SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: CIVIL TERM, PART LL1

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YESTER CASTILLO,

Plaintiff,

Index. No. 522504/2018

-against-

Jury Trial

1248 ASSOCIATES, LLC,

Defendant.

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May 7, 2024
Kings Supreme Court
360 Adams Street
Brooklyn,New York 11201

B E F O R E :
DEVIN COHEN,
Supreme Court Justice

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

For the Plaintiff:
GORAYEB & ASSOCIATES, P.C.
100 William Street, 19th Floor
New York, New York 10038
BY: CHRISTOPHER VARGAS, ESQ.

For the Defendant:

CULLEN & DYKMAN, LLP.
One Battery Park Plaza, 34th Floor
New York, New York 10004
BY: KENNETH BUFFALOE, ESQ.

John Cardillo
Senior Court Reporter

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jurors enter the courtroom and the following occurred:)

THE COURT: Hope you had a good evening. We expect two witnesses today beginning with Dr. Kolb; is that correct?

THE WITNESS: Yes.

THE COURT: You can call your next witness.

MR. VARGAS: I call Dr. Thomas Kolb to the stand.

THE CLERK: Good morning. Raise your right hand, please.

T H O M A S K O L B, Doctor, having been called as a witness by and on behalf of the People in this case, having first been duly sworn was examined and testified as follows:

THE WITNESS: I do.

THE CLERK: Be seated. Please state in a clear voice, for the record, state and spell your name and business address.

THE WITNESS: Dr. Thomas Kolb. K-O-L-B. M.D. 257 West 34th Street, New York. 10001.

THE CLERK: Thank you.

THE COURT: Good morning, Doctor. Your witness.

MR. VARGAS: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. VARGAS:

Q Doctor, can you start off by telling the jury how long have you been a doctor and your educational experience?

A Oh. I graduated medical school in 1983, and my educational experience is I went to Queens College, City of New York, from 1979 through 1983.

I then went to Downstate Medical School here in Brooklyn. From actually I graduated college in '79. I then went to medical school from '79 to '83. It was a long time ago, and became a physician in 1983.

As I said then, from '83 to '86, I did an internship and residency in pediatrics, and I became a pediatrician board certified. I did that training in The Bronx in Jacobi Medical Center and Montefiore from 1986 to 1990. I became a diagnostic radiologist. I did a four-year residency at Columbia Presbyterian in Washington Heights. I have been practicing radiology since 1990.

Q What is a doctor in radiology?

A It is using x-rays called CAT Scans, MRIs, ultrasounds mammograms, et cetera, to look inside the body to see if there is a problem or not a problem.

Q Do you have a speciality within diagnostic radiology?

A I have two specialities. One is breast cancer diagnosis. I specialize in young high risk women with dense

breasts. I do mammograms. I do biopsies, ultrasounds. I work with breast surgeons, in general. And I have written partners on research, and so on one of my papers won the American Medical Association Scientific Paper of the year.

Over 27,000 consecutive women. So that is part of what I do. What I practice and the other part of what I do is x-rays and CAT Scans and MRIs for parts of the body where patients complain of symptoms. It is a problem, usually pain, and I interpret those and send those reports to the referring physicians.

Q Do you have your own practice?

A Yes, I do.

Q And if you weren't here today testifying, what would you be doing?

A I would be in my office.

Q Are you being compensated for your time here today?

A I am.

Q How much are you getting paid?

A $9,500.

Q And Doctor -- sorry.

MR. VARGAS: Your Honor, I ask that Dr. Kolb be deemed an expert in diagnostic radiology.

MR. BUFFALOE: I can't consent to that.

THE COURT: You can't consent?

MR. BUFFALOE: I don't think so.

THE COURT: Would you like some voir dire?

MR. BUFFALOE: I will save it for cross. I just can't consent.

THE COURT: Well, since just forced me to say it out loud then. Since Dr. Kolb has been a physician for 40-years practicing radiology for sounds like 32 roughly of those years, and given awards for his publications on diagnostic radiology. Then, the Court will deem him an expert in diagnostic radiology.

Q Since we will be talking about MRIs and x-rays today, can you tell the jury the difference between the two?

A X-rays. We discovered x-rays many years ago, over a hundred years ago. It is a foreman of energy.

Basically when we take an x-rays we shoot x-rays through the body part, and x-rays are very, in this point of radiology, a little bit crude. It only tells the difference between things that are hard or soft.

If you are looking for a fracture x-rays is a really good thing to do. If you think you have broken a bone, you will take an x-ray, and an x-ray is good for that, but there are a lot of structures around the bones. There is muscles, tendons, ligaments, nerves that you can't see on an x-ray. You can't see.

So a CAT Scan is a form of utilizing x-rays. Instead of taking one picture you take many, many, many thin pictures,

and we get a little bit of a better idea of all the things that are soft. We can still see bones very well, but we can start seeing other things in the body as well.

MRI is a totally different technology. MRI uses magnetic waves. Magnetic waives, when we use that, they are pulsing through our body. As a patient in this large magnet and a strong computer reconstructs pictures of our body in how we react to those magnetic waves. Bottom line no, I don't.

Do you see the bones? But you see inside the bones, the bone marrow. You see everything that is on. You see the arteries. The veins, the nerves, tendons, muscles, everything in the shoulder. You will see tendons in the back you will see disks, but you won't see that on a regular x-ray. So that is a big difference in MRIs, of course, which is pretty standard now than it used to be.

Q And, Doctor, did there come a time when you reviewed some films of Mr. Yester Castillo?

A Yes.

MR. VARGAS: Your Honor, with your permission, if Dr. Kolb could step down. We have some blowups of MRIs or x-rays marked into evidence.

THE COURT: In evidence?

MR. VARGAS: Yes.

THE COURT: That's fine.

(Witness exiting.)

THE COURT: When you step off the stand, you are under oath. I know you know that, but I have to tell you.

THE WITNESS: Yes, sir.

Q Let's start with the shoulder.

MR. VARGAS: And this is Plaintiff's 17.

Q Can you start by telling the jury what are we looking at here?

A So we are looking at an MRI of the shoulder, and this is the left shoulder on the patient. It is like if you were looking at me and you felt your shoulder you feel this bump right here, and that is the humorous, which is this long bone in your arm, and this here is the bone, and you can see the bone very easily on an MRI.

But in addition to the bone, this bone is the humorous, when we move our arm around, this is a bone here. You don't have to remember any medical words. It will all makes sense.

As I explain, there is another bone here, which is the glenoid humoral joint. And this white area inside the joint is what's called the labrum. So let me just say one thing. In our body bones touching bones is a very bad thing. It is very painful.

In your knee you have meniscus. In the shoulder you have what's called the labrum. These are shock absorbers. When we talk about the neck there are disks between the bones

of the neck. That keeps the bones apart, and that is very important.

If there is a problem in between these two bones, you will see it is possible. You can feel a lot of pain, but in addition to these two bones here, in order for this humorous to stay in position we have what's called the rotator cuff tendons.

There are four tendons in the shoulder. They all have their own name, which you don't have to remember. But they are the suprasinatus, the infra-spinatus, subscapularis and the teres minor.

There are four things. The important things to understand is these tendons, two of the major tendons cross right above this bone right here, right above, and you can actually feel them here in your shoulder.

And on MRI, a normal tendon is completely black, because it has very little fluid in there. Anything that is white on this picture means there is fluid in it. So you can see very easily that this tendon that goes all the way across like that in here to here is a tendon. It should look completely black, just like that. All of this, from here to here, that white area is a tear of the tendon. When tendons tear the fluid in the joint goes into the tendon, and that's why when you do an MRI, and you see white in here, you know that there is a tear.

