MEROLA

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK - CIVIL TERM - PART: 9

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CHRISTOPHER YESNICK and STACEY YESNICK,

Plaintiffs,

-against-

COLUMBUS CENTRE, LLC
and BOVIS LEND LEASE, LMB, INC.,

Defendants.

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Index No. 123909/02
TRIAL EXCERPT

71 Thomas Street
New York, N.Y.
December 9 and 13, 2004

(Testimony of Andrew Merola, M.D.)

B E F O R E:

HONORABLE HAROLD B. BEELER,
Justice; and a jury

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

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Official Court Reporter

A N D R E W M E R O L A, M. D., called as a witness by the plaintiffs, having been first duly sworn, was examined and testified as follows:

THE CLERK: Please be seated.

(Witness complied.)

THE CLERK: And in a loud, clear voice, please state your name and professional address for the record.

THE WITNESS: Andrew Merola, at 36 Seventh Avenue, Suite 502, New York, New York 10011.

THE CLERK: Thank you.

THE COURT: Dr. Merola, as I tell every witness and I'm telling you, please speak slowly and speak loudly, so we all can hear and follow your testimony. Okay?

THE WITNESS: Okay.

THE COURT: Let's proceed.

MR. DOMAN: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. DOMAN:

Q Dr. Merola, please tell the jurors your educational background.

A I am an orthopedic reconstructive spinal surgeon. I did my orthopedic residency at SUNY Downstate in Brooklyn. After my orthopedic residency

was completed, I went to the University of Colorado, in Denver, where I did a spinal surgical reconstructive fellowship. I came back to SUNY Downstate as the director of spinal surgery for the department of orthopedic surgery, and I currently hold that position, as well as a private-practice position.

Q What is orthopedics?

A Orthopedics and orthopedic surgery is the treatment of the musculoskeletal system in the human body: bones, joints, tendons, ligaments; that kind of thing.

Q How does that relate to spinal surgery?

A The spine is composed of muscles, tendons, ligaments and bones; they fit together in a very precise way. The way they work, the way they move and the way they interact with the rest of the body makes it part of the domain of orthopedic surgery.

Q Are you board-certified, Doctor?

A Yes, I am.

Q And what are you board-certified in?

A I am board-certified in orthopedic surgery as well as spinal surgery.

Q And what is the significance of being board-certified in orthopedic surgery?

A Board certification means that I've met the

academic and practice guidelines set forth by the American Board of Orthopedic Surgery. It involves taking several exams. The first examination is given after you complete your orthopedic residency; it's a written examination. It's given in Chicago, where we all go to take that exam on a given day.

When you successfully pass that examination, the second part of the examination is given after you've been in private practice for two years. It's a review of all of your cases and your surgeries, where you are orally examined by an American Board of Orthopedic Surgery examiner, and you present all of your cases to him and he ascertains that you know what you're doing with respect to your given profession.

After you pass that portion of the examination, you are considered to be board-certified by the American Board of Orthopedic Surgery.

Q Is every orthopedist board-certified?

A No.

Q Now, what is the significance of being board-certified in spinal surgery?

A Board certification in spinal surgery is a separate examination, administered by the American Board of Spinal Surgery. That examination pays specific attention to spine and spine-only cases, and knowledge.

It is a written examination, with a recertification examination as well.

Q Would you please provide a brief synopsis of your employment history, once you became a medical doctor, to the jurors?

A Sure.

After I became a medical doctor, my first job was that of a general surgical resident and an orthopedic resident, which I did at SUNY Downstate. After that, I progressed over to the University of Colorado, where I became a junior attending and a fellow for spinal surgery. While I was there, I was asked by the chairman at SUNY Downstate to come back and head up SUNY Downstate's spinal surgical division in orthopedics, so I returned as the director of that program. So I have an academic affiliation and an academic title with SUNY Downstate, as well as a private practice, which also began when I returned from my fellowship in 1996, and I've been doing both of those since 1996.

Q Have you written any publications?

A Yes.

Q Approximately how many?

Tell us about a couple of them.

A Sure.

Part of my job as an academic surgeon is

to do research regarding the latest orthopedic techniques and spine techniques. Part of my job in orthopedics is to look at biomechanics, or how things work in the body. The publications that I've had generally center around spinal surgery, spinal implants, reconstructive surgeries and deformity surgeries. Those are presented at national and international meetings, and then those presentations are later developed into articles that are then submitted to what we call peer-review journals that are then published in the general-orthopedic and spinal literature.

Q Are you a member of any professional associations or societies?

A Yes, I am.

Q Which associations or societies are those?

A I am a past president of the Brooklyn Medical -- of the Brooklyn Orthopedic Society. I am a member of the American Academy of Orthopedic Surgeons. I am a member of the Scoliosis Research Society.

Q Approximately how many spinal surgeries have you performed in your career?

A I would say, in the neighborhood of about 3,000.

Q Now, Doctor, I'm going to ask you to describe to the jurors the anatomy of the spine, but before I ask

you to do that, would there be a demonstrative aid which would aid you in doing that?

A Yes.

Q And would that be a diagram (indicating)?

A Yes.

THE COURT: We need the easel.

Do you want the witness to step down?

MR. DOMAN: Please, your Honor.

THE COURT: Why don't you step down?

As soon as she sets it up, then you can step down, Dr. Merola.

Thanks, Ann.

THE CLERK: Okay.

(Diagram placed on easel in the well of the courtroom.)

THE CLERK: Do you want to turn it in such a way for you, Judge?

THE COURT: No, I'm fine.

You can step down, sir.

(The witness stepped down and approached said diagram.)

(During the following testimony, the witness indicated variously on said diagram:)

Q Doctor, if you will, please, can you please describe the anatomy of the human spine to the jurors?

A The spine is that portion of your body that is responsible for maintaining your head over your pelvis. It's located in your back but also within the center of your body: your chest and your abdomen.

This is a diagram that shows the pelvis as well as the lumbar spinal segments, and by "lumbar" we mean the lower portion of your back. There are five lumbar segments that then hook up with your pelvis through a segment called the sacrum. Each one of those lumbar segments has associated with it a disc which sits in between the bones and it acts as a load-bearing structure and a shock absorber. And it also has joints, so that the bones themselves actually come into contact with each other through the joints, and those joints are known as the facet joints.

Inside the central portion of the spine is a canal, very much like a drainpipe, and in that canal are contained the nerves that then pass into your legs. The spine in the lower lumbar portion of your back protects those nerves and provides motion so that those nerves go uninjured as you perform your activities of daily living.

The spine and the pelvic area are covered over by some very large muscles; those muscles go all the way from the backs of your legs to the back of your head.

Those muscles completely cover all of the bones and provide for a tension-band device, or a -- a way of pulling upon the back in order to help maintain an erect posture, or an upright posture, so that you can walk on two legs.

Q What's a disc space?

A A disc space is the space in between the bones of your lower back where the disc is located.

Q And what's a disc?

A A disc is a cartilage-and-ligament structure in your spine that does several things: it provides for normal motion between the bones; it acts to hold those bones together; it bears load; it absorbs shock. It's made out of two components. There's an outer component that's very tough and rigid, and there's an inner component that is softer and more jelly-like. The outer component is called the annulus and the inner component is called the nucleus.

Q And what's a vertebral body and how does that relate to the disc?

A A vertebral body is the actual bone that is above and below the disc. You can think about the disc as the -- the inside portion of a sandwich and that disc is sandwiched between two vertebral bodies.

Q So when you're talking about -- well, in the --

What's the lumbar spine?

A The lumbar spine are the five lumbar vertebral bodies and discs that are at the lowest-most portion of your spine, before it becomes your pelvis and sacrum.

Q If you can, utilizing -- I guess it's going to be -- the L3-S1 incision area, to the best you can, can you show the jurors the lumbar spine, utilizing all of the discs: L1-L2 -- if you can -- L3-L4, L4-L5, L5-S1?

A It's a little bit difficult to see the exact discs on this picture because this is a front-to-back picture. The discs themselves are located more on the front portion of your spine but they lie in between each one of these bony elements.

The way we're looking at it right now, we get a very clear view of the actual joints that exist in between those bones, where they meet up and touch each other, called the facet joints.

Q Tell us a little more about the facet joints.

A The facet joints, in addition to being the -- the joints that the bones themselves touch on, are responsible for maintaining about 20 percent of your body's load, under normal circumstances.

If the disc is behaving properly and acting normally, it will absorb about 80 percent of your body weight, and it will also control normal motion in

between the bones.

Twenty percent of that motion and load, or weight, of your body will go through the facet joints, so those facet joints play an important role in backing up the disc in the disc's job.

Q Where are the facet joints located in relationship to the body and to the disc?

A The facet joints are behind the vertebral body and behind the disc; they are closest to the muscles in your back. And when you feel your back or your spine, what you're feeling are what we call the spinous processes, which are -- they look like little dinosaur outgrowths. If you ever see a dinosaur and they have those spikes on their back, those little spikes are the spinous processes. And then, right below the spinous processes, underneath a thick layer of muscle, lie the facet joints.

Q All right. Now, what is an articulating surface?

A An articulating surface is a surface upon which the facet joints meet, and they slide across that. It's lined with something that looks like icing on a cake. That icing is -- is cartilage, and when the facet joints meet, they meet on that cartilage surface, and that cartilage surface slides across itself so that they can

move smoothly.

Q Can the facet joints get overloaded?

A Yes.

The facet joints can absorb more than 20 percent load, in the event that there is a disc derangement, and in that case, the facet joint can start to absorb more than it does under normal circumstances, or more than 20 percent load.

Q What happens, proportionately, as the load is increased upon the facet joint, as opposed to the disc itself?

A As load is increased on those joints, those joints begin to wear on themselves more than they could otherwise normally wear, and your body's normal response to that is to try to shore up those joints, or make them stronger. And in so doing, your body will try to put more cartilage into the joint; it will try to stabilize the joint by throwing more bone up into the joint area, and those joints have a tendency to become thicker and larger; and the articular cartilage, or that icing, can start to wear out if those joints are abnormally loaded.

Q Thank you, Doctor.

(The witness resumed the stand.)

Q You know Chris Yesnick?

A Yes.

Q How do you know him?

A Christopher Yesnick was referred to me by my colleague, Dr. Touliopoulos.

Q Have you treated him?

A Yes, I did.

(Pause.)

Q Doctor, what's a first responder?

A A first responder is --

Q In the medical profession.

A I'm sorry?

Q In the medical profession.

A A first responder is a health care professional that is the first on the scene of an accident or an incident.

Q Doctor, if you can, please -- I'm showing you Plaintiffs' Exhibit 1 (handing) -- can you identify what that is? It's in evidence.

A This is an emergency room record, from the St. Luke's-Roosevelt Hospital, on Mr. Christopher Yesnick.

Q And is that record from September 30th, 2002, the date of his accident?

A Yes, it is.

Q Can you turn to the Ambulance Call Report?

A Yes.

Q What's an Ambulance Call Report?

A An Ambulance Call Report is a report that's filled out by one of the emergency medical technicians in the ambulance and it -- it gives a -- basically -- an intake, or a documentation of what the call is about: who the patient is, what their chief complaints are, and what their findings were when they saw that patient.

Q Is there a diagnosis on the Ambulance Call Report?

A Yes.

Q What is that diagnosis?

A That diagnosis is, an injury to the right knee, back and shoulder.

Q And where it says "Trauma" --

A Yes.

Q -- where is the trauma located?

A Right knee, lower back, right shoulder.

Q Doctor, I would also like you to take a look at the records of a Dr. Hearns, who treated Mr. Yesnick one day after this accident (handing).

MR. DOMAN: That's Plaintiffs' Exhibit 3. I apologize.

Q In that chart, is there a record for October 1st, 2002?

A Yes.

Q As we look at that chart, on the --

Well, not to bore the jurors with things we've already gone over, but on the second page, I believe, of that chart --

A Yes.

Q -- under "Lower Back" -- I realize Dr. Hearns isn't the greatest writer in the world -- can you see what his findings were on that day?

A "Lower Back," it says: straight-leg -- "SLR, positive."

Q What does that mean?

A Straight-leg raise, positive.

Q What's a straight-leg raise?

A Straight-leg raise is what we call a tension sign, or a root-tension sign. It's when you take a nerve root in your arm or your leg and you stretch it, it reproduces pain, and that's known as a tension sign.

And in -- when you do it to a leg, or a lower leg, it's known as a straight-leg raise because you put the leg into a straight position and raise it up, reproducing pain.

Q And where would that produce the pain?

A That would produce the pain in the distribution of a nerve going down into your leg; typically, the sciatic nerve.

Q And that test is to try and find what?

A It's looking for nerve-root irritation.

Q And what's nerve-root irritation?

A Those nerves that we spoke about, that are in the lower portion of your back, in that spinal-canal area, that then go down into your -- into your legs --

Q Before that, how do they get into your legs?

A They leave the spinal canal through a small opening.

Q What's the name of that opening?

A It's called a neuroforamen.

Q And what happens when they --

MR. DOMAN: Withdrawn.

Q Is there just one neuroforamen in the spine?

A There's a neuroforamen on either side of the spine, both right and left, at each level.

Q And when you say, "each level," what do you mean?

A L1, L2, L3, -4, -5, and then sacral, and so on.

Q Now, when you say, for example, L1-L2, what does that signify?

A When we say, "L1-L2," we're describing the actual neuroforamen itself, or exit for the nerve root. That opening, or hole, is a space that's located between the L1 and the L2 vertebral body. So we would refer to

it as the L1-L2 neuroforamen.

Q And L5-S1, there would be two neuroforamens there; one left, one right?

A Yes.

Q That's all the way down at the lower part of the spine?

A Yes.

Q And on top of it would be what?

A L4-L5.

Q And on top of that?

A L3-L4.

Q On top of that?

A L2-L3.

Q And on top of that?

A L1-L2.

Q And that's the end of the lumbar spine.

A Yes.

Q Now, once the disc exits the neuroforamen from whichever section of the spine, what occurs?

MR. DOMAN: I'm sorry; withdrawn.

