SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: CIVIL TERM: PART: 46

----------X

RODERICK MANNING, GABRIEL COOK and NORA COOK,

Plaintiffs,

-against-

Index No. 111701/04

TISHMAN CONSTRUCTION and SILVERSTEIN PROPERTIES,

Defendants.

----------X

TESTIMONY OF RODERICK MANNING

71 Thomas Street
New York, New York 10013
June 3, 2010

B E F O R E:

THE HONORABLE LUCY BILLINGS,
J U S T I C E

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

SACKS and SACKS, LLP
Attorneys for Plaintiff
150 Broadway
New York, New York 10038
BY: JOSEPH CARFORA, ESQ.

WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER, LLP
Attorneys for Defendants
150 East 42nd Street
New York, New York 10017
BY: MICHAEL W. COFFEY, ESQ.
ROSE M.J. CHARLES, ESQ.

Eric Allen, RPR
Official Court Reporter

DR. A. MEROLA / PLAINTIFF / DIRECT

THE COURT OFFICER: Jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Good afternoon, everyone.

Thank you once again for your patience. I assure you that the time you were kept waiting was hopefully time that is going to -- time well spent to make the trial run much more efficiently and take up less of your time this afternoon.

Plaintiff is now ready to call another witness?

MR. CARFORA: Yes, your Honor.

THE COURT: Go ahead.

MR. CARFORA: Dr. Andrew Merola.

THE COURT: Good afternoon, Doctor. I am Judge Billings.

Raise your right hand.

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

THE COURT: Have a seat.

Doctor, I don't know if you have testified in trials before, but there are a couple of rules.

One is you really have to keep your voice elevated at all times. I want you to shout all the way back to the last juror and to the people that are sitting back there.

attorneys say, "I object," please just stop your testimony and I will decide whether the question is permissible before you can continue; okay?

THE WITNESS: Yes.

THE COURT: Go ahead.

MR. CARFORA: Thank you, your Honor.

DIRECT EXAMINATION BY

MR. CARFORA:

Q Good afternoon.

A Good afternoon.

Q Are you a physician duly licensed to practice medicine in the State of New York?

THE COURT: Sorry, Doctor, would you spell your name? Andrew is the first name?

THE WITNESS: Yes, Andrew, last name Merola, M E R O L A.

THE COURT: Thank you.

Sorry, go ahead.

Q Are you a physician duly licensed to practice medicine in the State of New York?

A Yes, I am.

Q When were you licensed?

A 1992.

Q And what is your educational background?

A My background is that I attended New York University for my undergraduate studies. From there I went to

Howard University College of Medicine in Washington, D.C. After that, I did a residency in orthopedic surgery at SUNY Downstate Medical Center in Brooklyn and after that I did a spinal surgery fellowship at the University of Colorado in Denver.

Q And what is your current position?

A Right now, I am an associate professor of orthopedic surgery at SUNY Downstate in Brooklyn, New York and I am also on the faculty at New York University.

Q Had you been on the faculty or affiliated with St. Vincent's Hospital?

A Yes.

Q When was that?

A That was from the time of my residency up until the hospital closed in April.

Q Of this year?

A Correct.

Q And what was your position there?

A I was an attending spine surgeon at St. Vincent's Hospital. I was also an assistant orthopedic professor at New York Medical College.

Q Are you board certified?

A Yes, I am.

Q In?

A Orthopedic surgery.

Q And what does that mean, to be board certified?

A Board certification is a process that you

undergo after you finished your education and training. Basically, it's an examination. It's a two-part exam. The first part is taken after you finish your residency. It is a written examination.

And after you pass that and proceed into practice, after you have been practicing for two years, you collect all of your surgical cases and then you sit before the orthopedic board that then examines you on those surgical cases and asks you oral questions about your practice. And then when you pass both parts, you are board certified.

Once you are board certified, you are recertified every ten years by taking another examination and going through another exam process.

So, I have been board certified for over ten years so I have just been recently recertified two years ago.

Q And affiliations, are you affiliated with any societies?

A Yes, I am.

Q What is that?

A So I am affiliated with the American Academy of Orthopedic Surgeons, of which I am a fellow. Also, the

Scoliosis Research Society, the New York State Society of Orthopedic Surgeons and the New York State Medical Society.

Q Do you teach?

A Yes, I do.

Q What do you teach?

A I teach orthopedic surgery.
Q And have you written any books?
A Yes, I have.
Q On what subjects?
A Orthopedic surgery and, specifically, spinal reconstructive surgery.
Q What is the practice of orthopedics?
A Orthopedics is that practice of surgery that deals with problems with your musculoskeletal system; that is, your muscles, your bones and your joints.
Q I want to show you what's been marked as Plaintiff's Exhibit 6 for identification.

Can you tell us what this is.

THE COURT: I assume that's stipulated into evidence.

MR. CARFORA: I'm not putting it into evidence.

MR. COFFEY: I have no objection.

THE COURT: Just make sure there is no objection before you show the models or diagrams or whatever you have.

Q Let's back up a second.

THE COURT: Exhibit 6 is admitted for demonstrative purposes only.

MR. CARFORA: Thank you, your Honor.

Q Do you deal with injuries to the spine?
A Yes.
Q And Roderick Manning became a patient of yours

back in '04; is that correct?

A Yes.

Q And so what we are dealing with in this case is the spine; correct?

A Correct, yes.

Q And for demonstrative purposes, can you explain to the jury the different parts of the spine and what composes it?

A Sure.

So, what we are looking at is a model of the human spine. At the top of the model is the base of your skull, or the bottom of the top of your head.

At the bottom of this model is your pelvis connected to your hip joints and the top part of your leg bones.

And the spine sits in between your head and your pelvis and your legs. The spine is made up of multiple bones and the bones in the spine are called the vertebra. Each one

of the bones is represented as this white -- as a white block and they range from your cervical spine, or your neck. There is the thoracic spine or the upper portion of your back. There is the lumbar spine, or your lower back.

And in between each of the bones is what's represented here as a plastic, clear -- relatively clear plastic cushion, known as the disc.

So, in between all of the bones of your spine

lie the discs of your spine, and these discs act like shock absorbers. They help to hold the bones together and they help to hold your spine in an appropriate position so that it can support your head over your pelvis, or your waist.

The front of your spine contains the vertebral bodies and the back of the spine contains a canal, and that's an opening within the vertebral bodies through which the spinal cord and the nerves pass.

And the spinal cord and the nerves then go into your arms and your legs. So, the nerves that are coming out of each particular portion of your spine go into your arms and your legs and are responsible for controlling the actions of your arms and your leg as your brain sends signals to those nerves to tell them what to do.

Q What represents the nerves on that model?

A On this model, the nerves are represented by what appear to be yellow wires coming out of the spine on both

the right and left sides.

Q Does something have to affect those wires or nerves to cause pain to the arms and legs?

A Yes.

Q And what could cause that?

A Anything that causes irritation to the nerves or the spinal cord will produce pain, which we say radiates or goes into your arms and/or your legs.

Q When we talk about a herniated disc, what are we talking about?

A The disc -- if you think about the disc as a structure, the disc is very much like a jelly doughnut. There is an outer covering to the disc -- that's like the pastry of the jelly doughnut -- and the inside of your disc actually contains a jelly-like material that we call the nucleus propulsus. It is a very spongy, resilient flexible core to the disc.

And when we speak about a herniation, what we are saying is that that center jelly-like, what we call nuclear material, has come outside of that pastry covering. So if you took a jelly doughnut, put it on the table and then crushed it and the jelly came out of the doughnut, that would be a disc herniation.

Q Is that represented on the other side, even though that may not be the right level?

A Correct. On this model, it is represented as a red excrescence or a red protrusion coming off of the disc. So, it's material, it's disc material that is irregularly outside the confines of the otherwise oval disc.

Q And what happens when that touches a nerve?

A This material actually does two things. Number one, it contains certain chemicals inside of it that have -- that are irritative. These chemicals, when they come into contact with a nerve, produce nerve irritation because those chemicals belong on the inside of the disc and not outside the disc and they actually produce an irritation to the nerve and

can thereby produce pain.

The other thing is that because this material doesn't belong inside the spinal canal, the nerves want to be free in that canal. This material also produces some pressure on the nerves and that touching of the nerves or that pressure of the nerves also produces irritation to the nerve.

Q Does this material dry up when it protrudes?

A The -- when we say drying, the medical term for drying is desiccation. The material itself can dry, or become desiccated, or a disc can dry or become desiccated. And what we mean by that is all of our bodies are made up of water and there is water in every piece of your body and every particular tissue of your body and that water content can either be a high content of water or a low content of water. And so, in

relative terms, desiccation means a low water content or drying of a particular body part or disc.

Q Once that occurs, the drying or herniation, can the body repair itself?

A The body is not very good at replacing water into a tissue that has lost water. So, that reparative process or the process of rehydrating, or putting water back into something that has dried itself out, does not typically happen to a normal human body.

Q In addition to nerve pain or radicular pain, is there mechanical pain, as well?

A Yes.

Q What's the difference?

A When we say -- when we talk about nerve pain, we talk about a radiculopathy, which means pain in the distribution of a nerve. "Radic" is just the Latin term for nerve, and radiculopathy means problem with a nerve root, and that differs from what we call mechanical pain or mechanical axial pain. That is pain that you have in your neck or back area and that mechanical pain can come from an injured disc or an abnormal disc because the disc, as I said previously, is responsible for controlling normal motion in between the bones of your spine. And if that motion is abnormal, you are going to generate pain.

The disc itself also contains some very tiny

little nerve fibers, very much like little hairs. And if the disc is damaged, those nerve fibers in the damaged disc, can also produce pain. So the disc can produce what we call mechanical axial pain or, that is, neck or back pain, because of abnormal motion and because of irritation of the small little nerves that are actually within the disc itself.

Q And did you explain to us the different parts of the spine?

A Yes --

Q The cervical --

A The cervical, thoracic and the lumbar.

Q Fair enough.

By the way, you have testified on behalf of your patients in court on previous occasions; is that correct?

A Yes.
Q In fact, you and I had consulted on a number of cases; would that be a fair statement?
A Yes.
Q I want you to assume that Mr. Manning went to the St. Vincent's emergency room and was referred to you by someone at that emergency room. Is that unusual?
A No. That's actually -- that is a usual occurrence.
Q Are patients referred to you by other ironworkers?

A Yes.
Q And has my firm, on occasion, referred patients to see you?
A Yes.
Q Now, you are compensated for your time; correct?
A Yes.
Q To be here in court?
A Yes.
Q What is your compensation?
A $650 per hour.
Q And you're compensated for any report that you would do; is that a fair statement?
A Yes.
Q And you have your own patients, as well; correct?
A Correct.

Q How many patients do you see per week?

A In a typical week, I have office hours three days a week and I usually see about 40 to 45 patients per office hours, so probably 120 to 125 patients per week.

Q What do you do the other two days?

A The other two days I am in the operating room, so I will be operating on patients those other days.

Q How many spine surgeries have you done, would you say?

A I have been doing spine surgery for about 15 years now and I do about 200 to 225 cases a year, so over 3,000 cases.

Q And these are patients of yours; correct?

A Correct.

Q What is the typical treatment for someone who has an injured spine and, specifically, a herniated disc? I mean, do you do surgery immediately?

A No.

Q How does that work?

A Typically, what we like to do is when a patient has an injury to their neck or their back, we try to decrease those things which are causing pain. So, we spoke about the inflammatory or the irritative effect of these chemicals that can leak out of discs and the pressure effect that these discs may have on nerves.

So, when we treat the injuries, we try to do

things that limit those effects or decrease them from happening. For example, activity modifications: If you modify your activities to decrease the stress and strain on your back, you will decrease the mechanical component of irritation. If you start to take an anti-inflammatory medication, you can block the chemical signal from those leaking chemicals. So, things like physical therapy and anti-inflammatories are very important when you are treating these types of injuries.

Q What about epidural injections?

A An epidural injection is another way of delivering an anti-inflammatory medication to the area of injury, and that is also an important part of treating this type of a problem.

Q So if you had a patient with chronic back pain, you would treat that patient over the course of time, you would use those modalities that you just told us about before surgery would be discussed; is that a fair statement?

A Yes.

Q Now, these modalities, do they fix the problem?

A No.

Q Why not?

A They are treatment. And what we mean by "treatment" is we are doing some type of intervention to limit the problem that an injury is causing. You can't reverse an injury once it has happened. You can never put it back together exactly the way it was before it was injured. It's very much like Humpty Dumpty: All the king's horses and all

the king's men couldn't reassemble him, but you can treat a problem. And that treatment is designed towards limiting the effects of the injuries, and that's the basic principle behind treatment.

Q And if those modalities are used on -- by the way: Is it important for a patient to come for office visits?

A Yes.

Q In other words, if someone was hurt in 2004, you wouldn't see that person once and then say come back five years later.

A Correct.

Q Because the clinical analysis is important; would that be a fair statement?

A Yes.

Q Because patients have good days, bad days?

A Yes.

Q Now, someone with chronic back pain due to an injury, who goes through all of those modalities and does not have any relief, what's the next step?

A The next step -- at that point in time, when we say "chronic pain," we are talking something in excess of about six months or so. And once you have exhausted what we call your conservative care and management treatment, then you start to think about a surgical solution or a surgical treatment for the problem.

Q And are there cases where there is just no point

in having any more physical therapy?

A Yes.

Q Why is that?

A Physical therapy, in terms of being able to make parts of your body compensate for the injury, like core

strengthening and physical therapy modalities to decrease the pain, can only go so far towards treating a particular problem. And if that problem hasn't gotten better within about six months' worth of time, which is what we would consider chronic, the chances of success after that are exceptionally small.

Q Can physical therapy make it worse?

A In some cases it can, yes.

Q How about epidural injections; does there come a point in time where you stop giving those?

A Yes.

Q And for the same reasoning?

A For exactly the same reasoning, correct.

Q Now, the surgery that you are talking about would be spinal surgery; correct?

A Yes.

Q Is that guaranteed to cure the problem?

A No.

Q Now, I want to step back for a second.

You talked about radiculopathy. I just want to be sure that we understand that. If someone is complaining of pain, numbness, tingling running down their legs, is that considered radiculopathy?

A Yes.

Q Is that consistent with a herniated lumbar disc that's pressing a nerve?

A Yes.

Q Why is that? Why would a nerve in your back affect your legs?

A Because the nerves that are in your back travel into your legs.

For example, the sciatic nerve travels all the way down your leg into your foot and it's responsible for sensation in your leg and foot, it's responsible for moving the muscles in your leg and foot, it's responsible for feeling sensation on the skin that goes down your leg and it's responsible for the reflexes that happen in that leg. So, that root, that nerve root travels down your leg. So, radiating pain that travels down into the leg follows what we call the distribution of the nerve root.

Q And so each disc level has a corresponding distribution; would that be a fair statement?

A Yes.

Q Is it an exact science or -- does it have to be a specific point on your leg or...?

A There are some -- there is some overlap to the distributions. And the levels depend upon, for example, how large the herniation is. So, if we're talking about herniation between the L5, for example, and the S1 level, we're looking

at, basically, two nerve roots there; the L5 nerve root and the S1 nerve root, depending on the size of the disc herniation.

In some cases, the herniation can be so large that it actually migrates up to another level and it can produce symptoms at even a higher level than that. But, in general, you are looking at the nerve roots that run next to the area or the level that you are interested in where the damage is.

Q Now, let's go back to the surgery for a second.

Correct me if I am wrong, but if someone has chronic radiculopathy, that's an indication that the nerve is affected and causing pain; correct?

A Yes.

Q When you do a back surgery, is it to relieve the nerve pain, the mechanical pain, both, or how does that work?

A It's a little bit of both and it depends on what type of an operation you are doing. And the operation that you perform also depends on what we call the pathology or the problem that exists.

Removing the pressure, the primary reason to take it off is to actually prevent the nerve from getting worse, so that's the primary reason to do something.

Q What happens if the nerve is continually damaged? Does something happen?

A Sure.

The nerve -- if you think about the nerve like a telephone cable, inside that nerve it has small little subcables inside of it. And each one of those little subcables

is responsible for a different thing. One little cable feels pain; one feels touch; one moves a reflex; one moves a muscle. Each one of those fibers is susceptible to damage in a different way.

The fibers that feel sensation, or produce numbness if they are damaged or produce a reflex or move a muscle, are very sensitive to damage. Once they have been damaged, it's very hard for that damage to ever be reversed or recovered. So, you want to prevent those fibers from being damaged as much as you can, particularly if you have evidence that they are continually being damaged. Because over time, the more damage you have the weaker that nerve will get and eventually it will affect the muscles and the sensation and the reflexes of that nerve.

Q So you could do a spinal surgery, alleviate any further nerve damage, but the patient can still be left with mechanical pain?

A Yes.

Q Now, Mr. Manning, is he a candidate for spine surgery?

A Yes.

Q Why?

A Mr. Manning has a chronic problem, so it's been going on for much more than six months. He has had conservative care and management including medications,

physical therapy and epidural steroid injections. He has what we call radicular pain, radiating pain, so we know he has nerve root pain, and that nerve root pain is confirmed by imaging studies which tell us and correspond to the levels of pain that he has.

So, based on that, he is what we call a surgical candidate. He is indicated for surgery based on his failure of conservative care and management.

Q And what type of surgery -- do you have an opinion, with a reasonable degree of medical certainty, as to what type of surgery he needs?

A Sure. The location -- the nature and the location of the herniation and the type of nerve compression that it's causing is in an area that would require what we call a laminectomy and a fusion.

Q Can you show us on this model what you are talking about?

A Sure.

(Exhibit 6 displayed.)

A So if we look at this model, and we have to go all the way down to the bottom of the model where the lower back meets the pelvis, and it meets the pelvis at a portion of the back called the sacrum. It's this triangular bone that's here inside your pelvis. The lower back has five vertebral bodies or five bones. They are numbered 1 through 5.

DR. A. MEROLA / PLAINTIFF / DIRECT

Q What is this level that we are talking about?

A The level we are talking about here is between the fifth or L5 and S1 or the first portion of the sacrum.

Q I want you to assume that he complains of hip pain, as well. Is there any correlation to that level and having hip pain in addition?

A Yes. In many ways, as you can see, the hip is attached to the pelvis and the sacrum. And the lower portion of the back, where it attaches to your pelvis and your sacrum, can produce what we call mechanical axial pain in your lower back, and this portion of your lower back can also produce buttock pain and hip pain.

Q Sorry I interrupted you.

I think you said -- you were saying the levels and I think you were going to say about the laminectomy.

A Right.

Now, so, there is a herniation between the L5 and the S1 segment and that herniation, that disc material that is herniated is inside the spinal canal in the area where the nerve root is that descends into the leg.

He has a herniation that is centrally located and a portion of it is off center. And that portion that is off center is in an area where the joint of the spine is, the lumbosacral joint between the L5 and the S1 segment.

In order to completely and entirely remove that

disc material and the pressure off the nerve root, you actually also have to do what is called a transforamanil or through-the-nerve-hole decompression. And the way you do that is you remove the joint that's in that segment.

Now, once you have removed that joint, you actually surgically create an unstable situation, so you need to do something to stabilize the bones in that area and the procedure you do to stabilize those bones is called a fusion, and that involves the insertion of rods and screws into the L5 bone and into the sacral bone.

Q Does that immobilize that level?

A Yes.

Q So any movement, then, of the spine, after this fusion, occurs from the level of the fusion up, above the fusion; correct?

A Yes, correct.

Q Does that put more pressure on the spinal column?

A It does. On those levels that are above the area that you have fused.

Q Do you have an opinion, with a reasonable degree of medical certainty, as to whether or not Mr. Manning will have chronic pain in the future if he does not have the surgery?

A Yes.

Q And why is that?

A That is -- given the track record that he already has, we know he has chronic pain. We know also, from his imaging studies and his treatment records, that that herniation has gotten worse over time and it's going to reasonably continue to get worse and enlarge.

Q And just so I am clear, the rods and screws would go from what level to what level?

A From L5 to Sacral 1.

Q And that's really -- is that the pivot point of the spine?

A That's the lower -- what we call the lumbosacral junction or the connection between the lower part of your spine and your pelvis.

Q What is the recovery from that?

A There is short-term and long-term recovery from this.

The short-term recovery from this is it's about a three to four-day stay in the hospital, whereby after surgery there is a physical therapy process that you undergo. When you cleared that physical therapy process and are up and walking around, you can be discharged home, and that averages somewhere around three to four-days. That's the short-term recovery.

Long-term recovery is continued physical therapy and healing of that surgical site.

The fusion, itself, takes about a year to mature, so your body is healing the fusion site and putting

bone into that area that you have locked together for up to a year. So, the fusion healing process is at minimum of a year.

Q I have two questions for you.

You know he is an ironworker; correct?

A Yes.

Q You have treated many ironworkers?

A Yes.

Q You are familiar with what they do?

A Yes.

Q Do you have an opinion, with a reasonable degree of medical certainty, as to whether or not Mr. Manning can return to ironwork if he doesn't have this surgery?

A I do, yes.

Q And what is it?

A That he cannot return to ironwork without the surgery.

Q Do you have an opinion, within a reasonable degree of medical certainty, as to whether or not he can return to ironwork if he does have the surgery?

A I do, as well.

Q And what is that?

A That undergoing the surgery to prevent further neurological deterioration also will not put him back into a

category where he can go into ironworker status.

Q Either way, can he work, whether he has the surgery or not? Is there other kind of work that he can do? What would you recommend?

A He would be able to do some type of nonstressful work, work that would fall under the category of decreasing stress and strain on the spine which would avoid things like lifting, repetitive motion, bending, twisting; those types of things.

Q Would you recommend that he drive a commercial truck all day?

A No.

Q Would you recommend that he drive a bus all day?

A No.

Q And for the reasons you stated?

A Correct, yes.

Also, driving happens to set up what we call a vibratory cycle that's not good for your disc. So, in addition to the reasons that I have listed, there is a vibration cycle from use of repetitive machinery and/or driving that would not be advisable.

Q So whether he has the surgery or not, you would not advise that as a profession for him?

A No.

Q Fair enough.

Let's talk about degenerative. What do we mean by degenerative changes to the spine?

A Sure.

Q And maybe we will use the model again.

A Fine, sure.

(Exhibit 6 displayed.)

A It as an interesting term, the term "degenerative," because degeneration is something that we all experience on a daily basis.

The discs and the bones and the joints -- well, specifically the discs are made up of collagen. And, in a very similar way, they are made up of the same type of collagen that your skin is made of. When we talk about degeneration, it's very much like the wrinkles that you see on your skin as the years go by. The reason that happens is that the collagen fibers that are in your skin start to dry up a bit -- that process of desiccation that we talked about -- and that loss of water causes degenerative changes.

Q Is that normal over the course of your life?

A Correct. That is a normal process. That is what we call the process of senescence, or the normal typical aging process.

Q Is that a debilitating thing?

A No. That's part of the normal senescence process of your body.

Q Let's talk about severe degeneration. If you had severe degeneration of your spine, would you expect to find osteophytes, spurs; things of that nature?

A Sure.

Q Quickly explain.

A A severe degenerative process -- so a mild degenerative process is that process whereby you start to lose

water from the tissues in your body that contain water, like the collagen in your skin.

A severe degenerative process would involve your body trying to stabilize the degenerative process, and that's why you form what are called bone spurs.

So, older people have a tendency to develop pretty bad arthritis in their knees and hips and in their hands and elbows. And if you look at those joints, they appear to be swollen or larger than normal joints. That swelling that you see are bone spurs. Your body is actually putting down extra bone to try to stabilize that joint to prevent it from hurting. So, a severe degenerative process in the spine or any of the other joints that you have produces these bone spurs.

Q Would you expect a 43-year-old ironworker, who has been an ironworker since he was 19, to have degenerative changes?

A Yes.

Q Which are normal; correct?

A Correct, yes.

Q Now, we are talking about a disc, which is the doughnut, as you explained to us, and then there is bone. And if you want to look at bone, do you use an X-ray or an MRI?

A If you want to look at bone, you would use an X-ray.

Q Would an X-ray show osteophytes, spurs; things of that nature?

A Yes.

Q If you want to look at a disc or soft tissue damage, you would use an MRI; would that be fair?

A Yes.

Q Now, I want to show you what's been marked in evidence as Plaintiff's Exhibit 4, which is the St. Vincent's certified hospital record.

I want you to assume that when the accident occurred on August 5th, 2004, paramedics came to 7 World Trade Center, took Mr. Manning to St. Vincent's Hospital. This is the emergency room record.

Can you just tell us what his complaints were in the emergency room?

(Witness handed exhibit)

A Sure.

So, the emergency room assessment, when he was in there, were that he complained of right shoulder pain, right

hip pain and low back pain.

Q Now, did they or did St. Vincent's -- or I guess I will tell you they did -- did they take an X-ray of his lumbar spine?

A Yes, they did.

Q And as we just talked about, an X-ray would show whether or not he had severe degenerative changes in the form of osteophytes, bone spurs or things of that nature; correct?

A Yes.

Q Can you read to us what it says in regard to the

X-ray findings of his lumbar spine?

A Sure. Lumbar spinal examination full result and impression is unremarkable examination of the lumbar spine.

Q Does it talk about the disc spaces?

A The report indicates there is minimal disc space narrowing at L5-S1.

Q What does that mean, "minimal disc space narrowing"?

A When you are -- since you can't see the disc on the X-rays since they are made out of soft tissue and the X-ray looks at hard tissue like bone, what you can see is the spaces between the bones. So when the radiologist reports minimal disc space narrowing, what he is doing is he is comparing the size of all of the spaces in between the bones that are on the film. And minimal disc space narrowing means that it's not

quite as high, there is not quite the thickness to the disc space that the other discs have.

Q So what would "minimal" mean?

A "Minimal" would mean a very mild discrepancy between the other disc spaces.

Q Would that be normal for a 43-year-old ironworker?

A Sure, yes.

Q Is there any indication of any type of severe degenerative changes to his lumbar spine?

A No.

Q Is there any mention anywhere in there about osteophytes, spurs or anything like that?

A No.

Q And would they put that in there if that's what they found on the X-ray?

A Yes.

Q That's important, right, for the technician to put in?

A Yes.

Q Is there any indication on that X-ray of any prior injury to the spine?

A NO.

Q Now, did you bring your file with you, Doctor?

A Yes.

Q Let's just go to your notes for a minute.

And just so we can clarify for the jury, he saw you initially; correct?

A Yes.

Q And then at some point, he saw a couple of your partners for his other complaints; is that fair?

A Correct.

Q And then you are aware that he went back to Texas?

A Yes.

Q And he saw Dr. Jarolimek?

A Yes.

Q And when he was back working in New York, he saw

you again; correct?

A Yes.

Q And he saw you in December of 2009, as well?

A Yes.

Q So let's look at your first note.

Did you take a history?

A Yes.

Q What was the history?

A The history was that he came into the office after sustaining a fall on August 6th of 2004, with injuries reported to me, including his neck, low back, hips, right hip worse than left, with low back pain, as well; treated in the

emergency room at St. Vincent's Hospital.

Q Did you do a physical exam?

A Yes.

Q Did you examine the cervical spine?

A Yes, I did.

Q And when we say "cervical spine," we are talking about the neck; right?

A Correct.

Q What was your finding with regard to the cervical spine?

A He had a diminished cervical spinal range of motion with a positive compression maneuver.

Q Meaning?

A A compression maneuver is whereby you put

pressure on the top of the head when you are examining the neck to test whether or not the pressure that you put on the top of the head produces what we -- pins, needles, numbness or tingling going into the arms or legs.

A positive test would be when we compress the neck, you get the pins and needles, numbness.

Q So what does that mean, if that's positive?

A That's an indication of nerve root irritation in the neck area.

Q And how about the lumbar spine?

A The lumbar spine also demonstrated a decreased

range of motion; what is known as a positive spinal failings maneuver.

Q And right above that I think you say here "the gait"?

A Yes.

Q "Bilateral heel to toe reciprocal although antalgic." What does that mean?

A "Heel to toe reciprocal gait" means the way you walk, and that means that you don't have any serious nerve deficits to your legs. If you had a bad nerve problem, for example, the nerve that moves your foot up and down, you have what we call a dropped foot gait. If you had a problem with the nerve that moves your knee, you would have what we call the lock knee gait.

So, there are different ways you can walk to assess the neurological status of the patient.

"Heel to toe reciprocal" means that neurologically the lower extremities are intact. Antalgic means, though, that there is a limp and the limp happens because of pain in the legs.

So, the gait pattern that he had was a lower-extremity pain-related gait pattern.

Q And you have other partner doctors at your office; correct?

A Yes.

DR. A. MEROLA / PLAINTIFF / DIRECT

Q Who is Dr. Bhram?

A Dr. Bhram is an orthopedic surgeon who specializes in arthroscopy of the hip and hip injuries.

THE COURT: Do you have the spelling?

THE WITNESS: B H R A M.

Q And a Dr. Touliopolous?

A Yes.

Q What does he specialize in?

A Dr. Touliopolous is a sports orthopedic surgeon who specializes in shoulders and elbows, knees and ankles.

THE COURT: Can you spell his name?

THE WITNESS: Sure. T O U L I O P O L O U S.

Q I see the next note from your office I think is Dr. Bhram's note of the same day, 8/9/04.

A Let's see.

(Witness perusing.)

Q Here, let me show you.

A 8/9/04, yes.
Q Did you refer Mr. Manning to Dr. Bhram?
A I did, yes.
Q For which part -- for which injury?
A The hip.
Q And did you refer him to Dr. Touliopolous for the shoulder?
A Yes.

DR. A. MEROLA / PLAINTIFF / DIRECT

Q And so you were going to focus more on the spine?
A Correct. Fair enough.
Q And briefly, does he complain about his right shoulder on that same day to Dr. Bhram?
A Yes.
Q Now, was he referred for MRIs?
A Yes.
Q Of what parts of his body?
A Lumbar spine.
Q What about the cervical?
A He eventually did end up with MRIs of the cervical spine, as well, yes.
Q I want to show you what's been marked as Plaintiff's Exhibit 7, which is an MRI report of the lumbosacral spine dated 1/18/05, which is in evidence based on stipulation between the attorneys; correct?
MR. COFFEY: Yes.
Q Is that a report of the MRI?

A Yes.
Q What are the findings?
A This is an MRI on January 18th of 2005, Roderick Manning, and the findings are a desiccation, central herniation of L5-S1 extending to the left side.
Q And is that consistent with his complaints to

you on 8/9/04.
A Yes.
Q And your findings: The lumbar compression maneuver -- I might be mixing it up, but your findings in regard to the lumbar spine?
A Yes.
Q The antalgic gait?
A Correct.
Q I want you to assume that on August 5th, 2004, while at work as an ironworker, he fell from the 28th floor to either the 27th or 26th floor -- we're not quite positive -- 15 to 18 feet and landed on his right side.
Do you have an opinion, within a reasonable degree of medical certainty, as to whether or not that is a competent-producing cause of his herniated lumbar disc?
A Yes.
Q And what is your opinion?
A That it is a competent producing cause of the disc herniation of the lumbar spine.
Q Would that be based, in part, on the X-ray from

St. Vincent's, your findings and --

A Yes, correct.

Q By the way, if you had a centrally located herniated disk that was causing pain in your hip and your leg and an antalgic gait, would you be able to work for 40 hours a

week as an ironworker without knowing it?

A No.

Q Would it produce pain?

A Yes.

Q I want to show you an MRI film of the same date that's in evidence as Plaintiff's Exhibit 5 in evidence.

MR. CARFORA: By stipulation between counsel; correct?

MR. COFFEY: Yes.

Q Can you show the jury what the film shows?

MR. CARFORA: Your Honor, is it all right if they kind of move up for one minute?

THE COURT: Yes. If there are members of the jury who want to step up closer to the shadowbox, feel free. Or you can come down in front of the railing, if you like.

(MRI image displayed.)

A So, this is an MRI of Mr. Roderick Manning that was done on January 18th of 2005 at MRI On 11th.

These are multiple side views of the lower back. And so what we are looking at are slices through the lower back. And what we see -- the squares are the bones and in

between the squares are the discs. And behind the squares and the discs is a white stripe. This white stripe represents the spinal canal and this is where the nerves are that go down into

your legs.

So, if we count the bones in your lower back -- 1, 2, 3, 4 and 5 -- that's the last bone of your lower back, L5. The bones that are below L5 are the sacrum. That's the part of your pelvis that we spoke about before at the junction between your low back and your pelvis. And we are looking at the disc between L5 and S1 and we can see that disc is not quite like the other discs.

And it's not quite like the other discs for two reasons. Number one, it's not the same color as the other disc. It's dark. The other discs are light colored or gray. The reason this disc is dark is it is desiccated. It has lost water so it's not as hydrated. It's not as full of the water as the other discs are, so it appears to be dark, and that makes it different.

The other thing that we see is that the disc, if you look at the spinal canal area, the spinal canal area contains some disc material. And because that disc material is outside the confines of the actual disc itself, it is herniated. And it is herniated into the spinal canal, which is the area where the nerves are that then go down into your legs, so this is a herniation of the L5-S1 disc with nerve root compression because it's in the spinal canal touching the

nerves that go down into your legs.

Q And will that cause pain?

A Yes.

Q Will it cause pain only on movement or even if you don't move?

A This will cause -- its location and the fact that it is putting pressure on those nerves will produce constant pain.

Q Thank you.

THE COURT: All right, let's just take a break until five minutes to four for all the members of the jury and anyone else.

Doctor, you may also step down. Please return at five minutes to 4 and please do not discuss your testimony with anyone in the meantime.

(Whereupon, a short recess was declared and taken.)

THE COURT: All right, we'll bring the jury back in.

THE COURT OFFICER: jury entering.

(Whereupon, the jury entered the courtroom.)

THE COURT: Have a seat, Doctor. You are still under oath.

MR. CARFORA: Thank you, your Honor.

DIRECT EXAMINATION BY
MR. CARFORA (Continued)

Q Doctor, I want to show you what's been marked

DR. A. MEROLA / PLAINTIFF / DIRECT

into evidence as Plaintiff's Exhibit 8, dated 7/20/07, which is another MRI of the lumbar spine, which counsel and I have stipulated to going into evidence.

MR. CARFORA: Correct?

MR. COFFEY: So stipulated.

Q Doctor, can you take a look at that and tell us if there is any difference between the '05 MRI of the lumbar spine and the '07 MRI of the lumbar spine?

THE COURT: Sorry, this is Exhibit 7?

THE COURT OFFICER: 8.

THE COURT: 8.

A July 20th of 2007, Roderick Manning, MRI lumbar spine. The MRI -- the MRI demonstrates an increasingly worsening herniation at L5-S1.

Q It also indicates, I think, stenosis?

A Correct.

Q Is that something that he didn't have on the first MRI?

A Actually, he did have it on the MRI. Stenosis is a -- it's a narrowing, so that narrowing can be caused by the multiple reasons, and in his case, the reason for the narrowing is the herniation.

THE COURT: Narrowing of?

THE WITNESS: The spinal canal.

Q It says "completely occludes." What does that

mean?

A That indicates that the herniation has gotten larger.

Q Is that typical of a herniation?

A That is typical of a post-traumatic disc herniation over time for Mr. Manning, yes.

Q Post-traumatic as opposed to...?

A A degenerative change.

Q Do you have an opinion whether, with a reasonable degree of medical certainty, his herniation is a traumatically induced herniation?

A Yes.

Q And your opinion is?

A That it is.

Q Now, I want to show you, just quickly, the MRI of the cervical spine dated 12/5/05 --

THE COURT: The MRI report?

MR. CARFORA: Report.

THE COURT: Is this a different exhibit?

MR. CARFORA: Yes. Plaintiff's Exhibit 10. Which counsel and I have stipulated to go into evidence; is that correct?

MR. COFFEY: Yes.

THE COURT: The date again?

MR. CARFORA: 12/5/05.

DR. A. MEROLA / PLAINTIFF / DIRECT

THE COURT: Thank you.

MR. CARFORA: Cervical spine.

Q What I really kind of want to look at is the impression. Can you read that to us?

A (Reading): Impression: 3.5 millimeter central disc protrusion with annular tear compressing the cervical cord at C5-C6.

Q What do we mean by "annular tear"?

A A tear is a rip. It's as though you would tear a piece of paper, so it's torn or ripped.

Q Is that consistent with his complaints to you and your examination of his cervical spine?

A Yes.

Q Do you have an opinion, with a reasonable degree of medical certainty, as to whether or not falling 15 to 18 feet can cause an annular tear?

A Yes.

Q Is that a traumatically induced injury?

A Yes.

Q Is there anything else of significance on that MRI report?

A No.

Q Now I want to show you -- by the way --

THE COURT: When you -- is this the only page that's going to be admitted into evidence or what?

MR. CARFORA: No, both pages, your Honor.

THE COURT: Both pages but not the top page?

MR. CARFORA: No.

THE COURT: All right, so you will remove that?

MR. CARFORA: Yes.

Q Does that disc and tear cause pain?

A Yes.

Q Then I want to show you what's been marked as Plaintiff's Exhibit 9 in evidence, which is a 2007 MRI report of the cervical spine, which counsel and I have stipulated goes into evidence.

MR. CARFORA: Correct?

MR. COFFEY: Yes.

Q Is there any significance to this later cervical MRI?

(Witness handed exhibit)

A Yes.

Q What is it?

A This MRI demonstrates that the herniation at C5-C6 continues to be present with spinal cord and nerve root compression, and that there is adjacent segment herniations, as well; that is, also at C4-C5 and at C6-C7.

Q Is that different from the first MRI?

A It is progressively worse than the first MRI.

Q Now, do you have an opinion, with a reasonable

degree of medical certainty, in regard to the herniated lumbar

disc, whether or not that condition is permanent?

A Yes.

Q What is your opinion?

A That it is permanent.

Q In regard to the cervical herniation, tear and herniation, do you have an opinion, within a reasonable degree of medical certainty, as to whether or not that condition is permanent?

A Yes.

Q And what is it?

A That it is permanent.

Q And let's go to your -- now, you are aware -- Doctor, you are aware that in addition to that, he has a shoulder injury; correct?

A Yes.

Q And I want you to assume that prior to the date of the accident he never had a problem with his shoulder, he never had a problem with his neck -- let's just stick with the shoulder.

He was working as an ironworker since the age of 19. He never had treatment for his shoulder. On the date of the accident, he fell 15 to 18 feet and landed on his right side, which I assume includes the right shoulder. Do you have an opinion, with a reasonable degree of medical certainty, as

to whether or not that was the competent-producing cause of his shoulder injury?

MR. COFFEY: Objection.

THE COURT: Grounds?

MR. COFFEY: Based on your Honor's prior discussion with counsel about the limits of this witness.

MR. CARFORA: He is right, your Honor. I withdraw it.

Q All right, let's go to your last note, which I believe is December 14th of 2009.

THE COURT: Do you have Exhibit 9 there?

MR. CARFORA: Yes.

(Court handed document.)

THE COURT: Thank you.

Go ahead.

Q Did you do a follow-up visit with him?

A Yes.

Q Give us a little bit of the history.

A Mr. Manning was in Texas, where he underwent treatment with Dr. Lubor Jarolimek.

Q What were his complaints to you on this day, if any?

A Sure. Neck pain, low back pain, right hip pain and right shoulder pain.

Q Unable --

A Inability for him to bend, lift, twist, push, pull, stoop, crawl, sit or stand for prolonged periods of time.

Q Did he indicate anything about the pain in his

lower back?

A Progressively worsening low back pain.

Q Are these complaints consistent with your clinical examinations, the history of the accident, the X-rays, the MRI films, his complaints, your examinations; is this all consistent?

A Yes.

Q You examined him on this date, physically examined him; correct?

A Yes.

Q Can you tell us about his gait?

A He had a Trendelenburg gait pattern.

Q What is that?

A The Trendelenburg gait pattern means that there was a drooping of his pelvis as he walked, and that is a secondary to a hip problem.

Q Spasm; what is spasm?

A Spasm is a charley horse, and when you palpate for spasm, you can actually feel the muscle contract and it becomes hard.

Q Is that an objective finding?

A Yes.

Q As opposed to subjective?

A Correct.

Q Was there any atrophy?

A Yes.

Q To where?
A Right side deltoid.
Q Where is that?
A That is the shoulder on the right side, top of the shoulder.
Q What does atrophy in the shoulder indicate to you?
A "Atrophy" means that the muscle on the top side of the right shoulder was smaller than the one on the other side.
Q Less use?
A Yes.
Q Would you expect that from a dominant arm?
MR. COFFEY: Objection, your Honor.
THE COURT: Sustained.
Q Well, do you have an opinion --
MR. CARFORA: You're right. I withdraw it. I apologize.
Q At that point, did you discuss surgery with him?
A Yes.

Q Under what circumstance? Did you tell him, did he ask you; what?
A Well, basically, we discussed surgery, particularly given the fact that his low back pain was getting worse over time; that he had failed conservative care and management and that at this point in time he was basically at the end of his rope with respect to other options.

Q Is there a risk with a laminectomy and a fusion?
A Yes.
Q What are the risks?
A The risks of surgery for this particular procedure include the risk of anesthesia, blood loss, infection, something called a dural leak. You need to move the nerves out of the way. And those nerves are being compressed by disc, so the nerves or the covering of those nerves can leak. That is called a dural leak.

There can be the requirement for a transfusion, depending upon how much blood is lost during the surgery. You can have medical complications from the operation such as a blood clot or what we call pulmonary embolus, which is the traveling of a blood clot from your leg to your lungs; stroke, heart attack and blindness. Those are the major potential complications or possible complications.

Q What about paralysis?
A Paralysis is a possibility, as well, yes.

Q You have treated many patients who are construction workers; correct?
A Yes.
Q And who have been injured on the job?
A Yes.
Q Would it be fair to say that everything you want to do for them you have to get approval for?
A Yes.

Q And would it be fair to say that approval sometimes takes a very long time?

MR. COFFEY: Objection.

THE COURT: Sustained.

MR. CARFORA: No further questions. Thank you.

THE COURT: Cross-examination?

MR. COFFEY: Yes, your Honor.

CROSS-EXAMINATION BY

MR. COFFEY:

Q Good afternoon, Doctor.

A Good afternoon. How are you?

Q Good. How are you?

A Good, thanks.

Q How many of these fusions have you done in your career, about?

A Quite a bit, so 15 years --

Q What's "quite a bit"?

A Neck and back surgeries, in the neighborhood of about 3,000.

Q 3,000?

A Yes.

Q So it is a pretty common procedure?

A For me it is, yes.

Q So 3,000 of them. And how many years have you been doing this?

A Fifteen.

Q So you got about 3,000 people out there on the

street that you have done these procedures for?

A Yes.

Q And now when is the last time that he went to see you?

A Last visit with me was December 14th, 2009.

Q Five and a half months ago?

A Correct.

Q And he hasn't come to see you since then?

A That's correct.

Q And so that was almost half a year ago?

A Correct. December of 2009.

Q Did you send him for any more MRIs at that time?

A No.

Q Did you take any X-rays of him at that time?

A No.

Q So, as far as you are aware, he hasn't had that surgery in those five and a half months since then; correct?

A Correct.

Q What else did he tell you? Did you talk to him about it when he was there with you?

A About what?

Q About what he has been up to in those five and a half years -- withdrawn.

When is the last time before that he went to see you?

A The visit before December of 2009 was February

of 2005.

Q And how long is that about?

A Between 2005 and 2009? Approximately, I guess, three-and-a-half years or so.

Q Did you talk to him at all about what he had been up to since then?

A Yes.

Q And what did he tell you?

A That he was treating in Texas with the physicians there.

Q Did he tell you anything else? Did you have any other discussions that are in your records?

A He had right shoulder reconstructive surgery done in Texas; being treated for his neck, his shoulder, his

low back, his hip and then we had our surgical discussion.

Q How much have you been paid in total since you have been working on Mr. Manning's case, about?

A I haven't been paid.

Q Well, you haven't been paid for treatment with him back in 2004-2005?

A Are you saying about reimbursement for visits or --

Q Yes.

A It's what's called -- there is an insurance reimbursement for each visit, so the initial visit and his follow-up visits would be somewhere in the neighborhood of -- I'll tell you how many visits in a second. Hold on.

(Brief pause.)

A Probably about $425.

Q So for your orthopedic care to date for him, it's been about $425?

A Correct.

Q Now, you said you get paid about $650 an hour?

A Correct.

Q How many hours did you take to review the file?

A Half an hour.

Q And then you met with Mr. Carfora?

A Yes.

Q And how long did you meet with him?

A Half an hour.

Q So that's it. You have got one other hour of time before this for $650?

A Correct.

Q And you are being paid today how much?

A 650 per hour.

Q Per hour. When did the hours start? When you left your office or how did it work?

A No. This afternoon at, I guess, we are starting at about noon or so when I got downtown.

Q So now we'll go over to Sacks and Sacks. Is it fair to say that you have testified the last three years in court for Sacks and Sacks about three times; is that fair to say?

A Yes.

Q Would you be surprised to see a Jury Verdict search on you would show that almost every time you have come to court it's been on behalf of a plaintiff?

A No, I would not be surprised.

Q How many times did you testify in court on behalf of plaintiffs who are your patients?

A Usually about four to five times a year.

Q And how many years have you been doing it?

A Coming to court? I want to say somewhere in the neighborhood of about -- maybe about six years or so.

Q Six years or so?

A Yes.

Q And some of the other cases you have testified for Sacks and Sacks you have also been part -- you have also been part of a team with Dr. Missun, Dr. Kinkade; do you know who they are?

A Yes.

Q And you have testified in other cases where they have been witnesses, as well?

A Yes.

MR. CARFORA: Judge, they have -- sorry, never mind.

THE COURT: Was that an objection?

MR. CARFORA: No. Withdrawn.

Q Have you testified in other cases with them, as well?

A Yes.
Q And also you testified in other cases for Sacks and Sacks with Dr. Root?
A Correct, yes.
Q Do you know who he is?
A Yes.
Q And about how many times have you testified in cases with Dr. Missun?
A I can't recall off the top of my head.

Eric Allen, RPR
Official Court Reporter

Q More than ten, fair to say?
A I don't believe so.
Q More than five?
A I couldn't give you an exact number.
Q How about Dr. Kinkade?
A Once again, I couldn't give you an exact number.
Q But it's been more than once; is that fair to say?
A I would say more than once, yes.
Q Same with Dr. Root?
A Yes.
Q Now, in addition to testifying in court, you see some of -- you see other patients that haven't been in court, other Sacks and Sacks clients who are also patients of yours?
A Yes.
Q How many is that over the years? Maybe more than 50?

A I wouldn't be able to tell you what the exact numbers are.

Q More than 25?

A I would say over all of the years that I have been in practice, most likely over the number of 25, yes.

Q And how many of their clients or how many of your patients that are also represented by Sacks and Sacks have you performed surgeries on? More than 25, probably?

A Well, in the number of years that I have been doing surgery and the amount of surgery that I have done, I would have to say more than likely over 25.

Q So it's also fair to say, then, that for their clients who are also patients of yours, it's a fairly common to do some of these fusion procedures; is that fair to say?

A I would say for a spine surgeon it's fairly common to do spinal surgery, yes.

Q Let's talk about "fairly common." The L5-S1, you called that the fulcrum? A fulcrum joint? I think that was your term; is that fair to say?

A I think I said junction.

Q What's a junction joint?

A A transition from one segment to another.

Q Isn't that -- when you perform fusions throughout your career, wouldn't that be the most common area that you perform fusions on, the L5-S1?

A L4-L5 is, in many ways -- can in many ways be ore common than 5-1. 4-5 and 5-1 are commonly treated levels.

Q And also for people who are involved in manual labor, that's a common area to see herniations; isn't that correct?

A It can be, yes.

Q And that's due to the repetitive stress on a daily basis in the duty of heavy manual labor; isn't that correct?

A It can be, yes.

Q And that's also common for ironworkers to have degeneration in that area from years and years of working as ironworkers; isn't that correct?

A Yes.

Q Now, is it fair to say that ironworking speeds up the degenerative process in backs?

MR. CARFORA: Objection, your Honor.

THE COURT: Sustained.

Q Now, in the common population, how prevalent are herniations? Are you familiar with any of those studies, Doctor?

A There are studies discussing herniations. Actually, there are studies discussing MRI abnormalities in the general population.

Q And it's fair to say that a large portion of people over 30 years old would have herniations; is that correct?

A It depends on what age group we are talking

about.

Q Over 40; large percentage of the population has herniations, fair to say?

A You can't clump it into herniations. The studies that we have done looked at what we call MRI

abnormalities and we broke them up into desiccation; desiccation, bulging, stenosis, so there were separate subcategories to their findings.

Q You are also familiar with the Harvard Medical study on herniations?

A Yes.

Q And in that study, doesn't that study also say that after a year, one-third of the herniations, approximately, will go away, one-third of them will stay the same size; are you familiar with that study a little?

A Yes. But go away -- I don't think "go away" is the actual technical term they used, so it depends on what your outcome measures were for the herniations. And it also depends on what is known as the ideology or the cause of the herniations.

Q But it's fair to say that a percentage of them do decrease in nature over time; correct?

A A percentage can decrease in time, yes.

Q And that was with the Harvard Medical study did opine in the conclusions; correct?

A Correct.

Q Now, you are not board certified in radiology;

is that correct?

A That's correct.

Q So who would be in a better position to read

films; you or a board certified radiologist?

A I would be.

Q You would be?

A Yes.

Q Please explain that.

A Absolutely.

I have an opportunity to not only read the films, but examine the patient and operate on patients. A radiologist essentially reads a film but never has an opportunity to clinically correlate a film so they never examine a patient and they have never operated on a patient. So, I can actually see the pathology not only on film, but in real life and actually feel, touch it and see it with my own eyes and hands.

So, in terms of reading films in my specialty, orthopedic reconstructive spinal surgery, I am actually better at reading those films than a radiologist.

Q Right, okay.

So your testimony would be that if I bring in a board certified radiologist, you are still in a better position to testify as to films than she is?

A Absolutely.

Q Okay.

Now, is a history important?

A Yes.

DR. A. MEROLA / PLAINTIFF / CROSS

Q Why is a history important, Doctor?

A A history tells us before what is going on, how it happened and what's going on with the patient.

Q Now, when Mr. Manning went to your office -- let me ask you one other thing:

Do you base your prognosis and your conclusions on histories?

A A history is a part of what we call the office visit or the examination, so a pertinent history is important in helping us to determine what the problem is and what we can do about it.

Q So what would a pertinent history typically include?

A A chief complaint, which is pain, and the nature of that pain, and factors that aggravate or alleviate it or describe it in some way.

Q Do you ask about any prior surgical intervention or any prior accidents or anything such as that?

A Yes.

Q Did you get an intake form for Mr. Manning when he went to your office?

A Yes.

Q And what did he say? Do you have it with you?

A I do have his prior history.

Q What do you have down as prior history?

DR. A. MEROLA / PLAINTIFF / CROSS

A He had a left Achilles tendon repair.

Q Other than that, did he have anything else?

A Hypertension.

Q Did he have down, in 1993, a motor vehicle accident?

A Not that I can see, no.

Q Have you heard at all, from talking with anyone in the last day or so here, that he had a 1993 motor vehicle accident or is this the first time you are hearing of it?

A I don't recall a '93 motor vehicle accident.

Q Okay, so you don't know one way or the other what would have happened to Mr. Manning in 1993 if he was involved in a motor vehicle accident; correct?

A But I do know his work history since then.

Q Okay, so what work history do you have?

A He was a full-time, full-duty ironworker.

Q From what years?

A From up until he was injured. From an early age, as we had seen before.

Q And do your records show anything after that or no work history after the accident?

A As far as I know, he did try to get back to work after the accident. In fact, I believe he tried to get back into the workforce, perhaps driving a bus or some other vehicle, so I do know that he did try to go back to work after

the injury.

Q And you heard that from Mr. Carfora in the last day; isn't that far to say, Doctor?

A No. Actually, I remember speaking to Mr. Manning when he had come back to see me in Manhattan.

Q But it's nowhere indicated in your notes; is it?

A It wasn't really pertinent to whether or not that would influence a decision to perform surgery on him.

Q It wouldn't have been relevant to know that he went back and started to -- and worked at all at ironwork? That wouldn't be relevant to you that he worked a thousand hours in 2006 to 2007? That's not relevant?

A More relevant would be his progressively worsening condition.

Q Well, wouldn't it be relevant because that could have been one of the causes why the 2007 cervical and lumbar MRI showed a progressively worsening herniation? Couldn't that have been caused because of that?

MR. COFFEY: Don't shake your head, Mr. Carfora. That's okay.

Q Isn't that why?

A Not if he was able to continue working.

Q But you don't note that anywhere in your records, Doctor?

A Correct.

DR. A. MEROLA / PLAINTIFF / CROSS

Q So it wasn't significant at all?

A It's is not significant in terms of making a decision about whether or not he requires an operation.

Q Isn't it more fair to say that you only heard about that because that was the testimony Attorney Carfora told you about that? Isn't that more fair to say, Doctor?

A Is that a question or --

Q Yeah, it is a question, actually.

A So I am not sure I understand that question.

Q Isn't it fair to say that you heard that that was the testimony that was talked about; is that fair to say?

A I am not even sure I know that that was the testimony that was talked about.

Q Well, you did talk to attorney Carfora about this. You didn't explain pleasantries for a half hour; isn't that correct?

A Correct.

Q And when the jury took a break today, you two did speak today, so you weren't exchanging pleasantries the whole time; is that fair to say?

A Actually, he told me he was going to try to get me out of here this afternoon.

Q So you talked nothing about the case?

A Not between when we were talking about you saying we shouldn't talk about it, no.

Q Okay, now, how about when you met for half an hour?

A Yes, we did talk about the case.

Q Did you talk about how the trial was progressing at all?

A No.

Q Not one bit? Not one question about that?

A In terms of trial progression, no.

Q Now, where in your -- so in your history, there is no mention that he had had a stiff back after a 1993 motor vehicle accident; is that mentioned anywhere in your history?

A No.

Q Is it mentioned anywhere in your history that he underwent physical therapy in 1993? Is that mentioned anywhere?

A No.

Q Now, is it mentioned anywhere in your history that he went back for a period of time driving a bus?

A No.

Q And you talked about -- what did you call it -- a vertebral shaking or something?

A Vibration.

Q Vibration.

A Correct.

Q Would that have impacted his back in any way,

A It can produce pain, yes.

Q Would going back to work for over a thousand hours between 2006-2007, in any way, as a full ironworker, have injured his back in any way?

A It can also produce pain.

Q Well, if he had -- let me go back to this: You did talk about that the -- that there would be some nerve pain. So if that pain -- if it was that bad back then, he wouldn't have been able to work at all, isn't that fair to say, in a heavy capacity as an ironworker?

A It would have been difficult for him to do that, yes.

Q So I want you to assume that there was testimony from the head of the union that there was no such thing as light-duty ironworking in New York City. So, that being said, if the herniation was that bad, he would not have been able to work as an ironworker; is that fair to say?

A It would have been very, very difficult for him to do that, yes.

Q But you weren't there with him also on a daily basis; is that fair to say?

A Correct.

Q So you don't know if when he lifted any of these hundreds-of-pound loads, if his back jerked --

MR. CARFORA: Objection, your Honor. There is no testimony that he lifted "hundreds-of-pound" loads.

THE COURT: Sustained.

Q Do you know if he injured his back on the jobsite in those six months and over thousand hours?

A Not as far as I know. I have no history of any injury reported subsequent to this fall.

Q Now, before you came here today, those years you first saw Mr. Manning again in 2009, did you review any of his records from 2006, 2007, 2008 and 2009 up until the time he went to see you?

A Yes. In fact, one of the things he did was when he came in to talk to me about his lower back, he did bring the treating records from Texas and the majority of our conversation revolved around what his options were or were going to be regarding his lower back.

Q Did you review any of his films back then?

A Yes.

Q Which films did you review back in 2009?

A In 2009, we had the lumbar spine MRI film and we also reviewed the films that were done in Texas, particularly the -- as far as I recall, the neck and the back.

Q Now, the laminectomy and fusion, isn't the purpose of it, as well, Doctor, both to stabilize and to reduce pain?

A It's -- yes, stabilization and to ameliorate some of the pain that he is having, yes.

Q Because it's fair to say you have done over 3,000 times. People wouldn't come to you if it didn't do

something for the pain; is that fair to say?

A That is correct, yes.

Q And you don't tell people, well, it will only reduce a little bit of your pain; is that fair to say?

A Actually, we go over a pain scale and it depends on where they lie on the pain scale in terms of pain reduction. It also depends on how chronic or long standing the problem is.

Q Did you give him any prescriptions at the time for pain medication?

A No.

Q Did you give him prescriptions for any orthopedic devices?

A No.

Q You are talking about X-rays and what X-rays do and don't do. It's fair to say MRIs are much more reliable than X-rays for discs; isn't that correct?

A For looking at disc pathology, yes.

Q Because you said that is why you use MRI's. You are not saying that the X-ray does -- is the gold standard for discs; are you saying that?

A No, I am not.

DR. A. MEROLA / PLAINTIFF / CROSS

Q Now, what is the difference between "acute" and "degenerative"?

A That's interesting. One is a temporal relationship and the other is a description of a process. So, "acute" means soon or quickly, and "degenerative" is a process.

Q Now, it also says -- back in the January 18th, 2005 MRI, it talks about the narrowing being congenital; isn't that correct? That's not degenerative; isn't that fair to say?

A I believe the reference is to congenital canal narrowing of the lumbar spine, yes.

Q So congenital is not degenerative. Congenital is what you are born with; correct?

A That's right, yes.

Q So you did use the word that it was a degenerative narrowing. It actually said a congenital narrowing in the report itself; did it not, Doctor?

A No, I don't think I said degenerative narrowing.

Q You did actually. That's why I wrote it down.

A I think we said he had degenerative changes with desiccation.

Q But the narrowing was congenital.

A He had a congenital narrowing of his canal, which means that his canal -- if you look at his canal diameter, it's smaller than the general population's canal diameter.

Q Did you review any of Dr. Jarolimek's records as far back as August 24th of 2005? He had said that with respect to the lumbar spine, Roderick Manning has improved?

A I did see Dr. Jarolimek's records, yes.

Q And you are also aware that at points in time, Dr. Jarolimek did approve him to go back to work?

A Yes.

Q So do you disagree that Dr. Jarolimek should have never allowed him to go back to ironwork?

MR. CARFORA: Your Honor, objection. It's out of context. That's not what Dr. Jarolimek said. I didn't want to object, but it's out of context.

Dr. Jarolimek said --

THE COURT: It's also hearsay.

Sustained.

Q And moving forward, Doctor, you are not opining today that Mr. Manning cannot work in any capacity; is that correct?

A Correct.

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

MR. CARFORA: Just a couple follow-ups, your Honor.

REDIRECT EXAMINATION BY
MR. CARFORA.

Q The fact that he has congenital spine narrowing, does that change your opinion in regard to the causation of this injury from falling 15 to 18 feet?

A No, it does not.

Q The congenital spine doesn't -- didn't cause the herniation?

A Correct.

Q Are you aware of whether or not he was getting

pain medication from Dr. Jarolimek?

A Yes.

Q Is that why you didn't give him any?

A Correct.

Q When you talk about pain scale, is it 1 to 10?

A Yes.

Q So if someone has a 10 pain level and undergoes a spinal fusion and his pain level becomes 1 out of 10, is that something that's -- that you want to have happen to the patient?

A That would be wonderful, yes.

Q So it's not always 0; correct?

A Correct.

Q But it is a reduction in his pain level?

A Yes.

Q Now, we saw his X-ray from the day of the accident and you have already talked about that; correct?

A Yes.

Q And his MRI. And he did go back to ironwork, or tried to. Does that change your opinion in regard to the original injury from falling?

A No.

MR. CARFORA: No further questions.

MR. COFFEY: No further questions.

THE COURT: Thank you, Doctor.

I am going to give you back Exhibits 8 through 10 for you to eliminate, together with Mr. Coffey, the

pages that you don't want.

MR. CARFORA: The legal pages, you mean, yes.

THE COURT: All right.

Members of the jury, that concludes the evidence for this week. Thank you very much for your attention, your patience, your overall cooperation throughout the week.

Have a wonderful weekend. I know it may be tempting during a longer break to discuss the trial with your family or friends or others, but please do not do that. Please refrain from visiting any location you may have heard or seen any evidence about and please refrain from having any contact or communication with anyone involved in the trial.

Thanks again. Have a great weekend.

Eric Allen, RPR
Official Court Reporter

Doctor, you can step down.

See you 10 o'clock on Monday.

(Whereupon, the witness was excused and retired from the witness stand)

(Whereupon, the trial proceedings were adjourned to Monday, June 9th, at 10 o'clock a.m.)

Eric Allen, RPR
Official Court Reporter