In The Matter Of:

Jose Carlos DeSouza v.
Hudson Yards Construction II, et al

October 29, 2026

Deborah A. Rothrock, RPR

Original File Transcript Trial De souza v Hudson Yards 10292026.txt

Min-U-Script® with Word Index

SUPREME COURT OF THE STATE OF NEW YORK.
COUNTY OF NEW YORK - CIVIL TERM - 8

----------X

JOSE CARLOS DE SOUZA,

Plaintiff,

-against-

HUDSON YARDS CONSTRUCTION II LLC, 50 HYMC OWNER LLC and GILBANE BUILDING COMPANY,

Defendants.

----------X

Index # 157354/2019

JURY TRIAL
60 Centre Street
New York, New York 10007

October 29, 2026

B E F O R E:

HONORABLE LYNN R. KOTLER,
Supreme Court Justice and a jury.

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

LAW OFFICES OF LAWRENCE PERRY BIONDI, P.C.
81 Main St Ste 305
White Plains, New York 10601
BY: LAWRENCE PERRY BIONDI, ESQ.
Attorney for Plaintiff

ABRAMS, GORELICK, FRIEDMAN & JACOBSON, LLP
One Battery Park Plaza, 1 Battery Place
New York, New York 10004
BY: STEVEN DiSIERVI, ESQ.
Attorney for Defendants

DEBORAH A. ROTHROCK, RPR
Official Court Reporter

THE COURT: On the record.

So, good morning. I am going to be the bearer of some bad news. We have lost a juror, alternate number two, due to illness.

THE COURT: One other housekeeping issue.

When we do have a break in the action, once you finish with your summations -- I know this is not until next week-ish -- once you're finished with your summation and the Court charges the jury, I don't wait for the jury to ask for specific exhibits, the entire pile goes into the jury room.

MR. BIONDI: Fine by me.

MR. DiSIERVI: We're going to have to redact them.

THE COURT: Yes. That is the whole point, making sure everything is in order. When you have a break in the action, whenever that is, I'm just giving you a heads-up, that's all.

MR. BIONDI: Thank you.

THE COURT: You're welcome.

So, are we ready to proceed?

MR. BIONDI: Yes, Your Honor.

MR. DiSIERVI: Your Honor, I have two issues to raise with the Court.

THE COURT: All right. Hang on one second.

(Pausing.)

THE COURT: Okay.

MR. DiSIERVI: Your Honor, the first issue is, I am currently suing Dr. Merola for malpractice and fraud. It was commenced in this action and severed. Only because my ethical obligation not to speak to the adverse party, who has counsel, I just want to ask for the Court's permission to cross-examine him and I'm not violate my ethical obligations of speaking to a party to the action without his counts present.

MR. BIONDI: No objection to that, Judge.

MR. DiSIERVI: Just for me.

MR. BIONDI: I would have an objection to any mention of the third-party action.

MR. DiSIERVI: I am not mentioning it.

THE COURT: Okay. Okay.

MR. DiSIERVI: Your Honor had ruled --

THE COURT: Also with no prior bad acts or RECO allegations.

MR. DiSIERVI: That is where I am going next.

Your Honor ruled on the motion in limine that I can not question the witness concerning prior bad acts or the RECO allegations. I do plan on questioning the witness on two judges against him.

One judgment is for fraud in Brooklyn, the other judgment in Suffolk County, in a case where 36 individuals staged an automobile accident and the Doctor was a

Defendant, because the Defendant was claiming that he was owed money for the surgical procedures he performed. The Court in Suffolk County found for the Plaintiffs against the Defendants, including the Doctor, that it was a staged accident and that the Doctor was not entitled to any compensation.

I plan on using those findings to cross-examine the Doctor about his treating of patients involved in staged accidents. And I plan on asking the Doctor about the judgment against him of the fraud in Brooklyn.

MR. BIONDI: Judge, he had mentioned that in the motion in limine. I can tell you, let me tell you about the case he's referring to.

That was a case when there was --

THE COURT: Are we talking about --

MR. BIONDI: Integon.

THE COURT: --is that the Brooklyn or Suffolk action?

MR. DiSIERVI: No Suffolk County Integon.

I have a copy of the judgment.

THE COURT: I'll take it. Is that the Suffolk or Brooklyn, just look at the caption.

MR. BIONDI: Yes, Suffolk. And counsel had referenced this in the motion that Your Honor has previously decided.

THE COURT: I'll have to take a look at that again, okay.

MR. BIONDI: What I can tell you, Judge, is that, in this action there's probably 100 -- more than 100 defendants, even more than that. Like seven, maybe more than seven hospitals, the New York City Fire Department, EMS, these are individuals that were owed money.

The fraud ring had to do with Plaintiffs who perpetrated these staged car accidents. That is what the case was directed at. That is what the judgment was about.

All of these Defendants here, as I indicated New York City, all these hospitals in New York City, they were owed money.

So what happened was that, since the Court found that there was a fraud, that there was these motor vehicle staged accidents, the insurance didn't kick in. So as a result of that, everyone named here was not entitled to get paid for their services, vis-à-vis insurance policies;

Nothing to do with anything that Dr. Merola did or didn't do, Judge.

MR. DiSIERVI: Your Honor, with respect to that.

Dr. Merola submitted medical bills to this insurer, that the treatment and the complaints were causally related to the accident and the finding of fact is critical here. Because we know that Dr. Merola's treatment, including the

surgery, including the diagnostic findings were not related to the accident because an action in which Dr. Merola was a party to was determined to be fraud.

I am not going to suggest that Dr. Merola was involved in the fraud. My suggestion is going to be that he has examined these patients, these patients were found to have committed insurance fraud and staged accidents. And he submitted invoices to that insurer claiming that they sustained injuries in that accident, and those injuries were causally related to that accident. That is how I'm using it it.

I'm not going to suggest at all that Dr. Merola was involved in the fraud.

THE COURT: But it does -- it makes the assumption that he was.

MR. BIONDI: Correct.

THE COURT: That is my concern.

MR. DiSIERVI: Your Honor, he found causally related injury on a patient that was not even in an accident --

MR. BIONDI: How is he supposed to know what the Plaintiff is telling him in an accident. How is that different than anyone else walking into his office.

New York City committed fraud, every hospital in New York committed fraud --

MR. DiSIERVI: No.

MR. BIONDI: They are named defendants, just like he's a named defendant. This is ridiculous.

MR. DiSIERVI: I'm not saying that they comitted fraud. I am saying that they found a causal relationship between injuries and an accident that did not occur, which, logically, there's no causal relationship.

Dr. Merola can explain to the jury, the patient came in, told me what they told me, that is what I based it on, fine.

To say that I can't use it and it is not relevant, nor is it useful for impeachment purposes, I believe, it's to the contrary.

MR. BIONDI: There's no prior bad act, Judge, and obviously it is prejudicial. There's nothing that he did or didn't do.

MR. DiSIERVI: I'm not going say again. I am not going to allege that he was involved in the fraud.

It's going to be that he found -- he made certain diagnoses, he found the causal that relationship and there was no accident. It goes directly to his credibility and competency.

He can explain and say, hey, these people came into my office, they told me it had started that day so I thought it was, that is for the jury to determine.

With respect to the second accident, Your Honor, there's a default judgment against Dr. Merola in Brooklyn. The Complaint is specifically for fraud.

The Complaint is specifically for submitting bills for procedures he did not perform.

The Complaint is specifically for making false diagnoses and there's a judgment against him. I have a copy of it for the Court, if the Court would like to see it.

MR. BIONDI: Is that the Helio case?

MR. DiSIERVI: Yes, it is.

MR. BIONDI: I can speak to that, Judge, that is my case.

THE COURT: Okay.

MR. BIONDI: So, what happened in that case, Judge, is that, Dr. Merola was between two attorneys. Dr. Merola made a motion to dismiss in that case, had counsel do A motion to dismiss the Complaint against him. Then as, I said, he was between attorneys. There was a 13-day delay in him answering. Judge Sweeney in Brooklyn --

THE COURT: Did they ever make a motion to vacate the default?

MR. BIONDI: -- granted the default. There was a motion to vacate, which was denied. As we speak, Judge, there's an order to show cause in the Appellate Division to --

THE COURT: Second Department?

MR. BIONDI: Yes. To stay the trial on the Helio case. That case, Judge, is going to get reversed.

There is no basis, with a 13-day delay, to grant a default judgment.

The reason why Judge Sweeney granted the default. He said in their opposition papers, counsel only used an affirmation verified by counsel.

THE COURT: So he didn't have personal knowledge?

MR. BIONDI: It wasn't that. Whereas the motion for a default was made by the attorney.

As I say, this is not on the merits. It was an administerial issue as to why the fault -- now counsel wants to say Dr. Merola was found guilty of all the allegations in the third-party Complaint before that issue ever gets resolved. As I said, it is going to get reversed. We're going to allow him to be questioned on that and then he gets reversed, then what do we do Judge.

MR. DiSIERVI: I am going to read one sentence from decision.

MR. BIONDI: Same issue as the prior bad acts.

THE COURT: But you agree that the case is now before the Appellate Division and there is a stay in the Brooklyn case?

MR. DiSIERVI: There's not a stay.

MR. BIONDI: No.

THE COURT: No?

MR. BIONDI: There is an application for a stay.

THE COURT: An application for a stay?

MR. DiSIERVI: And, Your Honor, I'm going to ask this Court give full weight and comity to the decision in Brooklyn.

And the Court decided, Dr. Merola failed to submit admissible evidentiary proof to establish a notorious defense. That is the finding.

If we wait for Appellate Division decisions to deem something final, next that they will go to the Court of Appeals.

THE COURT: Doesn't really matter. Both of you don't want to follow any of the Appellate Division decisions. It doesn't really matter.

MR. DiSIERVI: Your Honor, so at this point, I ask that this Court give full wait to the decision out of Brooklyn, it is final until the Appellate Division says otherwise.

THE COURT: Do you have a copy of it? Do you have everything?

MR. DiSIERVI: Yes.

THE COURT: Right now I have a Suffolk Verified Complaint and I have a Brooklyn Decision on a default

judgment; fair? Is that correct?

MR. DiSIERVI: Yes. I'm going to give you a copy of the Brooklyn Summons and Complaint as well.

(Handing.)

MR. DiSIERVI: And a copy of the judgment in the Suffolk County case.

THE COURT: All right.

(Handing.)

MR. BIONDI: May I Judge?

THE COURT: No, give me a second. Thank you.

MR. BIONDI: Okay.

(Pausing.)

THE COURT: Briefly.

MR. BIONDI: The Dearaujo case, Judge. Again harkens back to all the allegations in had the RICO case, which had since been dismissed and they're just rehashing that.

As I said, it was a very unfortunate situation that he didn't put in the answer as he was changing attorneys on time. But it is the same allegations that Your Honor has already ruled on.

THE COURT: All right.

MR. DiSIERVI: If I may have one minute, Your Honor.

THE COURT: To speak to someone or the Court?

MR. DiSIERVI: Speak with the Court.

THE COURT: Okay.

MR. DiSIERVI: Counsel said that the claims against him were dismissed. They were dismissed because of a settlement. In federal court, after a settlement, instead of a stipulation of discontinuance, you get a stipulation or a voluntary dismissal, that is one point.

The other point is, I'm not going to bring up RECO at all. I'm bringing up this case where there's a judgment against Merola, what the allegations were in that case. I'm not going to mention RECO or anything in the RECO Complaint. It is going to be strictly to the Integon third-party Complaint.

THE COURT: When did you know about this?

MR. DiSIERVI: I've known about it for a while. It is in my motion papers.

THE COURT: All right. Let me double-check.

(Whereupon, a recess was taken.)

THE COURT OFFICER: All rise. Court is in session.

THE COURT: On the record. Okay. So earlier defense counsel had indicated that he wanted to question Dr. Merola with regard to the two actions, one in Suffolk County and one in Brooklyn Kings County.

With regard to the Suffolk County one, the Defendant indicated that he wanted to question Dr. Merola

based on Plaintiff's staged accident, the insurer denying the claims, the fact that Dr. Merola treated the plaintiffs and found that the injuries were causally related to the accident in this staged incident.

Here, the Court is not going to allow that line of questioning.

The Defendant would have to prove that the Doctor knew that the accident was staged and that it's confusing to the jury.

Here, the Defendant is asking the jury to make a leap of faith that the doctor's treatment of these patients were involved in the staged accident, the Doctor knew that the accident was, in fact, staged. Therefore, the Defendant will be precluded from the asking the Doctor about the stage on accident.

With regard to the Brooklyn action. That involved a default judgment against Dr. Merola, based on 13-day late answer. Subsequently the doctor's motion to vacate was denied. It is now before the Appellate Division. The default judgment decision was not based on the merits. These are allegations of fraud. It detracts from the relevant issues in this case and, therefore, the Court will preclude the Defendant from asking about the Brooklyn action.

MR. DiSIERVI: Your Honor, I take my exception.

Could I put the Index numbers of the two cases in the record?

THE COURT: You certainly can.

MR. DiSIERVI: Thank you, Judge.

THE COURT: I'll just give it to Deborah right here.

MR. DiSIERVI: Perfect.

(Handing.)

Index number 601531 of 2024, Integon National.

Index number 527715 of 2019, Helio Araujo.

THE COURT: Thank you.

Okay. Are we ready for the jury?

MR. BIONDI: Yes, Judge.

THE COURT: Do we have a Doctor outside?

MR. BIONDI: Yes, Judge.

THE COURT: All right. Very good.

MR. BIONDI: Could I tell the Doctor your ruling? May I step out and tell him?

THE COURT: Yes.

(Pausing.)

THE COURT OFFICER: All rise. Jury entering.

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

THE COURT: Thank you, very much. You may have a

seat. We will proceed.

I just wanted to let you know, we had some housekeeping issues that we needed to take care of outside the presence of the jury. That was the reason for our delay this morning.

Thank you very much for your attention.

MR. BIONDI: Thank you, Your Honor.

Plaintiff calls Dr. Andrew Merola.

THE COURT: Okay.

(Witness approaches the witness stand.)

THE COURT OFFICER: Raise your right hand. The Clerk will administer the oath.

THE COURT CLERK: Do you solemnly swear or affirm that the testimony you are about to give, will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: Yes.

THE CLERK: Please state and spell your first and last name.

THE WITNESS: Andrew Merola. A-N-D-R-E-W M-E-R-O-L-A.

THE COURT CLERK: Please state your address.

THE WITNESS: 567 First Street, Brooklyn, New York 11215.

THE CLERK: Thank you. You may have a seat.

Your Honor, the witness is sworn and affirmed.

THE COURT: Thank you.

DIRECT EXAMINATION

BY MR. BIONDI:

Q Are you a physician duly licensed to practice medicine in the State of New York?

A Yes, I'm.

Q How long have you been so licensed?

A Since 1992.

Q Do you have a particular specialty?

A Yes.

Q What is your specialty?

A Orthopedic surgeon.

Q And within is the practice of orthopedic surgery, do you have subspecialties within that field?

A Yes, I do spinal reconstruction surgery.

Q Generally, briefly, describe to the jury what a spinal surgeon does?

A Sure. So orthopedics is that branch of medicine in surgery that deals with your musculoskeletal system, which is everything that you need to be up and walking around, your muscles, tendons, ligaments, joints, bones, et cetera.

Spinal surgery focuses on your spine, which is your neck and back. So everything that has to do with your neck and back, that is responsible for you to be able to get up and about and walk around and do your normal activities.

Q And, Doctor, could you please go through your educational background for us, starting with medical school?

A I went to Howard Medical University College of Medicine in Washington D.C., I graduated in 1990.

I then came back here to New York City. I did an internship in general surgery at State University of New York Downtown State, Kings County Hospital.

I then did a four-year residency in orthopedic surgery at the same institution, Kings County Down State.

When I finished my orthopedic training, I went to University of Colorado in Denver where I did an additional year in spinal reconstruction.

Q And are you board certified?

A Yes, I am.

Q What are you board certified in?

A Orthopedic surgery.

Q Briefly tell us how you became a board certified?

A Sure. Board certified is, essentially, it is an academic process and it starts after you complete your training program. You take a written examination in orthopedics.

Then when you've been in practice for at least two years, you collect all of your cases that you've taken care of, all your patients, basically. And you present them in front of a board of examiners. You actually bring all of those cases with you to Chicago. You sit down in front of a board of

examiners, and they ask you questions about your cases.

At the end of that process, when you pass both parts of that examination, you've been board certified.

And board certified process last for ten years. During which time we're doing the process of recertification, which means we're taking more examinations, we are sending more cases to the board, and we are continuing our education.

Q And, Doctor do you hold any clinical appointments?

A Yes, Sunny Downstate Medical Center, as well as New York Presbyterian.

Q And have you held any teaching positions?

A Yes, both of those institutions.

Q What does that teaching consist of?

A So that is, basically, residents and/or fellows, and/or medical students that are rotating or working in orthopedics and doing their spine rotation. I came into contact with them and teach them about orthopedics and spinal surgery. That involves both being in the office, in the clinical setting, and also in the hospital and operating room.

Q Doctor, in the course of your career, can you tell us or give us an approximation of how many spinal surgeries that you've done?

A So, after I finished my training in 1996, I came back to practice here in New York City full-time. So that was 30 years ago. Typically I do a couple hundred cases per year. So

200 cases per year, times 30 years, that is probably about 6,000 cases.

Q And you alluded to it, just tell us a little bit about what your practice consists of?

A So my practice consists of seeing patients who have spinal problems, in their in neck and their backs. And I treat anything from children all the way up to seniors and elderly adults.

Q And when was the last time you did spine surgery?

A Yesterday.

MR. BIONDI: Could you please hand up Plaintiff's Exhibit 5 in evidence to the witness.

(Handing.)

THE COURT OFFICER: Plaintiff's 5 in evidence has been handed to the witness.

BY MR. BIONDI:

Q Doctor, is that your chart in front of you in connection with your treatment of Mr. DeSouza?

A Yes.

Q When was the first time you saw Mr. DeSouza?

A I have to go through it. I think it is out of order a bit.

Q Sorry about that.

Let me ask you, if you could look at your visit dated September 9, 2019. You can look at the visit dated September 9,

2019.

A Yes, I have it.

Q And, by the way, did Mr. DeSouza to your office with an interpreter?

A Yes, he did.

Q And you did an examination on that date?

A Yes.

Q You took a history?

A Yes.

Q What was the patient's complaints at that time?

A He had symptoms to both his neck and back where he indicated that he had neck had pain that traveled into his arms and hands. And he was also having back pain which traveled into the legs and feet.

Q Did you conduct a physical examination at that time?

A Yes, I did.

Q Okay. And that is with respect to both the cervical spine and the lumbar spine?

A Yes.

Q So, what were your findings in connection with -- let's look at first the cervical spine?

A Sure. So, in his cervical spine, looking at the his ranges of motion there were palpable spasm and tenderness in his neck. He had something called the positive Spurling maneuver, which is a test whereby you take the patient's head, basically,

while examining them. You push down, rotate, and turn, in order to try to reproduce symptoms that the patient is complaining about. And you're trying to see if there's any spasm or resistance to you performing that particular activity.

If it is positive it reproduces the patient's symptoms. If it is negative it means that it does not. In this case it was positive.

And you look at where the symptoms are reproduced. In this case they went down into the area where the thumb and the index figure is, which is a specific area of nerves that come out of neck, which are related to the C5 and C6 nerves.

Q Okay. And what were the significance of those findings in connection with Plaintiff's condition?

A Sure. So when you see a patient in the office, you try to find out what bothers them. And then you try to figure out what possible issues are going on in their body that could be causing their symptoms. So the symptoms are important. The physical exam then correlates those symptoms.

In other words, we put together the symptoms with their physical findings. If you have a patient that has pain that travels into their arms and hands, when you compress, and rotate, and bend them, and it reproduces symptoms into a distribution of a nerve, that is an indication that there's irritation in that nerve area.

Q Okay. And did you also do a lumbar exam on that visit?

A Yes, I did.

Q What were your findings with respect to the lump spine?

A So the lumbar spine, the examination proceeds along the same lines, which is, in this case, feeling the spasm in the back. In the lower back the tests for nerve root irritation are something called a straight leg raise. And in this case he had a straight leg raise on his right side. And that means that when you're pulling on the large nerve that comes down your leg, your body wants to pull away from that if it is causing pain and it is irritated.

So a positive test is, you feel the patient pull away from you, plus they complain about pain in the nerve distribution. That is a positive test.

A negative test would be, you would able to get your leg all the way up without any symptoms traveling down your leg at all.

In this case it was positive. And there was also some loss of the Achilles tendon reflexes. Those are the tendons at the back of your leg that go into your heel. If you feel back there it is a big tendon. That tendon is controlled by the L5 and the S1 nerve reports.

Q And again, Doctor, what were the significance of those findings in connection with the Plaintiff's condition at that time?

A So, when you corollate your physical findings with the

patient's complaints, you can understand that they are having, what we call a radiculopathy. That is a problem with their nerves. Where there is nerve irritation coming from the neck area and nerve irritation coming from the low-back area.

Q And, at that time were the MRI films, the cervical and lumbar, available for your review?

A Yes.

Q And did you actually look at those films yourself?

A Yes.

Q And what was your interpretation of the -- let's start with the lumbar MRI.

That was a lumbar MRI that was done on July 8th of 2019; is that correct?

A Yes.

So, when looking at the MRI film there was, essentially, what is known as a herniation at L5-S1, which is an abnormal protrusion, or a sticking out of disc material in between the L5 and the S1 segments.

Your lower back has five segments. Your pelvis begins with what is known as the first sacral segment. So if you are between L5 and S1, you're at the lowest part of your back in the area where the L5 nerve roots and the S1 nerve roots are.

Q And what was your interpretation of the cervical spine MRI film, which I believe also was conducted on that same date July 8, 2019?

A So, the MRI of the cervical spine showed an area that correlated with his symptoms between the C5 and the C6 vertebrae. And I've describe it as a symmetrical disc protrusion at C5-C6.

Q And, Doctor, with respect to lumbar spine, were those MRI findings consistent with the Plaintiff's complaints at that time, as well as your physical examination?

A Yes.

Q How were they consistent?

A The physical findings corroborated what the patient was complaining about. So he had positive provocative finds with correlative symptoms. So the symptoms are what the patient is telling you is going on. And the physical findings is what is happening as you examine the patient's body.

Q And same question with respect to the cervical spine. Was the MRI consistent with the patient's complaints and symptoms, as well as your finding on examination?

A Yes.

Q For the same reasons?

A Yes, correct.

Q So, Doctor, what I would like to do now, I would like you to take a look at those MRI films. Why don't we start with the lumbar.

(Pausing.)

So, you can describe for the jury exactly what it is

that is on those films.

MR. BIONDI: I will ask you to come down with the Court's permission?

THE COURT: Yes, of course.

MR. BIONDI: Would you like a chair, Doctor?

THE WITNESS: If I'm kneeling or standing, that is fine, I'm not used to sitting all day.

Q Okay.

MR. BIONDI: For the record, Your Honor, we have up on the screen MRI films.

THE WITNESS: I have to scroll through these to find the 2019 films.

(Pausing.)

THE WITNESS: Here is the July -- this is July 8th.

MR. BIONDI: For the record, Your Honor, Plaintiff's Exhibit 23.

(Shown.)

BY MR. BIONDI:

Q Which film are you looking at?

A Okay. So these on the screen, you could see in yellow, July 8, 2019, up at the top. On the top part of the screen, there's three images. Those are the lower back MRI of the lumbar spine, with the patient facing the clock.

And with this one, this is a top down view where you're looking down into the spinal canal. You would be looking like

this.

These are the side views as if you were looking from the side.

So these are the three areas of the lumbar.

And then if you use the mouse, you could kind of cycle through. For example, here I am I'm looking down into the lower back area L5 and S1. These are slices or cuts. And these slices and cuts, they are a thickness of typically about a half centimeter or so, like you are slicing bologna cutter.

If you look down here between L5 and S1, which is on the bottom. You're looking at this Y. This Y shape is the top of what is known as your spinal canal, which is the area where your nerves are.

Out in front, this ovoid area is the area of the disc. And that area is coming into these little white areas, these little white areas are fat inside the canal and where the nerves are.

If you see something gray, it is a nerve. If you see something bright or white it is either fat cerebral spinal fluid. So here between L5 and S1, if you scroll through all these areas, particularly, on the side view, you could see that these discs between L4 and L5, 3 and 4 and so on, are relatively well contained in the margins of the vertical body.

At L5-S1, you could see that there's something that looks like something poking out beyond the margins of the

vertebral body. This thin gray line that is passing behind that area is an area where the nerve root is, inside the sac that contains the nerve roots.

And because this little poking out area is pretty much localized to kind of the central region, it is a protrusion or a sticking out. It would be classified more as a herniation, more so than a bulge.

A bulge is symmetrical protrusion. A herniation is an asymmetrical protrusion.

Q So, I believe you told us that your interpretation of the MRI is that there was a herniation with impingement at L5-S1; is that correct?

A Yes.

Q Is that what you just showed to the jury as depicted on the MRI film?

A Yes. I have the curser on the area that is abnormally protruding. That is next to the disc herniation. This is the sac that contains the nerves. The gray signals -- when we talk about MRI, we talk about signal. The gray signals here are nerves. You could see that there is -- here is another picture where that is a nerve region.

These discs -- this disc here is coming into contact with these nerves down at the lower part of the back.

Q What image is that?

A Okay. This is Series 3. And it looks like 2, 5, 6 --

no. That is not the image number. They have it down as time. So that is 11:55:52.

Q That is fine. So, Doctor, you mentioned the term impingement. Can you describe what that means for the jury?

A Typically what that means is, that there's an area where the disc is coming up into contact with a nerve, which will cause some irritation to the nerve which can result in pain.

Q And was your interpretation of that MRI of the lumbar spine of July 8, 2019, consistent with the MRI report for that MRI?

A I believe so, yes.

Q Okay. And, Doctor, could you turn to the cervical MRI of that same date?

A Sure.

Q Before you begin. You testified that your interpretation of the cervical MRI was a symmetrical disc protrusion at C5, C6; is that correct?

A Yes.

Q Could you show the jury that on the MRI?

A Sure. So, if we are looking at the top right two images. Those are the side view images of the neck.

Down on the bottom we're looking at the top down images.

And if we go to the 5, 6 area, which is where this

yellow line is, on 11:38:45. We could see that in the top down view, this dark shadow is a symmetrical protrusion of disc material into the area of the spinal canal.

The neck is a little different than the lower back. Because here, in the neck, we don't -- individual nerve roots come out of the openings only. The spinal cord in the neck. The spinal cord contains the cell bodies for the nerves. And the spinal cord is the continuation of your brain. That is known as the central nervous system.

Your brain and spinal cord are central nervous system, which is important because the brain and spinal cord function a bit differently than your peripheral nervous system, which are just nerve roots. Low-back, peripheral nervous system, just nerve roots.

Cervical spine, central nervous system, big thick gray line coming out of your brain containing the cell bodies for the nerves.

This top down view showing a symmetrical protrusion of disc at C5-C6 impinging upon your -- going into the spinal canal region.

You could tell that the area where the nerves exit, there's a little more narrow on the left than right on 12:07:15.

And as you travel up it cuts. Here are two cuts per disc level. So the one cut that I showed you, showed a little bit of narrowing on the right side, this one just above shows a

touch of narrowing on the left side. For the most part it is symmetrical disc protrusion.

Q And what is the significance of a protrusion being symmetrical?

A So if you think about -- the disc is kind of like -- it is a piece of cartilage. It has like a squishy jelly-like inside and a tougher outer covering called a ring, which is made up of these interwoven fibers.

There are different ways that the disc can stick out, right. So for lack of better term, something sticks out, it protrudes. And there are two basic ways that something can protrude. It can produced symmetrically, which means it goes all the way around evenly. Or it can produced asymmetrically, which means it is coming out a little more in one area than the other.

In general, if someone says there's a herniation, it refers to asymmetrical protrusion of disc;

If someone says there's a bulge, it refers a symmetrical protrusion of disc.

Q And, Doctor were those cervical MRI findings consistent with the patient's complaints and symptoms, and your physical exam and findings?

A Yes.

Q Why is that?

A So, this spinal cord area and the nerves that come out

of the spinal cord at C5 and C6 travel down into your hands and fingers, between your thumb and index fingers. If you think about it that way, it kind of makes a six, right. So that is an area that correlates to that C5-C6 area. The lower part of the back, these nerves that are down here, and the lowest portion of your back, make up part of the sciatic nerve that travels down back in your leg, which controls the reflexes on the back of your leg and the Achilles' tendon region.

Q Okay. Doctor, I would like you to assume that there may be testimony in this case from a radiologist called by the Defendant, that his interpretation of the lumbar MRI film of that date, was the degenerative disc disease, degenerative arthropathy and a disc protrusion at L5-S1.

Do you agree or disagree with that proposed testimony?

A So I agree there's a disc protrusion at L5-S1. I see it as more central, which is asymmetrical and, therefore, by my definition a herniation.

In terms of the degeneration. If you look at -- the discs should contain a certain amount of fluid or water. As you get older you could lose that fluid and water. And that would be what we call a degenerative disc because it is losing fluid and water. There's some grade of the disc between L5 and S1. It is not so much worse than any of the other discs are. There's still a signal of brightness within that disc. Si it still has some fluid in it. You could say there's a little bit

of degeneration in there.

The other thing I would say is, you know, when you say degenerative disc disease, you put the term disease on something, it means that there's a clinical problem, right. So when a radiologist makes a reading, that reading can hint at a clinical problem. But technically really can't diagnosis the clinical problem, because you could have a degenerative disc that is completely and entirely asymptomatic and you would not know unless you were with the patient and examined him.

Q And as we age, are all of us here, unfortunately, going to have a certain amount of degeneration in our spine?

A Yes.

Q And is that part of the normal aging process?

A Yes.

Q To what extent would you describe the degree of degeneration in the lumbar spine for Mr. DeSouza?

A So, if you were to go from a scale with zero, no degeneration, completely and entirely healthy person, to five, which is bone on bone, rubbing with massive big osteophytes and all sorts of stuff, this is like maybe a one and-a-half, maybe a one.

Q Okay. And while you're up there. I would like you to further to assume that there may be a radiologist called by the Defendant who may testify that the July 8, 2019, cervical MRI indicates degenerative disc disease, degenerative arthropathy,

no acute herniations or annular tears.

Do you agree or disagree with that interpretation?

A Okay. So if we take step-by-step, I believe the first thing you said was degeneration. So here again, if you look at the discs and the cervical spine is smaller than the lumbar spine, so these discs are tinier than the low-back, we could see that the signals are -- once again pretty well maintained.

There's a little bit of loss of signal here between C3 and C4 on that particular cut. But if you go to the next cut there's signal in there. So the same holds true with C4-5 and same holds true with C5-6. So once again, if you would, there's a grade one kind of degenerative thing going on in the neck. I would not completely entirely disagree with that.

Q Then you said, degenerative arthropathy?

A So arthropathy looks at the joints. To look closer at the joints you have to look at this film here. These joints -- so this is a joint, here. And if you look just at the joint in the way we're looking at it, think about it as a hamburger.

