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2
3 STATE OF ILLINOIS)
4) SS.
5 COUNTY OF MCHENRY)

6 IN THE CIRCUIT COURT OF THE TWENTY-SECOND
7 JUDICIAL CIRCUIT, MCHENRY COUNTY, ILLINOIS

8 PAUL DULBERG,)
9)
10 Plaintiff,)
11 vs.)
12)
13 DAVID GAGNON,)
14 Individually, and as) Case No.
15 Agent of CAROLINE) 12 LA 178
16 McGUIRE and BILL)
17 McGUIRE, and CAROLINE)
18 McGUIRE and BILL)
19 McGUIRE, Individually,)
20)
21 Defendants.)

22 The deposition of

23
24 DR. SCOTT SAGERMAN

25 October 15, 2013

26
27 Reported by:
28 Jill S. Tiffany, CSR

29 VAHL REPORTING SERVICE, LTD.
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31 11 N. Skokie Highway, Suite 301
32 Lake Bluff, Illinois 60044

33 and

34 53 West Jackson, Suite 656
35 The deposition of DR. SCOTT

36 Chicago, Illinois 60604

1 SAGERMAN, taken before Jill S. Tiffany, CSR,
2 a notary public within and for the County of
3 Lake and State of Illinois, on October 15,
4 2013, at the hour of 9:24 a.m., at 515 West
5 Algonquin Road, Arlington Heights, Illinois.

6

7

8 APPEARANCES:

9

10 MR. ROBERT LUMBER, of the
11 Law Offices of Thomas J. Popovich, P.C.
12 3416 West Elm Street
13 McHenry, Illinois 60050,
14 appeared on behalf of plaintiff;

15 MR. PERRY A. ACCARDO, of the
16 Law Office of Steven A. Lihosit
17 200 North LaSalle Street, Suite 2650
18 Chicago, Illinois 60601,
19 appeared on behalf of Defendant David Gagnon;

20

21 MR. RONALD A. BARCH, of the firm of
22 Cicero, France, Barch & Alexander, P.C.
23 6323 E. Riverside Boulevard
24 Rockford, Illinois 61114,
25 appeared on behalf of Defendants Caroline
26 McGuire and Bill McGuire.

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29

I N D E X

1

2 WITNESS:

3 DR. SCOTT SAGERMAN

4

5 EXAMINED BY: PAGE

6 MR. ACCARDO 4

7 MR. BARCH 52, 61

8 MR. LUMBER 59, 62

9

10 EXHIBITS:

11 No. 1 5

12

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1 (Exhibit No. 1 was marked
2 for identification.)
3

4 DR. SCOTT SAGERMAN,
5 called as a witness and having been first
6 duly sworn under oath, was examined and
7 testified as follows:

8 E X A M I N A T I O N

9 BY MR. ACCARDO:

10 Q. Doctor, could you please state
11 your name and spell it for the court
12 reporter?

13 A. Scott David Sagerman,
14 S-A-G-E-R-M-A-N, M.D.

15 MR. ACCARDO: Let the record
16 reflect this is the discovery deposition of
17 Dr. Scott Sagerman taken pursuant to notice,
18 taken in accordance with the Rules of the
19 Circuit Court of McHenry County, the Rules of
20 the Supreme Court of the State of Illinois
21 and any other applicable Local Court Rules.

22 Q. Good morning, Dr. Sagerman. I'm
23 going to be asking you some questions today
24 about a patient of yours by the name of Paul

1 Dulberg, okay?

2 A. Yes.

3 Q. You've given depositions before?

4 A. Yes.

5 Q. You're familiar with the ground
6 rules governing depositions?

7 A. Yes.

8 Q. Now, we've been tendered a copy of
9 your C.V. which we've marked as Exhibit No. 1
10 for identification. Is that relatively
11 current and up-to-date?

12 A. Yes.

13 Q. And what kind of doctor are you?

14 A. Orthopedic surgeon.

15 Q. And do you have a specialty within
16 the orthopedic field?

17 A. Yes.

18 Q. And what is that?

19 A. Hand and upper extremities.

20 Q. And you're currently affiliated
21 with Hand to Shoulder Associates?

22 A. Yes.

23 Q. And that is in Arlington Heights,
24 Illinois?

1 A. Yes.

2 Q. And that's where we're located
3 today; is that correct?

4 A. Yes.

5 Q. Now, do you have any independent
6 recollection of Paul Dulberg?

7 A. Somewhat.

8 Q. You have your chart here today for
9 Mr. Dulberg; is that correct?

10 A. Yes.

11 Q. And what you have in front of you,
12 does that comprise your entire chart for Paul
13 Dulberg?

14 A. I think he had a Volume 1 chart
15 from previous treatments in 2003 and 2004. I
16 don't have that whole chart, but I have the
17 typed office notes from that chart.

18 Q. Okay. And then in regards to this
19 accident or care and treatment starting in
20 2012, you have your complete chart for Mr.
21 Dulberg; is that correct?

22 A. Yes.

23 Q. Feel free to refer to your records
24 and your notes when you need to. Now, the

1 accident that we're here to talk about took
2 place on June 28th of 2011. And it looks
3 like Mr. Dulberg first came to see you on
4 February 27th of 2012?

5 A. Yes.

6 Q. And he was referred to you by a
7 Dr. Frank Sek; is that correct?

8 A. I'm not sure. Dr. Sek was the
9 addressee of my correspondence from the first
10 office note.

11 Q. Do you know what kind of doctor
12 Dr. Sek is? Is he an internist?

13 A. I don't know. But Mr. Dulberg had
14 been to my office before that when he had
15 treatment in 2003 and 2004.

16 Q. Right. Let's talk a little bit
17 about that 2003 and 2004 treatment. What did
18 he come to your office for generally?

19 A. He came for a left arm condition
20 of cubital tunnel syndrome.

21 Q. And what is cubital tunnel
22 syndrome?

23 A. Ulnar nerve dysfunction due to
24 compression at the elbow.

1 Q. And what is the ulnar nerve?

2 A. The ulnar nerve is one of the main
3 peripheral nerves in the arm that passes
4 behind the elbow in a region called the
5 cubital tunnel before it extends down to the
6 inner side of the hand to provide sensation
7 and motor function to the muscles.

8 Q. Generally what were Mr. Dulberg's
9 complaints in relation to his left arm when
10 he came to see you back in 2003, 2004?

11 A. Numbness and tingling in the ulnar
12 nerve distribution of the left hand.

13 Q. And what is the ulnar nerve
14 distribution of the left hand?

15 A. The inside of the hand, the ring
16 and small fingers especially.

17 Q. And is there an indication from
18 those records from 2003 and 2004 as far as
19 the onset or triggering event for those
20 symptoms that Mr. Dulberg complained of back
21 then?

