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

(Admelinda Rubio relieves Nadonna Ferguson.)

THE CLERK: You are reminded you are still under oath.

THE COURT: Go ahead.

CONTINUED DIRECT EXAMINATION

BY MR. SCHWITZER:

Q. I believe when we left off, I was at your medical records, January 26, 2009.

A. Yes.

Q. Now January 26, 2009, backing up, doctor. As of that time, he had undergone those three injections with Dr. Kaisman?

A. Yes.

Q. Could you tell us, could you read for us your followup visit?

A. Mr. Gustavo returns to the office today. He has had a full course of conservative care and management including injection treatments as administered by Dr. Kaisman.

They have not helped. He has severe pain in the lower extremities which is what was accompanied to the office by family members who help him with his ability to commute.

He cannot bend, lift, twist, push, pull, stoop, or crawl and he cannot assume upright posture without reproducing pain into the legs. He walks with antalgic and kyphotic gate. He has severely restricted lumbar and lumbosacral range of motion. He has reversal of lumbar lordosis upon ascent. He has positive Phalen's maneuver, positive straight leg raise on the right side at 50 degrees and on the left side at 40 degrees.

Q. That's what you told us. It should be 90 when it is normal?

A. Yes.

Q. Please continue.

A. He has loss quadriceps and achilles tendon reflexes and has decreased sensation contractile sensation in the L-4 through S-1 dermatomes. He is unable to heel or toe raise on either the right or left sides.

Q. What is loss of quadricep and achilles tendon reflex?

A. Those are the reflexes when you tap on the tendon, the knee jerk reflex or the ankle jerk reflex.

Q. If somebody is fine, what should happen when you do that?

A. The knee will extend or the ankle and foot

will dorsiflex.

Q. Is that when you use a rubber hammer?

A. Yes.

Q. And involuntarily my leg will move?

A. Yes.

Q. Did it move in his case?

A. No. No motion.

Q. What was the significance of that?

A. There is a problem with reflex arc or the nerves that control the reflex arc that go down the into the legs.

Q. The last line?

A. He was unable to heel to toe raise on either right or left side.

Q. What is the significance of that?

A. That's the weakness in being able to dorsiflex your foot and ankle, plantar flex, your foot or ankle.

Q. You next see him March 30, 2009. He can't ambulate. He has antalgic, or kyphotic gait pattern, correct?

A. Yes.

Q. Still unable to heel or toe stand.

A. Yes.

Q. Moving ahead to June 1, 2009, now. Would you read that followup visit for us, please?

A. Returns to the office today, continues to have significant and severe mechanical axial lower back pain.

Q. What is severe mechanical axial?

A. Pain in the lower back aggravated with motion. Rated as ten out of ten on a ten scale with bilateral lower extremity radiating pain rated as 8 out of 9 on 0 to ten scale.

Q. Was that the time, was he on prescription pain medication?

A. Yes.

Q. Please continue.

A. Repetitive motion exacerbate the pain as does bending, lifting, twisting, pushing, pulling, stooping, crawling and or sitting and standing for prolonged periods of time. Bowel movements exacerbate the pain, particularly pain into the lower extremities.

Q. What is -- number one, did you perform physical exam?

A. Yes.

Q. What did that reveal?

A. Antalgic and kyphotic gait pattern.

Q. You told us before what antalgic was. That is somewhat of a limp?

A. Yes.

Q. Kyphotic is the spine you told us about?

A. Yes.

Q. Did you categorize in your record the type of antalgic kyphotic pattern you saw, did you label it?

A. When you say did I label it?

Q. Well, you have terms like minimal, moderate, severe. Do you label things?

A. Yes.

Q. How did you label it on that day?

A. Severely antalgic and kyphotic.

Q. As a result of that severely antalgic kyphotic gait pattern, what, if anything, happened on that day as far as getting on and off the table?

A. Required assistance on and off the exam table.

Q. On that particular day, did you have to do anything to assist him?

A. I had to help him take his clothes off for the exam.

Q. He was unable to do that?

A. Correct.

Q. What did you find that day as far as spasm?

A. Palpable spasm and tenderness in the lower back area.

Q. Now, turning ahead to July 13, 2009, on the followup visit?

A. Yes.

Q. Can you read what it says, Gustavo?

A. Gustavo continues to remain symptomatic with severe and unremitting back pain and bilateral lower extremity pain unresolved with conservative care and management getting worse over time.

Q. What does that mean?

A. That means he is getting worse.

Q. Did you indicate who he came to the office with?

A. Came in with his wife.

Q. What did your exam reveal?

A. Once again had the kyphotic and antalgic gait. He utilized a cane, he required assistance on and off the exam table. He had palpable spasm and tenderness in his lower back. He had decreases in the L-4/L-5 and S-1 sensation of the lower extremities and could not heal heel or toe raise right or left sides, continued to have positive spinal Phalen's maneuver.

Q. He comes to you on October 12, 2009, correct?

A. Yes.

Q. What is his pain rated on on that day?

A. Ten out of ten.

Q. What does he tell you as far as his good days and bad days, what does he say to you?

A. He said he has mild good days but bad days are

worsened and bad days outnumber good days.

Q. He comes back to you on November 9, 2009, correct?

A. Yes.

Q. At that time, did you have any conversation with him about the need for him to have more surgery?

A. Yes.

Q. Did you do that in English or with the help of a translater?

A. Although I speak Spanish, I also had Sarah there who works in our office to help with any other questions he may have had.

Q. You speak Spanish as well?

A. Yes.

Q. And at some point, did you make a request for further surgery?

A. Yes.

Q. Prior to you being allowed to do that surgery, do you know whether Mr. Tapia had to undergo some type of independent exam?

A. Yes.

Q. Do you know who performed that exam?

A. Yes.

Q. Who was that?

A. That is a physician that the employer uses in

order to review treatment.

MR. BRODY: Objection. I thought he asked him for a name.

THE COURT: Just tell us a name, if you know.

A. I don't recall the name of the examiner off the top of my head.

THE COURT: If there are no records in evidence about any of this, then you cannot ask any questions about it.

Q. Doctor, whatever the name of the doctor and I am going to move ahead, did you review that doctor's report and findings?

MR. DEMERS: Objection.

THE COURT: He can answer yes or no. That's an innocuous question.

A. Yes, they send us those questions as part of the treatment for Mr. Tapia.

Q. Was the surgery performed eventually authorized?

A. Yes.

Q. Going ahead.

The first time he came to you after the surgery was January 18, 2010?

A. Yes.

Q. What I would like you to do at this time, first of all, is take the shadowbox and put this film up.

MR. SCHWITZER: This would be MRI of the lumbar spine, taken at Doshe Diagnostics, dated 9/18/08.

Q. For the record, and so counsel can have an idea, is there a notation as to which particular film that is in addition to the MRI of 9/18/08?

A. Yes.

Q. What is that?

A. It is Doshe diagnostic.

Q. So that if someone wanted to know specifically what cut that was, is there a designation there as to a number on the film in any way?

A. This is a, this is a T-2 sagittal image and it is 7 out of 15.

Q. Doctor, did you -- by the way, how is it that Mr. Tapia came to go to Doshe diagnostic?

A. I sent him for the MRI.

Q. You told him he needed MRI?

A. Yes.

Q. You did not say go here, go there?

A. No, I send him for an MRI, that's a process that requires MRI.

Q. Moving ahead. Can you tell us what that film as of September '08, approximately 16 months after this accident shows?

A. This film sideview, lower back MRI are looking at the bones once again, and the discs in between the bones and the spinal canal that contains the nerves, the fracture site is up at the top of the film. You can see that as triangular wedge up on the top as part of the film. What we are looking at here, we are looking at the disc in the lower -- as part of the back.

Q. Why are we still looking on September 18, '08 that even after the surgery, this is still wedged and collapsed?

A. That's the fracture site, that's the fracture area, that's the position that the fracture has remained in after the injury.

Q. So there was no way to bring the height back up to where it was before?

A. Correct. With the procedure that was done, this is still in kyphotic or anterior angulated aspect.

Q. Please continue?

A. So, we are looking at the area where the discs are and they are in between each of the bones and we are looking at the spinal canal which is the thick bright line behind the vertebral bodies or to the right of this

image. The gray lines, within that spinal canal area are the nerve roots that travel down into the legs.

And we can see that at L-3/L-4, there is some bulging of disc material at L-4/L-5, there is a central herniation of disc material in the canal beyond the confines of the vertebral bodies. And L-5/S-1, there is some disc material inside the spinal canal, beyond the confines of the vertebral bodies.

