UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK
Civ. No. 15-CV-02845
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ZBIGNIEW PAPIEZ,
Plaintiff,
vs.
HOME DEPOT U.S.A., INC.,
Defendant.
----------)

DEPOSITION OF ANDREW MEROLA, M.D.
New York, New York
November 26, 2018

Reported by:
Linda Salzman
JOB NO. 151727

November 26, 2018

4:54 p.m.

Deposition of ANDREW MEROLA, M.D., the witness herein, held at the offices of Lewis Brisbois Bisgaard & Smith LLP, 77 Water Street, New York, New York, pursuant to Notice, before Linda Salzman, a Notary Public of the State of New York.

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

EDELMAN & EDELMAN
Attorneys for Plaintiff
61 Broadway
New York, NY 10006
BY: HOWARD ENGLE, ESQ.

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Attorneys for Defendant
77 Water Street
New York, NY 10005
BY: DAVID POLLACK, ESQ.

STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED by and among counsel for the respective parties hereto, that the sealing and certification of the within deposition shall be and the same are hereby waived;

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

IT IS FURTHER STIPULATED AND AGREED that the within deposition may be signed before any Notary Public with the same force and effect as if signed and sworn to before the Court.

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

EXAMINATION BY
MR. POLLACK:

Q. Good evening, Dr. Merola.
A. Good evening.
Q. Thank you for coming out in this inclement weather. We will try to get you out of here by 7:30. I can't promise you that, but the Court Reporter has a hard stop by then.
So if we don't finish, we will deal with it later, okay, but I will do my very best to get you out?
A. Thank you.
Q. Okay. I know you've testified before at trials, right?
A. Yes.
Q. You know my partner, Alan Kaminsky?
A. Alan Kaminsky.

A. Merola

Q. Alan Kaminsky, yes.

A. Oh, yeah.

Q. So have you ever given deposition testimony before?

A. Yes.

Q. Okay. So you're familiar with the general rules. I ask you a question; you give me an answer. If Mr. Engle has an objection to the question, he will verbalize that and then he and I will --

MR. ENGLE: Spar.

Q. We'll gentlemanly debate it. So don't answer the question until we've resolved that issue, okay?

A. Yes.

Q. If you don't understand a question, just let me know and I will be happy to rephrase it. It's a little different than a trial. You have a little bit more leeway here. I will be happy to rephrase it or repeat it.

If you don't indicate that you are having an issue understanding the question I will assume you understood it.

A. Merola

Fair enough?

A. Yes.

Q. And you obviously need to verbalize your answers because the Court Reporter isn't looking at you. She can't see gestures. She needs to hear your answers. Fair enough?

A. Yes.

Q. If you need to take a break, just let us know. We will be happy to accommodate you. The only caveat to that is if I ask you question, you need to answer the question before you take a break. Fair enough?

A. Yes.

Q. Okay, great.

MR. POLLACK: So I want to mark this as Defendant's A.

(Defendant's A, Notice of Expert Witness Exchange, marked for identification, as of this date.)

Q. And I ask you if you recognize that? Feel free to flip through the pages.

A. Merola

A. Yes, I do.

Q. This is the formal legal document that Mr. Engle's office produced to us identifying you as an expert and exchanging your expert opinion in this case, which is Exhibit A, which is followed by Exhibit B, which is your curriculum vitae, your CV, and also includes a list of your articles and periodicals that you have contributed to, correct?

A. Yes.

Q. I'm going to assume that when this was provided to us in April of 2017, that it was current up to that date.

Do you know if there are any additional articles or positions -- articles that you have written or contributed to or positions that you have held since April of 2017 which you would want to supplement this document with?

A. No.

Q. Okay.

MR. POLLACK: Now I also note,

A. Merola

Howard, and obviously, we can do this at a later date, that the Doctor was still compiling his comprehensive list of testimony within the last four years. I don't believe that was ever supplemented.

So, when you get a chance, at your earliest convenience, at least before the end of the year, can you get that to me.

MR. ENGLE: Sure.

MR. POLLACK: Okay. Thank you.

Q. The compensation information on the second page, is that still correct?

A. Yes.

Q. And this is a report dated April 4, 2017, which you prepared for Edelman & Edelman, Mr. Papiez's attorneys in this case, representing your expert opinion in this case, correct?

A. Yes.

Q. Could you summarize in a sentence or two, or if you need more or less, that's fine, what the essence of

A. Merola

your opinion is regarding Mr. Papiez in this case?

MR. ENGLE: Objection to the form.

Over objection you can answer.

A. I guess the best summary -- there's lots of data and information within the actual report itself. I guess the best summary would just be the causation section, if we were going to specifically focus on causation.

Q. So that's page 7?

A. Yes.

Q. And so it says what it says, but could you summarize that for me in layperson's terms?

MR. ENGLE: Objection to the form.

Over objection you can answer.

A. Sure. I would basically just summarize that, to the best of my knowledge, having treated the patient and reviewed medical records concerning the patient that, within a reasonable degree

A. Merola

of medical certainty, the injury of October 31st of 2013 resulted in a symptomatic herniation at C6-C7, which subsequently underwent a revision surgical procedure.

Q. What does a "symptomatic" herniation mean?

A. It is a herniation that causes symptoms which initially present as some type of a problem that a patient is having. The patient would make complaints and offer symptoms to a treating physician, and then, based on physical examinations and diagnostic studies and those complaints and symptoms, one would be able to come up with a diagnosis.

And in this case a symptomatic herniation would cause neurological issues involving the nerves at the C6-C7 segment, in addition to pain as well.

Q. So I do not want to put words in your mouth, but even if I did, Mr. Engle, I know, would stop me. But let me just see if I can understand it.

A. Merola

Are you saying it's your opinion, the causation, that the injury that Mr. Papiez claims to have sustained on October 31, 2013, caused a physical change at the C6-C7 level of his spine which produced pain symptoms that were not previously present?

A. Yes.

Q. Okay. And was the physical condition, the herniation, right, which is a change from its normal position -- or condition, that was caused by that incident of October 31, 2017; is that your opinion?

MR. ENGLE: Objection to the form.

A. I would opine that the physical condition of the C6-C7 segment --

Q. The herniation?

MR. ENGLE: Objection. Let the witness -- don't put words in the witness' mouth. He wasn't finished with his answer. You know there is a pre-existing herniation. Let the

A. Merola

witness give the answer as he chooses to give, not as you want him to give.

MR. POLLACK: Okay. Sorry.

Q. Sorry. Why don't you start from the top.

A. Will do.

I would say that the condition at C6-C7 was caused to become symptomatic, that is, to cause a condition resulting in pain from the C6-C7 segment, with neurological findings into the C6-C7 nerve root distributions that eventually required surgery.

Q. And were you aware when you wrote this opinion and, of course, when you were treating Mr. Papiez -- I believe, beginning in February 2014, and we will get to that -- that he had experienced an earlier, a previous injury back in, I believe, 2006?

Were you aware of that?

A. Yes.

Q. And were you aware that at that time there was an MRI study performed

A. Merola

which showed, at the C6-7 disc space level, a central disc herniation of small size that was evident without spinal cord compression?

A. Yes.

Q. And is it your testimony or understanding -- and I assume, in part, based upon what Mr. Papiez was conveying to you -- that that condition as described in the 2006 MRI had not produced any pain or any symptoms until October 31, 2013, when he had his incident which is what we're here for?

MR. ENGLE: Objection to the form.

You can answer over objection if you understand.

A. There is a lot to unpack in that question. But once again, I would go back to saying that Mr. Papiez did have a prior C5-C6 herniation that required surgery.

Q. Which you performed?

A. Correct. And that there was a small central disc herniation at C6-C7

A. Merola

which did not previously require surgery.

Q. Okay. Do you know if prior to October 31, 2013, which is the date of the accident of this case, he had ever complained about any pain or symptoms at the C6-C7 area?

A. I know that he did have longstanding pain and symptoms to his neck. Nothing more specifically relating to C6-7 though.

Q. So it could have been coming from something else?

MR. ENGLE: Objection to the form.

Q. Could it have been coming from somewhere else than the spine?

A. He had prior pain to his neck area, yes.

Q. As part of your treatment of Mr. Papiez -- and it included surgery to the C6-c7, a revision of that area -- but beginning in February of 2014, which is when I believe you first saw him --

MR. ENGLE: Hold on. A revision

A. Merola

to the area of C6-C7?

MR. POLLACK: That's what he just said.

MR. ENGLE: No, he didn't.

Q. Did you perform a revision surgery?

A. Well, I performed an initial surgery at C5-C6.

Q. Right.

A. Prior.

Q. Correct.

A. And then there was a revision cervical surgery specifically focused at C6-C7.

MR. ENGLE: He didn't revise C6-C7, as your question seemed to suggest. I'm just trying to get specific because we need to be specific.

MR. POLLACK: That's fine.

Q. During the course of your treatment beginning in February of 2014, when you first saw him, did you ever have an opportunity to review other medical

records other than MRI imaging from other doctors pertaining to Mr. Papiez?

A. Well, prior to when I had previously seen him, yes, I had treated him previously. So, of course, I was privy to those records, having been his primary surgeon for the C5-C6 issue.

Q. And that was over a period of roughly six or seven years?

A. Yeah. It was over a number of years, yes.

Q. Do you know which doctors' records you reviewed prior to beginning to treat him again in February of 2014?

A. I know that he was under the treatment and care of Dr. Podhorodecki, also Dr. Grimm, Dr. Kaplan.

Q. Okay. Now, just turning to your report, and the first page of the report, which is the third page of Exhibit A, it indicates here you initially saw him in the office February 3, 2014, correct?

A. Yes.

Q. For this injury, for this

A. Merola

condition, correct?

A. Yes.

Q. You indicated that you had previously treated him for the disc herniation C5-C6, and then you wrote, "He had done quite well up until October 31, 2013, whereby he sustained a trauma, having a load of bricks fall onto his head."

Do you see that?

A. Yes.

Q. Then you go on to say, "Since that time" -- I assume that means since October 31, 2013, correct?

A. Yes.

Q. " -- he had been having significant neck pain and headaches, with upper extremity pain, and particularly right greater than left upper-extremity numbness, tingling and weakness."

And this concerned him to the point where he was referred to you by Dr. Podhorodecki?

A. Yes.

A. Merola

Q. For evaluation and management and surgical consult regarding his neck, correct?

A. Yes.

Q. What was the basis of you writing in this report that he had done quite well up until October 31, 2013, when this load of bricks allegedly fell onto his head?

A. He was essentially clinically stable. In other words, his physiatrist, his treating physiatrist, Dr. Podhorodecki, was treating him, and he had not clinically deteriorated to the point where a surgical consultation was required.

Q. So what does "clinically deteriorated" mean?

A. It means getting worse.

Q. Getting worse relative to what?

A. Baseline.

Q. And what was the baseline?

A. His chronic neck pain from his previous injury.

A. Merola

Q. Just out of curiosity, frankly, what is the significance, if any, of the finding that the upper extremity pain was more particular on the right, or greater than it was on the left?

A. So when questioning the patient specifically about pain and weakness, there was more localization to one extremity than another.

Q. Okay. And you -- take a look at the next page.

You see where it says "subsequent treatment" --

A. Yes.

Q. -- in the third paragraph?

So Mr. Papiez returned on June 20, 2014, to your office, correct?

A. Yes.

Q. And you indicated that you had consulted had with Dr. Podhorodecki, who indicated to you that his condition had gotten worse over the course of time.

Do you see that?

What was the course of time?

A. Merola

What was the period of time? From when you had last seen him in February?

A. Since -- well --

MR. ENGLE: Objection to the form. Where are you referring to in the report, if I may ask?

MR. POLLACK: The last sentence.

Q. You see that, Doctor, correct?

MR. ENGLE: Well, I don't see it, and that's the issue.

MR. POLLACK: "I had an opportunity to consult with Dr. Podhorodecki, who also indicated to me that Mr. Papiez's condition had gotten worse over the course of time."

MR. ENGLE: Thank you. So it's the last sentence of the paragraph. That's all you had to do, was tell me that. Don't ignore me --

MR. POLLACK: I'm not ignoring you.

