MR. GJELAJ: Plaintiff calls Dr. Lattuga to the stand.

S E B A S T I A N L A T T U G A, called as a witness on behalf of the plaintiff, having been first duly sworn,testified as follows:

DIRECT EXAMINATION

BY MR. GJELAJ:

Q. Good morning, doctor. You and I have met before?

A. Yes.

Q. Have you ever testified in a case that I was the lawyer on, sir?

A. No, sir.

Q. What about a case that Miss Ronai has been the lawyer on?

A. No, sir.

Q. Are you currently licensed to practice medicine in the state of New York?

A. Yes, as an orthopaedic surgeon in the State of New York since 1991.

Q. Can you please tell the jury your educational background up to the point in time we are at now?

A. I'm a board certified orthopaedic

surgeon. I am licensed to practice medicine, my specialty is orthopaedic surgery specifically surgery of the spine. I received my board certification initially in 1998 and recertified in 2008. My training includes residency in orthopaedic surgery. You probably know from watching television, a residency is subspecialty training after medical school. You pick what field of medicine you want to practice in and then you spend a number of years, five years in this case, learning and training in that particular subspecialty. I chose orthopaedic surgery. Towards the end of my orthopaedic residency I decided to subspecialize further in spinal surgery. So at the end of my orthopaedic residency I did what's called a fellowship in spinal surgery, adult and pediatric spinal surgery. My residency was at Stoneybrook and my fellowship was at University of Miami Jackson Memorial Medical Center for spinal surgery.

Q. You mentioned board certified, explain what it means to be board certified?

A. Yes. Once you complete your

medical school education and then you choose a field of specialty like I did, orthopaedics, after an opportunity to practice and learn in that field of orthopaedic surgery, at some point you are allowed to go out and practice. You practice in a community or hospital for a specified number of years. In this case it's a year and a half. After that year and a half you are obligated to collect all of the work that you do in practice, meaning the patients you see, the surgeries that you do, you collect the data and at the end of this year and a half of practice you send this to the board. The board is the organizational structure that oversees the practice of that specialty, orthopaedic surgery in my case. And so then they review all of the cases, every patient you see. It's mostly the surgery they do. And they review the cases and then they have you select a dozen cases, you bring the cases to the board, you carry everything to Chicago and you sit in front of a panel of doctors and they review all the cases you've done. After they review what you've done, and there is also a

written component, then you present the oral portion of the boards and then you are board certified.

Q. You mentioned a fellowship, explain what that means?

A. A fellowship is a layer of further subspecialization. So within the field of orthopaedics which is the treatment of bone and joint disorders, the surgical treatment, within that broad specialty is also neck and back, spinal injuries. Spinal surgery. Obviously spinal surgery is more complex, you actually spend additional years of training after you've completed medical school, after your residency, four years of medical school, five years of orthopaedic surgery and another two years of fellowship dealing with just spinal surgery. That's what I chose to do and then I went into practice.

Q. Do you currently maintain an office?

A. Yes.

Q. Where?

A. My main office is 2001 Marcus

Avenue Lake Success, New York.

Q. Do you maintain any hospital affiliations?

A. Chief of spinal surgery at North Shore Franklin Hospital.

Q. How long have you been chief there?

A. Approximately seven years.

Q. Doctor, I've asked you to give your qualifications to the jury. Can you define what exactly the field of orthopaedics is?

A. Briefly orthopaedic surgery is when someone breaks a bone, they get a cast. That's bread and butter of orthopaedics. So it's the study and treatment medical and surgical treatment of bone and joint disorders, fractures, knee problems, hip problems, spine problems, children with crooked legs, adults with hip fractures, spinal deformities, fractures and trauma in general as it affects multiple from childhood up to adulthood. All of that is orthopaedic surgery.

Q. Now, your treatment of Mr. Robles focused on his spine; is that correct?

A. Yes.

Q. Please educate the jury to the spine.

A. Well, again most the jurors when they think of the spine they think of neck or back. It's a column of bones that helps to serve two main functions. First is it's a stablizer of the torso. Your entire upper body moves about a semi flexible construct of bones, ligaments and structures. There is some flexibility, unlike your thigh bone, a solid bone. It's actually a stablizer. Without a spine the entire torso would collapse. So one main function is to provide support for the upper body.

The second function of the spine is as a conduit for the spinal cord and nerves. All signals originate in the brain. Your brain creates the thoughts and it sends signals out to the periphery. The tunnel through which it sends that signal is the spine and actually like a cable that it sends that signal across, it is an electrical chemical signal, is the spinal cord and individual nerves that come out at every segment. So each of the spine is

divided into three parts, your neck cervical, thoracic spine -- which has seven bones and thoracic is twelve bones, the chest area also attached to the ribs and lumbar spine which is five bones. That would be lower back. Neck is cervical, chest area is thoracic and low back is lumbar. That's an overview of the spine.

Q. You mentioned the bones to the jury along your spine. Do these bones ever come into contact with each other?

A. Yes. In general the way the jury should see the spine is a semi rigid structure that provides the functions which I described to you, stability as a conduit of electrical signals. You've seen a fish, the bones, or animals that you prepare for meals that the vertebrae it's a series of boney objects called vertebrae which are connected by the intervertebral disc and ligaments. That holds the structure together such that there is the individual bones don't move apart. You can't separate them. They provide a rigid core structure around the body. The way the jury

should think of the spine as an analogy is a rigid bamboo rod, a fishing pole has a lot of flexibility, that's a good analogy for a normal functioning spine as a rigid bamboo pole. That structure of the spine which is composed of multiple vertebral bodies or bones separated by a structure called intervertebral disc which allows for a little flexibility but mostly stability is generally how the spine is assembled.

Q. Have you ever heard the disc referred to as a shock absorber?

A. It's considered by many to be a shock absorber. I don't characterize it that way. That suggests it's soft like a marshmellow. It's not. It does allow for some flexibility in that it's not bone and softer than bone. More importantly it's a stablizer, it connects one bone to the other and prevents bones in a healthy spine from slipping passed each other.

MR. GJELAJ: I would move to qualify Dr. Lattuga in the field of orthopaedic surgery.

MR. SHAPIRO: No objection in the field of orthopaedic surgery.

THE COURT: Okay. So qualified.

Q. In order to come here and testify today, did you cancel appointments?

A. Yes, sir.

Q. Cancel office visits?

A. Yes, sir.

Q. Surgeries cancelled?

A. Yes.

Q. What are you being compensated for your presence?

A. $600 an hour.

Q. I'll try to make it quick. Sir, did there come a time that you first met Mr. Robles?

A. Yes, sir.

Q. Doctor, what do you have in front of you?

A. My office chart.

MR. GJELAJ: May I have that marked.

(Plaintiff's 1 for identification.)

Q. Just marked Plaintiff's 1, it's a copy of your office report. You maintain that

in the ordinary course of your business?

A. Yes.

Q. Is it your business to maintain that chart?

A. Yes.

MR. SHAPIRO: I haven't seen it yet.

THE COURT: Show it to Mr. Shapiro.

MR. SHAPIRO: I don't want to have the jury waiting. I will need to see the notes before I question him. I'll look at it during the break.

THE COURT: Do you consent to it in evidence?

MR. SHAPIRO: No.

MR. GJELAJ: I'll use it to refresh your recollection now. We can review my application to move it in evidence.

THE COURT: So he should only refer to it when he cannot recall.

Q. If you cannot recall something feel free to refresh your recollection with the chart?

Q. When did you first meet Mr. Robles?

A. Approximately October of '08.

Q. Who referred Mr. Robles to you?

A. I don't recall.

Q. Was it Dr. Berkowitz?

A. Yes, it was.

Q. Who is Dr. Berkowitz?

A. He's an orthopaedic surgeon.

Q. Do you recall the first date you met Mr. Robles?

A. No. October of '08.

Q. Do you want to look at your notes to refresh your recollection. If I told you October 23, 2008?

A. That would be accurate.

Q. Did he come to your office?

A. Yes, sir.

Q. What's the first thing that happens when you get a new patient that comes to your office, doctor?

A. We take a patient history. We ask the patient what are the circumstances around which he is visiting. In this case he was involved in an accident. We take that history and once we take a history about the presenting complaint we may -- we ask about past relevant

medical history. We do a physical exam consistent with what the complaints are and, if available, I make an attempt to make diagnostic imaging, MRI or x-rays. Then you create a working diagnosis, differential diagnosis, any one of those depending on the circumstances and you make a plan for treatment.