Q. Has this film that was done in '08 of those lower levels, as opposed to the original film that we went through earlier a little bit of the MRI in '07, are there differences to your knowledge?

A. Yes.

Q. What are they?

A. Couple of differences: Number one, what we had previously seen as an annular tear at L-4/L-5 segment which is that area where we saw a bright signal on the back side of the disc, we no longer see that because the acute or abrupt onset tear that filled up with fluid, that fluid has disappeared or resorbed so that is no longer there.

You start to see disc material protruding into the canal so there is a central herniation at L-4/L-5. At L-5/S-1, we see herniation in the canal area in the area where the nerve roots go down into the legs.

Q. Now, doctor, without doing an MRI of me, Mr. Brody, Mr. Demers, his honor or whoever else in this courtroom, would you have an opinion without looking at a film as to whether us here at a certain age would have certain bulges and certain herniations?

A. Yes. As time goes on, as part of the natural course of degeneration, we are going to have disc changes which can include bulges or herniations.

Q. Can you tell the jury the difference between having herniation or bulge that is symptomatic versus one asymptomatic?

A. Sure. That's one word that describes a constellation or a group of problems that a patient may have, so symptomatic means that it is producing symptoms for a patient.

When these things produce symptoms, they produce symptoms of radiating pain, pain traveling down into the extremities and to the feet and legs, combined with sensation problems or problems with their activities in daily living or problems with lower back range of motion, etc. These issues can be symptomatic or asymptomatic depending on whether or not the nerves are irritated or not.

Q. Without you asking me or these gentlemen of the jury a question, have you ever had any back pain in

your life --

MR. BRODY: Objection.

Q. Without asking me whether I had any back pain, would you know whether someone has at one time or another encountered some type of back pain?

MR. BRODY: Objection.

MR. SCHWITZER: I will move on.

Q. Is there a difference between muscloskeletal pain and the pain you observed on the film which leads to radiating pain down the legs?

MR. DEMERS: Objection.

MR. BRODY: Objection.

THE COURT: There is no pain on the film.

Q. Fine I will withdraw the question.

Can you tell us the difference between the average muscloskeletal pain someone may encounter versus conditions that would occur as a result of what you are seeing on that film as far as the ideation?

MR. DEMERS: Objection.

MR. BRODY: Objection.

THE COURT: I will allow it.

A. Typical lower back pain or typical lower back symptoms can come and go. You can have some good days, bad days. There can be periods where you have an exacerbation of your pain and then the pain goes away

versus symptomatic herniations or nerve root irritations that over the course of time or the clinical course of a patient progress and continue to cause problems that require care and management and treatment.

Q. The pain that he had, can you describe what it was?

MR. BRODY: Objection.

MR. DEMERS: Objection.

THE COURT: Go ahead. Do you know?

A. Mr. Tapia's pain, over the course of time, since the fracture was constant, involved lower back, involved radiation, involved positive provocative signs like straight leg raising, phalen's, failed long course of treatment which included modifying activities, taking medications and series of three epidural injections. That's persistent, progressive pain.

Q. At some point you perform surgery, correct?

A. Yes.

Q. That was back on January 12, 2010?

A. Yes.

Q. Do you have the St. Vincent's record?

A. I do not have that here.

Q. Please put down the shadowbox.

Do you have a copy of St. Vincent's?

A. No.

THE CLERK: Plaintiff's 45.

Q. Doctor, turning to page 9. Whose handwriting is that?

A. That's my handwriting.

Q. What do you have as chief complaint?

A. Two year history of progressive S-1 pain, right side worse than left, history of prior spinal fusion, secondary to fracture.

Q. What do you have under medical history?

A. Past medical history, denies significant except for hypertension and capital DM diabetes mellitus.

Q. Turning to page 10, whose handwriting is that?

A. That's my handwriting.

Q. Was that muscloskeletal exam?

A. Yes.

Q. What did that reveal?

A. Spinal range of motion, 0 degrees at which gave positive spinal phalen's test. That's zero degrees extension of lumbar spine.

Q. What does that mean spinal range of motion, was at zero degrees?

A. If you bend him back, lower back beyond 0 degrees, that produces palpable spasm in the lower back with radiating pain to the legs.

Q. The zero extension?

A. That's zero extension.

Q. Next?

A. Positive straight leg raise, right lower extremity at 30 degrees.

Q. Now, doctor, when you straight leg raise, you told us before, normal is 90.

Can you explain to the jury what it means that if someone has SLR at 30?

A. 30 is significant in terms of nerve root irritation, it means you are irritating the nerve root at a lesser angle of knee extension.

Q. How significant was it that he was at 30?

A. Very significant.

Q. Can you quantify -- you do surgery, you ended up doing surgery?

A. Yes, that's bad enough to require operation. 30 degrees is very painful.

Q. Did you find anything else?

A. And there was right lower extremity atrophy 4 centimeters when compared to the left-lower extremity around the gastroc soleus.

Q. Why are you looking for atrophy?

A. So we have baseline understanding of what the muscle bulk is in the lower extremities pre-op.

Q. Is atrophy objective?
A. Yes.
Q. What is atrophy?
A. Atrophy means shrinkage when you are comparing shrinkage, when you are comparing one side to the other.
Q. Turning to page 14. What is that?
A. It's an admission, physical assessment.
Q. Was that done by you or someone else?
A. Someone else.
Q. Next to musculoskeletal what is written in?
A. It says pain when walking, worse in the right leg.
Q. Before the words when walking, what does it say? Can you read that?
A. Loses balance when walking.
Q. Now, doctor, you know that Mr. Tapia uses a cane?
A. Yes.
Q. Do you have an opinion with reasonable degree of medical certainty as to whether he uses the cane because he like canes and it makes him more comfortable or is there a medical reason that requires him to use a cane?
MR. BRODY: Objection.
MR. DEMERS: Objection.

THE COURT: Did you prescribe the cane, why is he using a cane, let's move this along.

Go ahead you. Can answer the question.

A. He requires the cane so he does not fall over.

Q. Now, doctor, turning to page 22.

Do you have that?

A. Yes.

Q. What is that?

A. That's the physical therapy evaluation in the hospital.

Q. Was that done by you or somebody else?

A. Somebody else.

Q. What did that indicate on strength?

A. It indicates right versus left leg weakness Grade 4 over 5.

Q. What is the significance of that?

A. It means weakness in the leg.

Q. Doctor, on page 24, you have that?

A. Yes.

Q. In addition to whatever meds he was receiving, was he receiving anything for any other condition in addition to pain meds?

A. In addition to his pain medications, he was also on finger stick coverage for his diabetes.

Q. Turning to page 25. Under nursing?

A. Yes.

Q. It says patient remains -- can you read what it says?

A. Patient remains on PCA, patient controlled analgesia, that's a device that the patient controls to administer pain medication, which in this case is dilaudid for pain control.

Q. What is that?

A. That is a morphine derivative, intervenous morphine used post-operatively, used to control pain.

Q. What I would like to do is have you go through your surgery.

These have been previously marked as Plaintiff's 7, 8, 9 in evidence, and I would like you to come down and we will do what we did the last time.

Using plaintiff's 24 and 25, whichever one you want me to put up first.

What I would like you to do is walk us through that surgery of what you did and why.

A. This is my operative report for the surgery. That was on January 12 of 2010 and my pre-operative diagnosis is herniated nucleus pulposus, L-5/S-1 severe bilateral neural foraminal nerve root compression. Progressive, severe right lower extremity radiculopathy with weakness and atrophy of the right lower extremity,

primarily S-1 myotome.

Q. Can you tell us in English what you said?

A. Real bad lower back. Pain add weakness, radiating down the right greater than the left leg.

Q. Please continue.

A. The operation I did, was a decompression, I took the pressure of the nerve roots at L-4, L-5/S-1, I did a transforaminal decompression which means I went across the neural foramen. I did radical discectomy, which means I removed the entire disc. I replaced that disc with biomechanical device, basically, carbon fiber shin that recreates disc height space, stimulates effusion between the bones.

Q. Why are you doing that?

A. I am reconstructing the L-5/S-1 junction, that's the junction between L-5 and the pelvis. The reason I am reconstructing that junction, that's where the majority of his clinical deterioration occurred S-1 nerve root. I am also decompressing the nerve roots above that area to take pressure off of those nerves, in addition to the biomechanical device, I used rods, screws as well.

