WCB#G2333899

STATE OF NEW YORK

WORKERS' COMPENSATION BOARD

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CLAIMANT: ALASTAIR KENNEDY

WCB#: G2333899

EMPLOYER: 3RD TRACK CONSTRUCTORS

DATE OF ACCIDENT: 10/29/2019

CARRIER: LIBERTY MUTUAL INS.

CARRIER'S CASE#: WC205-C93361

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August 14, 2020
9:31 a.m.

Telephonic deposition of Dr. Alexander DeMoura, a nonparty witness, taken by all parties, held at the above-mentioned time, pursuant to Workers' Compensation Law and Rules of Testimony, before Amanda DePalma, a Shorthand Reporter in the State of New York.

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

GOLDBERG & ALLEN, LLC

Attorneys for Claimant

101 Front Street

Mineola, New York 11501

BY: ANDREW GOLDBERG, ESQ.

(Via Telephone)

THE CHARTWELL LAW OFFICES, LLP

Attorneys for Carrier

One Battery Park Plaza, 35th Floor

New York, New York 10004

BY: MISHA IOKHELES, ESQ.

(Via Telephone)

ALSO PRESENT:

Dr. Alexander DeMoura

WCB#G2333899

S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and between the attorneys for the respective parties hereto that all rights to object to any questions, except as to the form, or to move to strike any testimony at this deposition, are reserved, and, in addition, the failure to object to any question or to move to strike any testimony at this deposition shall not be a bar or waiver and said objections or motion is reserved for the hearing before Workers' Compensation Law Judge.

IT IS FURTHER STIPULATED AND AGREED by and between counsel for the respective parties hereto, that this deposition transcript may be utilized for all purposes as provided by C.P.L.R.

IT IS FURTHER STIPULATED AND AGREED by and between counsel for the respective parties hereto, that the filing and certification of the original of the deposition transcript be the same hereby are waived.

A L E X A N D E R D E M O U R A, MD, duly sworn, testified as follows via telephone:

VOIR DIRE EXAMINATION

BY MR. GOLDBERG:

Q Doctor, please give us your medical school and year of graduation?

A Chicago Medical School, 1990. Rated COS Workers' Compensation Board. Board certified orthopedic surgery. Licensed in New York, New Jersey, Florida. All in good standing. Never subject to disciplinary action. Director of New York Spine Institute. Assistant clinical professor of orthopedic surgery at NYU School of Medicine.

MR. GOLDBERG: Counsel, any questions as to the doctor's qualifications?

MR. IOKHELES: I will stipulate to the doctor's credentials as coded by the Board.

DIRECT EXAMINATION

BY MR. GOLDBERG:

Q Doctor, per my review of the file your first exam of Mr. Alastair Kennedy was 1/16/2020, is that accurate?

A Yes, it is.

Q Please give us the history you were provided at that time?

A The patient presented with a chief complaint of neck pain. He also was having headaches. He was 48 years of age, and he sustained an injury to his spine while working on October 29, 2019. He fell into an 8-foot hole and jammed his lower extremities, and with axial loading injured his cervical spine.

Q What were his complaints at that time?

A The patient had pain in the lower extremities. He had immediate neck pain. When presenting to me he continued to have neck pain, but he also had radicular symptoms into the bilateral ulnar distributions. He had not started conservative treatment and was subsequently going to start conservative treatment with our recommendations.

Q How did he characterize those radiating symptoms to you?

A He appeared to be in extreme pain. He was having weakness into the upper extremities,

numbness in the fourth and fifth digits, and he was viewed to be in a very difficult situation.

Q What were the results of the clinical exam at that time?

A So, physical examination at that time proved positive for paraspinal musculature spasms. Range of motion was decreased and quantified. He had decreased pinprick to light touch in the left C-6 distribution. He had absent left brachial radialis reflex.

MRI study was reviewed. It was performed on December 5, 2019. It proved positive for disc herniation at C-6, 6/7, and based on all that together with his clinical findings, clinical complaints and MRI study I believe the patient was suffering from a cervical radiculopathy.

