COPY

UNITED STATES DISTRICT COURT
EASTERN DISTRICT
Index No. 11 CV 4671

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ALEJANDRO AGUILAR and ROSA ESPINAL

Plaintiffs,

- against-

TARGET CORPORATION d/b/a TARGET STORES, INC.,

Defendant.
----------x

15 Jericho Turnpike
Jericho, New York

October 23, 2012
9:15 a.m.

EXAMINATION BEFORE TRIAL

of a non-party witness, ALI E. GUY, MD, taken by the Defendant, pursuant to Subpoena, and held at the above-mentioned time and place, before Deirdre Randles, a Stenographer and Notary Public within and for the State of New York.

A P P E A R A N C E S

STEVEN WILDSTEIN, ESQ.
Attorney for Plaintiffs
98 Cutter Mill Road
Suite 335 South
Syosset, NY 11791

SIMMONS JANNACE, LLP
Attorneys for Defendant
115 Eileen Way
Syosset, NY 11791
BY: STEVEN JANNACE, ESQ.

S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and between the attorneys for the respective parties herein that this examination may be sworn to before any Notary Public.

IT IS FURTHER STIPULATED AND AGREED that the filing and certification of the said examination shall be waived.

IT IS FURTHER STIPULATED AND AGREED that all objections to questions, except as to the form of the question, shall be reserved for the time of trial.

A L I E. G U Y, M D,
called as a witness, having first been duly sworn by the Notary Public, was examined and testified as follows:
BY THE REPORTER:
Q. Please state your name for the record.
A. Dr. Eli E. Guy.
Q. Please state your address for the record.
A. 15 Jericho Turnpike, Jericho, New York 11753.

EXAMINATION BY MR. JANNACE:
Q. Good morning, Doctor. My name is Steve Jannace. I represent Target in a lawsuit brought by Mr. Aguilar and his wife.
I'm going to be asking you some questions this morning. If, at any time, you don't hear me or don't understand the question, please ask me to rephrase or repeat it and I will do so.
A. Okay.
Q. Can you give me, briefly, your CV?

A. I can give you a copy of it.

MR. Jannace: I'll take that, it will be much easier.

Q. What is your board certification?

A. I'm board certified in physical medicine and rehabilitation.

Q. How do you keep current with changes in medicine in your specialty?

A. I attend lectures, seminars. I read different journals, and I talk to colleagues. I teach at NYU School of Medicine. We attend regular journal clubs. We attend grand rounds. We attend annual meetings, et cetera.

Q. Would one of the journals you read be the Archives of Physical Medicine and Rehabilitation?

A. Let me advise you, it's not authoritative. I read it.

Q. What do you find authoritative?

A. None. The only authoritative thing is the word of all mighty God.

These books and journals only have the opinions of the authors, and different authors have different opinions, and the

opinion keeps changing, from time to time.

That is why it's a guide, it is not authoritative.

Q. What are some of the other periodicals you read to keep current and subscribe to?

A. What I read is Pain Journal, Pain News. I read the American Journal of Pain Medicine, Pain Management. And, also, the Archives of Physical Medicine and Rehabilitation, and the AMA News.

Q. Thank you.

MR. JANNACE: Can we have this marked as Exhibit A.

(Whereupon, the above mentioned document was marked Defendant's Exhibit A, for identification.)

Q. Your CV, we had marked Defendant's Exhibit A.

Is this up to date?

A. Let me take one quick last look at it. Yes. One more special membership I'll put down, New York State Pain Society. It is current and up to date.

Q. Doctor, the office where we're in

right now, in Jericho, is this your only office?

A. No.

Q. What other offices do you have?

A. I have an office 7 Gramercy Park, Manhattan. I have an office 111-20 Queens Boulevard, Forest Hills. And at Med Alliance. That's not my office. I'm an employee there. It's not my office. I work there, 625 East Fordham Road, Bronx, New York 10458.

Q. Can you explain to me how much time you spend, or what time you spend in each office and how it is broken down?

A. It varies. This office, I spend about two to two and-a-half days a week.

In the Bronx office, I spend two half days a week, one full day.

Manhattan, I spend two half days, one full day, which is Saturday. I work Saturdays, also.

And in the office in Queens, one day a week. Half a day a week, actually.

Q. Med Alliance, you said you're an employee. Tell me exactly what is your

relationship as an employee?

A. I think we all know what an employee is. I'm an employee of Med Alliance. I get paid by the hour, depending on how many hours I work.

Q. That's specifically in that facility?

A. That is correct, yes.

Q. That's the one in the Bronx?

A. That is correct.

Q. How long have you been an employee of Med Alliance?

A. Since 2006.

Q. Do you have any other affiliation with Med Alliance, other than an employee, as a principal?

A. No.

Q. In addition to your medical practice, do you assist in helping attorneys with lawsuits, either through testimony or reviewing records and providing reports?

MR. WILDSTEIN: Objection.

A. Exactly.

MR. WILDSTEIN: To form.

A. The way you phrased the question

is completely inappropriate.

Q. Doctor, do you ever testify in court, in lawsuits?

A. There's a big difference between testifying in court and the way you phrased it, assisting attorneys.

I don't assist anybody. I do testify in court when it comes, when I'm asked to do so, because I'm required by OPMC rules and regulations to testify in court, when I'm asked to do so as part of my medical duties.

Yes, I do testify in court. On the average, I testify eight to ten times per year. That's between all my offices, including my hospital practice, which constitute less than one percent of all the patients I treat.

Q. Do you testify in eight to ten times a year, exclusively for plaintiffs and patients?

A. My patients, yes.

Q. Do you ever testify on behalf of defendants?

A. I have.

Q. When was the last time you testified for a defendant?

A. It was a long time ago.

Q. How long?

A. I can't tell you. Many years ago.

Q. More than ten?

A. Could be about ten, plus or minus.

Q. Other than testifying eight to ten times a year, do you also review records and provide reports to attorneys?

A. When asked to do so, I do, yes.

Q. Approximately how many times a year do you do that?

A. I cannot tell you. It's a very small percentage of my practice. I cannot tell you exactly.

Q. Would it be more than the eight to ten times that you testify?

A. It would be more than eight to ten times per year.

Q. Would it be more than twenty times?

A. It could be more than twenty or it

could be less than twenty. I'd be guessing. That's a guess.

Q. For the review of the reports you provide, do you ever do that for defendants?

A. I have.

Q. When was the last time you did that for a defendant?

A. Over five years ago.

Q. What is your typical fee for testifying in court?

A. My fee's four thousand for half a day, one thousand for pretrial preparation.

Q. As far as reviewing records and providing a report?

A. It depends. If it's just the average report, five hundred. If I treated the patient, there's no fee.

Q. In this case of Mr. Aguilar, he is a patient of yours; correct?

A. Yes.

Q. Have you spoken to plaintiffs' counsel with regard to this case?

A. About coming for this deposition only. I've never met this gentleman before in my life. This is the first time I'm

meeting him.

Q. When did you speak to Mr. Wildstein?

MR. WILDSTEIN: Objection.

A. I don't know that I spoke with him.

Q. Or his office?

MR. WILDSTEIN: About what?

MR. JANNACE: About coming here today.

A. I don't believe I spoke.

MR. WILDSTEIN: About anything, quite frankly.

A. I didn't speak to anybody. My office manager, Navida, spoke about the meeting first. I thought, I was surprised, because I don't think anybody is going to want to ask me to do a report or come to court to testify, that's why I'm surprised at this deposition. Because, nobody has any intentions of calling me or asking me.