Q. Tell us why?

A. The illustration on your right is a description of the first as part of the operation, which

is finding the bones, doing an incision in the lower back, where you move the muscle out of the way, expose the bones and then start to take the pressure off the nerves in the same way we saw the pressure taken off the nerves where that fracture site was previously. Only this is being done to the lower part of the back. It is being done between L-5/S-1 and also between L-4 and L-5.

This also involves a removal of the entire disc L-5/S-1 to remove the herniation in the canal, add disc in between the bones so that we can then do what is known as interbody fusion.

Interbody fusion simply means you are fusing in between the vertebral bodies by placement of this caged device, which is made out of carbon fiber mesh. And in addition to fusing in between the vertebral bodies, we are also doing standard posterior fusion with the rods and screws.

Q. How significant a surgery is this?

MR. BRODY: Objection to form.

Q. How extensive a surgery is this?

A. That's a rather extensive surgery in terms of once again you are totally removing a disc, you are moving nerves out of the way, you are doing a replacement with biomechanical device and you are inserting rods and screws and doing a posterior fusion

as well.

Q. Now earlier on, when Dr. Betchen last saw Mr. Tapia, in addition to the L-1 collapse, I don't remember, do you remember what level she said there was instability?

A. She said instability at L-3/L-4 site.

Q. Do you do anything regarding that?

A. No.

Q. Are you done with the surgery for a moment?

A. Yes.

Q. In Dr. Betchen's records, when she last saw him in March -- sorry when she saw him at the end of March and the last time in May, she recommended surgery which she discussed with him and it is in her record to extend the instrumentation, if I am quoting you correctly.

MR. BRODY: Objection.

MR. DEMERS: Objection. She did not recommend it.

MR. SCHWITZER: I will rephrase the question. One moment.

Q. This is March 31, 2008. Mr. Tapia has pseudo-arthrosis, has not fused and has increased kyphosis. He is to come back and see me after he has a CAT scan to discuss the possibility of further operation

to keep him from kyphosing more.

On May 5, the last time she sees him, plane fields were done after his previous visit that showed further kyphosis and collapse at L-1 with some signs of instability at L-3/L-4. If this continues to progress, you told us earlier, if this continues to progress and to kyphosis and collapse, is that correct?

A. Yes.

Q. If this continues to progress then I would strongly recommend that he have another operation to extend his instrumentation and assess the fusion.

Now my question to you is: The surgery that you did, which was the surgery she had discussed with Dr. Tapia was not at that time to extend the instrumentation?

MR. BRODY: Objection. The surgery is different than what she discussed with him.

MR. SCHWITZER: I will ask it differently. Is the surgery that you did different than the surgery Dr. Betchen discussed back --

THE COURT: Recommended. Go ahead.

Q. Back in May of 2008 with Mr. Tapia?

A. Yes.

Q. Turning to your informed consent of the surgery you did, I would like you to read it to the jury

please. This is back on January 12, 2010.

A. I sat down with Gustavo and had a lengthy and detailed conversation outlining his treatment options and alternatives, his surgical options and alternatives, the surgical procedure and type, the realistic goals and expectations therein including the fact revision surgical intervention in the form of a long thoracospinal and thoracopelvic fusion will be required and indicated in the future.

Q. In this procedure you just read to us, you said he is going to require in the future. Is that -- do you have an opinion to a reasonable degree of medical certainty as to whether that was Dr. Betchen was talking about as far as extending the instrumentation?

A. Yes.

Q. Was it the same, is that what we are talking about?

A. Yes.

Q. Why is it, doctor, that you, in 2010, did not do that procedure but performed a different one?

MR. BRODY: Objection.

THE COURT: I will allow it.

A. The reason is over my course of treatment of Mr. Tapia, his lower back symptoms and his leg symptoms pre-dominated the instability at the fracture site.

Most of those symptoms if not all of those symptoms were going down into the lower extremity nerve roots, lower extremity nerve roots as I wrote in my physical history section for admission into the hospital.

The right leg weakness he was having and the radiating pain down the right worse than left leg was mostly due to the lower portion of the spine becoming problematic; more so, than just the fracture site.

So, what Gustavo has is not a curable problem. it is a manageable problem. When you have to manage the problem based on what is happening in the patient clinically, clinical deterioration, lower portion of the spine necessitated fixing that segment to prevent those nerves from getting worse while preserving as much motion as possible above that area to avoid having to do a major thoracopelvic fusion in a relatively young adult.

Doing thoracopelvic fusion would involve having to remove all of the old implants, and then inserting rods and screws above the level of the prior fusion and then into the pelvis. So you basically remove all of the motion of the thoracic and lumbar spine and down to the pelvic area as well, which, in relatively young adult, carries with it significant post-operative consequences in terms of restricted range

of motion, having to walk in a completely different way because your pelvis can no longer accommodate tilt after you lock it in place.

Q. Let me stop you for a moment.

Explain to us, in layman's terms, why you did what you did and had the delay in doing this revision surgery?

MR. BRODY: Objection.

MR. DEMERS: Objection.

THE COURT: He testified to what he did.

Q. Let me ask you this question so we are clear: The need for the surgery you performed on 1/12/2010, is that as a result of -- do you have opinion with a reasonable degree of medical certainty whether that was as a result of what happened to him, the original burst fracture, added trauma of falling on his buttocks or was that from some unrelated condition.

MR. BRODY: Objection.

THE COURT: I will allow it.

A. As a result of the original trauma.

Q. Why do you say that?

A. Several reasons. Number one, not only are we dealing with subadjacent post-traumatic kyphosis breakdown but we also have the annular tear and herniation from L-4 to S-1 which now becomes symptomatic

to the point where it causes nerve problems that need to be addressed.

Q. What was the reason you did not do anything at this level. What level is this?

A. What I did, I did surgery L-5/S-1. I left the L-4 /L-5 segment free to move. I left the L-3/L-4 segment free to move so he could still have some ability to accommodate his spine and his pelvis without locking everything together at the same time --

Q. Do you have an opinion with reasonable degree of medical certainty as to whether in the lumbar spine medically as to whether certain portions of the lumbar spine carry a heavier load than other levels if you understand the question?

A. -- there are certain portions of the lumbar spine that are more, have more stress on them than other segments of the lumbar spine. One of those segments is L-5/S-1 because it is the junction between the spine and pelvis, followed by L-4/L-5 and L-3/L-4 less so.

Q. Now, you ordered some films, correct?

A. Yes.

Q. This would be post-operative films of November 20, 2012, exhibit 26 and then number 27 would also show what was done here. Are there any findings as to what you see going on now after both these surgeries?

A. Yes.

This shows the original fracture implants and instrumentation with the area of the fracture, which is still wedged. It shows the fusion of the L-5/S-1 segment and the intervening two segments, L-3/L-4 and L-4/L-5 show decreases in disc space height; more so, at L-3/L-4, L-4/L-5, both these sections have decreased height in their disc spaces.

Q. Doctor, this revision surgery that you had been trying to delay, do you have an opinion with reasonable medical degree of medical certainty as we sit here in court as to one whether Mr. Tapia is going to have to have that surgery?

MR. BRODY: Objection.

MR. DEMERS: Objection.

THE COURT: I will allow it.

A. Yes.

Q. Number one, what is your opinion, with a reasonable degree of medical certainty whether he has to have it and two, how long will it be before you will not be able to put this off any more?

MR. DEMERS: May we approach?

THE COURT: The question is when we need the surgery.

MR. SCHWITZER: Yes.

THE COURT: Okay. Go ahead.

A. Within the next five years.

Q. Can you explain to us when you do that surgery, what you are going to have to do?

A. Sure.

MR. DEMERS: Objection. May we have side bar?

MR. BRODY: Objection.

THE COURT: Go ahead.

A. What you need to do in order to eventually revise it and extend fusion is you need to first remove the implants from the prior two fusions. And then, you need to reconstruct above the level of the prior fusion, the prior fusion went from T-11 down to L-3, thoracic spine.

Most of the kyphosis in the thoracic spine is around the, if you look at it, 10, 9, 8, 7, it is around T-7/T-8 where most of that apex of that curvature is you have to come above that curvature, we generally come up to the T-4 or T-5 area on top to be able to capture the upper portion of the thoracic spine, then you need to come down into the pelvis to be able to capture the pelvis to include it as part of your fusion because otherwise what you have is a very long lever arm connected to the sacrum only through the L-5/S-1

section.

To decrease the chance of non-union or psuedo-arthrosis as well as to recreate sagittal balance, you need to able to lock yourself down to the pelvis as well that would involve a revision from the upper portion of the thoracic spine down into the pelvis.

