SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: CIVIL TERM PART 47
- X

LUCIA REINOSO,

Plaintiff,

- against -

INDEX NUMBER:
155622/13

NEW YORK CITY TRANSIT AUTHORITY,
METROPOLITAN TRANSPORTATION AUTHORITY,
MTA BUS COMPANY INC., MANHATTAN AND
BRONX SURFACE OPERATING AUTHORITY
AND LUIS PENA (Bus Operator),
AND DANIEL LUGO(Bus Operator),

Defendants.

- X

60 Centre Street
New York, New York
December 17, 2018

BEFORE:

HONORABLE PAUL A. GOETZ, Justice
(A jury of 6 and 2 alternates.)

APPEARANCES:

LAW OFFICES OF JON L. NORINSBERG
Attorney for the Plaintiff
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New York, New York 10007
BY: JON L. NORINSBERG, ESQ.,
JOHN J. MEEHAN, ESQ.,

APPEARANCES CONTINUED:

O'BRIEN LAW FIRM, PLLC
Attorney for the Defendant
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New York, New York 10005
BY: MICHAEL P. O'BRIEN, ESQ.,

MONICA HORVATH
SENIOR COURT REPORTER

Mandelbaum - Direct - Plaintiff (Norinsberg)

THE COURT: Good morning, folks.

Before we call in the jury, who are you calling today, Mr. Norinsberg?

MR. NORINSBERG: We are calling Dr. Mandelbaum. He is the pain management doctor, treating physician. That's in the morning.

And, then, we have Dr. Fitzgerald in the afternoon. And, I think counsel, will take the radiologist out of turn after we finish with Dr. Mandelbaum.

THE COURT: Okay.

What about defendant's radiologist.

MR. NORINSBERG: Yeah.

That's right after Dr. Mandelbaum.

MR. O'BRIEN: Yeah.

THE COURT: Okay.

Are we ready to go?

MR. NORINSBERG: Yes, Your Honor.

MR. O'BRIEN: Yes.

THE COURT: Okay, let's call in the jury.

THE COURT OFFICER: All rise.

Jury entering.

(Whereupon, the jury, enters the courtroom.)

THE COURT: Folks good morning.

Welcome back.

Have a seat.

And, this morning, we will continue with the plaintiff's case.

Mr. Norinsberg, call your next witness.

MR. NORINSBERG: At this time, plaintiff calls Dr. Chaim Mandelbaum to the stand, please.

(Whereupon, the witness takes the stand.)

THE COURT OFFICER: Remain standing for a moment to be sworn in.

CLERK OF THE COURT: Raise your right hand.

DR. C-H-A-I-M M-A-N-D-E-L-B-A-U-M, having been called as a witness on behalf of the Plaintiff, having been duly sworn by the Clerk of the Court, was examined and testified as follows:

THE WITNESS: Yes, I do.

CLERK OF THE COURT: Have a seat, please.

THE WITNESS: Okay.

CLERK OF THE COURT: And, for the record, just give us your name and business address.

THE WITNESS: Okay.

It is Chaim Mandelbaum. My address is 75 Maiden Lane, Suite 1206, New York, New York, 10038.

CLERK OF THE COURT: Thank you.

THE COURT OFFICER: Keep your voice up loud and

clear.

Okay?

THE WITNESS: Yes.

THE COURT: Okay, thank you, doctor.

Go ahead, Mr. Norinsberg.

DIRECT EXAMINATION

BY MR. NORINSBERG:

Q Good morning, Dr. Mandelbaum.

A Good morning.

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

A Yes, I am.

Q Can you tell us briefly about your educational background?

A Yes.

I attended State University Health Science Center, in Brooklyn, otherwise, known as Downstate Medical Center.

I graduated in 1992.

I then proceeded to do an internship at Staten Island University Hospital and then a residency in anesthesiology, at Mount Sinai Hospital in New York City. That was for three years.

Followed by a pain management fellowship for a year after that.

Q Are you board certified, doctor?

A Yes.

I'm board certified in anesthesiology, and subspeciality board certified in pain medicine

Q What is the field of pain medicine?

A Pain medicine, in particular, deals with typically, chronic, longstanding, pain, beyond the course of normal healing.

We deal a lot with, for instance, back pain. Patients who have chronic disorders and who have had surgery and still have continued pain and deal with chronic headaches, chronic nerve related pain that just doesn't respond to conventional treatment.

Our focus, a lot, besides medications, is dealing with, we do a lot of injections and other procedures that are very helpful for these chronic pain syndromes.

Q Are you currently affiliated with any hospitals?

A Yes.

Q Which hospitals are you affiliated with?

A So, I am affiliated with Mount Sinai Medical Center, at Beth Israel, and, New York Methodist Hospital in Brooklyn.

Q Do you currently have a private practice?

A Yes.

Q Can you tell the jury about your private practice?

A Yes.

So, I am part of a two physician pain management practice.

We do a little anesthesia, but, mostly, pain management.

It's a private practice. We have an office in lower Manhattan not far from here in the financial district, and, also, an office in Brooklyn, and Park Slope.

Q Did there come a time where you did an initial evaluation of Miss Lucia Reinoso?

A Yes.

Q Okay.

And have you brought your chart to court today?

A Yes.

MR. NORINSBERG: Your Honor, this has been premarked as Plaintiff's Exhibit 31.

I would like to have this shown to the witness.

(Whereupon, counsel, hands to counsel.)

(Whereupon, counsel, hands to the court officer.)

MR. O'BRIEN: Can we come up for a second, Your Honor?

THE COURT: Sure.

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

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MR. NORINSBERG: May I hand the chart to the witness, Your Honor?

THE COURT: Yes.

(Whereupon, counsel, hands to the court officer.)

(Whereupon, the court officer, hands to the witness.)

Q Do you recognize the chart in front of you, sir?

A Yes, I do.

Q Is that chart for Miss Reinoso?

A Yes.

Q Is that prepared in the regular course of your business?

A Yes.

Q Was it maintained in the regular course of your business?

A Yes.

MR. NORINSBERG: I offer Plaintiff's Exhibit 31 into Evidence.

THE COURT: Any objection?

MR. O'BRIEN: No objection, Your Honor.

THE COURT: All right, it is entered.

THE COURT OFFICER: We will pause to mark it.

(So marked.)

THE COURT OFFICER: Okay, counsel.

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(Whereupon, the court officer, hands to the witness.)

Q When did you first see Miss Reinoso?

A Okay, she was initially seen actually by my partner on September 11, 2015.

Q And, can you tell us, was a history obtained from Miss Reinoso?

A Yes.

Q What was the history?

A So, the history was, at that time, she was a 63-year old female, who was working as a home attendant, and was helping a patient off a bus, it was a New York Transit bus, and, she was on a wheelchair ramp and while they were exiting the bus, the ramp had moved causing her to fall.

Q And, did she present with you with complaints that day?

A Yes.

Q What were her complaints?

A The complaints were of both lower back pain as well as neck pain.

She was having continued headaches from the lower -- from the neck as well as ongoing lower back pain that was shooting down into her lower extremities, her legs.

She also had some left shoulder pain as well that she sustained from the fall.

Q Was an examination performed?

A Yes.

Q And, what were the significant findings on exam?

A So, the examination during that initial office visit with regard to her neck, she was having significant cervical spasm on the cervical paraspinal muscles, the neck muscles, and the neck going down from C3 through C7 on both sides.

She had diminished range of motion because of the significant spasm.

She was noted to have with flexion at 15 degrees.

Q What is the significance of that?

A Um, because it is significant diminished range of motion with regard to flexion.

Normal flexion is 40 degrees, and, that is forward flexion. If you move your head down, she is only moving it significantly less than what would be normal, which would be 40 degrees.

So, you are talking about 15 degrees, versus something that's 40 degrees.

(Whereupon, the witness indicates.)

She also had diminished range of motion with extension, on physical examination. That was at 20 degrees. When normal is about 40 degrees.

She also had diminished lateral bending, both right and

left.

She was noted to have diminished strength to her hand grasp, both right and left.

On the left side it was measured at 25 pounds, on the right side, it was measured at 15 pounds to hand grasp.

And, that was also significantly diminished on both upper extremities.

With regard to her lower back which was her major complaint at that time, she also was noted to have bilateral spasms.

She is somebody who already had lower back surgery and she was noted to have spasm bilaterally.

She was complaining of pain radiating into her lower extremity, and, it was noted to be a positive straight leg raise into the lower extremity, mostly, on the left at 30 degrees, and, then, on the right at 45 degrees.

Which is significant because there is some nerve irritation going on there.

When you raise the leg up, it aggravates that irritation by pulling the nerve from the leg that originates from the back.

She was again noted to have diminished range of motion. Extension, was at 10 degrees. Normal extension, is 30 to 40 degrees.

Flexion, was at 15 degrees, and, normal flexion should be, approximately, 90 degrees.

And, she had diminished right and left movement of her spine.

She was also noted to have decreased sensation into the lower extremities at the L4, L5 dermatone, which are the nerves from the back that goes into the legs.

When they are affected they can cause decreased sensation along those dermatone's.

And, she also, had a gait disturbance and she was walking with a cane, was using a cane during that initial office visit.

Also of note was, she had left shoulder pain. She had diffused pain on palpation of the shoulders.

She had some limited range of motion with abduction, which is an outward movement up to 100 degrees.

She could not raise her hand above her head above that.

Forward flexion, approximately, to 150 degrees. So, again, she couldn't reach from above.

And, then, she also had pain on extension which is reaching behind her, at approximately 30 degrees.

She was also complaining of some left hip pain during that office visit. And there was some tenderness over the left hip.

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Q Was any treatment given to Miss Reinoso that day?

A Yes.

Q Can you describe the treatment that was given?

A Yes.

She was having -- I guess, her major complaint during that initial office visit was of lower back pain. And she was having a lot of positional spasm and pain along the lower back.

She is someone that did have lower back surgery.

The date of the surgery was in March of 2015.

Because of that positional back pain, she had what we call a facet block.

So, there are small nerves in the spine that go into the joints of the spine and you can block actually those nerves and it can help with the pain.

So, there is something called a "diagnostic facet", which is injecting local anaesthetic along those nerves to see if it helps with the pain.

If it does help with the pain, you can actually do something more permanent called a "radiofrequency" of those same nerves.

So, the idea was, oh, let's try this diagnostic block. Let's see if it helps with her pain.

And that was done during that initial office visit.

Q What is that diagnostic block called?

A It's a facet or dorsal media nerve block.

That's the particular nerve -- the small little nerve that goes to the facet joints.

Q Did Miss Reinoso, continue to go to your office for treatment?

A Yes.

Q And did -- is she still a patient of your office?

A Yes.

Q I would like to ask you about certain entries in the record relating to certain procedures that your office performed.

And I would like to ask you to explain those procedures.

A Sure.

Q Now, when it says here -- first, let's get the date.

THE COURT: Mr. Norinsberg, what are we looking at?

MR. NORINSBERG: We are looking at Plaintiff's 31.

This is a record from September 11, 2015. This is the initial record.

Q This is the next visit at your office, is that correct?

A Yes, yes.

Q When it says "lumbar bacit", you are saying it is "facet"; is that how you say it?

A Yes.

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Q Lumbar facet block number one today, is that what you just described?

A Yes.

Q What was the impact of that treatment?

A It did help significantly with her ongoing pain.

Q Okay.

Then just moving down a little bit, it says:

"Consider lubrication using Orthovisc or steroid."

What is that?

A There is a medication called "Orthovisc".

"Orthovisc" is a thick fluid that can be injected into a joint such as a knee or a shoulder.

What it does is add essentially a lubrication, almost like oil, machine oil that goes into a joint.

That actually can help with range of motion and it also helps with arthritic type pain.

And, usually, it is done in a series of injections. Up to three is pretty typical.

Q Just going back to the treatment.

Number 3, it says:

"Consider radiofrequency cervical facet ablation; right sided."

Can you describe what does that mean?

A So, what I described before was a diagnostic block,

which is the facet block.

