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New York Supreme Court

Appellate Division—First Department

DENNIS CIOFFI and SHERYL CIOFFI,

Plaintiffs-Respondents,

– against –

AMERICAN AIRLINES, INC., and V.R.H./TORCON, A JOINT VENTURE,

Defendants-Appellants.

RECORD ON APPEAL
Volume I of V (Pages 1a–76a; 1-610)

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this is one of those situations where we are interrupting the previous witness' testimony to call the next witness, who is a doctor.

And, as you can imagine, doctors' schedules are very hard to change, so we are trying to work around that.

MR. BOROWICK: He, apparently, stepped out to the rest-room. He should be here.

I know he is here.

THE COURT: The case of the vanishing doctor.

(Pause.)

MR. BOROWICK: If the Court wants, we can premark an exhibit. That will save time.

(Pause.)

(The aforementioned Accident Report was marked Plaintiffs' Exhibit 2, for identification, as of this date.)

(Continued on next page.)

Merola - By Plaintiffs - Direct

(Witness enters Courtroom.)

A N D R E W M E R O L A, M. D.,

Manhattan, New York, called as a witness on behalf of the Plaintiffs, having first been duly sworn, was examined, and testified as follows:

MR. BOROWICK: May I proceed, Judge?

THE COURT: Yes.

DIRECT EXAMINATION

BY MR. BOROWICK:

Q Sir, will you tell the jury your occupation?

A I am an orthopedic reconstructive spinal surgeon.

Q Are you licensed in the State of New York?

A Yes.

Q What is your educational background which allows you to say you are whatever you just said you are?

A I went to medical school.

After medical school, I did orthopedic surgery residency.

After my orthopedic residency, did a fellowship in spinal reconstruction.

Board Certified after that.

I have been in private practice since.

Q What does "Board Certified" mean?

A A board certification process whereby we fulfill academic and clinical requirements of our field, which

means completing an accredited residency program, taking two exams, one is a written examination after your residency is finished; the other is an oral examination after you have been in practice for two years.

After you do that, you pass both examinations, you fulfill the requirements of the board of orthopedic surgery, and, therefore, are certified.

Q Tell the jury, are you affiliated with any hospital in the City of New York?

A Yes, I am.

Q What does that mean, to be affiliated, and where?

A Sure.

I am chief of spinal reconstruction for the Department of Orthopedic Surgery at SUNY Downstate in Brooklyn.

I am on the staff of -- as attending surgeon, at St. Vincent's Hospital in Manhattan.

That allows me to -- the privilege of admitting and treating patients at those institutions, so the hospital recognizes my qualifications and credentials.

Q Are you a member of any professional societies in your field?

A Yes, I am.

Q What are those?

A I am a member of the -- Fellow of the American

Academy of Orthopedic Surgeons, also, Fellow of the Scoliosis Research Society.

Q Now, will you tell the Jury, with regard to your patients with your private practice, what kind of patients come to you?

You don't treat patients with a cold, right?

A Correct.

I see patients that have musculoskeletal problems, mostly dealing with the neck and back.

That is -- can be patients that injured themselves through trauma, or patients that have acquired things like cancers, infections, or other illnesses of the neck and back.

Q When you talk about "musculoskeletal," what is the skeletal features related to the spine?

A The spine itself is composed of a number of bones that are then held together by disks.

Those bones interact with each other through joint muscles, tendons, and ligaments.

Q I will ask you to look at this exhibit, which I will ask be used as a demonstrative exhibit, not necessarily --

MR. BOROWICK: Any objection?

MR. WHITELEY: No.

Q Will you describe for the jury -- if you could,

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come down, and just give us a little bit of an anatomy lesson to understand your testimony about the spine.

A Sure.

MR. BOROWICK: With the Court's permission?

THE COURT: Yes.

(The witness leaves the witness stand.)

A This is a model of what is known as functional spinal (indicating) --

THE COURT: You know, when you turn away, you have to shout.

The Reporter cannot hear you.

A This is a model of what is known as a functional spinal unit (indicating).

Basically, it is two bones.

These are the vertebral bodies (indicating).

In between, there is a disk (indicating).

In back of those bones, in this area here (indicating), known as the spinal canal, are the spinal nerves that run past the bone and past the disk into your legs.

Q How do they come out of the spinal cord?

A The spinal cord itself terminates or ends somewhere up in your upper back.

This is your lower back (indicating). It

contains all the nerve roots that come off the spinal cord and run into your legs.

They exit the spinal canal at these areas called the foramina (indicating), or the opening for the nerves.

Q With what proximity to the disks are the foramina?

A The disks themselves -- the disk itself actually forms the floor of the foramen. It's the bottom part of the foramen as that nerve exits to travel into the legs.

Q Now, using the -- the other plastic on the diagram or the model, what is the disk made of, and what can happen to them?

A The disk itself is a structure that has two major components, it has an inner -- like, inner jelly core, it has an outer, hard or harder area called the anulus.

The disk has two primary functions.

The first is, they absorb stress and shock within the spinal column.

The other thing it does is, it holds these two bones together (indicating) so that they can move or slide on each other appropriately.

It has a stabilizing function as well as a shock-absorption function.

Q Does it play into flexibility of the spine?

A Yes.

Q How?

A It -- it allows the bones themselves to move normally with respect to each other so there is no injury to the nerves that pass through the spinal canal.

Q Now, what kind -- do you treat the trauma relating to disks?

A Yes.

Q And what kind of disk injuries occur through trauma?

A There are several types of disk injuries that occur traumatically.

One of them is known as an anular tear.

The anulus is the outer covering of the disk.

An anular tear means that hard outer layer has been twisted and torn, and it can, therefore, leak certain chemicals that produce pain.

The other type of injury that can happen is that the outer section of the disk can have a defect in it that causes the jelly on the inside of the disk to protrude, and that can result in herniation or a disk protrusion.

Q When a disk herniates, you mentioned the pain chemical.

Mérola - By Plaintiffs - Direct

What about disk herniation -- how does that result in a problem to the patient?

A Two things happen when a disk herniates.

The first thing is, that inner jelly core contains certain chemicals.

Those chemicals leak out into the area where the nerves are. They produce what is known as an inflammatory response or swelling around the nerve.

That produces pain.

Another thing that happens is that the disk protrusion itself, because it's sitting directly next to the nerve root, puts pressure on the nerve, and pushes it up against the other bony element of the spinal canal.

There is a pressure effect and a chemical effect on the nerve.

Q Once there is a rupture of the anulus, and the jelly comes out as you described, does it ever go back?

A The jelly itself does not go back into the disk, no.

Q Is there anything you can do surgically to cram that back in there?

A The surgical procedure to treat that problem with protrusion is, if the protrusion is fresh -- and the disk is a soft disk, which means a removable disk, or disk that can be sucked out of the canal -- you would remove that

gelatinous material from the canal, and take it away from the nerve.

If the disk itself becomes calcified or hard, which is the body's normal response to injury, which occurs over a long period of time, it's impossible to remove the disk protrusion because in so doing, you can injure the nerve roots that pass by.