This gray line here, that is the hamburger pattie. There is a bun on top and bun on bottom. If you think that looks like hamburger, okay. If it is degenerative and has arthropathy, which means it has bone spurs. Picture a hamburger with a bun spilling over the sides. So that looks like not too bad of a hamburger. This bun looks like a little bit of a smaller hamburger, not too too bad.

This is down the thoracic spine. They have a different appearance. That one, not too bad, not too bad.

So, I mean, I would not say there's significantly degenerative. So it is not really arthropathic.

Again, if you look at that slight losses of fluid, yeah, I mean, you could say he has on that scale of zero to five, maybe a grade one kind of degenerative changes on the cervical spine.

Q And there may be proposed testimony from the Defendants' radiologist that he doesn't see any acute herniations or annular tears on that cervical MRI.

Do you agree or disagree with that?

A So acute means of immediate onset, right. Abrupt or immediate onset. Sometimes it is very easy to make a decision about something that is acute. You see a fracture and it hasn't healed, that may likely be acute. If you see blood, that is some indication of an acute problem. If you see a lot of swelling, that is an indication of an acute problem. So, I would agree, you don't see any of that stuff here.

And annular tear, that would mean a tear in those fibers of the anulus. Depending on the slice thickness of the MRI. And if you look at the thicknesses of these slices, it is each jump of the yellow line. That yellow line does not take into consideration every micromillimeter of disc.

So there can be an annular tear present that is not

large enough to appear on the MRI.

Q And, Doctor I'm not sure if I asked you this. Was the patient's complaints and symptoms, and your findings on your cervical exam consistent with the cervical MRI films that you just described for us?

A Yes.

Q Why is that?

A Pain in the neck and back traveling into the arms and hands, legs and feet. Positive physical findings with disc findings at 5-6 and 5-1 corollate with, or add up to a patient having the problem that they are complaining about.

Q Now, Doctor, as of that first visit on September 9, 2019, what was your plan?

A He had had some nerve testing done. The plan at that point in time was to see and review the nerve testing.

Q You next saw the patient on September 16th?

You can have a seat.

(Witness resumes the witness stand.)

Q At that visit the EMG results were available to you?

A Yes.

Q Okay. And, first of all, just describe what an EMG is and what it is designed to do.

What is it designed to tell us?

A Sure. An EMG is kind of like an EKG, right. So for your heart, to test your heartbeat, what is happening with the

electrical system in the heart, you would do an EKG.

An EMG is very similar but for your nerves. The "M" in EMG refers to the muscles. So, if you think about what your nerves do, they do multiple different things, right. Think about your arm and your hand, you could feel stuff. So the nerve is responsible for feeling things. You could have pain going down your arm and your hands, so the nerve is responsible for pain. You have reflexes in your arm and your hands. So the nerve is responsible for reflexes. And you have muscles in your arm and your hand, so the nerve is also responsible for the muscles.

The EMG specific looks at what portion of the nerve is having a problem with the muscles. And the significance of that is the pain fibers of the nerve and the sensory fibers of the nerve have a tenancy to get much better if you treat them, particularly, if you take pressure off of them.

The muscular portion of the nerves have a tendency not to get completely and entirely better, and are much more prone to having -- for lack of a better term, some damage, if there's prolonged irritation or compression of a nerve.

So when you're looking at an EMG, you're looking at one of the very critical parts of the way your nerve works, which is the muscle portion of the way the nerve works.

Q And is an EMG test an objective test?

A Yes.

Q And what do you mean by that?

A Subjective is what a patient tells you. So if they say I have pain in my neck, it goes into my arm and hand, that is subjective. That is what the patient tells you.

If the patient tells you, oh, I could only move my wrist this or that much, that is subjective because the patient has control over that.

Something that is objective is not under the patient's conscious control, such as an EMG test, for example.

Q And what were the results of the EMG test on Mr. DeSouza?

A I looked at them and I -- to me they look like they are consistent with radiculopathy, which is a problem with the nerve roots.

MR. BIONDI: Could you hand the witness Plaintiff's Exhibit 1?

(Handing.)

THE COURT OFFICER: Plaintiff's Exhibit 1 has been handed to the witness.

Q Actually, are the results in your chart from the EMG?

A I don't know that I copied them and placed them into the chart, I just read them.

BY MR. BIONDI:

Q I believe the EMG results are in that exhibit, Doctor. I ask you to find them.

(Pausing.)

A Yes, they are.

Q Actually there were two EMG tests. The first one was on July 16, 2019?

A That is correct.

Q Can you read the result of that EMG?

A Sure. So, if you're looking at this EMG, it has what are known as positive sharp waves and positive fibulation potential. And sharp waves and fibulation potential refer to abnormal nerve activity as the nerve is working inside of a muscle in it. The areas that are abnormally functioning are L5 and S1. And also here indicated the C4 and the C5 nerve roots, which are the fifth nerve roots adjacent to the C5-C6 segment.

Q Could you read the impression?

A Sure. The above EMG study is abnormal. There is evidence of right C5 and bilateral S1 radiculopathy.

Q And, Doctor, were the results of that EMG consistent with the patient's complaints and symptoms, your findings on examination, as well as the actual MRI films?

A Yes.

Q Explain how that all went together?

A So we start with the patient's symptoms. Neck pain radiating arms and hands; back pain radiating legs and feet.

Part II, physical exam. Reproducing those symptoms and findings in between the fifth and sixth roots and down between

the fifth and first roots, positive physical findings.

Part III. We're looking at the MRIs in those areas and they correlate with everything we have seen so far.

We also have a electrodiagnostic study that says those nerves are having a problem with the way they are functioning inside the muscles.

Q And, Doctor at this point now, after your second visit, did you have an opinion with a reasonable degree of medical certainty as to whether the accident that Mr. DeSouza had was a substantial factor in causing or contributing to his complaints and symptoms, as well as your findings on exam?

A Yes. So based on the information that I had available to me, which included the patient and the treatment therein for those visits, I would make that conclusion, yes.

Q And why is that?

A That there was a date of accident. I didn't have any prior contributory neck or back issues with respect to the past medical or surgical history regarding his neck or back. He had complaints and symptoms that were consistent with his physical findings. They were then further consistent with his diagnostic films and studies. And also happen to be consistent with his electrodiagnostic testing.

Q Was your plan at that time to request authorization for surgery?

A Yes.

Q And the first surgery was with respect to the cervical spine?

A Yes.

Q And what type of surgery did you request authorization for?

A Basically what is known as a decompression. That is removing pressure from the spinal cord and the nerves, and stabilization which is called fusion. So basically a decompression and a fusion. Also known as an anterior, which means through the front; cervical, which means your neck; discectomy, complete removal of the disc; and spinal fusion, which refers to stabilizing the area that you remove pressure in.

Q And then do you have to wait for until you receive authorization to actually perform the surgery; is that correct?

A Yes.

Q So after that second visit you have a number of -- the patient had a number of visits with you; is that correct?

A Yes.

Q And where his complaints and symptoms essentially the same during those subsequent visits?

A Yes.

Q And then you actual performed that cervical surgery on July 21st, 2020?

A Yes.

Q And what was your preoperative diagnosis? You could look at your operative report.

A Sure. So I indicated there was a cervical spine injury with an associated herniation, myelopathy and radiculopathy at C5-C6.

Q What is a myelopathy?

A That refers to some evidence of spinal cord irritation. There's spinal cord in the cervical spine that can happen with patients who have this condition.

Q And what was your indication or indications for that surgery?

A So indications are the rationale why you would do the surgery.

The primary reason to do the surgery is to stabilize the condition to prevent it from getting worse; but I listed what it was that was concerning. And the things that were concerning were Spurling maneuver, loss of reflexes, some sixth nerve root weakness, which went along with the electrodiagnostic studies. Something called a Hoffman sign, which is -- it is a sign of early spinal cord irritation. If you take a patients hands and you basically hold them, relax, and then you kind of flick the middle digit, the tip of your middle digit, you should not really see any response in the hand. If you see that the hand tries to contract, it is a sign of some spinal cord irritation.

Q Did you also indicate sensory loss and reflex loss?
A Yes.
Q Motor weakness?
A Yes.
Q All the concerns you said you have, the myelopathy and the radiculopathy, the positive Spurling, positive inverted flexor response, positive Hoffman, sensory loss, the reflex loss, are all of those things what you would consider neurological findings?
A Yes.
Q And are those neurological findings consistent with compression?
A Yes.
Q Describe that for us?
A Essentially nerves and spinal cords don't like to be irritated. And irritation can come in two major forms. One is compression, which means that when your head and your neck are moving around, the area that is kind of protruding is banging up against your nerves, so it doesn't like that. Your nerves don't like that.

The other thing that your nerves don't like is the disc can also leak internal chemical irritants that additionally disturb the nerve.
Q And what was the nature of the surgery that you performed?

A So it's the surgery that has going through the front of the neck, because there's a spinal cord on the backside of your neck. Typically procedures that are done through the back of your neck are something that, if possible to avoid are avoided, because you're dealing with a cord. You don't really want to put any pressure on a cord or touch a cord.

The disc is easily accessible through the front because it is right between the crease between your windpipe and your sternocleidomastoid muscle. There's a crease here if you put your finger in there and just push, you'll find yourself touching the bones and discs in your neck. It is an very easy area to get to. The only thing that you really have to cut is the skin. And then you just basically move everything away and you're looking at the bones and disc. So it is easy to access that area from the front. It is also very safe. Because the disc then is removed through the front. So you start to scoop away disc and you scoop away areas of the bones in order to make room to get to the backside of the disc, in order to get into the canal to make sure no pressure on the spinal cord and the nerves. So it is a very easy -- if you think about surgery in easy ways -- but it is an easy way to access that area. It is a safe way to access that area and it is a safe way to remove pressure on a cord and on nerves.

Q And you performed what is called a cervical interbody arthrodesis of C5 and C6. What is that?

A That is also known as fusion. A fusion basically means you're gluing those bones together and you're turning them into one bone.

The disc between the bones act as a shock absorber it also makes sure that the bones maintain their normal position; both their height and the way they move.

So if you're removing all of these things that are on the front side of your spine, you might imagine there's no stability there after all of this stuff has been removed. So you need to basically glue everything together in order to prevent it from collapsing or moving in an abnormal manner.

Q Any connection with that, do you place some type of spinal instrumentation?

A Yes.

Q What is that?

A There are two things that you use -- actually three things.

One is that you take away the bone that you've removed and you grind it up with a little bit of donated bone. That is known as bone graft. Your body turns that into new bone because bone will regrow over time. And you put it inside of what is known as a cage or biomechanical device. It is just a fancy way of saying shim. If you ever put a shim underneath a piece of furniture to level it out or prevent it from moving, we basically take a shim of the identical size of the space that we

have made, slip it in between the bones so that we recreate the appropriate height and their alignment. And then we put a titanium clip on the front of the bones to lock it in place so that the patient can then after surgery get up and walk around and do their normal activities while the bones heal.

Q And did you also do what is called partial vertebral resection at both C5 and C6?

A Yes.

Q Describe how you did that? What is the purpose of doing that and how you did it?

A Sure. So when you're taking the disc out, in addition to removing the disc you're going to rebuild that area and you're going to want to make it turn into one piece of bone. So you have to scoop away portions of C5 and C6 to be able to get that shim in there and the bone graft to get everything to heal together.

The other thing is that you want to be able to access the spinal canal safely in the area where the nerve roots are safely so that you can make sure there's nothing left behind that can be causing any more impingement and irritation.

Q And your operative report indicates that you did a decompression of the spinal cord nerve roots at C5-C6. What is that?

A Exactly what I just described.

Q Okay. And so, in fact, is that the actual purpose or

goal of this entire surgery is to do the decompression?

A The decompression and then to stabilize it so that it doesn't continue to cause any more damage.

Q Thank you.

Now, there was a subsequent cervical MRI that was done on October 4th of 2021; so what is that, about 15 months later, or thereabouts?

A Yes, correct.

Q And I would like you to assume that there may be testimony from a defense radiologist, that based upon his review of that cervical MRI, the 10/4/21 MRI, that there was evidence of a discectomy and fusion at C5-C6. But that that cervical MRI doesn't demonstrate that a corpectomy/resection was performed.

Do you agree or disagree with those opinions?

A So I agree in part. I agree with the fact that he's seeing the discectomy and the spinal fusion. The essence of the fusion is to get bone to grow in there. So at about -- honestly at about six to seven months you're going to start to see bone regrow. You're going to start to see regrowth of bone. It is very difficult to comment on whether or not you do or do not see any corpectomy there. You really want the bone to grow back, otherwise you would not have one big piece of bone or a fusion.

Q And, Doctor, I would like you to step down and take a look at that 10/4/21 MRI and tell us what is on those films?

A Okay. So I'm looking at the bottom right-hand portion

of the video screen. I have a date 10/6/21.

Q There was one on 11/04 and one on 10/6; the one with contrast and one without?

A So this is 10/6/2021.

Q Okay. Which is the better one to show the description of what is there?

A This is the one I just bumped into.

They are both going to show what is there. It is pretty clear on both.

Q Okay, that is fine.

A So, if you look at the side views of these, this is the base of your brain. The gray stripe is your spinal cord, basically brain spinal cord.

These are the bones, these grey 2 are the bones, 2, 3, 4, 5, 6, 7. In between the bones are the discs.

What you see here, you kind of see this black area that looks like there is kind of a blackout or a blur out in that region. That happens because the MRI is -- it is a magnetic study. Your body is magnetized. The implants, although they are titanium and have a very low affinity for being magnetized. Nevertheless, they will cut out some signal in the area where the implants are. And that is why you kind of see them kind of blacked out a little bit here.

So those are the implants in the C5 and C6, the vertebral body within interbody cage.

You see a little bit more dark on this particular image, which is 14:10:01, and also 14:08:24.

Q And 14:08:22 and 14:10:00 show the areas that kind of -- you see some whiteness here in this vertebral bodies. There's a white signal that you don't see in the other vertebral bodies. Those are areas that bone is growing into the areas where the vertebral body was kind of removed. The reason for that is the cage that is in there.

So you could see that this little round area with gray inside of it is the cage. And you could see there's a signal changes adjacent to the cage, which is the area where the implants are, where the bone graft is growing into everything, which is what you want it to do, particularly, at this stage?

Q Is a corpectomy the same thing as a vertebral resection?

A So when you say the word corpectomy, you're saying a removal of the vertebra or the vertebral body. Vertebral bodies, there's kind of a square front. There are these things transverse processes. There's a lamina, facet joints, those are your bodies.

Corpectomies in any degree that you do them are designed to do a couple of different things. When you're decompressing something, the rationale is to make sure you have a complete safety compression. If you have a deformity, kyphosis, you're hunched over, or scoliosis, you're turned over

to the side. Corpectomies are done to reestablish some kind of better alignment. They are done different ways and under different methods in order to accomplish different things.

Q Is that different than a vertebral resection or is that the same thing?

A Resecting means removing. Ectomy means removal. So if you're ectomizing or resecting, you're removing things.

Q And, Doctor, did you do a partial vertebral resection at C5 and C6?

A Yes.

Q How do you know that those resections were done in this particular case?

A So, I mean, you could see the MRI changes here. Plus intraoperatively, you have to put -- you got to get a cage in there, and you've got to make sure there is no more pressure on the spinal cord or the nerve roots. So really the only way to do that is, you have to take out some bone in order to make that happen.

Q So, just so that I understand. To make room, so to speak, for the cage to be put in there, by definition, you have to do this partial vertebral resection; is that a fair statement?

A Yes.

Q There was a fluoroscopy?

A It is a picture you do during surgery in order to make

sure you're at the correct level.

You might imagine, portions of your spine all kind of looks the same when you're looking at it; but you can make sure that you are where you are. And you can make sure that your implants are in the right place by taking a quick intraoperative fluoroscopic image. A fluoroscope is a modified x-ray device that takes images during the surgery in very small increments. You basically push the button and a quick image to make sure you are where you think you are, and make sure the implants are not in a bad place. You want to make sure they are in the good place.

Q Are any fluoroscopy images going to add or show anything more than you've already described for us on these MRIs?

A What they will do is they will confirm is that at C5-C6 we placed our implants and placed our cage and did the procedure.

Q Okay. So it doesn't add anything to the MRIs in terms of the actual procedures that were performed?

A No.

MR. BIONDI: Your Honor, is this a good time to take a couple minute break?

THE COURT: That is a good idea.

Ladies and Gentlemen of the Jury, we are going to take about a 5 or 7-minute break. Please just remind you do

not discuss the case, have the case discussed in your presence, or conduct any internet searches of any kind.

Thank you, very much. We will see you in about 5 to 7 minutes.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom and the following is heard outside the hearing and presence of the jury.)

THE COURT: Doctor, please just a reminder, you're under oath. Do not discuss the case with anybody.

THE WITNESS: Yes.

THE COURT: Also, if you do need to use the rest room, you could use only the first and the third floor, not the second floor rest room.

Thank you.

(Recess taken.)

THE COURT OFFICER: All rise. Court is in session.

THE COURT: Mr. Biondi, are you ready to go?

MR. BIONDI: Yes.

THE COURT: All right. You will bring the witness back to the witness stand and we could get the jury.

(Witness resumes the witness stand.)

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury enters the courtroom and the following is heard inside the hearing and presence of the

jury.)

THE COURT: Thank you. Have a seat. We are going to proceed.

Dr. Merola, just a reminder, you're still under oath.

THE WITNESS: Yes.

MR. BIONDI: Thank you, Judge.

BY MR. BIONDI:

Q I would like you to turn to the patient's visit to you dated September 28th of 2020?

A What was that date?

Q September 28, 2020?

A I have it.

Q Okay. And this was a postoperative visit in connection with the cervical surgery?

A Yes.

Q What were the findings with respect to a cervical spine at that visit?

A So he had said that surgery was helpful. It helped decrease pain going into the arms and hands.

Physical exam as well?

Q Yes.

A And on his physical exam for his neck, he had some restrictions with spasm, which I thought he had about 50 percent of his normal motion. No progressive neurology deficits, no

other deficits or issues.

Q Okay. At that visit you also addressed his lower back complaints; is that correct?

A Yes.

Q Okay. What were your findings on exam in connection with the lumbar spine at that visit?

A Sure. So he had said that his low-back was getting worse. In the low-back area he had -- so he had a straight leg raise test which was also positive, that was consistently positive. But he also had something called a femoral stretch test. It is like a straight leg raise but it is on the front of the leg.

So if you think about the sciatic nerve goes down the back of the leg goes into your butt. Hamstring, your soleus-gastroc in the back of your leg, that is your sciatic nerve.

The front side of the nerves that go down your legs into your quads and into the front part of your lower legs, below your knees, that is where your femoral nerve is mostly located.

So a femoral stretch test is the analogous test to a straight leg raise, but instead of pulling on the sciatic nerve, you're pulling on the femoral. That is the area where the quadriceps are.

Once again, if the patient pulls away from that, it is

positive, which means there's some irritation there.

That was relatively a knew finding here in September of 2020.

Q Did you test any sensory loss?

A His sensory loss -- when I originally saw him it was, mostly L5 and S1 and this time he started to have L4 nerve root sensory loss.

Q He had some difficulty with certain activities?

A Yeah, his low-back, as I said, he said that it was getting worse. He noticed an improvement in his neck and noticed a decrease in his low-back condition and effort-related low-back activity-like putting on shoes and socks, and things like that increased his symptoms.

Q Could you tell us something about an extension maneuver?

A Yeah. So that is another test where, instead of pulling on the nerves, what you're doing is you're trying to compress the canal. So in the neck, remember we had the Spurling where you're pushing, turning, bending.

In the lower back, if you bend the spine backyards and you're closing down the areas where the nerves are, that is called a spinal failing. If that is positive, there's nerve root irritation in the lower back.

Q So, Doctor, your finding on that exam are the positive extension maneuver, the positive femoral stretch testing, the

positive straight leg raise, the sensory loss at L4/L5 and S1. Were all of those findings considered neurological findings?

A Yes.

Q And are those neurological findings consistent with compression?

A Yes.

Q And what was your plan at that time?

A Well, he had subjective complaints. His low-back was getting worse. Objectively his examination showed that he did have some deterioration in his low-back condition. So I suggested an updated MRI.

Q And that MRI was performed on September 28th of 2020?

A Yes.

Q And what were the results of that?

A Okay. Let's see. And that office visit -- I want to go to the office visit for that.

Q I think that was November 2nd of 2020.

A Correct, yes.

So that MRI showed that he had actually developed a new onset herniation at L4/L5 on the right side, which was displacing the exiting L4 nerve root. L4 comes out directly below the L4 region.

The L5 root was pushed over to the side a little bit but more on the L4 root which was consistent with his increasing symptoms.

Q So, in plain language. The condition in his lumbar spine was getting worse at that point?

A Yes.

Q What was causing this nuance of a herniated disc at L4/L5?

A So if you think about the way the disc is put together, jelly on the inside, fibers, they are woven together on the outside. For a disc to protrude, bulge, or herniate, there has to be some defect, that is a problem with those interwoven fibers. There can be tears in those fibers that did not heal. Because they are avascular, they do not have a blood supply, per se, like most of the other tissues in your body have a very vigorous blood supply and heal very nicely. That is not so with pieces of cartilage, like the outer anulus of the disc.

If there's an area that has a tear in it and it doesn't heal, and you're up and about and walking, and the disc is shock absorbing and doing it's job, slowly over the course of time that material can start to protrude and you could develop another herniation. Which should the rationale for having updated the MRI in the first place.

Q And, Doctor as of that point, did you have an opinion, with a reasonable degree of medical certainty, as to whether the accident was a substantial factor in causing or contributing to all of the patient's complaints, symptoms, and your physical findings at that time, including the new onset of that L4/L5

herniation in the lumbar spine?

A Yes.

Q Why is that?

A There was no interval history of illness or injury. The MRI didn't show any -- what we would say are occult findings like an infection, or a tumor, or anything else that would be explaining that herniation at L4-5. And it correlated with his symptoms where he said his low-back was getting worse.

Q I'm going to ask you to come to the screen again and just show the jury the herniation at L4-5?

A What was the date on that?

Q 9/28/2020?

A 9/28/2020. All right.

Yes, this is the lower right-hand corner of this video screen. September 28, 2020. It is the side view of the lower back. So on that side view, when we're taking the cuts, as the cuts go through you, they go from one side to the other. They go from the left side to the right side.

So we're going to look at different slices in that region. What we could see L5-S1 in the center. We know it is the center because we see a big canal region. L5-S1 still has this central -- what we had seen from before, the herniation. It is persistent, still there.

L4 has some pretty bright disc signal. If you go further away from the center, we are now looking at the area

where the nerve roots exit. They exit through an opening called the neuroforamen. Means the nerve opening. Foramen means opening. Those openings should be large enough to contain a nerve root and fat around the nerve root.

So, if you look at this level between L3 and L4, that is the opening. You see the gray signal in the middle. That is the nerve root. And you see there's brightness around the nerve root, which is fat surrounding the nerve root. You could think almost think of it a sunny side up egg. The egg yoke in the middle, the nerve. The egg white around it is the fat sort of floating in it as it exits the neuroforamen.

What is happening here between L4/L5. That does not look like a sunny side up egg. It looks like a squashed neuroforamen. Why would you have a squashed neuroforamen?

Two things could happen. One, a big joint that swatches the neuroforamen. Or two, you could have a disc that protrudes into the neuroforamen.

If you look at the other, you could see the beginning of the protrusion here as it starts to encroach on the canal. That is 11:5913.

And then here at one section beyond that, it says 11:59:13 but it is the next cut over. You see that foramen is cut off.

The other thing happening there is -- this is interesting. If you look at the joints are these areas that are

lining up on top of each other like this. And they are right behind the area where the foramen is. There's a little fluid in that joint which means that that joint is taking up extra stress. That disc is abnormally protruding.

All of those things are leading to a displacement of that L4 nerve root that wants to exit there. And the L5 nerve root right next to it.

Q Thank you. You could sit down.

(Witness resumes the witness stand.)

Q I want to go ahead to the lumbar back surgery. That was done on March 16, 2021?

A Yes.

Q And you had -- similarly like the cervical spine, you had to wait for the authorization to do that procedure and you got the authorization and finally did the surgery at that time?

A Yes.

Q So tell us what the indications for that surgery were?

A So the indications were, or the reason for doing it were, the patient was getting worse. And the worsening in his condition included not evenly on his symptoms, but it also included some sensory abnormalities in the L4, L5 and S1 nerve roots. Also included a little bit of weakness, which I graded as three plus, three over five on his right side, which is where most of that compression is happening, in a tendon called the extensor hallux longus, which is your big toe. It is your big

toe extensor. It is the one tendon that goes into your toe that makes your toe do that. That is L5 nerve root.

Also a tendon called the tibialis anterior, which is a tendon that comes down the front of your ankle which is responsible for making your foot ankle raise when you're walking around. Three over five means the muscle weakness was better than gravity. So five is really strong, you could lift weights; four is not so strong, maybe not able to lift weights; three is it is working against your body weight and gravity; two is less than gravity; one is worse than that; and zero is nothing.

So, he had had a clinical condition which had deteriorated, combined with MRIs that showed he's deteriorating because he's got compensation here at L4-5 and compression in the L5-S1.

Q Doctor, describe the surgery that you performed?

A Sure. So this is a little different than the neck. Because this is done through the back in your lower back. It is an incision made straight up and down in your lower back. You move the muscles out of the way so that you could look at the vertebral bodies.

You then begin by removing the areas of the canal that cover the canal, or where the nerves are. That proceeds to including removing portions of those joints that you see, that are blocking up the area where the nerve is. And then, additionally, you're also once again scraping away areas of the

bone, what you would call a partial corpectomy, to make sure you have no pressure in any of those areas and also to accommodate bone when you do your fusion. We're going to fuse or glue this area together as well. Which means we're going to put bone in there and have bone grow back to stabilize the area we took apart in order to prevent it from getting worse.

Now, the other difference with the neck is, in the neck, not only did we go through the front side, but we utilized that shim, that biomechanical device shim. And we put a little clip or plate to it hold together.

On the back side we're inserting these things that are called pedicle screws. They are like carpentry screws that go into the bones. And then they are held together by some rods. Those screws and rods hold those bones together while they heal.

Once again, the patient can get up, walk around, start walking around, doing normal activities.

Q Okay. And, Doctor, could you tell us what you actually found during the surgery?

A So we found that there was somewhat of what is known as olisthesis or a displacement of the joints in L4, L5 and L5, Sl, which along with the area of bright signal is between L4 and L5.

Let's see. We did see that there was some disc material with herniation at L4-5, which was protruding through a defect in the annulus known as a tear. We saw some central disc material also associated with a tear at L5-S1.

Q Did you also see a severe compression of the nerve roots?

A Yes.

MR. DiSIERVI: Objection.

THE COURT: Sustained.

BY MR. BIONDI:

Q What else did you see?

A Okay. What I said was disc space collapse, symmetrical protrusion angular fibers, decompressed nerve roots.

THE COURT: Doctor, I can remind you, glance at the report and then testify. Don't read from the report.

A Will do.

Basically olisthesis, nerve root compression, annular tears and disc material.

Q Doctor, were those intraoperative findings consistent with the patient's complaints and symptoms, your findings on physical exam, as well as the MRI results?

A Yes.

Q Why is that? How is that?

A Pretty much the same way that we had in the neck. We had symptoms correlated with positive physical findings, correlated with an MRI which showed increasing compression and also had prior diagnostic studies that showed radiculopathy, the electrodiagnostic studies. All the things added up to a person with a problem involving their nerve roots secondary to

compression.

Q I would like you to assume that there may be testimony in this case from a defense radiologist, that an MRI that was performed on October 4th of 2021, that there was no evidence of L4 or L5 partial corpectomy, in addition there was no laminectomy, and also no facetectomy.

Do you agree or disagree with that proposed testimony?

A I would disagree.

Q Explain to the jury why you disagree?

A Sure. So there's a description of a procedure. If we actually look at the MRI --

Q Sure.

A -- I could pull it up.

Q Absolutely.

A So this is postoperative MRI on October 6th.

Q With respect to the lumbar spine?

A Lumbar. Correct.

MR. DiSIERVI: If you could just say which slice it is.

THE WITNESS: Yes. I'm going to cycle through a number of them. They are beginning with 14:14:23, starting there.

The top down are beginning 14:18:35.

One thing I see on here is that you see that there's this -- remember the cervical spine we saw the dark

area adjacent to the vertebral bodies where the implants were. The implants are made out of metal. So that they have some magnetic affect to them where the magnetic signal blackout, if you will.

So these are the implants at L4/L5 and S1. And you notice around the area where the screws are there's that blurriness. That blurriness occurs in the areas where the vertebral bodies are. There's a signal loss in those areas because of the screws and rods.

If you go into areas that don't show the screws and rods, you will see here vertebral body, vertebral body, sacrum. You'll see that there is some bright signals in these vertebral bodies at L4/L5. Those are area of new bone growth. There's a healing process that is happening in there.

This MRI was done nine months postoperative -- seven months or so.

Q Yes, that is correct.

A So you're seeing new bone growth there. And if we look at the area top down. You can seen that there is scar tissue and bone growth along the area of the facets. Where this facet is gone, that is 14:20:54. And also 14:20:54, L4-5, you could see where the area, the lamina has been removed, bone growth and signal blocking everything. But you could see that those are the areas that there's bone graft back here as well, also bone

graft over on the side.

So you could see that those areas have changes in them that are postsurgical changes related to the surgical procedure.

Q So, Doctor, you performed a laminectomy during that surgery?

A Yes.

Q And you performed a facetectomy during that procedure?

A Yes.

Q And does the MRI report for that MRI indicate whether or not those procedures were done?

A Yes, I believe it was facetectomy and laminectomy.

Q Right in the MRI report?

A Yes.

Q Which directly contradicts the proposed --

MR. DiSIERVI: Note my objection.

THE COURT: Sustained.

BY MR. BIONDI:

Q You could sit down.

(Witness resumes the witness stand.)

Q Okay. Doctor, I would like you to skip to the October 4th, 2021 visit. What were the patient's complaints and symptoms at that time?

A Let's see. His complaints and symptoms were pain localized to his neck and back areas.

Q Okay. And what were your findings on exam?

A On his exam he had what is known as an antalgic, a little bit of a limp. Kyphotic, which means low-back pinched forward gait pattern. At that time he had a brace. In his cervical spine he had some sixth nerve root distribution sensory loss. He did have in residual Hoffman's. He did not have any significant motor deficits or any other progressive deficits.

In his lower back he did have persist L4, L5 and S1 sensory deficit. He had some difficulty with his ability to heel-toe raise. That was on the right side more than the left, with some mild right greater than left atrophy.

Q At that visit, Doctor, did you comment on Mr. DeSouza's functional capabilities?

A Yes.

Q In your opinion, what were his functional capabilities at that time?

A So with respect to returning to heavy occupations, I indicated less than sedentary capacity.

Q What does that mean?

A So the definitions of occupational capacity in doing this type of examination look at things such as, how often he would do particular maneuvers. They fall under the category of never, occasional, frequent, or constant.

So if you think about an eight-hour day. Constant is, you could do that activity throughout the entire day.

If you think about never, it means you are capable of

doing that activity less than one-third of that particular day.

If you go into the categories of repetitive motion, bending, lifting, twisting. If you fall under the less than one-third of a day, you would then meet the criteria for sedentary.

