UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------x
STANLEY WOJCIK,

Plaintiff,

- against -

42ND STREET DEVELOPMENT PROJECT, INC. and TURNER CONSTRUCTION COMPANY,

Defendants.
----------x

April 26, 2004
1:30 p.m.
59 Maiden Lane
New York, New York

Deposition of ANDREW MEROLA, M.D., a non-party witness, taken by Defendants, pursuant to Notice of Taking Deposition, held at the above-mentioned time and place, before Dale W. Tice, a Registered Professional Reporter and Notary Public of the State of New York.

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

SACKS & SACKS, ESQS.
Attorneys for Plaintiff
150 Broadway, 4th Floor
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BY: HOWARD BOROWICK, ESQ.

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Attorneys for Defendants
59 Maiden Lane
New York, New York 10038
BY: JOHN E. SPARLING, ESQ.

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

IT IS HEREBY STIPULATED AND AGREED by and between the Attorneys for the respective parties hereto that filing and sealing be and the same are hereby waived.

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

IT IS FURTHER STIPULATED AND AGREED that the within examination may be signed and sworn to before any notary public with the same force and effect as though signed and sworn to before this Court.

A N D R E W M E R O L A,

having first been duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

EXAMINATION BY

MR. SPARLING:

Q. Please state your name for the record.

A. Andrew Merola.

Q. Please state your address for the record.

A. 36 Seventh Avenue, Suite 502, New York, New York 10011.

Q. Good afternoon, Doctor. My name is John Sparling and I represent the defendants in the lawsuit brought by Stanley Wojcik. I'm going to be asking you some questions. If at any time you don't understand, please let me know. I will be more than happy to rephrase them. Do you understand?

A. Yes.

Q. You need to respond verbally, of course, as opposed to gesturing or nodding your head. Do you understand?

A. Yes.

Q. And please wait until I finish my question before answering so that you understand what it is that you are answering.

A. Yes.

Q. I'm going to show you what has been marked as Defendants' Exhibit A.

(Exhibit Number A was marked for identification.)

Q. It is a Notice of Deposition. And I would ask, after you have had a chance to review that, if you could identify it for me.

A. All right. So it appears to be a Notice to Take Expert Deposition Upon Oral Examination.

Q. Okay. And did you see the part on page 2 that asks you to bring all records and other items relating to your treatment of Stanley Wojcik?

A. Yes.

Q. Did you bring with you today all the records and other documents as referred to in the notice relating to your treatment or care of Stanley Wojcik?

A. That I have in my office, yes.

MR. BOROWICK: Other than the films which we have available, if you need them.

MR. SPARLING: Okay.

Q. What did you bring with you today?

A. My office chart.

Q. What other documents or records are there relating to your treatment and care of Stanley Wojcik that you did not bring with you today?

A. X-ray and MRI films.

Q. What did you review for purposes of the preparation of your deposition here today?

A. My chart.

Q. Did you have any meetings or telephone conferences or discussions relating to the preparation for your deposition here today?

A. Yes.

Q. What meetings did you have?

A. Howard and I actually met a little bit just to go over my chart and make sure I have my office chart with me.

Q. When did you meet with

Mr. Borowick?

A. Right before we came over.

Q. How long was that meeting?

A. Ten minutes.

Q. And what did you discuss about your chart?

A. We just went over my notes in the chart and Mr. Borowick asked me some questions about Mr. Wojcik.

Q. What notes do you recall going over with Mr. Borowick?

A. My handwritten notes and my office dictated notes.

Q. What handwritten notes did you go over?

A. The notes in my chart.

Q. Can you describe which ones you went over?

MR. BOROWICK: Just note my objection.

Right now as we speak, the chart is being photostatted by your office, so it's a little unfair to ask him without his chart to describe in more detail than

he has already described what notes we discussed.

Q. Do you need the chart respond to my question about what handwritten notes you went over or not?

A. Well, we went over the notes in general. I don't remember which ones specifically, because it was kind of a Gestalt, asking me questions about Mr. Wojcik and then me referring to my office notes and chart about it.

Q. Are there any handwritten notes in particular that you remember without looking at your chart?

A. No.

Q. Do you recall any of the office notes, the typewritten notes that you went over and discussed with Mr. Borowick before your deposition here today?

A. Basically, just my log of typewritten notes. And dictated office notes.

Q. Are there any dictated office notes that you recall having discussed with Mr. Borowick before you came here today?

A. Specifically, no.

Q. What questions were you asked by Mr. Borowick relating to Mr. Wojcik?

A. How is Mr. Wojcik doing? How is his coccyx? Do you think he would need surgery? That kind of thing.

Q. Okay. And what did you say when he asked you how is he doing?

A. I said his coccyx is a significant problem for him, and that I do feel that he is going to require a coccygectomy.

Q. And how did you respond when he asked you how was his coccyx?

A. That is exactly what I told him.

Q. Was there a different answer to the question you were asked: Do you think he would need surgery?

A. I'm not sure I understand.

Q. How did you respond when Mr. Borowick asked you do you think he would need surgery?

A. That is when I told him about the coccyx.

Q. Do you need your chart to tell me when the last time it was that you saw

Mr. Wojcik?

A. Yes.

Q. Do you need your chart to --

MR. BOROWICK: Why don't you go on collateral stuff?

MR. SPARLING: I'm going to do that.

(Exhibit Number B was marked for identification.)

Q. I'm going to show you what has been marked as Defendants' Exhibit B for identification, and I would ask if you could review that and identify it for me.

A. Yes. This appears to be a list of some cases that I have testified on.

Q. Have you seen that document before?

A. No, I have not.

Q. Had you seen Defendants' Exhibit A before today?

A. No.

Q. Were you asked to bring with you the radiographic films and MRI films today?

A. No. I generally give the patient their films.

MEROLA

Q. Did you do that with respect to Mr. Wojcik?

A. As far as I know, yes.

Q. Is that a complete listing of the cases that you have testified in at trial?

A. I had testified on a -- I think it's Federal, for the United States of America. I was testifying on behalf of the United States, and I don't remember who the plaintiff was. But I think I think is the only other time that I testified in court.

MR. BOROWICK: There was an additional one, with me, since you have gotten this, named Blake Kirby. I don't know, I don't remember who the defendants were, but I think that was in front of Emily Goodman in Supreme New York, and I think it was -- it was within the last month.

Q. Do you recall testifying in the Blake Kirby case?

A. Yes.

Q. What was the injury in the Blake Kirby case?

A. He had a cervical spine injury, amongst others.

Q. Did he or she have injury to the coccyx?

A. I don't think so, no.

Q. How about in that other case, the United States of America case?

A. That was a cervical injury.

Q. Where was that case venued?

A. I can describe the court for you. I'm not sure what the -- it's the Federal Courthouse.

Q. In Manhattan or Brooklyn?

A. Manhattan. Federal Courthouse in Manhattan.

Q. Who was the attorney that retained you?

A. The United States District Attorney for the Southern District of New York.

Q. What was his name?

A. I don't remember her name, but -- who was the last U.S. District Attorney that we had for the Southern District? She was in charge of the whole thing.

MR. BOROWICK: Mary Ann White.

A. She is the one that is doing the 9/11 prosecution as well. I forgot her name. She is in charge. I forgot her name.

Q. The United States of America was a defendant in that action?

A. Yes, correct.

Q. Did you conduct an independent medical exam of the plaintiff in that case?

A. Yes.

Q. What was the name of the plaintiff?

A. I don't remember.

Q. When was the testimony?

A. That is a good question. I think it was several years ago.

Q. Do you have records that would indicate when that testimony was?

A. I don't know where they are, honestly.

Q. Would you have the billing record to reflect who the name of the patient was?

A. I might. My office -- I moved my office, and then we renovated. I'm not even sure where that stuff is going to be.

Q. Did anyone ask you to provide, from the office of Sacks & Sacks, a list of your testimonies?

A. No, I don't think so.

Q. Was the Blake Kirby case a case with Sacks & Sacks?

A. Yes.

Q. Have you consulted or given testimony on any other cases involving Sacks & Sacks?

MR. BOROWICK: Which is consulted or given testimony?

Q. Why don't we go with consulted first.

A. As a physician?

Q. Yes.

A. Does that mean having seen the patient as a patient?

Q. Not necessarily.

A. I don't know what the question is then. I'm not sure.

Q. Have you been consulted in cases where you didn't see the patient with Sacks & Sacks?

A. No.

Q. Other than Blake Kirby and Stanley Wojcik, have you consulted with Sacks & Sacks where you have examined the patient?

A. Yes.

Q. What other cases are those?

A. I don't remember their names offhand.

Q. And how many of those cases are there?

A. Oh, I honestly don't know offhand.

Q. Can you approximate for me how many there would be?

A. That would be tough. I see so many patients during the day. It's hard to -- it's kind of hard to keep track of them.

Q. Would it be more than ten additional cases?

A. I don't think so, no.

Q. Are any of the three cases that are listed on Defendants' Exhibit B cases in which you were retained by Sacks & Sacks?

A. I don't remember. But Clyde Daniel, maybe, but I'm not sure.

Q. Do you know who retained you in the Theologis case?

A. No.

Q. How about the Shirley Phillip case?

A. I don't remember his name.

Q. Did any of those cases involve an injury to the coccyx?

A. Not that I can recall, no.

Q. Have you performed a coccygectomy before?

A. Yes.

Q. When did you perform a coccygectomy before?

A. It's difficult to give you an exact date. But I have done coccygectomies, yes.

Q. How many coccygectomies have you done?

A. It's a rare operation and, as such, I think I have done somewhere in the neighborhood of about a dozen or so.

MR. SPARLING: Off the record.

(Off-the-record discussion was held.)

(Exhibit Number C was marked for

identification.)

(Exhibit Number D was marked for identification.)

Q. Dr. Merola, I'm going to show you what has been marked as Defendants' Exhibit D for identification. I would ask that you take a look at that exhibit and confirm for me, if you can, whether it is a complete copy of the chart for your care and treatment of Stanley Wojcik.

MR. BOROWICK: Do you want him to go page by page? How else could he do it? Let's just assume it is.

MR. SPARLING: I asked him before and we were off the record and he did browse.

MR. BOROWICK: He didn't correlate. If you want him to do that.

MR. SPARLING: I would like to know that the exhibit is the exact copy of his chart.

A. (Reviewing document.)

Yes.

Q. Doctor, you mentioned that you had performed somewhere in the neighborhood of a

dozen coccygectomies before; is that correct?

A. Yes.

Q. Do you keep any records particularly relating to the coccygectomy procedures you have performed?

A. Just an individual -- just in individual charts.

Q. Do you recall the names of any of those individuals?

A. I am really bad with names.

Q. Have you ever written any publications or memorialized the results of those coccygectomies?

A. Not those particular coccygectomies, no.

Q. Have you ever written literature relating to the performance of coccygectomies?

A. Yes.

Q. What have you written?

A. I have edited a textbook of spinal surgery that includes a chapter on coccygectomy.

Q. What is the name of that book?

A. Techniques for spinal surgery. It is published by Thieme, T-H-I-E-M-E.

Q. I just want to make sure I understand. Did you say you edited the textbook for techniques for spinal surgery?

A. Yes.

Q. Did you say there's a chapter that involves coccygectomies?

A. Yes.

Q. And did you edit that chapter?

A. Yes.

Q. How many chapters are there in the book?

A. There are approximately 40 chapters or so in the book. The book goes from base of the skull to the coccyx.

Q. When did you edit that book?

A. That was a process that took several years. It began approximately four to five years ago, and we were just recently published.

Q. When was that published?

A. This year.

Q. Have you written any other publications or articles that relate to coccygectomies?

A. No.

Q. Well, we don't have the benefit of your textbook here today, Doctor, but can you tell me generally whether in your textbook coccygectomies are recommended as a normal course of practice or something else?

A. The coccygectomy is generally recommended for coccygeal pain that is unresolved with conservative care.

Q. What is coccygeal pain?

A. It is pain in the buttock area that localizes itself to the coccyx. Generally, patients have tenderness over the coccygeal area with difficulty sitting, putting pressure on the coccyx, or with any activities that involve contraction of the muscles around the coccyx.

