

**In The Matter Of:**

*Juan Julca v.*

*ERY Tenant, LLC ERY Retail Podium, LLC*

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*Dr. Shlomo Minkowitz & Dr. Thomas Kolb*

*March 12, 2026*

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*Supreme Court State of New York - Civil Term*

*60 Centre Street - Room 420*

*New York, New York 10007*

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SUPREME COURT OF THE STATE OF NEW YORK  
 COUNTY OF NEW YORK - CIVIL TERM - PART 58

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JUAN JULCA,

Plaintiff,

-against-

ERY TENANT, LLC, ERY RETAIL PODIUM, LLC,

Defendants.

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Index # 161813/2019

INPERSON TRIAL  
 71 Thomas Street  
 New York, New York 10007

March 12, 2026

B E F O R E:

HONORABLE DAVID B. COHEN,  
 Supreme Court Justice.

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

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 Senior Court Reporters

dar

**-Proceedings-**

1 THE COURT: Case on trial continued.

2 Appearances are the same.

3 Good morning counsel. Is there anything before I  
4 bring in the jury?

5 MR. MALECKI: Yes, your Honor.

6 The first issue is from yesterday. Your Honor's  
7 order provided that Dr. Kaplan provide us with original  
8 copies of the photographs, that has not been done.

9 My understanding is, counsel is taking the position  
10 that he does not have them, even though he testified quite  
11 clearly that they were at his surgery center and store it  
12 there.

13 MR. ROSENGARTEN: Your Honor, that is a  
14 misrepresentation.

15 I spoke with Dr. Kaplan yesterday and he told me  
16 the actual photographs, which I, by the way, have not seen,  
17 that he actually handed to Mr. Malecki at this table, are  
18 the photographs from his file.

19 I don't believe, your Honor, I can read the  
20 transcript, I have, I don't think your Honor required that  
21 the digital photos be turned over. You required the  
22 photographs. That was what was turned over. They were not  
23 photocopies. The thing you asked for not was photocopies.

24 According to Dr. Kaplan, those are the photographs  
25 he has in his file, period.

**-Proceedings-**

1           He's talking about stuff from the surgical center.  
2           It is interesting that he brings it up because, while he  
3           made a whole dog and pony show about his subpoenas and  
4           speaking to someone at Dr. Kaplan's office, there wasn't  
5           anything about him reaching out to the surgical center. I  
6           don't know why he didn't. He seems to-- there was testimony  
7           yesterday --

8           THE COURT: Was this surgical center subpoenaed, I  
9           believe it was?

10          MR. ROSENGARTEN: It was.

11          THE COURT: Did those photographs get turned over  
12          by the surgical center, they did not, right?

13          MR. ROSENGARTEN: I don't believe they were. My  
14          understanding is that --

15          THE COURT: So there's still an outstanding  
16          subpoena, right, they still have an ongoing continuing  
17          obligation to comply with the subpoena. Does the surgical  
18          center have it?

19          MR. ROSENGARTEN: I don't know. I reached out to  
20          them, I did not hear back.

21          But I know what the Court Ordered yesterday, which  
22          was complied with the photographs that Dr. Kaplan has, the  
23          actual photographs. My understanding --

24          THE COURT: Mr. Malechi has those. Those were  
25          handed over to MR. Malechi by Dr. Kaplan from his file?

**-Proceedings-**

1 MR. ROSENGARTEN: Yes.

2 THE COURT: They were not turned over pursuant to  
3 subpoena but he had them with him?

4 MR. ROSENGARTEN: Correct.

5 THE COURT: Okay.

6 MR. ROSENGARTEN: It is our position that nothing  
7 else needs to be turned over at this point.

8 THE COURT: No, the surgical center has an ongoing  
9 obligation to comply with that subpoena and turn over those  
10 records; so they need to go ahead and do that.

11 MR. ROSENGARTEN: Are you ordering me to speak to  
12 the surgical center to get those photographs, if they have  
13 it; which, by the way, I can't guaranty they do. These are  
14 if a 3, 4, 5 years ago and the subpoena was from January of  
15 this year, I can look into it.

16 THE COURT: Mr. Malechi, have you been in contact  
17 with the surgical center?

18 MR. MALECKI: No. Let's be clear, Dr. Kaplan owns  
19 the surgical center. He performed three surgeries at the  
20 surgical center. He testified yesterday, I have the  
21 transcript in front of me, that they are stored in digital  
22 form at the surgery center.

23 They are pretending like these are two different  
24 people is crazy.

25 Also, the surgical center is on 54th Street, Dr.

**-Proceedings-**

1 Kaplan's office is on 56th Street, I'm not asking him to go  
2 to New Jersey. I'm asking him to walk down the street or,  
3 frankly, make a phone calls.

4 THE COURT: He doesn't need to do anything at all,  
5 other than to direct his staff at the surgical center to  
6 comply with that subpoena.

7 MR. MALECKI: Correct.

8 THE COURT: They need to do that.

9 Mr. Rosengarten, they need to do that today.

10 MR. ROSENGARTEN: Okay. And to be clear, that is  
11 the photographs, which have already been turned over. That  
12 is what the Court asked for, the photographs.

13 THE COURT: Which Dr. Kaplan said are not as good  
14 quality, right, when they are copied.

15 MR. ROSENGARTEN: No. That is why I think there's  
16 some confusion and I think there's an issue and mistake.

17 Dr. Kaplan said the photographs that he had  
18 yesterday, if he would have photocopied them, would not have  
19 been good quality, that is fair.

20 The reason, after speaking to Dr. Kaplan yesterday,  
21 that his office reached out to Mr. Malechi is because the  
22 photographs that he had have to be printed on special paper  
23 for it to make to not have the issue of photocopy.

24 THE COURT: I think he used the term "high  
25 resolution."

**-Proceedings-**

1 MR. ROSENGARTEN: Exactly.

2 That is what he turned over to Mr. Malechi here, as  
3 far as I know, as far as what Dr. Kaplan told me. I have  
4 not seen the photographs. Those are not photocopies. The  
5 issue is with photocopies, those are not photocopies.

6 THE COURT: Are you telling me those are the high  
7 resolution photographs that Dr. Kaplan referred to?

8 MR. ROSENGARTEN: Yes, correct.

9 THE COURT: And what is the resolution of those  
10 photos, are they black white or color?

11 MR. MALECKI: They are color. Your Honor, could we  
12 stop pretending we are in the 1990's. He did not take the  
13 photographs with a Polaroid that he is now scanning that  
14 Polaroid. These are digital photos. The original copy is  
15 the digital copy, not a printout of the digital copy, that  
16 is what this is.

17 THE COURT: What is wrong with the printout of the  
18 digital copies?

19 MR. MALECKI: To have the metadata so one can use  
20 it and zoom in closer.

21 THE COURT: You did not subpoena the metadata.

22 MR. MALECKI: We subpoenaed original photographs.

23 THE COURT: And you have them.

24 MR. MALECKI: These are not the original  
25 photographs.

**-Proceedings-**

1 THE COURT: You have them or you don't have them.

2 MR. MALECKI: I don't have original photographs. I  
3 have what Dr. Kaplan printed out.

4 THE COURT: It is a printout of a digital image  
5 that is taken during the surgery.

6 MR. MALECKI: Correct.

7 THE COURT: Is it printed in color and in good  
8 quality resolution?

9 MR. MALECKI: It is printed in color, I don't know  
10 the resolution, your Honor.

11 THE COURT: Okay. Okay.

12 If you can articulate some inaccuracy in them to  
13 me, then maybe I'll make a further direction; but barring  
14 that, I'm not directing anything further at this time, Mr.  
15 Malechi.

16 MR. MALECKI: Inability to zoom in on the  
17 photographs, which you can do on any digital photograph, I  
18 can do it on my phone when I take a photograph, that alone  
19 to be able to zoom in and look closer at the pictures, that  
20 alone our expert should be able to do that.

21 THE COURT: Did your subpoena request digitized  
22 imaging or merely imaging.

23 MR. MALECKI: Requested the inner operative  
24 photographs.

25 THE COURT: Then that is what you have, counsel.

**-Proceedings-**

1                   No further action on this at this time.

2                   What else?

3                   MR. MALECKI: Your Honor, we filed a motion to  
4                   renew our arguments with respect to the cross-examination of  
5                   Dr. Weinstein and Dr. Grimm on the Workers' Compensation  
6                   Board.

7                   The Article 78 was recently denied. And there was  
8                   specific findings. During the pendency of this trial the  
9                   Article 78 was denied. There were specific findings made in  
10                  there that goes against every argument that was made, with  
11                  respect to Workers' Compensation Board being solely  
12                  peer-reviewed. The Court agreed that was a legitimate way,  
13                  that he had more than enough time, more due process time to  
14                  go through and affirm the decisions of the Workers'  
15                  Compensation Board. And we believe that now this is giving  
16                  ammunition to the idea that the Workers' Compensation Board  
17                  decision was correct and was not based on this problem with  
18                  insurance companies, behind the scenes, which is what  
19                  counsel argued during our argument on this motion.

20                  THE COURT: So when was this Article 78 decision  
21                  handed up?

22                  MR. MALECKI: March 5th.

23                  THE COURT: This is with respect to doctor --

24                  MR. MALECKI: Dr. Weinstein, specifically.

25                  Dismissed his Article 78 petition and made specific findings

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1 as to why they were dismissing it.

2 THE COURT: March 5th?

3 MR. MALECKI: Yes. The decision is dated--  
4 March 5th, yes.

5 THE COURT: And that was the date he testified.

6 Well, it would have been helpful to have had that  
7 decision before, but it was not available before he  
8 testified, right?

9 MR. MALECKI: It was not.

10 THE COURT: So, you want to recall Dr. Weinstein,  
11 you want to call Dr. Weinstein?

12 MR. MALECKI: I want to recall him in order to  
13 cross-examine him on the issues in the Workers' Compensation  
14 decision.

15 THE COURT: I'll take a look on the decision.

16 Do you have anything on that Mr. Rosengarten.

17 MR. ROSENGARTEN: Yes. First of all, I believe I  
18 got the motion at 9:39 a.m. today, I have not had time to,  
19 frankly, look at it.

20 I will say, in terms of Dr. Grimm, I don't see how  
21 Dr. Weinstein's Article 78 has any bearing on Dr. Grimm at  
22 all. It seems the motion is for Dr. Grimm too, I don't know  
23 why that would be would be appropriate in way, shape or  
24 form.

25 In terms of Dr. Weinstein, this Court, while I

**-Proceedings-**

1       tried to argue that the Article 78 petition says that this  
2       is not a final determination, the Court, essentially,  
3       rejected that. And the Court really found, my  
4       understanding, in line with Justice Cohen in Brooklyn, the  
5       idea that the denial of further Workers' Compensation is,  
6       essentially, not probative, nothing to do with this specific  
7       case, was not denied in this specific case. And I would  
8       say, your Honor --

9               THE COURT: It is not disciplinary determination.

10              MR. ROSENGARTEN: Correct.

11              And I would further say, if he does want to recall  
12       Dr. Weinstein, that opens up a whole can of worms. Because  
13       if he is going to talk about being denied by Workers'  
14       Compensation, I should be able to talk about how his surgery  
15       was authorized by Workers' Compensation. It goes hand in  
16       hand.

17              We can talk about how Dr. Weinstein's lumbar  
18       surgery was authorized by Workers' Compensation.

19              THE COURT: I'm take a look at the Article 78  
20       Proceeding. And I will have a decision and make a  
21       determination if it is persuasive in determining my ruling.  
22       You can hand it up.

23              MR. ROSENGARTEN: And one thing I will add, your  
24       Honor. This is, essentially, all related to the RECO  
25       matters. I did want to point out to your Honor, that the

**-Proceedings-**

1 RECO complaint filed with my specific firm, including Dr.  
2 Weinstein, including Dr. Grimm, including Dr. Kaplan was  
3 dismissed yesterday by the District Court on the merits  
4 without leave to amend the complaint without a motion. So I  
5 can provide a copy of that decision, if the Court would like  
6 to see it. I'm sure at some point you will see that  
7 decision in some other way, shape, or form. I wanted to  
8 bring that into the Court's attention, as this is sort of a  
9 collateral issue to that as well.

10 THE COURT: I would like to see that decision at  
11 some point in time, but you can certainly provide it if you  
12 have it.

13 Thank you, counsel.

14 Bring in the jury -- first let's make sure we have  
15 our technology set up.

16 (Pausing.)

17 THE COURT OFFICER: All rise. Jury entering.

18 (Whereupon, the jury enters the courtroom and the  
19 following is heard inside the hearing and presence of the  
20 jury.)

21 THE COURT: Please be seated.

22 Members of the Jury, good morning, welcome back. I  
23 hope you're enjoying the dreary Thursday as much as I am.

24 Our next witness will also be a defense witness  
25 taken out of turn as the Plaintiff has not completed their

**-Proceedings-**

1 witnesses and rested their case. Also, this witness will  
2 testify via video link.

3 At this time, I call upon Mr. Malechi to call your  
4 next witness.

5 (Witness appears remote via Microsoft Teams.)

6 THE COURT: Please swear in the witness.

7 THE CLERK: Good morning.

8 THE WITNESS: Good morning.

9 THE CLERK: Please raise your right hand.

10 Do you solemnly swear or affirm that the testimony  
11 you're about to give will be the truth, the whole truth, and  
12 nothing but the truth?

13 THE WITNESS: Yes.

14 THE CLERK: In a loud clear voice, please state  
15 your name and address for the record, spelling both your  
16 first and last name.

17 THE WITNESS: Yes. My name is Shlomo, S-H-L-O-M-O,  
18 Minkowitz, M-I-N-K-O-W-I-T-Z. Address 15 Beverly Road,  
19 Chester, New York 10918.

20 THE CLERK: Thank you.

21 Your Honor, the witness has been sworn and  
22 affirmed.

23 THE COURT: Mr. Malechi you may inquire.

24 MR. MALECKI: Thank you, your Honor.

25 DIRECT EXAMINATION

**Dr. Minkowitz - Direct - Defendant/by Mr. Malecki**

1 BY MR. MALECKI:

2 Q Doctor, could you please tell us what your medical  
3 specialty is?

4 A I'm a diagnostic radiologist.

5 Q And could you give us a brief description of you  
6 educational background?

7 A Yes. I went to medical school at Weil Cornell. I  
8 stayed on for radiology residency at Weil Cornell. I stayed on  
9 for a radiology fellowship in neuroradiology at Weil Cornell and  
10 I am currently there as an attending physician.

11 Q And hat have been have you been doing since schooling  
12 professionally?

13 A So, I split my time between reading general radiology  
14 for the emergency department, so musculoskeletal, chest,  
15 abdomen, and pelvis; and half my time reading neuroradiology  
16 which is spine, head and face.