Now, in tendons, in the shoulder, you can have a partial tear, a complete tear. Partial tear means only a piece of this tendon this suprasinatus tendon here is torn. When you see the whiteness go all the way from this part of the tendon against the bone, and this part of the tendon away from the bone, but the muscle.

This is your deltoid muscle in your shoulder. This here is the deltoid muscle. This whiteness or abnormal signal extends the entire width of the tendon, and that means it is completely torn.

Now, in tendon tears are rotator cuff. When you tear a tendon, it could still be attached to the bone, or it can be ripped off the bone.

The fact that all of this whiteness exists here means a tendon is being pulled off the bone, and that's called retraction of the tendon. It is being pulled off. This is a very, you may not have seen the MRI of the shoulder before. This is a very abnormal looking MRI of the shoulder.

So there is a complete tear. It is 1.5 centimeters. That is the size of the tear, and this is partial retraction. This is also an abnormal tendon, which you see it is darker, and this here is whiter. This portion of the tendon is retracted off.

And that's one finding in this shoulder. Another finding, as we talked about the labrum. The labrum, just like

the tendon, should be back. There should be nothing white in this, this tray angle, between this bone, and that bone should be completely back, since there is whiteness in here. There is a tear of the superior labrum, and it is a certain type of tear called a slap tear. So this is another tear in the shoulder but in a different part of the anatomy on this patient.

Q Just so we are clear, for that film on September 10th, 2019, what was your diagnosis?

A There is a complete and partially retracted rotator cuff tear, and there is also a slap tear.

Q Okay. And the next.

A So radiologists like taking a lot of pictures, and we can take things different ways. We will talk about that in a second. This is the same shoulder.

Q And this is Plaintiff's 18.

A So what have we done here, it's the same shoulder. It is the same time. So the easiest way to understand this, if you take a long loaf of bread. You can cut it all the way lengthwise, and you will have two big slices, and you will have a hero, right? Or you can take the bread and cut slices instead of having one long picture, you will have many round or square pictures, many slices.

So what we have done here is we have taken this picture, a machine does this. Nobody really gets cut. It is

the machine doing this. Right.

Q This is Plaintiff's 16?

A Same as the one before I showed. Where instead of looking at the entire bone, like the hero sandwich, we are now taking pictures like that coming down like this long bone with taking pictures like that, and we pull them out and look at them and we get that picture. So instead of the bone being long, the bone is now round. It is a slice of the bone.

And it gives us an idea of the anatomy around the bone. Remember I told you that there is the labrum, have to be dark, and here you see two parts of the labrum and they are both normal.

The anterior and posterior labrum here. The superior labrum, which is up here, is torn. We have many ways of looking at the shoulder. Bottom line patient had a rotator cuff tear, as I described, and also a slap tear, which is a tear of the superior labrum. Those are the findings on the MRI.

Q If you can go to the cervical spine now, Doctor.

A Okay.

Q Plaintiff's 25.

A So in this picture, we are changing gears. We have left the shoulder, and we are going to look only at the neck right now. Now, a little bit of anatomy of the neck. So we

are all on the same page. This is the patient's head up here. Patient's feet down here. This is the patient. Front of the patient anterior. The patient is looking that way, looking at my side, and this is the back of the patient, and this gray stripe coming down here is the spinal cord. Spinal cord starts in the brain.

Here is the bottom of the brain and goes all the way down the spine this way. We are looking at the entire patient from top to bottom. The sagittal image like we are doing like a long hero sandwich and seeing everything.

The only thing that you really have to understand is in the anatomy is that each of these gray boxes is a bone, and there are seven bones in the cervical spine. Whether you are tall or short, male, female, we all have the same anatomy, and as I told you before, a bone touching a bone is not a good thing. It is very painful. So in the spine, we have what are called disks.

We have disks in the spine, and the disks are between the bones. So there are seven bones, and I will label them two, three, four, five, six, seven, and then we get to a different part of the spine called the mid back, the thoracic spine. We are going to stay up here. This is called the cervical spine, because it is the neck.

When I talk to you about a certain bone or a certain disk, I am going to use numbers. So, for example, this is C2

for the second bone on the cervical spine. C3, C4, C5, C6, C7. And the disks in between the bones are called the C, let's say this one C3-4 disk.

C4-5 disk. And you will see the disks here are darker than the bones. You will see them very easily. The disks are shock absorbers. When you jump up and down, and you move your head around, why don't the bones just touch each other? Because these like have little shock absorbers.

When you move around, they compress, and they spring back so the bones don't touch each other. That is their function, and there is actually the jelly, gelatinous material in the middle of these disks, which keep them springy.

But what keeps the disks in their normal place? Mind you when you move around, don't the disks just move out of position? What keeps them in position? They are very strong ligaments that run down the back of the bones and in front of those, and there is also a strong ligament called the annulus that runs around, it wraps around the disk at every single level.

And the bottom line is, let's look at this disk here. C7-T1 here. This is the only thing for you to understand here.

Is that the disk normally comes to the very edge of the bone. Bone, bone, disk, goes to the edge of the bone. And doesn't go out beyond the margin of the bone. That means

that this ligament and this annulus is intact. It is holding the disk in place normally. That is a normal level, and you are going to compare it on all these other levels in a minute.

But what could go wrong here with these ligaments is that you could have a partial tear of the ligament, and the disk will come out and start pushing out a little bit, because the ligament and the annulus is partially torn, and that is called a disk bulge.

A bulging disk in your neck is when there is a partial tear of the annulus, and the disk starts pushing back, and it pushes back and you see an indentation in this white stripe here. As we will talk about up here, but here, you don't see it, which means that it is normal, but a disk bulge will be a small piece of disk that is pushing back together with the ligament.

Now, if the ligament or the annulus completely tears, the disk goes through like that, and if the disk goes through that is called a disk herniation, a herniated disc in your neck. That is what it is.

Now, why do we care about any of that? Disk bulges and herniations. This space between the disk here and the bone and the spinal cord is tiny. It is literally this big, even though this is blown up, it is literally this big. So any disk material that occupies space that shouldn't be there will cause pressure or can cause pressure to nerves. Also

remember that the spinal cord comes down that at every level between our bones a nerve has to go out. Eventually all the nerves have to come out of our brain, down the spinal cord and got down our shoulder to our finger and go down our legs to our toes.

All of these nerves come out from the spinal cord. I will show you a picture at each level. There comes the left and one goes to the right.

So these disks if they are abnormally positioned, because they are either bulged or herniated, can cause pressure on the nerves. Pressure on the nerves can cause pain, and that's why we do the MRI. If the patient is complaining of a symptom, and the doctor sends them for an MRI, to look for these abnormalities.

All you have to really know that is a normal disk is like the one here between these two levels. So let's look at this particular MRI. What do we see?

Well, this disk here is pushed out here, and you can see that it is starting to be compressed a little bit onto the sac that contains the spinal fluid. This gray stripe is a spinal cord. This white stripe is the fluid that surrounds the cord. Spinal fluid.

So on these two areas here, the disks are being pushed out and really, by the way, we have many pictures. This is just the one central picture. I will show you other

pictures, as well.

As being pushed out where at 5-6, which is the largest one, there is a complete tear of the ligament. And a disk herniation at this level at let's say the level above it C4-5, this is being pushed out but not as completely as 5-6. This is a partial tear. This is a complete tear and in this particular case, there are disk herniations at this level C2-3, and C5-6.