THE WITNESS: -- to the extent -- you are because you said, "Doctor, you heard it, you read it."

A. Merola

MR. POLLACK: Okay.

MR. ENGLE: Show me the same respect I showed you.

Q. What was the course of time that you're referring to?

A. So that would have been since I had initially seen him in February.

Q. Okay. And there's some redundancy in this report, but that's fine. If you go to page 3, you indicate that -- four paragraphs down begins with the words "the indications for surgery."

Do you see that?

MR. POLLACK: Howard, you got it?

MR. ENGLE: Thank you.

Q. Okay. "Indications for surgery are that Mr. Papiez is a 45-year-old man who had history of prior anterior cervical discectomy and spinal fusion of the C5-C6 segment that was doing quite well up until he sustained a new trauma to his neck that produced an acute herniation with cord injury and nerve root injury at C6-C7."You

A. Merola

then go on to say, "He had progressive pain in his neck, with pain shooting into the upper extremity, arms, and hands since the time of the trauma, and it failed conservative care management treatment."

You see that?

A. Yes.

Q. Now, is that, again, based on what he told you was his symptoms, or lack thereof, prior to and then after the incident on October 31?

A. Well, that's based on his history. That is the patient's history.

Q. That's what he tells you?

A. Correct. It's based on records from Dr. Podhorodecki and Dr. Grimm. It's based on MRI films, and it's based on physical examinations and clinical correlation.

Q. And when you say Dr. Podhorodecki's records, do you -- as you sit here today, do you have a recollection of the time frame of the records that you had in your possession

when you considered, among other things, Dr. Podhorodecki's records, in opining, or concluding, that he had done quite well, up until the moment of the injury, when the pain began?

A. Yes.

Q. And what was that?

A. So there were records from Dr. Podhorodecki both before the incident of October 2013 and then after the incident of October 2013 as well.

Q. And when did you receive those records relative to writing this report?

A. I would say prior to writing the report.

Q. Did you have them with you when you were treating him, or did you get them in connection with preparing the report for your testimony in this case?

A. I had records during treatment as well.

Q. You go on to say at the bottom of that same paragraph that, "Cervical intervention was indicated and warranted

A. Merola

at that time," meaning September 3, 2014, "in order to prevent further neurological deterioration."

Can you explain that to me?

A. Sure. So it's a stabilization procedure. It's a decompression and a stabilization procedure. And the rationale for doing a decompression and stabilization is to protect neurological function in the area where the compression is, to prevent nerves, and in this case, nerves and spinal cord from getting worse.

Q. And that's the ACDF that you performed in September 2014, at the C6-C7 level, correct?

A. Yes.

Q. Okay. Now, if you move along to page 6 of your report, the third full paragraph that begins "I discussed at length."

A. Yes.

Q. So I can read the whole paragraph, but what I'm really interested in is beginning with the second sentence,

A. Merola

"It is not unusual for multilevel cervical spinal fusions to undergo an adjacent segment issue as a consequence of an increase in stress factors at the proximal junctional segment, and, indeed, Mr. Papiez has experienced this and will, indeed, require revision surgical intervention to the neck. I have, once again, outlined all the current conditions to Mr. Papiez, who has verbalized to me a good understanding therein."

Can you first explain to me what is "adjacent segment issue"? What is that?

A. So when a fusion is done to the spine, it's done on a specific segment of the spine. The segments that are attached to the fused segment are known as "adjacent segments." So they are the segments that are directly attached to the area where the fusion is.

Q. Above or below?

A. Correct.

Q. So as an example -- well, let me

A. Merola

ask you this question: When you wrote this paragraph, were you referring to the adjacent segment C6-C7 being adjacent to the C5-C6 that had undergone the original, or were you referring to, perhaps, a future surgery after the C6-7?

MR. ENGLE: Objection to the form.

Q. You understand my question?

A. Yes, I do.

This statement is based on the examination of July 30 of 2015, where the patient had some, by examination, C5 nerve root findings. And based on an MRI from June of 2016, I counseled the patient regarding the C4-C5 segment.

Q. Which was adjacent to the C5-C6 segment ACDF that you had performed back in -- I believe it was 2007?

A. Correct.

Q. But the concept of an adjacent segment issue developing as a consequence of the increase in stress factors at the proximal junctional segment could apply to

A. Merola

a segment above or below where the surgery was originally performed, correct?

MR. ENGLE: Objection to the form. Are you speaking about generally?

MR. POLLACK: Generally.

MR. ENGLE: Not specifically in this case?

MR. POLLACK: Correct.

A. In general, yes.

Q. Did you consider the possibility that the -- withdrawn.

The adjacent segment issue, does that create a radiographical change, or a change that's visualized or capable of being visualized on a radiograph, or is it only something that produces pain?

In other words, when you have those increased stresses above or below the area where there has been a stabilizing surgery such as C5-C6, generally speaking, if the person develops an adjacent segment issue, will that physically change the condition of the

A. Merola

adjacent segment that is visual -- capable of being visualized on an MRI or does it just cause pain, or both?

A. Well, it can be both or neither, depending upon the resiliency of the segment. So there are circumstances under which you can see a radiographic change and you may not have a clinical change.

Q. Meaning pain?

A. Correct. Or you may have a clinical change but not necessarily see a radiographic change.

Q. Thank you.

When you were considering -- or when you were diagnosing his condition when he first came to you in February of 2014, did you consider the possibility at that time, or any time thereafter, that the condition that you saw in the C6-C7 segment was a product of an adjacent segment issue stemming from the many-years-earlier C5-C6 that you had performed -- which is an adjacent segment, correct? -- at that time?

A. Merola

Did you consider that as a possibility?

MR. ENGLE: Objection to the form.

Over objection you can answer.

A. Yes.

Q. Did you rule out that possibility?

A. In part, yes.

Q. Okay. Can you explain to me what you mean by "in part" and then tell me why?

A. Sure. Typically, adjacent segment issues will cause a gradual progressive clinical deterioration over time because of their degenerative wear-and-tear nature.

Q. So --

MR. ENGLE: Let him finish his answer.

Q. Okay. Can you explain that?

MR. ENGLE: He wasn't done explaining. You asked him did you consider it? Did you rule it out, in

A. Merola

part? And he's explaining it.

MR. POLLACK: Okay, Howard.

MR. ENGLE: Respect, please.

Q. Do you find me disrespectful in my questions?

MR. ENGLE: I'm just asking you to let him finish his answer. You know he wasn't done when you interjected with another question.

A. So, in general, yes. When looking at a patient that has a fusion, we consider the adjacent segments. And typically those adjacent segments will have a clinical course that shows gradual clinical deterioration over time.

Q. Meaning the patient will complain of pain over time?

A. Well, pain and/or other symptoms with correlative physical findings that relate to the adjacent segment becoming symptomatic.

Q. Okay.

MR. ENGLE: Can he finish his answer now? Allow him to finish.

A. Merola

Write down your questions and let him finish.

MR. POLLACK: Okay.

A. So that's always something that we look for in terms of the treatment that they've had before we're seeing that patient, in this case, Mr. Papiez, with his treatment with Dr. Podhorodecki.

Of course, when there is a sudden deterioration in their clinical condition, as in this case, then -- and you see a deterioration in clinical function with an inciting event, you can clinically understand that it's not a result of the adjacent segment itself.

MR. POLLACK: Let's mark this as Defendant's B.

(Defendant's B, curriculum vitae, marked for identification, as of this date.)

Q. So Exhibit B is an -- I'll call it a "note" from you; is that fair?

A. Yes.

Q. Which I believe you actually

A. Merola

signed.

Do you see that?

A. Yes.

Q. And it's dated July 14, 2008. So, by my calculations, it's seven months post-op the ACDF of the C5-C6 that you performed following his earlier industrial workplace accident; is that accurate?

A. Yes.

Q. And in it, in this report, you state that Mr. Papiez returned to your office, and you said that he has been having mechanical axial neck pain. Can you just define that for me?

A. Pain in the neck that's aggravated with activity.

Q. Then you go on to say that "Surgical intervention was successful" -- and I think you meant "in ameliorating," correct?

A. Yes.

Q. Okay. "-- in ameliorating some of his radicular complaints and symptoms."

So that would be the surgical

A. Merola

intervention that you performed, the ACDF of the C5-C6, back seven months earlier, correct?

A. Yes.

Q. And then it says, "but has not completely and entirely alleviated or ameliorated everything."

A. Yes.

Q. Do you recall, as you sit here today looking at your record, what other complaints, radicular complaints and symptoms or other clinical findings he was experiencing at that time?

A. Neck pain, which I described as axial and mechanical, which means pain in the neck, activity related.

Q. So when he's at rest, he's not experiencing the pain?

A. Less so.

Q. Okay, fine.

A. And also low back pain, which I also described as mechanical and axial, meaning activity related.

Q. You then go on to -- the next

A. Merola

sentence in that paragraph says, "Particularly given the fact that he has adjacent segment disc herniations," plural, "which we are continuing to observe from a surgical point of view."

What did you mean by that statement?

A. So that means that there are areas adjacent to C5-C6 where at both C4-C5 and C6-C7 there were small herniations. Not clinically significant, warranting surgery, but areas of adjacent areas that one needs to monitor over the course of time.

Q. And were those -- was the adjacent segment disc herniation, that's referring to C4-5 and C6-C7?

A. Yes.

Q. Okay. Now, as I understand it -- and if I'm wrong, please tell me -- the adjacent segment syndrome, if you will, or adjacent segment issues, are brought about by increased stress on an adjacent segment, following the

A. Merola

stabilization of a segment that is adjacent to it. So, for example, following a C4-C5 -- I'm sorry, a C5-C6 ACDF, over time, the increased stress on the 6-7 and the 4-5 can cause either or both a clinical change in those two adjacent segments or a physical change, correct?

A. Yes.

Q. And that's due to stress?

A. Yeah.

Q. Additional stress that's not being absorbed?

MR. ENGLE: You're talking generally?

MR. POLLACK: Generally speaking.

MR. ENGLE: Not in this case?

MR. POLLACK: Not in this case.

Q. Additional stress that's being absorbed by those two segments because they don't have the one that's been stabilized to help them out, basically; is that right?

A. Merola

A. Yes.

Q. So the MRI of 2006, which was taken following his earlier industrial accident, that showed C6-C7 disc space level essential disc herniation of small size.

That wasn't due to adjacent segment stress; that was either pre-existing or caused by that earlier accident, correct? -- to the best of your knowledge?

A. Yeah. Or -- right, correct. That could have been pre-existing and/or imparted upon by some stress from C5-C6, yes. Either/or.

Q. So the adjacent segment disc herniations as of July 14, 2008, which are seven months after C5 and C6 have been stabilized, are you saying that, due to the stress on C6-C7, that's where the herniation or the additional pain was continuing to come from?

MR. ENGLE: Objection. The witness already answered the question

A. Merola

in the last question. He answered that in the last question. Now you're flipping it around and asking him the opposite, is the opposite true.

MR. POLLACK: Well, that's exactly right.

Q. In your report you attributed the fact that he was having pain in the adjacent segments C6-C7, C4-C5, to adjacent segment disc herniations.

And my question to you is if, generally speaking, that's caused by stress following the stabilization of one level, how does that square with the fact that prior to that stress, because prior to that surgery back in 2007, he already had a disc herniation, admittedly small, at the C6-7?

Do you understand my question?

MR. ENGLE: I'm going to object to the form of your question because you're presupposing that the herniations caused pain, number

A. Merola

one. Number two, you're presupposing that the herniations in C6-C7, small after the prior C5-6 surgery, was because of an adjacent segment condition, when the witness has already said it could have been pre-existing or could have been from the prior accident.

Q. Well, I guess that's what my question is.

When you said adjacent segment disc herniations in July of 2008, referring to C6-C7 -- when you said, "Particularly given the fact that he has adjacent segment disc herniations," referring to C6-C7 and C4-C5, as an explanation for why he was continuing to have pain, my question to you is, were those adjacent segment disc herniations caused or increased by the stress levels placed upon those adjacent segments, or were they the same as what they were

A. Merola

before the surgery?

