ORIGINAL

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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CHRIS ANTIGONE,

PLAINTIFF,

-against-

Case No:
17-CV-5296

PEDRO ROJAS, JR & CONWAY SYSTEMS LLC,

DEFENDANTS.

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DATE: January 3, 2020
TIME: 11:01 A.M.

DEPOSITION of the non-party witness, ANDREW MEROLA, M.D., taken by the Defendants, pursuant to a Notice and to the Federal Rules of Civil Procedure, held at the offices of William Schwitzer & Associates, P.C., 820 Second Avenue, 10th Floor, New York, New York 10017, before Norah Colton, CM, a Notary Public of the State of New York.

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

WILLIAM SCHWITZER & ASSOCIATES, PC
Attorney for the Plaintiff
CHRIS ANTIGONE
820 Second Avenue - 10th Floor
New York, New York 10017
BY: NEIL FLYNN, ESQ., of Counsel

LEWIS BRISBOIS BISGAARD & SMITH, LLP
Attorneys for the Defendants
PEDRO ROJAS, JR & CONWAY SYSTEMS LLC
77 Water Street, 21st Floor
New York, New York 10005
BY: KEVIN M. ZIMMERMAN, ESQ.
File #: 31165.210
Kevin.Zimmerman@lewisbrisbois.com

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F E D E R A L S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and between the counsel for the respective parties herein that the sealing, filing and certification of the within deposition be waived; that the original of the deposition may be signed and sworn to by the witness before anyone authorized to administer an oath, with the same effect as if signed before a Judge of the Court; that an unsigned copy of the deposition may be used with the same force and effect as if signed by the witness, 30 days after service of the original & 1 copy of same upon counsel for the witness.

IT IS FURTHER STIPULATED AND AGREED that all objections except as to form, are reserved to the time of trial.

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ANDREW MEROLA, M.D.

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

EXAMINATION BY.

MR. ZIMMERMAN:

Q. Please state your name for the record.

A. Andrew Merola.

Q. What is your address?

A. 567 1st Street, Brooklyn, New York 112215.

Q. Good morning, Dr. Merola. My name is Kevin Zimmerman and I represent the Defendants this morning and maybe the early part of the afternoon. I'll be asking you some questions.

If at any point you don't understand my question let me know and I'll rephrase it for you. Please keep all your responses verbal, no head nods or hand gestures, so the Court Reporter can take down your answers.

If for any reason you need a

break whether to use the bathroom, make a phone call, that's fine. I only ask that if I just asked the question you answer my last question before we take that break, okay?

A. Yes.

Q. Even if you know what my question's going to be, do your best to try to let me finish my question before you start your answer, and likewise I'll do my best to try to let you finish your answer before I ask my next question just so we're not speaking at the same time.

A. Yes.

Q. Okay? Have you ever been deposed before?

A. Yes.

Q. So you're familiar with the process?

A. Yes.

Q. Are you currently employed?

A. Yes.

Q. And by whom are you employed?

A. Myself.

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Q. Are you affiliated with any hospitals?

A. Yes.

Q. And what hospitals are you currently affiliated with?

A. Mount Sinai Hospital and New York Presbyterian.

Q. And do you have a position or a title at Mount Sinai Hospital?

A. I'm an attending surgeon at both hospitals.

Q. Are you a specialized type of surgeon?

A. Yes, I am.

Q. What specialty or what field?

A. I'm an orthopedic surgeon that subspecializes in spinal reconstructive surgery.

Q. Approximately how long have you been an orthopedic surgeon for?

A. I graduated medical school in 1990 and finished my residency in '95 and then finished my fellowship in '96. So I've been in active practice on my own

since 1996.

Q. And how about the specialized field of spinal reconstruction?

A. Since 1996.

Q. In a given year approximately how many times would you say you testify either at a deposition or trial?

A. I'd say about six or seven times per year depending on the year.

Q. And approximately of those six or seven times per year, if you know, what percentage is for Plaintiff versus for Defendant?

A. I would say the majority is for Plaintiffs since I'm essentially testifying on behalf of my patients.

Q. Have you ever testified before for William Schwitzer's office?

A. Yes.

Q. And how often, if you know?

A. I don't know an exact number but I have testified in the past for William Schwitzer's office.

Q. More than once a year, if you

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know?

A. I don't know but I'm sure there may have been a year or so when it was more than once per year.

MR. ZIMMERMAN: Let's mark.

(Whereupon, the aforementioned document entitled Plaintiff's Expert Exchange was marked as Defendant's Exhibit A for identification as of this date by the Reporter.)

Q. I'm just going to show you what's been marked as Defendant's Exhibit A and just look through it quickly. There's no pending question right now. I just want to make sure you're familiar with the document.

A. (Witness reviewing.)

Yes.

Q. What I've shown you that was marked as Defendant's Exhibit A is Plaintiff's Expert Disclosure of yourself in this matter. Do you agree with that statement?

A. Yes.

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Q. I just want to refer you to Exhibit "A" of that exhibit, which appears to be your CV. Would you agree that that's correct?

A. (Witness reviewing.)

Yes.

Q. Can you tell in looking at it briefly if that's the most updated CV you currently have, or is there anything that needs to be added to it as we sit here today?

A. Yes, the Mount Sinai and the New York Presbyterian Hospital should be added to this CV.

Q. Anything else that you recall or that you notice by reviewing that document?

A. The -- sorry, recertified in 2008 and then I just recently recertified until 2028. So I'd just done my re-re-re-re cert for orthopedic surgery.

Q. Based on the years you've given is that something that's required every ten years?

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A. Yes; exactly. Those are the two major things I would have added to this particular thing to update it.

Q. And then going to Exhibit "C" of Defendant's Exhibit A from today, that would appear to be a prior testimony list?

After you look that over just let me know if that's the most updated list with respect to those.

A. (Witness reviewing.)

It appears to be most recent except it doesn't look like it contains, 2019, but we just finished 2019.

Q. Okay. In your recollection do you remember testifying in 2019?

A. Yes.

Q. Approximately how many times?

A. I would say probably five times or so in 2019, I believe.

Q. I'll just call for the supplemental production of that testimony list once the same is created and produced.

A. Yes.

Q. And then finally, per this

disclosure it indicates your fee schedule under No. 5., second page of this exhibit.

A. Yes.

Q. Has anything changed with respect to your fee schedule that's listed in paragraph 5?

A. No.

Q. With respect to this particular case, do you have an actual file?

A. I brought my office treatment records.

Q. Aside from your office treatment records would there be any other records, would there be any other items contained in a file pertaining to this case?

A. Not specifically. I had reviewed some medical records for a narrative which I had prepared which I believe there's a copy of in that document, and then those medical records are listed there. And then other than that, only my treatment notes, which I brought with me.

Q. And your treatment notes are

different than your treatment records?

A. No. They would be the same, yeah. And then of course I'd seen and treated him in the hospital. I don't have the hospital chart or file with me at all.

Q. All right. So just so I make sure I understand that. A file for this particular case you would have your office treatment records. Any additional treatment records from other providers that you reviewed in preparation of your report?

A. Yes.

Q. It may have hospital charts and hospital records from that surgery?

A. The only thing I have from the hospital record is the operative report, but I brought a copy of that.

Q. And when you refer to your office treatment notes are those just handwritten notes that you then turned into those actual treatment records or are they something else?

A. So after, immediately after I see the patient I would dictate into a

digital Dictaphone and then that digital Dictaphone is downloaded for transcription. So I don't do handwritten notes but I do a verbal digital dictation that then gets transcribed and placed into the file as my summary of my treatment of the patient on that particular day.

Q. And the records you reviewed in preparing your report dated September 13, 2018, those were all treatment records relating to this patient?

A. As far as I could recall, yes.

Q. What is the first date for your treatment records you have with respect to this patient?

A. November 1 of 2013.

Q. And the accident we're here for today, do you know the date of that accident?

A. I have the date of the accident as April 8, 2016.

Q. So fair to say you saw this patient prior to this accident, correct?

A. Yes.

ANDREW MEROLA, M.D.

Q. Do you remember on how many occasions you saw this patient prior to this accident?

A. Once.

Q. Just once, okay. How did that patient come before you? What brought him to you in November of 2013?

A. He had been referred to me by his pain management physician, a Dr. Canty, C-A-N-T-Y. I have it misspelled in my note, my transcription is wrong, but it's C-A-N-T-Y.

