

1 IN THE COURT OF COMMON PLEAS

2 CUYAHOGA COUNTY, OHIO

Doc. 387

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4  
5 SHARON BRANAND, et al., )

6 Plaintiffs, )

7 vs. )

Case No. 343745

) Judge McDonnell

8 NATALIE C. BLEVINS, )

9 Defendant. )

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11 - - -

12  
13 Deposition of PAUL C. SHIN, M.D., a witness  
14 herein, called by the Plaintiffs for direct  
15 examination pursuant to the Rules of Civil  
16 Procedure, taken before me, Michael Christy, a  
17 Stenographic Reporter and Notary Public in and for  
18 the State of Ohio, at the offices of Paul C. Shin,  
19 M.D., 14601 Detroit Avenue, Lakewood, Ohio, on  
20 Tuesday, the 26th day of May, 1998, at 6:28 o'clock  
21 p.m.

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24  
25

1     APPEARANCES:

2             On Behalf of the Plaintiffs:

3                     Hollister, Leiby, Hanna & Rasnick

4             BY:       Timothy H. Hanna, Attorney at Law  
5                     2100 One Cascade Plaza  
6                     Akron, Ohio 44308

6             On Behalf of the Defendant:

7                     Meyers, Hentemann & Rea Co., L.P.A.

8             BY:       Gerald L. Jeppe, Attorney at Law  
9                     2121 The Superior Building  
10                    Cleveland, Ohio 44114

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EXAMINATIONPAGE

By Mr. Hanna

4, 60

By Mr. Jeppe

42, 65

EXHIBITSMARKED

Plaintiff's

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1                   PAUL C. SHIN, M.D.

2       of lawful age, a witness herein, having been first  
3       duly sworn, as hereinafter certified, deposed and  
4       said as follows:

5                   DIRECT EXAMINATION

6                   (Whereupon, Plaintiff's Exhibits  
7                   2, 3 and 4 were marked for  
8                   purposes of identification.)

9                   MR. HANNA:                   May we  
10       stipulate to the waiving of the filing of the  
11       deposition?

12                   MR. JEPPE:                   Yes.

13       BY MR. HANNA:

14       Q.       Doctor, can you please tell us your name?

15       A.       Name is -- full name is Paul Charles Shin.

16       Q.       And Doctor, what is your profession?

17       A.       Field of anesthesiology with the added  
18       certification in pain management.

19       Q.       And are you licensed to practice medicine in  
20       the state of Ohio?

21       A.       Yes, I am.

22       Q.       And when were you licensed?

23       A.       1991.

24       Q.       And can you please tell us about your medical  
25       education?

1 A. Medical school, allopathic medical school,  
2 Medical College of Ohio in Toledo '86 through 1990,  
3 graduate there; did my internship at The Cleveland  
4 Clinic Foundation and did my anesthesia training, a  
5 residency training, then after that one year of a  
6 special fellowship in pain management.

7 Q. Okay.

8 Do you hold any board certifications?

9 A. Yeah.

10 I'm board-certified in American Board of  
11 Anesthesiology, also board-certified in American  
12 Board of Anesthesiology with added certification in  
13 pain management.

14 Q. And can you tell us what is anesthesiology?

15 A. It's -- actually it's a complex field.

16 Anesthesiology is a field that really deals  
17 with perioperative care, also includes operative  
18 surgical anesthesia, providing anesthesia for people  
19 that are going for surgery; perioperative care  
20 meaning that preoperatively preparing patients for  
21 surgery and anesthesia; and also postoperative  
22 course, which is pain management, acute pain  
23 management as well as other things such as nausea  
24 and other hypertensive.

25 Blood pressure control and all those --

1 oxygenation, those are part of like field of  
2 anesthesia.

3 Q. Okay.

4 And what do you have to do to become  
5 board-certified in anesthesiology?

6 A. Well, you have to go through a four-year  
7 residency program that are accredited by American  
8 College of Graduate Medical Education.

9 Now, you'd have to go through a year of  
10 clinical training and internship, by a three-year  
11 residency that -- that -- it's a discipline that  
12 goes through all different parts of anesthesia which  
13 may include -- or which does include cardiac,  
14 cardiothoracic, obstetrics, pediatrics, general,  
15 vascular, neuroanesthesia, critical care medicine,  
16 also pain management subspecialties.

17 Those rotations, once you were completed those  
18 rotations in satisfactory level and three years of  
19 training, you go through a written board process.

20 Once you're past the written boards, then you  
21 are eligible. Then you have to go through oral  
22 board process; and once you pass the oral board  
23 examination, then you become American Board of  
24 Anesthesiology board-certification.

25 Q. And what additional education do you have to

1 go through to qualify for certification in pain  
2 management?

3 A. Once you've graduated from residency program,  
4 then you apply for a fellowship program and --

5 Q. Now, what does fellowship mean?

6 A. Fellowship means further training, further  
7 special training.

8 These are people that have completed the  
9 residency, so they do have background knowledge,  
10 they know about the field of anesthesia, they know  
11 about some aspect of pain management so they're not  
12 somebody without any clue as to what pain management  
13 is, but they have some background.

14 Those people that are interested in pursuing  
15 that field go in for a one-year fellowship.

16 Q. Doctor, we've already heard comments  
17 concerning different other specialties like  
18 orthopedic surgery and now we've heard of pain  
19 management and anesthesiology.

20 What's the difference between those two  
21 subspecialties, orthopedic surgery and pain  
22 management anesthesiology?

23 A. Well, we work closely with orthopedic  
24 surgeons.

25 When orthopedic surgeons are involved in doing

1 a case in the operating room, for instance, they  
2 have a broken leg, a broken femur or knee  
3 replacement or hip replacement, they require --  
4 patients require anesthesia so we work closely with  
5 the orthopedic surgeons.

6 The orthopedic surgery in general are a  
7 department of surgery, so they're mainly involved in  
8 correcting a surgical lesions which may be a joint  
9 replacements, ligamentous tear such as rotator cuff  
10 tear, broken bone, trauma cases.

11 They're mainly dealing with sports medicine,  
12 mainly dealing with patients who require joint  
13 replacements, but they basically as a field is a  
14 surgical field, so they're really responsible for  
15 surgeries.

16 Q. Okay.

17 And what is the difference between the  
18 subspecialty of orthopedic surgery --

19 A. Uh-huh.

20 Q. -- and your subspecialty of pain management?

21 A. Okay.

22 Pain management is a complex field.

23 Now, it came to -- really into a light -- into  
24 a light that as a specialty in -- back in 1950s and  
25 it's sort of grown kind of slowly, but pain



1 management is a field that are -- that are trained  
2 under anesthesia as well as neurology as well as  
3 physical medicine.

4 People have different approaches about pain  
5 management in general because pain management is a  
6 kind of a loose term.

7 You can almost say it's a pain medicine. It's  
8 like an internal medicine, so it's like a wide  
9 field.

10 People are doing different things. People are  
11 doing invasive procedures, people are doing  
12 treatments with therapy, people are doing treatments  
13 with even just the medication adjustments.

14 So there are different field, but in --  
15 generally in -- what we talk about in pain  
16 management in generally, we talk about the same  
17 thing.

18 It's a pain management. People with chronic  
19 pain, may have an acute pain, cancer pain, people  
20 with a certain types of disease entities like people  
21 with fibromyalgia type of pain and there are  
22 different types of pain out there, but generally  
23 people that are in pain management deal -- they deal  
24 with all different types of pain.

25 Q. Can you tell us what hospitals are you

1 affiliated with?

2 A. I'm affiliated with The Cleveland Clinic  
3 Foundation, I also work at Lakewood Hospital, I also  
4 spend a day at Meridia Huron Hospital as well.

5 Q. And the orthopedic surgeons at The Cleveland  
6 Clinic, are they generally involved in pain  
7 management treatment of patients?

8 A. Traditionally at Cleveland Clinic the postop  
9 pain management after the operation are dealt  
10 with -- dealt by anesthesiologist.

