1 State of Ohio,)
)
2 County of Cuyahoga.)
\- - -
3 IN THE COURT OF COMMON PLEAS
\- - -
4 JAN S. GLASSER, et al.,)
)
5 Plaintiffs,)
vs.) Case No. 350062
6) Judge Greene
DR. NOEL ABOOD, et al.,)
7)
Defendants.)
8 - - -

9 DEPOSITION OF MATT J. LIKAVEC, M.D.
Thursday, May 13, 1999
10

11

12 The deposition of MATT J. LIKAVEC, M.D., a
13 witness, called for examination by the Defendants
14 under the Ohio Rules of Civil Procedure, taken
15 before me, Diane M. Stevenson, a Registered Merit
16 Reporter, Certified Realtime Reporter, and Notary
17 Public in and for the state of Ohio, by agreement
18 of counsel, at the MetroHealth Medical Center,
19 2500 MetroHealth Drive, Cleveland, Ohio,
20 commencing at 5:10 p.m., the day and date above
21 set forth.
22 - - -
23
STEVENSON REPORTING SERVICE, INC.
24 12500 Edgewater Drive, Suite 904
Lakewood, Ohio 44107
25 (216) 221-0140

1 APPEARANCES:

2 On behalf of the Plaintiffs:

3 Mark W. Ruf, Esq.
Linton & Hirshman
4 Hoyt Block, Suite 300
700 W. St. Clair
5 Cleveland, Ohio 44113

6

7 On behalf of the Defendants:

8 Victoria L. Vance, Esq.
Arter & Hadden, LLP
9 1100 Huntington Building
Cleveland, Ohio 44115

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

1 MATT J. LIKAVEC, M.D.
2 A witness, called for examination by the
3 Defendants, under the Rules, having been first
4 duly sworn, as hereinafter certified, was
5 examined and testified as follows:
6 CROSS-EXAMINATION
7 BY MS. VANCE:
8 Q. Doctor, would you state your full name and spell
9 your last name for the court reporter.
10 A. Yes. My full name is Matt John Likavec,
11 L I K A V -- as in Veronica -- E C.
12 Q. Doctor, can I just take a quick peek at your file
13 materials so I know what we have before us?
14 A. Yes.
15 (Thereupon, a discussion was had off the
16 record.)
17 Q. I am going to keep a few of these things standing
18 upright just so that we can get copies.
19 A. Okay.
20 Q. Those are just some pages I had not seen in the
21 prior set of records that I was provided.
22 A. What are these from? Oh, '98. Okay.
23 Q. Doctor, I am going to be taking your deposition
24 today. I understand you have given deposition
25 testimony before in other matters.

1 A. Yes.
2 Q. If I ask you any question, of course, that you
3 don't understand, stop me, and I will rephrase
4 the question. Otherwise, if you answer the
5 question, I will rely upon the answers that you
6 provide here today.
7 A. Okay.
8 Q. It is my understanding that you had a chance to
9 treat Jan Glasser, and were the surgeon who
10 operated upon her. Is that true?
11 A. That is true.
12 Q. Have you also been retained as an expert witness
13 in connection with the litigation that Jan has
14 against my client, Dr. Abood?
15 A. Yes.
16 Q. Doctor, Mr. Ruf was kind enough to provide us
17 with a copy of your curriculum vitae. You are
18 currently practicing here at MetroHealth Medical
19 Center?
20 A. That is correct.
21 Q. When did you make the move over from Mt. Sinai?
22 A. February 1, 1998.
23 Q. And you are the Director of the Division of
24 Neurological Surgery here at MetroHealth?
25 A. That is correct.

1 Q. Do you have any continuing ties or affiliations
2 with Mt. Sinai?
3 A. Just the patients that I have from there. But I
4 don't even have privileges there anymore, I don't
5 believe.
6 Q. You don't admit patients over at Mt. Sinai
7 anymore?
8 A. No.
9 Q. In your curriculum vitae, you have a number of --
10 some publications, book chapters, things of that
11 nature, some presentations. Without going
12 through each and every one of them, can you tell
13 me if there are any articles that you have that
14 would be particularly pertinent, as you would see
15 it, to the issues involved in this case?
16 For example, have you written any articles
17 addressing patients who have experienced disk
18 conditions following chiropractic treatments?
19 A. No, I do not see any. No to both questions. No,
20 there are no publications that I have written
21 that are particularly applicable to this case.
22 And no, nothing about chiropractic manipulation
23 and disk herniation.
24 Q. Have you looked at any medical literature, just
25 from MEDLINE sources or publications, textbooks,

1 in order to prepare for today's deposition?
2 A. No.
3 Q. Have you ever received any training as a
4 chiropractor?
5 A. No.
6 Q. You don't hold yourself out as an expert in
7 chiropractic medicine?
8 A. No, I do not.
9 Q. Have you ever worked with a chiropractor in a
10 chiropractic office?
11 A. No, I have not.
12 Q. Have you ever taken any of the chiropractic
13 training courses, attended any of their lectures,
14 taken their exams, anything of that nature?
15 A. No, I have not.
16 Q. Have you ever given testimony before in a
17 medical/legal case that involves issues of
18 chiropractic care or treatment?
19 A. Not that I remember at all.
20 Q. Do you consider yourself an expert in the
21 standard of care of chiropractic medicine?
22 A. No, I do not.
23 Q. In preparation for today's deposition, you have
24 told us that you didn't look at any medical
25 literature or do any medical reviews in

1 particular. Is that true?
2 A. That is true.
3 Q. Did you have a chance to look at any of the
4 materials that we have on the table here in front
5 of us to prepare for the deposition?
6 A. I looked at my file. I looked through the
7 medical record again, which is what I used to put
8 my letter together, and I started to read one
9 deposition, and I couldn't follow it, so I
10 stopped.
11 Q. Is that the deposition of Dr. Dock?
12 A. I believe so, yes, that was it.
13 Q. You also have been provided with, I believe, the
14 deposition of Jan Glasser?
15 A. I probably did not -- I read, I am sure -- well,
16 I am not sure. I don't remember the date of that.
17 Q. It was provided on October 12, '98.
18 A. So I read that and had it in mind when I prepared
19 my letter to Mr. Ruf, but I did not review that
20 specifically this weekend or just before this.
21 Q. And you tried to get through some of Dr. Dock's
22 deposition, but didn't really follow it, and
23 didn't complete that review?
24 A. I probably read four pages.
25 Q. So is it fair to say nothing in Dr. Dock's

1 testimony -- you are not relying upon any of that
2 in formulating any of your opinions that you have
3 come to hold in this case?
4 A. That's correct.
5 Q. Have you been provided with the deposition of
6 Dr. Abood, the chiropractor?
7 A. I don't know. I don't think so. I may have.
8 Q. There have been depositions also of Mr. Glasser,
9 Jan's husband.
10 A. I don't have any memory or recall of that.
11 Q. Some of her friends, some lady friends of hers.
12 MR. RUF: Can I see those letters?
13 A. I don't know. This is everything I have.
14 Q. And the deposition of a Dr. Randy Reed, R E E D,
15 another chiropractor who treated her.
16 A. I don't recall that.
17 Q. You have some films here I see on the tab e here
18 in front of you. Did you take a look at the
19 films again before the deposition?
20 A. No, not in months.
21 Q. Not in months, you said?
22 A. Yes.
23 Q. Have you spoken with Jan Glasser recently?
24 A. No.
25 Q. Do you know, is she still a patient of yours?

1 A. I would be available to her if she needed me, but
2 I haven't seen her medically, as a patient, since
3 my last office notation, which would be -- I
4 would have to look. I saw her sometime in August
5 of '97.
6 Q. In all fairness to you, Doctor, I think we have
7 one other more recent note.
8 A. Okay. November 18 of '97 would be the last time.
9 Q. And according to the way you have dictated your
10 note, in your own office practices, can you tell
11 whether you expected or asked her to return at
12 any certain interval, or was it just left prn?
13 A. It was just left prn.
14 Q. There are references in the records to a number
15 of other physicians who have cared for
16 Mrs. Glasser from time to time. Just real
17 quickly, do you imagine you know some of these
18 other physicians, maybe not all of them, but some
19 of them from personal dealings or having worked
20 over at Mt. Sinai over the years?
21 A. Yes.
22 Q. What is Dr. Robert Leb's specialty?
23 A. He is an orthopedic surgeon.
24 Q. Keith Byers, internist?
25 A. I think he is an internist, if I remember

1 correctly.
2 Q. Theresa Ruch?
3 A. Is a neurological surgeon.
4 Q. And your specialty is also neurological surgery;
5 is that correct?
6 A. That is correct.
7 Q. You are Boarded in neurosurgery?
8 A. That is correct.
9 Q. Do you hold any other Board certifications?
10 A. No.
11 Q. Board eligible in any other areas?
12 A. No.
13 Q. Generally speaking, Doctor, what is your basic
14 understanding of the facts of the case involving
15 Mrs. Glasser?
16 A. Mrs. Glasser was the -- the facts are she was a
17 young woman with a history of back and leg
18 problems that had some problems on and off for
19 years. She was functional.
20 Approximately, I believe, two months -- I
21 would have to check the record to make sure --
22 before I saw her, she had a flare-up of these
23 problems. She was taken care of and treated by
24 Dr. Abood.
25 During that time, she developed pain,

