UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

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NANCY M. ESPINAL LORA,

Plaintiff,

v.

COWAN INTERMODAL GROUP, LLC AND STEPHEN K. WIRTZ,

Defendant.

----------X

ZOOM DEPOSITION
Friday, December 20, 2024
01:08 p.m.
VOL II

Continued deposition of SEBASTIAN LATTUGA, MD, the Witness herein, taken by the Defendant's Counsel, held at the above-mentioned time and place, before SKYLAR SENA, a Court Reporter and Notary Public of New York.

* * *

MAGNA LEGAL SERVICES

APPEARANCES:

HARMON, LINDER & ROGOWSKY
Attorney for the Claimant
3 Park Avenue
Suite 2300
New York, NY 10016
(212) 732-3665

BY: KESETE TAYE, ESQUIRE

LEWIS BRISBOIS BISGAARD & SMITH LLP
Attorney for the Defendants, Cowan International Group, LLC and Stephen K. Wirtz
77 Water Street
Suite 2100
New York, NY 10005
(646) 783-0901

BY: JENNINE GERRARD, ESQUIRE

S. LATTUGA, MD

SEBASTIAN LATTUGA, MD, after having first been duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

THE WITNESS: I do.

THE COURT REPORTER: Thank you. Counsel, you may proceed.

MS. GERRARD: Just for the record, I want to document what happened because I'm not sure -- our last court reporter left so fast that I'm not sure it was documented in part one of the transcript.

We started the deposition at 10 a.m. Our court reporter advised us at 11-something that he had to leave at 12 and said that the deposition had only been ordered from 10 to 12. I since checked with our office and that was not the case. So now Magna has been good enough to find us a second court reporter and we're going to continue with the deposition of Dr. Lattuga.

MR. TAYE: And the time will be reflected, right, on the record, on the transcript?

THE COURT REPORTER: Correct.

MR. TAYE: Thank you.

MS. GERRARD: As always.

Doctor, I can only see the top of your head. There you go. I guess it's cold in your house.

S. LATTUGA, MD

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EXAMINATION

- - -

BY MS. GERRARD:

Q. Question for you. Referring to the MRI of the cervical spine that was taken at Stand-Up MRI, there's a note at the bottom of the 2nd page at the end that says that the radiologist found "a thyroid lesion probably representing an adenoma. However, carcinoma cannot be excluded."

Did you ever speak to the patient about the fact that she might have cancer when you first met with her or at any time?

A. No.

Q. Did you note that in the radiology report?

A. I'm sorry. Did I note -- I didn't create a report. It's not part of my specialty. So I have no expertise with respect to thyroid lesions. And I haven't -- and, you know, it wouldn't be part of my record, right? And so I think, though, I mentioned to you earlier that she was on thyroid medicine. So I'm not sure -- you asked me to go through the medicines. I see she was on some kind of thyroid medicine. Again, it's not my specialty, so I don't know if she was

already being treated for it or -- I -- I don't have any information with respect to that.

Q. Okay. The question was that in the MRI report, which you said you read and agreed with, it says, "carcinoma cannot be excluded." The question was simply yes or no.

Did you ever discuss the possibility that the patient might have cancer with her during your treatment?

A. I don't have an independent recollection.

Q. Okay. Would that normally be something that you would bring to a patient's attention?

A. Yeah, if there was a, you know, again -- and Dr. McGee ordered this test, right? So Dr. McGee was the first one to re -- review it. So --

Q. Right.

A. And -- and he's -- and he's more the generalist, right? So he would say, oh, here's all the things we found and you found it. You know, I -- what typically happens in this, if they come to me and say, oh, you know about this? Do you know about this issue with the thyroid on the MRI? And the patient says, oh, yes or no. If they go, oh, yes, and then I don't -- I don't follow through with it. I mean, I'm not -- I'm

not a cancer specialist. I'm not a thyroid specialist. If he says, no, then I make them aware of it. I circle it and I hand it and I say you need to see your PCP. I don't -- I don't know -- I really don't know what it means. I wouldn't be giving advice on it. So that's my customary practice. I hope that answers your question.

Q. Not really, but I'll move on. We were talking earlier about cervical spinal instability.

Can you tell me what your definition of cervical spinal instability is?

