

IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

BENJAMIN SCHECHTER,

et al.,

Plaintiffs,

vs.

Case No.

HENRY H. BOHLMAN, M.D.,

et al.,

Defendants.

SCANNED
11-23-04

Deposition of JAIMIE HENDERSON,
M.D., called for examination under the
statute, taken before me, Michelle
Lewis, a Registered Professional
Reporter and Notary Public in and for
the State of Ohio, by agreement of
counsel, at the offices of The Cleveland
Clinic Foundation, 9500 Euclid Avenue,
Cleveland, Ohio, on Wednesday, July 30,
2003, at 4:40 p.m.



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1 APPEARANCES:

2
3 On behalf of the Plaintiff:

4 LAWRENCE F. PESKIN, ESQ.

5 1300 East 9th Street, Suite 900

6 Cleveland, Ohio 44114

7 (216) 621-8400

8
9 On behalf of the Defendants:

10 Reminger & Reminger, by

11 MARC GROEDEL, ESQ.

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16 - - - - -



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1 JAIMIE HENDERSON, M.D., of lawful
2 age, called for examination, as provided
3 by the Ohio Rules of Civil Procedure,
4 being by me first duly sworn, as
5 hereinafter certified, deposed and said
6 as follows:

7 EXAMINATION OF JAIMIE HENDERSON, M.D.

8 BY-MR.GROEDEL:

9 Q. Please state your name.

10 A. Jaimie Henderson.

11 Q. Dr. Henderson, as you know,
12 my name is Marc Groedel. I represent
13 Dr. Schechter -- I'm sorry, Dr. Bohlman
14 in a lawsuit that's been filed by Dr.
15 Schechter against Dr. Bohlman. I'm
16 going to ask you some questions about
17 opinions that apparently you hold that
18 are relevant to the issues of this
19 lawsuit.

20 Have you ever been deposed
21 before?

22 A. Yes, I have.

23 Q. If I misuse a medical term
24 or a medical phrase, make sure you
25 correct me so that the two of us are on



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1 the same wavelength this afternoon,
2 okay?

3 A. All right.

4 Q. Okay. Tell me a little bit
5 about your current practice.

6 A. My current practice consists
7 of about 60 percent surgical treatment
8 for chronic pain, approximately 20
9 percent surgical treatment of movement
10 disorders. So it's about 85 percent
11 what's called functional neurosurgery or
12 procedures which alter the function of
13 the nervous system. The remainder is
14 spine surgery of various kinds.

15 And I will rarely do intracranial
16 surgery, although earlier in my career
17 that was a bigger part of my practice.

18 Q. Okay. Now, it looks like
19 you've written two reports in this case.
20 From Mr. Peskin I have one report dated
21 March 18, 2003 and another one dated
22 April 14, 2003. Have you authored any
23 other reports to Mr. Peskin concerning
24 Dr. Schechter?

25 A. Not to my recollection.



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1 Q. And the CV that you've given
2 me that was last revised on May 9 of
3 this year, I assume that's relatively
4 up-to-date?

5 A. Yes, as of May 9th.

6 Q. How is it that you first
7 came into contact with Dr. Schechter?

8 A. I first saw Dr. Schechter in
9 October of 2002 in referral from Dr.
10 David Thomas of pain management.

11 Q. And what was the reason for
12 that referral?

13 A. He was referred for
14 evaluation for further options for
15 treatment of his lower extremity pain.

16 Q. And what surgical options did
17 Dr. Schechter have at that time?

18 A. Well, at the time I felt
19 that he would be a good candidate for a
20 trial of spinal cord stimulation.

21 Q. Okay. Did you perform an
22 examination of him?

23 A. Yes, I did.

24 Q. Can you tell me essentially
25 what your findings were?



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1 A. Briefly, on neurologic
2 examination he did have some lower
3 extremity weakness, more so proximally
4 than distally and also had some left-
5 sided distal weakness, especially of the
6 extensor hallucis longus, which is the
7 extensor of the big toe.

8 He also had decreased sensation
9 in the upper portion of the legs as
10 well as in the lower portion of the
11 legs, worse on the right than on the
12 left. So that was sensory loss, which
13 was somewhat opposite motor loss.

14 His reflexes were hyperactive
15 with clonus, and at the time his toes
16 were down going.

17 Q. Okay. Did you form an
18 opinion as to the cause of those
19 findings?

20 A. Yes, I did.

21 Q. And what is your opinion?

22 A. That that was related to a
23 spinal cord injury.

24 Q. Okay. And when you say
25 spinal cord injury, are you referring to



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1 a specific traumatic event as opposed to
2 pathologic changes in that area?

3 A. Well, that's impossible to
4 differentiate that, but by his history
5 it sounded as if there was a particular
6 event which caused a compressive injury
7 and these findings were most likely
8 related to that.

9 Q. Okay. And the event would
10 be what?

11 A. He underwent surgery in
12 December of 2000, from which he awoke
13 with complete paralysis of his lower
14 extremities according to his history.

15 Q. Did you review any
16 radiographic studies as part of your
17 initial evaluation?

18 A. I did not.

19 Q. Have you since?

20 A. Yes, I have.

21 Q. Okay. Which films have you
22 looked at?

23 A. I've seen both preoperative
24 and postoperative MRI scans.

25 Q. What was your impression of



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1 the preoperative MRI scans? And when
2 you say preoperative you're talking
3 about prior to --

4 A. Prior to the other --

5 Q. -- prior to Dr. Bohlman's
6 operation?

7 A. I presume that's the
8 operation in December of 2000.

9 Q. Yes.

10 A. Preoperatively, the films
11 demonstrated a fair amount of narrowing
12 and circumferential stenosis, as well as
13 anterior pathology. So he had really
14 both compression from in front and in
15 back on the preoperative films. And the
16 postoperative films showed cord changes
17 which were consistent with spinal cord
18 injury.