Q. Did Mr. Wojcik have hypermobility of his coccyx?

A. No.

Q. Did Mr. Wojcik have a rigid coccyx?

A. I'm not sure what you mean by rigid.

Q. Do you view your textbook as authoritative on the subject of coccygectomies?

A. No.

Q. Do you believe your treat us or the chapter on coccygectomies is an important work in the field of coccygectomies?

A. No more important than any other work written on coccygeal problems.

Q. What treatises do you find are important works for the subject of coccygectomies?

A. I think they all need to be taken as a whole and interpreted in the light of any given patient's clinical situation.

Q. Okay. Are there any that you can name for me that are important relating to coccygectomies?

A. No.

Q. Do you know if the works of a Dr. Jean J-E-A-N, Ycev, Y-C-E-V, Magne, M-A-G-N-E?

A. Yes.

Q. And are those important works relating to the field of coccygectomies?

A. No more or less important than any other written material on coccygectomy.

Q. What has Dr. Magne done relating to coccygectomies?

A. I can't quote you exactly what he's done at this time.

Q. Are you familiar with any study that he has done?

A. Familiarity, yes. But unfortunately I cannot quote you specifics at this time.

Q. Is there anything about that doctor's study that you can tell me about here, today, doctor?

A. Nothing specific.

Q. Did Mr. Wojcik have lesions in the coccyx area?

A. What type of lesions, specifically? I'm not sure I understand the question.

Q. Are there lesions that are routinely found, in relation to coccygeal pain, in the coccyx area?

A. You have to be a little more specific.

Q. What would you need to know in order to answer that question?

A. Lesion is a very broad term that can mean anything from a psychological lesion, skin, hair. Lesion is so generalized a term that I don't think it's very easy to answer that question as asked.

Q. Is there skin around the coccyx?

A. There's skin superficial to the coccyx.

Q. Describe the skin that is superficial to the coccyx.

A. It's the gluteal fold of the buttock.

Q. Is that in contact with the coccyx?

A. Not direct contact.

Q. Is there hair around the coccyx?

A. It depends on the specific gluteus involved, in terms of the skin, but not around the bone itself, no.

Q. Where is it in your chart that reflects you tested for the hypermobility of Mr. Wojcik's coccyx?

A. I don't recall ever talking about hypermobility.

Q. Did you test Mr. Wojcik's coccyx to

determine whether it had hypermobility or not?

A. His coccyx was palpated.

Q. What is palpated?

A. Felt.

Q. Where is it in your chart that reflects that you felt Mr. Wojcik's coccyx?

A. The first time is July 8, '02 under the section on palpation and percussion of the spine.

Q. Are we now referring to your office notes?

A. Yes. On the typewritten note.

Q. Can you show me where that is, please.

A. 7/8/02, page 2: Percussion of spine, palpation and percussion indicate rather significant pain and tenderness in the area of the coccyx.

(Indicating.)

Q. Does that also reflect an indication of pain in the area of the left heel?

A. Yes.

Q. What is the left heel?

A. The foot.

Q. Does that reflected most notably the fleet post-lateral aspect of the left heel?

A. Yes.

Q. So was it your impression at the time, Doctor, that the pain in the left heel was worse than the pain in the coccyx?

A. No.

Q. Can you explain then what you meant by most notably in the post-lateral aspect of the left heel?

A. When the heel was palpated, there are different anatomical regions to the heel, so the pain during palpation of the heel was on the posterolateral aspect of the heel.

Q. Is there anything else that you can recall relating to the condition of the coccyx when it was palpated on July 8, '02?

A. With respect to its palpation?

Q. Yes.

A. That is the section on palpation of the coccyx.

Q. Have you performed a rectal exam for Mr. Wojcik since the time of July 8, '02?

A. No, I have not.

Q. Have you recommended physical therapy relating to the coccyx?

A. There is no coccygeal specific physical therapy.

Q. Is there a noted treatment that includes physical therapy to treat for coccygeal pain?

A. Coccygeal pain secondary to fracture is generally treated with rest, decrease in pressure on the coccyx, and having the fracture take its natural course in healing.

Q. Could you answer that question, please.

(The requested portion was read back.)

A. There is no specific physical therapy program for coccygeal pain secondary to fracture.

Q. Is manipulating the coccyx, massaging the performus treatment for coccygeal pain?

A. The treatments for coccygeal pain depend upon the etiology of the pain. So if the etiology is a fracture, it's fracture healing and

decreasing stress on the fracture site.

Q. What is a coccygectomy?

A. Removal of the coccyx.

Q. When is the last time you have performed a coccygectomy?

A. I don't remember, but it's been within the last year.

Q. Where did you perform that?

A. In one of my hospitals.

Q. What hospitals are you associated with?

A. SUNY Downstate, Brooklyn, New York. Kings County Hospital, Brooklyn, New York. New York Methodist Hospital, Brooklyn. Long Island College Hospital, Brooklyn. St. Vincent's Hospital, Manhattan. Mount Sinai Hospital, Queens.

Q. Do you perform surgeries at all of those hospitals?

A. Yes.

Q. Are there limited coccygectomies that do not involve the removal of the entire coccyx?

A. You can remove segments of the

coccyx, yes.

Q. Have you performed those limited coccygectomies?

A. No.

Q. So on all of the 12 or approximately 12 coccygectomies that you have performed, those involve the removal of the entire coccyx?

A. As far as I can recall. But I would have to check each specific case to be 100 percent affirmative.

Q. Can you describe the coccygectomy surgery?

A. Yes. After a general anesthetic is administered to the patient, the patient is then placed prone or face down onto a specially padded operative table with a special frame to support the patient. The buttock area, depending upon the size of the buttock itself, is retracted with nonsterile surgical tape. Then utilizing a sterile technique, the coccyx is localized utilizing a needle and a fluoroscopic image machine. After localized, the area of surgery is prepped and draped. After this is completed, a

surgical dissection is carried out down to the level of the coccyx. The coccyx, once again, is visually identified and inspected. An intraoperative fluoroscopic confirmation is made at that point in time. And then, utilizing special instruments, the coccyx is removed from its surrounding muscular attachments. The point of attachment of the coccyx and the sacrum is disarticulated, and the coccyx is removed and sent for pathological examination. The incisional area is then reapproximated with suture material. The wound is closed. Sterile dressings are applied. The patient is then rolled back onto an operative gurney, the general anesthetic is completed and then the patient is taken to the recovery room.

Q. Is the coccyx ligametus or is the coccyx not ligametus?

A. No, the coccyx itself is not ligametus. It is a bony structure.

Q. Are there ligaments that directly surround the coccyx?

A. There are ligaments that attach to the coccyx.

Q. What are those ligaments?

A. They are -- they are the ligaments of the pelvic floor and buttock musculature, as well as the ligaments that attach the coccyx to the sacrum, including ligaments that attach the coccyx and sacrum to the bony pelvis.

Q. Does the coccygectomy procedure involve the ligaments that you just described?

A. Yes.

Q. How does it involve those ligaments?

A. Those ligaments need to be detached from the coccyx itself and retracted out of the way, so that the coccyx can be -- coccyx can be thoroughly exposed, identified and removed.

Q. What do you do with the ligaments after the coccyx is removed?

A. The ligaments are then reapproximated with suture and attached to themselves.

Q. Is that a difficult surgery, doctor?

A. It is no more or less difficult than any other surgery we do.

Q. What are the complications for that procedure?

A. The complications for this procedure can include general anesthesia, death, infection, blood loss, persistent pain, difficulty with ambulation, sitting, bowel and/or bladder disturbances, difficulty with bowel movements, scarring, and concomitant post-operative medical complications, such as deep venous thrombosis, phlebitis, pneumonia and others which can sometimes be unforeseen.

Q. Were any materials added to your chart today?

A. I had received a fax copy of some notes from prior treating physicians.

Q. Who gave you that faxed copy?

A. They came from the offices of Sacks & Sacks.

Q. Where were you when you received those?

A. In my office.

Q. Can you identify for me what documents you received by fax today from Sacks & Sacks?

A. How should we identify those?

Q. If you can describe them for me, that would be best.

A. Sure. Okay. I have a July 7, 1995 note from Dr. Glassgold G-L-A-S-G-O-L-D. I have a 6/20/95 nasal bone examination, Stanley Kron M-D, K-R-O-N. July 7, 1995, Southeast Diagnostic, Inc. letter. 6/20/95 Ultramade Partnership spinal ultrasound. I have something that didn't fax over very well. It looks like a list. It's a numerical list of codes, but it's very difficult to read. I have 6/14/95 South Edison Chiropractic Center. I have 9/21, illegible legible year, looks like '98, evaluation from I don't know where. I have a report from Dr. Edward Stivers, S-T-I-V-E-R-S, no date. I have a Appendix A, Diagnostic Ultrasound. I have a David Callahan, looks like license, October 31, '96. This -- I don't know what this is. This is a Dr. Gupta, Echo Cardiography Institute certificate, May 1987. I have a health insurance claim form from Dr. Stivers from 7/24/95. Another one from Dr. Stivers, no date. I have a date of

operation, 10/4/02, Dr. Jaffe, J-A-F-F-E.

Q. Did you ask for those records, Doctor, before you came here today?

A. I don't remember.

Q. Was there a discussion prior to your receiving those records today?

A. No.

Q. Did you have any other meetings with anyone associated with Sacks & Sacks, other than what you described this morning with Mr. Borowick, relating to this case?

A. No.

Q. Did you have teleconferences with anyone associated with Sacks & Sacks relating to your deposition before you came here today?

A. No.

Q. Have there been diagnostic studies done of Mr. Wojcik's coccyx?

A. Yes.

Q. What studies have been done?

A. Let me pull those out. I have an MRI of the sacrum and coccyx, 8/13/02. I have an X-ray of the coccyx and sacrum, 7/9/02. I have those two diagnostics of the coccyx.

Q. Would it be fair to say that the records that you received via facsimile today were not utilized by you in the treatment of Mr. Wojcik or any opinions that you have in this case?

A. I haven't had a chance to fully digest and examine all of the records yet, no.

Q. Well, prior to today you were recommending coccygectomy as a treatment for Mr. Wojcik; is that correct?

A. Yes.

Q. And those records weren't available to you before today; is that right?

A. Yes.

Q. Have you reviewed any portion of those records yet?

A. I have not reviewed those records in detail, no.

Q. My question was: Have you reviewed any portion of those records?

A. I read the operative note from Dr. Jaffe.

Q. Did you provide any treatment to Mr. Wojcik relating to the injury he claims to

his shoulder?

A. No. Specific treatment, no.

Q. How about any general treatment?

A. I had recommended him to follow up with Dr. Jaffe and also offered him an opportunity to see my partner, Dr. Toulipolous T-O-U-L-I-P-O-L-O-U s. I think that is pretty close.

Q. Did you examine Mr. Wojcik's shoulder?

A. Yes, I did.

Q. Was that only on July 8, '02, or something else?

A. Let's check.

10/20/03, handwritten note. Impingement right upper extremity. 8/18/03, questionable shoulder pain with impingement.

That looks like it's it.

Q. Does that reflect that you actually manipulated or provided treatment or just made a notation of something Mr. Wojcik had told you?

A. If I noted impingement, it means that I did an impingement test.

Q. Do you have opinions today with

respect to any injuries Mr. Wojcik sustained relating to his shoulder?

A. Yes.

Q. What opinions do you have relating to Mr. Wojcik's shoulder?

A. My impression is that he has an internal derangement of the shoulder, including a rotator cuff tear, and impingement.

Q. Has that been healed?

A. I don't know.

Q. Would you agree that you would need to have been treating Mr. Wojcik relating to the shoulder to form that opinion?

A. No. That is an opinion that depends on his physiology of being able to heal the tear or not.

Q. Do you plan on offering any opinions at trial relating to the injuries to Mr. Wojcik's shoulder?

A. If asked, I will probably say exactly the same thing I just said right now.

Q. Do you have any records at all relating to the treatment or diagnosis of Mr. Wojcik's shoulder in your chart, other than

the one page that was faxed to you today and your two references in your records that you mentioned earlier?