Q Once the nerve exits the neuroforamen from whatever section of the spine, what occurs?

A When that nerve leaves the neuroforamen from the spine, it begins to travel down into your legs, through the muscles and tendons and ligaments of your

lower legs and abdomen, and it sometimes meets up with other nerves; it travels in and around muscles, and it proceeds down into your leg, into the area where that -- that that nerve now controls.

Q And what is that area called?

A That area is called a -- it's called a neurodermatomyotome.

Q Like a dermatome?

A Yes.

Q And, getting back to the straight-leg-raising test, when you do it and it's positive, what, if anything, does that indicate as pertains to the nerves exiting the neuroforamina?

A It tells you that that nerve, the particular nerve that you're putting tension on, is irritated and inflamed and reproductive of pain. It tells you that there has been some type of injury to that nerve, causing it to become inflamed, causing the positive straight-leg raise.

Q And what was Dr. Hearns's findings, that day, on low back, again? It says -- I think I stopped -- I think I interrupted you.

A It says: "SLR, positive. Acute tenderness."

Q After "SLR, positive," is there something indecipherable and then does it say, "right leg"?

A Yes.

Q And what does it say on the next line after that?

A It says: "Positive acute tenderness."

Q Okay. Can you read anything else that makes sense to you?

A It's -- it's a little bit -- it's kind of illegible just beyond that.

Q To the right of it, is there something that says: "Neuro Exam"?

A Yes.

Q What's a neuro exam?

A A neuro exam pays specific attention to the nerves themselves.

Q What findings, if any, did Dr. Hearns have on October 1st, 2002, one day after Christopher Yesnick's accident, concerning his neurological examination of Mr. Yesnick?

A He had what looks like: decreased sensation, L5-S1, right leg.

Q And what significance, if any, is that?

A That's sensation in the dermatome of the positive straight-leg raise, or the nerve root of the sciatic nerve, going down the leg.

Q So, in plain English, what is that saying to

you?

A That tells me that he has what we call a radiculitis or a nerve -- an acute radiculitis or acute nerve-root irritation of his right sciatic nerve.

Q And what is radiculitis?

A Inflammation of the nerve root.

Q Now, who is Dr. Steven Touliopoulos?

A Dr. Steven Touliopoulos is my colleague and partner.

Q I'd like you to take a look at Dr. Touliopoulos's chart, if you will.

Now, on October 7th, two thousand --

MR. DOMAN: Withdrawn.

Q When did he first see Mr. Yesnick?

A October 7th, 2002.

Q And what were Mr. Yesnick's chief complaints at that time?

A He had -- his right knee was wobbling.

Q Well, is there an area there that says, "Chief Complaint," on his report?

A Yes.

Q What does it say?

A It says: "Right-knee, right-shoulder, right-ankle, upper- and low-back injuries."

Q Let's just jump around real fast. I just want

to take you to October 21st, 2002, in Dr. Touliopoulos's records. Did Dr. Touliopoulos examine the thoracolumbar spine on that day?

A Yes.

Q Real fast, what's the thoracolumbar spine?

A It's the junction between the thoracic spine and the lumbar spine, and the area of the lower back.

Q And if you can, can you show us where the thoracolumbar spine is?

MR. DOMAN: I think the court reporter is going to volunteer for a demonstration.

A Sure. Or -- I can show you on myself or I can show you on the court reporter. No problem.

Q Well, Dr. Touliopoulos showed it on Alan.

THE COURT: Alan, are you all right in that regard?

COURT REPORTER: Yes, Judge.

(The witness stepped down and approached the court reporter.)

Q Where does the thoracolumbar spine extend to?

(Witness indicated.)

Q Okay. And which is the thoracic spine?

(Witness indicated.)

Q And which is the lumbar spine?

A And the lumbar spine is down here, this area

(indicating).

Q Okay, thanks.

(The witness resumed the stand.)

THE COURT: So what's really hard is him taking it all down and being demonstrated on.

MR. DOMAN: He's good.

THE COURT: Very good.

Q Now, what findings did Dr. Touliopoulos come up with on October 21st, 2002, when he examined Mr. Yesnick's thoracolumbar spine?

MR. COHEN: Your Honor, this is cumulative. I'm going to object, unless there's something additional to add to it.

THE COURT: Well, if it's --

Overruled.

I'm assuming you're relating it to his treatment that he's going to be testifying about.

MR. DOMAN: Yes, your Honor.

THE COURT: All right. I think, in the interests of time and economy, we should try to limit that, but I am going to certainly allow you to have a certain amount of leeway in that regard.

MR. DOMAN: Thank you, your Honor.

THE COURT: The objection is overruled.

MR. DOMAN: And I'll try and push it

along.

THE COURT: Objection is overruled.

Alan, read that very last question back, please.

(The reporter read back the requested portion of the record.)

A "Tenderness in the lower-thoracic, as well as lower-lumbar, regions, with associated muscle spasm. Flexibility is limited with extension to approximately ten degrees and flexion to 25 degrees. Lower-extremity tension signs are positive."

Q As a spinal surgeon, tell the jury whether it is significant that his flexibility was limited.

A Yes, very significant.

Q What is that significance?

A Your lumbar flexibility is the way your lower back moves (simulating) and how much it's able to move. That type -- the type of motion and the amount of motion are a very sensitive indicator of disc derangement.

Q Now, how much are you normally supposed to flex? What's normal flexion?

A Normal?

Q What is flexion?

A Flexion is bending over to touch your toes.

Q And so, flexion would be going forward like

this (demonstrating)?

A Yes.

Q What's normal?

A Normal varies from person to person, but most people should be able to bend over and touch their toes so that they could tie their shoelaces or get their shoes on.

Q So if you are -- I guess, I'm abnormal (demonstrating), but if you're going to judge it in terms of degrees, what would normal flexion be?

A Normal flexion would be in excess of 110 degrees of forward flexion in the lumbar spine.

Q On October 21st, 2002, what was the flexion --

MR. DOMAN: Withdrawn.

Q On October 21st, 2002, what finding did Dr. Touliopoulos have concerning his (indicating) lumbar flexion?

A His lumbar flexion was limited to 25 degrees.

Q Out of how many, again?

A In excess of 110.

Q Is that a significant finding to you, as a spinal surgeon?

A Yes.

Q And is that for the reasons you had just stated?

A Yes.

Q You also said that the lower-extremity tension sign was positive. Real briefly, what does that mean to you?

A That is a straight-leg raise.

Q And you already discussed that with us concerning Dr. Hearns.

A Yes.

Q And those two positive findings, is that significant to you?

A Yes.

Q What is that indicative of to you, as a spinal surgeon?

A This is a gentleman suffering from radiculitis.

Q And radiculitis being what, again?

A Inflammation of the nerve root.

Q I want to just take you to November 6th, 2002. I'm going to get to your records very soon because time is limited, but did Dr. Touliopoulos perform an examination of Mr. Yesnick's (indicating) lumbar spine on November 6th, 2002?

A Yes.

Q What were those findings?

A "Examination of the thoracolumbar spine reveals tenderness in the mid-to lower lumbar regions. Pain is

greatest at the L3-4, 4-5 and L5-S1 regions. Flex" --

Q Let me just stop you there.

Those are the three-lowest lumbar regions?

A Yes.

Q As the surgeon who opened up his back and actually went in there and saw what was there to be seen with your own eyes, what significance, if any, is that to you?

A That gives me a nice idea of where his pain is stemming from, where the "money area," as we would say, or where the problem, is.

Q And flexibility; was there a finding about flexibility?

A "Flexibility remains limited."

Q And when you look at all of those findings by Dr. Touliopoulos on November 6th, 2002, what is the significance of that to you?

A To me, that's significant because we have a man who has consistent and persistent low-back derangement with root-tension signs.

Q And just trying to move along, if I was to tell you, for instance, that on January 20th, 1993 --

COURT REPORTER: 19...?

MR. DOMAN: I'm sorry.

Q Just to move along, if I was to tell you

that on January 20th, 2003, Mr. Yesnick reported to Dr. Touliopoulos intermittent numbness of his right-lower extremity, would that be consistent with the prior findings?

A Yes.

Q Why is that?

A That numbness is indicative of, now, nerve-root damage and persistent radiculopathy or radiculitis of the nerve roots going into his leg.

Q And, just looking at February 5th, 2003, can you please read the findings on physical examination of Mr. Yesnick's lumbar --

MR. DOMAN: Withdrawn.

Q Was there a physical examination performed of Mr. Yesnick's lumbar spine on February 5th, 2003?

A Yes.

Q What were the findings?

A "Examination of the lumbar spine reveals significant tenderness in the lower lumbar quadrants, greatest on the right side. The lower-extremity tension signs are positive. Deep-tendon reflexes are symmetrical. There is decreased sensation noted along the lateral aspect of the patient's right thigh."

Q Are those findings consistent with the prior findings?

A Yes.

Q When did you first see Mr. Yesnick?

A June 23rd of 2003.

MR. DOMAN: Actually, before we get to that, if I can use the shadow box?

THE COURT: Yeah.

(Shadow box placed on jury-box rail.)

MR. DOMAN: With the Court's permission --

THE COURT: Yes.

MR. DOMAN: -- the doctor may get up?

THE COURT: You may step down, sir.

Of course.

(The witness stepped down and stood beside the shadow box, onto which was placed Plaintiffs' Exhibit 4 in evidence, on which the witness indicated variously during the following testimony:)

Q I take it, Doctor, that that is an X-ray of Mr. Yesnick's back?

A Yes, it is.

Q And when was that X-ray taken?

A February 5th, 2003.

Q What does that X-ray show to you?

A This X-ray is a side view of an adult patient, and it shows us the pelvis, the sacrum, the five lumbar segments, their disc spaces, and the bony and facet-joint

architecture of those segments.

Q How do the disc spaces appear to you?

A The disc spaces appear to be what we would call well maintained, or he has retained disc height at each one of his lumbar segments.

Q What is the significance of that?

A That tells me that we don't have any degenerative changes appreciated on this X-ray.

Q And what type of degenerative changes would those be?

A If we were to see degenerative changes on this X-ray, we would see the vertebral bodies start to come very close together where they could touch each other; we would see these disc spaces disappear because the vertebral bodies would start to collapse down on each other (simulating); we would see, at the edges of the vertebral body, what would be like parrot beaks and those parrot beaks would be bone-spur formations around the vertebral bodies.

Q And what are those bone-spur formations called?

A Osteophytes.

Q Osteophytes. And what's an osteophyte?

A An osteophyte is a bone spur. It is your body's making extra bone in an area where you're starting to have a degenerative process.

Q How do the facet joints appear to you on this X-ray?

A The facet joints are behind us, and they're in these areas; they appear as gray lines on the back side of this X-ray.

And the facet joints themselves have a smooth appearance; they are gray and not overly white, or sclerotic. That tells us that those facet joints are not degenerative.

Q And when you say," not overly white, or sclerotic," what is the significance of that?

A When something appears to be white on an X-ray, we mean to say that that is sclerotic, or excessively hard. That's an area where your body puts extra, extra, extra bone into and it shows up as white, and it will do that in a degenerative or arthritic condition.

Q And where are those facet joints, again?

A In these areas.

Q Okay. If you had a pen, could you point them out (handing)? Because...

(Witness complied.)

Q Right there.

A That's one, that's another one, that's another one, and that's one between L5 and S1 (handing).

Q Thank you, Doctor.

(The witness resumed the stand.)

(Shadow box removed from witness-box rail.)

Q Let's go to June -- what was it? -- 23rd, 2003, when you first saw him?

A Yes.

Q Did Mr. Yesnick give you a history?

A Yes.

Q What was that history?

A Mr. Yesnick indicated to me that he was injured at work on September 30th of 2002. He was having severe and unremitting back pain, where --

Q Let me stop you there.

What -- well, when you say, "severe and unremitting," what does that mean?

A That means that he's having pain that is interfering with his normal activities and it's pain that is not going away.

Q And "severe" means what?

A Severe means really bad.

Q Now, are there levels that you doctors judge things on?

A Yes.

Q There's, like, three levels?

A Four.

Q And what are those levels?

A One is no pain, no problem, everything is hunky-dory, good.

"Mild." Mild means it's bothersome from time to time; it may bother you and come and go.

"Moderate" means it's something more than just annoying now; it's around all the time; it starts to interfere with your life.

And "severe" means that it's always there and you are having difficulty performing your normal routine and it's keeping you from doing the things that you want to or have to do.

Q And what's "unremitting"?

A Unremitting means that it has not gone away, by any means, up to that point in time.

Q Now, we, as human beings, what do we rely upon our lower back to do for us?

A Our low back really does just about everything that we do, and we rely upon it to get up out of bed in the morning; it -- it starts to function as soon as you assume an upright posture. It's functioning when you're walking. It's functioning when you're washing dishes, taking out the garbage, doing just about everything you do, because it's the area in between your upper body and your pelvis and your legs. So it's under a constant use

throughout the entire day.

Q Is it functioning when you're sitting?

A Yes.

Q When you're standing?

A Yes.

Q When you're sleeping?

A Yes.

Q When you're bending?

A Yes.

Q When you're kneeling?

A Yes.

Q Can you think of many things that a person would do when it's not functioning?

A I can't really think of any instance whereby your lumbar spine is not performing a function, no.

Q In addition to Mr. Yesnick having severe, unremitting back pain, what else did you derive from his history?

A That he also had pain radiating into his right-lower extremity in the S1 dermatomal distribution.

Q Is there a difference between back pain and pain radiating --

MR. DOMAN: Well, withdrawn.

Q When you say, "right-lower extremity," what do you mean?

A I mean his leg.

Q Which leg?

A Right leg.

Q Is there a difference between back pain and pain that radiates into a leg?

A Yes.

Q What's that difference?

A The difference is that pain radiating into a leg means that we now have a neurological component to the back pain. Back pain has a musculoskeletal component to it: disc, joint, bone. Radiating pain has a neurological component to it: nerve root.

Q And you said that it was radiating into the S1 dermatomal distribution, right?

