, just socially gregarious and friendly.

Since then, over the course of that time, my practice has grown in numbers of Polish patients. I have seen by leaps and bounds. Now I hired three full-time translators.

Q. How many Polish construction workers would you estimate you have treated over the years?

A. Couldn't begin to estimate that, but over 100 I am sure.

Q. Doctor, did their come a time that you met Mikolaj Jakociuk in your professional capacity?

A. Yes.

Q. And when was that for the first time?

A. I first met him on December 18 of 2007.

Q. When you met him for the first time, did he furnish you with a history?

A. He did.

Q. What was the history that he furnished you with?

A. He advised me of a work related accident that he had had. He had a fall from a ladder. He fell from a height and actually the ladder apparently fell on top of him as well. He lost consciousness.

At the time when I was first seeing him he indicated that he had not gone to the hospital on the day of the accident. He was reluctant to do that.

When I saw him he had been referred to my office. He told me he was vomiting. He was having headaches. He was complaining of pain in his left side of his chest as well as at his elbow. Left wrist and hand. He was having pain in his neck and low back.

When I first saw him he was complaining of shortness of breath and he was having a hard time catching his breath.

Q. And did you examine him?

A. I did. I did a physical examination of him.

Q. Before you go there, did you ask him about his past medical history?

A. I did.

Q. Was any of it of any medical significance?

A. No. He had had an amputation of his ring and long finger on his left hand in the distant past, but nothing, no injuries to the areas where he was complaining of, chest, elbow, wrist, shoulder, neck, back.

Q. Okay, now go on, did you examine him and if so, what were the results?

A. On exam he was tender about the left chest in what is called mid axillary. Axillary is the armpit, down the midline. He was having pain when he breathed in, when he inspired. He was tender along the left clavicle and shoulder. He had popping and clicking, which is called crepitus at the elbow. His motion was restricted. He had crepitus at the wrist as well.

I took some x-rays of him because I was concerned about many things that were going on, shortness of breath, difficulty breathing, nausea, vomiting. So I took some quick x-rays just to sort of see where we were.

I took an x-ray of his chest to look at his lungs. What I was looking for was whether he had a punctured lung, which he did not. I couldn't see any definite fractures in the ribs.

I took an x-ray of his elbow and forearm and the x-ray of the forearm showed a crack in one of the forearm

bones called the radius.

I took an x-ray of his wrist, which was not particularly impressive, an x-ray of his low back and pelvis which showed no fractures.

On that day I sent him to the emergency room because I was concerned about his complaints of headaches, nauseous and vomiting, which can be an indication of closed head injury, especially with the loss of consciousness and because of his difficulty breathing and I thought he should be assessed by the emergency room.

The only thing that I did for him actively at this time, besides sending him to the emergency room, I placed his forearm in a cast to try to keep the bone aligned and hopefully save him from having surgery for a radius fracture.

Q. Is there anything else of particular medical significance that occurred on this first day?

A. No that was sort of a triage visit, meaning he was having such difficulty that I really was trying to get him to the emergency room.

My diagnosis at that time was simply multiple trauma, neck, low back, left shoulder, left upper extremity and chest. Rule out head injury.

MR. PERECMAN: Your Honor, at this time I would like to offer the -- I will hold off on that.

Q. Did you stay in touch with the hospital about him; did you call them?

A. Yes, I would call the hospital and tell them that he is on his way. The residents and the staff at the hospital there report back to me.

Q. Was there anything from the CT scan of his head to be concerned with?

A. He had a CT scan of his head -- do you have a hospital record?

MR. PERECMAN: Yes, I do. Your Honor, this is part of the subpoenaed record. May I show it to the doctor and ask the Court to have it marked later on?

THE COURT: Why don't you move it into evidence now?

MR. PERECMAN: I will offer it in evidence, your Honor.

THE COURT: Counsel, do you have any objection?

MR. BOULE: May I take a look at them?

THE COURT: Yes, absolutely. Show it to counsel.

MR. BOULE: Can we approach for a second?

THE COURT: Sure.

(Whereupon an off-the-record discussion was held.)

THE COURT: The hospital records from St. Lukes Roosevelt Hospital, medical records, are in evidence as Plaintiff's Exhibit number 2. And that is without objection, all right, counsel?

MR. BOULE: Yes, your Honor.

(Received and marked Plaintiff's Exhibit 2 in evidence)

THE COURT: Thank you.

Okay, you can proceed counsel.

Q. He was answering a question. There is an open question.

Was there anything about the CT scan of his head that was any concern and he asked to see the hospital records.

THE COURT: Okay.

A. CT scan was performed of the head to rule out head injury, bleeding in the brain and it did not show any bleeding in the brain or any collection outside of the brain of blood.

Q. Okay and when is the next time that you saw Mr. Mikolaj?

A. I saw him two days later on December 20 of 2007.

Q. And did you speak to him about what he was experiencing at that time?

A. At that time he was continuing to have pain at the

left side of his chest, which we characterized at this time as severe. I went through his examination that we had taken the day before, reviewed his x-rays again and did not see any injury to the lung.

I felt there may be a rib fracture in the lower portion of his chest, but it was difficult to be sure. I felt he may have had a compression fracture on one of his spinal vertebra and so I sent him for a CT scan of his low back -- of his chest to show the ribs and the spinal column.

Q. Did you at that point have any desires to have any further testing done?

A. Yes.

Q. Can you tell us what part or parts of his body that was and what kind of tests did you want?

A. Sure. I requested MRI studies of his neck and of his low back.

Q. Okay, now did the MRI studies actually get done?

A. They did.

Q. Do you have them with you? I saw you had x-rays, do you know if those are the hard copies? I only have disc.

A. I should have hard copies.

Q. Films?

A. Yes. I also have some discs, but I believe I have hard copies.

Q. We will get to those in just a moment.

When did you see him again?

A. I next saw him on 1/7 of 2008 so about two or three weeks later.

Q. Was he having any treatment in between there that you had prescribed physical therapy or anything or nothing at that point in time?

A. At that point he was not having anything specific done. He was taking pain medications. And we were awaiting some of his test results for beginning physical therapy.

Q. What were his complaints in January?

A. He was complaining of persistent pain at the chest as well as numbness in his left thumb and upper arm -- upper extremity rather. He was complaining of pain about the shoulder and had difficulty moving the shoulder. He was complaining of pain in the area where he had the fracture at the forearm. He was complaining of difficulty moving.

Q. What kind of things did you do for him that day, if anything?

A. At that time I cut his cast down from a long arm cast to a short arm cast to allow for a little bit of motion. About the arm and the hand I took some x-rays which again showed the fracture of the mid shaft of the radius, the bone in the forearm. That was a nondisplaced fracture of the forearm.

I took an x-ray of his ribs at that point. We were

beginning to see some evidence there had been a fracture of the ninth and tenth rib on the left. Sometimes if there is a crack in a bone and it is not grossly out of place you can't see the fracture line, especially ribs because you have shadows overlying from the lungs, but what you can see is the bone starts to knit, you can see new bone formation or resorption of the calcium around the bone. At that time I felt we had a pretty good look at the ninth and tenth rib fracture.

Q. Did you give him any pain medication?

A. At this time I prescribe for him some narcotic pain medication, a medication called Vicodin, which is a narcotic medication used for severe pain.

Q. And did you see him again on the 28th of January?

A. I did.

Q. Did you make any notes about what his complaints were?

A. At that time he continued to have neck pain. He continued to have pain into the shoulder blade area which was, again, characterized as severe at that time.

His left arm was getting more comfortable. He was complaining of some numbness in the thumb and around the base of the thumb. At that time we were about five weeks following his fracture and I removed his cast. He was noted to have marked tenderness about the neck and about the

musculature of the neck with pain in the musculature of the midthoracic region, which is the upper back.

It was noted to have very limited motion present at that time and I felt it was safe to start him on physical therapy. He was given a prescription for that and I renewed his prescription for narcotic pain medication because of continued pain.

Q. What, if any, medical significance did your finding that he had tenderness of the cervical paraspinous musculature to the midthoracic region have to you?

A. That is an indication of pain in the neck. Cervical paraspinous musculature, the muscles that hold the neck steady. When someone injures their neck you often see musculature spasms. It is the body's attempt to hold the neck steady so that the injured areas don't move and cause pain. That is usually accompanied with paraspinous musculature spasm, which he was having.

Q, okay the next time you saw him was about a month later, correct?

A. Approximately.

Q. Okay and what were his complaints?

A. At that time he was complaining about pain about the left wrist where he had the injury to the forearm. And he was having pain about the base of the thumb. He was complaining of some numbness and tingling in the thumb as

well. We discussed use of medications and bracing at that time.

Q. You saw him then, am I correct, on 3/13/08?

A. Yes.

Q. And what did he tell you about how he was feeling?

A. At that time he was having complaints of pain and weakness in the left arm. He was having pain about the elbow. On exam he was noted to have compass called a positive tinel sign. Positive tinel is when you tap a nerve in the -- in this case in the arm. That nerve if it is irritated or compressed, if there is any problem with the nerve, can send an electric feeling signal down the course of the nerve.