MR. ZIMMERMAN: May have this marked as Exhibit B.

(Whereupon, the aforementioned evaluation note was marked as Defendant's Exhibit B for identification as of this date by the Reporter.)

Q. Can you just take a look at B and make sure it matches up with the treatment record you've referring to that's in front of you from your file?

A. Yes, it does.

ANDREW MEROLA, M.D.

Q. I'll just refer to this one on my end and yours on your end, that way we don't have to pass it back and forth. Okay?

A. Yes.

Q. Do you have an indication as to why Dr. Canty referred Mr. Antigone to you back in November of 2013?

A. Yes.

Q. What was the reason?

A. The reason was severe low back pain, which he had rated as an 8 out of 10 on a zero to 10 scale.

Q. And did you have an indication at that time as to how long that back pain had been ongoing for?

A. The patient had indicated that there was a fall at work which happened on November 7 of 2012.

Q. And if you know, why did Dr. Canty specifically refer Mr. Antigone to you at that time?

A. He referred him to see whether or not I felt that Mr. Antigone would be a

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surgical candidate.

Q. And what type of surgical candidate?

A. A spinal surgical candidate.

Q. And could that encompass a variety of surgical options?

A. Yes.

Q. Back in November of 2013, when you first saw Mr. -- do you know if it's An-ti-gone or An-ti-go-knee?

A. I don't know.

Q. I don't either, that's okay --

A. I pronounce it Anti-go-knee.

MR. ZIMMERMAN: An-ti-go-knee.

MR. FLYNN: Sure.

Q. Do you know back when you first started treating Mr. Antigone in November of 2013, was that with respect to solely his back, or his back and neck, or something else?

A. That was specifically only for the lower back.

Q. And did you conduct an examination of Mr. Antigone on November 1,

2013?

A. Yes, I did.

Q. What did your examination reveal?

A. It showed that he had what I recorded as a severe antalgia and kyphosis while walking with asymmetrical central contraction of his lumbar paravertebral muscles. And he had what's known as a reversal of lordosis when arising from a seated position.

His low back extension was 5 degrees and had a positive spinal Phalen's test, which is spasm in the low back with some pain radiating down the legs. Forward bending was 30 degrees. Right bending was 20 and left bending was 25. Right rotation was 15 and left rotation was 25.

He had some decrease in pinprick and tactile sensation in the L4-L5, and S1 roots. And had a -- from a stretch test which I recorded as positive and had a right-sided straight leg raise as 45 degrees.

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Q. Can you tell me as a layperson what severe antalgia means?

A. It means that he had a noticeable pitched forward gait, that's kyphosis. That means instead of normal upright posture and a normal what we call reverse curvature to the lumbar spine, it's a flattened lumbar spine with a pitched forward posture. Antalgia means there was a noticeable limp. So he was spending less time on one leg than another leg.

Q. And are those findings something of a traumatic nature? As opposed to a something you're born with, genetic?

A. Well, based on the history for this examination at that time with a history of a fall in November of 2012, you would make the connection between the fall and that physical finding.

Q. The range of motion degrees that you listed in your report after your examination of Mr. Antigone, were those findings normal?

A. No.

Q. What were they?

A. They were abnormal, significantly decreased.

Q. In addition to your physical examination of Mr. Antigone on November 1, 2013, did you review any other records or films?

A. I did locate an MRI that he had done, and I recorded the results of what I saw.

Q. Looking at your records, are you able to tell the date of that MRI?

A. I don't have the date recorded, no.

Q. Is there anywhere you would have that date recorded?

A. No. I'd have to go back and look at the actual film itself.

Q. Would you still have the actual film?

A. I do not hold onto the films. You know, we usually access them through the server or the MRI facility.

Q. And I'm assuming based on your

notes there's no way of knowing the name of that facility either, correct?

A. No. That's correct.

Q. And what did you see when you reviewed that MRI?

A. I recorded it as a central disc herniation at L4-5.

Q. The fact that you only referenced one level of the lumbar spine, the L4-5 level in your note, treatment notes from November 1, 2013, does that mean there were no findings at any of the other levels with respect to that particular film?

A. It indicates that there were no other correlative clinical findings. In other words, the MRI L4-5 segment in my opinion correlated with his current symptoms and his physical exam.

Q. And why does that level or that finding correlate with the findings in the exam?

A. It's just based on what the imaging study looks like, and then

comparing it to the abnormal physical findings, so they correlate most closely with the L4-5 level.

Q. Would your file have any treatment records regarding any treatment Mr. Antigone underwent prior to you seeing him on November 1, 2013 with respect to this work-related accident in November of 2012?

A. No.

Q. In other words, would Dr. Canty send over his records?

A. Sometimes the treating physician does. Sometimes they don't. I don't recall that he had.

Q. The top paragraph of this page it indicates he did make complaints of neck pain. Do you see that?

A. (Witness reviewing.)

Yes.

Q. Do you recall if you performed any sort of physical examination of Plaintiff's neck or cervical spine area on November 1, 2013?

A. No, I did not perform an exam of the neck or upper back at that time.

Q. Any reason for that?

A. I was not impressed that it was of significance.

Q. He also seems to have reported difficulty with sexual function?

A. Yes.

Q. Is there any sort of examination or testing that you conducted with respect to that particular complaint?

A. Nothing other than the exam of the lower back that I looked at.

Q. Under your Impression and Plan it says the majority of this gentleman's complaints and symptoms are axial in nature? What does that mean?

A. That means low back pain versus nerve pain. So axial essentially means confined to what we call the axial skeleton, which is the spine, spinal column itself and back.

Q. And as of this date, November 1, 2013, which was approximately one year

after his work-related fall, you still found that he was 100 percent totally disabled from work, correct?

A. Yes.

Q. And that was based on your examination and your review of his lumbar MRI?

A. Yes.

Q. Was that based on anything else?

A. His symptoms as well.

Q. Meaning what he relayed to you?

A. Yes.

Q. At that time did you find that he was a candidate for surgical intervention?

A. No.

Q. And why not?

A. Because the majority of his symptoms were low back pain related, and the primary indication for most surgeries is to take some pressure off nerves because of neurological problems, and I didn't feel that surgery in this patient at his young

age would be helpful in terms of making any back symptoms better.

Q. What did you suggest Mr. Antigone do going forward?

A. I had suggested that he continue conservative care, which is non-operative care, such as physical therapy and pain management and also to remain off work at that time to avoid excessive stress on the back until he resolved his condition.

Q. And as far as your treatment notes, records indicate, this was the only time you saw Mr. Antigone prior to April 8, 2016?

A. Yes.

Q. As part of your plan for him on November 1, 2013, was any part of that plan to follow up with you?

A. Only on what's known as a p.r.n. basis. In other words, if as necessary basis, should his condition deteriorate.

Q. And who determines if it's

necessary for him to come see you again?

A. Either the patient or any other physician who might be treating him.

Q. Other than Dr. Canty do you know of anyone else who was treating him in and around the time you saw him in November of 2013?

A. No.

MR. ZIMMERMAN: Mark this.

(Whereupon, the aforementioned two-page Bay Ridge Medical Imaging P.C. MRI report was marked as Defendant's Exhibit C for identification as of this date by the Reporter.)

Q. I'm going to show you what's been marked as Defendant's Exhibit C. Just let me know if that refreshes your recollection at all as to any records you may have seen with respect to Mr. Antigone with respect to his work related accident.

A. This would be consistent with an MRI taken after the work accident of November 7, 2012.

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Q. Are you able to tell if that's the film that you reviewed that you reference in your November 1, 2013 treatment record?

A. Yes.

Q. And what makes you say "Yes" looking at that document?

A. The radiology report does confirm a central disc herniation at L4-5.

Q. In addition to the disc herniation/protrusion it also indicates with annular fissure. What does that mean?

A. It means that there's a signal inside the disc annulus that has fluid within it that would be consistent with a defect or a tear.

Q. Is there a distinction between a herniation and a protrusion?

A. So in general -- protrusion is a more general term that refers to a sticking out, if will you, of disc material beyond the confines of the vertebral bodies. A herniation would more specifically refer to asymmetrical

protrusion or sticking out of disc material beyond the confines of the vertebral bodies.

Q. And how about a bulge?

A. A bulge would refer to a symmetrical protrusion or sticking out of disc material beyond the confines of the vertebral bodies.