11 So when the surgery is patient's out of the  
12 surgical OR, basically the perioperative  
13 care/postoperative care for pain management is left  
14 to anesthesiologist.

15 So in Cleveland Clinic the anesthesiologist  
16 and the pain management specialist manage  
17 postoperative care.

18 We work closely with them in outpatient. Most  
19 the pain patients, they do not have any clinical  
20 diagnosis or surgical diagnosis are referred to our  
21 clinic for our evaluation.

22 Q. That was my next question.

23 Are there patients that are treated at The  
24 Cleveland Clinic at The Pain Management Center that  
25 are non-orthopedic patients?

1 A. Yes.

2 Q. Okay.

3 Can you explain that to the jury, how you can  
4 have a patient that is treated by doctors such as  
5 yourself who don't have anything to do with  
6 orthopedic surgeons?

7 A. Well, we have at The Cleveland Clinic -- I  
8 can't give you exact figure, but the percentage of  
9 referral from orthopedic departments may be about 30  
10 percent, so 70 other percent **of** the patients are  
11 referred by other services that come to us.

12 They may be through a rheumatologist,  
13 palliative medicine, cancer -- oncologist for cancer  
14 pain, people with prolonged postoperative course  
15 pain that have had surgeries. This may be general  
16 surgery, colorectal surgery, it could be  
17 neurosurgery, plastic surgery.

18 So we have all these referrals, so orthopedic  
19 department isn't the primary referral. They are  
20 part of the referral source, but we do see an array  
21 of patients that are from other departments.

22 Q. Okay.

23 So if you have a patient who has a  
24 non-orthopedic pain syndrome, they would come to a  
25 doctor such as yourself as opposed to an orthopedic

1 surgeon?

2 A. Right.

3 Usually the case is that the patients usually  
4 go to -- go to their physicians in general, their  
5 primary care physicians.

6 Q. Like Dr. Gannon?

7 A. Yeah, absolutely.

8 They go to the primary. In these days with  
9 HMOs they can't come to even a specialist directly,  
10 so they have to be referred by the primary care  
11 physician.

12 So they go to primary care physician, primary  
13 care physician may facilitate some diagnostic  
14 studies.

15 If the patient does not have any specific  
16 disease entities or it's something that can't be  
17 done, then they're -- and they can't put a finger on  
18 exactly what's going on but they're having chronic  
19 pain, they refer to The Pain Center.

20 Q. Okay.

21 And what type of pain management or pain  
22 management syndromes do you deal with?

23 A. Oh, boy. All -- all kinds.

24 I deal with -- my area of interest is a  
25 postlaminectomy syndrome, patients who've had

1 multiple back surgeries yet they have chronic pain.

2 I deal with cancer pain, people with shingles  
3 pain, herpes zoster. You've heard of shingles  
4 pain?

5 People with -- that's a neuropathic pain,  
6 diabetic neuropathy pain, people with just lot --  
7 myofascial type of pain.

8 That is the most -- the frequently seen  
9 patients at our clinic and they do carry diagnosis  
10 myofascial pain and I do see a large number of  
11 patients with a diagnosis with myofascial pain.

12 Subcagatory of myositis, fibrositis,  
13 fibromyalgia, interstitial myositis, these are all  
14 the sort of terms that people have placed in the  
15 past by other specialty groups, but they're really  
16 under the category of myofascial pain syndrome.

17 Q. Myofascial pain syndrome, is that a recognized  
18 medical diagnosis by the doctors here at The  
19 Cleveland Clinic?

20 A. Absolutely.

21 Q. And in the medical community is it recognized  
22 as a --

23 A. Absolutely.

24 Q. There's been some testimony by a doctor who's  
25 going to testify in this case that he considers

1 myofascial pain syndrome a wastebasket term.

2 Would you agree with that?.

3 A. No, I don't agree with that.

4 If I can further explain that, myofascial pain  
5 in general as I mentioned came sort of a new-vogue  
6 term.

7 Like I said, it's a -- it's a classification  
8 of fibromyalgia, myositis, fibrositis and these are  
9 the terms that they've used in past, in the back in  
10 the '60s and '50s and older -- older profession.

11 As we know more about these skeletal injuries  
12 and pain, there are more research and more articles  
13 that are coming out and I think that these weren't  
14 in the textbooks in the '70s or '60s.

15 I think more and more coming out these days  
16 and I think more and more as we explain more of  
17 these pain syndromes, I think the medical  
18 communities are more aware of it and they are --  
19 they are understanding of what this pain process is.

20 Q. We're coming up-to-date.

21 A. Absolutely.

22 Q. Doctor, do you know Sharon Branand?

23 A. Yes, I do.

24 Q. And how do you know Sharon Branand?

25 A. She was a patient of mine that was referred by

1 Dr. Patricia Gannon.

2 Q. And who is Dr. Gannon?

3 A. Dr. Gannon is an internal medicine primary  
4 care physician with The Cleveland Clinic.

5 Q. And Doctor, when did you first see Mrs.  
6 Branand for her condition?

7 A. Believe I saw her March 28th of 1997 and she  
8 was referred by Dr. Gannon with chronic pain  
9 complaints involving the right side upper neck and  
10 upper shoulder area.

11 Q. Okay.

12 Did you take a history at that time?

13 A. **Yes**, I did.

14 Q. And what history were you given?

15 A. She basically stated that she was in the usual  
16 good state of health until she was involved in a  
17 motor vehicular accident where she was a pedestrian,  
18 and that occurred March of 1994, and the patient  
19 stated that initially she had a lot of difficulty  
20 with her pain complaints.

21 She did go having multiple evaluations,  
22 including MRI, the CT scan, the x-rays which were  
23 all negative.

24 She was treated conservatively and then did  
25 well, however, she apparently had a normal pregnancy

1 and just did deliver a healthy baby girl, and after  
2 delivery of her baby and her becoming more active  
3 with housework and taking care of the child, she  
4 apparently had a flareup of her pain symptoms, went  
5 to Dr. Gannon, Dr. Gannon basically referred the  
6 patient to me for further evaluation.

7 Q. And that was on March 28th of '97?

8 A. Uh-huh.

9 Q. And can you please tell us what examinations  
10 you conducted at that time?

11 A. I did rather complete examination.

12 Basically she really at that time was not in  
13 any acute distress.

14 She -- examination of the neck revealed she  
15 had excellent range of motion.

16 Her motor sensory examination of the upper  
17 extremities were really within normal limits.

18 She had good deep tendon reflexes throughout.  
19 They were equal and symmetric.

20 Upon closer examination of the spine, she had  
21 normal alignment of the spine, yet upon palpation  
22 around the -- the superior border of the trapezius  
23 as well as the lateral aspect of the  
24 thoracic/perithoracic musculatures and just medial  
25 to the right scapular area she demonstrated these



1 pain -- painful areas.

2 By palpation, a light palpation of this area  
3 produced similar reproduceable pain that she has  
4 been experiencing.

5 Really otherwise the rest of the examination  
6 really unremarkable.

7 Q. Okay.

8 Doctor, you testified earlier that you were  
9 aware of the fact that she had MRIs and nerve  
10 conduction studies that were normal.

11 A. Uh-huh.

12 Q. What significance did that have to you  
13 relative to a myofascial pain syndrome patient?

14 A. Well, it's -- it's nonrelated in a primary.

15 There are obviously -- there are -- there are  
16 two types of myofascial pain, primary and secondary  
17 what we call it; but by having these CT scan, MRIs  
18 and EMGs, what we're looking for is a surgical  
19 lesion.

20 What we're looking for is a lesion that needs  
21 to be operated, that needs to have intervention  
22 done.

23 By having those things normal and having  
24 her -- having Sharon Branand having persistent pain  
25 symptoms, that adds to a diagnosis of myofascial

1 pain.

2 We know that there is a soft tissue injury,  
3 there is a skeletal muscle injury.

4 In her case it's become a chronic nature where  
5 she has exacerbation of her pain symptoms.

6 So by having those studies are being negative,  
7 nothing -- and having the pain symptoms, that  
8 clearly says that she does have myofascial pain  
9 syndrome.