We corroborate that with other pictures, and there are disk bulges or partial tears at this level C3-4, C4-5, and C6-7. Very tiny one at C6-7. Just starting to peak out a little bit. The major finds of these on two herniations C2-3 and C5-6.

Here is the same day, same patient. What we have done here is, like I said, you can slice the bread two different ways, and now, where the spinal cord is long, like I showed you before, the bone was long. We can now take pictures this way at every level.

For example, just to make life easier for you to see, you can see it. I will just go ahead one second to Exhibit 20. See these lines here? These green lines here? What we have done is we have just taken a picture here and put it up here next to it.

And instead of the spinal cord being long, the spinal cord here is round. Just like the analogy I gave you with the

sandwich. We can look and we do, at every patient at every single disk level. We look at lengthwise and round. Both ways.

So, if we go back to the first MRI, since 2018, you will see this is at C5-6. Where I told you that there was a herniation on Number 25. This level here, if you look at it, the axial view, the round view, you will see the actual herniation coming down and pushing on the fecal sac. You see how asymmetric it is. There is a tear of the ligament in here, and the disk material is being pushed down.

Q And that is Plaintiff's 24?

A Plaintiff's 24. So that is the major finding, a herniation at C5-6. A smaller herniation at C2-3 and smaller partial tears or bulges at C3-4, C4-5, and C6-7. So there is stuff going on at every level but some worse than others.

Q Next slide.

A If you move on, and you look at 2019, April 8, 2019, which is Number 27. It doesn't look very different. It's stayed. Basically it stayed very similar to the one before from 2018.

This herniation is still here at C2-3. There is a bigger herniation at 5-6. Maybe this one changed a little bit, but there are still bulges here at 3-4 and 4-5 and here you see normal again, and a tiny little bulge here at C6-7. I will pull numbers on so you can compare. Now, remember when I

put up that other picture a minute ago, which was the round picture.

THE COURT: It's behind.

A 2018?

THE COURT: Behind the pile.

A Now, one point that is important to know is that this round picture, this axial picture, C5-6. Remember I told you that this herniation was asymmetric. Let's talk one second about anatomy, because this is really important. This gray circle is the spinal cord. Right? We know that. We know that and I told you that the nerves come off the spinal cord and have to go down our arms and down our back and down our legs. This is how it happened.

The nerve comes off the spinal cord here and goes to the patient's left side this patient's left and to the patient's right side. Patient's right and they go through what are called neuro-foramen, which means holes that contain nerves, how the herniation doesn't just push back. It also can push to the sides.

So in this particular case, and it is not that uncommon that this particular herniation is a little bit more to the left. This is the patient's left side. Patient's right side. It says right there. And it is a little bit more to the left side of the patient, than it is to the right.

So the herniation is going down and it is narrowing

this neuro-foramen right here. This is the left neuro-foramen. This little break line in there is the nerve root that is going to come out of C5-6. This is the left C6 nerve right, and it is narrowed a little bit more than the right side. So not only is a herniation going back, but it is also narrowing the neural foramena, left greater than right. We can see all that on this picture.

Now, moving ahead to 2019. That was 2018. Not much has changed. And in 2019 we were talking about '19 already. This is Number 27. Now, not much as changed here.

There is a herniation at C2-3 and C5-6, and I think there is an axial of 2019, as well, right here and it is Number 26. And you can see there that both the neural foramena are narrower than they should be, and that contains the nerve roots, but not much has changed between '18 and '19. That just hasn't changed. It is the same. Okay.

Now, moving forward to 2021. Yeah. So 2021 this is a picture we are used to looking at, and this is Number 19. This is 2021, three-years later. Again, you see these disk abnormalities, mostly of these two levels two, between 2-3 and 5-6, 4-5, and 3-4 are all pushing out a little bit less. Those show these are bulges. Still we have the same herniations at these two levels.

We also took that other round picture, which was Number 21 on, I'm sorry, Number 23. Number 23, which was

again April 3, 2021, and here you can see very well, how the herniation is dipping in and pushing the left side of the sac or the left lateral recess and the neural foramena is on both sides.

Again, in 2021, pictures are very similar. In that there are two herniations and three bulges, and the amount that it is pushing on the sac, and the foramena that holds the nerves has not changed very much. That is taking you through 2018 through '21.

These pictures here are really very similar. I have showed you this one before. This is Number 21, where we can take these axial views, just to show you how we look at pictures, and then, this is what happened to the patient.

Q Correct.

A So the last picture to show you is actually Number 22.

Q Yes.

A Okay. So looks very different, because it's an x-ray. And you see a lot less than on an x-ray. You only see things that are hard on an x-ray. As I told you, here are the bones. I will label them the same way I label the MRI.

The seven bones, starting from two through seven. Each one of these squares is a bone, and we talked about disks and tears and herniations and all that, and you can't see it

on an x-ray, but what you can see is this all this white stuff here. This is because a surgeon went in and fused C5-6 and S6-7 and put these intra-body disk stabilizers.

MR. BUFFALOE: Objection.

THE COURT: Okay. Let's have a quick sidebar.

(At this time a sidebar conference was held between both counsels off the record.)

(Sidebar over.)

THE COURT: Objection overruled. Doctor, you can describe sort of the end result. Since you are not a surgeon, I assume you won't be describing the intricacies of the surgery, the mechanics of what goes left behind.

THE WITNESS: Correct.

THE COURT: Overruled.

A So all the white stuff here is metal. That's what a surgeon put in, and the point of doing this and when radiologists look at x-rays is we see the hardware that the surgeon put in, and the point of doing this is to fuse these bones so that they don't move, and that's the point of that is try to alleviate the patient's pain.

MR. BUFFALOE: Objection.

THE COURT: Overruled.

A So that's what we see on the x-ray.

Q Thank you, Doctor, you can take the stand.

(Witness entering the stand.)

Q To sum it up with a reasonable degree of medical certainty, do you have an opinion as to what were the injuries that you saw in the films regarding Mr. Yester Castillo for the cervical spine?

A Well, the findings were two disk herniations, one at C2-3, and one is at C5 C6 and three smaller disk bulges.

Q And, Doctor, with a reasonable degree of medical certainty, as to the left shoulder, can you tell the jury the injuries you observed in those MRI films?

A There was a complete partially retracted tear of the rotator cuff.

MR. VARGAS: Thank you. No further questions.

THE COURT: Thank you. Cross? Do you need five minutes? Great. We are going to take a five-minute recess. You can also take a five-minute-break. Please don't do any research. Don't have any conversations. We will see you shortly. Thanks.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jurors exited the courtroom and the following occurred.)

(Whereupon, there was a recess, after which the following occurred.)

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jurors enter the courtroom and the following occurred:)

THE COURT: Doctor, you remain under oath. Mr. Buffaloe, your witness.

CROSS-EXAMINATION

BY MR. BUFFALOE:

Q Good morning, Dr. Kolb.

A Good morning, sir.

Q Sir, Dr. Kolb, let's start with where you started out with, you review mammograms.

A Yes.

Q So your website indicates that you have reviewed over 150,000 mammograms, correct?

A Yes, at least that, yeah.

Q And you have been practicing since, you said approximately 30 years since 1990, correct?

A 1992, yes.

Q And so if you calculate that out, that is more than a hundred mammograms every single week?

A It comes out to about 5,000 mammograms a year, which is the height of when I was practicing, yeah, that 30 years, 5,000.

Q Do you work a full year?