Q. So is it fair to say that both a bulge and a herniation are both protrusions?

A. Yes.

Q. Bulge being symmetrical; herniation being asymmetrical?

A. Yes; correct.

Q. You said the annular fissure involves fluid, presence of fluid, which is usually a sign of some sort of tear or defect?

A. Yes.

Q. And that tear or defect is with respect to the disc itself?

A. The annulus of the disc. Actually, so it means -- when you see it on

an MRI it means that that fluid is a bright signal on the MRI, so that's how it pops up on the MRI as showing area of increased signal intensity.

Q. And you could obviously have a herniation without the presence of an annular fissure?

A. You can have a herniation without the presence of a visualized fissure. So you could have a herniation in the absence of fluid on the MRI, because the MRI is based on water signal changes. But technically, anatomically, or structurally, to have a herniation, or a bulge, or a protrusion there has to be some defect within the annulus, because it's the annulus's job to maintain the disc within the confines of the vertebral bodies.

Q. Is there anything that would be present on the MRI film that would indicate whether that herniation or that defect with respect to the disc is trauma based?

A. So, the presence of an increased signal intensity on an MRI if,

and you only see it in some circumstances, if you see it tells you that there's most likely inflammation within the disc. So if there's a history of a trauma and you see an annular fissure then you would tie the annular fissure to the trauma.

Q. Could you see the annular fissure if a patient didn't report an accident or any trauma?

A. You can. There are circumstances where you can have an increased signal intensity within the disc in the absence of a specific traumatic occurrence.

Q. Is it your testimony that there's sort of no way to tell one way or the other, other than to rely on the patient's reporting of an incident? In other words, to determine whether it's trauma-related or not?

A. Yeah. The MRI film is essentially one part of the diagnostic, for lack of a better term, puzzle to try to figure out what's happening with the

patient. So it has to be taken into consideration along with basically everything that's happening to that patient.

Q. The MRI report also indicates presence of central canal stenosis. What is that?

A. Stenosis is a term that refers to a decrease in the volume of the canal; and central canal stenosis is consistent with a central herniation, which means that if there's herniated material in the central portion of the canal it will narrow the canal in that region. So that's technically stenosis.

Q. Again, I guess back to my question of trauma or not, is that an indication of a traumatic event, the presence of central canal stenosis?

A. So central canal stenosis in general can either be -- there can be multiple reasons for it. But on this film, in this patient, it would be consistent with a work injury.

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Q. And that's again relying on the whole part of the puzzle with respect to this patient's reporting of the work injury?

A. Yes.

Q. Does the timing of an MRI film with respect to the timing of an incident have any role in the part of the puzzle? In other words, if an MRI film was taken just one week after an accident as opposed to taken six months after an accident does that play a role in the diagnosis and the puzzle that you're relying on?

A. Yes, it can.

Q. And how so?

A. Since it's a -- basically since the MRI is a snapshot in time, you can sometimes see things early on that you may not see later on. And likewise, there could be later MRI's that are taken that might show changes that are not seen initially. So as a snapshot in time it can give you information that's anatomically significant to the injury.

Q. This MRI film would appear to be taken 16 days after Plaintiff's, Mr. Antigone's reported work-related accident; is that correct?

A. Yes, I do agree.

Q. If the findings of this MRI film were related to his work-related accident, given the very short time period that followed, would you expect to see anything else on here that would be a sign of a trauma-related accident?

A. Nothing else that's not reported in the report, no.

Q. Although not indicated in your treatment records, recorded date November 1, 2013, this MRI film report indicates that at L5-S1 and L3-S4 there were disc bulges with facet arthrosis as well as L2-L3 disc bulge; is that correct?

A. Yes.

Q. Did you agree with those findings as well?

A. I don't recall because I don't have the film in front of me, but based on

what I recorded for the MRI, I didn't think that those were contributing factors to his condition when I first saw him.

Q. But I guess you have no way of knowing as to whether you agreed or disagreed with that, just the finding itself at those levels?

A. Correct. I'd have to look at the film again.

Q. What is dextroscoliosis?

A. So scoliosis means any displacement in what we call the coronal plane. So coronal is when I'm looking at you front to back, so if you're facing me directly your spine should be completely and entirely straight up and down. If there is any displacement of the spine towards one or the other side, you would technically have a scoliosis.

Dextro means that there is a displacement of the spine a bit toward the right. So there's an asymmetrical spinal contour towards the right.

Q. When you say "towards the

right" would that be since you were referring to when you're looking at me but towards the patient's right?

A. Correct, that's right. So it would be towards the patient's anatomical right side, which would be consistent with your right side of your body.

Q. And could that be either way, meaning the top half of the spine is towards the right or the bottom half of the spine is toward the right?

A. So since this is an MRI of the lumbar spine it would mean the lower portion of the spine.

Q. And what can cause dextroscoliosis?

A. So any number of things can cause a dextroscoliosis. You could be born with a dextroscoliosis or develop it over the course of your growth. Or it could be the consequence of a trauma, or a tumor, or an infection, or muscle spasm itself can also cause dextroscoliosis. So there could be multiple causes for that particular

displacement.

Q. Could general wear and tear on a spine depending on what a person does in their given day be the cause of something like dextroscoliosis?

A. Yes.

Q. If someone has dextroscoliosis are they more inclined to sustain herniations or show the presence of herniations and bulges in their spine?

A. It can be depending on the magnitude of the scoliosis.

Q. Just looking at this report is there any way to know the magnitude of Mr. Antigone's dextroscoliosis as of November 2012?

A. (After reviewing.)

No.

Q. What is facet arthrosis?

A. The facet joints are the joints that exist in between the spinal bones. They're on the back side of the spinal bones closest to your back. The disc is on the front side of the spinal bones, and the

joints are on the back side of the spinal bones. Arthrosis means an abnormal contour with degenerative changes in the appearance of the joints. So facet arthrosis refers to an abnormal appearance of the facet joints consistent with some degenerative changes.

Q. And what does degenerative changes mean?

A. So degenerative changes are generally, when talking about the joints, a thinning of the cartilage layer within the joint. So you could see that the joint surfaces become more closely approximated or closer together. It can also sometimes refer to an increase in size of the joint. So an increase in size, an abnormal contour of the joint or a thinning of the cartilage in the joint would all be considered types of joint arthrosis.

Q. And the fact that those things are labeled as degenerative changes, does that mean it's just something that happens over time?

A. That's correct. Those are wear

and tear changes that happen over the course of one's life.

Q. So according to this MRI film there were degenerative changes at the L5-S1 and L3-L4 levels with respect to the facet joints?

A. Yes.

Q. Are there any other findings on this MRI report that would reflect degenerative changes with respect to Mr. Antigone's lumbar spine?

A. (After reviewing.)

No.

Q. Before, when were you indicating, you were describing for me the difference between a bulge and herniation, one being symmetrical and one being asymmetrical, the fact that a bulge is symmetrical does that make surgical intervention any less likely as opposed to at a level where there's a herniation?

A. It depends on what the symmetrical protrusion of disc material is doing to the nerves and how that correlates

with what it's manifesting on a physical exam.

Q. In other words, if the bulge is symmetrical but it could be a large bulge?

A. That's correct. It could be large enough to result in stenosis that causes neurological problems.

Q. Or the location of it could be pressing on some nerve despite the fact that it's symmetrical?

A. Yes.

Q. Are you aware of Mr. Antigone going to an Emergency Room in July of 2011 with respect to pain in his back?

A. No.

Q. Do you recall if during any of the treatment that you've rendered to Mr. Antigone since November 1, 2013 if he ever complained about a fall on concrete steps leading to back pain?

A. No. The only fall that I had recorded was the November 2012.

Q. After falling a few flights of concrete steps and landing on his back and

tailbone would that, in 2011, would that change any part of your report dated November or treatment records dated November 1, 2013?

A. No, not significantly.

Q. With respect to his 2012 work-related accident, did you ever send Mr. Antigone for films yourself?

A. No.

Q. Did you ever write an actual prescription for any medication following his 2012 work-related accident?

A. No.

Q. And did you ever write a prescription for any of the conservative treatment that you discussed with him on November 1, 2013?

A. No.

Q. Did there come a time where you began treating Mr. Antigone again?

A. Yes.

Q. And when was the first time you saw him again after November 1, 2013?

A. February 3rd, 2017.

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Q. Did he present to you on February 3rd, 2017?