22 A. He said it was following a motor
23 vehicle accident which occurred in March of
24 2002.

1 Q. Did he describe to you at all how
2 that accident happened or explain any type of
3 the mechanism of that particular injury or
4 those symptoms that he was claiming?

5 A. I don't recall, and those are not
6 reflected in my notes.

7 Q. And what would be some common
8 causes of cubital tunnel syndrome?

9 A. Well, the cause is compression on
10 the nerve which may arise spontaneously. But
11 there are some other factors that can
12 contribute to it or cause it such as a direct
13 injury to the vicinity of the nerve, or
14 sometimes strenuous manual activities can
15 contribute to the nerve compression.

16 Q. Can repetitive use -- typing,
17 using the computer, using a mouse, anything
18 like that -- can that cause cubital tunnel
19 syndrome?

20 A. No, I wouldn't think so; not those
21 type of sedentary activities.

22 Q. When you said a direct impact to
23 the vicinity of the nerve, where are we
24 talking about? We're talking about over the

1 elbow?

2 A. Yeah. It's the inner side of the
3 elbow, toward the back where the nerve runs
4 behind the joint.

5 Q. And you performed a couple of
6 procedures to correct that cubital tunnel
7 syndrome on Mr. Dulberg back then?

8 A. Yes.

9 Q. And were those procedures
10 successful as far as you know?

11 A. I think so.

12 Q. So now when he first came to see
13 you in February of 2012, what did he come to
14 see you for?

15 A. For a right arm laceration of the
16 forearm from a chain saw accident which
17 occurred June 28, 2011.

18 Q. Did he tell you at all or give you
19 any description of how this chain saw
20 accident occurred?

21 A. No, not specifically.

22 Q. And I'm looking -- I'm referring
23 to your February 29th letter to Dr. Sek. Mr.
24 Dulberg indicates that he developed symptoms

1 of numbness in the small finger with
2 weakness; is that correct?

3 A. Yes.

4 Q. Is there any indication as to when
5 those symptoms started? Was it something
6 that was immediate? Did it take some time?

7 A. I don't know.

8 Q. Did Mr. Dulberg ever provide you
9 with any records from the emergency room
10 shortly following this particular accident or
11 did your office ever obtain any?

12 A. No, I don't believe so.

13 Q. His past medical history indicates
14 remarkable for arthritis and cervical disc
15 disease. Is the arthritis, would that have
16 been located in the neck?

17 A. I don't know. He didn't specify.

18 Q. He was on some medications when he
19 first came to see you?

20 A. Actually, he did specify
21 degenerative discs in the neck. And the
22 medications were naproxen, paroxetine,
23 tramadol, cyclobenzaprine.

24 Q. Did he ever indicate to you that

1 he ever experienced any symptoms relating to
2 the degenerative disc disease in his neck?

3 A. Well, he said he had neck pain on
4 the health information form that he filled
5 out that day I first saw him.

6 Q. He didn't go into any more detail
7 about that?

8 A. No.

9 Q. The medications, naproxen, what is
10 that for or what is that medication?

11 A. That's an anti-inflammatory
12 medication used for typically pain symptoms
13 related to inflammation.

14 Q. And how about tramadol?

15 A. That's another type of analgesic
16 pain medicine.

17 Q. And fluoxetine?

18 A. I don't know. He indicated that
19 it was for depression.

20 Q. And cyclobenzaprine?

21 A. He said it was for muscle spasms.

22 Q. Now, you performed an examination
23 when Mr. Dulberg first came to see you; is
24 that right?

1 A. Yes.

2 Q. And what were the results of that
3 examination?

4 A. The right forearm showed a 7
5 centimeter transverse scar at the ulnar
6 aspect of the mid forearm.

7 Q. And what area are we talking about
8 there?

9 A. The inner side of the forearm
10 between the elbow and the wrist. There was
11 local tenderness and sensitivity to
12 percussion with a positive Tinel's sign and
13 paresthesias radiating into the small finger.

14 Q. What is a positive Tinel's sign?

15 A. Tapping or percussion over a
16 peripheral nerve will elicit symptoms of
17 sensitivity or shooting pain or electric
18 shocks indicating nerve injury or nerve
19 dysfunction.

20 Q. Is that a subjective or an
21 objective finding?

22 A. Subjective.

23 Q. And then going on with his
24 examination?

1 A. There was also sensitivity of the
2 cubital tunnel region.

3 Q. And we're talking about on the
4 right side; is that correct?

5 A. Yes.

6 Q. And you already talked about when
7 he came to see you previously in 2003, 2004
8 about the cubital tunnel region of his left
9 arm; is that correct?

10 A. Yes.

11 Q. And as far as --

12 A. I'm sorry, you said about the left
13 arm?

14 Q. Right. Well, when he came to see
15 you previously it was for the left?

16 A. Correct.

17 Q. And when he came to see you here
18 it's for the right?

19 A. Correct.

20 Q. And then we get into wrist and
21 elbow motion are unrestricted?

22 A. Yes.

23 Q. And then going on with his
24 examination?

1 A. There was no atrophy. He was
2 unable to adduct his small finger.

3 Q. What does that mean?

4 A. Bring the small finger closer to
5 the other fingers, draw it back in. Flexion
6 strength was grossly normal. Sensation was
7 decreased to light touch in the small finger
8 only with inconsistent two point
9 discrimination.

10 Q. What does that mean, inconsistent
11 two point discrimination?

12 A. His ability to sense one or two
13 points on the fingertip was not consistently
14 correct.

15 Q. You reviewed X-rays that were
16 taken of his right forearm?

17 A. Yes.

18 Q. Did you review the films
19 themselves or just the radiologist's report
20 or both?

21 A. I think the films.

22 Q. And those appeared to be normal --

33 23 A. Yes.

24 Q. -- as far as fracture or anything

1 like that?

2 A. There was no fracture or foreign
3 body.

4 Q. And then there was an MRI that you
5 reviewed from February 3rd of 2012?

6 A. Yes.

7 Q. And again, would that have been
8 the film or the radiologist's report or both?

9 A. The films.

10 Q. And that indicates that no
11 abnormality was seen; is that correct?

12 A. Yes. I think I also have copies
13 of the report of the MRI in my file, although
14 I didn't refer to that specifically in the
15 report.

16 Q. Right.

17 MR. BARCH: Yeah, it did come in
18 your records.

19 BY MR. ACCARDO:

20 Q. And if I could just look -- if I
21 could refer you to the report of the MRI,
22 under clinical history he gives complaints or
23 a reason why this particular MRI was taken
24 was weakness in the fourth and fifth fingers,

1 is that correct, under clinical history?

2 A. Yes.

3 Q. And which are the fourth and fifth
4 fingers?

5 A. I think the ring and small
6 fingers.

7 Q. And also he was indicating pain in
8 the forearm and hand?

9 A. Yes.

10 Q. And I know that the MRI came back
11 normal. But under impression, I just wanted
12 to ask you a couple of questions. It says
13 that there's no forearm abnormality
14 appreciated, but this does not exclude the
15 possibility of an ulnar nerve impingement or
16 injury, but there is no gross mass or
17 abnormal infiltration along the expected
18 course of the ulnar nerve. What does that
19 mean?

20 A. Well, nothing abnormal was
21 appreciated on these images. And I think the
22 radiologist is saying that the lack of an
23 imaging abnormality does not exclude the
24 possibility that the nerve could have been

1 injured.

2 Q. Then it goes on to state that
3 there was no obvious tendon or muscle
4 abnormality appreciated.

5 A. Yes.

6 Q. And it looks like your office
7 received a copy of a nerve conduction report
8 or nerve conduction study that was performed
9 by Dr. Levin back in -- on August 10th of
10 2011? I have a copy of it if you want to
11 take a look at it. It came in your records.

12 A. Oh, yes, I have it.

13 Q. Oh, okay.

14 A. This is a different exam here.

15 MR. BARCH: Is this March 13 of
16 '12?

17 MR. ACCARDO: Oh, I'm sorry.
18 That's the later one.

19 THE WITNESS: There's two.

20 BY MR. ACCARDO:

21 Q. Yes. You have both, right?

22 A. Yes.

23 Q. From August 10, 2011 and March 13,
24 2012?

1 A. Yes.

2 Q. All right. Let's talk about that
3 August 10, 2011. You reviewed a copy of that
4 report from Dr. Levin?

5 A. Yes.

6 Q. And what did that indicate?

7 A. No electrophysiologic evidence of
8 diffuse neuropathy.

9 Q. Is that significant to you at all?

10 A. Yes.

11 Q. How so? Obviously it's a negative
12 finding?

13 A. Yeah. Diffuse neuropathy would
14 possibly be a contributing cause of nerve
15 symptoms if it was present, but this report
16 states that it's not present.

17 Q. And sort of going back to when we
18 asked you that question about, under the
19 impression in the MRI report, about not
20 excluding the possibility of an ulnar nerve
21 impingement or injury, does that -- do the
22 results from the nerve conduction study from
23 August 10, 2011 sort of rule that out? Does
24 that sort of take care of that little caveat,

1 if you know what I mean?

2 A. Well, I don't think it rules it
3 out either. I felt that additional testing
4 was warranted to evaluate the possibility of
5 nerve injury.

6 Q. Now, after taking the history and
7 your examination and your review of the
8 radiological studies as well as the nerve
9 conduction study, you came up with an
10 impression back in February of 2012?

11 A. Yes.

12 Q. And what was that impression?

13 A. Right forearm laceration with
14 probable partial ulnar nerve injury.

15 Q. And what indications led you to
16 come up with the impression of a probable
17 partial ulnar nerve injury?

18 A. Well, he had a scar over the
19 region of the forearm where the ulnar nerve
20 travels. He said it was a deep laceration,
21 so there's a possibility that the nerve was
22 directly injured by the chain saw. And that
23 he had symptoms of paresthesias, numbness and
24 weakness, that could be attributable to an

1 ulnar nerve injury. There were findings on
2 examination of local sensitivity and altered
3 sensation in the distribution of the ulnar
4 nerve that again suggests the possibility of
5 a nerve injury.

6 Q. And your plan was, I think as you
7 said before, was to send him out for some
8 additional testing?

9 A. Yes.

10 Q. And specifically, you wanted him
11 to go get an EMG?

12 A. Yes.

13 Q. Now, what's the difference -- he
14 had the nerve conduction study from Dr.
15 Levin. What's the difference between a nerve
16 conduction study and an EMG?

17 A. Well, an EMG is electromyography,
18 where the muscles are tested for signs of
19 denervation that would indicate a nerve
20 injury.

21 Q. As opposed to a nerve conduction
22 study which is what?

23 A. Yes. A nerve conduction study
24 measures the velocity of the nerve impulses

1 which is another way of detecting signs of a
2 nerve injury.

3 Q. Why was it then that you wanted
4 him to have an EMG if he had already had a
5 nerve conduction study? Just because they
6 measure two different things?

7 A. Yes. I think for a more complete
8 assessment of the nerve function, an EMG in
9 my opinion is warranted.

10 Q. And you first brought up the
11 possibility of a surgery for nerve
12 exploration pending the results of the EMG;
13 is that correct?

14 A. Yes.

15 Q. What is nerve exploration surgery?
16 I'm guessing it's somewhat self-explanatory,
17 but in layman's terms if you could just sort
18 of explain what you were talking about there.

19 A. A surgical procedure under
20 anesthesia to expose the area of the presumed
21 nerve injury to determine the extent of the
22 injury and the need for nerve repair or other
23 treatment if the nerve injury is confirmed.

24 Q. And he indicated that he would

1 follow up with his EMG and actually go get
2 that; is that correct?

3 A. Yes.

4 Q. Now, you also have work status is
5 no restriction. Did Mr. Dulberg give you any
6 indication or do you know what he was doing
7 for a living back in February of 2012?

8 A. He said he was involved in graphic
9 design printing.

10 Q. Did he ever make any complaints or
11 indicate to you that he was unable to perform
12 his job duties back in February of 2012?

13 A. I don't recall.

14 Q. So Mr. Dulberg did go have the
15 EMG; is that correct?

16 A. Yes.

17 Q. And he went back to Dr. Levin who
18 was the doctor that had performed the
19 previous nerve conduction study?

20 A. Yes.

21 Q. And it looks like that EMG was
22 done on March 13th of 2012?

23 A. Yes.

24 Q. And then he came back to see you

1 on April 2nd of 2012?

2 A. Yes.

3 Q. And he indicated there was no
4 change in his symptoms at that time?

5 A. Yes.

6 Q. And you reviewed the report of the
7 EMG?

8 A. Yes.

9 Q. And what did that show?

10 A. There was no denervation and ulnar
11 nerve conduction was within normal limits.

12 And the report states there was no evidence
13 of focal or diffuse peripheral neuropathy.

14 Q. And is that significant to you?

15 A. Yes.

16 Q. Why or how so?

17 A. It means that there's no
18 documentation that the nerve was not
19 functioning normally.

20 Q. And you performed an examination
21 again of Mr. Dulberg --

22 A. Yes.

23 Q. -- in April?

24 A. Yes.

1 Q. His right forearm scar was stable
2 and non-tender?

3 A. Yes.

4 Q. And he still had a positive
5 Tinel's sign?

6 A. Yes.

7 Q. And you indicate that adduction of
8 the small finger remains limited, consistent
9 with a positive Wartenberg's sign. What is
10 Wartenberg's sign?

11 A. The patient will have difficulty
12 bringing the small finger back toward the
13 other fingers, indicating weakness in one of
14 the intrinsic muscles of the hand.

15 Q. And again, this sensitivity to
16 percussion with a positive Tinel's sign and
17 adduction of the small finger with a positive
18 Wartenberg's sign, are those subjective or
19 objective findings?

20 A. Well, Tinel's sign is purely
21 subjective. The Wartenberg's sign, I suppose
22 there's a voluntary component possibly, so I
23 don't know if I would call it purely
24 objective. I don't know how to answer that

1 exactly.

2 Q. Okay.

3 A. I suppose it's partly both.

4 Q. And your plan was -- you gave him
5 some different treatment options, and he did
6 not wish to pursue that exploratory surgery;
7 is that correct?

8 A. Yes.

9 Q. At least at that time?

10 A. Yes.

11 Q. You gave him a referral out for
12 some therapy?

13 A. Yes.

14 Q. For strengthening and scar
15 management. What is scar management?

16 A. Treatment for a sensitive scar
17 from an injury. Maybe local soft tissue
18 modalities being applied to the scar directly
19 or scar mobilization with massage and
20 stretching, those type of things.

21 Q. Would that be sort of just to
22 loosen up whatever scar tissue there is in
23 that area?

24 A. I suppose. Loosen up and diminish

1 sensitivity, discomfort or abnormal sensation
2 related to the scar.

3 Q. And again, his activity and work
4 status was unrestricted?

5 A. Yes.

6 Q. He came back to see you to follow
7 up in May of 2012?

8 A. Yes.

9 Q. And his complaints at that time
10 were a little different than they had been
11 previously?

12 A. Yes.

13 Q. How were they different?

14 A. He said he had persistent pain
15 with use of his arm, especially gripping
16 activities.

17 Q. That was something new to you?

18 A. Well, I didn't note that earlier.
19 I don't know if he said it earlier or not,
20 but it's not in my notes that way. He also
21 had no change in other symptoms of numbness.

22 Q. And he indicated that the no
23 change in his symptoms of numbness which is
24 not bothersome?

1 A. Yes.

2 Q. And as far as the way that's
3 written, would that indicate to you that his
4 symptoms of numbness were not bothersome to
5 him at that time?

6 A. Yes.

7 Q. And he claimed that his function
8 was limited because of this pain?

9 A. Yes. That seems to be a new
10 complaint compared to the initial evaluation.

11 Q. And upon examination, what were
12 your significant findings, if any?

13 A. The right forearm scar was tender
14 with positive Tinel's sign, local
15 sensitivity. His finger flexion was full.
16 There was no triggering or locking, no
17 clawing. The Wartenberg's sign was still
18 positive. The intrinsic strength was
19 slightly weak.

20 Q. What is intrinsic strength?

21 A. Strength of the muscles in the
22 hand that control movement of the fingers.

23 Q. And how is that measured?

24 A. With resistance by the examiner.

1 Q. And you said that there was no --

2 A. I mean, it can't be graded
3 numerically, but a judgment is made about
4 whether the strength of the muscles is normal
5 or weak.

6 Q. During that, is there any
7 comparison made between a patient's left and
8 right sides, whatever side they're
9 complaining of versus, I guess for lack of a
10 better term, a normal side or an asymptomatic
11 side?

12 A. Yes. You can judge whether one
13 hand is weak when you compare it to the other
14 side being examined simultaneously.

15 Q. And you indicate no clawing. What
16 is clawing?

17 A. An abnormal posture of the finger
18 related to muscle weakness or muscle
19 imbalance which can be seen in an ulnar nerve
20 injury situation.

21 Q. And under your treatment plan you
22 bring up again the possibility of surgery --

03 23 A. Yes.

24 Q. -- for ulnar nerve neurolysis.

1 What is that?

2 A. Neurolysis is an exploration of a
3 nerve, surgical exploration of the nerve to
4 determine the extent of injury to the nerve,
5 possibly decompress the nerve or release it
6 from scar.

7 Q. And he was going to follow up with
8 Dr. Levin for medication, and then he was
9 also going to see Dr. -- how do you pronounce
10 his name?

11 A. Dr. Biafora is my partner.

12 Q. Does he have the same specialty as
13 you?

14 A. Yes.

15 Q. Why was it that he wanted to go
16 see him? Or did you send him to the other
17 doctor for a second opinion?

18 A. I think I possibly suggested it,
19 yes.

20 Q. And again, his activity and work
21 status as of May of 2012 was still
22 unrestricted?

23 A. Yes.

24 Q. And he did go see your partner a

1 few days later in May of 2012?

2 A. Yes.

3 Q. And did you have a chance to
4 review Dr. Biafora's report?

5 A. Yes.

6 Q. Was there anything significant to
7 you in there? Was there anything different
8 than what you had found?

9 A. Yes.

10 Q. And what was that?

11 A. He noted a positive Tinel's at the
12 cubital tunnel.

13 Q. Why is that significant to you?

14 A. That's another potential location
15 for compression or dysfunction of the ulnar
16 nerve.

17 Q. Which would also explain the
18 symptoms that Mr. Dulberg was complaining of
19 to you?

20 A. Some of them. It wouldn't explain
21 scar symptoms at a more distal location, but
22 it may explain nerve symptoms in the ulnar
23 nerve distribution of the hand.

24 Q. And what were Dr. Biafora's

1 recommendations?

2 A. He thought there was a likely
3 partial ulnar nerve injury in the right
4 forearm and ulnar nerve neuritis. And he
5 felt the patient may benefit from an ulnar
6 nerve exploration with neurolysis, including
7 cubital tunnel decompression with possible
8 anterior transposition, and exploration of
9 the tender portion of the scar in the
10 forearm.

11 Q. And then Mr. Dulberg follows up
12 with you after his visit with Dr. Biafora?

13 A. Yes.

14 Q. It looks like he had started on
15 some medication from Dr. Levin?

16 A. Yes.

17 Q. And what was that that he started
18 on?

19 A. Neurontin.

20 Q. And what is that?

21 A. Medication used to treat nerve
22 related pain.

03 23 Q. Have you used that drug to treat
24 nerve related pain in your patients?

1 A. Well, I don't prescribe it myself,
2 but I've had patients who were prescribed
3 that medication by other physicians to treat
4 nerve related pain.