1 weakness, had increasing difficulty functioning,
2 continued to have treatments by Dr. Abood, and
3 continued to have increasing complaints of pain,
4 weakness, and inability to function.
5 She sought help or sought -- "help" is not
6 the right word, sought an answer, had an MRI scan
7 at The Cleveland Clinic, which showed a large
8 disk herniation. She was told to follow up.
9 She hurt so bad she saw Dr. Leb, who
10 evaluated her and said "This is terrible."
11 She was sent to my office where I evaluated
12 her and said, "You have a large disk herniation,
13 pain, weakness." Trying further nonoperative
14 therapy is probably not in her best interest.
15 And we proceeded with surgery shortly after that.
16 Q. So it is your understanding that she had some
17 sort of a flare-up of her chronic back condition
18 that is what prompted her to come under
19 Dr. Abood's care in the first place?
20 A. Yes. That, and I think she worked for him.
21 Q. Did you have any understanding from anything you
22 have read or reviewed in this case that because
23 she worked for him that she had to treat with
24 him?
25 A. No. 1 mean, she wasn't -- I wasn't under the

1 impression that she was forced into being treated
2 with him, or manipulated into being treated with
3 him.
4 Q. She had back problems and sought his care?
5 A. I wasn't sure on that. I mean, she had back
6 problems, she worked for this gentleman, and my
7 memory is that he offered to help her is what --
8 that is by memory from now three years ago.
9 Q. And your memory is that she accepted that offer?
10 A. Yes.
11 Q. And willingly subjected herself to his care?
12 A. At least at the beginning, yes.
13 Q. Do you know from your recollection of the case
14 whether she sought the care of any other medical
15 doctors during the time interval that she was
16 treating with Dr. Abood?
17 A. Not to my knowledge. I remember from sometime in
18 reviewing this case that she was seen by Dr. Reed,
19 or something in that time period, and he decided
20 not to treat -- by my memory, decided not to
21 treat her further. But no, not that she saw any
22 other medical doctors.
23 Q. Your understanding of her history and the facts
24 of the case is that while she treated with
25 Dr. Abood she was experiencing pain, weakness,

1 increasing difficulty of functioning, and that
2 those complaints continued while she treated with
3 him. What is the source of that information?
4 A. Ms. Glasser.
5 Q. Any other sources for that information other than
6 the patient, herself?
7 A. Possibly part of that was her husband the first
8 or second time I saw her. I mean, he talked
9 about she kept getting worse while she was being
10 treated. But no, not that I know of.
11 Q. So you are relying upon the history obtained from
12 both the patient and her husband in providing you
13 with that information about her course while
14 under Dr. Abood's care?
15 A. That's correct.
16 Q. So you did see Mr. Glasser once or twice early on
17 when you were caring for Mrs. Glasser?
18 A. I remember seeing him and her the first time I
19 saw her the morning of surgery in the hospital,
20 and afterwards in the first couple of appoint-
21 ments.
22 Q. You mentioned that she went to The Cleveland
23 Clinic and had an MRI. Did she bring the MRI to
24 you, and did you have a chance to see that film?
25 A. Yes.

1 Q. Did she bring to you at that point prior to
2 surgery any other of her prior films?
3 A. I would have to check my note. Let me do that.
4 No, my note from October 9 shows only an MRI
5 from The Cleveland Clinic. I have no notation of
6 any others.
7 Q. You may want to keep that note handy. I am going
8 to ask you a couple other questions since you
9 have that out.
10 The note of your first visit with the
11 patient is actually in the form of your letter to
12 Dr. Frolkis?
13 A. That's correct.
14 Q. And your practice would be to dictate this sort
15 of note to the referring physician shortly after
16 your initial visit with a patient that has been
17 referred to you?
18 A. Yes. As soon as they walk out the door, I
19 dictate my notes.
20 Q. So we wouldn't find any other substantive
21 handwritten notes; your typewritten notations
22 really are the best memorialization of your
23 office contact?
24 A. That's correct. There may be a scribbled sheet
25 of paper that says something like "40, back,

1 leg," and then, if it is in here, I don't know
2 what it means now, and most of the time I throw
3 it away because I have this.
4 Q. Based on your initial visit with the patient, can
5 you tell us what were her subjective complaints,
6 on the one hand, then also tell us what were your
7 physical exam findings, which would be the more
8 objective findings, of her condition at that
9 point?
10 A. Her physical complaints when I saw her were back
11 and leg pain, and that she could not walk more
12 than five or ten feet, and spent most of her time
13 at home in bed taking pain medicine.
14 Q. Did she give you a history to indicate when she
15 had the onset of the back and leg pain?
16 A. I am sure she did, but I don't have it recorded
17 specifically as to the exact time in the note.
18 Q. At the point when you first saw her on October 9,
19 were there any complaints of numbness or
20 tingling?
21 A. There may have been, but I don't have it recorded
22 in this note.
23 Q. If she had complaints of numbness and tingling,
24 would those be significant to you in evaluating a
25 patient who is coming in with this type of

1 history of low back complaints?
2 A. Yes.
3 Q. would it be fair to say that based on what you
4 dictated you tried to capture in your dictation
5 the most remarkable or noteworthy of her
6 complaints?
7 A. That's correct.
a Q. And what did you find on physical exam?
9 A. On physical exam, she was a female who hurt.
10 That is what it means by "in acute distress."
11 She had positive straight-leg-raising on the left
12 at 60 degrees, and positive cross straight-leg-
13 raising on the right to the left side from 60
14 degrees.
15 She had weakness of dorsi and plantar
16 flexion of her left foot. That is her ability to
17 move her foot up and down. And she had a
18 decreased ankle jerk. And I have that she had
19 numbness. So yes, there is a notation that she
20 had numbness in the medial three toes of her left
21 foot, so I did check for that. I stand corrected.
22 Q. You checked for that, pin prick test?
23 A. Yes.
24 Q. When you refer to "knee jerk" and then also
25 "ankle jerk," what are you referring to?

1 A. I am referring to the neurologic test in which a
2 force is applied to any muscle or tendon, and
3 when it is stretched by the tap, it conducts up
4 the spinal cord and then to another neuron and
5 down the spinal cord, and it kicks out -- this
6 isn't before a jury, but for the jury, it would
7 be the kind of thing you see on the Three Stooges
8 where the leg kicks out.
9 Q. When one refers to a knee jerk or an ankle jerk,
10 would that be equivalent to referring to an ankle
11 reflex or knee reflex?
12 A. I am sorry, yes.
13 Q. So the terminology "knee jerk," "ankle jerk" --
14 A. Knee reflex, ankle reflex. Different nomenclature.
15 Q. And when you saw her on the 9th, the knee jerk or
16 knee reflex was intact, which would mean that it
17 was normal?
18 A. That's correct.
19 Q. However, in the left ankle you found a slightly
20 decreased ankle jerk or ankle reflex?
21 A. That's correct.
22 Q. And you found numbness of the medial three toes
23 of her left foot. And that would be based on a
24 pin prick exam, or something similar?
25 A. Yes.

1 Q. And this does reflect that you looked at her MRI
2 from The Clinic which showed a large left side
3 L4-5 disk with a severe compromise of the spinal
4 canal?
5 A. That's correct.
6 Q. Is that your interpretation, or did you record
7 what was written in a radiology report from The
8 Clinic?
9 A. That would be my interpretation.
10 Q. By the way, did you ever talk to any of the
11 doctors from The Clinic about this patient at any
12 time?
13 A. No.
14 Q. You state your impression is that she has a
15 herniated disk.
16 A. That's correct.
17 Q. I know different doctors in literature and books
18 will refer to different categories of herniated
19 disk, using such terms as prolapse, bulging,
20 sequestered, things of that nature.
21 Do you recognize any sort of nomenclature
22 when it comes to talking about disk involvement,
23 disk disease?
24 A. No. I know of no universally or by convention
25 accepted nomenclature for disk disease. I can

1 tell you what herniated means to me.
2 Q. That is fine. How did you use that term when you
3 wrote your letter to Dr. Frolkis?
4 A. When I use the term ''herniated,"a piece has gone
5 through the ligament and extruded out. It may be
6 still contiguous, but it has gone through and is
7 still sticking out. It is just not bulging or,
8 as you referred to, prolapsed or stretched.
9 There is literally a piece that has stuck out
10 through the ligament.
11 Q. Your recommendation was to schedule her for
12 surgery?
13 A. That's correct.
14 Q. So you found her to be a surgical candidate as of
15 her condition when she presented to you on
16 October 9?
17 A. Yes.
18 Q. Do you know if any of the doctors she had seen
19 before she came to you recommended surgery?
20 A. I do not know.
21 Q. And you scheduled her for October 14?
22 A. That's correct.
23 Q. How would you categorize the urgency of her
24 condition when you saw her on October 9? Was
25 this an emergent case, urgent case, one that had