A. This was a car accident in April, April 8, 2016.

Q. And was he referred to you by someone else?

A. Yes.

Q. And who referred him to you?

A. I don't have it recorded.

Q. And why was he referred to you?

A. Once again he was coming in for symptoms related to his neck and back, which had what we call failed conservative treatment.

Q. And what was the basis of your understanding as to why it had been failed conservative treatment?

A. He had had therapy, medications, and epidural steroid injections, and was having what we call radiating symptoms traveling down into his legs.

Q. Do you recall if Mr. Antigone complained of radiating symptoms traveling

down into his legs in November of 2013?

A. (Witness reviewing.)

He did, yes.

Q. With respect to your evaluation in February 3, 2017 why had the conservative treatment in that case failed but had not failed when you saw him on November 1 of 2013?

A. Well, in November of 2013, when I had seen him, I don't know that he had had any -- I don't know at that time whether or not he had had any epidurals or not, and at least up until when I saw him in 2013 he had a significant amount of back pain.

Q. But in both cases he was referred to you more or less a year after his respective accident date; is that correct?

A. Yes.

Q. In both cases he was referred to you by some sort of provider who was providing either pain management or conservative treatment at that time.

A. Yes.

Q. The difference being this time, he had received injections whereas last time he hadn't?

A. As far as I know, yes.

Q. This time you were asked to evaluate him with respect to both his back and his neck?

A. Yes.

Q. And did you provide an examination of Mr. Antigone on February 3, 2017?

A. Yes.

Q. And what were the results of that examination with respect to the lumbar spine?

A. In his lower back his extension was 10 degrees. His forward flexion was 40. His right bending was 40. Rest bending also 40. His right rotation was 35, and his left rotation was 40. He had femoral stretch tests which were positive on both sides, and he had a loss of both pinprick and tactile sensation involving

mostly the L4 and the L5 roots of the legs.

Q. Looking at your November 1, 2013 report would you agree that Plaintiff demonstrated better range of motion with respect to his lumbar spine in February 2017 than he did in November of 2013?

A. Yes.

Q. And despite performing better with respect to his range of motion it was your opinion that he had failed conservative treatment in February of 2017 as opposed to --

A. Well, range of motion is only one part of the assessment.

Q. In addition to your examination, did you also review any records or films in preparation of your first consultation with Mr. Antigone in February of 2017?

A. I did look at an MRI of the lower back.

Q. If you're able to tell, when you indicate that he was undergoing conservative treatment, including therapy,

injections, medication, was that just based on the history he represented to you, or were you actually provided with those records to review?

A. I did review those records.

Q. With respect to the MRI of the lumbar spine that you reference in your February 3, 2017 report what did you find?

A. I had said that in the lumbar spine the thing that I found most significant was an L4-L5 herniation.

Q. Are you able to tell me what was different, if anything, with respect to the herniation that was found in the November 23, 2012 report at L4-L5 as opposed to the herniation that you found in the MRI that you reviewed for the February 3, 2017 examination?

A. Not based solely on the MRI, no.

Q. Do you believe any of the findings were different between those two MRI films?

A. I don't know. I never

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considered making assessment just based on the MRI, so I don't know.

Q. When you examined Plaintiff on February 3, 2017 and you reviewed that more recent MRI film would you compare it to the old MRI film?

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

You can answer.

A. Not necessarily, no.

Q. Would there be certain factors that would lead you to compare the films as opposed to not?

A. If there was a question in my mind based on his symptoms or his physical exam that led me to have an uncertain diagnosis or to suspect that there might be something else related to his problem, you might compare MRI films. But in terms of treatment, you're basically looking at the patient, doing an exam, and then using the MRI to confirm your diagnosis.

Q. And what was your plan for Mr. Antigone following your examination on

February 3?

A. EMG testing.

Q. And what do you send patients for EMG testing for?

A. Well, in this case it was to get an assessment of whether or not what I found on my examination was leading to or becoming a concern neurologically. So I was more concerned about his neurological condition here, and so that is one of the indications to get an EMG.

Q. Similar for a nerve conduction study?

A. Yes.

Q. Aside from the records you had reviewed prior to February 3rd's examination and the injections that Mr. Antigone had previously received, is there anything else that was forming or was causing you to be concerned about this patient on a neurological level?

A. I mean, based on his symptoms and history and physical findings, including the fact that I had known that he

had had a prior issue at L4-5, I think that my feeling at that time was he's worse now, and I'm concerned, so I thought an EMG would be indicated.

Q. And your opinion that he was worse now, again, is that based on how many treatments he had received up to that point?

A. In part, sure.

Q. And what else was it based on?

A. His symptoms and the physical findings.

Q. How were his symptoms that he was demonstrating worse than they were back in November of 2013?

A. Let's see. Just my overall gestalt based on having seen him before and having seen him yet again in February, I felt as though he had a significant issue which was of concern to me.

Q. And when did you next see Mr. Antigone after February 3, 2017?

A. April 14 of 2017.

Q. I'm just going to show you --

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MR. ZIMMERMAN: Go off the record a second.

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

Q. And what brought Mr. Antigone into your office on April 14, 2017?

A. It was a followup visit, and he had had nerve testing done.

Q. And what were the results of the nerve testing?

A. I had recorded them as nerve root electrical instability.

Q. What does that mean?

A. It means that the nerves were showing signs of a not working properly with respect to how they were controlling muscular function.

Q. Other than reviewing the results of the EMG's and nerve conduction studies with Mr. Antigone, had anything else occurred during that April 14, 2017 visit?

A. I did an examination and reviewed with him his current condition,

his symptoms, went over his treatment with him, looked at the MRI again, and then also looked at the EMG.

Q. Did you ever send Mr. Antigone for MRI's yourself?

A. No.

Q. And did you come up with a plan for him at that point?

A. So, at that time we discussed a decompression procedure known as a laminectomy and possible partial discectomy. Also known as a microdiscectomy.

Q. Tell me what a laminectomy is.

A. A laminectomy means a removal -- anytime you see the word ectomy it means removal of. Laminectomy, that means the covering of the spinal canal. So a laminectomy is a removal of a portion of the spinal canal done to take pressure off nerves, visualize the nerves, and get to any herniation that may be contained within the canal.

Q. And what is a microdiscectomy?

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A. So a microdiscectomy is another term for the procedure, which means utilizing a small incision to remove a portion of lamina, visualize the nerves, and then remove a portion of any herniated material that may be touching the nerves.

Q. Can you do a microdiscectomy without a laminectomy?

A. You have to do -- well, I won't say have to, but there is an overlapping of the lamina in the lumbar spine, and some lamina are more overlapped than others. So to be able to get in between lamina to safely enter the canal most, if not all times, you do have to remove a portion of lamina. Some rare cases the overlapping is nonexistent, really, and then you can sort of enter the canal region without having to remove lamina.

Q. It indicates that this procedure may also involve the L5-S1 level; is that correct?

A. Yes.

Q. And how so?

A. He had what appeared to be on the MRI a central portion of disc herniation at L5-S1. So when 4-5 was the majority of his correlative symptoms, but if doing the procedure I was unhappy with the amount of decompression at L4-5 I would also go down into the L5-S1 to make sure there was no pressure on any of the nerves in that region.

Q. And this was your second visit with Mr. Antigone following his April 2016 accident, correct?

A. Yes.

Q. And were any other options presented to Mr. Antigone at that time aside from this laminectomy and microdiscectomy procedure?

A. Yes.

Q. What else was presented to him?

A. Continuing nonsurgical care. In very much the same way we had done that beforehand as well. Continuing nonsurgical treatment and not proceeding with a surgical procedure.

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Q. And what did Mr. Antigone decide?

A. He decided to proceed with the lumbar procedure.

Q. Were any other physicians or doctors consulted with respect to that decision?

A. When you say "with respect to the decision" I'm not sure what you mean.

Q. Sure, I'll rephrase. I guess you discussed a few options, right? You discussed the laminectomy and microdiscectomy procedure, and you also discussed continued conservative treatment, correct?

A. Yes.

Q. Did you have a recommendation as to one or the other at that particular point?

A. So we just discussed what are called the risks and benefits or realistic goals and expectations of surgery and advantages and disadvantages of surgery versus non-surgery, laid those out along

with potential complications, and let the patient make an informed decision about whether or not they wanted to proceed with surgery.

