IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

BENJAMIN SCHECHTER,
et al.,

Plaintiffs,

vs. Case No.

HENRY H. BOHLMAN, M.D., 471455
et al.,

Defendants.

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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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APPEARANCES:

On behalf of the Plaintiff:

LAWRENCE F. PESKIN, ESQ.
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On behalf of the Defendants:

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

EXAMINATION OF JAIMIE HENDERSON, M.D.

BY-MR.GROEDEL:

Q. Please state your name.

A. Jaimie Henderson.

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

Have you ever been deposed before?

A. Yes, I have.

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

the same wavelength this afternoon, okay?

A. All right.

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

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

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

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

A. Not to my recollection.

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

A. Yes, as of May 9th.

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

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

Q. And what was the reason for that referral?

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

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

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

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

A. Yes, I did.

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

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

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

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

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

A. Yes, I did.

Q. And what is your opinion?

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

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

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

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

Q. Okay. And the event would be what?

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

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

A. I did not.

Q. Have you since?

A. Yes, I have.

Q. Okay. Which films have you looked at?

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

Q. What was your impression of

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

A. Prior to the other --

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

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

Q. Yes.

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

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

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

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

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

A. That's correct.

Q. Would findings along those lines cause symptoms?

A. They could, yes.

Q. What sort of symptoms could they cause?

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

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

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

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

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

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

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

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

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

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

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

A. That's correct.

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

A. I'm not aware of any

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

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

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

Q. Do you perform operations on the thoracic pain?

A. Yes, I do.

Q. What sort of operations do you perform?

A. In the past I have performed

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

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

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

A. Correct.

Q. Was that report generated after your initial evaluation?

A. Yes, it was.

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

A. Sure.

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

A. I don't recall.

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

A. Yes.

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

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

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

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

Q. Do you recall what study it was?

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

Q. Okay.

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

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

follow-up now.

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

Q. Of the MRI you mean?

A. Correct.

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

A. Mild.

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

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

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

use of a neurotransmitter, I think you called it?

A. Spinal cord stimulator.

Q. Stimulator, I'm sorry.

A. Yes.

Q. And how does that device work?

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

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

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

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

A. To decrease pain.

Q. And what is done to decrease the pain?

A. The electrical stimulation decreases the pain.

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

potential theories as to how it works.

Q. Is this a patient controlled device?

A. Yes.

Q. How does that work?

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

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

Q. And this is all underneath the skin?

A. Correct.

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

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

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

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

A. Correct.

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

A. That's correct.

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

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

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

A. That would be ideal.

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

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

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

A. Correct.

Q. Describe that for me.

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

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

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

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

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

Q. Where was the incision for Dr. Schechter?

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

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

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

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

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

A. Correct.

Q. Where was Dr. Schechter's pain?

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

sometimes extend down as far as the calves.

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

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

Q. Does the spinal cord reach those areas?

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

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

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

Q. Sure.

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

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

Q. Does it stop at about --

well, you tell me.

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

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

A. No, I don't.

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

A. Yes.

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

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

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

A. Yes.

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

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

A. No.

Q. Okay. And why is that?

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

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

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

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

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

(Discussion off record.)

THE WITNESS: I'll finish up.

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

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

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

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

Q. Was there a syrinx in this case in any of the findings?

A. I don't recall.

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

MR. GROEDEL: Postoperatively.

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

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

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

Q. April 14th?

A. Correct.

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

A. Could you clarify that?

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

A. No, I don't.

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

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

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

A. I don't recall.

Q. Is it mentioned anywhere in your history?

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

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

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

MR. PESKIN: At what time?

Q. When you saw him.

A. No, I don't.

Q. And what's the reason for that?

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

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

A. Yes, I did.

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

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

Q. Did you evaluate him?

A. Yes, I did.

Q. And what was the result of your evaluation?

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

Q. What had been his narcotic intake?

A. He was averaging two Percocet per day.

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

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

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

A. Yes, he did.

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

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

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

A. Unfortunately, no.

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

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

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

A. Extremely successful.

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

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

today.

