2019 WL 13095793 (N.Y.Sup.) (Expert Trial Transcript)
Supreme Court of New York.
New York County

Michael SAGINOR, PlaintiffK,
v.
OSIB-BCRE 50TH STREET HOLDINGS LLC, and Flintlock Construction Services, LLC, Defendants.

No. 152479/2013.
May 14, 2019.

Testimony of Plaintiff's Expert Witness, Chaim Mandelbaum - Direct Examination

Name of Expert: Chaim Y. **Mandelbaum**, M.D.
Area of Expertise: Medical & Surgical >> Pain (Chronic) Management
Area of Expertise: Medical & Surgical >> Anesthesiology
Representing: Plaintiff
Jurisdiction: New York County, New York

For the Plaintiff: Lipsig, Shapey, Manus & Moverman, P.C., Fulton Street, New York, New York 10038, By: Marc E. Freund, Esq., Matthew J. Peluso, Esq.

For the Defendants: Marshall Dennehey Warner Coleman & Goggin, Pine Street - 21st Floor, New York, New York 10005, By: Thomas G. Vaughan, Esq.

Before: Honorable John J. Kelley.

THE COURT: Mr. Freund, your next witness, please.

MR. FREUND: Thank you, your Honor.

Good afternoon.

THE JURORS: Good afternoon.

MR. FREUND: Your Honor, right before I call the next witness I would like to take a minute to review these two items that were just marked into evidence. It'll take one minute.

THE COURT: Okay.

MR. FREUND: Sure. Marked into evidence as Plaintiff's Exhibit 20 is the New York District Counsel of Carpenters Benefit Fund unit records for Michael Saginor. The record indicates that Michael Saginor is a member since June 22nd of 1987. The record indicates that in the year 2011 Michael worked a total of 1,013 hours. He earned $51,156, and his employer contributed to the pension on his behalf $12,986 and contributed to the annuity $9,076.

And in 2012, Michael worked 1,259 hours. His wages and earnings were 63,600. The pension contribution from his employer 116,145, and the annuity contribution from his employer $11,284.

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In addition, marked in as Plaintiff's Exhibit 21 is the collective bargaining agreement with the union that describes the contributions to the annuity and pension and the wage rates.

Thank you.

At this time, your Honor, the plaintiff calls to the stand Dr. Chaim Mandelbaum.

(Whereupon, the witness took the witness stand.)

COURT OFFICER: Witness entering. Remain standing, face the clerk.

THE CLERK: Please raise your right hand.

CHAIM MANDELBAUM, M.D., a witness called on behalf of the Plaintiff, after having been first duly sworn by the Clerk of the Court, took the witness stand and testified as follows:

THE CLERK: Please, in a loud, clear voice, state your name and address for the record.

THE WITNESS: It's Chaim, C-H-A-I-M, Mandelbaum, M-A-N-D-E-L-B-A-U-M. My office address is 75 Maiden Lane, Suite 1206, New York, New York 10038.

THE CLERK: You may be seated.

THE WITNESS: Thank you.

THE COURT: Doctor, I want you to keep your voice up so all the jurors can hear you. Please wait for the attorney to finish asking his question before you start to answer.

If you see one of the attorneys get up or start to object, I want you to make sure you do not answer. Give me the opportunity to please rule on the objection.

If you are called upon to answer a question that can be done with a yes or no, please limit your response to yes or no. If you can't answer with a yes or no, then let the attorney know that, and he'll rephrase the question or ask you for a further explanation. Please don't offer an explanation until you're asked.

If you don't understand a question or need to have something repeated or whatever, that's fine, just let the attorney know.

And also, advise me if you need a break for any reason. Bear in mind that during any breaks you may not speak with any of the attorneys concerning your testimony. Also, you may not interact with any of the jurors under any circumstances. Okay?

THE WITNESS: Yes.

DIRECT EXAMINATION

BY MR. FREUND:

Q Good afternoon, Dr. Mandelbaum.

A Good afternoon.

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Q How are you today?

A Good.

Q What kind of doctor are you?

A I'm an anesthesiologist, Board certified, as well as Board certified in pain management.

Q What does it mean to be Board certified in anesthesia and pain management?

A Okay. So Board certification means that I've met the requirements and qualifications that the Board deemed appropriate to actually practice anesthesia and pain management. That includes taking examinations. I mean, through my training, doing anesthesia for three years, followed by a Fellowship for a year, and that's all followed by an examination period where you take a written examination as well as an oral examination both in pain management and anesthesiology.

Q Where did you go to medical school, Dr. Mandelbaum?

A So I attended the State University of Health Sciences Center in Brooklyn, otherwise known as Downstate. I graduated in 1992. That was followed by an internship in internal medicine in Staten Island University Hospital, which was followed by a residency in anesthesiology for three years at Mount Sinai Hospital here in New York City. That was followed by a Fellowship for a year in pain management medicine at Mount Sinai Hospital in New York City.

Q Dr. Mandelbaum, have you also been involved in the course of your career in the teaching of pain management or anesthesia?

A Yes. So we do -- and I'm affiliated with a couple of two hospitals in New York City. One is New York Methodist Hospital in Brooklyn. The other one is Mt. Sinai Medical Center at Beth Israel. And there is a teaching component to the residents who all rotate through as far as watching procedures and dealing with patients, as well as we've had other medical students actually recently rotate from different parts of the country in our practice.

Q In the course of your training in anesthesia, when you were a resident, Fellow, the first few years out, were you involved in all sorts of pain -- anesthesia-related procedures?

A Yes.

Q Like labor and delivery?

A Correct. I mean, that's part of anesthesia as far as pain management, but definitely labor and delivery, which the procedures involved with that are really epidural injections and spinal injections.

Q And all sorts of surgeries that are performed in the hospital?

A Correct.

Q How many times have you testified -- strike that.

How many years have you been practicing as a Board-certified anesthesiologist and pain-management specialist?

A For over 20 years now.

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Q Over the course of the 20 years, how many times have you testified in court?

A Approximately 13 times.

Q Why so seldom?

A Well, there's a lot of time and effort in testifying. If these -- and I only testify on behalf of my patients. So when these issues come up and something unfortunately goes to trial, I will take the time and come to court. But, usually, I don't personally like coming to court, but at times it just unfortunately does happen.

Q Okay. You're trained and you went to medical school and residency, and how many years did it take you to train to become a doctor in pain management medicine, Doctor?

A If you include the four years of medical school, the internship, the three years of anesthesia, plus the Fellowship, it's over eight years, and then I did practice for a little while in New Jersey, and then was with Dr. Thomas for approximately 20 years doing pain management here in the City.

Q And describe your current practice.

A So our current practice, it's a private practice pain management office. We do some anesthesia in the office as well, but our focus is dealing with chronic pain issues. We have two offices; one in Manhattan close to here, and one in Brooklyn near New York Methodist Hospital in Park Slope.

We see a wide variety of pain. We do see everything from nerve-related issues to chronic back pain, to headaches, chronic headaches. Just to describe the practice, these are -- when patients are referred, and all our patients are referred to us from other doctors, they usually have tried other conventional modalities and the doctor feels frustrated and they end up sending to them to pain management, one, so that we handle these ongoing patient issues even though they've tried other modalities, and we specialize in those type of patients both on the medication front as well as interventional, which is really the focus of our practice is doing interventional procedures.

Q Is there a specific area of pain management that you and the late Dr. Thomas focused on?

A Yes. Well, unfortunately, Dr. Thomas, who had also seen Mr. Saginor, he recently expired. He had a long illness with cancer and expired a couple of months ago already. So the -- I'm sorry. I lost my train of thought for a minute.

Do you want to repeat the question?

Q Sure, sure. It's understandable.

Is there a specific focus, like a sub-focus that your practice focuses on?

A Yes. I mean, we deal a lot with nerve-related issues, including RSD, otherwise more commonly known or that's a more common phrase, but complex regional pain syndrome is the current nomenclature for that particular disorder, and there's type 1 and type 2, but it's more commonly known as RSD, or reflex sympathetic dystrophy. We do get specific referrals just for that diagnosis and helping with treatment because these are things beyond the scope of most physicians actually dealing with or treating or know how to treat. So we do specialize in that.

Q And is it known that you have a reputation as experts sort of in that field?

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A Yes. So we do have that reputation, and when other physicians have issues or even if they suspect a diagnosis they kind of rapidly send them to our office so that we can aggressively treat it.

Q What is RSD?

A So RSD, which stands for reflex sympathetic dystrophy, and the current nomenclature is complex regional pain syndrome, but reflex sympathetic dystrophy describes it probably a little bit more is a phenomenon when there is a severe injury, typically to an extremity, where, for whatever reason, the nerves go a little haywire and it results in chronic pain, typically burning pain. It affects the vasculature. It affects the musculature. It causes muscle weakness, atrophy, and that hypersensitivity even to light touch.

And again, they describe it typically as burning pain and it's something that's chronic. It's something that doesn't go away. It needs to be aggressively treated, with different modalities. Unfortunately, there's no specific great treatment that just subsides everything. But it still needs -- it's an ongoing process and treatment that needs to be, again, treated early on, as early as possible if you even suspect the diagnosis, and unfortunately throughout somebody's life.

Q In addition to the things you mentioned, does RSD have any effect on the skin or sensation in terms of cold or hot, things of that nature?

A Yes. So there are -- there's general phases of RSD when somebody has an injury. So typically, initially, there's an inflammatory reaction. There may be swelling, edema in the extremity, which is probably the most common area, for instance, an upper extremity is probably the most common area. But as things progress and the skin becomes very hypersensitive even to light touch, the term that is -- the medical term that is used is allodynia, which really means that even to something that's non-noxious, even a light touch, it is very painful. So it becomes very, very hypersensitive to the point where it's actually very painful, and patients describe, especially later on in the disease, a lot of burning sensations.