A. Well, it's, you know, it include -- I mean, so it's -- it could be -- it could be present on the radiographs. It could be present on MRI. It could be present just from a clinical presentation where patients can say certain things that are suggestive of instability, meaning -- and what instability -- the way I'm defining it is excessive motion of the -- of the vertebral segment that exacerbates their pain, right? And it's very generally, and it -- and I -- it's -- it's not an all-inclusive definition. There are other issues with respect to instability, right? But clinically what we see is patients that show -- even -- even if it's -- even if it's micro motion, right, it doesn't have to be gross instability like a -- like a dislocation, that

that's an exacerbated radiculopathy. And that was based on the history she gave me, that she had, you know, arm pain, and when she moved her neck, it went down her arm more, for example. That's an example of -- of how I use the word instability in -- in a generic form. So I hope that answers your question.

Q. But you were aware that she also had a shoulder injury. Correct?

A. Dr. Mian did shoulder surgery on her, yes.

Q. And that her arm pain could have been related to that injury?

MR. TAYE: Objection as to form. He can answer.

THE WITNESS: Her arm pain -- well, her shoulder pain is from her shoulder and her arm pain that was radiculopathic is not from her shoulder, right? It's the same -- it might be the same area, but they're two different syndromes.

BY MS. GERRARD:

Q. So your determination of her cervical instability was based on complaints, subjective complaints that she gave you.

A. Correct. And then, yeah, subjective and -- and my objective findings of -- of diminished sensation,

my review of the MRI. Those are all how I assess whether instability is a factor in -- in the radiculopathy. That's -- well, I mean, you know, I think that that's my opinion. My medical opinion is that instability was a factor in her -- in her radiculopathy. It -- it's not more than that.

Q. Can you point to anything in the cervical MRI from Stand-Up MRI of Queens that indicates that she had instability in her cervical spine?

A. No.

MR. TAYE: Objection as to form. Asked and answered. He can answer.

THE WITNESS: No.

BY MS. GERRARD:

Q. Okay. And during your operation on her cervical spine, you noted that -- I think you said earlier there were no fractures found. Right?

A. No, there were no fractures found.

Q. And there was no damage to her ligaments. Correct?

A. On the MRI reports, there makes no mention of ligamentous damage.

Q. And in your op report, you noticed that the PLL was intact. Correct?

A. Yes, ma'am.

Q. And that's a ligament that would affect stability of the cervical spine.

A. Yes. If the PLL is damaged, it -- it would affect the cervical spine. Yes, ma'am.

Q. All right. But it was not damaged. Correct?

A. No, ma'am.

Q. Okay. Did you rely on the lumbar MRIs from Stand-Up MRI before you performed her lumbar fusion?

A. Yes.

Q. You didn't take any additional studies?

Did you answer? I didn't hear you.

A. No, I didn't answer. I'm going -- what I'm doing is just going to the record where I -- the -- the date that I recommended surgery.

Q. Okay.

A. So I'm sorry, repeat the -- I found the note, if you repeat the question.

MS. GERRARD: Can you read the question back, please, Skylar?

THE COURT REPORTER: Sure.

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(Whereupon, the pertinent portion of the record was read.)

S. LATTUGA, MD

- - -

THE WITNESS: Well, my note says there was an x-ray taken on that day that was consistent with instability.

BY MS. GERRARD:

Q. There was an x-ray taken when?

A. On 5/10 -- 5/10/23.

Q. Was that a flex study?

A. Yes, ma'am.

Q. I'm looking at your op report from the lumbar fusion, if you want to get that in front of you.

A. Yes, ma'am.

Q. This was approximately five months after her initial accident. Correct?

A. It's like 6/1. 6/1/23 was the date of surgery. So yes, I would say approximately.

Q. And on the beginning of your op report, you say, "The patient complains of low back pain and neck pain with radiation into both right and left upper extremities."

Was that still the case as of June 2023, after you'd performed your cervical fusion?

A. I mean, there was still symptomatic from their neck, right? She's still symptomatic. But I -- this is

just -- just I'm giving a history as to the -- like the background of -- of -- for the -- for the report of this patient's history.

Q. Now, on the patient's MRIs from Stand-Up MRI, both cervical and lumbar, there's no indication of any acute injury. Correct?

MR. TAYE: Objection as to form. He can answer.

THE WITNESS: Correct.