10 Q. And you also talked about her having an  
11 excellent range of motion and motor function of the  
12 extremities and normal alignment when you saw her on  
13 March 28th, 1997.

14 What if any effect did those findings have on  
15 your diagnosis and treatment of Sharon Branand for  
16 myofascial pain syndrome?

17 A. Basically she was very functional, and let me  
18 get back to other thing.

19 She was breast-feeding her child at that time  
20 and she was very functional, yet some of the things  
21 that she was doing at home were exacerbating her  
22 pain symptoms.

23 And my assessment was that she did have at  
24 that time chronic myofascial pain, that she could be  
25 treated conservatively, and that would be the first

1 thing I usually consider in the patient with  
2 myofascial pain anyway.

3 That would be adjustment of medication, it may  
4 include some nonsteroidal anti-inflammatory, may  
5 require use of the short course of muscle relaxants,  
6 sometimes antidepressants, but also get those  
7 patients into a therapy program.

8 That may include massotherapy, myofascial  
9 release program as **well** as routine physical therapy  
10 evaluation.

11 Q. Doctor, if you could quickly for us so that we  
12 understand the difference between a range of motion  
13 and motor function and alignment versus myofascial  
14 pain, can you explain that to us?

15 A. Yeah.

16 She -- she doesn't have any neurological  
17 findings obviously. She doesn't have any nerve  
18 damage, she doesn't have any findings of that  
19 sensory damage.

20 So there is no loss of functioning, but some  
21 of those -- some of those activities that she does  
22 are limited by the repetitive nature of her -- what  
23 she does.

24 In fact, if she was lifting something,  
25 initially she won't feel any pain, but as she does

1 more and more **of** repetitive type of activity, she'll  
2 have -- basically have worse range of motion because  
3 of the pain.

4 If she rested, went through the program,  
5 whatever, then she would have a regain of full  
6 function again, but the pain is there.

7 Her range of motion may decrease because she  
8 won't **be** able to do the extension or flexion. There  
9 are -- there are normal range of motion.

10 Q. **So** it's almost like a machine.

11 The machine can function, but in a human being  
12 pain will limit the ability to function?

13 A. Absolutely.

14 Q. Okay.

15 Doctor, I have behind you an illustration  
16 that's been marked as Sharon Branand and I believe  
17 it's marked as Plaintiff's Exhibit 3.

18 I've given you a pen here, and if you could  
19 for us, can you mark on that exhibit those areas on  
20 Sharon Branand that you found to be positive for the  
21 myofascial pain syndrome?

22 A. Yeah.

23 Basically she had couple areas of tender  
24 spots, and when she demonstrated the first she came  
25 in, she actually had pain -- the most -- most

1 pronounced over here about -- about this location  
2 here, okay?

3 She also had some mild tenderness just above  
4 this area and also right about this area, but this  
5 was the area of most significant amount of pain that  
6 she had on that -- on that side; and if you look at,  
7 that's the superficial -- looking at this, it's more  
8 superficial musculature -- muscle group.

9 Q. And when we're talking about superficial  
10 muscles, we're talking about those muscle groups  
11 that are closest to the skin?

12 A. Absolutely.

13 Q. Okay.

14 A. There are a number of levels of muscles in the  
15 back and back is very complex.

16 There are a lot of small muscle fibers that  
17 run -- cross transversely as well as this  
18 vertically, but what you see is one level deeper  
19 actually. This is a deeper level.

20 She'd have tenderness that -- that if you were  
21 to correlate with that would be somewhere over here  
22 and the pain also over here and over here.

23 Q. And Doctor, the testing that was done on  
24 Sharon Branand, the MRIs, the x-rays, the EMG  
25 studies, would those studies be specific for the

1 injuries to the muscle groups that you have just  
2 marked on that Plaintiff's Exhibit 3?

3 A. No.

4 Q. Okay.

5 Now, Doctor, based upon your examinations and  
6 the history that you were given on March 28th, 1997,  
7 what was your diagnosis at that point in time?

8 A. My diagnosis at that time was chronic  
9 myofascial pain syndrome with chronic thoracic  
10 strain component.

11 Q. And can you explain that to the jury --

12 A. Well --

13 Q. -- so I can understand it?

14 A. Well, it's a -- it's sort of a -- you know,  
15 once again, this -- the pain symptoms or pain  
16 diagnosis is not a disease entity.

17 These aren't your appendicitis or gastritis.

18 These are something that are part of a  
19 multitude of presentations that make up this  
20 diagnosis of chronic myofascial pain syndrome and  
21 thoracic strain component.

22 Thoracic strain component really is a part of  
23 a myofascial pain syndrome.

24 It's explaining that there was a strain  
25 involved somewhere along the line of the skeletal

1 muscle injury that basically led to myofascial pain  
2 syndrome, but what it really is explaining is that  
3 the patient does have pain symptoms that are really  
4 related to the strain component, which is the  
5 sprain, which is like a stretching or injury of the  
6 skeletal muscle fibers.

7 Q. And is that diagnosis consistent with someone  
8 who's been hit by a car?

9 A. Well, it's by consistent with a trauma.

10 For instance, if you -- if you got a severe  
11 sprain of your ankle, you're going to rupture  
12 tendons and muscles and ligaments.

13 Same thing. If you were hit by something,  
14 even if you ran into something, hit something, you  
15 can have these injuries.

16 So any type of trauma, they may disrupt  
17 skeletal fibers, may lead to chronic myofascial pain  
18 syndrome.

19 Q. Okay.

20 Doctor, I have what's been marked as  
21 Plaintiff's Exhibit 2.

22 Can you tell me what that is and tell me if  
23 that would aid you in explaining this syndrome in  
24 more detail to the jury?

25 A. Well, it looks like this is a -- sort of a --

1 sort of we call it -- we would call it as almost  
2 like a nursing level or layman's level of explaining  
3 what trigger points are and what the myofascial pain  
4 syndrome is.

5 It -- it goes through -- what it -- what it  
6 visualize here is that mostly the muscle fibers.  
7 What you see is all these diagrams of muscle fibers  
8 at different part of the body.

9 What that really explains in trigger point is  
10 that you have skeletal muscle injury.

11 When there's a skeletal muscle injury, what  
12 happens is that there is going to be some scar  
13 tissues that form where there was an injury there.

14 Just like if you cut your skin with a knife,  
15 when it heals back up you're going to have a scar  
16 tissue there.

17 If you ruptured or pulled or strained your  
18 muscle severely, you're going to get these fibrotic  
19 areas of the muscle tissues; and what you're going  
20 to get is some of these deposits, hyalin deposits.

21 These are -- these are fiber deposits. When  
22 you injure a salient component, they're are going to  
23 some excretion these hyalin component.

24 These are like a substance that makes a body  
heal, but they form scar tissue.



1           What happens is that then these -- these  
2 muscles fibers that are normally aligned like this  
3 will have -- that move like with this your  
4 contraction and -- and extension, what happens is  
5 that there's a disruption of these muscle fibers so  
6 that you can't have a normal contraction and  
7 extension activity with the muscle fibers that are  
8 injured.

9       Q.     Doctor, if we look at in more detail  
10 Plaintiff's Exhibit 2, would that help you in  
11 explaining again the superficial and the deep muscle  
12 trigger point aspect of the myofascial pain  
13 syndrome?

14     A.     Yeah.

15           I'm going to just kind of -- since -- I'm  
16 going to go over this just a little bit.

17           Obviously we talked about different --  
18 different groups of muscle levels in the back.

19           What you're seeing is a superficial level  
20 here. That means it's just below the skin, close to  
21 the skin.

22           You can have any -- any part of this along  
23 this muscle fibers you can have disruption.

24           Now, if you were to take this apart and deeper  
25 level -- and I see that you see some deeper levels

1 here -- you do have a muscle fibers that are deeper  
2 by the spine, you also see muscle fibers that are  
3 going across from the spine to the ribs, also see  
4 that you have the muscle that go from the neck to  
5 the scapula.