In that case, what you need to do, you need to do a formal opening of the spinal canal in the area where the nerve root is.

That is a laminectomy with foraminotomy.

Q Have you treated patients with no trauma or accident history, but with spinal problems relating to disk either tears or herniation, again, without any accident?

A Yes.

Q What causes those things in those patients that have those injuries?

A In those patients, where trauma is not involved, one generally sees a gradual thinning out and disruption over the anulus over time, with a gradual onset of symptoms and complaints.

Q Now, if they come to you with symptoms, can people have a disk -- let me ask you about the aging process.

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Does the aging process affect all of us, and all of our disks?

A Yes.

Q How so?

Will you describe, for the jury, what is going on in our bodies?

A A normal, healthy disk, before you start to incur the aging process, contains water.

Our bodies are made up mostly of water.

The disks hold on to the water.

The water inside the disk helps to enable that disk to absorb shock, and function properly.

As we age, the water leaves the disk, and it becomes dry.

There is a drying of the disk over time.

With that drying of the disk over time, what we can see is that the bones start to collapse down on each other, and we can see what is known as a gradual symmetrical bulge of that disk.

The entire disk can begin to flatten itself out as water dries itself out of the disk, it is not -- not as fluffy and spongy.

We see a gradual bulging of -- of the disk over time, as well as the loss of water.

Q Will the natural aging process in a 20-, 30-,

40-, 50-year-old, with different stages, does it do that, every disk, whether or not there are symptoms?

A It does not do that for all disks, no.

Q What about in the low back or neck?

A It can do that to disks in the low back and neck.

Q You can resume your seat, Doctor.

(The witness resumes the witness stand.)

Q Now, the term "degenerative disk disease," what does that mean?

A Degenerative disk disease is that term which implies desiccation, and gradual bulging, over time, of whatever disk we are talking about, cervical disk, thoracic, or lumbar.

Q When does it start generally, absent trauma?

A Without trauma, that process can be seen to start somewhere in the neighborhood of about, 30 years and up.

Q Okay.

Who has it?

A We all get some stage of degenerative disk disease.

Q Are there sometimes symptoms?

A The disk can sometimes become symptomatic, and sometimes not.

Q How is that?

Why would it be symptomatic to some, and not

for others?

A A lot of it depends on our body's own susceptibility to pain, and the effects of these chemicals that leave the disk or the anula.

It depend on how much stress and strain are on the disk and the bone.

And everybody is different.

Q If degenerative disk disease is not necessarily symptomatic, is it necessarily disabling?

A It is not necessarily disabling, no.

Q Are there some people that have a mild to moderate form of it that don't even know it?

A Yes.

Q Are there people with that kind of level of disease that don't feel it?

A Yes.

Q It does not affect their work --

A Correct.

Q -- their play?

A Right.

Q Can people go through their entire life with some measure of degenerative disk disease without it ever cramping or affecting their life?

A Yes.

Q Now, I want you to assume, Dr. Merola, that my

client, Dennis Cioffi -- by the way, have you ever -- have I ever represented other patients of yours besides Dennis Cioffi?

A Yes.

Q Who referred Dennis Cioffi to your office?

A My partner, Steven Touliopolus.

Q Your partner, is he an orthopedic surgeon?

A Yes.

Q What is his specialty?

A Sports medicine.

Q Does he have a part of the body that he specializes in?

A He does the -- he does shoulders -- shoulders, knees, ankles.

Q When did he first refer the patient to you for treatment?

A In May of 2003.

Q Did you, during -- by the way, are you still treating him?

A Yes.

Q When I say, "still," when is the last time you saw him in your office?

I don't mean today, in the Courthouse.

When did you see him in your office for the last time?

A I saw him on October 18.

Q When -- when you have patients -- by the way, do you have patients who have experienced industrial accidents?

A Yes.

Q Do you have more than one?

A Yes.

Q Would you explain that?

A Yes.

A lot of what I do specifically involves the neck and back, involves persons injured, and particularly, people in -- patients that are working in construction and heavy labor.

Q When a patient is injured and brings a lawsuit, such as Dennis Cioffi, are there occasions where you will come into Court to offer opinions on diagnosis, treatment, prognoses for one of your patients?

A Yes.

Q When you come to Court, do you exact a fee from the lawyer, like my firm, for your time away from your practice?

A Yes.

Q Sir, will you tell the jury, when did you first -- when you first met Dennis Cioffi, did you do an initial exam?

A Yes.

Q In addition to the exam -- I'll get to the exam in a moment -- in addition to the exam, have you reviewed the records from the day of the accident from Mary Immaculate, have you reviewed other doctors' treating records, et cetera?

A Yes.

Q Tell us about -- who is -- I'll get to your review in a second.

Who is Dr. Sisto?

A Dr. Sisto is Mr. Cioffi's orthopedist in California.

Q Who is Dr. Lefkowitz?

A Dr. Lefkowitz is a pain management physician.

Q Where is he?

A He is here in New York City.

Q Who referred the patient to him?

A I did.

Q Who is Dr. Hausknecht?

A He is a neurologist.

Q Where is he?

A In New York City .

Q Now, I want you to assume, for a moment -- I want to give you some information about the activity of the life of this individual before the accident, because I

will ask you a follow up question.

I want you to assume that Mr. Cioffi was 42 at the time of the accident, and, for the 20 or so years before the accident, he had -- or 18 years before the accident, he had been working at -- actively as a construction worker, specifically, an ironworker.

I want you to assume his average of those years in the union in New York City was about 1,600 -- a little more than 1,600 hours per year, and that takes into consideration down time, seasonal changes, et cetera.

Assume further that he was -- and this is subject to connection -- that he was an avid athlete, surfing, scuba diving, is playing baseball with retired professional baseball players, and he was extremely active and athletic.

Assume, before this accident, other than a muscle strain in the early '80s, which resolved within days, other than that, he had, up until the time of the accident, for those 20 years, no symptoms, no treatment, no medication, no therapy, and no physical limitations.

Sir, do you have an opinion as to whether or not that muscle strain in the early '80s was a significant past medical history?

A That muscle strain was insignificant.

Q To your knowledge, based on your review of all

the records and your treatment of him over the last year and a half, did he have any preexisting condition which was either symptomatic, disabling, or problematic for him?

A No.

Q In any way limiting for him?

A No.

Q Sir, when you examined him for the first time, what was the history you produced?

A Mr. Cioffi told me he had sustained a twisting injury in a fall, landing on the left side of his body. He injured his left shoulder, left knee, and lower back.

Q Now, at that point in time -- and let's confine your testimony subject to producing Dr. Touliopolus -- where did you confine your treatment of this man? I'll refrain, or keep the testimony within that for my question.

A My area of concentration for treating Mr. Cioffi was his lower back.

Q Okay. Have you treated any other part of his body in the spine, any other level of the spine beside the low back?

A Yes. More recently, his neck.

Q Now, in the initial hospitalization, and --

MR. BOROWICK: Do you have the record you wanted me --

MR. WHITELEY: Just the subpoenaed records for Mary Immaculate.