19 Q. What would be the source of
20 the narrowing and circumferential
21 stenosis that you found on the
22 preoperative films?

23 A. I don't have a specific
24 reference to that, although I do believe
25 I recall the appearance of the films and



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1 there was as I recall -- this is my
2 imperfect recollection -- there was
3 anterior disk bulging and soft tissue
4 mass, also accompanied by facet
5 hypertrophy posteriorly, causing
6 circumferential stenosis of the spinal
7 canal at that point.

8 Q. So was there narrowing both
9 in the anterior and posterior portions
10 of the spine at that level?

11 A. That's correct.

12 Q. Would findings along those
13 lines cause symptoms?

14 A. They could, yes.

15 Q. What sort of symptoms could
16 they cause?

17 A. Well, it's difficult to -- I
18 would have to hypothesize about symptoms
19 that they could cause.

20 MR. PESKIN: Just show an
21 objection. Go ahead.

22 A. It could be anything from
23 some mild tingling or paresthesia in the
24 lower extremities, to weakness, to pain.
25 It could cause radicular symptoms with



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1 pain radiating around the chest. It
2 could potentially cause back pain as
3 well. So they're really protean
4 symptoms which could be referred to that
5 level. It would be difficult to know
6 without examining the patient exactly
7 which ones apply to Dr. Schechter.

8 Q. Okay. Are you going to be
9 offering an opinion one way or the other
10 as to whether or not the symptoms that
11 he came to Dr. Bohlman with were related
12 to the pathology in his thoracic spine?

13 A. I don't have an opinion on
14 that.

15 Q. Leaving aside for a moment
16 the range of clinical symptomatology
17 that one could see with those
18 radiographic findings, would the
19 radiographic findings by themselves be a
20 possible indication for surgery at that
21 level?

22 A. Everyone's practice is
23 different, but I operate on patients and
24 not films. That's one of the things I
25 tell my patients all the time. So I've



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1 seen patients who have very bad looking
2 x-rays who may be essentially
3 asymptomatic and whom I do not recommend
4 surgery despite the fact that their
5 films look pretty frightening.

6 Then there are the patients who
7 have minimal findings but very clear
8 relationship between those minimal
9 findings and their symptoms, and in
10 those patients I would tend to operate.
11 So it's very patient-dependent and it
12 really depends on the individual
13 symptoms.

14 Q. So I guess what you're
15 saying, and feel free to correct me if
16 I'm wrong, is that the x-ray findings
17 could be compatible with a patient that
18 needs surgery; it's going to be
19 dependent, though, upon the patient's
20 symptoms?

21 A. That's correct.

22 Q. Would x-ray findings like
23 those place a patient at risk for spinal
24 cord injury?

25 A. I'm not aware of any



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1 literature that addresses that. My own
2 personal opinion is that it does not.

3 I've personally had patients who
4 had very severe stenosis and narrowing
5 in the cervical spine, one particularly
6 memorable patient who was waiting to
7 have an operation and was involved in a
8 pretty severe auto accident, one that
9 you would expect would be enough trauma
10 to cause any narrowing or compression to
11 worsen, and he came through that without
12 any change in his neurologic examination
13 whatever.

14 So I generally tell my patients
15 not to be overly concerned about the
16 possibility of sudden paralysis or other
17 frightening sequelae if they're
18 essentially asymptomatic or have minimal
19 symptoms.

20 Q. Do you perform operations on
21 the thoracic pain?

22 A. Yes, I do.

23 Q. What sort of operations do
24 you perform?

25 A. In the past I have performed



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1 many different types of thoracic spine
2 operations, including decompressions,
3 fusions, instrumentation operations.

4 Now I limit my practice more to
5 essentially transpedicular discectomies
6 or other minimally invasive operations
7 on the thoracic spine for the most part.
8 Anyone who requires a bigger operation,
9 I have world recognized experts here at
10 The Clinic that I can refer them to, so
11 I tend to defer to them.

12 Q. It looks like you've got a
13 report there that you wrote to Dr.
14 Thomas, the referring physician?

15 A. Correct.

16 Q. Was that report generated
17 after your initial evaluation?

18 A. Yes, it was.

19 Q. Could I take a look at that,
20 please?

21 A. Sure.

22 Q. Based upon your review of
23 the preoperative films, did you see any
24 evidence of changes in the spinal cord?

25 A. I don't recall.



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1 Q. Is it your belief, though,
2 that in the postoperative films you did
3 see some changes in the spinal cord?

4 A. Yes.

5 Q. What's the date of those
6 postoperative films? Do you have that
7 referenced?

8 A. I'm sorry, I don't.

9 Q. From your memory, without
10 having these films in front of you,
11 could you tell me what you saw on the
12 films that allowed you to conclude that
13 there were spinal cord changes?

14 A. I wouldn't trust my memory
15 enough to be able to describe that
16 precisely.

17 Q. Do you recall what study it
18 was?

19 A. It was an MRI study, but
20 beyond that I can't tell you.

21 Q. Okay.

22 MR. PESKIN: The report may be
23 in the records. I don't know.

24 MR. GROEDEL: I know, but there
25 may be something in here that merits



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1 follow-up now.