6 Q. And what is the scapula?

7 A. Scapula is a -- well, is a -- is a bony -- a  
8 bony part of our body that's -- it just lies behind  
9 our shoulder -- I mean our thorax and really it --  
10 it's -- it -- it's -- it's the one that humerus, our  
11 arm is connected to.

12 Q. Shoulder blade?

13 A. Shoulder blade, okay, but -- used to be a  
14 remnants of like wing here. That used to be a  
15 scapula. The bird has a prominent scapula because  
16 they have wings.

17 But there are other groups of muscles here.

18 Now, there are complex -- as complex as there  
19 are, they got rhomboids here, muscles that go from  
20 the spine to the scapula; you have alleviator  
21 scapula that goes from the neck to the scapula; you  
22 have the muscle groups that go across from the  
23 spinous processes to the ribs; and then above that  
24 you have these -- these semi-spinalis muscle groups  
25 that run above that, and these are all involved in

1 our -- our -- our -- our -- the way we stand, our --  
2 our -- the way how we -- how we bend our backs and  
3 all of our mechanics are involved in these muscles  
4 in the back. They're very important.

5 Anything that we -- we do sometimes, it can  
6 injure these back muscles because these muscles are  
7 not ordinarily involved in exercise, see?

8 We exercise the arm, we exercise the legs, but  
9 we never exercise the -- these muscles here.

10 So when we have these injuries, the most  
11 prominent area of myofascial pain is these axis  
12 muscles in the back.

13 Q. Doctor, Sharon Branand has testified that she  
14 doesn't have a constant pain, but that it is  
15 intermittent and is exacerbated by activity and  
16 during her pregnancy, for example, she has stated  
17 that she -- the syndrome almost literally  
18 disappeared.

19 Is that inconsistent with the myofascial pain  
20 syndrome?

21 A. That actually is consistent with myofascial  
22 pain syndrome because these patients do get better  
23 with a -- with an interventions, with physical  
24 therapy and medicine, sometimes with trigger point  
25 injections to the affected areas they have a

1 complete relief of the pain symptoms and they may go  
2 for awhile.

3 It's hard to predict. They may go for weeks  
4 to months to a year.

5 However, something they may do may exacerbate  
6 the symptoms again and you need interventions again,  
7 otherwise you won't know the chronic phase.

8 So really these patients do go into phases  
9 where they do get better with interventions with  
10 therapy and something they do tends to bring this  
11 pain back on.

12 Q. Are there differences in myofascial pain  
13 between the genders, males and females?

14 A. Well, you know, there -- it's more frequent in  
15 females.

16 Q. And why is that?

17 A. We don't know. We really don't know.

18 Now, I can't give you exact numbers.

19 It's not two to one female to male, but it's  
20 more prominent in females.

21 It may be that -- it may be the makeup of  
22 their muscle fibers. Men are -- men tend to have  
23 a -- a sort of a -- much more of a muscle mass so  
24 they're more protecting of -- protectant of  
25 injuries.

1 Women aren't as much, but I can't give you  
2 specific theories on that or reasons behind it.

3 Q. And do you have an opinion why during Sharon  
4 Branand's pregnancy she had an abatement of this  
5 myofascial pain syndrome?

6 MR. JEPPE: Objection.

7 THE WITNESS: Now -- yes.

8 MR. HANNA: Within the  
9 realm of reasonable medical certainty.

10 MR. JEPPE: Objection.

11 MR. HANNA: Go ahead.

12 THE WITNESS: You know, quite  
13 honestly, I can't explain that.

14 The -- it -- it could have been the  
15 inactivity. She was carrying a child so she wasn't  
16 doing a whole lot, she wasn't doing any heavy  
17 lifting maybe.

18 So I can't say why, but -- no -- I can't  
19 really comment on that really why.

20 MR. HANNA: Okay.

21 BY MR. HANNA:

22 Q. Doctor, behind what's been marked as  
23 Plaintiff's Exhibit 3, there's another illustration,  
24 if you can get that out.

25 (Whereupon, a discussion was

1 held off the record.)

2 BY MR. HANNA:

3 Q. And what has been marked as Plaintiff's  
4 Exhibit 4, what is that?

5 A. Well, what it -- what it shows, it's a  
6 microscopic level of muscle fiber.

7 What you see is a -- a -- a muscle bundle.

8 This may be right here, what you see is a huge  
9 thing, might be big like this, okay? It might be  
10 part of our -- our biceps muscle, okay?

11 And what you see is within that big mass of  
12 muscle are smaller groups of muscles and they formed  
13 a contractile component of the muscles, and these  
14 are what contracts so that you can lift something or  
15 you can flex and that's complex -- it's complicated  
16 by the blood vessels.

17 Here is vein, arteries.

18 It has to feed. The muscle has to feed by the  
19 artery so that they can move, oxygenate.

20 Then you got the muscle nerve bundles and  
21 these control contraction, when to contract, when  
22 not to contract, when to relax.

23 Also, these are also involved in our autonomic  
24 control when we're -- we have a flight of flights,  
25 when there is a -- sudden things like we need to run

1 there **is** increase in blood flow to the muscles and  
2 these control in dilating the -- the arteries and  
3 vessels, too, so the blood flow can go.

4 So this is -- this is normal-appearing sort of  
5 a microscopic overview of the muscle fibers.

6 Q. Okay.

7 And how does the muscle fiber again in the  
8 genders differ, you know, male and female?

9 Are the muscle fibers in the female more  
10 susceptible to injury than in males and, if so, why?

11 A. Well, as I mentioned, there is no really a  
12 theory that -- that really -- that points to that,  
13 but we know that in comparison from male to female  
14 the -- the size of the muscle fibers and the number  
15 of these bundles are -- are less in females so that  
16 they're maybe less protectant of the skeletal  
17 injury.

18 Q. Okay.

19 And what effect does trauma have on these  
20 muscle fibers and specifically in Shar n Branand's  
21 case?

22 A. Well, if you -- if you look at this as a  
23 normal muscle fiber, if you were to stretch that,  
24 you were to damage the muscle fibers, what it's  
25 going to have is that what -- you're going to have

1 disruption of this -- these muscle bundles here and,  
2 as I sort of mentioned earlier, this may disrupt the  
3 blood vessels, it may also disrupt muscles deep  
4 inside, may disrupt the nervous tissues here.

5 So what happens is that you have a normal  
6 contracture, but when it's disrupted you have these  
7 deposits of local metabolites to heal this area.

8 So what happens, you get fibrous areas,  
9 fibrotic areas some across to here where it's been  
10 injured and it's not going to contract in a normal  
11 basis.

12 Sometimes may cause muscle spasm from that.

13 Q. Okay.

14 And what effect do these lesions in the muscle  
15 fibers have on the sensory nerves in the muscle?

16 A. It doesn't, but there is a theory -- again  
17 this is hypothesis, is that -- very complex and what  
18 happens again, it -- when you have an injury to a  
19 certain area, acute injury, you're going to have the  
20 8 delta fibers.

21 These nerve fibers will enter the spinal cord  
22 and it's going to go up to the brain and tell the  
23 brain that there is -- there's something going on,  
24 there's pain going on.

25 Now, if you were -- you were to put your hand



1 on a hot stove, you're going to take that apart and  
2 you're going into little -- just a little phase of  
3 sweating, kind of flushing and kind of reaction from  
4 that. Your heart will kind of race a little bit.

5 What happens, same thing. When you have an  
6 injury to one area, you're going to have those nerve  
7 fibers and they'll go to the brain, the brain is  
8 going to say -- send an autonomic message so  
9 something happened there.

10 What happens is that there is a constriction  
11 of blood vessels, there is going to be some sweating  
12 that may be going on, there is going to be some --  
13 some changes that are going on here.

14 Now, what happens in a chronic phase is that  
15 that becomes a circle.

16 You have a stimulus that goes to the brain,  
17 brain tells "There's something going on. Let's  
18 constrict."

19 What happens then is that there is less blood  
20 flow to this area, further injuring it, and it's  
21 called a vicious cycle we call it.

22 It hurt it, it goes up to the brain, brain  
23 says "Something's going on down there. Let's  
24 constrict. Let's -- you know, let's try to protect  
25 ourselves" and that causes more injury sort of.

1 Q. And in --

2 MR. JEPPE: I object and  
3 ask the last answer be stricken from the record  
4 based -- 'cause it's based on theory.

5 Go ahead.

6 BY MR. HANNA:

7 Q. Doctor, and based on this theory, is that part  
8 of why the treatment you deal with behavior of the  
9 patient?

10 MR. JEPPE: Objection.

11 MR. HANNA: Go ahead.

12 You can answer.

13 THE WITNESS: Yes, I **do**.

14 MR. HANNA: Okay.

15 BY MR. HANNA:

16 Q. And tell us what sorts of treatment do you  
17 give patients to prevent those types of reactions in  
18 the muscles from a psychological standpoint, I  
19 guess?

20 A. Well, that's why that in people with  
21 myofascial pain syndrome we frequently treat them  
22 with antidepressants.

23 Antidepressants are -- are -- they work with  
24 the neurotransmitters, they do help to increase the  
25 neurotransmitters that are good and transmitting

1 good messages and depressing those things that are  
2 transmitting bad messages, and these patients do  
3 rather well taking those antidepressants.

4 Q. And these -- this muscle damage theory, was  
5 that a basis for part of your treatment of Sharon  
6 Branand?

7 A. Yes.

8 Q. And how so?

9 A. In terms of directing my care for her?

10 Q. Yes.

11 A. Yes, I did.

12 I'm a -- my recommendation for Sharon Branand  
13 initially when I saw her was that -- that wanted to  
14 optimize the medication, do the therapy; if they  
15 failed, we'll go ahead and do the injections.

16 But injections have some corticosteroids.  
17 Those have some side effects and can with a  
18 lactating mother, she was breast-feeding the child  
19 at that time and that was sort of contraindicated so  
20 we decided to go with the more conservative route  
21 of -- of just physical therapy, no medications.

22 Q. Okay.

23 Doctor, in April of 1997 Mrs. Branand was  
24 prescribed a TENS unit.

25 A. Uh-huh.

1 Q. What is a TENS unit?

2 A. TENS unit is a -- is a device called a  
3 transcutaneous electro -- you know, I can't -- I  
4 can't recall right now, but there is -- it's a long  
5 term for it.

6 Physical therapists, rehabilitation medicine  
7 have used it for many, many years.

8 What it is, is that it's an electrical  
9 stimulation just like as though based upon a therapy  
10 of rubbing an area of the body that hurts and you  
11 apply these TENS unit little pads to the area that's  
12 painful and you turn on these electrical  
13 stimulations.

14 What it does is that gives you electrical  
15 stimulation, vibration stimulation of that area.

16 Theoretically it's supposed to release  
17 metabolites and theoretically it's supposed to be  
18 similar to like an acupuncture by going deeper into  
19 the tissue and disrupting, but mainly we feel as  
20 though TENS unit's for like a rubbing effect for  
21 temporary relief of pain symptoms.

22 Q. And if we look at Plaintiff's Exhibit 4 again,  
23 the muscle fibers, what does the TENS unit  
24 theoretically do to those muscle fibers during its  
25 treatment?

1     **A.**     Well, let me tell you about myofascial pain.

2             Once you have the scar tissue there, it's  
3 going to be there for forever, okay?

4             Myofascial pain, there is no definitive  
5 treatment for it.

6             It's not like as if you have an appendicitis,  
7 you take it out, it's gone.

8             What you're trying to do is you -- you try **to**  
9 control the symptomatic pain. So it's a symptom  
10 control really.

11            So what you're doing -- we're trying to do  
12 with a **TENS** unit is that you apply that to the skin  
13 level and -- and it -- for -- for instance, there is  
14 going to be a lot of metabolite buildup here, you're  
15 going to have some fibrotic tissues there.

16            You're going to have a difficulty moving that  
17 and spasm does occur from that; and if you put **TENS**  
18 unit on it, theoretically it's going to go in there  
19 and stimulate that area and loosen that up so that  
20 the muscle spasm is less.

21     **Q.**     And did you find that that helped Sharon  
22 Branand in this case?

23     **A.**     You know, I think that she had tried to fit a  
24 **TENS** unit for her and she did follow back and felt  
25 that **TENS** unit was maybe a moderate level of

1 improvement but wasn't the significant improvement.

2 Q. And the records indicate that in June of 1997  
3 Mrs. Branand was then referred to physical therapy.

4 A. Uh-huh.

5 Q. Who referred her to physical therapy?

6 A. Once again, where -- which one?

7 Q. I think it was in June of 1997 over at  
8 Lakewood Hospital.

9 A. That was me.

10 Q. Okay.

11 And why did you do that?

12 A. The reason I did that was I want her to get  
13 involved in a myofascial release program.

14 These -- these are a sort of subcategory of  
15 physical therapy maneuvers that they do for people  
16 with myofascial pain, basically for soft tissue  
17 injuries and skeletal injuries.

18 Myofascial pain is really releasing that  
19 muscle of tension. So that the spasm is there, they  
20 do certain maneuvers to stretch that out.

21 They spend half their session stretching the  
22 muscles, then the other half of the session is doing  
23 range of motion and strengthening.

24 Q. Okay.

25 It also indicates that in August of 1997 Mrs.

1 Branand was referred over to Stephanie Pritts.

2 A. Uh-huh.

3 Q. Who is Stephanie Pritts?

4 A. Stephanie Pritts is a -- is physical --  
5 licensed physical therapist who has a -- sort of a  
6 private office in Lakewood.

7 I have actually recommended Stephanie Pritts  
8 to Sharon Branand.

9 Q. And why was that?

10 A. Because I have used her in the past with  
11 excellent success with people with myofascial pain  
12 syndrome.

13 Q. Okay.

14 And do you know what Stephanie did for Sharon?

15 A. I did get a report for -- from Stephanie  
16 Pritts and I don't know the details of her program,  
17 but mainly dealt with a myofascial release, which  
18 does mean that it's releasing the muscles, and then  
19 working with range of motion and, in fact, that the  
20 report that I remember -- recall was that it was  
21 positive, that it was working for her.

22 Q. Good.

23 Now, Doctor, based upon everything that we've  
24 heard and up through today, what is your final  
25 diagnosis of Sharon Branand?

1 A. Well, she has a chronic myofascial pain  
2 syndrome.

3 Q. And Dr. Shin, throughout your testimony now  
4 I'm going to be asking you questions where I'll be  
5 asking you to express opinions.

6 When you render opinions in the case, I want  
7 you to base those opinions upon your education,  
8 training and expertise in anesthesiology and pain  
9 management.

10 I also want you to base your opinions on the  
11 history given to you by Mrs. Branand, the  
12 physical -- and the physical examinations you  
13 conducted.

14 Furthermore, I want you to express your  
15 opinions within the realms of reasonable medical  
16 certainty.

17 Do you understand what I'm asking?

18 A. Yes, I do.

19 Q. Okay.

20 Doctor, do you have an opinion within the  
21 realm of reasonable medical certainty as to whether  
22 or not Mrs. Branand's myofascial pain syndrome which  
23 you diagnosed and just described was a direct and  
24 proximate result of her being hit by a car on March  
25 2nd, 1994?



1 A. Yes, I do.

2 Q. And what is that opinion?

3 A. The opinion is that the -- that the -- the  
4 accident itself initiated her initial injury that  
5 led to the chronic phase or chronic myofascial pain  
6 symptoms.

7 Q. And Doctor, do you have an opinion within the  
8 realm of reasonable medical certainty as to whether  
9 or not Mrs. Branand's myofascial pain syndrome which  
10 was caused by her being hit by a car on March 2nd,  
11 1994 is a permanent condition?