BY MS. GERRARD:

Q. And what would the signs of an acute injury be on MRI?

A. I mean, generally, it -- it would be ligamentous edema or blood or other evidence of -- of tissue disruption. And it -- I mean, that's how it's classically described, right? And so -- like a herniated disk is -- is an example of tissue destruction too, but it's characterized differently than acute -- acute traumatic changes of the spine, so.

Q. Right. You can have a herniated disk for years and not know it. Correct?

MR. TAYE: Objection as to form. He can answer.

THE WITNESS: Herniated disks are common in

the population. Yes, ma'am. And those that are not (inaudible).

BY MS. GERRARD:

Q. Throughout your chart, you document several x-rays that were done in your office, which we don't have. I think I mentioned that earlier.

Are those still maintained in your office?

A. Probably, yes. I mean, I haven't seen them physically in a while, but I would say yes.

MS. GERRARD: Okay, I'm going to call for production of any x-rays taken in Dr. Lattuga's practice, and I'll follow up in writing.

MR. TAYE: Thank you. We'll take it under advisement.

BY MS. GERRARD:

Q. In your operative report for the lumbar fusion, you write "traumatically induced disk herniation."

What was the basis for that?

A. The basis was history. It was a traumatic event. It was the MRI findings of extr - of extrusion. Let me pull up the report if it's okay. One second. Yeah, extruded disk at L4-5, which I -- you know, based on the MRI and then my intraoperative observation. So

all those factors would -- is my opinion that it's traumatic.

Q. How were you able to tell during your operation in June whether a disk herniation was traumatically induced when you just told me that there's absolutely nothing on her lumbar MRI from a month after the accident that indicates trauma?

MR. TAYE: Objection as to form, argumentative. He can answer.

THE WITNESS: Yeah, I mean, and I think I tried -- I tried to explain that, right? And so like you can have -- like a herniated disk in itself, it's not necessarily traumatic, but in this case, my opinion is it is traumatic, right? And then it -- depending on the degree of herniation, you can have more or less degrees of -- of inflammation, edema, and other associated tissue. So you -- so classically, when they say a traumatic injury to the spine, they're talking about a fracture dislocation, really, is what they're talking about. So you see, you know, pretty -- pretty large changes of edema and hematoma in the area. So that's -- that's what I was answering you about. But a herniated disk in and of itself could be -- could be -- could be traumatic, right? You can bend over, twist,

and you -- and you extrude a disk. And so what I found in the surgery was a disk that was consistent with -- consistent with a disk that was herniated traumatically.

BY MS. GERRARD:

Q. Right. Was that just based on the fact that you knew this woman had been in an auto accident and what she told you at your first visit with her?

A. No, like I said before, it was -- it's part of it, right? So there's the history of the traumatic that's true. There's an MRI review, which, you know, it appeared to be a traumatic disk. And then intraoperatively it was, you know, maybe -- so what I didn't see was a hard calcified old disk herniation, right? Like you can -- you see that, right? We have lots of patients that have old, hard, calcificated (sic) disks. This was not of that consistency. This was more consistent with a traumatic herniation. That's all -- that's all I was saying.

Q. But you can't tell for sure whether it was from the accident that she was involved in in January. You're just saying that based on the fact that it was calcified, you assume that it was --

A. It wasn't calcified. It wasn't calcified.

MR. TAYE: Obje -- let her finish, Doc.

Objection as to form. Asked and answered repeatedly, argumentative. He can answer.

MS. GERRARD: You're so cute. I'm going to send you a list of objections so you can have them at the ready.

THE WITNESS: Repeat the question. I'm sorry.

MS. GERRARD: Hold on one second.

MR. TAYE: You got that on the record, right, Skyler? Thank you. The cute part?

MS. GERRARD: Very.

BY MS. GERRARD:

Q. You performed a foraminotomy --

A. Yes, ma'am.

Q. -- during the laminectomy surgery?

A. Yes.

Q. Why did you do that?

A. Because that's part of decompression, right? And so what -- the -- the nature -- to be as brief as possible, you're -- you're doing a laminectomy, removing some of the lamina, right? And then there's -- the nerve roots travel out the foramen, right? And so the disk, like in this particular case at 4-5, for example, is -- is extruded, displacing the nerve, right, into the foramen. So by removing the disk and then enlarging the

foramen, you -- you're maximally giving the oppor -- the nerve the opportunity to heal by decompressing. It's all part of the decompression procedure. It's also part of retrieving the disk. You know, it doesn't always just come right out. It's not easy to see all the time. So you have to enlarge -- you have to enlarge the space, right? You're enlarging the exposure of the nerves and it's just -- it's part of a decompression.