Do you understand my question?

MR. ENGLE: Objection to the form. Let me just simply say I think we're confusing two things. He has herniations in adjacent segments versus he has herniations from an adjacent segment syndrome following a fusion.

The word "adjacent" is in both of those, but now you're mixing them up.

Q. Doctor, did you understand my question?

A. Correct me if I'm wrong, but I think the question you're asking me is, is C4-C5 and C5-C6 resulting in pain on July 14, 2008?

Q. Yes.

A. Okay. I will apologize for a poorly worded paragraph, but I will explain that in this -- where he is right now, C5-C6 was stabilized and we were able to help his neurological condition of

A. Merola

radiating pain, but he still had axial pain. That's mechanical pain.

Q. In the neck?

A. Correct. The mechanical pain in the neck comes from the C5-6 damaged area. Had I thought it was C4-5 and 6-7, I would have operated on those areas. My rationale for writing this report is to say we should treat the neck from a conservative perspective, so as not to increase stress at 4-5 and 6-7. And that's why I indicated "stable."

Q. Where?

A. If I may, his neurological status remains stable but has palpable pain, spasm, and tenderness in both his neck and back areas. And he also was utilizing a soft cervical collar and treating with Dr. Podhorodecki. So for the axial pain which we can really attribute to the 5-6 traumatic injury from his work accident, that would require conservative treatment, and in so doing, we would also decrease stress at 4-5 and

A. Merola

at 6-7.

Q. When you said "particularly given the fact that he has adjacent segment disc herniations, which we are continuing to observe from the surgical point of view," what did you mean from "we are continuing to observe fro the surgical point of view"?

A. So those are always areas that, should they become a problem, we would treat from a surgical perspective.

Q. Okay. So were you suggesting at that time the possibility that the C6-C7 and the C4-C5 might require surgical intervention at a later date, should they become a problem clinically for the patient at a later date in the future?

A. Well, of course. If there's a problem at an adjacent segment, we would treat it accordingly.

Q. Okay. And the problems that you would be -- the indicia you would be looking for to determine whether or not surgical intervention is appropriate,

A. Merola

let's just take C6-C7, in the future, would include the clinical picture, his complaints of pain, correct? And the length of time that the pain persisted?

MR. ENGLE: I object. Why don't you ask the witness when a patient would surgically -- you're talking about two things. There could be many other things.

MR. POLLACK: I said "among other things."

Q. That would be one of the things that you would consider, would be the clinical picture that he presents with; meaning, the complaints of pain and the duration of that pain, that would be a factor that you would consider in determining whether surgical intervention was necessary at a later date; is that correct?

MR. ENGLE: Objection to the form. I think your question is too limited in form.

MR. POLLACK: Okay.

A. Merola

MR. ENGLE: You're leaving out various other things I won't say so you won't suggest I'm coaching the witness.

A. I would say that it's not just as simple as pain. So it would depend on their clinical presentation.

Q. It's one of the factors?

A. Pain is always a potential factor.

Q. What are the other factors that you would consider?

A. I mean, there are multiple factors. I mean, if we're going to specifically look at this particular patient, for example: Was their condition clinically deteriorating; was there a clinical deterioration in condition where a treating re-referred to a surgeon for deterioration; was there a specific inciting incident that caused the clinical deterioration.

So there are multiple issues that go into the treatment of the

A. Merola

patient's condition.

Q. Now, if you take a look at -- by the way, you mentioned earlier that the pain is just one of the clinical indicators, that other clinical indicators -- that there are other -- what are those other clinical indicators?

A. Numbness.

MR. ENGLE: You just asked two questions.

Are you asking what are the various indications for surgery? In other words, various testing is done, nerve involvement?

I mean, do you want the witness to explain what the presentation was that indicated for surgery at C6-C7, or are we still speaking generally?

MR. POLLACK: Well, he mentioned that pain is just one of the clinical factors and that there are other clinical factors, and I'm trying find out from the witness what those other clinical factors were generally, and

A. Merola

then I will ask if they were present in this plaintiff.

MR. ENGLE: Fair enough.

A. The other clinical factors include aggravating -- what aggravates the pain; what, perhaps, might ameliorate the pain; does the pain travel or radiate; is there associated numbness or tingling or weakness. Those kinds of things would be taken into consideration.

Q. Continuing on page 7 right below where you gave your -- I guess, the summary of your opinion, the paragraph right below that which begins, "Mr. Papiez had undergone an anterior cervical discectomy and spinal fusion of the C5-C6 segment, but he did quite well after that surgical procedure up until the accident of October 31, 2013, and there was nothing to suspect that he would have otherwise necessitated surgical interventional, albeit for the trauma of October 31, 2013."

Do you see that?

A. Merola

A. Yes.

Q. What did you mean that there was nothing to suspect?

A. Well, up until that traumatic incident had happened, he was essentially clinically stable and continuing to treat with Dr. Podhorodecki much the same way as he had been in July of 2008, from this previous record that we had reviewed, when I saw him on July 14, 2008.

Q. What does "clinically stable" mean?

A. In other words, no neurological deterioration, no progressive pain.

Q. Meaning getting worse?

A. Meaning getting consistently and persistently worse and no deterioration to the point where Dr. Podhorodecki had re-referred him to me for surgical evaluation.

Q. So then you continued. After you say "albeit for the trauma of October 31, 2013," then you go on to say that "the C3-C4, C4-C5, C6-C7 and C7-T1 herniations

A. Merola

were caused and/or significantly accelerated and/or exacerbated by the 2013 trauma."

So what did you mean by that?

A. Well, his deterioration over time -- and I think it's best to be more specific for the C6-C7 segment --

Q. Okay.

A. -- as an exacerbation and an aggravation. I think that's a more specific term with respect to what happened.

Q. An exacerbation and?

A. Aggravation.

Q. Okay. Of the earlier C6-C7 small herniation that was identified back in 2006, correct?

A. Yes.

Q. So what you're saying is that -- if I'm misstating what you're saying, please tell me -- that at least insofar as the C6-C7 herniation is concerned, it was significantly accelerated and/or exacerbated by the 2013 trauma because it

A. Merola

had -- it was already in existence; it was just made worse by this particular event, correct?

A. Yes.

Q. As to the others, do you have an opinion as to whether it was caused by or accelerated or exacerbated?

A. I would consider those to have been exacerbated because of his overall clinical deterioration. But I would specifically be able to opine that 6-7 clearly got to the point where it did require surgery.

Q. Just to bring it all together, when you say it clearly got to the point --

A. Yes.

Q. -- that's because of what?

A. That's because his clinical condition deteriorated.

MR. ENGLE: Objection to the form. You're saying "because of what." You mean -- you're asking him because of the accident of October 31,

A. Merola

2013?

Are you asking that question?

MR. POLLACK: No.

You want to read back the question.

(Whereupon, the requested portion was read back by the court reporter.)

Q. And that is what caused you to believe or conclude that surgical intervention was necessary, correct?

A. Yes.

Q. And then, just to finish out that paragraph, "It was the 2014 posttraumatic fusion at C6-C7 which caused and significantly accelerated progression of the C7-T1 herniation."

What did you mean by that?

A. There's a C7-T1 herniation on some post-op MRIs that he's had. So that's an area of potential concern.

Q. What did you mean by "2014 posttraumatic fusion"?

A. Oh, the C6-C7 level having been

A. Merola

undertaken because of the October 31, 2013, accident.

Q. Okay. Going back to page 4 of your report -- I promise I'm not going to do the whole report; I'm just doing parts of it -- second full paragraph which begins "I next saw Mr. Papiez."

Do you see that?

A. Yes.

Q. The last sentence?

A. Yes.

Q. He previously had an AC -- this is your note of April 10, 2015, correct?

A. Yes.

Q. So you've already done the C6-C7 surgery, correct?

A. Yeah.

Q. In September 2014?

A. Correct.

MR. ENGLE: Seven months earlier.

Q. It says here "He had previously had an ACDF of the C5-C6 segment."

That's the 2007 surgery,

A. Merola

correct?

A. Yes.

Q. And developed a posttraumatic herniation at C6-C7 with cord and nerve root compression for which you performed the revision anterior cervical surgery on that segment, correct?

A. Yes.

Q. So when you say he developed a posttraumatic herniation, again, are you saying that the disc became herniated post-trauma 2013?

MR. ENGLE: Objection to the form. He says "posttraumatic herniation C6-C7 with cord and nerve root compression."

You know very well and he has already explained there was a prior herniation. Now he's talking about his developed nerve root -- cord and nerve root compression post-10/31/13.

So I object to the form of your question. It's misleading. It's not fair to this witness and it's wrong.

A. Merola

Q. So are you saying then that the post-trauma of the 2013 incident caused the herniation to now have cord and nerve root compression?

A. And become symptomatic, yes.

Q. And become symptomatic, whereas, previously it was not symptomatic, correct?

A. Correct.

MR. ENGLE: Objection to the form. And previously did not have nerve root compression or cord compression. Let's ask the question in proper form.

MR. POLLACK: Okay.

Q. How do you know that there was no cord and nerve root compression?

MR. ENGLE: Objection to the form of the question.

MR. POLLACK: That's because I didn't finish it.

MR. ENGLE: No, no. "How do you know" is improper as to form to a physician. The question is "to a

A. Merola

reasonable degree of medical certainty or probability" or --

Q. You're stating your opinion here that the incident of October 2013 -- October 31, to be precise -- 2013, caused a condition whereby the C6-C7 now had cord and nerve root compression that did not previously exist prior to that incident, correct?

A. Yes.

Q. What's the basis for your opinion?

A. When I saw the patient on February 3rd of 2014, there was no appreciable atrophy in the upper extremities.

Q. Meaning what?

A. Meaning that there was no shrinkage of the C7 muscle that is the triceps.

Q. And therefore?

A. It had not been longstanding.

Q. What's the time frame that you would require to find something to be

A. Merola

longstanding?

A. The time frame can vary, but in general, patients such as Mr. Papiez who had prior fusions with some small adjacent segment herniations, had there been a pre-existing nerve compression with these neurological findings, you would anticipate appreciable muscle atrophy, which he did not have.

Q. Does that preclude the possibility, within a reasonable degree of medical certainty, that the cord compression could have been present prior to October 31, 2013?

MR. ENGLE: Objection to the form of the question. Don't answer the question in that form. The appropriate form for a medical expert is not about possibilities.

MR. POLLACK: I said "within a reasonable degree of medical certainty."

MR. ENGLE: Guess what? You didn't. You used the word

A. Merola

"possibility" in your question.

MR. POLLACK: You want to read my question back.

(Whereupon, the requested portion was read back by the court reporter.)

MR. ENGLE: I stand by my objection.

Don't answer the question in that form.

Q. With a reasonable degree of medical certainty, could the cord compression of Mr. Papiez at the C6-C7 segment have pre-existed October 31, 2013?

MR. ENGLE: Objection to the form.

Don't answer the question.

It's about probabilities. You know, you didn't even ask about the prior MRI showing no nerve root involvement and the one afterwards showing nerve root involvement.

MR. POLLACK: The one seven years later?

A. Merola

MR. ENGLE: Yes, the one seven years later. And, by the way, there's no nerve root involvement for a number of months --

MR. POLLACK: Howard, you can't direct him not to answer on a form question.

MR. ENGLE: I can.

MR. POLLACK: You can't.

MR. ENGLE: You have to ask questions about probability.

Q. Okay. What is the probability, within a reasonable degree of medical certainty, that the cord compression that I will represent to you was found on December 9, 2013 -- so roughly five weeks after this incident, by Dr. Payne -- what is the probability that that cord compression was in existence prior to October 31, 2013?

MR. ENGLE: Is there any evidence of that? What are you talking about that? Does he have the films in front of him? You're not

A. Merola

showing him a report. There's no pre-existing cord compression at all and any evidence of that whatsoever.

So what are you talking about "probabilities that existed before" if there's no evidence of it? It makes no sense.

