

In The Matter Of:
James De Leon Marquez, et al. v
Hadi M. Do Rassael, et al.

Charles Citrin, M.D.
January 13, 2010

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1 NANCY H. MARQUEZ, et al.

IN THE

2 Plaintiffs

CIRCUIT COURT

3 vs.

FOR

4 HADI M. RASSAEL, D.O.,

MONTGOMERY COUNTY

5 et al.

Case No. 298673-V

6 Defendants

7 _____/

8
9 The deposition of CHARLES CITRIN, M.D.,
10 was held on Wednesday, January 13, 2010, commencing
11 at 2:30 p.m., at the Offices of Charles Citrin, M.D.,
12 1201 Seven Locks Road, Suite 100, Rockville, Maryland
13 20856, before Heather Avalos, a Notary Public.
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20

21 REPORTED BY: Heather Avalos

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1 PROCEEDINGS

2 Whereupon,

3 CHARLES CITRIN, M.D.

4 called as a witness, having been first duly sworn to
5 tell the truth, the whole truth, and nothing but the
6 truth, was examined and testified as follows:

7 EXAMINATION BY MR. BELSKY:

8 Q Good afternoon, Dr. Citrin. My name is
9 Alan Belsky. I represent the plaintiffs in this case.
10 We are here to take your deposition. I know you've had
11 your deposition taken many times before. You've
12 testified in a number of medical malpractice cases.
13 I'm not going to spend a lot of time in your background
14 as far as your litigation involvement.

15 What I'm here to do today is to discover,
16 to the extent that I can, your opinions relative to
17 issues in this case. You've been designated as a
18 radiology expert. I'm going to be asking you questions
19 in regard to your opinions relative to you expertise in
20 radiology.

21 Before we start, let me ask you what you

1 have reviewed in preparation for this deposition today.

2 A Well, in preparation for this deposition
3 today, I've reviewed the files here, which are the
4 abstracted files that I have gleaned over the last
5 several months. What I have reviewed in toto are these
6 documents that I have brought into this office. I
7 think it's a comprehensive total of Mrs. Marquez's
8 medical records.

9 Q It's my understanding that you intend to
10 limit your opinions to issues involving radiology in
11 this case, meaning interpretation of studies that have
12 been -- radiology studies that have been performed upon
13 Mrs. Marquez over the course of the last four or five
14 years.

15 A Not just the interpretation but the meaning
16 of the findings.

17 Q So tell me, in some summary form, what your
18 opinions are relative to your role as an expert in the
19 field of radiology.

20 A Sir, it distills down to two areas. The
21 first would be the cervical spine where it is my

1 opinion that Mrs. Marquez has -- prior to the complaint
2 in this case had suffered -- or had mild and diffuse
3 degenerative disease of the cervical spine involving
4 multiple cervical and defebri (phonetic) disks. And
5 that over time those disks have continued to
6 degenerate.

7 To the contrary, however, I see no evidence
8 of any acute injury to the cervical spine at any point
9 in time of her medical evaluation that I've had an
10 opportunity to review.

11 My second opinion is that Mrs. Marquez
12 demonstrates absolutely no evidence of abnormality
13 involving the soft tissues, musculature, or neural
14 structures arising in relationship and residing in
15 relationship to the brachial plexus and its neural
16 distribution.

17 Q Anything else?

18 A No, sir.

19 Q Let's start with the mild diffuse multiple
20 disk degeneration testimony that you're given.

21 A Yes, sir.

1 Q Tell me upon what you rely to base your
2 opinion.

3 A Sir, my review of the MRI scans of July
4 21st, 2005. There was apparent, to me, evidence of
5 mild degenerative disk desiccation involving C2-3,
6 C3-4, C4-5, and C5-6 in the vertebral disks.

7 Q Can I stop you and ask what you are reading
8 right now.

9 A I'm reading from my note at the bottom of
10 the MRI scan report dated July 21st, 2005.

11 MR. BELSKY: I would like to have this
12 marked as Exhibit Number 1.

13 Q And I would like for you to get me the film
14 that you have reviewed in connection with this report.
15 Were those images you had on the screen relative to
16 Mrs. Marquez?

17 A Yes.

18 This may not open on this computer, but
19 let's try it. I have a note here open on MRI computer,
20 which means I have to go to a different room. But I've
21 updated my computer so maybe it will open. I don't

1 know.

2 I can't make this image go beyond this
3 point. If I try to go to advanced viewer, it doesn't
4 let me do that. So if we're going to want to look at
5 this, we have to pick up everything and move into a
6 different room, which we may not be able to do because
7 I don't think we can put five people into that room.
8 It's the scanner suite. I don't know what we can do.

9 Q I would like you to show me -- point to
10 me --

11 A I understand what you would like.
12 Unfortunately, I can't provide that to you right now.
13 I'm not trying to be difficult. You can see what
14 happens. I click on advanced viewer and I get this.

15 Q I am willing to go off the record --

16 A Pardon me, sir. Let me quit. I think I
17 have Explorer on the -- we'll reload it.

18 (There was a break in the proceedings.)

19 Q While you're doing whatever you're doing,
20 let me ask you -- I'm going through these binders as we
21 are waiting for you. And I note that there are certain

1 pages that have red grease pen markings. Are they your
2 markings?

3 A Yes.

4 Q We're talking about a film this is an MRI
5 scan?

6 A Yes, sir.

7 Q And this is of the cervical spine?

8 A Yes.

9 Q And this relates to the study that was
10 performed on July 21, 2005?

11 A Correct.

12 Q All right. Can you identify for me -- can
13 you point out to me on this film the locations of the
14 degenerative changes that you note on this film.

15 A Yes, sir.

16 I am -- I have got my cursor on what is the
17 C2 vertebral body. The one below it is C3. I'm
18 pointing to these things as I speak. C4, C5, C6. The
19 disk between C2 and C3 is dark. Between C3 and C4 is
20 dark. Between C4 and C5 is not as dark as the other
21 two but darker than normal. The C5-6 disk is dark.

1 The C6-7 and C7 to T1 disks are almost normal. They're
2 white. They're normally hydrated. That's what disks
3 should look like. These disks are dried out or
4 desiccated.

5 Furthermore, there is a spur arising from
6 -- a moderately sized spur arising from C5 inferiorly,
7 which is a real sign of chronicity. So this has been
8 going on -- there is degenerative disease in the C5-6
9 area for quite a while.

10 Q And the length of this degeneration is?

11 A Years.

12 Q And your opinion is based upon the
13 spurring. Is that my understanding?

14 A Well, desiccation itself takes usually
15 about a year to develop in a multilevel fashion like
16 this. The multilevel distribution of the disk
17 desiccation is that of degenerative disease. Traumatic
18 disease is usually at one level. Multilevel is usually
19 -- especially four levels -- is usually not associated
20 with a traumatic injury but rather a degenerative
21 process. So that alone would date it a year or more.

1 Certainly this spur at C5 would put it into several
2 years, three years, four years, five years, six years,
3 something of that nature.

4 Q So is it my understanding that other than
5 the spur it is the color of the disks that gives you an
6 indication that these disks are degenerating?

7 A Well, I would also comment that the disk
8 height at C3-4 and the disk height at C4-5 is also
9 reduced. There is probably a small spur arising from
10 inferior C4 as well. Now that I look at that inferior
11 C4 level and check it out on the adjacent slice, there
12 is a spur arising from inferior C4 as well.

13 So there are multiple manifestations of
14 pre-existing chronic degenerative disease as of July,
15 2007 --

16 MR. MORTER: We're talking about 2005.

17 THE WITNESS: July of 2005. I beg your
18 pardon. That's correct.

19 Q You're aware that there have been multiple
20 x-rays, MRIs, and radiological studies done to
21 Mrs. Marquez's spine since February of '05, are you

1 not?

2 A Yes, sir.

3 Q And you are aware that essentially all of
4 those except for perhaps the 2007, '08 there are no
5 findings similar to the ones that you mentioned today
6 in your deposition.

7 Can you explain to me how it is that all of
8 these radiologists have not seen what you're describing
9 in your testimony today?

10 A No. There is a difference between not
11 seeing and not mentioning. The presence of mild and
12 diffuse degenerative disease is a very common
13 occurrence. It's oftentimes not mentioned because it's
14 so frequent. And I am certain that these were not
15 missed, it was just thought not to be of consequence.
16 As it turns out, given the setting in which they were
17 occurring -- that they were obtained, it is of
18 consequence.

19 Normally, this type of thing is not
20 something you're going to do anything about. It's not
21 surgical. So there is no urgency or compelling reason

1 to mention it. It has nothing to do with competency or
2 observation. It has to do with the determination of
3 importance or not importance. And the radiologist just
4 didn't deem it sufficiently important to mention it.

5 Q You're not certain that that's the case.
6 That's your guess, right?

7 A No. No. That's -- well, within a
8 reasonable degree of medical certainty, that is my
9 opinion.

10 Q If a patient came to you and complained of
11 the pain and symptoms that Mrs. Marquez complained
12 about as of the date of this radiological examination,
13 your testimony is that the standard of care warrants or
14 dictates that the disk degenerative that you've
15 described today would not be mentioned in a report
16 interpreting this film?

17 A That's not exactly right. I think the
18 standard of care would not call for you to have to
19 mention it. It's certainly acceptable to mention it.
20 Since it would have no bearing on the patient's
21 treatment, it would be of clinical inconsequentiality.

1 And therefore, it might not be mentioned.

2 Q And why would it have no bearing on the
3 patient's treatment and the patient's diagnosis in the
4 identification of Mrs. Marquez's problems?

5 A It depends upon what the medical history is
6 and what the particular radiologist was thinking.

7 Q And you don't know that either, do you?

8 A Well, it's in the history she has a severe
9 neck pain since June of 2005. Left occipital pain.
10 That's the history available. He would I think -- and
11 I think probably rightfully so that this kind of mild
12 degenerative disease would not be associated with a
13 severe neck pain. It might be associated with some
14 mild neck pain.

15 Q So this degenerative pain would not -- this
16 degeneration that you have testified to and showed me
17 would not be consistent with the severe pain that
18 Mrs. Marquez has complained of. Is that your
19 testimony?

20 A I would say within a reasonable degree of
21 medical certainty this type of mild and diffuse

1 degenerative pain is usually associated with some
2 cervical spine discomfort but not severe pine.

3 Q So this wouldn't explain the severe pain
4 that she's having?

5 A This would not explain the severe pain in
6 which she's complaining of.

7 Q I understand. So your testimony is that
8 you believe that this would have been visible to the
9 radiologist reading this and the radiologist elected
10 not to record his findings related to the multilevel
11 long-standing in some level degenerative changes that
12 you have testified to in this case?

13 A That is correct.

14 Q And that is so despite the fact that the
15 clinical history indicates severe neck pain since June,
16 2005?

17 A I think I've already responded to that.

18 Q And that is based upon your belief that
19 because the radiologist would have interpreted this as
20 creating no more than mild pain in the back or the neck
21 that that would justify, based on reasonable medical

1 probability, the omission of the findings in the
2 report. Is that my understanding?

3 A Omission intimates that it was done -- as
4 long as the word omission means it can be done
5 purposely, yes, that's correct.

6 Q As long as it does?

7 A In other words, it was noted but not
8 listed. I don't think that any radiologist would miss
9 these observations.

10 Q Okay. Are there any other films that show
11 the disk degeneration that you've described?

12 A This is the one that shows it the best.

13 Q Can you tell me what film that is, what
14 number?

15 A This is the -- I don't have any numbers on
16 here. I'll describe it in a way that anybody could
17 figure it out. It's the T2 weighted sagittal scans.
18 On the advanced viewer, it would be seen on the fifth,
19 the sixth, the seventh, and the eighth, a little bit on
20 the ninth image. I think anybody would be able to find
21 it with that description.