That can be done in the lower back. It can also be done in the neck.

That particular was talking about the neck.

So, she does have ongoing neck pain.

Some of the pain is positional with movement.

There are facet joints as well in the neck, as well as the lower back.

There is the possibility of doing the same type of diagnostic block in the neck area and then following that up with something called the "radiofrequency", which I described for the lower back that can be done essentially to destroy the nerve.

And that can help with the pain.

Q How does the radiofrequency work?

A Radiofrequency, is a probe.

So, it's a needle procedure, percutaneous.

It is a needle -- and, I do have a slight model of the spine, but -- it is a needle that's put through the skin and gets directed toward where the nerve is under x-ray guidance.

A patient usually gets a little bit of sedation before this.

So, the needle goes in, gets to where we know where the nerve is anatomically speaking, and, then, through that needle,

you can actually heat the tip of the needle to 80 degrees celsius, which is very hot.

Essentially, that destroys the nerve.

Now, it is not a permanent procedure. It's what we call "long standing". It could last for six months, it could last for a year.

But, nerves tend to regenerate, so you are not actually specifically, cutting the nerve and removing it.

You are essentially, burning that nerve in that spot.

Q And did you use this technique throughout the course of treatment with Miss Reinoso?

A She did have -- I mean, she had the diagnostic block, she had a second diagnostic block.

She did have other procedures as well.

I don't believe that we actually did the radiofrequency procedure on her.

Actually, I am just double checking.

We did one more recently.

She had a radiofrequency in 2018.

Q So, you did do the procedure on her?

A Yes.

Q When was that done?

A It was April 30th, 2018.

She had a radiofrequency lumbar facet on the left side,

of the lower back.

Q Okay.

Now, I am showing you a record from March 2018?

A Yes.

Q And it lists a number of procedures that were done under something called "operation."

Do you see that up there on the screen?

A Yes, yes.

Q First, it says:

"Lumbar transforaminal injection, left" -- I'm not sure about the pronunciation, but -- can you tell us what that means?

A So, it's a lumbar transforaminal injection.

So, Mrs. Reinoso, is a rather complicated patient, because she is somebody who has already had surgery of the lower back.

So, typically, when somebody presents to the office and they have pain shooting into the leg, there's a reason why it is shooting into the leg.

There is usually some nerve compression that's coming from the back and the spine.

Now, she had surgery; she has hardware in her back. You can't do a simple injection which would typically be, for instance, an epidural injection -- I don't know if anyone is familiar with that but -- that's going in directly through the

skin into the space between the bone, right into the epidural space.

It's similar to obstetrics, OBGYN delivery. They are in the same space. It is done rather easily into that space just using x-ray to just guide you.

But, now, she is somebody who has had surgery. They removed part of the bone; they put in hardware. She had a fusion.

So, the approach, is actually coming from the outside; something called a "foramen".

So, the foramen, is this part of the spine where the nerve actually comes through.

So, there is this hole -- that's why it is called a "foramen"; that refers to a hole -- so this hole, this exit of the nerve is where we can put the needle into that area.

And, then, a small dose of steroid medication can be injected into that where that nerve is.

And you can pick different nerves, depending on anatomically speaking where her pain is.

So, if she has pain that shoots down her leg that goes into her big toe, for instance, which follows, typical, L5, we can actually look on the x-ray and say, okay, there's L5, let's put a needle, let's gets it close to where that nerve is, inject the steroid medication right there, and, hopefully, that helps

with her pain.

So, that is the modality, that was actually used on this side.

Again, her pain during the prior office visit, she was having a lot of pain going into the left side.

So, the idea, was to do a left-sided transforaminal injection.

And, I believe it was done at a couple levels; L3-4, L4-5.

Q Okay.

Moving down to where is says:

"Number 2, trigger point injections", what does that represent?

A So, along the outside of the spine -- so, again, we are looking at the spine -- you all know you can feel the bones on the outside, but, along the sides of the bone, there are muscles -- and we have all had muscle spasms sometimes, where everything spasms up -- now, she has an underlying problem where there is inflammation.

The muscles tend to react to that, and, they guard the inflammation, so you tend to spasm up.

Essentially, that's the body's reaction to protect the spine, so that you don't further aggravate it. But that just leads to more weakness of the muscle, and, more pain.

But, you can actually do an injection, where you can inject those muscles with a muscle relaxant -- also, numbing medication, and, a muscle relaxant -- into those muscles, and that's what we call "trigger point" -- so, these are areas of the muscles, so, muscle spasm, severe spasm -- that you can inject that helps, hopefully, with her pain, helps with range of motion.

And, we like to followup with her actively doing physical therapy modalities. Um, she has done that throughout. And, it is actually very helpful.

Does it last?

It can last 2, 3, 4 weeks, hopefully, to the next time. Sometimes, it can last even longer.

Q Okay.

I would like to show you another record, this is going to be from April 6, 2016.

Let's just start at the top here.

It says:

"Operative report of preop diagnosis, left hip arthropathy."

Can you explain what that means please?

A Okay.

She had ongoing pain from the left hip.

"Arthropathy" refers to some type of hip pain.

So, she has ongoing hip pain, ongoing hip disorder.

So, that's what it is referring to with that left hip.

A lot of the pain was from the left side.

Q Referring to where it says "Operation":

It says:

"Left hip intraarticular bursa injection."

Can you explain to us what that is?

A Yes.

So, using x-ray technology to guide you, you can actually take a needle and you are coming in from the side of the hip, and, you are directing that needle into the hip joint itself.

There is also what they call a "bursa", which is an area right outside the hip, that can be inflamed, as a reaction to whatever changes are going on in the hip, whatever damage is there.

So, that particular injection, is again taking the needle, putting it into that area, and, then, again, injecting, a steroid medication.

Which was done during that office visit.

Q Okay.

I would like to show you now, a record dated, November 16, 2017.

It says: "Treatment."

And then, it talks about something called "Myobloc injections today."

Can you just describe what that means; what are Myobloc injections?

A Okay.

So, at that particular office visit, and, actually, it was on earlier office visits as well, she always had a significant amount of neck spasm.

So, when the neck spasm is ongoing and severe and diminishes range of motion, one term that is used is called "torticollis," which is a very descriptive term medically speaking, to say this is significant, this is bad spasm, she has very diminished range of motion, she has inability to straighten out her neck.

So, what is typically done are things like I described before, which are trigger point injections.

So, trigger point injections, are the numbing medication to the neck area that could help with some of the spasm and diminish that.

Now, trigger points, like I said before, don't always last. They can last two weeks, three weeks, a month, and, then, the spasm comes back. And, it is just ongoing

So, there is a particular injection, called "Myobloc".

Myobloc, is a botulism toxin, which can be injected in

a muscle. And, what that does is cause very profound muscle relaxation that could last for months.

And, during that office visit, she actually had the Myobloc injections done again for the cervical spine.

And the idea is to help diminish that spasm.

Q So, in your notes on "Physical Examination":

"Patient has spasms and severely locked bilateral cervical paraspinal muscles bilateral trapezius muscles in C3 to C7 para vertical muscles."

Did this Myobloc injection help at all with that spasm?

A Yes.

It did help with the spasm.

Q And how long do these generally work for?

A Um, it will vary per patient.

Typically, we tell patients at least three months, but, again, it could last even longer.

Usually, we followup with any of these injections with physical therapy modalities whether on their own or with a physical therapist to help again to get that active range of motion, and, help keep that spasm away.

Q This is referring to a record from December 6, 2017?

A Yes.

Q And just starting over here, Number 3, it says:

Patient is "SP".

That means status post?

A Correct.

Q That means afterward?

A Yes.

Q "Facet block x 2"?

A Yes.

Q "At L4-L5 and L5-S1 levels from the left."

Can you explain what that means?

A Correct.

So, that's what I described before.

The facet blocks, which are -- again, the facet joints are these joints, but, when bone sits on the other bone, it's a movable joint and that can cause pain when there is a disorder of that joint.

She had pain in the lower back, on the left side. So, there was a facet block which is injected along that joint to see if it helps with the pain.

And, she had two of them that was helpful.

And, the idea was, we were trying to get authorization to do a radiofrequency to those joints on the left side.

Q And, is that what the "RFLF", stands for?

A Correct.

Q What is that?

A Radiofrequency lumbar facet.

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Q Now, your office has treated Miss Reinoso, for the past three-and-a-half years.

Is that correct?

A Correct.

Q Do you believe that she is in need of future treatment?

A Yes.

Q Can you tell the members of the jury, what type of future treatment you believe Miss Reinoso needs?

A Yes.

So, we did put together a list of the future treatments for Mrs. Reinoso.

I believe you have part of the copy here.

And, one of them is, she is going to need medication, ongoing medication.

There is a cost of medication. And, medication varies a little bit.

The projected cost for her medication which includes an antiinflammatory, a muscle relaxant, something for nerve pain, which she has nerve pain from her back going down into the legs, that is still there.

And, we projected the cost to be about $3,800 per month, again, for the rest of her life.

She will need to followup with pain management.

Q Have you prepared a summary of the treatment that you

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believe is necessary and cost associated with that treatment?

A Yes, I have.

MR. NORINSBERG: I would like to have this marked as 31A for Identification, please.

THE COURT: Okay.

(So marked.)

(Whereupon, the court officer, hands to the witness.)

THE WITNESS: Thank you.

Q Do you recognize this document?

A Yes.

Q And is this a summary of the treatment and costs associated with that treatment that you prepared?

A Correct.

Q Would that chart assist you in explaining to the jury --

A Yes.

Q -- the cost of the treatment?

A Yes.

MR. NORINSBERG: I would like to display this on the projector.

MR. O'BRIEN: Objection.

THE COURT: What's the basis?

MR. O'BRIEN: It hasn't been offered in Evidence

yet.

And, also, there is an insufficient foundation for it.

As much as I would like to move this along, the foundation is not there.

THE COURT: Okay, sustained.

Q When did you prepare this?

A Um, we did a narrative report in January of 2017.

And this is an updated cost that I prepared this month, in December.

Q And, how did you go about preparing this chart?

A As far as -- well, again, these are what I feel the patient will need in the future as far as future diagnostic studies and future treatment that she is going to need for the rest of her life.

The values associated with these are based on routine values that are -- for instance, I discuss in this latest, spinal cord stimulator.

These are actually the costs that the hospitals receive for these valuations.

Our office visit costs, MRI costs, are pretty standard and straightforward.

MR. NORINSBERG: I would like to have this document displayed for demonstrative purposes to the jury to assist

the doctor in explaining the summaries.

MR. O'BRIEN: Objection.

I think this is an end round to actually getting it into Evidence.

If it is going to assist the doctor, that's one thing. If it's going to be displayed to the jury, another.

MR. NORINSBERG: Okay, I offer Plaintiff's Exhibit 31A into Evidence.

MR. O'BRIEN: Objection, Your Honor, based upon my prior objection, admissibility, foundation, and, the basis for it.

THE COURT: It's overruled.

THE COURT OFFICER: I request to mark it.

(So marked.)

(Whereupon, the court officer, hands to the witness.)

MR. NORINSBERG: Let's display that on the screen.

(Whereupon, the exhibit, was displayed on the screen.)

Q So, describe -- what are we looking at here, doctor?

A These are projected future costs for the patient both with regard to medication with regard to diagnostic studies with regard to office visits, and, the possibility, or, the need that she will have for future treatments.

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Q And, so, we already covered the first category of medicine.

Let's go to the second one.

"Pain management office visits at a cost of $200 per visit, once per month for lifetime duration."

Can you explain that?

A Correct.

She has a chronic pain condition for multiple reasons, both neck, back, etcetera, hip, and she will need constant care, and, she will need constant reevaluation, changes in medication.

And that's where the pain management, our facility, offers.

In addition to the possibility of other injections, which I describe later on.

Q "Trigger point injections at a cost of $300 per set of injections. One set of injections every three months for a lifetime duration."

What is the basis for doing this over every three months?

A She's somebody that has ongoing neck, lower back pain. She has had surgeries.