Q. In the Stand-Up MRI report, it states "The neural foramina are not narrowed."

Do you recall that?

A. Yeah, it does say that, but there's more things here, right? So, but those words, it does -- what is that, at the bottom, right? Let's just go over it. We -- we're talking about the lumbar MRI? You -- you want to show me where it says that? I think that was for the cervical spine.

Q. Yes.

A. Yeah, well, okay. So I thought we were talking about the lumbar decompression.

MR. TAYE: That's why I keep making repeated objections because the question's not clear.

BY MS. GERRARD:

Q. During the lumbar fusion, you iatrogenically

destabilized her lumbar spine. Correct?

A. Correct.

Q. Why would you do that when she already had instability of her lumbar spine according to your flex study?

A. So, it's all part of the decompression. So to get to the -- there was, if you read the words, facet hypertrophy, right? You read that in the report, right? So, the stenosis is created in multiple different ways, you know, and so the nerves could get trapped immediately behind, I'm simplifying -- the nerves could get trapped right behind where the disk comes out. It could get trapped on the way out the foramen, not quite out the foramen by -- by the facet hypertrophy, which is what she had, right? And so you have to take the facet off, right? You have to remove that part of the bone. It gets pinched underneath the bone, right? And then, so you remove that part and that destabilizes the spine.

If you don't do that, then you're basically leaving the stenosis underneath the -- underneath the lateral recess. In other words, you're not really giving the patient the chance not to have nerve pain because you left the nerve partially compressed. You could take the disk away alone, but the nerve just

continues to be compressed further as it exits -- as it exit out -- exits out. And the first -- and the facet joint overgrowth typically overgrows in stenosis, that's what she has, that was encroaching on the nerve. So you have to remove the facet, which destabilized the spine, and then continue to decompress the nerve by doing the foraminotomy. So the next -- the next step out is the foramen. So then you do -- enlarge the foramen, and then you're left with a nerve root that is no longer pinched, either from the disk herniation, the facet hypertrophy in the lateral recess or -- or at the level of the foramen. And so it's a -- it's just a -- it's a thorough way, is my argument, right, to be sure that that patient doesn't get relief of their nerve pain, that there is no longer -- there's no longer residual compression. That's why I do it that way.

Q. All right. So was it your expectation that after undergoing the foraminotomy and releasing compression on the nerves going down the patient's leg, that she would no longer suffer from any kind of nerve pain in her legs?

A. Correct.

Q. And was that successful?

A. To a certain extent, yes. I mean, again, the

-- the nerve was -- was injured, right? So I'm not fixing the nerve. I'm just decompressing the nerve. And so just doing decompression alone isn't a guarantee, you know, but most people -- most people say that it's better, but having less nerve pain and a better nerve doesn't mean it's a normal nerve, right, 'cause it was injured. There was residual. So she, you know, I mean, if you want to go back to the notes, basically, I think she was having residual symptoms. I mean -- so I mean I haven't -- I -- I didn't go there, but they could have residual symptoms for the reasons I outlined.

Q. Even though there's no nerve being compressed anymore?

A. Oh absolutely. Just like you can imagine if someone gets a -- gets a spinal cord injury and they hit their spinal cord and the doctor goes back and puts -- you know, they still do surgery. They line up the spine and they un-pinch the spine, but they never recover their paralysis. It isn't because there's still -- still compression. It's because once the nerve gets injured, that -- there's a chance it may never work again. So, you know, that's why -- that's why we do surgery. We take the pressure off the nerve. And then we hope that the patient feels better. They usually do.

They don't always do. It could feel worse. It's a risk of surgery. That's just -- that's the nature and the art of what I do.

Q. Art? So, is it your belief that her nerve was injured as opposed to compressed?

A. Absolutely. It's -- that's what radiculopathy means, right? It's -- it means sick nerve or injured nerve, and she had those symptoms from the outset.

Q. Right. Which you decompressed? So are you saying that she had radiculopathy from some cause other than nerve compression in the foramen, which you relieved during your surgery?

