SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS : CIVIL TERM : PART64

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LUIS ALMONTE,

Plaintiff,

-against-

PEARSON CAPITAL PARTNERS, LLC and CONGRESS BUILDERS, LLC,

Defendants.

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Index # 5382/13 **TRIAL**

360 Adams Street
Brooklyn, N.Y. 11201

June 26, 2018

B E F O R E :

HONORABLE KATHY KING,
Justice, and a jury.

(Appearances same as previously noted.)

VANESSA DEL VALLE
KIMBERLY MANNING
OFFICIAL COURT REPORTERS

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THE COURT: Good morning.

MR. VARGAS: Good morning.

MR. VAN ETTEN: Good morning, Your Honor.

THE COURT: Okay. Mr. Carr, my court attorney, has already spoken with counsel to determine if there are any issues to be addressed. There are none?

MR. VARGAS: Nope.

THE COURT: Okay. Excellent.

Off the record for a moment.

(Whereupon, there was a discussion held off the record.)

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Please be seated.

Good morning, ladies and gentlemen.

THE JURY: Good morning.

THE COURT: Okay. We are about to continue with plaintiff's case this morning.

Are all phones on silent?

JUROR: Yes.

THE COURT: Okay. Thank you. Thank you.

We have a new person here today, another intern from my alma mater, SUNY Buffalo School of Law.

JUROR: All right.

THE COURT: So she's joining us here today.

That being said, Mr. Vargas, you can call your witness.

MR. VARGAS: Thank you.

I call Dr. Matthew Grimm to the stand.

MR. VARGAS: Your Honor, we've marked his chart into evidence. If I may give that to him.

THE COURT: So moved.

THE CLERK: Good morning.

THE WITNESS: Good morning.

D R. M A T T H E W G R I M M,

called as a witness, having been first duly sworn by the clerk of the court, was examined and testified as follows:

THE WITNESS: Yes.

THE CLERK: Okay. Have a seat.

In a loud, clear voice just state your name and address for the record.

THE WITNESS: Matthew Grimm. 160 East 56th Street, New York, New York 10022.

THE CLERK: Thank you.

THE COURT: You may inquire, Mr. Vargas.

MR. VARGAS: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. VARGAS:

Q Good morning, Dr. Grimm.

A Good morning.

Q Could you start by telling the jury your profession?

A I'm a physical medicine rehabilitation and pain management specialist.

Q What exactly is that?

A I deal with a lot of non-surgical orthopedic complaints. Patients will come to me if they get injured. And I am sort of the conservative approach to treatment before surgery.

Or if patients have surgery and are still having a

great deal of pain, they come to me as well for treatment of pain both in a multidisciplinary approach, both using medications, as well as interventional procedures with injections. Also recommending physical therapy, acupuncture, massage. Just sort of anything conservative that is not surgery for treatment of a patient.

Q And can you tell the jury your educational background?

A Yes.

I went to college at Pennsylvania State University graduating in electrical engineering. I then took a side course to medical school, the Jefferson Medical College in Philadelphia. Then did my residency in physical medical and rehabilitation, starting out at the University of California in Irvine. And then finish up at William Beaumont Hospital in, right outside of Detroit where I was the chief resident there.

I then did a fellowship, which is sort of post residency training in interventional pain management done at Non-Surgical Orthopedics in Atlanta, Georgia.

Then I started my -- I didn't start my practice. I started working for Non-Surgical Orthopedics in New York following my training.

Q And you are duly licensed in New York?

A Yes.

Q And are you board certified?
A Yes.
Q What are you board certified in?
A I'm board certified in physical medicine and rehabilitation.
Q Presently you work in a private practice you mentioned?
A Yes. I work for Non-Surgical Orthopedics in Manhattan.
Q And, doctor, did you have an opportunity at some point to treat a Mr. Luis Almonte?
A Yes.
Q And when was the first time you saw him?
A I saw Luis the first time on March 15, 2013.
Q And at that time did you take a history from Mr. Almonte?
A Yes.
Q And what was that history?
A He presented to me with complaints of neck and lower back pain following a construction or following an accident on March 5, 2013. I believe he is working as a plumber. He was on a six foot ladder tightening some pipes. In the process of tightening, he fell backward following, causing injury to his neck and his lower back.
Q And after taking the history, what did you do next?

A I did a physical examination.

Q What were your findings?

A Uh, on that day he had pain with transitional movement. Initially he was ambulating with a severely antalgic gait. Just means a painful walking pattern.

He had severely decreased range of motion. The lumbar spine, any motions past neutral caused severe pain. Unable to straighten really to a zero degree neutral position. Ambulating with a hunched over kyphotic just sort of gait pattern (indicating).

It was difficult to test his strength on that day just 'cause he had severe pain with any sort of straining.

Sensation was intact. He had a positive straight leg raise on the right. And with a straight leg raise is a test of the nerves in the lumbar spine to see if there's any inflammation being caused by a nerve being compressed in the lower back.

When you stretch a straight leg out, has to be in a straight manner, past 30 degrees. If the nerve is inflamed or being impinged or pinched in the back, it can reproduce pain going into the leg.

His reflexes were normal. He had cervical pain with extension. And left and right lateral flexion past approximately ten degrees. And the pain with extension was past approximately five degrees.

His upper extremity strength was intact. His sensation in the upper extremities was intact. And he had palpable spasm in his cervical and lumbar paraspinal musculature.

Q After performing the exam, did you have a recommendation for him?

A Yes.

Q What was that?

A At that time I was sending, I sent him for MRIs of his lumbar spine due to his symptoms. I started him on a Medrol dose pack just. Strong anti-inflammatory steroid to try and knock out the inflammation. I started him on a antispasm agent Flexeril for spasm. He was taking Percocet at the time for pain. I advised to continue for, in the acute treatment period of his pain.