A I do work a full year, yeah, sure, of course.

Q So you take vacation?

A Small amounts of vacation.

Q So two weeks of vacation a year, four weeks?

A Whatever you say, sure.
Q Let's go with four weeks, working 48 weeks a year.
A Yeah.
Q To review 150,000 and arguably that is not up to date. It could be more, correct?
A No, it is a little less now, because of COVID, and I cut back, because of that. At the height, as I said, I was reading 5,000 mammograms a year.
Q The total amount could be more now, correct?
THE COURT: More than meaning the gross total over four years?
THE WITNESS: It may be a small amount, larger. I mean, the website was put up by somebody that works in my office. I don't know what year she put it up.
Q 150,000 starting from 1992?
A Two. 150,000.
Q 150,000. If you just work 48 weeks out of the year that you are working --
A Sure.
Q -- that is approximately a hundred mammograms evaluations every single week, correct?
A Okay. I'll go with that. That's not a very large number, yeah.
Q It is not a very large number?
A That is 20 a day.

Q Twenty a day.
A Yeah.
Q So when you do that, do you evaluate the patient, as well?
A Yes.
Q So this is not only just reading the mammogram itself, but meeting with the patient, discussing the mammogram, 20 a day, every day?
A Yes.
Q By the way, Dr. Kolb, when was the last time you were in court testifying?
A A few weeks ago.
Q Was it here in this building?
A It may have been.
Q Was it for this firm for Gorayeb?
A It may have been.
Q Approximately how many times a year do you testify?
A I'd say I testify around five to six times a year.
Q So we got five to six times a year. Each one of those times you are in court at least half a day, correct?
A Yes, four hours.
Q And that is not accounting for the time that you take to prepare for that testimony, correct?
A Well, my preparation is reading the films, which most often the films that I read from my own MRI sites and writing

reports, which is my usual course of daily work, correct.

Q Four times that you spend in court for the testimony doesn't include the time for prep that is on top of that?

A But it is on top of that, but I don't know what you mean by prep. I write my reports and I discuss my reports with you and that's my prep. I don't do anymore prep.

Q That is still time, correct? I am talking about in addition to the four hours that is, there is additional time for prep, correct?

A Well, I just, it is exactly what I just said.

Q Do you discuss it with the lawyers before you take the stand, as well?

A I spoke to Mr. Vargas maybe five minutes about this case where before I got on the stand, yes.

Q And is that your normal custom? You speak to the lawyers about five minutes before you get on the stand. Let them know what you are going to say?

A Not what I am going to say. My reports are here and I say what is in my reports. The answer to your question is, yes, I spend on the average of five minutes talking to them.

Q Okay. So between and also you take MRIs and x-rays yourself, correct?

A Yes.

Q And you read and review those MRIs and x-rays, as well, correct?

A Sure.

Q So that is on top of the approximately 20 mammograms every single day.

A Sure.

Q So, by the way, you have known plaintiff's counsel firm for quite some time, correct? For at least 30 years, correct?

A I have known of them, and I have read films and they have asked me to testify, yes. The answer to your question is yes.

Q And you have been testifying for them since the 1990s, correct?

A Yes.

Q Now, as far as your work is concerned, your consulting work for reviewing x-rays, do you have patients referred to you?

A I don't understand.

Q Do you have patients referred to you?

A So what I do every day is I take MRIs, CAT Scans, x-rays. Those patients are referred to me by doctors, yes.

Q Any of those patients referred to you by lawyers?

A No.

Q Never?

A A lawyer? You mean referring a patient to me to do an MRI? To do a test?

Q To review, to do the test on any of your patients referred to you by lawyers.

A Let's be clear. To do a test it has to be a referring physician. It has to be an M.D. A doctor that refers a patient for me to review films that were done elsewhere at some other institution that wasn't me, just to look at them. A lawyer can send me the films to look at.

Q Do you have any of your business referred to you by lawyers?

A I just answered you.

Q Do you have any of your patients referred to you by lawyers?

A No, patients are not sent to me by lawyers. Films are sent to me by lawyers. Patients that are imaged have to be sent to me by doctors.

Q A few years back you were in business with a Jacob Liche. L-I-C-H-E?

MR. VARGAS: I have to object. If we can have a sidebar.

THE COURT: Sure.

(At this time a sidebar conference was held between both counsels off the record.)

(Sidebar over.)

THE COURT: All right. The objection is sustained. You can try to narrow down what you are

saying.

Q So, Dr. Kolb, do you have ongoing relationships with attorneys referring you business?

THE COURT: Not patients. You mean work?

MR. BUFFALOE: Any one way or the other.

THE COURT: We have already clarified this in the objection. The doctor has said a couple of times if by referrals you mean patients, the answer is no. That has been asked and answered two or three times now. If you mean other types of objects or business or work, that, you can continue to inquire.

Q Do you have ongoing relationships with attorneys with firms to solicit work?

A I don't solicit work from any attorney.

Q Do you have attorney referral sources?

A I don't know what that means. Attorneys can call me, whether they are plaintiffs and Defense on both sides call me to look at films. Every once in a while I end up in court testifying. That's the sum total of what I do.

Q Did you -- have you worked on patient records that attorneys sent you directly?

A I don't know what that means.

Q Well, you didn't get it from another doctor. You got it from a lawyer; is that correct?

THE COURT: Records you mean diagnostic are the

reports or films?

Q Any records.

A Yes, I will repeat again. There are attorneys that send, both Plaintiffs and Defense, that send me MRIs, like in this case, for me to review, yes.

Q And do you send your records and your reports directly to them, as well?

A Yes, just like in this case. All my reports are addressed to them, correct.

Q So just so I am clear. Then, I am going to move on. Your testimony is that you do get work referred to you by attorneys?

MR. VARGAS: Objection.

THE COURT: Sustained. The doctor has already objected to the characterization of his referrals, and he said that he takes that to mean patients. In any event, it was asked and answered.

Q So, Dr. Kolb, did you review the plaintiff's emergency room records?

A I did not.

Q Did you review any records, aside from the films that you've discussed today?

A It is possible sometimes I get sent the original radiology reports, if the films were done elsewhere, and I didn't do them. I don't recall, in this case, whether I saw

them or not.

Q As you sit here right now, you don't recall reviewing any other records, aside from the films themselves?

A Correct.

Q Even if the films were done by someone else at another facility, you don't recall if you read their report, the interpretation of the MRI?

THE COURT: In this case you mean?

Q In this case.

A That's correct.

Q Or the x-ray or whatever, correct?

A Correct.

Q Doctor, I noticed that in your testimony you didn't mention anything about observing the deterioration in any of the films. In fact, your reports don't mention it either, correct?

A They do.

Q They do?

A Sure.

Q You have reports that do?

A They do.

Q Did you mention anything about degeneration in your testimony however?

A I did not.

Q So in someone who is the plaintiff's age 56, at the

time of the 2019 films --

A Yes.

Q -- you would expect to see degeneration, correct?

A You can. It is more likely at 56 than 36, sure.

Q You would expect to see it?

A The older you are, the more likely you are and expect to see degeneration, correct.

Q So that is a yes?

A It wasn't be unusual.

Q Say that again.

A It would not be unusual.

Q And, in fact, those films do show degeneration, correct?

A There are some degenerative changes in my reports, correct.

Q Did you do take a history from the patient, as well?

A I never saw this patient. This patient was done elsewhere. I only am looking at the films and talking about the films. The answer to your question is no.

Q You didn't review any records to get a history, as far as the incident --

MR. VARGAS: Objection. This has now been answered twice.