Q Were you able to assign a degree of disability based on that exam?

A At that time the patient was temporarily totally disabled.

Q You mentioned the MRI, doctor. Was your clinical correlation for that C-6/7 pathology, and if so, what was it?

A The patient had subjective numbness into the C-7 distribution. He also had findings regarding the C-5/6 level at that time that indicated he had weakness in the wrist extensor. So, clearly his clinical findings correlated with the MRI findings.

Q Your next exam was when?

A The patient returned on February 17, 2020.

Q What were his complaints at that point? Changed or stayed the same?

A Once again, he continued to have severe neck pain and cervical radiculopathy. I believe he had undergone an epidural steroid injection and his symptoms had actually worsened. So, at this point it was touch and go, and it appears the patient required surgical intervention.

Q What was the basis for that conclusion that this surgery was necessitated?

A He was in agonizing pain. He continued to have weakness, positive physical findings that correlated with his MRI finding. So, the constellation of factors put together

indicated that the patient required surgery in the cervical spine.

Q Was it eventually performed?

A The patient eventually did undergo surgery. It was performed on an urgent basis, and the patient had surgery on May 13, 2020.

Q What procedure did you perform?

A The patient underwent an anterior cervical discectomy and fusion at C-6/7. There was evidence of the extruded disc herniation originating from his work related injury that was viewed intraoperatively by me, and the surgery was uneventful, and the patient has continued to follow-up post-operatively.

Q Subsequent to the surgery and your subsequent visit, have the symptoms changed? Has there been any improvement?

A The radicular symptoms have abated, and now it's at the point of letting the spine continue to heal and undergoing physical therapy at this time.

Q When is the most recent evaluation?

A He was seen actually on the 13th of this month back in the office.

Q That was yesterday, doctor?

A Yes.

Q What were his complaints, what were the findings, if any?

A He continued to have good and bad days. The wound is healing. He has the scar from the surgery on the anterior aspect of the spine. He was having some oozing from the wound prior, but now presently there does not appear to be any signs of injection, which is good news. I'd like him to enroll in physical therapy at this time.

His examination showed that the muscle strength and tingling has improved, and we'll see him back in another six weeks.

Q Just back to your comment, doctor, that surgery was needed on an urgent basis, what was the potential if it was not done on an emergency basis? What were some of the possible issues if it wasn't done?

A I feel if the C-7 nerve root continued to be compressed the patient would have continued permanent numbness, increasing weakness in the upper extremity, and based on that it was important to decompress the nerve, remove the

pressure and allow the nerve root to try to heal itself.

Q Just so I understand, you said if it wasn't done that type of compression could be permanent?

A Exactly. Yes, sir.

MR. GOLDBERG: I have nothing further at this time.

CROSS-EXAMINATION

BY MR. IOKHELES:

Q Hi, doctor. My name is Misha Iokheles. I'm going to ask you some additional questions on behalf of the insurance company.

Can you just explain a little bit more in detail how the numbness would last forever had the surgery not been performed right away?

A Well, just imagine, counselor, if you're sleeping on your sofa with your arm bent and you wake up in an odd position, in that short amount of time you can subjectively feel numbness and tingling in your arm. You may have to shake your arm to try to wake it up, and that's just with a short amount of time of pressure on the

nerve.

The nerves in our body are not meant to be squeezed upon, and when they are it diminishes the blood flow to the area which causes numbness, can cause weakness to the innervation of the nerve into the muscle, and ultimately it can actually permanently damage the nerve or kill the nerve.

So, based on that going beyond a certain period of time over six months a patient runs a high risk of developing permanent neurological damage. Sometimes it can actually even occur sooner.

So, it was important to go in, open the patient's spine, free the nerve so that his nerve would have a better chance of recuperating from the trauma that occurred and the subsequent numbness, tingling and weakness that the patient was experiencing.

Q Is this a procedure you typically perform on an emergent basis, or did you rush it a little bit in this case because Mr. Kennedy had extreme pain?