2 A. I don't have a record of it
3 in my shadow chart of the specific
4 findings.

5 Q. Of the MRI you mean?

6 A. Correct.

7 Q. How would you characterize
8 the degree of weakness that you found?

9 A. Mild.

10 Q. If you were to grade his
11 level of pain on a scale of 1 to 10,
12 based upon what Dr. Schechter was
13 telling you, how would you have graded
14 it?

15 A. Let me see what I have there
16 in the note. We generally have an
17 intake sheet questionnaire that we have
18 the patients fill out, which has a
19 visual analog scale on it where we have
20 them mark their pain level and,
21 unfortunately, I don't seem to have that
22 in the chart, so I can't quantify that
23 for you.

24 Q. As a result of your initial
25 evaluation, did you recommend to him the



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1 use of a neurotransmitter, I think you
2 called it?

3 A. Spinal cord stimulator.

4 Q. Stimulator, I'm sorry.

5 A. Yes.

6 Q. And how does that device
7 work?

8 A. The precise mechanism of
9 action is unknown, but the procedure
10 involved is placement of a wire
11 electrode with four contacts and
12 insulation between them in the epidural
13 space over the surface of the spinal
14 cord. We then run low voltage
15 electricity through those contacts,
16 which is pulsed at usually around 50
17 cycles per second. We have the patient
18 tell us about the perception of
19 paresthesias or tingling sensations in
20 their areas of pain and we'll move the
21 stimulator around until we get it just
22 to the point where we cover the
23 patient's pain.

24 It seems that that paresthesia
25 coverage is necessary for pain relief.



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1 And it's not effective in all patients.
2 About 70 percent of patients will have
3 50 percent or greater pain relief from
4 it. But as I said, the exact mechanism
5 is unknown.

6 Q. Okay. And what's the
7 purpose behind the device?

8 A. To decrease pain.

9 Q. And what is done to decrease
10 the pain?

11 A. The electrical stimulation
12 decreases the pain.

13 I tell patients that it's similar
14 to when you hit your thumb with a
15 hammer and you rub it. It's the input
16 of both pain sensing fibers and nonpain
17 sensing fibers as they come into the
18 spinal cord. There's an interference
19 there that, quote, closes a gate, end
20 quote, according to a theory that was
21 published back in 1965, and helps pain
22 in that way. That theory is
23 probably the most prevailing theory at
24 the present time, although, you know,
25 there are detractors and there are other



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1 potential theories as to how it works.

2 Q. Is this a patient controlled
3 device?

4 A. Yes.

5 Q. How does that work?

6 A. There is a control unit,
7 which is similar to a television remote.
8 It's placed over the pacemaker, which is
9 usually placed in the buttock region,
10 and it's all underneath the skin. And
11 then the pacemaker can be turned up and
12 down by using the buttons on the remote
13 control device.

14 You may or may not know that
15 Jerry Lewis had one of these implanted
16 and he likes to show off his remote
17 control unit.

18 Q. And this is all underneath
19 the skin?

20 A. Correct.

21 Q. So how do you activate or
22 adjust the device?

23 A. In the office we can use a
24 computer which has a programming head
25 which communicates with the device by



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1 radio frequency. And we're able to
2 change more parameters in the office
3 than the patient is with their hand held
4 programmer, but they're allowed to turn
5 the stimulator up and down and change a
6 few parameters with that hand held
7 programmer, which communicates by radio
8 frequency.

9 Q. So the patient can to some
10 degree control the amount of electrical
11 activity?

12 A. Correct.

13 Q. And can also turn it on and
14 turn it off?

15 A. That's correct.

16 Q. How is it supposed to work?
17 Does the patient turn it on when he or
18 she feels pain or is it supposed to be
19 on on a continuous basis? How does it
20 work?

21 A. It's different for every
22 patient. The majority of patients who
23 have pain like Dr. Schechter does, which
24 is continuous, leave the stimulator on
25 continuously.



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1 Q. And it's my understanding
2 that one of the goals behind this
3 machine would be to reduce the amount of
4 pain to the extent that you could then
5 reduce his medication requirements?

6 A. That would be ideal.

7 Q. About how many of these have
8 you inserted in your career?

9 A. Well, I haven't kept perfect
10 records, but it would have to be over a
11 hundred, but beyond that I can't say.

12 Q. Okay. Now, it's a two stage
13 procedure?

14 A. Correct.

15 Q. Describe that for me.

16 A. The first stage is a trial,
17 and generally it's done with a
18 percutaneous type of lead, which is a
19 wire introduced through a needle and
20 then that's anchored underneath the skin
21 and a separate wire is brought out
22 through a separate incision.

23 The patient then goes home with
24 the device for a week and tries it out.
25 They have a hand held remote that they



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1 can use to turn it up and down. If
2 they like the stimulation and it's
3 helpful for their pain, then we go ahead
4 and do the second stage, which is the
5 implant of the pulse generator or
6 pacemaker. If the stimulation is not
7 helpful for them, then we remove it.

8 Q. The second stage of the
9 procedure is an open operation?

10 A. They both are to some
11 extent, but they're small incisions.
12 This incision in the neck is perhaps an
13 inch and a half long and then the one
14 to implant the pulse generator is
15 perhaps three inches long.

16 Q. Where was the incision for
17 Dr. Schechter?

18 A. The incision to implant the
19 stimulator electrode was in his upper
20 thoracic -- mid thoracic spine around T
21 -- at T-10. I'm sorry, lower thoracic
22 spine at T-10 and partially at T-9.