Q. Now, doctor, is the objective of this to make him pain-free; what is the objective to a reasonable degree of medical certainty?

A. The purpose of doing that revision surgery is to prevent these segments from breaking down to the point where they will start to cause the problem with the nerves that are behind those segments, so you want to stabilize the spine to prevent these areas from causing damage to these nerve roots that are adjacent to those segments.

The surgery does not alleviate the pain or the symptoms from the back pain. Axial pain we talk about, as pain limited to the back area but it provides an environment, stable environment that prevents further nerve root damage.

Q. Doctor, do you have an opinion with reasonable degree of medical certainty, I am not going to repeat everything, he can not do as far as activities of daily

living, crawling, sitting, standing, you went through the whole litany, do you have an opinion to a reasonable degree of medical certainty what will happen to his activities of daily living after you do this surgery?

MR. BRODY: Objection.

MR. DEMERS: Objection.

THE COURT: What's the question?

Q. As far as his activities as daily living with reasonable degree of medical certainty how will this impact his activities of daily living once he does this surgery?

THE COURT: Post-surgery?

MR. SCHWITZER: Yes.

THE COURT: Go ahead.

MR. DEMERS: Objection. It is speculative.

THE COURT: If it is speculative, he will tell us.

A. The reason I am prolonging here for as long as I can prolong it, it significantly increases your mobility because you are locking the pelvis into the rest of the spine. Oftentimes these patients have pretty restrict gait and ambulation tolerance. And oftentimes, you have to prescribe assisted devices for them to help them with their gait and ambulation.

Q. Do you have an opinion within reasonable degree of medical certainty as we are here right now, this is his one and only time to be in court as far as his ability to ambulate in the future after the surgery, what is going to happen to, with a reasonable degree of medical certainty, to Mr. Tapia?

MR. BRODY: Objection.

MR. DEMERS: Objection.

THE COURT: I will allow it.

A. It will be decreased where we have to use motorized scooter, wheelchair device, something like that.

Q. Do you have an opinion with reasonable degree of medical certainty as to what the cost of that surgery is going to be?

A. Yes.

Q. What will that be?

A. The cost of that type of revision surgery, which would include hospitalization, implants, surgeons, anesthesia, rehab, etc., hospital stay, would be 175 thousand dollars.

Q. Do you have an opinion with reasonable degree of medical certainty as to whether Gustavo Tapia will need to continue to see you on some basis from now up to the surgery and from the surgery forward?

A. Yes.
Q. What is your opinion?
A. That he will continue to need to see me for surgical followups.
Q. What before the surgery, how often does he need to see you?
A. Biennial basis.
Q. What does that mean, twice a year?
A. Yes.
Q. After the surgery, will he still need to see you twice a year?
A. Yes.
Q. At the present time, what do you charge for an office visit?
A. Follow up visits are 175.
Q. In addition to the surgery and followup office visits, will you also be asking him to undergo any type of diagnostic testing?
A. Yes.
Q. What would that be?
A. We look at MRI, we usually get MRI's.
Q. How often would you want to do that?
A. Reasonably, once every couple of years.
Q. Now, doctor, at the present time, you are familiar that he is treating with Dr. Gary Thomas?

A. Yes.
Q. Who is Dr. Thomas?
A. Pain management treatment.
Q. Do you know him?
A. Yes.
Q. Do you do referral work back and forth with him as well as Dr. Kaisman?
A. Yes.
Q. And other doctors?
A. Yes.
Q. Only if you know, do you know why Dr. Kaisman who is a pain management doctor, why he stopped treating him at some point?
A. Yes.
Q. Do you know the reason Dr. Kaisman stopped treating him and referred him to Dr. Thomas?
MR. DEMERS: Objection.
MR. BRODY: Objection.
THE COURT: He answered yes. What's your reason?
Q. Is this based on conversation?
A. It is based on their practice.
THE COURT: Go ahead.
A. Dr. Kaisman does acute pain and Dr. Thomas does acute and long-term pain.

Q. What do you mean acute versus long term?

A. Acute pain management is pain management that is much more oriented toward injections and procedures. Long term pain management does not only injections and procedures but also manages pain on long term basis so it could also involve things such as spinal cord stimulators and/or medication pumps, so Thomas's practice does those type of things where Kaisman practice does not.

Q. Now, doctor, turning to your records, February 1, 2010.

Do you have that?

A. Yes.

Q. What do you note for his gait?

A. Antalgic and kyphotic.

Q. Continue reading.

A. It requires assistance on and off examination table, consistent with his pre-operative status.

Q. As far as the right lower extremity, neurological status, what did you indicate?

A. It remained stable, approximately Grade 3/4 over 5 weakness.

Q. What else did you note?

A. Atrophy right lower extremity when compared to left side.

Q. What did you note about the radicular symptoms at that time?

A. I said his radicular complaints and symptoms had been ameliorated post-surgical.

Q. In addition to your surgery of Mr. Tapia, did you recommend that he undergo physical therapy?

A. Yes.

Q. At the present time, do you know whether he is undergoing physical therapy?

A. Yes.

Q. Is he?

A. Yes.

Q. Why do you want him to have some degree of physical therapy?

A. Physical therapy is good basically on what we call maintenance basis.

Q. What does that mean?

A. It means it maintains mobility of your joints, flexibility and as much strength as possible to prevent retrogression or back-sliding in your condition.

Q. The surgery you did, the one in 2010?

A. Yes.

Q. Was that to get rid of his pain?

A. That was to prevent the nerves from continuing to get worse over time.

Q. When you did the procedure, was that something you said to Mr. Tapia, I am planning on you being pain free after this surgery?

A. No.

Q. Can you explain to the jury why you knew he would not and what you were doing?

A. Sure. Spinal surgery, particularly when you are doing a reconstruction and fusion is very good at protecting and decompressing the nerve roots and maintaining as much nerve function as you can into the legs and feet.

In this case, it is a lot less helpful in terms, helpful in terms of making the pain in your back go away because there are multiple factors that cause pain in the back. So, it is not only a disc or a nerve root that is involved but there are multiple issues, in balance muscles, tendons and other joints in your spine that had increased load and increased stress, so there is a multiple reason for back pain to occur and exist and surgery only addresses very specifically nerve root damage and nerve root issues, in the specific area that you are operating on. It does not fix all of the problems.

Q. When he came back to you in June of 2010, doctor, you have that?

A. Yes.

Q. On your physical exam, what did you note as far as range of motion and compare them to what you would consider normal/average?

A. So, his ranges of motion were extension of zero degrees, we talked about extension. You should be able to extend your spine, lower back to 30, 35 degrees at least. Flexion to 30 degrees. We are talking about at least 90 degrees forward flexion. Right lateral bending was 20. Left lateral bending was ten.

Once again, we are looking into 45 degree area for those and rotations were on right side at ten, and on the left side at five.

Once again, you want to be able to rotate your spine at least to be able to see over your hips, you are talking at least 60 degrees to 70 degrees rotations minimum.

Q. Did he still have spasm?

A. Yes.

Q. Doctor, you continue to see him, correct?

A. Yes.

Q. And you saw him -- I am not going to go through every note -- july 26, you saw him. You saw him on October 18, 2010?

A. Yes.

Q. And, on that followup visit of October 18, 2010, which is approximately ten months after his surgery, what did you note as far as the first paragraph?

A. Mr. Tapia returns to the office today, status post-decompression and reconstruction of lumbar spine. Continues to suffer from chronic residual permanent sequelae of injury sustained, utilizes cane to ambulate. Requires assistance with activities of daily living, able to perform some hygiene maneuvers and can robe and disrobe himself but does require assistance, particularly, robing/disrobing. Repetitive motion produces severe pain.

Q. Did you refer him out to someone under the plan?

A. Yes.

Q. Who was that?

A. A physiatrist by the name of Dr. Schwartz.

Q. For what purpose did you send him to?

A. Have him look at him from therapy point of view, see if could he make recommendations for us as far as long-term physical treatment.

Q. Did you have an opinion with reasonable degree of medical certainty and did you note the level of his disability at that time?