Her spasms -- she is realistically, going to have continued spasm. She is going to have exacerbation of her spasm depending on her daily activity.

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So, realistically, speaking, she, once every three months, she is going to need a set of trigger point injections.

She will need some physical therapy associated with that.

And there is a cost associated with those trigger point injections.

Q And how is the time interval of three months determined?

A That's just, in my experience, a lot of patients, actually get more frequent than every three months, but, interspersed, with physical therapy modalities, and, injections, which others may need including the Myobloc injections.

The beauty behind the trigger point injections, is that they are done very easily in the office. You don't need any special materials.

It is a muscle relaxant. It can be done really at any time.

We do them quite frequently and easily. You don't need sedation for that type of particular injections.

Q Okay, moving on.

"Radiofrequency lumbar facet ablation, at cost of $2,000, plus, $1,000 for anesthesia services, plus, $2,500 facility fee costs, fluoroscopic guidance once every two years for a lifetime duration."

Tell us about this schedule?

A So, the lumbar facet, which I described before are those injections in her lower back, they do help her pain, her ongoing pain.

How long can that last?

It could last for -- typically, we tell patients, six moths. It could last a year, it could last two years.

It is just with other modalities, we hope that it will last a couple of years.

It is within a reasonable degree of medical certainly, that she is going to have ongoing back pain and that she is going to need radiofrequency procedure.

Again, once every two years is a long time, so, hopefully, it will last that long.

But, I think that it is a reasonable expectation that she will need that radiofrequency procedure.

Now, don't forget, sometimes, the lumbar facet, there is a right and a left side, so, depending on where her pain is and position of the pain, she may actually need one on the right, she may need one on the left.

Again, that has to be clinically assessed

Q When it says, "$1,000 per anaesthesia services", what are you referring to?

A Um, typically, it is done in a hospital surgery center,

where there is a radiofrequency machine which is a rather expensive machine.

It could be rather uncomfortable, because it does take 30 minutes to do the procedure, so, that is positioning the needle, and, then, burning the nerve at 80 degrees celsius.

So, they do feel some pain, so, usually, they get a little bit of anaesthesia for that just to try to calm the patient down.

You don't want them to move during any of the procedures, so that little sedation and under anesthesia is actually very, very, helpful.

Q And "$2,500 facility fee", what is that referring to?

A It refers to the hospital costs, or, the surgery center costs.

Whatever facility that the patient may actually be in.

Q Okay.

And, the next category seems to be identical, except, it talks about cervical as opposed to lumbar.

Is that correct?

A Correct.

Q And your opinions about the need for this treatment, would be the same as though you just expressed for the back?

A Correct.

Q Just moving down.

"Joint lubrication injection using Orthovisc, cost of $400 per injection. A series of three injections to the left hip, every 12 months for lifetime duration."

Can you explain that, doctor?

A Yes.

So, she does have hip issues and problems.

The idea is to put that lubrication, which I described before, which is typically can be injected into a hip joint, can help sustain the longevity of the hip, help add a little bit of cushion to that hip, help with range of motion, and, her ability to function a little bit more comfortably typically.

And, that's very conservative to say that to do three injections every 12 months, most insurances actually will do three injections every six months.

But, the reality is, I believe, that she is actually scheduled for her hip surgery, so, that may actually change that a little bit. But, that is something that I believe is going to be scheduled.

Q Next, "one steroid injection to left hip, at a cost of $300, once every one 12 months for lifetime duration."

Can you explain that?

A Yes.

So, besides the lubrication injection, when there is

Mandelbaum - Direct - Plaintiff (Norinsberg)

inflammation there, you can inject a steroid medication to help with inflammation to help with the pain.

So, part of the idea is, okay, let's do the Orthovisc injection.

I know there's a cost associated with it, which is rather expensive. Sometimes, you can intersperse that with an occasional steroid injection into the joint, so you don't have to constantly do the Orthovisc injection. And that is another modality to help the pain, and, it helps to diminish the cost.

Q Moving to the next category:

"Myobloc injections for the neck at a cost of $1,500 per set of injections, one set of injections per year for lifetime duration."

Can you explain that?

A Yes.

So, Myobloc, is that botulism toxin, that I described before.

That can help a spasm significantly and lasts for an extended period of time.

So, typically, it lasts anywhere between three to six months depending on the patient

Again, realistically speaking, with a reasonable degree of medical certainty, she will have periodic exacerbation of her spasm that is only going to get worse despite trying trigger

point injections, which we might try.

Myobloc injections is something a lot more expensive, but, it is so much more effective in diminishing that pain and spasm together with physical therapy modalities in conjunction with that.

And, for that reason, within a reasonable degree of medical certainty, one set per year is actually not a lot, because typical Myobloc injections are done every three months. So, you are talking probably about four injections per year.

But, together, with all these other modalities, again, you are minimizing the costs.

It would be nice to do it once every three months, but, that typically doesn't happen.

Q So, would you say, doctor, that your approach to these projections has been on the conservative side of the treatment?

A Yes.

Q Looking at the last category on this page:

"The greater occipital nerve block injections, a cost of $500 per set of injections, once every six months for lifetime duration."

Can you explain that?

A Yes.

So, she has a neck issue and problems. She's had neck surgery.

They are -- as a result of her ongoing injuries, she has headaches, chronic headaches. So, she has headaches, coming from the back of her neck over the top of her head into her eyes. So, that is ongoing.

So, there are nerves in the back of the neck called "occipital nerves". You can actually place a needle and inject those nerves.

You can block those nerves and put a little bit of steroid which can help with the inflammation on those nerves, and, that's what is referred to as greater occipital nerve block.

It can be very effective. Especially, for an acute headache, when they come in and just have a headache that just doesn't go away, you can actually block that nerve and diminish the headaches substantially.

Q "Transforaminal steroid injection lumbar at the cost of $2,000, plus, $2,500 facility fee cost per fluoroscopic guidance, once every two years for lifetime duration."

Can you explain that?

A So, the transforaminal injection, which I described before is used especially for acute exacerbation of pain.

So, she's a patient that will have chronic pain. Let's say it is stable chronic pain. There will be times when the pain gets worse for whatever reason, and, that's a normal

course; we see it all the time.

So, there is an acute exacerbation of her chronic pain. So, all of a sudden, the pain gets worse and it is shooting down her leg.

How did you treat that?

So, again, the transforaminal injection is again taking a needle and putting it into the foramina, and getting into that nerve and getting that nerve to subside.

And that's what we are referring to.

And, conservatively speaking, once every two years, is realistic.

Q Okay.

The next two categories, you are describing doctor visits, one to a spinal surgeon, one to the one who did the knee and shoulder.

Is that correct, doctor?

A Correct.

Q And, you are estimating that at about $300 cost per visit, and, you are putting that at once every six months.

Is that correct?

A Correct.

Q What's the basis for that?

A She has hip and knee pathologies; she has had surgeries. She will have surgery.

She will need probably more followup than that, but, realistically speaking, she is going to have to followup with her orthopedic surgeon regarding that, making sure everything is okay, see how she is functioning, if she needs physical therapy for those particular areas.

Q Now, the next one is:

"Left hip total joint arthroplasty. Cost to be determined by orthopedic surgeon scheduled for January 2019."

I assume we have had testimony about that taking place January 25th with an estimated cost of 75 to $80,000.

The next five categories are all MRI's, so, let's just tackle one of them.

You have:

"MRI of left shoulder, at a cost of 1,300 once every five years for lifetime duration."

What's the basis for that?

A The basis for that is when someone has an injury and you are still using the joints, there is more -- there is what we call an accelerated degeneration, accelerated trauma that happens to the joint. It is not functioning the same way it did before. It is going to cause pain. It is going to have to be reevaluated.

So, within a reasonable degree of medical certainty,

she will need a MRI for these areas some time within five years of each other just to see because the change is going to change. You want to know if something has gotten worse, or, changed, if there is something surgically that needs to be done, or, maybe an injection, but, you need proper diagnostics, and, the best way is a MRI.

Q And, then, in the next category, you refer to physical therapy at a cost of 120 per visit, and, you describe a timeframe of that.

What's the basis for that category?

A Again, with all these modalities -- and, I have said it repeatedly -- when a patient has an injection, when a patient has trigger points, or, has Myobloc injections, that's usually followed up with some type of physical therapy modality to enhance the effect, keep the range of motion, keep the joints moving.

So, physical therapy, is very key to keeping her active and her joints moving.

And, that's extremely important throughout all of this whatever modalities that we do.

Q "Home health aid, 24 hours per day, seven days per week to assist with activities of daily living. Cost to be determined; services needed, number of hours a day, and, home care company prices."

Mandelbaum - Direct - Plaintiff (Norinsberg)

What's the basis for that category?

A That she will need a home health aid just to help on a daily basis just to help with her functioning, her ability to do things around the house.

She has ongoing pain from numerous sources. She is not able to take care of herself, keep her home the way it should be, and, will need help. And, that's the basis for that.

Again, cost, it really depends on what the home health aid is helping with, and the hours, but, she will need somebody seven days a week.

Q "Spinal cord stimulator trial, lumbar, two leads, cost $2,550, plus, surgeon, would be 2,000 to 3,000, facility fee 2,500 to $5,000."

Can you explain what you mean by that category?

A Okay.

So, there's a device called a "spinal cord stimulator", which, I actually love the device, and, I think it's a great modality for her, someone who has had surgery.

For instance, taking her lower back, there is a device, there is a wire that can be put into the epidural space. There is usually two wires put into the epidural space, and, you can do a trial and leave those two wires in there for a week, and, it gets hooked up to a little generator, and, it causes an impulse, or, a current that goes into the spinal cord, in the

epidural space, and, that can really help dramatically ease up pain from the back, for instance, if you put it into the lower back, the back all the way into both legs.

And it is something that they have made dramatic improvements over the past five years, but, the drawback is it is implanted. It is something that is implanted.

There are risks associated with it, it's a surgical procedure, but the trial is that temporary two leads that can be put in, the trial is done through a needle. If we find there is at least 50% percent diminished pain after that trial, then a decision can be made whether to put in a permanent one, which is actually surgically implanted, two wires that go into the epidural space, a little generator, a little box that looks like a pacemaker that gets implanted under the patient's skin, they get a handheld remote control, they can control what they feel, they can turn it on and off, and, it can dramatically help, with lower back and pain into the lower extremities and maybe help with her overall condition.

Again, we are looking for at least 50% improvement in symptoms.

It will not probably help with her total ability to function, and, some of her range of motion, or, limited range of motion because of all of her surgeries, that just will be limited, but these modalities are something.

And, we had numerous office visits actually more recently to describe this and give her an information book in English, and Spanish, regarding that.

Q How long does the trial period last for a spinal cord stimulator?

A Typically, five days to a week.

Q And, you said there were risks with this procedure. What are some of those risks?

A Yes.

First of all, it's a surgical procedure to put in a permanent one, so, there is the risk of surgery, risk of anesthesia.

The trial is a fairly lengthy needle, you are getting into the epidural space, you are putting two wires in there. The risk of bleeding, infection, any time you have an implant, that risk is fairly significant.

And, then, there is a risk of the surgical risks because you are talking about now that you have to put in a permanent one, you are actually doing what they call an epinotomy(phonetic), you are removing some of the bones and putting lead into the epidural space, and, it remains there.

So, there are inherent risks again.

Probably, the biggest risk is bleeding, infection, nerve damage are probably the biggest risks associated with

that.

Q Assuming the trial period is successful, how long does the permanent stimulator, permanent implant last?

A So, we tell patients that it is permanent, but, permanent in the sense that it is going to probably stay in your body for the rest of your life.

The generator itself needs to be replaced once every approximately every ten years depending on usage and that's the longevity of the battery.

What's nice about it in a way to change it every ten years is the technology has vastly improved.

Every year, there are a lot of new companies and new technology that make vast improvements on how to stimulate.

So it's a good thing sometimes to make that change. And, then they can actually upgrade them.

Q And what procedure would be used to change a generator?

A It is a surgical procedure to put in the generator.