He was fit for a lumbosacral custom orthosis.

Q Which is a -- you were saying?

A Back brace just to give him some support. Advised not to wear that more than five hours a day. You wear it more than five hours a day, often caused some muscular atrophy. Muscle breakdowns in the back, 'cause your muscles will normally be used to firing, and if you are using a brace then they won't.

I recommending him to hold off the physical therapy initially until his pain level came down some.

Q And you mentioned you had recommended MRI.
Was the MRI done?
A Yes.
Q And do you know when it was done?
A Yes.
(Whereupon, there was a pause in the proceedings.)
A March 21, 2013.
Q And did you personally review the MRI?
A Yes.
Q After reviewing that MRI, did you meet with Mr. Almonte again?
A Yes.
Q And when was the next visit?
A His next visit was then April 4, 2013.
Q And at that time did you discuss the findings of the MRI with Mr. Almonte?
A Yes.
Q And what were the findings?
A His MRI had, I mean the major areas where I thought that was the problems, he had a posterior disc bulge.
So I mean in the MRI you have the bones, then you have discs in between the bones (indicating). The discs will give you some mobility in this, the spine, sort of act as shock absorber. Kind of like a jelly doughnut, hard

exterior and a soft interior. If that's soft, if there's trauma or uneven pressure on the spine, the jelly can push out (indicating). And at L4-5 he had a bulge.

I think of it kind of like a Quarter Pounder with cheese where the meat is sort of coming out all the way around outside of the bun. That's sort of what a bulge is.

At L3-4 there's a herniation. Which is coming in effacement of the thecal sac. The thecal sac is just the covering, the spinal cord.

Also a bulge at that level at L2-3. Another bulge that was coming into effacement and coming into contact with the thecal sac and also causing some narrowing of the foramen. The foramen where the nerves come out of the spine. That's doing that on both levels.

He also had a herniation at L5-S1. That's this lowest level which was causing some, again some narrowing where the nerves come out of the spine.

Q After reviewing the MRI and seeing Mr. Almonte again, did your recommendation for treatment change at all?

A No. I just, I recommended further treatment with nerve conduction EMG studies.

What those are, it evaluates the nerves of the spine. If the nerve is being pinched by a disc, if you think of it kind of like a, the water hose being kinked, anything downstream can start to die.

In this case being the musculature in the spine. And a nerve test will test each individual level by putting a pin into different muscles of the extremities to see if there's any degeneration of the muscle. It's important to tell 'cause if a disc isn't causing any severe compression, then the muscle will be okay. If it's causing a severe compression, compression you can start to see some breakdown on this test, sort of helps to determine which levels need treating or which levels are a bulge or a herniation, which is not causing any issue.

Q And was the EMG performed?

A Yes.

Q When was it performed?

A That was performed on... July 18, 2013.

Q And did you review the results of it?

A Yes.

Q And what were the results?

A The results of the EMG showed a bilateral S1 radiculopathy, as well as a tibial mononeuropathy.

Q For the jury, what does that mean?

A That means that as a result of this lowest disc herniation, the L5-S1 (indicating), it was causing the S1 nerve, again sort of be kinked, so signal is not reaching the musculature of the lower, sort of the back of the leg.

When people kind of think of sciatica and also

going down to the calfs and into the foot, you can get pain in that distribution.

Q After reviewing the EMG report, did your recommendations for treatment change at all?

A The next step I believe we then discussed epidural steroid injections for treatment, as he had already had conservative treatment with... already had conservative treatment with physical therapy, and anti-inflammatory treatment, like I said, with the steroid taper.

Kind of a step wise process. You start with the most conservative treatment and you sort of move upwards as if the pain persists, despite that treatment.

Q Physical therapy, how is that supposed to help the patient?

A Physical therapy can help in many ways. One, you need to maintain range of motion. Stretching of the musculature. Sometimes the muscles you can form spasm in what we call trigger points and tight bands of muscle spasm. That can sort of work it out.

You also want to strengthen patient's core musculature in the front of their body, 'cause when you strengthen the core, that can sort of help take some of the pressure off the spine in the back. Take the pressure off the nerves.

You can also do something in therapy called

traction where they will actually manually try and sort of expand this bind to try and relieve some of the pressure on the nerves.

Also use, called TENS Unit to try and take, to stimulate the muscles. And that can help with pain.

And then of course just aerobic exercise to try and strengthen accessory muscles and whatnot.

Q And Mr. Almonte attended physical therapy?

A Yes.

Q And how often would he go?

A I generally recommend patients go, try to go two to three times a week, with also instruction for home exercise as well while they're at therapy for simple stretching and exercises they can do at home.

Q And you mentioned epidural injections after he had performed physical therapy for some time?

A Yes.

Q And when did you first recommend epidurals?

A The first time an epidural was recommended was on August 5, 2013.

Q August 5, 2013?

A Yes. That's the...

Q And between April 4, 2013 and August 5, 2013, how many times did you see Mr. Almonte?

A I saw him again in May, on May 23. I saw him then

again on July 3, and then August 5.

Q And on August 5 did you perform an exam?

A Yes.

Q And what were your findings?

A Regarding his cervical spine, he had range of motion, his extension was 55 degrees. Or normally would be approximately 60 degrees. Six zero. He had full flexion with pain at end range. Normal is around 50 to 80 degrees, depending on the patient. He had left and right lateral flexion at the neck at 35 degrees. Normal is approximately 45 degrees in normal population. He had left rotational pain past 70, seven zero, degrees. Normal was at 80 degrees. And to the right he had a pain past 75 degrees.

He had maintained upper extremity strength. Sensation was normal. Reflexes were normal. And he had, the only other positive, he had some spasm in his paraspinal musculature of the neck.