MR. BOROWICK: Judge, I know we have -- have time constraints with the other witness.

May I offer that subject to taking the time of marking it?

MR. WHITELEY: Mary Immaculate, I have no problem.

MR. BOROWICK: All right.

Q I want you to assume, Dr. Merola -- I will read from the -- you have seen the hospital record, correct?

A Yes.

Q I want you to, for purpose of your testimony -- let me ask you take my word for it that in the hospital record, there are complaints made initially, immediately after the accident, of left shoulder pain, left knee pain, and lower back pain.

Do you have an opinion, based upon his past medical history, and no relevant past medical history relating to the injuries, do you have an opinion as to what was the competent producing cause of the injuries that he sustained?

A His fall at work.

Q And, in connection with the record of Dr. Sisto, Dr. Lefkowitz, Dr. Hausknecht, did you also review objective tests done by those physicians, or at the behest of those physicians?

A Yes.

Q Have you examined films?

A Yes.

Q What is an MRI?

A An MRI is also known as a magnetic resonance imaging scan.

That is the process whereby we obtain photographs of the inside of the human body with a magnetic field.

It tells us about soft tissue, bone, inside the body, to look at them more closely without having to open a person up.

Q And were there MRIs done on this man's body?

A Yes.

Q Again, I will ask you not to refer to the shoulder or the knee MRI, and confine yourself to the spine.

What parts of the body were MRIed, if -- for want of a better word?

A Lumbar spine, and more recently, the neck.

Q With regard to the lumbar spine, can you tell the

jury -- by the way, are these tests done before operations are had?

A Yes.

Q Did you, ultimately, operate on Mr. Cioffi?

A Yes, I did.

Q What did the MRI tell you -- by the way, you reviewed the films, correct?

A Yes.

Q Did they confirm the report of -- the film by the radiologist?

A Yes.

Q Will you tell us -- and if you need to refer to your chart, feel free to refer to your chart to refresh your recollection -- what was the significance of the MRI of the low back, first?

A The MRI of his lower back that was done in December, after the accident, demonstrated two things, one, it showed disk protrusion at the L4-L5 level.

It showed an anular tear at L5-S1 level.

Q Let me stop you.

You used a term, "L4-L5," or "L5-S1."

Help us out.

What does that mean?

A Those refer to the levels of the lumbar spine where the disks are located.

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There are five bones in the lumbar spine. The last bone comes in contact with the sacrum. That is S-1.

The L4-L5 level refers to the disk in between the fourth and the fifth bone in the lower back, and the L5-S1 level referring to the disk between the last bone in the lumbar spine and the sacrum.

Q Okay.

Now, how many lumbar vertebrae are there?

A Five.

Q How many -- what is the next level up as you go up the back?

A It goes from 5, 4, 3, 2, 1, then T-12, which is the lowest one --

Q How many T vertebrae are there?

A Twelve.

Q Now, you mentioned that you have been treating him for his neck, there was an MRI of the neck.

How many levels, or how many vertebrae are in the neck?

A Seven.

Q Are they all delineated by the initial "L," or "T," or "L" -- "C," "T," "L," cervical, thoracic, lumbar, are they all numbered after that?

A Yes.

Q When you refer to a disk, you refer by it the vertebra above and below?

A Yes.

Q That having been said, will you tell the jury what it means to have a protrusion, and what significance it is in his case, protrusion at L4-5, and an anular tear at L5-S1?

A Sure.

"Protrusion" means there is a focal, discrete area where the disk has leaked out or protruded, if you will, herniated, and that is different than a bulge, which is symmetric.

A bulge is what we expect to see over time, over, even in the normal condition.

A protrusion is an abnormal finding, which means there is a discrete area of disk sticking out into the spinal canal, and near the spinal nerve.

That is the significance of protrusion.

Q Is that traumatic, or degenerative?

A Traumatic.

Q Where is the anular tear?

What is the significance of that, and is it degenerative, or traumatic?

A An anular tear is at the lowest level, between L-5 and S-1.

An anular tear is significant because it means the outer covering of that disk, the anulus, which is the hard, rubbery outer covering of the disk, is torn.

It's usually torn where -- when there is twisting of that disk traumatically.

That tear causes a leakage of an inflammatory chemical into the spinal canal.

Q What is a dermatome?

A A dermatome is an area of the body on the skin that relates to a spinal nerve. We have them from head to toe.

Each spinal nerve has its own area that -- that it feels sensation in. That is a dermatome.

Q I want you to tell me, during your exam, were you able to correlate any of the symptoms reported by Mr. Cioffi with any of the objective testing, or your own clinical examination?

A Yes.

Mr. Cioffi's complaints were, not only in the lower back, although that is the majority of the pain and symptoms, they also referred themselves into the dermatome of the lower leg.

The specific dermatome they referred themselves into corresponded to the L4 and L5 nerves, which are directly adjacent to those injured disks at both

L4-L5 and L5-S1.

Q Given the history, can you correlate the accident and mechanics of the accident that he described to you to the cause of these tears and protrusion?

A Given his history, yes, those are, indeed, traumatic injuries that resulted in his complaint.

Q When you first saw him, what did you -- did you decide to operate immediately?

A No.

Q Why not?

A Oftentimes, the disk protrusion, or anular tear, or post-traumatic injuries, because there is a chemical effect from the injured disk on those nerves and inflammatory response, we can sometimes make the patient's symptoms get better and tolerable by treating them with medication and physical therapy.

Q What is physical therapy?

A Physical therapy involves getting a patient exercises and treatment that stabilize the lower back, and decrease pain in those areas where they are feeling pain.

Q Did he have it?

A Yes.

Q Did it cure him?

A No.

Q What is medication therapy?

A Medication, particularly for these problems, are two types, one is a pain medication which is like a narcotic that acts to decrease the pain that the patient feels.

Other medications are anti-inflammatory medicines that act to neutralize the effects of the chemicals that have leaked out of those injured disks.

Q Did he receive them?

A Yes.

Q Did they cure him?

A No.

Q Did they eliminate the symptoms?

A No.

Q What are epidurals?

A An epidural is the injection of an anti-inflammatory medication, particularly steroids, into the spinal canal area, where those injured disks are, to directly try to neutralize the chemical effect of the disk injury.

Q Did he receive them?

A Yes.

Q How many?

A Three, at least three.

Q By whom?

A Dr. Lefkowitz.

Q Did they cure him?

A No.

Q Did they eliminate the symptoms?

A No, no.

Q What is radiofrequency in the nature of conservative treatment?

A Radiofrequency is another pain management technique whereby a special needle is placed into the area where the disk derangements are, the needle vibrates very quickly. As it vibrates, it heats up, and it destroys the pain nerves that are around the area where the disks and the joints are to try to alleviate the pain in the lower back.

Q Now, for how long did you continue him on this course of treatment before you decided to operate?

A He underwent all those conservative care and management programs from the time of his injury through when I saw him up until we operated in October of 2003.

Q By the time you operated in October of 2003, approximately, a year after the accident, had he gotten -- had -- especially with the area you were concerned with, his low back, had he gotten better, worse, or stayed the same?