A. Yes.
Q. What was it?
A. I had him 100 percent total.
Q. Going back to the surgery of January 2010, did you prescribe something for Mr. Tapia to help him with the healing process?
A. Yes.
Q. What was that?
A. Bone growth stimulator.
Q. Did you bring that with you today?
A. Yes.
Q. Could you please show it to us, what it is, the purpose of it?
A. A bone growth stimulator.
MR. DEMERS: Objection.
THE COURT: Overruled.
A. It is an electrical device that you wear, like a little belt over the area where the fusion is so it straps on. It is powered by batteries and you turn it on. It causes a, it sets up electrical field that then stimulates bone cells to fuse or to heal. It is what we call an adjunct to the fusion process. It decreases the pseudo-arthrosis rate, the rate of non-healing. It increases fusion rate or rate of healing.
Q. You next saw him on July 20, 2012, correct?

A. Yes.

Q. The last time you saw him, prior to coming in today, would that have been December 14, 2012?

A. Yes.

Q. So let's go to the very last time you saw him. Can you read and tell us what you noted?

A. Mr. Tapia returns to the office today, he is accompanied by his family members. He continues to have mechanical axial neck pain as well as lower back pain. He modifies his activities to include the avoidance of repetitive motion to the neck and back, remains on medication, had multiple injury which required surgical intervention, particularly surgical intervention to the lumbar spine in the form of decompressed lumbar laminectomy and lumbar spinal fusion undertaken principally to prevent further neurological deterioration, secondary to high grade nerve root impingement and damage to both L-4/L-5 and L-5/S-1 segments.

Q. Please continue.

A. Mr. Tapia continues to demonstrate antalgic and kyphosis during gait and ambulation with spasm and tenderness present in the neck and lower back areas, continues to require assistance on and off the examination table, because of difficulty in rotating

spine.

Q. I want you to go down to where it starts with lumbar spinal extension.

A. Approximately 0-5 degrees. Spasm and tenderness present and palpable beyond those ranges of motion. Flexion is approximately 35-40 degrees. Right lateral bending 20 degrees. Left lateral bending 20 degrees, right lateral rotation 20 degrees. Left lateral rotation 20 degrees.

Q. Do you have an opinion with reasonable degree of medical certainty as to whether the accident of 5/26/07 was the competent producing cause of the burst fracture at L-1, the fracture at T-12, the fracture at L-2, the annular tear at the lower lumbar spine at L-3/L-4, the impingement at L-5/S-1 the need for surgery with Dr. Betchen performed at Maimonides Hospital, the need for your surgery in January 12, 2010 and the need for the future surgery for the revision and extension of the instrumentation that you have testified earlier will occur within five years, do you have an opinion as to whether they are causally related to the accident of May 26, 2007?

MR. BRODY: Objection.

MR. DEMERS: Objection.

THE COURT: Overruled. Go ahead.

A. Yes.
Q. Yes what?
A. Yes, that the accident was the principal responsible cause for the injuries outlined above.
Q. Doctor, do you have an opinion with reasonable degree of medical certainty and you indicated that Mr. Tapia is on medications, as to whether Mr. Tapia will require pain medications, muscle relaxants and other medications in regard to the injuries he sustained on May 26, 2007?
A. Yes.
Q. What is your opinion?
A. That he will continue to require those medications.
Q. Do you have an opinion with reasonable degree of medical certainty as to whether Mr. Tapia will require a life-time of pain management care?
A. Yes.
Q. What is your opinion --
MR. BRODY: Objection.
THE COURT: I will allow it.
A. That he will continue to require lifetime pain management.
Q. As you know, one of the questions is this: When you say the word "prognosis", can you tell the jury

what that means?

A. Prognosis is what you foresee in the future with respect to how a patient is going to do.

Q. Doctor, do you have an opinion with reasonable degree of medical certainty as to what the prognosis is for Mr. Tapia as a result of the accident, May 26, 2007.

MR. BRODY: I object. That's the second question and it requires a third question.

THE COURT: We will get to that too.

A. Yes.

Q. What is your opinion?

A. That the prognosis overall is poor.

Q. Why?

A. Because he is going to require revision surgery with locking down of pelvis, decrease in function over the course of time.

MR. SCHWITZER: I have nothing further.

THE COURT: Go ahead counsel. You can start.

CROSS EXAMINATION

BY MR. BRODY:

Q. There came a time on November 23, 2012 that you were wrote a lengthy report to Mr. Schwitzer, is that correct?

A. Yes.

Q. You basically, you paste a lot of stuff from your prior reports and added a few comments along the way?

A. Yes.

Q. How many times is the word "diabetes" in that report?

A. I don't know. I don't think it is in there that often.

Q. Would zero be okay?

A. Yes.

Q. How many times did you use the word "wheelchair" in your report. You want to tell the lawyer what is going to happen to his client so he can present it to the defendant so we all know what it is you are going to come in and tell the jury.

How many times in that report did you mention that Mr. Tapia will need a wheelchair in the future?

A. I did not put it in that report.

Q. You did not put it any report?

A. No.

Q. You did not make any mention of him needing some motorized cart to get him around, did you?

A. No.

Q. The last time you saw him, you did not tell him that he would need surgery in five years, did you?

A. No.

Q. In fact you said that if you start to get radicular pain again in the future, it is possible you might need revision surgery, isn't that what you put in your report?

A. Yes.

Q. Today, he definitely needs it in five years, then he has to be in a wheelchair and motorized device because we have jurors here who will award him damages?

A. No, not because there are jurors here who will award him damages.

I was asked a temporal relation to when he will require the revision surgery.

Q. A temporal relation would mean that he would absolutely need it in the future but you wrote "possible"?

MR. SCHWITZER: Objection.

THE COURT: Go ahead.

MR. SCHWITZER: I would like to offer Dr. Merola's report in evidence.

MR. BRODY: I have no problem.

THE COURT: Go ahead.

Q. Let's see if we can get the words correctly. December 4, 2012. That's in evidence.

Doctor did you use these words --

MR. SCHWITZER: One moment. He crossed him on the narrative report now he wants to cross him on a record.

Q. December 4, 2012?

MR. SCHWITZER: The narrative report is in evidence.

THE COURT: Go ahead.

Q. Did you say doctor the possibility of recurrent neurogenic or radicular symptoms would require revision surgery in the future?

A. Yes.

Q. That means if those radicular symptoms do not come back he does not need the surgery?

A. That's offering him the hope of possibly not having to have future surgery, yes.

Q. When you spoke to him in your office, you talked in the positive but when you speak to the jury today, he is going to have to have the surgery in five years or less, correct?

A. I am here to tell the jury the facts. In my office, I am not there to discourage hope in my patient.

Q. You are here to tell the jury the facts. How often do you tell the juries the facts?

A. Always.

Q. How many times a year?

A. Three to four.

Q. How many times have you been cross examined by Alan Kaminsky?

A. You told me five times today but I would not be able to give that you number otherwise.

Q. Doctor, you actually testified before Judge Vaughn before, didn't you?

A. Yes, I have had the pleasure.

Q. How many other times in the past 12 months have you testified?

A. In the past 12 months, maybe once but I cannot recall the last time I testified.

Q. How many times have you testified for Sax and Sax?

A. In 16 years of practice, I have been in the courtroom about three to four times a year. That's three to four, times 16.

Q. You testified about 50 times?

A. I guess that's three to four times over 16 years, yes.

Q. Is that referring there to times when you were testifying for patients in accident cases, correct?

A. Treating for patients.

Q. In each of those cases, did you testify that the patient was 100 percent disabled?

A. I don't recall specifically every testimony, no.

Q. Let's go over your background if I can. Counsel asked you something about being board certified, is that correct?

A. Yes.

Q. By how many boards are you certified?

A. I am certified by the American Board of Orthopedic Surgery, charter member of spinal board. The spine board is not accepted by the overall board body for the country so I don't generally list that when we are discussing board certification.

Q. In the past, you mentioned when you testified, isn't that correct?

A. I think I mentioned it sometimes. One of the reasons I am charter member of that spine board.

Q. Now, doctor, let's talk first -- let me ask you this: Before you came to court, had you looked at Maimonides Hospital MRI's?

A. Yes.

Q. When?

A. When you wrote the narrative.

Q. You looked at the films?

A. Correct.

Q. Can you tell me what in the narrative the

findings are of those films?

A. I mentioned I reviewed the records from Maimonides Hospital.

Q. You did not mention anything about any of the findings in any of the films, did you?

A. I think when I reviewed the medical records, I don't think that I listed all of the findings of all of the tests I had done so I think my narrative report might have been 30, 40 pages.

Q. Aren't they fairly significant findings in that MRI as they relate to care and treatment of Mr. Tapia?

A. There are, yes.

Q. You did not think it was important to list what you found on the film?

A. No, it is part of the overall impression in the narrative.

Q. What was that that you were reading in front of you, you had some records, what are those?

A. These are my office records.

Q. Those are not all of your office records?

A. Those are my treatment records for Mr. Tapia, correct, those are all of my notes.

Q. When a law firm sends you an authorization, asks for all of your medical records, do you send all of

your medical records?