In his lumbar spine he was ambulating with an antalgic gait.

Q What does that mean?

A He had some tenderness over his spinous process of the lumbar spine. That's just the, you can have some, develop some tenderness over these posterior spinous process of the spine sometimes if you get an injury.

He had pain with extension of his lumbar spine

bending backwards past five degrees. Normal is approximately 25 degrees. Pain with flexion past 30, three zero, degrees. Normal is at 85 to 90 degrees. He had pain with left and right lateral flexion past ten degrees. Normal would be 25 degrees.

He had a decreased sensation in his right lower extremity involving the posterior lateral outer portion and back of his calf and to his lateral foot, which corresponds with your S1 nerve root in the lumbar spine. So goes along with that.

He had a positive straight leg raise with pain radiating in a posterior lateral direction in his leg. And he had some spasm in his lumbar paraspinal musculature as well.

Q And at this visit you recommended the epidural?

A Yes.

Q And what is an epidural, for the jury?

A So an epidural steroid injection is an injection that you'll put -- do you want me to --

Q Yeah. Whatever would help you.

A Yes. It's a procedure that I do in my field sort of when conservative treatment has failed. We use, it's done under fluoroscopy.

What fluoroscopy is, just an x-ray that can be controlled and maneuvered to get different angles of this

spine in order to do the procedure.

We use a kit like this (indicating). We have the patient laying on a table in a surgical center. An ambulatory surgical center is where I do my procedures at. And then it's under a sterile field. Everybody is on gloved. I am sterile. The patient's on the table, he gets prepped and sterilized on his back.

And then the kit is opened. And this is what we'll use to sterilize. We do a triple sterile. A triple sterilization three times to make sure we get any bacteria, anything that's on the back, off.

Then once that's done I will use a small 25 gauge needle to anesthetize the skin at the area where the injection will go in. And that's used with Lidocaine.

When you go to the dentist, if you get Novocaine.

Then once -- while that is becoming numb I use a different needle and different syringe to take up steroid and Lidocaine into the syringe. This is what's injected into the spine. I will also take a dye. And what the dye is used for is to make sure that we're injecting in the right place. Number one -- it's done for two reasons.

One, to make sure we are not in soft tissue. You inject in sort of muscle or fat in the back, you are not going to get any effect from it.

Two, to make sure I am not injecting into a blood

vessel. If I inject into a blood vessel, it can lead to paralysis, death. I mean bad stuff. We don't want to do that.

Once the area's anesthetized, I use a needle and it goes down to the space, the L5-S1 in Luis' case. And in order to do that, there's two different approaches.

Initially we did what's called an interlaminar approach, which is going down into the back of the spine. Sort of in the same if the women are getting an epidural for baby, it's the same space essentially, only we are putting different medication in. It's a little different needle that's used.

In order to do that, I use a little plunger here that I place on the needle. Because once you're getting down into the area there is a ligament that is over the epidural space. When you get into the ligament you'll, you get some resistance. And I can feel it. I've done tens of thousands of these procedures so I know how it feels. And then I went, get through that ligament, I will get a loss of resistance. And so that's how I know I'm in the epidural space. Or I could be in a blood vessel.

You can also get what's called a false loss of resistance. And that's when you are in a blood vessel and that's why we use the dye, then inject the dye. I will interpret the dye, what's called an epidural gram, which is

where you are just making sure the dye is following the nerve roots. It's not in soft tissue, it is not going into a blood vessel. And then we inject the medication. And the medication essentially will coat the nerves and decrease, the goal is to decrease the inflammation and decrease the pain.

Q You mentioned the drug is Lidocaine and steroid, correct?

A Yes.

Q And why is it that mixture?

A The Lidocaine is just to give the injection some comfort. It wears off after about seven, eight hours. The steroid is the anti-inflammatory part of the injection by which that's what's actually taking effect in providing the improvement in pain. That takes effect usually starting around 12 to 24 hours. You will get maximum improvement around three days to five days.

Q In your experience administering epidurals, how long do they usually last?

A It's a patient dependent. Some patients get improvement for months, years. Some patients get improvement for days or weeks. And then unfortunately some patients won't get any improvement. Usually patients will get, I'd say, a good few months, if not up to a year.

Q And there's also, later on we are going to talk

about trigger point injections.

You administered some of those, too, correct?

A Correct.

Q What's the difference between epidural and trigger point injections?

A An epidural injection is going very deep to treat nerve pain in the spine, the nerve inflammation. Whereas a trigger point injection is used to treat more musculoskeletal pain in muscles.

If your muscles have formed spasms or tight bands called trigger points, using a smaller needle kind of like the one I used to numb the skin up, if you put that into a tight banded muscle, that muscle can then release and it can relieve muscular pain in the back or the neck or any muscle that's spasmed.

Q After administering the epidural on August 5, 2013, when was the next time you saw Mr. Almonte?

A I saw him... again on September 25.

Q And on the 25th did you examine him?

A Yes.

Q And did you take a history from him?

A Yes.

Q And what was the history?

A He had returned following his epidural steroid injections. He stated that he initially noted approximately

80 to 90 percent improvement for approximately two to three weeks of his pain.

At that time of the visit he was then placing it more at a 50 to 60 percent improvement. He noted being able to ambulate further following the injection.

Q And the next time you saw Mr. Almonte?

A I saw him then again on November 13, 2013.

Q Now, I see also was there another epidural on October 25?

A Yes. I thought you meant the next time I saw him in the office.

I had recommended at the last visit recommended additional epidural injection, as often times the injection sometimes can be additive on top of each other. You can do up to three in a six month time frame. You only go on to additional injections if the patient still has some pain.