Because there's effects on the vasculature, there are actually noted to be skin color changes, atrophy of the muscle from disuse. They don't -- patients tend to not use that hand or extremity, and that just leads to ongoing atrophy of the musculature and the vasculature.

Q I know you can go on and on, Dr. Mandelbaum, but try to keep it a little bit shorter.

Looking at Plaintiff's Exhibit 11, with your Honor's permission you can come off the stand and use this diagram to explain a little bit more about how RSD works.

A So this is the proposed mechanism of --

MR. VAUGHAN: Objection.

THE COURT: Have you seen this before?

MR. FREUND: Yes. It was marked and used during Dr. Winiarsky's testimony.

MR. VAUGHAN: It was marked, Judge.

THE COURT: Approach, please.

(Whereupon, an off-the-record conference was held between all counsel and the Court at the side-bar.)

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THE COURT: Sustained.

MR. FREUND: It's already in, Judge.

THE COURT: Oh, overruled. I thought it was just demonstrative.

MR. FREUND: It's actually for ID.

THE COURT: Sustained.

MR. FREUND: Demonstrative. Sorry.

Q Dr. Mandelbaum, would this demonstrative drawing of the mechanism of RSD be helpful in aiding and assisting you in explaining to the jury what RSD is and how it applies to Michael Saginor?

A Yes.

Q And would you be able to describe using this board what parts are applicable to Michael Saginor in more specific terms; would that be fair?

A Yes.

THE COURT: Okay. I'll allow its use.

MR. FREUND: Thank you.

Q You can go ahead, Dr. Mandelbaum.

A I have not seen this before, but this demonstrates the effects of RSD. No one fully understands the mechanism, but it's multifaceted. There's a lot of things going on when there's an injury.

So what's depicted here is let's say there is an injury to the arm, such as a small fracture, any crush injury, any fracture injury, and it causes an inflammatory reaction. It causes issues with the nerves. In particular, there are specialized nerves that are called sympathetic nerves, and that's what really gets affected through RSD. That's why it's called reflex sympathetic dystrophy.

The typical conduction of the nerve is from the hand going to the arm. It goes to the spinal cord and then travels up to the brain. So with RSD for some reason this area of that initial injury becomes so hypersensitive the nerve just ends up firing multiple times over and over and over again, and there is nothing to stop it. It doesn't -- what normally would happen is the process heals, but for whatever reason there's a mis-wiring of nerves, in particular the sympathetic nerves, and it keeps on firing and firing and causes changes that go through the arm, through the spinal cord, into the brain.

So not only are there changes peripherally, there are changes within the spinal cord, and there are changes within the brain. For instance, if you were to say, okay, the pain is in the hand, the arm, let's just cut off the hand, the arm, they're still going to have pain. The pain ends up over time becoming more centrally focused and oriented.

That's one reason why treatment is not just, okay, let's just treat the pain locally here and you can inject something locally. You have to treat it more centrally within the spinal cord or within the brain itself. And you want to catch those nerves over there. And what happens is the nerves keep on firing and firing and firing. There is changes within the sympathetic nerves. Those

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are your fight-and-flight nerves where the vasculature constricts because the sympathetic nerves are firing, so the blood vessels become tight. There is less blood flow to the extremity. That's typically where it's cold to touch.

Also, the sympathetic nerves are part of the pain pathway, and when they're hyperactive it causes a lot of burning pain and sensations, and that's why patients actually have vasculature changes as far as the musculature, the vasculature, skin color changes and the hypersensitivity which is characteristic of complex regional pain syndrome.

Q Let me stop you there for a second, Dr. Mandelbaum.

If you can stay standing for a second. Just remind the jurors in terms of Michael Saginor what are the injuries he suffered originally, the injuries he suffered in this incident when he fell.

A Well, he had an injury to his hand after he suffered that fall onto the wrist area. He had two fractures that caused a lot of pain and did affect the nerves.

Q The fracture that he actually suffered to the fifth metacarpal and the hamate, can you show where that is on the diagram.

A Again, it's all in the wrist area, so in this area over here (indicating). So the fifth metacarpal and as well as the hamate area.

Q The hamate would be that bone that's sticking out on that area?

A Yes.

Q And the ulnar and median nerve innervating it go through that area?

A Yes.

Q In talking about the sympathetic nerves, can you just explain how the ulnar nerve and median nerve how that relates to the sympathetic nerves.

A The sympathetic nerves actually are right next to the ulnar nerve. So those are separate nerves but they do travel along the same area as the ulnar and median nerves so they also get affected by it. Of course, nerves, the sympathetic nerves, the parasympathetic nerves, they're all interconnected, and they do -- there is, I guess, a talking or speaking between the nerves. So when one nerve is affected, it's going to affect some of the other nerves, especially the sympathetic nerves.

Q What is the history of RSD? How did we come to learn about RSD?

A RSD, it was first described in the 1800s where during the Civil War there were soldiers who actually were shot and they had injuries to an extremity, and these soldiers even if their arm was amputated but they would have ongoing changes that did not get better. They had atrophy or misuse -- disuse of the extremity or hand with a lot of burning sensations and burning pain. The term that was used in the first description was causalgia, which is complex regional pain syndrome type 2, which really refers to the same syndrome but it's a nerve injury and that's why they called it causalgia. So it's been described as really as early as the mid 1800s.

Q And can RSD spread?

A Yes. So RSD, especially if it's untreated, can actually spread. Typical spread is from an area of injury; for instance, in the hand it usually can typically spread proximal, or upwards to the arm and affect as far as going even over to the other arm. Sometimes you can have an injury on one arm and then have RSD symptoms and sometimes it may affect the other arm, and it can affect

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other extremities as well. So a lot -- there's a lot of theory as to why that happens. Again, it has to do with circuitry within the spinal cord and the brain, which is rather complicated.

So no one fully understands why if you have an injury on one hand all of a sudden they develop RSD symptoms in the other hand, and so, but it is somewhat complicated, and presentation can be slightly different besides the typical in one hand, one arm and spreads proximally and goes up.

Q You can resume your seat. Thank you, Dr. Mandelbaum.

I assume research continues on RSD, correct?

A Yes.

Q How did you come to treat Michael Saginor for this incident in February of 2013?

A So Mr. Saginor was involved, again, in a work-related accident on February 26th, 2013. He was seen -- he went to the emergency room and was seen by an orthopedic surgeon, Dr. Winiarsky, and Dr. Horowitz I believe, and he was sent over to our office with discussion with the surgeons because he was having ongoing persistent pain despite the surgery, and they were concerned about RSD, or complex regional pain syndrome.

Q And was he under the care of any other physicians at that time besides Dr. Horowitz and Dr. Winiarsky?

A I believe he also had seen a neurologist, Dr. Friedman, I believe, and he had somewhere in that interim seen another pain management physician, Dr. --

Q It's okay.

A -- Wauchwager.

Q Rauchwerger.

A Okay.

Q And so he came into your office. Did you perform an examination on him?

A Yes.

Q What was the result of the examination?

A So he was having -- he actually had just undergone surgery and was having persistent pain. So on physical examination his hand was splinted, I believe. I'm just referring to my notes. He was immobilized in a cast. He had diminished blood flow to the area, though he was able to move all the digits. He had some swelling of his hand and was very hypersensitive to touch.

Q Okay. And let me ask you, had you treated, either Dr. Thomas or yourself, treated Mr. Saginor in the past?

A Yes.

Q What was that relative to?

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A He was treated by us in the past and that was for a motor vehicle accident in 2009 which resulted in him having a neck surgery, as well as shoulder surgery, and he was treated as far as ongoing pain. He was treated fairly well and he did return to work and was working again for at least three years at the time of this accident, and then again he came back to our office because of concern about the ongoing pain.

Q Did any of your prior treatment relate whatsoever to the RSD or the fractures or any of the conditions in the right wrist, right arm they were talking about?

A No.

Q Now, and how often did you continue to see Mr. Saginor?

A We continued to see him. Again, the first time we saw him was March 12th, 2013, and we had continued to see him at least on a monthly basis, if not even every two, three weeks. Again, our treatments, and I guess we'll go through it, but he constantly came back to our office wanting injections and because of ongoing pain and discomfort.

Q And over time did you describe the symptoms and conditions that you noticed with respect to his wrist based on your observations, your examinations, your testing?

A Over time, over years he continued to have ongoing pain, the hypersensitivity, the allodynia, which is that painful sensation even to light touch, the burning sensations, as well as progression of atrophy, skin color changes, which we noted again over time. The extremity was much colder to touch or temperature versus the other, the left upper extremity, and that had continued and remained; and if not, the reality is it's gotten worse over time and may continue and will likely continue and continue to get worse.

Q And he was in court the other day showing us, you know, bluish-purplish discoloration. Is that something you noticed?

A Yes. So there is definitely discoloration. There's some lack of blood flow to the extremity. Those things come and go. The injections that I will describe but they do help with some of the blood flow, so they do help with some of those skin color changes. A lot of it is self-limiting. They don't last forever, unfortunately, but they do help and they do help maintain at least some of the blood flow and, you know, hopefully minimize atrophy and ongoing skin color changes, nailbed changes that are persistent.

Q How do you know that one arm is colder than the other arm?

A Well, a lot -- first of all, you do it by feel, but we do have a temperature gauge that can feel external temperature on the skin. So there is a way to actually at least measure that there is a differential between the right and left upper extremity besides just actually touching it.