A. Yes. I do have an MRI from 8/13/02 of the right shoulder.

Q. Did Mr. Wojcik have the injuries repaired by surgery?

A. Yes, I believe so.

Q. Where is it in your chart that reflects that the injuries were repaired by surgery?

A. 11/25/02, we had spoken about his shoulder and, I believe, pending surgery.

Q. My question was: Where is it in your chart that reflects that Mr. Wojcik had it repaired with surgery?

A. I don't have that in here, from what I can see right now.

Q. Would you agree that other than the report that was faxed to you today, and the two references you mentioned earlier, you have no records of the treatment of Mr. Wojcik for his shoulder injury in this case?

A. Although Mr. Wojcik and I did

discuss his shoulder and the surgery of his shoulder on that date that I did indicate --

Q. Which date is that? The date where he was pending surgery; is that what you are referring to, doctor?

A. Yes.

Q. Other than the records that were faxed to you this morning and that you identified, were there any changes in your file within the past two weeks relating to this case?

A. Not as far as I know, no.

Q. Were any documents removed from your file?

A. Not as far as I know, no.

Q. Has the file been within your control and custody within the last two weeks?

A. It's been at the office.

Q. Did you provide the file, or a copy of the file, to Sacks & Sacks before your deposition today?

A. I don't remember if my office sent up a copy of it or not.

Q. Is there in your file a copy of a reserve decision from the Workers' Compensation

Board?

A. Yes.

Q. Is that a two-page document?

A. Yes.

Q. Do you know when you received that?

A. No, I don't.

Q. Did you testify at a workers' compensation hearing?

A. Yes.

Q. When did you do that?

A. It was via telephone. I don't remember the date.

Q. Did you have any discussions or meetings with Sacks & Sacks prior to giving that testimony?

A. I don't recall. I don't think so, no.

Q. Have you seen a transcript of your testimony from that occasion?

A. No, I have not.

Q. Have you diagnosed Mr. Wojcik with a coccygeal fracture?

A. Yes.

Q. Upon what did you base the

diagnosis that he has a coccygeal fracture?

A. His history, his physical findings, the MRI examination, and his X-rays.

Q. What about his history reflects a coccygeal fracture?

A. Pain in the coccyx after trauma.

Q. Anything else about his history that was the basis for your diagnosis of coccygeal fracture?

A. Pretty much, pain after trauma.

Q. Is trauma one of the potential causes for coccydinia?

A. Yes.

Q. And wouldn't you agree that you can have coccydinia absent fracture?

A. Can you rephrase that question. I'm not sure --

MR. SPARLING: Can you read it back.

(The requested portion was read back.)

A. Can you have coccygeal pain without a fracture?

Q. Yes.

A. Yes.

Q. What was it about Mr. Wojcik's pain that indicated to you that it was a coccygeal fracture as opposed to just pain following trauma?

MR. BOROWICK: Note my objection. He didn't say it was just based on the history. He said it was the history, exam. And MRI and X-ray.

MR. SPARLING: Right. I'm just focusing on the history aspect of it.

A. With a history of trauma, fracture is your number one differential.

Q. What physical findings did you make or observe that were the basis for your diagnosis of coccygeal fracture?

A. Pain to palpation over the coccyx as well as his history.

Q. How soon after the accident did you have the palpation?

A. Let's see. Fall on 6/28/02. I saw him on 7/8/02. So somewhere in the neighborhood of 10 days or so.

Q. How do you describe the pain that

he had to palpation on July 8, '02?

A. Significant pain and tenderness in the area of coccyx.

Q. Do you recall performing that palpation?

A. No.

Q. Do you recall whether he had acute point tenderness on the region of the coccyx?

A. I don't have point tenderness noted.

Q. What acute point tenderness?

A. Acute means sudden onset. Point tenderness means a specific point.

Q. What area of the coccyx did you palpate?

A. The whole coccyx.

Q. How do you describe Mr. Wojcik's coccyx?

A. Painful to palpation.

Q. Are there segments to his coccyx?

A. There are.

Q. How many segments does he have?

A. Anatomically, I would have to look at his X-ray again. They are very small

segments.

Q. Do you have a recollection as to how many segments he has?

A. No.

Q. Did you identify that Mr. Wojcik had a fracture of his coccyx on July 8, 2002?

A. At that time we were pending X-rays of the coccyx.

Q. So would it be fair to say that as of July 8, '02 you had not made your diagnosis yet that Mr. Wojcik had a fracture of the coccyx?

A. Not fracture per se. But injury.

Q. What injury did you determine he had sustained on July 8, '02?

A. At that time my assessment was injuries to the lumbosacral spine, coccyx and left foot and ankle, currently pending X-rays.

Q. When did you first diagnose Mr. Wojcik with a fracture of the coccyx?

A. 7-15-02.

Q. Is there a record that you looked at in order to answer that, Doctor?

A. Yes.

Q. What record was that?

A. Dictated note, 7/15/02.

Q. Did you obtain an X-ray prior to making that diagnosis?

A. Yes.

Q. Did you obtain a report from a radiologist relating to that?

A. Yes.

Q. And did you review that report prior to making your diagnosis?

A. No.

Q. When did you get the report?

A. After the X-rays.

Q. Did you get the X-ray prior to the report?

A. Yes.

Q. Is the report of July 15th the one that reflects that you're suggesting an MRI?

A. Yes.

Q. Where was the fracture that you noted on July 15, '02?

A. I would have to show you the area on the X-ray.

Q. Okay.

(Recess taken.)

Q. On July 15th I believe you indicated that you have diagnosed a coccygeal fracture; is that correct?

A. Yes.

Q. On July 15th, would you agree that there was some doubt in your mind whether the fracture existed or not?

A. Yes.

Q. And you needed to have an additional study?

A. Yes.

Q. Would you agree that diagnosis of coccygeal fractures are difficult?

A. They can be, yes.

Q. Is that difficult in this case?

A. Not particularly so.

Q. You would agree, though, that as of July 15th, you are uncertain as to whether he had a fracture?

A. I don't know about uncertain or just wanting more information.

Q. Is there a definitive way that one can diagnose a coccygeal fracture?

A. Yes. You can use an X-ray or you

can use an MRI or you can use a bone scan, or a combination thereof.

Q. Can you describe the three diagnostic procedures?

A. X-ray is a picture utilizing radiation to look at bone and bone detail. An MRI is a magnetic computer-assisted technique to look at areas of abnormal bone morphology or injury. And a bone scan is a technique that utilizes a radioactive element to analyze bone physiology.

Q. Is one more definitive in diagnosing coccygeal fracture than the others?

A. If there's a displaced fracture of the coccyx, a plain X-ray is usually all you need.

If there is a nondisplaced fracture of the coccyx, another technique to give you more information helps to confirm the diagnosis.

Q. Is the bone scan more definitive than an MRI?

A. If the MRI exam is questionable, a bone scan can help.

Q. What training do you have in

reviewing X-rays and MRIs?

A. The training that comes with an orthopedic residency.

Q. Are you a radiologist?

A. No.

Q. Are you a neuroradiologist?

A. No.

Q. Don't the hospitals that you are associated with require that a radiologist or neuroradiologist review the diagnostic films?

A. I don't know. As an orthopedic surgeon, we can actually review and comment upon films and bill separately for that. So as orthopedic surgeons, we are recognized to do that. So a certain extent --

Q. What training does the neurologist or radiologist have that do you not in interpreting those films?

A. I don't know.

Q. Did you obtain a report from a radiologist on the reading or impression of the X-ray?

A. Yes.

Q. Did you send Mr. Wojcik for the

X-ray?

A. Yes.

Q. And who did you send him to?

A. Let me get the report. Diagnostic Radiology Associates.

Q. Is that a reputable establishment?

A. Yes.

Q. Do you utilize them on a regular basis?

A. They are close to the office, yes.

Q. Did you send Mr. Wojcik to Diagnostic Radiology Associates for the MRI?

A. No.

Q. Why not?

A. When I got -- the X-rays are in the neighborhood of the office. So it's a relatively quick and easy thing for him to get the X-ray and bring the film back to the office so I could look at it.

The MRI required an approval, and so I believe that we tried to make the MRI a little bit more convenient for his social, home status, and make it easier for him to be able to do that for us.

Q. Where did you send him for the MRI?

A. The MRI he had at Associates Radiologists.

Q. Did you have a relationship, business relationship with that outfit before you sent him there?

A. No.

Q. Who is the radiologist that did the MRI?

A. Eric Lazar, L-A-Z-A-R.

Q. Was that MRI done with contrast or not?

A. Without.

Q. What is the significance of whether an MRI is done with contrast or not?

A. Contrast can help when a tumor is suspected or in post-surgical patients that may have scar formation.

Q. Would it be helpful medically in any way if the MRI had been done with contrast?

A. I didn't think we needed to use contrast for this.

Q. Did you direct that it was to be performed without contrast?

A. I don't have my -- I don't have a copy of the prescription that I used. So I don't recall. But I wouldn't necessarily want a contrast for this.

Q. And my question was whether, medically, it would be helpful to have had contrast.

A. I don't think it would have added any information to this particular study.

Q. How is Mr. Wojcik's shoulder today?

A. I'm not sure.

Q. Does he need any additional treatment for his shoulder?

A. I'm not certain.

Q. When was the last time Mr. Wojcik received treatment for his shoulder?

A. I don't know.

Q. Was the MRI that was performed multi-planar?

A. Yes.

Q. What is a multi-planar MRI?

A. It means that it looks at the area in question from more than one perspective. Side view and cross-sectional view.

Q. What are fat-suppression techniques?

A. It's a way for the -- it's a way for the MRI technique -- it's a technique so that the MRI can decrease the fat signal from the image.

Q. And what effect does a fat signal on the image have in interpreting the MRIs?

A. The MRI looks at the way our tissues resonate or the way the electrons in our tissues vibrate. So the magnet excites the electrons in your tissue and then as those electrons relax, an image is generated. Now, your body is mostly water and fat. So what happens, when you use a fat -- and the bone itself is mostly fatty. So when you use a fat suppression technique, it's a way of adjusting, really, the contrast and brightness of the MRI so that you can better delineate a fracture or other abnormality in that bone without getting background signal from the fat.

Q. Was that successful in the MRI of the sacrum and coccyx of Mr. Wojcik?

A. Insomuch as it helped to define the

fracture, yes.

Q. Did you independently review the MRI?

A. Yes.

Q. Did you do that during the course of your treatment of Mr. Wojcik prior to today's deposition?

A. I don't remember when I saw the film.

Q. When was the last time that you saw any of the diagnostic films relating to Mr. Wojcik?

A. I actually saw -- I saw -- I think I saw some MRIs -- I actually saw a whole bunch of films just in passing when we were at the office. And I think I saw a plain X-ray, an MRI of the low back, and I think I saw his sacrum and his coccyx as well.

Q. My question was: When did you last see the diagnostic films?

A. Today.

Q. Where were you when you saw those?

A. At Sacks & Sacks' office.

Q. Did you see a fracture on the X-ray

when you saw it today?

A. I didn't look very closely at it.

Q. Did you have discussion with any attorney at Sacks & Sacks whether a fracture was noted on any of the diagnostic films?

A. Actually, we just talked about whether or not they had the films, and I think I just looked at them to say yes, they are here.

Q. And when you say yes, they are here, the films are here or the fractures?

A. The films.

Q. Did you see a fracture on any of the films that you did look at today?

A. I didn't look that closely at them. I didn't really examine them.

Q. Does that mean no; no, you didn't see a fracture?

MR. BOROWICK: Objection. He said he didn't look that closely.

Q. Did you see a fracture or not?

A. I didn't look for one.

Q. I understand.

Where is it in your records or chart that reflects your independent review of

the MRI?

A. (Reviewing document.)

I don't have it in my note.

Q. Would that be something that would be important to have maintained the record of?

A. I have the report.

Q. Okay. Does Mr. Wojcik need any additional treatment for his shoulder?

MR. BOROWICK: Asked and answered. You just asked that.

MR. SPARLING: I don't think I did. I asked something different.