And I always liken it to try to put a fire out, if you are throwing water on it, it's still simmering. I recommend to proceed on to an additional injection to knock out the additional inflammation.

Q And on the 25th, October 25, 2013 he had an epidural and a trigger point, correct?

A Yes.

Q And then the next time you saw Mr. Almonte?

A That was the November 13 visit.

Q And did you take a history from him at that time?

A Yes.

Q And what was the history?

A He was, at that time he had reported some improvement in his radicular symptoms. Again, that's the nerve pain which you'd expect following getting some epidurals.

He was reporting more axial pain. That is, more musculoskeletal or back pain without radiation. And pain wears with extension and lateral flexion in spine pain with bending back and left to right.

Q Did you have a recommendation at that time for future treatment?

A Yes.

Often times patients can have multiple source pain in the spine. It can be coming from the nerves, which is, again if the disc herniations pinch on the nerves. It can also come from the joints in the back, like any area in your body. The knee has bones that interact with each other. A joint. The back. These vertebrae interact with each other at what's called a facet joint.

Facet pain, again, can normally be caused by putting pressure on the joint. And but it often times will not radiate. It just stays in the spine.

So at that time I was recommending injections into

the joints at the lower areas where he was feeling his pain when we were stressing the joints to see if that was causing some of his pain.

Q And did he have those injections?

A I believe so.

(Whereupon, there was a pause in the proceedings.)

A Yes. On December 13, 2013.

Q And at that time you gave him the facet injections in the lumbar spine?

A Yes. With trigger point injections at the same time.

Q And after those injections, the next time you saw Mr. Almonte?

A I saw him... on December 30, 2013.

Q You take a history from him at that time?

A Yes.

Q What was the history?

A He was reporting continued back pain following the diagnostic injections. He reported minimal improvement after the injections, which again led me to believe that the majority of his pain was coming from the, both the muscular issue from the spasm and the trigger points, as well as the discogenic pain, which is the disc pinching on the nerves.

Q Did you have a recommendation for treatment at that

time?

A Yes. I was recommending continued physical therapy.

And as he was still experiencing continued pain in his spine, despite treatment with the injections, I referred him for evaluation for surgery with Dr. Brisson.

Q And did you have your own assessment and plan in that December 30 visit?

A Yes.

Q What was it?

A Patient failed conservative efforts with injection therapy, sending for surgical evaluation with Dr. Brisson. Continue with physical therapy to the cervical and lumbar spine. Percocet for pain control, Ibuprofen for inflammation, Flexeril for spasm, Protonix for gastritis. And then in-office trigger point injections were performed to the musculature.

Q Now, those drugs you listed, Percocet for the pain, and Ibuprofen for the inflammation, Flexeril for the spasm and Protonix?

A Protonix.

Q Why was that prescribed?

A Protonix is a, what's called a proton pump inhibitor. And what that is for is if a lot of times taking pain medication, taking anti-inflammatory medication, they can cause issues with your stomach and your gut.

The Percocet can slow everything down. Which can cause some gastritis or stomach upset.

The Ibuprofen is a what's called a nonsteroidal anti-inflammatory. One of the side effects of that, unfortunately, is gastritis.

So what a proton pump, what a proton pump inhibitor does is it sort of inhibits acid being released into the stomach, which then can help with the gastritis.

Q And the next time you saw Mr. Almonte?

A I saw him... again on January 27, 2014.

Q And this time you took a history again, correct?

A Yes.

Q And what was it?

A He had sought treatment with Dr. Brisson. He was still experiencing pain in his lumbar spine at an eight out of ten level on the VAS pain scale.

Q What is that?

A It's the visual analog pain scale. Just a pain scale that's often used in medicine. Meaning zero means you're having no pain, and ten is the worst pain you've had all your life.

Eight out of ten means you are having pain that pretty much inhibits you from doing many everyday activities.

Q And your assessment and plan at that time?

A At that time I was requesting Dr. Brisson's consultation report. I was recommending continued physical therapy, as well as a continued treatment with Percocet, Ibuprofen, Flexeril and Protonix.

Q And the next time you saw him?

A I saw him on February 27, 2014.

Q And did you take a history at that time?

A Yes.

Q And what was it?

A At that time he continued -- had experienced continued back pain. He was reporting worsening radiating right lower extremity pain. Due to the pain becoming worse, he was requesting to try an additional lumbar epidural for symptomatic treatment.

Q And the next time you saw him?

A I saw him -- let me see if we did the epidural.

(Whereupon, there was a pause in the proceedings.)

A I saw him on, looks like March 14, 2014, for an epidural injection.

Q Okay. And this is two years -- or a year after the accident?

A Yes.

Q And you performed another lumbar epidural?

A Yes.

Q And the next time you saw him?
A I then saw him again on April 28, 2014.
Q And did you take a history?
A Yes.
Q And what was the history?
A He had described continued lumbar radiating pain into his legs. Again he was requesting an additional epidural as he received transient or short-term improvement from his pain and comfort from the last one. And he was just trying to remain comfortable enough until he was able to undergo surgery.
Q And the next visit?
A The next visit.
(Whereupon, there was a pause in the proceedings.)
A The next visit was... June 4, 2014.
Q And, doctor, I'm going to skip ahead to September 8, 2014.
A Okay.
Q And do you see that note?
A I'm looking for it.
(Whereupon, there was a pause in the proceedings.)
A September 8?
Q Yes. 2014.

A Yes. Got it.

Q Do you see --

A Yep.

Q Okay. Did you take a history from the patient at that time?

A Yes.

Q And what was it?

A He had, he was presenting post lumbar fusion surgery on July 8, 2014 with Dr. Paul Brisson.

On this date he was rating his pain nine out of ten on the visual analog pain scale. He was reporting requiring assistance with dressing and cleaning at his home from his family. And he was there for medication management post surgery.