12 MR. JEPPE: Objection.

13 MR. HANNA: You can answer.

14 THE WITNESS: Yes.

15 As I mentioned earlier, that these patients  
16 have cycles and she may do great for a period of  
17 time, it may return, and these are almost a sort of  
18 a permanent damage and they do -- she can do great  
19 for awhile but, again, she may have a recurrence of  
20 pain symptoms by doing something that she -- lifting  
21 a child or lifting something or doing something  
22 strenuous.

23 BY MR. HANNA:

24 Q. And this is something she can expect for the  
25 rest of her life within the realm --

1 A. Absolutely.

2 MR. JEPPE: Objection.

3 MR. HANNA: -- of

4 reasonable medical certainty?

5 MR. JEPPE: Objection.

6 THE WITNESS: Absolutely.

7 MR. HANNA: Okay.

8 That's all I have, Doctor. Thank you very  
9 much.

10 CROSS-EXAMINATION

11 BY MR. JEPPE:

12 Q. Doctor, my name is Jerry Jeppe and I want to  
13 ask you a few questions about your direct  
14 examination here today.

15 First of all, you have used some charts in  
16 your direct examination.

17 Did you prepare those charts, sir?

18 A. No.

19 Q. Do you have those charts in your office?

20 A. No.

21 Q. You don't use those charts for teaching I take  
22 it?

23 A. No, I don't.

24 Q. Where did they come from, sir?

25 A. Well, they came from the -- they came from you

1 guys.

2 Q. Did they come from me?

3 Did they come from me?

4 A. To you -- from you?

5 Q. Did I give you those charts, Doctor?

6 A. No, you didn't.

7 Q. Who gave you those charts, sir?

8 A. Mr. Hanna did.

9 Q. Thank you.

10 Now, Doctor, we're dealing here I believe --  
11 and correct me if I'm wrong -- with a strain-type  
12 injury?

13 A. Uh-huh.

14 Q. Is that correct?

15 A. That's correct.

16 Q. I note that in the visit of August the 8th of  
17 1997, you state here "Mrs. Sharon Branand has  
18 chronic upper back pain secondary to whiplash-like  
19 injury in the past."

20 A. Uh-huh.

21 Q. What were you referring -- referring to as  
22 secondary to whiplash-type injury in the past?

23 A. Well, you know, whiplash injury still is -- I  
24 think is a -- sort of a general term.

25 Q. Uh-huh.

1 A. Whiplash could be either forward to extension  
2 or it could be lateral, to the side, and I felt that  
3 because she was not getting better and the fact that  
4 from what I can gather from the information how she  
5 was involved in this accident, that if she was hit  
6 by the side she's going to have a flexion -- or not  
7 a flexion, but sort of a rotation type of injury.

8 Q. A side-to-side type of injury?

9 A. A side to side.

10 Q. All right.

11 That's what I was trying to get at here.

12 So the accident that you're referring to in  
13 the past --

14 A. Uh-huh.

15 Q. -- or the whiplash injury was the accident of  
16 March the 2nd of 1994?

17 A. Yes.

18 Q. All right. Thank you.

19 I just wanted to clear that up.

20 Throughout The Cleveland Clinic records, they  
21 use the term fibromyalgia --

22 A. Uh-huh.

23 Q. -- in describing Sharon Branand's condition.  
24 You used the term myofascial pain syndrome.

25 A. Uh-huh.

1 Q. Are they one and the same or are they  
2 different?

3 A. Well, they're actually one and the same.

4 The -- the fibromyalgia is commonly-used  
5 term. It's more commonly used than myofascial pain.

6 People have always referred, especially the  
7 physicians -- primary care physicians referred this  
8 type of myofascial pain as fibromyalgia in the  
9 past.

10 Fibromyalgia is a myofascial pain, but it has  
11 to occur in more than one area. It has to be  
12 diffuse throughout your body, different parts of the  
13 body to make up the diagnosis of fibromyalgia.

14 Q. As I understand it -- and maybe I'm incorrect  
15 here -- a lot of physicians use the term  
16 fibromyalgia in a general sort of way in relating to  
17 all types or different types of pain syndromes such  
18 as myofascial pain syndrome.

19 Is that correct?

20 A. Let me -- yes, in a way.

21 Let me -- let me -- let me kind of explain  
22 that and -- and why they do so.

23 It's a -- it's a sort of a -- it's an entity  
24 that's misunderstood by a lot of people and the  
25 fibromyalgia by definition really is the -- is a

1 painful area of the skeletal muscles and the fascia  
2 that lies over the muscle.

3 So it's just like saying that you are having  
4 an inflammation of the muscle.

5 Q. Is fibromyalgia -- excuse me.

6 Is fibromyalgia an inflammation?

7 A. Well, what I'm saying is that that's like  
8 saying you have an inflammation of the muscle.

9 Q. Okay.

10 But if --

11 A. That's what you were actually kind of people  
12 are referring to.

13 If you have pain in a certain area of the  
14 muscle, soft tissue, skeletal pain, generally at  
15 different part of the areas people tend to call it  
16 fibromyalgia.

17 Now, there is no diagnostic studies for that.

18 I mean, you can't get a lab report, you  
19 can't -- you can't get MRI imaging.

20 These are just purely by physical examination  
21 and findings on examination.

22 Q. By -- by findings, what do you mean, sir?

23 A. Findings mean that -- fibromyalgia is that  
24 tender -- a focal area of tenderness in different  
25 part of the body overlying -- overlying by the

1 muscles.

2 So these are the muscular areas. Not so much  
3 as you're pressing on a bone that hurts, but these  
4 are muscle groups you're pressing on.

5 Q. When diagnosing -- let's say -- let's call  
6 it -- no, let's not call it fibromyalgia.

7 Let's call it myofascial pain syndrome.

8 A. Okay.

9 Q. Okay?

10 When diagnosing that in Mrs. Branand --  
11 Branand's case, other than symptoms that she gives  
12 you of pain or tenderness -

13 A. Uh-huh.

14 Q. -- what objectively is there for the diagnosis  
15 of that particular syndrome?

16 A. There is no objective test to -- to diagnose  
17 that. The objective test is -- is an examination.

18 In -- in our medical notes when patients  
19 complain of something, that's a subjective  
20 complaint.

21 When we do the examination, that's an  
22 objective component of --

23 Q. So Mrs. Branand --

24 A. -- f the exam.

25 Q. -- tells "That hurts in that place" or "It's

1 tender here," "It's tender there," and your physical  
2 examination, you put that all together, you arrive  
3 at a diagnosis of myofascial pain syndrome?

4 A. Uh-huh.

5 Q. But no objective findings of any injury?

6 A. Well, the history, there is a history of  
7 injury.

8 Usually patients present with some type of  
9 history of injury or trauma.

10 Q. But history is something given to you by the  
11 patient, too, is it not?

12 A. Absolutely.

13 Q. Let's talk about history for a second.

14 A. Uh-huh.

15 Q. Is the history that's given to you by the  
16 patient important to you in arriving at a diagnosis?

17 A. Yes, it is.

18 Q. Could you tell the jury why?

19 A. Well, because the nature of the injury is that  
20 you do not have any objective criteria.

21 That means that we're -- we don't have the **MRI**  
22 or **CT** scan, x-rays that show that there is something  
23 going on.

24 You do have to take close -- closer history of  
25 what has happened, what has been going **on**, where is



1 the pain, what kind of pain is it, when do they come  
2 about, how do they go away.

3 Those are all important in accumulating with  
4 the examination process to come up with the  
5 diagnosis of myofascial pain.

6 Q. Okay.

7 And that history is supplied by the patient?

8 A. Yes.

9 Q. All right.

10 Now, in Mrs. Branand's case, did you review  
11 any medical records with regards to injuries she may  
12 have sustained in the accident of March the 2nd of  
13 1994?