A. The office sends out the medical records, yes.

Q. When you sent your records out to Mr. Demer's firm or my firm, did you not send copies of Dr. Kaisman's records, did you?

MR. SCHWITZER: Objection.

A. My office would have sent those records out. So whatever you received, you would have received from my office staff.

Q. If I did not get Dr. Kaisman's records, does that mean you did not have them in your office records?

A. No.

Q. It just means you did not send them to us?

A. When we receive an authorization through HIPAA health insurance, you are requesting patient records for my treatment. Dr. Kaisman's records would be coming from Dr. Kaisman's office.

Q. Is your office policy to send only your record but you may have other records contained within the file?

A. I think the request is for my treatment records of the patient.

Q. Are you certain that you got Dr. Kaisman's records in this case?

A. I had seen Dr. Kaisman's records.

Q. When?

A. When I was treating the patient. In fact Mr. Tapia would come in with the records, the films that we reviewed have St. Vincent's sticker which I use during surgery.

Q. The films you review, doctor, did you compare your films with the films that Dr. Kaisman sent to you?

A. I actually had Dr. Kaisman's films, because that particular folder that we have here, I actually use those as part of the operative procedure along with the MRI that I sent them to at Doshe.

Q. Dr. Kaisman's notes say he sent Mr. Tapia with x-ray but does not say anything about the records?

A. Kaisman would have sent the records as well, correct.

Q. So you knew -- withdrawn.

Did you ever review any records of Mr. Tapia, prior to the accident?

A. Yes, I did review some records from his primary care physician, prior to the accident.

Q. When did you review those?

A. I reviewed those at the time of the narrative, I believe.

Q. Then why didn't you include them in the list of the records that you said that you reviewed in your

narrative report?

A. It should have been. I recall reviewing Dr. Kaisman records.

Q. What do they say?

A. Primary care physician.

Q. Yes?

A. Treatment records regarding medical problems and some issues with back pain and prior problem he had with one of his fingers.

Q. Let's start with back pain, what do the records indicate about back pain?

A. We have to look at the records specifically because I don't have them memorized.

Q. If he had back pain before the accident, would it be important to know what was causing it?

A. If he had persistent deteriorating back pain over the course of time and had prior treatment including MRI epidural injection prior to the accident.

Q. He was getting anti-inflammatories?

A. So do many construction workers and laborers.

Q. Why is that?

A. They are subject to muscloskeletal symptoms from the work they do.

Q. Do they start to develop wear and tear in the spine?

A. As we all do, yes.

Q. I understand we all develop wear and tear in the spine. You made sure the jury understands that but do people who do manual labor tend to incur more wear and tear in the spine than others?

A. Yes.

Q. People who develop wear and tear in the spine that can cause discs to desiccate, correct?

A. Yes.

Q. What is disc desiccation?

A. Desiccation is a term that means drying up of or loss of water.

Q. When disc desiccate, they shrink, correct?

A. The disc can shrink, when it is desiccated, yes.

Q. As the disc shrinks when it is desiccating, it creates a gap between the squares as you referred to them, correct?

A. Actually, as it is shrinking the gap is closing because it is shrinking.

Q. The canal and I think you often refer to those squares as or those areas as the house starts to get smaller and smaller, correct?

A. The room in the house starts to get smaller, yes.

Q. As it gets smaller, it can impinge on the nerves, can't it?

A. Yes.

Q. Do they have a term for what it is when the room is getting smaller?

A. There are multiple terms.

Q. How is the term "stenosis"?

A. That's an excellent term that describes narrowing.

Q. Let's talk for a second. Do you have the Coney Island Hospital. It was deemed -- marked into evidence. Do you have that handy?

A. I no longer have it in front of me.

Q. I would like to show you page 115 out of the Coney Island Hospital record.

What is that?

A. This is lumbar spine radiology results.

Q. When is that taken?

A. This is 26 May, 2007.

Q. When is that in relation to the accident?

A. This is at the time of the accident.

Q. That's the same day, right?

A. Correct.

Q. That x-ray says that he has a fracture at L-1, correct?

A. Yes.
Q. What else does it say?
A. It says evidence of compression fracture L-1, vertebral body with mild retropulsion into the spinal canal.
Q. What does it say above that?
A. It says degenerative disc disease L-5/S-1 level.
Q. For an x-ray taken the day of the accident to show disc degeneration at L-5/S-1, that disc disease had to pre-exist before the accident?
A. Yes.
Q. What disc disease did it show?
A. Degenerative disc disease.
Q. You are an orthopedic surgeon, correct?
A. Yes.
Q. You know there is a case going on here, correct?
A. Yes.
Q. You know that lawyers like me kind of get a little knitpicky when we start throwing medical terms such as the accident caused something, around?
A. Yes.
MR. SCHWITZER: Objection.
THE COURT: He answered the question. Go

ahead.

Q. So, I am sure before you came here today you anticipated I was going to ask you what x-ray showed?

MR. SCHWITZER: Objection.

THE COURT: Sustained.

Q. What did the x-ray show, doctor?

A. It shows the L-1 burst fracture, retropulsion of bone into the canal and degenerative disc disease at L-5/S-1.

Q. Did it show stenosis, did it show neural foraminal narrowing, it shows osteophyte complex, what did it show?

A. It does not say, it says degenerative disc disease.

Q. Didn't you look at that film to see what pre-existing conditions Mr. Tapia had on the day of the accident?

A. Yes.

Q. What did the film show when you looked at it?

A. You would like me to describe the film for you?

Q. Yes.

A. It shows a degeneration of L-5/S-1 disc with something known as MACNAB traction spurs on the anterior aspect of L-5/S-1 segment with disc desiccation.

Q. Did it also show facetal arthritis?
A. Facetal arthritis, fair to say.
Q. Do you ever mention in your any of your reports that Mr. Tapia suffered facet joint pain?
A. Do I mention that he suffered from facetal joint pain in my treatment records, I don't think I referred to that.
Q. Are you aware in every single one of Dr. Thomas records, he refers to Mr. Tapia as suffering from facet joint pain?
A. Yes. There is a good reason for that.
Q. I am sure there is. That facet joint pain has nothing to do with the accident?
A. It has everything to do with the accident.
Q. He had the facet joint arthritis and arthrosis before the accident, correct?
A. Correct.
Q. Let's go over the MRI for a minute on the report of the lumbar spine taken two days after the accident. That's exhibit 29 and 30.
Doctor L-1/L-2 was where the fracture was?
A. L-1/L-2 is the disc below the fracture.
Q. Above it would be T-11 --
A. T-12/L-1.
Q. At L-1/L-2 he had central canal stenosis,

correct?

A. Yes.

Q. What is that?

A. Narrowing of central canal.

Q. If someone has central canal stenosis, what would that look like on one of these pictures?

A. This is a little tough to look at because you are not looking --

MR. SCHWITZER: Sorry. For the record, exhibit number?

MR. BRODY: 19.

Q. We are now looking at number 13.

A. Sideview x-ray lumbar spine. We are looking at the vertebral bodies to the right of the x-ray. We are looking at the spine process to the left of the x-ray.

Spinal canal is the canal going down the middle of the hole in your spinal canal, where the spinal cord and the nerve roots are. That hole should be large enough to accommodate your middle finger, so it should be that much around. And stenosis, basically, means instead of the canal being large enough to accommodate the diameter of the middle finger, the diameter of that area is smaller or stenotic.

On the x-ray, that is happening because this

is the canal area, where I am pointing to with my finger behind the vertebral body, there is bone and disc material in the canal zone. So by definition that takes up room or volume in the canal and it has to narrow that canal.

Q. That can cause nerve root injury?

A. Yes.

Q. That can cause pain?

A. Yes.

Q. That condition existed before the accident, correct?

A. Not in the area of the fracture.

Q. So the MRI is incorrect when it says central canal stenosis?

A. No, it is not wrong. It is giving you the anatomical description of central canal stenosis occurring at L-1/L-2 segment because there is protusion of disc and bone into the spinal canal from the fracture.