A Yes.

Q What is that?

A The S1 dermatome, in your leg, is the lateral portion, or the outside, of your leg --

Q Can you -- can you show us?

(The witness stepped down.)

A It's the outside portion of your leg, going down the back of your lower leg, down into your heel, outside portion, and little toes of your foot (indicating).

Q So there is actually a nerve that innervates

that area of your body?

A Yes.

(The witness resumed the stand.)

Q And from which neuroforamina does it exit?

A That nerve exits the L5-S1 neuroforamen, S1 neuroforamen, and it passes by the L5 and S1 neuroforamens as it exits.

Q What else did you learn, on your history?

A That his pain was worsened by the upright posture, worsened with his activities of daily living and, pretty much, all of his activities that involved lumbar motion.

Q And what does that mean to you, as a human being?

A That means he's miserable.

Q Did you perform a physical examination on Mr. Yesnick on that day?

A Yes, I did.

Q What were your findings?

A His lumbar range of motion was diminished, with pain into the right-lower extremity beyond 50 degrees of flexion of the lumbar spine.

Q What does that mean?

A That means that if he bent over beyond 50 degrees, he started to have pain radiating down into the

right leg.

There was a positive straight-leg raise, loss of the right Achilles tendon reflex.

Q What is the significance of that?

A That is a -- that's a reflex that's governed by the S1 nerve root.

Q What else did you find?

A Loss of his S1 dermatomal sensation.

Q How did you test for that?

A You can do it in several ways. The easiest way to do it is by tactile sensation, or feeling (simulating) various parts of the leg, and then asking the patient if they can feel you touching them, with a side-by-side comparison.

Q And do you just examine one nerve -- one dermatome?

A No. You're looking at all of them, because you'd like to see if there are any differences in any of those dermatomes in the legs.

Q And did you test the range of motion of his lower extremities; his legs?

A Yes.

Q And how were they?

A They were good, with the exception of the right knee.

Q Why is that?

A He had an ACL reconstruction to the right knee.

Q And did you review the MRI?

A Yes.

Q What was your impression?

MR. COHEN: Objection, your Honor.

THE COURT: Overruled.

MR. COHEN: May we approach?

THE COURT: Step up.

Doctor, do you want to just step back for one second?

THE WITNESS: Sure.

(The witness stepped down and entered the jury room.)

(Discussion off the record at sidebar.)

THE COURT: Are you withdrawing that question, counsel?

MR. DOMAN: I'll withdraw that question.

THE COURT: Okay.

THE COURT: Have the witness come back.

(The witness resumed the stand.)

Q What's a diagnosis or an assessment?

A A diagnosis or an assessment basically means, What's wrong with this patient that I can deal with?

Q What did you think was wrong with this patient

on June 23rd, 2003?

A I thought he had a right-lower-extremity radiculopathy secondary to his work-related accident.

Q And what were you going to do to try and make it better, to try and make it right?

A At that point in time, I suggested that he undergo a trial of epidural steroid injections.

Q What's epidural steroid injections?

A Epidural steroid injections are the injection of a steroid medication into the epidural space, or the lum -- the lumbar-canal area, where those nerves are.

Q Why didn't you just -- why did --

MR. DOMAN: Withdrawn.

Q Why did you decide to do lumbar epidural injections?

A It's part of a full course of conservative care and management, or nonsurgical management, for his problem. We always attempt to try to fix something nonsurgically before we proceed to surgery.

Q What's the preferred course?

A The preferred course is to be able to treat it nonsurgically.

Q We'll skip over to September 8th of 2003. What occurred on that visit?

A On that visit, he had had epidural steroid

injections, and they had failed to relieve his symptoms.

Q What does that mean?

A That means that he was still in a considerable amount of pain.

Q What was your plan at that time?

A At that time, he had had a full trial of all forms of nonsurgical management, and a request was made for a decompressive lumbar laminectomy.

Q Now, did you have a discussion with him about treatment options at that point?

A Yes.

Q What was discussed?

A At that point in time, I sat down with the patient and I basically laid out all of our options, as well as realistic goals and expectations of surgery, including potential surgical complications.

Q What potential surgical complications were those?

A They are: anesthesia, death, blood loss, infection, dural injury, with dural leak.

Q What's a dural injury?

A A dural injury --

The nerves are covered by the dura, which is a hard, outer, leather-like covering of the nerves, and that dura can be injured during the course of the

procedure or it can be injured by the spine itself.

Disc herniations, for example, can wear out a portion of the dura. When you open the canal, if that dura is worn in that area, it will have a hole in it and then it will -- it will leak. If it leaks, it needs to be fixed and repaired.

Q What is the effect of a dural leak or a dural injury?

A A dural leak or a dural injury can lead to meningitis and/or death.

Q You said you discussed with him the realistic expectations of surgery. What were the realistic expectations of surgery that you discussed?

A Realistically, this particular kind of problem does not have a cure and surgery should not be looked upon as a cure, so what we try to communicate to the patient is what we are hoping to attain from a surgical intervention.

So, what can he expect after an operation is completed? We try to get decreased pain and prevent further neurological deficit. So, realistically, that would be the goal of surgery, to try to decrease pain and to try to prevent further neurological deterioration.

Q When was the surgery performed?

A The surgery itself was performed on May 4th of

2004.

Q And between the time you first saw him in June of 2003, to almost a year later, on May 4th, 2004, describe for the jurors, physically, what was occurring with him every single day.

MR. COHEN: Objection, your Honor.

THE COURT: Well, sustained as to the form of that question.

Q Between when you first saw him in June of 2003 until May of 2004, when the surgery was -- when the surgery occurred, about a year later, describe, anatomically, what was occurring to him.

A For that period of time, the lumbar vertebral units and discs and facet joints that we saw on the X-rays and in the diagram were behaving badly. The discs were not functioning correctly; nerve root [sic] was being irritated; the lumbar functional unit was producing pain, discomfort and was debilitating, with both back pain and leg pain.

As time goes on, those lumbar units start to -- they try to -- heal themselves. Your body is now starting to try to heal the lumbar disc herniation. The facet joints are taking up excessive load. The nerve root is being irritated. There's pain, ligamentous hypertrophy, scar tissue and bone spurs forming in this

period of time, now.

Q You said the facet joints are trying to relieve the load?

A Yes.

Q How does that work?

A If you're in a car and you have shocks and springs, if the shocks go out on your car, the springs that are there are going to take up the load that the shocks were bearing.

The same holds true in your spine. The disc acts as the shock absorber, if you will, and the facet joints are acting like a set of springs. When the disc is gone and they can no longer behave properly, those facet joints are now overworking.

Q And what happens when those facet joints are overloaded or overworked?

A When the facet joint is overloaded or overworked, they start to wear down; they rub down on each other; they produce pain; they produce more pain; there's inflammation, swelling and a cascade of events that results in abnormal lumbar physiology, or abnormal lumbar motion.

Q And what is that cascade of events?

A That cascade of events starts with the disc and can end up all the way to a progression of events

where the bones have collapsed on each other, the joints are completely gone and those holes, or neuroforamina, where the nerves exit become blocked by large bone spurs, resulting in significant pain, neurological deterioration and a loss of function.

Q How can the foramina become obstructed by bone spurs?

A The facet joints themselves actually form part of that neuroforamen, or part of the exit hole, for that nerve. So, if those joints are starting to collapse down on each other (simulating) and the capsule, or the covering, of that joint swells and small bone spurs start to form, that all spills over into the nerve hole and therefore puts pressure, an extra pressure, on the nerve root.

Q Let's just backtrack a minute.

As far as the discs were concerned, did you have an impression as to whether the discs were herniated or not?

A Yes.

Q What was that impression?

A Herniated.

Q What's a herniated disc?

A A disc, for all the other descriptions I've given you, when we're looking at herniation, can be

considered a jelly doughnut. It's got this outer covering, pastry-like, and then it's got this inner, jelly-like nuclear area. A herniation means that that jelly on the inside of the jelly doughnut now protrudes, or leaks, out of the pastry.

Q And when it protrudes and leaks out of the pastry, what happens to the nerve roots?

A The nerve roots are next to the disc. As that jelly leaks and leaks out of the disc, it produces inflammatory chemicals that then bathe the nerve root and result in inflammation, and that results in pain.

As the jelly also comes out, it pushes on that nerve root and starts to cause pressure on the root, which also results in pain.

Q When the jelly starts to come out -- not so much when it's pushing on the nerve root, but as it comes out and it starts to leak -- the inflammation that occurs to the nerve root, is that consistent with some of the findings that Dr. Touliopoulos had?

A Yes.

Q And when that disc herniates and it starts to leak, mechanically, what's now occurring with the spine?

A Mechanically, the bones and the joints are not taking up their normal load pattern, so that load is being shifted backwards to the facet joints; the joints

themselves, as we've said, become degenerative; the nerve root becomes irritated, and then we have this low-back syndrome of dysfunction.

Q And the osteophytes start to grow?

A Yes.

Q Now, you mentioned ligamentous hypertrophy.

A Yes.

Q What is that?

A The facet joint is covered by a joint capsule and, attached to that joint capsule, there are certain ligaments; one of them is called the "yellow ligament." It's a portion of the back part of the spine. That ligament, as well as the other ligaments attaching themselves to those bones, become thicker because they try to secondarily stabilize the joints.

Q And as far as his activities of daily living, in the year or so when you first saw him and up to the date of the surgery, can you describe what his activities of daily living were like?

MR. COHEN: Objection, your Honor.

THE COURT: Well, sustained, unless he has personal knowledge of that.

Q Doctor, as a spinal surgeon, are you aware of the effects of an injury such as the one we've just described on a normal human being's activities of daily

living?

MR. COHEN: I'm going to object, your Honor.

THE COURT: Sustained.

Q The symptomology that you just described, can that affect a person's activity of daily living?

MR. COHEN: Objection, Judge.

THE COURT: Overruled.

A Yes.

Q How so?

MR. COHEN: Objection, your Honor.

THE COURT: Overruled.

You may answer.

A It will decrease the ability of that patient to perform a normal activity of daily living.

And what do I mean by that? What are your activities of daily living? Waking up, brushing your teeth, having breakfast, cleaning up after breakfast, taking out the trash, walking the dog, going out to the corner to get a carton of milk. All those things are activities of daily living, things that you need to do in order to survive and function as a human being.

Q Work?

A Yes.

(Diagram placed on easel in well of

courtroom.)

Q Doctor, if you can, using this diagram as an aid, please describe to the jurors --

THE COURT: Please step down, sir.

(The witness stepped down and approached said diagram.)

Q -- the surgery that you performed on Christopher Yesnick on May 4th, 2004.

Just hold on a second, Doctor.

(Pause.)

Q Go ahead.

(During the course of the following testimony, the witness indicated variously on said diagram:)

A This diagram describes the basic steps involved in the procedure. The first step -- after the patient has been successfully anesthetized and positioned on a table with his back side up, the first step is to identify the lumbar spinal area, and we usually do that with an intraoperative x-ray machine.

After we know where the incisional area and site is, it's sterilized and cleaned, prepped and draped, so that we can make an approach, a surgical approach, to the spine; make a skin incision in the area of the involved segments; use specialized dissecting

devices to move and retract the muscles that are in the back out of the way so that you can then see the bones themselves.

Retractors are placed to hold those muscles spread apart so that the bones are exposed to you, so that you can work on them without having to worry about the muscles popping back into your field.

Q And are we looking at the first diagram over there (indicating)?

A Yes.

Q No. 1?

A Yes.

Q And where are the retractors?

(Witness indicated on diagram.)

Q Okay. And after you expose the bone, what happens next?

A After the bone's exposed, we want to make sure that we're at the correct levels; and that can be done by looking at and feeling the normal anatomy that's there, combined with a fluoroscopic, or an X-ray, visualization of the area.

After that's done, we do the next step of that procedure, which is now to get down into the neural elements, or get into the spinal canal itself, to release pressure on the nerves and open that spine [sic] canal

up, and that's a process called a laminectomy. That's done with some specialized tools that are made to remove bone and expose the dura, which is the covering of the nerves, and the nerve roots. So the laminectomy is an exposure of the canal and the canal area.

While this is being done, I'm looking at the nerve roots themselves and the dura and the spinal canal, as well as the joints, to try to pay any and -- most particular attention to any areas where the nerves may be having pressure on them.

After the canal itself is open, I try to identify each nerve and trace it out to where it exits the nerve holes, or the neuroforamina, to make sure that that nerve has an appropriate amount of room to exit. There are these small, little feelers that you can slide up along the nerve and get out into the hole and you -- you feel and look at the holes to make sure they're open and free and clear.

The other thing that I do is, I move the nerves out of the way and I look at the discs. If there is disc material that is soft and easily removable, I'll grab it and pull it out or use a suction device to pull it out. If it's a little harder, I'll usually make an incision in it; I'll try to cut it with a knife and then try to take it out piecemeal.

If that disc material has solidified or calcified, my preference is to leave it alone, because if I try to take it out too aggressively, I can injure the nerve root that passes next to it and then a patient can end up with a neurological injury, like a foot drop or a portion of their leg that won't work.

So, after the depression and the cleaning out of that canal and nerve roots is finished and completed, I next proceed to do something called a fusion, to try to give the spine a little more stability, to try to decrease the ability of those nerves -- of those nerves to become reinjured. And that's a fusion.

There are multiple ways to do a fusion. There are really-big fusions, where you open people up from their bellies and their backs and put plates and screws and rods into -- in through -- their bellies and their backs, and then there are smaller, less-invasive, less-traumatic fusions; and in this case, I chose the smaller, less-traumatic fusion, called a "bone-only fusion."

And to do that, what I do is, I take the joints and I scrape away the surfaces where those joints slide on each other. So I'm trying to get those joints to stick together; I'm trying to glue them together. I take bone away from what's left of the lamina, and

sometimes the transverse processes, so that I get that bone to bleed, and then your body puts cells into that area, through bleeding, that help glue things together and make it sticky. And then I take what's called bone graft from the patient, grind that up with the bone I needed to remove to do the laminectomy, make kind of a glue and a paste, and then put it down into the areas that I scraped clean.