23 Now, his trial was slightly
24 different because of the presence of
25 scar tissue in the area where we were



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1 interested in implanting the stimulator,
2 due to the prior surgery, so we couldn't
3 do a percutaneous trial with a needle,
4 we had to do it open. So we had to
5 open up, in his case, and do --
6 actually take -- do a laminectomy and
7 take bone off.

8 We did that with him awake so
9 that we would be able to tell when we
10 had the stimulator in good position and
11 so if anything happened during the
12 operation to change his neurologic
13 function we'd know right away and be
14 able to stop the operation.

15 Q. So I assume after the first
16 stage of the procedure Dr. Schechter
17 reported to you good relief with the
18 device and that's why you went ahead
19 with stage two?

20 A. Correct.

21 Q. Where was Dr. Schechter's
22 pain?

23 A. Mainly in the front or
24 anterior portion of his thighs in the
25 quadriceps region, although it did



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1 sometimes extend down as far as the
2 calves.

3 Q. What dermatomes would be
4 involved with pain in those areas?

5 A. Approximately L-2 through L-4
6 or 5.

7 Q. Does the spinal cord reach
8 those areas?

9 A. I'm sorry, I don't understand
10 the question.

11 Q. Does the spinal cord reach
12 L-2 through L-5?

13 A. Let me see if I can answer.
14 I'm not exactly sure what you're asking.

15 Q. Sure.

16 A. I'll give you two answers.
17 One answer is that all nerve impulses
18 travel through the spinal cord so that
19 the spinal cord reaches every part of
20 the body by definition, but I don't
21 think that's what you're asking.

22 I think what you're asking is,
23 how far down does the spinal cord extend
24 within the spinal canal?

25 Q. Does it stop at about --



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1 well, you tell me.

2 A. Right around L-1, L-2 is the
3 usual level, although there's anatomic
4 variation. It could be anywhere from
5 the bottom of L-2 all the way up into
6 the lower thoracic spine.

7 Q. Do you know where it ended
8 in Dr. Schechter's spine?

9 A. No, I don't.

10 Q. Is it your belief that the
11 pain in his thighs is due to spinal
12 cord injury?

13 A. Yes.

14 Q. If that's your opinion, is
15 that consistent with where the
16 dermatomes would be on his thigh?

17 A. Again, I'm not sure I
18 understand the question.

19 Q. Well, I think you said that
20 the dermatomes affected by the area
21 where he was having pain would be L-2
22 through L-5?

23 A. Yes.

24 Q. If the spinal cord ends at
25 L-1 or maybe L-2, but he's having pain



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1 in dermatomes affected by L-2/L-5,
2 wouldn't that be inconsistent with a
3 spinal cord injury?

4 A. No.

5 Q. Okay. And why is that?

6 A. Spinal cord injury can
7 produce pain below the level of the
8 lesion but not above the level. So for
9 example, a cervical spinal cord injury
10 could produce pain anywhere from the
11 arms to the abdomen to the legs, and it
12 may not be the entire area below the
13 spinal cord injury. So it's not
14 inconsistent.

15 Q. How is it then that an
16 injury to the spinal cord can affect a
17 dermatome below it? How does that
18 happen?

19 A. I can draw a picture if you
20 like. Or I can tell you that the
21 organization of the pain fibers within
22 the spinal cord and the dorsal column
23 fibers and the organization of the
24 spinal cord in general is onion-like, so
25 the closer you get to the center of the



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1 spinal cord, the lower the levels are;
2 the further out, in general the higher
3 the levels are on the sensory side, and
4 it's reversed on the motor side, because
5 of where the fibers enter and exit the
6 spinal cord.

7 THE WITNESS: I need to take a
8 break and answer a page, but I'll be
9 right back.

10 (Discussion off record.)

11 THE WITNESS: I'll finish up.

12 A. So we were talking about the
13 organization of the spinal cord and how
14 things can happen. Any potential part
15 of that spinal cord may be injured any
16 more than another.

17 For example, a syrinx may -- a
18 syrinx is a hole in the spinal cord or
19 a fluid filled portion in the spinal
20 cord which may produce what's called a
21 cape like sensory loss in the upper
22 extremities.

23 If it's in the neck, it can
24 produce numbness or, less commonly,
25 pain, but usually numbness in just sort



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1 of a suspended dermatome, so the same
2 thing can happen in the lower spine as
3 well. It's certainly not unheard of.

4 Q. Was there a syring in this
5 case in any of the findings?

6 A. I don't recall.

7 MR. PESKIN: Talking about when,
8 preoperatively or postoperatively?

9 MR. GROEDEL: Postoperatively.

10 A. I don't have a note of that.
11 I don't recall.

12 Q. Is that something you would
13 have noted in your records if you saw
14 it?

15 A. Not necessarily, because the
16 only record that I have of the
17 interpretation of the films was a note
18 addressed to Mr. Peskin, which I believe
19 you have.

20 Q. April 14th?

21 A. Correct.

22 Q. Do you have an opinion as to
23 the type of spinal cord injury that Dr.
24 Schechter sustained?

25 A. Could you clarify that?



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1 Q. Yes. There's been some
2 testimony from Dr. Bohlman that, in his
3 opinion, the spinal cord injury that
4 occurred is vascular in origin, as
5 opposed to as a result of direct trauma
6 or indirect trauma to the spinal cord.
7 Do you have an opinion one way or the
8 other on that issue?

9 A. No, I don't.

10 Q. Is there any way one can
11 look at objective studies post surgery
12 and come to some conclusion one way or
13 the other on that issue?

14 A. I don't know the answer to
15 that question.

16 Q. Okay. When Dr. Schechter
17 came to you did he say anything in his
18 history about having an operation on his
19 thoracic spine that he didn't know he
20 was having preoperatively?

21 A. I don't recall.

22 Q. Is it mentioned anywhere in
23 your history?

24 A. My history states that he
25 underwent another procedure -- that he



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1 underwent lumbar surgery in 98 and then
2 in December 2000 underwent another
3 surgical procedure which was intended to
4 be a thoracolumbar decompression. And
5 then he awoke from surgery with complete
6 paralysis of his lower extremities.

7 Q. Do you believe that any
8 component of his pain was secondary to
9 the pathology in his lumbar spine?

10 MR. PESKIN: At what time?

11 Q. When you saw him.

12 A. No, I don't.

13 Q. And what's the reason for
14 that?

15 A. Because of the time course
16 of the development of his pain.

17 Q. I assume you saw Dr.
18 Schechter after you inserted the spinal
19 cord stimulator?

20 A. Yes, I did.

21 Q. When was the first time you
22 saw him after the procedure?

23 A. It looks like I saw him on
24 January 31st of 2003.

25 Q. Did you evaluate him?



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1 A. Yes, I did.

2 Q. And what was the result of
3 your evaluation?

4 A. He was getting excellent pain
5 relief, he was able to perceive the
6 stimulation throughout the areas of his
7 pain, he was using a stimulator
8 intermittently, noting fairly dramatic
9 changes in stimulation strength due to
10 changes in position, and he had
11 decreased his narcotic intake.

12 Q. What had been his narcotic
13 intake?

14 A. He was averaging two Percocet
15 per day.

16 Q. To your knowledge, was he
17 taking anything else besides the
18 Percocet?

19 A. According to my evaluation in
20 October of 2002, he was also taking
21 OxyContin, 10 milligrams twice a day, as
22 well as Celebrex, which is an anti-
23 inflammatory.

24 Q. Did he require the OxyContin
25 after the stimulator was placed?



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1 A. Yes, he did.

2 Q. Okay. How much of it was he
3 taking?

4 A. When I saw him in May of
5 this year, he was taking 10 milligrams
6 three times a day.

7 Q. Was that a reduction from
8 what he had been taking?

9 A. Unfortunately, no.

10 Q. Did Dr. Schechter grade his
11 level of pain for you?

12 A. In the immediate
13 postoperative period his pain level was
14 a 1 to 2 out of 10, in January of this
15 year.

16 Q. How would you characterize
17 that in terms of degree of success for
18 the procedure?

19 A. Extremely successful.

20 Q. And did he grade his level
21 of pain for you in any subsequent
22 visits?

23 A. Again, we generally give the
24 patients visual analog scale sheets,
25 which for some reason I don't have



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1 today.

2 Q. Look at that maybe.

3 A. I had that tabbed for a
4 reason. I'm not sure why. This is the
5 follow-up.

6 Q. Okay.

7 A. And this is his follow-up
8 visit in May.

9 Q. Okay.

10 A. Two out of 10, yes, here it
11 is. But that was in January -- so
12 that's January.

13 Q. How did he grade it in May?

14 A. We don't have it in the
15 chart, but we should have it someplace,
16 but it's not in my shadow chart and
17 it's not in the patient's chart at this
18 point.

19 Q. Based upon your recollection
20 of Dr. Schechter, how was he doing? Do
21 you think he --

22 A. Not quite as good as he was
23 in January, but still much better than
24 preoperatively.

25 Q. Have you seen him since May?



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1 A. I don't have any record of
2 having seen him since then.

3 Q. Do you have any plans on
4 seeing him again?

5 A. He will at some point
6 require a replacement of the pulse
7 generator since it's battery driven, so
8 I'll need to see him back for that.
9 And I would anticipate that he probably
10 will require some programming changes
11 over time. Most of these patients do
12 have relatively stable stimulation
13 patterns but do require some adjustments
14 over time.

15 Q. What's involved with the
16 battery replacement?

17 A. Making an incision over the
18 pulse generator or pacemaker, removing
19 it, disconnecting the extension wire,
20 placing a new pulse generator,
21 retightening the screws, placing it back
22 into the pocket and closing.

23 Q. Is that done under general,
24 local? How is that done?

25 A. Generally it's done under



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1 general anesthesia.

2 Q. Outpatient procedure?

3 A. Yes.

4 Q. There's a few things here in
5 your progress note for this last visit
6 that I don't understand. He says that
7 he desires more coverage of his anterior
8 thigh. What would he be referring to
9 there?

10 A. That he's feeling the
11 stimulation in most of his areas of pain
12 but not as much in the anterior thigh
13 as he would like it.

14 The patients feel the stimulation
15 in different areas, and we can adjust
16 the stimulation by changing the
17 contacts, changing the rate pulse with
18 an amplitude in order to sort of steer
19 the coverage to different parts.

20 Q. So by adjusting it you could
21 increase the amount of coverage that it
22 gets to a particular spot?

23 A. Correct.

24 Q. Which should decrease the
25 level of pain he's having in the area?



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1 A. That's right.

2 Q. Is the goal for a patient
3 like Dr. Schechter to reduce his pain
4 level to a level of 1 or 2 on that 1 to
5 10 scale?

6 A. The goal is to try to
7 achieve 50 percent or better pain
8 relief, which he was convinced that he
9 had achieved. I don't have numerical
10 documentation of that, but in my
11 conversation with him I do recall that
12 he was able to report greater than 50
13 percent pain relief.