1 to be scheduled that night -- I am sure you have
2 seen those kind of cases over the years -- or did
3 she have a little bit more time or leeway in
4 getting her into surgery?
5 A. I guess the term I would use is it had to be done
6 expeditiously. And just for her comfort, I would
7 want to do it sooner rather than later because
8 this woman was obviously in pain when I saw her
9 that day.
10 Q. Was pain the most predominant feature of her
11 presentation when she came to see you that day?
12 A. Yes. She had difficulty sitting. Most of the
13 exam was done with her lying on her back. I
14 talked to her with her lying on her side because
15 she just couldn't get comfortable.
16 Q. If we can go to your next office visit or your
17 next notation in your chart, which I have as
18 being dated 10/11/96, do you have that?
19 A. Yes.
20 Q. This appears to be a telephone call that the
21 patient had with you.
22 A. I believe so. That is my standard practice.
23 Q. At this point she told you that she was again in
24 extreme pain and has numbness and tingling around
25 her perineum. Was that a new report or a new

1 complaint, that of the numbness and tingling
2 around the perineum?
3 A. I don't remember if that was a new complaint or
4 an increase of a complaint she gave me earlier.
5 I just don't remember now.
6 Q. Is it fair to say that there is nothing in your
7 report to Dr. Frolkis that mentioned any
8 involvement of numbness or tingling in the
9 perineal area?
10 A. No, there was not.
11 Q. Assuming that Mrs. Glasser did not have numbness
12 and tingling around her perineum when she saw you
13 on October 9, would this complaint represent a
14 change in her condition?
15 A. Yes.
16 Q. Would it represent a worsening of her condition?
17 A. Yes.
18 Q. You asked her a number of questions to explore
19 her comments to you. And she told you that she
20 could still feel things, that she was not
21 incontinent, and she did not have any accidents.
22 Does the reference to "accidents" refer to
23 bowel or bladder accidents?
24 A. That's correct.
25 Q. Is it fair to say that you were concerned about

1 this developing into a cauda equina situation
2 when you got that telephone call from her on
3 October 11?
4 A. That's correct.
5 Q. But at the point when she was calling you, she
6 did not seem to have the symptoms of a cauda
7 equina?
8 A. No, she did not. How do I put it -- no.
9 Q. You go on in your note to indicate that if she
10 developed symptoms involving incontinence or
11 inability to urinate, you would want her to
12 notify you, and you would do this as an emergency
13 case.
14 A. That's correct.
15 Q. Otherwise, the surgery would remain scheduled for
16 the following Monday, which was the 14th?
17 A. That's correct.
18 Q. Do you have in your records any of the notes from
19 Mt. Sinai other than your operative note? I know
20 that the operative note is there, but do you have
21 any of the hospital records themselves?
22 A. I don't know, unless they are in here. I have my
23 operative note, and I don't believe they are.
24 No, not to my knowledge. I have my operative
25 note.

1 Q. Did you check the patient's Babinski or do a
2 Babinski test with the patient when you saw her
3 on October 9?
4 A. I assume so, but I don't remember.
5 Q. I am going to ask you to assume, based on the
6 review of the Mt. Sinai records, that when the
7 patient came in on Monday, October 14, for the
8 surgery, that at that time she was complaining of
9 numbness and tingling in her perineal and
10 perirectal area; that she complained of
11 significant numbness and tingling to the left
12 leg, and a decreased sensation to urgency.
13 If those notations appear in the Mt. Sinai
14 records, would that suggest or indicate a
15 worsening of Mrs. Glasser's back condition?
16 MR. RUF: Objection. Have you
17 obtained records that have not been produced to
18 me?
19 MS. VANCE: No. Everything has
20 been produced that we have.
21 MR. RUF: Go ahead.
22 A. It can, yes.
23 Q. What would an increase in Babinski refer to, a
24 positive Babinski test?
25 A. Well, if it is a positive Babinski, I probably

1 didn't write it.

2 Q. That is not a test you typically do?

3 A. No, I do. But when I write "positive Babinski,"

4 to some people that means you scratch the bottom

5 of the foot and toes go down, which is normal,

6 hence it is positive.

7 Other people say a positive Babinski is when

8 I scratch the bottom of the foot and the toe goes

9 up, which is positive for an abnormality. So I

10 try not to use "Babinski." I try to use "plantar

11 reflex."

12 Q. If the reference to the Babinski meant that the

13 toes went up, would that mean an abnormality?

14 A. Yes.

15 Q. And assuming that that was found when the patient

16 was at Mt. Sinai, how would that compare to the

17 exam you performed when you saw her on October 9?

18 A. Assuming the toe went up -- and since I didn't

19 make a notation of it on the 9th, I assume the

20 toe went down at that time -- that that would be

21 a change.

22 Q. And a change for the worse or the better?

23 A. It would be a change -- it is a bad sign.

24 Q. Do you know if the patient ever developed any

25 bowel or bladder symptoms before the surgery that

1 you performed on October 14?
2 A. I recall from the records some complaints, vague
3 complaints, in the past of some trouble voiding.
4 And if I remember correctly, I think she had some
5 female problems.
6 Q. Is a decreased sensation to urgency, again, a
7 sign of a cauda equina concern?
8 A. It could be. I am not sure what a decreased
9 sensation to urgency means. I mean, urgency
10 isn't normal, so --
11 Q. Have you seen any of the records from
12 Dr. Frolkis? Have you had any of those provided
13 to you?
14 A. I may have. Here they are.
15 Q. Do you have his October 1, 1996 note?
16 A. Yes.
17 Q. In that note, does Dr. Frolkis indicate that the
18 patient had excruciating low back pain and pain
19 in the left lower extremity for one week or for
20 the last week?
21 A. Yes.
22 Q. He indicates negative bowel and bladder symptoms?
23 A. That is what he says.
24 Q. He found there to be a normal neurological
25 examination of the legs, except a possible

1 weakness of the left great toe?
2 A. That is what he says.
3 Q. Then on October 3, the patient called, or the
4 patient's husband called, one or the other.
5 There was a telephone call with his office.
6 A. Okay.
7 Q. And she mentioned, again, the excruciating pain
8 and hearing a cracking noise when she leans over.
9 A. Yes.
10 Q. And then on October 4 another phone call, this
11 time from the husband, again the reference to the
12 excruciating back pain, and also a mention of
13 radicular pain down her leg.
14 Do you see that noted there?
15 A. Yes.
16 Q. Just in these three notations from Dr. Frolkis's
17 office, in particular reference to the pain down
18 the left leg, does that seem to be an increasing
19 or worsening of her condition, based on what
20 Dr. Frolkis found in his neurological exam on
21 October 1, compared to what the husband is
22 complaining of on October 4?
23 A. I can't say that. I can say that it is a
24 notation by Dr. Frolkis that the husband either
25 had the same concerns again and again, or it

1 could be an increase. I just can't say. I don't
2 know.
3 Q. Dr. Frolkis does note a normal neurological
4 examination of the legs, except for the possible
5 weakness of the left great toe.
6 A. That is what he has recorded on October 1, 1996.
7 Q. Do you have the records there of The Cleveland
8 Clinic? Have you been provided with any of those
9 records? And specifically I would refer you to
10 the visit on October 7, 1996.
11 A. Yes.
12 Q. When she came to The Cleveland Clinic on October
13 the 7th, she was examined. And did they find
14 that there was a positive finding of numbness?
15 A. I see a notation that records decreased
16 sensation. So I assume that is what you mean by
17 "numbness."
18 Q. Does that refer to the decreased sensation of the
19 left lateral calf?
20 A. It just says lower extremity here. "LE" I assume
21 is lower extremity. "Motor positive. Reflex is
22 positive. Decreased sensation," yes, "left
23 lateral calf." I can make that out.
24 Q. "Left lateral foot," is that also noted there?
25 A. I don't see that. Maybe you can help me.