When this heals, it heals into a bony mass that provides extra support and stability on the back side of the spine, to try to shore things up, to give nature a little bit of a hand to try to prevent further deterioration and degeneration in the lumbar area and, hopefully, protect those nerve roots and dura for some time to come.

And so, that's a laminectomy and a fusion.

Q Now, when you performed this procedure on Mr. Yesnick, what were your findings?

A If I may refer to my operative report (indicating)?

Q Absolutely.

Doctor, why don't you just bring your report with you --

A Okay.

Q -- and just show the jurors exactly what your

findings were, where they were, and what was going on?

(The witness took documents from the witness box and returned to the diagram.)

A The facet joint between the L4 and L5 vertebral body was particularly involved. The covering of that joint, or the joint capsule, was hypertrophic, or swollen. So the capsule in that area around that joint was swollen and inflamed and causing impingement into the canal and down onto the nerve roots. So I had to remove all of that, clean it out and take off some osteophytes, or the beginnings of bone spurs, at the L4-L5 joint.

That resulted in what we call a stenosis, or a narrowing, of the neuroforamen.

Q What is stenosis, again?

A Stenosis is a narrowing.

Q And in this particular instance, what narrowed the neuroforamen?

A The swollen joint capsule and joint.

And then I looked at the discs and I found that the disc, particularly at the L4-L5 level, was calcified, or hard. So I made a decision to leave that alone and to further open up the canal to free up the L5 and the S1 nerve roots as they passed beyond that calcified area.

Q And what was the significance that L4-L5 was

calcified?

A The significance of that finding means that the body -- that time has gone on and the body has tried to heal over that disc herniation.

Q Now, Doctor, do you have an opinion, to a reasonable degree of medical certainty, what caused the ligamentous hypertrophy and what caused the osteophytes and what caused the hardening of that disc?

A The -- the traumatic disc derangement or traumatic disc herniation.

Q And can you explain that, please?

A As we said before, if we look at the various components of the spine, the disc is really the most important component of the spine. It serves to hold the bones together in their normal positions; it tells the bones how they're supposed to move, or articulate; it bears the majority of load in the spine. And when that structure becomes injured, a cascade of events goes into place that then result into an abnormal lumbar loading pattern and pain that we then try to address, hopefully, by nonsurgical means and, if not nonsurgically, then surgically.

Q And that cascade of events, again, was what?

A That's -- that's the cascade of events that result in narrowing of the facet joints, with bone-spur

formation, bone-on-bone rubbing, disc herniation, and back pain.

Q Thank you.

(The witness resumed the stand.)

Q And, Doctor, you said you performed a fusion. How many levels did you fuse?

A I fused four levels: L3, L4, L5, S1.

Q Is this also known as a "four-level spinal fusion"?

A Yes.

Q And when you fuse those areas of the spine, is there any permanent effect regarding mobility?

A You permanently alter the way those areas function; you eliminate the normal motion between the joints in the back, between the facet joints, and you thereby entirely change the way that lumbar spine works.

Q Now -- I'm trying to move along here -- did you see Mr. Yesnick in a follow-up visit, after the surgery, on May 17th, 2004?

A Yes.

Q And how does a patient such as Mr. Yesnick present to you 13 days after spinal fusion?

A After they've had a spinal fusion and they come into an office, they present with postoperative pain. They're in the healing portion of the procedure,

so they now have an incision. Their muscles that have been moved out of the way and their bones that have been scraped down and fused and sewn back together again are now swollen, painful. They're healing. So they have low-back pain. They are, and can be, having difficulty, sometimes more so than they had prior to the surgery, in terms of their activities of daily living, their ability to sleep, their ability to get around, because now we've added a surgical trauma to their -- to their body.

So they often present to the office with a relatively decent amount of postoperative misery, I'd like to call it.

Q Did you see him again, on May 24th, 2004?

A Yes.

Q And what did you prescribe for him at that time?

A At that time, I suggested physical therapy, continued lumbosacral orthotic containment and pain medications, as well as Ambien for sleep.

Q Why did you first start him on physical therapy at that time?

A I like to see the wound heal up as much as possible before starting therapy, to avoid potential wound complication.

Q Why did you give him Ambien?

A He was having difficulty sleeping.

Q Is that unusual?

A No.

Q Why is that?

A It's tough to get to sleep at night when your back hurts from a surgical incision.

Q Did you see him on August 23rd, 2004?

A I'm sorry; I didn't hear the date?

Q August 23rd, 2004.

A Yes.

Q What information did you derive on that day?

A On that day, we talked about how he was doing.

Q How was he doing?

A He was overall doing well.

Q And what does that mean?

A That means that we hadn't encountered any postoperative complications.

Q What does that mean?

A Death, infection, dural leak, deep-venous thrombosis or blood clots, pneumonia.

Q Had his radicular complaints subsided?

A Yes.

Q What else did you note?

A That he had easy fatiguability in the low back, with a significant amount of low-back pain, particularly

at the end of the day.

Q What type of activities did he have pain with?

A Walking, as well as -- let's see -- including bending, lifting, pulling, pushing, stooping, crawling, sitting or standing for prolonged periods of time.

Q And what did you believe concerning that information?

A That those were the -- part of the -- original sequelae of his injury.

Q What does that mean in plain English?

A That that was secondary to the disc derangement that he had sustained from work.

Q Did you do a physical examination of him on that day?

A Yes.

Q Did you do a sensory examination?

A Yes.

Q What were the findings of the sensory examination?

A That his sensory examination was intact on that day.

Q And what was your impression?

A At that time, my impression was that he was healing from the results of his surgery, that he continued to require his lumbosacral orthotic, needed

physical therapy and pain medications, and that he was disabled at that time.

Q And did you see him again, on October 4th, 2004?

A Yes, I did.

Q And what were your findings on that day?

A On that day, his wound was healed; he had diminished lumbar and lumbosacral range of motion, with positive paravertebral strain and spasm. His sensory, motor and neurological examination remained intact and stable.

Q And "he had diminished lumbar and lumbosacral range of motion." What does that mean?

A That means he was having difficulty moving his lower back.

Q And spasm, what's a spasm?

A Spasm indicates that the muscles around the lower portion of the back would suffer a charleyhorse during range of motion.

Q And how do you find that on physical examination?

A You can feel it.

Q With your hands (simulating)?

A Yes.

Q That's what you did that day?

A Yes.

Q All right. And what was your plan?

A I planned continued physical therapy, continued lumbosacral orthotic, gave him Vicoprofen for pain and wanted to see him back in six weeks.

Q Now, to your knowledge, has he been compliant with physical therapy?

A Yes.

Q Now, what's a lumbosacral orthotic?

A A lumbosacral orthotic is a -- it's a brace, and that brace covers the lumbar area and the sacrum.

Q Is that what he's wearing right now (indicating)?

A Yes.

Q And why is he wearing it now?

A That brace does several things. Number one, it acts as a reminder for what he can and can't do; it takes stress off the lower back, to decrease the easy fatiguability that we can see at the end of the day; and it also helps to immobilize the lumbosacral area, to help us get that bony fusion that we're trying to get operatively.

Q Is his back fused yet?

A No.

Q How long will it be until the bones on those

four levels are fused?

A In general, we like to wait approximately a year or so to see a full fusion.

Q And when will he reach maximum medical improvement from this surgery?

A With respect to his back, that number is generally about a year or so from the time of surgery.

Q What's your prognosis as to his condition --

What's your prognosis as to what his condition will be after he has reached maximum medical improvement.

A His prognosis is what I would call guarded. That means it needs to be watched; we need to keep an eye on him; we need to see how he progresses over time.

His low back has been surgically altered, it's prone now to extra stress and strain because of the fusion and the way I've changed his joints, and we need to carefully watch him to see when and if he develops conditions that may require further surgical intervention.

Q Do you believe further surgical intervention is going to be warranted?

MR. COHEN: Objection, your Honor.

THE COURT: Sustained.

Q Do you have an opinion, to a reasonable degree

of medical certainty, whether surgical intervention will be warranted?

A Yes.

Q What is that opinion?

A He will eventually need reconstructive-revision lumbar surgery.

Q Why?

A As I said before, the surgical intervention that we do is not -- it's not a cure. It also changes his lower back. The main purpose of that surgery is to try to, in as little or in as least a traumatic fashion as possible, prevent further neurological injury and provide him with some stability.

He's a young man and as time goes on, he's going to put more stress on that low back. It's going to wear down; the fusion will wear down, extra stress and strain will be seen at other levels that are adjacent to the fused segments, and he will therefore require further surgery at some point in the future.

Q Can you say when, with any degree --

Can you say when?

A Under normal circumstances, this type of a procedure can last him anywhere between five to ten years.

Q So what's your prognosis for this man

(indicating) going into the future? How is he going to be five years from now, ten years from now, twenty years from now?

A As I said before, it's guarded, and what that means is that we anticipate --

Given his age, given the procedure that he's had, given the amount of damage that he sustained, we can reasonably predict that he is going to require more surgery and have persistent pain.

Q And if he reports persistent pain in his low back, going down, maybe, a little into his cheeks (indicating) but not down his legs, is that consistent with your treatment and your observations?

A Yes.

Q Is that consistent, for instance, with the spasm that you found on his last visit?

A Yes.

Q His limited range of motion?

A Yes.

Q What type of physical limitations do you expect for this man in the future?

A The limitations that I would impose upon him are limitations to try to decrease stress and strain on the lower back.

Q What limitations would those be?

A These would be to avoid activities that require bending, lifting, twisting of the lower back; stooping, crawling, standing or sitting for prolonged periods of time; exposure to activities that would load his lumbar spine with vibrations, things like driving, driving cars for long distances, driving trucks; that type of thing.

Q What about climbing scaffolds?

A Certainly, climbing scaffolds would be in there.

Q Should he climb ladders?

A No.

Q Should he work at the edge of a building?

A No.

Q Can he return to work as an ironworker?

A No.

Q How about driving a cement truck; can he drive a cement truck?

A No.

Q Can he drive a tractor trailer?

A No.

Q Now, Doctor, a couple of things:

When this trial ends, in a week or so, is he (indicating) going to continue to need any type of care?

A Yes.

Q Really. What kind of care is that?

A He's going to need physical therapy and orthopedic follow-ups.

Q Let's start with the orthopedic follow-ups.

What's an orthopedic follow-up?

A An orthopedic follow-up is a visit to his surgeon's office so that we can monitor the results of our surgery and how he's doing.

Q And how often should he have that?

A After -- for me, for his lumbar spine, at -- after one year has been reached, I'd like to see him back every quarter.

Q That's what; four times a year?

A Yes.

Q And until that time, how often do you want to see him?

A Until that time, I'd like to see him back anywhere between six- to eight-week intervals.

Q Now, a couple of things here:

Have you testified in cases like this before?

A Yes.

Q By the way, I forgot to ask you: How much are you being compensated?

A About $400 per hour.

Q And if you weren't here, talking to these jurors (indicating), what would you be doing today?

A Today is Thursday; I'd be in the operating room and I would have a clinic after that.

Q And presently, when you examine Mr. Yesnick (indicating), do you charge a certain rate?

A Yes.

Q Why do you charge that rate?

A That rate makes up for my overhead to keep an office open.

Q But I mean, the rate that you charge, is that negotiated or something?

A It can be negotiated, depending upon the insurance carrier.

Q When this case ends, that carrier that you're charging now, are they -- is he (indicating) going to still have insurance provided by them?

MR. COHEN: Objection, your Honor.

THE COURT: Well, sustained.

I --

MR. DOMAN: He (indicating) opened the door.

THE COURT: Well, in the event he doesn't have insurance in the future, the same carrier he has now, how would you compute his rates for treatment?

THE WITNESS: He would go with our office's usual and customary.

Q And what is your office's usual and customary rate?

A It's about $200 per visit.

Q Now, you said you've testified in cases like this before?

A Yes.

Q Have you treated patients after cases like this are over?

A Yes.

Q And do they have the same type of coverage before the case as Mr. Yesnick has?

MR. COHEN: Objection, your Honor.

THE COURT: Sustained.

I think we've gone --

I don't think you need to do this, counsel. He just answered in the way he just answered.

Q Let's talk about physical therapy.

Presently, how often should Mr. Yesnick (indicating) go to physical therapy?

A Two to three times per week.

Q Once he reaches maximum medical improvement, how often should he go?

A Three to four times per month.

Q And how much does physical therapy cost?

A About $60 per session.

Q Now, should he have any other type of therapeutic modalities, other than physical therapy, things you might consider to be a good idea?

A In addition to physical therapy, chiropractic care can be very helpful. Hydrotherapy, massage therapy, those can all also be helpful.

Q What's hydrotherapy?

A Hydrotherapy specifically involves getting a patient into a pool so that you can decrease the effects of gravity; you can improve -- gradually improve -- muscular strength; you can decrease muscle fatiguability and pain; you can decrease musculoskeletal pain by relieving the effects of gravity through the use of a pool.

Q And how often would you recommend hydrotherapy?

A For the lower back, I would say, hydrotherapy is, in general, a good idea three to four times per quarter.

Q And chiropractic treatment?

A As well.

Q And what's the cost of chiropractic treatment?

A I would say, somewhere between 175 to 200 per

visit, depending on what they were doing.

Q And the cost of hydrotherapy?

A Hydrotherapy should run approximately 75 or so per visit.

Q You mentioned a future spinal surgery, and you also mentioned your usual and customary rate.

What would be the usual and customary rate for a future spinal surgery, for your time, the anesthesiologist's time, the hospital's time, physical therapy's time --

Am I missing anything?

A Implants.

Implants and necessary surgical equipment, if need be.

Q What would be the total cost?

A That can run between seventy-five and one hundred twenty-five thousand dollars, depending upon implant cost.

Q What's a lumbar brace?

A A lumbar brace is an external support worn around the lower back.

Q Is that what he's wearing now (indicating)?

A Yes.

Q Are all lumbar braces the same?

A No.