The generator is implanted, so, you are talking about making an incision, taking out the old generator, putting in the new generator, attach it to the leads, and, then, closing up.

So, it is a surgical procedure.

Q So, would these costs be replicated in that ten-year period?

A Yes.

Mandelbaum - Cross - Defendant (O'Brien)

Q And, doctor, do you have an opinion within a reasonable degree of medical certainty as to whether or not she requires a spinal cord stimulator?

A Yes.

In my opinion, within a reasonable degree of medical certainty, she would require a spinal cord simulator.

Q At what time period would you recommend that?

A I would do it now.

Q Doctor, with respect to all of the various treatment modalities that you described, do you have an opinion within a reasonable degree of medical certainty as to whether or not these procedures should be performed over the course of the patient's lifetime?

A Yes.

In a reasonable degree of medical certainty, these procedures will need to be performed, including, the spinal cord stimulator.

Despite the fact that she may have a spinal cord stimulator, she still may need some of these other procedures.

Even with the stimulator, you can have exacerbation of pain. It doesn't necessarily preempt the idea that you don't need a transforaminal injection because the pain is dynamic.

There are exacerbations of pain, so, even with the stimulator, you can have all of a sudden increased pain shooting

down into the leg that won't subside.

So, within a reasonable degree of medical certainty, you know, she will need these procedures in addition to.

And, again, that's ultimately her decision about the stimulator, but, it is something that is now -- the benefits of the stimulator far outweigh the risks. And, again, it is done as a trial, and, then, a permanent one.

Q Doctor, are you being compensated for your time today?

A Yes.

Q Did you have to cancel any office hours to be here?

A Yes.

Q What is your rate of compensation?

A It is $350 an hour, both for the time spent in preparation, as well as rescheduling patients.

MR. NORINSBERG: Thank you, doctor.

No further questions.

THE COURT: Cross examination?

MR. O'BRIEN: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. O'BRIEN:

Q Doctor, based upon that $350 an hour, what would be the total that you are receiving?

A Um, I don't know offhand.

Q About?

A Um, 6 to $8,000, depending on the hours.

Q Okay.

And that included review of the records and travel time and everything else?

A Correct.

Q Okay.

Now, did you actually ever do a physical examination of plaintiff?

A Yes.

Q Okay.

When was that examination?

A The first time that I had seen her was on October 9, 2015.

Q Okay.

And, then, was Dr. Thomas also seeing the plaintiff at some point?

A Yes.

Q And he is affiliated with the practice Comprehensive Pain Management?

A Yes.

Q So, how many of the visits were with you, and, how many of the visits were with Dr. Thomas?

A I don't know the exact number offhand.

She roughly comes monthly. She was seeing Dr. Thomas,

a little more frequently than seeing me.

Again, I did see her quite a number of times.

I would have to count the exact office visits, but, I did see her more than a couple times.

Q She saw Dr. Thomas more than you, but you are not sure of the breakdown.

Right?

A Again, it could be looked at.

If you want me to review my charts, I can give you an exact number.

Q So, I just wanted to know who saw her and when, that's the idea.

And, I understand that Dr. Thomas could not be here; right; he is not well?

A Correct.

Q Okay.

That's the reason why, right?

A Yes.

Q And, I'm sorry to hear about that.

A Thank you.

Q Now, did -- the first time you saw the plaintiff, did you specifically ask her how this accident had happened?

A Yes.

Q Okay.

Mandelbaum - Cross - Defendant (O'Brien)

Now, you have a report, a January 27, 2017 report.

Do you have that one in front of you?

A Yes.

Q Now, did you prepare that report, did Dr. Thomas, or, did both of you, or, something else?

A Doctor Thomas had seen her during that particular office visit.

Q Okay.

Now, the history given in that particular report is that the patient was in a wheelchair when the lift was going down.

The patient was coming off with the wheelchair and the bus driver did not see the patient on the lift, because he raised the lift causing the patient off from the lift landing on right-hand, and, left side of her body.

Do you know where wither you, or, Dr. Thomas, or, whoever in the office got that information; would that have been from the plaintiff?

A That was the information that was obtained during her initial office visit.

And, that is just, that is a reiteration. It was basically a copy and paste from the initial office visit, when we had first seen her.

Q So, once that information goes into the computer, or,

form, or, whatever you use, that kind of becomes the basis of the history of what had happened?

A Correct.

Q Now, you specifically used the word "lift" several times in the first examination and every examination after that, and, today, you use the word "ramp."

Do you know why you switched it from lift to ramp, or, would that matter to you from a clinical perspective?

A It is semantics in a way, but, it is a lift -- I have seen the buses -- and, as far as getting wheelchairs down from the bus.

Um, so, a lift is something that is more mechanical and a ramp would be something that is nonmechanical in my mind.

Q Right.

So, the lift would be the big thing that goes up and down, and, lifts the wheelchair itself and the person is on it, and, etcetera, etcetera?

A Correct.

Q Okay.

And the ramp would be something that flips out from the front of the bus.

Right?

A Correct.

Q Now, all the testimony in this case has been about a

ramp that flips out from the front of the bus as opposed to a lift that goes up and down.

Would that be significant at all in your treatment and diagnosis?

A Again, from my understanding of the mechanism of injury, that it was a mechanical lift or ramp.

Q And, that would have come from the plaintiff herself?

A Correct.

Q Okay.

Now, would it be fair to say that if there's -- your testimony about what the plaintiff told you, there being a ramp -- I'm sorry -- a lift involved and other testimony that there was a ramp involved, would it be fair to say that you as the pain management person are not particularly concerned about specifically how this happened.

Would that be fair to say?

A No.

I mean, I am concerned about how the mechanism of injury that happened to the patient as far as her falling and the movement of the lift or ramp.

Q Okay.

So, would the lift indicate that there was some height involved, that she fell from some high level?

A There is height involved getting on and off a bus.

Q Okay.

Were you concerned about how many feet above the ground she was from the lift to the ground or something else?

A I do not know the exact answer to the exact height, just the mechanism of injury.

Q All right.

So, would it be fair to say that you don't know specifically what happened back on the date of the accident, February 12, 2013?

A I do know what happened during that date of the accident.

Q Okay.

And, it's -- you know what happened based upon what plaintiff told you?

A Correct.

Q And, it's a lift?

A Correct.

Q Okay.

A Again, I am using the term synonymously.

Q All right.

Now, did you read any of the MRI films that the plaintiff had of the knees, shoulders, back, or, any of the films?

A Yes.

Mandelbaum - Cross - Defendant (O'Brien)

Q Okay.

At what point did you look at the films?

A They were seen throughout.

There was some initial films when she had come in and then she had gotten subsequent MRI's and films later on after.

For instance, she, in 2014 she had some MRI's.

Most of her MRI's were done prior to coming to our office.

Q Okay.

And, did you look at the Third Avenue MRI films?

A Um, I did have them available, yes.

Q Do you specifically recall reading the films, reports, or, something else?

A Um, I definitely had the reports. I definitely saw films.

I don't recall exactly which films that I actually visually visualized.

Q Right.

You don't know which films you actually looked at, would that be fair to say?

A It would be documented in the narrative.

Q Okay.

But, based upon your testimony, can you tell me right now which films you looked at?

A I had access to all her films, including, the MRI, and, reports, so, I did look at all the films to the best of my knowledge.

Q All right.

Can you tell me whether or not, yes, or, no, you looked at the Third Avenue MRI films from about March of 2013?

A Yes.

I did look at all the films that were available and that was one of the films that were available.

So, yes.

And, I do have the reports

Q Okay.

I am just trying to figure out was it the report you looked are, or, the film that you looked at?

A Both.

Q And, just to confirm, the examination that was done September 11, 2015, was that you or Dr. Thomas?

A On September 11th, that was Dr. Thomas.

Q Okay.

And that drop leg test that you talked about --

A Yes.

Q -- Dr. Thomas found that it was positive on the left leg?

A It was actually positive both right and left.

I believe the left was more significant than the right.

Q Okay.

So, it was more significant on the left as of September of 2015?

A Correct.

Q Okay.

Are you aware that Dr. Dosa found back in March of 2013, drop leg test was positive on the right; would that conflict with your finding that it was more significant on the right, or Dr. Thomas's finding?

MR. NORINSBERG: Objection.

THE COURT: Overruled.

You may answer.

A She had significant positive straight leg raise, both right and left during that particular office visit.

It was slightly worse on the left.

Q So, as of your visit -- plaintiff's visit -- to your office in September of 2015, the plaintiff had already had knee surgery.

Right?

A Yes.

Q She had already had shoulder surgery?

A Yes.

Q And, she had also had lower back surgery.

Right?

A Correct.

Q Now, at this point she has had physical therapy.

Correct?

A Correct.

Q And, she had been taking medication?

A Yes.

Q And, she has had three surgeries.

Right?

A Yes.

Q And, she had already had injections up to that point?

A She did have some injections prior to coming to our office.

Q Okay.

And, those injections, were through her orthopedist, Dr. Dosa.

Correct?

A I think she had actually seen a pain management physician early on and had some injections, and, Dr. Dosa, I believe, also did some injections.

Q Okay.

But, she has had all this treatment and she is still having pain in her lower extremities.

Right?

A Correct.

Q So, at what point is all the treatments not working; I mean, can you come to a medical conclusion?

A Well, I would not say that the treatment is not working.

The treatment is, in a way, you can call it almost palliative, in the sense that it diminishes the pain.

The treatment helps with the pain. It is not going to help forever.

Even the spinal cord stimulator, which is a more permanent solution is not going to necessarily help with the pain forever.

And there is going to be an exacerbation of pain throughout.

So, I would say, the treatment is geared toward the exacerbation of the pain to try to diminish the pain and try to get it back to baseline.

And, unfortunately, there is going to be worse pain periodically, depending on her activity level, depending on, you can wake up in the morning, and, all of a sudden, the pain is worse for whatever reason.

Q Now, you said you did a radiofrequency, in April 30, 2018.

Right?

Mandelbaum - Cross - Defendant (O'Brien)

A Yes.

Q And the idea of the radiofrequency is to "destroy the nerve with the intention of eliminating the pain".

Correct?

A Correct.

Q And, based upon what you said, it should last at least six months.

Correct?

A Yes.

Q And, upwards of a year?

A Correct.

Q So, if she had that on April 30th, 2018, would it be fair to say, that she should be experiencing no pain from the lower back through the lower extremities through November 30, 2018?

A No.

Unfortunately, the -- her pain generators, are multifactorial.

There is a lot of reasons for pain.

So, you are talking about pain from the spine, you are talking about pain from disks, you are talking about pain from hardware. Even, you are talking about pain from the muscles.

There is more than one factor, so, a radiofrequency is geared toward one source of pain. And, that's why we talk about

some of these -- all these other modalities that help with pain including, medication.

And, it is also geared to one side. And, she may have pain, and, she does have pain on the opposite side, so, I believe that radiofrequency was done on the left because that's predominantly the most severe pain, but, she still has pain on the right.

And, again, it is not going to get rid of all of her pain realistically speaking and she is well aware of that, and, it will help diminish some of the pain.

She still needs some of these other modalities that I described.

Q All right.

So, based on the answer that you just gave, would it be fair to say within a reasonable degree of medical certainty, that you have no idea of where the pain is coming from?

A Not true.

We know where the pain is coming from, but, it is multi.

There are a lot of generators of pain.

Pain from the spine -- spinal pain -- is rather complicated.

No one ultimately understands why patients have pain despite having surgery, despite having fusions of the neck and

lower back, yet, they still have pain that cannot be explained.

So, whatever knowledge that we have with pain generators, that can be explained.

That's why modalities like the stimulator are so beneficial.

Q But, the radiofrequency, is supposed to block the pain. Isn't that true?

A Radiofrequency blocks specific generators of pain, and, that's just geared toward those specific joints.

And, again, there are a lot of generators of pain

Q So, you say the pain comes from a lot of different sources for this person, right, this, plaintiff?

A Correct.

Q All right.

Is it possible that she thinks she has pain?