MR. POLLACK: Because the Doctor said that because of the lack of atrophy, which he would have expected to have found if it was of prolonged duration, that's why he concluded that it was due to the trauma. And I am simply asking him, Howard, that the finding --

MR. ENGLE: And there's no evidence of nerve root compression even after the accident for a while.

MR. POLLACK: There's no MRI so that's exactly my point.

MR. ENGLE: But there's no clinical --

MR. POLLACK: Howard, listen. If my questions aren't good, then the

A. Merola

Judge will strike them, and they won't go in, and it will be like this thing never happened.

MR. ENGLE: I'm just saying --

MR. POLLACK: I know what you're just saying.

MR. ENGLE: -- there's no nerve root involvement afterwards for quite a period of time, even after the accident.

MR. POLLACK: I didn't say anything about nerve root compression.

BY MR. POLLACK:

Q. I will represent to you, Doctor, that on December 9, 2013, roughly five weeks after the incident in question in this case, Dr. Payne concluded that, at C6-C7, based on an MRI, there was a right foraminal and para-sagittal herniation, with hemicord compression and impingement upon the exiting C7 and originating right C8 roots.

That was his finding, okay. And that was roughly five weeks after the

A. Merola

incident in question in this case.

My question to you is: Based upon what you observed in terms of the lack of muscle atrophy, what is the probability that what Dr. Payne observed on the MRI five weeks after the incident pre-existed the incident -- simple question -- within a reasonable degree of medical certainty?

MR. ENGLE: Objection. May I see that?

MR. POLLACK: (Handing.)

MR. ENGLE: And you're talking about which exam of his?

MR. POLLACK: It's in his report. And he was just explaining why he believed there was a posttraumatic herniation which now caused cord and nerve root compression -- Howard, look, we're not going to get anywhere. If we have to get a federal magistrate to sit here and referee, then we will, but -- no, I'm sorry --

A. Merola

MR. ENGLE: Stop shouting at me.

MR. POLLACK: It's 6:00 already.

MR. ENGLE: I understand that. Here's the question. Here's the question: I think you just want to understand how quickly you go from a herniation to nerve root compression following a trauma -- a herniated disk and then there's trauma, and then there's nerve root compression.

Is that your question?

MR. POLLACK: That's not my question.

Q. Do you understand my question, Doctor?

A. I think I'm getting the gist. I don't know. Ask me again, I guess, and I will see if I can answer.

Q. When you concluded that the post -- that the trauma of October 31, 2013, caused the pre-existing herniation at C6-C7 to now cause cord compression, just cord compression, when you concluded that, did you rule out the possibility

A. Merola

that that cord compression pre-existed the traumatic event?

MR. ENGLE: Objection. He just said it's causally connected so how can he talk about a pre-existing event? He's just given the opinion that it's related to the accident.

Objection to the form of your question. It is contradictory in the question.

MR. POLLACK: Okay. I got you.

Q. Can you answer that question?

A. I thought I answered that with the atrophy issue.

Q. Right.

And what did you tell us about the atrophy?

A. That I did not see any atrophy on February 3, 2014.

Q. And what did that tell you?

A. It told me he had no longstanding compression or previous neurological compression that would have led me to believe that this condition was

A. Merola

longstanding prior to the trauma.

Q. Generally speaking, is there a standard or a time frame which you look at to conclude that something is of such recent nature that it will not result in the atrophy?

MR. ENGLE: Objection.

A. That's a difficult question to answer because, if atrophy is longstanding -- you know, longstanding means what? Greater than three months, greater than six months? -- it's reasonable to think in terms of three-month time periods because you would have to have the nerve die within the muscle, and then the muscle is no longer able to respond to nerve death, and then you incur atrophy.

So it does take some time for that to occur. And had that been the case here, before this accident happened, you would have seen some evidence of muscular atrophy that he was not present. He did have sensory loss, and he had muscular

A. Merola

weakness.

MR. ENGLE: On what date?

THE WITNESS: February 3, 2014.

A. So he was on the road to getting worse at this point in time.

Q. So the accident occurred on October 31, 2013, so you've got November, December, and January, and you saw him on February --

A. 3rd.

Q. -- February 3rd. So pretty much three months, okay. It's a simple question.

Within a reasonable degree of medical certainty, could there have been cord compression already beginning sometime earlier in October and by the time you saw him February 3, not showing those atrophy signs?

MR. ENGLE: Objection to the form of your question.

Q. You can answer it.

MR. ENGLE: Let me finish my objection first, if you don't mind.

A. Merola

To say it's a simple question is argumentative to this witness and disrespectful and presumes that he didn't answer the question already, which he already did. And, secondly, to say "could" isn't inappropriate as to form.

So I'm saying the witness has already answered the question, and it's inappropriate as to form.

Q. So, in your opinion, you would rule out, with a reasonable degree of medical certainty, that the cord compression existed at any time prior to October 31, 2013?

MR. ENGLE: Objection to the form.

Q. Is that your opinion?

A. I would rule out significant pre-existing cord compression at that level, yes.

Q. Now, when you said significant --

A. At C6-C7, to cause atrophy.

A. Merola

Q. So we're right in that three-month window, correct?

MR. ENGLE: Objection to the form.

A. Which clinically correlates to the traumatic injury, yes.

Q. Let's take a look at your February 14 -- we will mark this Defendant's C.

(Defendant's C, physician's note dated February 3, 2014, marked for identification, as of this date.)

Q. This is your note of February 3, 2014, when you first saw him following -- for the first time following the October incident, correct?

A. Yes.

Q. A lot of your report was, for lack of a better word, "cut and pasted" from these notes?

A. The narrative was a summary of my treatment, yes.

Q. Now, in the first paragraph towards the end, it said that "He is

A. Merola

presently on hydrocodone, as well as gabapentin."

A. Yes.

Q. What's hydrocodone?

A. It's a narcotic pain medication.

Q. Do you know when that was first prescribed for him?

A. I believe Dr. Podhorodecki had prescribed medications for him. I don't know the first time he had been prescribed hydrocodone.

Q. Do you know how long he had been taking hydrocodone?

A. I believe he had been taking hydrocodone, or some form therein, off and on since the time of his initial industrial accident.

Q. And what's gabapentin?

A. It's a neurological medication.

Q. And what does it do for you?

A. It decreases nerve sensitivity and nerve pain.

Q. At the bottom it says, "MRI scans, magnetic resonance imaging scan,

A. Merola

demonstrates a right para-foraminal herniation at C6-C7 sub-adjacent to the prior fusion site.

Do you see that?

A. Yes.

Q. And the prior fusion site is the C5-6, correct?

A. Yes.

Q. And do you recall the date of the MRI that you looked at?

A. This was the post-accident MRI. I don't recall the specific date.

Q. December -- does October 10 sound familiar?

A. Park Place MRI?

Q. Yes.

A. I believe so, yes.

Q. Now, did you look at a report from Park Place, or did you actually look at the film?

A. The film.

Q. How did you get the film?

A. We have online access. Park Place is no longer in existence, by the

A. Merola

way, but when it was, we had online server access to acquire images.

Q. So you could personally visualize the actual film that was taken on December 9, 2013, correct?

A. Yes.

Q. And your opinion, when you were treating him on February 3, 2014, was that the MRI showed a right para-foraminal herniation at C6-C7, correct?

A. Yes.

Q. If you had seen cord compression, would that have been significant to you?

A. I may not have indicated it at the time.

Q. That wasn't my question.

Would that have been significant to you?

A. Cord compression is always significant.

Q. In fact, that's one of the pain producing --

A. Could be.

A. Merola

Q. Could be, okay.

But that would be significant, correct?

A. Can be.

Q. And what about root impingement?

A. Yes.

Q. Do you typically, as a matter of practice, record on your notes significant findings?

A. In terms of -- I'm not sure I understand what you mean in terms of "significant."

Q. When you're reporting what you see on an MRI film, as part of your treatment of a patient, which ultimately may lead to surgery, would it be part of your practice -- it would be good practice to record on your notes findings of significance, correct?

A. Yes.

Q. And cord compression is a finding of significance?

A. Can be, yes.

Q. And in what situations is cord

A. Merola

compression not significant?

A. Asymptomatic cord compressions.

Q. Okay. Well, with Mr. Papiez, who was symptomatic when he came to you on February 3, 2014, correct?

A. Yes.

Q. Cord compression would be, then, significant, correct?

A. Cord compression would be an issue, yes.

Q. And it's something you would have reported had you seen it, as a matter of good practice?

A. And I did.

Q. Where?

A. When I say "right para-foraminal herniation," it is the anatomical location of the cord and the roots. So it is understood anatomically, within the sentence, that cord and root compression are present.

Q. So when Dr. Payne, who's the radiologist -- it's his specialty to read and interpret MRIs, correct?

A. Merola

A. Yes.

Q. When he wrote on December 9, 2013, "At C6-C7, there is a right foraminal and para-sagittal herniation with hemicord compression, was he being redundant?

A. Yes.

MR. ENGLE: Objection to the form. Different physicians have different practices.

MR. POLLACK: Okay.

Q. When you saw Mr. Papiez on February 3, 2014, did you know the dosage of hydrocodone that he had been taking?

A. No.

Q. Is that significant to you?

A. No.

Q. To know what it is?

A. No.

Q. So a lot or a little doesn't make a difference?

MR. ENGLE: Objection to the form. It's argumentative and disrespectful --

A. Merola

MR. POLLACK: Argumentative? Oh, my goodness. I'm not being disrespectful.

MR. ENGLE: -- of the witness and his stature.

Q. Dr. Merola --

MR. ENGLE: "A little or a lot doesn't make any difference?" Give me a break. It's not what -- it's not what the witness --

MR. POLLACK: I think it is. I think disrespect is a subjective thing, and if Dr. Merola doesn't feel disrespected --

MR. ENGLE: Well, he's got a thicker skin. The point is not what he felt by your question, whether you were acting professionally or not to ask a question that showed disrespect to the witness.

MR. POLLACK: Thank you. Thank you. Okay. God.

MR. ENGLE: You're welcome.

BY MR. POLLACK:

A. Merola

Q. Do you remember when, for the first time, Dr. Podhorodecki -- or when she actually referred him to you, prior to February 3, 2014?

A. I don't recall the initial referral, no.

Q. Now let's take a look at June 20, 2014.

MR. POLLACK: Which you can mark as Defendant's D.

(Defendant's, physician's note dated June 20, 2014, marked for identification, as of this date.)

Q. Now, you told us a couple of minutes ago that cord compression or root impingement with a patient who is symptomatic, comes to you with clinical findings of pain, would be significant findings, but you don't -- didn't write them down in February of 2014, but you referred to them when you wrote "right para-foraminal herniation," correct? -- because that's the area where the cord compression would be, correct?

A. Merola

MR. ENGLE: Objection to the form. I don't understand it.

But over objection.

A. Yeah, I think -- when you say "didn't write them down."

Q. You didn't feel the need to actually report the significant finding of cord compression or nerve root impingement verbatim, but you were actually reporting it when you wrote a "right para-foraminal herniation"?

MR. ENGLE: Objection to the form. It was implicit in what he said.

Q. That he was your testimony?

A. I indicated the anatomical location of the herniation.

Q. So take a look at June 20, 2014. So that's roughly three months -- well, seven months later, right?

At the bottom. That's Exhibit D, which -- (handing).

A. Thank you.

Q. You wrote "MRI" -- and I assume

A. Merola

you're still referring to December '13, correct?

A. Yes.

Q. December 2013?

A. Yes.

Q. -- is consistent with significant right-sided para-foraminal herniation at C6-C7 segment, with cord compression and nerve root compression.

A. Yes.

Q. So two questions.

First of all, can you tell us why, seven months later, when you were reporting on the same image that you had seen earlier, you now referred to the right-sided para-foraminal herniation as significant but did not when you first reported it in February of 2014?

MR. ENGLE: Note my objection to the form of the question. It does not include the physical examination and complaints in your question, just based on the scans. And that's not appropriate because there was an

A. Merola

actual physical examination.

MR. POLLACK: Well, there was an actual physical examination in February as well.