MR. WILDSTEIN: Objection.

Please just answer the question.

A. Okay.

Q. Doctor, please continue, what is

your rationale for that? Please explain what you were just saying.

A. Do I continue or don't I continue?

Q. Yes, you continue.

A. As I was saying, I don't think anybody had any intentions of calling me or asking me for a report. That's why I'm surprised at this deposition.

Q. Why do you believe that?

A. I had my office manager call Mr. Wildstein's office and say what is this all about. It's a Federal deposition, you have to be present you have to respond.

I said do you guys have any intentions of calling me or asking me for a report? They said no. I said why am I being called? I was told we don't know, but you have to respond.

Then, your office sent me another telephone call, no no, we don't need you, we just need Dr. Erlich, because you didn't do anything.

Then you called my office back and said no, no, we need you again. It was on

off, on, off.

Q. Doctor, do you have your chart for Mr. Aguilar in front of you?

A. I do.

Q. May I see it?

A. Sure.

Q. Is this the entire chart for Mr. Aguilar?

A. Yes.

Q. Other than what's here in paper form, Doctor, do you have access to any other medical records of Mr. Aguilar, via computer system?

A. Med Alliance is a paperless facility, it's an Article 28 facility, and these are just my records.

I'm sure there's other records from other practitioners, such as the physical therapist, Dr. Erlich, so on and so forth. These are just my records.

Q. As far as other doctor's records, whether they be from Med Alliance or not, do you keep copies of them regarding your patients?

A. It's in the computer.

Q. That would be only Med Alliance records, or other doctors records, as well?

A. This is all that I have in my possession.

Q. As far as on the computer?

A. That's right.

Q. This is all you have access to?

A. This is the only thing I have access to, in terms of medical records.

Again, if there's any records that are specific to Dr. Erlich, to the physical therapist, I don't have them.

I could go on line and look at them, when I'm at Med Alliance, but not from here.

Q. Have you ever seen Mr. Aguilar at this office?

A. No, never. He's only been seen in the Med Alliance office.

MR. JANNACE: Can we get this marked.

(Whereupon, the above mentioned document was marked Defendant's Exhibit B, for identification.)

MR. JANNACE: I'll count the

pages.

Check me on this, it's twenty-seven pages, and they begin with a record of September 20, 2010, and end with a record from Dr. Guy. I believe it's dated March 8th, 2011. And an operative report dated August 4th, 2011.

Q. Is that correct, Doctor?

A. That is correct, yes.

Q. Doctor, did you review those records before this morning?

A. Yes.

Q. Referring to your records, does it indicate anywhere who referred the plaintiff to you?

A. No.

Q. Was he, in fact, referred to you or Med Alliance?

A. Med Alliance, not to me.

Q. If you can take a look at your first record there, Doctor?

A. Okay.

Q. Did you take a history from the plaintiff, Mr. Aguilar, on that first visit?

A. Yes.

Q. What was the history?

A. Patient was 37 years of age, Hispanic male, he was well until September 4th, 2010 when he went to Target, had a slip and fall on a grape. He went to Albert Einstein Hospital where he was treated and released.

When he came to see me the first time, he complained of neck pain, no radiation, complained of lower back pain without any radiation, numbness, or tingling. Complained of pain in his left knee. He denied any prior history of any trauma to the other areas. He was taking Motrin with for pain, with some relief.

He was unable to work since the day of the accident. The pain was affecting his sleep, and he no complaints of headaches, bowel, or bladder disturbance.

Q. This was the history based on what he told you?

A. That's right.

Q. Did you have an opportunity, at that time, to review the Albert Einstein

Hospital record or the emergency room record?

A. No.

Q. Have you ever reviewed the Albert Einstein or Jacobi Medical Center Record?

A. I have not.

Q. Did he indicate to you whether x-rays were taken?

A. I have no indications whether they were taken or not.

Q. So, as far as even after today, you have no information concerning whether x-rays were ever taken of Mr. Aguilar, is that fair to say?

A. Just give me a second.

Q. Take your time, Doctor.

A. X-rays, no.

Q. As far as how the accident occurred, again, he told you that; correct?

A. That's correct.

Q. Did you ever have a chance to look at the incident report?

A. No.

Q. As far as whether he can work, again, that's something he told you?

A. That is correct.

Q. Did he tell you what he does for a living?

A. No.

Q. As you sit here today, are you aware of what he does for a living?

A. I do not know, no.

Q. Do you have any information in your records, or from personal knowledge, as to his level of education, his skill, his training, anything of that nature?

A. No. He's a laborer, he's not -- he's a blue color worker, he's not a white color worker.

Q. Do you have any information concerning his education or specifically what he does?

A. No, I do not.

Q. Doctor, you mentioned in your history, I think you started with the back, then the knee.

Is there any significance to the order that you wrote that in?

A. Head to toe.

Q. On the review of medical records,

it indicates Med Alliance patient chart.

When you first saw Mr. Aguilar, was there any other record that existed at Med Alliance, or were you the first person at Med Alliance to see him?

A. I don't know if I was the first or Dr. Erlich was the first. I'm not sure.

Q. What did your physical examination show?

A. The neck showed guarding throughout the examination.

Q. Let me ask you, what does that mean?

A. The patient holds himself in a reflex protective posture. I'm showing on my body, like this, they're afraid to be touched (indicating).

Q. Is that something that can be feigned?

A. Guarding can be feigned, but when you put it all together, then the answer is no.

In itself, can it? Yes, it can be.

Q. Please continue.

A. There were multiple trigger points present. Trigger points, muscle scarring. Scarring is muscle fibrosis typically caused by trauma.

Diffuse spasm. There was tenderness. Range of motion for flexion was normal. Extension was sixty degrees out of eighty. Lateral bending was thirty degrees out of forty-five. Right and left lateral direction.

The back showed diffuse tenderness, diffuse spasm, normal gate.

There were multiple trigger points present. Forward flexion was sixty out of ninety. The rest of the range of motion was essentially normal.

Straight leg raising was seventy-five out of ninety. Sensation was normal. Reflexes were normal.

Left knee showed tenderness over the medial joint line. There was a positive McMurray's test. McMurray is indicative of a torn meniscus.

Muscle strength of the left knee four plus over five. Normal, it's five over

five. Five, four plus over five. It was two grades weaker than normal, and the rest of the exam was unremarkable.

Q. As far as the cervical strength of five slash five, that would be normal?

A. That is normal.

Q. Lumbar strength of five over five is also normal?

A. That is normal.

Q. You did seated straight leg raising, Doctor.

Is there a reason you did seated as opposed to lying down?

A. You can do it both ways.

Q. Isn't seated less sensitive than lying down, as far as straight leg raising test?

A. Both ways is okay. Lying down is a little bit better. They're both fine.

Q. Is there a reason why you only did seated, as opposed to lying down, or both?

A. No.

Q. Would that be considered an invasive procedure?

A. Invasive?

Q. Yes.

A. No, it's not an invasive procedure.

Q. Did you note any crepitus in the knee?

A. Not on the first visit, no.

Q. Any buckling?

A. Well, buckling in the way you phrase it, no.

McMurray's test is a form of internal buckling, because it indicates that the meniscus is torn. It protrudes out, when you put the patient through inversion and aversion of the foot and the ankle.

MR. JANNACE: Move to strike as not responsive.