A. I think I said I don't know. I don't know.

Q. Have you provided any treatment to Mr. Wojcik for his back in the year 2004?

A. Not in 2004.

Q. When is the last time you provided any treatment to Mr. Wojcik for his back?

A. I had recommended that he see one of my pain management colleagues, and I have been prescribing him pain medications.

Q. Okay. And my question was, when was the last time you provided treatment to him

for the back?

A. Yes. In that sense, I have given him pain medications this year. So I have given him pain medicines for his back because my 2004 notes do indicate that he remains symptomatic.

Q. Where is it in your chart that reflects that he is symptomatic in 2004 for his back?

A. February 2, 2004, Mr. Wojcik remains status quo; no changes from his prior exams.

Q. Where in your chart does it reflect that he has been prescribed medicine in the year 2004?

A. My last indication for his pain medications was 10/20/03.

Q. Has that prescription been renewed?

A. I don't have a copy of his prescription in the chart.

Q. Where is that located?

A. You know, it depends on the type of prescription. Sometimes we have a duplicate copy, a carbon copy script. If we did, that should have been in his chart. Otherwise, he

gets the original and then takes it to the drugstore. And then I think the drugstores keep a copy of the script.

Q. What treatment did you give to Mr. Wojcik for his back the last time you provided treatment?

A. For his low back, really just continuing his pain medications and having referred him to the pain management doctors.

Q. When did you refer him to pain management doctors?

A. September of 2002.

Q. Who did you refer him to?

A. There are a number of physicians that I work with, and I don't know exactly who I suggested that he see.

Q. Is there any record in your chart that reflects who you recommended him to see?

A. I haven't gotten any notes back from the pain management doctors, no.

Q. Who are the ones that you do refer patients to?

A. There are a lot of doctors. I can probably provide you with a list of physicians.

Off the top of my head, I can think of several doctors. Dr. Lefkowitz is one. Dr. Solici is another. Dr. Hausknecht is one. Dr. U at University Pain Management. He has an unpronounceable name. I only know him as Dr. U. Is another one. And sometimes if the -- if the patient has been treating with some physicians, I will generally say just stay with them and see what their recommendations are in terms of pain management.

Q. Has the fracture that you have diagnosed for the coccyx healed?

A. He remains tender and painful, so my impression is that it hasn't healed.

Q. Would it be important in determining whether the coccyx fracture has healed to have an updated diagnostic study?

A. It's a clinical call in terms of the amount of pain that the patient is having. So the diagnostics are confirmatory or not, and then the patient's clinical situation is followed.

Q. You have recommended surgery?

A. Yes.

Q. And the last diagnostic study is in August of '02; is that correct?

A. August of '02, correct.

Q. Can a low-back condition cause coccygeal pain?

A. Not specifically coccygeal pain. It can cause low back and buttock pain. But the low back conditions are generally absent the tenderness in the area of the coccyx.

Q. What conditions have you ruled out in determining that Mr. Wojcik's pain is due to a coccygeal fracture today?

A. We know he doesn't have a tumor or an infection, which are two very important rule-outs. Those are two of the major problems we would want to make sure that he doesn't have prior to entertaining a coccygectomy.

Q. Is he to have surgery?

A. I'm sorry?

Q. Is Mr. Wojcik having surgery?

A. We had an approval for surgery and then I believe that approval was denied.

MR. BOROWICK: Actually, it's under appeal. It's on appeal by the insurance

company.

MR. SPARLING: Off the record.

(Off-the-record discussion was held.)

Q. Let me show you what has been marked as Defendants' Exhibit C. I would ask you could review that and identify it for me.

A. This is my curriculum vitae.

Q. Is that the most current copy?

A. No.

Q. Can you tell me what is new that is on the most current copy?

A. I would have to give you a new copy of my CV, because I know this isn't the new one -- maybe it is. I think I might have taken my kids' name off my most recent copy. I'm not sure. I have to look at it. And I think the last -- yes, because the textbook was just published. So here it's still in publication on this one. So there's another -- there's an updated CV.

Q. There aren't any addition to your articles or publications that relates to the coccyx specifically?

A. No.

Q. Did you review the report of July 15th of the X-ray and making your diagnosis of coccygeal fracture?

A. I'm sorry. The X-ray report on July 9, '02?

Q. Yes. There's only one X-ray, right?

A. Yes.

Q. Okay.

A. Yes.

Q. When did you review that?

A. At some point after I had seen him. Usually it takes about a week or so for the report to come to the office.

Q. And what was the finding of the radiologist?

A. No radiographic evidence of fracture. Clinical correlation as to an MRI examination of the pelvis.

Q. Do you have any reason to doubt the accuracy of that report, of the radiologist?

A. From what I had seen on the actual X-ray itself, yes.

MEROLA

Q. And what is it that you saw on the X-ray that changed your opinion?

A. On 7/15/02, I thought I had seen a hairline -- maybe a hairline fracture in the coccyx.

MR. SPARLING: Off the record.

(Off-the-record discussion was held.)

Q. What treatment did you employ prior to recommending surgery for Mr. Wojcik's coccyx?

A. The basic treatment for a coccygeal fracture, which I hate to say is not a lot, except advice to stay off of it, try to avoid pressure on it, and to try to avoid irritating the area.

Q. And do you find that that procedure is typically successful?

A. It can be. Sometimes coccygeal fractures can take quite a time to heal. Sometimes coccygeal fractures can take a long time to heal. And sometimes that treatment doesn't always really work.

Q. Did you fill out any forms for Mr. Wojcik relating to claims for disability

benefits?

A. I don't remember. But I can't find any in the chart.

MR. BOROWICK: Would you just look at this and make sure it's what it's supposed to be.

(Off-the-record discussion was held.)

Q. Did you recommend any local injections or medication to the coccyx?

A. No. I didn't inject him, no.

Q. Did you give him any oral medication for the coccyx?

A. The Vicodin.

Q. Anything else?

A. As far as I recall, the Vicodin.

Q. What is Vicodin?

A. It's a hydrocodone and acetaminophen, combination of small narcotic and say acetaminophen which acts as an ancillary pain medicine as well.

Q. Have you prescribed any anti-inflammatory medication?

A. Although it's not been proven in

the literature that an anti-inflammatory can affect fracture healing, bones that have difficulty healing may be inhibited by long-term anti-inflammatory use. So I generally don't like to give any anti-inflammatory if there is something that I think may have a little trouble healing.

Q. Did you prescribe an anti-inflammatory?

A. I don't think so, no. I don't have that in my note.

Q. Did you prescribe a foam cushion or a pad for the buttocks area?

A. No. I didn't give him any of those things as a prescription, no.

Q. Did you recommend steroid injections into the coccyx area?

A. No. I wouldn't want to inject a fracture with a steroid, pretty much for the same reasons. The potent anti-inflammatory effect of the steroid can decrease the ability of that fracture site to heal, and the steroid can also predispose him to having an infection of the fracture if the fracture is unhealed.

MEROLA

Q. When did Mr. Wojcik sustain a fracture to the coccyx?

A. By history, 6/28/02.

MR. SPARLING: I want the record to reflect that during the course of the examination I asked counsel for copies of the original MRIs and X-rays, and we had a hand-delivery to our office here from Sacks & Sacks, and we have with us now, to be marked, the X-ray of July 8, 2002, and we had a discussion off the record with Dr. Merola as to where to place the exhibit marker so that it did not affect or cover in any way the findings as shown on the X-ray.

Is that correct?

THE WITNESS: Yes.

(Exhibit Number E was marked for identification.)

Q. Doctor, I'm going to show you what has been marked as Defendants' Exhibit E for identification. Can you identify what that is?

A. This is a lateral projection of Stanley Wojcik's sacrum and coccyx.

Q. Was that the X-ray that you reviewed in making your diagnosis of coccygeal fracture?

A. Yes.

Q. And when was that X-ray taken?

A. July 8, 2002.

Q. Do you need the assistance of a view screen in order to completely review that X-ray?

A. It would be helpful, yes.

Q. Can you tell, looking at that X-ray, whether there is a coccygeal fracture?

A. There is an abnormality at the end of the coccyx.

Q. How many coccygeal vertebra does Mr. Wojcik have?

MR. BOROWICK: If it would be helpful for him to read it, why doesn't he just put it on the screen.

Put it on the screen and then answer it.

THE WITNESS: It would be more helpful.

MR. SPARLING: Let the record

reflect that we are viewing the X-ray on the view screen.

A. So here is the coccyx (indicating), and this is the tip, the tip of the coccyx. If you look at the bone in the tip of his coccyx here (indicating), and compare it to the rest of the sacrum and coccyx, you will notice that it doesn't look quite as dense as the rest of the sacrum or coccyx does. And if you look at the cortex where the outline of that bone -- there appears to be a break in that area. There appears to be an area where -- right there and it comes across as a gray line where we don't see bony continuity. And that to me looks like that area has a hairline fracture in it.

Q. Okay. We have a crayon. Can you circle the area where you view a coccygeal fracture on that X-ray.

A. Sure.

What I will do is, I'll put a tic mark next to it so we don't throw off the way of the rest of the bones look.

Q. Is there an area where you can place an arrow pointing to the area of the bone

where you first see the fracture begin, without actually placing a mark on the bone itself?

A. Yes.

Q. Okay.

Can you do that, please.

A. Yes.

(Indicating.)

Q. You have placed two arrows, one on either side of the bone; is that correct, doctor?

A. Yes.

Q. And what is it about the area of the coccyx that you have placed the arrow that reflects a difference in the bone density compared to the rest of the coccyx and the sacrum?

A. There is -- the bone itself has kind of a grainy appearance to it. And if we look at all the little grains of the bone, throughout all the little areas of the bone, you can follow each one of those little individual grain lines, like the grain in a piece of wood, and you can see clearly -- clearly, you can see all those lines. The area where I have drawn the arrows, it's very difficult to see those lines

completely intact across the bone. So it looks like there's a break in those lines.

Q. Does Mr. Wojcik have three coccygeal vertebral bodies?

A. He is a little bit osteopenic in that area here, which means the bones, they don't stand out and project that well. But it looks like he may have three, yes.

Q. So where is the fracture that you are identifying?

A. It's in the -- if we say he has three parts, it is actually here in the middle portion or that second portion (indicating), depending on which way you count. But it doesn't matter, because if it's three, two is always in the middle.

Q. Is it a transverse fracture?

A. Yes, it appears to be right across the coccyx.

Q. Did you call the radiologist after you got the report that indicated no fracture?

A. No, I didn't.

Q. Why not?

A. A lot of times -- I mean, if I

called the radiologist every time I saw a hairline fracture and they didn't, I would be on the phone a lot with radiologists. Which is not to say anything bad or negative about radiologists. It's just that they are looking at bone, they might not get into the detail that I do. They may not have the benefit of a physical exam or the patient there with them when they are doing their reading.

Q. Is the coccyx displaced as identified in the X-ray?

A. Not particularly, no.

Q. Is there any evidence of trauma to the area as reflected on the X-ray?

A. That little hairline fracture area. (Indicating.)

Q. Anything else?

A. And the fact that density in the lower portion of the coccyx, it's not quite as dense as the rest of the bone is, as the remainder of the bone.

Q. Is that disparity in density due to trauma?

A. Yes, it can be. With a fracture,

the bone gets an increased blood flow, and that increased blood flow can suck out some of the mineralization in that bone and thereby make it look as though it has less density than the remainder of the bones do.

Q. Is there hemangioma identified in that X-ray?

A. I do not see evidence of hemangioma within the X-ray itself.

Q. Is there edema noted on the X-ray?

A. It's difficult to see edema on the film, but the osteoporosis tells you there is an inflammatory reaction or increased blood flow to the coccygeal area.

Q. What is osteoporosis?

A. Osteoporosis refers to a decrease in the mineralization content of the bone, so a decrease in the bone calcium content. Osteopenia means that -- the appearance on X-ray means that it's not quite as dense as the remaining bone. When you take an X-ray, you can really only make by X-ray, you can only make a diagnosis of osteopenia, you can't call it osteoporosis, unless you either do a special osteoporosis scan

or take a piece of that bone and then find out how much mineral it contains.

Q. Did Mr. Wojcik have any therapy for his back?

A. I don't remember. I don't recall if he had any PT per se, but I do think he was seeing a physical therapist for his injuries. But I don't remember it specifically.