Q. What was Mr. Robles' chief complaint?

A. Chief complaint was neck and back pain.

Q. Did he tell you which one was hurting more, neck or back?

A. His primary was neck pain. I'm an orthopaedic spinal surgeon. He was referred to me because he was not responding to conservative treatment. The context of the interaction is seeing me as a surgeon to get a surgical opinion. So his primary complaint and primary focus of that initial visit was cervical problems.

Q. You say he had exhausted conservative measures, can you give us some examples of what conservative measures are?

A. His injury was approximately February of '08. I saw him in October of '08. In that time he was being treated by physical therapy, receiving medicine. He had some interventional pain management, epidural injections in the neck. A whole host of what is considered to be conservative non-surgical modality to help alleviate his condition. Because he failed that, he was not responding to that, he was referred to me for surgical evaluation.

Q. Did you ask him if he had ever injured his neck or back before?

A. Yes.

Q. What did he tell you?

A. No.

Q. Is that significant?

A. Yes.

Q. Why is that significant?

A. A prior -- in taking a history, if the patient says I've had back pain since I was a child, had a football injury, that's relevant in terms of helping to make a diagnosis and also a treatment plan. It feeds into the

algorithm in how I make a decision of how to treat someone.

Q. Did you ask him if he was in pain?

A. Yes.

Q. Did he tell you if he was?

A. Patient --

MR. SHAPIRO: Objection.

MR. GJELAJ: Medical history.

THE COURT: Overruled.

A. Yes, his chief complaint was neck pain on presentation.

Q. Did he quantify the pain?

A. Yes.

Q. What did he say?

A. Seven out of ten on that date.

Q. Did you do an examination?

A. Yes.

Q. Tell the jury the type of examination you performed and findings that you had, if any?

A. It's a dedicated spinal exam. Essentially it is as follows: We observed the patient ambulate. After that we take the patient's spine through a range of motion. We

start with the cervical spine we do flexion extension. For example, the neck we ask the patient to bring their chin to chest, as far as back as he can bring it, we ask the patient to go to the left and right as far as they can go. It's quantified by the examination. With respect to low back, similarly we ask the patient to go through a similar range of motion, forward flexion, bending forward, leaning back, twisting to the left, twisting to the right as far as you can go. Then we qualify that and document that exam. Tied to the function of the spine is not only to stablize it but it houses the neural structures. A neurological exam is part the spine exam. Sometimes there are neurals that go along with spine injuries. In terms of neurological exam we bring each motor groups and nerves through an assessment specifically muscle testing, motor strength of each muscle of the upper extremity and lower extremities as well. It's not just-- it's multiple levels. Motor is one, sensory is number two, the sensation in the areas of the nerves as they

affect upper and lower extremities. The third parameter we examine is reflexes. For those of you not familiar it's when the doctor hits your knee. That's reflex. Also a function of the nerves. If you have a disorder of the nervous system affects the reflexes. That's part of what we examine. That's part of the spine exam which was performed on that date.

Q. When you examined his neck, did you gauge his range of motion?

A. Yes.

Q. Did you compare it to a normal range of motion?

A. It's all compared to normal. Mr. Robles had a greater than fifty percent loss of motion, in flexion, extension and lateral bends. Frequently spine surgeries is an extremity injury. The function of that joint or body part is limited both structural by the damage and pain. A limitation of range of motion as characterized here reflects some problem with that body part. It's a little confusing in the spine. If you sprain your ankle, within a few hours of that severe sprain

someone tries to move your ankle you would say it hurt. You would be limited. That reflects not only that it hurts that the movement is now disordered and there is a loss of function and that's why it moves less. That's a reasonable way of making an analogy.

Q. When you examined Mr. Robles did you note a spasm?

A. Yes. Spasm and tenderness like the ankle analogy, if you go to squeeze an ankle, they jump in pain. That reflects a problem. Spasm which is involuntary muscle contraction, you might not know what spasm is, if you had a charlie horse in the middle of the night, you can't control it. That's an involuntary muscle contraction in response to some problem. In the spine, we pick it up on exam. We could see one of the muscles is abnormally firing, contracting and that reflects a way of a doctor to observe that there is something wrong in this situation.

Q. You use the word involuntary. Is a spasm something a person can control?

A. No.

Q. Something they can fake?

A. No.

Q. Is this objective or subjective?

A. Objective.

Q. Explain the difference objective and subjective test.

A. In medicine we try to make a delineation things that are objective and subjective. It's very difficult to say purely one or the other. In this case on spasm especially on the spine a patient can't fake one of the muscles is firing. Any time a doctor approaches a question and does an exam the patient has to participate. The way I characterize certain portions is mostly objective, the doctor is able to make a good assessment as to the accuracy, but if the patient has the ability to influence it then there is a subjective component. All the tests done in this exams are primarily objective other than subjective which is purely objective.

Q. Did you note any tenderness?

A. Yes.

Q. What is tenderness and what's the significance?

A. Tenderness if you hurt your ankle or wrist and somebody squeezes it, it hurts. That reflects an underlying pathology. Something is wrong with the body part. The pain is the body's way of protecting the patient re-injuring that body part.

Q. Did you examine his lower back?

A. Yes.

Q. What, if anything, did you find?

A. Similarly there were abnormalities in his lumbar spine with loss of range of motion. Similar to cervical spine with less than fifty percent of normal function.

Q. You testified a while ago you did some neurological testing as well?

A. Yes.

Q. Did you come up with any findings neurologically?

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. As part of your practice do you conduct neurological tests as well?

A. Yes.

Q. Have you been doing that-- how long?

A. Since 1998. A neurological is part of the orthopaedic exam.

Q. Is that something you rely on?

A. Yes.

Q. Do other spinal surgeons in the field rely on these tests as well?

A. It's part of the orthopaedic spine exam.

Q. Tell us the neurological finding you found?

THE COURT: Side bar please.

(Off the record.)

THE COURT: You may answer.

A. On the first date -- I don't have an independent recollection. If I can refer to my chart.

MR. GJELAJ: Can I have this marked?

(Marked Plaintiff's 2.)

MR. GJELAJ: Two of them came in. I will put into evidence the one pursuant to your subpoena.

MR. SHAPIRO: I consent. I will look subject to redaction during the break.

(Plaintiff's 2 in evidence.)

THE COURT: Is it different from Plaintiff's 1.

MR. GJELAJ: I'm not sure. I'm just trying to move things along.

A. The neurological exam on 10/23/08 revealed a normal motor strength in the left wrist to extension flexion four out of five. Muscle strength is graded by numbers. A normal motor strength is five over five. Any number below that is less than normal. This case is extension and flexion were diminished in motor strength. One grade four over five. Similarly in sensation in the upper extremities, in both C-6 and 7 nerve roots was also found to be abnormal. Reflex on the left upper extremity were found to be abnormal as well. A normal reflex is greater than three. This was two out of three. This is how we assess to the best of our ability if there is any alteration. In this case this exam reflects there has been some nerve damage in the upper extremities.

Q. Did you review the films themselves?

A. Not on this occasion but the following visit.

Q. Which film?

A. The 3/7/08 MRI of the cervical spine.

Q. You told us you're an orthopedist. How often do you review films?

A. The review of MRI diagnostic studies is an integral part of becoming a spinal surgeon. When we get boarded and to pass our exams we have to be certified in reading MRI's of the spine. Every day I review the films for patients that are seeking an opinion with respect to their problem.