A His low back did not get any better at all.

Q Did it stay the same, or get worse?

A It had gotten worse.

Q Can you tell me, by the time you -- you operated on his low back, had he complained of any symptoms relating to his neck, cervical spine?

A Yes.

Q The interrelationship of the injuries of his left knee, left shoulder, low back, does that have any impact on a person's neck?

A Yes.

Q Assuming he had no problem with the neck before, never had an injury, chiropractor, therapy, medication, anything for the neck, how do you account for the onset of cervical symptoms given that he did not complain of the neck in the hospital record?

A Several things.

One, his extremity injuries.

The knee makes his gait antalgic. He can no longer have a smooth walk.

Because there is no -- can no longer move smoothly, there is excessive stress on his back and on his neck.

The shoulder injury and use of the cane concomitantly affects the neck more specifically in terms of increasing stress and strain on the cervical spine.

These things add up in combination, and make

the problem worse.

Q Is there a balance in the spine, based on the geometry of the spine, that that is a -- a natural balance that we have if we are not feeling pain?

A Yes.

Q Would you describe the mechanics of the geometry of the spine, and how, if it's off kilter like that, with an antalgic gait, it's disrupted?

A The purpose of the spine is to hold your head squarely over your center of gravity, which is located in the pelvis.

Your neck has a backward curve to it, upper back placed forward, lower back has another backward curve.

If you look from the spine from a side view it looks like an "S."

It balances the head on top of the middle of your pelvis.

When you walk, you try to keep your head on the pelvis.

When you injure your disk and injure your extremities, that normal balance and the ability of your spine to maintain the head over your pelvis is altered.

Now, what happens is, the disks in your neck and your back, as well as muscles, are working overtime to

try to maintain your head over your pelvis.

Q At some point -- when you did surgery in October of '03, what was the surgery you did?

A What I did was, I decompressed his hemilaminectomy, or cleaning out of the pressure on the nerve in the lower back, as well as fusion or gluing together of the joints in the lower back to try to decrease painful motion in the lower back.

Q Sir, I will show you this exhibit which is marked for ID as Exhibit 2.

Do you know what this represents?

A This is a representation of the surgical procedure.

Q Is it a fair and accurate depiction of the surgical procedure, not of anybody, but of Mr. Cioffi?

A Yes.

Q Is it -- would it be helpful, for the jury to understand your testimony, if you were able to demonstrate, during the discussion of your surgery, what actually was done visually?

A Yes.

MR. BOROWICK: I offer it in evidence.

MR. WHITELEY: No objection.

THE COURT: We will mark it later.

Q Step down, please.

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And keep your voice up so you do not have to move so far back.

THE COURT: You know, I think that easel is blocking the Reporter.

It is going to be hard to hear the witness.

Am I right?

Perhaps the doctor can stand on the other side.

MR. BOROWICK: I'll move out of the way.

(The witness leaves the witness stand.)

Q First, what was your preoperative diagnosis?

A Disk derangement in the lumbar spine with neural foraminal stenosis.

Q What is that a fancy term for?

A Pressure on the nerve.

Q Okay.

Tell us what you did.

A Sure.

The first thing you do is, when -- a patient is taken into the operating room, put on an operating table so their back, and the skin of the low back is available for you to operate on after they have been anesthetized.

After that, we localize the low back area with an x-ray machine in the operating room, known as a

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fluoroscope.

After that is done, an incisional site and area are well-delineated, we prep and drape the area so it is sterile, and the next thing is the approach.

The approach involves getting down to the area where the problem is, where the bone and the nerves are.

The first part of the approach is the skin incision.

I make a skin incision of the lower area of the lower back, and, utilizing special retractors and special dissecting tools called electrocautery, I move the muscles off of the bones of the lower back so I can get down into the area where the problem actually is.

Retractors hold the muscle out of the way so I can see those bones.

After I see those bones, and I am sure that I am where I need to be with an x-ray, and by feeling certain landmarks in there, certain particular bones; namely, the sacrum, I then start to do what is called laminectomy.

Laminectomy involves removing the roof of the spinal canal.

It -- that is known as a lamina.

Laminectomy is removal of the roof.

That is done with a kerasin.

A kerasin is a surgical instrument that is made to sneak under the roof of the bone by using small bites, removing the bone without injuring the nerves that are underneath it.

Laminectomy itself --

Q Let me interrupt.

How do you control bleeding?

A Several ways.

Bleeding can be controlled by slowing the blood pressure during the operation, and there are retractors putting pressure on the muscles, and nerves, and arteries that -- that control bleeding.

I use the electrocautery, which is an electrical device that I can touch bleeding areas to control the bleeding.

Q How does that control it?

A It coagulates the bleeding like a hot poker coagulates.

When you barbecue something, you have the area of charcoal on the hamburger, hot dog or steak -- charcoal don't bleed, as they say in Texas.

That prevents bleeding.

That charcoal tissue coagulates, and stops blood from coming through the open vein or artery.

Q Now, you have gotten under there with the biting thing.

What do you do next?

A I expose the dura, or covering of the nerve, which is this gray, cylinder-like structure (indicating), and I look for the nerve roots themselves under the area where the neural foramina are.

I gradually open those exit holes for the nerve with this special tool called keratin in order to free the nerve up.

In so doing, I begin to release the pressure in the lumbar canal.

The other thing I do is, I look at, and I try to identify the disks that are in the canal.

I move -- I put a retractor on the dura itself.

I pull the dura out of the way.

I pull the nerve out of -- out of the way, and look at the disk.

If the disk is soft and easily removable, I can suck it out of the spinal canal and get it away from the nerve.

If the body's started to form what we call an osteophyte or hard disk, meaning it is beginning to calcify, removing it can pull the nerve out or tear the

dura.

It's better to leave it alone in that area, and make a larger opening for the nerve to exit to give it more room.

Q Let me ask you, when you say, "calcify," if -- over the course of a year, after an accident like this, with the injuries you have described, what would happen over the year that the surgery -- not, has been delayed, but what happens, over the year, to the vertebrae and the disk?

A Over that year of time, what happens, the body tries to heal that disk protrusion and the disk injury, so it -- it sends in cells and material to heal over the disk injury, and it makes it hard, it calcifies it, it turns it into a piece of cement on the spinal canal.

Q Without interruption, please go through the rest of the surgery, and move it along.

A Okay.

After that has been completed, and I have the nerves open, free and clear, I am satisfied that the pressure is off of them.

The next thing is the fusion portion of the procedure.

There are different ways to do a fusion. There are minimally invasive fusions, maximally invasive

fusions.

For Mr. Cioffi, we used screws known as facet screws, which are screws, stainless steel, placed into the joints of the lower back to hold them together while the bones themselves can be glued together through a process called "fusion."

Screws are placed across the joints, the bones covering those joints, and those vertebral bodies are scraped away with a high-speed burr. It makes the bone bleeding-- bleeding is good because the bleeding is the forbearer of healing and fusion.

