SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS - CIVIL TERM - PART 64

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LUIS ALMONTE,

Plaintiff,

-against-

PEARSON CAPITAL PARTNERS, LLC, and CONGRESS BUILDERS, LLC,

Defendants.

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Index # 5382/13

TRIAL

360 Adams Street
Brooklyn, New York

June 22, 2018

B E F O R E:

HONORABLE KATHY KING,
Justice, and a jury.

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

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VANESSA DEL VALLE
Senior Court Reporter

gentlemen.

THE JURY: Good afternoon.

THE COURT: Firstly, the Court would just like to apologize. I know the Court represented prior to the lunch break that we would start promptly at 2. The Court thanks you for you getting back in a timely manner.

Due to, you know, due to matters beyond the control of the Court, there was a little delay, traffic delay with the witness, so that is the reason why we are a little bit behind. But I, and I tell you this because I want to emphasize that the Court, as well as the parties, appreciate you and your time. Okay?

JUROR: Okay.

THE COURT: So sometimes, what do they say, things happen.

(Whereupon, there was laughter in the courtroom.)

THE COURT: Okay. That being said, plaintiff, do you want to call your first witness?

MR. VARGAS: Yes, Your Honor.

Dr. Thomas Kolb to the stand.

THE CLERK: Raise your right hand, please.

D R. T H O M A S K O L B,

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

THE WITNESS: Yes.

THE CLERK: Take a seat, sir. Thank you.

State your name and your address clearly for the Court.

THE WITNESS: Dr. Thomas Kolb. 307 East 60th Street, New York 10022.

THE CLERK: Thank you, sir.

THE WITNESS: Thank you.

THE COURT: You may inquire, counsel.

MR. VARGAS: Thank you.

DIRECT EXAMINATION

BY MR. VARGAS:

Q Good afternoon, doctor.

Could you start out by telling the jury your occupation?

A Yes. I'm a physician. I'm a diagnostic radiologist.

Q And can you tell them your educational background?

A Yeah.

I went to college here at Queens College City of New York. Graduated a while back. Then went to Downstate Medical Center here in Brooklyn for medical school. Graduated in 1983. Then I did an internship and residency in the Bronx in pediatrics and became a pediatrician. Board certified pediatrician in 1986.

And then I went back, did another four years of training in radiology at Columbia Presbyterian Medical Center in Manhattan. Catching all the boroughs. And became board certified again in diagnostic radiology in 1990.

For the last many years I've been practicing diagnostic radiology.

Q Diagnostic radiology. What is that?

A It's using CAT scans, MRIs, x-rays, to mammograms, ultrasounds to look inside the body to see if there is a problem or not a problem if the patient is complaining of a symptom.

Q And you mentioned board certified.

Could you explain to the jury what board certification is?

A We have to first finish the number of years of training in pediatrics.

It was three years in radiology. It was four years in each area. You have to pass a written test and then pass an oral examination. A lot of testing. And if you pass everything and complete the study, you become a member of the American Board of Radiology. So you are board certified in radiology.

So that's what I did in both.

Q And you are licensed to practice in New York?

A I am.

Q And have you published any articles?

A I have.

Q And what are some examples of these articles?

A Well part of what I do is breast cancer diagnosis. May not have anything to do with today, but it's a part of what I do every single day.

I won the American Medical Association scientific publication of the year award. Paper I published over 27,000 consecutive women where I used mammograms, ultrasounds, physical examination to find how frequently these tests find or miss breast cancer.

It became a relatively important paper. That's the most important paper that I published. I published other papers as well. But I think that's the most important one.

Q And do you ever lecture?

A Yeah. I've lectured all over the world.

Q What are some examples of lectures?

A A lot have to do with breast cancer diagnosis. Taught many people, physicians mostly, breast ultrasounds, how to correlate it with mammograms young. Now we take for granted dense breasts. May have heard what dense breasts are. There are New York State laws, other states as well, require physicians to tell patients whether they're dense breasts or not.

All that information came from my research back

about, which started about 15 years ago. So, I have done a lot in that field.

In addition to doing breast imaging, I also read CAT scans, MRIs and x-rays every single day. Literally every single day. On many, many, many thousands of patients.

So there's two very separate things that I do every single day.

Q And, doctor, for your time to testify today, is my office compensating you?

A Yes.

Q And how much are we paying you?

A $8500.

Q Okay. And, doctor, at some point my office retains you to consult on this case and review some films of Luis Almonte; is that correct?

A Yes.

Q And could you tell us when that was?

A In October 2016 was the earliest time.

Q And when you were consulted, what did you review?

A I reviewed, a lot of x-rays of the lumbar spine I reviewed that were multiple dates in 2013, in 2016. As well as other dates. MRI of the lumbar spine of March 21, 2013. Another MRI of a lumbar spine. That's the lower back. The lumbar spine in 2016. March 31, 2016. A CAT scan of the

lower back on the same day, March 31, 2016. I also looked at studies of neck, the cervical spine. And finally I also looked at MRIs of the right hip from 2015 and 2016.

So that... in general gives you an idea of what I looked at.

Q And could you please explain to the jury some anatomy as far as when we are talking about the spine, the different parts as far as what a disc is and then --

A If we have a picture I will explain it. Show it to start. Maybe we will understand the picture together.

In the lumbar spine there are five bones. And you don't have to remember any of this. But just so we are on the same page now.

(Whereupon, there was laughter in the courtroom.)

A Just so we are on the same page when I explain something.

So in the lumbar spine there are five bones. And we will see that on the picture, label them one through five. Each bone is called L, for lumbar, one. Next bone is L2. Goes through L5.

After the L bones, the lumbar spine in your back, comes the sacrum, which is lower down (indicating). And the first bone is called S, for sacrum, one.

And so these bones are like little squares as

you'll see them, but in between the bones are the discs.

You may have heard problems with discs in the back, disc herniations, for example, which we will talk about. These discs are there in order to be like little shock absorbers. When you move around, twist, jump up and down, the bones don't touch each other. The disc are gelatinous, jelly-like in the middle. They compress a little bit back and pop back to the normal height. The bones here and here don't come together.

So we have the bones. Then we have the discs in between the bones. And if, can be easier when I show pictures.

There are, you would ask why don't these disc just spurt out if they're just there between the bones? What holds the disc in place?

Well there are ligaments that hold the disc in place. Ligament's very tough covering. Different types of ligaments you really don't have to remember. You, only thing you really have to know, the ligaments hold the disc tight to the bone.

So, and a major ligament, you may hear the term the annulus. It is a ligament goes around the whole disc and holds it in place.

Very important concept to know is let's say the ligament is torn. What happens? So, if the disc is here

(indicating), the ligament is here (indicating), on the side of the bone the ligament can be partially torn and bend back and the disc will come out a little bit like that (indicating), but that's called the disc bulge, because a bulge is a partial tear of the ligament. Not a complete tear.