Q. Prior to testifying did you come into courtroom and look at the films?

A. Yes.

Q. You made notations on the films to help you differentiate. Can you show me which is the cervical MRI?

A. These.

Q. You reviewed these personally?

A. Yes, I did.

Q. Can you select one or two that best help you testify.

A. This one.

Q. When you reviewed the films-- when you read the films what was your interpretation?

A. My interpretation is the patient sustained a herniated disc at C-4-5, C-5-6 and a small herniation at C-6-7.

Q. Did you note anything else in there?

A. With respect to his particular problem, that's what I thought the main diagnosis was and the cause of his symptoms, pain, numbness and weakness of the arm with the consequential herniated disc at C-4-5 and 5-6.

Q. The findings were they consistent with your physical findings during the first and second exam?

A. Yes.

Q. How so?

A. The body is hard wired. If a patient comes in and says this part of their

arm hurts, even without seeing an MRI, the surgeon can anticipate where the problem is. Obviously we like corroboration to be consistent with the patient, especially pre-operatively if you consider surgery. So we like to see consistency between what the patient is saying, where the symptoms are and what the MRI is showing. Those are the best patients to operate on. They are most likely to get the benefit from surgery. There was consistency with his verbal complaints and objective findings.

Q. Can you please show the jury the film you pulled out?

MR. SHAPIRO: Which date of treatment is he referring to?

MR. GJELAJ: The second one.

MR. SHAPIRO: What date is that?

MR. SHAPIRO: Is that November 20?

THE COURT: Side bar.

(Off the record.).

Q. Doctor, please show the jury what you found on the MRI film you just testified to?

A. This is an MRI of the patient's cervical spine. The MRI looks inside you. X-rays give you images of bones. MRI gives you images of not only bones but soft tissue structures, things with fluid, things with fat. The body is not all bone. In this case the image I selected was the easiest one to portray where the damage is. It's a sagital reconstruction. That means we slice the patient length wise. And it gives us a nice comparative image of these structures, you can broadly make out the brain here, the face, mouth. We see a vertical line with white in front and behind it. To orient you, you will all be able to read this when I'm done, here is the brain, this is the neck, it's a long slice through the middle of the spinal canal. What you see hear is the brain with the spinal cord and white, bright white is cerebral spinal fluid. The fluid contained inside the spinal canal. To the right is a column of squares, like little dice stacked, those are vertebrae. The little lines between each one are the discs they bind one vertebrae to the other. These

both reflect clearly what is going on. If this vertical gray stripe is the spinal cord you could see the relationship to the vertebrae and disc in front and some structures behind. You see the lower area down here where it's normal, that's the first thing you should know is what it should look like. You see a gray stripe with fluid on both sides, it's clear nothing is touching it. As you go up higher up the spine you see a wavy structure sticking out and digging into the spinal cord. That's what you see here. You see one which is C 6-7. Above that is 5-6 and 4-5. You don't need to be a doctor, you can all see, down here the spinal cord, these best demonstrate that there are areas where there is nothing touching the spinal cord and that's normal, and there is something sticking out and touching the spinal cord. Those things sticking out are the herniated disc. That's the word you always here. That's what it looks like on a MRI. My review of this MRI, which it is my custom and practice, I ask all my patients to bring me the films so I can see it because what generally

happens is they bring a report. I have a report. I don't necessarily agree with what other doctors say. I disagreed with the radiologist's reading in this case. If I'm a surgeon and cut somebody open, I'm not relying on someone else to tell me where the disc is herniated. I better see it myself before I do a surgery and go in and try to find it. It's clear to me even today and it was then after I saw the patient and before I did the surgery this patient had these herniated discs in a multiple, more than one herniated disc. It was 4-5, 5-6 , 6-7. You see some is sticking out more or less. It's a large herniated disc, medium. That's my reading of the MRI.

Q. You just said you disagreed with the radiologist's finding. How so?

A. The radiologist says it's a small disc herniation at 5-6. He says a large one at 6-7. He doesn't mention 4-5. It's pretty clear that there are three structures deforming the spinal cord. Two significantly and one less so. That's the way I read it. I think the jury can read it that way.

Q. Are you familiar with degeneration?

A. Yes.

Q. What is degeneration?

A. The word, broadly speaking, something is wearing out.

Q. Did you note any degeneration to the cervical spine?

A. The MRI is not the best picture to make the best characterization of that. A degeneration finding usually have to do with boney changes. Most people in their 30's and 40's begin to get some wear and tear changes to the spine. We begin to see certain changes to reflect the fact this is not an eight year old or sixteen year old but a thirty or forty year old man. Often times radiologists characterize those age related changes, wear and tear, they say degenerative. It's an easy way for them to see things, it is not an eighteen year old. There are some mild degenerative changes in here. My primary read is not the fact that I think the MRI of a 33 year old male. There is significant traumatic injuries to the spine.

Q. What do you mean by traumatic

injuries?

A. The herniated discs are a consequence of trauma. That's the primary mechanism for large herniated discs that decompress the spine.

JUROR: Can we take closer look?

THE WITNESS: I'll slide it down.

THE COURT: I will allow the doctor to show it.

THE WITNESS: Again, here you see where --

MR. SHAPIRO: He's reiterating his testimony again.

MR. GJELAJ: They asked for it.

MR. SHAPIRO: They just asked to see it, not to hear his testimony again.

(Witness resumes his seat in the jury box.)

Q. As people are aging their body tends to change; is that correct?

A. Yes.

Q. Everyone?

A. Yes, everyone.

Q. The fact there may have been

degenerative changes, does that mean that leads to pain?

A. No.

Q. Assume there will be testimony by Mr. Robles that prior to this accident he never had any treatment whatsoever for his back or for his neck. And then was involved in a motor vehicle accident on February 6, 2008. Further assume there will be testimony from Mr. Robles that he was taken by ambulance to Greenwich Hospital where he complained of back and neck pain. Further assume that there will be testimony from Mr. Robles and his doctors that he presented to a neurologist, had physical therapy, various other modalities, what you testified you knew about before he saw you. Do you have an opinion within a reasonable degree of medical certainty as to what the competent producing cause of the herniated discs in his back were?

A. If all that's accurate, it's from that car accident.

Q. You are sure about that?

A. Yes.

Q. Within a reasonable degree of medical certainty?

MR. SHAPIRO: Objection.

THE COURT: Overruled.

A. I'm sure.

Q. After that first and second visit, did you come up with a game plan in terms of your treatment of Mr. Robles?

A. Yes.

Q. What was that?

A. Based on the history that I told the jury, the fact that he was treated by everybody else for eight months, I had an opportunity to review the MRI, I felt he would benefit from surgery.

Q. Did he agree to have the surgery?

A. Yes.

Q. Was it done?

A. Yes.

Q. When was it done?

A. 3/31/09.

Q. What type of surgery did you perform?

A. A cervical discectomy and fusion.

Q. I show you Plaintiff's 4. Have you ever seen this before, I showed you this morning?

A. Yes.

Q. Is this anatomically correct?

A. Yes.

Q. Would this better help you explain to the jury the surgical procedure you performed on Mr. Robles neck?

A. Yes.

Q. Would it help the jury understand your testimony?

A. Yes.

MR. GJELAJ: Move into evidence.

MR. SHAPIRO: No objection.

(Plaintiff's 4 in evidence.)

Q. Please explain to this jury using Exhibit 4 the type of procedure you performed?

A. He had a herniated disc in his neck. The operation is called anterior cervical discectomy. What happens is I, the surgeon, go in and do two things. Remove the damaged disc. Take pressure off the nerve and reconstruct that space. It's an incision on

the left hand side. Through that incision gives me the exposure to the area where the damage is done. You cut through skin and some of the muscles you displace, move, the tube, pharynx over. That gives me access to the vertebrae here and intervertebral disc between them. I remove all of the intervertebral disc.