A I'm sorry, counselor. Repeat that

again.

Q Is this a procedure you typically perform on an emergent basis, or did you expedite it in this particular case because Mr. Kennedy was complaining of excruciating pain?

A Actually, he was a candidate for surgery approximately eight weeks after the injury. So, based on the fact that he did not have resolution of symptoms, which usually occur within six to eight weeks, that in and of itself made him a surgical candidate.

What even makes it more imperative for surgery was that he continued over this span of time over the Spring to continue to have numbness, tingling and weakness and actually subjective worsening of his pain.

So, all of those factors put together is the reason why he definitely required surgery, but, yes, surgery can be done on an emergent basis if there is paralysis, you know, spinal cord injury. That can be done right away, but typically most of these types of injuries we like to treat conservatively and see how the person does over six to eight weeks.

The ones that don't improve, then they require surgery.

Q What kind of conservative treatment did he have before the surgery?

A He had physical therapy, he had pain management, he had taken medications. All those had failed.

Q When you say he had pain management, are you referring to epidural steroid injections, or something else?

A Yes. That's what I'm referring to.

Q Do you know how many he had before the surgery?

A I don't recall, counsel. I believe he had one that I'm aware of.

Q Do you know when he had physical therapy?

A From my understanding we indicated him for therapy when we saw him initially in January, but when we saw him back he actually told me that his symptoms worsened.

I would like to give you an analogy of having a pebble in your shoe. I don't care how small the pebble is. You know immediately

there's a pebble in your shoe, and that's the bottom of your foot, which is not nearly as sensitive as the cervical central nervous system, cervical spine. So, imagine having a disc, which I saw intraoperatively, pressing in that area. That was the irritant that caused him to have unremitting symptoms that required surgery.

So, eventually, if the pebble is big enough or it continues to bother you, you got to take the shoe off and take the pebble out, and that's similar to what happened to this patient. He had to have surgery to take the offending agent out which was causing him neurological damage and subjective pain.

Q Okay. I understand, but just to be clear, did he ever actually get physical therapy?

A I thought he started therapy. I can't attest to it right now. I don't recall the extent of physical therapy, but based on what I saw intraoperatively no physical therapy was going to remove that pressure off of the nerve, just like if do you physical therapy with a pebble in

your shoe.

Q Would the physical therapy have occurred in your office or at an outside facility?

A Well, we have physical therapy. I don't believe he came to my facility for therapy.

Q Do you believe this particular surgery was within the medical treatment Guidelines?

A Yes, sir.

Q So, then as a Workers' Compensation Board authorized doctor I'm sure you know that the MG-2 form is filed when one wishes to vary from the Guidelines. So, is there a reason you filed that particular form if a procedure was already within the Guidelines?

A It wasn't authorized, and I believe the patient didn't have the authorization to proceed with surgery. As you know, the Guidelines can be met. Unless the carrier approves the surgery hospitals will not allow the surgeries to be scheduled. So, based on that I believe that's why that was requested.

Q Was this patient's nerve root

compression confirmed by the MRI?

A The MRI proved positive for a disc protrusion at that level. There was also foraminal narrowing which confounded his situation.

So, imagine the head, which is heavier than a bowling ball, is accelerated with the body, and subsequently stops at a rate when you hit the bottom of the hole. So, all that kinetic energy is transferred from the head to the cervical spine compressing the cervical levels, and I believe within a reasonable degree of medical certainty the disc at C-6/7 was pushed out from the head, the weight of the cranium pressing on the cervical spine, which caused the disc to protrude out, and that's the mechanism of how the patient sustained this injury.

Q But I just want to make sure I understand. Which finding on the MRI is equivalent to nerve root compression, because I don't see the words in there?

A The MRI indicates that there is a disc osteophyte complex at the C-6, C-7 level.

So, there is a disc herniation where it's not supposed to be. So, if the disc herniation is in the spinal canal it has to be pressing on the neural element in the spinal canal, and that's exactly what I visualized when I was inside the patient's neck when I performed surgery.