Q. Is there anything else that you note about the X-ray that was relied upon by you in forming your opinions in the case?

A. That's pretty much it.

Q. Could you initial next to one of the arrows.

(Indicating.)

Q. Date it, if you don't mind.

A. (Complying.)

Q. Doctor, do we have with us today the MRIs also?

A. Yes.

Q. What MRIs were provided here today?

A. We have the right shoulder. We have the lumbar spine. And we have the sacrum and coccyx.

MEROLA

Q. I'm just going to go back for a moment about Mr. Wojcik's back. Does Mr. Wojcik need any additional treatment relating to his back?

A. Yes.

Q. What is in your file or chart that reflects he needs additional treatment for his back?

A. 11/24/03, decreased lumbar spinal range of motion and paravertebral spasm persists. And the subsequent notes that indicate that he continues to remain symptomatic And essentially status quo.

Q. What plan of action did you set in place for his treatment related to his back after your visit on November 25th -- I'm sorry. November 24, '03?

A. At that time my notes were concentrating on his coccygectomy. Everything else I had made no changes to anything else that was going on for him at that time.

Q. What is the prognosis for Mr. Wojcik following the coccygectomy?

A. Prognosis is guarded. It's

difficult to say. Most coccygeal fractures will heal to the point where patients can tolerate their symptoms. If the fracture has not healed, coccygectomy itself may be able to decrease pain but may not entirely eliminate it because of the effect, shall we say, of almost like a phantom limb type of pain. That painful segment becomes imprinted on the brain's pain cortex. Removal of the part should decrease that pain by eliminating the feedback loop that your brain is getting from the painful area. But if the imprint is very strong, then the pain may persist. Number one.

Number two, the ligaments and muscles that attach to the coccygeal area after they are reattached themselves -- to themselves, that healing process now needs to accommodate for the lack of a coccyx, and that, in and of itself, can also sometimes cause pain. This is one of the problems with the coccygeal fracture and coccygectomy.

Q. Do you anticipate that Mr. Wojcik should be able to return to his prior employment following the healing process of the coccygectomy surgery?

A. I don't think he is going to be able to go back to work as an ironworker. That is a problem, especially for this particular area.

Q. Why is that?

A. The attachments -- because this area, because the coccygeal attachments involve the pelvic floor, the ligaments from the pelvis, the bony pelvis to the coccyx, the gluteal musculature, and the muscles that attach that, the lower portion of the genitourinary tract, valsalva-type maneuvers, which are those maneuvers which we employee when we are bending, lifting, twisting, moving heavy objects, can become very difficult and persistently painful. Because of the attachment area of this section of the body.

Q. Have any of the other patients that you have performed coccygectomies on not been able to return to work whatever they were doing before?

A. I have not performed a coccygectomy on a heavy laborer, as far as I know, to date.

Q. What is it about Mr. Wojcik's

occupation that would prevent him from continuing to work after the coccygectomy?

A. Ironwork itself involves significant amounts of bending, lifting, twisting, carrying heavy loads, and not only carrying those loads, but it requires him to really use his arms and his legs to manipulate those loads in order to make various attachments as needed, and for the structural portion of his work. That is very difficult, with this particular kind of injury.

Q. Does Mr. Wojcik have coccygeal pain at all times?

A. Yes. Yes. As far as I know, he does, yes.

Q. Well, does your chart reflect whether he only has pain while sitting or something else?

A. No, it doesn't. It does reflect that he does have persistent pain.

Q. Is the coccygeal pain caused by the direct pressure on the coccyx or the movement of the coccyx, or something else?

A. Usually a combination of both.

Q. What about the work of Mr. Wojcik would cause direct pressure to the coccyx?

A. Those maneuvers involving valsalva, which is a increase in intra-abdominal pressure. Usually when you employ your core muscles, your intra-abdominal pressure increases. Your pelvic floor compensates by putting back pressure on your abdomen. So that is one way in which the toxic can be painful. The other thing is that when you're stabilizing your lower extremities or both your legs in order to move an object or perform a duty, the pelvic wall and floor musculature there also pull on the lower portion of the sacrum and the coccyx. So they pull on that area in order to stabilize your lower extremities.

Q. As far as you understand, does Mr. Wojcik's occupation require does mostly standing and lifting?

A. Yes.

Q. Would there be any medical value to having injections to the coccyx area prior to performing coccygectomy?

A. The thing that concerns me about

injecting the coccyx, particularly where you have persistent pain after a fracture is the possibility of, number one, infection because of the traumatic and traumatized area, and, number two, is an inability to interfere with healing of that area post-operatively. Because of the steroid deposition.

Q. Did you see Mr. Wojcik between November 24, '03, and February 2, '04?

A. I don't have any notes. I don't have any notes indicating that I saw him in between those dates.

Q. What pain management did Mr. Wojcik receive?

A. I don't have it listed in the chart.

Q. Do you know whether the pain management that he has received has improved his condition at all?

A. Upon his last visit to me, the coccygeal area was still painful and symptomatic.

Q. Have you been provided with any of the independent medical examination reports by -- that were done of Mr. Wojcik on behalf of the

defendants in this case?

A. No, I don't believe I have seen those.

Q. Are you aware that a physiatrist and orthopedist and a radiologist have examined the films, and Mr. Wojcik, and determined that there is no coccygeal fracture?

A. No.

Q. Does the MRI films reveal coccygeal fracture?

A. Yes.

Q. Can you identify which of the films that we have here today identify a coccygeal fracture.

A. Yes. It's on several films.

Q. Have you selected two of the sheets of MRI views that reveal fracture?

A. Yes.

Q. Can you identify where would be an appropriate place to mark those films so as not to inhibit the impression of the MRIs?

A. Yes.

Q. Would you do that, please.

A. Yes. Actually, the radiologist has

marked them for us.

Q. Okay. But we need to mark them as exhibits for the case.

A. Sure. And these views on this sheet.

(Exhibit Number F was marked for identification.)

(Exhibit Number G was marked for identification.)

Q. Let me show you what has been marked as Defendants' Exhibit F for identification. Can you identify that for me.

A. Yes. These are multiple coronal images of the sacrum and coccyx.

Q. Did you make any markings on that film?

A. No.

Q. Are there markings on the film that were placed after the film was taken?

A. Yes.

Q. What markings were placed on Defendants' Exhibit F?

A. There is a radiologist's red grease pen circle around the area in question.

Q. How many views are there on that sheet of?

A. Sixteen.

Q. And how many of those views reflect a fracture of the coccyx?

A. One is marked by the radiologist.

Q. Do you need to view that on the screen to answer questions about your diagnosis?

A. Yes.

Q. Just to clarify, can you identify, of your own expertise, whether there is a fracture depicted on any of the views that are on Defendants' Exhibit F?

A. Yes.

Q. Which of the views can you identify as reflecting a fracture of the coccyx?

A. There are two good views on this sheet. This is one. And this is the other one.

(Indicating.)

Q. How can you identify the two from the other views that reflect coccygeal fracture?

A. Let's see. Generally they number the slice. So let's see where they put their slice number. They have their seven slices out

of 16 and eight out of 16.

Q. And are there four rows of views on that film?

A. Yes.

Q. And there are four views on each row?

A. Yes.

Q. And the two that you have selected are in the second row, third and fourth view reading left to right?

A. Yes.

Q. Can you identify where on view number seven the coccygeal fracture is noted?

A. These views, the coccyx -- the coccyx tips into the pelvis. So these views -- so this if this is us looking at the patient (indicating). And my hand and fingers are the coccyx, these views are slices (indicating), taken in the front to back direction, as we are looking at the coccyx.

Q. That is coronal; is that correct?

A. Yes. So the coccyx is kind of tipped in and facing us, it's like Pinnochio's nose looking at us. And what we see in these

views (indicating), as the coccyx comes into view, is that there's an area of increased signal, which represents an area of edema or swelling in the coccyx. And on its companion view, which is view number eight. We see that there is a thin grayer line disrupting that area of edema. And that thin gray line that we see disrupting that edematus area represents the area of the fracture. We start to see it on seven and we get a relatively decent picture of it on eight.

Q. With respect to view eight, have the markings of the radiologist covered the edema that you have noted?

A. No. We can still see it.

Q. Is the gray line that you are referring to within the circle that was drawn by the radiologist?

A. Yes.

Q. How do you know the circle was drawn by the radiologist?

A. That is usually the way a radiologist will denote his findings on the film.

Q. With respect to view number seven,

can you draw an arrow to the area where you first see the fracture line?

A. The fracture line isn't yet apparent on seven, but the inflammation around the fracture line, we can see that.

Q. Can you see a fracture line on view eight?

A. Yes.

Q. Can you draw an arrow to the area where you see the swelling beginning that you said was indicative of a fracture on view seven but also without drawing on top of the bone or swelling depicted in that view?

A. Yes.

Q. Could you do that, please.

A. (Complying.)

Q. Is the swelling transverse in nature or something else on view seven?

A. Something else.

Q. What is it?

A. It's kind of a generalized, if you will, cloud around the area where the fracture is.

Q. Does that view number seven show

the entire segment of the coccyx that you believe was fractured?

A. No. Only a portion of it. Only that particular slice through the coccyx.

Q. But does it show the entire width of that coccyx for the entire slice?

A. It shows the width of that coccyx for the slice, yes.

Q. Is the swelling that you have noticed through the entire width of that coccyx, of that slice?

A. Yes.

Q. There appears to be a white line on the left arrow that you have drawn. Do you see that?

A. Yes.

Q. What is that white line?

A. This, over here?

(Indicating.)

Q. Yes.

A. That whiteness that we see is inflammation. So that is an increased water signal that the MRI has picked up.

Q. Was Mr. Wojcik given any medication

or substance to benefit the results of the MRI?

A. Not as far as I know.

Q. Can you draw, on view number eight, an arrow to the area where you believe a fracture is shown but without drawing on the bone or the fracture?

A. Yes.

Q. Could you do that, please.

A. (Complying.)

Q. What about the view of number eight indicates to you that there is a fracture?

A. The gray line going across the width of the coccyx at that point.

Q. Is there a white line or white area that is shown within the circle?

A. Yes.

Q. What is that white line or white area?

A. Edema within the bone area itself.

Q. When you say the fracture line, are you referring to this darker gray area?

(Indicating.)

A. No. Right in the middle of the circle.

MEROLA

Q. So there's a line in the circle directly below where the white area is?

A. Yes. It almost looks like the diameter of the circle. Like that circle was drawn and the diameter of that circle is the fracture line.

Q. Isn't that line one of the segments of the coccyx?

A. No. Here is the other segment. See, it's up here. This is the articulation above.

(Indicating.)

Q. Now you are referring to view seven?

A. Exactly.

Q. There's a white line across?

A. Yes. You drop below it, and you start to see the edema here. There's a little bit of edema here. You start to see this edema here, and you proceed down here. And once again, this and this, the -- you line up those areas. That line is here. And by this time we are out of the articulation of that coccyx.

MR. BOROWICK: Let the record

reflect that he has referred from a progression from six to seven to eight. Whenever you say from here and to here, nobody is going to know what you mean.

Q. How many segments of the coccyx are shown in seven and eight?

Let me just ask you, with respect to seven first, how many segments of the coccyx are shown?

A. We are looking at a portion of one of the segments of the coccyx. Because we don't see the entire coccyx on these corona slices.

Q. Which segment do we see?

A. The middle section.

Q. And with respect to number eight, what segments do we see?

A. Also the middle section. It's another slice through that -- through the middle section.

Q. Are there any other sections shown on seven or eight or, only that middle section?

A. Only really that middle section.

Q. Let me ask you, with respect to -- if you compare Defendants' Exhibit E and

Defendants' Exhibit F, can you indicate whether the area where you believe the hairline fracture on the X-ray is the same area or in the same area of the coccyx as depicted on Exhibit F?

A. Yes. This particulation here, this is where this joint here.

(Indicating.)

MR. BOROWICK: On the X-ray.

A. On the X-ray, above the area that I have indicated with the arrows, there is a clear, distinct joint articulation line here. And that line, that line right there, that line is what we see on seven, on image -- slice number seven as the area of the articulation that we were talking about before.