5 Q. Why is it that you don't prescribe
6 it yourself?

7 A. Well, there's a potential for side
8 effects, and sometimes the dose has to be
9 adjusted. And I think it's best prescribed
10 by a physician with more expertise in that
11 particular drug.

12 Q. Would a doctor with more expertise
13 be Dr. Levin?

14 A. Yes, a neurologist.

15 Q. He did indicate no change in his
16 symptoms despite taking this medication and
17 that he did have some side effects. Did he
18 tell you what those side effects were?

19 A. I don't recall.

20 Q. And indicates that interfere with
21 functioning. Did he tell you what kind of
22 functioning that he was talking about?

23 A. I don't recall. That medication
24 can cause some drowsiness. I don't know if

1 that's what he was referring to. I don't
2 have any recollection of this conversation.

3 Q. So it's not necessarily, as far as
4 you recall or would know, specifically
5 related to having functioning difficulties
6 with his hand or his arm?

7 A. I don't know.

8 Q. And Mr. Dulberg had then made the
9 decision to go ahead with the surgery?

10 A. Yes.

11 Q. Now, he had been undergoing some
12 therapy which in June of 2012 he said was
13 discontinued due to lack of progress. Was
14 that therapy that you had referred him out
15 for?

16 A. I think at one point I had
17 referred him for therapy. I don't know if
18 anybody else had as well. We do have some
19 records from the therapist. I see one from
20 April 22, 2013 that has me listed as the
21 referring physician. And it says discontinue
22 occupational therapy with home exercise
23 program.

24 Q. That was in April of 2013?

1 A. Yes.

2 Q. Who was that from, what therapy?

3 A. Dynamic Hand Therapy.

4 Q. I was just sort of interested
5 because, going back to your note from
6 May 14th of 2012, he indicated that the
7 therapy was beneficial, and then in June of
8 2012 he indicates that it was discontinued
9 due to lack of progress. I just didn't know
10 whether your notes reflected or if you had
11 any of the notes from any physical therapy
12 showing any lessening of effectiveness or
13 anything between May of 2012 and June of
14 2012.

15 A. I don't have those in my file.
16 They may have been received and discarded. I
17 don't know.

18 Q. And your examination of Mr.
19 Dulberg on June 6th of 2012 revealed what
20 that was significant?

21 A. He had pain with gripping
22 activities localized to the forearm region,
23 resulting in increased numbness in the ring
24 and small fingers with weakness of his grip.

1 The rest of it was I think unchanged from
2 what we had previously documented.

3 Q. And you were able to duplicate the
4 positive Tinel's sign at the cubital tunnel
5 area?

6 A. Yes.

7 Q. And it says without ulnar nerve
8 subluxation. What does that mean?

9 A. The nerve did not subluxate or
10 move out of position when the elbow was bent.
11 So the nerve was stable.

12 Q. You went over your plan for
13 surgery with him, he said everything was good
14 to go with that, is that right, insofar as he
15 wanted to have the procedure done?

16 A. Yes. I think he wanted to
17 proceed, and he understood the risks and
18 benefits and possible complications and the
19 expected outcome and the prognosis. And
20 informed consent was obtained for the
21 procedure.

22 Q. Now, you note the prognosis is
23 guarded in terms of symptom improvement. Why
24 is that or why was that at that time?

1 A. Well, we didn't know exactly how
2 much improvement there would be, so that's
3 why the prognosis is guarded. It's hard to
4 predict how much better the symptoms will be
5 when we don't know the extent of the nerve
6 injury until we explore it. So we just
7 couldn't make a firm prognosis without
8 knowing the extent of the nerve injury and
9 how it would respond to the surgical
10 treatment.

11 Q. And he did have the procedure then
12 on July 9th of 2012?

13 A. Yes.

14 Q. And you performed that surgery?

15 A. Me and Dr. Biafora.

16 Q. Biafora, okay. Sorry if I'm
17 mispronouncing his name.

18 A. I'll tell him.

19 Q. Your preoperative diagnosis and
20 postoperative diagnoses were the same; is
21 that correct?

22 A. Yes.

23 Q. As far as under what circumstances
24 the procedure was performed, is that under

1 general anesthesia, local anesthesia,
2 inpatient, outpatient?

3 A. I think it was outpatient surgery
4 under regional block anesthetic which would
5 also include sedation.

6 Q. Would he have been under at that
7 time or more like in like twilight? He
8 wouldn't have been all the way under.

9 A. Not a general anesthetic, but he
10 would have been sedated which you might refer
11 to as twilight. And his arm was blocked with
12 local anesthetic so that it was numb during
13 the procedure.

14 Q. And what were your findings? Now,
15 there were a couple of components to this
16 procedure; is that correct?

17 A. Two, yes.

18 Q. One was to the right elbow region
19 which would have been the cubital tunnel
20 release; is that correct?

21 A. Yes.

22 Q. And the other one was in regards
23 to the area of the right forearm; is that
24 correct?

1 A. Yes.

2 Q. In regards to the cubital tunnel
3 area, what procedure and what findings did
4 you come up with during that?

5 A. Cubital tunnel release was
6 performed and there was thickening of the
7 cubital tunnel ligament with scarring of the
8 ulnar nerve to the floor of the cubital
9 tunnel and local constriction. The nerve
10 also appeared constricted at the flexor
11 pronator aponeurosis. And there was another
12 structure above the cubital tunnel but no
13 constriction of the nerve at that level.

14 Q. What does all of that mean in
15 layman's terms?

16 A. That he had a pinched nerve at the
17 elbow.

18 Q. Is that similar to the findings in
19 regards to his left arm back in 2003, 2004?

20 A. I don't have the operative report
21 in the records here from that procedure, so I
22 can't tell you the specific findings that
23 were noted.

24 Q. The findings at least in your

1 operative report from July of 2012 in regards
2 to the cubital tunnel, are those consistent
3 with cubital tunnel syndrome? Is that sort
4 of what we're talking about?

5 A. Yes.

6 Q. And we had already talked about
7 some common causes of cubital tunnel syndrome
8 before?

9 A. Yes.

10 Q. In regards to the area where the
11 injury was -- strike that.

12 In regards to the right forearm,
13 what did you find?

14 A. There was extension of the
15 laceration into the subcutaneous tissues and
16 fascia overlying the flexor carpi ulnaris
17 muscle. A piece of retained absorbable
18 suture material was present. The muscle
19 fibers were intact. The ulnar nerve was
20 intact beneath the muscle belly. There was
21 no visible scarring around the ulnar nerve at
22 this level.

03 23 Q. And again, in layman's terms, what
24 does that mean?

1 A. It means that the laceration from
2 the chain saw was relatively deep -- below
3 the skin, below the fat, and into the muscle
4 covering -- but the muscle fibers were
5 intact. There was a suture material present
6 presumably from when the laceration was
7 originally repaired at the time of the
8 injury. And the nerve was not cut or visibly
9 scarred in that area.

10 Q. Was that, what you found during
11 the procedure in regards to the right
12 forearm, is that significant to you at all
13 either one way or the other in regards to the
14 complaints that Mr. Dulberg had made before
15 the surgery.

16 A. Yes, it's significant.

17 Q. How so or why?

18 A. Well, I think that scarring from
19 the laceration would account for his
20 symptoms. And fortunately, the nerve itself
21 was not cut or scarred and we didn't have to
22 repair the nerve, so that was fortunate.

23 Q. How would it be that the scarring
24 from the laceration would cause his symptoms?

1 What exactly would have been happening there?

2 A. Well, it's hard to know

3 specifically what the mechanism of the pain

4 symptoms and nerve symptoms was. We can't be

5 sure what's causing those symptoms, although

6 there's certainly scarring from the

7 laceration involving the muscle, fascia, and

8 near the nerve. So I think that's about all

9 we can say in terms of an explanation for his
10 symptoms.

11 Q. How about what you found in

12 regards to his cubital tunnel syndrome in

13 relation to the complaints that he was

14 making, could that also have been a cause?

15 A. Yes. I think the nerve

16 compression could account for the symptoms of

17 paresthesias, the numbness in that

18 distribution of the ulnar nerve, and the

19 weakness.

20 Q. And those are two independent

21 findings or independent areas in regards to

22 the cubital tunnel area and the right

23 forearm; is that a fair statement?

24 A. Yes, two separate sites.

1 Q. Now, after the procedure you
2 performed, he came back to see you for
3 various follow-ups in July, August, and then
4 October of 2012; is that correct?

5 A. Yes.

6 Q. And how was he progressing during
7 that time in regards to his recovery from the
8 procedure?

9 A. His pain was controlled. His
10 incisions were clean. There was no
11 infection. The incision healed, incisions
12 healed. He was doing well. His arm felt
13 better. His function had increased. His
14 symptoms had improved.

15 Q. Did his symptoms completely
16 resolve or were they just improved?

17 A. They did not resolve completely.
18 But through August 27th it says that his
19 progress -- he was making progress in
20 therapy. His strength had increased. His
21 function had improved. There was still some
22 scar tenderness and soreness in the elbow.

03 23 Q. And was he put on any restrictions
24 as far as use or work?

1 A. Yes.

2 Q. And what were those?

3 A. Initially he was off work after
4 the surgery until July 30th. Then he was
5 given restriction to limit activities
6 requiring forceful gripping and avoid
7 lifting, pushing and pulling with the right
8 arm. And those restrictions were modified
9 October 22, 2012 to be limited forceful
10 gripping and limited lifting, pushing and
11 pulling.

12 Q. Would he have been limited or were
13 the limitations that you imposed on him,
14 would they have been in any way related to
15 any type of use of the computer, mouse, track
16 pad, keyboard, anything like that?

17 A. No, those activities would not
18 need to be avoided or restricted because they
19 don't require forceful gripping, lifting,
20 pushing or pulling.

21 Q. And it looks like then he started
22 to -- or he came back and, starting in
23 December of 2012 and thereafter, started
24 making some complaints related to his left

1 arm; is that correct?

2 A. Yes.

3 Q. And did he indicate when those
4 difficulties with his left arm started?

5 A. He said recent onset. Well, that
6 was my report saying recent onset. I don't
7 recall if he said exactly when it started.

8 Q. And what types of symptoms was he
9 complaining of in his left arm?

10 A. There was tenderness to the
11 lateral epicondyle and guarded range of
12 motion. Pain at the end range of extension
13 and pain reproduced with resisted wrist
14 extension. So those were consistent with
15 lateral epicondylitis.

16 Q. Which is what?

17 A. Degeneration of the tendon origin
18 at the elbow.

19 Q. Is that in any way related to what
20 people refer to as tennis elbow?

21 A. Yes, that's another term given to
22 it.

23 Q. And what are some causes for that
24 particular condition?

1 A. It's typically degenerative. It's
2 wear and tear. The tendon fibers lose
3 strength and pain symptoms can develop.
4 There can also be injuries that precipitate
5 symptoms like blunt trauma to the area or
6 certain strenuous manual activities that can
7 aggravate it and cause symptoms to arise.

8 Q. Can it result from somebody
9 overcompensating in using one arm over the
10 other?

11 A. Well, that's kind of a vague
12 scenario, overcompensating. I think if that
13 resulted in enough strain to the involved
14 tendon, it could aggravate it and precipitate
15 symptoms of it. Depends on what activities
16 we're talking about.

17 Q. Starting in December and up to --
18 it looks like your last visit with him was in
19 late August of 2013, were the complaints
20 limited to the left side or was he also still
21 making complaints of anything related to the
22 right side?

23 A. Well, in March of this year he
24 said that his right forearm was sore

1 intermittently and there was mild sensitivity
2 at the forearm scar. And then most recently,
3 in August of this year, he described
4 intermittent right forearm muscle cramping
5 with discomfort.

6 Q. Was that cramping with use or
7 certain activities or was it just sort of
8 coming out of nowhere or doesn't it indicate?

9 A. It doesn't say for sure, but I see
10 a note that the patient's neurologist
11 suspected possibly dystonia and suggested a
12 referral for evaluation and medical treatment
13 by a neurologist who specializes in that
14 condition.

15 Q. Did you make any referrals out to
16 any other medical care providers?

17 A. I see a note of referral to Dr.
18 Kujawa, a neurologist.

19 Q. And that would have been done by a
20 referral that you made?

21 A. Yes.

22 Q. And in regards to his complaints
23 of left-sided problems beginning in December
24 of 2012, what if any treatment did you

1 provide him and what was your impression? Or
2 I guess that would sort of go vice versa.
3 What was your impression and what if any
4 treatment did you provide for him?

5 A. The impression was left lateral
6 epicondylitis. We gave him a referral for
7 therapy for epicondylitis protocol. We gave
8 him activity and work restrictions to avoid
9 aggravation of his symptoms. We gave him a
10 local steroid injection in the left elbow
11 with continuation of occupational therapy.
12 And then as far as the last visit in August
13 of this year, he was allowed to follow up as
14 needed.

15 Q. Does your office, as far as you
16 know, show any future appointments scheduled
17 with Mr. Dulberg?

18 A. I don't know. I don't have that
19 information available here in the file.

20 Q. Is that something we would be able
21 to check?

22 A. Yeah. It would be on the computer
23 in the office.

24 Q. I'm going to ask you some opinion

1 questions. I would just ask that any
2 opinions you give be within a reasonable
3 degree of medical and orthopedic surgical
4 certainty. Fair enough?