Q. Why do you take the whole disc out, why not just the piece pinching?

A. The disc is completely fragmented at the time. Because of the traumatic nature and we can see the disc is fragmented from the trauma, you can't just take the piece out pinching the nerve. The remaining disc will continue to cause pressure. I remove it all. Once I remove the disc I can visualize the spinal cord and nerve roots. That's the first part of the operation, decompression. This part is not finished until I see the cord and nerves. That's how I make my observations as part of the procedure and preparation for the reconstruction. There are two parts, we have to use a burr to prepare it. Sometimes bone spurs we like to make the tunnels larger where

the nerves pass through. That gives us an opportunity to and that's what C and D reflect, we prepare the plates, we make the tunnel bigger and make the passage ways larger. They were encroached and impinged on by the herniation. Once we've done that we rebuild the spine. We use a variety of techniques. These implants now take the place of the disc damaged in the accident. They act as spacers and bone grafts so they will grow together. This is placed in between each one. This is anatomically correct. Once implants are placed we put a titanium plate over it. It stays inside permanently. In old days people wore the halos or collar. The internal fixation gives enough stability so we don't need to use a halo after. This is a good overview of what went on during surgery.

Q. You testified you removed the disc?

A. Yes.

Q. It's a bone?

A. The disc and part of the bone.

Q. That was removed from his neck?

A. That's correct.

Q. Will that ever grow back again?

A. No.

Q. It's a permanent loss of use?

A. The whole thing is a permanent loss of use.

Q. The hardware, what are these, pedicle screws?

A. Regular screws. Vertebral screws.

Q. The hardware shown here, is that ever going to be removed from his neck?

A. No.

Q. Stay there until the day he dies?

A. Yes.

MR. GJELAJ: This is a good time to break.

THE COURT: Okay. Be back at two o'clock. Do not discuss the case with anyone during the break. Have a great lunch.

(Jury exits courtroom. Luncheon recess. Case adjourned to 2:00.)

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

MR. GJELAJ: Can I make an application? I have no idea about cross

examination, but what I heard about based on pending medical malpractice cases. That can't be brought up in terms of cross examination. It doesn't go to credibility. They are still pending.

THE COURT: You raised an issue I have not thought about. Did you plan to ask him?

MR. SHAPIRO: I appreciate counsel bringing those to my attention. I don't see why I wouldn't ask the doctor about malpractice claims.

THE COURT: These are sustained claims. By virtue they were brought doesn't mean there is justification for them. If there is no award or decision on malpractice claim it's highly prejudicial. I don't know why you would raise it.

MR. GJELAJ: The last thing I want is him coming to the podium and asking the question, even if Your Honor sustains it, you can't unring it.

MR. SHAPIRO: I appreciate counsel indication of that. I assume he will practice what he preaches and having an objection sustained and asking it again. That rings the bell more than once.

THE COURT: That's fair comment.

MR. GJELAJ: I'm not sure what that has to do with my application.

MR. SHAPIRO: You've done exactly that throughout the trial.

MR. GJELAJ: Make your application before I get up.

MR. SHAPIRO: You surprise me with those. When the judge sustains the question and you ask the question again and again.

THE COURT: I do understand your position. I made my ruling on the malpractice issue unless you know of some kind of finding that there committed malpractice by a court or judge. The mere question is highly prejudicial. That's my ruling. I will not allow it.

MR. GJELAJ: Mr. Shapiro surprised me boy a lot of accusations.

(The sworn jury enters the courtroom.)

DIRECT EXAMINATION CONTINUED

BY MR. GJELAJ:

Q. Good afternoon. Did you enjoy your lunch?

A. Yes.

Q. Did we have lunch together?

A. No.

Q. Did we discuss your testimony?

A. No.

Q. As part of your practice, did you prepare an operative report?

A. Yes.

Q. Is that in your file?

A. Yes.

Q. If you want to refresh your recollection you can. Look at the operative report you prepared?

THE COURT: Plaintiff's 2.

MR. GJELAJ: Correct.

THE COURT: Not his office notes.

MR. GJELAJ: No. The records that came in via subpoena.

A. I have it here.

Q. Where was the surgery done?

A. 3/31/09.

Q. Where?

A. Franklin North Shore Hospital.

Q. That's where you are chief of spinal surgery?

A. Yes.

Q. What was your pre-operative diagnosis?

A. Cervical radiculopathy.

Q. Explain what radiculopathy is?

A. When I mention to everyone before I discussed the nerve and things like motor weakness or sensory abnormalities reflex changes. The nerve has four functions. It comes from the brain through spinal cord out to the arm or leg, that particular nerve carries four pieces of information. It carries pain. It carries sensation, three. Motor function and reflex information. All found in the cables. Any of those functions, pain,

numbness, reflex changes, doctors use the word for that disorder is radiculopathy. Disease of the nerve root. It's very frequently a diagnosis of patients with herniated discs. It refers to the pathological change, the damage to the disc. What the patient is complaining of what, what the patient is exhibiting is radiculopathy. A disorder of the nerve root. That's a diagnosis that we would operate for.

Q. In this case the radiculopathy is that on the shoulders down to where?

A. The arms.

Q. Were any tests performed prior to this, EMG?

A. Yes.

Q. Was it positive?

A. I believe it was positive.

Q. Would that be consistent with your testimony this morning that Mr. Robles suffered a herniated disc?

A. Yes.

Q. Is that consistent with your testimony he suffered a herniated disc with radiculopathy?

A. It is consistent.

Q. Is that within a reasonable degree of medical certainty?

A. Yes.

Q. If you had a herniated disc without radiculopathy would you operate on it?

A. No, not for the word herniated disc.

Q. Just because a disc is herniated doesn't mean you operate on it?

A. That's correct.

Q. You need radiculopathy?

A. It's more complicated than just diagnosis of herniated disc.

Q. What's the term you used?

A. Indications.

Q. Were those indications such for Mr. Robles in terms of the neck?

A. Yes.

Q. Can you explain to the jury what you did when you went into his neck?

A. Yes.

Q. When you opened up his neck you went through the front?

A. Yes.

Q. Did you visualize the spinal cord?

A. Yes.

Q. Did you use any instruments?

A. Well, I used an operative microscope, it further magnifies the structures that I'm operating on. I described to the jury how part of the operation is removing all of the disc until I see the spinal cord and nerve roots. That is an integral part of the operation. I was able to visualize the spinal cord, visualize nerve root as part of the operation.

Q. When you visualize -- did you visualize the disc?

A. Yes.

Q. When you did that, what did you see?

A. I found -- I described a little bit earlier, when you open the disc space I saw and see frequently in traumatic discs, they are fragmented, pieces have displaced from the normal place to a different place, they are herniated. And you can see they are causing

some degree of compression as well. Compressing spinal cord and nerve roots. It is my testimony that's what I found on that day during surgery.

Q. Did that confirm your findings based on your review of the MRI that you had done in prior visits?

A. Yes.

Q. Was it consistent with the complaints Mr. Robles made in regard to his neck?

A. Yes.

Q. As a matter of fact, doctor, when you removed the disc it's called a specimen?

A. Yes.

Q. What did you do with that specimen?

A. It gets sent to pathology lab and it's quantified and qualified by the pathologist. That's a specialty of medicine that examines tissue under microscopes and that's routine part of an operation where you send specimens of human tissue down to pathology for confirmation and analyses.

Q. Was it done here?

A. Yes.

Q. Did it confirm your findings?

A. Yes.

Q. That it was herniated disc?

A. Yes. The pathologist finding is it's a disc. The fact that it's herniated is intra-operative observation by the surgeon.

Q. You saw it. You saw it was a traumatic herniation. Explain that how it was traumatic?

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. You had a post operative diagnosis?

A. Yes.

Q. What was post operative diagnosis?

A. Traumatic induced herniation.

Q. Was this disc caused by the accident of February 6, 2008?

A. Yes, that's my testimony.

Q. I used the wrong word before, you see the screws there, how many did you implant into the neck?

A. Six.

Q. That's permanent, correct?

A. Yes.

Q. How long was he hospitalized for?

A. I don't recall, it's usually two days.

Q. This was at Franklin hospital?

A. Yes.

MR. GJELAJ: Pursuant to subpoena I move into evidence Franklin hospital medical records for cervical fusion. I would like it marked Plaintiff's 5.