Q. And what are some of the -- what was the intended goal of this particular recommended procedure?

A. The primary reason or rationale for doing the surgery, also known as the indication for the surgery, is to prevent further neurological deterioration; that is, nerves that are irritated and not functioning properly can continue to have further deterioration in function as exhibited on the EMG.

So the EMG tells us about how the nerve is working when it's inside the muscle, and that's an important nerve function, because if that nerve deteriorates that will lead to muscle weakness, atrophy and could lead to difficulty walking, for example.

So the goal of surgery is to get pressure off the nerves in order to

give that nerve an opportunity to breathe, if you will, and to prevent it from getting worse. That's the ultimate goal of doing a decompression surgery.

Q. And the risks with respect to that procedure?

A. So the risk for this particular procedure are first of all, a general anesthetic, because there's a general anesthesia that's involved. There is a skin incision. So anytime an incision is made there is the risk of a possible infection for which we give antibiotics both before and after surgery. There's always the risk of bleeding with any type of an incision. The nerves are irritated, so there can be a risk of nerve, further irritation from having to move them out of the way to get to the disc, so we do spinal cord monitoring in order to prevent that particular problem.

And then afterwards there's a healing process where the incision, the muscles and the tendons and the joints and

the bones and the discs need to heal. So those tissues are also at risk for not healing properly after surgery. And these are some of the more short-term potential complications from the operation.

Q. So the risk for continued conservative treatment would essentially mostly rely on the fact that you could just be continuing in the direction that you're currently going?

A. That's correct, yes.

Q. And in presenting these two options to Plaintiff prior to, to Mr. Antigone prior to doing so, did you consult with any other of his treating providers at that time?

A. No.

Q. Do you know if he spoke to any of his other treating providers about the two options you presented before making his decision?

A. I don't know.

Q. And he ultimately decided to go forward with the surgery, correct?

A. Yes.

Q. And when did that surgery take place, if you remember?

A. So that was done on June 20 of 2017.

Q. And where did that surgery take place?

A. Mount Sinai Hospital.

Q. And for a procedure like this what is required of Mr. Antigone prior to the operation, if anything?

A. Patient's generally do some presurgical testing before the surgery itself.

Q. Is this a procedure that is done and patient is discharged same day?

A. Yes.

Q. Did you yourself perform this procedure?

A. Yes.

Q. How long does this procedure take, start to finish, approximately?

A. Yeah, it can vary. In general, uncomplicated partial discectomies for the

surgical time, because anesthesia time can vary more than the surgical time, the surgical time is generally somewhere in the neighborhood of about 45 minutes plus, minus 15 minutes or so in an uncomplicated case. Although anesthesia appears to be a little more variable, because it depends upon the patient's ability to metabolize the anesthetic.

Q. The 45 minutes plus or minus 15, that's excluding the anesthesia time?

A. Yes.

Q. Is there any way reviewing this operative report any indication that this was complicated, or there were complications, or this took a significantly longer time than the timeframe you provided?

A. No. This is an uncomplicated procedure.

Q. What was your opinion as to how the surgery went?

A. My opinion was that it had gone well.

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Q. Were you able to -- is remove the herniation a correct term?

A. Yes.

Q. And were you able to remove the herniation?

A. I did remove the herniation at L4-5 yes.

Q. Did you have to do anything with respect to the L5-S1 level?

A. I did not.

Q. And why was that?

A. So the intraoperative findings at L5-S1 were that there was asymmetrical protrusion of the disc fibers, but there was no discrete herniation inside the canal itself, and there didn't appear to be any significant pressure on the nerves at L5-S1.

Q. In intraoperative findings it says you found a rupture in the annulus?

A. Yes.

Q. Is that something that was not shown on the prior MRI reports, if you know?

A. Yeah, that wasn't visualized.

Q. And what was that an indication of?

A. That was consistent with the disc material herniation.

Q. Is a rupture in the annulus a more significant annular fissure?

A. So a fissure is a defect in the annulus. This is described as a rupture primarily because when looking at it -- so we're looking -- when you do a surgery you're looking -- you know, the MRI looks at specific slices through the disc, right? So you can see kind of like inside the disc and portions of the outside of the disc.

When you're doing a surgery you're really looking directly outside in, because you're looking down onto the disc, and you're looking in the area of the canal. So a rupture describes a disc continuity of all the annular fibers with this inner-like jelly material sticking out of the disc. So it's a bit more detailed than you were able to visualize on the

particular MRI that he had preop.

Q. Was there anything else found during this operation that was not previously known going in with respect to Mr. Antigone's lumbar spine?

A. No.

Q. And when you said the surgery was a success and that you had removed the herniation, did you expect that Mr. Antigone's condition would improve going forward?

A. Yes.

Q. At that moment that the surgery was over did you have any reason to think that his prior complaints and condition would continue?

A. Well, it depends on what parts of his condition we're looking at. So the primary reason for the surgery is the neurological issue, and I was rather confident that his neurological condition would not deteriorate.

Surgeries are not always very good at making back pain or back symptoms

go away, and that's one of the reasons why I hadn't recommended it previously. So prior, my impression was this axial back pain issue, and in this case it was more of a neurological condition. So neurologically I was happy here, and I thought that he would have a typical postsurgical course based on his neurological condition.

Q. You indicated you were pretty confident that his neurological condition would not deteriorate. Is that the same as -- I guess it's not the same as his neurological condition would improve.

A. Well, a decrease in radiating pain. So the nerve does several things. The nerves do several things. One is they feel pain. Two is they feel sensation. Three, they work the reflexes in your legs, and No. 4 they work the muscles in your legs. These types of surgeries are very helpful for making the pain that radiates, or travels, get better, and they're also very helpful in preventing the muscle component from getting worse. So I thought he would

fulfill those criteria postsurgically.

Q. And what were your instructions for Mr. Antigone following this surgery?

A. So following this surgery the instructions include, first of all, activities as you tolerate them, because you have a healing incision that is going to be tender and painful in the area of the incision. And you have a disc that's also healing.

The collagen of the disc is generally somewhere about eight to twelve weeks to form what we call a mature collagen plug that starts to scar over. So heavy lifting at that time is to be avoided. And for the incision to heal, which is usually about six to eight weeks, you avoid bending forward because that puts a lot of stress on the low back, also lifting and also twisting at the waist. Other activities can really be on an as-tolerated basis.

Q. Anything else with respect to your instructions following the procedure?

A. No. Those are usually I usually summarize it as saying no BLT, bending lifting and twisting.

Q. How about treatment going forward? Is any of that necessary?

A. So the most important part of treatment is really being up and walking. Walking is really the best exercise after a low back surgery. Physical therapy can be helpful to decrease some muscular soreness, and that's usually based on the patient.

Q. When did you next see Mr. Antigone following the June 2017 surgery?

A. So the first postoperative visit was July 14 of 2017.

Q. And what, if anything, occurred during that visit?

A. So that was the first postoperative visit. So we're essentially checking to make sure there haven't been any surgical complications, and we're checking to make sure that he is progressing with the healing process. So on that day it's an exam in order to make sure

we don't have(1) an infection, (2) anesthetic complications, or (3) any neurological complications.

Q. And as of July 14, 2017 were there any surgical infection issues?

A. No.

Q. Were there any anesthetic issues?

A. No.

Q. Were there any neurological issues?

A. No.

Q. With respect to your treatment notes that day it indicates there were no acute complaints.

A. Yes.

Q. What does that mean?

A. That means he didn't come in saying "My leg hurts more"; or "My back pain is horrible"; or "I have a headache or stomachache"; or "a flu symptoms" or any other issues that would lead me to believe that something had happened postsurgically.

Q. Under your Physical Examination

section, the last line, it says that: The sensory motor and neurological function of the upper and lower extremities tested today and compared to preoperative findings and found to be stable.

The use of the word "stable," is that meant to indicate that the findings were improved as opposed to the preoperative findings? Or does that mean something different?

A. Something different.

Q. Okay. What does the use of "stable" mean?

A. No progressive deficits. So when manipulating the nerves to get to the disc, as we had previously indicated, a risk is that you could further irritate a nerve and either cause pain, or weakness, or another neurological problem and that was not found here.

Q. Under your Impression and Plan you advise that Mr. Antigone may start physical therapy on an as-tolerated basis. Do you know if he did in fact start

physical therapy?