You all probably hit your funny bone and get that electric shock, that is the tinel sign you injured the nerve momentarily.

In people who have an irritable nerve, even if you tap them lightly, they can have a positive tinel sign and he did have a positive tinel sign about the elbow, shooting numbness and tingling into his fingers on his left hand.

He also had tenderness along the spine. The mid and low spine. He had musculature spasm in the mid and low spine. He had multiple areas of the trigger point formations in the mid back.

The trigger point formation is the formation of

sustained muscle spasms. Again, the body's response to an injury, trying to hold the body steady so that it doesn't cause pain to itself by moving.

Q. Were you at all surprised by the numerous findings that you had here?

A. No, I think he had a significant injury in his fall and I think he was still having significant discomfort from those injuries.

Q. Okay, now were you seeking at that point in time on March 18 and I am specifically speaking to the last sentence in your note about having any other kind of studies or treatment?

A. We requested an authorization on this day for what is called electric diagnostic studies, the studies that test the nerves. Again, he had that positive tinel sign, we are looking to see if he had irritable nerve in the arm or it was actually coming from a problem with the nerve as it came out of the neck.

We also requested an authorization for some special injections about the spine called cervical -- cervical means neck. Epidural steroid injections in the neck at this time.

Q. Why were you going to administer cervical epidural steroid injections?

A. Epidural steroids is a way to give a steroid medication, which is a strong anti-inflammatory medication,

directly in the area where there is a problem. This gentleman had an injury to the neck, he was having pain and radiation of pain down the arm, neck pain, so this would be a treatment for that particular problem.

Q. And the next time you saw him was May 20th?

A. That's correct.

Q. And did you review some test results at that point in time?

A. I did. He had had a CT scan of his hand because of some increase pain at the base of the thumb that I was talking about. And that test did not show anything that looked like a fracture or anything like that. He had some degenerative changes in the base of the thumb, both on the right and the left.

Q. Now, the degenerative changes, is there a common word for that?

A. Degenerative change? Well, degenerative change is a change that occurs over time, so the type of degenerative change that they are talking about here is some arthritis-type changes in the base of the thumbs.

Q. He had arthritis in his hand?

A. He did.

Q. And you next saw him again in July?

A. Next saw him July, that's correct.

Q. And what were his complaints?

A. At that time he was complaining of pain in the wrist and hand. He was having difficulty doing things like holding onto a subway strap. He was having pain about the elbow. He continued to have that positive tinel showing an irritated nerve about the elbow going into the fingers.

Q. Just a yes or no, did you consider doing some type of surgical procedure at that point in time?

A. Yes.

Q. What procedure were you considering doing?

A. Surgery that we were talking about was decompressing the nerve that runs around the elbow and into the hand called the ulnar nerve. There are three major nerves that go to your hand, the radial nerve, median nerve and ulnar nerve. The ulnar nerve seemed to be compressed and he was having symptoms associated with ulnar nerve problem called ulnar neuropathy.

Q. At this point in time this was close to seven months after he initially injured his arm, correct?

A. That's correct.

Q. Was it normal for him -- if his harm had healed properly, would it have been normal for him to still have a positive tinel sign?

MR. BOULE: Objection.

THE COURT: I will allow it.

A. Obviously, the tinel sign is an abnormal finding.

It actually -- this history follows the pattern that you would expect to have scar tissue formation over time. That tinel was much more apparent as the scar tissue matured and began to compress the nerve. At that point he had pressure on the nerve that was giving him trouble.

Q. And did you see him again in August?

A. I did.

Q. And what were his complaints and findings?

A. At that time he was having worsening pain by the left elbow as well as pain into the small and ring fingers. Those are the fingers that are innervated, giving sensations by the ulnar nerve. He was having some wasting of the musculature of the hand.

Q. What is wasting of the musculature?

A. What are called the intrinsic muscles of the hand, which are the muscles that are actually in the hand, are given nerves by the ulnar nerve. Most of your hand motion, the flexion and extension of your fingers and actually the muscles up to the forearm, which is why when you move your fingers you feel these muscles moving in the forearm.

The muscles within the hand that do this motion, spread your finger, put them together, are called intrinsic muscles. If there is a problem with the ulnar nerve that gets -- if you get a problem with the ulnar nerve the muscle that gets a signal from the ulnar nerve will start to waste

away. They get smaller.

You can actually see that because there will be a hollowing of the spaces that are usually filled by those muscles in between the finger bones. He was beginning show that. That is an indication of ongoing ulnar neuropathy.

Q. Did you discuss any surgical procedure with him?

A. Let's see -- eventually I did. I don't believe we did it on this day. I am sorry -- yes, we did discuss ulnar nerve transposition.

Q. So that was August of '08, when is the next time you saw him?

A. Next time he was seen him was back in September of '08. September 9th of '08.

Q. You hadn't done surgery at that point?

A. We had not done the surgery at that point.

Q. Then you saw him in October?

A. That's correct.

Q. When you were trying to get cardio clearance for him to do the surgery?

A. Trying to get medical clearance in order to proceed with the surgery. That's right.

Q. Did you notice anything about whether he still had the wasting or weakening of the intrinsics?

A. He had parathesia, which is, again, numbness and tingling, in the small and ring finger and weakness of the

musculature of the hand.

Q. Now, earlier on had you referred him to see Dr. Kushnerik?

A. Yes.

Q. And why did you send him to Dr. Kushnerik?

A. Dr. Kushnerik is a doctor who practices pain management and he is a specialist in treating injuries of the neck and the back with the injections that we talked about, the epidural steroid injections.

He also does a number of other pain management modalities including medications and what is called endoscopic surgery, which is done basically through a needle and placement of things called a spinal cord stimulator, which is a way of dealing with pain in the back.

That is from the spine -- I am sorry, pain in the back and the legs was from the spine by stimulating the spinal cord. That is sort of confusing. The message of pain that ultimately gets to the brain.

Q. Okay, now you saw him again after the October visit in December of 2008?

A. Yes.

Q. So, now it is about a full year since the accident?

A. That is a right.

Q. Was he having some other treatment at that point in time with regard to the arm pain?

A. He was. He had started, in addition to the physical therapy, he started some acupuncture therapy, which was initially giving him some diminution, some relief, of the numbness and tingling pain that he was having in the hand.

Q. Now, were you discussing the surgery with him?

A. Yes we continued to discuss surgery with him.

Q. What was he saying to you about it?

A. At that point he was feeling somewhat better from the acupuncture and so he clearly didn't want to have surgery. My concern was that he still had wasting of those muscles, so there was clearly a problem with the nerve and I encouraged him to not wait too long, but to see if he wanted to try the acupuncture for a while. He was okay with that.

Q. Okay, then you saw him again in January of '09?

A. I did.

Q. Yes. What were the final discussions?

A. At that time he had worsening, wasting of those muscles. The muscles were getting smaller in the hand. He had weakness when I tested it and still had a positive tinel sign indicating an irritated nerve.

I again discussed surgery with him and we decided we would proceed with that one. We were able to get medical clearance. He was given a prescription for some narcotic pain medication because of his ongoing pain. Again, Vicodin

and that was it.

Q. Okay, now do you know whether he was getting physical therapy during this time?

A. I believe he was getting therapy intermittently, yes.

Q. Do you know whether Dr. Kushnerik was prescribing therapy or not?

A. I don't know the answer to that.

Q. You don't have his record in front of you?

A. I do not.

Q. You saw him again in April of '09?

A. That is correct.

Q. Okay, any important findings?

A. In April of '09 we were waiting for cardiac clearance, meaning medical clearance to proceed with surgery. He continued to have symptoms of the left ulnar neuropathy, cubital carpal tunnel syndrome. On exam indicating a weakness of the hand.

We tried to arrange for him to see the cardiologist again to try to get medical clearance.

Q. Did you make any referrals to him of other physicians he should see?

A. I did sent him to Dr. Szpitalnik S Z P I T A L N I K. Dr. Szpitalnik is a psychiatrist and this gentleman was having a good deal of anxiety. He was having difficulty

sleeping and things like that. I felt he would be helped with a psychiatrist.

Q. Do you know what language Dr. Szpitalnik speaks?

A. I know he speaks English and Polish. One of the reasons I sent a number of patients to them.

Q. Does he speak Russian?

A. I am not sure.

Q. Okay on 2/23 of '09, do you have that note in front of you? Can you find that?

A. Yes.

Q. No, that is Dr. Boppana, I am sorry.

Did you have a partner in your practice at this time?

A. I had a Dr. Boppana working for me at this time.

Q. What kind of doctor is Dr. Boppana?

A. Dr. Boppana who worked in my office was a neurologist.

Q. When is the next time you saw Mr. Jakociuk?

A. The next time I saw him, Mr. Jakociuk, was 06/17 2009.

Q. And what were your findings?

A. My findings were persistent pain at elbow with numbness in the ulnar nerve distribution. He was complaining of pain about his shoulder and he was seeing Dr. Kushnerik. We talked about -- he was taking some

antianxiety and antidepressant medication called Buspar.