1 Q. Do you have another page of -- or is that
2 something else?
3 A. That is something else, the emergency department.
4 Q. Right. That is where she was seen on the 7th.
5 A. Oh, I am looking at a written -- "decreased
6 sensation on the outside of the left foot and
7 calf." Yes, it says that here.
8 Q. Does it make reference there to "numbness," too,
9 in that typewritten note?
10 A. "Pain radiating left lower extremity accompanied
11 with numbness, decreased sensation in lower
12 extremity."
13 Q. Given that Dr. Frolkis's exam showed a normal
14 neurological exam of the legs, and now at The
15 Cleveland Clinic on October 7 we see a reference
16 to numbness and a decreased sensation of the left
17 lateral calf, left lateral foot, would that seem
18 to indicate a progression or a worsening of her
19 condition?
20 A. It could.
21 Q. The Cleveland Clinic tested her reflexes and
22 found the left reflexes to be equal and normal.
23 A. Yes.
24 Q. And when you tested the patient on October 9, you
25 found there to be a slight decrease of the left

1 ankle reflex?
2 A. That's correct.
3 Q. So that would represent, from The Cleveland
4 Clinic visit to when you saw her on the 9th, a
5 change of her condition, a worsening of her
6 condition?
7 A. Yes.
8 Q. Do you have the records there of Dr. Leb,
9 orthopedic surgeon?
10 A. Yes.
11 Q. When Dr. Leb saw her on October 8th, which was
12 one day before you saw her and one day after The
13 Clinic visit, he examined the patient and found
14 there to be positive straight-leg-raising.
15 Is that true?
16 A. I assume the typed note -- yes, okay.
17 Q. And that is the same thing that you found the
18 following day, a positive straight-leg-raising?
19 A. Yes.
20 Q. He noticed a mildly positive cross straight-leg-
21 raise.
22 A. That's correct.
23 Q. However, you found a positive straight-leg-raise
24 right to left at 70 degrees?
25 A. Yes.

1 Q. Is that equivalent, or does your finding suggest
2 any change or worsening of her condition?
3 A. No, it may be the exact same exam.
4 Q. Dr. Leb noted numbness down the entire left leg,
5 all the way down to the toes, especially in the
6 great toe.
7 A. Okay, yes.
8 Q. Does that suggest a worsening of the numbness
9 condition from which she had just the day before
10 at The Cleveland Clinic?
11 A. No. I mean, because the note from The Cleveland
12 Clinic says "Decreased sensation on the outside
13 of the left foot and left calf."
14 Q. Do you interpret Dr. Leb's notation to make
15 reference to numbness down the entire left leg,
16 all the way down to the toes?
17 A. I don't know if that is her complaint or his
18 exam, because that is under "subjective." So I
19 assume that is her complaint.
20 Q. And her complaint, if it is subjective, was of
21 numbness down the entire left leg?
22 A. That is what it says.
23 Q. Dr. Leb did not find any bowel or bladder
24 involvement. That was still negative; is that
25 right?

1 A. Let me find all that. I don't see that notation.
2 You will have to help me.
3 Q. In his letter to Dr. Frolkis dated October 21.
4 A. Okay.
5 Q. Last line under "Objective."
6 A. Okay.
7 Q. He found that she had "Numbness in the L5 nerve
8 distribution. She denies any bowel or bladder
9 symptoms, and she has no groin numbness."
10 A. That is what he says.
11 Q. He is reporting what she reported to him back on
12 October 8?
13 A. I assume so, yes.
14 Q. You are not aware that she saw him any other day
15 other than the October 8 visit?
16 A. No, not that I know of.
17 Q. And, again, when you received a phone call from
18 the patient on October 11, she was mentioning
19 numbness and tingling around the perineum when
20 she called you on October 11; is that right?
21 A. I believe so, yes.
22 Q. Whereas three days earlier, Dr. Leb's note would
23 indicate that she did not have any groin numbness
24 of any kind.
25 A. Dr. Leb's letter of the 21st, referring to the

1 8th, says that, yes.
2 Q. And assuming that Dr. Leb's letter of the 21st
3 was an accurate recitation of how the patient
4 presented to him on October 8th, in not
5 complaining of groin numbness at that time, would
6 the complaint to you in the telephone call on
7 October 11 represent a change or a worsening of
8 her condition?
9 A. It could.
10 Q. You made a diagnosis for the patient when you saw
11 her on October 9 that she had a disk herniation?
12 A. That is correct.
13 Q. And you have already told us what you mean by
14 that term. Did your diagnosis for the patient
15 change from October 9 to the day of your surgery
16 when you saw her in the operating room on October
17 the 14th?
18 In other words, based on your intraoperative
19 findings, did that change or modify your diagnosis?
20 A. No.
21 Q. Was there anything about your findings in the
22 operating room that were either different from
23 what you expected in terms of severity or
24 magnitude from what you were anticipating when
25 you saw the patient in your office on the 9th,

1 you saw her MRI film from The Clinic, compared to
2 the preoperative evaluation that you had of her?
3 Did you find anything intraoperatively that
4 surprised you or you thought was unexpected?
5 A. I remember I thought the surgery was technically
6 more difficult than I would have given it credit
7 for beforehand.
8 Q. Otherwise, other than it being more technically
9 difficult, was there anything else about the
10 surgery that you performed that you were not
11 expecting, based on, again, your pre-op evalua-
12 tion and the imaging that you had available to
13 you?
14 A. That's correct.
15 Q. When you operated on her, and I see you have your
16 op. note in your hands, did you find any signifi-
17 cant scarring in the area of the L4-5 level where
18 you were operating?
19 A. I don't make any notations about the severity or
20 the presence of scarring.
21 Q. Would you expect that a patient with her history
22 of many years of disk problems, bad back
23 problems, would develop scarring from the
24 presence of a disk if she had not undergone any
25 prior surgery?

1 A. No.
2 Q. In other words, just the presence of call it
3 bulging, protruded, short of herniation, using
4 your definition, would the presence of that sort
5 of disk disease lead to scarring?
6 A. It can, but not regularly, and not with any
7 predictability.
8 Q. And you, based on your operative note, are not
9 commenting on anything significant in the way of
10 scarring that you had encountered or adhesions or
11 anything of that nature that you needed to work
12 through before you were able to remove the disk?
13 A. No. I commented on the large size of the disk.
14 Q. Are you able to formulate a diagnosis of the
15 patient based on your findings and your exam of
16 her on October 9?
17 Are you able to formulate any sort of
18 diagnosis as to what her condition was, let's say
19 on August 1, 1996, before she began to treat with
20 Dr. Abood?
21 A. I can formulate an opinion.
22 Q. What would your opinion be based on --
23 A. The history --
24 Q. -- since you didn't see her on August 1?
25 A. On the history and the findings at surgery.

1 Q. Based on the history obtained from the patient?
2 A. That's correct.
3 Q. And based on your findings at surgery in October,
4 you can go back and formulate an opinion as to
5 what her diagnosis would have been on August 1?
6 A. It can help me formulate an opinion. Most of the
7 opinions would be based on the history.
8 Q. Based on the history from the patient?
9 A. That's correct.
10 Q. Or her husband?
11 A. That's correct.
12 Q. And based on that history, what would your
13 opinion be as to her diagnosis as of August 1,
14 1996?
15 A. That she had a bulging disk at that time.
16 Q. And what specifically about the history would
17 inform you to reach the diagnosis of bulging disk
18 versus any other classification of disk?
19 A. I have knowledge that she had a previous MRI
20 scan; that she had been seen by a previous
21 neurosurgeon and other physicians for this, and
22 that the MRI showed a bulging or at least a less
23 herniated disk than what I saw on her studies in
24 1996.
25 Q. You say "less herniated." Do you allow for the

1 fact that her disk may well have been herniated
2 under your diagnosis even on August 1, 1996?
3 A. Yes, that could have been.
4 Q. Could you form an opinion as to her diagnosis as
5 of September 1, 1996?
6 A. Yes, I could form an opinion.
7 Q. What would that opinion be based on?
8 A. Her history.
9 Q. And what about her history would enable you to
10 formulate an opinion as to her condition on
11 September 1?
12 A. Once again -- would you repeat the question.
13 Q. Bad question. Let me try again.
14 What information did she convey in her
15 history that would enable you to form an opinion
16 as to her diagnosis on September 1?
17 A. I would have to check the dates specifically, but
18 it was my recollection of her history that her
19 symptoms were getting worse.
20 Q. So you would formulate a diagnosis based on
21 history obtained from the patient, and/or her
22 husband describing her symptomatology while she
23 was under Dr. Abood's care?
24 A. That's correct.
25 Q. You have been provided, I know, with Dr. Abood's

1 treatment records.
2 A. Yes.
3 Q. Have you looked at those and do you, as a
4 neurosurgeon, take anything away from his
5 chiropractic records that would help in forming
6 these opinions?
7 A. I looked at those records, and I do not under-
8 stand his notations.
9 Q. You don't understand the type of notations he
10 makes, as a chiropractor, and what his notations
11 would mean to a chiropractor, or to anyone else
12 for that matter?
13 A. Or to anyone else. It is like ophthalmologists,
14 they may have their own language. I don't know.
15 Q. You would have a hard time reading ophthalmology
16 records if I presented them to you, too?
17 A. They are out there, yes.
18 Q. At any point while you were treating the patient
19 from October 9 through the surgery and your
20 surgery findings, did you ever reach the
21 conclusion or form a diagnosis that this patient
22 had cauda equina syndrome?
23 A. No, I did not.
24 Q. In fact, as you look at all of your findings,
25 would you say that she did not have cauda equina,

1 if asked that?
2 A. Yes.
3 Q. Based on your intraoperative findings, when you
4 actually have the patient on the operating room
5 table and you are looking at her disk, is there
6 anything about the conditions that you found in
7 surgery that would tell you when her disk
8 herniated, as you define that term?
9 A. Not from the operative record. I would say
10 before October 14, 1996.
11 Q. Other than saying it was before when you opened
12 her up, can you be any more specific or put any
13 other kind of time frame on what you found at
14 surgery?
15 A. What I found in surgery looked very similar to
16 what I would have predicted based on the MRI
17 scan.
18 Q. But can you date the herniation based on what you
19 find intraoperatively to say that it happened
20 either to a date certain, or can you even pin it
21 down to a 30-day time frame, 60-day time frame?
22 Can you be that specific based on what you found
23 intraoperatively?
24 A. I would say it is less than three months.
25 Q. Why do you say that?

1 A. Because I didn't comment on the scarring. And
2 after three months of a significant disk
3 herniation and pressure, I would expect to see a
4 lot of capillaries and scarring in the area, and
5 I didn't comment on that in my operative note, so
6 sometime -- it didn't happen seven months ago or
7 a year ago.
8 Q. So you can say that it happened probably within
9 three months, but whether it was two weeks prior
10 or 12 weeks prior, you would not be able to get
11 that specific?
12 A. Right.
13 Q. You can't call it that close?
14 A. Right. I mean, it is a bell curve. I would say
15 it is -- no, no.
16 Q. Is there anything about the pathology report, if
17 you have that with you, the surgical pathology,
18 that would speak to the same issue of the dating
19 or the age of the disk that you removed?
20 A. I would have to --
21 Q. Here is a copy of it.
22 A. No.
23 Q. You followed the patient for nearly a year, I
24 believe, after the surgery, as we talked about
25 earlier. If you can go to some of your post-

1 operative notes, I just want to sort of trace
2 some of her changes and improvements postopera-
3 tively.
4 A. Okay.
5 Q. Your first post-op visit is October 29, '96?
6 A. That's correct.
7 Q. And she complained that she still has some
8 numbness in the pelvic area and buttocks area?
9 A. That's correct.
10 Q. And that would, again, relate to the perineal
11 complaints that she mentioned in the phone call
12 to you?
13 A. Yes.
14 Q. You said that she has a decreased left ankle
15 jerk, she has weakness of plantar flexion of her
16 left foot, but her dorsiflexion is much better?
17 A. That's correct.
18 Q. Still has numbness of the three lateral toes on
19 the left foot, I imagine?
20 A. That's correct.
21 Q. Negative straight-leg-raising on the right, and
22 tightness of the hamstring on the left, but no
23 positive straight-leg-raising sign anymore.
24 That would be an improvement over what you
25 found preoperatively?

1 A. Yes.
2 Q. Your impression is that she was making a slow but
3 good recovery?
4 A. That's correct.
5 Q. The next time you saw her was November 19?
6 A. That's correct.
7 Q. Again, she is complaining of the numbness in the
8 pelvic area, buttocks, and foot, and this, again,
9 is the same continuing complaint that we have
10 seen since preoperatively?
11 A. Yes.
12 Q. "The weakness to the plantar flexion of her left
13 foot is improved over what it was three weeks
14 ago. Her dorsiflexion is almost normal." So
15 just those two comments, again, would reflect
16 signs of an improvement, signs of recovery?
17 A. That's correct.
18 Q. "Still has the numbness in the lateral three
19 toes." You say, "By her own admission she is
20 doing much better. Doesn't look like she has any
21 straight-leg-raising to comment on."
22 A. Yes.
23 Q. And at this point, according to this note, she is
24 beginning to think of returning to work, at least
25 on a part-time basis, in about a month or so. Is

1 that about right?
2 A. Yes.
3 Q. In the middle of this November 19 note, you do
4 make a comment about "Her present problem centers
5 around cervical dysplasia of her cervix, and she
6 is going in for a cone biopsy."
7 Did she make any complaints of physical
8 discomfort from that condition?
9 A. Not that I remember specifically. I remember the
10 talk about she was concerned about she had had a
11 Pap test and it showed cervical dysplasia, and
12 she was thinking about putting things off because
13 it was so close to her previous surgical insult.
14 And hence my note commenting that "When you
15 are worried about cervical cancer, you have to
16 get that taken care of." But I don't recall
17 anything specifically at that time that she had
18 some complaints to it.
19 I know she had had some female problems and,
20 if I recall correctly, she had some gynecologic
21 problems before this.
22 Q. From her history, she had a history in the nature
23 of a vulvodynia?
24 A. That was it.
25 Q. From your standpoint as the neurosurgeon, do you

1 see any overlap, if you will, between the
2 complaints involving vulvodynia and these
3 perineal complaints that she expressed to you
4 shortly before surgery and then continuing on
5 postoperatively?
6 A. They are in the same area. I mean, the vulva is
7 part of the perineal sensation area. But I
8 couldn't tie the two together.
9 Q. Did vulvodynia involve complaints of either pain
10 or numbness or tingling or loss of sensation?
11 A. I believe so. I am the wrong person to ask about
12 that.
13 Q. Your next visit with the patient I think was
14 February 4 of '97.
15 A. Yes.
16 Q. She is now three months following the surgery,
17 still complaining of numbness and the decreased
18 sensation in her pelvic area and down her left
19 leg?
20 A. That's correct.
21 Q. She says sex feels unsatisfactory?
22 A. That's correct.
23 Q. Do you know, Doctor, if that is a consequence of
24 a vulvodynia, of her other female concerns, or of
25 the perineal numbness that she mentioned to you

1 prior to and following surgery, or a combination
2 of all three?
3 A. No, I don't know. It could be a combination of
4 all three. If I referred to this in relation to
5 her neurologic problems, my usual practice would
6 mean that it was due to decreased sensation.
7 Q. You go on to say that "She cannot feel well." Is
8 that a reference to the decreased sensation?
9 A. That's correct.
10 Q. "She is able to get up on her toes when walking.
11 She really does not have any back or leg pain"?
12 A. That's correct.
13 Q. "She has more discomfort and she fatigues easily.
14 She denies incontinence." In general, based on
15 those comments about her mobility, her ability to
16 get up on her toes, not having any back or leg
17 pain, are those all good signs of improvement?
18 A. Yes.
19 Q. "On physical exam she has a little weakness of
20 plantar flexion of her left foot, but it is
21 significantly better than it was, a slightly
22 decreased left ankle jerk compared to the right."
23 Again, are these signs or findings of an
24 improved condition?
25 A. Yes.

1 Q. "Negative straight-leg-raising bilaterally."
2 Your impression is that she is making good
3 progress?
4 A. That's correct.
5 Q. And just scanning through the next few notes,
6 April 10, I don't want to take up too much time
7 on this, July 15, as you look through those next
8 couple of office notes, tell me if you would
9 agree that she is generally showing improvement,
10 with the exception of some certain complaints
11 that just seem never to go away?
12 A. Yes.
13 Q. And the complaints that seem never to go away
14 involve the numbness in her perineum and down her
15 left leg?
16 A. That's correct.
17 Q. When we trace through her preoperative course
18 with some of those other doctors, I think we
19 found that when Dr. Frolkis examined her on
20 October 1 there was no neurological problems
21 involving the legs, but over the few days between
22 early October and October 9 she started to show
23 more signs of numbness, more signs of decreased
24 sensation, to the point where she called you on
25 October 11 with the numbness and tingling around

1 the perineum.
2 How do you, from I guess a medical standpoint,
3 neurological standpoint, disk standpoint, how
4 would you explain that progression of numbness
5 and tingling that we see noted in these records?
6 A. She had more complaints. How do I put this?
7 Q. Is the disk changing? Is the degree of herniation
8 getting worse, the progression getting worse?
9 What accounts for a patient having increasing
10 complaints?
11 A. The nervous system can tolerate a lot of insult
12 if it comes on slowly. However, when it loses
13 its ability to compensate for what has gone on,
14 the most minuscule of changes that we can't see
15 on repeated studies, and for all practical
16 purposes no change at all, people will have
17 increased symptoms.
18 Nobody knows the particular cause in each
19 case. What is hypothesized is things like free
20 radicals, acute phase reactants, a little more
21 edema. But when you get films that we look at to
22 see edema, there is no difference. I mean, she
23 just has more symptoms. I couldn't tell you the
24 exact cause of that.
25 Q. You didn't take serial MRIs, and we don't have

1 the availability of serial MRIs from October 1 up
2 to October 14 when you operated on her. Is that
3 true?
4 A. That's correct.
5 Q. The only MRI study we have is just the one
6 snapshot, if you will, that was done at The
7 Clinic on October 7?
8 A. That's correct.
9 Q. So what we have are subjective complaints that
10 you would agree with me seem to be increasing or
11 worsening over that 14 days from the first to the
12 14th?
13 A. They are certainly becoming more frequent, yes.
14 Q. Because we don't have serial MRIs over that time
15 period, we can't rule out the fact that the disk
16 is herniating more or putting increasing pressure
17 on those nerve roots?
18 MR. RUF: Objection.
19 A. No, we cannot rule that out.
20 Q. And have you seen in some patients that during a
21 period of time increasing symptoms, subjective
22 complaints, do correlate with increasing hernia-
23 tion, increasing degree of pressure on the nerve
24 roots?
25 MR. RUF: Objection.