Q. This is just your report about what you were seeing when you looked at the radiograph of December 9, 2013.

My question is, when you saw it, when the patient first came in with the complaints, you did a physical examination, and you read the MRI personally, and you referred to a right para-foraminal herniation at C6-C7; seven months later, when he came back, you referred to it as a "significant right-sided para-foraminal herniation."

My question is very simply, why did you find at to be significant seven months later, or report it as being significant?

MR. ENGLE: Objection to the form.

MR. POLLACK: Okay.

Q. You may answer.

A. Merola

MR. ENGLE: Excuse me. Objection to the form of your question. It's four months. Not seven months.

MR. POLLACK: Fine. Four months.

A. So every report is handmade, which means I dictate at the time I see the patient. None of it is cut and paste. So, in June of 2014, I likely had a couple of extra seconds' worth of dictation time, and I was more redundant and specific in my reporting of the MRI scan.

MR. POLLACK: Mark this E.

(Defendant's E, physician's note dated October 13, 2008, marked for identification, as of this date.)

Q. Let's take a look at your note of October 13, 2008, which by my calculation, is ten months post-op from the original surgery, okay?

A. Yes.

Q. It says here in the first paragraph, "He continues to have

A. Merola

mechanical axial neck pain."

So that's pain in the neck when he moves, right?

A. Yes.

Q. "With bilateral upper extremity pins and needles, numbness and tingling."

Can you tell us in your opinion if you know what would cause those clinical complaints?

A. It's actually in the body of the report.

MR. ENGLE: Objection to the form of the question. "Do you know" is inappropriate as to form.

But over objection...

A. The initial injury of C5-C6.

Q. So ten months after the surgery, he's still having complaints stemming from the C5-C6?

A. Given the fact that it is a stabilization and not a repair, because nerves can't really be repaired, yes.

Q. Then you go on to say, "The plan: Indeed, this is secondary to the

A. Merola

fact that neurological damage secondary to the injury itself is irreversible."

What does that mean that?

A. That means he was having persistent pain as a consequence of the C5-C6 trauma that he had sustained.

Q. Was it coming from the C5-C6?

A. Yes.

Q. Do you know or was it also coming from other segments of the spine?

MR. ENGLE: Objection to the form. "Do you know" is inappropriate as to form. No foundation.

But over objection, you can answer.

Q. As the treating physician who examined him, do you have an opinion as to whether or not his clinical complaints were coming from sources in the body other than the C5-C6 area that you had previously operated on?

MR. ENGLE: Objection to the form of the question.

MR. POLLACK: Okay.

A. Merola

A. This would be as a consequence of the C5-C6 injury.

Q. Now, February 16, 2009, he came back.

MR. POLLACK: We will mark this as F.

(Defendant's F, physician's note dated February 16, 2009, marked for identification, as of this date.)

Q. This is your report?

A. Yes.

Q. You signed it on the second page?

A. Yes.

Q. Indeed, all the reports I gave you before were your reports, correct?

A. Yes.

Q. You dictated them?

A. Yes.

Q. And they're accurate, to the best of your knowledge?

A. Yes.

Q. So now we're 13 months post-op, a little over a year, correct?

A. Merola

A. Yes.

Q. Where it says "impression and plan," it say, "He, at this point in time, manifests signs and symptoms which are consistent and concordant with total disability and an inability to perform duties."

Do you see that?

A. Yes.

Q. Did you have an opinion at that time as to whether Mr. Papiez was permanently totally disabled, or was this a transient condition?

A. Well, it was certainly as of this office visit, and this is a report specifically indicating that he was disabled from work as a consequence of his work injury.

Q. My question is, in your opinion at that time, was that disability permanent so that he would never be able to work again; or barring any future trauma or any other incident, he might someday be able to return to work?

A. Merola

A. That would be speculative on my part. I can only comment as to it being done for the purposes of his industrial injury and that he was disabled from duties based on that injury.

Q. At that time?

A. Correct.

Q. In the "impression and plan" section there, after number 2, it talks about the surgical intervention?

A. Yes.

Q. That, it was "successful in ameliorating some of his radicular complaints and symptoms, but unfortunately, unsuccessful in completely and entirely alleviating them or alleviating mechanical" -- I think you meant "axial pain"?

A. Yes.

Q. Okay. Then you go on to say, "Mr. Papiez understands that, within a reasonable degree of medical certainty, the amelioration of his complaints and symptoms and progression of further

neurological deficits is within the realm of realistic goals and expectations with surgical intervention."

What did you mean by that?

A. That we stabilized him with surgery.

Q. So where he was at that time in terms of pain in certain areas was within the realistic goals of that surgery?

A. Yes.

MR. POLLACK: Mark this G.

(Defendant's G, physician's note dated June 28, 2010, marked for identification, as of this date.)

Q. So referring to Exhibit G which is June 28, 2010, your note -- that's your note, correct?

That's your signature there?

A. Yes.

Q. The first paragraph, it says -- I'm sorry, second paragraph, under "physical examination." It says, "Biceps and brachioradialis reflexes are absent."

What does that mean?

A. Merola

A. Those are the C5 and C6 nerve roots.

Q. And "pinprick and tactile sensation," that's touch?

A. Yes. And pinprick, which is a mildly painful stimulus.

Q. Right. I was referring to the "tactile" part.

A. Yes.

Q. Okay. "-- is absent in C4, C5, and C6 dermatomal distributions of the upper extremities."

What are the dermatomal distributions?

A. Those refer to the nerves of C4, -5 and -6.

Q. Okay. Would the C6 dermatomal distributions of the upper extremities, or the absence of pin prick or tactile sensations -- would that be reflective of a condition in the C6-C7 segment?

A. No.

Q. In June of 2010, when you were developing -- you did your physical exam

A. Merola

and you were developing your impression and plan, you said that "This gentleman may return to me on an as-needed basis, depending on whether or not future surgical and/or lumbosacral" -- and that's the lower back, correct?

A. Yes.

Q. -- "radicular complaints or symptoms worsen in the future."

What did you mean by that?

A. Come back if the pain got worse.

Q. Okay. And what are some of the possibilities in terms of treatment that you might offer a patient such as Mr. Papiez, who might return to you if you things get worse?

A. Surgery, if need be.

Q. Surgery in other areas?

A. If necessary.

Q. So his coming to you in February of 2014 was consistent with him returning for a surgical evaluation, at least, when his symptoms became worse than what they were in June of 2010?

A. Merola

And I'm not attributing it to any particular cause; is that right though?

A. Yes.

MR. ENGLE: Let's take a quick break.

(Recess taken.)

MR. POLLACK: So let's take a look at the next exhibit, which is H.

(Defendant's H, physician's note dated July 30, 2015, marked for identification, as of this date.)

Q. So this is your note of July 30, 2015, right?

A. Yes.

Q. And that's roughly ten months after the surgical procedure on the C6-7 on September 2014?

A. Yes.

Q. Now, the last sentence of the physical examination -- actually, the second to the last sentence, "There were decreases in pinprick and tactile sensory findings involving the C4-C5, C6-C7, and

A. Merola

to some extent, C-8 dermato myotomal distributions of the upper extremity, arms and hands, with some evidence of proximal junctional segment radiculopathy present. This is correlated with new magnetic resonance imaging scan demonstrable of a proximal junctional herniation with compression at C4-C5."

Do you see that?

A. Yes.

Q. So can you tell us what the cause of the proximal junctional herniation with compression at C4-C5 was?

A. There was some stress at C4-C5, and it's causing symptoms.

Q. And the stress is following the -- withdrawn.

The C4-C5 is immediately adjacent to the 5-6, correct?

A. Yes.

Q. So this herniation was caused just without any particular trauma. It was just from the stress following the -- over time, following the surgery on the

A. Merola

C5-C6 back in 2007, correct?

MR. ENGLE: Objection to form.

Q. Is that right?

A. In part, yes.

Q. And that roughly took about eight years, correct?

A. Yes.

Q. Now, when you say "in part," what other parts are there?

A. Well, he is symptomatic here, on July 30, 2015, at C4-C5, more so than he is in February of 2014. So he's also had, you know, a fusion at 6-7. So you have a longer segment which may be increasing some stress at 4-5, causing some symptoms at C4-C5.

Q. But, predominantly, the proximal junctional herniation with compression at C4-C5 is as a result of the stress on that area caused over time, stemming from the original surgery at C5-C6 in 2007, correct?

MR. ENGLE: Objection to "predominantly." Well, objection to

A. Merola

the form of your question.

MR. POLLACK: He will tell me "It's not predominantly," the same way he will say "in part."

MR. ENGLE: Except if I have a problem with the form of the question --

MR. POLLACK: You can't explain what your problem is. You can only say you have a problem with the form of the question, and then a judge will go ahead and rule.

MR. ENGLE: Go ahead and guess, because I'm going to ask you to rephrase the question.

MR. POLLACK: Okay.

MR. ENGLE: Rephrase the question.

MR. POLLACK: You can just object to it. If you don't like it --

MR. ENGLE: The problem is the "predominance." You also haven't talked about "reasonable degree of medical probability."

A. Merola

BY MR. POLLACK:

Q. I assume all of your testimony here is to a reasonable degree of medical certainty, Doctor.

MR. ENGLE: If you could stop interruption me --

MR. POLLACK: Howard, all you're doing is trying to interject --

MR. ENGLE: All I'm trying to do is get good, clean, appropriate questions.

MR. POLLACK: If it's not good and clean, the judge will penalize me.

MR. ENGLE: And I'm objecting and stating that it's not because you're talking about predominantly he was talking about a number of factors.

MR. POLLACK: Okay. You've now just ruined the entire record.

Can you read back my question and his answer?

MR. ENGLE: Thank you for taking it so personally.

MR. POLLACK: Okay. Fine.

A. Merola

Can you just read back my question and Dr. Merola's answer.

(Whereupon, the requested portion was read back by the court reporter.)

MR. ENGLE: Objection to the form.

MR. POLLACK: I heard you. I got you.

MR. ENGLE: You also said the "extension of 6-7," so that's the problem with your question and the "predominantly."

Objection to both.

BY MR. POLLACK:

Q. Did you understand my question, Doctor?

If there are other factors, you're more than welcome to tell me, but predominantly, this is a proximal junction segment issue, stemming from the stress over the prior eight years or so, stemming from the original surgery in the C5-C6 to a reasonable degree of medical certainty;

A. Merola
is that correct?
MR. ENGLE: Objection to the form.
A. In part, yes.
Q. What are the other factors other than the fact that you've also got the C6-7 and that there's a longer stabilized area?
What other factors?
MR. ENGLE: Objection. He's also talked about --
MR. POLLACK: Okay. You know what? I'm sorry. You need to stop feeding the witness information, Howard. This is so palpably wrong --
MR. ENGLE: You have ignored page 7.
MR. POLLACK: I'm asking the Doctor his opinion. He has his report in front of him. If he wishes to add -- he's already said "in part," and I have invited him to tell me anything else he wants to tell me. He does not need you to read from his

A. Merola
report to tell him what he should tell me.
MR. ENGLE: I'm telling you --
MR. POLLACK: Now, either --
MR. ENGLE: Stop yelling at me.
MR. POLLACK: No. Either you stop doing this, or I'm going to bus this deposition, and I will go to the Judge, and I will show him this.
I'm inviting the Doctor to tell me anything he wants to tell me about what other reasons might have caused this proximal junctional segment issue at C4-C5.
MR. ENGLE: And I'm asking you to stop yelling at me. Stop making it a personal thing. I'm telling you that you're ignoring prior testimony; you're ignoring what you also read before in his report, and I think it's unfair to this witness and, therefore, that's my objection to the form of the question.
MR. POLLACK: Do you really

A. Merola

think you will be able to pull this off at trial, Howard?

MR. ENGLE: Do you think you will?

MR. POLLACK: There will be an objection.

MR. ENGLE: Ignoring prior testimony --

MR. POLLACK: It will be objected to.

MR. ENGLE: It is.

MR. POLLACK: There will be a ruling, and we will move forward.

MR. ENGLE: I'm objecting to it.

MR. POLLACK: Okay.