THE COURT: It is asked and answered. Sustained.

Q What degeneration did you find?

A So I found, I will tell you in one second. In the shoulder there are degenerative changes at the achromic clavicular joint. In the cervical spine there are hypertrophic changes, which are degenerative changes at two levels posteriorly and the cervical spine and one level anteriorly. That is all in my reports. I did find degenerative changes.

Q What are the two levels in the spine?

A In the spine there are C3-4, C4-5. Those are major levels and that here. Those are the two main levels. C3-4 and C4-5. If you give me one more second, I will just make sure by looking at everything else.

(Witness perusing document.)

A Yeah, those two levels had the greatest degenerative change.

Q You said greatest. There are degenerative changes throughout his cervical spine?

A I didn't see throughout. I saw in my report those two levels. That is what struck me.

Q That was C --

A C3-4 and C4-5.

Q Now, and in the shoulder you saw degenerative changes as well, correct?

A In the achromic clavicular joint.

THE COURT: In the AC joint.

Q That's not usual or surprising to someone of the plaintiff's age, correct?

A Yes.

Q Do you know what the plaintiff did for a living?

A No.

Q Do you know what his work history was?

A No.

Q If someone had worked for 20 years in manual labor, would you expect to see more degenerative changes than someone who had not, no matter what the age?

A That's a very individual question. If you have someone sitting at a disk at a computer all day there are degenerative changes, and you can have someone in manual labor that has less. So it is very individual.

Q Again, you would expect to see more than someone who was sedentary, correct?

A No, I think I just answered that. You can have sedentary people who have horrible arthritis, and manual laborers that look pretty good. It is individual.

Q The degenerative changes that you noted in the plaintiff's films, those were not trauma related, correct?

A Correct.

Q Those are what happens over the course of time. Over wear and tear, say over 20 years of working manual labor,

correct?

A It's possible, sure.

Q And even if he was, as you point out, he was sedentary, he didn't have a manual labor job, someone at 56-years old, they would be wear and tear, as evidenced in his shoulder, in his spine and his cervical spine, correct?

A There could be, sure.

Q When you say "could be," what is that like 99 percent possibility?

A I can't. I'm sorry.

Q 90 percent possibility?

A No, I can't give you numbers. You look at a spine, and you see what you see, and the patient could be whatever age they are.

Q Can you tell the jury what disk desiccation is?

A It means drawing out.

Q And that's also a degenerative change, as well, correct?

A Yeah.

Q Did you note any disks desiccation on this cervical spine?

A No, because the way they were done, all the MRIs were done, they weren't done specifically for that.

MR. BUFFALOE: Thank you, Dr. Kolb.

THE COURT: Any redirect?

MR. VARGAS: No, your Honor.

THE COURT: Thank you, sir. You are excused.

(Witness exiting.)

THE COURT: We don't have another witness until two; is that right?

MR. VARGAS: Yes.

THE COURT: We are making good time, ladies and gentlemen of the jury. I think the weather is okay today. It is not a bad day to have an extended lunch. We will see you back here again for 2:00 with the understanding that we will not guarantee it but our best chance of being on standby is 2:15.

In the meantime, don't discuss the case amongst yourselves or with anyone else. Don't do any outside research or have any contact with any of the people we have asked you not to speak with, including the witness that was on this morning. Thank you very much.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jurors exited the courtroom and the following occurred.)

(A luncheon recess was taken at this time.)

* * *

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

* * *.

COURT OFFICER: Ready?

THE COURT: Yep.

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jurors enter the courtroom and the following occurred:)

THE COURT: You all can be seated. You ready to call your next witness?

MR. VARGAS: Yes, I call Dr. Jeffrey Kaplan to the stand.

J E F F R E Y K A P L A N, Doctor, having been called as a witness by and on behalf of the People in this case, having first been duly sworn was examined and testified as follows:

THE WITNESS: Yes.

THE CLERK: You can be seated. State and spell, in a clear voice, for the record, your name and business address.

THE WITNESS: Jeffrey Kaplan. K-A-P-L-A-N. My office is 180 East 56th Street in Manhattan 10022.

THE CLERK: Thank you.

THE COURT: Good afternoon, Doctor.

THE WITNESS: Hi.

THE COURT: Your witness.

MR. VARGAS: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. VARGAS:

Q Good afternoon, Dr. Kaplan. If you can tell the jury how long have you been a doctor and your educational background?

A I have been a doctor since 1989. Education, I went to college at Yale University. I graduated from college. I went to medical school at Columbia University here in the City. Following that, I did a training program in orthopedic surgery. I did that in a place called the Campbell Clinic in Memphis, Tennessee. I moved back to New York, where I have been in practice ever since.

Q Are you board certified?

A Yes.

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

A Yes.

Q How much are you being paid?

A My office gets a fee of $8,500 for the day.

Q And Doctor -- strike that.

MR. VARGAS: Your Honor, I ask the Court to deem Dr. Kaplan as an expert in orthopedic surgery.

MR. BUFFALOE: No objection.

THE COURT: Without objection he is an expert in orthopedic surgery.

Q Doctor, did there come a time when you treated a Mr. Yester Castillo?

A Yes.

Q And when was that the first time you saw Mr. Castillo?

A For this accident I initially saw him on 11/8/2018.

Q Did you take a history from him?

A Yes.

Q When was the history?

A History were some injuries that were sustained in a work-related accident that occurred on 7/27/2018. He had been struck by a piece of laminent that fell on him at work.

He was initially treated at Mount Sinai Hospital. He had some sutures placed for laceration in his nose. He had some follow-up with a Dr. Etienne. Some physical therapy, some pain in the neck, in the shoulder, which he was looking for some opinions on.

Q And that is the left shoulder?

A That is the left shoulder, correct.

Q At that time, did you do an exam of him?

A I did.

Q And what were your findings?

A I noted that he had tenderness about the shoulder, which means pain when you touch it. That was particularly in what's called the subacromial space, the bone here that you have on the top of our shoulder.

He had crepitus with motion, which means cracking and

popping. When you move the joint he had motion, which was limited, including abduction, which means you take the arm away from the body onto 160 degrees normal, 180 degrees. He had some weakness with motion testing of the shoulder and specifically with rotation testing, which usually speaks to a rotator cuff injury, which is a cuff, the tendons and muscles around the shoulder.

I also noted that he had tenderness about the neck. He was able to flex all the way down. I noted it. He had limited extension. It means putting your head back, and then, I reviewed some imaging studies, some MRIs that he had had as part of his exam.

Q And after the exam, the history and reviewing the reports, did you have a recommendation for treatment for Mr. Castillo?

A I did. I felt that he had an injury to his rotator cuff. Given his MRI findings and his injury to his other structures inside the shoulder, one called the labrum, which is what the biceps tendon attaches to inside the shoulder. I recommended an injection.

I gave him an injection of some steroid at the shoulder to try to calm down, decrease his pain, and then, I requested that he be authorized to have some surgery and some therapy for the shoulder.

Q And I see under report there is a portion called

plans.

A Yes.

Q And what does that refer to?

A Plan is just what we are going to do for him. One. Give him an injection. One. Talk about surgery. And, one, talk about physical therapy. I also referred him to pain management, which is a speciality that takes care of pain and cervical, the neck and the lumbar spine.

Q That is Dr. Grimm?

A Dr. Grimm, yeah.

Q And the next time you saw Mr. Castillo was January 7th, 2019?

A Yes.

Q And, at that time, did he have any complaints to you at that time?

