CC NO.: 71930051-061 WCB CASE NO.: G2461410

NEW YORK STATE

WORKERS' COMPENSATION BOARD

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In the Matter of the Claim of

DAVID BOURNE,

Claimant,

vs. CC NO.: 71930051-061

PELICAN PAINTING CONTRACTORS OF NY, LLC,

WCB NO.: G2461410
Employer, D/A.: 3/07/2019

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TELEPHONE CONFERENCE

March 12, 2020
8:30 a.m. - 8:50 a.m.

TELEPHONE EXAMINATION of DR. ANGEL MACAGNO, a Non-Party Witness herein, taken by all parties at their respective locations pursuant to Workers' Compensation Law and Rules of Testimony, held at the above-mentioned time and date before Susette Arthur, a Shorthand Reporter and Notary Public of the State of New York.

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

MCINTYRE, DONOHUE, ACCARDIA, SALMONSON & RIORDAN
Attorneys for Claimant
399 Knollwood Road
Suite 220
White Plains, New York 10603
BY: JAMES SEGANTI, ESQ.
(Via Telephone Conference)

NEW YORK STATE INSURANCE FUND
Attorneys for Employer
1045 7th North Street
Liverpool, New York 13088
BY: JEFFREY FOX, ESQ. OF COUNSEL
(Via Telephone Conference)

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A N G E L M A C A G N O, M.D., the witness herein, having been first duly sworn by a Notary Public of the State of New York, testified as follows:

DIRECT EXAMINATION BY MR. SEGANTI:

Q Please state your name for the record.

A Angel Macagno.

Q Please state your business address for the record.

A 761 Merrick Avenue, Westbury, New York 11590.

Q Hi, Doctor. Can you give us your medical school and year of graduation?

A I graduated in 1988, National University of Cordoba School of Medicine in Argentina.

Q Okay. And are you licensed to practice medicine in the State of New York?

A Yes, since 2012.

Q Has your license remained in good standing since 2012?

A Yes.

Q And are you Board certified?

A Yes, in orthopedic surgery.

Q Are you coded by the Workers' Compensation Board in orthopedic surgery?

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A Yes.

Q Do you have any hospital affiliations?

A I'm affiliated with NYU Medical Center in Manhattan, with Bellevue Medical Center in Manhattan, Hospital for Joint Disease in Manhattan, in Long Island, Mercy Medical Center, St. Francis Hospital, Winthrop Hospital.

MR. SEGANTI: Counselor, do you have any questions regarding the doctor's qualifications?

MR. FOX: No. Thank you. I will stipulate to his qualifications. Thank you.

Q So, Doctor, throughout your course of practice have you had the opportunity to examine David Bourne?

A Yeah, I saw him once.

Q One occasion, and what was that date?

A October 17, 2019.

Q And what was the purpose of the evaluation for a surgical consult?

A He came for a worker's compensation injury, including his neck and lower back.

Q Okay. What history, specifically, did you receive?

A He said the date of the injury he is

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spray-painting the ceiling and tripped on a ladder on the floor, hit the wall injuring his neck and lower back.

Q And what were his complaints of pain at the time of your examination?

A He was complaining of neck pain shooting down to the left upper extremity, and lower back pain shooting down to left lower extremity.

Q Okay. And did you perform a physical examination on that day?

A Yeah, I performing some -- regarding his neck he was -- he had evidence of bilateral muscle spasm; the range of motion was painful; he had tenderness to palpation; range of motion was decreased, significantly; the same thing for the lower back, pretty similar findings. And at the same time he had neurological changes in upper and lower extremities, more, specifically, left arm. He had a Spurling's sign positive; he had numbness and tingling to lateral aspect of left arm and left forearm, including the left thumb; and he had weakness bilateral deltoids, and significant weakness left biceps and left brachioradialis. He had similar findings in the left lower extremity; Lasegue's positive, which is going to

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be equivalent to straight leg raising, numbness and tingling, and some weakness in some of the muscles in the left lower extremity.

Q Okay. Doctor, in regard to the neck, you indicated spasm; is spasm something that is an objective finding?

A Yeah, you can palpate spasm, yes.

Q And you indicated a positive spalding's test; what does that mean?