14 Q. Okay. The note also says
15 that he has not been aggressive at
16 titrating the amplitude upwards. What
17 does that mean?

18 A. Generally, by increasing the
19 strength of the stimulation or the
20 amount of voltage that's put through the
21 stimulator, you can increase the
22 intensity of the paresthesias, increase
23 the spread of stimulation and often do a
24 little bit better job in improving the
25 pain.



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1 Q. And would he be instructed
2 then on how to do that?

3 A. Yes. And, in fact, it
4 sounds as if at this visit it was
5 demonstrated to him what the different
6 sensations were at the different levels,
7 and that he was instructed on how to do
8 that.

9 Q. And then your note says, he
10 states that his coverage is somewhat
11 positional and that he gets better
12 coverage when supine than when
13 standing/sitting. He denies new
14 symptoms. What's he referring to there?

15 A. Part of the efficacy of a
16 spinal cord stimulator is the thickness
17 of the spinal fluid. The spinal fluid
18 tends to conduct current away from the
19 spinal cord, so the more spinal fluid
20 there is between the stimulator
21 electrode and the spinal cord, the less
22 stimulation you'll get, which is what he
23 was describing.

24 When you stand or sit the cord
25 tends to fall away from the stimulator,



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1 decreasing the stimulation. And when
2 you lay down, the cord tends to fall
3 back toward the stimulator, increasing
4 the amount of stimulation. That's why
5 the hand held programmer is important,
6 so that the patients can adjust their
7 own levels as the day goes on.

8 Q. So if he's standing or
9 sitting he can increase the amount of
10 electricity, so to speak --

11 A. That's correct.

12 Q. -- and get better pain
13 relief?

14 A. That's correct.

15 Q. How long does the battery
16 last?

17 A. It really varies depending on
18 the amount of electricity used; anywhere
19 from 12 months to 6 or 7 years.

20 Q. Have you placed any
21 limitations on Dr. Schechter's
22 activities?

23 A. I generally tell patients
24 with spinal cord stimulators that they
25 can participate in most everyday



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1 activities. I tell them not to do
2 extreme things like water skiing or
3 skydiving, but for the most part I let
4 them do most of their daily activities,
5 including such things as golf or bowling
6 or other things, with the knowledge that
7 there is a mechanical system in place
8 and there's a potential that it could
9 break.

10 Q. In your interaction with Dr.
11 Schechter did you ever have the
12 opportunity to observe his gait?

13 A. I don't have a specific
14 record of it, but as I recall he does
15 have a somewhat slow, wide-based and
16 somewhat slightly spastic gait.

17 Q. Did that improve after the
18 placement of the stimulator?

19 A. No.

20 Q. And what's the reason for
21 that?

22 A. The stimulator is really
23 intended to only treat pain and usually
24 doesn't treat other signs or symptoms of
25 neuropathy or spinal cord injury or



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1 whatever it's being implanted for.

2 Q. Is it your belief that the
3 abnormalities with respect to his gait
4 are due to spinal cord injury?

5 A. Yes.

6 Q. Have you told him that you
7 don't believe he'd be able to work as a
8 dentist?

9 MR. PESKIN: Objection.

10 A. I don't remember. I do
11 recall the tone of our conversations,
12 which were that he has, I believe, cut
13 back somewhat on his practice due to
14 various factors, including pain, and
15 part of the goal was to try to see if
16 we can increase his activity by
17 decreasing his pain and increase his
18 participation by decreasing his pain,
19 but I can't recall specifics of the
20 conversations.

21 Q. Well, based upon the results
22 of this procedure that you performed, do
23 you believe that he is capable of
24 working as a dentist?

25 MR. PESKIN: Objection.



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1 A. It's very hard for me to
2 say. I'm very cautious about placing
3 restrictions on patients because
4 everyone's individual and what one
5 person may be able to do, another person
6 may not be able to do.

7 And to me it really depends on
8 how much pain he can tolerate and how
9 much that distracts him from his job and
10 how effective the stimulator is
11 controlling that pain, and he's the only
12 one who can make that determination, so
13 I tend not to make those determinations
14 for patients if I can avoid it.

15 Q. As far as you know, does he
16 have any limitations with respect to his
17 manual dexterity?

18 A. I didn't evaluate him for
19 that.

20 Q. Did he tell you anything
21 that would lead you to believe that he
22 had any problems there?

23 A. I don't recall.

24 Q. Has he told you that he's
25 limited in his ability to stand for



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1 periods of time?

2 A. I don't have any independent
3 recollection and I don't have any
4 documentation of that.

5 Q. Has he reported to you any
6 problems with respect to either bladder
7 or bowel function?

8 A. On my initial evaluation he
9 did report episodes of incontinence as
10 well as urinary urgency, and privately
11 he's told me that he's had some sexual
12 difficulties as well.

13 Q. When did he tell you that?

14 A. I don't recall, but most
15 likely at his initial visit. But I do
16 recall him telling me that.

17 Q. Okay. Do you know whether
18 or not there's been any change in any
19 of these symptoms over the course of
20 time that you've seen him?

21 A. I don't.

22 Q. Did you refer him to any
23 other specialist to address those
24 issues?

25 A. No.



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1 Q. Is it your belief that the
2 films taken following Dr. Bohlman's
3 surgery show evidence of spinal cord
4 compression?

5 MR. PESKIN: Objection.

6 A. I would have to review the
7 films to render that opinion.

8 Q. Is it your belief that Dr.
9 Schechter is going to require any
10 further surgery beyond battery
11 replacements?

12 A. I don't know.

13 Q. And why is it that you don't
14 know?

15 A. I can't predict how his
16 symptoms will change over time, whether
17 they'll improve or worsen, whether any
18 other portions of his spine will develop
19 worse degeneration. It's just hard for
20 me to predict the future.