Q Would you recommend that he wear a lumbar brace in the future?

A Yes.

Q Why?

A For a couple of the reasons that I had mentioned before.

After a fusion has occurred, the brace still serves a function in terms of being able to remind the patient, dos and don'ts of his low-back care, and at the end of the day, it can relieve stress on the lower back and decrease fatiguability and decrease pain.

Q At some point down the line, two years down the line or three years down the line, would it be a good idea to still wear a lumbar brace, from time to time?

A Yes.

Q Why is that?

A For those same reasons.

Q And how much does a lumbar brace cost?

A Depending upon the brace type, it can run anywhere between $275 up to a thousand dollars.

Q Because there's all different types.

A Yes.

Q That would depend upon his (indicating) needs?

A Yes.

Q And how often should that be replaced?

A A brace? Depending upon wear, normal wear and tear and use, one brace every year or so.

Q What's a TNS unit?

A A TNS unit is a device that electrically stimulates the -- the muscles and the skin on any given particular body part, and that can be useful in decreasing pain and helping with blood flow to certain muscular areas.

Q What happens if you have a muscle spasm?

A If you have a muscle spasm, that TNS unit can also be adjusted to decrease pain associated with the spasm.

Q Not a bad thing to have?

A A good thing to have.

Q How much do they cost?

A A TNS unit can run, depending upon the make and model of that unit, in the neighborhood of about $850 or so.

Q How often are they replaced?

A That unit could last him about a year or so.

Q Any type of radiologic studies that should occur later on, in the future?

A X-rays up until the point of fusion; after fusion has been accomplished, a lumbar X-ray just about every quarter.

Q Doctor, I want you to assume the following facts:

I want you to assume that on September 30th, 2002, Chris Yesnick was on the AOL Time Warner job site.

I want you to assume, Doctor, that the week before this accident he worked 44 hours, nine hours overtime; the week before that he worked 44 hours, more overtime; the week before that he worked 50-and-a-half hours, more overtime; and I want you to assume that he's performing a physically demanding job.

I want you to assume that he's an ornamental ironworker.

I want you to assume that on that day, September 30th, 2002, he's entering the threshold of a stairway and as he steps onto the threshold, he trips onto -- on rebar with his right foot.

I want you to further assume, Doctor, that when he trips, he falls forward (simulating) and sees that he may fall, between a mid-rail -- a top rail and a mid-rail -- maybe ten or twelve feet, to the staircase below.

I want you to assume, he reaches out with his right hand as an instinctive reaction (simulating).

I want you to assume, he grabs onto the

mid-rail with the right hand, tries to stabilize himself with his right foot, his right foot misses at around the second step from the top and he goes into the hole, into the hole (simulating).

I want you to further assume, Doctor, that he's now twisted (simulating), going from, I guess, right to left. He's twisting.

I want you to further assume that as he's twisting, he feels his shoulder tear, his knee -- his leg is caught and he feels his knee tear; he continues to twist and continues to twist (simulating). His leg eventually lets go, continues to twist (simulating), and does, in essence, a 360; winds up landing on his shoulders, on his back, on his legs.

I want you to further assume that EMS arrives to the job site and he complains of right-ankle pain, right-shoulder pain and low-back pain.

And I want you to further assume that he went to a doctor by the name of Hearns, who found a positive straight-leg-raising test.

And based upon those facts, Doctor, I'm going to ask you, are the injuries that you treated Christopher Resnick -- Yesnick -- for and continue to treat him for -- were those injuries caused by that accident?

MR. COHEN: Objection, your Honor.

THE COURT: Sustained as to that --

Are you asking him whether he can do that with a reasonable degree of medical certainty?

MR. DOMAN: With a reasonable degree of medical certainty.

THE COURT: Are you able to draw a conclusion, based on that set of assumptions, with a reasonable degree of medical certainty?

THE WITNESS: Yes.

THE COURT: What is your conclusion, sir?

THE WITNESS: That that accident, given that mechanism, has resulted in his injuries that I did treat.

Q Did that accident result in the herniated discs, Doctor?

A Yes.

Q And the leaking of the discs?

A Yes.

Q And the subsequent ligamentous hypertrophy, and osteophytes in the facet joints?

A Yes.

MR. DOMAN: Thank you.

THE COURT: Counsel, come up for a minute, please.

Proceedings

(Discussion off the record at sidebar.)

THE COURT: All right, we're going to take about a five-minute recess at this point, so you can just step in, jurors.

(The jury left the courtroom.)

THE COURT: You can speak to your client [sic] with respect to scheduling only.

Not your client; the doctor. Excuse me. I'm sorry.

You're not allowed to talk to counsel with respect to testimony itself, the substance, but in terms of scheduling, things like that, you're free to speak with him.

Okay?

THE WITNESS: Thank you.

THE COURT: Okay.

(The witness stepped down.)

(Recess.)

(The witness resumed the stand.)

COURT OFFICER: Jury entering.

(The jury entered the courtroom.)

THE COURT: All right, we're going to do a little bit of cross-examination of this witness now, and we're going to continue with the witness' cross on Monday afternoon. But we have a few minutes to

start, at least.

So you can begin, counsel.

MR. COHEN: Thanks, Judge.

(Continued on next page.)

CROSS-EXAMINATION

BY MR. COHEN:

Q Good afternoon, Doctor.

A Good afternoon.

Q Doctor, you and I have met before; correct?

A Yes.

Q We've met on the Rivera case, up in The Bronx, a couple years ago?

A Yes.

Q And also on the Clyde Daniels case, in Supreme, New York?

A Yes.

Q That was a Sacks and Sacks case, right?

A Yes.

Q How often do you testify for Sacks and Sacks, on average?

A To be honest with you, I'm not sure; I don't know.

Q Can you give us an estimate, an approximation?

MR. COHEN: Let me withdraw the question.

Q How often do you testify, for anybody?

A Maybe about four times per year.

Q Okay. And of those four times per year, how many times is for Sacks and Sacks?

A Honestly, it's hard for me to know because I

don't really keep track of the attorneys.

Q Okay. How many times have you testified this year, 2004?

THE COURT: In total, you mean?

MR. COHEN: Yeah.

A I want to say, three times.

Q Would that be including this time?

A No.

Q This would be four.

A Yes.

Q Okay. You did testify in the Cioffi case a couple weeks ago, or last week, for Sacks and Sacks?

A Yes.

Q And Dr. Touliopoulos testified in that case, as well?

MR. DOMAN: Objection.

THE COURT: If he knows.

Overruled.

A I don't remember.

Q You don't remember from a week ago?

A I usually do whatever my secretary tells me to do on any given day, so it's -- it's kind of hectic.

Q You and Dr. Touliopoulos don't both talk about your patients before you go into court to testify?

A No.

Q You didn't talk about this patient, right?

A No.

Q I want to ask you a question.

Do you have your operative report in front of you, Doctor?

A Yes.

MR. COHEN: Your Honor, this (indicating) operative report is contained within Dr. Touliopoulos's file but it's really not his record, so I'm going to ask if the Court would mark this for identification as Defendants' Exhibit -- whatever.

THE COURT: Okay, where are we on letters? This is contained in Plaintiffs' --

THE CLERK: Letter D.

THE COURT: All right, we'll mark it as Defendants' D.

MR. COHEN: We didn't agree to all of what's in that file. That's what I'm saying. There's a lot of stuff that's not Dr. Touliopoulos's in that file. We only agreed to his notes.

THE COURT: All right. So this is Defendants' D, his operative report; is that correct?

MR. COHEN: Yes.

THE COURT: Is there going to be any objection to it, counsel?

MR. DOMAN: The operative report?

THE COURT: Yes.

MR. DOMAN: It's already in evidence, as far as I'm concerned, in Plaintiffs' Exhibit 2.

THE COURT: There's a disagreement in that regard.

MR. DOMAN: Are you agreeing that his operative report is in evidence in Plaintiffs' Exhibit 2?

MR. COHEN: Why don't we go up and talk to the Judge?

MR. DOMAN: Sure.

THE COURT: Why don't you step back for one second.

(The witness stepped down and entered the jury room.)

(Discussion off the record at sidebar.)

THE COURT: All right, you can come back, Doctor.

(The witness resumed the stand.)

THE COURT: You're not objecting to the operative report coming into evidence as Defendants' D?

MR. DOMAN: No, absolutely not.

THE COURT: All right, that's in evidence now as Defendants' D.

Let's have it marked by our court reporter.

(Defendants' Exhibit D marked and received in evidence.)

(Said exhibit handed to witness.)

MR. COHEN: Now, may I have the shadow box, please?

(Shadow box placed upon jury-box rail.)

MR. COHEN: Can I approach, Judge?

THE COURT: Yes.

(Mr. Cohen approached the witness.)

BY MR. COHEN:

Q Doctor, can you just come down here (indicating) for a second?

(The witness stepped down and stood beside both Mr. Cohen and the shadow box.)

Q And show the jury, where are the L4-L5 vertebral bodies?

(During the following series of questions and answers, both the witness and Mr. Cohen indicated on Plaintiffs' Exhibit 4 in evidence placed on shadow box:)

A This is L4 --

Q Yes?

A -- and this is L5.

COURT REPORTER: For the record, what is being exhibited?

MR. COHEN: This (indicating) is an exhibit; yes, it is.

MR. DOMAN: Plaintiffs' Exhibit 4.

THE COURT: It's 4.

MR. COHEN: 4, Plaintiffs' Exhibit 4.

Q So we're referring to these two vertebral bodies as L5, L4.

And then you have L3; correct?

A Yes.

Q L2?

A Yes.

Q And L1?

A Yes.

Q And down here would be S1?

A Yes.

Q Now, we know that you fused these, L4 and L5, together during the surgical procedure; correct? We discussed that.

A Yes. Part of the longer fusion, yes.

Q Okay. And you said you packed in some

allograft bone mixture, almost like a paste, in order to get these two bones to fuse; right?

A L3 through S1.

Q I'm talking about 4-5, Doctor, okay?

A Yes.

Q And then you told the jury that you also fused L3 to L4, L2 to L3; right?

A No, not -2 to -3.

Q Not -2 to -3.

What did you fuse?

You said, four levels of the spine; correct?

A Yes.

Q L3 to -4?

A Yes. -4 to -5; -5 to -1.

Q Okay. So there's three disc spaces that have been filled up with bone.

A No, that -- I did not do an interbody fusion at those levels.

Q So when you said "fusion," what were you referring to?

A Posterior spinal fusion.

Q Meaning...?

A The -- the posterior, or backside, elements: the facet joints, the pars interarticularis, the remnant

of the posterior, or back, portion of the vertebral segments L3 through S1.

Q That's where you performed the laminectomy?

A Yes.

Q Have a seat, please.

(The witness resumed the stand.)

Q You see, I got the impression that you fused everything, so --

MR. DOMAN: Objection.

THE COURT: Well, the objection is sustained, unless it leads directly to a question, which I think is better to put in the form of a question.

Q When you told the jury that you fused L4 to L5, you discussed that you roughed up the bone -- right? -- on the bottom of L4 and the top of L5?

A Yes.

Q And then you told the jury that you created a mixture of bone-graft material, including some allograft; correct?

A Yes.

Q What you did was, you aspirated some bone marrow out of --

Was it Mr. Yesnick's hip?

A Yes.

Q Okay. And you took that bone marrow, you mixed it with the allograft --

Which is from a corpse?

A Yes.

Q -- and you created this paste; correct?

A Yes.

Q And then what you did was, you pushed the paste, if you will, into the space between the L4 vertebra and the L5 vertebra?

A No; on the posterior elements of the L4 and the L5 vertebrae, where the facet joint is.

Q Okay. So you didn't actually fuse the space between where the disc is.

A Correct.

Q Okay, that's what I was confused about.

There is a procedure whereby a physician such as yourself, an orthopedic surgeon, will remove the discs between two vertebrae; correct?

A Yes.

Q And then fill that space up, where the disc used to be, with bone.

A Yes.

Q And then that eventually becomes one solid mass: L2, for example, L3, with where the disc used to be, bone all the way through; correct?

A Yes.

Q That's not what happened here, though; right?

A Correct.

Q Can you take out that operative report?

Do you have it in front of you?

A Yes.

Q On page 2, if you go about halfway down, it says: "Next, a midline laminectomy was performed."

Do you see that?

It's not quite halfway down.

A Yes.

Q Okay. The laminectomy, you said, was removal of the bones along the back (indicating) so that you could get access to what you needed to see and work on?

A Yes.

Q Okay. So you took that bone out and then what you did is, you noted that the facet joints at L4-5 were surrounded by the hypertrophic synovium; right?

A Yes.

Q And I believe you told the jury that there was the beginnings of bone spurs, as well; correct?

A Yes.

Q The way you described them in your report, however, was "very large osteophytes"; isn't that right?

A Yes.

Q And these very large osteophytes, along with the hypertrophic synovium, was causing a contracture or a stenosis of the neural foramen at that level, and also of the canal; correct?

A Yes.

Q And you felt that this condition was responsible for the radicular pain?

A Yes.

Q In fact, when you shaved off the bone, these very large osteophytes, when you removed them and you shaved off the hypertrophic portion of the synovium and you closed him up, he went on to have a relief of symptoms -- of radicular symptoms; didn't he?

A Yes.

THE COURT: All right, we're going to -- I think we should stop here, counsel.

MR. COHEN: Okay.

THE COURT: We're going to resume with this witness on Monday afternoon. Because of scheduling issues, tomorrow we'll have other witnesses who will be examined and cross-examined.

So have a good evening. I'll see you all promptly at 9:30 tomorrow morning, when we'll continue with this case.

Please don't speak with each other at all

about this case, or anyone else about the case. Please remember all the instructions I've given you.

(The jury left the courtroom.)

THE COURT: You're excused. Thanks, Doctor.

(The witness stepped down.)

(Whereupon, the matter was adjourned to Friday, December 10, 2004, at 9:30 a.m.)

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK - CIVIL TERM - PART: 9

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CHRISTOPHER YESNICK and STACEY YESNICK,

Plaintiffs,

-against-

COLUMBUS CENTRE, LLC
and BOVIS LEND LEASE, LMB, INC.,

Defendants.