5 A. Yes.

6 Q. Do you have an opinion regarding
7 what if any injuries Mr. Dulberg suffered as
8 a result of the incident with the chain saw
9 back in June of 2011?

10 A. Yes.

11 Q. And what is that opinion or
12 opinions?

13 A. A deep soft tissue laceration in
14 the right forearm.

15 Q. And what if any treatment that you
16 rendered was related to that particular
17 injury?

18 A. The EMG test I ordered; the
19 supervised occupational therapy before
20 surgery; the second opinion visit by Dr.
21 Biafora; the surgical procedure of July 9,
22 2012; and the postoperative therapy and the
23 -- well, those are the treatments I believe
24 were needed as a result of the accident.

1 Q. And your prognosis, at least as
2 far as your last visit with him on
3 August 26th of 2013, what would your
4 prognosis be in relation to any injury that
5 you believe he suffered as a result of the
6 chain saw accident, the deep soft tissue
7 laceration?

8 A. The prognosis would be for
9 symptoms to remain stable, unless the patient
10 gets treatment by another neurologist which
11 is effective, which I don't know. So within
12 certainty I can say that the prognosis for
13 symptoms to remain unchanged is expected.

14 Q. Are you able -- do you have an
15 opinion as to whether the cubital tunnel
16 syndrome that you found in the surgery that
17 you performed, is that in any way related to
18 the incident with the chain saw?

19 A. I don't think so.

20 Q. Are you able to differentiate
21 between symptoms that Mr. Dulberg was
22 complaining of in relation to -- or comparing
23 the cubital tunnel syndrome versus the deep
24 soft tissue laceration in the right forearm?

1 A. Yes, to some degree.

2 Q. Could you tell me what those
3 differences are? What symptoms would you
4 attribute to which condition?

5 A. The forearm laceration would
6 account for the symptoms of scar sensitivity,
7 tenderness, pain with gripping. And the
8 cubital tunnel syndrome would account for
9 sensitivity at the cubital tunnel region and
10 paresthesias in the ring and small fingers,
11 numbness in the ring and small fingers.

12 Q. Was any of the treatment that you
13 rendered to Mr. Dulberg directed specifically
14 or in part to the cubital tunnel symptoms or
15 syndrome?

16 A. Yes.

17 Q. What treatment was that?

18 A. The cubital tunnel release surgery
19 and the therapy treatments directed at the
20 scar related to that surgery and the elbow
21 motion.

22 Q. Is there any overlap in the care
23 that he -- or the care or the treatment that
24 he received for the soft tissue laceration

1 from the chain saw and the cubital tunnel --
2 I know that the surgery was for both
3 conditions. But as far as the therapy, is
4 there overlap there?

5 A. Yes. I presume they would have
6 treated both areas at the same time.

7 MR. ACCARDO: All right. I don't
8 think I have anything else. Thank you,
9 Doctor.

10

11 E X A M I N A T I O N

12 BY MR. BARCH:

13 Q. Doctor, Ron Barch again on behalf
14 of the McGuires. I think Attorney Accardo
15 covered almost everything I wanted to, which
16 will expedite my questions. Just a couple
17 things, though, in follow-up.

18 There were some questions earlier
19 that Mr. Accardo had about the left elbow,
20 the tennis elbow, we were referring to that,
21 that he developed or he saw you for in 2013.
22 And he was asking whether overcompensating,
23 overcompensating use of the left arm due to
24 problems with the right arm might cause that.

1 And I'm just going back. When you said -- I
2 think you answered, it would be dependent on
3 the activities that they're doing with the
4 left elbow?

5 A. Yes.

6 Q. What about just like adult daily
7 living activities, like getting dressed or
8 doing dishes, just doing normal, everyday
9 things? Or are you talking about something
10 more specific like work related repetitive
11 trauma, that type of thing?

12 A. Well, I think in order to have a
13 bearing on causation it would have to be
14 beyond ordinary arm use, because we know that
15 the degenerative process affects the tendon
16 origin over time anyway. So normal, everyday
17 tasks or usage wouldn't be expected to cause
18 that condition beyond the chance it would
19 already occur.

20 Q. And then with respect to the
21 laceration of the arm, you talked in detail
22 in response to Mr. Accardo's questions about
23 the symptoms he had before the exploratory
24 surgery and after. Anything about the left

1 arm, having seen him post-op, that would
2 render him totally disabled? The left arm
3 meaning the laceration part of the injury.

4 A. The laceration was the right
5 forearm.

6 Q. Excuse me. Let me start that
7 question over.

8 I just need to find out whether or
9 not you saw anything about the laceration to
10 the right arm, the things you saw during
11 surgery and then your observations of him and
12 his complaints following the exploratory
13 surgery of the forearm injury, the
14 laceration, anything about that that you
15 believe would have rendered him totally
16 disabled?

17 A. What do you mean, totally
18 disabled?

19 Q. Unable to work any job at all.

20 A. Well, for the time period after
21 the surgery was performed, he was given a
22 restriction to be off work. That was until
23 July 30th of 2012. After that he was given
24 restrictions to limit use of the right arm

1 related to that injury and that surgery. But
2 restrictions and disability don't necessarily
3 equate. So disability would depend on what
4 his function was and what his capability was
5 and what his opportunities were, I suppose.

6 Q. And so if I understand your
7 testimony, with respect to -- are you talking
8 about the elbow surgery or the forearm
9 laceration that necessitated the restriction
10 against pushing, pulling and lifting with the
11 right arm?

12 A. Well, the restriction was given
13 after the surgery which had two parts. Are
14 you asking which part necessitated the
15 restriction?

16 Q. And that's what I'm trying to get
17 at. I know that there's two different areas
18 that you focused on during the surgery; the
19 laceration of the right forearm, which I
20 believe you said did not actually cut or scar
21 the nerve, correct? Having gone through that
22 exploratory surgery, it does not appear that
23 the chain saw severed, cut or scarred that
24 ulnar nerve in the forearm where the

1 laceration was?

2 A. Correct.

3 Q. And then there was some -- and you

4 described in detail how deep you believe it

5 went, having done that exploratory surgery.

6 And then there's obviously the left -- the

7 right elbow surgery that you did. And I know

8 that for a period of time there was

9 overlapping therapy for the forearm, the

10 right forearm, and then the right elbow. And

11 at some point he's released from care and he

12 stopped the physical therapy on the arm

13 totally, correct?

14 A. Yes. He was allowed to continue

15 home exercises as of October 22, 2012 and

16 advance activities with use of his right arm

17 as tolerated at that time.