A My personal opinion and my professional opinion is she has ongoing pain. She has reason.

She has a lot of significant reasons to have pain.

Q Is this generalized pain?

A She doesn't have -- she has very specific pain.

Q You are saying left leg, right leg, left extremity, right extremity, neck, back, headaches, hip.

It sounds like pain everywhere to me.

A Unfortunately, she has a lot of generators of pain,

but, each site has been treated.

She has had multiple surgeries.

She has a lot of reasons to have ongoing pain. And, you can call it all body pain.

She does not have a diagnosis of fibromyalgia, for instance, which has no specific cause.

She actually has reasons, medical reasons, that she has pain.

Q And with initial points of contact that we have established in this case, so, left knee, and, right hand, there is no medical basis for neck, back, right leg, right arm, those parts of the body; isn't that he correct, shouldn't that be the medical conclusion?

A I'm not sure where you are leading with that, but, she had injuries to her neck and her back.

Q That were unrelated to falling on her left knee and right hand.

Right?

MR. NORINSBERG: Objection.

THE COURT: Overruled.

A She had a fall. She had reason enough to injure her neck and her lower back.

In my opinion, it was her generators. It was the mechanism that caused the ongoing pain, the ongoing disk

disorders and subsequent surgeries.

Q So, the left knee and right hand hit the ground and everything fell apart.

Right?

MR. NORINSBERG: Objection, Judge.

The emergency room record talks about multiple areas.

THE COURT: Sustained.

It is sustained.

MR. O'BRIEN: No further questions.

THE COURT: Any re-direct?

MR. NORINSBERG: Yes.

RE-DIRECT EXAMINATION

BY MR. NORINSBERG:

Q So, doctor, you were just asked questions about whether she thinks she has pain.

When we were looking earlier, we looked at the severe spasm in her neck.

Can you tell us, is that something that can be controlled by a patient?

A No.

Q What is spasm?

A Spasm is involuntary contraction of musculature.

Again, it's a protective mechanism for the underlying

Mandelbaum - Re-Direct - Plaintiff (Norinsberg)

condition or problem. That is what spasm is.

And it is something that you can palpate. You try to elicit it with range of motion on the patient, but, when there is significant spasm, you can actually feel those tight, tight muscles.

Q And, doctor, you were asked about the various areas that she has pain in.

I would like you to assume that we have had evidence in the emergency room record from day one that she injured her neck, left shoulder, left hip, left knee.

Does it surprise you that you these various areas still cause her pain?

A It does not surprise me.

Q And, doctor, did you ever have any impression, at any time in the three-and-a-half years that your practice has been treating her that in any way this patient was malingering, or, exaggerating her pain?

A No.

Q And, in your experience, can you tell if somebody is?

A Yes.

Q How, how can you tell?

A Usually, there are symptoms.

First of all, if they are malingering, and, exaggerating, they tend not to have surgery. That's number one.

But, on physical examination -- and, we followup, so frequently with these patients -- we get a good sense of what they are doing and who they are with.

And, so, there is such constant followup. We followup typically once a month. If they are having procedures, more than that.

She is somebody that is trying to help herself as best she can and taking whatever knowledge that we have and other doctors have and which entails surgery in her case, which is not a sign of malingering.

Q You were asked questions about whether Dr. Thomas and why he can't be here.

Why can't he be here?

A Unfortunately, he has ongoing cancer, and, he is undergoing treatment, and, he is rather ill.

Q And, doctor, you were asked questions about the history of the accident.

Would you agree having first treated the patient two-and-a-half years after the accident, that your primary concern at that time was to relieve her pain?

A Correct.

Q Were you really interested at that point exactly how the accident happened, or, were you interested in helping this patient get better?

A We were interested in helping this patient get better.

And, we were given information about the accident. But the idea was -- I mean, we saw her a couple years after the accident. She did have surgery already multiple times.

And, our real treatment was geared towards helping her with the pain.

MR. NORINSBERG: Thank you, doctor.

Nothing further.

MR. O'BRIEN: Nothing further, Your Honor.

THE COURT: Okay, thank you, doctor.

You may step down.

THE WITNESS: Okay.

THE COURT OFFICER: You can leave all the paperwork there.

(Whereupon, the witness, is excused and steps down.)

THE COURT: So, folks, now, would be a good time to take a ten-minute break.

Please, don't talk about the case, and, we will see you in ten-minutes.

THE COURT OFFICER: All rise.

Jury exiting.

(Whereupon, the jury, exits the courtroom.)

(Whereupon, there was a brief recess held.)

(Whereupon, the proceeding resumes.)

THE COURT OFFICER: Come to order.

The court is now back in session.

THE COURT: Okay, let's proceed.

Bring the jury in.

THE COURT OFFICER: All rise.

Jury entering.

(Whereupon, the jury, enters the courtroom.)

THE COURT: Folks, welcome back.

Have a seat.

As we have had to do before, we are now going to take a witness out of turn to accommodate scheduling.

So, you will now hear from a witness for the defendant.

Plaintiffs are not yet finished with their case, but, we will call defendant's witness to accommodate scheduling.

So, Mr. O'Brien, call your witness.

MR. O'BRIEN: Thanks, Your Honor.

The defendants call Dr. Roger Mosesson.

THE COURT OFFICER: Remain standing.

Raise your right hand.

DR. R-O-G-E-R M-O-S-E-S-S-O-N, having been called as a witness on behalf of the Defendant, having been duly sworn by the

Clerk of the Court, was examined and testified as follows:

THE WITNESS: Yes.

CLERK OF THE COURT: Have a seat.

And, for the record, please, just give us your name. Spell out your name. And give us an address.

THE WITNESS: Doctor Roger Mosesson, M-O-S-E-S-S-O-N, 315 West 70th Street, New York, New York, 10023.

CLERK OF THE COURT: Thank you.

THE COURT: Okay, thank you, doctor.

You may proceed, Mr. O'Brien.

MR. O'BRIEN: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. O'BRIEN:

Q Good morning, Dr. Mosesson.

A Good morning.

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

A Yes, I am.

Q Okay.

Can you give the jury your educational background, please?

A Beginning when?

Q Let's do college and from there.

A Um, I went to college at Columbia University, where I got a bachelors's degree.

When I finished there, I went to Harvard Medical School, for a medical degree.

When I finished there, I stayed in the Harvard system, and, did an internship in Internal Medicine at the New England Deaconess Hospital.

Then I came back to New York and did a residency in Diagnostic Radiology at Columbia Presbyterian Medical Center.

When I finished my residency in Diagnostic Radiology, I did a speciality fellowship in Neuroradiology at the Neurological Institute at Columbia Presbyterian Medical Center.

Q Doctor, are you board certified?

A Yes, I am.

Q And, what is "board certified"?

A When I did it, it meant that one prepared for an exam, one went and took an oral exam, and, also, a written exam.

Q Okay.

And, what are you board certified in now?

A I am board certified in Diagnostic Radiology, with what is called a Certificate of Added Qualification in Neuro Radiology, also, from the American Board of Radiology.

Q And, what is Diagnostic Radiology?

A It's distinguished from therapeutic radiology.

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That is when radiation, is used to treat tumors and other conditions.

Diagnostic Radiology it easiest to think of it as the picturing of the human body using x-rays, MRI's, CT Scans ultrasound and similar technologies.

Q And, what about Neuro Radiology?

A Neuro Radiology deals with picture taking imaging of the central nervous system, the brain, the spine, and, the head, and, neck structures.

Q Speaking of MRI, can you explain what MRI is and what it means?

A MRI, stands for Magnetic Resonance Imaging.

It's a nonradiation technique we use to acquire pictures of the body without cutting into the body.

What we do is we subject the body to a magnetic field, and, then, we change the magnetic field, and, then we watch what happens to the cells of the body.

Depending on what happens, they give off radiofrequencies, we capture the radiofrequencies, and, we make pictures out of them.

Q Now, were you asked to look at MRI films on a case involving Lucia Reinoso; specifically, MRI's from March of 2013?

A I looked at MRI pictures, and, I also looked at some x-rays.

Q Okay.

Now, I have preloaded, in the laptop in front of you, what's been marked in evidence as Plaintiff's Exhibit 9, which is the CD containing Third Avenue MRI films.

Now, doctor, the defense, the Transit Authority, has called you this case.

Correct?

A Yes.

Q Are you being compensated for your time away from the office today?

A Yes, I am.

Q And, what are you being compensated?

A $8,000.

Q And, what does that cover; time away from seeing patients, travel time; what does it cover?

A All of the above.

Q Okay.

Anything else that I didn't mention?

A No.

Q Okay.

How about the review of records in this case?

A No.

I reviewed the records before today.

Q Okay.

Now, do you recall what records you actually reviewed?

A I reviewed the images that I'm going to show you, I reviewed the reports that were generated when the images were obtained, and, I reviewed the Bills of Particulars, that were submitted to the court.

Q And, Bills of Particulars, those are legal documents?

A Yes.

Q Exchanged by the attorneys?

A Yes.

Q Now, you were subpoenaed actually -- you received a subpoena from the plaintiff in this case.

Is that correct?

A I did, yes.

Q And, do you recall what that subpoena asked you to provide or do?

A It asked me to provide all of the records that I had pertaining to this case.

Q Okay.

And what did you do, if, anything, when you received that subpoena from the plaintiff's office?

A I forwarded the subpoena to the Transit Authority --

Q Right.

A -- and I called the office of the person who served the subpoena on me and explained that I didn't have any records

related to the case. I had returned everything to the Transit Authority.

Q Okay.

So, you had reviewed the films some time ago?

A Correct.

Q And, did you formulate an opinion about those films, or, did you -- what did you do when you had the films?

A Um, I reviewed the pictures.

Q Um hum.

A I formulated an opinion, and, then I had a telephone discussion with the attorney for the Transit Authority.

Q Okay.

And, it wasn't me.

Right?

A That's correct.

Q It was another attorney?

A Yes.

Q Now, if you would, doctor, could you bring up the MRI of the cervical spine that is -- it is already in the machine.

And you could click on the file to bring it up.

A Is this as large as it gets?

Q Could you possibly maximize it?

(Whereupon, the exhibit is displayed on the screen.)

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A Okay.

Q You are pointing to the one on the top left.

Okay, you have it on the full screen.

Right?

A Yes.

Q Okay.

Now, explain to the jury what we are looking at, please.

A Okay.

So, when we do MRI scans, we don't take one picture, the way one takes an x-ray, and, you get one image.

We take a series of pictures and we take multiple series.

Sometimes, we slice the body part that we are looking at.

Sometimes we slice it in this direction. Sometimes, we slice it in this direction. Sometimes, we slice it in this direction.

(Whereupon, the witness indicates.)

Every now and then, we have to do it in another direction.

We can actually tell the machine to do that also.

What you are looking now is a picture focused on the cervical spine. That is the spine in the neck. That is taken

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slicing like this.

(Whereupon, the witness indicates.)

So, this is the nape of the neck, the back, all of this is the cervical spine, and, this is the mouth, and, you can just make out the nose here.

So, this is the face and profile, and, also, the cervical spine, the neck spine in profile.

(Whereupon, the witness, indicates.)

Q Now, can you give the jury basic anatomy of the cervical spine; what it does and how it is built?

A Sure, okay.

Can we turn the lights down just a little bit, if that's possible?

(Whereupon, the lights are dimmed.)

THE WITNESS: Thank you.

Much better.

A Okay, so the cervical spine, again, is the spine in the neck.

There's a spine in the chest, which is called the "thoracic spine," which we are not going to look at today. And, there's the spine in the lower back, which is called the "lumbar spine." The spine below that is the "sacrum", the "sacral spine", and there are a couple of little bones below that which we won't get into today.

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So, the cervical spine has several levels; there are seven vertebrae. It's the same in all mammals. Giraffes, have seven vertebrae also. Their vertebrae are just a lot taller.

So, because the first cervical vertebrae is up against the base of the skull, it's different from all of the others. And, then, the second cervical vertebra is slightly different and all of the others are pretty much the same.