A. No, ma'am, I -- you know, I'm not being evasive. I think that, you know, this is as much as you could do as a sur -- there's only so much you can do, right? So you take -- you take the herniated disk off the nerve. You -- you open -- you enlarge the entry to the foramen. Then you do a foraminotomy. At the end, you can see the nerve pass a probe. It's clean. You've done everything you can do. There's nothing else to do. And then, you know, some people get complete relief. Most people get partial relief. They don't get complete relief. But partial, substantial relief is what -- that's my opinion. That's my experience for 30 years.

And they're happy with the outcome. Not everybody is. And sometimes you could be worse, even if you do a perfect operation. That's just the way it works.

Q. Right. I think my question was more focused on your comment that she had damage to her nerve. I'm trying to get you to distinguish between what you mean between nerve damage and temporary nerve compression that's relieved by a foraminotomy when the pressure is taken off the nerve.

MR. TAYE: Objection as to form. Asked and answered. He can answer.

THE WITNESS: The best way I can answer is the patient presented with a lumbar radiculopathy, was treated conservatively, failed, continued to have radiculopathy. I did - I did -- the word radiculopathy means sick nerve. Okay, maybe I didn't answer very clearly. And we had that -- we had sensory changes consistent with someone that had a nerve problem. Based on her objective findings, my objective review of the MRI, my intraoperative findings, the nerve was compressed --

MS. GERRARD: Right.

THE WITNESS: -- and the thecal sac was compressed and so she was experiencing nerve pain,

right? And whether or not it's permanent, that -- you know, that -- that goes to how she did. But she certainly had evidence of ner -- of -- of nerve damage. I mean, I didn't -- there may be an EMG in here. I don't know.

BY MS. GERRARD:

Q. Are you using nerve damage and radiculopathy interchangeably?

A. Yeah, I'm using it just to answer your question.

Q. No, do you use the terms nerve damage and radiculopathy interchangeably? Do they --

A. I do often because I think it's -- most people don't know what the word radiculopathy is.

Q. Right.

A. So -- if -- if you want, I'll give you the exact definition of radiculopathy, and you let me know if that -- if I've confused you. But certainly, if you lose sensation in a -- in a dermatome, that's consistent with some type of dysfunction of the nerve, right? If you make -- if you lose function and damage, you know, you know the nerve wasn't severed. If you're asking me, did my intraoperative findings reveal that there was a severed nerve as a consequence? Again, I'm just trying

to answer your question to get done. No, there was not a severed nerve, right? But there was clearly evidence of nerve dysfunction preop.

Q. Right.

A. The intraoperative findings were consistent with the -- with the compression phenom -- compressive phenomena. And so I would say the nerve was dysfunctional. And I use that word dysfunction and nerve damage often inter -- interchangeably because the patient -- that's what patients understand, right? That's the kind of language -- that's -- saying the word radiculopathy, the patient isn't as -- as communicative as saying there's -- there's dysfunction of the nerve or nerve damage. That's my answer.

Q. Okay. In your experience, can radiculopathy be caused by compression of a nerve in the foramen?

A. Yes. Absolutely.

Q. Did you speak to this patient through a Spanish interpreter, or did you speak to her in English, or how did you communicate?

A. We -- we al -- we have Spanish interpreters full time in my office.

Q. So did you speak to this patient through a Spanish interpreter or you don't know?

A. All my patients are spoken through -- if that's their language, we speak through a Spanish interpreter.

Q. Right. Maybe my question wasn't clear.

Do you have an independent recollection of whether you communicated with this patient in English or Spanish?

A. I don't have an independent recollection.

Q. Now, I noticed in your postop films that you did not use spacers in the lumbar fusion, multilevel fusion.

A. Mhm.

Q. And this is a patient that -- you have to say yes. You can't say mhm.

A. Yes.

Q. And this is a patient that you had determined --

A. Can you clarify? Are you saying I didn't use an inter -- intervertebral device?

Q. Yes.

A. Okay.

Q. That's correct, right, you didn't --

A. Correct. That's correct.

Q. -- use any?

A. That's correct.

Q. Okay. And this is a patient that you had determined had instability in her lumbar spine. Correct?

A. Correct.

Q. Why did you not use spacers?

A. I used pedicle screws. So, it's a whole conversation to have. Like what, you know, how do you -- how do you -- you just have to -- so you have to fuse the spine. If you want to reduce instability, you fuse the spine. There are multiple different techniques to achieve a solid fusion. Okay? There are interbody devices, there's pedicle screws, and the interbody devices can go anteriorly, laterally, posteriorly. They go all different ways. I do those surgeries as well. I do a lot -- substantial number of interbody cases, but it's usually tailored to the patient. Some people, depending on -- it's again, the art of surgery. Are they heavy? Are they wide? Are they short? So it's a technical decision the surgeon makes in order to achieve a solid fusion, right? 'Cause once you get a solid fusion, whether it's through an interbody device or just a straight posterolateral fusion with screws, like in this case, the results are -- are the same, that the

patient's pain is relieved.