(Indicating.)

Q. Let me show you what has been marked as Defendants' Exhibit G. I would ask if you could review that and identify that for me, doctor.

A. Yes. These are multiple sagital sections of the sacrum and coccyx.

Q. Now, are there markings on the film that were not there when the film was first

taken?

A. Yes.

Q. And how many markings have been made on the sheet?

A. Four.

Q. How many views are there on that exhibit?

A. There are 28 slices on this sheet.

Q. Are those slices designated on the view?

A. Yes.

Q. Which views have been marked by the radiologist?

A. Slices 14, 15, 16 and 17.

Q. With respect to slice 14, what is that view?

A. This is a sagital image through what appears to be the mid portion of the sacrum and coccyx.

Q. Can you independently determine that view 14 reflects a fracture?

A. Yes.

Q. Where is the fracture on view 14?

A. View 14 contains that circle, that

red circle mark once again. And in the middle of our circle marking, at the end of the segment of the coccyx that we are looking at, we see this gray area.

Q. How many segments are shown of the coccyx on view 14?

A. At this point, we are looking at two segments.

Q. Is the circle placed on any portion of the segments of the coccyx?

A. It's centered around the fracture itself, in the second segment.

Q. Does that view 14 show the third segment?

A. Difficult to see. The third segment is not clearly visible in that slice.

Q. Okay. Is the area where you believe the fracture is shown in view 14 in the general area where the segment would be located between segments two and three?

A. Yes. It is below the clear, that clear line of articulation that we see on the X-ray in the area of the coccyx that appears to have the hairline fracture in it.

MEROLA

Q. Are you able to draw a line with the pen to the area where the fracture is shown without drawing on the bone?

A. Yes.

(Indicating.)

Q. Are you indicating, well, is the fracture transverse as shown in view 14?

A. Image number 14 is the beginning of the fracture area. Because the MRI is looking at the signal from the bone, we are getting what appears to be a gray area in the bone itself. So we are losing the fault signal from the bone here, and that is because that area is being replaced by a -- an inflammatory reaction. This is the beginning, this is as we are coming across the sagital width of the coccyx, this is the slice where we start to see the inflammatory section.

Q. So in other words, the entire coccyx segment is not shown in view 14; is that correct?

A. Correct.

Q. This is the first view that you have not drawn two arrows on other side of the

bone; is that correct?

A. Yes.

Q. Now, with respect to view 15, does that indicate a fracture of the coccyx?

A. Yes. We are getting deeper -- with each successive slice from 14 on down to 17, we are getting deeper into the area of fracture, and more of the bony outline of that coccygeal segment becomes visible.

Q. Does 18 reveal a fracture?

A. 18 is taking us away from that, the outer width of the fracture area.

Q. Can you draw an arrow to the areas where the fracture is shown on view 15 without drawing on the bone?

A. Yes.

Q. Could you do that, please.

A. (Indicating.)

Q. Did you draw the arrow only on one side of the bone?

A. Yes.

Q. Did you initial that?

A. (Indicating.)

Q. Am I incorrect, with respect to

view 15, that there's a white portion below a segment within the circle that reflects a piece of the bone?

A. This; this area right here?

Q. (Indicating.)

A. That is above the actual area of the fracture.

Q. Does that area reflect a segment of the coccyx?

A. Yes.

Q. Is this area a segment of the coccyx?

A. Yes. And this is the articulation segment. And that is another clean area of articulation. See if you see these joints here and here (indicating), and we have one a little bit further down.

Q. How can you tell that the area where at the tip of your arrow is actually pointing to bone as opposed to below the lowest segment of the coccyx?

A. We go out, we proceed to the subsequent slices to see where that edema works its way out. And then on slice number 17, we see

another segment of bone. You see this piece of bone below that area. And once again, there is a rather generally delineated gray line within that segment.

Q. And that is 17; that is 17 that you are referring to?

A. Yes, slice number 17.

Q. Now, is the area of fracture separated from the rest of the area of the coccyx; has the piece actually separated?

A. No. No, it hasn't. It's inflamed. But it's not separated or displaced. Which is why it looks like the way it does on the X-ray.

Q. Would it be important to determine whether that segment has become displaced since August of 2002 and prior to conducting the coccygectomy?

A. It wouldn't make too much -- it wouldn't make too much difference in terms of his treatment whether or not it's symptomatic or not. It would make a difference in terms of the incision. But we would see that on the floor -- on the fluoroview, on the fluoroscopic view of the examination, preoperatively, so there would

be an exam under fluoroscopy, and we would look at it.

Q. Is the fracture that you have noted in view 15 in the third coccygeal section?

A. No. It's still that second section. It's that second or middle area.

Q. Can you draw where the fracture is identified in view 16?

A. (indicating.)

Q. Again, you have drawn the arrow only on one side; is that correct?

A. Yes.

Q. Is that fracture depicted on the other side of the bone?

A. Yes.

Q. Can you draw where the fracture is identified on the other side of the bone on view 16?

A. Yes. I'm going to interfere with his -- with this internal pelvic stuff.

(Indicating.)

Q. What is it that you need to draw over in order to show the area of the fracture on the left side of the bone?

MEROLA

A. This is valve, valve and pelvic floor.

Q. Is there anything about the bowel or bowel area or the pelvic floor that is indicative of there being a fracture or not as shown in that view?

A. There is a portion here of the pelvic floor where you see the pelvic floor come into continuity with the remainder of the coccyx. I guess I could draw an arrow up to that point.

Q. What about that area is indicative or not of that being a fracture?

A. It just helps outline, delineate the area where the fracture is around the coccyx.

Q. How about with respect to the bowel; is there anything about the bowel that is indicative of the fracture?

A. No.

Q. If you could make that marking.

A. (Indicating.)

MR. SPARLING: Is there any objection to that?

MR. BOROWICK: I don't have a problem with it.

MEROLA

Q. Does view 17 identify the fracture?

A. Yes.

Q. -- is the fracture shown on both side of the bone?

A. Yes.

Q. Could you draw where that is indicated.

A. (Indicating.)

Q. Is there anything else reflected on the MRIs other than the edema and the areas of fracture that are indicative of there being a fracture on views 14 through 17?

A. We do see some areas of intensity within the sacrum itself that look as though they may be some hemangioma possibly.

Q. What is hemangioma?

A. Angioma is what I like to describe not unlike birth marks inside the bone. All of us sometimes have small little red, almost look like little blood blisters on our skin and sometimes those can form within bones themselves and those are known as hemangiomas, where there is an accumulation of blood vessels causing a change in that bone marrow area.

Q. Do you have an opinion that there are hemangioma in the sacral area that is relating to the incident with Mr. Wojcik on June 28th?

A. Those are not related -- they should not be related to trauma.

Q. Okay. Did Mr. Wojcik have a hairline fracture of the Wojcik?

A. I believe so, yes.

Q. Is there more than one fracture?

A. I'm sorry?

Q. Is there more than one fracture?

A. No. Of the coccyx, no.

Q. Is there any other fractures that Mr. Wojcik had as a result of this incident?

A. Not with respect to the coccyx, no.

Q. How about anywhere else on his body?

A. Not as far as I have diagnosed, no.

Q. Did you diagnose Mr. Wojcik as having a fracture of the neck?

A. No.

Q. What treatment did you recommend for Mr. Wojcik's cervical and lumbar areas?

A. Continued pain management.

Q. Anything else other than pain management?

A. And the pain medications that I had been prescribing for him.

Q. What is the condition of Mr. Wojcik's cervical and lumbar area today?

MR. BOROWICK: Did we describe it?

Q. Okay. Cervical. Do you understand the question?

A. Yes.

Cervical, from my notes, my impression is that he continued to remain symptomatic with respect to his neck.

Q. Well, what symptoms does he have in the neck?

A. Pain, and in my indications, when I indicate status quo with no changes, basically that means that all the areas that had been symptomatic do remain symptomatic.

Q. Okay. What was symptomatic?

A. His neck, his low back, his coccyx.

Q. What about his neck was injured?

A. I'm sorry. I don't understand the

question.

Q. What injuries did he sustain, as a result of the accident, to his neck?

A. We haven't obtained any diagnostic imaging of the cervical spine yet.

Q. What did your clinical findings reveal?

A. Neck pain, cervical radiculopathy.

Q. Have you completed your answer?

A. With respect to the neck, correct?

Q. With respect to the neck.

A. Yes, yes. Neck pain and cervical radiculopathy.

Q. What is cervical radiculopathy?

A. It means pain radiating into the upper extremities, coming from the neck, producing neurogenic or nerve irritation.

Q. What recommendations do you have for Mr. Wojcik today with respect to the neck?

A. That he continue his treatments as he has been receiving up to when I have seen him.

Q. And what treatment have you given him in the last five months respecting the neck?

A. The pain medicine.

Q. Does he have a herniation in his neck?

A. I'm not sure.

Q. Does he have pain in the neck in the year 2004?

A. Yes.

Q. And again, is that based on the status quo reference?

A. Yes.

Q. Is there anything else about your chart that reflects his neck pain other than the status quo reference?

A. His 10/20/03 typewritten note. Mr. Wojcik remains symptomatic with neck, low back and coccyx, physical examination remains concordant with his prior exams. All are consistent with cervical radiculopathy, lumbar radiculopathy and coccydinia.

MR. SPARLING: Read that back, please.

(The requested portion was read by the reporter.)

Q. I would like to call your attention to the September 9, '02 report.

A. Yes.

Q. Do you see that?

A. Yes.

Q. Does that reflect that he has a fracture of the neck?

A. That is a mistake. It should say he has a fracture of the coccygeal vertebral body. Not neck and. Also, I think that says Henry. That should be Stan.

Q. There are handwritten changes on that record.

A. Yes.

Q. Did you make those?

A. I don't remember. I believe so. I'm not sure.

Q. Let me ask you the same series of questions with respect to Mr. Wojcik's lumbar area. Has he had any treatment in the year 2004, relating to his lumbar area, from you?

A. No. I haven't changed any of his treatments with respect to his lumbar area for 2004.

Q. And would you agree that the treatment consists solely of medication?

MEROLA

A. Yes.

Q. Does he have herniations today in his lumbar region?

A. Let me just check the MRI.

Small central disk herniations, L4-5 and L5-S1.

Q. And when was that taken?

A. August 14, '02.

Q. And my question was: Does he have herniations today?

A. Generally those herniations do not resolve. Once you have blown out a disk, and it's herniated, it's generally a permanent change.

Q. You would agree you would need to see an updated film to be certain?

A. If we were contemplating doing something surgical for his lumbar spine, he would require another MRI of the lumbar spine.

Q. Do you have any additional treatment plan for Mr. Wojcik relating to his lumbar area?

A. Not at this time. We are really concentrating on the coccyx.

Q. Have you seen Mr. Wojcik more than twice in the year 2004?

A. I have seen him February and March.

Q. Other than the coccygectomy, do you have any plans for any additional treatment for Mr. Wojcik?

A. It's been difficult because trying to get any approvals for him has been very tough. So I think we have been trying to concentrate on one problem at a time, and try to work that out and proceed from there.

Q. What complaints does Mr. Wojcik have today about his lumbar spine?

A. As far as I know, they are the same as they have been from his prior exams.

Q. What other treatment are you proposing that has not been permitted other than the coccygectomy?

A. As far as I know, and as you have mentioned, because these other areas do remain symptomatic, I do agree that he needs to have a further work-up of both the neck and the lower back. And that is something that we have put on hold, trying to get the coccyx taken care of.

MEROLA

Q. What is the treatment you are recommending for the neck and the back?

A. I have not proposed a specific treatment to date.

Q. So what is it that you would like to do that you are unable to do?

MR. BOROWICK: He said a work-up. Not treatment.

A. At this point, I would like to be able to see some new MRIs of his lower back and to obtain an MRI of his neck.

Q. Have you requested authority for that?

A. We haven't because we have been having such trouble with the coccygectomy.

Q. Well, you would agree that you can't get approval for it until you ask, right?

A. That's true. But I was trying to really address the majority of his complaints and problems, kind of in a delineated order, and I thought if we are able to get his coccyx at least taken care of and out of the way, and then we could start to treat the other body parts, if need be, with more aggressive treatments, if they

needed them.