BY MR. POLLACK:

Q. Do you understand my question, Doctor?

So we've got that it's, in part, related to the fact that it's right next to the 5-6, in part related to the fact there was also the C6-7, which made that a longer segment that was now stabilized.

What other factors?

A. Merola

A. And at this point in time, he has become a little bit more symptomatic at C4-C5, manifesting some C4-C5 symptoms, which -- for which I counseled him on this particular day, July 30, 2015.

Q. And you indicated that future surgery might be necessary, correct?

A. And we would need to, of course, monitor and treat that area as well, yes.

Q. Okay. And then you said, in the middle of the impression and plan: "He is advised that should his condition progress over the course of time, future surgical intervention will be indicated and required. And, particularly, based upon his age, one may suggest and justify that this particular segment" -- referring to 4-5 -- as it appears on the MRI now may, indeed, require revision within the next ten years or so.

So just two questions. Question one: The revision is a first-time surgery, right?

It's not a revision; you haven't

done anything yet on the 4-5, correct?

A. Correct.

Q. So the revision is some type of surgical intervention, correct?

A. Yes.

Q. Within the next ten years or so, correct?

A. Yes.

Q. Why within the next ten years or so?

A. It's an educated medical prognosis based on a two-level fusion with a patient who has symptoms at C4-C5.

Q. So, if I understand, you already have a two-level fusion, which is 5-6 and 6-7, generally speaking, it could take up to another ten years for, in this case, the 4-5 to require surgical intervention, just a general proposition?

A. In general, yes.

Q. Is there, within the literature or within the scientific community or the medical community, within a reasonable degree of medical certainty, a general

A. Merola

time frame over which an adjacent segment without trauma may be expected to take to herniate -- or that the herniation would increase over time, because of the stress factor, following the stabilization or the fusion of the adjacent segment?

Just general time frame?

Do you understand?

MR. ENGLE: Objection to form.

A. So much of that depends on wear and tear and the patient's overall status which is one of the reasons you would restrict their activities.

Q. To keep them calm?

A. Correct.

Q. Okay. But someone not working as a laborer, not bending over every day, just going about his business, what would you expect to see as a general time frame for that condition to develop?

MR. ENGLE: Objection to the form. Generally, for all people, all ages?

Over objection to form.

A. Merola

A. So it depends on age, work status, stress, body habitus, many different things, so you would have to make it more patient-specific.

Q. Do you have any intention of recommending in the near future that Mr. Papiez receive any further surgical intervention?

MR. ENGLE: Objection.

A. Let's see. I haven't recommended any incipient surgery within the short-term future, no.

Q. What does "incipient" mean?

A. Means we don't have anything planned at this time, as of our last visit.

Q. Let me show you what we will mark as I.

MR. POLLACK: And this is the Notice of Exchange of Medical Records that I received September 19, 2018, from Mr. Engle's office. And it contains the operative report, it says as of November 27, 2012, but the

A. Merola

operative report that is attached is September 4, 2014. I think that was a typo -- actually, September 3, 2014.

Can we agree on that, Howard --

MR. ENGLE: Yes.

MR. POLLACK: -- that it's different?

Here, you can have your copy. So we're going to note that for the record.

Then it also contains treatment medical records of -- this is March 2nd, June 20, and September 12, 2014, and then April 10, July 30 of 2015. July 21st of 2016. January 23rd of 2017. And July 2nd of 2018, by Dr. Merola.

So we will mark that.

(Defendant's I, Notice of Exchange of Medical Records, marked for identification, as of this date.)

Q. You see that?

A. Yes.

Q. I just wanted to very quickly go

A. Merola

through the operative report, which is towards the back.

A. Yes.

Q. Is this the operative report of the surgical intervention you performed on September 3, 2014, on Mr. Papiez at the C6-C7 segment?

A. Yes.

Q. And you also did an exploration of the spinal fusion at C5-C6?

A. Yes.

Q. What does that mean?

A. Just to see whether it was stable.

Q. Did you do any further treatment to it?

A. No.

Q. You left it alone?

A. Correct.

Q. Did you take any intraoperative photographs?

A. Just x-rays.

Q. Just x-rays.

Is it your practice to take

A. Merola

photographs of what you visualize when you open up the patient?

A. Only x-rays.

Q. Okay. So when I say "photographs," I mean pictures, right?

A. Yes.

Q. But that's not x-rays, right?

A. Correct.

Q. Okay, fine.

Now, at the bottom of the first page of the operative note, under where it says "indications" --

A. Yes.

Q. -- it says, "45-year-old man," so on and so forth, "He was doing quite well up until he sustained a new trauma to his neck that produced an acute herniation with cord injury and nerve root injury at C6-C7."

Do you see that?

A. Yes.

Q. What's an acute herniation?

A. A herniation that occurred as a consequence of trauma.

A. Merola

MR. ENGLE: Objection to the form. Just so you know -- counsel didn't quote the entire line.

MR. POLLACK: I did, Howard.

MR. ENGLE: "With cord injury and nerve root injury at C6-C7."

MR. POLLACK: Howard, I did. So...

Q. You indicated he had a pre-operative MRI at the bottom there.

Do you see that?

A. Yes.

Q. Is that the same MRI as the one that was taken in December of 2013?

A. Correct. This was the MRI that was done after the accident, yes.

Q. Is there a reason why another MRI, taken closer in time to the surgery, was not done?

A. He had no other traumatic injuries, and his examination and findings correlated consistently with all of my exams.

Q. Okay. Do you recall if you

A. Merola

observed any osteophytes in the C6-C7 area?

A. No osteophytes appreciated or removed.

Q. What are osteophytes?

A. Bone spurs, or extra bone formation.

Q. Are they indicative of anything in particular?

A. They can occur in any conditions that are inflammatory in an area where there is an articulation. It could be a joint; it could be a disc attachment to a bone, things like that.

Q. Are they a degenerative conditions?

A. They can be degenerative or inflammatory.

Q. But you didn't see any?

A. Correct.

Q. And you didn't see any on the MRI or when you visualized the patient, when you actually had him opened up?

A. Well, I didn't have to remove

A. Merola

any osteophytes. So in the dictation itself there were no osteophytes that required removal, or osteotomies and nothing that I appreciated on my pre-operative plan that would have indicated significant osteophytes.

Q. By the way, does smoking one to two packs a day over a period of decades -- is that relevant to the disc and the development of a herniation or the exacerbation of a herniation?

MR. ENGLE: Over objection you can answer.

Q. Is that a relevant factor?

A. Not in this particular patient.

Q. Okay. Can it be a relevant factor in some patients?

A. Sometimes, yes.

Q. And what's the correlation between the cigarette smoking?

MR. ENGLE: Objection. Generally speaking, not for this patient?

A. Yeah. I mean, in general,

A. Merola

cigarette smoking can sometimes lead to a failure to fuse.

Q. And so, in following a fusion surgery?

A. Correct.

Q. Otherwise it has no other relevance or significance?

A. In general, clinically, we deal with smokers and non-smokers, and they seem to have essentially the same types of issues with respect to their discs.

Q. I just wanted to -- I think we're going to have you out of here by 7:30.

I just want to go back to the original opinion that you gave us, which you summarized at page -- in the causation section on page 7 of your report which, I believe, is Exhibit A -- sort of correlate that with your initial examination of him in February of 2014, which you have in front of you as well.

And there he complained that, since October -- I'm sorry -- yeah.

A. Merola

Since October 31, 2013, after he had this trauma, "Since that time," you wrote, "he's been having significant neck pain and headaches, with upper extremity pain, extremity numbness, tingling, and weakness."

And it was of concern to Dr. Podhorodecki, who referred him to you, correct?

MR. ENGLE: Can you read it properly? Particularly "right-greater-than-left upper extremity tingling."

MR. POLLACK: Right, okay.

Q. And those -- in June of 2014, which you also have in front of you -- I forget the exhibit -- he reported "Progressive pain in the neck with pain radiating into the upper extremity, arms, and hands, including headaches, difficulty with ability to focus and concentrate, difficulty with ability to sleep at night, pain shooting in the upper extremity, arms and hands, including

A. Merola

right-greater-than-left upper extremity weakness."

And you, by that time, had spoken to Dr. Podhorodecki, who indicated that his condition had gotten worse over time?

A. Yes.

Q. Okay. And based upon his clinical complaints as reported to you as having begun on October 31, 2013, following the traumatic event, coupled with your review of the MRI and, of course, your physical examination, you ultimately concluded, with a reasonable degree of medical certainty, that the injury on October 31 directly resulted in the sub-adjacent posttraumatic, symptomatic herniations of the C6-C7 and the C7-T1 segments, which subsequently underwent surgical intervention at the C6-C7 level, in order to prevent further neurological deterioration, right?

That was your opinion? -- that the need for this surgery, within a

A. Merola

reasonable degree of medical certainty, was because of a traumatic incident that occurred to him on October 31, 2013, and the basis for that opinion is that he was not having any pain prior to that date and said that, since that time, he has been having all the pains that we previously described, plus your review of the MRI, plus your own clinical examination.

And that was your conclusion; is that accurate?

MR. ENGLE: Objection to the form of your question. It's overly confusing, "is that accurate"?

MR. POLLACK: Did I cover all of the bases for supporting your opinion that the incident that occurred at the Home Depot on October 31, 2013, caused the sub-adjacent symptomatic herniations of C6-C7.

MR. ENGLE: Objection. You left out the history.

MR. POLLACK: The history that he told you.

A. Merola

MR. ENGLE: You left it out from your question.

Objection to the form.

Q. Did I miss anything, Doctor?

A. Well I was going to answer your question by saying no.

Q. Okay. What did I miss?

A. You had said that he had no pain prior to the accident.

Q. Okay.

A. And I didn't base my opinion on the fact that he had no pain prior. I based my opinion on my previous treatment of the patient, my review of all the medical records, including the imaging studies and the records demonstrating a clinical symptomatic deterioration over time that correlated with a nerve root and cord compression at C6-C7, from -- stemming from the accident of October 31 of 2013.

Q. And you had all of Dr. Podhorodecki's records up until October 31, 2013, when you considered

A. Merola

them?

A. Of course, I certainly had Dr. Podhorodecki's records, yes. And I do know that he had been treating with her and had, as evidenced in my previous treatment records, a chronic pain syndrome from the prior C5-C6 injury.

Q. Do you know how long a period of time after you stopped seeing him in roughly 2010 that he continued to see Dr. Podhorodecki?

A. I don't have the record memorized, but I know that he saw Dr. Podhorodecki throughout. In fact, I, at one point in time, had -- I think he had requested a separate physical medicine doctor, and I made a recommendation. But he continued to treat with Dr. Podhorodecki, and he stayed very faithful to her care and treatment for all these years.

Q. As you sit here today, or as you sat there in February of 2014, and more importantly, when you wrote your report in

A. Merola

April '17, were you familiar with any complaints he was making to Dr. Podhorodecki in the month or two months or three months leading up to the Home Depot accident in 2013?

A. Yes.

Q. What were those?

A. He had chronic neck pain. He also had back pain, and he had exacerbations of neck and back symptoms, for which Dr. Podhorodecki would treat and prescribe medications.

Q. Did you ever categorize or describe those pains as minimal, mild, moderate, severe -- whatever nomenclature you would use?

A. Chronic.

Q. Chronic just means continuous?

A. Correct.

Q. I'm talking in terms of severity.

A. Not warranting a surgical consultation up until the accident occurred.

A. Merola

Q. Okay.

MR. POLLACK: So let me mark as Exhibit I, which, hopefully, Howard, you and I can agree to let this go into the record at trial; otherwise, we will have to take her deposition.

MR. ENGLE: We will have to discuss that separately.

MR. POLLACK: Yeah.

(Defendant's J, Affidavit of Areta Podhorodecki, M.D., marked for identification, as of this date.)

Q. So I'll represent to you, Doctor, that this is an affidavit from Dr. Podhorodecki, whose records I was unable to read, so before you look at the exhibit, I just want to ask you a couple of questions -- or tell you what this is.