17 Q And are you a member of any professional associations?

18 A So the American Board of Radiology and the American  
19 College of Radiology.

20 Q And have you received any awards or recognition for  
21 your work?

22 A I have in residency.

23 Q All right. Are you licensed?

24 A Yes.

25 Q Are you licensed in New York?

**Dr. Minkowitz - Direct - Defendant/by Mr. Malecki**

1 A Yes.

2 Q And how long have you been licensed in New York?

3 A Since 2013, I believe.

4 Q And in your career, approximately, how many MRI scans  
5 have you reviewed?

6 A Thousands, many thousands, hard to know.

7 Q And have you testified before in court?

8 A Yes.

9 MR. MALECKI: Your Honor, I would ask that Dr.  
10 Minkowitz be certified as an expert in radiology.

11 THE COURT: The witness is so qualified.

12 MR. MALECKI: Thank you, your Honor.

13 BY MR. MALECKI:

14 Q Now, Doctor, you were asked to review some of the MRI  
15 films in relation to Mr. Julca; is that correct?

16 A Yes.

17 Q And so that we know, how much do you charge for  
18 reviewing those films?

19 A \$600 an hour.

20 Q And are you charging the same for your testimony today?

21 A No.

22 Q And what do you charge for testimony?

23 A \$6,000.

24 Q All right. And did you review any of Mr. Julca's  
25 lumbar spine MRIs?

**Dr. Minkowitz - Direct - Defendant/by Mr. Malecki**

1 A Yes.

2 Q Which ones did you review?

3 A I reviewed an MRI that was done on April 13th, 2018.  
4 And I reviewed another one that was done on October 27th of  
5 2021 -- sorry, October 28th, 2021.

6 Q All right. And let's start, could you explain to us  
7 what is an MRI and what it is used for?

8 A An MRI is a special way of taking pictures of the  
9 inside of the body. It uses magnetics, essentially, to create  
10 very detailed pictures of all the different soft tissues inside  
11 of the body to help us make a diagnosis.

12 Q And let's start with that April 13th, 2018, MRI. And  
13 you reviewed the films of that MRI?

14 A Yes.

15 Q And with respect to that lumbar spine MRI, what  
16 findings did you make in reviewing those films?

17 A I made that there were several levels of the  
18 degenerative change of wear and tear, mostly pronounced at the  
19 L4/L5 level, which is kind of lower down in the lumbar spine;

20 There was narrowing of the canal, which is where the  
21 nerve roots run;

22 The facets, which are joints that help the spine have  
23 mobility, they were overgrown and worn away;

24 Those were the findings that I saw.

25 Q All right. And could you explain to me what a

**Dr. Minkowitz - Direct - Defendant/by Mr. Malecki**

1 narrowing of a canal means?

2 A Sure. The spinal canal is, I think of it as a highway  
3 for the nerves. The nerves kind much rundown from the brain.  
4 And it is kind of a superhighway for the nerves and they have  
5 all their exits along the way to, you know, innervate the body.

6 When it's narrowed, it could be for a couple of  
7 reasons. But when it is narrowed, that kind of highway is kind  
8 of smaller and it can actually cause some sort of narrowing on  
9 the nerves, depending how bad it is.

10 Q And you mentioned degenerative changes. What did you  
11 mean by that?

12 A So, over time, almost all of us, many of us, we have  
13 this gradually wear and tear on our spine and many of our joints  
14 but on our spine, especially. And the spine is a very dynamic  
15 structure. It moves a lot, it has a lot of joints, the way that  
16 it turns and those swears down in time. You can see evidence of  
17 it wearing down on a MRI.

18 Q And those degenerative changes, how long does it take  
19 to develop those?

20 A So they can take, you know, many months to years. They  
21 typically take over the course of years and years.

22 Q And now, did you also look at the report from the  
23 radiologist who reviewed that April 13th, 2018, MRI from Lenox  
24 Hill Radiology?

25 A Yes.

**Dr. Minkowitz - Direct - Defendant/by Mr. Malecki**

1 Q And were your findings consistent with that  
2 radiologist?

3 A Yes.

4 Q Now, is it uncommon for a radiologist to review films  
5 and see something different in them?

6 A It is not uncommon. It can happen depending on --  
7 depending on how, you know, how different the interpretation is.  
8 It could happen more or less common, it is not uncommon, no.

9 Q Now, the findings that you saw in this April 13th,  
10 2018, back MRI, are they findings that would be consistent with  
11 a traumatic injury such as the one that Mr. Julca had?

12 A No.

13 Q And why do you say that?

14 A Because the appearance of the findings is very very  
15 typical of that wear and tear, that takes many months to years  
16 to develop. And so when I look at that spine MRI and I see  
17 these all the time, it is a very very typical pattern of kind of  
18 bony overgrowth that happens slowly over time.

19 Acute trauma, or relatively acute to subacute trauma  
20 has a different appearance and that appearance is not present  
21 here.

22 Q And first, when you say bony overgrowth, what do you  
23 mean by that?

24 A So, the joints-- we have many joints in our bodies;  
25 hips, knees, but actually every level in our spine has two

**Dr. Minkowitz - Direct - Defendant/by Mr. Malecki**

1 paired joints at the back, almost like hinges. And just like  
2 the knee and hip can get arthritis over time, these little  
3 joints called the facet joints can also get arthritis. One of  
4 the ways that the body responds to the arthritis, it creates  
5 --it generates more bone to try to make more surface area. It  
6 tries to ease the load on the body. And that is a very --that  
7 is a process that takes months to years. That is what I mean  
8 when I say here, the facets have a lot of bony overgrowth to  
9 them.

10 Q And I believe that you said there were certain things  
11 that were missing that would have shown acute trauma, what  
12 specific things?

13 A Mainly a lot like of edema. You could see edema,  
14 inflammation that has a specific pattern or fractures,  
15 especially, these are findings that are specific for trauma but  
16 they were not present.

17 Q And you also reviewed, you said you reviewed the MRI  
18 from several years later on October 28th, 2021, correct?

19 A Yes.

20 Q And were there any changes from the 2018 MRI to the  
21 2021 MRI?

22 A No appreciable changes. The facet overgrowth was the  
23 same, the canal narrowing was the same.

24 Q And so is your interpretation as to whether that  
25 October 28th, 2021, MRI showed any evidence of acute trauma, has

**Dr. Minkowitz - Direct - Defendant/by Mr. Malecki**

1 that changed any?

2 A No.

3 Q Now, let's go to the left shoulder.

4 Did you review any MRIs for the left shoulder?

5 A Yes.

6 Q And which MRIs did you review?

7 A April 13th, 2018 MRI.

8 Q Was that also from Lenox Hill Radiology?

9 A I believe it was.

10 (Pausing.)

11 Let me check my notes. I believe it was.

12 (Pausing.)

13 Yes, Lenox Hill Radiology.

14 BY MR. MALECKI:

15 Q Now, what specific findings did you determine when  
16 looking at that left shoulder MRI?

17 A One of the rotator cuff tendons --so we have rotator  
18 cuff tendons which help us move our shoulder. Those are, like,  
19 vulnerable to wear and tear over time.

20 One of those tendons, called the supraspinatus tendon,  
21 had a small tear just underneath the bone there.

22 The other finding was that one of the bones in the  
23 shoulder called the acromion bone was kind of --different  
24 people have different ways of the way that their anatomy looks.  
25 Some people that bone is a little bit higher or sometime that

**Dr. Minkowitz - Direct - Defendant/by Mr. Malecki**

1 bone is a little bit lower. It is what we call impinges. It  
2 impinges against the tendon and rubs against it. Every time  
3 they move the shoulder, that tendon rubs against the bone and  
4 over time they get tear over there.

5 I saw both finding. I saw a partial tear along the top  
6 of the tendon and the bone on top of it kind of tilted down  
7 against it.

8 Q Now, this acromion, is that something that is a genetic  
9 condition?

10 A It is something people are born with. I would think of  
11 it as an anatomic variation. Some people have more space, some  
12 people have less space.

13 Q Is it your testimony that that anatomic variation is  
14 what is causing these tears in the rotator cuff?

15 A Yes, that would be the explanation. Because in the  
16 literature it is very well described that when the acromion is  
17 lower, it causes impingement on that tendon. As patients move  
18 their shoulder over the course of months and years, they can get  
19 that tendon gets frayed and torn.

20 On this MRI I seen the bone down and I'm seeing the  
21 tendon right under that a little frayed. And that is all that I  
22 am not seeing. I am not seeing any fracture or edema. I am not  
23 seeing anything that tells me that there was an acute or  
24 subacute trauma. I'm also seeing the classic appearance of what  
25 causes a little bit of fraying and tear to the tendon due to the

**Dr. Minkowitz - Direct - Defendant/by Mr. Malecki**

1 bony anatomy of the patient.

2 Q Now, did you also review the report from a radiologist  
3 from Lenox Hill Radiology?

4 A Yes.

5 Q And did your interpretation of the films differ from  
6 that radiologist?

7 A No.

8 Q And to make sure I understand, did you make a  
9 determination as to whether the findings in this left shoulder  
10 MRI from April 13th, 2018, could have been caused by an injury,  
11 such as the one that Mr. Julca had?

12 A There's no evidence for that. There's no evidence on  
13 the MRI that those findings are caused by injury.

14 Q And explain to me why you say that?

15 A Because the -- any findings that would point towards  
16 trauma are not there. And the findings that are there are very  
17 well described in the literature as being caused by wear and  
18 tear over time, due to the patient's anatomy.

19 Q Now, let's move on to the right knee.

20 Am I correct you reviewed an MRI of the right knee?

21 A Yes.

22 Q And when was that MRI taken?

23 A July 10th, 2018.

24 Q And am I correct that is done at Kolb Radiology?

25 A Yes.

1           Q     And, in reviewing this July 10, 2018 MRI, what findings  
2 did you make with respect to the right knee?

3           A     With respect to the right knee, the meniscus is a  
4 little bit worn. It is a little bit worn, which happens. That  
5 is really the only finding that I was able to see on my review,  
6 that I saw, a little bit of wear of the meniscus.

7                     (Whereupon, Shameeka Harris relieved Deborah Rothrock  
8 as the Official Court Reporter.)

9                     (Continued next page.)

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**Dr. Minkowitz - by Defendant - Direct**

1 DIRECT EXAMINATION

2 BY MR. MALECKI:

3 Q And explain to me what is the meniscus?

4 A So, the meniscus is -- it is kind of like a -- you can  
5 almost think of it as a washer for the knee. It kind of  
6 provides cushioning for when the bones are against each other  
7 and it goes -- you have one on the left. One on the inner and  
8 one on the outer side of the knee. And in many patients who get  
9 arthritis in their knees as they get older, part of that picture  
10 of the arthritis -- so there is some cartilage wear. There can  
11 be some bone changes and the meniscus also gets worn down over  
12 time. So that is something that we look for when we read a MRI  
13 is is there any kind of change in the meniscus that would  
14 indicate some wear that occurs over time.

15 Q And this wear in the meniscus, is this something that  
16 you attribute to Mr. Julca's accident from March 3, 2018?

17 A No.

18 Q And why do you say that?

19 A Because when trauma affects the meniscus, what it  
20 usually does is it causes a tear and it causes tears in specific  
21 patterns and that's not present here. What we are seeing the  
22 meniscus is a very typical just wearing of the meniscus and any  
23 findings that would be seen in trauma like a large joint  
24 effusion or edema or, you know, inflammation, those are not  
25 present here.

**Dr. Minkowitz - by Defendant - Direct**

1 Q And did you also review the report from Kolb radiology  
2 of this July 10, 2018, MRI?

3 A Yes.

4 Q And were there any differences in your findings from  
5 that report?

6 A Yes.

7 Q In what way was it different?

8 A The radiology report does describe meniscus tears. I  
9 don't see evidence of a meniscus tear. I see a little bit of  
10 wear, wear on the meniscus. A tear has a very specific  
11 appearance and it is not here. The radiology report describes  
12 that there's a tear of the ACL which is a ligament that  
13 stabilizes the knee. I don't see that here. The ACL normally  
14 has a little bit of higher signal along the fibers that's been  
15 very well described in the literature. That is here. That's  
16 normal. It is not considered a tear.

17 And I also disagree because the radiology report  
18 describe that there is a joint effusion. And over here, normal  
19 joints have some fluid in them. It is part of how joints are  
20 lubricated. So every joint that we see has a little bit of  
21 fluid that's normal. What we look for is whether there is an  
22 abnormal amount of joint fluid which would indicate that the  
23 joint is angry, either it is angry because of trauma or it's  
24 angry because of arthritis.

25 What I'm seeing here is a little bit of normal fluid so

**Dr. Minkowitz - by Defendant - Direct**

1 the description of a joint effusion, which usually in a  
2 radiology report implies that in abnormal amount of fluid, I  
3 disagree with. I don't see that here.

4 Q The next MRI you reviewed is of the left knee, correct?

5 A Correct.

6 Q And when was that taken?

7 A That was May 1, 2018.

8 Q And is that from Lenox Hill Radiology?

9 A Left knee was Lenox Hill Radiology, yes.

10 Q And what findings did you make when reviewing the MRI  
11 of the left knee?

12 A So, on the left knee, there was some wear of the  
13 meniscus, a little bit more than it was on the right. So, you  
14 know, there's a grading system or a classification system called  
15 Cruess. The grading he had was called Cruess I. This knee was  
16 Cruess II. So it was a little more progressed, still very  
17 typical of a worn down meniscus. So that's one thing I saw.

18 And then the other thing that was there was that there  
19 was some cartilage that was thinned over the upper half of the  
20 knee and there was a little area of just bony change underneath  
21 it which we can see sometimes with early arthritis. Those were  
22 the findings that -- that I saw.

23 Q This Cruess system, first of all, how do you spell  
24 that?

25 A It's C-R-U-E-S.

**Dr. Minkowitz - by Defendant - Direct**

1 Q And you mentioned level one and level two. What levels  
2 does it go up to?

3 A Three. So three would be like an actual total tear  
4 through the meniscus. And once you have level three, then what  
5 matter is you want to look at the patterns. Some patterns are  
6 typical for wear and tear, longstanding arthritis. Some  
7 patterns are more typical of trauma. This one was Cruess II so  
8 it's maybe like partially little fibers are disrupted inside and  
9 that's also been classically associated with just worn down  
10 menisci over time.

11 Q And the findings that you made in this left knee MRI  
12 from May 1, 2018, are they findings that, in your opinion, could  
13 be caused by a traumatic injury such as the one that Mr. Julca  
14 had?

15 A No. They're typical of just a little bit of like early  
16 arthritis, degeneration. The findings that would be typical of  
17 like a recent or acute or subacute trauma like a fracture or  
18 some large area of, you know, marrow swelling that's not here.

19 Q And now you also reviewed the report of that MRI?

20 A Yes.

21 Q And did your findings differ with the radiologists from  
22 Lenox Hill?

23 A To some degree. To some degree.

24 Q In what way?

25 A So, they described an ACL tear and, again, I -- it

**Dr. Minkowitz - by Defendant - Direct**

1 looks normal. There is some normal increased signal along the  
2 fibers and that's present here and that's not a tear in my  
3 opinion. They also described a joint effusion which same as the  
4 other knee there is a small amount of fluid here. It's  
5 completely within normal limits. It doesn't point to anything  
6 unusual. And the other finding, and this is more subtle, is we  
7 both have the same finding about that part of the upper knee.  
8 They interpret it to be what's called an OCD, an osteochondral  
9 defect. In my opinion, that is a misinterpretation.

10 It doesn't have the classic appearance of that. It  
11 actually has the appearance of some early mild arthritis because  
12 the overlying cartilage is thinned and there is a little bit of  
13 change in underlying bone which is very typical.

14 Q And can you explain to me what an osteochondral defect  
15 is?

16 A Yeah. It's typical, we see it in adolescents, it's  
17 where the -- so the bone of the knee is covered by cartilage.  
18 It's almost where like a chunk of the cartilage and the bone are  
19 dislodged together and there's different grades depending how  
20 stable or dislocated it is, but it is a pretty typical  
21 appearance often in the adolescent age group. That's not the  
22 appearance we have here.

23 Q The mild arthritis you keep mentioning is that  
24 something that is unusual to find?

25 A No. No.

**Dr. Minkowitz - by Defendant - Direct**

1 Q So were any of the findings that you made in this  
2 May 1, 2018, MRI of the left knee, in your opinion, were they  
3 connected at all to Mr. Julca's accident?

4 A No.

5 Q Now, in this case, you also reviewed an additional MRI  
6 of the left knee that was done later?

7 A Yes.

8 Q And when was that?

9 A January 12, 2023.

10 Q And was that done at Kolb?

11 A That was done -- that was done in Kolb, yes.

12 Q And now this is an MRI about five years after that  
13 initial one. Did you notice any changes between the 2018 MRI  
14 and the 2023 MRI?

15 A Yes.

16 Q And in what way were there changes?

17 A So that worn down meniscus that we described that was a  
18 Cruess Stage II, over that five-year span, it had progressed to  
19 a Cruess Stage III. So, it progressed with that idea of a true  
20 tear. The pattern, it's called horizontal. The pattern is very  
21 typical for degeneration which is exactly what we saw. We  
22 watched it over five years go from Cruess II to Cruess III which  
23 is very common. That's why it's called degeneration and that's  
24 the difference that I -- that I saw on the later MRI.

25 Q And can you explain to me this horizontal pattern you

**Dr. Minkowitz - by Defendant - Direct**

1 just mentioned?

2 A Yes. So the meniscus is -- think of it like a disk  
3 that is wider at the periphery and narrower on the inside. And  
4 there is a few different ways you can tear it. You can tear it  
5 from the inside almost like if you took a pizza cutter to it.  
6 You can tear it almost like along the rim. You can tear it as  
7 if you're slicing it from the side and that's called a  
8 horizontal tear.

9 In the literature, that tear is the one that's  
10 associated with degeneration. That's often what we see with the  
11 wear and tear of menisci when they progress like that and that's  
12 what we're seeing here.

13 Q And was there anything in this subsequent MRI of the  
14 left knee taken five years later that changes your opinion about  
15 whether the results are connected to Mr. Julca's accident?

16 A No.

17 MR. MALECKI: All right, Doctor. That's all the  
18 MRIs so that's all the questions I have for you.

19 THE WITNESS: Thank you.

20 CROSS-EXAMINATION

21 BY MR. ROSENGARTEN:

22 Q Good morning, Dr. Minkowitz.

23 A Good morning.

24 Q My name is Harold Rosengarten. And I'm just going to  
25 be asking you a few questions about your testimony today, okay.

**Dr. Minkowitz - by Defendant - Direct**

1 A Sure.

2 Q Most of my questions are going to be yes or no so I  
3 would just ask if you would stick to yes or no if that's an  
4 appropriate answer, okay?

5 A Okay.

6 Q I know Mr. Malecki talked to you about what you were  
7 paid to be here today, right?

8 A Yes.

9 Q And you were paid \$6,000 to be here, right?

10 A Yes.

11 Q And then you were also paid \$600 an hour to review the  
12 films?

13 A Yes.

14 Q How many hours did you spend reviewing those films?

15 A I have to check. Maybe three. I have to check  
16 exactly, a few hours.

17 Q So either -- so another 12 to \$1,800 on top of the  
18 \$6,000 that you received for being here today?

19 A Yeah. I'd have to check the exact time but within that  
20 ballpark.

21 Q And you never met with Mr. Julca, right?

22 A No, I have not.

23 Q When were you first hired by Mr. Malecki?

24 A When was I first what?

25 Q Hired by Mr. Malecki.

**Dr. Minkowitz - by Defendant - Cross**

1 MR. MALECKI: Objection.

2 THE COURT: Overruled.

3 A I think it was several weeks ago.

4 Q And you were hired specifically to review these  
5 radiological films prior to trial?

6 A I was asked to review the films and render an opinion.

7 Q Now, did you meet with Mr. Malecki before you testified  
8 here today?

9 A We didn't meet, no.

10 Q Did you speak to him before?

11 A Yes.

12 Q And you spoke about your testimony here today?

13 A I spoke about my findings on the imaging, yes.

14 Q And you also, besides for your testimony, you also  
15 prepared a report, right?

16 A Yes.

17 Q And that report is dated, I believe, it's February 13,  
18 2026?

19 A Yes.

20 Q Which is only from a few weeks ago, right?

21 A Yes.

22 Q Were you paid for the report as well?

23 A It's part of the time so the time counts for it.

24 Q So you were paid the \$6,000 to be here today remotely.  
25 You were paid a couple of hours to review films and then you

**Dr. Minkowitz - by Defendant - Cross**

1 were also paid time-wise \$600 downward to prepare the report,  
2 right?

3 A Yeah, a couple of hours is to review and do the report,  
4 three or four hours. I don't know exactly. I'd have to check.

5 Q Now, just looking at your report, for the first second,  
6 I'm just going to focus on the right knee -- excuse me. I am  
7 going to go with the left knee. I apologize. So, in your  
8 reports, you, for the left knee, you say this pattern of  
9 meniscus tear is more consistent with degenerative wear and  
10 tear, right?

11 A Yes.

12 Q And you call it a tear there, right?

13 A Yes.

14 Q And today I don't think you used that term. You used  
15 the term worn down. I have that right here actually, meniscus  
16 worn?

17 A Yeah. I used the term that there is also a partial  
18 disruption of the fibers like a partial tear. It's probably in  
19 the records.

20 Q So there is a tear, right, of the left knee of the  
21 meniscus?

22 A So --

23 Q There is a tear, right?

24 A A partial -- partial tear.

25 Q And you wrote that there's a tear in your report,

**Dr. Minkowitz - by Defendant - Cross**

1 right?

2 A Yes.

3 Q And today you use the term meniscus -- wear of  
4 meniscus, right?

5 A Yes. I also used the term partial tear.

6 Q You first started off with the term wear of meniscus,  
7 right?

8 A Yes.

9 Q Now, let's go specifically with general MRI's. You had  
10 said --

11 A Okay.

12 Q -- you said you reviewed thousands in your life, right?

13 A Yes.

14 Q You've been practicing for about, what, 12 years,  
15 15 years, something like that?

16 A It depends if you include training but 8 to 12 years,  
17 yeah.

18 Q Now, an MRI can't tell whether an injury occurred on  
19 one day or another day, right?

20 A What do you mean by that?

21 Q For example, MRI, if you look at a MRI, you can't say,  
22 well, this tear happened on August 25th, right?

23 A It depends how much you're trying to narrow it down.

24 Q But you can't do a specific day, right?

25 A Well, some tears are typical. The pattern is very

**Dr. Minkowitz - by Defendant - Cross**

1 typical of something that takes a very long time, right. So if  
2 I see rust on a bicycle, I can't say it's August 25th, but I  
3 know it took a while to develop.

4 Q You are essentially interpreting the MRI to make that  
5 determination, right?

6 A Well, that's what we do, yes.

7 Q So you're interpreting. You're just making an  
8 interpretation of what you saw on the MRI, right?

9 A Yes.

10 Q And that interpretation that you made, right, you were  
11 paid to do that by defense counsel, right?

12 A Yes.

13 Q And that specific interpretation as you mentioned could  
14 have differences between various radiologists, right?

15 A I guess different radiologists could interpret it  
16 differently, yes.

17 Q And you interpreted some of the findings different than  
18 Kolb Radiology and Lenox Hill Radiology, right?

19 A Yes.

20 Q And the reason why there are differences because it is  
21 not objective. There is an interpretation going on, right?

22 A To some degree, there is an objectivity there and there  
23 is a literature base. I don't want to speak to my radiology  
24 colleagues. I would just say that my interpretation is based on  
25 the available literature about patterns that we see in the MRIs.

**Dr. Minkowitz - by Defendant - Cross**

1 Q Now, let's go to the left shoulder for a minute if you  
2 don't mind.

3 A Okay.

4 Q So, you saw a tear in the left shoulder, right?

5 A Yes.

6 Q And then you also mentioned that Mr. Julca, my client,  
7 had, what's called, a downsloping acromion, right?

8 A Yes.

9 Q And you explained what this downsloping acromion is  
10 this bone that sort of goes a little more down, right?

11 A Yes.

12 Q And that was very rudimentary, but I am not a doctor  
13 and neither is the jury.

14 A Well done.

15 Q And you said before that that's an anatomic variant  
16 essentially, right?

17 A Yes.

18 Q Some people have this and some people don't, right?

19 A Everybody has an acromion but they are tilted to  
20 different degrees depending on the person.

21 Q What percentage, if you know, of the population has a  
22 downsloping acromion?

23 A I don't know the percentage. I don't know the exact  
24 breakdown.

25 Q Is it fair to say I might have a downsloping acromion?

**Dr. Minkowitz - by Defendant - Cross**

1 A You might.

2 Q And I wouldn't know it, right?

3 A I don't know.

4 Q Well, is there anything specific that I would know  
5 how -- that I would -- that would let me know that I have a  
6 downsloping acromion?

7 A I mean, I'm a radiologist so my expertise is looking at  
8 the images and interpreting them. You are asking me about  
9 symptoms and stuff like that. There's a specific pattern on  
10 MRIs and that pattern is anatomic and due to wear and tear not  
11 trauma. That's my expertise that I stick with. I don't know  
12 your personal orthopedic histories or your symptoms. That's not  
13 really what I do as an expert.

14 MR. ROSENGARTEN: I am going to move to strike the  
15 portion that's nonresponsive.

16 THE COURT: Which portion is that, Counsel?

17 MR. ROSENGARTEN: The very whole beginning. The  
18 last line he said I don't know from you.

19 THE COURT: I am going to allow the answer. You  
20 ask your next question. Overruled.

21 Q So it's fair to say a number of people have downsloping  
22 acromions, right?

23 A Yes.

24 Q And a lot of those people don't have rotator cuff  
25 tears, right?

**Dr. Minkowitz - by Defendant - Cross**

1           A     I don't know. Many of them do. I haven't looked at  
2 every single MRI, but more people who have that acromion are  
3 more likely to have that exact type of tear. It predisposes  
4 them.

5           Q     It might predispose them but it doesn't mean they are  
6 going to have it, right?

7           A     It doesn't mean they are going to have to it. But if  
8 they do have a tear right there, then we attribute it to the  
9 acromion.

10          Q     So you're saying, your testimony here today is, I have  
11 a downsloping acromion, right, let's say. And I bang my  
12 shoulder as hard as I can against this wood, right?

13          A     Yes.

14          Q     Your testimony here today is, well, you have a  
15 downsloping acromion so that's why you have the tear?

16          A     Well, to take your example, if we do an MRI and there's  
17 no evidence of anything else, there is no edema. There is no  
18 effusion and all there is is a little divot exactly where the  
19 bone is pushing on it, then I would think that that is caused by  
20 the bone. It is a very typical pattern and there is nothing  
21 else here that makes me think otherwise.

22          Q     So it's fair to say that a down -- the presence of a  
23 downsloping acromion doesn't rule out traumatic injury, right?

24          A     The presence of a downsloping acromion in and of itself  
25 doesn't mean a person can hurt themselves if that's what you are

**Dr. Minkowitz - by Defendant - Cross**

1 asking me.

2 Q I am asking it doesn't rule out traumatic injury,  
3 right? It is a yes or no question, right?

4 A It doesn't rule out, no.

5 Q Now, I am going to direct you because you mentioned it.  
6 It you mentioned a bunch of -- you would have some sort of -- I  
7 think you have -- you said you would see signs of trauma, right?

8 A Yes.

9 Q And one of those signs I think you mentioned, specific  
10 to the left shoulder, I think you would have seen -- you said  
11 you would have seen an edema, right?

12 A Yes.

13 Q What is an edema?

14 A Edema is basically swelling, inflammation. You could  
15 see it in bone. It can manifest as a joint effusion. These are  
16 some of the ways that when the joint is angry or hurt it let's  
17 us know.

18 Q And just to be clear, in terms of the left shoulder MRI  
19 you reviewed, the date was -- I think it was April 3, 2018,  
20 right?

21 A I would have to check but that sounds right.  
22 April 3rd. April 13th, I think.

23 Q And do you know the day of Mr. Julca's accident?

24 A I believe it was March 3rd.

25 Q So it was a month later, right?

**Dr. Minkowitz - by Defendant - Cross**

1 A Yeah.

2 Q So your testimony here today is because you didn't see  
3 this inflammation, this edema, a month later, therefore, there  
4 must not have been trauma, right?

5 A Not exactly. The testimony is the -- what we are  
6 seeing is a very clear classic pattern of wear and tear over  
7 time due to the anatomy. If there was some -- if I had also  
8 edema and a joint effusion, then I would have to wonder what  
9 happened here because, you know, four to six weeks later there  
10 usually is still some inflammation and swelling or edema. I  
11 don't have anything here which is consistent with my saying,  
12 okay, this is a classic pattern of wear and tear.

13 Q You don't have anything here that's a classic pattern  
14 of wear and tear, right?

15 A No, we do.

16 Q I thought you just said you don't.

17 A We don't have any -- any -- we don't have any evidence  
18 here of something which gives me any other explanation other  
19 than classic wear and tear.

20 Q Did you ever review any MRI's of Mr. Julca from before  
21 March 3rd, 2018?

22 A No.

23 Q And you said edema, you know, could last 4 to 6 weeks,  
24 right, but it could resolve before that, right?

25 A Usually, there is still some evidence. So edema and

**Dr. Minkowitz - by Defendant - Cross**

1 all this stuff starts maybe like one to two days or 48 hours  
2 after an injury and then it can take months to fully resolve.  
3 It happens gradually. So if I still saw some, I would say,  
4 okay, I still see something. But I don't see anything, and I  
5 have a very typical wear and tear pattern.

6 Q So I just want to clarify something. At first, you  
7 said the edema would clear up 4 to 6 weeks. Now, you just said,  
8 unless I misheard, months. So which one is it, is it 4 to  
9 6 weeks or months or are you just on the fly?

10 A I think you misheard. The edema doesn't clear up by 4  
11 to 6 weeks. It can take months to fully clear up.

12 Q And it can also take less than 4 to 6 weeks, right?

13 A Usually by six weeks, based on the literature that I've  
14 seen, there is still some evidence of swelling or effusion. It  
15 happens gradually but usually there is some. The fact that we  
16 don't see any here is a significant negative finding and it  
17 serves to support what we do see which is typical wear and tear.

18 Q Now, going back to the left shoulder. Going back to  
19 the acromion, the downsloping acromion?

20 A Yes.

21 Q Your testimony today you said that when you have a  
22 downsloping acromion you'll have some sort of an impingement,  
23 right?

24 A Yes.

25 Q What's an impingement?

**Dr. Minkowitz - by Defendant - Cross**

1           A     An impingement just means that one thing is kind of  
2 getting pushed upon by another. And in anatomical terms, often  
3 it is a bone that's pressing on either a tendon or a ligament or  
4 a muscle. And when you have -- and one form of impingement is  
5 subacromial impingement and that kind of chronic pushing and  
6 like wearing against it can cause some partial tearing at that  
7 site.

8           Q     Impingement it sounds like something you would feel,  
9 right?

10          A     Again, I am looking at the pictures as a radiologist.  
11 I see those -- I see that pattern of finding. I am not an  
12 orthopedic surgeon. I am not going to speak to symptoms.

13          Q     So an impingement though often times will cause some  
14 sort of sensation in that shoulder, right, if there is an  
15 impingement, right?

16          A     Again, I am a radiologist. My job is to look at  
17 pictures and say does this look like trauma or does this look  
18 like wear and tear. This picture looks like wear and tear.

19                   MR. ROSENGARTEN: I am going to move to strike that  
20 as unresponsive.

21                   THE COURT: Stricken. You may ask the question  
22 again.

23          Q     Does an impingement normally cause some sort of  
24 symptom?

25          A     It very often can, but I am saying -- I am not an

**Dr. Minkowitz - by Defendant - Cross**

1 expert orthopedic surgeon. I am not going to speak to symptoms,  
2 but impingements can often cause symptoms, sure. That's why it  
3 is an issue.

4 Q So would it surprise you if there was an impingement  
5 for this downsloping acromion and it was -- there was never any  
6 symptoms reported in terms of the left shoulder -- left shoulder  
7 pain?

8 MR. MALECKI: Objection.

9 THE COURT: Sustained.

10 Q Let's go to the back. Let's go to the back. So you  
11 reviewed some MRI's of the back as well. Once again, April 3,  
12 2018, correct?

13 A April 13th, I believe.

14 Q Once again, that's about five weeks after the accident,  
15 right?

16 A Yes.

17 Q And, once again, you said you didn't see an edema so it  
18 must have been, it couldn't have been no possibility of trauma  
19 here, right?

20 A I saw no evidence for recent trauma, correct.

21 Q You didn't see any edemas, right, five weeks  
22 afterwards?

23 A Well, there's no -- there are certain things that are  
24 typical of trauma and none of those findings were here.

25 Q Now, you also talked about a narrowing of the canal,

**Dr. Minkowitz - by Defendant - Cross**

1 right?

2 A Yes.

3 Q And you saw a narrowing of the canal, right?

4 A Yes.

5 Q And I think you described that canal as sort of the  
6 highway of the nerves, right?

7 A Yes.

8 Q And you said that a -- the canal can narrow, and I  
9 wrote it down here, for many reasons, right?

10 A Yes.

11 THE COURT: You need to answer out loud.

12 A Yes.

13 Q You didn't give any of those reasons, right?

14 A I began to elaborate but, no, I didn't get into detail  
15 about it.

16 Q And one of the reasons that a canal can narrow is  
17 trauma, right?

18 A Yes, sure. But when it does that, it has a specific  
19 appearance and that's not here.

20 Q Now, let's go to -- let's go to the right knee.

21 A Okay.

22 Q The right knee, you reviewed the right knee MRI of  
23 July 10, 2018, right?

24 A Yes.

25 Q And you testified here today that the meniscus was

**Dr. Minkowitz - by Defendant - Cross**

1 worn, correct?

2 A Yes, correct.

3 Q Now, you also testified today that the right knee  
4 meniscus being worn was, once again, regular degenerative wear  
5 and tear, right?

6 A Yes.

7 Q And you didn't see any evidence of any sort of trauma,  
8 right?

9 A Correct.

10 Q And one of those -- some evidence of that would have  
11 been an edema as well?

12 A Yes, it could have been.

13 Q Now, that you talked about -- excuse me. Earlier in  
14 this testimony today, you talked about edemas clearing up, I  
15 think you said, 4 to 6 weeks, sometimes months, whatever it is,  
16 right?

17 A Yes.

18 Q I see --

19 A My apologies. I need to be answering out loud.  
20 Correct. Generally, edema has an pattern. It does clear up.  
21 This MRI is about four months later so the absence of edema is  
22 less of a relevant factor here four months later. It's just the  
23 fact that there is not much going on here that tells me there  
24 was trauma four months ago.

25 Q And also you mentioned in the right knee you mentioned

**Dr. Minkowitz - by Defendant - Cross**

1 that there was joint effusion, right?

2 A No.

3 Q Well, the radiology --

4 A I disputed that.

5 Q The radiology report mentions joint effusion, right?

6 A Correct.

7 Q That's essentially just fluid in the joint, right?

8 A So there is always fluid in the joint. When they say  
9 joint effusion -- again, I don't want to ascribe intent, but  
10 typically if they are mentioning it, it's because they think  
11 it's more than there should be there. On my review, there is a  
12 very normal amount of joint fluid there as we all have normal  
13 joint fluid.

14 Q And this was, what, four months after the accident,  
15 right?

16 A Correct.

17 Q Would the fluid that you mentioned, the joint effusion,  
18 would that be more likely to happen closer to the time of the  
19 accident or would it stay the whole time or something else?

20 A Can you explain your question again?

21 Q Sure. I will ask it again. So if you were to see  
22 joint effusion, would you expect to see that closer to the  
23 accident or further away or when would you expect to see that  
24 joint effusion?

25 A If somebody gets a joint effusion, it would typically

**Dr. Minkowitz - by Defendant - Cross**

1 happen very soon after the accident. And then over time, over  
2 the course of months, depending on the accident, it would  
3 normalize unless there is other things going on because  
4 sometimes, you know, if there is still -- if they are  
5 reinjuring. In this case, I just don't see a joint effusion  
6 there. So there is not a lot to speculate. We have a MRI four  
7 months later and there is no joint effusion.

8 Q Even though the radiology report says there is, right?

9 A Correct.

10 Q And we established, you know, radiology reports are  
11 essentially various interpretations, right?

12 A Again, I don't want to speak to my radiology  
13 colleagues. I will say that having looked at many, many, many  
14 of these this is a normal amount of fluid.

15 Q Now, going back to the knee for a second. Now, you  
16 mentioned -- I think this went for both knees if I am not  
17 mistaken -- that you saw some arthritis, right?

18 A Which knee are you referring -- are you referring to  
19 both knees?

20 Q I think you said for both, right?

21 A So in the right knee, all there is is a little bit of  
22 meniscus wear at Cruess Stage I. The left knee has findings of  
23 early arthritis, yes.

24 Q It's fair to say that there is such a thing called  
25 posttraumatic arthritis, right?

**Dr. Minkowitz - by Defendant - Cross**

1 A There is such a thing, yes.

2 Q Now, did you see any injury to the joint surface of  
3 either the right or the left knee?

4 A Injury, no. There were some cartilage wear on the left  
5 which is typical of early arthritis, yes.

6 Q Now, going back to MRI's in general, right. You  
7 explained at the beginning of your testimony the way an MRI  
8 works is some sort of magnetic generation of a photograph inside  
9 your knee, right?

10 A Yes.

11 Q Or inside the shoulder or your back or something like  
12 that, right?

13 A Yep.

14 Q Now, is there a difference between an MRI and actually  
15 opening up a knee in terms of your findings?

16 A I don't know. I mean, yeah, they are very different  
17 things. I don't mind getting a MRI. I would mind getting it  
18 open. They are different things.

19 Q And you can see different things when you open up a  
20 knee or when you open up a shoulder or when you open up a back,  
21 right?

22 A I have never done surgery and so I don't want to speak  
23 to what you can see on arthroscopy.

24 Q Now, would it surprise you if I told you there was an  
25 orthopedic surgeon who testified here today -- I mean,

**Dr. Minkowitz - by Defendant - Cross**

1 yesterday. And he reviewed the same radiological films that you  
2 did and he also did surgery. And, for example, for the ACL, he  
3 saw that there was ACL -- the report said there was a ACL tear  
4 and then he went in and he saw there wasn't an ACL tear. Would  
5 that surprise you?

6 A He saw that what?

7 Q There was not an ACL tear that needed to be repaired.  
8 Would that surprise you?

9 A I don't know how to answer something that would  
10 surprise me. I am here as an expert radiologist. All I can say  
11 is what the picture show. So this picture doesn't show an ACL  
12 tear. That's all I can really speak to.

13 Q You can only speak to looking at pictures, essentially,  
14 correct?

15 A And interpreting them in line with radiology expertise,  
16 yes.

17 Q You can't speak to what is actually seen inside the  
18 knee or is actually seen inside the shoulder or is actually seen  
19 inside the back, right?

20 A Well, what's seen on an MRI I could. What's seen on  
21 arthroscopy I can't.

22 Q Now, in your reports of February 13, 2026, you said,  
23 and I think you said this is a bunch of times, you are not a  
24 surgeon and you don't really offer any surgical opinions, right?

25 A Correct.

1 Q So you cannot opine if the lumbar surgery that  
2 Mr. Julca had was necessary, right?

3 A Right. I don't recommend or not recommend surgery.

4 Q And you actually, in your conclusion, are totally  
5 silent regarding the left shoulder injury, the right knee  
6 surgery, and the left knee surgery, right?

7 A Correct.

8 Q And you have no idea if those were necessary, right?

9 A The surgeries on the shoulder or the knee?

10 Q The knees, both knees, right and left knees.

11 A Yeah, I have no opinion -- I mean, I don't recommend or  
12 say whether surgery is indicated. All I say is there are things  
13 here on the imaging. They are just not due to the trauma.

14 (Continued on next page)

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**Dr. Minkowitz - Cross - Defendant/by Mr. Rosengarten**

1 Q You can't say that Mr. Julca's accident did not cause  
2 Plaintiff's back injuries, right. You can only say that what  
3 you looked at is consistent but you cannot say it didn't cause  
4 it, right?

5 A I can say that, based on the MRIs that I reviewed,  
6 there's no evidence of trauma, yes.

7 Q But you can't say that for sure?

8 A Well, there's no signs of trauma.

9 Q Right. And there are no signs of trauma in terms of  
10 the MRI that you reviewed that took place a month, or even four  
11 months after the accident, right?

12 A Yes, on the MRIs that I reviewed there no signs of  
13 trauma, correct.

14 Q Right. And you can't say the accident didn't cause the  
15 meniscus tear that you talked about to the right knee, right?

16 A You mean the left?

17 Q Well, excuse me, the left, correct?

18 A The partial tearing is very typical of degeneration. I  
19 can say that this does not look like it was caused by trauma,  
20 yes.

21 Q Now, you didn't treat Mr. Julca, right?

22 A Correct.

23 Q You didn't examine Mr. Julca?

24 A Correct.

25 Q You didn't see if he had any bruising, right?

**Dr. Minkowitz - Cross - Defendant/by Mr. Rosengarten**

1 A Correct.

2 Q You didn't see if he had any other clinical signs,  
3 right?

4 A Correct.

5 Q The only thing you did was look at photographs, right?

6 A Correct.

7 Q And, ultimately, isn't it fair to say, that to make  
8 these determinations, in terms of trauma versus degeneration,  
9 imaging along with clinical analysis by treating physicians is  
10 what really would be able to make a determination if it was  
11 trauma versus degeneration, right?

12 MR. MALECKI: Objection. Outside the scope of the  
13 expertise.

14 THE COURT: I'm sorry, did you say objection  
15 counsel?

16 MR. MALECKI: Yes.

17 THE COURT: Overruled. I will allow the answer.

18 A Depending what you're looking at, if you were looking  
19 at an MRI finding and the question is, is this from trauma or  
20 wear and tear, you can say, yes, it is from wear and tear, not  
21 trauma; that, yes, you could say.

22 Q But you couldn't say that without clinical evaluation,  
23 right?

24 A No. As a radiologist, you look at --in other words, if  
25 I see a bone broken in half, I can say this was a trauma, even

**Dr. Minkowitz - Redirect - Defendant/by Mr. Malecki**

1 if I didn't evaluate the patient. If I see rust on a bicycle, I  
2 can say this did not happen because I knocked this down two  
3 seconds ago. There are things that can be said.

4 The findings on the MRIs, as I look at them as an  
5 expert radiologist, I can say, these are due to long-standing  
6 processes, not from a recent trauma.

7 Q And those finding that you reviewed, taken about a  
8 month, two months, four months after, that is what you are  
9 basing it on, right?

10 A Yes, the MRIs that we discussed this entire time, yes.

11 Q You're basing that on after being hired by Mr. Malecki  
12 to testify at this trial, correct?

13 A Yes.

14 MR. ROSENGARTEN: No further questions. Thank you.  
15 Thank you for your time.

16 THE COURT: Any re-direct?

17 MR. MALECKI: Short re-direct.

18 THE COURT: All right.

19 RE-DIRECT EXAMINATION

20 BY MR. MALECKI:

21 THE COURT: Short means different things to  
22 different people.

23 MR. MALECKI: I mean very short, I promise.

24 Q Doctor, you were just asked about with respect to the  
25 left shoulder, the canal narrowing. Do you recall that?

**Dr. Minkowitz - Redirect - Defendant/by Mr. Malecki**

1 MR. ROSENGARTEN: Objection.

2 THE COURT: Overruled.

3 A Uhm, we spoke about canal narrowing of the lumbar spine  
4 MRI, is that what you are referring to?

5 Q Yes. Counsel asked you about whether acute trauma  
6 could be one of thing that cause canal narrowing, correct?

7 A Correct.

8 Q What other things can cause canal narrowing?

9 A Bony overgrowth is a very common one.

10 The ligament that gets like thickened behind the canal,  
11 it can get thickened and press in. The discs can kind of bulge  
12 out and narrow it. Those are the main things in the lumbar  
13 spine.

14 Q What did you determine in reviewing this film caused  
15 this canal narrowing?

16 A Primarily the bony overgrowth of the facets; those are  
17 pretty prominent and narrow the canal.

18 Q And counsel also asked you about the arthritis that you  
19 saw, that was on the left knee, right?

20 A Yes.

21 Q And are you able to tell from looking at the left knee  
22 film, whether arthritis is from a traumatic injury or whether  
23 it's from degeneration?

24 A So, arthritis that occurs after traumatic injury takes  
25 many months to develop. So, these findings that we have here,

**Dr. Minkowitz - Redirect - Defendant/by Mr. Malecki**

1 the meniscus and along that upper knee, those are very typical  
2 of just early arthritis that is developing from the wear and  
3 tear.

4 Q And counsel also asked you about conversations that I  
5 had with you prior to today's testimony, right?

6 A Yes.

7 Q At any point, did I tell you how to interpret any of  
8 these films?

9 A No.

10 MR. MALECKI: Thank you, Doctor.

11 That's all that I have, your Honor.

12 THE COURT: The witness is excused.

13 THE WITNESS: Thank you. Have a good day  
14 everybody.

15 THE COURT: Counsel, our next witness will be here  
16 2:00 p.m.

17 MR. ROSENGARTEN: Correct.

18 THE COURT: Members of the Jury, I'm excusing you  
19 for lunch at this time. Be back promptly at 2:00 p.m.

20 THE COURT OFFICER: All rise. Jury exiting.

21 (Whereupon, the jury exits the courtroom.)

22 THE COURT: The court stands in recess until  
23 2:00 p.m.

24 We are off the record.

25 MR. ROSENGARTEN: Thank you.

1 MR. MALECKI: Thank you.

2 (Whereupon a lunch recess took place.)

3 (Continued next page.)

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**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

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

2

3 (Whereupon, the exhibit was marked Plaintiff's  
4 Exhibit 23 for identification.)

5 (Whereupon, the exhibit was marked Plaintiff's  
6 Exhibit 24 for identification.)

7 (Whereupon, the exhibit was marked Plaintiff's  
8 Exhibit 25 for identification.)

9 (Whereupon, the exhibit was marked Plaintiff's  
10 Exhibit 26 for identification.)

11 THE COURT: Are you ready?

12 MR. ROSENGARTEN: Yes.

13 MR. MALECKI: Yes.

14 THE COURT: On the record bring in the jury.

15 THE COURT OFFICER: Jury entering.

16 (Whereupon, the jury enters the courtroom and the  
17 following is heard inside the presence and hearing of the  
18 jury.)

19 THE COURT: Please be seated. You may call your  
20 next witness.

21 MR. ROSENGARTEN: Thank you.

22 Dr. Thomas Kolb to the stand.

23 (Witness approaches the witness stand.)

24 THE CLERK: So you solemnly swear or affirm the  
25 testimony you are about to give will be the truth, the whole

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**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 truth, and nothing but the truth?

2 THE WITNESS: Yes.

3 THE CLERK: In a loud clear voice please state your  
4 name and address, spelling both your first and last name.

5 THE WITNESS: Dr. Thomas Kolb, T-H-O-M-A-S  
6 K-O-L-B, 257 West 34th Street, New York New York 10001.

7 THE CLERK: You may be seated.

8 Your Honor, the witness has been sworn and  
9 affirmed.

10 THE COURT: Thank you, you may examine your  
11 witness.

12 MR. ROSENGARTEN: Thank you.

13 BY MR. ROSENGARTEN:

14 Q Good afternoon, Dr. Kolb?

15 A Good afternoon.

16 Q Could you tell the jury a little bit about your  
17 educational background?

18 A My educational background, I went to college a ways  
19 back, to Queens College, City of New York. I graduated in 1979;

20 And I went to medical school right here in Brooklyn,  
21 Downstate Medical Center graduated, in 1983;

22 I then became a pediatrician. I did an internship and  
23 residency at Jacobi Hospital in the Bronx, Montefiore Hospital,  
24 Albert Einstein College of Medicine, became board certified in  
25 pediatrics 1986.

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1           Then went back and did another residency in diagnostic  
2 radiology at Columbia Presbyterian Medical Center in Washington  
3 Heights at Columbia University. I finished that in 1990 and  
4 became board certified again in diagnostic radiology.

5           That is my educational background.

6           Q     You mentioned you are board certified. You are board  
7 certified in two different things, right?

8           A     I am.

9           Q     Let's talk about radiologist.

10          What is radiology?

11          A     Radiology is using of different tests that look inside  
12 the body to see if there's an abnormality or everything is  
13 normal;

14                 So we use X-rays, we use CAT scans, we use MRIs, we use  
15 ultrasound, mammograms, things like that to look inside the body  
16 to see if everything is okay or not.

17          Q     And are you licensed to practice medicine in New York?

18          A     I am.

19          Q     And do you currently have your own practice?

20          A     I do.

21          Q     So what type of practice do you currently have?

22          A     So my practice is made into two parts.

23                 I have a breast cancer diagnosis practice where I see,  
24 many women every year. I do mammograms, ultrasounds, biopsies,  
25 MRIs, detect breast cancer, I work generally in the City with

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 some of the major breast surgeons as part of my practice.

2 My other part of my practice is doing reading MRIs, CAT  
3 scans, X-rays on patients that are sent that have certain  
4 complaints; pain, or whatever their complaints may be and I'll  
5 do those tests and a technologist under my direction will do  
6 those tests. I will read them and provide a report and send  
7 that report to the referring doctor who sent the patient in to  
8 be looked at.

9 So there is two very distinct areas of medicine that I  
10 perform.

11 Q Now, I know you mentioned before that you also did  
12 pediatrics at one point. Do you still do pediatrics?

13 A I do not.

14 Q So you are just strictly a radiologist this point?

15 A Strictly.

16 Q And how long have you been radiologist for?

17 A Since 1990, so it is 36 years.

18 Q And you said that one of the things you look at in your  
19 radiology practice is MRIs, right?

20 A Yes.

21 Q How many MRIs would you say you looked at in your  
22 career?

23 A Hundreds of thousands.

24 Q And how many X-rays have you looked at in your career?

25 A Hundreds of thousands.

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 Q And how many CT scans have you looked at in your  
2 career?

3 A Similar.

4 Q Now, are you being compensated for your time here  
5 today?

6 A I am.

7 Q What are you being compensated?

8 A My office is getting \$12,000.

9 Q Do you regularly testify on behalf of your patients?

10 A I testify on the average four to five times per year.  
11 So that is --when you say regularly, that is fact, that is what  
12 I do. Some years it may be one more, some years it may be one  
13 less, but in that range.

14 Q Now, I know you mentioned MRIs, CT scans and X-rays;  
15 could you describe the difference between those three things?

16 A Sure.

17 X-rays are a form of energy, we have known about it for  
18 over 100 years. In this day and age it is pretty cool to do an  
19 X-ray, the reason we do an X-ray. We can tell the difference  
20 between something hard and something soft.

21 For example, if you do an X-ray of your knee, shoulder,  
22 back, we will see all the bones, the bones are all hard.

23 What is between the bones, cartilage, tendons,  
24 ligaments, arteries, veins, menisci, rotator cuff tendons,  
25 muscles, that you wouldn't see on any X-rays. So it tells the

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 difference between hard and soft.

2 CAT scans take X-rays and instead of taking one picture  
3 of your back, let's see all the bones, it takes many many thin  
4 pictures through your back. And so not only can we see the  
5 bones but we can now start seeing a lot of these other soft  
6 tissues, not as well as an MRI but we could see them, because it  
7 is still an X-ray.

8 MRI, the M stands for magnetic. Because it is magnetic  
9 waves. Magnetic waves that are pulsed into your body. It is a  
10 very large machine with a big circle that you lie in nowadays.  
11 People know about this, it has been around for many years.

12 Magnetic waves are pulsed into your body and then there  
13 is a rearrangement of protons in your body and we see these  
14 amazingly exquisite pictures inside your body by doing MRIs.  
15 They are very different tests.

16 MRIs are very good at finding the soft tissues, whether  
17 they are disc or rotator cuffs, menisci or any part of your  
18 body.

19 Q Now, did there come a time where up treated someone by  
20 the Juan Julca?

21 A Yes.

22 Q And when was the first time you treated Mr. Julca?

23 A Excuse me one second, I will tell you.

24 So on July 10, 2018, I did an MRI of the right knee on  
25 this patient;

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1 And on May 1, 2018, left knee.

2 Those are the earliest, I believe, that I did any  
3 imaging on this patient, those two studies.

4 Q How did you first come to see Mr. Julca, was he  
5 referred to you?

6 A Yes.

7 Q Who was he referred by?

8 A By Dr. Jeffrey Kaplan.

9 Q Now, besides for the films you may have conducted of  
10 Mr. Julca, did you ever review films of Mr. Julca?

11 A Yes.

12 Q What firms did you review of Mr. Julca?

13 A I reviewed an MRI of the lumbar spine that he had done  
14 in 2018.

15 My office and myself performed an MRI of the lumbar  
16 spine in 2021;

17 And then I also did a CAT scan of this patient's back  
18 in August of 2022.

19 This patient had a left shoulder MRI in April 13, 2018,  
20 that I reviewed.

21 So I don't know if you want me to go through all of  
22 them. I saw the patient first in 2018 and then I was shown  
23 additional studies of the patient as well in the recent past.

24 Q Now, you mentioned a number of body parts. For ease of  
25 sake, we're going to just go body part by body part.

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1           The first thing you mentioned, we're going to go with  
2 is the lumbar spine, okay.

3           A     Yes, sure.

4           Q     You mentioned you reviewed MRI of the lumbar spine  
5 taken on April 13, 2018, correct?

6           A     Correct.

7           Q     And was that MRI taken by you or somebody else?

8           A     Somebody else.

9           Q     So you just reviewed it, correct?

10          A     Correct.

11          Q     So I'm going to show you what previously has been  
12 marked as Plaintiff's 12 for identification.

13                 I'm going to put it up on this easel over here.

14                 (Shown.)

15          Now Dr. Kolb, could you recognize what is in  
16 Plaintiff's 12 for identification?

17          A     Yes.

18          Q     And what is Plaintiff's 12 for identification?

19          A     An MRI of the lumbar spine taken on April 13, 2018.

20          Q     And is this the MRI that you reviewed?

21          A     Yes.

22          Q     Would you come down to the easel and the MRI and  
23 explain your findings from that April 13, 2018 MRI?

24                 THE COURT: Go ahead.

25                 THE WITNESS: Thank you.

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 (Witness approaches the exhibit.)

2 A So this is an MRI of the lumbar spine. We're going to  
3 do a little bit of anatomy, just a little bit.

4 So the lumbar spine MRI, each of these gray boxes are  
5 bones. And there are five bones in the lumbar spine. They're  
6 all the same whether we are tall or we are short, male or female  
7 all from the same anatomy; five bones. These are all bones.

8 Between the bones, these areas here, this long areas  
9 here are the discs. And the reason we have discs in our back  
10 between the bones, anywhere in our body, any of our joints, is  
11 very bad if bone touches bone. Bone on bone is very very  
12 painful. We are born with shock absorbers in all of our joints.  
13 They all have different names.

14 In the shoulder they are called the labrum, in the knee  
15 they are called the meniscus, in the back they are called the  
16 discs.

17 These discs, when you jump up and down they are like  
18 little springs, they compress down and then they go back to the  
19 height that they are supposed to be to keep the bone away from  
20 each other. That is how we're able to move because the bones  
21 are not touching each other.

22 So these discs are held in place. Why when we jump up  
23 and down don't the discs just spurt out? It keeps them in  
24 place. So they are very tight coverings, ligaments that hold  
25 the discs in place.

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1           There's a ligament in front of the disc here, this is  
2 the front of the patient, this is the back of the patient and  
3 then there's a ligament that runs all the way around, that is  
4 called the annulus. These coverings hold the disc in place.

5           So two things can happen with these coverings, these  
6 ligaments that hold in place. You can have a partial tear of  
7 ligament or annulus.

8           So the disc is here, this could be the edge of the bone  
9 with the ligament going up, down, and around.

10           The disc will go to the side of the bone will stop.  
11 But if there's a partial tear, the disc will start coming  
12 through.

13           The partial tear of the ligament with the disc coming  
14 through is called a disc bulge. A bulging disc in your back, or  
15 your neck, and partial tear of the annulus. So if you look at  
16 the MRI from the side, if you look at the back and the side,  
17 you'll see the disc pushing through a little bit.

18           If the ligament is completely torn, then the disc will  
19 go completely through like that from left side and that is  
20 called a disc herniation.

21           So disc bulge is a partial tear and disc herniation is  
22 a complete tear of the annulus.

23           Those are things that we find commonly on MRIs that we  
24 can see very easily on MRIs.

25           So in this particular patient, this disc, L4-5. So, if

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 we mark them, you won't be able to see this really well. But  
2 this is number five here. This is the fifth one.

3 This is another part of the spine, the sacrum down  
4 here. There are five bones. This is four, three, two and one.

5 Between the fourth and fifth bone where this yellow  
6 line is, is this picture.

7 So let's stop for one minute. Why are there two  
8 pictures here?

9 This picture shows you all five bones and more. The  
10 patient's head is up here and the patient's feet are down here.  
11 So you see all the bones of the spine;

12 But let's say you had a loaf of bread. Let's say it  
13 was Italian bread or French bread, which are very long. There  
14 are two ways to cut the bread. You could cut long ways and it  
15 would be a hero sandwich. Only have two pieces of bread but you  
16 would see the entire loaf of bread in each slice. And that is  
17 what we are seeing here.

18 This is when we cut, we are not really cutting anyone,  
19 it is a machine looking in. We can cut from top to bottom, we  
20 can see all five bones.

21 If we take that loaf of bread and we cut it, like we  
22 often do, across, then you have many sandwiches and you pull out  
23 the piece, it is not long any more, it is round or square. And  
24 that is one of the beauties of MRI. We can do that without the  
25 patient feeling anything.

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1           We can take this picture, which is called the sagittal  
2 picture and see all of the bones. If we see an abnormality  
3 right here, because here the disc is pushing out beyond the  
4 margin of the bone. We can then take a slice like that, like we  
5 are cutting the loaf of bread and bring it down here and now  
6 everything that you saw here, right in the slice is here.

7           So, for example, this disc here is long, okay. And you  
8 could see all five of them.

9           This is the same thing we're looking at, this is the  
10 disc here that we are going through right there. Everything is  
11 round, just like the bread.

12           These are the muscles on the side of the disc and the  
13 bone.

14           Let's go back to the disc for one second and talk about  
15 why bulges or herniations are important to know about.

16           Because in the back, the spinal cord comes out of our  
17 brain, goes all the way down our back. And then nerves from the  
18 spinal cord in your neck, nerves from the spinal cord in your  
19 back will go out to your arms and legs so that you could do  
20 everything you do and feel things. They come out of the spine  
21 through little bony holes that are called neuroforamina, holes  
22 that contain the nerves. You don't have to remember anything  
23 medical.

24           Nerves coming down off the spinal cord and they come  
25 out. One nerve goes out the left side, one nerve goes out the

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 rights.

2 In between each one of these discs, right here in the  
3 back, this little dot right there is a nerve root that is going  
4 to come out to one side of the patient. Here is another one.  
5 And here on this side you can see --you see the white area here,  
6 that white area is fat in the nerve hole that is holding it  
7 here. Here, you could pretty much make out the white. Here you  
8 lose it.

9 The reason you lose it is because there is a disc bulge  
10 pushing out to the side of the patient where the nerve root is  
11 coming out.

12 That is why it is important to know about discs bulges  
13 and herniations. Because they can push out on the nerve or  
14 cause pressure on the nerve. That is why you feel pain if you  
15 have a bulge or herniation, you could.

16 So this spinal canal behind which contains nerves is  
17 this little gray circle right here. We just took the slice and  
18 brought it down like that.

19 This here is a bulging disc at L4-5, which means  
20 between the fourth bone and the fifth bone.

21 So the finding on this particular picture there is a  
22 disc bulge, meaning there's a partial tear of a ligament that  
23 should hold it in place. And the bulge is pushing out onto the  
24 sac that contains the nerve roots. And on to the sides of the  
25 sac. And also onto the neural foramina which is a hole that

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 contains the nerve root coming out.

2 So that is the major finding on this particular picture  
3 here.

4 The patient also had a similar disc bulge here, you see  
5 how you could see the white line here, and the white line here  
6 and this fat in the nerve canal. Here you start losing it and  
7 here it is completely gone and here it comes back, this white  
8 line. That is because this bulge is the largest one pushing out  
9 to the side where the nerve root is here and this bulge here  
10 starting to push out onto the lower part of the hole that  
11 contains the nerve root.

12 So those are the major findings. There's another  
13 finding higher up in the back where another part of the spine  
14 is, but those are the major findings for this on this date.

15 Q Now, you talked a lot about bulges. What would cause a  
16 bulge?

17 A So a bulge is caused by a partial tear of the ligament  
18 and what can cause bulges are trauma. You can hurt yourself,  
19 cause a bulge, because that ligament can tear.

20 As we get older our ligaments are not as healthy as  
21 they used to be during the normal aging process. You can get a  
22 partial tear through the process of aging.

23 Q Are they mutually exclusive?

24 A No, absolutely not.

25 You can have aging features in your spine, arthritis

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 and not have any bulges; or you could be very young and have no  
2 aging signs in your spine and have a bulge.

3 Q You could step back up. Thank you.

4 (Witness resumes the witness stand.)

5 Q Now, in terms of the lumbar spine, you also mentioned  
6 there was another MRI taken in October of 2021; is that right?

7 A Correct.

8 Q Now, did you take that MRI or did someone else?

9 A I did.

10 Q And I'm going to show you what has been previously  
11 marked as Plaintiff's 13 for identification.

12 Let me put it on top here.

13 (Displayed.)

14 BY MR. ROSENGARTEN:

15 Q Do you recognize what is in Plaintiff's 13, Doctor?

16 A Yes.

17 Q What is in Plaintiff's 13?

18 A An MRI lumbar spine on October 28, 2021.

19 Q That is the lumbar spine MRI that you took?

20 A Yes.

21 Q Could you appreciate again with the Court's permission  
22 and explain your findings in 2021?

23 A Sure.

24 (Witness approaches the exhibit.)

25 A So, again, we have our five bones. This is the lowest

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 one, the five. This is a different part of the spine, there's  
2 four, three, two, one.

3 And if you remember, I told you, that if these discs go  
4 beyond the margin of the bone, here, if it is a partial tear it  
5 is a bulge, if it is a full tear it is herniation.

6 Now you could see that this piece of disc material  
7 here, at L4-5, is definitely way beyond the margin of the bone.  
8 Compare up here. This is what normal looks like between one and  
9 two, these two bones or between two and three.

10 This disc goes to the margin of the bone and stops  
11 completely.

12 This white line that comes down is spinal fluid.

13 These gray lines that come down are the nerve roots  
14 coming off of the end of the spinal cord, which is up here.

15 Spinal cord comes down, nerve roots come off the spinal  
16 cord and a nerve root will come out one to the right side of the  
17 patient between each bone, and one to the left side between each  
18 bone, through those neuroforamina or the holes that I told you  
19 about, this is dead center of the patient.

20 Here you see very abnormal disc because there's a disc  
21 herniation pushing out.

22 Here, at the same level of L4-5, you can compare it to  
23 the one we saw before where it was pushing down a little bit  
24 because it was disc bulge. Now it is completely pushing down  
25 much more onto the sac, which is the gray area here and pushing

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 on the nerve roots. There are nerve roots here that are about  
2 to come out which are L5 nerve roots. Again, the numbers are  
3 not important.

4 But there are also nerve roots that come out as I told  
5 to you the sides. And that fat that we saw on the first picture  
6 inside the nerve root is this white here. And the dot that I  
7 showed on the previous picture of the nerve root is now the long  
8 area right here.

9 So this nerve root now to the right of the patient, and  
10 the nerve root here to the left of the patient, is being hit or  
11 impinged upon by this broad disc herniation now at L4-5. So,  
12 that is what happened in the interim, in the last two and-a-half  
13 years.

14 There's also, as you could see here. Here is a piece  
15 of disc material coming out here. This is a smaller disc  
16 herniation between L-3 and L-4, the larger one is at L4-5.

17 Those are the major findings. There's a smaller  
18 --again, you could see here that this little herniation is  
19 coming out, pushing on the white spinal fluid here, much  
20 smaller. The larger one is at L4-5 causing problem here,  
21 pressing on nerve roots.

22 Q And why would the disc bulge have turned into a disc  
23 herniation over the course of those years?

24 A Because the tear got bigger of the annulus holding it  
25 in place got bigger.

**Dr. Kolb - Direct - Plaintiff/by Mr. Rosengarten**

1 Q I am going to keep you there for a minute. I'm going  
2 to show you something else, if you don't mind.

3 This is what has previously been marked as Plaintiff's  
4 23 of today. Let's see if it fits. I may have to start taking  
5 it off.

6 Still good for now.

7 (Displayed.)

8 What do you see in Plaintiff's 23?

9 A So, very different picture but it kind of looks a  
10 little similar. This is CAT scan. So everything that is hard  
11 is bone and you could see really well. Everything that is white  
12 here is a bone, you could see it really well. All the squares  
13 are the bones. Right here is number five and four, and three,  
14 and two. And we were talking about herniation there, and there  
15 and was a smaller herniation here at five-on.

16 This is what it looks like on a CAT scan, the white is  
17 the bone and the gray is the disc. You're not ever going to see  
18 it as perfect as an MRI, but you could see all of this gray  
19 stuff in here. That is a disc herniation at this level right  
20 here.

21 That is what it the looks like on a CAT scan. Just so,  
22 you know, to get an understanding of what the different tests  
23 look like.

24 Q And you reviewed this as well?

25 A Yes.

1           Q     Now, when you review MRIs or CT scans, what do you do  
2 with that information?

3           A     I put it into a report.

4           Q     And who do you give it to?

5           A     I send to whoever the referring doctor who sent the  
6 patient in.

7                     (Whereupon, Shameeka Harris relieved Deborah Rothrock  
8 as the Official Court Reporter.)

9                     (Continued next page.)

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**Dr. Kolb - by Plaintiff - Direct**

1 CONT'D DIRECT EXAMINATION

2 BY MR. ROSENGARTEN:

3 Q And do you remember who the referring doctor was for  
4 the lumbar spine MRI or CT scan?

5 A So, for the MRI the lumbar spine in 2021 was  
6 Dr. Weinstein and in 2022 CAT scan was also Dr. Weinstein.

7 Q Now, based on the films that you reviewed and the CT  
8 scan that you reviewed, do you have a diagnosis, within a  
9 medical degree of certainty concerning plaintiff's lumbar spine?

10 MR. MALECKI: Objection.

11 THE COURT: Step up.

12 (Whereupon, the following discussion takes place at  
13 sidebar among the Court and Counsel, outside the hearing of  
14 the sworn jurors.)

15 THE COURT: Are you going to withdraw and restate  
16 the question?

17 MR. ROSENGARTEN: Withdraw the question.

18 Q Do you have a diagnosis of the film that you -- films  
19 that you studied?

20 A Yes.

21 Q And what is that?

22 A Well, on the MRI of 2021, the most recent MRI that I  
23 showed, there was a large posterior disk herniation at L4-5. It  
24 was impinging on the thecal sac and the bilateral lateral  
25 recesses and with bilateral foraminal stenosis which means that

**Dr. Kolb - by Plaintiff - Direct**

1 the holes where the nerve roots come out were severely narrowed.  
2 There is direct impingement upon the bilateral extra thecal L5  
3 nerve roots as well as the bilateral exiting L4 nerve roots.  
4 And then there are smaller disk herniations at other levels.

5 Q Let me show you one more thing that has been previously  
6 marked. This has been previously marked as Plaintiff's 15.  
7 Now, do you recognize what is in Plaintiff's 15?

8 A Yes.

9 Q What's in Plaintiff's 15?

10 A So that's an X-ray of the lumbar spine on this patient  
11 Mr. Julca June 29, 2023.

12 Q And what is shown in this X-ray?

13 A So here you got to look at what an X-ray looks like you  
14 can only see the bones which are these squares. But now we know  
15 that there are disks in between these bones and ligaments and  
16 annulus and nerves and spinal fluid but you can't see on an  
17 X-ray but the X-ray is great for showing things that are hard  
18 like metal.

19 And so what we're seeing here is these are screws and  
20 fixation rods that were put in here in order stabilize L5-S1 --  
21 I'm sorry, L4-5. So between these two bones here, the surgeon  
22 fused the level.

23 Q You could sit down. So that's regarding Mr. Julca's  
24 lumbar spine and then you also said that you reviewed his left  
25 shoulder as well, correct?

**Dr. Kolb - by Plaintiff - Direct**

1 A Yes.

2 Q And there was a left shoulder MRI of also April 13,  
3 2018, correct?

4 A Yes.

5 Q And did you take that left shoulder MRI?

6 A No. I reviewed it.

7 Q Who took the left shoulder MRI?

8 A I believe it was Lenox Hill Radiology. I could be  
9 wrong but that's what I think. I didn't take it.

10 Q So I am going to put something up on the screen that  
11 has previously been put into evidence as Plaintiff's 5A. Now,  
12 Dr. Kolb do you recognize what is in Plaintiff's 5A that's being  
13 shown on the screen here?

14 A Yes.

15 Q What is that?

16 A It's actually one picture of many pictures of the left  
17 shoulder. It's an MRI of the left shoulder.

18 Q And is this the MRI from April 13, 2018, that you  
19 previously reviewed?

20 A Yes.

21 Q Can you come up to the screen and describe your  
22 findings based on your review of the April 13, 2018, MRI of the  
23 left shoulder of Mr. Julca?

24 A Which gears, shoulder, shoulder is the bone and socket  
25 joint. We can all do this, hopefully. The reason is because

**Dr. Kolb - by Plaintiff - Direct**

1 this round here, this round object here is gray is the bone.  
2 It's the humerus. It's the long bone of our arm. It comes up  
3 to the shoulder joint right here and it connects with a  
4 different bone. On this picture, it's a triangle. That's  
5 called the glenoid. So we have a joint here between the  
6 humerus, the arm bone and the glenoid which is the part of the  
7 bone you can feel in your back.

8           So we have this joint. But in order for us to move,  
9 the muscles have to be in action to move our shoulder. So we  
10 have four muscles that allow us to have motion in our joints.  
11 And the four muscles they all have medical names. You don't  
12 have to remember them. They are called the supraspinatus  
13 muscle, the infraspinatus, the subscapularis and the teres  
14 minor.

15           So in order for a muscle to connect to the bones so we  
16 can move, there's a tendon. Muscles that connect to bones have  
17 tendons. Each one of those four muscles have their own tendon.  
18 This is the tendon from the supraspinatus muscle that connects  
19 to the bone. The tendon should be completely black on this  
20 sequence of the MRI. If there is any whiteness in there, that  
21 means fluid which is white here. So this is fluid in the joint  
22 space and all fluid here. Fluid has gotten into the tendon and  
23 that tendon is now partially torn.

24           So there is a partial tear of the anterior  
25 supraspinatus tendon. Those four tendons are the rotator cuff

**Dr. Kolb - by Plaintiff - Direct**

1 tendons and so this is a partial rotator cuff tear. That's the  
2 main finding in this examination.

3 Q And how would someone get a partial tear of the  
4 supraspinatus?

5 A Again, it could be from trauma. It could be you hurt  
6 your shoulder doing something, some type of trauma, or it could  
7 be an aging process where you really didn't do anything but you  
8 get some shoulder pain. So those are the two ways that tears  
9 occur in the shoulder.

10 Q And, once again, are those -- are those mutually  
11 exclusive?

12 A No. As you get older, you don't need to have a rotator  
13 cuff tear at all. You could have a tear and be very young or  
14 you can be older and have an older shoulder and not have a tear.

15 Q Now, Dr. Kolb, previously in this trial there has been  
16 mention of something called a downsloping acromion. Are you  
17 familiar with that term?

18 A Yes.

19 Q What is a downsloping acromion?

20 A So, if -- let's go to the -- so we have AC joint. The  
21 AC joint, AC joint injuries, AC joint. "A" stands for acromion.  
22 We are going to talk about a downsloping acromion and "C" is the  
23 clavicle which you feel here. The clavicle hooks up with the  
24 acromion and forms your AC joint which you can feel on the top  
25 of your shoulder here. So this, this right here, this is a

**Dr. Kolb - by Plaintiff - Direct**

1 piece of bone, the clavicle which actually goes this way.  
2 Remember, we are not cutting it perfectly. The clavicle, a  
3 little off. You see the end of the clavicle here and then this  
4 piece of bone here is called the acromion. And a downsloping  
5 acromion is important to know about because between the acromion  
6 and the humeral head lie two of the rotator cuff tendons.

7           So it's important to know whether the patient has a  
8 downsloping acromion because the space could be narrowed because  
9 of that. So that's what a downsloping acromion is. In other  
10 words, acromion could go -- this is -- let's say the rotator  
11 cuff tendon. Here's the bone for the humerus that it's  
12 attaching to. It's round. This is the tendon coming across  
13 like that. And then the acromion could either be -- go straight  
14 out or it could be down and narrow the space between the bone  
15 and the humeral head so that's what it is.

16           Q     Now, does a downsloping acromion necessarily have to  
17 cause a tear?

18           A     No. A downsloping acromion you are born with. It  
19 doesn't occur during your life. You're born with it. That's  
20 the way you are. It doesn't -- it does not have to be a tear  
21 with a downsloping acromion, no, of course not.

22           Q     And in this specific MRI, you said there is a  
23 downsloping acromion. That caused the tear here; can you tell?

24           A     So, I say in my report that there's narrowing of the  
25 anterior subacromial space. What I really care about is the

**Dr. Kolb - by Plaintiff - Direct**

1 space. Whether it is downsloping or not downsloping, I care  
2 about the space and the space here is narrowed. So does that  
3 mean because he has a narrowed subacromial space that there is a  
4 tear? No. But he happens to have a tear. So the important  
5 finding is that he has a tear.

6 Q So, based on this MRI of the left shoulder from  
7 April 13, 2018, do you have a diagnosis regarding this specific  
8 film with a -- within a degree of medical certainty concerning  
9 plaintiff's left shoulder?

10 A Yeah, there is a partial rotator cuff tear in the  
11 supraspinatus tendon and there is narrowing of the subacromial  
12 space. That's all in my report.

13 Q Now, if I represented to you that Dr. Kaplan, who I  
14 believe, at least referred you one or two of these MRIs, not  
15 necessarily this one, did a surgery on the left shoulder and he  
16 found the torn supraspinatus, would that be consistent with your  
17 findings here?

18 A Yeah, that's what we're seeing on the MRI.

19 Q You can sit down again for a minute. So let's shift  
20 gears to the left knee. I know you mentioned that you reviewed  
21 some films regarding the left knee, correct?

22 A Yes.

23 Q I am going to show you what has been marked today as  
24 Plaintiff's 25 for identification. I am going to put that on  
25 the easel. I am going to show you actually what has been marked

**Dr. Kolb - by Plaintiff - Direct**

1 as Plaintiff's 24. Do you recognize what's in Plaintiff's 24,  
2 Dr. Kolb?

3 A Yes.

4 Q What is in Plaintiff's 24?

5 A It is a MRI of the left knee on May 1, 2018, of  
6 Mr. Julca.

7 Q And did you take this MRI or someone else?

8 A I did.

9 Q And did you review it as well?

10 A Yes.

11 Q Would you come down and describe your findings from  
12 this MRI to the jury, please?

13 A Sure.

14 Q So knee, which gears. The knee we are able to do this.  
15 We are able to flex it because there are three bones in the  
16 knee. There is your thigh bone which is called the femur.  
17 There is your shin bone which is called the tibia and fibula,  
18 two bones in here. They come together and form a joint. And in  
19 front of that joint is your kneecap which is right here, the  
20 patella. This is your thigh bone and this is your shin bone.  
21 And in between here, you are able to move your knee.

22 You're able to, as I said, bone touching bone is a very  
23 bad thing. So in the knee, we have shock absorbers and they are  
24 called the menisci. The menisci, there are two of them. There  
25 is one on the inside of your knee called the medial meniscus.

**Dr. Kolb - by Plaintiff - Direct**

1 There is one on the outside of the knee that's called the  
2 lateral meniscus. This picture is right in the middle of the  
3 knee so it is not showing the menisci. They are on both sides  
4 of here. They are supposed to be black with not any white in  
5 them. And this patient had a tear of the posterior horn of the  
6 medial meniscus with a small cyst in the back here. And the  
7 patient also has this here which is called an osteochondral  
8 defect. Again, the gray is the bone. It should be completely  
9 gray just like this and you obviously see this here and this is  
10 a defect in the cartilage in front of the bone, the protection  
11 for the bone here and that's also a major finding.

12 So there are two -- three findings on this MRI. One is  
13 a tear of the posterior horn of the medial meniscus which is  
14 back here but more medial. There's a partial tear of this  
15 ligament here which we didn't talk about until this very second.  
16 This is the anterior cruciate ligament. This is the posterior  
17 cruciate ligament.

18 So, when you move your knee, there's a bunch of  
19 ligaments in there that holds things together. The cruciate  
20 ligaments criss-cross each other like this. The top one is the  
21 anterior cruciate -- you don't have to remember any medical  
22 things. The back one is the posterior cruciate. And the reason  
23 that we're able to move is because these cruciate holds the  
24 bones together so that they don't -- the knee slide apart. If  
25 we didn't have the cruciate ligament, the knee, instead of

**Dr. Kolb - by Plaintiff - Direct**

1 bending like this, will go like that. What holds it in place is  
2 that. That's why when you tear an ACL, if you have a ACL tear,  
3 that makes the knee unstable, okay.

4 So -- so the major findings are tear of the meniscus,  
5 posterior horn medial and osteochondral defect here and a  
6 partial tear of the anterior cruciate ligament.

7 Q Now, let's go with some of those findings for a second.  
8 How would one has a tear of the meniscus?

9 A So, it is really the same reason from trauma you can  
10 tear your meniscus, whatever trauma it was. That's the most  
11 common, in terms of the menisci, that's the most common or as we  
12 age, we deteriorate, unfortunately, and our knees are not as  
13 beautifully young as they used to be and you can form a tear as  
14 well.

15 Q Once again, those aren't mutually exclusive, right?

16 A No. You can have arthritis in your knee without a  
17 tear. You can have a tear in your knee without any arthritis at  
18 all. Each patient is individual.

19 Q Now, you also mentioned the osteochondral defects?

20 A Yes.

21 Q A white little thing over there, right?

22 A Signal.

23 Q How would one get one of those osteochondral defects?

24 A Again, from trauma, having a direct injury here can  
25 cause that. This is all swelling in the bone or it can be as we

**Dr. Kolb - by Plaintiff - Direct**

1 age we can form them without having a major trauma.

2 Q Is there a way to tell the difference between the two?

3 A You can't. You can without -- not on the picture  
4 though. You got to examine the patient, get a history from the  
5 patient. If this patient was walking around on their right knee  
6 without any problems and not seeing doctors and not getting  
7 injections and not getting treatment and not getting surgery and  
8 not getting MRI's and then the patient had a trauma and has all  
9 of these findings, then you would logically conclude, with the  
10 clinical correlation with all that information that you would  
11 know, that these findings are from the trauma. And that would  
12 go for any body part. That's just not the knee. That would be  
13 for the shoulder and the back too. But you can tell by looking  
14 at an MRI picture how old that tear is.

15 Q Now, I am going to show you what's been marked as  
16 Plaintiff's 25 for identification. I believe it will also fit.  
17 Do you recognize what's in Plaintiff's 25?

18 A Yes.

19 Q And what is in Plaintiff's 25?

20 A Well, that same patient, same knee, different day,  
21 January 12, 2023.

22 Q Do you know who took this MRI?

23 A I did.

24 Q And did you review this MRI as well?

25 A Yes.

**Dr. Kolb - by Plaintiff - Direct**

1 Q And what were your findings in this MRI?

2 A Yeah. So, again, there's a tear. You need more than  
3 one picture. You could see that there is a tear here of the  
4 posterior horn of the medial meniscus. This osteochondral  
5 defect is still there. You are seeing that and the partial tear  
6 of the ligament. Again, to be clear, this is one picture from  
7 the center or a little to the side. We take many, many pictures  
8 going across. But for the sake of just showing things, I chose  
9 one picture to show but, basically, the same findings that we  
10 saw before, this osteochondral defect. There is a tear of the  
11 medial meniscus and a partial tear of the anterior cruciate  
12 ligament which you do not see on this picture.

13 Q Now, based on the MRI's of the left knee that you've  
14 looked at, both of these, do you have a diagnosis, within a  
15 degree of medical certainty, regarding this film concerning  
16 plaintiff's left knee?

17 A The same things I just said, the meniscal tear, the  
18 osteochondral defect and the partial ACL tear.

19 Q And if I represent to you that Dr. Kaplan did  
20 arthroscopic surgery on this left knee and he found a torn  
21 meniscus, would that be consistent with your findings?

22 A Yeah, it would be.

23 Q If he found the osteochondral defect, would that be  
24 consistent with your findings?

25 A Yes.

**Dr. Kolb - by Plaintiff - Direct**

1 Q Now, let's say Dr. Kaplan went in there and he didn't  
2 see an ACL tear. Would that be consistent with your findings?

3 A Well, it could be. There are two reasons for that.  
4 One is the tear could have been in mid substance. We don't have  
5 to go back to pictures. We are just going to move on. The ACL  
6 is actually not just a string. Actually, think about it as a  
7 string. A string is not really a string. There are many fibers  
8 in a string, right. It is not like the ACL when it's partially  
9 torn you can -- that -- that the whole thing from the outer side  
10 is torn.

11 So, you can have a tear of any of these ligaments that  
12 are inside. So let's say this is, pretty thick, let's say this  
13 is, if we take the ACL and look at it and it is a round thing,  
14 the tear could be in the middle of it. So when a surgeon looks  
15 from the outside inside the knee and sees the outside of the  
16 ligament, he won't see the tear. It could be what's called an  
17 interstitial tear, a tear inside the ligament. They won't see  
18 it. If they don't see it, they are not going to fix it. But  
19 the MRI will show you all -- if you put on the picture before  
20 which is we need to do. That's very easy.

21 Number 24, this is the ACL. There are many parts of  
22 it. This is the ACL here. All the way from here to here is the  
23 ACL and the tear is in here. So you could see it from the  
24 outside or it could be just on the inside. That's just a long  
25 way of answering your question why a doctor won't see it or in

**Dr. Kolb - by Plaintiff - Direct**

1 the time interval between the surgery and this picture it healed  
2 up. Those are two common reasons why the surgeon won't see it.  
3 Sometimes the MRI see a little bit more.

4 Q Okay. So let's go to the right knee. I know you  
5 mentioned before that you reviewed a film of the right knee. I  
6 am going to show you -- I know you said you reviewed a MRI of  
7 Mr. Julca's right knee dated July 10, 2018. And I am going to  
8 show you what's been marked as Plaintiff's 26 for  
9 identification. Do you recognize what is in Plaintiff's 26 for  
10 identification?

11 A Yes.

12 Q What is in Plaintiff's 26 for identification?

13 A This patient's right knee MRI done on July 2018.

14 Q Do you know who did this MRI?

15 A Actually, I did this MRI.

16 Q Did you review this MRI?

17 A Yes.

18 Q What were your findings of the MRI of the right knee  
19 from July 10, 2018?

20 A So, here you see this black triangle which has this  
21 white substance in it. It is supposed to be completely back.  
22 That's the posterior horn of the medial meniscus that we are  
23 talking about and that's the tear in it. So there is a tear of  
24 the posterior horn of the medial meniscus. On the other side of  
25 this board -- because the patient is three dimensional. This

**Dr. Kolb - by Plaintiff - Direct**

1 picture is only two dimensional -- the patient also has an  
2 intrasubstance tear of the posterior horn of the lateral  
3 meniscus, the other one. This is a smaller partial tear of the  
4 ACL and there is a chondral defect in the inter-aspect of the  
5 medial femoral chondral. It is right here in the front. No  
6 osteochondral defect. The bone marrow here is normal, but just  
7 the chondral surface here is -- has a defect in it. Those are  
8 the major findings of the right knee.

9 Q Now, the defect in terms of the -- I guess that would  
10 be like the joint surface?

11 A That's the joint surface.

12 Q How would you get the defect in the joint surface such  
13 as the one that you described in the MRI of July 10, 2018?

14 A The same reasons as before. Either you can have it  
15 from a traumatic event or you can have it from just getting  
16 older and forming some chondral defects.

17 Q And, once again, those aren't mutual exclusively?

18 A No. You can have a chondral defect with having a  
19 beautiful rest of your knee being extremely young and you can  
20 have an arthritic knee and you're older in your 80s and not have  
21 a chondral defect so they are not mutually exclusive.

22 Q From an MRI, can you tell which one it is?

23 A No, you can't tell.

24 Q Why not?

25 A Well, hold on. Sorry. When you say you can't tell, if

**Dr. Kolb - by Plaintiff - Direct**

1 the patient had a pristine knee that everything looked perfect,  
2 let's say the patient was 20 years old and you see a chondral  
3 defect, then you are thinking something must have happened to  
4 the knee as opposed to, let's say, an 80 year old person when  
5 there is a lot going on and there is a chondral defect then the  
6 answer would be you can't tell. So most of the time you can't  
7 tell. Sometimes you can but most of the time you can't just on  
8 the MRI itself.

9 Q And then you also mentioned the tears of the meniscus,  
10 correct?

11 A Yes.

12 Q And, once again, that's the same idea that it could  
13 either be from a traumatic experience or from some sort of  
14 degeneration?

15 A Yes.

16 Q And they are also, once again, not mutually exclusive?

17 A Right. You can have one without the other.

18 Q Now, based on this MRI of the right knee, do you have a  
19 diagnosis, within a degree of medical certainty, regarding this  
20 film concerning the plaintiff's right knee?

21 A Yes. So what we discussed there is a tear of the  
22 posterior horn of the medial meniscus. There is an  
23 intrasubstance tear to the posterior horn of the lateral  
24 meniscus. There is a partial tear of the tibia insertion of the  
25 ACL which you don't see here. And there is a chondral deformity

**Dr. Kolb - by Plaintiff - Direct**

1 to the anterior aspect of the medial femoral chondral. There is  
2 a joint effusion here and the rests are smaller findings.

3 Q What is a joint effusion?

4 A That's fluid, fluid in the knee.

5 Q Why would there be fluid in the knee?

6 A The fluid is a response. Your body is responding to  
7 some injury in the knee and it produces fluids to kind of  
8 lubricate or to extend the joint to try to decrease your  
9 bone-on-bone or some injury. It could also be a direct result  
10 of trauma at some time where your body is reacting to that so it  
11 produces fluid.

12 Q Now, here you said there is a joint effusion. Can you  
13 tell if that joint effusion that you see there is just normal,  
14 the normal fluid that you see or is it more than normal?

15 A No, it's more than normal.

16 Q And how can you tell that?

17 A Well, usually, there is a very -- again, this is one  
18 picture. There are many pictures to look at. Usually, there is  
19 a very trace amount of fluid, a very thin line and this picture  
20 has a lot more fluid than is usual.

21 Q And if I represented to you that Dr. Kaplan did  
22 arthroscopic surgery once again on this right knee and he found  
23 torn meniscus and he found the joint surface defect, would that  
24 be consistent -- that would be consistent with your findings,  
25 correct?