Q. It is still showing core compression and canal stenosis?

A. It is showing stenosis with compression of the lower spinal cord.

Q. At L-2/L-3, that's the disc below?

A. Yes.

Q. It says circumferential disc bulge?
A. Yes.
Q. It says the central canal patented?
A. No stenosis of central canal at L-2, L-3.
Q. That disc was the disc with the most water in it in his spine at time of the accident.
A. That disc had the same amount of water in it as the lower thoracic disc did. That disc signal is comparable to those other disc signals.
Q. L-3/L-4 circumferential disc bulge, what is that?
A. That is symmetrical protusion of the disc, going outside the confines of the vertebral body.
Q. By definition, disc bulge is something that is either congenital or degenerative as opposed to traumatic?
A. Congenital means you are born with it. I would describe a bulge, you could describe it as being physiological which bulge can exist in the normal state.
Q. It says there are central canal and lateral recess stenosis. What is lateral recessed stenosis?
A. Lateral recess are the areas, we are looking at number 19, this is an illustration of the spine. The lateral recesses are these things that appear to look like ears or the neural foramen. That is loss also

known the lateral recesses or the areas where the nerve roots exit.

Q. If they have stenosis, it means those places where the nerve roots were existing, back two days after the accident, those had already begun to narrow, correct?

A. That means there was a narrowing of those areas, correct.

Q. At L-3/L-4 it says non-compressive which means it is not significantly closed in the neural foramenal area to be causing impingement, at least on the film?

A. At least by description of the film, yes.

Q. Doctor, I think you said earlier that the film is taken laying down, correct?

A. Yes.

Q. So there is less pressure on the spine when the film is taken then for example if Mr. Tapia was standing, correct?

A. I don't think pressure is exactly the term I would use. I would say the spine -- it depends on what as part of the spine you are looking at. If you are looking at the lumbar spine -- if you are lying down, the force of gravity is going to extend the thoracic spine, it is going to flatten out the lumbar spine and it is going to flatten out the cervical spine by force

of gravity. When you are lying down supine in MRI machine, there is some affect of that position in terms of altering the position of the vertebral bodies.

Q. You used an expression earlier that sometimes pain comes and goes?

A. Yes.

Q. Isn't it true that even in patients with herniated disc, some times they are symptomatic but sometimes they are not?

A. Depends on the herniation.

Q. Depends on how much it is compressing and irritating the nerve?

A. Yes.

Q. Depends how active they have been for a period of time?

A. Yes.

Q. The mere fact that somebody has herniated disc does not mean it is causing pain, does it?

A. Correct.

Q. Let's move to L-4, 5, here it says disc desiccation with broad based posterior disc bulge?

A. Yes.

Q. The disc is dry?

A. Yes.

Q. It has this broad based bulge, it does not say

herniation, correct?

A. Correct.

Q. It has the annular tear which you told the jury about before, correct?

A. Yes.

Q. Bilateral facet arthrosis, that's what we talked about earlier?

A. Yes.

Q. There is moderate central canal and lateral recessed stenosis, we talked about that too, correct?

A. Yes.

Q. Now let's go to L-5/S-1, it says disc desiccation narrowing with the prominent circumferential disc bulge. Do you see that?

A. Yes.

Q. It says severe neural foraminal stenosis?

A. Yes.

Q. With impingement on the right and probably on the left, correct?

A. Yes.

Q. Doctor, the condition depicted on this MRI, two days after the accident, can that condition cause radiculopathy?

A. That condition can cause a radiculopathy, yes.

Q. According to you, based upon your review of

this gentleman's history, he was not experiencing any radiculopathy prior to the date of this accident, is that right?

A. He did not have significant, severe or progressive pain radiating into the lower extremity, correct.

Q. He did have some weakness in his leg, correct?

MR. SCHWITZER: I ask if we are done with the diagrams, can the doctor sit down.

MR. BRODY: We are done with this one for a moment.

Q. Dr. Bass reported he was having some leg weakness, correct?

A. I have to review the record to see where he put that in.

Q. I want you to assume that Dr. Bass is coming and we will put his record into evidence. I want you to assume that he described the patient having lower back pain with weakness. That would be enough to tell you what was causing his leg weakness, correct?

A. Correct.

Q. Dr. Bass did not have the ability to review the MRI two days after his accident, a year and-a-half before his accident, correct?

A. Correct.

Q. When someone has L-5/S-1 stenosis impinging upon the nerve, does the pain just show up one day badly or does it increase gradually over time?

A. Degenerative conditions increase gradually over time.

Q. What effect would things like Naprosyn have on a person who has canal stenosis?

A. It depends on what you are giving them. The Naprosyn for, whether or not the stenosis is symptomatic, anatomically. The Naprosyn is not doing anything to change the stenosis.

Q. It is anti-inflammatory designed to slow down the inflammation?

A. The stenosis does not cause inflammation. Stenosis is only a term that means a narrowing of, so the anti-inflammatory decreases inflammation in a body part that is symptomatic; for example, lower back pain, because of an inflammatory reaction can be painful, the anti-inflammatory ameliorates the inflammatory reaction that is causing the lower back pain.

Q. A person who has L-4/L-5 facet arthrosis, where would that cause them pain?

A. Facet pain is persistent lower back pain. That is generally referred in the lower back area then down into the buttock.

Q. Isn't that exactly the type of pain that Dr. Kaisman was reporting that Mr. Tapia was experiencing when he referred him to you?

A. In addition to the lower back symptoms, he also had right lower extremity radiating symptoms.

Q. You reported that?

A. No, I think that's in Dr. Kaisman's notes as well.

Q. Doctor, let's go to the record of October 25, 2007 for the moment.

Have you ever seen that record before?

A. Yes.

Q. Do you see any mention of any foot or lower extremity weakness in that record?

A. No.

Q. Let's go to December 28, 2007, do you see any mention of it in the record?

A. December 20, 2007.

Q. December 28.

A. I have 20 on here.

Q. December 20.

Do you see anything in there about lower extremity, pain, weakness?

A. No.

Q. Isn't it a fact that every time Mr. Tapia went

to Dr. Kaisman, he had normal motor strength in his lower extremities?

A. Early on, those are the 2007 records, yes.

Q. Let's take a look at June 26 and August 21 of 2008.

Do you ever remember seeing a record of Dr. Kaisman where the plaintiff did not have normal motor strength?

A. I recall the reference that he made to right lower extremity symptoms and straight leg raising as well.

Q. So, your answer, since I asked you a question about motor strength and you answered with somebody else you said he always reported normal motor strength, correct?

A. At least for me, yes.

Q. Counsel asked you over and over about March 31, 2008 report of Dr. Betchen where she looked at an x-ray and said gee it does not look like I am getting a lot of fusion here, I better send him for a CAT scan, correct?

A. Yes.

Q. He did not ask you for the CAT scan, he went for a CAT scan?

A. Yes.

Q. The scat CAT scan showed that he had instrumentation in good place?

A. Yes.

Q. It actually showed that he was starting to fuse, correct?

A. Yes.

Q. So Dr. Betchen instead of saying you need surgery, I recommend that you have surgery, you say if kyphosis continues to progress, that's not what she says, then I would recommend he have another operation to extend his instrumentation, correct?

A. Yes.

Q. That was in 2008, he had an MRI in 2009, an x-ray in 2012, correct?

A. Yes.

Q. Those are the two films that you testified from today?

A. Yes.

Q. There has been no change in that instrumentation, has there?

A. In the instrumentation, no.

Q. It is stable and intact?

A. Yes.

Q. It is doing its job?

A. Yes.

Q. In fact, when the plaintiff goes to Dr. Thomas, Dr. Thomas identifies him as having pain from L-3 to S-1 but plaintiff is not demonstrating any pain or spasm above that level, is he?

A. Correct.

Q. So really doctor, right now, it would not make sense to revise a procedure that is working, would it?

A. That's why I have not done it, correct.

Q. I want to go back earlier on, so this gentleman goes to the hospital and he has degenerative disc disease at L-5/S-1 that can be competent producing cause of radiculopathy down his leg, correct?

A. It can be, yes.

Q. He has diabetes, is that correct?

A. Yes.

Q. What is diabetes mellitus?

A. There are two types of diabetes. It depends on which type we are talking about.

In general diabetes, it refers to abnormal increase in your blood sugar because your body does not have an ability to properly store and process the sugar that you take in when you are eating.

Q. And is that the type of diabetes mellitus the plaintiff had?

A. That's a general description of diabetes. As

I said, there are two types. One is insulin dependent diabetes and the other is non-insulin dependent. Mr. Tapia has non-insulin diabetes.