21 Q. So if you were to testify at
22 trial, you wouldn't state that he's
23 going to require an anterior surgery on
24 his thoracic spine, would you?

25 A. I wouldn't have sufficient



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1 information to say that at this present
2 time.

3 Q. During the period of time
4 that you've treated him have you seen
5 any evidence of decline in his
6 neurologic function?

7 A. No.

8 Q. Has there been any
9 improvement in his neurologic function?

10 A. I don't believe so.

11 Q. Do you have an opinion as to
12 whether he's going to require narcotic
13 medications on an indefinite basis?

14 A. That's a difficult question
15 to answer. I have a fair amount of
16 experience with maintenance opioid
17 narcotic medications in patients, and
18 things change over time.

19 Some patients who take narcotics
20 daily are over time able to wean off
21 the medications. There are other people
22 who require them essentially for the
23 rest of their lives.

24 Ideally, every 18 months or so I
25 try to wean patients off of narcotic



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1 medications and some patients are able
2 to and other patients are not. So
3 that's a process that I would foresee
4 continuing with Dr. Schechter.

5 Q. So you would at least
6 attempt to wean him off the narcotic
7 medications?

8 A. That's correct.

9 Q. Is it more difficult to wean
10 somebody off narcotics if they're on a
11 higher dose of narcotic medication?

12 A. Yes.

13 Q. How would you characterize
14 the amount of narcotic medications he's
15 taking now?

16 A. I would say it's a
17 relatively low dose with respect to my
18 patient population.

19 Q. 10 milligrams of OxyContin
20 three times a day?

21 A. It's a low dose for chronic
22 pain patients. It's certainly a high
23 dose for somebody who's actively
24 functioning in society.

25 Q. It wouldn't prevent somebody



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1 from actively functioning in society,
2 though, would it?

3 A. Not necessarily. You know,
4 the idea obviously it to strike a
5 balance between side effects of
6 medication and analgesia, and it's
7 always a tricky question as to what the
8 degree of impairment is.

9 For example, if someone's driving
10 a bus, can they be taking OxyContin?
11 That's a debate that pain specialists
12 have on a yearly basis and it's a very
13 difficult thing to evaluate. But
14 in general, the goal is obviously to get
15 people back to the best function that
16 they can achieve and so we try to
17 titrate the dose so that they can get
18 the best pain relief, better still, able
19 to function.

20 Q. Based upon your interaction
21 with Dr. Schechter, have you been made
22 aware of him having any problems as a
23 result of the narcotic pain medications,
24 in other words, problems with his
25 ability to function --



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1 MR. PESKIN: Objection.

2 Q. -- during the day?

3 A. I haven't specifically
4 inquired about those, so it's hard for
5 me to say.

6 Q. But you would agree that at
7 the level that he's at now, he would be
8 a good candidate for being a patient who
9 could be weaned off his narcotics?

10 A. I see every patient as
11 someone who can be weaned off their
12 narcotics.

13 Again, it just depends on how the
14 nervous system has changed over time to
15 adapt to chronic pain. Some people
16 become somewhat tolerant to it. Perhaps
17 stimulation will have some cumulative
18 effect that he may be able to wean the
19 medication off. On the other hand, we
20 may not be able to. It's hard for me
21 to say.

22 Q. If you're able to wean
23 somebody off of their narcotic
24 medications, what usually takes the
25 place of the narcotics?



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1 A. They generally go completely
2 off of them and don't take other,
3 similar medications.

4 Q. So they don't need Advil,
5 Tylenol, things like that?

6 A. I try to recommend against
7 those types of medicines because they
8 can cause long-term organ damage. So if
9 I'm going to use a long-term agent and
10 it's a choice between an anti-
11 inflammatory and an opioid, I'll use the
12 opioid because it's safer, with the
13 caveat that there are side effects from
14 withdrawal and dependence and tolerance
15 and all of the other things that go
16 along with opioid use. So it again
17 varies per patient.

18 Q. So you would say from a
19 long-term standpoint, it would be safer
20 to keep Dr. Schechter on OxyContin than
21 it would be Advil?

22 A. Correct.

23 Q. Do you have an opinion as to
24 whether the pathology that was in Dr.
25 Schechter's thoracic spine before Dr.



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1 Bohlman's surgery is contributing to his
2 current condition today?

3 MR. PESKIN: Objection.

4 A. I have no opinion on that.

5 MR. GROEDEL: Can I take a look
6 at that chart?

7 MR. PESKIN: Can I take a break?
8 There's something we need to talk about
9 either on or off the record, in all
10 fairness to you, because he's going to
11 look at the films again at some point.

12 MR. GROEDEL: Well, I'm -- see,
13 and I've asked him those questions
14 and --

15 MR. PESKIN: Can we just take a
16 little break?

17 MR. GROEDEL: Yeah, go ahead.

18 (Discussion off record.)

19 A. Can I clarify then something?

20 Q. Sure, go ahead.

21 A. I don't have a clear
22 recollection of the findings on the
23 films, whether or not there was a syrxinx
24 or was not a syrxinx, whether there were
25 high signal and low signal changes. I



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1 don't have a clear enough recollection
2 of the films to be able to state in
3 this deposition exactly what the films
4 showed.