And, we count the cervical vertebrae, C1, cervical 1, C2, C3, C4 and C5 and C6.

I can't show you on this picture C1 -- but I can show you C2, it's the easiest one to see, it is this vertebral bone, this vertebra, with like a finger coming up out of the box, so, that's C2.

C3, is just the box, C4, is just the box, C5, the box, C6, the box, C7, the box, and, then, this, is the top of the thoracic spine, we call it T1.

So, again, C2, C3, C4, C5, C6 C7, T1.

Between any two adjacent vertebrae there's a gel-like material called a disk. And, you can see that very easily on this image.

This is C2, and, this is C3. And, this black material between C2 and C3 is C2-3.

The black material between C3 and C4 is C3-4.

Between C4 and C5 is the C4-5 disk. Between C5 and C6,

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is the C5-6 disk, between C6 and C7, is the C6-7 disk, and, between C7 and T1, is the C7-T1 disk.

So, again, taking it from the top, we have C2 and C2-3, and C3, and, C3-4, then C4, then, C4-5 and C5, C5-6 and C6, C6-7, and C7, C7-T1 and, then, T1.

So, we all know how to label the different levels now.

Q And, doctor, can you explain to the jury, what is a "bulging disk", and, what is a "herniated disk"?

A Well, we have just seen the disks.

In between any two adjacent vertebrae, there's a disk, okay, and, the disk, is a cushion so that the vertebrae aren't rubbing against each other.

And, they are also there, so that the whole cervical spine isn't one bone, because if the cervical spine was just one bone, we wouldn't be able to bend our necks; it would just be one bone, okay.

But, we can bend our necks a little, and, a little more, and, a little more, because we are bending, a little bit more at each of those levels every time that we try to.

So, if the body wasn't built in such a way as to protect the disk, what would happen to it?

It would come out from between the two vertebrae, when we bent our necks.

It is like a jelly, and, it would just squeeze out.

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So, the body has to contain it within that space between the two adjacent vertebrae where it lives.

And, we can't see it, but there's a tough layer of connective tissue at the edge of the disk, which extends from the vertebra above to the vertebra below. And that tough material is called the "annulus", A-N-N-U-L-U-S.

So, that anulus keeps the disk material where it's supposed to be, so it doesn't come out, and, so, it can cushion between the two vertebrae, and, it will allow motion between the two vertebrae.

If the anulus, if that tough material gets generally weak, then the disk, doesn't leak out from between the two vertebrae, but, it kind of bulges from the space, and, so it's called a "bulge."

And a bulge happens when all of the materials that's containing the disk, in the back between these two vertebrae, all that material gets a little weak, and, all of the disk bulges from between the vertebrae, as distinct from a disk herniation.

What is a "disk herniation"?

Well, the disk, comes out from between the two vertebrae, but it doesn't come out everywhere, it comes out just in one place.

And, the reason it comes out in one place is because

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that tough connective tissue which is along the back of the disk, it gets torn. And, because it is torn, it can no longer contain the disk.

But, the tear happens in one point in the connective tissue.

It doesn't happen everywhere, it happens just in the one point.

So, the herniation can come out only in the point where that tear happened.

So, the difference between a herniation and a bulge, is that a herniation is focal; it's localized. Whereas, a bulge, it's everywhere.

And, I'm going to show you -- we won't talk about bulges or herniation apropos, this particular patient, but, remember, we are going from left to right, and, we are taking a picture, here, and, then, here, and, then, here, and, then, here.

If we were to go out all the way, the first picture that we would have is of the left ear, and, then, the last picture that we would have is of the right ear.

But, we don't tell the machine to scan all the way out here because we are just interested in the neck.

So, we have the patient scanned, from here to here.

(Whereupon, the witness indicates.)

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So, we can see, this is the left side of the cervical spine, and, then we come over a little more, to the right, and, there's more cervical spine, and, then, that's more to the right, and, that's the middle, and, then, we keep going, and, it's all the way to the right, and, then, we are out of the cervical spine.

So, when I look at a disk -- let's look at the C2-3 disk -- I see the C2-3 disk, all the way on the left, and, then, on the next picture, and, the next picture, and, maybe, a little bit on this picture.

So, we have at least five pictures, where we see the C2-3 disk.

Q And, what can you tell the jury about the C2-3 disk, as it pertains to this image, the March 2013 MRI, cervical spine MRI of the plaintiff Lucia Reinoso?

A Okay, now, I should have shown you the date of the examination is bottom right, 3/22/2013. The patient's name is top right, then, there's a medical record number, and, then, there's the patient's date of birth.

So, all of this identifies this examination as having been performed on this patient.

So, this patient's C2-3 disk, we see stays securely between the C2 and the C3 vertebrae. It's not going anywhere. It's confined to that space.

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If it were bulging, it would come out like this. If it were herniated, it would come out like this on one picture, but not, on the other picture.

(Whereupon, the witness indicates.)

So, let's look at the C2-3 disk, on all the pictures of the cervical spine we have.

This is the C2-3 disk, and, then, coming a little bit more to the midline, that's the C2-3 disk, and, that's, the C2-3 disk, and there's a little bit of the C2-3 disk here.

So, the C2-3, disk, is living where it is supposed to live. It's not coming out from between the two vertebrae.

Q Now, doctor, if it's not coming out between the two vertebrae, can it cause pain?

A The disk itself, no.

Q And, how about the -- you know, if it's not bulging and it's not herniated, there should be no symptoms.

Right?

A That's correct.

Q Now, if you could go on to the C3-4.

A Okay.

The C3-4 disk, um, you can -- I would call it normal essentially, for the patient's age; somebody born in 1951.

Everybody has a little bit going on with their disks, but, you can see that if anything the disk, is coming out ever

so slightly.

Whereas, this line is straight; that's the back of the disk, and, this line bulges slightly, but, we see that the bulge is there on every picture.

So, it is a bulge it's not a herniation.

So, the C3-4 disk, I would call it normal. Some people might say there's a minimal bulge.

The C4-5 disk, the same thing. I would call it normal.

The C5-6 disk is not normal, it's different from the other vertebrae as you can see.

So, we won't talk about the C5-6 disk yet.

But, let's talk about the C6-7 disk' that's this one.

So, again, 2, C3, C4, C5, C6, C7. And, this is the C6-7 disk. And, it's pretty much where it's supposed to be.

And, again, the C7-T1 disk, is the same thing. It's pretty much where it is supposed to be.

The only disk which is questionably abnormal on this particular picture is this disk, which is the C2, C3, C4, C5, C6, this is the C5-6 disk, it's coming out ever so slightly.

It's not pressing on this grey structure. That grey structure is the spinal cord

(Whereupon, the witness, indicates.)

Okay, which connects on top to the brain stem. And, these are all brain structures up here.

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So, the C5-6 disk, is coming out slightly from between the two vertebrae, and, the question is, is it a herniation, or, is it a disk, because, if it's a herniation, it means that there was a tear in the material that was supposed to keep the disk in it's place, and, that tear is in only one place. Whereas, if it's a bulge that material is just generally weak, and, the bulge is going to be everywhere.

So, let's look at the C5-6 disk, to the left, and, to the right. And that's where we see it coming out from between the vertebrae here.

And, we see it here, it's coming out slightly, and, there, and, there.

(Whereupon, the witness, indicates.)

So, it's coming out everywhere slightly.

It is by definition a "bulge". It's not a herniation. It's a bulge.

A bulge again is a degenerative change from weakening, of that called the membrane, that anulus, which keeps the disk where it's supposed to be.

It's not a herniation. It's just a degenerative change.

And it's a very common degenerative change, because when we bend our necks, we are mostly bending at C5-6, and C6-7. So, that material gets weakest at C5-6, and, C6-7.

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Q Would you ordinarily see that condition, that bulging disk, in someone of the plaintiff's age?

A Yes.

It's very common in even much younger people.

Q Okay.

So, specifically, as to that bulge, you found, that's C5-C6?

A Correct.

Q Is that the most common area for someone to experience a bulge?

A Yes.

C5-6 and C6-7.

Q Okay.

Is there any indication -- all the testimony in this case is about an accident that happened on February 12, 2013 -- did you formulate an opinion whether the February 12, 2013 fall or incident is in anyway related to your finding of C5-C6?

A Yes, I can.

Q Okay.

Can you tell that to the jury, sir?

A This is a degenerative change it is not a traumatic change.

If there was an injury in the setting of trauma, there would have been a tear at that membrane at the back end of the

disk, and, the disk would have leaked out the jelly, the disk would have leaked out at one point, and, it's not leaking out in one point.

As we have seen, it is sort of bulging out everywhere. That is by definition "nontraumatic". It is by definition a "degenerative change", a wear and tear change.

Q So, now, C5-6 you see it bulging out everywhere.

Is there any impact of that bulge everywhere on the spine itself on the spinal column?

A Well, all of this is the spine.

Are you asking me is there an impact on the spinal cord?

Q Yes.

In relation with the C5-6 bulge --

A Yeah.

Q -- and the spine, is it pressing up against the spinal cord, or, some issue there?

A No.

As we can see, there's no space.

This white material between the spinal cord and the back of the disk, that white material is what's called "cerebral spinal fluid."

And, so, there's a space between the disk itself and the spinal cord. It is not pressing on the spinal cord.

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And I have other pictures.

We have been talking now about just one kind of picture, but, there are other pictures here, and, so, I don't want to confuse you too much, there are other ways that we look at the cervical spine also, and, there is no evidence on any of the pictures that this disk bulge, which is nontraumatic to begin with is compressing either the spinal cord or any of the nerves coming off the spinal cord.

Q Now, we have looked at the side view.

Does that have a specific medical name the side view that you have up now?

A Yes.

Q What's it called?

A It's called the "sagittal view".

Q The sagittal. Okay.

And, the other one that you brought up looks like from the top down?

A It is called the "axial view".

Q Okay.

A Axial pictures are taken like this, and, sagittal pictures, are taken like this.

(Whereupon, the witness, indicates.)

Q So, when you say "like this", you are saying from front to back potentially?

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A I have sliced it from front to back.

Q Yes.

A Saggittis, is like Sagittarius, the zodiac sign, refers to arrows, or, an archer.

So, somebody thought that if you are standing right there and I shoot an arrow into you, you will split like this.

(Whereupon, the witness, indicates.)

And the surface that's exposed is called the "sagittal surface".

Q Okay.

If we look at the axial view, would that help explain to the jury a little bit more C5-C6?

A I think that it will confuse everything.

We see the disk well enough here.

In clinical practice, I would use the axial view just to confirm what I have just said to you --

Q All right.

A -- and it does confirm it.

So, I didn't want to make anybody's head explode

Q All right.

Are there any other images that you would like to use with regard to the cervical spine to explain to the jury; meaning, from this disk itself?

We looked at the sagittal and we talked about the

axial.

Any other views?

A Well, on this examination it doesn't look like there are any others.

Q Okay.

Now, based upon what you are saying with that space in between the spinal cord and the disk should there be any pain experienced by the plaintiff?

A Pressing on the spinal cord, even if it did, which it doesn't, the disk pressing on the spinal cord usually doesn't cause pain.

It's when the disk presses on a nerve coming off the spinal cord that pain actually happens.

Q All right.

So, now, with that C5-6 bulge, do you see anything pressing on the nerve?

A No.

Q Okay.

Can you point this out on this image?

A Well, again -- okay, I really do hate to confuse you all.

So, these are, on the left side of the screen, are sagittal images. So, the top of the head is up here, and, the chest is down here, and this is the angle of the jaw.

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(Whereupon, the witness, indicates.)

And, you saw before, but, I will show you again, you can almost make out the nose here.

(Whereupon, the witness, indicates.)

Okay, these pictures, are taken in the plane of this yellow line that you see in the left-hand image. So, they are taken from top going from top to bottom, right, and, now, bottom to top, okay.

So, when we take pictures from top to bottom, you she that this image where right now I have the yellow line going through the C3 vertebral body, we see the vertebral body is sort of slightly whitish or grey, and, then, the C3-4 disk, is black.

So, if we go down the spine, we see that this is the vertebral body. It's sort of whitish, and, then, as we go down, we come into this black material, which is the disk, and, then, we come into the top of the C4 vertebrae, which is, again, sort of whitish, and, then, we are on the bottom of the C4 vertebra, so, it's a little white, and, then, we are in the disk, which is black.

So, again, this can be very confusing, to somebody who doesn't look at MRI scans all the time, but, what we are doing is we are looking at the same structures in two different projections.

We are looking at the structures slicing like this,

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and, we are looking at the structures, slicing, like this.

And, if you think of the cervical spine, the neck spine, as a cake, a jelly cake, there are layers of vertebrae, and, then, there's jelly between them. Okay.

So, it's going to be a little oval, when we look at it like this.

So, this is a vertebrae, and, then, this is the jelly at the bottom of the vertebrae, and, then that's the top of the next vertebrae, okay.

Again -- it's very confusing, but -- this is the C5-6, disk; this black structure here, okay. This is the spinal cord behind the C5-6 disk. This is the C5-6 disk. And this is the spinal cord behind the C5-6 disk, okay.

This is where the nerves come off the spinal cord and go out into the body, on the right, and, on the left.

And those canals, where the nerves come out between the bones are completely open. There's nothing that's constricting the nerves as they come out of the spine.

So, there's no evidence of compression, by the disk, or, by anything else.

There's no evidence of compression of the spinal cord, nor, is there any evidence that any of the nerves coming off the spinal cord is affected.

I call this a normal for age spine with mild

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degenerative change with no evidence of trauma.

Q So, doctor, within a reasonable degree of medical certainty, did you come to an opinion as to whether the February 12, 2013, accident caused that C5, C6 bulge?

A Yes, I did.

Q And, what is that?

A It did not.

Q Why?

A It's a degenerative change.

Bulge, is a degenerative change, as compared to herniation, which is a traumatic change.

Q And, so, there's no evidence of a herniation on the cervical spine.

Is that correct?

A That's correct.

Q You did find a bulge, but, it was longstanding, you said?

A That's correct.

Q And, can you give an opinion as to how long a bulge would take to develop; I mean, it's longer than 4, 5, or 6 weeks.

Right.

A Much longer.

MR. NORINSBERG: Objection.

THE COURT: Overruled.

Q By "much longer", what do you mean?

A Well, it's a question of degree.

A minimal bulge --

Q Um hum.

A -- um, a bulge till it gets to this degree, even though it's mild, before that it was minimal, and, before that, it was very minimal.

So, it takes a while to progress from normal to very minimal to minimal to mild to moderate to severe.

Q Okay.

And, then, what is this one; what category does that fall into?

A I call it mild.

Q If a herniation in the cervical spine had happened on February 12, 2013, what, if anything, would have been on this MRI?

A I would see a herniation.

Once that disk material comes out, it's there. And 5, 6 weeks after an accident it should sill be there. I should see it.

Q And, it's not there?

A It's not there.

Q Doctor, can we move to the lumbar MRI, please?

A Yes.

Q You provide similar to the cervical spine the anatomy of the lumbar spine?

A Sure.

This will be much easier for everybody.

We say that there is a cervical spine, the spine of the neck, there's a thoracic spine, the spine of the chest, and, there's a lumbar spine, the spine of the lower back. So, this is the lumbar spine.

The cervical spine, the neck spine, has seven vertebrae. The lumbar spine, the lower back spine, has five vertebrae normally. And we count them from the top of the sacrum.

So, this is the sacrum, okay.

The first -- the last -- vertebrae in the lumbar spine, the lowest one, is L5, lumbar 5, the one above that is L4, lumbar 4, above that is L3, and, then, L2, and L1.

So, this is L1, L2, L3, L4, L5. And, then, the top of the sacrum is called S1.

There are disks between any two adjacent vertebrae in the lumbar region also.

So, in the lower back, we label the disks in a similar fashion that we label them in the cervical spine.

So, the disk, between L1 and L2, is L1-L2, the disk

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between L2 and L3, is L2-L3, the disk between L3 and L4, is L3-4, the disk between L4 and L5, is L4-5, and, the disk between L5 and S1 is L5-S1.

Q Okay.

Now, could you confirm for the jury, briefly, that this is the lumbar spine MRI, the date and the patient?

A Sure, sure.

I'm sorry, I should have said something before.

Q It's okay.

A Again, patient name, top right, examination number, just under that, date of birth in the third line, and, then, bottom right, is the date of the examination, 3/14/2013.

Q Okay.

And, what were your findings for the lumbar MRI of the plaintiff's lumbar spine that we are looking at here?

A Okay.

So, um, first, we will look at the lumbar vertebra.

And, remember, in the vertical spine they were boxes. There was a box at C3, and, there was a box at C4, and, there was a box at C5.

Here, there's kind of a box at L5, and there's kind of a box at L4. But, at L3, there is no box. The bottom corner is coming out a little bit; do you see that; it's coming to a point, and, the top corner is actually this; it's coming out a

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lot.

And, then, if you look at -- this is 5, 4, 3, 2 -- at L2, the bone is coming out like this; it's peaking in front, okay.

(Whereupon, the witness, indicates.)

And, then, the same thing, the top of L2, is coming out, and, the bottom of L1 is coming out.

This is called "spondylosis". This is bony rigid, which takes a long time to perform.

You are not used to seeing it in the lumbar spine, but you are used to seeing it in the fingers of some older people, around their joints. The bones start to overgrow. And, they get little almost nodules around their knuckles, okay.

It's the same thing in the joints of the spine.

So, we know that this is -- even without knowing the date of birth -- we know that we are not looking at a little kid because this doesn't happen in little kids, it's a chronic degenerative change, and, it's accompanied by changes in the disks.

So, if you look at the L5-S1 disk I'm going to describe it on this kind of picture that we are taking as kind of bright, all right, and, then, the disk above that, the L4-5 disk, is bright in the back, but, kind of dark in the front. And, then, the disk above that is black throughout. And the disk above that

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is kind of very black in the back and very black in the front.

Also, you will notice that if we call this L4-5 disk, normal, you will see that the L3-4 disk, is not as high top to bottom. This distance to this distance is kind of compressed, and, in this even more so, the L2-3 disk, it is compressed. And, the L1-2 disk, is also a little compressed.

These are all degenerative changes.

The disk, over time begins to loose water. It becomes dehydrated, or, we say, desiccated, because there's a lot going on. We are pressing on our spines all the time, and, after a while, degeneration of the disk happens, and water comes out of the disk, so the disk, becomes less bright on these pictures, and, since there isn't as much water, it's not as plump and the space starts to decrease.

So, there are degenerative changes of the disks, which include, desiccation, dehydration, and, loss of height.

What else is happening with the disks?

We see that in the back, the disk, is sort of pouching out between these two vertebrae and between these two vertebrae and between these two vertebrae and between these two vertebrae.

So, all of these disks are either bulging, or, they are all herniated.

How do we know the difference?

If it's a herniation, it's just going to be on the one

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picture that we take through this area going like that.

(Whereupon, the witness, indicates.)

But, if it's a bulge, it's going be on every picture going from the left and to the right.

So, let's look at the pictures going from the left to the right.

Still there, still there, still there, the little bit that we can see in each of them. And, then, we are going to sweep around the other way, still there, still there, still there, still there.

So, at every level, each of the disks comes out a little bit from between the two vertebra where they are supposed to live.

They are by definition disk bulges and not disk herniations.

There is no disk herniation. There are multiple disk bulges.

Q Can you talk about facet joints, doctor?

A Again, it's going to be very confusing, but, the facet joints -- we have been talking all along both in the cervical spine and in the lumbar spine about the front business end of the spine, where the vertebrae, we say the "vertebral bodies" actually live.

There's the back of the spine also.

And, the back of the spine, just the same way there's a joint between any two vertebra, there's a joint in the back also.

The joint in the back is called the "facet joint". And, there's a facet joint on the left, and, on the right, at every level of the cervical and thoracic and lumbar spine.

Those facet joints develop degenerative changes as well.

And, in this patient, there are degenerative changes in the back of the lumbar region too at every level.

Q So, doctor, are there any herniated disks in the lumbar spine?

A No.

There's no evidence of herniation, or, any other trauma to the lumbar spine on this examination performed 3/14/2013.

Q Just a little bit over a month after the February 12, 2013, accident?

A Um hum.

Maybe a day over a month.

Q Well, with the 20th being -- February, being a short month.

A Right.

Q Now, with regard to the bulging disks that you talked about with the plaintiff's lumbar spine, are those in any way

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related to the February 12, 2013 incident?

A No.

They are degenerative changes.

Q And, again, how long would it take for those degenerative changes to develop?

A In this instance, I can say, a very long time because they developed along a timeframe which allowed the bones to remodel.

We talked about the link of the bones, and, it takes a long time for bones to overgrow like that, okay.

I would say years.

Q Now, is there anything else on the lumbar spine MRI's that would help explain to the jury any of your findings, or, have you sufficiently explained it in your opinion?

A Just that I don't see any herniation or other evidence of trauma.

Q Okay.

Now, if we can move on to the plaintiff's left shoulder, if you would?

A Yes.

(Whereupon, the exhibit, is displayed on the screen.)

Okay, so this is left shoulder MRI scan.

(Whereupon, the witness, indicates.)

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Q And, what date was it taken?

A It was taken, as we see on the bottom right on 3/22/2013.

Patient's name, top line, top right, date of birth, the third line, top right, and, here, we see it's the left shoulder.

Q Would you explain the basic anatomy of the left shoulder to the jury, please, or, shoulders, but, more specifically, the left shoulder because that's the one that we are looking at?

A Okay.

This is a little bit more difficult in a way than the cervical spine, because on the cervical spine, the same thing happens at every level, over and over and over and over again, but, on the shoulder, the shoulder is different no matter where you look at it because it is just the one structure, this one large structure.

So, the cervical spine, the best way to understand -- this picture is what's called a "coronal image". So, it's taken like this.

(Whereupon, the witness, indicates.)

And, we see the head of the arm bone; it's called the "humerus", and, it's up against this, which is the end of the scapula.

So, the actual shoulder joint is the space between this

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round bone, the humerus, and, this bone, okay.

So, this is the actual shoulder joint.

But, around the joint are all of these other structures, which are coursing in particular waves because they are there, first of all, to make sure that the arm doesn't fall off, and, second of all, to make sure that we can move our arm in every direction that we need to; up and back and raise inward, and, rotating in and rotating out.

And, all of those motions are accomplished by muscles. A muscle here at the top contracts, and, it lifts the arm.

So, there are -- from moving the shoulder -- there are four main muscles involved.

The most important muscle, is called the "supraspinatus muscle", S-U-P-R-A-S-P-I-N-A-T-U-S, okay.

That muscle courses like this, and, then, it goes to here, and, then, it has to lift the arm up.

That's the main muscle for the shoulder.

(Whereupon, the witness, indicates.)

So, when you say it is for the shoulder, it is really the main muscle for the upper arm, to move the upper arm that way.

So, the muscle itself has to both be able to contract, and, it has to be able to pull on the bone so that the bone will come up.

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This is that muscle. This is the supraspinatus muscle. And, the muscle, itself, actually doesn't detach to the bone. The muscle morphs, or, changes into this black structure, which is called a "tendon."

So, this is the supraspinatus muscle, and, this is the supraspinatus tendon, which is really just a continuation of the muscle.

And, that tendon, is going to insert, it's going to attach on this part of the bone, so, that when the muscle contracts, it will pull the tendon and the tendon will pull the bone, okay.

There are multiple muscles in the shoulder. Each one of them attaches in a different place, so, as I say, we can move the arm this way, we can move it this way, this way; we can turn it in, we can turn it out, and, some combination, of all of those things.

Q Now, doctor, when you looked at the left shoulder MRI of the plaintiff, did you make any findings, or, anything significant on here?

A Yes.

Q Can you tell the jury what those are?

A I mentioned the supraspinatus muscle and tendon even though there's a lot of other anatomy because the supraspinatus tendon is the most common one to be damaged when the shoulder

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sustains an injury.

So, if we look at the tendon -- and this is a different exposure; the same structures -- we see the muscle, it's darker on this set of picture, and, then, the muscle continues here and it inserts, directly on the bone.

So, it is inserting on the bone, and, it is continuous, which means that there's no tear of the tendon.

If there was a tear in the tendon, we would see it as a discontinuity in this structure, which is coursing from the muscle to the bone. And, we don't see it.

We see that it gets -- on this set of pictures -- it gets a little grey, instead of being black. It's a little grey. That's a degenerative change, because, again, we are using our muscles and our tendons, a lot.

And, so, over time, they develop wear and tear. And, that's just normal wear and tear, of the tendon.

And, it's interesting, because usually, when there's wear and tear, on the tendon, there's also rubbing of the tendon, and wear and tear, in the adjacent bone.

And, indeed, we see that there is a small area, which is very bright in the bone that's right under the tendon.

So, this little bright area is also a degenerative change. It takes a long time for this to develop.

So, we know that the degenerative change in the tendon,

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is a long standing degenerative change.

So, not only is it not traumatic, not related to an injury, we know it couldn't be related to anything recent; injury or otherwise because the associated finding in the bone is old.

So, we are looking at an old shoulder.

Q Now, if the plaintiff had impacted her shoulder, torn her shoulder on February 12, 2013, what would it show?

A If there had been a direct impact to the shoulder, which caused a tear, of the tendon, we would see not a continuous tendon connecting the bone to the muscle, we would see a rupture in the tendon. We would see the tear, itself. It would fill with fluid, and, we would see also fluid above the tendon and below the tendon.

Because everybody knows that when you sustain a significant injury, you get swelling in the area also. That swelling is fluid.

We don't see any fluid around the tendon and the tendon itself is in tact.

So, there's no evidence that this part of what's called a "rotator cuff", this particular tendon or any other tendon, or, muscle in the shoulder sustained trauma in the month, month-and-a-half before this accident, before this scan.

Q And, could the tear, can it repair itself?

A No.

Q Okay.

Now, within a month would the tear go from being torn to being not torn within a month?

A No.

If a structure is torn, then it stays torn until it's fixed.

Q And, you would see that -- if it were torn -- you would see that on the image?

A Correct.

Q Now, you mentioned swelling.

What significance is swelling in relation to the left shoulder MRI?

Q Again, if there was an acute abnormality of any kind, either, an exacerbation, an aggravation, inflammation, or, if there was trauma, or, anything else going on that was acute, I would expect to see edema, fluid, swelling, related to it.

And, there's no edema, there's no fluid, there's no swelling, anywhere in the shoulder to suggest an active, acute, ongoing process?

Q So, the only, I guess, abnormality, you see here on the left shoulder is that it would be the bone structure?

A No.

I think that the tendon itself is greyer than it should

be. It should be jet black, and, it's not. So, that's a degenerative change.

And, then, there's degenerative change also in the bone adjacent to the degenerative change of the tendon, which is a very common combination of bone and tendon together developed wear and tear.

Q So, within a reasonable degree of medical certainty, did you form an opinion as to whether any of the findings of the left shoulder are related in any way to the February 12, 2013 incident?

A Yes, I did.

Q And, what's your opinion?

A That they are not related.

I will mention also, just parenthetically, just for completeness sake, there's another tendon coming from below at a different part of the shoulder, okay, this is another tendon, and, right at that tendon is degenerative also.

Hard to see on this one picture, but, you see adjacent to it there is a smaller area of bone, which is pocketing the fluid, which is a chronic change.

So, there's evidence of chronic degenerative change in the shoulder, but, no evidence of trauma related to injury that happened anytime at around the date of the scan.

MR. O'BRIEN: Your Honor, I was going to go into the

hip, and, knee.

Do you think there would be time, or, shall we break and do that after lunch?

THE COURT: How long do you think it will take the hip and the knee?

MR. O'BRIEN: I think we could probably get through in 15 minutes for the knee.

Doctor, do you think we can do it?

THE WITNESS: We can try.

MR. O'BRIEN: Okay, all right.

THE COURT: Let's go for at least one.

MR. O'BRIEN: Okay.

Q Doctor, can you bring up the left knee MRI, please?

A Yes.

(Whereupon, the exhibit, is displayed on the screen.)

Okay.

Q Can we just identify for the jury what we are looking at?

A Sure.

Top right, patient's name, date of birth, line 3. This is the left knee, as it says on line 5, top right, and, the date of examination, bottom corner, 3/8/2013.

Q Can you give a brief anatomy of the knee, and, specifically, the left knee?

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A Sure.

The knee has three bones. There's the thigh bone, which goes down, and, then, there's a leg bone, which comes up, and, then, there's a kneecap in front of the two of them.

So, the bone that comes up from the leg is called the "tibia", the bone that comes down from the thigh is called the "femur", and, the kneecap is called the "patella".

We won't talk about the patella on the set of pictures that I have now on the screen, but, we can talk about the bottom of the thigh bone; the femur, and, the top of the leg bone, which is the tibia.

So, the space between the two of them is the actual knee joint.

Q Now, doctor, are there any significant findings on the left knee MRI, for March 8, 2013?

A Yes.

Q And, can you tell the jury, what you saw?

A They are clinically significant.

Q Explain what that is briefly?

A Um, I see, I see multiple findings, which tell me that the patient's knee presumably is a painful joint.

So, the femur is supposed to come down and is supposed to be quite round, so, then it comes up and it is supposed to be round again, so, two balls, essentially, communicating with the

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top of the tibia, but, it's not.

There's a little -- not so little actually -- piece of bone coming off of the end of the knee here, and, then, there's a tinier piece coming off here, and, then, instead of the top of the tibia being nice and round the way it is over here, it's actually peaking ought over here.

(Whereupon, the witness, indicates.)

So, the bone has overgrown -- the way we talked about it having little fingers -- and, then we saw it happening in the cervical spine. And, then, in the lumbar spine, the spine has overgrown. That's a chronic, longstanding, degenerative change.

And, the reason it has occurred is because this joint space between the femur and the tibia is abnormal.

There are supposed to be two very prominent completely black structures in the space between these two bones on each side that's called the "meniscus". There's a medial meniscus, along the inner aspect of the knee, which you can kind of make out here, and, there is a lateral meniscus, which is supposed to be in here.

(Whereupon, the witness, indicates.)

There is no meniscus.

The meniscus, the medial and lateral, both, has the job of cushioning the space between those two, so, the bone, when you stand up, your bones aren't hitting each other, they are

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actually being cushioned in this gel-like material between the space, both on the inside of the knee and the outside of the knee.

There's no normal meniscus in this knee, either, inner, or, outer.

That's a chronic and/or postoperative degenerative change.

Q Okay.

A And, it is certainly a cause for pain.

Also, if we look -- so, these pictures are taken as if the patient is standing in front of you, and, first, you take a little bit of the front, and, then, the front, front, front.

We have another set of pictures, which are sagittal, like the pictures that we saw on the cervical spine. Those are taken like this. So, it's the same bone coming down from the femur, the same bone coming up from the leg, but, now, we are seeing them from the side.

(Whereupon, the witness, indicates.)

And, you can see that in the tibia, there's this vague area of white. That vague area of white is blood.

So, there's blood in the marrow cavity of this tibia. And, that's not normal.

Q Okay.

Is there any indication of what might have caused that

blood in the marrow?

A Yes.

This is a very common traumatic finding. It's what's called a "bone bruise."

Just the same way we can get a bruise under our skin, we can get a bruise in muscle, we can get a bruise in liver. We can also get bruises in bone.

And this is a classic textbook bone bruise.

Q If there was testimony that the plaintiff fell onto her left knee on February 12, 2013, would that correlate, with the finding here on this MRI?

A Yes.

Q Okay.

Now, in a subsequent MRI, will the bone bruise clear up?

A Absolutely, yes, 100%.

Q And, can you explain that to the jury, how that happens?

A It's just a bruise, the body -- the same way a bruise under the skin goes away, a bruise in the muscle goes away, a bruise in the bone goes away also.

This is not an indication of fracture. There is no fracture.

We have other pictures on a different disk, which, if

necessary, I can pull it out and take time, but, x-rays were done the date of the accident, and, there's no bone fracture.

This is just a bruise. It doesn't need to be casted. It doesn't need to be instrumented. No metal plate.

It is just a bruise. The bruise will go away over time.

Even, if it's painful, it will go away over time, and, it will be normal.

Q Now, doctor, there was testimony that the plaintiff had left knee arthroscopy, either in 1999 or 2000.

Can you explain to the jury the significance of that prior surgery on any of your findings in this MRI?

A Well, it's not so much -- arthroscopy, is just a word saying that we are looking into a joint. The arthro, is joint, and, the scope is looking.

But, the thing is, when they go and they look in a joint, they don't just look, they also start to move things around, take things and fix things.

And, my guess, is that they took a big chunk of her meniscus, at least, one of the meniscus, possibly, both of them.

And, she has all this degenerative change. Presumably, something happened before which prompted them to do an arthroscopy procedure with surgery in 1998 are '99, whichever you are saying.

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Q Now, can you see on here evidence of surgery being done as far as the meniscus being taken out or altered in some way?

A Well, as I say, it's not just that there was a meniscus here, which is torn, we would see it as torn, it's gone, which means that somebody has to have taken it.

It doesn't just disappear on its own.

Q So, if she fell on her left knee on February 12 of 2013, the meniscus would match, right?

A It wasn't there. It's gone.

Q All right.

So, someone, or, something, a surgical procedure, removed it is what you are saying?

A Correct.

Q Okay.

Now, as far as any -- so, we have the recent impact, and, we have the prior 1999 injury and surgery.

Can you talk about anything degenerative that you see specifically, in the left knee?

A Well, again, all -- we don't see normal disk, normal meniscus anywhere. We see all of this bone overgrowth.

You can see it -- again, you don't have the benefit of having seen a normal knee, but -- - this is, again, the knee from the side, so, there is the femur bone coming down the tibia coming up, and this is the kneecap.

The kneecap is supposed to be a nice round structure, and, it's not. It's got this piece of bone poking up top and poking down.

It's just another indication that there's chronic degenerative, wear and tear, on the knee. And, it's usually symptomatic.

Usually, it's painful.

Q Other than the bruise, do you see anything acute or --

A No.

If there were a significant certainly acute injury, I would expect to see fluid in the joint.

And, there's absolutely no fluid in the joint.

So, even before I look at everything else, when I look at a knee MRI scan, the first thing I look for is fluid. If I don't see any fluid, then I know whatever it is I am going to fined, it is not acute, it is going to be chronic.

There's no fluid here, so, there's nothing recent on this scan done 3/8/2013.

Q And, you also had the opportunity to look at the x-ray of the left knee taken at the hospital?

A Correct.

Q And, does that correlate with a finding of about a month later, or, 3 or 4 weeks later?

A Yes, it does.

Q And, what is that?

A It shows no fracture, and, it shows degenerative narrowing of the spaces between the bones and it shows peaking or limiting of an overgrowth of the margins of the bones, which are typical of degenerative change.

Q Now, doctor, we have to start talking about the hip.

THE COURT: I think now would be a good time to take our break.

MR. O'BRIEN: Okay, sounds good, Your Honor.

Thank you.

THE COURT: So, folks, we will break for lunch, and, Mr. Mahan, you are falling down on your light rasing job, so, turn the lights on, please.

(Whereupon, the lights are turned on.)

And, we will resume at 2:15.

Have a good lunch.

Please, don't talk about the case.

We will see you then.

THE COURT OFFICER: Jury exiting.

(Whereupon, the jury, exits the courtroom.)

THE COURT: Doctor, please stand up while the jury exits.

(Whereupon, the witness stands.)

THE COURT: You may step down.

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Thank you.

THE WITNESS: Thank you.

(Whereupon, the witness, is excused and steps down.)

(Whereupon, the luncheon recess was held.)