A He still continued to have pain at the left shoulder. In fact, it was getting worse. He was having difficulty sleeping, which is a very common complaint with injuries to the shoulder, because a lot of people sleep with their arm up, which causes impingement. He also continued to have neck pain and pain radiating all the way down to his hand.

Q And the next you saw him at the surgery center?

A Yes.

Q When you performed the surgery on the shoulder.

A Yeah, I did get authorization for surgery and

performed that surgery on February 6th of 2019.

Q And can you describe, for the jury, what the surgery entails?

A Sure. The surgery, we found that he does have a tear of two of the tendons of the rotator cuff and damage to his biceps tendon. This muscle here that attached up to the shoulder joint. He had enough damage to that structure that it wasn't repairable. So released it. We disconnected it up at the top of the shoulder to take the tension off of it.

We also took out some inflammatory tissue called synovia and bursa, and that was all done with an arthroscope, which is a special surgical tool. I have a model here of the shoulder.

Q If it will help you explain.

A Yes.

THE COURT: It is a demonstrative of a shoulder.

MR. BUFFALOE: Can I see it?

THE COURT: Sure.

MR. BUFFALOE: No objection.

THE COURT: Without objection. All right. Ladies and gentlemen, you are reminded that this is just a demonstrative exhibit. It is not recommended to show defendant's particular shoulder, but every man's shoulder, as it were, and it is just used to help illustrate whatever the doctor is talking about.

A So this is a model of a shoulder. This is actually a right shoulder. Most models come on the right side. The shoulder is made up of three bones, the collarbone, what we think of as the shoulder blade, and the top of the arm bone called the humorous.

What I think is important to show this group of muscles that is called the cuff of muscles that goes around the top of the arm, that is called the rotator cuff, because if any one of those muscles fires contracts, it causes the arm to rotate in different ways.

Also this is the arm. So this would be the biceps muscle. The muscle on the top -- of the top of the arm here, and it goes all the way up into the shoulder joint. In Mr. Castillo's case it was torn and injured, in a way, that could not be repaired. So we do what's called a tenotome or cutting of a tendon that releases this tendon. It slides down. The muscles are grouped up a little bit. It is Popeye Deformity, because the arm can look like Popeye's muscles, because it is not attached up top, but it is still attached to the bone, and you can still have pretty good strength, because it does not affect your strength terribly, and it does get rid of the pain associated with that tear.

The other thing Mr. Castillo had was a tear of the tendon of the rotator cuff, and we repaired that by putting stitches through the tendon by drilling holes into the bone

and anchoring these tendons back into the bone with what is called a surgical anchor.

Q And, after the surgery, you saw him next on February 14th, 2019?

A Yes, February 14, 2019.

Q And, at that time, did you examine Mr. Castillo?

A I did. At that time we took out his stitches from the surgery. He has very limited motion at that time, because of the surgery. He had only 30 degrees of abduction. That is about what we would expect at that point. It is a long recovery period from this type of surgery, but the tendon has to grow up back into the bone, and then, you have to rehabilitate the muscle, because it gets very weak. So that's early in his recovery.

Q You said a long period of time. What would be your expectation for time of recovery?

A It is really different for everybody that I generally tell people that at least six months to get your motion back and to start getting your strength back in the rotator cuff muscles.

Q And you next saw Mr. Castillo on March 14th of 2019.

A Yes.

Q And then April 25th, 2019.

A Correct.

Q June 6th, 2019. I want to draw your attention to

July 17th, 2019.

A Okay.

Q At that time, did you examine Mr. Castillo?

A I did.

Q And what were your findings?

A At that time he was having pain at the area of the biceps where we had released it. Sometimes people get some pain down the arm, as the body is trying to figure out what to do with that tendon that we have relieved. It gets some inflammation around that.

He was getting his rotator cuff motion back to some degree. He had 165 degrees of motion at that point in abduction. Still had very limited internal rotation, which is turning the arm in this way, which is usually the last motion you really recover with any significance.

Q And did you have recommendations for him at that time?

A We discussed continuing physical therapy, and I recommended that we discussed injections. Just to decrease some of the inflammation with the film was causing some pain at that time.

Q And you next saw him on August 28th, 2019.

A That's right.

Q And, at that time, did you examine Mr. Castillo?

A I did.

Q And what were your findings?

A At that time he was still having a lot of pain around the front of the arm, the biceps, and he was having trouble firing his biceps, because of pain. He had what's called a positive speed sign, which is named after Dr. Speed, basically testing the biceps muscle and tendon.

He was having pain and pain of the shoulder. So we recommended additional testing for him again. A new MRI of the shoulder to make sure that everything was progressing, as I had hoped, and that was the case.

Q And earlier this morning the jury saw that MRI. It was September 10th, 2019, correct?

THE COURT: He wasn't here this morning.

MR. BUFFALOE: Objection.

THE COURT: Sustained. He wasn't here this morning. He doesn't know what the jury saw this morning.

Q Do you know was that MRI performed?

A Yes.

Q And do you know when it was performed?

A Yes, I thought that is what you were asking me to confirm. The date was 9/10/19.

Q Did you review that MRI once it was taken?

A Yes.

Q Did you have a different diagnosis after reviewing the MRI?

A The diagnosis, things were going, as I had hoped, you know, the MRI does show abnormalities, which I feel were postsurgical, showed a rotator cuff tear. It did not grow in fully. It still showed up on the MRI, still had some tearing around some of the cartilage that is not something we address. He still had some ongoing reasons to have pain in shoulder.

Q Did you have recommendations for him for treatment going forward from there?

A I did. I recommended, again, a steroid injection to try to calm down the inflammation, as well as some additional physical therapy.

Q And you next saw him on November 7th, 2019.

A That's right.

Q At that time, did you examine him?

A I did.

Q What were your findings?

A He had better motion, 175 degrees of abduction at that time. He did not have significant pain associated with that. He did have continued tightness and internal rotation, as well as what's called forward inflexion, and he continued to have the short end of the bicep, which is what we expect after the biceps tenotome surgery.

Q And next you saw him January 14th, 2020?

A That's right.

Q And, at that time, did you examine Mr. Castillo?

A I did.

Q And your findings?

A Still had 175 degrees of abduction. He had crepitus, cracking and popping, still had some weakness on rotation tests and still had a Popeye deformity. That is going to be important.

Q And next, May 27th, 2020 was in the middle of COVID, correct?

A Yes.

Q And then August 21st, 2020?

A Right.

Q At that time, did you examine Mr. Castillo?

A I did.

Q And your findings?

A He had limited motion especially in forward inflexion. His abduction bringing out to the side, one was 175 degrees but his forward inflexion was to 140, and he still had some weakness with external rotation testing, still had the Popeye deformity.

Q And you noted crepitus, as well?

MR. BUFFALOE: Objection.

THE COURT: On this visit, you are asking if he noted?

MR. VARGAS: Yeah.

THE COURT: Sustained. Meaning you just can't lead him.

Q Under your objective findings, can you tell the jury what you found?

A He did have crepitus, which is a cracking and popping in the joint.

Q And is that an objective or subjective finding?

A That is an objective finding, meaning it's something I hear, not something the patient tells me.

Q And what is the cause of the crepitus?

A Crepitus can be from several things. It can be damage from the joint surface where the joint is not moving smoothly. It can be from adhesions or inflammation of joint that make noise.

Q And, at that time, did you have recommendations for his treatment going forward?