Q. Okay. Can you just tell me why in this patient you decided not to use intervertebral spacers?

A. I can't -- I can't tell you.

MR. TAYE: Objection as to form. Asked and answered. He can answer.

THE WITNESS: I can't answer it.

BY MS. GERRARD:

Q. Wouldn't that have given a patient with instability in her lumbar spine more stability?

A. No, ma'am. She has -- she -- she went on to have a solid fusion, so she's fused.

Q. Okay. Did you factor in her levoscoliosis in your decision not to use intervertebral spacers when you did the --

MR. TAYE: Objection.

MS. GERRARD: -- lumbar fusion?

MR. TAYE: Sorry. Objection as to form. He can answer.

THE WITNESS: Ma'am. When we do scoliosis surgery on -- on children and we put screws in from the middle of -- the top of their spine to the bottom, we often don't use interbody spacers. You don't need to put an interbody spacer in order to achieve the goal of

straightening the spine or fusing the spine. It is surgeon's preference and everybody has their own preferences. One -- one method isn't worse than the other. I do interbody spacers all the time. I did it in the cervical spine, for example, and I do it in the lumbar spine. It's very much based on the patient's body habitus and age is really what it comes down to.

And I don't remember the specifics of this. I -- I do have extensive experience, as you're probably aware, of -- of picking these kinds of surgeries. So I generally try to pick an operation that -- that is best suited for the particular patient in which I think the surgery will -- is easiest to do and -- slash least risky for the patient. And that's the rationale, the general rationale I use. I don't have a more specific answer for this patient.

Q. Did you feel there would have been a risk for this patient to use spacers in your lumbar fusion?

A. I really object to this line of questioning. I think this -- this -- your questions come from a position where -- the patient went on to have a solid fusion. We don't need to have a thorough -- put this on the record. I don't need to have a thorough discussion with the argument or debate on what the proper method

for fusion is. That's not really what this should be about, right? This is what I do. I'm an experienced surgeon. This is what I chose. There was no failure of fusion. And so then, therefore, I answered your questions about interbody spacers, but for them, perhaps. And I don't feel a need -- I don't -- I don't feel a need to continue to have to give you more reasons of why I didn't use them. I gave you the answer already.

MS. GERRARD: What was the question, Skyler? The original question before we went off on a tangent.

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(Whereupon, the pertinent portion of the record was read.)

- - -

BY MS. GERRARD:

Q. Yes or no?

A. I can't answer that.

MR. TAYE: Asked and answered. He told you he cannot answer it in the way it's presented.

MS. GERRARD: No, he didn't. That's not what his answer was.

MR. TAYE: He said he can't. Okay.

THE WITNESS: I don't remember if there's a

question.

MR. TAYE: There is no question.

MS. GERRARD: Not yet. Doctor, I want you to look at page 14 of the report that you drafted at the request of Harmon Linder in September of this year.

MR. TAYE: Objection as to form. He can answer. There is no question, but I object to the form.

THE WITNESS: What pa -- what page?

MS. GERRARD: Page 14. My PDF is 25 pages. Let me see --

THE WITNESS: Okay, okay, I got it. To the end.

MS. GERRARD: It's page 6 of your numbered pages.

Do you see it?

THE WITNESS: Okay. So page 6 of -- okay.

MS. GERRARD: Of your 14?

THE WITNESS: I'll get there.

MS. GERRARD: Okay. Take your time. I'm almost done.

THE WITNESS: Six?

MS. GERRARD: Yes. You got it?

THE WITNESS: Yes, ma'am. Yes.

BY MS. GERRARD:

Q. At the top of the page, it says "The indication for surgery with fusion is number one, failed conservative treatments." I guess this is after six months of physical therapy.

You see that?

A. Yes.

Q. And this patient had two fusion surgeries performed by you less than six months after her accident. True?

A. Yes.

Q. Now, just comparing your notes from your chart where you initially encountered the patient and measured her flexion and extension. I'm going to go with cervical first. On March 8th, when she first presented to you, you documented that she had cervical flexion of 40 degrees, extension of 45, left and right 60.