A Spurling sign is when a patient is complaining of radicular symptoms, it's a sign that you try to compress the nerve, you twist the head to the same side, flex the head to the same side and then, you compress, axially, with that time the patient is going to report inter -- significant findings, like, when he have the nerve injury, like, numbness, shooting pain to the specific dermatomes, or specific zones that are -- including the nerve, and that was, totally, positive in this patient.

Q Okay. And did you review any diagnostic studies in regard to this --

A Yeah, I, personally, reviewed two MRIs, another report, the MRIs, the images. He has a MRI of the cervical spinal from March 14, 2019 that

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showed -- I put here disc herniation C4-C5, C5-C6. I saw it again last night, he had multiple disc herniations, but these are the two significant that are even symptoms. And he had a MRI of the lumbar spine that showed disc herniations, a loss of disc height, disc dehydration L4-5 and L5-S1.

Q Okay. So, Doctor, for today's deposition we're just concentrating on the neck.

A Okay.

Q In regard to the neck, disc herniations in the neck, are any of them abutting the cord?

A Say it again? I couldn't hear you, I'm sorry.

Q The disc herniations in the neck, are any of them effecting the ventral cord?

A Let me see.

Yes, it's not the cord, it is mostly, the nerve because they are (inaudible), if I remember good, I saw last night. (Inaudible) are compressing the two aspects of the cord, but, mostly, the exiting of the nerve inside the foramina.

Q Okay. And are the findings on your physical examination and the patient's complaints of radicular pain, is that consistent with the MRI

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findings?

A Totally consistent.

Q Okay. And what was your diagnosis?

A My diagnosis are that this gentleman suffered at work, work injury I'll describe of the patient, that is consistent with the symptoms that he has with the images that we see in the MRI with compression of two nerves and increasing weakness most of the left upper extremity.

Q Okay. So but, Doctor, your specific medical diagnoses in regard to the neck, was what?

A Disc herniation, acute disc herniations compressing the nerve.

Q Okay. And what treatment did you recommend?

A At that time the patient underwent conservative treatment. I think he was scheduled for an injection, but we're discussing with the patient due to his increasing weakness, the significant disc herniations, I gave the options of treatment and one of the options is surgery. The patient, at that time, wanted to discuss surgery and we requested a fusion of the cervical spine.

Q And do you think a fusion of the cervical

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spine is necessary and causally related?

A Yeah, absolutely.

Q And why is that?

A Because the main problem in this patient is not only the neck pain, it's increasing weakness in the upper extremity. If the -- when I examine, three plus five is significant weakness. If you keep waiting for -- and the patient has increased weakness, even if you did compress after a long time, maybe he's never going to recover 100 percent, that is why, at this point, the recommendation is to do a mechanical treatment, that is removing all -- everything that is compressing the nerve.

Q And, specifically, what surgery would do that?

A It's anterior cervical and discectomy fusion.

MR. SEGANTI: Okay. Okay. Doctor, thank you.

I don't have any further questions.

THE WITNESS: Thank you.

MR. FOX: Okay.

CROSS-EXAMINATION BY MR. FOX:

Q Good morning, Doctor. This is Jeff Fox.

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I represent State Insurance Fund. I just have a few questions.

A Good morning.

Q You only saw Mr. Bourne on one occasion; is that correct?

A Correct.

Q And you recommended some cervical flexion films; did those ever get performed?

A The flexion/extension?

Q Yes.

A Yes. I always recommend when I request surgery for a patient because you want to be sure there's not any unstable segment above or below. It's a pre-surgical plan and it's routine.

Q So, that would be done -- that would be done in conjunction with the surgery, not before the surgery?

A Yeah, before the surgery.

Q Okay.

A It's for pre-surgical planning.

Q Okay. And did the patient indicate whether or not he wished to proceed with the surgery at the time, or was he just getting (inaudible) to discuss it?

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A No, no, he -- we discussed the surgery. He verbalized understanding and wants to proceed with surgical request.

Q Okay. And did you have a chance to review the EMG studies from May 6, 2019?

A I don't have it written here. I don't have it in my records.

Q Okay. If those indicated no evidence of cervical radiculopathy and if they were negative for neurocompression, would that be inconsistent with his complaints at the time you saw him?