**Dr. Kolb - by Plaintiff - Direct**

1 A Yes.

2 MR. ROSENGARTEN: Thank you very much for your  
3 time. I have no further questions at this time.

4 THE COURT: Okay. Are you ready to proceed,  
5 Mr. Malecki?

6 MR. MALECKI: Sure.

7 THE COURT: I would say you got ten minutes until  
8 our next break. If you wanted to break now, I wouldn't have  
9 a problem.

10 MR. MALECKI: Why don't we take a break, and we can  
11 get everything situated.

12 THE COURT: Why does it always have to be me  
13 deciding. I think we are going to take a ten-minute break  
14 at this time. That's my decision and then we will resume  
15 with the cross-examination.

16 COURT OFFICER: All rise, jury exiting.

17 (Whereupon, the sworn jurors exit the courtroom.)

18 THE COURT: We are off the record.

19 (Whereupon, the witness was excused from the  
20 stand.)

21 (Whereupon, a recess was taken.)

22 (Whereupon, the witness resumes the witness stand.)

23 THE COURT: On the record. Bring in the jury.

24 COURT OFFICER: All rise, jury entering.

25 ///

**Dr. Kolb - by Plaintiff - Cross**

1                   (Whereupon, the sworn jurors enter the courtroom  
2                   and take their respective seats.)

3                   THE COURT: Please be seated.

4                   Mr. Malecki, you may inquire.

5                   MR. MALECKI: Thank you.

6 CROSS-EXAMINATION

7 BY MR. MALECKI:

8           Q     Good afternoon, Doctor.

9           A     Good afternoon.

10          Q     Am I correct as a radiologist in reviewing films you're  
11                using your eyes to look at the films and then you use your  
12                training and experience over many numbers of years to interpret  
13                those films, correct?

14          A     Yes.

15          Q     And I am also correct that there are some radiologists  
16                that nowadays have computer-aided detection systems that they  
17                use; am I correct in that?

18          A     I suppose there are. I know it's there for breast  
19                imaging, maybe for other parts of medicine as well.

20          Q     And do you use any of those in your practice?

21          A     I don't.

22          Q     Now, is it also fair to say that radiologists can  
23                interpret films in different ways?

24          A     Yes, within reason. Yes.

25          Q     Now, I want to start and talk about the lumbar spine

**Dr. Kolb - by Plaintiff - Cross**

1 first. I note you said you looked at the radiology from Lenox  
2 Hill from April 13, 2018, for the lumbar spine, correct?

3 A Yes.

4 Q And that's where you saw that disk bulge at L4-L5,  
5 correct?

6 A Yes.

7 Q And do you acknowledge disk bulges could be caused by  
8 trauma, could also be caused by wear and tear aging of the body,  
9 correct?

10 A Yes.

11 Q And you then looked at the next film in 2021 of the  
12 lumbar spine, correct?

13 A Yes.

14 Q And that's the one you conducted, right?

15 A Yes.

16 Q And in that one you said now there is a disk herniation  
17 at L4-L5, correct?

18 A Yes.

19 Q Now, am I correct that after you do these diagnoses and  
20 you write up your report you then send that information to the  
21 treating physician?

22 A Yes.

23 Q And in this case that lumbar spine MRI would have gone  
24 to Dr. Weinstein, correct?

25 A Yes.

**Dr. Kolb - by Plaintiff - Cross**

1 Q And then the doctor uses those -- your interpretations  
2 and the films to determine whether to schedule a surgery or not?

3 A Well, they also look at the films themselves. All  
4 doctors who do surgery do look at the MRI's to decide what they  
5 think is there as well.

6 Q Now, counsel asked this about the knee, but I am going  
7 to ask it about the back. When the surgeon opens someone up,  
8 would they have a better view of what's going on inside the body  
9 than you as a radiologist who's looking at the pictures?

10 A In some respects, they would. In other respects, MRI  
11 could see things that the surgeon won't like internally. For  
12 example, if there is something inside of the bone, but it wasn't  
13 in good, for the surface of the bone, they won't see that. So  
14 the answer to your question is, yes, in general, when a surgeon  
15 see something that's considered, you know, very highly accurate.

16 Q And you talked, and I will probably go back to it on  
17 the knee, the ACL tear, but what about a disk herniation? Is  
18 that something when a surgeon opens up that they should be able  
19 to see?

20 A They could.

21 Q Now, in this case, Dr. Weinstein testified and he  
22 testified about his surgery. And he told us that that surgery  
23 in no way involved the disk herniation. Are you aware of that?

24 A No.

25 Q So if Dr. Weinstein opened Mr. Julca up during surgery,

1 looked in and did not see a disk herniation, would it be fair to  
2 say that there was never a disk herniation to begin with?

3 A No.

4 Q Why not?

5 A Because as I told you, you can see things on an MRI  
6 that you wouldn't see otherwise. For whatever reason that he  
7 said he didn't see herniation on the MRIs, on the second MRI,  
8 there is herniation. On the first, there isn't. There are  
9 criteria for reading MRIs as well. I don't know what he saw. I  
10 didn't read the surgical report.

11 Q And defense radiologist testified this morning and he  
12 testified to having reviewed the films this same October 28,  
13 2021, MRI and he also said that there was no herniation at that  
14 L4-L5. So would it be fair to say you disagree with his  
15 interpretation?

16 A Yeah, for sure.

17 (Continued on next page)

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**Dr. Kolb - Cross - Plaintiff/by Mr. Malecki**

1 Q And now let's talk about the left knee.

2 You did the MRI of the left knee on May 1st, 2018,  
3 correct -- I am sorry, I directed you wrong, Doctor.

4 Lenox Hill actually did the MRI of the left knee on  
5 May 1st, 2018, right?

6 (Pausing.)

7 You could double check me, Doctor.

8 A Let me --I did the MRI on May 1st, 2018, I did it.

9 Q Okay. Then I wrote it down wrong.

10 And you talked about finding the meniscus tear,  
11 correct?

12 A Yes.

13 Q And you testified, correct, that meniscus tears have  
14 many causes, some can be from accidents, some can be from  
15 degenerative wear and tear of the body, yes.

16 A Yes.

17 Q Now, a meniscus tear that would be caused by trauma.  
18 Is that something that would be caused by the twisting of the  
19 knee, or a direct impact, or something else?

20 A Either of those.

21 Q And now you also testified to seeing that partial tear  
22 of the ACL, anterior cruciate ligament, in that 2018 MRI of the  
23 left knee, correct?

24 A Yes.

25 Q And as counsel mentioned, Dr. Kaplan did testify here

**Dr. Kolb - Cross - Plaintiff/by Mr. Malecki**

1 and he did say that he not see that during his surgery?

2 A Sure.

3 Q You gave several reasons why that may be.

4 Is it possible that one of the other reasons why that  
5 partial tear of the ACL was not seen during surgery, that you  
6 were potentially incorrect in your review of the MRI?

7 A Anything is possible. But I'm here to look at the  
8 films directly, again, and say that there is a partial tear  
9 there.

10 Q And the left knee also had that second MRI in 2023,  
11 that you also did, correct?

12 A Yes.

13 Q Yes.

14 A Sorry, yes, correct.

15 Q And were there any additional changes from 2018 to 2023  
16 in that left knee?

17 A Nothing significant. Nothing significant.

18 Q And earlier today there was a defense radiologist who  
19 testified --strike that.

20 I'll go to the right knee. Correct, you did the MRI of  
21 the right knee on July 10, 2018, correct?

22 A Yes.

23 Q And you also found the tear of the meniscus?

24 A Well different area, but yes, there was also a tear to  
25 the meniscus.

**Dr. Kolb - Cross - Plaintiff/by Mr. Malecki**

1 Q And in that same way, that tear could have also been  
2 caused either from an accident or the degenerative wear and tear  
3 over time, correct?

4 A Yes.

5 Q Now, this morning, as to the right knee, defense  
6 radiologist testified that he did not see any tear in that  
7 medial meniscus. I assume you disagree with his analysis then?

8 A Yes.

9 Q And, again, you also found that partial tear of the ACL  
10 of the right knee in this MRI, correct?

11 A Yes.

12 Q And, again, Dr. Kaplan did testify the other day that  
13 he did not see it during surgery?

14 A Yeah, I don't know when the surgery was done but as I  
15 said, ACLs will heal up, so I'm not surprised.

16 Q And you talked about joint effusion. Was that in the  
17 right knee as well?

18 A No -- yes, it is. It is in the right knee, I'm so  
19 sorry. Yes, it is.

20 Q That's okay.

21 A Yes.

22 Q And would it be fair to say that all joints in the knee  
23 have some kind of fluid in it?

24 A Oh, of course.

25 Q So your analysis of joint effusion is measuring how

**Dr. Kolb - Cross - Plaintiff/by Mr. Malecki**

1 whether there is more fluid than expect to be?

2 A Yes, the reason that you use the term joint effusion is  
3 meaning, you're say more than normal. You would not use that  
4 term if it was the normal amount of fluid in the knee.

5 Q And it defense radiologist testified this morning that  
6 he found the fluid within the knee to be within normal range. I  
7 assume you disagree with that analysis?

8 A Yes.

9 Q And this morning we also heard about something called  
10 the Crues grades, C-R-U-E-S, do you know what that is?

11 A There's a radiologist and that is his grading of it. I  
12 don't use the Crues grade. There are many different ways of  
13 looking at tears. I don't use that grading system. Most of the  
14 radiology reports that I have seen don't use it, so less common.

15 Q You didn't make any kind of analysis as to the Crues  
16 grade of any of these issues?

17 A No, absolutely not.

18 Q All right. And talking about the left shoulder. I  
19 don't know whether you fully answered the question.

20 So are you confirming that, with respect to Mr. Julca's  
21 left shoulder that he does have a downsloping acromion?

22 A I think my report just says narrowing of the sub  
23 acromion space. So the importance of the downsloping acromion  
24 is whether that space is normal or not, I am getting to the  
25 point of by saying there's a narrowed acromion space. I'm not

**Dr. Kolb - Cross - Plaintiff/by Mr. Malecki**

1 disagreeing, I think I'm being more specific.

2 Q Now, does a downsloping acromion predispose individuals  
3 to rotator cuff tears?

4 A Yes, that is why it was in the report. There is a  
5 narrowing of the sub acromion space. You can have a tear,  
6 rotator tear, partial tear because of that. You don't have to,  
7 I mean, most people don't but...

8 Q And I apologize, you mentioned the AC joint. What does  
9 AC?

10 A Acromioclavicular.

11 Q And we talked about the acromion as one part of the  
12 joint and the other is the clavicle?

13 A Correct.

14 Q Now, in doing your tests on Mr. Julca, do you ask him  
15 things like the history of the accident or his past medical  
16 history, or anything like that?

17 A So there's a form that patient fills out that asks if  
18 there is any previous trauma, surgery, things like that. It is  
19 not a comprehensive history that his referring physician will  
20 take.

21 Q And did Mr. Julca identify any prior injuries to any of  
22 his body parts?

23 A I don't know. I don't have the history here.

24 Q In your analysis of the radiology, does knowing the  
25 past medical history of a patient affect that?

**Dr. Kolb - Cross - Plaintiff/by Mr. Malecki**

1           A     It is possible, but not in these reports here. I'm not  
2 ascribing any findings to a specific time.

3           Q     Now, Doctor, talking about the knees again. If someone  
4 has blunt force trauma to the knees, would that cause typically  
5 in an MRI some kind of bone bruising or edema?

6           A     So anything is possible. Often, most often by the time  
7 they get an MRI, unless it is in the hospital you're not going  
8 to see bone bruising. It is possible he had bone bruising at  
9 the time of the injury. I can't tell you, I don't know for sure  
10 either way.

11          Q     All right. And I'm correct that you are a radiologist  
12 and you're making no opinions as to Mr Julca's need for surgery,  
13 correct?

14          A     Correct.

15          Q     And outside of what you saw in the MRIs and the another  
16 tests that you performed, you don't have any basis for an  
17 opinion as to the cause of Mr. Julca's injuries?

18          A     Right. Nobody could look at the MRI and say they  
19 occurred on a particular day or not, you can't say either way,  
20 you just know it is there.

21          Q     And now you indicated --I know I wrote it down.  
22                 What was your charge for the time spending here  
23 testifying?

24          A     My office gets \$12,000.

25          Q     And then you --I'm assuming your office charges when

**Dr. Kolb - Cross - Plaintiff/by Mr. Malecki**

1 what patient comes in and you perform the test, you do an MRI,  
2 correct?

3 A Yes, that is an insurance payment, patient are covered.

4 Q Do you know how much is charged for that?

5 A No.

6 Q And then, in this case, you also reviewed MRIs that  
7 your office did not perform, correct?

8 A Yes, that is correct.

9 Q And did you charge a fee for that?

10 A Yes.

11 Q What did you charge for that?

12 A Around \$900, \$850 or \$900 for an MRI and then \$400,  
13 \$450, somewhere around that for an X-ray. I believe those are  
14 the numbers.

15 MR. MALECKI: That's all the questions I have  
16 for you. Thank you doctor.

17 THE WITNESS: Thank you.

18 THE COURT: Any re-direct?

19 MR. ROSENGARTEN: No re-direct, your Honor.

20 THE COURT: The witness may step down.

21 THE WITNESS: Thank you.

22 (Witness exits.)

23 THE COURT: Counsel, please step up.

24 (Whereupon, a bench conference took place between  
25 counsel and the Court.)

**Dr. Kolb - Cross - Plaintiff/by Mr. Malecki**

1 THE COURT: Mr. Rosengarten, do you have any  
2 further witnesses?

3 MR. ROSENGARTEN: I do not.

4 At this time the Plaintiff rests.

5 THE COURT: Very good.

6 Members of the Jury, do not discuss this case  
7 amongst yourselves or with anybody else. Do not do any  
8 independent research. Do not visit the scene.

9 I know I told you we are down tomorrow, so that  
10 means you get a three-day weekend from us. I'm sure you're  
11 all cheering on the inside, right.

12 We have a witness like today, we have a witness  
13 Monday in the morning and in the afternoon. The lawyers  
14 have expressed with me with high confidence that we don't  
15 need the entire morning. So like today, we will start at  
16 10:30 Monday and we will have enough time to complete that  
17 witness in the morning and then another witness in the  
18 afternoon.

19 Members of the Jury, you are excused for the day.  
20 Have a nice weekend.

21 THE COURT OFFICER: All rise. Jury exiting.

22 (Whereupon, the jury exits the courtroom and the  
23 following is heard outside the hearing and presence of the  
24 jury.)

25 THE COURT: The jury has exited. Anything before

1 we recess for the day?

2 MR. ROSENGARTEN: No, your Honor.

3 MR. MALECKI: No.

4 THE COURT: All right. Trial stands in recess  
5 until Monday morning, March 16th at 10:30 a.m.

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