1 A. Yes, I have seen that.
2 Q. And given this case and the lack of any MRI
3 findings, serially, are you able to say one way
4 or the other whether in this case the herniation
5 stayed the same but she is just complaining more,
6 or she is complaining more because the herniation
7 is increasing?
8 A. She had a very impressive herniation on the scan
9 on the 7th. And, as I stated earlier, my
10 findings at surgery were consistent with that
11 impressive herniation.
12 And the only other comment we have
13 discovered or noted about that was there wasn't a
14 significant amount of scarring, by my record.
15 Q. So it is conceivable that the degree of disk
16 herniation remained the same between the first
17 and the 14th?
18 A. That's correct.
19 Q. Or the 7th and the 14th, I should say, when that
20 MRI was taken.
21 A. Right. And if I had to bet, and I think of all
22 the patients I have taken care of in the past who
23 have had increasing complaints, the repeat MRIs,
24 even a week or two weeks apart, the vast, vast
25 majority of the time look the same.

1 Q. Is it because the MRIs can't capture subtle
2 enough change of disk change that could correlate
3 with the patient's increasing symptoms?
4 A. That is what we would like to think, but I can't
5 tell you. I mean, good MRIs in good hands by
6 good people with increasing complaints and/or
7 even increasing weakness, the vast, vast, vast
8 majority of the time the MRIs look very much the
9 same.
10 Q. When you operated and relieved the disk pressure,
11 we see over the course of weeks and months a
12 gradual improvement in many of Mrs. Glasser's
13 both subjective and objective preoperative
14 problems. Leg strength was getting better, toe
15 walking was improving, pain was diminished. Over
16 time she seemed to get a better knee reflex,
17 ankle reflex. A lot of things recovered; is that
18 fair to say?
19 A. Yes.
20 Q. Why is it that certain functions recovered nicely
21 in this patient, whereas the perineal numbness
22 and the numbness down the leg seemed never to
23 have improved?
24 A. I don't know. I mean, I can tell you I have seen
25 this before. I can give you the theory that the

1 nerves that supply sensation are unmyelinated,
2 they have less insulation, and so pressure on
3 those nerves will cause more symptoms and
4 complaints than pressure on the motor nerves that
5 allow muscles to work. That is one theory.
6 The other theory is certain nerves are a
7 little more sensitive, for reasons of anatomic
8 course.
9 The third is that the disk could have
10 pressed up, one little knuckle of it could have
11 pressed a little more on those nerves.
12 I can't tell you why.
13 Q. Following surgery of this nature, you are hopeful
14 that there will be some nerve recovery?
15 A. Yes.
16 Q. Even of those nerves that control sensation?
17 A. Yes.
18 Q. As well as the nerves that control motor
19 function?
20 A. That's correct. And there was some recovery of
21 those nerves, because she lost pain.
22 Q. Is there any either rule of thumb that one would
23 follow that would say that if you can operate on
24 a patient with a herniated disk before they
25 develop the perineal sensations or the

1 complaints, that the likelihood is that
2 postoperatively they won't have perineal problems
3 or complaints?
4 In other words, you intercept the problem
5 before it gets to the point that the patient has
6 perineal numbness, bowel and bladder function
7 loss, things of that nature?
8 A. Yes. There is a rule of thumb that the neuro.
9 problems do better prevented than treated after
10 the fact.
11 Q. And is there also in that same way of thinking a
12 certain course that will follow the onset of new
13 symptoms, progressive symptoms, worsening of
14 condition as a disk is left to be herniated and
15 it goes untreated?
16 In other words, is there any kind of a time
17 course that would correlate with first you have
18 pain, and then you will have a certain onset of
19 other symptoms, and a certain sequence, at the
20 far extreme of that would be the frank cauda
21 equina, when it gets really bad?
22 Is there a spectrum, if you will, of
23 problems, symptoms, findings, that one would
24 expect to have any kind of a sequence as a
25 patient's disk at this level of L4-5 is herniated

1 and left untreated?
2 A. No.
3 Q. Are cauda equina symptoms recognized as sort of
4 the end point of an untreated L4-5 disk?
5 A. No.
6 Q. What would be sort of the end point?
7 A. I mean, most people with a herniated L4-5 disk
8 don't even need surgery. So that is the first
9 thing.
10 The second thing is cauda equina syndrome
11 can be caused by a herniated disk at L2, L3, L4
12 or L5.
13 And third, it has to be a massive herniation,
14 and then it has to catch the nerves just right,
15 because a number of people have massive hernia-
16 tions and don't develop cauda equina syndrome.
17 It is very, very unusual.
18 Q. To what do you attribute Mrs. Glasser's symptoms
19 of the perineal injury, which, admittedly, is not
20 quite cauda equina, but her symptoms given the
21 size of her disk?
22 A. It was a big disk. I don't know how to answer
23 that. I mean, the doctor books and my experience
24 is that big disks are the ones with cauda equina
25 syndromes. I don't know if I answered your

1 question.
2 Q. Well, I am trying to understand or trace through
3 her chronology, if you will, of symptoms that
4 went from just very excruciating pain in early
5 October to the development of radicular pain down
6 the leg, onset of numbness, decreased sensation
7 in the lateral foot, then the lateral calf, then
8 the entire left leg; initially no complaints of
9 groin numbness, then we see the diminishment of
10 the ankle jerk, then we have a complaint of
11 numbness and tingling around the perineum, but
12 still no incontinence; to the day of surgery when
13 she is complaining of significant numbness and
14 tingling down the entire leg, significant
15 numbness in the perineal/perirectal area, and
16 what is being described as positive or
17 unfavorable Babinski finding and diminished
18 sensation to urgency. Are we watching a
19 progression of symptoms?
20 A. I don't know, because you have -- I don't know,
21 for a number of reasons. Number one, they are
22 different spots in time.
23 Number two, you have made, and it is not
24 necessarily true, an assumption that all
25 examiners and all historians are created equal,

1 so that you are getting the same consistent
2 findings from each physician along the way. And
3 you may or may not, because different physicians
4 have different areas of expertise, different --
5 how do I put this -- different light bulbs that
6 go off in their head when somebody gives a
7 complaint.
8 So when you ask me, "Did he say that," I can
9 only attest to the fact that he or she said that
10 at that time. But I don't know if it means the
11 same thing for them as it does for me.
12 Q. Given your experience in treating patients with
13 disks, all other things being equal, is this
14 listing of symptoms, in the order that it is
15 recited in these different records, recognizable
16 to you as a pattern consistent with a progres-
17 sively enlarging or progressively extruded disk
18 that is placing pressure on these nerve roots?
19 MR. RUF: Objection. He has
20 already answered that he doesn't know.
21 A. No. They are increasing complaints. I can't
22 tell you that it is an increasing disk herniation.
23 Q. So the pattern of these type of complaints
24 occurring in the sequence is not something that
25 one would recognize as being the signs of a disk

1 that we know is at the L4-5 level that is putting
2 pressure on the thecal sac at that region, and if
3 left untreated over a period of days or weeks
4 these are the kind of complaints or symptoms one
5 would expect to see in this sort of an order?
6 A. No, I can't say that.
7 Q. Are you able to say that this patient's disk was
8 not enlarging or expanding or extruding further
9 during the period of the 14 days prior to
10 surgery?
11 A. No, I would not be able to say that.
12 Q. In your experience, do you have patients who
13 present to you with a back condition that you
14 consider to be a surgical case and, like
15 Mrs. Glasser, you would like to see them
16 scheduled for surgery in the relatively near
17 term, ten days, two weeks at the outset?
18 Have you had cases like that?
19 A. Yes.
20 Q. On the other hand, have you had cases where it is
21 such a frank emergency that this patient needs to
22 get into the operating room immediately?
23 A. Yes.
24 Q. Taking the first category of patients, those who
25 are clearly surgical candidates, need to get

1 operated on, but we can wait ten days, two weeks,
2 or so, to do that, have you ever had any of those
3 patients have their conditions worsen at all
4 during the time that you were waiting to schedule
5 them for surgery?
6 A. No. I have had one patient that comes to mind
7 that complained a lot more and hurt so bad that
8 he pushed the right buttons so I came in on a
9 Saturday morning to do his disk, which was no
10 different by exam and everything else, because he
11 said "I can't pee" because he was tired of living
12 with the pain, and admitted that to me afterwards.
13 But no one who I was going to expeditiously
14 progressed.
15 Q. At least in Mrs. Glasser's case you were
16 sufficiently concerned that that might happen to
17 her that you told her, "If you have any new
18 complaints that involve incontinence or bowel or
19 bladder dysfunction, that she should call you,
20 and the case would be moved up and scheduled on
21 an emergency basis?
22 A. Yes.
23 Q. So, medically speaking, it is conceivable that a
24 patient's condition can worsen to the point that
25 what was an expeditious case can become an

1 emergency case?

2 MR. RUF: Objection.

3 A. That is true. And I mention those same caveats

4 to all my patients with lumbar disk herniations,

5 or significant bulges, even those that are not

6 going to have surgery. I tell them, "If you have

7 problems with incontinence, you have to call and

8 come in to the emergency room quick."

9 Q. And you tell them that because you recognize that

10 these patients with disk conditions can have a

11 worsening of their disk that can lead to those

12 symptoms of cauda equina?

13 A. That's correct.

14 Q. And how is it, physiologically, that a disk can

15 lead to cauda equina symptoms in patients?

16 A. A number of possibilities. Number one, the disk

17 herniates more.

18 Number two, there is bleeding or swelling in

19 the area.

20 Number three, I have had people who have

21 gotten injured who have a little bleeding in the

22 area, so the space is compromised.

23 And, number four, I don't know the etiology

24 of it.

25 Q. In your experience, can maneuvers that might be

1 thought of as simple movements of daily activity
2 cause a bulging disk to move from being in a
3 bulging state to a herniated state in that it
4 breaks through that ligament?
5 MR. RUF: Objection.
6 A. Yes, that can occur.
7 Q. And do you know patients who have had movements,
8 either, for example, sneezing, straining at the
9 bathroom, turning funny in bed, lifting something
10 heavy, things even as simple as getting in and
11 out of a car funny, can be enough of a quirky
12 motion that it can cause a disk to go from a
13 livable bulging condition to a herniated
14 condition?
15 MR. RUF: Objection.
16 A. I know they start complaining right after those
17 minor acts of living. I don't know whether the
18 disk pouched out more. We assume it does.
19 Q. Is it fair to say that sometimes it doesn't take
20 much to go from a nonsurgical state to being a
21 surgical candidate for patients if the disk is
22 already in some kind of a bulging or protruded
23 state?
24 MR. RUF: Objection. There has
25 been no foundation on any of these statements

1 applying to this specific case. Go ahead.
2 A. Yes, that is true.
3 Q. Doctor, did you form any opinion in this case at
4 all concerning any of the care or treatment
5 rendered by Dr. Randy Reed, who was another
6 chiropractor who saw Mrs. Glasser?
7 A. I didn't form any opinion as to that treatment.
8 I don't think he did much, if I remember
9 correctly.
10 Q. Are you aware of an orthopedic surgeon by the
11 name of Dr. Landsman? Do you know anybody by
12 that name?
13 A. Yes.
14 Q. Where does Dr. Landsman maintain his practice
15 now? Do you know?
16 A. He is, and it may be "was" shortly, at 26900
17 Cedar Road at the IMC, Independent Medical Center,
18 of Mt. Sinai Hospital. I heard he was moving to
19 Phoenix. I don't know if he has or is yet, but I
20 know he was in town a couple weeks ago.
21 Q. Did you know that Dr. Abood had referred the
22 patient to see Dr. Landsman prior to her visits
23 with Dr. Frolkis and the others in October of
24 1996?
25 A. I had no knowledge of that.

1 Q. Have you formed any opinion or do you consider
2 yourself qualified to form any opinion as to
3 Dr. Abood's care and treatment, chiropractically,
4 of this patient?
5 A. What do you mean by "chiropractically"?
6 Q. Do you feel qualified to address Dr. Abood's --
7 the nature and extent of his care and treatment
8 of this patient?
9 A. Yes, I feel qualified to make some opinions about
10 that.
11 Q. You told me earlier that you don't hold yourself
12 out as an expert in chiropractic. Is that true?
13 A. That's correct.
14 Q. What would be the basis, then, for you to feel
15 qualified to express any opinion about Dr. Abood's
16 care and treatment of this patient?
17 A. Rational patient care.
18 Q. Do you know specifically what type of care and
19 treatment Dr. Abood provided to the patient?
20 A. I know he gave chiropractic treatment.
21 Q. You know that based on conversation with your
22 patient, Mrs. Glasser, and her husband?
23 A. Yes, and the notations that I am not sure what
24 they meant.
25 Q. In Dr. Abood's records?

1 A. Right.
2 Q. Do you know specifically what type of chiropractic
3 treatment or care he provided to the patient?
4 A. I know he provided manipulations, that is all, by
5 the record and history.
6 Q. Do you know what kind of manipulation, how it was
7 performed, patient positioning? degree of force
8 applied, angle of force, things of that nature?
9 A. No. I remember Mrs. Glasser telling me that she
10 would sometimes lay on her side and he would do
11 the manipulations, and sometimes I believe on her
12 stomach and he would do the manipulations. But I
13 don't know and don't recall exactly what he did,
14 if she told me.
15 Q. Have you ever seen any manipulations performed by
16 a chiropractor?
17 A. Just once. I mean, and that was I was there with
18 a friend, so I wasn't there to study it.
19 Q. You have never trained with chiropractors or
20 spent any time rotating through a chiropractic
21 office in order to learn chiropractic techniques
22 or things of that nature?
23 A. That's correct.
24 Q. Are you familiar at all with the recognized
25 schools of thought of chiropractic and how

1 different chiropractors are trained at their
2 different chiropractic colleges?
3 A. No, I am not.
4 Q. So you wouldn't consider yourself an expert in
5 the straight type of chiropractic versus mixer
6 type of chiropractic versus diversified type of
7 chiropractic, et cetera?
8 A. No.
9 Q. You probably don't even know what those terms
10 mean; is it fair to say?
11 A. No, I do not know what those terms mean.
12 Q. What is your opinion that you have of Dr. Abood's
13 care and treatment of this patient?
14 A. Number one, there is no notation in the records I
15 saw, and maybe they are in those notations that I
16 can't make out because I don't understand, of
17 anything mentioning a neurologic exam, i.e.,
18 weakness, loss of sensation.
19 Q. Do you not find any notation of an exam, or not
20 find any notation of pertinent negative exam
21 findings or pertinent positive exam findings?
22 A. I found no notation that I could point to a
23 neurologic exam. I mean, maybe they are there
24 because I don't understand those scribbles, but I
25 saw nothing that I could see.

1 Number two, in the face of a treatment
2 protocol or treatment regimen, whatever he was
3 doing, with increasing complaints would cause one
4 to -- how do I put this -- reassess their
5 treatment.
6 Q. Anything else?
7 A. Number three, in the face of increasing
8 complaints, that your treatment isn't working,
9 asking for a study or help or a referral. Those
10 would be the three areas.
11 Q. When you prefaced those last two comments with
12 "increasing complaints," or "in the face of
13 increasing complaints," that, again, is a
14 reference to the history obtained from the
15 patient?
16 A. That's correct.
17 Q. And you are accepting as true the history she
18 provided to you that she was experiencing
19 increasing complaints while under the care of
20 Dr. Abood?
21 A. That's correct.
22 Q. Have you discussed this case with any of your
23 medical colleagues?
24 A. The legal case or the medical case?
25 Q. Well, separate them out in case the answer is

1 different.

2 A. The legal case, no. The medical case I might

3 have commented -- I think I called Dr. Leb

4 afterwards and told him what I found and told

5 Dr. Frolkis, medically, what I found. So I did

6 discuss it in that much.

7 And I discussed it with my partner, as is

8 notated in here, when she came back and had the

9 complaints and we had the follow-up MRI scan.

10 Q. Was that Ben Colombi?

11 A. Yes. But I did not discuss the legal case with

12 any of them.

13 Q. Did you discuss this case with any chiropractic

14 acquaintances? I don't know if you know any

15 chiropractors. But did you discuss this case to

16 solicit any chiropractic point of view at all?

17 A. I talk to chiropractors all the time, and I don't

18 remember talking to any specific chiropractor

19 about this case.

20 I do recall in the background asking some

21 chiropractor, and I don't even remember if it was

22 with this case, it was, "Do you guys still do

23 manipulation in face of a herniated disk?"