Q Could you tell us what you noted in that report with respect to whether the patient could perform any work activities with or without restrictions. That is on the second page.

A I indicated, no.

Q Why not?

A So, that is with specific respect of him being able to work in his activities as a carpenter.

Q Now, Doctor, as of that time, in October of 2021, did you have an opinion, within reasonable degree medical certainty, as to whether the patient's complaints and symptoms, your findings on exam, the MRI findings, your findings upon operations, whether the accident was the substantial factor in causing all of those conditions with respect to both the lumbar spine and the cervical spine?

A Yes.

Q Why is that?

A I didn't have any significant prior medical or surgical history to his neck or back, nor of a history of an injury occurring subsequent to which he required treatment. He had complaints and symptoms that were consistent with his physical

findings that were also consistent with the diagnostics, including the MRIs and nerve testing. And they were also consistent with surgical findings.

Q And, Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to whether the patient's complaints and symptoms are permanent in nature?

A Yes.

Q What is your opinion?

A I would say that, based upon the amount of time that I had seen him post-operatively, he did have some residua. And the residua, in my opinion at that time, were permanent.

Q Specifically what residuals are you talking about?

A Some sensory loss in the upper and lower extremities and some lower extremity difficulty with his ability to heel-toe raise.

Q Is it your opinion, with a reasonable degree of medical certainty, as to whether those residuals, as of that visit, prevented the patient from returning to his work?

A Yes.

Q Now we are almost done.

Let's turn to, I think, it was the last visit on June 6th of 2022?

A Yes.

Q Had his condition changed at all at that time?

A No.

Q Did you make a determination as to what his disability was?

A Yes.

Q What did you note in your report?

A Let's see.

Q Right on the top.

A That he had remained disabled from his duties.

Q What is the first sentence on the June 6, 2022?

MR. DiSIERVI: Note my objection.

THE COURT: Noted.

A 100 percent totally disabled.

Q And in your report, did you make any prognosis as to whether Mr. DeSouza would need any additional surgeries in the future?

A I did.

Q What did you say?

A I said that he should be monitored over time. The rationale for that is that, the mechanical reconstructions can have a lifespan in the neighborhood of about ten years. So he requires reassessment in the future.

Q Could you read the past paragraph on Page 3 for us in your report?

A Sure. More likely than not, given his young age revision surgical interventions to both the neck and back regions would be undertaken over the course of his lifetime,

generally this is known to occur within about 7 to 10 years of the index, that is primary procedures. As a consequently of adjacent segment issues and I had spoken to the patient about that.

Q What is adjacent segment issues?

A The other areas that are adjacent to the areas that you've operated upon.

Q Why does that happen?

A There is typically extra stress. If you think of you neck and back being a mechanical device. And you add a very sniff device into flesh and bone, those other areas can take up extra stress and kind of wear down prematurely.

Q And did you have an opinion, with a reasonable degree of medical certainty, as to whether the Plaintiff would need those procedures in the future?

A Yes.

Q And what is that opinion?

A That that is a concern, which is why I indicated that paragraph in the report.

Q Okay. And also in that are report, the June 6th, did you make any recommendations for future care for the Plaintiff?

A Let's see. I indicated physical therapy and pain management and surgical follow-up.

Q Why did you recommend pain management and physical therapy management?

A Pain management and physical therapy are helpful in patients who have a chronic pain syndrome.

Q What would be the goal of doing physical therapy for the patient going forward?

A The primary goal would be maintenance. Maintenance there to prevent him from backsliding.

Q In other words, from getting worse?

A Correct.

Q Did you make any recommendation in terms of a spinal cord stimulator?

A I did not know.

Q Why not?

A I would defer that to pain management specialist.

Q So you didn't have an opinion one way or the other?

A Right. That is why I recommended that he continue to follow with pain management and then discuss that with them.

MR. BIONDI: I think we are done. Give me one second.

(Pausing.)

MR. BIONDI: Thank you, Doctor, nothing further.

THE COURT: Thank you. Probably best we start after the break, or do you want to start now.

MR. DiSIERVI: Probably take a break.

Ladies and Gentlemen of the Jury, we are going to on take our lunch break now. Just as a reminder, please do

not discuss the case, have the case discussed in your presence, or conduct any internet searches of any kind. We will see you around 2:00 and then we will start our examination of the Doctor.

Thank you so much.

THE COURT OFFICER: All rise. Jury existing.

(Whereupon, the jury exits the courtroom and the following is heard outside the hearing and presence of the jury.)

THE COURT: Doctor, you are excused for the lunch break. As a reminder, do not discuss the case with anybody, including Mr. Biondi. You're still under oath. See you at 2:00.

Thank you. You may step down.

(Witness exits.)

(Lunch recess taken.)

(Continued next page.)

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

THE COURT: Are we ready to bring in the jury?

MR. BIONDI: Yes.

MR. DiSIERVI: Yes.

THE COURT: Bring in the jury.

THE COURT OFFICER: All rise. Jury entering.

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

THE COURT: Thank you. You may have a seat.

(Witness resumes the witness stand.)

THE COURT: Doctor, you may have a seat.

We will start with the cross-examination. Are you ready?

MR. DiSIERVI: Yes, Your Honor.

THE COURT: Thank you.

CROSS-EXAMINATION

BY MR. DiSIERVI:

Q Good afternoon, Dr. Merola.

A Good afternoon.

Q My name is Steven DiSiervi. I'm with the law firm of Abrams, Gorelick, Friedman & Jacobson. I'm going to ask you a series of questions this afternoon. If any of my questions are unclear, I ask that you not answer it, okay?

A Yes.

Q And, Doctor, you've testified before?
A Yes.
Q Approximately, how many times have you testified?
A Typically six or seven times per year. I've been doing that at least for the last 25 years or so.
Q However 100 times?
A I would say, yes, probably close to that, sure.
Q So you're familiar that a lot of my questions will be yes, no questions.
A Yes.
Q If I ask you a yes, no question, answer it yes, no. If you can't answer yes, no, please tell me you can't, okay?
A Will do.
Q Doctor are, you familiar with Mr. Biondi?
A Yes.
Q Have you ever treated patients for Mr. Biondi?
A Yes.
Q Mr. DeSouza is not the first patient, would you agree?
A Yes.
Q Who referred Mr. DeSouza to you?
A I believe it was Dr. Colon.
Q Do you know who referred the Plaintiff to Dr. Colon?
A No, I do not.
Q Have you ever gotten a direct referral from Mr. Biondi?
A I do not know.

Q Sir, do you know how many patients of Mr. Biondi's you've treated?

A No, I do not.

Q Sir, would you agree with me that in 2017, you've treated 12 patients who were represented by Mr. Biondi?

A I would have to look at the numbers. But if you have a list, I would not dispute that.

MR. DiSIERVI: Your Honor, may I have the witness look at this?

THE COURT: Yes, sure.

MR. DiSIERVI: It doesn't have to be marked.

THE COURT: Sure.

THE COURT OFFICER: The witness has been given the document.

(Pausing.)

MR. BIONDI: May I see the list?

MR. DiSIERVI: Sure.

MR. BIONDI: Unless you want to testify.

(Handing.)

(Pausing.)

Q Doctor, now that you've reviewed the list, would you agree with me, in 2017, you've treated at least 12 patients who were represented by Mr. Biondi?

A Yes, according to that list it says 2017 and 2019 there was that number of patients, yes.

Q No, I'm only referring to 2017.
A Okay. I thought it was the whole thing.
Q That is just the caption. We will get to '18 and '19.
Would you agree with me that for 2017 you treated approximately 12 patients who were represented by Mr. Biondi?
A On that list, yes.
Q Would you agree with me, in all 12 patients, you performed spinal surgery?
A I don't know that I operated on every 12. There were some there where I didn't do surgeries; some where I did, some where I did not.
Q Approximately 90 percent?
A I don't know. I would have to go back over the list again.
Q Please let the record indicate that I'm showing the Doctor the list again, which is not in evidence.
THE COURT OFFICER: The witness has been given the document.
(Handing.)
A Yes.
Q Doctor, you agree that you performed surgery on all 12 of them?
A I did not perform surgery on one of them.
Q So 11 out of 12?
A Yes.

Q Sir, did you perform surgery on a gentleman by the name of Jose Ricardo Scardua.

A I don't remember off the top of my head. I guess if he's on your list...

Q Okay. Now, sir, I'm going to turn your attention to 2018.

Would you agree with me that in 2018 you performed surgery -- withdrawn.

Sir, would you agree with me that in 2018, you treated nine patients who were also represented by Mr. Biondi?

A If they are on your list, I would not dispute that.

Q Would you like to see the list?

A Sure.

MR. BIONDI: May I see it first?

MR. DiSIERVI: Sure.

(Handing.)

THE COURT OFFICER: The witness has been given the second unmarked document.

(Handing.)

(Pausing.)

A One of them is -- one of them is not listed as a patient though, number 18.

Q Did you treat him?

A I don't see a name.

Q Okay. So it's one out of nine?

A Seven. One out of seven.
Q One out of seven?
A Yes.
Q So it's six patients you treated in 2018 that were represented by Mr. Biondi?
A Yeah, I mean, I have not verified the list. I'm going on what you have down on the list.
Q Would you agree with me that on all seven of those patients you performed surgery?
A Yes.
Q Doctor, would you agree with me that in 2019 you saw an additional nine patients that were represented by Mr. Biondi?
A Sure. If you have a list, I'm happy to do that one as well.

(Shown.)

THE COURT OFFICER: The witness has been given a third unmarked document.

(Handing.)

A Yes.
Q And, Doctor, would you agree with me that of those 12 patients, you performed surgery on all 12?
A Yes. Yes, according to the list.
Q So, Doctor, to sum it all up -- if I could have the list back.

You agree with me that in 2017, 2018, 2019, you saw

approximately 27 patients who were represented by Mr. Biondi, and two of which you did not perform surgery on?

A Yes, based on those lists, yes.

Q Approximately 95 percent?

A Sure.

Q And of those 27 patients, were they all seen by Dr. Colon?

A I don't know.

Q Of those 27 patients, were they all seen by Dr. Seidenstein?

A I don't know.

Q Were some of them seen by Dr. Seidenstein?

A Perhaps.

Q Is the first time you have heard the name Dr. Seidenstein here today?

A No.

Q You've heard his name before because he's treated some of the same patients you've treated, correct?

A Yes.

Q And the name Dr. Colon is the first time you've heard it here today?

A No.

Q And you've heard it on multiple occasions because some of the patients you've treated were also represented by Mr. Biondi, also went to Dr. Colon?

A Yes.
Q Doctor, is there a referral system between you, Mr. Biondi and Dr. Colon?
MR. BIONDI: Objection.
THE COURT: Sustained. Let's keep moving.
BY MR DiSIERVI:
Q Now, Doctor, how much money do you make as an expert?
A I'm not getting paid as an expert here today at all.
Q Are you getting paid?
A No.
Q So you're here today, you're free?
A Yes.
Q And, Doctor, how much money do you generally make for fusion procedures, generally?
A It depends on the insurance carrier.
Q How much money were you paid in this case?
A I don't know I would have to look at the billing.
Q Of all the Biondi cases where you treated the patient, you would agree with me that you were paid in those cases to treat those patients?
A I was hopefully paid to treat those patients, yeah.
Q Doctor, you would agree with me, the more patients you receive from Mr. Biondi, the more money you make?
MR. BIONDI: Objection --
MR. DiSIERVI: Withdrawn.

Q Doctor, you would agree with me, the more patients you received from either Dr. Colon, Dr. Seidenstein, or Mr. Biondi the more money you make?

MR. BIONDI: Objection, Judge, to received from me. No cases were received by me.

THE COURT: I will sustain the objection.

BY MR DiSIERVI:

Q Doctor, would you agree with me, the more referrals you get from any source, the more money you make?

A I'm basically just like my grandmother was, which was a seamstress and she got paid her shirt sewn. As doctors and surgeons we hopefully get paid for every case we sew.

Q Doctor, are you expected to receive a sum of money if there's a judgment or settlement?

A No.

Q Now, Doctor, I believe you testified on your direct examination, that your opinion is based on three categories; history, clinical findings, and diagnostic findings; is that correct?

A I believe there was one more that I had indicated as well, which was any pertinent past medical or surgical history.

Q Would you agree that is part of the history?

A You know, I mean -- no, it is separate. I mean, when you're doing a history and a physical, those are separate and distinct portions.

Q Doctor, is would you agree with me that the history is subjective?

A Yes.

Q Meaning, that the patient tells you, and you're relying on the patient's truth and veracity?

A Yes.

Q And the part you just said, the past medical history, would you agree with me that that is also subjective?

A Yes, in part it is subjective. As we treat those patients, we sometimes find out about their past medical histories as we go along.

Q Sp you would agree with me that that component -- withdrawn.

Would you agree with me that if the history or past medical history is inaccurate, then your conclusion may be inaccurate?

A Sure.

Q Now, Doctor, when a patient comes to your office, do they fill out an intake form?

A Sometimes they do, yes.

Q That is actually kind of common with physicians that, when a patient comes in, you fill out an intake form, right, your name, what are your complaints, what body parts were injured, correct?

A Yes.

Q Okay. Doctor, yes, no. Does your medical records contain an intake form for Mr. DeSouza?

A No.

Q And the intake form prepared by Mr. DeSouza, yes, no, would have been written by him or his interpreter?

A If he had filled one out, yes.

Q Now, Doctor, we talked about clinical findings also being part of your opinion, correct?

A Yes.

Q And you described a number of tests you performed in the office to get those clinical findings?

A Yes.

Q Would you agree with me that some of those tests are completely subjective?

A In part. In part, they can be, sure.

Q Just so that we are clear on how these tests are performed. Could a patient self-perform any of these tests?

A I mean, you're doing it for 30 years, you'll know whether or not a patient is, I guess, for lack of a better term, self-performing something.

Q Oh, I'm sorry. I don't think you're understanding my question, I apologize, I wasn't clear?

A No, I'm not.

Q The straight leg raise test, could a patient perform it on themselves?

A Could they do it to themselves?
Q Yes.
A The test?
Q Yes.
A Sure.
Q Would it be a different test if they were asked to raise their own legs under their own power?
A Yes, that would not be a straight leg raise test.
Q So, if you ask a patient to raise their legs with their own power, as opposed to a physician raising their legs, it is a different test?
A Correct.
Q Some of the other tests you described about, applying force to the patient's shoulders, to elicit a response, could that be self-performed?
A Could they apply pleasure to their neck or shoulder?
Q Yes.
A Not really, no.
Q Okay. So you would agree with me that certain examinations can't be done by telemedicine?
A Yes, that's correct.
Q Now, the examinations, some of them, are influenced by the patient's desire to cooperate?
A Sure.
Q For example, one of the things you test is strength,

correct?

A Yes.

Q And I believe you said the Plaintiff had a loss of strength in his calf?

A Difficulty heel-toe raising.

Q And That is subjective?

A Yes and no. I mean, to a certain extent it can be. You're also observing their gait pattern to see whether or not it correlates with what they are able to do.

Q For the most part, if the patient doesn't want to walk heel-to-toe, they will not walk heel-to-toe?

A Sure.

Q Now, I would like to talk about the diagnostic findings.

On direct examination, you had used the term acute --withdrawn.

During your direct examination, I believe you testified -- and don't let me put words in your mouth -- that you agreed with the Defendants' radiologist that there was no evidence of an acute finding?

A Yes.

Q So I would like to explore that.

A Sure.

Q Acute means sudden onset?

A Yes.

Q So, layman's terms, I'm not a physician. What we're saying is that there was no evidence that the items you were seeing, the herniation, the bulge, whatever it was, that appeared suddenly?

MR. BIONDI: Objection, Judge. Can we know which MRI is being referred to?

MR DiSIERVI: All of them.

THE COURT: Okay. Overruled.

MR DiSIERVI: I will withdraw the question and reask it.

THE COURT: Rephrase.

MR. DiSIERVI: Thank you.

BY MR DiSIERVI:

Q Doctor, would you agree with me that all of the MRIs that you looked at today with the jury there was no evidence, that whatever the MRI showed, that it was sudden onset?

A There was no radiographic evidence just based on the films. For example, I think I mentioned on direct, bleeding, fracture, edema, those kinds of things.

Q Exactly. So those are the kinds of things you would expect to see when it's a sudden onset of a spinal injury?

A Depending upon the extent of the injury you could see those things, yes.

Q And, sir, we had used a term degeneration. Do you recall that?

A Yes.

Q Degeneration is, generally, arthritic?

A Not really. Arthritis could be a part of degeneration. You could acquire arthritis through a degenerative condition, yes.

Q And, sir, degeneration, in and of itself, is not a traumatically caused condition, is it?

A Correct.

Q So when you talked about seeing degeneration, that certainly wasn't from the accident?

A Yes.

Q And because degeneration takes years to occur?

A It can certainly take time, yes.

Q And once the degeneration starts, is there any pill or surgery, or thing you could do as a physician to stop it?

A They are working on that right now with peptides, yes. In the past there really wasn't.

Q Unfortunately, as human beings our bodies age and there's nothing that could stop this aging process?

A Not yet.

Q Not yet. I'm sure we all hope we get there at one point?

A Yes.

Q And, Doctor, you used a term herniated disc.

Herniated disc, in and of itself, is that a traumatic

injury?

A It doesn't have to be.

Q Doctor, unfortunately, I'm going to use the jury as an example. 60 percent of them sitting right now probably have a herniated disc?

A Depends on their ages. But I'm sure that if we MRI'd everyone we would see disc abnormality.

Q I'm not going to ask them their ages, I promise. I promise. I'll ask the Judge -- kidding, Your Honor.

THE COURT: I'm not telling the truth.

Q And, sir, you had used another term, bulging disc?

A Yes.

Q Would you agree with me that a bulging disc is not a traumatic injury?

A Not necessarily, correct.

Q Not necessarily?

A Right.

Q Does the fact that a bulge occurred mean that there was trauma?

A Not in and of itself, no.

Q And, Doctor, would you agree with me that all of these films are snapshots in time?

A Sure.

Q And when you look at a bulging disc on a film, you can't tell if it occurred a year earlier, or if it occurred a

day earlier?

A Correct.

Q Okay. And the same would be true of a herniation?

A Yes.

Q Okay. So, as you sit here today, would you agree with me that the herniation and bulge, as you described in the cervical spine and the lumbar spine, you can't tell this jury when that started?

A Based on the films alone, you are correct.

Q Now, Doctor, you're a spinal surgeon, correct?

A Yes.

Q You're not a certified diagnostic radiologist?

A No.

Q Radiologists specialize in interpreting the films, such as the ones you showed?

A Yes.

Q And you rely upon those MRI studies for your patience before you recommend spinal surgery?

A In part. I look at all the films, but I will review a radiology report as well.

Q You beat me to my next question.

A Sorry.

Q You also rely upon radiologist reports in forming your opinion?

A I read it, certainly, yes.

Q And, Doctor, an MRI can demonstrate an abnormality without establishing when it occurred?

A Yes.

Q But some abnormalities will tell you when it occurred?

A Some abnormalities can give you more proximity. As you said, snapshot in time. If you see a fracture and there's no healing in the fracture. And you see bleeding or fluid, you can say that's kind of an acute process. That is an example of something with a snapshot in time that will give you an idea that it was quote/unquote acute.

Q And you would agree with me, identifying an abnormality is different from determining it's cause?

A Yes.

Q Doctor, I would like to turn your attention to the July 8, 2019 MRI, cervical MRI.

Would you agree with me that it showed no evidence of a fracture?

A Yes.

Q Would you agree with me it showed no evidence of bleeding?

A Yes.

Q Would you agree with me that it showed no in dicta of trauma?

A Yes.

Q Doctor, now earlier you had testified that there was a

change in the lumbar MRI. Do you recall that?

A Yes.

Q And I believe you had said there was an additional abnormality found in the subsequent MRI, correct?

A Yes.

Q And that subsequent MRI occurred more than a year after the accident?

A Yes.

Q And so that would be a new finding that wasn't seen on the prior MRI, correct?

A Yes.

Q And could a subsequent accident have caused that?

A If one had occurred, yes.

Q And I believe you also said that there might have been a tear not visible?

A That is Correct. You could have an annular tear that does not showing up on the MRI, depending on size.

Q The fact that there was a tear that was invisible doesn't tell you when that tear occurred, correct?

A Yes.

Q So that tear could have predated the accident?

A We talking about that L4-5 level?

Q Yes.

A So if there was a tear predating the accident, I would have expected to have seen an L4-5 abnormality on the first MRI.

Q There was a L4-5 abnormality on the first MRI, wasn't there a herniated disc?

A I think it was just a symmetrical bulge. L4-5 looked pretty good on the first MRI.

Q But there was an abnormality, there was a bulge?

A Kind of, sure.

Q Okay. I believe you said earlier --withdrawn.

Dr. Merola, was your surgery a success?

A Yes.

MR. DiSIERVI: Thank you. Nothing further.

THE COURT: All right.

Any re-direct?

MR. BIONDI: Yes, thank you, Judge.

REDIRECT EXAMINATION

BY MR BIONDI:

Q Doctor, if an MRI doesn't show bleeding, a fracture, or edema, does that mean that any abnormality noted on that MRI was not caused by an accident?

A No.

Q Okay. Explain that to the jury.

A Sure. So, you know, we talked about this before a little on direct, where you could grade things between zero and five, for example.

Zero, complete and entirely nothing wrong, right.

Five, massive fracture, dislocation, the guy's head

falling off, right. But there are grades between.

So it depends on how bad an annular tear is or how much of a herniation is in that spectrum between zero and five. Some tests are going to show you a fracture, or bleeding, or something acute on them, and some may not.

Q Okay. And can a patient have complaints and symptoms that are caused by an accident, but you don't see a fracture on the MRI, or blood on the MRI, or edema on the MRI?

A Right, sure.

Q And is that what happened in this case?

A I believe so, sure.

Q Now, counsel asked you about degenerative condition. And can an individual have a degenerative condition in his spine, which is asymptomatic, no symptoms, no complaints, and that individual have an accident that can activate or exacerbate degenerative condition and cause symptoms?

A Sure.

Q Explain how that works for the jury?

A Best example I could probably give you that is really obvious, for example, if my grandmother the seamstress was walking down the street and she slipped and fell, but she had underlying arthritis of her hips. That would not preclude her from having a hip fracture or a pelvic fracture.

Same thing with us. We have degeneration of collagen in our fares and our skin. If you incur trauma to your face,

you're maybe a little bit more prone to getting a cut, then if you did not have the degenerative issues.

Yeah, you could have an asystematic degenerative issue. You could have trauma superimposed on an asystematic degenerative issue as well.

Q Did that happen in this particular case?

A I mean, I think when we looked at the MRIs we saw that there were, I think I said grade one, grade 1 and-a-half degenerative changes. I didn't really disagree so much with the interpretation from the radiologist, other than the facet arthropathy that I disagreed with. There are degenerative conditions there, absolutely.

But, you know, putting it altogether, it looks like there was a history of an accident with symptoms thereafter.

Q And even, let's assume that there's a greater than 1 or 1 and-a-half degenerative condition in a patient's spine, can that condition remain asymptomatic absent a trauma?

A Sure.

Q Now, counsel asked you whether a herniation can be nontraumatic in nature. You said, yes?

A Yes.

Q And counsel asked whether a bulging disc can be not caused by trauma. You said, yes, correct?

A Yes.

Q Okay. Similarly, can a patient have a herniation which

is caused by trauma?

A Yes.

Q And can a patient have a bulging disc which is caused by trauma?

A Yes.

Q By the way, did I ever call you up, your office up, and refer a patient to -- any patient to you?

A No.

Q And those clients that counsel asked you about, that you had the pleasure of doing surgery on, do you know whether they live in Newark, New Jersey?

A I believe they may, yes.

Q And they talk -- clients talk among themselves?

MR. DiSIERVI: Note my objection.

THE COURT: Sustained.

BY MR. BIONDI:

Q Do you know if those clients are happy with your services, Doctor, happy with my services?

MR. DiSIERVI: Objection.

THE COURT: Sustained.

BY MR BIONDI:

Q I think the last question to you, counsel asked you whether surgery was success.

Can a surgery be a success and the patient still have complaints, and symptoms, and limitations, and still be

disabled?

A It is possible, yes.

Q And, in fact, is that what happened in this particular case?

A Yes.

Q So when you say the surgery was successful, what do you mean by that?

A It helped decrease his radiating symptoms into his arms and hands, decreased radiating symptoms down into his legs and feet. Prevented the neurological condition from getting worse. Made him better than he was when I had initially seen him and stabilized him. And we had no complications as well. So none of those surgeries had any complications or anything.

Q And despite the surgery being termed a success, does that mean that the patient is not going to need additional surgeries in the future as a result of the accident that he had in this particular case?

A As I had talked to him about, you know, that is of concern. That is always of a concern when you're doing something to the body and altering it in some type of mechanical way.

Q And the fact that the surgery is a success, does that mean that the patient is not going to have permanent complaints and limitations in the future?

A Not necessarily, no.

Q And, in fact, that is what happened in this particular case, correct?

A Up to when I last saw him, yes.

MR. BIONDI: Nothing further, Judge.

THE COURT: Any recross?

MR. DiSIERVI: Real short.

RECROSS EXAMINATION

BY MR. DiSIERVI:

Q Doctor, Mr. Biondi asked about a lot of your patients being from Newark.

Do you have an office in Newark?

A I do not, no.

Q Your office is in Brooklyn?

A Manhattan and Brooklyn.

Q And there are orthopedic surgeons in Newark, just like yourself --

MR. BIONDI: Objection.

MR. DiSIERVI: I didn't ask a question.

THE COURT: Overruled.

BY MR DiSIERVI:

Q There's orthopedic surgeons just like yourself in Newark, who perform the same type of surgeries?

A Yes.

Q Now, you had drawn an analogy to your grandmother who is a seamstress. I believe you said, if my grandmother falls

and she has arthritis and breaks her hip, it doesn't mean that the broken hip was from the arthritis, correct?

A That is right, yes.

Q But if your grandmother falls with arthritis and breaks her hip, does it mean that the arthritis was from the fall?

A No.

MR. DiSIERVI: Thank you.

MR. BIONDI: Nothing further.

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

THE WITNESS: Thank you.

(Witness exits.)

MR. DiSIERVI: Could we take a two-minute break? If you want, we can approach?

THE COURT: No, let's take a two-minute break.

Ladies and Gentlemen of the Jury, very brief, okay. You know the rules, so I'm not going to repeat myself right now, it is going to take the two minutes.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom and the following is heard outside the hearing and presence of the jury.)

(Recess taken.)

THE COURT: Ready for the jury.

THE COURT OFFICER: All rise. Jury entering.

(Whereupon, the jury enters the courtroom and the

following is heard inside the hearing and presence of the jury.)

THE COURT: We'll continue, Mr. Biondi. Do we have our next witness?

MR. BIONDI: Yes. Plaintiff calls Dr. Michael Seidenstein.

THE COURT: Come up Doctor.

(Witness approaches the witness stand.)

THE COURT OFFICER: Please remain standing, the Clerk will swear you in.

THE COURT CLERK: Please raise your right hand.

Do you solemnly swear or affirm that the testimony you are about to give, will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: Yes, I do.

THE CLERK: Please state your name and address for the record.

THE WITNESS: Dr. Michael Seidenstein. 630 Mt. Prospect Avenue, Newark, New Jersey 07104.

THE COURT CLERK: Spell your name.

THE WITNESS: M-I-C-H-A-E-L S-E-I-D-E-N-S-T-E-I-N.

THE CLERK: Thank you. Your Honor, the witness is sworn and affirmed.

THE COURT: Great. Thank you very much.

Have a seat, Doctor. Thank you, very much.

Just please speak into the microphone and wait until the attorney finishes asking the question before you respond.

THE WITNESS: Okay.

THE COURT: Thank you.

DIRECT EXAMINATION

BY MR BIONDI:

Q Doctor, are you a physician duly licensed to practice medicine?

A Yes, in New York since 1971, and I'm licensed in New Jersey and California as well.

Q And can you give us your educational background, starting with medical school?

A I went to medical school at New York Medical College. I did an internship at Metropolitan Hospital, New York. I did an orthopedic residency at the Hospital For Joint Disease. I did a fellowship in England with Professor John Charnley. And then I've been a private practice in New Jersey and New York since then.

Q And do you have a particular speciality?

A Orthopedic surgery.

Q And do you do spine surgery?

A No, I don't treat or do spine surgery at all.

Q Other than spine surgery, what other body parts or joints do you operate on?

A I do reconstructive surgery. Primarily shoulders and knees, but I do other joints as well.

Q How many knee surgeries have you done over the course of your career?

A Thousands, thousands.

Q What does your practice presently consist of? What do you do?

A I have an office in New Jersey. I have one and-a-half offices in New York as well.

MR. BIONDI: Can Exhibit 1 be handed to the witness?

(Handing.)

THE COURT OFFICER: Exhibit 1 being handed to witness.

BY MR BIONDI:

Q Those are the Newark Rehabilitation Center records in evidence.

A Yes.

Q I kind of marked your notes in that chart, okay, for your convenience.

When was the first time you saw Mr. DeSouza? Look at the sticky notes.

(Pausing.)

A If this is in correct order, October 30th, 2019.

Q Okay. Looking at it, I believe there was a visit for

September 4, 2019.

(Pausing.)

MR. BIONDI: May I assist the witness.

THE COURT: Of course, yes.

MR. BIONDI: You probably can't read my handwriting.

BY MR BIONDI:

Q Seems like the first visit is not in the subpoenaed records?

THE COURT: Okay.

MR. BIONDI: We do have the doctor's note for that visit? I would ask that we mark that for identification, unless there's no objection we can mark it in evidence.

MR. DiSIERVI: Let me take a look at it.

September 4, 2019.

(Pausing.)

MR. BIONDI: Sorry about that, Doctor.

MR. DiSIERVI: No objection. I have this as 24.

(Handing.)

MR. BIONDI: So it is in evidence?

THE COURT: Not yet. We can mark it.

(Whereupon, document is so marked as Plaintiff's Exhibit 24 in evidence.)

THE COURT OFFICER: Plaintiff's Exhibit 24 is in front of the witness.

BY MR BIONDI:

Q Doctor, is that the first time you saw Mr. DeSouza?

A Yes, September 4, 2019.

Q And you saw him at Newark Rehab?

A Yes.

Q Do you know how he got to you?

A No.

Q Was he referred by anyone?

A How he -- he was referred to me from another doctor in the same practice.

Q Do you know who that was?

A I believe it was Dr. Perez, but I'm not sure.

Q Did you have an interpret for Mr. DeSouza?

A I have an interpret with me every time I go to see a patient whether it's required or not.

Q So at that initial visit you took a history?

A Yes.

Q And the patient had certain complaints?

A Yes.

Q What was the patient's complaints?

A I noted he was a right-handed dominant male who has been sent here for problems related to both knees, presently the left knee. He states that the has no problems with the left knee prior to his accident on that date. Where he was tripping -- should be stripping -- with a crowbar, he slipped, fell

backward, hanging from the dock from his seatbelt.

That is what he recorded to me at that time.

Q Okay. What specifically were his complaints about -- just focusing on the left knee.