What happens if there's a complete tear of the ligament? The disc will go through the hole in the ligament. That's a disc herniation. A disc herniation is a tear of the ligament and annulus, which is a ligament, and the herniated segment of the disc pokes through.

So you and I will both be able to look at disc herniations. Because if I tell you that any time the disc goes beyond the margin of the bone and looks like that (indicating), you know it's a disc herniation.

So normally all discs line up with the side of the bone and stop. If you see a disc going beyond the margin of the bone, you know that it's herniated. We will see pictures of that.

So, that's a little bit of anatomy.

The only other thing you have to know is what's so important about disc herniations and tears is because your back is actually a very small space like that. Your spine (indicating), it's very tiny. And actual measurements on the films which will show that the entire caliber of the

spine, the spinal cord comes out of our brain and goes down our back (indicating). And gives off nerve roots.

That's how the nerves get to our shoulder and neck in the lumbar spine, go to our feet, buttock, feet and legs. Very tight space. If it is a herniation pushing back on the sac, causes pressure on the nerve roots.

Any type of disc herniation may cause the patient to have symptoms such as pain. Such as pain that could radiate down a leg or pain that just stays in the buttock or stays just in the thigh or just back pain.

So, that's really, I think, all the anatomy you need to know for now until we see some pictures.

Q Before we show the pictures, doctor, could you explain the difference between MRIs, CAT scans and x-rays?

A So x-rays have been around for over a hundred years. They're naturally occurring. And we use x-rays as a beam that we shoot through the patient. Patient's not getting shot, just the x-ray beam.

But it's a very crude way of looking at things nowadays. Nowadays, because it tells the difference between the things that are hard and soft, if I were to take an x-ray of your back, I would see the five bones but I wouldn't see a disc, I would just see a space. I wouldn't see ligaments, I wouldn't see veins and arteries. I wouldn't see nerves. I would just see a space because all

those structures, the nerves, the ligaments, the discs are soft. And x-ray can't tell the difference between them.

When you get it, a CAT scan that also uses x-rays, but instead of taking one picture of the whole back, we take many, many, many, many, many thin pictures and we can see nerves and we can see discs. Not as great as we can see on an MRI as I'll get to, but we can see things a lot better.

CAT scan's a much better way of looking at a spine than a regular x-ray. If you were looking for lung cancer, took a chest x-ray, nowadays that's a crude way. Not a very effective way for looking for abnormality in the lungs. Same as the lung.

But if you do a CAT scan of the chest, you'll have a much better shot at finding abnormality. And same with the spine. MRIs done use x-rays. MRIs use magnetic rays. Magnetic waves. Which is the best way to tell the difference between these soft structures.

And you can see and you will see discs and ligaments and nerves. And the top of the -- bottom of the spinal cord. And you'll see all of that on MRI. You lie in a large tube, large magnetic field. The magnetic waves get pulsed into your body and the computer takes a picture of the reaction that your body has to these magnetic waves.

So, that's a much more effective way for looking for abnormalities.

MR. VARGAS: With Your Honor's permission, if the witness could step down to show the jury some premarked exhibits.

THE COURT: No objection?

MR. VAN ETTEN: No. No objection, Your Honor.

THE COURT: So moved.

MR. VAN ETTEN: Your Honor, while he does that, if I can go in the corner over there so I can see. Thank you.

MR. VARGAS: Set them up over here (indicating).

THE COURT: Yes.

MR. VARGAS: You want me to put it somewhere else?

THE COURT: No. That's fine. That's fine.

MR. VARGAS: Okay. I can move this back.

THE COURT: Yeah. That would be good.

MR. VARGAS: Like that. (Indicating) more?

THE COURT: Yeah. That's good.

MR. VARGAS: Okay.

Q Doctor, when you reviewed the films of -- these are some of the films that you reviewed, correct?

A Yes.

Q And it's a mixture of x-rays, MRIs, CAT scans; is that correct?

A Yes.

Q Okay. You picked up one of these. Do you know which one that is marked as?

A 6 A.

Q Okay. And if you could tell us what that is?

A So it's an x-ray of the lumbar spine from March 18, 2014.

The only reason I show it to you, because we were just talking about anatomy. Let's look at a regular x-ray of the back.

This is what our backs look like. Whether you are male, female, tall or short, we have the same anatomy. Especially one of these squares is a bone. This is the 5th bone (indicating), which is L5. L, for lumbar, five. Four, three, and two, and one. This here is S1. Different part of the spine (indicating).

So if I was to -- and look at the spaces between the bones, right? Between these squares are these, just the space that's where the disc is, you can't really see it on an x-ray. You can see it on an MRI and you will see it.

But just so we understand what we are talking about, the L4-L5 disc is here (indicating). The L5-S1 disc is here (indicating). And the L1-2 disc is here (indicating).

So just for the sake of being on the same page to

look at this picture.

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

Q Which one is this, doctor?

A This is 2 B.

So, this 2 B. This is the MRI of the lumbar spine done March 21, 2013. March 21, 2013. And there are a lot of pictures here. But the reason why there are a lot of pictures, because these pictures only this thin (indicating).

So we take a lot of pictures starting from one side, keep taking more picture, more pictures 'til we get to the other side. We are looking at the side of the patient just like this (indicating), right. It's those, you see that squares there, (indicating) but this is a picture of the entire back, one picture, and these are 14 pictures of the back. But it's all the same back on the same day.

So, you see our squares here (indicating), right? You see these squares? That's the same squares as here. This is enlarged. This is not the size of the real back. This is too small for the real back.

This is the way radiologists read things just to mark things. These are five, four, three, two, one and this is S1. So these squares are the same as these squares here (indicating).

So, but there is an MRI. And now look between the squares. So you see these little white or gray structures that are long? Those are the disc I told you. A disc is normal. It goes to the edge of the bone and it stops.

That's all you really need to know.

Let's take a level that's normal. Let's take this level up here, which is the very top of the spine (indicating). Here's a square.

I probably have to go closer. You have to look a little closer.

But here is a square. Here is a square. Look at the disc that comes out. It comes to the back of the bone, the gray square, and stops. Look at the white line behind the bone. That white line is spinal fluid, if you can see it.

When you do a spinal tap, you put a needle, take a fluid out. That's the fluid up here, the white line going up here.

MR. VARGAS: Your Honor, could he move it a little closer? Is that okay?

THE COURT: Sure.

Q I'll help.

A So, this white line going up here in front and back of this gray line is the spinal fluid. There is gray line coming down is part of the spine cord with all the nerves in

it. And from here (indicating) to here (indicating) is one inch. One inch this big (indicating).

From here to here from the end of the bone to the nerve roots in the spinal cord is much smaller than and much, much smaller than half an inch. Talking about really tiny spaces.

So this disc goes to the end of the bone and stops.

But let's take a look at a picture of the disc. That doesn't stop, right? Let's look here at 5-1. I will put an arrow there. Do you see there is a black space? That a black area that comes out beyond the margin of the bone here is the end of the bone here. Here is the end of the bone there.

And you see that there's black that goes beyond it. Forget about the other levels. We will get back to those.

But in this level here, each level here, look here (indicating). There is, and every picture here you can see it nicely, it goes beyond the level of the bone. That's because the ligament has torn and the disc is now through it.

If the ligament had not torn, it would look like this (indicating). Which is normal. This is the way we all should look.

So this particular patient has three disc herniations where the ligaments are torn. The largest one

is at L5-S1, five and one. This level here.

But look at 2-3, here, and look here at 3-4. Look inside there as well. On all of these pictures here you can see it really low. 2-3, 3-4. See how it looks different than up here where it's normal? The ones in the circles. That's because the ligament is torn and the discs are herniated. So this patient has three herniations.

Now the importance of that is that the herniations push on the sac. You see how this white line comes down. Pushed in this white line is the spinal fluid here is pushed in. That means it's causing pressure on the nerve roots that come down, also on the sides of the spine, which you have to look at three dimensional.

I will show you another picture in a second.

There are these here (indicating). There should be here. This is normal. Up here. Right there is no herniation. Up here there should be a white line goes down. That's fat and fluid. And inside that white line is a tiny dot. That's the nerve root coming out.

So what happens when you have a herniation is it pushes back on the spinal fluid and the sac, but it also pushes to the sides into the, what's called neuroforaminal, which are the holes contain the nerves. It doesn't look normal any more like this does. It looks pushed in here or here.

In fact, this dot right there, black dot, may have to come closer to see it, this dot right there in that circle is the nerve root. And this herniation at 5-1 is touching that nerve root on one side.

I will show you other pictures.

And right here (indicating) and here you can see it really well is the disc herniation pushing into. See this is normal. Put an N here for normal. That's the way they all should look, but they don't. They're pushed in most prominently at 5-1 and touching the nerve roots.

Two ways we can look at a spine. We can look at it from the side like I just showed you here, but also we can look at it from top to bottom.

And very quick analogy. It's hard to really grasp that quickly on a Friday afternoon.

(Whereupon, there was laughter in the courtroom.)

A If you had a long loaf of bread, you can cut it two ways. You can cut it long ways and make one big sandwich, a hero, right. That's what we are looking at here.

Taking the spine doing, cutting it from the side. Each picture is long. But you can take that loaf of bread and cut it from left to right and it wouldn't be one long sandwich. You would have multiple slices of bread. Slices of bread are not long like this. They're round or square,

but they're round.

So, look at those pictures here, which is 2 A --

Q Before you go there, doctor, when you did review this film, what did you, what were your findings, just so we are clear?

A The largest herniations L5-S1. Also herniations here pushed out here and here. That's 2-3 and 3-4. And this one you see 4-5 here really is maybe pushing, maybe not pushing out a little bit. That's a disc bulge. That's a partial tear. You can tell the difference.

Look at the difference between 4-5, the disc coming out to the edge of the bone and stopping, pushing out just a little, versus 2-3, 3-4 and 4-5 here. You can see it beautiful here. Here. These are pushed out and herniated at 2-3, 3-4, and 5-1.

And there are just, there is a disc bulge or partial tear at 4-5.

The herniation that we talked about, I already said to you 5-1 pushes on the sac and the holes that contain nerve roots.

So those are the major findings this study on the MRI of the lumbar spine on the first view.

Q And the next one.

A So the next one is 2 A.

So here we are taking the same spine on the same

day but each picture looks like this (indicating). Because instead of the bone, this is actually the bone, this gray, okay. This bone here is one of these bones here (indicating). L2. But here it's a square. Here it's round. Just like cutting the loaf of bread.

Whoever created this system was very smart.

So we take pictures from the side and up and down.

So, I told you already that the disc goes to the margin of the bone and stops. That's normal. So here is a bone, this is S1, and this is L5, and they look round, which is hard to kind of get in your brain because we cut them just like a loaf of bread.

And the disc I told you is between five and one was herniated. And you can see this gray area here (indicating). You can see how the bone is a dark gray line, but this disc material here pushes down. And it pushes on the sac that contains many small -- see those small little dots inside the sac with the white spinal fluid? Those are the nerve roots coming down.

If you look at... sorry. If you look at 2 B, you see the gray lines coming down the nerve roots? Well if I cut 'em like a loaf of bread, they look like dots. Each one will look like a dot.

So going back to 2 A, you see many little dots. I'll just fill in this one.

You can look at each picture here, here, here. There are a little on this one. And this one I'm not really obstructing anything. All those nerve roots go down and go to the buttocks, the thighs, the legs.

So here is a herniation that's pushing on the sac and it also narrows this, uh, hole with where the nerve root come to the left of the patient. It's the patient's left. That's the patient's right. A nerve root goes out to the left. It's the L5 nerve root.

You can see here the herniation is touching this little gray line right in here. And the herniation completely narrows the foramen here.

The bottom line, there are three herniations at L2-3, L3-4 and L5-S1. The herniation impinges on the sac that contains the spinal fluid. It narrows the neuroforaminal. Contains the L5 nerve roots impinges on the nerve roots at L5-S1. And to a lesser degree here is five, so this is four, and this is three, and two. 3-4 and 2-3 also come out and narrow, but not as much as 5-1.

Those are all the findings on this MRI.

Q And the next film, doctor.

A Well this patient, the next film is what happened to the patient is, just to jump forward to this, which is 3 A to move forward. This patient wasn't, I guess, responding to treatment; having pain and had to go on to have surgery.

So this is what surgery looks like in the spine. I showed you 6 A before surgery (indicating). This is after surgery, which is 3 A (indicating). Okay. You see the difference on the bottom between there.

There between 5-1 the metal, all the white there is metal. There are screws, now looking at 3 A, screws (indicating) in L4 -- sorry in L5 and S1. And you're looking at one picture of the whole back. But there's one screw in L5 on the left, and one in S1 on the left and one in, on L5 on the right, and another one at S1 on the right. They're connected by rods. Surgeon connects them by rods. These are the rods (indicating).

And the purpose of the surgery is to fuse the spine to not allow the patient to move (indicating). So when the patient bends, normally our spines go like that. When we bend forward and backward, this spine is now fused and doesn't move. All of the, um, bendability of the spine goes is above. Starts at 4-5, but this area is fused so that the patient shouldn't further herniate a disc herniation at 5-1.

You see these white dots here? One, two, three, four white dots. A couple more here. That is a disc stabilizer. The surgeon put that in there. I told you that the function of the disc to keep the bones apart because it would be bad if the bones touched each other. The surgeon created a disc to keep those bones apart, so that when the

patient walks and moves, those bones don't come together.

So this is what it looks like after surgery.

So, the patient had two more tests after surgery. This, what I just showed you on 3 A, done March 16, 2016.

On March, two weeks later, March 31, 2016 the patient had two other studies on the same day. One is a CAT scan. Just look at one picture. One is CAT scan on 5 B. On March 31, 2016.