A At that time I felt that he had exhausted his physical therapy recommendations. So we went over some home exercises to do, and we discussed the use of anti-inflammatory medications, I believe, at that time.

Q And the next time you saw Mr. Castillo was January 15th, 2021. And then, I want to draw your attention to April 15th, 2021.

A Okay.

Q At that time, did you examine Mr. Castillo?

A I did.

Q And your findings?

A He complained of painful popping at the left upper arm. That was manual lifting. I felt that was consistent with his biceps tenotome where the tendon had been torn. When he fired his biceps muscle, the tendon would pop. He was finding that painful.

So I examined him. He still had the Popeye deformity. He had tenderness up at the top of the biceps for being consistent with that. He had limited abduction or moving away from his body this way, as well as internal rotation. His external rotation was approaching normal but still not normal. Those were the findings.

Q And then, you next saw him on October 21st, 2021 and December 14th, 2021. And if I can draw your attention to March 15th, 2022.

A Okay.

Q And, on that date, did you examine Mr. Castillo?

A I did.

Q And what were your findings?

A At that time he was having shoulder pain on both sides, right and left; pain radiating down in the shoulders from the neck. I felt he on exam had what's called dense trigger point formation. Trigger points are muscle spasms that are sustained in the area. In this case, the neck and

shoulder, and still had some limited motion to 170 degrees by abduction, 90 degrees of external rotation. Internal rotation was limited to 70 degrees forward. Inflexion was limited to 160 degrees. He continued to have tenderness along the biceps and the Popeye deformity.

Q And next, if I can draw your attention to September 1st, 2022.

A Okay.

Q And, at this time, did you examine Mr. Castillo?

A I did.

Q And your findings?

A Let's see. He continued to have intermittent discomfort at the left shoulder, primarily a lot of it was radiating in the back from the neck. My findings included persistent limited motion to 170. Abduction, external rotation was a little more limited than the last visit at 180 degrees and internal rotation was at 75 degrees.

He had shoulder atrophy is loss of muscle bulk. When you look at someone's shoulder you can see rather than the normal outpouching of the muscle. Sometimes it will have a divot in the rotator cuff muscles that you can see. That's called atrophy, loss of muscle wall and he had crepitus, which is the cracking and popping you hear in an abnormal joint.

Q And under your plans in your report --

A Yep.

Q -- what were those?

A We went over home exercises. I had requested some additional therapy that was denied. I felt that he was reaching maximum improvement, as far as active treatment meaning that, at this point, we were just treating the symptoms. I didn't think he needed surgery, but I felt like he should continue with pain management and see what went on with that.

Q And the next time you saw him was January 17th, 2023.

A Yes.

Q April 18th, 2023. July 24th, 2023. And then October, I am going to draw your attention to October 23rd, 2023.

A Okay.

Q At that time, did you examine Mr. Castillo?

A I did.

Q And what were your findings?

A At that time with regard to the shoulder he had 170 degrees of abduction, which is still not quite normal. External rotation was to 80 degrees. Internal rotation was to 75 degrees. Those are both limited again. He had atrophy about the left shoulder as compared to the right. He had tenderness in what I call the posterior shoulder, which is sort of the neck and shoulder region.

And then tenderness in the cervical paraspinous

musculature, which is the, again, is next to the trapezius muscles and the parascapular muscles, reach from the spine all the way to the shoulder, and he had tenderness there, as well.

Q And, Doctor, was that the last time you saw him?

A That was, yes.

Q Doctor, do you have an opinion with a reasonable degree of medical certainty, as to whether the injuries to the shoulder, that you have described for the jury today, were causally connected to the accident of September 27th, 2018?

A I do have an opinion.

Q And what is your opinion?

A My opinion is given the history that I've reviewed and the timing of complaints, that his shoulder injuries are from his accident.

Q And, Doctor, do you have an opinion with a reasonable degree of medical certainty as to a future prognosis for Mr. Castillo?

A Yes.

Q What is that?

MR. BUFFALOE: Objection.

THE COURT: Overruled.

A Prognosis is looking into the medical future. Based on what we found, I think he has had some significant injury for the surgery on his shoulder. He still has loss of motion

several years after the injury and certainly after the surgery, and I think that will be permanent, and the loss of motion, loss of strength and pain he's experiencing will be important.

MR. VARGAS: Thank you, Doctor. No further questions.

THE COURT: Thanks. Do you want a few minutes or are you ready?

MR. BUFFALOE: Just a few.

THE COURT: Let's take five. Doctor, I remind you, you remain under oath.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jurors exited the courtroom and the following occurred.)

(Whereupon, there was a recess, after which the following occurred.)

COURT OFFICER: All rise. Jury entering.

(Whereupon, the jurors enter the courtroom and the following occurred:)

THE COURT: You can all be seated. Thank you. You remain under oath, Doctor. Your witness, sir.

CROSS-EXAMINATION

BY MR. BUFFALOE:

Q Good afternoon, Dr. Kaplan.

A Hi.

Q Let's start off with something simple. When was the last time you testified this year?

A Two-weeks ago maybe.

Q How many times have you testified in court so far this year?

A Probably four or five.

Q And each time has been in a case for the plaintiffs, correct?

A For my patients, yes.

Q Who were plaintiffs in the case, correct?

A That's the way it goes, yes.

Q So, by the way, you said your patients. Some of your patients are referred to you by plaintiff's attorneys, correct?

A Yes.

Q Including this, the firm that's plaintiff's counsel in this case, correct?

A That's true.

Q As a matter of fact, Mr. Castillo was referred to you by the plaintiff's firm in this case, correct?

A I don't know about that. It's probable.

Q You also testified that the first time you saw Mr. Castillo was back in 2018. That is not correct. You saw him well before then, correct?

A Sir --

THE COURT: Sustained. He didn't say that. He said the first time I saw him for this accident I remember, because I made a note about it.

Q You have seen him before, correct?

A I have operated on him before.

Q You have operated on him at least once, correct?

A That's right.

Q And that was in connection with his other shoulder; is that correct?

A That's correct. His other shoulder.

Q With regard to that, in the course of your treatment, do you remember when that particular accident occurred?

A That was many years ago. It was in 2011 or something like that.

Q All right. I would refresh your recollection. It was 2009.

A Okay.

Q During the course of your treatment with him, do you recall diagnosing him with brachial plexopathy?

A With what?

Q Brachial plexopathy.

A Brachial plexopathy. Yes, he did have some irritation of his brachial plexus, yes.

Q And, as a matter of fact, you sent him for an EMG to confirm the diagnosis?

A I think so. I don't recall.

Q Now, that said, can you tell the jury what that is?

A Sure. The brachial plexus is a plexus or group of nerves that run down the arm. It exits from the spinal cord into the armpit and down the arm. If you have a shoulder injury, sometimes you can get what's called a brachial plexopathy, meaning a problem with the brachial plexus.

Q And there are certain parts of the cervical spine that are implicated in that diagnosis, correct?

A Not really. So the nerves that make up the brachial plexus come out of the spine, but the injury is in the axilla, in the armpit.

Q So it doesn't implicate the C4, C5 nerve root?

A It implicates the nerve but not the neck. The nerve runs all the way down the arm.

Q So it is fair to say that it could cause complaints of cervical pain?

A No, absolutely not.

Q Absolutely not. Okay. In connection with your treatment for him for the 2009 accident, were you aware that he complained at Comprehensive Pain Management, that he was having pain in his right arm back in, what is it? In 2017?

A I don't recall but if you show it to me and it is there I certainly would accept that.

Q When you saw him for the first time in connection

with this accident in 2018, did you take a history from him?