A. Yes, ma'am.

Q. On 9/24 in your report, you indicate that now post cervical fusion, she's gone from 40 in flexion to 35, from 45 in extension to 30, and left and right movement from 60 to 45 on one side and 50 on the other side.

Would you consider that worsening of her range of motion following the cervical fusion that you

performed?

A. I wouldn't -- I wouldn't characterize it as worsening. I think it's normal for a postoperative patient. It's -- it's a different number. I recorded whatever the findings were that day, but I wouldn't say it was a failure.

Q. It's certainly less than what she had when she first came to you. Right?

A. And she -- she had surgery, right? So.

Q. Right. And for the lumbar measurements that you list in your report that you drafted for Plaintiff's counsel, for the lumbar spine, this is comparison between her March office visit, she had 40 degrees of flexion, which is the same as what she had after your lumbar fusion, 10 degrees of extension, and 25 degrees of range of motion left and right before, and then 15 to 20 after your lumbar fusion.

MR. TAYE: Objection as to form. Compounded questions. He can answer.

BY MS. GERRARD:

Q. Is that an improvement?

A. I mean, I wouldn't -- I wouldn't characterize it as -- it's just my finding that day. I wouldn't assess the success of improvement and non-improvement

based on that number.

Q. Do you not usually assess the success of your surgeries after you perform them by measuring the patient's range of motion or asking them questions about changes in pain?

A. I mean, yes, of course we discuss their outcomes of surgery, but some people -- the findings are whatever the findings are on that day. And I just record the findings as they present.

Q. Are you aware whether the plaintiff is undergoing any physical therapy now?

A. No, ma'am.

MR. TAYE: No, ma'am, you're not aware or?

THE WITNESS: No, I mean, I don't -- I don't know what she's doing at this present time, obviously. I mean --

MR. TAYE: Okay. I just want it to be clear on the record.

THE WITNESS: Yeah.

BY MS. GERRARD:

Q. As her spinal surgeon, would you want her to be continuing with physical therapy after a cervical and lumbar fusion?

A. I mean, for a certain period of time, I would

say yes. I'm just -- I'm looking at the last note, right, just to see. We have it. She's performing the home --

Q. The last -- the last office note?

A. Yeah.

Q. Well, I don't have those.

Did you email that to --

A. I'll be happy to -- I'll be happy to read it to you. Okay?

Q. Okay.

A. On 11/7/2024, "Patient improving postoperatively. Continues to have pain and symptoms consistent with the preoperative condition. She stopped receiving therapy. Performs home exercise program. Patient complains of continued neck and back pain with radiation. She uses a brace." So that's the -- that's the history she gave when she showed up on 11/7.

Q. That was not a visit with you. Right? That was Mikelis?

A. Mikelis.

Q. Okay. So as of her last visit with your office in November of this year, she showed no improvement as a result of your two surgeries. Correct?

MR. TAYE: Objection as to form. He can

answer.

THE WITNESS: I would disagree with that characterization.

BY MS. GERRARD:

Q. Why would you disagree?

A. Because she's had some -- it says there, "patient improving." He documented that she was improving.

Q. Does it say what was improving? What complaints?

A. No. No.

Q. Did this patient ever indicate to you that she was improving in her complaints of pain after your surgeries?

MR. TAYE: Objection as to form. Asked and answered. He can answer.

THE WITNESS: I mean, like I said, her preoperative symptoms were improving. That's -- that's what we documented.

BY MS. GERRARD:

Q. Okay. And as her spinal surgeon, would you want her, based on the last note that you just read us from Dr. Mikelis from November of this year, a month ago, would you want this patient to continue with

physical therapy?

A. I mean, that's been our recommendation. I mean, that's what he -- so "the patient is to attend physical therapy, continue a home exercise program, and refrain from any activity that exacerbates symptoms such as lifting, carrying, bending, twisting, and then follow up." And -- and you're probably aware, right, that -- that sometimes they don't have insurance for the physical therapy. So I -- I don't -- again, I don't -- I don't know independently. So, you know, we recommend therapy for as long as it's effective, right? And then if the patient says it's not effective anymore, then they stop. I don't know if that's the case here, or that no one's going to pay for it, then they can't go. They have to do their home exercise program. I -- I can't speak to the details of that, because I don't have those documents.