A Through an interpreter he said he's been having pain, giving away, buckling, collapsing. The last time it was a day ago when it happened in the shower.

Q And did you do an exam at that time?

A Yes, I said on examination, patient also had therapy and injection without any benefit. I noted that he was working with a mild and antalgic gait. He has patellofemoral crepitation with mild patellar tilt. He has no varus or valgus instability in flexion or extension. He has at least 2+ Lachman and pain which is duplicated with attempted pivot shift. There is posterior medial joint line tenderness noted as well.

Q Doctor, what is patellofemoral crepitation?

A Crepitation pain between the kneecap and the femur of the thigh bone.

Q What is a patellar tilt?

A If your leg is extended out, your kneecap should be parallel to it. Tilt means it is leaning so you have less of the patellar rubbing against the femur.

Q Doctor, what is the significance of 2+ Lachman test?

A That designates anterior cruciate ligament insufficiency.

Q Is that referred to as an ACL?
A Yes, ACL insufficiency.
Q I think you indicated that he had an injection in his left knee prior to the time he saw you?
A Yes.
Q Did the patient get any benefit from that injection?
A No.
Q What is the significance of that, not getting a benefit from an injection?
A You're trying to reduce the inflammation and pain. When you have structural abnormalities, sometimes it doesn't work, which it didn't in this case.
Q At that first visit, Doctor, did you also review an MRI that the patient had of his left knee on July 8, 2019?
A Yes. The MRI revealed a highgrade partial ACL tear thin remnant evidence of ACL insufficiency with posterior displacement of the femoral condyles, a partial medial meniscectomy, but the patient never had previous surgery.
Q Doctor, first explain to the jury what is a highgrade partial ACL tear?
A A partial tear means that part of the ligament is torn. Highgrade means significant tearing.
Q And the report indicates that he had partial medial meniscectomy. What does that mean?
A It would mean that a patient had prior surgery, but

this patient never had prior surgery.

Q So how do you know that he didn't have a prior surgery?

A He said he didn't have a prior surgery and he had no scars around his knee.

Q Okay. So, as of that visit, based on the history, physical exam, and the MRI findings, did you have an opinion, with a reasonable degree of medical certainty, as to whether these conditions you told us about, the ACL tear, and the partial medial meniscectomy, whether those conditions were preexisting to the date of his accident?

A Yes, I believe he had an aggravation of previous illness.

Q Was the patient's complaints and symptoms with respect to his left knee asymptomatic, or nonexistent prior to the accident?

A Well, a patient related no history of any problems with the knee. He's never lost time from work. He's been working construction for 25, 30 years. There was nothing -- there was no history prior to any involvement at all.

Q So, at that time, did you have an opinion, with a reasonable degree of medical certainty, as to whether the accident that the patient had, caused or contributed to those conditions noted on the MRI?

A Certainly with the ACL it did contribute to it.

Q What do you mean by contribute?

A Well, he had no demonstrative instability that stopped him from working prior to the injury. At the time the surgery, when I did his ACL reconstruction, there was no evidence of the ligament at all. I believe that that is what aggravated and gave him the instability and why he needed the surgery.

Q So, is it -- I'm just focusing on that time. Was it your opinion, at that time, that the accident activated or exacerbated those preexisting conditions and then caused symptoms?

A Yes.

Q Absent the accident, would the patient have required -- can you make a determination as to whether the patient would have required surgery for those preexisting condition absent the accident?

A No, I can't really make a comment. He had no reason -- he was working with those conditions at the knee at the time of the MRI. So, I don't know why he would have required it then.

Q You have to speak up.

A I don't know why he would have required it prior to the accident, as he had those conditions at the time. They didn't require an instability. The answer is, it is consistent with the accident aggravating it.

Q You testified to that.

What I'm asking you is, is there any reason to believe that the patient would have required surgery based upon those

underlying conditions, absent the accident?

A At that time, no.

Q And he could have continued being asymptomatic with those underlying conditions for the rest of his life?

A In theory, yes.

Q What do you mean buy, in theory?

A If he stayed the same way as he was prior to the injury and he never got worse, the answer would be, yes.

Q So, explain for us a little bit as to why in the MRI report indicates this medial meniscectomy, correct?

A That is what the radiologist felt, yes.

Q Do you know why the radiologist noted that?

A I can't be specific. If I was -- if you look at the MRI or the operative findings the posterior horn in the back of the knee meniscus is absent. I presume he thought it happened by a surgeon.

Q So can you have --

A I'm not sure of his reasoning.

Q Can you have that condition with it not being absent without a surgery?

A Yes, that is what he did.

Q Explain that to the jury how you could have something that looks like you had a surgery, but was not?

A The cartilage looks like had a letter C. The back of the cartilage, if there's a tear, it doesn't have blood supply,

it generated into pieces and absorbed. That is why we did not find the piece at the time of surgery.

Q And certainly if there had been a surgery there would be some type of scars there, correct?

A Yes, there has to be.

Q Did you see any scars on left knee?

A No, he had none.

Q And was that something you look -- after you look at that MRI report, was that something you looked at to see whether the Plaintiff had a prior surgery? Did you look at the knee to see whether there were scars?

A I asked the patient. I looked at his knee. He said, no, he had no scars. So I did not pay attention to the MRI findings.

Q Did you also comment on his left ankle during that first visit?

A Yes. I noted regarding his left ankle, he also injured at the time of the accident, and says he has been having pain, difficulty when he walks for a long periods of time, going on his toes and giving weight. I noted clinically he had pain tenderness over the anterior talofibular ligament and calcaneofibular ligament, eversion stress. He had loss of ten degrees of dorsiflexion, bringing the ankle up. It was tenderness noted on the medial aspect of the dome of the talus. I noted that the MRI of June 8, 2019, revealed peroneal longus

tendinitis chronic, calcaneofibular ligament and anterior talofibular ligament partial tear osteochondral dome medially 7 x 16 millimeter.

Q Explain those three conditions that were found on the MRI.

A Most common torn ligament in the body is the outside of the ankle. He had evidence of tears on two of the three ligaments on the outside of the ankle. The ankle bone has bone that has a dome and he had a defect in the dome as well.

Q And do you have an opinion, with a reasonable degree of medical certainty, as to whether those conditions that were shown on the MRI, whether they predated his accident?

A I think they predated the accident.

Q Okay. Do you have an opinion, with a reasonable degree of medical certainty, as to whether --withdrawn.

And was the patient asymptomatic with respect to his left ankle prior to this accident?

A That's what he said.

Q And do you have an opinion, with a reasonable degree medical certainty, as to whether the accident activated or exacerbated those preexisting conditions which were asymptomatic and now became symptomatic?

A Yes, they did.

Q Explain that to the jury?

A You could have a preexisting injury and just trauma

will create inflammation. The inflammation gives you all symptomatology that he didn't have prior to the accident.

Q And, again, the same question. Absent this accident, is there any reason to believe that he would have had surgery to his left ankle absent the accident?

A Not at this time I examined him.

Q You had your next visit October 30, 2019?

A October 30th, yes.

Q By the way, based upon that first visit what, was your treatment plan?

A I gave antiinflammatory medication, brace, therapy and we requested surgery.

Q And as of that second visit, October 30, 2019, was the patient's condition essentially the same as the prior visit?

A Yes.

Q Okay. And then there was another visit January 8th of 2020?

A January 8th?

Q Yes.

A I have June 10th.

Q Let's go to June 10th. At that visit, did you request an ultrasonic injection to his left knee.

A Yes.

Q Why did you make that request?

A Because he was having pain in the ankle. With those

findings, I thought we might be able to give him pain relief.

Q I don't know if I said knee or ankle. If I said knee, I meant ankle.

A I gave him a support brace as well.

Q That is the support brace for his ankle?

A Yes.

Q At that time, were you still waiting authorization for the left knee surgery?

A Yes.

Q And then could you look at operative report. You did the surgery to the left knee on October 15th of 2020?

A Yes.

Q You have your operative report in front of you?

A Yes.

Q First of all, what was the indication or what was the reason why you were doing the surgery at that time?

A Because of the pain and the instability; primarily the instability.

Q And do you have opinion, with a reasonable degree of medical certainty, as to whether the accident that he had, was a substantial factor in the need for that surgery?

A Yes.

Q Why?

A Because he was asymptomatic prior to it.

Q All right. Describe the surgery that you performed?

A Arthroscopic surgery. A scope is inserted into the knee, a videotape is performed. I cleaned up the damage to the lining of the bone, the two cartilages. And since he had no anterior cruciate ligament, I created one using allograft.

Q That is what is called ACL reconstruction?

A Yes.

Q So you mentioned in your operative report that there was a partial lateral meniscectomy, a partial medial meniscectomy, a chondroplasty patella, and a chondroplasty medial femoral condyle.

MR. DiSIERVI: Just note my objection.

THE COURT: Noted.

Q Is that correct?

A Yes.

Q Could you briefly explain each of those procedures for the jury and what they mean?

A Well, there was a tear of the c-shaped cartilage on the lateral side, which I cleaned up. There was of the existing medial meniscus there was a tear which I cleaned up. I smoothed down the lining of the condyles of the bone and I created an anterior cruciate ligament for him.

Q Now, Doctor, based upon what you actually found at that surgery, were you still of the opinion that the accident was the cause of those symptoms and the conditions that you found at surgery?

A I have not changed my opinion at all.

Q You had several more visits. And then can you take a look at your visit for February 17th of 2021?

A Yes.

Q What symptoms or limitations did the patient have at that time?

A I noted he's doing better regarding his left knee. He does have marked weakness of the quad and the VMO, which is a muscle, part of the quadriceps, the fine muscle. I said he had no evidence of any anterior drawing stability. He maintained patella femoral compressive syndrome where he had the articular defect noted at the time of surgery. He's having problem with his left ankle. He has tenderness to palpation over the talus. He had pain and tenderness over the anterior talofibular ligament with a positive anterior draw. I related the MRI findings of the chronic tear, as well as a 16 millimeter osteochondral lesion of the talus. We discussed surgery, which he declined.

Q So let's just focus on the knee for a second. And you indicated that the patient had marked weakness of the quad and VMO. What is the significance of those findings existing after the surgery you performed?

A Most important finding is that he needed to have more therapy to give him more stability and strength.

Q And did you make that recommendation?

A Sorry?
Q Did you make that recommendation?
A Yes. I recommend that he go back to therapy specifically for that.
Q And you also mentioned that he has a patellofemorally compression syndrome?
A That is the same irritation under the kneecap that he had before. At the time of surgery, a normal looking lining should be like two pieces of ice. When you have compress syndrome it is more like crab meat and sandpaper. You could smooth it, but it is like having a yard of grass that is orange and you can't make it green. That is why the symptoms persist. When yo have instability of the ACL because of the moment it irritates the patella in almost every case where there's ACL insufficiency.
Q So despite the surgery you did, he still had patella femoral compression syndrome; is that correct?
A Yes.
Q And you also told us a little bit about the left ankle. And what does that mean that he had pain and tenderness over anterior talofibular and calcaneofibular?
A It means a tear of the lateral ligament, it means producing pain. I gave him options as to treatment and he declined the surgery.
Q Is that the reason why you recommend the surgery?

A Yes.

Q And did he tell you why he was declining the surgery at that point?

A No. I know he was concerned about the knee and he was having other surgeries. I'm not sure which kind. I know he had other surgeries as well. He declined the surgery to his ankle.

Q And, Doctor, do you have an opinion, with a reasonable degree of medical certainty as to whether the knee for surgery left ankle surgery that you recommended at that time was caused by the accident that he had?

A Yes.

Q Explain how?

A I think we did already. He had the preexisting conditions and increased inflammation, more damage to the anterior cruciate ligament following knee injury and this is why.

Q Okay. And then could you turn to, I believe, your last visit, October 6, 2021. With respect to the left knee, did you make some determinations at that time as to the degree --

A Which date?

Q 10/6/21?

A Yes.

Q Did you make some determinations at that time as to the nature, extent, and degree of his limitations?

A Yes.

Q What did you find?

A I noted that on that date reached maximum medical benefits.

Q What does that mean?

A I don't feel at that time any further treatment would change his condition.

I say, based on the Compensation Guidelines of 2017, he had an active flection of 120 over 150, loss of ten percent of the right knee. The left knee --

Q Focus on the left.

A The left knee flection to 100 degrees, with lacking ten degree of extension for a total of 30 percent of the left knee due to episode. I gave him ten percent for chondromalacia patella compression syndrome, 40 percent due to the episode.

Q When you say 40 percent, is that 40 percent loss of the left knee?

A Yes.

Q What does that mean?

In lay terms what does that mean?

A It is supposed to be -- supposed to represent how much damage he has to a particular joint based on injury he has at work. There are guidelines which relate to range of motion deficits and any other findings. That is how the numbers accrue.

Q So was it your opinion at that time to a reasonable

degree of medical certainty, that the patient had a 40 percent degree loss of use of his left knee?

A Yes.

Q Okay. What were the symptoms associated with that? Why did you say it was 40 percent?

A It is not symptomatology with loss. It is loss of active range of motion, which is measured three times with a goniometer in the office. Sometimes there are other findings. The other finding in this case were the damage underneath the kneecap. So he lost 30 percent range of motion, ten percent because of the degree of the kneecap involvement.

Q Okay. Is that the chondromalacia?

A Yes.

Q Again explain that to the jury. What is chondromalacia?

A Softening and irregularity damage to the lining of that area of the bone, in this case it was the kneecap.

Q And were there certain symptoms associated with his knee at that time that you noted?

A Yes. He persisted with compression syndrome difficulty when you bend it.

Q Did he still have quad weakness?

A I don't think I related anything.

Q Could you take a look at the note?

A Let me take a look.

(Pausing.)

A Not that I recorded.

Q Okay. So as of that time, as of your last visit, 10/6/21, did you have an opinion, with a reasonable degree of medical certainty, as to whether the Plaintiff's condition with respect to his left knee was permanent or not?

A Yes.

Q What is your opinion?

A No question it was permanent.

Q Explain to the jury why?

A As I stated before, I don't think it would be getting any better. He has a possibility of it getting worse. Needing more surgery, arthroscopic. And if the knee were to deteriorate more rapidly he might require total knee replacement as well.

Q And, again, going to the last visit. With respect to the left ankle, what degree of loss did you find with respect to the left ankle?

A Because of the loss of dorsiflexion I found 7.5 percent loss of the left ankle.

Q And do you have an opinion as to whether that condition was permanent?

A Yes, it was.

Q Again, why is that?

A He's had all the treatments that I could offer him, same surgery, he declined it, that is why.

Q What affect would, withdrawn. As of 10/6/21, what effect of these losses that you noted with respect to left knee left ankle, what effect would that have on the activities or function of the knee and the ankle for the Plaintiff?

A Prior to or postoperative?

Q Postoperative. As of 10/6/21?

A He's going to be -- ACL reconstruction, all these things are salvage procedures. You don't make them what they were before they got hurt. He will have restriction. Although better than preoperatively. He will he continue some symptoms related to the chondromalacia as well.

Q Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to whether the Plaintiff will need a total knee replacement in the future?

A I just said that he may require arthroscopic surgery, depending if he has more lining damage. And if the pathology gets much worse faster, he will require total knee replacement.

Q Can you pinpoint exactly when that is going to occur, or is that something that will occur during the course of his lifetime?

MR. DiSIERVI: Note my objection.

THE COURT: Sustained.

BY MR BIONDI:

Q Do you have an opinion when that will occur?

MR. DiSIERVI: Note my objection.

THE COURT: Overruled.

A With the amount of damage he had at the time, I would expect it would happen, yes.

Q When you say you expect it to happen; are you referring to the total knee replacement or arthroscopy, or both?

A I'm talking total knee replacement. I don't know that he will need arthroscopy. The damage to the lining that he had, in all probability that will progress, although I don't know any kind of rate of progress that would require total knee replacement, yes.

Q Is that opinion with a reasonable degree of medical certainty?

A Yes.

Q Doctor, do you have an opinion, with a reasonable degree of medical certainty, as to whether the need for a total knee replacement in the future was caused by the accident he had?

A Certainly accelerated by the accident, no question.

Q Explain that to the jury.

A As we discussed before because the instability on top of his preexisting conditions, everything got worse requiring surgical intervention?

Q At the time you saw him, the last time you saw him 10/6/21, did you have any recommendation with respect to whether

he needed physical therapy to both his knee and ankle?

A At that time he was on a home physical therapy program.

Q I'm not asking what he was doing. Would you make a recommend that that is what he needed?

A I did for the knee. I don't think I did for the ankle.

Q And if the condition was permanent as you said -- let's focus on the left knee for a second -- why would you still order or recommend that he continue to have physical therapy?

A Because of the weakness. The muscles around your knee get weaker, you have more instability.

Q Did you make any recommendation with respect to -- withdrawn.

Besides the surgery, did you make any recommendation with respect to physical therapy in the future about the left ankle?

A I don't believe I did.

Q Do you have any recommendation -- withdrawn.

Do you have an opinion, with a reasonable degree of medical certainty, whether he needs physical therapy for his ankle?

A No, I do not. I'm sure I recommended him to use a work boot because of the instability.

MR. BIONDI: Nothing further. Thank you.

THE COURT: Ladies and Gentlemen of the Jury, we are going to take a brief recess. Reminder, please do not

discuss the case, have the case discussed in your presence or conduct any internet searches of any kind. Thank you very much.

THE COURT OFFICER: All rise. Jury existing.

(Whereupon, the jury exits the courtroom and the following is heard outside the hearing and presence of the jury.)

THE COURT: Doctor, I remind you, you are under oath. Please do not discuss your testimony, you're still under oath.

(Recess.)

THE COURT: Okay. We will bring in the jury.

(Whereupon, the jury enters the courtroom.)

THE COURT: Thank you. You may have a seat. We'll continue.

Doctor I remind you you're still under oath.

Thank you so much.

CROSS-EXAMINATION

BY MR. DiSIERVI:

Q Good afternoon, Doctor. My name is Steven DiSiervi. I am with the law firm of Abrams, Gorelick, Friedman & Jacobson and I represent the Defendants.

Doctor, is this the first time you've testified.

A Could you talk into the microphone?

Q Doctor, is this the first time you've testified?

A First time I testified?
Q Yes.
A 2000 -- I think 2009.
Q Is this the first time you've testified?
A On this case?
Q On any case.
A No, it is about the third or fourth.
Q So, Doctor, you understand that a lot of my questions are going to be yes or no questions?
A Yes.
Q And that if you could answer yes or no, I ask that you not answer and tell me you can't do it and I will do my best to rephrase, okay?
A Okay.
Q Doctor, do you regularly treatment patients involved in personal injury litigation?
A Yes, I do.
Q Are some of those patients represented by Mr. Biondi?
A Yes.
Q Would you agree with me that in 2017 you treated five patients who were represented by Mr. Biondi?
A I don't know.
Q Do you recall how many?
A Do I what?
Q Do you recall how many patients in 2019 you treated?

A No.
Q Would it more than one?
A No.
Q No, you don't know or no, it is not?
A I don't remember.
Q And does Mr. Biondi refer patients directly to you?
A Sorry, I'm having difficulty hearing.
Q I am sorry. Does Mr. Biondi refer patients directly to you?
MR. BIONDI: Objection.
THE COURT: Overruled.
A I don't know, I presume.
Q And the patients that you've seen who were represented by Mr. Biondi, you've done surgery on all of them?
A I can't say I saw patients for him, I don't know. I can't even say.
Q How much are you being paid to testify today?
A How many cases have I testified when?
Q How much are you being paid to testify?
A My office is being paid $9,000 for loss of surgery today.
Q How much were you paid to prepare reports?
A I don't know, that we have -- I don't know. That would be rehab would have to tell you that.
Q And, Doctor, were you also paid to prepare for today?

A Was I paid for what?
Q To prepare for today?
A No.
Q Doctor, would you agree with me that the Plaintiff has a long-standing history of problem with his knees?
A I don't know that he had a history with a problem with his knee. Based on what he told me, he had no problems with the knee prior to the accident.
Q Sorry if I was unclear. I pluralized it. We will do it differently.
Would you agree with me that the Plaintiff had a problem with his right knee before this accident?
A He gave me no history of that.
Q Doctor, I would like you to take a look at your first initial report. And I have a copy if you need it. I believe you have one in front of you.
I would like you to review it for yourself and tell me if it refreshes your memory about whether the Plaintiff had a problem with his right knee before the accident?
MR. BIONDI: Right knee, not left?
A Not that I record.
Q Right knee we are talking about?
A Is that what you asked me?
Q Yes.
A Correct.

Q Sir, the initial report is dated when?
A 9/4/2019.
Q Doctor, did you write in your initial report that he had a prior knee surgery to his right knee in Brazil?
A Did I?
Q Yes.
A No.
Q And, sir, didn't the Plaintiff complain to you that he had right knee pain a year before the accident?
A He gave me no history of either of his knee being involved. We were focusing on the left knee because that was his predominant problem regarding his knees at the time.
Q It is your testimony that the Plaintiff never told you anything about right knee?
A That is correct.
Q Now, sir, the MRI was performed on the Plaintiff's knee -- left knee?
A Yes.
Q Would you agree with me that that MRI did not show a healthy knee?
A Yes, I would agree with you.
Q And would you agree with me that the posterior portion, which I believe is the outside of the meniscus was missing?
A It was the inside, the back, posterior is back.
Q Yes. So the inside back of the Plaintiff's meniscus

was missing?
A Correct.
Q And that predates this accident?
A Correct.
Q Does a meniscus grow back?
A No.
Q And once a meniscus is gone, doesn't it change the way force is applied to the knee?
A It can. It depends on how big and how much of the remnant is left.
Q So what happens is, when you walk on an knee that is missing a piece of the meniscus, it actually starts wearing away the rest of the meniscus?
A Not necessarily.
Q But it can happen?
A Anything can happen, yes.
Q Would you agree with me that the Plaintiff had tried compartmental osteoarthritis in his left knee which predates this accident?
A No.
Q Would you agree with me that he had arthritis in his knee which predates this accident?
A No.
Q So you think the meniscus just disappeared on his own?
A No, you asked me arthritis. That is a different of a

meniscus. Two totally different things.

Q What caused the meniscus to disappear?

A As I said during examination, you can have a tear, then degenerates into pieces and the pieces get absorbed.

Q And what caused the initial tear?

A He's been working 25, 30 years in construction, I imagine something he did then.

Q So you think it is an accident?

A Well, wear and tear.

Q Now, Doctor, do you recall that an MRI was performed of the Plaintiff's left knee?

A Yes.

Q Do you recall that that MRI found that his ACL was partially intact?

A Yes.

Q And do you recall when you performed your surgery there was no ACL?

A That is correct.

Q At some point, Doctor, after this accident the ACL ruptured?

A No. The MRI, if I'm correct, is less than one month before it happened. The ACL has peculiar blood supply. It comes in from the most dependant part. You could have a trauma to it, it loses blood supply and then it goes.

Q I want to make sure I heard you correctly.

The MRI was done before the accident?

A No, following the accident. I'm saying from the time of the accident to the MRI was less than one month; am I correct?

Q Correct.

From the time of the MRI to the surgery, how much time past?

A Close to a year.

Q So, had between the MRI and the surgery, the ACL ruptures?

A Because of the trauma of surgery -- the trauma of the accident -- excuse me -- correct.

Q If there was trauma from the accident, wouldn't the ACL have ruptured on the day of the accident?

A Could it have ruptured on te day of the accident?

Q No. Would it have ruptured?

A I don't know. I only know what I found at the time of surgery.

Q So, you don't know if the partial tear existed before the date of the accident?

A He didn't have any intact ACL at the time of the surgery. That progressed from the MRI three weeks after the his injury.

Q Okay. Now, Doctor, an ACL tear is a pretty significant injury to the knee?

A It can be. In this case it was.
Q And an ACL rupture causes pain?
A It can.
Q An ACL rupture causes limitation of motion?
A Yes.
Q The Plaintiff testified that after the accident he walked approximately 30 minutes, which was, approximately, a half a mile.
Would that be consistent with someone with a tear of the ACL?
A Yes.
Q And would it produce pain?
A He could have pain.
Q Doctor, you took a history from the Plaintiff?
A Yes. Actually the interpreter did and told me what was said.
Q What was that history?
A I would have to -- that he know problem to left knee. On June 17, 2019, when he was stripping with a crowbar, it slipped, he fell backwards, was hang by the dock on the safety belt. And I remember he said he hit against the wall his shoulder and his knee, I believe.
Q Is that in the report?
A No.
Q Did you just make that up?

A No.

Q Are you testifying from memory or you report this entire time?

A I remember that.

Q Do you remember, I want you to turn to the June 10th, 2020, report. I have a copy for you so that it will help?

A I remember this case, yes.

Q You remember it?

A Yes.

Q Do you remember in your report you wrote: He has a previous history of having problems in Brazil to his right knee and stated the right knee did not bother him for at least one year prior to this case?

A Did you ask me the right knee?

Q Yes.

A Sorry, I was replying to the left. No, he did have a problem with the right prior.

Q So the testimony you said earlier when I was asking you about right knee you mistakenly --

A Sorry he did have a problem with the right knee prior.

Q Did he miss any time from work?

A I don't know.

Q You said he never missed time from work?

A I don't know whether he lost time from work.

Q Do you know what kind of knee injury he sustained to

his right knee?

A No.

Q Do you know if it is the same kind of loss of meniscus we've been describing on the left?

A No.

Q And if this is a ware and tear injury, you would agree with me that wear and tear injuries are usually bilateral, meaning both sides?

A Not necessarily.

Q Most likely?

A No.

Q From running?

A No, from injury.

Q So you say that bilateral is usually from injury?

A I'm saying, can you have bilateral diseases from injury? I don't understand your question.

Q It is all right. Just tell me. I know it's getting late.

What I am saying is, when you have a ware and tear component to an unhealthy knee, meaning from years of use?

A I don't know what he has on right knee at all.

Q I did not finish the question.

Doctor, would you agree with me, when you have a wear and tear injury, meaning from years of use, running, walking, standing, it is usually bilateral, meaning it is on both sides?

A No, I disagree.
Q You think one joint wears quicker than the other?
A Certainly can, depends on your alignment and other conditions in your body. No question.
MR. DiSIERVI: I have nothing further.
THE COURT: Any re-direct?
MR. BIONDI: Yes, Judge.

REDIRECT EXAMINATION

MR. BIONDI:

Q Now, how it works at Newark Rehab is that, typically you're not the first doctor that a patient sees when they come to that facility; is that correct?
MR. DiSIERVI: Note my objection.
THE COURT: Noted.
A Yes, that's correct.
Q And then the referrals to you are made by the physicians who initially see the doctor at Newark Rehab?
MR. DiSIERVI: Note my objection.
THE COURT: Noted.
A Yes.
Q Okay. And, in fact, in this particular case, the patient was referred to you by Dr. Perez, correct?
A Yes.
Q And that is typically how it has been done for all the years that you worked at Newark Rehab, correct?

A Different doctors as well, but that is correct.
Q And I have never called you or your office and referred a patient to you; is that correct, Doctor?
A Yes.
Q And I think you testified for a patient -- for a client of mine one time, approximately, 10, 15 years ago?
A You seem to remember more than I do, to be honest.
Q Okay. You stay young and I've gotten a little older since that time.
Any of the questions that counsel asked you today on cross-examination caused you to change any of your opinions that you expressed on direct examination when I was questioning you?
MR. DiSIERVI: Note my objection.
THE COURT: Overruled.
A No.
BY MR BIONDI:
Q And did the ACL tear get worse from the time of the initial MRI, post-accident MRI, until the time of your surgery?
A Yes.
Q Okay. What accounts for that? How does that happen?
A The only variable was the injury.
Q Okay. Counsel asked you whether the patient could walk after that accident and you told us that he could walk. Why is that?
A Well, as long as he's on steady ground, doesn't do

rotation, you can walk as far as you want to walk.

Q Even with an ACL tear?

A You can.

Q And is the mechanism of injury that you have in your reports, is that mechanism sufficient to cause the injuries to Mr. DeSouza?

A Yes.

Q How does that the mechanism of injury -- how does that cause the symptoms?

A I don't -- I remember when he fell he said he was hitting against the wall. Direct trauma, twisting his leg when it happened, all of that can contribute.

MR. BIONDI: Thank you, Doctor.

THE COURT: Anything further, Mr. DiSiervi?

MR. DiSIERVI: One final question.

THE COURT: Of course.

BY MR. DiSIERVI:

Q Doctor, in all of your reports, has the Plaintiff ever described radiating pain to his feet?

MR. BIONDI: Objection.

THE COURT: Could you repeat the question?

BY MR DiSIERVI:

Q In all of your reports, did the Plaintiff ever describe radiating pain to his feet?

THE COURT: Is this report in evidence?

MR. DiSIERVI: Yes.

THE COURT: Overruled.

A What? I could not hear.

Q In all of your reports, has the Plaintiff ever described to you radiating pain to his feet?

A Not that I recorded.

MR. DiSIERVI: Thank you.

THE COURT: Doctor, thank you so much. You are excused.

THE WITNESS: Thank you.

(Witness exits.)

THE COURT: Okay, so, Mr. Biondi, is that it for the witnesses for today?

MR. BIONDI: Yes, Judge.

THE COURT: Full day. Tomorrow we have our next witness; is that correct?

MR. BIONDI: Yes, Judge.

THE COURT: Okay. Very good. So, Ladies and Gentlemen of the Jury, we're going to break.

Thank you so much for your attention.

Reminder, please do not discuss the case, have the case discussed in your presence, or conduct any internet searches.

We look forward to tomorrow morning.

Thank you.

THE COURT OFFICER: All rise. Jury exiting.

(Whereupon, the jury exits the courtroom and the following is heard outside the hearing and presence of the jury.)

(Off the record discussion held.)

(Whereupon, the trial stood in recess until Friday, October 30, 2026.)