And remember I told you that these squares here (indicating) are the bones. But now look what's happening at 5-1. This is the disc stabilizer. And if we go to -- we should be fine here. Here is a screw. Looks exactly like a screw. Really is a screw. This is the right side of the patient. Two screws. There are more pictures on 5 C.

This is the left side of the patient, (indicating) with two screws. On both sides. And the surgeon has fused L5-S1 to stabilize the level because it was unstable.

So that's what the CAT scan looks like.

And this is the MRI. Now that we have seen some MRIs. This is 5 A.

Q Doctor, when you reviewed this March 31, 2016, 5 B and C, what was your diagnosis?

A So, the reason that we do tests after surgery is to see if there's still a herniation or if it's gone.

This patient's herniation did not come back at 5-1

and at L2-3 and L3-4.

Since the patient wasn't fixed at those levels, they're still there. That was the finding on the CAT scan. And those were confirmed on an MRI of the same day, 5 A. And again here's an MRI which looks similar to the MRI I just showed you.

Each one of those boxes is five, four, three, two, one. And this level here as well was operated on right there (indicating). You see the screws better on the CAT scan, but here's the screws here on the right side of the patient, and here is screws on the left side of the patient.

Since we used magnetic waves and it's metal that's put in, there's a kind of more funky look because it's magnetic and it's metal. So, surgeons like doing both CAT scans and MRIs.

But the bottom line, you can see now that there really -- look how this white area here is not being pushed in anymore, but still being pushed in at 2-3 and the 3-4. The surgeon fixes 5-1, but still herniates at 2-3 and 3-4 and bulge at 4-5. So those findings are still there. Look, they were two years earlier and the patient had this level fixed.

Those are the findings on the MRI and the CAT scan after surgery.

Q And the next film.

A I think we finished the lumbar. There's one more of the most recent one -- no. Just one more, which is really 6 B. Which is from March 30, 2015.

Again it just shows you, I think the patient also had anterior fusion also. So this is back of the patient, this is the front of the patient (indicating). These are the screws we talked about. There's also another screw that the patient put in -- that the surgeon put in this way. Into the bone.

So the patient is not only fused from the back, but needed additional stabilization from the front. So this patient is now walking around looking exactly like this with all that. And that stays there unless there is a problem, which we don't have to go into now. This will stay with the patient for the rest of his life.

Q And the next film.

A So that's the end of the lumbar spine, right? But the next, the hip?

Q Yeah. The hip.

A Okay. So that's all lumbar spine.

So, the hip is another part of the body that we haven't talked about. On 1 B is July 2, 2015. And --

Q And before you go into the film, there's going to be discussion about labrum.

Could you describe to the jury what a labrum is?

A Just anatomy in the hip. So the hip is like a ball and socket joint. Like that (indicating). Right? When we move our hip, it's a ball that moves like that (indicating). It's a joint. That's called the ball and socket.

Again, there's a big round bone called the femur. That's our thigh bone. Comes to a ball here. And then there's another bone on top of it like the roof of the hip like that (indicating). And that's called acetabulum.

I told you that you can never have bone touching bone. That would be very bad. So between the femur and the head of the femur and the acetabulum is another piece of cartilage called the labrum. It's like a disc but not really. It functions like it 'cause it keeps the bones apart. The labrum is cartilage. We have that in all of our joints, whether elbow, shoulder or knee. All called different names.

The labrum is what separates this bone. Again it's gray from this bone. The labrum is cartilage just like in the knee. It's not that there are no herniations in the hip, no ligaments to tear in terms of being like a herniation. But you can tear the labrum just like you can tear a meniscus in a knee, just like you can tear cartilage in a shoulder. If you tear the cartilage in your hip, that's called labrum.

On this patient on this date --

Q Oh, what? I am sorry. Did you get the letter, number?

A Yeah. 1 B. July 2, 2015.

So the labrum goes like that (indicating). It is a semicircle, right, because our hip -- our femur comes up like I just showed you like a ball in a socket. You don't need the labrum to go all around. Only need to go around like a semicircle like that.

Let's say this is the hip, there are different parts of the labrum. This is the top of the labrum called the superior. There's the bottom called the inferior.

You don't have to know any of that.

The part of the labrum called the superolateral, superior and lateral, a lot of stress on this labrum normally.

In this particular patient, this patient tore the labrum. You'll see that there is an area of whiteness there that isn't there anywhere else. So there is a tear on this side of the labrum called the superolateral labrum. That's what that was. Really the main finding this patient had.

You see how it comes around very nice and thin like that and then there is a, comes here and then it pushes in. It's much wider. I will put arrows on (indicating).

I mean I think you can see that pretty easily, that piece of white in here is different than everywhere else.

So there's a tear of the superolateral labrum.

There's also other tears, just to be complete, there is a tear of a ligament called the iliofemoral ligament. The chondral, which is the cartilage around the labrum, is torn as well. There is a lot of fluid in the knee -- in the hip. Sorry. Fluid in the hip which is called joint effusion. Just to put those words in.

So those are the major findings of the hip.

Q Doctor, would an x-ray show a tear of the labrum?

A No. It would show the space.

Again, an x-ray of the hip will not show the labrum. You will see the space between the two bones.

Q How about a CAT scan through the labrum?

A A normal CAT scan, if it's a significant tear, may show it. We sometimes inject die into the hip and do a CAT scan, but we don't do that much anymore because we have MRIs. These show it really well. The MRI is the best test for this.

So I believe that this patient had their labrum fixed. Yeah. The patient had a labral repair in October 2015, which is five months -- four months after this. And had another MRI.

So, this MRI is like we take the bread, we slice it from side to side. Each picture is round. But if you want to look, this will make more sense to you now, we look at 1

A. Now you got a picture of when you can really understand.

Here's the hip. See the hip here. Here is the bone. Here is the head of the femur (indicating). This is the right side, this is the left side (indicating). This is the patient's pelvis. Here (indicating). You can see the right hip here. The bone. This bone on top of it is the acetabulum in between this bone, the femur, and this bone, is that thin curvilinear semicircle labrum. Here you can see it very nicely here.

See that thin semicircle. Remember there was some cartilage damage before, but now you get a chance to compare the right side of the patient to the left. Same patient, both hips.

So, if you compare the right to the left you see something very obviously different, right, and it's this (indicating). There's a white blob.

(Whereupon, there was laughter in the courtroom.)

A So it's obviously different. And this is where the patient had surgery and the patient has re-torn the superolateral labrum. There (indicating). You can see it's cut off. The labrum is supposed to be black. You can see there is a large area of whiteness here. This MRI was done March 24, 2016 which is about five months after surgery.

So, while they tried to fix this labrum, it's torn

again here (indicating). So you can see very nicely because you now can compare it to the left side.

And that's the major finding on this MRI of 2016. There's a torn labrum again, re-tore. There is chondral defect now in this fluid. Look at all the fluid in the joint. Look at this whiteness here. That's all effusion. That's water in the joint, which you don't see here (indicating). Here's fluid; here's just nothing.

So, look at this right hip versus this left hip. Much more obvious here on looking at this way. All this is a tear of a labrum. And fluid around it (indicating). Here, nothing. The left side. So the right side is torn, the left side is okay. This is after surgery.

Those are all the findings.

Q Thank you, doctor. You can take the stand again.

MR. VARGAS: Should I move that, Your Honor?

THE COURT: Yes, please. Thank you.

MR. VARGAS: I'll put it over here.

Q Doctor, I am going to ask you to assume that Mr. Luis Almonte, prior to March 5, 2013, was a healthy 56 year old man who, while working as a plumber, was caused to fall off a ladder and complained of pain and injuries to his right hip, neck and lower back. And subsequently following that -- or I am sorry. And before that he had been to the hospital back in 2012 with back spasms.

Do you have an opinion with a reasonable degree of medical certainty as to whether the herniations of L5-S1, L2-L3, L3-L4, the disc bulges of L4-L5, L1-L2, and the tear of the labrum are causally connected to his accident?

A Just to clarify, he had back spasms a year before?

Q Correct.

A Didn't have any x-rays that I'm aware of.

Q Correct.

A Didn't have MRIs or CAT scans.

Q Correct.

A Didn't have treatment. Ongoing treatment.

Q Correct.

A Went back to work.

Q Correct.

A Wasn't complaining of pain. Got in an accident.

Q That's correct.

A Then complained of pain. Had x-rays, CAT scans, MRIs and two surgeries.

Q Correct.

A So then the herniations in the lumbar spine and the tear of the labrum in the hip are then therefore related to the trauma. To this fall.

Q To the accident of March 5, 2013?

A Correct.

Q And would you consider those injuries, the

herniations, the discs bulges and the labrum tear to be permanent?

A Well they're permanent, but the surgeon went in and changed that ball game by fusing the spine and by fixing the hip. And even though it re-tore, all herniations are permanent. Once the ligament is torn, it's torn.

In this case the surgeon went in and tried to fix things. But the herniations that are still there at 2-3 and 3-4 will still be there. In fact, we have MRIs three years apart that shows the herniations are still there.

And by the way, you know, if it was caused by something else other than the fall, then you would expect an ongoing process to look worse and worse and worse every year. We don't have that. We have of the three year period. We have MRIs comparing '13 to '16, 2013 to 2016, showing that the herniations are still there. But with no change.

So, why would something just stop changing if they occurred without a trauma? In other words, it was the accident that must have caused, I mean just logically, caused herniations.

Q And, doctor, in the normal course of people aging, is it common for people to have disc herniations?

A Yes.

Q And would you consider Mr. Almonte's, the films that

you have reviewed, does he have age, appropriate aging of the subpoena?

A He does. There are some degenerative changes there.

The patient, I think, was in his 50's at the time of most of these pictures. So in our 50's it would not be surprising to see degeneration, aging changes due to the aging in the spine. That is correct.

Q Is it possible to have disc bulges and disc herniations but not have any symptoms?

A Yeah.

MR. VAN ETTEN: Objection, Your Honor. Sorry. Possible.

THE COURT: As to form.

Q Doctor, are you aware of people who have, or patients that you've had in general who've had disc bulges and disc herniations but no symptoms?

A Definitely possible to have disc bulges and herniations without having symptoms.

Q Why is that?

A Why is that? Could be the bulge or the herniation is not pressing on a nerve root causing enough pressure. But there are people walking around with herniations that don't have symptoms.

Q And is it also possible for a hern -- strike that.

Are you aware of patients who have disc herniations

and disc bulges caused by a trauma?

A Yes. Definitely.

Q And what is the difference?

Or can you explain why some people it's caused by trauma and why some people it's caused by age?

A Well just very simply. If you are in an accident or trauma, you can tear a ligament. If you can tear a ligament, you can have a herniation. But as we age, our backs are not the same as when we were 20 if we are 80. And what happens is that we degenerate and we form arthritic changes. Those can cause stress on the ligaments and cause them to tear, too. So you can have a disc herniation just by twisting your back a little bit. If you -- in any case.

So it doesn't have to be from a trauma. So it could be either or.

MR. VARGAS: No further questions, Your Honor.

THE COURT: Thank you.

Cross examination, Mr. Van Etten.

MR. VAN ETTEN: Yes, Your Honor.

CROSS EXAMINATION

BY MR. VAN ETTEN:

Q Sir, just going back real quick, the fact scenario for the episode you were given in May of 2012 was just spasms.

You said you are unaware of any films or anything

of that nature; is that correct?

A Correct.

Q Did you read the records from the hospital treatment of Mr. Almonte from at that time?

A No, I did not.

Q And are you aware of with the first sets of films that the doctors at Beth Israel Hospital referred back to the treatments for May of 2012?

A No. I don't have that in front of me. I'd be happy to read it but I don't know that.

Q So you did not review any of the prior medical records to see if there was symptomatic back pain before March 3 of 2013, correct?

A That is correct. Just what I'm told here.

Q Okay.

A That is correct.

Q So when you made your opinion of this being based on trauma as opposed to degeneration, it was based on the assumption that it was asymptomatic, correct?

A Yes.

Q Okay. So, if Mr. Almonte goes to the hospital and complains that while lifting pipe he feels a pop, not spasms, but a pop in his back, that would be something that you commonly get with patients coming in that have a traumatically induced disc, correct? Something pops in their

back?

A No. It's not actually the disc that's popping. Actually it's a muscle.

Q So the muscle pops?

A The muscle --

Q Because the weakness in the back?

A That's where the muscle --

MR. VARGAS: Objection. He is not letting him finish.

A That's where the muscle spasm is. It's a partial tear or pulling of the back, of the muscle in the back. The tear of the ligament where the disc goes through is not a pop.

Q And as a result of that tear he had to receive medicines for treatment. Are you aware of that?

A No. I wasn't told that.

Q So again, you don't have a full history of Mr. Almonte, correct?

A Correct.

Q Okay. And did you ever go back and ask Mr. Almonte had he ever been injured beforehand?

A No. I did not.

Q Okay. And you were asked in that original hypothetical with the assumption counsel asked you then to assume that Mr. Almonte, after the May 2012 incident, had

continued to go back to work?

A Correct.

Q That was the assumption you based your opinion on, correct?

A One of the assumptions. One of multiple. Yes.

Q Are you aware that Mr. Almonte actually didn't start working again, that we know of from the records that will be coming in, until some point in time in October of 2012?

A No. I don't know the dates. No. I don't.

Q Okay. Are you aware that leading up to this event in May there are multiple records from Beth Israel Hospital that say that he was not working?

Were you aware of that?

A Same. I don't know the dates and when he started working and when he stopped working.

Q Let's go then to what you looked at. All right.

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

Q By the way, you testified yesterday, correct?

A I did.

Q And that was in Queens?

A Queens.

Q Okay. That was also for the Gorayeb Law Firm?

A I believe so.

Q Yeah. Greg Gastman was over there?

A I believe so.

Q You met Greg yesterday. That's a follow-up. You started testifying a week before. You couldn't finish it and you had to come back, correct?

A That's correct.

Q You testified for the Gorayeb Law Firm before, correct?

A I have.

Q How many occasions?

A Well I go to court probably five times per year the entire year. So, a handful.

Q I think --

A Over the last 20 years, probably a number of times. Yes.

Q Okay. Would you have testified for them more than five times in the last five years?

A Yes. Because I've been to court, I believe, five times per year. Yes.

Q Okay. So you predominantly testify for just the Gorayeb Law Firm?

A No. Not at all.

But I believe the answer to your question is more than five times over the last five years.

Q Okay. Now, in that case that you just testified at yesterday, you were also claiming that the disc herniations

were not degenerative in nature and were traumatic in nature, correct?

A Yeah. I think that was in a 30 year old man. So a whole different case. That's correct.

In other words, it wasn't an issue of degenerative.

Q I believe Mr. Montedeosca, he is 47 years old?

A I don't know that. I am more than happy to know.

Q You testified yesterday. You don't know the age?

A I thought he was younger. Yeah, I believe he was younger.

Q That involved a case where a gentleman fell into a hole, correct? Into a pit?

A I believe so.

Again, with the mechanism of injury, I'm not involved with that, so I am happy to agree with you.

Q So, when you are not involved with the mechanism of injury, you're not looking at how it was that trauma may or may not have played a role.

Fair statement?

A No. That wouldn't be a fair statement.

Q You didn't look the mechanism of injury in this one either. It's not in any of your reports?

A Right.

Q All you looked at were the films?

A Correct.

Q And you looked at the films and you also looked at the reports by the other doctors, correct?

A Mmm, I may have. Sometimes they're sent to me, sometimes they're not. So I don't know.

Q Well did you look at the Beth Israel Hospital films from the day that Mr. Almonte presented on March 5, 2013?

A March 5, 2013?

Q Right.

Did you look at the reports?

I am sorry. I think I said films.

Did you look at the reports from the radiologist?

A No. Again, I can't say that I have. I looked at this a year and a half ago from those 2013 films, so I can't say that I remember that I did. So I don't know that I did.

Q Well the x-ray films are that day of the lumbar spine. The diagnosis and the impression in the radiologist was a severe degenerative disc disease.

Do you recall that?

A I don't. But I'm happy to read it with you or just accept that. Yes.

Q Okay. Well did you see the severe degenerative disc disease in the lumbar spine?

A I don't have that x-ray of the MRI. I have just the MRI and, which is more sensitive than the x-ray. And I do not see that severe degenerative disease.

Q Well you looked at the x-ray --

A Just to finish answering, that commensurate with age which is a 50 -- born in '56, 57 year old gentleman patient, the degree of arthritis is appropriate for a 57 year old person.

Q You looked at the March 5, 2013 x-rays, correct?

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

A Yes.

Q All right. So you would agree you did look at the x-rays?

A Yes.

Q And the x-ray radiologist, a Dr. Liebfeld I believe it is, where this was Liebfeld said severe degenerative disc disease seen at L2-L3, L3-L4 and L5-S1.

Do you concur from your review of the films that there was severe degenerative disc disease as seen at those three levels?

A No. I say that there is degeneration appropriate. Those would not be my words. My words would be there are degenerative changes appropriate for age at those levels. Yes.

Q Okay. And when you talked about terms --

A Yes.

Q -- physicians, mild, moderate, severe, correct?

That's the way you classify things?

A You can. There are plenty of radiologists that do. Yes.

Q Okay. I think you've made references to mild at various times within these various reports, correct?

A Correct.

Q So if someone's saying that they say severe, that would be the most extreme?

A Right. So I would disagree with that, yes, to answer your question.

Q You are disagreeing with a radiologist at Beth Israel Hospital, correct?

A Yes.

Q Okay. And you also disagree with Dr. Brisson, right?

A I don't know. You have to explain.

Q You looked at Dr. Brisson. I think those were the x-ray films you saw there, right?

A Okay.

Q You gave a report on various disc height levels, correct?

A Uh, which date?

Q Well Dr. Brisson would have been... excuse me. January 20, 2014.

(Whereupon, there was a pause in the

proceedings.)

A Yes. I do have it. Yes.

Q Okay. And in your report from that date -- let me just go back there. Excuse me one second.

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

Q By the way, can you tell the jury what spondylosis is? Sorry.

A Degenerative changes.

Q Okay. And in your report you make reference those degenerative changes at L2-3 and L3-L4, correct?

A I say there is a mild loss of height of the L2-3 and L3-4 disc spaces. Yes.

Q You make no references to L5-S1 in your area where he had the surgery, correct?

A Correct.

Q Dr. Brisson in his report of January 20, 2014 says that his study, the one you reviewed --

A Mmm-hmm.

Q -- reveals L2-L3, L3-L4 and L5-S1 spondylosis?

A Okay.

Q Okay.

A That doesn't --

Q You do disagree with Dr. Brisson, correct?

A No, I am not disagreeing. I think there are

degenerative changes at those levels that I speak about earlier on earlier films, right, prior to 2014 that don't go away. I would agree with him.

Q So why didn't you mention the degenerative changes at the disc where the surgery was actually performed in your report?

A I believe I mentioned it earlier.

Q I am asking from the review of those films, specifically in your report of October 6, 2016 where you are referencing the January 20, 2014 report, for some reason even though you agree with Dr. Brisson, you didn't put it in your report?

A Yeah.

Q Correct?

A I didn't think it was very important, to tell you the truth, because this is a patient who has been looked at multiple times. I am trying to find the earlier one for you.

Q Sorry. Just said you didn't think it was important. That's what you said. That's what you just said, correct?

A I didn't think that it was, it would make a difference to -- in other words, I didn't read Dr. Brisson's chart to know whether he noted it or not. And this patient already had had surgery by the time I looked at it.

Q I understand.

A Let me see if I can find it.

Q You just gave an opinion to this jury that this was a traumatically based injury and not a degenerative injury. And in your report you make no reference of the degenerative disease.

But the actual surgeon who did the surgery for plaintiff states that he had degenerative disease in that area of the back before the surgery, correct?

A So I am not disagreeing with that at all. I am saying --

Q Wouldn't that be important?

A I am not sure if, how it's important. You can tell me.

But I am saying that I am agreeing that there's degeneration. I am not disagreeing with that.

Q You chose when you were hired by this firm to provide the consultation, not to state the fact that there were degenerative changes at that level when you drafted a report about Dr. Brisson's films. Correct?

A I will answer you in one second.

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

A Yes, I did not put it in that report. You were correct. You are right.

Q Were you asked not to put it in your report?

A No. Nobody asked me to -- nobody asked me or told

me how to write any reports.

Q Okay. Just making sure.

There were also CAT scans taken of Mr. Almonte's neck, correct?