I then take a bone graft, which I used from Mr. Cioffi, all this stuff I took out, all the bone I took out to do the laminectomy, I grind it up, make a paste, combine that with some of his own bone and blood, I make a bony glue, and then I put that over the screws and the scraped-away bone to fuse the lower back.

That is this process here (indicating).

That fusion or gluing together of the bones in the lower back decreases the rubbing together of those bones, and thereby, should decrease the amount of back pain he has by buffering the action of those injured disks.

Q Was the surgery successful?

A Yes.

Q What does that mean?

A That means that we had no complications, smooth surgery, and complete decompression of the nerve roots and dura.

Q Did he tolerate the procedure well?

A Yes.

Q Given it was surgically successful, and he tolerated the procedure well, was he cured?

A No, he is not cured.

Q How can it be successful when he tolerated it well, and not cured?

A It meant -- successful and tolerated means I did not hurt Mr. Cioffi by doing the procedure. We had no complications.

The cure comes with the ability of those nerves to recover from the damage they have suffered.

Q You can resume your seat, if you will.

(The witness resumes the witness stand.)

Q Sir, will you tell the jury, postoperatively, did the symptoms disappear, and did he resume normal function?

A Immediately following the operation, his symptomatology decreased, he got better, and he noticed improvement.

As time has gone on since then, he has had recurrence of lower back pain, with some leg pain as

well.

Q What does that tell you?

What is the significance of that?

A That tells us that the nerves that are in the lower part of the back, decompressed, are hypersensitive, and have long-standing damage.

Q In your opinion, what is the future course for Mr. Cioffi to return to pain-free function, if at all?

A Poor.

Q What would the course be if the prognosis is poor?

Is there anything you can do, or would do to address that?

A Yes.

Q What is your opinion as to what he needs to at least give him a chance?

A To at least give him a chance, he will require additional surgery from the front side or belly side in order to remove those disks entirely, and add what is called anterior fusion to what he currently has now.

Q Is that similar to the process you referred to with the decompressive surgery?

A It's different. It's different.

It's an additional fusion and a reconstruction of vertical height with anterior or

through-the-belly surgery versus what we have done in the past, which was through-the-back surgery.

Q How do you compare it?

A It's more invasive than the back surgery.

Q How do you compare the rehab or convalescence time, expense, and effort required from that surgery?

A Longer for all of those.

Q Now, in the year and half that you treated Mr. Cioffi, would you tell the jury, have you found him to be a cooperative patient?

A Yes.

Q Would you tell the jury, as part of your practice, do you sometimes get phonies who come in?

A Yes.

Q And --

THE COURT: Is that a medical term?

MR. BOROWICK: What?

THE COURT: Is that a medical term?

MR. BOROWICK: Yes.

Q Are you -- are you trained, in your practice or experience, over the course of a number of years, to detect whether or not someone is reporting subjectively, their own reports, symptoms which you cannot correlate clinically?

A Yes.

Q Okay.

Did you find Mr. Cioffi to be at all one of those people?

A No.

Q What is a malingerer?

A A malingerer is someone who purposely takes advantage of a situation to get themselves out of work, and has no objective evidence correlating with either findings or imaging studies.

Q Were his imaging studies -- did we discuss EMG?

A You asked if I had seen one.

Q He had them, you reviewed them?

A Yes.

Q Would imaging studies, whether EMG, orthopedic MRI, would they -- were his symptoms, and what you eyeballed when you opened him up consistent with the objective tests?

A Yes.

Q What is adjacent segment disease?

A Adjacent segment disease refers to early degeneration and breakdown in the area of a previous fusion.

MR. WHITELEY: Judge, I am going to object.

May we approach?

THE COURT: You're objecting?

MR. WHITELEY: To the line of questioning that is coming out.

THE COURT: I know that.

On what ground?

MR. WHITELEY: On the ground none of this was exchanged.

MR. BOROWICK: It's --

THE COURT: On what?

MR. WHITELEY: On the ground none of this was exchanged to us, and it's outside --

THE COURT: You have not seen the --

MR. BOROWICK: Judge, I'll ask it a different way.

MR. WHITELEY: May I approach?

THE COURT: It is withdrawn.

He is asking --

MR. WHITELEY: I also --

THE COURT: It does not matter.

He will ask a different question.

MR. WHITELEY: The other surgery, I also ask, Judge, for a corrective ruling.

That was not exchanged either.

The future claim for future surgery is the first time we are hearing it.

MR. BOROWICK: Judge, I believe it was, and

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we will look at the pleadings.

MR. WHITELEY: The pleadings are right here.

THE COURT: I will have to look at it.

MR. WHITELEY: It was a month ago, and a half a month ago.

There is no reference to future surgery, no reference to bone diseases.

MR. BOROWICK: There are consequences of --

THE COURT: Do you have the relevant documents?

MR. BOROWICK: I am looking for them, Judge.

MR. WHITELEY: Here they are, counsel.

(Pause.)

MR. BOROWICK: My associate will take a minute while I go on to something else.

THE COURT: Okay.

Q Doctor, let me move on to the neck.

You described how the symptoms started presenting themselves later on.

How did you treat his neck?

What did the objective finding of the test show?

A Right now, treatment for the neck is conservative, anti-inflammatory pain medication, physical therapy.

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He has decreased cervical, with spasm in the muscle of the neck itself.

And there is an MRI to --

Q What is spasm?

A Spasm is when a muscle is tense and swollen, it locks up like a charleyhorse.

Q Can somebody fake a spasm?

A Hard to do.

Q In your opinion, up until the present time, has my client been disabled from construction work?

A Yes.

Q And is he presently disabled from construction work?

A Yes.

Q Do you have opinion, with a reasonable degree of medical certainty in your field, as to whether or not he is permanently disabled from construction work?

A He is permanently disabled from construction work.

Q Has he -- based on the present film, based on your review, treatment, and surgery, has he been, to -- for the last two years, has he been disabled from any work, even sedentary work?

A Yes.

Q What about at the present time, is he presently

disabled from even sedentary work?

A Yes.

Q Why?

A The problem with sedentary work is, when you are in, for example, a seated position for prolonged periods of time, your intra-distal pressure is elevated.

What you need to do is get up and move around.

The lowest amount of intra-distal pressure, lowest amount of pressure in the spine, is when you are lying flat on your back, elevating your head or lower back.

It's what we call-- it's the weight of your body piled up on the disk, and increasing the pressure.

Sitting is a particularly increased pressure risk on the lower back, so sitting for prolonged periods of time is not recommended.

Q Sir, can a patient with the problem that he has -- and I just, again, isolate it to the back and neck -- can a patient have good days -- does this patient have good days and bad days?

A Yes.

Q Okay.

Would you describe -- based on your treatment and discussion with him, what would you

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characterize as a good day for this man?

A A good day -- we use a pain scale, zero and ten.

Zero is no pain at all.

Ten, you are, like, dipped in hot oil.

A good day makes him in the five to six neighborhood for pain.

A bad day would be, you would not be able to get out of bed.

Q Would there be any guarantee, future surgery, even though -- though he needs it --

MR. WHITELEY: Objection.

We raised this issue. It was not resolved.

He had exchanged a BP that does not have any claim --

THE COURT: Apparently, there is -- may I see it?

MR. WHITELEY: You may see the exchange, too your Honor.

(Handed.)

MR. WHITELEY: They are the medical exchanges from the doctor --

THE COURT: What?

MR. WHITELEY: Those are 3101 responses.

MR. BOROWICK: They're not 3101. They're actual treating doctors.

THE COURT: From the record I am looking at, the Supplemental Verified Bill of Particulars and the exchange --

MR. BOROWICK: The reference is on the second page, Judge.

THE COURT: Of the exchange?

MR. BOROWICK: Yes.

(Pause.)

THE COURT: Well --

MR. BOROWICK: Excuse me.

THE COURT: -- I have reviewed both, and it appears in both.

MR. WHITELEY: Sorry?

THE COURT: It appears in both documents.

The exchange --

MR. WHITELEY: The medicals do not have any reference --

THE COURT: Excuse me.

I am reading.

(Pause.)

MR. BOROWICK: Can we do this afterward, and I can go on to something else?

THE COURT: Come up, and I will show it to you in case you do not believe me, which you seem not to.

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(Pause.)

THE COURT: You appear to be correct.

MR. WHITELEY: We ask for a corrective charge.

MR. BOROWICK: Excuse me.

Can I see it?

MR. WHITELEY: She said it was correct.

I ask for a curative charge, your Honor.

THE COURT: Just hold it.

(Pause.)

THE COURT: The testimony is limited to the extent that only future examination and testing will tell whether future spinal surgery is in order.

That is what it is.

Q Sir, based upon your present analysis of his back --

MR. WHITELEY: Objection, your Honor.

That has not been exchanged in terms of any need for future surgery.

I will argue this in private, Judge.

It's not in the four corners of his exchange, it is not.

THE COURT: In preparing your -- your report, did you conclude that future MRIs are what would determine if an additional back surgery was

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required?

THE WITNESS: Yes, he would require testing, correct.

THE COURT: Testing?

THE WITNESS: Correct.

MR. BOROWICK: I have a doctor's report we have exchanged.

THE COURT: Another one.

Okay.

MR. BOROWICK: We can do this after the doctor-- there are legal issues -- I am not going into --

THE COURT: What are you showing me, what page?

(Pause.)

Q Doctor, Dr. Merola, with regard to his neck and his back -- and those are the areas I want you to limit yourself to -- how would you characterize the level of his disability in terms of a scale of mild, moderate, severe?

First, his neck.

A The neck is, at this time, moderate.

Q What about his low back?

A Severe.

Q And would you tell us what types of activities would he be limited in if he wanted to do activity

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painlessly?

I don't know if I am clear.

Could he walk, could he climb stairs, could he walk a half mile?

What could he do painlessly now, with those two parts of his body disabled, as you described?

A Painlessly, very little.

Activities that involved any type of postural changes, any bending, any lifting, any twisting, standing for a prolonged period of time, sitting for prolonged periods of time, walking in excess of three or four blocks, they are all painful activities.

Activities that involve the use of the upper and lower extremities, for example, bending over a sink at home to wash dishes, difficult, painful.

Q Sir, other than these activities of daily living, what about avocation, sports, can he resume his sports, can he play baseball, surf --

A No.

Q -- ever again?

A No.

Q Do you have an opinion as to whether or not his type of injuries -- take the whole patient -- his type of injuries affect his ability to enjoy a physically, romantically -- relationship with his wife?

A Yes, they do.

Q Let's talk about -- I don't want to get graphic.

How does it relate in a general way?

Without getting graphic, how does it relate to that disability.

MR. WHITELEY: Objection, Judge.

Again, this is not anything exchanged.

THE COURT: What?

MR. WHITELEY: This is not anything that has been exchanged or made known to the Defendant.

MR. BOROWICK: It's --

THE COURT: Again, I don't know.

I have to review --

MR. BOROWICK: It's the claim, the wife's derivative claim.

This is not new.

THE COURT: Well, he says it is new.

I don't know.

MR. WHITELEY: There is a claim for consortium, Judge. It does not encompass medical testimony.

This doctor has provided no testimony or opinion --

THE COURT: That is what consortium entails.

MR. BOROWICK: I am talking about mechanical

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changes.

THE COURT: I'll allow it.

It is not -- Doctor, are you able to answer the question?

THE WITNESS: Yes.

THE COURT: We are talking about participating in sex, isn't that correct?

MR. BOROWICK: Yes.

A Can you --

Q How does that affect his ability in that arena, in that general nature?

A He is unable to do that.

He has to assume a passive role, and cannot utilize upper or lower extremities or spine during that.

Q As a physician, can you tell us whether or not, even if he is totally passive -- and talking now about loss of enjoyment of life -- is there any loss of enjoyment of those activities?

THE COURT: The jury can conclude that on its own.

MR. BOROWICK: Got it.

Thank you.

Q I -- at your request -- did you, at my request, review the reports of Mr. Whiteley's examining doctor, Dr. DiGiacinto?

A Yes.

Q I will ask you some points that were made.

Do you agree this man's problems were all chronic, has nothing to do with the trauma?

A No.

Q Do you agree that there was no pathology appreciated in the case, on surgery, there was nothing wrong?

A Absolutely not.

Q What is "myelopathy"?

A That refers to neurological changes in the spinal nerves.

Q Did he have it, or not?

A Yes.

Q And, at my request, did you speak with Mr. -- Dr. Kinkaid, a life care planning specialist?

A Yes.

Q Did you communicate with him about the cost of the future surgery and rehab?

A Yes.

MR. WHITELEY: Objection.

Q Are you an economist?

MR. WHITELEY: Objection.

THE COURT: One at a time.

You are objecting to the question, are you

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an economist?

MR. WHITELEY: The question before that.

MR. BOROWICK: Did he communicate with Dr. Kinkaid?

THE COURT: Do you know Dr. Kinkaid?

THE WITNESS: Yes.

THE COURT: Have you communicated with him?

THE WITNESS: Yes.

THE COURT: Do you adopt that question?

MR. BOROWICK: That is what it is about.

THE COURT: You communicated with Dr. Kinkaid about this patient.

What is the next?

Q And did you discuss with him issues of future care and future cost?

A Yes.

Q Sir, would you tell us, if Dr. DiGiacinto is right, and all these problems, he had before, at least with the back and the neck, do you see any evidence of that anywhere in his history or his work history, working 1,600 hours a year over the last 20 years?

Do you see anything to support that?

A No.

Q Did you see anything, when you eyeballed his spine, to support this injury was just a chronic

degenerative condition?

A No.

Q If he had any degeneration like you described that we all have, would that make him, as any of us, more vulnerable to a trauma to sustain an injury which would be symptomatic?

A Yes, it makes him more vulnerable.

Q If he had any -- any degeneration we might all have, would -- did his trauma, if that was even remotely in the picture, but did his trauma activate the symptoms, orthopedic problems that may have been festering asymptomatically?

A Yes.

MR. BOROWICK: Nothing further.

THE COURT: Are you ready for cross?

Do you need a few minutes?

MR. WHITELEY: If the jury would like a short break --

THE COURT: Does anybody need to step out?

(Jury shakes heads in the negative.)

MR. WHITELEY: Then we will go right ahead.

MR. BOROWICK: Before I finish, I would like to offer that in evidence, the model.

THE COURT: What?

MR. BOROWICK: The model.

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THE COURT: No objection to that?

MR. WHITELEY: No objection.

THE COURT: We will mark that and the other things later.

CROSS-EXAMINATION

BY MR. WHITELEY:

Q Good afternoon, Doctor.

A Hello.

Q You are being paid by Sacks & Sacks for your testimony here today?

A Yes.

Q How much?

MR. BOROWICK: Excuse me.

That is really amateurish.

Not for his testimony.

THE COURT: What?

You object to the form of the question?

MR. BOROWICK: I don't think you meant for your testimony.

Q For your time and testimony?

A For my time.

Q Yes?

A Yes.

Q How much are you being paid?

A $400 an hour.

Q What does that work out to in this case with regard to the work you put in on this case?

A I don't have a final number as of yet.

Q How many hours, approximately, have you been working on the case, including today's testimony?

A So far, including today?

Q Correct.

A Somewhere in the neighborhood of about, ten hours or so.

Q About $4,000 in addition to the medical fees you received in treating the Plaintiff, and so forth, correct?

A For medical fees, were not for testimony, no.

Q I'm not saying they were in addition to medical fees you -- you're receiving 4,000?

A For time, and not my testimony, correct.

Q And, Doctor, have you ever testified for the office of Sacks & Sacks, or for Howard Borowick of counsel, on any prior occasion?

A I have testified for my patients.

Q How many times?

A About three times, I would say.

Q How many times this year?

A This year?

Q Yes.

A Perhaps, in total, -- and not for this law firm

only, about two or three times for the year.

Q Doctor, what does the term "exacerbation" mean to you?

What does that term mean in medical terms for the Jury?

A Exacerbation?

Q Yes.

A Exacerbation can mean something is being made worse.

Q And what does "exacerbation aggravation" mean to you?

A That is, something has been made worse, and has been instigated to be made worse.

Q Does that term, by itself, indicate that there was some things that were happening before it?

A Not necessarily.

A lot of it depends on the context in which it is used.

Q If something is exacerbated, something had to have been exacerbated, correct?

A Yes.

I can see it happens in multiple contexts.

Q Exacerbation aggravation of an L4-5 disk bulge -- what is an L4-5 disk bulge?

A Which disk bulge are we talking about?

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Q L4-5 disk bulge in --

MR. BOROWICK: Are we talking about this patient, or just generally?

I am just --

MR. WHITELEY: This patient.

This is their exchange, Bill of Particulars.

Q An L4-5 disk bulge, Doctor, what is that?

Tell the jury.

A Mr. Cioffi has an L4-5 disk protrusion.

Q Excuse me?

A Mr. Cioffi has an L4-5 protrusion.

Q Disk bulge before the accident, did he have a --

A Did he have a bulge prior?

Q He never told you about--

MR. BOROWICK: I'm sorry --

Can we approach?

THE COURT: If you have to.

(Discussion held off the record.)

MR. WHITELEY: They're his Bill of Particulars.

MR. BOROWICK: Can you curtail the discussion?

THE COURT: Ask it the right way.

Q Tell us, Doctor, tell the jury what is meant by the term exacerbation aggravation of an L4-5 disk bulge.

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THE COURT: Maybe, to clarify it --

MR. WHITELEY: Thank you.

THE COURT: -- are you familiar with that term, or --

THE WITNESS: That is not a term I would use.

THE COURT: All right.

Q Have you heard the phrase "disk bulge" used in the context of the -- your practice of lumbar orthopedics that you are engaged in, sir?

A Disk bulge, yes.

Q Tell us what it means.

A Disk bulge -- we reviewed this before -- we talk about a bulge as a symmetrical protrusion of a disk over time, and that loses water and degenerates as vertebral bodies collapse down own each other.

MR. WHITELEY: Can I use the model in evidence?

THE COURT: Yes.

Q If you can, show the jury, with your model, and use whatever you want here, explain what a disk bulge is, and how that looks on that same model.

A With a bulge, a disk bulge would look exactly like this disk without (indicating) -- this is a protrusion or herniation (indicating).

I will cover that up.

Let's make believe the herniation does not exist.

A bulge merely means you are seeing the exact same disk you are seeing now, but it comes outside the confine of the edges of the vertebral body.

Q But whether or not something comes outside the confines of the edges of the vertebral body, as you just said more here clearly than I, does that -- is that an area where -- where the disk material can come in contact with a nerve root?

MR. BOROWICK: Objection as to what could and --

THE COURT: Ask it another way.

Q Is that where the nerve root is located, outside the vertebral body, where the disk bulge could be?

MR. BOROWICK: Objection, the same thing, where it could be.

It has nothing to do with the patient.

THE COURT: Is that where it is?

MR. WHITELEY: Right.

A The nerve root is outside the vertebral body.

Q So I am clear, if something is asymptomatic at the time of the accident, if a disk bulge is not symptomatic at the time of the accident, what does that

mean to you in medical terms, so we understand that?

A If a disk bulge is asymptomatic, it means there are no symptoms produced from that disk bulge.

Q At the time of the accident --

A Then there are no symptoms from --

Q -- an exacerbation and aggravation of the disk bulge --

MR. BOROWICK: Of an asymptomatic disk bulge?

Q -- what would that mean to you, if there was at the time of the accident?

THE COURT: Do you understand the question?

THE WITNESS: I'm a little confused.

THE COURT: The witness is confused.

Q If something is asymptomatic, and there is exacerbation and aggravation at the time of the accident, what does that tell us about the condition?

A The exacerbation and aggravation means that you are aggravating something, so, then, it's not asymptomatic.

Q You cannot have something asymptomatic if there is a disk bulge there, correct?

MR. BOROWICK: Objection.

THE COURT: Do you understand that?

MR. WHITELEY: I will withdraw it.

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THE COURT: Okay.

Q Doctor, were you ever informed by Mr. Cioffi, or by any of the attorneys that retained you, about a preexisting disk bulge?

MR. BOROWICK: Objection, Judge.

What he is doing is reading from a legal document that we have to prepare, not a medical document.

Lawyers don't tell him what a medical condition is.

THE COURT: Thank you.

Thank you for the summery.

Thank you both very much.

Now, to your knowledge, did you have something of that nature in the history?

THE WITNESS: No.

Q Your impression, Doctor, of Mr. Cioffi, is based, in large part, is it not, on what Mr. Cioffi tells you?

A His history, the examination, our diagnostic imaging studies.

Q When was the first time you ever saw Mr. Cioffi?

A In May of 2003.

Q So, about six months after the accident happened?

A Yes.

Q That was the first time you laid eyes on him?

A Yes.

Q You were not there at the time of the accident, so, basically, everything you know about the accident itself is stuff that Mr. Cioffi has told you?

A Although I had the opportunity to review the report from the hospital which he was taken to after the accident.