Q How confident are you in the diagnosis of RSD as it relates to Michael Saginor?

A Hundred percent confident. I mean, I have seen countless number of patients. Though it's not common, we do have a bunch of patients with complex regional pain syndrome that present with ongoing pain and discomfort and skin color changes that can't be explained by any other means, and that's really the way to make that diagnosis. There's no specific diagnostic test. Though there are tests that may be helpful in making the diagnosis, but there is no test. It's a clinical diagnosis. It's made by history, physical examination, treatments, which we'll discuss, including the sympathetic blocks to kind of lead us or make it a hundred percent that he has RSD and needs to continue with ongoing treatment.

Q And in addition to yourself, are there other physicians that you conferred with with respect to the RSD and what their opinion was regarding it?

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A Yes. So we did have -- again, he was referred to our office by the orthopedist. Again, they were very concerned, and we've seen this countless numbers of times when patients have surgeries, and especially surgery on the wrist, for whatever reason, once you're so close to nerves and it's most common over there, but once they're concerned about the possibility of complex regional pain syndrome they refer to our office.

He had continuation of pain. We had continued discussions with Dr. Winiarsky, Dr. Horowitz, Dr. Friedman, the neurologist, and everybody concurred that this is a complex regional pain syndrome, or RSD, and he should continue and have aggressive treatment, because without treatment, unfortunately, these things really get out of hand and they can get out of hand quickly.

Q Okay. And in addition, were EMGs, nerve conduction, MRIs and X-rays performed?

A Yes.

Q And how did those tests relate in terms of RSD?

A Well, they're consistent with RSD. Again, like I stated before, there's no specific test that diagnoses RSD. Sometimes you're just looking for other causes of it. So the EMG nerve conduction study, he did have nerve injury to the ulnar nerve and median nerve. He did have the fracture on the MRI. But there was no other modality. There's no other reason for him to have ongoing pain. So that's part of how we make that diagnosis of complex regional pain syndrome.

Q Was there any complicating factors in terms of treating the RSD as it relates specifically to Michael?

A Yes.

Q Okay. Can you describe those to the jury.

A So Michael is a bit of a character. So but he -- I mean, he had issues with pain medications, especially with opioid medication. And we had known him before and had issues with that, which puts this overlying, I guess, about how to treat and how to go about treating him. He had an injury. He had ongoing pain. Do you give him pain medication? And he had issues with pain medication, especially opioid medication.

Unfortunately, there's no -- you know, there's no other great alternative, and he's tried multiple alternative types of medications. There are medications geared towards nerve pain; for instance, Lyrica, Gabapentin injections.

And so the confusing part, he did respond somewhat to some opioid medication, but that is something that's ongoing and it's not our goal to keep him on opioid medication, especially nowadays with the potential for addiction, et cetera.

For him it's probably more of a dependency issue, and that's always the underlying fear. And our ultimate goal was really to get him off the opioid medication, which he has, and try other modalities, whatever we can, even experimental stuff. There are a whole bunch of different newer treatments and modalities that we haven't even fully touched with Michael. There are constraints with insurance.

THE COURT: Okay. Doctor, wait for the next question.

Q And slow down a drop so we don't put the court reporters -- they don't get RSD too, God forbid. Dr. Mandelbaum, you described the issues with the opioids and that you were cognizant of that, is that something that you're aware of, Dr. Thomas aware of, Dr. Winiarsky, and Dr. Horowitz, that's something you guys conferred about?

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A Yes. That is definitely on the radar, our full focus and attention is to make sure that we prescribe things appropriately or take him off of things appropriately. The orthopedic surgeons we're also very concerned --

Q Slow down a drop.

A The orthopedic surgeons were also concerned about his usage of the opioid usage. You don't have a choice after surgery but to give a opioid medication and somebody who has been on opioid medication they may need doses that they're certainly not comfortable with, that's part of why he came to our office to help with those issues and to offer other treatments, which we did.

Q And other treatments would be the injections and the compound creams and nonopioid forms of medications, correct?

A Correct. So our treatments, and we'll go through it, consisted of multiple injections. He had over 50 or 60 injections over the course of these years since 2013.

Q I'll stop you right there. I requested from your office that you bring with you certain equipment or tools you use to give the injections, did you bring any of those with you today?

A Yes.

Q Would those be helpful in aiding and assisting the jury in understanding how these injection techniques are performed and what they're intended to accomplish?

A Certainly.

MR. FREUND: Your Honor, would it be okay if he comes off the stand?

THE COURT: Sure. Why don't we take five minutes before we do that?

MR. FREUND: Sure.

COURT OFFICER: All rise, jury exiting.

(Whereupon, the jury exits the courtroom.)

THE COURT: I just want to remind you to please listen to the question and answer that question and then stop talking. We're getting into lengthy explanations and things that are not necessary. Thank you.

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

THE COURT: All right.

COURT OFFICER: All rise, jury entering.

(Whereupon, the jury enters the courtroom.)

THE COURT: Okay.

MR. FREUND: Thank you, your Honor.

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Q Dr. Mandelbaum, continue coming off the stand and I'm going to give you the device. Can you describe the procedure you performed on Michael and how they're performed and the result of the procedures were.

A Okay. One of the main procedures which we did over 40 or 50 times over the course of the years since 2013 is a stellate ganglion block. What's interesting about the stellate ganglion is that there are sympathetic nerves that come out of the spinal cord. They're actually not these nerves, there's another set of nerves on the outside and the nerves that go -- the sympathetic nerves that go to the arm actually travel through the neck, then to the brain, but they all from the upper extremities and pass through an area called the ganglion. In this case it's the stellate ganglion which is in the vertical spine.

If this is a patient and they're laying on their back, their spine kind of looks like this. You do an x-ray to see where it goes, and then you take a needle, this is a specialized needle and that could be directed, again, through the neck area and directed to the area where the stellate ganglion is. Again, it's used in the x-ray. You want to stay away from the nerve and you want to stay away from the vasculature.

There are side affects and issues if you accidentally inject it into a vasculature or a spinal column, so those are serious issues that we try to avoid. And then once you get to the top of the bone here, you can actually inject medication. Typically it's a long acting mobile anesthetic medication that responds to a radiofrequency which is a particular needle. It's a mobile anesthetic, it's a local anesthetic that's injected to those stellate ganglions that's blocking all the sympathetic nerves that are going into the arm.

With the radiofrequency, it's a similar procedure where you take a specialized needle, an insulated needle that gets hooked up to the machine, once you get to the stellate ganglions you actually heat up the tip of this needle to 80 degrees celsius which is extremely hot and you're burning that ganglion, that sympathetic nerves which hopefully provides more longstanding relief than mobile anesthetic injections.

Even the radiofrequency procedure is something that needs to be repeated so it offers more longstanding relief, it's not full relief, it doesn't last. You're technically destroying the nerve but it still doesn't last, it's still better than the local anesthetic.

Q Let me stop you there. With respect to Michael, when you do these procedures and he comes back and signs consent for the procedure and all the possible complications, you do this procedure monitoring it, right, like with a fluoro?

A Yes.

Q It's not just an x-ray, it's showing you realtime as you're putting it in?

A Correct. You could direct the needle exactly where you want it to go to, you also feel the space, you're also looking for potential issues and side affects, for instance, in the blood vessel or in the spinal cord itself which can be a serious issue.

Q These are performed either in a surgical suite or in a hospital or some other place where it's --

A Where it's a little bit safer and more, I guess, directed as a safety factor, these particular injections.

Q What would be the result of these procedures?

A What it does, once you block the sympathetic nerves, these are the chain of nerves that goes into the right upper extremity, all the sympathetic nerves come from the arm, they travel to this area, the ganglion, then they go up to the brain. By blocking those nerves, you're actually blocking the sympathetic nerves.

If you are blocking the nerves now you're going to open up those blood vessels. It's going to help the blood flow to the extremities, with the cold nature of the upper extremities, the diagnosis, the bluish tinge, and it does help, it does help with pain.

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Q With respect to Michael Saginor, typically how long would he get relief for?

A Two to three weeks, that's why he repeatedly comes to the office wanting more injections and he pops up.

Q Does the injections give you a high, are they addictive, are their any addictions at all?

MR. VAUGHAN: Objection.

THE COURT: Can you repeat the question?

Q Sure. Are there any addictions like with opioids or anything to that effect with the injections?

THE COURT: Is that your objection?

MR. VAUGHAN: He changed the question, I have no objection.

MR. FREUND: Thank you. It wasn't an artfully constructed question.

THE COURT: Glad I could help.

A There is no addiction risk with the injection other than relief of some of the pain and symptoms, in that sense it's positive feedback.

Q He wants to feel better?

A He wants to feel better.

Q But he's not getting high off the particular treatment?

A No.

Q In addition to this injection that you performed, the compound creams, how do they work?

A The compound creams are unique. The compound creams can be used on an extremity and there are various -- you could put various drugs in these compound creams especially for nerve pain. One of the common drugs is a numbing medication, local anesthetic like lidocaine or ketamine which is actually used a lot. Ketamine is a unique drug. A receptor, a little bit differently than an MDA receptor. Not really important other than it could help a lot with pain and issues. It is a unique drug so compounds with ketamine we use quite frequently for RSD patients.

Q Is there a risk of addiction with that?

A No, there's no risk of addiction, there's no narcotics in these gels and creams.

Q That's something that you focused on in particular because of Michael's history?

A Yes, as best we could. There were barriers with getting medication, so samples of gels and creams that we have available we give him. Whenever he could afford to get some medication, it could be rather costly, unfortunately.