* * *

$

$9,000 (1)
457:20

A

ability (2)
398:8;400:14
able (8)
348:24;354:14;
377:14,17;392:8;
399:11;417:9;444:1
abnormal (4)
355:17;370:10,15;
376:11
abnormalities (4)
391:21;422:4,5;
437:11
abnormality (8)
420:7;422:1,11;
423:4,25;424:1,5,17
abnormally (3)
359:16;370:11;
391:4
above (2)
361:25;370:15
Abrams (2)
405:22;455:21
Abrupt (1)
366:13
absent (8)
426:17;439:11,13;
440:1,15,19;443:3,5
Absolutely (2)
395:14;426:12
absorbed (2)
441:1;461:4
absorber (1)
376:4
absorbing (1)
388:17
academic (1)
349:19
accelerated (1)
453:19
access (4)
375:14,21,22;
377:17
accessible (1)
375:7
accident (73)
335:25;336:5;
337:24;338:2,9,10,20,
22;339:6,21;340:1;
345:1,4,8,12,13,15;
371:9,16;388:23;
399:17;419:10;423:7,
12,21,24;424:18;
425:7,15;426:14;
428:16;435:24;
438:10,15,22;439:7,
11,14,20,22;440:1;
441:18;442:12,13,17,
20;443:2,3,5;444:20;
445:23;448:10;
453:17,19;458:8,12,
19;459:9;460:3,19,
22;461:8,19;462:1,2,
3,12,13,14,15,20;
463:6;467:23
accidents (4)
336:9;337:9,16;
338:7
accommodate (1)
393:2
accomplish (1)
381:3
according (2)
407:24;410:22
accounts (1)
467:20
accrue (1)
449:24
Achilles (1)
354:18
Achilles' (1)
363:8
ACL (25)
437:1,2,15,16,20;
438:8,24;439:3;
445:5;447:13,14;
452:7;461:13,17,19,
22;462:9,13,21,24;
463:2,4,10;467:17;
468:2
acquire (1)
419:4
act (2)
339:14;376:4
action (10)
334:6,15;335:3,7,
12;336:18;337:4;
338:2;345:16,24
actions (1)
344:22
activate (1)
425:15
activated (2)
439:7;442:20
active (2)
449:8;450:7
activities (7)
348:25;377:5;
386:8;393:16;399:7,
12;452:3
activity (4)
353:4;370:10;
398:24;399:1
activity-like (1)
386:12
acts (3)
335:16,20;341:21
actual (4)
370:19;372:23;
377:25;382:19
actually (13)
349:24;355:8;
369:20;370:3;372:15;
376:16;387:19;
393:17;395:11;
414:21;445:22;
460:12;463:15
acute (13)
365:1;366:10,13,
15,16,17,18;417:16,
20,24;422:8,10;425:5
add (4)
367:10;382:12,18;
402:10
added (1)
394:24
addition (2)
377:11;395:5
additional (5)
349:11;401:13;
410:12;423:3;428:15
additionally (2)
374:22;392:25
address (2)
347:21;431:16
addressed (1)
385:2
adjacent (6)
370:13;380:11;
396:1;402:3,5,6
administer (1)
347:12
administerial (1)
341:13
admissible (1)
342:9
adults (1)
351:8
adverse (1)
335:4
affect (2)
396:3;452:1
affinity (1)
379:20
affirm (2)
347:13;431:12
affirmation (1)
341:8
affirmed (2)
347:25;431:23
afternoon (4)
405:19,20,23;
455:20
again (18)
337:1;339:17;
343:14;354:22;365:4,
7,11;366:5;385:25;
389:9;392:25;393:15;
408:14,16;443:3;
450:14;451:15,23
against (14)
335:22;336:3,10;
340:2,7,17;344:3,10;
345:17;374:19;392:9;
436:22;463:21;
468:11
age (3)
364:10;401:23;
419:18
ages (2)
420:6,8
aggravated (1)
439:4
aggravating (1)
439:22
aggravation (1)
438:11
aging (2)
364:13;419:19
ago (3)
350:25;436:7;467:6
agree (51)
341:22;363:14,15;
365:2;366:12,19;
378:14,15,15;395:7;
406:18;407:4,22;
408:4,7,21;409:7,9;
410:8,11,20,25;
412:19,22;413:1,8,22;
414:1,8,12,14;415:13;
416:19;418:14;
420:13,21;421:5;
422:11,16,19,22;
456:20;458:4,11;
459:19,21,22;460:17,
21;465:6,23
agreed (1)
417:18
ahead (1)
391:10
alignment (3)
377:2;381:2;466:3
allegations (7)
335:17,21;341:14;
343:15,20;344:10;
345:21
allege (1)
339:18
allograft (1)
445:4
allow (2)
341:17;345:5
alluded (1)
351:3
almost (3)
390:9;400:20;
447:14
alone (1)
421:9
along (5)
354:3;373:18;
393:21;396:21;
414:11
altering (1)
428:20
alternate (1)
334:3
although (3)
379:19;452:9;453:9
altogether (1)
426:13
always (1)
428:19
among (1)
427:13
amount (4)
363:19;364:11;
400:9;453:3
analogous (1)
385:21
analogy (1)
429:24
and/or (2)
350:14,14
and-a-half (4)
364:20;426:8,16;
433:8
Andrew (2)
347:8,19
A-N-D-R-E-W (1)
347:19
angular (1)
394:9
ankle (27)
392:4,5;441:15,17,
23;442:7,8,8,17;
443:5,25;444:2,3,5;
446:13;447:19;448:6,
9;451:16,17,19;452:3,
4;454:1,5,15,20
annular (7)
365:1;366:11,20,
25;394:13;423:16;
425:2
annulus (1)
393:24
antalgic (2)
398:1;436:11
anterior (12)
372:9;392:3;
436:24;441:21;442:1;
445:4,21;446:10,14,
15;447:21;448:15
antiinflammatory (1)
443:11
anulus (2)
366:21;388:14
apart (1)
393:6
apologize (1)
415:22
Appeals (1)
342:13
appear (1)
367:1
appearance (1)
366:2
appeared (1)

418:4
Appellate (6)
340:24;341:23;
342:11,15,19;345:19
application (2)
342:3,4
applied (1)
460:8
apply (1)
416:16
applying (1)
416:13
appointments (1)
350:8
approach (1)
430:13
approaches (2)
347:10;431:8
appropriate (1)
377:2
Approximately (8)
406:3;408:5,12;
411:1,4;463:7,7;
467:6
approximation (1)
350:21
Araujo (1)
346:10
area (52)
353:9,10,24;355:4,
4,22;356:1;358:7,12,
14,14,15;359:2,2,4,
16;360:5,25;361:3,
21;362:14,25;363:4,
4;372:12;374:18;
375:12,15,21,22;
377:12,18;379:16,21;
380:9,11;385:8,23;
388:15;389:25;391:2;
392:24;393:4,5,21;
396:1,6,13,20,21,23;
450:17
areas (24)
358:4,15,16,21;
370:11;371:2;375:17;
380:3,6,6;386:21;
390:25;392:21,25;
393:2;396:7,8,10,25;
397:2,24;402:6,6,11
arm (5)
368:5,7,8,10;369:3
arms (6)
352:12;353:21;
367:8;370:23;384:20;
428:8
around (15)
348:20,25;362:13;
374:18;377:4;390:4,
7,10;392:6;393:15,
16;396:6;404:3;
438:4;454:9
arthritic (1)
419:2
Arthritis (9)
419:3,4;425:22;
430:1,2,4,5;460:21,25
arthrodesis (1)
375:25
arthropathic (1)
366:4
arthropathy (6)
363:13;364:25;
365:14,15,22;426:11
Arthroscopic (3)
445:1;451:13;
452:15
arthroscopy (2)
453:6,8
articular (1)
446:11
aspect (1)
441:24
assist (1)
434:3
associated (4)
373:4;393:25;
450:4,18
assume (5)
363:9;364:23;
378:9;395:2;426:15
assumption (1)
338:14
asymmetrical (3)
359:9;362:17;
363:16
asymmetrically (1)
362:13
asymptomatic (8)
364:8;425:14;
426:17;438:14;440:3;
442:16,21;444:24
asystematic (2)
426:3,4
atrophy (1)
398:10
attempted (1)
436:14
attention (5)
347:6;409:5;
422:14;441:13;
469:20
attorney (2)
341:11;432:2
attorneys (3)
340:15,18;343:19
authorization (6)
371:23;372:4,15;
391:14,15;444:7
automobile (1)
335:25
available (3)
355:6;367:19;
371:12
avascular (1)
388:11
Avenue (1)
431:19
avoid (1)
375:4
avoided (1)
375:4
away (12)
354:9,11;375:13,
17,17;376:18;377:14;
385:25;389:25;
392:25;436:6;460:12

B

back (55)
343:15;348:23,24;
349:5;350:23;352:11,
13;354:5,5,19,19;
355:19,21;357:22;
358:7;359:23;361:4;
363:5,6,7,7;367:8;
370:23;371:17,18;
375:3;378:21;383:21;
385:2,14,15;386:20,
23;389:16;391:10;
392:17,17,18;393:5,
11;396:25;397:24;
398:7;399:23;401:24;
402:10;408:13;
410:24;440:14,24;
447:3;459:24,24,25;
460:5
background (2)
349:2;432:12
backs (1)
351:6
backside (2)
375:2,18
backsliding (1)
403:6
backward (1)
436:1
backwards (1)
463:20
backyards (1)
386:20
bad (11)
334:3;335:16,20;
339:14;341:21;
365:24,25;366:2,2;
382:10;425:2
banging (1)
374:18
base (1)
379:12
based (18)
339:9;345:1,17,20;
371:12;378:10;400:9;
411:3;413:17;418:17;
421:9;438:5;439:25;
443:9;445:22;449:7,
21;458:7
basic (1)
362:11
basically (14)
349:23;350:14;
352:25;372:6,8;
373:21;375:13;376:1,
10,25;379:13;382:8;
394:13;413:10
basis (1)
341:4
bearer (1)
334:2
beat (1)
421:21
became (2)
349:17;442:22
begin (2)
360:16;392:21
beginning (3)
390:18;395:21,23
begins (1)
355:19
behind (3)
359:1;377:19;391:2
beings (1)
419:18
below (2)
385:19;387:22
belt (1)
463:21
bend (3)
353:22;386:20;
450:21
bending (2)
386:19;399:3
benefit (3)
436:10;437:6,8
benefits (1)
449:3
Besides (1)
454:13
best (3)
403:21;425:19;
456:12
better (12)
362:10;368:15,18,
19;379:5;381:2;
392:6;415:19;428:11;
446:7;451:12;452:10
beyond (2)
358:25;390:21
big (9)
354:20;361:15;
364:19;378:22;
389:21;390:15;
391:25,25;460:9
bilateral (5)
370:16;465:7,14,
15,25
billing (1)
412:17
bills (2)
337:22;340:4
biomechanical (2)
376:22;393:9
BIONDI (109)
334:11,17,20;
335:9,11;336:11,16,
23;337:3;338:16,21;
339:2,14;340:9,11,14,
22;341:2,10,21;342:1,
3;343:9,11,14;346:13,
15,17;347:7;348:3;
351:11,16;357:2,5,9,
15,18;369:15,23;
382:21;383:18,19;
384:7,8;394:6;
397:17;403:17,20;
404:12;405:3;406:14,
16,24;407:5,16,18,23;
408:5;409:10,14;
410:5,12;411:1,25;
412:3,4,18,23,24;
413:2,4;418:5;
424:13,15;427:16,21;
429:4,9,17;430:8;
431:3,5;432:7;
433:10,15;434:3,5,7,
11,17,20;435:1;
452:24;454:23;
456:18,21;457:6,8,10,
14;458:20;466:7,9;
467:16;468:13,20;
469:12,14,17
Biondi's (1)
407:1
bit (16)
351:3,22;361:12,
25;363:25;365:8,24;
376:19;379:23;380:1;
387:23;391:22;398:2;
426:1;440:9;447:19
black (1)
379:16
blacked (1)
379:23
blackout (2)
379:17;396:4
bleeding (5)
418:18;422:7,20;
424:16;425:4
blocking (2)
392:24;396:24
blood (7)
366:16;388:11,13;
425:8;440:25;461:22,
24
blur (1)
379:17
blurriness (2)
396:7,7
board (9)
349:13,15,17,18,24,
25;350:3,4,7
bodies (11)
361:7,16;380:4,6,
18,20;392:20;396:1,8,
13;419:18

body (19)
353:16;354:9;
356:14;358:23;359:1;
376:20;379:19,25;
380:7,17;388:12;
392:9;396:11,11;
414:23;428:20;
432:24;442:6;466:4
bologna (1)
358:9
bone (36)
364:19,19;365:22;
376:3,18,19,20,20,21;
377:13,15;378:17,18,
19,21,22;380:6,12;
381:17;393:1,3,4,5;
396:13,19,21,23,25,
25;402:11;436:18;
442:8,8;445:3,20;
450:17
bones (15)
348:21;375:11,14,
17;376:2,4,5;377:1,3,
5;379:14,14,15;
393:13,14
boot (1)
454:22
Both (17)
342:14;350:2,12,
18;352:11,17;376:6;
377:7;379:8,9;
399:18;401:24;
435:22;453:6;454:1;
465:8,25
bother (1)
464:12
bothers (1)
353:15
bottom (4)
358:11;360:23;
365:20;378:25
brace (4)
398:3;443:11;
444:4,5
brain (6)
361:8,10,11,16;
379:12,13
branch (1)
348:18
Brazil (2)
459:4;464:11
break (11)
334:6,14;382:22,
25;403:22,23,25;
404:11;430:12,14;
469:19
breaks (2)
430:1,4
brief (2)
430:15;454:25
Briefly (4)
343:13;348:16;
349:17;445:15
bright (4)
358:19;389:24;
393:21;396:12
brightness (2)
363:24;390:7
bring (6)
344:8;349:24;
383:20;405:2,5;
455:12
bringing (2)
344:9;441:23
broken (1)
430:2
Brooklyn (17)
335:23;336:10,17,
22;340:2,19;341:24;
342:7,19,25;343:3;
344:23;345:16,23;
347:22;429:13,14
buckling (1)
436:6
bulge (9)
359:7,8;362:18;
388:8;418:3;420:18;
421:6;424:3,5
bulging (5)
420:11,13,24;
426:22;427:3
bumped (1)
379:7
bun (4)
365:20,20,23,24
butt (1)
385:14
button (1)
382:8
buy (1)
440:6

C

C3 (1)
365:8
C4 (2)
365:9;370:12
C4-5 (1)
365:10
C5 (11)
353:11;356:2;
360:18;363:1;370:12,
16;375:25;377:7,14;
379:24;381:9
C5-6 (1)
365:11
C5-C6 (8)
356:4;361:19;
363:4;370:13;373:5;
377:22;378:12;
382:15
C6 (9)
353:11;356:2;
360:18;363:1;375:25;
377:7,14;379:24;
381:9
cage (8)
376:22;379:25;
380:8,10,11;381:14,
20;382:16
calcaneofibular (3)
441:22;442:1;
447:21
calf (1)
417:4
California (1)
432:11
call (4)
355:2;363:21;
393:1;427:6
called (17)
352:24;354:6;
362:7;363:10;364:23;
372:8;373:19;375:24;
377:6;385:10;386:22;
390:1;391:24;392:3;
393:12;445:5;467:2
calls (2)
347:8;431:5
came (5)
339:9,23;349:5;
350:16,23
can (73)
335:19;336:12;
337:3;339:8,23;
340:11;346:3;350:20;
351:25;355:1;356:25;
360:4,7;362:9,11,12,
13;364:5;366:25;
367:17;370:6;373:8;
374:16,22;377:4,19,
20;382:3,4;388:10,
18;393:15;394:10;
396:20;401:18;
402:11;415:15;417:7;
418:5;419:13;422:1,
5,7;425:6,13,15;
426:16,19,22,25;
427:3,24;430:13;
432:12;433:10;
434:13,21;439:12;
440:17,19;446:2;
452:18;460:9,15,16;
461:3;463:1,3;
465:15;466:3;468:1,
3,12
canal (12)
357:25;358:12,16;
361:3,19;375:19;
377:18;386:18;
389:21;390:19;
392:21,22
capabilities (2)
398:12,14
capable (1)
398:25
capacity (2)
398:17,19
caption (2)
336:22;408:3
car (1)
337:9
care (3)
347:3;349:22;
402:21
career (2)
350:20;433:4
carpenter (1)
399:12
carpentry (1)
393:12
carrier (1)
412:15
cartilage (5)
362:6;388:14;
440:24,25;445:17
cartilages (1)
445:3
case (53)
335:24;336:13,14;
337:10;340:9,12,14,
16;341:3,3,22,24;
343:6,14,15;344:9,10;
345:22;353:6,9;
354:4,6,17;363:10;
381:12;383:1,1,10;
395:3;404:1,1,11;
412:16;413:12;
425:10;426:6;428:4,
17;429:2;437:12;
447:14;450:9,17;
455:1,1;456:5,6;
463:1;464:7,13;
466:21;469:21,22
cases (12)
346:1;349:22,24;
350:1,6,25;351:1,2;
412:18,19;413:5;
457:18
categories (2)
399:2;413:17
category (1)
398:21
causal (3)
339:5,7,20
causally (4)
337:23;338:10,18;
345:3
cause (8)
340:24;360:7;
378:3;422:12;425:16;
445:24;468:5,9
caused (14)
419:7;423:12;
424:18;425:7;426:23;
427:1,3;438:22;
439:8;448:9;453:17;
461:2,5;467:11
causes (2)
463:2,4
causing (7)
353:17;354:9;
371:10;377:20;388:4,
23;399:18
cell (2)
361:7,16
Center (5)
350:9;389:20,21,
25;433:16
centimeter (1)
358:9
central (7)
359:5;361:9,10,15;
363:16;389:22;
393:24
cerebral (1)
358:19
certain (8)
339:19;363:19;
364:11;386:8;416:19;
417:7;435:18;450:18
certainly (8)
346:3;419:10,13;
421:25;438:24;441:3;
453:19;466:3
certainty (19)
371:9;388:22;
399:14;400:5,17;
402:14;438:7,21;
442:11,15,20;444:20;
448:8;450:1;451:5;
452:13;453:13,16;
454:19
certified (7)
349:13,15,17,18;
350:3,4;421:12
cervical (34)
352:17,21,22;
355:5,23;356:1,15;
360:13,17;361:15;
362:20;364:24;365:5;
366:8,11;367:4,4;
372:1,10,23;373:3,8;
375:24;378:5,11,12;
384:15,17;391:13;
395:25;398:4;399:19;
421:7;422:15
cetera (1)
348:21
chair (1)
357:5
change (4)
423:1;449:6;460:7;
467:11
changed (2)
400:24;446:1
changes (6)
366:7;380:11;
381:13;397:2,3;426:9
changing (1)
343:19
charges (1)
334:9
Charnley (1)

432:17
chart (4)
351:17;369:20,22;
433:19
chemical (1)
374:22
Chicago (1)
349:25
children (1)
351:7
chondromalacia (4)
449:13;450:12,15;
452:11
chondroplasty (2)
445:9,9
chronic (3)
403:2;442:1;446:16
City (6)
337:6,12,12;
338:24;349:5;350:24
claiming (2)
336:1;338:8
claims (2)
344:3;345:2
classified (1)
359:6
cleaned (3)
445:2,18,19
clear (3)
379:9;415:16,22
Clerk (10)
347:12,13,17,21,24;
431:10,11,16,20,22
client (1)
467:5
clients (3)
427:9,13,17
clinical (9)
350:8,18;364:4,6,7;
392:11;413:18;415:7,
11
clinically (1)
441:20
clip (2)
377:3;393:10
clock (1)
357:23
close (2)
406:7;462:8
closer (1)
365:15
closing (1)
386:21
collagen (1)
425:24
collapse (1)
394:8
collapsing (2)
376:11;436:6
collect (1)
349:22
College (2)
349:3;432:14
Colon (7)
406:21,22;411:7,
20,25;412:3;413:2
Colorado (1)
349:11
combined (1)
392:12
coming (7)
355:3,4;358:15;
359:22;360:6;361:16;
362:14
comitted (1)
339:4
comity (1)
342:6
commenced (1)
335:3
comment (4)
378:20;398:11;
439:15;441:15
committed (3)
338:7,24,25
common (2)
414:21;442:6
compartmental (1)
460:18
compensation (3)
336:6;392:13;449:7
competency (1)
339:22
complain (2)
354:12;459:8
complaining (3)
353:2;356:11;
367:11
Complaint (9)
340:3,4,6,17;
341:15;342:25;343:3;
344:11,13
complaints (29)
337:23;352:10;
355:1;356:6,16;
362:21;367:3;370:18;
371:10,19;372:20;
385:3;387:8;388:24;
394:16;397:21,23;
399:15,25;400:6;
414:23;425:6,14;
427:25;428:23;
435:18,20;436:3;
438:13
complete (4)
349:19;372:11;
380:24;424:24
completely (5)
364:8,18;365:13;
368:18;415:14
complications (2)
428:12,13
component (2)
414:12;465:20
compress (3)
353:21;386:18;
447:9
compression (15)
368:20;374:12,17;
380:24;387:5;391:24;
392:13;394:1,13,22;
395:1;447:6,17;
449:14;450:20
compressive (1)
446:11
concern (4)
338:17;402:18;
428:19,19
concerned (1)
448:4
concerning (3)
335:20;373:16,17
concerns (1)
374:5
conclusion (2)
371:14;414:15
condition (25)
353:13;354:23;
373:9,15;386:11;
387:10;388:1;391:20;
392:11;400:24;419:4,
7;425:12,13,16;
426:16,17;428:10;
439:13;440:19;
443:14;449:6;451:5,
20;454:6
conditions (17)
399:18;426:12;
438:8,9,23;439:8,16,
20;440:1,4;442:4,11,
21;445:24;448:14;
453:22;466:4
conduct (5)
352:15;383:2;
404:2;455:2;469:22
conducted (1)
355:24
condyle (1)
445:10
condyles (2)
437:17;445:20
confirm (1)
382:15
confusing (1)
345:8
connection (7)
351:18;352:20;
353:13;354:23;
376:12;384:14;385:5
conscious (1)
369:9
consequently (1)
402:2
consider (1)
374:8
consideration (1)
366:24
considered (1)
387:2
consist (2)
350:13;433:6
consistent (20)
356:6,9,16;360:10;
362:20;367:4;369:13;
370:17;371:19,20,21;
374:11;387:4,24;
394:15;399:25;400:1,
3;439:21;463:9
consistently (1)
385:9
consists (2)
351:4,5
constant (2)
398:22,23
construction (2)
438:18;461:6
contact (3)
350:16;359:22;
360:6
contain (3)
363:19;390:3;415:2
contained (1)
358:23
containing (1)
361:16
contains (3)
359:3,18;361:7
continuation (1)
361:8
continue (6)
378:3;403:15;
431:3;452:10;454:8;
455:15
Continued (2)
404:17;440:3
continuing (1)
350:7
contract (1)
373:24
contradicts (1)
397:14
contrary (1)
339:13
contrast (1)
379:3
contribute (3)
438:24,25;468:12
contributed (1)
438:22
contributing (2)
371:10;388:23
contributory (1)
371:17
control (2)
369:7,9
controlled (1)
354:20
controls (1)
363:7
convenience (1)
433:20
cooperate (1)
416:23
copied (1)
369:21
copy (7)
336:20;340:7;
342:21;343:2,5;
458:15;464:6
cord (23)
361:6,7,8,10,11;
362:25;363:1;372:7;
373:7,8,20,24;375:2,
5,6,6,19,23;377:22;
379:12,13;381:16;
403:10
cords (1)
374:15
corner (1)
389:14
corollate (2)
354:25;367:10
Corpectomies (2)
380:21;381:1
corpectomy (5)
378:21;380:14,16;
393:1;395:5
corpectomy/resection (1)
378:13
correctly (1)
461:25
correlate (1)
371:3
correlated (4)
356:2;389:7;
394:21,22
correlates (3)
353:18;363:4;417:9
correlative (1)
356:12
corroborated (1)
356:10
counsel (15)
335:5;336:23;
340:16;341:7,8,13;
344:3,21;425:12;
426:19,22;427:9,22;
467:10,22
counts (1)
335:8
County (9)
335:24;336:3,19;
343:6;344:22,23,24;
349:7,9
couple (3)
350:25;380:22;
382:22
course (8)
350:20;357:4;
388:17;401:25;433:3;
434:4;452:19;468:16
COURT (145)
334:1,5,9,13,18,22,
23,25;335:14,16;
336:3,15,17,21;337:1,

14;338:14,17;340:8,8,13,20;341:1,9,22;342:2,4,6,8,12,14,18,21,24;343:7,10,13,22,25,25;344:1,2,5,14,17,19,19,20;345:5,22;346:3,5,11,14,16,19,21,25;347:9,11,13,21;348:1;351:14;357:4;369:18;382:23;383:5,9,12,17,17,18,20,23;384:2;394:5,10;397:16;401:10;403:21;404:6,10;405:2,5,6,10,12,16;407:10,12,13;408:17;409:17;410:16;412:5;413:6;418:8,11;420:10;424:11;427:15,20;429:5,19;430:9,14,18,23,24;431:3,7,9,11,20,24;432:5;433:13;434:4,10,21,24;445:12;452:22;453:2;454:24;455:4,8,12,14;457:11;466:6,14,19;467:14;468:14,16,21,25;469:2,8,12,15,18;470:1
courtroom (10)
346:22;383:6,24;404:7;405:7;430:19,25;455:5,13;470:2
Court's (2)
335:5;357:3
cover (1)
392:22
covering (1)
362:7
crab (1)
447:10
crease (2)
375:8,9
create (1)
443:1
created (2)
445:4,20
credibility (1)
339:21
crepitation (3)
436:12,16,17
criteria (1)
399:4
critical (2)
337:24;368:22
cross-examination (4)
405:13,17;455:18;467:11
cross-examine (2)
335:6;336:7
crowbar (2)
435:25;463:19
cruciate (4)
436:24;445:4,21;448:15
c-shaped (1)
445:17
currently (1)
335:2
curser (1)
359:16
cut (8)
361:24;365:9,9;375:12;379:21;390:22,23;426:1
cuts (6)
358:7,8;361:23,23;389:16,17
cutter (1)
358:9
cycle (2)
358:5;395:20

D

damage (10)
368:19;378:3;445:2;448:14;449:21;450:9,16;452:16;453:3,8
dark (3)
361:2;380:1;395:25
date (13)
352:6;355:24;360:14;363:12;371:16;379:1;384:11;389:11;435:24;438:10;448:20;449:2;462:20
dated (4)
351:24,25;384:10;459:1
day (11)
339:24;357:7;398:23,24;399:1,4;421:1;436:6;462:14,15;469:15
DC (1)
349:4
dealing (1)
375:5
deals (1)
348:19
Dearaujo (1)
343:14
Deborah (1)
346:5
decided (2)
336:25;342:8
decision (6)
341:20;342:6,18,25;345:20;366:14
decisions (2)
342:11,16
declined (4)
446:18;447:24;448:6;451:25
declining (1)
448:2
decompressed (1)
394:9
decompressing (1)
380:23
decompression (5)
372:6,9;377:22;378:1,2
decrease (3)
384:20;386:11;428:8
decreased (1)
428:9
deem (1)
342:11
default (9)
340:2,21,22;341:5,6,11;342:25;345:17,20
defect (4)
388:9;393:24;442:9;446:12
Defendant (10)
336:1,1;339:3;344:25;345:7,10,13,23;363:11;364:24
Defendants (5)
336:4;337:5,11;339:2;455:22
Defendants' (2)
366:10;417:19
defense (4)
342:10;344:21;378:10;395:3
defer (1)
403:13
deficit (1)
398:8
deficits (5)
384:25;385:1;398:6,6;449:23
definition (2)
363:17;381:20
definitions (1)
398:19
deformity (1)
380:24
degenerates (1)
461:4
degeneration (14)
363:18;364:1,11,16,18;365:4;418:24;419:2,3,6,9,12,14;425:24
degenerative (22)
363:12,12,21;364:3,7,25,25;365:12,14,21;366:4,7;419:4;425:12,13,16;426:2,3,5,9,11,16
degree (27)
364:15;371:8;380:21;388:22;399:14;400:5,16;402:13;438:7,21;442:10,14,19;444:19;448:8,19,24;449:12;450:1,2,11;451:4,16;452:13;453:12,16;454:18
degrees (2)
441:23;449:11
delay (3)
340:18;341:4;347:4
demonstrate (2)
378:13;422:1
demonstrative (1)
439:1
denied (2)
340:23;345:19
Denver (1)
349:11
denying (1)
345:1
Department (2)
337:6;341:1
dependant (1)
461:23
Depending (4)
366:21;418:22;423:17;452:16
depends (5)
412:15;420:6;425:2;460:9;466:3
depicted (1)
359:14
describe (11)
348:16;356:3,25;360:4;364:15;367:21;374:14;377:9;392:15;444:25;468:23
described (8)
367:5;377:24;382:13;415:10;416:13;421:6;468:19;469:5
describing (1)
465:4
description (2)
379:5;395:10
designates (1)
436:24
designed (3)
367:22,23;380:22
desire (1)
416:23
DeSouza (15)
351:18,20;352:3;364:16;369:11;371:9;401:13;406:18,20;415:2,4;433:21;435:2,13;468:6
DeSouza's (1)
398:11
despite (2)
428:14;447:16
deteriorate (1)
451:13
deteriorated (1)
392:12
deteriorating (1)
392:12
deterioration (1)
387:10
determination (2)
401:1;439:12
determinations (2)
448:19,23
determine (1)
339:25
determined (1)
338:3
determining (1)
422:12
detracts (1)
345:21
develop (1)
388:18
developed (1)
387:19
device (5)
376:22;382:6;393:9;402:10,11
diagnoses (2)
339:20;340:7
diagnosis (2)
364:6;373:1
diagnostic (6)
338:1;371:20;394:23;413:18;417:13;421:12
diagnostics (1)
400:1
dicta (1)
422:22
difference (1)
393:7
different (18)
338:23;361:4;362:9;366:1;368:4;380:22;381:2,3,3,4;389:19;392:16;416:6,11;422:12;460:25;461:1;467:1
differently (2)
361:12;458:10
difficult (1)
378:20
difficulty (7)
386:8;398:8;400:14;417:5;441:19;450:20;457:7
digit (2)
373:22,22
DIRECT (10)
348:2;406:24;