14 As an example, did you review any medical  
15 records from the emergency room?

16 A. No, I did not.

17 Q. Did you review any medical records with  
18 regards to Mrs. Branand from Kaiser Permanente?

19 A. No, I did not.

20 Q. Or any other physician or hospital?

21 A. No.

22 Q. Obviously 'cause all the diagnostic studies,  
23 the MRIs, the x-rays, the EMGs, the CAT scans are  
24 always normal, so there's really no reason to review  
25 those?

1 A. Right.

2 She was actually -- the only source of  
3 information I got was the assessment by Dr. Gannon.

4 I didn't have any other information on Sharon  
5 Branand when she presented to me.

6 Q. You said one place in your notes or maybe it  
7 was in your report, Doctor -- it was in your  
8 report.

9 It says "Mrs. Branand presented with a  
10 longstanding history of upper back pain."

11 A. Uh-huh.

12 Q. Now, what did you mean by a longstanding  
13 history of upper back pain?

14 A. Well, that again is a general -- sort of  
15 general statement. It's my style of dictating.

16 Q. Were you referring to any injury or pain prior  
17 to the accident of March the 2nd of 1994?

18 A. Prior to it?

19 No.

20 Q. Okay.

21 Did she give you any history of being involved  
22 in any accidents or having problems with her upper  
23 back or neck or shoulder area, right shoulder area  
24 prior to March the 2nd of 1994?

25 A. No.

1 Q. Did you ask her about prior history with  
2 regards to injury?

3 A. Yes, I did.

4 Q. And did -- did she say anything to you or what  
5 did she say to you about injury?

6 A. She was as I -- she was in good health prior  
7 to and she was -- she never had a history of back  
8 pain prior to the -- the accident.

9 Q. I notice also in the second page of your  
10 report it says -- it's the report dated June the  
11 24th of 1997?

12 A. Uh-huh.

13 Q. Do you have a copy of that, sir?

14 A. Yep.

15 Second page?

16 Q. Yeah, second page.

17 It's the first full paragraph on that page.

18 It says "My impression is the patient does  
19 suffer from chronic myofascial pain syndrome with a  
20 chronic thoracic strain component."

21 You've testified to that already?

22 A. Uh-huh.

23 Q. Okay.

24 "Without any reported preexisting conditions  
25 prior to the motor vehicle accident of March the

1 2nd, 1994, the patient's soft tissue injury --" is  
2 that myofascial pain syndrome?

3 A. Right.

4 Q. "-- soft tissue injury is probably the result  
5 of the motor vehicle accident of March the 2nd of  
6 1994."

7 A. Uh-huh.

8 Q. Now, Doctor, I want to tell you that back on  
9 September the 6th of 1992 --

10 A. Uh-huh.

11 Q. -- that Sharon Branand was involved in a motor  
12 vehicle accident, injured her neck and upper back  
13 and was treated for that condition; and on September  
14 the 17th of 1992, about 11 days after that, she went  
15 back to the hospital complaining of tingling in the  
16 right arm.

17 I also further want to advise you that Sharon  
18 Branand and was treated at Kaiser Hospital on  
19 February 11th, 1993 complaining that she had put her  
20 back out at work, had upper back pain, difficulty in  
21 moving her neck or torso and pain in the arms.

22 Now, assuming that history is correct, would  
23 you still have -- be of the same opinion that the  
24 myofascial pain syndrome was in fact the direct and  
25 proximate result of the motor vehicle accident of

1 March the 2nd of 1994?

2 MR. HANNA: Show an  
3 objection.

4 THE WITNESS: Well, first of  
5 all, I don't have any clear sort of report on that,  
6 exactly what had happened.

7 In the -- in -- in looking at the -- I would  
8 probably need to review some of the, again, history  
9 and closer pain symptoms with her, what kind of pain  
10 she's had and at what point she got better, which  
11 she did get better.

12 Those are very important in trying to  
13 determine what the source is.

14 BY MR. JEPPE:

15 Q. Were you given any of those records to review,  
16 sir?

17 A. Nope.

18 Q. Would they have been beneficial to you, if you  
19 had had those records?

20 A. Absolutely.

21 Q. All right. Thank you, sir.

22 I note also here that have on page to 2 in the  
23 following paragraph "The patient's diagnosis --"  
24 excuse me.

25 "The patient's prognosis --"

1 A. Uh-huh.

2 Q. "-- is good."

3 A. Right.

4 Q. Is that correct?

5 A. Yes.

6 I mean, that's again sort of what we say good  
7 meaning she's functional.

8 She doesn't have a loss of limb, she doesn't  
9 have a loss of motor function.

10 She can probably lead a normal daily  
11 activities and lifestyle until she has  
12 exacerbation. Then -- then she needs to have  
13 interventions to get that better, but still the  
14 prognosis is good.

15 Q. Finally, in the very last paragraph on that  
16 page, and correct me if I'm wrong on this, but it  
17 appears that a lot of what you are testifying here  
18 today is speculative in nature.

19 As an example, it says "These symptoms may  
20 persist as a chronic phase with acute exacerbation  
21 stages -- exacerbation stages. These acute  
22 exacerbations may bring about secondary to increased  
23 activity such as heavy lifting," and it goes on to  
24 say "If the patient will continue --" no, "The  
2E patient will continue to require intervention with

1 physical therapy and possibly injection," et  
2 cetera, "if these acute exacerbation stages do not  
3 respond to conservative approach."

4 I guess, Doctor, am I not correct that you're  
5 saying if this happens --

6 A. Yeah.

7 Q. -- if this happens or this may happen or it  
8 may not?

9 A. Yeah.

10 Q. This doesn't seem to be based upon a  
11 reasonable degree of medical probability.

12 A. Well, you know --

13 MR. HANNA: Show an  
14 objection.

15 THE WITNESS: You know, we --  
16 that's our style, I think, and -- and I think that  
17 all of these sort of -- the way we word certain  
18 things is -- is from our informed consent.

19 Something may happen, something may not  
20 happen, there's a chance of one in a hundred million  
21 that it can happen.

22 So we do put these things down because it may  
23 happen with one activity, may not happen at that  
24 session, but later on when she did the same -- she  
25 does the same thing it may happen again.

1           So it's just that you have to kind of put that  
2 down is that it may not be the case each and every  
3 time that she does that.

4 **BY MR. JEPPE:**

5 Q.       She may go for years and not have any  
6 exacerbations?

7 A.       She may. She may -- she may do that.

8           If she's away from doing certain activities  
9 that may exacerbate the symptoms, then she may go  
10 for -- for awhile, years without the symptoms.

11          But I think that she has already demonstrated  
12 that she does things of lifting things like sort of  
13 the daily routine activity that she does have  
14 exacerbation of pain.

15 Q.       Now, Doctor, do you also -- when did you first  
16 see her, by the way?

17 A.       I saw her March 28th of '97.

18 Q.       '97?

19 A.       Yeah.

20 Q.       Did you also ask her about any other injuries  
21 that she may have sustained to these areas of her  
22 body since the motor vehicle accident on March the  
23 2nd of 1994?

24 A.       Yes, I did.

25 Q.       And did she say anything about any subsequent



1 injuries to these areas of her body?

2 A. Nope.

3 Q. Did she -- excuse me.

4 Did she say anything to you about an injury on  
5 December the 20th of 1995 wherein she sustained a  
6 sprain/straining-type injury of the upper cervical  
7 and upper thoracic spine?