On examination, he had positive tinel, he had numbness and tingling in the small and ring finger. He had limited motion of shoulder and shoulder girdle at that time.

Q. Did you do surgery on him for the positive tinel sign that he was showing?

A. I dod surgery for the ulnar neuropathy damage to the ulnar nerve entrapment -- rather to the ulnar nerve. That was performed 7/10, 2009. I did that at New York Downtown Hospital.

MR. PERECMAN: Your Honor, may we have that marked for identification please.

THE COURT: If he is using that for demonstrative purposes and not going to be moved into evidence.

MR. PERECMAN: I would like to.

THE COURT: Show it to counsel. If he has no objection.

MR. BOULE: I object to it going into evidence. I have no objection for demonstrative purposes.

THE COURT: You can put it up on the easel. It can be used for demonstrative purposes.

Q. Doctor, would you be kind enough to step down.

THE COURT: You can step down, Doctor.

(Witness complies.)

Q. Use this exhibit and explain the surgical procedure that you did to Mr. Jakociuk?

A. The procedure that we did was an ulnar nerve decompression and transposition. The ulnar nerve, as I say, is a nerve that runs out of the spinal cord, down under the armpit, down the arm and goes to the fingers, this part of the hand and the muscles through the intrinsic muscles of the hand.

The procedure is done where a patient is put on the operative table and a nerve block is given. An incision is made over the inside of the forearm about the elbow. That is taken sharply down through the skin and what is called subcutaneous tissue, fatty tissue.

The nerve sits in a groove in the back of the elbow. You can all feel it on yourself. There is a two bony prominences and then a soft spot. In that soft spot is where the nerve lives. So you find those two bony prominences here and here, you dissect down with surgical instruments and find the nerve.

In finding the nerve in this case there was a good deal of scar tissue around the nerve and that was putting pressure on the nerve, short of choking it off.

So, what we did is cleaned up all the scar tissue off allowing us to take the nerve from behind his bony

prominence in the elbow and flip it over to the front of that bony prominence and that shortens the distance between the end part of the nerve and the beginning part of the nerve, so that when you flex or extend your arm rather than having to pull all the way around your arm and elbow this way, it typically slides back and forth.

It takes a lot of pressure off that nerve and we removed a lot of scar tissue from that nerve and immobilized it.

Q. Can you explain what these images are on the right side?

A. Sure, these are the easy ones to see because we are looking at the arm. Imagine if you were to cut through the arm this way and it will allow you to look down the arm in the long axis. If you were to remove my hand you can look down into my arm, so you are looking at the elbow and this is the end of the arm bone sitting on top of the elbow like this.

If we were to take a look through the arm at this level we would see the ulnar nerve, which is here, which runs out into the hand behind the bone. In it's normal position. In this case there was a good deal of scar tissue encircling and choking the nerve giving it that abnormal nerve signal, which gave the numbness and tingling in the fingers as well as the atrophy of the hand.

These pictures show taking the nerve from his normal position, cleaning it out with scar tissue and flipping it over to the front part of the arm and in order to keep it from slipping back in there when you straighten your arm out, we actually take some of the fat that is over there and sew it into that groove that you feel here that keeps the nerve on this part of the arm.

Q. Thank you Doctor.

Is the procedure such as that -- I know when you do it the patient is under anesthetic, but afterward when they wake up, is it dissociated with pain?

MR. BOULE: Objection.

THE COURT: I will allow it.

A. Yes, it is an open procedure, meaning that an incision is made from about here to here (indicating). The nerves are manipulated, so yes, it is a very painful procedure once the anesthesia wears off.

Q. For how long is a patient with a procedure like that usually in acute pain?

A. The acute pain lasts several days. That is why we give narcotic pain medications for the patient to use after the procedure to try to quiet down some of the pain, but for several days to several weeks they can have significant pain.

Q. Okay and after several weeks is the pain all gone?

A. The pain goes away over a period of time. It is different in each patient.

Q. Now, did you continue to see Mr. Jakociuk?

A. Yes.

Q. The first time you saw him after the operation was on July 15th?

A. That is correct, July 15, 2009.

Q. Other than the large bruise, is there anything notable that you saw?

A. No, he had sutures that were ready to be taken out. Sutures were removed. He had a large bruise from the surgery. In order to get to the nerves sometimes you have to cut through vessels. He also he had some bleeding under the skin and you can have a crushing injury of some vessels from the tourniquet that we use.

I felt that was what was going on with this gentleman and his numbness and tingling was starting to show some improvement even at that early stage.

Q. What about the next time you saw him on August 13th?

A. The next time I saw him he continued to have some pain about the elbow. The scar had sort of stuck down, so he had some adherence of his scar. He was complaining of some numbness and tingling -- I am sorry, decreased numbness and tingling following the surgery in the fingers. He

continued to have loss of motion, which occurs after the surgery as well.

Q. Then you saw him on September 29th?

A. That is correct. I am sorry, back to the August visit we just talked about, he was also complaining of some low back pain and was noted to have tightness and tenderness and limited motion of the back in that post-operative period as well.

Q. Now, throughout this period of time, his neck problem, was that being treated by Dr. Kushnerik?

A. Mainly by Dr. Kushnerik. That is correct.

Q. September 29th, how was he doing with regard to the surgery, had it helped?

A. Yes, he had a return of sensation in his fingers which indicated the surgery obviously was necessary. It had helped him. He was still having pain about the elbow when he tried to fully extend or fully flex the elbow.

That is about two months after surgery and he still was having some discomfort, so that is post-operative type pain. He was complaining of worsening low back pain at that time and he was having a hard time getting comfortable with regard to his low back.

Q. The procedure that you performed, the cubital tunnel release, what it is designed to alleviate? Did that make sense to you in terms of the injury he had?

MR. BOULE: Objection.

THE COURT: I will sustain that as to form.

What does that mean?

Q. Doctor, do you have an opinion within a reasonable degree of medical certainty as to whether he needed the left ulnar nerve transposition because of the accident he had?

A. Yes.

Q. When he fell off the ladder?

A. My opinion is that the need for ulnar nerve surgery was caused by the accident. I feel he injured his elbow in the accident and he had gradual progression and worsening of the symptoms from the time of the accident until the time he had surgery and surgery got rid of the numbness and tingling. He did have a fair amount of postoperative pain for a long period of time, but the surgery, I believe, was successful, yes.

Q. Now, the next time you saw him was in November of 2009?

A. That is correct.

Q. How was he doing with regard to his neck and low back?

A. Let's see, he was having limited motion of his neck and his low back in all plains, meaning every way he tried to move he had limited motion. He had spasm present in the lumbar paraspinous musculature. He also continued to lack

motion of his elbow at that time, even four -- three months after his accident -- after his surgery rather.

Q. Okay now, Doctor, when he had the CT scan of his neck, did it reveal any positive results?

A. He had a CT scan of the --

Q. I am talking about the one that was done in December 22007, right after the accident?

A. Are you talking about the MRI scan?

Q. Yes, I misspoke.

A. Yes, through the MRI scan of his cervical spine of his neck it did show herniations of two of the discs in the neck. The discs are soft tissue in between the bones of the neck. If you had a herniation of those disc, the part of the disc that pops out can put pressure on the nerve root and he had herniated disc at C5-6 and C6-7, which are a way of naming the different levels of the neck.

Q. Doctor, I would like to show you in the exhibit --

MR. PERECMAN: Again your Honor, just for demonstrative purposes.

THE COURT: For demonstrative purposes he can step down.

Q. Could you explain to the jury what we are seeing there and what the findings were on an MRI?

A. So, this is an MRI picture of a spine. These sort of square images are the bones of the neck. They are

stacked one on top of another.

In between this is a drawing superimposed on this picture so that you can see there are bones of the neck and they are numbered from the top which is cervical or C1 down to C-7. There are seven cervical vertebra.

Under that the thoracic vertebra, those are number 1 through 12. And lumbar vertebra are numbered L1 through 5.

So, we are looking at the bones of the neck. In between each bone is a disc. The disc is a soft tissue that allows motion between the bones, but also ads shock absorber. The bones and disc sits in front of the spinal cord and the spinal cord is wrapped in the bony cage of the cervical vertebra. So this is actually -- can I use my model?

Q. Sure.

THE COURT: Absolutely you can use that. This is actually a lumbar vertebra, but easier to see the neck and the back.

THE COURT: I want to make sure all the members of the jury can see. If you can't let me know.

Is it okay?

THE JURY: Yes.

A. The way the spinal cord is built, that, again, the discs allow for motion in between the bones. The major

purpose of the spinal cord not only is to hold us upright, but also to protect the nerve cord that runs down the center of the spinal column. The way that the body is built that nerve cord is well protected as it runs down the spinal column and little nerve branches, run out of the spinal cord, in this case, going down from the neck into the arms and from the low back into the legs.

When all that is working great you have good protection and you have motion around the spinal cord. If there is an injury or abnormality that causes the disc to herniate or push backward, it will push -- can push into the nerve root and it can trap the nerve root into the bones that are normally there to protect it. So you get pressure on the nerve? That is what we may refer to as a pinched nerve from a herniated disc.