1 Q Now, with regard to the length of time that
2 these conditions had existed as of the date of this
3 study, as to each level tell me your opinion based on a
4 reasonable degree of medical probability as to the
5 length of time that each degenerative change existed.

6 A Well, C4-5 and C5-6 are measured in years.

7 Q How many, sir?

8 A I don't know how many.

9 Q Well, more than a year or two? Is it two
10 years or more? Two or more years?

11 A Two or more years at C4-5 and C5-6.
12 C2-3 and C3-4 a year or more.

13 Q And what's the basis of your opinion?

14 A That this desiccation process as part of
15 the degenerative disease takes that long to develop.

16 Q You're not intending to offer any opinions
17 as to the reason of why the degeneration occurred, are
18 you?

19 A I would only be speculating. I don't have
20 anything within a reasonable degree of medical
21 certainty. But I think there are readily available

1 explanations.

2 Q Understood. You don't intend to express
3 them, right?

4 A If asked I would express them.

5 Q Well, I'm asking you.

6 MR. BELSKY: Are you offering him for that?

7 MR. MORTER: I think he can tell you in
8 general how these changes can occur across the board.
9 So, yeah, I would ask him that.

10 Q I'm going to ask you, just for purposes of
11 discovery, your opinion and reserving my right to
12 object to your testimony at trial.

13 A I would say it's exactly within my purview,
14 more so than treating physicians. That's exactly what
15 I do. These types of degenerative changes are related
16 to activity, weight bearing, and genetics.

17 In the case of Mrs. Marquez, she has a
18 history of significant use of her neck in a repetitious
19 fashion in multiple circumstances. By this I mean --
20 I'm referring specifically to activity having to do
21 with swimming when you're turning your head every

1 second or so multiple times, as well as bicycling which
2 puts your neck in an unnatural position when you're
3 racing. I'm not talking about bicycling down to the
4 7-Eleven. I'm talking about racing. And, lastly, to
5 the pounding of the head on the neck support structures
6 while running.

7 All of these activities contribute to the
8 onset of degenerative disease and to the development of
9 degenerative disease. And given Mrs. Marquez's
10 history, I think she's a prime candidate to develop
11 these types of changes somewhat earlier and at somewhat
12 greater level than the average individual.

13 Q And your opinion that these repetitive
14 stressors caused the degenerative changes I assume is
15 based on reasonable medical probability?

16 A Well, I don't know what else might be going
17 on -- what other activities she might have. I think
18 those certainly are contributing to it.

19 Q I need your opinions --

20 A Yes, I think with a reasonable degree of
21 medical certainty, that's a much more likely cause of

1 these findings than any other explanation available.

2 Q What other explanations are you aware of?

3 A I don't know of any other explanations.

4 Q Are you aware of anyone else that has even
5 found, other than C5, any degenerative changes in any
6 of the levels of her cervical spine in all of the
7 thousands of pages of medical records that you have?

8 A I don't recall.

9 Q You don't recall one way or another?

10 A I don't recall one way or the other.

11 Q Did you review these medical records?

12 A Yes, I did. They're large. I didn't look
13 specifically for that.

14 Q Did you pull out the radiology reports?

15 A Yes, I do.

16 Q Take a look through those. Then you can
17 answer my question.

18 A I think there is an x-ray from Dr. Bloom's
19 office.

20 Do I have that film?

21 Q I have no idea what you have, Doctor.

1 A Do I have the report of Dr. Bloom's? Where
2 would I find that?

3 MR. MORTER: I thought it was on one of the
4 CDs provided to you.

5 THE WITNESS: But do I have Dr. Bloom's
6 records?

7 MR. MORTER: That, I don't know. I would
8 have to go through the entire index.

9 THE WITNESS: Well, yes, the answer is yes,
10 there are.

11 Q Yes, there are what?

12 A The answer to your question. Don't you
13 know what question you asked.

14 MR. BELSKY: Read it back, please.

15 THE WITNESS: Are there any other studies
16 that show evidence of disease elsewhere other than
17 C5-6. That was the question you asked me.

18 Q Yes.

19 A I said I didn't recall. I assumed you
20 would know.

21 Q Listen, Doctor, if you want to be

1 argumentative --

2 A No. No. I just like people who are nice
3 and courteous. That's all. You're being abrupt so I'm
4 being abrupt back.

5 But there is an MRI scan report of April
6 16, 2007 by Dr. Ahn, A-H-N.

7 Q What's the date of that again?

8 A April 16, 2007.

9 Q Okay.

10 A He says, findings, normal alignment,
11 signal, and height of the vertebral bodies are noted
12 desiccations of the disks is present at C2-3 through
13 C5-6.

14 Q Anything else?

15 A C4-5 bulging disk is identified in 2008,
16 September 15th. That's the only one I saw.

17 Q Is that packet collectively marked as
18 Number 1?

19 MR. MORTER: The only thing that you asked
20 to be marked, Alan, is that report from 7-21-05. But I
21 have no objection if you would like to redesignate that

1 as collective Exhibit Number 1. You conduct it however
2 you wish.

3 MR. BELSKY: I would like to do that. Let
4 me count the pages. I found eight pages of records.

5 I'll have that collectively marked as 1.

6 (Citrin Deposition Exhibit Number 1 was
7 marked for purposes of identification.)

8 MR. MORTER: Why don't we, for the sake of
9 clarity, inventory each and every radiology report that
10 is contained within Exhibit Number 1.

11 MR. BELSKY: Shady Grove Radiology dated
12 7-21-2005. MRI of the cervical spine.

13 Community Radiology Associates. ID number
14 736195. MRI scan of the cervical spine without
15 contrast. The date is 6-28-06.

16 Next Generation MRI. MRI of the C spine
17 dated April 16, 2007.

18 Capital Imaging. MRI of the cervical spine
19 dated May 31, 2007.

20 Next Generation MRI. Exam date 9-15-2008.
21 MRI of the cervical spine.

1 CMI MRI and CT Center. Date of exam -- I
2 believe it says 11-5-08. MRI of the cervical spine.

3 Q I want to ask you about your notes on these
4 documents. Let's start with the first Shady Grove
5 Radiology record.

6 A Yes, sir.

7 Q Can you tell me what you've written on this
8 page.

9 A Yes, sir. I see -- I wrote --

10 Q Start at the top.

11 A Yes. You mean this?

12 Q Yes.

13 A It says five cervical spine MRI reports.
14 And on the report dated July 21st, 2005, I wrote I see
15 desiccation C2 through C6. Mild desiccation C2 through
16 C6. WNL for age. No protrusions. Region of brachial
17 plexus seen on axials and WN within normal limits.

18 Q I'm sorry. What is the last --

19 A Region of brachial plexus seen on axials
20 and within normal limits.

21 Q So which image is the axial image where you

1 see the brachial plexus?

2 A This series of images here. As we get down
3 towards the lower cervical region, the region of the
4 brachial plexus is visualized.

5 Q Can you point it out to me?

6 A Well, you can't point it out. It's an
7 area. The brachial plexus is not a spot.

8 Q Would this be a view that you typically,
9 under the standard of care for radiology practice, use
10 to diagnose whether a brachial plexus has suffered
11 injury --

12 A Yes.

13 Q -- a stretch injury where there is no frank
14 perforation or tear?

15 A Would you rephrase the question, sir.

16 Q Would this be the image that you would rely
17 upon as a radiologist in ruling out or confirming the
18 presence of a brachial plexus injury in the dorsal
19 scapular nerve area?

20 A It would be one of the sequences you would
21 use. Yes.

1 Q What other sequences would you use?

2 A You would use -- a stir scan would be the
3 other preferred image sequence in addition to this T2
4 weighted study.

5 Q Is there any stir scans in this collection
6 of medical records that you've reviewed?

7 A Yes.

8 Q And do you recall who performed the stir
9 scan?

10 A Well, are we switching horses now or do we
11 want to get to that later.

12 Q Whatever I ask, you answer. That's the
13 rule.

14 A That's another question. So I have to go
15 to a different set of images.

16 Q You can just tell me who it was and we can
17 go back to that.

18 A I don't remember the names of the doctors
19 who read the scans.

20 Q Do you know what facility it was or what
21 institution it was?

1 A Sir, I have not committed this chart -- in
2 all fairness, there are a thousand pages here. You who
3 are studying this case every day couldn't name the
4 documents. You didn't even know about the cervical
5 spine. So how would you expect me to know it.

6 Q You're the radiology expert --

7 A But I have not committed this document to
8 memory, sir. I think it's unreasonable for you to ask
9 me. I'll be glad to look it up. But don't ask me to
10 recite it, please.

11 Dr. Alexander Mark, M-A-R-K, reviewed a
12 scan of 5-31-07 of the brachial plexus.

13 Q The type that you mentioned?

14 A He did T2 weighted scans. There is --

15 Q That's not the type that you mentioned,
16 right?

17 A That was the first one I mentioned. I said
18 T2 and stir.

19 Then there is an MRI of the neck which
20 would include the area of the brachial plexus done at
21 Johns Hopkins where they did T1 and stir images. We

1 have another one.

2 A thoracic spine MRI was done by -- done at
3 Next Generation MRI which might include a portion of
4 the brachial plexus region. That was done with T2
5 weighted scans.

6 Another thoracic spine MRI was done at Anne
7 Arundel Diagnostics. And it doesn't indicate what
8 sequences were used on the report.

9 There is an MRI of the chest that might
10 cover parts of the brachial plexus done with Community
11 Radiology. But it doesn't cite what sequences were
12 used.

13 Those are the ones I have handy right now.

14 Q So which study, specifically, are you
15 relying on to render an opinion based on reasonable
16 medical probability that there is no evidence of a
17 brachial plexus injury in any of the scans? Which
18 scans are you relying on?

19 A Sir, I've looked at the brachial plexus
20 on -- the brachial plexus region on every scan that
21 would cover any part of the brachial plexus. So that

1 might include the thoracic studies. That might include
2 the chest studies. And would certainly include
3 portions of the cervical spine studies. And then there
4 are specific brachial plexus studies. I've examined
5 each and every one of them for abnormalities involving
6 the brachial plexus on the left or right sides. And I
7 found two things. Number one, there is no evidence of
8 brachial plexus abnormality. And even more importantly
9 to my mind, there is no evidence of abnormality
10 involving the muscles that deal with the scapula having
11 to do with winging of the scapula. That is the
12 rhomboids and the levator scapulae are normal at all
13 times. So to suggest that there is chronic winging of
14 the scapula due to denervation of those muscles for
15 years - -and those muscles are normal -- is something
16 that is not medically tenable.

17 You would have to see some atrophy. You
18 would have to see some fatty replacement of muscle.
19 You would have to see loss of muscle mass. You have to
20 see abnormal signal in the muscle, something. And all
21 of those muscles are normal on every scan that they're

1 visualized on.

2 So there is therefore no direct evidence of
3 brachial plexus abnormality as visualized on multiple
4 different scans through multiple different parts of the
5 brachial plexus. And there is no evidence whatsoever
6 to suggest abnormality of the final recipient of the
7 nerve in question as the muscles that receive that
8 nerve are totally normal on every scan.

9 Q You would agree, however, that the physical
10 observations of the physician outside of the use of a
11 scan would be equally, if not more, conclusive as to
12 issues of atrophy, as to issues of function, as to
13 issues of winging then would your MRI or other scans?

14 A I would not. This is a totally objective
15 study where there is no patient input into the study
16 whatsoever. And therefore, the patient is subject to
17 an examination without any ability to influence it.
18 And I think in that regard the MRI scan is more
19 insightful and more accurate than the clinical exam.

20 Q So you're aware that there are a number of
21 doctors in this case who have noted winging of the

1 scapula, are you not?

2 A Yes, I have read that.

3 Q And it is my understanding, based on your
4 testimony today, that you disagree with their findings
5 based on what you have seen on the MRIs. Is that
6 correct?

7 A No. What I'm saying is that there is no
8 muscle denervation that is the cause of that winging.

9 Q Do you have an opinion, based on reasonable
10 medical probability, as to whether she, indeed, has
11 scapular winging?

12 A The answer is I do not know if she has it
13 or if she has not because I have not examined her
14 myself. What I do know is that if she has winging of
15 the scapula it is not related to denervation of either
16 the rhomboids or the levator scapulae on the left side
17 because those muscles are absolutely normal in every
18 way on multiple studies over a period of time.

19 Q Do your studies evidence any adhesion of
20 the long thoracic nerve or the dorsal scapular nerve to
21 any adjacent structures?

1 A Sir, I'm not able to determine that with my
2 scans.

3 What I can tell is that the structures
4 adjacent to those neural structures are normal. Again,
5 there is no evidence of swelling in those muscles.
6 There is no evidence of atrophy of those muscles.
7 There is no evidence of hemorrhage within those
8 muscles. There is no evidence of residual hemorrhagic
9 components that might exist after a hemorrhage had
10 occurred and resolved. All those muscles are normal.
11 And they're symmetric, left and right sides.

12 Q Have you taken a look at Dr. Dillon's
13 intraoperative photographs?

14 A No.

15 Q Have you been provided with those?

16 A No. I was provided his report, which I've
17 read.

18 Q And you understand Dr. Dillon's role in the
19 course of care in this case?

20 A Yes.

21 Q And what is your understanding?

1 A He was to do an exploratory study with the
2 idea to decompress the dorsal scapular nerve.

3 Q And what is your understanding, based on
4 your review of his report, as to his findings and
5 conclusions?

6 A He found some adhesion of the nerves to the
7 adjacent soft tissues.

8 Q Is there anything within that report that
9 you can recall about his opinions relative to the cause
10 of those adhesions?

11 A No, sir. I don't recall.

12 Q Do you intend to offer any opinions as to
13 the cause of those adhesions?

14 A No. Because I don't think -- I don't see
15 any reason for those adhesions to exist secondary to a
16 traumatic lesion.

17 Q Do you intend to offer any opinions
18 relative to the cause of the traumatic lesions?

19 MR. MORTER: To what --

20 Q To a degree of medical probability.

21 A Traumatic lesions, you said?

1 Q To the adhesions of the thoracic -- long
2 thoracic nerve and the dorsal scapular nerve --

3 A No, sir. I will not be offering an opinion
4 on that.

5 Q Are there any scans that you believe would
6 be able to conclusively rule out whether there were
7 adhesions to either of the nerves that I've spoken of?

8 A I can't see those areas, sir, on the scan.

9 Q On the first page that you read to me, you
10 read to me a line that said within normal limits for
11 age, no protrusions.

12 A That's correct.

13 Q If the findings are within normal limits
14 for age, are you assuming that everyone of this age
15 undergoes and participated in the athletic activities
16 that Nancy Marquez participated in?

17 A No, sir.

18 What I was trying to say there is that this
19 is not unusual to see a woman in her thirties who is
20 active. And that's the sum total of that intent.

21 Q So it's not an abnormal finding. Is that

1 my understanding?

2 A Again, it depends how you define abnormal.
3 If everybody gets it, is it abnormal. It you get
4 wrinkles when you're seventy in your face, is that
5 normal or abnormal. I would leave that up to
6 individuals to decide. I think this is something that
7 occurs in everyone over time. It occurs more
8 frequently and to a greater degree in people who are
9 extremely active. Less in people who are not. It
10 occurs to all of us as long as you live a relatively
11 normal, active life.

12 Q What, if any, pain would you expect that
13 these changes that you describe here would cause in a
14 person of Nancy's age and activity level?

15 MR. MORTER: I object because I don't know
16 at this point in the deposition as to what we're
17 talking about with the terms "these changes."

18 Q We're talking about the degenerative
19 changes that you're speaking of from C2 through C6.

20 A I think that these would present with some
21 mild intermittent neck discomfort.

1 Q Have you found any records preceding the
2 February, '05 manipulation at issue in this case that
3 would evidence any complaints of pain in any area of
4 the neck, specifically any of those levels?

5 A Not that I recall, sir.

6 Q So do you have an explanation as to how it
7 is that a patient has changes that you have identified
8 as degenerative in multiple levels but have described
9 as being within normal limits that has no complaints of
10 pain?

11 A Yes.

12 Q What is the explanation?

13 A That people, as they age and as they're
14 active, recognize that they're going to have some
15 discomfort from time to time. And that intermittency
16 is due to the inflammatory nature of arthritis.
17 Sometimes it comes. Sometimes it goes. Sometimes you
18 wake up in the morning and feel great. Sometimes you
19 wake up in the morning and you don't feel so great.
20 You might take a couple of Advil or Motrin or Tylenol
21 and go on your way and feel better later in the day

1 because you've taken an anti-inflammatory. That's
2 pretty common. I think most people have those types of
3 occurrences from time to time. That's all part of
4 being active and aging.

5 Q On the second page of Exhibit Number 1, you
6 have a sticky note there. Can you tell me what that
7 says.

8 A It says desiccation C2 through C6. No
9 change since 7-21-05. Region of proximal brachial
10 plexus is normal.

11 Q So your opinion is that there is no change
12 from the 7-21-05 up through the 6-28-06 MRIs. Is that
13 my understanding?

14 A Yes, sir.

15 May I respond to that comment?

16 Q You may respond any way you wish, sir.

17 A I won't.

18 Q Page one of two of the Next Generation MRI
19 dated September 15, '08. You have some grease pen
20 writing. Can you tell me what that says?

21 A First disk protrusion after several years.

1 Q Do you have -- are you intending to give
2 opinions as to the cause of that disk protrusion
3 several years after, I guess -- are you referencing the
4 date of the --

5 A First study.

6 Q The first study?

7 A Yes, sir.

8 Q Do you have an explanation as to how that
9 occurred?

10 A Yes, sir.

11 Q Tell me.

12 A That occurs because that's the natural
13 history of degenerative disk disease. It's
14 progressive, although slowly progressive.

15 Q And then the CMI MRI dated 11-5-08. You
16 have some pen writing there.

17 A It says artificial disk C5-6 in January of
18 '09.

19 Q And there are two exclamation points after
20 that.

21 A Yes.

1 Q Is there a reason that you're excited about
2 that?

3 A I think I was just informing myself of what
4 happened subsequently. I wanted to make sure I didn't
5 miss it.

6 Q Are you intending to render an opinion as
7 to whether Mrs. Marquez was a candidate for
8 disk-replacement surgery?

9 A No.

10 MR. BELSKY: Off the record.

11 (A discussion was held off the record.)

12 Q So we've talked about the disk degeneration
13 that you've seen at the multiple levels.

14 A Yes, sir.

15 Q We've established that you don't believe
16 that those changes in the disk would generate severe
17 pain as Mrs. Marquez has described it, correct?

18 A Correct.

19 Q You've indicated that you have reviewed
20 MRIs that do not reflect any brachial plexus injuries
21 that you can tell?

1 A Well --

2 Q You've identified on --

3 A I would extend it to anybody beyond myself.

4 I think nobody -- she had multiple studies done but
5 nobody found anything with the brachial plexus as far
6 as imaging is concerned. I think that's correct.

7 Q You would agree that there are other
8 methods by which brachial plexus injury can be
9 diagnosed?

10 A Yes, sir.

11 Q And you would -- are you intending to offer
12 any opinions as to the accuracy of EMG studies and the
13 diagnosis of brachial plexus injury?

14 A No.

15 Q And you do not intend to offer -- we've
16 already established you're not intending to speak to
17 the issue of the disk replacement and need for that?

18 A That's correct, sir.

19 Q With regard to the propriety of the
20 diskogram as a method of diagnosing disk disease or
21 problems, are you intending to render opinions as to

1 the propriety of diskograms and as a method of
2 diagnosing disk problems?

3 A Yes.

4 Q Tell me what your opinions are.

5 A My opinions are that diskography in the
6 best hands is at best a dicey diagnostic test. It is
7 highly subjective. The results are patient controlled.
8 And the attestation to this is that many institutions
9 do not use this procedure. It is not one that is
10 founded on a solid scientific basis. There have been
11 no control studies that I'm aware of that have proven
12 its efficacy. And usually when studies of that type
13 are done, they're done in institutions that are already
14 doing it. So they go in with a predetermined bias, if
15 I may say that.

16 The -- for instance, I work with four
17 neuroradiologists in my group. None of us have ever
18 done a diskogram. And the reason we haven't done them
19 is not because we have a bias against them. It's
20 because we trained at four different institutions and
21 none of those institutions did diskography. One on the

1 West Coast, one on the East Coast, one here in DC --
2 myself -- and another one in New York City.

3 Q Is there special training required to
4 perform diskography?

5 A It would be part of a neuroradiologist's
6 fellowship. And, you know, fellowships -- these are
7 four neuroradiologists. They've all had at least one
8 year, if not two years of training, after their
9 residency. This would be where it would be done. It
10 would be done by the neuroradiologists. And none of us
11 have done it. That's just one. That's the case in
12 many institutions. And the reason for it is that it's
13 not reliable.

14 Q You understand that many people believe
15 that it is reliable?

16 A Of course.

17 Q You understand that many institutions do
18 use this as a method of determining disk problems at
19 multiple levels?

20 A That's correct.

21 And, in fact, a lot of neurosurgeons do it

1 themselves.

2 Q A lot of neurosurgeons decide to separate
3 themselves from doing diskograms for a variety of
4 reasons --

5 A That's correct too.

6 But I think by and large -- it's not like
7 an MRI. Every doctor who is a radiologist says that's
8 a great test. It's reliable. It's accurate. You can
9 count on it.

10 That's not what happens with diskography.
11 People say it's helpful once in a while. Patients, you
12 know, they are influenced by what the doctors are
13 saying, what the doctors are doing, what they're
14 seeing, what they're hearing. And it's not just not --
15 and for that reason -- I'm not talking about the x-ray
16 part of it. I'm talking about the -- what is termed
17 the -- I forget the term that they use where the pain
18 generation is coordinated with the patient's complaint.
19 That is just too fraught with danger to be used with
20 reliability.

21 Q Now, with regard to your opinions relative

1 to no evidence of acute cervical spine trauma, tell me
2 about your opinions in that regard. Explain to me what
3 your opinions are and the basis for your opinions.

4 A Well, acute cervical spine trauma is
5 usually associated with -- if it's done something to
6 the patient, it's associated with some sort of a
7 finding, whether it's a fracture or a dislocation or a
8 bone bruise or a hemorrhage or a disk herniation,
9 something that would be a manifestation of the trauma
10 that would be structurally affecting the patient's
11 cervical spine.

12 When we look at the images that we have
13 from Mrs. Marquez, there -- none of those things are
14 seen in a time period near the treatment for which we
15 are meeting. So it's my opinion that there was no
16 structural acute traumatic injury to her cervical
17 spine.

18 Q Are you intending to offer any opinions --
19 going back to the brachial plexus -- that Mrs. Marquez
20 did not suffer a brachial plexus injury at the time
21 that Dr. Dillon performed his surgery?

1 A Yes.

2 Q And your opinion is what?

3 A She did not.

4 Q And are you intending to offer any opinions
5 as to whether Mrs. Marquez suffered from compression
6 injury to either the dorsal scapular nerve or the long
7 thoracic nerve at a moment in time immediately prior to
8 when Dr. Dillon performed his surgery?

9 A May I answer that a yes or no --

10 Q You can answer any way you want.

11 A My answer to that is that -- I forgot what
12 your exact question was. But whatever might or might
13 not have happened to those structures it did not affect
14 the musculature of the periscapular region. And that
15 all the musculature on multiple imaging studies is
16 normal without any evidence whatsoever of denervation.
17 And for that reason, I am excluding the diagnosis of
18 brachial plexus injury.

19 Q And what I'm asking you specifically is --
20 as a premise, you are aware that Dr. Dillon, when he
21 opened her, found that the long thoracic nerve and the

1 dorsal scapular nerve were adherent to other
2 structures.

3 Are you intending to offer an opinion as to
4 whether, indeed, that was found and whether, indeed,
5 that was a cause of pain?

6 A Well, pain I can't address. I don't know.
7 I'm not going to dispute it was found, obviously. If
8 Dr. Dillon said it was found, it was found. I have no
9 way of measuring pain. My commentary has to do with
10 the muscles.

11 Q And you don't intend to offer any opinions
12 as to the cause of the adhesions found by Dr. Dillon
13 during his surgery?

14 A No, sir.

15 Q When you reviewed -- I assume you reviewed
16 some type of radiological film produced by Dr. Thompson
17 during his diskogram.

18 A Yes, sir, I did.

19 Q How many different films did you review?

20 A May I put them on the screen?

21 Q Sure.

1 A Let me see what I have.

2 MR. BELSKY: I'm going to mark the CV as
3 Exhibit Number 2.

4 (Citrin Deposition Exhibit Number 2 was
5 marked for purposes of identification.)

6 Q I want to ask you -- in connection with
7 your writings, are there any publications within the
8 CV or not included in the CV that you believe have
9 information relevant to the opinions you've reached in
10 this case?

11 A I don't think so, sir.

12 MR. MORTER: That's the September, '08
13 diskogram. I believe there was one that preceded that.

14 THE WITNESS: This is an MR scan. I'm
15 trying to find the diskograms.

16 This is December 14, 2006.

17 Q In connection with the film that you have
18 up on the screen there dated December 14, 2006, tell me
19 what you see on that film, if anything, relative to
20 within normal limits of abnormalities?

21 A Well, sir, the injection into the C4-5 and

1 C5-6 disks is indicative of degenerated disks at both
2 of those levels.

3 Q What tells you that, based on what you're
4 looking at?

5 A The disk material is not confined to the
6 central nuclear portion. It's spread out in a more
7 broad fashion.

8 Q So at C5, C6 when the doctor refers to
9 internal disk disruption, would you say that at that
10 level that that film is consistent with an internal
11 disk disruption?

12 A Yes, sir.

13 Q And is it my understanding that your
14 opinion is that the internal disk disruption is purely
15 degenerative and not related to any acute processes?

16 A That's correct, sir.

17 Q And the basis for your opinion is what?

18 A The basis for the opinion is that
19 Mrs. Marquez has multi level degenerative disk disease
20 from C2 through C6 with a small spur at
21 anterior/inferior C4 and a small spur at

1 anterior/inferior C5 in 2005 -- was that the first
2 study we looked at? Right. In 2005. Which would
3 indicate to me degenerative changes well before the
4 osteopathic visit. And those changes are now being
5 manifested again here in 2008.

6 In fact, you can see beautifully that
7 big -- moderate-sized spur off inferior C5 and to a
8 lesser degree that small spur at C4. You see it really
9 well now on this x-ray study.

10 Q Is the spur part of what you consider to be
11 degenerative changes?

12 A Absolutely. It's the bony part that takes
13 a long time to develop. That really hallmarks it back
14 to, you know, a couple years or more before 2005.

15 Q Does Dr. Thompson refer to that spur in any
16 of his findings during his original diskogram?

17 A Well, he, in his report of December 14,
18 2006 -- he reviews this outside cervical spine MRI and
19 he notes minor elements of spondylosis, which means
20 bony change, at C5-6 with minimal spondylosis at
21 C4-5.

1 This goes back, again, now to what we were
2 talking about earlier when you asked me who else had
3 seen these changes and I said Dr. Ahn had seen the disk
4 desiccation on the MRI. Now, Dr. Thompson is seeing
5 the bony changes I had alluded to that weren't
6 mentioned. I'm glad you pointed that out.

7 Q Would you agree that Mrs. Marquez was not
8 at all symptomatic from any of these changes prior to
9 February of '05?

10 A I saw no such history to indicate
11 otherwise.

12 Q So in regard to the document that you have
13 tabbed here, I need to do the same thing as to --

14 MR. BELSKY: I'll mark that as Exhibit
15 Number 3.

16 (Citrin Deposition Exhibit Number 3 was
17 marked for purposes of identification.)

18 MR. MORTER: So the witness is stepping out
19 and we'll read into the record what these are.

20 MR. BELSKY: The Anne Arundel Medical
21 Center Department of Radiological Sciences report of

1 Kerry Thompson, K-E-R-R-Y, dated 12-14-06.

2 MR. MORTER: Does that contain his amended
3 findings as well?

4 MR. BELSKY: There is an addendum also
5 dated 12-14-2006.

6 There is another page -- another addendum
7 dated 12-14-2006. I'm not certain it's exactly the
8 same. I think that the addendum is a multiple page
9 document also dated 12-14-2006.

10 There is a diskogram dated 9-18-08
11 report -- again, Kerry Thompson -- along with an
12 addendum -- strike that.

13 There is a repeat of the addendum in the
14 back of this packet. I'm going to propose that the
15 addendum be separated since it's duplicated in the
16 preceding pages. Unless you have reason to believe
17 that that's not correct.

18 MR. MORTER: I would like to keep it
19 together. And the reason why I would is there appears
20 to be a date and time of dictation on one addendum
21 which is not present on the other. Because the doctor

1 has them organized in this fashion, I would appreciate
2 keeping them together that way.

3 MR. BELSKY: No problem.

4 Q So tell me what you've written first.

5 A You mean my chicken scratches?

6 Q Right.

7 A I have two reports from 2006. Original and
8 contemporaneous report, first and second diskogram
9 report here, meaning it's in this packet of papers.

10 Q Now, in regard to the red arrows, tell me
11 why you have red arrows directed to that particular
12 paragraph.

13 A That was the one you pointed out to me
14 about the spondylosis that Dr. Kerry Thompson
15 confirmed. I didn't have it there before you had me
16 discuss it.

17 Q And you've highlighted some information on
18 the first page of this report. Tell me what you've
19 highlighted and why you've highlighted it.

20 A I'm just going to read what I highlighted.
21 The patient denies weakness as well as any clinical

1 indicators to suggest myelopathy. Clinical notes from
2 the office of Dr. Lee Dillon indicate nonfocal
3 findings.

4 I thought that was important.

5 Q Why?

6 A Because he doesn't indicate that he found
7 focal findings. That might indicate a source of
8 problem.

9 Q What is your understanding as to what focal
10 findings and nonfocal findings --

11 A I told you what importance it means to me.
12 Focal means to a particular spot. Nonfocal means
13 general.

14 Q Okay.

15 A And then we already talked about the
16 highlighted area here about the spondylosis.

17 And then on the bottom paragraph, I
18 highlighted the following on the basis of the given
19 clinical history, clinical profile, and imaging results
20 by MRI, it is my opinion that the patient suffers from
21 elements of symptomatic cervical spondylosis -- that

1 means arthritis -- with post traumatic internal disk
2 disruption syndrome. This notion -- it's interesting
3 he used the word notion. This notion is based on
4 increasing frequency and severity of neck pain flare-up
5 despite appropriate treatment.

6 Q Have you had an opportunity to review Kerry
7 Thompson's deposition transcript?

8 A I have.

9 Q Are you aware of what Dr. Thompson
10 attributes his findings to in terms of the mechanism of
11 injury?

12 A I don't have a complete recollection of it.
13 But I have his deposition here someplace if you want me
14 to look at it.

15 Q To the extent that you recall, can you tell
16 me what you recall?

17 A I couldn't.

18 Q Do you intend to offer an opinion that you
19 agree or disagree with any of Dr. Thompson's findings
20 or conclusions?

21 A I'm certain I disagree with some of his

1 conclusions.

2 Q Why are you certain about that?

3 A Because he attributes the findings he made
4 to post traumatic disk disruption. And I don't agree
5 with that at all. I think that's absolutely incorrect.

6 Q Is that revealed within his report that he
7 concludes that or is that based on your memory of his
8 testimony?

9 A I think both. I'm a little bit guessing
10 there, sir.

11 Q I don't want you to guess.

12 A Well, I'm telling you I'm guessing. Maybe
13 I should just say I don't remember.

14 Q The next page, the highlighted information,
15 please.

16 A This is page two. The use of IV conscious
17 sedation with the prophylactic administration of
18 antibiotic as part of the procedure was discussed.

19 Q Any significance of that?

20 A No. Just describes how he does the
21 procedure.

1 Q Then regarding C4-5?

2 A I highlighted by diskogram, there is
3 asymptomatic anular tear with early elements of
4 degenerative disk change.

5 Q Anular tear. What does that mean?

6 A Anular tear is a manifestation of
7 degenerative disease.

8 Q Can that also be caused by trauma?

9 A No. Actually, the term has been changed.
10 It's now called anular fissure. It is strictly a
11 degenerative finding. It is not a traumatic finding.

12 Q C5-6?

13 A That would be on page three. I
14 highlighted -- I'll start from the beginning, even
15 though part of it isn't highlighted, so it makes sense.

16 The response was immediately and
17 unequivocally abnormal with normal applied pressure.
18 The patient described her awareness of typical
19 reproduced neck pain. With increasing applied
20 pressures, that response intensified with the patient
21 describing referred pain to the left shoulder.

1 Q Is there any significance to what you just
2 read?

3 A No. It just made it easier for me to find
4 the observation.

5 Q So paragraph one under the C6-7 --

6 A Actually, I think that's the conclusion
7 part. I highlighted -- I'll read the whole thing so it
8 makes sense.

9 A clinically significant response has been
10 observed at C5-6. As summarized above, the opinion is,
11 again, based on intense concordant pain response with
12 compelling post anesthetic outcome typical for a major
13 underlying discopathic pain mechanism.

14 Q If you can, just continue beyond what
15 you've highlighted so we can complete the record.

16 A Sure. In my opinion, this result closely
17 correlates with and best explains this patient's
18 chronic post traumatic neck condition.

19 Q So, firstly, you will note from what he
20 said that he does describe it as post traumatic neck
21 condition?

1 A Yes, sir.

2 Q And my understanding is that you disagree
3 with that conclusion.

4 A Well, I disagree that the findings that we
5 saw on the MRI scans right after in 2005 are post
6 traumatic. This is just the progress of that finding.

7 Q Do you have any -- are you intending to
8 offer any opinions as to whether what you've seen in
9 all of the scans that you've reviewed and all the
10 records that you've reviewed and all of the deposition
11 testimony that you've reviewed as to whether
12 Mrs. Marquez suffered any trauma to her neck on or
13 after February 19th, 2005?

14 A Sir, my comment would be that she suffered
15 no structural injury to her cervical spine or brachial
16 plexus.

17 Q Structure injury as opposed to trauma.
18 What is the difference?

19 A The difference would be that you could
20 twist your neck and get a muscle spasm and have an
21 injury but it's not structural insofar as the muscle

1 spasm will resolve and the muscle will return to
2 normal. The same situation could exist, for instance,
3 with cervical strain or sprain. These are
4 self-resolving, self-limiting, not structural problems.
5 A structural problem would be one in which there is a
6 permanent change to the spinal elements. And it is my
7 opinion that there is absolutely no evidence
8 whatsoever of a structural change.

9 Q In your opinion, based on reasonable
10 medical probability, if a patient starts out with
11 nonstructural injury such as spasm in the neck or
12 musculature of the neck that does not resolve, can
13 continuous, unresolved spasm cause structural problems
14 at some point in the future?

15 A I think I would pass on that. I would
16 leave that to the clinicians.

17 Q So you're not intending to render an
18 opinion one way or another in this case as to that --

19 A If I'm asked that specific question, I
20 think I would probably defer to neurologists or whoever
21 takes care of permanent muscle spasm.

1 Q Next page.

2 A This is another copy of the same report
3 that was corrected. And in this report I highlighted
4 in the clinical history, which I believe is the
5 correction, quote, please be advised that a correction
6 is in order regarding the transcribed patient history.
7 And the last sentence is, it is inferred that the
8 patient has no underlying weakness. The patient has
9 informed me that she does, indeed, have some weakness,
10 which has previously been confirmed by
11 electrodiagnostics, specifically an evaluation
12 performed at the National Rehabilitation Medical
13 Network. November 20th, 2006. Nerve conduction
14 studies with electromyograph that time demonstrated
15 neurologic compromise of left thromboid major muscle
16 group.

17 Q Is there any significance to this?

18 A I think there is a lot of significance to
19 that. To my mind, what happened here is that
20 Mrs. Marquez was queried by Dr. Thompson as to whether
21 or not she had weakness and she said no. And then when

1 she got the report, which she obviously studied, she
2 requested that he change it because she didn't think
3 that that was accurately stated. But to my mind the --
4 that's what I wrote here. In medicine, contemporaneous
5 reports are always considered to be the strongest and
6 most accurate of reports. And this is changed by -- we
7 have to face what it is. I'm not saying anything that
8 we don't know. This is changed by an individual who
9 has the potential to want to have it read the way it's
10 reading as opposed to the way it was originally
11 dictated.

12 Q Is it your -- do you intend to render
13 opinions in this case that Nancy Marquez desired that
14 the report read as it reads with change?

15 A Well, if I'm asked that question, I would
16 say I think that's pretty clear. I would say that.
17 Yes.

18 Q In your review of the medical records, have
19 you become aware of errors that Mrs. Marquez has
20 identified in reports that, in fact, were frank and
21 clear errors?

1 A No, I'm not.

2 Q You're not?

3 A No. I'm not saying there aren't. I just
4 haven't seen them.

5 Q And in your practice, have you ever had
6 errors in your reports where you've misstated a
7 patient's date of birth or the date of accident?

8 A Absolutely. Happens not infrequently. But
9 I just like to think that contemporaneous reports are
10 felt by most people to be the most valid. That's all.

11 Q But you would agree that if, in fact, an
12 error is found, that a report should be changed and
13 that the doctor retains the discretion to change or not
14 depending upon his personal beliefs as to the validity
15 of the information that's being put into the report?

16 A I would say that most people wouldn't
17 bother to do this, ask to have it changed. But
18 Mrs. Marquez had a reason and she asked him to do it.

19 Q So do you believe that Mrs. Marquez is
20 faking her injuries?

21 A No. I couldn't comment on her faking her

1 injuries.

2 Q With regard to no evidence of soft tissue
3 musculature structural injuries, would you agree that
4 there are other methods by which structural injuries to
5 the muscle can be identified other than by MRI, meaning
6 by palpation?

7 A Sure. Of course. Yes, sir.

8 Q By physician visualization during an
9 examination?

10 A Yes. I think that can occur.

11 Q By measurement perhaps with a -- some
12 special tool that could measure the thickness of a
13 muscle or the length of a muscle?

14 A Yes, sir.

15 Q And if, in fact, there were measurements
16 that referenced or reflected that there were changes to
17 the muscle such as atrophy, such as shortening, et
18 cetera, how would you reconcile the physician's
19 clinical observations during an exam versus the films
20 that you have testified to today do not reflect any of
21 those types of changes?

1 A My comment would be the measurements would
2 be invalid. And the reason the measurements would be
3 invalid is that they were measuring it when the scapula
4 was winged. That was her complaint. She was able to
5 present with a winged scapula.

6 So the ability to do a side-by-side
7 comparison of the rhomboids, for instance, left to
8 right or the levator left to right wouldn't be possible
9 because you have an asymmetric scapula. So I don't
10 think any measurements you'd make could be valid. The
11 muscles are in two different positions of elongation.
12 When you have elongation, you have thinning and
13 different conformity of the muscles than when they're
14 at rest. So that type of measurement would be invalid,
15 assuming that the scapula is winged at the time of the
16 measurement.

17 Now, if the scapula isn't winged, then you
18 could do it.

19 Q Now, are you intending to offer any
20 opinions as to whether Mrs. Marquez, at any time,
21 demonstrated winging of the scapula? I just need to be

1 clear about something. I may have asked it before, but
2 I'm not sure about it.

3 A I think the medical record is pretty clear
4 that she has multiple presentations of the winging of
5 the scapula.

6 Q Are you intending to offer any opinions as
7 to the cause of the winging?

8 A I'm only going to offer opinions relevant
9 to the competency of the musculature that is
10 responsible -- or the inactivity of the musculature
11 that is responsible for winging. And my commentary
12 about that is that that musculature is normal and
13 demonstrates no evidence of denervation.

14 Q If, in fact, that is so, are you intending
15 to offer any opinions as to why Mrs. Marquez's scapula
16 is noted as being winged yet the muscles do not support
17 the contention that it is winged?

18 A No, sir.

19 Q You're not intending to offer any opinions
20 that Mrs. Marquez was creating the winging by certain
21 actions that would not normally be present had she been

1 in a normal resting position?

2 A No, sir, I'm not going to do that.

3 Q So are you questioning whether the -- are
4 you questioning the physician's observations that she
5 did have winging upon examination?

6 A No, sir.

7 Q So you're willing to take those
8 observations at face value. Is that my understanding?

9 A Yes, sir.

10 Q How frequently in your practice have you
11 had to deal with diagnosing brachial plexus injuries as
12 part of your radiological exam? How many
13 brachial-plexus-injury patients -- meaning patients
14 that are sent to you specifically to try to rule out or
15 confirm the presence of brachial plexus injury?

16 A Well, may I include other brachial plexus
17 disease or just brachial plexus injury?

18 Q Just injury.

19 A Injury is --

20 Q Tell me what other diseases you're talking
21 about.

1 A You can get brachial plexopathy from an
2 infection, from a tumor.

3 Q I'm not talking about that.

4 A I would say -- brachial plexus injury --
5 maybe three or four a year.

6 Q Okay. And of those three or four patients
7 a year that you were asked to evaluate, do you know
8 what other -- for example, what types of physicians
9 would refer a patient to you for an evaluation?

10 A I don't recall that. I'm sorry.

11 Q Of those -- in the last year, the three or
12 four patients that you have reviewed films for, have
13 you found brachial plexus injury in any of those
14 evaluations?

15 A I think one of the four had some abnormal
16 signal in the brachial plexus as it comes into the
17 upper chest where the chest meets the neck region.
18 That's my recollection. I don't recall specifically.

19 Q Are you able to specifically visualize on
20 these scans the dorsal scapular nerve itself where it
21 intersects with the rest of the brachial plexus?

1 A No. I know the area, but I can't identify
2 the nerve.

3 Q So you would not be able to identify the
4 nerve based on any of the scan results that you've
5 reviewed?

6 A Correct.

7 Q Would you agree that opening up someone and
8 looking down into the nerve, using an electroscoy or
9 other magnifying objects would be more conclusive as to
10 the existence of injury to the dorsal scapular nerve
11 than MRI scans, assuming it's not a frank lesion?

12 A I think that visual inspection might show
13 something an MRI might not.

14 Q Now, do you have an opinion as to the speed
15 with which Mrs. Marquez's changes to her spine happened
16 after February 19, 2005 up until today and whether the
17 speed with which you see deterioration is consistent
18 with the spondylitic and arthritic changes --
19 degenerative changes that you note versus some other
20 cause maybe, for example, weakness in the areas of the
21 body that might cause pressure or abnormal posture to

1 arise? Do you have any opinions about the speed --

2 A Yeah. My opinion is that we chatted
3 earlier about the two cervical spine MRI scans from
4 2005 and 2006, that there was no change. And that lack
5 of change is perfectly consistent with degenerative
6 disease and inconsistent with a traumatic injury.
7 Traumatic injuries evolve quickly. Change develops
8 rapidly as far as the disk is concerned. And alignment
9 changes occur quickly.

10 In Mrs. Marquez's case, I forget how much
11 time passed between those two. Let's look. We have a
12 scan in July of '05 and another one in June of '06. So
13 virtually a year has passed and there was no change in
14 the appearance of the cervical spine. It's my opinion
15 that that is absolutely incompatible with an acute
16 traumatic injury to a disk or the spine.

17 Q Okay. Are you intending to offer any
18 opinions relative to the mechanism of injury relative
19 to whether a twisting of the neck during an osteopathic
20 manipulation can cause injury to the spine or the disks
21 or the brachial plexus?

1 A No.

2 Q In terms of the records that -- the
3 radiology records that you've reviewed, have you looked
4 at all of the films that correlate with the
5 radiological reports that you possess?

6 A There are a couple of disks that I couldn't
7 open up. So I have not looked at those. The rest, I
8 have.

9 Q Can you tell me which ones you were unable
10 to open?

11 A Yes, sir.

12 This one dated -- cervical spine flexion
13 extension films which I think is an MRI examination
14 from Next Generation MRI dated 4-16-07. I tried to
15 open it up on three different PCs. I was unable to do
16 that.

17 This one probably is of no consequence.
18 It's an MRI from Hopkins of the brain dated October
19 24th, 2006 that I couldn't open.

20 Q Now, with regard to the disks -- I'm not
21 going to have them marked. I'm just going to count

1 them including the one that you have in your -- could

2 you pull the one out of your --

3 A Would you like me to?

4 Q Sure.

5 A There you go.

6 Q You would agree that that disk date is
7 3-13-08, thoracic with and without contrast?

8 A Yes, sir.

9 Q Your note attached to the disk says what?

10 A Pre and post contrast. Thoracic spine
11 within normal limits. Then I had some directions on
12 how to open the disk.

13 Q This disk is 11-15-06.

14 A Correct.

15 Q MRI of the brachial plexus and neck.

16 A Right. MR neurogram. Noncontrast study.

17 Q And what is your note?

18 A It's just directions on how to open the
19 disk.

20 Q What is the red pen?

21 A Non con. It means they didn't use contrast

1 as part of the study.

2 Q Is that important for you in terms of your
3 ability to visualize?

4 A Not for neurographic problems, no, sir.

5 Q C spine MRI, June 28, 2006. And your note?

6 A Desiccation C2 through C6. I think I read
7 this already. Desiccation C2 through C6 anterior spur
8 C6 inferiorly. No change since MRI of 7-21-05 and
9 x-ray of 8-21-98. So I guess I looked at the x-ray
10 from 1998.

11 Q So is it my understanding --

12 (There was a break in the proceedings.)

13 Q So is it my understanding, based upon this
14 note, that in your review of the x-ray of 8-21-98 that
15 you saw the same thing in terms of the C2 through C6
16 disk desiccation as you saw on the 6-29-06?

17 A No, sir. That would refer to the bony
18 changes.

19 Q Explain that to me.

20 A X-rays don't show you disk desiccation.
21 They would show you the bones only. So I wouldn't be

1 able to address the desiccation. So that would mean I
2 was talking about -- since it's a note to myself, I
3 know what it means. That would be referring only to
4 the bony changes.

5 Q So with regard to bony changes, what are
6 you speaking of --

7 A That there was a spur at inferior C5 and
8 maybe inferior C4 because that's what I saw in 2005.

9 Q Okay.

10 A This is an MRI of the brachial plexus, May
11 31, 2007. And I've written down the sequences that
12 were done, T1,3 and fat sat post con and in the axial
13 and coronal planes and a T2 fat sat. Then I have a
14 pink sticky that says cervical spine MRI, May 31, '07.
15 No change since MRI of 2005 and x-ray of 1998.
16 Brachial plexus okay.

17 Q And, again, you're speaking of bony
18 changes?

19 A No. Those would be disk changes because
20 that's an MRI. You only see bones on the x-ray. You
21 can see bones and disks on the MRI.

1 Q So when you say no change since MRI of '05
2 and x-ray of 1998, with regard to the x-ray, you're
3 only speaking to the bone?

4 A That's correct.

5 Sir, this is dated August 21st, 1998. This
6 is from Bloom Chiropractic. I have lumbar spine x-ray.
7 I don't have a comment there. I do have that this is
8 in Dearborn, Michigan. Cervical spine straightened
9 alignment. Mild spur -- anterior spur inferior C5.
10 Mild anterior slip, meaning slight dislocation, of C3
11 on C4. I asked the question why were these done
12 because I didn't have any medical records from Bloom
13 Chiropractic.

14 And I guess this is, in part, response to
15 your question to me earlier as to whether or not there
16 was a prior history of cervical disease. This would
17 make me think that there was. But I didn't have the
18 medical records so I couldn't recall directly. I had
19 asked for those medical records from Mr. Morter.

20 MR. MORTER: I have to check and see if we
21 have them.

1 THE WITNESS: Sir, this is a disk dated
2 July 21st, 2005 which is a cervical spine MR from Shady
3 Grove. I think we've done this one. This is the first
4 one we did. This is the 7-21-05 one, desiccation of
5 C2 through C6 in the spurs. We've already discussed
6 that.

7 That's the one I couldn't open.

8 Q I want to take a look at --

9 A Please. Have a blast.

10 (There was a break in the proceedings.)

11 Q What do your notes reflect as to when you
12 were first retained to serve as an expert in this case?

13 A I don't have any notes. There is a letter,
14 which I think you took earlier, February 20th, 2009.

15 MR. BELSKY: I would like to have this
16 marked as Number 4.

17 (Citrin Deposition Exhibit Number 4 was
18 marked for purposes of identification.)

19 Q I would like you to tell me what you've
20 written on this letter dated February 20, 2009 from
21 Robert Morter.

1 A It says I told Mr. Morter, one, that OMG
2 studies are within normal limits for the brachial
3 plexus injury and proper sequences were done. Two, all
4 musculature is within normal limits, no abnormal signal
5 and no atrophy. Three, no clinical evidence of injury
6 to muscles surrounding dorsal scapular nerve. Four,
7 cervical spine imaging studies are within normal
8 limits. No compressive -- no compression injury, I
9 guess. I'm not sure. I'm having difficulty with my
10 own handwriting. Five, diskography is a subjective
11 test. Patient controls results. And then I have
12 degenerative disk disease, DJD, desiccation anterior
13 spurs and disk at C4-5. No change since x-ray from
14 Bloom Chiropractic in 1998.

15 Q So you had a telephone conversation with
16 Mr. Morter?

17 A I did.

18 Q Would this have been the first conversation
19 that you had or did you have a conversation before that
20 warning you that you were getting probably thousands of
21 pages of medical records?

1 A He didn't warn me about that. I might have
2 said no. I don't recall, sir, the time. Obviously, I
3 had some communication with Mr. Morter or Mr. Morter's
4 office prior to the case being sent over to me. But I
5 don't know if there was a telephone conversation with
6 Mr. Morter or Mr. Morter's representative. This would
7 have been subsequent to receipt of the case.

8 Q Subsequent to the receipt of the documents,
9 right?

10 A Right, exactly.

11 Q Do you know approximately when you had this
12 conversation relative to the receipt of the --

13 A Sir, I would say within -- normally I take
14 a little time with these. I would say within a month
15 to six weeks, but I don't know exactly.

16 Q Are you aware of the trial date in this
17 case?

18 A I don't know if I am.

19 Am I aware of the trial date in this case?

20 MR. BELSKY: He can't answer you.

21 Q Do you know when the trial is in this case?

1 A No, I don't.

2 Q Are you going to be around in a couple
3 weeks?

4 A No.

5 Q Where are you going to be?

6 A Florida.

7 Q How long are you going to be in Florida?

8 A Three weeks.

9 Q What are the inclusive dates of your trip?

10 A Well, first of all, it doesn't mean I can't
11 come back. I'm leaving Saturday and I'll be back three
12 weeks later. This is what happens when you're a
13 newlywed.

14 Q We'll get back to records. Tell me about
15 your clinical practice.

16 How frequently are you interpreting
17 films --

18 A I work about three days a week. I read a
19 variety of studies, mostly MRIs and CAT scans and some
20 x-rays. I have other -- I do some teaching at GW about
21 once a month. I have another job with a company that

1 owns and operates scanners. I'm the medical director
2 for that company. So one day a week.

3 Q What's the name of that company?

4 A Medical Imaging and Diagnostics, Inc.

5 And I take more vacation now than I used to
6 as I've gotten older. So I'm not working full-time.

7 Q Tell me about your involvement in
8 litigation cases.

9 A I review about a case a week. That all
10 covers whether it's a medical-legal matter or a
11 personal injury matter. I review cases for both the
12 plaintiff's side and the defense side.

13 Q Percentages?

14 A Yes.

15 Q What, please?

16 A About two-thirds for the defense and about
17 one-third for the plaintiff.

18 Q So in addition to reviewing about one file
19 a week, how about testimony?

20 A I probably -- I'm in -- between depositions
21 and court, maybe fifteen times a year, something like

1 that, twenty times a year.

2 Q What percentage of your income would you
3 say is attributable to your serving as an expert
4 witness in any type of litigation matter?

5 A In all things?

6 Q All things?

7 A Chart review and not just depositions and
8 that kind of thing?

9 Q Right.

10 A Fifteen to twenty percent.

11 Q With regard to testimony, the preparation,
12 the depositions, the review with counsel, trial prep,
13 how much --

14 A Less than five percent.

15 Q And of the fifteen to twenty percent that
16 you mentioned in terms of your percentages that you
17 gave me plaintiff to defendant, do those percentages
18 clearly superimpose upon those numbers so that it's --

19 A I've never done that analysis. I have no
20 idea. I would assume so. I don't dote more on one
21 than the other.

1 Q Have you ever testified in a case involving
2 brachial plexus injury before?

3 A I don't think so.

4 Q Have you ever testified in a case where
5 there is a claim that the long thoracic nerve was
6 injured?

7 A No, sir, not to my recollection.

8 Q Have you ever reviewed a case involving
9 injury to the -- alleged injury to the brachial plexus?

10 A I don't recall. I don't know. I don't
11 think so, but I don't know.

12 Q Have you ever testified in federal court
13 before?

14 A Many, many years ago, ten or fifteen years
15 ago.

16 Q Do you maintain a list of cases that you
17 have served as an expert in?

18 A I have had a list. I don't know if I still
19 have it.

20 Q Can you do me a favor and see if you can
21 locate that list and send it to Mr. Morter.

1 A Sure.

2 Q If, in fact, the list existed, how current
3 would you say that list is?

4 A Not very.

5 Q In terms of "not very," give me an
6 approximate age.

7 A Three or four years old.

8 Q And you've been serving as an expert in
9 litigation matters for how long now?

10 A Since late -- mid to late 1990s.

11 Q Do you advertise anywhere that you are
12 available to serve as an expert? And if so, where?

13 A No.

14 Q Have you ever worked with Mr. Morter
15 before?

16 A I think this is the first case I have
17 worked with Mr. Morter.

18 Q Have you worked for Wharton, Levin before?

19 A Yes.

20 Q In the last year -- within this last year,
21 tell me what types of cases, if any, you have worked

1 with that firm on.

2 A I couldn't tell you. I have no
3 recollection of that.

4 Q Presently, how many cases are you actively
5 involved in as an expert witness in the field of
6 medical negligence?

7 A Five or six.

8 Q Tell me -- to the best that you can recall,
9 tell me what those cases involve or --

10 A I know one is a -- one is a baby that had
11 cerebral palsy. One is --

12 Q And you're testifying for which side in
13 that case?

14 A Defense.

15 Q Who is the lawyer that represents the
16 defendant?

17 A I don't know.

18 Q Go ahead.

19 A Then there is a case of a missed abscess,
20 lumbar spine abscess.

21 Q Who are you testifying for in that case?

1 A Jerry Holts.

2 Q Plaintiff?

3 A Plaintiff.

4 There is an allegation of a missed lung
5 cancer. I don't remember the name of the attorney.
6 But that's a defense case. I don't recall the others.
7 This case. That's the best I can recollect right now.

8 Q How much time have you spent in this case
9 so far?

10 A A lot. Much more than almost any other
11 case. I don't know. But it's in excess of ten hours.
12 Probably closer to twenty hours.

13 Q And what is your hourly rate?

14 A \$675 per hour.

15 Q Have you been paid any money thus far?

16 A I suspect I have. I have a bookkeeper that
17 takes care of that stuff. I would expect that --
18 because it's been going on for a while -- that had it
19 not been paid, it would be brought to my attention.

20 Q Do you usually bill out to get paid?

21 A Yes.

1 Q So you would have issued bills in this
2 case?

3 A Yes.

4 Q Do you have copies of those bills within
5 your file?

6 A If they've been paid, probably not. If
7 they haven't been paid, absolutely, yes.

8 Q And would they have been paid to you
9 personally or to your practice?

10 A To the practice.

11 Q I note in reviewing the folders that you
12 have a method of identifying records that you may find
13 of some significance and that is that they're kind of
14 folded and then highlighted within.

15 A That would be secondary significance.
16 Primary significance, I pull it out.

17 Most of those are the reports I think
18 because I think this is --

19 Q Do you have any other correspondence from
20 Mr. Morter other than --

21 A I think there was another letter that I had

1 here from him. I don't keep all the correspondence
2 because every time something else appears there is
3 another letter saying here it is.

4 Q Well, you know that lawyers always want to
5 see the communication between attorney and expert.

6 A Right. But that's not my concern. I don't
7 feel like I have to keep it so I don't keep it.

8 Q How about e-mails. Have you received any
9 e-mails from Mr. Morter?

10 A I don't think so. If I did, I don't have
11 it.

12 Q When was the last time you met with
13 Mr. Morter prior to me opening my mouth in the room
14 today?

15 A I don't remember.

16 Q Did you meet today?

17 A I'm not sure when we met.

18 Q Did you meet with him today?

19 A Yes.

20 Q Tell me what you discussed during your
21 meeting today.

1 A I just told him what my positions were.

2 All I did is review with him -- I did most
3 of the speaking. I reviewed with him my opinions in
4 this case having to do with the brachial plexus, the
5 musculature, the cervical spine. We looked at one MRI
6 scan.

7 Q Which one?

8 A I don't remember which one. It was on the
9 scan when you walked in here and you made me take it
10 off. I don't know which one it was. It may have been
11 the neck scan not the July 21st but the next one which
12 looked the same as July the 21st study.