A No, absolutely, not. EMGs are -- they are characteristic for having a high rate of false negatives, there are more than 60 to 70 percent of false negatives. That means, people that request it as a routine, if it's positive it's going it help with the case, but if negative it's not going to tell you anything.

Q Okay. Do you consider the MRI a more significant test?

A Yeah, I saw the MRI myself.

Q Okay. And with regard to the carrier's consultant, he expressed some concern that there were exaggerated subjective symptoms; did you find evidence

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of that, Doctor?

A No. And we examine these patients, because this happens, frequently, when we examine these patients we try to treat the patient, that is called Waddell's signs, you try to do things where the patient is going to shout or jump on the table and they are not related to, absolutely, anything that he had. I would write them in my computer, in my job for sure, as Waddell sign positive, telling that it's nothing to do, mostly, for my records. And they were negative in this patient. This patient was not lying as per my examination.

Q So, you have specific tests where you are looking for Waddell's or evidence that there might be nonanatomic symptoms that are being ascribed?

A We do it as a routine in every patient that we indicate surgery, correct.

Q Okay. Are there any contraindications for surgery that you saw from this examination?

A Not that I -- if it were contraindications I would not indicate surgery.

Q Well, just anything -- what are some possible complications from this type of surgery, Doctor?

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A For this type of surgery, let me see if I wrote it down here because -- if you read under my Discussion they are all there. They are always nerve injury, artery injury, hoarseness, difficulty swallowing; as in any surgery there could be paralysis. There are a million complications, but, in general, it's a surgery that is pretty well tolerated. It's the most performed surgery in the United States by spine surgeons with the best results for patients of this faction and doctors of this faction.

Q And why did you choose the cervical as opposed to the lumbar area to proceed with surgery, initially?

A Correct, yes. I always tell that patient the cervical -- when we have injuries in the cervical and the lumbar we are concerned, mostly, for the cervical, initially, because, first, he has the weakness was more significant, and we know that compressing the lower back it could take more time, it's not going to be significant. In this case the weakness was there, but not significant. But in the neck there was significant weakness. If we wait a long time to remove the compression in the nerve, sometimes the patient never regains full strength, or, fully,

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from that surgery, it's never going to happen, that is why we try to do the neck as soon as possible. Unless the lower back is the main complaints, we keep it and we can treat it more time, but the neck is kind of a priority.

Q Okay. And was he -- was he reporting to you progressive -- like, worsening weakness over the course of the four months from the time of the accident?

A Yeah, let me --

I don't remember this patient, specifically, but if we request surgery it's because the weakness he has is increasing and it was significant at this time.

Q Okay. But would you characterize it as significant weakness at the time of your examination, Doctor?

A Yeah, three-plus-five is a significant weakness in a specific dermatome, specific muscle, but they're consistent with the disc herniations.

Q Okay. And how is weakness tested?

A You test it comparing one side with the other, basically, trying to ask the patient to perform different movements that they're going to test specific

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muscles. That is part of the Waddell's sign because it's really difficult for the patient to know what -- unless he studies medicine -- to know what muscle is going to be weak. On the muscle that he's really related are to the disc herniation that he has in the neck.

Q So, the weakness he described followed an anticipated dermatomal pattern from those disc herniations?

A Correct.

MR. FOX: Okay. I think that's all the questions I have, Doctor. I didn't know if counsel had any additional questions.

MR. SEGANTI: I don't have any additional questions either.

I just ask for the appropriate testimony fee for the doctor. Thank you.

(Continued on next page to include jurat.)

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MR. FOX: Absolutely.

THE WITNESS: Thank you.

(Time noted 8:50 a.m.)

_____

ANGEL MACAGNO, M.D.

Subscribed and sworn to before me

this _____ day of _____, 2020.

_____

NOTARY PUBLIC

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

I, SUSETTE ARTHUR, a Stenotype Shorthand Reporter and Notary Public within and for the State of New York, do hereby certify that the foregoing is a true and accurate transcription of my stenographic notes.

I further certify that I am related to any parties by blood or marriage and that I am in no way interested in the outcome of the matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 20th day of March, 2020.

Susette Arthur

SUSETTE ARTHUR

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