A Yes.

Q And they were taken on the date of the incident, correct?

A Yes.

Q They essentially showed degenerative disc disease all the way from the top of the cervical spine to the end of the cervical spine, correct?

A Again, we are throwing out the term degenerative disc disease. There are degenerative changes that I specify in the report that I did write. At each of the levels I believe that's correct.

If there is a difference, there's a difference between degenerative disc disease and degeneration. One includes the disc and one doesn't.

So I am pretty specific in this report of the cervical spine.

Q Well the degenerative changes in the spine, I think you said where there is this rubbing can occur, that can lead to herniations, correct?

A In general, degeneration can lead to weakening of the ligament and to herniation. Yes.

Q And there are bulges and herniations through the cervical spine, taken on the day of the cervical spine films, taken on the day of the incident within a few hours, correct?

A That is correct.

Q And degeneration would not have occurred in a few hours, correct?

A Oh, no. The degeneration occurred before the date of the injury for sure. Absolutely. Correct.

Q In fact, by the way, you do mention in some of your reports on this that there are various manifestations of degenerative changes throughout Mr. Almonte's back, correct?

A Yes.

Q There were endplate changes, correct?

A Oh, yes. I agree there were degenerative changes in the back.

Q Can you tell them about endplate changes?

A Sure.

Endplate changes are the front of the spine not next to the herniations. We can look at a film if you want at some point. But that's what endplate changes are.

So whether you have those boxes with the herniations going back this way, the endplate changes are spurs that form in the front of the spine (indicating).

Q And spurs are a degenerative change, correct?

A They are.

Q You also found facet joint arthropathy, correct?
A Yes.
Q And facet joint arthropathy, I'm not good with the words, that's also degenerative change, correct?
A That's correct.
Q And that's similar to hypertrophic changes, correct?
A Yes.
Q In hypertrophic changes, by definition, describe a degeneration and enlargement of the facet joints, correct?
A Correct.
Q Can you tell the jury what the facet joints are?
A Two bones in the back of the spine, the other side. The facet joints are joints behind the spinal canal, again on the other side of the herniation, not near the herniation.
Q The endplate was on the anterior?
A Correct.
Q At facets on the posterior?
A Right.
Q Front and back?
A Right. The herniation's in the middle. Correct.
Q He's got degenerative changes front and back of his spine, correct?
A Front and back, but not at the level of the herniation. That's correct.
Q And again, continuing with the definition of

hypertrophic changes, they can enlarge, correct, to the point where pressure on the nerves takes place in the spine, which causes pain to radiate, correct?

A Certainly possible. Yes.

Q That's one of the common things you see in the aging process with people with degeneration in their back that it causes that radiation down, correct?

A I'm not trying to --

THE COURT: I am not sure if I understand that question.

Q It's one of the reasons that's degenerative change within the back that can cause radiation, correct?

A A degenerative change can cause pain that radiates. Yes. That is true.

Q And in Beth Israel Hospital, Dr. Liebfeld, when he looked at the various changes, also confirmed there was facet joint atrophy at that time, correct?

A I am assuming that's correct. I don't have it in front of me. I will agree.

Q Now, when the facet joint rub, though, that can create the impingement, correct?

A Impingement on what?

Q The spine. The spinal canal, right?

You have the facet joints rubbing. What happens? Tell the jury how they, what happens with the end

of the facet joints when they rub and they move.

A They can enlarge. They become hypertrophic.

Q When they enlarge, that's when they can impinge, correct?

A They can. It's possible.

Q And where Mr. Almonte had the enlarged facet joints, was that in the areas where he had the bulges?

A You mean bulges and herniations?

Q Yeah.

A Yeah. There are two separate -- they're at the same level two separate sites. They're not connected.

Q Now all of those degenerative changes, the facet joints, the endplates, that that would all have been preexisting, correct?

A Yes.

Q Osteophytes were also present, correct?

A Yes. Those are the endplates spurring. That's the spurs.

Q Different word for the endplate spurring?

A Correct.

Q And when, and those generally occur when they are not getting enough support in the back, correct?

A What occurs?

Q You get the osteophyte formation when you are not getting enough support for the vertebrae, correct?

A No. You get osteophytes in the, when there's instability of the spine. I am not sure what support means.

Q I am sorry.

If the disc -- by the way, we talked about the disc. I will go back to the disc for a second.

You told the jury about the disc being the cushion, correct?

A Yes.

Q Or the gelatinous center, correct?

A Correct.

Q Now, what happens if dehydration occurs to the disc?

A It dries out.

Q And the drying out then makes it so it doesn't bounce back and become stringy, correct?

A Correct.

Q There was dehydration seen in those MRI films that you reviewed, correct?

A I believe there is dehydration there. I have to look, but I'll agree.

Q And dehydration is also something that occurs over time. That is a degenerative change?

A Yes. Well it could be traumatic, too, but it occurs over time. Yes.

Q So in Mr. Almonte's back there was also a drying out of the disc which was creating a smaller space between the

vertebrae, correct? Between the bones?

A I said there was mild narrowing of the disc space at two levels. Yes.

Q Okay. And when that happens, and that drying out occurs and the discs get smaller, that is when you start having all of these degenerative changes start to exacerbate more, become more rubbing, more support, because the disc with the dehydration is not providing support?

A Yes. This is all true. It doesn't mean there is a disc herniation in any way. But all these facts you're saying are true.

Q But when you saw this patient's films from the very day of the incident, he had herniations from neck to lower spine throughout his entire spine and had all of these degenerative symptoms, correct?

A Well he didn't have herniations from his neck to his lower spine at all levels. That's not true. He did have degenerative which is appropriate for a 57 year old man. Yes.

Q I apologize. When I said herniations, I meant bulges.

In herniations from top to bottom through the, not every single level, but a large number, correct?

A Yes.

Q There were also osteophytes in the lumbar spine,

correct?

A Yeah. Those are the ones we just spoke about. Yes.

Q There was osteophytes in the neck then, too, if I wasn't clear?

A Yes.

Q So now we have bony growths in the neck and we have bony growths down in the lower back, correct?

A Correct.

Q Now, and when you go to the March 21, 2013 MRI of the lumbar spine that you showed the jury, you sat there and you talked about the disc. And looking at the disc you said this is all you need to see about the herniation, correct?

You made no reference to the posterior hypertrophic changes, correct?

A That's correct.

Q Right.

In fact, you made no reference to the jury about any of the degenerative changes in his back. You said all you have to see is the fact that there are herniations and bulges, right?

A No. I said all you have to know in order to see a herniation is that it goes beyond the bone. I wasn't saying, nor did I say, that all you have to see is the herniation, not look at anything else.

Q Well you knew when you were leading up and showing

the jury all of these films that you were gonna be asked that question with an opinion whether this was degeneratively caused or traumatically caused, correct?

A Yes.

Q When you were showing the jury all of these films of the lumbar spine, you chose not to point out any of the degenerative conditions before you give your opinion saying that that disc was traumatically caused, correct?