5 Q. If there was a syrinx on
6 those films, would you have an opinion
7 as to the cause?

8 A. That would make me think
9 much more of a traumatic or compressive
10 injury than a vascular injury.

11 Q. And why is that?

12 A. Because a syrinx is much
13 more likely to follow a compressive or
14 traumatic injury than it is a vascular
15 injury.

16 Q. What is a syrinx?

17 A. A syrinx is a cavity within
18 the spinal cord which is usually
19 expansile, and usually extends over
20 several levels.

21 Q. Did you say a cavity within
22 the spinal canal?

23 A. Within the spinal cord.

24 Q. Within the cord itself?

25 A. Yes.



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1 Q. And so was the syrinx itself
2 evidence of trauma to the spinal cord?

3 A. Not necessarily. There are
4 other etiologies for a syrinx, but in
5 the setting of an acute event, I would
6 ascribe it more to a compressive or
7 traumatic type of injury than to a
8 vascular injury.

9 Q. When you say a compressive
10 event, what are you referring to?

11 A. Some compression during the
12 operation.

13 Q. And what types of things
14 would cause compression?

15 A. Pushing on the cord with an
16 instrument.

17 Q. And how is that different
18 from a traumatic event, or is it not
19 different?

20 A. I guess mainly in degree
21 more than type.

22 Q. So traumatic implies a more
23 severe degree of trauma than just
24 compression?

25 A. I would guess so, yes.



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1 Q. What other causes are there
2 of a syrinx?

3 A. They can be congenital.
4 They can be caused by a tumor or by
5 differences in spinal fluid pressure
6 across a gradient, such as most of the
7 syringes that occur in the upper portion
8 of the spine with blockage of the
9 outflow of spinal fluid from the cranial
10 to the spinal axis.

11 Q. You mentioned a few moments
12 ago that you didn't have a memory as to
13 whether you saw high signal or low
14 signal changes in the spinal cord.
15 What's the difference between the two?

16 A. One's bright and one's dark.

17 Q. And is there any significance
18 to it from an etiology standpoint, high
19 signal versus low signal?

20 A. It would depend on all of
21 the other findings that were evident on
22 the film at the time.

23 THE WITNESS: Just a reminder, I
24 do have a 6:00 meeting.

25 MR. PESKIN: You're going to make



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1 it.

2 MR. GROEDEL: I'm done once I
3 finish reading through this.

4 Just for the record, why don't we
5 mark these as exhibits. We'll give them
6 back to you, but I want the record
7 marked. Why don't we mark that A and
8 mark this record B.

9 - - - - -
10 (Thereupon, Deposition
11 Exhibits-AthruB were
12 marked for purposes
13 of identification.)

14 - - - - -
15 Q. So Exhibit B, Doctor, can
16 you just identify that for the record?

17 A. This looks like the patient's
18 medical record from The Cleveland
19 Clinic.

20 Q. And Exhibit A?

21 A. This is my shadow chart.

22 Q. Okay. And assuming that Mr.
23 Peskin can give you the appropriate
24 signed release from Dr. Schechter, I
25 assume we can get complete copies of



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1 both of those files made for us?

2 A. There should be no problem.

3 Q. Thanks.

4 MR. PESKIN: I'll have to get --
5 I don't know if we've got one on record
6 or not. I think we do. This is -- all
7 of this is in there, too, I would
8 think, probably.

9 MR. GROEDEL: Okay. Very good.
10 Thank you, Doctor.

11 THE WITNESS: All right.

12 MR. PESKIN: I don't represent
13 you. You have the opportunity to review
14 this thing, which I would recommend that
15 you probably do just to make sure that
16 it was accurately transcribed. It gives
17 you a chance to clarify or make any
18 corrections if there were any errors in
19 transcription, and the court reporter
20 probably can produce that for review.

21 THE WITNESS: That would be
22 great. I usually don't waive
23 signature --

24 MR. PESKIN: I wouldn't recommend
25 it.



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1 THE WITNESS: -- unless it's a
2 straightforward Workers' Comp depo.
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1 CEFARATTI GROUP FILE NO. 8140

2 CASE CAPTION: BENJAMIN SCHECHTER VS.

3 HENRY BOHLMAN, M.D., ET AL.

4 DEPONENT: JAIMIE HENDERSON, M.D.

5 DEPOSITION DATE: JULY 30, 2003

6 _____
7 (SIGN HERE)

8 The State of Ohio,)

9 County of Cuyahoga) SS:

10 Before me, a Notary Public in and
11 for said County and State, personally
12 appeared JAIMIE HENDERSON, M.D., who
13 acknowledged that he/she did read
14 his/her transcript in the above-
15 captioned matter, listed any necessary
16 corrections on the accompanying errata
17 sheet, and did sign the foregoing sworn
18 statement and that the same is his/her
19 free act and deed.

20 IN TESTIMONY WHEREOF, I have
21 hereunto affixed my name and official
22 seal at _____, this _____
23 day of _____, A.D. 2003.

24 _____
25 Notary Public Commission Expires



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CERTIFICATE

State of Ohio) SS.:
County of Cuyahoga.)

I, Michelle M. Lewis, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, was duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.



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1 I am not, nor is the court
2 reporting firm with which I am
3 affiliated, under a contract as defined
4 in Civil Rule 28 (D).

5 IN WITNESS WHEREOF, I have
6 hereunto set my hand this 12th day of
7 August, 2003.

8
9
10
11
12 Michelle M. Lewis

13 Michelle M. Lewis, Notary Public
14 within and for the State of Ohio
15
16
17
18

19 My commission expires January 9, 2004.
20
21
22
23
24
25



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