Q And I then see a visit on October 7, 2014, October 21, 2014, and skipping through October 30, 2014, November, December, to January 29, 2015.

A Okay.

Q Did you take a history from the patient on this day?

A Yes.

Q And what was it?

A He was again reporting back pain, primarily on his neck pain, was at a three out of ten on the VAS pain scale. His low back pain was a nine out of ten.

He was there at the office for medication

management. He was attending physical therapy two to three times weekly. He was again noting back pain with pain radiating into his lower extremity from the buttocks, his posterior thigh. He had a follow-up with Dr. Brisson scheduled.

We had tried him on different medications, that one being anti-inflammatory Zipsor, which had not been helping. Note the Flexeril had been helping with him with the spasm but he was still experiencing difficulty with sitting or standing for a long period of time and he was unable to walk any type of long distance.

Q And had you changed his medications for the inflammation and pain?

A Yes.

Q And what had you changed them to?

A At that time we had tried to again wean off of the opioid medication following his surgery. To pain, anti-inflammatory that being Zipsor, which is a medication generics Dicycloverine, in that case just another nonsteroidal inflammatory similar to Ibuprofen, Aleve. Those types of medications.

Since that one was not working, I started him on another one called Duexis, which is a high dose Ibuprofen with something in it help with the stomach and the gastritis like we had talked about earlier.

He was placed on Cymbalta. Cymbalta is a depression medication, but it can also help with nerve pain. It causes an increase in serotonin and norepinephrine.

Norepinephrine can help with nerve mediated pain and sometimes muscular skeletal pain in the body. Can also help with anxiety and depression as well. Still on Flexeril for spasm.

Q And I see in your assessment and plan patient is enrolled in the Lower East Side Methadone treatment maintenance program?

A Yes.

Q Did this factor into the drugs you could prescribe him?

A Yes.

Q How does it factor in?

A I mean as with all the patients, I mean even this is sort of before all the stuff you see in the news about the opioid crisis. But I mean I was very cognizant of opioids. Being in pain management, we always try to not to utilize them if he doesn't need to.

I am very conservative in treating them initially or with all patients. But with Luis it just meant I was even more on top of it. He was tested regularly and we would try to treat without any use of opioids if at all possible. Or with ones that aren't as sort of, have as much

of the addictive properties as some of the Schedule 2 or the stronger opioids.

Q And when you say Schedule 2, drugs are classified by their powerfulness; is that correct?

A Yeah.

The DEA has different classifications for medications that are controlled, with Schedule 1 being the illegal medications; cocaine, heroin, marijuana at this point still. But that will be, probably be looked into in the future. Those type of medications.

Schedule 2 is the first legal area of the DEA or classification. That's your Percocet, Vicodin, Hydrocodone. Those type of medications. Schedule 3 get down to Tylenol with Codeine. Next is Schedule 4, which you can have medication such as Tramadol with Ambien is a Schedule 4 medication. And so on. Go to Schedule 5, which Lyrica is Schedule 5. Those are the least you can put refills on medications for like Schedule 5 medications, Schedule 2, 3, 4 up. Can't put refills on a patient. Have to follow up on a regular basis.

Q And the next time you saw Mr. Almonte after January 29, 2015?

A I saw him on March 5.

Q And this is now two years after the accident, correct?

A Yes.

Q And did you take a history from Mr. Almonte?

A Yes.

Q And what was it?

A When he was having difficulty with pain he was attending physical therapy still postoperatively. He describing sensations of sharp stabbing pains to his lower back, reporting that he was having a great deal of difficulty sleeping due to that pain. Again noting pain radiating into the right leg and buttocks into the posterior thigh. Difficulty with sitting, standing, and walking.

Q Did you do an exam?

A Yes.

Q And what was the findings of your exam?

A The cervical spine wasn't really bothering him, so essentially unchanged from the last time. Still having pretty good range of motion. What was bothering him most was the lumbar exam. So he was ambulating with an antalgic gait, using a single point cane at this point for stability.

He was, again was standing with a bent forward position. And when sitting, he would have to sit with his legs sort of outstretched to get comfortable for the examination. He would have to lean forward when I would have him on the table for the examination. It was difficult for him to sit up, upright.

He had range of motion with pain at extension from zero to five degrees. Pain with flexion at 60 degrees. Pain with left lateral flexion with pain past 15 to 20 degrees. Then pain with right lateral flexion with, at zero to five degrees.

Again, the normal with right lateral flexion is 25, normal to extension is 25, and normal to flexion forward is 85 to 90 degrees.

He had decreased sensation to his right lower extremity involving the posterior lateral thigh to calf. Had the positive straight leg raise on the right. Past 35 degrees. Pain radiating in a posterior lateral direction than he was displaying. So weakness in knee extension.

So, putting his legs straight he was having pain with ankle dorsiflexion, which is bringing his ankle up. Pain with ankle planter flexion, which is putting his ankle down. And pain with EHL extension. And that's bringing his big toe up.

Those are just tests for different nerves in the back to see if which nerves may be affected for the muscle strength.

Q Was that the right leg?

A Yes.

Q At that time of your assessment and plan, did you have exercises you recommended?

A Yes.

Q And what were those?

A I was recommending aerobic exercises and strengthening and stabilization exercise for his lumbar spine.

Q Had he had those prior to this date?

A Yes.

Q And the next time you saw Mr. Almonte?

A I next saw him on April 9, 2015.

Q And you took a history at that time?

A Yes.

Q And what was it?

A He was reporting his neck pain at a five out of ten. His lower back pain, eight to nine out of ten. He reported medication was not helping with his back pain. He was reporting difficulty with his activities of daily living. Stating his wife would need to help him get out of bed at times. Continued attending physical therapy two to three times weekly.