18 Q. And he continued, though, if I

19 understood your testimony in response to Mr.

20 Accardo's question, I have the restriction on

21 pushing, pulling and lifting with the right

22 arm?

03 23 A. Limited gripping, lifting, pushing

24 and pulling, yes.

1 Q. And what I'm trying to get at now
2 is, is that because of the injury he had to
3 the forearm, was it the cubital syndrome in
4 the right elbow, is it both, if you're able
5 to tell us, the ongoing restriction?

6 A. Well, from my examination at that
7 time, his tenderness was at the forearm scar
8 region and there was still some pain with
9 gripping at that location. So I would
10 attribute the need for those restrictions to
11 the forearm injury as opposed to the cubital
12 tunnel elbow condition.

13 Q. And then if I -- with respect to
14 whether he's disabled as an ongoing basis
15 from that point forward, it would be the --
16 he would be disabled only to the extent that
17 he would have to accommodate those
18 restrictions in any form of employment?

19 A. I suppose you'd have to
20 accommodate for his function, for his -- the
21 word I would use would be "impairment" as
22 opposed to "restriction."

23 Q. You wouldn't want him to -- I
24 guess if I'm understanding your restriction,

1 he would want to avoid work that would
2 require pulling, pushing and lifting on a
3 regular basis with the right arm?

4 A. To the extent that that causes his
5 symptoms to become intolerable.

6 Q. And then finally, is there
7 anything you saw at that time, in October
8 when he was let go with those limitations,
9 that rendered him incapable of working at
10 all?

11 A. No. He said he was currently
12 unemployed at that time and planned to pursue
13 disability, but he was allowed to use his
14 right arm as tolerated.

15 Q. And that's the confusing part for
16 me. Did you see anything that you would have
17 endorsed in terms of acquiring disability,
18 total and complete disability?

19 A. I think disability can be total or
20 partial and can depend on one's functional
21 abilities. So I think his function could
22 have been impaired to some degree. I don't
23 think it would necessitate a total disability
24 from any job, though. Is that what you're

1 asking?

2 Q. That's what I'm asking.

3 MR. BARCH: Thank you. That's all
4 I have.

5 MR. LUMBER: Do you have anything
6 further?

7 MR. ACCARDO: No.

8

9 E X A M I N A T I O N

10 BY MR. LUMBER:

11 Q. Doctor, I just have one question
12 that I want to follow up with you. If I
13 understood your testimony correctly,
14 regarding the cubital tunnel procedure that
15 was done on his elbow, you were asked whether
16 or not in your opinion you felt that was
17 related to the chain saw accident, and I
18 believe your answer was that you didn't think
19 so.

20 Can you just give me a little bit
21 of basis as to why that -- why you feel that
22 way? Mainly because, as we had stated
23 before, there is -- trauma and whatnot can
24 cause cubital tunnel syndrome I believe as

1 you had testified earlier. So can you just
2 clarify that a little bit for me as to what
3 your basis is for why you feel that was not
4 related to the accident?

5 A. I think the zone of injury for the
6 accident was relatively distant to the area
7 of the cubital tunnel, in the forearm as
8 opposed to the elbow. So trauma to the area
9 of the elbow would be suspected as a
10 potential cause for cubital tunnel if that
11 occurred. But I think this laceration was
12 too distal to affect the nerve at the level
13 of the elbow.

14 On the other hand, even though
15 it's not directly injuring the cubital
16 tunnel, the need for that surgery which
17 included the cubital tunnel arose after the
18 accident which brought him to see me. So I
19 suppose there's some relationship of the
20 injury and the surgery that included the
21 cubital tunnel, but I don't think the
22 specific laceration injured the nerve in the
23 area of the cubital tunnel.

24 MR. LUMBER: Okay. That's all I

1 have.

2 MR. ACCARDO: I don't have
3 anything else.

4

5 FURTHER EXAMINATION

6 BY MR. BARCH:

7 Q. Would it be fair to describe it,
8 your last comment, as being there's an
9 overlap in terms of timing but not a direct
10 connection in terms of the injury and the
11 location of the elbow, in relation to the
12 elbow?

13 A. Yeah. There's not a direct injury
14 to the nerve at the level of the elbow. But
15 the condition came to light potentially as a
16 result of the evaluations we did for the
17 laceration.

18 Q. Well, there was a period of time
19 before you did the surgery where you were
20 kind of struggling to figure out why he was
21 having the paresthesia and grip weakness in
22 the hand.

23 A. Yes. And I think the first time
24 it was really brought up as a diagnosis was

1 when he saw my partner, Dr. Biafora, who it
2 seems suggested that that was part of the
3 cause of his ongoing symptoms.

4 Q. And that was borne out during
5 surgery?

6 A. Yes.

7 Q. Thank you.

8 A. I think the findings there were
9 borne out.

10

11 FURTHER EXAMINATION

12 BY MR. LUMBER:

13 Q. Just one last follow-up. Any
14 chance that any of the cubital tunnel
15 dysfunction or ailment could have been any
16 type of byproduct from the injury from the
17 forearm, meaning from the injury of the
18 forearm somehow caused this later injury to
19 the cubital tunnel area?

20 A. I just don't think the mechanism
21 would -- that one incident would cause
22 cubital tunnel.

23

23 MR. LUMBER: Okay. Gotcha.

24 MR. ACCARDO: I don't have

1 anything else. I think we're done.

2 Signature? Waived or reserved?

3 THE WITNESS: I can waive the
4 signature.

5 MR. ACCARDO: Thank you.

6 (DEPOSITION CONCLUDED AT 10:41 A.M.)

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2 STATE OF ILLINOIS)
3) SS:
4 COUNTY OF L A K E)

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7 I, Jill S. Tiffany, CSR,

8 Certified Shorthand Reporter, and a notary

9 public in and for the County of Lake and

10 State of Illinois, do hereby certify that

11 DR. SCOTT SAGERMAN on October 15, 2013 was

12 by me first duly sworn to testify to the

13 truth, the whole truth, and nothing but the

14 truth, and that the above deposition was

15 recorded stenographically by me and

16 transcribed by me.

17

18 I FURTHER CERTIFY that the

19 foregoing transcript of said deposition is

20 a true, correct, and complete transcript of

21 the testimony given by the said witness at

22 the time and place specified.

23

24

25

1 I FURTHER CERTIFY that I am not a
2 relative or employee or attorney or
3 employee of such attorney or counsel, or
4 financially interested directly or
5 indirectly in this action.

6 IN WITNESS WHEREOF, I have set my
7 hand.

8

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13 _____
14 Jill S. Tiffany
15 Certified Shorthand Reporter
16 Certificate No. 084-002807

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