Q. Is there arthritis of the coccyx joint?

A. It's difficult to say. I'm not sure.

Q. Is there arthritis reflected on any of the films?

A. Not that I can see, no.

Q. Would you agree that there's a significant body of medical evidence that reflects that coccygectomies are not recommended?

A. No.

Q. What is a levator massage, L-E-V-A-T O R?

A. I can only assume that that refers to the levator muscle and the massage would thereby be working on that particular muscle.

Q. What are calcified pelvic phlebolits?

A. Those are calcifications within the vasculature of the pelvis, within the veins and/or arteries.

Q. Are they reflective of fracture or not?

A. No, they are not.

Q. Did Mr. Wojcik have calcified plebolits?

A. I believe I saw that on a report, yes.

Q. Do you have any opinions relating to Mr. Wojcik's condition or future treatment that we haven't talked about today?

A. I don't know. We have talked about a lot.

Q. Well, have we covered all of the opinions you have about Mr. Wojcik and his condition and treatment relating to the coccyx?

A. Yes.

Q. Does Mr. Wojcik have another appointment with you?

A. Yes.

Q. When is that?

A. In general, the appointments should be anywhere from four to six weeks from their last visit.

Q. Are you familiar with a textbook called "Colon, Rectum and Anus," by Phillip Gordon?

A. No, I'm not.

Q. Is there a difference between functional and organic coccydinia?

A. Yes.

Q. What is functional coccydinia?

A. Much of it depends on how we define the term functional or organic.

In general, functional refers to pain that results from the particular physiological function of the part in question, whereas organic refers to an intrinsic problem with the part itself. Once again, it depends on the definition of functional or organic.

MR. SPARLING: I have no further questions. Thank you.

(Recess taken.)

EXAMINATION BY

MR. BOROWICK:

Q. Dr. Merola, I'm going to ask you some follow-up questions about your reports, your chart, et cetera.

By the way, are you aware of the number of prior occurrences which happened in Mr. Wojcik's life before this accident?

A. Yes.

Q. Are you aware that these occurrences included but were not limited to a motor vehicle accident, a motorcycle accident, an assault in a bar, as well as strains and sprains?

A. Yes.

Q. I want you to assume for a moment that, as of the time of the accident, that Mr. Wojcik was working full time as an ironworker, putting in full-time hours, et cetera.

Do you have an opinion as to whether or not any of those preexisting occurrences or preaccident occurrences had any carryover or any effect on his ability to do his job?

MR. SPARLING: Object to form.

Q. Do you have an opinion?

A. Yes.

Q. Did they limit him in any way from doing his job?

A. No.

Q. And as a result of this accident, I want you to assume the following facts, subject

to connection from the testimony of Mr. Wojcik: That as he fell through an unguarded hole, he reached to grab with his right arm and he was caused to pull his arm out, his right arm, and then he landed on his leg, I think his left leg, and his butt. And that, subsequently, he was treated at Bellevue Hospital, where he was found to have abrasions and redness least around the buttocks area.

Do you have an opinion as to whether or not his coccyx fracture, which you have diagnosed, was caused by the fall?

MR. SPARLING: Object to form.

A. Yes.

Q. And what is your opinion?

A. That the fall caused his coccygeal fracture.

Q. I want you to assume that, with regard to his shoulder, he had previously had shoulder surgery, I believe it was back in the mid '90s, '94, as a result of some condition in his shoulder. And that thereafter he became an ironworker and worked as an ironworker as I have described.

MEROLA

Do you have an opinion as to whether or not the shoulder injury that he sustained, which he had during the time that you have treated him, was caused or exacerbated by his fall and his reach, et cetera?

MR. SPARLING: Object to form.

A. Yes.

Q. Was it caused or exacerbated or both?

A. Probably both.

Q. With regard to Mr. Wojcik's neck, you were asked several questions about your diagnosis. Let me ask you general question first. What is the term, what does the term mean, clinical correlation?

A. Clinical correlation means that you take a patient's history and their physical findings and their complaints into consideration when coming up with an opinion about what you think is wrong with them.

Q. And does a radiologist who you send the person to, to get a film done, does that radiologist, in the ordinary course of the business of radiology, et cetera, as part of a

medical practice, does that radiologist clinically correlate the symptoms to the objective testing?

A. No.

Q. Okay. As a treating physician, have you, as part of your treatment of Mr. Wojcik, tried to clinically correlate where possible his symptoms to his injuries?

A. Yes.

Q. Now, with regard to the neck, you said that you would be waiting for further work-up, or you would be desirous of a further work-up of the neck, you know, pending, you know, addressing his more serious problem in his coccyx.

Now, without that further work-up, have you been able to clinically correlate any of his complaints and symptoms to objective findings based on your exam?

A. Yes.

Q. And what has your clinical correlation consisted of and what is your diagnoses?

A. Decreased cervical and lumbar

ranges of motion, persistent and consistent pain. And the working diagnosis for this is a cervical radiculopathy, a lumbar are a --

Q. Let's restrict it to the neck.

A. Cervical radiculopathy.

Q. You said it was an irritation of the nerves or the nerve roots or whatever it is you said, nerve irritation.

A. Yes.

Q. Where would that nerve irritation take place?

A. In the neck.

Q. For it to generate the kind of complaints that he has, what is the mechanism of that irritation?

MR. SPARLING: Object to form.

A. The mechanism of irritation is generally a herniation with subsequent nerve root pressure and inflammation.

Q. And given the way in which he fell onto his leg and his butt, would that cause the kind of stress on the person's spine and/or specifically his neck that could give rise to a herniation? And when I'm talking about is the

axial load along the plane of the spine.

MR. SPARLING: Object to form.

A. Yes.

Q. Okay. I want you to -- would you then define for me, subject to the objection, what is axial load in the context of a fall from a height onto one's butt?

A. It's axial load involves, as a person falls, they acquire potential energy. When they make contact with the ground, there is an elastic collision that happens, that potential energy is then transferred, some to the ground, some to the patient. And then the patient's extremities and spine absorb the energy. And the axial load refers to the energy absorption that is happening in the direction of top to bottom spinal loading.

Q. Assume for a moment that as of the day of the accident, before it occurred Mr. Wojcik had no complaints, no difficulties and no limitation related to his neck or the cervical spine. And that after the accident he developed these symptoms for which you have seen him.

Do you have an opinion as to

whether or not the accident caused his neck injury, his radiculopathy. What is your opinion?

A. That the fall resulted in his neck problem and radiculopathy.

Q. Do you have an opinion as to what level, based on his symptoms, what level of his neck?

A. No, I don't have a specific level.

Q. Would that further work-up further identify the levels for you?

A. Yes.

Q. Now, with regard to the lumbar spine, what effect would the dynamics of the fall and the mechanics of the fall have upon his lumbar spine, given what the objective findings have been?

MR. SPARLING: Object to form.

MR. BOROWICK: Let me ask it in a different way then.

Q. Did the fall have any effect on the lumbar spine in your opinion?

A. Yes.

Q. How did that occur?

A. Acute energy transfer to the disks

in the lumbar spine resulting in herniation.

Q. I want you to assume again that there had never been any herniations in his back, no diagnoses for herniations in his back, no MRI findings of herniations in his back.

Given that he was working without limitation before this accident, and that as a result of the accident he sustained the complaints that arose, that he made to you in your office 10 days later, can you tell us whether or not you find there to be any causation between the accident and his lumbar energy?

A. Based on when I saw him in July, I would say that his symptoms were secondary to his fall.

Q. Now, with regard to the leg injury, you mentioned or counsel mentioned that somewhere in the record there was something about a leg or a heel. What was that?

A. He had -- when he presented to me in July, he had left heel pain.

Q. And has that resolved or is that persistent?

A. I think that is pretty much

resolved itself.

Q. Again, you are looking at your record. Let me ask you: When you create a record, as a treating doctor, when you create a record, do you include, in every note, every complaint that the patient makes and every conversation that you have with them?

A. No.

Q. Are there occasions where your notes will have brief references to conversations and other notes which will exclude or omit to put the conversations in?

A. Yes.

Q. Okay. And for the past almost two years that you have been treating Mr. Wojcik, and over the number of times that you have seen him for the various complaints that he has had, have there been occasions, for example, when counsel has asked you questions, or on other occasions where you just reviewing your chart, where you see that there's something that wasn't in there, that should have been in there, or something that was in there that was a mistake; have you seen that?

A. Yes.

Q. Now, in connection with Mr. Wojcik or any of your other patients, have you, on occasion, added to your notes even back-added to your notes, notes that you made in the past?

A. Yes.

Q. Okay. Is that unusual, when you are treating a patient, if something strikes you as something that would further complete your record, to put it in?

A. If I remember something, or I'm thinking about the patient and I'm trying to figure out what is going on with him, to remind myself, not unlike did I on the back of my chart, I will oftentimes make a notation and just put something in there so that I'm not completely off-base with the patient.

Q. Okay.

Now, did you have occasion to, for example, discuss the history of the dynamics and mechanics of this accident with Mr. Wojcik specifically? Do you remember?

A. I remember that he gave me the history that he had fallen on the date that he

had fallen, and that he had been taken to Bellevue, and that is where he underwent his initial work-up and his treatment.

Q. Now, without anymore detail, and you are reading now from your chart, without anymore detail in your chart, can you tell us today whether or not he described the fall: From how high, what were the circumstances; do you remember?

A. No.

Q. I want to take this individually. When you have described what conditions you found him to have sustained as a result of this accident, I'm going to ask you about which ones you consider permanent.

The radiculopathy, secondary to what you believe is a herniation, subject to confirmation by an MRI, do you believe his neck injury is, number one, causally related to the accident?

A. Yes.

Q. Number two, permanent?

A. It's been going on for over two years, so it is permanent.

Q. Well, the accident was about 22 months ago.

A. Twenty-two months.

Q. Does that change your opinion?

A. No.

Q. What about his shoulder? Even though you haven't treated him, have you followed his progress of his shoulder?

A. Yes.

Q. His shoulder injury, you have mentioned that it was either exacerbated or caused or both by the accident. Do you have an opinion as to whether or not the shoulder problem is permanent?

A. Yes.

Q. Now, is there a difference between progress, improvement and ability to return to one's occupation?

A. Yes.

Q. And what is the difference?

A. Progress refers to whether or not the patient is showing any signs of either improvement or worsening of the condition. So how does the condition progress?

MEROLA

The condition can get worse clinically or the condition can get better clinically. Improvement generally means that the patient is getting better. And ability to return to work depends on what that patient -- the given injury and then what that patient is required to do for their job.

Q. Okay. So if a person makes progress after surgery, or improves after a surgery, whether it's the shoulder surgery or the coccygectomy or whatever it was, if he improves after that, is that the same as he is able to go back to his job if that job is an ironworker?

MR. SPARLING: Object to form.

A. I'm sorry. Could you repeat the last part?

Q. I will change it, make it are acceptable.

Keeping those distinctions in mind, did he, did his neck improve at all over the last year and eight months?

A. Not as far as I can see, no.

Q. Did his low back improve at all over the last year and eight months?

A. No.

Q. Has his coccyx pain improved at all over the last year and eight months?

A. No.

Q. Has his shoulder improved at all from the time that you first saw him, through surgery up until today; have you noticed an improvement in his shoulder symptoms?

A. Not as far as I know, no.

Q. Any one or a combination of any of these injuries, there was coccyx, back, his neck, or shoulder; would any one or combination of them preclude him from going back to a heavy laborious job like ironwork?

MR. SPARLING: Object to form.

A. Yes.

Q. And would you explain that?

A. We had spoken about ironwork before with respect to the coccyx. The neck and the low back and the shoulder are similar insomuch as these are -- their anatomical structural areas that are very sensitive to repetitive motion, loading, and torque.

Q. And as an orthopedist, and an

orthopedic surgeon, have you had occasions where, for example, with shoulder surgery or spinal surgery the patient can become pain-free following procedures or therapy or conservative or invasive treatment and yet not be able to return to his occupation?