Q. Doctor, do you note that the patient ambulates with normal gate?

A. That's right.

Q. Is that something he told you, as well?

A. No. That's something that was observed.

Q. Now, what was your diagnosis?

A. On initial visit, multiple

traumatic injuries, cervical sprain and strain, lumbar sprain and strain.

Rule out cervical and lumbar disc bulge versus herniation.

Internal derangement of the left knee and traumatic myofascial pain syndrome.

Q. What was your plan?

A. Get MRIs of the neck, back, left knee.

Q. Why did you want MRIs of the neck and back?

A. To see if there's any bulge or herniation.

MRI of the left knee to see if there's any torn meniscus.

Q. In your record, you indicate that you wanted MRIs of the lumbar spine and cervical spine to find the source of the patient's radicular complaints; is that correct?

A. To basically find if there is a disc bulge or herniation.

Q. Is that what you meant by the source of patient's radicular complaints?

A. If you go to plan eight, second line, it tells you MRI of the lumbar spine and cervical spine have been requested to rule out disc bulge versus herniations, and then it goes on to mention radicular complaints.

That's a typical format that we have on the computer. It's generated as part of what an MRI is, why it's being ordered.

On the first visit, there were no radicular complaints.

Q. It's just simply something that's billed out by the computer?

A. By the computer, as part of an MRI medical necessity, yes.

Q. It also mentions in your plan that you discussed with the patient, and all of their questions related to diagnosis and treatment were discussed.

A. Correct.

Q. When you say their, was there more than one person?

A. No. Patient.

Q. What did you discuss with this

particular patient, Mr. Aguilar?

A. The fact that he may have a torn meniscus. The fact that he may have a disc bulge, herniation in his neck and the back, and the way to diagnosis it accurately is by way of an MRI.

Due to his insurance, we have to request authorization. We just can't go ahead and refer him.

Q. What insurance does he have?

A. I don't know.

Q. What questions did he have, or is that, again, something that comes from the computer?

A. The basic questions, you know, what's wrong with me, what are you going to do for me.

We put him on some pain medications, Naprelan, an anti spasmotic medication, and that we're going to do some physical therapy and see if he does improve.

If he doesn't improve, we'll give him trigger point injections, maybe epidural injections if the MRI showed disc pathology.

Q. You said Naprelan. Did you prescribe anything else for him?

A. Naprelan and Flexeril. That's a mistake. It should be Flexeril not Flex-a-min. Flexeril.

Q. Doctor, part of your diagnosis is to rule out traumatic injuries, post traumatic injuries, and so forth.

How do you determine, in treating a patient, whether an injury is due to trauma or to a degenerative condition?

A. We put the whole picture together, take a good history, ask if there's any prior or past medical records or any prior history of any prior injuries to the areas of the left knee flexion and back. In this case, there was not.

You do the MRI, and if there's radicular complaints, you do an EMG. An EMG can tell you if the injury is old or no polyphasic injuries.

If there are polyphasic injuries, it indicates the injury is more than nine to twelve months old. And when you do the MRI, you look to see if there's any ostephytes

around the disc bulges, herniations.

If there's a lot of osteophytes, only at that level of the disc herniation, then you could argue that maybe this is old and preexisting and made worse by this accident.

Q. What is an osteophyte?

A. A bony spicular.

Q. Is an osteophyte something you typically find with arthritis?

A. You can.

Q. Is an osteophyte you would only find in the vertebra, or any bone?

A. You can find it in any joint.

Q. Would the same rationale apply for any joint, if there's a bone spur or osteophyte?

A. It depends. For example, if, let's say if you have an MRI that shows you a C-5/C-6 disc herniation, there's a lot of ostephytes, only, only at that level, not anywhere else, then you can argue that disc herniation is probably old and preexisting, made worse by this accident.

If there's ostephytes all over the

spine, you cannot use that same argument. That's why I said it depends on the full picture.

Q. Again, Doctor, as far as the full picture, you went over a lot of things, if you can lay them out for me.

What are the most significant things you want to look at?

If you want to look at the patient, it was imperative you determine whether the source of the injury was traumatic or degenerative and vice-versa, in order of points, what would you look at, if we can break it down between neck and back as one element, and the knee as the second?

A. The first is the history. The fact that there was no prior injuries to those areas. Then you conduct your physical examination.

If there's spasm and trigger points, that indicates a recent traumatic event.

If there is no spasm or trigger points to the neck and the back, then just maybe there might not be a recent injury and

then you go and look at the diagnostic testing, which is MRIs and if EMGs are performed. Then you put it all together.

Q. Can you have spasm that occurs episodically and then dissipates over time, in someone with some kind of back injury, whether it's a herniated disc protrusion of some sort?

MR. WILDSTEIN: Note my objection to form. Can? Hypothetical.

A. Again, can, hypothetically? Anything can be hypothetical in the medical field.

So, the way you phrased your question, yes, it can, hypothetically. It doesn't mean that it happened in this case.

Can, hypothetically? Yes, it is possible.

Q. Does spasm, in your treatment of patients, typically resolve on its own?

A. They can resolve, yes. They can come back.

Q. If someone has spasm in their back or in their neck, and they have an underlying herniation, without treatment of

that herniation, can that spasm resolve on its own, over time?

MR. WILDSTEIN: Objection. Note my objection to not being specific to this patient, but a general hypothetical question.

A. In general, hypothetically, can it? Yes, it can. It can dissipate on its own.

Q. Doctor, when it dissipates, is it something if the underlying herniation isn't resolved, could it reoccur, a spasm that is?

MR. WILDSTEIN: Objection.

MR. JANNACE: We can just note it.

MR. WILDSTEIN: I want it for the record.

MR. JANNACE: The record, it's Federal Court, there can't be speaking objections other than simply objection as to form is fine, or whatever.

MR. WILDSTEIN: Objection. You're asking a general hypothetical again, not about this patient.

MR. JANNACE: I'll accept that,

that it was a hypothetical that I was asking?

A. I'm sorry, I forget your question.

Q. If you have a patient, as counsel said, this is hypothetical not related exclusively to Mr. Aguilar, if you had a patient that had an underlying herniation or disc bulge and had spasm that resolved on its own, at some point, if you don't treat the herniation or protrusion, could that spasm return?

A. Okay, it cannot be answered with a yes or no. That can be answered with a detailed explanation. If you want, I can give you a detailed explanation.

Q. Please do.

A. It's a very, very difficult question the way you phrase it. Once you have a patient with a disc herniation, the spasm can increase, can decrease, can come back.

Usually, what it does is, it increases, decreases, and comes back depending what is done for the patient for

that spasm.

After taking physical therapy, anti spasmotic medications, analgesics, any types of injections, of course the spasm will decrease.

But when you have a disc herniation, you have a ruptured disc, there's chemicals inside the disc, they constantly and continue to leak out, and they continuously irritate the surrounding structures. That's the muscles, the tendons, and the ligaments.

So the spasm keeps on reoccurring. So it can come and go. That's the best way I can answer that question.

Q. Fair enough, Doctor. I want to see if I understand.

It can come and go, which means there could be periods where you would have no spasm, and then subsequently, a spasm can return; is that correct?

A. There could be some rare periods where there will be no spasm. Generally, there's always some spasm. Generally. If you have a disc herniation.

Q. How about a disc bulge?

A. A disc bulge, then it is possible. You can have spasm and it's possible you can have no spasm.

Q. With this patient, Mr. Aguilar, did he ever have the MRIs of his neck or back?

A. No to my knowledge, to his neck and back, no.

Q. I think we started, Doctor, I asked you subsequent questions, as to the importance of the elements you look at to determine the difference between trauma and degenerative, and you talked about the history and you talked about spasm.