----------X

Index No. 123909/02
TRIAL EXCERPT

71 Thomas Street
New York, N.Y.
December 13, 2004

(Testimony of Andrew Merola, M.D.)

B E F O R E:

HONORABLE HAROLD B. BEELER,
Justice; and a jury

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Official Court Reporter

THE COURT: Counsel, do you want to come up a minute, please.

(Discussion off the record at sidebar.)

THE COURT: We have another witness, and I'm not sure whether the witness -- that's Dr. Merola, if you remember, who we just began cross-examination of. He's back to continue the cross, but we're going to take a few minutes. We want to make sure he's arrived, because he was scheduled just around this time, and then we'll start again with his cross. All right?

(The jury left the courtroom.)

THE COURT: We'll take five minutes and then we'll go with Dr. Merola.

(Recess.)

THE COURT: Dr. Merola, do you want to come back and have a seat?

A N D R E W M E R O L A, M. D., called as a witness by the plaintiffs, having been previously duly sworn, resumed the witness stand and was examined and testified further as follows:

COURT OFFICER: Jury entering.

(The jury entered the courtroom.)

THE COURT: Okay, have a seat, sir.

(Witness complied.)

THE COURT: We're going to continue the cross-examination of this witness, which was just begun by Mr. Cohen.

MR. COHEN: Thank you, Judge.

THE COURT: This is Dr. Merola again. And you're still under oath, Doctor.

THE WITNESS: Yes.

CROSS-EXAMINATION CONTINUED

BY MR. COHEN:

Q Good afternoon, Doctor. Thanks for coming back.

A Thank you.

Q Doctor, your very first visit with Mr. Yesnick was on June 23, 2003; correct?

A Yes.

Q And what were the complaints that brought Mr. Yesnick to you?

A Back pain, with pain radiating into his right lower extremity, and numbness and weakness in the right lower extremity.

Q Did you speak to Dr. Touliopoulos about his observations and findings from October 7th, 2002, when he first saw Mr. Yesnick, up until the date that you first saw him on June 23, 2003?

A I did read his notes about Mr. Yesnick, yes, I

did.

Q Okay. Did you have a conversation with the doctor, as well, or did you just read the notes?

A I don't remember if I spoke to him about it, but I do know that I did read his notes.

Q Okay. Now, is it your practice, Doctor, when you first see a patient, to take a history?

A Yes.

Q And did you take a history with respect to Mr. Yesnick?

A Yes, I did.

Q Did you ask him, generally, whether he had prior symptoms or conditions or injuries with respect to the back, for which he was consulting you?

A That's usually part of my standard history, yes.

Q Okay. And why do you do that?

A I like to find out whether or not there can be something else that may be contributing to their current complaints.

Q Okay. And is your history noted in your report?

A Yes.

Q Okay. What did Mr. Yesnick tell you?

A Mr. Yesnick said that he hurt himself at work

on September 30th of 2002. He had severe and unremitting back pain, with pain radiating into his right lower extremity, as well as numbness and weakness in the right leg.

Q Did you ask him about prior medical history, whether he had any previous condition, injury, symptoms prior to September 30th, 2002, with respect to the back?

A Yes. In general, I do.

Q What did he tell you?

A I did not note anything significant in the exam.

Q What does that mean?

A That means that there wasn't anything that impressed me in terms of his prior history.

Q Okay. So, if he did tell you something, it wasn't significant enough for you to record it.

A Yes.

Q Okay. Now, Mr. Yesnick originally consulted Dr. Touliopoulos on October 7, 2002, for shoulder pain, knee pain and back pain; correct?

A Yes.

Q And Dr. Touliopoulos also took a history; correct?

A Yes.

Q A past medical history?

A Yes.

Q Do you have his record in front of you?

A Yes.

Q And what did he write?

A "Past medical history, negative."

Q And what does that mean to you, Doctor?

A That means that there is no significant past medical history that would have any alteration in the way that we are going to see that patient.

Q And would that be with respect to all the various parts of the body that he came, originally, to see Dr. Touliopoulos about?

A No. The past medical history would include things like high blood pressure, cancer, diabetes; that kind of thing.

Q Okay. Do you take any history with respect --

For example, if someone comes to you and says, My back hurts and I injured my back on September 30th, 2002, do you take any prior history in regard to, well, is this a brand-new thing or is it something that's been going on for a long time?

A I -- usually, my second question, after that, is: Did you have any problems with your back before this? Was there anything debilitating before this that you can recall?

Q Okay. Now, do you know if Dr. Touliopoulos did that when he first saw Mr. Yesnick on October 7, 2002?

A It's pretty much standard for orthopedic surgeons to do that, so I would say that that would be something that he would note if there were significance there.

Q Okay. And the fact is that he didn't; correct?

A Correct.

Q Now, let me ask you something: When you first saw Mr. Yesnick in June 2003, did he tell you that he injured his lower back in 1991?

A Not at that time, no.

Q Did he ever tell you that?

A Not that I recall, no.

Q Okay. Did he ever tell you that he had a back injury in 1991 that caused him to be totally disabled?

A No.

Q Did he ever tell you about any medical treatment that he received in connection with a back injury in 1991?

A Not in -- no. Not at that time, no.

Q Did he ever tell you?

A Not that I can recall at this time, no.

Q Okay. Did he tell you that he was involved in a car accident on July 20th, 1996, where he crashed his

car into the front of a house at high speed and injured his back? Did he ever tell you that?

A No.

Q Now, according to your June 23, 2003, note, you felt that there was a herniated disc pressing on the right side of the S1 nerve root; correct?

A Yes.

Q "Right-sided S1 nerve-root impingement" would mean, something at the L5-S1 level is pressing on the nerve root on the right side; is that fair?

A It means that the -- the S1 nerve root has -- when it descends the spinal canal, it can be impinged at different areas.

Q Um-hmm.

A So there are different areas that are possible for that nerve root to be impinged upon.

So when I say, "right-sided S1 nerve-root impingement," I'm saying that that -- that is the nerve root that's being irritated, by the MRI findings and his physical examination. So that's the nerve root that we try to concentrate on.

Q Okay. What I'm asking you, though, is, are we talking about an impingement that would go down as opposed to going up (indicating)?

A The impingement itself is not so much

directional as it is geographic or anatomical, so the S1 nerve root --

When the S1 root is inside the spinal canal --

Q Um-hmm.

A -- there are several ways that S1 nerve root sits; it depends on where it is in the canal, and it changes positions in the canal before it exits.

It's kind of like people --

If you could picture soldiers about to jump out of an airplane, those soldiers line up to get to the door and when they jump out depends on what their position in line is, and their position in line in the airplane is their geographic location in the airplane at any given time.

So the S1 nerve root originates in your spinal cord, after it leaves your brain and that S1 nerve root, as it travels down your spinal canal, changes positions, depending on the level of the canal that it's in. So, depending on the type of herniation and where it is, it can hit that nerve root at different areas. So it depends upon its exact geography in the canal.

So when we talk about the S1 nerve-root impingement, we're saying that that's the nerve that's manifesting itself the worst and it's being pinched at a

point in that canal.

Q Okay. So, I mean, you're not necessarily referring to the point where the nerve root -- or the nerve -- leaves the spinal canal and passes through the neuroforamen, for example?

A Exactly, yes.

Q So it could be a point higher than that in the spine where it's being impinged by something.

A Yes.

Q And it could be impinged by a herniated disc; correct?

A Yes.

Q And it could be impinged by an osteophyte; correct?

A Yes.

Q Okay. Now, in this case, wherever this impingement was occurring, it was, according to what you wrote, producing pain radiating down the lower-extremity S1 dermatomal distribution; right?

A Yes.

Q And what you told the jury is, the dermatomal distribution would be down the back of the leg (indicating); right?

A Yes.

Q Okay. All the way down to the foot

(indicating)?

A Yes.

Q Okay. So something was pinching the S1 nerve, somewhere, causing symptoms down the S1 dermatomal pattern (indicating).

A Yes.

Q That's how you knew that it was S1, because of the area where Mr. Yesnick said he was experiencing symptoms.

A Yes.

Q Okay. Now, do you know, sir, if Mr. Yesnick had right-sided radiating pain into the S1 dermatomal distributions in 1991?

A No, I do not.

Q Do you know if he had right-sided radiating pain into the S1 dermatomal distributions in 1996?

A No, I do not.

Q When Dr. Touliopoulos first saw Mr. Yesnick, on October 7, 2002, Mr. Yesnick wasn't complaining of any right-sided radiating pain into the dermatomal distribution; isn't that correct?

A At that time, it was predominantly back pain.

Q All right. What Dr. Touliopoulos wrote when he examined was: "point tenderness in the lower-thoracic and the upper-lumbar spine"; correct?

A Yes.

Q So he didn't say anything about any findings of a radicular nature.

A Correct.

Q And he didn't do any test -- for example, the straight-leg-raising test -- that would indicate, if positive, that something was pinching the nerve root; correct?

A He didn't note a positive tension sign on that exam, no.

Q Right.

A Correct.

Q I mean, if it had been positive, I assume he would have noted that it was positive; right?

A Yes.

Q Okay. Now, if you could take a look, Doctor, at the February 5th, 2003, note of Dr. Touliopoulos?

Do you have that in front of you, sir?

A I am trying to get to it.

February 5th, 2003.

Q Yes.

(Pause.)

A Yes.

Q At the end of the second line, under "Follow-up Visit," it says: "The patient presents today with recent,

severe aggravation of his low-back pain."

You see that?

A Yes.

Q And it also says that his low-back pain radiates to his lower extremity, with his right extremity affected more than his left; correct?

A Yes.

Q And it also says that he had intermittent numbness in the right lower extremity; correct?

A Yes.

Q Do you know what happened to Mr. Yesnick at or about that time to severely aggravate his lower-back pain and bring him to see Dr. Touliopoulos on February 5th?

A When I read that note and Dr. Touliopoulos indicates "aggravation" --

In general, when we write clinical notes to ourselves, when we say something like, The patient has significant aggravation of his back pain or leg pain, or what have you, basically, that means to us, take note of the fact that this is something that is bothering him particularly bad on this particular day.

Q Okay. What the doctor wrote was: "He presents today with recent, severe aggravation"; correct?

A Yes.

Q So what I am asking you is, do you know if

there was an event or anything that occurred to Mr. Yesnick that produced the recent, severe aggravation?

A As far as I know, there was no event that produced that aggravation, no.

Q And what do you base that on?

You didn't see him for another four or five months.

A If there was an event, I'm sure Dr. Touliopoulos would have put it in his notes. That's our -- pretty much -- our standard.

Q All right. So you're not saying anything of personal knowledge. You're saying, the absence of any particular note in the record suggests to you that it wasn't an event; for example, an accident.

A Yes.

Q Okay. Now, the first X-ray that Dr. Touliopoulos ever ordered with respect to the lower back was after this recent, severe aggravation of lower-back pain on or about February 5th; correct?

A I believe so, yes.

Q And he never requested an authorization for an MRI of the lower back until after the February 5, 2003, visit, at which the recent, severe aggravation was noted; correct?

A Yes.

Q Now, if we go back to October 7th, Doctor, Mr. Yesnick did have back pain when he came to see Dr. Touliopoulos; correct?

A Yes.

Q But there was no radiating pain or symptoms, right?

A Correct.

Q And Dr. Touliopoulos did an exam and he found tenderness --

Right?

A Yes.

Q -- and he found spasm, and he found those two different findings in the lower-thoracic and the upper-lumbar region; correct?

A Yes.

Q According to his note, there were no findings in the lower-lumbar region (indicating); right?

Let me withdraw the question and ask you, did he make any findings with respect to the lower-lumbar region?

A No, not as far as I know. Correct.

Q Okay. Now, if we go forward, Doctor, to the 21st, October 21st, two weeks later, on this examination Mr. Yesnick had, according to what Dr. Touliopoulos wrote, "mid- and low-back discomfort"; correct?

A Yes.

Q It wasn't described as pain; it was described as "discomfort." Right?

A Yes.

Q And Dr. Touliopoulos again found tenderness with spasm, but now he found it in the lower-thoracic region; correct?

A Yes.

Q And this is when he did, for the first time, the lower-extremity tension signs and he found them to be positive.

A Yes.

Q Okay. Now, is this an exam that one can do in a seated position (simulating) with the witness [sic]?

A Yes.

Q You ask the witness to -- I'm sorry; not the witness, but the patient -- to lift his leg, or her leg?

A Yes.

Q And at a certain point, if the patient says, I have pain, you consider that to be a positive finding; correct?

A Yes.

Q Okay. It can also be done lying down; correct?

A Yes.

Q And the same thing: you lift the leg up and at

some point, if the patient says, I have pain, we've got a positive finding.

A Yes.

Q Okay?

And it's not unusual for a doctor to actually take a recording, by degree, of where the pain is; correct?

A Yes.

Q You've done that before, right?

A Yes.

Q So if you're lying down, your feet would be at zero (simulating); correct? And straight up would be 90 degrees?

A Yes.

Q And, for example, if you said, positive straight-leg raising on the right at 80 degrees, what that would mean was, when you lifted the patient's leg up, on the right, when it got to 80 degrees, the patient said, Stop, I have pain.

A Yes.

Q Okay. And Dr. Touliopoulos didn't do anything in that kind of detail; correct?

A Not as detailed as that, no --

Q Okay. He just said --

A -- noted.

Q All he wrote was: "Lower-extremity tension signs are positive."

A Yes.

Q Now, if we go ahead to November 6th, which is the next examination by Dr. Touliopoulos, he reported that Mr. Yesnick was improving with respect to his lower-back pain; correct?

A Yes.

Q And Mr. Yesnick described the back pain as "dull"?

A Yes.

Q And he also said, now, that he had intermittent paresthesias of both the upper extremities and the lower extremities; right?

A Yes.

Q Paresthesias can be any sort of an abnormal feeling?

A Yes.

Q It doesn't have to be numbness. It could be tingling; it could be numbness. A bunch of other things can wrap into "paresthesias"; correct?

A Yes.

Q So he had it, according to what Dr. Touliopoulos wrote, not only in both lower extremities, but both upper extremities, as well;

correct?

A Yes.

Q Okay. Now, on December 9th, which is the next visit with Dr. Touliopoulos, the lower-back pain was now described as "intermittent"; right?

A I'm just checking.

Q I can refer you, Doctor --

A Yes. Yes.

Q Okay. "He has intermittent upper- and lower-back pain, as well as right-ankle pain."

That's what Dr. Touliopoulos wrote?

A Yes.

Q "Intermittent" means on again, off again?

A Yes.

Q And he still had intermittent paresthesias, both in the upper extremities and the lower extremities.

A Yes.

Q So he had on-again, off-again abnormal feeling in the hands and in the feet.

A Correct.

Q Okay. Now, on January 20th, 2003, which is the next visit with Dr. Touliopoulos, Mr. Yesnick is reporting again intermittent paresthesias in the right-lower extremity; correct?

A Yes.

Q He doesn't report any lower-back pain or radiating pain, right?

A Correct.

Q And on exam, Dr. Touliopoulos found tenderness but no mention of spasm; right?

A Yes.

Q Flexibility was limited, according to what the doctor wrote; correct?

A Yes.

Q And the tension sign, on straight-leg raising, was still positive.

A Yes.

Q And that could account for the occasional feeling of paresthesias in the right-lower extremity; correct?

A Yes.

Q Okay. Now, the next visit is the February 5th visit that we talked about where he presents with the recent, severe aggravation of lower-back pain. At that time, the pain was radiating into the lower extremities; correct?

A Yes.

Q And Mr. Yesnick continued to report intermittent paresthesias; right?

A Yes.

Q And now Dr. Touliopoulos, on examination, found significant tenderness of the lower lumbar region; right?

A Yes.

Q Straight-leg raising was still positive; yes?

A Yes.

Q And Dr. Touliopoulos found decreased sensation along the right thigh; correct?

A Yes.

Q So then what we have, basically, Doctor, is a progression, involving Mr. Yesnick under his treatment with Dr. Touliopoulos, from low-back discomfort on October 21, 2002, with a positive straight-leg raising; to improving on November 6th, with dull back pain and occasional paresthesias into the lower extremity; to intermittent pain on December 9th, with intermittent numbness; to no report of pain on January 20th but the continued intermittent numbness, and tenderness; and then, on the 5th of February, something happens, recently, and he has a severe aggravation of lower-back pain.

MR. DOMAN: Objection to the form.

THE COURT: Sustained as to the form of that question.

Q How many lumbar MRI's has Mr. Yesnick had since October 7th, 2002?

A I believe, one, as far as I know.

Q And have you taken any X-rays in the course of your treatment of him?

A I have taken some postoperative X-rays, yes.

Q Okay. Are any of those X-rays referenced in any of your notes?

A I'd have to check in my -- in my follow-up notes after the operation.

Q Would you mind? There aren't that many.

A Sure.

(Pause.)

A July 26th, 2004.

That was the last note that I have a notation on for postoperative films.

Q What about before the operation?

You treated him for about a year before the operation?

A Yeah. I think I started treating him June 23rd of 2003 and then operated on May 4th, 2004.

Q Okay.

A With the MRI and the X-rays that Dr. Touliopoulos had obtained in between.

Q Right.

Did you do any X-rays?

A No new ones, no.

Q So, in the course of your treatment of Mr. Yesnick since June of 2003, you've taken one set of X-rays?

A Yes.

Q And you told the jury that you think that, on a going-forward basis, he's going to need four sets of X-rays a year?

A Postoperatively, yes.

Q For the rest of his life?

A For as long as you follow him, yes.

Q I mean, don't you think that's a little excessive in terms of radiation?

A Actually, it's a very small dose of radiation. It's about equivalent to what you get when you're riding in an airplane, in terms of what we can do today with a modern X-ray machine. So it's not really a significant dose of radiation.

Q But, you think, four a year would be good for you, diagnostically speaking?

A Conservatively speaking, yes.

Q Conservatively. You might actually do more?

A I might do more, yes, depending upon his course.

Q What if he's not complaining?

A If he doesn't have any complaints, every

quarter, if we're going to be seeing him and looking at his fusion site and his decompression, as time goes on, it's the safe thing to do.

Q And is that the same with the MRI films?

A The MRI's really depend upon his complaints and how often we need to monitor any changes that he may have in his neurological status.

Q Okay. I believe you told the jury that one every two years would seem to be in order for the rest of his life?

A That's a conservative estimate, yes.

Q Okay. What if he's not complaining; what if he's coming in and he's saying, I'm doing okay? Are you going to send him for an MRI, anyway?

A If two years have elapsed and I haven't seen him for a period of time, if I take X-rays and I'm not happy with his X-rays, I would send him for an MRI.

Q The MRI of the lumbar spine was done when in this case?

A The MRI for this case was done --

You know, I have it in my bag. I don't have the report here (indicating), but it was done -- I believe it was done in -- I want to say -- June or so. But I'm not positive of the exact date.

Q June 5, 2003? Does that refresh your

recollection?

A Yes.

Q Okay. And you did the surgery about 11 months later; correct?

A Yes.

Q You didn't do another MRI preoperatively; correct?

A Right.

Q And you haven't done one since, right?

A Correct.

Q Now, Mr. Yesnick isn't using a TNS unit presently, is he?

A I believe I -- I believe, on my last visit, I ordered something called a muscle stimulator, but I am -- I don't remember completely, offhand, because I don't know if that note is available to us, or not, yet.

Q So that would be --

When you say, "last visit," that would be very recently?

A Yes.

Q And that would be something that is not part of your chart?

A Yes.

Q So it's not here in court.

A Correct.

Q Okay. And let me ask you this: What's the benefit of a TNS unit?

A There's -- actually, there are several different types of units available. One is a simple TNS unit.

A TNS unit is transcutaneous electrical stimulation. It basically just runs electricity down onto the skin and it decreases pain by stimulating nerve endings in the skin.

Then there's a unit called a muscle stimulator, which does a TNS function where it runs electricity into the skin, and it also runs an electrical current into the underlying muscles, to stimulate blood flow and to keep those muscles active. That's called an RF-4 muscle stimulator unit. I actually prefer to use the RF-4 muscle stim rather than the TNS.

Q Does that help with pain?

A Yes.

Q It actually, maybe, decreases it?

A Yes.

Q Now, you treated him conservatively from June of 2003 until the surgery in May of 2004; correct?

A Yes.

Q You never prescribed a TNS unit or an RF-4 muscle stimulator during that period of time; correct?

A That is correct.

Q This is something that you did just recently, on his last exam before trial.

A They work very well postoperatively, yes. They're for chronic pain.

Q Doctor, this is something that you just did recently, on his last exam before trial?

A Yes.

Q Now, I want you to assume, Doctor, that Mr. Yesnick testified at his deposition, most recently on October 29th, 2004, that he treated with Dr. Hearns initially and yourself and Dr. Touliopoulos, and physical therapy, and that was the entire scope of his medical treatment following his alleged accident of September 30th, 2002.

In view of that, I want to ask you, have you ever prescribed for him chiropractic care?

A Not that I recall, no.

Q Again, you told the jury the other day that he needs, in your opinion, 24 visits a year for the rest of his life; correct?

A Yes.

Q But, during the year from January 23 -- I'm sorry -- June 23, 2003, up until the date of your surgery almost a year later, when you treated him

conservatively, you never prescribed chiropractic care; correct?

A Correct.

Q Do you have any chiropractors on staff at University Orthopedics of New York?

A No.

Q Do you have someone that you normally refer your patients to?

A No.

Q You guys have five offices, right?

A Yes.

Q Two in Queens, two in Brooklyn, and then one on Seventh Avenue?

A Yes.

Q Now, you've never prescribed, up until now, I suppose, hydrotherapy for Mr. Yesnick, either; isn't that correct?

A Correct.

Q So again, during the year that you treated him conservatively, before you decided that conservative treatment was not going to work and you had to go in surgically to take care of his problem, you never offered this type of treatment to him; correct?

A Correct.

Q Now, Doctor, how much did you charge for your

back surgery for Mr. Yesnick?

A It's -- my fee for the back surgery is contractual, based upon his insurance.

Q Okay. How much was it?

A I don't even re -- it depends on what his insurance plan was and, to be honest with you, I don't remember what the exact reimbursement for that case was.

Q Do you have a copy of the bill in your file?

A I do not have it in my file, no.

Q Well, when you testified the other day, you were familiar with the cost of chiropractic care, a TNS unit, hydrotherapy; you knew about the cost of a back brace; you knew about the cost of future surgery, but you can't tell the jury what you, yourself, charged in this case for his back surgery?

A I can't tell you what his insurance company reimbursed for me, but I can tell you what usual and customary is.

Q No, I'm not interested in usual and customary. I'm interested in what you put on the bill that you submitted to his insurance company for the surgery.

MR. DOMAN: Objection.

If he can't recall as --

THE COURT: Objection sustained.

He says he doesn't remember, counsel.

Q All right, let's talk about the back surgery that you did.

Do you have the operative report in front of you, Doctor?

A Yes, I do.

Q Okay. Now, according to what you wrote in the operative report, you said that this is a young gentleman who sustained a herniated lumbar disc as a work-related accident; correct?

A Yes.

Q And, you said, that disc herniation has now progressed to bilateral lower-extremity radiculomyelopathy with severe back pain secondary to facet-joint arthrosis and lumbar spondylosis; right?

A Yes.

Q Okay. The radiating symptoms, you said, were in the S1 dermatomal pattern; correct?

A Yes.

Q And when you went in, when you went in to do the surgery, you went in to address the back pain and radicular symptoms in the S1 dermatomal pattern; correct?

A In all of his complaint patterns, yes.

Q Hopefully, you were going to identify and remove the problem; correct?

A Yes.

Q The first thing you did, Doctor, was to remove the spinous process; correct?

A Yes.

Q And the lamina?

A Yes.

Q And I believe you told the jury that those are the bones on the back, if you were to feel the bumps on your back (indicating)?

A Yes.

Q Like the back of a dinosaur?

A Yes.

Q And you did that at the L5 vertebra and the L4 vertebra; correct?

A Yes.

Q And after that, Doctor --

By the way --

MR. COHEN: Withdrawn.

Q You did that so that you could gain access to what you needed to work on and what you needed to visualize, right?

A Yes.

Q After that, Doctor, you wrote: "After this was done, it was noted that the facet joints at the L4-5 levels were surrounded by hypertrophic synovium and very large osteophytes, which were responsible for

neuroforaminal and canicular stenosis"; right?

A Yes.

Q Now, the neuroforamen are the round openings through which the nerve roots exit at each level of the spine; correct?

A Yes.

Q And you have a left one and you have a right one at each level of the spine (simulating); right?

A Yes.

Q And if those openings become restricted, or smaller, then that could cause an impingement on that nerve root as it attempts to exit through the neuroforamina; correct?

A Yes.

Q So when you said that he had hypertrophic synovium and large osteophytes responsible for neuroforaminal stenosis, what you meant was, the hypertrophic synovium and these large osteophytes were causing the opening to become smaller; right?

A Yes.

Q And again, you described these osteophytes as being "very large"; right?

A Yes.

Q Osteophytes are bony growths?

A Yes.

Q And you also said that these large osteophytes were causing "cannicular stenosis"; correct?

A Yes.

Q So you're referring to the canal, right?

A Yes.

Q And stenosis is, again, a restriction, or narrowing, of the canal; correct?

A Yes.

Q And we say that the nerve roots are in the canal before they exit through the neuroforamina?

A Yes.

Q So that within the canal, now you've got these large osteophytes that are pressing, making the canal smaller, which could account for some impingement.

A Yes.

Q Okay. Now, once you identified this problem, the osteophytes in the neuroforamina were removed in order to open up the neuroforamina?

A Yes.

Q Okay. And then you inspected the area, after you did this; correct?

A Yes.

Q And you took a look at the disc at the L4-5 level, right?

A Yes.

Q And you wrote here: "The disc at L4-5 level was inspected and found to be partially calcified and hard"; right?

A Yes.

Q "The decision was made to leave the disc alone, since a complete and capacious decompression were effectuated with the laminectomy and partial facetectomy."

A Yes.

Q So, in other words, you had created enough room, in your opinion at that time, for the nerves to pass through the canal at L4-5, and also to pass through the neuroforamina, so that you didn't have to do anything with respect to the disc at L4-5; correct?

A Yes.

Q So you didn't remove any portion of the disc.

A Correct.

Q Okay. Then, Doctor, you said: "After this portion of the procedure was completed, the wound was copiously... irrigated."

So you sprayed in sterile saline?

A Yes.

Q Okay. To clear everything out.

And then what you did was, you took the bone marrow from the hip and you mixed it with some other

material in order to make that paste that you told the jury about, that would be used to create a fusion.

A Yes.

Q Yes? Okay.

And then, according to what you wrote, and I'm reading again: "The posterior elements at the L4-5 level were decorticated and packed with this admixture of bone-graft [material] including some allograft."

That's what you wrote, right?

A Yes.

Q And what you told the jury that you did was, you didn't remove the disc between the L4 vertebra and the L5 vertebra and fill the space with bone; right? You came in from behind the posterior element, where the facet joints are, and you packed the material there.

A Yes.

Q Okay. And after you did that, it says: "A closure was then affectuated [sic] over a large Hemovac drain"; correct?

A Yes.

Q Now, in this report, Doctor, the only level that I can see that you packed any of this mixture into was the L4-5 level. That's what this (indicating) says, right?

A That's where the principal fusion was

accomplished, at L4-L5.

Q Now, you told the jury that you also fused L3-4?

A 3 -- the -- when you put the mix down there, L4-L5 is decorticated and solidly fused, and the bone-marrow aspirate and what we call platelet-derived growth factor, which comes from the patient's own blood, which we prepare in the operating room in order to provide healing factors for that -- for the postoperative period, are injected all the way from -3 to -1 --

Q Okay.

A -- L3 to -1. But the fusion itself is L4-L5.

Q Okay. So the paste that would cause the facet joints to become stiff and to prevent them from moving on a going-forward basis was utilized at L4-5; correct?

A Yes.

Q And then, at the other levels, you said, you put a mixture in there that would stimulate the blood flow to the area?

A And the healing properties at that area.

Q But not to fuse them.

A Correct.

Q Okay. So there was no actual fusion between L3 and L4; correct?

A Correct.

Q And there was no fusion between L5 and S1.

A That is right.

Q Okay. And there was no disc material removed in connection with this procedure; correct?

A Correct.

Q Now, after the procedure, Doctor, you followed Mr. Yesnick up until the present; right?

A Yes.

Q And on May 24th, in your office note --

Do you have that in front of you, Doctor?

A May 24th, yes.

Q Yes.

-- you wrote: "So far, looks quite good. Neurologically, he remains intact and stable."

Correct?

A Yes.

Q Can I take that to mean that he no longer had the symptoms that were radiating down from the spine into his lower extremities?

A It means I didn't hurt him with the surgery.

Q Okay. So you didn't make it worse.

A Correct.

Q Okay. Let's go forward, then, to the next office visit, on July 26th.

Do you have that in front of you?

A Yes.

Q "Sensory-motor examination of the lower extremities is intact."

A Yes.

Q Okay. What does that mean?

A That means that neurologically, once again, I didn't cause him to have an injury intraoperatively.

Q Okay. Did you make any notation in your record that he was still having any pain or symptoms radiating down into his lower extremities?

A No lower-extremity pain on that visit.

Q Okay. In fact, you did a straight-leg-raising test and it was negative bilaterally.

A Yes.

Q So again, if we did it in a seated position, you raised the person's -- Mr. Yesnick's -- leg up (simulating) and it produced no pain or symptoms.

A Correct.

Q And the reason why you do that is because if something is in the spine that shouldn't be there, when you raise the leg you're going to force whatever that is up against the nerve, if it's there.

A Yes.

Q So you had removed those very large osteophytes, right? And you created nice openings for

the neuroforamina at L4-5; correct?

A Yes.

Q And you created a better opening for the spinal canal at that level, right?

A Yes.

Q And then, two months later, when you did straight-leg-raise tests, they were negative.

A Yes.

Q So that's a good thing.

A Yes.

Q They were positive before the surgery, right?

A Yes.

Q Okay. Now, on August 23, Doctor, you noted that the radiculopathic complaints subsided but he still had easy fatiguability of the lower back; right?

A Yes.

Q So that meant that his lower back tired easily? I mean, is that what it means?

A Yes.

Q Okay. And this is three months post surgery?

A Yes.

Q And then you mentioned that he was walking "Grange Village"?

A Greenwich. Should be Greenwich Village.

Q Greenwich Village, okay.

"He was walking in Greenwich Village several weeks ago and noted that at the end of the day, he had a significant amount of lower-back pain"; right?

A Yes.

Q Okay. Now, was that an unusual thing to occur three months post surgery, if you're walking in Greenwich Village and at the end of the day, your back hurts?

A Highly unusual, no.

Q Now, you said there that he also had pain with activities, including bending, lifting, pulling, pushing, stooping, crawling, sitting or standing for prolonged periods of time; yes?

A Yes.

Q Now, did you actually put him through the motions of bending and lifting and pulling and pushing, etcetera, or did he report that to you?

A That's reported.

Q Okay. Did you find it unusual that he would be doing that type of stuff only three months post surgery?

A No.

Q You still had him in the brace, right?

A Yes.

Q And he told you that he was stooping and crawling?

A Well, it's -- you know, when you're at home and

you perform activities of daily living, stooping can be something as simple as just bending over to pick up the trash and bending over to wash the dishes or help out with clearing the table, getting up out of bed; those types of things.

Q Um-hmm.

A So those activities do occur, and that's one of the reasons that I -- you -- normally put people into the back brace.

Q Okay. You said: "Sensory and motor neurological examination of the lower extremities was intact"; correct?

A Yes.

Q So you still were reporting that you hadn't made him worse.

A Yes.

Q And the negative -- I'm sorry -- the straight-leg-raising test was still negative bilaterally; correct?

A Yes.

Q And you noted that the calves were soft and nontender?

What's the significance of that, Doctor?

A Blood clots. We want to make sure that the patient hasn't developed any blood clots.

Q Okay. Now, your next examination of Mr. Yesnick was October 4th -- from August 23, 2004, until October 4th -- correct?

A Yes.

Q But Dr. Touliopoulos saw him, in the interim, on September 13th; correct?

A Yes.

Q And on that date, according to what's noted in Dr. Touliopoulos's records under "Physical Examination, the patient exhibits a normal gait pattern at this time."

Do you see that?

A Yes.

Q Now, before you did the surgery, he was limping; right? He had an antalgic gait?

A Yes.

Q And according to what Dr. Touliopoulos's notes indicate on September 13th, which would be four months post surgery, he's walking with a normal gait; correct?

A You know, I just saw it; I'm looking for it again. I'm sorry.

Q It's right at the bottom, under "Physical Examination," Doctor? The last sentence.

A Yes. Yes. Thank you.

Q So that's a good thing, too; right?

A Yes.

Q Now, the last record that we have in evidence before us was your note of October 4, 2004?

A That's my last one, correct.

Q Right. And you wrote in there that he's doing better than he did preoperatively but he does continue to have lumbosacral complaints; correct?

A Yes.

Q You did the --

Did you do a straight-leg-raising test?

A I didn't make notation of it at that time, but it's generally done during every visit, yes.

Q Okay. And can we assume that because there's no notation, it would have been negative?

A Yes.

Q Okay. So again, we're now in October, five months post surgery, and he's walking normally, according to what Dr. Touliopoulos's notes indicate two [sic] weeks earlier, and he continues not to have the radiating symptoms down the spine, into the lower extremities (indicating).

A Yes.

Q But you did note that he continued to have some lumbosacral complaints.

A Yes.

Q So he's better but not back to the place that he was at.

A Yes.

Q Now, you said that he's still getting physical therapy three times a week?

A I believe so, yes.

Q Okay. And is the purpose of that physical therapy in order to improve his situation?

A Yes.

Q I mean, you wouldn't be prescribing physical therapy three times a week if you didn't think it would help; right?

A Yes.

Q And physical therapy, hopefully, will give him a greater range of motion than he has currently?

A Yes.

Q And, hopefully, will give him stronger lumbosacral muscles than he has currently?

A Yes.

Q And, hopefully, will give him stronger abdominal muscles than he has currently?

MR. DOMAN: Objection to the form.

THE COURT: Overruled.

Q Doctor?

A Yes.

Q And, hopefully, will reduce his pain; correct?

A Yes.

Q Over what period of time, Doctor --

MR. COHEN: Withdrawn.

Q I believe you told the jury that he would continue to progress and eventually reach maximum medical improvement one year post surgery, right?

A Approximately, yes.

Q So, then, this being December, there's a good five more months of physical therapy during which Mr. Yesnick (indicating) can, hopefully, make some more progress; correct?

A Yes.

Q And it won't be, really, until that time that you know what the actual outcome of the surgery has been; correct?

A Correct.

(Whereupon, the court reporter advised the Court and counsel of the need to change stenographic paper.)

(Pause.)

MR. COHEN: Actually, Judge, I'm done. It's fine.

Thank you, Doctor.

THE COURT: How about you, counsel;

redirect?

MR. DOMAN: Five minutes.

THE COURT: Let's take five minutes. We'll recess anyway. Someone has to walk through the courtroom and get some materials. We'll take five minutes, let the reporter change what he has to. We'll let counsel do his redirect and I expect we'll finish early today.

(The jury left the courtroom.)

(The witness stepped down.)

(Recess.)

(The witness resumed the stand.)

THE COURT: Are you about ready, Mr. Doman, for the redirect?

MR. DOMAN: Sure, absolutely.

THE COURT: Okay, let's bring the jury back for redirect.

COURT OFFICER: Jury entering.

(The jury entered the courtroom.)

THE COURT: All right, let's continue now with the redirect examination.

REDIRECT EXAMINATION

BY MR. DOMAN:

Q Thank you for coming back again today, Doctor.

A Sure.

Q Doctor, given what you visualized when you actually performed the surgery and went into Mr. Yesnick's back on May 4th, 2004, given what you visualized and what you did on that day, does it surprise you in any way, shape, manner or form that there was a slow progression of symptomology with Mr. Yesnick that took a few -- that gradually occurred over a few months?

MR. COHEN: Objection to the form, Judge.

THE COURT: Are you talking about preop, presurgery?

MR. DOMAN: Presurgery.

THE COURT: Overruled.

THE WITNESS: That means I can answer, right?

THE COURT: That means you can answer, yeah.

THE WITNESS: Okay, thanks.

Actually, no, I'm not surprised.

Q Why?

A Mr. Yesnick's presentation, or how he came to manifest the signs and symptoms of what happened, is actually a very classical presentation for a disc herniation.

The disc has -- there's a little nerve; there's a very small, like the size of a hair, nerve that

goes -- that wraps itself around the disc; it's called the sinuvertebral nerve. When the disc starts to have a problem, that nerve starts to fire. The first thing that you start to feel is a gradual progression of back pain, and that back pain gets worse and worse and worse.

When that disc actually ruptures and material comes out of it, the sinuvertebral nerve gets trashed; it goes, and at that time, you begin to experience leg pain and your back pain abates.

Back pain can return, depending on whether or not there are other disc levels involved and whether or not other sinuvertebral nerves are now inflamed or are having a problem.

And indeed, when I teach herniated discs to my residents and medical students, I -- I tell them, especially the ones that are going into family practice or general medicine or internal medicine, that when they see patients come into the office and they have gradually progressive low-back pain with symptoms that continue to localize in the back, look for back pain going away and that's when you have to be aware of leg pain. That's when your exams and everything that you're doing for that patient when they walk into that emergency room or -- or your office has to center around the leg, because when you see back pain disappear, that's when the

radiculopathy happens.

And that's exactly what we saw happen with Mr. Yesnick.

Q Now, when we talk about maximum medical improvement for Mr. Yesnick, what are you really waiting for, come May of 2005?

A At that time, what we're waiting for is, we're waiting for me to look at an X-ray to see whether or not I can see a big, huge, solid chunk of bone at the L4-L5 level. That's the first thing I'm looking for. We generally give a fusion about a year to happen. It's an arbitrary amount of time but we look at it for about a year or so.

The other thing we're looking at is, for about that first year, before what we call maximum medical improvement, we have to be hypervigilant about any potential complications that could have arisen from the surgery, including things like blood clots and other postsurgical problems; dural leak. You can have a delayed dural leak that can happen anywhere between immediately postoperative all the way up to a year or so. You can have delayed infection, blood clots in your legs, and -- and these types of things, including neurological progression.

So, in that year of time, that's a period

of time where we want to be as vigilant as we possibly can be about any potential complications that have come from the surgery.

Q Doctor, by the way, when you went inside and visualized and looked inside Chris Yesnick's back, is that the best way to actually see what is occurring in that back?

MR. COHEN: Objection, your Honor.

THE COURT: Overruled.

A Yes, that's -- I mean, that's the best way to know exactly what you have going on in there. Everything else that you get up to that point in time is really -- it's really secondhand information.

Q Is that better than an MRI?

A Yes.

Q Why?

A Well, I mean, there's nothing like being there. There's no substitute for being there. An MRI is just a computer recording signal changes in the water content of your tissues. So think about it: that's -- that's almost third-hand information. It's very good for telling us -- confirming -- our physical diagnosis and telling us whether or not there is something very strange going on.

So the two indications for an MRI are to confirm the diagnosis that we've already suspected, given

a history and a physical examination, and to rule out what we call occult pathology, like a tumor or something that might be responsible for his symptoms.

But the best way to judge the structure and function of what is happening is to touch it and feel it and play with it, if you will.

Q Now, you didn't prescribe chiropractic care for Mr. Yesnick in the past, when he was under conservative treatment, but now you're suggesting it for the future. Why?

A The treatments that we do preoperatively versus postoperatively try to center around different things and there are different treatments that are better or worse for different things.

When we're looking at chronic pain or long-standing pain, there are certain things that are very good for that. As I mentioned before, what's called an RF-4 muscle stimulator is very good for chronic, long-term pain.

Chiropractic care is very good for chronic, long-term pain.

Hydrotherapy is good, as well, because it alleviates the effects of gravity and decreases wear and tear. That gives you more traction to what you've already done surgically.

So there are different types of treatments that you would prescribe based upon where you're encountering that patient; are they preoperative treatments and therapies or are they postoperative treatments and therapies? And then we balance that with what the patient needs. So it can be very different, depending on where you are, in the time frame of where that patient is in relationship to surgery.

Q Is that also why you did not prescribe hydrotherapy presurgery and now you're prescribing it -- you will prescribe it -- after he reaches maximum medical improvement?

MR. COHEN: Objection to the form, Judge.

THE COURT: Overruled.

A Yes.

Q Now, you mentioned that these modalities are good for chronic long-term pain. What is that?

A That's pain that's going to be with you, basically, for the rest of your life.

Q And is that something that he has to look forward to?

A Yes.

MR. DOMAN: Thank you.

THE COURT: Nothing else, counsel?

MR. DOMAN: No, Judge.

Proceedings

THE COURT: Anything else, Mr. Cohen?

MR. COHEN: No, nothing.

THE COURT: All right, thank you very much.

Thank you, Doctor.

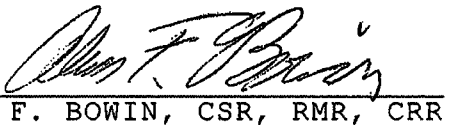
THE WITNESS: Okay, thank you.

(Witness excused.)

(Continued on next page.)

* * *

CERTIFIED to be a true and accurate excerpt transcript of the proceedings.



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Official Court Reporter