A. Yes.

Q. And would you explain that.

A. A good example is a lumbar reconstruction and decompression. If a patient has a herniated lumbar disk that causes a nerve root problem in the legs, and you take the pressure off that disk herniation and then do a reconstruction or a fusion of the vertebral bodies involved, you may have a patient that is either pain-free or has decreased their pain status, but the reconstruction and the decompression need to be protected because repetitive motion, torque, and loading can, number one, break down the reconstruction that you have done, or, number two, irritate the nerve root that you have decompressed.

Q. Now assuming that this gentleman had required surgery by Dr. Jaffe, as you have

referred to him in some of your notes, if that surgery resulted in a lessening of the complaints and symptoms following that surgery, does that mean if that were his only injury he could return to the heavy job of ironwork?

MR. SPARLING: I'm going to object to form.

Q. If that was his only injury?

A. If that was his only injury, he would not be able to return to ironwork.

Q. What effect would that kind of heavy labor have on a repaired shoulder?

A. Rerupture of the tendon, number one. Number two, chronic irritation of the tendon and the muscles in the shoulder joint itself. And number three, accelerated degeneration of the shoulder joint.

Q. Now, would those complications of the absorption required for those jobs be true of his neck injury?

A. Yes.

Q. Would it be true of his back injury, low back injury?

A. Yes.

Q. And what about his coccyx injury; if you did the coccyx surgery and then he went back to work, would the permanent change in his anatomy be able to handle that kind of work in your opinion?

MR. SPARLING: Object to form.

A. It would make it -- it would be difficult for him to return to work as an ironworker with the coccygectomy for all those reasons we had brought up previously.

Q. Now, you mentioned that he needs the coccygectomy, and once he has that, what would be the next priority for him in his treatment?

A. Cervical MRI.

Q. And having had the lumbar MRI and the persistence of his symptoms, how would you treat his low back? And which would be a priority, low back or cervical?

MR. SPARLING: Object to form.

A. I would first like to get an MRI of the cervical spine to see what the cervical disks look like. And then based on what we saw on his cervical spine, the neck and/or the back would be

treated most probably with epidural steroid injections and/or, worst-case scenario, failure of all other things, surgical intervention.

Q. And surgical intervention, is that any guarantee of success or recovery full?

A. No.

Q. Based on your treatment for almost two years, do you have an opinion as to whether or not this man will ever return to his career as an ironworker?

A. I wouldn't want him to return as an ironworker.

Q. Has he ever indicated to you anything that would lead you to believe that he was a mal lingerer.

A. No.

Q. A liar?

A. No.

Q. Faker?

A. No.

Q. An exaggerator?

MR. BOROWICK: Nothing further.

FURTHER EXAMINATION

BY MR. SPARLING:

MEROLA

Q. Mr. Wojcik made complaints to you, did he not, about his cervical spine when you first saw him in July, right?

A. Yes, I believe so.

Q. Can you tell me any reason why you didn't ask for an MRI of the cervical spine at any point between 2002 and today?

A. Well, Stanley's major overlying complaint and symptom and number one problem has been his coccyx and his pain in the coccygeal area. You know, for whatever reason, I like to really delineate his primary pathology first because sometimes when we start ordering different tests through Comp and asking for multiple approvals. My impression has been that Compensation holds back even more than they usually do. So I want to kind to try to make it as simple as I can in terms of being able to approve the care and treatment that he needs based on what his chief complaint is, and then follow through on his other complaints after we have been able to hopefully alleviate the worst problem first.

Q. Are you suggesting that Mr. Wojcik,

your patient, needed medical treatment back in 2002 that you didn't recommend?

A. No. No. Conservative care is always the front line of treatment for all of these injuries. And following his clinical course. Had Mr. Wojcik had a neurological deterioration, which we saw on his clinical findings, if need be, I would have admitted him to the hospital had I noticed a neurological change that I thought required more urgent treatment. My impression was that he was continuing his normal treatments for his neck and his lower back and the thing that was really on his mind the most, and making his life absolutely miserable was his coccyx.

Q. Would you agree that you would make notes in your chart of anything that was important respecting the treatment and care?

A. For the most part. My chart is generally a way for me to try to understand the patient and his clinical course.

For example, if he had come in and began to develop weakness in one of his arms. If he came into the office and said Dr. Merola: I'm

having difficulty using my arm, or if I noticed on inspection or gait or by observation or by palpating or testing that he had had a neurological deficit or issue or problem, that would go in there and then I would say: Listen, this needs to take precedence over your coccygeal problem.

Q. Are there notations in your chart that you plan on going back and amending today, Doctor?

A. I don't understand.

Q. Do you plan on altering your chart and your notes?

A. No.

Q. Is there anything that was important that you can tell us was left out of your chart today?

A. No, not that I can remember.

Q. Do you have any of the hospital records relating to Mr. Wojcik's care?

A. No, I don't.

Q. Did you ask to get copies of his treatment and care at Bellevue Hospital before you made your recommendation on surgery?

A. I didn't ask for the Bellevue notes, no.

Q. Is that important to obtain all of the medical records for a particular condition before making recommendations?

A. If there's a question in my mind about the diagnosis or about how I'm going to treat him, and I'm unsure of that, then I would want to see some of the older notes.

Q. Were there diagnostic studies done at Bellevue?

A. He indicated to me that he had been treated and released, so I would think that they had done some diagnostics.

Q. Do you know whether they did or not, as you sit here today?

A. No.

Q. You would need to get the records, right?

A. Yes.

Q. Now, you were asked a number of questions about ruling out prior injuries by Mr. Borowick. Do you recall that?

A. Yes.

Q. What prior injuries are you aware of that relate to Mr. Wojcik specifically?

A. I think he had had a nasal fracture or septal injury. I think he had had some prior history of a neck and back problem. Those are the ones that stand out most in my mind.

Q. We went over and you identified the records that were faxed to you this morning.

A. Yes.

Q. Did you have any records at all that related to Mr. Wojcik's prior treatment prior to today?

A. I don't believe so, no.

Q. And would you agree that all of the records that you had faxed to you today relate solely to 1995?

A. For the most part, I think they are '95. Although there are some pages that don't have a date, don't have a date on them.

Q. Are all these records relating to the injuries sustained during a fight?

A. Glassgold notes a fight -- assault. An assault. I'm just trying to see if there's anything else in there. The ultrasound report

notes an accident, assault.

Q. When is the ultrasound report?

A. Ultrasound is 6/20/95.

Dr. Callahan.

Another note indicating an assault from Dr. Stivers. HCVA forms do not indicate a mechanism. And that's it.

Q. Have you had a chance today to review in detail those records that you have been faxed?

A. In detail, no.

Q. Well, how is it that you are able to rule out all of the prior injuries for records that you haven't even reviewed in detail, doctor?

A. Rule out -- I'm sorry, the what? How am I able to rule out --

MR. SPARLING: Do you want to read it back?

MR. BOROWICK: I will object to the form of the question.

Rule out, I think, is the wrong phrase.

MR. SPARLING: Okay. All right.

Q. Did Mr. Wojcik also have motor

vehicle accidents?

A. I'm not sure.

Q. Did Mr. Wojcik have any other workplace accidents?

A. I'm uncertain.

Q. What injuries did he have to his shoulder before this incident?

A. I'm not sure as to the exact injury that he had to his shoulder.

Q. Okay. Do you have any records of the prior shoulder injury?

A. Not unless they are in those records that I just looked at.

Q. Do you want to take a look at them and see if it talks at all about shoulder injuries, Doctor.

A. (Reviewing document.)

He has got a positive shoulder exam on page 2 of Dr. Stivers' note, although that wasn't one of his presenting complaints on that exam.

Q. What was the problem with his shoulder?

A. He said that he had, in the right

shoulder Cogmen's test was positive on the right and supraspinatus muscle testing was hampered due to pain. It looks like he was having right shoulder pain on that exam, and then they also put that into these disability diagnosis.

Q. Did Mr. Wojcik tell you that he had a workplace accident and hurt his back within eight months of this incident?

A. Let me just check.

No. Not that I have noted, no.

Q. And you have no records of any workplace accident in the year 2001?

A. No. 2001, no.

Q. And you have no records of any motor vehicle accidents that Mr. Wojcik has had?

A. No.

Q. And you don't have any records involving his prior shoulder surgery or injuries other than what you may have mentioned?

A. That's correct.

Q. How is it that you can rule out prior motor vehicle accidents, prior workplace accidents, prior shoulder injuries and surgeries as not contributing or being exacerbated in this

injury when you don't know what they are and you have no records about them?

A. It's my understanding that he was back to work as a full-duty ironworker prior to the fall in June of '02.

Q. Does that mean that he wouldn't have any medical conditions that were relevant to a diagnosis on the day before his incident?

A. Yes, I wouldn't expect him to be working full duty if that were the case.

MR. SPARLING: I have no further questions.

FURTHER EXAMINATION

BY MR. BOROWICK:

Q. We are talking about the shoulder injury and the prior shoulder injury. I'm going to read to you from a record dated July 25, 2002 from Leonard Jaffe, a doctor of orthopedic surgery and sports medicine. Within a month after the accident, he writes this to a person whose name and position I will move to redact and exclude from this question. Her name is Pat Collins at Liberty Mutual Insurance Group. That being said, listen my question. Okay?

MEROLA

A. Okay. Yes.

Q. Now I'm going to start the question. Assume that Dr. Jaffe wrote within a month after the accident that Mr. Wojcik, a 33-year-old ironworker who on June 28, 2002 fell through some decking, approximately 20 feet injuring his heel, the lower portion of his spine and right shoulder. He was kept overnight, et cetera. He has been under the care of Dr. Merdola at St. Vincent's. Is that you?

A. Yes, that is probably me, misspelled.

Q. Okay. On examination of the right shoulder, there is evidence of previous surgery. I believe this was for capsular stabilization many years ago, that subsequently resolved and he returned to full active duty after our treatment. And then he sends him out for an MRI after describing a rotator cuff injury with mild impingement. And after the MRI on August 28th of 2002, he writes as follows, to the same person: Mr. Wojcik returns today after reviewing MRI. On examining the patient, the radiologist and myself interpreted the films independently in the same

format. The patient has impingement, and AC joint injury that may reflect a tear as well as an instability and possible laboral tear that was not mentioned by the radiologist but was noticed by me on one of the axial sections. At this point, he has failed conservative management and is a candidate for acromioplasty, AC joint resection, partial clavectomy and arthroscopic evaluation of librum with possible cuff repair and a transfer of the CA ligament of the AC joint -- if the AC joint is unstable.

Sir, now, knowing what the previous surgeon had done and evaluated, as well as for the surgery after this accident for the shoulder, do you find anything about the prior shoulder condition which had, according to the doctor, subsequently resolved before he returned to full duty; do you have any opinion as to whether or not that carried over and is causing any of his present problems?

MR. SPARLING: I'm going to form and the series of questions that preceded.

A. If he was back at full-duty work

after that, and asymptomatic up to that point in time, then the fall that he had had to cause his shoulder problem.

Q. Okays. And assuming the doctor that treated him for the shoulder before and after this accident indicated that the prior condition had subsequently resolved, is that sufficient for you to give the opinion now which is the same opinion you gave before?

MR. SPARLING: Object to form.

A. Yes.

(Continued on next page to accommodate signature and jurat.)

MEROLA

Q. This information, this factual basis in the context of his medical treatment, does that change your opinion at all or does it support your opinion?

MR. SPARLING: Object to form.

A. It doesn't change my opinion. It supports if.

MR. BOROWICK: Okay. Nothing further.

Thank you.

MR. SPARLING: All right.

(Time noted: 5:45)

_____

ANDREW MEROLA, M.D.

Subscribed and sworn to
before me on this _____ day
of _____, 2004.

_____

NOTARY PUBLIC

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CERTIFICATION

I, DALE W. TICE, a Notary Public in and for the State of New York, do hereby certify:

THAT the witness whose testimony is hereinbefore set forth, was duly sworn by me; and

THAT the within transcript is a true record of the testimony given by said witness. I further certify that I am not related, either by blood or marriage, to any of the parties to this action; and

THAT I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 19th day of May, 2004.

Dale W. Tice

DALE W. TICE, R.P.R.

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