Q Right.

Not anything about the disk bulge?

MR. BOROWICK: Objection.

It's a legal document.

THE COURT: Thank you.

Sustained.

MR. WHITELEY: I presume it comes from --

MR. BOROWICK: It's a legal document.

Objection.

THE COURT: Have a seat.

MR. BOROWICK: He added commentary.

THE COURT: You have another witness.

Q Doctor, when you were talking earlier, on direct examination, you mentioned all of us have, in our spine, from age 30 on, degeneration of our spine, is it -- am I saying that correctly?

A As we age, we do.

We have degenerative changes that occur

within our spine, yes.

Q All of us have that?

A Yes.

Q And you also said that when someone has -- whether or not we develop back pain depends, in large part, upon whether or not there is stress and strain on the disk and the bone, that was the quote I tried to get from you, I think.

Is that correct?

A No, I did not say, in large part.

That is one of the factors that goes into whether or not we develop pain.

Q Stress and strain on the disk and the bone?

A Is one of the factors that go into pain, yes.

Q Would you say someone, an ironworker for 18 years doing construction work would be someone who would routinely have a great deal of stress and strain on his disk and bone?

A He does have a significant amount of stress and strain on the bone, yes.

Q Would you say someone who is an athlete like Mr. Cioffi, who plays baseball, and golfs, and scuba diving, and I think he mentioned surfing also, if someone is an athlete, and out here doing these sports, would that kind of person, in your opinion, have stress and strain on

his disk and bone?

A He would.

Q And, if someone has an occupation or a hobby that has a lot of stress and strain, is it possible that Mr. Cioffi, in your opinion, could have had an injury to his back at any time in his lifetime?

MR. BOROWICK: Objection.

THE COURT: Sustained.

Q You mentioned, Doctor, that the surgery that you performed was a successful surgery?

A Yes.

Q Could you have done anything greater than what you did for Mr. Cioffi in the surgery that you performed?

A Not at the time, no.

Q You indicated it was tolerated -- it was tolerated well, and no complications, is that correct?

A Yes.

Q Now, if someone has an x-ray, that does not always tell us whether or not there is a problem with the disk material, would that be a fair statement medically?

A X-rays can sometimes tell us whether or not there is a problem with the disk.

Q You're aware there were x-rays taken on the first day of this accident?

A Yes.

Q You reviewed those?

A Yes.

Q What did the x-rays say with regard to the lumbar spine?

A I don't have the reading in front me.

Q Do you have any recollection of that?

That is an important medical document, isn't it?

A It's an important medical document.

I don't recall what they said offhand --

Q Do you know if there was an x-ray of the cervical spine on the day of the accident?

A I don't recall, no.

MR. WHITELEY: These are both in evidence.

Can -- he can mark them.

These are the x-rays from the Mary Immaculate chart.

(Handed.)

(Pause.)

MR. BOROWICK: I'll take your word.

MR. WHITELEY: You can check the chart.

MR. BOROWICK: I said, I will take your word for it.

I am taking your word for it.

You want me to check, I'll check it.

Q What is an anterior osteophyte?

A An anterior osteophyte?

Q Yes.

A Bone spur in front of the vertebral body.

Q Can you get those in the cervical or lumbar spine, or both?

A You can get those in both.

Q If someone had an anterior osteophyte on the day of the accident, would it be fair to say that was a condition that existed for some period of time before the accident?

A Yes.

Q You cannot get an anterior osteophyte like that on the day of the accident, correct?

A Yes.

Q I ask you to look at the radiology report dated November 1, 2002, the date of the accident.

Just confirm for the jury, if you would, sir, that report indicates he had an anterior osteophyte in the cervical spine on the day of the accident.

(Handed.)

Q Or read it.

A It says, "Small anterior osteophyte noted at C-6."

"The remainder of the bony structures, soft

tissues and joint spaces about the cervical spine show no radiographic abnormality. There is no evidence of fracture or dislocation."

Q So, after the accident, so I am clear, Doctor, an x-ray is a very good indicator if there is fracture or dislocation, correct?

A Yes.

Q There is no fracture and there is no dislocation of the cervical spine, according to the x-ray, on that day?

A Yes.

Q With respect to the lumbar spine -- I will try to finish up quickly -- with respect to the lumbar spine -- I ask you to read from that document also in evidence -- tell the jury what was done on the accident date.

A "There is a suggestion of a grade I retrolithiasis of L-3 on L-4. There is a minimal disk narrowing at L4-L5."

"The remainder of the vertebral bodies, disk space and pedicles show no radiographic abnormalities."

Q No radiographic abnormality of the lumbar spine other than disk space narrowing and retrolithiasis?

A Yes.

Q What is retrolithiasis?

A Backward slipping of one bone on the other.

Q Where was that?

A At L3-L4.

MR. WHITELEY: Thank you very much, Doctor. We will have Joe Desthers.

MR. BOROWICK: Can I?

THE COURT: Do you have any redirect?

MR. BOROWICK: Yes.

REDIRECT EXAMINATION

BY MR. BOROWICK:

Q Sir, counsel just asked you about disk bulges, and I think you mentioned, on direct, disk bulges is the pancake while it retains its shape.

Do they necessarily have nerve root impingement?

A No.

Q When he asked you could it, is there any evidence here -- I want you to assume that the work record of this man, for the 20 years before the accident, includes 1,600 hours, no limitation, and no medical treatment, no complaint, no limitation, no medication, physical therapy, chiropractor.

Is there anything you have seen, or anybody has shown you, anybody, that suggested there was preexisting impingement, when there was pancaking as

natural degenerative disk disease?

A No, I have not seen it.

Q Counsel asked about the stress and strain of ironwork.

By the way, have you treated other ironworkers?

A Yes.

Q Do all ironworkers have stress and strain that relate -- that result in traumatic herniation of their disks?

A No.

Q Traumatic protrusion of the disks?

A No.

Q Suffering and symptoms, do all of them have that absent the trauma?

A No.

Q He asked about a bone spur.

He said, was there bone spurs?

When you read that, "anterior osteophyte," was that, in any way, symptomatic before the accident?

A No.

Q About the lumbar spine, the retrolithiasis, one or two questions.

You said it was a slippage.

Can -- a retrolithiasis of grade I, is that

severe, or minimal?

A Minimal.

Q A minimal retrolithiasis -- after a twisting accident which herniates, protruded the disk, and tears the anulus, can that cause a grade I retrolithiasis?

A Yes.

Q And minimal narrowing, and no other finding besides minimal narrowing of the L4-5, is that consistent with the degenerative disk disease that we all suffer as a result of aging, plus athlete and ironworker?

A Yes.

MR. BOROWICK: Nothing further.

RECROSS-EXAMINATION

BY MR. WHITELEY:

Q Doctor, your opinion is that Mr. Cioffi cannot perform construction work, is that correct, in the future?

A Correct.

Q Do you have an opinion with regard to other forms of work?

Is it possible he could work in a more sedentary job?

A He can.

Q Thank you, Doctor.

MR. BOROWICK: Excuse me.

That is not fair.