MR. SHAPIRO: Subject to redaction. I need to look at what they are.

THE COURT: Plaintiff's 5.

MR. GJELAJ: Since we are on the same topic, I would move into evidence the Franklin hospital records in regard to lumbar surgery.

MR. SHAPIRO: Same reservation.

MR. GJELAJ: Subject to redaction.

(Marked Plaintiff's 5 and 6 in evidence.)

Q. This surgery wasn't an ambulatory procedure?

A. No, in-patient hospitalization.

Q. How long did surgery take?

A. Under two hours.

Q. What are some of the risks of the procedure?

A. The risks are number one the patient does not get better from surgery, the outcome of surgery is ninety plus get some relief of symptoms. Many many get no relief because trauma of the accident can cause significant nerve damage. I don't repair the nerve damage. All I do is repair or reconstruct the spine. So to the extent the nerve may have been damaged and tissues damaged permanently. My intervention might prevent it from getting worse but it doesn't undo the damage. The most obvious risk of surgery, any person who has an operation like this, spine procedure, they could die from surgery, anesthetic complications, cardiac, blood clots, pneumonias. Any time you deal with spinal cord surgery there is a risk of worsening neurological deterioration. One of the risks is they can wake up having more neurological deficit, weaker or paralyzed. Bleeding,

infection. Fluid drainage. Even in well done surgery those are known risks of the operation.

Q. You explained these risks to Mr. Robles?

A. Yes.

Q. Did he sign a consent?

A. Yes.

Q. After you performed the surgery-- was surgery a success?

A. From the perspective did I accomplish my aim with respect to decompression and the implants, yes.

Q. How was it not a success?

A. Well, we as doctors don't necessarily make that assessment was it a success or not. From a technical exercise of accomplishing the goal of taking pressure off the nerve and putting implants in it was a success. They are in, stabled, it all healed. On the broader spectrum we analyze success on did the patient get full recovery of their symptoms. When you look at it from that perspective, it may not be yes. As I discussed with you before, a biggest risk is the patients

don't get full recovery. An accident changes like this changes their life further. We may keep them from getting worse but they may remain with those deficits as a risk forever. If I use that bar for success, then no, it wasn't successful. Was this technical surgery executed correctly and were my goals of surgery accomplished? I would say yes. It's a double edge sword.

Q. Did the surgery take away his pain?

A. Not really.

Q. By the way, you see the areas you fused?

A. Yes.

Q. How many levels?

A. Two level fusion. Each two vertebrae is motion segment. We would say that was 2 levels even though it's three fused together.

Q. You see the 2 levels you fused. What, if anything, happens-- can you show us where those are in your neck?

A. It's right in the middle.

Q. What if any affect does it have on

those spaces, those levels?

A. Everyone thinks if you have the fusion now you are fused-- it's opposite. The disc get jurisdiction as a consequence of the accident. That motion segment is permanently distorted as a consequence of the injury. The surgical reconstruction is to provide stability. Yes you are fused together. If you examine these segments prior to the surgery, the motion is not normal. That disc is a necessary component of how the vertebrae move together. The permanent loss of use of function is the consequence of the traumatic event of the disc herniation. Adding the fusion, the fusion doesn't make you normal, feel like you were before the accident. What it does is it keeps the vertebrae from collapsing to continue to give impingement on the nerve. Surgery doesn't make people normal. That's a misconception. We take great efforts before surgery to manage the patient's expectation. It's hard in the jury to see because it's inside. If you were hit by a truck and shattered your thigh bone even though

we put a plate and rod back that leg will never be the same, you would limp, it's crooked, you would have scars. Even though a surgeon fixed it that leg is never the same again. It's not the same because the surgery made it different. It's not the same because the accident damaged the tissue. Caused irreversible damage and the surgery was meant to get things so the patient is more functionable with the rest of his life.

Q. You said permanent. Do you have an opinion with a reasonable degree of medical certainty as to whether the limitations in Mr. Robles neck are permanent?

A. Yes.

Q. What is that opinion?

A. The patient sustained a traumatic event in the motor vehicle accident and that created a permanent change in the vertebral structures in the neck and back. As a consequence of that and consequence of the need of surgery the patient has a permanent loss of function of his neck.

Q. That will never come back?

A. No.

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. Will it ever come back?

A. No.

Q. With the neck alone, do you have an opinion based on the neck as to within a reasonable degree of medical certainty as to whether Mr. Robles is disabled?

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. Did you examine Mr. Robles after the cervical fusion?

A. Yes.

Q. How many times?

A. Over the entire two years.

Q. When you saw him did he continuing complaining of pain to his neck?

A. Yes.

Q. Continue complaining of radiculopathy?

A. Yes.

Q. Did the surgery relieve the radiculopathy?

A. It did not reduce all of the

symptoms.

Q. Some of the symptoms?

A. Some.

Q. Let's talk about that, doctor.

MR. GJELAJ: I move into evidence the emergency room records from Greenwich hospital.

THE COURT: There was a motion this morning. Is that part of it?

MR. GJELAJ: It is.

THE COURT: Side bar.

(Off the record.)

THE COURT: Marked plaintiff's 7 in evidence.

MR. SHAPIRO: Subject to redaction.

Q. Showing you Greenwich records which are the records for Mr. Robles when he was taken by ambulance to the hospital. Do you see an x-ray report there?

A. Yes.

Q. What is it an x-ray report of?

A. .

MR. SHAPIRO: Objection.

MR. GJELAJ: It's in evidence.

MR. SHAPIRO: There is no foundation this person.

THE COURT: Lay a foundation.

MR. GJELAJ: It's a report. Not the film.

THE COURT: Okay.

Q. Have you taken x-rays before?

A. Yes.

Q. Cervical x-rays?

A. Yes.

Q. How many times have you taken cervical x-rays?

A. Five thousand.

Q. How many times have you read those?

A. Five thousand is that a report. An x-ray report.

MR. GJELAJ: A report in evidence.

THE COURT: It's an x-ray report that a radiologist read and is part of the Greenwich hospital record.

MR. GJELAJ: Yes.

THE COURT: You want the doctor to review the report of the x-ray.

MR. SHAPIRO: That's the basis of my

objection.

THE COURT: Excuse the jurors please.

MR. SHAPIRO: How can this witness comments on someone elses report, this the first time he's seen it.

MR. GJELAJ: His doctor, a couple of his experts hired refer /REPB that report specifically. For their defense. That report claims there is degeneration in the neck.

THE COURT: You qualified this witness as an expert in orthopaedic surgery. Now we're talking about radiology.

MR. GJELAJ: He's not reading the film. It's just the report.

THE COURT: Then we can say the report speaks for itself. You want him to read it.

MR. GJELAJ: I have no problem with your ruling. Then his doctors who will base their testimony on that record, what's goose for goose and /TKPWAPBD.

They are not radiologist.

MR. SHAPIRO: I am producing a radiologist. Number two I served /TKHRUPB oh one D.

MR. GJELAJ: He's a treat.

MR. SHAPIRO: He's never seen these records.

MR. GJELAJ: He can testify as to anything. I have a memo of law here ready to back up my position. I don't need /TKHRUPB oh one.

MR. SHAPIRO: Not to something he's ever seen before.

THE COURT: If you ask the proper foundational question it will make it much simpler. The document is in evidence. The jury can look at it. It's part of the case. Whether or not this particular witness is qualified to read that document. It's in evidence. The jurors will get it.

MR. SHAPIRO: He can read it. Can he comment on what he said read. There is no 3101(d)

MR. GJELAJ: I have a trial memorandum for treating witness. I was anticipating this 3101 is not required for treating physician. Every department in this state says that. The first department, second department. I list eight cases in the second department which stand for that proposition. It is well settled that the disclosure requirements of 3101(d) do not apply to treating physicians.

MR. SHAPIRO: I think plaintiff's counsel is miss stating my position. I'm saying he can't testify about records that he's never seen before and were not part of his disclosure. They are not refer render in his record.