13 Q You had that one ready for me --

14 A Right. Was that a study we looked at?
15 Yeah. I think so.

16 Q So I just want to make sure that I'm not
17 missing something you have shown me that I'll have put
18 up on the screen at trial that I haven't asked you
19 about.

20 A That's not going to happen.

21 Q So have you reached any opinions in this

1 case initially that you have changed today, meaning
2 that you had believed one thing at an earlier time and
3 then you have come to change your opinion today?

4 A No.

5 Q Or at some point before today?

6 A Well, I don't recollect before today but
7 not today.

8 Q This record that I have, you indicated that
9 what you pulled out was the most significant --

10 A Usually, yes.

11 Q And the records are folded over in the
12 secondary.

13 A Right. Or they were stuck in the file too
14 tough that I couldn't pull them out.

15 Q Can you tell me what that document is and
16 what relevance it has, what your sticky note says.

17 A MRI scan report of the cervical pain from
18 Johns Hopkins dated November 15, 2006. And I wrote NB,
19 take note of, rhomboids bilaterally within normal
20 limits as other periscapular muscle groups. No
21 inflammation in brachial plexus.

1 Q And then there is some excitement there
2 again with the double exclamation point.

3 A I just thought that was important -- and we
4 talked about this quite a bit -- that all the
5 periscapular muscles were normal.

6 Q And that was the study ordered by
7 Dr. Corse, C-O-R-S-E?

8 A Yes, sir.

9 Q Let me ask you about this blue note right
10 here. Tell me what that --

11 A I was looking for that. That goes on one
12 of the disks. I read it. This was on that July 21,
13 2005 disk, MR. And I rewrote it because it
14 disappeared.

15 Q So when Dr. Docker and Dr. Dicks saw
16 Mrs. Marquez, the neurosurgeons, and relied upon
17 Dr. Thompson's diskogram to conclude that Mrs. Marquez
18 needed a -- or was a candidate for a disk replacement,
19 is it your testimony that they erroneously relied upon
20 the diskogram in reaching their opinions about the need
21 for the disk replacement?

1 MR. MORTER: Objection.

2 THE WITNESS: Are you offering me as a
3 neurosurgical expert.

4 Q Are you telling me that you can't give that
5 opinion?

6 A Well, what I'm going to say is if you allow
7 me to give that opinion, then I'll assume you think I'm
8 neurosurgically competent. I'm asking you if you want
9 to ask me that and you're going to have me answer it,
10 then I expect my answer to be admissible --

11 Q Don't expect that.

12 A Unless you tell me that you accept my
13 answer --

14 Q I'll accept it. I won't accept your
15 qualification.

16 A I think a replacement disk surgery was
17 inappropriate. She could have had something much more
18 conventional.

19 Q Like what?

20 A Like a diskectomy. If they felt the disk
21 was not good, she could have had a much less complex,

1 much more reliable -- I mean, it's just -- I think it's
2 part of the complex that's going on.

3 Q Are you talking about a discectomy, a
4 fusion --

5 A If she would have had a conventional
6 procedure that's well-known, easily done by anybody in
7 the country that's a neurosurgeon. They do 10,000 a
8 week. And instead she opted for something that I think
9 is, you know, risky, untested, unproven long term. It
10 wasn't a good decision.

11 Q And I assume that your opinion is it wasn't
12 a good opinion for either the doctors or the patient?

13 MR. MORTER: I'm going to object.
14 Dr. Citrin, a radiologist, will not be asked to offer
15 any opinion as to the propriety or not of a
16 disk-replacement surgery based upon his skills and
17 expertise.

18 A I'll withdraw my comments. I think I said
19 to you earlier I'm not going to comment on that.

20 Q I'm not going to allow you to withdraw your
21 comments. But Mr. Morter's objection is noted.

1 THE WITNESS: Thank you, Mr. Morter, for
2 having me shut my gap.

3 MR. MORTER: I don't think it's an
4 appropriate line.

5 THE WITNESS: I agree. That was an
6 off-the-record comment on the record.

7 Q On the front of this additional medical
8 record in blue --

9 A Received and reviewed May, '09.

10 Q So this would have been one of those files
11 or binders that you would have received at about the
12 time that you received that letter that we've
13 discussed?

14 A Correct, sir.

15 Q And that letter has been marked, the letter
16 from Mr. Morter?

17 MR. MORTER: That's a February letter. I
18 think those indicate there were additional records
19 provided in May.

20 Q So in May of '09, you received, I assume
21 for the first time, records in this binder which go

1 from number -- well, let me ask you first. You'll note
2 from the binder and the tabs that there is no real
3 order numerically to the tabs, correct?

4 A I think that there is an order.

5 Q Tell me what your understanding is as to
6 the order.

7 A My understanding to the order is that there
8 are forthcoming additional medical records that would
9 fit numerically within the spaces, the numerical spaces
10 that exist between the numbers. So in other words, the
11 first one is four. The next is nine. At some point in
12 time, I would get five, six, seven, and eight.

13 Q So is it your --

14 A It's so indicated right here. It indicates
15 in this binder. That's the way it came. It's either
16 been provided previously or will be forthcoming in the
17 future.

18 MR. BELSKY: So for the record, I want to
19 review the documents that are in this binder in terms
20 of the index. I'm going to read from and note that the
21 index has highlighting in yellow consistent with what

1 I've seen in Dr. Senate's office.

2 Number four, Elizabeth Michels,
3 M-I-C-H-E-L-S, M.D. dermatology. Tab four records
4 present.

5 Number nine, A-M-I-T, R-A-J-V-A-N-S-H-I-M-D
6 family practice. Number nine, records present.

7 Number sixteen, Wesley, W-E-S-L-E-Y,
8 Lockhart, L-O-C-K-H-A-R-T, DO. Number sixteen, records
9 present.

10 Number twenty-seven, Michael K-U-O, M.D.
11 Number twenty-seven, again, records present.

12 Number thirty, John W-A-N-E-B-O, M.D.
13 Number thirty, records present.

14 Number thirty-one, I-V-I-C-A, D-U-C-I-C,
15 M.D. Thirty-One, records present.

16 Number fifty-three, Mona Mendelson, MSW.
17 It's M-E-N-D-E-L-S-O-N. Records present.

18 Number fifty-five, Michelle Thomas, M.D.
19 Records present.

20 Number fifty-nine, Nancy Woods, OTR.
21 Records present.

1 Number sixty-two, C-H-E-T-A-N, Patel, M.D.

2 Records present.

3 Q I'm going to show you these two binders
4 that are rubber banded together. It says from
5 plaintiffs' production, volume two; plaintiffs'
6 production, volume one.

7 Do you know whether you received these
8 records before the defendants' records or after? Any
9 way to know?

10 A I have no idea.

11 Q You don't have any correspondence that
12 reflect when the plaintiffs' records were sent to you?

13 A No, sir.

14 Q You've reviewed a fair amount of deposition
15 testimony in this case.

16 A Yes, sir.

17 Q Now, I have to ask you some questions about
18 the depositions and the notations you've made on the
19 depositions.

20 A Yes, sir.

21 Q So I was going to -- in order that they

1 appear in your pile here.

2 A Yes, sir.

3 MR. MORTER: I would like the record to
4 reflect, before you do that, that you did not inventory
5 each and every medical record that the doctor has
6 reviewed. I didn't want any issues down the road.

7 Q Let's start with Dr. Gerwin, September 17,
8 2009. Tell me what your notes on the front of that
9 say.

10 A It says page twenty-five, injuries. Page
11 twenty-six, nerves involved. Page twenty-eight, is
12 there a record of pain in this area post manipulation.
13 Page thirty, why not. Then I say about dorsal scapular
14 nerve, C5. Page thirty-one, dash, two nerve conduction
15 and EMG. Page thirty-three, diagnosis equals mid
16 plexus injury. Page thirty-eight, RE anular -- no -- I
17 think it's anular tear and trauma. Page fifty-six,
18 opinion. I'm not sure what that is. Also, bill to
19 Dr. Thompson's -- I have no idea what that is. Sorry.

20 Q I understand your opinions relative to
21 whether you believe, radiologically speaking, whether

1 Mrs. Marquez suffered from any traumatic injury to her
2 disk or her brachial plexus.

3 Other than the fact that, for example,
4 Dr. Gerwin believes that, in fact, she did, is it fair
5 to say that your disagreement is primarily with
6 Dr. Thompson in this case as a neuroradiologist?

7 MR. MORTER: Objection.

8 THE WITNESS: No. Well, again, because I
9 want to talk about the -- again, I'm not going to argue
10 with Dr. Gerwin neurologically, but I feel very
11 strongly that denervation of musculature is going to
12 show some sort of finding in the area of the rhomboid
13 muscles of the levator. I don't want to go tit for tat
14 with Dr. Gerwin as a neurologist. I'm not going to
15 argue with him about his neurologic findings. But I
16 will argue with him about the result of any neuropathic
17 injury suffered by those nerves as it pertains to the
18 musculature that is involved with winging of the
19 scapula. That's my only concern. If Dr. Gerwin has a
20 neurologic opinion, that's his neurologic opinion. I
21 wouldn't disagree with it. I would only disagree with

1 the fact that there is an end result of denervation as
2 it affects those muscles.

3 Q So if Dr. Gerwin says I examined Nancy, I
4 saw atrophy of her rhomboid, you're going to disagree
5 from the standpoint that radiologically you don't see
6 it but you're not going to disagree with what he
7 observed?

8 A Well, unless he said that I observed a
9 rhomboid when the scapula wasn't winged. We talked
10 about this earlier. It's like saying look at my
11 biceps. I have a problem with my left biceps. One is
12 flexed and the other one is flaccid. You can't do
13 that. You can't compare them for symmetry when they're
14 in two different states.

15 So if he said there was a period of time
16 when the scapula wasn't winged and I looked at the
17 rhomboid and I saw it was atrophied, then I would give
18 him credence for that observation. But if the scapula
19 is winged, I don't think he can make any comment as to
20 the presence of atrophy or not atrophy.

21 Q Do you say that based on a reasonable

1 degree of medical probability as to the positioning of
2 the scapula whether you can determine atrophy or not?

3 A What I want to say is you can't compare it
4 to the other side. I don't know how else you would
5 make a determination of atrophy.

6 Q That's not really within your parameters,
7 is it, expert in radiology, is it?

8 A I think when it comes to asymmetric
9 muscles, it is within my purview.

10 Q As it relates to both the positioning of a
11 patient during a physical examination by a
12 nonradiologist or just based upon your review of films
13 or studies?

14 A Well, I think this is basic medical -- this
15 has got nothing to do with neurology or radiology. It
16 has to do with just basic medicine and basic common
17 sense. Muscles in two different phases of stretching
18 or relaxation cannot be compared for symmetry.

19 Q But you're not certain about the
20 methodology for performing the examination --

21 A Well, that's true. If Dr. Gerwin has some

1 sort of compensatory mechanism that he applied to
2 account for that, then I would accept that.

3 Q I want to ask you about page 306,
4 Dr. Gerwin's testimony where he's talking about
5 bleeding. Would you read the circled portion into the
6 record.

7 A I think I'm quoting Dr. Gerwin. There may
8 be bleeding in that area. There may not be. You don't
9 have to have it but bleeding may lead to scarring that
10 you may not see if you simply stretch -- bleeding may
11 lead to scarring that you may not see if you have
12 simply a nerve stretch or a development of adhesions.
13 You may get a pair of fiber muscles depending on the
14 particular anatomy.