So I was unable to read them. I saw some words -- no, before you look at it. Well, you can look at that one. That's fine. That's okay. You can look at her original records.

So we were going to take her

deposition, and she offered to transcribe her records, typing them and then giving them back to us in lieu of -- if Mr. Engle agreed, so that hasn't happened yet, and that's fine -- so we could avoid taking her deposition, just tell us what the words mean because I couldn't read them.

You, presumably having reviewed the records, may have had a better chance of being able to read the records, right, because all doctors can read each other's handwriting.

So what this is, is an affidavit she signed, authenticating certain of her records, beginning in July of 2013, going all the way up to October 30, 2018, along with the corresponding transcription. Okay?

A. Yes.

Q. That's what he this is.

So, if you go back to the original pages, which is basically Exhibit A, which she has before a notary public, attested that those are true and

A. Merola

accurate -- stick with A, right -- true and accurate, the first five pages from her records. Okay?

A. Yes.

Q. So can you take a look at July 8, 2013, and tell me what, if any, conclusions you made -- could make about Mr. Papiez's condition and the complaints he was making of a cervical nature in July of 2013, based upon your review of these records, which you earlier indicated was part of your review in advance of your report?

A. Sure. So, basically, this is a record indicating chronic cervical radiculopathy. Old injury. Working a little on and a little off. Needs Vicodin for pain. Chronic pain syndrome. Old cervical injury.

Q. Okay. And from that, can you tell whether or not any of that pain is emanating from the C6-C7 area?

A. Nothing here that indicates C6-C7.

A. Merola

Q. Do you have an opinion as to where you believe the pain would have been stemming from?

A. It says "chronic old injury," so C5-C6.

Q. The one that you surgically fused and stabilized, correct?

A. Yes.

Q. Let's go to the next one, September -- I think it's 7 -- 2013.

A. Yes.

Q. What do you see there of any significance to his clinical condition?

A. This is about chronic low back pain. Neurologically, nothing significant. Nothing that indicates any progressive deterioration. Follow-up visit. Prescribed what appears to be Vicodin for pain, 7.5/750.

Q. What is 7.5/750?

A. 7.5 milligrams of hydrocodone and 750 milligrams of acetaminophen, which is Tylenol.

Q. Is that a strong dosage or?

A. Merola

A. In the middle.

Q. In the middle?

A. Yeah.

Q. Would you expect to see from your patients requiring that kind of narcotic medication six years post-op, if it's only coming from the area that you surgically infused?

A. Sure. It's a chronic pain patient.

Q. What about --

MR. ENGLE: Objection to the form. Also it says "chronic low back pain."

Objection to the form of the question.

Q. October 6, 2013 the next one?

A. Yeah. It says: Neck pain; old injury; low back pain; DGD, degenerative joint disease, decreased ROM, range of motion; no neurological changes; no neurological triangle-S; no neurological changes.

Q. Any indication of any issues in

A. Merola

the C7 para-spinal area that you can see on this record?

A. Not neurologically, according to this, no. Prescribed some medications.

Q. What do you mean "not neurologically"?

A. Well, it says there is a decreased cervical range of motion, but there are no neurological changes.

Q. But, specifically, do you see anything -- any reference to the C7 para -- spinal area?

MR. ENGLE: You're reading the handwritten notes?

THE WITNESS: Yes.

MR. POLLACK: I'm just asking him a question.

MR. ENGLE: And you're looking at the typed ones. And I am too. And I think --

MR. POLLACK: Don't do this, Howard. Howard.

You're going to have to step outside, Doctor. I'm going to ask you

A. Merola

to step outside.

MR. ENGLE: The witness is not looking at what you're looking at. He has the typewritten document. You're intentionally not directing him towards it. You know very well it says "tender C7 para-spinal" in the typewritten document which you gave me -- you gave the witness, but you're not letting him look at it.

I think it's only fair that you say to him, "Please look at the transcribed chart," so that can he see what you can see. I think it's actually really -- I think it's --

MR. POLLACK: Careful now. Careful now.

MR. ENGLE: I'm being careful. I'm being very careful. You don't have to tell me how to be careful. I think it's not fair to know he is reading the handwritten notes. You're looking at the typewritten notes, and you're asking him a question that you

A. Merola

know the answer is in the typewritten notes, and it may or may not be easy to read in the handwritten notes. That's why you asked for Dr. Podhorodecki to transcribe her notes.

That's all I have to say.

MR. POLLACK: Okay. So to respond to you, Howard, this Doctor testified that he reviewed all of these records and that there was essentially nothing in these records to indicate that any of the patient's chronic pain was stemming from any area other than the surgically fused C5-C6, and was simply nothing more than chronic pain and that what happened to him on October 31 is the first time he is having any pain emanating from the C6-C7. That's his opinion based on his review of the records.

I am entitled to ask him if there's anything in those records that

A. Merola

indicate that there was any complaints or any notation by Dr. Podhorodecki about the C7 area. Yes, of course I have it in the transcription, because I can't read her handwriting. But if he couldn't read her handwriting, it was up to him to call her and say, I'm not sure what I'm reading.

He felt comfortable giving an opinion, and based upon what he read, there was no references to the C7 area, and I'm allowed to ask him that question.

MR. ENGLE: I agree with you. I think you are allowed to ask him that question, but I think that he should have the benefit of the transcribed part, if you're asking him a question that you know you can now see from the transcription. I can see from the transcription. I think it's only fair you show the witness the transcription, because it may be that he can't read that particular

A. Merola

reference --

MR. POLLACK: But he based his opinion on that. So I am certainly going to ask him questions about what I see in the transcription later, but right now, I'm entitled to cross-examine him on his understanding of the records he reviewed and relied upon in coming to his conclusions in his expert report.

MR. ENGLE: I understand that. I hear you.

MR. POLLACK: And I'm warning you now, Howard --

MR. ENGLE: Don't warn me. I don't need to be warned. You're the one who's pulling a fast one with the witness, knowing that it's in the transcription and not even showing it to him.

MR. POLLACK: These are records he's had for years.

MR. ENGLE: You just handed him the transcription.

A. Merola

MR. POLLACK: No. The transcription --

MR. ENGLE: Why hand him the transcription if you're not going to let him look at it?

MR. POLLACK: Okay.

(Recess taken.)

BY MR. POLLACK:

Q. I think we're still on July 8, I believe. I'm sorry. We moved on. We are on October 6.

A. October 6.

Q. October 6, 2013.

So would a reference by Dr. Podhorodecki on October 6, 2013, to a tender C7 para-spinal area be of significance to you?

A. It would tell me he had tenderness at the base of his neck.

Q. And would that correlate to the C6-C7 segment?

A. Not always.

Q. Well, so C7 is irrelevant to you?

A. Merola

A. No. It just means C7 is the base of the neck.

MR. ENGLE: Objection to the form of the last question.

Q. Let's take a look at October 23, 2013.

That's roughly a week before the incident?

A. Yes.

Q. These are some of the -- you recognize these records?

A. Yes.

Q. And you have reviewed them?

A. Yes.

Q. Did you review them in preparation for your deposition or did you review them as part of your treatment and preparation for the expert report?

A. Both.

Q. Okay. So what does her October 23rd notes tell you, significant to the patient's condition?

A. That he had a severe relapse of his neck pain.

A. Merola

Q. Okay.

A. Also had headaches, had complaints of some good days and some bad days. It says "very severe for the last two months." It refers to previous surgery with questionable C6 pain, and then a plan of trying a Medrol dose pack.

Q. What's that?

A. An anti-inflammatory.

Q. As part of your ultimate conclusion, would it be fair to say you attributed the severe relapse of neck pain and the clinical findings that she made to nothing more than the continued chronic condition from the C5-C6, but not attributable to any progressive condition in the C6-C7 area?

A. Yes.

Q. You just ruled that out?

A. Well, it doesn't clinically follow as a C6-C7 problem.

Q. Why is that?

A. It's a relapse of the chronic condition that he has been having with

A. Merola

good days and bad days. And it doesn't demonstrate that there are any progressive neurological deficits.

Q. What do you mean by it doesn't demonstrate any progressive? C7 nerve root, sensory loss, motor loss, weakness, pathological reflexes.

And so, all of the clinical findings the complaints that he is making are all, in your opinion, directly related to the chronic condition from the C5-C6 that you surgically stabilized roughly six years earlier, correct?

A. This is all part of his chronic pain condition, not unlike what he had presented to me with previous to when I revisited with him in February of 2014. So the notes that we had reviewed from you 2008, and prior to the accident, where I personally had an opportunity to treat with him, these are not inconsistent with that.

Q. And October 30?

A. Yes.

A. Merola

Q. Anything there of any significance?

A. Same. It's severe cervical radiculopathy relapse, pain 6-7 out of 10 in the shoulders, Medrol dose pack, x-rays, osteophyte at C6. Prescribed lidocaine patches and hydrocodone, once again 7.5/750, Medrol dose pack.

Q. Now, if you take a look at the final page which is October 31, 2013, it's actually November 3rd. That was the visit?

A. Yes.

Q. But -- right. But she handwrote "October 31," so that's the date of the incident, right?

A. Yes.

Q. Are any of his complaints, clinical complaints he is reporting to the doctor, different than what they were on the day before or the week before or the month before?

A. Yes.

Q. How so?

A. Merola

A. There's a trauma here. Well, the clinical complaint is trauma on October 31, 2013.

Q. So let me rephrase my question.

Other than reporting the traumatic incident, are his -- are the complaints about his physical condition that he is reporting to her and that she is reporting on her form different than what they were before?

So, for example, on October 30, the day before, she reported a recent recurrence of cervical radicular pains, with relapse of neck pain radiating into both shoulders.

A. Yes.

Q. And, on November 3rd, which is a couple of days after the incident, she reports, "Severe neck pains, 8 out of 10, now with left cervical radicular pain, shoulder sore."

Is that basically the same complaint that he was making the day before?

A. Merola

MR. ENGLE: Objection to the form. You, frankly, in the October 30, the pain was 6 to 7 out of 10. You didn't mention that. It's also in the -- that's October 30. In November 3rd, it is now 8 out of 10. And there are other differences between the two reports.

So why don't you either show him both reports and ask --

MR. POLLACK: He's got both reports.

MR. ENGLE: You're paraphrasing, and that's not right.

MR. POLLACK: For the record, on October 30, the pain in the morning was 10 out of 10. So, you know...

Q. My question to you is, as you look at his clinical reports, or his reports to her about what's bothering him and where, do you see any material difference between what she reported on October 23 and 30, for example, and what she reported on November 3rd?

A. Merola

MR. ENGLE: Objection to the form. The records can speak for themselves.

Q. Anything material to you?

A. The documentation of the trauma which takes up the bulk of the history section.

Q. Fair enough.

A. So I think that is of significance to Dr. Podhorodecki, in terms of assessing the patient at this time. And her concern here is, "needs diagnostic studies to rule out a fracture." She was concerned enough about the patient at that time. That's the bottom of the report.

It says, "neck, need x-rays. C-spine, rule out fracture. CT scan C-spine, whiplash type of" -- and then it's a little difficult to read.

Q. Okay. So what is ESI?

A. Epidural steroid injection.

Q. Would a paresthesia into his right hand digits be significant to you?

A. It has to be a little bit more

A. Merola

specific. But it could, of course, be an indication of a nerve root irritation.

Q. Again, my question to you -- and I appreciate that on November 3rd she had to report what he was telling her about the accident that occurred to him. I fully understand that.

My question to you is, when you actually look at what he was complaining about, the radiculopathy, cervical neck pain, crying in pain recently, pain is 10 out of 10 on October 23, is that all consistent with the same complaints he was making on November 3rd, when he visited her?

And I understand the report will be different because it will reference this incident, but I am just talking about physically what he is reporting to her.

Do you see any material differences?

MR. ENGLE: Note my objection to the form of the question.

MR. POLLACK: Okay. Noted.

A. Merola

MR. ENGLE: You just said -- you started the question with, "You didn't answer my question before," but the witness did answer the question. You're now asking the question a second time because you didn't like the first --

MR. POLLACK: Because the witness answered it by saying, "Well, she reported the traumatic incident." Obviously.