413:16;417:15,17;
418:18;424:22;432:6;
467:12;468:11
directed (1)
337:10
directly (5)
339:21;387:21;
397:14;457:6,8
disability (1)
401:1
disabled (3)
401:7,11;428:1
disagree (10)
363:14;365:2,13;
366:12;378:14;395:7,
8,9;426:9;466:1
disagreed (1)
426:11
disappear (1)
461:2
disappeared (1)
460:24
disc (58)
355:17;356:3;
358:14;359:17,22;
360:6,17;361:2,19,24;
362:2,5,9,17,19;
363:12,13,15,21,22,
24;364:3,7,25;
366:24;367:9;372:11;
374:21;375:7,14,16,
17,18;376:4;377:11,
12;388:4,6,8,14,16;
389:24;390:16;391:4;
393:22,24;394:8,14;
419:24,25;420:5,7,11,
13,24;424:2;426:22;
427:3
discectomy (3)
372:11;378:12,16
discontinuance (1)
344:6
discs (8)
358:22;359:22;
363:19,23;365:5,6;
375:11;379:15
discuss (8)
383:1,10;403:16;
404:1,11;455:1,9;
469:21
discussed (6)
383:1;404:1;
446:17;453:21;455:1;
469:22
discussion (1)
470:5
disease (5)
363:12;364:3,3,25;
432:16
diseases (1)
465:15
DiSIERVI (74)
334:12,21;335:1,
10,13,15,18;336:19;
337:21;338:18;339:1,
4,17;340:10;341:19,
25;342:5,17,23;343:2,
5,23;344:1,3,15;
345:25;346:4,7;
394:4;395:18;397:15;
401:9;403:23;405:4,
15,18,21;407:8,11,17;
409:15;412:6,25;
413:7;418:7,9,12,13;
424:10;427:14,19;
429:6,8,18,20;430:7,
12;434:14,18;445:11;
452:21;453:1;455:19,
20;466:5,13,18;
467:13;468:14,15,17,
22;469:1,7
dislocation (1)
424:25
dismiss (2)
340:16,17
dismissal (1)
344:7
dismissed (3)
343:16;344:4,4
displacement (3)
391:5;393:20;
437:17
displacing (1)
387:21
dispute (2)
407:7;409:11
distinct (1)
413:25
distribution (3)
353:23;354:13;
398:4
disturb (1)
374:23
Division (6)
340:24;341:23;
342:11,15,19;345:19
dock (2)
436:1;463:20
Doctor (113)
335:25;336:4,5,8,9;
345:7,12,14;346:14,
17;349:1;350:8,20;
351:17;354:22;356:5,
21;357:5;360:3,13;
362:20;363:9;367:2,
12;369:24;370:17;
371:7;378:23;381:8;
383:9;386:24;388:21;
392:15;393:17;
394:10,15;397:4,20;
398:11;399:13;400:4;
403:20;404:4,10;
405:12;406:1,14;
407:21;408:16,21;
410:11,20,23;412:2,7,
13,22;413:1,8,13,16;
414:1,18;415:1,7;
418:14;419:24;420:3,
21;421:10;422:1,14,
25;424:16;427:18;
429:9;430:9;431:7,
25;432:8;434:17;
435:2,9;436:16,23;
437:13,19;445:22;
448:7;452:12;453:15;
455:8,16,20,23,25;
456:8,15;457:25;
458:4,14;459:3;
461:10,19;462:24;
463:14;465:23;
466:11,17;467:3;
468:13,18;469:8
doctors (2)
413:11;467:1
doctor's (3)
345:11,18;434:11
document (5)
407:14;408:18;
409:18;410:17;
434:22
dome (4)
441:24;442:2,9,9
dominant (1)
435:21
donated (1)
376:19
done (19)
350:22;355:12;
367:14;375:3;378:5;
381:1,2,11;391:11;
392:17;396:16;
397:10;400:20;
403:17;416:20;433:3;
457:14;462:1;466:24
dorsiflexion (2)
441:23;451:18
double-check (1)
344:17
Down (39)
349:9,25;353:1,9;
354:8,15;357:2,24,25;
358:6,10;359:23;
360:1,23,23;361:1,18;
363:1,5,6;366:1;
368:7;370:25;378:23;
385:13,17;386:21;
391:8;392:4,18;
395:23;396:20;
397:18;402:12;
404:14;410:7;425:21;
428:9;445:20
Downstate (1)
350:9
Downtown (1)
349:7
Dr (36)
335:2;337:19,22,
25;338:2,4,12;339:8;
340:2,15,15;341:14;
342:8;344:21,25;
345:2,17;347:8;
384:4;405:19;406:21,
22;411:6,9,12,14,20,
25;412:3;413:2,2;
424:8;431:5,18;
435:12;466:22
draw (1)
446:15
drawing (1)
446:10
drawn (1)
429:24
due (3)
334:4;449:13,14
duly (2)
348:4;432:8
duplicated (1)
436:14
During (11)
350:4;372:21;
381:25;382:7;393:18;
397:4,7;417:17;
441:15;452:19;461:3
duties (1)
401:7

E

earlier (6)
344:20;420:25;
421:1;422:25;424:7;
464:18
early (1)
373:20
easily (1)
375:7
easy (6)
366:14;375:11,14,
20,21,21
ectomizing (1)
381:7
Ectomy (1)
381:6
edema (3)
418:19;424:17;
425:8
education (1)
350:7
educational (2)
349:2;432:12
effect (2)
452:2,3
effort-related (1)
386:11
egg (4)
390:9,9,10,13
eight-hour (1)
398:23
either (3)
358:19;413:2;
459:10
EKG (2)
367:24;368:1
elderly (1)
351:7
electrical (1)
368:1
electrodiagnostic (4)
371:4,22;373:18;
394:24
elicit (1)
416:14
else (3)
338:23;389:6;394:7
EMG (17)
367:19,21,24;
368:2,3,12,21,24;
369:9,10,20,24;370:3,
6,7,15,17
EMS (1)
337:7
encroach (1)
390:19
end (1)
350:2
England (1)
432:17
enough (2)
367:1;390:3
entering (4)
346:21;383:23;
405:6;430:24
enters (5)
346:22;383:24;
405:7;430:25;455:13
entire (4)
334:10;378:1;
398:24;464:3
entirely (5)
364:8,18;365:13;
368:18;424:24
entitled (2)
336:5;337:17
episode (2)
449:13,14
essence (1)
378:16
essentially (5)
349:18;355:16;
372:20;374:15;
443:14
establish (1)
342:9
establishing (1)
422:2
et (1)
348:21
ethical (2)
335:4,6
even (5)
337:5;338:19;
426:15;457:16;468:2
evenly (2)
362:13;391:20
eversion (1)

441:22
everyone (2)
337:17;420:7
evidence (22)
351:12,14;370:16;
373:7;378:11;395:4;
408:16;417:19;418:2,
15,17;422:16,19;
433:17;434:13,20,23;
437:16;439:3;442:7;
446:10;468:25
evidentiary (1)
342:9
exacerbate (1)
425:15
exacerbated (2)
439:8;442:21
exactly (4)
356:25;377:24;
418:20;452:18
exam (16)
353:18,25;362:22;
367:4;370:24;371:11;
384:21,23;385:5;
386:24;394:17;
397:25;398:1;399:16;
436:8;438:6
EXAMINATION (22)
348:2;349:20;
350:3;352:6,15;
354:3;356:7,17;
370:19;387:9;398:20;
404:4;413:17;417:15,
17;424:14;429:7;
432:6;436:9;461:3;
466:8;467:12
examinations (3)
350:6;416:20,22
examine (1)
356:14
examined (3)
338:6;364:9;443:6
examiners (2)
349:24;350:1
examining (1)
353:1
example (9)
358:6;369:9;
416:25;418:18;420:4;
422:8;424:23;425:19,
20
exception (1)
345:25
excuse (1)
462:12
excused (3)
404:10;430:9;469:9
Exhibit (9)
351:12;357:16;
369:16,18,24;433:10,
13;434:23,24
exhibits (1)
334:10
existed (1)
462:19
existing (4)
404:6;445:18;
446:21;455:4
exit (4)
361:21;390:1,1;
391:6
exiting (4)
383:5;387:21;
430:18;470:1
exits (9)
383:6;390:11;
404:7,15;430:11,19;
455:5;469:11;470:2
expect (3)
418:21;453:4,5
expected (2)
413:13;423:25
expert (2)
412:7,8
explain (16)
339:8,23;370:21;
395:9;424:20;425:18;
437:19;440:9,22;
442:4,24;445:15;
448:12;450:14;
451:10;453:20
explaining (1)
389:7
explore (1)
417:22
expressed (1)
467:12
extended (1)
436:20
extension (4)
386:14,25;436:13;
449:12
extensor (2)
391:25;392:1
extent (4)
364:15;417:7;
418:22;448:24
extra (3)
391:3;402:9,12
extremities (1)
400:13
extremity (1)
400:14

F

face (1)
425:25
facet (3)
380:19;396:21;
426:10
facetectomy (3)
395:6;397:7,11
facets (1)
396:21
facility (1)
466:12
facing (1)
357:23
fact (11)
337:24;345:2,13;
377:25;378:15;
420:18;423:18;428:3,
22;429:1;466:21
factor (4)
371:10;388:23;
399:17;444:21
failed (1)
342:8
failing (1)
386:22
fair (2)
343:1;381:21
faith (1)
345:11
fall (3)
398:21;399:3;430:5
falling (1)
425:1
falls (2)
429:25;430:4
false (1)
340:6
familiar (2)
406:8,14
fancy (1)
376:22
far (2)
371:3;468:1
fares (1)
425:25
faster (1)
452:17
fat (5)
358:16,19;390:4,8,
10
fault (1)
341:13
February (1)
446:3
federal (1)
344:5
feel (4)
354:11,19;368:5;
449:5
feeling (2)
354:4;368:6
feet (7)
352:14;367:9;
370:23;428:10;
468:19,24;469:5
fell (4)
425:21;435:25;
463:20;468:10
fellows (1)
350:14
fellowship (1)
432:17
felt (1)
440:11
femoral (9)
385:10,19,21,23;
386:25;437:17;
445:10;446:11;
447:17
femur (2)
436:17,22
fibers (8)
362:8;366:21;
368:14,14;388:7,10,
10;394:9
fibulation (2)
370:8,9
field (1)
348:14
fifth (3)
370:13,25;371:1
figure (2)
353:10,15
fill (2)
414:19,22
filled (1)
415:6
film (7)
355:15,24;357:19;
359:15;363:11;
365:16;420:24
films (15)
355:5,8;356:22;
357:1,10,12;367:4;
370:19;371:21;
378:24;418:18;
420:22;421:9,14,19
final (3)
342:12,19;468:15
finally (1)
391:15
find (8)
353:15;357:12;
369:25;375:10;
414:10;441:2;449:1;
451:16
finding (9)
337:24;342:10;
356:17;386:2,24;
417:20;423:9;446:23;
450:9
findings (52)
336:7;338:1;
352:20;353:12,20;
354:2,23,25;356:6,10,
13;362:20,22;367:3,9,
10;370:18,25;371:1,
11,20;374:9,11;
384:17;385:5;387:2,
2,4;388:25;389:5;
394:15,16,21;397:25;
399:16,16,16;400:1,3;
413:18,18;415:7,11;
417:14;438:6;440:14;
441:14;444:1;446:16,
21;449:23;450:8
finds (1)
356:11
Fine (6)
334:11;339:10;
357:7;360:3;379:10;
446:9
finger (1)
375:10
fingers (2)
363:2,2
finish (2)
334:7;465:22
finished (3)
334:8;349:10;
350:23
finishes (1)
432:2
Fire (1)
337:6
firm (2)
405:21;455:21
first (36)
335:1;347:17,22;
351:20;352:21;
355:20;365:3;367:12,
21;370:3;371:1;
372:1;383:13;388:20;
401:8;406:18;409:14;
411:14,20;423:25;
424:1,4;433:21;
434:8;435:2;437:13,
19;441:16;443:9;
444:15;455:23,25;
456:1,4;458:14;
466:11
five (10)
355:19;364:18;
366:7;391:23;392:6,
7;424:23,25;425:3;
456:20
flection (2)
449:8,11
flesh (1)
402:11
flexion (1)
436:13
flexor (1)
374:7
flick (1)
373:22
floating (1)
390:11
floor (2)
383:13,14
fluid (8)
358:20;363:19,20,
21,25;366:5;391:2;
422:7
fluoroscope (1)
382:6
fluoroscopic (1)
382:6
fluoroscopy (2)

381:24;382:12
focus (3)
446:19;449:10;
454:7
focuses (1)
348:22
focusing (3)
436:4;439:6;459:11
follow (2)
342:15;403:16
following (11)
346:23;383:7,25;
404:8;405:8;430:20;
431:1;448:15;455:6;
462:2;470:3
follow-up (1)
402:23
foot (1)
392:5
Foramen (3)
390:2,22;391:2
force (2)
416:14;460:8
form (4)
414:19,22;415:2,4
forming (1)
421:23
forms (1)
374:16
forward (3)
398:3;403:4;469:24
found (18)
336:3;337:14;
338:6,18;339:5,19,20;
341:14;345:3;393:18,
19;423:4;442:4;
445:22,24;451:18;
461:13;462:17
four (1)
392:8
fourth (1)
456:7
four-year (1)
349:8
fracture (11)
366:15;418:19;
422:6,7,17;424:16,25;
425:4,7,23,23
fraud (15)
335:2,23;336:10;
337:8,15;338:3,5,7,
13,24,25;339:5,18;
340:3;345:21
free (1)
412:11
frequent (1)
398:22
Friday (1)
470:6
Friedman (2)
405:22;455:21
front (20)
349:23,25;351:17;
358:14;372:10;375:1,
7,15,16;376:8;377:3;
380:18;385:11,17,18;
392:4;393:8;434:25;
444:13;458:16
full (3)
342:6,18;469:15
full-time (1)
350:24
function (2)
361:11;452:4
functional (2)
398:12,14
functioning (2)
370:11;371:5
furniture (1)
376:24
further (11)
364:23;371:20;
389:25;403:20;
424:10;429:4;430:8;
449:5;454:23;466:5;
468:14
fuse (1)
393:3
fusion (11)
372:8,9,11;376:1,1;
378:12,16,17,22;
393:3;412:14
future (9)
401:14,20;402:15,
21;428:16,24;452:14;
453:17;454:14

G

gait (3)
398:3;417:8;436:11
gave (7)
439:5;443:11;
444:4;447:23;449:13;
458:13;459:10
general (2)
349:6;362:16
Generally (5)
348:16;402:1;
412:13,14;419:2
generated (1)
441:1
gentleman (1)
409:1
Gentlemen (5)
382:24;403:24;
430:15;454:24;
469:19
gets (3)
341:15,17;452:17
given (5)
401:23;407:13;
408:17;409:17;
410:16
gives (1)
443:1
giving (3)
334:15;436:6;
441:20
glance (1)
394:10
glue (2)
376:10;393:3
gluing (1)
376:2
goal (3)
378:1;403:3,5
goes (8)
334:10;339:21;
362:12;369:3;385:13,
14;392:1;461:24
goniometer (1)
450:8
good (10)
334:2;346:16;
382:10,21,23;405:19,
20;424:4;455:20;
469:18
Gorelick (2)
405:22;455:21
grade (6)
363:22;365:12;
366:7;424:22;426:8,8
graded (1)
391:22
grades (1)
425:1
graduated (1)
349:4
graft (5)
376:20;377:15;
380:12;396:25;397:1
grandmother (5)
413:10;425:20;
429:24,25;430:4
grant (1)
341:4
granted (2)
340:22;341:6
grass (1)
447:11
gravity (3)
392:7,9,10
gray (9)
358:18;359:1,18,
19;361:15;365:19;
379:12;380:9;390:6
Great (1)
431:24
greater (2)
398:10;426:15
green (1)
447:12
grey (1)
379:14
grind (1)
376:19
ground (1)
467:25
grow (4)
378:17,21;393:5;
460:5
growing (2)
380:6,12
growth (4)
396:14,19,21,23
guess (2)
409:3;415:19
Guidelines (2)
449:7,22
guilty (1)
341:14
guy's (1)
424:25

H

half (2)
358:8;463:8
hallux (1)
391:25
hamburger (6)
365:18,19,21,22,24,
25
Hamstring (1)
385:14
hand (9)
347:11;351:11;
368:5,10;369:3,15;
373:23,24;431:11
handed (4)
351:15;369:19;
433:10,13
Handing (12)
343:4,8;346:8;
351:13;369:17;
407:19;408:19;
409:16,19;410:18;
433:12;434:19
hands (10)
352:13;353:21;
363:1;367:9;368:7,8;
370:23;373:21;
384:20;428:9
handwriting (1)
434:6
Hang (2)
334:23;463:20
hanging (1)
436:1
happen (11)
371:21;373:8;
381:18;390:15;402:8;
426:6;453:4,5;
460:15,16;467:20
happened (9)
337:14;340:14;
425:10;428:3;429:1;
436:7;440:15;461:22;
468:12
happening (6)
356:14;367:25;
390:12,24;391:24;
396:14
happens (2)
379:18;460:11
happy (3)
410:13;427:17,18
harkens (1)
343:15
head (4)
352:25;374:17;
409:3;424:25
heads-up (1)
334:15
heal (6)
377:5,15;388:10,
13,16;393:14
healed (1)
366:16
healing (2)
396:14;422:7
healthy (2)
364:18;459:20
hear (1)
469:3
heard (14)
346:23;383:7,25;
404:8;405:8;411:14,
17,20,23;430:20;
431:1;455:6;461:25;
470:3
hearing (10)
346:23;383:7,25;
404:8;405:8;430:20;
431:1;455:6;457:7;
470:3
heart (2)
367:25;368:1
heartbeat (1)
367:25
heavy (1)
398:16
heel (1)
354:19
heel-toe (3)
398:9;400:14;417:5
heel-to-toe (2)
417:11,11
height (2)
376:6;377:2
held (3)
350:11;393:13;
470:5
Helio (3)
340:9;341:2;346:10
help (1)
464:6
helped (2)
384:19;428:8
helpful (2)
384:19;403:1
herniate (1)
388:8
herniated (5)

388:4;419:24,25;
420:5;424:2
herniation (21)
355:16;359:6,8,11,
17;362:16;363:17;
373:4;387:20;388:19;
389:1,7,10,22;393:23;
418:3;421:3,6;425:3;
426:19,25
herniations (2)
365:1;366:11
hey (1)
339:23
highgrade (3)
437:15,19,22
hint (1)
364:5
hip (4)
425:23;430:1,2,5
hips (1)
425:22
histories (1)
414:11
history (25)
352:8;371:18;
389:4;399:23,23;
413:18,21,22,24;
414:1,7,14,15;426:14;
435:16;438:5,16,19;
458:5,6,13;459:10;
463:14,17;464:11
hit (1)
463:21
hitting (1)
468:11
Hoffman (2)
373:19;374:7
Hoffman's (1)
398:5
hold (4)
350:8;373:21;
393:10,14
holds (2)
365:10,11
home (1)
454:2
honest (1)
467:7
honestly (1)
378:17
Honor (23)
334:20,21;335:1,
15,19;336:24;337:21;
338:18;340:1;342:5,
17;343:20,24;345:25;
347:7,25;357:9,15;
382:21;405:15;407:8;
420:9;431:22
hope (1)
419:21
hopefully (2)
412:21;413:12
horn (1)
440:14
hospital (5)
338:24;349:7;
350:19;432:15,16
hospitals (2)
337:6,12
housekeeping (2)
334:5;347:3
Howard (1)
349:3
human (1)
419:18
hunched (1)
380:25
hundred (1)
350:25
hurt (1)
452:9

I

ice (1)
447:9
idea (2)
382:23;422:9
identical (1)
376:25
identification (1)
434:12
identifying (1)
422:11
II (1)
370:24
III (1)
371:2
illness (3)
334:4;389:4;438:12
image (5)
359:24;360:1;
380:2;382:6,8
images (6)
357:22;360:22,22,
24;382:7,12
imagine (3)
376:8;382:2;461:7
immediate (2)
366:13,14
impeachment (1)
339:12
impingement (3)
359:11;360:4;
377:20
impinging (1)
361:19
implants (10)
379:19,22,24;
380:12;382:5,9,16;
396:1,2,5
important (3)
353:17;361:11;
446:23
impression (1)
370:14
improvement (1)
386:10
inaccurate (2)
414:15,16
incident (1)
345:4
incision (1)
392:18
included (4)
371:13;391:20,21,
22
including (7)
336:4;337:25;
338:1;388:25;392:23;
400:2;404:12
increased (2)
386:13;448:14
increasing (2)
387:24;394:22
increments (1)
382:7
incur (1)
425:25
Index (6)
346:1,9,10;353:10;
363:2;402:2
indicate (3)
374:1;397:9;408:15
indicated (13)
337:11;344:21,25;
352:12;370:12;373:3;
398:17;399:9;402:18,
22;413:20;437:3;
446:20
indicates (4)
364:25;377:21;
437:23;440:10
indication (5)
353:23;366:17,18;
373:10;444:15
indications (4)
373:10,12;391:17,
18
individual (3)
361:5;425:13,15
individuals (2)
335:24;337:7
infection (1)
389:6
inflammation (4)
437:10;443:1,1;
448:14
influenced (1)
416:22
information (1)
371:12
initial (6)
435:16;458:15;
459:1,3;461:5;467:18
initially (2)
428:11;466:17
injection (5)
436:10;437:3,6,9;
443:22
injured (2)
414:24;441:17
injuries (6)
338:9,9;339:6;
345:3;465:7;468:5
injury (25)
338:19;373:3;
389:4;399:23;418:21,
22;420:1,14;439:2;
440:7;442:25;448:15;
449:21;456:16;
462:23,25;464:25;
465:6,13,14,16,24;
467:21;468:4,8
inserted (1)
445:1
inserting (1)
393:11
inside (14)
346:23;358:16;
359:2;362:7;370:10;
371:6;376:21;380:10;
383:25;388:7;405:8;
431:1;459:24,25
instability (10)
436:13;439:1,5,21;
444:17,18;447:13;
453:21;454:10,22
instead (3)
344:5;385:22;
386:16
institution (1)
349:9
institutions (1)
350:12
instrumentation (1)
376:13
insufficiency (4)
436:25;437:2,16;
447:15
insurance (4)
337:16,18;338:7;
412:15
insurer (3)
337:22;338:8;345:1
intact (2)
461:14;462:21
intake (4)
414:19,22;415:2,4
Integon (4)
336:16,19;344:12;
346:9
interbody (2)
375:24;379:25
interesting (1)
390:25
internal (1)
374:22
internet (4)
383:2;404:2;455:2;
469:22
internship (2)
349:6;432:15
interpret (2)
435:13,14
interpretation (8)
355:10,23;359:10;
360:9,17;363:11;
365:2;426:10
interpreter (4)
352:4;415:5;436:5;
463:15
interpreting (1)
421:14
interval (1)
389:4
intervention (1)
453:23
interventions (1)
401:24
interwoven (2)
362:8;388:9
into (46)
334:10;338:23;
339:23;350:16;
352:12,13;353:9,21,
22;354:19;357:25;
358:6,15;359:22;
360:6;361:3,19;
363:1;366:24;367:8;
369:3,21;375:18;
376:2,20;377:13;
379:7;380:6,12;
384:20;385:14,18,18;
390:17;392:1;393:13;
396:10;399:2;402:11;
428:8,9;432:1;441:1;
445:1;455:24;461:4
intraoperative (2)
382:5;394:15
intraoperatively (1)
381:14
inverted (1)
374:6
invisible (1)
423:18
invoices (1)
338:8
involved (8)
336:8;338:5,13;
339:18;345:12,16;
456:15;459:11
involvement (2)
438:19;450:11
involves (1)
350:17
involving (1)
394:25
irregularity (1)
450:16
irritants (1)
374:22
irritated (2)
354:10;374:16
irritates (1)

447:14
irritation (14)
353:24;354:5;
355:3,4;360:7;
368:20;373:7,20,25;
374:16;377:20;386:1,
23;447:7
issue (7)
334:5;335:1;
341:13,15,21;426:3,5
issues (9)
334:21;345:22;
347:3;353:16;371:17;
385:1;402:3,5;426:2
items (1)
418:2

J

Jacobson (2)
405:22;455:21
January (2)
443:16,18
jelly (1)
388:7
jelly-like (1)
362:6
Jersey (5)
427:11;431:19;
432:11,18;433:8
job (1)
388:17
John (1)
432:17
joint (9)
365:17,17;390:15;
391:3,3;432:16;
436:15;449:21;466:2
joints (10)
348:21;365:15,16,
16;380:19;390:25;
392:23;393:20;
432:25;433:2
Jose (1)
409:2
Judge (26)
335:9;336:11;
337:3,20;339:14;
340:11,14,19,23;
341:3,6,18;343:9,14;
346:4,13,15;384:7;
413:4;418:5;420:9;
424:13;429:4;466:7;
469:14,17
judges (1)
335:22
judgment (14)
335:23,24;336:10,
20;337:10;340:2,7;
341:5;343:1,5;344:9;
345:17,20;413:14
July (11)
355:12,25;357:14,
14,21;360:10;364:24;
370:4;372:24;422:15;
437:14
jump (1)
366:23
June (8)
400:22;401:8;
402:20;441:25;
443:20,21;463:19;
464:5
juror (1)
334:3
jury (66)
334:9,9,10;339:8,
25;345:9,10;346:12,
21,22,24;347:4;
348:16;356:25;
359:14;360:4,20;
382:24;383:5,6,8,21,
23,24;384:1;389:10;
395:9;403:24;404:6,
7,9;405:2,5,6,7,9;
418:15;420:3;421:7;
424:20;425:18;
430:15,18,19,21,23,
24,25;431:2;437:19;
440:22;442:24;
445:16;450:14;
451:10;453:20;
454:24;455:4,5,7,12,
13;469:19;470:1,2,4

K

keep (1)
412:5
kick (1)
337:16
kidding (1)
420:9
kind (30)
358:5;359:5;362:5;
363:3;365:12;366:7;
367:24;373:21;
374:18;379:16,17,22,
22;380:3,7,18;381:1;
382:2;383:2;402:12;
404:2;414:21;422:8;
424:6;433:19;448:5;
453:10;455:2;464:25;
465:3
kinds (2)
418:19,20
Kings (3)
344:23;349:7,9
knee (80)
433:3;435:23,24;
436:4;437:4,14;
438:4,14,17;439:16;
440:15;441:6,10,12;
443:22;444:2,2,8,11;
445:2;446:7,19;
448:4,8,15,18;449:9,
9,11,12,16;450:2,19;
451:6,13,14;452:2,4,
14,17;453:6,7,10,17;
454:1,5,7,9;458:7,8,
12,19,20,22;459:4,4,
9,10,11,14,17,17,20;
460:8,11,18,22;
461:11;462:25;
463:18,22;464:11,12,
14,19,20,25;465:1,20,
21
kneecap (6)
436:17,20;447:7;
450:10,11,17
kneeling (1)
357:6
knees (5)
385:19;433:2;
435:22;458:5;459:12
knew (3)
345:8,12;386:2
knowledge (1)
341:9
known (15)
344:15;355:16,20;
358:12;361:9;370:8;
372:6,9;376:1,20,22;
393:19,24;398:1;
402:1
kyphosis (1)
380:25
Kyphotic (1)
398:2

L

L3 (1)
390:5
L4 (14)
358:22;386:6;
387:21,21,22,24;
389:24;390:5;391:6,
21;393:20,21;395:5;
398:7
L4/L5 (7)
387:1,20;388:5,25;
390:12;396:5,13
L4-5 (9)
389:7,10;392:13;
393:23;396:22;
423:22,25;424:1,3
L5 (20)
354:20;355:18,21,
22;358:7,10,20,22;
363:22;370:11;386:6;
387:23;391:6,21;
392:2;393:20,20,21;
395:5;398:7
L5-S1 (9)
355:16;358:24;
359:12;363:13,15;
389:20,21;392:14;
393:25
Lachman (2)
436:13,23
lack (3)
362:10;368:19;
415:19
lacking (1)
449:11
Ladies (5)
382:24;403:24;
430:15;454:24;
469:18
lamina (2)
380:19;396:23
laminectomy (3)
395:6;397:4,11
language (1)
388:1
large (3)
354:8;367:1;390:3
last (12)
347:18;350:4;
351:9;400:21;406:5;
427:22;429:3;436:6;
448:17;451:3,15;
453:24
late (2)
345:17;465:18
later (1)
378:6
lateral (3)
445:8,18;447:22
law (2)
405:21;455:21
lay (1)
449:19
layman's (1)
418:1
leading (1)
391:5
leak (1)
374:22
leaning (1)
436:21
leap (1)
345:11
least (5)
349:21;406:5;
407:22;436:13;
464:12
left (48)
361:22;362:1;
377:19;389:18;398:9,
10;435:23,23;436:4;
437:4,14;438:14;
441:6,15,17;442:17;
443:5,22;444:8,11;
446:7,13;447:19;
448:9,18;449:9,10,11,
12,16;450:2;451:6,16,
17,19;452:2,3;454:7,
14;458:20;459:11,17;
460:10,18;461:11;
463:18;464:16;465:4
leg (19)
354:6,7,8,15,15,19;
363:7,8;385:8,11,12,
14,15,22;387:1;
415:24;416:8;436:20;
468:11
legs (9)
352:14;367:9;
370:23;385:17,18;
416:7,9,10;428:9
lesion (1)
446:17
less (7)
392:9;398:17;
399:1,3;436:21;
461:21;462:3
letter (1)
440:24
level (5)
361:24;376:24;
382:1;390:5;423:22
licensed (4)
348:4,7;432:8,10
life (1)
440:4
lifespan (1)
401:19
lifetime (2)
401:25;452:20
lift (2)
392:7,8
lifting (1)
399:3
ligament (13)
436:24;437:21;
439:4;441:21,22;
442:1,2,6;445:4,21;
446:15;447:22;
448:15
ligaments (2)
348:21;442:8
likely (3)
366:16;401:23;
465:10
limine (2)
335:19;336:12
limitation (1)
463:4
limitations (4)
427:25;428:24;
446:5;448:24
limp (1)
398:2
line (8)
345:5;359:1;361:1,
16;365:19;366:23,23;
436:15
lines (1)
354:4
lining (7)
391:1;445:3,20;
447:8;450:16;452:16;
453:8

list (15)
407:7,16,21,24; 408:6,13,16;409:4,11, 12;410:6,7,13,22,24
listed (2)
373:15;409:21
lists (1)
411:3
litigation (1)
456:16
little (26)
351:3;358:15,16; 359:4;361:4,22,24; 362:14;363:25;365:8, 24;376:19;379:23; 380:1,9;387:23; 391:2,22;392:16; 393:9;398:2;424:22; 426:1;440:9;447:19; 467:8
live (1)
427:11
localized (2)
359:5;397:24
located (1)
385:20
lock (1)
377:3
logically (1)
339:7
long (3)
348:7;441:19; 467:25
long-standing (1)
458:5
longus (2)
391:25;441:25
look (46)
336:22;337:1; 351:24,25;352:21; 353:8;355:8;356:22; 358:10;363:18;365:4, 15,16,17;366:5,22; 369:12;373:2;378:24; 379:11;389:19;390:5, 13,18,25;392:19; 395:11;396:19; 398:20;407:6,9; 412:17;420:24; 421:19;433:21; 434:14;440:13;441:8, 8,10;444:10;446:3; 450:24,25;458:14; 469:24
looked (6)
369:12;418:15; 424:3;426:7;441:9,12
looking (21)
352:22;355:15; 357:19,25,25;358:2,6, 11;360:21,23;365:18; 368:21,21;370:7; 371:2;375:14;378:25; 382:3;389:25;433:25; 447:8
looks (13)
358:25;359:25; 365:15,21,23,24; 368:12;379:17;382:3; 390:13;426:13; 440:23,24
lose (1)
363:20
loses (1)
461:24
losing (1)
363:21
loss (26)
354:18;365:8; 373:17;374:1,1,7,8; 386:4,5,7;387:1; 396:8;398:5;400:13; 417:3;441:22;449:8, 15;450:2,6,6;451:16, 18,19;457:20;465:3
losses (2)
366:5;452:2
lost (4)
334:3;438:17; 450:10;464:24
lot (4)
366:17;406:8; 429:9;456:8
low (1)
379:20
low-back (12)
355:4;361:13; 365:6;385:7,8;386:9, 11,12;387:8,10; 389:8;398:2
lower (18)
354:5;355:19; 357:22;358:6;359:23; 361:4;363:4;385:2, 18;386:20,23;389:14, 15;392:17,18;398:7; 400:13,14
lowest (2)
355:21;363:5
lumbar (23)
352:18;353:25; 354:3;355:6,11,12; 356:5,23;357:23; 358:4;360:9;363:11; 364:16;365:5;385:6; 388:1;389:1;391:10; 395:16,17;399:18; 421:7;423:1
lump (1)
354:2
lunch (3)
403:25;404:10,16