A I did.

Q Did you ask him if he had prior shoulder complaints?

A I asked him if he had prior injury to his shoulder, problems with his shoulder, which he did not.

Q You didn't ask about the shoulder complaints, pain to his shoulder, an injury to his shoulder?

A Not that I recall.

Q In connection with this accident, this 2018 accident, do you know what hospital he went to immediately after the accident?

A Initially, my notes indicate Mount Sinai Hospital.

Q Do you know how he got there?

A I don't recall.

Q Do you know if an ambulance was called?

A I really don't recall.

Q Did he tell you that he wasn't removed by ambulance?

A I'm not sure what that means "removed".

Q Taken from the scene.

A As I said, I don't recall.

Q Did you review the Mount Sinai Hospital records?

A I believe I had the opportunity to read the discharge memo from Mount Sinai hospital.

Q At the hospital, do you recall him denying a loss of consciousness?

A I don't.

Q Do you remember him denying that he had any -- that he hit his head or that he had any neck or shoulder complaints?

A He denied that he hit his head.

Q Yes.

A Didn't he have a laceration on his face? That is part of his head.

Q I am asking you, did you review the records?

A I think I reviewed the records. I don't recall.

Q Do you recall, when you reviewed the records, that he denied having any left shoulder pain or neck pain?

A I don't recall. If you have got them there, I would be happy to review them.

Q Doctor, so when you saw him for the first time on 11/8/2018 --

A Yeah.

Q -- if I am understanding your direct testimony correctly, on that first visit you recommended surgery, correct?

A I'm sorry?

Q On that first visit you recommended surgery, correct?

A I did, because he had had physical therapy. He had already had an MRI. He was still having problems. I started the process for getting authorization for surgery, yes.

Q When you saw him, did you see any signs of degeneration --

A Not that I recall.

Q -- or Degenerative Disk Disease?

A I was focused on his shoulder.

Q Any signs of degeneration in his shoulder?

A No.

Q When you looked at films of his shoulder, did you see any signs of degeneration?

A Not significant degeneration.

Q What does that mean significant? Sounds to me like something.

A Significant means something you would expect, and so we all have some degeneration. This gentleman has worked in construction. You would expect to have, you know, some changes but not significant.

Q So what did you observe, as far as deterioration is concerned?

A Nothing significant.

Q What did you observe specifically? When you say "nothing significant", you mean age appropriate?

A Exactly.

Q Someone of his age, someone of his profession?

A That's exactly right.

Q What did you see?

A You would have to show me the MRI, so I could point it out to you. In my mind it is not significant. So it is not really something that I registered. In fact, the diagnosis of a rotator cuff tear, that's not degenerative. It is not significant for the labial tear, and the biceps problem, that I didn't feel was degenerative. It had not responded to physical therapy.

Q Are you saying that a tear could not be degenerative?

A It can be. I don't believe it was in this case.

Q Do you know when the -- by the way, you are the director and president of New York Orthopedic Sports Medicine, correct?

A I am the owner NY Ortho Sports Medicine and Trauma, yes.

Q It is fair that Dr. Grimm works for you, correct?

A He does, yes.

Q And, by the way, Jodi Gelfand, does she work for you, as well?

A She does not.

Q Not anymore?

A Correct.

Q When was the last time she did?

A Years ago. She was my physician's assistant for years.

Q So is it fair to say that you would expect to see

degeneration in an individual's shoulder, who is on their feet all day, who is doing manual labor and is 56-years old?

A Can you see some degeneration? It will be different in everybody, sure.

Q And it would be more -- you would expect to see more than you would to say someone that is working at a desk?

A It really depends on what they do and their genetics at that time.

Q By the way, you talked about atrophy, correct?

A Yes.

Q How did you mention atrophy?

A It is different, different body parts. A limb you can measure around. In like a shoulder where you can't measure around, it is just observational and that's what I described as the normal contour of the muscles, as opposed to a hollowing out of the muscles.

Q Okay. And an appropriate measurement is a sign of no atrophy, correct?

A An appropriate measurement? I'm not sure what you mean.

Q When you find a normal measurement of him, there is a sign of no atrophy?

A There is no normal atrophy of a limit.

Q How do you decide if it is abnormal?

A In an individual, you compare side by side.

Q So if they are equal bilaterally, there is no sign of atrophy?

A That is what you would expect.

Q Before I forget. I forgot to ask you earlier, how much of your business is referrals by attorneys?

A Certainly a portion of it. I don't keep a record of what percent.

Q Is it more than 50 percent? Is it more than 90 percent?

A I don't keep a record. It is probably around 50 percent, because I see a lot of people who are injured at work.

Q So, Doctor, I just want to draw your addition to your report of April 8th of 2023.

A Say the date again. I'm sorry.

Q April 18th of 2023.

A I'm sorry 2000?

Q '23.

A Thank you. Okay.

Q The range of motion in that report is identical. Your findings are identical to the one the last time you saw him on October 23rd, 2023, correct?

A It's been similar for a while.

Q And that report, there is no finding of atrophy, correct?

A I don't note it but that doesn't mean this wasn't there. That I didn't have him take his shirt off.

Q Let's talk about the one of January 17th of 2023.

A Yes.

Q Again, you don't note any atrophy there either.

A If I don't take his shirt off, I am not observing it. So I can't say one way or the other.

Q When you say observed, do you mean measure or just eyeball?

A I just described this to you, sir.

Q You did.

A I did.

Q I don't know why you couldn't measure with his shirt on though.

A Because you are not measuring with a tape measure. You are looking at it.

THE COURT: The shoulders.

A I have said this, right?

THE COURT: For shoulders you did say this.

Q And the same thing on June 30th of 2023.

A Same answer.

Q You didn't measure?

A It is not a measurement in the shoulder, because you can't put a tape measure around it. It is an observation. If I don't take the patient's shirt off for an exam, when I

am doing a range of motion, I am not going to say whether or not there is atrophy, because I haven't observed it.

Q And, by the way, and, again, same thing on May 6th?

A Same answer.

Q Any time in your reporting that you didn't look at -- you don't record atrophy it is your testimony that you didn't bother. You didn't look at it. You didn't observe.

A I didn't have the gentleman take his shirt off, that's correct.

MR. BUFFALOE: Nothing further.

THE COURT: Okay. Thanks. Redirect?

MR. VARGAS: No, your Honor. Your Honor, no.

THE COURT: All right. Nice to see you. Thanks for coming in. You have any other witnesses for today?

MR. VARGAS: No.

THE COURT: Well, we have done a good deal more than I thought we would. I thank you for your work. Remember that you are off tomorrow. Right? So that I can do my motion conference calendar. We will be back Thursday 9:30 when we expect to have one witness Thursday morning and then, one witness.

We think will be Friday morning, but we will let you know more on Thursday. Have a good productive day tomorrow at work, school, whatever you are doing on your off day. Remember not to do any research, discuss the

case amongst yourselves or with anyone else or have any contact with any of the folks we previously asked you not to have contact with or this witness, who just appeared.

Thanks very much for your time. We look forward to seeing you on Thursday.

COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jurors exited the courtroom and the following occurred.)

THE COURT: We will see you on Thursday morning.

(Whereupon the trial was adjourned to May 9th, 2024 at 9:30 a.m.)

CERTIFIED TO BE A TRUE AND ACCURATE TRANSCRIPT OF THE ABOVE-MENTIONED TRANSCRIPT.

_____

JOHN D. CARDILLO

SENIOR COURT REPORTER

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