A. I believe he did.

Q. And then at some point did you see him again?

A. I did. I then saw him, we saw him in July of 2017. And then it looks like I saw him in February of 2018.

Q. Is it common for you to have gone roughly six or seven months between visits?

A. Yeah. Postsurgically if there are no major issues patients oftentimes have massive intervals between the times they come back to see me. And sometimes folks that are really doing well can linger for even more time.

Q. As of February 19, 2018, from your position was this surgery still a success?

A. Yes.

Q. From Mr. Antigone's position did he also believe that the surgery was still a success?

A. I'd have to just check his --

Q. Sure.

A. Let's see. Helpful in terms of that was the radiating symptoms, so he had indicated that that was helpful. Sure.

Q. Were there any instructions for him going forward as of February 19, 2018?

A. Sure; yes. I did indicate that he could try to go back to work if he could tolerate doing so.

Q. During this whole time period we haven't really discussed Mr. Antigone's cervical spine or his neck. I know he initially in February of 2017 presented to you with complaints of neck and back pain and you did examine his neck on that date, correct?

A. Yes.

Q. After that initial consultation with respect to his cervical spine did you render any further treatment to his neck?

A. I didn't -- I did not recommend anything surgical. And the primary focus was the lower back.

Q. During all your followup visits

with Mr. Antigone did he ever continue to express any issues of pain with respect to his cervical spine or neck?

A. When I saw him in February I did palpate his neck and looked at his overall range of motion. And when I saw him in September of 2018 I had examined his neck as well, and it appeared to be essentially stable, no progressive problems.

Q. During your physical examination of Mr. Antigone on February 19, 2018, the examination demonstrated spasm in the cervical, thoracic, and low back region. What does that mean?

A. It means spasm is an abnormal contraction of muscle. So when palpating the spine and looking at overall range of motion you'd generally take the motion up to where the patient has a spasm. So you can palpate spasm to help you determine a range of motion.

Q. So that's not an abnormal finding on examination?

A. It would be abnormal in so much is it's an abnormal contraction of muscle. To splint a body part to prevent it from being placed into a painful, a painful position.

Q. Okay. But it's a finding that you were intending on reaching? In other words, you were testing to the point of seeing a spasm be demonstrated?

A. I would not -- I was not surprised by spasm when testing range of motion. Yes, that's correct.

Q. It occurs common during examinations?

A. In patients with spinal pathology, yes.

Q. And you saw Mr. Antigone one last time?

A. Yes.

Q. And when was that?

A. September of 2018.

Q. And why did you see him in September of 2018?

A. He had come in for a followup

at that time.

Q. Just a general followup or was there something that --

A. Let's see.

Q. Meant for him to come in that time?

A. I don't see that there were any new or acute complaints at that time.

Q. This treatment record, or I guess you want to call it a report, is much more detailed than your prior, his prior visits; is that correct?

A. Yes.

Q. What was the basis for that?

A. Just -- let's see, September of 2018, it had been over a year since we operated on him, so we operated in June, so it had been almost a year and a quarter or so postop. So it's a good postoperative baseline exam.

Q. In addition to sort of a treatment record from his visit that day is this also a general summary of his entire treatment with you following this

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particular accident?

A. In and itself, no. Just based on the history section whether or not there were any new complaints, and then an exam to see whether or not he remained neurologically stable or not.

MR. ZIMMERMAN: Let's go off the record.

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

MR. ZIMMERMAN: We can go back on.

Q. So it looks like the last time you actually saw him, I was mistaken, I was looking at a date on a narrative, the last time you saw him was September 10, 2018 not September 13, 2018?

A. Correct.

Q. At some point following that last visit on September 10 you created a narrative on September 13 sort of encompassing all of his visits; is that correct?

A. Yes.

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Q. As of September 10, 2018 it appears, according to your treatment notes, that Mr. Antigone indicated the surgery was helpful but he does have some residual numbness and tingling.

A. Yes.

Q. Is that common?

A. Yes.

Q. Does that ever go away?

A. If it's going to go away it's usually within a year postop. Usually that's when we say maximum medical improvement at some time about a year or so. So I think we're -- September 2018, he's a year and three months postop, so he does -- so that's why it would be some residual.

Q. In the past you had told him he could resume work duties; however, here it says he's back to no -- to the BLT thing that you were mentioning before.

A. Yes.

Q. What changed as of September 10, 2018?

A. I don't know.

Q. Did you find anything different on his examination that day that would have led you to sort of change your plan for him going forward?

A. No, the plan was pretty much the same. I told him to avoid activities that reproduce and then other activities on an as-tolerated basis.

Q. But with respect to your examination did anything new pop up on your examination of Mr. Antigone that day that would now lead him to no longer be able to do any of the lifting, bending and twisting?

A. No.

Q. Is there any reason why you told him no lifting, bending, and twisting on that date?

A. Those are typically things that could reproduce pain, so just as a matter of precaution don't forget, try to avoid bending, lifting and twisting particularly if they cause pain.

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Q. But this wasn't some sort of directive like you're back to where you were, like, immediately after the surgery because of some setback or some additional finding you found on his examination that day?

A. Correct. It is not.

Q. This type of surgical procedure that you performed on Mr. Antigone, would you expect to see an improved range of motion with respect to his lumbar spine following the procedure?

A. Sometimes you can. And sometimes you don't. The range of motion is and can be variable.

Q. And what would that vary based on?

A. Depends on how much pain they're having.

Q. Would it surprise you that Mr. Antigone demonstrated the exact same range of motion in his lumbar spine in February 2017 and September of 2018?

A. No.

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Q. What made you examine his cervical spine on September 10, 2018 after not really examining it over a few of his prior visits?

A. Just to make sure it wasn't progressively getting worse.

Q. Would it surprise you that his cervical spine range of motion was exactly the same on February 3, 2017 and September 10, 2018?

A. No.

Q. Can you tell me what's meant by your last sentence in this treatment note of September 10, 2018?

A. (Witness reviewing.)

The last paragraph, which is I think would be the sentence, that one?

Q. Yes.

A. Yeah.

Q. Surgery.

A. Basically, patients who I think at this point in time, Christopher is in his early 40s, who have had at least two incidents that we know of with their lower

back, who have persistent what we call mechanical axial pain in their lower back, these are the kind of patients that are at risk for future surgeries as they get older. So it's something that they need to be aware of and we are able to follow should they have any problems in the future.

Q. As of September 10, 2018, did you have any reason to believe Mr. Antigone would need a future surgery?

A. Certainly a patient at risk for future surgery, yes.

Q. But there was no current recommendation for a future surgery at that time?

A. Correct.

Q. Would you say it was just as likely he would not need a future surgery?

A. It's really more of an age-related issue. So in -- I would say if he were far older, less likely. Younger, more likely. So early 40s, more likely than not over the course of his life to require a

future surgery.

Q. And the need for that future surgery would be based on his entire history of back issues, not just back issues related to April 8, 2016; is that correct?

A. Sure. I mean, it's based on him as an individual, sure.

Q. In other words, his work-related accident in 2012 and the fall in 2011 that I referenced in the Emergency Room records would also play a role in the need for any future surgery he may have?

A. Some need, yes, of course.

Q. Do you have any future plans to see Mr. Antigone again, any scheduled appointments?

A. Not that I'm presently aware of.

Q. Do you have any reason to believe his condition has deteriorated or worsened since your last visit with him in September of 2018?

A. Had it, I would anticipate he

would have returned.

Q. I'm just going to go over your narrative with you dated September 13, 2018. Under your causation paragraph you indicate: Within a reasonable degree of medical certainty the accident occurring on April 8, 2016 is the competent cause of some aggravation/exacerbation of preexisting injury but also new injuries for this accident sustained to Mr. Christopher Antigone's low back and neck requiring surgical intervention to the lumbar spine.

A. Yes.

Q. When you say new injuries what are the new injuries you're referring to?

A. Neurological. Radiculopathy.

Q. And that's with respect to the nerve discussions we've had today?

A. Yes.

Q. Any other new injuries that you are stating were caused by this accident of April 8, 2016?

A. No. Not specifically.

Q. And what is the preexisting injury that you are stating this was the cause of some aggravation and exacerbation of?

A. He had a prior herniation of L4-5 and had had a prior history of back pain.

Q. Can you have lumbar radiculopathy without the presence of a herniation or a bulge?

A. You can. And in that case it would have to be related to some of the other conditions that can lead to a lumbar radiculopathy. So there can be compression of the nerve outside of the spinal canal. There can be a tumor within the nerve or outside the nerve that can cause a radiculopathy. There can be intrinsic neurological disease, which could also lead to a lumbar radiculopathy. So those are some of the more obscure rationale for having a lumbar radiculopathy.

Q. With respect to Mr. Antigone it's your position that the radiculopathy

he was presenting with was as a result of his L4-5 herniation?

A. Yes.

Q. Following his 2012 work-related accident do you know if Mr. Antigone underwent any EMG or nerve conduction studies?

A. I hadn't seen any.

Q. Do you know, aside from those two particular types of tests are there any other tests or findings, I mean tests, or examinations, or studies that would help one determine whether a patient had radiculopathy at a given time?

A. When you say at a given time I'm not quite sure what you mean.

Q. Sure. Following your one-treatment visit with Mr. Antigone in November of 2013?

A. Yes.

Q. You did not send him for an EMG or conduction study, correct?

A. Correct.

Q. But during your first visit

with him following this accident you did.

A. Yes.

Q. And it was the study findings following that EMG that led you to confirm that he had lumbar radiculopathy?

A. In part.

Q. What else helps you confirm that he had lumbar radiculopathy?

A. His physical exam and the MRI, of course.

Q. What on the MRI films showed or confirmed the presence of radiculopathy?

A. Compression on the nerves at L4-5.

Q. And you recall that that was present on that film?

A. Yes.

Q. Is there anywhere in your treatment notes that would reflect that?

A. Just in so much as I had when I reported the MRI I reported that the L4-5 level was of concern to me based on his examination.

Q. Is it possible had you sent Mr.

Antigone for an EMG or nerve conduction study in November of 2013 that that study would have shown he had lumbar radiculopathy?

A. I don't know. I don't know what it would have shown at that point in time. Anything is possible.

Q. You also have a paragraph in your narrative dated September 13, 2018 that discusses future care and management. This indicates Mr. Antigone will require continued orthopedic observational care and management visits approximately one to two times per year at a cost of 275 per visit for his neck and back.

What is your basis for forming the opinion that he needs continued orthopedic observational care at this point?

A. It's just based on his course over time where he has persistent pain. So optimally, once to twice a year to make sure there's no clinical deterioration is optimal for a followup.

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Q. Do you know if in the year-plus since you last saw Mr. Antigone if he's actually gone for orthopedic observational care?

A. I don't know.

Q. It also states: He will require surgical intervention in the future in the form of revision lumbar surgery at the cost of $125,000 as well as possible surgical -- cervical surgery at a cost of $125,000 should radiculo --

A. Athy.

Q. -- radiculopathic symptoms progress?

A. Yes.

Q. Here you're saying he will require surgical intervention in the future in the form of a revision lumbar surgery. Before we discussed him being just at risk for the same.

Will he definitively, definitely need lumbar surgery in the future?

A. I would say it's more likely

than not, given his age, at some point in time in his life, in his lifetime.

Q. Is there any way of knowing what type of surgery is more likely than not to be needed? With respect to the lumbar spine?

A. Yeah, usually patients over the course of their life, because of the normal degenerative condition that occurs will more likely than not require fusion surgery.

Q. And why is it a fusion surgery that would particularly be needed?

A. Fusion surgeries are generally undertaken where there is progressive disc space collapse whereby the joints themselves need to be removed to open the nerve openings up, and in general those types of surgeries require a stabilization because of joint removal. That's the most common reason.

Q. And with respect to that he will require possible cervical surgery should the radiculopathic symptoms

progress, are you able to say as of now is that more likely than that that he will require that surgery less likely than not?

A. I would say that's less likely in the lower back.

Q. How about just less likely than not?

A. I wouldn't disagree with that.

Q. Okay. Further discussion of future care and management, including physical therapy four times a month, cost of 150 per visit for his lifetime. Is that a typical treatment plan for someone who has undergone a laminectomy/discectomy?

A. It's optimal treatment for a patient with persistent mechanical pain, which would be along the lines of conservative treatment for back pain.

Q. If Mr. Antigone is feeling fine is that type of treatment that's necessary?

A. No.

Q. In other words, it's not necessary to prevent symptoms from occurring? It's something, the treatment

that would be necessary if he's still exhibiting symptoms or --

A. Well, it's maintenance, and generally maintenance is undertaken where patients do remain symptomatic.

Q. It further says he'll require MRI's to the neck and back once every two years.

Since the MRI you reviewed in -- at his first visit, February of 2017, do you know if Mr. Antigone has gone for any additional MRI's?

A. Not that I'm aware of.

Q. You'd agree that more than two years have passed since you first saw him in February of 2017, correct?

A. Yes.

Q. So what is the basis for suggesting that he will need one every two years if he hasn't had one in the last three almost?

A. It's optimum care for postoperative patients that remain symptomatic to obtain a postoperative MRI.

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Usually within one or two years depending upon their symptoms.

Q. But you've never sent him for one since you started treating with him, correct?

A. Yes; correct.

Q. When taking into account a patient's medical history that they present to you at examination, do you take into account the timeframe as to when an initial complaint was made with respect to a particular part of the body in terms of a timeline from an accident date?

A. Sure.

Q. Would any of your opinions in this case change if you knew that Mr. Antigone did not make any back complaints when he sought treatment for the first time following April 8, 2016?

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

A. No.

Q. And why is that?

A. Well, some disc problems can

start to occur over time as patients weight bear. It depends, as with anything else, the spectrum of injury. And some injuries can take time to manifest themselves, which is why Emergency Room treatment is not definitive. It's primary, and it's focused on either a life-or-limb-threatening issue, but it's not all-inclusive.

Q. Would the fact that Mr. Antigone -- I see you noted in your narrative that he suffered from asthma. Why is that significant with respect to either your treatment or your findings?

A. It might have implications for the general anesthetic.

Q. Would it have any other basis with respect to your treatment or your findings with respect to his lumbar or cervical spine?

A. Not significantly, no.

Q. How about insignificantly, how would it affect?

A. Sometimes patients with asthma are treated with steroids. So as they age,

you can develop osteoporosis from chronic steroid use, so that's something we think of in older adults who have a history of asthma that may have been treated with either a steroid inhaler or oral steroids, that's one issue. That's really the primary musculoskeletal issue that I can think about with patients who have asthma or an asthma-like syndrome.

Q. How about smoking? If someone was a smoker would that affect the treatment you've rendered or the conclusions you reached?

A. Smoking can sometimes affect the way spinal fusion procedures heal. So they can sometimes influence the healing aspect of patients who have undergone or undergo spinal fusion.

Q. It wouldn't affect the healing on a laminectomy/discectomy procedure?

A. No.

Q. Why one versus the other?

A. It has something -- we think there is some evidence that tells us that

smoking within a certain timeframe of having a spinal fusion can interfere with the way bone cells heal, and so bone growth and bone healing can be affected by the smoking process.

Q. What is neural impingement?

A. Nerve impingement.

Q. And the presence of neural impingement on a film would indicate -- is that the same as saying there's radiculopathy?

A. No, because the film has to be correlated with the physical finding. So you can have a film finding that may not correlate with a physical finding.

Q. Neural impingement would be something found on a film?

A. It could be a phrase you describe -- you use to describe findings on a film.

Q. Do you know if neural impingement was present on the film you reviewed in either 2016 or 2017?

A. Yes.

Q. And how do you know that?

A. Well, I have my surgical -- his physical findings correlated with the MRI film, correlated with surgical findings.

Q. What is disc desiccation? Did I say that right?

A. Yes, you did. And desiccation refers to a drying, a drying out, so a loss of water. And when describing an MRI film, because the MRI film is based on water signal, so the shades of gray that are on the MRI film are based on the water signal.

In general, the term desiccation means a loss of water signal usually referred to with respect to the disc when looking at an MRI film.

Q. Is that an indication of anything?

A. Yes.

Q. What is that an indication of?

A. So generally as you age, your discs will lose water as time goes on. That's one of the components of the typical degenerative process.

Q. So is that water something that's different than fluid that we were discussing earlier today?

A. So it is a fluid, and every fluid signal that you see on an MRI has to be based on where it is and what the quality of that fluid signal is. In general, we were previously talking about an annular fissure, which meant a bright signal or an intense water signal in just one little specific area of the disc.