Q Are you suggesting that any time there is a herniation in the spine a nerve is compressed?

A The neural elements in the spinal canal -- by definition if you have a herniation, a piece of material that comes out of the disc, if it goes into an area where it did not originate, it would have to compress something in that area. It could be the thecal sac, it could be the spinal cord, or it could be a nerve root.

In this case the disc herniation that I visualized was adjacent to the nerve root exiting, and that's one of the reasons why the patient was having excessive amounts of pain.

Q So, if the nerve root was compressed, why would the MRI report not state that?

A The MRI is not as good as actually

visualizing something in person. It depends on the quality of the MRI, it depends on the interpretation of the radiologist. It's not an actual photograph. It's a magnetic resonance imaging, which is a reproduction of what actually is going on into the human body. It's our best way of visualizing what's inside the human body, but as we know, the best way to actually visualize something is with your own eyes, and me as a surgeon, that is what I was able to visualize when I went in.

Q Does Mr. Kennedy have progressive neurological deficits?

A At this time they are not progressing.

MR. IOKHELES: I'm sorry. Counsel, were you saying something?

MR. GOLDBERG: I just want you to clarify the question.

Q Sure. Doctor, I was asking about prior to the surgery. Were there progressing neurological deficits?

A There was progression of subjective pain, and that in and of itself was progression.

His weakness, numbness and tingling remained the same.

Q Was the disc at C-6, C-7 actually ruptured?

A Yes. I viewed it piercing the posterior longitudinal ligament. It was extruded, and that in and of itself indicates that it was a traumatic origin for that disc to protrude through the posterior longitudinal ligament.

Q Again, prior to the surgery, did Mr. Kennedy have spondylosis?

A Yes, he did.

Q How about spinal instability?

A Instability wasn't a confounding factor in this case.

Q Would you agree that his spondylosis and spinal stenosis are degenerative?

A Yes, they are.

Q So, is it your impression that they were asymptomatic prior to the accident?

A That's correct.

Q Now, doctor, let's discuss the accident a bit. What is your understanding of

exactly what happened here?

A I just went into clear detail regarding that, counsel. Do you want me to repeat the entire mechanism of injury again?

Q I'll ask you specific questions about it. So, based on what you said previously, is my understanding correct that Mr. Kennedy told you he fell down 8-feet into a hole, fell straight in?

A Correct.

Q Is it your impression that he slid into the hole along the side of it, or just dropped into it?

A From my understanding he dropped into it.

Q Do you know how he landed?

A He landed on his feet.

Q Did he fall down after that?

A I don't know the specifics after the moment of impact, counsel.

Q Did you say earlier that he felt neck pain right away?

A Yes.

Q Now, doctor, you said that this

injury occurred as a result of Mr. Kennedy falling 8-feet. Could this same injury result if a person simply fell backwards on the ground?

A Yes.

Q How would the mechanism work then?

MR. GOLDBERG: Just note my objection.

Q Doctor, you can still answer.

A You just said if you fall backwards and strike your head, you have the head striking the ground. If you strike the back of your head the spine will go into flexion. Flexion puts pressure on the disc. If the disc is squeezed enough it will rupture, but that's another mechanism of injury.

You can also have axial impact where the load is axially transmitted across the disc space. That can also squeeze the disc causing the disc to herniate.

Q But that would depend on an individual striking his head, correct?

A No. There's two mechanisms that I just gave you, counsel. One of the scenarios that you gave me that the patient fell back and hit his

head on the ground, that in and of itself could rupture a disc.

If a patient is also falling through space and coming to an abrupt stop, the impact and the force transmitted from the cranium coming to a hault through the cervical spine can also put pressure on a disc to cause it to rupture. So, it can be either one of those or it can be a combination of those that can cause the disc to rupture.

Q What if it is neither of those? What if somebody just fell backward without striking their head on the ground?

A It depends when you're falling backwards. So, if you're also falling back and not hitting your head, is this the third scenario you want me to describe now?

Q Yes.