MR. ENGLE: You interrupted him. He wasn't done. Once again, I'm just asking you -- you're looking at the typewritten transcription by Dr. Podhorodecki and you're not allowing the witness to do that.

Q. Feel free, Doctor. Go ahead. You can go to the back and look at the transcript.

MR. ENGLE: There's October 30th and November 3rd.

Q. Why don't we go to October 23, which is a week before the incident. Or,

A. Merola

why don't we go to October 6. The pain is 7 out of 10. Burning in hands, cervical radiculopathy, neck pain, paresthesias in arms; you see that?

A. Taking into consideration all of the prior notes, including October 6, 2013, October 23, 2013, October 30 of 2013, and November 3rd of 2013, of significance to me in reviewing the issue is that Dr. Podhorodecki specifically utilizes the modifier "now" with left cervical radicular pain," which is different than the previous reports.

Q. Other than the "left" reference, how does that differ from "cervical radiculopathy" on October 6th?

A. The prior issues dealt with his previous cervical radiculopathy and not a new problem.

Q. Well, would it be fair to say that, on November 3rd, he was now -- his severe neck pain is 8 out of 10. But on October 30, in the "recent recurrence of cervical radicular pains with relapse of

A. Merola

neck pains radiating into both shoulders" -- so that would include the left?

So that would have been present on October 30, correct?

A. I don't understand the question.

Q. Well, you're saying that there's a difference because on November 3rd, she noted that, now, on October 3rd, following the incident, he was complaining of left cervical radicular pain, right?

A. Well, yes. There are two sentences that indicate "now." Intimate to me, interpreting this as a medical professional and spine surgeon, that the condition is different than it had been prior to the accident.

Q. And the two differences are -- if I'm incorrect, please correct me -- now the severe neck pains is 8 out of 10 on November 3rd, correct?

A. Well, there are technically three differences.

Q. But that's one of them?

A. Yes.

A. Merola

Q. So let's go through the three distinctions in order.

One of the distinctions between November 3rd and the prior few visits is that, on November 3rd, he was experiencing severe neck pains, which he characterized as 8 out of 10, correct?

A. Yes.

Q. Whereas, the day before, he categorized it as 6 to 7 out of 10?

MR. ENGLE: Not "severe."

Q. Okay, Doctor?

A. Yes.

Q. And then, in -- on October 30th, he also said that the pain, which is "the recurrence of cervical radicular pains with a relapse of neck pains radiating into both shoulders," was 6 to 7 out of 10, and in the mornings, 10 out of 10, such that he cannot get out of bed, right?

My question to you is, is it your opinion that that is significantly less than, now, with severe neck pains, 8 out of 10 post-incident?

A. Merola

MR. ENGLE: Objection to the form.

Q. Is that really your testimony?

Do I understand that correctly?

MR. ENGLE: Now with "left cervical radicular pain."

MR. POLLACK: That's another differentiation. I'm just going on his characterization of the neck pains.

MR. ENGLE: Note my objection to the whole line of testimony because, frankly, these questions are better asked of Dr. Podhorodecki.

A. My interpretation is they're different.

Q. And everything prior to November 3rd had nothing to do with the C6-C7 condition, and everything on November 3rd was a result of the C6-C7 condition caused on October 31; is that your opinion?

A. The note of November 3rd of 2013, from what I can interpret based on the record, indicates to me an aggravation

A. Merola

or an acceleration of his pre-existing condition, in addition to some new findings.

Q. And so what are the new findings?

The 8 out of 10?

A. Yes.

Q. Okay. The left cervical radicular pain, how is that different than cervical radiculopathy pains? Would that be bilateral?

A. Because of the qualifier "now." It means different. It means new.

Q. Okay. It means different than the day before, "recent recurrence of cervical radicular pains," plural, "bilateral"?

A. It's absolutely different, because this note cannot be taken out of the context of the trauma that takes up the bulk of the note.

Q. Okay. The October 30, 2013, where the neck pains were radiating into both shoulders, how does that compare to

A. Merola

November 3rd, where "shoulders sore," or is that the same?

MR. ENGLE: Objection to the form of the question.

A. It's different.

Q. And it's -- again, by the way, did we get all three?

A. Yes.

Q. So I guess the bottom line is that it is different, in your view, and therefore, sufficient for you to rule out that any of the prior complaints that he was making on October 30, October 23, October 6, and then a month or two earlier, had anything to do with the C6-C7 segment?

MR. ENGLE: Objection to the form. Inappropriate foundation.

Q. Is that your opinion?

MR. ENGLE: He gave his opinion as to the basis before.

Q. Yes, Doctor?

A. My opinion is that this note demonstrates a difference between the

A. Merola

patient's condition when examined and treated on November 3rd than prior treatments, according to the medical record as I interpret it as written by Dr. Podhorodecki.

Q. Fair enough.

And contains different clinical findings, based on the patient reporting, than the prior ones?

A. There's a different history. There are different clinical findings. There's a different assessment here. In fact, the assessment as I indicated previously, is now "needs x-ray, rule out fracture. CT scan C-spine for whiplash type of injury with left cervical radiculitis. Exacerbation of previous condition."

Q. So what would "exacerbation of previous condition" mean? Would that mean he was having these pains before and now it's a little worse?

A. No, essentially, this note, as read and interpreted says this patient had

A. Merola

a trauma. I'm concerned enough and the condition is worse and different.

It's gotten different than it was previously, and it's worse.

Q. That's how you interpret it?

MR. ENGLE: That's what you asked him to do.

MR. POLLACK: It sounded like he was saying that's what she was saying.

Q. This is your interpretation of what she's saying, correct?

A. Yes.

Q. So, I guess, to round it all out, then, the differences between what you read and interpret on the November 3rd note are sufficiently different from what you read on the prior notes that we've discussed from Dr. Podhorodecki, to allow to you conclude that the complaints and the clinical condition that she was identifying in the prior notes were not stemming from the C6-C7 segment, but were stemming exclusively from the earlier unrelated C5-C6 fusion area, and that the

A. Merola

new notes of November 3rd reflect the clinical findings attributable to an acute or traumatic condition caused on October 31?

MR. ENGLE: Objection to the form. "And all of his treatment." You're not asking him about his treatment, his findings, his examination, his history that he took after October 31, 2013, to be able to formulate his opinion as to the aggravation/exacerbation of C6-7 necessitating surgery.

Q. Is that right?

A. Well, there is a lot to unpack on both ends.

Q. Oh, yeah.

To make it very simple -- and I really will be done with this -- what I was trying to get from you is, you have ruled out in your opinion that Mr. Papiez was suffering from a herniation of the C6-7, causing him symptoms: Pain, cervical radiculopathy, shoulder, neck

A. Merola

pain, numbness, tingling et cetera -- you have ruled that out as having pre-existed the October 31st date, and that that did not begin until October 31, 2013?

The prior complaints that he made to Dr. Podhorodecki were part of the chronic history of the same complaints that he had back in 2008 and 2009 and 2010, all stemming from his original injury and the surgery that you performed?

That was your opinion, and that this was a new injury that was not previously experienced in terms of his pain and symptoms prior to October 3st.

And I'm just simply trying to get you to confirm for me now -- and with this, we can leave -- that even though you reviewed all of the notes that she provided to you, Dr. Podhorodecki, when you first treated him, when you wrote your report, including all of the reports -- the notes we've been discussing today, that you felt there was a significant enough difference between what she

A. Merola

reported on November 3rd to allow you to rule out that his earlier pains on the 30th and the 23rd, et cetera, were related to the C6-C7 AND that was first caused on October 31st; is that fair?

MR. ENGLE: Objection to the form. Again, you've left out his history, his examination of the patient, complaints he received from him, and his review of other records as well.

Over objection to form.

And, also, your question was extremely confusing.

Q. Did you understand the question?

A. Dr. Podhorodecki's records that I've had an opportunity to review form a part of my opinion regarding the causation of the accident causing C6-C7 to become symptomatic, requiring surgery.

Q. And would it be fair to say that the only records from Dr. Podhorodecki that are significant to that opinion that surgery was required as a result of what

A. Merola

occurred on October 31, are the November 3, 2013, records?

A. No. All of her records.

Q. And yet you don't attribute any of his pain in the prior records in earlier October to be attributable to the C6-C7 segment, correct?

A. Correct. He had chronic pain.

MR. POLLACK: Okay. That's all I have.

MR. ENGLE: One question.

EXAMINATION BY

MR. ENGLE:

Q. Doctor, is it your opinion that the accident of October 31, 2013, was a substantial factor -- was a competent producing cause and substantial factor in the need for Mr. Papiez to undergo surgical intervention performed by you at the level C6-7?

A. Yes.

MR. POLLACK: Follow-up question.

EXAMINATION BY

A. Merola

MR. POLLACK:

Q. Do you have an opinion, within a reasonable degree of medical certainty, that if Mr. Papiez had not sustained the injury of October 31, 2013 -- whether or not there is a probability, with a reasonable degree of medical certainty, that he would have required the same fusion surgery at the C6-C7, based upon the history stemming back from 2006, including Dr. Podhorodecki's records?

A. I would say the probability of that surgery, having reviewed his treatment which includes Dr. Podhorodecki's records, did not indicate to me that he clinically deteriorated requiring surgery prior to the accident.

The prediction of future surgery in Mr. Papiez, specifically in his treatment records and in my treatment of him both pre- and post-accident did not indicate to me that he was on the road to surgery for a revision, absent that trauma

A. Merola

at that time. Other than that, it would only be speculation.

So I can only base it on what we have, the medical knowledge based on the evidence, until that point of time.

Q. So you can't rule out with a reasonable degree of medical certainty, if there had been no incident on October 31, 2013, and Mr. Papiez had continued to just experience the pain as described on October 20 and 23, the relapse that he reported -- you can't rule out with a reasonable degree of medical certainty that he would not have ultimately required surgery?

MR. ENGLE: Objection to the form of "relapse."

MR. POLLACK: Well, I was using the language --

MR. ENGLE: He didn't say --

Q. Can you rule it out?

A. Cannot rule out or rule in. As I said, I can only -- I only want to base this on the medical evidence that we have

A. Merola

in front of us, based on what has happened to this patient.

Q. Fine. Last question.

Do you have an opinion within a reasonable degree of medical certainty to explain why Mr. Papiez experienced a recurrence of the chronic condition beginning in July of 2013, with all of the complaints that we just described, whereas he had -- I will represent to you that he had not been to Dr. Podhorodecki on a regular basis for some time?

MR. ENGLE: You mean prior to the accident of October 31, 2013?

MR. POLLACK: Yeah.

Q. What caused, if you know, what she referred to as "severe relapse of neck pain" on October 23, and "recent recurrence of cervical radicular pains with relapse and neck pains radiating to both shoulders," et cetera, et cetera?

What --

A. It's part of his chronic pain syndrome that is consistent with my

A. Merola

previous treatment of the patient with his C5-C6 injury.

Q. So it can be quiescent, or quiet, for some long period of time and then just come back for no apparent reason?

A. It can wax and wane, yes, as I had indicated in those prior notes from University Orthopedics.

MR. POLLACK: Okay.

(Time noted: 7:45 p.m.)

STATE OF _____)
) :ss
COUNTY OF _____)

I, ANDREW MEROLA, the witness herein, having read the foregoing testimony of the pages of this deposition, do hereby certify it to be a true and correct transcript, subject to the corrections, if any, shown on the attached page.

_____
ANDREW MEROLA

C E R T I F I C A T E

STATE OF NEW YORK)
: ss.
COUNTY OF NEW YORK)

I, Linda Salzman, a Notary Public within and for the State of New York, do hereby certify:

That ANDREW MEROLA, the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 6th day of December, 2018.

_____

Linda Salzman

---------- I N D E X ----------

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----------EXHIBITS----------

Exhibit J Affidavit of Areta Podhorodecki, M.D. 113

NAME OF CASE:

DATE OF DEPOSITION:

NAME OF WITNESS:

Reason Codes:

1. To clarify the record.

2. To conform to the facts.

3. To correct transcription errors.

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