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Q Compound creams are costly?

A Yes.

Q Those are made by specialty pharmacies?

A Yes.

Q In addition, physical therapy or occupational therapy or both are a necessary component?

A Yes. Your main objective by helping with the pain is so they could do physical therapy. Not using the hand or arm because of ongoing pain is going to cause further progression of changes in the skin and weakness, not just in the hand, you're talking about the whole arm. Physical therapy and ongoing physical therapy is an important treatment of RSD. So part of the goal is, let's try to diminish the pain, let's facilitate physical therapy, let's do whatever we can so he can try to maintain the range of motion and the muscular strength and blood flow.

Q Has he been able to get physical or occupational therapy in the last few years?

A No, it's been an issue.

Q Due to resources?

A To resources.

Q Okay. And another thing that you recommended, Dr. Winiarsky had talked about it, was a spinal cord stimulator, that's something that he hasn't been able to get as well?

A Correct.

Q Did you bring with you a model of the spinal cord stimulator?

A Yes.

Q And you can use this as well and I'll bring this over, if you can explain to the jury what this spinal cord stimulator is, how the surgery is performed, and what the potential benefits are.

A So a spinal cord stimulator, the name is descriptive its name, a device or a lead that's inserted within the spine, within the epidural space which is right along where the nerves are. And these wires or leads are permanently placed, in this case it would be in the neck area where there are two leads or contacts.

So that's surgically placed within the cervical spine because you want to get proper coverage between the arms and all the nerves that go into the arm are in the neck area. These wires or leads are placed underneath the skin and placed in a pocket with a generator, which is a pacemaker type generator, is then attached to those leads and that is all fully implanted in the patient.

Q When you say pocket, you mean underneath the skin?

A Underneath the skin. Essentially what you're having this pacemaker device which is placed typically in the buttock area where there are wires that are placed within the epidural space, within the spinal canal, that's threaded all the way up to the neck area. In this situation what that does is it causes impulses. This happens to be a newer device called a high frequency

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stimulation, there's been advances over the past couple of years and those impulses with the high frequency -- he's not going to actually feel but it stops the nerves from conducting pain and causes a different sensation or no sensation at all or it also helps increase vasculature and blood flow.

It's something that stays in for an extended period of time. They do have a lifespan of approximately ten years depending on usage. Inten years it would have to be replaced. Of course there's been advances and in ten years from now there's probably more advances of this stimulator device.

Q If you can take the stand again. You can sit down again, Dr. Mandelbaum, I appreciate it. Just so I can understand, so essentially the way it works it's sending pulse or signals that sort of drown out the sympathetic nerve signals or reprogram it or somehow deafens the signal?

A Yes, that's one way to describe it, yes.

Q And there's actually a program, these devices are programmed by someone from the company that manufacturers this devices, you try to send different signals to stay ahead of the body, correct?

A Correct. There could be multiple programs to help the pain and what he feels and does not feel and to make sure that he gets proper coverage.

Q And there's a technician that works with the program, the patient and you to every few months try to give the optimal relief?

A Correct. These nerves are very funny, they do change and if you block a nerve in one area sometimes they still have pain because there are other pathways that have to be blocked. Things have to be constantly reprogrammed and changed.

Q And this procedure is done often with a neurosurgeon?

A Yes.

Q And what is the role of the neurosurgeon?

A The neurosurgeon would place the leads within the spinal canal. So for it to be done you have to remove some of the bone, so the paddle could be placed within the epidural space. That's the best approach to putting these spinal cord stimulators.

Q And, Doctor, is Michael a candidate for the spinal stimulator?

A Yes, he is.

Q Why is that?

A Because he has a diagnosis of RSD, treatment modalities, there are no great treatment modalities but this is one of the most upcoming and probably the best treatment to date for this condition. Though it's not a cure all, unfortunately, but it's very helpful in diminishing the pain and long term hopefully there may be other advances or other procedures or injections.

Q This is a procedure that you have performed, correct?

A Yes.

Q And is this, the spinal stimulator, does it have any addictive qualities, any abuse, concerns, anything like that?

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A No.

Q In addition to the compound creams, the therapy, the injections, the stimulator, this is all following your treatment plan that's completely devoid of any addictive medication, correct?

A Correct.

Q How long has Michael been off opioid medications?

A For over a year, probably a year and a half now.

Q No addictive opioid medication, correct?

A Correct. He is currently taking a medication called Suboxone. Suboxone is a great modality, one, because it blocks these opioid receptors. So someone who is on Suboxone, they can't take opioid. If they do take opioid medication it's ineffective but it still has -- it still binds the receptors and can help with ongoing pain. He's been on it for over a year now.

Q And in the course of your treatment of Michael is it standard industry to perform toxicology tests, drug tests?

A Yes.

Q How often do you perform those tests?

A We roughly do it every three months in patients and sometimes more frequently, sometimes less frequently.

Q In addition to that, is there a database that you check to make sure that you're the only doctor prescribing his medication and he's filling his medication?

A Yes. There is at least over the past couple of years when it became available there is a prescription monitoring program that took a long time but finally New York State got to that, so we can actually access and see what prescriptions patients are actually getting when it comes to narcotic medication.

Q And over the years, we're talking six years now, has Michael been compliant with his medication regimen based on toxicology tests as well as the database?

A Yes, in general he's been good with his medication. We keep continuing to monitor him, make sure he is taking the appropriate medication. He had been on opioid medication and that was an ongoing issue, though in my practice and I felt that he needed the opioid medication but eventually his tolerance, unfortunately, was so high that we -- our long term goal, let's do the injections, let's do the gels and creams, let's deal with the stimulator and let's get him off the opioid medication.

Q So in the last year and a half there is no sign in his system as well as the database of any opioids, correct?

A Correct.

Q Doctor, did there come a time that together with Dr. Thomas and Dr. Winiarsky and Dr. Freidman, at my office request or my office's request that you guys put together a treatment plan?

A Yes.

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Q And if you can come off the stand -- it's already in evidence, your Honor -- take us through what the treatment -- first of all -- strike that.

Dr. Mandelbaum, in the course of your 20 years of pain management and prescribing medication, are you fully familiar with medication costs?

A Yes.

Q And fully familiar with physical therapy costs?

A Yes.

Q And injection costs?

A Yes.

Q And spinal cord stimulator costs?

A Yes.

Q And these are things that you have to take into consideration all the time when prescribing medication or sending patients to therapy?

A Yes.

Q Can you take us through the treatment plan?

A Our overall treatment, as I stated before, is to, one, keep him off opioid medication and then do whatever we can to maintain function and help with the pain. So he currently will continue to need Suboxone and compound creams.

The cost of Suboxone is stated here $850 for the 12 milligrams, that's 30 of them per month, as well as the compound creams which has the lidocaine and the ketamine which has a cost of $1200 per month. We're talking about a monthly cost of $1250.

Q Let me stop you there. Is there any costs put in there for any opioid medications?

A No.

Q Is there any costs put in there for neuro pathetic medication like Lyrica or Neurontin or sleeping medication or any other medications that may be needed in the future?

A No, that's not though my feeling is he may need some of the neuro pathetic medication and the ones that I described before that you mentioned, Neurontin and Lyrica, and there may be further advances in medication in the future.

Q So would you describe that as a conservative estimate at 1250?

A Yes.

Q Physical therapy you described before the importance and you have that at two times a week?

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A Yes, physical therapy again is the ultimate -- what you really want to do with this patient is diminish the pain and do physical therapy to maintain that function.

Q Would you like it to be more than twice a week?

A Yes.

Q And pain management visits you have that 200 a lifetime, that's required under the law when you're prescribing that medication?

A Yes, Suboxone is still a controlled substance and to follow it and if he needs periodic injections which he has and he will continue to followup.

Q Together with Dr. Mandelbaum and Dr. Thomas -- together with Dr. Winiarsky and Dr. Thomas, you guys came up with a regimen and you approximated $15,000 a year for the injection treatment, correct?

A Yes.

Q Now, describe that in detail, the different types of injection, you always trying to stay ahead of it and try different things, would he still need that if he goes to the spinal cord stimulator?

A Yes, he will continue to need that. Even with the stimulator you have exacerbation of pain and symptoms. The stimulator, unfortunately, is not the cure all, there is no cure for RSD.

Q Your body over time like anything else, medications, sort of get used to it even with the stimulator?

A Yes. Like I described before, sometimes you can block a nerve and nerve signals reroute through different pathways, you still constantly need to confuse the body, block nerves, change the nerves stimulation therapy. It offers good stimulation for a year or two and then needs to be reprogramed or changed or advances in the stimulator technology, updated. Unfortunately, you can't just change a stimulator but you can do injections.

Q And then together with Dr. Thomas and Dr. Winiarsky you put the cost of spinal cord stimulator inclusive of hospital, anesthesia, equipment fees at $82,000 and you said -- there you guys said it would have to be changed a second time because the lifetime you put there is 15 years.

Now, let me ask you, Dr. Mandelbaum, spinal cord stimulator, is that procedure done in a hospital?

A Yes.

Q And that $82,000 price, how would you describe that figure as relating to a current cost?

A Very conservative price. The reality is that the stimulator itself is probably about $50,000 plus the generator, surgical costs, that is rather conservative number.

Q The surgical fee for yourself and the neurosurgeon?

A The anesthesia, the facility fees.

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Q Often the patient has to stay overnight with these procedures, right?

A Yes.

Q It says it would have to be placed once in 15 years, is that a conservative or aggressive projection?

A That's conservative, that's what I would say is ten years.

Q That could be three or four times over Michael's life expectancy?

A Yes.

Q Nothing else that comes out whether the MRIs, the EMGs, you need to see an orthopedist, he needs to see a neurologist, nothing else is included in that plan, correct?

A Correct.

Q You can retake the stand, Dr. Mandelbaum. Thank you. What are Michael's restrictions in daily living from the RSD?

A Well, unfortunately RSD which has affected his upper extremity especially when he has exacerbation of pain which he quite frequently does, it's going to limit the usage of the hand. So he has difficulty with writing, with holding a cup, even taking care of himself, combing his hair, taking a shower which water becomes so hypersensitive to light touch.

Q That's when it's flaring up, correct?

A Correct.

Q In the few weeks when he gets relief from the injection you expect him to be able to do those daily activities, open doors, hold a cup, shower, all those things, correct?

MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q What would you expect of him when he has relief?

A That's the goal of these injections is to offer some type of relief so he could do these types of activities and be a little bit more comfortable which it has helped and then he gets the pain again and he comes running back to the office and wants to get another injection. That's been ongoing ever since we known him for the past few years.

Q In your experience treating RSD patients is a psychological effect of this cycle of feeling good after injections, getting relief, then the pain coming back?

A Yes.

Q Can you describe that for the jury particularly how it applies to Michael?

A Anybody, and especially with Michael with chronic pain that is persistent, one, they don't respond like other patients. It's, for instance, if you broke an ankle or fractured a femur you have all this excruciating pain and you're trashing around in pain.

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Somebody who has chronic pain, they don't come across that way, they don't display that. They still describe the pain as being severe and it's affecting their ability to function. They do cope somehow at times when the pain gets really worse and severe he's not able to function well and he basically isolates himself and he stays at home, he's unable to do his normal activities, take care of his grandchildren, and there are times when it's better and he's able to do those functions. But with that waxing and waning it does have a toll on his psychological being.

It's very frustrating, he's overly frustrated. He's expressed that multiple times when he comes running into our office, you know, describing the pain and wanting injunctions just to get things to subside. He's done that countless number of times, so he just comes running in without an appointment.

Q Is that your experience with many of your RSD patients?

A Yes, unfortunately it does happen where the pain just -- they may have some relief and then all of a sudden it comes back and it's very depressing --

THE COURT: Please.

MR. FREUND: I'm almost done, Judge, couple of minutes.

Q Dr. Mandelbaum, you have Michael here, you've been treating him for six years, over 50 visits, he showed his arm to the jury the other day, it's still bluish and purple, still the same regimen, medications, injections, compound creams, so what have you really done for him?

A One we offered him some relief of the symptoms. Again, they have been barriers into his treatment, he still needs further treatment, unfortunately this is something that's not going to go away, it's going to last the rest of his life. With the waxing and waning of his relief and back and forth, unfortunately there's no great long term modality and this is something that he is going to have to cope with and deal with.

Again, we do offer and he gets some relief from what we've done but ultimately what we've done is prevent it from getting worse which is the ultimate goal, let's see how we can prevent it from getting worse. Without proper treatment the hands, and we've seen it -- I have patients, they can't function at all and you can see pictures of patients who have untreated RSD and it's not a pretty sight.

Q Almost like a clawhand?

A Yes.

Q Has the RSD spread in Michael, up his arm?

A It hasn't spread into his other limb but there is some spread into the upper arm a little bit. There's been changes throughout the year with his hand, at least contain it, and, again, it's -- part of it is the therapy and injections.

Q In terms of the therapy and those things, he's been restricted in terms of the resources as well, correct?

A Correct.

DIRECT EXAMINATION

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BY MR. FREUND: (Continued)

Q Now, and we're talking about his dominant arm, correct?

A Correct.

Q To summarize, I mean, the goal is to control it and try to make him comfortable and give him some form of quality of life, correct?

A Correct.

Q Do you have an opinion, based on your six years of treatment, on Michael's ability to return to any form of gainful employment?

A Michael, unfortunately, will not be able to have gainful employment, certainly not within doing construction or electrical work because of the ongoing pain. He even has great difficulty doing sedentary work, and I have doubts -- almost none of our patients with RSD actually go back to work, unfortunately. Because the pain just, again, it waxes and wanes. There are bouts where the pain is severe, especially with changes in weather, cold, and I can't see him going back to work at all.

Q Would it be safe for Michael to work in any capacity? Would he be reliable?

MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q One second. Are you giving up on Michael, Doctor?

A No.

Q Why not?

A Because I think that, one, our treatment which should be ongoing has helped him at least maintain his ability to have some reprieve from his ongoing pain. And there are future treatments and modalities that still are available for us to go ahead and treat. And the reality is we haven't fully touched upon everything.

We've described some of the things that can be done, but there are other and probably slightly more invasive procedures that can be done to help with nerve reprogramming, and the future, hopefully, has even better modalities out there.

MR. FREUND: Thank you, Dr. Mandelbaum.

THE COURT: Ladies and gentlemen, does anybody need a break? Yes.

MR. FREUND: I'll take two minutes as well.

COURT OFFICER: All rise, please.

(Whereupon, the jury exited the courtroom; a recess was taken.)

COURT OFFICER: All rise, jury entering.

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(Whereupon, the jury entered the courtroom.)

MR. FREUND: We're going to mark -- we can keep those records, Dr. Mandelbaum?

THE WITNESS: Yes.

MR. FREUND: We're going to mark them in evidence as plaintiff's next exhibit.

(Whereupon, Plaintiff's Exhibit 22, Dr. Mandelbaum's records, were received and marked in evidence.)

MR. VAUGHAN: May I proceed?

THE COURT: Yes.

CROSS-EXAMINATION

BY MR. VAUGHAN:

Q Good afternoon, Doctor.

A Good afternoon.

Q My name is Tom Vaughan.

You brought your records, your paper records today?

A Yes.

Q Can you tell us what date those records begin?

A On March 12th, 2013.

Q March 12th, 2013.

But you told this jury, I think, in response to one of Mr. Freund's questions that you actually -- your office actually treated Mr. Saginor prior to that date.

A For an unrelated accident, yes.

Q Okay. Well, did you bring your record of February 15th, 2013 with you?

MR. FREUND: Note my objection, your Honor.

THE COURT: Approach, please.

(Whereupon, an off-the-record conference was held between all counsel and the Court at the side-bar.)

THE COURT: Overruled.

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Q Did you bring it with you?

A No.

Q May I show you my copy (handing).

Do you recognize that?

A Yes.

Q Is that a business record that your office made in the normal course of its business in treatment of Mr. Saginor?

A Yes.

Q Is that a document that's authored by you or one of the people in your office?

A Yes.

MR. VAUGHAN: Your Honor, I offer that in evidence. It's a record dated 2000 -- I'm sorry.

MR. FREUND: No objection.

THE COURT: I thought there was a stipulation for all prior treatment records anyway.

MR. FREUND: The stipulation was for relevant records, but I have no objection to that particular one.

Q Now, that record --

THE COURT: Can we mark it?

MR. VAUGHAN: I'm sorry.

THE COURT: That's okay.

(Whereupon, Defendants' Exhibit B, office record date February 15, 2014, was received and marked in evidence.)

THE COURT: Defendants' B is marked in evidence.

Q That record is dated February 15, 2013, eleven days before the accident that we all agree was on 2/26/2013?

A Correct.

Q Would you tell me what Mr. Saginor was in your office for on that date, ten days or eleven days prior to this accident.

A He was there for evaluation after his motor vehicle accident for neck and back pain.

Q And what did he tell you? What did he tell you on that date about his neck and back pain?

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A That he was doing better, using less medication, but still having some neck pain and spasm, as well as back pain and spasm.

Q And now out of a scale of ten what was his reported pain threshold?

A Six out of ten.

Q And was he taking any type of medication which you prescribed for that pain?

A Yes. He was being --

Q I'm sorry. What was he taking?

A He was -- he had a bunch of different medications, and he was being tapered down on some of the pain medication.

Q Okay. Well, just tell me what he was taking.

A Okay. He his current medication on the list here was Prednisone, Seroquel, Requip, Ativan, Amitriptyline, Oxycodone, Trazodone, Flector patch, and methadone and Tizanidine.

Q So he was taking methadone and Oxycodone?

A Correct.

Q Before his accident of -- February 26, 2013?

A Correct.

Q He was on those medications and he had been on those medications for a period of years, correct?

A Correct.

Q And he had been on those medications before he complained of pain in his neck and his back to you?

A Correct, unrelated to the accident that he subsequently had, yes.

Q Now, did there come a time when the issues with his back and his neck resolved?

A His issues with his back and his neck were never totally resolved. It was more focused on his accident that happened afterwards. Those issues with the back and neck --

Q Let me stop you for a second.

What do you mean “more focused on”?

A Once we started dealing with -- this is an issue with ongoing pain. A new accident which was limited to his upper extremity on the right. Our focus was on that and we really could not mention his other painful areas and we didn't focus our treatment on other painful areas.

Q But he was still being treated for his neck and his back injury during the course of your treatment of him for his arm injury?

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A No specific treatment was for his neck and the back. There were a few episodes where maybe he had some type of treatment, but the reality is we are unauthorized at least under that work-related accident to treat his neck and his back.

Q But you continued to treat it?

A He was treated for that specific accident in February 26, 2013 for his complex regional pain syndrome of the right upper extremity.

Q Let me ask you this, Doctor. I want you to assume that Mr. Saginor testified from the chair that you're sitting in on Friday to the following question by his attorney, Mr. Freund:

“Now, Michael, when Dr. Winiarsky was on the stand, he talked about, you know, from 2009 you had the motor vehicle incident and you needed the spinal fusion and the shoulder surgery. Did that give you any issue in the years working in carpentry and as an electrician prior to this incident?”

Answer: “No.”

“Was that affecting or impairing your life in any way before this incident?”

Answer: “No.”

Continuing: “Actually, I felt pretty good after the spinal surgery. I felt like a new person.”

He then proceeded to shake his head vigorously, which I can't do, on that witness stand and said that he had absolutely no impairment whatsoever as a result of the motor vehicle accident and the surgery performed by Dr. Winiarsky. I want you to assume that.

A Okay.

Q Now, that's what he told this jury. But he told you something else prior to this incident, prior to this accident, didn't he? He told you he was in pain from his cervical spine?

A He actually stated that his pain was a lot better and he wanted to come down and taper off his medication on that office visit prior to the accident.

Q But you continued to prescribe medication?

A Again, when it comes to opioid medication, unfortunately, there are dependency issues. It can't be abruptly stopped. That leads to withdrawal effects and it is something that we had to deal with with Mr. Saginor. The idea of tapering medication is somewhat controversial as to how rapidly to taper, especially someone who has been on chronic opioid medications.

Nowadays, there's definitely backlash on patients who are on chronic opioid medication on that rapid tapering that everybody wants to do. It's not fair to patients, unfortunately; you just can't do it.

Q Can you turn to your note or your office record dated 3/12/2013.

A Yes.

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Q And can you go down on the first page -- well, let me -- I'm sorry. Look at the very top where it says Reason For Appointment.

THE COURT: Question. Is this marked in evidence?

MR. VAUGHAN: Yes, this is part of his office record.

THE WITNESS: Yes.

MR. VAUGHAN: Yes.

Q Can you look at that.

A Yes.

Q The reason for appointment. Would you tell the jury what that was.

A It says, new injury, pain.

Q All right. Now, go down to where it says Medication Management and Follow-Up. Do you see that just on that first page. It's on the first page.

A Yes.

Q Okay. And what does it say about neck pain?

A That he continued to have lower back as well as cervical neck pain. He did describe it as being a -- the neck pain as six out of ten, the lower back pain a three out of ten, which he described again as the right upper extremity as a ten out of ten.

Q And then there are current medications listed. What are those medications?

A The medications listed were Oxycodone, Percocet, Prednisone, Trazodone, Tizanidine, and Kadian which is morphine.

Q Now, Oxycodone is an opiate, correct?

A Correct.

Q What about Percocet?

A It's the same, Oxycodone.

Q And for how long a period of time had he been on those before this accident?

A He was on -- as you stated on the earlier note, he was still on the Oxycodone and he was maintained on that and tapered down prior to this accident.

Q Now, I don't know if you brought all these records with you, but can you tell the jury approximately when you first prescribed Oxycodone for Mr. Saginor.

A I do not recall, but it was years before. He's been on opioid medication.

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Q And for how long a period of time under your care was Mr. Saginor on opiates?

A He was on opiates for a period of time prior while we were treating him for the motor vehicle accident for his surgeries, including the cervical fusion and the shoulder surgery, so.

Q Can you guess the number of years? Did Mr. --

A Three.

Q Did Mr. Saginor become addicted to opiates?

A No.

Q Well, you say that with confidence, sir?

A Again, he's developed a dependency. There's a huge difference between addiction and dependency. You have to define addiction; that's a lecture within itself.

Q Did he become dependent upon opiates?

A He's certainly dependent upon opiates.

Q And did he return to your office frequently during the course of your treatment? And when I say you, I mean you and Dr. Thomas and anybody else in your office. Did he return to your office frequently to have new prescriptions for opiates?

A He returned to our office quite frequently to actually have injections and to renew some of the opioid medication which was ongoing that he has developed a tolerance to and of course dependency on it.

THE COURT: Doctor, remember the yes-or-no instruction.

THE WITNESS: Okay.

THE COURT: Thank you.

Q Doctor, can you take a look in your notes at 7/30/2013, and if you'd go to page 3 on that note, we can make this quicker.

THE COURT: What is this?

MR. VAUGHAN: This is his office record.

THE COURT: What date?

MR. VAUGHAN: It's the date of 7/30/2013.

THE COURT: Thank you.

A Your page 3 may be different than mine, so if you could be more specific.

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Q Page 3 (indicating).

A Okay.

Q Now, in the third line down from the top, I believe it says patient is very opioid tolerant. What does that mean?

A That, again, I don't see it here, but with longstanding usage of pain medication you develop a tolerance to an opioid medication. What that means is your body gets used to a certain dosage. It becomes less effective with time. So you have a choice. You can increase the medication or maybe switch it to a different opioid medication, because they all bind to receptors slightly differently. So a different opioid may actually become more effective without increasing it. Or you can increase the medication to kind of override that tolerance of medicines. There are problems with both directions, but that's something that we deal with quite frequently in our practice.

Q Would you please turn to your notes dated August 21, 2013.

A Yes.

Q Do you see where it says History of Present Illness?

A Yes.

Q What does it say there?

A I'm reading from the note: Patient could not fill his last prescription of Oxycodone dated 7/30/2013. The pharmacy held onto the prescription. He did not get -- he did get a prescription from Dr. Winiarsky for 90 tablets. He is healing after surgery. Still he has pain along the forearm with decreased range of motion. He's willing to wean off the Oxycodone. He is traveling to Pennsylvania next week for vacation.

Q Now, what does that signify to you that the pharmacy held onto his prescription?

A That, one, more than likely it was an insurance issue or problem with the pharmacy holding onto the prescription and not filling it at that point.

Q Now, did you and Dr. Thomas ever have a conversation with Mr. Saginor about overusing the medications which you prescribed?

A We constantly are discussing proper usage of opioid medication, yes.

Q Well, my question is did you have that conversation with Mr. Saginor.

A Of course.

Q Did you have him sign a contract or an agreement?

A Yes, there is an opioid agreement that all patients who are taking pain medication have to sign.

Q And when was that done?

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A That was done on the initial evaluation sometime, and again, I don't have that actual opioid contract, but all our patients do sign it.

Q And was this -- he signed this before the accident of 2/26/2013?

A I'd have to find the contract and I'll let you know.

Q Did there come a time when you urged Mr. Saginor to stop taking opiates?

A Well, our whole goal repeatedly has been to try to --

THE COURT: Is that a yes or no?

Q Just did there come a time when you did.

A There were multiple times.

Q Multiple times?

A Correct.

Q And were you successful in weaning him off of narcotic substances?

A Yes.

Q When was that?

A When we had on different occasions tapered him down or changed him over to Suboxone which he currently is on.

Q When?

A Again, I can go through my notes, but he was on Suboxone a couple of times, and unfortunately we had to restart some of the opioid medication because of ongoing pain. And then about a year and a half ago he was placed on Suboxone and he has remained on that.

Q Did there come a time when you counseled Mr. Saginor to refrain from taking recreational drugs along with his medications?

A Again, we are very aware of recreational drugs and patients, and Mr. Saginor was counseled on usage of any other medications than what we prescribed.

Q Were you aware that Mr. Saginor had Crohn's disease?

A Yes.

Q Were you aware that as part of his self-medicating for Crohn's disease he smoked marihuana?

MR. FREUND: Just note my objection to “self-medicating.” Mr. Saginor testified as being prescribed.

THE COURT: Sustained.

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Q Were you aware that he smoked marihuana?

A Yes.

Q What other drugs was he taking for his Crohn's disease?

A It's not something that I particularly was treating. The marihuana happens to be effective for Crohn's disease, especially the CBD portion of marihuana.

Q Was he taking meth -- methadone for his Crohn's disease?

A He was taking methadone, not particularly for the Crohn's disease, but he was taking -- he was on methadone.

Q And did you prescribe the methadone?

A I believe he was prescribed it from our office at some point even prior to the accident. Methadone is kind of a unique opioid medication.

Q When was he first diagnosed with what we're calling RSD? It's actually complex regional pain syndrome, isn't it, now?

A Correct.

Q When was he first diagnosed?

A The first time that -- first of all, from the initial accident that he came in on that first office visit on 3/12/2013, there was high suspicion for complex regional pain syndrome, though he wasn't given that as an official diagnosis until about three, four office visits later, which is approximately a month later or two months later from that initial office visit.

Q So he was diagnosed with -- let's make it easier.

I guess we're calling it RSD. Is that what we're calling it?

A RSD is the typical nomenclature, though it's not the technical medical nomenclature. It's complex regional pain syndrome. We use it interchangeably.

Q So within a month of his accident, the one that we're here for, someone diagnosed him with RSD, yes?

A Yes.

Q Who was that?

A We actually had made that diagnosis, but in conjunction with speaking to the surgeon, Dr. Horowitz, Dr. Friedman, Dr. Winiarsky, because of the ongoing pain that could not be explained in any other way.

Q Now, when you say “we,” were you the one who diagnosed the RSD?

A I'm going to look at the -- even as far as my visiting him, he was already -- and the description was of a upper extremity nerve-related issue.

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THE COURT: Doctor, was it you or not?

THE WITNESS: It was probably more likely Dr. Thomas, and I'd have to look back at when we switched the diagnosis.

Q So it wasn't you?

MR. FREUND: He needs to look at it. Can he have a chance to look at it?

THE COURT: He seems more than happy to look at it, but to start talking aimlessly --

MR. FREUND: That's fine, that's fine.

A As of the second time that we had seen him, in April 15th, 2013, which I had personally seen him, he had a diagnosis of a nerve-related issue of that upper extremity.

Q All right. Now nerve-related issue and RSD could be two different things, correct?

A Correct.

Q What other nerve-related issues were you considering at that time? When I say you, I'm also including Dr. Thomas.

A Again, it was always RSD, which is something that we don't jump to that conclusion so rapidly after seeing a patient initially, and it's something that we made that diagnosis fairly quickly so we can aggressively treat it.

Q And what brought you to that diagnosis within two months of his accident? When I say what brought you to that diagnosis, what did you see in this patient which permitted you to make a diagnosis of RSD?

A Because of the ongoing pain, the quality of pain, the discoloration, the hypersensitivity, the burning quality, the allodynia, which is that hypersensitivity, it all is consistent with RSD, and to make that diagnosis it's very important to do early on so that you can adequately treat.

Q Now, when was the first operation that Mr. Saginor underwent on his hand or wrist? What was the date?

A I believe it was 3/6/2013.

Q It was what?

A March 6th, 2013.

Q All right. So was that operation done to alleviate some type of nerve pain? Do you understand my question?

A Correct.

Q It was done for that purpose?

A I did not evaluate him at the time, but from my understanding and from the operative report and discussion with the surgeon, he had urgently gone or had surgery because of the fractures and because of some impingement on the nerve, and that had to be addressed rapidly.

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Q Now, these fractures, these fractures were not treated with surgery, were they, the fractures?

A Again, things were stabilized with surgery.

THE COURT: Doctor, yes, no, I can't answer with a yes or no, are all acceptable answers.

THE WITNESS: I'll let the surgeon.

THE COURT: Thank you.

Q And that surgery by Dr. Horowitz was performed within, if my understanding of the chronology is correct, like a week before you diagnosed him with RSD?

A He wasn't diagnosed with RSD -- again, you're the one that brought it up as far as we didn't initially diagnose him with RSD. We said that he had a nerve-related issue or problem, which we had attempted to treat, which remained, and gave him the diagnosis of RSD shortly thereafter.

Q I guess my question must have been inartful. When was he diagnosed with RSD? Just when. No explanation needed.

A I'm going to give you a date. So the formal diagnosis of RSD was November 15th, 2013, though he was being treated even prior to that for RSD.

Q Who made the diagnosis?

A He was seen during that office visit by Dr. Thomas.

Q So Dr. Thomas made the diagnosis of RSD, correct?

A He formally made that diagnosis on our record of RSD on that date.

Q Was your treatment of Mr. Saginor changed once that diagnosis was made?

A Yes. We were much more aggressive.

Q And when you say “much more aggressive,” what did you do?

A As far as the injections, we aggressively approached it as a RSD, as far as medication, especially the injections, especially with the radiofrequency sympathectomy which is -- and the spinal cord stimulator potential for that and the physical therapy modalities. So once that diagnosis is made, and we always had suspicion of that diagnosis, he had to be aggressively treated.

Q Okay. Aggressively treated, I understand that.

Did you increase his medication?

A There were constant changes in his medication.

Q Okay. Did you increase it in terms of strength?

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A Of the opioid medication, no.

Q Of any medication.

A Yes. He was changed on the medication.

Q All right. And did you -- when was the first needle placed in his spine?

A Give me a second. Well, he had undergone -- and I can't be a hundred percent certain that he didn't have an injection before this, but a radiofrequency cervical sympathectomy because of that ongoing diagnosis on December 26th, 2013, and I'm looking through some of the earlier notes to make sure to see when he's had other injections as well.

Q I'm just talking about your office?

A Our office.

MR. FREUND: He's looking through his own notes.

THE COURT: Do you know of any sooner and you could direct his attention, that would be very helpful.

MR. VAUGHAN: No, I don't.

Q Doctor, let's assume that's the first, what do you call it, RFS?

A Radiofrequency sympathectomy.

Q That's what you demonstrated to this jury a little while ago, correct?

A Correct.

Q That's the first time that happened, did you change his medication at all once you started doing the RFS?

A His medication was constantly changed. Even prior to that when we made the first diagnosis he was placed on Suboxone, it was constant evaluation and he had constant changes in the medication.

Q How many RFS injections has your office performed on Mr. Saginor to this date?

A One.

Q One?

A Correct.

Q And what other injections -- withdrawn. What you demonstrated to the jury right here with the spine and your needle, what was that called?

A That was a stellate ganglion block as well as the radiofrequency procedure, they're very similar procedures in the same area.

Q So the RFS that I'm talking about, just one time?

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A Correct.

Q The other procedure that you just referred to, is it done the same way?

A Yes.

Q Needle to the spine, correct?

A Correct.

Q How many of those has your office performed?

A Over 60.

Q And that provides some reported relief for Mr. Saginor, correct?

A Yes.

Q When Mr. Saginor tells you he's in pain, is there any way for you to objectively assess that pain?

A The pain is subjective, unfortunately.

Q So when Mr. Saginor says to you, doctor, I'm in great pain, do you give him a pain scale ten out of ten?

A He -- we do ask patients and ascertain their description of pain, we do evaluate the patient's physical examination, subjective complaint of pain is one. Again, it's asking the patient -- we do ask him, how do you rank that pain on a scale from 0 to 10?

Q What is 10 out of 10 pain, can you describe that to the jury?

A Ten out of ten pain, which 10 we tell the patient is the most severe pain that they can imagine and 0 is no pain at all, give us on a scale from 0 to 10 how their pain is at any given moment or during that day or on average.

Q Can you describe to the jury what ten out of ten pain is?

A I just said, very, extremely severe pain that a patient could imagine.

Q And what would cause the patient to exhibit it in terms of physical symptoms?

A For somebody with chronic pain, which I actually told the jury before, someone who has chronic unremitting pain, they describe it a ten out of ten. They actually may look like they're not in pain. Believe it or not patients dying of cancer may not exhibit pain, they may be comfortable in that position. It is tough to actually -- especially when it comes to chronic pain versus acute pain to look at somebody -- to look at somebody to say they're in pain or not in pain, it's impossible.

Q Fair to say that one even with your medical credentials cannot objectively assess the amount of pain a patient is in?

A Correct, pain is subjective.

Q But pain is also a vital part of a history that you take in order to prepare a treatment plan?

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A In conjunction with diagnostic studies and physical findings.

Q But it's a part of the necessary history that any doctor would rely upon in preparing a treatment plan?

A Yes.

Q Now, a few more questions, Doctor. Your office has treated Mr. Saginor since shortly after 2008, is that a fair statement?

A Correct.

Q Have you noticed during the period between 2008 and 2013 any improvement in Mr. Saginor? Got those dates, 2008 to 2013?

A Correct.

Q Did you notice improvement in him?

A Again, I don't have those notes available. Even with the note that you supplied the court on February 13, 2013 he stated he was doing better.

Q Since the date of this accident, which we agree is 2/26/2013, has Mr. Saginor improved at all?

A He's had improvements and then a relapse and that's why he had multiple injections.

Q What are the relapses attributable to?

A To pain and the complex regional pain syndrome.

Q And the pain, again, that's something that he reports to you?

A Correct.

Q And when he comes to your office, sometimes unannounced, I think you told us that, right?

A Quite frequently.

Q He comes in and says I'm in horrible pain and I need medication?

A One has nothing to do with the other. He'll come to our office and want injections. The most likely scenario when he comes in and says do a quick injection which I reluctantly do but we did quite frequently.

Q It's based upon his report of pain?

A Yes.

Q And before you do any of these injections, do you do any objective testing of Mr. Saginor?

A There is a physical examination, visualization, as far as examination of the extremity.

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Q Okay. What are you looking for?

A Mostly what we see, longevity, the skin coloration, the atrophy, the temperature changes which he's got repeatedly on ‘and off.

Q Do you do measurements of his extremities to compare, like the left wrist and the right wrist?

A I believe so, I don't know if you're referring to any particular exam.

Q I'm not -- in general when he comes in -- I'm trying to make this fast, but when he comes in saying I'm in pain, I need an injection, do you do any objective testing where you measure his wrists, for example?

A I don't specifically recall.

Q How about his biceps?

A I don't recall. I don't recall seeing that it was done.

Q You just mentioned the word atrophy, atrophy is like a wasting of the muscle, correct?

A Correct.

Q Do you make any measurements to document that atrophy?

A No, atrophy is comparison between the right and left extremities.

Q That's important, right, to see whether or not -- withdrawn. Any other objective testing before you give him an injection based upon his complaint of pain?

A Again, it's major complaint which is the burning and ongoing pain. As far as we've measured temperature changes between the right and left extremities, the atrophy, the coldness, that's been ongoing especially when he comes in for injections.

Q What is your present treatment plan for Mr. Saginor?

A Well, our overall treatment which I described before, one, keep him off opioid medication, there are dependency issues, Suboxone, which he will continue, the physical therapy modalities, ongoing treatment as far as injections, the ganglion blocks, the spinal cord stimulator, any in the future, hopefully, new modalities or medication that may come.

Q Has Mr. Saginor been approved for spinal cord stimulator?

MR. FREUND: Note my objection.

THE COURT: Sustained.

Q Have you recommended to anyone that Mr. Saginor is a candidate for spinal stimulator?

A Yes.

Q And is it your belief that a spinal stimulator will help him?

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A Yes.

Q So my question is this, have you written to anyone --

MR. FREUND: Note my objection, Judge.

THE COURT: Sustained.

Q What relief would a spinal stimulator provide to Mr. Saginor?

A It should help, hopefully, significantly with his upper extremity of pain, that burning sensation. Again, as I stated before, it's not a cure all but he does have a control over what he may or may not feel because he does have a remote control, you can turn it on and off, hopefully to get things to subside. Will he still need future treatment and injections, yes, more than likely. The stimulator, I guess the nerves the sensory nerve conduction of different pathways, even though the stimulator may block certain pathways over time it may become unreceptive but it happens to be a great modality.

Q I want you to assume that Dr. Winiarsky was here and told this jury that Mr. Saginor's right extremity mechanically is sound, would you agree with that, mechanically?

A You really have to define it, mechanically, he has limitations with his right upper extremity.

Q That's because of what?

A The complex regional pain syndrome.

Q Because of pain, right?

A It's not just pain, there's pain in the manifestation of complex regional pain syndrome.

Q Is the pain that he's experiencing now, in your opinion, the reason that he cannot be gainfully employed?

A Again, pain is the one complaint. It's not just pain, the pain, complex regional pain syndrome is an ongoing process that affects the vasculature, musculature, the blood flow, that's causing pain. It's not just pain.

Q We're running out of time but musculature, is he lacking musculature on his right side?

A On his whole body.

Q You measured that?

A No, I just observed him.

Q How about blood flow, have you done any testing for blood flow?

A Yes, there's testing, again, with temperature which is most likely because of diminished blood flow and differences between the right and left extremities.

Q And is that something that causes a physical limitation in using his right extremity?

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A It's part of the manifestation of complex regional pain syndrome.

Q You keep coming back to that, Doctor. Isn't it true that the most decisive element in a diagnosis of complex regional pain syndrome is the report of pain by the patient?

MR. FREUND: Judge, can we approach?

THE COURT: Yes.

(Whereupon, there was an off-the-record discussion held at the Bench.)

THE COURT: Asked and answered. Sustained.

MR. VAUGHAN: Doctor, I have nothing further.

THE COURT: Thank you.

MR. FREUND: My redirect, your Honor?

THE COURT: Yes.

REDIRECT EXAMINATION

BY MR. FREUND:

Q I just pulled out one of your notes, Dr. Mandelbaum, this is from March 31, 2015 and for order of time I'll stand next to you right here, you did a full physical examination of the right wrist, correct?

A Correct.

Q And you document severe losses and range of motion of the right wrist?

A Correct.

Q You documented temperature is vastly different at the right compared to the left?

A Correct.

Q 88 degrees on the left and 68 degrees on the right?

A Correct.

Q And you document erythema?

A Yes.

Q And you document swelling?

A Yes.

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Q And you document skin and nail bed changes?

A Correct.

Q And you documented right hand and form atrophy which is waisting away of muscle tissue?

A Correct.

Q Those are all objective signs, correct?

A Correct.

Q Michael can't tell you these things, these are things that you examined and found?

A Correct.

Q So if Marc Freund walked into your office and said I have severe pain, give me opioid medications, give me injections, are you going to give me that?

A No.

Q To nobody, right?

A No.

Q So you have the history, the trauma, the fracture, the nerve reconstruction surgery as well as objective signs on each visit?

A Correct.

Q In fact, you tested motor strength with devices, correct?

A Correct.

Q Which means his ability to grasp, pull objects?

A Yes.

Q Severe motor weakness is documented, correct?

A Yes.

Q In fact, you compared the right to the left and the nondominant hand is far stronger than the, right?

A Correct.

Q It's not just the pain that causes the disability, it's the inability to have strength, the lack of muscle, the discoloration, the sensitivity to changing temperature all things are objective?

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A Correct.

THE COURT: A little less leading, please.

MR. FREUND: Time wise, Judge.

Q And you discussed before you had discussions with his other doctors in terms of the diagnosis of RSD?

A Correct.

Q And these conditions that you document, is that consistently found by the other physicians as well?

A Yes.

Q And is there any, from the neurologist to the other pain management physician, Dr. Rauchwerger that he went to for a second opinion, to Dr. Horowitz, Dr. Winiarsky, is there anybody that you know of that hasn't diagnosed RSD?

MR. VAUGHAN: Objection, your Honor.

THE COURT: Sustained.

Q Now, Mr. Vaughan brought up with respect to the cervical spine fusion from prior?

A Yes.

Q That's a serious surgery, a spine fusion?

A Yes.

Q The treatment over time, it's gotten better, the surgery itself, the approach?

A Yes.

Q In your experience you have patients that will return right, you have Tiger Woods, he returned to golf, he won a masters?

MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q People now these days with spinal fusion are able to return to work, right?

MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q Mr. Vaughan was asking you about Mr. Saginor's recovery. I'm going to refer you to Plaintiff's Exhibit 20, I want you to assume, and you can look here in evidence that in 2011 and 2012 Mr. Saginor worked as a carpenter, he worked over a thousand hours in 2011, nearly 1300 hours in 2012, and Mr. Vaughan asked you about his recovery and you described it as good and Mr. Saginor described it as good. Knowing the amount of work he performed --

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MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q Assuming the amount of work that Mr. Saginor performed in the construction industry, how would you describe his recovery?

MR. VAUGHAN: Objection.

THE COURT: How does he know how much work he performed?

MR. FREUND: It's in evidence. I can ask him an assumption question.

THE COURT: I'll allow it.

Q Assuming he worked nearly 3,000 hours in construction in the two years prior to this incident, right up until the time he suffered this fracture, how would you describe his recovery?

A As good.

Q Does that mean he's not going to have flare ups from time to time?

MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q Would someone who has a good recovery from a cervical fusion, they can go back to heavy manual labor, would you still expect in your course of treatment for there to be flare ups?

MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q Is there a single instance in your records in the last three or four years that mentions any treatment for the neck?

A I don't believe so.

Q Did you prescribe any medication in the last several years for the neck?

A No.

Q And, in fact, your projection going forward there is not a single dollar allocated to any opioid medication, correct?

A Correct.

Q He has been off opioids for over a year and a half, correct?

A Correct.

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Q He's not taking any methadone, correct?

A Correct.

Q Mr. Vaughan asked you about the RSD diagnosis but you and Dr. Thomas, in fact, waited about seven months before you formally diagnosed him with RSD?

MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q How long did you and Dr. Thomas waited until you formally diagnosed him with RSD?

MR. VAUGHAN: Objection.

THE COURT: Basis?

MR. VAUGHAN: Form.

Q How long?

A About seven months as I stated before.

Q Why is that, why didn't you rush to diagnose RSD?

A It's not a great diagnosis to have so you want to be certain that you have that diagnosis and then you want to treat early. So eventually you will make that diagnosis if they're not responding to normal treatment. Don't forget he just had surgery, came to our office, the pain remained, everybody was concerned despite our treatment he still had significant pain so we rapidly made that diagnosis in anticipation of treating it appropriately.

Q Okay. And that was based on your examinations?

A Correct.

Q It's not just based on Michael saying I'm having the worse pain ever, correct?

A Correct.

Q That was based on your physical examination as well as you described before MRIs, EMGs, x-rays, as well as the findings of Dr. Winiarsky, Dr. Horowitz, and Dr. Thomas, correct?

A Correct.

Q In fact, you guys have worked as a team in the last six years in treating --

MR. VAUGHAN: Objection.

THE COURT: Sustained.

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Q Now, Mr. Vaughan mentioned the RSD being just as a result of complaints of pain. You document hair and nail growth changes, is that something that is subjective under the control of Mr. Saginor?

A No.

Q And when you describe changes to hair and nail growth in the hand, can you explain to the jury what that means?

A That means that -- and, again, in comparison to the right and left arm that something is happening to the right upper extremity. In this case the RSD which is a vascular problem because of constriction issues because of the RSD.

Q I get how it's diagnosed but what does it mean, abnormal hair and nail growth, what does it mean?

A He has an ongoing issue or problem consistent with that diagnosis.

Q That means your hair on your hand is not growing -- I'm asking a dumb question?

A Yes. That means that the nailbed is going to look different, it's not growing the same way and the hair -- a lot of time they lose their hair because of abnormal blood flow to an extremity, that's what it's referring to.

Q Now, Mr. Vaughan asked you, you know, about drug addiction and we got into a little bit of hysterical argument about dependency and addiction, you are aware that Mr. Saginor did receive counseling or addiction treatment, whatever you want to call it?

A Yes.

Q And that's something that you were cognizant of in treating him?

A Very much so.

Q Are you aware of any RSD patient that you've treated in your practice that at some point in time didn't need opioids?

MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q Have you ever experienced a patient in the course of your RSD practice in the past 20 years at some point that didn't need opioid medication?

MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q Doctor, showing you what I have in evidence and Mr. Saginor is working full time for years in construction before this incident, in the absence of this incident and the RSD would you have any expectation that he wouldn't have become disabled?

A I don't think that he would have become disabled. There is no reason to think that he would, he was working.

Q Based on your treatment or any prior condition you wouldn't have expected that that would have resulted in any disability, correct?

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MR. VAUGHAN: Objection.

THE COURT: Sustained.

Q I know we talked about the disability, to be clear, do you feel the disability was a caused as a result of this incident, correct?

A Correct.

Q Let's talk about the treatment needs in terms of the injection, the spinal cord stimulator, the Suboxone, the compound creams, is that something that he needs because of this incident or because of something prior?

A It's because of this incident.

Q Okay. He never would have required spinal stimulator for the prior, correct?

A Correct.

Q He definitely wouldn't need compound creams on his arms for the prior injury, correct?

A Correct.

Q Definitely wouldn't need therapy on his hands for the prior injury, correct?

A Correct.

Q You definitely weren't going to do injections that you described to treat the radiofrequency nerves and the sympathetic nerves for any prior issues, correct?

A Correct.

MR. FREUND: Thank you for your patience, Judge, no further questions.

THE COURT: Thank you, Doctor. You may step down.

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