In this case if we were to look at MRI's at the bones and the disc normally, the disc sort of sits flush to the bone and allows the spinal cord, which is here, sort of a sharp white line of fluid.

When we get down to this level, which is here, the C5-6 disc between the fifth and sixth vertebra, you can see the disc material in between the bones has pushed backward and is actually pushing significantly on the spinal cord and abut the spinal cord.

In this x-ray we also see some degenerative changes

that you would expect in a gentleman of that age. You actually see a bone spur, but you also see that the majority of the discs are clean. Even though there is some degenerative change there.

Q. What is the medical significance of the disc pressing against the nerve cord?

A. Sure. Just like in the elbow, pressure on the nerve can give you symptoms of numbness and tingling or pain or loss of sensation because the nerves and the nerve cord are sensitive to feeling and again, give you the ability to move.

So you can have symptoms of pain not only in the neck because pain going down the arms, numbness and tingling, things like that.

Q. And Doctor, do you have an opinion within a reasonable degree of medical certainty as to whether those disc herniations, whether the accident of December 17, 2007, was the competent producing cause of those herniations?

MR. BOULE: Objection.

THE COURT: I will allow it.

A. My opinion is that the accident was responsible for the symptoms associated with these discs, meaning the pain, the limited motion of the neck, the musculature spasm and, in general, had none of those symptoms prior to the accident and after the accident he did.

So even in the face of some degenerative changes, I believe, that the disc herniations, the symptoms that it caused, were caused by the accident.

Q. Okay, now in that regard, can people have bulging or herniated discs of varying sizes without symptomatology?

A. Yes, absolutely, depends where the disc and the disc herniates out from. You don't have to have symptoms, you may have some back pain, but not necessarily pain running down the arms or legs, things like that, but posterior disc herniations that abut the nerve cord generally give symptoms.

Q. Now, other than having an MRI of his spine prior to the accident, is there any way to tell exactly what condition this disc was in before the accident?

A. There is no way to know for sure.

Q. So, when you have a patient like this and you tell us that you feel that the symptoms were caused and the pain was caused by this accident, what do you base that on?

A. I base that on his history, what he tells me. Whether his symptoms are consistent with this type of injury and his symptoms have been neck pain, muscle spasm, limited motion consistent with an injury like this and your findings on the MRI's.

Q. Thank you. Now the nerve stimulator in his neck that was done by Dr. Kushnerik, right?

A. The placement of the spinal cord stimulator is by Dr. Kushnerik, that is correct.

Q. Have you continued to treat Mr. Jakociuk?

A. Yes.

Q. How often do you see him?

A. I see him, approximately, every six to eight weeks.

Q. And what is going on during that time since then?

I think we last were talking about after a couple of months after the ulnar transposition?

A. He eventually underwent placement of the spinal cord stimulator by Dr. Kushnerik. He has continued to have complaints associated with pain. Those have been pain in his left shoulder. He has a good feeling here. He still has some limited motion at the elbow. He still has some crepitation, meaning popping and clicking in the wrist and he continues to have pain associated with his low back and low back motion.

Q. Are you prescribing any medications for him?

A. Majority of his pain medications are being prescribed by Dr. Kushnerik. Again, he is a specialist in pain management and that is one of the big bases of his treatment is pain medications and at this point we have been -- the last thing that we prescribed for him are called Flector patches. Anti-inflammatory medications not by mouth but by patch. This he used on his neck and his back.

Q. What is his prognosis?

A. His prognosis is poor. Prognosis is looking into the medical future, trying to predict what will be for him given what he has had injured and how it has been treated.

Clearly, he has improved from some of the treatment we have given him, his back pain has diminished with a spinal cord stimulator. He has a permanent stimulator that is permanently formed in the body. It is implanted in him it will always been in him. It is not going to be taken out.

He requires ongoing treatment for low back pain. He requires ongoing observation for his neck pain. We have been treating him for some upper extremity pain on the left, since the time of this accident. He gets treatment for that today. He requires ongoing treatment for sure.

Q. Okay, will he get better?

A. No, I don't think he will get significantly better. I think certainly some of the things are under control now with the treatment that he has and again, requires ongoing treatment.

We all age. We all of degenerative change overtime and this gentleman who has these multiple injuries, the degenerative change will have a relatively larger affect than it would in a person who did not have injuries.

Q. Okay, will it get worse?

A. I think it will worsen over time, sure.

Q. Okay, what injury do you think will worsen over time, predominantly the arm or the neck?

A. I believe the neck is the bigger problem.

Q. Okay and when you see him, what does he say about his neck pain?

MR. BOULE: Objection.

THE COURT: I will allow it.

Q. What are his complaints?

A. As of the last time I saw him, which was less than a month ago, he continued to have complaints of neck pain. He continued to have pain radiating to the forearm, wrist and elbow. He was having clicking and popping when he moved his neck. He had sharp pain occasionally with quick motions on his neck. On exam there was stiffness in his neck and low back with spasm present.

We are still six to seven years down the road now, six years down the road and he still has musculature spasms indicating ongoing problems. He had difficulty even getting on and off the examining table when I saw him about a month ago.

Q. Doctor, do you have a opinion with a reasonable degree of medical certainty as to whether Mr. Jakociuk can engage in physical labor?

MR. BOULE: Objection.

THE COURT: I will allow it.

A. There are certainly things that I would advise him not to do. Those would include any type of lifting of greater than five to ten pounds. Repetitive lifting greater than five pounds. Carrying, going up on heights. Certainly, he would not be able to safely do.

Stair climbing exacerbates his pain, back pain. Sitting for a long period of time exacerbates his neck and back pain. He shouldn't certainly be carrying things on his back or shoulder or in front of him which load the back. He has good deal of restrictions.

Q. So do you think he should do construction work?

MR. BOULE: Objection.

THE COURT: I will sustain that.

Q. Do you think he can do construction work?

THE COURT: I will sustain that.

MR. BOULE: Objection.

Q. Based on your examination of him, would it be recommended from a medical point of view as his orthopedic surgeon that he do construction work?

MR. BOULE: Objection.

THE COURT: I will allow that. Yes or no.

A. From what I understand of construction work it would entail all of those things that I just said he cannot do, so certainly not.

Q. Now, how often does he need to see you?

A. At this point I see him about every six to eight weeks. That in the ideal world I would continue to see him every couple of months. I can recommend that he sees me at least four times every three months or so, just to keep track of his orthopedic injuries and how they are fairing. He also need to see Dr. Kushnerik.

MR. BOULE: Objection to Dr. Kushnerik.

THE COURT: All right. Ask another question.

Q. Okay in order for -- do you know the types of medication Dr. Kushnerik is prescribing for him?

A. I don't have a list that I think is current at this time.

Q. What is your usual and customarily charge for a standard orthopedic visit?

A. Usually my customary charge meaning if someone --

Q. These days, dollars and cents?

A. Usually between $150 and $250.

Q. You are saying that at least four times a year, at least?

A. Yes.

Q. Okay, for how long would that go on?

A. As long as he is having symptoms. I believe his symptoms are permanent, so the rest of his life.

Q. Do you have an opinion within a reasonable degree

of medical certainty as to whether the injuries and the symptoms that Mr. Jakociuk is experiencing are permanent?

A. Yes, I believe his symptoms are permanent.

Q. Do you know whether he is seeing any other physicians other than Dr. Kushnerik at the time?

A. I believe he still sees Dr. Szpitalnik and Dr. Kushnerik. Other than that, I am not aware.

Q. How does he appear to you when you see him in terms of his mood, the way he behaves?

MR. BOULE: Objection.

THE COURT: Sustained.

Q. Why did you refer Mr. Jakociuk to Dr. Szpitalnik?

A. Throughout my notes I have noted that he appears anxious, stressed. He has had bouts where he appears depressed. He has had a stressful life since this accident. So stress reaction.

Q. Have you seen that change in him since your most recent visit?

MR. BOULE: Objection and move to strike.

THE COURT: I will allow it.

A. If anything I think it has been worse. Certainly the last time I saw him he was really quite anxious and almost mournful. He was upset. I have seen him in my office crying.

Again, my office has sort of become central station

for a lot of Polish gentleman who have been hurt in construction accidents and my staff is sort of known as care taking staff. So I think people feel very free to come in and talk about not only orthopedic problems, but their life stressers and things. I know his father recently died. I tried --

MR. BOULE: Move to strike, your Honor.

THE COURT: I will strike that from the record.

MR. PERECMAN: Thank you, Doctor.

THE COURT: Counsel?

CROSS EXAMINATION

BY MR. BOULE:

Q. Good afternoon Dr. Kaplan, how are you?

A. Good.

Q. Now, part of your practice is coming into testify in court, fair to say?

A. I wouldn't say part of my practice. Part of being an orthopedic surgeon who treats patients with injuries, sure.

Q. You testify 20 times a year?

A. Approximately about once or twice a month.

Q. And the large majority, 90 plus percent, were on behalf of the plaintiffs, parties bringing the lawsuit,

correct?

A. By the nature of the fact that I usually come in and testify for patients that I have been treating for a period of time that is true. I also testify as an expert witness for both plaintiffs and defendants.

Q. But the testimony for the defendant is far less than for the plaintiff, would you agree with that?

A. As I said most of the time I am here for my patient and that is generally the plaintiff. That is the way it works, yes.

Q. You are being compensated for your time here today?

A. Sure.

Q. What are you being compensated?

A. My office receives a fee of $6,500. That pays my salary, the 19 people that we talked about that are working today. I receive the same salary whether I am here or in the office.

Q. Do you know, Doctor, who referred Mr. Jakociuk to you for treatment?

A. I don't know for sure, no.

Q. As part of your practice, the attorneys for injured parties do refer their clients to you for treatment, correct?

A. I have certainly had patients referred to me by attorneys, just like I have had referred by doctors and

friends and people around patients.

Q. Do you know who Mr. Jakociuk's original attorney was?

A. I probably have a list over here. I think the original attorney was Sam Lurie.

Q. Does your list say there if he referred the plaintiff to you?

A. No.

Q. You have treated many of Mr. Lurie's patients, correct?

A. I don't know about many. I certainly treated patients that have been clients of Mr. Lurie's. He also has a large Polish practice.

Q. You have testified in Court on behalf of Mr. Lurie several times, fair to say?

A. I have, yes.

Q. And you have treated patients of Mr Perecman, fair to say?

A. That is correct, he also has a large Polish practice.

Q. You have testified in court on behalf of Mr. Perecman, right?

A. Right. I think once or twice.

Q. The plaintiff in this case did not go to the hospital on the day of his accident, correct?

A. That is correct.

Q. He made a choice voluntarily not to go to the hospital, correct?

A. He had had a head injury that day. He made a bad choice, but yes, it was his choice.

Q. The first person he came to see was you, right?

A. Correct.

Q. And you did your examination and you already told us what it was that you found?

A. Yes.

Q. And you took x-rays?

A. Yes.

Q. And you found a nondisplaced fracture of the left wrist, correct?

A. Of the forearm, yes.

Q. Where, approximately, based upon what your notes say was that fracture; if you indicate?

A. Based upon the x-rays it was mid proximal forearm.

Q. What is a nondisplaced fracture?

A. In describing a fracture, a fracture can either be displaced meaning that the bones are no longer touching or nondisplaced, meaning that even though the bone is fractured the bones are still touching.

Q. The bones are still touching?

A. Yes.

Q. A significant fracture is a displaced fracture?

A. Only it is significant meaning that it doesn't immediately need surgery.

Q. In this case he never needed surgery?

A. Correct.

Q. You also took an x-ray of his elbow that day?

A. Yes.

Q. That showed no fracture, correct?

A. It did not show any bony fracture, right.

Q. And there were no other fractures found?

A. He had fractures of the ninth and tenth rib. I couldn't see that initially. Again, those were also nondisplaced.

Q. And there was no treatment done for the fractures of the rib, correct?

A. That's correct. There is no treatment for that.

Q. And you sent him to St. Lukes Hospital because of the concern about the head injury, correct?

A. That's correct.

Q. It turns out that there were no abnormal findings at St. Lukes Hospital?

A. There was no bleeding in his head.

Q. Were there any abnormal findings on the CT scan, Doctor?

A. No.

Q. In fact, didn't St. Lukes do a physical examination?

A. They did.

Q. And didn't they find that he had full range of motion in his neck?

A. I would have to look at the record. That would be okay. Do you have that record?

Q. Yes, I believe it is in evidence.

(Handed to the witness.)

Q. If you want my assistance, I would be happy to provide it.

A. If you want to assist me for time sake, thank you.

(Whereupon, a brief pause was taken.)

Q. You see a reference there to the neck?

A. Yes.

Q. I says, negative bony tenderness, correct?

A. I believe that is positive bony tenderness.

Q. Okay.

A. And says full range of motion.

Q. Full range of motion means what?

A. That means he can move his neck up and down, side to side.

Q. And someone who has significant pain in his neck would be unable to do that; fair to say?

A. Not necessarily. No significant pain you can still

move.

Q. So the findings that you made when you examined him that day, are you saying are exactly the same as the findings that they made with respect to the neck?

A. My findings on this day show that he has crepitus -- I don't actually make a note of his cervical motion on that day.

Q. Why not?

A. As I said, my main concern was this guy was nauseous, vomiting, headaches, difficulty breathing. I wanted to get him to the emergency room as soon as possible, so we did a stabilizing triage exam and sent him on.

Q. Are you aware that at times during his treatment Mr. Jakociuk complained of restricted range of motion in his neck, correct?

A. I actually had restricted range of motion, according to my notes.

Q. That is later on?

A. During the course of his treatment.

Q. That was due to the pain, allegedly, that he was experiencing?

A. Due to the muscle spasm which occurs over time to help the neck not move over injured parts.

Q. The fact that he had full range of motion at St. Lukes on the day of the accident indicates no musculature

spasm; fair to say?

A. That he didn't make a note regarding musculature spasm. You make a leap that is not necessarily true.

Q. I believe you just said that muscle spasm restricts range of motion and he has full range of motion at St. Lukes?

A. What I said is the muscle spasm, which I felt was the reason he had restricted range of motion. They made no mention of muscle spasm there.

Q. Would you expect that someone who had muscular spasm, significant muscular spasm, would have full range of motion in their neck?

A. Generally, someone with muscle spasm has less than normal range of motion, but again, they note bony tenderness, but they do not note whether he had muscular spasm or not.

Q. They found no neurologic deficits?

A. That's correct.

Q. And what does that mean?

A. That means there was no nothing focal on the exam that would lead to the assumption of a neurologic injury.

Q. Which is part of the reason you sent him there or is that something else?

A. That was the main reason I sent him there so he can get a CT scan.

Q. They also refer to a steady gate, what does this mean?

A. That means he was walking at a normal pattern.

Q. Up above they have a section pmh, psh, which I believe stands for prior medical history, prior surgical history; do you see that?

A. Yes.

Q. What is written there?

A. It says, "arthritis".

Q. Do you know what that refers to?

A. What arthritis refers to?

Q. With respect to this patient first?

A. Nothing. Just had history of arthritis. They don't say where or what it has to do with.

Q. Did you ever ask Mr. Jakociuk his about history of arthritis?

A. I asked him specifically if he had had injuries or abnormalities to the places that he was complaining about and he said no. I did know that he had, as I said, some arthritic changes in his neck and hand.

Q. What causes arthritis?

A. Arthritis is a degenerative change. It occurs over time. Everybody gets a little bit of arthritis in their joints at some point in their life.

Q. By the way, as part of your x-rays you did not find

any fractures of his spine; is that correct?

A. No fractures of the spine, that's right.

Q. Now, Mr. Perecman had gone through your notes. I am not going to be as tedious, I hope, but I am going to ask you some questions about some of them.

On December 20, '07, and January 7, '08 you don't make any reference to neck or back pain in you records?

A. I do not make reference to neck or back pain, but I did request an MRI on the cervical and lumbar spine on those dates.

Q. Did you make any reference to elbow pain on either of those dates?

A. I don't specifically speak about the elbow, no. I talk about the radius again. That is part of the forearm.

Q. Now, you had testified with the use of this demonstrative picture of the spine, what did you call it, degeneration of the spinal bones?

A. Exactly that.

Q. Okay, is there a word for that?

A. There are many words. Would you like to throw one at me.

Q. Osteophyte.

A. Osteophyte is a bone spur. A nub in a bone that occurs with some degeneration.

Q. Were there osteophytes present on the MRI scan of

the cervical spine?

A. Yes, that is what we showed there.

Q. That shows it here at C-5, correct?

A. Yes.

Q. According go this diagram, that osteophyte appears to be compressing the cord, no?

A. It is actually is the disc that is compressing the cord. The osteophyte is pushing backwards into the space available to the cord, but it is not suppressing the cord.

Q. Would it be my eyes are playing tricks on me if I saw that, perhaps?

A. Okay.

MR. PERECMAN: Is that a question, your Honor?

THE COURT: I didn't hear that. I didn't get that. What you did you say, counsel?

MR. BOULE: I said guess that would be my eyes playing tricks on me if I think I saw that on the diagram.

THE COURT: I will sustain the objection. That is stricken from the record.

Q. Osteophytes do, in fact, on occasion press on the spinal column cord, correct?

A. If they are big enough, yes.

Q. And an osteophyte does not form within -- well, this was taken 11 days after the accident, correct?

A. I think we made it quite clear this osteophyte and the degenerative changes -- he certainly had some degenerative changes of the spine before the accident. He simply didn't have symptoms associated with those.

Q. Again, I am sorry I cut you off. I believe in an answer to Mr. Perecman's question, you testified that the symptoms from the herniated disc were related to the accident; do you recollect that?

A. Yes.

Q. Does that mean the herniated disc themselves were caused by the accident, correct?

A. I think my testimony was that since the symptoms were associated with the accident and he had no symptoms prior to that and that I felt the disc was the cause of the symptoms that I felt the disc herniation was related to the accident.

Q. And a disc herniation that compresses on the spinal cord, as we see in this diagram, I believe you testified that it causes certain signals to be sent down the associated nerves?

A. It can, yes.

Q. If the discs were herniated at the time of the accident, you would expect these symptoms to occur at this time, correct?

A. Not necessarily, no. That occurs as the disc goes

through a process of inflammation and scarring down. If the disc is big enough it can cause immediate symptoms. Very frequently I see symptoms that happen over time. Just like we saw the collection of scar tissue cause the nerve injury and nerve symptoms at the elbow.

Q. So acute in other words, caused by an accident, herniated disc, that compresses on the spinal cord, does not cause immediate symptoms; is that your testimony?

A. No, you are taking what I am saying and taking parts of it. It can cause immediate symptoms, just like I just said if it is large enough, but generally someone will have neck pain and symptoms of radiating pain can start a little bit later. It goes through the process of inflammation and scarring.

Q. Well, why don't you tell me then based upon your notes when that process started when you say radiating pain associated with this herniated disc?

A. I don't know that. I have notes regarding that, but the majority of my notes are talking about neck pain and the pain about the elbow and forearm and Dr. Kushnerik did the majority of the treatment associated with the radiculopathy, which is the pain which radiates.

Q. But if you were recording notes when you saw Mr. Jakociuk about his neck pain, if he complained to you about symptoms associated with compression on his spinal cord, is

that something you would write in your notes?

A. It will depend on how the patient is being treated and again, I wish I had time and the ability to write down everything that I spoke about with the patient, but it is simply not practical, so we focus on the things that I am treating and that I can help him with and I leave the other things to the doctors who are treating those specific problems.

Q. Well, he didn't treat with Dr. Kushnerik until for or five months after the accident, correct?

A. That is when I sent him over there, yes.

Q. In that time you are his only treating physician, correct?

A. That is correct.

Q. Isn't it fair to say that radiating pain that one asserts with compression on a disc is a significant symptom; fair to say?

A. It can be, sure.

Q. That is something, since you are focusing on the significant issues, that you would write in your notes if you found that symptom; fair to say?

A. Not necessarily, no.

Q. Why would you leave it out?

A. Because, again, I wish I would write down everything they speak about, but it is not practical. And

so we write down neck pain, back pain, spasm present, things like that. They are significant and eventually I felt the need to send it to Dr. Kushnerik.

Q. You are saying that a spasm would be more significant than radiating pain caused by a disc?

A. From an orthopedic who doesn't treat radiculopathy as specifically as a pain management physician does, yes.

Q. In any event, you didn't write it in your notes?

A. That's correct.

Q. Now, you touched on during you examination by Mr. Perecman electrodiagnostic studies; do you recollect that?

A. I believe so, yes.

Q. And, in fact, your office had electrodiagnostic studies of Mr. Jakociuk performed?

A. Yes.

Q. And there were electrodiagnostic studies of his upper extremities performed, correct?

A. Yes.

Q. And that was March 3rd, 2009, correct?

A. Upper extremities, March 3rd, 2009.

Q. You have the report there from that test?

A. Yes.

Q. Now, the diagnosis based upon that test is distal symmetric peripheral polyneuropathy; do you see that?

A. Yes.

Q. Now, that term does not mean injury to the ulnar nerve, does it?

A. Absolutely not.

Q. What does distal symmetric peripheral polyneuropathy mean?

A. Distal means away from the body, so not central. Symmetric means both sides. Peripheral means, again, the nerves in the upper extremities. Polyneuropathy means there are multiple nerves involved, radial, ulnar, medial nerve.

Q. Based upon the finding on this electrodiagnostic study, Mr. Jakociuk had problems with his nerves on both side of his body, correct?

A. Based upon the study, yes.

Q. And, in fact, several nerves throughout his body, not the just ulnar nerve that you operated on, correct?

A. That's correct.

Q. In fact, Doctor, isn't it true that this study found normal readings with respect to the ulnar nerve that was tested?

A. Normal latency, which is just one aspect of this test.

Q. Doctor, you answered my question. Thank you.

A. You are completely misinterpreting this test.

Q. I am not aware that I am, but I am sure that you will clear that up with Mr. Perecman.

Latency refers to how quickly the signal travels down the nerve, correct?

A. That is correct. That is one aspect of that test.

Q. The test says that at the elbows there were some difficulties or -- not difficulties, excuse me. There is some findings indicative of compression of the ulnar nerve; am I reading that right?

A. That is what it says. There is compression of the ulnar nerve, talking about at the elbows.

Q. That is both nerves, correct?

A. That is correct.

Q. That means that ulnar compression that we have been talking about was present in both Mr. Jakociuk's elbows, correct?

A. Not ulnar nerve compression. The findings of electrical study, which is one study. Certainly you do not do surgery based on the study alone. If I had done that I would have operated on both elbows, both nerves, all three nerves of the hand.

That is ridiculous. When we are talking about medicine, which is not only science, but also the art of medicine. This gentleman had absolute ulnar nerve symptoms on the left. He had wasting muscles on the left, not on the right. He got better from the surgery. Improved from the surgery. The surgery was necessitated by his injury and

appropriate treatment was done.

Q. While we are on the topic of this particular study, also tested were the nerves that come from the cervical spine, correct?

A. The end part of those nerves, yes, that's the ulnar, radial and medial nerve, yes.

Q. That's the needle EMG study?

A. Yes. Again, that is the part of the nerves that come out of the neck and turn into the ulnar and radial nerve that we are speaking about.

Q. If I am reading it right, if I am not I am sure you will correct me, did the needle EMG study of the upper extremity and cervical paraspinal muscles reveal normal motor unit action potential?

A. Yes.

Q. In terms that you might use, does that mean that there were no problems with symptoms running down those nerves?

A. No, it means that what we are calling is the normal motor unit actual potential, motor unit is where the nerve hooks into the muscle. That is where -- what they are testing there, so there is no problem where the nerve hooks into the muscle.

Q. So, I believe EMG tests are used to diagnose cervical radiculopathy?

A. It can be one of the things you can sometimes diagnose with it, yes.

Q. In cervical radiculopathy, is pain shooting down an extremity from the cervical spine; fair to say?

A. Yes.

Q. In this case the finding was normal, correct?

A. The finding was of a polyneuropathy.

Q. I am referring to the EMG study here, Doctor?

A. EMG study is the motor potential was normal. This is a very complex test and you are picking it apart. That is not -- you are picking normals and that is not the way that the test is read. It is read as a whole and in conjunction with the physical exam findings.

Q. Well, as a whole what the test concluded was that distal symmetric peripheral polyneuropathy, which I believe you said earlier does not mean the injury is on the ulnar nerve?

A. There is slowing at the ulnar nerve. The problem with the ulnar nerve -- the problem with the ulnar nerve is the compression that has developed and is symptomatic because of his injury. He has compression on both sides. The other side that he did not injure is not symptomatic.

Q. Well, in any event, on your April 9th 2009 note you seem to disagree with the findings, correct, of that study that we have been talking about?

A. Yes, that is exactly what we have been talking about. I said he had diagnostic studies showing distal symmetric peripheral neuropathy, however his examination, physical exam, when I actually touch and look at the patients inconsistent with ulnar neuropathy and cubital tunnel syndrome.

Q. You disregarded those positions of the study that didn't support your diagnosis; fair to say?

A. Absolutely false and a ridiculous statement, in my opinion. I am sorry to say that.

Q. It wouldn't be the first time someone said to that me?

A. The way medicine is done -- I am not going to try to tell you how to do law. The way medicine is done you take the study and a portion of your diagnosis. Especially with nerve problems, a lot of the diagnosis has to be made clinically. You have to touch the patient, you have to examine the patient and you have to make a decision based upon the physical examination and findings.

There are a lot of times that carpal tunnel surgery which is a nerve compression surgery, ulnar nerve surgery, is done based solely on physical exam findings.

Q. Why did you bother to have a electrodiagnostic study done?

A. Because it can sometimes help pick out where the

neuropathy is coming from, at what level.

Q. Didn't you already in you mind determine it was coming from the ulnar nerve?

A. Certainly I felt it was, sure.

Q. Okay, now on your March 3rd 2008 note you don't make any reference to the neck, back, elbow, correct?

A. That is correct. His main complaint at this time was of increasing pain about his wrist and his thumb base on the left.

Q. Okay.

A. It was still tender in the forearm and numbness and tingling.

Q. The first time you mention positive tinel sign, which you talked about with respect to the ulnar nerve, was about four months after the accident on March 18, 2008 correct?

A. Yes.

Q. So, that is the delayed onset to the tinel sign, Doctor?

A. That is the tinel sign that is occurring as injury scar tissue forms and stuff like that.

Q. You testified that he didn't fracture his elbow, correct?

A. Correct.

Q. And I believe in your operative report there was no

reference to any scar tissue, was there?

A. I don't specifically talk about scar tissue, that is correct.

Q. So if scar tissue is not referenced in your operative report -- this surgery was done when?

A. This surgery was done 07/10/2009.

Q. So where do you base your testimony that there was scar tissue?

A. Because scar tissue was present. I don't use the word scar issue. I use the words that the nerve was dissected free proximally and distally. Nerve branches were protected and that it was freed from scar tissue. That is what we were freeing it from.

Q. Do you say in there as being freed from scar tissue opposed to being free from the tunnel it normally sits in?

A. It doesn't have to be free from the tunnel if it is normal.

Q. Did you use the word scar tissue in there?

A. No, I don't.

Q. Is it referenced anywhere in your notes?

A. Not this note.

Q. Did he break his elbow?

A. No.

Q. Where did the scar tissue come from, Doctor?

A. He had a fall with trauma to the forearm hard

enough to break the bone.

Q. The trauma was here, correct?

A. That is correct.

Q. Scar tissue found is here, that is where you did the surgery, right?

THE COURT: Let the doctor explain.

A. When you fall from a height far enough and hit hard enough to break a bone the whole area is traumatized. It was in a cast for a period of time. Scar tissue occurs over time in traumatized soft issue. It just does. I don't use the words that you would like for me to use, scar issue, but I do indicate that I freed the nerve.

Normally if there is normal nerve you don't have to free the nerve, you just move the nerve. I was there, there is scar tissue there.

Q. Scar tissue was your word, not mine, correct?

A. I am telling you there was scar tissue there.

Q. Now, Doctor, when you first saw him either December 18th or the 20th, and I assume thereafter, did you note any bruising on this part of the elbow?

A. No.

Q. And wouldn't you expect to find that if there was an injury significant enough to result in scarring?

A. Sure you would, eventually, but you would also expect to see if there was a fracture, he didn't have one.

He didn't have bruising there initially.

Q. So he had no bruising, no fractures in the elbow, correct?

A. He had a fracture of the forearm in the radius, which is one of the bones of the elbow. You have three bones, the humorous, the radius and ulnar. He broke his radius.

Q. When we first started I believe you told me the fracture was here, right, one-third distally?

A. One-third proximally.

Q. Down?

A. Do you want to see the x-ray? You can see it on the elbow x-ray. That is how close it is to the elbow. That is how we saw it.

Q. On that day, March 18, 2008, do you make any reference to the neck or the neck and back?

A. I don't believe so.

Q. We already talked about you never referenced radicular findings, radiculopathy?

A. That's correct.

Q. May 1st, 2008, I believe you saw Mr. Jakociuk, correct?

A. Yes, I saw him may 1st, yes.

Q. Now, on this date you do a physical exam and you find positive straight leg raising test, correct?

A. Yes.

Q. That is a test for pain in the back, correct?

A. It is a test for lumbar radiculopathy.

Q. And at that point I thought you said that Dr. Kushnerik was treating his neck and back?

A. I believe he was.

Q. But you continued to treat his neck and back as well?

A. This is a report, this is not a -- this is for purposes of examination, yes.

Q. Understood. Okay.

If you found positive straight leg test that day and another doctor made no mention of it four days later, what does that mean to you?

MR. PERECMAN: Objection, your Honor.

THE COURT: I don't know. Could you answer that or not?

MR. PERECMAN: Are you referring to May 1st? That is not an office note.

THE COURT: All right.

MR. BOULE: I thought you did see him on this day?

THE WITNESS: I did see him on this day, but I can't speak for the other doctor.

THE COURT: I understand, doctor. You can't

speak for the other doctor.

Q. May 20, 2008, you see him again?

A. Yes.

Q. At this point you don't make any reference to the neck or the back or elbow, correct?

A. Again, talking about the injuries to his hand that day.

Q. So the answer is no?

A. That is correct.

Q. July 8, 2008?

A. Correct.

Q. No reference to the neck or the back?

A. That is right. Talking ulnar nerve at that point, seeing Dr. Kushnerik.

Q. Same on August 5th, 2008, no reference to the neck or back?

A. That is right. Again, talking about ulnar neuropathy. Treating with Dr. Kushnerik.

Q. Then when it came time to consider the surgery for the elbow there were some complications, correct?

A. Yes.

Q. Some cardiac complications?

A. Right.

Q. That was due to an abnormal EKG?

A. I believe so.

Q. And he had to be seen by a cardiac specialist for that?

A. Right.

Q. October 21, 2008 no reference to the neck or the back?

A. No. Talking about his treatment. That is around the time that we are trying to get authorization for the elbow surgery.

Q. We can go faster if you say yes or no.

December 2, 2008, no reference to neck or back?

A. If you want to go fast why don't you go through every day at once?

Q. Well, I can do that, then it wouldn't be clear.

December 2nd?

A. December 2nd, again, talking about his ulnar neuropathy, weakness, tingling in the fingers.

Q. January 27, 2009, any reference to neck or back or the shoulder for that matter?

A. Again, at that point we are trying to get him treated for his surgery to his elbow.

Q. You are disregarding the other injuries at that point?

A. As far as my notes go, yes. I wish in an ideal world that I can take notes. I would have a stack of pages for each patient a mile thick. It is just a matter of

practicality. I don't prepare these notes for you. I prepare them for the patient.

Q. The notes, you understand, is all we have to go by here?

A. That is fine with me. You also have my testimony to go by, I suppose.

Q. Correct. Now you are aware that -- maybe you are not aware, that Mr. Jakociuk was assaulted in February of 2009?

A. Yes.

Q. And he was seen at Maimonides Medical Center on this day?

A. Yes.

Q. And they reference normal range of motion in all joints?

A. Okay.

Q. Do you recollect that?

A. I don't believe I have seen those records, but I would disagree with that. That is an emergency room visit, not a frequent visit, but I can't speak to what the doctors write.

MR. BOULE: Your Honor, I am going to offer into evidence certified copies of the Maimonides medical record that we discussed yesterday.

MR. PERECMAN: Objection, your Honor.

THE COURT: I will allow it subject to redaction as Defendant's Exhibit B.

(Received and marked Defendant's Exhibit B in evidence)

Go ahead, counsel.

Q. Can you turn to Page 3?

A. Yes.

Q. At the bottom of the examination?

A. Yes.

Q. There where is it says, "neck", could you read what that says there?

A. Sure, it says, "supple; non-tender to palpation without stepoff or deformity; no cervical lymphadenopathy".

Q. That would indicate that they did not find spasms at that time?

A. It says nothing about spasm.

Q. What does non-tender to palpation mean?

A. That means it doesn't hurt when they push on it.

Q. So, is that evidence of no pain then, correct?

A. When they push on it. It doesn't say he doesn't have pain. It also says has no bleeding from his nose and that is the reason he is in the hospital.

Q. I am not here to talk about the nose, but thank you.

A. I am telling you this emergency room record is an

emergency room record.

Q. Bottom of that page it says "EXT", which refers to extremities, what does that say?

A. It says, extremities, it says, "normal range of motion in all four extremities, no clubbing, cyanosis or edema. Non-tender to palpation. Distal pulses intact".

Q. All four extremities means the arms and the legs, correct?

A. That is what we are talking about, yes.

Q. Range of motion means moving them about in their normal range?

A. That is what is noted here, yes.

Q. You have not seen that before?

A. No.

Q. June 17, 2009, could you turn that note of yours, Doctor?

A. Yes.

Q. And here they mention the left shoulder, I believe?

A. Yes.

Q. And this would be the first mention of the left shoulder since that May 1st, 2008 report that we talked about, correct?

A. In my notes, yes.

Q. No reference to the back and neck noted there?

A. No. He is seeing Dr. Kushnerik for neck and back.

Q. Understood. Thank you.

Q. Now August 13th, 2009, you have that note?

A. Okay.

Q. At that point he is still seeing Dr. Kushnerik, correct?

A. Yes, correct.

Q. Now, you did start talking about the back, right?

A. Mainly talking about the tenderness in the elbow, tinels. I note continued tenderness and tightness at lumbar spine, yes. He was clearly complaining about it significantly that day to me.

Q. At that time it warranted putting it in you notes, correct?

A. I think you are reading too much into it. Again, I would like to be able to put everything in every note, but he was clearly focused on it that day. Even with me, even though I am not the major treating doctor at that time.

Q. Fair to say that you haven't referenced anything about that lower back since that May 1, 2008 report that we talked about?

A. There are intermittent notes about tenderness in the back and things, but certainly they are not the focus of my treatment.

Q. September 29, 2009, this would be after your surgery?

A. Yes, it would be.

Q. And you report excellent, return sensation in the small and ring finger?

A. That's correct.

Q. No reference to the shoulder then?

A. Correct.

Q. But on November 18, 2009, you start talking about other body parts, the neck, the back, the left shoulder, the rotator cuff?

A. Yes, these are all things that he had injured. I am making a summary of things.

Q. But most --

A. I am not treating those things, Kushnerik is. We talked about recommending the spinal cord stimulator on this day. Just making a summary.

Q. Left shoulder was something that you had concerned yourself with?

A. Yes, he complained about shoulder injury pain.

Q. And this would be the first reference, according to my review, of the shoulder since June 17 about five months before?

A. Okay.

Q. By the way, did your office send the plaintiff to be examined by a Dr. Paul Brisson?

A. I don't recall if we sent him or Dr. Kushnerik sent

him.

Q. If his records indicate that he was referred by Dr. Boppana, would that be your office?

A. Dr. Boppana worked in our office, yes.

Q. And Dr. Brisson is a spinal specialist, correct?

A. Yes.

Q. So your office referred him for examination and treatment of the spine?

A. Dr. Boppana did, yes.

Q. Okay, do you have anything to do with Dr. Boppana or does he do his own thing?

A. He is an independent doctor.

Q. Do you ever consult on the patients that you share?

A. Not at this time.

Q. Back in 2010 did you?

A. We may have, yes.

Q. Did Dr. Boppana come to you and tell you he was sending Mr. Jakociuk to Dr. Brisson?

A. No.

Q. Would that be unusual seeing how Mr. Jakociuk was under the care of yourself and Dr. Kushnerik?

A. No, Dr. Brisson is a spinal surgeon. If another doctor felt that he should be evaluated for surgery because his injuries were significant enough that they needed an evaluation for surgery, That is something, a decision, he

would make in my opinion. Dr. Kushnerik was treating him appropriately.

Q. Is Dr. Brisson someone that you have ever referred patients to in the past?

A. I have, yes.

Q. Now, did you ever see Dr. Brisson's notes related to his findings?

A. I don't recall specifically, but I may have. I don't have those notes if my file.

MR. BOULE: Your Honor, I will offer into evidence the certified copy of the record of Dr. Paul Brisson.

THE COURT: Show them to counsel, please.

Any objection?

MR. PERECMAN: One second, Judge. No objection, Judge.

THE COURT: Dr. Brisson's records are in evidence without objection as Defendant's Exhibit C. Mark it, please.

(Received and marked Defendant's Exhibit C in evidence)

Q. Can you turn right to the January 13, 2010 note at Page 2?

A. Okay.

Q. You did a physical examination of Mr. Jakociuk on

this day?

A. Okay.

Q. And you found that the upper extremity strength testing was equal and in tact bilaterally?

A. Yes.

Q. What does that mean, what is the significance of that?

A. That means that both arms had the same strength and that he had graded the strength grossly as normal.

Q. A he also found, did he not, that in sensation testing of both arms did not reveal any numbness; do you see that?

A. Yes.

Q. And he found that he had a negative Hoffman sign?

A. Okay.

Q. And that is a sign to test for damage to the spinal cord?

A. It is very specific sign for death of the spinal cord. It is more than just random damage to the spinal cord.

Q. He found negative spurling sign?

A. That is right.

Q. That is one of the tests for cervical radiculopathy?

A. Yes.

Q. Those findings are somewhat different than the findings that you made?

A. No.

Q. Did you not find that there was weakness in the plaintiff's left arm or was I mistaken when I heard that?

A. Are you talking about before surgery?

Q. Yes.

A. Yes, this is after the surgery.

Q. So surgery took care of that?

A. Surgery got the ulnar nerve working again, that's right.

Q. You found generally that after the spinal cord stimulator was implanted that Mr. Jakociuk's symptoms improved?

A. Spinal cord, yes. He had got some improvement in back pain, yes.

Q. And his range of motion improved?

A. Range of motion of his back.

Q. In his neck?

A. His neck, no. I don't think it improved his range of motion. He still had sharp shooting pain in his neck with quick motion.

Q. If he testified yesterday that the range of motion in his neck was improved, he would have been wrong?

A. I didn't say that, did I? You asked me if I felt

his range of motion improved. I don't feel like it is improved. It may be less painful, but I don't think it improved.

Q. If he testified that it did --

THE COURT: I will sustain the objection.

A. It is his position.

Q. It is his next right, but his opinion --

THE COURT: Let's not argue with each other. Let's get this done.

MR. BOULE: Okay, Doctor, thank you very much for your time.

THE COURT: Counsel?

REDIRECT EXAMINATION

BY MR. PERECMAN:

Q. Doctor, you said when you examined Mr. Jakociuk early on that you found crepitus in his elbow, what was the medical significance of that?

A. Crepitus is an abnormal finding. It is popping and clicking in the joint. It usually goes along with formation of scar tissue or irregularity on the surface indicating an injury.

Q. Doctor, is there any one group of symptoms and way in which a doctor will hear from patients their symptoms are when there are injuries to their spinal cord, like their neck, like this one?

MR. BOULE: Objection.

Q. Are they always the same?

THE COURT: What is the question, counsel? I am going to sustain the objection. I don't understand.

Q. When a person with an injury like Mr. Jakociuk had and it involves their neck, do all people experience the same symptoms over the same periods of time in the exact same way?

MR. BOULE: Objection.

THE COURT: I will allow it.

A. The answer is the neck is a complex system and as I showed you there, involves bones, discs, ligaments, nerves. Some people have more neck pain than arm pain. Some people have more arm pain than neck pain. Some people's pain comes on later than in other's. Some people's comes on earlier than others.

So no, that what I was talking about there, there is an art and a science to medicine. Not all tests are going to be exactly as you would say they would be in textbook. You have to examine the patient, touch the patient and you have to corollate that with findings.

Q. How many times have you treated someone where you either clinically or through MRI evidence, CT scans or both, after an accident, somewhere along the way after an accident, diagnosed a herniated disc in their neck?

MR. BOULE: Objection.

THE COURT: I will sustain that.

Q. Doctor, if a person herniates a disc in their neck as a result of an accident, do they necessarily feel acute pain immediately?

MR. BOULE: Objection.

THE COURT: I will allow it.

A. No. It is well known that a herniated disc often does not cause an immediate pain. There is usually pain in the neck, but the symptoms associated with herniated discs can be things like pain radiating down the arm, stiffness. Things like that can come on later, that is well known.

Q. Well, now, when you first saw Mr. Jakociuk he had a broken arm, correct?

A. Yes.

Q. Was that causing an acute amount of pain?

MR. BOULE: Objection.

THE COURT: Can it cause an acute amount of pain?

THE WITNESS: Yes.

Q. Now, you were being asked some questions about latency on EMG and you said there was another aspect, do you care to explain what the other aspect was?

A. The other aspect is you have to take that test as simply one test in a number of pieces of evidence. This

gentleman clearly had cubital tunnel syndrome, ulnar neuropathy pressure on the nerve. This test showed compression at the elbow. It actually showed it on both sides.

Clinically, in the course of examining him it was clear that he was having symptoms on the left side where he had the fracture of the arm, where he had injury to the arm and not on the right. He was having weakness, wasting of his muscles and the surgery was done in the appropriate fashion.

Surgery actually relieved a number of his symptoms. He got his sensation back, so the EMG test is not the end all and be all in diagnosing this injury.

Q. And this spurling test for cervical radiculopathy, is that the only test for cervical radiculopathy?

A. No, the spurling test is a test where you tilt the head back in an attempt to push the herniated disc into the nerve to see if it causes symptoms. If there is enough scar tissue, if there is not a lot of inflammation, a lot of times that would be negative if there is a herniated disc.

Q. Doctor, over the years when you have seen Mr. Jakociuk and when you first saw him, did he ever tell you anything or did you ever learn from all the tests that were done and all the doctors that he saw that he ever saw another physician prior to the date of this accident or any

physician for any problems in his neck?

A. No, none that I am aware of.

MR. PERECMAN: Nothing further.

THE COURT: Anything, counsel?

MR. BOULE: No, you Honor.

THE COURT: Thank you, Doctor. You can step down, please.

All right, ladies and gentlemen. We are going to recess for the evening. I am going to ask you to return to Court tomorrow promptly 9:30.

Remember my admonitions. Don't discuss this case with anybody and don't let anybody discuss this case with you.

MR. PERECMAN: Can we approach the bench for a minute, please

(Off-the-record discussion held at the bench)

Ladies and gentlemen, we have to have a brief recess. Don't discuss the case.

(RECESS TAKEN)

THE COURT: Ladies and gentlemen, you can be seated. Listen I have news for you and some of you may consider it good news. Some of you may consider it bad news. In any event, because of the scheduling of the next doctor, set of doctors, we are not going to be able to have a session on this case until next Monday. So we

are going to have a long recess.

So, I am going to apologize for the delay. I really didn't expect this, but sometimes these things do happen.

There is a holiday intervening, so I want to wish you all a very pleasant holiday and remember all my admonitions. Don't discuss this case with anybody. Don't let anybody discuss this case with you or don't form any opinions yet because you haven't heard the entire case.

Make sure you are back here Monday morning at 9:30 and we will resume taking testimony.

Have a pleasant week and a pleasant weekend.

COURT OFFICER: All rise as the jury exits the courtroom

(At this time, the jury left the courtroom)

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CERTIFIED TO BE A TRUE AND ACCURATE TRANSCRIPT OF THE MINUTES TAKEN IN THE ABOVE-CAPTIONED PROCEEDING.

JEANMARIE EPISCOPIA
SENIOR COURT REPORTER