Q. Mr. Tapia is Type 2 diabetic?

A. That's another way of saying that, yes.

Q. Can diabetes affect the nervous system?

A. It can, yes.

Q. Can it cause radiculopathy?

A. In general, diabetes does not cause radiculopathy, it causes poly-neuropathy.

Q. Have you ever testified that diabetes can cause and or contribute to radiculopathy?

A. Diabetes can contribute to radiculopathy depending upon whether or not you had the ravishes of diabetes that also contributed to poly-neuropathy and other organ system changes over a long period of time.

MR. SCHWITZER: May we come up?

THE COURT: Come up.

(Discussion held off the record.)

THE COURT: Go ahead.

Q. Have you testified in a case, Passlalaequa versus Keyspan and Motorola.

Page 76: Diabetes is contributory to radiculopathy, it contributes to just about every process in your body inflammation, pain. Was that your

testimony?

A. Yes.

Q. In fact did you further go on to say with my favorite word in it, page 69 diabetes is co-morbidity. Diabetics can suffer from poly neuropathy is that correct?

A. Yes.

Q. In a person who has, what you have described as L-5/S-1 radicular pain, can diabetes contribute to that radiculopathy?

A. It can, yes.

Q. In fact -- let's go back a second. L-5/S-1 radicular pain, is that impingement on L-5/S-1 nerve root?

A. There are multiple reasons why you could have L-5/S-1 radicular pain. Impingement is one of them.

Q. Diabetic poly-neuropathy is one of them?

A. No diabetic poly-neuropathy refers to a condition whereby patients oftentimes, poorly controlled diabetics suffer from a problem with multiple nerves, usually, in the peripheral extremities, usually distribution in the knees and/or below, usually presenting with burning dysesthesia.

Poly means many. Neuropathy means problem with nerves. A poly neuropathy or diabetic neuropathy

refers to a problem with many of the nerves because it is a generalized condition that affects particularly nerves in the periphery of your feet and below your knees. Often times occurs in particularly type one diabetics who are poorly controlled with respect to sugar control.

Q. How control was Mr. Tapia?

A. Pretty well controlled, if you look at his blood values.

Q. If I look at his blood values where?

A. If you look at his blood values in any of the blood tests that were done in the hospital.

Q. Which hospital?

A. St. Vincent's Hospital, you look at his finger stick, or the blood value at Maimonides. Mr. Tapia is not insulin dependent. He is on medications for the diabetes but he does not take insulin for the diabetes.

Q. Do you know if he was missing a lot of his appointments before he had his accidents?

A. I saw he missed some of his appointments.

Q. Did you see anything else in the records -- I will not get into the specifics now that will not be indicated with a person with elevated blood sugar levels?

MR. SCHWITZER: Objection to form.

THE COURT: Sustained.

Q. Did you see anything else in Dr. Bass record that was contra-indicated for people with blood sugar levels?

A. I am not sure I know what you mean by that.

Q. Doctor, when Mr. Tapia went to Maimonides Hospital and they did this MRI, they found that he had an L-1 burst fracture to non-displaced, two non-displaced thoracic and one at low lumbar spine and lumbar non-displaced fracture of the level below the burst fracture?

A. Say that again.

Q. The MRI shows L-1 burst fracture, correct?

A. Yes.

Q. They found based upon x-rays other tests, T-12 non-displaced fracture and L-2 non-displaced fracture, correct?

A. T-12, yes in L-2 anterior portion of that L-2 that was fractured.

Q. Non-displaced?

A. Yes.

Q. There is fracture line there?

A. Yes?

Q. They found significant disc degenerative disease at L-5/S-1?

A. Yes.

Q. Did you ever note any where in your records two days before the accident he had significant disc degenerative discs at L-5/S-1?

A. In my treatment records?

Q. Yes any where?

A. No.

Q. Counsel asked you in that last question about causal relation. He listed 20 things. Do you remember that?

A. Yes.

Q. Did you listen to things that he listed that you said were causally related to the accident?

A. Yes.

Q. Carefully?

A. Yes.

Q. One of the things he said was annular tear at L-3/4?

A. Yes.

Q. Wasn't the anterior tear at L-4/5?

A. Yes.

Q. Was the L-3/4 tear causally related to the accident, there was none at that point?

A. L-4/5.

Q. The tear from L-5 to S-1 but there was no tear

from L-4 to S-1, correct?

A. No.

MR. SCHWITZER: I ask it is the jury's recollection.

THE COURT: It is always the jury's recollection.

Q. Let's talk about these discs for a second. L-5/S1 the disc back on the inside?

A. Yes.

Q. Are you aware that a radiologist is going to come in and testify in this case that a vacuum disc --

MR. SCHWITZER: Objection.

THE COURT: Sustained.

Q. Did you review Dr. Fischer's report?

A. No.

Q. Are you a radiologist?

A. No.

Q. What is a vacuum disc?

A. A vacuum disc is a description of a disc space that has very dark space that has very dark core or dark center to it.

Q. That dark core or dark center is caused by gas, correct?

A. It has the same consistencies as gas but I

don't know whether it is or not unless you open up the disc and go into its core.

Q. At some point you did do that?

A. I did that, yes.

Q. Was it a black disc?

A. When you are looking at it, it does not appear to be black, it shows up black in the MRI.

Q. It had the consistency of vacuum disc?

A. No, there was disc material in there. I removed that material and sent it to pathology.

Q. Can you take a look at St. Vincent's hospital record and show me the pathology report.

A. I don't see the path report in the chart.

Q. There is no evidence that you sent anything to the pathology department, is there?

A. Everything we remove during the operation, particularly discs, are sent as a standard to pathology.

Q. You wrote your operative report that you removed disc material from this patient?

A. Correct.

Q. But you did not describe the disc material that you removed any where in your report, did you?

A. No, I was too busy doing the operation.

Q. You have written many operative reports and in many of them you describe the disc material you remove,

don't you?

A. Sometimes yes.

Q. It is important when you are removing healthy disc tissue that is spongey, it is easily removed but when you are removing hard disc material, it is much more difficult to remove, isn't it?

A. It can be but it depends on the specific case. I don't recall any specific difficulties with this particular procedure.

Q. You would not know because you did not write it in your report?

A. If had been particularly difficult, I would have noted it.

Q. Let me ask you this: Counsel asks some nebulous questions about you getting authority going forward with treatment, do you recall that?

A. Yes.

Q. Isn't it true that if you did not report that the conditions at L-5/S-1 were causally related to the accident, you would not get paid for the procedure?

MR. SCHWITZER: Objection.

THE COURT: Sustained.

Q. Doctor, when you reported to whomever you reported to the conditions that you were going to operate on, did you mention the words "stenosis"?

A. I don't --

Q. Yes or no -- did you mention the word "stenosis"?

A. Well it is -- when you mention, when we request authorization for the surgery it is not only based on my records it is based on all of the patients treatment records. It is not me saying this is what I want to do and why I want to do the review of patient's treatment.

Q. Your records are in front of you?

A. Yes.

Q. You sent a copy to have somebody authorize treatment?

A. As part of his treatment record, yes.

Q. No where in any of your records does it use the word stenosis, does it?

A. No.

Q. It does not say he has neural foraminal narrowing, does it?

A. No, because --

Q. I did not ask you why. You have your own reason why.

MR. SCHWITZER: Objection.

Q. You don't mention it any where?

A. Correct.

Q. You don't mention that he had any degenerative disc disease in any of your records, do you?

A. Correct.

Q. That is because if you wrote that he was suffering from degenerative disc disease that you were treating, you would not get paid.

MR. SCHWITZER: Objection.

THE COURT: Sustained.

Q. Doctor the disc desiccation that appears on this 5/28/2007 MRI, that was not caused by the accident, was it?

A. No.

Q. Doctor, you said there was a difference between the CAT scan taken in 2008 and the MRI taken in 2007, is that correct?

A. I think one of the things I said CAT scans and MRI look at things in different ways.

Q. Let me rephrase it.

Were you shown the Doshe diagnostic, correct?

A. Yes.

Q. You looked at this MRI from Maimonides Hospital, correct?

A. Yes.

Q. They show the same herniated disc at L-4 L-5/S-1?

A. Yes, they show the disc degeneration.

THE COURT: We have to break. Return promptly at 9:30.

Do not discuss the case, do not form any opinion.

Have a pleasant evening. See you tomorrow at 9:30.

(Jury exits courtroom.)

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The foregoing is hereby certified to be a true and accurate transcript of the proceedings as transcribed from the stenographic notes.

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ADMELINDA J. RUBIO, RPR

Senior Court Reporter

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NADONNA FERGUSON

Senior Court Reporter

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