At that time he was describing increasing right hip pain and right groin pain. And he had been referred to a hip specialist by Dr. Brisson at a follow-up recently.

Q Was that Dr. McCollough?

A Yes. He was referred to Dr. McCollough, I believe, by Dr. Brisson.

Q And then I am going to skip ahead.

I see May 14, 2015 you saw him, and then June 11, 2015. Is that correct, doctor?

A Yes.

Q And on June 11, again you took a history and examined him, correct?

A Yes.

Q And was there a change in your assessment and plan on this day?

A Yes.

Q What was it?

A We had discussed a right hip injection, fluoroscopically guided, pending his MRI and Dr. McCollough's recommendation.

Q This is a trigger point injection?

A No. The hip injection is a different type of injection. If you have damage in your hip joint, the hip is kind of a ball and cup joint and it can be, it was all kinds of tissues that can be damaged. You have cartilage on your sort of cup area which can be torn and ripped, which can cause inflammation in the joint (indicating).

And if that happens or if there's arthritis in the joint, you can put an injection into the joint, usually going down from the front down to the hip joint capsule, which would go in right here, being careful to avoid the

femoral artery, which is running right down in this area as well.

So again that's another risk of the procedure.

So I need to, while I'm preparing the joint, I am feeling for that artery to make sure I'm missing it. Again, this is done using x-ray as well. Again I will inject a dye into the joint as well to make sure that it is again going into the joint region and not in soft tissue and not in a vessel. And then it's similar medication that was used for the epidural but putting it in the joint area for inflammation.

Q And the drugs you are prescribing, did that change at all on this day also?

A Yes.

Q And how did it change?

A We had tried multiple trials of non-opioid medications without getting really a control of his pain. And again that would cause him to have difficulty with ambulation and a great amount of difficulty with his overall quality of life.

I started him on a Tramadol, which is a, it's an opioid medication. Like I said, it's of that lowest sort of schedule group. In the journal articles I have read says it has very low addictive property. One article placed it at approximate a half percent of patients becoming addicted to

the Tramadol. Not to say it's still an opioid. Still needs to be monitored. But his history I was, and his pain, I was comfortable prescribing it to him and my supervision.

I also like utilizing that medication 'cause it has two components. One is the opioid agonist, which it will hit the receptor to help with pain. Another is norepinephrine re-uptake inhibitor, which is like the Cymbalta. Increases the norepinephrine in your body in patients like Luis who have both nerve pain and just overall pain. It sort of can kill two birds with one stone.

He was started on this medication.

Q Is there any side effects to Tramadol?

A Yes.

Q What are they?

A Tramadol can cause constipation. It can cause gastritis. It can cause lethargy. Some patients report dizziness. Those are the common ones.

And then there if you read any side effects of medications, it's a book. Those are the common ones.

Q Then, doctor, I'm going to skip ahead again. 6/25 you saw him. And then 7/17/15 I believe you saw him next.

A Yes.

Q And at that time did you take a history?

A Yes.

Q And what was it?

A He had returned post MRI with Dr. McCollough.

Q On the hip?

A Yes. The MRI revealed a labral tear. Which again, labral tear is that cartilage in the cup area of the hip joint.

So this is the femur is the ball, and then the hip has the cup (indicating). This is your pelvis area. And if there's a tear on it, it can be quite painful. So they were planning surgery on that.

He reported difficulty with ambulation due to his pain. Reported the Tramadol had been helping with his pain. Still having difficulty with ADLs. Still reporting difficulty getting out of bed at times. Attending physical therapy one to two times. Still experiencing radiating pain in his leg.

Q And then, doctor, I am going to skip ahead again. August 27 you saw him again. And then 9/24/2015.

(Whereupon, there was a pause in the proceedings.)

A Okay.

Q And at this time he was scheduled for the surgery, correct?

A Yes.

Q And did your assessment and plan change at all?

A Yes. On this time, I mean his hip issue had been

getting worse. He was having surgery scheduled, so he was given Norco, which is Hydrocodone; again, which is one of the Schedule 2, very controlled opioids. But he was given that for postoperative pain only.

He was to follow up two weeks after surgery again, when reassessment is made, to determine if we are able to come down on the medication or what changes need to be made post surgically for his pain.

Q And he had the surgery on October 1?

A Yes.

Q And you saw him on October 8, 2015?

A Yes.

Q And... did you take any history at that time?

A Yes.

Q And what was it?

A He was again post one week surgery with Dr. McCollough, still having pain postoperatively. Reported the medication was helping. He was continued utilizing a cane. And he was driven to his appointment.

Q And the assessment and plan? The last paragraph.

A Patient was undergoing continued treatment for his work related injury. Still recommending the ongoing treatment.

My medical opinion, he had remained at temporary impairment of a hundred percent at that time.

Q Maximum --

A 'Til maximum medical improvement would be determined.

Q And when you say a hundred percent, temporary improvement a hundred percent, what does that mean?

A Just means at that time I didn't feel he would be really capable of performing any type of working position, that even in a sedentary position, due to his pain and disability level.

Q But it was still open that he may be able to in the future?

A Yeah. I mean the goal is always to try and treat the issue. I mean granted he likely wouldn't be able to ever go back to his prior level of employment. I mean you want to get people back gainfully employed.

Q The next is October 22, 2015, and then November 23, 2015, and then January 14, 2016.

Did you take a history from him on January 14, 2016?

A Yes.

Q And what was it?

A At that time when he was post right hip surgery with Dr. McCollough, he had been switched to a different pain medication, Nucynta, which again is a strong opioid pain medication but has a less of a additive property than the

Hydrocodone. But it was a stronger medication than the Tramadol.

But he was experiencing side effects with the medication. Dizziness. He reported that he felt sort of like blacking out at times with the medication, so he stopped taking it.

Then he was here for medication management. And he was again requiring canes for stability and assistance with his activities of daily living.

Q Pain with weather related changes?

A Yes.

Q And you next saw him on March 1, 2016?

A Yes.

Q And this is now three years post accident?

A Yes.

Q And did you take a history from him?

A Yes.

Q And what was it?

A At that point we had transitioned him back to the Tramadol for his pain. He said it was helping. He reported he was reporting significant amount of hip pain and tightness in the hip. He advised me Dr. McCollough had recommended a cortical steroid injection in the right hip for further treatment.

Q What is that? Is that different from what you have

given?

A Same injection into the hip we discussed earlier.

Q Okay.

A Again, he was being driven to his visits 'cause he had difficulty utilizing the train due to his hip and back pain. Again, pain with weather related changes.

Again, with his medication closely monitored, he had brought his pills in for a pill count, which was appropriate. And he was utilizing approximately three to four tablets a day for the Tramadol, depending on the severity of his pain.

Q Did you do a physical exam?

A Yes.

Q What were the findings?

A Again I'm going to stick mostly to the lumbar spine.

His neck wasn't bothering him too much. Still had slight deficits, but for the lumbar spine ambulating, antalgic gait, ambulating with a single point cane. He was moving very slowly from a standing and getting up and down from a seated position for examination.

He had well healed both anterior and posterior incisions on his lumbar spine following his surgery. He had pain with extension of his lumber spine past five degrees. Pain of flexion past 50 degrees. He had left lateral flexion pain past 15 to 20 degrees. Right lateral flexion

pain past zero to five degrees. He had decreased sensation in the right lower extremity.

And again had positive -- oh, his hip pain was quite severe that day. I defer the straight leg raising testing due to pain. Any movement of the right leg was causing severe pain in the groin on the hip.

Q So there are all abnormal findings, correct?

A Yes.

Q And the next time you saw him was March 24, 2016?

A Yes.

Q And at that time, why were you seeing Mr. Almonte?

A That was, again we did a hip, right hip joint injection like I described earlier at the surgical center for his pain in his right hip.

Q And the next time you saw him, April -- I am sorry, March 29, 2016. And then --

A Yes.

Q -- April 27, 2016. And then May 5, 2016?

A Yes.

Q And at that time what were -- why were you seeing Mr. Almonte?

A At that time again his, he was continuously experiencing significant postoperative radiating pain.

Often times if patients have surgery and their nerves are still inflamed, you can get something called

failed back syndrome, which is one reason or another a lot of times the nerves in the, nerves in the spine will remain inflamed. Sometimes can be from new herniations. Sometimes can be from scar tissue. Sometimes we don't know. Just it's just a condition that happens in patients.

So we will do what's called a postoperative epidural injection, or nerve block, where we go down to the nerve roots and inject the medication as well around the nerves to try and decrease inflammation to help with the radicular pain.

Q So that's a different type of injection than the trigger points and the epidurals?

A It's different from the trigger points. It's in the same family as the epidurals, just a different approach.

Earlier I was stating we were going in from the back. At this point you can't go in from the back 'cause he now has all this hardware here, and this ligament that I was talking about going through that would allow me to feel the loss resistance is now, it would be quite dangerous to go in from the back. You could pierce the cord. Then that's again paralyzation, infection, death. We don't want that. So, I go a different approach. Again, it's precise.

Since a lot of his symptoms were coming from the right side, I went in from the right side from the lateral approach. And would go right around the nerve roots.

At this point I went around the S1 nerve root on the L4 nerve root, get spreads up and down. You can usually hit multiple levels from the injection. That's why we don't start at L3. Just do level, level, level, level. You get some spread.

And you use, again, it's a precise procedure. You taking a picture this way (indicating) or from the, at an angle to make sure we are going in at the right location. You take a picture from the side to check the depth 'cause you don't want to go too far anterior. You don't want to hit vasculature. Don't want to go into the disc or hit the nerve.

Then you take a picture from the top. Again, you don't want to go too far into the spine. You can pierce the spinal cord and lead to other complications.

So we take all those precautions, inject the dye, then inject the medication.

Q Next time you saw Mr. Almonte was March, I am sorry, May 27, 2016?

A Yes.

Q And the reason you saw Mr. Almonte on that day?

A May 27.

(Whereupon, there was a pause in the proceedings.)

A That was for a hip injection involving his left hip.

Q Why his left hip?

A He was experiencing bilateral hip pain.

Again, often times with patients, I mean your body has, was meant to be symmetrical. I mean with even pressure. If you think of the physics behind it, everything is supposed to be, muscles on the right equal the muscles on the left. The joints on the right and everything is equal.

If that sort of delicate equilibrium is interrupted with him, his right hip being injured, as well as his back being injured, then he'll start relying on his other joints more.

And so as that joint is normally used to having the weight equally distributed among both joints, now the left hip is getting a greater portion of the pressure and then you can get injury to the opposite side as well.

Q So it would be a consequential effect of the right hip injury?

A Yes.

Q And he was experiencing pain, so you gave him an injection that day?

A Yes.

Q Same as you did, you described before?

A Same as the right side.

Q And the next time you saw Mr. Almonte, June 28, 2016, correct?

A Yes.

Q And you took a history?

A Yes.

Q And what was the history?

A Again, utilizing a cane. He got a ride to the office from his daughter. Didn't require assistance in his activities of daily living.

We did a pill count with his medication, which was appropriate.

Q When you say requires assistance in daily living, what exactly is that?

A Your activities of daily living would be dressing, sometimes cleaning, personal hygiene, utilizing the restroom. Shopping. Anything that everyone sort of takes for granted and just does on their own.

A lot of patients you have an injury, you need assistance with that; good days, some bad days. If they don't need it. Shower. Often times it's putting shoes on, putting pants on. That's the hard part usually.

Then he was requiring that on from his family at times.

Q And, I am sorry, the rest of the history was?

A Again, pain with weather related changes. Pill count was appropriate. Reported that his back pain had been getting much worse with pain radiating to his feet. And an

additional postsurgical epidural had been scheduled.

Reported following the left hip injection he had approximately 50 percent improvement in his pain. On this date it was his lower back pain that was causing him the most severe pain. And he requested a surgical second opinion for treatment 'cause he was concerned he was having more pain despite having surgery.

Q And did you recommend him to anyone to have a second opinion?

A Yes. I referred him to Dr. Merola for a second opinion.

Q And did he go for that second opinion?

A Yes.

Q And do you know what that second opinion was?

A I believe Dr. Merola was recommending a revision surgery on adjacent levels of the lumbar spine.

Q And when you say adjacent levels, is that above where the surgery had been performed?

A Yes. Like I said earlier, often times if you fuse one area of the spine, this level had you previously been sort of free of moving in ability to do it, when you fuse that level, the area now puts more pressure on the levels above.

Q And you next saw him July 27, 2016, September 2, 2016, September 13, October 19, 2016.

And again you took a history, correct?

A Yes.

Q And what was that?

A On October 19, again, ride from his daughter. Cane for stability. Assistance with his activities of daily living. Pill count appropriate. Neck pain, two out of ten. Again, stating his low back pain was getting worse. Radiating into his feet.

We had done an additional right hip injection which he reported 50 percent improvement. And 50 percent improvement following his left hip injection.

Again, lumbar spine causing his most severe pain. And he reported apprehension regarding the additional surgery to the lumbar spine.

Then there's another treatment that in my field of expertise offers what's called a spinal cord stimulator.

What a spinal cord stimulator is, it's a device where we will put leads. It's hard to see here. It's leads you will put in the spine. You do a trial first where you just take a needle and you thread the leads into the epidural space.

And the goal of the stimulator is to trick your mind into believing there's no pain in the region of the spine. It's generally not a first line treatment for patients because if there's something structurally wrong,

you want to take care of that. Or unless the patient has medical issues that they can't go ahead with surgery or they don't want the surgery, they want to try something less invasive.

So he elected to try that for his pain as he was still requiring regular pain medication and he wished to try to cut down on this medication and try something for the pain to improve his quality of life.

Q And you then next saw him November 16, 2016, December 6, 2016, January 30, 2017, and then on February 23, 2017, correct?

A Yes.

Q And on February 23, why were you seeing him?

A He was there for follow-up. Again, just same thing. He was having continued pain.

Q Was it -- February 23, 2017 patient wasn't that --

A Yeah. We had done, we had performed the -- oh, wait. What date?

Q February 23, 2017.

A Sorry. I was looking at... I think that was the day we did the spinal cord stimulator trial.

Q And that's when you implanted it?

A That's when we, yeah.

Like I said, for the spinal cord stimulator there is two parts to it. One is a trial, so allows you to

test-drive it. You wear it around for five days, approximately, to see if you like it. And that's sort of the beauty of the procedure. You can try it first before going through a major surgery.

And so we were doing the trial on this day. And you get anesthesia. You put the leads in, they get sewed to an outside battery you wear around for five days.

Q And after five days you saw him again?

A Yes.

Q And February 28, 2017?

A Yes.

Q Can you tell us what happened then?

A We saw him following the spinal cord stimulator. He said he didn't like the sensation of the stimulator. Sort of replaces the pain with almost like a white noise feeling. I said it helps somewhat with the pain, sort of replacing the pain with another feeling. That was kind of weird, so he elected to not go ahead with the permanent.

Again, that's sort of the beauty of the trial. Some people feel that that sensation is better, some people don't. He didn't.

Q And the next time you saw him was March 3, 2017?

A Yes.

Q And this is now four years after the accident.

And why were you seeing him on this day?

A I was giving him an additional left hip joint injection.

Q He was still having continued pain in the left hip now?

A Yes.

Q And you next see him March 13, 2017?

A Yes.

Q And then April 20, 2017?

(Whereupon, there was a pause in the proceedings.)

A Yes.

Q And why did you see him on April 20?

A That time we, again, I did an additional epidural injection for his radiating pain from his back.

Q And was it in the lumbar spine?

A Yes.

Q Okay. Next, May 3, 2017, June 14, 2017, August 1, 2017 and August 21, 2017.

(Whereupon, there was a pause in the proceedings.)

A Yes.

Q If I could just, I am sorry. Just to back up, doctor.

Back in July of 2000 -- July 13, 2016, did you fill out a form for Dr. Schuster?

A Yes.

Q And what was that for?

A That was a... that was a physical and sensory environmental capacity. It is a checklist.

Q Do you ever have to fill these forms out?

A I fill them out on occasion. Yes.

Q What are they used for?

A I believe they're used for other doctors to determine sort of patients' work capacity or capabilities.

Q And you filled this out. And what were your recommendations on this form?

A The question, what is the maximum patient can occasionally lift? Occasion is it was ten pounds/sedentary.

What amount could this patient lift or carry frequency? I said small articles.

And then it says, assuming an employer allows reasonable breaks and an employee can alternate between sitting and standing for comfort, how long could a patient sit, stand, and walk in an entire eight hour workday? Sitting, two to three hours. Standing, two to three. Walking, two.

Q Those aren't continuous, correct?

A No. It's with breaks. Again, there's a range. Patients can have good days, bad days.

(Whereupon, Kimberly Manning took over for Vanessa del Valle.)