24 And that particular chiropractor, and I

25 don't know if it was a referral from the outside,

1 said something like, "No," or "You really have to
2 be careful."
3 But I didn't call any chiropractor and say,
4 "Hey, Jack, this lady who had this disk, what
5 would you do?"
6 Q. And that other comment you are referring to was a
7 very general statement, maybe not even connected
8 with this case?
9 A. It may not have been. It might have been to
10 educate myself.
11 Q. It may even have been before you saw Mrs. Glasser?
12 A. Right, right.
13 Q. Do you get referrals from chiropractors?
14 A. Often.
15 Q. So when you say you talk often to chiropractors,
16 is it most often in connection with referral of a
17 patient?
18 A. Referral of a patient or sending a patient back.
19 And you have referred to -- I don't know if you
20 referred to, or I am assuming some chiropractors
21 do some physical therapy in their offices, and I
22 have operated on some patients and sent them back
23 to their chiropractor to get physical therapy to
24 get going.
25 Q. You did a repeat MRI of the patient in July of

1 1997?
2 A. That's correct.
3 Q. About ten months or so after the surgery. The
4 repeat MRI showed either a retained disk fragment
5 and/or recurrent disk herniation at the surgical
6 site. Do you attribute any of the patient's
7 continuing complaints with perineal numbness,
8 numbness, tingling down the left leg, to what we
9 find on that MRI in July of 1997?
10 A. No, I do not.
11 Q. Why not?
12 A. Number one, it is rarely seen after things like
13 this that they have it.
14 Number two, going back and operating for
15 perineal numbness because of a recurrent disk or
16 a retained disk or scar is universally a failure.
17 So, to fill in your question, I would have
18 to say, if I took that out, that would make
19 things better. And, as my notes say, I don't
20 think that would do that. And I believe, as I
21 said, I discussed it with my partner, who
22 believed that. And I believe Dr. Bell at The
23 Clinic believed that, also.
24 Q. Do you think that there is a retained disk
25 fragment?

1 A. I don't know. I think there may be a small
2 piece, yes. If you asked me with a reasonable
3 degree of medical certainty, I would think that,
4 yes, there is a small piece of retained disk.
5 Q. Is that small piece of disk herniated?
6 A. It is scarred in there.
7 Q. Is there also the presence of significant
8 scarring at the surgical site?
9 A. There is some scarring, yes.
10 Q. The presence of that scarring, could that
11 scarring be contributing to any of her perineal
12 complaints and/or the complaints involving the
13 left leg, numbness and tingling?
14 A. Yes.
15 Q. Could the retained disk fragment be contributing
16 to those same complaints in the perineal area and
17 down the left leg?
18 A. Yes.
19 Q. Could disk herniation, that retained fragment, if
20 it is herniated and scarred in, could that be
21 contributing to these complaints of the perineal
22 area and down the left leg?
23 A. Yes.
24 Q. But what you are indicating is that even if those
25 findings are contributing to her complaints,

1 operating to remove those problems, the scarring,
2 the herniation, the retained disk fragment, are
3 unlikely to lead to a recovery of this neurological
4 function?
5 A. That's correct.
6 Q. And is it not likely to lead to a return of
7 function just because of the passage of time and
8 the fact that the nerves have been compressed for
9 such a long period of time; that going in now and
10 removing the source of pressure is unlikely to
11 lead to a recovery of nerve function?
12 A. There is that, and there is the other fact that
13 the spine surgeons I know will tell their
14 patients, "You herniated a disk on Monday, you
15 came to your doctor on Tuesday, and you had
16 terrible leg pain, spasm, leg numbness, and on
17 Wednesday we operated." We tell them beforehand,
18 "You may still have some numbness afterwards."
19 We hope and plan that the surgery will
20 improve pain and weakness, but numbness is one of
21 those things where --
22 Q. Using your example, if a patient herniates their
23 disk on Monday, sees the doctor on Tuesday,
24 operates on Wednesday, even with such a short
25 time course from herniation to surgery, one may

1 not recover numbness and tingling sensations?
2 A. Right. Some people will still have numbness and
3 tingling. They will tell us their pain is better
4 -- or, hopefully, with a good result they will
5 tell you their pain is better and their weakness
6 has improved.
7 Q. So because the numbness and tingling are the kind
8 of symptoms that are difficult to correct, it is
9 unlikely that any surgeon is going to go in and
10 operate in hopes of recovering and restoring
11 those functions?
12 A. I would hope so.
13 Q. I asked you a moment ago if retained disk
14 fragment, herniation of that fragment, and
15 scarring could even be contributing to the
16 complaints that Mrs. Glasser has today.
17 Would you agree that those three factors,
18 taken together, are the major cause of her
19 continuing complaints, the major contributing
20 causes to her continuing complaints?
21 MR. RUF: Objection.
22 A. No, I would not say that.
23 Q. What do you think is the major contributing cause
24 to her continuing complaints?
25 A. She has permanent injury from the original

1 insult.

2 Q. And going back to your example of what doctors
3 tell patients, not to get their hopes up for
4 return of numbness and tingling problems, it
5 sounds like those are the kind of symptoms that
6 can be adversely affected even under a short time
7 course from the time that their disk herniates to
8 the time that they can present to their doctor?

9 A. That's correct.

10 Q. In other words, the loss of those symptoms or
11 the loss of those feelings or sensations and
12 perhaps --

13 A. It is not even the loss, it is altered.

14 Q. All right. The altered sensation is not a
15 function of time, so much, it is just a function
16 of the fact of the disk herniation?

17 A. And the damage to the nerve.

18 Q. And such damage can happen quickly or it can be a
19 gradual process over a period of time?

20 A. Yes.

21 Q. I think I am just about done. Can I see your
22 file and see if there was anything in those
23 letters I stood up that I need to ask you about?

24 Doctor, I am going to hand you what was in
25 your file, which appears to be a letter that you

1 wrote to Attorney Cary Zabell on April 3, 1998.
2 First of all, can you confirm that that, in
3 fact, is a letter, and that is what it was?
4 MR. RUF: Objection and move to
5 strike any reference to that letter.
6 A. I go on?
7 Q. Yes. Is that what that --
8 A. Yes, that is.
9 Q. Can you tell from your dictation what information
10 you had available to you to review or look at
11 before you prepared that letter to Attorney
12 Zabell?
13 MR. RUF: I have a continuing
14 objection to any discussion of that letter.
15 MS. VANCE: Yes, you do. That is
16 fine.
17 A. I don't know what I -- I mean, I had my records.
18 Q. Did you have any records from the chiropractor?
19 A. I don't refer to them here, so I can't tell you.
20 I mean, I may have. I just don't know.
21 Q. Can I direct your attention to the second page,
22 the second last paragraph, and just if you can
23 review the sentence that begins with "With the
24 information I have --" you can review anything
25 else you want, as well, but that is what I am

1 interested in.
2 A. "As far as your questions going, first of all,
3 looking at the patient information form you were
4 kind enough to forward a copy of --" I don't
5 know, that may have been a copy of Dr. Abood's
6 patient information form.
7 Q. Can you continue reading on in that paragraph?
8 A. "With the information I have on the form, I would
9 have no difficulty considering conservative
10 therapy for her low back problems."
11 Q. Is that a comment with regard to Dr. Abood's
12 therapy?
13 A. I don't know what I am -- I mean, whatever that
14 form is, based on what is on the form, you could
15 consider conservative therapy. But I don't
16 remember what the form is. I mean, it may have
17 been Dr. Abood's intake. It may have been
18 something -- I just don't remember now.
19 Q. I am showing you a copy of a letter from Attorney
20 Zabell to you dated February 26, 1998. Does that
21 refresh your recollection as to what information
22 you had available to you when you wrote your
23 letter to Mr. Zabell of April 3?
24 A. As I assume that is it, "Patient information form
25 copy attached." Whatever she filled out for the

1 patient, or whatever is recorded on the patient
2 information form.
3 MR. RUF: Continuing objection to
4 that document, as well.
5 Q. I am going to keep these standing up. And if I
6 can arrange to get copies of those tomorrow when
7 your secretary is back in.
8 A. Sure.
9 MS. VANCE: I don't believe I have
10 any further questions, Doctor. Thank you very
11 much, I appreciate your time here today.
12 THE WITNESS: Okay.
13 MR. RUF: Doctor, would you like
14 to read this transcript, or do you want to waive?
15 THE WITNESS: I probably should
16 read this.
17 - - -
18 (DEPOSITION CONCLUDED.)
19
20
21 ______________________________
22 MATT J. LIKAVEC, M.D.
23 - - -
24
25

CERTIFICATE

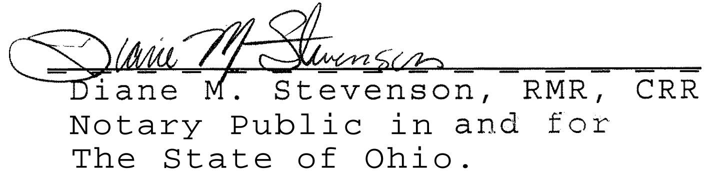
State of Ohio,)
) SS:
County of Cuyahoga.)

I, Diane M. Stevenson, a Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, MATT J. LIKAVEC, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed by means of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony as given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 17th day of June, 1998.



Diane M. Stevenson, RMR, CRR
Notary Public in and for
The State of Ohio.

My Commission expires October 31, 2000.