MR. GJELAJ: I don't understand the argument. One second it's not 3101. Then he realizes I don't need one he changes his argument. I don't need to serve /TKHRUPB oh one.

MR. SHAPIRO: I reference /TKHRUPB oh one, it's either or. He doesn't have it

nor. Here is something knew tell us about this. He can't do that at trial.

MR. GJELAJ: That document is in evidence. Mr. Shapiro agreed to allow them in.

THE COURT: Maybe if I have an idea what he's commenting on.

(Handing to Court.)

(Doctor steps off stand. /STKPHRAOEUFRPLT.

THE COURT: If the doctor is in evidence, part of the records. The jury will see it. Document says soft tissue appeared you know remark /ABL narrowing at disc space. Mild anterior 84 /OFT fight formation at this level. No fracture seen. No /PHAL /HRAEPLT is noted.

This speaks for itself. What will he testify that relates to this.

MR. GJELAJ: They have a doctor who will--

THE COURT: I don't know what it is.

MR. GJELAJ: I've seen the /TKHRUPB oh one. Have you not conceded I don't need 3101.

MR. SHAPIRO: You don't have to serve it for the purpose of this witness testifying. He can't testify to something that's not in 3101 and not in the records.

MR. GJELAJ: That's not correct. You are making up law now. The purpose of me questioning him is A why would they take an x-ray at the hospital. B based on your review of the report do you think there was degeneration in his neck.

THE COURT: What is wrong with those questions.

MR. SHAPIRO: How can he go based upon a report. Can you tell based on what the other guy said is what you think about what he said.

THE COURT: It's a radiologist from the Greenwich hospital. Radiologist read x-ray. He's qualified as an expert

in orthopaedic surgery. It relates to vertebrae in the neck. He's asking him to look at a report in evidence and he's asking to make some comments on the report. It relates to the area of specialty that he was qualified to as an expert. I don't see a problem with the doctor commenting on it as an expert in other /PAEBGS. This is an x-ray of the persons spine at the hospital. You never objected to him qualified as an orthopaedic expert. He's looking at the x-ray at the time of the emergency room. I don't have a problem with it. It would be better if you asked a few more questions.

MR. SHAPIRO: I need to look at his file, before I cross.

THE COURT: I will read my decision on the three issues raised. The defendant's application to preclude witness and /TPHA C U B A S is granted. The notice of /THEURS witness was served on counsel just this past weekend with

the damages portion of the trial scheduled to commence this morning. The witness was not disclosed to defendant and there has not been a prior opportunity to depose witness. Because defendant failed to question plaintiff as to daily activities or required whether plaintiff required assistance on day to day basis defendant cannot object to plaintiff's late notice of intent to use miss /KUB /PWAUS as a witness. Colon V /TPUT man. 22 AD2d five freight. First department 1995.

MR. GJELAJ: Note my exception.

THE COURT: The witness has been sitting in the courtroom threw the entire trial. The witness would not have been in the courtroom every day. If I had known she was a witness or potential witness I would have her removed from the courtroom. She sat in here almost every day.

Defendant's also October /-D to amended witness disclosure served on

defendant in late December 2011. The Amendment is result of amend the tax return and not considered by economics when prepared initially report. The impact is there is an increase in the amount of damages that the economist witness will attempt to prove. It seems clear the defendant is not materially prejudiced by Amendment and had not initially planned to offer rebuttal of an economic expert. The amended report is admissible.

Plaintiff established good cause for the amended witness disclosure having realized a report is premises /-D upon an earlier tax return that has subsequently /TPHUL /TPAOEUD by plaintiff's filing of the amended return. L I S S A K. V sir /RO bone /TPHA. First department case. Mad today loan V Rolex watch. 73 A D three D six 29 first department.

Defendant's motion for preclusion is denied. Although defendant may have to

bring an economist and /AULT it's initial strategy. The theory was known to defendant and this Amendment is not willful or prejudicial to defendant. That's my ruling on that.

MR. SHAPIRO: Note my exception.

THE COURT: Plaintiff's application to redact hospital records to remove reference in the record as to plaintiff being settle belt /-D at the time of impact is granted. Physician office records or hospital records are ordinarily admissible to the extent they are /TKPWER main to diagnose and treatment including medical opinions. Doctors records are known records are I know admissible. Begins /PWERG V begins /PWERG. 2 13 A D five 72 second department 1995. Same result is found in calm lot V B A I group. 79 A D three D one ten. As I stated to counsel if counsel Mr. Shapiro can lay the foundation as to the source of this information then the Court will revisit

the issue to admissibility of the statement in the Greenwich hospital records.

MR. SHAPIRO: Please note my exception to that ruling.

THE COURT: That I will give you a chance.

MR. SHAPIRO: The first part of the ruling.

THE COURT: It's still open for you to lay a foundation. If you lay a foundation I can readjust.

(Open Court)

Q. Was there an x-ray of Mr. Robles neck taken in the hospital?

A. Yes.

Q. What if any significance do you attach to the fact they took an x-ray of his neck at the hospital?

A. Generally it's a reference to some type of complaint. Clinical information motor vehicle accident with neck pain.

Q. They thought you have enough of that to take an x-ray. Did you read the review

of the x-ray?

A. Yes.

Q. Does that change your opinion at all as to what the competent producing cause of the herniated disc in Mr. Robles neck was?

A. No.

Q. What does it say there?

A. Paravertebral soft tissue appear unremarkable. Narrowing at disc space 4-5 is mild osteophyte formation at this level is evident. No fracture seen. No malalignment noted. No boney or soft tissue are appreciated.

Q. What does it mean narrowing?

A. The space is narrowed at C 4-5.

Q. What about ostephyte, what's that?

A. That's a bone spur.

Q. He had a bone spur in his neck?

A. Yes.

Q. This is before the accident?

A. That would be from before the accident.

Q. He will testify tomorrow that he had never had any treatment whatsoever for his

neck, no physical therapy, no doctors visits, no pain medication, nothing at all. Do you think the competent producing cause of the pain he was experiencing was that osteophyte?

A. No, I believe that's just a typical finding that someone would find on an x-ray.

Q. Someone in their mid 30's typical?

A. Yes.

Q. Is there any proof had this accident not occurred and his neck was as it appears in that x-ray, do you have an opinion with a reasonable degree of medical certainty as to whether Mr. Robles would have required surgery?

MR. SHAPIRO: Objection.

THE COURT: Form.

Q. Based on the findings alone on that x-ray, assuming that this accident had not happened, do you have an opinion within a reasonable degree of medical certainty as to whether or not Mr. Robles would have required surgery on his neck?

MR. SHAPIRO: Objection.

THE COURT: Side bar.

Q. You testified he complained about his back as well?

A. Yes, neck and back injuring.

Q. The focus was his neck?

MR. SHAPIRO: Leading.

MR. GJELAJ: I'm trying to move along.

THE COURT: You can't lead first.

Q. Did there come a time after surgery where your focus turned to Mr. Robles back?

A. Yes.

Q. When was that?

A. June of '09, about three months.

Q. June 11 of '09?

A. Yes.

Q. On that exam did you examine him that day?

A. Yes.

Q. Just like-- did you examine him every time he came to see you in your office?

A. Yes.

Q. How many times have you seen him?

A. A dozen.

Q. Not including the two surgeries?

A. No.

Q. What, if anything, did he tell you about his back?

A. We are focused we tend to deal with the issues at hand. At this visit there were conversations that occurred prior to that, in terms of documentation I began to lay a foundation for the need for lumbar surgery. I believe this is a Workers' Compensation case which requires a certain amount of specific documentation, I began to include in my narrative and evaluation of the patient that we are going to request surgery. You need a formal authorization from Workers Comp to get it.

Q. How was his range of motion in the lumbar spine?

A. On 6/11/09.

Q. At all?

A. Throughout the course, as I testified, the patient had a significant symptoms with respect to lumbar spine. He had loss of range of motion. The biggest concern was neurological deficit.