Q. Look at that maybe.

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

Q. Okay.

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

Q. Okay.

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

Q. How did he grade it in May?

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

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

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

Q. Have you seen him since May?

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

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

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

Q. What's involved with the battery replacement?

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

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

A. Generally it's done under

general anesthesia.

Q. Outpatient procedure?

A. Yes.

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

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

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

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

A. Correct.

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

A. That's right.

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

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

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

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

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

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

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

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

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

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

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

A. That's correct.

Q. -- and get better pain relief?

A. That's correct.

Q. How long does the battery last?

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

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

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

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

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

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

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

A. No.

Q. And what's the reason for that?

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

whatever it's being implanted for.

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

A. Yes.

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

MR. PESKIN: Objection.

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

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

MR. PESKIN: Objection.

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

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

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

A. I didn't evaluate him for that.

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

A. I don't recall.

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

periods of time?

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

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

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

Q. When did he tell you that?

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

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

A. I don't.

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

A. No.

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

MR. PESKIN: Objection.

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

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

A. I don't know.

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

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

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

A. I wouldn't have sufficient

information to say that at this present time.

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

A. No.

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

A. I don't believe so.

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

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

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

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

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

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

A. That's correct.

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

A. Yes.

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

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

Q. 10 milligrams of OxyContin three times a day?

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

Q. It wouldn't prevent somebody

from actively functioning in society, though, would it?

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

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

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

MR. PESKIN: Objection.

Q. -- during the day?

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

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

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

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

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

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

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

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

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

A. Correct.

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

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

MR. PESKIN: Objection.

A. I have no opinion on that.

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

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

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

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

MR. GROEDEL: Yeah, go ahead.

(Discussion off record.)

A. Can I clarify then something?

Q. Sure, go ahead.

A. I don't have a clear recollection of the findings on the films, whether or not there was a syrinx or was not a syrinx, whether there were high signal and low signal changes. I

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

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

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

Q. And why is that?

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

Q. What is a syrinx?

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

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

A. Within the spinal cord.

Q. Within the cord itself?

A. Yes.

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

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

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

A. Some compression during the operation.

Q. And what types of things would cause compression?

A. Pushing on the cord with an instrument.

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

A. I guess mainly in degree more than type.

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

A. I would guess so, yes.

Q. What other causes are there of a syrinx?

A. They can be congenital. They can be caused by a tumor or by differences in spinal fluid pressure across a gradient, such as most of the syrinxes that occur in the upper portion of the spine with blockage of the outflow of spinal fluid from the cranial to the spinal axis.

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

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

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

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

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

MR. PESKIN: You're going to make

it.

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

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

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(Thereupon, Deposition Exhibits-AthruB were marked for purposes of identification.)

- - - - -

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

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

Q. And Exhibit A?

A. This is my shadow chart.

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

both of those files made for us?

A. There should be no problem.

Q. Thanks.

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

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

THE WITNESS: All right.

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

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

MR. PESKIN: I wouldn't recommend it.

THE WITNESS: -- unless it's a straightforward Workers' Comp depo.

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CEFARATTI GROUP FILE NO. 8140

CASE CAPTION: BENJAMIN SCHECHTER VS. HENRY BOHLMAN, M.D., ET AL.

DEPONENT: JAIMIE HENDERSON, M.D.

DEPOSITION DATE: JULY 30, 2003

_____

(SIGN HERE)

The State of Ohio,)

County of Cuyahoga) SS:

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

IN TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at_____, this _____ day of_____, A.D. 2003.

_____ _____

Notary Public Commission Expires

ERRATA SHEET

PAGE	LINE	CORRECTION

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.

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

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

Michelle M. Lewis

Michelle M. Lewis, Notary Public
within and for the State of Ohio

My commission expires January 9, 2004.