A So, if you're falling back, and unless you're inebriated and you can't control your body, you would still strike your head. If you're not inebriated and you have some mechanism or reflex, you most probably would try to break the fall in some nature, and if you do try to

break the fall, your arms can reach backwards which can jar your shoulder, your cervical region, and that in and of itself can cause a herniation. So, there are many ways that herniations that I've seen over the years can occur.

Q Given Mr. Kennedy's age, is it possible that these herniations were pre-existing?

A Not from what I saw intraoperatively, counsel. I believe the patient had a pre-existing condition that was exacerbated by the disc herniation that occurred at the work related injury time. So, the actual herniation itself occurred from his injury. The spondylosis that was there pre-dated the work injury, but the spondylosis is not what caused him to require surgery. It's the disc herniation that caused him to require surgery.

Q So, would it be fair to say that your opinion that the herniation was caused by this accident is based on Mr. Kennedy's description of the accident?

A That's a major factor, yes.

Q When Mr. Kennedy first came to you,

did he tell you anything about any prior injuries?

MR. GOLDBERG: You have to be a little more specific. The doctor is only treating the neck.

Q Doctor, did he tell you about any prior injuries about the neck?

A My notes indicate that he did not have a prior history of neck related injury.

Q Are you aware that he injured other body parts in this accident as well?

A Yes, I am.

Q Do your notes indicate whether he had any prior injuries to either of those body parts?

MR. GOLDBERG: Objection. Relevance.

A That I'm not aware of, sir. Regarding his feet or ankles, no.

Q What about the shoulder?

A I don't believe I have anything documented regarding the shoulder.

Q Do you recall if you asked Mr. Kennedy about prior injuries yourself, or

did he fill out an intake form?

A Usually it's both.

Q Do you have a copy of the intake form with you?

A No, I don't.

Q I believe you said you saw him most recently yesterday. Do you believe that Mr. Kennedy is able to return to work in any capacity whatsoever, be it light work or sedentary work as of today?

A Not at this time. He's still within the first three months status post spinal fusion. I would not recommend him returning to work until a minimum of Fall.

Q When you say Fall, do you mean possibly September, or are you referring more to later if the Fall?

MR. GOLDBERG: Objection. Speculative.

Q I'm sorry. There was an objection being noted. So, I didn't hear your answer, doctor.

MR. GOLDBERG: Objection. It's speculative. The doctor doesn't know what's

going to happen in September.

MR. IOKHELES: He still could answer the question.

A Tentative return to work six months after surgery.

MR. IOKHELES: Thank you, doctor. I have no further questions, subject to re-cross.

MR. GOLDBERG: Briefly, doctor, you mentioned that visually when you were doing the surgery you saw the herniation. In your opinion, was that traumatically induced, or was that degenerative?

DR. DEMOURA: As I stated prior I believe the disc herniation in and of itself was traumatic in origin.

MR. GOLDBERG: If someone fell and slid down a hole partially or fully and hit their head on a high-beam while wearing a hardhat, could that type of scenario generate what you saw when you opened up the claimant's neck?

DR. DEMOURA: Absolutely.

MR. GOLDBERG: Nothing further.

We would ask that the judge award the doctor the appropriate fee for his cooperation today. Thank you.

(Time noted: 10:01 a.m.)

WCB#G2333899

C E R T I F I C A T I O N

STATE OF NEW YORK.)

SS:

COUNTY OF NASSAU.)

I, Amanda E. DePalma, a Shorthand Reporter and Notary Public in and for the State of New York, do hereby certify:

That the testimony of Dr. Alexander DeMoura, was held before me at the aforesaid time and place. That said witness was duly sworn before the commencement of the testimony and that the testimony was taken stenographical by me and is a true and accurate transcription of my stenographic notes.

I further certify that I am not related to any of the parties to the action by blood or marriage and that I am in no way interested in the outcome of this matter. IN WITNESS WHEREOF, I have hereunto set my hand this 14th day of August, 2020.

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AMANDA E. DEPALMA

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