Q. What kind of neurological deficits?

A. Weakness of tibial anterior and extension hallous.

Q. You named three different muscle groups in the legs.

A. The muscles that lift your foot up and down, the muscles that lift your toes up and down and calf muscles all showed a weakness as characterized by that muscle testing. On this day it was four out of five. He continued to show symptoms that were consistent with a lumbar radiculopathy and now he had had it before but we are focusing in my notes because we were moving towards lumbar surgery.

Q. Were there any tests performed on Mr. Robles?

A. I reviewed a MRI of his lumbar spine.

Q. Do you recall what the date of that was, the late of the film, not the date you reviewed it.

A. 10/8.

Q. 10/20/08?

A. 10/20/08.

Q. In terms of cervical MRI, how many times have you reviewed them, rely on them, would your answers be the same with regard to lumbar MRI?

A. All MRI of the spine.

Q. And you reviewed these films prior to today?

A. Prior to the surgery.

Q. And you based your opinion on those?

A. Yes.

MR. GJELAJ: I would like to mark that and move it into evidence.

MR. SHAPIRO: Are these all MRI.

THE COURT: Plaintiff's damage 8.

(Plaintiff's 8 in evidence.)

Q. Can you show the jury with the shadow box the lumbar film taken on 10/20/08.

(Showing jury plaintiff's 8.)

A. Similar to the other MRI I showed you this is a sagital reconstruction, the long view of the lumbar spine, the low back and similarly to the other explanation it's a series of sequences slicing the body at some

point we get an image like this one. Focus on this one and this one. It shows this canal. You see this long central canal. We pick in one it's the middle so gives you a nice representation of the overall picture of the spine. The best way to convey to you is to see what's normal and then abnormal. Similar to the other example there is a section of the spine which appear more normal. If you follow this view and this view we can see a canal of clear fluid. We don't have that solid gray line like in the neck, in the lumbar spine it looks like the horses tale. Cauda equina. You see the relationship of the central canal vertebrae and discs. That's what I focus your thoughts on. What's normal in this section is the square and this white shaped structure. Focus here and relationship to the clear space here and here. You see a white structure with a nice finite contour in the back. It's not really protruding into the spinal canal. This is the spinal canal with the vertebrae. Normal disc is represented by white. That's normal. Below that is where the disc herniations are.

This is characterized as L-4-5 and L-5 S-1. The disc is no longer white, it's turned from black to white. If you look over here you can see it protruding and sticking out as opposed to flush, normal is white. It's flush with the back border and below it is where the disc begins to change color and protrude out. Above that is normal and below that is abnormal herniations. At this level it's normal. At this point below disc is dark and protruding out. Diminishing the space and compressing the nerve. Above my finger is normal. Below it's abnormal. This MRI to me and again the easy way is the white looks normal and ones below are difficult. When they turn black and begin to protrude out like that that's the way we observe and characterize that disc as being injured, disorders and in this case we call that a herniated disc. These two L-4-5, L-5 S-1 show evidence of damage and herniation and protrusion. I read this before the surgery and that was my impression before I did the surgery.

Q. We discussed degeneration in terms

of the cervical spine. Is that lumbar film show degeneration?

A. Like the neck similarly shows areas of wear and tear which one would typically see in this age group. It's not advanced. It's not an old degenerative spine. You see changes in the shape of the bone that suggest this patient lived on the earth for a few years and experienced a life. These are typical changes like graying of hair. It's not abnormal but it suggests you've been through life a little bit. Thinning hair, all of that.

Q. Were there any EMG performed to his lower extremity?

A. Yes, one was performed 2/29/08.

Q. Is that consistent with your reading of the film that shows herniated discs?

A. The EMG showed radiculopathy. This was positive for radiculopathy.

Q. We have herniations on the film?

A. Yes.

Q. I asked you if herniations alone cause pain?

A. They don't necessarily cause pain.

Q. How many herniations?

A. Two.

Q. And you have a positive EMG shows there is tingling, whatever, pain going down the leg?

A. Yes.

Q. What, if anything, did you do next, did you come to a conclusion?

A. My conclusion was not only based on those two pieces of evidence. Based on a history of the accident, on his verbal complaints and showing there were neurological abnormalities. On the MRI review which is very, very powerful piece of information. EMG is also important, not an essential component in arriving at a diagnosis, all this cumulatively helps me formulate my diagnosis of lumbar radiculopathy from two herniated discs. That's a working diagnosis and similar the same strategy we follow with the neck and low back. The same history applied in terms of treatment, physical therapy, medicine, injection. All that prior conservative non-surgical remedies were attempted before the patient came to me .

Q. You are a last resort?

A. That's correct. All that happens before they come to me . It's only then that we begin some surgical consultation. He went through those things and we offer him options. I thought he would benefit from surgery.

Q. Do you have an opinion within a reasonable degree of medical certainty as to what the competent producing cause of the herniated disc you just testified to in his back were?

A. If the history is accurate, and I believe it to be so, that's the car accident.

Q. You did a surgery on him?

A. Yes.

(Plaintiff's 9 in evidence.)

MR. GJELAJ: Mr. Shapiro told me he will stipulate to this going in evidence.

Q. Can you explain the surgery you performed on Mr. Robles on August 18, 2009?

A. This is of the low back. Specifically L-4-5, L-5 S-1. This represents basically what I do is similar to the neck, the

two main goals of surgery is decompression and stablization or fusion. Given the initial part of the operation which is an incision on the low back that gives me an opportunity to expose the areas of the spine that are involved in this problem. L-4-5 and L-5 S-1.

A. You expose the spine by disecting the muscles and tissues of the spine. That exposes the bones. The bones are removed. They are traumatized in the injury. You get areas of collapse and displacement of the bones. They begin to pinch the nerve. The big picture I have to take the pressure off the nerve. We do that by removing all the tissue. You will see the nerves are gray. This is what I see under the microscope. I can see the relationship between disc, the damage bones and nerves. Specifically we look to make sure it's same principles of the neck, there is no longer compression. There are three on each side, we make sure no pressure on the nerve. Once I'm satisfied I've done what I could to help them fully recover. The traumatic injury occurred at the time of the accident. They are hurt.

That damage is initially done. That continued compression causes continued symptoms and continued nerve damage I take the pressure off the nerve and did as much as I could do. Once I've done this and remove those tissues damaged in the spine I have to set about to restablize the spine. There is instability. I use implants in the spine, like titanium, we use implants in the spine all the time. What they help us to do is help us to reconstruct the spine so we are in an artificial way providing the spine with the stability it needs it has prior to the accident. The intrinsic part is damaged, they collapse. We use a pedicle screw. It's a screw that goes in, attaches to a rod and we use sinthetic bone that grows all around the rod. It ends up mimicking what the spine would look like. Functionally and visually you get a reconstruction of the spine. This is the side view. The rod really attaches the screw but it's a scaffold. It's like rebar and concrete. Once this is all healed if you open a patient up it looks similar in my estimation to what the spine used to look like.

Q. How many levels did you fuse?

A. 4-5, 5 S-1. That's considered two level fusion, three vertebrae were fused.

Q. How many screws?

A. Six screws.

Q. A rod?

A. Rod screw construct.

Q. Your pre-operative diagnosis was radiculopathy and stability?

A. Yes.

Q. Did you correct that?

A. That's hard to answer. I decompress the nerve roots and recreated the stability by putting in the implants. This is called grafting procedure. Over the ensuing months it fuses. We do the surgery. God does the fusion. That happens months later. To the extent I took the pressure off the nerve, put implants in, surgery went fine. No post operative complications and the disc goes on to fusion, I accomplish my goal.

Q. Severe neuro compression, that was your post diagnosis?

A. I see this and was able to make

observation. People want to know is it mild impinged, severely impinged. That's my way of characterizing what my observations during surgery were and I observed severe neuro compression.