A Yes. I am going to give you the same answer I gave you before.

It's true that he has degenerative changes. But that in no way means he has herniation the day before the trauma. Nobody knows that. We only know that from putting the pictures that we show together with the clinical information of the patient of how the patient felt before the trauma and how the patient was treated by doctors before the trauma. So, there's no way to say that there was degenerative changes that caused the herniations.

Q Do you know he was on Gabapentin for years before this incident?

A Again, I didn't read his medical chart. I was here to read the MRIs and CAT scans and x-rays. So I, the answer is the same. I don't know.

Q Is Gabapentin used to treat herniated discs?

A I don't know.

Q Is that something you should have learned before you gave an opinion where a disc is degenerative or traumatic?

A My opinion, to be very clear, is based on the findings of the films and what I have been told about the patient.

If you want to tell me something different about the patient, then I may have to modify my opinion. But if you tell me something different, then I'll listen to you. I'm not hearing it.

Q Well we know we have the event where he had the pain and the popping in his back in May of 2012, right? So we know we are having symptomatic back pain months before this incident, correct?

A I'm not disagreeing with you. I am saying the likelihood of that patient has three herniations in his back, even with degenerative changes, is not from a muscle spasm that he was treated for. As I understand it, as I was told, not treated for much at all a year earlier.

Q Let me --

A I can't answer that question any better to you.

Q Okay. Let me ask you this then.

When you see a traumatic disc, okay, when you see a patient that comes in and they're sent to you from another doctor, I assume they don't come to you. They have to be referred to you. Is that fair?

A Yes.

Q They come in and give a little history. They say I was hitting something or I was in a car accident. I was in something. Whatever that is. They talk about a traumatic event and you take films from immediately after that.

Do you not, in fact, see evidence of the trauma in the spine in the area where the herniation occurs?

A 99 percent of the time you will not.

Q Okay. Did you see any extrusion on any of these films taken on May 21, 2013?

A What's an extrusion?

Q You didn't see any extruding disc coming from the fresh disc material coming through? You didn't see that?

A Can you define extrusion?

Q E-X-T-R-U --

MR. VARGAS: He doesn't need a spelling lesson.

MR. VAN ETTEN: I am not the doctor.

A Right. Right. Correct. Therefore I am asking you what you mean by extrusion.

Q Have you ever seen with a traumatically induced disc, disc herniation, an annular tear?

A You can see an annular tear. Yes.

Q And an annular tear, similar to what you showed the jury with the labrum tear with that white spot, that will represent with a white spot or a bright spot on an MRI,

correct?

A Most of the time it will not. It can. But most of the time it will not.

Q If you have a recent traumatic event which causes an annular tear with a traumatic herniation, you will see that bright spot on an MRI, correct?

A No. You are telling me? Same answer. No. You won't see it most of the time.

Q Then my question would be, if you were to say that you think you're right, I mean, what's the time interval between the trauma at MRI? Do you see it the same day only or --

A Do you see it at the time of the injury if the patient would have had an MRI? Do you see it three weeks later like here? Do you see it ninth months later?

So, that question, to me, the answer, straightforward answer is you generally do not see what you are saying. You would see an increased, an area of increased signal in the annulus.

Q Do you know David Yousem?

A No.

Q Do you know the author of *Neuroradiology, the requisite*? Johns Hopkins.

You are not familiar with him?

A No.

Q So you are not familiar with the principle that if you have a traumatically induced disc where you would see that bright spot on the MRI, that within two years or so you will no longer see the evidence of the trauma in an MRI?

You are not familiar with any studies or literature on that fact. Is that your testimony?

A I certainly disagree with that statement.

Q Okay. And you made no reference in your reports to any annular tears, correct?

A Right. I'm saying by definition a herniation is an annular tear. I don't put that in my reports unless --

Q Usually when you say see those annular tears as said the annulus sits there and covers the disc and protects when degenerative occurs.

That's when you get the cracking in the annulus, correct?

A You may or you may not.

Q And nowhere in your report did you say that you saw any annular tears. Fair statement?

MR. VARGAS: Objection.

THE COURT: Overruled.

A I never used those terms. Right. Unless it's important for another reason.

Q So if you didn't use those terms, you did not include it in your reports when you reviewed these films?

MR. VARGAS: Objection.

Q Correct?

MR. VARGAS: Asked and answered.

THE COURT: Overruled.

A That's correct. I did not put it in my report.

THE COURT: Mr. Van Etten, will you be winding up shortly?

MR. VAN ETTEN: I don't know, Judge. I don't think I can get it done in five. I have been trying to get it quick.

THE COURT: Could you both step up, please. I am sorry to do this.

MR. VAN ETTEN: I am sorry. I apologize.

THE COURT: I generally don't do this but, you know.

MR. VAN ETTEN: I know.

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

THE COURT: Okay. Ladies and gentlemen, I am going to keep my promise to you. I said that we would adjourn today at 4. It is now 4 o'clock. Unfortunately we were not able to conclude with the cross examination of this witness. The witness will be consulting with counsel to determine when he can return to court to continue his cross examination.

Okay. We will continue with the proceeding on Monday morning at 10 and plaintiff will continue his case at that time.

I'm going to remind you that you are not to discuss the case amongst yourselves, with any other person, or communicate virtually about this matter. Okay.

That being said, the matter is adjourned to Monday, June 25 at 10 a.m.

JUROR: Thank you.

MR. VAN ETTEN: Thank you, Your Honor.

COURT OFFICER: All rise. Jurors leaving.

(Whereupon, the jury left the courtroom.)

THE COURT: Okay. Please be seated.

Doctor, you're excused at this time. You're reminded that you're still under oath and that you are not to discuss with your, your testimony with anyone, okay.

THE WITNESS: Thank you.

THE COURT: Okay.

(Whereupon, the witness was excused from the stand.)

THE COURT: Okay. The matter is adjourned until Monday morning.

Defense, I just want to, my court attorney

advised me of your personal circumstances. I am sorry to hear about that.

MR. VAN ETTEN: Thank you.

THE COURT: You will keep the Court apprised.

MR. VAN ETTEN: I will. I will let you know if anything transpires. I am going to get out of here as soon as I can. Thank you very much.

THE COURT: Okay.

MR. VARGAS: Monday morning does the courtroom open at 9:30? I have a projector and a screen I wanted to set up.

THE COURT: Okay. Miss Tate.

THE CLERK: We will open up a little earlier.

MR. VARGAS: Okay. Thank you.

Your Honor, is it all right if I leave some papers on this table?

THE CLERK: You can leave everything where it is.

MR. VARGAS: Okay. Great. Thank you.

THE COURT: Thank you.

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(Whereupon, the proceedings were adjourned to June 25, 2018.)

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It is hereby certified that the foregoing is a true and accurate transcript of the proceedings.

Vanessa del Valle

VANESSA DEL VALLE
Senior Court Reporter

VdV