15 Q And you've written on the top why not with
16 double exclamation points.

17 A Right.

18 Q What are you --

19 A I'm not sure. I may have to read the
20 paragraphs above it.

21 Q Do it to yourself. Yeah.

1 A I think I'm asking the question that if
2 there was a significant stretching of things to the
3 point that something was compromised you would expect
4 to have bleeding. I think that's what I was saying.
5 He's saying there may be bleeding in that area and
6 there may not be. I'm saying why wouldn't there be.

7 Q So you would expect there to be bleeding if
8 there was significant injury?

9 A I think I'm asking the question.

10 Q You're asking it?

11 A Yeah. The why not.

12 Q So when you asked the question, your
13 understanding of the medicine is that you would expect
14 there to be the presence of blood --

15 A No. I'm just querying why one expected to
16 see bleeding. I don't think it's a -- the double
17 exclamation point may be misleading.

18 Q You have so much marked.

19 Dr. Thompson's deposition transcript,
20 September 15, 2009. Can you read for me, you know,
21 first what you wrote on the front cover.

1 A Sure. Page fourteen, diagnosis. Page
2 twenty-four, page twenty-five, double star. Page
3 twenty-six, double star. Page thirty, anular tear.
4 Page thirty-six, page thirty-nine, due to degenerative
5 disease. Page forty-three, correction to report. Page
6 forty-five, forty-six, take note C5-6 disk does not
7 equal rhomboid innervation. Page fifty-two, disruption
8 causes.

9 Q So now we have to go -- I need to go
10 through the painful process of asking you to go through
11 this deposition. And I need you to tell me everything
12 you disagree with that Dr. Thompson said.

13 A I can't do that unless I read the whole
14 deposition. I can't possibly do that. Just because I
15 haven't circled something doesn't mean I didn't
16 disagree with it. I can address the things that are
17 circled.

18 Q If you feel that will allow me to
19 understand your disagreement --

20 A I can't say that. If you want me to say
21 everything I disagree with Dr. Thompson, we have to

1 start on page four and go to page sixty, whatever it
2 is.

3 Q Okay.

4 MR. MORTER: I'm going to step out while
5 you're refreshing your recollection of Dr.
6 Thompson's --

7 THE WITNESS: I disagree with where he
8 says -- this is page fourteen. Mrs. Marquez suffered a
9 disk-related injury as a result of an osteopathic
10 manipulation. I strongly disagree with that. It's of
11 interest.

12 I would disagree that I think Dr. Doctor
13 was misinformed by Mrs. Marquez where he said that
14 Mrs. Marquez indicated to him that she had no
15 pre-existing cervical spine issues. That's clearly not
16 the case since she had a cervical spine x-ray at Bloom
17 Chiropractic. So in that regard, I would disagree with
18 Dr. Thompson's assumption that there was no prior
19 history of cervical spine complaints.

20 Q But you have no records -- you have no
21 records of Bloom, correct?

1 A I have a cervical spine x-ray. Why else
2 would a cervical spine x-ray be taken other than for a
3 cervical spine complaint.

4 Q So you're presuming that that's the case?

5 A What else would you presume?

6 Q I'm just asking.

7 A It's within a reasonable degree of medical
8 certainty. That's my assumption.

9 Q That was in 1998?

10 A Right.

11 MR. MORTER: Perhaps Mrs. Marquez will
12 voluntarily produce the record.

13 THE WITNESS: Please forward that to me if
14 it appears.

15 MR. MORTER: I will.

16 THE WITNESS: I would disagree with
17 Dr. Thompson where he said that they use conscious
18 sedation to reduce bias. Not that I disagree with his
19 comment they do it for that purpose. But I would
20 comment that it didn't work. Because he said, quote,
21 on page twenty-three, despite her subconscious sedation

1 awareness, she became quite animated. In terms of
2 answering questions as to the nature is this your pain,
3 are you aware of any typical neck discomfort, and the
4 answer was positive. So it seems to me that he himself
5 has said that she was pretty much aware of what was
6 going on.

7 Q And you call that bias?

8 A No. I said -- what I call that is
9 ineffectiveness to reduce bias.

10 Q So you equate her complaints as bias?

11 A No. I didn't say that. I said the use the
12 conscious of sedation to reduce bias -- because
13 Dr. Thompson recognizes that bias is in play when
14 you're dealing with patients like Mrs. Marquez have a
15 complaint. The use of conscious sedation to reduce
16 that bias was not effective in her case because she
17 became quite animated.

18 Q Isn't a diskogram, as you've indicated
19 earlier, based upon the patient complaining of pain?

20 A All I'm trying to say is that Mrs. Marquez
21 was awake and aware as opposed to being markedly

1 sedated.

2 Q So is it your opinion that she was biased?

3 A No. My opinion is that he did not
4 successfully reduce bias.

5 Q And that's because she was animated?

6 A No -- well, yes. Because she was not
7 sedated well.

8 Q So your opinion would be that a properly
9 sedated patient would be such that they would not be
10 able to express any pain?

11 A No. It would be less animated.

12 Q Just less animated?

13 A Right.

14 I disagree with Dr. Thompson on page
15 twenty-five that the spondylitic changes are related to
16 the osteopathic manipulative procedure. That's
17 outrageous and incorrect. And we know that for sure
18 because she had those findings on the Bloom x-ray.

19 Q So outrageous --

20 A Well, because you can't get those kinds of
21 bony changes so quickly as she had on the MRI scan soon

1 thereafter.

2 On page thirty-one, Dr. Thompson says that
3 99.9 percent of patients who have asymptomatic disk
4 have an anular tear. I don't think Dr. Thompson is
5 saying the anular tears are what's causing the
6 symptomatic disks. If he is, I disagree with it. If
7 he isn't, I agree with it. I'm sure he's saying
8 they're not related.

9 On page thirty-three, I would state that
10 Dr. Thompson's use of the term internal disk disruption
11 is synonymous with degenerated disks. If he's
12 suggesting that is something different than a
13 degenerated disk, then I would disagree with that.

14 I disagree with Dr. Thompson that the
15 internal disk disruption is related to trauma. Unless
16 he defines traumatic wear and tear that all of us have
17 every day.

18 I would comment also that I don't think an
19 EMG examination -- I've seen this more than once not
20 just from Dr. Thompson but I think you mentioned it,
21 Mr. Belsky, that an EMG examination can diagnose

1 weakness. I don't think that's correct. And
2 Dr. Thompson is assuming because Mrs. Marquez had a
3 positive EMG examination that she had weakness. I'm
4 not an EMG -- I've already said that. But it's my
5 limited knowledge that a positive EMG in and of itself
6 does not indicate that the muscle is weak. I would
7 leave that open for further discussion amongst the
8 experts.

9 Q Meaning you would defer?

10 A Yes, I would defer. As I think
11 Dr. Thompson will.

12 I also think that the dorsal scapular nerve
13 arises from the C5 nerve root. And the disk pathology
14 that Dr. Thompson's identified is at the C6 nerve root.
15 It's at the C5-6 disk. And therefore, I don't think
16 that he states that the C5-6 disk was the cause of the
17 weakness -- that was the question Mr. Morter, I guess,
18 asked. He said yes, I do. I don't think
19 neurologically that fits. I think the C5-6 disk gives
20 rise to the C6 nerve root. And that does not give rise
21 to the dorsal scapular nerve. So I don't think those

1 two things fit together. In that regard, I would
2 disagree with Dr. Thompson.

3 He, in fact, does say that later on that
4 the C5-6 nerve root does not play a major role with the
5 rhomboids. He is stating that he thinks it's C6, C7,
6 and T1. I think it's C5. So we'll let the
7 neurologists hash that out. I'm pretty sure the dorsal
8 scapular nerve arises from C5.

9 Q What page are you on?

10 A Page fifty.

11 Mr. Morter asked Dr. Thompson that you
12 had -- there was an anular tear in C4-5 in December of
13 2006 but September of 2008 you don't make reference to
14 that. Can you explain why not. His answer, maybe I
15 simply did not include the appearance of a diskogram.
16 So it seems like lots of physicians don't comment on
17 everything that's on the film. He states further that
18 an anular tear never heals. It's very likely if I go
19 back and look at the C4-5 disk injection from 9-18-08 I
20 will probably see an anular tear. So he just left it
21 out of the report.

1 I disagree with Dr. Thompson's commentary
2 that an internal disk is ruptured. It is related
3 strictly only to axial forces.

4 Q Tell me what it is that you --

5 A Just general movement of that -- general
6 use of the disk, whatever the forces are, would be
7 sufficient.

8 Q So it could be compression, shearing?

9 A Well, 99.9 percent of the time it's simply
10 just wear and tear whatever you do. You nod, you
11 shake, you jump up and down, you support your head.
12 Now, maybe you consider all of those axial forces. If
13 those are all axial forces, then I agree. If he means
14 one specific force, then I would disagree.

15 Q You don't believe that one specific force
16 can cause an anular tear?

17 A I think anular tears are felt by
18 neurosurgeons and neuroradiologists to be a
19 degenerative finding.

20 Q Is that within your purview of expertise?

21 A Yes, absolutely.

1 Well, I disagree with Dr. Thompson on page
2 fifty-four where he suggests -- when he says -- he's
3 talking about how difficult it is to cause a disk
4 herniation in a twenty-eight-year-old. I suspect it's
5 easier to do it in a sixty-year-old who has
6 pre-existing degenerative changes in that disk. I
7 would comment that Mrs. Marquez already had
8 pre-existing degenerative changes in her disk at the
9 time of her MRI imaging in 2005. I'm losing my voice.

10 Q Is it your opinion that she would more
11 easily suffer from a disk herniation as a result of
12 that?

13 MR. MORTER: Objection to foundation.

14 THE WITNESS: I don't necessarily think
15 that's true either.

16 Q What do you think is true?

17 A I don't think that degenerative changes of
18 the sort that Mrs. Marquez had makes it easier to have
19 a disk herniation. All I'm saying is that she already
20 had degenerative disease. So Dr. Thompson suggesting
21 she didn't, when he's already commented earlier that

1 she had spondylosis of the cervical spine. So he knows
2 she has degenerative disease. He's implying here that
3 she does not.

4 Unless I've missed something, that would be
5 the bulk of my opinions.

6 Q Speaking of the bulk of your opinions, I'm
7 ready to wrap it up now.

8 Is there anything else that we haven't
9 spoken about thus far as to your opinions that you
10 intend to speak about at trial?

11 A No, sir.

12 Q I don't want any surprises.

13 A I would not do that to you, nor would you
14 let me.

15 Q That's why we spent some time going over
16 this because I want to make sure I understand your
17 opinions.

18 MR. BELSKY: I thank you very much.

19 MR. MORTER: No questions.

20 (Deposition concluded at 5:13 p.m.)

21

CERTIFICATE OF DEPONENT

I hereby certify that I have read and examined the foregoing transcript, and the same is a true and accurate record of the testimony given by me.

Any additions or corrections that I feel are necessary, I will attach on a separate sheet of paper to the original transcript.

Charles Citrin, M.D.

1 State of Maryland

2 Prince George's County, to wit:

3 I, HEATHER AVALOS, a Notary Public of the
4 State of Maryland, County of Prince George's, do hereby
5 certify that the within-named witness personally
6 appeared before me at the time and place herein set
7 out, and after having been duly sworn by me, according
8 to law, was examined by counsel.

9 I further certify that the examination was
10 recorded stenographically by me and this transcript is
11 a true record of the proceedings.

12 I further certify that I am not of counsel
13 to any of the parties, nor in any way interested in the
14 outcome of this action.

15 As witness my hand and notarial seal this 18th
16 day of January, 2009.

17 _____
18 HEATHER AVALOS

19 Notary Public

20 My Commission Expires:

21 December 21, 2011

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