Q. Okay.

A. In general, when you refer to desiccation you're referring more to an overall disc appearance, comparing one disc to the other. So it's the color of the entire disc as compared to other discs when you're using the term desiccation.

Q. Sorry, again what does the presence of disc desiccation indicate?

A. A gradual loss of water signal, water fluid within the substance of the disc.

Q. And what is that? What does

that mean or what is that based on? What causes that?

A. Sure. It happens as you -- after you achieve skeletal maturity and you are starting to wear down your body parts more than you are replacing them, desiccation happens gradually over the course of time.

Q. Is desiccation an indication of a degenerative condition?

A. Yes, it can be.

Q. Can it be a representation of a traumatic condition?

A. It can also be, yes.

Q. And how about a herniated nucleus pulposus?

A. Yes.

Q. What is that?

A. That's a disc herniation. And it's specifically referring to the jelly-like core of disc material that is protruding beyond the confines of the vertebral bodies.

Q. Do you know if there was any

disc desiccation present on any of the or either of the two MRI films of Mr. Antigone that you reviewed?

A. I believe in looking at the reports there was some indication of some disc desiccation, yes.

Q. Are you able to say one way or the other whether that disc desiccation was caused or the result of degenerative condition as opposed to a traumatic condition?

A. Desiccation in patients over the age of 30 such as Mr. Antigone would most likely be caused by the normal degenerative process over time.

Q. Would the fact that Mr. Antigone was a plumber as his employment play a role in some of the conclusions you may reach with respect to his MRI findings, or your examination of him? In other words, does a plumber who is on his feet and is using his arms and his back on a daily basis as opposed to someone who sits at a desk all day long?

A. Actually, in some ways a person who is active during the day may actually have a better spinal condition than someone who sits all day, so in general I wouldn't be able to make that correlation.

Q. If I represent to you that my expert in this case, Dr. Kim -- have you ever seen his report in this case?

A. No.

Q. If I represented to you that he said there was no significant neural impingement seen on Plaintiff's 2016 lumbar spine MRI, would you disagree with that statement?

A. Yes.

Q. If a film report indicates that there is a presence of degenerative disc disease what does that refer to?

A. So the report -- so there are three terms there that we need to look at. The first one is degenerative, and that would refer to a loss of water signal. Disc, which would mean a loss of water signal within the discs. And then the last

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term, which is disease, which I generally disagree with radiologists using the term, because disease has to be symptomatic and the radiologist would not know whether the patient was or was not symptomatic from the degenerative disc. So in general that terms means a process occurring within the discs that's a consequence of the aging process where there is a loss of water signal.

MR. ZIMMERMAN: All right Doctor, no further questions. Thank you.

THE WITNESS: Yeah, my pleasure.

MR. FLYNN: I have.

MR. ZIMMERMAN: Go ahead.

EXAMINATION BY

MR. FLYNN:

Q. Doctor, why did you refer Mr. Antigone for an EMG in 2017 but not '13?

A. I was more concerned about his neurological condition when I saw him in 2017 than I was with his previous condition.

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Q. And his previous condition I think you told us was axial back pain as opposed to the neurological condition?

A. Yes.

Q. Do you have an opinion with a reasonable degree of medical certainty as to whether the car accident in 2017 that's the subject of this lawsuit was a competent producing factor of the neurological conditions?

A. Yes.

Q. Would you explain that opinion, please?

A. Sure. I believe that it was the reason or the competent producing cause of his neurological findings, traveling down into his legs, that were correlated with the physical exam and the nerve testing, and the MRI, and the operative findings.

Q. And do you have an opinion with a reasonable degree of medical certainty as to whether that car accident was a competent producing factor of the need for

the surgery that you performed?

A. Yes.

Q. Would you please explain that?

A. Sure. Because of his neurological condition and in order to prevent the neurological condition from getting worse, that was the primary rationale or indication for surgery.

Q. And I would like you to presume, Doctor, that Mr. Antigone has testified that he continues to suffer from some pain and restrictions in his activities of daily living that prevent him from performing his previous employment as a plumber. Does that surprise you?

A. No.

Q. Do you have an opinion with a reasonable degree of medical certainty as to whether the car accident could reasonably be expected to prevent him from working as a plumber in the injuries he sustained in that car accident?

A. As best I can tell and within a reasonable degree of medical certainty,

persistent pain after having had the accident would prevent him from heavy labor as a plumber.

Q. And just one more, Doctor. Counsel asked you a moment ago about his own expert's opinion. I'm going to read to you a section of that opinion: It should be noted that the actual MRI images of the lumbar spine were not available for my personal review. Therefore, the clinical significance of the reported findings in the lumbar spine as they relate to the surgical intervention cannot be determined at this point.

It then goes on to opine that it appears that the surgery was performed on the Claimant to address the preexisting changes noted in the lumbar spine.

In the absence of reviewing those MRI films, Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether Dr. Kim's conclusion in that regard is reliable?

A. Well, I think Dr. Kim explained

his opinion based on the fact that he's looking at the report and hadn't seen the film yet. So I mean, you have to look at the film and of course correlate the film with his physical findings and then further correlate it with any operative findings.

Q. Do you have an opinion with a reasonable degree of medical certainty, Doctor, as to whether his conclusion that the surgery was performed to address the preexisting changes is accurate?

A. So I would respectfully disagree with the fact that it was undertaken for preexisting degenerative changes in and of themselves.

Q. And in fact that's not an opinion, that's your factual determination, correct?

A. Yes.

MR. FLYNN: Thank you, Doctor.

FURTHER EXAMINATION BY

MR. ZIMMERMAN:

Q. Just one followup on the Dr. Kim issue. Before, when I read to you that

Dr. Kim found that there was no significant neural impingement seen on that particular film and you respectfully disagree with his opinion, I'm going to report to you that he did in fact review those films and that statement I'm reading is from his report, his supplemental report, in which he did in fact review that film and that was his finding following his review thereafter of that film.

So just to the extent do you still disagree with his position whether he saw the film or not? I mean, he did see the film, but does that change the fact that you disagreed with him?

A. No. I would respectfully disagree with his opinion.

Q. Okay. And before Counsel asked you, he made an indication that it was in fact fact, not opinion. But it's your opinion that the surgery was necessary following this car accident, correct?

A. Yes.

Q. It's a fact that he had it.

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It's not a fact that it was -- it's your opinion as opposed to a fact that that surgery was required following this car accident?

A. Yes.

MR. ZIMMERMAN: No further questions.

FURTHER EXAMINATION BY MR. FLYNN:

Q. Why did you perform that surgery?

A. To prevent further neurological deterioration.

MR. FLYNN: Thank you.

MR. ZIMMERMAN: Good.

(Whereupon, at 1:07 P.M., the Examination of this witness was concluded.)

° ° ° °

ANDREW MEROLA, M.D.

D E C L A R A T I O N

I hereby certify that having been first duly sworn to testify to the truth, I gave the above testimony.

I FURTHER CERTIFY that the foregoing transcript is a true and correct transcript of the testimony given by me at the time and place specified hereinbefore.

_____

ANDREW MEROLA, M.D.

Subscribed and sworn to before me this _____ day of _____ 20___.

_____

NOTARY PUBLIC

ANDREW MEROLA, M.D.

E X H I B I T S

DEFENDANT EXHIBITS

EXHIBIT LETTER	EXHIBIT DESCRIPTION	PAGE
Exh A	Document entitled Plaintiff's Expert Exchange	8
Exh B	Evaluation note	14
Exh C	Two-page Bay Ridge Medical Imaging P.C. MRI report	25

(Exhibits retained by Counsel.)

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(None)		

* * *

ANDREW MEROLA, M.D.

C E R T I F I C A T E

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

I, NORAH COLTON, CM, a Notary Public for and within the State of New York, do hereby certify:

That the witness whose examination is hereinbefore set forth was duly sworn and that such examination is a true record of the testimony given by that witness.

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

IN WITNESS WHEREOF, I have hereunto set my hand this 30th day of January 2020.

Norah Colton, CM

NORAH COLTON, CM

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NAME OF CASE: Antigone, Chris v. Rojas, Pedro, Jr & Conway Systems Llc

DATE OF DEPOSITION: 1/3/2020

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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