M

magnetic (3)
379:18;396:3,3
magnetized (2)
379:19,20
maintain (1)
376:5
maintained (2)
365:7;446:10
Maintenance (2)
403:5,5
major (1)
374:16
makes (5)
338:14;363:3; 364:5;376:5;392:2
making (3)
334:13;340:6;392:5
male (1)
435:21
malpractice (1)
335:2
management (6)
402:23,24,25; 403:1,13,16
maneuver (4)
352:24;373:17; 386:15,25
maneuvers (1)
398:21
Manhattan (1)
429:14
manner (1)
376:11
many (7)
350:21;406:3; 407:1;433:3;456:23, 25;457:18
March (1)
391:11
margins (2)
358:23,25
mark (3)
434:12,13,21
marked (5)
407:11;433:19; 434:22;446:8,20
massive (2)
364:19;424:25
material (6)
355:17;361:3; 388:18;393:23,25; 394:14
matter (2)
342:14,16
maximum (1)
449:2
May (24)
343:9,23;346:18, 25;347:24;363:10; 364:23,24;366:9,16; 378:9;395:2;404:14; 405:10,12;407:8,16; 409:14;414:15;425:5; 427:12;434:3;452:15; 455:14
maybe (6)
337:5;364:20,20; 366:7;392:8;426:1
mean (28)
366:3,6,20;369:1; 381:13;398:18;410:6; 413:23,23;415:18; 417:7;420:18;424:17; 426:7;428:7,15,23; 430:1,5;437:24,25; 438:25;440:6;445:16; 447:20;449:4,18,19
Meaning (5)
414:4;465:8,20,24, 25
means (30)
350:6;353:6;354:7; 360:4,5;362:12,14; 364:4;365:22;366:13; 372:10,10;374:17; 376:1;381:6,6;386:1; 390:2,2;391:3;392:6; 393:4;398:2,25; 417:24;436:21; 437:21,22;447:22,22
meant (1)
444:3
measured (1)
450:7
meat (1)
447:10
mechanical (3)
401:18;402:10; 428:20
mechanism (3)
468:4,5,8
medial (9)
436:15;437:17,23; 438:9;440:10;441:24; 445:8,10,19
medially (1)
442:2
medical (35)
337:22;349:2,3; 350:9,15;371:8,18; 388:22;399:14,22; 400:5,16;402:14; 413:21;414:7,10,15; 415:1;432:13,14,14; 438:7,21;442:11,15, 20;444:20;448:8; 449:2;450:1;451:5; 452:13;453:12,16; 454:19
medication (1)
443:11
medicine (4)
348:4,18;349:3; 432:9
meet (1)
399:4
memory (2)
458:18;464:2
meniscectomy (6)
437:18,24;438:9; 440:10;445:8,9
meniscus (12)
440:15;445:19; 459:23,25;460:5,7,12, 13,24;461:1,2;465:3
mention (2)
335:12;344:11
mentioned (5)
336:11;360:3; 418:18;445:7;447:5
mentioning (1)
335:13
merits (2)
341:12;345:20
Merola (22)
335:2;337:19,22; 338:2,4,12;339:8; 340:2,15,15;341:14; 342:8;344:10,22,25; 345:2,17;347:8,19; 384:4;405:19;424:8
M-E-R-O-L-A (1)
347:20
Merola's (1)
337:25
metal (1)
396:2
methods (1)
381:3
Metropolitan (1)
432:15
Michael (2)
431:5,18
M-I-C-H-A-E-L (1)
431:21
micromillimeter (1)
366:24
microphone (2)
432:1;455:24
middle (4)
373:22,22;390:6,10
might (5)
376:8;382:2; 423:14;444:1;451:14
mild (3)
398:10;436:11,12
mile (1)
463:8
millimeter (2)
442:3;446:16
mine (1)
467:6
minute (2)
343:23;382:22
minutes (3)
383:4;430:17;463:7
miss (1)
464:21
missed (1)
464:23

missing (3)
459:23;460:1,12
mistakenly (1)
464:19
modified (1)
382:6
moment (1)
447:13
money (10)
336:2;337:7,13;
412:7,13,16,23;413:3,
9,13
monitored (1)
401:17
month (2)
461:21;462:3
months (4)
378:6,18;396:16,17
more (40)
337:4,5,5;350:6,6;
359:6,6;361:22;
362:14;363:16;
368:18;377:20;378:3;
380:1;381:15;382:13;
387:24;398:9;401:23;
412:22,23;413:1,3,8,
9,20;422:5;423:6;
426:1;446:2,23,24;
447:10;448:14;
451:13,14;452:16;
454:10;457:2;467:7
morning (3)
334:2;347:5;469:24
most (8)
362:1;388:12;
391:24;417:10;442:6;
446:23;461:23;
465:10
mostly (2)
385:19;386:6
motion (17)
335:19;336:12,24;
340:16,17,20,23;
341:10;344:16;
345:18;352:23;
384:25;399:2;449:22;
450:7,10;463:4
motor (3)
337:15;374:3;398:6
mouse (1)
358:5
mouth (1)
417:18
move (4)
369:5;375:13;
376:6;392:19
moving (4)
374:18;376:11,24;
412:5
MRI (94)
355:5,11,12,15,24;
356:1,6,16,22;357:10,
22;359:11,15,19;
360:9,10,11,13,17,20;
362:20;363:11;
364:24;366:11,22;
367:1,4;370:19;
378:5,11,11,12,24;
379:18;381:13;
387:11,12,19;388:20;
389:5;394:17,22;
395:3,11,15;396:16;
397:9,9,12;399:16;
418:6,16;421:17;
422:1,15,15;423:1,4,
6,10,17,25;424:1,4,
16,17;425:8,8,8;
437:13,15;438:6,23;
439:17;440:9,14;
441:9,13,25;442:5,12;
446:15;459:16,19;
461:10,13,21;462:1,3,
6,9,22;467:18,18
MRI'd (1)
420:6
MRIs (7)
371:2;382:14,18;
392:12;400:2;418:14;
426:7
Mt (1)
431:18
much (28)
346:25;347:6;
359:4;363:23;368:15,
18;369:6;383:3;
394:20;404:5;412:7,
13,16;425:2;426:9;
431:24,25;449:20;
452:17;455:3,17;
457:17,19,22;460:9;
462:6;469:8,20
multiple (2)
368:4;411:23
muscle (6)
368:23;370:11;
375:9;392:6;446:9,9
muscles (8)
348:21;368:3,9,11,
13;371:6;392:19;
454:9
muscular (1)
368:17
musculoskeletal (1)
348:19
myelopathy (3)
373:4,6;374:5
myself (1)
430:16

N

name (11)
347:18;405:21;
409:1,24;411:14,17,
20;414:23;431:16,20;
455:20
named (3)
337:17;339:2,3
narrow (1)
361:22
narrowing (2)
361:25;362:1
National (1)
346:9
nature (4)
374:24;400:6;
426:20;448:24
necessarily (5)
420:15,16;428:25;
460:14;465:9
neck (36)
348:23,23;351:6;
352:11,12,24;353:11;
355:3;360:22;361:4,
5,6;365:12;367:8;
369:3;370:22;371:17,
18;372:10;374:17;
375:2,3,4,11;384:23;
386:10,18;392:16;
393:7,8;394:20;
397:24;399:23;
401:24;402:10;
416:16
need (11)
348:20;376:10;
383:12;401:13;
402:14;428:15;
444:21;452:14;453:8,
16;458:15
needed (5)
347:3;439:5;
446:23;454:1,4
Needing (1)
451:12
needs (1)
454:19
negative (2)
353:6;354:14
neighborhood (1)
401:19
nerve (68)
353:23,24;354:5,8,
12,21;355:3,4,22,22;
358:18;359:2,3,21;
360:6,7;361:5,13,14;
363:6;367:14,15;
368:6,7,9,10,12,14,15,
20,22,23;369:13;
370:10,10,12,13;
373:18;374:23;
377:18,22;381:16;
385:13,16,19,22;
386:6,22;387:21;
390:1,2,4,4,7,7,8,10;
391:6,6,21;392:2,24;
394:1,9,13,25;398:4;
400:2
nerves (28)
353:10,11;355:3;
358:13,16;359:18,20,
23;361:7,17,21;
362:25;363:5;368:2,
4,17;371:5;372:7;
374:15,19,19,21;
375:20,23;385:17;
386:17,21;392:22
nervous (5)
361:9,10,12,13,15
neuroforamen (6)
390:2,11,14,14,16,
17
neurological (5)
374:9,11;387:2,4;
428:10
neurology (1)
384:25
Nevertheless (1)
379:21
New (27)
337:6,11,12;
338:24,25;347:22;
348:5;349:5,6;350:9,
24;376:20;387:19;
388:25;396:13,19;
423:9;427:11;431:19;
432:10,10,14,15,18,
18;433:8,9
Newark (11)
427:11;429:10,11,
15,22;431:19;433:16;
435:4;466:10,17,25
news (1)
334:3
next (13)
334:7;335:18;
342:12;359:17;365:9;
367:16;390:22;391:7;
404:17;421:21;431:4;
443:7;469:15
nicely (1)
388:13
nine (4)
396:16;409:10,25;
410:12
none (2)
428:12;441:7
nonexistent (1)
438:14
nontraumatic (1)
426:20
nor (2)
339:12;399:23
normal (7)
348:25;364:13;
376:5;377:5;384:25;
393:16;447:8
Note (12)
397:15;401:4,9;
427:14;434:11;
445:11;450:24;
452:21;453:1;466:13,
18;467:13
noted (20)
399:6;401:10;
424:17;435:21;
436:10,15;438:23;
440:12;441:17,20,24,
25;445:12;446:7,12;
449:2;450:19;452:2;
466:14,19
notes (2)
433:19,22
notice (1)
396:6
noticed (2)
386:10,11
notorious (1)
342:9
November (1)
387:17
nuance (1)
388:4
number (10)
334:3;346:9,10;
360:1;372:17,18;
395:21;407:25;
409:22;415:10
numbers (3)
346:1;407:6;449:23

O

oath (7)
347:12;383:10;
384:5;404:12;455:9,
10,16
objection (23)
335:9,11;394:4;
397:15;401:9;412:4,
24;413:4,6;418:5;
427:14,19;429:17;
434:13,18;445:11;
452:21;453:1;457:10;
466:13,18;467:13;
468:20
objective (2)
368:24;369:8
Objectively (1)
387:9
obligation (1)
335:4
obligations (1)
335:7
observing (1)
417:8
obvious (1)
425:20
obviously (1)
339:15
occasional (1)
398:22
occasions (1)
411:23
occult (1)
389:5

occupational (1)
398:19
occupations (1)
398:16
occur (6)
339:6;402:1;
419:12;452:18,19,25
occurred (8)
420:18,25,25;
422:2,4;423:6,13,19
occurring (1)
399:24
occurs (1)
396:7
October (12)
378:6;395:4,15;
397:21;399:13;
433:24;443:7,8,13;
444:11;448:18;470:7
off (5)
368:16;390:23;
409:3;425:1;470:5
offer (1)
451:24
office (16)
338:23;339:24;
350:18;352:3;353:14;
387:15,16;414:18;
415:11;427:6;429:11,
13;433:8;450:8;
457:20;467:2
OFFICER (21)
344:19;346:21;
347:11;351:14;
369:18;383:5,17,23;
404:6;405:6;407:13;
408:17;409:17;
410:16;430:18,24;
431:9;433:13;434:24;
455:4;470:1
offices (1)
433:9
often (1)
398:20
older (2)
363:20;467:8
olisthesis (2)
393:20;394:13
once (9)
334:6,8;365:7,11;
385:25;392:25;
393:15;419:14;460:7
One (62)
334:5,23;335:23;
341:19;343:23;344:7,
22,23,24;357:24;
361:24,25;362:14;
364:20,21;365:12;
366:2,7;368:21;
370:3;374:16;376:3,
18;377:13;378:22;
379:2,2,2,3,5,7;
389:17;390:15,21;
392:1,10;395:24;
403:14,17;408:23;
409:21,21,25;410:1,2,
13;413:20;415:6;
416:25;419:21;
423:13;426:8;433:8;
445:4;457:2;458:16;
461:21;462:3;464:12;
466:2;467:6;468:15
ones (1)
421:15
one-third (2)
399:1,4
Only (11)
335:3;341:7;361:6;
369:5;375:12;381:16;
383:13;393:8;408:1;
462:17;467:21
onset (7)
366:13,14;387:20;
388:25;417:24;
418:16,21
opening (4)
390:1,2,3,6
openings (2)
361:6;390:3
operate (1)
432:25
operated (2)
402:7;408:9
operating (1)
350:19
operations (1)
399:17
operative (6)
373:2;377:21;
440:14;444:10,13;
445:7
opinion (33)
371:8;388:21;
398:14;399:14;400:4,
8,11,16;402:13,17;
403:14;413:17;415:8;
421:24;438:6,20;
439:7;442:10,14,19;
444:19;445:23;446:1;
448:7;449:25;451:4,
8,20;452:12,25;
453:12,15;454:18
opinions (2)
378:14;467:11
opposed (1)
416:10
opposition (1)
341:7
options (1)
447:23
orange (1)
447:11
order (13)
334:14;340:24;
351:21;353:1;375:17,
18;376:10;381:3,17,
25;393:6;433:24;
454:7
originally (1)
386:5
Orthopedic (9)
348:12,13;349:8,
10,16;429:15,21;
432:16,21
orthopedics (4)
348:18;349:20;
350:15,17
osteoarthritis (1)
460:18
osteochondral (2)
442:2;446:17
osteophytes (1)
364:19
otherwise (2)
342:20;378:22
out (35)
342:18;346:18;
351:21;353:11,15,15;
355:17;358:14,25;
359:4,6;361:6,16;
362:9,10,14,25;
376:24;377:11;
379:17,21,23;381:17;
387:21;392:19;396:2;
408:24;409:25;410:1,
2;414:10,19,22;
415:6;436:20
outer (2)
362:7;388:14
outside (11)
346:14;347:3;
383:7;388:8;404:8;
430:20;442:6,8;
455:6;459:23;470:3
over (20)
365:23;369:7;
376:21;380:25,25;
387:23;388:17;
390:22;391:23;392:6;
397:1;401:17,25;
408:13;433:3;441:21;
446:13,14;447:20;
449:8
Overruled (6)
418:8;429:19;
453:2;457:11;467:14;
469:2
ovoid (1)
358:14
owed (3)
336:2;337:7,13
own (4)
416:7,7,10;460:24

P

page (3)
399:8;401:21;
404:17
paid (14)
337:18;412:8,9,16,
19,21;413:11,12;
457:17,19,20,22,25;
458:1
pain (40)
352:12,13;353:20;
354:9,12;360:8;
367:8;368:6,8,14;
369:3;370:22,23;
384:20;397:23;
402:22,24;403:1,2,13,
16;436:5,14,17;
437:10;441:18,20;
443:25;444:1,17;
446:14;447:20,23;
459:9;463:2,12,13;
468:19,24;469:5
palpable (1)
352:23
palpation (1)
446:13
papers (2)
341:7;344:16
paragraph (2)
401:21;402:19
parallel (1)
436:21
part (23)
355:21;357:21;
359:23;362:1;363:4,
6;364:13;370:24;
371:2;378:15;385:18;
413:22;414:7,9;
415:8,15,15;417:10;
419:3;421:19;437:21;
446:9;461:23
partial (15)
377:6;381:8,21;
393:1;395:5;437:15,
17,20,21,23;438:9;
442:2;445:8,8;462:19
partially (1)
461:14
particular (14)
348:9;353:4;365:9;
380:1;381:12;398:21;
399:1;426:6;428:3,
17;429:1;432:20;
449:21;466:21
particularly (3)
358:21;368:16;
380:13
parts (4)
350:2;368:22;
414:23;432:24
party (3)
335:4,7;338:3
pass (1)
350:2
passing (1)
359:1
past (8)
371:17;401:21;
413:21;414:7,10,14;
419:17;462:7
patella (5)
445:9;446:11;
447:14,16;449:14
patellar (3)
436:12,19,22
patellofemoral (2)
436:11,16
patellofemorally (1)
447:5
pathology (1)
452:16
patience (1)
421:17
patient (68)
338:19;339:8;
353:2,14,20;354:11;
356:10,12;357:23;
364:9;367:10,16;
369:2,4,5,6;371:13;
372:18;377:4;385:25;
391:19;393:15;399:7;
400:18;402:3;403:4;
406:18;409:22;
412:18;414:4,18,22;
415:17,19,24;416:9;
417:10;425:6;426:25;
427:3,7,7,24;428:15,
23;435:15,18;436:9;
437:6,14,18,25;438:1,
16,22;439:11,12,25;
441:12;442:16;446:5,
20;450:1;466:11,22;
467:3,5,22
patients (40)
336:8;338:6,6;
345:11;349:23;351:5;
373:9,20;403:2;
406:16;407:1,5,22,25;
408:5,7;409:10;
410:4,9,12,21;411:1,
6,9,18,24;412:20,21,
22;413:1;414:10;
429:9;456:15,18,21,
25;457:6,8,13,15
patient's (24)
352:10,25;353:5;
355:1;356:14,16;
362:21;367:3;369:8;
370:18,22;384:9;
388:24;394:16;
397:21;399:15;400:5;
414:5;416:14,23;
426:16;435:20;
438:13;443:14
pattern (2)
398:3;417:8
pattie (1)
365:19
Pausing (14)
334:24;343:12;

346:20;356:24;
357:13;370:1;403:19;
407:15,20;409:20;
433:23;434:2,16;
451:1
pay (1)
441:13
peculiar (1)
461:22
pedicle (1)
393:12
pelvic (1)
425:23
pelvis (1)
355:19
people (1)
339:23
peptides (1)
419:16
per (5)
350:25;351:1;
361:23;388:11;406:4
percent (16)
384:24;401:11;
408:12;411:4;420:4;
449:8,12,13,14,15,15;
450:1,5,10,10;451:18
Perez (2)
435:12;466:22
Perfect (1)
346:7
perform (8)
340:5;372:15;
399:7;408:23;409:1;
411:2;415:24;429:22
performed (24)
336:2;372:23;
374:25;375:24;
378:13;382:19;
387:12;392:15;395:4;
397:4,7;408:8,21;
409:7;410:9,21;
415:10,17;444:25;
445:2;446:22;459:16;
461:10,16
performing (1)
353:4
Perhaps (1)
411:13
periods (1)
441:19
peripheral (2)
361:12,13
permanent (7)
400:6,11;428:23;
451:6,9,21;454:6
permission (2)
335:5;357:3
peroneal (1)
441:25
perpetrated (1)
337:9
persist (2)
398:7;447:12
persisted (1)
450:20
persistent (1)
389:23
person (2)
364:18;394:24
personal (2)
341:9;456:16
pertinent (1)
413:21
physical (29)
352:15;353:18,20;
354:25;356:7,10,13;
362:21;367:9;370:24;
371:1,19;384:21,23;
388:24;394:17,21;
399:25;402:22,24;
403:1,3;413:24;
438:6;454:1,2,8,14,19
physician (5)
348:4;416:10;
418:1;419:15;432:8
physicians (2)
414:21;466:17
picture (3)
359:20;365:22;
381:25
piece (6)
362:6;376:23;
377:13;378:22;441:2;
460:12
pieces (5)
388:14;441:1;
447:9;461:4,4
pile (1)
334:10
pill (1)
419:14
pinched (1)
398:2
pinpoint (1)
452:18
pivot (1)
436:14
place (6)
376:12;377:3;
382:5,10,11;388:20
placed (3)
369:21;382:16,16
plain (1)
388:1
Plaintiff (21)
338:22;347:8;
402:14,21;406:22;
417:3;431:5;441:10;
452:4,13;458:4,11,18;
459:8,13;460:17;
463:6,14;468:18,23;
469:4
Plaintiffs (3)
336:3;337:8;345:2
Plaintiff's (15)
345:1;351:11,14;
353:13;354:23;356:6;
357:16;369:15,18;
434:22,24;451:5;
459:16,25;461:11
plan (8)
335:21;336:7,9;
367:13,14;371:23;
387:7;443:10
plate (1)
393:10
Please (16)
347:17,21;349:1;
351:11;382:25;383:9;
403:25;406:12;
408:15;431:9,11,16;
432:1;454:25;455:9;
469:21
pleasure (2)
416:16;427:10
pluralized (1)
458:9
plus (3)
354:12;381:13;
391:23
point (11)
334:13;342:17;
344:7,8;367:15;
371:7;388:2,21;
419:22;448:3;461:19
poking (2)
358:25;359:4
policies (1)
337:18
portion (6)
363:5;368:12,17,
23;378:25;459:22
portions (4)
377:14;382:2;
392:23;413:25
position (1)
376:5
positions (1)
350:11
positive (23)
352:24;353:5,7;
354:11,13,17;356:11;
367:9;370:8,8;371:1;
374:6,6,7;385:9,10;
386:1,22,24,25;387:1;
394:21;446:15
possibility (1)
451:12
possible (3)
353:16;375:4;428:2
post-accident (1)
467:18
posterior (5)
436:15;437:16;
440:14;459:22,24
postoperative (5)
384:14;395:15;
396:16;452:5,6
post-operatively (1)
400:10
postsurgical (1)
397:3
potential (2)
370:9,9
power (2)
416:7,10
practice (10)
348:4,13;349:21;
350:24;351:4,5;
432:8,18;433:6;
435:10
preclude (2)
345:23;425:22
precluded (1)
345:14
predated (3)
423:21;442:12,13
predates (3)
460:3,18,22
predating (1)
423:24
predominant (1)
459:12
preexisting (7)
438:10;439:8,13;
442:21,25;448:13;
453:22
prejudicial (1)
339:15
prematurely (1)
402:12
preoperative (1)
373:1
preoperatively (1)
452:10
prepare (3)
457:22,25;458:2
prepared (1)
415:4
Presbyterian (1)
350:10
presence (14)
346:23;347:4;
383:2,7,25;404:2,8;
405:8;430:20;431:1;
455:1,6;469:22;470:3
present (3)
335:8;349:23;
366:25
presently (2)
433:6;435:22
pressure (8)
368:16;372:7,12;
375:6,19,23;381:15;
393:2
presume (2)
440:15;457:12
pretty (7)
359:4;365:7;379:9;
389:24;394:20;424:4;
462:24
prevent (5)
373:15;376:11,24;
393:6;403:6
prevented (2)
400:18;428:10
previous (3)
437:18;438:11;
464:11
previously (1)
336:24
Primarily (2)
433:1;444:17
primary (3)
373:14;402:2;403:5
prior (30)
335:16,20;339:14;
341:21;371:17;
394:23;399:22;
423:10;435:24;437:4,
25;438:1,2,3,14,19;
439:2,19;440:7;
441:10;442:17;443:2,
14;444:24;452:5;
458:8;459:4;464:13,
17,20
private (1)
432:18
probability (1)
453:9
probably (8)
337:4;351:1;
403:21,23;406:7;
420:4;425:19;434:5
problem (21)
355:2;364:4,6,7;
366:17,18;367:11;
368:13;369:13;371:5;
388:9;394:25;446:12;
458:5,6,12,19;459:12;
463:18;464:17,20
problems (6)
351:6;435:22,23;
438:16;458:7;464:11
procedure (5)
382:17;391:14;
395:10;397:3,7
procedures (10)
336:2;340:5;375:3;
382:19;397:10;402:2,
15;412:14;445:15;
452:8
proceed (3)
334:19;347:1;384:3
proceeds (2)
354:3;392:22
process (8)
349:19;350:2,4,5;
364:13;396:14;
419:19;422:8
processes (1)
380:19
produce (1)
463:12

produced (2)
362:12,13
producing (1)
447:23
Professor (1)
432:17
prognosis (1)
401:12
program (2)
349:20;454:2
progress (2)
453:9,10
progressed (1)
462:22
progressive (2)
384:25;398:6
prolonged (1)
368:20
promise (2)
420:8,9
prone (2)
368:18;426:1
proof (1)
342:9
proposed (4)
363:14;366:9;
395:7;397:14
Prospect (1)
431:19
protrude (3)
362:12;388:8,18
protrudes (2)
362:11;390:17
protruding (4)
359:17;374:18;
391:4;393:23
protrusion (16)
355:17;356:4;
359:5,8,9;360:18;
361:2,18;362:2,3,17,
19;363:13,15;390:19;
394:9
prove (1)
345:7
provocative (1)
356:11
proximity (1)
422:5
pull (3)
354:9,11;395:13
pulling (4)
354:8;385:22,23;
386:17
pulls (1)
385:25
purpose (2)
377:9,25
purposes (1)
339:12
push (3)
353:1;375:10;382:8
pushed (1)
387:23
pushing (1)
386:19
put (15)
343:19;346:1;
353:19;364:3;375:6,
10;376:21,23;377:2;
381:14,20;388:6;
393:4,9;417:18
putting (2)
386:12;426:13

Q

quad (3)
446:8,20;450:22
quadriceps (2)
385:24;446:9
quads (1)
385:18
quick (2)
382:5,8
quicker (1)
466:2
quote/unquote (1)
422:10

R

radiating (7)
370:23,23;428:8,9;
468:19,24;469:5
radiculopathy (6)
355:2;369:13;
370:16;373:4;374:6;
394:23
radiographic (1)
418:17
radiologist (12)
363:10;364:5,23;
366:10;378:10;395:3;
417:19;421:12,23;
426:10;440:11,12
Radiologists (1)
421:14
radiology (1)
421:20
raise (16)
334:22;347:11;
354:6,7;385:9,11,22;
387:1;392:5;398:9;
400:15;415:24;416:7,
8,9;431:11
raising (2)
416:10;417:5
range (3)
449:22;450:7,10
ranges (1)
352:23
rapidly (1)
451:14
rate (1)
453:10
rationale (4)
373:12;380:23;
388:19;401:18
reached (1)
449:2
read (8)
341:19;369:22;
370:6,14;394:11;
401:21;421:25;434:5
reading (2)
364:5,5
ready (6)
334:19;346:12;
383:18;405:2,14;
430:23
Real (1)
429:6
really (16)
342:14,16;364:6;
366:4;373:23;375:5,
12;378:21;381:16;
392:7;416:18;419:3,
17;425:19;426:9;
439:15
reask (1)
418:10
reason (10)
341:6;347:4;
373:14;380:7;391:18;
439:15,24;443:4;
444:16;447:25
reasonable (19)
371:8;388:22;
399:14;400:4,16;
402:13;438:7,21;
442:10,14,19;444:19;
448:7;449:25;451:4;
452:12;453:12,15;
454:18
reasoning (1)
440:18
reasons (1)
356:19
reassessment (1)
401:20
rebuild (1)
377:12
recall (7)
418:25;423:1;
456:23,25;461:10,13,
16
receive (3)
372:14;412:23;
413:13
received (3)
413:2,4,5
recertification (1)
350:5
recess (7)
344:18;383:16;
404:16;430:22;
454:25;455:11;470:6
RECO (5)
335:16,21;344:8,
11,11
recommend (6)
402:24;421:18;
447:3,25;454:4,8
recommendation (7)
403:9;446:25;
447:2;453:25;454:11,
13,17
recommendations (1)
402:21
recommended (3)
403:15;448:9;
454:21
reconstruction (5)
348:15;349:12;
439:3;445:5;452:7
reconstructions (1)
401:18
reconstructive (1)
433:1
record (9)
334:1;344:20;
346:2;357:9,15;
408:15;431:17;
458:21;470:5
recorded (3)
436:2;451:2;469:6
records (3)
415:1;433:16;434:9
recreate (1)
377:1
recross (2)
429:5,7
redact (1)
334:12
REDIRECT (2)
424:14;466:8
re-direct (2)
424:12;466:6
reduce (1)
437:10
reestablish (1)
381:1
refer (4)
370:9;427:7;457:6,
8
referenced (1)
336:24
referral (2)
406:24;412:2
referrals (2)
413:8;466:16
referred (8)
406:20,22;418:6;
435:8,9;437:1;
466:22;467:2
referring (3)
336:13;408:1;453:5
refers (5)
362:17,18;368:3;
372:12;373:7
reflex (2)
374:1,7
reflexes (5)
354:18;363:7;
368:8,9;373:17
refreshes (1)
458:18
regard (3)
344:22,24;345:16
regarding (4)
371:18;441:17;
446:7;459:12
region (8)
359:5,21;361:20;
363:8;379:18;387:22;
389:20,21
regions (1)
401:25
regrow (2)
376:21;378:19
regrowth (1)
378:19
regularly (1)
456:15
Rehab (5)
435:4;457:24;
466:10,17,25
Rehabilitation (1)
433:16
rehashing (1)
343:16
relate (1)
449:22
related (12)
337:23;338:1,10,
19;345:3;353:11;
397:3;435:22;438:16;
446:15;450:23;
452:11
relationship (3)
339:5,7,20
relatively (2)
358:22;386:2
relax (1)
373:21
relevant (2)
339:11;345:22
relief (1)
444:1
rely (2)
421:17,23
relying (1)
414:4
remain (2)
426:17;431:9
remained (1)
401:7
remember (12)
386:18;395:25;
409:3;457:5;463:21;
464:4,5,7,8,10;467:7;
468:10
remind (4)
382:25;394:10;
455:8,16

reminder (6)
383:9;384:4;
403:25;404:11;
454:25;469:21
remnant (2)
437:16;460:10
removal (3)
372:11;380:17;
381:6
remove (2)
372:12;375:22
removed (5)
375:16;376:9,18;
380:7;396:23
removing (7)
372:7;376:7;
377:12;381:6,7;
392:21,23
repeat (2)
430:16;468:21
repetitive (1)
399:2
Rephrase (2)
418:11;456:13
replacement (7)
451:14;452:14,17;
453:6,7,11,17
replying (1)
464:16
report (28)
360:10;373:2;
377:21;394:11,11;
397:9,12;399:6;
401:4,12,22;402:19,
20;421:20;437:23;
440:10;441:9;444:10,
13;445:7;458:15;
459:1,3;463:23;
464:2,6,10;468:25
reports (7)
354:21;421:23;
457:22;468:5,18,23;
469:4
represent (2)
449:20;455:22
represented (11)
407:5,23;408:5;
409:10;410:5,12;
411:1,24;456:18,21;
457:13
reproduce (1)
353:2
reproduced (1)
353:8
reproduces (2)
353:5,22
Reproducing (1)
370:24
request (4)
371:23;372:4;
443:21,24
requested (1)
443:12
require (5)
439:21;451:14;
452:15,17;453:10
required (7)
399:24;435:15;
439:11,13,17,19,25
requires (1)
401:20
requiring (1)
453:22
Resecting (2)
381:6,7
resection (5)
377:7;380:15;
381:4,8,21
resections (1)
381:11
residency (2)
349:8;432:16
residents (1)
350:14
residua (2)
400:10,11
residual (1)
398:5
residuals (2)
400:12,17
resistance (1)
353:4
resolved (1)
341:16
respect (24)
337:21;340:1;
352:17;354:2;356:5,
15;371:17;372:1;
384:17;395:16;
398:16;399:7,11,18;
438:13;442:16;
448:18;451:6,15,16;
452:2;453:25;454:11,
14
respond (1)
432:3
response (3)
373:23;374:7;
416:14
responsible (6)
348:24;368:6,7,9,
10;392:5
rest (4)
383:12,14;440:4;
460:13
restriction (1)
452:9
restrictions (2)
384:24;399:8
result (4)
337:17;360:7;
370:6;428:16
results (7)
367:19;369:10,20,
24;370:17;387:14;
394:17
resumes (5)
367:18;383:22;
391:9;397:19;405:11
returning (2)
398:16;400:18
revealed (2)
437:15;441:25
reversed (3)
341:3,16,18
review (6)
355:6;367:15;
378:10;421:19;
437:13;458:17
reviewed (1)
407:21
revision (1)
401:24
Ricardo (1)
409:2
RICO (1)
343:15
ridiculous (1)
339:3
right (62)
334:23;342:24;
343:7,22;344:17;
346:5,16;347:11;
354:7;360:21;361:22,
25;362:10;363:3;
364:4;366:13;367:24;
368:4;370:16;375:8;
382:5;383:20;387:20;
389:13,18;391:1,7,23;
397:12;398:9,10;
401:6;403:15;414:22;
419:16;420:4,17;
424:11,24;425:1,9;
430:3,16;431:11;
444:25;449:9;458:12,
19,20,22;459:4,9,14;
464:11,12,14,17,19,
20;465:1,17,21
right-hand (2)
378:25;389:14
right-handed (1)
435:21
ring (2)
337:8;362:7
rise (11)
344:19;346:21;
383:5,17,23;404:6;
405:6;430:18,24;
455:4;470:1
rods (4)
393:13,14;396:9,11
room (6)
334:10;350:19;
375:18;381:19;
383:13,14
root (18)
354:5;359:2;
373:18;386:6,23;
387:21,23,24;390:4,4,
7,8,8;391:6,7;392:2;
394:13;398:4
roots (19)
355:22,22;359:3;
361:5,13,14;369:14;
370:12,13,25;371:1;
377:18,22;381:16;
390:1;391:22;394:2,
9,25
rotate (2)
353:1,22
rotating (1)
350:15
rotation (2)
350:16;468:1
round (1)
380:9
rubbing (2)
364:19;436:22
ruled (3)
335:15,19;343:21
rules (1)
430:16
ruling (1)
346:17
running (2)
465:12,24
rupture (2)
463:2,4
ruptured (4)
461:20;462:14,15,
16
ruptures (1)
462:10

S

S1 (15)
354:21;355:18,21,
22;358:7,10,20;
363:22;370:12,16;
386:6;387:1;391:21;
396:5;398:7
sac (2)
359:2,18
sacral (1)
355:20
sacrum (1)
396:12
safe (3)
375:15,22,22
safely (2)
377:18,19
safety (2)
380:24;463:20
salvage (1)
452:8
Same (26)
341:21;343:20;
349:9;354:4;355:24;
356:15,19;360:14;
365:10,11;372:21;
380:14;381:5;382:3;
394:20;411:18;421:3;
425:24;429:22;
435:10;440:7;443:3,
14;447:7;451:25;
465:3
sandpaper (1)
447:10
saw (16)
351:20;367:16;
386:5;393:24;395:25;
410:11,25;426:7;
429:3;433:21;435:2,
4;437:4;453:24,24;
457:15
saying (8)
339:4,5;376:23;
380:16;418:2;462:2;
465:15,19
scale (2)
364:17;366:6
scar (1)
396:20
Scardua (1)
409:2
scars (5)
438:4;441:4,6,11,
13
school (3)
349:2;432:13,14
sciatic (4)
363:6;385:13,15,22
scoliosis (1)
380:25
scoop (3)
375:16,17;377:14
scope (1)
445:1
scraping (1)
392:25
screen (6)
357:10,20,21;
379:1;389:9,15
screws (6)
393:12,12,14;
396:6,9,10
scroll (2)
357:11;358:20
se (1)
388:12
seamstress (3)
413:11;425:20;
429:25
searches (4)
383:2;404:2;455:2;
469:23
seat (8)
347:1,24;367:17;
384:2;405:10,12;
431:25;455:14
seatbelt (1)
436:1
second (13)
334:23;340:1;

341:1;343:10;371:7;
372:17;383:14;399:8;
403:18;409:18;
443:13;446:19;454:7
secondary (1)
394:25
section (1)
390:21
sedentary (2)
398:17;399:5
seeing (5)
351:5;378:16;
396:19;418:3;419:9
seem (1)
467:7
Seems (1)
434:8
sees (1)
466:11
segment (4)
355:20;370:13;
402:3,5
segments (2)
355:18,19
Seidenstein (6)
411:10,12,15;
413:2;431:6,18
S-E-I-D-E-N-S-T-E-I-N (1)
431:21
self-perform (1)
415:17
self-performed (1)
416:15
self-performing (1)
415:20
sending (1)
350:6
seniors (1)
351:7
sensory (11)
368:14;374:1,7;
386:4,5,7;387:1;
391:21;398:4,8;
400:13
sent (1)
435:22
sentence (2)
341:19;401:8
separate (2)
413:23,24
September (12)
351:25,25;367:12,
16;384:10,12;386:2;
387:12;389:15;434:1,
15;435:3
Series (2)
359:25;405:23
services (3)
337:18;427:18,18
session (2)
344:19;383:17
setting (1)
350:18
settlement (3)
344:5,5;413:14
seven (9)
337:5,6;378:18;
396:17;406:4;410:1,
1,2,8
several (1)
446:2
severe (1)
394:1
severed (1)
335:3
sew (1)
413:12
sewn (1)
413:11
shadow (1)
361:2
shape (1)
358:11
sharp (2)
370:8,9
shift (1)
436:14
shim (6)
376:23,23,25;
377:15;393:9,9
shirt (1)
413:11
shock (2)
376:4;388:16
shoes (1)
386:12
short (1)
429:6
shoulder (2)
416:16;463:22
shoulders (2)
416:14;433:1
show (12)
340:24;360:20;
379:5,8;380:3;
382:12;389:5,10;
396:10;424:16;425:4;
459:19
showed (14)
356:1;359:14;
361:24,24;387:9,19;
392:12;394:22,23;
418:16;421:15;
422:16,19,22
shower (1)
436:7
showing (3)
361:18;408:15;
423:17
Shown (3)
357:17;410:15;
442:12
shows (1)
361:25
Si (1)
363:24
side (26)
354:7;358:2,3,21;
360:22;361:25;362:1;
376:8;379:11;381:1;
385:17;387:20,23;
389:15,16,17,18,18;
390:9,13;391:23;
393:8,11;397:1;
398:9;445:18
sides (3)
365:23;465:8,25
sign (3)
373:19,20,24
signal (13)
359:19;363:24;
365:8,10;379:21;
380:5,10;389:24;
390:6;393:21;396:3,
8,24
signals (4)
359:18,19;365:7;
396:12
significance (7)
353:12;354:22;
362:3;368:13;436:23;
437:8;446:21
significant (4)
398:6;399:22;
437:22;462:24
significantly (1)
366:3
similar (1)
368:2
similarly (2)
391:13;426:25
sit (4)
349:25;391:8;
397:18;421:5
sitting (2)
357:7;420:4
situation (1)
343:18
six (4)
363:3;378:18;
406:4;410:4
sixth (3)
370:25;373:17;
398:4
size (2)
376:25;423:17
skin (2)
375:13;425:25
skip (1)
397:20
Sl (1)
393:20
slice (2)
366:21;395:18
slices (4)
358:7,8;366:22;
389:19
slicing (1)
358:9
slight (1)
366:5
slip (1)
377:1
slipped (3)
425:21;435:25;
463:20
slowly (1)
388:17
small (1)
382:7
smaller (2)
365:5,25
smooth (1)
447:11
smoothed (1)
445:19
snapshot (2)
422:6,9
snapshots (1)
420:22
sniff (1)
402:11
socks (1)
386:12
Softening (1)
450:16
solemnly (2)
347:13;431:12
soleus-gastroc (1)
385:15
someone (4)
343:25;362:16,18;
463:9
Sometimes (5)
366:14;414:10,20;
437:11;450:8
somewhat (1)
393:19
Sorry (10)
351:23;415:21;
421:22;434:17;447:1;
457:7,8;458:9;
464:16,20
sort (1)
390:10
sorts (1)
364:20
source (1)
413:9
Sp (1)
414:12
space (2)
376:25;394:8
spasm (4)
352:23;353:3;
354:4;384:24
speak (8)
335:4;340:11,23;
343:25;344:1;381:20;
432:1;439:18
speaking (1)
335:7
specialist (1)
403:13
speciality (1)
432:20
specialize (1)
421:14
specialty (2)
348:9,11
specific (5)
334:10;353:10;
368:12;399:11;
440:13
specifically (6)
340:3,4,6;400:12;
436:3;447:4
spectrum (1)
425:3
spell (2)
347:17;431:20
spilling (1)
365:23
spinal (41)
348:15,16,22;
349:12;350:17,21;
351:6;357:25;358:12,
19;361:3,6,7,8,10,11,
19;362:25;363:1;
372:7,11;373:7,8,20,
24;374:15;375:2,19;
376:13;377:18,22;
378:16;379:12,13;
381:16;386:22;403:9;
408:8;418:21;421:10,
18
spine (45)
348:22;350:16;
351:9;352:18,18,21,
22;354:2,3;355:23;
356:1,5,15;357:23;
360:10;361:15;
364:11,16;365:5,6;
366:1,8;372:2;373:3,
8;376:8;382:2;
384:17;385:6;386:20;
388:2;389:1;391:13;
395:16,25;398:4;
399:19,19;421:7,7;
425:14;426:16;
432:22,23,24
spoken (1)
402:3
Spurling (4)
352:24;373:17;
374:6;386:19
spurs (1)
365:22
square (1)
380:18
squashed (2)
390:13,14
squishy (1)
362:6
stability (3)

376:9;446:10,24
stabilization (1)
372:8
stabilize (3)
373:14;378:2;393:5
stabilized (1)
428:12
stabilizing (1)
372:12
stage (2)
345:14;380:13
staged (11)
335:25;336:4,8;
337:9,16;338:7;
345:1,4,8,12,13
stand (8)
347:10;367:18;
383:21,22;391:9;
397:19;405:11;431:8
standing (3)
357:6;431:9;465:25
start (12)
355:10;356:22;
370:22;375:16;
378:18,19;388:18;
393:15;403:21,22;
404:3;405:13
started (3)
339:24;386:6;421:8
starting (3)
349:2;395:21;
432:13
starts (4)
349:19;390:19;
419:14;460:12
state (7)
347:17,21;348:5;
349:6,7,9;431:16
stated (2)
451:11;464:12
statement (1)
381:22
states (1)
435:23
stay (6)
341:2,23,25;342:3,
4;467:8
stayed (1)
440:7
steady (1)
467:25
step (3)
346:18;378:23;
404:14
step-by-step (1)
365:3
sternocleidomastoid (1)
375:9
Steven (2)
405:21;455:20
stick (1)
362:9
sticking (2)
355:17;359:6
sticks (1)
362:10
sticky (1)
433:22
still (15)
363:24,25;384:4;
389:21,23;404:12;
427:24,25;444:7;
445:23;447:16;
450:22;454:7;455:9,
16
stimulator (1)
403:10
stipulation (2)
344:6,6
stood (1)
470:6
stop (2)
419:15,19
stopped (1)
439:1
straight (9)
354:6,7;385:8,11,
22;387:1;392:18;
415:24;416:8
Street (2)
347:22;425:21
strength (3)
416:25;417:4;
446:24
stress (4)
391:4;402:9,12;
441:22
stretch (3)
385:10,21;386:25
strictly (1)
344:12
stripe (1)
379:12
stripping (2)
435:25;463:19
strong (2)
392:7,8
structural (1)
437:11
students (1)
350:15
studies (5)
371:21;373:19;
394:23,24;421:17
study (3)
370:15;371:4;
379:19
stuff (4)
364:20;366:19;
368:5;376:9
Subjective (9)
369:2,4,6;387:8;
414:2,8,9;415:14;
417:6
submit (1)
342:8
submitted (2)
337:22;338:8
submitting (1)
340:4
subpoenaed (1)
434:8
subsequent (6)
372:21;378:5;
399:24;423:4,6,12
Subsequently (1)
345:18
subspecialties (1)
348:14
substantial (4)
371:10;388:23;
399:17;444:21
success (5)
424:8;427:23,24;
428:14,22
successful (1)
428:6
sudden (3)
417:24;418:16,21
suddenly (1)
418:4
sufficient (1)
468:5
Suffolk (10)
335:24;336:3,17,
19,21,23;342:24;
343:6;344:22,24
suggest (2)
338:4,12
suggested (1)
387:11
suggestion (1)
338:5
suing (1)
335:2
sum (2)
410:23;413:13
summation (1)
334:8
summations (1)
334:7
Summons (1)
343:3
Sunny (3)
350:9;390:9,13
superimposed (1)
426:4
supply (5)
388:11,13;440:25;
461:22,24
support (2)
444:4,5
supposed (3)
338:21;449:20,20
sure (58)
334:14;348:18;
349:18;352:22;
353:14;360:15,21;
367:2,24;370:7,15;
373:3;375:19;376:5;
377:11,19;380:23;
381:15;382:1,3,4,8,9,
10;385:7;392:16;
393:1;395:10,12;
401:23;406:7;407:10,
12,17;409:13,15;
410:13;411:5;414:17;
415:15;416:5,24;
417:12,23;419:21;
420:6,23;424:6,21;
425:9,11,17;426:18;
435:12;440:18;448:5;
454:21;461:25
surgeon (4)
348:12,17;421:10;
440:16
surgeons (3)
413:12;429:15,21
surgeries (9)
350:21;401:13;
408:10;428:13,16;
429:22;433:3;448:5,6
surgery (104)
338:1;348:13,15,
19,22;349:6,8,16;
350:17;351:9;371:24;
372:1,4,15,23;373:11,
13,14;374:24;375:1,
20;377:4;378:1;
381:25;382:7;384:15,
19;391:10,15,17;
392:15;393:18;397:5;
408:8,21,23;409:1,8;
410:9,21;411:2;
419:15;421:18;424:8;
427:10,23,24;428:6,
14,22;432:21,22,23,
24;433:1;437:18,25;
438:1,2,3;439:2,5,13,
25;440:20,23;441:2,3,
10;443:4,12;444:8,11,
16,21,25;445:1,23,25;
446:12,17,22;447:8,
16,24,25;448:2,6,8,9;
451:13,25;452:15;
454:13;457:14,20;
459:4;461:16;462:6,
9,11,18,22;467:18
surgical (9)
336:2;371:18;
397:3;399:22;400:3;
401:24;402:23;
413:21;453:23
surrounding (1)
390:8
sustain (1)
413:6
sustained (8)
338:9;394:5;
397:16;412:5;427:15,
20;452:22;464:25
swatches (1)
390:16
swear (3)
347:13;431:10,12
Sweeney (2)
340:19;341:6
swelling (1)
366:18
sworn (2)
347:25;431:23
symmetrical (10)
356:3;359:8;
360:17;361:2,18;
362:2,4,19;394:8;
424:3
symmetrically (1)
362:12
symptomatic (1)
442:22
symptomatology (2)
443:2;450:6
symptoms (50)
352:11;353:2,5,8,
17,17,18,19,22;
354:15;356:2,12,12,
17;362:21;367:3;
370:18,22,24;371:11,
19;372:20;386:13;
387:25;388:24;389:8;
391:20;394:16,21;
397:22,23;399:15,25;
400:6;425:6,14,16;
426:14;427:25;428:8,
9;438:13;439:9;
445:24;446:5;447:12;
450:4,18;452:10;
468:9
syndrome (7)
403:2;446:11;
447:6,10,17;449:14;
450:20
system (8)
348:19;361:9,10,
12,13,15;368:1;412:2

T

talk (6)
359:18,19;417:13;
427:13,13;455:24
talked (4)
415:7;419:9;
424:21;428:18
talking (5)
336:15;400:12;
423:22;453:7;458:22
talofibular (4)
441:21;442:2;
446:14;447:21
talus (3)
441:24;446:13,17
te (1)
462:15
teach (1)

350:17
teaching (2)
350:11,13
tear (35)
366:20,20,25; 388:15;393:24,25; 423:15,16,18,19,21, 24;425:2;437:15,20, 21;438:8;440:25; 442:2;445:17,19; 446:16;447:22;461:3, 5,9;462:19,24;463:9; 465:6,7,19,24;467:17; 468:2
tearing (1)
437:22
tears (5)
365:1;366:11; 388:10;394:14;442:7
technically (1)
364:6
telemedicine (1)
416:20
telling (3)
338:22;356:13; 420:10
tells (4)
369:2,4,5;414:4
ten (7)
350:4;401:19; 441:22;449:8,11,13; 450:10
tenancy (1)
368:15
tendency (1)
368:17
tenderness (7)
352:23;436:15; 441:21,24;446:13,14; 447:20
tendinitis (1)
442:1
tendon (8)
354:18,20,20; 363:8;391:24;392:1, 3,4
tendons (2)
348:21;354:18
term (9)
360:3;362:10; 364:3;368:19;415:19; 417:15;418:24; 419:24;420:11
termed (1)
428:14
terms (5)
363:18;382:18; 403:9;418:1;449:19
test (22)
352:25;354:11,13, 14;367:25;368:24,24; 369:9,10;385:9,11,21, 21;386:4,16;415:24; 416:3,6,8,11,25; 436:23
testified (14)
360:16;406:1,3; 413:16;417:17; 422:25;439:23; 455:23,25;456:1,4; 457:18;463:6;467:5
testify (5)
364:24;394:11; 407:18;457:17,19
testifying (1)
464:2
testimony (11)
347:14;363:10,14; 366:9;378:10;395:2, 7;431:12;455:9; 459:13;464:18
testing (5)
367:14,15;371:22; 386:25;400:2
tests (8)
354:5;370:3; 415:10,13,16,17; 416:13;425:4
theory (2)
440:5,6
therapy (13)
402:22,25;403:1,3; 436:9;443:11;446:24; 447:3;454:1,2,8,14,19
thereabouts (1)
378:7
thereafter (1)
426:14
Therefore (3)
345:13,22;363:16
therein (1)
371:13
thick (1)
361:15
thickness (2)
358:8;366:21
thicknesses (1)
366:22
thigh (1)
436:18
thin (2)
359:1;437:16
third (3)
383:13;410:17; 456:7
third-party (3)
335:12;341:15; 344:12
thoracic (1)
366:1
though (1)
409:22
thought (5)
339:24;384:24; 408:2;440:15;444:1
thousands (2)
433:5,5
three (12)
357:22;358:4; 376:16;391:23,23; 392:6,8;413:17; 442:4,7;450:7;462:22
throughout (1)
398:24
thumb (2)
353:9;363:2
tibialis (1)
392:3
tilt (3)
436:12,19,21
times (5)
351:1;406:3,4,6; 450:7
tinier (1)
365:6
tip (1)
373:22
tissue (1)
396:20
tissues (1)
388:12
titanium (2)
377:3;379:20
today (12)
411:15,21;412:8, 11;418:15;421:5; 457:17,21,25;458:2; 467:10;469:13
toe (4)
391:25;392:1,1,2
toes (1)
441:20
together (11)
353:19;370:21; 376:2,10;377:16; 388:6,7;393:4,10,13, 14
told (10)
339:9,9,24;359:10; 438:8;447:19;458:7; 459:13;463:15; 467:23
Tomorrow (2)
469:15,24
took (4)
352:8;393:5; 435:16;463:14
top (15)
357:21,21,24; 358:11;360:21,23; 361:1,18;365:20; 391:1;395:23;396:20; 401:6;409:3;453:21
torn (2)
437:21;442:6
total (8)
449:12;451:14; 452:14,17;453:6,7,10, 16
totally (2)
401:11;461:1
touch (2)
362:1;375:6
touching (1)
375:11
tougher (1)
362:7
training (3)
349:10,19;350:23
transverse (1)
380:19
trauma (14)
420:19;422:23; 425:25;426:4,17,23; 427:1,4;442:25; 461:23;462:11,11,13; 468:11
traumatic (2)
419:25;420:14
traumatically (1)
419:7
travel (2)
361:23;363:1
traveled (2)
352:12,13
traveling (2)
354:15;367:8
travels (2)
353:21;363:6
treat (7)
351:6;368:15; 409:23;412:20,21; 414:9;432:23
treated (14)
345:2;406:16; 407:2,5,22;408:4; 409:9;410:4;411:17, 18,24;412:18;456:20, 25
treating (1)
336:8
treatment (10)
337:23,25;345:11; 351:18;371:13; 399:24;443:10; 447:23;449:5;456:15
treatments (1)
451:24
trial (2)
341:2;470:6
tried (1)
460:17
tries (1)
373:24
tripping (1)
435:24
true (3)
365:10,11;421:3
truth (8)
347:14,15,15; 414:5;420:10;431:13, 13,14
try (3)
353:2,14,15
trying (3)
353:3;386:17; 437:10
tumor (1)
389:6
turn (9)
353:1;360:13; 377:13;384:9;400:21; 409:5;422:14;448:17; 464:5
turned (1)
380:25
turning (2)
376:2;386:19
turns (1)
376:20
twisting (2)
399:3;468:11
two (22)
334:3,21;335:22; 340:15;344:22;346:1; 349:21;360:21; 361:23;362:11;370:3; 374:16;376:16; 390:15,16;392:9; 411:2;430:17;442:7; 445:3;447:9;461:1
two-minute (2)
430:12,14
type (6)
372:4;376:12; 398:20;428:20; 429:22;441:4
Typically (8)
350:25;358:8; 360:5;375:3;402:9; 406:4;466:10,24

U

ultrasonic (1)
443:22
unclear (2)
405:24;458:9
under (12)
369:8;381:2; 383:10;384:4;398:21; 399:3;404:12;416:7; 447:7;455:8,10,16
underlying (3)
425:22;440:1,4
underneath (2)
376:23;450:9
undertaken (1)
401:25
unfortunate (1)
343:18
unfortunately (3)
364:10;419:18; 420:3
unhealthy (1)

465:20
University (3)
349:3,6,11
unless (3)
364:9;407:18;
434:13
unmarked (2)
409:18;410:17
up (41)
344:8,9;348:20,24;
351:7,11;354:15;
357:9,21;360:6;
361:23;362:8;363:6;
364:22;367:10;
374:18;376:19;377:4;
388:16;390:9,13;
391:1,3;392:18,24;
393:15;394:24;
395:13;402:11;
410:23;423:17;427:6,
6;429:3;431:7;
439:18;441:23;445:2,
18,19;463:25
updated (2)
387:11;388:20
upon (11)
361:19;378:10;
399:16;400:9;402:7;
418:22;421:17,23;
439:25;443:9;445:22
upper (1)
400:13
use (10)
339:11;358:5;
376:16;383:12,13;
420:3;450:2;454:21;
465:20,24
used (6)
341:7;357:7;
417:15;418:24;
419:24;420:11
useful (1)
339:12
using (3)
336:7;338:10;445:4
usually (3)
465:7,14,25
utilized (1)
393:8

V

vacate (3)
340:20,23;345:18
valgus (1)
436:12
variable (1)
467:21
varus (1)
436:12
vehicle (1)
337:15
veracity (1)
414:5
verified (3)
341:8;342:24;410:6
vertebra (1)
380:17
vertebrae (1)
356:3
vertebral (18)
359:1;377:6;
379:25;380:4,5,7,14,
17,17;381:4,8,21;
392:20;396:1,8,11,11,
13
vertical (1)
358:23
video (2)
379:1;389:14
videotape (1)
445:2
view (7)
357:24;358:21;
360:22;361:2,18;
389:15,16
views (2)
358:2;379:11
vigorous (1)
388:13
violate (1)
335:6
vis-à-vis (1)
337:18
visible (1)
423:15
visit (35)
351:24,25;353:25;
367:12,19;371:7;
372:17;384:9,14,18;
385:2,6;387:15,16;
397:21;398:11;
400:17,21;433:25;
434:8,12;435:16;
437:13;438:5;441:16;
443:7,9,13,14,16,21;
446:3;448:18;451:3,
15
visits (4)
371:14;372:18,21;
446:2
VMO (2)
446:8,21
voluntary (1)
344:7

W

wait (6)
334:9;342:11,18;
372:14;391:14;432:1
waiting (1)
444:7
walk (10)
348:25;377:4;
393:15;417:10,11;
460:11;467:22,23;
468:1,1
walked (1)
463:7
walking (7)
338:23;348:20;
388:16;392:5;393:16;
425:21;465:24
walks (1)
441:19
wall (2)
463:21;468:11
wants (3)
341:13;354:9;391:6
ware (2)
465:6,19
Washington (1)
349:4
water (3)
363:19,20,22
waves (2)
370:8,9
way (24)
351:7;352:3;
354:15;362:13;363:3;
365:18;368:22,23;
371:5;375:21,22,22;
376:6,22;381:16;
388:6;392:19;394:20;
403:14;427:6;428:21;
440:7;443:9;460:7
ways (4)
362:9,11;375:21;
381:2
weaker (1)
454:10
weakness (8)
373:18;374:3;
391:22;392:6;446:8,
20;450:22;454:9
wear (4)
402:12;461:9;
465:7,23
wearing (1)
460:12
wears (1)
466:2
week-ish (1)
334:8
weeks (1)
462:22
weight (3)
342:6;392:9;441:20
weights (2)
392:7,8
welcome (1)
334:18
whenever (1)
334:15
Whereas (1)
341:10
whereby (1)
352:25
Whereupon (13)
344:18;346:22;
383:6,24;404:7;
405:7;430:19,25;
434:22;455:5,13;
470:2,6
white (5)
358:15,16,19;
380:5;390:10
whiteness (1)
380:4
whole (4)
334:13;347:15;
408:2;431:13
windpipe (1)
375:8
withdraw (1)
418:9
withdrawn (9)
409:8;412:25;
414:13;417:16;424:7;
442:15;452:1;454:12,
17
within (6)
348:13,14;363:24;
379:25;399:14;402:1
without (7)
335:7;354:15;
379:3;399:8;422:2;
436:10;440:20
witness (53)
335:20,21;347:10,
10,16,19,22,25;
351:12,15;357:6,11,
14;367:18,18;369:15,
19;383:11,20,21,22,
22;384:6;391:9,9;
395:20;397:19,19;
404:15;405:11,11;
407:8,13;408:17;
409:17;410:16;
430:10,11;431:4,8,8,
15,18,21,22;432:4;
433:11,14;434:3,25;
469:10,11,16
witnesses (1)
469:13
word (1)
380:16
words (3)
353:19;403:7;
417:18
work (10)
399:7,12;400:18;
437:12;438:17;
449:22;454:21;
464:21,23,24
worked (1)
466:25
working (9)
350:15;370:10;
392:9;419:16;436:10;
438:17;439:2,16;
461:6
works (4)
368:22,23;425:18;
466:10
worse (17)
363:23;373:15;
385:8;386:10;387:9;
388:2;389:8;391:19;
392:10;393:6;403:7;
428:10;440:8;451:12;
452:17;453:22;
467:17
worsening (1)
391:19
woven (1)
388:7
wrist (1)
369:6
write (1)
459:3
written (2)
349:20;415:5
wrong (1)
424:24
wrote (1)
464:10

X

x-ray (1)
382:6

Y

yard (1)
447:11
year (9)
349:11;350:25;
351:1;406:4;420:25;
423:6;459:9;462:8;
464:13
years (15)
349:22;350:4,25;
351:1;401:19;402:1;
406:5;415:18;419:12;
438:18;461:6;465:20,
24;466:25;467:6
yellow (4)
357:20;361:1;
366:23,23
Yesterday (1)
351:10
yo (1)
447:13
yoke (1)
390:9
York (16)
337:6,12,12;
338:24,25;347:22;
348:5;349:5,6;
350:10,24;432:10,14,
15,18;433:9
young (2)

401:23;467:8

Z

zero (6)
364:17;366:6;
392:10;424:22,24;
425:3

0

07104 (1)
431:19

1

1 (7)
369:16,18;426:8,
15,16;433:10,13
10 (2)
402:1;467:6
10/4/21 (2)
378:11,24
10/6 (1)
379:2
10/6/2021 (1)
379:4
10/6/21 (6)
379:1;448:21;
451:4;452:1,6;453:25
100 (5)
337:4,4;401:11;
406:6;449:11
10th (3)
443:20,21;464:5
11 (1)
408:24
11/04 (1)
379:2
11:38:45 (1)
361:1
11:55:52 (1)
360:2
11:59:13 (1)
390:22
11:5913 (1)
390:20
11215 (1)
347:23
12 (9)
407:5,22;408:5,7,9,
21,24;410:20,21
12:07:15 (1)
361:22
120 (1)
449:8
13-day (3)
340:18;341:4;
345:17
14:08:22 (1)
380:3
14:08:24 (1)
380:2
14:10:00 (1)
380:3
14:10:01 (1)
380:2
14:14:23 (1)
395:21
14:18:35 (1)
395:23
14:20:54 (2)
396:22,22
15 (2)
378:6;467:6
150 (1)
449:8
15th (1)
444:11
16 (4)
370:4;391:11;
442:3;446:16
16th (1)
367:16
17 (1)
463:19
17th (1)
446:3
18 (2)
408:3;409:22
19 (1)
408:3
1971 (1)
432:10
1990 (1)
349:4
1992 (1)
348:8
1996 (1)
350:23

2

2 (3)
359:25;379:14,14
2:00 (2)
404:3,13
2+ (2)
436:13,23
200 (1)
351:1
2000 (1)
456:3
2009 (1)
456:3
2017 (8)
407:4,22,24;408:1,
4;410:25;449:7;
456:20
2018 (5)
409:6,7,9;410:4,25
2019 (25)
346:10;351:25;
352:1;355:13,25;
357:12,21;360:10;
364:24;367:13;370:4;
407:24;410:11,25;
422:15;433:24;434:1,
15;435:3;437:14;
441:25;443:7,13;
456:25;463:19
2020 (10)
372:24;384:10,12;
386:3;387:12,17;
389:15;443:17;
444:11;464:6
2021 (7)
378:6;391:11;
395:4;397:21;399:13;
446:3;448:18
2022 (2)
400:22;401:8
2024 (1)
346:9
2026 (1)
470:7
21st (1)
372:24
23 (1)
357:16
24 (3)
434:18,23,24
25 (3)
406:5;438:18;461:6
27 (3)
411:1,6,9
28 (2)
384:12;389:15
28th (2)
384:10;387:12
2nd (1)
387:17

3

3 (4)
358:22;359:25;
379:14;401:21
30 (11)
350:24;351:1;
415:18;438:18;443:7,
13;449:12;450:10;
461:6;463:7;470:7
30th (2)
433:24;443:8
36 (1)
335:24

4

4 (5)
358:22;379:15;
434:1,15;435:3
40 (5)
449:14,15,15;
450:1,5
4th (3)
378:6;395:4;397:21

5

5 (7)
351:12,14;359:25;
360:25;379:15;
382:25;383:3
50 (1)
384:24
5-1 (1)
367:10
527715 (1)
346:10
5-6 (1)
367:10
567 (1)
347:22

6

6 (5)
359:25;360:25;
379:15;401:8;448:18
6,000 (1)
351:2
60 (1)
420:4
601531 (1)
346:9
630 (1)
431:18
6th (3)
395:15;400:22;
402:20

7

7 (4)
379:15;383:4;
402:1;442:2
7.5 (1)
451:18
7-minute (1)
382:25

8

8 (7)
355:25;357:21;
360:10;364:24;
422:15;437:14;
441:25
8th (4)
355:12;357:14;
443:16,18

9

9 (3)
351:25,25;367:12
9/28/2020 (2)
389:12,13
9/4/2019 (1)
459:2
90 (1)
408:12
95 (1)
411:4