Q. I'm just asking if you as her spinal surgeon would want -- forget about insurance for a second and the ability to pay, as a matter of recovery and improvement in her symptoms, would you as her spinal surgeon want her to continue receiving physical therapy as of a month ago?

A. Probably, right? Because we'd want her to

continue to work on range of motion. That's something the therapist can be very helpful for, right? But if there's no progress, right? If she doesn't make progress, then they're -- they're almost what you would call them maximally medically improved, right? So you don't -- you don't want to keep doing it if they're not getting any better about it, you know? Oftentimes they do get a lot of subjective relief. They say it helps them. The stretching, the modalities eases their symptoms. But if they're not making progress, then, you know, then it's really -- it's a call, right? You say, well, it helps them subjectively, and it's available, they -- they should go and get it. On the -- on the other hand, like it's -- it's not helping and they're making no progress, so why waste everybody's time and have the patient go? I mean, that's how -- that's the bifurcation. I don't -- I don't know what -- what happened here.

Q. You don't know if she went to physical therapy after her lumbar fusion?

A. Yeah, I don't have physical therapy records.

Q. Okay. So that's a no? You don't know --

MR. TAYE: Objection.

MS. GERRARD: -- one way or the other.

MR. TAYE: Objection as to form, mischaracterizing the witness answer.

MS. GERRARD: No, it's a clarification of his previous answer.

BY MS. GERRARD:

Q. I'm just saying you don't know one way or the other if she continued -- if she went to physical therapy after the spinal fusion, after the lumbar fusion?

A. We usually keep -- same answer as before. We usually keep people in therapy for as long as it helps them. Now, that -- the word help is vague, okay. That determination is made by the physiatrist and the patient, and -- and, you know, less -- less so by me -- by me. But you know if they're -- if the patient advocates themselves and said that helps them, I'm certainly going to do the same, try to get it for them.

Q. Right. The question is --

A. I don't know -- I don't have records though.

Q. Okay, so you don't know if she's had -- it's a yes or no. Do you know --

A. But I've answered your question already. I told you I don't have physical therapy records. I've answered that question 11 times.

Q. Right. You might --

A. I don't know. I mean, asking me again doesn't mean I'm going to come up with the answer -- a different answer.

Q. Do you believe having physical therapy records would be the only way that you would have that information?

A. Well, how else would I know if a patient's actually going to physical therapy? How would I know that?

Q. Speaking to Dr. McGee, speaking to the patient.

A. We don't --

MR. TAYE: Doctor, just -- don't ask her any questions, and you don't have to answer his questions Counselor.

MS. GERRARD: Thank you.

THE WITNESS: It's two o'clock. So if you'd like to schedule another appointment with me, I would be -- I would respectfully request you to tell me how many hours ahead of time you would be expecting me.

MR. TAYE: I think she's almost done.

MS. GERRARD: Yes, just give me a second. I'm looking at my notes. I think I'm done.

S. LATTUGA, MD

Okay, thank you so much, Doctor. Have a great day.

MR. TAYE: Thank you, everyone. Have a good one.

MS. GERRARD: Thank you.

- - -

(Whereupon, a discussion was held off the record.)

- - -

THE COURT REPORTER: Thank you. And will either counsel be ordering a copy of the transcript today?

MR. TAYE: Yes, I will be ordering.

THE COURT REPORTER: Electronic or standard paper?

MR. TAYE: Electronic, please. And I have put in the firm name and my --

THE COURT REPORTER: Thank you so much.

MR. TAYE: -- email. You're very welcome.

MS. GERRARD: We ordered when we ordered you, so.

THE COURT REPORTER: Okay. Great. So you have -- we have the order form for you.

- - -

S. LATTUGA, MD

(Time Noted: 02:01 p.m.)

- - -

_____

SEBASTIAN LATTUGA, MD

Signed and subscribed to
before me, this _____ day
of _____ 202_.

_____

Notary Public

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C E R T I F I C A T E

STATE OF NEW YORK

COUNTY OF NASSAU

I, SKYLAR SENA, a Notary Public within and for the State, do hereby certify:

THAT SEBASTIAN LATTUGA, MD, the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by such witness.

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

IN WITNESS WHEREOF, I have hereunto set my hand this 20TH day of DECEMBER 2024.

SKYLAR SENA

SKYLAR SENA

LAWYER'S NOTES

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