8 A. Huh-uh.

9 Q. Anything like that?

10 A. Huh-uh.

11 MR. HANNA: Show an  
12 objection.

13 THE WITNESS: Yeah, I don't  
14 have that information.

15 MR. JEPPE: No, no.

16 THE WITNESS: Well, she  
17 didn't -- she didn't present with that information  
18 to me.

19 BY MR. JEPPE:

20 Q. Did she give you that -- did she give you that  
21 history?

22 A. She did not.

23 Q. Did you ever have Dr. Betor's records to  
24 review?

25 A. No, I didn't.

1 MR. HANNA: Show an  
2 objection, move to strike that; any reference to Dr.  
3 Betor.

4 BY MR. JEPPE:

5 Q. Okay.

6 Now, on physical examination, and again from  
7 what I can gather here, she was in no acute  
8 distress, correct?

9 A. Uh-huh.

10 Q. Excellent range of motion in the neck --

11 A. Uh-huh.

12 Q. -- correct?

13 She did not demonstrate any specific localized  
14 tenderness in the spine --

15 A. Uh-huh.

16 Q. -- correct?

17 Spine had normal alignment?

18 A. Uh-huh.

19 Q. Range of motion of the upper extremities,  
20 shoulder, elbow and wrist were fully intact?

21 A. Uh-huh.

22 Q. Motor exam normal, correct?

23 A. Uh-huh.

24 Q. Sensory exam normal?

25 A. Uh-huh.

1 Q. Reflexes normal?

2 A. Uh-huh.

3 Q. No atrophy?

4 A. Uh-huh.

5 Q. Is atrophy important to you?

6 A. Yeah, because, again, these are -- these are  
7 the examination that I'm performing to rule out  
8 neurological problems, other impending problems that  
9 may need surgery, may need other interventions.

10 She did have normal -- really normal physical  
11 examination and the -- the only abnormality she had  
12 was tender areas.

13 Q. One second.

14 MR. JEPPE: Can I go off  
15 the record a second?

16 (Whereupon, a discussion was  
17 held off the record.)

18 BY MR. JEPPE:

19 Q. Doctor, would you agree or disagree with the  
20 statement I'm about to read to you?

21 "It is often suggested in medical/legal cases  
22 that the claimant's fibromyalgia or myofascial pain  
23 syndrome is related to a motor vehicle accident or  
24 some other trauma. In view of the fact that both  
25 the etiology and the pathogenesis of fibromyalgia

1 and myofascial pain syndrome is unknown to science,  
2 such statements are no more than a speculation based  
3 on no scientific evidence."

4 MR. HANNA: Objection.

5 BY MR. JEPPE:

6 Q. Would you agree or disagree with that  
7 statement?

8 A. I disagree with that and -- 'cause I do see a  
9 significant number of patients that are not involved  
10 in motor vehicular accidents they do have myofascial  
11 pain.

12 Q. Okay.

13 One more -- one second, please.

14 I have nothing further, Doctor. Thank you.

15 REDIRECT EXAMINATION

16 BY MR. HANNA:

17 Q. Doctor, Mr. Jeppe asked you questions  
18 concerning a motor vehicle accident Sharon Branand  
19 was involved in on September 6th, 1992 and symptoms  
20 of tingling in the right arm she complained of in  
21 September 17th of 1992.

22 Assuming that that was an acute event and it  
23 resolved before this motor vehicle/pedestrian  
24 accident on March 2nd, 1994, what if any effect  
25 would that -- those facts have on your opinions in

2  
1 this case?

2 A. What we look for -- what we look for is a  
3 recurrence of pain symptoms.

4 Just like if you have a sprained ankle and you  
5 walk on it, you get better.

6 You've had sprained ankle, it got better but,  
7 unfortunately, there are times when you have a  
8 sprained ankle that became chronic, sort of a  
9 chronic nature or chronic injury, so really needs to  
10 have a -- I think that we -- you know, I have to  
11 focus on the patient's presentation and examination  
12 at that time that I see the patient.

13 So, you know, for my opinion, I can't say that  
14 that 1992 accident, that led to her chronic  
15 myofascial pain syndrome but, however, with her --  
16 with -- with the history that you've given me at  
17 this point and the fact that it wasn't a recurrence  
18 of pain symptoms, it could -- you know, most likely  
19 it could have been an isolated incident.

20 Q. Okay.

21 And assuming that it was an isolated incident,  
22 what effect would that have on your opinions  
23 concerning her myofascial pain syndrome in this  
24 case?

25 A. Well, it's -- it's different.

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accident --

A. Uh-huh.

Q. -- what effect if any would that have on your  
opinions in this case?

A. Well, she didn't complain of any -- any of  
this tingling sensation or that -- that -- this type  
of symptoms when she presented to me.

She really presented with a sort of a focal  
tender spots in the upper trapezius area so I would  
say that it's different.

Q. Okay.

1           What effect if any does a lack of atrophy or a  
2   finding of atrophy have on your opinions regarding  
3   Mr. Branand's myofascial pain syndrome?

4   A.     Well, again, that -- that you may have  
5   atrophy, you have a lack of use of the muscle group.

6           With these particular patients you can get  
7   atrophy, but at the same time you can get muscle  
8   spasm.

9           When you get muscle spasm, you have more  
10   prominent muscular area where you have the pain; and  
11   typically with people with trigger point areas you  
12   may be able to feel -- you may be able to feel by  
13   tactile sensation this is a little knotty area in  
14   that -- in that region of pain.

15          So you could have a muscle spasm, chronic  
16   contracture of that muscle so that you may not see  
17   any atrophy at all.

18   Q.     So is a finding or a lack of a finding of an  
19   atrophy specific for ruling out myofascial pain  
20   syndrome?

21   A.     No.

22   Q.     Okay.

23          And if she complained of a sprain or strain in  
24   December of '95 and that was a short-lived thing,  
25   does that have any effect on your opinions

1 concerning her chronic myofascial pain syndrome?

2 A. Let me -- why don't you restate that  
3 question -- I mean the --

4 Q. Yeah.

5 A. -- question again.

6 Q. I think Mr. Jeppe asked you concerning a  
7 complaint to Dr. Betor in December 20th, 1995  
8 concerning a pain in her upper back, and I don't  
9 remember exactly what the details were.

10 But if that was a short-lived thing, an  
11 isolated incident, what effect would that have on  
12 your opinion concerning the chronic myofascial pain  
13 syndrome you diagnosed?

14 A. Well, it would have little and I have to say  
15 that. This is important.

16 These myofascial pains are -- syndrome are --  
17 they occur consistently in the same area.

18 So the physical examination, today you examine  
19 the patient, down the road five years later when she  
20 have recurrence she would have the area of the pain  
21 that's very same, so these -- these have to be  
22 consistent.

23 Q. Okay.

24 What if the pain to Dr. Betor, the complaint  
25 of pain to Dr. Betor was in a different area than



1 the myofascial pain syndrome that you diagnosed?

2 A. Then it's a -- I think then it's different  
3 from what she presents it with in the past and what  
4 she presented with in -- in '97.

5 Q. So unless these extraneous events are in  
6 exactly the same areas that you diagnose the  
7 myofascial pain syndrome, they have nothing to do  
8 with that myofascial pain syndrome diagnosis that  
9 you have?

10 A. Right, unless it was -- you know, was it  
11 diagnosed?

12 Was that diagnosed with myofascial pain  
13 syndrome in the past?

14 Unless, again, that it was -- occurred in the  
15 same area with the persistence and recurrence of  
16 similar fashion, that you'd have to -- it has to be  
17 different.

18 Q. Thank you, Doctor. That's all I have.

19 A. Okay.

20 RECROSS-EXAMINATION

21 BY MR. JEPPE:

22 Q. Just one question.

23 Doctor, she never gave you a history of any  
24 prior or subsequent injuries to those areas of the  
25 body even though you asked her; isn't that correct?

1 A. That's correct.

2 Q. Thank you.

3 I have nothing further.

4 (Thereupon, the deposition was  
5 concluded at 7:35 o'clock p.m.)

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C E R T I F I C A T E

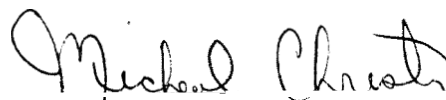
STATE OF OHIO,       )  
                              )   SS:  
COUNTY OF SUMMIT, )

I, Michael Christy, a Stenographic Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, PAUL C. SHIN, 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 prepared and produced by means of computer-aided transcription and that the foregoing is a true and correct transcription of the testimony so 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, counsel 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 Akron, Ohio, on this 1st day of June, 1998.



Michael Christy, Stenographic  
Reporter and Notary Public  
in and for the State of Ohio.

My commission expires February 12, 2002.

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