What else?

A. Well, the history, very, very important.

As part of the his history, the fact that there was no prior accidents or injuries to those body parts, and then your physical examination. You look for spasm, tenderness, trigger points, range of motion, deficits. If you examine the knee, to see if there's any joint line tenderness, that

could be indicative of a torn structure.

You check for McMurray's. If you have a McMurray's, that's indicative of a torn meniscus.

Q. As far as McMurray's, or your physical examination determining a torn structure in the knee, can you have a torn structure in the knee that is degenerative?

A. Can you have a --

MR. WILDSTEIN: Objection. Again.

MR. JANNACE: Hypothetically.

MR. WILDSTEIN: It's a hypothetical. You didn't phrase it.

MR. JANNACE: I will only refer to Mr. Aguilar specifically.

If I refer to Mr. Aguilar, I will say, specifically. Otherwise, I'm asking general questions.

MR. WILDSTEIN: Objection for the reason you just stated, it's not specific to Mr. Aguilar.

Q. As a general question?

A. As a general question, can you have a torn meniscus that's degenerative?

Is it possible? Yes, you can, it's possible.

Q. Typically, Doctor, a posterior meniscal tear is more likely to be degenerative; isn't that correct?

A. No. You can have it both ways. It can be traumatic. It can also be degenerative. Both ways is possible.

Q. Most of the degenerative findings of torn posterior meniscal tears are degenerative?

A. It depends on how it is torn. If it's a complete tear, it's traumatic. If it's fraying, partial tears, that could be both traumatic and/or degenerative.

Q. In this case, did you look at the MRI for Mr. Aguilar, for his knee?

A. Did I look at the actual MRI? I did not.

Q. Do you have the MRI report?

A. No.

MR. WILDSTEIN: Could you read back the question.

(Whereupon, at this time, the requested portion of testimony was read

by the Reporter.)

Q. Doctor, would you expect to find swelling if a patient, in the knee, a patient had a traumatic as opposed to a degenerative meniscus tear in the posterior?

A. You can have swelling. You can also have absence of swelling and still have a traumatic meniscal scale tear.

Then, one of the other things, you asked me earlier, how do you know it's traumatic, you look at the whole picture.

One of the other things you look at is the operative report, which is much more accurate than the MRI findings.

Q. Is there anything in the operative report that leads you to believe this is caused by traumatic as opposed to degenerative?

A. Yes. There was a lot of reactive hypertrophic incarcerating synovitis. That means there's a lot of inflammation to the synovium.

The synovium is the membrane that covers the knee, and if there's a lot of synovitis, that is usually indicative of a

lot of inflammation.

You take the history as to how it was caused, and you go to the history, and it came from the traumatic fall injury.

Q. Again, that's the history provided solely by Mr. Aguilar?

A. Yes. History comes from the patient.

Q. As far as whether he had prior incidents of knee problems or treatment, if he doesn't tell you about it, you wouldn't know?

A. That is correct.

Q. As far as the operative report, what is the difference between a complex tear and some other type of tear of the meniscus?

A. We all know what complex means. Complex means it's a complicated tear, as opposed to a simple tear.

Q. Wouldn't you expect a complex tear to be more likely to be a result of degenerative changes, as opposed to a trauma?

A. No. You can have it from both and

degenerative, both ways is possible.

Q. What are loose condyle flaps?

A. The chondral is right at the joint line, the lateral tibial plateau. There's a joint line there, and that is the surface of that joint line. It is torn.

Q. What are these flaps?

A. It's typically traumatic in nature, especially in a 38 year old male.

If this patient was a sixty year old male, we have to ask additional questions and do additional investigations.

The fact that he's 38, had no prior problems to his knee, and the fact that the operative report indicates a lot of synovitis and a condyle injury to the lateral tibial plateau and trochlea, that is indicative of a traumatic event.

Q. Doctor, as far as synovitis, what caused the synovitis?

A. Trauma is the most common cause of synovitis.

Q. Describe for me the mechanism, please?

A. When you have a fall, the body

responds and produces irritation to the synovium and you can have increased fluid production, effusion, or you can have no effusion when the meniscus is torn.

And once the meniscus is torn, the function of the meniscus is three fold. One, it's a shock absorber separating the two bones from each other. Second, it serves as an attachment from two bones to the other, tibial plateaus and chondral of both bones, femur and tibia.

The most important function of the meniscus, it takes the synovial fluid, squishes it around the knee joint and lubricates the knee joint.

If it's torn, the lubricating effect has been altered. It's like having your oil pump in your car damaged and the pistons and rods are not being lubricated, you have a lot of access wear and tear, and it starts to damage the joint very, very rapidly.

Q. Doctor, I guess the question I have, though, how can the presence of synovial fluid indicate traumatic as opposed

to degenerative?

A. If it happened after a traumatic event, with all these other findings, okay, then based on the history, the physical exam and the operative findings, history, and experience, it typically comes from trauma.

Can it come from degeneration? It can. In this case, I don't believe it came from degeneration. I believe it came from the trauma.

Q. That's based on all the information you just discussed?

A. That's correct.

Q. If a patient was undergoing an extensive course of physical therapy on their knee, wouldn't that increase the synovial fluid in the knee?

A. No. Physical therapy typically reduces, typically reduces the fluid in the knee because of the pumping effect of electrical stimulation. You're pumping all the fluid out. You're reducing swelling and you reduce inflammation.

By reducing inflammation, the fluid is reduced. He's been on Naprelan

since day one. That's a very strong antiinflammatory which takes care of the swelling, that takes care of the irritation and the pain.

Q. Would you expect someone who had a traumatically induced meniscus tear, such as this one, with the synovial fluid in there, as you discussed, to know about it immediately? I mean it's something they feel pain immediately?

A. They can feel pain immediately, they can feel pain a few days later, or a couple of weeks later.

Typically, the full inflammation takes about twenty-eight days to fully manifest itself. That's when the full information manifests itself.

Q. So, Doctor, is it possible that anything that happened in those twenty-eight days could be the cause of a traumatic injury to a meniscus, as opposed to one event that the patient thinks might have caused it?

MR. WILDSTEIN: Note my objection.

A. The way you phrase the question, I don't know how to begin to answer it, because of the way you phrased the question. It's too convoluted to answer.

If you ask me, hypothetically, is it possible, again, I repeat my answer, anything is possible. It doesn't mean that's the case here.

In this case, I gave you my opinion. I believe the operative findings were causally related to this accident.

Q. Doctor, you mentioned his age as being one of the relevant factors; correct?

A. Yes.

Q. Is it possible that there is something called chronological age as opposed to real age of a patient, is that something you would consider?

A. Whereas a person may have abused their body, their health, and they can look like they could chronologically be thirty, but physically they can look like they're sixty, is that possible? Yes, that's possible.

Q. Can joints be worn more rapidly on

someone who is overweight, if they're obese?

A. If that's the case, it would be bilateral, not unilateral.

This man had no findings on the right knee. His findings were only on the left knee.

On physical exam, the right knee was asymptomatic. There was no clinical findings. It was just the left knee. There was a McMurray's present.

Q. If Mr. Aguilar, specifically, worked in a very physical job where he was on his knees constantly, working sanding floors, would that change your opinion as to the fact that it is more likely to be degenerative, or degenerative is more of a possibility than in someone who had an office job?

MR. WILDSTEIN: Note my objection.

A. The answer is, again, it would be bilateral, not unilateral.

He fell and he injured his left knee, not so much the right knee. There was no physical exam findings on the right knee,

nothing relevant.

He had a positive McMurray's, he had joint line tenderness right from the get-go, with decreased muscle power.

So, based on that, the fact that it's only on one side, not both sides, it goes against your hypothesis.

Q. Did you examine his left knee, or his right knee?

A. We do both. If there's nothing to report, we don't put anything down. Yes, we examine both sides.

Q. In your treatment of patients of all these many years, have you had occasion where you you've had a patient present with degenerative meniscal tears to one leg, as opposed to the other?

A. More degeneration than one side, but there was always bilateral degeneration. Always bilateral degeneration.

I cannot recall, in all of my years of practicing, that I had a case where there was only one sided degeneration and not to the other side.

There was degeneration on both sides. One side could be slightly more symptomatic, one side can have slightly more degeneration.

Q. Doctor, without performing an MRI, can you determine whether the other leg had any degeneration in it, other than just going by his complaints?

A. The fact of the history indicates no pain and no pertinent physical exam findings, I rule out that possibility.

Q. Doctor, what if there was a finding of osteonecrosis on the MRI of his knee, the left knee, what would that indicate?

A. Can I see it, so I can answer your question. There might be a lot of other stuff that goes with it.

Q. Well, if you answer in general about osteonecrosis, I'll show you.

MR. WILDSTEIN: Can you restate the question, then, if you want a general answer.

Q. What does osteonecrosis indicate to you?

A. Very simple, osteo means bone, necrosis means the dieing off of the bone.

Q. What causes the dieing off of the bone?

A. It can be caused by trauma. It can also be caused by degeneration. It can also be caused by blood supply damage to that specific area. If a blood supply has been cut off, that's another possibility. That usually happens in people that are very, very old, above 65 and above.

Q. Is it possible there can be a reduction of blood supply due to progressive use of a knee or work that involved progressive work loads on that knee, that damaged it to the point where the blood supply was diminished and eventually reached the point of osteonecrosis?

MR. WILDSTEIN: Objection.

A. No. Just by work, no.

The blood supply to the hip can be compromised by different medications, by trauma, not just simple wear and tear, unless the patient is eighty years and above, not thirty-eight.

Q. I will show you the MRI, Doctor.

Is there anything in there that points to being degenerative or traumatic?

A. This MRI shows that there is no osteophytes. That goes against the possibility of being an old preexisting and degenerative.

There is a joint effusion present that indicates inflammation present inside the knee joint. It says mild, that also indicate that it's not.

MR. WILDSTEIN: Mild for what, Doctor?

A. Mild joint effusion. That indicates there's some sort of inflammation going on. It could be from trauma or from degeneration, if the patient's age is older than 38.

But now that I've looked at this report, and I'll put everything in proper context, this gives him more confirmation that this is not old and preexisting. Again, simply because there's no mention of any ostephytes.

Q. Why is that significant?

A. I just told you. I told you earlier, if you have ostephytes, it means that the condition is old and preexisting.

The lack of ostephytes rules against that condition of being old and preexisting.

If this was a degenerative tear, you would expect to see ostephytes around the area.

Q. What area, the medial area, where the meniscus is?

A. The joint line where the pathology is, the torn meniscus.

Q. You don't find any significance to osteonecrosis being found?

A. I told you earlier, osteonecrosis can be caused by trauma.

Q. It can also be caused by degeneration?

A. If the person is passed in their seventies and eighties, yes. Not thirty-eight.

Q. What if the x-ray taken at the emergency room showed osteoarthritis of the knee, wouldn't that indicate a degenerative

condition?

A. If you have a mild osteoarthritis for a thirty-eight year old man, mild without ostephytes, it's normal.

We probably have it in this room. Every one of us probably has it.

Q. Why is it significant? It's mild osteoarthritis without ostephytes. If it had ostephytes, it would make a difference?

A. That's part of the normal aging process. The aging process in the female starts at age twenty-four to twenty-six. In the male, it starts in the age around thirty-seven to forty.

So, having some mild osteoarthritis is part of the normal, natural aging process.

Q. But if there's osteoarthritis with ostephytes, that would be significant?

A. For a 38 year old male, if there's a lot of ostephytes, yes, that would be significant. That could go in favor of the theory of the possibility that it could be old and preexisting.

You have to study the ostephytes

to see how many there are, exactly where they are.

Q. Does size matter, as far as ostephytes?

A. The size and number could matter, yes.

Q. Doctor, if Mr. Aguilar was diagnosed with, or it was determined at the emergency room that he had ostephytes at the patella femoral compartment and medial joint line, would that indicate a degenerative disease in his knee, left knee?

A. Patella femoral, I would have to see the x-rays to answer your question.

The way you are phrasing it, it's insufficient. I would have to see the x-rays myself.

Q. Have you ever asked for the x-rays from the emergency room?

A. No. There's a good reason for that.

Q. What's that?

A. Dr. Erlich and Med Alliance handles shoulders and knees. I handle the spine cervical and lumbar. So I left it to

his discretion, to his expert hands.

Q. Is it fair to say once Dr. Erlich came on the scene to treat the knee, that was no longer something you were treating Mr. Aguilar for?

A. I was still treating it, still watching it. I left it to his expert hands.

Q. The primary responsibility were with Dr. Erlich?

A. Yes.

Q. Do you perform surgery, still?

A. I do not perform surgery still.

Q. Excuse me for the question, I think I know from your past that you have performed surgery. I've included that presumption in my question.

Let me ask you clearer, did you perform surgery in the past?

A. I did, yes.

Q. What type of surgery did you perform?

A. As part of my general surgery, I have assisted on almost every part of the surgical procedure you could imagine.

I've assisted on these types of

arthroscopic procedures, and I have performed some of these arthroscopic surgical procedures under supervision by an attending orthopedic surgeon during my general surgery at Cabrini Medical Center, and I've also assisted on numerous other operative orthopedic procedures as part of my training in physical medicine and rehabilitation.

Q. Did you perform arthroscopic knee surgery, as the primary surgeon, during your career?

A. No. I have not.

Q. When is the last time you performed surgery of the knee?

A. Gosh, over twenty years ago.

Q. Did you ever perform surgery of the back?

A. Alone, never, no. I've assisted and watched many of these procedures.

Q. When was the last time that you assisted in surgery?

A. Again, over twenty years ago.

Q. Doctor, again, going back to your records, after that first visit, can you

tell me when is the next time you saw Mr. Aguilar?

A. 12-16, 2010.

Q. Do you have a November record in there, Doctor? I believe November 3rd?

A. Yes, somehow the order got messed up here. Okay, November 3rd.

Q. Can you, again, just tell us what your examination and what your history and examination showed?

A. Again, similar history, that he was out of work since September 4th, 2010. He had a slip and fall at Target, slipping on a grape, injuring his neck and back and left knee.

He continues to take Naprelan and Flexeril with some transient relief.

MRIs have not yet been performed to the cervical spine, lumbar spine, or left knee.

The patient is scheduled to see an orthopedic surgeon for his knee pain. That would be Dr. Erlich. That's when he comes into the picture.

He's been going for physical

therapy and to the chiropractor, with some transient relief. He has not returned to work since the date of the accident.

He continues to have the neck pain and the lower back pain and the left knee pain. The neck and the back is not radiating, and there's no complaint of numbness or tingling from the neck or the back.

Q. Now you note that the neck pain and back pain has improved.

Is there any degree of improvement that you noted?

A. Just what it says, it's improving. He's getting physical therapy, and he's taking medications for pain, spasm. It's improving.

Now, let's go back to --

Q. Let me ask you one question before you do that.

It actually says improved, not improving. Is there a significance between using the word improved versus improving?

A. Improved, if you are trying to say that it's one hundred percent gone away,

no. Improved simply means it's improved. It's better than it was day one. Has it gone away one hundred percent? No.

Q. Please go back to what you were saying, I'm sorry I interrupted.

A. Then I conducted the physical examination. Again, the neck showed tenderness, spasm, multiple trigger points were present.

Q. It says diffuse spasm.

What's the significance of diffuse?

A. Diffuse means the entire area to the neck. We have pinpoint and diffuse.

Pinpoint means exactly what it says. Diffuse means the whole entire area.

Q. Please continue.

A. Extension with sixty out of eighty. Lateral bending was thirty out of forty-five. Essentially, the same as it was day one.

The back showed diffuse tenderness, diffuse spasm. Multiple trigger points were present. Flexion was sixty out of ninety, and the rest of the exam was the

same. Straight leg raising in the seated position was seventy-five degrees. The left knee continued to show tenderness over the medial joint line with a positive McMurray's test, and the strength still remained four plus over five.

Q. Is there anything significant in this report, as opposed to the prior one?

A. Essentially, the same.

Q. When was the next time you saw Mr. Aguilar?

A. 12-16, 2010.

Q. Again, can you tell me what you found?

A. Pertinent findings was the neck showed diffuse tenderness, some guarding, multiple trigger points.

Forward flexion was thirty degrees out of sixty. Extension was forty out of eighty. Lateral rotation was forty out of eighty, both sides. Lateral bending was twenty out of forty-five. This indicates his neck was getting worse now.

The back showed tenderness, spasm. His gate now became slow and

antalgic. That means he walked with a limp.

Forward flexion was forty-five out of ninety. Extension was fifteen degrees out of thirty. Rotation, both sides was fifteen degrees out of thirty. Lateral bending was fifteen degrees out of thirty.

The muscle power testing for the entire left lower extremity, abduction and adduction, for both lower extremities was now four over five. This is significantly worse than before.

Straight leg raising in the seated position was forty-five degrees on the right, sixty degrees on the left.

The left knee showed tenderness over the medial joint line, positive McMurray's. The muscle strength before was four plus over five, is now four over five, and the range of motion of the left knee shows thirty degrees extension and flexion to ninety degrees.

The range of motion had significantly decreased. So, his overall condition was getting progressively worse at

this time.

Q. Yet, Doctor, didn't his neck pain improve and back pain improve on this visit?

A. He says his neck pain, subjectively, his neck pain is improved. Objectively, it has worsened.

You can have a patient who has subjective improvement, but objective findings are worse. The reverse can also be true. You have to put the picture together.

Q. Can they have subjective complaints of pain, not objective?

A. The reverse can be true, in a hypothetical situation.

Q. Doctor, can a patient limit range of motion testing by claiming pain at any subjective point?

MR. WILDSTEIN: Note my objection. Same objection.

A. Not to an experienced examiner like myself. I'm doing this for many years, since 1985.

Q. With all due respect, isn't it

possible, I'm not going to say it's impossible, in those years, of all the patients and plaintiffs that you ever treated and provided reports for, haven't you been fooled at least once by one of them?

A. If I wasn't fooled the first time, the second time, why would I be fooled the third time?

MR. WILDSTEIN: Objection.

A. When you put all the pathology together, it fits. It fits the picture.

Q. Again, you prescribed Naprelan and Flexeril?

A. Flexeril.

Q. That's a mistake?

A. Yes.

Q. Do you recall a plaintiff that you were going to testify for by the name of Patrick Johnson, suing Home Depot, who had a claw hand, he couldn't open or close it, based on your examination?

A. I don't recall. How many years ago was that?

Q. Probably about fifteen.

A. You expect me to remember fifteen years ago? No, my memory isn't that good, fifteen years ago.

Q. If I mention to you this is a person who was injured in a Home Depot, and brought a lawsuit against Home Depot, he had a claw hand, he couldn't open or close it, substantially.

You were going to testify. At the start of the trial, there was the finding, he was found on surveillance the day before trial moving his hand freely.

Does that refresh your recollection?

A. Absolutely not.

Q. Does that remind you, though, perhaps you have been fooled by plaintiffs who have a financial motive to misrepresent?

MR. WILDSTEIN: Objection. Objection to every part of that question.

He's not reviewed any records here, he doesn't recall it. You're asking if he's been fooled.

MR. JANNACE: You said objection on the record.

Q. Please answer.

A. Have I been fooled? It's possible I have been fooled. To having a clawing deformity and to be stiff, and all of a sudden be opening, that's a big, big fool.

Yes, I could say if that happened, then obviously, I was fooled, yes.

Q. Is there an element of subjectivity in range of motion testing?

A. When you do the passive range of motion, no. I do passive range of motion, especially when I examine the knee, when you have a loss of range of motion of this much, that's significant.

Then, when you put the pathological findings together, it all correlates and makes sense.

If a patient has decreased range of motion, let's say to the knee, MRI is negative, x-ray is negative, decreased range of motion and the physical examination is no tenderness, no McMurray's, and their range of motion is decreased, yes, you could say

that has a subjective component.

When you put it all together, you examine the knee, it is exactly the same as you did at day one, day one was normal, the second time it's normal, all of a sudden 12-16, 2010, everything starts to worsen, maybe those statistics, the cold weather has an affect on the joints, which it does, cold contracts, heat expands, joints stiffen up and they become more painful, both in rainy weather and in cold winter months.

Q. Doctor, when you're doing a range of motion test passively, is it fair to say that you're moving the joint or the body part to the point of where the patient indicates that it is painful for them?

A. That is not passive.

Q. Explain to me exactly how you did Mr. Aguilar's passive range of motion?

A. To the point of resistance, not to the point of pain. That's not a valid passive range of motion test.

Q. If a patient is guarded, wouldn't that present a resistance to your passive range of motion?

A. If the person is guarding intentionally, I would know. I would say relax, relax.

Because if they guard, not only does this muscle become tense, the upper traps is tense. I say relax, hit them a couple of times, relax your shoulders.

But if the trapezius relaxes and his neck is still tight, then that's real, that's a real spasm. When you have a real spasm, the fibers shorten, when the fibers shorten, you lose range of motion.

Q. What was your plan now?

A. As of 12-16-10?

Q. As of 12-16?

A. Again, the plan was getting an MRI of the cervical lumbar spine.

Q. Was there any explanation as to why he had not gotten it yet, either the cervical or the back?

A. Some insurance companies don't approve these things. Depends on his plan. If he has a bad HMO, they don't want to approve these things.

Q. You have no idea if that's the

reason?

A. I have no idea.

Q. He never explained to you of the reason, is that fair to say?

A. That's correct.

Q. Do you ask them?

A. We don't ask the patient to get an MRI. We contact the insurance company ourselves, by way of a report. We send a report and we ask that an MRI be approved and they say okay, we will have our medical department review it and we'll get back to you.

This is not the first time this has happened. If you talk to all the physicians, this is the widespread academic. Nobody wants to approve MRIs because they cost money, and HMOs don't want to pay for MRI approvals.

So the plan was getting the MRIs, continue with the physical therapy and follow up with the orthopedic surgeon. That would be Dr. Erlich.

Q. When was the next time you saw the patient?

A. Did not see him after this.

Q. Doctor, did you have a sensory nerve conduction test performed on this patient in January 2011?

A. Me?

Q. Yes. Or was that performed?

A. Can I see?

Q. On this patient, I think it's in your records?

A. I don't have it.

MR. JANNACE: Unfortunately, mine all have notes on it.

A. I'll just tell you if it was me or it wasn't me.

Q. I'll show you mine, there's not much on it.

A. This was never done by me, and this is not an EMG, this is a sensory test. This has no validity for cervical lumbar radiculopathy. I did not do it, so I can't answer your question.

Q. Let me ask you, based on what's here, what body part would have been tested?

A. This is just a sensory motor study. This is not an accurate test for

radiculopathy.

I don't do this test. I've never ordered this test and I don't rely on this test.

Q. Is there anything in here that would indicate who ordered the test? It does say Med Alliance on the top.

A. Med Alliance has fifty doctors, two hundred employees, an Article 28 facility, which is like a hospital. It has a lot of doctors in it. It may have been the chiropractor, I don't know.

Q. If the testing relates to the finger, the thumb, and so forth, as in here, as in this record, would that typically indicate a complaint related to upper extremities, or a different body part?

A. I don't know why you keep asking me this question. I don't consider this test valid. I don't order it, I don't rely upon it, I don't consider it valid for radiculopathy, and I don't know why you keep asking me questions, when I told you I didn't order it, I don't consider the values as relevant, I don't use those values in my

diagnosis and treatment of a patient, based on those studies. I have never ordered them in my own private practices. Never.

Q. Doctor, you had indicated the last visit was in December?

A. Yes.

Q. May I see your records again?

A. Yes. My last record, that is correct.

Q. May I just see it?

A. Last record was 3-8-11.

Q. We hadn't gotten to 3-8-11.

A. My last visit is 3-8-11 was my last visit.

Q. Tell me what happened on 3-8-11?

A. Complains of the same findings. He says that his neck pain continues to improve. He continues to have low back pain, continues to improve.

He's taking Medprin and Naprelan with transient relief. Not yet performed MRIs of the cervical lumbar spine. Going for physical therapy and chiropractic treatment.

He continues to have left knee

pain, but it has improved.

On physical examination, the neck shows diffuse spasm. There's some guarding. There's multiple trigger points present.

Cervical flexion has now improved to normal, sixty over sixty. Extension has now improved to normal, eighty over eighty. Lateral rotation is still abnormal, sixty out of eighty. Lateral bending is better than before, it's thirty degrees out of forty-five, both legs. Muscle power is normal.

Back shows tenderness. There's still slow antalgic gate. Back shows tenderness and spasm. Flexion is sixty out of ninety. Extension is twenty out of thirty. Left and right lateral flexion, bending rotation is twenty out of thirty. Strength of both lower extremities is four over five.

The straight leg raising has improved since last visit, now seventy-five out of ninety, on the right, and on the left, sixty out of ninety bilateral. Low

back pain.

Left knee continues to have tenderness over the joint line. Positive McMurray's test.

Strength testing is four over five for the left knee. Right knee is five over five. Range of motion of the left knee shows minus thirty degrees of extension, and flexion is ninety degrees out of one forty. So it's still abnormal.

And the plan was to again, get the MRIs of the cervical lumbar spine, continue with physical therapy, follow up with the orthopedic surgeon and the chiropractor, continue with Naprelan and Flexeril.

Consider trigger point injections and epidurals as future options, and the patient was told to come back and see us in five weeks, especially after his MRIs were done.

Q. Did he ever return?

A. No. That was my last note.

Q. You have no other records related to Mr. Aguilar?

A. No. He followed through with Dr.

Erlich.

Q. He was seeing a physical therapist and a chiropractor during the course of your treatment, as well?

A. That is correct, yes.

Q. You indicate you don't have records in your file of those treatments, but did you look at them before Mr. Aguilar would come in to see you, or would you just ask him what he's doing?

A. Sometimes I would look at them. Sometimes I would not. It all depends on whether I needed to look at them or not.

The fact that he's improving, I don't think I looked at them, no.

Q. Would you note in your record if you had reviewed the chiropractic or physical records?

A. No. Chiropractors don't give much records. Patient comes in, I have pain, they do an adjustment. They don't keep much, in terms of a three page, detailed note like this.

Q. Physical therapy?

A. They indicate subjective

components, what bothers them on that day, no physical exam.

They put down what modalities they gave the patients, hot packs, electrical stimulation, and exercise.

Q. Would it be fair to say what's listed in your report, all the various elements that you referred to, would be what you would be relying on, versus what a physical therapist or chiropractor would be doing?

A. That is correct.

Q. Doctor, I want you to assume that the plaintiff saw Dr. Bazos for an IME, independent medical examination in June, 2012.

A. Okay.

Q. The medications you prescribed on the last visit, were they capable of being refilled continuously, or would Mr. Aguilar have had to come back to you to get a refill of those prescriptions?

A. If we put refill, you can get them refilled. They're not narcotic, they can be refilled.

Q. Do you have any indication of whether he was refilling the medication?

A. No. I don't know. Every time he was coming, we were giving him a new prescription.

Q. Is it significant to you that he would not have continued to use those medications?

Would that indicate anything to you concerning the progress he was making concerning his neck and back?

MR. WILDSTEIN: Note my objection.

A. If he was not taking them, it wouldn't change the fact that he has a torn meniscus and osteonecrosis and reactive synovitis. It wouldn't change that.

It would just, if he didn't take them, he would just suffer the ill effects of his condition more.

Q. I want you to assume that Dr. Bazos, in his review and examination of Mr. Aguilar, indicated the following: If Mr. Aguilar had suffered an acute traumatic tear of the meniscus, as alleged in this case,

pain would have been extraordinary and immediate, certainly noted at the scene of the incident.

Do you agree with that statement?

A. Absolutely disagree.

Q. Why?

A. No such thing exists in the medical field, it has to be immediately. Only thing, it's immediate, even a fracture is not immediate. I've had patients that have been walking on fractures, undetected until three to four days later.

I saw a woman with a skull fracture a week after trauma, and she had no pain. I touched it. I had a massive indentation of her head. I panicked. I called 911. She was walking around with a skull fracture, no pain.

That makes absolutely no sense.

Q. He next says that he required emergent medical attention, which I think you addressed this part, he'd, without question, would not have been able to ambulate with a normal gate?

A. Absolutely not true. I don't know

how much training this doctor has, who he is, or who's side he's trying to protect, I can tell you that you go around the block, there's hundreds and hundreds of athletes that have torn menisci and don't even know they have it. That theory is wrong. I completely disagree with it.

MR. JANNACE: Move to strike the non responsive part of it.

Q. Meniscus tears may be present with or without any symptoms and not always indicative of an acute trauma. He sites to a couple of studies.

Do you agree with that study?

A. Yes. I told you earlier.

MR. WILDSTEIN: Agree with what statement?

MR. JANNACE: What I just read.

MR. WILDSTEIN: Can you read it back.

(Whereupon, at this time, the requested portion of testimony was read by the Reporter.)

A. We covered that earlier.

MR. WILDSTEIN: Just note it's a

compound question, go ahead.

Q. Another statement, the surgery performed by Dr. Erlich addressed only the chronic changes, nothing that was causally related to the subject incident itself.

A. First of all, I would like to bring him up here, any medical arena and any Court and ask as to how he can make that statement. Absolutely, absolutely defamatory, wrong and inappropriate.

Q. Why?

A. Why? First of all, he did not look at the operative findings. He did not examine the patient on a continuous basis. He didn't put the proper history together. There's nothing here that says chronic. There's absolutely nothing here that is chronic. Not one thing here that's chronic.

Q. Doctor, you're indicating there's nothing chronic, based on your history?

A. No. Based on the operative findings. Read back that sentence. He says that Dr. Erlich's operative findings, go ahead. Repeat that.

Q. Surgery performed by Dr. Erlich in this case addressed the chronic changes and nothing causally related to the subject incident itself.

A. There is no way anybody sitting over there can say these things, and there's nothing on his operative findings that indicates that.

I would like you to ask the same question to Dr. Erlich. He would be in a much better position to answer that question. Much, much better. Much, much, more detailed than I am.

It would be the person who performed the surgery, versus the person who's coming in as a midnight cowboy to try to make comments for one side over the other side.

Q. In fairness, aren't you interpreting Dr. Erlich's report?

A. Whatever it says here. I'm reading exactly what it says here. It's medical terminology. I'm reading exactly what it is.

So, the fair thing to do is to ask

Dr. Erlich, since he did the surgery, ask him those questions. That would be the logical thing to do.

Q. Do you know if Mr. Aguilar paid for any of the treatment that he received for you?

A. I have nothing to do with payments in an office.

Q. Do you have any lien?

A. I have no knowledge. I have nothing to do with the financials of that office.

MR. JANNACE: Just give me a couple of minutes, I'm winding down here.

Q. Do you know when you received Dr. Erlich's report about the surgery?

A. It was in the computer.

Q. Is that something you pulled out today?

A. No. I pulled it out before I came here, not today.

Q. Had you reviewed it?

A. Yes.

Q. Other than looking at it in

preparation for the deposition, you had never seen it before?

A. That is correct.

MR. JANNACE: I have no further questions.

MR. WILDSTEIN: I just have a few.

MR. JANNACE: You want to take over and be responsible, if it's a few?

MR. WILDSTEIN: I just have a few.

EXAMINATION BY MR. WILDSTEIN:

Q. To a reasonable degree of medical certainty, do you have an opinion as to whether or not the injuries that we have spoken about to Mr. Aguilar's left knee were traumatic or degenerative in nature?

A. Yes. In my opinion, they were traumatically induced and causally related to the incident of 9-4, 2010.

Q. Do you have an opinion, to a reasonable degree of medical certainty, as to whether the cervical and lumbar injuries you discussed, concerning Mr. Aguilar, were

traumatic or degenerative in nature?

A. Well, with all due respect, we have not finished diagnosing him, he needs an MRI. So we need to have the MRIs and based on the MRI finding, I would be in a better position to answer those questions.

He needs those MRIs.

Q. Doctor, to a reasonable degree of medical certainty, do you have an opinion concerning Mr. Aguilar's left knee, whether or not his symptoms are permanent in nature?

A. His symptoms are permanent in nature, because meniscus is cartilage, once it is torn, it is a permanent irreversible injury. It's permanent, irreversible, and progressive.

Q. What do you mean by that, progressive?

A. As I explained earlier, the function of the meniscus is three fold. One, as a shock absorber. Two, it serves as an attachment. Three, it serves as a lubrication medium. The synovial fluid squishes around the different portions of the knee joint, and the fact that it is

torn, its function has been lost and the knee is going through a very accelerated wear and tear and degeneration.

And so, a good example is when you have an engine in a car that runs on five quarts of oil. That engine has been running for five thousand miles on three quarts of oil, is the equivalent of three times or four times that amount. That extra wear and tear to the pistons, rods and rings.

Q. Doctor, to a reasonable degree of medical certainty, do you have an opinion concerning Mr. Aguilar's prognosis concerning his left knee?

A. He's left with a permanent --

MR. JANNACE: Note my objection. Go ahead.

A. He's left with a permanent partial disability to his left knee, which means that it's a permanent condition. He can still work, but to some capacity.

MR. WILDSTEIN: Thank you very much.

MR. JANNACE: Couple of follow ups.

EXAMINATION BY MR. JANNACE:

Q. Doctor, your opinion, to a reasonable degree of medical certainty, is based on everything you testified to today, and it's limited by what you were told by the plaintiff?

A. It's based on the history.

MR. WILDSTEIN: Note my objection. Please don't.

A. It's based on the history, physical examinations, numerous times, and the MRI findings that you just showed me, and the operative findings. The whole picture, together.

Q. But you didn't see the x-rays; correct?

A. I didn't see the x-rays. I don't need to see the x-rays.

Q. Did you see the report?

A. I don't need to see the report.

Q. Did you see the MRI, itself?

A. The operative report is much more accurate than the MRI findings.

Q. You didn't see the incident report, either?

A. I did not.

Q. If the accident happened in a different way than you were told, it could affect your opinion?

MR. WILDSTEIN: Note my objection.

A. It would depend. I'm going based on my history, my physical exam, and the review of the documents before me.

Q. If there are records you hadn't reviewed, and information you weren't provided, it could impact your --

A. May or may not. That's possible, yes. May or may not.

Q. You indicated that it's a permanent condition.

Is arthritis in the knee a permanent condition?

A. Arthritis is also a permanent condition, yes.

Q. Are ostephytes in the knee a permanent condition?

A. They don't always cause pain.

Q. Are they permanent?

A. Ostephytes are permanent, yes.

Q. As far as the surgery performed here, to your knowledge, was there a good result? Did Dr. Erlich do a good job?

A. I have not seen the patient. You have to ask Dr. Erlich.

Q. You have no idea what Mr. Aguilar's current condition is?

A. I have no idea.

MR. JANNACE: Thank you.

MR. WILDSTEIN: I have a couple more follow up, based on that.

EXAMINATION BY MR. WILDSTEIN:

Q. You indicated the hierarchy value of testing here, one being the operative report, another being the MRI, another being the x-ray?

A. Right.

Q. Which ones would be the most important there, for this kind of injury, meniscal injury?

A. The operative findings, for a variety of reasons.

Number one, the MRI tells you exactly what it is, imaging. It's an image of the pathology.

The arthroscopic surgery is direct visualization of the pathology. With the arthroscope, you're able to put the arthroscope in and around the grooves where the MRI cannot go. It gives you much more findings than an MRI.

If you study one hundred arthroscopic findings and one hundred MRIs, and you correlate them, you will see the operative findings always find a lot more pathology.

Even at the best teaching hospitals, Mass General, John Hopkins, Columbia Presbyterian, all of them, all those guys always find a lot more findings on the arthroscopic findings than the MRIs or the x-rays.

X-rays, just for bones, tells you nothing about the meniscus, nothing about the ligaments, nothing about the joint or the condyle bones.

MR. WILDSTEIN: Thank you very much.

(Continued on the following page to include jurat...)

MR. JANNACE: Thank you, Doctor.

(Time noted: 10:45 a.m.)

_____
Dr. Ali Guy

Subscribed and sworn to before me this

_____ day of _____, 2012.

_____
Notary Public

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REQUEST FOR INFORMATION/DOCUMENTS

(None)

C E R T I F I C A T E

State of New York)
County of Westchester)

I, DEIRDRE RANDLES, a Stenotype Reporter and Notary Public within and for the State of New York, do hereby certify:

That the witness whose deposition is herein before set forth, was duly sworn by me, and that such examination is a true record of the testimony given by such witness to the best of my ability.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS HEREOF, I have hereunto set my hand this 26th day of October, 2012.

Deirdre Randles

Deirdre Randles

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