Q. Did you use the same apparatus that you use during cervical surgery?

A. Yes.

Q. Did you visualize the spine?

A. I did.

Q. It's not the old once sticking out?

A. No, with a candle, no.

Q. When you use that what did you see?

A. I was be able to visualize each nerve root. The relationship between those nerve roots, the damage tissue including the bones and the discs.

Q. Did you see the herniated discs?

A. Yes.

Q. You listed your findings were traumatically induced herniations?

A. Yes.

Q. Please explain why?

A. During surgery sometimes I see

things congenital, developmental in origin or age related changes, spinal stenosis in elderly, in this case I notice it was a traumatic induced herniation. As I pointed out to you in the MRI that's exactly what I found during surgery and that note is meant to convey I found that.

Q. Did you take out any bone?

A. As the image portrays the decompression part is laminectomy. That's the actual part of the procedure. That bone is sent to pathology for collection and examination. And the disc removed as well.

Q. Does that bone grow back?

A. No.

Q. The pedicle screws and hardware shown, will that be removed from Mr. Robles back?

A. No.

Q. Until the day he dies?

A. Yes.

Q. Do you have an opinion within a reasonable degree of medical certainty as to what caused the need for Mr. Robles to have a

back surgery?

A. Similar to the neck, if everything told to me by patient and I believe it to be accurate this was causally related to the motor vehicle accident.

Q. He was hospitalized for that?

A. Yes.

Q. Frankln hospital?

A. Yes.

Q. Have you seen Mr. Robles since the back surgery?

A. Yes.

Q. Lumbar is back?

A. I understand when you say back you refer to lumbar.

Q. I will not go through each visit, up until today how is his back?

A. I think his recovery has been with respect to the x-rays and some of the symptoms he's had resolution and in some the pain never seems to subside despite the fact he had surgical intervention.

Q. Does he still have radiculopathy?

A. Yes.

Q. In his legs?

A. Yes.

Q. At some point when Mr. Robles was scheduled for his neck surgery in March of '09, do you recall that?

A. Prior to the neck.

Q. Do you recall the neck surgical being postponed?

A. Vaguely.

Q. If I told you it was postponed because his blood sugar was high would that refresh your recollection?

A. Yes.

Q. Are you aware Mr. Robles some time in March of 2009 was diagnosed with diabetes?

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. Are you familiar with diabetes?

A. Yes.

Q. Do you treat patients that have diabetes?

A. A percent of my patients have diabetes.

Q. Are you familiar with neuropathy?

A. Yes.

Q. The pain Mr. Robles is currently experiencing down his legs, do you have an opinion within a reasonable degree of medical certainy as to whether or not that pain is related to the accident that occurred on February 6, 2008?

MR. SHAPIRO: Objection. Asked and answered.

MR. GJELAJ: I didn't ask that question.

THE COURT: You may answer the question.

A. I believe it's causally related to the accident. Radiculopathy is different than diabetic neuropathy. That's generally painless, and different distribution than radiculopathy. I am an expert in people come to me with pre-opt neuropathy versus radiculopathy. This case it was clearly radiculopathy that was present prior and persistent after the surgery.

Q. Did you come to a conclusion after all your visits as to whether or not the

condition of in Mr. Robles back and neck is permanent?

A. I believe it to be permanent.

Q. Please explain why?

A. When I explained before how these injuries affect people's lives. His spine even before he had the surgery, and then the surgery, certainly not the spine of a healthy eighteen year old person. Everything thereafter is a structural alteration from what's considered normal. In many respects there are consequences to that. In this case from the history he was asymptomatic. Gets into an accident. I see the MRI. It shows damage. Patient has symptoms. Doesn't do well with conservative treatment. Now there is structural aberration of his spine, no pill or shot that gets that spine to make it look like it was before the accident. You might try with non-surgical remedies to make it feel better. Those are the people that don't end up having surgery. In this case that was not the case. He had other treatments and didn't get better. And then I did this operation. A further

change into the natural status, does this look like the spine of an eighteen year person? Obviously not. It's alterated by the initial trauma, the herniations and then by an operation. It's a long answer. Will it return to normal? It can't.

Q. Do you have an opinion, that opinion you just gave was that within a reasonable degree of medical certainty?

A. Yes.

Q. Do you have an opinion with a reasonable degree of medical certainty as to whether or not Mr. Robles is disabled from working?

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. Did you come to a conclusion in your report as to his ability to work?

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. Do you think he can work based on his neck and back?

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. Are you aware that Mr. Robles was a taxi driver?

A. Yes.

Q. Are you aware they have to sit for long periods of time?

A. Yes.

Q. Do you think based on his back condition he can sit for long periods of time?

A. I think the patient in general and specific to Mr. Robles he's not the first truck driver cab driver I've operated on. There are significant limitations depending on the outcome. Depending on the severity of disc herniation and prior. In this case a person sustained a neck and back fusion that has significant persistent symptoms, he's still on narcotics, residual weakness of arms and legs. I think it's dangerous for him to go back professionally driving a cab. I would advise against it from his perspective and I'd be worried about the passengers he's driving.

Q. There will be testimony from Mr. Robles prior to being a cab driver he was working at a company doing cleaning. Are you

familiar with what is required?

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. Do you think he can do any work at all?

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. What does the future hold for Mr. Robles?

MR. SHAPIRO: Objection.

THE COURT: Sustained.

Q. From a medical perspective, orthopaedic perspective, what does the future hold for Mr. Robles?

A. It's hard to say in front of the patient. It's a sad and tragic situation where you have someone who really has permament dysfunction of two significant body parts. And suffers in chronic pain. That's a significant issue with patients. A combination of both those events lead unfortunately to bleak prognosis. Is it good? Guarded. Bleak. That's the best way we can catergorize patients to make a projection going forward. He's

obviously not going to have a complete recovery that he will be as good as he was before the accident. If you use that as a benchmark. It's clear he sustained significant change in his ability to perform all his activities of life, especially work and home function, no bending, no carrying. He has a bleak prognosis with severe limitation of function. Well what can he do or what can't he do? There are certain patients that have this that can do more. It's not every patient that has lumbar fusion or cervical fusion, it depends on the initial trauma. Is every patient that has a severe fracture of the leg no longer a runner? It depends. In this case the damage was very severe. Specifically to the nerves. So he's left with a significant deficit in his function and he will need treatment, therapy. He has some permanent loss of function in terms of his arms and legs. He is on narcotics chronically. To get narcotics medicine you have to be treated by pain management. It's a controlled substance. Someone has to give him the medicine. It's not me. I'm a surgeon. He has

to see a doctor every six months. He has to be monitored for the narcotics, blood tests and urine tests. For this area he will not need another operation at L-4-5. The whole package of being injured in the future he will need further medical treatment. I will not say too much because it could be anything. It could be more or what I just described depending on how much pain it causes him.

Q. I asked you in regard to the neck, once it's fused it becomes more rigid?

A. That's the goal. That's a good thing. Being more rigid those nerves won't get more damaged. The whole consequence including the surgery, yes, that body part is no longer the way it was like he was when he was eighteen and there are limitations because of that. Less flexible.

Q. Plaintiff's 9, the illustration, because L-4 L-5 have now become fused what, if anything, does that do to L-3?

A. I would say the way I answered question before is the way I feel comfortable.

MR. SHAPIRO: Objection.

MR. SHAPIRO: I don't think that's part of any claim. It's not alleged.

THE COURT: You may answer.

Q. Do you believe-- in the neck and back when bones are fused does the level above have to exert more stress?

A. I think anything is possible but it isn't necessarily the case if you have one operation and you might have another.

Q. Do you think Mr. Robles will ever be pain free?

A. No.

MR. GJELAJ: Thank you, doctor.

MR. SHAPIRO: May we approach.

(Approach off the record.)

THE COURT: Ten minute break. Excuse the jurors.

(Jury exits for brief recess.)

MR. GJELAJ: Plaintiff's 1 is not in evidence. I'll withdraw my application for that. Plaintiff's 2 is.

THE COURT: Yes.

CROSS EXAMINATION COMMENCE

BY MR. SHAPIRO: