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1. *EXPERT TRIAL TRANSCRIPT OF ANDREW MEROLA, M.D., 2019 Trial Trans. LEXIS 14*
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EXPERT TRIAL TRANSCRIPT OF ANDREW MEROLA, M.D.; 2019 Trial Trans. LEXIS 14

Supreme Court of New York, Special Term, New York County

INDEX NO. 156347/13

February 4, 2019

Reporter
2019 Trial Trans. LEXIS 14 *

GERMAN PAUCAY, Plaintiff, - against - D.P. GROUP GENERAL CONTRACTORS/DEVELOPERS, INC., and HP MAPLE MESA HOUSING DEVELOPMENT FUND COMPANY, INC., Defendants.

Expert Name: Andrew Merola, M.D.

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Counsel

[*1] WILLIAM SCHWITZER & ASSOCIATES, P.C., Attorneys for Plaintiff, New York, New York, BY: PAUL J. BOTTARI, ESQ.

KENNEDYS CMK, Attorneys for Defendants, New York, New York, BY: MICKEY R. SCHNEIDER, ESQ.

Judges

BEFORE THE HON. FRANCIS A. KAHN, III, Justice of the Supreme Court And a Jury

Proceedings

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[8]111 Centre Street

New York, New York

[9]February 4, 2019

[24]JACK L. MORELLI

Senior Court Reporter

[25]
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[1]AFTERNOON SESSION

[2]MR. BOTTARI: At this time we marked as 22 A and

[3]22 B, medical illustrations which show the lumbar spine

[4]surgery that Dr. Merola performed on May 17 **[*2]** of 2017. The

[5]doctor is here to testify. Per our off the record

[6]conversation, you indicated that you have no problem

[7]marking these for identification.

[8]THE COURT: Well, let's not stick to what I said

[9]off the record, let's just stick with what we have.

[10]MR. SCHNEIDER: I'll make the application. It

[11]was my application to have them precluded.

[12]THE COURT: What we have is two exhibits created

[13]by plaintiff which supposedly show the procedures done on

[14]the plaintiff because the surgeon is here to testify

[15]about. In fact, counsel had an application to preclude

[16]those from being used to aid the testimony and being

[17]introduced into evidence.

[18]MR. SCHNEIDER: On behalf of the defendant, it's

[19]our application that these two illustrations should both

[20]not be permitted in as demonstrative evidence or as

[21]evidence in chief. The reason is, as we acknowledge, the

[22]Court has wide latitude in terms of demonstrative

[23]evidence, A, and it's a judgment call as to whether or not

[24]certain evidence should be shown to the jury to aid in an

[25]expert's testimony.

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[1]However, in this instance what they would be

[2] **[*3]** looking at are blowups showing varying openings inside of

[3]a back. It's a drawing of a back, it's not a drawing of

[4]Mr. Paucay's back. It's a drawing of the lower portion of

[5]a back, not Mr. Paucay's. And the purpose of it would be

[6]to prejudice the jury because they are trying to inflame

[7]the jury by these types of illustrations.

[8]So, it's our argument that these are far more

[9]prejudicial than they are probative because the doctor is

[10]here, he's able to give testimony and explain what he did,

[11]how he performed the surgeries, what the surgeries entail.

[12]So, these are not probative of anything and for that

[13]reason it's our application these should not be coming in

[14]even as demonstrative evidence.

[15]MR. BOTTARI: It's our position there is no

[16]prejudice. This is merely a drawing of what's in the

[17]operative report. It's our contention that the doctor

[18]will testify that these two blowups are fair and accurate

[19]representations of surgical procedures that he did and

[20]will aid the jury in understanding exactly what problems

[21]there were in Mr. Paucay's back, what surgical procedures

[22]were performed. In fact, on 22 B **[*4]** under the moniker G it

[23]shows the discectomy and the annular tear that will be

[24]referred to. This is the exact area where Dr. Merola

[25]performed the discectomy and shows the type of
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[1]instrumentation and certain of the other frames in the

[2]proposed exhibit that I believe, A, will aid the jury and,

[3]B, will help them and, C, make it more understandable than

[4]just looking at an operative report. I think that this

[5]coupled with the doctor's testimony will aid the jury in

[6]understanding what's going on in Mr. Paucay's back.

[7]THE COURT: And in and of themselves would be

[8]the pictures to be inflammatory with models of brain and

[9]spine shown to the jury for identification. I don't think

[10]this is out of any realm of what's normally shown to

[11]juries in personal injuries cases.

[12]In terms of whether or not it could be used to

[13]aid a physician in his testimony, certainly the testimony

[14]that's going to be offered regarding back surgery is

[15]complex and is dense even for physicians. And I don't

[16]know that I can see how something of this type, when

[17]guided by professional medical testimony, could not aid

[18]the jury **[*5]** in understanding what exactly occurred to Mr.

[19]Paucay. I don't know that you necessarily need the actual

[20]photographs to be admissible so long as the proper

[21]foundation is laid to introduce them into evidence.

[22]For the time being, however, I'll allow them to

[23]be used by the physician to aid in his testimony. So it

[24]will remain as marked for I.D. and reserve decision on the

[25]application and have them introduced into evidence, and

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[1]have a ruling for you no later than say Wednesday, okay?

[2]MR. SCHNEIDER: My note my exception. I'm not

[3]going to object when we talk about it on the record, I'm

[4]noting it now, so.

[5]THE COURT: Understood, that his use of them

[6]is -- you've got your ruling and any questions he asks I

[7]assume that those objections will flow from it.

[8]MR. BOTTARI: Should I offer them in evidence

[9]after he authenticates them?

[10]THE COURT: No, you can just use them as an aid

[11]for testimony. You've already marked for I.D. and let me

[12]look and see if I want to put them in evidence and I'll

[13]give you an answer no later than Wednesday morning.

[14]MR. BOTTARI: Yes.

[15]THE COURT: **[*6]** You want to bring the jury in.

[16]COURT OFFICER: All rise.

[17](Jury present)

[18]THE COURT: Good afternoon, ladies and gentlemen

[19]of the jury. We are going to continue with the

[20]plaintiff's direct case.

[21]Counsel, you have a witness you'd like to call?

[22]MR. BOTTARI: Yes, Dr. Andrew Merola.

[23]THE COURT CLERK: Remain standing and raise your

[24]right hand.

[25]
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[1]ANDREW MEROLA, M.D.,

[2]Called as a witness by the Plaintiff, was first duly

[3]sworn or affirmed and testified as follows:

[4]THE COURT CLERK: Please state your name and

[5]business address spelling both first and last name.

[6]THE WITNESS: ANDREW MEROLA. 567

[7]First Street Brooklyn, New York 11215.

[8]THE COURT: You may inquire, counsel.

[9]DIRECT EXAMINATION

[10]BY MR. BOTTARI:

[11]Q Good afternoon.

[12]A Good afternoon.

[13]Q Can you briefly give me your professional and

[14]educational background? And speak loudly because we have to

[15]hear all the way back here.

[16]A Sure. I went to NYU undergraduate. After I

[17]graduated from college I went to Howard University Medical

[18]School. Graduating from medical school **[*7]** I went to the State

[19]University of New York in Brooklyn where I then took up

[20]training in general surgery for one year. Then I did four

[21]years of orthopedic surgery. So I did a five year residency in

[22]orthopedics. Finishing that residency program I went to the

[23]University of Colorado in Denver and I did an additional year

[24]in what's known as spinal reconstructive surgery. Came back

[25]here to New York City in 1996, full-time practice in
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[1]orthopedics spinal surgery.

[2]Q Are you what's known as board certified?

[3]A Yes, I am.

[4]Q Can you briefly tell us, we've heard from other

[5]physicians and medical professionals, can you briefly tell us

[6]what board certification is and what your field of specialty

[7]is?

[8]A So, I'm an orthopedic surgeon. So I'm board

[9]certified in orthopedic surgery. That's surgery that involves

[10]your musculoskeletal, your bones, joints, nerves, all of those

[11]things. Specifically in my subspecialty your neck and your

[12]back.

[13]Board certification is a process where you take a

[14]written examination after your training period is done. So

[15]that you pass your general knowledge **[*8]** in your field of

[16]specialty, and then after you've been in practice for a minimum

[17]of two years, in my case as a surgeon, you then collect all of

[18]your patient information on the patients that you've operated

[19]upon, and you turn all of that information in your notes, MRIs,

[20]operative findings, all these things to an actual Board of

[21]Medical Examiners. That they actually ask you verbal questions

[22]about what you did and why you did it. And when you pass both

[23]parts of that exam, you then become board certified. Then that

[24]process repeats itself every ten years. So I was first

[25]certified in 1998, then again in 2008 and 2018. And then I'm
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[1]do for my next certification 2028. So we maintain our

[2]certifications through examinations and staying current with

[3]what we're doing in our field of practice.

[4]Q Do you know the difference between a plaintiff and a

[5]defendant?

[6]A Yes.

[7]Q You've testified in the past, correct?

[8]A Yes.

[9]Q Have you testified mostly for plaintiffs or for

[10]defendants or tell us?

[11]A My patients which are, in general, folks who are

[12]plaintiffs.

[13]Q Have you **[*9]** ever met me prior to today?

[14]A Yes.

[15]Q Have you ever testified for the William Schwitzer

[16]firm?

[17]A Yes.

[18]Q About how many times over how many years?

[19]A I've been in practice since 1996, so I've been doing

[20]this for 23 years I guess or so. I generally end up in court

[21]about five or six times a year. And I have testified for Mr.

[22]Schwitzer's firm for -- I don't know the exact number but

[23]that's generally the extent of my medical legal work.

[24]Q Do you expect to be compensated for your time away

[25]from your practice today?
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[1]A Yes.

[2]Q And what is the rate?

[3]A $ 650 per hour for time away my office, the office and

[4]hospital.

[5]Q If you weren't here where would you be?

[6]A So, I make rounds in the morning, I have office

[7]hours. And then I finish off the office hours the rest of the

[8]day on Monday. So I would actually be, I would still be in the

[9]office right now doing hours.

[10]Q And we spoke Saturday I think?

[11]A Correct.

[12]Q It was a couple of times I tried to reach you by

[13]phone and it wasn't convenient because you were operating?

[14] **[*10]** A Yes.

[15]Q You reviewed records before coming here today?

[16]A Yes.

[17]Q We spoke right before this afternoon, correct?

[18]A Yes.

[19]Q Okay. Now, did that come a time when a patient by

[20]the name of German Paucay-Sumba was referred to you?

[21]A Yes.

[22]Q Can you briefly tell me when you first saw him what

[23]did he complain of, did you take a history, what did he do?

[24]A Sure. So when you first meet a patient you meet them

[25]and I speak with them so that you can get an idea for what's
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[1]going on with them. And usually we call that the chief

[2]complaint or the presenting complaint, along with a history.

[3]Q By the way, doctor, let me stop you. We've been

[4]calling him Mr. Paucay, does he speak essentially Spanish?

[5]A Yes, I do, I'm fluent in Spanish.

[6]Q Continue.

[7]A So, you have a conversation with the patient so that

[8]you can try to understand what the problem is. And how it

[9]relates to what I as a spinal surgeon might be able to help him

[10]with.

[11]So he was referred in July of 2016 when I first saw

[12]him. He had given me a history of an accident which occurred

[13] **[*11]** on June 19th of 2013. And presented with or came in with

[14]symptoms that is pain in both of his neck area and his back

[15]area. The neck pain was described as a five out of ten on a

[16]zero to ten scale constant. The low back pain was worse, it

[17]was seven out of ten on a zero to ten scale.

[18]Both the neck and the back got worse with activities.

[19]So activities that we call mechanical activities. In other

[20]words, activities that require bending or lifting or twisting

[21]activities that put pressure on the neck and back increased

[22]those symptoms, increased the pain level.

[23]There are also symptoms of radiating or traveling

[24]pain into the extremities, arms and hands, legs and feet. So

[25]basically he presented with pain in his neck and his back. The
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[1]back was most severe. And the aggravating factors were

[2]activities. And they were associated with radiating symptoms

[3]or traveling symptoms going down into the legs and feet and

[4]also the arms and the hands.

[5]Q Clinically what is the significance of radiating pain

[6]going down into the legs or arms and legs in general?

[7]A In general it has to do with the nerves that **[*12]** are

[8]involved that travel into your arms and hands and your legs and

[9]feet. Because your nerves are responsible for sensation. The

[10]way your muscles work, the way your reflexes work and those

[11]nerves connect to your brain. Radiating symptoms are generally

[12]symptoms that concern us because they involve the nerves in the

[13]arms and hands or legs and feet.

[14]Q Did you take what's called a surgical history from

[15]him?

[16]A Yes.

[17]Q What, if anything, did he tell you? What's the

[18]significance of that?

[19]A Sure. So he had had a surgery to his right knee.

[20]And he was also being treated by pain management. So he had

[21]some pain management procedures and he had a right knee

[22]surgery.

[23]Q Did you do a physical exam on him as part of your

[24]general practice?

[25]A Yes, I did.

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[1]Q What did you do, what type of exams did you do? What

[2]did you find out and what was the significance of any of your

[3]findings?

[4]A So because his symptoms involved pain in the spinal

[5]area I wanted to assess the pain. So I did some range of

[6]motion in the back, for example. And in his back he had spasm,

[7] **[*13]** which is an abnormal contraction of the muscles when you're

[8]palpating or feeling the muscles particularly when the back is

[9]placed into a position that is either uncomfortable or painful.

[10]Q Is spasm something that you can fake?

[11]A No, a spasm is like a charlie horse. It's an

[12]involuntary strong contraction of a muscle that you can feel as

[13]the muscle turns pretty much like rock hard. So it's an

[14]abnormal contraction of muscle tissue. And this was palpable
[15]in the lower back with an extension or a backward bend of five
[16]degrees. When you are upright you are at zero degree. So
[17]beyond zero up to 5 degrees of extension or back bending
[18]reproduced spasm in the lower back that was associated with
[19]traveling symptoms down into the legs.
[20]That's a maneuver or an examination test called a
[21]Phalen's maneuver. It's significant because it is a test that
[22]actually increases pressure on nerves. And if those nerves are
[23]irritated, the test is positive when you palpate spasm and it
[24]reproduces the patient's symptoms. So in this case for the
[25]lower back it was a positive test at five degrees of extension.
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[1]Additionally **[*14]** to that there was another test done
[2]called a straight leg raise test. A straight leg test is a
[3]test where you can look at the nerve a little more closely by
[4]actually pulling on the nerve that travels down your leg.
[5]There is a large nerve that travels down the front of your leg
[6]it's called the femoral nerve. And the large nerve traveling
[7]down the back, the nerve that goes down the back of the leg is
[8]called the sciatic. That runs below your knee and past your
[9]ankle and your foot. So if you extend or straighten out the
[10]knee joint and the foot and ankle joint and pull on that nerve,
[11]if that nerve is irritated and swollen the body will recoiling
[12]from you pulling on that nerve. So a positive straight leg
[13]raise test is a test that tells you whether or not the sciatic
[14]nerve specifically is inflamed or irritated. And in this case
[15]the straight leg raise was positive on the right side at
[16]40 degrees. And the left side also had a positive test.
[17]Q Doctor, just so I can get an idea. What is the

[18]normal range that a human can do in general if there is no pain

[19]on nor damage to a sciatic nerve?

[20]A If you're sitting **[*15]** down upright in a seated position

[21]you should be able to fully extend your knee and fully extend

[22]your foot and ankle so that that nerve is totally passing down

[23]your leg and foot and ankle without producing pain or spasm.

[24]Q Would that be about 90?

[25]A Correct, 90 degrees.

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[1]Q So at about 40 degrees this gentleman had some

[2]symptoms, some pain?

[3]A Yes.

[4]Q That's not normal?

[5]A Correct.

[6]Q That's symptomatic of a problem?

[7]A That is indicative of a problem, it points to a

[8]problem with the sciatic nerve, yes.

[9]Q Please continue.

[10]A The other test was to look for the reflexes that the

[11]sciatic nerve works. It specifically works the reflex on the

[12]back of your ankle. There is a big tendon that goes down past

[13]your ankle joint into your feet, it's called the Achilles

[14]tendon. And if you tap on the Achilles tendon the ankle should

[15]extend and that's the normal reflex for the ankle's tendon.

[16]And in this case it was absent. That's the reflex that is

[17]specifically involved with the sciatic nerve. So this also

[18]pointed to a sciatic nerve problem.

[19]Q Did **[*16]** you view any MRIs or images studies prior to --

[20]well, once you saw him did you actually see some of the old

[21]films that he had taken?

[22]A Yes.

[23]Q What, if anything, did you see and what, if anything,

[24]was the significance of what you saw?

[25]A So what I saw on the MRI film was what I described as
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[1]a central herniation of disc. The discs are cartilage cushions

[2]that sit in between the bones of the spinal column. And the

[3]discs should be contained within the borders of the bones. The

[4]reason for that is the spinal canal contains the nerves. So if

[5]there is anything in the area where the canal is or where the

[6]nerves are, it can cause irritation to those nerves by either

[7]leaking chemicals down to the nerves that come out of the disc

[8]or by putting pressure on the nerves.

[9]So, in a patient that has a herniation or an abnormal

[10]protrusion or sticking out of disc material into the canal with

[11]these positive findings, the diagnosis here is what we call a

[12]radiculopathy, a problem with the nerve root. And as a

[13]consequence, a low back disc herniation.

[14]Q I want you to assume that there was a MRI **[*17]** done within

[15]a month after the accident of June 19, 2013 and it essentially

[16]showed muscle spasm. Do you have an opinion with a reasonable

[17]degree of medical certainty what, if anything, or how that

[18]correlates to this gentleman's injuries from the six foot fall

[19]from a scaffold?

[20]A Sure. The disc being made out of cartilage has two

[21]specific parts, there is an outer ring of cartilage that holds

[22]an inner jelly-like cartilage in place. How that outer ring

[23]are interwoven fibers of cartilage and collagen. For a

[24]herniation to an occur there is a tear that happens within

[25]those fibers. And so gradually over the course of time, as
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[1]you're up and about and walking and putting pressure on the
[2]disc, the disc material slows leaks out. The amount of time
[3]that it takes for the material to leak depends on the size of
[4]the tear. Two things can happen, one, the tear can heal. And
[5]sometimes can happens just with time and physical therapy and
[6]medications, which is why we often do that when we have
[7]patients who have disc injuries or back injuries, because your
[8]body can heal a tear just like it can heal a cut or scrape. **[*18]** If
[9]the tear does not heal and gets larger and material starts to
[10]leak out patients become more symptomatic, which means they
[11]have more pain. And then they start to experience irritation
[12]in the nerves.
[13]So it's important to look at MRIs over time in
[14]patients that remain symptomatic because we want to see if the
[15]disc is herniating or not. We want to see if the annular tear
[16]is healing or not.
[17]Q I want you to assume there is an MRI of approximately
[18]December 2013 that shows a bulging disc at L-5, S-1. What is
[19]the clinical significance to you as a surgeon of a bulging disc
[20]five or six months later after the original disc showed just
[21]muscle strain and muscle spasm?
[22]A So that a bulging disc, when you see a bulge it means
[23]that the disc is sticking out asymmetrically, it's coming out
[24]of the border of the vertebral column. A herniation is
[25]asymmetrical, it's more in one place than another. But now
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[1]that you're going from essentially normal MRI with muscle spasm
[2]to a MRI showing where the disc is now starting to stick out,
[3]it correlates with or it adds up to a annular tear that's not
[4]healing **[*19]** with a disc that is progressively getting worse. So it

[5]gives you an idea that the lower back disc is continuing to

[6]progressively get worse.

[7]Q What if the patient complained of symptoms to a

[8]medical facility like eight days later where he said that he

[9]had low back pain, pain radiating down his leg, what would the

[10]significance of anything like that be?

[11]A Those would be symptoms that are consistent with this

[12]sciatic problem for the radiculopathy located in the lower

[13]portion of the back. That as time goes on, as you're up and

[14]walking and doing your normal activities, increasing pressure

[15]on the disc with increasing jelly that leaks out causing

[16]increasing nerve root irritation.

[17]Q I want to show you what's been marked as a

[18]plaintiff's exhibit and just if you would note the date. This

[19]is from Dr. Pappas' physical evaluation. And the date is

[20]6/27/13. Under subjective finding it says -- can you read that

[21]for me?

[22]A It says eight forward slash or eight out of ten low

[23]back pain.

[24]Q And does it indicate -- and what does it say with

[25]regard to the pain, whether it's sharp, intermittent, **[*20]**
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[1]consistent?

[2]A It says two things with respect to the pain. Number

[3]one, it says that it is a constant pain with radiating.

[4]Q And what does L/S mean?

[5]A Lumbosacral, which is the area of L-5, S-1.

[6]Q I want you to assume that Mr. Paucay went -- what's

[7]conservative treatments? Can you define what's conservative

[8]treatments?

[9]A Conservative treatment is nonsurgical. So that would

[10]involve restricting your activities. So if you were working,

[11]restricting work and avoiding activities that reproduce pain,

[12]bending, lifting, twisting, that's number one. Number two,

[13]medications, that is conservative treatment. Taking

[14]medications by mouth or having medications injected into the

[15]area where the problem is, that's conservative. And therapy is

[16]also conservative. So nonsurgical management would consist of

[17]what we call conservative treatment.

[18]Q Now, after your initial visit with Mr. Paucay did you

[19]come to some sort of a plan, an impression?

[20]A Yes.

[21]Q What was that?

[22]A So the impression or the diagnosis was sciatic

[23]radiculopathy with a herniation visible on the **[*21]** MRI. And at

[24]that time what I wanted to look at was some EMGs or nerve

[25]testing.

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[1]Q Did you actually see certain EMGs that were done?

[2]A I did.

[3]Q What did they show you, what's your impression of

[4]that?

[5]MR. SCHNEIDER: Can we have a date?

[6]THE COURT: What documents did you review?

[7]A They were EMGs, two sets of EMGs. Most recent set of

[8]EMGs I saw to that physical exam were done in 2015.

[9]Q Do you know if it was Dr. Krishna who did them?

[10]A Yes.

[11]Q So that's what you saw?

[12]A Yes. Like I said, there were two sets of EMGs, an

[13]earlier set and a subsequent set in 2015.

[14]Q What did they show?

[15]A So, the EMG is an electrical study of nerves and it

[16]shows that there was what we call electrical instability within

[17]the nerves of the sciatic nerve, which correlated or added up

[18]to this sciatic radiculopathy.

[19]Q Now, you noted that Mr. Paucay was undergoing pain

[20]management, correct?

[21]A Yes.

[22]Q Did you make any recommendations at that point in

[23]time?

[24]A So let's see. So, in my next visit with him, which

[25]was in December **[*22]** of 2016, he was still doing conservative
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[1]treatment. He was doing pain management. And at that time I

[2]had indicated that I would continue his conservative treatment

[3]and then see him back in the office to see what progress, if

[4]any, he made.

[5]Q Did he have, whatever his complaints, were they about

[6]the same?

[7]A They were essentially about the same pain in the

[8]spinal column, in the back, with radiating symptoms into the

[9]legs and feet.

[10]Q So, did you prescribe any meds or was he already on

[11]medication?

[12]A He was already on medicines.

[13]Q So, did you see him after that second visit?

[14]A I did.

[15]Q And when was that?

[16]A I saw him in January of 2017.

[17]Q What type of an exam, if any, did you do in January

[18]of 2017?

[19]A So, I did the same exam to examine the nerves to see

[20]if there was any progress or did he remain the same or were

[21]there any changes in his overall condition. And on that day

[22]the testing, once again, showed a positive what we call

[23]Phalen's maneuvers, which is extension reproducing his

[24]symptoms, a positive straight leg raise in the legs, **[*23]** and a loss

[25]of L-5 and S-1 nerve root sensation which remained pretty much
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[1]consistent with his previous exams. So, he had what we would

[2]consider, after having seen him on multiple times, a persistent

[3]radiculopathy with nerve findings.

[4]Q Did you make any comments on how he had walked?

[5]A His gait pattern or exactly how he walked showed that

[6]he did have -- he had a limp, it's an antalgic gait, which

[7]means you spend more time on one than the other. All of this

[8]are problems with his knees and a kyphotic pattern, which means

[9]that walking completely upright reproduced pain. So patients

[10]will walk pushed forward a little in order to, once again, over

[11]all the canal area where the nerves are, to decrease pressure

[12]and pain in the sciatic nerve.

[13]Q Did you do straight leg testing? I'm just trying to

[14]speed it up a little.

[15]A He had a positive straight leg raise on that day as

[16]well, also at 40 degrees.

[17]Q So clinically he's about the same in terms of where

[18]the problems are, lower back?

[19]A Yes, correct.

[20]Q On a clinical basis if you saw him without looking at

[21]anything **[*24]** else, what would your opinion be?

[22]A That he had a significant sciatic radiculopathy.

[23]Q At what levels?

[24]A L-5, S-1.

[25]Q Did you see him in April of 2017?
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[1]A Yes.

[2]Q Did you start talking to him about surgery at that

[3]time or actually before that?

[4]A Actually before that in December, because he had

[5]persistent symptoms with nerve deficits L-5, S-1, positive

[6]MRIs, positive EMGs. My recommendation at that time in

[7]December was for surgery. And we were finally able to discuss

[8]that further in April.

[9]Q So his gait was still antalgic or --

[10]A Correct, yes.

[11]Q And his spinal extension was limited?

[12]A Yes.

[13]Q Had pain when you went back a little too far?

[14]A Correct.

[15]Q Did he still have what was called radiculopathy?

[16]A Yes.

[17]Q And just so we're clear, it was going down his leg?

[18]A Yes.

[19]Q So at some point in time, doctor, did the patient

[20]consent to surgery and did you do surgery on him?

[21]A I did, yes.

[22]Q What type of surgery did you do, in English and then

[23]we'll use some blowups to try to aid **[*25]** the jury in understanding

[24]what you did.

[25]A Surgery is generally what we call decompression. The
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[1]nerve is inside of a spinal canal and in the case of a

[2]herniation there is an increase in pressure inside the canal on

[3]the nerve. So the procedure is a decompression, a release of

[4]pressure on the nerve. And that's done by opening the canal

[5]and then actually removing the piece of disc material that is

[6]causing the pressure. Technically it's also known as a

[7]laminectomy, which means an opening of the canal and a partial

[8]discectomy. In other words, a removal of that portion of disc

[9]material that is causing the pressure to the nerve.

[10]Q Now, you actually went into Mr. Paucay's back,

[11]correct?

[12]A Yes.

[13]Q There has been some comments that some of the MRIs

[14]early on did not show bulges or herniations, correct?

[15]A Yes.

[16]Q What did you find when you went inside of Mr.

[17]Paucay's back in May of 2017?

[18]A Sure. So the operative findings, in other words,

[19]what we're actually able to see, was a torn annulus, which is

[20]the area through which the herniation had occurred, which is

[21] **[*26]** exactly where I was able to remove the herniated disc material.

[22]Q Did you actually remove herniated disc material?

[23]A Yes.

[24]Q What is the result to someone's back if you take out

[25]an area of herniated disc, does it relieve pain or pressure?
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[1]A So, removing of the disc material takes the pressure

[2]off the nerve and prevents the nerve to continue suffering any

[3]further damage. Removal of the disc material can decrease that

[4]nerve radiating symptoms by getting the pressure off the nerve.

[5]And number two, it can prevent further damage to the nerves.

[6]So if the nerves are not working normally for using

[7]your reflexes and some loss of sensation, we can prevent the

[8]legs from becoming weak and we can preserve the ability to

[9]walk; that's the reason to do the surgery.

[10]Q You actually saw and document, you had documented in

[11]the operative report taking out the herniated disc material?

[12]A Yes.

[13]Q You send that to the lab for review or whatever?

[14]A Yes.

[15]Q Did you notice any areas of granulation or anything

[16]like that when you were in his back?

[17]A So, when you have **[*27]** a herniation that is removed you

[18]can see that that herniation -- granulation essentially means

[19]inflammation or inflammatory changes which are consistent with

[20]the area where the herniation is. And those are generally

[21]visible as areas of irritation in and around where the

[22]herniation is.

[23]Q So you actually saw that there also?

[24]A Yes.

[25]Q What is the clinical significance of that?

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[1]A It goes along with an inflammatory nerve condition

[2]secondary to a disc herniation with an annular tear.

[3]MR. BOTTARI: With Your Honor's permission I

[4]would like the doctor to come down and if we have an easel

[5]we can put them up.

[6]THE COURT: I don't know if we have an easel.

[7]MR. BOTTARI: I can hold them.

[8]JUROR # 1: There is an easel in the jury room.

[9]THE COURT: There is?

[10](Pause)

[11]Q Doctor, I'd like you to try to explain the operation

[12]you did to Mr. Paucay with the aid of these illustrations.

[13]First let me ask you this, you've seen these illustrations

[14]before today, correct?

[15]A Yes.

[16]Q Are they a fair and accurate representation of the

[17]surgical **[*28]** procedure that you performed on Mr. Paucay?

[18]A Yes.

[19]Q Do you think that it would help you in telling the

[20]jury what you did by referring to them?

[21]A Yes.

[22]Q Okay, could you please use these two blowups 22 A and

[23]B and go through the surgery that you performed on Mr. Paucay

[24]on May 17, 2017?

[25]A Yes.

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[1]Q By the way, where was the surgery done?

[2]A New York Presbyterian, Lower Manhattan Hospital.

[3]Q Go ahead, doctor.

[4]A So the top portion of this illustration is a diagram

[5]showing the lower back. The squares are the bones. And in

[6]between the bones are the individual discs. And the nerves are

[7]to the left of where the bones and the discs are. The top two

[8]A and B are side views of the lower back to get an idea of how

[9]the spine lines up in a side view. C is a back to front view

[10]illustration of the lower back. And it illustrates the

[11]incision or the opening in the skin that is necessary to be

made over the lower back in the area where the two bones, L-5
and S-1 are located.
So the first portion of the actual surgery itself,
after the patient has had a **[*29]** general anesthesia, is to make an
incision in the lower back and to move the muscles away so that
the bones themselves can be exposed. And the lower
illustration D shows the muscles being retracted and the
exposure of the L-5, what is known as the lamina or covering of
the spinal canal or the S-1 lamina of the covering of the
spinal canal between L-5 and S-1. Once the area, local area
has been located, and the way we do it is take an X-ray during
the surgery and we compare that X-ray with the MRI film so we
know our exact location. Once we're satisfied that we're at
the exact location we need to be at, we can then proceed to
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remove portions of the lamina. And we do that by basically
drilling away the bone and we make it thinner and thinner and
thinner until we see the opening of the spinal canal. Once we
can see the opening of the spinal canal we can then directly
look at the nerves. And then move the nerve away from the area
where the herniation is.
So we mobilize or move the nerves away from the area
of the disc so we can then visualize the disc itself. And in
looking at the disc we can **[*30]** see that there is an area that is
sticking out abnormally into the nerves of the L-5 and S-1
nerve roots which make up the sciatic nerve. And we can see
that there is a tear in the area of the outer covering of the
disc.
Q Is that the annular that you're talking about?
A Yes. Now, once the disc itself is identified and we

[16]have safely moved the nerves out of the way, we can then remove

[17]the disc material that has herniated onto the nerve itself. So

[18]we can directly visualize and then remove that material with a

[19]special device that is designed to pick it away from the nerve

[20]safely. Once that's been done we then both look at the nerves

[21]and feel the area where the nerves are to make sure that there

[22]is no remaining pressure on the nerves and no remaining disc

[23]material on the nerves.

[24]So this is the entire procedure of taking the

[25]pressure off the nerves and removing the fragment of disc
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[1]material that was compressing the nerves.

[2]Q Thank you, doctor. You can resume your seat.

[3](Witness resumes stand)

[4]Q Now, doctor, did you then do what's called a post-op

[5]visit with Mr. Paucay? **[*31]**

[6]A Yes, I did.

[7]Q And when was that?

[8]A So that was after the surgery was done and the date

[9]of that was June 12 of 2017.

[10]Q By the way, I'm going to show you part of the New

[11]York Presbyterian Hospital records which are in evidence. Is

[12]there what's called a postoperative MRI performed?

[13]A We did a postoperative MRI as well, yes.

[14]Q Can you tell us what it showed, when it was done and

[15]what it showed with regard to Mr. Paucay?

[16]A Sure. So the postoperative MRI tells --

[17]MR. SCHNEIDER: What's the date? I'm sorry.

[18]THE WITNESS: The date of this MRI was May 18,

[19]of 2017.

[20]Q That's the day after the surgery?

[21]A Correct, this is the first operative day. It shows

[22]the laminectomy between L-5, S-1, it shows the normal amount of

[23]fluid that you could expect is in that area where the disc was

[24]removed. Because once you remove the disc that area of the

[25]space that's left behind fills up with fluid. Your body will
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[1]generate fluid through your own normal healing abilities in

[2]order to heal over that area with some scar tissue. So if you

[3]scratch your skin and **[*32]** there is an opening in your skin, you'll

[4]notice that the skin bleeds and gets weepy. Those are the

[5]fluids that your body secretes to heal that area with the scar.

[6]It's the same thing when you have to remove that

[7]disc, it fills up with fluid in the area where the disc was

[8]removed in order to go through the normal healing processes,

[9]and that's basically what the MRI shows.

[10]MR. BOTTARI: For the record I wanted to have a

[11]copy of the operative report marked separately so we can

[12]refer to it. A letter, what's it? 13 A.

[13](Plaintiff's Exhibit 13 A received in evidence)

[14]Q Is it your practice to have a, what's called a

[15]post-op visit for someone who has laminectomy?

[16]A Yes.

[17]Q How long after the surgery do you see them?

[18]A I usually see the patient a week or two after the

[19]surgery.

[20]Q By the way, is the patient given additional pain

[21]killers while they are in the hospital or get out of the

[22]hospital because of that type of a surgery?

[23]A Yes.

[24]Q That's standard?

[25]A Yes.
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[1]Q When was your post-op visit? What did you test for,

[2]what did it show **[*33]** and what was the clinical significance, if

[3]any?

[4]A June 12, 2017, saw the patient back in the office to

[5]make sure that he was healing from actual surgery itself.

[6]Postoperatively he had some what we call urinary retention,

[7]which is some difficulty with his ability to urinate, which can

[8]generally come from one of two things, usually comes from the

[9]medications the anesthetic and the pain medications result in

[10]difficulties with your urinary process.

[11]Muscles that contract and relax because urination can

[12]sometimes be a problem after. And he had some urinary

[13]retention which was getting better. And I did an examination

[14]on him to make sure that the incision, the area that was

[15]operated upon was healing properly and that his nerves were in

[16]proper order. And indeed, the incision was healing and he was

[17]what we call neurologically stable, that is no progressive

[18]neurological problems were appreciated.

[19]Q Did you make any comments with regard to his gait?

[20]A Yes, he was able to walk with both legs, what I call

[21]bilateral heal to toe, which means that the nerves in the legs

[22]were working properly. **[*34]**

[23]Q Was this an improvement over his antalgic gait?

[24]A Yes.

[25]Q So, some of his surgery worked?
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[1]A Yes.

[2]Q Did you give an opinion as to if he could start

[3]physical therapy?

[4]A Yes, I said that he could start therapy as long as he

[5]felt comfortable to do so. Sometimes the therapy can be a

[6]little painful after surgery. So I generally let patients know

[7]they can start physical therapy as long as they can tolerate

[8]getting to therapy and it's not too painful for them.

[9]Q When did you see him again?

[10]A I next saw him in August of 2017.

[11]Q Did you ask him if he had any complaints?

[12]A He had no new complaints. So basically just some of

[13]what we call mechanical symptoms, the pain in the neck and back

[14]areas. Nothing new appreciated at that time.

[15]Q Did you make any comments with regard to his care,

[16]physical therapy, medications, things like that?

[17]A I said that he should continue all of his other

[18]treatments as needed and necessary.

[19]Q Did you see him after that point in time, for

[20]example, in January of 2018?

[21]A Yes, I did.

[22] **[*35]** Q What, if anything, were his complaints, what is

[23]clinically significant, please tell us?

[24]A Stiffness in his neck and back areas. The back was

[25]stiff which was consistent with his preoperative findings as
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[1]well. And on his physical exam he did have to -- he reverted

[2]back to that antalgic and kyphotic gait. And I tested his

[3]overall range of motion at that time and found that it was

[4]about 40 percent of normal, normal for his entire spine.

[5]Q Did you continue his physical therapy prescription?

[6]A I did, I thought he should continue his therapy, yes.

[7]Q Did you see him again after that?

[8]A Yes.

[9]Q When was that, sometime in April?

[10]A April 2nd, 2018.

[11]Q Did he explain about stiffness?

[12]A Yes, he did have persistent stiffness. And one of

[13]the things we specifically spoke about, bending forward,

[14]putting on shoes and socks, to do that maneuver did cause an

[15]increase in stiffness and pain.

[16]Q When was the last time you seen him or the next time?

[17]A I saw him in November of 2018.

[18]Q What, if anything, were his complaints about at that

[19]time?

[20] **[*36]** A Essentially the same complaints, which are what we

[21]call mechanical axial pain, pain in the neck and back

[22]aggravated with activities consistent with prior disc

[23]herniations, that is typical with patients with a disc problem.

[24]He had no new complaints. Continued to have difficulty, for

[25]example, with his ability to bend over and, once again, for
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[1]example, the most common thing he might do, bending over,

[2]putting on shoes and socks and indeed, that is something that

[3]reproduced pain.

[4]Q Is that the last time that you saw him, doctor?

[5]A Last -- yes, that is.

[6]Q Do you have an opinion with a reasonable degree of

[7]medical certainty if the accident of June 19, 2013 was a

[8]substantial factor in causing the herniations and the back

[9]problems that you saw, clinically diagnosed on various MRIs and

[10]various other scans, including EMGs, which ultimately resulted

[11]in you doing a surgical procedure on him?

[12]A Yes, I do.

[13]Q And what is that opinion?

[14]A My opinion is that the accident of June 19 of 2013

[15]caused the L-5, S-1 herniation with radiculopathy requiring the

[16]surgery.

[17]Q What's **[*37]** the basis of that, just so we have it for the

[18]record?

[19]A Well, my treatment of the patient which includes my

[20]operative and surgical findings. And, of course, an extensive

[21]review of his records and treatment since the time of the

[22]accident.

[23]Q Do you have an opinion with a reasonable degree of

[24]medical certainty of what Mr. Paucay needs in the future?

[25]A Sure.

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[1]Q With regard to your specific profession, that being

[2]orthopedic surgery?

[3]A Yes.

[4]Q And what is --

[5]MR. SCHNEIDER: Objection.

[6]THE COURT: Overruled.

[7]A So, patients who are young and younger patients can

[8]often times, not always, but often times have more of a problem

[9]than older patients can. Post-traumatic disc herniation is

[10]with persistent back symptoms, axial symptoms, pain in the

[11]back. The discs that are herniated or damaged have a tendency

[12]to wear down and that wearing down process can cause and often

[13]times causes as you get older a problem with the joints of the

[14]lower back that eventually end up requiring a process called

[15]fusion, also known as arthrodesis, which basically means having

[16] **[*38]** to stabilize the lower back at some point in the future.

[17]Q Do you have an opinion with a reasonable degree of

[18]medical certainty as to whether Mr. Paucay would need a lumbar

[19]fusion or an arthrodesis at some point in the future?

[20]MR. SCHNEIDER: Objection.

[21]THE COURT: Overruled.

[22]A Generally you see post-traumatic disc space clasp and

[23]arthropathy or joint problems occur somewhere in the

[24]neighborhood of about seven to ten years of when you last

[25]operated on them. And that's the best educated guess that we
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[1]can have for someone. Sometimes it's a little more, sometimes

[2]it's a little bit less. A lot of it depends on wear and tear

[3]and treatment as time goes on.

[4]Q What is the approximate cost of the surgery in

[5]today's dollars?

[6]A So those surgeries, taking into consideration the

[7]hospitals and the inpatient stay and implants that are involved

[8]in doing this kind of procedure all total, you're looking in

[9]the neighborhood of $ 125,000.

[10]Q And if this procedure is performed ten years down the

[11]road could it cost more than that?

[12]MR. SCHNEIDER: Objection.

[13]THE COURT: **[*39]** Sustained.

[14]THE COURT: You want to approach?

[15]MR. BOTTARI: Sure.

[16](Discussion held off the record at the bench)

[17]Q Doctor, ten years ago did medical procedures cost

[18]less than today?

[19]A Yes.

[20]Q Do you anticipate that in ten years medical

[21]procedures will cost more than today?

[22]MR. SCHNEIDER: Objection.

[23]THE COURT: Why don't we talk about this

[24]particular procedure.

[25]Q This particular type of procedure, have hospital
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[1]costs gone up over the last ten years?

[2]A Yes.

[3]THE COURT: What did this surgery cost ten years

[4]ago?

[5]THE WITNESS: In the neighborhood of between 75

[6]to a hundred thousand.

[7]Q So, would it be a fair statement, doctor, that with a

[8]reasonable degree of medical certainty that this procedure will

[9]cost more in the future ten years down the road?

[10]MR. SCHNEIDER: Objection.

[11]THE COURT: Overruled.

[12]A Given that history of cost, yes.

[13]Q You have no specific number but except it will cost

[14]more, correct?

[15]A Yes.

[16]MR. SCHNEIDER: Objection.

[17]THE COURT: Overruled.

[18]Q Now, are **[*40]** there other types of things that in your

[19]opinion Mr. Paucay will need from an orthopedic point of view

[20]or neurological?

[21]A Yes.

[22]Q And what is that?

[23]A So, in order to generally monitoring patients over

[24]time, we follow them up with X-rays and MRIs every year to two

[25]depending upon how many more symptoms they are having. So, new

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[1]symptoms over a shorter period of time, more diagnostics. So,

[2]from an orthopedic perspective we look at MRIs and X-rays every

[3]one to two years.

[4]Q And how much are they about?

[5]A X-rays are about 125 for a lumbar series. MRIs are

[6]generally a thousand.

[7]Q Do you recommend physical therapy for this patient?

[8]A Yes, sure.

[9]Q How often?

[10]A Well, what we consider maintenance therapy which is

[11]done on a weekly basis.

[12]Q One time a week?

[13]A Sure.

[14]Q What is the cost of that, approximately?

[15]A Depending on how long the treatment session is, but

[16]they are generally between 75 and a hundred per session.

[17]Q You also recommended lumbar epidural steroidal

[18]injections?

[19]A Yes.

[20]Q How often?

[21] **[*41]** A Quarterly or sooner depending upon symptoms.

[22]Q And what's the cost of those?

[23]A Generally several thousand for an injection.

[24]Q That's just for the injection?

[25]A Yes.

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[1]Q That doesn't include the hospital or anything else?

[2]A Right.

[3]Q Given what you've seen in terms of Mr. Paucay's

[4]records, the surgery that you've done on his back, the fact

[5]that he's undergone physical therapy and your post-op visits,

[6]do you have an opinion with a reasonable degree of medical

[7]certainty if the injuries to Mr. Paucay are permanent?

[8]A Yes.

[9]Q And the treatment that you've indicated that he

[10]needs, is that for a few years, lifetime or what?

[11]A Lifetime treatment.

[12]Q That's with a reasonable degree of medical certainty?

[13]A Yes.

[14]MR. SCHNEIDER: Objection.

[15]THE COURT: Overruled.

[16]MR. BOTTARI: I have nothing further.

[17]THE COURT: Counsel.

[18]CROSS-EXAMINATION

[19]BY MR. SCHNEIDER:

[20]Q Good afternoon, doctor.

[21]A Good afternoon.

[22]Q Just as a general question, can you have a bulging

[23]disc in your back and have it give no symptoms? **[*42]**

[24]A Yes.

[25]Q And same question with a herniation, could you have a
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[1]herniated disc in your back and not have any symptoms?

[2]A Yes.

[3]Q And symptoms are something that you learn from

[4]patients, correct?

[5]A Yes.

[6]Q When you see the patient you examine them and you

[7]talk to them and you get an understanding of what it is that

[8]they're complaints are, right?

[9]A Yes.

[10]Q Symptoms such as pain is a subjective symptom,

[11]correct, that's something that the patient tells you?

[12]A Yes.

[13]Q I want to just ask you briefly, doctor, about

[14]motivation. You see patients in your practice who aren't

[15]plaintiffs in personal injury litigation, correct?

[16]A Yes.

[17]Q You see patients in your practice who just come to

[18]you for treatment, right?

[19]A Yes.

[20]Q Would it be a fair statement to say that there might

[21]be different motivations for different patients in different

[22]settings?

[23]A Yes.

[24]Q In terms of the motivations for someone who is a

[25]plaintiff in a personal injury setting, when you get these
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[1]subjective complaints and these subjective **[*43]** symptoms, would it

[2]be fair to say that something you want to do is test

[3]objectively whether you believe they're valid?

[4]A Yes.

[5]Q One of the things -- so when you first examined Mr.

[6]Paucay back in June of 2016 and then again in January of 2017,

[7]one of the things I think that you mentioned that you really

[8]wanted to see was whether there was EMG studies, right?

[9]A Yes.

[10]Q And EMG studies, is that with needles get put on

[11]certain areas of a person's body?

[12]A Yes.

[13]Q The point of that is to test to see whether there is

[14]actually any radiating pain going to certain areas where there

[15]is a radiculopathy?

[16]A Electrical instability, yes, or nerve root death

[17]causing electrical instability.

[18]Q That test, an EMG test is a way to test for

[19]radiculopathy, correct?

[20]A Yes.

[21]MR. SCHNEIDER: If we can have the Pappas I'm

[22]going to have the EMG marked.

[23](Plaintiff's Exhibit 6 A received in evidence)

[24]Q I'm going to ask you to take a look at what I've just

[25]provided you that's marked as Exhibit 6 A.

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[1]A Yes.

[2]Q Do you recognize what that **[*44]** is?

[3]A Yes.

[4]Q And what is it?

[5]A This is an EMG of the lower extremities done by Dr.

[6]Pappas.

[7]Q And the lower extremities, so if someone has a L-5,

[8]S-1 problem, the lower extremities would be what you would be

[9]testing, correct?

[10]A Yes.

[11]Q You wouldn't test the arms because that would be if

[12]you had a neck problem, correct?

[13]A Yes.

[14]Q And you had reviewed Dr. Pappas' records when you saw

[15]Mr. Paucay, correct?

[16]A Yes.

[17]Q Dr. Pappas when he did the EMG, would it be a fair

[18]statement that he did not find any evidence of radiculopathy,

[19]correct?

[20]A Yes.

[21]Q That's correct?

[22]A Yes.

[23]Q Thank you. And what's the date of that EMG?

[24]A This is August 27, 2013.

[25]Q Which is about two and a half years, almost three
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[1]years before you first saw him, correct?

[2]A Yes.

[3]Q You saw him, Mr. Paucay.

[4]I'm also going to ask you if you can take a look at a

[5]MRI.

[6]MR. SCHNEIDER: These have already been marked

[7]in evidence as Lenox Hill Hospital records and Doshi.

[8]They are marked as Plaintiff's **[*45]** Exhibit 2 B, is that right?

[9]MR. BOTTARI: No objection.

[10]Q Doctor, I'm going to show you a document that's been

[11]marked as Plaintiff's 2 B and it looks to be a MRI of the

[12]lumbar spine down at Doshi Diagnostic?

[13]A Yes.

[14]Q It looks like it's issued to Dr. Pappas who had been

[15]treating Mr. Paucay initially?

[16]A Yes.

[17]Q And you see it's done by a radiologist, correct?

[18]A Yes.

[19]Q Who is the radiologist?

[20]A Michael Green.

[21]Q According to radiologist Michael Green that MRI did

[22]not show any evidence of either a bulge or a herniated disc at

[23]any level in Mr. Paucay's back, correct?

[24]A Yes, correct.

[25]Q That was about three years before you saw Mr. Paucay,
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[1]correct?

[2]A Yes.

[3]Q You said that before you had done the surgery you had

[4]seen a MRI that showed a central disc herniation?

[5]A Yes.

[6]Q What MRI is that?

[7]A That was the MRI that was done after the Doshi MRI.

[8]Q Was it also done in 2013?

[9]A I believe so, yes.

[10]Q Was it the one that was done in December of 2013?

[11]A Yes.

[12]MR. SCHNEIDER: **[*46]** Can I have that marked as 2 C.

[13]THE COURT: Have you seen, it counsel?

[14]MR. BOTTARI: No objection.

[15]Q Doctor, I'm going to ask you to take a look at a

[16]document it's from I think Lenox Hill Radiology.

[17]A Yes.

[18]Q And that's an MRI also of the lumbar spine that was

[19]done December 10, 2013?

[20]A Yes.

[21]Q And who's the radiologist, who did that one?

[22]A This is Dr. Himelfarb [phonetic].

[23]Q That MRI, is that the one that you said showed the

[24]central disc herniation?

[25]A Yes.

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[1]Q Now, does Dr. Himelfarb say that there is a central

[2]disc herniation?

[3]A No.

[4]Q Would it be fair to say that Dr. Himelfarb actually

[5]reads this as, reads the MRI as showing that there is, the

[6]lumbar vertebral bodies are normal in size and shape without

[7]evidence of fracture or suspicious intrinsic lesion. There is

[8]no evidence of a spondylolisthesis, there is no significant

[9]loss of height in the lumbar disc. There is a posterior disc

[10]bulge at L-5, S-1?

[11]A Yes.

[12]Q Were there any other MRIs that you looked at before

[13]you performed the surgery?

[14] **[*47]** A No.

[15]Q And the surgery was that 2017, correct?

[16]A Yes.

[17]Q When you performed the surgery in 2017 that you

[18]described to the jury, you found a herniated disc, correct?

[19]A Yes.

[20]Q When you examined Mr. Paucay initially you had

[21]mentioned that his reflexes were absent, do you remember saying

[22]that?

[23]A The Achilles reflexes, yes.

[24]Q And the Achilles reflexes absent would be the

[25]opposite of -- doctors use the word "two" with a plus sign,

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[1]that would be a positive reflex?

[2]A Yes.

[3]Q Did you review the records of Dr. Ari Lerner?

[4]A Yes.

[5]Q And Dr. Ari Lerner was here earlier today, did you

[6]know that?

[7]A No.

[8]Q I'm going to show you a record from Dr. Ari Lerner

[9]that is from June of 2016, around the time when you said that

[10]the reflexes were absent. I'm going to ask if you could just

[11]take a look Dr. Lerner's record on page three at the end of his

[12]neurological examination.

[13]A Yes.

[14]Q So, do you see at the end of his neurological

[15]examination he does the same testing of the reflex?

[16]A Yes.

[17]Q Would it be fair **[*48]** to say that he found the exact

[18]opposite of what you said you found also in June of 2016,

[19]correct?

[20]A Well, I actually saw him in July of 2016, but in Dr.

[21]Lerner's note of 2016 in June he said two plus.

[22]Q So, a month earlier he was saying that the reflexes

[23]were normal and a month later you were saying that they were

[24]absent, correct?

[25]A Yes.

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[1]Q You had mentioned that Mr. Paucay had an antalgic

[2]gait?

[3]A Yes.

[4]Q You said that's when someone doesn't use one side of

[5]their body, it's a limp in layman's terms, when somebody limps?

[6]A Yes.

[7]Q When you had seen Mr. Paucay it was approximately

[8]three years, right, after the accident?

[9]A Yes.

[10]Q And did you take any measurements for atrophy of his

[11]legs?

[12]A No.

[13]Q At any of your visits did you ever measure his legs

[14]to see if he had atrophy?

[15]A I didn't appreciate any gross palpatory abnormalities

[16]so I did not measure for atrophy, no.

[17]Q When you saw Mr. Paucay in August of 2017, in June of

[18]2017 in your postoperative visits, I'm just going to direct you

[19]to those two reports **[*49]** from June 12 of 2017. I may have said

[20]'16, sorry. June 12 of 2017 and August 14th of 2017, do you

[21]have those reports?

[22]A Yes.

[23]Q When you saw him at each of those days one of the

[24]things that you say in your physical examination, if you look

[25]at the second line, you say mentation and affect are
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[1]appropriate?

[2]A Yes.

[3]Q And you say that on both occasions, correct?

[4]A Yes.

[5]Q And also in advance of the surgery that you performed

[6]that you showed the diagrams earlier to the surgery, you had

[7]issued a report where you said that you explained both the

[8]risks of the procedure, the benefits of it, you went through

[9]the whole thing with Mr. Paucay himself, correct?

[10]A Yes.

[11]Q And you saw no reason why Mr. Paucay didn't

[12]understand what you were saying to him, correct?

[13]A Yes.

[14]Q You believed that he gave you his understanding that

[15]he was able to understand what the risks and benefits were,

[16]correct?

[17]A Yes.

[18]Q And you mentioned that he's going to need X-rays.

[19]How many X-rays do you say that he's going to need for the rest

[20]of his life? **[*50]**

[21]A We generally do them about every one or two years

[22]depending how they are from surgery or what their symptoms are.

[23]Q Has he had any X-rays yet?

[24]A We haven't done any post-ops yet, we haven't done a

[25]fusion yet and we're not at that seven to ten year timeframe,
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[1]so we haven't done any post-ops.

[2]Q So the X-rays you were talking about wouldn't even

[3]start until seven to ten years out?

[4]A Correct.

[5]Q Those X-rays that you were talking about, are you

[6]saying that with a degree of medical certainty that he's going

[7]to require an X-ray or two every two years for the rest of his

[8]life for sure?

[9]A Yes.

[10]Q Without a doubt?

[11]A Yes.

[12]Q No matter what happens?

[13]A Well --

[14]Q What if he feels better?

[15]A I wouldn't anticipate that he would feel better.

[16]Based on the facts that I have available now I would say every

[17]two years.

[18]Q The MRIs you talked about, you said that he would

[19]need a MRI once every two years?

[20]A Yes.

[21]Q Has he had that?

[22]A He had the post-op MRI which we did at surgery, so

[23]that was '17; this **[*51]** is 2019. So within the next year or so he

[24]would need a post-op MRI as well.

[25]Q The epidurals that you talked about that he had, you
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[1]said quarterly, correct?

[2]A Yes.

[3]Q So that would be four a year. And you're talking

[4]about his lumbar spine?

[5]A Yes.

[6]Q So four a year for the rest of his life?

[7]A Yes.

[8]Q And how many epidurals has he had yet?

[9]A I don't know. I don't know because Dr. Lerner is

[10]doing the pain management.

[11]Q So if Dr. Lerner testified, this morning testified

[12]that he had one, would you dispute that or disagree with that?

[13]A No, I will not.

[14]MR. BOTTARI: Objection.

[15]THE COURT: Overruled.

[16]Q So, he's had one and it's your testimony that for the

[17]rest of his life, and earlier we were using 45 more years as

[18]where we were going with that, four per year would be

[19]approximately 180 epidurals that he's going to need for sure

[20]for the rest of his life, but he's one so far?

[21]A Yes.

[22]MR. SCHNEIDER: I have nothing else.

[23]THE COURT: Redirect.

[24]REDIRECT EXAMINATION

[25]BY MR. BOTTARI:

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[1]Q Doctor, **[*52]** are MRIs a hundred percent foolproof?

[2]A No.

[3]Q Is there literature that you're aware of that gives a

[4]range of how good they are?

[5]A Well, there are what we call probabilities. The

[6]test, every test has a sensitivity and a specificity.

[7]Sensitivity is the ability of the test to pick up the condition

[8]that you're looking for if it's that sensitive. Specificity is

[9]how specific it is to picking up, for example, a herniation.

[10]The best tests are somewhere in the plus 90 percent range

[11]because no test is a hundred hundred for each of sensitivity or

[12]specificity because all tests have some shortcomings.

[13]Q So you're aware of literature that says that there is

[14]false positives and false negatives for MRIs?

[15]A Correct. That's why none of them are a hundred

[16]percent sensitive or specific.

[17]Q When you went into his back you saw a herniated disc?

[18]A Yes.

[19]Q And you took it out?

[20]A Right.

[21]Q And you saw a ruptured annulus?

[22]A Yes.

[23]Q You saw granulated tissue, correct?

[24]A Yes.

[25]Q Now, with regard to this test on Mr. Paucay's ankle,
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[1]if **[*53]** it was the knee is that like the cartoon thing, you hit with

[2]a hammer?

[3]A You use a hammer or there is several things you could

[4]use as long as the device is hard enough to be able to hit the

[5]tendon without causing pain.

[6]Q Do you know how much medication Mr. Paucay was on

[7]when he underwent that test?

[8]A No.

[9]Q Can medication sometimes mask a reflex or a pain?

[10]A Sure.

[11]Q Do you know if he was on an Oxycodone type of pill or

[12]Fioricet?

[13]A I know that he does take medicines but I don't

[14]specifically on any given day.

[15]Q That can affect the way someone reacts to a test like

[16]that?

[17]A Sure.

[18]Q And when you were asked about whether, in fact, you

[19]explained the risk of surgery to Mr. Paucay, correct?

[20]A Yes.

[21]Q Did he ever tell you that he wanted the pain to go

[22]away?

[23]MR. SCHNEIDER: Objection.

[24]THE COURT: Sustained.

[25]Q Well, without the surgery he would have been in the
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[1]position he was when you first saw him in the middle of 2016,

[2]correct?

[3]MR. SCHNEIDER: Objection.

[4]THE COURT: Overruled.

[5] **[*54]** A Yes.

[6]Q Would it be a fair statement that he's had some

[7]benefits from the surgery?

[8]A Yes.

[9]Q Would it be a fair statement that he's never going to

[10]be pain free from the surgery?

[11]MR. SCHNEIDER: Objection. Also beyond my

[12]cross.

[13]THE COURT: I will allow that one last question.

[14]You can answer that, doctor.

[15]A Yes.

[16]MR. BOTTARI: I have nothing further.

[17]THE COURT: Doctor, you're excused. Thank you.

[18](Witness excused)

[19]THE COURT: Anything else?

[20]MR. BOTTARI: Can we approach?

[21]THE COURT: You want to come up?

[22]MR. BOTTARI: Yes.

[23](Discussion held off the record at the bench)

[24]THE COURT: Ladies and gentlemen of the jury,

[25]we're finished for today. And because I have other
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[1]matters that I tend to on certain days, Tuesdays, so we're

[2]not going to be working tomorrow. We will be working a

[3]full day Wednesday. So usual admonishments, don't talk

[4]about the case among yourselves or with anyone else.

[5]Don't think about the case. Don't do any research. We'll

[6]see you back here on Wednesday at 9:30, please. Thank

[7]you. **[*55]**

[8]COURT OFFICER: All rise.

[9](Jury exits)

[10](Court stands in recess until Wednesday,

[11]February 6, 2019 at 9:30 a.m)

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